National Medicaid Fee-For-Service (FFS) 2019 Drug Utilization Review (DUR) Annual Report

Executive Summary
National Medicaid Drug Utilization Review (DUR)
Federal Fiscal Year (FFY) 2020
Fee-For-Service (FFS) Annual Report
(FFY 2019 Data: October 2018-September 2019)

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, 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.

I. Demographic Information

All states, including the District of Columbia, have submitted a FFY 2020 Medicaid DUR Annual Survey encompassing FFY 2019 reported responses.[2] The information in this report is focused on national Medicaid FFS DUR activities.

- FFY 2019 reported responses include 22,020,013 beneficiaries (30%) enrolled in national FFS Medicaid programs and 53,221,573 beneficiaries (70%) enrolled in national Medicaid Managed Care programs. This represents a 1% beneficiary increase in enrollment for both the FFS and the MCO programs from FFY 2018.

II. Prospective DUR (ProDUR)

ProDUR functions are performed at the point-of-sale (POS) when the prescription is being processed at the pharmacy.

- FFY 2019 reported responses show 47 states (94%) continue to contract with an outside vendor to process their POS claims, and that 3 states (6%) process their own claims, consistent with FFY 2018.
- ProDUR criteria approval by the state DUR board, as reported in FFY 2018, remains consistent with FFY 2019 reported responses with 32 states (64%) requiring their DUR boards to approve all ProDUR criteria as 18 states (36%) utilize other resources.

[1] All data presented within these reports originate from state responses to the FFY 2019 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.

- FFY 2019 reported responses confirm all states set early prescription refill thresholds as a way of preventing prescriptions from being over utilized:
    - Non-controlled substances: State reported thresholds range from 75% to 93% of a prescription being used, with a national average of 80% of the prescription being used, before a prescription could be refilled, consistent with FFY 2018.
    - Controlled substances (CIII to CV): State reported thresholds range from 75% to 95% of a prescription being used, with a national average of 85% of the prescription being used, before a prescription could be refilled, a 1% increase from FFY 2018.
    - Controlled substances (CII): State reported thresholds range from 75% to 100% of a prescription being used, with a national average of 86% of the prescription being used, before a new prescription can be filled, a 1% increase from FFY 2018.
- In FFY 2019 reported responses, 23 states (46%) utilize a system-accumulation edit as part of their ProDUR edits for preventing early prescription refills as 15 states (30%) plan to implement this edit in the future. This is a 53% increase of states planning to implement this edit from FFY 2018.

III. Retrospective DUR (RetroDUR)

The RetroDUR process allows states to use evidence-based literature, clinical data, and existing guidelines, to evaluate patients' prescription data to identify patterns of clinical concerns. These functions reside primarily with a state vendor in 35 states (70%) and with an academic institution in 11 states (22%). The remainder of the states utilize a combination 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. FFY 2019 reported responses confirm that all 50 states utilize their DUR Board to review/approve RetroDUR criteria while additionally, 13 states (26%) use multiple resources for RetroDUR criteria review/approval.

IV. DUR Board Activity

Each state establishes a DUR board responsible for application, review, evaluation, and re-evaluation of DUR standards, reviews and interventions on an ongoing basis. DUR boards are comprised of physicians, pharmacists and members of the public. These boards on an average meet quarterly and are open to the public. All states provided a summary of their DUR Board activities. Based on FFY 2019 reported responses, 7 states (14%) reported utilization of a Medication Therapy Management (MTM) program, a professional service provided by pharmacists, as 15 states (35%) have plans to implement an MTM program in the future.

V. Physician Administered Drugs

Physician-administered drugs are drugs, other than vaccines, that are covered outpatient drugs under section 1927(k)(2) of the Social Security Act, and are typically administered by a medical professional in a physician's office or other outpatient clinical setting. According to FFY 2019 reported responses, 16 states (32%) have incorporated physician administered drugs into DUR criteria for ProDUR reviews, an increase of 1% from FFY 2018, as 11 states (32%) plan to incorporate these drugs in the future. Additionally, 19 states (38%) have incorporated physician administered drugs into their DUR criteria for RetroDUR reviews, while 10 states (32%) plan to incorporate these drugs in their RetroDUR reviews the future.

VI. Generic Policy and Utilization Data

In an ongoing effort to reduce spending on prescription drugs, states continue to encourage the use of lower-cost generic drugs. The national percent average for generic utilization rate was 82%, consistent with FFY 2018. FFY 2019 reported responses confirm that many states base decisions of "brand-versus-generic" product preferred status on the net cost of the drug to the state, taking into consideration federal and

supplemental rebate dollars on brand and generics.

VII. Program Evaluation / Cost Savings / Cost Avoidance

All states reported their ProDUR, RetroDUR and other program cost savings/cost avoidance in addition to their estimated percent impact. Detailed state responses for FFY 2019 can be accessed under *State FFS Individual Reports* on Medicaid.gov.

VIII. 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. According to the responses, 46 states (92%) have a Lock-In program for beneficiaries, consistent with FFY 2018. Additionally, 28 states (61%) restrict beneficiaries to a specific prescriber and 37 states (80%) restrict beneficiaries to a specific pharmacy.

FFY 2019 reported responses show an increase in the number of states with a process to identify possible fraudulent practices of health care providers. For example, 46 states (92%) have processes in place to identify potential fraudulent practices by prescribers, a 22% increase from FFY 2018; 45 states (90%) have processes in place to identify potential fraudulent practices by pharmacies, an 18% increase from FFY 2018.

These reviews trigger actions such as denying claims written by that prescriber, denying claims submitted by that pharmacy, alerting the state integrity or compliance unit, and/or making referrals to the appropriate licensing board.

B. Prescription Drug Monitoring Program (PDMP)

PDMPs are statewide electronic databases that collect designated data on controlled substances that are prescribed and dispensed in the state. Depending on the state, prescribers and pharmacists have access to these databases to identify patients that are engaging in potential fraud or misuse of controlled substances. Consistent with FFY 2018 reported responses, 49 states (98%) indicated having a PDMP in their state.

- 25 states (51%) have the ability to query their states' PDMP database. Additionally, 4 states (8%) receive PDMP data from their state upon request.
    - 19 of these 29 states (66%) have the ability to access border state PDMP information.
- 21 states (43%) require that prescribers access the patient history in the PDMP database prior to prescribing controlled substances, a 24% increase from FFY 2018.
- 38 states (78%) responded that they face a range of barriers that hinder their ability to fully access and utilize the PDMP database to curb abuse, a 5% increase from FFY 2018.

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 16 states (32%) to identify prescribers not authorized to prescribe controlled substances, a 1% increase from FFY 2018. In sum, 9 of these states (56%) apply the DEA Active Controlled Substance Registrant's File to their ProDUR edits and 3 of these states (19%) apply this file to their RetroDUR reviews. An additional pain management control mechanism employed by states include measures

to either monitor or manage the prescribing of methadone. That is, 46 states (92%) have monitoring in place for methadone prescribing, consistent with FFY 2018.

D. Opioids

The average maximum number of "days allowed" for an initial opioid prescription ranges nationally from 5 days to 100 days. This initial opioid prescription policy applies to all opioids dispensed by 30 states (60%) as 20 states (40%) apply other limitations and restrictions. FFY 2019 reported responses are consistent with FFY 2018. 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 milligram equivalent (MME) daily dose programs and pharmacist overrides. Requirements for obtaining high dose or large quantities of opioids may include documentation of urine drug screening results, pain management contracts or patient-provider agreements. Additionally:

- 43 states (86%) have prospective edits or a retrospective claims review process to monitor opioids and benzodiazepines being used concurrently. This is a 33% increase from FFY 2018.
- 41 states (82%) have prospective edits or a retrospective claims review process to monitor opioids and antipsychotics being used concurrently. This is a new survey question for FFY 2019.
- 32 states (64%) utilize abuse deterrent opioids to prevent misuse and abuse. This is a 1% decrease from FFY 2018.
- 37 states (74%) develop and/or provide prescribers with pain management or opioid prescribing guidelines. This is a 34% increase from FFY 2018.

E. Morphine Milligram Equivalent (MME) Daily Dose

MME is the amount of morphine in milligrams equivalent to the strength of the opioid dose prescribed. Using an MME approach allows comparison between the strength of different types of opioids. A total of 43 states (86%) 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. This is a 26% increase in the number of states from FFY 2018. A total of 7 states (14%) have yet to implement MME limits, but are currently in process of establishing these limits. The national range of MME values vary from 30 to 500mg/day, each state having their specific methodology used for MME calculation. FFY 2019 reported responses confirm that 35 of the 43 states (70%) whom limit the amount of opioid products containing morphine or morphine derivatives that a patient may receive in a specific time frame, provides information to their prescribers on how to calculate an MME or provides a calculator to determine a patients specific MME daily dose, a 26% increase from FFY 2018. Additionally:

- 39 states (78%) have an edit in their POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded. This is a 26% increase from FFY 2018.
- 20 states (40%) have an automated retrospective claims review process to monitor the total daily dose of MMEs for opioid prescriptions dispensed. This is an additional question added to the FFY 2019 survey.

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 OUD. Based on FFY 2019 reported responses, 42 states (84%) set total milligrams per day limits on the use of buprenorphine and buprenorphine/naloxone combination

drugs, a 1% increase from FFY 2018. Accordingly, 11 states (22%) also set limitations on allowable length of treatment for a beneficiary receiving buprenorphine and buprenorphine/naloxone combination drugs while 39 states (78%) have no limits assessed, an 8% increase from FFY 2018. FFY 2019 reported responses confirm 42 states (84%) provide at least one buprenorphine and buprenorphine/naloxone combination drug without a prior authorization requirement while 8 states (16%) require prior authorization for these products, a 50% decrease from FFY 2018. Additionally, 36 states (72%) have system edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of medication-assisted treatment (MAT), a 9% increase from FFY 2018.

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 recommend 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. Based on FFY 2019 reported responses, 43 states (86%) provide coverage for methadone for OUD through an OTP, a 12% increase from FFY 2018 as 7 states (14%) provide no methadone coverage for OUD.

Naloxone is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist and can reverse and block the effects of opioids. Naloxone is available without prior authorization in 49 states (98%), a 2% decrease from FFY 2018, and all states allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols, an increase of 14% from FFY 2018.

G. Antipsychotics / Stimulants

Antipsychotic Medication

According to FFY 2019 reported responses, 48 states (96%) have a program in place for managing or monitoring appropriate use of antipsychotic drugs in children, consistent from FFY 2018. Additionally, 44 of these 48 states (92%) manage or monitor antipsychotic medication for all children, including children in foster care, a 5% increase from FFY 2018.

Stimulant Medication

According to FFY 2019 reported responses, 42 states (84%) have a program in place for managing or monitoring appropriate use of stimulant drugs in children, a 2% increase from FFY 2018. Additionally, 38 of these 42 states (90%) manage or monitor stimulant medication for all children, including children in foster care, a 6% increase from FFY 2018.

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

Sharing of new ideas and best practices is an invaluable resource to all states. FFY 2019 reported responses include 48 state (96%) submissions for DUR innovative practices. Previous innovative state practices from FFY 2014 to FFY 2018 can be accessed on Medicaid.gov.

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. Based on FFY 2019 reported responses, 25 states (50%) have the ability to electronically provide patient drug history and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry, consistent from FFY 2018. Additionally, of the 25 states without this functionality, 6 states (24%) plan to implement a system in the future.

XI. Managed Care Organizations (MCOs)

Based on FFY 2019 reported responses, 39 states (78%) (Non-inclusive of Arizona) have active MCOs encompassing 261 programs. Furthermore, 4 of the 39 states (10%) (MO, TN, WI, and WV) carve out their drug benefit and submitted an abbreviated MCO survey for each of their programs. For more information, contact the respective State Pharmacy Director or the State DUR Contact.

XII. Executive Summary

All 50 states have submitted Executive Summaries and can be accessed at the end of this report.

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PLEASE NOTE: This is a standalone report posted on Medicaid.gov.

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Section 1 - Enrollees

1. On average, how many of your state's Medicaid 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

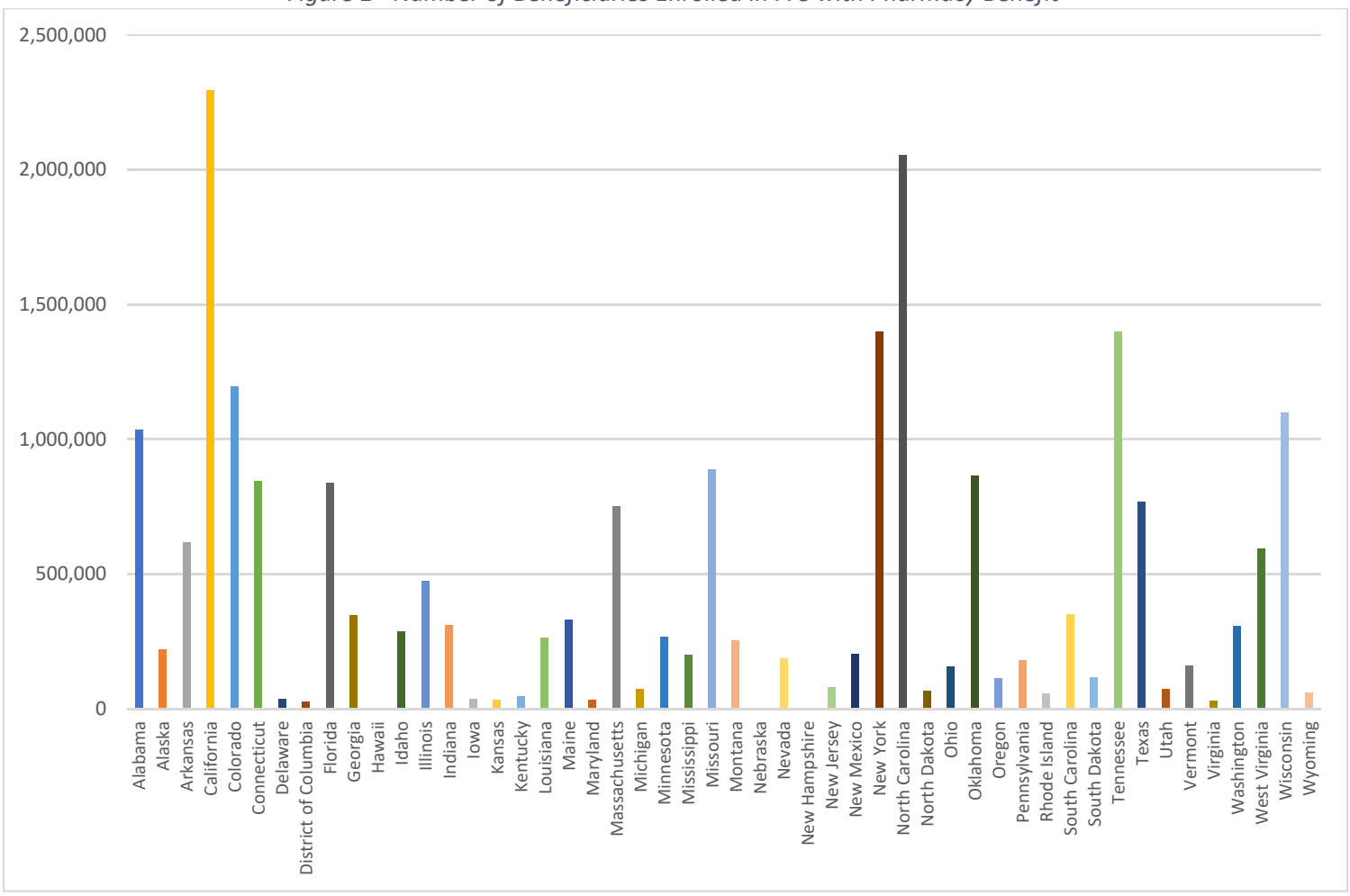

Table 1 - Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
Alabama	1,034,562
Alaska	220,000
Arkansas	617,333
California	2,294,983
Colorado	1,195,000
Connecticut	843,503
Delaware	35,500
District of Columbia	25,000
Florida	837,952
Georgia	345,368
Hawaii	1,000
Idaho	287,000
Illinois	473,110
Indiana	309,941
Iowa	37,821
Kansas	33,922
Kentucky	45,000
Louisiana	264,404
Maine	330,000
Maryland	32,858
Massachusetts	751,190
Michigan	71,648
Minnesota	267,190
Mississippi	200,467
Missouri	887,550
Montana	253,678
Nebraska	2,000
Nevada	185,958
New Hampshire	3,304
New Jersey	81,000
New Mexico	201,834
New York	1,400,000
North Carolina	2,052,569
North Dakota	67,576
Ohio	156,667
Oklahoma	865,851
Oregon	113,228
Pennsylvania	180,000
Rhode Island	57,116
South Carolina	350,000

State	Number of Beneficiaries Enrolled in FFS with Pharmacy Benefit
South Dakota	116,000
Tennessee	1,400,000
Texas	767,971
Utah	73,152
Vermont	158,512
Virginia	31,157
Washington	305,410
West Virginia	595,713
Wisconsin	1,100,000
Wyoming	59,015
Total	22,020,013

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

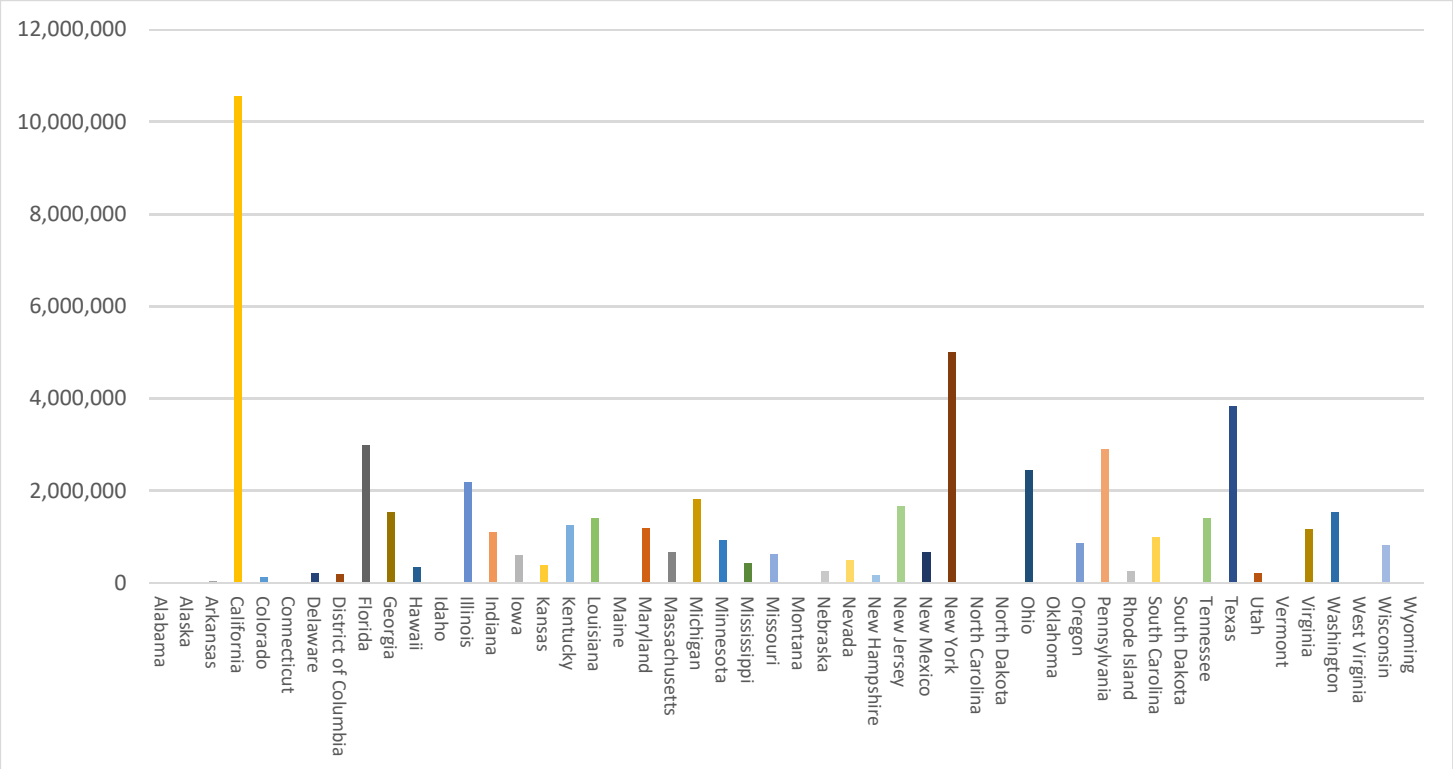

Table 2 - Medicaid Beneficiaries Enrolled in MCOs by State

State	Number of Beneficiaries Enrolled in MCO Plans
Alabama	0
Alaska	0
Arkansas	45,045
California	10,559,452
Colorado	113,000
Connecticut	0
Delaware	199,877
District of Columbia	190,000
Florida	2,992,055
Georgia	1,535,917
Hawaii	350,000
Idaho	0
Illinois	2,183,709
Indiana	1,109,477
Iowa	604,881
Kansas	386,857
Kentucky	1,242,000
Louisiana	1,396,122
Maine	0
Maryland	1,194,164
Massachusetts	661,187
Michigan	1,813,557
Minnesota	933,893
Mississippi	435,496
Missouri	617,696
Montana	0
Nebraska	249,395
Nevada	481,090
New Hampshire	164,402
New Jersey	1,663,018
New Mexico	661,840
New York	5,000,000
North Carolina	0
North Dakota	19,474
Ohio	2,444,757
Oklahoma	0
Oregon	862,247
Pennsylvania	2,900,000
Rhode Island	257,663
South Carolina	1,000,000

State	Number of Beneficiaries Enrolled in MCO Plans
South Dakota	0
Tennessee	1,400,000
Texas	3,835,619
Utah	216,892
Vermont	0
Virginia	1,163,353
Washington	1,525,197
West Virginia	0
Wisconsin	812,241
Wyoming	0
Total	53,221,573

Section II - Prospective DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) Vendor.

Figure 3 - Pharmacy POS Type of Vendor

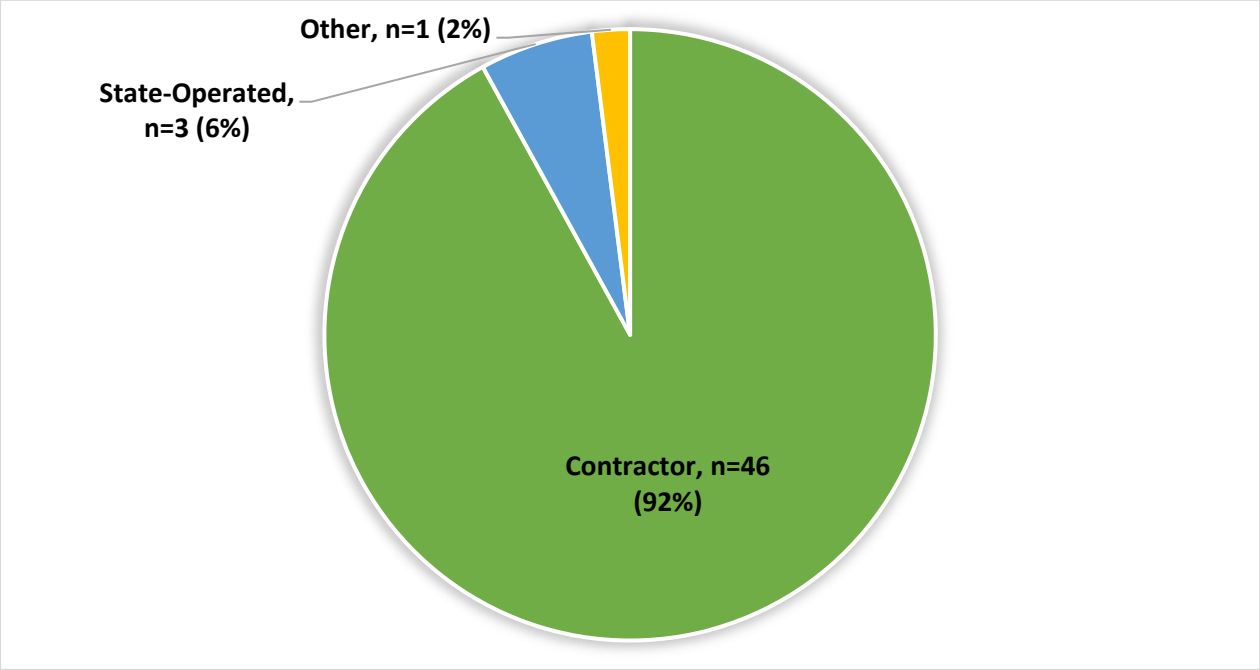

Table 3 - Pharmacy POS Type of Vendor

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, 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	46	92.00%
State-Operated	Minnesota, North Dakota, Washington	3	6.00%
Other	Illinois	1	2.00%
Total		50	100.00%

a. Vendor Name

Table 4 - POS Vendor Name

Response	States	Count	Percentage
DXC Technology	Alabama, Connecticut, Delaware, Kansas, Louisiana, New Jersey, Oklahoma, Oregon, Pennsylvania, Rhode Island, West Virginia, Wisconsin	12	25.53%
Magellan	Alaska, Arkansas, District of Columbia, Florida, Idaho, Kentucky, Michigan, Nebraska, New Hampshire, South Carolina, Virginia	11	23.40%
Conduent	California, Hawaii, Maryland, Massachusetts, Mississippi, Missouri, Montana, New Mexico, Texas	9	19.15%
Magellan Health, Inc.	Colorado	1	2.13%
OptumRx	Georgia, Indiana, Nevada, South Dakota	4	8.51%
State operated using Change Healthcare Pharmacy Benefits Management System (PBMS) to process claims.	Illinois	1	2.13%
Change Healthcare	Iowa, Maine, Ohio, Utah, Vermont, Wyoming	6	12.77%
General Dynamics Information Technology	New York	1	2.13%
CSRA/GDIT	North Carolina	1	2.13%
Magellan Medicaid Administrators	Tennessee	1	2.13%
Total		47	100.00%

b. If not state-operated, is the POS vendor also the MMIS fiscal agent or a separate PBM?

Figure 4 - Is the Vendor also your MMIS Fiscal Agent or Separate PBM

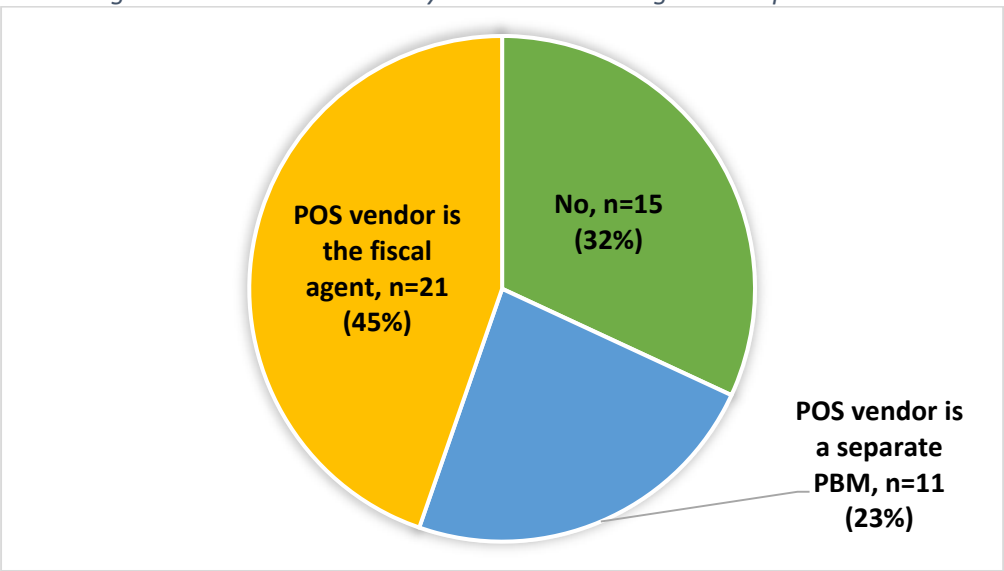

Table 5 - Is the Vendor also your MMIS Fiscal Agent or Separate PBM

Response	States	Count	Percentage
No	Alaska, Arkansas, Colorado, Florida, Idaho, Illinois, Indiana, Iowa, Maryland, Michigan, Missouri, Nebraska, South Carolina, South Dakota, Utah	15	31.91%
POS vendor is a separate PBM	District of Columbia, Georgia, Kentucky, Maine, Nevada, New Hampshire, Ohio, Tennessee, Texas, Vermont, Wyoming	11	23.40%
POS vendor is the fiscal agent	Alabama, California, Connecticut, Delaware, Hawaii, Kansas, Louisiana, Massachusetts, Mississippi, Montana, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, Virginia, West Virginia, Wisconsin	21	44.68%
Total		47	100.00%

2. Identify ProDUR criteria source.

Figure 5 - ProDUR Criteria Source

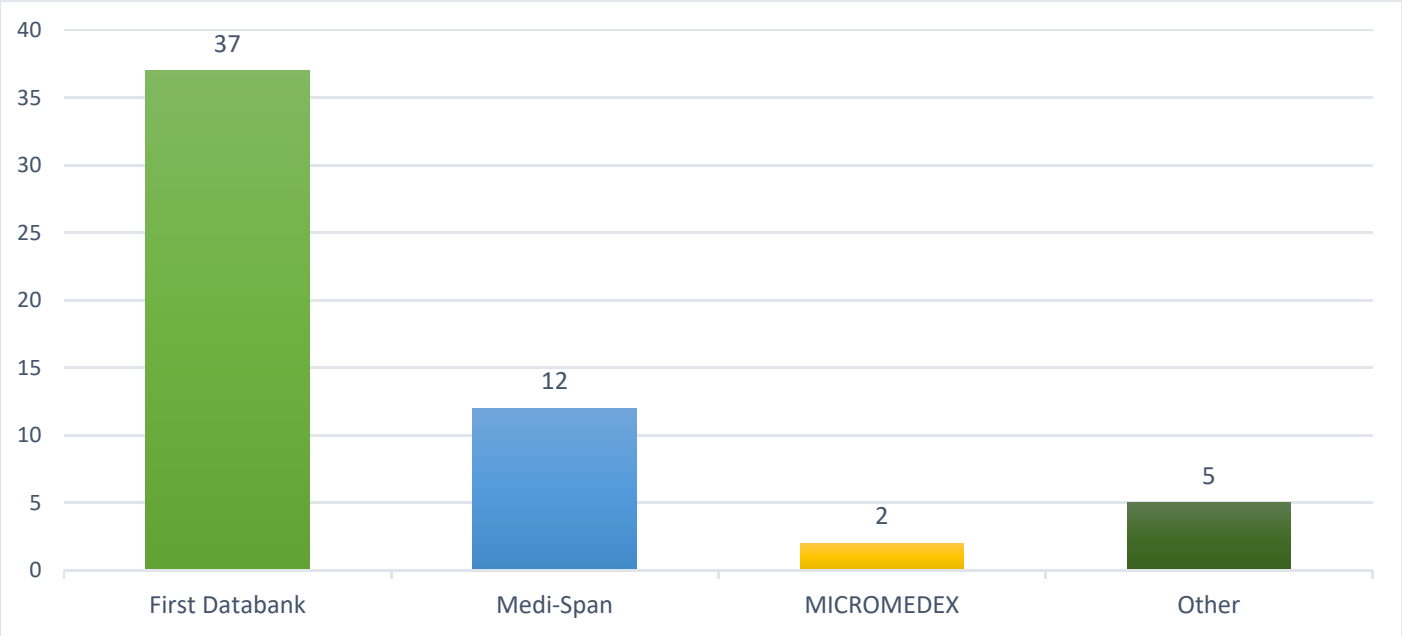

Table 6 - ProDUR Criteria Source

Response	States	Count	Percentage
First Databank	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	66.07%

Response	States	Count	Percentage
Medi-Span	Georgia, Illinois, Indiana, Iowa, Maine, Nevada, Ohio, South Dakota, Utah, Vermont, Washington, Wyoming	12	21.43%
MICROMEDEX	Mississippi, Oregon	2	3.57%
Other	Louisiana, Mississippi, Texas, Vermont, Washington	5	8.93%
Total		56	100.00%

Table 7 - "Other" State Explanations for ProDUR 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, DXC technology, and the University of Louisiana-Monroe.
Mississippi	Micromedex is reviewed for compendia supported indications by contractor for ProDUR edits.
Texas	Some of the pro-DUR criteria are from First Data Bank. Some others, such as the High Dose Acetaminophen edit, or the Antifungals Treatment Duration edit, are developed by the state.
Vermont	Clinical Literature and FDA Safety Alerts.
Washington	Pre-set DUR criteria and functionality are provided through the POS vendor's built in DUR module. Additional DUR criteria based on medically accepted indications/dosing are developed by state staff.

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

Figure 6 – New ProDUR Criteria Approved by DUR Board

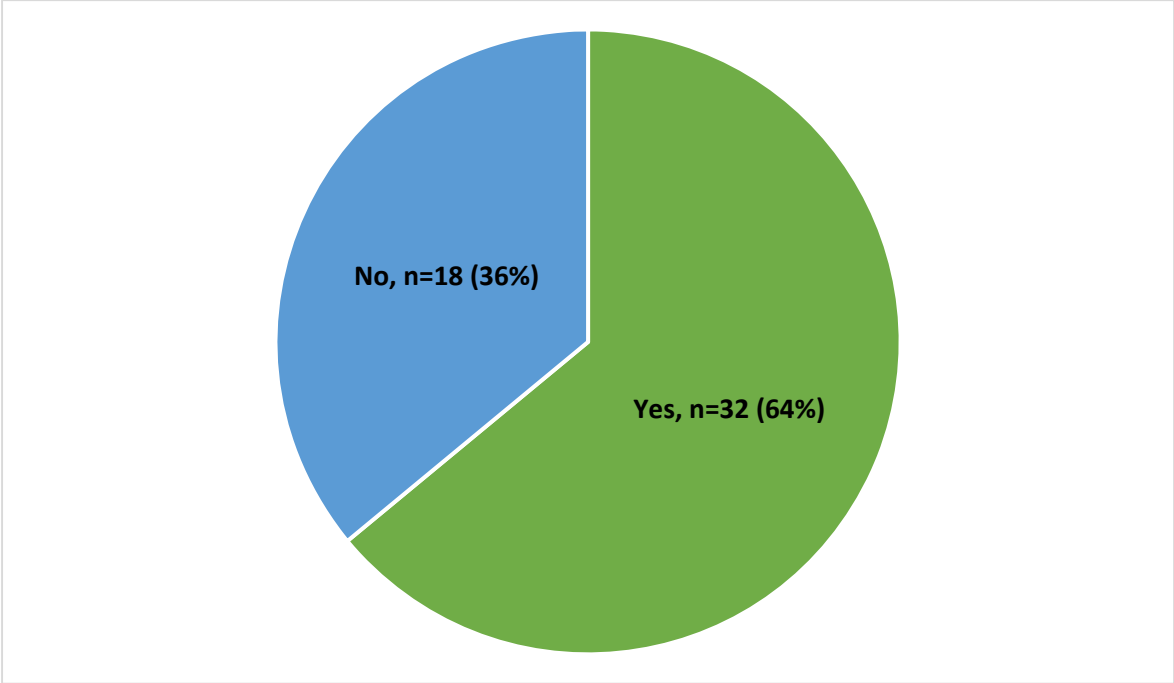

Table 8 – New ProDUR Criteria Approved by DUR Board

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, South Dakota, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	32	64.00%
No	Arkansas, California, Colorado, Georgia, Idaho, Iowa, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, North Dakota, Oklahoma, Rhode Island, Tennessee, Texas, Washington	18	36.00%
Total		50	100.00%

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

State	Explanations
Arkansas	Standard ProDUR criteria for new medications are provided by First Databank and are automatically updated in our POS system without additional review by the DUR Board. Weekly updates from FDB outside of standard ProDUR criteria are reviewed by the vendor and the Medicaid program. Medications deemed needing prior authorization criteria and clinical review will be presented to the DUR Board for their recommendations. The DUR Board may review major ProDUR updates which doesn't happen often. ProDUR data summary for DUR alerts and pharmacist POS overrides are provided to the DUR Board quarterly.
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 alter is reviewed and discussed at all DUR Board meetings. Individual criteria may be recommended by the Board for implementation. All new security level one drug interaction criteria is automatically implemented by the Point-of-Sale (POS) vendor as it becomes available from the 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	Information edits are not reviewed by the DUR Board. High dose or quantity limits which cause the claim to reject are reviewed by the DUR Board.
Missouri	Automatic updates are made from First DataBank which are incorporated into our DUR criteria.
Nebraska	New ProDUR criteria are created by the DUR Board, pharmacy POS vendor and are approved by the Medicaid Program.
Nevada	Medi-Span provides the ProDUR criteria for the State of Nevada. The DUR Board does not review or approve the ProDUR criteria.
North Dakota	The frequency and scope of updates does not make it timely or efficient to have the DUR Board review and approve these criteria.

State	Explanations
Oklahoma	Guidelines have been approved and new criteria is updated as it comes from FDB, as long as parameters are met.
Rhode Island	The Prospective DUR criteria is auto loaded from First Databank.
Tennessee	The DUR Board approves ProDUR criteria when claims are found retrospectively showing that prospective edits need to be examined. With over 100,000 drugs in the FDB drug file it is not possible to approve all ProDUR edits by a Board that meets only quarterly, nor is it necessary, as ProDUR edits are a function of the Drug Database vendor (e.g., FDB or MediSpan).
Texas	The clinical prior authorization criteria are reviewed and approved by the DUR Board. The pro-DUR alerts are updated automatically in the claims system. Additionally, the program implements prospective claims edits for certain drugs or drug classes that are not reviewed by the DUR Board.
Washington	Standard automated DUR criteria which are overridable by pharmacists with the use of submitted DUR codes are provided through Medispan and applied by the OptumRx claim processing system. These DUR criteria are not reviewed by the DUR Board. Active DUR criteria in the form of prior authorization requirements (including quantity and dosing limits, step therapy, etc..) applied by the state which are based solely on the definition of medically accepted indications are not reviewed by the DUR Board, as federal rule requires the state to use medically accepted indications as a standard. The DUR Board reviews those active Prospective DUR criteria which represent predetermined standards more stringent than medically accepted indication alone.

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 NCPDP Drug Use Evaluation Codes

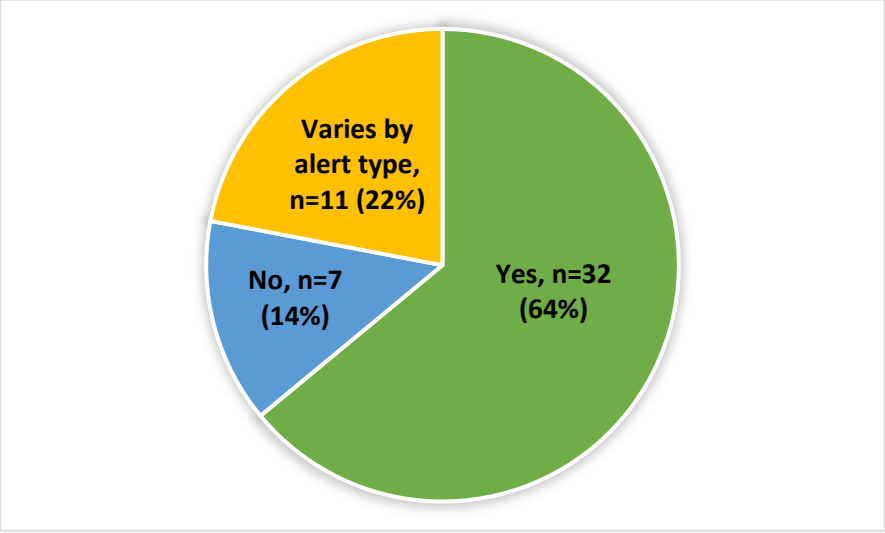

Table 10 - ProDUR Alert Message for Pharmacist Override using NCPDP Drug Use Evaluation Codes

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Connecticut, Delaware, District of Columbia, Florida, Idaho, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, Texas, Utah, Vermont, Virginia, Wyoming	32	64.00%
No	Colorado, Hawaii, Illinois, Iowa, Maine, New Jersey, Pennsylvania	7	14.00%
Varies by alert type	Arkansas, Georgia, Indiana, New York, North Dakota, South Carolina, South Dakota, Tennessee, Washington, West Virginia, Wisconsin	11	22.00%
Total		50	100.00%

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

State	Explanations
Arkansas	Most level-one alerts can be overridden by the pharmacist at POS. An exception would be an early-refill (ER) alert for controlled and non-controlled medications. ER DUR alerts cannot be overridden at POS and require a manual review by the contractor's help desk.
Georgia	Only soft reject allowing pharmacist override is Concurrent use of opioids + prenatal vitamins.
Indiana	A pharmacist may override level-one drug-drug interactions only when the pharmacy has received direction to discontinue one of the drugs involved in the interaction. All other level-one drug-drug interactions will require prior authorization.
New York	Any anti-retroviral (used in the treatment of Aids/HIV) level 1 drug interaction encountered cannot be overridden by the pharmacist and the prescriber must obtain a PA. All other level 1 ProDUR edits can be overridden by the Pharmacist.
North Dakota	Pharmacy can only override early refill denials.
South Carolina	SC allows level one ProDUR alerts to be overridden for TD (Therapeutic Duplication) and DDI (Drug-Drug Interactions)
South Dakota	Not all edits allow for the pharmacist to override. Ex. early refill for vacation supply is not allowed.
Tennessee	Yes we do allow, with the exception of those edits that result in a hard reject, which would include early refill edits for controlled substances, and skeletal muscle relaxants for duplicate therapy.
Washington	Washington Apple Health (Medicaid) Fee-For-Service (FFS) has two levels of ProDUR rejections, a 'hard' DUR edit that requires authorization and a 'soft' DUR edit that allows the pharmacist to override the edit. Most of these ProDUR rejections are a 'soft' DUR edit, in some situations, i.e. refill too soon, etc., a 'hard' edit is applied as determined by the state.
West Virginia	The retail pharmacist cannot override this, but the pharmacist at our prior authorization vendor can.
Wisconsin	There are drugs in the ER alert that requires a call to the DAPO (Drug Authorization Policy Override) center to require an override before dispensing the medication. All other prospective DUR alerts allows the pharmacist to override the alert.

5. Do you receive and review follow-up 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

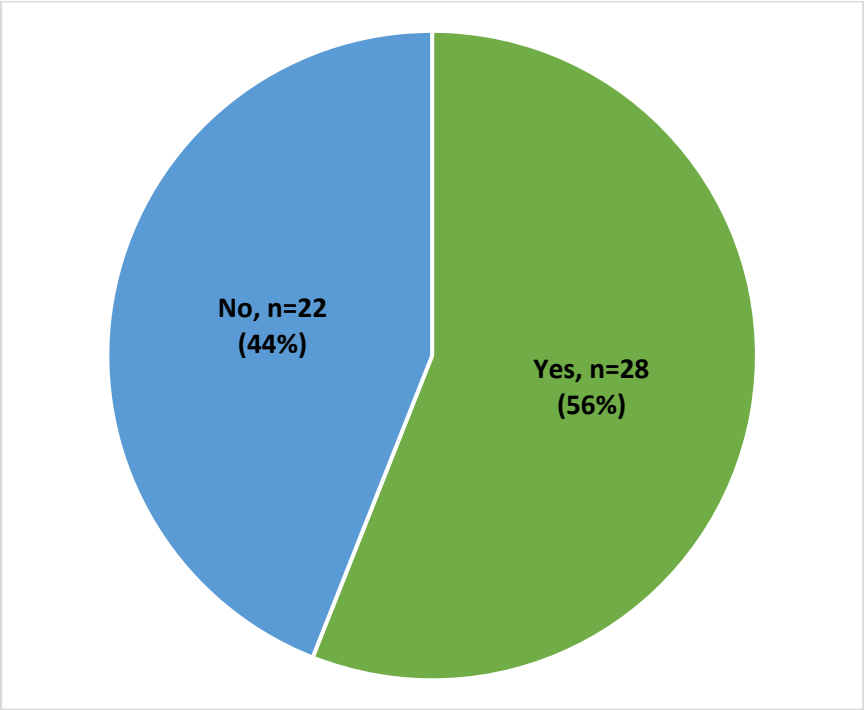

Table 12 - Receive/Review Follow-up Periodic Reports Providing Individual Pharmacy Provider DUR Alerts Override

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Kentucky, Massachusetts, Michigan, Mississippi, Nebraska, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia	28	56.00%
No	Arkansas, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Jersey, Tennessee, Washington, West Virginia, Wisconsin, Wyoming	22	44.00%
Total		50	100.00%

If “No,” please explain.

Table 13 – State Explanations for No Receive/Review Follow-up Periodic Reports Providing Individual Pharmacy Provider DUR Alerts Override

State	Explanations
Arkansas	ProDUR response reports with overall override activity by pharmacists are provided by our contractor quarterly and presented to the DUR Board. These reports include total claims screened by DUR , % of total claims screened by DUR, and quantity of alerts and overrides for the following alerts--high dose, early refill, therapeutic duplication, drug-drug interaction, and incorrect duration. Also, we receive this information from our MCOs quarterly. Currently, we have not requested the contractor to provide ProDUR response reports on individual pharmacies. It was more beneficial to actually review the drugs involved in the ProDUR categories than to review massive reports on individual pharmacies. Individual pharmacies can be audited based on Office of Medicaid Inspector General (OMIG) reporting.
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. The Bureau of Medicaid Program Integrity reviews the pharmacy provider activity, not Pharmacy policy.
Georgia	Follow-up reports specifying individual pharmacy override activities are not provided.
Hawaii	Less than 500 claims per month allows manual review of random claims sampling as needed, quarterly or at least annually.
Idaho	No individual pharmacy 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 submission 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 quarterly by the top 100 pharmacies by paid amount and top 100 pharmacies by prescription count.
Kansas	We will request this information from our Fiscal Agent, so we can implement this process in the future. We will request and review with our MCOs to ensure that this process will be done going forward.
Louisiana	DUR overrides are reviewed on an ad hoc basis.
Maine	Currently we do not allow pharmacist to override conflict codes/interventions. Soft messaging is relayed back to the pharmacist
Maryland	Reports are generated and reviewed ad hoc or as necessary.
Minnesota	We can get information from DHS data warehouse queries whenever we want.
Missouri	Reports can be requested as needed, but are not generated 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	A process to identify individual pharmacy provider DUR alert override activity in summary and/or in detail has not yet been implemented.
New Jersey	Pharmacy providers are not allowed to override DUR alerts for FFS.

State	Explanations
Tennessee	We have not looked at individual pharmacy results, however it could be valuable information if a provider was suspected of fraud or referred for fraud.
Washington	Washington Apple Health (Medicaid) considers potential misuse of submitted DUR codes to be an issue of fraud and abuse, rather than a clinical issue, and defers review of submitted DUR codes to the Program Integrity team as permitted under 42 CFR 456.714, and limits the review activities of DUR staff to those that focus on what constitutes appropriate and medically necessary care. Use of DUR codes are reviewed for accuracy and appropriateness during individual pharmacy audits.
West Virginia	We can request 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 review; either outreach to the prescriber or counseling the patient. The response may not accurately reflect the final decision of what occurred for the prescription.
Wyoming	These reports have been reviewed in the past and were found to be unactionable.

a. How often do you receive reports?

Figure 9 - Frequency of Reports Providing Individual Pharmacy Provider DUR Alerts Override

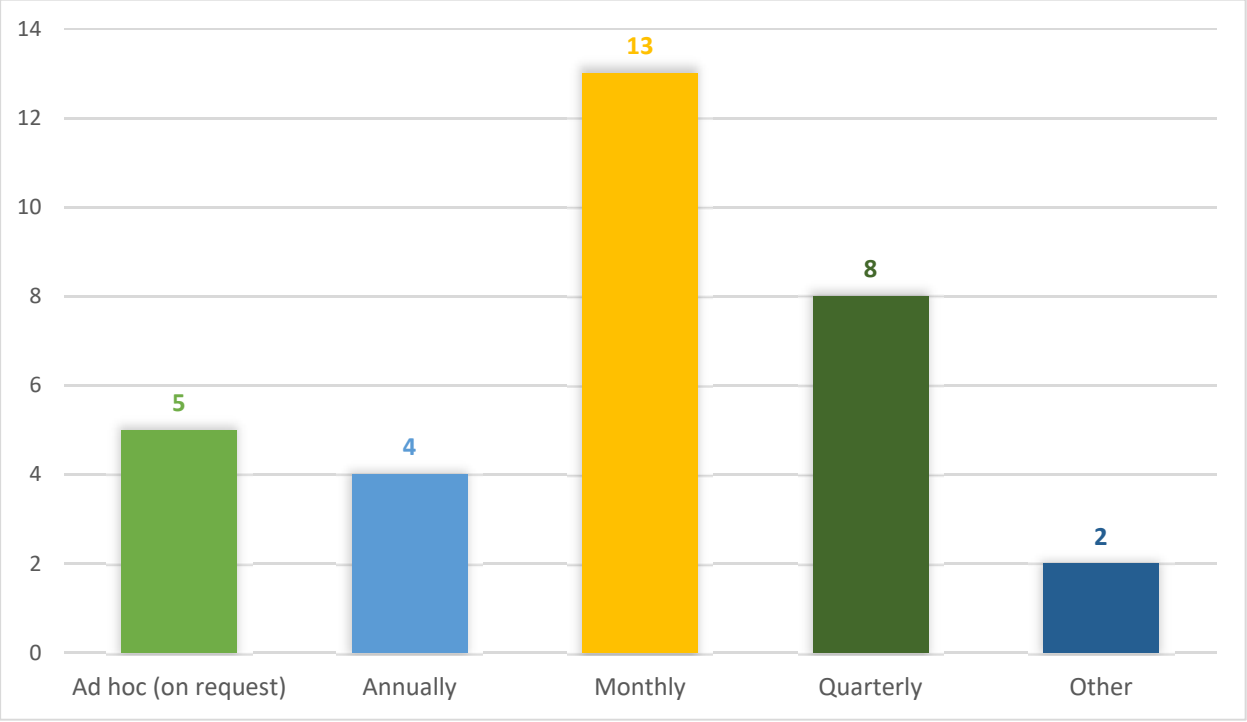

Table 14 - Frequency of Reports Providing Individual Pharmacy Provider DUR Alerts Override

Response	States	Count	Percentage
Ad hoc (on request)	California, Colorado, North Carolina, North Dakota, South Dakota	5	15.63%
Annually	California, New York, Rhode Island, Utah	4	12.50%
Monthly	Alabama, Connecticut, Delaware, District of Columbia, Kentucky, Massachusetts, Mississippi, Nebraska, New Hampshire, New Mexico, Ohio, Pennsylvania, Virginia	13	40.63%
Quarterly	Alabama, Alaska, Michigan, North Carolina, Oklahoma, Oregon, South Carolina, Vermont	8	25.00%
Other	Texas, Utah	2	6.25%
Total		32	100.00%

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

State	"Other" Explanations
Texas	Monthly report files are stored in document library. Staff can access and review reports as necessary.
Utah	Reports are received on an "as needed" basis.

b. Do you follow up with those providers who routinely override with interventions?

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

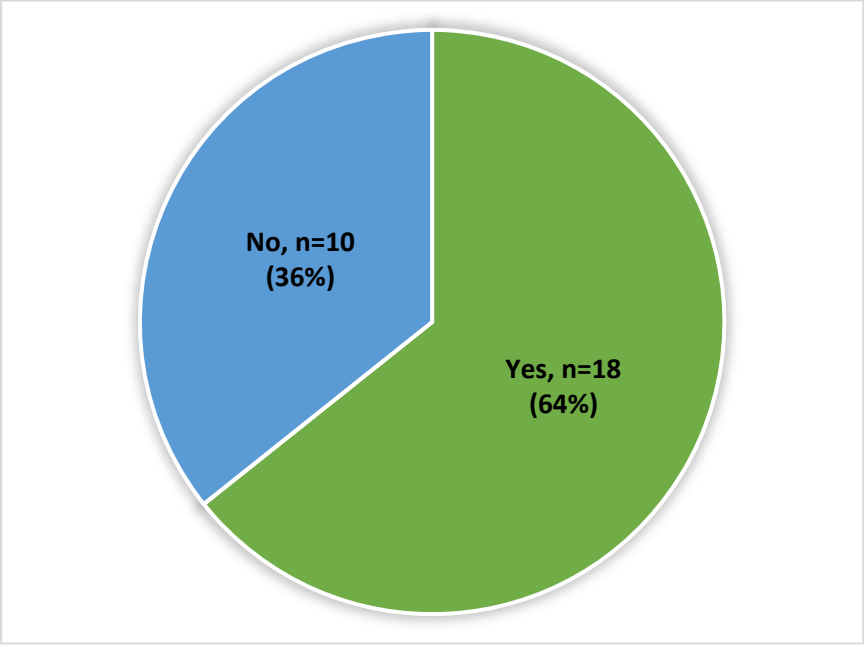

Table 16 - Follow-up with Providers who Routinely Override with Interventions

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Colorado, Delaware, District of Columbia, Kentucky, Massachusetts, Michigan, Nebraska, New York, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Utah, Virginia	18	64.29%
No	Connecticut, Mississippi, New Hampshire, New Mexico, North Carolina, Oregon, Pennsylvania, Rhode Island, Texas, Vermont	10	35.71%
Total		28	100.00%

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

Figure 11 – Follow-up Methods for Providers who Routinely Override with Interventions

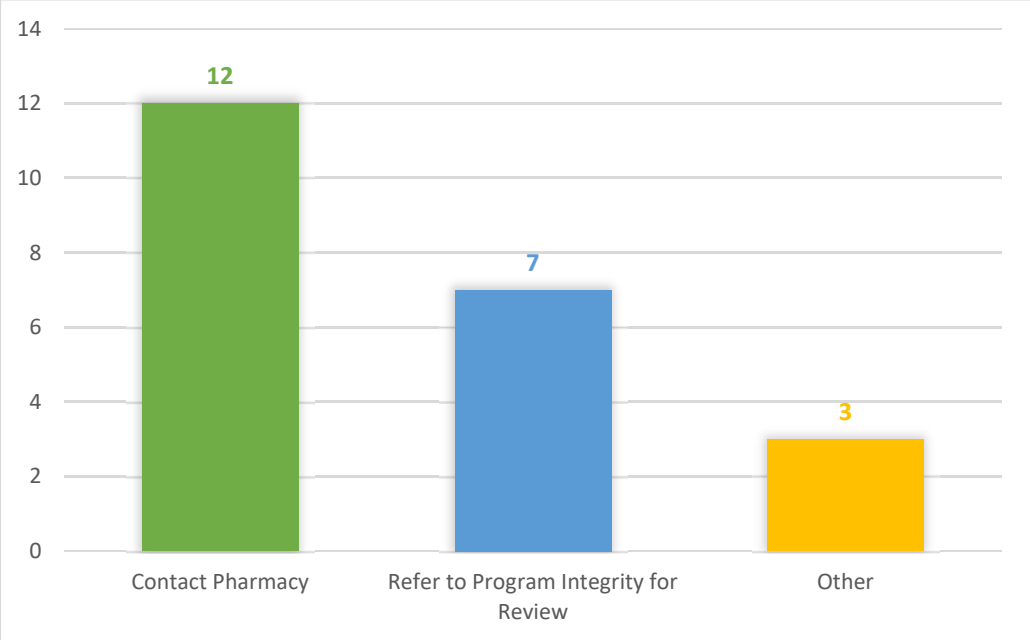

Table 17 – Follow-up Methods for Providers who Routinely Override with Interventions

Response	States	Count	Percentage
Contact Pharmacy	Alaska, California, Delaware, District of Columbia, Kentucky, Massachusetts, Michigan, Nebraska, North Dakota, Oklahoma, South Dakota, Utah	12	54.55%
Refer to Program Integrity for Review	Colorado, Kentucky, Michigan, South Carolina, South Dakota, Utah, Virginia	7	31.82%
Other	Alabama, New York, Ohio	3	13.64%
Total		22	100.00%

Table 18 – "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.
New York	Program activity that appear to have a high level of overrides are evaluated through clinical review by the DUR Board using utilization information to evaluate the effectiveness of system edits. Potential upgrades/modification of ProDUR edits may result. RetroDUR activity is evaluated by the DUR Board using "educational letters" where appropriate.
Ohio	The information collected may be used to guide other policy decisions.

If "No," please explain.

Table 19 – Explanations for No Follow-up Methods for Providers who Routinely Override with Interventions

State	Explanations
Connecticut	We do not routinely follow up with providers who override interventions.
Mississippi	This is monitored periodically. However, staff time does not allow for real-time evaluation and intervention due to need to implement SUPPORT Act SPA and other Medicaid priorities. Projected in 2022, the state's new fiscal agent is adding and revising ProDUR interventions for implementation.
New Hampshire	NH has not found any trend in this information requiring follow up with providers. There is a very low Fee-for-Service population to manage.
New Mexico	System edit overrides are allowed through the Conduent helpdesk at this time. Follow-up is only on a case-by-case basis.
North Carolina	The DUR Board reviews the DUR Alert Overrides quarterly, but there is no follow up interventions with individual providers.
Oregon	We do not specifically audit providers 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	The most severe alerts require agency review for medical necessity.
Rhode Island	Fee for Service is routinely secondary payer.
Texas	Vendor Drug Program has not conducted pharmacy audit for the FFS claims activities since 2014.
Vermont	Policy allows the pharmacist to override the interventions as allowed by NCPDP format. this is used to alert the Pharmacist or potential DDI., therapy conflicts and other requirements

6. Early Refill

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

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

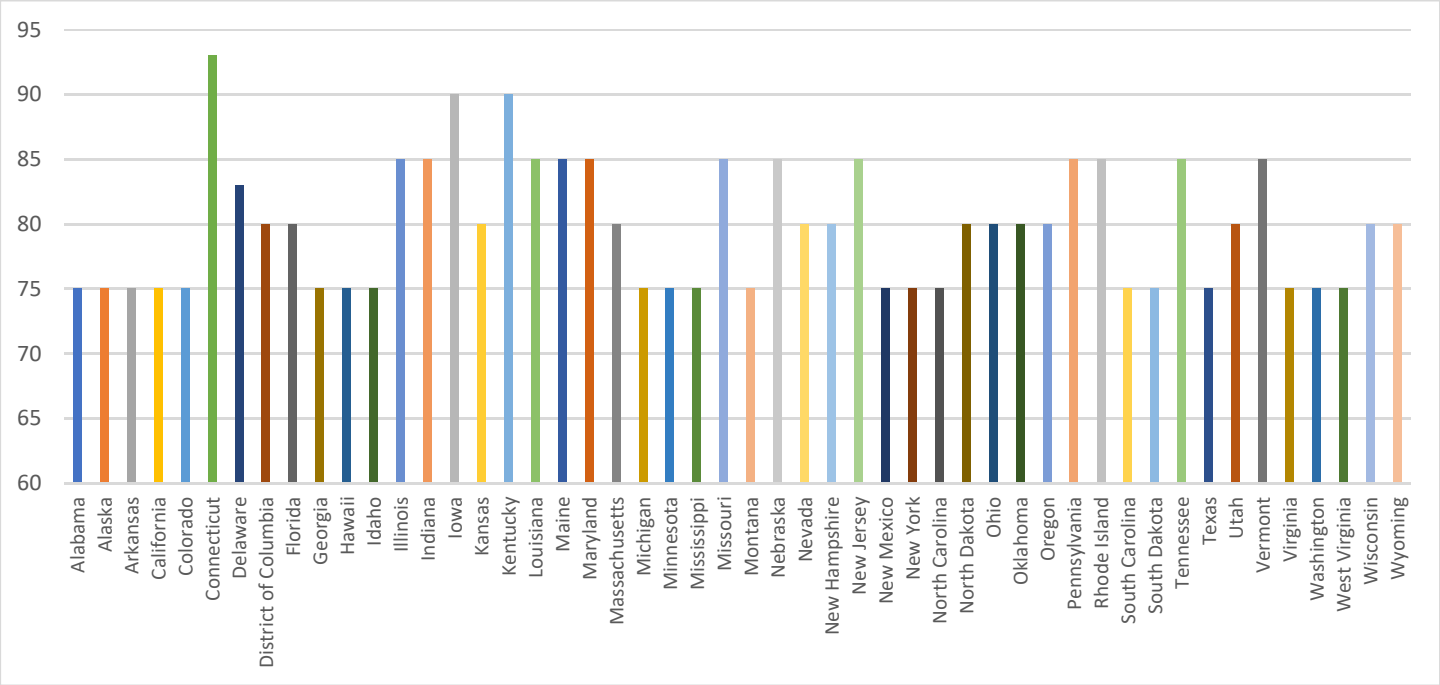

Figure 13 - Schedule II Controlled Drugs Early Refill Percent Edit Threshold

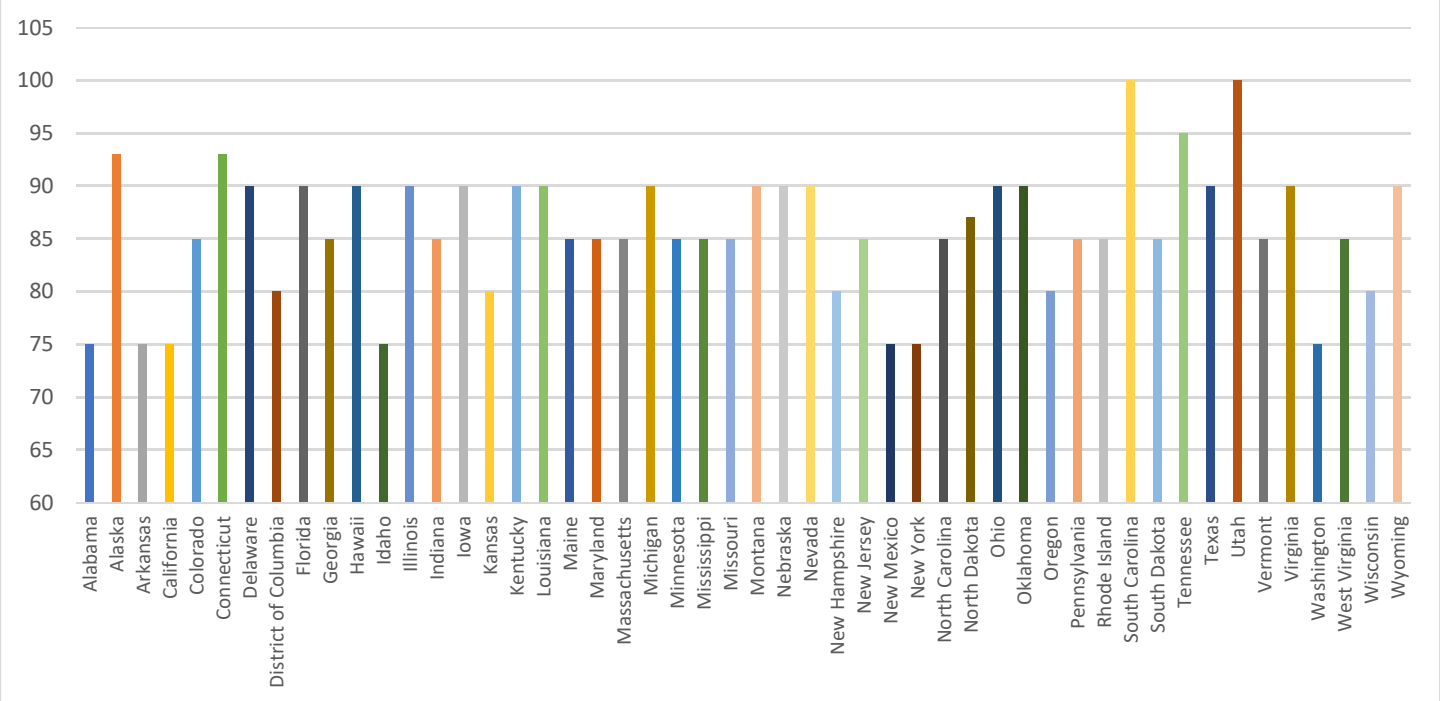

Figure 14 - Schedule III through V Controlled Drugs Early Refill Percent Edit Threshold

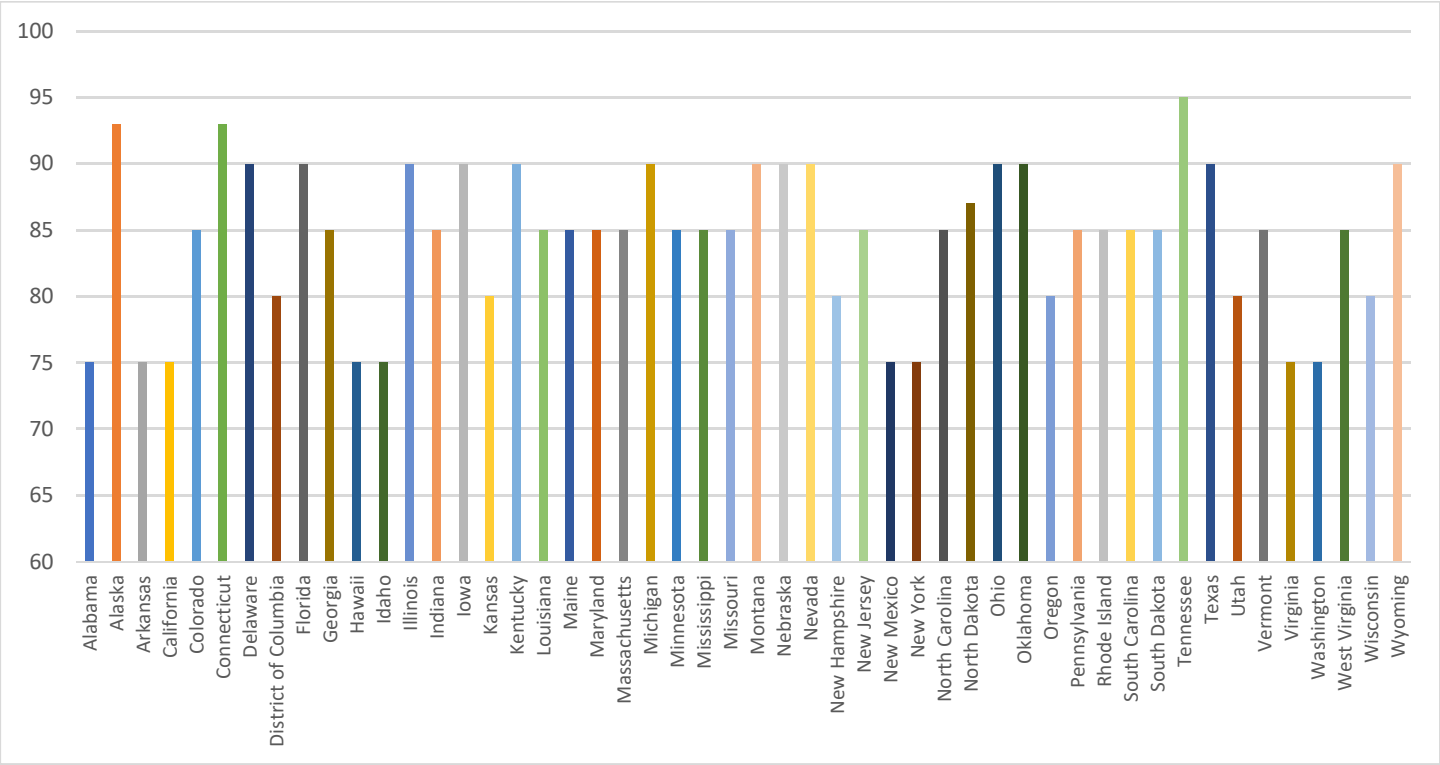

Table 20 - Early Refill Percent Threshold for Non-controlled and Controlled Drugs

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	83.00%	90.00%	90.00%
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%	90.00%	75.00%
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%

State	Non-controlled Drugs	Schedule II Controlled Drugs	Schedule III through V Controlled Drugs
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	80.00%	90.00%	90.00%
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%
Virginia	75.00%	90.00%	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%

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

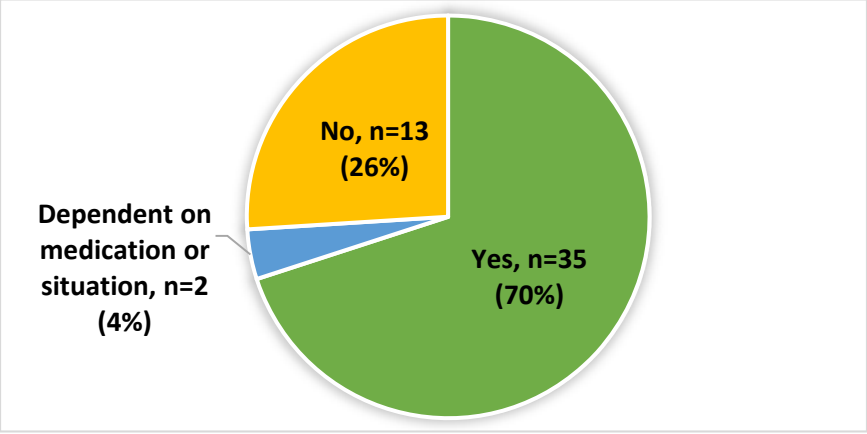

Table 21 - Non-Controlled Drugs, Early Refill Requirement for Prior Authorization

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, New York, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wyoming	35	70.00%
Dependent on medication or situation	Hawaii, Washington	2	4.00%
No	California, Kansas, Louisiana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Wisconsin	13	26.00%
Total		50	100.00%

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

Figure 16 - Non-Controlled Drugs Early Refill Authorization Sources

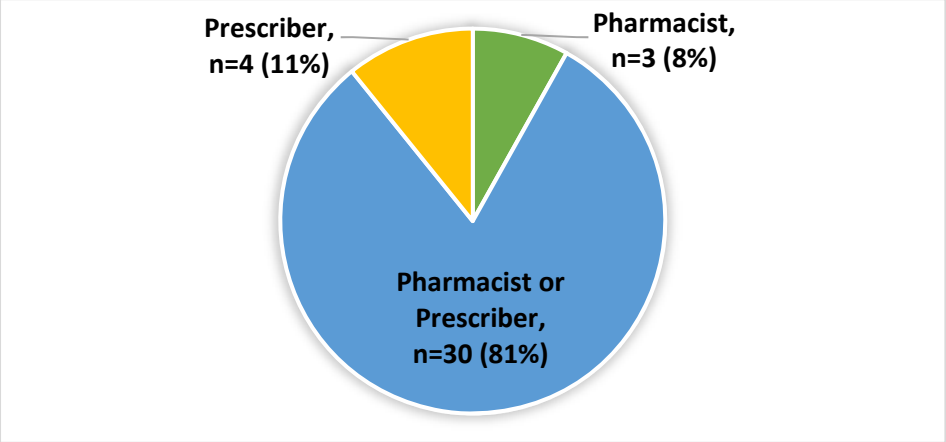

Table 22 - Non-Controlled Drugs Early Refill Authorization Sources

Response	States	Count	Percentage
Pharmacist	Michigan, Oklahoma, Texas	3	8.11%
Pharmacist or Prescriber	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Mexico, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	30	81.08%
Prescriber	Idaho, Indiana, Iowa, New York	4	10.81%
Total		37	100.00%

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

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

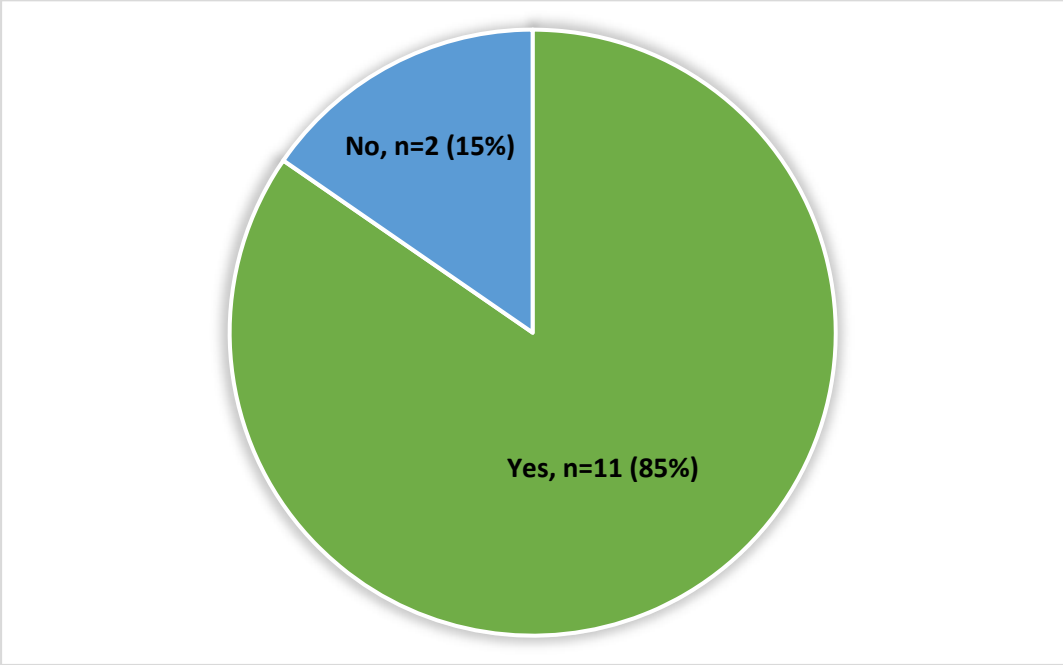

Table 23 - Non-Controlled Drugs: Pharmacist Override at Point of Service

Response	States	Count	Percentage
Yes	California, Kansas, Louisiana, Nebraska, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Dakota, Wisconsin	11	84.62%
No	New Hampshire, New Jersey	2	15.38%
Total		13	100.00%

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

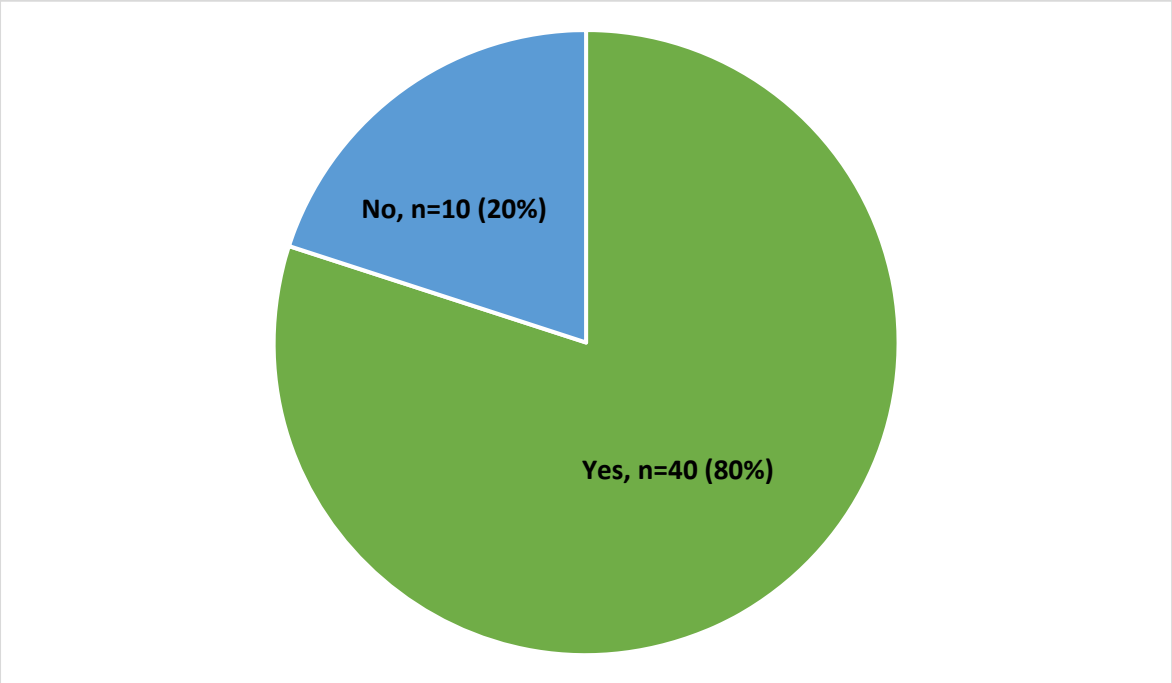

Table 24 - For Controlled Drugs, Early Refill Requirement for Prior Authorization

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, 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	40	80.00%
No	California, Kansas, Louisiana, New Hampshire, New Jersey, North Carolina, Ohio, Oregon, Rhode Island, South Dakota	10	20.00%
Total		50	100.00%

i. If "Yes," who obtains authorization?

Figure 19 - Controlled Drugs Early Refill Authorization Source

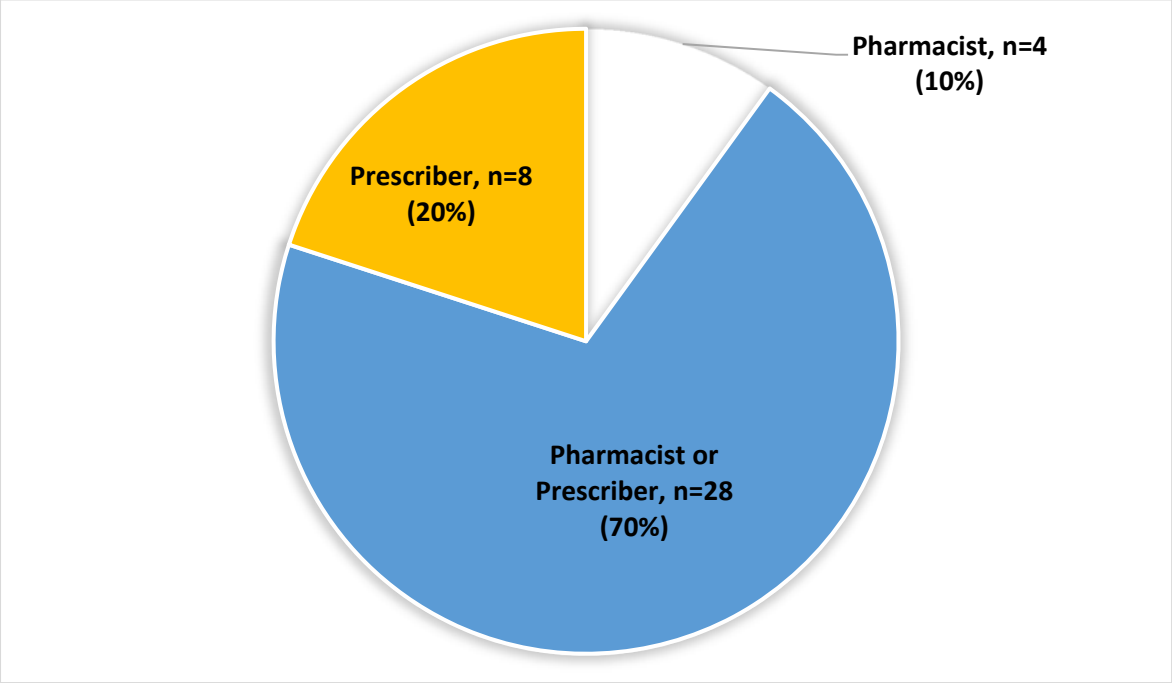

Table 25 - Controlled Drugs Early Refill Authorization Source

Response	States	Count	Percentage
Pharmacist	Massachusetts, Oklahoma, Texas, Wisconsin	4	10.00%
Pharmacist or Prescriber	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Illinois, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	28	70.00%
Prescriber	Connecticut, Florida, Hawaii, Idaho, Indiana, Iowa, Kentucky, New York	8	20.00%
Total		40	100.00%

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

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

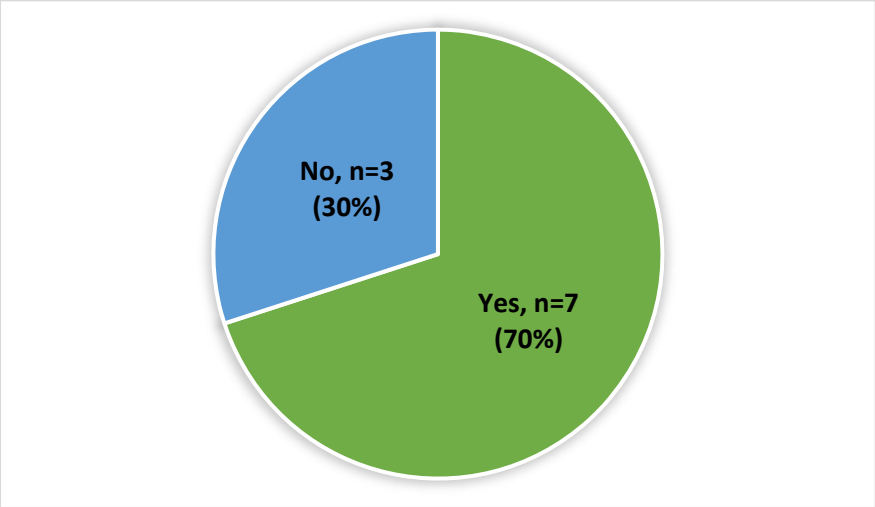

Table 26 - Controlled Drugs: Pharmacist Override at Point of Service

Response	States	Count	Percentage
Yes	California, Kansas, Louisiana, North Carolina, Oregon, Rhode Island, South Dakota	7	70.00%
No	New Hampshire, New Jersey, Ohio	3	30.00%
Total		10	100.00%

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

a. Lost/stolen Rx

Figure 21 - Allows for Pharmacist Overrides for an Early Refill for Lost/Stolen Rx

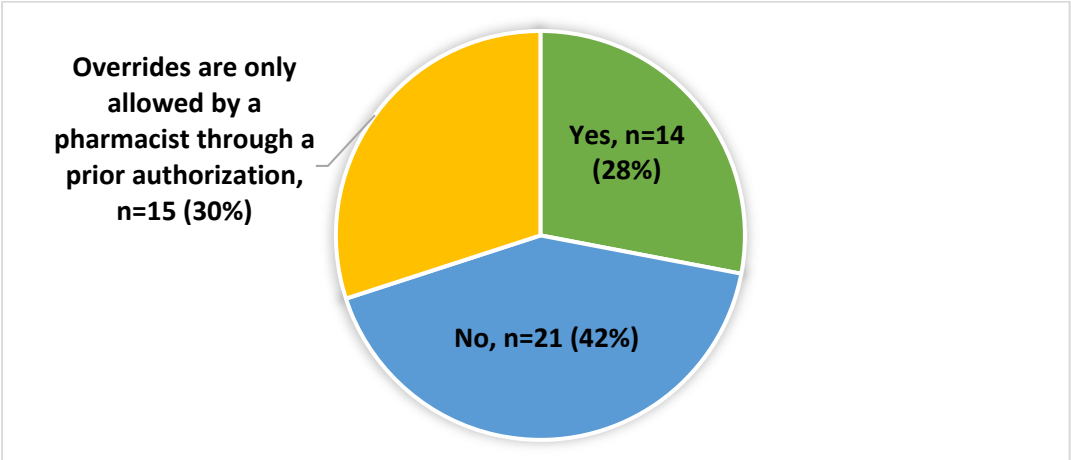

Table 27 - Allows for Pharmacist Overrides for an Early Refill for Lost/Stolen Rx

Response	States	Count	Percentage
Yes	California, Kansas, Louisiana, Nebraska, New Hampshire, New Mexico, North Carolina, Oregon, Rhode Island, South Dakota, Utah, Virginia, Washington, Wisconsin	14	28.00%
No	Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Michigan, Mississippi, Nevada, New Jersey, New York, North Dakota, Ohio, Tennessee, Texas, Vermont, West Virginia	21	42.00%
Overrides are only allowed by a pharmacist through a prior authorization	Alabama, District of Columbia, Georgia, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Oklahoma, Pennsylvania, South Carolina, Wyoming	15	30.00%
Total		50	100.00%

b. Vacation

Figure 22 - Allows for Pharmacist Overrides for an Early Refill for Vacation

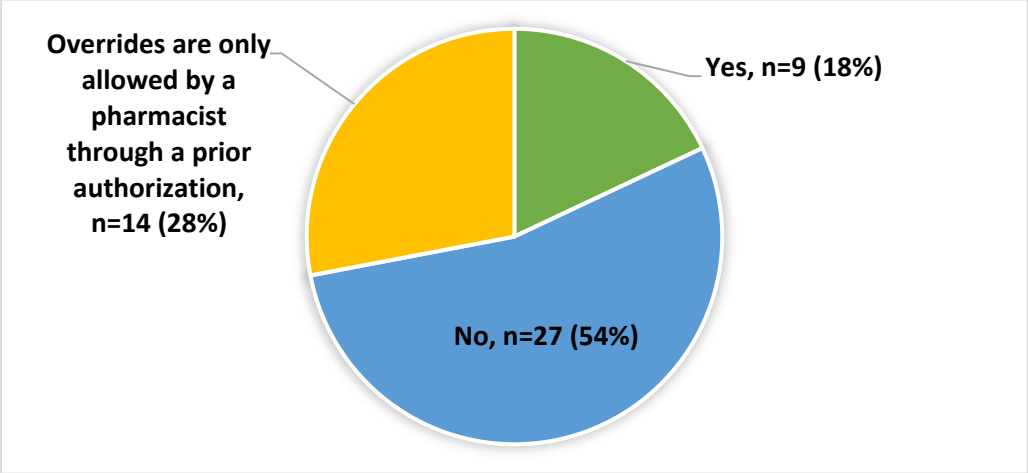

Table 28 - Allows for Pharmacist Overrides for an Early Refill for Vacation

Response	States	Count	Percentage
Yes	California, Louisiana, Nebraska, New Hampshire, New Mexico, North Carolina, Oregon, Virginia, Wisconsin	9	18.00%
No	Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Mississippi, Nevada, New Jersey, New York, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia	27	54.00%
Overrides are only allowed by a pharmacist through a prior authorization	Alabama, District of Columbia, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Pennsylvania, South Carolina, Washington, Wyoming	14	28.00%
Total		50	100.00%

c. "Other," please explain

Table 29 - "Other" Explanations for Allowing Pharmacist Overrides for an Early Refill

State	"Other" Explanations
Alaska	Lost or stolen only in the event a police report has been filed and upon coordination/approval of the prescriber.
Arkansas	Dispensing pharmacists are not allowed to override an early refill DUR message for lost/stolen RXs or for vacations at POS. Early refill requests (no matter the reason) 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. However, the pharmacist may contact the pharmacy call center help desk for authorization to override the edit.
Connecticut	For non-CS for lost or stolen or vacation, either the pharmacist or prescriber can override with a PA. For CS for lost or stolen or vacation, only the prescriber can request a PA.
Delaware	Overrides by pharmacist are allowed for changes in direction with a prior authorization or entry of Submission Clarification code of 5.
District of Columbia	Pharmacists are allowed to override early refill edits due to dose changes.
Hawaii	Change of dose, additional therapy authorized, readmit to a long term care facility or discharged from hospital without medication allowed by a pharmacist through a prior authorization
Idaho	Overrides are allowed for change of dose only.
Iowa	Pharmacists are not able to do any override at the point of sale. Any lost/stolen rx or vacation overrides are handled through the POS help desk where the technician can provide an override if appropriate.
Kansas	Therapy change is also a reason to allow a pharmacist override. Clarification- only beneficiaries 18yo and younger qualify for the lost or spilled medication early refill override.
Louisiana	Other situations may be overridden using the pharmacist's professional judgement.
Maine	Nursing Home admissions are allowed by the pharmacist override at the Store level.
Montana	We do not allow the pharmacist to override an early refill DUR message for any reason. It always requires a prior authorization.
Nebraska	Lost or stolen controlled substance prescriptions require a prior authorization.
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 or Conduent helpdesk for approval prior to overriding.
North Carolina	For controlled substances, only override is for change of therapy. No vacation or lost med is allowed for controlled substances.
Oklahoma	All overrides require a prior authorization.
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.

State	"Other" Explanations
South Carolina	Lost/Stolen require documentation (police report documenting) and notification/approval by prescriber (if Control Rx) Miscellaneous: spills/stability (meds left unrefrigerated/left in car/heat), etc. - are referred back to the State for their review/approval. Typically these are $$ medications/sometimes controls) and/or unusual circumstances
South Dakota	Pharmacist is required to verify police report for stolen prescriptions. Lost prescription overrides limited to one per year. Early refills may require PA if the reason for the early refill (ex. increased dose) exceeds the dose required for PA.
Tennessee	all lost/stolen/vacation supply early refills must be called in by the pharmacy or provider to the PBM's call center, and these are forwarded to the State for a decision on each request.
Texas	Dispensing pharmacist must call state pharmacy helpdesk for an override. Necessary information and reasons for early refill must be provided. For the stolen controlled substance drugs, Vendor Drug Program must either receive a police report or have the prescriber attest to that. For non-controlled prescription, the help desk staff documents the information and allows an additional prescription to be dispensed for the lost or stolen quantity.
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 Help-desk. If appropriate then an override may be applied.
Washington	Pharmacists may also self-authorize early refills for situations where separate supplies are needed for separate locations, such as a home supply and a school supply, or when the patient is being actively monitored by the prescriber.
West Virginia	The retail pharmacist cannot override the eary refill edit.
Wisconsin	Wisconsin allow for a dosage change, natural disaster and when the member misunderstood the directions from the prescriber.

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

Figure 23 - System Accumulation Edit for Prevention of Early Prescription Filling

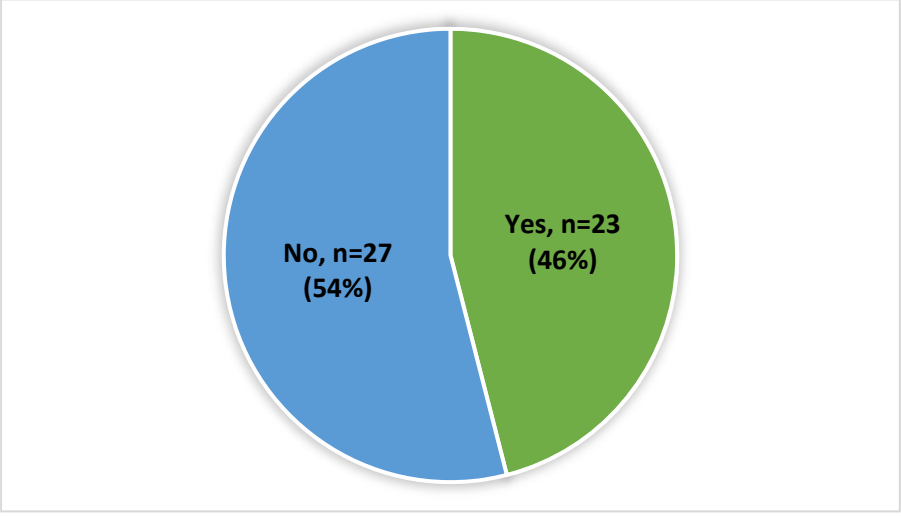

Table 30 - System Accumulation Edit for Prevention of Early Prescription Filling

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, New Mexico, New York, North Dakota, Oklahoma, Rhode Island, South Carolina, Virginia, West Virginia, Wyoming	23	46.00%
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%
Total		50	100.00%

If "Yes," please explain your edit

Table 31 - 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	Alaska Medicaid allows a 7 day accumulation over a 120 day look-back for control medications and a 21 day accumulation over 120 days for non-controlled medication filled for 90 days.
Arkansas	We have a Refill Too Soon logic that allows refills when 75% of a previous prescription has been used, and we have an Early Refill Accumulation Limit that allows a maximum accumulation in a 180-day look-back period. The Refill Too Soon logic applies to both controlled and non-controlled drugs. The Early Refill Accumulation Limit identifies the same drug/same strength/same dosage form and adds up the days' supply for each time the drug is filled early during the look-back period. Recipients with non-controlled drugs are allowed a 12 days' supply extra in the 180-day period, and recipients with controlled drugs are allowed only 7 days' supply extra in the 180-day period.
Colorado	A cumulative total of twenty days is allowed over a 180 day period.
Delaware	Delaware posts an audit on claims If the accumulative refills are greater than 4 in 120 days post the audit. Early refill date: From date of service plus (days' supply 83% for non-controls and 90% for controls)
Florida	Certain classes have accumulation edits (proton pump inhibitors, skeletal muscle relaxants, and controlled substances). The edit counts refills over a particular time frame to prohibit a total accumulation amount.
Georgia	The claims processing system will evaluate the days supply for historical claims against the days supply of new claims.
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.

State	Explanations
Kentucky	Kentucky allows a three (3) day tolerance per month.
Louisiana	We have accumulation edits on proton pump inhibitors. The pharmacist may override the maximum duration of therapy after consultation with the prescribing provider.
Maine	edit calculates the remaining supply of medication and only allows a refill up to 7 days early. once the accumulator is hit it requires prior authorization
Michigan	MI 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	At the time of refill the edit allows for an existing supply of no more than 10 days of medication which is determined by a refill "look-back" of 90 days. For controlled substances, the existing supply at the time of refill must be no more than 7 days as determined by a 90 day "look back".
North Dakota	Max of 15 days of accumulation for non-controlled / max of 10 days of accumulation for controlled in a 180 day lookback period.
Oklahoma	We have this for stimulants and buprenorphine/naloxone 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	The system only allows one original prescription and 5 refills per prescription.
South Carolina	75% of fill required for non control drugs and 85% for controls
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 all subsequent claims, and the refill tolerance will be calculated on that accumulated total.

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

Figure 24 - Plans to Implement a System Accumulation Edit

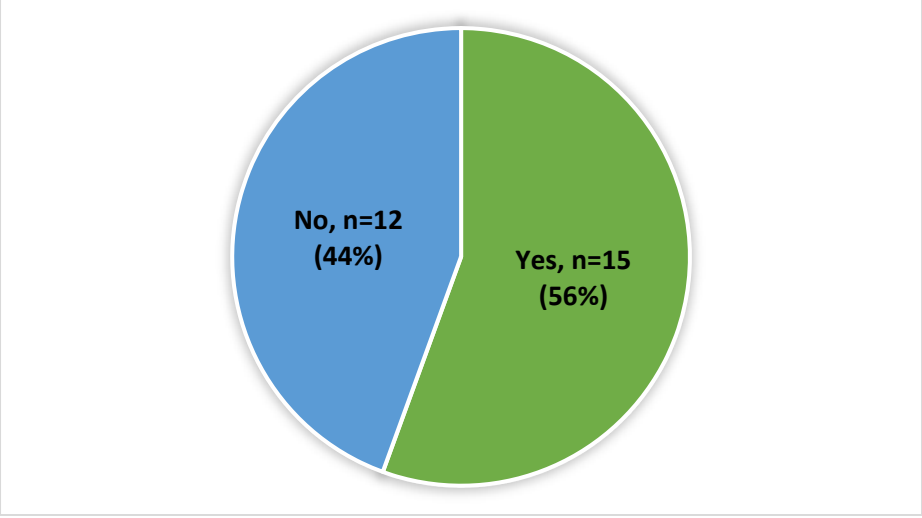

Table 32 - Plans to Implement a System Accumulation Edit

Response	States	Count	Percentage
Yes	District of Columbia, Iowa, Kansas, Maryland, Massachusetts, Mississippi, Montana, New Jersey, North Carolina, Ohio, South Dakota, Tennessee, Utah, Vermont, Washington	15	55.56%
No	California, Connecticut, Hawaii, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, Oregon, Pennsylvania, Texas, Wisconsin	12	44.44%
Total		27	100.00%

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 25 - State Policy Prohibiting Auto Refill

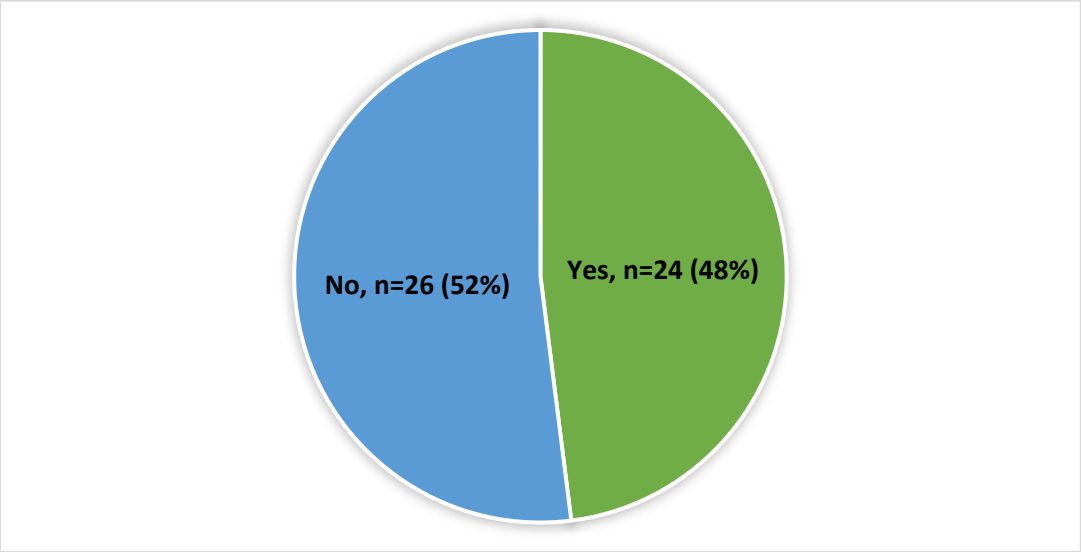

Table 33 - State Policy Prohibiting Auto Refill

Response	States	Count	Percentage
Yes	Alabama, Delaware, Florida, Georgia, Idaho, Illinois, Maryland, Massachusetts, Minnesota, Mississippi, Nebraska, 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, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Ohio, Pennsylvania, Rhode Island, Vermont, Washington, Wisconsin	26	52.00%
Total		50	100.00%

10. Does the state Medicaid agency have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient 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 26 - State Policy for Synchronization of Prescription Refills

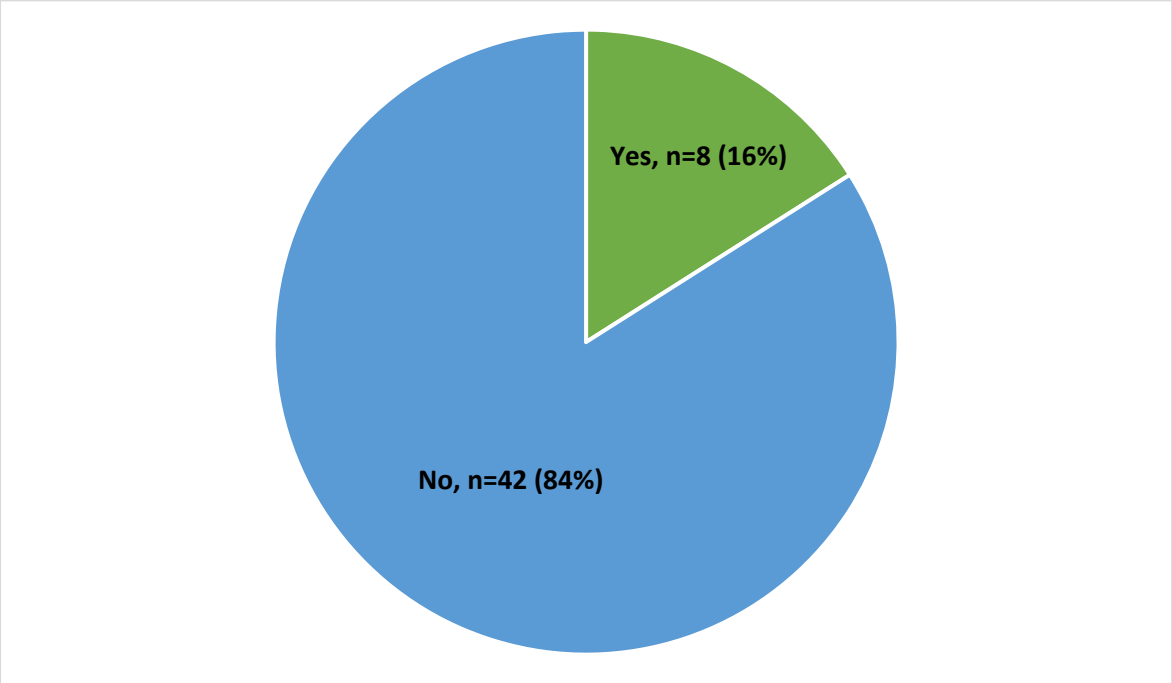

Table 34 - State Policy for Synchronization of Prescription Refills

Response	States	Count	Percentage
Yes	Kentucky, Nevada, New Hampshire, Ohio, Oregon, Texas, Vermont, Virginia	8	16.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Washington, West Virginia, Wisconsin, Wyoming	42	84.00%
Total		50	100.00%

11. For drugs not on your formulary, does your agency have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?

Figure 27 - Documented Process to Access Any Covered Outpatient Drug (COD) when Medically Necessary

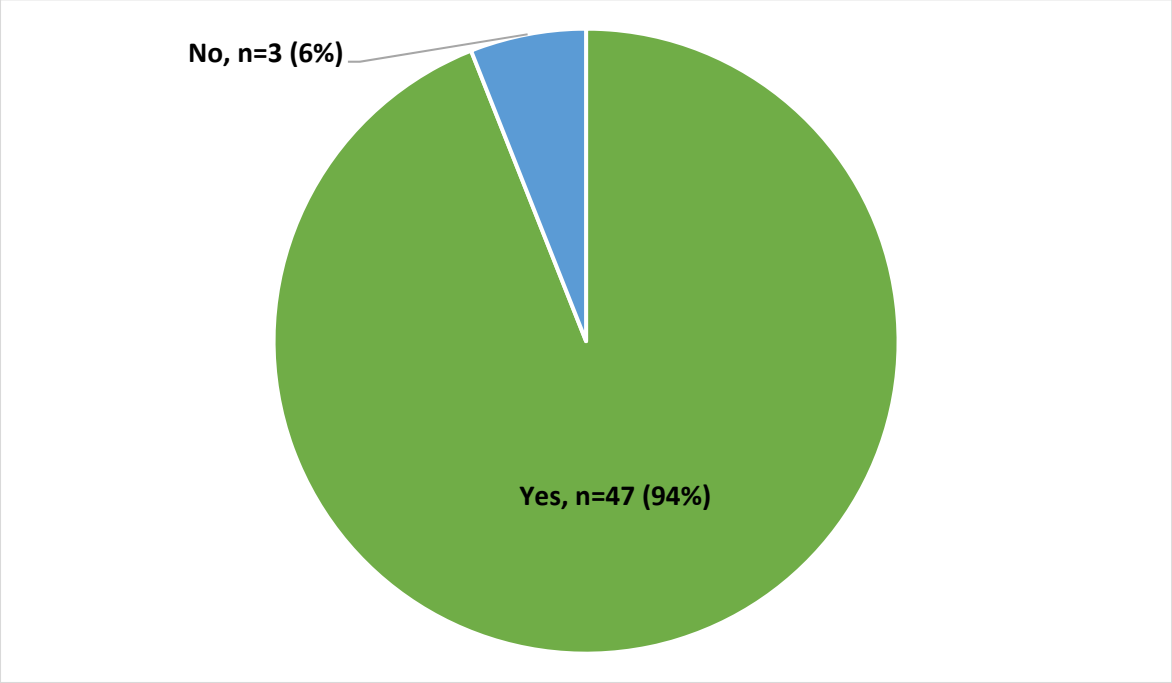

Table 35 - Documented Process to Access Any Covered Outpatient Drug (COD) when Medically Necessary

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 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	New Jersey, Rhode Island, South Dakota	3	6.00%
Total		50	100.00%

If “Yes,” what is the preauthorization process?

Table 36 - Explanations for the Preauthorization Process to Access Any Covered Outpatient Drug (COD) when Medically Necessary

State	Explanations
Alabama	For drugs not preferred on the preferred drug list (PDL), prior authorization may be obtained for medication approval.
Alaska	Alaska Medicaid does not maintain a formulary. Alaska Medicaid maintains a Preferred Drug List (PDL) for covered outpatient drugs that are non-preferred on the PDL the prescriber must write "Brand Medically Necessary" on the prescription. The pharmacist may override at the point of sale.
Arkansas	Drugs not on the preferred drug list will either process without a PA or require manual review (PA). Criteria for manual review for many drugs can be found on the PA criteria document and in provider memos accessed through the contractor website. https://arkansas.magellanrx.com/client/documents. PA requests are only accepted from prescribers (not pharmacists or other third parties) for manually reviewed drugs. Prescribers submit a letter of medical necessity, completed PA form (if required), chart notes, and labs (if warranted). Requests are reviewed by a clnical pharmacist that is either employed by the contractor or the State. Antipsychotics are reviewed by a clinical pharmacist and our chief psychiatrist. Each request is reviewed on a case-by-case basis with guidance from the DUR Board approved criteria, clinical guidelines, and support in MicroMedex. New drugs on the market are reviewed weekly by the contractor and the State to determine how the drug will be reviewed. If the drug class is already on the PDL, the new drug will typically be placed on the PDL as a non-preferred option. If the new drug is novel, requires monitoring, or is a specialty drug, it will be designated manual review and placed on an upcoming DUR Board agenda for review. New drugs not yet reviewed by the DUR Board requiring a PA will be reviewed with reference to the package insert and clinical trials.
California	The Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug not on the Medi-Cal Fee-for-Service List of Contract Drugs (CDL) with an approved Treatment Authorization Request.
Colorado	Prescribers may submit a pharmacy prior authorization to the State's PBM by phone or by faxed form 24 hours a day, 7 days a week. Prior authorization denials are eligible for expanded clinical review with prescriber submission of pertinent patient clinical information and/or clinical literature supporting safe and effective use and medical necessity.
Connecticut	The prescriber submits a non-preferred drug list prior authorization.
Delaware	Drugs not listed on our formulary require prior authorization. In those cases, the provider will submit a prior authorization through our portal, fax, or telephone. Upon receipt of the prior authorization, the Pharmacist will consider available drug information such as the FDA package insert, clinical trials, other available therapies, as well as patient need, history, and appropriateness in determining coverage status for that specific patient. If the request is for a multisource drug, use of the generic version is required, or a Med Watch form showing a contraindication to generic would need to be provided. Medicaid has a universal form for non-formulary related denials to address cost threshold, quantity limitation, and nonspecific prior authorization denials.
District of Columbia	Providers will be asked to use a preferred agent. Acceptable reasons for use of non preferred agents include: Allergy to medications not requiring prior approval; Contraindication to or drug-to-drug interaction with medications not requiring prior approval; History of unacceptable/toxic

State	Explanations
	side effects to medications not requiring prior approval; Clinical stability; Changing to a medication not requiring prior approval might cause deterioration of the patient's condition. The requested medication may be approved if therapeutic failure to no less than a one-month trial of at least two medications within the same class not requiring prior approval; Therapeutic failure of the requested brand medication's corresponding generic (if a generic is available and preferred by the state).
Florida	Non-preferred medications with set criteria and prior authorization forms are posted on the Agency for Health Care Administration Pharmacy Policy site (https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/paforms.shtml). Medications that do not have set criteria can be submitted on the miscellaneous prior authorization form. The forms list the requirements and documentation necessary for review. The clinical reviewers have 24 hours to review the prior authorization request and provide a response.
Georgia	Coverage can be requested through the Appeal's process by the prescriber submitting a letter of medical necessity.
Hawaii	prior authorization.
Idaho	Many have an auto-PA process that looks at past drug use and Medical history. For example if the drug is non-preferred and the beneficiary has history of using the preferred agent, it may auto-PA. Others require a manual PA to be submitted by the prescriber to the Idaho Medicaid Clinical Call Center. Note that Idaho has a preferred drug list, but not a formulary.
Illinois	In the POS, if a non-preferred medication is requested, it rejects with a prior authorization required message. The pharmacist or prescriber can submit a prior authorization request via the hotline, fax, or through the prescriber portal, IMPACT. Criteria must be met for prior authorization approval. Prior approval can be requested by the prescriber even before the prescription is sent or presented at the pharmacy.
Indiana	All covered outpatient drugs are part of the formulary. Certain agents may require prior authorization due to non-preferred status or drug-specific criteria.
Iowa	Iowa does not have a formulary, pursuant to section 1927(d)(4) of the Social Security Act. Instead we have a Preferred Drug List (PDL) which utilizes a prior authorization (PA) program pursuant to section 1927(d)(5). Drugs that meet the definition of a covered outpatient drug are available on the PDL to the Medicaid beneficiary or the Medicaid beneficiary's prescriber, when medically necessary. Prescribers submit PA requests for drugs with clinical PA criteria and/or a non-preferred status on the PDL via fax for consideration.
Kansas	We cover all drugs deemed Covered Outpatient Drugs (CODs) by CMS standards. For drugs with a prior authorization requirement, our process is as follows: Hard stop at the point-of-sale (and via medical claims request) followed by manual/automated review of submitted provider information and prior authorization criteria approved by the DUR Board. For requests for drugs not considered a COD benefit, coverage may be allowed through the EPSDT benefit.
Kentucky	The process is the same for drugs that are listed on the preferred drug list (PDL); a prior authorization is submitted through the usual channels (phone, fax, electronic). Many non-PDL drugs are available without a PA.
Louisiana	The preauthorization process utilizes a single preferred drug list (PDL) for selected therapeutic classes. Drugs included on the PDL are preferred. Drugs in these classes that are not included on the PDL require prescribers to obtain prior authorization.
Maine	exactly as described, Prior authorization with supporting medical necessity for clinical review..

State	Explanations
Maryland	Maryland Medicaid utilizes a prior authorization process to provide coverage for all non-preferred covered outpatient drug products. When a claim is rejected for prior authorization, a message is provided through the POS system that alerts the pharmacy provider. The prescriber is then contacted with the prior authorization rejection information as well as any contact information provided. Prescribers must then contact the appropriate party to resolve the claim denial. This may include diagnostic or laboratory data, attestation of baseline and subsequent evaluations, or patient specific past medical history required to assure the safe and appropriate use of the requested drug product. Additionally, prior authorization forms are available online at https://mmcp.health.maryland.gov/pap/Pages/Pharmacy-Program-Forms.aspx
Massachusetts	Submission and approval of a prior authorization.
Michigan	MI has a non-formulary prior authorization process. Prescribers must submit a request stating the clinical necessity of the non-formulary medication over similar covered formulary products. All requests are reviewed on a case-by-case basis by the MDHHS physicians.
Minnesota	The prior authorization process consists of providers submitting patient specific documentation which will be reviewed against established prior authorization (PA) criteria. PA criteria are developed using FDA approved labeling information and other evidence-based sources. For PDL drug classes, besides clinical PA criteria, non-preferred drugs contain the PA criteria of using preferred drug(s) before non-preferred drugs unless there is a documented clinical reason not to do so.
Mississippi	For federally rebated covered outpatient drugs not managed by the PDL (formulary), the POS system is programed to allow for coverage with appropriate age and quantity limits when medically necessary.
Missouri	Prior authorization requests are accepted and responded to via telephone or by faxing the Drug Prior Authorization form. Requests may be initiated by either pharmacy or prescriber staff. Requests received that have sufficient information receive a response either during the requestor's call or by return fax or phone call.
Montana	For medications that are not covered per our state plan and/or are not rebateable, providers can submit an EPSDT request supporting medical necessity in children 20 and younger. There is no mechanism for adults to receive medications that are not covered per state plan and/or not rebateable.
Nebraska	If rejected at POS, the provider is contacted and can either switch to the approved product or start the prior authorization process.
Nevada	The prescribing provider may fax or call the OptumRx Prior Authorization Call Center to request authorization. Medicaid Services Manual (MSM) Chapter 1200 - Prescribed Drugs includes criteria which states that drugs not on the PDL, but within drug classes reviewed by the Silver State Scripts Board (formerly known as the P&T Committee), require prior authorization, unless exempt under NRS or federal law or excluded through recommendations of the Silver State Scripts Board or excluded by DHCFP. New pharmaceutical products not within reviewed PDL drug classes and not excluded under the state plan or by NRS are covered without a Standard Preferred Drug List Criteria.
New Hampshire	The Medicaid beneficiary's prescriber my request prior authorization from the State's PBM by calling, faxing or submitting a prior authorization request electronically. All prior authorization criteria and prior authorization request forms are available on the Department's website, https://www.dhhs.nh.gov/ombp/pharmacy/authorization.htm.
New Mexico	The provider can contact the state pharmacist at Medical Assistance Division with the New Mexico Human Services Department to obtain a prior authorization.

State	Explanations
New York	Prescribers initiate a prior authorization (PA) request by contacting the NY Medicaid pharmacy clinical call center via telephone, fax or by way of a web-based application. In certain cases, an authorized agent (i.e. nurse, medical assistant with patient medical record access) can initiate the PA process. Each drug has specific clinical information that must be provided to the clinical call center before prior authorization may be issued. In general, prescribers or an authorized agent initially speak with a Certified Pharmacy Technician (CPT) when requesting authorization. If the information provided meet the clinical criteria, a PA may be issued by the CPT. Information not meeting the criteria are referred to a pharmacist for discussion of additional supporting information. If the clinical criteria are met, a PA is issued. Further escalation to a Medical Director may be necessary for certain PA requests. The Medical Director or pharmacist may contact the prescriber's office to discuss the rationale for use of a drug when the PA criteria is not met.
North Carolina	For non-formulary requests for children, prescribers can submit an EPSDT PA request. The request will be reviewed using EPSDT criteria for approval. Rebateable active drugs not listed on the PDL and not requiring a PA are covered if allowed by CMS.
North Dakota	We don't have a formulary, but we have a PDL, and medications not on the PDL can be accessed through the prior authorization process if they meet the criteria.
Ohio	An online Drug Lookup Tool is available on Ohio Medicaid Website to assist in determining coverage of a specific product. If the Drug Lookup Tool indicates that the drug requires a prior authorization, there is a process in place to access a drug when medically necessary.
Oklahoma	Oklahoma doesn't have a PDL per se. We have a product based prior authorization program. Categories that require clinical criteria and/or step therapy are posted on our website with criteria and access to the prior authorization forms. Products/categories not posted on the website are generally covered with open access. These may have age or quantity limits in place. Prescribers also have access to covered products through their e-prescribing platform.
Oregon	Claim would deny as a non-preferred drug that requires a prior authorization. Prescriber submits prior authorization request to vendor via phone, fax, mail, or provider web portal. Prior authorization is reviewed and responded to within 24 hours.
Pennsylvania	Per the Social Security Act, Pennsylvania Medicaid covers all outpatient covered drugs as defined by CMS. See the Pennsylvania FFS website at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Pharmacy-Prior-Authorization-General-Requirements.aspx.
South Carolina	Denials letters are returned outlining the appeals process for products not uendproves dare prooaiThe For children- medically necessary documentation is requested upon , providereer
Tennessee	For products that are non-preferred, or not listed on the PDL, Prior Authorization is required, and this process is managed by the PBM. All PA requests are subject to a 24-hour mandated turnaround time, unless additional information is required by the provider or needed from the enrollee's medical records.
Texas	Prescriber may contact Vendor Drug Program (VDP) for requested non-formulary product. Reasons for requesting a non-formulary product as well as the duration of therapy must be provided. VDP will, then, review and approve on a case-by-case basis.
Utah	There are two pathways which a drug may require a prior authorization. The first pathway is identified by the PDL. For these drugs, prior authorizations are available, non-drug specific (Medication Exception PA Form) and drug specific, for the beneficiary's prescriber to submit a request for medication use. The second pathway is when a prior authorization requirement is identified at the point of sale for drugs that are not listed on the PDL; the prescriber may submit a (Medication Exception Form). Note, there are drugs that are not listed on the PDL and do not require a PA.

State	Explanations
Vermont	The Provider may request through Prior Authorization. The Prior authorization is reviewed for clinical appropriateness and the members medication history is reviewed for prior therapies. The provider may also be contacted to suggest other similar drugs already listed on the Preferred Drug list.
Virginia	- PDL preferred drugs do not require Service Authorizations (SA) unless subject to additional clinical criteria (e.g., long acting opioids, hepatitis C therapies, growth hormone) - Non-preferred drugs require an SA - Drugs not on the PDL are subject to Virginia's mandatory generic substitution requirements. - Several DUR drugs require an SA - fax forms with criteria available at: https://www.virginiamedicaidpharmacyservices.com/provider/authorizations - SAs may be submitted by fax, phone or WebPA. For urgent requests, call 800-932-6648. Fax requests receive a response within 24 hours. The following routine PDL criteria guidelines will be applied to all non-preferred drugs. 1. Is there any reason the member cannot be changed to a preferred drug within the same class? Acceptable reasons include: - Allergy to preferred drug. - Contraindication to or drug-to-drug interaction with preferred drug. - History of unacceptable/toxic side effects to preferred drug. - Member's condition is clinically stable; changing to a preferred drug might cause deterioration of the member's condition. 2. The requested drug may be approved if both of the following are true: - There has been a therapeutic failure of at least two preferred drugs within the same class as appropriate for diagnosis unless otherwise noted in the clinical criteria. A therapeutic failure of only one preferred drug is required when there is only one preferred drug within a therapeutic class. - The requested drug's corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated.
Washington	Washington Apple Health (Medicaid) prior authorization (PA) determination and process is documented in Washington Administrative Code (WAC) 182-530-3000 through 182-530-3200. Additional information related to PA process and criteria may be found in the Washington Apple Health (Medicaid) Prescription Drug Program Billing Guide and on the Washington Apple Health (Medicaid) Drug Coverage Criteria webpage. Some drugs have PA requirements that may be self-authorized by a pharmacist with use of expedited authorization (EA) code. For all other PA, pharmacies or prescribers must request a prior authorization. Washington Apple Health (Medicaid) processes the PA request per timelines and makes an authorization determination based on WAC 182-530-3200(3)(4).
West Virginia	Prior authorization criteria must be met. The request goes to Rationale Drug Therapy for clinical review. If the request is denied by RDTP the physician can request an appeal that gets reviewd by a pharmacist at BMS along with the medical director who makes a final decision.
Wisconsin	Wisconsin does not use a formulary, but a Preferred Drug List (PDL). Wisconsin's PDL is not a comprehensive list of outpatient drugs that Wisconsin covers. The Wisconsin PDL is a limited number of drugs and drug classes. Many covered outpatient drugs that are not part of the Wisconsin PDL are covered without a prior authorization (PA) requirements. When a covered outpatient drug that is not part of the Wisconsin PDL does have a PA requirement, Wisconsin has documented the PA policy and procedures to obtain PA.
Wyoming	The prior authorization process is primarily done electronically through the POS system. As a pharmacy claim is processed, the POS system checks the claim against clinical rules based on

State	Explanations
	prescription, diagnostic, and therapeutic histories. If the clinical rules are met, the claim will pay. If not met, the claim will deny and a PA form must be completed and signed by the prescriber. Point-of-sale prior authorizations reduce the number of paper prior authorization requests due to the system's ability to check both prescription and medical claims information. High cost prescription claims may require PA approval prior to dispensing. If a claim is approved, notification will be sent to the provider and pharmacy. PA approval will include documentation of the approved quantity and days supply. Claims that are submitted for a larger quantity than the approved PA will be denied. Claims that are submitted for a shorter days supply than the approved PA (without prescription direction support) may be subject to recovery and further audit proceedings.

If "No," please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.

Table 37 - Explanations for not having a Process for The Beneficiary to access a Covered Outpatient Drug when it is Medically Necessary.

State	Explanations
New Jersey	NJ FFS has an open formulary. Medicaid FFS beneficiaries have access to all covered outpatient drugs when deemed necessary.
Rhode Island	We do not have a state formulary.
South Dakota	N/A We do not have a formulary.

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

Figure 28 - Provide for the Dispensing of at least a 72-Hour Supply in an Emergency Situation

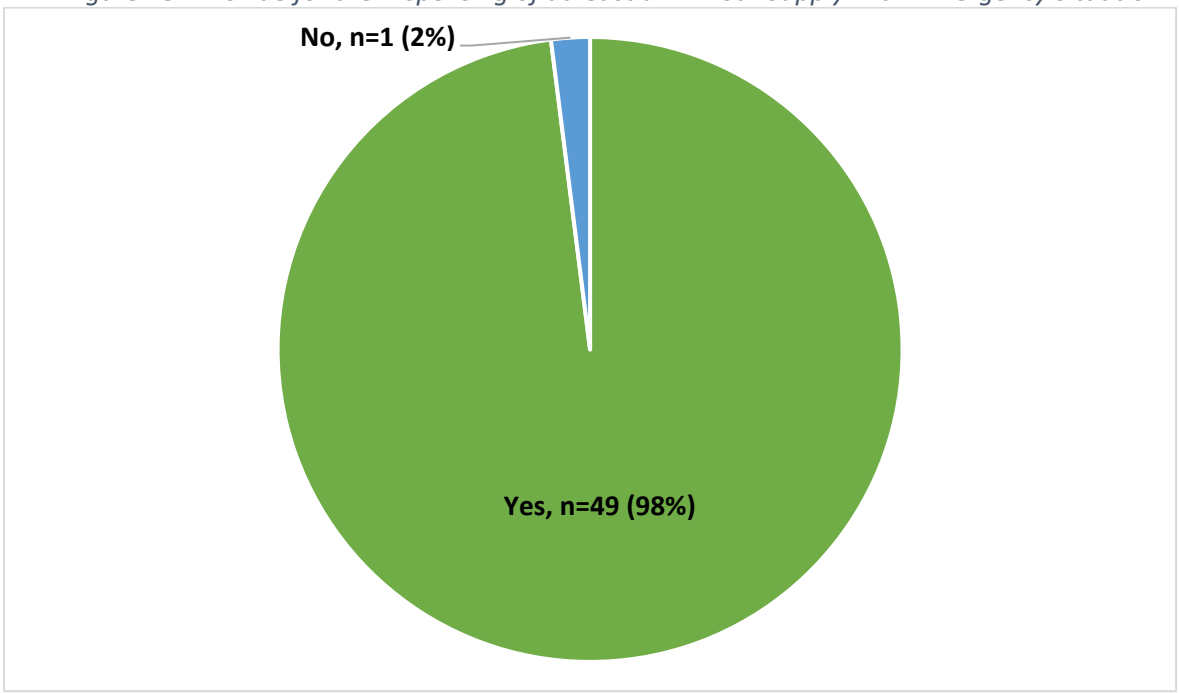

Table 38 - Provide for the Dispensing of at least a 72-Hour Supply in an Emergency Situation

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, West Virginia, Wisconsin, Wyoming	49	98.00%
No	New Mexico	1	2.00%
Total		50	100.00%

If "Yes," what is the process?

Table 39 – Process for Dispensing at Least a 72-Hour Supply in an Emergency Situation

State	Explanations
Alabama	The use of the emergency PA code is to be used only in cases of emergency. Federal Law makes a provision for a 72-hour supply by using the following authorization number: 0000999527.
Alaska	The pharmacist may call for a 5 day emergency override.
Arkansas	In an emergency, an Arkansas Medicaid enrolled pharmacy may dispense up to a five day supply of a drug that requires a prior authorization. This provision applies only in an emergency situation when the contractor's Prescription Drug Help Desk and the State Medicaid Pharmacy Program offices are closed, AND the pharmacist is not able to contact the prescribing provider to change the prescription. The Emergency Supply Policy does not apply to drugs that are not covered by the State. Frequency of the emergency override is limited to once per year per drug class for non-long term care beneficaries and once per 60 days per drug class for long term care beneficaries. To file a claim using this emergency provision, the pharmacy provider will submit a "03" in the level of service field.
California	The pharmacy may manually bill a 72-hour supply of a covered outpatient prescription drug in an emergency situation.
Colorado	Pharmacists or prescribers may call the pharmacy help desk to request an emergency override to dispense a 3-day supply of a medication in an emergency situation.
Connecticut	The pharmacy submits a claim with all 9's in the prior authorization field.
Delaware	Pharmacy manual allows a Pharmacist to dispense a 72 hours supply or 10 units with guarantee of payment. A look back of 120 days is required to establish a new start. Pharmacy submits the claim for less than or equal to 72-hour supply.
District of Columbia	Pharmacy providers can override the PA requirement for a non-preferred drug by entering "3" (emergency) in the Level of Service field (NCPDP Field #418-DI).
Florida	In the event of a natural disaster, the Bureau Chief will work with Magellan Medicaid Administration to selectively open payment to counties under threat. In the event of a fire or catastrophic loss, one early refill per year may be granted for non-controlled substances. The beneficiary's provider must submit an early refill request with a copy of the official police report. Medications that qualify for approval include those that prevent hospitalization (i.e., diabetic and blood pressure mediation), have a significant societal impact (i.e., seizure and HIV/AIDS

State	Explanations
	medication), or used to treat major mental health disorders (i.e., schizophrenia, bipolar disorder, major depression).
Georgia	If a pharmacist deems it necessary to dispense a 72 hour supply of medication, they may provide the medication, then contact the State for billing and reimbursement approval.
Hawaii	Prescriber cannot be reached to authorize medication changes and delayed receipt of the medication will be extremely detrimental to the patient's health, no similar medication available without prior authorization or patient has a documented intolerance for the similar agent, and emergency supply of the brand name drug may be dispensed if the patient's physician has previously documented that the patient is unable to use a generic form of a drug because of an allergy or history of a serious adverse reaction to the generic drug. A prior authorization form must be submitted to pharmacy fiscal agent: in lieu of the prescriber's signature, the words "emergency dispensing" must be written in the signature space on the claim form. In addition, "emergency dispensing," the date, time and justification for dispensing of the drug must be entered under the name of the drug on the claim form, and also documented on the prescription. A verbal prior authorization approval from the pharmacy fiscal agent, the claim can be processed via point of sale.
Idaho	The pharmacy can submit the appropriate ProDUR field responses that allow the emergency supply to pay at POS
Illinois	Pharmacist may fill the prescription for a 72-hour supply and must submit a 72-hour claim request for payment.
Indiana	Pharmacies may submit a 4-day supply via point-of-sale with a level of service override of 03 to indicate emergency supply.
Iowa	In the event of an emergency when the prescriber cannot submit a prior authorization request, the pharmacist may dispense a 72-hour supply of the drug, except when noted in policy, and reimbursement will be made. A 72-hour emergency supply of medication may be dispensed using prior authorization type code 1 as a point of sale override. The provision for a 72-hour supply can be used in an emergency situation only one time per member, per drug. A seven-day override of the prior authorization requirement will be allowed while the prescriber is requesting prior authorization for certain mental health drugs. The override applies to drugs that are deemed to have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class. The pharmacy may use a prior authorization type code 7 as a point of sale override for applicable mental health drugs. The seven-day provision can be used only one time per member, per drug, per 30 days.
Kansas	PROVIDER MANUAL GUIDANCE LANGUAGE: When a prescription is dispensed that requires PA in an emergency or after regular office hours, the pharmacy should call and leave a message on the voicemail indicating the date, time, beneficiary ID, and medication being dispensed. This will be taken as intent to begin the PA process. When medications are needed without delay and PA is not available, an emergency 3-day supply (72-hour) should be dispensed to the beneficiary until PA can be secured. The PA department will return the telephone message the next working day and process the request. If the PA request is approved, the remainder of the prescription will be considered for reimbursement. If PA is denied, only the portion of the medication dispensed emergently during nonworking hours/days will be considered for reimbursement.

State	Explanations
Kentucky	Providers may override PA requirements by entering LEVEL OF SERVICE (NCPDP Field 418-DI) 03 (emergency) under the following guidelines: -Overrides must be outside of normal business hours. -Overrides must be for a three (3)-day supply except where the package must be dispensed intact. -OTCs cannot be overridden. -Drugs normally not covered cannot be overridden.
Louisiana	In emergency situations, providers may dispense at least a 72 hour or a three day supply of medication.
Maine	pharmacist enters one time only override at the store level.
Maryland	A 72 hour emergency supply is available to all participants. A pharmacist must contact the POS vendor to request authorization to dispense.
Massachusetts	Pharmacist may override emergency supply at point of sale
Michigan	A Medical Emergency override requires that the Registered Pharmacist's or Licensed Prescriber's first and last names be documented by support center staff. This protocol allows for override of all applicable drug coverage edits with the exception of plan-excluded products. The required requester must attest to the following statement of a Medical Emergency as defined by MDHHS: Emergency care is defined as medically necessary services provided to an individual who requires immediate medical attention to sustain life or to prevent any condition which could cause permanent disability to body functions. Please note that if upon post payment review/audit this request is not deemed an emergency, then the payment for the medication is subject to recovery. The allowed quantity is typically a 72-hour supply; however, the supply may be increased to cover longer weekends/holidays as authorized by MDHHS.
Minnesota	In an emergency situation, the pharmacy may dispense and be reimbursed for up to a 72-hour supply of a drug that requires prior authorization without a prior authorization being obtained in advance.
Mississippi	The 72-hour emergency supply should be dispensed any time a PA is not available and the prescribed drug must be filled. If the presciber cannot be reached or is unable to request the PA, the pharmacy should submit an emergency 72-hour prescription. Pharmacist should use his/her professional judgment regarding whether or not there is an immediate need every time the 72-hour option is used. The 72-hour emergency procedure should not be used for routine and continuous overrides. A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g. an albuterol inhaler, as a 72-hour emergency supply.
Missouri	Pharmacy or prescriber staff may fax a backdated prior authorization request for approval of up to a 72-hour emergency supply. Requests received that have sufficient information receive a response via mail once approved.
Montana	The pharmacy can change the dispensed quantity to a 3 day supply and resubmit the claim with a prior authorization type code of "8" in field 461-EU.
Nebraska	The pharmacy can contact the PBM or plan to request a 72 hour supply to assist in processing.
Nevada	The pharmacy may call the OptumRx Call Center to request up to a 96-hour emergency situation coverage.

State	Explanations
New Hampshire	Pharmacies must request payment for the 72-hour supply from the member's prescription plan, either Fee-For-Service or the appropriate Medicaid MCO. On each provider notice we include the following. Emergency Drug Coverage Pharmacies are reminded that federal statute requires Medicaid programs (Fee-for-Service and managed care) provide payment for dispensing of at least a 72-hour supply for any drugs requiring prior authorizations if prior authorization cannot be obtained outside of Medicaid business hours. (Section 1927 of the Social Security Act. Codified as Section 1396r-8 of Title 42.(d)(5) (B))
New Jersey	FFS program will cover a 72-hour supply of a covered outpatient drug when the pharmacy provider submits a claim for 72-hour supply or less.
New York	A pharmacist can request a prior authorization for medication that is urgently needed. The supply amount would be for a 3-day period only. In addition, New York Medicaid FFS and Medicaid Managed Care provide at least 5 days' coverage for emergencies, without prior authorization, for medications used to treat substance use disorders.
North Carolina	A 72-hour emergency supply may be provided if a beneficiary is waiting for prior authorization request determination. The pharmacy is reimbursed for the supply if the prescription is changed to an alternative medication. A "3" in the Level of Service field (418-DI) should be used to indicate that the transaction is an emergency fill. The claims will only allow a 72-hour supply. Co-payments will apply and only the drug cost will be reimbursed.
North Dakota	If a medication requires prior authorization, a 5 or less day supply can be dispensed without the prior authorization being completed to allow for time to complete it.
Ohio	For controlled medications, the pharmacy has to call the helpdesk. For non-controlled medications, the pharmacy can use a submission clarification code.
Oklahoma	Pharmacies can obtain authorization for coverage of a 3-day emergency supply of medication by calling the Pharmacy Help Desk. For members who have an initial prior authorization request during the time the Help Desk is closed, the pharmacy may dispense an emergency 3-day supply, and an authorization can be approved retroactively when the Help Desk reopens.
Oregon	Pharmacy can call the Oregon Pharmacy Call Center 7 days a week to request a 96-hour emergency supply for a drug that is needing a prior authorization submitted. Emergency supplies permitted as long as drug is rebatable and covered.
Pennsylvania	Pennsylvania Medicaid allows for a 5 day supply of a covered outpatient drug without prior authorization. Process described at following webpage: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Pharmacy-Prior-Authorization-General-Requirements.aspx
Rhode Island	Submit a claim for a days supply of less than or equal to 3 and a quantity less than 10 with no claim for a duplicate NDC in the past 180 days.
South Carolina	The provider/pharmacy may fax/call the Call Center, which can then provide an emergency fill (authorization). Policy/procedure (Controlled Substance Act/DHEC) are applied in regard to controlled substances.
South Dakota	Requires pharmacist input on claim.

State	Explanations
Tennessee	Claim must be denied for non-preferred or requiring PA. --The pharmacist should determine if an immediate threat of severe adverse consequences exists should the patient not receive an emergency supply. --In the pharmacist's judgment, if the dispensing of an emergency supply is warranted, determine the appropriate amount for a three-day supply. For unbreakable packages, the full package can be dispensed. --Resubmit the adjusted claim to the PBM, including both a Prior Authorization Type Code (NCPDP Field 461-EU) of 8 and Prior Authorization Number (NCPDP Field 462-EV) of 88888888888 to override the POS denial. --The enrollee is not charged a co-pay for the emergency supply. --The emergency supply DOES count toward the monthly prescription limit. --Only one emergency supply is provided per drug per member per year. --Recipients are not permitted to receive, nor will TennCare pay for the remainder of the original prescription at any pharmacy unless the prescriber has received a PA. If the prescriber obtains a PA OR changes the drug to an alternative not requiring a PA in the same month, the remainder of the prescription and/or substitute prescription does not count toward the monthly limit. --To exempt the remainder of the prescription from the prescription limit once a PA is obtained, or to exempt the replacement prescription from counting toward the prescription limit, the value of 5 must be submitted in the Submission Clarification Code (NCPDP Field 420-DK) on the incoming claim within 14 days of the initial prescription.
Texas	A 72-hour emergency supply of the prescribed drug should be provided by the pharmacy when a medication is needed without delay and prior authorization is not available. This applies to drugs that are non-preferred on the preferred drug list and/or drugs subject to clinical PA. The emergency override protocol applies to people enrolled in either traditional Medicaid or Medicaid managed care. Before dispensing a 72-hour emergency supply, the dispensing pharmacist should use professional judgment to determine if taking the prescribed medication jeopardizes the person's health or safety and make good faith efforts to contact the prescribing provider. A 72-hour emergency prescription will be paid in full, and it does not count toward the three-prescription limit for adults who have not already received their maximum prescriptions for the month. This procedure should not be used for routine and continuous overrides.
Utah	Pharmacist can place an override on the claim using PA Type Code: 461-EU = 2 and PA number: 462-EV = 72.
Vermont	the Pharmacy may utilize the 72 hour override at the store level when adjudicating the claim. This store generated override allows up to a 72 hour supply of the covered drug
Virginia	The pharmacist may dispense a 72-hour supply of the prescribed medication if the physician is not available to consult with the pharmacist, including after hours, weekends, holidays, and the pharmacist, in his or her professional judgment, consistent with current standards of practice, feels that the patient's health would be compromised without the benefit of the drug.
Washington	Washington Apple Health (Medicaid) Emergency Fill Policy guarantees claim payment for emergency fills. The policy allows the dispensing pharmacist to use their professional judgment to meet a client's urgent medical needs and dispense the medication, up to a 34 day supply. Once the prescription has been dispensed, the pharmacy requests an authorization for reimbursement of the emergency fill.
West Virginia	No copay is required for a 3-day emergency supply. The 3-day emergency supply does not count as a refill and no Prior Authorization (PA) is required. However, an override code of 99 must be submitted in the Submission Clarification Code. The claim for a 3-day emergency supply could be

State	Explanations
	the original filling waiting for a PA or a refill during off hours. Only three 3-day emergencies are allowed for the life of a given prescription, but there is no limit on the total number of different prescriptions that a member can receive a 3-day emergency supply for. Both controlled and non-controlled products may be obtained with a 3-day emergency supply, but products in bottles or glass containers specifically are not allowed to be obtained with a 3-day emergency supply.
Wisconsin	Wisconsin has a documented emergency supply dispensing policy for these situations.
Wyoming	In the event of an emergency the pharmacy is authorized to dispense up to a seventy-two (72) hour emergency supply. An emergency supply may only be used twice for each drug per 30 days. A dispensing fee and copay will not apply. Please refer to the payer sheet for instructions for PA code type and PA number field. Use of the emergency supply for non-emergency situations or to override the PA process will result in recovery of claim payment and further audit proceedings. Emergency supply overrides cannot be used for controlled substances or by Indian Health Services (IHS), tribal, or urban Indian pharmacies. A six (6) day emergency fill at the initiation of therapy with Suboxone films or buprenorphine/naloxone tablets is allowed. Once a claim for Suboxone films or buprenorphine/naloxone tablets has been processed, emergency supplies will only process one year after a client's last prescription fill of Suboxone films or buprenorphine/naloxone tablets.

If “No,” please explain

Table 40 - Explanations for not having a Process for The Beneficiary to access a Covered Outpatient Drug when it is Medically Necessary.

State	Explanations
New Mexico	Nothing is mandated by State Medicaid rules. However, a pharmacist can use his or her professional judgment to dispense up to a 3-day supply of a non-narcotic prescription in an emergency situation.

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

*Table 41 - 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
Aripiprazole	Anticonvulsants	Prior Authorization Required	Glecaprevir/pibrentasvir	Albuterol
Methylphenidate	Opioid Analgesics	Plan Limitations Exceeded	Lurasidone	Amoxicillin
Dextroamphetamine/ amphetamine	Antipsychotics	Therapeutic Duplication	Adalimumab	Ibuprofen
Quetiapine	Antidepressants	Age	Aripiprazole	Gabapentin
Risperidone	Proton Pump Inhibitors	Refill Too Soon	Lisdexamfetamine	Cetirizine
Hydrocodone /apap	Adrenergics, Aromatic, Non-catecholamine		Sofosbuvir/velpatasvir	Ergocalciferol
Omeprazole	Opioid Withdrawal Therapy Agents, Opioid-type		Paliperidone	Fluticasone
Oxycodone	Direct Factor Xa Inhibitors		Somatropin	Montelukast
Buprenorphine Hcl/naloxone Hcl	Analgesics		Buprenorphine Hcl/naloxone Hcl	Omeprazole
Lisdexamfetamine	Stimulants		Methylphenidate	Lisinopril

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

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

Figure 29 – Monitoring Oral Counseling Requirements

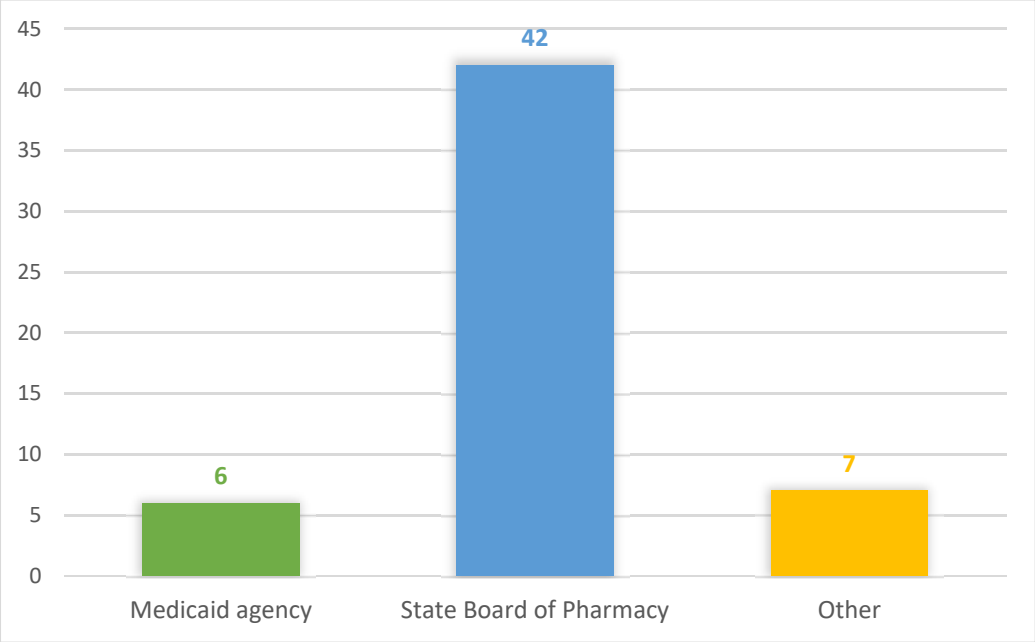

Table 42 – Monitoring Oral Counseling Requirements

Response	States	Count	Percentage
Medicaid agency	Alaska, Colorado, Connecticut, Florida, Hawaii, Kansas	6	10.91%
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, 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, West Virginia, Wisconsin, Wyoming	42	76.36%
Other	Hawaii, Illinois, Missouri, New York, South Carolina, Utah, Washington	7	12.73%
Total		55	100.00%

If “Other,” please explain

Table 43 - “Other” Explanations for Monitoring Oral Counseling Requirements

State	“Other” Explanations
Hawaii	FFS vendor monitors for organ transplant program. Dental claims to FFS handled like managed care plan dental oral counseling. FFS monitors both.
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	State Educational Department through the Office of Professional Discipline which performs on-site inspections.
South Carolina	(L)(1) Upon receipt of a prescription drug order for a new medication and following review of the patient's pharmacy record, the pharmacist shall personally offer counseling to the patient or the patient's agent. Using his best professional judgment, the pharmacist's counseling shall include a discussion of those matters that the pharmacist considers appropriate for the patient or patient's agent in that particular situation. The discussion must be in person, whenever practicable, or by telephone and shall include appropriate elements of patient counseling. The elements may include: (a) the name and description of the drug; (b) the dosage form, dose, route of administration, and duration of drug therapy; (c) intended use of the drug and expected action; (d) special directions and precautions for preparation, administration, and use by the patient; (e) potentially serious side effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur; (f) techniques for self-monitoring drug therapy; (g) proper storage; (h) prescription refill information; (i) action to be taken in the event of a missed dose; and (j) pharmacist comments relevant to the individual's drug therapy, including any other information peculiar to the specific patient or drug. (2) Alternative forms of patient information may be used to supplement patient counseling when appropriate including, but not limited to, written information leaflets, pictogram labels, or video programs. (3) Patient counseling is not required for inpatients or emergency department patients of a hospital or institution where other licensed health care professionals are authorized to administer the drug. https://www.scstatehouse.gov/code/t40c043.php (4) A pharmacist is not required to counsel a patient or caregiver when the patient or caregiver refuses the consultation. Patient Counseling Patient counseling is defined as the oral or written communication by the pharmacist to a patient or caregiver providing information on the proper use of drugs and devices. South Carolina Medicaid requires that, upon receipt of a prescription drug order for a new medication and following review of the patient's pharmacy record, the pharmacist shall personally offer counseling to the patient or the patient's agent. Using his or her best

State	"Other" Explanations
	professional judgment, the pharmacist's counseling shall include a discussion of those matters that the pharmacist considers appropriate for the patient or patient's agent in that particular situation. The discussion must be in person, whenever practicable, or by telephone or written communication and shall include appropriate elements of patient counseling. https://provider.scdhhs.gov/internet/pdf/manuals/pharm/Manual.pdf
Utah	Division of Occupational and Professional Licensing (DOPL) under the Pharmacy Practice Act Rule.
Washington	Pharmacy Quality Assurance Commission (PQAC) of Washington State is responsible for monitoring compliance for oral counseling.

14. Summary 1 – Pharmacy Oral Counseling Compliance

Summary 1 Pharmacy Oral Counseling Compliance reports the 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 and should describe in detail, utilizing the text box below, the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.

Table 44 - Pharmacy Oral Counseling Compliance

State	Explanations
Alabama	The Alabama Medicaid Agency has made efforts to monitor pharmacy compliance with the oral counseling requirement through retrospective audits. For additional information, please refer to Medicaid's Administrative Code, Chapter 16, Rule No. 560-X-16-.24-(8).
Alaska	The Department of Health and Social Services relies on the Board of Pharmacy within the Division of Corporations, Business and Professional Licensing under the Department of Commerce, Community, and Economic Development to enforce the State of Alaska Pharmacy Practice Standards. Alaska Regulations 12 AAC 52.585 (a) and (b) require the pharmacist to provide face-to-face counseling to the patient or patient's agent on matters considered significant in the pharmacist's judgment. When the Board of Pharmacy conducts an inspection of a pharmacy, one of the questions asked involves the requirement of 12 AAC 52.585. Mandatory patient counseling outlined below. The Department of Health and Social Services has not received any details of non-compliance in this area. 12 AAC 52.585. MANDATORY PATIENT COUNSELING. (a) With each new prescription dispensed, the pharmacist shall verbally provide counseling to the patient or the patient's agent on matters considered significant in the pharmacist's professional judgment. The counseling may include (1) the name and description of the prescribed drug; (2) the dosage and the dosage form; (3) the method and route of administration; (4) the duration of the prescribed drug therapy;

State	Explanations
	(5) any special directions and precautions for preparation, administration, and use by the patient that the pharmacist determines are necessary; (6) common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, how to avoid them, and what actions should be taken if they occur; (7) patient techniques for self-monitoring of the drug therapy; (8) proper storage; (9) prescription refill information; and (10) the action to be taken in the event of a missed dose. (b) A pharmacist shall counsel the patient or the patient's agent face-to-face. If face-to-face counseling is not possible, a pharmacist shall make a reasonable effort to provide the counseling by use of a telephone, two-way radio, or in writing. In place of a pharmacist's own written information regarding a prescribed drug, the pharmacist may use abstracts of the Patient United States Pharmacopoeia Drug Information or comparable information.
Arkansas	Monitoring pharmacies for oral counseling compliance with Omnibus Budget Reduction Act (OBRA) of 1990 prospective DUR requirement is the responsibility of the Arkansas State Board of Pharmacy. The Arkansas Medicaid Pharmacy Program is not responsible for this requirement or for collecting this data.
California	California pharmacy regulations require pharmacies to maintain patient medication profiles and counsel patients regarding their prescription medication before dispensing. Consultation provides the pharmacist with the opportunity to educate patients who present new prescriptions and protect them from potential problems associated with a new medication by discussing possible side effects, contraindications and the importance of following directions. Consultation also provides the pharmacist one more opportunity to prevent dispensing errors by inspecting the medication container's contents to assure that the proper drug is dispensed. Compliance to these requirements is the responsibility of the California Department of Consumer Affairs, Board of Pharmacy, which compiles annual reports that are available at: https://www.dca.ca.gov/publications/annual_reports.shtml. As part of its ongoing activities, the California Board of Pharmacy investigates complaints involving care provided in pharmacies. The California Board of Pharmacy typically will inspect the pharmacy in question at the start of each complaint investigation. Other inspections the Board performs include but are not limited to initial licensure, changes in ownership, change in location or a remodel, or simply a random inspection. A major function of an inspector's activities during these inspections is education of licensees regarding compliance with laws and regulations. When an inspector, who is a licensed pharmacist, visits a pharmacy to investigate a complaint or inspect a pharmacy, the inspector observes whether patient consultation is occurring and specifically notes the progress and components of the consultations; e.g., the temporal relationship between review of the patient profile and the consultation. Failure to consult or perform prospective drug utilization review prior to consultation results in a "correction ordered" and, possibly, a notice of violation. To ensure compliance, inspectors revisit pharmacies and follow up on correction notices. Violation notices usually result in the pharmacist, pharmacist-in-charge, and pharmacy management meeting with a subcommittee of the Board to discuss the violation. The above-referenced Board of Pharmacy regulations were determined previously by the Centers for Medicare & Medicaid Services, in order to comply with the prospective DUR requirements of OBRA 90. A specific report about compliance with oral counseling requirements

State	Explanations
	is not available from the California State Board of Pharmacy. As described by this Board, they typically evaluate compliance whenever a pharmacy is brought to the Board's attention through issues of fraud or abuse or a complaint of any sort. Verification of oral counseling is contained within these reports (made to various state and federal agencies) and is not separated out.
Colorado	This summary reports the 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 Reconciliation Act (OBRA) of 1990 prospective DUR requirement. This report details state efforts to monitor pharmacy compliance with the oral counseling requirement. This attachment should describe in detail the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported. Prospective DUR (ProDUR): Section 3.00.50 of the Colorado State Board of Pharmacy Rules require drug regimen review that includes evaluation of all prescription orders and patient records for known allergies; rational drug therapy and contraindications; reasonable dose, duration of use, and route of administration; reasonable directions for use; potential of actual adverse drug reactions; drug-drug interactions; drug-food interactions; drug-disease contraindications; therapeutic duplication; proper utilization and optimum therapeutic outcomes; and potential abuse/misuse. State's Efforts to Monitor Compliance with Oral Counseling Requirements Pursuant to the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), pharmacists in Colorado are required to offer to discuss matters related to the patient's prescription order which are deemed significant in the pharmacist's professional judgment. If the patient or caregiver is not available, they must make know that patient counseling is available and how he/she may be reached. The Colorado Board of Pharmacy Rules further state that pharmacists are required to offer counseling upon patient or caregiver request, or if the pharmacist deems that counseling is in the best interest of the patient. During the FFY 2019, the Board did not receive any complaints involving oral counseling and no patient counseling infarctions were noted and/or reported by the Colorado Board of Pharmacy to the Colorado Division of Medicaid.
Connecticut	MEDICAL AUDIT TRACKING SYSTEM-AUDIT PROVIDER INFORMATION TYPE SPEC NUMBER: NAME ADDRESS PHONE SEL CODE: SURS DATE: STATUS: RANK: DESELECTION DATES: TO: REVIEW PERIOD: FROM: TO: REVIEW AMOUNT: $ LAST REVIEW: FROM: TO: AUDITOR: ASSIGNED: STARTED: ONSITE START DATE: EXIT CONFERENCE: ESTIMATED HOURS: ACTUAL HOURS: UNIVERSE: UNIVERSE $: SAMPLE SIZE: CLAIM BREAKDOWN BY PROGRAM: STATISTICAL INFORMATION CLAIMS: PAID: UNDER $1000 OVER $1000

State	Explanations
	TITLE 19: CONFIDENCE INTERVAL GA: STANDARD DEVIATION TITLE 18: AVG. ERROR PER CLAIM PHARMACY SEED FOR SAMPLE OVER $1000 LOWER END LIMIT: SAMPLE SIZE UPPER END LMIT: CLOSING INFORMATION: DRAFT AUDIT REPORT DATE: CLOSED CODE: LETTER / RECOUPMENT DATE: LETTER NUMBER: OVERPAYMENT: $ COST AVOIDANCE: $ PCAR NUMBER: RECOUPMENT AMOUNT: $ AUDIT NUMBER: AUDIT ADJUSTMENT: $ PCAR ADJUSTMENT: $
Delaware	In Delaware, enforcement of the oral counseling requirement has been overseen by the state Board of Pharmacy. The oral requirement to counsel is on all prescriptions dispensed in Delaware. The state Board of Pharmacy performs this check. The rules and definitions that surround patient counseling in Delaware are available via the following link http://regulations.delaware.gov/AdminCode/title24/2500.shtml. The Division of Medicaid and Medical Assistance team does not perform random audits on the oral counseling. Audits have been performed on signature logs for dispensing. These logs serve a dual purpose not only for a dispensing record, but for the offer to counsel. Delaware Medicaid has a working relationship with the Board of Pharmacy where concerns that arise from our investigations can be reported and further reviewed for disciplinary action.
District of Columbia	Under the District of Columbia government structure, the Department of Health, Health Regulations and Licensing Administration, Pharmaceutical Control Division for the DC Board of Pharmacy has responsibility for monitoring pharmacy activities. The Pharmaceutical Control Division has the regulatory responsibility that involves annual licensure inspections, surveillance and the monitoring of activities in establishments that procure, distribute, dispense and manage prescribed/prescription products for sale or use to consumers in the District of Columbia. Regulated facilities include; pharmacies, hospitals, substances abuse treatment programs, researchers, local wholesalers, distributors, long term care facilities, animal clinics, dialysis centers and ambulatory surgical centers. Pharmaceutical Control Division enforces all District and federal pharmacy laws and regulations (pharmacy, controlled substances, prescription substitution, drug purity, and drug distribution and manufacturing laws and accompanying regulations, etc.). The monitoring activity includes pharmacy compliance with the oral counseling requirement mandated by OBRA 1990 by review of manual and electronic signature logs maintained in each pharmacy during both scheduled and unscheduled inspections. Pharmaceutical Control Division serves as a liaison between District Government and Federal Agencies, (i.e. Food and Drug Administration, Drug Enforcement Administration, Health and Human Services, the Consumer Protection Agency, etc.), involving regulatory control matters. Pharmaceutical Control Division conducts investigations and provides consultation to all facilities and programs that provide pharmaceutical products and services to District of Columbia residents.

State	Explanations
Florida	Florida Medicaid Pharmacy Program Drug Utilization Review Annual Report: FFY19 Pharmacy Oral Counseling Compliance Report Currently all Florida Prospective Drug Utilization Review (DUR) requirements are electronic with the exception of patient counseling. All pharmacists are required to submit each claim through the point-of-sale system in order to receive payment from Florida Medicaid. With each electronic claim submission, the claim is reviewed against the past 90 days of claims for age specific appropriate dosing, early refill, therapeutic or ingredient duplication and drug-to-drug interactions. The Florida Medicaid Program Integrity Bureau monitors pharmacy compliance with the OBRA 1990 oral counseling requirement. Pharmacy surveys are conducted in which a questionnaire is used to access oral counseling compliance. During the fiscal year period of October 1, 2018 to September 30, 2019, 1 survey was conducted including the questionnaire. The pharmacy demonstrated they were compliant with OBRA requirements to offer counseling. 64B16-27.820 Patient Counseling. (1) Upon receipt of a new or refill prescription, the pharmacist shall ensure that a verbal and printed offer to counsel is made to the patient or the patient's agent when present. If the delivery of the drugs to the patient or the patient's agent is not made at the pharmacy the offer shall be in writing and shall provide for toll-free telephone access to the pharmacist. If the patient does not refuse such counseling, the pharmacist, or the pharmacy intern, acting under the direct and immediate personal supervision of a licensed pharmacist, shall review the patient's record and personally discuss matters which will enhance or optimize drug therapy with each patient or agent of such patient. Such discussion shall be in person, whenever practicable, by toll-free telephonic communication, or by an interactive audio and digital image format, and shall include appropriate elements of patient counseling. Such elements may include, in the professional judgment of the pharmacist, the following: (a) The name and description of the drug; (b) The dosage form, dose, route of administration, and duration of drug therapy; (c) Intended use of the drug and expected action (if indicated by the prescribing health care practitioner); (d) Special directions and precautions for preparation, administration, and use by the patient; (e) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur; (f) Techniques for self-monitoring drug therapy; (g) Proper storage; (h) Prescription refill information; (i) Action to be taken in the event of a missed dose; (j) The potential for physical dependence, addiction, misuse, or abuse; and (k) Pharmacist comments relevant to the individual's drug therapy, including any other information peculiar to the specific patient or drug. (2) Patient counseling as described herein, shall not be required for inpatients of a hospital or institution where other licensed health care practitioners are authorized to administer the drug(s). (3) A pharmacist shall not be required to counsel a patient or a patient's agent when the patient or patient's agent refuses such consultation.

State	Explanations
	Rulemaking Authority 465.022, 465.0155 FS. Law Implemented 465.0155 FS. History New 8-18-93, Formerly 21S-27.820, 61F10-27.820, 59X-27.820, Amended 7-11-18.
Georgia	Pharmacy Oral Counseling Compliance Reports are compiled for the State's review upon request. Although the GA State Board of Pharmacy has previously declined to provide an analysis of the requested information, information may be compiled by manually reviewing meeting minutes available on the Board's website. Additionally, the Board reviews consent orders during the executive session so only blinded information is available to the public.
Hawaii	FFS vendor monitors for organ transplant program; annual oral report received. FFS monitors random patients for dental claims. Specific survey or sampling is not needed at this time.
Idaho	Pharmacy Oral Counseling Compliance Report The following Idaho Statutes give details on the requirements for counseling in the State of Idaho. Statute 54-1705 (2) give definition to counseling and Statute 54-1739 describes the process required. Idaho Statutes TITLE 54 PROFESSIONS, VOCATIONS, AND BUSINESSES CHAPTER 17 PHARMACISTS 54-1705.Definitions. (4) "Counseling" or "counsel" means the effective communication by the pharmacist of information as set out in this chapter, to the patient or caregiver, in order to improve therapeutic outcomes by maximizing proper use of prescription drugs and devices. Specific areas of counseling shall include, but are not limited to: (a) Name and strength and description of the drug; (b) Route of administration, dosage, dosage form, continuity of therapy and refill information; (c) Special directions and precautions for preparation, administration, storage and use by the patient as deemed necessary by the pharmacist; (d) Side effects or adverse effects and interactions and therapeutic contraindications that may be encountered, including their avoidance, which may interfere with the proper use of the drug or device as was intended by the prescriber, and the action required if they occur; (e) Techniques for self-monitoring drug therapy; and (f) Action to be taken in the event of a missed dose. TITLE 54 PROFESSIONS, VOCATIONS, AND BUSINESSES CHAPTER 17 PHARMACISTS 54-1739.prospective drug review and counseling. (1) Before dispensing any prescription, a pharmacist shall complete a prospective drug review as defined in section 54 1705, Idaho Code. (2) Before dispensing a prescription for a new medication, or when otherwise deemed necessary or appropriate, a pharmacist shall counsel the patient or caregiver. In addition to the counseling requirements provided in section 54 1705, Idaho Code, counseling shall include such supplemental written materials as required by law or as are customary in that practice setting.

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	For refills or renewed prescriptions, a pharmacist or a technician shall extend an offer to counsel the patient or caregiver. If such offer is accepted, a pharmacist shall provide such counseling as necessary or appropriate in the professional judgment of the pharmacist. All counseling and offers to counsel shall be face to face with the patient or caregiver when possible, but if not possible, then a reasonable effort shall be made to contact the patient or caregiver. Nothing in this section shall require a pharmacist to provide counseling when a patient or caregiver refuses such counseling or when counseling is otherwise impossible. Patient counseling shall not be required for inpatients of a hospital or institutional facility when licensed health care professionals administer the medication. (3) This section shall apply to all registered and licensed pharmacies, including mail service pharmacies. In cases of prescriber dispensing, the prescriber shall perform the prospective drug review and counseling consistent with the provisions of this section. The Idaho Code is made available on the Internet by the Idaho Legislature as a public service. This Internet version of the Idaho Code may not be used for commercial purposes, nor may this database be published or repackaged for commercial sale without express written permission. Search the Idaho Statutes The Idaho Code is the property of the state of Idaho, and is copyrighted by Idaho law, I.C. 9 352. According to Idaho law, any person who reproduces or distributes the Idaho Code for commercial purposes in violation of the provisions of this statute shall be deemed to be an infringer of the state of Idaho's copyright. Pharmacy Compliance with Oral Counseling The Idaho State Board of Pharmacy has the legal authority to inspect all licensed pharmacies in the state to ensure compliance with OBRA 90. Each pharmacy is surveyed at least once annually by a state board compliance officer. At each visit the officer examines the quantitative and qualitative level of patient counseling taking place for new as well as refill prescriptions. The Board of Pharmacy has attempted several different approaches to evaluate pharmacist counseling. In 1997, the Board of Pharmacy conducted a study to directly measure the quality of counseling provided across the state. An unidentified investigator entered pharmacies as a patient and evaluated the counseling services offered. This evaluation demonstrated to the Board of Pharmacy that the level of counseling in the state was sufficient. At that time, they chose to use the annual inspection of pharmacies as the means to determine compliance with OBRA 90 counseling requirements. Also, incident complaint forms would lead to investigation of counseling violations. Attempts to verify the provision of counseling and the quality of the information received are difficult to assess. Pharmacies consistently maintain logs of patient signatures designating their receipt or refusal of counseling. The refusal of counseling by a patient may simply indicate a lack of understanding of the need for important information. In some settings, the patients may not read what they are signing. Pharmacists are increasingly busy and rely on printed information to relay important messages to patients. This is not considered by the Board of Pharmacy to be an adequate replacement for face to face counseling. Documentation by pharmacists of information that they communicated directly to the patient would be a more valid approach than signature logs, but it is prohibited in the current retail pharmacy environment by time constraints. The evaluation of counseling through Board of Pharmacy inspections is problematic because pharmacists often recognize compliance officers. Also, deficits observed by these officers may be easily disputed with the patient signature logs showing that patients did receive or refuse counseling. The Board of Pharmacy continues to address all of these issues in attempts to effectively ensure that medication counseling in the state meets OBRA 90 requirements.

State	Explanations
Illinois	Under the Illinois Pharmacy Practice Act (Illinois Administrative Code Title 68, Section 1330.700), pharmacists are required, upon receipt of a new or refill prescription, to perform prospective drug regimen review/drug utilization evaluation. Effective August 18, 2017, the Act was updated to require verbal counseling on pertinent medication information for all new patients, new medications for existing patients, and when medications have had a change in dose, strength, route of administration, or directions for use. An offer to counsel the patient should be made on all other prescriptions. Previously only an offer to counsel was required for all prescriptions. If a patient refuses counseling, the refusal must be documented. Counseling must include, at a minimum: 1) Name and description of medication; 2) Dosage form and dosage; 3) Route of administration; 4) Duration of therapy; 5) Techniques for self-monitoring; 6) Proper storage; 7) Refill information; 8) Actions to be taken in cases of missed doses; 9) Special directions and precautions for preparation, administration and use; 10) Common severe side effects, adverse effects, or interactions and therapeutic contraindications that may be encountered, including their avoidance and the action required if they occur. If, in the pharmacist's professional judgment, oral counseling is not practical for the patient or patient's agent, the pharmacist must use alternative forms of patient information which must advise the patient or patient's agent that the pharmacist may be contacted for consultation in person at the pharmacy, or by toll-free or collect telephone service. Pharmacies directly servicing patients at a physical location must now post a required 81/2 x 11 sign by the cashier counter or waiting area clearly visible to patients that explains the patient's right to counseling, provides the consumer hotline number and information about filing complaints for failure to counsel. The Illinois Department of Financial and Professional Regulation (IDFPR) Division of Professional Regulation makes the sign that must be posted available at https://www.idfpr.com/forms/DPR/PharmPatientEducationSign082017.pdf. This part of the Illinois Administrative Code can be found at: http://www.ilga.gov/commission/jcar/admincode/068/068013300G07000R.html. Section 1330.30 of the Pharmacy Practice Act was updated also and now deems the following activities as unprofessional and unethical conduct: failure to provide patient counseling, failing to respond to requests for patient counseling, attempting to circumvent patient counseling requirements, or otherwise discouraging patients from receiving patient counseling concerning their prescription medications. The IDFPR licenses pharmacists in the State of Illinois. IDFPR pharmacy inspectors inspect pharmacies and, during the course of the inspection, evaluate compliance with the requirement for prospective drug regimen review and counseling. The inspectors report findings to the State Board of Pharmacy which is responsible for disciplining pharmacists and pharmacies.

State	Explanations
	The IDFPR publishes a monthly report detailing disciplinary action taken by the Department. It is available at: http://www.idfpr.com/News/Disciplines/DiscReports.asp. For the period of October 1, 2018 to September 30, 2019 no disciplinary actions related to counseling were noted.
Indiana	The Indiana Board of Pharmacy, in coordination with Indiana Medicaid, promulgated patient counseling regulations that became effective January 1, 1993. These regulations (856 IAC 1-33-1, 856 IAC 1-33-1.5, and 856 IAC 1-33-2) ensure that pharmacists offer pro-DUR counseling. Indiana Board of Pharmacy is the controlling authority over the patient counseling regulations portion of OBRA '90 for the Indiana Medicaid program. The Board of Pharmacy inspects pharmacies and measures conformance with patient counseling requirements. The Indiana Board of Pharmacy has requested that the Consumer Protection Division of the Indiana Office of the Attorney General forward all consumer complaints regarding patient counseling activities directly to the Board of Pharmacy. The Indiana Board of Pharmacy reviewed all relevant records and determined that no complaints against pharmacists or pharmacies had been filed due to lack of patient counseling during FFY 2019.
Iowa	This is a requirement by the Iowa Board of Pharmacy, and they alone are responsible for monitoring compliance.
Kansas	Pharmacy Oral Counseling Compliance Report Below is a patient counseling survey that was created. Due to past experiences from the MCOs, there is a low volume of surveys returned, so it was decided that it may be more effective to e-mail the survey. We have not yet pursued e-mailing the survey to FFS beneficiaries/MCO members. Patient Satisfaction Survey for Prescription Counseling 1. How do you get your medicines most of the time? o Walk in store o Use drive-thru o Delivered/mailed to you 2. How often do you speak with someone from your pharmacy? In person or over the phone. o Every few days o Every 1-3 weeks o Once monthly o Every 2-3 months o More than every 3 months 3. Thinking about the last time that you picked up your new medicine(s)- %uf0a7 Did anyone offer to talk to you about your medicine(s)? o Yes o No If so, who was it? o Clerk o Technician o Pharmacy Student o Pharmacist o Not sure %uf0a7 %uf0a7 Did anyone offer to talk to you about any of the following? Name of each medicine o Yes o No What they are used for and/or what they do o Yes o No How you should take your medicines

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	(How often, what time of day, with or without food, etc.) o Yes o NO Possible side effects or drug interactions o Yes o No 4. Please rate how happy you were with your last talk: Answered your questions fully- o Poor o Fair o Good o Excellent o Not Applicable Talked to you in a way you could easily understand- o Poor o Fair o Good o Excellent o Not Applicable Overall way you were treated- o Poor o Fair o Good o Excellent o Not Applicable Additional comments:
Kentucky	Currently all Kentucky Medicaid Fee-for-Service (FFS) Program Prospective DUR requirements are electronic with the exception of patient counseling. All pharmacists are required to submit each claim through the point-of-sale system in order to receive payment from Kentucky Medicaid. With each electronic claim submission, the claim is reviewed against the past ninety (90) days of claims for age specific appropriate dosing, early refill, therapeutic or ingredient duplication and drug-to-drug interactions. Kentucky law requires that pharmacists shall offer to counsel a patient or caregiver and maintain a log of those who refuse such counseling. (201 KAR 2:210) The Kentucky Pharmacy and Drug Inspectors ensure compliance with the patient counseling statutes with each routine pharmacy inspection. Kentucky law mandates that pharmacists provide patient counseling to all of Kentucky's citizenry. The pharmacist shall offer to counsel each patient or caregiver on matters which he believes will optimize drug therapy with new prescriptions and refill prescriptions if professional judgment dictates. The offer shall be made by the pharmacist face-to-face with the patient or caregiver, unless, in the professional judgment of the pharmacist, it is deemed impractical or inappropriate. If a face-to-face offer to counsel is deemed impractical or inappropriate, the offer to counsel may be made by the pharmacist designee, in written communication, by telephone through access to a toll-free phone number unless the primary patient population is accessible through a local, measured, or toll-free exchange, or in another manner determined by the pharmacist to be appropriate. Mail-order pharmacies are held to the same counseling requirements as other pharmacies. In the event a patient or caregiver should refuse the pharmacist's offer to counsel, a record should be maintained for one (1) year. If there is no record of the patient's refusal, it will be presumed that the offer to counsel was made and accepted, and the counseling was performed according to regulation.
Louisiana	This is a requirement by the Louisiana State Board of Pharmacy, and they are responsible for monitoring for compliance.
Maine	ATTACHMENT 1 PHARMACY ORAL COUNSELING COMPLIANCE REPORT

State	Explanations
	The Maine Board of Pharmacy, in coordination with Maine Medicaid promulgated patient counseling regulations in STATUTORY AUTHORITY: 32 M.R.S.A. 13720, 13721(1), 13722, 13723, 13784. The Maine Board of pharmacy is the controlling authority over the patient counseling regulations of OBRA '90 for the MaineCare program. The Board of Pharmacy inspects pharmacies and measures compliance with patient counseling requirements. All consumer complaints or disciplinary actions regarding patient counseling are forwarded directly to the Maine Board of Pharmacy. No complaints against pharmacist or pharmacies for lack of patient counseling were noted by the Board of Pharmacy during FFY2013. The State's Department of Program Integrity supplements this process in its on-site visits for appropriate record keeping when conducting claims auditing. All the recoupment's involved non-compliance with MaineCare Benefits Manual (MBM), Chapter II, Section 80.07-6F: Upon dispensing the prescription in person, the pharmacy provider must obtain a signature verifying receipt from the member or person picking up the prescription. Please see a copy of the inspection report utilized by the Maine Board of Pharmacy inspectors in the documentation below as well as the Statutory Rules from the Department of Professional and Financial Regulation. 392 MAINE BOARD OF PHARMACY Chapter 25: PATIENT COUNSELING Summary: This chapter sets forth the pharmacist's obligation to counsel patients. 1. New Prescription Drug Orders With each new prescription dispensed, the pharmacist shall: 1. Review Review the individual's patient profile for the following potential drug therapy problems: A. Therapeutic duplication; B. Drug disease contraindications when such information has been provided to the pharmacist; C. Drug interactions; D. Incorrect drug dosage or duration; E. Drug allergy interactions; and F. Clinical abuse or misuse. 2. Explain Orally explain to the patient or the authorized agent of the patient the directions for use and any additional information, in writing if necessary, to assure the proper utilization of the medication or device prescribed. Such explanations may include, but are not limited to, the following: A. Name and description of the medication; B. Dosage form, dosage, route of administration and duration of therapy; C. Special directions, precautions for the preparation, administration and use by the patient;

State	Explanations
	D. Common significant side effects, adverse effects of interactions, and therapeutic contraindications; E. Techniques for self monitoring; F. Proper storage; G. Refill information; and H. Actions in the case of missed dosages. For prescriptions which are not supplied directly to the patient or to the caregiver responsible for administering the medication or device to the patient, the pharmacist shall make the required counseling available to the patient through access to a telephone service which is toll-free for long distance calls. 2. Refill Prescription Drug Orders With each refill prescription dispensed, the pharmacist shall offer to counsel the patient on the medication or device being dispensed, or to review with the patient the clinical information provided with the initial dispensing. This offer may be made in the manner determined by the professional judgment of the pharmacist, and may include any one or more of the following: 1. Face-to-face communication with the pharmacist or designee; 2. A notation affixed to or written on the bag in which the prescription is dispensed; 3. A notation contained on the prescription container; or 4. Telephone conversation. The offer to counsel may be made by a designee of the pharmacist, but only the pharmacist may counsel the patient. 3. Refusal to Accept Counseling Nothing in this chapter shall be construed as requiring a pharmacist to provide counseling when the patient, the patient's caregiver or the authorized agent of the patient refuses to accept counseling. The pharmacist shall document the refusal. 4. Documentation of Intervention The pharmacist shall record in the patient profile any significant intervention in the patient's medication utilization that has occurred, in the judgment of the pharmacist, as a result of the counseling required by this chapter. 5. Patients in Hospital or Institution The obligation to perform or offer counseling set forth in Section 1(2) and Section 2 of this chapter does not apply to those prescriptions for patients in hospitals or institutions where the medication is to be administered by a nurse or other individual licensed to administer medications or to those prescriptions for patients who are to be discharged from a hospital or institution. 6. Opiate Treatment Programs

State	Explanations
	The obligation to perform or offer counseling set forth in Section 1(2) and Section 2 of this chapter does not apply to prescriptions for opiate agonist treatment medications dispensed at an opioid treatment program licensed by the board pursuant to Chapter 36 of the board's rules. The dispensing pharmacist shall discharge the pharmacist's statutory obligation to offer counseling in connection with new prescriptions by ensuring that written directions for use and other information relating to proper utilization of the medication prescribed are included with each new prescription delivered by the opioid treatment program. The written information must include a telephone number at which the pharmacist in charge may be contacted by patients. STATUTORY AUTHORITY: 32 M.R.S.A. 13720, 13721(1), 13722, 13723, 13784 EFFECTIVE DATE: November 8, 2004 - filing 2004-527 AMENDED: March 11, 2012 filing 2012-70 December 11, 2013 filing 2013-311
Maryland	The Maryland State Legislature passed a law, which requires pharmacists to offer counseling to medical assistance participants who present with new prescriptions (see next page). The law includes a requirement that pharmacists maintain a log of offers to counsel patients. The monitoring for compliance with this law falls under the authority of the Maryland Board of Pharmacy. Currently, there are no proactive measures to enforce this law. The Maryland Board of Pharmacy responds to complaints by medical assistance or non-medical assistance patients regarding professional pharmacy issues. Maryland Statute Article - Health Occupations [Section sign] 12 507 (a) A pharmacist who provides prescription services to medical assistance recipients shall offer to discuss with each medical assistance recipient or caregiver who presents a prescription order for outpatient drugs any matter which, in the exercise of the pharmacist's professional judgment, the pharmacist deems significant, which may include the following: (1) The name and description of the medication; (2) The route, dosage form, dosage, route of administration, and duration of drug therapy; (3) Special directions and precautions for preparation, administration, and use by the patient; (4) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their savings and the action required if they occur; (5) Techniques for self monitoring drug therapy; (6) Proper storage; (7) Prescription refill information; and (8) Action to be taken in the event of a missed dose.

State	Explanations
	(b) The offer to discuss may be made in the manner determined by the professional judgment of the pharmacist, which shall include either: (1) A face to face communication with the pharmacist; or (2) At least 2 of the following: (i) A sign posted so it can be seen by patients; (ii) A notation affixed to or written on the bag in which the prescription is to be dispensed; (iii) A notation contained on the prescription container; or (iv) Communication by telephone. (c) Nothing in this section shall be construed as requiring a pharmacist to provide consultation if the medical assistance recipient or caregiver refuses the consultation. (d) A pharmacist must make a reasonable effort to obtain, record, and maintain, at the individual pharmacy, at least the following information regarding a medical assistance recipient: (1) Name, address, telephone number, date of birth or age, and gender; (2) Individual history when significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices; and (3) Pharmacist comments relevant to the individual's drug therapy which may be recorded either manually or electronically in the patient's profile. (e) This section shall apply only to medical assistance recipients presenting prescriptions for covered outpatient drugs. (f) The requirements of this section do not apply to refill prescriptions. (g) The Secretary, after consultation with the Maryland Pharmacists Association and the Maryland Association of the Chain Drug Stores, shall adopt regulations in accordance with pharmacy practices in Maryland to implement the provisions of this section.
Massachusetts	Pharmacy investigators inspect for the counseling requirement during routine inspections and will cite the pharmacy to remediate if not compliant. The investigators use the Pharmacy Compliance Inspection Tool for their inspections: https://www.mass.gov/lists/pharmacy-practice-resources
Michigan	Section 4 - Counseling Requirements within the Pharmacy Chapter of Michigan's Medicaid Provider Manual specifies the ProDUR counseling components required at the point of sale before each prescription is delivered to a Medicaid beneficiary and outlines the responsibility of each pharmacy as a requirement of Medicaid participation. It also specifies that pharmacies must follow the counseling requirements mandated in State and Federal statutes and regulations. The counseling requirement includes 1) Offer to Discuss and 2) Components of the Discussion. To assure that pharmacy counseling and other data collection requirements were performed, pharmacies must record the required information in the beneficiary's manual or electronic profile, in the prescription signature log, or any other system of records.

State	Explanations
	The Michigan Department of Health and Human Services Office of Inspector General is responsible for performing post payment pharmacy audits and monitoring for compliance of requirements outlined in policy and terms and conditions of participation in the program. These pharmacy audits do include review of signature log documentation and absence of the appropriate signature indicates that the beneficiary did not receive the prescription and/or counseling and funds are recouped from the pharmacy in that scenario. The volume of signature log audit findings is very low which may be interpreted as indicative of satisfactory compliance with this requirement.
Minnesota	Cody Wiberg, Pharm.D., M.S.,R.Ph., Executive Director, Minnesota Board of Pharmacy, provided the following response in an email dated July 22, 2020 regarding Pharmacy Oral Counseling Compliance. The Minnesota Board of Pharmacy assesses compliance with the state's counseling requirements during the inspection of licensed pharmacies. The Surveyors that inspect pharmacies look for the existence of an adequate counseling policy and evidence that staff members received training for the policy. They also examine prescriptions that are waiting to be picked up to see if those that require counseling have been flagged. The Surveyors will also discreetly observe the pharmacy before announcing their arrival, to try to determine if pharmacists are interacting with and counseling patients. They also review the required counseling refusal log. Unfortunately, due to the COVID-19 pandemic, on-site inspections of pharmacies has not been occurring for several months. However, prior to March of this year, counseling appeared to be mostly taking place as required. Pharmacies at which counseling as not taking place were either issued warnings or even disciplined.
Mississippi	Article VIII, Section 3 of the Mississippi Pharmacy Practice Act states that before a prescription is dispensed, delivered or distributed, a pharmacist shall review the patient record and each prescription drug order presented for dispensing for purposes of promoting therapeutic appropriateness. The Mississippi Board of Pharmacy is the responsible state agency to enforce OBRA '90 oral counseling laws. As part of its regular inspections of pharmacies, the Board notes whether oral counseling is offered to patients.
Missouri	The Missouri Medicaid Audit and Compliance Unit (MMAC) requested documentation from 5 pharmacy provider regarding the oral counseling requirement. Below are details of their review and findings. Food Merchants LLC Date of Service 3/7/2019 - Documentation submitted from this provider for one participant for one date of service. The documentation for this date of service was missing offer to counsel. Provider was/will be educated once the State Audit Sample review is complete. Medicine Shoppe Pharmacy 1717 Date of Service 3/26/2019 - Documentation submitted from this provider for one participant for one date of service. The documentation for this date of service was missing offer to counsel. Provider was/will be educated once the State Audit Sample review is complete. Walmart Pharmacy 10-0895 Date of Service 4/3/2019 - Documentation submitted from this provider for one participant for one date of service. The documentation for this date of service was missing offer to counsel. Provider was/will be educated once the State Audit Sample review is complete.

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	The Medicine Shoppe Pharmacy Date of Service 4/15/2019 - Documentation submitted from this provider for one participant for one date of service. The documentation for this date of service was missing offer to counsel. Provider was/will be educated once the State Audit Sample review is complete. SEMO Drugs of Kennett Inc Date of Service 11/26/2018 - Documentation submitted from this provider for one participant for one date of service. The documentation for this date of service was missing offer to counsel. Provider was/will be educated once the State Audit Sample review is complete.
Montana	The pharmacist oral counseling requirement is not monitored by Montana Medicaid. The following Montana State statute discusses counseling: http://www.mtrules.org/gateway/RuleNo.asp?RN=24%2E174%2E903
Nebraska	Investigations (Disciplinary Actions) No disciplinary actions were brought against any Nebraska pharmacist for failure to counsel nor failure to offer counseling during FFY 2019, according to the records of disciplinary actions provided by the Nebraska Board of Pharmacy. Inspections (Compliance Monitoring) The Nebraska Board of Pharmacy reports that pharmacy inspectors are monitoring for compliance with drug utilization review and the state's counseling statutes. These statutes are more stringent than Federal requirements and require verbal offer to counsel on all prescriptions, whether new or refill, without regard to payer. Nebraska statutes require that a pharmacist ensure that a verbal offer to counsel the patient or caregiver is made. (Nebraska Revised Statute 38-2869)
Nevada	The State of Nevada Medicaid Program relies on the State Board of Pharmacy to audit pharmacist/pharmacy compliance with the oral counseling requirement. The Nevada State Board of Pharmacy includes adherence with counseling requirements as part of each annual pharmacy inspection. In addition, during any investigation of an incident or patient complaint, counseling records are checked by the inspector.
New Hampshire	In New Hampshire, all new prescriptions or following review of a patient's record, requires pharmacist or his/her designee to offer oral counseling to a patient or the caregiver of the patient that will improve or enhance medication therapy (State Pharmacy Rule Ph 706.03-Patient Counseling). Compliance is monitored by the Board of Pharmacy as part of their inspections. Patient counseling includes: Mandatory counseling of prescription medication. (a) Pharmacists shall be required to make a reasonable attempt to counsel the patient or patient's caregiver in person or by telephone when dispensing the first fill of a new prescription in the following situations:

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	(1) Prescriptions for patients under the age of 13; (2) Concentrated medications; (3) Anticoagulant/antiplatelet medications; (4) Endocrine medications; and (5) Anti-infective medications. (b) Pharmacists, pharmacy interns or New Hampshire certified technicians shall document that counselling was given. (c) In situations where there is no direct contact with the patient or caregiver including but not limited to nursing homes, assisted living or prisons, supplemental printed information shall be provided. (d) Upon receipt or delivery of a new prescription, where mandatory counseling is not required, and following a review of the patient's record, a pharmacist or his/her designee, shall orally offer to discuss matters which will enhance or optimize drug therapy with each patient or caregiver of such patient. (e) Patient counseling shall: (1) Be by the pharmacist or pharmacy intern and in person, whenever practicable, or by telephone; and (2) Include appropriate elements of patient counseling, such as the following: a. The name and description of the drug; b. The dosage form, dose, route of administration, and duration of drug therapy; c. Intended use of the drug and expected action; d. Special directions and precautions for preparation, administration, and use by the patient; e. Common side or adverse effects or interactions and therapeutic contraindications that might be encountered, including their avoidance, and the action required if they occur; f. Techniques for self-monitoring drug therapy; g. Proper storage; h. Prescription refill information; i. Action to be taken in the event of a missed dose; and j. Pharmacist comments relevant to the individual's drug therapy, including any other information peculiar to the specific patient or drug. (f) Alternative forms of patient information may be used to supplement patient counseling. Examples shall include written information leaflets, pictogram labels, or video programs. (g) Patient counseling, as described above shall not be required for inpatients of penal institutions or inpatients of a hospital or long-term care facility where other licensed health care professionals are authorized to administer the drugs and drug therapy reviews are conducted on a routine basis. (h) A pharmacist shall not be required to counsel a patient or agent when the patient or agent refuses such consultation. However, failure to document the patient's refusal of counseling shall imply that counseling was provided.
New Jersey	N/A
New Mexico	The standards for counseling by pharmacies of recipients or the recipients' caregivers must be established by State law or other method that is satisfactory to the State agency. The state of New Mexico has decided that each dispensing pharmacist must offer to counsel each Medicaid eligible recipient receiving benefits (or the caregiver of such individual) who presents a new prescription. The recipient or caregiver may refuse counsel. Pharmacists must document refusals. If documentation of refusal of counseling is not available, it is assumed that appropriate counseling and prospective drug use has taken place. A reasonable effort must be made to

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	record and maintain the pharmacist's comments relevant to counseling. Counseling must be done in person. The pharmacy provider must provide access by telephone if counseling in person is not practicable. The access must be local or by a toll-free number.
New York	The State Education Department through the Office of Professional Discipline incorporates observation of counseling in their routine inspections of pharmacies. Office of Professional Discipline reviews counseling procedures whenever noncompliance is brought to their attention.
North Carolina	NORTH CAROLINA BOARD OF PHARMACY- The North Carolina Board of Pharmacy was created by the North Carolina Legislature (Chapter 90 Article 4A) to protect the public health, safety and welfare in pharmaceutical matters. The Board sets standards for academic and practical experience programs prior to licensure, issues permits to operate pharmacies and annually renews licenses and permits. The Board Members meet on the third Tuesday of the month in the Board's Chapel Hill office to conduct business, set policy and hold disciplinary hearings for pharmacists and pharmacies. These meeting are open to the public except during the time when the Board Members are in closed session deliberating a decision for a disciplinary action. The North Carolina Board of Pharmacy is responsible for ensuring compliance with the prospective review and patient counseling requirements for the Medicaid population and the general population. NC Pharmacy Rules regarding patient counseling are included in this attachment. The investigations conducted by the inspectors/investigators for the Board of Pharmacy continue to be complaint driven. The complaints come primarily from private citizens, pharmacists who do not practice and are in a consumer role, and physicians and their office staff. A summary of the Board's position on handling these complaints as well as anticipated actions is as follows: After receiving a citizen's complaint about a pharmacist's failure to offer to counsel on a new prescription, the Board staff initiates an investigation which usually involves a visit by an inspector/investigator in an undercover capacity to determine if the complaint can be verified. If the complaint is valid and the failure to offer to counsel can be demonstrated on more than one occasion, the policy is to bring this matter to a hearing before the Board. If the complaint cannot be verified, the pharmacist receives a letter from the Board explaining what has occurred with a reminder about the patient counseling rule. Board members have acted on violations of the patient counseling rule in a variety of ways. In relatively minor cases, the members have issued a reprimand or short suspension followed by a probationary period. In other cases in which the patients have suffered severe adverse effects, the members have determined that a short to moderate suspension is necessary in conjunction with the other requirements such as additional continuing education to renew a license and, where justifiable, passing a jurisprudence exam for license renewal. As a result of its experience, the Board opines that a much higher rate of acceptance of the offer to counsel occurs when the pharmacist personally makes the offer. Offers made by ancillary personnel do not convey the importance of the communication. The Board of Pharmacy rule regarding patient counseling requires that such offers be made orally, in person, and in a positive manner to encourage acceptance. Offers to counsel must be made on all new prescriptions, and the pharmacist must use his/her professional judgment on refills. NCBOP - Pharmacy Rules NORTH CAROLINA ADMINISTRATIVE CODE --- UPDATED FEB 2017 21 NCAC 46 .2504 PATIENT COUNSELING

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	(a) "Patient Counseling" shall mean the effective communication of information, as defined in this Rule, to the patient or representative in order to improve therapeutic outcomes by maximizing proper use of prescription medications, devices, and medical equipment. All provisions of this Rule shall apply to device and medical equipment permit holders, except Subparagraph (a)(8) of this Rule and except where otherwise noted. Specific areas of patient counseling include, but are not limited to, those matters listed in this Rule that in the exercise of the pharmacist's or device and medical equipment permit holder's professional judgment are considered significant: (1) name, description, and purpose of the medication; (2) route, dosage, administration, and continuity of therapy; (3) special directions for use by the patient; (4) common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur; (5) techniques for self-monitoring drug therapy; (6) proper storage; (7) prescription refill information; and (8) action to be taken in the event of a missed dose. (b) An offer to counsel shall be made on new or transfer prescriptions at the time the prescription is dispensed or delivered to the patient or representative. Ancillary personnel may make the offer to counsel, but the pharmacist must personally conduct counseling if the offer is accepted. Counseling by device and medical equipment permit holders must be conducted by personnel proficient in explaining and demonstrating the safe and proper use of devices and equipment. The person in charge shall be responsible for ensuring that all personnel conducting counseling are proficient in explaining and demonstrating the safe and proper use of devices and equipment and for documenting the demonstration of such proficiency. The offer shall be made orally and in person when delivery occurs at the pharmacy. When delivery occurs outside of the pharmacy, whether by mail, vehicular delivery or other means, the offer shall be made either orally and in person, or by telephone from the pharmacist to the patient. If delivery occurs outside of the pharmacy, the pharmacist shall provide the patient with access to a telephone service that is toll-free for long-distance calls. A pharmacy whose primary patient population is accessible through a local measured or toll-free exchange need not be required to offer toll-free service. Counseling may be conducted by the provision of printed information in a foreign language if requested by the patient or representative. Professional judgment shall be exercised in determining whether or not to offer counseling for prescription refills. An offer to counsel shall be communicated in a positive manner to encourage acceptance. (c) In order to counsel patients effectively, a reasonable effort shall be made to obtain, record, and maintain significant patient information, including: (1) name, address, telephone number; (2) date of birth (age), gender; (3) medical history: (A) disease state(s); (B) allergies/drug reactions; (C) current list on non-prescription and prescription medications, devices, and medical equipment. (4) comments relevant to the individual's drug therapy. A "reasonable effort" shall mean a good faith effort to obtain from the patient or representative the foregoing patient information. Ancillary personnel may collect, record, and obtain patient profile information, but the pharmacist or person in charge of the facility holding the device and medical equipment permit must review and interpret patient profile information and clarify

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	confusing or conflicting information. Professional judgment shall be exercised as to whether and when individual patient history information should be sought from other health care providers. (d) Once patient information is obtained, this information shall be reviewed and updated by the pharmacist or person in charge of the facility holding the device and medical equipment permit before each prescription is filled or delivered, typically at the point-of-sale or point of distribution to screen for potential drug therapy problems due to: (1) therapeutic duplication; (2) drug-disease contraindication; (3) drug-drug interactions, including serious interactions with prescription or over-the-counter drugs; (4) incorrect drug dosage or duration of drug treatment; (5) drug-allergy interactions; and (6) clinical abuse/misuse. (e) Unless refused by the patient or representative, patient counseling shall be provided as follows: (1) counseling shall be "face to face" by the pharmacist, or personnel of a device and medical equipment permit holder when possible; (2) alternative forms of patient information may be used to supplement patient counseling; (3) patient counseling, as described in this Rule, shall be required for outpatient and discharge patients of hospitals, health maintenance organizations, health departments, and other institutions; however, compliance with this Rule in locations in which non-pharmacists are authorized by law or regulations to dispense may be accomplished by such authorized non-pharmacists; and (4) patient counseling, as described in this Rule, shall not be required for inpatients of hospitals or other institutions where a nurse or other licensed health care professional administers the medication(s). (f) Pharmacists that distribute prescription medication by mail, and where the practitioner-pharmacist-patient relationship does not exist, shall provide counseling services for recipients of such medication in accordance with this Rule. (g) Records resulting from compliance with this Rule, including documentation of refusals to receive counseling, shall be maintained for three years in accordance with Section .2300 of this Chapter. (h) Personnel of device and medical equipment permit holders shall give written notice of warranty, if any, regarding service after the sale. The permit holder shall maintain documentation demonstrating that the written notice of warranty was given to the patient. (i) Offers to counsel and patient counseling for inmates need not be "face to face", but rather, may be conducted through a correctional or law enforcement officer or through printed material. A pharmacist or a device and medical equipment permit holder dispensing drugs or devices or delivering medical equipment to inmates need not comply with Paragraph (c) of this Rule. However, once such patient information is obtained, the requirements of Paragraph (d) of this Rule shall be followed.
North Dakota	The North Dakota Board of Pharmacy inspectors have visited each pharmacy on an annual basis. Currently 100 % of North Dakota pharmacies use a computer based pro DUR program. Patient counseling is required on all new and refill prescriptions in North Dakota and pharmacies are in substantial compliance with this requirement. In 95% of dispensing encounters the oral patient counseling is augmented with manufacturer produced or pharmacy generated written patient counseling information. North Dakota pharmacies are in compliance with OBRA 90 prospective DUR requirements

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Ohio	During the reported time frame of October 1, 2018 through September 30, 2019, the State of Ohio Board of Pharmacy inspected 131 retail pharmacies for the counseling requirement. The inspection reports indicate a 96.4% compliance rate by retail pharmacist on the requirement to provide or offer counseling to patients for every prescription dispensed.
Oklahoma	Pursuant to the Oklahoma State Board of Pharmacy rules codified in Title 535 of the Oklahoma Administrative Code (OAC): Counseling shall be performed by the pharmacist when deemed appropriate in the pharmacist's professional judgment or when required by applicable federal or state laws or rules. Currently there are no official efforts by the State Board of Pharmacy to monitor compliance with the Medicaid counseling requirements of OBRA '90. Monitoring of Prospective DUR is done by the clinical staff of Pharmacy Management Consultants in the form of issuing overrides for early refills and review of alert information generated by the fiscal agent.
Oregon	OAR 855-019-0230 Counseling (1) The pharmacist or intern shall orally counsel the patient or patient's agent on the use of a drug or device as appropriate: (a) The pharmacist or intern shall counsel the patient on a new prescription and any changes in therapy, including but not limited to a change in directions or strength, or a prescription which is new to the pharmacy; (b) Only the pharmacist or intern may accept a patient's or patient's agent's request not to be counseled. If, in their professional judgment, the pharmacist or intern believes that the patient's safety may be affected, the pharmacist or intern may choose not to release the prescription until counseling has been completed; (c) Effective July 1, 2008, the pharmacist or intern that provides counseling or accepts the request not to be counseled shall document the interaction; (d) A pharmacist shall not allow non-pharmacist personnel to release a prescription that requires counseling, or accept the request not to be counseled; (e) For a prescription delivered outside of the pharmacy, the pharmacist shall offer in writing, to provide direct counseling and information about the drug, including information on how to contact the pharmacist; (f) For each patient, the pharmacist or intern shall determine the amount of counseling that is reasonable and necessary under the circumstance to promote safe and effective use or administration of the drug or device, and to facilitate an appropriate therapeutic outcome for that patient. (2) Counseling on a refill prescription shall be such as a reasonable and prudent pharmacist would provide including but not limited to changes in strength or directions. (3) A pharmacist may provide counseling in a form other than oral counseling when, in their professional judgment, a form of counseling other than oral counseling would be more effective. (4) A pharmacist or intern shall initiate and provide counseling under conditions that maintain patient privacy and confidentiality. (5) For a discharge prescription from a hospital, the pharmacist must ensure that the patient receives appropriate counseling. Stat. Auth.: ORS 689.205

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	Stats. Implemented: ORS 689.151, 689.155 Hist.: 1PB 2-1980, f. & ef. 4-3-80; PB 8-1990, f. & cert. ef. 12-5-90; PB 5-1992, f. & cert. ef. 10-23-92; PB 1-1994, f. & cert. ef. 2-2-94; BP 4-1998, f. & cert. ef. 8-14-98; BP 1-2002, f. & cert. ef. 1-8-02; Renumbered from 855-041-0100, BP 2-2008, f. & cert. ef. 2-20-08
Pennsylvania	Pharmacy Oral Counseling Compliance is performed by the Pennsylvania State Board of Pharmacy.
Rhode Island	This is a requirement by the Rhode Island State Board of Pharmacy, and they alone are responsible for monitoring for compliance.
South Carolina	South Carolina Medicaid requires that, upon receipt of a prescription drug order for a new medication and following review of the patient's pharmacy record, the pharmacist shall personally offer counseling to the patient or the patient's agent. Using his or her best professional judgment, the pharmacist's counseling shall include a discussion of those matters that the pharmacist considers appropriate for the patient or patient's agent in that particular situation. The discussion must be in person, whenever practicable, or by telephone or written communication and shall include appropriate elements of patient counseling. The State generates surveys monthly.
South Dakota	During the Federal Fiscal Year of October 1st, 2018 to September 30th, 2019, the SD Board of Pharmacy Inspectors conducted 295 pharmacy inspections. As part of the inspections process our staff reviews compliance with Administrative Rule 20:51:25 and OBRA 90 guidelines related to prospective drug utilization reviews and patient counseling. Unfortunately, the board staff was unable to conduct any inspections on behalf of the Consumer Product Safety Commission (CPSC) specifically as it applies to the Poison Prevention Packaging Act (PPPA) to determine if South Dakota pharmacies are in compliance with the requirements of United States Pharmacopeia packaging guidelines. As part of the annual inspection process, pharmacists must be able to demonstrate their skills and knowledge of all the Drug Utilization Review to include over and underutilization; therapy duplication; drug allergies; drug - disease interactions; drug - drug interactions; drug - food interactions; proper dosages; and potential abuse or misuse of the patients' medications. If applicable, pharmacists must also demonstrate their skills for both sterile and non-sterile compounding. There continues to be significant compliance with regulations pertaining to collecting and maintaining patient demographics, patient counseling and medication review. Technology has certainly assisted along these lines; however, pharmacists and well-trained personnel work in concert to maintain a high standard of patient care. When a physician - patient - pharmacist relationship is fostered through the continuum of care, patients' health care is enhanced directly.
Tennessee	Tennessee Board of Pharmacy Rule 1140-3-.01 addresses responsibilities for pharmaceutical care, including patient counseling. Upon the receipt of a medical or prescription order and following review of the patients' record, a pharmacist shall personally counsel the patient or caregiver face-to-face if the patient or caregiver is present (all new prescriptions). If the patient or caregiver is not present, a pharmacist shall make a reasonable effort to counsel through alternative means. Counseling is required for all patients on an outpatient basis and an exemption to counseling is made for patients of an institutional facility. Patient counseling shall cover matters, which in the exercise of the pharmacist's professional judgment, and the pharmacist deems significant including: the name and description of the medication; the dosage form, dose, route of administration, and duration of drug therapy; special directions and precaution s for preparation, administration and use by the patient; common side effects or

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	adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur; techniques for self-monitoring drug therapy; proper storage; prescription refill information; and action to be taken in the event of a missed dose. Additionally, upon the receipt of a request for a refill of a medical or prescription order, a pharmacist or person designated by the pharmacist shall offer for the pharmacist to personally counsel the patient or caregiver. Drug Regimen Review (DRR) is the responsibility of a pharmacist and this information is contained with in the Rule 1140-3-.01 of the Tennessee Board of Pharmacy. The DRR shall include evaluating the medical and prescription order for: over-utilization or under-utilization; therapeutic duplication; drug-disease interactions; incorrect drug dosage or duration of drug treatment; drug-allergy interactions; and clinical abuse/misuse. If a pharmacist recognizes any of the required components of a DRR are in questions, then the pharmacist shall take appropriate steps to avoid or resolve the problem. In closing, the Tennessee Board of Pharmacy investigations are observant to the requirement of this rule. They observe pharmacists in the State of Tennessee to assure compliance of these requirements. Our investigations do cite pharmacists for violation of this or any other rule or regulation that this regulatory agency has jurisdiction over. Our routine inspection forms have specific check items that include counseling and the components of the rule associated with counseling. In addition, the public or other practitioners may lodge complaints against pharmacies or pharmacists for violations which would then be investigated. Any complaint either from our investigators, the public or practitioners is heard before the entire board for disciplinary consideration.
Texas	On Site Prospective DUR Compliance Monitoring Texas State Board of Pharmacy Rules and Regulations incorporate the prospective drug use review and patient counseling provisions of OBRA '90 and make them applicable to all patients in Texas, both Medicaid and non-Medicaid. The Texas State Board of Pharmacy routinely monitors compliance and issues warnings related to violations of these requirements. The following is a summary of Board activities related to violations of OBRA requirements during the fiscal year (FY) 2019 (September 1, 2018 to August 31, 2019). FY2019 Warning Notice No Oral Counseling 31 No Written Information 39 Patient Medication Record Absent or Incomplete 11 No Drug Regimen Review 9 Inadequate Counseling Area 2 Totals 92

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	Disciplinary Actions / Complaints Disciplinary Actions In FY 2019, the Texas State Board of Pharmacy entered 36 Disciplinary Orders involving prescription counseling (16 orders on pharmacists and 20 orders on pharmacies). These orders may have involved other alleged violations as well as counseling violations (e.g., dispensing errors). Complaints In FY 2019, the Texas State Board of Pharmacy closed 54 complaints, where the primary alleged violation involved DUR and prescription counseling violations
Utah	Division of Occupational and Professional Licensing (DOPL) under the Pharmacy Practice Act Rule.
Vermont	Administrative Rules of the Board of Pharmacy effective: September 15, 2015 9.2 Counseling Area Required Each pharmacy providing outpatient prescriptions directly to the public or employees, shall maintain an area designated for the provision of patient counseling services. This area shall be designed to provide reasonable privacy. 9.16 Inspection of Drug Outlets (a) Biennially, a Board member, a representative appointed by the Board, or an employee of or contractor with the Office of Professional Regulation, shall inspect a drug outlet in Vermont during regular business hours, for compliance with these rules. Deficiencies shall be handled in the manner set forth in Rule 7.2(i). (b) The Board shall not authorize any inspection that extends to financial data, sales data other than shipping data or pricing data of the drug outlet. 10.30 Prospective Drug Review (a) A pharmacist shall review the patient record and each prescription drug order presented for dispensing for purposes of promoting therapeutic appropriateness by identifying: (1) Over-utilization or under-utilization; (2) Therapeutic duplication; (3) Drug-disease contraindications; (4) Drug-drug interactions (including serious interactions with non-prescriptive or over-the-counter drugs); (5) Incorrect drug dosage or duration of drug treatment; (6) Drug-allergy interactions; and (7) Clinical abuse or misuse. (b) Upon recognizing any of the above, the pharmacist shall take appropriate steps to avoid or resolve the problem which shall, if necessary, include consultation with the practitioner. 10.31 Patient Counseling (a) Patient counseling is the effective oral consultation by the pharmacist, in the exercise of his or her professional judgment and consistent with state statutes and Board rules regarding

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	confidential information, with the patient or caregiver, in order to improve therapy by ensuring the proper use of drugs and devices. (b) Upon receipt of a new prescription drug order and following a review of the patient's record, a pharmacist, pharmacy technician, or pharmacy intern shall offer counseling with the pharmacist or pharmacy intern of matters which will enhance or optimize the patient's drug therapy. The discussion with the pharmacist or intern shall be in person, whenever practicable, or by telephone and shall include appropriate elements of patient counseling which may include the following: (1) The name and description of the drug; (2) The dosage form, dose, route of administration, and duration of drug therapy; (3) Intended use of the drug and expected action; (4) Special directions and precautions for preparation, administration, and use by the patient; (5) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur; (6) Techniques for self-monitoring drug therapy; (7) Proper storage; (8) Prescription refill information; (9) Action to be taken in the event of a missed dose; and (10) Pharmacist comments relevant to the individual's drug therapy. . (c) Alternative forms of patient information may be used to replace patient counseling when verbal face-to-face counseling is not possible. Alternative forms of patient information may be used to supplement patient counseling when appropriate. Examples include written information leaflets, pictogram labels, video programs, etc. (d) Each pharmacy shall post a notice advising, You have the right to confidential consultation with a pharmacist about your prescription. If you wish, a confidential consultation will be provided. (e) Patient counseling, as described above and defined in these rules, shall not be required for inpatients of a hospital or institution where other licensed health care professionals are authorized to administer the drug(s). (f) A pharmacist shall not be required to counsel a patient or caregiver when the patient or caregiver refuses such consultation and such refusal is documented.
Virginia	Department of Health Professions David E Brown, D.C. Board of Pharmacy www.dhp.virginia.gov/pharmacy Director Perimeter Center TEL (804) 367-4456 9960 Mayland Drive, Suite 300 FAX (804) 527-4472 Henrico, VA 23233-1463 June 5, 2020 Rachel Cain, PharmD Sent by email to:

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	Department of Medical Assistance Services rachel.cain@dmas.virginia.gov 600 East Broad Street, Suite 1300 Richmond, VA 23219 Dear Dr. Cain: For inspections conducted during the period of October 1, 2018 through September 30, 2019, no deficiencies were identified for §54.1-3319 (B) requiring the pharmacist to offer to counsel any person who presents a new prescription. Please feel free to contact me at 804-367-4465 should you have any questions. Sincerely, J. Samuel Johnson, Jr. Deputy Executive Director Board of Pharmacy Patient counseling. Consistent with federal law and regulation a pharmacist must offer to discuss in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls with each individual receiving benefits or the caregiver of such individual who presents a prescription, matters which in the exercise of the pharmacist's professional judgment are deemed to be significant. The offer to counsel shall be made consistent with the requirements in § 54.1-3319 B of the Code of Virginia. The specific areas of counseling shall include those matters listed below that, in the exercise of his professional judgment, the pharmacist considers significant: 1. Name and description of the medication; 2. Dosage form and amount, route of administration, and duration of therapy; 3. Special directions for preparation, administration and use by the patient as deemed necessary by the pharmacist; 4. Common or severe side or adverse effects or interactions that may be encountered which may interfere with the proper use of the medication as was intended by the prescriber, and the action required if they occur; 5. Techniques for self-monitoring drug therapy; 6. Proper storage; 7. Prescription refill information; 8. Action to be taken in the event of a missed dose. 9. Any other matters the pharmacist considers significant.

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	Alternative forms of patient information may be used to supplement, but not replace, oral patient counseling. A pharmacist shall not be required to provide oral consultation when a patient or a patient's agent refuses the pharmacist's attempt to consult. When prescriptions are delivered to the patient or patient's agent who resides outside of the local telephone calling area of the pharmacy, the pharmacist shall either provide a toll free telephone number or accept collect calls from such patient or patient's agent. Patient counseling as described in this part shall not be required for inpatients of a hospital or institution where a nurse or other person authorized by the Commonwealth is administering the medication. D. Compliance monitoring. An ongoing program shall be developed for the purpose of monitoring pharmacists' compliance with the prospective DUR requirements of this part. The director may establish the compliance monitoring program through agreements with other state agencies, the DUR Board or other organizations. As determined to be appropriate by DMAS, the methods used to monitor compliance shall include but shall not be limited to: 1. On-site inspections, 2. Patient surveys, 3. Desk audits, or 4. Retrospective pharmacy profile reviews. 5. Electronic messages as well as rejection or denial of claims until there is resolution of the conflict with DUR criteria.
Washington	Washington State regularly monitors compliance with oral counseling requirements to ensure the citizens of our State receive critical information when filling new prescriptions or refilling existing prescriptions. Washington State law is more stringent than federal requirements, identifying oral counseling as a service required for all prescriptions filled or refilled in Washington State, not just those filled for Medicaid clients per WAC 246-869-220: Patient counseling required. As a requirement universal to all prescriptions rather than just Medicaid clients, assuring compliance with all Washington State rules and laws for pharmacies falls to Washington State Department of Health's Pharmacy Quality Assurance Commission (PQAC). PQAC monitors oral counseling as a standard part of pharmacy inspections. PQAC is also responsible for monitoring compliance with record retention requirements and prospective Drug Utilization Review (DUR) requirements as detailed in Washington Administrative Code 246-875. Any compliance issues discovered during an inspection are annotated on pharmacy inspection report's statement of deficiencies/violations. Pharmacies must submit a plan of correction (POC) for noted

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	deficiencies/violations to be reviewed by PQAC. If the POC is sufficient, pharmacies implement the POC and may be subject for re-inspection at the discretion of PQAC. If pharmacies fail to submit a POC or the POC is insufficient, PQAC enforcement/discipline process is initiated. During FFY2019, PQAC was unable to report the total number of inspections preformed based on inadequate tracking system design to retrieve data. PQAC was able to report the number of violations, 14 of which were due to inadequate oral counseling. PQAC reports that no violations due to inadequate oral counseling resulted in discipline and all submitted acceptable plans of correction. Incomplete documentation in patient records of drug allergies and chronic medical conditions is the most common deficiency noted in pharmacy inspections. During the reporting period, 418 such deficiencies were documented, categorized as follows: Violation Description, Total Violations Patient Counseling - In Person, 14 Patient Counseling - In Writing, 0 Patient Counseling - RPh Determines, 4 PMR - Name/Strength/Dose/Qty, 0 Auto PMR - Prescriber Info, 2 Auto PMR - Doc Allergy/Chronic Cond, 367 Auto PMR - Authorization Non-CRC, 12 Auto PMR - Doc Allgery/Chronic Cond (Inst), 4 Auto PMR - Label/Special Alerts (Inst), 0 Manual PMR - Sys Doc Allergy Chr Cond (Inst), 1 Manual PMR - Prescriber Info (Inst), 2 Using PMRs - Drug Utilization Review, 12
West Virginia	This is a requirement set forth by the West Virginia State Board of Pharmacy and they alone are responsible for monitoring compliance. The requirement of an offer to counsel patients on new prescription orders is stated specifically in Rule 15-1-19.13.6 of the West Virginia Code of State Rules governing the practice of pharmacy. The Board's outpatient pharmacy inspection forms prompt the inspectors to confirm that the pharmacies are complying with this requirement. If there is not appropriate documentation of compliance, then it will be documented on the inspection form and the pharmacy may be subject to adverse action ranging from an informal warning to formal discipline.
Wisconsin	The State of Wisconsin has nothing to report.
Wyoming	The Wyoming State Board of Pharmacy continually monitors compliance with the oral counseling requirement.

Section III - Retrospective DUR (RetroDUR)

1. Indicate the type of vendor that performed your RetroDUR activities during the time period covered by this report.

Figure 30 – Type of Vendor Performing RetroDUR Activities

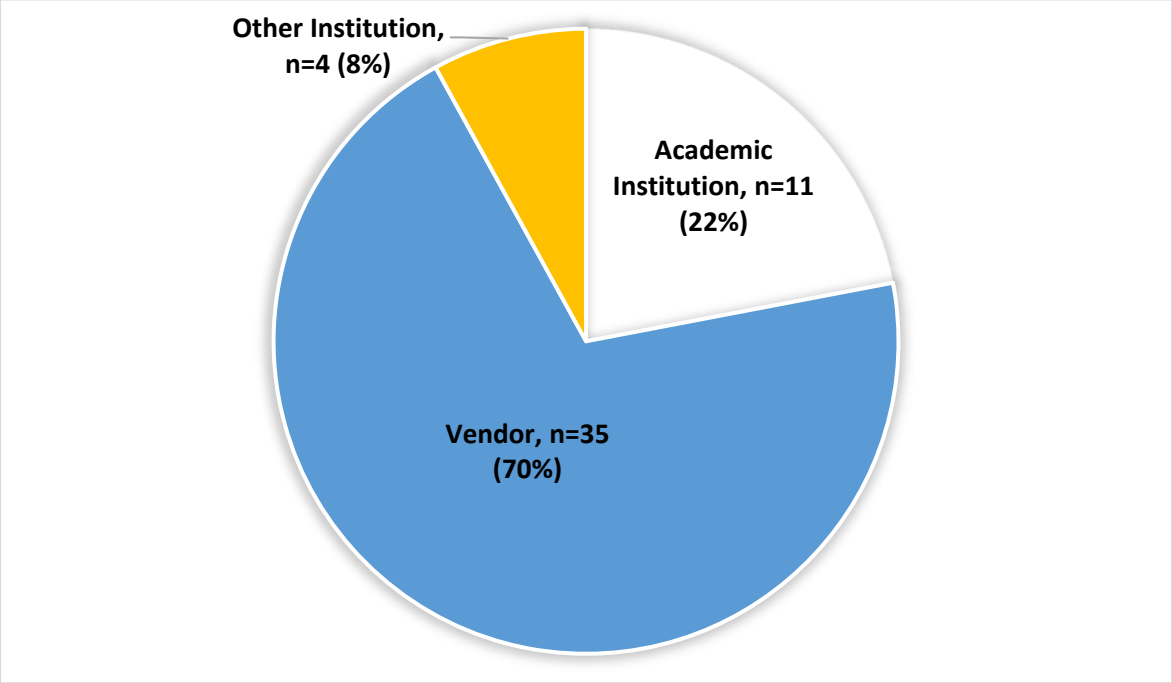

Table 45 – Type of Vendor Performing RetroDUR Activities

Response	States	Count	Percentage
Academic Institution	California, Colorado, Illinois, Massachusetts, Mississippi, Oklahoma, Oregon, South Carolina, Utah, West Virginia, Wyoming	11	22.00%
Vendor	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, 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, Wisconsin	35	70.00%
Other Institution	Hawaii, Montana, Nebraska, Washington	4	8.00%
Total		50	100.00%

a. Identify, by name, your RetroDUR vendor

Table 46 - Vendor Names

Response	States	Count	Percentage
Health Information Designs	Alabama, Arkansas, Connecticut, Kansas, Maryland, New York, North Dakota, South Dakota, Wisconsin	9	25.71%
Magellan	Alaska, Florida, Idaho, Kentucky, Michigan, New Hampshire, North Carolina, Tennessee, Virginia	9	25.71%
DXC Technology	Delaware, Louisiana, New Jersey	3	8.57%
Conduent	District of Columbia, Minnesota, Missouri, New Mexico, Texas	5	14.29%
NorthStar Healthcare Consulting	Georgia	1	2.86%
OptumRx	Indiana, Nevada	2	5.71%
Change Healthcare	Iowa, Maine, Ohio, Pennsylvania, Vermont	5	14.29%
KEPRO	Rhode Island	1	2.86%
Total		35	100.00%

Table 47 - Academic/Other Institution Names

State	Academic/Other Institution Name
California	University of California, San Francisco (UCSF)
Colorado	The Regents of the University of Colorado, School of Pharmacy
Hawaii	State
Illinois	University of Illinois College of Pharmacy staff and use of Change Healthcare RetroDUR for other rev
Massachusetts	University of Massachusetts Medical School
Mississippi	University of Mississippi School of Pharmacy
Montana	Mountain Pacific Quality Health Foundation
Nebraska	Nebraska Pharmacists Association
Oklahoma	University of Oklahoma College of Pharmacy: Pharmacy Management Consultants (PMC)
Oregon	Oregon State University (OSU), College of Pharmacy, Drug Use Research & Management Program
South Carolina	MUSC (Medical University of South Carolina)
Utah	University of Utah Drug Regimen Review Center (DRRC), Utah Department of Health Medicaid Pharmacy Te
Washington	Washington Apple Health (Medicaid)
West Virginia	West Virginia Retrospective Pharmacy DUR Coalition- Marshall University
Wyoming	University of Wyoming School of Pharmacy

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

Figure 31 – Is RetroDUR Vendor the State MMIS Fiscal Agent

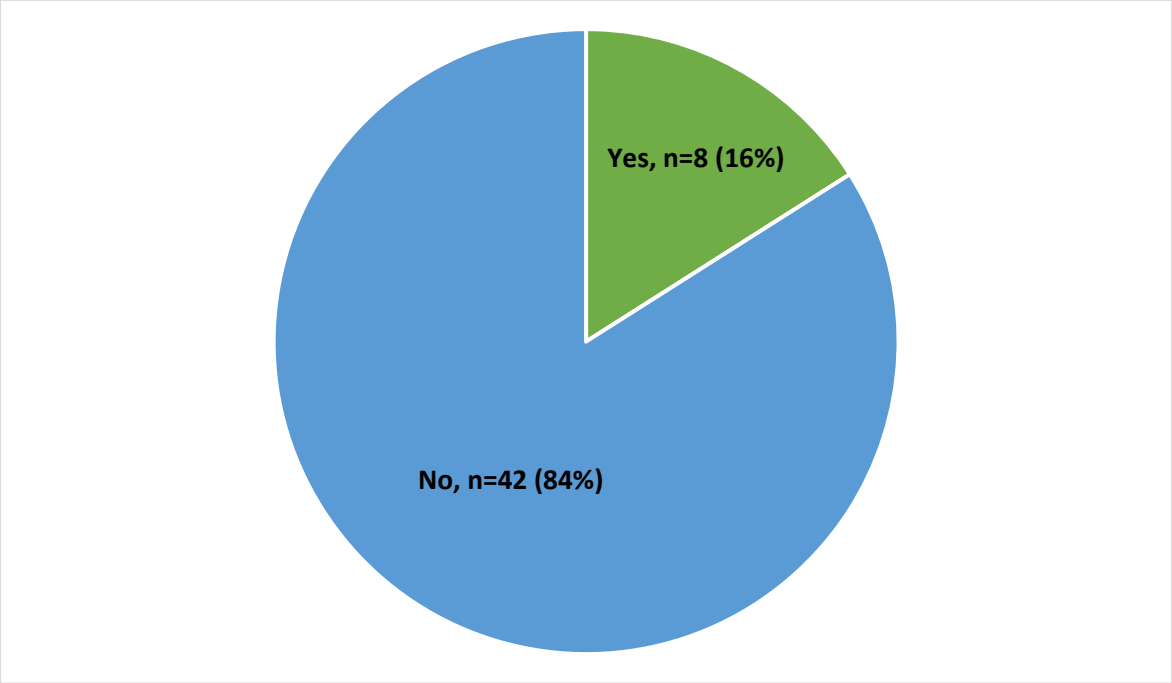

Table 48 – Is RetroDUR Vendor the State MMIS Fiscal Agent

Response	States	Count	Percentage
Yes	Delaware, District of Columbia, Louisiana, New Jersey, New Mexico, Oklahoma, Virginia, Washington	8	16.00%
No	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, 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, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, Wyoming	42	84.00%
Total		50	100.00%

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

Figure 32 – Is RetroDUR Vendor the Developer/Supplier of RetroDUR Criteria

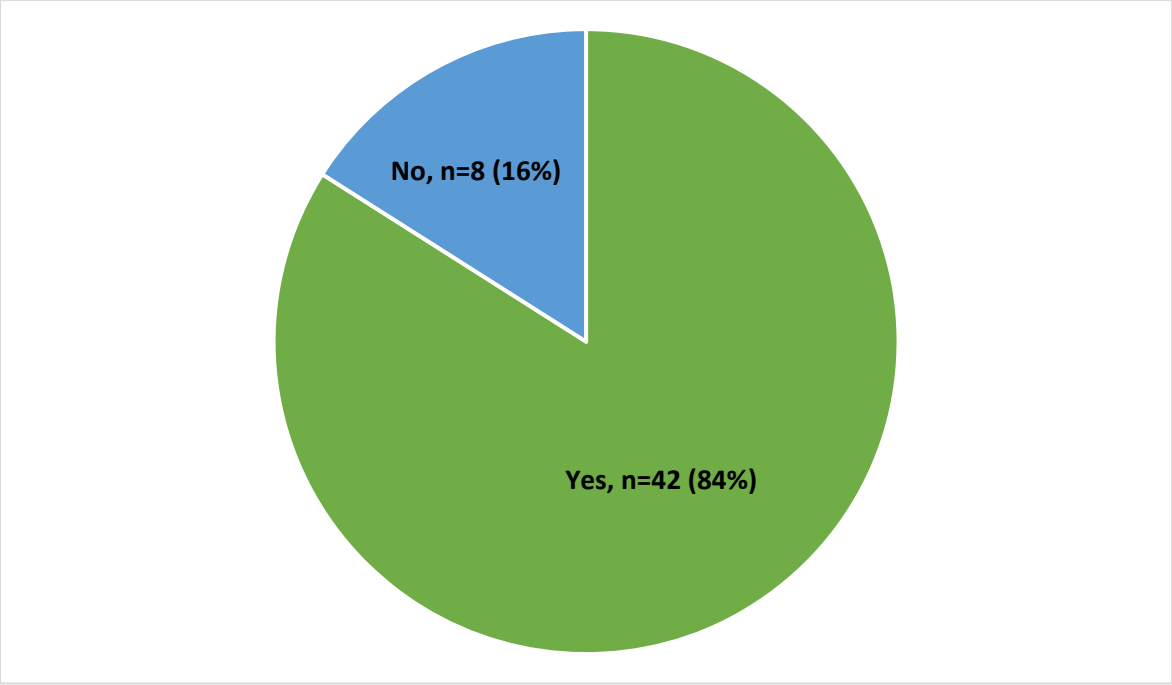

Table 49 - Is RetroDUR Vendor the Developer/Supplier of RetroDUR Criteria

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, 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, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	42	84.00%
No	California, Florida, Hawaii, Idaho, Louisiana, Nebraska, Pennsylvania, Utah	8	16.00%
Total		50	100.00%

If "No," please explain.

Table 50 - Explanations for the RetroDUR Vendor not the Developer/Supplier of Retrospective DUR Criteria

State	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.
Florida	The developer of the retrospective DUR criteria is provided by the State DUR Board in collaboration with the Agency.

State	Explanations
Hawaii	The State develops and supplies.
Idaho	The Medicaid Pharmacy staff pharmacists develop the retrospective DUR criteria, with input from the DUR Board and P&T Committee as necessary
Louisiana	Retrospective DUR criteria are developed through collaboration of pharmacists at LDH, DXC technology, and the University of Louisiana-Monroe.
Nebraska	The State DUR Board
Pennsylvania	The state agency's clinicians and DUR Board develop the RetroDUR criteria.
Utah	The Retro-DUR criteria are developed in a partnership with the Medicaid Pharmacy Team and the University of Utah DRRC.

2. Who reviews and approves the RetroDUR criteria?

Figure 33 - RetroDUR Criteria Approval/Review Sources

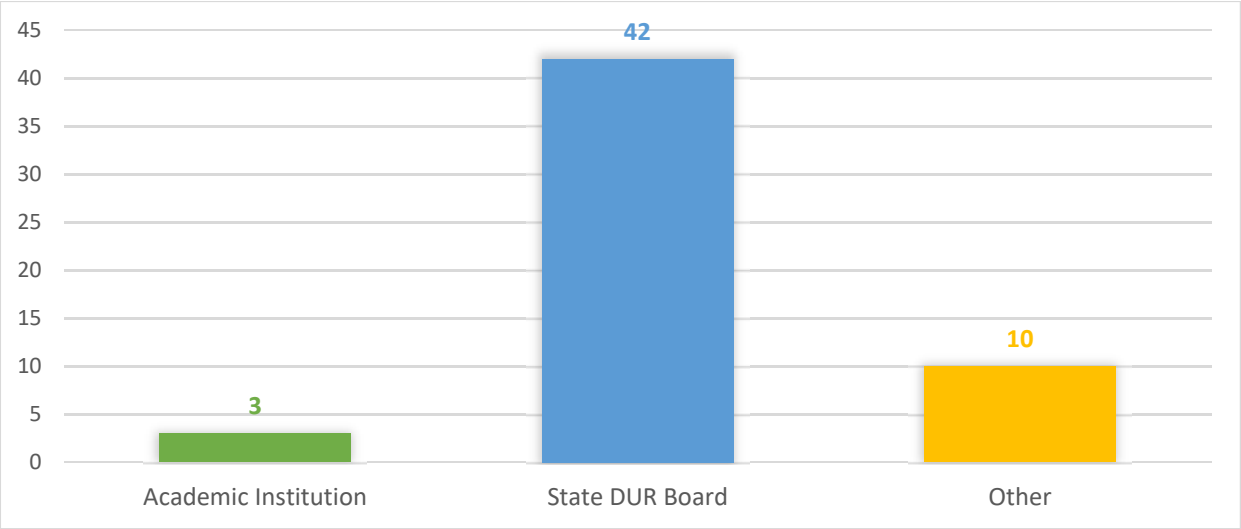

Table 51 - RetroDUR Criteria Approval/Review Sources

Response	States	Count	Percentage
Academic Institution	Oklahoma, South Carolina, Wyoming	3	5.45%
State DUR Board	Alabama, Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, 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, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin	42	76.36%
Other	California, Colorado, Idaho, Illinois, Iowa, Kansas, Nevada, Tennessee, Utah, Washington	10	18.18%
Total		55	100.00%

"Other," please explain.

Table 52 - "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	State Medicaid Pharmacy Unit with input from the DUR Board as needed.
Illinois	The State DUR Board will suggest and approve some criteria for retrospective reviews. Problem identification using PBMS RetroDur 300 application is based on MediSpan criteria.
Iowa	Change Healthcare utilizes MediSpan for retrospective DUR criteria involving a complex screening process for member profile reviews (conducted 4 times per year). The DUR Board discusses RetroDUR educational initiatives and provides input as to what data points are needed for further discussion and potential outreach to providers.
Kansas	Each month, HID evaluates pharmacy and medical claims data against a library of clinical criteria. (These criteria are HID determined.) The DUR Board reviews specific examples that HID proposes for a more expanded RDUR process. The State Medicaid Agency may also propose RDUR criteria to the DUR Board.
Nevada	The DUR Board offers topics and reviews but does not approve the letters and final initiatives.
Tennessee	Criteria is approved by both the Board and the State.
Utah	RetroDUR criteria are reviewed and approved in conjunction with the Medicaid Pharmacy Team and the U of U DRRC.
Washington	RetroDUR criteria is approved by both the State DUR Board and the Health Care Authority. Some activities included as RetroDUR are initiated and completed by other program sections within the Health Care Authority and are not approved by the State DUR Board; examples of these activities include Program Integrity activities and provider oversight resulting in provider education or care gap analysis that include a pharmacy component but are not solely pharmacy based.

3. Summary 2 – Retrospective DUR Educational Outreach

Summary 2 Retrospective DUR Educational Outreach is a year-end summary report on RetroDUR screening and educational interventions. The year-end summary should be limited to the most prominent 10 problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed below.

Table 53 - Retrospective DUR Educational Outreach

State	Retrospective DUR Educational Outreach
Alabama	1. Appropriate Use of Opioids 2. Duplicate Antipsychotic Therapy 3. SUPPORT Act of 2018 (opioid and antipsychotic) 4. Overuse of Stimulants 5. SUPPORT Act of 2018 (opioid and benzodiazepine) 6. Adverse Metabolic Effects (second-generation antipsychotics) 7. Appropriate Use of Opioids 8. Adverse Antipsychotic Effects 9. Adverse Metabolic Effects (atypical antipsychotics in pediatric patients)

State	Retrospective DUR Educational Outreach
	10. Appropriate Use (opioid agonist, skeletal muscle relaxant, and benzodiazepine) Recipients Reviewed Selected for Intervention Letters Generated Letters Mailed Appropriate Use of Opioids 1,151 292 312 306 Duplicate Antipsychotic Therapy 525 12 15 15 SUPPORT Act of 2018 501 385 404 404 Overuse of Stimulants 472 348 366 363 SUPPORT Act of 2018 449 187 199 197 Adverse Metabolic Effects 289 207 219 214 Appropriate Use of Opioids 220 172 299 295 Adverse Antipsychotic Effect 217 31 37 37 Adverse Metabolic Effects 191 39 53 52 Appropriate Use of Opioid, Skeletal Muscle Relaxant, and Benzodiazepine 163 31 41 41 Totals 4,178 1,704 1,945 1,924
Alaska	General Information The Alaska Medicaid Drug Utilization Review (DUR) Committee was established to comply with Sec. 1927(g) of the Social Security Act, Title 42 CFR 456 and Alaska Administrative Code 7 AAC 120.120. Retrospective screening and educational interventions for FFY 2019 are summarized below: Highlighted Activities: Opioid Morphine Equivalent Dose - prescriber education; letters sent to providers; patient outreach; is ongoing - Education runs concurrent with long-acting opioid PA requests and letters sent to providers with patients in excess of the established MME New POS edits for Opioids in combination with benzodiazepines and antipsychotics - Pharmacist level overrides made available after consultation with the prescriber Gabapentin and Pregabalin - Letters sent to prescribers regarding potential overuse, misuse, interactions, and potentiation of other medications Retrospective Drug Utilization Review (RetroDUR) The DUR Committee conducts retrospective reviews approximately once per quarter. The criteria for claims review is typically selected by the committee coordinator or suggested drug related issues by the committee members. For profile reviews, the committee evaluates a recipient's medication history for the criteria under review in addition to therapeutic duplications, drug

State	Retrospective DUR Educational Outreach
	interactions, overutilization, and poly-provider situations. Introduced starting in FFY2016, the utilization of FDA FAERS reports and the evaluation of impact on Alaska Medicaid beneficiaries has continued. RetroDUR issues are generally addressed with educational interventions such as prescriber letters or direct prescriber contact via phone. Additional means, such as web-based notices, newsletters, and email bulletins, were utilized for outreach. The logistics of face-to-face interactions with prescribers is difficult due to the large geography of the state and many communities have limited road access. The DUR Committee may also refer potential cases of overutilization or fraud, waste or abuse identified during the RetroDUR to the Care Management program and/or the Program Integrity unit.
Arkansas	ARKANSAS RETROSPECTIVE EDUCATIONAL OUTREACH EXECUTIVE SUMMARY This report prepared for the Arkansas Department of Human Services summarizes the top 10 Retrospective Drug Utilization Review (RDUR) interventions as ranked by the number of intervention letters mailed to prescribers during Federal Fiscal Year (FFY) 2019. Intervention letters are mailed to prescribers to encourage appropriate prescribing and improve drug utilization, which will, in turn, prevent possible adverse drug reactions and improve patient outcomes in the targeted recipient population. A total of 5,981 prescriber letters were mailed for the top 10 criteria evaluated. Each letter included a response form, soliciting feedback from the prescriber. Responses are voluntary and a response rate of 15.3% was achieved for the top 10 criteria and a response rate of 15.9% was achieved for total interventions during FFY 2019. In their responses, 25% of prescribers indicated that some positive action had been or would be taken to address the drug therapy issue identified in the intervention letter. In an effort to promote appropriate prescribing and utilization of medications, HID evaluates claims data against selected criteria on a monthly basis to identify recipients with drug therapy issues and mails the corresponding educational intervention letters to those recipients' prescribers. A copy of the recipient's complete drug and diagnosis history, including medications prescribed by other providers, is also provided with the letter. Prescribers have the opportunity to review the entire drug and diagnosis history and make changes to therapies based on this information. Analysis Methodology Each month HID evaluates Arkansas fee-for-service Medicaid pharmacy claims data against criteria for several hundred potential drug therapy issues. Criteria are developed by HID and presented to the Arkansas Medicaid Drug Utilization Review Board for approval and implementation. Recipient Selection The drug history and diagnosis profile for each recipient who meets the selected criteria are reviewed by members of the Arkansas Medicaid Retrospective Drug Utilization Review Committee to determine if the recipient should be selected for intervention. After recipients are selected for intervention, educational intervention letters are mailed to all prescribers of drugs included in the criteria. Letters are sent with a complete drug history and all diagnoses obtained from claims data submitted during the past 6 months. Some letters cannot be mailed or are returned after mailing due to missing or invalid provider addresses.

State	Retrospective DUR Educational Outreach
	Once a recipient is selected for intervention, the specific criteria are suppressed by the RDUR system for that recipient for 6 months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, recipients could be selected for additional criteria exceptions later in the year. Recipients may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle. Retrospective DUR Intervention Summary Below is a summary of educational outreach letters mailed for the top 10 retrospective DUR interventions based on number of letters mailed for FFY 2019. The list includes the criteria description, criteria type, # of recipients selected for intervention, # of intervention letters mailed to prescribers, # of prescriber responses, and physician response rate. 1) OPIOID & ANTIPSYCHOTIC USE (SUPPORT Act): drug-drug interaction - 876, 1516, 196, 12.9% 2) OPIOID & BENZODIAZEPINE USE (SUPPORT Act): drug-drug interaction - 801, 1118, 165, 14.8% 3) OCs WITHOUT FAMILY PLANNING DIAGNOSIS: therapeutic appropriateness - 733, 729, 71, 9.7% 4) OPIOID, GABAPENTIN & BENZODIAZEPINE USE: drug-drug interaction - 555, 910, 258, 28.4% 5) LOW-DOSE QUETIAPINE (<100 mg/day): underutilization/low-dose alert - 458, 458, 54, 11.8% 6) GABAPENTIN & BENZODIAZEPINE USE: drug-drug interaction - 295, 485, 72, 14.8% 7) FLOVENT HFA NON-ADHERENCE: underutilization/low-dose alert - 254, 196, 50, 25.5% 8) ACC/AHA HIGH BLOOD PRESSURE GUIDELINES: therapeutic appropriateness - 252, 260, 25, 9.6% 9) CODEINE IN PEDIATRIC PATIENTS: therapeutic appropriateness - 169, 171, 23, 13.5% 10) ANTIEPILEPTICS & SUICIDAL RISK: drug-disease interaction - 154, 138, 3, 2.2% Prescriber Response Tabulation In addition to the intervention letter and the recipient's drug and diagnosis history, a response form is included in the mailings. The response form allows prescribers to give feedback and informs HID if any action will be taken in response to the letter. The response form contains standard responses that allow the provider to check a box for the response that best fits their intended action and provides space for handwritten comments. Providers are encouraged to return the response form using the self-addressed, stamped envelope included with the intervention letter or send the form via fax. HID tracks all returned response forms. Results Provider Responses to Intervention Letters A total of 9,345 DUR educational intervention letters were mailed to prescribers during FFY 2019 and 1,485 responses were received for a response rate of 15.9%. A summary of all coded responses from prescribers is listed in the table below. Prescriber Response Total BENEFITS OF THE DRUG OUTWEIGH THE RISKS 77 MD UNAWARE OF WHAT OTHER MD PRESCRIBING 23

State	Retrospective DUR Educational Outreach
	PATIENT IS NO LONGER UNDER THIS MD'S CARE 98 MD SAYS PROBLEM INSIGNIFICANT NO CHANGE THERAPY 429 MD WILL REASSESS AND MODIFY DRUG THERAPY 119 MD TRIED TO MODIFY THERAPY; PATIENT DECLINED 26 PATIENT UNDER MY CARE BUT NOT SEEN RECENTLY 72 PATIENT DECEASED 4 PATIENT WAS NEVER UNDER MD CARE 17 HAS APPT TO DISCUSS THERAPY 145 MD DID NOT HAVE RX DRUG ATTRIBUTED TO HIM 129 TRIED TO MODIFY THERAPY; SYMPTOMS RECURRED 56 MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD 41 PHARMACY CAN'T PROVIDE MD INFORMATION 239 PHARMACY WILL COUNSEL PATIENT ON NEXT VISIT 6 PATIENT NO LONGER USES PHARMACY / OR SEES MD 1 BENEFIT OUTWEIGHS RISK; NO CHANGE REC. 3 TOTAL OF ALL RESPONSES 1485 Response Rate 15.9% Results Discussion With respect to prescriber responses to RDUR letters, a response rate of 15.9% was achieved. Approximately 25% (343 of 1485 responses) of responding prescribers indicated that some positive action resulted from the intervention letter. These actions include: patient has an appointment to discuss therapy, will reassess and modify drug therapy, tried to modify therapy, and unaware of other prescribers. All intervention letters include the recipient's drug claims data within the previous 6 months and any available diagnosis data to provide as complete of a drug and diagnosis history as possible. This approach provides prescribers and pharmacies with the information needed to fully review and evaluate each recipient's drug history. Conclusion For FFY 2019, a total of 5,981 intervention letters for the top 10 criteria alerts were mailed to prescribers, with a response rate of 15.3%. There was also a 15.9% physician response rate for all criteria alerts, and 25% of prescribers who responded to the letters indicated that some positive action had been or would be taken to address the drug therapy issue identified in the intervention letter.
California	1. Additive toxicity (AT) alert provider letter sent January 2019 - The objectives were 1) to identify beneficiaries at high-risk for adverse events associated with the use of certain opioid medications in combination with benzodiazepines and other CNS depressants; and 2) to help inform health care providers and patients of the serious risks attributed to co-prescribing of opioids with CNS depressants, including benzodiazepines, non-benzodiazepine receptor agonists, and antipsychotics. The study population included 31 beneficiaries who were continuously eligible in the Medi-Cal fee-for-service program between October 1, 2018, and January 31, 2019. Each beneficiary generated an AT alert with pharmacist override during December 2018 and had at least one paid claim for both an opioid and a benzodiazepine, as well as paid claims for at least two additional CNS depressants between October 1, 2018, and December 31, 2018. Those with claims

State	Retrospective DUR Educational Outreach
	with practice locations including SNF, ICF, home health, and hospice, and diagnostic codes indicating palliative care or cancer treatment were excluded. A total of 67 prescribers were identified for educational outreach letters, which were mailed on January 18, 2019. Any paid claims for gabapentin during the same time period were also included on patient profiles. 2. Alert: New Naloxone Regulations Effective on January 1, 2019 educational alert published January 2019 - This alert reviewed California Assembly Bill 2760 (Wood, Chapter 324) that was signed into law in 2018 and became effective on January 1, 2019. AB 2760 requires California prescribers to offer a prescription to a patient for either naloxone or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of opioid-induced respiratory depression, as a rescue medication under certain conditions. 3. Clinical Review Update: Morphine Equivalent Daily Dose a. Educational bulletin published February 2019 - This bulletin reviewed the morphine equivalent daily dose (MEDD) and how it is being used to indicate potential dose-related risk for prescription opioid overdose. This article also summarized best practices for prescribing opioids, identified resources available that promote responsible opioid prescribing, and described recent state legislation related to prescription opioids. b. Provider letter sent April 2019 - The objective was to educate providers about morphine equivalent daily dose (MEDD) thresholds and updated legislation regarding prescribing opioids in California. The study population included 87 Medi-Cal fee-for-service beneficiaries with at least 1 paid claim > 120 mg MEDD since January 1, 2019. A total of 85 prescribers were identified for educational outreach letters, which were mailed on April 26, 2019. Each letter included patient profiles, the updated Medi-Cal DUR MEDD article, a naloxone handout, and provider response surveys. 4. Drug Safety Communication: Updated Adverse Effects from Fluoroquinolone Antibiotics educational alert published March 2019 - This alert summarized an FDA warning based on epidemiological studies and cases from the FDA Adverse Event Reporting System (FAERS) database that found fluoroquinolone antibiotics could increase the occurrence of rare but serious events of aortic dissections or ruptures of an aortic aneurysm, which can lead to dangerous bleeding or even death. The FDA is requiring inclusion of these new risks in the prescribing information and patient Medication Guide for all fluoroquinolones. 5. Drug Safety Communication: Risks with Sudden Discontinuation of Opioids educational alert published April 2019 - This alert was based on an FDA warning of reports of serious harm in patients who are physically dependent on opioid pain medicines when these medicines are suddenly discontinued or the dose is rapidly decreased. Examples of serious harm include serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide. The FDA is requiring expanded guidance within the prescribing information of opioids that are intended for use in the outpatient setting on how to safely decrease the dose in patients who are physically dependent on opioids. 6. Drug Safety Communication: Sleep Behavior Risks with Select Sleep Aids a. Educational alert published April 2019 - This alert was based on an FDA announcement regarding safety label changes for eszopiclone, zaleplon, and zolpidem because of the risk of complex sleep behaviors, including sleepwalking, sleep driving, and engaging in other activities while not fully awake. While rare, these complex sleep behaviors have resulted in serious injuries and death. Safety label changes include a Boxed Warning added to the prescribing information and

State	Retrospective DUR Educational Outreach
	patient Medication Guides and a Contraindication to avoid use of these drugs in patients who have previously experienced a complex sleep behavior with the use of eszopiclone, zaleplon, and zolpidem. b. Provider letter sent August 2019 - The objective was to determine whether there was inappropriate use of zolpidem products, based on FDA warnings that female patients have lower clearance rates than males. Educational outreach letters were mailed on August 20, 2019, to the top 100 prescribers of zolpidem in the Medi-Cal fee-for-service population. Each letter included the Medi-Cal DUR zolpidem alert, a provider response survey, and provider-specific data including the percentage of female Medi-Cal beneficiaries with an initial dose of zolpidem exceeding the recommended initial dosage limits, the percentage of female Medi-Cal beneficiaries with an initial dose of IR zolpidem > 5 mg, and the percentage of female Medi-Cal beneficiaries with an initial dose of ER zolpidem > 6.25 mg. 7. Tramadol provider letter sent July 2019 - The objective was to inform health care providers and patients of the serious risks attributed to prescribing tramadol to patients younger than 18 years of age. The study population included 40 Medi-Cal fee-for-service beneficiaries younger than 18 years of age (65% were 17 years of age) who had at least one paid claim for tramadol between January 1, 2019 and June 30, 2019. A total of 44 prescribers were identified for educational outreach letters, which were mailed on July 29, 2019. Each letter included patient profiles, the Medi-Cal DUR tramadol alert, and a provider response survey. 8. Codeine provider letter sent August 2019 - The objective was to inform health care providers and patients of the serious risks attributed to prescribing codeine to patients younger than 18 years of age. The study population included 450 Medi-Cal fee-for-service beneficiaries younger than 18 years of age who had at least one paid claim for codeine-containing medication between January 1, 2019 and June 30, 2019. A total of 313 prescribers were identified for educational outreach letters, which were mailed on August 1, 2019. Each letter included patient profiles, both of the Medi-Cal DUR codeine alerts, and a provider response survey. 9. Clinical Review Update: Concomitant Anticholinergic and Antipsychotic Use educational bulletin published August 2019 - This bulletin focused on understanding the role of anticholinergic medications in the prevention and treatment of antipsychotic-induced extrapyramidal symptoms (EPS). The bulletin also describes factors that should be considered when deciding to initiate and/or continue the concomitant use of anticholinergic with antipsychotic medication therapy. 10. 2019 Immunization Updates: Flu, HepA, HPV, Measles, CA School Requirements educational bulletin published September 2019 - This bulletin is an annual publication provided by the DUR program to provide updates on immunization guidelines, products, policy and/or research each year. Links to recommended immunization schedules for 2019 in the United States were also provided. The summary for 2019 included updates for influenza vaccine, Hepatitis A (HepA) vaccine, human papillomavirus (HPV) vaccine, and measles, as well as a review of changes in vaccination requirements for California schools.
Colorado	Summary 2: Retrospective DUR Educational Outreach 1. Members with multiple claims for opioid prescriptions that total an amount > 200MME calculated as a daily dose averaged over a 30-day period.

State	Retrospective DUR Educational Outreach
	Problem Category: Therapeutic, High Dose; Drug or Drug Class Reviewed: Opioids; Number of members meeting criteria: 994; Number of prescribing providers: 815; Exceptions and number of provider intervention letters: 815. 2. Opioid plus antipsychotic letters (45/90 or 60/90 days). Problem Category: Disease-Drug Interaction; Drug or Drug Class Reviewed: Opioids, Antipsychotics; Number of members meeting criteria: 2711; Number of prescribing providers: 2935; Exceptions and number of provider intervention letters: 2935. 3. Members receiving an opioid, benzodiazepine, and muscle relaxant medication concomitantly for 45 days during the measurement quarter. Problem Category: Therapeutic, High Dose; Drug or Drug Class Reviewed: Opioids; Number of members meeting criteria: 1774; Number of prescribing providers: 2108; Exceptions and number of provider intervention letters: 2108. 4. Children receiving 2 or more antipsychotics for >45 days of measurement quarter. Problem Category: Therapeutic, Age Restriction; Drug or Drug Class Reviewed: Psychotropic Medications; Number of members meeting criteria: 467; Number of prescribing providers: 387; Exceptions and number of provider intervention letters: 283. 5. Children receiving 3 or more psychotropic medications for >45 days of measurement quarter. Problem Category: Therapeutic; Drug or Drug Class Reviewed: Psychotropic Medications; Number of members meeting criteria: 786; Number of prescribing providers: 814; Exceptions and number of provider intervention letters: 814. 6. Fluoxetine 60mg tablets (recommendations to use capsule). Problem Category: Therapeutic; Drug or Drug Class Reviewed: Psychotropic Medications; Number of members meeting criteria: 60; Number of prescribing providers: 60; Exceptions and number of provider intervention letters: 60. 7. Fluoxetine all other strength tablets (recs to use capsule) Problem Category: Therapeutic; Drug or Drug Class Reviewed: Psychotropic Medications; Number of members meeting criteria: 238; Number of prescribing providers: 238; Exceptions and number of provider intervention letters: 238. 8. Concomitant benzodiazepine prescribing/utilization (greater than or equal to two benzodiazepine medications prescribed/utilized) - Intervention planned for FFY2020.
Connecticut	Executive Summary This report prepared for the Connecticut Medial Assistance Program summarizes the top 10 Retrospective Drug Utilization Review (RDUR) interventions as ranked by the number of intervention letters mailed to prescribers during Federal Fiscal Year (FFY) 2019. Intervention letters are mailed to prescribers to encourage appropriate prescribing and improve drug utilization, which will, in turn, prevent possible adverse drug reactions and improve patient outcomes in the targeted recipient population. A total of 11,409 prescriber letters were mailed for the top 10 criteria evaluated. Each letter included a response form, soliciting feedback from the prescriber. Responses are voluntary and a response rate of 15% was achieved for both the top 10 criteria reviewed and for all overall interventions performed during FFY 2019. Program Background Health Information Designs, LLC (HID) currently provides RDUR services for the Connecticut fee-for-service Medicaid population as a subcontractor with DXC Technology. In an effort to promote appropriate prescribing and utilization of medications, HID evaluates claims data against selected criteria monthly to identify recipients with drug therapy issues and mails the corresponding educational intervention letters to those recipients' prescribers. A copy of the

State	Retrospective DUR Educational Outreach
	recipient's complete drug and diagnosis history, including medications prescribed by other providers, is also provided with the letter. Prescribers have the opportunity to review the entire drug and diagnosis history and make changes to therapies based on this information. Analysis Methodology Each month HID evaluates Connecticut fee-for-service Medicaid pharmacy claims data against criteria for several hundred potential drug therapy issues. Criteria are developed by HID and presented to the Connecticut Drug Utilization Review Board and DXC for approval and implementation. Recipient Selection The drug history and diagnosis profile for each recipient who meets the selected criteria are reviewed by a HID clinical pharmacist to determine if the recipient should be selected for intervention. After recipients are selected for intervention, educational intervention letters are mailed to all prescribers of drugs included in the criteria. Letters are sent with a complete drug history and all diagnoses obtained from claims data submitted during the past 6 months. Some letters cannot be mailed or are returned after mailing due to missing or invalid provider addresses. Once a recipient is selected for intervention, the specific criteria are suppressed by the RDUR system for that recipient for 6 months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, recipients could be selected for additional criteria exceptions later in the year. Recipients may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle. Retrospective DUR Intervention Summary The table below is a summary of educational outreach letters mailed for the top 10 retrospective DUR interventions based on number of letters mailed for FFY 2019. CRITERIA TYPE, CRITERIA DESCRIPTION, # OF CASES CREATED, # INTERVENTION LETTERS MAILED TO PRESCRIBERS, # PRESCRIBER RESPONSES LI, Connecticut lock-in (LI) criteria, 1,456, 4,352, 519 TA, All children and adolescents on stimulant medications should have routine follow-up studies and monitoring every 3 months for blood pressure, pulse, weight, height, and BMI/BMI percentile., 1,079, 1,083, 340 TA, Fluoroquinolones should be reserved for use in patients who have no other treatment options for acute bacterial sinusitis, (ABS), acute bacterial exacerbation of chronic bronchitis (ABECB), and uncomplicated urinary tract infections (UTI) because the risk of serious side effects (e.g., tendinitis, tendon rupture, peripheral neuropathy, and CNS disorders) generally outweighs the benefits in these patients. For some serious bacterial infections, the benefits of fluoroquinolones outweigh the risks, and it is appropriate for them to remain available as a therapeutic option., 962, 968, 106 TA, Immediate-release opioids should be reserved for pain severe enough to require opioid treatment for which alternative treatment options such as non-opioid analgesics are inadequate or not tolerated. These agents expose patients to the risks of opioid addiction, abuse, and misuse, potentially harmful interactions, and adverse effects on the endocrine system. Prolonged use of immediate-release opioids in pregnant women can also result in NOWS (neonatal opioid withdrawal syndrome)., 754, 863, 140 TA, The effects of prolonged use of atypical antipsychotics in pediatric patients are unknown. Preliminary evidence suggests that pediatric patients experience more prevalent and severe adverse effects than those reported in adults (e.g., weight gain, extrapyramidal side effects, and insulin resistance). If therapy with these agents is clinically necessary, use the lowest effective dose and observe patients closely for adverse events. If adverse effects cannot be controlled, consider switching, if clinically possible, to a second-generation antipsychotic with a more favorable adverse

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	effect profile. The SUPPORT Act of 2018 requires that Medicaid monitor antipsychotic prescribing for children., 870, 858, 144 LR, Low dose Seroquel (quetiapine), less than 200 mg, is sometimes used off-label as a sedative agent. Quetiapine is not FDA-approved for the treatment of sleep-related problems. The long-term safety and efficacy of this treatment strategy have not been evaluated., 774, 769, 94 DD, Co-administration of opioids and benzodiazepines should be done with extreme caution as the combination may result in respiratory depression, hypotension, profound sedation, coma, and death. If concurrent administration is clinically warranted, consider dosage reduction of one or both agents. Re-evaluate the patient's treatment plan on a regular basis to determine the necessity for continued concomitant use of these agents. The SUPPORT Act of 2018 requires that Medicaid monitor the concurrent use of opioids and benzodiazepines., 431, 748, 122 TD, Therapeutic duplication of benzodiazepine therapy may be occurring., 423, 663, 125 DD, The patient is receiving two highly addictive and often abused controlled substances, opiates and stimulants. Before prescribing any controlled substance, check the Ct Prescription Monitoring and Reporting System (CPMRS) to review the patient's controlled substance history and rule out possible polysubstance abuse and "doctor shopping". While stimulants are used off-label with opioids to counter opioid-induced sedation the combination can be used for a "high". This drug combination can also mask overdose and serious adverse effects of either drug., 330, 572, 104 TA, All antidepressant-containing medications may increase the risk of suicidal thinking and behaviors (suicidality) in children, adolescents, and young adults. Patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior especially during the initial months of drug therapy, or at times of dose changes., 506, 533, 94 , Total Top 10, 7,585, 11,409, 1,788 , Total all letters for all criteria, 21,576, 26,697, 4,067 LI-Lock In, DD-Drug Drug, TA-Therapeutic Appropriateness, LR-Underuse Precaution Prescriber Response Tabulation In addition to the intervention letter and the recipient's drug and diagnosis history, a response form is included in the mailings. The response form allows prescribers to give feedback and informs HID if any action will be taken in response to the letter. The response form contains standard responses that allow the provider to check a box for the response that best fits their intended action and provides space for handwritten comments. Providers are encouraged to return the response form using the self-addressed, stamped envelope included with the intervention letter or send the form via fax. HID tracks all returned response forms. Results Provider Responses to Intervention Letters A total of 11,409 DUR educational intervention letters were mailed for the top 10 interventions to prescribers during FFY 2019, however, a total of 26,697 letters were mailed for all interventions performed during FFY 2019. 4,067 responses were received during FFY 2019 for a total response rate of 15%. A summary of all coded responses from prescribers is listed in the table below. Prescriber Response, Total BENEFITS OF THE DRUG OUTWEIGH THE RISKS, 283 MD UNAWARE OF WHAT OTHER MD PRESCRIBING, 52 PT IS NO LONGER UNDER THIS MD's CARE, 311 MD SAYS PROB INSIGNIF NO CHG THX, 1,716 MD WILL REASSESS AND MODIFY DRUG THERAPY, 273 MD TRIED TO MODIFY THERAPY, PT NON-COOP, 94

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	PT UNDER MY CARE BUT NOT SEEN RECENTLY, 172 PATIENT DECEASED, 4 PATIENT WAS NEVER UNDER MD CARE, 75 HAS APPT TO DISCUSS THERAPY, 420 MD DID NOT RX DRUG ATTRIBUTED TO HIM., 239 TRIED TO MODIFY THERAPY,SX RECURRED, 117 MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD, 311 Total Responses for FFY 2019, 4,067 Response Rate, 15% Conclusion The top 10 interventions to prescribers were conducted for the Connecticut Medical Assistance Program population during FFY 2019 which resulted in 7,585 cases created and 11,409 prescriber letters mailed. The overall response rate, as well as the response rate for the top 10 interventions, was 15% during FFY 2019.
Delaware	For FFY 2019, Delaware Medicaid continued to operate under a Medicaid Management Information System (MMIS) and third-party vendor contracts. Delaware designed an improved electronic drug utilization review process and a concurrent review functionality that accounts for both pharmacy and medical claim types in the drug utilization review process for the Fee for Service (FFS) program. This continues to benefit the providers of the program by providing a holistic view of drug utilization issues. Retrospective DUR is frequently used as a means of reviewing potential interventions and providing provider outreach to improve outcomes. For example, a review of Therapeutic Duplication (TD) errors was used to identify patients receiving duplication of therapy within the laxative drug class in long term and assisted living facilities. This commonly occurs due to patients seeing multiple providers who are not aware of the patient's other medications. The providers that were identified received targeted outreach with the goal of improving client care, reducing pill burden and preventing unnecessary expenditures for the State In FFY 2019, top ten alerts selected for review was from alert category from in high dose (HD), therapeutic duplication (TD), drug -disease (MC), based on DUR boards primary focus on Mental health and long -term care medication management aligned with clinical recommendation. Therapeutic duplication in the following drug classes Laxative and Cathartics (client taking greater than two different drugs with different mechanism of action), Atypical antipsychotics (review of profiles with duplicate agents, dose titration, use of submission clarification code 5 to bypass TD edit) , Insulins (category in top 10 drug expenditure by state, re view of claims optimal formulation) and Selective Serotonin reuptake inhibitors (SSRI). High dose alerts selected for intervention in drug class categories, Aniticonvulsants, SSRIs, Atypical antipsychotics aligned with FDA approved dosing by indication, and age. Drug disease reported contraindication in Anticonvulsants, Antipsychotics, SSRIs and Cardiovascular therapeutic categories. Identifying client with contraindicated diagnosis obtained from client disease profile, based on severity provider is sent an alert. Provider education topics from reviewing retrospective claims intervention alerts and promote better health outcomes. For example, a review of Therapeutic Duplication (TD) errors was used to identify patients receiving duplication of therapy within the laxative drug class in long term and assisted living facilities. This commonly occurs due to patients seeing multiple providers who are not aware of the patient's other medications. The providers that were identified received targeted

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	outreach with the goal of improving client care, reducing pill burden and preventing unnecessary expenditures for the State. TD alerts within the antipsychotic drug class, led to targeted outreach to providers, educating providers on frequent medication review, and integration of non-pharmacological counseling to achieve better health outcomes. Additionally, allowed the state to facilitate provider engagement to promote mental health care, increased patient compliance with therapy, and optimize financial outcomes. Due to the nature of the condition being treated, clients on antipsychotics are often prescribed successive agents and even strengths within the same drug to find the best treatment option. Another method through which Delaware performs RetroDUR to improve client health and fiscal responsibility is through Pharmacy provider outreach using blast faxes to registered pharmacies, bulletins to providers, and notifications on Healthcare Portal. For example, Alprazolam due to abuse potency, and dependence concerns from chronic use, was changed to a non-preferred requiring Prior authorization. A survey from Department of public health, found accidental overdose deaths had a mixture of Opioids, benzodiazepines and other synthetics agents. To drive awareness, Delaware prospectively and retrospectively communicated to our providers the rationale behind the decision and necessary information such as options for transitioning their patients to less risky agents, conversion off these medications with no qualifying diagnosis. In FFY 2019, Delaware continued to closely monitor and provide outreach to assist in educating providers on safe opioid prescribing. For example, auto-generated letters were sent to 28 providers in FFY 2019 when their patient reached the threshold of greater than 90 MME. The numbers of providers targeted represent a significant decrease from previous FFY 2018 and indicates an overall reduction of patients receiving high total daily doses of morphine milliequivalents.
District of Columbia	SUMMARY The District of Columbia DUR Board conducts monthly clinical reviews of patient profiles for retrospective DUR screening and interventions. At least 300 patient profiles are presented at each DUR Board Meeting during the program year. During this program period, 11 months of data was reviewed and profiled for intervention mailings to providers. The DUR Board selected several population-based clinical interventions to focus on recurring drug therapy issues encountered during individual patient profile reviews. The top DUR clinical interventions and their clinical analysis are listed below with the results. Chronic Non-Cancer Pain Management: This intervention was designed to improve the appropriate and effective management of chronic non-cancer pain (CNCP) with opiate analgesics. The population-based mailing intervention targeted 239 physicians treating 183 beneficiaries identified as being at increased risk for adverse events using the following indicators: Indicator#1: Increased Risk of Adverse Drug Event: Excessive Dose of Tramadol or Opiate Analgesics Containing Acetaminophen or Ibuprofen By exceeding the recommended daily dosages, patients may be placed at an increased risk of experiencing an adverse event: Acetaminophen- hepatic impairment Ibuprofen - gastrointestinal bleed or renal impairment Tramadol - headaches, dizziness, seizure Candidates (denominator): Patients receiving tramadol or opiate analgesics containing acetaminophen or ibuprofen in the last 60 days

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	Exception Criteria (numerator): Candidates receiving greater than the recommended daily doses of tramadol or acetaminophen/ibuprofen as part of a combination opiate product. Tramadol Immediate-Release (IR), orally disintegrating tablets ODT: Candidates <75 years of age receiving quantities>400 mg/day. Candidates >75 years of age receiving quantities >400mg/day Tramadol Extended-Release (ER): an average dose > 300mg/day Acetaminophen: Quantities of an acetaminophen-containing opiate analgesic=>4000mg acetaminophen/day Ibuprofen: Quantities of an ibuprofen-containing opiate analgesic=> 3200mg ibuprofen/day Indicator #2: Increased Risk of Adverse Drug Event: Tramadol Use with Renal or Hepatic Disease Patients with renal disease or cirrhosis are at increased risk of adverse events if tramadol IR/ODT is not prescribed at recommended dosages. Tramadol ER should not be used in patients with a creatinine clearance less than 30 ml/min or in those who have severe hepatic disease (Child-Pugh Class C). Candidates(denominator): Patients with a history of severe renal impairment, dialysis, or hepatic disease in the last 2 years who received tramadol in the last 60 days. Exception Criteria (numerator): Tramadol IR/ODT Renal disease or dialysis: candidates receiving quantities that could provide a daily dose exceeding 200mg tramadol IR/ODT Cirrhosis: candidates receiving quantities that could provide a daily dose exceeding 100 mg Tramadol ER: Renal disease, dialysis or hepatic disease candidates who have received tramadol ER in the last 60 days Indicator #3: Increased Risk of Adverse Drug Event: Pediatric Use of Tramadol The use of tramadol and tramadol ER has not been studied in patients less than 16 years of age and 18 years of age, respectively. Therefore, the use of tramadol is not recommended in these age populations. Candidates (denominator): All patients who have received tramadol in the last 60 days Exception Criteria (numerator): Candidates less than 16 years of age receiving tramadol IR/ODT Candidates less than 18 years of age receiving tramadol ER Indicator#4: Increased Risk of Adverse Drug Event: Meperidine Use Meperidine is not recommended in the treatment of CNCP. It has a neurotoxic metabolite, normeperidine, which accumulates with repeated dosing and can produce anxiety, tremors, myoclonus and seizures. Meperidine should be avoided in patients with renal insufficiency. Finally, meperidine has a short duration of action and relatively large doses are required for the relief of moderate to severe pain. Candidates (denominator): All patients receiving oral meperidine in the last 60 days Exception Criteria (numerator): Candidates with a history of chronic renal insufficiency in the last 2 years or candidates receiving 3 or more prescriptions and 90 or more tablets of oral meperidine in the last 60 days Indicator #5: Underutilization of Long-Acting Opiates Excessive use of short-acting opiate analgesics may indicate inadequate pain relief. Although short-acting opiate analgesics are easier to titrate to pain relief they require frequent dosing. In addition, chronic use of short-acting opiate analgesics has been shown to increase the potential for abuse: therefore, they are best reserved for breakthrough pain. Long-acting opiates can provide sustained pain relief with less frequent dosing. Candidates (Denominator): Patients receiving 8 or more short-acting analgesic prescriptions within the last 150 days (excluding patients with a history of malignancies, migraine headaches or sickle cell disease)

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	Exception Criteria (numerator): Candidates not receiving a long-acting opiate analgesic in the last 60 days Indicator #6: Coordination of Care: Use of Multiple Opiates from Multiple Prescribers In patients with CNCP obtaining opiate analgesics from more than one physician may suggest the possibility of inadequate pain relief and pain management. To monitor and optimize the patient's opiate usage, opiates should be prescribed by only one physician or one chronic pain treatment team whenever possible. Treatment form one physician encourages continuity of care and can provide improved pain management. Candidates (denominator): Patients receiving opiate analgesics in the last 60 days (excluding patients with a history of malignancies) Exception Criteria (numerator): Candidates that received 8 or more opiate analgesic prescriptions in the last 6 months from 4 or more physicians Indicator # 7: Overuse of Short Acting Opiate, Titrate Long Acting Opiate Once the daily dose for effective analgesia has been established with a short acting opiate, a long acting opiate should be initiated and titrated to effective pain relief. Long acting opiates are preferred because they provide sustained pain relief, dosing convenience and enhanced compliance. Candidates (denominator): Patients receiving short acting opiates in the last 30 days and currently receiving a long acting opiate Exception Criteria (numerator); Candidates who averaged more than 4 solid dosage units per day of a short acting opiate in the last 30 days Clinical Results: The change in the number of patients identified for Increased Risk of Adverse Event decreased by 31.5% in the target group overall. The biggest percent risk decrease (-40%) was seen in ADEs associated with acetaminophen or ibuprofen containing opiates or tramadol. This decrease was closely followed by 37.5% change in the number of patients using multiple opiates from multiple prescribers. Polypharmacy Management This population-based mailing intervention was undertaken as a quality management program to assist in caring for beneficiaries using multiple drug therapies. Patients who receive multiple medications are at an increased risk of drug-drug or drug-disease interactions, duplicate or unnecessary therapy, non-adherence, and hospitalization. Improvements in communication between providers and better coordination of care may lessen potential problems. A reduction in the number of medications taken per patient can result when multiple drug therapy regimens are brought to the attention of the prescriber(s). Indicator #1: Increased Risk of Adverse Drug Event: Receipt of 10 to 19 medications within a 30-day time frame Multi-drug therapy regimens may be necessary to treat certain medical conditions. However, all multi-drug therapy regimens merit periodic review to minimize potential risk or development of drug related problems. Communication with other providers about potential concerns should be undertaken when necessary. Candidates (denominator): All patients 18 years of age and older with pharmacy claims activity within the most recent 30 days. Antibiotics are excluded. Exception Criteria (numerator): Candidates receiving 10 to 19 medications within the most recent 30-day time frame. Clinical Results: The targeted patient population was seeing 5.9 providers, receiving 12.2 prescriptions per month, and taking an average of 17.4 intervention-related drugs at baseline. Overall, the clinical indicator decreased by 27% in the target group over the six-month intervention period.

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Florida	Top 10 Retrospective DUR Education Outreach 1. Exception Period Covered by Run: 01/01/2017-05/31/2017 Problem Type Description: Therapeutic Appropriateness/Safety/Overutilization Criteria Description: Recipients using more than two unique antipsychotic therapies Number of Exceptions Per Problem Type: 2,041 recipients Results of RetroDUR Screening and Interventions: The DUR Board voted to implement an edit to limit a recipient to two antipsychotics with unique chemical entity per 30 days. The third antipsychotic would require a clinical prior authorization. The DUR Board reviewed and approved the criteria for approval. The edit deployed on 09/19/19. 2. Exception Period Covered by Run: 10/1/2017-12/31/2017 Problem Type Description: Safety Criteria Description: Review utilization of opiate containing cough and cold preparations and percentage of utilization in children under 18 years of age Number of Exceptions Per Problem Type: 9 recipients Results of RetroDUR Screening and Interventions: Given the risks of opiate containing cough and cold preparations in children, the DUR Board voted to change age minimum to 18 following the FDA safety alert recommendations. The edit deployed on 05/14/18. The DUR Board reviewed the post impact data run from 05/15/18-08/15/18. The DUR Board determined no further intervention was required as there was a 100% decline in claims for children less than 18 years of age. 3. Exception Period Covered by Run: 01/01/2018-03/31/2018 Problem Type Description: Therapeutic Appropriateness/Safety/Overutilization Criteria Description: Review utilization and appropriate age limitations for oral codeine in children under 12 years of age Number of Exceptions Per Problem Type: 50 claims Results of RetroDUR Screening and Interventions: The DUR Board voted to update the age minimum of oral codeine products from six to twelve years of age following the FDA safety alert and the DUR Board reviewed the post impact data. 4. Exception Period Covered by Run: 01/01/2018-06/30/2018 Problem Type Description: Therapeutic Appropriateness/Safety/Overutilization Criteria Description: Overutilization of selected topical products and review of off-label usage Number of Exceptions Per Problem Type: 301 claims Results of RetroDUR Screening and Interventions: The DUR Board voted to implement an automated prior authorization on all formulations of Calcipotriene for age, diagnosis, and duration of therapy and the DUR Board voted to create an automated prior authorization for Doxepin 5% cream to include diagnosis.

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	5. Exception Period Covered by Run: 10/01/2018-12/31/2018 Problem Type Description: Safety Criteria Description: Review concomitant utilization of opiates and antipsychotics Number of Exceptions Per Problem Type: 351 recipients; 1,722 claims Results of RetroDUR Screening and Interventions: The DUR Board reviewed the impact data. In response to the Support Act, a soft edit was deployed for recipients on concomitant therapy. The dispensing pharmacist has the capability to override the claim at the point of sale with approved DUR intervention codes. Seizure, Cancer/Palliative Care, Sickle Cell and Long Term Care (LTC) recipients are excluded from the soft edit. The edit deployed on 09/27/19. 6. Exception Period Covered by Run: 10/01/2018-12/31/2018 Problem Type Description: Safety Criteria Description: Review utilization of opiates and Narcan (Naloxone) Number of Exceptions Per Problem Type: 73 recipients; 198 claims Results of RetroDUR Screening and Interventions: The DUR Board reviewed the impact and will continue to monitor opiate claims for appropriate use. 7. Exception Period Covered by Run: 10/06/2018-01/06/2019 Problem Type Description: Safety Criteria Description: To review the post impact of the Zolpidem step therapy edit Number of Exceptions Per Problem Type: 96 recipients Results of RetroDUR Screening and Interventions: The DUR Board reviewed the post impact data and there was a significant decline (94%) in patients starting therapy at the higher dose. 8. Exception Period Covered by Run: 01/01/2019-03/31/2019 Problem Type Description: Safety Criteria Description: Review prescribing trends for recipients prescribed opiates with a MME > 90 Number of Exceptions Per Problem Type: 259 recipients; 659 claims Results of RetroDUR Screening and Interventions: The DUR Board moved to amend and expand the soft edit from targeting recipients on > 300 MME to recipients on > 50 MME based on a single or accumulation of opiate claims. 9. Exception Period Covered by Run: 02/02/2019-05/02/2019 Problem Type Description: Safety Criteria Description: To determine pre and post impact of deployment of the maximum dose of antidepressants in children >/= 6 years of age Number of Exceptions Per Problem Type: 14 recipients Results of RetroDUR Screening and Interventions: The DUR Board reviewed the post impact data and decline in claims for recipients exceeding the antidepressant FDA prescribing limits. The DUR Board requested follow up on recipients exceeding the limits. 10. Exception Period Covered by Run: 03/07/2019-06/07/2019 Problem Type Description: Therapeutic Appropriateness Criteria Description: To determine pre and post impact of deployment of the polypharmacy in TNF inhibitors edit Number of Exceptions Per Problem Type: 699 claims Results of RetroDUR Screening and Interventions: The DUR Board reviewed the post impact data and significant decline in claims (100% decline) on polypharmacy in TNF inhibitors.

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Georgia	1. Concomitant Use of High Dose Opioids and Benzodiazepines While Visiting Multiple Prescribers or Multiple Pharmacies -The Centers for Disease Control and Prevention (CDC) have previously advised against the concomitant prescribing of opioids and benzodiazepines whenever possible. In August 2016, the Food and Drug Administration (FDA) added black box labeling to opioid and benzodiazepine containing products warning against coadministration unless alternative treatment options are inadequate. -Physician outreach/education regarding prescribing daily MME>90 and concomitant use of benzodiazepines and opioids was conducted. Targeted physicians were informed of the most recent CDC guidelines. -Opioid prescribing continues to decrease quarter-over-quarter. 2. Alert of Coverage Change in Hemlibra -Prescribers were informed of new procedure regarding submitting Hemlibra requests. -A customized Hemlibra prior authorization form was created so that the Department could streamline the data needed to evaluate Hemlibra requests on a case-by-case basis. This form is available on the Department's website. -Since the procedure change, the Hemlibra review process has become significantly more efficient. Prescribers and pharmacies are complying with the process as well. 3. Alert of Change in Opioid Quantity Limits -In response to the growing opioid crisis, the Centers for Disease Control and Prevention (CDC) published guidelines for the use of opioids in chronic, non-cancer pain in 2016. In the Guidelines for Prescribing Opioids for Chronic Pain, the CDC recommends careful justification for titrating opioid doses above an average of 90 morphine milligram equivalents (MME) per day to avoid potential overdose. In an effort to reduce the risk of opioid-related harms while preserving access to appropriate pain treatment, the Department implemented a prior authorization for cumulative morphine milligram equivalent (MME) doses exceeding 210 MME per day. -Since the adoption of this process for patients receiving high doses of opioids, the Department has obtained much needed transparency into the prescribing habits of physicians. Moreover, the Department has been able to communicate with physicians to understand rationales for why such high doses may be needed in certain patients. -Opioid prescribing continues to decrease quarter-over-quarter.
Hawaii	Provider Memorandums were educational outreach: 1. Hepatitis C fibrosis score reduced from F1 to F0; utilization and costs continued to decrease from 2 years ago and stable from last year. 2. Synagis criteria update for RSV season Pharmacy outreach by phone for Valcyte brand not switched to generic use 1) generic not in stock but will bring in and 2) young patient temporarily required compounding with brand diluent until child aged out of need. No educational outreach done for DUR on chronic opioid use (less than 10 claims), naloxone (no utilization), no concurrent use of opioids plus antipsychotic or benzodiazepine, brand Sensipar to generic: (generic availability delayed).
Idaho	A summary of the topic and number of profiles reviewed, and letters sent out is described below: Methadone: Idaho removed methadone from preferred status in October 2015. Prior authorization is now required initially and for continuing therapy. Outreach has been done by a

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	State pharmacist to the prescriber of each recipient requiring a prior authorization and that pharmacist is working one on one with the provider to taper the dose of methadone to less than 40 mg/day with preferentially tapering off and/or switching to another opioid for a cumulative dose of MME. Buprenorphine: A pharmacist reviews all buprenorphine patients on a quarterly basis. They contact the prescriber for a one- on- one discussion if the patient is paying cash for opioids and the prescriber is either the same or a different prescriber than the buprenorphine or if the patient is receiving concurrent benzodiazepines from any prescriber. The prescriber is also educated on how to run and evaluate a PDMP report to check for these two things before each buprenorphine prescription is written. An average of 40 prescribers are contacted each quarter. High Utilization of benzodiazepines: A review was performed looking at patients routinely filling more than 90 tablets monthly of benzodiazepines and it was determined that daily quantities would be adjusted appropriately. PA's were now required for levels above the determined thresholds. Letters were sent to prescribers of 8 members that stated Idaho Medicaid will be changing quantity limits on diazepam to three tablets daily. Your patient has been identified as being on four tablets daily. Please submit a quantity override prior authorization request with medical necessity documentation if you wish your patient to remain on four tablets daily (120 tablets monthly). Members identified on alprazolam had a fax sent to their prescribers stating Idaho Medicaid will soon be decreasing the tablets per day of alprazolam allowed without prior authorization to three. Your patient has been identified as being on six (or whatever number was calculated) tablets daily. Please send in a quantity override prior authorization with medical necessity justification for this quantity or submit a taper schedule if clinically appropriate. Uloric: Nine letters along with the FDA Drug Safety Communication: FDA to evaluate increased risk of heart-related death and death from all causes with the gout medicine febuxostat (Uloric) were sent out to prescribers of current Medicaid patients receiving Uloric. Along with letters, future prior authorizations requests will screen for pre-existing cardiac disease and inform prescribers of the FDA Safety Communications. Two or more benzodiazepines: Idaho Medicaid put a hard stop in the claims adjudication system on 12/13/2018 not allowing two or more benzodiazepines as well as not allowing pharmacist overrides at the POS. Prior to edit being put in place, 64 letters were sent out to prescribers alerting them of the new edit going in and that a therapeutic duplication prior authorization was going to be required moving forward to ensure the safety of the Medicaid member. Butalbital Migraine Medications: A claims review of paid claims between 10/1/2018-12/31/2018 for butalbital 50mg/acetaminophen 325mg/caffeine 40mg tablets was performed. On March 14, 2019, 141 letters went out to the prescribers of 156 identified members. The letter shared the concern of the DUR Board about medication overuse headaches due to chronically used butalbital containing medications (e.g. butalbital/caffeine/acetaminophen tablets). The letter also had the American Migraine Foundation definition and caution in this patient population. It also had suggested tapering recommendations for those with medication overuse headaches.
Illinois	Retrospective reviews and related educational efforts are summarized below. One-on-one provider discussion and faxes continued as strategies to address appropriate medication use. Spacer devices. At least 9,350 Fee-for-Service (FFS) fills for a steroid-containing inhaler, spacer, or a spacer prior authorization request occurred from January 2016 through June 2018. Most

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	participants (primarily children through 11 years of age) filled only 1 spacer device during the review period. Steroid inhaler adherence remains a problem (only up to 13% of participants filled 11-12 inhalers). Less than a quarter of those filling steroids filled a spacer device. For about 50% of those filling a spacer, a steroid inhaler was filled, signaling use with non-steroidal inhalers. In cases of multiple spacer device fills, the second spacer was filled 7-11 months after the first spacer fill. Review of select prior authorization requests showed that approval does not guarantee fill by the participant. A trend toward improved adherence with spacer use was evident. Pharmacist education and targeted prescriber letters were recommended. A spacer/VHC option was added to the inhaled corticosteroid prescription request form for prescribers of montelukast monotherapy for asthma. Potential HFS policy of an automatic spacer fill with the first inhaler fill in younger children to be considered. Gabapentin utilization. FFS and Managed Care (MCO) pharmacy claims for gabapentin from August 19, 2018 through September 25, 2018 were reviewed. Most participants (86%) filled one strength of a solid oral dosage form, most commonly 100-399 mg or 800-1199 mg daily. If multiple strengths were used to achieve a daily dose, the most common dose was 2000-3199 mg daily. It is unclear if titration or multiple prescribers resulted in need for more than one dosage form. About 2,900 participants filled total daily doses 2400 mg or greater. A gabapentin-focused prescriber letter was recommended to clarify diagnosis, confirm need/obtain medical justification for use of higher doses, and warn about respiratory/CNS depression with concomitant therapy. Targeted monitoring of gabapentin misuse if history of substance abuse or concomitant opioids filled, warning about increased risk of opioid-related death, and potential dose adjustment are recommended. Ketorolac utilization. The DUR Board pharmacists noted frequent longer duration of ketorolac use beyond labeled total of 5 days. HFS ketorolac pharmacy claims between September 1, 2017 and September 1, 2018 were reviewed. At least 9,629 unique participants filled ketorolac during the evaluation period. No participant filling injectable ketorolac filled oral ketorolac, but 50% of injectable ketorolac users did fill other NSAIDs either before, during, or after the month ketorolac injection was filled. A few cases of monthly or intermittent fills were noted. The FFS participants had 415 fills of oral ketorolac, with 63% of these participants filling ketorolac as the only NSAID. At least 11% of patients filled oral ketorolac 2-8 times. Approximately 30% of ketorolac fills were in children 7-17 years of age. Claims review revealed that 8% of participants filled oral daily doses > 40 mg, approximately 6% filled for a quantity that exceeded 5-day use (> 20 tablets), about 15% received prescriptions written for a 6-30-day supply, and 6% had more than one risk for adverse events present. Repeated courses of therapy occurred within 3 to 17 days in 5.5% of participants, while 7% of participants had longer intervals between doses. Multiple prescribers and concomitant NSAID (ibuprofen, meloxicam, naproxen) use in the same month did not occur in many participants. Most ketorolac use was acute. Most prescribers were physicians representing 12 specialty areas. Overall top 3 diagnoses were trauma, migraine/headache, and abdominal pain/appendicitis. In adults with multiple ketorolac fills, arm pain, migraines, and chest/lung pain were the top 3 diagnoses. Two adults and two children had the sickle cell trait/disease, but ketorolac administration did not coincide with sickle cell crises. Within 12 months prior to ketorolac administration 7 children had potential contraindications for ketorolac and within 2 weeks to 4 months after ketorolac administration, three participants experienced gastritis and epigastric pain. Within 12 months after ketorolac use, 5 pediatric participants had anemia, melena, hematuria, or hematemesis. Pharmacy claims revealed 23 concomitant opioid fills, 20 concomitant acid suppression therapy fills, and 7 concomitant corticosteroid fills within 1 to 3 months before ketorolac use. A 1-page provider notice was recommended to remind prescribers of safe ketorolac prescribing as well as educate patients about NSAID classes to help decrease duplicate therapy and adverse effects. Ketorolac was restricted to 5 days at a maximum of 20 mg daily to help assure

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	appropriate use. Exceeding the edit requires prior authorization and allows for individual prescriber education. RetroDUR 300 study. An overview of the RetroDUR 300 study of medications filled through August 2018 was provided. The most common issue was underdosing, followed by duplicate therapy, potential inappropriate therapy, and drug interactions. Pharmacist review noted that 22% of the potential problems warranted prescriber follow-up, particularly almost 50% of the duplicate therapy and inappropriate therapy problems, and 75% of the drug interactions. Medications identified for each type of problem were reviewed and prescriber follow-up recommended for incorrect bupropion dosing (IR vs ER formulations), drug interactions (potassium and spironolactone or lithium and hydrochlorothiazide), duplicate therapy (> 3 antidepressants, > 2 stimulants or antipsychotics), and benztropine use with second-generation antipsychotics. Prescriber outreach for metformin underdosing. RetroDUR 300 studies identified 170 participants with potential metformin underdosing (< 2000 mg daily). Pharmacist review confirmed underdosing in 109 participants. Prescribers outreach determined the last 2 glycosylated hemoglobin (A1c) levels, GFR, ASCVD history, and changes in metformin regimens. Prescribers were informed of their patient's metformin adherence. Recommendations regarding the diabetes therapy were made based on the ADA-EASD 2018 guidelines via fax for 14.7% participants. At least 37.5% responses were received from prescribers. For almost 26% of participants, therapy was deemed appropriate because A1c goals were met. Prescribers agreed to implement recommendations with the next visit. Previous patient history resulted in no change in dosing in some patients. Glycemic control (A1c of 6%-7%) was noted in one patient filling metformin 500 mg daily, 7 participants filling metformin 1000 mg daily, and one patient filling 1500 mg daily. Metformin underdosing identified by the algorithm did not necessarily require dose adjustment. It was recommended to not evaluate underdosing. Hepatitis C infection. Adherence with direct acting antiviral (DAA) therapy from May 2018 through 2019 in Fee-for-Service (FFS) participants was reviewed. There were 5 cases each of non-adherence with Epclusa and Mavyret. Non-adherence occurred due to end of Medicaid eligibility or transitions between MCO or third-party insurance and FFS Medicaid. FFS Medicaid continues therapy for participants who were taking a DAA and are transitioning from a Medicaid MCO to FFS. Overall, 12-week regimens are the most common. Fill history is tracked and if more than 4 weeks have passed since a fill, the prescriber is contacted. The prior authorization HFS specialist requirement was discussed. Naloxone. Overall and per dosage form naloxone utilization for Medicaid FFS and MCO from 2016 through 2019 were reviewed. The Illinois Department of Public Health (IDPH) and UIC College of Pharmacy cooperated to educate approximately 1,000 retail pharmacists about the naloxone standing order and related procedures. Education about addiction being a disease is helping change negative perceptions about naloxone use throughout the state. Chain pharmacy initiatives include automatic naloxone fill under the standing order if 50 or more morphine milligram equivalents (MME) of an opioid is prescribed. Dispensing with education takes about 30 minutes. Pharmacy soft edits educate regarding the process and a hard edit is in place once high MME is reached. Education and website information. During FFY19, the DUR Board learned about opioid-related topics and naloxone. The DUR Board approved posting links to these resources on the DUR Education page. During FFY19, it was accessed 767 times. The DUR Board Web page was accessed 934 times and the Pharmacy Services Web page providing forms and prior authorization criteria was accessed 17,818 times. Provider outreach via fax regarding benzodiazepine, opioid, or montelukast monotherapy use. Provider outreach continued to prescribers of chronic benzodiazepine monotherapy for anxiety, opioids for pain management, and montelukast monotherapy for asthma. During FFY19, at least 77 faxes regarding inappropriate benzodiazepine therapy; 1,776 faxes regarding opioid therapy (33 for

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	methadone); and 62 letters regarding montelukast monotherapy were sent. Prescribers are asked to justify the treatment plan and provide taper plans as appropriate. Evidence-based recommendations are made for therapy. Benzodiazepine faxes have been largely replaced by determination letters to prescribers from within the HFS prior authorization system. Recommendations are now placed in the determination letters. At least 3,733 prior authorizations for benzodiazepines for 2,469 participants were adjudicated from 1,891 prescribers in FFY19. Medication adherence. The prior authorization staff monitors adherence for medications to treat cystic fibrosis, direct-acting oral anticoagulant therapy (DOAC), and hepatitis C infection.
Indiana	The following information is an annualized analysis of retro-DUR activities and outcomes that were approved by the DUR Board and performed by OptumRx pharmacists through facsimile of retro-DUR education materials. A savings summary and detailed outcomes report for each retro-DUR program type is provided below. The detailed outcomes report for each retro-DUR intervention also includes savings (cost avoided, if any). Real savings, while controlling for changes over time, are calculated using the comparison and intervention groups where possible. All savings amounts are reported as state and federal Medicaid dollars combined. June 2017 Caring for your Patients with Hepatitis C: Follow-up from FFY 2018 report, below is the SVR results after completion of the late refill tracking. OptumRx received 465 (57.6%) SVR responses from prescribers out of the 807 members that completed therapy during the tracking period. SVR was achieved in 355 members (76.3%), while 110 (23.7%) did not achieve SVR. Since completion of this retro-DUR, fibrosis requirements have been removed from the prior authorization criteria. January 2018 Caring for Your Patients with Asthma This intervention focused on improving prescribing practices in the treatment of members requiring asthma therapy. This is a follow-up finalization of retro-DUR data from the FFY 2018 report. As this retro-DUR focused on the addition of therapy, it was not expected to generate savings through the pharmacy benefit. At completion of the retro-DUR, 510 members were identified as eligible for outcomes, where 40 members had a positive intervention (7.8%). These outcomes resulted in a negative cost savings of -$3991.38. February 2018 Caring for Your Patients with At-Risk Opioid Dosing The retro-DUR intervention focused on reducing opioid dosing and utilization. This is a follow-up finalization of retro-DUR data from the FFY 2018 report. Prior to the letter-mailing initiative and the addition of prior authorization requirements, spend across the entire benefit (managed care included) for opiates was $32,499,129.75. After one year, claims decreased by 25.5%, and total spend was $23,275,516.47. This resulted in a one-year savings of $9,223,613.28 across the benefit. November 2018 Caring for Your Patients with Long-Term Benzodiazepine Use Members utilizing greater than 30 days of a benzodiazepine therapy in the past 90 days without a diagnosis code related to a seizure disorder had a near real-time letter faxed to the prescriber. The goal of this program is to ensure members are receiving guideline-recommended treatment and standard of care for these agents, as they are often not recommended in current guidelines. Evaluation was made to determine if members had the benzodiazepine dose decreased or discontinued.

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	Claims data for members utilizing benzodiazepine therapy were reviewed from August 1, 2017 to August 1, 2018. During this period, 4,824 unique utilizers of benzodiazepines greater than 30 days in 90 days were identified. Of these utilizers, 2,811 (58%) did not have a seizure diagnosis. A total of 18,558 claims for benzodiazepines were processed for these members during the reporting period, totaling $204,274.39. OptumRx proposed this intervention at the October and November 2018 DUR Board meetings and obtained approval of this topic. As of September 30, 2019, 2,075 members were identified for a near real-time fax intervention. At the one-year completion of this intervention, 1,733 were eligible for outcome. Of those eligible, 277 (15.98%) had discontinued benzodiazepine therapy, resulting in a savings of $1,460.85. May 2019 Caring for Your Patients with Long-Term Sedative Hypnotic Use Members utilizing greater than 30 days of sedative-hypnotic therapy (eszopiclone, zolpidem, zaleplon) in the past 90 days have a near real-time letter faxed to the prescriber. The goal of this program is to ensure members are receiving guideline-recommended treatment and standard of care in the treatment of insomnia. Evaluation will be made to determine if members have the sedative-hypnotic discontinued. Claims data for members utilizing sedative-hypnotic therapy were reviewed from January 1, 2018 to January 1, 2019. During this period, 416 unique utilizers of sedative-hypnotic agents greater than 30 days in 90 days were identified (average day supply of 165 days). 2,427 claims were processed (43% zolpidem 10mg) totaling $29,122.71 during the reporting period. OptumRx proposed this intervention at the March and April 2019 DUR Board meetings and obtained approval of this topic. As of December 31, 2019, 24 members were eligible for outcome. Of those eligible, 10 (41.67%) discontinued sedative-hypnotic therapy, resulting in a savings of $4.59. Further data will be provided at the one-year follow-up in the FFY2020 report.
Iowa	Problem Type Therapeutic Class Interventions Number of Claims Percent Intervention in Class Therapeutic Duplication Dibenzapines 4 3,335 0.12% Therapeutic Duplication Quinolinone Derivatives 3 1,865 0.16% Therapeutic Duplication Antipsychotics - Misc. 3 676 0.30% Therapeutic Duplication Anticonvulsants - Misc. 1 9,064 0.01% Therapeutic Duplication Antiadrenergic Antihypertensives 1 5,011 0.02% Patient Overuse Opioid Combinations 1 4,329 0.02% Therapeutic Duplication Central Muscle Relaxants 1 3,201 0.03% Patient Overuse Opioid Agonists 1 2,924 0.03% Therapeutic Duplication Benzodiazepines 1 2,843 0.04% Therapeutic Duplication Benzisoxazoles 0 2,152 0.05%

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Kansas	RETROSPECTIVE DUR EDUCATIONAL OUTREACH FOR FFY 2019 Each month HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once recipients have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. During FFY 2019, HID reviewed 55 recipients with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. There were a couple of outlier beneficiaries that decreased the cost savings calculations. Two members started expensive treatments during the evaluation periods and the expenses were enough overshadow cost savings from other interventions. However, these treatments weren't related to the interventions so the data can be a bit misleading. There were no total cost savings observed in FFY 2019. The RDUR program provides an important educational service to providers enrolled in the Kansas Medical Assistance Program. The RDUR intervention program alerted the recipient's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history.
Kentucky	During FFY2019, the following RetroDUR activities were performed: Prescriber-lettering activities: Recommend flu vaccine to members prescribed oseltamivir during 2017-2018 flu season (4Q2018) FDA warnings and risks with DPP-4 and SGLT2 inhibitors (1Q2019): -226 letter sent, 54 returned -14 responses returned: 6 no change, 5 flagged for monitoring; 2 counsel; 1 modified drug therapy - 11 of 14 respondents found communication useful Antipsychotics in children (2Q2019): -736 letters sent; 123 returned and destroyed -71 responses returned: 58 aware/no change; 13 previously attempted; 12 flagged; 5 modified therapy; 4 counsel patient; 3 discontinue med; 1 dose change - 43 of 71 respondents found the communication useful Opioids and antipsychotics (3Q2019): -336 letters sent; 97 returned -27 responses returned: 13 aware/no change; 3 discontinue med; 3 flagged for monitoring; 3 counsel; 1 previously attempted -15 of 27 respondents found the communication useful Newsletter features: 1Q2019: FDA warnings and risks with DPP-4 and SGLT2 inhibitors; available at https://kyportal.magellanmedicaid.com/public/client/static/kentucky/documents/KYRx_Quarterly_201903_v10n1.pdf

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Louisiana	Top Ten Problems 1. Antipsychotic agents: Therapeutic duplication Recipient Profiles Screened: 529 Interventions: 651 2. Depressive disorders: Therapeutic duplication, Adherence Recipient Profiles Screened: 424 Interventions: 284 3. A1C testing: Underutilization Recipient Profiles Screened: 292 Interventions: 110 4. Hypertension agents: Underutilization Recipient Profiles Screened: 223 Interventions: 115 5. Opiates & benzodiazepines/sleep agents: Concurrent use Recipient Profiles Screened: 109 Interventions: 108 6. Albuterol inhaler: Overutilization Recipient Profiles Screened: 89 Interventions: 78 7. Hypertension agents: Therapeutic duplication, Adherence Recipient Profiles Screened: 77 Interventions: 84 8. Sleep agents: Duration of therapy Recipient Profiles Screened: 50 Interventions: 44 9. Antipsychotic agents: Adherence Recipient Profiles Screened: 48 Interventions: 22 10. Fentanyl transdermal: Education Recipient Profiles Screened: 28 Interventions: 25
Maine	o Appropriate Use of Asthma Controller Medications o Use of statins in members with diabetes mellitus o Continuous use of antidepressants at 3, 6 and 12 months after initiation o Vivitrol Adherence o Chronic Triptans Use Maintenance 90 day Update and PDL Updates Provider Newsletter February 2018 PDL Changes Provider Newsletter May 2018 PDL Changes Provider Newsletter June 2018 PDL Changes Provider Newsletter September 2018 PDL Changes Pharmacy Benefit Update Winter 2018 Provider Newsletter January 2019 PDL Changes Brand Name Suboxone Film Update Provider Newsletter April 2019 PDL Update Provider Newsletter May 2019 PDL Update Provider Newsletter July 2019 PDL Update

State	Retrospective DUR Educational Outreach
Maryland	Summary 2: Retrospective Educational Outreach Summary (Annual DUR report) Executive Summary This report prepared for the Maryland Medicaid Pharmacy Program (MMPP) summarizes the Retrospective Drug Utilization Review (RDUR) Program in the state of Maryland for Federal Fiscal Year (FFY) 2019. The report presents a summary of RDUR interventions performed using provider education letters. Intervention letters are mailed to prescribers and pharmacy providers to encourage appropriate prescribing and improve drug utilization which, in turn, will prevent possible adverse drug reactions and improve patient outcomes in the targeted participant population. The following educational interventions were conducted during FFY 2019: potentially inappropriate use of opioids (Corrective Managed Care Program), therapeutic duplication of sedative/hypnotic agents, overutilization of gabapentin, concurrent use of gabapentin and pregabalin, overutilization of benzodiazepines, and concurrent use of an opioid, benzodiazepine and carisoprodol-containing product. A total of 1,834 unique participants were selected for intervention, and 2,632 prescriber letters were mailed. Each letter included a response form soliciting feedback from the prescriber. Responses are voluntary, and a response rate of 21% was achieved. Prescribers were also asked to evaluate the usefulness of the intervention letters. Of those who responded, 67% of prescribers found the letters to be either useful or extremely useful. Copies of intervention letters were also sent to each dispensing pharmacy. A total of 2,154 pharmacy letters were mailed, and a response rate of 30% was achieved. Of those who responded, 77% of pharmacy providers found the letters to be either useful or extremely useful. Analysis Methodology Each month, HID evaluates Maryland Medicaid pharmacy claims data against criteria for potential overutilization and inappropriate use of opioids. Other criteria, developed in conjunction with HID, MMPP, and the Maryland Drug Utilization Review Board are selected for DUR evaluation on a quarterly basis. For FFY 2019, the following criteria were evaluated, and intervention letters were mailed to providers: 1. Potentially inappropriate use of controlled substances (known as the Corrective Managed Care Program). 2. Therapeutic duplication of sedative/hypnotic agents. 3. Overutilization of gabapentin. 4. Concurrent use of gabapentin and pregabalin. 5. Concurrent use of an opioid, benzodiazepine and carisoprodol-containing product. 6. Overutilization of benzodiazepines. 7. Therapeutic appropriateness of medium-high dose gabapentin and an opioid with increased risk of morbidity/mortality. 8. Therapeutic duplication gabapentin and pregabalin. Overuse of Opioid Criteria (Corrective Managed Care Program) The following criteria were used to determine potentially inappropriate use of opioids: 1. Utilization of narcotics in participants with a diagnosis of a history of substance use disorders. 2. Simultaneous utilization of any narcotic and buprenorphine or buprenorphine/naloxone-containing products for substance use disorders. 3. Long-term use of short-acting narcotics with no utilization of a long-acting narcotic agent. 4. Participants with at least a 120-day supply of any opioid within the most recent 90-day time period based on an evaluation of the day supply field. 5. Overutilization of hydrocodone/chlorpheniramine ER suspension (Tussionex).

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6. Identification of all participants with claims for methadone. Participants newly initiating methadone therapy are selected for intervention in an effort to caution providers on the use of methadone due to its long half-life.

MARYLAND MEDICAID PHARMACY PROGRAM RETROSPECTIVE EDUCATIONAL OUTREACH SUMMARY REPORT FOR FFY 2019

CRITERIA TYPE	CRITERIA DESCRIPTION	PARTICIPANTS WHO MET CRITERIA	PARTICIPANTS SELECTED FOR INTERVENTION1	INTERVENTION LETTERS	PRESCRIBERS2	INTERVENTION LETTERS	PHARMACIES2
MC	Opioids and history of substance use disorder	216	87	180	76		
ER	Over-utilization of Tussionex	17	6	7	7		
TA	Use of methadone	64	16	20	17		
ER	Over-utilization of narcotic agents (opioids) based on days supply	1152	235	495	368		
ER	Over-utilization of narcotic agents (opioids) based on dose per day	53	9	17	11		
LI	Long-term therapy with short-acting opioids in absence of long-acting agent	152	22	38	29		
LI	Buprenorphine/naloxone containing products for opioid use disorder and another opioid	1,840	187	197	193		
TD	Therapeutic duplication of sedatives/hypnotics	1,067	329	461	390		
ER	Over-utilization of gabapentin	40	33	48	43		
DD	Concurrent use of gabapentin and pregabalin	520	367	596	451		
TA	Concurrent use of opioid, benzodiazepine and carisoprodol-containing product	7	6	9	9		
ER	Over-utilization of benzodiazepines	678	537	564	560		
Totals		5,806	1,834	2,632	2,154		

1. Not all participants are selected for intervention. Selection is based on review by a Clinical Pharmacist.
2. Letters mailed are noted in this table. Copies of intervention letters are also mailed to the dispensing pharmacy. Some letters cannot be mailed due to inaccurate/missing address information. Participants may also use multiple prescribers and/or pharmacies.

Provider Responses to Intervention Letters

A total of 2,632 DUR educational intervention letters were mailed to prescribers, and 564 responses were received for a response rate of 21%. A summary of all coded responses from prescribers is listed in the table below:

Prescriber Response	Number of Responses
PRESCRIBER DISCONTINUED MEDICATIONS	114
PARTICIPANT IS NO LONGER UNDER THIS PROVIDER'S CARE	85
BENEFITS OF THERAPY OUTWEIGH THE RISKS	75
PRESCRIBER WILL REASSESS AND MODIFY DRUG THERAPY	66
PROVIDER DID NOT PRESCRIBE DRUG ATTRIBUTED TO HIM/HER	59
PARTICIPANT HAS APPOINTMENT TO DISCUSS THERAPY	36
PRESCRIBER TRIED TO MODIFY THERAPY,SYMPTOMS RECURRED	33
PARTICIPANT UNDER PRECRIBER'S CAREBUT NOT SEEN RECENTLY	21
PRESCRIBER TRIED TO MODIFY THERAPY, PARTICIPANT NON-COOPERATIVE	18
PARTICIPANT HAS DIAGNOSIS THAT SUPPORTS TREATMENT	

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	Pharmacy DUR educational intervention letters mailed totaled 2,154, with 643 responses received for a response rate of 30%. A summary of coded responses from pharmacies is listed in the table below. Pharmacy Response Number of Responses PHARMACIST WILL COUNSEL PARTICIPANT ON NEXT VISIT 193 PARTICIPANT NO LONGER USES THIS PHARMACY 169 PHARMACIST SPOKE WITH PRESCRIBER; EXPECT MODIFICATION IN THERAPY 95 PHARMACIST SPOKE WITH PRESCRIBER; NO MODIFICATION IN THERAPY 71 NO CHANGE IS RECOMMENDED; PROBLEM IS INSIGNIFICANT 71 PHARMACIST DISAGREES; NO FURTHER ACTION TAKEN 39 QA ISSUE1 5 TOTAL RESPONSES 643 Provider Feedback on Intervention Letters In addition to indicating their course of action on the response form, prescribers are also able to evaluate the usefulness of the information discussed in the intervention letter. Of the 564 prescribers who responded, 484 completed the evaluation question. Moreover, 86% of prescribers ranked the letters as Useful or Extremely Useful. A table showing the responses in each evaluation category is shown below: Prescriber Feedback/ Evaluation Responses Extremely Useful 195 Useful 133 Neutral 67 Somewhat Useful 27 Not Useful 62 Total Responses 484 Pharmacy providers are also able to evaluate the information discussed in the intervention letter. Of the 643 pharmacy providers who responded, 542 completed the evaluation question. Furthermore, 84% of pharmacy providers ranked the letters as Useful or Extremely Useful. A table showing the responses in each evaluation category is shown below: Pharmacy Feedback/ Evaluation Responses Extremely Useful 249 Useful 168 Neutral 77 Somewhat Useful 29 Not Useful 19 Total Responses 542 Results Discussion With respect to prescriber responses to RDUR educational intervention letters, a response rate of 21% was achieved. Sixty-seven percent (67%) of prescribers indicated that the letters were useful. Prescribers indicated that some positive action had been or would be taken to address the drug therapy issue discussed in the educational intervention letter. These actions include the following: patient has an appointment to discuss therapy, prescriber will reassess and modify drug therapy, therapy was discontinued or prescriber tried to modify therapy. Regarding responses from prescribers that indicated there may be concern for fraudulent or inappropriate activity (responses include anything related to the participant not being under this prescriber's care or that the wrong

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	prescriber was identified), further action was taken by the clinical pharmacist for the case. Direct contact with prescribers and pharmacies was made to resolve the issue. After further investigation it was found there were no instances of fraud that occurred for the intervention group. A response rate of 30% was received from RDUR educational intervention letters sent to pharmacies. Seventy-seven percent (77%) of pharmacy responders indicated the letters were useful. Pharmacy providers indicated that a positive action had been or would be taken to address the drug therapy issue discussed in the intervention letter. These actions include the following: the patient would be counseled on the next visit to the pharmacy or that the prescriber had been contacted about the issue.
Massachusetts	CMS Report FFY 2019 Attachment 2 Report Date: 3 6/4/2020 Retrospective Educational Outreach Summary Top 10 Problems By Number of Exceptions, With Number of Interventions NCPDP Reject Code 75, Prior Authorization Required Date Range: 10/1/18 - 9/30/19 Problem — Number of Exceptions — Letters Sent — Calls To Prescriber Drug requires prior authorization — 540,744 — 78,135 — 6,048 Pediatric behavioral health initiative — 145,960 — 13,183 — 1,855 Prior authorization required for quantity over limit — 40,116 — 5,286 — 270 Inappropriate dose — 39,997 — 1,547 — 34 Polypharmacy/duplicate therapy — 25,889 — 2,376 — 354 Age restriction — 24,678 — 5,303 — 165 Quantity limit exceeded for drug that requires prior authorization — 6,792 — 900 — 36 Brand name requires prior authorization — 5,784 — 1,900 — 60 Polypharmacy restriction for drug that requires prior authorization — 5,402 — 205 — 17 Dosage form requires prior authorization — 4,322 — 866 — 32
Michigan	Letters and prescriber visits were performed on five algorithms involving 1,476 distinct prescribers and 11,951 distinct members. Below is a summary of each. 1. Medication Adherence to Antipsychotics a. 618 prescribers; 4,483 members b. Medication adherence (PDC) increased from 77.6% to 81.8% c. At six months post initial identification of members, 23.3% increase in members with greater than or equal to 80% PDC 2. Medication Adherence to Antidepressants a. 643 prescribers; 5,808 members

State	Retrospective DUR Educational Outreach
	b. Medication adherence (PDC) increased from 76.8% to 82.3% c. At six months post initial identification of members, 33.4% increase in members with greater than or equal to 80% PDC 3. Atypical Antipsychotic Polypharmacy a. 699 prescribers; 2,748 members b. Observed a 9.3% reduction in atypical antipsychotic utilization c. At six months post initial identification of members, 40% of the gaps in care were closed (1,106 members) 4. High Morphine Milligram Equivalent Dosing [>= 90] a. 293 prescribers; 256 members b. Observed a 23% reduction in opioid utilization c. Observed a 33% reduction in the average morphine milligram equivalents (MME) per member per claim from 93.2 to 62.5 d. Observed a 31% reduction in claims with greater than or equal to 90 MME e. At six months post initial identification of members, 58% of the gaps in care were closed (149 members) 5. High Morphine Milligram Equivalent Dosing [>= 90] with Benzodiazepine Use a. 70 prescribers; 50 members b. Observed a 13.5% reduction in opioid utilization c. Observed a 22.9% reduction in the average MME per member per claims from 82.7 to 63.8 d. Observed a 21% reduction in claims with greater than or equal to 90 MME e. Observed a 12% reduction in benzodiazepine utilization f. At six months post initial identification of members, 66% of the gaps in care were closed (33 members)
Minnesota	Problem Type | Indicator Group | Drug Class | Denominator | Number of Exceptions |Provider Letters Pediatric-related | Child Psych Polypharmacy | Mental Health | 28,203 | 1,613 | | 2,145 Increased Risk of ADE |SGA Antipsychotic Lipid Monitoring | Mental Health | 2,364 | 1,293 ||1,846 Increased Risk of ADE | SGA Antipsychotic Glucose Monitoring | Mental Health | 2,385 | 1,206 | 1,700 Underutilization | Nonadherence with Antidiabetics | Diabetes | 4,904 | 489 | 0.0997 | 1,570 Increased Risk of ADE | Diabetes Dx <2 HbA1C Labs in 550d | Diabetes | 4,904 | 1,545 | 5,574 Increased Risk of ADE | Diabetes Dx: No Eye Exam < Last 550d | Diabetes | 4,904 | 2,320 |5,347 Increased Risk of ADE | Diabetes Dx No Lipid Panel in 550d | Diabetes | 4,904 | 1,686 | 0.3438 | 5,574 Increased Risk of ADE | DM-Increased ADE with Non-insulin Antidiabetics | DM| 4,904 | 2,110 | 1,183 Underutilization | Diabetes -- Underutilization of Antiplatelets | Diabetes | 4,904 | 592 |1,529 Duplicate Therapy | Atypical Antipsychotics 1 MD | Mental Health | 2,574 | 107 |1,556
Mississippi	RetroDUR Educational Outreach Summary: During FFY2019, our retrospective DUR (retroDUR) program educational and intervention activities were targeted at improving adherence to safety recommendations, early notification of providers about policy changes in order to avoid disruptions in treatment, and improvement on national quality measures. The retroDUR vendor continued educational outreach efforts where most of our exceptions monitoring and intervention activities were directed at improving performance on pharmacy quality measures relevant to the Medicaid population.

State	Retrospective DUR Educational Outreach
	Our retrospective DUR intervention activities were educational in nature and were primarily directed at provider education to speed adoption and minimize difficulties with new policies and clinical criteria. Prescribers were provided Information on specific patients as part of some interventions to promote treatment changes to improve performance on nationally accepted pharmacy quality measures. Most of our retrospective DUR efforts are directed at identifying potential areas where prospective DUR efforts can improve performance on quality measures. Each month MS-DUR conducts educational mailings or phone contacts directed at DUR issues identified by DOM, the DUR Board or through exceptions monitoring. These mailings were targeted to the prescribers with the greatest need for the information or intervention that was the focus of each months mailing. In addition to target provider mailings, DOM also distributed provider notices through provider member organizations and DOM's Provider Bulletins. Topics and issues that were addressed in educational/intervention mailings during FFY2019 included: - Quality measure initiative: High Morphine Equivalent Daily Dose (MEDD) for Opioid Prescriptions - Quality measure initiative: Concomitant Use of Opioids and Benzodiazepines - Quality measure initiative: Opioid Provider Shopping - Quality measure initiative: Metabolic Monitoring for Children Prescribed Antipsychotics Summaries of each educational outreach are below: 1 - High Morphine Equivalent Daily Dose (MEDD) for Opioid Prescriptions Objective - To identify beneficiaries that are prescribed opioids > 90 MEDD, excluding those with cancer or sickle cell disease diagnosis. Results - This ongoing monthly provider mailing began in September 2016 and concluded in July 2019 at the time opioid prescribing prior authorization edits were implemented. A total of 9688 opioid prescription claims were screened during FFY 2019 with a total of 1753 prescription exceptions noted. In FFY 2019, 317 prescribers were mailed letters addressing 439 beneficiaries. 2 - Concomitant Use of Opioids and Benzodiazepines Objective - To identify beneficiaries concomitantly prescribed opioids and benzodiazepines. Results - This ongoing monthly provider mailing began in February 2017 and concluded in July 2019 at the time opioid prescribing prior authorization edits were implemented. A total of 250,440 prescription claims were screened during FFY 2019 with a total of 22,755 exceptions noted. Providers were prioritized for mailings each month based on the number of beneficiaries with exceptions. The top 150 providers were mailed each month. In FFY 2019, 1,822 prescribers were mailed letters addressing 3,182 beneficiaries. 3 - Opioid Provider Shopping Objective - To identify beneficiaries without a cancer diagnosis that had an opioid prescription filled the prior month and had opioid prescriptions filled from four (4) or more prescribers and four (4) or more pharmacies during the prior six months. Results - This ongoing monthly mailing to providers and pharmacies began in November 2017 and continues. A total of 561,297 prescription claims were screened during FFY 2019. In FFY 2019, 553 mailings were sent to providers and pharmacies addressing 566 beneficiaries. 4 - Metabolic Monitoring for Children Prescribed Antipsychotics

State	Retrospective DUR Educational Outreach
	Objective - To identify beneficiaries aged < 18 years prescribed antipsychotics without documented metabolic monitoring within the prior year. Results - This one-time mailing was distributed to 116 providers impacting approximately 3300 beneficiaries. In addition to the mailings, a portion of the providers were randomly selected to receive academic detailing via telephone contact. This academic detailing provided opportunities to assess provider knowledge of the HEDIS quality measure and ascertain potential barriers to meeting the HEDIS measure. 5 - Opioid Prior Authorization Edit Provider Notification Objective - To identify beneficiaries receiving chronic opioid therapy with a cumulative MEDD > 90 that would require completion of a prior authorization once new opioid edits were implemented. Results - This mailing was distributed in June/July 2019 prior to the implementation of new opioid prescribing prior authorization edits. A total of 6,952 prescription claims were screened with letters sent to 188 providers impacting 342 beneficiaries.
Missouri	POPULATION-BASED INTERVENTION SUMMARY Conduent completed five population-based interventions in the FFY 2019. Table 1 includes a summary of the outcomes reports for the Migraine Intervention, Naloxone Intervention, Methadone Intervention, Polypharmacy Intervention, and Opioids, Benzodiazepines and Antipsychotics Intervention. Migraine Intervention Overall, there was a 16.8% reduction in the clinical indicators for the Migraine (e.g., increase risk of ADE) over the six-month intervention period. Additionally, there was a decrease in targeted drug costs of $19,709.47 for the six-month period. The total annualized decrease in costs would be expected to be $38,418.94. Naloxone Intervention Overall, there was a 50.8% reduction in the clinical indicators for the Naloxone intervention (e.g., increased risk of ADE) over the six-month period. Additionally, there was an increase in targeted drug costs of $12,714.72 for the six-month period. The total annualized increase in costs would be expected to be $25,429.44. Methadone Intervention Overall, there was a 27.2% reduction in the clinical indicators related to the Methadone intervention (e.g., increased risk of ADE) over the six-month intervention period. Additionally, there was a decrease in targeted drug costs of $10,361.43 for the six-month period. The total annualized decrease in costs would be expected to be $20,722.86. Polypharmacy Intervention Overall, there was a 22.3% reduction in the clinical indicators related to the Polypharmacy intervention (e.g., increased risk of ADE) over the six-month intervention period. Additionally,

State	Retrospective DUR Educational Outreach
	there was a decrease in targeted drug costs of $10,842,320.30 for the six-month period. The total annualized decrease in costs would be expected to be $21,684,640.60. Opioids, Benzodiazepines and Antipsychotics Intervention Overall, there was a 29.4% reduction in the clinical indicators related to the Opioids, Benzodiazepines, and Antipsychotics intervention (e.g., increased risk of ADE) over the six-month intervention period. Additionally, there was a decrease in targeted drug costs of $556,223.92 for the six-month period. The total annualized decrease in costs would be expected to be $1,112,447.84. CONCLUSION The population-based interventions were effective in improving quality of care for Missouri Medicaid beneficiaries. When considering changes in drug costs only, the FFY 2019 net cost avoidance for the population-based interventions for the RetroDUR program administered by Conduent is estimated to be a decrease in costs of $22,831,800.80. Population-Based Intervention Summary for FFY 2019 Intervention: Migraine Date of Intervention: December 2018 Adjusted Number of Recipients Targeted: 667 Number of Physicians Targeted: 333 Outcomes Summary: This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. During the intervention, targeted patients saw average reductions in the clinical indicators by 16.8%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased $5.25 in the post-intervention period. This yielded overall decreased costs of $19,709.47 in intervention-related drug expenditures during the six-month post-intervention period. The total annual decrease in costs due to the intervention was $39,418.94 during the twelve-month post-intervention period. Intervention: Naloxone Date of Intervention: January 2019 Adjusted Number of Recipients Targeted: 3,064 Number of Physicians Targeted: 693 Outcomes Summary: This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. During the intervention, targeted patients saw average reductions in the clinical indicators by 50.8%. In terms of financial outcomes, the amount paid for intervention-related drugs increased $1,60 in the post-intervention period. This yielded overall increased costs of $12,714.72 in intervention-related drug expenditures during the six-month post-intervention period. The total annual increase in costs due to the intervention was $25,429.44 during the twelve-month post-intervention period. Intervention: Methadone Date of Intervention: May 2019 Adjusted Number of Recipients Targeted: 112 Number of Physicians Targeted: 185

State	Retrospective DUR Educational Outreach
	Outcomes Summary: The methadone intervention focused on identifying providers whose patients were affected by increased risk of ADE. This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. During the intervention, targeted patients saw average reductions in increased risk of ADE by 27.2%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased $16.45 in the post-intervention period. This yielded overall decreased costs of $10,361.43 in intervention-related drug expenditures during the six-month post-intervention period. The total annual decrease in costs due to the intervention was $20,722.86 during the twelve-month post-intervention period. Intervention: Polypharmacy Date of Intervention: July 2019 Adjusted Number of Recipients Targeted: 16,433 Number of Physicians Targeted: 1,677 Outcomes Summary: The polypharmacy intervention focused on identifying providers whose patients were affected by increased risk of ADE and coordination of care. This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. During the intervention, targeted patients saw average reductions in increased risk of ADE by 22.3%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased $121.88 in the post-intervention period. This yielded overall decreased costs of $10,842,320.30 in intervention-related drug expenditures during the six-month post-intervention period. The total annual decrease in costs due to the intervention was $21,684,640.60 during the twelve-month post-intervention period. Intervention: Opioids, Benzodiazepines and Antipsychotics Date of Intervention: September 2019 Adjusted Number of Recipients Targeted: 4,451 Number of Physicians Targeted: 1,192 Outcomes Summary: This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. During the intervention, targeted patients saw average reductions in increased risk of ADE by 29.4%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased $23.68 in the post-intervention period. This yielded overall decreased costs of $556,223.92 in intervention-related drug expenditures during the six-month post-intervention period. The total annual decrease in costs due to the intervention was $1,112,447.84 during the twelve-month post-intervention period.
Montana	Criteria Type / Criteria Description / # TCEs Reviewed / # Cases / # Letters Sent Therapeutic Appropriateness (TA) / Chronic Opioid w/o Naloxone / 108 / 74 / 84 Drug-Drug Interaction (DDI) / Opioids and Antipsychotics / 35 / 26 / 55 Drug-Disease Interaction / Opioids & SUD / 27 / 15 / 17 TA / Therapeutic Dup of Dopamine Agonists / 26 / 6 / 8 TA / Codeine Use in Pediatric Patients / 24 / 22 / 23 DDI / Opioids and Antipsychotics (2nd intervention) / 20 / 13 / 26 TA / Chronic Opioid w/o Naloxone (2nd intervention) / 14 / 13 / 16 TA / Atypical Antipsychotics in Pediatric Patients / 10 / 2 / 2 DDI / Opioids and Benzodiazepine / 10 / 6 / 11 DDI / Opioids and Antipsychotics (3rd intervention) 10 / 8 / 16 Opioid Use Disorder (OUD):

State	Retrospective DUR Educational Outreach
	-Suboxone/Sublocade Provider outreach: 171 interventions with MAT providers aimed at addressing complex medication authorization requests. -Combining our CM efforts with the prior authorization of both agents, we have been able to decrease the number of concomitant opioids, benzodiazepines, and tramadol medication use in Medicaid members receiving MAT therapy. This has also diminished the risk of overdose in this population by restricting their access to other opioid medications while receiving MAT therapy. Naloxone Best-Practices Prescribing Education: -175% increase in number of patients who received a naloxone prescription from FFY 2018 Medications to avoid < 18 years-Codeine/Hydrocodone/Tramadol: Evidence-based prescribing guidelines were shared with providers who were outliers. Reductions in use of these medications which may correlate to a lower number of adverse events or overdoses in this population. The following outcomes were realized: -13.9% reduction in overall number of prescriptions containing codeine/hydrocodone/tramadol for children < 18 years of age from FFY18-FFY19 Reduction in concurrent opioid and benzodiazepine prescribing: Evidence-based prescribing guidelines were shared with providers (often multiple) who have prescribed this combination and education provided regarding risks. -17.6% reduction in total number of patients receiving the combination from FFY18-FFY19 Provider Outreach for Opioid MME reduction efforts: -159 patients were initially identified by the Department at doses greater than 150 MME, but less than or equal to 180 MME. Of these 44 were identified as chronic non-cancer pain patients. Prior to implementation of the limit reduction on 1/7/2019, 34 different providers were contacted for these 44 patients. -105 patients were initially identified by the Department at doses greater than 120 MME, but less than or equal to 150 MME. Of these 74 were identified as chronic non-cancer pain patients. Prior to implementation of the limit reduction on 6/3/2019, 48 different providers were contacted for these 74 patients. -CM contacted each provider associated with those patients to inform and provide education on the CDC's recommended opioid guidelines (2016). Providers were given time to consider possible opioid tapers with their patients and were also given opportunity to attest that their patient has an appropriate clinical need for the dose they are currently on. Foster Care Review and Psychotropic Drug Oversight: Increased coordination of care for psychotropic medications in children within the Foster Care program. The purpose of this project is to improve the prescribing and monitoring of psychotropic medication use through educational and clinical interventions. Monthly claims are used to identify the number and type of psychotropic medications being prescribed in foster care children less than or equal to18 years of age. The reviews utilize the following criteria, but is not limited to (*indicates criteria which prompts further review/intervention): Greater than or equal to 1 Antipsychotic* Greater than or equal to 2 Atypical Antipsychotics* Greater than or equal to 3 Psychotropic Medications* Less than or equal to 6 Years of Age on an Atypical Antipsychotic* Greater than 1 ADHD Treatment* No Well Child Check Within 365 Days*

State	Retrospective DUR Educational Outreach
	Greater than or equal to 2 Prescribers of Psychotropic Medications* Diagnosis/Indication FDA Approved Dosing Medication Compliance Lowest Effective Dose Appropriate Lab Monitoring Drug-Drug Interactions Medication misuse/abuse Polypharmacy Multiple Pharmacies/Physicians FY2019 Data Outcomes: -307 clinical reviews were performed on 179 individual children. --Of those reviews, 116 interventions were made to providers/caseworkers regarding issues noticed on the patient's profile based on the above criteria. --Of the completed data at the time of review, 168 individual children were reviewed, requiring 92 interventions. -27% of the children who were taking a medication that required metabolic monitoring did not have current metabolic syndrome lab monitoring in claims databases. -After CM intervention, 60% of the children obtained metabolic labs or drug discontinuation. This testing may lead to decreased long term risks (e.g. diabetes, heart disease, obesity and joint problems) associated with these medications. -18% of the children did not have any current psychotherapy claims in databases upon review, but 67% began psychotherapy after working with individual providers. -72% provider response rate -Currently, 24 interventions are still pending with the provider. Atypical Antipsychotic Medication in Children under 6 years of age: By identifying children less than 6 years of age who are receiving antipsychotic medications and associated providers, we have been able to better coordinate prescribing (often multiple different prescribers are involved) and reduce the number of and/or dose of atypical antipsychotic medications in this population. -Baseline metabolic lab were obtained in 100% of the patients less than or equal to 6 years of age receiving an antipsychotic medication -Initial drug starting dose recommendations were accepted in 3% of the patients requesting an atypical antipsychotic. -20% of the medications requested were withdrawn after discussion with the provider Fraud/Abuse Review: -19 members reviewed for potential fraud --100% of members referred to Department per protocol -10 members reviewed for potential abuse -- 70% of members referred to Department per protocol Program Successes We have highlighted the following significant program successes for the Pharmacy Case Management Program.

State	Retrospective DUR Educational Outreach
	1. Hepatitis C Management - the number of patients completing treatment and therefore achieving a cure in addition to the education we have extended to providers for appropriate selection of the Hep C drug regimen. 2. Foster Care Program - this program has proven to be successful not only in terms of provider education of antipsychotic medication treatment and corresponding clinical management including metabolic lab monitoring, but the greatly improved outcomes for Foster Children and their drug therapy management. 3. MME reduction efforts - using the CM pharmacy staff and embedding the effort in the prior authorization process, we have seen a significant reduction in the number of Medicaid members receiving high MME prescriptions as well as preventing new therapy starts exceeding CDC recommended MME levels. 4. Provider relationships -Pharmacy Case Management has been very successful in building great provider relationships with the programs we administer for Montana Medicaid. The staff has become a very respected and reliable source of patient information, clinical acumen, and literature/evidence source for providers. 5. CM Outcome Tracking Protocol Development. We have strategically developed and built more robust tracking protocols utilizing our SharePoint infrastructure. This will allow for more efficient data tracking within various CM programs. 6. Antipsychotic Use in Pediatrics. We have recommended expansion of the lower age limit on prior authorization for atypical antipsychotic use in children. This was presented to the DUR Board in September 2019 (and again in October (FY2020)). Additional details will follow for FY2020 on progress. 7. SUPPORT Act Requirement Implementation-Educational preparedness during FFY 2019 has allowed us to be flexible with respect to the requirements of the SUPPORT Act and implement required monitoring protocols which are effective as of 10/1/2019.
Nebraska	Month Project Topic Specific Therapeutic Class Specific Therapeutic Class Desc Problem Type # claims # exceptions # profiles for review # interventions # responses % responses Oct-18 Concomitant Mood Stabilizers in < 18yo TC= 47, HIC3 =H2M, HSN=001670,001893,001669TC = 48, HIC3=H4B, HSN = 001893, 001884, 007378, 011735 Mood Stabilizers (Duplicate Therapy/Concomitant Use) 0 0 0 0 N/A N/A Nov-18 Concomitant Antidepressants < 18yo TC = 11, HIC3 = H2H, HSN = 33510TC = 11, HIC3 = H2S, HSN = 025796,010321,024022,006338,007344,001655,006324TC = 11, HIC3 = H2U, HSN = 001643,004744,001648,00651,001641,001645,001644,001650,001649,001642,001646TC=11, HIC3=H2W, HSN = 013819TC=11, HIC3=H2X, HSN=001656TC=11, HIC3=H7B, HSN=0011505TC=11, HIC3=H7C, HSN=026521,040692,040632,040202,035420,008847TC = 11, HIC3=H7D, HSN=036156,001653TC=11, HIC3=H7E, HSN = 001652,009612TC=11, HIC3=H7J, HSN=001638,001639,001640TC=11, HIC3=H7Z, HSN=025800TC=11, HIC3=H8P, HSN = 037597TC=11, HIC3=H8T, HSN=040637 Antidepressants (Duplicate Therapy/Concomitant Use) 0 0 0 0 N/A N/A Dec-18 MME>250/day TC=40 Opioid High Dose 0 0 0 0 N/A N/A

State	Retrospective DUR Educational Outreach
	Jan-19 N/A Feb-19 N/A Mar-19 Concomitant Opioid and Benzodiazepine Opioid TC=40Benzodiazepine TC = 07,47,48, HIC3=H4A, H20, H21 Opioid and Benzodiazepine (Duplicate Therapy/Concomitant Use) 13 13 13 0 - info only N/A N/A Mar-19 Concomitant Opioid and Antispychotic Opioid TC=40Antypsychotics: TC =7, HIC3s: H2G, H7O, H7P, H7R, H7S, H7T, H7U, H7X, H8Y, H8W Opioid and Antipsychotic (Duplicate Therapy/Concomitant Use) 5 5 5 0 - info only N/A N/A Apr-19 Diabetes 40-75yo c/o statin Diabetes TC=58Statin TC = 65 Diabetes and Statin Missing Therapy 13 13 13 0 - info only N/A N/A May-19 Stimulants for on-label diagnosis Stimulant TC= 10,11,12; HIC3=H2V, J5B, H7Y, HSN= 001682,033556,022987,010865,034868,013449,043652,005014,002065,002064,034486,024703 Stimulants Diagnosis Codes 4 4 4 0 - info only N/A N/A Jun-19 Hepatitis C PA Data Request TC=33, HIC3=W5G, W0D, W0E, W0G, W0A, W5V, W0B, W5Y Hepatitis C Appropriate Therapy 0 0 0 0 - info only N/A N/A Jul-19 N/A Aug-19 MME>200/day TC=40 Opioid High Dose 0 0 0 0 N/A N/A Aug-19 Concomitant Benzodiazepine and Antipsychotic Benzodiazepine TC = 07,47,48, HIC3=H4A, H20, H21Antypsychotics: TC =7, HIC3s: H2G, H7O, H7P, H7R, H7S, H7T, H7U, H7X, H8Y, H8W Opioid and Benzodiazepine (Duplicate Therapy/Concomitant Use) 1 1 1 0 - info only N/A N/A Aug-19 Concomitant Benzodiazepine and Stimulant Benzodiazepine TC = 07,47,48, HIC3=H4A, H20, H21Stimulant TC= 10,11,12; HIC3=H2V, J5B, H7Y, HSN= 001682,033556,022987,010865,034868,013449,043652,005014,002065,002064,034486,024703 Opioid and Antipsychotic (Duplicate Therapy/Concomitant Use) 0 0 0 0 - info only N/A N/A Sep-19 N/A
Nevada	The Top Ten Retro-DUR activities for 2019 are as follows: Diabetics Without a Statin: We identified 202 recipients who receive an anti-diabetic medication without receiving a statin for cholesterol. We received 20 positive responses back. Opioid Use Disorder Diagnosis and Receiving an Opioid: Recipients who have a diagnosis of opioid use disorder were identified and letters were sent to prescribers if the member also had an opioid filled. There were 86 letters sent and 7 returned.

State	Retrospective DUR Educational Outreach
	Zolpidem Utilization: Female recipients who are receiving over 5mg of zolpidem were identified. 131 letters were sent, and 12 responses were received. Anti-anxiety and Hypnotic Combination in Members Over 65-Years Old: Members over the age of 65 with concurrent fills of an anti-anxiety medication and a hypnotic medication were identified. Letters were sent to 48 prescribers and 3 responses were received. Hepatitis C treatment Follow-Up: Letters were sent to 28 prescribers asking for follow-up on completed hepatitis-C treatment after completion. Five responses were received. COPD Compliance: Recipients with a record of admission to urgent care or the emergency department with the primary diagnosis of COPD exacerbation were identified. Letters were sent to prescribers of recipients with sub-optimal therapy. 15 letters were sent, and 2 responses were received. Top 10 Opioid Prescribers: Based on the DUR Board recommendation, the top ten opioid prescribers by the number of claims were notified by letter of where they rate among their peers. Ten letters were sent, and one response was received. Buprenorphine and Opioid in Combination: Recipients were evaluated for concurrent use of buprenorphine and an opioid. 65 recipient profiles were reviewed, but no members were found to have concurrent opioids and a buprenorphine product. High Potency Topical Steroids and Extended Duration: Recipients with consecutive claims for a high potency topical steroid were queried. No recipients with extended consecutive claims were identified.
New Hampshire	Letters were mailed on ten algorithms involving 236 distinct prescribers and 200 distinct members. Below is a summary of each. 1. NSAIDS increase the risk of stroke or heart attack_FDA warning change a. 508 prescribers; 471 members b. 9.3% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary. 2. Diabetics ages 40-75 with no statins a. 76 prescribers; 74 members b. 17.1% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary. 3. Members with 6 or more Narcotic claims, diagnosis for substance abuse or overdose and no claims for naloxone in 180 days a. 2 prescribers;2 members b. No prescribers responded with changes in therapy or explanation of why continues therapy is necessary. 4. Bipolar Disorder with antidepressants and no mood stabilizer a. 15 prescribers; 15 members b. 6.6% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary. 5. Diabetics without an ACEI or ARB in history a. 14 prescribers; 14 members b. 14.3% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary. 6. SABA_ 2 or more in 90 days without a controller medication

State	Retrospective DUR Educational Outreach
	a. 5 prescribers; 5 members b. 40.0% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary. 7. Use of antipsychorics in children < 18 without metabolic testing a. 12 prescribers; 11 members b. 25.0% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary. 8. Polypharmacy a. 32 prescribers; 5 members b. 18.8% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary. 9. Serotonergic Agents with Serotonergic Agents a. 11 prescribers; 9 members b. No prescribers responded with changes in therapy or explanation of why continues therapy is necessary. 10. Atypical Antipsychotics without metabolic testing a. 69 prescribers; 65 members b. 10.0% of prescribers responded with changes in therapy or explanation of why continues therapy is necessary.
New Jersey	1. Retrospective Compliance of HIV drugs - Goal is to improve adherence to HIV drug treatment. During this reporting period, an average of 125 profiles were reviewed and 19 retroDUR letters were sent to prescribers. 2. Retrospective Compliance of Oral Diabetes Medications - Goal is to improve adherence to oral hypoglycemic medications. During this reporting period, an average of 170 profiles were reviewed and 10 retroDUR letters were sent to prescribers. 3. Retrospective Review of claims exceeding claim payment >$4000 - FFS and Encounter claims were reviewed for appropriateness, clinical drug related issues, and correct billing. Eleven claims required intervention yielding a cost-savings of $38,559.
New Mexico	Intervention: 1. Opioid Prescribing Educational Newsletter - Date of Intervention was 03/12/2019 targeting 338 pharmacies and 558 physicians 2. Codeine and/or Tramadol in Youth Intervention - Dater of Intervention was 06/05/2019 targeting 38 recipients and 20 physicians 3. Multiple Seconds Generation Antipsychotics - Date of Intervention was 09/30/2019 targeting 49 recipients and 38 physicians.
New York	criteria type criteria number Description Criteria # recipients mailed letters Responses DD 3592 Concurrent opioids & benzodiazepines SUPPORT Act 282 659 80 DD 10890 Concurrent opioids & antipsychotics SUPPORT Act 206 489 38

State	Retrospective DUR Educational Outreach

TA 9237 Cholesterol guidelines in diabetic patients age 40-75 195 302 21
TA 3739 Immediate-release opioids for pain management 166 265 31
DD 3093 Concurrent CNS stimulants & serotonergic agents 96 220 43
TD 454 Duplicate therapy of atypical antipsychotics 84 169 13
DD 10670 Concurrent opioids & gabapentin (>900mg/day) 91 183 14
DD 10899 Concurrent opioids & pregabalin 100 169 27
TA 8807 PPI's & risk of osteoporosis 116 150 14
DB 3232 Antipsychotic use in diabetic patients 72 147 12

Total Top 10 1408 2753 293
Total all letters 3713 6381 668

Key: TA, therapeutic appropriateness; DD, drug-drug interaction; TD, therapeutic duplication; DB, drug-drug marker and/or diagnosis

Results

Provider Responses to Intervention Letters

A total of 6,381 DUR educational intervention letters were mailed to prescribers during FFY 2019 and 668 responses were received for a response rate of 10%. A summary of all coded responses from prescribers is listed in the table below.

Prescriber Response	Total
MD UNAWARE OF WHAT OTHER MD PRESCRIBING	8
PT IS NO LONGER UNDER THIS MD's CARE	70
MD SAYS PROB INSIGNIFICANT NO CHG THX	246
MD WILL REASSESS AND MODIFY DRUG THERAPY	122
MD TRIED TO MODIFY THERAPY, PT NON-COOPERATIVE	19
PATIENT DECEASED	4
PATIENT WAS NEVER UNDER MD CARE	36
HAS APPT TO DISCUSS THERAPY	21
MD DID NOT RX DRUG ATTRIBUTED TO HIM.	41
TRIED TO MODIFY THERAPY, SX RECURRED	37
MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD	58
MD RESPONSE FORM RETURNED BLANK	4
RPH WILL COUNSEL PT ON NEXT VISIT	1
PT NO LONGER USES PHARM / OR SEES MD	1
TOTAL OF ALL RESPONSES	668
Response Rate	10%

Conclusion

State	Retrospective DUR Educational Outreach
	For FFY 2019, a total of 2,753 intervention letters for the top 10 criteria alerts were mailed to prescribers, with a response rate of 11%. There was also a 10% physician response rate for all criteria alerts, and 28% of prescribers who responded to the letters indicated that some positive action had been or would be taken to address the drug therapy issue identified in the intervention letter.
North Carolina	During October 2018 through September 2019, the North Carolina Medicaid Drug Utilization Review (DUR) Board reviewed several therapeutics areas such as anxiolytics, opioids, behavioral health medications, hepatitis C medications, Medicated-Assisted Treatment (MAT) therapies, and antibiotics. Educational outreach primarily consisted of educational letters to prescribers and pharmacies identifying their patients impacted. Educational outreach was also provided by Pharmacy Newsletters that are auto-generated and electronically available to subscribers; the newsletter is also posted on North Carolina Medicaid's website. Despite several topics being discussed during the year the most prominent topics addressed behavioral health and controlled substances. The North Carolina Medicaid DUR Board examined the use of ADHD medications stratified by age and discovered most use was in the pediatric population but there was use in the adult population as well, primarily young adults. The Board further examined patients prescribed ADHD medication who had depression in both the pediatric and adult populations. The Board concluded no action was needed at this time. In May 2017, North Carolina Medicaid implemented new point-of-sale (POS) clinical edits for behavioral health medications in pediatric and adult populations. The edits were specifically related to dosage and quantity prescribed which exceed the Food and Drug Administration (FDA) approved maximum dosage and dosage schedule. The Board examined claims before and after the edits were implemented and, using trend analysis, the Board was provided an estimated cost savings. The Board concluded the policy aligned clinically appropriate prescribing and reduced medication expenditures; no further action was recommended at that time. The DUR Board also examined the Medicaid patients' use of lithium and compliance with lithium level laboratory testing. The medication has a boxed warning, is considered a narrow therapeutic index medication, and lithium toxicity is closely related to serum lithium concentrations which can occur at doses close to therapeutic concentrations. The Board discussed the importance of testing, frequency of testing, and commented patients' laboratory non-compliance is a barrier to use. The DUR Board reviewed data on patients' using lithium in the previous 6 months and the number of patients undergoing laboratory testing in the previous 6, 8, 10, and 12 months. The Board determined provider outreach notifying them of patients who have not had a lithium level in the last 10 months would be beneficial. The North Carolina DUR Board reviewed and discussed the use, benefits, and challenges associated with clozapine. Data revealed, compared to all antipsychotic use, the use of clozapine remains consistently low which might be reflective of difficult drug monitoring and some prescribers are uncomfortable prescribing it. The Board discussed cost savings associated with clozapine and the reduction of mortality associated with the drug. Over multiple meeting the Board reviewed clozapine utilization, patient compliance, top prescribers of clozapine, top prescribers of antipsychotics who are not prescribing clozapine, geographic locations of those prescribers, and patients on multiple antipsychotics and their history of clozapine use. The Board recommended North Carolina Medicaid engaging in conversation with the North Carolina Psychiatric Association and continued Board monitoring of use. The use of benzodiazepines for the treatment for anxiety disorders was reviewed among the Board member in SFY 2019. First-line therapies for generalized anxiety disorder (GAD), social anxiety disorder (SAD), panic disorder, obsessive compulsive disorder (OCD), and post-traumatic stress

State	Retrospective DUR Educational Outreach
	disorder (PTSD) were discussed. The Board reviewed patients identified as having greater than or equal to 2 benzodiazepine prescriptions in the last 90 days, without a SSRI in the past year, and with/without a diagnosis of panic attack. The Board also discussed the concurrent use of benzodiazepines and opioids, noting utilization is trending downward. The Board is continuing to monitor the patient population and will be reviewing data on patients' use of greater than or equal to 2 benzodiazepines claims in the last 90 days, with a day's supply of greater than or equal to 60 days, and without a SSRI, SNRI, or TCA in the last year at a future Board meeting. The North Carolina DUR Board monitored 2-year opioid trends across multiple meetings. The data illustrated that both pediatric opioid and adult opioid use decreased over the 2 years examined. The Board noted dentists were among the highest prescribers and therefore reviewed the top 50 dental prescribers for opioids. Two-year trending for morphine milligram equivalents (MME) was also reviewed in addition to top prescribers of opioids, in general (cancer and sickle cell patients were removed). The data indicated a downward trend in claims, utilizers, prescribers writing for, and pharmacies dispensing prescriptions with MME > 90 MME daily. The Board continues to monitor opioid utilization trends. Opioid use in the pediatric population was also reviewed at 2 Board meetings. The data revealed that patients < 1 year old showed opioid claims on file and therefore, the Board also examined the prevalence of neonatal abstinence syndrome and opioid dependence within this population. The Board considered the risk of opioid use within the pediatric population therefore, examined the specific medications used stratified by age; focused reporting on tramadol and codeine use; frequency of use for tonsillectomy, and top prescribers. Data revealed most prescriptions were for hydrocodone and oxycodone written by prescribers with the taxonomy of "Dentist Oral and Maxillofacial". The Board felt it was reasonable to prescribe pain medications to pediatrics in certain situations and quantities and also observed quantities have decreased. Over several Board meetings, the North Carolina DUR Board reviewed and discussed the use of short-acting oxycodone and quantities which would suggest patients' need for a long-acting oxycodone product or a long-acting oxycodone dose increase. Patients with greater than or equal to 4 tablets/capsules daily with a total day supply of greater than or equal to 60 days within 90 days were reviewed. Approximately 19% of short-acting oxycodone users met the inclusion criteria. The Board also discussed the North Carolina Medicaid Lock-In Program and opioid prior authorization criteria. The incidence of substance abuse disorder diagnoses was examined by the Board. The Board recommended prescriber education through lettering notifying them of patients taking greater than or equal to 4 units daily with a total day supply of 60 within 90 days requesting consideration for a long-acting product or non-pharmaceutical therapy be considered when medically appropriate. Patients with cancer and/or sickle cell disorder were excluded. The Board analyzed the concurrent use of opioids and benzodiazepines since the combination can be unsafe due to the additive effects of sedation and respiratory depression. The patient use of naloxone was also reviewed. The Board discussed the benefits of sending educational letters to pharmacies since often opioids are prescribed by emergency room prescribers. The Board also reviewed and discussed the point-of sale edits that were in place to prospectively identify potential issues. The Board will continue to monitor concurrent use. In 2017, North Carolina Medicaid increased accessibility to buprenorphine to Medicaid beneficiaries. However, the programmatic changes did require clinical justification for the use of single ingredient buprenorphine. To examine the effects of the policy change, the Board requested utilization trends before and after the changes went into place. The Board discovered the policy change resulted in more patients receiving the buprenorphine/naloxone combination while fewer patients received the single ingredient buprenorphine product. The Board also examined pregnant patients' use of buprenorphine and found that, on average, 47% of those patients were taking the single ingredient buprenorphine product. In October 2018, a maximum daily dose edit for opioid

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	dependence treatment medications went into place. This edit allows the dispensing pharmacist the ability to override the edit at point-of-sale after consulting the prescriber for clinical necessity. The Board reviewed statistics of pharmacy level overrides resulting from the edit. No further action was taken by the Board at that time. In summary, the North Carolina DUR Board monitored several topics during 2018 and 2019 with a high concentration in controlled substances (i.e. opioid and benzodiazepines) and behavioral health. Educational outreach is primarily done through mailed letters to prescribers and/or pharmacies. As a whole, the program witnessed a decrease in the utilization of opioids and an increase in Medicated-Assisted Treatment (MAT) therapies which resulted from North Carolina Medicaid's multifaceted interventions. There was also an emphasis in behavioral health for much of the year with a focus in improving patients health and safety through appropriate medication use. Additionally, educational outreach was also provided by auto-generated pharmacy newsletters electronically available to subscribers; and those newsletters were also posted on North Carolina Medicaid's website.
North Dakota	Below is a list of the most prominent 10 problems identified in the North Dakota Medicaid Retrospective DUR Educational Outreach program, based on those with the largest number of exceptions. The list includes the criteria name and type of problem identified, followed by parentheses containing the number of exceptions identified, the number of cases reviewed for that exception, the number of physician education letters sent for identified cases, the physician response rate, the number of pharmacy education letters sent for identified cases, and the pharmacy response rate (all numbers are presented in this order, separated by commas). 1: Overutilization of Cyclobenzaprine - Overuse Precaution (150, 126, 129, 11.6%, 126, 15.1%) 2: Coadministration of Benzodiazepines and Opioids - Drug/Drug Conflicts (93, 56, 81, 6.2%, 59, 23.7%) 3: Coadministration of Oxycodone and Benzodiazepines - Drug/Drug Conflicts (81, 67, 100, 14%, 74, 16.2%) 4: Therapeutic Duplication of Anxiolytic Agents - Therapeutic Duplication (78, 45, 60, 16.7%, 50, 12%) 5: Use of Tizanidine and CNS Depressants - Drug/Drug Conflicts (76, 56, 100, 18%, 61, 24.6%) 6: Utilization of Benzodiazepines with History of Drug Abuse - Therapeutic Appropriateness (72, 62, 64, 3.1%, 62, 6.5%) 7: Use of Antidepressants in Patients with Mania - Drug/Disease Interaction (70, 63, 69, 7.2%, 64, 9.4%) 8: Use of Atypical Antipsychotics in Patients with Diagnoses Associated with Metabolic Syndrome - Drug/Disease Interaction (66, 56, 56, 17.9%, 56, 26.8%) 9: Appropriate Use of Immediate-Release Opioid Analgesic Agents - Therapeutic Appropriateness (66, 59, 74, 20.3%, 70, 21.4%) 10: Underutilization of Antidepressants - Underutilization (63, 59, 63, 3.2%, 59, 6.8%)
Ohio	October 2018-September 2019 Every month, outreach is made to each prescriber whose patients are taking MAT in combination with an opioid, or MAT in combination with a benzodiazepine. The outreach is made to determine if the prescriber is aware that their patients are taking these combinations of drugs, and to ensure that they are checking OARRS before prescribing. An outreach is made to the pharmacies to determine if they contacted the prescriber and checked OARRS before dispensing these medications. October 2018-Opioids, Benzodiazepines, and Sedative Hypnotics

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	Retrospective DUR Educational Outreach to prescribers whose patients were receiving opioid medication(s) in combination with benzodiazepine(s) and sedative hypnotic(s). Reminded prescribers that co-prescribing opioids with benzodiazepines and sedative hypnotics increases potential harm to the patient and is associated with drug interactions and adverse events. 107 members were identified for this intervention. November 2018 Reviewed 70 profiles of members who were proposed for enrollment in the Coordinated Services Program (CSP). January 2019- Adherence to non-insulin Antidiabetic medication Retrospective DUR Educational Outreach to prescribers whose patients were non-adherent to their non-insulin antidiabetic medications based on their pharmacy claims. Reminded prescribers that optimal medication adherence to antidiabetic medications is associated with lower rates of diabetes related complications, outpatient costs, emergency room (ER) visits, decreased hospitalizations, and all-cause mortality. 353 members were identified who were 60% or below adherent to their non-insulin antidiabetic medication. February 2019 Reviewed 38 profiles of members who were proposed for enrollment in CSP. March 2019-Insulin without glucose test strip claims Retrospective DUR Educational Outreach to prescribers whose patients were receiving insulin but were not showing claims for glucose test strips. Reminded prescribers that self-testing blood glucose is an important tool in managing a diabetic treatment plan and preventing hypoglycemic or hyperglycemic episodes, which can lead to serious health problems, such as neuropathy, kidney disease and vision loss. 499 members were identified for this intervention. May 2019 Reviewed 21 profiles of members who were proposed for enrollment in CSP. July 2019-Tamiflu and no flu shot Retrospective DUR Educational Outreach was performed to identify high risk members who received a prescription for Tamiflu but did not receive a flu shot during that flu season. Pharmacy and medical claims were researched for a flu shot claim. 474 adult members who had chronic obstructive pulmonary disease, heart disease, diabetes or asthma were mailed a letter explaining the importance of receiving an annual flu shot. August 2019 Reviewed 19 profiles of members who were proposed for enrollment in CSP. September 2019-Adherence to Atypical Antipsychotic medication Retrospective DUR Educational Outreach was performed on adult and children populations for adherence to atypical antipsychotic medications. Identified adult members who were 50% or less adherent on taking their atypical antipsychotic medication based on pharmacy claims. The purpose of this intervention was to identify patients who were potentially non-adherent with their atypical antipsychotic medication and to notify their prescribers. 338 members were identified. Also identified children who were 70% or less adherent on taking their atypical antipsychotic medication based on pharmacy claims. 135 members were identified.

State	Retrospective DUR Educational Outreach
	The purpose of a DUR re-review is to determine the impact of an intervention. Re-reviews are performed one year after the intervention. All of the following are re-reviews. January 2019-High dose and duplicate Proton Pump Inhibitors (PPI) Re-reviewed members who were either taking high doses of PPIs or duplicate therapy of PPIs. The purpose of this intervention was to notify prescribers of patients under their care, who were either on high dose Proton Pump Inhibitors (PPIs) for over 6 months or who were taking duplicate PPIs. Original member count was 117 for high dose. Re-review member count 102. 59 members were either no longer taking PPIs or had reduced their dose (58%). Original member count was 7 for duplicate PPIs. Re-review member count 5. All 5 members were no longer taking duplicate PPIs (100%). March 2019-Diabetic members not taking an Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or a statin Re-reviewed diabetic members who were not taking either an ACE Inhibitor/ARB or a statin. The purpose of this educational intervention was to notify prescribers of patients under their care who were on anti-diabetic agent(s), however were not filling an ACE inhibitor, ARB or a statin prescription. Original member count for no ACE inhibitor /ARB was 61 members. Re-review member count 47. 3 members had an ACE/ARB added (6%). Original member count for no statin was 61. Re-review member count 47. 10 members had a statin added (21%). May 2019-400 Morphine Equivalent Dose (MED) of opioids Re-reviewed members who were taking more than 400 MED of opioids per day. The purpose of this intervention was to notify prescribers of patients under their care who were taking more than 400 MED of opioids per day. Original member count was 26. Re-review member count was 19. A total of 12 members experienced a decrease in their total MED value, including two members who are no longer taking opioids (63%). July 2019-Muscle relaxants long-term Re-reviewed members who were taking muscle relaxants for greater than 90 days. The purpose of this intervention was to notify prescribers of patients under their care who were taking muscle relaxants for greater than 90 days. Original member count 104. Re-review member count 87. 48 members experienced a decrease in utilization, including 8 members who were no longer taking a muscle relaxant (55%). August 2019-Albuterol without controller medication Re-reviewed members who were receiving six or more albuterol prescriptions in six months without the use of a controller medication. The purpose of this intervention was to notify prescribers of patients under their care who were using a short-acting bronchodilator chronically without the use of a controller medication. Original member count 364. Re-review member count 296. 70 members added a controller medication (24%).
Oklahoma	Medication Category|Educational Intervention Criteria|Cases Reviewed|Cases Intervened|Affected Members|Total Members|Total Claims|Minimum Cost Savings

State	Retrospective DUR Educational Outreach
	Atypical Antipsychotics|Adherence/Diagnosis/Metabolic/Polypharmacy|48,215|26,523|11,900|64,305|522,275|Clinical Outcomes Diabetes/Cardiovascular|Chronic Medication|Adherence|38,180|6,411|18,413|38,180|205,759|Clinical Outcomes Atypical Antipsychotics|Adherence/Diagnosis/Metabolic/Polypharmacy|48,390|25,483|11,882|64,159|520,112|Clinical Outcomes Diabetes/Cardiovascular|Chronic Medication|Adherence|37,972|6,036|18,341|37,972|202,100|Clinical Outcomes ADHD/Atypical|Antipsychotics Academic Detailing Program Update|70,290|22,614|4,890|70,290|511,304|$211,850.75* Atypical Antipsychotics|Adherence/Diagnosis/Metabolic/Polypharmacy|48,880|24,411|12,074|65,280|525,368|Clinical Outcomes Diabetes/Cardiovascular|Chronic Medication Adherence|37,723|5,557|17,981|37,723|198,367|Clinical Outcomes ACEI/ARB|Use of ACEI/ARB|Therapy in Pts with DM and HTN Mailing Update|717|108|288|717|n/a|Clinical Outcomes Atypical Antipsychotics|Adherence/Diagnosis/Metabolic/Polypharmacy|48,738|23,353|11,838|64,678|523,149|Clinical|Outcomes Diabetes/Cardiovascular|Chronic Medication Adherence|37,491|5,167|17,574|37,491|195,476|Clinical|Outcomes ADHD = Attention-Deficit/Hyperactivity Disorder; ACEI = Angiotensin Converting Enzyme Inhibitor; ARB = Angiotensin Receptor Blocker; DM = diabetes mellitus; HTN = hypertension; n/a = not applicable *Cost savings inclusive of all federal and supplemental rebates.
Oregon	1. Change fluoxetine form from tabs to caps: In Oct. - Dec. 2018 we identified 637 unique prescribers and 891 unique patients. We sent 517 faxes. 353 prescriptions were changed to the recommended form within six months of intervention. We estimate $94,358 in savings over 12 months with this intervention. 2. Change lamotrigine form from extended release to immediate release: In Oct. - Dec. 2018 we identified 363 unique prescribers and 652 unique patients. 130 prescriptions were changed to the recommended form within six months of intervention. We estimate $94,002 in savings over 12 months with this intervention. 3. Dose optimization project: During period identified a total of 372 claims that could be optimized and sent 147 faxes. A total of 78 prescriptions were changed to the recommended dosing within three months, 53 were changed to alternative dose and 150 were unchanged. We identified 16 safety monitoring profiles. We estimate $167,328 in savings over 12 months with this intervention. 4. Expert consultation referral project for antipsychotic use in children: In July - Sept. 2019 we identified 1,099 unique patients for potential intervention and selected 67 profiles for expert review with 60 prescribers being notified. Within the following 90 days, we saw a change in antipsychotic drug for three patients and 41 continued their antipsychotic therapy.

State	Retrospective DUR Educational Outreach
	5. Non-adherence project for antipsychotics in people with schizophrenia: In July - Sept. 2019 we identified 84 unique patients and notified 81 unique prescribers. Within the following 90 days, we saw 31 patients had claims for the same antipsychotic and three had claims for a different antipsychotic. 6. During the reporting period, we conducted profile reviews for the following groups: Children under age 12 antipsychotic (286 total reviews); Children under age 18 on 3 or more psychotropics (97 total reviews); Children under age 18 on any psychotropic (449 total reviews); Children under age 6 on any psychotropic (42 total reviews); Dose Consolidation Safety Monitoring (10 total reviews); High Risk Patients - Asthma (12 total reviews); and High Risk Patients - Polypharmacy (81 total reviews). We send 15 letters to providers for the identified High Risk patients and received responses from 3 indicating the provider agreed or found the intervention useful. 7. Lock-in: During the reporting period, we conducted a lock-in program that involved 108 profiles reviewed, 4 letters sent to providers (none responded) and three lock-ins. 8. Polypharmacy review: During the reporting period, we conducted a polypharmacy review program that involved 257 profile reviews, 49 letters sent to providers. Five providers responded and agreed or found the intervention useful. 9. Safety net review for combination opioid-sedative: In July - Sept. 2019, we identified 138 patients, 132 prescribers and notified all 132. In the following 90 days: 27 patients discontinued the therapy and one patient had a new prescription for naloxone. The average number of sedative drugs dispensed to the identified patients in the subsequent 90 days was zero and the average number of sedative prescribers for the identified patients was zero. This was initiated at the end of the SFY, so 90 days had not elapsed and would be reported in subsequent year 10. ICS/LABA safety net: we identified clients who hit a PA requirement for inhaler but had no subsequent claim. Through this intervention, we notify prescribers that the client needs PA and may not have medication. We sent a total of 26 provider faxes (18 for combination inhaler, 2 for controller, three for SABA, and 3 for no subsequent pulmonary claim).
Pennsylvania	The Pennsylvania Medical Assistance Program performs RetroDUR and educational outreach through problem-focused reviews. Problem-focused reviews narrow the emphasis of review to a specific issue that has been determined to be an area where a targeted educational effort to providers may be valuable. Topics for review are selected from reviews of medical literature, emerging trends in local or national news, suggestions by the DUR Board, etc. Criteria are developed to identify the members who may benefit from an intervention and educational materials are disseminated to their prescribers. Prescribers are encouraged to voluntarily respond. The member profile is generated again in an appropriate amount of time (typically 6 months) to determine the impact rate of the intervention, along with any fiscal considerations. Activities of the RetroDUR Program were evaluated for interventions performed in FFY19. The activities of the RetroDUR program resulted in a calculated cost savings of $238,547.42, equating to a savings of 27 cents for every $1.00 of combined federal and state dollars spent administratively on the RertroDUR program. Savings reported are before rebate, total dollars.

State	Retrospective DUR Educational Outreach
	During this evaluation period, 5,045 educational intervention letters were mailed to prescribers regarding medication therapy. Prescribers returned 741 responses to these letters, resulting in an overall response rate of 14.68 percent. In these 5,045 educational letters, the RetroDUR Program made 7,334 observations and subsequent educational outreach. All of these observations were therapeutic in nature. The suggested change was implemented in 3,293 cases, resulting in an overall impact rate of 44.90 percent. Study Number Description 113 Entresto with concomitant ACEI, ARB or aliskiren 114 Entresto without evidence-based beta blocker 119 Therapeutic duplication of statin therapy 125 Buprenorphine without naloxone claim 136 Therapeutic duplication of PPIs 151 Concomitant emtricitabine + lamivudine 156 Therapeutic duplication of LABAs 158 Concomitant use of an opioid (excl. bup) + BZD + sedative hypnotic + carisoprodol 159 NSAID + ACEI/ARB + diuretic in patients 50 years of age and older 160 Therapeutic duplication of PPIs 162 Multiple prescribers, opioids within a 10 day period (excluding buprenorphine) 166 Buprenorphine without naloxone claim 171 Therapeutic duplication of LABAs 185 Therapeutic duplication of PPIs 199 Buprenorphine without naloxone claim 201 Therapeutic duplication of oral anticoagulants 202 Asthma + LABA + SABA + PO nonselective beta-blocker 203 NSAID + ACEI/ARB + diuretic in patients 50 years of age and older (excluding COX-2 inhibitors)
Rhode Island	Executive Summary This report prepared for the Rhode Island Medial Assistance Program summarizes the top 10 Retrospective Drug Utilization Review (RDUR) interventions as ranked by the number of intervention letters mailed to prescribers during Federal Fiscal Year (FFY) 2019. Intervention letters are mailed to prescribers to encourage appropriate prescribing and improve drug utilization, which will, in turn, prevent possible adverse drug reactions and improve patient outcomes in the targeted recipient population. A total of 2,589 prescriber letters were mailed for the top 10 criteria evaluated. Each letter included a response form, soliciting feedback from the prescriber. Responses are voluntary and a response rate of 24% was achieved for the top 10 criteria and a response rate of 22% was achieved for total interventions during FFY 2019. In their responses. Program Background Health Information Designs, LLC (HID) currently provides RDUR services for the Rhode Island fee-for-service Medicaid population as a subcontractor with DXC Technology. In an effort to promote appropriate prescribing and utilization of medications, HID evaluates claims data against selected criteria monthly to identify recipients with drug therapy issues and mails the corresponding educational intervention letters to those recipients' prescribers. A copy of the recipient's complete drug and diagnosis history, including medications prescribed by other providers, is also provided with the letter. Prescribers have the opportunity to review the entire drug and diagnosis history and make changes to therapies based on this information.

State	Retrospective DUR Educational Outreach
	Analysis Methodology Each month HID evaluates Rhode Island fee-for-service Medicaid pharmacy claims data against criteria for several hundred potential drug therapy issues. Criteria are developed by HID and presented to the Rhode Island Drug Utilization Review Board and DXC for approval and implementation. Recipient Selection The drug history and diagnosis profile for each recipient who meets the selected criteria are reviewed by a HID clinical pharmacist to determine if the recipient should be selected for intervention. After recipients are selected for intervention, educational intervention letters are mailed to all prescribers of drugs included in the criteria. Letters are sent with a complete drug history and all diagnoses obtained from claims data submitted during the past 6 months. Some letters cannot be mailed or are returned after mailing due to missing or invalid provider addresses. Once a recipient is selected for intervention, the specific criteria are suppressed by the RDUR system for that recipient for 6 months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, recipients could be selected for additional criteria exceptions later in the year. Recipients may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle. Retrospective DUR Intervention Summary The table below is a summary of educational outreach letters mailed for the top 10 retrospective DUR interventions based on number of letters mailed for FFY 2019. CRITERIA TYPE CRITERIA DESCRIPTION # RECIPIENTS SELECTED FOR INTERVENTION # INTERVENTION LETTERS MAILED TO PRESCRIBERS # PRESCRIBER RESPONSES TA NSAIDs can increase the risk of heart attack or stroke in patients with or without heart disease or risk factors for heart disease. 610 621 135 TA Antidepressants may increase risk of suicidal thinking 385 387 110 TA A review of the patient medical and prescription history revealed that the patient was recently discharged from the hospital and is currently receiving a proton pump inhibitor (PPI) with no supporting indication for PPI use. 315 315 96 TA The use of second-generation antipsychotics (SGAs) has been associated with the development of serious health risks (e.g., cardiovascular disease, diabetes, dramatic weight gain, and atherogenic lipid profiles). 286 291 54 DB Epidemiological studies suggest atypical antipsychotics may exacerbate pre-existing diabetes. A dose adjustment in the patient's current diabetic medication(s) may be necessary for optimal blood glucose levels. Blood glucose and HgA1c monitoring should be conducted in conjunction with monitoring for weight gain and signs of hyperglycemia. All patients should be advised to report signs of ketoacidosis or glycosuria. 141 201 40 TA The patient is receiving a drug that has the potential to cause adverse outcomes in the elderly unless specific benefits outweigh the risks and the patient is monitored appropriately. 163 176 47 TA Misuse of amphetamines and cardiovascular warning 164 167 52 TA ACC/AHA Blood Cholesterol Guidelines recommend the use of moderate-intensity statin therapy as primary prevention to reduce the risk of atherosclerotic cardiovascular disease in diabetic patients 40 to 75 years of age with a LDL-C of 70 - 189 mg/dL, unless contraindicated. If the diabetic patient has an estimated 10-year ASCVD risk of 7.5% or greater high-intensity statin therapy is recommended. Refer to the ACC/AHA guidelines for agents and dosage. 142 148 24 DD Concurrent use of stimulants and serotonergic agents can increase the risk of serotonin syndrome 122 142 39

State	Retrospective DUR Educational Outreach
	DD Diabetic would benefit from addition of an ACE or ARB 128 141 28 Total Top 10 2,456 2,589 625 (24%) Total all letters 6,169 6,736 1,501 (22%) Prescriber Response Tabulation In addition to the intervention letter and the recipient's drug and diagnosis history, a response form is included in the mailings. The response form allows prescribers to give feedback and informs HID if any action will be taken in response to the letter. The response form contains standard responses that allow the provider to check a box for the response that best fits their intended action and provides space for handwritten comments. Providers are encouraged to return the response form using the self-addressed, stamped envelope included with the intervention letter or send the form via fax. HID tracks all returned response forms. Results Provider Responses to Intervention Letters A total of 2,589 DUR educational intervention letters were mailed to prescribers for the top 10 DUR criteria, and 625 responses were received for a response rate of 24%. A summary of all coded responses from prescribers is listed in the table below. Prescriber Response Total BENEFITS OF THE DRUG OUTWEIGH THE RISKS 248 MD UNAWARE OF WHAT OTHER MD PRESCRIBING 3 PT IS NO LONGER UNDER THIS MD's CARE 1 MD SAYS PROB INSIGNIF NO CHG THX 87 MD WILL REASSESS AND MODIFY DRUG THERAPY 115 MD TRIED TO MODIFY THERAPY, PT NON-COOP 45 PT UNDER MY CARE BUT NOT SEEN RECENTLY 39 PATIENT DECEASED 6 PATIENT WAS NEVER UNDER MD CARE 32 HAS APPT TO DISCUSS THERAPY 324 MD DID NOT RX DRUG ATTRIBUTED TO HIM. 39 AWARE OF INTERACTION, MONITORING PATIENT 268 TRIED TO MODIFY THERAPY,SYMPTOMS RECURRED 97 MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD 104 I AM PROVIDING THE ICD-10 CODE ASSOCIATED WITH MEDICATION(S) BEING PRESCRIBED 93 TOTAL OF ALL RESPONSES 1,501 Response Rate 22% Results Discussion With respect to prescriber responses to RDUR letters, a response rate of 22% was achieved. All intervention letters include the recipient's drug claims data within the previous 6 months and any available diagnosis data to provide as complete of a drug and diagnosis history as possible. This approach provides prescribers and pharmacies with the information needed to fully review and evaluate each recipient's drug history. Conclusion For FFY 2019, a total of 2,589 intervention letters for the top 10 criteria alerts were mailed to prescribers, and a response rate of 24% was achieved.
South Carolina	Opioid Products: Characteristics and Conversion Factor Handouts : Delivered by Detailer-37 Issue No. 1- Opioids by the Numbers: CME Completion-4

State	Retrospective DUR Educational Outreach
	Issue No. 2- Opioids are Constipating: CME Completion-7 Issue No.3- Opioids and Benzodiazepines Just Don't Mix: Academic Detailing Visits- 20 CME Completion-38 Issue No.4- Opioid Addiction Isn't a Choice: Academic Detailing Visits-8 CME Completion- 16 Issue No .5- Depression and Anxiety are Painful: Academic Detailing Visits-7 CME Completion-15 Special Edition- SOS for Safer Opioid Prescribing: Academic Detailing Visits -49 CME Completion-45 Issue No.7- Medication Disposal Better Safe than Sorry Academic Detailing Visits-68 CME Completion-58 Issue No.8- Naloxone and Nalterxone, What's the Difference? Mailings-516 Academic Detailing Visits-14 CME Completion-22 Opioid Use Disorder: Overview, Screening, Diagnosis and Treatment (CME) was presented at the Grand Strand Advanced Practice Nurses Association Conference (16th Annual Lecture at the Beach) 9/12/2019 Tonsillectomy with or without adenoidectomy was the surgery selected to build the first pediatric and adult models to help predict chronic opioid use post-surgery. Data Analysis and Evaluation Plan/Modeling Activities is currently in development.. New content development continued to focus on promoting practice behavior changes or validation of current practices that address the opioid epidemic, with a shift in emphasis from chronic pain to acute pain. Early 2020 is the target month for the December 2019 tipSC issue on acute non cancer pain to be available online and delivered by US mail. While face to face delivery of this topic will likely not be a focus until later in the year, it may be the right next topic of discussion for any given provider or practice. This transition to an acute pain focus will continue as we develop topics on management of post surgical pain to be shared with both primary care providers and surgeons.
South Dakota	Criteria-Criteria Type-Criteria Description-# TCEs Reviewed-# Cases-# Letters Generated-# Responses -Response Rate 3023-Therapeutic Appropriateness-Controlled Substances -431-67-286-95-33% 3592-Drug-Drug Interaction-Opioids/Benzodiazepines-91-32-110-45-41% 8614-Drug-Drug Interaction-Duloxetine/Serotonergic Agents-89-14-43-2-5% 9237-Therapeutic Appropriateness-Diabetes/Statins-72-51-132-32-24% 10890-Drug-Drug Interaction-Support Act Criteria-45-5-19-6-32% 10878-Therapeutic Appropriateness-Fluoroquinolones/Aortic Dissection-39-15-33-1-3% 97-Drug-Drug Interaction-ACE Inhibitors/NSAIDs-32-4-12-1-8% 8569-Overutilization-Zolpidem-30-8-19-4-21% 103-Drug-Disease Interaction-Stimulants/Hypertension-26-3-12-5-42% 79-Underutilization-Beta-blockers-24-14-28-7-25%
Tennessee	Following is a listing of the 10 problems and number of letters that were sent for each: Non-compliance with oral diabetes medication, 942 letters sent Members with 6 or more Narcotic claims, with risk factors and no claims for naloxone in 180 days, 922 letters sent Non-compliance with Atypical Antipsychotics, 856 letters sent APAP with other meds which may have hepatotoxic side effects, 802 letters sent CNS Stimulants may retard growth in pediatric patients ages 4-10, 700 letters sent Non-compliance with anticonvulsant therapy, 590 letters sent Lithium therapy with no recent level, 407 letters sent

State	Retrospective DUR Educational Outreach
	Non-compliance with Antiretroviral Drugs, 248 letters sent SUPPORT ACT - Concomitant Opioids and Atypical Antipsychotics, 231 letters sent Diagnosis megestrol tabs vs suspension and Adverse Effects, 190 letters sent
Texas	Retrospective Drug Utilization Review (RetroDUR) Program Program Summary A proposal is developed with specific performance indicators that have been identified for the intervention. A clinical rules engine is used to identify the number of candidates with exceptions for each performance indicator. The clinical rules engine applies criteria on a focused topic for an entire member population to identify members with a specific issue. Intervention proposals are prepared and presented at quarterly DUR Board Meetings for feedback and approval. The intervention package delivered to providers includes a provider letter with referenced educational materials and modified patient profiles. Also included are provider messages addressing flags for each patient profile. Educational materials developed by the Conduent clinical team are used to communicate prescribers on how to be more efficient and effective in their prescribing practices. Overall Cost Savings The PBIs were effective in improving quality of care for Texas Medicaid recipients. The RetroDUR program administered by Conduent demonstrated net cost avoidance for FFY 2019. The overall cost savings for Texas Medicaid is $10,301,812.05. Population-Based Intervention Summary Intervention Date Recipients Pharmacies Physicians Outcomes Summary Antibiotics 02/22/2019 NA NA 1,528 In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $2.31 in the post- intervention period. This yielded an overall estimated decrease of $1,587,468.96 in intervention-related drug expenditures on an annualized basis. Medication Adherence 04/10/2019 1,069 NA 1,159 During the intervention, targeted patients saw average reductions in clinical indicators by 23.6%. In terms of financial outcomes, the amount paid for intervention-related drugs increased by $3.20 in the post-intervention period. This yielded an overall estimated increase of $3,676,983.60 in intervention-related drug expenditures on an annualized basis.

State	Retrospective DUR Educational Outreach
	Respiratory Disease 06/21/2019 1,329 NA 1,074 During the intervention, targeted patients saw average reductions in clinical indicators by 29.3%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $2.96 in the post- intervention period. This yielded an overall estimated decrease of $451,271.86 in intervention-related drug expenditures on an annualized basis. Mental Health 06/04/2019 1,273 NA 1,000 During the intervention, targeted patients saw average reductions in clinical indicators by 21.6%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $3.62 in the post- intervention period. This yielded an overall estimated decrease of $2,554,033.05 in intervention-related drug expenditures on an annualized basis. Opioid Prescribing 10/30/2018 1,069 NA 911 During the intervention, targeted patients saw average reductions in clinical indicators by 33.1%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.12 in the post- intervention period. This yielded an overall estimated decrease of $21,385.92 in intervention-related drug expenditures on an annualized basis SGAs in Youth 11/13/2018 1,48 NA 614 During the intervention ,targeted patients saw average reductions in clinical indicators by 32.0%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $10.97 in the post intervention period. This yielded an overall estimated decrease of $7,899,431.18 in intervention-related drug expenditures on an annualized basis Psychotropics- Adults 04/01/2019 599 NA 503 During the intervention, targeted patients saw average reductions in clinical indicators by 27.3%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $4.34 in the post-

State	Retrospective DUR Educational Outreach
	intervention period. This yielded an overall estimated decrease of $1,446,548.04 in intervention-related drug expenditures on an annualized basis PPIs 01/11/2019 47 NA 44 During the intervention, targeted patients saw average reductions in clinical indicators by 39.6%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.96 in the post- intervention period. This yielded an overall estimated decrease of $18,656.64 in intervention- related drug expenditures on an annualized basis.
Utah	Utah Medicaid contracts with the University of Utah's Drug Regimen Review Center (DRRC) to review clients who have high drug utilization and drug costs. The DRRC contacts the prescribers of identified Medicaid clients and performs educational peer reviews of targeted clients. The goal of the reviews is to reduce waste, duplication, and unnecessary prescription utilization. A report is composed and submitted to Utah Medicaid each year. For this Federal fiscal year, the DRRC program achieved $3,758,156 in estimated savings by assisting prescribers in the pharmacological treatment of their patients. The Utah Medicaid Drug Regimen Review Center retrospectively conducts patient-level reviews and makes educational interventions through prescriber letters that address identified drug therapy problems (DTPs) to patients' prescribers as appropriate. While these recommendations are patient-specific, they also served to increase individual provider awareness with the goal of improving overall population-based utilization of these medications. A voluntary feedback form is included with each letter. The 10 most frequent DTP interventions used during the reporting period are summarized below. The listed DTP interventions are the most common that emerged over the course of our regular process. 1. Adherence: Pharmacists from the DRRC review medication fill patterns over the 6-12 months preceding the month of review and notify prescribers of chronic medications with 1 or more missed fills over the most recent 6 months (or longer as appropriate). In addition, prescribers may be given targeted strategies associated with an improvement in patient adherence such as suggestions to simplify complex therapies. 2. Untreated Indication: Sometimes after reviewing available diagnosis codes and medications, pharmacists will note diagnoses that may require treatment based on best practices or guidelines. For example, initiation of a moderate to high-intensity statin among patients aged 40-75 years old with diabetes who have not been receiving statin therapy. Another example is recommending a prescription for naloxone among patients at high-risk for an opioid overdose based on submitted diagnoses and medications (eg, morphine dose equivalent > 50 mg morphine units daily, clinical characteristics, a history of a non-opioid substance use disorder, or concomitant use of medications like benzodiazepines). 3. Consider Alternative: Current medications and diagnosis histories are reviewed and pharmacists from the DRRC provide recommendations to prescribers about various alternative

State	Retrospective DUR Educational Outreach
	therapies for consideration in the specific patient. For example, for a patient with fibromyalgia, pharmacists may recommend that prescribers taper off opioid therapy and initiate an appropriate evidence-based therapy (eg, specific antidepressants, pregabalin) along with continuing important non-drug therapies. 4. Additive Toxicity: The concomitant use of medications with similar pharmacodynamic actions that may produce excessive pharmacologic or toxic effects when given together. To minimize additive toxicity, a patient's drug regimen may need to be adjusted to include a decreased number of medications that cause a given toxicity. Pharmacists from the DRRC review medication fills and provide prescribers recommended actions that can be taken to minimize the additive toxicity. 5. Treatment without an Indication: Occasionally, patients may have been continued or started on therapies that do not appear to correlate with current diagnoses. In this case, pharmacists recommend trialing a discontinuation of the therapy. For example, long-term use of a proton-pump inhibitor in the absence of an appropriate indication. 6. Therapy Duplication: The inappropriate use of multiple medications for the same indication. Pharmacists from the DRRC review medication fills and provide prescribers recommended actions that can be taken to optimize member's medication therapy, if clinically appropriate. 7. Medication Over-Utilization: Pharmacists may note that a medication has been used for a longer duration, or more frequently than is usually recommended based on the patient's diagnoses. For example, a patient with asthma frequently filling of a short-acting beta-2 agonist metered dose inhaler especially in the absence of an appropriate controller therapy (eg, inhaled corticosteroid). In this case, the pharmacist would advise the prescriber about the frequent beta-2 agonist prescription fills and advise assessing disease control, inhaler technique, and considering initiation of a controller medication in accordance with the most recent Global Initiative for Asthma (GINA) guideline. 8. Drug-drug Interaction: Occasionally pharmacists will note that a patient fills prescriptions for interacting medications that increase the risk of adverse effects or toxicity when used concurrently. For example, concurrent use of an angiotensin-converting enzyme inhibitor, nonsteroidal anti-inflammatory medication, and diuretic increases the risk for kidney damage. In this case, pharmacists would provide prescribers with information about the risks associated with this combination of medications and advise discontinuing one or more or the medications if feasible, suggest alternative therapies, and monitoring for signs or symptoms of toxicity. 9. Sub-Therapeutic Dose: The use of a medication below the recommended dosage range for the patient's age or condition. Subtherapeutic dosing may cause patients to experience adverse effects without therapeutic benefit or may require the addition of other medications to control a disease state that could be controlled by the use of a single medication at an appropriate dosage level. 10. Streamline Therapy: Some patients fill multiple prescriptions to treat a condition where a reduction in the number of medications or daily doses may be possible. For example, use of multiple antipsychotic medications to treat schizophrenia. In this case, pharmacists may recommend consolidating therapy or switching to an evidence-based antipsychotic for treatment refractory disease (ie, clozapine) in accordance with clinical practice guidelines. For the targeted educational interventions, a 6-month follow-up is conducted to determine if the patients still had the specified DTP 6 months later, among those who were still eligible for Medicaid benefits. On average, the proportions of patients who still had the identified DTP in the follow up month diminished by a monthly average of 72.5% (range 44.4% to 95.7%). These reductions were explained by a combination of (A) a reduction in the numbers of patients still Medicaid eligible at 6

State	Retrospective DUR Educational Outreach
	months (14.1%) as well as (B) a reduction in the numbers of patients who had the DTP among those who continued to have benefits (67.6%).
Vermont	Retrospective Drug Utilization Review (RetroDUR) and Educational Outreach Program FFY 2019 The goal of the Vermont RetroDUR Program is to promote the safe and appropriate prescribing and use of medications. RetroDUR identifies prescribing, dispensing, and utilization patterns which may be clinically and therapeutically inappropriate and may not meet the established clinical practice guidelines. Data is collected and reviewed in detail and presented to the DUR Board. Further analysis is conducted as needed. Depending on the specific issue identified, various interventions are then employed to correct these situations. Prospective edits in the Point of Sale System, educational mailings or new utilization controls such as prior authorization or quantity limits, among others are employed as appropriate. The DVHA RetroDUR program takes an individualized approach to identifying, evaluating and developing improvements specific to each intervention. The cornerstone of the RetroDUR process is based on a review of peer-reviewed evidence as well as considerations of recognized guidelines and best practices. This information is evaluated in the context of the claims reviewed and then reviewed with the DUR Board for input and then interventions, as appropriate, are implemented. DVHA Retrospective DUR and Educational Outreach Summary (FFY 2019) Description Triptan RetroDUR Prescriber Letter Important Changes to Sildenafil Coverage-RetroDUR Changes to Suboxone Film Prior Authorization Requirements Effective October 12 Notice of Legislative Changes Affecting Medicaid-Biosimilars Synagis 2018/2019 Season- Prior Authorization Important Changes to Coverage for Actavis (Labeler 00591) Authorized Generic of Concerta DVHA Pharmacy Newsletter- News and Updates Hematopoietics: Colony Stimulating Factors- Effective 1/1/19 Pharmacy Benefit Update Newsletter- Preferred Drug List (PDL): Effective 1/1/19 DVHA Pharmacy Newsletter- February 2019 Important Changes to Coverage for Brand and Generic Formulations of Retin-A (tretinoin) and Differin (adapalene) DVHA Pharmacy Newsletter- May 2019 DVHA Preferred Drug List (PDL)- Effective 10/11/2019
Virginia	Summary 2 Virginia Medicaid RetroDUR Intervention Activities - FFY 2019 Profile Cycle Profile/Criteria Criteria Description Total Interventions Total Members Total RPhs Total to Nursing Homes Average Response Month-Year Review Date

State	Retrospective DUR Educational Outreach
	Oct-18 Nov-18 Combination Therapy with Opioid and Benzodiazepines 121 70 0 0 38.0% Nov-18 Dec-18 Concomitant Oral and Injectable Antipsychotics 111 101 0 0 38.7% Dec-18 Jan-19 Stimulant Use in Children under Ages of 3 and in Adults 472 421 0 0 29.0% Jan-19 Feb-19 High Risk for an Opioid Overdose and NO Naloxone Claims 365 326 0 0 24.4% Feb-19 Mar-19 Opioid and Gabapentin Concurrent Use 75 49 0 0 25.3% Mar-19 Apr-19 FDA Warning for Increased Risk of Ruptures or Tears in the Aorta with Fluoroquinolones 654 654 0 0 22.8% Apr-19 May-19 Opioid and Pregabalin Concurrent Use 229 143 0 0 31.4% May-19 Jun-19 Gabapentin as a Schedule V Controlled Substance as of July 1, 2019 1,080 1,080 0 0 26.6% May-19 Jun-19 Gabapentin Doses Greater than 3600 mg per day 7 5 0 0 28.6% Jun-19 Jul-19 Atypical Antipsychotics without Metabolic Testing 1,037 961 0 0 28.4% Jul-19 Aug-19 CNS Polypharmacy 526 317 0 0 28.5% Aug-19 Sep-19 Diabetes and HTN without an ACE Inhibitor or ARB 293 263 0 0 23.5% Sep-19 Oct-19 High Risk Medications in the Elderly 151 130 0 0 23.2% FFY 2019 YTD Totals 5,121 4,520
Washington	For FFY 19 the Agency focused our efforts on establishing a single Apple Health Preferred Drug List (AHPDL) to be used by the fee-for-service (FFS) and all five Managed Care (MCOs) pharmacy programs. The pharmacy program in collaboration with the Optimal PDL Solution (TOP$) supplemental rebate vendor reviewed utilization data (FFS claims and MCO encounters) to determine the most cost effective drug classes to implement. We conducted quarterly analysis that resulted in 267 drug classes being added to the AHPDL along with the development of nineteen drug or drug class policies during FFY 19 (see list below). These policies are used as part of our prospective DUR prior authorization review to determine medical necessity, safety and efficacy, or less costly alternatives. The policies and drug classes were reviewed and approved by the State DUR board during the open public meetings held throughout FFY 19. The Agency published all meeting materials and finalized AHPDLs and policies on our Pharmacy webpage and sent provider notices announcing the changes.

State	Retrospective DUR Educational Outreach
	The policies implemented during FFY 19: 1. Antibiotics : Anti-Infective Agents : Oral rifaximin (Xifaxan) 2. Antihyperlipidemics : Apolipoprotein B Synthesis Inhibitors: lomitapide mesylate 3. Antiparasitics : Antiprotozoal Agents : nitazoxanide (Alinia) 4. Brands with Generic Equivalents 5. Cardiovascular Agents : Sinus Node Inhibitors 6. Cardiovascular Agents : valsartan-sacubitril (Entresto) 7. Endocrine and Metabolic Agents : Metabolic Modifiers : X-Linked Hypohosphatemia (XLH) a. Agents burosumab-twza (Crysvita) 8. Endocrine and Metabolic Agents: Metabolic Modifiers - Phenylketonuria (PKU) Agents : sapropterin (Kuvan) 9. Endocrine and Metabolic Agents: Metabolic Modifiers - Phenylketonuria (PKU) a. Agents- Pegvaliase-pqpz (Palynziq) 10. Endocrine and Metobolic Agents : Metobolic Modifiers : Tripeptidyl Peptidase 1 Deficiency a. Agents cerliponase alfa (Brineura) 11. Hematopoietic Agents : Granulocyte Colony Stimulating Factors(G-CSF) 12. Hematopoietic Agents: Erythropoiesis-Stimulating Agents (ESAs) 13. Hematopoietic Agents: Thrombopoiesis(TPO) Stimulating Proteins 14. Migraine Products : Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist 15. Ophthalmic Immunomodulators : lifitegrast 5% ophthalmic solution (Xiidra) 16. Psychotherapeutic and Neurological Agents : MISC : Multiple Sclerosis Agents Ocrelizumab (Ocrevus) 17. Psychotherapeutic and Neurological Agents : MISC : Transthyretin Amyloidosis Agents 18. Pulmonary Fibrosis Agents 19. Respiratory Agents : MISC : Alpha-Proteinase Inhibitor (Human)
West Virginia	Clinical Intervention Program Recognizing that West Virginia has unique health care needs, the Marshall DUR Coalition sought to identify specific clinical interventions that would have the most benefit for WV Medicaid clients as well as cost savings. A total of 2308 profiles were reviewed for the clinical programs. Of the Clinical members reviewed, 58% (1335) received an intervention (letter). The following clinical interventions were approved and prioritized by the WV DUR Board. In order of prioritization: 1. Concurrent Opioid and Benzodiazepine Therapy Patients who receive an opioid equivalent to 50 MME or greater and also receive a benzodiazepine are at a higher risk of respiratory failure. Lower opioid dosages with underlying lung disease or other therapy which contributes to respiratory depression place the patient at risk. Total profiles reviewed: 1387 Letters sent: 911 Letter rate: 66% 2. GERD and PPI therapy greater than 90 days The usual duration of PPI therapy in GERD is 8 weeks (about 60 days). Long-term PPI therapy is associated with osteoporosis and fractures, pneumonia, hypomagnesemia, and Clostridium difficile (C. diff) infections.

State	Retrospective DUR Educational Outreach
	Total profiles reviewed: 286 Letters sent: 156 Letter rate: 55% 3. Diagnosis of Diabetes Mellitus (DM) without either an ACE Inhibitor or an ARB Many studies have demonstrated the benefit of ACE inhibitors or ARBs in DM patients, including the prevention of both macrovascular and microvascular complications, with moderate hypertension. Data from the ONTARGET Trial showed that both telmisartan and ramipril offered equivalent renal protection. Clinical guidelines for the management of DM strongly recommend the use of an ACE Inhibitor or ARB if tolerated. RetroDUR Committee clinicians look for diagnoses or signs of adverse effect which may restrict the use of ACE Inhibitors or ARBs prior to prescribers receiving a letter. Total profiles reviewed: 161 Letters sent: 88 Letter rate: 55% 4. Diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD) without statin therapy The 2018 Cholesterol Clinical Practice Guidelines recommend intensive statin therapy for patients who are 75 years of age or younger with clinical ASCVD. Intensive statin therapy can only be achieved with atorvastatin or rosuvastatin. Evidence is suggestive that cholesterol-lowering alone does not explain all the benefits of statin therapy in ASCVD. RetroDUR Committee clinicians look for evidence that a statin is not tolerated prior to prescribers receiving a letter. Total profiles reviewed: 158 Letters sent: 26 Letter rate: 16% 5. Concurrent GLP-1 receptor agonists and DPP-4 inhibitor therapy The mechanisms of actions of GLP-1 receptor agonists and DPP-4 inhibitor therapy overlap to some degree leading to the likelihood concurrent therapy is less beneficial than if another agent had been selected. DPP4-inhibitors decrease the elimination of gut incretins and GLP-1 is a gut incretin. Prescribers receive a letter explaining this overlap of mechanisms of action. Total profiles reviewed: 105 Letters sent: 44 Letter rate: 42% 6. CHF and concurrent NSAID therapy NSAIDs are not to be used in patients with CHF per the Heart Failure guidelines. There are several mechanisms of adverse effects however the most rapid adverse effect is fluid accumulation due to inhibiting prostaglandin activity in the kidneys. NSAIDs also have been shown to blunt the effects of diuretics in CHF patients. Patients who have CHF and are receiving systemic NSAIDs have a greatly increased incidence of hospitalizations due to acute CHF exacerbation. The American Heart Association guidelines on heart failure strongly discourage their use and indicate these agents cause harm to such patients. Total profiles reviewed: 98

State	Retrospective DUR Educational Outreach
	Letters sent: 44 Letter rate: 45% 7. Diagnosis of Helicobacter pylori and PPI therapy greater than 14 days The usual maximal duration of therapy for the treatment of Helicobacter pylori is 14 days with PPI therapy. Long-term PPI therapy is associated with osteoporosis and fractures, pneumonia, hypomagnesemia, and Clostridium difficile (C. diff) infections. Total profiles reviewed: 39 Letters sent: 17 Letter rate: 44% 8. Heart Failure with Reduced Ejection Fraction (HFrEF) and on diltiazem or verapamil Diltiazem and verapamil are non-dihydropyridine calcium channel blockers and have strong negative inotropic effects further suppressing the ability of the heart to contract adequately. The American Heart Association guidelines on heart failure strongly discourage their use and indicate these agents cause harm to HFrEF patients. Total profiles reviewed: 4 Letters sent: 3 Letter rate: 75% 9. CHF and on a thiazolidinedione (pioglitazone or rosiglitazone) The thiazolidinedione class has been proven to increase the risk of and worsen existing CHF. The American Heart Association guidelines on heart failure discourages their concurrent use with CHF and warn these agents cause harm to CHF patients. Likewise, the 2020 American Diabetes Association's Standards of Medical Care also recommends avoiding the thiazolidinedione class in patients who are at risk for CHF or have existing CHF. Total profiles reviewed: 53 Letters sent: 31 Letter rate: 55% 10. CHF and Dronedarone therapy Several clinical trials have established an increased risk of mortality and stroke in CHF patients. Dronedarone has a Black Box Warning against use in patients with decompensated heart failure. The American Heart Association guidelines on heart failure discourages their concurrent use of Dronedarone with CHF. Total profiles reviewed: 2 Letters sent: 2 Letter rate: 100% The Marshall DUR Coalition overall saw a 78% reduction in patients being admitted or visiting the ED, a 71% reduction in claims, and a 64% reduction in charges between the pre-post intervention periods.
Wisconsin	Executive Summary

State	Retrospective DUR Educational Outreach
	This report prepared for the Wisconsin Badger Care Plus, Medicaid and SeniorCare Program summarizes the top 10 Retrospective Drug Utilization Review (RDUR) interventions as ranked by the number of criteria exceptions reviewed during Federal Fiscal Year (FFY) 2019. Intervention letters are mailed to prescribers to encourage appropriate prescribing and improve drug utilization, which will, in turn, prevent possible adverse drug reactions and improve patient outcomes in the targeted recipient population. Program Background Health Information Designs, LLC (HID) currently provides RDUR services for the Wisconsin Badger Care Plus, Medicaid and SeniorCare population. In an effort to promote appropriate prescribing and utilization of medications, HID evaluates claims data against selected criteria on a monthly basis to identify recipients with drug therapy issues and mails the corresponding educational intervention letters to those recipients' prescribers. A copy of the recipient's complete drug and diagnosis history, including medications prescribed by other providers, is also provided with the letter. Prescribers have the opportunity to review the entire drug and diagnosis history and make changes to therapies based on this information. Analysis Methodology Each month HID evaluates Wisconsin Badger Care Plus, Medicaid and SeniorCare pharmacy claims data against criteria for several hundred potential drug therapy issues. Standard criteria are developed by HID with any customized applications presented to the Wisconsin Drug Utilization Review Board for approval and implementation. Recipient Selection The drug history and diagnosis profile for each recipient who meets the selected criteria are reviewed by an HID clinical pharmacist to determine if the recipient should be selected for intervention. After recipients are selected for intervention, educational intervention letters are mailed to all prescribers of drugs included in the criteria. Letters are sent with a complete drug history and all diagnoses obtained from claims data submitted during the past 12 months. Some letters cannot be mailed or are returned after mailing due to missing or invalid provider addresses. Once a recipient is selected for intervention, the specific criteria are suppressed by the RDUR system for that recipient for up to 12 months so that duplicate letters for the same problem are not mailed to the same prescriber month after month. However, recipients could be selected for additional criteria exceptions later in the year. Recipients may also be selected for more than one intervention in a given monthly cycle or for another intervention in a later cycle. Retrospective DUR Intervention Summary The table below is a summary of standard educational outreach letters mailed for the top 10 retrospective DUR interventions based on the number of therapeutic criteria exceptions reviewed for each criteria type. For FFY 2019, Wisconsin reviewed at least one recipient in each of 360 different criteria. In addition to these standard HID criteria, Wisconsin performs targeted interventions that include custom prescriber education letters addressing potential medication issues. These interventions include an opioid and benzodiazepine intervention, and recipients receiving a drug in each of the following drug classes: opioid agonist, opioid dependency, stimulants, benzodiazepines, and sedative hypnotics.

State	Retrospective DUR Educational Outreach

WISCONSIN BADGER CARE PLUS, MEDICAID AND SENIORCARE STANDARD EDUCATIONAL OUTREACH SUMMARY
FFY 2019

CRITERIA TYPE	CRITERIA DESCRIPTION	# OF RECIPIENTS SELECTED FOR INTERVENTION	# OF LETTERS MAILED	# OF PRESCRIBER RESPONSES
LI	OVERUTILIZATION OF CONTROLLED SUBTANCES	888	1,366	333
ER	APPROPRIATE USE OF IMMEDIATE RELEASE OPIOIDS	26	38	5
LI	OVERUTILIZATION OF CONTROLLED SUBTANCES W/ POISIONING	454	735	181
TA	MULTI-CLASS POLYPSYCHOPHARMACY	13	14	0
TA	SECOND GENERATION ANTIPSYCHOTICS METABOLIC SCREENING	25	36	4
LR	LOW DOSE QUETIAPINE USE	96	104	26
ER	OVERUTILIZATION OF STIMULANTS/HIGH DOSE	138	160	40
TA	ANTIDEPRESSANT BEHAVIOR CHANGES IN PEDS/YOUNG ADULTS	143	202	39
DD	CONCURRENT OPIOID/ANTIPSYCHOTIC USE SUPPORT ACT	399	985	150
TA	ASTHMA TREATMENT INHALED CORTICOSTEROIDS	382	452	111
	TOTAL	2,564	4,092	889
RESPONSE RATE		22%		

Prescriber Response Tabulation
In addition to the intervention letter and the recipient's drug and diagnosis history, a response form is included in the mailings. The response form allows prescribers to give feedback and informs HID if any action will be taken in response to the letter. The response form contains standard responses that allow the provider to check a box for the response that best fits their intended action and provides space for handwritten comments.
Providers are encouraged to return the response form using the self-addressed, stamped envelope included with the intervention letter or send the form via fax. HID tracks all returned response forms.

Results

Provider Responses to Intervention Letters
A total of 4,092 DUR educational intervention letters were mailed to prescribers for the top 10 DUR criteria, and 889 responses were received for a response rate of 22%. A summary of all coded responses from prescribers is listed in the table below.

RESPONSE CODE	PRESCRIBER RESPONSE	# OF RESPONSES
AA	BENEFITS OF THE DRUG OUTWEIGH THE RISKS	179
AB	PHYSICIAN UNAWARE OF CONCURRENT USE	16
AE	PATIENT IS NO LONGER UNDER THIS PHYSICIAN'S CARE	157
AF	PHYSICIAN FEELS PROBLEM IS INSIGNIFICANT. NO CHANGE IN TX.	18
AG	PHYSICIAN WILL REASSESS AND MODIFY DRUG THERAPY	104
AI	PATIENT HAS DISCONTINUED OR WILL DISCONTINUE THE DRUG	48
AK	MD DOES NOT DISCUSS DRUG THERAPY CONFLICT	7
AP	PHYSICIAN TRIED TO MODIFY THERAPY, PATIENT NON-COOPERATIVE	32
AS	IS MY PATIENT BUT HAVE NOT SEEN IN MOST RECENT 6 MONTHS	47

State	Retrospective DUR Educational Outreach
	AW PATIENT DECEASED 5 BA PATIENT NEVER UNDER THIS PHYSICIAN'S CARE 35 BB PATIENT HAS APPT. TO DISCUSS DRUG THERAPY PROBLEM 43 BE MD DID NOT PRESCRIBE DRUG ATTRIBUTED TO HIM/HER 30 BG AWARE OF INTERACTION, MONITORING PATIENT 168 TOTAL RESPONSES 889 Results Discussion With respect to prescriber responses to RDUR letters, a response rate of 22% was achieved. Approximately 46% of prescribers indicated that some positive action resulted from the intervention letter. These actions include: prescriber was alerted to unknown concurrent use, patient has an appointment to discuss therapy, will reassess and modify drug therapy, therapy was discontinued, tried to modify therapy, currently monitoring patient. All standard, and most customized, intervention letters include the recipient's drug claims data within the previous 12 months and any available diagnosis data to provide as complete of a drug and diagnosis history as possible. This approach provides prescribers and pharmacies with the information needed to fully review and evaluate each recipient's drug history. Conclusion For FFY 2019, a total of 4,092 intervention letters for the top 10 criteria alerts were mailed to prescribers, and a response rate of 22% was achieved. In their responses, 46% of prescribers indicated that some positive action had been or would be taken to address the drug therapy issue identified in the intervention letter.
Wyoming	Wyoming converted from the traditional retrospective profile review and individual letters to comparative prescriber reports on targeted prescribing issues in FFY15. The Wyoming DUR program sent education letters or comparative reports on the following topics in FFY19: Concurrent use of gabapentin and opioids (23) Guidelines for prescribing opioids for chronic pain (326) Concurrent antipsychotic use (18) Febuxostat (Uloric) prescribing (153) Concurrent use of stimulants and opioids (9) Benzodiazepine use in pregnancy (336) Controlled substance prescribing trends (20) Global Initiative for Asthma Guidelines Update (520) Narcotic use during pregnancy (36) Prescription drug monitoring program (102)

Section IV - DUR Board Activity

1. Summary 3 – DUR Board Activities Report

Summary 3 DUR Board Activities Report should be a brief descriptive report on DUR Board activities during the fiscal year reported. Please provide a detailed summary below:

Table 54 - DUR Board Activities

State	DUR Board Activities Report
Alabama	Attachment 3 Summary of DUR Board Activities The Alabama Medicaid Drug Utilization Review (DUR) Board held four meetings during fiscal year 2019. Meetings were held in October 2018 and January, April, and July of 2019. The following retrospective DUR (RDUR) therapeutic categories were added: Therapeutic Appropriateness Overutilization Drug-Disease Interaction Drug-Drug Interaction High Dose Non-Adherence Therapeutic Effectiveness Therapeutic Duplication Appropriate Use There were no RDUR therapeutic categories deleted during fiscal year 2019. Retrospective DUR and Prospective DUR (ProDUR) are both utilization review techniques; however, the methods used in each type of review differ. ProDUR is an online review that assists the pharmacist in screening drugs for potential drug therapy problems before the prescription is ever delivered to the patient. Reports generated from prospective DUR can show trends and patterns to focus on during a manual review using Retro DUR techniques and provides valuable targeting for educational intervention. DUR Board policy establishes activities of the DUR Board and states that the DUR Board shall identify and develop topics of education for practitioners based on common identified drug therapy problems as needed to improve prescribing or dispensing practices. During FFY 2019, the DUR Board recommended articles for the quarterly newsletter, as well as verbiage for electronic based intervention letters to providers that contain patient specific information. Articles included information regarding the Centers for Disease Control and Prevention (CDC) guidance on influenza vaccination in children; information regarding the Morphine Milligram Equivalent (MME) edit; AL Medicaid Smoking Cessation services guidance and covered Smoking Cessation product information; The Comprehensive Addiction and Recovery Act (CARA) of 2016 and partial filling of a Scheduled II controlled substance; Hepatitis A virus and vaccine information; and guidelines regarding the use of Dispense as Written (DAW) code of 9. During FFY 2019, the DUR Board reviewed palivizumab utilization. For FFY 2019, the DUR Board reviewed opioid utilization trends, the short-acting opioid naive override edit, and the morphine

State	DUR Board Activities Report
	milligram equivalent edit. The DUR Board voted and approved two criteria related to the SUPPORT Act of 2018. DUR minutes can be located at the following link: http://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME/4.3.3_DUR_Board.aspx
Alaska	General Information The Alaska Medicaid Drug Utilization Review (DUR) Committee was established to comply with Sec. 1927 (g) of the Social Security Act, Title 42 CFR 456 and Alaska Administrative Code 7 AAC 120.120. During FFY 2019 the committee was comprised primarily of 4 physicians and 4 pharmacists, who were licensed and actively practicing health care professionals in the State of Alaska. The DUR committee met four times during FFY 2019 and discussed the following retrospective and prospective criteria: November 2018 - Prospective DUR Interim prior authorization 6 month review Orilissa (review of criteria) CGRP antagonists (review of criteria) Epidiolex (review of criteria) Xyrem (review of criteria) HP Acthar (review of criteria) Lidoderm (review of criteria) - Retrospective DUR Opioids, utilization patterns, ICD-10 compliance Gabapentin/pregabalin letters sent to providers Dental analgesia protocol update January 2019 - Prospective DUR Interim prior authorization 6 month review Baxdela (review of criteria) Lucemyra (review of criteria) Palanziq (review of criteria) Neudexta (review of criteria) Hetlioz (review of criteria) - Retrospective DUR Opioids, utilization patterns, ICD-10 compliance April 2019 - Prospective DUR Interim prior authorization 6 month review Crysvita (review of criteria) VMAT2 inhibitors (review of criteria) Hemlibra (review of criteria) Stelara (review of criteria) Orkambi (review of criteria) Orilissa (review of criteria) Benzodiazepines (review of criteria and quantity limits) - Retrospective DUR Opioid MME limits discussion Sept 2019

State	DUR Board Activities Report
	- Prospective DUR Interim prior authorization 6 month review Mavenclad (review of criteria) Mayzent (review of criteria) Sunosi (review of criteria) Emflaza (review of criteria) Clobazam (review of criteria) Relistor (review of criteria) HMG-CoA reductase inhibitors (retired criteria) - Retrospective DUR Reviewed opioid utilization Prospective Drug Utilization Review (ProDUR) The DUR Committee has continued their attention on ProDUR issues during FFY 2019. New prior authorizations and quantity limit edits were approved to address issues of actual or potential fraud, waste, abuse, misuse, overuse or medically unnecessary care. Emphasis was also given to review of existing criteria to ensure relevancy and medical appropriateness. ProDUR interventions are monitored periodically and presented to the committee to assess the success of the intervention and to determine if additional edits are required to address safety or utilization issues. Modifying current edits to other drug classes has been a good tool in maintaining cost effective use of generics and reduce the amount of possible waste and overutilization. The biggest challenge and most consuming issues during FFY 2019 revolved around opioid use and Medication Assisted Therapy. Retrospective Drug Utilization Review (RetroDUR) The DUR Committee conducted retrospective reviews during FFY 2019. The criteria for claims review are frequently selected by the committee coordinator based on trend reports or suggested drug related issues by the committee members. In addition to the selected criteria members review for therapeutic duplication, drug interactions, overutilization, and poly-providers usage. The retrospective reviews periodically unearthed opportunities to consider the development of prospective edits. RetroDUR issues are generally addressed with educational interventions such as prescriber letters or direct prescriber contact via phone. The logistics of face-to-face interactions with prescribers is difficult due to the large geography of the state with many communities having limited road access. The DUR Committee may also refer potential cases of overutilization or fraud, waste or abuse identified during the RetroDUR to the Care Management program and/or the Program Integrity unit. Relaying relevant prescription information to providers is a challenge. One enhancement the committee is attempting to use to further communicate with providers is automatic emails delivered by GovDelivery. Additionally, data trends identified by other organizations such the FDA (e.g. FAERS reports), Pharmacy Quality Alliance [PQA] (e.g. quality measures), and the Drug Abuse Warning Network [DAWN] (e.g. DAWN reports) have been incorporated to aid in directing our focus on nationally identified issues. Given our smaller relative patient population and regional isolation, trends observed nationally may not have triggered signals in our data. By evaluating nationally identified trends in our own data, we hope to catch the early signals and work on prevention initiatives before they blossom into larger issues.
Arkansas	Summary of Arkansas Medicaid DUR Board Activities for FFY 2019: CMS Survey Report The Arkansas Medicaid DUR Board meets quarterly (January, April, July, and October) on the 3rd Wednesday of the meeting month. The Arkansas Medicaid Drug Review Committee (DRC) meets quarterly (February, May, August, and November) on the 2nd Wednesday of the meeting month to discuss preferred drug list changes.

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	ProDUR alert level is set at the highest severity level to avoid false positive messages. In the ProDUR Early Refill (ER) overrides, the Program decision was to implement a system edit to stop the override rather than use an educational approach with the RDUR vendor. Therefore, the POS DUR override for early refill is minimal. It is more beneficial to our program to actually review the drugs involved in the different ProDUR categories causing the overrides than to review massive reports on individual pharmacies or to develop RDUR educational letters. The AR Medicaid DUR Board reviews and approves all RDUR educational intervention criteria and educational flyers that are mailed to Medicaid enrolled providers. Educational letters based on the Board approved criteria are mailed to providers who have patients identified with the review criteria. Leading up to the deadline for meeting the SUPPORT Act requirements, ProDUR edits were put into place and RDUR review/educational criteria was established. The RDUR program typically provides the following information: top therapeutic categories by claims cost, top drugs by claims cost, and program summary with cost PMPM and state comparison. Results of these reports prompt updates to ProDUR criteria and PDL changes. Providing education to prescribers and pharmacies is an important part of our DUR program. Quarterly, a provider memo is posted on the contractor website and Medicaid website with new information approved during the DUR and DRC meetings. The contractor also tracks changes made during the DUR Board meeting by updating a PA criteria document with links to memos and criteria that is posted on their website as well. Prescribers and pharmacy providers are emailed the link to the new memos when posted. October 2018 The DUR Board discussed and established manual review criteria for Spiriva Respimat, Orilissa, Doptelet, Mulpleta, Siklos, Mektovi, Braftovi, and Lokelma. ProDUR reports were provided by the contractor which included drugs with ProDUR alert overrides along with percentages of claims overridden. Approximate percentages of ProDUR alerts overridden by the pharmacists for therapeutic duplication (TD) was 33.8%, early refill (ER) was <1%, drug-drug interaction (DD) was 15.5%, incorrect duration (ID) was 49.5% and high dose (HD) was 49.5%. RDUR reports provided the impact of RDUR interventions performed 6 months prior which included underutilization of multiple agents, gabapentin with benzodiazepines, and low-dose quetiapine. RDUR reports also discussed pharmacy lock-ins, top therapeutic categories and top drugs by claims cost, and program summary with cost PMPM and state comparison. During this quarterly meeting, an outlying prescriber report for total cost was provided for review. The contractor consulted with the Board on RDUR educational intervention criteria recommendations. The Board approved criteria for educational intervention for the next quarter for the following agents/classes: Rydapt, Nerlynx, underutilization of multiple antipsychotics (ziprasidone, clozapine, risperidone, quetiapine, paliperidone, aripiprazole, cariprazine, iloperidone, lurasidone, asenapine, brexpiprazole, pimavanserin, haloperidol, fluphenazine, loxapine, molindone, perphenazine, pimozide, thioridazine, thiothixene, trifluoperazine, chlorpromazine), aliskiren, atomoxetine, opioids with benzodiazepines, Synjardy, Nucala, Steglujan, Dexilant, Alecensa, and Xeljanz. January 2019

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	Manual review criteria for Jakafi (update to existing criteria), Xofluza, Ryclora, Copiktra, Vizimpro, Epidiolex, Nocdurna, Lobrena and Galafold were established. Updates to point-of-sale criteria were made for Zortress and Qbrexza. ProDUR reports were provided by the contractor which included drugs with ProDUR alert overrides along with percentages of claims overridden. Approximate percentages of ProDUR alerts overridden by the pharmacists for therapeutic duplication (TD) was 34.4%, early refill (ER) was <1%, drug-drug interaction (DD) was 17.1%, incorrect duration (ID) was 49.1% and high dose (HD) was 49.1%. RDUR reports provided the impact of RDUR interventions performed 6 months prior which included proper use of NSAIDs, use of CII stimulants, and low-doses of quetiapine. RDUR reports also discussed pharmacy lock-ins, top therapeutic categories and top drugs by claims cost, and program summary with cost PMPM and state comparison. During this quarterly meeting, an outlying prescriber report for total cost was provided for review. The contractor consulted with the Board on RDUR educational intervention criteria recommendations. The Board approved criteria for educational intervention for the next quarter for the following agents/classes: Apadaz, Saphris, Austedo, Verzenio, amantadine, Segluromet, Nuedexta, Xolair, Orkambi, Rayaldee, oral contraceptives with family planning, Uptravi, Daliresp, Soliqua, Xultophy, and Orilissa. April 2019 Manual review criteria was updated for all medications for hereditary angioedema therapy and criteria for oral antipsychotic agents for adults with quantity limits. The DUR Board discussed and established manual review criteria for Dupixent, Daurismo, Xospata, Vitrakvi, Sympazan, Talzenna, Tegsedi, and Arikayce. New claim edits were implemented for Primaquine and Krintafel. ProDUR reports were provided by the contractor which included drugs with ProDUR alert overrides along with percentages of claims overridden. Approximate percentages of ProDUR alerts overridden by the pharmacists for therapeutic duplication (TD) was 33.6%, early refill (ER) was <1%, drug-drug interaction (DD) was 16.5%, incorrect duration (ID) was 51.4% and high dose (HD) was 51.4%. RDUR reports provided the impact of RDUR interventions performed 6 months prior which included underutilization of multiple agents, medications affecting pregnancy and lactation, and medication overdose. RDUR reports also discussed pharmacy lock-ins, top therapeutic categories and top drugs by claims cost, and program summary with cost PMPM and state comparison. During this quarterly meeting, an outlying prescriber report for total cost was provided for review. The contractor consulted with the Board on RDUR educational intervention criteria recommendations. The Board approved criteria for educational intervention for the next quarter for the following agents/classes: Symtuza, opioids with antipsychotics, benzodiazepines with opioids, Symdeko, Baxdela, Lenvima, Epidiolex, Olumiant, fluoroquinolines, Bonjesta and Tagrisso. July 2019 Based on previous changes to opioids with maximum quantities, accumulation edits and MME updates, an update on opioid usage was provided to the Board. Updated medication-assisted treatment forms were presented to the Board. Manual review criteria was updated for Emflaza, proton pump inhibitors, and osteoporosis agents. The DUR Board discussed and established manual review criteria for Nuzyra, Abilify Mycite, Firdapse, Ruzurgi, Balversa, all Alpha-1 proteinase inhibitors, Hepatitis C agents in pediatrics, Tibsovo, Tarceva and Vyndaqel/Vyndamax.

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	ProDUR report: The contractor explained ProDUR reporting to our new Board members, but they did not present a ProDUR report during this meeting as data from the PASSEs skewed the numbers generating incorrect reporting. Arkansas Medicaid added our first MCOs (also called PASSEs) in March 2019. Reporting was not accurate until all encounter data was provided which did not occur in FFY 2019. RDUR reports provided the impact of RDUR interventions performed 6 months prior which included appropriate use of atypical antipsychotics, criteria around AHA/ACC hypertension guidelines and pediatric appropriate use and adult polypharmacy with opioids. RDUR reports also discussed pharmacy lock-ins, top therapeutic categories and top drugs by claims cost, and program summary with cost PMPM and state comparison. The contractor consulted with the Board on RDUR educational intervention criteria recommendations. The Board approved criteria for educational intervention for the next quarter for the following agents/classes: Kevzara, amantadine, Trogarzo, new CGRP injections (Aimovig, Ajovy, and Emgality), Talzenna, Triptans, Dupixent, itraconazole, fluoroquinolines, buprenorphine transdermal, Calquence, and Motegrity.
California	The DUR Board met four times during FFY 2019. Prospective DUR Criteria Presented 1. Therapeutic Duplication (TD) Alert - An issue was discovered within the Medi-Cal prospective DUR system in which turning off the ingredient duplication (ID) alert for a drug may lead instead to a therapeutic duplication (TD) alert, unless the TD alert is also turned off for a specific drug. This is due to the Duplicate Therapy Module combining ID and TD alerts into one single alert. The issue was discovered when investigating why there were so many TD alerts being generated for quetiapine. The Board had previously recommended turning off the ID alert for quetiapine, which then caused the ID alerts that had been generated by two formulations of quetiapine to instead trigger TD alerts. The same problem was observed with lithium, which had the ID alert turned off for all non-300 mg formulations. The Board recommended to turn off the TD alert for lithium for non-300 mg formulations and to turn back on the ID alert for all formulations of quetiapine, in order to distinguish between true therapeutic duplication with other antipsychotic medications. 2. Additive Toxicity (AT) Alert: Gabapentinoids - A proposal to add gabapentinoids to the list of drugs for the AT alert based on side effect profile, literature review, and analysis of pharmacy claims data was presented. States are limiting claims to FDA-approved diagnoses or have taken legislative action to classify gabapentin as a scheduled drug, in order to allow gabapentin claims to be reported as part of the prescription drug monitoring program. Effective April 15, 2019, both pregabalin and gabapentin were added to the list of drugs for the AT alert based on side effect profile, literature review, and analysis of pharmacy claims data. An initial review demonstrated a 12% increase in AT alerts since that time, and alert burden will continue to be monitored over time. 3. Review of new Generic Code Number (GCN) sequence numbers: The DUR Board recommended turning on additional alerts for 55 new GCNs that matched drugs appearing on the Medi-Cal target drug list for prospective DUR. Retrospective DUR Criteria Presented 1. Review of Retrospective DUR Criteria: New Additions to the Medi-Cal List of Contract Drugs in FFY 2017 - During FFY 2017 there were a total of 16 new prescription medications added to the Medi-Cal List of Contract Drugs. Utilization data (total number of paid claims and utilizing beneficiaries with at

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	least one paid claim) were reviewed for each of these drugs. Thirteen drugs had low utilization (< 20 utilizing beneficiaries during all of the months reviewed) and were not reported in detail. The Board did not suggest additional evaluation for any of these drugs. 2. Hepatitis C Virus (HCV) Drugs: HCV medication utilization is reviewed on an annual basis, primarily to evaluate potential HCV reinfection and retreatment in the Medi-Cal FFS population. Data showed a 32% decrease in total utilizing beneficiaries with a paid claim for an HCV treatment medication since the previous evaluation. However, after the July 2018 policy change a slight increase was noted in new starts (29.5 in July and August 2018, in comparison to 22.4 new starts in the preceding 10 months). A review of drug utilization over time showed an increase in beneficiaries with paid claims for glecaprevir/pibrentasvir, which was added to the Medi-Cal Fee-for-Service List of Contract Drugs on January 1, 2018. Of note, there were no claims for ombitasvir/paritaprevir/ritonavir/dasabuvir or simeprevir during FFY 2018. A review of medical claims data found that all beneficiaries with a paid claim for an HCV treatment medication had at least one HCV-RNA level, HCV genotype test, and comprehensive metabolic panel, which follows AASLD-IDSA recommended guidelines. The Board recommended continuing with annual review. 3. Gabapentinoids - A retrospective DUR review found that a total of 393,514 Medi-Cal enrollees had a paid claim for a gabapentinoid during calendar year 2018, including a total of 38,532 FFS enrollees (4,102 of these were continuously-eligible in the FFS program for all of calendar year 2018). Utilization trends showed increasing use of gabapentinoids over time and only 12% of continuously eligible FFS beneficiaries had an FDA-approved indication for a gabapentinoid within the last five years. The Board agreed that gabapentinoids, specifically gabapentin, should be the topic of an educational bulletin. DUR Board Involvement in Provider-specific Interventions: The DUR Board advises and makes recommendations for educational articles, alerts, and provider intervention letters. The Board chair may appoint a Board member with subject matter expertise to perform a focused review, as appropriate. Educational articles and alerts: 1. Alert: New Naloxone Regulations Effective on January 1, 2019 2. Clinical Review Update: Morphine Equivalent Daily Dose 3. Drug Safety Communication: Updated Adverse Effects from Fluoroquinolones 4. Drug Safety Communication: Risks with Sudden Discontinuation of Opioids 5. Drug Safety Communication: Sleep Behavior Risks with Select Sleep Aids 6. Clinical Review Update: Concomitant Anticholinergic and Antipsychotic Use 7. 2019 Immunization Updates: Flu, HepA, HPV, Measles, CA School Requirements Provider intervention letters: 1. Additive Toxicity Letter - January 2019 2. MEDD - April 2019 3. Tramadol Letter - July 2019 4. Codeine Letter - August 2019 5. Zolpidem Letter - August 2019 Ongoing DUR Board projects: The DUR Board goals for FFY 2019 were as follows: 1. Advise DHCS regarding the revision of DUR reports to include drugs commonly used in both Medi-Cal Fee-for-Service (FFS) and Managed Care Organizations (MCOs) 2. Promote dialogue, collaboration among MCOs o Present best practices and projects

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	o Share innovative ideas and lessons learned o Update list of priority areas (topic clusters) o Disseminate DUR educational bulletins o Integrate/align FFS and MCO DUR action items 3. Align goals with DHCS Quality Strategy o Better health, better care, lower cost 4. Advise DHCS in the implementation of Medicaid Drug Utilization and Review Minimum Standards for the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act 5. Priority Area Topic Clusters o Optimizing Drug Prescribing and Dispensing, including specialty drugs o Optimizing Pain Management and Opioids o Optimizing Chronic Disease Management, including prevention
Colorado	Question 1: Four DUR Board meetings in total in FFY2019: November 13, 2018; February 12, 2019; May 14, 2019; August 13, 2019 Question 2a: The following summary highlights changes and coverage criteria reviewed during quarterly DUR Board meetings during FFY2019 (relating to prospective DUR): Antidepressants Drug Class: Loosened restrictions on duloxetine Antiemetics Drug Class: Diagnosis limitations for Dronabinol, Limitations for Bonjesta Antipsoriatics Drug Class: Newly added PDL drug class criteria reviewed Ulcerative Colitis Agents Drug Class: Newly added PDL drug class criteria reviewed Hepatitis C Virus Treatments Drug Class: Addition of ribavirin management to drug class Antihyperuricemics Drug Class: Newly added PDL drug class criteria reviewed NSAIDs Drug Class: Addition of QL and days supply limits to ketorolac PPIs: Removal of PA requirements for preferred products Antipsychotics: Addition of genetic metabolic polymorphism to failure definition, limitations for Abilify MyCite CGRP Inhibitors Drug Class: Newly added PDL drug class criteria reviewed Intranasal Rhinitis Drug Class: Expanded drug class to include management of non-steroidal agents Lipotropics and Bile Salt Agents: Newly added PDL drug class criteria reviewed Parkinson's Disease Agents Drug Class: Newly added PDL drug class criteria reviewed Ophthalmic Glaucoma Agents Drug Class: Newly added PDL drug class criteria reviewed Topical Steroids Drug Class: Newly added PDL drug class criteria reviewed Rosacea Agents Drug Class: Newly added PDL drug class criteria reviewed Opioids: Addition of limitation for dental opioid prescriptions, removal of certain limitations on Nucynta IR and Butrans, addition of limitations for methadone prescribed for pain Phosphate Binders Drug Class: Newly added PDL drug class criteria reviewed Benign Prostatic Hyperplasia Drug Class: Newly added PDL drug class criteria reviewed GLP-1 Analogues Drug Class: Addition of max dose limitations Stimulants Drug Class: Changes to age and indication limitations The DUR Board also reviewed coverage criteria for the following individual products not contained within PDL drug classes: Syprine (trientine hydrochloride), Dificid (fidaxomycin), Orilissa (elagolix), Alinia (nitazoxanide), Vyzulta (latanoprostene bunod), Rhopressa (netarsudil), Solosec (secnidazole), PSK9 Inhibitors, Xyrem (sodium oxybate), Sivextro (tedizolid), Fasenra (benrelizumab), Dihydroergotamine products, Changes to expand OTC product coverge, Dupixent (dupilumab), Ilumya (tildrakizumab-asmn), Infliximab products, Doxepin, and Oxandrin (oxandrolone)

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	Questions 2b: The following are examples of retrospective DUR activities reviewed by the DUR Board during FFY2019: Proposed opioid policy change for concomitant utilization of opioids and benzodiazepines based on data from retrospective DUR analysis Proposed opioid policy change for dental opioid prescriptions based on data from retrospective DUR analysis Evaluation of prescriber educational outreach letter identifying patients/members with multiple claims for opioid prescriptions that total an amount > 200MME calculated as a daily dose averaged over a 30-day period Retrospective analysis of opioid plus antipsychotic utilization Retrospective analysis of members receiving an opioid, benzodiazepine, and muscle relaxant medication concomitantly for 45 days during the measurement quarter Retrospective analysis of children receiving 2 or more antipsychotics for >45 days of measurement quarter Retrospective analysis of children receiving 3 or more psychotropic medications for >45 days of measurement quarter Prescriber educational letter regarding potential change in therapy for fluoxetine 60mg tablet (recommendations to use capsule) Retrospective analysis for all other fluoxetine formulations Question 3: There are not written policies regarding using ProDUR to change RDUR or vice-versa. The Board reviews trends in the RDUR reports on a quarterly basis, which has in a couple cases, led to further analyses completed by the CO-DUR team and subsequent recommendations provided to the Colorado Department of Health Care Policy and Financing (HCPF). Inversely, ProDUR criteria can influence RDUR if there is a lot of activity with a drug/drug class and is believed to require more regular monitoring for impact of ProDUR changes (i.e. opioids and psychotropic medication use in children). Question 4: CO-DUR did not publish educational newsletters during FFY 2019, funds were re-allocated to manage an influx in the pain management specialty consult service volume. The Board is not involved with the consult service. Interventional letters are sent on a quarterly basis and tend to include rotating intervention topics such as; high risk opioid prescribing, high risk benzodiazepine prescribing, and high risk psychotropic prescribing in children.
Connecticut	Indicate the number of DUR Board meetings held. Four DUR Board meetings were held during FFY 2019; December 2018, March 2019, June 2019, and September 2019. See link below for meeting minutes. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Minutes.pdf DUR BOARD MEMBERSHIP - 10/01/2018 to 09/30/2019 Kenneth Fisher, R.Ph. (Chair), Dennis Chapron, M.S., R.Ph., Richard Gannon, Pharm.D., Keith Lyke, R.Ph., Bhupesh Mangla, M.D., MPH., Ram Illindala, M.D., Carol Drufva, R.Ph., Angela Boggs, Pharm.D. BCPP, Damian Dos Santos, M.D. List additions/deletions to DUR Board approved criteria. 1. For prospective DUR, list problem type/drug combinations added or deleted. No Prospective DUR criteria were added, deleted or modified during FFY 2019 by the DUR Board.

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	2. For retrospective DUR, list therapeutic categories added or deleted. See link below for meeting minutes, criteria reviewed by DUR Board included. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Minutes.pdf Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. No specific Board policies were in place for the coordination of prospective and retrospective DUR screenings. The Retrospective DUR vendor, Health Information Designs Inc. account representatives attended DUR Board meetings and RetroDUR criteria were proposed to the Board. It has always been standard practice for the state of Connecticut to expect that the Retrospective DUR vendor would be familiar with and report any pharmacy who was consistently overriding ProDUR alerts through the retrospective review of client-specific, prescriber, and most certainly pharmacy-specific profiling reviews. The RetroDUR vendor was aware of the ProDUR criteria and the clinical review pharmacists kept the ProDUR criteria in mind with each client-specific profile review. Retrospective DUR screens have always been used by the state of Connecticut, Department of Social Services to help in establishing new cost-containment and appropriate therapy policies and programs, including changes to ProDUR edits when necessary. If pharmacies are found to be overriding ProDUR criteria excessively then the problem is investigated for creative solutions. Describe DUR Board involvement in the DUR education program. (e.g., newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring). The quantities of RetroDUR intervention types are set contractually by CT Medical Assistance Program Department of Social Services. The DUR vendor reviews prescription drug history and diagnosis claims data to perform monthly interventions. Numbers and types of interventions are included in attachment 2. The contractor is required to review 2,000 patient profiles per month for the regular RetroDUR program based upon criteria approved by the DUR Board. 1,000 monthly profiles focus on an adult intervention and 1,000 monthly profiles focus on a pediatric intervention. Separate from the RetroDUR program is the Lock-In Program. For the Lock-In Program, the contractor is required to review 800 patient profiles per month. The contractor is required to conduct educational interventions with prescribers based upon criteria involving overuse of drugs with potential for abuse, doctor shopping, and pharmacy shopping. Patients are warned and if their excessive use does not change within 90 days, the recipients are locked-in to one pharmacy for one year, at which time their drug usage is re-evaluated. The criteria reviewed by the DUR Board during FFY 2019, see link to meeting minutes above. Four educational newsletters were mailed to targeted prescribers and pharmacies during FFY 2019. See link below for DUR newsletters. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/DUR_Board_Newsletters.pdf
Delaware	During the Federal Fiscal Year 2019, Delaware continued to have combined DUR and the Pharmacy and Therapeutic (P&T) committee meetings. By having one cohesive board, Delaware facilitates broad ranging discussions on drug utilization, drug coverage policies and feedback from the community. The Board's executive sessions focus on financial issues with open dialogue between all members. The annual DUR/P&T Meeting occurred September 19, 2019. Both managed care organizations' pharmacy

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	directors, which represent 85% of the Medicaid population in Delaware, participated in the DUR/P&T committee meeting. During the FFY 2019 the board met 3 times. Members are non-paid volunteers who often also serve in several different capacities for multiple professional organizations, so scheduling conflicts do occur. When scheduling conflicts occur and board members were not present for the meetings, they were contacted both prior and post meeting for feedback on the topics presented. Delaware protects our clients by implementing software DUR warnings directly into our system from our drug database vendor, FDB. We balance the need for alerting providers with important warnings on medications while attempting to prevent warning overload and the increased likelihood such alerts will be disregarded. With that balance in mind we directly adopt all severity warnings 1 (major) and 2 (moderate) into our system. The following are several areas where new warnings have been adopted: Drug Drug interactions: Providing appropriate warnings to providers for the many novel antineoplastic agents that were released in FFY 2019 was one area of particular importance. Although these agents provide hope for better patient outcomes, many providers may not be informed of risks associated with various drug interactions. For example, providers will receive alerts on claims for Lobrena when the client is on a concurrent CYP3A4 inhibitor or inducer. Agents to treat multiple sclerosis was another class that saw a surge in novel therapies during FFY 2019. Again, the newness of the agents and their unique mechanisms of action could potentially place clients in danger due to provider lack of familiarity. For example, claims for Mayzent will also be flagged for providers in cases where the client is on a concurrent CYP3A4 inhibitor or inducer. Drug Pregnancy warnings: These warnings are one of the most important tools we utilize in Delaware to ensure the safety of this group of our clients. While providers may be aware of classic medications to avoid in pregnancy, the risk of novel medications inadvertently being provided to our pregnant clients is avoided by the direct implementation of drug-pregnancy severity 1 and 2 warnings from the FDB files. An example that best highlights this situation are the new tetracycline antibiotics Xerava, Nuzyra, and Seysara. While pharmacists will know to avoid doxycycline in pregnant patients, they may not even know that Nuzyra is in the tetracycline class and carries the identical risk Additionally, since the board had previously decided to change Alprazolam to a non-preferred status on February 1, 2019, this topic was revisited at the September 2019 meeting. It was reported that there had been very little provider or member negative experience from this change. Members who were previously identified as using alprazolam were grandfathered to continue use until appropriate replacement therapy could be identified and implemented. A subsequent review of the Prescription Monitoring Program also saw very little increase in cash payment for alprazolam during the month of February despite the change to non-preferred. Additionally, the claims data for alprazolam for the year was reviewed by the Board at the annual P &T meeting, and a decrease in the overall number of alprazolam claims was noted.

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	Building on this success, the DUR board further discussed of requiring a diagnosis code for all benzodiazepines and a list of valid appropriate codes was distributed to the advisory committee for their input. Fee for service claims can be monitored for diagnosis codes for claims analysis purposes but claims without a code will not currently deny avoiding creating a barrier to patient access. Therapeutic duplications in this class are being reviewed for all clients.
District of Columbia	There were twelve (12) meetings of the DUR Board held once monthly during FY18. List additions/deletions to DUR Board approved criteria a) For prospective DUR, list problem type/drug combinations added or deleted. Epidiolex clinical criteria: Remove requirement for treatment exclusively by pediatric neurologist. Add attestation of treatment effectiveness for renewal criteria Sickle Cell Disease clinical criteria: Add criteria to establish accurate diagnosis and special allowance for increased opiate use Movement Disorder Treatment clinical criteria: Add criteria for AIMS testing results as an objective measurement parameter Long-acting injectable antipsychotic clinical criteria: Aristada Initio added to PA form CNS Stimulants clinical criteria: Research criteria for ADD/ADHD use in adults; change compliance threshold from 90% to 80% for PA renewal approval Hard stop POS edit for benzodiazepine/opiate concurrent use Zolgensma Prior Approval criteria Buprenorphine and buprenorphine/naloxone: Removal of PA requirements for daily dosage </= 24 mg b) For retrospective DUR, list therapeutic categories added or deleted Aspirin utilization without CVA diagnosis Evaluation of 7-day initial opiate rule utilization patterns Polypharmacy: target opiate and benzodiazepine concurrent use; include all CII to V drugs Trinity drug utilization: alprazolam, promethazine and clonidine concurrent use Naloxone prescribing patterns Board members routinely raise concerns about issues encountered during their retrospective review of patient profiles. By motion and voice vote, the Board states the problem encountered and requests the State and/or Pharmacy Benefit Manager staff to research root causes and to present proposed interventions at subsequent meetings for Board review. One example is when Board members raised concerns about the effectiveness of severity level 1 alert messages sent to pharmacists during point of sale electronic claims processing, the PBM staff was able to provide an analysis that gave the incidence of level one hard edit stops and the reasons entered for any subsequent system overrides. As a result, provider communications on the most frequent drug-drug interactions resulting in severity level one alerts were included in the bi-monthly Provider Bulletin sent to all Medicaid enrolled providers. The Board welcomed two new members this year: A Board-certified Child and Adolescent Psychiatrist and a Clinical Pharmacist trained in HIV treatment bought additional expertise and professional knowledge. The Board requested face to face presentations from community-based thought leaders and Medicaid providers on (1) Sickle Cell Treatment best practices and (2) on the role of naloxone access in addressing the Opioid Epidemic in the District. Discussion with these providers assisted the Board members in drafting recommendations to Sickle Cell Disease and MAT clinical criteria. Balancing the requirements and goals of the SUPPORT Act and the District's legislative mandate to removal barriers to all MAT modalities, including medications, has been a Board focus this year to

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	assure that appropriate prospective edits and retrospective reviews are in place. Members share peer-reviewed articles of interest and provide critiques and recommendations for District Medicaid staff follow-up where applicable. Each month Board members review 300 randomly generated patient profiles to make determinations on the type of provider specific intervention that will be sent to give an update on new treatment guidelines or as a reminder of current peer-reviewed standards of care. Most of these interventions take place in the form of a letter addressed to the prescriber detailing the individual patient, medication(s) and treatment protocol in question. In some cases, Board members have initiated direct peer-to-peer contact with a prescriber to discuss the rationale for that particular treatment protocol and whether clinically supported alternatives are available. Additionally, Board members select four population-based disease management topics each year that are used in a more general education/awareness campaign.
Florida	Summary of DUR Board Activities The Drug Utilization Review (DUR) Board reviews and approves drug use criteria and standards for both prospective and retrospective drug use reviews. It applies these criteria and standards in the application of DUR activities. The goal of the Florida Medicaid DUR program is to promote appropriate prescribing and use of medications. Magellan Medicaid Administration's ProDUR system is an integrated component of the online, real-time point of sale (POS) system. It compiles both medical and pharmacy claims data into comprehensive online beneficiary health summaries. Pharmacy claims are evaluated according to approved criteria against each member's summary. Claims history includes current, historical, paid, and denied claims data, regardless of the media source of the claims submission. The real-time evaluation of POS claims permits identification of drug therapy problems prior to dispensing. The RetroDUR utilization analyses, as described below, provides information which assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians to potential drug therapy problems, identifies opportunities to improve drug therapy and makes recommendations to avoid drug therapy problems. The ongoing operation of the RetroDUR program is a shared responsibility of Magellan Medicaid Administration, a Magellan Medicaid Administration Company, and the Agency for Health Care Administration (Agency). Each quarter, specific therapeutic areas that have been approved by the DUR Board are targeted for focused review under the RetroDUR program. Magellan Medicaid Administration applies the specified criteria established by the Board to the prescription and health claims files and identifies medication regimens that violate the criteria. Results of analyses are provided to the Board during quarterly meetings. Electronic educational letters are created by Magellan Medicaid Administration, regarding targeted criteria. Letters are reviewed and approved by the DUR Board and the Agency. The electronic letters are posted to a designated provider alert area of the Agency's website for the provider community. (http://ahca.myflorida.com/medicaid/Prescribed_Drug/banners.shtml). With enhanced technology, Magellan Medicaid Administration offered the DUR Board the ability to provide recommendations to the Agency for POS edits to assist in the mission of the Board, which include educating physicians and positively impacting prescribing for Florida Medicaid recipients. The DUR Board reviews the potential edits and makes recommendations based on their clinical expertise and knowledge. DUR Board members frequently collaborate with colleagues regarding drug utilization issues and bring the results of those discussions back to the DUR Board for consideration.

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	The Florida Medicaid DUR Board met four times during the Federal Fiscal Year 2019. During this timeframe, Magellan Medicaid Administration recommended RetroDUR criteria associated with drug to drug interactions, inappropriate dosing, therapeutic duplication, polypharmacy, safety precautions and overutilization of medications. Magellan Medicaid Administration produces a monthly newsletter/Clinical Alert to educate the provider community about the most recent issues in the pharmaceutical industry and new drug information. These newsletters are available on the Magellan Rx Management website and can be accessed at: https://www1.magellanrx.com/magellan-rx/publications/pharmacy-clinical-alerts.aspx Summary of DUR Board activities: Review the top 20 therapeutic classes by claims volume and expenditure. Review asthma recipients on inhaled corticosteroid monotherapy without receiving rescue therapy. Continued review of recipients on Long Acting Injectable Antipsychotics (LAI AP) to assess compliance and rationale for non-compliance. The DUR Board reviewed LAI AP utilization in children less than 18 years of age. Review of recipients on oral antipsychotic therapy concomitantly with injectable antipsychotic therapy. The DUR Board voted to create a hard edit denying the oral antipsychotic if a recipient has been on concomitant therapy for over 90 days. Review of recipients utilizing two or more oral antipsychotic therapies. The DUR Board voted to implement an edit to limit a recipient to two antipsychotics of the different chemical entities. Review concomitant use of opiates and antipsychotic therapy. In response to the Support Act, a soft edit was deployed for recipients on concomitant therapy. Review recipients with overlapping claims for both an opioid and a benzodiazepine. An education campaign indicating the Centers for Disease Control and Prevention (CDC) recommendation followed by a soft message to pharmacies regarding the interaction. A follow-up analysis 6 months after deployment was reviewed. The DUR Board voted to create a hard edit denying concomitant therapy at the POS following a provider educational campaign. Review utilization of opiates and Narcan (naloxone). Review recipients who had claims deny due to the morphine milligram equivalent (MME) hard edit for recipients that are treatment naive to opiate therapy. The DUR Board voted to create a soft edit on recipients with MME>50 based on a single or accumulation of opiate claims. Review utilization of opiate containing cough and cold preparation in children. The DUR Board voted to change age minimum to 18 years of age following the FDA safety alert recommendations. Review utilization of oral codeine medication in children younger than 12 years of age. The DUR Board voted to change the age minimum from 6 years of age to 12 years of age following the FDA safety alert recommendations. Review non-benzodiazepine sedative utilization and concomitant use with opiates. The DUR Board voted to create a hard edit for concomitant therapy. Assessment of hepatitis C medication utilization and retreatment. Review of adolescent utilization of hepatitis C therapy. Review recipients with overlapping claims for both a benzodiazepine and a stimulant medication due to the drug interaction and opposing pharmacologic actions. Edit deployed to deny claim requiring DUR intervention codes for claims to adjudicate. The DUR Board reviewed the post impact analysis of soft edit and voted to move to a hard edit denial. Review recipients with overlapping claims for both a non-benzodiazepine sedative and a stimulant medication. Review recipients over 6 years of age who were receiving doses of an antidepressant medication which exceeded the recommended maximum daily dose. The DUR Board approved implementation of maximum daily dose/quantity limits on this class of medications for all patients.

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	Review recipients utilizing more than one DPP-4 inhibitor, GLP-1 agonist, or the two concomitantly. The DUR Board voted to implement a therapeutic duplication edit. This edit will deny claims if recipients are utilizing more than one DPP-4 or more than one GLP-1 or a combination of both within 90 days. Review recipients initiating zolpidem therapy at higher doses than the FDA recommended starting dose of 5mg immediate release (IR) and 6.25mg extended release (ER). The DUR Board voted to extend the lower dose step therapy to both genders as a safety precaution. The intervention will prohibit use of 10mg or 12.5mg zolpidem, then look back 90 days for 5mg or 6.25mg for at least a 24-day supply. Review recipients identified as using polypharmacy in tumor necrosis factors (TNF). The DUR Board recommended the implementation of a therapeutic duplication edit across the classes of biologics, non-biologics, and oral therapy. The DUR Board reviewed Chantix utilization, adherence to the full course of therapy and updated the criteria to include non-pharmacologic smoking cessation therapy. The DUR Board reviewed appropriate utilization of selected topical medications and reviewed off-label use. The DUR Board voted to implement an automated prior authorization on all formulations of Calcipotriene for age, diagnosis, and duration of therapy and the DUR Board voted to create an automated prior authorization for Doxepin 5% cream to include diagnosis. The DUR Board reviewed therapeutic duplication among a select group of therapeutic classes. The DUR Board voted to create a therapeutic duplication edit for statin and long acting insulin therapeutic classes. The DUR Board reviewed utilization of anticonvulsants for seizure diagnoses and neuropathy diagnoses. The DUR Board reviewed Epidiolex utilization and FDA approved diagnosis in patient health conditions history. The DUR Board analyzed anticonvulsant use based on product specific FDA approved indications. The DUR Board reviewed HIV therapy to determine the average length of overlap for recipients transitioning from single ingredient HIV therapy to an equivalent combination product. Review utilization and compliance to Xolair. Review utilization and availability of biosimilar therapy. Review utilization of Xofluza. The DUR Board reviewed pancreatic enzyme utilization based on FDA approved indications. The DUR Board voted to implement an automated prior authorization including a FDA diagnosis look back. Review utilization trends for novel therapy. Review utilization of Lyrica and percent recipients with prior trial of gabapentin in claims history. The DUR board reviewed concomitant utilization of gabapentin and opiates. Summary of additions/deletions to DUR Board approved criteria: Amend the Chantix criteria to include documentation of non-pharmacologic smoking cessation therapy: Create an automated prior authorization for Calcipotriene and Doxepin topical therapy; Create an automated prior authorization for pancreatic enzymes to include the FDA approved indication for treatment: Reviewed novel therapy criteria including Spinraza, Exondys 51, Zolgensma, Luxturna, Yescarta, and Kymriah.
Georgia	-4 meetings were conducted on the following dates: November 6, 2018; March 5, 2019; May 7, 2019; and Aug 6, 2019 -New drugs reviewed included: Aimovig Crysvita Mircera Rhopressa Trogarzo

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	Vyzulta Fasenra Lokelma Lucemyra Orilissa Solosec Zemdri Ajovy Delstrigo Doptelet Emgality Ilumya Jivi Mulpleta Olumiant Pifeltro Nuzyra Yupelri Zolgensma Xofluza -In addition to the classes which these drugs fall under, several other classes were also reviewed including: Anticonvulsants Antihyperuricemics Antipsychotics Colony Stimulating Factors COPD Agents Glucocorticoids, Inhaled Ophthalmics, Anti-inflammatory/Immunomodulator Stimulants and Related Agents Due to limited characters that can be inputted, detailed meeting information cannot be provided here. However, meeting minutes for all DURB meetings can be found at https://dch.georgia.gov/providers/provider-types/pharmacy/drug-utilization-review-board.
Hawaii	4 quarterly DUR Board meetings were held in FFY 2019. There were no DUR Board approved criteria for Pro-DUR or Retro-DUR. Criteria discussed were cost ceiling limits triggering a prior authorization, SUPPORT Act changes for both pro- and retro-DUR screens. With a major decrease in need and costs, Hepatitis C drugs prior authorization remained but less restrictive with the change of fibrosis score from F1 to F0. Removing the fibrosis score of F1 to F0 required a provider memorandum. DUR education programming was not identified as needed at this time but in the near future as provider memorandums.
Idaho	DUR Board Activities:

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	The DUR Board conducted three meetings during the year, with Board members playing an active role in intervention selection and decision making. All meetings were conducted in Boise, Idaho on the indicated dates: DATES November 15, 2018 January 17, 2019 April 18, 2019 July 18, 2019 During FFY19, the following RetroDUR activities were performed on behalf of the Idaho DUR Board: 1. Narcotic Prescribing Improvement Project o Idaho Opioid Equivalent Dosing Project o Methadone 2. Buprenorphine and Benzodiazepine Concomitant Use 3. Hepatitis C Update 4. Benzodiazepines o Two or more benzodiazepines o High utilization of benzodiazepines 5. Buprenorphine monotherapy 6. Buprenorphine patients without psychotherapy 7. Uloric utilization and new adverse event information 8. Cystic Fibrosis 9. Foster Children and behavioral health medications 10. Oral health issues from mental health medications 11. Venlafaxine 12. Clorazepate dipotassium tablets (Tranxene) 13. Chlordiazepoxide 14. Butalbital Migraine Medications 15. Typical Antipsychotic Use in Children 16. Injectable Testosterone 17. Alprazolam Utilization: looking for patients without any other anti-anxiety medications 18. Tramadol 19. Opioid Use Disorder 20. Epidiolex 21. PCSK9 Inhibitors 22. Targeted Immune Modulator Utilization Board policies on prospective and retrospective DUR screens. Prospective DUR messages are presented and reviewed quarterly at the DUR Meetings. If the Board feels that results from these reviews warrant action prospective DUR screens are adjusted accordingly. Results from retrospective interventions undergo assessment by the DUR staff on a quarterly basis as well. Areas of prescribing and dispensing practices that are inappropriate and potentially widespread are identified. These may require the addition of prospective screens via the on-line system and are presented at the next Board meeting and voted on for approval. Describe policies used to encourage use of therapeutically equivalent generic drugs.

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	The DUR Board encourages the use of therapeutically equivalent generic drug products as established under rules promulgated by the Idaho State Board of Pharmacy and the Rules Governing the Medicaid Basic Plan Benefits. Idaho Statute Title 54-1768 of the Idaho State Board of Pharmacy and Section 660 through 679 of the Rules Governing the Medicaid Basic Plan Benefits provide information on the selection of therapeutic equivalents by the pharmacist. In addition, the DUR board has expanded its activities to include outcomes studies to evaluate potential clinical and financial outcomes associated with the implementation of the enhanced prior authorization program (EPAP). This program receives input and recommendations from the P&T committee regarding high cost and other significant drug categories. A complete list of drug products requiring prior authorization and criteria for approval in the Idaho Medicaid program may be found at the following website: http://www.healthandwelfare.idaho.gov/Medical/PrescriptionDrugs/tabid/119/Default.aspx The DUR Board, with recommendations from the DUR staff, approves all intervention strategies deemed necessary to improve the quality of care for Medicaid recipients. Data in attachment 2 of this report indicates the type and quantity of interventions involved in this program. For example, providers receive direct personal communications from the Board requesting information and documentation for specific drug use decisions, when prescribing practices have not met the criteria adopted by the Board. These interventions have been mailed to both physicians and pharmacists where possible. The DUR Board approves which type of educational leaflets are enclosed for each intervention mailing to inform the provider of the criteria and literature used to support the intervention.
Illinois	The Illinois Drug Utilization Review (DUR) Board conducted four meetings during FFY19. Meeting agendas and minutes are available on the Illinois Department of Healthcare and Family Services (HFS) Drug Utilization Review Board Web site. Clinical staff from HFS Medical Programs and the University of Illinois at Chicago College of Pharmacy develop prospective criteria for DUR Board approval at the quarterly meetings. Medication utilization review, adjudication processes, and Illinois DUR Board discussion are used to generate prospective and retrospective DUR items for evaluation and edits. Retrospective review of established edits allows for adjustment of prospective criteria. Prior authorization criteria and forms are posted on the Prior Authorization Web. During FFY19, the following prospective edits were discussed or implemented: Four Prescription Policy criteria for diabetes management focused on metformin as first-line therapy Albuterol HFA inhaler quantity limits Spacer devices/Valved holding chamber incorporation into the Inhaled Corticosteroid Prescription Request Form Ketorolac duration limit of 5 days with a 20-tablet maximum quantity for fill Opioid-related edits and reviews in relation to the Support for Patients and Communities Act Group accumulation edit for mometasone furoate breath-activated inhalation powder High dose override edit to allow 1 tablet for digoxin for participants 65 years of age and older. Medispan pre-set specification allowed for 0.5 tablets only. Group accumulation edit for continuous glucose monitor systems for the receiver, sensor, and transmitter

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	The Illinois DUR Board addressed the following drug classes and issues retrospectively during FFY19: Spacer devices/valved holding chambers for asthma inhalers Gabapentin utilization Ketorolac utilization which resulted in ketorolac prospective edits Prescriber interventions for metformin underdosing identified in RetroDur 300 RetroDUR computer-generated list of 300 participants who filled medications through August 2018 that have potential drug-related issues Medications for the treatment of hepatitis C infection Naloxone utilization from 2016 through 2019 The DUR Board and Drug Utilization Review Web pages continued to be used as educational vehicles for providers during FFY19. The following educational topics were discussed and/or links approved for posting for providers on the Drug Utilization Review Web site: FDA Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS) updates Opioid Analgesic REMS Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain FDA Opioid Policy Steering Committee Department of Health and Human Services' Five-point strategy to combat the opioid crisis FDA Animal Veterinary Resources for veterinarians who stock and administer opioids Opioid analgesics REMS patient counseling guide Surgeon General's Advisory on naloxone and opioid overdose. Illinois Department of Public Health Naloxone page Centers for Disease Control and Prevention (CDC) opioid prescribing guideline factsheet and mobile application
Indiana	DUR Board meetings are held monthly. Eleven meetings were held during FFY 2019. For prospective DUR, the DUR Board focuses on three major initiatives: SilentAuth applications, prior authorization criteria, and mental health medication utilization edits. During FFY 2019, the DUR Board reviewed and approved the continued use of SilentAuth, an automated point-of-sale prior authorization application. New and updated prior authorization criteria were implemented for the targeted immunomodulators, opiates, duplicate sedative hypnotic/benzodiazepines, antiseizure agents, monoclonal antibodies for the treatment of respiratory conditions, Multiple Sclerosis, and COX II inhibitors and select non-steroidal anti-inflammatory agents (NSAIDs). The DUR Board reviewed and approved the following new and updated manual prior authorization criteria: hepatitis C agents, cystic fibrosis agents, Synagis®, pumonary antihypertensive agents, Dificid®, Spinraza®, Lucemyra®, carisoprodol and combination agents, human parathyroid hormone agents, testosterones, growth hormone, Nuedexta®, ophthalmic anti-inflammatory agents/immunomodulator type, Lyrica® CR, NSAID step therapy, topical Doxepin®, allergy specific immunotherapy, topical steroids, Vynaqel® and Vyndamax®, Corlanor®, PCSK9 inhibitors, bone formation stimulating agents, and muscular dystrophy agents. The DUR Board approved additional utilization edits on mental health medications. This is an ongoing effort to enhance quality and appropriateness of mental health prescribing practices. Claims that exceed or do not meet the established utilization edit will require prior authorization. No therapeutics categories for retro-DUR were added or deleted during the reporting period. Analyses of both pro-DUR edits and retro-DUR criteria are used by OMPP (through its contractors and the DUR Board) to help establish new cost-containment initiatives and to monitor rational drug use and prescribing. It has been standard practice by the OMPP and DUR Board to expect that OptumRx will develop and present innovative ideas on cost containment & therapeutic appropriateness through DUR program efforts. The DUR Board advises on the Preferred Drug List (PDL), pro-DUR and retro-DUR

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	programs, PA programs, and newsletters that address educational issues that relate to the prescribing and utilization of prescription drugs in the most cost-effective manner. Provider Bulletins and DUR Board Newsletters that notify and educate prescribers and pharmacists on specific topics associated with the prospective DUR and retro-DUR programs are reviewed and approved by the DUR Board. These documents are posted publicly online for review and referenced in retro-DUR faxes. For more information regarding the DUR Board review, please utilize the following link to access DUR Board minutes, Dear Dr. Letters, Newsletters, and other pertinent documentation. https://inm-providerportal.optum.com/providerportal/faces/PreLogin.jsp
Iowa	Summary 3 DUR Board Activities Report Number of DUR Board meetings held: 5 out of 5 scheduled Additions/deletions to DUR Board approved criteria Prospective DUR: Currently, the DUR Board does not review the Prospective DUR criteria specific to problem type/drug combinations. Change Healthcare utilizes MediSpan for prospective DUR criteria. Retrospective DUR: Currently, the DUR Board does not review the Retrospective DUR criteria. Change Healthcare, utilizes MediSpan for retrospective DUR criteria involving a complex screening process. Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens and whether results of retrospective DUR screening are used to adjust prospective DUR screens: Prospective DUR system reporting has not been developed to support this function. When conflicts between the ProDUR and RetroDUR systems are discovered, the Board determines appropriate resolution of these conflicts and recommends appropriate actions. The Iowa DUR program has several prior authorization categories that prospectively promote therapeutically appropriate and cost-effective use of medications. DUR Board involvement in the DUR education program and policies adopted to determine mix of patient or provider specific intervention types: Interventions are directed to both physician and pharmacist providers. The DUR Board approves all educational information that is utilized when performing interventions. Letter intervention is utilized in most cases. Telephone intervention may be utilized, particularly when patients are using multiple providers in a patterned fashion or in serious or life threatening circumstances. When no provider response is received following letter intervention and the medication therapy continues to put the patient at risk for an adverse event, another intervention may be attempted such as a registered letter, a telephone intervention, or a face-to-face intervention. Selection of an intervention depends on the severity of patient risk and is determined on a case-by-case basis. The need for these more intensive interventions is rare. Patient-focused reviews are completed with the review of select Fee-for-Service (FFS) patient profiles coinciding with each meeting (four times annually). The DUR contractor generates these profiles through a complex screening process. The first step of the screening process subjects member profiles to a therapeutic criteria screen. If a profile is found to have failed one or more therapeutic criteria, the patient profiles are then assigned a level of risk based on their medication history and potential for adverse events regarding medication. The profiles with the highest level of risk are then selected for review. Six months of prescription claims data and medical claims data, if available, are assessed to determine this risk factor. The DUR modules developed by MediSpan are used to screen for therapeutic problems. Problem-focused reviews target specific issues for an in-depth educational effort. Issues stimulating review are selected from findings of patient-focused reviews, reviews of medical literature, as well as the Board members' practice experiences. Criteria are developed to identify the patients who may

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	benefit from intervention. Patient profile selection is developed for each problem-focused review. All initiatives are discussed at DUR meetings in coordination with the MCOs with all entities reviewing their member population. The DUR Board develops and distributes a newsletter two times annually. The DUR Board also maintains a web site, www.iadur.org.
Kansas	SUMMARY OF DUR BOARD ACTIVITIES FOR FFY 2019 1. Four DUR Board meetings. *Dates: October 10, 2018; January 9, 2019; April 10, 2019; July 10, 2019 2. a. Additions/Changes/Deletions to DUR Board Approved Criteria are listed below. 2. b. DUR contractor RDUR report activity is given in other DUR survey sections. 3. Working on a single policy. Currently, DUR Board responsibilities and activities are part of contracts. 4. We have increased DUR Board inclusion of provider education and have discussed that a more effective and engaging process needs to be initiated. *The DUR pharmacist creates quarterly newsletters for the providers. *Bulletins regarding drugs requiring prior authorizations (PAs) and pharmacy-related changes in general are posted to the Kansas Medical Assistance Program (KMAP) website, as well as notices sent through global messaging. OCTOBER 10, 2018 DUR BOARD APPROVED PA CRITERIA Revised Prior Authorization (PA) Criteria 1. Botulinum Toxins 2. CFTR Modulators 3. Chemotherapy Agents 4. Enzyme Replacement Therapy 5. Immunomodulators 6. Kymriah™ (tisagenlecleucel) 7. Opioid Agents 8. Somatropin Products 9. Spinraza (nusinersen) New Prior Authorization (PA) Criteria 1. CGRP Antagonists 2. Orilissa™ (elagolix) 3. Trogarzo™ (ibalizumab-ulyk) 4. Advanced Medical Hold Manual Review PA Mental Health Medication Advisory Committee PAs 1. ADHD Medications 2. Antidepressant Medications 3. Antipsychotic Medications 4. Benzodiazepine Medications Miscellaneous Items 1. Pharmacy Committee Summaries & General Program Updates 2. PA Process - Updates and Demonstration 3. Fee-for-Service Annual Program Assessment JANUARY 9, 2019 DUR BOARD APPROVED PA CRITERIA Revised Prior Authorization (PA) Criteria 1. Spinraza™ 2. CGRP Antagonists (Emgality™[galcanezumab-gnlm])

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	3. Anti-Constipation Agents (Motegrity™[prucalopride]) 4. Botulinum Toxins New Prior Authorization (PA) Criteria 1. Arikayce® 2. Step Therapy Guidelines for Prior Authorization Criteria Miscellaneous Items 1. Fee-for-Service Retrospective Drug Utilization Review Topic Selections APRIL 10, 2019 DUR BOARD APPROVED PA CRITERIA Revised Prior Authorization (PA) Criteria 1. Non-Preferred PDL PA Criteria 2. Advanced Medical Hold Manual Review PA 3. Anti-Emetics: Neurokinin 1 (NK-1) Antagonists/NK-1 Antagonist Combinations 4. Hepatitis C Agents 5. Long-Acting Hemophilia Factors 6. Opioid Products Indicated for Pain Management New Prior Authorization (PA) Criteria 1. Calcimimetic Agents 2. Hemlibra® 3. Interleukin-5 (IL-5) Receptor Antagonist Agents 4. Topiramate Extended Release 5. PDL Expanded Consent Agenda Item Mental Health Medication Advisory Committee PAs 1. Antipsychotic Medications - Safe Use for All Ages Miscellaneous Items 1. Management of Medications Not Addressed in Their Associated Class PA JULY 10, 2019 DUR BOARD APPROVED PA CRITERIA Revised Prior Authorization (PA) Criteria 1. Non-Preferred PDL PA Criteria 2. Blanket Statement - New Indications/Age Changes 3. CGRP Receptor Antagonists 4. Botulinum Toxins 5. Topiramate Extended Release New Prior Authorization (PA) Criteria 1. Adult Rheumatoid Arthritis 2. Ankylosing Spondylitis 3. Asthma 4. Atopic Dermatitis 5. Crohn's Disease 6. Juvenile Idiopathic Arthritis 7. Plaque Psoriasis 8. Psoriatic Arthritis 9. Ulcerative Colitis 10. Spinal Muscular Atrophy Mental Health Medication Advisory Committee PAs 1. Antidepressants - Safe Use for All Ages Miscellaneous Items 1. Managed Care Organization Annual Reports

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	Appointment of Chairperson and Interim Chairperson
Kentucky	The operation of the DUR program is a shared responsibility of Magellan Rx Management (MRx), the Kentucky Cabinet for Health and Family Services and the Drug Management Review Advisory Board (DMRAB). The DMRAB did not meet during FFY2019. During FFY2019, the following RetroDUR activities were performed on behalf of the DMRAB: Prescriber-lettering activities: Recommend flu vaccine to members prescribed oseltamivir during 2017-2018 flu season Antipsychotics in children Opioids and antipsychotics FDA warnings and risks with DPP-4 and SGLT2 inhibitors Newsletter features: FDA warnings and risks with DPP-4 and SGLT2 inhibitors; available at https://kyportal.magellanmedicaid.com/public/client/static/kentucky/documents/KYRx_Quarterly_201903_v10n1.pdf All specific drug and drug classes reviewed are targeted for focused review under the RetroDUR program monthly with additional quarterly in-depth review. MRx then applies the specified criteria established to the prescription drug and health claims files and identifies medication regimens that are not congruent to the criteria established. Copies of individual claims history profiles that are not consistent with the criteria are generated by MRx and sent to clinical reviewers for in-depth review. If, based on the professional judgment of the clinical reviewers or the MRx Kentucky Medicaid Clinical Manager, an aberrant pattern of prescribing and/or utilization is indeed present, an educational letter is sent to the prescribing physician and/or the dispensing pharmacist informing the provider of the suspected problem. MRx produces and mails provider letters documenting the therapeutic effects of the RetroDUR program and tracks provider responses associated with the interventions. Based on provider responses and recommendations from DMRAB, the Pharmacy and Therapeutics (P&T) Advisory Committee, and the Kentucky Pharmacy Program, the RetroDUR criteria may be changed or specific ProDUR edits or clinical prior authorization criteria may be added to the drug or drug class. Additionally, the program's quarterly newsletter is used to provide general education to prescribers and pharmacists about FDA alerts and other safety concerns.
Louisiana	Summary 3 DUR Board Activity The Louisiana Drug Utilization Review Board held three meetings during federal fiscal year 2019. Managed care organizations (MCO) are required to perform DUR and to report activity in the FFY 2019 DUR Annual Report. The DUR Board includes three voting members representing MCOs. A Hepatitis C subscription model for treatment of hepatitis C was implemented in Louisiana. Clinical authorization requirements for agents in this class were removed.

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	FFS had policies in place to address opioid safety, including therapeutic duplication, early refills, maximum doses and appropriate diagnosis on most opioids, benzodiazepines and anti-psychotic agents. MCOs were directed to implement these policies in compliance with the SUPPORT Act. Point of Sale diagnosis requirements were added to more drugs and drug classes. Safety alerts (letters) were sent to prescribers of quetiapine >800mg/day. Consideration was given to 90-day supply of maintenance drug prescriptions. Indicate the number of meetings held 3 For prospective DUR, list problem type/drug combinations approved by the DUR Board, added or deleted. New Diagnosis requirement: HIV agents, Agalsidase beta injection, Alglucoside alfa injection, Amikacin oral inhalation Concurrent use: Opiates & benzodiazepines Therapeutic duplication: Benzhydrocodone/acetaminophen Quantity limit: Benzhydrocodone/acetaminophen, CGRP inhibitors, Collagenase topical, Sodium zirconium cyclosilicate, patiromer Dose limit: Liquid opiates Prior drug use requirement: SGLT2 agents New for MCO Diagnosis requirement. Antipsychotic agents Dose-age limits: Antipsychotic agents Prior drug use requirement. Long-acting opiates Therapeutic duplication: Short-acting opiates, Long-acting opiates MME limit: Benzhydrocodone/acetaminophen Revised Therapeutic duplication: Antipsychotic agents Quantity limits: 2nd generation long-acting antipsychotic agents, Sumatriptan, Rivaroxaban Prior drug use requirement: 2nd generation long-acting antipsychotic agents Diagnosis requirement: MS agents, Tazarotene, Progesterone vaginal, Tobramycin oral inhalation, Ivacaftor, IncobotulinumtoxinA injection, Sumatriptan, Eculizumab, Infliximab Age limit: Prampanel, Ivacaftor Exceeds duration: Proton pump inhibitors, H2 antagonists Dose limit: Buprenorphine. Removed Remove mandatory dose decrease: Buprenorphine/naloxone. Diagnosis requirement: Cytokine/CAM antagonists, Natalizumab New Educational alerts Concurrent use: Opiates & antipsychotic agents Therapeutic Duplication, Level One Educational Alerts A5B , HYPERTROPHIC CARDIOMYOPATHY TX AGENTS; ABLATIVE A9C , CALCIUM CHANNEL BLOCKER AND NSAID; COX-2 INHIBITOR H1F , HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONIST

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	H1G, NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST H33 , OPIOID WITHDRAWAL THER; ALPHA-2 ADRENERGIC AGONIST H6O, ANTIEMETIC; CANNABINOID-TYPE M4U, HMG-COA INHIB; ACE INHIB; CALCIUM CHANNEL BLCKR COMB P7B, RENIN-ANGIOTENSIN-ALDOSTERONE SYS. (RAAS) HORMONES P9B, AMYLOIDOSIS AGENTS-TRANSTHYRETIN (TTR) SUPPRESSION S22, ANTI-INFLAM.;ANTIPRURITIC-JANUS KINASE(JAK)INHIBIT S23, NSAID ANALGESICS; PGE2 EP4 RECEPTR ANTAGONIST TYPE S24, NSAIDS (COX NON-SPEC.INHIBITOR) AND GLUCOCORTICOID S25, NSAIDS(COX NON-SPEC.INH) AND SKELETAL MUSCLE RELAX W0J, ANTIRETROVIRAL - ANTI-CD4 DOMAIN 2 MONOCLONAL AB Drug Interactions, Level One Educational Alerts ABIRATERONE; PREDNISONE; PREDNISOLONE/RADIUM RA 223 DOFETILIDE/BICTEGRAVIR BICTEGRAVIR/RIFAMPIN S-ADENOSYLMETHIONINE (SAM-E)/TRANYLCYPROMINE ATAZANAVIR-COBICISTAT/SELECTED CYP3A4 INDUCERS ELAGOLIX/STRONG OATP1B1 INHIBITORS DOFETILIDE/TAFENOQUINE ASUNAPREVIR/STRONG AND MODERATE CYP3A4 INHIBITORS DORAVIRINE/CYP3A4 INDUCERS LOVASTATIN; PRAVASTATIN/GEMFIBROZIL LORLATINIB/STRONG CYP3A4 INDUCERS TAMOXIFEN/STRONG CYP3A4 INDUCERS For retrospective DUR, list therapeutic categories added or deleted. New Concurrent use: Opiates & antipsychotics New for MCO Therapeutic duplication: Antipsychotic agent therapeutic duplication Revised Underutilization: Hydroxyurea Duration of therapy: Proton pump inhibitors Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. Discussions at the Louisiana DUR Board meetings include prospective DUR and its impact on established retrospective DUR criteria. Policies are not written for global implementation; rather, criteria or drug classes are reviewed for effectiveness in prospective DUR and applicable modifications in retrospective criteria. For example, the prospective duration of therapy edit for high-dose anti-ulcer drugs have reduced the need for examining this issue retrospectively.

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	The Board has recommended implementation of prospective DUR criteria based on exception reports from retrospective reviews. Again, criteria or drug classes are reviewed individually. For example, retrospective reviews targeting therapeutic duplication of non-steroidal anti-inflammatory agents led to the implementation of a prospective DUR edit. Describe DUR Board involvement in the DUR education program. (e.g., newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face to face visits, increased monitoring). The DUR Board recommends topics for educational articles to be included in the "Provider Update" newsletter targeting Louisiana Medicaid providers. Educational efforts by individual DUR Board members may include writing articles for the "Provider Update" newsletter or sharing the DUR Annual Report with interested parties. DUR Board-initiated criteria recommendations for prospective and retrospective DUR supply providers with additional educational information. In the prospective DUR process, pharmacy providers receive educational alerts or "deny" edits on selected medication-related issues. In the retrospective DUR process, recipient-specific profiles along with therapeutic criteria are sent to physician and pharmacy providers. Additional educational information is included for selected criteria topics.
Maine	The ME Medicaid (MaineCare) DUR Board acting as the program's Pharmacy and Therapeutics (P&T) Committee met (5) five times in FFY2019. The combined functions of the DUR Board results in the DUR Board having a unique perspective on the evaluation and Preferred Drug List (PDL) placement of newly released drugs. As new drugs are brought forward for evaluation, the DUR Board chooses to manage these medications in a manner that will result in appropriate prescribing from the time of introduction of the drug (prospectively) rather than in a retrospective manner when inappropriate patterns of prescribing may have become ingrained. This results in the early adoption of quantity limits, step therapy and promotion of generic drug choices. At the same time, as new drugs are evaluated, patterns of prescribing for alternative drugs may become apparent and lead the Board to undertake retrospective drug utilization review activities for those other medications. Additionally, the DUR Board will recommend that follow-up RetroDUR be performed of relatively new drugs to ensure that the adopted clinical criteria are appropriate and result in patterns of utilization that are appropriate and cost-effective. In FFY 2019, the ME DUR Board activities included: 78 New Drug Reviews 7 Revised Clinical Coverage Criteria 43 Therapeutic Class Reviews 16 Quantity Limits established for new or previously reviewed drugs 7 FDA Safety Alerts reviewed RetroDUR Analyses o Appropriate Use of Asthma Controller Medications o Use of statins in members with diabetes mellitus o Continuous use of antidepressants at 3, 6 and 12 months after initiation o Vivitrol Adherence o Chronic Triptans Use

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	The Drug Utilization Review (DUR) Board will advise MaineCare on how best to educate providers and address the impact of pharmacy manufacturers advertising. In the course of DUR activities, the DUR Board may select certain drugs to target for review in order to ensure that clinical criteria and prescribing patterns are appropriate. Staff makes recommendations for targeted areas and the Board selects those most relevant. The Board then determines if follow-up is appropriate either with the identified prescribers or with a clinical advisory to all providers. In the event a preferred drug is changed to a non-preferred status and specific beneficiaries are affected, prescribers are provided with two tools as recommended by the DUR Board. One is a list of all the patients who were prescribed the specific drug that is being changed. The second is a profile unique to each patient with the drug change listed. This creates a record for use in the patient's file. To educate providers on general PBM Program coverage activities, various methods are used. Most frequently, mailings are prepared around both general and specific changes and they are targeted to prescribers and pharmacies separately. The mailing topics are generally complimentary so that pharmacies understand the communications that have been sent to prescribers. These mailings are also sent electronically to provider affiliates and representatives so that these organizations can use their proprietary methods to distribute the materials. Providers may find all general pharmacy benefit management materials posted on the MaineCare webpage at http://www.mainecarepdl.org/ These materials include the description of the PBM Program; DUR Board information; the Preferred Drug List and Criteria; prior authorization information and forms; bulletins and mailings; and other information, instructions and alerts.
Maryland	Summary 3: DUR Board Activities Report Indicate the number of DUR Board meetings held The Maryland Medicaid Drug Utilization Review Board met four (4) times during FFY 2019. Meetings were held on the first Thursday of the months of March, June, September and December. List additions/deletions to DUR Board approved criteria. a) For prospective DUR, list problem type/drug combinations added or deleted. Prospective DUR screening criteria utilized by the current vendor (Conduent State Healthcare, LLC) are based on First Data Bank criteria. All First Data Bank severity level 1 drug-drug interaction alerts are activated by the ProDUR vendor on an ongoing basis. At each DUR Board meeting a review of the top 20 prospective DUR alerts is presented by the prospective DUR vendor for the following types of alerts: Drug-Drug Interactions, Early Refill, Therapeutic Duplication Early refill alerts require a prior authorization (PA). Calls requesting a PA can be made by the pharmacist or prescriber. Therapeutic duplication alerts can be overridden at point of service by the pharmacy by entering the appropriate NCPDP conflict, intervention and outcome codes. A summary of conflict, intervention and outcome codes entered by the pharmacy to override therapeutic duplication claims is reviewed by the DUR Board at each meeting. A summary of other edits that include low dose, high dose, drug age and drug gender alerts is also reviewed at each meeting. Estimated cost savings/cost avoidance and the number of calls taken by the call center help desk is reviewed at each meeting as well. During FFY 2013, the DUR Board requested a therapeutic duplication alert be developed for the concurrent use of clonazepam and another benzodiazepine. This particular alert is not included in the

standard therapeutic duplication alert for benzodiazepines since clonazepam is classified as an anticonvulsant. The alert was implemented in FFY 2014 and continues to be presented to the DUR Board on a quarterly basis.

b) For retrospective DUR, list therapeutic categories added or deleted.
During FFY 2019, retrospective DUR interventions were performed to identify participants with potentially inappropriate use of controlled drug substances, therapeutic duplication of sedative/hypnotic medications, concomitant use of an opioid, benzodiazepine and carisoprodol-containing product, overutilization of gabapentin, overutilization of benzodiazepines, and therapeutic duplication of gabapentin and pregabalin.

The DUR Board is presented with new relevant criteria from the RDUR vendor at each quarterly meeting. The Board votes to approve the addition of criteria for monitoring purposes and for potential future interventions. Criteria added during FFY2019 may be found in the DUR Board meeting minutes available at https://mmcp.health.maryland.gov/pap/Pages/dur-minutes.aspx

Describe Board policies that establish whether and how results of prospective DUR screenings are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens.

The Maryland DUR Board meets quarterly to review Prospective and Retrospective DUR information. If information is presented that is concerning to Board members, such as overutilization of high risk medications, inappropriate therapeutic use of medications, or high rates of drug interactions with common medications, a request may be made to retrospectively analyze the claims information to determine if a true issue exists within the participant population. In some instances, an intervention may become a recurring intervention that is performed continuously due to the findings from the initial intervention. Conversely, when retrospective DUR interventions are performed, if the outcomes show an unacceptable improvement in practice, the Board may create a Prospective alert, when possible, to further prevent adverse drug events for the participant population, and ensure safe and effective use of medications.

Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring).

Information regarding newsletters and upcoming continuing education events are discussed with the DUR Board at each meeting. The DUR Board members routinely offer recommendations for topics in the newsletter as well as continuing education programs. Board members also attend continuing education events in support of the Program.

During FFY2017, the DUR Board recommended further review of provider responses that may indicate fraudulent activity. Educational intervention letters include a voluntary response form that the provider may use to indicate follow-up actions in response to the information provided. Some responses include that the provider was incorrectly identified as the prescriber or that the participant was never under the provider's care. In those instances, the RDUR vendor was instructed to contact

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	the provider directly to further investigate the prescription claim and determine if fraud or abuse by the participant was occurring. In some instances, copies of the prescription(s) were obtained for evaluation. This practice continued into FFY2019. Further review of these discrepancies has not uncovered any illicit activity by participants. Further, the DUR Board and RDUR vendor initiated an update to the intervention letters that would identify providers by name instead of Medicaid identification number, in order to facilitate communication between providers in instances where multiple providers are involved in a potential drug therapy problem. This update to the RDUR intervention letters has decreased the instances where a provider may indicate Annually, MMPP has sponsored a live continuing education program. In FFY 2019, MMPP sponsored its tenth (10th) live continuing education program HIV Management in Primary Care on Saturday, October 27, 2018. Members of the DUR Board have actively participated as speakers at these events in past years, provided recommendations for potential speakers and attended the presentation.
Massachusetts	The purpose of the DUR Program is to ensure that prescribed drugs are appropriate, medically necessary, and not likely to result in medication related problems. DUR Board Activities 1. To advise and assist the Office of Medicaid in the performance of DUR within the MassHealth Program and in compliance with the Omnibus Budget Reconciliation Act of 1990 as codified in 42 USC 1396r - 8 and 42 CFR 456.700 et seq. 2. To advise the DUR Program on the criteria, standards, and content of the MassHealth Drug List (MHDL); 3. To make recommendations concerning ongoing types of provider and MassHealth Member interventions as part of the DUR Program and participate in the evaluation of the results; 4. To prepare an annual DUR Report describing the nature and scope of the DUR Board's activities, an assessment of the DUR Program, and a statement of goals and objectives; 5. To evaluate the use of criteria and standards; to assess the operational effect of the criteria and standards; to identify inappropriate or medically unnecessary care provided by physicians and other providers, to individuals receiving benefits under the MassHealth Pharmacy Program; 6. To oversee the operation of the DUR Program by ensuring that that criteria and standards applied are consistent across all DUR activities; and 7. To identify educational needs and develop educational plans to improve prescribing or dispensing practice, and to evaluate the effect of these educational interventions. DUR Board Meetings Four Quarterly meetings of the MassHealth DUR Board were held for the Federal Fiscal Year period October 1, 2018 to September 30, 2019. The DUR Board also participated in seven monthly Clinical Workgroup meetings to address ongoing clinical updates and issues. Clinical Work groups are held during the months between DUR Board Meetings. DUR presentations to the Board include New Drug Reviews, Drugs in Development, Guidelines Quality Assurance, and Performance Metrics. The Guideline Quality Assurance presentations include utilization trends, prior authorization volume and trends and the most recently published evidenced based medical information for a particular guideline. These reviews lead to the expansion of the scope of retrospective DUR screens and guide future prospective DUR criteria development and implementation strategies. DUR Board Educational Activities The DUR Board also approves changes to the MassHealth Drug List website where educational materials are posted, such as Hepatitis C Clinical Information, MassHealth Pain Initiative, and MassHealth ADHD Initiative. The MassHealth Website posts the Prescriber e-Letter, also available by web mail.

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	Ninety guidelines were reviewed for changes to prospective DUR criteria. Of which, 71 had additions to criteria and 19 had deletions of criteria. A retrospective DUR review was performed for 25 therapeutic classes. Of which, 14 had additions to criteria and 11 had deletions of criteria. In addition, 20 criteria were related to underutilization, 16 related to overutilization, 15 related to appropriate use of generics, 13 related to incorrect duration, 12 criteria related to insufficient dose, seven related to drug/disease contraindication, and four related to therapeutic duplication. All classes were related to at least two different retro-DUR categories with an average of three categories per therapeutic class.
Michigan	The Michigan Medicaid DUR Board meets quarterly in March, June, September and December of each year. They review activities and reporting associated with both prospective DUR (ProDUR) and retrospective DUR (RetroDUR). The MI Medicaid pharmacy claims processing system utilizes clinical criteria for ProDUR provided by First Data Bank (FDB). The DUR Board selected specific problem types and therapeutic classes that will deny at point-of-sale (POS) and require pharmacy level overrides as well as those problem types that will return an alert message only. The denials for therapeutic duplication (TD) are for drugs in the narcotic analgesic class only. For all denials involving TD, the pharmacist may override the edit by entering the appropriate override code as established by the MDHHS. Early refill and drug-to-gender alerts may only be overridden after consultation by the dispensing pharmacy or prescriber with the clinical personnel at Magellan Rx Management (MRx). At each meeting, the DUR Board reviews utilization patterns as well as RetroDUR activity recommendations. During FFY 2019, the DUR Board reviewed analyses targeting appropriate prescribing patterns and recommended guidelines for medications such as narcotics, gabapentin, naloxone, migraine treatments, asthma and COPD treatments, and influenza vaccinations and antiviral utilization trends. The utilization patterns of opioids including high morphine equivalent daily doses (MEDD) and concurrent utilization with opioid potentiators are reviewed at each meeting. Also, medication assisted treatment (MAT) utilization metrics, patient demographics, patient diagnoses and prescriber taxonomies for these medications are reviewed. The DUR Board also oversees an academic detailing program, called WholeHealthRx, designed to identify prescribing patterns that are inconsistent with evidence based, best practice guidelines for behavioral health medications. The program reaches out to the primary care or behavioral health provider to engage in a personalized consultation. The interventions and outcomes for the activities are reviewed at each meeting.
Minnesota	The Minnesota Department of Human Services (DHS) Drug Utilization Board met for four quarterly meetings during Federal Fiscal Year 2019. Below are highlights of the criteria discussions per meeting. October 17, 2018 DUR Board Meeting Old Business: Proton Pump Inhibitors

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	The criteria was updated. Long term use is defined as greater than 60 days in recent 120 days. Exclude patients with concurrent NSAID and/or aspirin and exclude if diagnosis of Zollinger Ellison syndrome, GI Bleed, Barrett's esophagus, gastrostomy, cystic fibrosis, celiac disease, and endocrine neoplasms. The paragraph to providers was revised accordingly. New Business: Diabetes Disease Management Proposal This intervention was approved as presented. There were no criteria changes since the last mailing May 17th, 2018 when revisions occurred. Polypharmacy Proposal This intervention was approved as presented. There were no changes in the criteria as presented. This intervention has been mailed previously on November 30, 2016 and November 30, 2018. March 20, 2019 DUR Board meeting New Business: Ad Hoc Polypharmacy Analysis: Results confirmed this population have a number of chronic, concurrent disease states with the highest Number of drugs per patient was the mental health drug group at 3.5 drugs per patient. Polypharmacy Disease Specific Proposal The concept was explored to add more disease specific intervention paragraphs to the polypharmacy intervention. The patient population with a polypharmacy indicator were then run against the rules engine for chronic diseases which included asthma, CVD and/or CHF, Diabetes, GI Disorders, Mental Health, and Opioid Therapy. The resulting corresponding disease indicators were further discussed. Medication Adherence Proposal The RetroDUR contractor suggested a medication adherence proposal. Candidates are patients receiving current drug therapy in the most recent 45 days and chronic therapy in the last 90 to135 days. The DUR Board feedback was the information may be useful but it is hard to incorporate follow-up within in a practice's workflow. This proposal was not accepted. Adherence is already included as one of the indicators in disease state interventions. May 15, 2019 DUR Board Meeting Department Update: The Uniform PDL goes into effect July 1, 2019. For FFY 2018, the Minnesota Annual DUR Survey to CMS included reporting from each of the eight Medicaid Managed Care Organizations (MCOs). Old Business: Suggested changes in the Diabetes Mellitus intervention clinical paragraphs provided by Dr. Schlichte, DUR Board member, will be incorporated into the clinical paragraphs. Revised Polypharmacy Disease Specific Proposal This intervention was brought back to finalize the DUR Board recommendations from last meeting's discussion. The proposed prescriber letter includes a paragraph that describes what is included in the comprehensive medication review, Medication Therapy Management Services (MTMS), which are covered by Minnesota Health Care Programs (MHCP). New Business:

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	Opioid Proposal - Concurrent Antipsychotic Drugs and Benzodiazepines (H.R. 6-16) Before going over the DUR section of H.R. 6-16 or the SUPPORT Act, background information was presented on other Minnesota opioid prescribing effects which originated with the Minnesota legislatively mandated Opioid Prescribing Improvement Program (OPIP). After two years of work, OPIP now consists of opioid prescribing guidelines, sentinel prescribing measures, provider education, reporting, and a quality improvement program. One of the main goals of OPIP is to prevent the progression from opioid use for acute pain to chronic opioid use. Another goal is to reduce unnecessary variation in opioid prescribing. Annually, each Minnesota Medicaid opioid prescriber receives a comparison of their prescribing metrics to the average of their specialty group across seven opioid prescribing measures. In subsequent years, there will be an actionable quality improvement expected based on some of the established thresholds. H.R. 6-16. The discussion as it pertains to tonight's meeting is the concurrent prescribing of opioids with benzodiazepines and/or antipsychotics. This drug-drug interaction is already flagged as a prospective DUR edit which pharmacists can view. Minnesota FFS uses First Data Bank as the source of POS drug-drug interaction information. Both of these opioid drug-drug interactions are level 3 which means to assess risk to the patient and take action as needed. Utilization of opioids, benzodiazepines, and antipsychotic drugs. In a recent 30-day period, FFS utilization showed 2,794 patients who received opioids; 3,599 patients who received benzodiazepines; and 7,036 patients who received antipsychotic medications. Using the criteria greater than seven cumulative days of overlap, results were n=442 for concurrent opioids and benzodiazepines, n=256 for concurrent opioids and antipsychotics, and n=116 when all three drugs overlapped. The criteria of greater than seven days of overlap during a 30 day period was approved by the DUR Board. Second criteria approved was multiple prescribers defined as two or more prescribers for the drugs: opioids and benzodiazepines or drugs or opioids and antipsychotics where there was a greater than seven days of overlap. Besides POS edit, the DUR Board recommended mailing the RetroDUR intervention regarding opioid drug interactions with antipsychotics and opioid drug interactions with benzodiazepines referencing the SUPPORT Act DUR requirements. A summary of the DUR Board recommendations are below: 1. Mail the 4th quarter of calendar year to correspond with CMS October 1st implementation date of the SUPPORT Act. 2. Exclude MAT drugs and exclude Z-drugs. 3. Use greater than 7 days of overlap for concurrent criteria 4. Use 2 or more providers for coordination of care indicator 5. Do not include Medication Assisted Treatment (MAT) drugs, such as Suboxone, when identifying the drug-drug interactions. 6. Add disclaimer sentence to closing paragraph: This DUR letter is not used for the DHS Opioid Prescribing Improvement Program (OPIP). August 21, 2019 DUR Board Meeting Updated DM messages 1. A statement will be added to the end of Metformin-Containing Product(s) with H/O Acidosis bullet point: if the patient currently has lactic acidosis, please discontinue the medication.

2. A statement will be added to Metformin Product(s) with Renal Impairment bullet point: metformin should be stopped if the eGFR is less than 30. Please review for the use of appropriate alternatives, and regularly monitor for clinical signs and symptoms of lactic acidosis or worsening of existing renal impairment.
3. GLP1 and Renal Impairment bullet point: Per the prescribing information, GLP1 therapy should not be used in severe renal impairment will be changed to per the prescribing information, some GLP1 therapy should not be used in severe renal impairment.

New Business:
RetroDUR Outcome Methodology for Polypharmacy
Because there was twice the savings in FFY 2018 savings compared to the FFY 2017 mailing with the similar number of patients, using the data from the polypharmacy outcome completed in 2018, Conduent explained the steps of their savings calculations.
A summary of the presentation is below:
1. Adjusted Target Patients are determined based on receiving any Rx therapy in the last 90 days.
2. The same adjusted target patient count is used for each month of the pre- and post- period.
3. Only intervention drugs costs are included which for polypharmacy would be all drugs.
4. A six month savings is determined than multiplied by two for annual savings.
5. Findings were that even though the cost per prescription increased in the post-period, the overall drug expenditures decreased due to a decrease of ten percent in the number of prescriptions in the post-period compared to the pre-period.
6. User months rather than the PMPM numbers are employed to better capture the dollar savings

Additional ad hoc information was provided which contained more details about the FFY 2018 polypharmacy outcome report. Changes by therapeutic classes, changes between pre- and post-paid periods, and savings by individual drug class within the targeted population were included.

Minnesota Program Assessment FFY 2018
This assessment is completed annually by RetroDUR contractor Conduent to identify the best opportunities for the next year. Recommendations included psychotherapeutic agents, Diabetes management, and polypharmacy.

Psychotropic Drugs in Adults 2019 Proposal
The purpose of this proposal is to promote the safe and cost-effective use of psychotropic drugs in adults. The use of psychotropic drugs at doses above recommended maximum are associated with adverse outcomes and associated costs. The use of multiple SGAs have not been shown to improve efficacy or outcomes. A greater number of concurrent psychotropic medications may not show any additional benefit. The population includes all adult patients receiving any of the targeted psychotropic drug therapy in the past 60 days. The type of intervention is a cover letter and modified profiles. Criteria approved by the DUR board are listed below:
1. High Dose: ADHD Medications
2. High Dose: Antidepressants
3. High Dose: Second Generation Antipsychotics
4. Non-Adherence: ADHD Medications, Antidepressants, Bipolar Medications, SGAs
a. This indicator has the highest number of exceptions, which does not count as needed or prn use.
5. Multiple (two or more) Oral SGAs
a. This indicator includes patients with history of epilepsy.

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	6. Polypharmacy: greater than 3 Psychotropic Medications 7. Monitoring of SGAs: Glucose and/or Hemoglobin A1C 8. Monitoring of SGAs: Lipids 9. Use of oral Antipsychotic Concomitantly with Long-Acting Injectable greater than 90 days There will be no changes in the letter itself, and response forms will not be sent.
Mississippi	DUR Board Activity Summary DUR Board Meetings: Mississippi Division of Medicaid uses two provider boards to provide review and input on prospective and retrospective DUR efforts. The Pharmacy and Therapeutics (P&T) Committee reviews selected drug classes on a regular basis and makes recommendation regarding the Preferred Drug List and clinical edits for specific products and/or classes. The DUR Board reviews utilization reports and retrospective studies conducted by the DUR Vendor and makes recommendations about prospective and retrospective utilization management interventions that should be taken for specific drugs and/or therapeutic classes and what items should be included or deleted from the retrospective exceptions monitoring program. The two groups are closely coordinated with prospective DUR vendor representatives and retrospective DUR vendor representatives attending both meetings. During P&T Committee meetings, issues are frequently identified for retrospective review for potential further action by the DUR Board. The Pharmacy and Therapeutics Committee met four (4) times during the 2019 Federal Fiscal Year on the following dates: - October 23, 2018 - February 12, 2019 - May 7, 2019 - August 13, 2019 There were four (4) DUR Board meetings held during the 2019 Federal Fiscal Year on the following dates: - December 6, 2018 - March 7, 2019 - May 23, 2019 - September 19, 2019 Prospective DUR problem type/drug combinations added or deleted by DUR Board Problem Type/Drug Combinations Added: APU - appropriate use (appropriate trial of metformin in diabetic patients) APU - appropriate use (improving the utilization of controller medications for asthma and COPD) APU - appropriate use (improving the use of hydroxyprogesterone during high-risk pregnanacies) Categories and Drugs Deleted: None Retrospective DUR therapeutic categories added or deleted Categories and Drug Types Added: APU - appropriate use (concurrent prescribing of opioids and antipsychotics) IDO - polypharmacy (provider/pharmacy shopping for opioids)

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	DDI - drug-drug interaction (concomitant use of opioids and benzodiazepines) IDO - inappropriate dose (high morphine equivalent daily dose of opioids) APU - appropriate use (metabolic monitoring of children prescribed antipsychotics) CAP - clinical appropriateness (evaluation of use of calcitonin gene related peptides) CAP - clinical appropriateness (evaluation of use influenza vaccine and strategies to improve adherence) DUR Board Policies for Collaboration between Prospective and Retrospective DUR MS-DUR works with the prospective DUR vendor, Conduent, Inc. to facilitate collaboration between the prospective and retrospective DUR functions. Prospective clinical edit criteria are recommended by the P&T during preferred drug list decision making or by the DUR Board during utilization review discussions. Clinical edit criteria utilized in electronic prior authorization are evaluated by the retrospective DUR vendor to confirm logic and assess potential impact on utilization before implementing into the prospective DUR. They are also evaluated after implementation to assure appropriate coding and implementation. DUR Board Involvement in the Education Program The DUR Board for the Mississippi Division of Medicaid review utilization reports prepared by the retroDUR vendor and when appropriate, request educational intervention mailings to providers. Provider interventions are primarily mail-based, with special effort to focus on non-punitive Medicaid program information dissemination. Exceptions-driven provider interventions are targeted on improvement of performance on Adult and Child Core Set quality measures, therapeutic categories particularly sensitive to non-adherence and non-persistence on drug therapy and other safety related issues (e.g., prescribing of opioids).
Missouri	The MO HealthNet DUR Board held one meeting on July 17, 2019. The prior quarterly meetings scheduled for October '18, January '19 and April '19 were not held do to a lack of quorum. At the July '19 Board meeting the Board reviewed and approved all new edits and edit renewals scheduled for this meeting and the prior quarterly meetings which included 26 new additions (Galafold, Onpattro, Orilissa, Anti-Parkinsonism MAO-B Inhibitor Agents, Antipsychotics 2nd Generation (Atypicals) Reference Product List, Electrolyte Depleters Potassium Lowering Agents, Hereditary Angioedema Treatment Agents, Thrombocytopenia Treatment Agents, 15 Day Supply Oral Oncology, Crysvita, Jynarque, Palynziq, Sympatholytic Agents, Lipotropic Agents: Proprotein Convertase Subtilisin Kexin type 9 (PCSK9) binder, Antianxiety Benzodiazepines, Epidiolex, Nocturnal Polyuria, Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR), Systemic Antifungals, Calcitonin Gene-Related Peptide Inhibitors, Psoriasis Agents Oral, Respiratory Monoclonal Antibodies, Gamifant, Lambert-Eaton Myasthenic Syndrome (LEMS), Oxervate, Parathyroid Hormone and Bone Resorption Suppression Related Agents, Colony Stimulating Factors).
Montana	Report on DUR Board Activities (FFY 2019) A. Number of DUR Board Meetings Held Six (6) DUR Board meetings were held in FFY 2019. B. Deletions or Additions to Prospective DUR Criteria

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	The following drug criteria were approved and added: New Drug Reviews Galafold - criteria for use developed with QL limit Ajovy - criteria for use developed with QL limit Epidiolex - criteria for use developed with QL limit Nocdurna - criteria for use developed with QL limit Noctiva - criteria for use developed with QL limit Emgality - criteria for use developed with QL limit Arikayce - criteria for use developed with QL limit Olumiant - criteria for use developed with QL limit Kevzara - criteria for use developed with QL limit Oxervate - criteria for use developed with QL limit Tegsedi - criteria for use developed with QL limit Diacomit - criteria for use developed with QL limit Motegrity - criteria for use developed with QL limit Zelnorm - criteria for use developed with QL limit Updated Drug Criteria Ingrezza/Austedo - AIMS score, functional impairment requirement, initial authorization to 12 weeks Dupixent - new indication Growth Hormone - updated criteria for Small for Gestational Age Codeine/hydrocodone/tramadol use in pediatrics - per DEA guidelines Atypical Antipsychotics under age 6 - per updated guidelines and DUR Board direction C. Deletions or Additions to Retrospective DUR Criteria Criteria changes/additions/deletions have been incorporated into existing criteria sets and are available in full criteria format upon request. D. Describe Retrospective DUR Criteria that resulted in changes to prospective DUR and vice-versa Prospective DUR criteria are provided by a different vendor than the Retrospective criteria. The DUR Board recognized the need for consistency between criteria sets and attempts to align them as closely as possible. In all cases, prospective criteria are more selective and refined because of internal access to the criteria development process. The DUR Board also matched Retrospective DUR criteria to those that are utilized by the Formulary and Prior Authorization Program. The Formulary and Prior Authorization criteria are reflected in both the Retrospective and Prospective DUR systems. This accounts for lower than anticipated cost savings on the Retrospective side of the program, i.e. that many of the potential conflicts are solved before they appear in the Retrospective program. E. Describe DUR Board involvement in the DUR education program The DUR Board directs development of both educational and prior authorization formularies, and the review of educational intervention letters generated to providers. The DUR Board makes

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	recommendations to the DUR coordinator for quarterly newsletter topics. The Board has also been involved in direct peer-to-peer interventions when necessary. Through the Formulary and Prior Authorization program, the DUR Board also directed a consensus effort of physicians and pharmacists to create several educational formulary guidelines as well as strict formulary guidelines that are used in the Prior Authorization Program. Since 2004, when Montana Medicaid began development of a Preferred Drug List (PDL), the DUR Board has made recommendations to the Department based on evidence and literature-based evaluation of drug therapy for the PDL. The DUR Board and the Department collaborated in developing a pharmacy case management intervention tool that makes phone appointments with physicians to discuss utilization issues, counter-detailing, and cost appropriateness. In addition, our pharmacy case management program provided academic detailing to providers in FFY2019. A link to on-line quarterly newsletters are distributed to nearly 1000 pharmacies and providers with timely drug utilization review topics and newly developed criteria information.
Nebraska	SUMMARY OF DUR BOARD ACTIVITIES The Nebraska Medicaid DUR Board met in Lincoln, Nebraska, five times during FFY 2019. November 6, 2018 January 8, 2019 March 12, 2019 May 14, 2019 July 9, 2019 DUR Board Approved Prospective Criteria (Additions or Deletions) IGF-1 - Annual Review of Prior Authorization Criteria Recommended that no changes be made. Growth Hormone - Annual Review of Prior Authorization Criteria Recommended that no changes be made. Opioids Limits Recommended an initial total daily limit of 201 MME, to be decreased every 6 months to a target of 90 MME or less, excluding patients with cancer or in hospice care. Recommended that patients new to opioids (no claims in previous 90 days) be limited to a 7-day supply, not to exceed 50 MME for initial prescriptions. Hepatitis C Fibrosis score decreased Recommended modifying fibrosis score to patients with a score of 2 or higher. Concomitant Opioids and Benzodiazepines soft edit recommended soft edit for any new start (defined as none in the last 90 days) for opioid/benzodiazepine combination when not prescribed by the same prescriber for a patient already on a opioid or benzodiazepine. Retrospective DUR Projects Each month, profiles of patients utilizing more than 6 prescribers and 3 pharmacies in a month are reviewed. Patients utilizing multiple providers to receive similar medications are referred to their respective managed care organization for Restricted Services evaluation. MME daily limit was decreased during FFY 2019 on a scheduled determined by the DUR Board and letters sent to providers with patients above the MME included information on naloxone. Seven day limit in new patients to opioids (max of 50 MME per day) were monitored and letters send to prescribers. Of the providers that responded a majority noted the information as useful and either planned on changing the patient therapy or monitoring the patient. Adult patients taking stimulants exceeding FDA-approved limit were reviewed and letter sent to prescribers. Adults taking stimulants without an FDA-approved diagnosis on file were reviewed and board proposed a process to have an FDA indicated diagnosis on file. Project to be reviewed in 2020 for process discussion regarding retail pharmacy software limitations. Diabetic patients between the ages of 40 and 75 years old not taking a statin were reviewed and managed care organizations shared their outreach efforts to outreach to members and educate pharmacists to engage patients. Patients with asthma filling 2 or more short-acting beta agonist inhalers in 30 days with no inhaled corticosteroid on file were reviewed and the DUR board set the retrospective review indicator at consistent use of 2 or more short-acting beta agonist inhalers over a longer time period. Concomitant antipsychotics in children were an ongoing monitoring program by the managed care organizations with identified providers sent letters on mental health drug utilization. Quarterly Newsletters The DUR Board sends a quarterly newsletter, DUR Matters, to providers on a variety of topics. In FFY 2019, the titles of the newsletters were: Tapering Opioids and Withdrawal Management; How do Opioids Compare to Each Other? Calculating MME; The Dangerous Combination of Opioids and Benzodiazepines; Complete Coding of Office Visits. Subscriptions to the electronic newsletter are free of charge. Nebraska Medicaid DUR Board Policy Statements (Reviewed

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	2019) The purpose of the Drug Utilization Review (DUR) Board is to improve the quality of pharmaceutical care by ensuring that prescribed medications are appropriate, medically necessary and that they are not likely to result in adverse medical results. 1. All pharmacist and physician members of the Nebraska DUR Board with voting privileges are licensed in the State of Nebraska and are actively practicing their profession as defined by the DUR Contract. Pharmacy students and medical students serving on the DUR Board do not have voting privileges. 2. The Board may serve as a teaching body welcoming pharmacy students and medical students to participate in all Board functions except voting when such students are willing to donate their time. 3. All voting members of the Nebraska DUR Board shall be paid an honorarium for attendance at meetings, the time necessary for travel and meeting preparation. Such honorarium shall be determined by the DUR Director and the Executive Vice President of the Nebraska Pharmacists Association. 4. All voting members of the Nebraska DUR Board attending meetings shall be reimbursed for the actual mileage driven to attend the meeting. 5. The voting members of the Nebraska DUR Board shall include at least one-third (1/3) but no more than fifty-one percent (51%) physicians and at least one-third (1/3) pharmacists, not exceeding a total of thirteen (13) people. 6. Board membership vacancies shall be filled, and board reappointments shall be made by the DUR Director upon the recommendation of the appropriate state professional association (Nebraska Medical Association or Nebraska Pharmacists Association) with the final approval by the Nebraska Department of Health & Human Services, Division of Medicaid & Long-Term Care. Board members shall serve one (1) term of five (5) consecutive years with the privilege of being reappointed for one (1) additional five-year term. A quorum shall consist of 7 voting members. Conflicts on the Board will be resolved by majority vote of the voting members present. In the event of a tie vote, the DUR Director shall cast the tie-breaking vote. Pursuant to contract with the State of Nebraska, DUR Board members may be removed from the Board for failure to attend meetings. 7. The Nebraska DUR Program shall, when appropriate, refer specific cases or providers to the Nebraska Department of Health & Human Services, Division of Medicaid & Long-Term Care or the Nebraska Department of Health & Human Services, Licensing and Regulatory Affairs division for action. 8. Public comment at DUR Board meetings will follow these guidelines: Unsolicited presentations are limited to 5 minutes per drug or topic, regardless of the number of presenters and time will be evenly divided among presenters. Public comment must be presented in person at the meeting. 9. All meetings of the Nebraska DUR Board or any subcommittee of the Board shall be open meetings, unless a specific beneficiary or provider or proprietary information is being discussed. Should specific persons be under discussion or proprietary information be discussed, the DUR Board shall enter closed session. 10. The Nebraska Medicaid DUR Board shall conduct meetings in the following order, unless special circumstances dictate a different order: 1. Opening and Introductions 2. Declaration of any Conflict of Interest or changes 3. Approval of Agenda 4. Approval of Minutes of Previous Meeting 5. Update on Recommendations from Previous Meeting 6. Retrospective DUR Old Business Current Profile Review New Business Recommendations for Future Profile Review 7. Prospective DUR Old Business New Business 8. Special Requests from the Department 9. Future Meeting Dates 10. Concerns & Comments from the Board 11. Concerns & Comments from the Director 12. Concerns & Comments from State Representatives 13. Concerns & Comments from MCO Representatives 14. Concerns & Comments from Public Attendees 15. Adjournment 16. It shall be the general policy of the Nebraska DUR Board that 6 meetings will be held annually. 17. DUR Board members shall be involved in the education program by providing content and review for quarterly newsletters. At least one physician board member shall assist the DUR Director in the preparation of intervention letters. All DUR intervention letters shall be signed by one board physician and the DUR director, when it is possible to do so. The DUR Board shall not intervene directly with patients. Providers may be notified by letter of patients' drug use. Inquiries from patients shall be referred to the Nebraska Department of Health & Human Services, Division of Medicaid & Long-Term Care. 18. The DUR Board shall conduct a minimum of two Retrospective DUR projects annually that address the most clinically relevant Prospective DUR

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	messaging, as identified in the CMS Annual Report. When necessary, the DUR Board may review profiles generated and shall select those profiles requiring intervention. When the results of each Retrospective DUR project are reviewed by the DUR Board, the DUR Board may decide to recommend changes for Prospective DUR screens. 19. The DUR Board may research and develop drug use criteria for recommendation to the Medicaid department after approval by the DUR Board. The DUR Board shall annually review all existing criteria. 20. All intervention letters from the Nebraska DUR Project will be informative in nature. 21. All communication sent to the Nebraska DUR Program for distribution to the Nebraska DUR Board must be accompanied by twenty (20) copies. Any communication not meeting these requirements will be sent at the discretion of the DUR office staff. No communication is to be sent directly to any member of the DUR Board from any interested party without first being sent to the DUR Program office. Communication intended to be provided to subcommittees of the Board will require additional copies. Contact dur@npharm.org for additional information. 22. The DUR program may charge a reasonable fee for copying and mailing of information to the Board members. 23. Meeting agendas will be posted to the website 30 days prior to the scheduled meeting. From the date that the agenda is posted until after the DUR Board meeting is held, it is inappropriate for anyone receiving compensation from a pharmaceutical manufacturer, to contact a board member regarding DUR Board agenda items. www.durnebraska.org.
Nevada	Nevada Medicaid held four meetings between October 1, 2018 and September 30, 2019. For prospective DUR and retrospective DUR, the DUR Board can recommend updates and changes to initiatives, policies and education. The OptumRx DUR Pharmacist provides education and resources to providers through retrospective DUR initiatives. The DUR Board did not establish new policies as a result of prospective or retrospective DUR screenings. Below is a summary of each meeting. October 18, 2018 Clinical Presentations and Board Discussion: Immunomodulator Drugs; Addition of criteria for Ilumya Opioids Specific to Recipients Under 18 Years of Age; decrease day supply to three days for recipients under age 18 Calcitonin Gene-Related Peptide Receptor (CGRP) Inhibitors; addition of new criteria Board Reports: High Dollar Claims (Claims over $10,000) Top Opioid Utilization by Prescriber and Member Antibiotic Utilization Oncology Medication Utilization January 24, 2019 Clinical Presentations and Board Discussion: Anti-Neoplastic Agents; addition of criteria for all oral anti-neoplastic agents Inhaled Short-Acting Beta Agonists; quantity limit of two units per month added Compound Medications; criteria revised to include all outpatient compounded medications Sacubitril/Valsartan (Entresto); criteria removed Cannabidiol (Epidiolex); addition of new criteria Medications for the Treatment of Pulmonary Arterial Hypertension; added diagnosis requirement Board Reports: High Dollar Claims (Claims Over $10,000) Top Opioid Utilization by Prescriber and Member Antibiotic Utilization

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	April 25, 2019 Clinical Presentations and Board Discussion: Substance Abuse Agents; addition of criteria for Lucemyra ADD/ADHD Treatments; revised existing criteria Androgen/Testosterone Replacement Agents; criteria revised to include injectable testosterone Fentanyl; revised existing criteria Board Reports: Top Opioid Utilization by Prescriber and Member Top Claims for Members Under 18 years of age July 25, 2019 Clinical Presentations and Board Discussion: Growth Hormones; revised criteria Esketamine (Spravato); addition of new criteria Agents for the Treatment of Chronic Idiopathic Constipation (CIC); added additional agents and updated the criteria Triptans; revised the existing criteria Board Reports: Top Opioid Utilization by Prescriber and Member Opioid Use Disorder and Opioid Use Specialty Drug Utilization
New Hampshire	The NH Medicaid DUR Board met once during FFY19 on March 12, 2019 where drug utilization patterns for prospective and retrospective activity were discussed as well as 22 current clinical criteria updates and 3 new clinical criteria were approved. During FFY 2019, the following clinical criteria were updated with new medications, new indications and guideline changes: 1. Allergen Extract Criteria 2. Anti-fungal for Onychomycosis Medications Criteria 3. Anti-obesity Criteria 4. Asthma/Allergy Immunomodulators Criteria 5. Atopic Dermatitis Criteria 6. Brand Name Multiple Source Prescription Drugs Criteria 7. Direct Renin Inhibitors & Combinations Criteria 8. Hematopoietic Agents Criteria 9. Hepatitis C Criteria 10. Huntington's Disease Criteria 11. Legend Topical NSAIDs Criteria 12. Long-acting Opioids Criteria 13. Lyrica Criteria 14. Morphine Milligram Equivalent (MME) Criteria 15. New Drug Product Criteria 16. Oral NSAIDs Legend Criteria 17. Proton Pump Inhibitors Criteria 18. Pulmonary Arterial Hypertension (Phosphodiesterase Type 5 (PDE05) Inhibitors Only) Criteria 19. Short Acting Fentanyl Analgesics Criteria 20. Spinraza Criteria 21. Syndros Criteria

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	22. Systemic Immunomodulators Criteria The following were new clinical criterion approved during FFY 2019: 1. Carisoprodol & Combination Medications Criteria 2. Calcitonin Gene-Related Peptide (CGRP) Inhibitors Criteria 3. Rho Kinase Inhibitors Criteria NH DUR Board continues to monitor Therapeutic Duplications, Drug Drug interactions, Duplicate Ingredients and Early Refills. NH Medicaid continues to utilize First Data Bank for Prospective DUR criteria. For FFY 2019 the following therapeutic classes for retrospective DUR were reviewed: 1. NSAIDS increase the risk of stroke or heart attack_FDA warning change 2. Diabetics ages 40-75 with no statins 3. Members with 6 or more Narcotic claims, diagnosis for substance abuse or overdose and no claims for naloxone in 180 days 4. Bipolar Disorder with antidepressants and no mood stabilizer 5. Diabetics without an ACEI or ARB in history 6. Direct-acting antivirals- FDA warning on reactivation of Hepatitis B_no medical claims 7. SABA_ 2 or more in 90 days without a controller medication 8. Use of antipsychorics in children < 18 without metabolic testing 9. Polypharmacy 10. Serotonergic Agents with Serotonergic Agents 11. Atypical Antipsychotics without metabolic testing The second meeting scheduled did not have a quorum.
New Jersey	October 17, 2018 - The Board reviewed and updated its recommendations for: a. Morphine milligrams equivalents (MME) for both short and long acting opioids b. The need for prior authorization for concomitant use of opioids and benzodiazepine - The Board reviewed and recommended a protocol for pancreatic enzymes - As part of its overview of the MCOs, the Board reviewed and commented on pregabalin protocols from MCOs and Fee for Service (FFS) programs - The Board reviewed its own annual report for SFY 2018 in preparation for publication in the NJ Register - The Board reviewed prior authorization denial report for FFS and all MCOs for the 2nd quarter of CY2018. The purpose of this review is to ensure unhindered access of medications for patients - The August 2018 Top Drugs report was also reviewed January 16, 2019 - The Board discussed ongoing processes at the State in preparation for removing prior authorization from Medication Assisted Treatment (MAT) products - The Board reviewed opioid utilization from October 2015 thru September 2018. The report showed a 21 percent decrease in prescribing per 100 persons for New Jersey during the review period. - The Board reviewed and tabled a proposed protocol for dupilumab - The Board reviewed and recommended a proposed protocol for cannabidiol - The Board reviewed and recommended a proposed protocol for pregabalin (Lyrica) - The Board reviewed prior authorization report comparing all MCO plans including FFS for the 3rd quarter of CY2018. - The Board reviewed November 2018 Top Drugs was also reviewed.

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	April 19, 2019 - The Board reviewed and recommended a proposed protocol for dupilumab (Dupixent) - The Board reviewed and recommended a proposed protocol for calcitonin gene-related peptides (CGRP) antagonists used in migraine prophylaxis - The Board reviewed and recommended a proposed protocol for gout products (febuxostat [Uloric], lesinurad [Zurampic], peglogicase [Krystexxa]). - The Board reviewed a prior authorization report comparing all HMO plans including FFS for the 4th quarter of CY2018. - January 2019 report of the Top 100 Drugs by dollar amount, claims and service units was also reviewed. July 17, 2019 - The Board reviewed and recommended a proposed protocol for Hereditary Angioedema (HAE) products. - The Board reviewed and recommended a proposed protocol for Urea Cycle Disorder products. - The Board reviewed and recommended a proposed protocol for chelating agents (Cuprimine [penicillamine] and Syprine [trientine]) used in the treatment of specific disease states - Wilson's disease, cystinuria, severe rheumatoid arthritis - The Board reviewed and recommended a proposed protocol for onasemnogene abeparvovec-xioi (Zolgensma) - The Board reviewed a prior authorization report comparing all HMO plans including FFS for the 1st quarter of CY2019. - The Board reviewed the top 100 drugs used in April 2019 by dollar amount, claims and service units.
New Mexico	Four meetings were held in FFY 2019. a. The DUR Board did not approve, delete, or change any NCPDP ProDUR criteria. b. The DUR Board approved and completed one educational newsletter and two interventions for Federal Fiscal Year 2019. There are no written DUR Board policies per se. One educational outreach newsletter was delivered to fee-for-service providers and pharmacies and two patient-focused interventions were delivered to selective providers in FFY 2019. The newsletters contained articles reviewing clinical topics approved by the New Mexico DUR Board. The first intervention focused on codeine and tramadol use in youth and the second intervention focused on management of patients on multiple second-generation antipsychotics.
New York	During the period of October 1, 2018 to November 30, 2019 the DUR Board held three meetings: February 14, 2019, May 16, 2019 and September 19, 2019. The following discussions and resolutions took place during the following meetings: February 14, 2019 Drug Cap Review of Remicade (infliximab) The Board was apprised of the expenditures for Remicade as this product was identified as piercing the State's Medicaid Drug Cap. State legislation requires that the absence of positive rebate negotiations for products identified as piercing the Drug Cap requires the Commissioner of Health to direct the Drug Utilization Review (DUR) Board to perform a drug review with the intent of suggesting a targeted supplemental rebate from the manufacturer. A product review of Remicade (infliximab) was presented emphasizing its place in therapy, indications, and utilization data. A cost comparison of the biosimilar

products to Remicade were outlined. The Board decided upon a supplemental rebate target amount and recommended that value to the Commissioner of Health.

Drug Utilization Review : Concurrent use of opioids with gabapentin/pregabalin
A drug utilization review of the concurrent use of opioids with gabapentinoids was presented which demonstrated safety concerns with the gabapentinoid doses being used. The Board made three recommendations:1) PA requirement for gabapentin doses >900mg per day and pregabalin doses > 150 mg per day in patients currently on an opioid dose > 50 morphine milligram equivalent /day. 2) PA requirement for concurrent opioid use beyond 7-day supply in patients established on a gabapentinoid. 3) Dose limitations for pregabalin IR and ER, 4) Intervention letter to prescribers highlighting safety concerns associated with concurrent use of opioids and gabapentinoids.
Prevention of Migraine Headaches and Concurrent use of Triptans
A drug utilization review was conducted on the prevention of migraine headaches and the concurrent use of triptans. The data showed that there may be some overutilization of triptans by way of utilizing different strengths or agents to receive dosage units above the programs monthly quantity limits.
Utilization of Systemic Immunomodulators
A drug utilization analysis was presented to assess if products in the systemic immunomodulator class were being used for FDA approved indications. The data identified 5 top agents all of which were used for FDA-approved indications.

Review of Clinical Edits
Drug utilization data illustrating the role of current pharmacy criteria/intervention initiatives developed for the Medicaid Program (FFS and MC) and their effects on the use of opioids for pain management was presented to the Board. The data demonstrated a downward trend in opioid use for the Medicaid Program for the periods State Fiscal Year (SFY) 2014 through SFY 2018. In addition, data was presented illustrating the use of medications for opioid dependence within the Medicaid Program (FFS and MC). The data showed an increase in members utilizing buprenorphine containing products. The presentation summarized for the Board the benefits legislative initiatives and pharmacy management programs had on the use of opioids in the Medicaid Program.

May 16, 2019
Preferred Drug Program
A clinical and financial review of products being added or moved between the preferred and non-preferred sections of the Preferred Drug List (PDL) were outlined for the Board. The therapeutic classes reviewed for PDL status. The categories reviewed were as follows: Tetracyclines, Anticonvulsants, Anti-Migraine agents, CNS Stimulants, Movement Disorder Agents, Multiple Sclerosis Agents, Growth Hormones, Colony Stimulating Factors, Erythropoiesis Stimulating Agents, Immunosuppressives, Anti-hyperuricemics, Anticholinergics/COPD Agents. Suggested changes to the PDL by the Department of Health were recommended by the Board.

September 19, 2019
Drug Cap Update
A Drug Cap update was presented as an overview for the Board focusing on pharmacy expenditures for SFY 2019 and projections for SFY 2020. Based upon projections, pharmacy expenditures are expected to exceed the States Medicaid Drug Cap.

Support for Patients and Communities Act (The SUPPORT ACT)
The Board was provided a dissertation on the Support for Patients and Communities (SUPPORT) Act went into effect October 1, 2019. The report focused on section 1004 of the Act which is specific to

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	Medicaid review and utilization. The SUPPORT ACT effects both Medicaid and Managed Care Entities. Specific DUR provisions become effective on October 1, 2019 and it was reported that provisions of the ACT are in place for FFS. Early indications suggest that the provisions are in place for the Managed Care Plans after a review of their CMS Annual DUR Survey for compliance. Opioid Utilization as it Relates to the SUPPORT ACT A review was presented to the Board to illustrate the tools currently used by the New York Medicaid Program to comply with the standards of the SUPPORT ACT. Focus was placed on the prospective (ProDur) and retrospective (RetroDur) initiatives as applied to opioid utilization within the Medicaid Program. Point of service edits (ProDur initiative) have impacted opioid utilization which have led to a decrease in opioid use from SFY 2014 to the present. Retrospective evaluations (RetroDur initiative) identify drug therapy concerns involving opioids. Targeted educational letters are then sent to Medicaid providers (prescribers and pharmacists). Trends involving suspected fraud and abuse with opioids are then extracted and sent to the Office of the Medicaid Inspector General for review. After the presentation the Board acted on opioid utilization as related to the SUPPORT ACT by recommending that a prior authorization be required for opioid-naive patients exceeding a morphine milligram equivalent (MME) of 90 mg per day. Antipsychotic Utilization in Children as Related to the SUPPORT ACT A drug utilization review was presented evaluating the concurrent use of antipsychotics and opioid medications in children in both the Medicaid and Managed Care programs. Utilization data was inclusive of age, metabolic monitoring and poly pharmacy and included the foster care children population. Clinical monitoring criteria from the ProDur and RetroDur programs were identified as being consistent with the positions of the FDA, CMS, and the requirements of the SUPPORT ACT. At the conclusion of the presentation the Board recommended that a targeted educational letter be sent to prescribers regarding antipsychotic therapy and metabolic monitoring for patients less than 21 years of age. A second recommendation by the Board required prior authorization for patients less than 21 years of age when there is concurrent use of two or more different oral antipsychotics for greater than 90 days. Concurrent Utilization of Opioids and Antipsychotics as related to the SUPPORT ACT A second drug utilization review was conducted with the purpose of evaluating the concurrent use of antipsychotics, opioid medications and benzodiazepine agents in conjunction with the mental health treatment and the coordination of care of recipients within the Medicaid FFS and MC populations. Once again, the current clinical criteria edits and programs (ProDur and RetroDur) utilized by the Medicaid FFS program illustrated consistency with the positions of the FDA and CMS as they pertained to opioid and antipsychotics monitoring. The review concluded that the aspects of the ProDur and RetroDur programs should continue to be used to monitor the concurrent use of these agents with the Medicaid Program. The Board recommended that a targeted educational letter be sent to prescribers highlighting the SUPPORT ACT requirements addressing the concurrent use of antipsychotic and opioid medications and the importance for mental health treatment and coordination of care. Leukotriene Modifier Utilization in the Treatment of Asthma A third drug utilization review was presented which reviewed the use of leukotriene modifiers in patents being treated for asthma. Current treatment modalities from both the Global Initiative of Asthma and the National Heart, Lung and Blood institute served as guidelines. Data presented reflected the utilization of leukotriene modifiers with and without a diagnosis of asthma. Combined therapies with and without short acting beta agonists, with inhaled corticosteroids as well as with inhaled corticosteroids and long acting beta agonists were identified. The review concluded that 2.4% of Medicaid members with asthma using leukotriene modifiers did not have a claim for another agent

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	used to treat. The Board recommended that a targeted educational letter be sent to prescribers regarding leukotriene modifier use relative to as asthma treatment guidelines. Clinical Editing Updates An update on clinical editing with respect to anti-retroviral (ARV) agents and associated drug interactions was presented. It was explained that the current coding system to categorize drug to drug interactions (DDI) based on severity of clinical significance has changed resulting in interactions of level 1 severity not being captured and reported properly. To compensate, point-of-service edits have been enhanced to report ARV-ARV interactions as level 1. As a result, select ARV-ARV drug interactions previously masked by the change in severity level coding are now able to be identified using point-of-service edits. The process of updating ARV-ARV drug interactions using point-of-service editing will continue as new ARVs or post marketing drug interaction data become available.
North Carolina	The North Carolina Drug Utilization Review (DUR) Board meets quarterly in January, April, July, and October of each year. During each Board meeting the Board is presented prospective DUR and retrospective DUR information. The following prospective DUR categories are reviewed with the Board during each meeting: drug disease contraindication alerts, drug-drug interaction alerts, overuse alerts, high dose alerts, ingredient duplication alerts, low dose alerts, drug underuse alerts, drug age alerts, pregnancy alerts, and therapeutic duplication alerts. The top drug disease alerts during the year consistently included the drug classes: antihyperglycemic, biguanide type (C4L), skeletal muscle relaxants (H6H), and treatment for ADHD/narcolepsy (H2V). Drug-drug interaction alerts included SSRIs (H2S), antipsychotic, atypical, dopamine, serotonin antagonists (H7T), narcotic, analgesic and non-salicylate analgesic (H3U), and opioid analgesics (H3A). Consistently, antipsychotic, atypical, dopamine, serotonin antagonist (H7T), adrenergics, aromatic, non-catecholamine (J5B), and treatment for ADHD/narcolepsy (H2V) were the top overuse alerts quarter over quarter. High dose alerts were driven by narcotic analgesic and non-salicylate analgesic (H3U), antipsychotic, atypical, dopamine, serotonin antagonist (H7T), adrenergics, aromatic, non-catecholamine (J5B), SSRIs (H2S), and antihistamine- 2nd generation (Z2Q). Top ingredient duplication alerts encompassed treatment for ADHD/narcolepsy (H2V), adrenergics, aromatic, non-catecholamine (J5B), antipsychotic, atypical, dopamine, serotonin antagonist (H7T), and beta-adrenergic agents, inhaled, short-acting (B6W). Macrolides (W1D), nitrofuran derivatives antibacterial agents (W2F), penicillins (W1A), and lincosamide antibiotics (W1K) were the top low dose alerts. Top drug underuse alerts included anticonvulsants (H4B), SSRIs (H2S), adrenergics, aromatic, non-catecholamine (J5B), and treatment for ADHD/narcolepsy (H2V). Antihistamines- 1st generation (Z2P), absorbable sulfonamide antibacterial agents (W2A), anti-parkinsonism drugs, anticholinergic (H6B), and non-opioid antitussive- 1st generation-decongest (B3R) lead the drug age alerts. The highest alerts for pregnancy were anticonvulsants (H4B), contraceptives, oral (G8A), SSRIs (H2S), and opioid analgesic and non-salicylate analgesic (H3U). The Board recommended stopping the lactation alert 2 and narrowing the age range to 10 - 50 years old for pregnancy alerts. Anticonvulsants (H4B), SSRIs (H2S), and antipsychotic, atypical, dopamine, serotonin antagonist (H7T) consistently lead the top alerts in therapeutic duplications. During each quarterly meeting, the Board reviews the top 15: drugs (GSN) by total amount paid, drugs (GSN) by total amount paid (all strengths), drugs (GSN) by total claims, and GC3 classes by payment amount. The top 15 drugs (GSN) by total amount paid were Humira Pen (~$3.5M to $4.4M), Mavyret (~$2.9M to $3.7M), albuterol HFA (~$3M to $3.5M), Tamiflu suspension (~$10.7M), and Suboxone Film (~$3M). Pulmicort, Concerta, Spinraza, Epi-Pen, Tecfidera, Enbrel, Sklice, Synagis, and Tamiflu suspension and capsule dropped from the list throughout the year. The top 15 drugs (GSN) by total amount paid (all strengths) included Humira (~$5.2M to $6.7M), Vyvanse (~$4.1M to $4.8M), Latuda (~$4.1M to $4.3M), and Tamiflu (~$13.6M). Throughout the year Spinraza, Genvoya, Epi-Pen, Onfi, and Synagis dropped from the top 15 drugs. The top 15 drugs (GSN) by total claims included albuterol HFA

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	(~36K to 41K claims), cetirizine tab 10 mg (~29K to 36K claims), cetirizine 1 mg/mL (~25K to 45K claims), Tamiflu suspension (~44K claims), and Amoxil 400 mg/5 mL oral (~34K claims). Montelukast, albuterol nebulizing solution, hydrocodone/APAP, cefdinir, ondansetron, and Tamiflu suspension and capsule dropped from the list during this time. The top 15 GC3 classes by payment amount was reviewed with the Board and the top classes were anticonvulsants (~$8.2M to $9.1M; H4B), antipsychotic, atypical, dopamine, serotonin antagonist (~$7.8 to $8.4M; H7T), insulins ($7.3M; C4G), adrenergics, aromatic, non-catecholamine (~$6.7M; J5B), antihemophilic factors (~$18.4M; M0E), antiviral, general (~$10.4M; W5A), and treatment for ADHD/narcolepsy (~$8.1M; H2V). In 2018 and 2019 the retrospective drug utilization categories included: concurrent benzodiazepine and opioid use; clozapine utilization; ADHD medication use by age; Mavyret utilization; pediatric opioid utilization; opioid dependence treatment trend; antipsychotics; methadone utilization; duplication of therapy-short-acting narcotics; monitoring of lithium levels; fluoroquinolone use in diabetic patients; opioid utilization; short-acting oxycodone utilization; codeine use in pediatric patients; fibromyalgia diagnosis: opioid utilization, no fibromyalgia non-opioid utilization; migraine diagnosis: opioid utilization, no triptan utilization; benzodiazepine utilization without SSRI utilization with/without panic attacks; opioids and antipsychotics; and orally disintegrating fentanyl use in non-cancer patients. The DUR Board recommends lettering prescribers and/or pharmacies when appropriate regarding specific topics. Additionally, topics may be addressed in newsletters when trying to reach all prescribers and pharmacies.
North Dakota	North Dakota Summary of DUR Board Activities FFY 2019 Four North Dakota Medicaid DUR Board meetings were held during FFY 2019. The meeting were held during the 1st Wednesday of December 2018, April 9, 2019, and on the 1st Wednesday of June and September 2019. For prospective DUR, prior authorization criteria was put in place for the following problem types/drugs by the DUR Board: criteria for the use of Lucemyra, Palynziq, Roxybond & Siklos, Orilissa, Sivextro, Nuzyra, estrogen agents, vaginal anti-infective agents, short-acting opioid analgesics; and agents for the treatment of osteoporosis, hyperkalemia, glaucoma, dry eye syndrome, Parkinson's disease, thrombocytopenia, narcolepsy and interstitial cystitis. No deletions of DUR Board approved prospective DUR criteria occurred in FFY 2019. For retrospective DUR (RDUR), the DUR Board voted to approve and add a total of 317 criteria designed to evaluate potential problems including drug utilization (overutilization and nonadherence/underutilization), therapeutic appropriateness (based on age, length of therapy, gender, etc), drug-drug interactions, drug-disease state interactions, and needed drug education. The therapeutic categories with new criteria added included cystic fibrosis agents, endocrine and metabolic agents, opioid analgesics, antipsychotic agents, gastrointestinal agents, immunomodulatory agents, renal and genitourinary agents, antiemetic agents, anti-neoplastic agents, respiratory agents, CNS stimulants, anti-infective agents, cardiovascular agents, sedative/hypnotic agents, antiepileptic agents, migraine prophylaxis agents, anti-Parkinson's agents, antiviral agents. No deletions of DUR Board approved retrospective DUR criteria occurred in FFY 2019. The RDUR vendor for the North Dakota Medicaid program, Health Information Designs, LLC uses results from RDUR screens to make determinations on potentially beneficial adjustments to RDUR criteria (new criteria additions or changes to current criteria.). Any new RDUR criteria is brought to the DUR

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	Board for review and approval before being implemented. If information from RDUR screens indicates an issue that could be prevented via new prospective DUR edits, the state implements those edits. The ND DUR Board is directly involved in the DUR educational program. All new outpatient pharmacy prior authorization criteria and RDUR criteria are reviewed by the DUR Board at the quarterly meetings, and all criteria and prior authorization request forms are re-reviewed annually. The Board offers suggestions for educational endeavors and provides input on the quarterly newsletters that are developed. North Dakota also participates in Academic Detailing with quarterly face-to-face visits to pharmacies and prescribers to discuss PDL changes, new edits, targeted provider interventions and education, and other pertinent information important in supporting the provider community. Drug utilization information and provider prescribing rates are used to determine candidates for in-person targeted educational interventions, which are conducted during the same time as academic detailing visits. Targeted education letters are sent out based on provider drug utilization, based on the intervention topic.
Ohio	The Ohio Department of Medicaid (ODM) Drug Utilization Review (DUR) Board met four times during FFY 19: November 13, 2018; February 12, 2019; May 14, 2019 and September 17, 2019. All interventions and results listed in Summary 2 were presented to the DUR Board. Results of prospective DUR screening are used to adjust retrospective DUR screenings and vice versa. At the November 13, 2018 DUR Board meeting, the albuterol intervention where members were receiving six or more albuterol prescriptions in six months without the use of a controller medication was presented. Board members discussed how this intervention could best target potential gaps in care and the coverage of controller medications. Next, the Board agreed with establishing a $100 limit on compounds in an effort to curb potential fraud, waste and abuse. If this threshold is exceeded, a prior authorization is required. Also, the Board approved the RetroDUR intervention that notifies prescribers who have patients taking an opioid in combination with a benzodiazepine and a sedative hypnotic agent. At the February 12, 2019 DUR Board meeting, a summary of the RetroDUR intervention directed at the prescribers of members taking concurrent opioids, benzodiazepines, and sedative hypnotics was presented. Also, the re-review results of the high dose and duplicate proton pump inhibitor (PPI) intervention were presented and the re-review results of the HIV medication adherence intervention were presented. The Board recommended a re-review of the HIV intervention to follow up on members who are no longer taking these medications. An overview of the Diabetes medication adherence intervention which was directed at prescribers whose patients had an adherence rate of 60 percent or below for non- insulin antidiabetic medications was presented. The Board reviewed the intervention for members who were 60 percent or below adherent to their non-insulin antidiabetic medications. Then, the Board recommended that the March 2019 intervention focus on members who are using insulin without glucose test strips. The DUR Digest is ODM's quarterly educational newsletter that addresses DUR interventions and relevant clinical information from the past quarter. This Digest is included with prescriber mailings for RDUR interventions and is also posted to the Ohio Medicaid pharmacy website. The Board recommended that next DUR Digest issue contain an update regarding the subacute pain prescribing guidelines for opioids and also the new Ohio Automated RX Reporting System (OARRS) tracking of naltrexone and medical marijuana. At the May 14, 2019 DUR Board meeting, a summary of the RetroDUR intervention directed at the prescribers of members with pharmacy claims for antidiabetic medications who appeared to be nonadherent to medications was presented. Next, a summary of the RetroDUR intervention directed

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	at prescribers of members with pharmacy claims for insulin, but no pharmacy claims for blood glucose test strips was presented. The re-review results from the intervention directed at prescribers of patients with diabetes who were not taking a statin, angiotensin converting enzyme (ACE) inhibitor, or angiotensin receptor blocker (ARB) was also presented. The Board recommended a prescriber mailing entailing the new lipid guidelines. Also, a short list of the least severe DUR interactions in POS was presented. The DUR Board was in favor of limiting potential pharmacist fatigue and asked for additional follow up before making changes in POS. Next, the concept of extending the package size edit to include medications that are recommended to be dispensed in the original packaging was presented. The DUR Board recommended pursuing this edit. At the September 17, 2019 DUR Board meeting, a summary of the RetroDUR intervention directed at members who received a prescription for Tamiflu but who did not receive a flu shot during the subsequent flu season was presented. Next, the re-review results from the RetroDUR intervention directed at the prescribers of patients who were taking greater than 400 morphine equivalent doses (MED) of opioids per day were presented. Next, the re-review results from the RetroDUR intervention directed at the prescribers of patients who were taking muscle relaxants for greater than 90 days was presented. The Board approved the original packaging edit that would be incorporated into a retrospective claims review. Then, an update on the DUR interactions was provided. Next, an intervention that focused on adherence to atypical antipsychotic medications was presented. The DUR Board recommended sending letters to prescribers whose patients are less than eighteen years old and are at seventy percent or less adherent, and prescribers whose patients are greater than eighteen years old and are at fifty percent or less adherent. Lastly, the concept of prescriber benchmark cards was presented. A discussion ensued around what categories of drugs should be targeted.
Oklahoma	During FFY 2019 the DUR Board met 9 times. Meetings were held in Oct, Nov, & Dec 2018, & in Feb, Mar, Apr, Jun, Jul, & Sept 2019. There were 35 speakers who addressed the board during public comment. DUR Board topics include Product-Based Prior Authorization (PBPA) and Criteria-Based Prior Authorization (CBPA) categories and/or product additions, changes, & reviews. CBPA selections come from new products on the market, new indications of existing products, new therapeutic guidelines, or safety updates. These medications will require a manual prior authorization (PA) & claims will reject at the point of sale if the member does not meet automated preset criteria in the claims history or diagnosis profile. If the member does have clinical exceptions for medical necessity a manual PA from the provider will be required for coverage consideration. The Following Were Added to the CBPA Program during FFY19: NutreStore®, Siklos®, Palynziq™, Galafold™, Qbrexza™, Ogivri™, Verzenio™, Orilissa™, Yescarta®, Braftovi™, Mektovi®, Libtayo®, Krystexxa®, Jivi®, Hemlibra®, Feiba®, NovoSeven® RT, Onpattro™, Tegsedi™, Zemdri™, Xerava™, Nuzyra™, Seysara™, Signifor® LAR, Symdeko®, Arikayce®, Revcovi™, Dupixent®, Lokelma™, Tavalisse™, Doptelet®, Mulpleta®, Carbaglu®, Makena® Sub-Q, Akynzeo® IV, Inbrija™, Osmolex ER™, Aimovig™, Ajovy™, Epidiolex®, Diacomit®, Sympazan™, Gamifant®, Firdapse®, Retacrit™, Takhzyro™, Adcetris®, Beleodaq®, Calquence®, Folotyn®, Istodax®, Poteligeo®, Truxima®, Zevalin®, Zolinza®, Copiktra™, Lutathera®, Vitrakvi®, Naglazyme®, Aldurazyme®, Plenvu®, Kapspargo™, Fulphila®, Nivestym™, Udenyca™, Cablivi®, Dextenza®, Oxervate™, Lorbrena®, Mvasi®, Vizimpro®, Sunosi™, Balversa™, Annovera™, Bijuva™, Cequa™, Crotan™, Gloperba®, Glycate®, Khapzory™, Seconal Sodium™, TaperDex™, Tiglutik™, Tolsura™, Yutiq™, Cassipa®, Zolgensma®, Duobrii™. The Following Had Criteria Which Were Modified in the CBPA Program during FFY19: Endari™, Kuvan®, Afinitor®, Kisqali®, Lynparza®, Perjeta®, Bosulif®, Kymriah®, Opdivo®, Yervoy®, Mekinist®, Tafinlar®, Zelboraf®, Oral Antibiotic Special Formulations, Avycaz®, Orkambi®, Kalydeco®, Trelegy™ Ellipta®, Xolair®, Fasenra™, Veltassa®, Marinol®, Nuplazid®, Gocovri™, Trokendi XR®, Briviact®, Cinryze®, Haegarda®, Kalbitor®, Keytruda®, Gazyva®, Imbruvica®, Venclexta®, H.P. Acthar® Gel, Cyramza®, Tecentriq®, Corlanor®, Medication Assisted Treatment (MAT) Products, Botulinum

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	Toxins, Spinraza®. PBPA selections come from new products on the market, new indications of existing products, new therapeutic guidelines, or safety updates. The Following Were Added to the PBPA Program during FFY19: FloLipid®, Ilumya™, Olumiant®, Rituxan®, Triptodur®, Nocdurna®, Impoyz™, Lonhala® Magnair®, Yupelri™, Xelpros™, Cosensi®, Xyosted™, Jatenzo®, Inveltys™, Lotemax® SM, Jornay PM™, Adhansia XR™, Evekeo ODT™, Qmiiz™ ODT, TobraDex® ST, Aristada Initio®, Perseris™, Abilify MyCite®, Levorphanol Tartrate, Bryhali™, Lexette. The Following Requirements Changed for the PBPA Program during FFY19: Antihyperlipidemics, Noctiva™, Bladder Control, Topical Corticosteroids, Arnuity® Ellipta®, ArmonAir™ RespiClick®, AirDuo™ RespiClick®, Breo® Ellipta®, Glaucoma Meds, Anti-Migraine Meds, Calcium Channel Blockers, Angiotensin Receptor Blockers (ARBs) and ARB Combination Products, Methylin®, Opioid Daily Morphine Milligram Equivalent (MME) Limit, Topical Corticosteroid Meds. Retrospective Drug Evaluation selections come from categories/products annual reviews presented, U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) updates, safety updates, changes within therapeutic guidelines, quarterly SoonerPsych program updates, and quarterly Chronic Medication Adherence program updates. Annual Reviews: Each CBPA or PBPA categories/product are reviewed annually for market updates, utilization trends, and cost-effective treatments. FDA and DEA Updates: FDA alerts, including safety updates, and DEA changes are reviewed monthly to educate providers if necessary. Therapeutic Guidelines: Guidelines considered gold standards or that are widely accepted are reviewed for changes in recommendations and updates are made to corresponding clinical categories. SoonerPsych Program: The SoonerPsych program is an educational quarterly mailing to prescribers with members utilizing atypical antipsychotic Meds. Each mailing includes a gauge showing prescribers how their prescriptions compare to those of other SoonerCare prescribers of atypical antipsychotic Meds regarding potential differences from evidence-based prescribing practices. Each mailing also includes an informational page with evidence-based material related to the mailing topic. Mailing topics include 4 modules: polypharmacy, adherence, metabolic monitoring, and diagnosis. Chronic Medication Adherence Program: This program provides educational quarterly mailings to prescribers with members on chronic maintenance Meds for diabetes, blood pressure, or cholesterol to encourage medication adherence and improve the quality of care for SoonerCare members on these Meds. Academic Detailing Program: This program provides educational, evidence-based, in-person meetings to prescribers of targeted medication categories including ADHD Meds, atypical antipsychotic Meds, and antibiotic Meds. The program is intended to encourage evidence-based prescribing practices among contracted SoonerCare prescribers. Educational Initiatives: Project goals include reviewing current usage and educating prescribers, pharmacies, and members of access and necessity of selected medication therapies. Current organizational communications for all avenues such as: letters, faxes, website, and newsletters are employed to increase awareness. The following were reviewed for RetroDUR during FFY19:SoonerPsych Program: Atypical Antipsychotic Meds - Appropriate Diagnosis, Polypharmacy, Metabolic Monitoring, and Adherence; Chronic Medication Adherence Program: Maintenance Diabetes and Cardiovascular Meds; Overview of U.S. FDA Safety Alerts; Academic Detailing Program Update; Narrow Therapeutic Index (NTI) Drug List; Review of Prenatal Vitamins (PV); Long-Acting Beta2-Agonist Utilization: Pediatric Members; Use of Angiotensin Converting Enzyme Inhibitor (ACEI)/ARB Therapy in Patients with Diabetes and Hypertension (HTN) Mailing Update. Prospective DUR edits for the following were developed/implemented during FFY19: Non-controlled medication refill threshold increased to 80%; 7-day initial acute pain opioid prescription limit; Cumulative MME per day limit (90 MME); MME bypassed due to diagnosis history; CII medication mid-level provider edit; Controlled medication refill threshold increased to 90%; Categories are continuously reviewed and quantity limits are implemented and updated according to FDA recommended dosing where appropriate. The annual reviews of all PA categories were presented to the DUR Board or made available to the board for review in FFY 2019. Oklahoma State Statues require review of any drug or category placed on prior authorization to be reviewed 12 months after placement. CBPA Drugs and Categories Reviewed and

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	Presented to the DUR Board during FFY19 Included: Acute Lymphoblastic Leukemia & Chronic Myeloid Leukemia, Skin Cancer, Constipation & Diarrhea, Gout, Factor Replacement, Cystic Fibrosis Transmembrane Conductance Regulator Modulators, Various Systemic Antibiotics, Hepatitis C, Thrombocytopenia, Inhaled Anti-Infectives, Anti-Emetics, Muscular Dystrophy, Injectable & Vaginal Progesterones, Hyperkalemia, Mepsevii™, Nuedexta®, Zilretta®, Anticonvulsants; Erythropoietin Stimulating Agents, Parkinson's Disease, Chronic Lymphocytic Leukemia, Lymphoma, Anticoagulant & Platelet Aggregation Inhibitors, Hereditary Angioedema, Multiple Sclerosis, Luxturna™, Lung Cancer, Granulocyte Colony-Stimulating Factors, Bowel Preparations, H.P. Acthar® Gel, Jynarque®, Various Special Formulations, Botulinum Toxins, Spinal Muscular Atrophy, Qbrexza™, Breast Cancer, Prostate Cancer, Crysvita®, Synagis®, Sickle Cell Disease, Actinic Keratosis, Allergen Immunotherapy, Alpha1-Proteinase Inhibitors, Alzheimer's, Antifungals, Anti-Parasitics, Antivirals, Arcalyst®, Benlysta®, Benzodiazepines, Brineura®, Butalbitals, Cholbam®, Chorionic Gonadotropin Meds, Daraprim®, Defitelio®, Diabetic Supplies, Elaprase®, Gattex®, Gaucher Disease, Heart Failure Meds, Idiopathic Pulmonary Fibrosis, Iron Chelating Agents, Kanuma®, Keveyis®, Leukotriene Modulators, Lidocaine Topicals, Lumizyme®, Mozobil®, Myalept®, Mytesi®, Naloxone, Northera®, Ocaliva®, Pancreatic Enzymes, Phosphate Binders, Prednisolone Special Formulations, Prenatal Vitamins, Procysbi®, Pulmonary Hypertension, Qualaquin®, Qutenza®, Radicava®, RavictRavicti®, Retisert®, Smoking Cessation, Soliris®, Strensiq®, Sylvant®, SSymlin®, Topical Acne Products, Ulcerative Colitis & Crohn's Disease, Vasomotor Symptom, Vesicular Monoamine Transporter 2 Inhibitors, Vimizim®, Xgeva®, Xiaflex®, Xuriden®, Zinplava™. PBPA Categories Reviewed and Presented to the DUR Board during FFY19 Included: Targeted Immunomodulator Agents, Gonadotropin-Releasing Hormone,, Bladder Control, Topical Corticosteroid, Maintenance Asthma & Chronic Obstructive Pulmonary Disease, Glaucoma, Anti-Migraine, Osteoporosis, Anti-Diabetic, Antihypertensive, Ophthalmic Anti-Inflammatory, Testosterone Products, Atypical Antipsychotic, ADHD & Narcolepsy, Opioid Analgesic & MAT, Topical Corticosteroid, Antihyperlipidemic, Antidepressant, Antihistamine, Anti-Ulcer, Benign Prostatic Hypertrophy, Fibric Acid Derivative, Fibromyalgia, Inhaled Short-Acting Beta2 Agonist, Insomnia, Muscle Relaxant, Nasal Allergy, Nonsteroidal Anti-Inflammatory Drugs, Ophthalmic Allergy, Ophthalmic Antibiotic, Otic Anti-Infective, Pediculicides, Topical Antibiotics, Topical Antifungals.
Oregon	Number of DUR Board meetings held: 6 Prospective, retrospective and PDL changes approved by the Oregon Health Authority: November, 29 2018 https://www.oregon.gov/oha/HSD/OHP/Therapeutics/recommendations121218.pdf January, 24 2019 https://www.oregon.gov/oha/HSD/OHP/Therapeutics/recommendations021319.pdf March, 21 2019 https://www.oregon.gov/oha/HSD/OHP/Therapeutics/recommendations041819.pdf May, 23 2019 https://www.oregon.gov/oha/HSD/OHP/Therapeutics/recommendations052919.pdf July,25 2019 https://www.oregon.gov/oha/HSD/OHP/Therapeutics/recommendations073019.pdf September, 26 2019 https://www.oregon.gov/oha/HSD/OHP/Therapeutics/recommendations100319.pdf Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens: * GLP-1 Receptor Agonists - allow use of basal insulin when in combination with a GLP-1; and auto-PA preferred products for patients with claims for metformin use in the previous 40 days * Updated benzodiazepine PA criteria to include outpatient management of alcohol withdrawal syndrome * Cannabidiol maximum dose limits

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	* Reinforce periodic tuberculosis testing for combination Biologic Therapy & provider education on disease modifying antirheumatic drug (DMARD) adherence * Evaluation of concomitant stimulant and antipsychotic medications prescribing * Retrospective initiative to notify providers when patients on routine therapy for schizophrenia miss a medication refill * SUPPORT Act: Letters sent weekly to prescribers notifying them if their FFS patients fill prescriptions for a combination of opioid and sedative medications, when the member has three or more unique prescribers of opioid and sedative therapy, or when there is a prior history of opioid or sedative poisoning Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring): DUR Board recommends RetroDUR education and recommends and reviews Published Newsletters: * Updates on Testosterone Therapy - October, 2018 https://www.orpdl.org/durm/newsletter/osdr_articles/volume8/osdr_v8_i6.pdf * Basal Insulin Update - December, 2018 https://www.orpdl.org/durm/newsletter/osdr_articles/volume8/osdr_v8_i7.pdf * 2017-18 Year in Review: Important Safety Updates - January, 2019 https://www.orpdl.org/durm/newsletter/osdr_articles/volume9/osdr_v9_i1.pdf * Benzodiazepine Safety and Tapering - February, 2019 https://www.orpdl.org/durm/newsletter/osdr_articles/volume9/osdr_v9_i2.pdf * Non-statin Low-Density Lipoprotein Cholesterol (LDL-C) Lowering Therapy and Cardiovascular Outcomes - March, 2019 https://www.orpdl.org/durm/newsletter/osdr_articles/volume9/osdr_v9_i3.pdf * Update on Medications Used to Manage Opioid Use Disorder and Opioid Withdrawal - May, 2019 https://www.orpdl.org/durm/newsletter/osdr_articles/volume9/osdr_v9_i4.pdf * Oregon Health Authority Mental Health Clinical Advisory Group (MHCAG) Recommendations for the Treatment of Schizophrenia - July, 2019 https://www.orpdl.org/durm/newsletter/osdr_articles/volume9/osdr_v9_i5.pdf * Stimulant Use in Excessive Somnolence Disorders - August, 2019 https://www.orpdl.org/durm/newsletter/osdr_articles/volume9/osdr_v9_i6.pdf * Pearls and Pitfalls of Clinical Practice Guidelines - September, 2019 https://www.orpdl.org/durm/newsletter/osdr_articles/volume9/osdr_v9_i7.pdf Minutes from the meetings held during this reporting period: https://www.orpdl.org/durm/meetings/meetingdocs/2018_11_29/finals/2018_11_29_PT_Minutes.pdf https://www.orpdl.org/durm/meetings/meetingdocs/2019_01_24/finals/2019_01_24_PT_Minutes.pdf https://www.orpdl.org/durm/meetings/meetingdocs/2019_03_21/finals/2019_03_21_PT_Minutes.pdf https://www.orpdl.org/durm/meetings/meetingdocs/2019_05_23/finals/2019_05_23_PT_Minutes.pdf https://www.orpdl.org/durm/meetings/meetingdocs/2019_07_25/finals/2019_07_25_PT_Minutes.pdf https://www.orpdl.org/durm/meetings/meetingdocs/2019_09_26/finals/2019_09_26_PT_Minutes.pdf
Pennsylvania	a) The DUR Board met twice in FFY 2019 on the following dates: 1. March 21, 2019 2. September 13, 2019

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	b) The DUR Board recommends prospective hard edits and develops prior authorization guidelines to help to ensure that the medications are used appropriately with respect to indications, duration, dosage and avoidance of potential drug or disease interactions. The following topics were identified during FFY 2019 as focus areas for the DUR Board to assess and promote appropriate utilization: 1. New clinical prior authorization of the following: a. Soliris (eculizumab) b. Ultomiris (ravulizumab-cwvz) c. Thrombopoietics 2. Revisions to the following prior authorization guidelines: a. Cytokine and CAM Antagonists b. MABs- Anti-IL, Anti-IgE (Dupixent) c. Antibiotics, GI And Related Agents d. Antidepressants, Other e. Antimigraine Agents, Other f. Analgesics, Opioid Short-Acting g. Beta Blockers h. Enzyme Replacement, Gaucher Disease i. Growth Hormones j. Lipotropics, Other k. Macular Degeneration Agents l. Pulmonary Arterial Hypertension (PAH) Agents, Oral and Inhaled m. Pituitary Suppressive Agents, LHRH c) Prospective DUR interventions made prior to claim adjudication is more effective than retrospective DUR interventions for modifying prescribing patterns and preventing adverse outcomes. Therefore, the State Agency mines the pharmacy data on an ongoing basis to determine where there are aberrant prescribing patterns that could lead to detrimental health and safety issues for the Medical Assistance Recipients of Pennsylvania. The DUR Board suggests the prospective claims edits and develops the prior authorization guidelines used by the Agency's clinical reviewers to determine medical necessity. d) The State Agency provides feedback to the DUR Board on the retrospective DUR program and consults with them on the development of new clinical guidelines.
Rhode Island	Indicate the number of DUR Board meetings held The Rhode Island Medicaid Drug Utilization Review Board met four (4) times during FFY 2019. List additions/deletions to DUR Board approved criteria. For prospective DUR, list problem type/drug combinations added or deleted. For retrospective DUR, list therapeutic categories added or deleted. Prospective DUR Prospective DUR criteria are not routinely reviewed by the DUR Board. However, specific criteria may be brought up for discussion. All severity level 1 First Databank criteria are active in the prospective DUR system. Retrospective DUR Rhode Island Medicaid uses a comprehensive list of retrospective DUR criteria, which include alerts for drug interaction, overuse, therapeutic duplication, black box warnings, and underuse (non-adherence).

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	Each month, claims data are run against criteria and approximately 1,000 recipient drug profiles are selected for review and evaluation by a clinical pharmacist. Many different types of criteria may be selected for review each month. For FFY 2019, the top 10 alerts are noted in attachment 2. Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. For the most part, prospective screening operates independently from retrospective screening. However, the Board has recommended that drug interactions that are black box warnings in the product labeling also be alerted as retrospective interventions, even though these alerts are included in the prospective DUR screening. Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring). For retrospective DUR, list therapeutic categories added or deleted. Currently, educational efforts include mailing of alert letters to prescribers based on criteria exceptions and further review by a clinical pharmacist. Therapeutic duplication, drug interaction, and underuse (non-adherence) retrospective and prospective DUR criteria are in place. In addition, drug interaction and therapeutic duplication alerts were mailed. These alerts included patients with specific diseases not found to have claims for drugs that are recommended as part of national guidelines. Specific examples include diabetic patients not taking lipid lowering therapy or ACE inhibitors. There continues to be a focus on appropriate use of opioids. Patients identified as possibly misusing opioids can be restricted to a single pharmacy as part of the State's Lock-In program. Individual outreach was also made to prescribers who did not respond to any DUR letters mailed. DUR Board meeting minutes can be found on the Rhode Island Drug Utilization Review webpage at: http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation/ProviderDirectories/Pharmacy/DrugUtilizationReview.aspx
South Carolina	The DUR Board is in the process of being restructured. Efforts include the expansion of both the roles/membership with inclusion of MCO presence (One individual per program/non-voting- currently there are five MCOs)- those requirements are pending review/finalization. The State entered into a partnership with MUSC (January 2017-December 31, 2022). Programs/Topics for 2019 included: -SOS for Safer Opioid Prescribing: Share Patient Provider Agreement, Optimize Patient Treatment (Drug/Non-Drug), and Screen for Appropriate Opioid Use: 49 academic detailing visits /45 completed CMEs (29 live and 16 online) -Opioid Products: Characteristics and Conversion Factors (Handout-37 delivered by detailer) -Promoting Safe Medication Disposal (Issue #7 March 2019) CME and Medication Disposal Patient Handout Other efforts include participation in the MUSC-MAT Access Team buprenorphine waiver trainings by SCOReX clinical pharmacy consultants), ongoing collaboration/efforts with the State/stakeholders and electronic engagement via the tipsSC website https://msp.scdhhs.gov/tipsc/site-page/drug-information-center The State continues to monitor/evaluate pharmacy claims-edits, utilization, etc. Of note were reviews/analysis of the following:

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	-Compound claims: products/providers/prescriber/$ - NCPDP edits supported in conjunction with OCC (other coverage codes- Primary Insurance) - MME- pre-implementation of 90MME (>90 MME: volume/actual MME/comorbid conditions) and post-implementation (denials/volume/confirmation of edits.
South Dakota	DUR Board Activities: Patient profiles were generated twelve times during the October 1, 2018 through the September 30, 2019 fiscal year. Profiles were reviewed and letters were created to be sent to prescribers of the problematic therapy as well as the pharmacies which dispensed the involved drugs for each of those twelve reviews. During that same period the DUR Review Committee had discussions concerning case or criteria issues with each other by phone or email. Attached are minutes of those meetings with background material on the reviews conducted. Note that the term DEEP refers to the South Dakota Drug Evaluation and Education Program the long time name for the state's retrospective DUR program. The term ICER refers to HID's Initial Criteria Exception Report. The ICER lists categories of exceptions to the clinical criteria appropriate for patient care. The cases to be reviewed can come from making specific case selection from the ICER. ICER of October 9, 2018 This was a general review of the 80 worst cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 106 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on November 5, 2018. ICER of November 7, 2018 This was a general review of the 80 worst cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 116 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on November 30, 2018. ICER of December 4, 2018 This was a review of the top 80 most severe cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 115 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on January 4, 2019. ICER of January 4, 2019 This was a general review of the 80 worst cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 115 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on February 1, 2010. ICER of February 6, 2019 This was a review of the 80 most severe cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 127 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on March 7, 2019. MARCH 2019 ICER of March 11, 2019 This was a review of 80 patient cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 98 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on April 2, 2019. ICER of April 11, 2019 This was a general review of the 80 worst cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 97 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on May 7, 2019. ICER of May 10, 2019 This was a general review of the 80 worst cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 124 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on June 6, 2019.

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	ICER of June 10, 2019 This month's review targeted criteria assessing diabetic patients that were not receiving a HMG Co-a reductase inhibitor (statin'). Statins are recommended in many guidelines for treatment of dyslipidemia in the majority of diabetic patients. A total of 80 cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 124 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on July 3, 2019. ICER of July 8, 2019 This was a general review of the 80 worst cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 115 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on August 1, 2019. ICER of August 3, 2019 This was a general review of the 80 worst cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 118 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on September 6, 2019. ICER of September 10, 2019 This was a review of the 80 worst cases (20 profiles per reviewer) as determined by the ICER. The committee sent letters to 131 providers (prescribers and pharmacies) for the cases deemed worthy of intervention were created on October 1, 2019. The DEEP committee met all 12 months and reviewed patient profiles and sent out letters to prescribers and pharmacies throughout the year. Total number of letters sent out was 1,338 for the year with an average of 116 letters per month.
Tennessee	The operation of the DUR program is a shared responsibility of Magellan Medicaid Administration (MMA) and the Bureau of TennCare. During FFY19, the TennCare DUR Board was scheduled to meet quarterly, however only met twice due to issues with quorum. The March 2019 and September 2019 meetings were cancelled. TennCare's pharmacy program has two different committees, with the PAC (Pharmacy Advisory Committee) being written in State Statue has having overall responsibility for the PDL, and for criteria and approvals. The DUR Board normally meets to review trends in TennCare's drug use along with reviewing drugs for potential over utilization, therapeutic duplication, drug to disease interactions, drug to drug interactions, appropriate dose and duration guidelines and adverse effects. Utilization management edits and limits may be recommended to the PAC by the DUR Board, however the ultimate responsibility for the final recommendation to the State is with the PAC. During FFY19, the DUR Board discussed and performed the following RetroDUR activities, where letters were sent to practitioners: Nonadherence to Anticonvulsant therapy Megestrol therapy regarding indication and adverse effects Lithium therapy with patients appearing to have not had a level reported FDA Drug Safety Notice on insomnia medications and complex sleep behaviors Increased risk of death with Uloric Increased risk of aortic rupture or tear with fluoroquinolones Nonadherence with adalimumab therapy Nonadherence with diabetic therapy Cyclobenzaprine use greater than 3 weeks Atypical antipsychotics and monitoring in pediatric patients, and Use of very-high potency topical corticosteroids

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	Specific drug classes that have been reviewed by DUR Board are targeted for focused review under the RetroDUR program monthly. Magellan Medicaid Administration then applies the specified criteria established to the prescription drug and health claims files and identifies medication regimens that are not congruent to the criteria established. Copies of individual medication profiles that are not consistent with the criteria are generated by MMA and reviewed. If, based on the professional judgment of the clinical reviewer, an aberrant pattern of prescribing and/or utilization is indeed present, an educational letter is sent to the prescribing physician and/or the dispensing pharmacist informing the provider of the suspected problem. Magellan Medicaid Administration produces and mails provider letters documenting the therapeutic effects of the RetroDUR program and tracks provider responses and cost savings associated with the interventions. Based on provider responses, cost savings and recommendations from DUR Board and the Pharmacy Advisory Committee (PAC), the RetroDUR criteria may be changed or specific ProDUR edits or clinical prior authorization criteria may be added to the drug or drug class.
Texas	DUR Board meeting dates: Oct. 26, 2018 Jan. 25, 2019 Apr. 26, 2019 Jul. 26, 2019 DUR Board DUR activities consists of the four sessions: 1. Review drugs within each therapeutic class for preferred/non-preferred recommendations 2. Retrospective Criteria Reviews-may be used as the basis for prospective and retrospective DUR proposals. Review is focused on criteria, such as: maximum daily dose in adults and pediatrics, Drug-Drug interaction, Therapeutic duplication, Over utilization, etc. 3. Retrospective DUR Intervention Proposals- Educational letters for provider outreach are developed and mailed to those with outlier prescribing activities. 4. Prospective Clinical Prior Authorization (PA) Criteria Proposal Review: Clinical prior authorizations are developed with input from State DUR staff, Medicaid Managed Care Organizations(MCOs), and the Sate's PA vendor. Criteria are mainly based on the available references such as drug Package insert, treatment practice guidelines, etc. In FFY 2019 the following retrospective criteria were reviewed 1. 5-HT3 receptor antagonists 2. Attention deficit disorder medications 3. GLP-1 receptor agonists 4. Oral anti-diabetic agents 5. Pramlintide (Symlin) 6. Substance P / Neurokinin 1 receptor antagonists 7. 5-HT3 receptor antagonists 8. Angiotensin II receptor blockers 9. Angiotensin-converting enzyme inhibitors 10. ADHD medications 11. GLP-1 receptor agonists 12. Oral anti-diabetic agents 13. Serotonin 5-HT1B/1D receptor agonists 14. Substance P / Neurokinin 1 receptor antagonists

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	15. Aerosolized Agents 16. Aerosolized Agents 17. Aerosolized Agents 18. Aerosolized Agents 19. Antidepressants (oral) - other 20. Antidepressants (oral) - SSRIs 21. Fentanyl (Inhalation/Oral/Transdermal) 22. Platelet aggregation inhibitors. 23. Proton pump inhibitors 24. Acetylcholinesterase Inhibitors 25. Cyclooxygenase (COX)-2 Inhibitors 26. Hepatitis C Direct Acting Antivirals 27. Histamine H2-Receptor Antagonists 28. Ketorolac 29. Leukotriene Receptor Antagonists 30. Mecasermin In FFY 2019 the following Retro-DUR intervention topics were reviewed: 1. Management of Psychotropic Drugs in Adults- The following performance indicators were considered for intervention: High doses ADHD medications, ADHD medication without indication, High dose antidepressants, High dose second generation antipsychotics(SGA), Multiple (3 or more) oral SGA, psychotropics Polypharmacy, Lab Monitoring (glucose, lipids, and A1c) in patients taking SGA, 90-days or more of concomitant prescribing of oral and long-acting injectable 2. Medication Adherences- The following performance indicators were considered for intervention: Antiasthmatics: Inhaled corticosteroids, Anticonvulsants, Antidepressants, Oral antidiabetics, Antihypertensives, Antilipemics, Oral second-generation antipsychotics, Inhaled COPD medications, Thyroid replacement 3. Appropriate Use of Antibiotics- the following performance indicator was considered for intervention: High percentage of oral broad-spectrum antibiotic use. 4. Respiratory Disease Management- the following performance indicators were considered for intervention: Overutilization of short-acting beta2-agonists (SABA) inhalers in patients with asthma, Underutilization of inhaled corticosteroids)ICS) in patients with asthma, Use of long-acting beta-agonists (LABA) inhalers without SABA inhaler in patients with asthma, Use of SABA inhaler without short-acting antimuscarinic antagonist (SAMA) inhaler in COPD, Use of ICS without LABA inhaler in patients with COPD, Overutilization of oral glucocorticoids in patients with asthma and/or COPD, Duplicate ingredient inhalers in patients with asthma and/or COPD, History of smoking in patients with asthma and/or COPD 5. Mental Health Disorders Management- the following performance indicators were considered for intervention. Antidepressant use extended duration (greater than 12 months)) in single episode depression, Duplicative antidepressants, Increased ADE- risk of serotonin syndrome, Benzodiazepine chronic use (greater than 4 months), Sedative/hypnotics chronic use (greater than 4 months), Duplicative anxiolytics and/or sedative/hypnotics, Concomitant long-acting injectable antipsychotics with oral agents, Multiple second generation antipsychotics (SGA) (3 or more), Inadequate lab monitoring of SGAs 6. Anticonvulsant Drug Use Review- the following performance indicators were proposed: Anticonvulsants drug-drug interactions, Increased risk of adverse drug events (ADE) with anticonvulsants, Concomitant use of anticonvulsants and contraceptives 7. Cough and Cold Medications- the following performance indicator was considered for intervention: Members age 2 and older to less than 12 y/o with pharmacy claims for cough and cold drugs are not

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	considered safe based on the cough and cold drugs listed on Texas Medicaid Cough and Cold Clinical Prior Authorization. 8. ADHD Medication Management- the following performance indicators were considered for intervention: ADHD medications without indication in adults; dose consolidation for the extended-release formulations in adults; stimulants duplicate therapy; high dose ADHD medications; multiple prescribers; risk of suicide ideation with atomoxetine in youth. 9. Influenza Prevention through Vaccination and Education-the following performance indicators were considered for intervention: Members with an influenza antiviral prescription who did not receive an influenza vaccine, Members who received more than 1 influenza antiviral prescription. In FFY 2019, the Board reviewed the following clinical prior authorizations (PA) 1. Calcitonin gene-related peptide receptor (CGRP) Antagonist- new criteria - approval criteria include: medication prescribed by or in consultation with a neurologist, age 18 and older, diagnosis of episodic or chronic migraines (verified manually with chart notes detailing number of migraine and headache days per month on average), history of a 30-day trial of 2 or more migraine prophylactic therapies in the last 365 days, quantity requested is equal or more than 2 per month. 2. Cytokine and CAM antagonists, addition of Olumiant criteria- approval criteria include: age requirement, diagnosis of Rheumatoid Arthritis, prior use of TNF-blockers, no claims for JAK inhibitors or DMARD or potent immunosuppressants. no recent claims for OAT3 inhibitors, no recent diagnosis of GI perforation, thrombosis or malignancies, no severe renal impairment, no active serious infections; daily dose of 1 table per day. 3. Epidiolex oral solution- approval criteria include: age equal or more than 2 years of age, diagnosis of Lennox-Gastaut syndrome or Dravet syndrome in the last 730 days 4. Orilissa (elagolix)- approval criteria include: age equal or more than 18 years, diagnosis of endometriosis found in the last 730 days, claim for an NSAID and 1 claim for an oral contraceptive found in the last 180 days, no diagnosis of osteoporosis found in the last 365 days, no claims for a strong OATP-1B1 inhibitor found in the last 90 days, dosing does not exceed maximum recommended 5. Arikayce (amikacin liposome inhalation suspension)- approval criteria include: appropriate age, diagnosis of MAC lung disease, therapy with at least 2 recommended initial drug therapy, concurrent use with the 2 initial therapy drugs. 6. HAE Agents- approval criteria include: age requirement, stable therapy (defined as 2 claims for the requested agent or a diagnosis of HAE in the past 730 days. 7. Inhaled ABX: Approval criteria include: Client meets age requirement, diagnosis of CF found 9. Cytokine & CAM Antagonists, addition of Skyrizi criteria- approval criteria included: age requirement, diagnosis of moderate-severe plaque psoriasis; no history of active infection. 10. Motegrity (prucalopride)- approval criteria included: age requirement, diagnosis of chronic idiopathic constipation found, no diagnosis of GI obstruction, quantity of 1 tablet per day 11. Skeletal Muscle Relaxants- approval criteria included: age requirements, no more than 60 days therapy in the last 90 days
Utah	During this reporting period's Federal fiscal year, Utah Medicaid's DUR Board held eleven meetings. The following topics were reviewed by the Board which resulted in the following accepted recommendations by the Utah Medicaid: ProDUR: 1. Oct 2018 : Discussed and updated Hemlibra prior authorization criteria to match manufacturer package insert. Educational information was provided regarding Hepatitis C treatments and Sublocade. 2. Nov 2018 : Discussed strategies for addressing inappropriate prescribing of macrolide antibiotics. Recommended to use the available tools in creating educational awareness campaign to promote to providers and at-risk patients in efforts to improve antibiotic use.

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	3. Dec 2018 : Discussed and reviewed CGRP and Exondys 51 prior authorization criteria including re-authorization criteria. 4. Jan 2019 : Discussed use of VMAT-2 inhibitors in the treatment of Hunting disease and tardive dyskinesia and prior authorization criteria. 5. Feb 2019 : Discussed prior authorization criteria for the use of brodalumab and guselkumab for the treatment of moderate to severe plaque psoriasis. Crisaborole prior authorization criteria was also discussed for the treatment of mild to moderate atopic dermatitis. 6. Mar 2019 : Discussed and updated prior authorization criteria for cannabidiol for the treatment of Lennox-Gastaut syndrome and Dravet syndrome. 7. Jun 2019 : Discussed and updated prior authorization criteria for Spravato. Additionally, the Board also reviewed various existing prior authorization forms: New to Market Drugs Prior Authorization Form, Brand Name Prior Authorization Form, Off-label Use Prior Authorization, Non-preferred Authorization Request form, Review of Opioid Prior Authorization Form. 8. Jul 2019 : Discussed and updated prior authorization criteria for Zolgensma and Spinraza indicated to treat Spinal Muscular Atrophy. The DRRC presented retrospective DUR work for 2018. Lastly, pharmacy policy changes were discussed surrounding the lowered MME limit, concurrent opioid-benzodiazepine use, and removal of Truvada prior authorization form. 9. Aug 2019 : The SUPPORT Act, the act requirements, and what current clinical measures are taken by Utah Medicaid were discussed in detailed. Also, prior authorization criteria for sacubitril/valsartan, rifaximin, and tesimelteon were reviewed and updated. 10. Sept 2019 : The Board discussed the Antiemetic Prior Authorization Form, pharmacy edits surrounding butalbital products, and antipsychotic use in children and adolescents. Findings from Prospective and Retrospective Drug Utilization Review directly affect each other. When focusing on prospective drug review, this may be motivated by new drug approvals, changes/updates to clinical practice guidelines, anticipation of misuse, follow up to prior authorization placement, or internal or external interest. In FFY19, prospective DUR also involved adjusting opioid quantity limits that were based upon the MME conversion to align with CDC standards, developing safety edits for dangerous drug-drug interactions (opioids and benzodiazepines), requiring a diagnosis code for antipsychotic medications, and further increasing access to MAT therapies. A comprehensive list of PRO-DUR edits is below: 1. 9/24/2019 : Removal of quantity limits for proton pump inhibitors and simvastatin 2. 9/20/2019 : Several updates made from Brand over Generic report. 3. 9/19/2019 : P&T motioned to add Spinraza and Zolgensma to PDL. 4. 8/22/2019 : Several updates made from Brand over Generic report. 5. 8/19/2019 : Implementation of a DUR Hard Edit, which triggered when a claim for an opioid that was dispensed with an active claim for high risk medication, benzodiazepine, on patient's profile. This edit functioned bidirectionally. This edit required the dispensing pharmacist to enter a Professional Service Code and Reason of Service Code to ensure appropriate proactive counseling measurements were taken place. 6. 8/14/2019 : Age limits were removed for Panretin and Retinoids 7. 8/5/2019 : Opioid limits were updated, specifically day supply limit, for pregnant Medicaid memebrs 8. 7/17/2019 : Day supply edit was added to Vivitrol to prevent overutilization. 9. 6/19/2019 : Clinical prior authorization removed for Truvada 10 4/1/2019 : Updated coding to exclude specified aid codes and provider types from the 90-day supply requirement. Cost sharing for prescriptions copays were updated to a lower amount, $3 copay for FFS (limited to $15 per month) and $6 for ACO recipients.

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	11. 2/12/2019 : Added multiple GPI to 90 day supply requirement 12 1/15/2019 : Removal of copays for Vaccines for certain health plans per state plan: Trad, Non-Trad, and PCN. 13 1/4/2019 : Updated refill tolerance to 80% for multiple products. 14 1/1/2019 : Built MME conversion table based on CDC standards and established MED daily thresholds across shorting acting and long-acting opioids in the MME table for POS edits. Two configurable MED thresholds were created, opioid naive and opioid experienced. Based on the patient's past opioid fill history, 90 day look back, corresponding MED limits would apply. 15. 1/1/2019 : P&T Motioned to add Factor IX-containing products to the Preferred drug list.
Vermont	Drug Utilization Review Board Activity Summary FFY2019 The VT Medicaid (DVHA) DUR Board acting as the program's Pharmacy and Therapeutics (P&T) Committee met 8 (eight) times in FFY2019. The combined functions of the DUR Board results in the DUR Board having a unique perspective on the evaluation and Preferred Drug List (PDL) placement of newly released drugs. As new drugs are brought forward for evaluation, the DUR Board chooses to manage these medications in a manner that will result in appropriate prescribing from the time of introduction of the drug (prospectively) rather than in a retrospective manner when inappropriate patterns of prescribing may have become ingrained. This results in the early adoption of quantity limits, step therapy and promotion of generic drug choices. At the same time, as new drugs are evaluated, patterns of prescribing for alternative drugs may become apparent and lead the Board to undertake retrospective drug utilization review activities for those other medications. Additionally, the DUR Board will recommend that follow-up RetroDUR be performed of relatively new drugs to ensure that the adopted clinical criteria are appropriate and result in patterns of utilization that are appropriate and cost-effective. In FFY 2019, the DUR Board activities included: - 2 Biosimilar New Drug Reviews - 42 New Drug Reviews - 20 Revised Clinical Coverage Criteria - 56 Therapeutic Class Reviews - 73 Quantity Limits established for new or previously reviewed drugs - 9 FDA Safety Alerts reviewed - RetroDUR Analyses -Concurrent use of Opiates with Benzodiazepines -Sildenafil Use -Statin Use in Congestive Heart Failure -Evaluation of Opioid Prescribing for Chronic Pain -Adherence to Anti-retroviral Therapy for HIV -Use of Gabapentin -Appropriate Use of Asthma Controller Medications The Drug Utilization Review (DUR) Board will advise DVHA on how best to educate providers and address the impact of pharmacy manufacturers advertising. In these meetings counter-detailing opportunities are considered. DVHA partners with The Vermont Academic Detailing Program which is a university-based prescriber education and support program that operates out of AHEC (Area Health Education Center Programs) to identify mutual areas of interest. The goal of the Vermont Academic Detailing Program is to promote high quality, evidence-based, patient-centered, and cost-effective treatment decisions by healthcare professionals. AHEC staff visit prescriber offices for person-to-person educational sessions.

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	In the course of DUR activities, the DUR Board may select certain drugs to target for review in order to ensure that clinical criteria and prescribing patterns are appropriate. Staff makes recommendations for targeted areas and the Board selects those most relevant. The Board then determines if follow-up is appropriate either with the identified prescribers or with a clinical advisory to all providers. In the event a preferred drug is changed to a non-preferred status and specific beneficiaries are affected, prescribers are provided with two tools as recommended by the DUR Board. One is a list of all the patients who were prescribed the specific drug that is being changed. The second is a profile unique to each patient with the drug change listed. This creates a record for use in the patient's file. To educate providers on general PBM Program coverage activities, various methods are used. Most frequently, mailings are prepared around both general and specific changes and they are targeted to prescribers and pharmacies separately. The mailing topics are generally complementary so that pharmacies understand the communications that have been sent to prescribers. These mailings are also sent electronically to provider affiliates and representatives so that these organizations can use their proprietary methods to distribute the materials. Examples of these organizations include the Vermont Medical Society and the Vermont Pharmacists Association. Providers may find all general pharmacy benefit management materials posted on the DVHA webpage at http://dvha.vermont.gov/for-providers. These materials include the description of the PBM Program; DUR Board information; the Preferred Drug List and Criteria; prior authorization information and forms; bulletins and mailings; and other information, instructions and alerts
Virginia	Virginia Medicaid DUR Board quarterly meetings were held on December 13, 2018, March 14, June 13 and September 26, 2019 for FFY 2019 to review, revise and approve criteria for new drugs as well as criteria for service authorizations and retrospective DUR (RetroDUR). The Board, along with the state and Magellan Rx Management, selects the criteria that will be used for RetroDUR activities for the subsequent months until the next quarterly meeting. The FFY 2019 RetroDUR intervention activities are reported in Summary 2 - RetroDUR Educational Outreach Summary. For FFY 2019, the problem types addressed in the RetroDUR intervention letters were overutilization, underutilization, drug-disease contraindications, drug-drug interactions, inappropriate use and duration as well as adverse drug reactions. VA also included polypharmacy and Beers review in the RetroDUR program. The DUR Board continued to discuss the expenditures for compounded prescriptions. Many topical compounds have research/study status and have no proven efficacy or evidence base. Based on the analysis of the compounded prescriptions utilization data, the Board voted to change the maximum per compound drug to $250 and $500 maximum for all compounds per 30 days. This will include oral and topical compounds. Compound claims over these limits will be forwarded to the DMAS physicians for review and approval/denial. This change to the compounded prescriptions edit was implemented on November 26, 2018. During FFY 2019, the DUR Board continued to review more closely the physician administered drugs as well as the specialty drugs. Magellan Rx Management along with DMAS work together to create clinical service authorization criteria for several of these drugs which get reviewed at the DUR Board Meetings. The DUR Board continued to address and review topics in reference to the SUPPORT Act. During FFY 2019, the DUR board addressed and sent letters to prescribers in reference to combination therapy with opioids and benzodiazepines and sent prescriber letters to address high risk for an opioid overdose and no naloxone claims. DMAS has also recently decreased the MME further down to 90 MME in addition to the existing quantity limits on all short and long acting opioids.

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	Also, Magellan Rx Management has added member lab value data which allows Magellan to execute RetroDUR algorithms with Fee-For-Service (FFS) or Managed Care Organization (MCO) data. The availability of lab results mitigates the outreach required to ask physicians to validate a test result or ask if a lab test had been done recently. The addition of the lab results information through this new process has potential to greatly improve RetroDUR capabilities and will help to better engage prescribers by not asking for information that we should already have. DUR Quarterly Newsletters were created and posted on VA Medicaid website. The summary of the minutes for each of the FFY 2019 DUR Board meetings are included below. Minutes Summary - December 13, 2018 RetroDUR Criteria Estimates: The DUR Board reviewed the Criteria Exception Estimates Report and the Criteria Exception Estimates Report for Lab Values. New Drugs: The DUR Board reviewed Ajovy™ (fremanezumab-vfrm), Braftovi™ (encorafenib), Delstrigo™ (doravirine/lamivudine/ tenofovir disoproxil fumarate), Doptelet® (avatrombopag), Galafold™ (migalastat), Lokelma™ (sodium zirconium cyclosilicate), Mektovi® (binimetinib), Mulpleta® (lusutrombopag), Orilissa™ (elagolix), Pifeltro™ (doravirine), Poteligeo® (mogamulizumab-kpkc), Symtuza™ (darunavir/ cobicistat/ emtricitabine/ tenofovir alafenamide) and Tibsovo® (ivosidenib). Physician Administered Drugs: The DUR Board reviewed the service authorization criteria and utilization for Onpattro™ (patisiran) and Soliris® (eculizumab). Analysis of Compounded Prescriptions - The DUR Board reviewed the different Analysis of Compounded Prescription reports for FFS and MCOs. Opioid Utilization - The DUR Board reviewed the utilization reports for pediatric FFS and MCO populations. Opioid Utilization and Alternative Treatment reports for Chronic Pain were presented which included specific demographic details. The Concurrent Opioid and Benzodiazepine report with Top 25 Diagnoses, Procedures, Prescribers and Geographic Locations for FFS and MCOs was presented. Long-Acting Reverse Contraception (LARC) - The DUR Board reviewed the LARC reports for FFS and MCOs and the utilization is plateauing and decreasing. Stimulant Utilization - The DUR Board discussed Stimulant Use by Age report. There is a concern over stimulant use under the age of 3 which is not FDA indicated. The DUR Board also reviewed Stimulant Use in Adults with Approved Indications and Stimulant Use in Adults with Unapproved Indications. Naloxone Utilization - The DUR Board reviewed the Naloxone Utilization for FFS and MCO. and the "Members on Opioids and No Naloxone with Risk Factors" report for FFS and MCO. Antipsychotic Duplication - The DUR Board reviewed the Antipsychotic Duplication with Antipsychotics for FFS and MCO. Minutes Summary - March 14, 2019 RetroDUR Criteria Estimates: The DUR Board reviewed the Criteria Exception Estimates Report and the Criteria Exception Estimates Report for Lab Values. New Drugs: The DUR Board reviewed Copiktra™ (duvelisib), Daurismo™ (glasdegib), Libtayo® (cemiplimab-rwlc), Lorbrena® (lorlatinib), Panzyga® (human normal immunoglobulin, IVIg), Talzenna™ (talazoparib), Vitrakvi® (larotrectinib), Vizimpro® (dacomitinib), Xospata® (gilteritinib) and Xyosted™ (testosterone enanthate). Physician Administered Drugs: The DUR Board reviewed the service authorization criteria and utilization for Crysvita® (burosumab-twza) and Ilumya™ (tildrakizumab-asmn). Analysis of Compounded Prescriptions - It was mentioned that the compound edit was implemented on November 26, 2018 that made the maximum per compound drug set at $250 and $500 maximum for all compounds per 30 days. The compound utilization reports showed a decline in claims for compounds since the edit. The Buprenorphine and Naloxone Compound Claims report was reviewed with the DUR Board.

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	Pediatric and Adult Opioid Utilization - The DUR Board reviewed the Opioid Utilization reports that included all ages for FFS and MCO populations. The utilization reports showed a decline in opioid claims in the pediatric population. Concurrent Use of Opioids and Benzodiazepines - The DUR Board reviewed Concurrent Use of Opioids and Benzodiazepines utilization reports for FFS and MCOs. Opioid Use with Risk Factors and No Naloxone - The DUR Board reviewed Opioid Use with Risk Factors and No Naloxone reports for FFS and MCOs. Antipsychotic Duplication - The DUR Board reviewed the Antipsychotic Duplication with Antipsychotics for FFS and MCOs. Minutes Summary - June 13, 2019 RetroDUR Criteria Estimates: The DUR Board reviewed the Criteria Exception Estimates Report and the Criteria Exception Estimates Report for Lab Values. The DUR board reviewed the gabapentin doses over 3,600 mg per day reports. The DUR Board discussed that gabapentin will be classified as a Schedule V controlled substance starting on July 1, 2019. New Drugs: The DUR Board reviewed Inbrija™ (levodopa inhalation powder). Physician Administered Drugs: The DUR Board reviewed the service authorization criteria and utilization for Immune Globulins, Mozobil® (plerixafor) and Imlygic® (talimogene laherparepvec). Specialty Drugs - Children with Peanut Allergy: Reports reviewed showing how many members have a peanut allergy and the members total claims across FFS and all the MCO plans. Analysis of Compounded Prescriptions - The DUR Board reviewed the different Analysis of Compounded Prescription reports for FFS and MCOs. Pediatric and Adult Opioid Utilization - The Opioid Utilization reports that included all ages for FFS and MCO populations was presented. The utilization reports showed a decline in opioid claims. Concurrent Use of Opioids and Benzodiazepines - The DUR Board reviewed Concurrent Use of Opioids and Benzodiazepines utilization reports for FFS and MCOs. Opioid Use with Risk Factors and No Naloxone - The DUR Board reviewed Opioid Use with Risk Factors and No Naloxone reports for FFS and MCOs. Antipsychotic Duplication - The DUR Board reviewed the Antipsychotic Duplication with Antipsychotics for FFS and MCOs. Minutes Summary - September 26, 2019 RetroDUR Criteria Estimates: The DUR Board reviewed the Criteria Exception Estimates Report and the Criteria Exception Estimates Report for Lab Values. New Drugs: The DUR Board reviewed Balversa™ (erdafitinib), Dovato® (dolutegravir and lamivudine), Egaten™ (triclabendazole), Nucala® prefilled autoinjector and syringe (mepolizumab), Piqray® (alpelisib) and Vyndaqel®/Vyndamax™ (tafamidis meglumine)/(tafamidis). Children with Peanut Allergy - The oral peanut allergy pipeline drug (AR101) will be managed by the P&T Committee once it is on the market. Antihemophilic Drug Factors - A motion was made and approved to remove the service authorization criteria from Hemlibra® and leave the other antihemophilic drug factors without SA criteria. Concurrent Use of Opioids and Benzodiazepines - The DUR Board reviewed Concurrent Use of Opioids and Benzodiazepines utilization reports for FFS and MCOs. Acetaminophen Doses Greater than 4 Grams - The DUR Board reviewed Acetaminophen Doses Greater than 4 Grams reports for FFS and MCOs. Analysis of Compounded Medications - The DUR Board reviewed the different Analysis of Compounded Prescription reports for FFS and MCOs. Pediatric and Adult Opioid Utilization - The DUR Board reviewed the Pediatric and Adult Opioid Utilization reports for FFS and MCOs. Antipsychotic Duplication - The DUR Board reviewed the Antipsychotic Duplication with Antipsychotics report for FFS and MCOs.

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	Opioid Use with Risk Factors and No Naloxone - The DUR Board reviewed Opioid Use with Risk Factors and No Naloxone for FFS and MCOs.
Washington	During the FFY 2019, the DUR Board met four times with meetings focused on implementing the Apple Health Preferred Drug List (AHPDL) specific to Medicaid. For both prospective and retrospective DUR interventions, the DUR Board does not have set policies on what types of interventions need to be adopted however if interventions are identified they are determined on a topic-by-topic basis. The following 102 drug classes were reviewed and approved by the DUR board for addition to the AHPDL: Acne products- oral Agents for external genital and perianal warts Alpha-2-receptor antagonists ALS agents Aminoglycosides- Oral Analgesics: opioid-injectable Androgens- other Anorectal agents Antidepressants Antifungals- oral Anti-ingective agents- Misc- Oral Antimyasthenic cholinergic agents Antimycobacterial agents- oral Antineoplastic or premalignant lesion agents- topical Antiparasitics Antiprotozoal agents Antipsoriatics- oral Antipsychotic/antimanic agents Antithyroid agents Asthma agents Barbiturates Bone density regulators- bisphosphonates Calcitonins Chelating agents CMV antivirals Contraceptives Cystic fibrosis agents Dermatologics Dermatologics: agents for wrinkles/lipoatrophy/other aesthetic uses Dermatologics: antipsoriatics- topical Dermatologics: PDE4 inhibitors Digestive Aids Eczema agents Endocrine and metabolic agents: Growth hormone releasing hormones (GHRH) Endocrine and metabolic agents: insulin-like growth factors Endocrine and metabolic agents: Progesterones Enzymes- topical Estrogen/androgen combinations Estrogen/progestin combinations Estrogen/selective estrogen receptor modulator combinations Estrogens- oral Estrogens- topical

	Estrogens- vaginal Estrogens-injectable Fluoroquinolones- Oral Gastrointestinal agents Gaucher Disease Genitourinary agents Glucocorticosteroids Glycopeptides- Oral Gout agents H. Pylori drugs Hematological agents: Misc- antihemophilic products Hematological agents: other Hematopoietic agents: hematopoietic mixtures, iron Hematopoietic agents: TPO Hematopoietics agents: Thrombopoietin (TPO) receptor agonists Hepatitis B agents Hereditary angioedema agents Herpes agents Hypnotics/sedatives/sleep disorder Influenza agents Injectable antifungals Leprostatics- oral Lincosamides- oral Macrolides- oral MAOIs Miscellaneous ulcer drugs Movement disorders Neuromusclar agents: neuromuscular blocking agents- neurotoxins Norepinephrine-dopamine reuptake inhibitors Ophthalmic antibiotics-steroid combinations Ophthalmic antifungals Ophthalmic antivirals Oxazolidinones- oral Parathyroids hormone derivatives Passive immunizing and treatment agents: Combinations and immune serums Penicillinase-resistant penicillins- oral Phosphodiesterase inhibitors PKU agents Potassium removing agents Psychotherapeutic agents Rank Ligand Inhibitors Rosacea agents RSV agents Selective estrogen receptor modulators (SERMS) Serotonin modulators Sickle Cell Disease Skeletal muscle relaxants Smoking Deterrents SNRIs

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	SSRIs Substance use disorder Thyroid hormone- oral Topical steroids- high potency Topical steroids- medium potency Topical steroids- very high potency Tricyclic agents Tripeptidyl peptidase 1 deficiency agents Vitamins: pediatric Xanthines X-linked hypophosphatemia agents (XLH) The DUR Board made changes to recommendations for prospective DUR prior authorization criteria in the following 22 classes/products: Alinia Alpha proteinase inhibitors Brineura CGRP Antagonists Crysvita Erythropoiesis Stimulating Agents (ESAs) Granulocute Colony Stimulating Factors (G-CSF) Growth hormone releasing hormones (GHRH)- tesamorelin (egrifta) Insulin like growth factors- mecasermin Ocrevus Oncology- Hematological Oncology- Prostate Oncology- Breast Oncology- renal Oncology- lung Oncology- skin Oncology- other Onpattro Palynziq Tegsedi Thrombopoesis Stimulating Agents (TPOs) Xifaxin
West Virginia	The West Virginia Drug Utilization Review Board (DUR) and the Pharmaceutical and Therapeutics Committee (P&T) meet separately once during each quarter of the year. During FFY 2019 the DUR Board met a total of four times. The first DUR Board meeting of the 2019 Federal Fiscal Year was held on November 14, 2018. The Pharmacy Services calendar is structured so that the P&T Committee meets two to four weeks before three of the four DUR Board meetings. Reports are presented at each DUR Board meeting by the MMIS Vendor, the prior authorization agent, and the RetroDUR vendor. The MMIS Vendor, Molina State Healthcare (DXC), presents several reports to the DUR Board. These reports include a list of the top 25 therapeutic classes by amount paid and prescription count, a generic utilization summary, and an overall summary comparing statistics for the quarter to the previous year.

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	Our prior authorization vendor, the Rational Drug Therapy Program (RDTP), is part of the West Virginia University School of Pharmacy. RDTP presents data on the number of prior authorizations approved, denied and pended and the level of service provided. An additional report is presented on the number of edit overrides approved. The Board uses the data presented to evaluate prior authorization programs and edits currently in place. Additions/Deletions to DUR Board: Approved Criteria Four (prospective) DUR Board meetings were held in the period between Oct 1, 2018 and Sept 30, 2019. The following indicates clinical criteria which were added or altered during these meetings. November 14, 2018 Prospective DUR topics covered included: CGRP receptor antagonists, Epidiolex, Dupixent, Latuda, Lucemyra February 27, 2019 Prospective DUR topics covered included: Cytokine and CAM antagonists, Ophthalmics, Glaucoma agents (prostaglandin analogs) Vyzulta, Pituitary Suppressive Agents, LHRH (new PDL class), CGRP Antagonists, Xolair May 22, 2019 Prospective DUR topics covered included: Lovaza, CGM Devices (Dexcom G6, Freestyle Libre), Omnipod, PCSK9 Inhibitors, Qbrexza, Spravato, HAE agents (Takhyzro), Xifaxan September 25, 2019 Prospective DUR topics covered included: Nucala, Stimulants (Class criteria), Palyniq, Dupixent (new indication: Nasal Polyps), Diclegis, HepC Agents, Xhance Involvement with Retrospective DUR: The WV Retrospective DUR committee is a sub-committee of the DUR Board and is composed of 4 members, along with bureau of medical services staff members, who meet once per month to perform retrospective reviews on patient profiles which hit on criteria. Each member reviews approximately 75 profiles as well as 10 Lock-in profiles. As new drug entities arrive and as current research dictates, our RetroDUR vendor, Marshall DUR Coalition, will submit new criteria to the RetroDUR committee for review. Any criteria approved are then implemented in the following cycle. Retrospective DUR reviews often provide the impetus for development of new DUR policy for our Medicaid program. Marshall uses data from these reviews and from claims extract files to make recommendations to the DUR Board for population-based educational interventions targeting disease states and observed patterns of medication use. Below is a list of newsletter topics, a list of targeted RDUR interventions, population health initiatives reviewed from 10/1/18 to 9/30/2019. Information about our lock-in program is also described below. Newsletter Topics: Stopping the Spread of HIV in Your Community Medications to Avoid in Patients with Systolic Heart Failure Improving Adherence - Overall Health & Wellbeing

Targeted Education/Interventions:
1. Concurrent opioid and benzodiazepine therapy.
2. Gastroesophageal reflux disease (GERD) and Proton Pump Inhibitor (PPI) therapy greater than 90 days.
3. Diagnosis of Diabetes Mellitus (DM) without Angiotensin II receptor blocker (ARB) or angiotensin converting enzyme inhibitor (ACE Inhibitor) therapy.
4. Diagnosis of Atherosclerotic Cardiovascular Disease without statin therapy.
5. Concurrent Glucagon-like peptide-1 (GLP-1) receptor agonists and dipeptidyl peptidase-4 (DPP-4) inhibitor therapy.
6. Congestive Heart Failure (CHF) and non-steroidal anti-inflammatory drugs (NSAIDs).
7. Diagnosis of Helicobacter pylori and PPI therapy greater than 14 days.
8. Heart Failure with Reduced Ejection Fraction (HFrEF) and on diltiazem or verapamil.
9. Congestive Heart Failure and on a thiazolidinedione (pioglitazone or rosiglitazone).
10. Congestive Heart Failure and Dronedarone therapy.

Population Health Initiatives Completed:
Diagnosis of Opioid Dependency and patient is on an opioid.
Patients concurrently prescribed opioids, benzodiazepines, and gabapentin or pregabalin.

Population Health Initiatives Approved and Pending:
1. Patients concurrently prescribed opioids and antipsychotics as defined in the National Target Support Act.
2.. Patient prescribed sedative for sleep disorder while concurrently prescribed stimulant.
3. Appropriate dosing of stimulants in adolescents.
4. Quality improvement of pediatric antibiotic prescribing.
5. Proton pump inhibitor prescribing and usage.
6. Patients with Hepatitis C. Monitor for appropriate documentation, immunizations, SVR12, Medicaid criteria for approval to treat.
7. Patients with chronic obstructive pulmonary disease (COPD) prescribed benzodiazepines.
8. Patients prescribed medications that interfere with QT interval that are also prescribed methadone.
9. Male patients prescribed Risperdal.

Lock-In Program:

The Lock-In Program reviews at-risk patients who may be misusing controlled substance therapy and may restrict the patient to receiving their prescriptions for controlled substances from a single pharmacy. Patients with cancer are excluded from the review. Similarly, Suboxone is not reviewed as a controlled substance for patients in recovery from substance abuse. Some of the criteria used to flag potential misuse include:

High Average Daily Dose: 120 morphine milligram equivalents or more per day over the past 90 days (patients with a cancer diagnosis are excluded).
Overutilization: Filling of seven or more claims for any controlled substances in the past 60 days.
Prescriber Shopping: Having three or more prescribers writing for any controlled substance in the past 60 days.
Pharmacy Shopping: Having three or more pharmacies filling controlled substance prescriptions in the past 60 days.

State	DUR Board Activities Report
	Use of a controlled substance with a History of Dependence: Any use of a controlled substance in the past 60 days with at least two occurrences of a medical claim for Substance Abuse or Dependence in the past 720 days. Use with a History of Overdose: Any use of a controlled substance in the past 60 days with at least 1 occurrence of a medical claim for controlled substance overdose in the past 720 days. Frequent Flyer: Three or more emergency department visits in the last 60 days. 2195 members have been reviewed for Lock-In consideration. 48 members were Locked-In, 798 received a warning letter, and 1349 were determined they should receive no letter by clinicians in the RetroDUR Program.
Wisconsin	Summary of Wisconsin Drug Utilization Review Board Activities Attachment_3CMS FFY 2019 The Wisconsin DUR Board convened in Madison WI for four regularly scheduled quarterly meetings. A quorum of members was present at each meeting. Minutes of each meeting follow this summary. Below are the DUR activities: For Prospective DUR: - Implemented the patient-age alert for children less than 18 years of age for all products containing codeine or tramadol, as well as prescription cough and cold products containing codeine or hydrocodone. - Updated the therapeutic duplication alerts based on recent First Data Bank (FDB) modifications. For Retrospective DUR: - Continued addition of RDUR criteria based on established guidelines with subcontractor HID as new criteria were created. - Reviewed Quarterly Reports of RDUR activity. - Targeted intervention, including intervention letters and peer to peer outreach calls, for appropriate use of triazolam. Outreach calls were made to prescribers with members identified as being on a high dose, chronic use, or use in advanced age. - Targeted intervention to address renal dosing for diabetic medications. - Focused intervention to address chronic use of benzodiazepines- Phase I: Phase I of this intervention included peer to peer outreach calls to a small number of prescribers with members identified as being on chronic high dose benzodiazepine therapy, specifically diazepam and alprazolam. Information gathered from outreach calls in regard to prescriber beliefs about chronic use and deprescribing of benzodiazepines was utilized in Phase II of this intervention. - Focused intervention to address chronic use of benzodiazepines- Phase II: Phase II of this intervention consisted of sending educational letters to identified prescribers with members meeting specific duration and dosing thresholds for diazepam and alprazolam. Letters focused on risks of chronic use and approaches to deprescribing benzodiazepines. Additional peer to peer outreach calls were made to select prescribers with a high volume of qualifying members to address techniques for deprescribing benzodiazepines. Of note, phase II of this intervention was started in FFY 2019, but letters and outreach calls were made outside of FFY 2019. Work on this intervention will continue during FFY 2020.

State	DUR Board Activities Report
	- Continued focused quarterly interventions on members who have claims for all five drug classes (opioids, stimulants, benzos, sedative hypnotics, and opioid dependence medications) that are tracked for use. Members that are receiving drugs from all five classes are reviewed for possible inclusion in the Lock-In program. DUR Activities for SUPPORT Act -Prospective DUR -Prospective Safety edits on opioid prescriptions include: -Opioid script limit: Limits the number of opioids allowed in a calendar month. -Opioid quantity limits: Limits the amount of short-acting and/or select long-acting opioids dispensed in a rolling calendar month. -Early refill: Limits when a subsequent opioid prescription can be filled. -Therapeutic Duplication: Limits duplicate fills of select drug classes (i.e. opioids, benzodiazepines, etc.) per DUR Board recommendations. -Morphine milligram equivalents (MME): Alerts the pharmacy when the MME on a claim exceeds the MME limit identified by the state. -Retrospective DUR -Retrospective Lock-In/High Utilization criteria: Review of MMEs, multiple high dose short-acting opioids, receiving more narcotics than intended or is using short-acting opioids when a long-acting formulation is available. -Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis. -Program to Monitor Antipsychotic Use in Children -Antipsychotic agents are reviewed for appropriateness in all children including foster children based on approved indications and clinical guidelines. -Retrospective letters are sent to prescribers when a child is on an antipsychotic medication that does not have an indication for use in children. -Fraud and Abuse Identification - The DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies. There are no specific policies of this Board which establish whether or how results of prospective DUR screens are used to adjust retrospective DUR screens. Likewise, there are no specific policies that establish whether or how results of retrospective DUR screening are used to adjust prospective DUR screens. The Board considers issues related to screenings on a case-by-case basis. The Wisconsin DUR Board takes an active advisory role in determining all aspects of the DUR education program. The Board reviews criteria for and results of monthly prescriber intervention lettering. Monthly, 1,000 member profiles are reviewed for regular RDUR and an additional 400 member profiles are reviewed for Pharmacy Services Lock-In.
Wyoming	Number of P&T Committee meetings held Four P&T Committee meetings were held. The meetings were convened quarterly in Cheyenne. A quorum of members was present at each meeting. The meetings begin with the business and professional discussions followed by an open comment period. The second half of the meeting is devoted to discussions of cost and individual patients or providers.

Prospective criteria additions/changes are listed below:

Dose limits:
- Antipsychotics
- Aimovig
- Lyrica
- Gabapentin
- Onfi
- Savella

Duration limits:
- Orilissa
- Lucemyra
- Vyvanse for binge eating disorder
- Evenity

Drug/indication limits:
Orilissa
Mulpleta
Takhzyro
Lucemyra
Palynziq
Epidiolex
Onfi
Dupixent
Emgality
Bijuva
Vyndaqel
Vyndamax
Diacomit
Zolgensma
Ruzurgi

Concurrent therapy:
Triptans
Aimovig and Botox
- Ajovy and Botox
- Lyrica and gabapentin
- Evenity and osteoporosis agents
- Diacomit (must be used concurrently with other anticonvulsants)

Other PA criteria/step therapy:
Humira in pregnancy and breastfeeding
Aimovig
Ilumya
Ajovy
Kevzara
- Olumiant

Baxdela
Yupelri
Cequa
Emgality
Motegrity
Apadaz
Uloric
Mayzent
Mayvenclad
Evenity
Skyrizi
Sunosi
Enbrace HR

In-depth Utilization Reviews
Suboxone
Antipsychotics
Triptans
Lyrica and gabapentin
Adult ADHD
Long-acting narcotics
High dose opioids and cancer diagnoses

Policies regarding the interaction between prospective DUR and retrospective DUR criteria and utilization reviews

Utilization issues identified during prospective review of claims are presented to the P&T Committee as necessary to determine if prior authorization criteria should be added, changed or deleted. When needed, in-depth retrospective review is completed to determine the type of problem and most reasonable solution. Similarly, retrospective reviews often identify utilization issues that require prospective criteria to be added. Both prospective and retrospective reviews drive the selection of education projects.

P&T Committee involvement in the education program

The following topics were included in provider education letters sent from the DUR Program during FFY 2019:
Guidelines for prescribing opioids for chronic pain
Febuxostat (Uloric) prescribing
Benzodiazepine use in pregnancy
Global Initiative for Asthma Guidelines Update
Narcotic use during pregnancy
Prescription drug monitoring program

The following topics were included in comparative prescriber reports sent from the DUR Program during FFY 2019:
Concurrent use of gabapentin and opioids

State	DUR Board Activities Report
	Concurrent use of oral and injectable antipsychotics Concurrent use of stimulants and opioids Controlled substance prescribing trends DUR Newsletters Four quarterly WY-DUR Newsletters were sent during FFY2019. Newsletters are sent to more than 2600 prescribers and pharmacists in Wyoming and the surrounding area. The P&T Committee provides recommendations regarding topics for general and targeted education letters and newsletter articles. Newsletters can be viewed at www.uwyo.edu/DUR. When appropriate, specific Committee members will draft and sign education letters.

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

Figure 34 - State has an Approved Medication Therapy Management Program

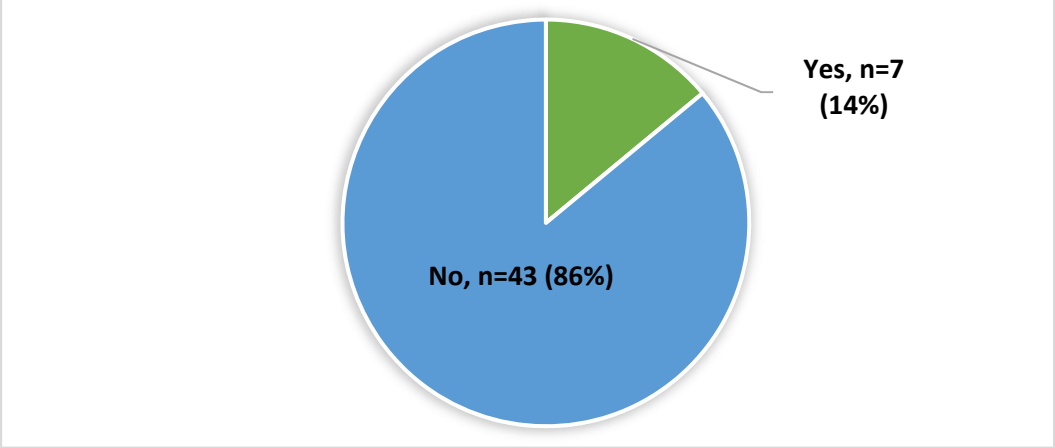

Table 55 - State has an Approved Medication Therapy Management Program

Response	States	Count	Percentage
Yes	Florida, Michigan, Minnesota, Missouri, North Dakota, Tennessee, Wisconsin	7	14.00%
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, Wyoming	43	86.00%
Total		50	100.00%

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

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

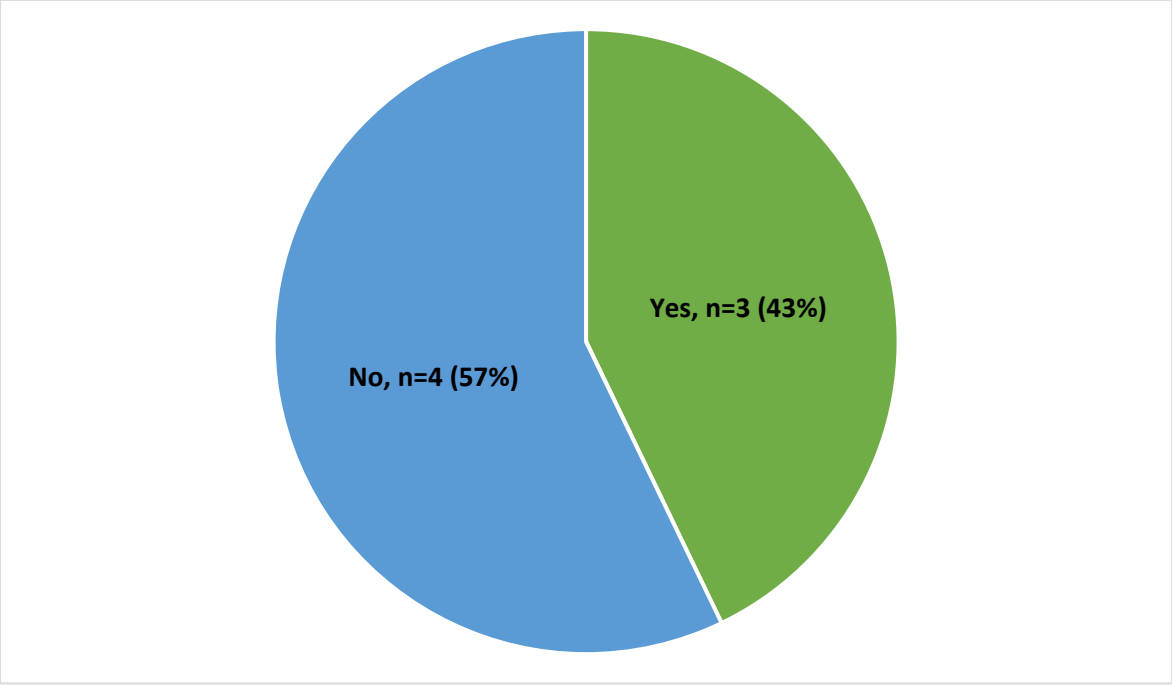

Table 56 - Analysis Performed for Effectiveness of an Approved Medication Therapy Management Program

Response	States	Count	Percentage
Yes	Florida, Tennessee, Wisconsin	3	42.86%
No	Michigan, Minnesota, Missouri, North Dakota	4	57.14%
Total		7	100.00%

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

Table 57 – Explanations of Effectiveness of an Approved Medication Therapy Management Program

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	The MTM program is a pilot program involving the University of Tennessee, TennCare's MCO partners and TennCare. The analysis is performed by the University of Tennessee, and the program involves TennCare's MCO's. The DUR program is not part of the MTM program.

State	Summary of Findings
Wisconsin	A report titled Medication Management: Evaluation and Lessons Learned was published in July 2016. Among a variety of measures and demographic findings, the report included a comparison of Medicaid members receiving MTM services to a control group that did not receive MTM services, since the program was initiated in September 2012. Key findings include: *The MTM program increased all medical costs by $556 per member per year compared to the control group. This includes a $389 increase in pharmacy costs (approximately 70% of the total cost increase). *In patient costs for member receiving MTM services were $102 per member per month less than the control group (with nearly the same number of claims in both groups), suggesting the MTM program may be improving member health. *The full report can be viewed at https://www.dhs.wisconsin.gov/publications/p01558. A similar report will be conducted in the future to determine if MTM services have an impact on the health of members with chronic conditions.

b. Is your DUR Board involved with this program?

Figure 36 – DUR Board Involved with an Approved Medication Therapy Management Program

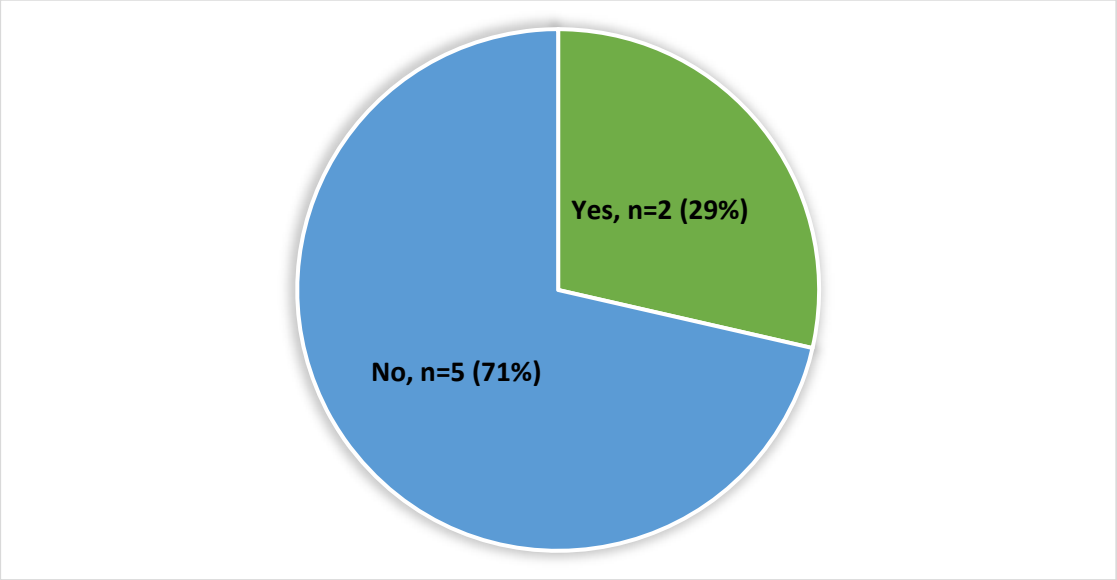

Table 58 - DUR Board Involved with an Approved Medication Therapy Management Program

Response	States	Count	Percentage
Yes	Missouri, Wisconsin	2	28.57%
No	Florida, Michigan, Minnesota, North Dakota, Tennessee	5	71.43%
Total		7	100.00%

If the answer to question 2 is “No,” are you planning to develop and implement a program?

Figure 37 - Plans to Implement an Approved Medication Therapy Management Program

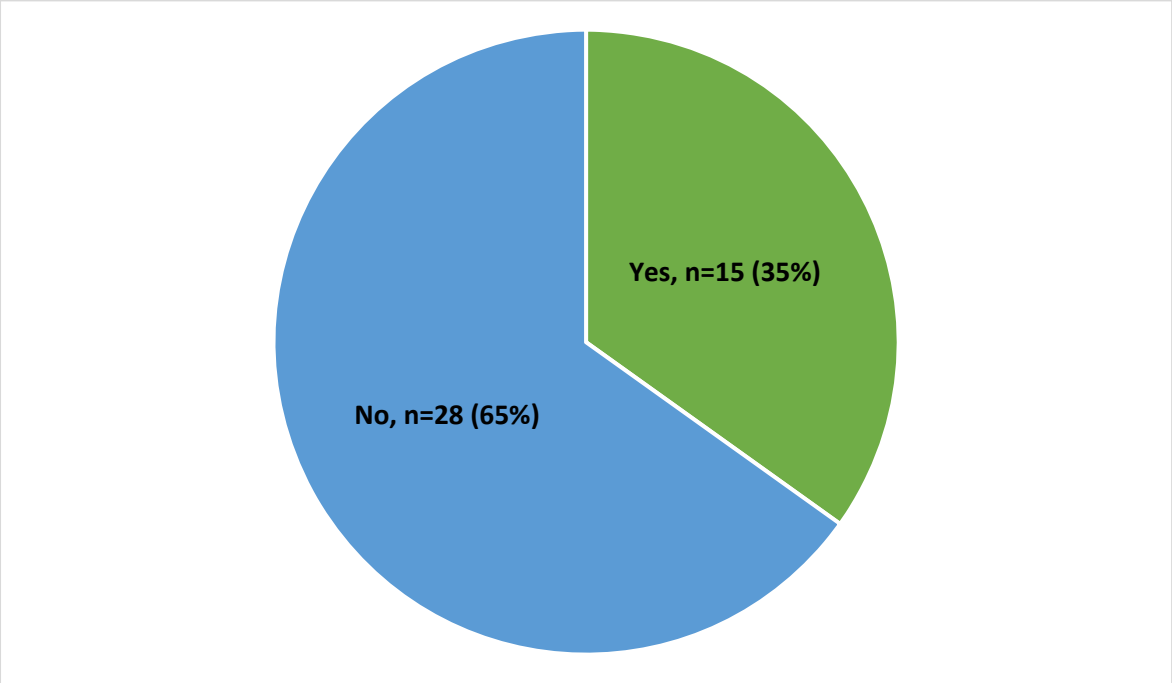

Table 59 - Plans to Implement an Approved Medication Therapy Management Program

Response	States	Count	Percentage
Yes	Alaska, California, District of Columbia, Idaho, Maryland, Massachusetts, Mississippi, Nevada, New Mexico, Oklahoma, Oregon, South Carolina, South Dakota, Vermont, Virginia	15	34.88%
No	Alabama, Arkansas, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, Utah, Washington, West Virginia, Wyoming	28	65.12%
Total		43	100.00%

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 MMIS 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

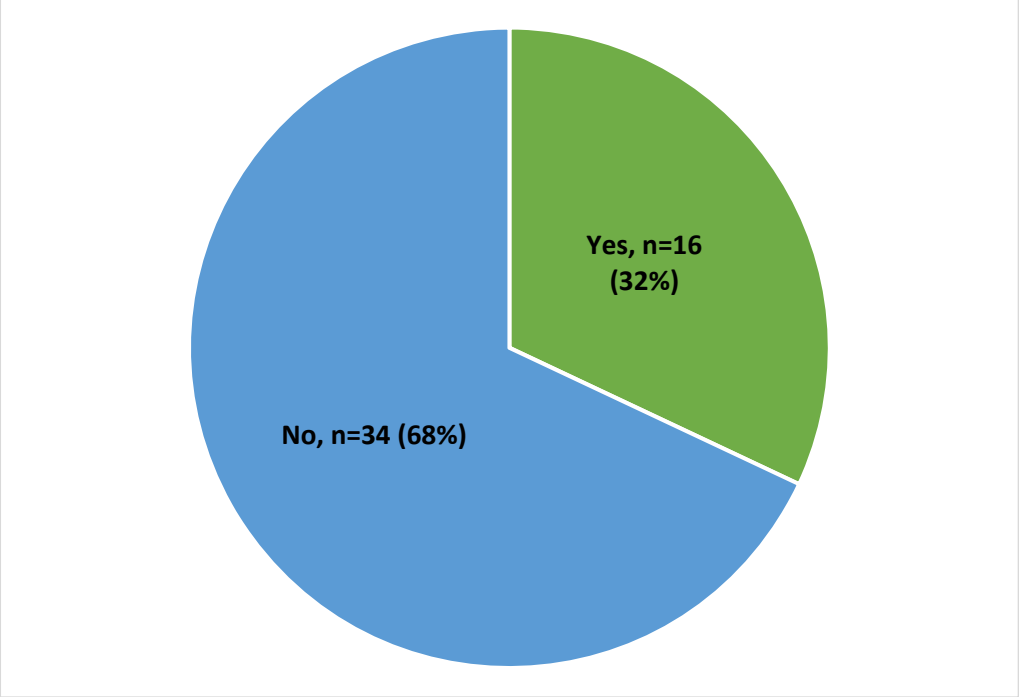

Table 60 - Incorporation of NDCs for Covered Outpatient Drugs Administered by Physicians into DUR Criteria for ProDUR

Response	States	Count	Percentage
Yes	Alaska, Delaware, Florida, Georgia, Hawaii, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nevada, New Jersey, Pennsylvania, Utah, Virginia	16	32.00%
No	Alabama, Arkansas, California, Colorado, Connecticut, District of Columbia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Minnesota, Mississippi, Nebraska, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, Wyoming	34	68.00%
Total		50	100.00%

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

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

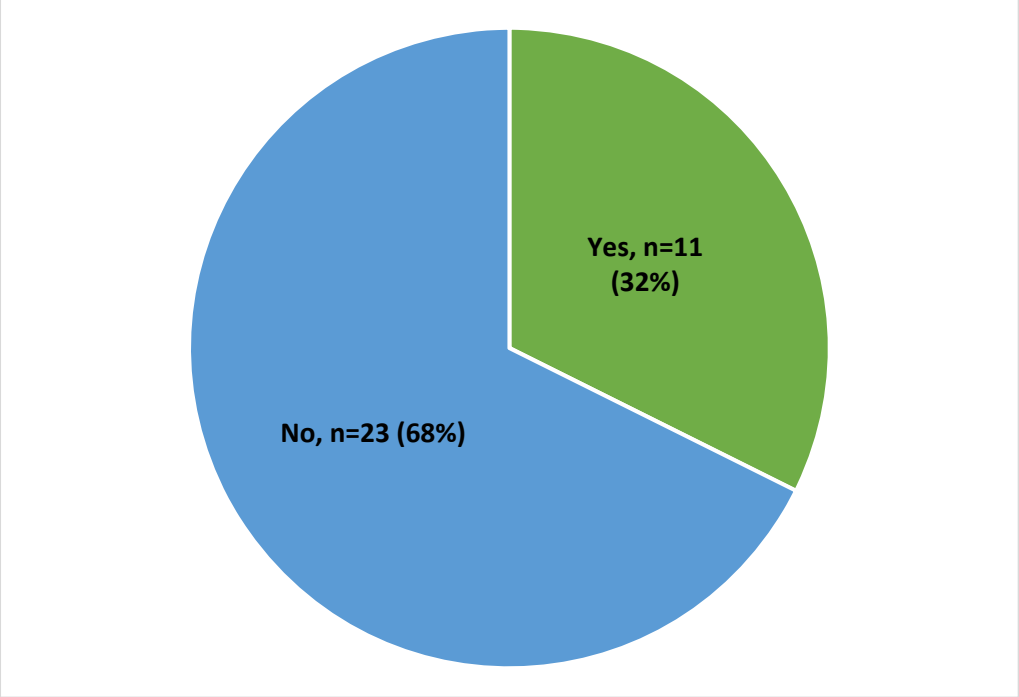

Table 61 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

Response	States	Count	Percentage
Yes	Colorado, District of Columbia, Illinois, Maryland, Mississippi, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Vermont	11	32.35%
No	Alabama, Arkansas, California, Connecticut, Idaho, Indiana, Iowa, Kansas, Louisiana, Minnesota, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Rhode Island, Texas, Washington, West Virginia, Wisconsin, Wyoming	23	67.65%
Total		34	100.00%

2. RetroDUR?

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

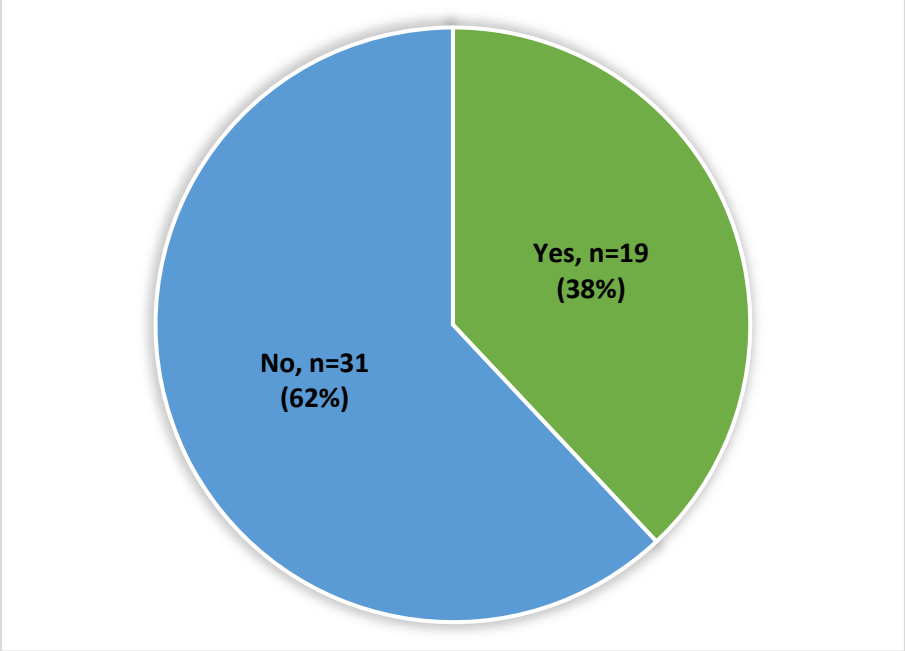

Table 62 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

Response	States	Count	Percentage
Yes	Alaska, California, Florida, Georgia, Hawaii, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, North Dakota, Oregon, Pennsylvania, Virginia, Washington	19	38.00%
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, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, Wyoming	31	62.00%
Total		50	100.00%

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

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

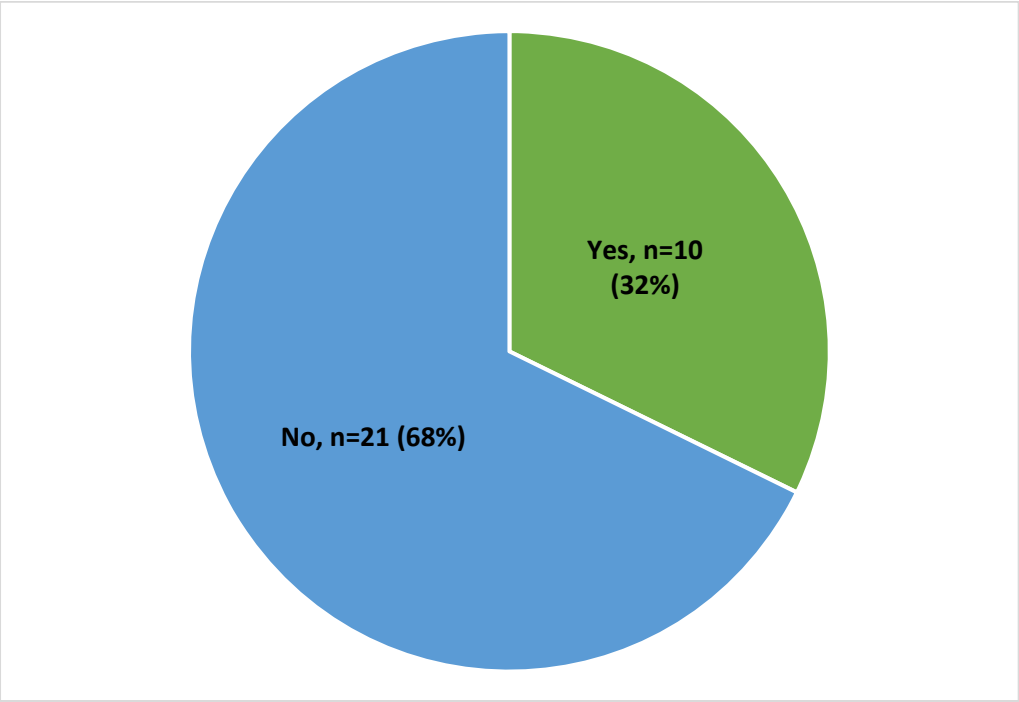

Table 63 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

Response	States	Count	Percentage
Yes	Colorado, District of Columbia, Idaho, Mississippi, New Jersey, North Carolina, South Carolina, South Dakota, Tennessee, Vermont	10	32.26%
No	Alabama, Arkansas, Connecticut, Delaware, Illinois, Indiana, Iowa, Kansas, Maryland, Montana, Nebraska, New Mexico, New York, Ohio, Oklahoma, Rhode Island, Texas, Utah, West Virginia, Wisconsin, Wyoming	21	67.74%
Total		31	100.00%

Section VI - Generic Policy and Utilization Data

1. Summary 4 – Generic Drug Substitution Policies

Summary 4 Generic Drug Substitution Policies summarizes factors that could affect your generic utilization percentage. Please explain and provide details below.

Table 64 – Generic Drug Substitution Policies

State	Generic Drug Substitution Policies
Alabama	Alabama Medicaid mandates generic substitution of therapeutically equivalent drugs. If the doctor requests that brand name be dispensed, he/she must submit an override request, including medical justification for the use of the brand name medication over the generic and a completed FDA MedWatch form; exclusions exist for certain drugs. The Alabama Medicaid program encourages the use of generics in the educational monographs issued to the prescribing and dispensing providers. As another way to encourage the substitution of therapeutically equivalent generic drugs, the Alabama Medicaid Agency has implemented a maintenance supply program. This program allows for the dispensing of a 3-month supply of certain medications for Medicaid recipients. Medications included in the maintenance supply program are primarily generic medications used to treat chronic conditions. Alabama Medicaid also makes use of a Preferred Drug List (PDL) as a way to promote use of generic products. The majority of generic drugs are preferred and providers are urged to utilize the PDL through provider education and academic detailing. Alabama Medicaid's academic detailing program utilizes a team of Medicaid Pharmacy Specialists (MPS) who live in and travel throughout their specific area making prescheduled visits to pharmacists and providers. The MPSs provide education regarding the preferred drug list, new edits, and other priority initiatives designated by the Alabama Medicaid Agency.
Alaska	The use of generic medications is encouraged through regulation 7 AAC 120.112(7). Additional initiatives to encourage the use of generic medications were continued by the Department in FFY 2019. This includes continuation of a point of sale edit which requires a prior authorization for brand name drug claims submitted with a DAW = 1. To the extent possible, and considering the net-net cost of therapeutic equivalents, PDL preferred drug selection encourages generic drug utilization. Educating providers and recipients that generic medications are therapeutically equivalent to the brand name product can be challenging due to periodically held perceptions that generic products are not as effective or potent as the brand product. Patients must trial a minimum of two generic products prior to utilization of a branded product to minimize selection bias. 7 AAC 120.112 Non-covered drugs Notwithstanding 7 AAC 120.110, the department will not pay for- (7) a brand-name covered outpatient drug described in 7 AAC 120.110(b) if a therapeutically equivalent generic covered outpatient drug is on the market, unless

State	Generic Drug Substitution Policies
	(A) the brand-name covered outpatient drug is included as a preferred medication on the Alaska Medicaid Preferred Drug List, adopted by reference in 7 AAC 160.900; or (B) the prescriber writes on the prescription "brand-name medically necessary"; the information may be submitted electronically or telephonically; if the information is submitted telephonically, the prescriber must document it in the recipient's record; the department may require prior authorization under 7 AAC 120.130 for a brand-name covered outpatient drug with a therapeutically equivalent generic covered outpatient drug on the market;
Arkansas	GENERIC DRUG SUBSTITUTION POLICIES Arkansas MEDICAID Generic Drug Substitution Policies -FFY 2019 The Arkansas Medicaid prescription drug program uses various methods to encourage generic drug utilization and cost containment. These methods include: 1) Brand medically necessary edit: This edit requires that physicians indicate that a multi-source brand drug is required for their patient. Claims for multi-source brand drugs will be paid at the MAC price if available unless the prescriber requests a prior authorization (PA) for the priced as brand multi-source product. Based on the Arkansas Medicaid definition of their brand versus generic pricing, the average rate of generic utilization is eighty-three percent (83%) for FFY 2019. 2) Maximum Allowable Cost (MAC): Arkansas Medicaid establishes and manages their MAC reimbursement levels. MAC reimbursement levels are generally applied to multi-source brand and generic products. However, MAC reimbursement may also be applied to single source drugs or drug classifications where appropriate (e.g. antihemophilic factors). 3) Preferred Drug List (PDL): The PDL drives market shift to the generic drugs when the pricing is less than the brand pricing net of CMS and supplemental rebates. The patents of the original brand drugs in many of the therapeutic classes have expired. These older drugs have been replaced with several generic versions that are now priced at MAC. 4) Tiered copays for brand/generic drugs: Arkansas Medicaid requires $.50 to $3 per prescription depending on drug cost for Medicaid beneficiaries age 21 years and older. 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. These sourcing status indicators are identified as follows: 1) Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market. 2) Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market. 3) Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity.

State	Generic Drug Substitution Policies
	Utilizing these indicators to determine generic utilization will allow for consistent reporting across all states. Based on calculations using these indicators, Arkansas Medicaid has a generic utilization of 83% for all outpatient claims comprising 19% of total drug expenditures for FFY 2019.
California	Among possible factors contributing to the Medi-Cal fee-for-service generic utilization percentage, the most impactful are the following: 1) supplemental rebate contracts with manufacturers; 2) carve-out drugs; and 3) generic drug pricing policies. 1) Restrictions to the Medi-Cal List of Contract Drugs The Medi-Cal Drug Rebate program negotiates supplemental rebate contracts with pharmaceutical manufacturers and collects rebates greater than rebates obtainable through federal contracts alone. As a result, the net cost to the State for some brand name drugs can be lower than the therapeutically equivalent generic drug. In some cases, contracted drugs are payable at the point of service, while their generic equivalents require prior authorization. On the Medi-Cal List of Contract Drugs, these drugs can be identified through restrictions to the NDC labeler code. 2) Carve-out Pharmacy Benefits The Medi-Cal fee-for-service program pays for certain carved-out therapeutic classes of drugs for beneficiaries in both the Medi-Cal fee-for-service program and the Medi-Cal managed care program. Most notably, this applies to selected psychiatric drugs, alcohol and heroin detoxification and dependency treatment drugs, coagulation factors, and drugs used in treatment of Human Immunodeficiency Virus (HIV) and AIDS. These classes of drugs are largely single-source innovator products and consistently account for a large portion of Medi-Cal drug benefit expenditures in the Medi-Cal fee-for-service population. 3) Policies encouraging generic equivalent substitution for drugs dispensed through the Medi-Cal program. In cases where generic drugs are more cost-effective, Medi-Cal encourages use of generic drugs. The providers, to the extent permitted by law, shall dispense the lowest cost drug product within the generic drug type in stock, which meets the medical needs of the beneficiary. The following policies affect generic utilization rate by establishing reimbursement rates for drugs dispensed through the Medi-Cal program: Reimbursement for any legend and non-legend drug covered under the Medi- Cal program is the lowest of: 1. Maximum Allowable Ingredient Cost (MAIC) plus current professional fee 2. Federal Upper Limit (FUL) plus current professional fees 3. Estimated Acquisition Cost (EAC) plus current professional fees 4. Charge to the general public Among these, whenever available, MAIC* and FUL** promote the use of generic equivalents unless restricted on the Contract Drug List. The rates established by MAIC or FUL are generally much lower than the cost of branded products, which discourages providers from filling prescriptions with name brand drugs. Full reimbursement of prescription ingredient cost requires use of a brand of a multiple source drug, which costs no more than the program specified price limits. When medically necessary for a specific recipient, approval of

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	reimbursement may be obtained for a product whose price exceeds the MAIC or FUL price limits by requesting authorization from a Medi-Cal consultant. *The Maximum Allowable Ingredient Cost (MAIC) The Maximum Allowable Ingredient Cost (MAIC) program establishes maximum ingredient cost limits for generically equivalent drugs. Each cost limit is established only when there are three or more generically equivalent drugs available for purchase and dispensing by retail pharmacies within California. **Federal Upper Limit (FUL) Federal Upper Limit (FUL) is an upper-limit of reimbursement for certain multiple source drugs established independently from the California MAIC Program by the United States Department of Health and Human Services (DHHS). The federally required FUL is administered by the Medi-Cal program in a similar manner as the MAIC program. The major difference is that changes to the FUL list of drugs and respective price limits are issued periodically by DHHS and then implemented by Medi-Cal. When a drug is listed on both the MAIC and FUL price lists, the reimbursement rate is the lower of the MAIC or FUL.
Colorado	Policy for mandated use of generic product formulations (generic mandate): Brand name drug products that have generic equivalent product formulations (multi-source innovator products) require a prior authorization. Exceptions to this policy include: The brand name drug has been exempted based on indicated use (see bulleted list below) The Department designates favored coverage of the brand drug product based on net cost for the brand product being lower than that of the generic equivalent The physician is of the opinion that a transition to the generic equivalent of a brand drug product would be unacceptably disruptive to the patient's stabilized drug regimen The patient is started on a generic drug but is unable to continue treatment on the generic drug as determined by the patient's physician The following drugs are exempt from the generic mandate policy (no PA is required): Medications used for the treatment of biologically based mental illness (as defined in 10-16-104 (5.5) C.R.S), cancer, epilepsy, and HIV/AIDS Other drug management strategies to encourage use of generic product formulations: Our program has implemented a Preferred Drug List (PDL) which, by incorporating available evidence-based research and public testimony, provides clinical input for necessary drug therapies. Using the clinical input, the program provides advantage to products that are most cost effective. By preferring generic options when clinically appropriate, we have been able to enhance generic utilization in a clinically appropriate way without sacrificing quality of care.
Connecticut	Currently the Connecticut DUR Board has no specific written policies concerning the use of generics. The DUR Board does encourage prescribers to consider judicious, wise use of limited public Medicaid funds while providing quality treatment. The Board does not feel that judicious use of funds and quality care are diametrically opposing goals. Prior to October 2002, the Connecticut Department of Social Services Medical Assistance pharmacy program had no specific policies, but encouraged the use of generics through:

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	1.) Educational monographs issued to the prescribing and dispensing providers, and 2.) Applying a $0.50 generic substitution incentive professional dispensing fee to prescriptions filled by licensed pharmacies for generic drugs dispensed to Medicaid recipients. Effective 10/1/02, pursuant to Section 50 of General Assembly Bill 6004 of the May 9, 2002 Special Legislative Session, the $0.50 generic substitution incentive professional dispensing fee applied to prescriptions filled by licensed pharmacies for generic drugs dispensed to Medicaid recipients was repealed. Current Connecticut Department of Social Services Medical Assistance pharmacy program policies designed to encourage the use of generics and to promote generic substitution are: 1.) NADAC Pricing List: Effective April 1, 2017, the Connecticut Medical Assistance Program implemented a new drug pricing methodology using National Average Drug Acquisition Cost (NADAC) files. This change was in compliance with the Patient Protection and Affordable Care Act of 2010. NACAC pricing is based on the average acquisition cost for covered outpatient drugs. a. Pharmacy claims were updated to price using NADAC values for dispense dates on or after April 1, 2017. Brand name single source and multisource drugs reimburse at the Brand NADAC price while generic drugs reimburse at the Generic NADAC price. Claims for drugs without a NADAC price will reimburse at the lesser of the Federal Upper Limit (FUL) or the Wholesale Acquisition Cost (WAC) with the following exceptions, which will always reimburse at WAC: i. Preferred brand name medications (as identified on the Preferred Drug List (PDL), and ii. Medications submitted with a Dispense as Written (DAW) Code of 1 (Substitution Not Allowed-Brand Medically Necessary), for all HUSKY A, HUSKY C, HUSKY D, TB AND FAMPL recipients. 2.) FUL Pricing List: DSS previously adopted the federal upper limit (FUL) list for pricing which helps to promote generic substitution. 3.) WAC Pricing List: Effective 4/1/2017, the average wholesale price (AWP) pricing segment is only being used to calculate the WAC rate for reimbursement when an NDC has no NADAC rate on file. The WAC rate is calculated by dividing the AWP rate by 1.2. 4.) State MAC Pricing List: The SMAC Program was end dated on 3/31/2017 with the implementation of NADAC Pricing changes to pharmacy reimbursement. 5.) Prior Authorization for Brand Drugs when 2 Generic Equivalents are available: Prior authorization is required if a prescriber believed that a documented clinical reason existed for a client to receive a brand name drug (Brand Medically Necessary) when two generic drug products plus brand that the FDA considered to be therapeutically equivalent, A-rated, was available. Exemptions: PA is not required for: A.) Compounded claims, B.) Brand name atypical antipsychotics for recipients who have had this medication filled within the last year; C.) HIV medications and D.) Non-maintenance medications prescribed for less than a 15-day supply E.) Cyclosporine or Levothyroxine products (due to the narrow therapeutic window). 6.) Preferred Drug List: While generics are preferred for most therapeutic classes, there are some instances where the brand is preferred over the generic because of the supplemental rebate contracts. In addition, there are instances where the generic is not preferred when new to the market because there is not significant enough pricing differences between brand and generic.

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Delaware	In federal fiscal year 2019, DMMA policy goals encourage generic usage unless there is a price guarantee offered by the labeler, regardless of the federal rebate, to lessen the cost burden on the MCOs and to be more supportive of generic substitution. Previously, when the net price of the brand product was more cost effective, DMMA selected the brand as preferred. In general, we limit brand multi-sourced products as preferred in Delaware, however there are a few drug classes where it has been deemed necessary. In these cases, prescribers are made aware of these drugs by the brand name product being listed as preferred on the PDL and the type being bolded to notate the brand name is preferred over the generic. Delaware utilizes NADAC pricing. Delaware Medicaid continues to mandate generic dispensing on all drug categories except for members with a seizure diagnosis and drugs deemed to be narrow therapeutic index medications. All other instances of brand name dispensing when generics are available require prior authorization. For members with a seizure diagnosis, the provider includes the diagnosis on the prescription and the pharmacy submits the diagnosis code in the corresponding NCPDP field which will override the need for any paper prior authorization to be submitted. Our state law requires that a doctor must write Brand Medically Necessary on the face of prescriptions for brand name but Medicaid takes additional steps to ensure the medical necessity of a brand name dispensing. If a patient requests brand and the pharmacy submits a DAW code of two, this code is automatically rejected in our point of sale system. Delaware also continues to mandate that a Med Watch form be submitted as the prior authorization for brand name multi-sourced medications. First and foremost, Med Watch forms are detailed descriptions of the generic product failed and the type of failure that occur. Using this form means that a generic must be tried prior to the request for a brand name product. A minimum of a two-week trial period is required unless an objective adverse event occurs that necessitates the medication being stopped. The Med Watch form must be completely filled out with the National Drug Code (NDC) and lot number. Along with this required information, the physician must document a valid side effect or lack of efficacy that occurred with the member utilizing a generic. The majority of Med Watch forms submitted to Delaware Medicaid do not meet our criterion as they lack information, have too short of a trial period, or listed symptoms that cannot be linked to the generic product itself. Delaware has had this policy requiring the Med Watch form to deter brand name dispensing of multi-source drugs for many years and continues to find it to be effective in decreasing unnecessary and costly use of brand name products
District of Columbia	There are several marketplace factors that could potentially influence the generic utilization percentage. The District of Columbia Medicaid program implemented a District Maximum Allowable Cost (DMAC) Program on April 1, 2010. The list is updated quarterly and the current listing is available on the Medicaid website at www.dc-medicaid.com and on the PBM website at www.dc-pbm.com. The DMAC program works in concert with the District's long-standing policy of mandating the substitution of an AB rated therapeutically equivalent generic product for a prescribed brand name product. If a prescriber has indicated on a written prescription that a branded product is medically necessary for his/her patient, the pharmacist must request a prior authorization before submitting the claim with DAW 1. Additionally, the District utilizes a Preferred Drug List to manage selected classes of drugs that are vetted for efficacy, safety and therapeutic equivalency. Preferred brand drugs are subject to a manufacturer supplemental rebate payable to the District based on utilization of the product. At times the net cost to the District for a brand product is more advantageous than if a generic

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	product is preferred mainly due to high federal and supplemental rebates on the brand product. In these instances, the District will make a brand product preferred over a generic. This fiscally sound practice however may negatively influence the generic utilization rate.
Florida	Florida Medicaid Pharmacy Program Drug Utilization Review Annual Report: FFY19 Generic Drug Substitution Policies Florida Medicaid has a prescribed-drug spending-control program that includes the Medicaid preferred drug list (PDL). The PDL is a listing of cost-effective therapeutic options recommended by the Medicaid Pharmacy and Therapeutics Committee. The primary goal of this Committee is to ensure availability of medications that are safe, efficacious, and cost-effective, via the PDL, to Florida Medicaid recipients. In many cases, generic drug utilization is encouraged as the most suitable medication for recipients. The Florida Agency for Health Care Administration is authorized to seek any federal waivers necessary to implement cost-control programs and to continue participation in the federal Medicaid rebate program. Due to the participation in the federal and supplemental rebate program, occasionally Florida Medicaid is afforded the opportunity to realize more cost savings when a branded product is dispensed versus the generic counterpart. In those instances, the branded product is included on the PDL and the generic is excluded. Florida Medicaid also promotes generic substitution through point of sale edits such as requiring a clinical prior authorization for any branded drug for which there is a generic available and implementation of a maximum allowable cost (MAC) program. Florida Medicaid continues to encourage generic substitution when possible. This is demonstrated by Florida Medicaid's generic utilization rate of 79% for Federal Fiscal Year 2019.
Georgia	The Georgia Department of Community Health (DCH) maintains a policy for generic dispensing. The generic dispensing rate is accomplished through various initiatives implemented over the course of several years. Preferred brand or generic medications have a co-payment of $0.50 and non-preferred brand or generic medications have a range of co-payments from greater than $0.50 to $3.00, depending on the cost of the drug. Activities include the use of an aggressive Maximum Allowable Cost (MAC) program and favorable placement of cost-effective brands and generics on the Preferred Drug List (PDL), being mindful of clinical appropriateness. DCH also continues to employ a generic mandatory program.
Hawaii	Generic substitution is mandatory by Hawaii Statute. Exceptions are anticonvulsants and narrow therapeutic index medications.
Idaho	GENERIC DRUG SUBSTITUTION POLICIES The use of generic medications is encouraged under the appropriate parameters set forth by different agencies. The State Board of Pharmacy gives definitions as to therapeutic equivalents, The Department of Health and Welfare has put forth rules to encourage the use of generic medications, and the Department has contracted with Myers and Stauffer to provide assistance in establishing and maintaining the Actual Acquisition Cost (AAC) list for all drugs. Working under these parameters, we have established Prior Authorizations of medications, utilized step wise edits when appropriate, and have an established Preferred Drug List which all encourage the use of generic medications when appropriate.

State	Generic Drug Substitution Policies
	Idaho State Board of Pharmacy 27.01.01. - RULES OF THE IDAHO STATE BOARD OF PHARMACY 010. DEFINITIONS AND ABBREVIATIONS (A -- D). 22. Drug Product Selection. The act of selecting either a brand name drug product or its therapeutically equivalent generic. (7-1-18) 23. Drug Product Substitution. Dispensing a drug product other than prescribed. (7-1-18) 012. DEFINITIONS AND ABBREVIATIONS (O -- Z). 16. Therapeutic Equivalent Drugs. Products assigned an A code by the FDA in the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book). (7-1-18) Idaho Administrative Code Department of Health and Welfare 16.03.09 - MEDICAID BASIC PLAN BENEFITS SUB AREA: PRESCRIPTION DRUGS 663. PRESCRIPTION DRUGS: PROCEDURAL REQUIREMENTS. 09. Comparative Costs to be Considered. Whenever possible, physicians and pharmacists are encouraged to utilize less expensive drugs and drug therapies. (3-30-07) State of Idaho Actual Acquisition Cost (AAC) List The Department of Health and Welfare has contracted with Myers and Stauffer LC, a national consulting firm, to provide assistance in establishing and maintaining the AAC list for all drugs. One of the goals of the state's contract with Myers and Stauffer is to improve the AAC program by bringing more consistency, openness, and accuracy to the process. As new AAC rates are developed, the rates are updated. The Department's Preferred Drug List is based on the principle of preferring those drugs primarily with the best comparative efficacy and safety profile. When those are equal then a comparative cost is done, with the net net cost being the acquisition cost minus the federal rebate and minus any supplemental rebate. There are frequent incidences when because of competitive rebates, the brand name may be more cost effective. To judge a program by the percentage of generic use vs overall cost savings is thus misleading.
Illinois	Illinois Medicaid uses multiple strategies to shift utilization to generic drugs: Illinois Medicaid's new PBMS system requires prior authorization for use of a brand product if a generic product is available. The prescriber must request prior approval and demonstrate that the brand name product is medically necessary.

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	Illinois Medicaid uses State Maximum Allowable Cost (SMAC) pricing on generic drugs that establishes the reimbursement rate on the acquisition cost of the generic products. The SMAC and Specialty medication SMAC lists are available at http://www.ilsmac.com/list. Effective July 15, 2019, the Fee-for-Service professional dispensing fee for brand and generic products is the same. There are different dispensing fees for 340B, Critical Access Pharmacies (CAP pharmacies) and non-CAP pharmacies. Illinois Medicaid uses tiered copayments to encourage utilization of generic products. During FFY19, the copayment for brand name drugs remained at $3.90 and the copayment for generic drugs and over-the-counter drugs was $2. The copayment is automatically deducted from the provider's reimbursement and collected from participants by the provider. Illinois Medicaid uses the Preferred Drug List (PDL) to shift utilization to generic products. In classes that contain generic products, generic products are preferred, and brand products are non-preferred, unless they offer a clinical advantage over the generic products. During FFY19 HFS laid the groundwork for a single state Medicaid PDL. With some exceptions, Illinois Medicaid limits the number of brand name drugs participants age 21 and over may receive each month. Prior approval is required for a brand name drug when the department has already been billed for three brand name drugs in the preceding 30-day period. Billing of a 90-day supply is allowed for certain generic, oral, non-narcotic, maintenance medications for disease states such as hypertension, diabetes, and hypothyroidism. In FFY19, the Illinois Medicaid generic utilization rate was 86.09% of total paid claims, an increase of 0.66 percentage point compared to the FFY18 generic utilization rate of 85.43%. In FFY19, brand name single-source drugs accounted for 7% of the total paid claims, which was 1.8% lower than in FFY18. In FFY19 innovator multiple source drugs accounted for 6.9% of the total paid claims, at least 1.21% percent higher than in FFY18. Many drugs that are considered innovator multiple source drugs are not traditional brand name drugs, but rather, authorized generics. Authorized generics are drugs sold by the brand name drug manufacturer or innovator company but distributed as generics with generic labels.
Indiana	Indiana statute mandates substitution of a generically equivalent drug for a prescribed brand name drug, unless the prescribing practitioner properly signs and indicates “Brand Medically Necessary” on the prescription and obtains prior authorization. Excluded from the prior authorization requirement are those claims for Coumadin®, Provera®, Synthroid®, Tegretol®, Lanoxin®, Premarin®, and Dilantin®, as well as claims with a dispense as written (DAW)/product selection code 01 indicating “Brand Medically Necessary.” In addition, brand name agents that are preferred by the plan due to cost savings do not require prior authorization or a prescription indicating “Brand Medically Necessary.” For your reference, the Indiana generic substitution law, Indiana Administrative Code on generic substitution are Indiana Code 16-42-22. Section 10 of the Indiana code describes the requirements for dispensing brand name drugs when a generically equivalent drug product is available (section provided below). The 405 Indiana Administrative Code 5-24-8 provides the requirements for brand name drugs dispensed to Medicaid benificiaries.

State	Generic Drug Substitution Policies
	Sec. 10. (a) If a prescription is filled under the traditional Medicaid program (42 U.S.C. 1396 et seq.) or the Medicare program (42 U.S.C 1395 et seq.), the pharmacist shall substitute a generically equivalent drug product and inform the customer of the substitution if the substitution would result in a lower price unless: • the words “Brand Medically Necessary” are written in the practitioner's own writing on the form; or • the practitioner has indicated that the pharmacist may not substitute a generically equivalent drug product by orally stating that a substitution is not permitted. If a practitioner orally states that a generically equivalent drug product may not be substituted, the practitioner must subsequently forward to the pharmacist a written prescription with the “Brand Medically Necessary” instruction appropriately indicated in the physician's own handwriting. This section does not authorize any substitution other than substitution of a generically equivalent drug product.
Iowa	While use of therapeutically equivalent generic drugs is encouraged, there are instances where a brand name drug is preferred over the generic equivalent. The Pharmaceutical & Therapeutics Committee (P&T) determines placement of drugs on the Preferred Drug List (PDL), taking into consideration the therapeutics and the cost of the drug. The overall cost determination of brand and generic drugs are based on a review of the net cost to the program, subtracting out all CMS and supplemental rebates. Because of varying rebates for brand name drugs, it is not uncommon for the net cost of brand name drug to be less than that of its generic counterparts thus making it preferred for Medicaid programs.
Kansas	Kansas State Board of Pharmacy allows for pharmacist substitution of generic drugs unless: • If the physician insists that brand name be dispensed, he/she must write “dispense as written” on the face of the prescription in his/her own handwriting. • A note stating “dispense as written” on an electronically sent prescription. • Verbally request was made when phoning in a prescription order. • The FDA has determined that a drug is not bioequivalent to the prescribed drug. Kansas Medicaid has a policy requiring generic drug use and requirements for when a provider requests brand drugs. When a prescriber specifies Dispense as Written (DAW) a.k.a “Brand Medically Necessary” on a drug which has a bioequivalent generic substitute available, this requires the pharmacy, in collaboration with the prescriber, to obtain a DAW prior authorization using the Food and Drug Administration (FDA) MedWatch form and completion of the DAW prior authorization form.
Kentucky	Kentucky law requires pharmacists to substitute and dispense US Food and Drug Administration (FDA)-approved generic drugs when presented with a prescription for a brand name drug, unless otherwise instructed by the patient or prescribing practitioner. (KRS 217.822) The prescriber may direct the pharmacist to forego the substitution regulation and dispense brand name medications. The prescriber can direct the pharmacist through a designation written on the prescription such as; Do Not Substitute (DNS), Dispense as Written (DAW), or Brand Medically Necessary (BMN). The patient may direct the pharmacist to forego the substitution regulation and dispense brand name medications verbally. However, a patient may be required to forego full reimbursement or pay a higher co-payment if the patient directs the pharmacist to dispense a brand name when the prescriber has not indicated that the brand is necessary.

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	Kentucky Medicaid also promotes generic substitution through point-of-sale edits such as requiring a clinical prior authorization for any branded drug for which there is a generic available and implementation of a maximum allowable cost (MAC) program. For patients that have a copay, a higher copayment for branded products is assessed unless the plan prefers a brand when a generic of that same product is available. As discussed above, generic utilization is encouraged whenever possible; however, generics must be cost effective as well. There are times when a branded product, after all rebates have been considered, proves to be more cost-effective to the Commonwealth. In those instances, the claims adjudication system is coded to require pharmacies to dispense the more cost-effective (brand) product and generic utilization numbers are negatively impacted.
Louisiana	1. When Brand name drugs are preferred on the PDL and the generic requires prior authorization. From the POS Manual: 4.2.3 Drugs with PA Criteria. Claim payments for Brand Name drugs at Brand reimbursement are allowed when the Brand drug is on the PDL and the generic drug requires Prior Authorization. Edits. The generic reimbursement of a Brand Name drug can be overridden when the Brand drug is on the PDL and the generic drug requires Prior Authorization. Louisiana Medicaid POS User Manual Revised Date: 08/11/14, Page 15 of 73 Override. Enter a value of 9 which is substitution allowed by prescriber but plan requests brand in the NCPDP field 408-D8 (Dispense as Written {DAW} Product Selection Code). Documentation. When 9 is entered in NCPDP field #408-D8, it will not be necessary for the Brand Medically Necessary to be handwritten on the prescription by the prescriber. 2. When the physician requests the Brand for medical necessity. From the POS Manual: 4.2.2 Federal Upper Limits (FUL). Claim payments are adjusted in accordance with the Maximum Allowable Reimbursement Methodology for drugs with FUL. Edits. The FUL can be overridden when the prescribing practitioner utilizing his/her medical judgment certifies in his/her own handwriting that a specific brand name drug is medically necessary for a specific patient. Override. Enter a value of 1 which is substitution not allowed in the NCPDP field 408-D8 (Dispense as Written {DAW} Product Selection Code). Please consult the pharmacy system vendor manual or your pharmacy system documentation or contact your software vendor on what codes need to be entered in this field. If a code is entered in this field, it could affect the amount received.

State	Generic Drug Substitution Policies
	Documentation. The certification must be written either directly on or must be a signed and dated attachment (which may be faxed) to the prescription. The certification must be in the prescriber's handwriting
Maine	The state encourages generic prescribing by virtue of a mandatory generic law, a Preferred Drug List that prefers all cost-effective generics and a rigorous prior authorization requirement for branded products that does not allow DAW 1 overrides at the pharmacies. Generic prescribing encouraged by: 1. State law (quoted below) Exhibit 5.1 Title 32: PROFESSIONS AND OCCUPATIONS Chapter 117: MAINE PHARMACY ACT HEADING: PL 1987, C. 710, 5 (NEW) Subchapter 9: MISCELLANEOUS PROVISIONS HEADING: PL 1987, C. 710, 5 (NEW) 13781. Generic and therapeutically equivalent substitution A written prescription issued by a practitioner in this State may contain a box in the lower right-hand corner of the prescription form. The following words must appear to the left of this box: "Any drug which is the generic and therapeutic equivalent of the drug specified above in this prescription must be dispensed, provided that no check mark ( ) has been handwritten in the box in the lower right-hand corner." [2003, c. 384, 1 (AMD).] Except with regard to a patient who is paying for a drug with the patient's own resources, any pharmacist receiving a prescription in which no handwritten check mark ( ) is found in the box provided shall substitute a generic and therapeutically equivalent drug for the drug specified on the prescription if the substituted drug is distributed by a business entity doing business in the United States that is subject to suit and the service of legal process in the United States and the price of the substituted drug does not exceed the price of the drug specified by the practitioner; except that, when the cost of a prescription is to be reimbursed under the MaineCare program pursuant to Title 22, chapter 855, the pharmacist shall substitute a generic and therapeutically equivalent drug only when the Department of Health and Human Services has determined that the substitute drug would be a more cost-effective alternative than the drug prescribed by the practitioner. Except for prescribed drugs listed under the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code, Section 812, as amended, as Schedule II drugs, with regard to a patient who is paying for a drug with the patient's own resources, a pharmacist shall inquire about the patient's preference for either the brand-name drug or generic and therapeutically equivalent drug and dispense the drug that the patient prefers. [2007, c. 85, 1 (AMD).] Except with regard to a patient who is paying for a drug with the patient's own resources, if a written prescription issued by a practitioner in this State does not contain the box described in this section, a pharmacist shall substitute a generic and therapeutically equivalent drug for the drug specified on the prescription if the substituted drug is distributed by a business entity doing business in the United States that is subject to suit and the service of legal process in the United States and the price of the substituted drug does not exceed the price of the drug specified by the practitioner, unless a practitioner has handwritten on the prescription form, along with the practitioner's signature, "dispense as written," "DAW," "brand," "brand necessary" or "brand medically necessary"; except that, when the cost of a prescription is to be reimbursed under the MaineCare program pursuant to Title 22, chapter 855, the pharmacist shall substitute a generic and therapeutically equivalent drug only when the Department of

State	Generic Drug Substitution Policies
	Health and Human Services has determined that the substitute drug would be a more cost-effective alternative than the drug prescribed by the practitioner. Except for prescribed drugs listed under the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code, Section 812, as amended, as Schedule II drugs, with regard to a patient who is paying for a drug with the patient's own resources, a pharmacist shall inquire about the patient's preference for either the brand-name drug or generic and therapeutically equivalent drug and dispense the drug that the patient prefers. [2007, c. 85, 2 (AMD).] Any pharmacist who substitutes a generic and therapeutically equivalent drug under this section shall inform the person to whom the drug is dispensed of the substitution. When any substitution is made under this section, the pharmacist shall cause the name of the generic and therapeutically equivalent drug, the name or abbreviation of the drug manufacturer or distributor of that substitute drug and all other information as required by section 13794 to appear on the container label of the drug dispensed. [1987, c. 710, 5 (NEW).] This section does not apply to prescriptions ordered by practitioners for patients in hospitals when those prescriptions are filled by a hospital pharmacy or in any institution where a formulary system is established. [1987, c. 710, 5 (NEW).] SECTION HISTORY 1987, c. 710, 5 (NEW). 1997, c. 245, 13,14 (AMD). 2003, c. 384, 1 (AMD). 2003, c. 689, B6 (REV). 2007, c. 85, 1, 2 (AMD). 2. Medicaid Preferred Drug List policy and criteria below. The PDL designates any generic that is more cost-effective than its brand version as preferred. Such brand drugs are non-preferred and require PA. Physicians are not allowed to write DAW/brand medically necessary on such brands to override these PA requirements. If a prescriber feels a brand is medically necessary then they must submit a PA with adequate justification.
Maryland	Section 15 118 of the Annotated Code of Maryland encourages the use of therapeutically equivalent generic drugs. Under this section, the generic form of the drug shall be used to fill the prescription, except for drugs generally not available in the State. The branded form may be used if the prescriber directs otherwise on the prescription or on a signed certification of need, and the pharmacist calls Medicaid for prior authorization of a branded drug. Generics include drugs that have been rated AB (product meets necessary bioequivalence requirements) by the Food and Drug Administration. These ratings are published in the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations (the "Orange Book"). Current Maryland Medicaid policy is to require the approval of a prior authorization, supported by the submission of an FDA Medwatch form, for a brand name drug to be dispensed for which there is an FDA approved equivalent generic agent on the market. The exception to this policy is that, in some instances, the multisource brand name drug is preferred on the Preferred Drug List (PDL) because the branded drug is more cost-effective than its generic counterpart. In the survey question VI. Generic Policy and Utilization Data, sub question 3, we have reported generic utilization percentage of 78%. However, due to the reason stated above, recalculated generic use rate would be 83%.
Massachusetts	MASSHEALTH GENERIC DRUG SUBSTITUTION POLICIES

State	Generic Drug Substitution Policies
	Within the MassHealth Pharmacy Program, generic utilization is part of an evidence-based approach to clinical decisions and program design. Generic utilization is also encouraged and mandated by several Massachusetts regulations. Less Costly Alternatives: Massachusetts regulation 130 CMR 450.204 states that The Division will not pay a provider for services that are not medically necessary. (A) A service is medically necessary if (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the Division. Preferred Copayment for generic medications: Massachusetts regulation 130 CMR 450.130 states that MassHealth members are responsible for making the following copayments unless excluded in 130 CMR 450.130(D) or (E). The copayment for pharmacy services is (a) $1 for each prescription and refill for each generic drug, and nonlegend drug covered by MassHealth in the following classes: antihypertensives, antihyperglycemics, antihyperlipidemics and (b) $3.65 for each prescription and refill for all other drugs covered by MassHealth. Limitations on Coverage of Drugs: 406.413: (A) Interchangeable Drug Products. The MassHealth agency pays no more for a brand-name interchangeable drug product than its generic equivalent unless (1) the prescriber has requested and received prior authorization from the MassHealth agency for a nongeneric multiple-source drug (see 130 CMR 406.422); and (2) the prescriber has written on the face of the prescription in the prescriber's own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated. (Interchangeable Drug Product a product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, A-rated) by the Food and Drug Administration Center for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.) Limitations on Cost: Maximum Allowable Cost (MAC), also known as Massachusetts Upper-Limit Price (MULP) an upper-limit price for multiple-source drugs as defined by DHCFP in 114.3 CMR 31.00. MassHealth Brand Name Preferred Over Generic Drug List A list of brand name drugs that MassHealth prefers over their generic equivalents because the net cost of the brand name drugs adjusted for rebates is lower than the net cost of the generic equivalents. This list may be updated often and is subject to change at any time. MassHealth may require prior authorization (PA) for clinical reasons. Drugs that require additional PA requirements are noted with PA on this list and are subject to 130CMR 406.000 and other MassHealth regulations. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent. MassHealth Supplemental Rebate/Preferred Drug List - A list of drugs for which MassHealth has entered into a supplemental rebate agreement with drug manufacturers, allowing MassHealth the ability to provide medications at the lowest possible costs. The items are listed alphabetically by therapeutic class, then by the name of the drug or drug ingredients. MassHealth may still require prior authorization for clinical reasons. Drugs that require additional prior authorization requirements are noted with PA on this list and are subject to 130CMR 406.000 and other MassHealth regulations. In general, MassHealth requires a trial of the preferred drug or clinical rationale for prescribing a non-preferred drug within a therapeutic class.
Michigan	he Michigan Medicaid prescription drug program uses various methods to encourage generic drug utilization and cost containment. These methods include a brand medically necessary edit,

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	maximum allowable cost (MAC) pricing, National Average Drug Acquisition Cost (NADAC) pricing, preferred drug list (PDL) and tiered copays for brand and generic drugs.
Minnesota	The Minnesota Department of Human Service's Pharmacy Program encourages the use of therapeutically equivalent generic drugs when appropriate. Pursuant to Minnesota Statutes, section 151.21, subdivision 3: When a pharmacist receives a written prescription on which the prescriber has not personally written in handwriting dispense as written or D.A.W., or an oral prescription in which the prescriber has not expressly indicated that the prescription is to be dispensed as communicated, and there is available in the pharmacist's stock a less expensive generically equivalent drug that, in the pharmacist's professional judgment, is safely interchangeable with the prescribed drug, then the pharmacist shall, after disclosing the substitution to the purchaser, dispense the generic drug, unless the purchaser objects. A pharmacist may also substitute pursuant to the oral instructions of the prescriber. A pharmacist may not substitute a generically equivalent drug product unless, in the pharmacist's professional judgment, the substituted drug is therapeutically equivalent and interchangeable to the prescribed drug. A pharmacist shall notify the purchaser if the pharmacist is dispensing a drug other than the brand name drug prescribed. Pursuant to Minnesota Statutes, section 256B.0625, subd. 13g (e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates dispense as written-brand necessary on the prescription as required by section 151.21, subdivision 2. Effective January 1, 2004, there was a change in the authorization of DAW Prescriptions. Authorization is required when prescribing a brand name drug if a generic equivalent is available. Prescribers must write DAW - brand medically necessary on a prescription and must obtain prior authorization meeting criteria approved by the Drug Formulary Committee authorizing payment for a brand name drug.
Mississippi	Mississippi Medicaid Generic Drug Substitution Policies Under the Mississippi Code Annotated Section 43-13-117(9)(1972, as amended), the Mississippi Division of Medicaid (DOM) mandates generic substitution of therapeutically equivalent drugs. The following is an excerpt from Section 31.11 of the Mississippi Medicaid Provider Policy Manual: Mississippi law requires that Medicaid shall not reimburse for a brand name drug if an equally effective generic equivalent is available and the generic equivalent is the least expensive. The only exceptions to this policy are: - Observed allergy to a component of the generic drug; or - An attributable adverse event; or - Drugs generally accepted as narrow therapeutic index (NTI) drugs. In the absence of a specific request for the brand name drug from the prescriber to the pharmacist, the pharmacist must follow standard practice guidelines for the State of Mississippi and fill the prescription with the generic equivalent. The prescriber must indicate the following on a written or faxed prescription: - Brand name medically necessary or - Dispense as written or

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	- Do not substitute. Prior authorization (PA) is required for any brand name multiple source drug that has a generic equivalent except NTI drugs. If a beneficiary requires a brand name multi-source drug, the prescriber must request a prior authorization by seeking approval from DOM's Pharmacy Prior Authorization (PA) unit. The following medications are identified as NTI drugs: - Coumadin - Dilantin - Lanoxin - Synthroid - Tegretol Please note that the Division of Medicaid does not have a state maximum allowable costs (MAC) program for multisource generic drugs; please refer to Westlaw system 20 So.3d 1236 (Miss. 2009). DOM does have a robust preferred drug list (PDL) with associated supplemental rebates. For some agents, the combination of Federal and supplemental rebates result in the branded agents being the least expensive to both the state and to the federal government. State law limits the adult non-institutionalized beneficiary to 5 drugs monthly of which no more than 2 may be branded - preferred brands do not count toward the two brand monthly prescription limit (effective 01/12/2012). There are some situations where a more expensive generic drug is co-preferred with the branded agent in order for beneficiary access.
Missouri	Effective for dates of service January 1, 2010 and beyond, the MO HealthNet Pharmacy Program began paying pharmacy providers a generic product preferred incentive fee. This program initiative will continue to emphasize the preference for generic utilization within the MO HealthNet pharmacy program by paying pharmacy providers an enhanced incentive fee. Effective April 1, 2017 the enhanced preferred generic product incentive fee increased from $4.00 to $5.00 for each eligible claim. Eligible generic products are identified as NDCs that have a First Data Bank Innovator Indicator of 0 and Generic Indicator of 1 (for Multi-Source Product). This enhanced preferred generic product incentive fee is paid in addition to the existing dispensing fee(s). The preferred generic product incentive fee is NOT applied to MORx coordination-of-benefit claims, but is applied to eligible generic Part D Excludable medications for dual eligible participants. All other third party coordination-of-benefit claims for eligible generic products that receive the existing dispensing fee(s), are eligible for the preferred generic product incentive fee. The preferred generic product incentive fee is applied to eligible claims for compounded generic prescriptions. The preferred generic incentive payment is structured to reimburse In-State pharmacies only. MO HealthNet does pay for a small number of brand name products which are listed as preferred under our preferred drug list edits. In these cases the net cost of the brand product, secondary to supplemental rebate is cheaper than the generic.
Montana	The Montana Medicaid Program prefers the use of generics except when the brand multisource drug is preferred and offers a better net cost over the generic. Pharmacy system edits drive the proper utilization of preferred brands and generics. Brand name drugs may be overridden when the prescriber personally writes that the brand medication is medically necessary on the face of the prescription and the pharmacy obtains a prior authorization.
Nebraska	GENERIC DRUG SUBSTITUTION POLICIES

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	Nebraska MEDICAID Generic Drug Substitution Policies -FFY 2019 The Nebraska Medicaid prescription drug program uses various methods to encourage generic drug utilization and cost containment. These methods include: Brand medically necessary edit: This edit requires that physicians indicate that a multi-source brand drug is required for their patient. Claims for multi-source brand drugs will be paid at the MAC price if available unless the prescriber requests a prior authorization (PA) for the priced as brand multi-source product. Based on the Nebraska Medicaid definition of their brand versus generic pricing, the average rate of generic utilization is 91% for FFY 2019. Maximum Allowable Cost (MAC): Nebraska Medicaid establishes and manages their MAC reimbursement levels. MAC reimbursement levels are generally applied to multi-source brand and generic products. However, MAC reimbursement may also be applied to single source drugs or drug classifications where appropriate (e.g. antihemophilic factors). Preferred Drug List (PDL): The PDL drives market shift to the generic drugs when the pricing is less than the brand pricing net of CMS and supplemental rebates. The patents of the original brand drugs in many of the therapeutic classes have expired. These older drugs have been replaced with several generic versions that are now priced at MAC. Tiered copays for brand/generic drugs: Nebraska Medicaid requires $2 for generic and $3 for brand prescriptions for Medicaid beneficiaries age 18 years and older (who have a pharmacy benefit and who are not LTC residents). Medicaid Maximum Amount Recipient Co-pay $10.00 or less $0.50 $10.01 to $25.00 $1.00 $25.01 to $50.00 $2.00 $50.01 or more $3.00 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. These sourcing status indicators are identified as follows: Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market. Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market. Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity. Utilizing these indicators to determine generic utilization will allow for consistent reporting across all states. Based on calculations using these indicators, Nebraska Medicaid has a generic utilization of 91% for all outpatient claims comprising 21% of total drug expenditures for FFY 2019.
Nevada	NRS 639.2583 requires that if a practitioner has prescribed a drug by brand name and the practitioner has not indicated that a substitution is prohibited, the pharmacist who fills or refills the prescription shall dispense, in substitution, another drug which is available to him or her if the other drug is a) less expensive than the drug prescribed by brand name; b) is biologically equivalent to the drug prescribed by brand name; c) has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the drug prescribed by brand

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	name; and d) is of the same generic type as the drug prescribed by brand name. If the pharmacist has available to him or her more than one drug that may be substituted for the drug prescribed by brand name, the pharmacist shall dispense, in substitution, the least expensive of the drugs that are available to him or her for substitution. Before a pharmacist dispenses a drug in substitution for a drug prescribed by brand name, the pharmacist shall: a) advise the person who presents the prescription that the pharmacist intends to dispense a drug in substitution; and b) advise the person that he or she may refuse to accept the drug that the pharmacist intends to dispense in substitution, unless the pharmacist is being paid for the drug by a governmental agency. If a person refuses to accept the drug that the pharmacist intends to dispense in substitution, the pharmacist shall dispense the drug prescribed by brand name, unless the pharmacist is being paid for the drug by a governmental agency, in which case the pharmacist shall dispense the drug in substitution.
New Hampshire	New Hampshire law requires pharmacists to substitute a FDA A rated generic equivalent (AA, AN, AO, AP, AT or AB) listed in the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) for a multi source legend medication product. New Hampshire Medicaid policy requires a Prior Authorization for all multi source legend medications unless: A. Patient must have experienced a therapeutic failure (inadequate response) to the A rated generic or the patient must have experienced an adverse reaction to the A rated generic. OR B. In the prescriber's opinion, transition to another generic in the same therapeutic category would represent an unacceptable risk to the patient. OR C. Allergy to one of the components of the generic (i.e. dye). If multiple generics available, must try another generic, AND D. In accordance with FDA regulations, the prescriber must submit a MedWatch form to the FDA to verify a documented failure and/or adverse reaction on an A-B rated generic product To further encourage generic utilization, New Hampshire Medicaid continues to enhance the maximum allowable cost (MAC) program. New Hampshire Medicaid participates in the National Medicaid Pooling Initiative (NMPI), a multi state purchasing pool that allow states to aggregate their eligible lives thereby leveraging pharmaceutical purchasing power as a group to achieve more supplemental rebates than could be achieved on their own. By being part of this initiative, it lowers the net cost of brand drugs and the overall pharmacy spend through a competitive bidding process.
New Jersey	The New Jersey Division of Medical Assistance and Health Services (DMAHS) implemented a Mandatory Generic Substitution Program on July 8, 2003. New Jersey FamilyCare/Medicaid fee-for-service payments for brand-name multi-source drugs require prior authorization, with exceptions for: - brand name drugs determined less costly than multi-source drugs; - the dispensing of a ten (10) days supply of the brand-name multi-source drug without prior authorization to allow the practitioner the opportunity to request prior authorization; and - Narrow Therapeutic Index (NTI) drugs, including: behavioral health meds, AIDS/HIV Drugs, anticonvulsants, digoxin, warfarin, cyclosporine, levothyroxine, theophylline and lithium carbonate. On October 21, 2011, the New Jersey Drug Utilization Review Board reviewed and approved an updated State's Mandatory Generic Substitution Exempt List from 2003. Changes were as follows:

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	+ The atypical antipsychotics would now be referred to as Behavioral Health Drugs + Hormone replacement therapy drugs will no longer be exempt + Transplant or anti-rejection drugs will be exempt The Board also discussed the current national drug shortage and the impact of this on the ever present debate about generic versus brand name drug substitution.
New Mexico	New Mexico Medicaid works to ensure that whenever possible therapeutically equivalent generic drugs are used in place of more expensive brand name alternatives. Covered drugs are subject to generic-first coverage provisions. The recipient must first use one or more generic items available to treat a condition before the Medical Assistance Division (MAD) covers a brand name drug for the condition. MAD publishes a list of the therapeutic categories of drug items that are exempt from the generic-first coverage provisions. Brand name drug items may be covered upon approval by MAD or its designee, based upon medical justification by the prescriber. Generic-first provisions do not apply to injectable drug items. The generic-first provision does not apply to Indian Health Service (IHS) facilities and PL 93-638 operated hospitals and clinics. The following categories of drug items are exempt from the generic-first requirements: Anti-asthmatic and other respiratory drugs; Anticoagulants, Anticonvulsants, Antipsychotics and antidepressants, Cancer chemotherapy items, and, Thyroid hormones, Oral birth control pills. Some categories of drugs, brand names will not be covered. The following categories of drug items, only generic items will be covered: Acne medications, Cough and cold medication.
New York	New York Generic Substitution Policies Medicaid generic substitution policy is aligned with Article 137 of New York State Education Law, which states that a pharmacist must substitute a less expensive drug product containing the same active ingredients, dosage form and strength as the drug product prescribed, ordered or demanded. provided that the following conditions are met: The prescription meets the requirements of subdivision six of section sixty-eight hundred ten of this article and the prescriber does not prohibit substitution, or in the case of oral prescriptions, the prescriber must expressly state whether substitution is to be permitted or prohibited. Any oral prescription that does not include such an express statement shall not be filled; and The substituted drug product is contained in the list of drug products established pursuant to paragraph (o) of subdivision one of section two hundred six of the public health law; and The pharmacist shall indicate on the label affixed to the immediate container in which the drug is sold or dispensed, the name and strength of the drug product and its manufacturer unless the prescriber specifically states otherwise. The pharmacist shall record on the prescription form the brand name or the name of the manufacturer of the drug product dispensed. Effective March 27, 2016, practitioners were mandated to electronically prescribe both controlled and non-controlled substances. Education Law 6810 allows the prescriber to electronically sign and insert an electronic direction to dispense the drug as written. New York State Medicaid administers a Dispense Brand when Less Expensive than Generic cost containment initiative which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent. Except for drugs subject to the Dispense Brand when Less Expensive than Generic program, State law excludes Medicaid coverage of brand name drugs when the Federal Food and Drug Administration (FDA) has approved a generic product, unless a prior authorization is received. Prescriptions for brand-

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	name drugs, where an A-rated generic equivalent is available, require that the prescriber obtain prior authorization for the brand name drug.
North Carolina	Generic Substitution Policies NC Division of Medical Assistance Medicaid and Health Choice Outpatient Pharmacy Clinical Coverage Policy No: 9 Revised Date: January 13, 2020 The General Assembly authorizes and mandates pharmacists participating in Medicaid to substitute generic drugs for brand or trade name drugs unless the prescriber specifically orders the brand name drug. A prescription for a drug designated by a brand or trade name for which one or more equivalent drugs are available is considered an order for the drug by its generic name, except when the prescriber personally indicates in his or her own handwriting on the prescription order "medically necessary." Current Session Law states: "Dispensing of generic drugs. - Notwithstanding G.S. 90-85.27 through G.S. 90- 85.31, or any other law to the contrary, under the Medical Assistance Program (Title XIX of the Social Security Act), and except as otherwise provided in this subsection for drugs listed in the narrow therapeutic index, a prescription order for a drug designated by a trade or brand name shall be considered to be an order for the drug by its established or generic name, except when the prescriber has determined, at the time the drug is prescribed, that the brand-name drug is medically necessary and has written on the prescription order the phrase "medically necessary." An initial prescription order for a Medicaid or NCHC beneficiary that is for a drug listed in the narrow therapeutic drug index that does not contain the phrase "medically necessary" shall be considered an order for the drug by its established or generic name, except that a pharmacy shall not substitute a generic or established name prescription drug for subsequent brand or trade name prescription orders of the same prescription drug without explicit oral or written approval of the prescriber given at the time the order is filled. Generic drugs shall be dispensed at a lower cost to the Medical Assistance Program rather than trade or brand-name drugs. Notwithstanding this subdivision to the contrary, the Secretary of Health and Human Services may prevent substitution of a generic equivalent drug, including a generic equivalent that is on the state maximum allowable cost list, when the net cost to the State of the brand-name drug, after consideration of all rebates, is less than the cost of the generic equivalent. As used in this subsection, "brand name" means the proprietary name the manufacturer places upon a drug product or on its container, label, or wrapping at the time of packaging; and "established name" has the same meaning as in section 502(e)(3) of the Federal Food, Drug, and Cosmetic Act, as amended, 21 U.S.C. 352(e)(3). The selection of a drug product must not be more expensive than the brand or trade name originally written by the prescriber. The pharmacist shall fill the prescription with the least expensive generic in the pharmacy, unless a specific brand or trade name is specified by the prescriber in the required manner or the net cost to the State of the brand-name drug has been determined to be less than the cost of the generic equivalent. NC Medicaid may use a certification form and procedures for "medically necessary" brand-name drugs. For audit purposes, the brand name and manufacturer must be documented on the prescription. The following list of NTI drugs is reviewed on an annual basis and submitted to the Office of Administrative Hearings by the N.C. Board of Pharmacy for publication in the N.C. Register. (As published in the N.C. Register, Volume 23, Issue 17, March 2, 2009)

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	Carbamazepine: all oral dosage forms Cyclosporine: all oral dosage forms Digoxin: all oral dosage forms Ethosuximide Levothyroxine sodium tablets Lithium: all oral dosage forms Phenytoin: all oral dosage forms Procainamide Tacrolimus: all oral dosage forms Theophylline: all oral dosage forms Warfarin sodium tablets 5.2 N.C. Medicaid and N.C. Health Choice PDL The N.C. General Assembly [Session Law 2009-451, Sections 10.66(a)-(d)] authorized the establishment of the N.C. Medicaid Preferred Drug List (PDL), which allows the Division of Medical Assistance to obtain better prices for covered outpatient drugs through supplemental rebates. All therapeutic drug classes for which the drug manufacturer provides a supplemental rebate under the Medicaid program are considered for inclusion on the list. B. Directions for Drug Reimbursement Reimbursement is determined using the cost per unit times the quantity dispensed plus the dispensing fee. Reimbursement is limited to the applicable price in effect on the date of service, not on the date of payment. B.1 Vaccines Vaccines must be billed using a professional claim with the appropriate CPT codes. Pharmacies shall use their NPI and proper taxonomy to bill vaccines. B.2 Dispensing Fee The dispensing fee for generic drugs or brand name drugs is added to the cost of the drug to equal the maximum allowed "Billed Amount" for each claim. The dispensing fee for generic drugs is based on a pharmacy's quarterly generic dispensing rate. Applicable dispensing fees are available in the State Plan, Attachment 4.19-B, Section 12, Page 1a, on NC Medicaid's website at https://medicaid.ncdhhs.gov/. The dispensing fee is automatically deducted from each repeated drug within the same calendar month. B.3 Definition of Repeat or Refill Drugs in the Same Month of Service The pharmacy program mandates that a dispensing fee, or professional fee, cannot be paid for repeats or refills of the same drug twice within the same calendar month; nor shall two prescriptions for the same drug be billed on the same day. The following defines what constitutes the same or different drug in the same month of service: a. A drug in which the active portion is different and is not generically equivalent to any other drug dispensed to the same beneficiary in the same calendar month shall be considered a different drug. Such as: Tetracycline, pilocarpine, and meprobamate are three different drugs. b. A different dosage form (liquid, tablet, suppository, injection, etc.) of the same drug constitutes a different drug. Such as: Phenergan tablets and suppositories are two different drugs. c. A different strength of the same drug constitutes a different drug. Such as: Mellaril 10 mg and 50 mg are two different drugs.

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	d. A different chemical form of the same basic drug does not constitute a different drug if the dosage form and strength is the same. Such as: Tetracycline hydrochloride and tetracycline metaphosphate buffered are the same drug. e. A generic equivalent by different trade name does not constitute a different drug. Such as: Tetracycline by Geneva, tetracycline by Rugby, and Achromycin are all the same drug. B.4 Cost of Drug Cost data is currently being obtained from First Data Bank. The cost of the drug is calculated from the North Carolina Average Acquisition Cost (AAC); North Carolina shall base brand and generic drug ingredient pricing on an average acquisition cost (AAC). The AAC is defined as the price paid by pharmacies based on an average of actual acquisition costs determined by a survey of retail pharmacy providers. The National Average Drug Acquisition Cost (NADAC) pricing must be used for AAC when available and the lessor of NADAC or Usual and Customary & Reasonable Charges (UCR) determines the cost of the drug. If NADAC is unavailable, then the AAC is defined as Wholesale Acquisition Cost (WAC). If WAC is used then the lessor of WAC; the state MAC price; the hemophilia enhanced specialty discount, if applicable; or the UCR determines the cost of the drug. WACs are updated weekly via File Transfer Protocol (FTP) from First Data Bank. State MACs are updated monthly. 340B Provision as It Pertains to the Cost for the Drug 340B providers must submit the actual purchased drug price in the usual and customary charge field. Providers who maintain two separate inventories- one for the 340B beneficiaries and a purchased inventory for non-340B beneficiaries- may not dispense a 340B-purchased drug and bill Medicaid or NCHC the calculated Medicaid price for non-340B beneficiaries. B.5 State Maximum Allowable Cost List The state MAC list contains products with A-rated equivalents and, in the great majority of cases, products marketed by at least two labelers. The State's MAC reimbursement is based on the application of a percentage factor applied to the lowest priced generic. In cases where the calculated MAC rate, based on the primary percentage factor, results in a price less than the cost of the second lowest generic product, at least an additional 10 percent margin is added to the cost of the second-lowest drug to establish the MAC price. The MAC pricing factor is set by NC Medicaid and may change as deemed appropriate. The additional margin is variable due to the wide range of differences in cost from product to product. The SMAC list is posted on the NC Medicaid website, https://medicaid.ncdhhs.gov/. For established generic drugs with only one supplier, the MAC price is established between the actual acquisition cost and average wholesale price of the generic drug. A minimum reimbursement of 20 percent above actual acquisition is guaranteed for these drugs. In most cases, MAC pricing is substantially higher than this 20 percent, which allows the state and pharmacies to share in the cost savings of using the generic product. Drugs subjected to MAC pricing must be in adequate supply. Drug shortage information is verified through national pharmacy websites as well as through information provided by national drug wholesalers. Due to the many variations in the ingredients in prenatal vitamins and the corresponding variation in the ingredient cost, a single MAC rate for prenatal vitamins is established and maintained. Current marketplace acquisition cost, average wholesale price and wholesale acquisition cost are evaluated to determine the single MAC rate.
North Dakota	North Dakota Medicaid mandates generic substitution of therapeutically equivalent drugs when there is federal upper limit (FUL) or state maximum allowable cost (MAC) pricing on the drug. If

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	the doctor insists that brand name be dispensed, he/she must write "Brand Necessary" on the face of the prescription in his/her own handwriting. Starting April 13, 2005, ND Medicaid requires Prior Authorization for "Brand Necessary" prescriptions and will only pay for the brand when a trial and failure of a generic has occurred. The North Dakota Medicaid program also encourages the use of generics in the educational monographs issued to the prescribing and dispensing providers. North Dakota Medicaid also requires brand name products in some situations where the costs net of rebate justify such preference. North Dakota Medicaid has room to do this as our MAC program gives us room on the 'in the aggregate' calculation for compliance with FUL requirements. Some of the brands that are preferred can be higher volume products which can impact generic percentage calculations by a fair amount and increase the total reimbursement amount significantly. The specific products can vary, but some examples include Adderall XR and Concerta, both high volume, high dollar ADHD medications.
Ohio	Copays-Generic drugs have a $0 copay, brand drugs have a $2 copay, and any drug requiring a prior authorization has a $3 copay. Drug shortages- If there is a drug shortage of a generic drug and that medication is unavailable, Ohio Medicaid may temporarily cover the brand name medication until the generic is available again. CMS rebates-Depending on the rebate received, a brand name drug may be less expensive for the state than a generic drug. Sometimes these brand name drugs are preferred and will prevent a generic drug from being dispensed.
Oklahoma	OHCA requires the use of generic drugs when available. Dispensing a branded medication that is available generically requires a brand override prior authorization. Approval of a brand override request requires a documented clinically significant reason to dispense the branded product. Exceptions are made to this rule for select drugs with a narrow therapeutic index or those branded agents that are preferred over the generic due to net cost. Adult members who do not reside in long-term care facilities are limited to two brand medications per month with limited exceptions. Generic medications typically occupy the first tier in Product Based Prior Authorization categories and are commonly available without prior authorization.
Oregon	410-121-0030 Practitioner-Managed Prescription Drug Plan (5) Pharmacy providers shall dispense prescriptions in the generic form unless: (a) The practitioner requests otherwise pursuant to OAR 410-121-0155; (b) The Division notifies the pharmacy that the cost of the brand name particular drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug. 410-121-0040 Prior Authorization Required for Drugs and Products (6) PA shall be obtained for brand name drugs that have two or more generically equivalent products available and that are not determined Narrow Therapeutic Index drugs by the DUR/P&T Committee:

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	(a) Immunosuppressant drugs used in connection with an organ transplant shall be evaluated for narrow therapeutic index within 180 days after United States patent expiration; (b) Manufacturers of immunosuppressant drugs used in connection with an organ transplant shall notify the Authority of patent expiration within 30 days of patent expiration for section (5)(a) to apply; (c) Criteria for approval are: (A) If criteria established in section (3) or (4) of this rule applies, follow that criteria; (B) If section (6)(A) does not apply, the prescribing practitioner shall document that the use of the generically equivalent drug is medically contraindicated and provide evidence that either the drug has been used and has failed or that its use is contraindicated based on evidence-based peer reviewed literature that is appropriate to the client's medical condition.
Pennsylvania	PENNSYLVANIA MEDICAL ASSISTANCE BULLETIN 01-94-17: PHARMACEUTICAL SERVICES PRIOR AUTHORIZATION REQUIREMENT MULTISOURCE BRAND NAME DRUGS PURPOSE: The purpose of this bulletin is to inform pharmacies and licensed prescribers enrolled in the Medical Assistance (MA) Program that effective July 18, 1994, the Department will require prior authorization on all multisource brand name drugs identified by the Department as having equivalent generic drug products available for substitution. SCOPE: This bulletin applies to pharmacies and licensed prescribers enrolled in the Medical Assistance Program. BACKGROUND: In January 1993, the Department adopted certain modifications to the scope of medical benefits available to persons who are eligible for Medical Assistance. Those modifications were challenged by Medical Assistance eligible clients as being in violation of their rights under federal and state law. The name of this class action litigation was Felix, et al. v Casey, et al., C.A. No. 92-CV-7376 (E.D., Pa.). Under the terms of a Stipulation of Settlement that was negotiated to resolve this litigation, the Department agreed to rescind certain modifications and the plaintiffs agreed to accept certain modifications and agreed as well to the Department's requiring all Medical Assistance recipients to obtain prior authorization with respect to all brand name drugs for which there are generic equivalents but limited to drugs listed in the FDA approved "A" list and also not precluded by state law. The Department will also require prior authorization to override the drug cost limit for any drug subject to a State MAC. The Department currently uses the full average wholesale price (AWP) to compute the maximum payment amount for all multisource brand name products prescribed for eligible medical assistance recipients unless the drug cost is limited by the State Maximum Allowable Cost (MAC). The Department also uses the full AWP for a brand name multisource drug subject to State MAC when the phrase "Brand Necessary" or "Brand Medically Necessary" appears on the prescription in the prescriber's own handwriting and the pharmacist indicates on the claim form or with the electronic transmission that the prescriber specified the brand name drug is medically necessary.

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	DISCUSSION: The Department will require prior authorization on those multisource brand name drugs that have "A" rated generics available for substitution as a condition for payment through the Medical Assistance Program. The Department will also require prior authorization as the override mechanism to pay the brand name rate for any State MAC drug. The prior authorization requirement will become effective beginning with claims submitted on or after a date of service of July 18, 1994. The Department will issue a periodic list of those brand name drugs which require prior authorization to all pharmacies and licensed prescribers enrolled in the Medical Assistance Program. All brand name drugs on the Medical Assistance Program's list will be treated as noncovered services. Therefore, the Department will not provide any payment for a multisource legend brand name product which can be filled with an "A" rated generic unless the prescriber receives approval from the Medical Assistance Program to do so. The Department will provide payment for those nonlegend multisource products having a State MAC up to the amount of the State MAC price. The full AWP will apply if prior authorization is requested by the prescriber and approved by the Department. Furthermore, if the prescriber does not receive approval for the brand name product but the recipient prefers the brand name product or the prescriber still does not permit substitution, the recipient will have to purchase the product at his or her own expense. The Department will issue Prior Authorization if the prescriber is able to provide documentation to the Department that the individual patient is in danger of an adverse reaction from the use of the generic equivalent drug and that use of the prescribed brand name drug would eliminate the danger of the adverse reaction. The prescriber will be required to maintain this documentation in the individual patient's medical file and be able to provide it to the Department in writing upon request. POLICY Effective July 18, 1994, the Department will apply 55 Pa. Code Chapter 1121 as follows: Section 1121.52 Payment conditions for various services. (a) Medical Assistance prescriptions, including those for recipients in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded, which have been either written or verbally ordered by a licensed prescriber, shall contain on the prescription form: * * * * * 6. The indication for "brand medically necessary" and the prior authorization number, when applicable, as specified in Section 1121.53(b) (relating to limitations on payment). * * * * *

State	Generic Drug Substitution Policies
	(b) The following services requires prior authorization as specified in Section 1101.67 (relating to prior authorization): (1) Multisource brand name products identified by the Department as having therapeutically equivalent "A" rated generic products available for substitution. (2) Multisource brand name products that are subject to a State MAC. * * * * * Section 1121.53 Limitations on payment. * * * * * (b) The Department establishes a maximum allowable cost (MAC) Program which sets a limit on the drug cost portion of the reimbursement formula on selected multisource drugs. The Department will send periodic notices to pharmacies listing the drug entities subject to the State MAC. The State MAC does not apply if either of the following exists: (1) The licensed prescriber does all of the following: (i) Certifies a specified brand is medically necessary by writing on the prescription for "Brand Necessary" or "Brand Medically Necessary" in the prescriber's own handwriting. (ii) Receives a prior authorization from the Department to use the brand name product and indicates the prior authorization number on the prescription form. (2) In the case of a telephone prescription, the licensed prescriber sends a properly completed prescription, as described in paragraph (1), to the pharmacy within 15 days of the date of service. * * * * * Section 1121.54. Noncompensable services and items. Payment will not be made to a pharmacy for the following services and items: * * * * * (26) Multisource legend brand name products, identified by the Department as having therapeutically equivalent "A" rated generic products available for substitution, except when the licensed prescriber receives prior authorization from the Department certifying that the particular brand name product is medically necessary for a specific recipient and indicates the prior authorization number on the prescription form. The Department will issue a periodic list of those brand name products which will require prior authorization. * * * * *

State	Generic Drug Substitution Policies
	PROCEDURE 1. The Department issued Medical Assistance Bulletins 01-94-15, 03-94-03, and 04-94-04 to prescribers listing the multisource brand name drugs which will require prior authorization and instructions for requesting prior authorization for these drugs. 2. The Department issued Medical Assistance Bulletin 19-94-10 to pharmacies listing the multisource brand name drugs which will require prior authorization and instructions for submitting claims for payment of these drugs.
Rhode Island	The following impact the generic utilization percentage for the State of Rhode Island. A pharmacist may substitute drugs containing all the same active chemical ingredients of the same strength, quantity, and dosage form as the drug requested by the prescriber. The director shall permit substitution of less expensive generic, chemical, or brand name drugs and pharmaceuticals considered by the director as therapeutically equivalent and interchangeable with specific brand name drugs and pharmaceuticals. 21-31-16.1 Substitution of generic drugs. (a) Product selection. The director shall permit substitution of less expensive generic, chemical, or brand name drugs and pharmaceuticals considered by the director as therapeutically equivalent and interchangeable with specific brand name drugs and pharmaceuticals, if they are found to be in compliance with 21-31-16 and standards set forth by the United States Food and Drug Administration under 505 and 507 of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355 and 357. The director shall consider, but not be limited to, the determination of the United States Food and Drug Administration, or its successor agency, as published under 505 and 507 of the Federal Food, Drug, and Cosmetic Act. The director shall provide for the distribution of copies of lists of prescription drug products that the director deems after evaluation not to be therapeutically equivalent, and revisions to the lists, among physicians and pharmacists licensed and actively engaged in practice within the state, and other appropriate individuals, and shall supply a copy to any person on request. The list shall be revised from time to time so as to include new pertinent information on approved prescription drug products, reflecting current information as to standards for quality, safety, effectiveness, and therapeutic equivalence. Rhode Island implemented a Preferred Drug List (PDL) which encourages the use of generic medications by requiring a prior authorization for most brand name drug products in the therapeutic classes that are managed by the PDL. Rhode Island implemented a State Maximum Allowable Cost (SMAC) list for generic drugs and brands that have a generic equivalent when there are three or more manufacturers of the product.
South Carolina	Medicaid does not routinely cover brand name products for which there are therapeutically equivalent, less costly generics available except for the following brand name products (traditionally categorized as Narrow Therapeutic Index [NTI] drugs): digoxin, warfarin, theophylline (controlled release), levothyroxine, pancrelipase, phenytoin and carbamazepine. In addition, continuity of care (beneficiary moves from MCO to FFS) where established on a Brand/clinical rationale.
South Dakota	Generic drugs required. Brand necessary prescriptions require prior authorization.

State	Generic Drug Substitution Policies
Tennessee	TennCare's primary tool to drive generic utilization is a benefit design that limits adult recipients to two brand prescription fills per month. Under this benefit design, recipients are charged a $1.50 copayment for generic prescriptions and $3.00 for brand prescriptions. Generic utilization is also attributable to drug status on the TennCare Preferred Drug List. TennCare places most multi-source brand products in the non-preferred status. Furthermore, TennCare's point of sale system is configured to not accept Dispense as Written (DAW) -1 or -2 claims. When a multi-source brand is clinically necessary, the prescriber must submit a prior authorization request. In addition to the TennCare initiatives, the State of Tennessee has mandatory generic substitution legislation in place that complements TennCare's requirements. Tennessee law requires pharmacists to substitute and dispense US Food and Drug Administration (FDA)-approved generic equivalent when presented with a prescription for a brand name drug, unless otherwise instructed by the patient or prescribing practitioner. The prescriber may direct the pharmacist to forego the substitution regulation and dispense brand name medications. Under Tennessee regulations, the prescriber must write: Brand name medically necessary, dispense as written medically necessary brand name no generic; or, any abbreviation of this language when a generic product is available and the prescriber wishes the brand name product to be dispensed. The patient may direct the pharmacist to forego the substitution regulation and dispense brand name medications orally under the circumstance the patient is individually paying the entire cost of the prescription at the time of dispensing and objects to any substitution (Tenn. Code Ann. 53-10-205).
Texas	Texas Administrative Code Rule (TAC Rule) 355.8546 -Brand-Name Drugs (a) Physicians who want a brand name drug dispensed on a prescription for a multisource drug must handwrite the phrase "Brand necessary" on the face of the prescription. This procedure enables payment for the drug at the more expensive brand name acquisition cost. To indicate this certification (override) on the pharmacy claim form, the pharmacy provider must enter "1" in the field for "Dispense as Written." For telephone orders involving physician overrides, a written prescription must be obtained from the prescribing physician within 30 days from the time the order was placed. (b) A physician override for a prescription is valid only for the life of the prescription. The life of the prescription is defined as the original dispensing and any authorized refills, not to exceed eleven refills or a twelve-month supply. The physician override cannot be forwarded or transferred to any other prescription for the same drug. (c) A pharmacy provider that dispenses a brand drug that is subject to a generic reimbursement and bills HHSC for the service must accept Medicaid reimbursement as payment in full. No additional dispensing fee or product cost amounts may be billed to the Medicaid recipient.

State	Generic Drug Substitution Policies
	Single PDL HHSC requires the MCOs to follow the same preferred drug list (PDL) as approved by the state. The PDL medications are recommended by the Texas Drug Utilization Review Board for their clinical significance and cost effectiveness.
Utah	As a result of the Pharmacy Practice Act, Medicaid has placed all name brand products on prior approval if a generic is available, except when allowed rebates bring the cost of the brand name product lower than the generic.
Vermont	Vermont is a mandatory generic state as outlined in the Vermont statute link below: Pharmacies must dispense generics or biosimilars unless the prescriber expressly requires the brand. https://legislature.vermont.gov/statutes/section/18/091/04605 Additionally, per this statutory authority, Medicaid can restrict coverage of a new generic entity if the net pricing of its branded alternative remains lower to the State. Such coverage restrictions will remain in place until the time when generic pricing results in greater cost savings to the State versus the branded alternative. This policy negatively affects the overall generic dispensing rate but reduces net spend for the state. VT Medicaid PDL Management of Generic Drugs, PDL Categories: Preferred Drugs Whenever possible, preferred drugs in a category will be generic. Clinical criteria for branded products will generally include a step through a generic product when available (generic first). The DUR Board heavily promotes the use of generics in general and directly through identified classes in the PDL by means of automated step therapies and/or prior authorizations in the many PDL categories: https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria New generic entries: When a new generic product becomes available within a PDL-managed therapeutic category, DVHA manages the addition of such generic product to the PDL without formal evaluation by the DUR Board. Generics are placed in Preferred position once the net cost of that product is lower than the brand. Movement of such generic products to preferred status would be limited to AB-rated (bioequivalent) drug products where there exists no significant evidence of increased safety risk or diminished efficacy as compared to alternative PDL options. Maximum Allowable Cost (MAC) List DVHA employs a MAC list provided by their PBM contractor, Change HealthCare. A drug is considered for inclusion in the MAC list when a combination of the following conditions is met: The drug must be a multi-source product (available from more than one source) per the Medi-Span multi-source drug indicator (an industry standard metric that indicates that a drug is available from more than one source/manufacturer) and/or the drug has a generic equivalent. The availability and the number of A-rated generic equivalent products using the Medi-Span Orange Book Code is considered. This criterion is designed to discourage inappropriate generic substitution for brand products with low therapeutic indices. Drugs that are widely available on the market as a generic formulation from multiple manufacturers without shortages are considered eligible for inclusion. If a highly utilized generic drug is not present on the MAC list per the previously defined & systematically discovered criteria, the clinical team will manually review the characteristics of

State	Generic Drug Substitution Policies
	that drug and make a decision regarding its eligibility for inclusion on the list. Methodology is employed by the contractor to ensure that the reimbursement pharmacies receive will allow them to procure the products and achieve a reasonable return within the MAC pricing schema. In order to operate at maximum efficacy, MAC lists are updated on monthly basis. This ensures the most correct pricing at any given moment and secures provider cooperation and satisfaction. Pricing data received from Medi-Span is updated weekly, while additional acquisition pricing is updated quarterly at a minimum. Once per quarter, MAC pricing files are completely refreshed. Generic market conditions are dynamic (e.g., drug shortages causing inflation of acquisition prices for drugs) and so there are a number of processes to capture price change information and the capability to update MAC pricing within one business day. To promote generic utilization, it is important that pharmacy providers are satisfied with the DVHA MAC pricing. When a discrepancy is reported by a pharmacy provider, a formal pricing dispute process is initiated. Pharmacies file a Pricing Dispute form located on the DVHA website, and the drug/strength/dosage form, current MAC price, and detailed pricing issue is recorded. This information is forwarded to the Clinical and MAC Team who verify/validate the MAC price against current acquisition pricing through research and application of the algorithm logic. Investigation into the availability of the drug is conducted. A final disposition is made and the provider is contacted per statutory requirement with an explanation of findings.
Virginia	The Virginia Medicaid prescription drug program uses various methods to encourage generic drug utilization and cost containment. These methods include: • Brand medically necessary edit: This edit requires that physicians indicate that a multi-source brand drug is required for their patient. This edit is based on the DMAS-specific definition of brand and generic drugs. The drug ingredient cost reimbursement shall be the lowest of: (1) The national average drug acquisition cost (NADAC) of the drug, the federal upper limit (FUL), or the provider's usual and customary (U&C) charge to the public as identified by the claim charge; or (2) When no NADAC is available, DMAS shall reimburse at the lowest of the wholesale acquisition cost plus 0%, the FUL, or the provider's U&C charge to the public as identified by the claim charge. Based on the Virginia Medicaid definition of their brand versus generic pricing, the average rate of generic utilization is eighty-five percent (85%) for FFY 2019. • Preferred Drug List (PDL): The PDL drives market shift to the generic drugs when the pricing is less than the brand pricing net of CMS and supplemental rebates. The patents of the original brand drugs in many of the therapeutic classes have expired. These older drugs have been replaced with several generic versions. • Tiered copays for brand/generic drugs: Virginia Medicaid requires $1 copayment for each generic drug dispensed, and a $3 copayment for each brand name drug dispensed, in general, for Medicaid beneficiaries age 21 years and older. 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. These sourcing status indicators are identified as follows: • Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market. • Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market.

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	• Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity. Utilizing these indicators to determine generic utilization will allow for consistent reporting across all states. Based on calculations using these indicators, Virginia Medicaid has a generic utilization of 85% for all outpatient claims comprising 21% of total drug expenditures for FFY 2019.
Washington	Washington Apple Health (Medicaid) utilizes various strategies to increase and maintain generic utilization rates. The following strategies employed could affect Washington State Medicaid's generic utilization percentage: Coverage of less costly generic over-the-counter (OTC) products Washington Apple Health (Medicaid) covers many OTC products in various drug classes as less costly alternatives to prescription medications. Standard generic substitution Washington Apple Health (Medicaid) follows generic substitution rules as authorized under State law. All prescriptions of any format (written, oral, electronic, out of state) must indicate whether generic substitution is permitted or if the prescription must be Dispense as Written. Prior authorization requirements and clinical policies Under the Washington Administrative Code 182-530-3100, Washington Apple Health (Medicaid) may require prior authorization on covered outpatient drugs for medical necessity. Drugs approved by the FDA are evaluated by the agency's clinical team based on quality evidence contained in compendia of drug information and peer-reviewed medical literature. The information evaluated includes but is not limited to evidence for efficacy and safety, cost comparisons of drugs with similar existing drugs, potential for misuse and abuse, drugs with a narrow therapeutic index, and cost and outcome data demonstrating the cost effectiveness of the drug. Clinical policies are created by Washington State Medicaid staff, which may include step-through less costly generic drugs with the same indication first before another drug product may be authorized . Implementation of a single PDL and PDL selection process Drugs listed on the Apple Health Preferred Drug List (AHPDL) reflect nearly all prescriptions covered under Washington State Medicaid. The single PDL is used by Fee-for-Service and the Managed Care Organizations (MCOs) and governs those organizations to use brand and generic drugs that are preferred or non-preferred. The PDL selection process takes into account product-by-product comparisons based on quality evidence reviews, utilization trends, market price, and if applicable, supplemental rebate offers. The drugs selected for preferred status represent the drug products which are least costly to the State and typically consist of generic drugs. Non-preferred drugs selected on the AHPDL ensures the majority of utilization is always for the least costly alternative. Therapeutic Interchange Program Under the Revised Code of Washington 69.41.190 and 70.14.050, State laws allow for substitution of a therapeutically equivalent drug that is not the generic active ingredient of the prescribed drug. Certain drug products that have been reviewed by the Washington Pharmacy and Therapeutics Committee can be interchanged for a different drug that is therapeutically equivalent (e.g: substituting one ACE inhibitor for another). This allows pharmacists a broader

State	Generic Drug Substitution Policies
	range of potential substitution for products that may have not have a generic equivalent but may have a therapeutic equivalent with a different active ingredient. The therapeutic interchange programs impacts classes on both the Washington PDL and AHPDL. State Maximum Allowable costs Washington State applies state maximum allowable costs (MAC) as a pricing strategy to help ensure that only the least costly generic options available fall within established reimbursement rates. These MAC rates incentivizes pharmacies to stock those least costly generic versions for which they pay less than the reimbursement rate provided by Medicaid.
West Virginia	West Virginia State Law requires the substitution of a generic drug whenever an AB rated agent is available. West Virginia Medicaid does not pay for brand name agents unless they are on the PDL and priced as a generic drug unless the prescriber writes Brand Medically Necessary on the prescription in his own handwriting. The prescriber is also required to fill out a Med Watch if he/she states that the generic is not as effective as the brand name formulation. WV Medicaid pays a flat dispensing fee of $10.49 for both brand and generic drugs. An aggressive State Maximum Allowable Cost (SMAC) Program further encourages the use of generics agents.
Wisconsin	Wisconsin Medicaid utilizes numerous policies to encourage the use of therapeutically equivalent generic drugs: 1.The Brand Medically Necessary (BMN) policy requires providers to prescribe generic equivalents to brand products when there is a cost effective generic available. The prescriber is required to document why it is medically necessary for the member to receive the brand name drug on the PA/BMNA (Prior Authorization/Brand Medically Necessary Attachment). Criteria for approval of a PA request for a brand name drug include the following: - At least 30 consecutive days of BMN drug use and had a measurable therapeutic response. - Documentation of how the BMN drug will prevent recurrence of an unsatisfactory therapeutic response or clinically significant adverse drug reaction. - The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to the generic equivalent drug from at least two different manufacturers. 2. The Brand Before Generic (BBG) policy requires providers to prescribe brand named products over generic equivalents when the brand name product is more cost effective to Wisconsin Medicaid. Criteria for approval of a PA for a generic drug that requires BBG PA include: - At least 30 consecutive days of generic drug use and had a measurable therapeutic response. - The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to the brand equivalent drug. 3. Wisconsin Medicaid implemented three month supply program on January 20, 2010. Dispensing a three-month supply of drugs was implemented to streamline the prescription filling process for pharmacy providers, encourage the use of generic, maintenance drugs when medically appropriate for a members, and result in savings to ForwardHealth programs. The

State	Generic Drug Substitution Policies
	three month supply program includes certain drugs that are required to be dispensed in a three month supply and other drugs that may be dispensed in a three month supply. Pharmacy providers may contact a specialized call center staffed by certified pharmacy technicians to request an override for drugs required to be dispensed in a three month supply. Examples of when a request override to dispense less than a three-month supply may be approved include, but are not limited to, the following: - The member's primary insurance does not allow a three-month supply. - The prescriber or pharmacist is concerned about dispensing a three-month supply to a member.
Wyoming	On 11/1/05, the Wyoming Medicaid program mandated generic substitution by implementing a generic mandatory policy. This policy requires a prior authorization for any brand name medication for which there are two or more A-rated generic equivalents available. Clients may receive the brand name following trial and failure of a generic equivalent in the specific class of drugs, or with a documented adverse effect caused by the generic formulation. Copays are lower for generic medications at $0.65 per prescription vs. $3.65 per prescription for brand-name medications. In addition, the Wyoming Medicaid Pharmacy Program encourages the use of generics in the educational monographs issued to the prescribing and dispensing providers. Federal and State MAC lists for pricing also help to enforce generic substitution.

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

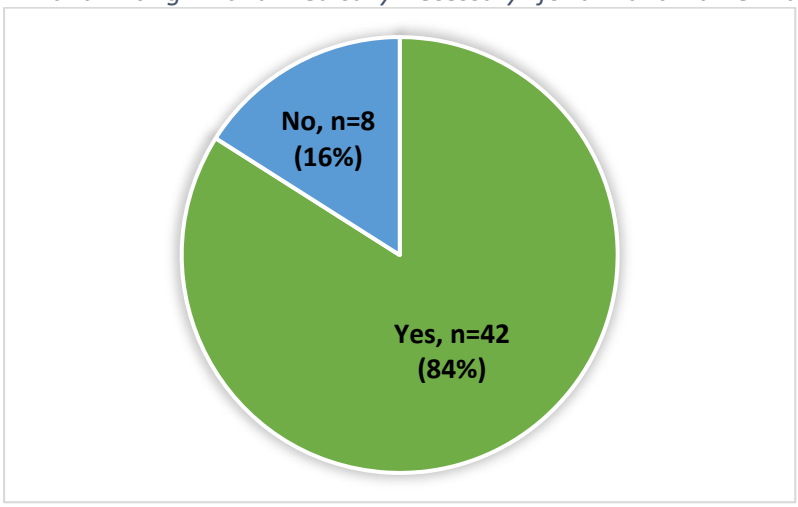

Table 65 - More Restrictive State Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, 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 Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	42	84.00%
No	Florida, Hawaii, Louisiana, New Mexico, Rhode Island, Tennessee, Texas, Virginia	8	16.00%
Total		50	100.00%

If "Yes," check all that apply

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

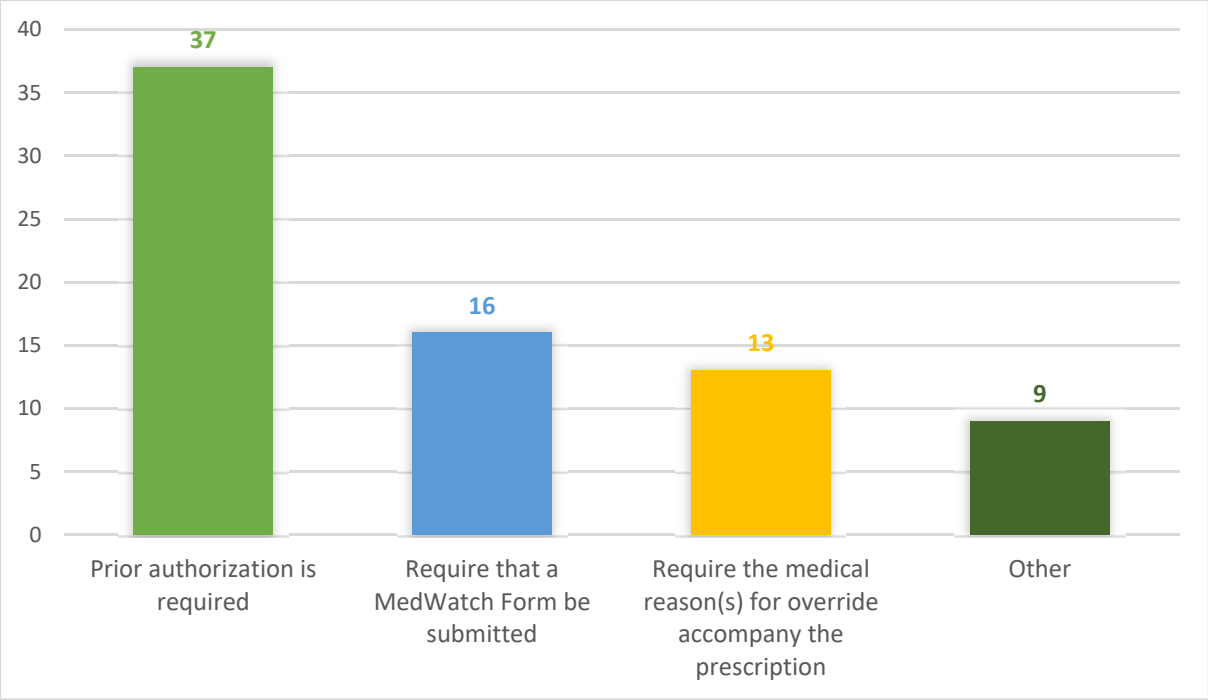

Table 66 - Additional Restrictive MCO Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

Response	States	Count	Percentage
Prior authorization is required	Alabama, Alaska, Arkansas, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	37	49.33%
Require that a MedWatch Form be submitted	Alabama, Alaska, Arkansas, Connecticut, Idaho, Indiana, Iowa, Kansas, Maine, Maryland, Mississippi, Nevada, North Dakota, South Carolina, West Virginia, Wyoming	16	21.33%
Require the medical reason(s) for override accompany the prescription	Alabama, Idaho, Kansas, Mississippi, Missouri, Montana, Nevada, North Dakota, Oklahoma, Pennsylvania, South Carolina, Washington, West Virginia	13	17.33%
Other	California, Colorado, Connecticut, Idaho, Maine, Michigan, Nebraska, North Carolina, Wisconsin	9	12.00%
Total		75	100.00%

"Other," please explain

Table 67 – "Other" Explanations for Additional Restrictive MCO Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

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	Prescriptions for multi-source innovator medications may require prior authorization with prescriber attestation that transition to the generic equivalent of the brand name drug would be unacceptably disruptive to the member's stabilized drug regimen or that the member is unable to continue treatment with the generic 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 seperate (different manufacturer) products
Maine	MaineCare does not allow DAW 1, must adhere to Preferred drug list or submit prior authorization for non-preferred medications
Michigan	Select drug classes determined by the State Legislature are exempt from prior authorization
Nebraska	Prescriber = must complete a form MC-6, which declares that the brand name medication is medically necessary.
North Carolina	Several drug classes on the Preferred Drug List have brand name drugs as non-preferred, thus requiring the try and failure of preferred drugs before using these non-preferred brands.
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

Single Source (S) – Drugs having an FDA New Drug Application (NDA), and there are no generic alternatives available on the market.
Non-Innovator Multiple-Source (N) – Drugs that have an FDA Abbreviated New Drug Application (ANDA), and generic alternatives exist on the market
Innovator Multiple-Source (I) – Drugs which have an NDA and no longer have patent exclusivity.

1. **Generic Utilization Percentage:** To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula:
   N ÷ (***S*** + ***N*** + ***I***) × 100 = Generic Utilization Percentage

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

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I, which can be found 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.

Generic Drug Utilization Data

Figure 44 – Single Source (S) Drugs Total Number of Claims by State

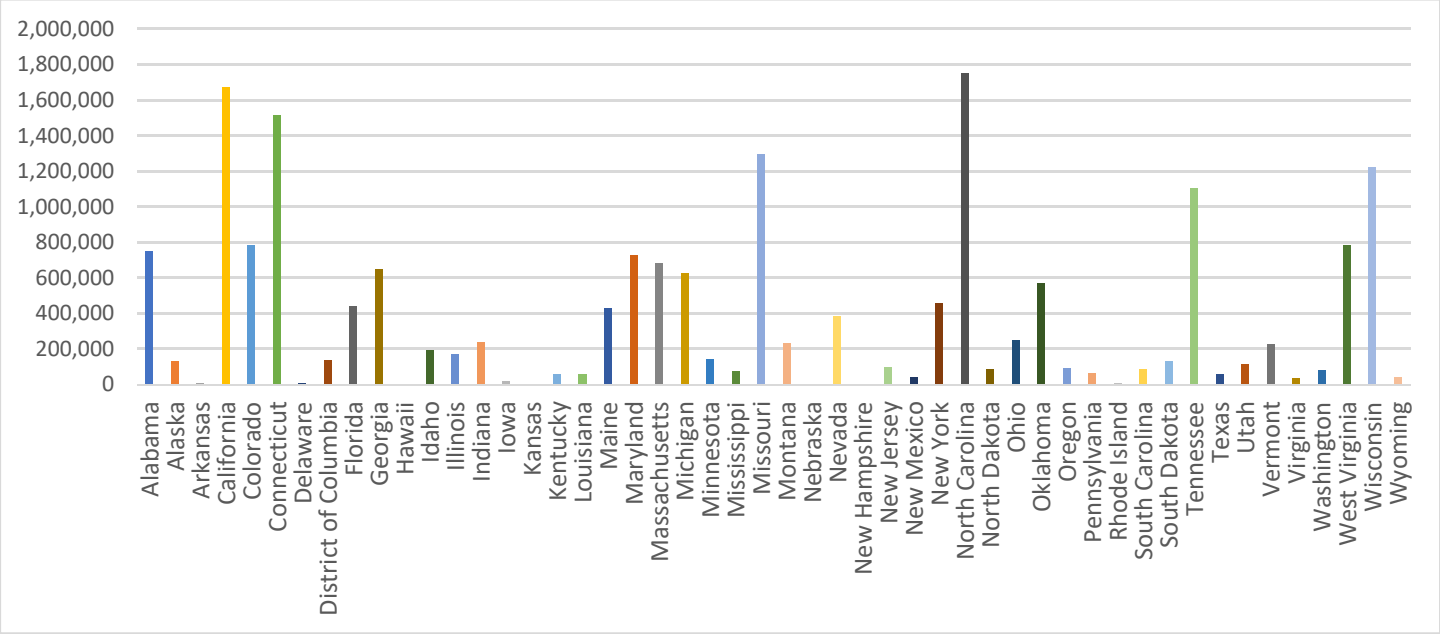

Figure 45 – Non-Innovator Source (N) Drugs Total Number of Claims by State

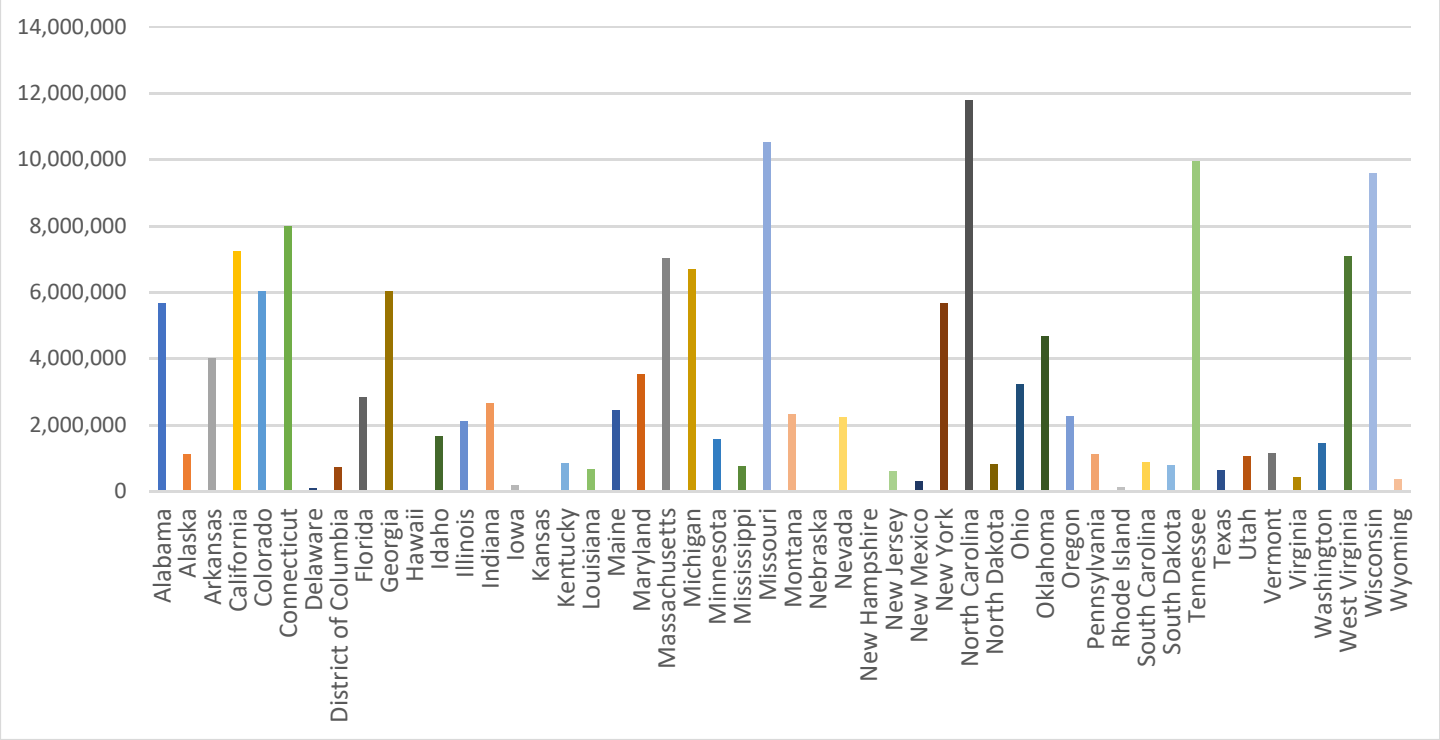

Figure 46 – Innovator Multi-Source (I) Drugs Total Number of Claims by State

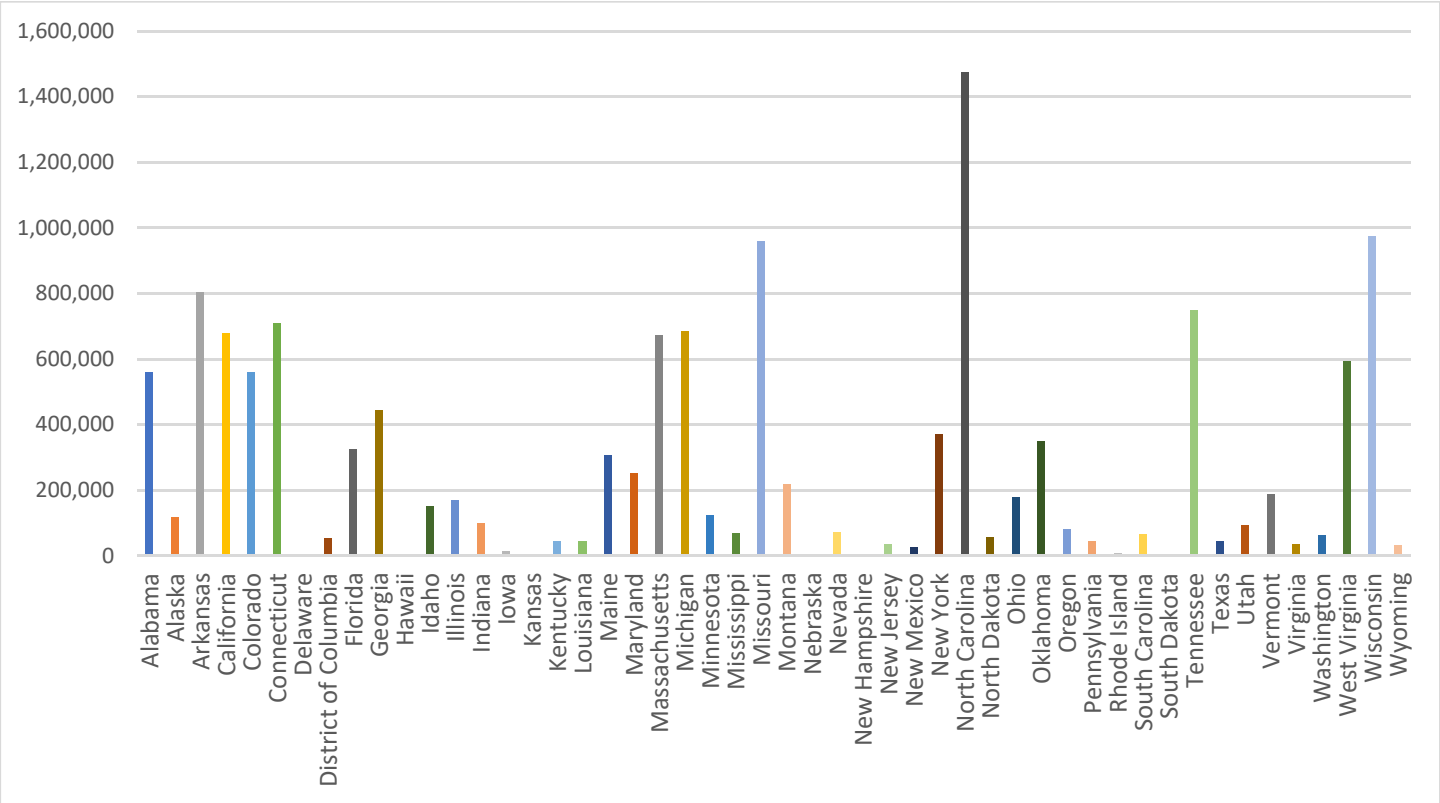

Table 68 – Drug Utilization Number of Claims by Drug Category

State	"S" Drugs	"N" Drugs	"I" Drugs
Alabama	748,444	5,682,275	558,865
Alaska	130,387	1,111,740	115,676
Arkansas	8,434	4,024,486	801,610
California	1,672,226	7,226,221	678,691
Colorado	781,639	6,028,742	557,767
Connecticut	1,515,182	8,010,844	709,639
Delaware	8,609	87,248	5,709
District of Columbia	136,369	721,674	52,995
Florida	443,764	2,853,968	323,268
Georgia	649,535	6,029,861	442,249
Hawaii	216	5,507	100
Idaho	196,210	1,669,759	150,862
Illinois	172,660	2,122,258	170,377
Indiana	240,974	2,650,922	99,605
Iowa	20,473	187,616	12,321
Kansas	1,794	35,825	1,446
Kentucky	61,573	837,501	43,297

State	"S" Drugs	"N" Drugs	"I" Drugs
Louisiana	57,315	683,834	43,605
Maine	428,727	2,460,956	307,172
Maryland	730,313	3,549,730	251,731
Massachusetts	685,236	7,035,300	672,039
Michigan	627,165	6,710,128	685,270
Minnesota	142,898	1,587,808	122,618
Mississippi	75,505	773,666	67,984
Missouri	1,298,555	10,511,458	958,155
Montana	231,853	2,336,317	217,621
Nebraska	589	8,826	285
Nevada	387,312	2,225,496	72,068
New Hampshire	3,989	34,998	4,018
New Jersey	97,301	599,085	35,937
New Mexico	41,845	320,826	24,767
New York	458,137	5,668,813	371,502
North Carolina	1,753,946	11,808,224	1,473,705
North Dakota	85,139	810,291	57,181
Ohio	248,826	3,235,325	179,514
Oklahoma	569,179	4,690,220	349,888
Oregon	93,498	2,276,959	80,011
Pennsylvania	64,164	1,109,963	45,171
Rhode Island	7,668	130,971	6,075
South Carolina	89,793	878,249	66,519
South Dakota	132,819	786,725	768
Tennessee	1,104,638	9,966,364	747,359
Texas	58,736	641,022	43,168
Utah	114,312	1,051,916	94,133
Vermont	225,539	1,142,922	186,192
Virginia	35,164	419,670	33,782
Washington	79,368	1,443,870	62,360
West Virginia	786,803	7,079,393	591,622
Wisconsin	1,224,513	9,593,832	972,401
Wyoming	39,778	377,989	30,739
Total	18,769,112	151,237,593	13,579,837

Figure 47 – Single Source (S) Drugs Total Reimbursement Amount Less Co-Pay by State

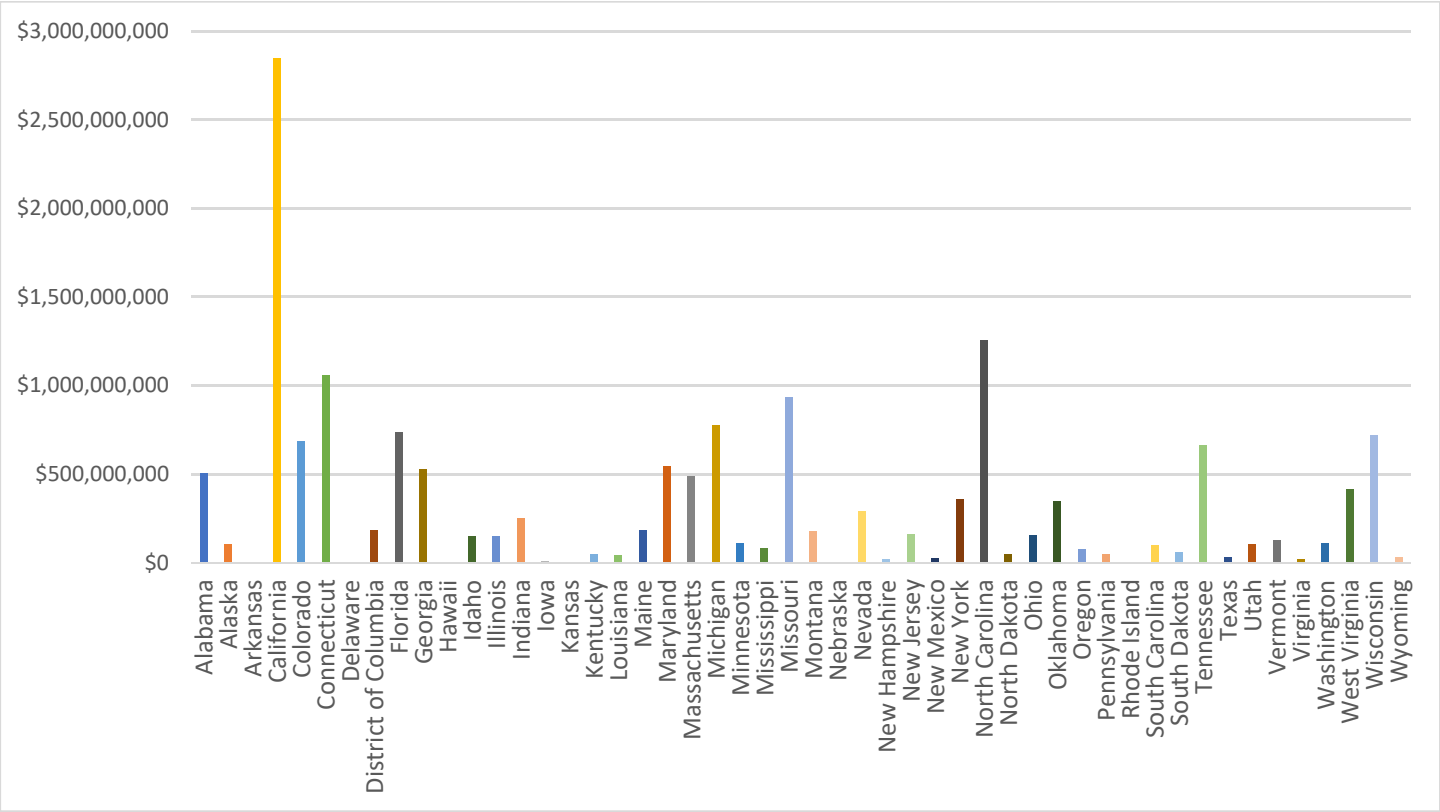

Figure 48 – Non-Innovator Source (N) Drugs Total Reimbursement Amount Less Co-Pay by State

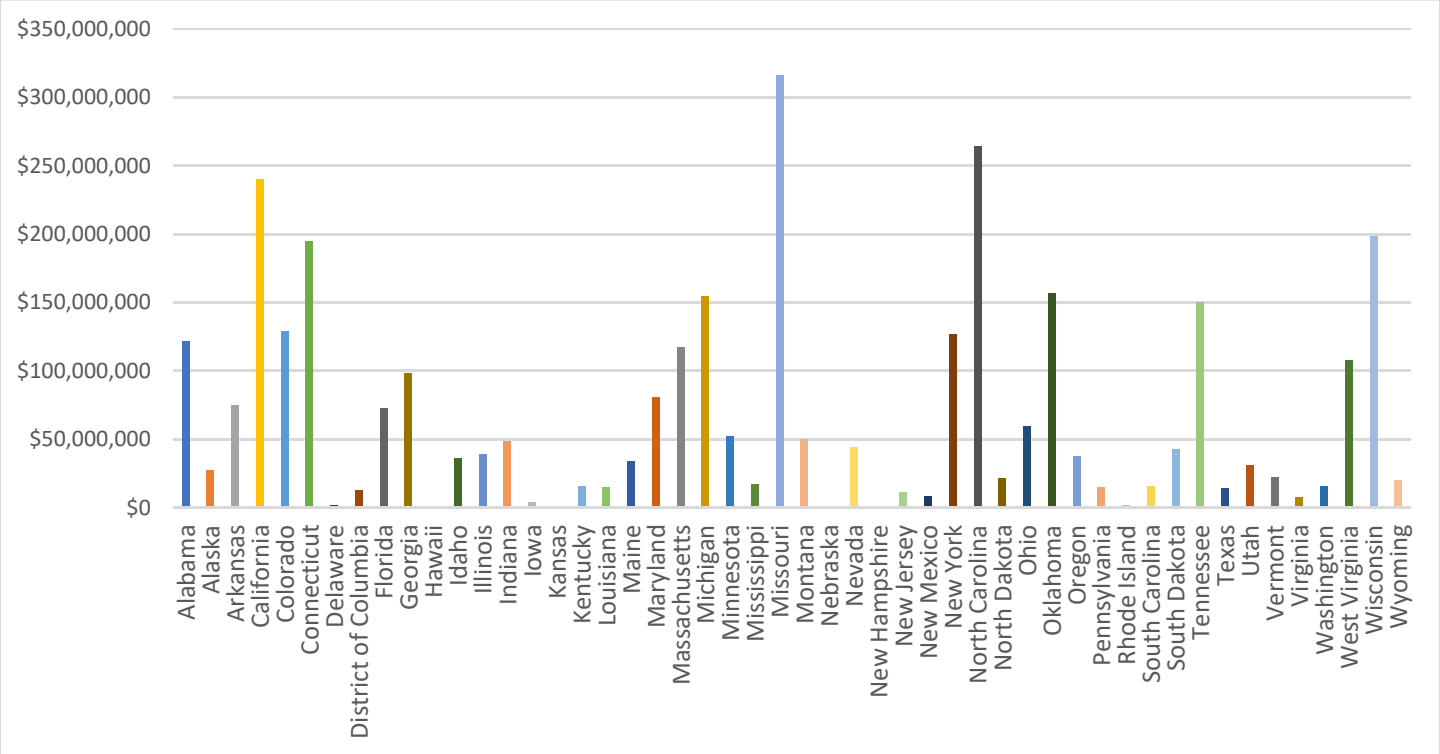

Figure 49 – Innovator Multi-Source (I) Drugs Total Reimbursement Amount Less Co-Pay by State

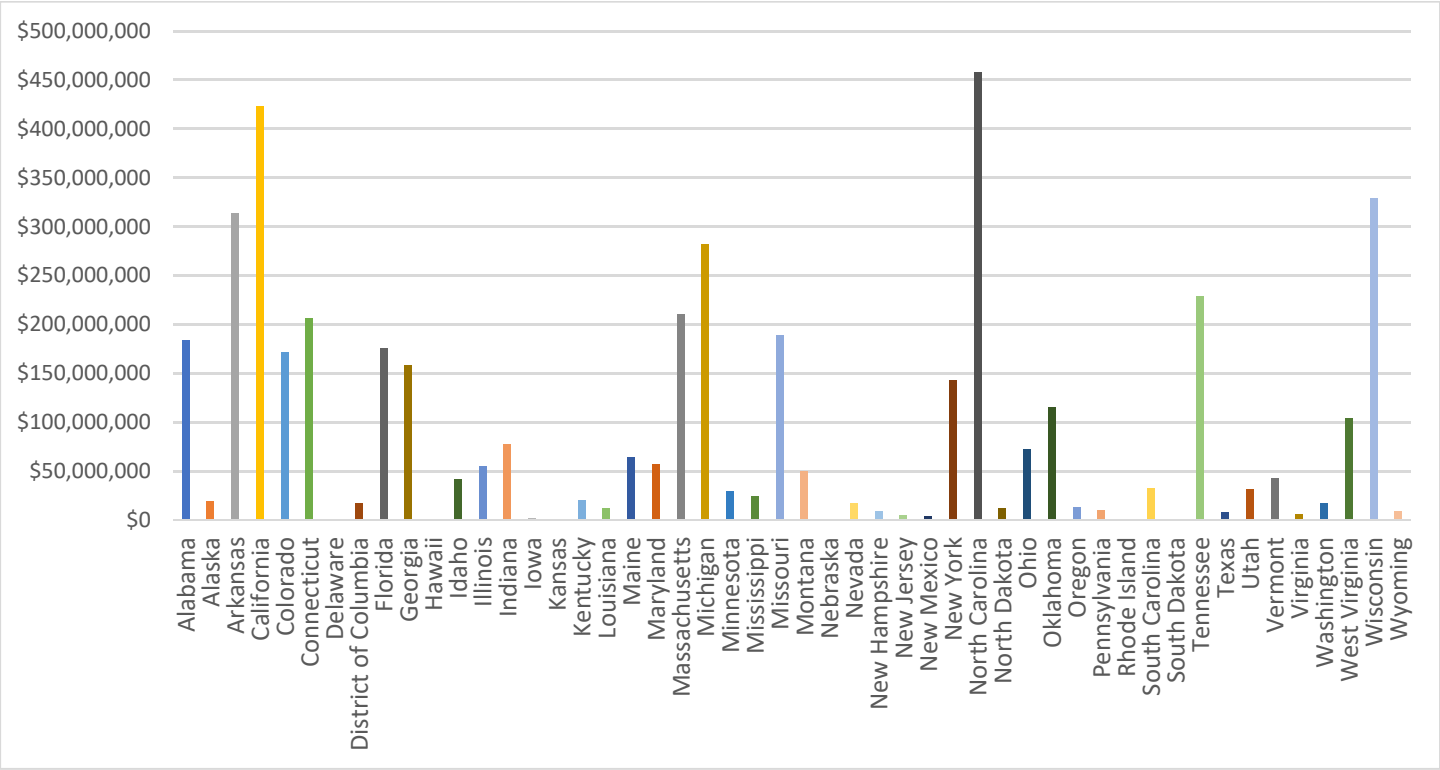

Table 69 – Drug Utilization Total Reimbursement Amount by Drug Category

State	"S" Drugs	"N" Drugs	"I" Drugs
Alabama	$504,606,116	$121,408,169	$184,288,608
Alaska	$106,645,190	$27,525,901	$19,469,445
Arkansas	$2,326,370	$74,591,041	$313,295,917
California	$2,849,635,819	$240,267,858	$423,507,461
Colorado	$687,601,912	$129,346,151	$171,560,880
Connecticut	$1,056,838,067	$194,650,095	$206,730,301
Delaware	$3,892,702	$1,554,719	$848,886
District of Columbia	$184,170,815	$12,803,214	$16,907,390
Florida	$735,567,202	$72,685,681	$175,249,376
Georgia	$526,533,554	$98,446,320	$158,264,071
Hawaii	$861,971	$303,737	$41,717
Idaho	$150,156,590	$36,200,674	$42,330,540
Illinois	$147,079,257	$39,212,380	$55,404,260
Indiana	$250,998,576	$48,340,119	$77,199,632
Iowa	$8,995,261	$3,987,274	$2,142,951
Kansas	$2,319,000	$739,000	$265,000
Kentucky	$50,903,269	$15,781,316	$20,098,955
Louisiana	$43,055,313	$15,325,791	$12,117,377

State	"S" Drugs	"N" Drugs	"I" Drugs
Maine	$182,268,275	$33,747,775	$64,099,995
Maryland	$543,261,803	$80,850,250	$57,532,669
Massachusetts	$486,670,458	$117,082,820	$210,776,498
Michigan	$774,760,707	$154,931,421	$281,552,066
Minnesota	$111,124,720	$52,004,743	$30,010,408
Mississippi	$80,061,464	$17,437,566	$24,121,624
Missouri	$935,658,399	$315,946,360	$188,771,332
Montana	$178,122,114	$50,034,770	$50,409,613
Nebraska	$409,439	$119,422	$36,456
Nevada	$288,072,796	$44,337,120	$17,397,802
New Hampshire	$20,097,081	$678,578	$8,616,905
New Jersey	$159,882,407	$11,548,979	$4,565,013
New Mexico	$28,118,715	$8,152,642	$3,903,736
New York	$359,542,203	$126,645,210	$142,858,136
North Carolina	$1,256,961,144	$264,041,701	$458,023,035
North Dakota	$46,781,445	$21,216,429	$12,456,611
Ohio	$153,770,593	$59,292,081	$72,745,816
Oklahoma	$344,519,978	$156,543,410	$115,458,407
Oregon	$78,879,069	$37,728,207	$12,678,820
Pennsylvania	$50,356,284	$14,885,426	$10,306,203
Rhode Island	$4,940,046	$1,691,665	$1,551,403
South Carolina	$96,849,180	$16,031,210	$32,790,025
South Dakota	$60,146,493	$42,817,956	$837,580
Tennessee	$660,836,203	$150,462,507	$228,776,825
Texas	$32,042,000	$14,188,000	$8,341,000
Utah	$102,510,573	$30,883,387	$31,713,475
Vermont	$124,556,590	$22,206,284	$42,798,042
Virginia	$21,910,966	$7,449,586	$5,798,266
Washington	$109,883,456	$15,817,095	$17,118,806
West Virginia	$415,670,900	$107,786,771	$104,636,476
Wisconsin	$716,610,835	$198,398,663	$329,319,368
Wyoming	$29,632,257	$19,811,700	$8,649,944
Total	$15,767,095,577	$3,327,939,174	$4,458,375,122

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

Figure 50 - Generic & Total Claims by State

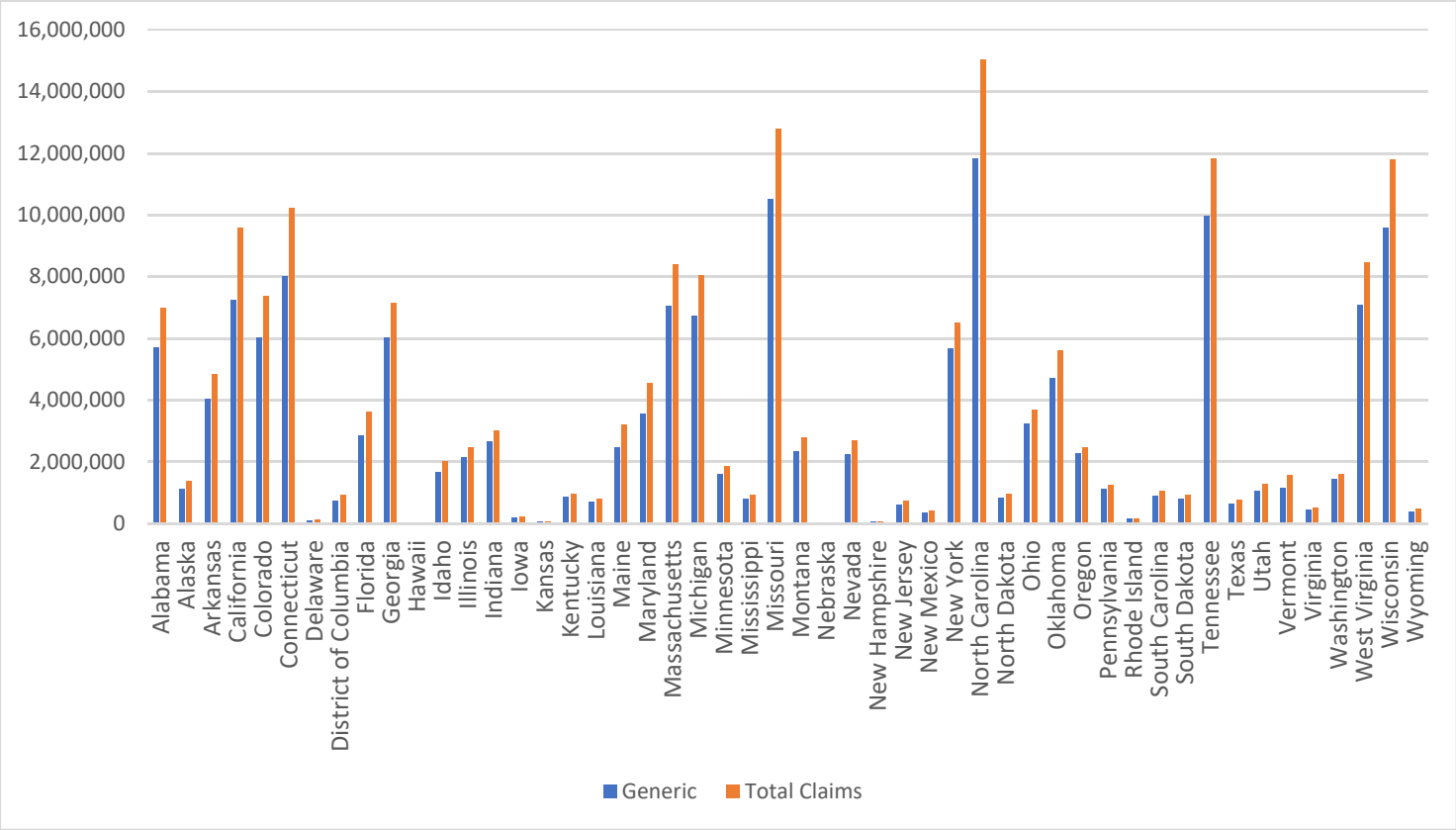

Table 70 - Generic & Total Claims by State

State	Generic Claim Count	Total Claim Count	Percentage
Alabama	5,682,275	6,989,584	81.30%
Alaska	1,111,740	1,357,803	81.88%
Arkansas	4,024,486	4,834,530	83.24%
California	7,226,221	9,577,138	75.45%
Colorado	6,028,742	7,368,148	81.82%
Connecticut	8,010,844	10,235,665	78.26%
Delaware	87,248	101,566	85.90%
District of Columbia	721,674	911,038	79.21%
Florida	2,853,968	3,621,000	78.82%
Georgia	6,029,861	7,121,645	84.67%
Hawaii	5,507	5,823	94.57%
Idaho	1,669,759	2,016,831	82.79%
Illinois	2,122,258	2,465,295	86.09%

State	Generic Claim Count	Total Claim Count	Percentage
Indiana	2,650,922	2,991,501	88.62%
Iowa	187,616	220,410	85.12%
Kansas	35,825	39,065	91.71%
Kentucky	837,501	942,371	88.87%
Louisiana	683,834	784,754	87.14%
Maine	2,460,956	3,196,855	76.98%
Maryland	3,549,730	4,531,774	78.33%
Massachusetts	7,035,300	8,392,575	83.83%
Michigan	6,710,128	8,022,563	83.64%
Minnesota	1,587,808	1,853,324	85.67%
Mississippi	773,666	917,155	84.35%
Missouri	10,511,458	12,768,168	82.33%
Montana	2,336,317	2,785,791	83.87%
Nebraska	8,826	9,700	90.99%
Nevada	2,225,496	2,684,876	82.89%
New Hampshire	34,998	43,005	81.38%
New Jersey	599,085	732,323	81.81%
New Mexico	320,826	387,438	82.81%
New York	5,668,813	6,498,452	87.23%
North Carolina	11,808,224	15,035,875	78.53%
North Dakota	810,291	952,611	85.06%
Ohio	3,235,325	3,663,665	88.31%
Oklahoma	4,690,220	5,609,287	83.62%
Oregon	2,276,959	2,450,468	92.92%
Pennsylvania	1,109,963	1,219,298	91.03%
Rhode Island	130,971	144,714	90.50%
South Carolina	878,249	1,034,561	84.89%
South Dakota	786,725	920,312	85.48%
Tennessee	9,966,364	11,818,361	84.33%
Texas	641,022	742,926	86.28%
Utah	1,051,916	1,260,361	83.46%
Vermont	1,142,922	1,554,653	73.52%
Virginia	419,670	488,616	85.89%
Washington	1,443,870	1,585,598	91.06%
West Virginia	7,079,393	8,457,818	83.70%
Wisconsin	9,593,832	11,790,746	81.37%
Wyoming	377,989	448,506	84.28%
Total	151,237,593	183,586,542	82.38%

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 51 - Generic/Total Amount Paid by State

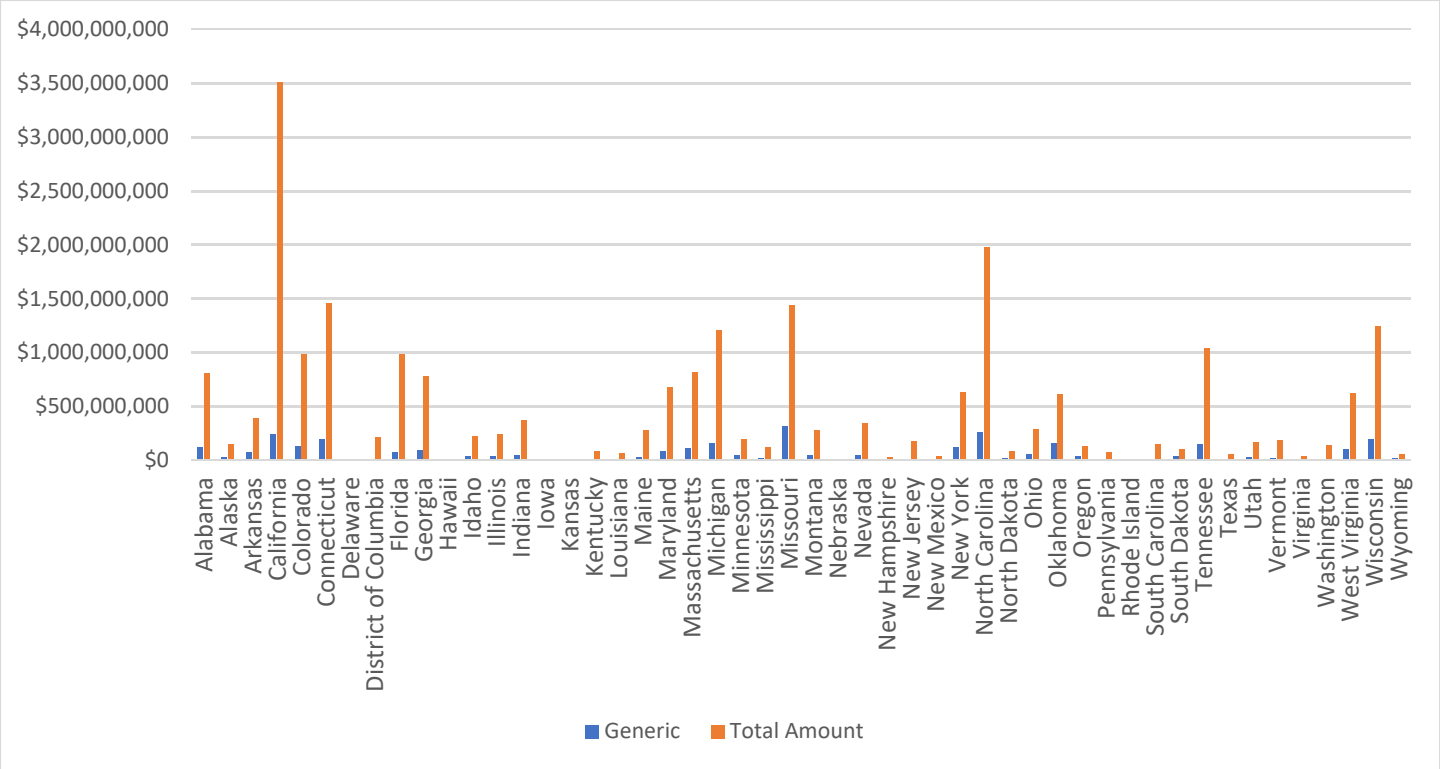

Table 71 - Generic/Total Amount Paid by State

State	Generic Claim Amount	Total Claim Amount	Percentage
Alabama	$121,408,169	$810,302,893	14.98%
Alaska	$27,525,901	$153,640,536	17.92%
Arkansas	$74,591,041	$390,213,328	19.12%
California	$240,267,858	$3,513,411,138	6.84%
Colorado	$129,346,151	$988,508,943	13.08%
Connecticut	$194,650,095	$1,458,218,463	13.35%
Delaware	$1,554,719	$6,296,306	24.69%
District of Columbia	$12,803,214	$213,881,419	5.99%
Florida	$72,685,681	$983,502,259	7.39%
Georgia	$98,446,320	$783,243,945	12.57%
Hawaii	$303,737	$1,207,425	25.16%
Idaho	$36,200,674	$228,687,805	15.83%
Illinois	$39,212,380	$241,695,897	16.22%
Indiana	$48,340,119	$376,538,327	12.84%

State	Generic Claim Amount	Total Claim Amount	Percentage
Iowa	$3,987,274	$15,125,486	26.36%
Kansas	$739,000	$3,323,000	22.24%
Kentucky	$15,781,316	$86,783,539	18.18%
Louisiana	$15,325,791	$70,498,481	21.74%
Maine	$33,747,775	$280,116,045	12.05%
Maryland	$80,850,250	$681,644,721	11.86%
Massachusetts	$117,082,820	$814,529,776	14.37%
Michigan	$154,931,421	$1,211,244,194	12.79%
Minnesota	$52,004,743	$193,139,871	26.93%
Mississippi	$17,437,566	$121,620,655	14.34%
Missouri	$315,946,360	$1,440,376,091	21.93%
Montana	$50,034,770	$278,566,497	17.96%
Nebraska	$119,422	$565,318	21.12%
Nevada	$44,337,120	$349,807,718	12.67%
New Hampshire	$678,578	$29,392,563	2.31%
New Jersey	$11,548,979	$175,996,398	6.56%
New Mexico	$8,152,642	$40,175,092	20.29%
New York	$126,645,210	$629,045,549	20.13%
North Carolina	$264,041,701	$1,979,025,880	13.34%
North Dakota	$21,216,429	$80,454,485	26.37%
Ohio	$59,292,081	$285,808,490	20.75%
Oklahoma	$156,543,410	$616,521,794	25.39%
Oregon	$37,728,207	$129,286,096	29.18%
Pennsylvania	$14,885,426	$75,547,913	19.70%
Rhode Island	$1,691,665	$8,183,114	20.67%
South Carolina	$16,031,210	$145,670,414	11.01%
South Dakota	$42,817,956	$103,802,029	41.25%
Tennessee	$150,462,507	$1,040,075,535	14.47%
Texas	$14,188,000	$54,571,000	26.00%
Utah	$30,883,387	$165,107,435	18.71%
Vermont	$22,206,284	$189,560,916	11.71%
Virginia	$7,449,586	$35,158,818	21.19%
Washington	$15,817,095	$142,819,357	11.07%
West Virginia	$107,786,771	$628,094,148	17.16%
Wisconsin	$198,398,663	$1,244,328,866	15.94%
Wyoming	$19,811,700	$58,093,900	34.10%
Total	$3,327,939,174	$23,553,409,868	14.13%

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

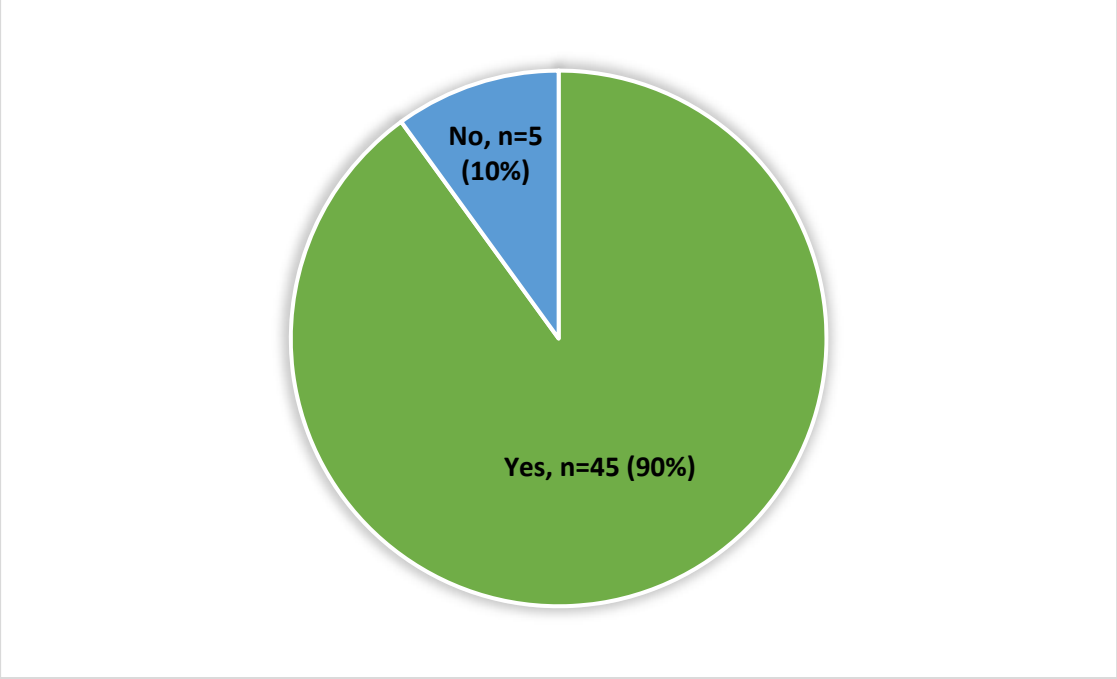

Table 72 - States Conducting DUR Program Evaluation of Estimated Cost Savings/Cost Avoidance

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, 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, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	45	90.00%
No	Hawaii, Oklahoma, South Carolina, Tennessee, Washington	5	10.00%
Total		50	100.00%

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

Figure 53 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation

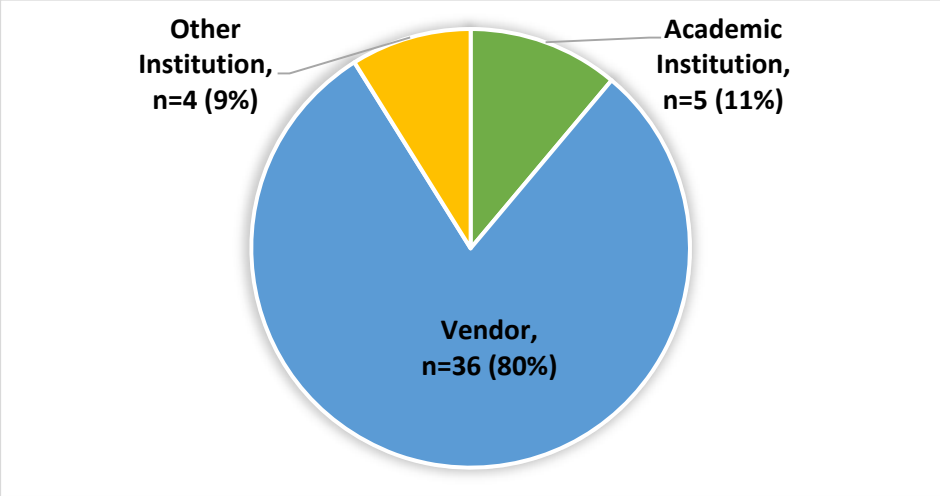

Table 73 - Institution Type that Conducted the Cost Savings/Avoidance Program Evaluation

Response	States	Count	Percentage
Academic Institution	California, Massachusetts, Oregon, Utah, Wyoming	5	11.11%
Vendor	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Texas, Vermont, Virginia, Wisconsin	36	80.00%
Other Institution	Illinois, Minnesota, Montana, West Virginia	4	8.89%
Total		45	100.00%

Table 74 - Vendors by State that Conducted the Cost Savings/Avoidance Program Evaluation

Response	States	Count	Percentage
Health Information Design	Alabama, New York, North Dakota, South Dakota, Wisconsin	5	13.89%
Magellan	Alaska, Florida, Idaho, Kentucky, Michigan, Nebraska, New Hampshire, Virginia	8	22.22%
Health Information Design and Magellan	Arkansas	1	2.78%
Magellan Health, Inc.	Colorado	1	2.78%
DXC Technology and Health Information Design	Connecticut	1	2.78%
DXC Technology	Delaware, Kansas, Louisiana, New Jersey	4	11.11%
Magellan/Conduent	District of Columbia	1	2.78%
OptumRx	Georgia, Indiana, Nevada	3	8.33%
Change Healthcare	Iowa, Maine, Ohio, Pennsylvania, Vermont	5	13.89%

Response	States	Count	Percentage
Conduent State Healthcare, LLC and Health Information Designs, LLC	Maryland	1	2.78%
Conduent and Change Healthcare	Mississippi	1	2.78%
Conduent	Missouri, New Mexico	2	5.56%
GDIT and Magellan	North Carolina	1	2.78%
KEPRO	Rhode Island	1	2.78%
Conduent and Health Informaton Design (HID)	Texas	1	2.78%
Total		36	100.00%

Table 75 - Academic/Other Institutions that Conducted the Cost Savings/Avoidance Program Evaluation

State	Academic/Other Institution Name
California	University of California, San Francisco (UCSF)
Illinois	IL HFS Bureau of Professional and Ancillary Services (BPAS) and Change Healthcare for SMAC
Massachusetts	University of Massachusetts Medical School
Minnesota	Minnesota does internally except for the RetroDUR savings is completed Conduent.
Montana	Mountain Pacific Quality Health Foundation
Oregon	OSU College of Pharmacy, Drug Use Research & Management Program and DXC Technology
Utah	University of Utah Drug Regimen Review Center
West Virginia	DXC AND The Marshall DUR Coalition
Wyoming	University of Wyoming School of Pharmacy

2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance.

   See the "State FFS Individual Reports" for details at Medicaid.gov.

3. The Estimated Percent Impact was generated by dividing the Grand Total Estimated Avoided Costs from Question 2 above by the Total Dollar Amount provided in Section VI, Question 4, then multiplying this value by 100.

   See the "State FFS Individual Reports" for details at Medicaid.gov.

4. Summary 5 – Cost Savings/Cost Avoidance Methodology

   Summary 5 Cost Savings/Cost Avoidance Methodology includes program evaluations/cost savings estimates prepared by state or contractor. Please provide detailed summary below.

Table 76 – Cost Savings/Cost Avoidance Methodology

State	Cost Savings/Cost Avoidance Methodology
Alabama	This report prepared for the Alabama Medicaid Program shows the expected estimated cost savings from implementing a retrospective drug utilization review (RDUR) and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2019 (FFY 2019). The drug claims for the selected recipients were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2018 and September 30, 2019, there was an estimated cost savings of $1,400,836. Intervention Group: Change between 6 Month Pre- and Post- / Comparison Group: Change between 6 Month Pre- and Post- / Estimated Cost Savings All Interventions: $1,187,827 / ($213,009) / $1,400,836 HID found the intervention group had a decrease of 15.25% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 11.20%. These changes resulted in an estimated cost savings of $804.62 per recipient who received an intervention during FFY 2019. During FFY 2019, HID reviewed 1,742 recipients with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Each month, HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once recipients have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. Beneficiary Selection A total of 4,556 recipients met the criteria for intervention letters during FFY 2019. Estimated Cost Savings Methodology To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters.

State	Cost Savings/Cost Avoidance Methodology
	The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same recipient within FFY 2019). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Results Discussion All drug claims and some medical claims or diagnosis data is available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems including inappropriate use of drugs and increased risk for drug interactions other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion The RDUR program provides an important educational service to providers enrolled in the Alabama Medicaid Program. During FFY 2019, 1,742 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $1,400,836 for FFY 2019.
Alaska	Prospective Drug Utilization Review (ProDUR) A cost savings estimate was prepared for the State of Alaska by Magellan Medicaid Administration. The cost savings estimate was calculated by identifying claims with ProDUR messages that were either reversed and resubmitted or reversed but not resubmitted. The cost savings was calculated as the difference between the allowable payment amounts of the reversed claim less the allowable payment amounts of the resubmitted claim. During FFY 2019 the pharmacy adjudication system resumed loading diagnosis information from the medical claims data, which had previously been on hold due to system limitations. This successfully increased the number of ProDUR edits that displayed for pharmacists during adjudication particularly for Drug to Known Disease from 195,636 in FFY2018 to 267,201 in FFY2019.This resulted in a significant cost savings increase from increased pharmacist intervention actions. Summary (ProDUR Paid Claims Savings Report, Severity Level 1) Total # of Reversed Claims 17,332 Allowable Amount ($) of Reversed Claims $6,606,512.36 Total # of Resubmitted Claims 9,449 Allowable Amount ($) of Resubmitted Claim $3,523,771.59

State	Cost Savings/Cost Avoidance Methodology
	Net Cost Savings $3,082,740.77 Summary (ProDUR Denied Claims Savings Report, Severity Level 1) Total # of Claims 39,713 Allowable Amount ($) of Claims $36,912,459.29 Total # of Resubmitted Claims 16,199 Allowable Amount ($) of Resubmitted Claims $6,104,306.00 Net Cost Savings $30,808,153.29 Retrospective Drug Utilization Review (RetroDUR) A cost savings estimate was not prepared for the State of Alaska by Magellan Medicaid Administration due to systems limitations. Summary The total cost savings estimate for ProDUR and RetroDUR interventions for FFY 2019 was $33,890,893
Arkansas	RETROSPECTIVE DRUG UTILIZATION REVIEW METHODOLOGY To determine the impact of the intervention letters on overall drug expenditures, total drug utilization (claims for all drugs) in the targeted population was evaluated 6 months before and 6 months after intervention letters were mailed. Total drug utilization was evaluated since a complete drug history was included with the educational intervention letters and prescribers could make changes to the entire drug regimen, in addition to the drugs noted in the letter. For a participant to be included in the analysis for cost avoidance, they had to have at least one claim for any drug during the pre-intervention time period and at least one claim for any drug during the post-intervention period. Patients who had no claims data during the post-intervention period were not included in the cost savings analysis. The total drug cost measured was based on the amount reimbursed to the dispensing pharmacy. For those participants who were selected for more than one intervention, drug utilization was calculated before and after each intervention. Each intervention represents a specific participant case. There are some limitations of the analysis. One is that no continuous eligibility data were available to determine whether participants maintained eligibility for Medicaid for the full 6 months before and after intervention letters were mailed. Therefore, the reduction in drug utilization and expenditures could be affected by multiple factors. Another limitation to cost-savings estimates relates to the type of interventions performed. Many retrospective interventions target non-adherence or underutilization of medications leading to increased use of medications, hence the increased expenditures. Cost avoidance estimates are based on total drug expenditure as calculated by the reimbursed amount paid to the dispensing pharmacy. This does not include any federal or supplemental rebates. Medical data that include the cost associated with hospitalization, doctor visits, and emergency room visits are not analyzed as part of the RDUR program. However, it is suspected that by reducing potentially inappropriate use of medications and alerting prescribers to drug therapy concerns, other associated medical costs would be reduced in addition to the reduction in drug expenditures. RDUR ESTIMATED COST AVOIDANCE SINGLE INTERVENTION $1,930,546.31 MULTIPLE INTERVENTIONS $645.232.56

State	Cost Savings/Cost Avoidance Methodology
	TOTALS $1,996,659.68 PROSPECTIVE DRUG UTILIZATION REVIEW METHODOLOGY The ProDUR cost avoidance report is based on data collected from an online ProDUR system and calculations from those electronically submitted claims. If an alert is triggered upon submission of a claim, the pharmacist must make the appropriate response to the alert. The response is captured electronically. By responding to the alert, the claim may be adjudicated, and the pharmacist would thereby dispense the medication and receive payment for the claim. This type of alert response to adjudicate a claim is referred to as a soft edit. The point of sale (POS) responses in the ProDUR system reflect the actions taken by pharmacists when presented with soft ProDUR alerts while dispensing prescriptions to Arkansas Medicaid beneficiaries. The codes 1A, 1B, and 1G are override codes and would not produce any program savings since no changes in the dispensed prescription took place. The pharmacist determines to his best professional judgment, with or without the communicated judgment of the prescriber, that the benefits of dispensing the medication outweigh the potential risks associated with the alert. Codes 1C, 1D, 1E, and 1F are adjustments made to the prescription in response by the pharmacist to the ProDUR alert which could produce program savings or increase in program costs depending on the response. Magellan's system has the ability to identify what alert was sent and when the response codes 1C, 1D, 1E, and 1F were used. The codes 2A and 2B are outcome codes for a cancellation response to a ProDUR alert and no claim was processed. A non-response to an alert indicates that the pharmacist did not respond to the soft alert. If a pharmacist does not respond to a ProDUR alert within seven days, the claim is denied, and no program funds are expended. This ProDUR cost avoidance estimate was prepared for the State of Arkansas by Magellan Rx Management and was calculated by identifying claims with ProDUR messages due to early refill (ER), therapeutic duplication (TD), drug-drug interaction (DD) and high dose (HD) alerts that were either denied claims that were not resubmitted or reversals of paid claims that were not resubmitted. When a claim is denied due to a prospective edit, there may or may not be a replacement or substitute claim. Each denied claim is compared and matched with paid subsequent claims based on the internal patient ID and the AHFS code. Only the last denied edit of the adjudicated claim will be utilized in order to not overestimate saving. ProDUR ESTIMATED COST AVOIDANCE Paid claim savings (Reversed claims not resubmitted) $15,202,573.34 Denied claim savings (Denied claims not resubmitted) $193,026,698.46 TOTAL ESTIMATED ProDUR SAVINGS $208,229,271.80 OTHER EDIT METHODOLOGIES AR Medicaid Pharmacy Program has an extensive list of drugs that require prior approval (PA) to override established clinical criteria edits and drug claim edits. Although patient safety and appropriate drug utilization are the focus when developing clinical algorithms and drug claim edits, generally the end result is cost containment or cost avoidance for the pharmacy program.

State	Cost Savings/Cost Avoidance Methodology
	The clinical criteria edits may use either POS clinical approval algorithms or a clinical manual review PA for approval of a particular drug. If a beneficiary does not meet the established prior approval criteria, the prescriber may submit a request in writing to provide additional documentation to substantiate the medical necessity of the beneficiary receiving the drug in question, or the prescriber may change the drug to an alternative drug that does not require prior approval. Drug claim edits (DUR reject error) are limitations placed on drugs or drug classes using gender, age, daily dose, monthly quantity allowed, quantity allowed per claim, or accumulation quantity edits that allow up to a certain quantity over a period of time. In addition to clinical edits and claim edits, AR Medicaid Pharmacy Program has a preferred drug list (PDL), and the drugs may be listed as preferred status, preferred status with criteria, non-preferred status, or non-preferred status with criteria. The non-preferred drugs on the preferred drug list will deny at POS and require an approved manual review prior authorization approval in order for the claim to pay. The prescribing provider must submit a request in writing explaining the medical necessity for the beneficiary to receive the non-preferred drug over the preferred drug(s), or the prescriber can change the prescription to a preferred drug as an alternative that does not require a prior approval. For the purposes of this cost avoidance or cost savings report, this section will only report the Matched and Unmatched claims data that pertains to drugs that denied at POS for Prior Authorization (PA) Required, Plan Limits Exceeded, DUR Reject Error, and Other Drug Claim Edits. The following definitions are offered for terminology used in the POS Magellan cost analysis system: 1) Unique Denied Claims: Some claims can stop for multiple edits, such as prior authorization edits plus drug claim quantity edits. The POS cost analysis system tracks the drug claim to the ultimate outcome and only counts the rejected claim one time as a unique denied claim so as not to overestimate the impact of the denied claim. 2) Matched Claim: The POS analysis system can track the rejected claim for matches to a suitable replacement, alternative, or substitute drug claim that paid. The cost difference between the rejected drug claim and the dispensed drug claim is the cost avoidance or cost savings. o If the POS analysis system tracks the rejected claim until it ultimately paid (for example due to an approved prior authorization at a Call Center), then it is not counted as a cost savings or a cost avoidance. These paid claims are not included in this report. 3) Unmatched Claim: If the POS analysis tracks a rejected claim and it is never matched to an alternative paid drug claim, it is called an unmatched claim. This means there was never a paid claim, or it was not replaced with a suitable replacement drug claim. The cost of the rejected drug is the cost avoidance or cost savings. 4) Other Drug Claim Edits: The POS analysis tracker can monitor a rejected drug claim that rejected due to specific drug claim edits on the drug, such as gender edits, age edits, daily dose edits, monthly quantity edits, and accumulation quantity edits. The rejected claim due to one of these types of edits is also monitored to determine the outcome. The cost difference between the rejected drug claim and the dispensed drug claim is the cost avoidance or cost savings. If it did not result in a paid claim with the original drug or it was not replaced with a suitable alternative, the cost of the rejected drug is the cost avoidance or cost savings. COST AVOIDANCE BY QUARTER FOR PA REQUIRED, PLAN LIMITS EXCEEDED, DUR REJECT ERROR AND OTHER DRUG CLAIM EDITS

State	Cost Savings/Cost Avoidance Methodology
	DUR ALERTS/REJECTIONS — ESTIMATED COST AVOIDANCE 1Q-FFY 2019 (OCT 1, 2018-DEC 31, 2018) $19,387,152.60 2Q-FFY 2019 (JAN 1, 2019-MAR 31, 2019) $19,443,537.33 3Q-FFY 2019 (APR 1, 2019-JUNE 30, 2019) $19,253,723.14 4Q-FFY 2019 (JULY 1, 2019-SEPT 30, 2019) $18,815,508.60 TOTAL FOR FFY 2019 $76,899,921.67
California	Prospective DUR alerts and educational bulletins provide health care providers and pharmacists with specific, focused, and comprehensive drug information. If DUR alerts and educational bulletins are reviewed as intended, then notification of a potential drug therapy problem through a DUR alert or the knowledge gained from educational bulletins will lead to appropriate action, including: 1. Discontinuing unnecessary prescriptions 2. Reducing quantities of medications prescribed 3. Switching to safer drug therapies 4. Adding a drug therapy recommended in evidence-based guidelines 5. Appropriate monitoring of patients taking prescription drugs The Medi-Cal DUR program has saved money by encouraging appropriate drug therapy in order to reduce total healthcare expenditures. Estimated prescription drug savings as a direct result of the prospective DUR system for FFY 2019 were calculated by taking each individual prospective DUR alert and multiplying the total claims cancelled or not overridden by the average reimbursement dollars paid to pharmacies per claim and a multiplier (allows for an adjustment of estimated costs using a conservative estimate that 90% of early refill claims are resubmitted and paid and that 20% of the remaining alerts are duplicate alerts for the same claim) in order to get the total estimated costs avoided through prospective DUR. Of note, multiple alerts can be generated per claim, so there may be duplicate alerts cancelled or overridden and the average reimbursement dollars paid to pharmacies per claim was calculated for each alert by looking at the total number of paid claims (including overrides) and total reimbursement dollars paid to pharmacies per claim (does not include adjustment for any rebates) for all drugs that generated that particular alert in FFY 2019.
Colorado	Paid Claims Cost Avoidance is calculated by taking the paid dollar amount of claims with a ProDUR message that paid, but were subsequently reversed and subtracting the paid amount the claims resubmitted within 72 hours. (Claim Amount - Reversal Amount + Resubmit Amount) Denied Claims Cost Avoidance is calculated by taking the submitted dollar value of the claims that were initially denied and had a ProDUR message and subtracting any of those claims that were then resubmitted within the same calendar month and then paid. (Claim Amount - Resubmit Amount) ProDUR Total Estimated Avoided Costs = Denied Claims Cost Avoidance + Paid Claims Cost Avoidance
Connecticut	This report prepared for the Connecticut Medical Assistance shows the expected estimated cost savings from implementing a retrospective drug utilization review (RDUR) and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2019 (FFY 2019). The

State	Cost Savings/Cost Avoidance Methodology
	drug claims for the selected recipients were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2018 and September 30, 2019, there was an estimated cost savings of $3,864,173. , Intervention Group Change between 6 Month Pre- and Post-, Comparison Group Change between 6 Month Pre- and Post-, Estimated Cost Savings All Interventions, $2,900,544, ($963,629), $3,864,173 During FFY 2019, HID reviewed 19,573 recipients with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Drug Therapy Problem Distribution Therapeutic Appropriateness 43% Drug-Drug Interactions 17% Over-Utilization 17% Under-Utilization 16% Drug Disease Interaction 7% Analysis Methodology Each month, HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once recipients have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. Beneficiary Selection A total of 33,566 recipients met the criteria for intervention letters during FFY 2019. Estimated Cost Savings Methodology To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same recipient within FFY 2019). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was

State	Cost Savings/Cost Avoidance Methodology
	compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Estimated Cost Savings Analyses Results For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed . Table 3 shows the results for both the intervention and comparison group for the pre- and post-intervention timeframes for recipients with single and multiple interventions during FFY 2019. Table 3 - Estimated Cost Savings for FFY 2019 , Intervention Group Change between 6 Month Pre- and Post-, Comparison Group Change between 6 Month Pre- and Post-, Estimated Cost Savings Single Intervention, $2,899,163, -$896,880, $3,796,043 Multiple Intervention, $1,381, -$66,749, $68,130 Total Estimated Cost Savings, $3,864,173 HID found the intervention group had a decrease of 4.19% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 5.07%. These changes resulted in an estimated cost savings of $241.03 per recipient who received an intervention during FFY 2019. Results Discussion All drug claims and some medical claims or diagnosis data is available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems including inappropriate use of drugs and increased risk for drug interactions other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion The RDUR program provides an important educational service to providers enrolled in the Connecticut Medical Assistance. During FFY 2019, 19,573 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $3,864,173 for FFY 2019. 5b PRO-DUR SAVINGS PLEASE NOTE: ProDUR Savings Calculation Methodology

State	Cost Savings/Cost Avoidance Methodology
	Savings for Pro-DUR alerts are derived from the soft-edit Pro-DUR alerts. A soft-edit alert notifies the dispensing pharmacist of a potential problem; the pharmacist evaluates the alert based upon the patient's situation and decides whether to override the alert or whether to cancel filling the prescription due to the alert. ProDUR Savings are estimated from the number of cancelled & no response prescriptions after the soft edit alert hits. The cancelled & no response prescriptions are also called the number of denied claims that are reviewed by pharmacists who decide not to fill the prescriptions after hitting a soft edit. Methodology of how DXC calculated the ProDUR savings is either DXC multiplied the number of cancelled & no response prescriptions by the average cost per prescription for each ProDUR Alert type; or, DXC tracked what the cancelled & no response prescriptions would have cost if they had been dispensed. Then each alert type savings were added to create a sum of all savings labeled, Cost Savings Total in Attachment 5b. ProDUR Savings ProDUR savings for FFY 2019, as calculated by the claims processor and fiscal agent DXC , was estimated to be a total of $95,702,538 on 3,953,033 prescriptions for patients. ALERT TYPE, # of Claims Cost Savings, Reporting the year of 10/01/2018 to 09/30/2019, Reporting the year of 10/01/2018 to 09/30/2019 , , , , , Total # of Claims, Total Cost Savings Drug-Drug, Rx, 19,933, DD, $, , $1,129,380 Early Refill, Rx, 2,430,372, ER, $, , $83,419,097 High Dose, Rx, 19,628, HD, $, , $77,693 Ingredient Duplication, Rx, 1,152,881, ID, $, , $8,472,052 Drug-Age, Rx, 4,433, PA, $, , $10,539 Drug-Pregnancy, Rx, 35,968, PG, $, , $80,193 Therapeutic Duplication, Rx, 289,818, TD, $, , $2,513,583 , , , TOTALS, Rx, 3,953,033, , $, , $95,702,538
Delaware	Delaware has continued to take a conservative approach in estimating our cost savings due to pro-DUR. While early refill denials could be considered, we have always deemed these savings to be more of cost deferral rather than cost avoidance. The refill percentage in Delaware is set at and for prior authorization claims we even tighten this percentage more by the date range and quantity for which the

State	Cost Savings/Cost Avoidance Methodology
	drug is approved. The two edits that Delaware uses to calculate cost savings are therapeutic duplication and dose optimization. The list of medications that hit for these two edits are extensive and have produced cost savings on the unnecessary dispensation of additional products or additional units of medication. Fee for service compromises about 15% of the Medicaid population, of which approximately a quarter of that population transitions to an MCO administered benefit. The tracked and reported savings for therapeutic duplication and dose optimization appears slightly higher than last year's result. At point of sale, therapeutic duplication within classes is the best way to proactively prevent duplicate therapy and unnecessary expenditures. In federal fiscal year 2019, the estimated therapeutic duplication alerts for FFS deferred the dispensing of 7,737 units with an estimated savings of $949,535 . Delaware has a long-standing history of maximizing dose optimization since its implementation in February 2005. Setting optimal dose edits ensures that the member receives a dose that maximizes compliance and therapeutic appropriateness, and as a result, decreases expenditures for the state by dispensing the minimum units and beneficial healthcare outcomes which drive future cost savings. One current trend that continues to be identified in Delaware by the dose optimization audit are those healthcare providers who prescribe an FDA approved drug for once daily dosing to be dosed multiple times per day. Research has continued to indicate that there is no benefit from more than once daily dosing. For FFY 2019, of the FFS claims that dispositioned by edit quantity units billed outside the limits, the drug class of proton pump inhibitors were the predominant result. Utilizing dose optimization produces savings and does not sacrifice level of member care; in fact, dose optimization reduces the dosing frequency or number of units taken; therefore, improving patient compliance. Even for products that are indicated with a dosing range such as once to twice daily, Delaware utilized the once daily regimen first and needs to see failure before twice daily dosing would be considered for approval. It is estimated during federal fiscal year 2019, Delaware's dose optimization edits prevented over 42,729 units of medication from being dispensed resulting in an estimated savings of $192,144. Delaware continues to review each drug as it enters the market and add it to the dose optimization list when appropriate
District of Columbia	ProDUR Methodology Step 1: Denied claims are extracted from the study quarter's data and linked to the external NCPDP error codes Step 2: Paid claims that do not fall into a refill' designation are extracted and matched to the respective denied claims becoming replacement claims Paid claims that have been filled with the same GSN within 90 days from the member's fill date are excluded Step 3: Denied and replacement claims are matched by patient ID and the GPI6 Code to ensure that the replacement claim is for the same therapy The replacement claim should have a service date on or after the denial claim date The window between the service date for the denial claim and the paid claim should be 14 days (denied date lesser than or equal to paid date The denied and replacement claims will lastly be matched by the HIC3, GSN, BRAND NAME, GENERIC NAME, NDC, and STANDARD THERAPEUTIC CLASS CODE RetroDUR Methodology Per patient per month PPPM drug amount paid for intervention-related drugs was calculated for the target group for the six-month baseline and six-month post-intervention periods. The post-period PPPM amount paid for the target group was subtracted from the baseline PPPM amount paid to obtain the

State	Cost Savings/Cost Avoidance Methodology
	estimated PPPM savings. The PPPM savings was then multiplied by the number of interventions months and number of target patients.
Florida	Florida Medicaid Pharmacy Program Drug Utilization Review Annual Report: FFY19 Cost Savings/Cost Avoidance Methodology Maximum Allowable Cost The Maximum Allowable Cost (MAC) program establishes a maximum price per unit at which Florida Medicaid will reimburse pharmacy providers for generic medications. By using the MAC price, the Medicaid Program reimburses at the same rate for the included products. This enables pharmacy providers to select the agent that is most effective for them without disadvantaging the Medicaid Program. MAC program savings are calculated by re-pricing each claim that paid at MAC as if the MAC price had not existed at the point of adjudication. MAC savings is the difference between the MAC price and the recalculated payment amount. During FFY 2019, the MAC program provided savings of $3,037,401. Preferred Drug List (PDL) Supplemental rebates are collected from pharmaceutical manufacturers for their inclusion as a preferred product. Additionally, market shift savings are generated by shifting the market from more expensive, non preferred products, to less expensive, preferred products. The total savings provided by the PDL program during FFY 2019 was $5,391,401. Retrospective DUR For all edits or criteria approved by the DUR Board, a pre-implementation analysis is conducted demonstrating the number of claims, number of recipients, and total amount paid that would be impacted by such an edit or criteria. At a reasonable amount of time after implementation of the edit or criteria, a post-implementation analysis is performed demonstrating the number of claims, number of recipients and total amount paid for a similar period of time. The standard post implementation analysis is conducted three months after deployment of the edit but may vary depending on the nature of the edit and the time needed to measure an impact. For example, if an edit allows for a six month window before claims denial, the impact of the edit would not be assessed until approximately nine months after the edit is deployed. The cost savings is considered to be the difference in the total amount paid between the pre-implementation and the post-implementation. These figures are then annualized to calculate the RetroDUR cost savings impact. The total savings measured at the time of report submission for RetroDUR edits in FFY2019 was $12,693,649.20. Prospective DUR- ProDUR cost avoidance for the Florida Medicaid prescription drug program is the sum of the claims that were reversed or denied and not resubmitted. The ProDUR cost avoidance for FFY 2019 was $337,535,420. The following table summarizes the FFY 2019 data. However, cost avoidance should not be interpreted as true cost savings. While the ProDUR edit may have resulted in a claim reversal or denial, it is not known what the complete impact this has on the program. There are many prescriptions that are switched after point of sale to alternative medications, which would have an improved therapeutic benefit to the patient and would not generate a ProDUR edit. The cost of this alternative medication is not reflected in the calculation of ProDUR cost avoidance. Another factor that influenced this calculation was multiple claim submission for an individual recipient's prescription. This would result in a number of claims and ProDUR edits for one prescription. If the provider fails to reverse the various claims, the calculations would be inflated.

State	Cost Savings/Cost Avoidance Methodology
Georgia	Pharmacy savings were based on the claims status associated with the claim transaction: Paid, Reversed, Rejected Paid Claims with CDUR edit(s) are those which had an override by a pharmacist Rejected claims with CDUR edit(s) include both hard and soft rejects Reversed claims with CDUR edit(s) include Paid claims which were reversed, originating with a message and an override by a pharmacist
Hawaii	When generics become available, providers have switched from brand to generic: Sensipar and Valcyte. Cost Savings were estimated at less than $5.000.00.
Idaho	ProDUR cost savings estimate was calculated by identifying claims with ProDUR messages that were reversed and those that were reversed but resubmitted. The cost savings was calculated as the difference between the allowable payment amounts of the reversed claim less the amounts of the resubmitted claim. RetroDUR were evaluated by reviewing costs before interventions compared to costs after intervention for pharmacogenetic testing, Hepatitis C, PCSK9 Inhibitors, butalbital and injectable testosterone. Lock-in was evaluated by cost avoidance.
Illinois	Four Prescription Policy The Department requires adults to obtain a prior authorization to fill a prescription beyond four in a 30-day period. Medications that do not count toward or require prior authorization due to the Four Prescription Policy include antineoplastic agents, antiretroviral agents, antipsychotics, immunosuppressive agents, and anticonvulsants for participants who have a diagnosis of epilepsy or seizure disorder in Department records. As pharmacies and prescribers learn what requires prior authorization, requests for prior authorization for the Four Prescription Policy are submitted prospectively to resolve issues before claims are processed. In FFY19 at least 237,450 pharmacy claims rejected due to the Four Prescription Policy edit. Prior authorization The prior authorization requirement for medications that are not preferred or preferred but require prior authorization to ensure clinical criteria are met resulted in an initial rejection of 494,267 unique claims. Final cost savings are impacted by meeting clinical criteria and will vary due to changes in drug therapy, such as the prescribing of a different drug or drug dosage. Drug Utilization Review (DUR) Edits Illinois Medicaid revised edits used to address DUR with implementation of the new PBMS. In FFY19, HFS rejected approximately 138,574 unique claims as a result of DUR edits addressing duplicate therapy, duration of therapy, daily dose, excess quantity, excess accumulated quantity, age, gender, and high dose. Some participants had more than one claim impacted by a DUR edit. In FFY19, Illinois reimbursed pharmacies $91.79 per prescription on average. Based on the average cost of a claim, Illinois rejected approximately $12.7 M in pharmacy claims as a result of DUR editing. Cost savings will vary due to changes in drug therapy, such as the prescribing of a different drug or drug dosage. Generic Product Utilization During FFY19, Illinois Fee-for-Service Medicaid's generic dispensing ratio increased by 0.77%. During FFY19, the average brand name/innovator prescription was reimbursed at $590.27, while the average generic prescription was reimbursed at $18.48. Illinois Medicaid reimbursed providers for approximately

State	Cost Savings/Cost Avoidance Methodology

2.47 M prescriptions. Each percentage point shift from brand/innovator to generic utilization would result in about $14.1 M in savings.

Three Brand Name Drug Limit

The Department limits the number of brand name drugs participants age 21 and older may receive each month. Prior approval is required for a fourth brand name drug in a 30-day period. The three brand limit does not impact the following drug categories:
Drugs for which there are no alternative generic therapies for the condition being treated.
Drugs for which the generic alternatives are deemed clinically inappropriate for the majority of participants.
Brand name drugs that are less expensive to the Department than their generic alternatives.
Drugs in the following classes: antiretroviral agents, antineoplastic agents, immunosuppressive agents.
During FFY19 the brand limit impacted 158 claims. At an average reimbursement of $91.79, this resulted in about $14,503 in savings.

State Maximum Allowable Cost (SMAC)
Illinois uses Change Healthcare Pharmacy Solutions as the SMAC vendor. The SMAC savings is calculated based on Illinois utilization data. The SMAC savings is calculated by comparing the difference between either the lesser of estimated acquisition cost (EAC) or the Federal Upper Limit (FUL) and the SMAC price. The difference is then multiplied by the total units dispensed with a SMAC price. The EAC price in Illinois during the first three quarters of FFY19 was set as WAC (wholesale acquisition cost). Effective 7/15/2019 the EAC for generic drugs changed from WAC to WAC minus 17.5%. Effective July 15, 2019, the National Average Drug Acquisition Cost (NADAC) was also introduced. The FUL price is determined by the Centers for Medicare and Medicaid Services (CMS). During FFY19, the SMAC pricing program saved Illinois Medicaid $23,763,219 (state and Federal dollars).

Illinois Pharmaceutical State Maximum Allowable Cost Savings FFY19

Month	Total Units with SMAC	Actual SMAC Savings*	Quarter	Actual SMAC savings by Quarter
October 2018	13,709,102	$2,126,747	Q1 FFY2019	$6,352,541
November 2018	12,931,175	$2,020,215		
December 2018	12,894,396	$2,205,579		
January 2019	14,088,956	$2,426,966	Q2 FFY2019	$7,221,171
February 2019	12,754,746	$2,469,474		
March 2019	14,169,573	$2,324,731		
April 2019	14,361,567	$2,340,509	Q3 FFY2019	$6,390,051
May 2019	14,056,564	$2,018,818		
June 2019	12,665,628	$2,030,724		
July 2019	13,197,588	$2,306,492	Q4 FFY2019	$3,799,456
August 2019	15,821,246	$829,333		
September 2019	12,983,880	$663,631		
			Total FFY2019	$23,763,219

* Actual SMAC Savings =Difference between [Lesser of EAC and FUL] and SMAC x Total Units with SMAC

State	Cost Savings/Cost Avoidance Methodology
	Illinois Medicaid Preferred Drug List Illinois Medicaid maintains a Preferred Drug List (PDL) in order to promote clinically appropriate utilization of pharmaceuticals in a cost-effective manner. The Illinois Medicaid PDL process ensures that the PDL is developed based on safety, effectiveness, and clinical outcomes. If these factors indicate no therapeutic advantage among the drugs being considered in the same drug class, then HFS considers the net economic impact of such drugs when recommending drugs for inclusion in the PDL. In FFY19, the PDL generated approximately $8.15 M in supplemental rebates from brand name drug manufacturers. Additional savings is achieved by using the PDL to encourage the use of lower cost generic alternative drugs. Lost, Stolen, or Destroyed Medications and Vacation Supplies of Medications As of September 12, 2014, HFS does not cover lost, stolen, or destroyed over-the-counter (OTC) medications for all participants. Lost, stolen, or destroyed prescription medications are not covered for adults except for contraceptives, anticonvulsants prescribed for seizures, albuterol inhaler prescribed for asthma or chronic obstructive pulmonary disease, immunosuppressive agents for transplant participants, insulin vials, and antipsychotics for schizophrenia. For children through the age of 20, one single approval per 365-day period can be approved if the medicine was lost, stolen, or destroyed. Vacation supplies of medications for adults are not covered and are reviewed on a case-by-case basis for children through age 20. 14-day Supply of Medications for Long Term Care Residents Effective May 1, 2013, the Department requires certain medications to be dispensed to nursing home residents in 14-day supplies in order to increase efficiencies and reduce waste. Medications include certain brand-name, solid oral drugs. Solid oral doses of antibiotics and drugs that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or that are customarily dispensed in their original packaging to assist participants with compliance, such as oral contraceptives, are excluded from this requirement and may be dispensed in days' supplies greater than 14.
Indiana	According to the Guidelines, limiting the DUR savings results to global estimates of savings in the drug budget or overall Medicaid expenditures is not acceptable. Pro-DUR savings estimates should specifically track results relative to individual cases affected by pro-DUR alerts. One cannot sum dollar amounts associated with all denials and/or reversals and claim these as the total pro-DUR cost savings, either. The reason being: one cannot assume that all denials of prescriptions through on-line pro-DUR edits results in changes in drug use and expenditures. If the claim is filled with a substitute medication or is delayed by several days in filling, states should track the net effects upon expenditures. Likewise, one must use caution in estimating the costs avoided from reversal of claims and only measure costs avoided from true reversals that remain reversed. Tracking and calculating costs associated with pharmacists' actions resulting from pro-DUR edit alerts have always been difficult at best. Comparison group designs are normally recommended; however, with on-line pro-DUR, comparison populations who are not receiving an alert are not possible. Zimmerman, T. Collins, E. Lipowski, D. Kreling, J. Wiederholt. “Guidelines for Estimating the Impact of Medicaid DUR." Contract #500-93-0032. United States Department of Health and Human Services, Health Care Financing Administration: Medicaid Bureau. August 1994 OptumRx's outcomes measures of therapy improvements and cost savings were not dependent upon receiving prescriber responses about the faxed letter. Instead, actions were measured from claims data to determine what prescribing patterns have actually changed as a result of educational interventions.

State	Cost Savings/Cost Avoidance Methodology
	Drug savings estimates from retro-DUR were measured by the claims 180 days before and after interventions. To analyze recipients' drug use, OptumRx followed the 1994 CMS "Guidelines for Estimating the Impact of Medicaid DUR." OptumRx compared the cost of all prescription drugs for each recipient before and after physicians received faxed alert letters. By following CMS' guidelines, our analysis measured "the substitution effect." That is, prescribers may substitute another drug in the same therapeutic class in place of the drug about which the faxed alert letter was sent. Therefore, OptumRx's analysis also included the cost of other drugs in the same therapeutic class. OptumRx calculated each period's costs using the exact quantities of each drug dispensed and the cost of the claims (defined as reimbursement formula specified in the plan). Cases were analyzed using 180 days of claims data before and after the faxed letter/intervention. The number of prescriptions and cost of drug therapy were then compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was evaluated compared to a control group. Any savings that occurred can then be attributed to the DUR intervention and not some other effect. The Indiana Medicaid DUR program has been shown to be beneficial to the state, provider community, and beneficiary population served. OMPP will continue to monitor and improve the retro-DUR and pro-DUR programs.
Iowa	Summary 5 PROGRAM EVALUATION/COST SAVINGS ESTIMATES Iowa Medicaid Drug Utilization Review - FFS Annual Report FFY 2019 Patient-Focused Profile Review Cost Savings Estimates: Dollars Saved per Patient Evaluated $50.67 Dollars Saved on Medication $1,317.31 Total $1,317.31 * Problem-Focused Profile Review Cost Savings Estimates: Problem-Focused Analysis $6,595.92 Total $6,595.92 * Cost Savings Estimate $7,913.23 * * Savings reported are pre-rebate, total dollars PATIENT-FOCUSED REVIEW

State	Cost Savings/Cost Avoidance Methodology
	MONTH BY MONTH BREAKDOWN FFY 2019 Initial Review Date Jan 18-Dec 18 Evaluation Date Oct 18-Sep 19 Profiles Available for Evaluation 455 Profiles Reviewed 26 Total Number of Suggestions Made 27 Therapeutic 27 Cost-Saving 0 Total Number of Changes Made 5 Therapeutic 4 Cost-Saving 0 Positive Impact Only 1 Total Dollars Saved - Therapeutic Changes $1,317.31 Total Dollars Saved - Cost-Saving Changes $0.00 Total Dollars Saved on Medication* $1,317.3 Total Dollars Saved per Profile Reviewed $50.67 *Savings reported are pre-rebate total dollars. Problem-Focused Studies FFY 2019 Focus Study Review Period Evaluation Period Patients Reviewed Patients Selected Cost Savings Calculated Duplicate LA Stimulants 01/01/2019 - 02/29/2019 05/01/2019 - 05/30/2019 2 2 $6,595.92 TOTAL 2 2 $6,595.92 * Savings reported are pre-rebate, total dollars. The goal of Drug Utilization Review (DUR) is to evaluate cost savings and provide quality assurance of medication use. The DUR Commission works in conjunction with the pharmacy medical program at the Iowa Medicaid Enterprise to contribute to the overall success of the program. The Drug Utilization program: *Evaluates three areas of activity including Patient-focused Drug Utilization Reviews, Problem-focused Drug Utilization Reviews, and Administrative Activities. *Examines only direct drug costs. DUR evaluation does not have the ability to quantify its impact on other health services such as hospitalizations, ER visits, and physician visits. *Reports pre-rebate savings since access to supplemental rebates is not within the scope of the DUR program. *Often provides recommendations that are qualitative, such as improved health outcomes, rather than quantitative in nature.

State	Cost Savings/Cost Avoidance Methodology
	As a general principle, evaluations are based upon an observed change in the targeted prescribing or dispensing pattern, as well as changes seen in therapy of the individual patients. One evaluation approach is to observe and quantify changes in prescribing due to a given intervention compared to a control group of providers who do not receive the intervention. The intervention's impact on prescribing may be more readily detectable by this method and could be measured by comparing the two groups of patients or prescribers. However, it is very difficult to design a scientifically sound control group given the many variables surrounding patient care. Therefore, in most instances the DUR Commission has chosen to forego use of a control group to achieve the greatest impact. Although the evaluation of the intervention may be less scientific, intervention on behalf of all the patients is more desirable. In this instance, prescribing trends may not be available for comparison, but savings and benefit can still be quantified at the individual patient level. Patient-focused DUR Patient-focused DUR concentrates efforts on specific suggestions made about an individual patient. Each suggestion, or template, attempts to make a change in therapy. These changes are either therapeutic or cost-saving in nature; however, these situations are not necessarily mutually exclusive. A therapeutic change -- one that improves the patient's therapy in some way -- may also produce cost savings. Cost-saving changes are attempted when a patient is not receiving a medication in the most economical form. The intervention does not change the medication but points out that the same medication could be given in a more cost-effective manner. Each template and intervention is evaluated to determine if the proposed change was implemented and, if so, what economic implications can be calculated. The calculation relating to therapeutic and cost saving interventions is tabulated by comparing a member's initial profile with the member's re-review profile. Each member profile is a six-month snapshot of medications covered by the Medicaid program. Pertinent information such as patient name and ID, date of service, drug name, strength, and quantity, RX number, day supply, prescriber and pharmacy ID, total price submitted, and amount paid appear on each profile. There are nine months in between the initial and re-review profiles to accommodate for provider review, response, and implementation for therapeutic and or cost changes. For each intervention, the total amount paid on the initial profile for any one intervention is noted. According to the intervention at hand, the re-review profile is evaluated for change. The amount paid on the re-review profile for the same intervention is also noted. A comparison between the profiles is calculated by subtracting the total amount paid from the initial profile with the total amount paid from the re-review profile. This calculation is then annualized multiplying the number by 2 to get the pre-rebate annualized savings. All savings for patient-focused review are based on annualized savings for one year only. Reporting on patient-focused interventions will provide the following information: *Total number of templates mentioned *Number of templates that were therapeutic in nature *Number of templates that were cost-saving in nature *Total number of changes implemented *Number of changes that were therapeutic in nature *Number of changes with positive impact without savings *Number of changes that were cost-saving in nature *Total dollars saved from therapeutic changes *Total dollars saved from cost-saving changes *Total dollars saved *Impact of interventions expressed as a percentage

State	Cost Savings/Cost Avoidance Methodology
	All templates are described by one of sixteen classifications. These classifications indicate the general type of intervention addressed by the template. Reports will also include a breakdown by classification (therapeutic or cost-saving) of the templates used in the patient-focused letters. This data will show which templates are cited most often, result in change most often, and result in higher cost savings. Templates that are therapeutic in nature include: *Not Optimal Drug *Not Optimal Dose *Not Optimal Duration of Use *Unnecessary Drug Use *Therapeutic Duplication *High Cost Drug *Drug-Drug Interaction *Drug-Disease Interaction *Adverse Drug Reaction *Patient Overuse *Patient Underuse *Therapeutic Alternative *Missing Drug Therapy Templates that are cost saving in nature include: *Not Optimal Dosage Form *Potential Generic Use *Inappropriate Billing Problem-focused DUR Problem-focused DUR concentrates efforts on a specific problem or trend in prescribing. While patient-focused reviews may address a multitude of situations, a problem-focused review addresses only one concern. The DUR Commission uses guidelines, literature and peer-group prescribing to identify particular clinical situations that need addressed. This process ensures that each intervention is unique due to the subject matter and may differ in steps of evaluation. Reporting for problem-focused interventions will include the types of intervention done and the resulting savings. Savings are always calculated based on one year of therapy only and are calculated in the same manner as explained in the patient-focused DUR section. Administrative Review The Drug Utilization Review (DUR) program is a component of the Pharmacy Medical Division of the Iowa Medicaid Enterprise (IME). DUR contributes expertise and information that leads to implementation in other programmatic areas including, but not limited to: Prospective Drug Utilization Review, Prior Authorization, Preferred Drug List, Disease Management, and Supplemental Rebates. Although the DUR program impacts all of the different pharmacy programs it is difficult to determine where its impact begins and ends. Therefore, the savings associated with DUR contribution in other pharmacy areas cannot be determined.
Kansas	Take the averaged PA timespan (days) per assignment code multiplied by average FFS utilization units per day multiplied by an averaged price per unit (PPU) from the Federal Fiscal Year.

State	Cost Savings/Cost Avoidance Methodology
Kentucky	ProDUR ProDUR cost avoidance for the Kentucky Medicaid Fee-for-Service (FFS) Program is the sum of the claims that were reversed or denied and not resubmitted. The estimated ProDUR cost avoidance for FFY 2019 was $57,939,791. However, cost avoidance should not be interpreted as true cost savings. While the ProDUR edit may have resulted in a claim reversal or denial, the complete impact this has on the program is unknown. There are many prescriptions that are switched at point-of-sale to alternative medications, which have an equivalent or improved therapeutic benefit and therefore do not generate a ProDUR edit. The cost of the alternative medication is not reflected in the calculation of ProDUR cost avoidance. Another factor that influences this calculation is multiple claim submissions for an individual beneficiary's prescription. This would result in a number of claims and ProDUR edits for one prescription. If the provider fails to reverse the various claims the calculations would be inflated. Maximum Allowable Cost The Maximum Allowable Cost (MAC) program establishes a maximum price per unit at which the Kentucky Medicaid FFS Program will reimburse pharmacy providers for generic medications. By using the MAC price, the Medicaid Program reimburses at the same rate for the included products, regardless of the Wholesale Acquisition Cost (WAC). This enables pharmacy providers to select the agent that is most effective for them without disadvantaging the Medicaid Program. On June 15, 2017 the FFS plan moved to a new pricing algorithm that includes NADAC. MAC program savings are calculated by re-pricing each claim that paid at MAC as if the MAC price had not existed at the point of adjudication. MAC savings is the difference between the MAC price and the recalculated payment amount. During FFY 2018, the MAC program provided an estimated cost avoidance of $1,330,310. Preferred Drug List (PDL) Supplemental rebates are collected from pharmaceutical manufacturers for their inclusion as a preferred product. Additionally, market shift savings is generated by shifting the market from more expensive, non-preferred products, to less expensive, preferred products. The estimated savings provided by the PDL program during FFY 2019 was $3,247,456. Preferring Brand Products over Generics When a new generic comes to market often times it is granted a six (6) month exclusivity period to allow the generic manufacturer time to recoup some of the monetary investment required to get that generic to market. During this time, there are no competitors; therefore, the price is not driven down by competition in the market. In order to maintain their current position in the market space, manufacturers of the branded product will continue to pay supplemental rebates as long as their branded drug is preferred over the new generic product. This results in the branded product being less costly to the Commonwealth; net of federal and supplemental rebates. As more generic products enter the market and the price is driven down by competition, the branded product, net of federal and supplemental rebates, eventually will become more costly than the generic product; and at this time, the generic will be preferred over the brand. By preferring more cost-effective branded products over generics the Commonwealth has experienced an estimated cost avoidance of $2,520,952 during FFY 2019. Dose Optimization and Quantity Limits The Dose Optimization Program encourages prescribers and pharmacies to use fewer tablets of a higher strength as opposed to more tablets of a lower strength. In many cases, all strengths of a medication

State	Cost Savings/Cost Avoidance Methodology
	have similar, if not identical, prices. This program promotes cost-effective drug utilization, without compromising quality of care. Dose optimization also serves to increase compliance by simplifying dosage regimens. Kentucky FFS Medicaid has instituted a limit to the number of dosage units per day that can be billed to Medicaid for certain drug products. FDA approved dosages and reports from clinical literature were considered when developing these limits. In addition to ensuring that Medicaid is not billed for inappropriate doses of the affected medications, this program also serves as a safety measure to Kentucky FFS Medicaid beneficiaries, ensuring that they do not receive inappropriate doses of these medications. Quantity limits also prevent billing errors and subsequent overpayment. Together, the dose optimization and quantity limit programs produced an estimated cost avoidance of $3,645,239 during FFY 2019. Diabetic Supplies Program Kentucky FFS Medicaid requires that diabetic supplies be billed through the pharmacy benefit. Similar to the PDL, the Diabetic Supplies Program solicits bids for rebates from the manufacturers of blood glucose monitors and test strips. Additionally, market shift savings is generated by shifting the market from more expensive, non-preferred products, to less expensive, preferred products. During FFY 2019, the KY FFS program invoiced for $646,212 in supplemental rebates for preferred diabetic supplies. Retro DUR Magellan Medicaid Administration uses a cost savings model developed by the Institute for Pharmacoeconomics of the Philadelphia College of Pharmacy and Science to quantify cost savings. When fully applied, the cost savings model has the ability to capture not only savings that are a direct result of the RetroDUR letter intervention process, but also savings due to indirect effects. Indirect effects arise when a prescriber applies changes in prescribing triggered by a letter intervention involving one patient to other patients in his/her practice. The model also takes into account the impact of prescription drug inflation, new drugs introduced into the market, and changes in utilization rates, recipient numbers and demographics. The cost savings analysis in this report was calculated based on changes in the prescription drug costs for those patients whose profiles were identified through the RetroDUR program. Cost savings are tracked over a twelve (12) month period. Changes in prescription drug costs are totaled to yield overall cost savings for the review period. The RetroDUR cost savings during FFY 2018 is estimated to be $43,724. Monthly cost savings may vary due to a variety of factors, including: -the class selection and problem type chosen for review -intervention letter dissemination after the RetroDUR profile run and/or tracking through the First IQ system -the lag time before the next physician visit when changes in drug therapy may occur -the incremental educational and familiarity impact on the prescriber after receiving intervention letters Month-by-month cost savings for all active interventions (i.e. interventions which have not completed twelve (12) consecutive months of review/tracking) vary with intensity of intervention activity. Intervention letters sent during the fiscal year, have not all completed follow-up review for one year. Consequently, the cumulative cost savings effect of intervention letters mailed during FFY 2019 will not be known until after the end of FFY 2020.

State	Cost Savings/Cost Avoidance Methodology
	Overall Cost Avoidance and/or Savings During FFY 2019 the combined cost avoidance or savings generated by all of the above initiatives was estimated to be $69,373,684.
Louisiana	Prospective DUR methodology: Cost avoidance attributed to prospective DUR in FFY19 is $37,568,155. The analysis included all claims that generated clinical alert messages. All claims that were denied or reversed for clinical alert issues that were not paid by subsequent resubmission were identified. These claims were grouped by alert type and included in the cost avoidance calculations. Claims which were first denied due to the early refill edit then were subsequently paid as the early refill threshold was reached were included in the report based on the following methodology: Dollar cost per day of the medication multiplied by the number of days span between the date the claim was initially denied and the date of which the claim was subsequently paid. Retrospective DUR (LADUR) methodology: The sum of retrospective DUR interventions in FFY19 did not result in cost avoidance. Factors contributing to these results ($23,308 increased expenditures) include the small number of recipients in FFS, interventions recommending additional drug therapy, and increased drug costs despite decreased drug utilization. LADUR effectively assists in overall pharmacy cost containment. The approach to measurement of cost avoidance was based on several conservative premises. Only recipients reviewed in the LADUR process were included. No extrapolation was made to any other segment of the Medicaid population. Recipients excluded from the process include: 1) Recipients whose eligibility did not extend continuously from three months prior to the profile review meeting date through six months following the date of review. 2) Recipients who expired prior to the post review period. Only expenditures in pharmacy services were measured. No attempt was made to measure changes in professional services, hospitalization, or ancillary medical services. No factor was included to adjust for escalating prescription ingredient costs, utilization of high-priced new drugs or changes in drug mix to more expensive products in the follow-up review period. Data indicates that significant drug utilization pattern changes and reductions universally occur in prescribing and utilization patterns within six months following drug utilization review intervention. The cost avoidance methodology used in this report measured two periods. Period one: each recipient's drug cost per day was calculated in a three-month period prior to the LADUR review. Period two: each recipient's drug cost per day was calculated in a three-month period following the LADUR review. This interval allows time for physician intervention and follow-up claim data to appear on the history file. Lock-in Program methodology: Cost avoidance attributed to the Lock-in Program in FFY19 is $10,000. The estimated cost savings attributable to the FFS Lock-in Program was based on a review of Medicaid claims pre and post Lock-in enrollment. An estimated member month savings was determined based on a cohort of beneficiaries and multiplied by the number of Lock-in member months during FFY 2019.
Maine	Total cost savings are based off of aggressive management of the MaineCare Preferred Drug list through careful management of SMAC savings, lower of cost pricing of pharmacy claims, timely PDL management and strong SR negotiations to maximize lower program cost and maintaining excellent quality care choices. Savings include AWP savings from a calculated claim level and rather than looking at ProDUR or RetroDUR as reflections of cost avoidance since these claims may come in through prior authorization or changed to another medication of choice and captured through PDL savings estimates. We look at true cost avoidance through TPL cost avoidance which is included in the estimates below.
Maryland	MARYLAND MEDICAID PAGE 1

State	Cost Savings/Cost Avoidance Methodology

AS OF 2019-09-30 ACS PRESCRIPTION BENEFIT MANAGEMENT RUN DATE 12/23/2019

P R O S P E C T I V E D U R S A V I N G S
R A N K E D B Y A M O U N T P A I D
CLAIMS PAID FROM 2018-10-01 - 2019-09-30

GROUP:CAID MARYLAND - DIVISION OF ME DUR ALERTS SUMMARY

0 CC	DESCRIPTION	PAID CLM	PAID AMT	DENIED CLM	DENIED AMT	REVERSE CLM	REVERSE AMT	TOTAL SAVINGS
DD	DRUG-DRUG INTERACTION	1,621,902	182,462,227	0	0	168,907	24,371,348	$24,371,348
TD	THERAPEUTIC DUP (NOT D.0 USE)	683,843	93,136,570	0	0	81,504	14,018,967	$14,018,967
ID	INGREDIENT DUPLICATION	608,418	36,636,968	0	0	60,767	5,771,217	$5,771,217
ER	OVERUSE	49,894	8,072,241	123,045	19,906,220	2	55	$19,906,275
LD	LOW DOSE	82,093	5,261,367	0	0	12,181	1,142,433	$1,142,433
HD	HIGH DOSE	59,161	1,875,622	0	0	3,264	426,595	$426,595
PA	DRUG-AGE	11,818	292,943	0	0	1,121	35,082	$35,082
SX	DRUG-GENDER (NOT D.0 USE)	138	68,488	0	0	34	18,264	$18,264
0		3,117,267	327,806,429	123,045	19,906,220	327,780	45,783,965	$65,690,185
0	SUMMARY LINE ALL CONFLICTS	2,344,997	271,962,182	123,045	14,269,528	252,402	37,575,991	$51,845,520

0 PLEASE NOTE:

1. A CLAIM IS COUNTED AS DENIED ONLY IF IT IS NOT FOLLOWED BY A PAID CLAIM FOR THE SAME INDIVIDUAL/DATE OF SERVICE/DRUG COMBINATION.
2. A CLAIM IS COUNTED AS REVERSED ONLY IF IT HAS BEEN REVERSED WITHIN 24 HOURS (A SAME DAY REVERSAL).
3. A DENIED CLAIM IS COUNTED AS DENIED ONLY ONCE IF FOLLOWED BY MULTIPLE DENIES FOR THE SAME INDIVIDUAL/D O S/DRUG COMBINATION.
4. SAVINGS ATTRIBUTABLE TO EARLY REFILL (ER) ARE PRIMARILY COSTS DELAYED. IN OTHER WORDS, APPROXIMATELY 80% OF ER CLAIMS GO ON TO BE FILLED AFTER WAITING A FEW DAYS. THEREFORE, ER SAVINGS ARE CONSERVATIVELY CALCULATED AS 20% OF THE CLAIMS THAT HIT ER (AND DO NOT GO ON TO BE FILLED LATER).
5. A CLAIM REVERSED FOR LOW DOSE (LD) WAS CONSIDERED SAVINGS, BECAUSE THE PRESCRIPTION WAS NOT DISPENSED IN AN INEFFECTIVE DOSE.
6. THIS REPORT ONLY USES CONFLICT CODES ASSOCIATED WITH ACTUAL SAVINGS. CONFLICT CODES INCLUDED IN SAVINGS CALCULATIONS ARE:

--DC, DD, ER, GA, HD, ID, LD, LI, MC, MX, PA, PG, SX, TD--

Retrospective DUR Cost Savings Methodology

To determine the impact of the intervention letters on overall drug expenditures, total drug utilization (claims for all drugs) in the targeted population was evaluated 6 months before and 6 months after intervention letters were mailed. Total drug utilization was evaluated since a complete drug history was

State	Cost Savings/Cost Avoidance Methodology
	included with the educational intervention letters and prescribers could make changes to the entire drug regimen, in addition to the drugs noted in the letter. For a participant to be included in the analysis for cost avoidance, they had to have at least one claim for any drug during the pre-intervention time period and at least one claim for any drug during the post-intervention period. Patients who had no claims data during the post intervention period were not included in the cost savings analysis. The total drug cost measured was based on the amount reimbursed to the dispensing pharmacy. For those participants who were selected for more than one intervention, drug utilization was calculated before and after each intervention. Each intervention represents a specific participant case. See Table below for calculation of estimated cost avoidance. There are some limitations of the analysis, one is that no continuous eligibility data was available to determine whether participants maintained eligibility for Medicaid for the full 6 months before and after intervention letters were mailed. Therefore, the reduction in drug utilization and expenditures could be effected by multiple factors. Another limitation to cost-savings estimates relates to the type of interventions performed. Many retrospective interventions target non-adherence or underutilization of medications leading to increased use of medications hence the increased expenditures. Cost avoidance estimates are based on total drug expenditure as calculated by the reimbursed amount paid to the dispensing pharmacy. This does not include any federal or supplemental rebates. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR program. However, it is suspected that by reducing potentially inappropriate use of medications and alerting prescribers to drug therapy concerns, other associated medical costs would be reduced in addition to the reduction in drug expenditures. Intervention Group Change between 6 Month Pre- and Post- $812,465 Comparison Group Change between 6 Month Pre- and Post- $188,430 Estimated Cost Savings $624,035
Massachusetts	MassHealth CMS DUR Report FFY 2019 Cost Avoidance Methodology To calculate cost avoidance, prescription denials for FFY2019 were analyzed. Because a prescription can be denied multiple times at the point of service (POS), unique MassHealth utilizers rather than claims were used to count claim denials. MassHealth has a prescription duration limit of 30 days for most drugs, and most prescriptions are for 30 days. Therefore, every member with a claim in a month for any drug was counted as one denial for that drug in that month. Drugs were classified by ingredient, strength, and dosage form using the First DataBank Generic Sequence Number (GSN). They were also divided into brand and generic using fields S, N, I as defined on the NDC extract file provided by CMS (see Table 2 of this survey). Drug category N Non-innovator Multiple-Source was used for generic drugs as in Table 2, and categories S (Single-Source) and I Innovator Multiple-Source were grouped together as brand drugs. Average cost per claim for each drug + brand/generic classification was computed using MassHealth paid claims for FFY 2019. Third party claims, and drugs not classified by CMS were not included in the computation. This cost avoidance calculation was restricted to denied claims with utilization review and early refill rejections. This includes NCPDP reject codes 75 (Prior Authorization Required), 79 (Refill Too Soon), and 88 (DUR Reject Error). Third party claims were not included. The amount that would have been paid for these claims was calculated, and then the presumed cost after utilization review was subtracted from this total. Reject Code 75 (Prior Authorization Required)

State	Cost Savings/Cost Avoidance Methodology
	The Drug Utilization Review Program reviews all prior authorizations (PAs) for prescription drugs. In this analysis, percentages of prior authorizations approved and denied for each drug by GSN were used as a proxy for prescription disposition after denial. For each drug denied with reject code 75, the average cost per claim (brand and generic) was computed using paid claims for FFY 2019. Subsequent member prescription history was estimated using First DataBank therapeutic classes. Each GSN was matched with the least costly GSN in its therapeutic class to represent the least costly alternative (LCA). To estimate potential cost avoidance, the following formulas were used: For each drug: Number of denied claims = Total denied claims by member count X prior authorization denial rate Cost savings = Number of denied claims X (average cost per claim minus cost of LCA) To estimate cost avoidance for the year, the totals for each month were multiplied by the number of months remaining in the year. Reject Code 88 (DUR Reject Error) The Drug Utilization Review Program reviews a proportion of reject code 88 denials through its call center. The percentages of reject code 88 denials approved and denied through phone submissions was computed. Then the same formulas used above for reject code 75 were applied. For each drug: Number of denied claims = Total denied claims by member count X phone override denial rate Cost savings = Number of denied claims X (average cost per claim minus cost of LCA) To estimate cost avoidance for the year, the totals for each month were multiplied by the number of months remaining in the year. Reject Code 79 (Refill Too Soon) The Drug Utilization Review Program monitors early refill percentages and administers emergency early refill overrides through its call center. Early refill thresholds for MassHealth are 80% for nonscheduled drugs and 85% for scheduled drugs. For MassHealth early refill denials, the average percent of days used was determined to be 51% for nonscheduled drugs and 64% for scheduled drugs. Using a pickup time estimate of 85% for nonscheduled drugs and 90% for scheduled drugs, the percent of days' supply avoided was calculated at 85% - 51% = 34% of days' supply for nonscheduled drugs, and 90% - 64% = 26% of days' supply for scheduled drugs. For each drug: Cost savings = Total denied claims by member count X average cost per claim X % of days' supply avoided Totals were calculated as a one-time savings for each member and month. Hepatitis C Prescriber Outreach on Hepatitis C Prior Authorization Requests - Projected Cost-Avoidance Cost-avoidance projections Following the Food and Drug Administration (FDA)-approval of Sovaldi (sofosbuvir) and Olysio (simeprevir) in late 2013, all prior authorization (PA) requests for hepatitis C regimens have been reviewed by Drug Utilization Review (DUR) to promote selection of the most cost-effective regimen. Several other products, Harvoni (ledipasvir/sofosbuvir), Viekira Pak and Viekira XR (ombitasvir/paritaprevir/ritonavir and dasabuvir), Technivie (ombitasvir/paritaprevir/ritonavir), Mavyret (glecaprevir/pibrentasvir), Daklinza (daclatasvir), Epclusa (velpatasvir/sofosbuvir), Vosevi (sofosbuvir/velpatasvir/voxilaprevir), and Zepatier (elbasvir/grazoprevir) were also included in the prescriber outreach to discuss treatment alternatives following their FDA-approvals.

State	Cost Savings/Cost Avoidance Methodology
	At the time PA request for one of the above products is received by the DUR, a clinical pharmacist may contact the prescriber to discuss an alternative, more clinically appropriate or more cost-effective regimen. If the prescriber agrees to switch the member to the suggested regimen, prescriber may resubmit the PA request for that regimen and receive an approval. In order to estimate cost-avoidance generated from switching members to alternative regimens, members were included in the analysis if a regimen change facilitated by the DUR pharmacist led to a virologic cure. Cost-avoidance is calculated as the difference between the cost of the initially requested regimen and the cost of the recommended and approved regimen. Additional costs that may have been incurred whenever a more a clinically appropriate, but not necessarily less costly regimens were recommended by the DUR pharmacist to the prescriber are included. Limitations: Cure rates from treatment with the initially requested and subsequently approved pharmacist-recommended regimen were assumed to be equal. Thus, cost-avoidance may be higher when adjusting for higher expected cure rates with the pharmacist-recommended regimen. While additional cost may have been incurred from extension of treatment duration, additional cost-avoidance is likely to have been generated from improved cure rates in these members.
Michigan	ProDUR cost avoidance for the Michigan Medicaid prescription drug program is the sum of the claims that were reversed or denied and not resubmitted. Cost Avoidance for paid claims is calculated by taking the dollar amount of paid claims with a ProDUR message that were subsequently reversed and subtracting the paid amount of the claims that were resubmitted within 72 hours. Cost Avoidance for denied claims is calculated by taking the submitted dollar value of the claims that were initially denied that had a ProDUR message and subtracting any of those claims that were then resubmitted within the same calendar month that paid. The DUR Board continually monitors prescribing patterns and drug appropriateness through trend analyses. No RetroDUR intervention letters were sent to prescribers during FFY 2019; however, new edits were implemented to manage the use of opioids and gabapentin. The DUR Board also oversees the specialized academic detailing program, WholeHealthRx, that targets the prescribing practices for behavioral health medications through intervention letters and face-to-face consultations. The program's evaluation methodology monitors for continuous enrollment for the targeted beneficiaries. Beneficiaries with no claims during the post intervention period are excluded for the analysis. A cross-sectional analysis compared the pharmacy spend six months pre- and post-evaluation. The consultation date served as the index date. Consultations were conducted between December 2018 and April 2019. A total of 1,476 prescribers of 11,951 distinct beneficiaries were targeted. The program measures the success in closing gaps in care for the targeted intervention. The interventions during this period ranged from 45% to 68% of gaps in care closed. The estimated cost savings generated from these interventions was $1,690,393.
Minnesota	The five areas included are prospective drug utilization review (ProDUR) edits, the refill too soon hard edit, the Minnesota SMAC (state maximum allowable cost) program, prior authorization of brand name drugs, and the retrospective drug utilization review (RetroDUR) program. This does not include savings from uniform Preferred Drug List (PDL) or from the Specialty Pharmaceutical Reimbursement Rate. Prospective DUR

State	Cost Savings/Cost Avoidance Methodology
	The Minnesota Department of Human Services (DHS) on-line prospective drug utilization review program (ProDUR) moved into production in MMIS II on February 27, 1996. On August 6, 1996, the first DUR edit, for overutilization, was set to deny. Additional edits were set to deny over the next year. For FFY 2019, the gross calculated allowable reimbursement amount for claims denied by ProDUR edits minus amounts that would have been paid by third party liability was $117,614,780. However, the gross amount does not take into account factors such as claim resubmissions and changes in the drug prescribed. In 1996, the Reports and Forecasts Division developed a method to estimate actual savings attributable to the ProDUR Program. Using this method estimated actual savings is in the range of $24,000,228 to $64,457,243. Refill too soon hard edit On January 22, 2004, there was a significant change in ProDUR edits. The refill too soon edit became a hard edit where claims are stopped if less than 75% of the previous prescription was utilized for non-controlled substances and 85% for controlled substances. Pharmacy providers now have to call the provider help desk in order to obtain an override where previously, the pharmacy providers only needed to enter an online DUR reason code and resend the claim. Reasons to allow the provider help desk to override the refill too soon were developed by the pharmacy policy area. The gross calculated allowable reimbursement amount for claims less TPL (third party liability) denied with the refill too soon edit was $47,578,599. Out of 434,991 denied claims, only 1,561 (0.4%) were given overrides by the provider help desk. The amount paid for claims with an override for refill too soon less TPL totaled $1,050,990 with an estimated savings in the range of $11,864,101 to $37,731,120 for the refill too soon edit. Minnesota State Maximum Allowable Cost (SMAC) program Beginning June 1, 2011, Change Healthcare entered into a contract with Minnesota Department of Human Services to provide suggested SMAC prices. The Minnesota SMAC programs total cost avoidance compared to the Federal Upper Limit (FUL) pricing was -$8,036,159. The value for FFY 2019 is negative because of the legislative change in FFS reimbursement methodology effective July 1, 2019. Ingredient cost reimbursement was changed to the CMS National Average Drug Acquisition pricing, NADAC-brand and NADAC-generic pricing. When NADAC pricing is not available, the ingredient price is based on the lower of SMAC or WAC-2% (WAC is the wholesaler acquisition cost). NACAC pricing is significantly lower the previous SMAC pricing. Specialty Pharmaceutical Reimbursement Rates continue to be provided by Change Healthcare. Prior authorization of brand name drugs To further encourage the use of generics, legend, brand name drug prescriptions require prior authorization in addition to the prescriber writing DAW-brand name necessary. This requirement became effective January 1, 2004. Administratively, this edit is tied to the NADAC-generic or, if none, then the Minnesota State Maximum Allowable Cost Program (SMAC) price fields. If there is a pricing value in either of these two fields, then Brand name drugs will pay according to values in those two fields. Only obtaining a prior authorization for DAW-brand name necessary will allow the claims to pay either the NADAC-brand or, if none, then the WAC-2%. Therefore, using prior authorization along with the SMAC program continues to provide a high rate of generic utilization within the SMAC program of 99%. Retrospective DUR

State	Cost Savings/Cost Avoidance Methodology
	During FFY 2019, there were six population-based DUR mailings. The DUR Board reviewed Conduent's population-based proposals and provided their recommendations to the criteria, letter content, and educational material. To determine cost savings, only those patients are who still eligible in the post intervention period are included. Drug costs include only targeted intervention drug costs, not all drug costs. Cost outcomes were available for (1) the Psychotropic Drugs in Adults which showed costs decreased by $853,626 (2) Polypharmacy which showed costs decreased by $2,280,795 (3) Psychotropic Drugs in Youth #1 showed costs decreased by $775,035 (4) PPI's which showed costs decreased by $91,493 and (5) Diabetes which showed costs increased by $383,785 and (6) Psychotropic Drugs in Youth #2 which showed costs decreased by $418,692. Therefore, the total RetroDUR intervention cost effect was a reported decrease of $4,035,856 in drug expenditures minus the amount of $120,000 paid per year to the RetroDUR contract resulting in a decrease of $3,915,856. Using this value, an estimated RetroDUR savings range is $977,006 to $2,613,050.
Mississippi	The prospective DUR cost savings estimate provided by Conduent was generated by summing all claims that post a DUR reject error, NCPDP reject code 88, during the 2019 Federal Fiscal Year (October 1, 2018- September 30, 2019). Conduent The ProDUR Total Estimated Avoided Cost was obtained by getting totals for the time period: 1. totaling the claims with ProDUR alerts that were denied: $23,645,046.71 2. totaling the claims with ProDUR alerts that were overridden: $ 6,482,019.35 3. subtracting the overridden claims from denied claims: $17,163,027.36 Prospective Total Estimated Avoided Costs $17,163,027.36 During FFY 2019 our retrospective DUR (retroDUR) program educational and intervention activities were targeted at promoting better use of preferred products, early notification of providers about policy changes in order to avoid disruptions in treatment, and improvement on national quality measures. The retroDUR vendor continued educational efforts where most of our exceptions monitoring and intervention activities are directed at improving performance on pharmacy quality measures relevant to the Medicaid population. Additionally, Mississippi Division of Medicaid Complex Pharmacy Care (CPC) program was impactful in achieving substantial cost savings of $1,846,162.62 during the Oct 1, 2018 - Sept 30, 2019 federal fiscal year. Thus cost avoidance was realized from a pharmacist's interventions addressing adherence issues identified, needed dose modifications, potential drug interactions, patient eligibility and/or health plan changes within Medicaid, ineffective duplicate therapy and billing errors. The interventions made were by the CPC pharmacist through medical and pharmacy provider as well as patient contacts. Change Healthcare Other Cost Avoidance $1,181,543.23
Missouri	For each Retrospective Drug Utilization Review that is performed there are members and prescribers identified with performance indicators. These indicators are suggestions that medical and pharmaceutical care can be improved by changing prescribing habits. These may include Drug-Drug Interaction, Medication Adherence, Underutilization, Overutilization, Coordination of Care and Risk of Adverse Drug Event. We mail on a specified date. When we have six-months of data following the mailing we then analyze utilization for the targeted members use of intervention drugs identified. From this we determine the

State	Cost Savings/Cost Avoidance Methodology
	targeted members PMPM (per-member-per-month) costs for the six-months prior to mailing (the pre period) and for the six months following the mailing (post period). Subtracting the post period PMPM from the pre period PMPM provides the savings per member per month for the target members. This is multiplied the number of member-months that the targeted members had in the post period. This gives us projected cost savings for the six-month period following the mailing. We then multiply this by two to obtain the annualized savings (cost avoidance) provided by each individual Retrospective Drug Utilization Review. These are summed to provide the total cost avoidance (Savings) for the entire RetroDUR program. For the ProDUR Total Estimated Avoided Costs we evaluate the cost of each medication rejected at point of sale. These claims are then deduplicated to remove double counting for prescriptions that were rerun and denied again. If the claim is rerun within 7 days it is not counted as a savings. We then evaluate if the participant received another medication in the same therapeutic class within 7 days. If the participant received another medication in the same therapeutic class within 7 days the cost of the new medication is deducted from the savings of the original denied prescription.
Montana	ProDUR--Prior Authorizations Total PA Requests 70652 / Approved 30752 / Denied 30259 / Denial Rate 50% / Non-Clinical Rate 13.63% / Total savings $24,820,920 Case Management--Other Cost Avoidance Total Cases Reviewed 2869 Total Clinical Interventions 2435 cost savings assigned 534 cost savings unable to determine 1901 Selection Method PA 209 CM 2220 Other 6 Contact Type MD 799 RN 942 RX 279 PA 176 NP 375 Other 546 Outcome Per Plan 2701 Other Change 127 No change 14 Drug DC 1 Dose Change 0 Drug Change 0 Compliance Noted 4 Labs Complete 3 Pending Response 483 Not Specified 3

State	Cost Savings/Cost Avoidance Methodology
	Criteria Narcotic Overuse 5 Multiple Meds 10 Multiple Pharm/MDs 34 Team Care 83 Suboxone 169 PA required 73 Cash for Meds 3 Narcotics 2 Med Overutilization 1 Medication Compliance 0 Clinical-General 412 Academic Detailing 69 Hep C 859 Fraud Refer to DPHHS 18 Abuse Refer to DPHHS 9 Foster Care Psychotropics 354 Atypical Antipsych </= 645 DPHHS High Use 0 MME 239 Team Care Referral 8 CF 8 Drug Not Covered 8 HAE 3 ITP 1 Movement Disorders 5 Potential Clinical Abuse or Misuse 1 Drug Recommendation Request 1 Overutilization 1 PA Requests Higher Level Clinical 8 Therapeutic Appropriateness 1 Therapeutic Duplication 1 Sublocade 3 Eosinophilic Asthma 1 Total in Progress 631 Total Completed 2238 Operational Monthly Cost Savings* $ 5,941 CM Monthly Cost Savings $ 1,458,969 Annualized CM Cost Savings $ 17,507,625 Total YTD Cost Savings $ 17,513,566 *Operational Cost-Savings: Identified by inappropriately paid claim and not attributable to a standard CM intervention Analysis Methodology for RetroDUR

State	Cost Savings/Cost Avoidance Methodology
	Each month, pharmacy and medical claims data are reviewed against a library of clinical criteria. Once members have been identified and RetroDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. Beneficiary Selection: A total of 358 members met the criteria for intervention letters during FFY 2019. Estimated Cost Savings Methodology To determine the impact of RetroDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RetroDUR intervention letters. The comparison group consisted of a random group of members who were not chosen for RetroDUR intervention letters. For a member to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, members were analyzed using 180 days of claims data before and after the RetroDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RetroDUR intervention letters. Members were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RetroDUR interventions on the same member within FFY 2019). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Estimated Cost Savings Analyses Results For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug expenditures and claims for the six months prior to and six months after intervention. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RetroDUR criteria. Educational interventions were completed with providers during federal fiscal year 2019 (FFY 2019). The drug claims for the selected members were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RetroDUR interventions. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2018 and September 30, 2019, there was an estimated cost savings of $135,932. Intervention Group Comparison Group Estimated Cost Savings Change between 6 month Pre and Post Change between 6 month Pre and Post

State	Cost Savings/Cost Avoidance Methodology
	All Interventions $131,082 negative $4,850 $135,932 Drug Therapy Problem Distribution Therapeutic Appropriateness 57% Drug-Drug Interactions 24% Drug-Disease Interactions 18% Over-Utilization 1%
Nebraska	SUMMARY 5 - COST SAVINGS/COST AVOIDANCE METHODOLOGY ProDur Cost Avoidance Calculations Attachment 5: The Paid Claim Savings are the savings that occurs when the pharmacy reverses a claim (in theory based on the ProDUR edit it hit) and then does not resubmit it. "Internal Claim Reversal Resubmit Savings Provider ID" NPI Count Amount Count Amount Count Amount Amount Total 6,725 $278,443.51 767 $45,704.62 294 $25,976.91 $19,727.71 The Denied Claims Savings are those claims that denied for a ProDUR edit and the pharmacist does not override it. The claim remains denied. "Internal Claim Resubmit Savings Provider ID" NPI Count Amount Count Amount Amount Total 26,993 $933,000 3,022 $346,000 $587,000 _____ ProDur Cost Avoidance Paid Claims (Reversed and Not Resubmitted) + Denied Claims (Not Resubmitted) ProDur Cost Avoidance Calculations Paid Claims Denied Claims Reversed and Not Resubmitted plus Not Resubmitted = Cost Avoidance $19,727.71 + $587,000 = $606,727.91
Nevada	OptumRx calculates the ProDUR savings by summing the amounts on claims either reversed or denied due to a ProDUR edit. We understand these numbers will be inflated as there is no way to track if the medication was later filled again after consulting with the prescriber or patient or taken to a different pharmacy. The retro-DUR cost avoidance is the reduction of pharmacy paid amount for opioids after notifying the top 10 opioid prescribers. The spend decreased from $345,705 to $342,694 from first quarter 2019 to second quarter 2019 after the letters were sent creating a savings of $3,010.
New Hampshire	Magellan Health Services uses a cost savings model developed by the Institute for Pharmacoeconomics of the Philadelphia College of Pharmacy and Science to quantify cost savings. When fully applied, the cost savings model has the ability to capture not only savings that are a direct result of the RetroDUR letter intervention process, but also savings due to indirect effects. This indirect effect arises when a prescriber applies changes in prescribing triggered by a letter intervention involving one patient to other patients in his/her practice. The model also takes into account the impact of prescription drug inflation,

State	Cost Savings/Cost Avoidance Methodology
	new drugs introduced into the market, and changes in utilization rates, recipient numbers and demographics. ProDUR Cost Savings The cost saving for Prospective Drug Utilization is based on cost avoidance when claims are reversed and not resubmitted. For FFY 2019 cost savings for ProDUR $5,032,992.72. RetroDUR Cost Savings The cost savings analysis in this report was calculated based on changes in the prescription drug costs for those patients whose profiles were identified through the RetroDUR program. Cost savings are tracked over a 12-month period. Changes in prescription drug costs are totaled to yield overall cost savings for the review period. The RetroDUR cost savings including polypharmacy cost savings during FFY 2019 was $24,981.18. Table 4A New Hampshire Medicaid Program RetroDUR Cost Savings FFY 2019 New Hampshire Medicaid RetroDUR and PolyPharmacy Cost Savings Report Cycle FFY 2019 Std Therapeutic Description Cost Savings Amt Anti-Ulcer Preps $0.00 Ataractics-Tranquilizers $115.13 Muscle Relaxants $2,215.35 Cns Stimulants $7,183.08 Psychostimulants-Antidepressants $0.00 Antihistamines $0.00 Bronchial Dilators $0.00 Analgesics, Narcotic $955.62 Analgesics, Non-Narcotic General $0.00 Antiarthritics $14,243.05 Sedative, Non-Barbiturate $268.95 Anticonvulsants $0.00 Glucocorticoids $0.00 Diabetic Therapy $0.00 Other Hormones $0.00 Lipotropics $0.00 Hypotensives, Other $0.00 Vasodilators, Coronary $0.00 Cardiovascular Preparations, Other $0.00 Anticoagulants $0.00 Diuretics $0.00 Unclassified Drug Products $0.00 Total Savings $24,981.18 Monthly cost savings may vary due to a variety of factors, including: 1. the class selection and problem type chosen for review 2. intervention letter dissemination after the RetroDUR profile run and/or tracking through the First IQ system 3. the lag time before the next physician visit when changes in drug therapy may be made 4. the incremental educational and familiarity impact on the prescriber after receiving intervention letters

State	Cost Savings/Cost Avoidance Methodology
	Month-by-month cost savings for all active interventions (i.e. interventions which have not completed twelve consecutive months of review/tracking) vary with intensity of intervention activity. Intervention letters sent during the fiscal year, have not all completed follow-up review for one year. Consequently, the cumulative cost savings effect of intervention letters mailed during FFY 2019 will not be known until the end of FFY 2020. Maximum Allowable Cost (MAC) Program The New Hampshire MAC program determines a maximum allowable cost Medicaid will reimburse pharmacy providers for generic medications. The cost savings is determined by re-pricing the claim paid at MAC as if the MAC price was not established. The New Hampshire MAC program cost savings during FFY 2019 was $88,758.35. Dose Optimization Program The New Hampshire Dose optimization program promotes the use of commercially available dosage forms for fewer tablet and cost effective drug utilization when pricing across dosage forms are similar. The New Hampshire Dose Optimization cost savings during FFY 2019 was $28,313.44.
New Jersey	The New Jersey Division of Medical Assistance and Health Services conducts an on-going analysis of cost savings resulting from the PDUR program. Contributing to this analysis is output from a denied claims report that assesses pharmacy claim activities after PDUR edits have denied initial payments. PDUR interventions manifest themselves in two ways. The first is through PDUR responses returned to pharmacies by the point-of-sale system. In these situations, the pharmacist makes a decision to intervene with the patient and/or practitioner to resolve the PDUR issue. These types of interventions are referred to as having a sentinel effect. Typically these types of interventions result in a PDUR service continuing to be denied or a change in medication or dosage. The second type of PDUR intervention involves the Medical Exception Process (MEP). Certain PDUR edits are set to deny payments without prior authorization. In either situation, the PDUR edits have identified reasons for denying payment without some type of intervention. In order to appreciate the cost savings from these PDUR interventions, a production report (see below) is in place that analyzes claim activities sixty (60) days after a pharmacy service has been denied payment due to a PDUR edit. Cost savings identified in the report reflect costs for PDUR claims denied by a PDUR Edit for which no future paid claims were identified for the 60-day period following the date of denial. The reported cost savings is limited to the absence of a payment for a single PDUR claim. Extrapolated savings are not reflected in this report. The analysis is also performed at the Generic Code Number (GCN) level to capture claim information for all drugs with the same description, strength and route of administration. MEDICAID PDUR SAVINGS* - Total Denied Claims (Nursing Home and Retail Combined) from reruns of report ID Q2862R01 Quarter/CY Year Total Amount 4th quarter 2018 $2,057,864 1st quarter 2019 $2,669,761 2nd quarter 2019 $2,072,299 3rd quarter 2019 $2,023,601 Grand Total $8,823,525 *Note: Reported cost savings may vary due to changes in drug therapy, such as the prescribing of a different drug or drug dosage.

State	Cost Savings/Cost Avoidance Methodology
New Mexico	Prospective DUR Savings Ranked by Amount Saved for Paid Date Range October 1, 2018 through September 30, 2019 Conflict Code Description # of Pd Claims Pd Amt # of Den Claims Den Amt Pd Rev Claim Rev Amount Total Savings DD DRG-DRG INT 45,088 $4,192,022 0 $0 5,132 $972,609 $972,609 TD THER DUP 25,845 $4,268,658 1,689 $278,227 4,128 $1,117,303 $1,395,535 ID INGRED DUP 20,266 $1,626,358 0 $0 2,718 $361,198 $361,198 LD LOW DOSE 6,341 $1,778,466 0 $0 789 $593,283 $593,283 ER OVERUSE 4,685 $556,500 2,747 $330,161 2 $50 $330,212 HD HIGH DOSE 3,515 $1,112,674 140 $45,314 754 $426,223 $471,544 PA DRG-AGE 333 $58,131 0 $0 62 $26,144 $26,144 PG DRG-PREG 134 $2,056 0 $0 6 $92 $92 SX DRG-GEN 77 $1,114 0 $0 5 $222 $222 Summary Line 106,284 $13,595,979 4,576 $653,702 13,596 $3,497,124 $4,150,839 Retro DUR Intervention Savings per Targeted Member per Month Projected FFY19 Savings Opioid Prescribing Newsletter N/A $80,412.05 Codeine and/or Tramadol in Youth Intervention $1.89 $974.02 Multiple Second Generation Antipsychotics $134.67 $54,944.86 Total N/A $136,330.93%u202c
New York	ProDur cost savings/cost avoidance is calculated by the Department of Health (DOH). It is determined by calculating the number of ProDUR edit override rejections encountered by pharmacists and multiplying that by the average cost per claim. There was a total of 1.7 million rejected pharmacist override attempts for FFY 2019. Cost per claim was determined by dividing the total claim expenditures (less rebates) by the number of claims for FFY 2019 which yielded a cost per claim of $30.58. Total estimated cost savings/avoidance from the ProDUR Program amounted to $53.1 million dollars.

State	Cost Savings/Cost Avoidance Methodology
	Retro DUR savings is determined by the contracted vendor, Health Information Designs (HID). Total savings was calculated at $2.3 million. Rebate amounts were not included since the vendor does not have access to that data. To determine the impact of RetroDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RetroDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RetroDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RetroDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RetroDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RetroDUR intervention letters on the same recipient within FFY 2019). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Other cost savings/avoidance were achieved during the State's Fiscal Year (SFY) 2018-2019. Cost savings/avoidance for the Preferred Drug Program totaled $8.1 million, the Brand less than Generic Program $4.3 million and savings attributed to the Lock-in Program $7.8 million.
North Carolina	2019 Estimated Savings: ProDUR $ 458.07 million RetoDUR $ 0.0 PA $ 16.76 million PDL $ 119.33 million TOTAL $ 594.16 million ProDUR = Prospective Drug Utilization Review RetroDUR = Retrospective Drug Utilization Review PA = Prior Authorization Program (other than PDL) PDL = Preferred Drug List Program (includes Supplemental Rebates) The ProDUR Cost Avoidance is calculated from the saving of not dispensing prescriptions that denied due to a Pro-DUR edit being applied to the claim. Period Cost Saving Reversals Non-responses Oct 2018 to Sep 2019 $458,069,294 1,791,324 1,842,128 The RetroDUR Savings are calculated from the Retro-DUR activities described in Section III of the Annual Report. Although the DUR Board was active in reviewing and monitoring drug usage, no action was taken during the year that would create cost savings. Period Cost Savings Oct 2018 to Sep 2019 $0

State	Cost Savings/Cost Avoidance Methodology
	The PDL Savings are the sum of the Supplemental Rebates collected as well as the Market Shift caused by the PDL. The calculations were provided by Magellan Medicaid Administration. Period — Supplemental Rebate and Market Shift 2018 Q4 — $27,189,685 2019 Q1 — $30,557,826 2019 Q2 — $33,076,730 2019 Q3 — $28,505,545 Oct 2018 to Sep 2019 — $119,329,786 The PA Cost Avoidance is calculated by the cost of drugs requiring Prior Approval when the requests were denied. The savings calculated were for drugs not on the PDL. Period — Cost Savings Oct 2018 to Sep 2019 — $16,757,076 The State of North Carolina contracts with Myers and Stauffer to provide reports on Program Evaluation and Cost Savings/Avoidance. However, at the time of this Annual Report, the reports were not complete. Calculations here are provided by the fiscal agent, GDIT, and their contractor, Magellan.
North Dakota	Summary: The cost savings report was prepared by Health Information Designs, LLC for the North Dakota Medicaid Program to illustrate the expected estimated cost savings from their retrospective drug utilization review (RDUR) program and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2019 (FFY 2019). The drug claims for the selected recipients were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2018 and September 30, 2019, there was an estimated cost savings of $1,545,834. During FFY 2019, HID reviewed 2,967 recipients with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Analysis Methodology: Each month, HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once recipients have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends. The methodology is validated by independent third party. Estimated Cost Savings Methodology: To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted

State	Cost Savings/Cost Avoidance Methodology
	intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same recipient within FFY 2019). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Estimated Cost Savings Analyses Results: For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed. During this time, the intervention group consisting of single interventions and the intervention group with multiple interventions experienced an estimated cost savings of $1,117,777 and $108,800 respectively. During this time period, the 2 comparison groups experienced a cost increase of $337,970 (-$337,970 in cost savings) and a cost savings of $18,713. Subtracting the estimated cost savings of the comparison groups (-$319,257) from the estimated cost savings from the intervention groups ($1,226,577) resulted in a total estimated cost savings of $1,545,834. Further analysis found the intervention group had a decrease of 12.96% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 14.62%. These changes resulted in an estimated cost savings of $521.01 per recipient who received an RDUR intervention during FFY 2019. Results Discussion: All drug claims and some medical claims or diagnosis data is available for analysis, and all medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each recipient. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems, including inappropriate use of drugs and increased risk for drug interactions, other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion: The RDUR program provides an important educational service to providers enrolled in the North Dakota Medicaid Program. During FFY 2019, 2,967 recipients were identified for RDUR intervention letters. The RDUR intervention program alerted the recipient's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $1,545,834 for FFY 2019.
Ohio	Claims reversed with a Pro DUR Reason Code that are not subsequently rebilled REVERSAL REASON SCRIPTS SAVINGS DD 61,750 $9,218,026 DD, HD 1,565 $524,480 DD, HD, LD 7 $393 DD, HD, LD, TD 7 $2,354

State	Cost Savings/Cost Avoidance Methodology
	DD, HD, TD 457 $153,059 DD, LD 4,010 $505,909 DD, LD, TD 844 $114,053 DD, TD 19,145 $2,394,688 HD 11,735 $3,068,076 HD, LD 7 $149 HD, LD, TD 2 $537 HD, TD 706 $345,658 LD 24,131 $3,298,986 LD, TD 2,091 $289,689 TD 23,033 $5,492,382 TOTAL 149,490 $25,408,438 Claims rejected with DUR Code 88 that are not subsequently accepted DUR 88 - Hard Rejects 70,369 $3,924,152 Total Pro DUR Cost Savings 219,859 $29,332,590
Oklahoma	The ProDUR savings calculation included for this federal fiscal year focused on three high cost avoidance categories: Early Refill Denials, Ingredient Duplication Denials, and High Dose Denials. Other Cost Avoidance savings includes the savings generated from our state maximum allowable costs and our avoidance on claims that require step therapy and/or have clinical PA criteria. For our Product Based Prior Authorization (PBPA) program savings, we took the average cost per claim for those drug products and multiplied that by the number of members who received a denial to obtain the cost avoidance. We subtracted the cost of the PMC contract to get a net savings.
Oregon	ProDUR Methodology: Claims that trigger ProDUR alerts are not always denied. The pharmacist will receive a denial for early refill or pregnancy alerted claims, but does not receive a denial when entering a claim that triggers any other informational alerts. Instead, the pharmacist receives an informational alert message that may help them make decisions about dispensing the drug. After receiving a denied ProDUR alert or an informational alert, the pharmacist may choose to override the alert, cancel the claim, resubmit a different claim, or take no action. The cost savings due to claims that were not dispensed because of these alerts is defined as being cancelled and then not being reprocessed again at a later date. RetroDUR and Cost Avoidance Methodology: The DURM group created a cost-avoidance methodology designed to conservatively estimate cost avoidance and avoid common overestimations. The methodology calculates savings by considering the ultimate therapy received by the member and the duration of cost avoidance. When payment for a claim is denied for PA required or non-preferred status, all subsequent claims (paid and denied) for the member within the drug class are monitored. Cost Avoidance is calculated based on the initial claim (index event) and the final disposition of therapy within the drug class for a member. The types of cost avoidance are: deferred, therapeutic duplication, switched, add-on, discontinued, and other. Each cost avoidance type has a distinctive calculation for the duration of cost avoidance and the amount saved, based on the most likely clinical treatment pathway. Deferred cost avoidance includes claims for which the requested therapy is eventually approved and savings are calculated based on the time from the initial request to the first paid claim. Therapeutic duplication cost avoidance is calculated when a drug is denied when there are already paid claims for an alternative in the same drug class.

State	Cost Savings/Cost Avoidance Methodology
	Switch cost avoidance covers situations when a restricted access drug (PA required or non-preferred) is denied, but an alternative within the PDL class is subsequently paid. The difference in cost between the initial drug requested and the actual drug dispensed is the cost avoided. Add on therapy is calculated when a drug is denied when there are already paid claims for an alternative that treats the same condition. There are limitations to the cost avoidance methodology. The method is dependent upon detecting a denied claim. Members new to the Medicaid program or newly marketed medications are examples of situations that make it more difficult to adequately track and model potential savings. However, providers who have learned the FFS Medicaid PDL (or have learned to consult it) will prescribe preferred and unrestricted medications without first generating a denied claim for a drug requiring prior authorization. These types of long-term behavior modifications represent significant cost saving for the FFS program but are difficult to reliably quantify. Another limitation of the methodology occurs at the beginning and end of the reporting periods. Only costs avoided due to an initial denied claim during the reporting period are included. When an index event occurs immediately before the reporting period, there are savings associated with that event which are not summarized in the report. Likewise, when the initial denied claim occurs immediately before the end of the reporting period, the costs avoided after the end of the reporting period are not included. Significant savings go undetected with the methodology in the interest of conservative reporting. The methodology may also potentially inflate savings. For example, assuming a denied claim for a chronic medication would have continued to be filled throughout the reporting period, or until the member dis-enrolled could overestimate savings resulting from the intervention. Brand over Generic: Select brand name medications are preferred over their generic alternatives when the net cost has been determined to provide substantial Cost Savings to the program.
Pennsylvania	The activities of the RDUR program resulted in an increase in expenditures of $35,314.29*, equating to an increased cost of 4 cents* for every $1.00 of combined federal and state dollars spent administratively on the RDUR program. Program Evaluation/Cost Savings Estimates Pennsylvania Medicaid RetroDUR Annual Report FFY 19 Problem-Focused Profile Review: Suggestions Made 7,334 Therapy Changed 2,875 Impact Rate 39.20% Cost Savings Estimates: Dollars Saved per Patient Evaluated -$7.00 Dollars Saved on Medication -$35,314
Rhode Island	Retrospective DUR Cost Savings Methodology To determine the impact of the intervention letters on overall drug expenditures, total drug utilization (claims for all drugs) in the targeted population was evaluated 6 months before and 6 months after intervention letters were mailed. Total drug utilization was evaluated since a complete drug history was

State	Cost Savings/Cost Avoidance Methodology
	included with the educational intervention letters and prescribers could make changes to the entire drug regimen, in addition to the drugs noted in the letter. For a recipient to be included in the analysis for cost avoidance, they had to have at least one claim for any drug during the pre-intervention time period and at least one claim for any drug during the post-intervention period. Patients who had no claims data during the post intervention period were not included in the cost savings analysis. The total drug cost measured was based on the amount reimbursed to the dispensing pharmacy. For those recipients who were selected for more than one intervention, drug utilization was calculated before and after each intervention. Each intervention represents a specific recipient case. See Table below for calculation of estimated cost avoidance. There are some limitations of the analysis, one is that no continuous eligibility data was available to determine whether recipients maintained eligibility for Medicaid for the full 6 months before and after intervention letters were mailed. Therefore, the reduction in drug utilization and expenditures could be effected by multiple factors. Another limitation to cost-savings estimates relates to the type of interventions performed. Many retrospective interventions target non-adherence or underutilization of medications leading to increased use of medications hence the increased expenditures. Cost avoidance estimates are based on total drug expenditure as calculated by the reimbursed amount paid to the dispensing pharmacy. This does not include any federal or supplemental rebates. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR program. However, it is suspected that by reducing potentially inappropriate use of medications and alerting prescribers to drug therapy concerns, other associated medical costs would be reduced in addition to the reduction in drug expenditures. Number of Recipients Included in Cost Savings Analysis Cost 6 Months PRE Intervention* Cost 6 Months POST Intervention* Estimated Cost Avoidance Single Intervention 2,624 $1,360,538 $629,978 $730,560 Multiple Interventions 1,447 $1,652,307 $2,007,123 ($354,816) Totals 4,071 $3,012,845 $2,637,101 $375,744 * Total drug cost reimbursed to pharmacy does not include any rebates.
South Carolina	ProDUR Paid Claims Savings/Denied- cost avoidance: claims denied/alternate therapy (switch therapy)/reversals and resubmissions Other Cost avoidance: MAC pricing/PDL management/PA criteria and Medical Director review of specific products/classes (Spinraza, Zolgensma, Exondys, etc.) RetroDUR- Difficult to place an actual amount as the majority of the focus has been with Opioids/Provider Education (Academic Detailing) and Resources (tipSC)- impact would be in cost avoidance from overdose/accidental exposure/prescribing practices/education (potential lives saved, potential identification and linkage to care, MAT services, proper disposal/potential decrease in diversion, etc.) Additional RetroDUR (pharmacy claims) also concentrated on implementation of MME (analysis/stratification of claims by MME levels), compound claims and post implementation of 90MME/next steps. The dollar amount noted is a result of cost avoidance due to several edits/PA put into place in association with compound claims (claims were being submitted OCC3 using NCPDP 70), Epidiolex renewal criteria
South Dakota	To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after

State	Cost Savings/Cost Avoidance Methodology
	intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same recipient within FFY 2019). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects.
Tennessee	We have normally submitted this information based on the Pharmacy Lock-In and Prior Authorization Status program, however with the change in PBM on January 1, 2020, it is difficult to report on this information from the prior year. Will submit this information again in the future.
Texas	Retro-DUR cost savings mythology Pharmacy claims data is mapped to allow CyberFormance, a web-based interactive data management system, to analyze and interpret data for FFS and 20 different MCOs. The medical claims data is mapped to evaluate up to two years of patient medical history for the RetroDUR interventions. Conduent delivers interventions to prescribers based on clinical performance indicators. Prescribers are mailed intervention letters based on the number of patients with identified clinical indicators. Target Prescribers are those that were identified and received intervention materials. Control prescribers are those prescribers that prescribed the intervention drugs, but did not receive intervention materials. When seven months of data have been received post-intervention Conduent prepares an outcome report. The analysis identifies all patients who had a prescription for an intervention drug for either the target or control group of prescribers. The number of patients treated and the total cost for intervention drugs are determined for the 6-month pre-intervention period and for a 6-month post-intervention period. Total drug costs can be defined as the total amount of paid intervention drug claims for the above time periods for the prescribers in the control and target groups. The number of panel patients is calculated by counting the distinct number of patients per month prescribed an intervention drug. Medicaid patients that did not have an intervention drug claim were not counted in the prescriber's panel. Average cost per patient per month (PPPM) is calculated by dividing the total dollars paid for drug claims during the analysis time period by the total number of Medicaid panel patients during the respective time period. The change in the control group is calculated by comparing the post-intervention per patient per month cost by the pre-intervention. This provides the expected change in costs for all patients for the intervention drugs. This amount represents the estimated amount paid per targeted provider per patient in the absence of the intervention (i.e., estimated paid amount). The estimated paid amount PPPM is then subtracted from the actual Intervention target group average cost PPPM to estimate the average cost savings PPPM. 6-Month Total Savings is the Intervention Average Cost Savings PPPM multiplied by the total number of targeted patients served over the 6- month time frame.

State	Cost Savings/Cost Avoidance Methodology
	Pro-DUR cost savings methodology The data used for this analysis was sourced by the RxPert prior authorization processing system and the PCRA vendor. statistics associated with prior authorization activity for the specified time frame (October 1, 2018 to September 30, 2019). Total Denials 152,618 Total Unique Clients 38,006 Total Unique Denials 56,923 Total Unique Denials with Follow-Up Approval 10,341 Total Unique Denials with Substitute Therapy 13,157 Total Unique Denials without Follow-Up Approval or Substitute Therapy 33,425 Total Unique Prescribers 16,710 Total Denials: Total number of denied prior authorization requests for the time frame across all request methods (includes duplicates) Total Unique Clients: Total number of unique client IDs associated with all denied prior authorization requests Total Unique Denials: Total number of non-duplicate denied prior authorization requests for the time frame across all request methods (duplicate defined as the same client ID and GCN within 7 days of the initial denied request) Total Unique Denials with Follow-Up Approval: Total number of non-duplicate denied prior authorization requests for the time frame, where an approved prior authorization request was granted for the same client ID and GCN within 7 days of the initial denied request Substitute Therapy: A drug in the HIC3 category for the drug specified on the original denied request Notes: Drugs that were already being taken 45 days prior to the request were excluded as substitute therapy Substitute therapy was not evaluated for Synagis or Increlex requests; these drugs do not have available alternatives Total Unique Denials with Substitute Therapy: Total number of non-duplicate denied prior authorization requests for the time frame, where the client had a paid claim within 7 days of the original denied request for a drug within the same HIC3 category Total Unique Denials without Follow-up Approval or Substitute Therapy: Total number of non-duplicate denied prior authorization requests for the time frame, where the client did not have a prior authorization approval within 7 days of the original denied request and the client did not have a paid claim within 7 days of the original denied request for a drug within the same HIC3 category Total Unique Prescribers: Total number of unique prescribers associated with all denied prior authorization requests Cost Savings Statistic Value Total Cost Savings for Unique Denials with Substitute Therapy $1,718,374 Total Cost Savings for Unique Denials without Follow-Up Approval or Substitute Therapy $9,740,995 Overall Cost Savings $11,459,369

State	Cost Savings/Cost Avoidance Methodology
	Total Cost Savings for Unique Denials with Substitute Therapy: Total dollar amount for all unique denied prior authorization requests with a substitute therapy within 7 days of the original denial for a drug within the same HIC3 category. Calculation: SUM (Estimated Denial Cost per unique denial minus Reimbursement amount of substitute therapy within 7 days of unique denial) where Estimated Denial Cost is the aggregated cost per unit for all paid claims for the same GCN within the specified time frame times the number of units for the denied request. If there were no paid claims for the GCN, then the cost per unit was established by looking for paid claims at the HICL sequence number or HIC3 category until paid claims were found to calculate an aggregated cost per unit. When no paid claims were found to calculate the aggregated cost per unit, no cost savings were associated with the original denied request. Total Cost Savings for Unique Denials without Follow-Up Approval or Substitute Therapy: Total dollar amount for all unique denied prior authorization requests without a prior authorization approval or a substitute therapy within 7 days of the original denial for a drug within the same HIC3 category. Calculation: SUM all Estimated Denial Cost per unique denial where Estimated Denial Cost is the aggregated cost per units for all paid claims for the same GCN within the specified time frame times the number of units for the denied request. If there were no paid claims for the NDC, then the cost per unit was established by looking for paid claims at the HICL sequence number or HIC3 category until paid claims were found to calculate an aggregated cost per unit. When no paid claims were found to calculate the aggregated cost per unit, no cost savings were associated with the original denied request. Cost Savings Associated with PDL and Clinical Edit Prior Authorizations, and Other Denials: Table 5 shows the cost savings by prior authorization type during the specified time frame. The table includes unique denied prior authorization requests with a substitute therapy and unique denied requests without a substitute therapy and also shows values for prior authorization requests that did not hit either a PDL or clinical edit due to validation errors. PA Type — With Substitute Therapy — Without Substitute Therapy PDL — $687,522 — $2,826,762 Clinical Edit — $556,430 — $4,425,677 PDL and Clinical Edit — $473,886 — $2,487,691 Validation Error — $1,295,073 — $2,624,678 With Substitute Therapy: Total cost savings for unique denials with substitute therapy Without Substitute Therapy: Total cost savings for unique denials without substitute therapy and another prior authorization approval Validation Error: Cost savings associated with prior authorization requests that were denied as a result of not passing validation. As these requests never hit criteria, savings cannot be measured under a specific PA type. These requests may have denied for any number of reasons. Even though the associated claims for these PAs did not hit criteria, data for follow up claims can be reviewed to determine if there were any substitutions. This data is included for reference purposes since the PA denials do attribute to savings outside of the PA Type and are included in the savings shown in other tables in this Estimated Cost Savings report. Cost avoidance associated with FFS Lock-In Program was 17,779.80. Please refer to the Lock-In section for more information. The total Dollar amount spent reported in section VI, Question 4, does not include payments for covered non-drug products such as diabetes supplies.
Utah	UT - CMS DUR Annual Report - PROSPECTIVE SAVINGS Run date: 6/2/2020

State	Cost Savings/Cost Avoidance Methodology

Report cycle date or Analysis Period: FFY 2019: 10/1/2018 - 09/30/2019

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Distribution List
Megan Smith (msmith@changehealthcare.com)
dpalyst@changehealthcare.com

Requestor
Megan Smith (msmith@changehealthcare.com)

Approved By
Not approved

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TRADNH	HD	HIGH DOSE	1,914.00	228,016	81	0	0	225.00	92,487.36	92487.36
TRADNH	LD	LOW DOSE	5,584.00	293,488	11	0	0	558.00	91,826.79	91826.79
TRADNH	DD	DRUG DRUG	9,817.00	643,537	27	0	0	690.00	106,935.40	106935.4
TRADNH	TD	THER DUP	62,064.00	2,765,425	145	0	0		4,051.00	477,211.90	477211.9
TRADNH	SUMMARY		79,379.00	3,930,466	264	0	0		5,524.00	768,461.45	768461.45
SUMMARY	HD	HIGH DOSE	13,302.00	1,765,478	368	0	0		3,681.00	1,683,378.67	1683378.67
SUMMARY	LD	LOW DOSE	63,358.00	6,855,363	1098	0	0		14,176.00	3,209,801.03	3209801.03
SUMMARY	DD	DRUG DRUG	71,813.00	8,679,371	752	0	0		12,369.00	3,315,727.49	3315727.49
SUMMARY	TD	THER DUP	590,034.00	39,580,794	6360	0	0		113,307.00	14,410,899.64	14410899.64

State	Cost Savings/Cost Avoidance Methodology
	SUMMARY SUMMARY 738,507.00 56,881,005 8578 0 0 143,533.00 22,619,806.83 22619806.83 ********** TRADNH HD HIGH DOSE 1,914.00 228,016 81 0 0 225.00 92,487.36 92487.36 TRADNH LD LOW DOSE 5,584.00 293,488 11 0 0 558.00 91,826.79 91826.79 TRADNH DD DRUG DRUG 9,817.00 643,537 27 0 0 690.00 106,935.40 106935.4 TRADNH TD THER DUP 62,064.00 2,765,425 145 0 0 4,051.00 477,211.90 477211.9 TRADNH SUMMARY 79,379.00 3,930,466 264 0 0 5,524.00 768,461.45 768461.45 SUMMARY HD HIGH DOSE 13,302.00 1,765,478 368 0 0 3,681.00 1,683,378.67 1683378.67 SUMMARY LD LOW DOSE 63,358.00 6,855,363 1098 0 0 14,176.00 3,209,801.03 3209801.03 SUMMARY DD DRUG DRUG 71,813.00 8,679,371 752 0 0 12,369.00 3,315,727.49 3315727.49 SUMMARY TD THER DUP 590,034.00 39,580,794 6360 0 0 113,307.00 14,410,899.64 14410899.64 SUMMARY SUMMARY 738,507.00 56,881,005 8578 0 0 143,533.00 22,619,806.83 22619806.83
Vermont	For ProDUR savings, we evaluated all reversed claims for which a DUR soft message or DUR reject was triggered. If a reversed claim was not followed within 60 days by a successfully adjudicated claim with the same Date of Service, prescription number, and Pharmacy we assumed it did not result in a paid claim and therefore we counted it as cost-avoidance. Other cost savings are based on aggressive management of the Vermont Medicaid Preferred Drug list through careful management of SMAC savings, "lower of" pricing of pharmacy claims, timely PDL management and strong SR negotiations to lower program costs and maintain excellent quality care choices.
Virginia	ProDUR Analysis ProDUR cost avoidance for the Virginia Medicaid prescription drug program is the sum of the claims that were reversed or denied and not resubmitted. The ProDUR cost avoidance for FFY 2019 was $13,281,889. The following table summarizes the FFY 2019 data. However, cost avoidance should not be interpreted as true cost savings. While the ProDUR edit may have resulted in a claim reversal or denial, it is not known what the complete impact this has on the program. There are many prescriptions that are switched after point of sale to alternative medications, which would have an improved therapeutic benefit to the patient and would not generate a ProDUR edit. The cost of this alternative medication is not reflected in the calculation of ProDUR cost avoidance. Another factor that influenced this calculation was multiple claim submission for an individual beneficiary's prescription. This would result in a number of claims and ProDUR edits for one prescription. If the provider fails to reverse the various claims, the calculations would be inflated. ProDUR Cost Avoidance Calculations

State	Cost Savings/Cost Avoidance Methodology

Paid Claims Reversed and Not Resubmitted + Denied Claims Not Resubmitted = ProDUR Cost Avoidance Total

$9,193,592.02 + $4,088,297.35 = $13,281,889.37

Month-Year	Total # Paid PRODUR Claims	Total Payment Savings From ProDUR	PAID ProDUR # Alerts	Savings From Reversals	ProDUR # Reversals Not Overridden	Total PAID ProDUR Claims Not Overridden	Cost Savings
October-18	73,006	$6,689,121.19	10,934	$1,747,878.97	6,213	$724,657.74	$2,472,536.71
November-18	68,636	$6,271,372.95	10,063	$1,552,670.42	5,786	$538,731.36	$2,091,401.78
December-18	63,608	$5,576,139.50	9,675	$1,435,767.32	5,706	$675,482.37	$2,111,249.69
January-19	29,309	$2,127,639.59	4,404	$544,350.83	2,537	$250,600.30	$794,951.13
February-19	25,193	$1,918,807.06	3,730	$428,633.16	2,186	$221,455.90	$650,089.06
March-19	26,918	$2,068,209.04	3,784	$545,220.70	2,118	$231,453.45	$776,674.15
April-19	26,778	$1,938,694.11	3,816	$525,033.76	2,171	$236,831.25	$761,865.01
May-19	23,828	$1,647,609.65	3,116	$426,327.73	1,853	$248,692.03	$675,019.76
June-19	20,517	$1,469,423.35	2,826	$402,761.65	1,631	$203,412.23	$606,173.88
July-19	22,351	$1,623,209.76	2,883	$454,833.46	1,631	$244,379.74	$699,213.20
August-19	22,658	$2,098,775.59	3,205	$689,962.92	1,719	$321,420.04	$1,011,382.96
September-19	21,609	$1,605,153.74	3,193	$440,151.10	1,722	$191,180.94	$631,332.04
FFY 19 Averages	35,368	$2,919,512.96	5,136	$766,132.67	2,939	$340,691.45	$1,106,824.11
FFY 19 Totals	424,411	$35,034,155.53	61,629	$9,193,592.02	35,273	$4,088,297.35	$13,281,889.37

RetroDUR Cost Analysis

The provision of high quality drug therapy not only results in improved patient health but may also result in program cost avoidance. It is important to quantify the effect of interventions on the cost of drug therapy. When fully applied, the Magellan Rx Management cost analysis model has the ability to capture not only cost avoidance that is a direct result of the RetroDUR letter intervention process, but also avoidance due to indirect effects. This indirect effect arises when a physician applies changes in prescribing triggered by a letter intervention involving one patient to other patients in his/her practice.

State	Cost Savings/Cost Avoidance Methodology
	The model also takes into account the impact of prescription drug inflation, new drugs introduced into the market, and changes in utilization rates, recipient numbers and demographics. The cost analysis in this report was calculated based on changes in the prescription drug costs for those patients whose profiles were identified through the RetroDUR program. Cost avoidance is tracked over a 12-month period beginning six months after the provider is sent a letter/intervention. Changes in prescription drug costs are totaled to yield overall cost avoidance for the review period. The total cost avoidance, attributed to RetroDUR, during FFY 2019 was $427,395.34. Monthly cost avoidance may vary due to a variety of factors, including: • the class selection and problem type chosen for review • the lag time before the next physician visit when changes in drug therapy may be made • the incremental educational and familiarity impact on the prescriber after receiving intervention letters Month-by-month cost avoidance for all active interventions (i.e. interventions which have not completed twelve consecutive months of review/tracking) vary with intensity of intervention activity. Intervention letters sent during the fiscal year, have not all completed follow-up review for one year. Consequently, the cumulative cost avoidance effect of intervention letters mailed during FFY 2019 will not be known until the end of FFY 2020. Dose Optimization and Maximum Quantity Limits Analysis In January 2008, Virginia Medicaid implemented dose optimization and quantity limits on selected medications. The purpose of a dose optimization program is to change multiple dose medications to a single daily dose where appropriate. Quantity limits provide a baseline for the recommended amount of medication that should be dispensed over a certain time period. These limits are based upon the drug manufacturer's recommendations and FDA guidelines. For FFY 2019, the savings for the dose optimization edit was $1,040,611.39 and for the quantity limits edit was $427,364.70. The combined savings for both edits was $1,467,976.09.
Washington	For FFY 2019, Washington Medicaid's cost savings/cost avoidance analysis includes savings based on prospective drug utilization review (ProDUR) and cost avoidance from prior authorization. For FFY 2019 Washington Medicaid has not included any direct savings based on retrospective drug utilization review (RetroDUR) activities. Savings based on ProDUR looked at unique prescription occurrences for payable claims that rejected for NCPDP reject 88 DUR and never resulted in a paid claim (i.e., not overridden by a pharmacy with DUR codes). All other NCPDP rejections and third part payer claims were excluded from the cost savings value reported. This analysis shows an estimated dollars savings of $4,399,571. The estimated savings does not reflect medication changes that may have occurred based on the reject 88 and may have resulted in separately payable claims that would reduce this savings. Savings based on cost avoidance from prior authorization looked at payable claims (claims for eligible clients, no missing or invalid data, all NDCs were rebate eligible, etc.) that rejected for NCPDP reject 75 and did not result in a paid claim. All other NCPDP rejections and third part payer claims were excluded from the cost savings value reported. This analysis shows an estimated dollars savings or cost avoidance

State	Cost Savings/Cost Avoidance Methodology
	of $37,852,929. The estimated cost avoidance savings does not reflect medication changes that may have occurred based on the need for prior authorization and would result in separately payable claims that would reduce this savings.
West Virginia	FFY 2019 Prospective DUR Savings (DXC Technology) Total estimated costs savings for the West Virginia Medicaid Pro-DUR program were estimated by our POS vendor, DXC Technology, to be $39,391,014.56 for FFY2019. The methodology used by DXC to calculate these savings is as outlined below. Annual FY2019 DUR Cost Save Report Data Gathering 1. Set date range for fiscal year 2019 (FY2019) a. Start Date = 10/01/2018 b. End Date = 09/30/2019 2. Calculate average total paid amount per claim for FY2019 a. Exclude claims with ADAP/LPS planID b. Claim start date must fall within the Start Date and End Date of FY2019 c. Claim status in the claim table is one of the following: PAY, WAITPAY, or PAID d. Claim has not been reversed 3. Get claims for FY2019 which denied due to a DUR edit a. Claim start date must fall within the Start Date and End Date of FY2019 b. Claim must have a status of DENY in the claimedit table c. DENY edit must be one of the following DUR edits: 7067, 7069, 7071, 7073, 7075, 7079, 7202, 7203, 7204, 7205, 7206, 7170, 7171, 7172, 7173, 7175, 7250, 7251, 7252, 7077, 7245 d. Exclude claims with ADAP/LPS planID e. Claim was not later paid with EO or DUR/PPS override (also not reversed) 4. Get all RX claims for the fiscal year that had a DUR override associated with them and the following conditions must also apply: a. Claim has not been reversed b. Claim is not a reversed claim c. Claim start date must fall within the Start Date and End Date of FY2019 d. Claim status in the claim table is PAID e. Exclude claims with ADAP/LPS planID f. Claim has Edit Override Authorization ID in the claim table or has a Professional Service Code 5. Create a temporary table to store summary data for each conflict type (DD, ER, etc.). Data in this table will be used for the report. a. Update denied dollar amount for each conflict type using table created in step 3 above (total amount for each conflict type) b. Update override dollar amount for each conflict type using table created in step 4 above (total amount for each conflict type) c. Update cost savings dollar amount for each conflict type using the data collected in a and b above by subtracting override dollar amount from

State	Cost Savings/Cost Avoidance Methodology
	denied dollar amount. If the result is <= 0, then cost savings = 0 Below is the information gathered from the DUR Alerts Summary: DD, Drug-Drug Interactions: Denied Dollars: $34,323,744.66 Override Dollars: $35,564,081.01 Cost savings: $0.00, Percent savings: 0.00% ER, Early Refill: Denied Dollars: $38,171,505.31 Override Dollars: $1,544,250.49 Cost savings: $36,627,254.82 Percent savings: 92.98% HD, High Dose Denied Dollars: $3,174,823.99 Override Dollars: $6,589,846.14 Cost savings: $0.00 Percent savings: 0.00% ID, Ingredient Duplication Denied Dollars: $5,074,447.38 Override Dollars: $2,381,734.05 Cost savings: $2,692,713.33 Percent savings: 6.83% TD, Therapeutic Duplication Denied Dollars: $12,423,157.10 Override Dollars: $34,316,834.49 Cost savings: $0.00 Percent savings: 0.00% PG, Pregnancy Precaution Denied Dollars: $1,319,444.66 Override Dollars: $1,895,385.75 Cost savings: $0.00 Percent savings: 0.00% LR, Late Refill Denied Dollars: $329,953.19 Override Dollars: $258,906.78 Cost savings: $71,046.41 Percent savings: 0.18% FFY 2019 Retrospective DUR Savings (Marshall DUR Coalition)

State	Cost Savings/Cost Avoidance Methodology
	Total estimated costs savings for the West Virginia Medicaid RetroDUR program were estimated by our RetroDUR vendor, Marshall DUR Coalition, to be $726,692 for FFY2019. The methodology used by DXC to calculate these savings is as outlined below: For each program, a retrospective pre-post evaluation was done to evaluate financial impact. Each intervention, (e.g., Lock-In, Congestive Heart Failure with thiazolidinediones (TZD's), Prescription of Opioid with Benzodiazepines, etc.,) was evaluated separately and patients were matched pre-post. The evaluation was based on presence of Common Procedural Technology (CPT codes) signifying either Emergency Department (ED) visits or hospital admissions. The pre-intervention period was 90 days prior to the intervention date. A 30-day waiting period after intervention was used to allow the letter to be sent, the provider to engage with their patient, and to respond to the letter. After the 30-day waiting period, there was a 90-day post-intervention period where ED visits and admissions were again measured. Charges for ED visits were extracted from the Medicaid data for the claims associated with the same Dates of Service (DoS) where the primary diagnosis (PDiagnosis) was within the scope of the metrics. For the admissions, as the admission data and Diagnosis-related Group (DRG) are not available, the PDiagnosis were mapped to appropriate Medicare Severity-Diagnosis Related Group (MS-DRG) cluster, with severity of the admission CPT designating the position of the DRG within the cluster (e.g., a higher severity CPT would result in a higher weighted DRG within the appropriate DRG cluster.) DRG weights were taken from the Content Management System (CMS) 2020 List of Medicare Severity Diagnosis-Related Groups (MS-DRGS), Relative Weighting Factors. The Base rate used was the CMS Operating Base Rate 2020 with no modifiers. While it is well known that the predicted compared to the final DRGs often change, this method allows for cost of care to be conservatively estimated based on the PDiagnosis at the time of admission. The Marshall DUR Coalition overall saw a 78% reduction in patients being admitted or visiting the ED, a 71% reduction in claims, and a 64% reduction in charges between the pre-post intervention periods (Table 2). Marshall DUR Coalition Pre-Post Intervention Measures (Table 2) Patients (pre intervention period): 37 Patients (post intervention period): 8 Change Amount: -29 % Change: -78% Claims for patients post intervention period): 59 Claims for patients pre intervention period): 17 Change Amount: -42 % Change: -71% Financial Estimate for pre intervention patients: $284,260 Financial Estimate for post intervention patients: $102,586 Change Amount: -$181,673 % Change: -64% The Clinical Program appeared to have the largest projected 90-day savings of $125,164. The Lock-In program had an additional 90-day savings $56,509. Calculated Marshall DUR Coalition annual savings are with $500,656 coming from the Clinical Program and $226,036 from the Lock-In Program (Tables 3 & 4). Marshall DUR Coalition Clinical Program Pre-Post Intervention Measures (Table 3)

State	Cost Savings/Cost Avoidance Methodology
	Patients (pre intervention period): 29 Patients (post intervention period): 5 Change Amount: -24 % Change: -83% Claims for patients post intervention period): 45 Claims for patients pre intervention period): 10 Change Amount: -35 % Change: -78% Financial Estimate for pre intervention patients: $203,633 Financial Estimate for post intervention patients: $78,469 Change Amount: -$125,164 % Change: -61% Annual Financial Estimate: -$500,658 Marshall DUR Coalition Lock-In Program Pre-Post Intervention Measures (Table 4) Patients (pre intervention period): 8 Patients (post intervention period): 3 Change Amount: -5 % Change: -63% Claims for patients post intervention period): 14 Claims for patients pre intervention period): 7 Change Amount: -7 % Change: -50% Financial Estimate for pre intervention patients: $80,626 Financial Estimate for post intervention patients: $24,117 Change Amount: -$56,509 % Change: - 70% Annual Financial Estimate: -$226,036
Wisconsin	Wisconsin Medicaid Program Centers for Medicare and Medicaid Services Medicaid Drug Utilization Review Annual Report Federal Fiscal Year 2019 Attachment 5: Wisconsin RDUR Estimated Cost Savings [ATT5-2019-WI-CSCAM] This report prepared for the Wisconsin Medicaid Program shows the estimated cost savings from implementing a retrospective drug utilization review (RDUR) and provider education program to effect change on prescribing and utilization. In an effort to improve clinical outcomes and reduce medication and overall healthcare-related costs, patients found to have a medication-related problem were identified based on the RDUR criteria. Educational intervention letters were mailed to providers during federal fiscal year 2019 (FFY 2019). The drug claims for the selected members were evaluated for the six months prior to the intervention and the six months post-intervention to determine the impact of the RDUR intervention letters. The estimated cost savings are calculated by looking at actual drug claims history for six months before intervention and six months following intervention in both the intervention and random comparison

State	Cost Savings/Cost Avoidance Methodology

groups. The difference between the two groups is the estimated cost savings. For interventions performed between October 1, 2018 and September 30, 2019, there was an estimated cost savings of $1,659,443.

Table 1: Estimated Cost Savings for FFY 2019- All Interventions

	Intervention Group Change between 6 Month Pre- and Post-	Comparison Group Change between 6 Month Pre- and Post-	Estimated Cost Savings
All Interventions	$1,396,790	(-$262,653)	$1,659,443

Table 2: Estimated Cost Savings for FFY 2019 - Lock-Ins only

	Intervention Group Change between 6 Month Pre- and Post-	Comparison Group Change between 6 Month Pre- and Post-	Estimated Cost Savings
Lock-Ins Only	$453,727	$65,748	$387,979

During FFY 2019, HID reviewed 6,533 members with potential drug therapy problems and mailed letters to their providers. The types of drug therapy issues were divided into five general categories: drug-disease interactions, drug-drug-interactions, over-utilization, under-utilization, and therapeutic appropriateness. Members reviewed for under-utilization issues are excluded from the cost savings calculation, as a cost increase would be expected in response to this type of intervention. For FFY 2019, 6,293 members were included in the intervention group.

Table 3: Drug Therapy Problem Distribution
Therapeutic Appropriateness: 23%
Drug-Disease Interactions: 12%
Drug-Drug Interactions: 21%
Overutilization: 38%
Under-utilization: 6%

Analysis Methodology
Each month HID evaluates pharmacy and medical claims data against a library of clinical criteria. Once members have been identified and RDUR letters have been mailed to their providers, HID tracks drug costs for both the intervention group and a comparison group. Both groups are followed for six months pre- and post-intervention to determine the change in pharmacy claims. The comparison group is used to account for changes within the program including new limitations, changes in drug costs, and overall utilization trends.

Member Selection
A total of 17,004 members met the criteria for intervention letters during FFY 2019.
Estimated Cost Savings Methodology
To determine the impact of RDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted

State	Cost Savings/Cost Avoidance Methodology
	intervention population for the pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the RDUR intervention letters. The comparison group consisted of a random group of members who were not chosen for RDUR intervention letters. For a member to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre- and post-intervention periods. For the purpose of this report, members were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RDUR intervention letters. Members were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RDUR intervention letters on the same member within FFY 2019). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects. Estimated Cost Savings Analyses Results For the intervention and comparison group beneficiaries who had claims for any drug during the pre- and post-intervention periods, HID evaluated total drug expenditures and claims for the six months prior to and six months after the letters were mailed . Table 4 shows the results for both the intervention and comparison group for the pre- and post-intervention timeframes for members with single and multiple interventions during FFY 2019. Table 4 - Estimated Cost Savings for FFY 2019 - Single/Multiple Interventions Intervention Group Change between 6 Month Pre- and Post- Cost Savings Comparison Group Change between 6 Month Pre- and Post- Estimated Cost Savings Single Intervention $1,528,181 (-$336,749) $1,864,930 Multiple Intervention (-$131,392) $74,095 (-$205,487) Total Estimated Cost Savings $1,659,443 HID found the intervention group had a decrease of 4.75% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 3.97%. These changes resulted in an estimated cost savings of $263.70 per member who received an intervention during FFY 2019. The intervention group utilized for the cost savings calculation included 6,293 members. Table 5- Cost Savings of Members' Total Prescription Medications for the Pre-and Post-Intervention Periods- Single Interventions Single Intervention Pre 6 Months Members 5,875 Average Cost/Member $4,597 Total Claims Cost $27,008,576 Post 6 Months Members 5,875 Average Cost/Member $4,337 Total Claims Cost $25,480,395 Comparison Group (Single Intervention) Pre 6 Months Members 5,875 Average Cost/Member $1,052 Total Claims Cost $6,183,205 Post 6 Months Members 5,875 Average Cost/Member $1,110 Total Claims Cost $6,519,954

State	Cost Savings/Cost Avoidance Methodology
	Single Intervention Outcomes Percent Change in Claims Cost -5.66% Change in Claims Cost $1,528,181 Comparison Group Claims Cost Change - $336,749 Total Savings for Single Interventions $1,864,930 Table 6- Cost Savings of Members' Total Prescription Medications for the Pre-and Post-Intervention Periods- Multiple Interventions Multiple Interventions Pre 6 Months Post 6 Months Members 418 Members 418 Average Cost/Member $5,715 Average Cost/Member $6,030 Total Claims Cost $2,389,083 Total Claims Cost $2,520,474 Comparison Multiple Interventions Pre 6 Months Post 6 Months Members 418 Members 418 Average Cost/Member $1,022 Average Cost/Member $845 Total Claims Cost $427,271 Total Claims Cost $353,176 Multiple Intervention Outcomes Percent Change in Claims Cost 5.50% Change in Claims Cost -$131,392 Comparison Group Claims Cost Change $74,095 Total Savings for Multiple Interventions -$205,487 Results Discussion All drug claims and some medical claims or diagnosis data is available for analysis. Any medical or diagnosis data available is processed along with the pharmacy claims data to provide as complete a drug and diagnosis history as possible for each member. Medical data that includes the cost associated with hospitalization, doctor visits, and emergency room visits is not analyzed as part of the RDUR intervention program. However, it is suspected that by reducing therapy problems- including inappropriate use of drugs and increased risk for drug interactions- other medically-associated costs due to adverse drug reactions, drug abuse, and diversion would be reduced in addition to the reduction in drug expenditures. Conclusion The RDUR program provides an important educational service to providers enrolled in the Wisconsin Medicaid program. During FFY 2019, 6,533 members were identified for RDUR intervention letters. The RDUR intervention program alerted the member's provider to the drug therapy issue and provided a complete patient profile including a complete pharmacy and medical claims history. This resulted in an estimated cost savings of $1,659,443 for FFY 2019.
Wyoming	For prospective cost avoidance: Total savings = Denied amount + reversed amount

State	Cost Savings/Cost Avoidance Methodology
	Denied amount is based on the average paid amount for accepted claims, grouped by conflict code. Reversed amount is the total amount paid for reversed claims that generated DUR messages (sum of absolute values since this amount is negative for reversed claims), grouped by conflict code. For retrospective cost avoidance: Total cost (medical + pharmacy) is calculated for the quarter prior to intervention and a quarter at least six months after intervention. The difference between cost before and cost after is converted to cost/eligible claimant and multiplied by eligible claimants in the post period. This quarterly amount is then multiplied by 4 to estimate annualized cost avoidance. For prescriber reports looking solely at prescribing trends, only pharmacy costs are included.

VIII - Fraud, Waste and Abuse Detection

A. Lock-In or Patient Review and Restrictions Programs

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

Figure 54 - Documented Process in Place by States to Identify Potential Fraud or Abuse of Controlled Drugs by Beneficiaries

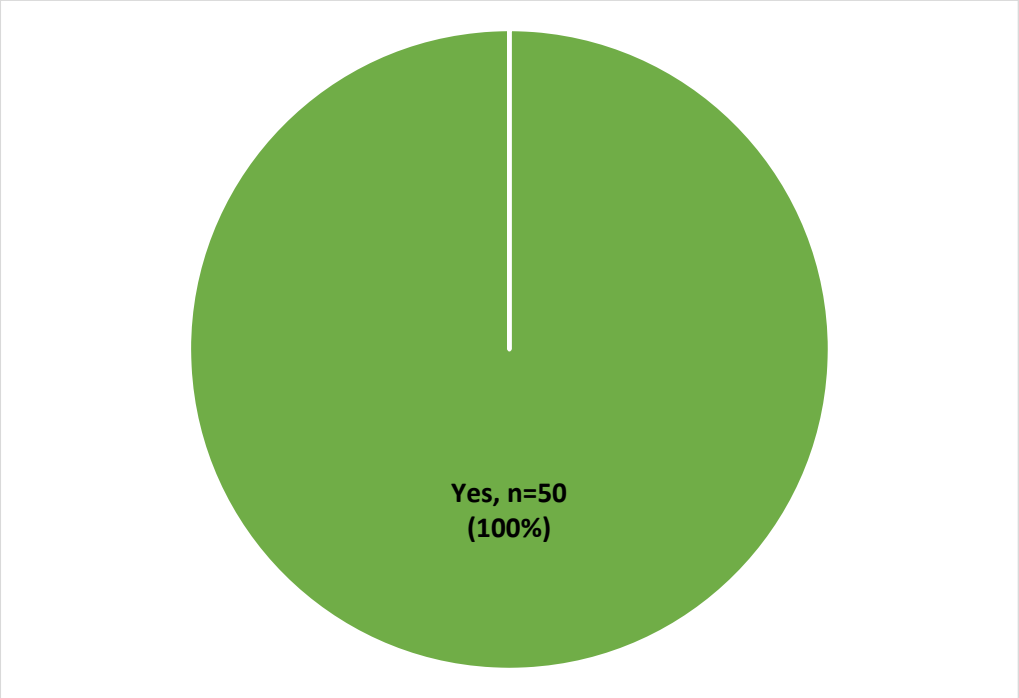

Table 77 - Documented Process in Place to Identify Potential Fraud or Abuse of Controlled Drugs by Beneficiaries

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%
Total		50	100.00%

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

Figure 55 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

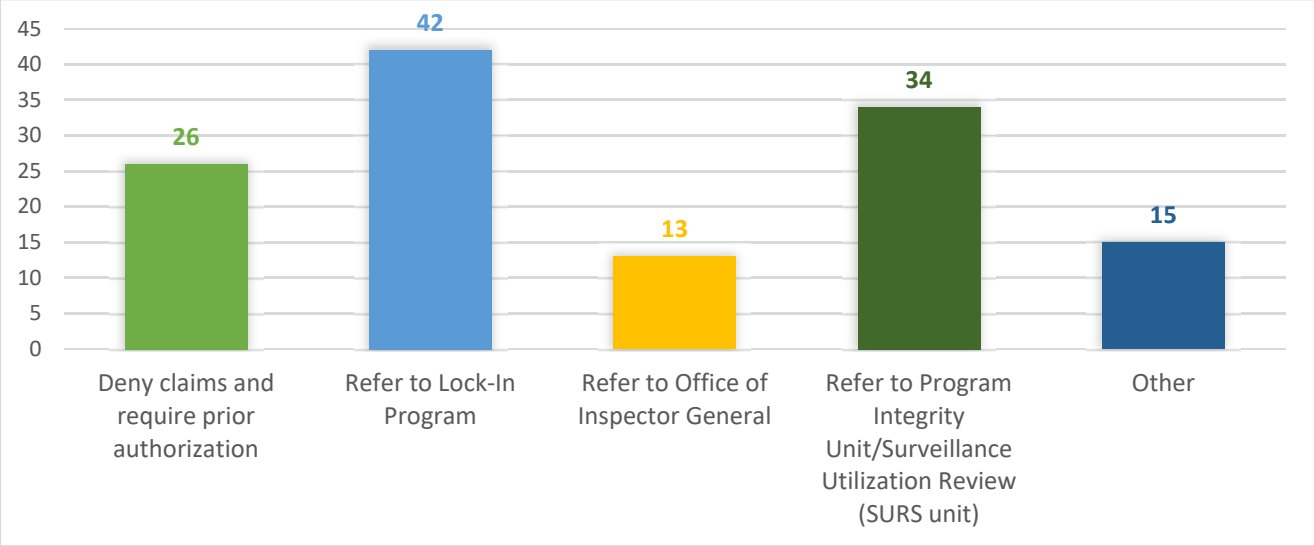

Table 78 - Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

Response	States	Count	Percentage
Deny claims and require prior authorization	Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Oregon, Tennessee, Vermont, Virginia, West Virginia	26	20.00%
Refer to Lock-In Program	Alabama, Alaska, Arkansas, 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, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	42	32.31%
Refer to Office of Inspector General	Arkansas, Indiana, Kentucky, Maryland, Michigan, New York, North Carolina, North Dakota, Pennsylvania, Tennessee, Texas, Utah, Wisconsin	13	10.00%
Refer to Program Integrity Unit/Surveillance Utilization Review (SURS unit)	Alabama, Alaska, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Vermont, Virginia, West Virginia, Wyoming	34	26.15%
Other	Alabama, Alaska, California, Florida, Indiana, Mississippi, Montana, New Hampshire, New Jersey, New Mexico, North Carolina, South Carolina, Utah, Vermont, Virginia	15	11.54%
Total		130	100.00%

"Other," please explain.

Table 79 - "Other" Explanations for Actions Process Initiates when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected

State	Explanations
Alabama	Refer to MFCU if necessary.
Alaska	SURS, MFCU
California	California legislation details available utilization restrictions when the Department has determined that a beneficiary is misusing or abusing Medi-Cal benefits, including being subjected to one or more of the following forms of utilization restriction: (1) Prior authorization for all Medi-Cal services. (2) Prior authorization for specific Medi-Cal services. (3) Restriction to utilization of a specific, beneficiary- or Department-selected pharmacy. (4) Restriction to a specific, beneficiary- or Department-selected primary provider of medical services. Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working potential fraud or abuse of controlled drugs by beneficiaries. MRB, SIU, and IB has an intake process for complaints which entails an initial case review and if warranted, assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and trends.
Florida	Deny claims and require a prospective drug utilization review by the pharmacist at the point of sale.
Indiana	Submit to FSSA Bureau of Investigations for member investigation
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
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. Program Integrity may also refer cases to the Medicaid Fraud Control Unit and/or the Office of the Inspector General. Providers may also be reported to the Office of Professional Licensure and Certification (OPLC).
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 opioid 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. Claims are denied for lock-in beneficiaries if not using designated providers (pharmacy and prescriber).
South Carolina	Managed by Program Integrity
Utah	Lock-in Program performs utilization review on members identified by the Surveillance report to assess necessity of beneficiary utilization. Beneficiaries who that review reveals possible fraud, are referred to the Utah Office of Inspector General.

State	Explanations
Vermont	-There is a standard operating procedure that outlines the process for review of data-mined claims information, screening for claims indicating a high number of prescribers, multiple ED visits, and/or use of multiple pharmacies. -Team members outreach providers, pharmacies, and EDs describing the Team Care program criteria, guidelines and referral process. -Provider notification through banner and mailing.
Virginia	Java- Server Utilization Review System (JSURS) identified members to review for enrollment in DMAS Client Medical Management Program (Lock- In program)

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

Figure 56 - Lock-In Program

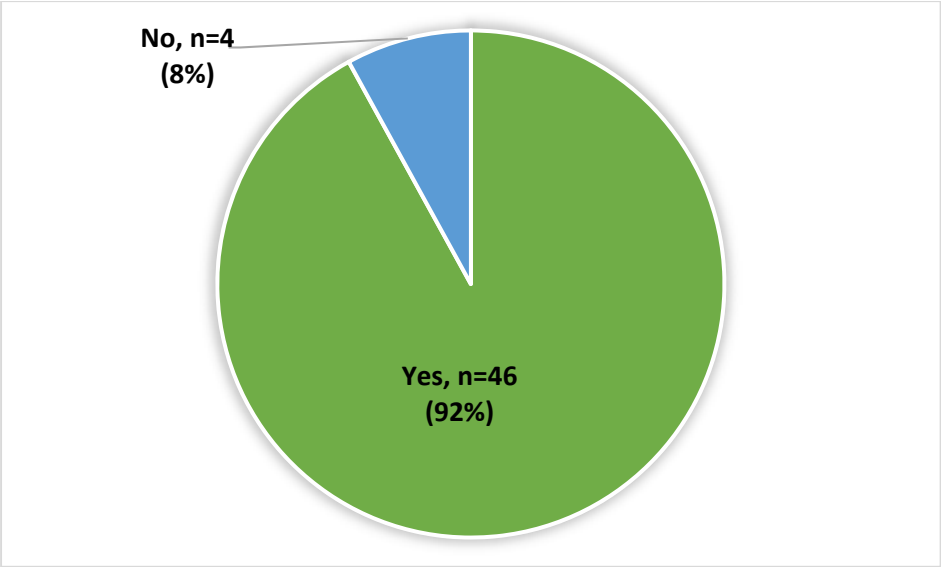

Table 80 - Lock-In Program

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, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	46	92.00%
No	California, Florida, Iowa, South Dakota	4	8.00%
Total		50	100.00%

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 57 - Lock-In Program Candidate Identification Criteria

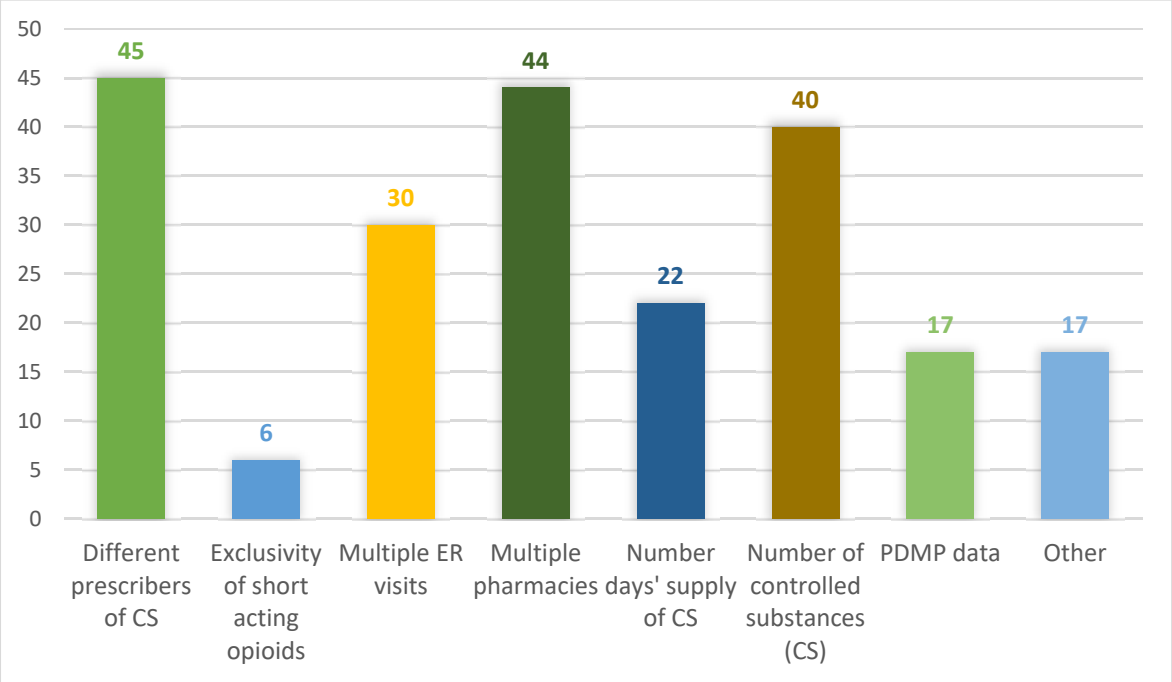

Table 81 - Lock-In Program Candidate Identification Criteria

Response	States	Count	Percentage
Different prescribers of CS	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	20.36%
Exclusivity of short acting opioids	Delaware, Georgia, Maryland, New Jersey, New York, Oklahoma	6	2.71%
Multiple ER visits	Alabama, Alaska, Colorado, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	30	13.57%
Multiple pharmacies	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts,	44	19.91%

Response	States	Count	Percentage
	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		
Number days' supply of CS	Alabama, Arkansas, Connecticut, Delaware, Georgia, Kansas, Louisiana, Maryland, Michigan, Missouri, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin	22	9.95%
Number of controlled substances (CS)	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, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	40	18.10%
PDMP data	Alaska, Arkansas, Georgia, Idaho, Indiana, Maine, Michigan, Mississippi, Montana, Nevada, North Dakota, Oklahoma, Tennessee, Utah, Virginia, Washington, West Virginia	17	7.69%
Other	Arkansas, Connecticut, Idaho, Illinois, Indiana, Mississippi, Montana, Nebraska, Nevada, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, West Virginia	17	7.69%
Total		221	100.00%

If answer is “Other,” please explain.

Table 82 - “Other” Explanations for Lock-In Program Candidate Identification Criteria

State	Explanations
Arkansas	Diagnosis of poisoning or overdose is monitored monthly. Patients are monitored for a billed diagnosis consistent with poisoning or overdose for opioids, narcotics, barbiturates, benzodiazepines, or unspecified drug or substances.
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	Referrals from Board of Pharmacy, Prescribers, Pharmacies or Program Integrity Program.
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

State	Explanations
Mississippi	Additional criteria that can be used to determine individuals for lock-in also include: - When an individual utilizes cash payments to purchase control substances - When any written prescription is stolen, forged, or altered - When the Division of Medicaid has received a proven report of fraud, waste, and/or abuse from either a prescriber, pharmacy, medical provider or law enforcement entity.
Montana	We review referrals from providers, pharmacists, and PA staff. We will also enroll members in the lock-in program at the request of their provider.
Nebraska	Provider Referral
Nevada	If the recipient has been diagnosed with a drug dependency related condition or if the dispensed quantity per prescription of controlled substances appears excessive by the clinical review team; or the recipient has other noted drug seeking behaviors.
Pennsylvania	Other criteria that warrants placement in the Lock-In program includes beneficiaries with an identified pattern of obtaining early refills in addition to one or more of the above listed criteria, have forged or altered prescriptions, using another beneficiaries card or sharing a card with an ineligible individual to obtain medical services.
South Carolina	In accordance with 42 CFR 431.54 (e), the Department will identify Members through SURs reporting who are using Medicaid services at a frequency or amount that is not Medically Necessary. Identified Members will be restricted to one pharmacy for a period of two years. Prior to the restriction and per 42 CFR 431.54 (e)(1)(2) and (3): The Member must be given notice and opportunity for a fair hearing before imposing the restriction. The Member must have reasonable access (taking into account geographic location and reasonable travel) to Medicaid services of adequate Quality. The restrictions do not apply to emergency services furnished to the Member. Enrollment in the Department's Statewide Pharmacy Lock-In Program (SPLIP) will not result in the denial, suspension, termination, reduction or delay of medical assistance to any Member. As required by 42 CFR 431 Subpart E, any Medicaid Member who has been notified in writing by the Department of a pending restriction due to mis-utilization of Medicaid services may exercise his/her right to a fair hearing, conducted pursuant to R126-150 et. Seq. Section 11.10.1: PI will generate a quarterly report that will review all Medicaid Member's Claims for a six (6) month period. The report will look at twenty (20) different weighted criteria as establish by PI based on research; with most of them analyzing the use of pain medications. The report will then

	assign a score and rank the Member based on that score. It will then select Members for enrollment into SPLIP based on a score determined by the SPLIP. The twenty (20) criteria are as follows: FFS and Encounter Claims included Pharmacy Dispensed Dates: XX/XX/20XX - XX/XX/20XX (6 months) Voids Removed Excluded Members in Hospice, with a date of death or no longer Medicaid eligible Excluded Members currently in the lock-in Program Only included Members with a Score > 0 Excludes members with sickle cell disease (ICD9 codes 282.60 thru 282.9 and ICD10 codes D57.00 thru D57.1 and D57.20 thru D57.219 and D57.4 thru D57.819) Excluded Members Age <= 16 and (Aid Category = 57 (TEFRA) or certain waiver programs Composite Score Measures 1. CII Without Prof Claim in Previous Six (6) Mo Identifies any Member with a DEA Schedule II prescription without a professional Claim in the previous six (6) months. The professional Claims look back was not limited to the time period of this report. (1) 2. Fifteen or More RX in Thirty (30) Days Identifies Members with fifteen (15) or more prescriptions (any schedule) within a thirty Day (30) period. This measure is based on a rolling thirty (30) Days within the six (6) month time period of this report. (0.5) 3. Five or More Controls in Thirty (30) Days Identifies Members with five (5) or more DEA Schedule II-V prescriptions within a thirty-Day period. This measure is based on a rolling thirty (30) Days within the six (6) month time period of this report. (3) 4. Two or More ER Visits In Thirty (30) Days and Controlled RX Identifies Members with two (2) or more Non-Emergent ER visits within a thirty-Day period and a DEA Schedule II-V prescription within the same thirty (30) Days. This measure is based on a rolling thirty (30) Days within the six (6) month time period of this report. fac_revenue_cd = '0450','0451' OUTPAT_SERVICE_LEVEL = '1' OUTPAT_SERVICE_LEVEL was tagged to Encounter Claims from Diagnosis record based on primary diagnosis code. (1) 5. GT 3600 mg Oxycodone HCL in Thirty (30) Days Identifies Members with more than 3600 mg of Oxycodone HCL (generic name for Oxycontin) in a thirty-Day period. This measure is based on a rolling thirty (30) Days within the six (6) month time period of this report. Total mg per prescription = strength * quantity dispensed (1) 6. Two or More Out of State Pharmacies for Controls Identifies Members with DEA Schedule II-V prescriptions from two (2) or more out of State pharmacies. (2) 7. Two Controls From Two (2) Pharmacies within Two (2) Days Identifies Members with two (2) or more DEA Schedule II-V prescriptions dispensed by two (2) different pharmacies on two (2) consecutive Days. (1) 8. Suboxone within Six (6) Months Identifies Members with Suboxone prescriptions during the time period of this report. generic_name = 'Buprenorphine Hydrochloride/Naloxone Hydrochloride' (1) 9. Opioid Within Thirty (30) Days After Suboxone Identifies Members with an opiod prescription within thirty (30) Days after a Suboxone prescription. Suboxone: generic_name = 'Buprenorphine Hydrochloride/Naloxone Hydrochloride') Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII' (10) 10. Ten or More Pills Per Day For Controlled RX

	Identifies Members with DEA Schedule II-V prescriptions allowing for ten (10) or more pills per Day. Master Form = Capsule or Tablet Qty_Dispensed / Days_Supply >= 10 (2) 11. Pill Count for Controls GT 600 Identifies Members with a pill count exceeding 600 for all DEA Schedule II-V prescriptions dispensed during the six (6) month time period of this report. Master Form = Capsule or Tablet (2) 12. Hist of Drug Dependence with Benzo or Opiate RX Identifies Members with a drug dependence diagnosis code and a Benzodiazapine or Opiate prescription during the six (6) month time period of this report. Diagnosis code like '304*' - checked all diagnosis codes on professional and hospital Claims Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII' Benzodiazepines: Redbook_int_ther_class like '*BENZODIAZEPINES*' and Redbook_dea_class_cd = 'CIV' (1) 13. Hist of Poison Overdose with Benzo or Opiate RX Identifies Members with a poisoning/overdose diagnosis code and a Benzodiazapine or Opiate prescription during the six (6) month time period of this report. Diagnosis code = '960' to '9799' - checked all diagnosis codes on professional and hospital Claims Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII' Benzodiazepines: Redbook_int_ther_class like '*BENZODIAZEPINES*' and Redbook_dea_class_cd = 'CIV' (1) 14. Five or More Prescribers Identifies Members with five or more prescribers during the six (6) month time period of this report. All prescriptions included.(0.5) 15. Two or More Opioid Prescribers Identifies Members with two or more prescribers issuing an opioid prescription during the six (6) month time period of this report. Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII' (1) 16. Three or More Prescribers for Controlled Substance Identifies Members with three (3) or more prescribers issuing a controlled substance (DEA Schedule II-V) during the six (6) month time period of this report. (1) 17. Four or More Pharmacies Identifies Members with drugs dispensed by four (4) or more pharmacies during the six (6) month time period of this report. All prescriptions included. (0.5) 18. Two or More Pharmacies for Controlled Substance Identifies Members with controlled substances (DEA Schedule II-V) dispensed by two or more pharmacies during the six (6) month time period of this report. (1) 19. Three or More Cntrl Subst and Drugs of Concern Identifies Member with three (3) or more drugs between controlled substances (DEA Schedule II-V) and other drugs of concern. Other drugs of concern incl tramadol, cyclobenzaprine, methocarbamol, tizanidine and metaxalone. Unique count of generic_name > 3 (1) 20. On Cocktail Reports Identifies Members also found on the "Holy Trinity" or "The Cocktail" reports for the same six (6) month time period. These reports identify Members who were dispensed all components of a known drug cocktail during a thirty-Day (30) period. (3) The Department can revise these criteria as needed; for example to include current drugs being sought by abusers according to national trends. The report will also automatically assign a Lock-In Pharmacy for the Member based on the pharmacy they have utilized the most during the six month period.

State	Explanations
	https://msp.scdhhs.gov/managedcare/sites/default/files/MCO%20PP%20July%202020%20FINAL%20P%26P%20V2.pdf
Tennessee	Enrollees are also subject to Lock-In and Prior Authorization Status if arrested for a drug offense, arrested for TennCare doctor shopping, drug sales or TennCare fraud, Convicted of TennCare drug sales, doctor shopping or fraud, or if they have been found with a diagnosis of poisoning due to an illicit substance.
Texas	In addition to the boxes checked above, the following are criteria for identifying candidates for Lock-In: Treatment that exceeds therapeutic daily Morphine Equivalent Dose (MED) Prescription combination with abuse potential Overlapping or duplicative psychotropic prescriptions from 2 or more unaffiliated prescribers. ER visits or hospitalizations due to suicide attempt, poisoning or overdose of drugs (intentional self-harm) A diagnosis of alcohol or drug abuse including non-therapeutic, recreational or illegal drug use Two or more occurrences of violating a pain contract with the same prescriber or with different prescriber(s) Conviction of a crime related to restricted medications within the past year (e.g., forgery, theft, distribution or Medicaid fraud)
Utah	Concurrent prescribed controlled substances by different prescribers, numbers of pharmacies accessed for controlled substances, number of providers accessed, and number of prescribers of controlled substances.
Vermont	Review claims and referral documentation, Health Information Exchange (HIE) documents, etc, for beneficiaries who are referred to Team Care to determine if enrollment criteria is met.
Washington	The Lock-In Program placement criteria: A. Two or more of the following occurred in a period of ninety consecutive calendar days in a twelve month period: 1. Received services from four or more different providers, including physicians, ARNPs, and PAs not located in the same clinic or practice; 2. Had prescriptions filled by four or more different pharmacies; 3. Received ten or more prescriptions; 4. Had prescriptions written by four or more different prescribers not located in the same clinic or practice; 5. Received similar services in the same day not located in the same clinic or practice; or 6. Had ten or more office visits. B. Any one of the following occurred in a period of ninety consecutive calendar days in the twelve period: 1. Made two or more emergency department visits; 2. Exhibits "at-risk" usage patterns; 3. Made repeated efforts to seek health care services that are not medically necessary; or 4. Was counseled at least once by a health care provider, or an agency or MCO staff member with clinical oversight, about the appropriate use of health care services. C. Received prescriptions for controlled substances from two or more different prescribers not located in the same clinic or practice in any one month within the ninety-day review period; D. Has a medical history or billing history, or both, that demonstrates a pattern of the following at any time: 1. Using health care services in a manner that is duplicative, excessive, or contraindicated; 2. Seeking conflicting health care services, drugs, or supplies that are not within acceptable medical practice.
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 58 - Prescriber Only Restriction Capability

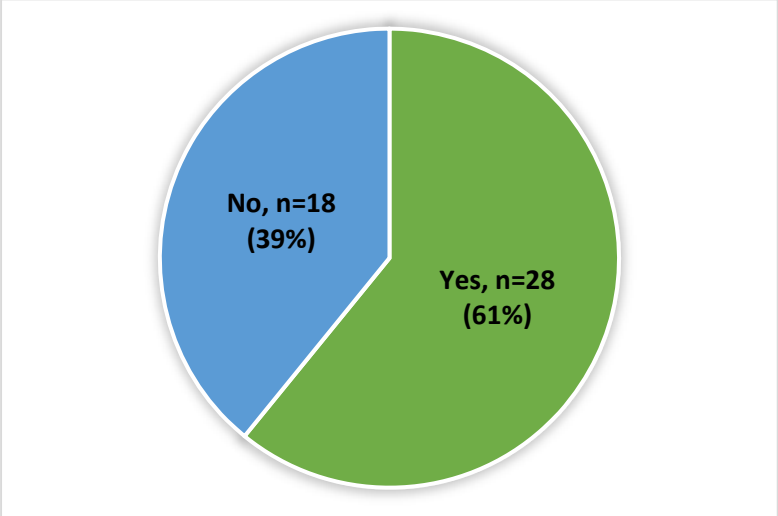

Table 83 - Prescriber Only Restriction Capability

Response	States	Count	Percentage
Yes	Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Texas, Utah, Vermont, Virginia, Washington, West Virginia	28	60.87%
No	Alabama, Alaska, Arkansas, District of Columbia, Louisiana, Maryland, Massachusetts, Montana, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Wisconsin, Wyoming	18	39.13%
Total		46	100.00%

ii. Pharmacy only

Figure 59 - Pharmacy Only Restriction Capability

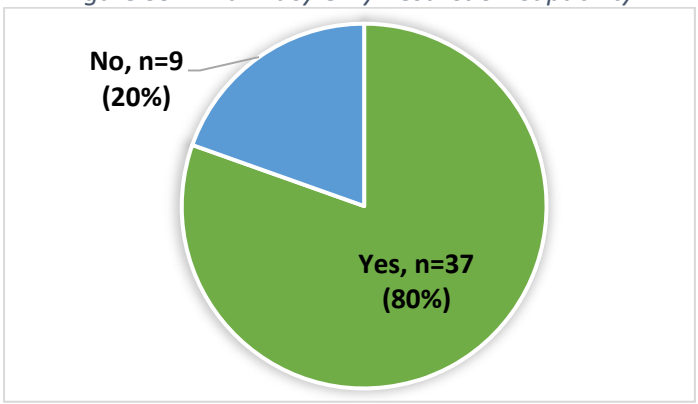

Table 84 - Pharmacy Only Restriction Capability

Response	States	Count	Percentage
Yes	Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wyoming	37	80.43%
No	Alabama, Alaska, Connecticut, Montana, Nebraska, North Carolina, Oklahoma, Vermont, Wisconsin	9	19.57%
Total		46	100.00%

iii. Prescriber and pharmacy

Figure 60 - Prescriber and Pharmacy Restriction Capability

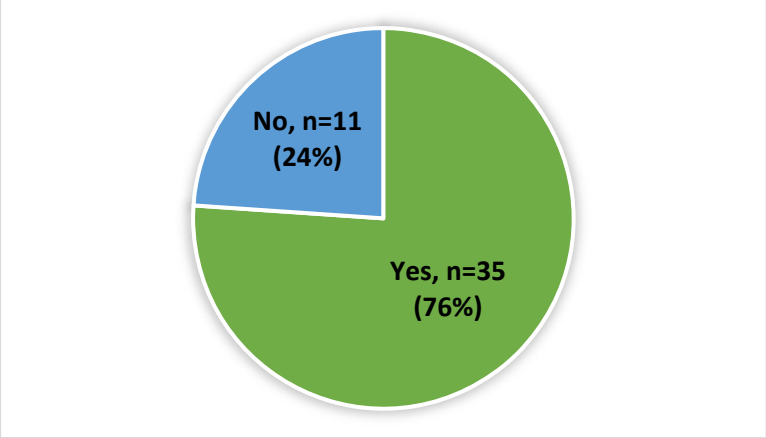

Table 85 - Prescriber and Pharmacy Restriction Capability

Response	States	Count	Percentage
Yes	Alabama, Alaska, Colorado, Delaware, 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	35	76.09%
No	Arkansas, Connecticut, District of Columbia, Maryland, Massachusetts, New Hampshire, Oregon, Rhode Island, South Carolina, Tennessee, Wyoming	11	23.91%
Total		46	100.00%

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

Figure 61 - Lock-In Time Period

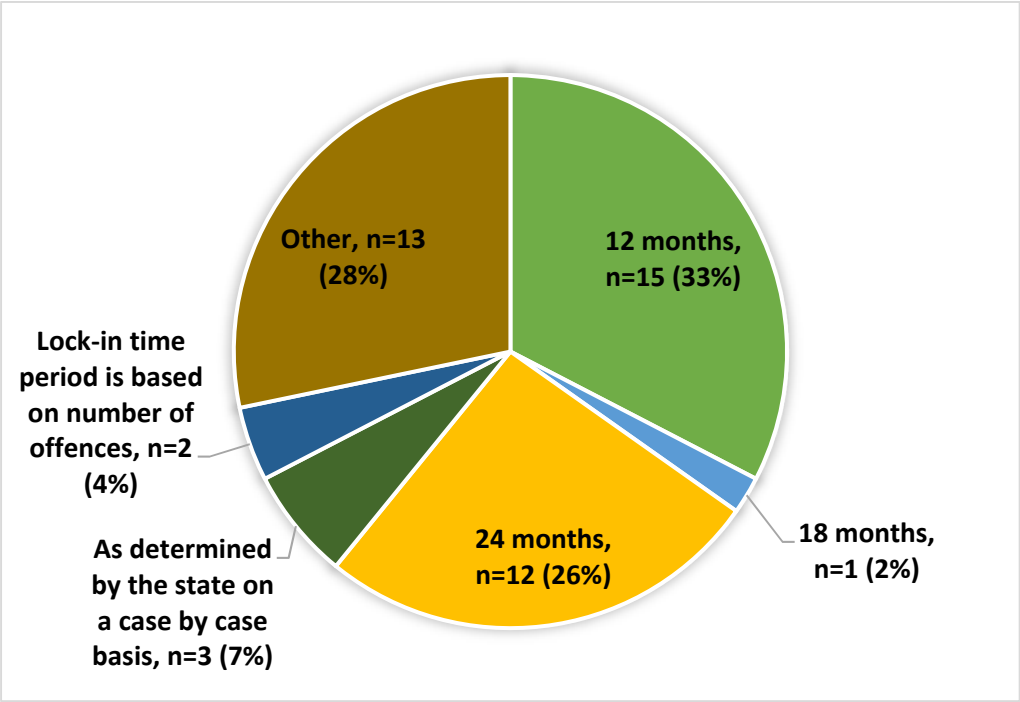

Table 86 - Lock-In Time Period

Response	States	Count	Percentage
12 months	Alabama, Alaska, Connecticut, District of Columbia, Georgia, Idaho, Mississippi, Montana, New Hampshire, Oregon, Rhode Island, South Carolina, Utah, Virginia, West Virginia	15	32.61%
18 months	North Dakota	1	2.17%
24 months	Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nebraska, North Carolina, Ohio, Oklahoma, Washington, Wisconsin	12	26.09%
As determined by the state on a case by case basis	Nevada, New Jersey, New Mexico	3	6.52%
Lock-in time period is based on number of offences	New York, Wyoming	2	4.35%
Other	Arkansas, Colorado, Delaware, Hawaii, Illinois, Indiana, Maine, Massachusetts, Minnesota, Pennsylvania, Tennessee, Texas, Vermont	13	28.26%
Total		46	100.00%

If answer is “Other,” please explain.

Table 87 - "Other" Explanations for Lock-In Time Period

State	Explanations
Arkansas	Lock-in beneficiaries are initially locked in for one year and then re-reviewed by the lock-in committee annually.
Colorado	Members that meet lock-in criteria are placed in the lock-in program (client over-utilization program) for an initial period of three months. During this time, State Regional Accountable Entities (RAEs) assist with care coordination with an appropriate primary care provider. Reporting is repeated quarterly and outreach and follow-up is initiated continued by the RAEs for members that newly meet, or continue to meet, criteria for that quarter's reports. Restricting members meeting lock-in criteria to provider and pharmacy through the pharmacy claims system is planned for implementation during FFY2020. For the time period of this reporting, the % of members in the pharmacy claims lock-in is zero, and there is no estimate of cost savings attributed to lock-in to provide for this time.
Delaware	Lock in period does not have an end date but can be reviewed at the member's request
Hawaii	Lock in for at least 6 months and can be extended up to 24 months; monitor for 24 months for compliance.
Illinois	The initial FFS client lock-in is for 12 months. All subsequent lock-ins for same recipient are implemented for 24 months.
Indiana	Two years, and then re-evaluation for graduation or re-enrollment.
Maine	Varies on the severity of the infraction coupled with the review of the urinalysis and medical chart notes and behavior changes
Massachusetts	Minimum of 12 months, and reviewed on a case by case basis.
Minnesota	Initial 24 months with possibility of a 36 month renewal.
Pennsylvania	Restrictions are lifted after a period of five years if improvement in use of services is demonstrated. An additional five-year Lock-In period is implemented if the beneficiary continues to abuse medical services including medications.
Tennessee	There is no time limitation. Members are re-reviewed at least yearly, and are not unlocked or removed from PA Status until they qualify according to our Rules. If Arrested for TennCare doctor shopping, drug sales or fraud there is no re-review and they remain until convicted or acquitted, nolled or dismissed, and if convicted, they are subject to Lock-In and PA Status as long as they have the benefit at any time.
Texas	Initial lock-in status period is a minimum of 36 months. Second lock-in status period will be additional 60 months. Third lock-in status period will be for the duration of eligibility and all subsequent periods of eligibility.
Vermont	Initial enrollment period is 24 months for most members, but this can be adjusted as appropriate on a case by case basis. Once enrolled in the lock-in program (Team Care), and the initial enrollment period has elapsed, periodic reviews of claims data are conducted. Periodic reviews are conducted in intervals as the case warrants, based on the claims data and other sources of information (such as provider input, HIE records). Typically, these are annual reviews but can be as soon as 3 months or up to 12 months until the next review. If members being reviewed no longer meet Team Care criteria, they are dis-enrolled as appropriate. A follow up review for dis-enrolled members is conducted 6-12 months following dis-enrollment.

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

Figure 62 - Percentage of FFS Population in Lock-In Status Annually

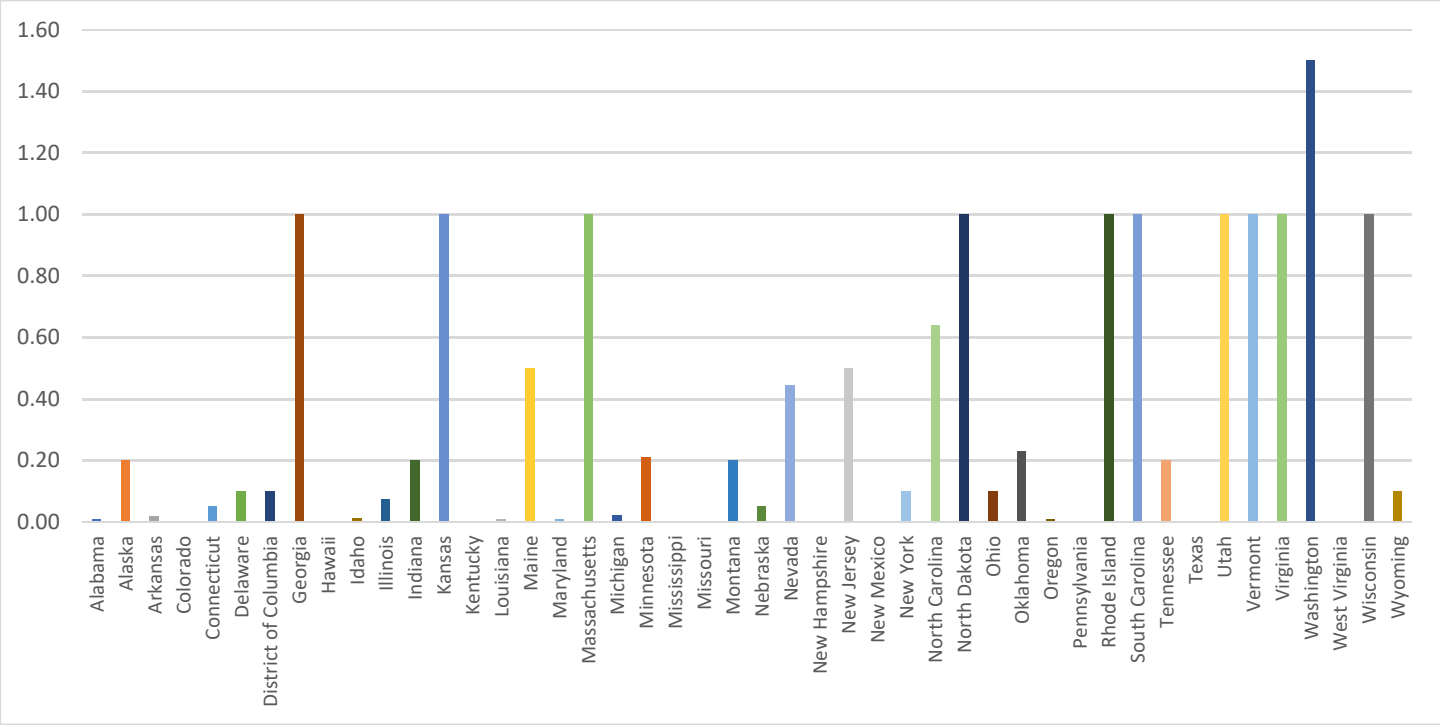

Table 88 - Percentage of FFS Population in Lock-In Status Annually

State	Percent
Alabama	0.0100%
Alaska	0.2000%
Arkansas	0.0200%
Colorado	0.0000%
Connecticut	0.0500%
Delaware	0.1000%
District of Columbia	0.1000%
Georgia	1.0000%
Hawaii	0.0000%
Idaho	0.0130%
Illinois	0.0730%
Indiana	0.2000%
Kansas	1.0000%
Kentucky	0.0000%
Louisiana	0.0100%
Maine	0.5000%
Maryland	0.0100%
Massachusetts	1.0000%
Michigan	0.0230%
Minnesota	0.2100%
Mississippi	0.0000%
Missouri	0.0020%

State	Percent
Montana	0.2000%
Nebraska	0.0500%
Nevada	0.4450%
New Hampshire	0.0000%
New Jersey	0.5000%
New Mexico	0.0000%
New York	0.1000%
North Carolina	0.6400%
North Dakota	1.0000%
Ohio	0.1000%
Oklahoma	0.2300%
Oregon	0.0100%
Pennsylvania	0.0016%
Rhode Island	1.0000%
South Carolina	1.0000%
Tennessee	0.2000%
Texas	0.0016%
Utah	1.0000%
Vermont	1.0000%
Virginia	1.0000%
Washington	1.5000%
West Virginia	0.0000%
Wisconsin	1.0000%
Wyoming	0.1000%

e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review as part of Attachment 5.

Table 89 - Estimate of Savings Attributed to the Lock-In Program

State	Savings Estimate
Alabama	$7,657
Alaska	$1
Arkansas	$157,302
Colorado	$0
Connecticut	$372,126
Delaware	$0
District of Columbia	$0
Georgia	$1
Hawaii	$0
Idaho	$465
Illinois	$13,408
Indiana	$0
Kansas	$1
Kentucky	$0
Louisiana	$10,000
Maine	$1
Maryland	$20,195

State	Savings Estimate
Massachusetts	$218,950
Michigan	$0
Minnesota	$1
Mississippi	$0
Missouri	$7,285,388
Montana	$379,576
Nebraska	$1
Nevada	$1,506,335
New Hampshire	$0
New Jersey	$302
New Mexico	$0
New York	$8
North Carolina	$897,448
North Dakota	$0
Ohio	$337,458
Oklahoma	$103,020
Oregon	$1,580
Pennsylvania	$22,500,000
Rhode Island	$0
South Carolina	$2,500,000
Tennessee	$0
Texas	$17,780
Utah	$1,070,990
Vermont	$0
Virginia	$0
Washington	$0
West Virginia	$226,036
Wisconsin	$0
Wyoming	$0

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

Figure 63 - Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Prescribers

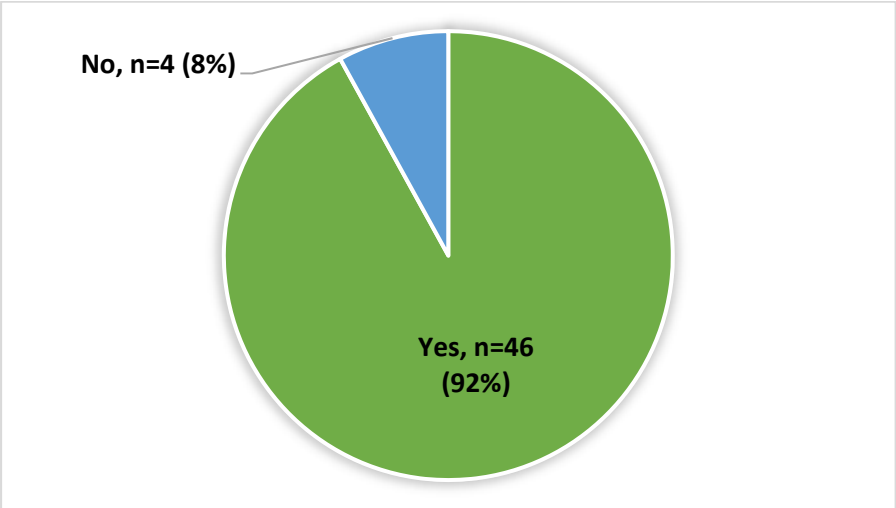

Table 90 - Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Prescribers

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	46	92.00%
No	Idaho, Montana, Nevada, Oregon	4	8.00%
Total		50	100.00%

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

Figure 64 - Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Prescribers is Detected

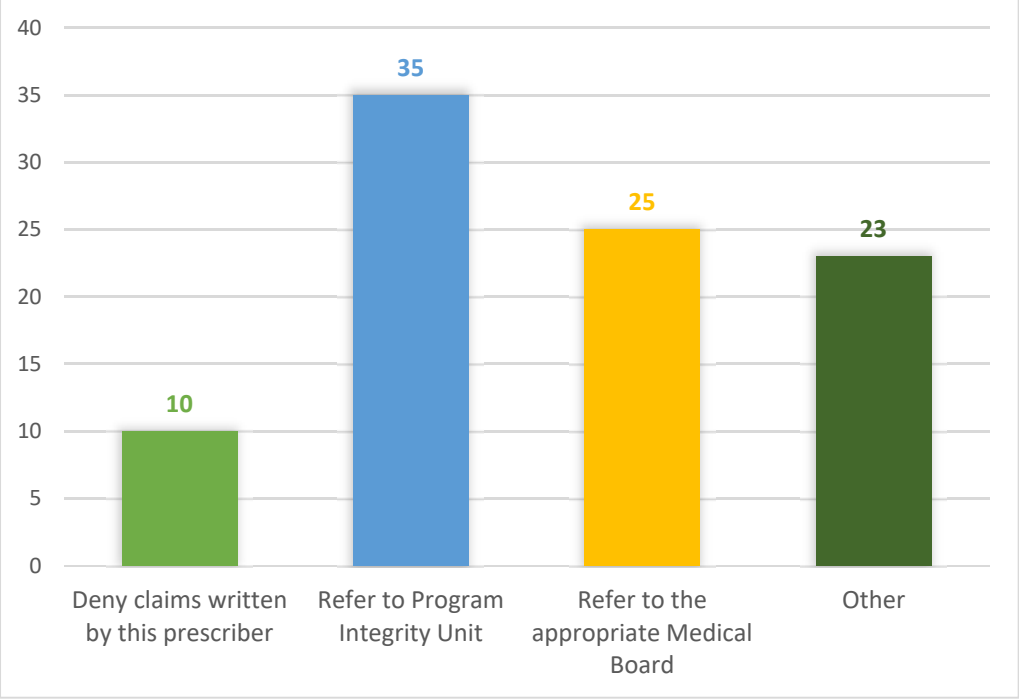

Table 91 - Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Prescribers is Detected

Response	States	Count	Percentage
Deny claims written by this prescriber	California, Florida, Georgia, Indiana, Maine, Massachusetts, Michigan, New Hampshire, Vermont, West Virginia	10	10.75%
Refer to Program Integrity Unit	Alabama, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi,	35	37.63%

Response	States	Count	Percentage
	Missouri, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming		
Refer to the appropriate Medical Board	Alabama, Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Vermont, West Virginia, Wyoming	25	26.88%
Other	Alaska, Arkansas, California, Hawaii, Illinois, Kansas, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Washington, Wisconsin	23	24.73%
Total		93	100.00%

Other, please explain.

Table 92 - "Other" Explanations for Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Prescribers is Detected

State	Explanations
Alaska	Alaska is currently utilizing JSURS to identify prescriber trends. the state is also working on the integration of the PDMP. Trends are reviewed by the DUR committee.
Arkansas	Arkansas Medicaid RDUR program identifies prescribing outliers which are presented to our DUR board for consideration. Depending on the situation, a peer-to-peer outreach may be recommended or referral to Arkansas Office of Medicaid Inspector General (AR OMIG). AR OMIG also performs random sampling for adherence to state and federal policies and procedures and for claim integrity. If AR OMIG identifies possible fraudulent behavior of a prescriber, the Medicaid Fraud Control Unit (MFCU) is notified.
California	Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working cases involving possible fraud or abuse of controlled drugs by prescribers. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and - if warranted - assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and prescribing trends. Current utilization controls include suspended provider lists, provider sanctions for a specified time period, provider sanctions from prescribing select medications, contracted drug list compliance, code 1 restrictions, treatment authorization requests, maximum dispensing quantity restrictions, and maximum dispensing restrictions during a specified time period.
Hawaii	Quarterly manual reviews of outlier claims with random sampling of one week of all claims at least once a year are performed by the DUR Board. No action was required. The monthly average of FFS claims paid is less than 500.
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.

State	Explanations
Kansas	Referrals can be made to the Attorney General's Office.
Louisiana	The Program Integrity audit process identifies possible fraud or abuse by prescribers.
Maryland	SURS, Office of Inspector General
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, there are 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 Hampshire	Prescribers may be suspended or sanctioned and prescriptions written by these prescribers would then be denied at point-of-sale.
New York	Professional retro-dur case reviewers refer potential prescriber fraud cases to the DUR program. They are then forwarded to the Medicaid Office of Inspector General for further review and/or possible investigation.
North Carolina	An audit of specific claims may be performed. If fraud is suspected, a referral is made to the NC DOJ.
Pennsylvania	The Bureau of Program Integrity (BPI) monitors prescribers for possible fraud, waste and abuse of controlled substances. BPI reviews the prescriber's medical and fiscal records, paid claims and historical allegations or complaints. If it is determined there is a credible allegation of fraud, BPI refers the prescriber to the Office of Attorney General's Medicaid Fraud Control Section and evaluates for possible payment suspension. A referral is sent to the Medical Board for concerns of quality of care following the completion of any criminal investigation. For reviews that are identified as possible abuse only, the BPI process is to notify the provider of the violation of PA MA regulations in a two-step process resulting in possible recovery of restitution of the medications reimbursement amount.
South Carolina	Managed by Program Integrity
Tennessee	May also be referred to TennCare's DUR Board for a vote of referral to Tennessee's Provider Review committee for further consideration
Texas	Medicaid Waste, Abuse, and Fraud Policy The OIG has the responsibility to identify and investigate cases of suspected waste, abuse, and fraud in Medicaid and other health and human services programs. This responsibility, granted through state and federal law, gives the OIG the authority to pursue administrative sanctions and to refer cases to prosecutors, licensure and certification boards, and other agencies. Additionally, Texas Medicaid is required to disenroll or exclude any provider who has been disenrolled or excluded from Medicare or any other state health-care program.
Utah	Peer to Peer Outreach
Vermont	Refer to Medicaid Fraud and Residential Abuse Unit
Washington	A referral is made to the Program Integrity and Quality Management Team for assessment.
Wisconsin	Refer to the Office of the Inspector General.

If “No,” please explain

Table 93 - “No” Explanations for Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Prescribers is Detected

State	Explanations
Idaho	We do not have a documented process. In general the Department would refer to the Program Integrity Unit. No referrals have been done during the Federal Fiscal Year of this report
Montana	We do not have a documented process in place to identify possible fraud or abuse of controlled drugs by prescribers. However, if we see inappropriate prescribing, case management will reach out to the prescriber to provide education. These are usually identified by the PA unit when a prescriber or pharmacy calls to get a prior authorization. The number of instances has decreased dramatically in recent years, but if we continue to see inappropriate prescribing despite education efforts, we will report severe cases to the medical board or DEA.
Nevada	Currently, the program does not include regular reviews to identify prescribers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board and regular reports are reviewed for other initiatives; any anomalies are reported to the SUR unit for investigation.
Oregon	We do not

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

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

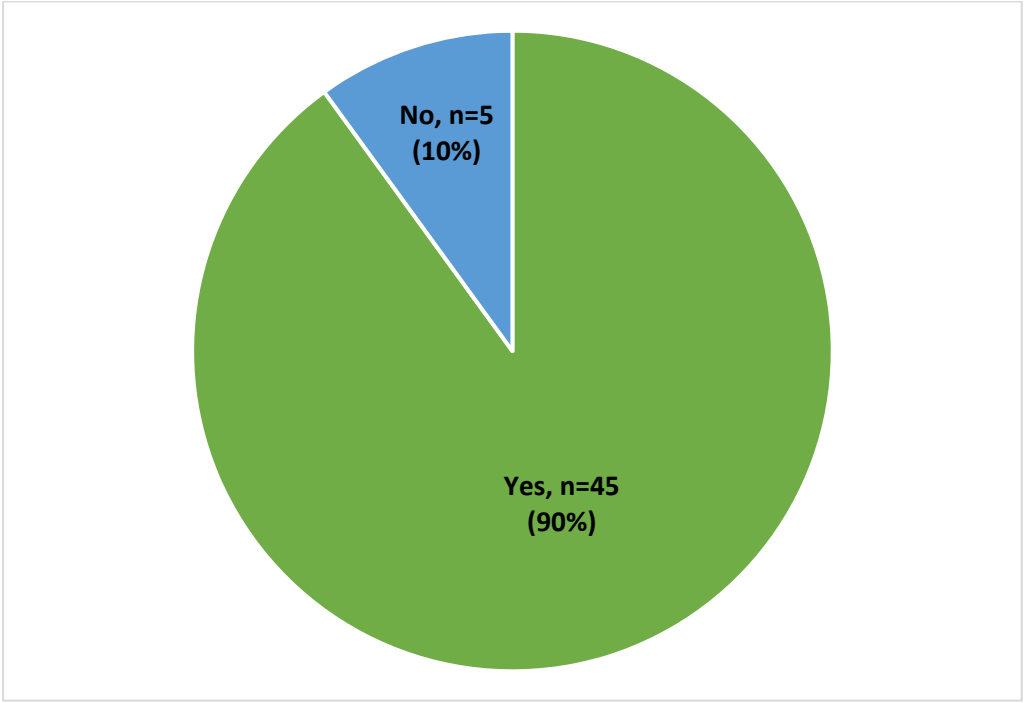

Table 94 - Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	90.00%
No	Idaho, Kansas, Montana, Nevada, Oregon	5	10.00%
Total		50	100.00%

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 Pharmacy Providers is Detected

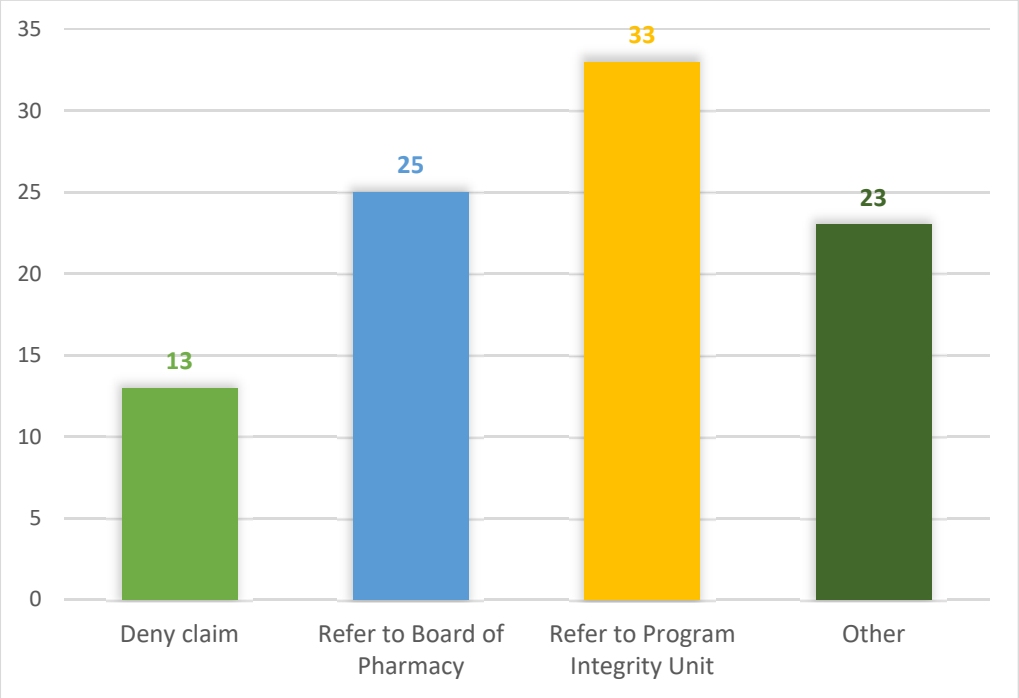

Table 95 - Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers is Detected

Response	States	Count	Percentage
Deny claim	Florida, Georgia, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, Vermont, West Virginia	13	13.83%
Refer to Board of Pharmacy	Alabama, Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Mississippi, New Hampshire, North Carolina, North	25	26.60%

Response	States	Count	Percentage
	Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wyoming		
Refer to Program Integrity Unit	Alabama, California, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	33	35.11%
Other	Alaska, Arkansas, California, Florida, Georgia, Hawaii, Illinois, Indiana, Maryland, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Washington, Wisconsin	23	24.47%
Total		94	100.00%

Other, please explain.

Table 96 - "Other" Explanations for Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers is Detected

State	Explanation
Alaska	Alaska is currently utilizing JSURS to identify prescriber trends. the state is also working on the integration of the PDMP. Trends are reviewed by the DUR committee.
Arkansas	AR OMIG performs random sampling for adherence to state and federal policies and procedures and for claim integrity. AR OMIG performs pharmacy audits twice a year on all Arkansas Medicaid enrolled pharmacies. The RDUR program, through periodic examination of claims data, will identify patterns of fraud and abuse, gross overuse and inappropriate or medically unnecessary care.
California	Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working cases involving potential fraud or abuse of controlled drugs by pharmacy providers. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and - if warranted - assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and pharmacy dispensing trends. Current utilization controls include suspended pharmacy provider lists, restrictions placed upon individual pharmacist licenses by the State Board of Pharmacy, contracted drug list compliance, code 1 restrictions documentation, treatment authorization requests, maximum dispensing quantity restrictions, and maximum dispensing restrictions during a specified time period.
Florida	Claims will deny that exceed the limits set by the Agency (i.e., Morphine Milligram Equivalent (MME), quantity limits, and day supply limits).
Georgia	Pharmacy will be referred for audit; we have an active pharmacy audit program; explanation of benefit surveys to patients regarding pharmacy claims. Several desk and field audits conducted in FY2019.

State	Explanation
Hawaii	Quarterly manual reviews of outlier claims with random sampling of one week of all claims at least once a year are performed by the DUR Board. No action was required. The monthly average of FFS claims paid is less than 500.
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
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 by pharmacies.
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, there are 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 Hampshire	Pharmacies may be suspended or sanctioned which results in in the denial of claims submitted by the pharmacy at point-of-sale.
New York	Professional retro-dur case reviewers refer potential prescriber fraud cases to the DUR program. They are then forwarded to the Medicaid Office of the Inspector General (OMIG) for further review and/or possible investigation.
North Carolina	An audit of specific claims may be performed. If fraud is suspected, a referral is made to the NC DOJ.
Pennsylvania	BPI refers to the PA Attorney General, Medicaid Fraud Control Section (MFCS).
South Carolina	Managed by Program Integrity
Tennessee	May also be referred to TennCare's DUR Board for a vote of referral to Tennessee's Provider Review committee for further consideration
Texas	Pharmacy Audits All pharmacies enrolled with VDP are subject to periodic audits. These may result from internal Texas HHSC auditors working with the Texas HHSC Inspector General (IG) or the Federal Medicaid Integrity Contractors working through the Centers for Medicare and Medicaid Services. • Refer to 1 TAC Section 354.1891 - Vendor Drug Providers Subject to Audit Pharmacy claims are sampled and reviewed for accuracy and compliance with state and federal laws and policies that govern the pharmacy programs. Any audit findings, derived by following procedures that are developed from accepted and approved audit standards, may subject the pharmacy provider to recoupment. The auditors determine the amount of overpayment in a sample set of claims and then apply a statistical extrapolation formula to estimate the overpayment across the universe of claims the pharmacy provider or supplier submitted over the selected audit period. Audits determine the pharmacy provider's compliance with federal and state laws, policies, procedures, and limitations. Claims transactions selected for audit are compared with documentation on the corresponding prescriptions, invoices, pharmacy daily logs, pharmacy delivery logs, etc. Overpayments are considered exceptions subject to restitution to HHSC. The audit process begins with an engagement letter, or notice of intent to audit, sent to the pharmacy provider. The letter includes the dates of the audit period and the proposed audit date. A request is made that pharmacy staff provide ample room and proper atmosphere for the

State	Explanation
	auditor to conduct the audit. On-site audit time periods vary between 1 and 3 days. At the end of examination of material relevant to the audit, an oral exit interview is conducted. The auditors then deliver the draft audit report listing findings, if any, to the pharmacy contact - usually the owner or the pharmacist-in-charge. The pharmacy then has 15 days to provide additional documentation and a response to the draft audit report. The response may include a management rebuttal to address any findings. A final audit report will be issued.
Utah	Peer to Peer Outreach
Washington	A referral is made to the Program Integrity and Quality Management Team for assessment.
Wisconsin	Refer to the Office of the Inspector General.

If "No," please explain.

Table 97 - "No" Explanations for Actions Process Initiates when Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers is Detected

State	Explanation
Idaho	Although we do not have a documented process, questions and potential fraud and abuse are referred to the Board of Pharmacy.
Kansas	We will review this internally and work towards being able to provide a "yes" next year.
Montana	We feel that our edits regarding duplicate fills, early fills, quantity limits, MME limits, etc. and not allowing pharmacist to override these edits prevents pharmacy providers from most forms of fraud or abuse of controlled drugs.
Nevada	Currently, the program does not include regular reviews to identify prescribers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board and regular reports are reviewed for other initiatives; any anomalies are reported to the SUR unit for investigation.
Oregon	We do not

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

Figure 67 - Documented Process to Identify Possible Fraud or Abuse of Non-Controlled Drugs by Beneficiaries

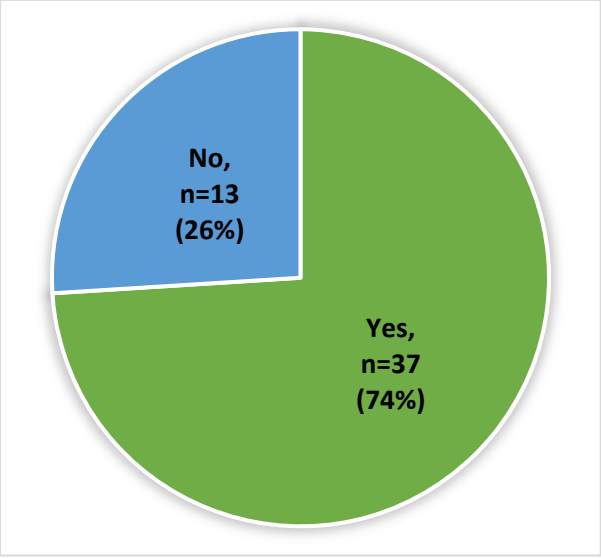

Table 98 - Documented Process to Identify Possible Fraud or Abuse of Non-Controlled Drugs by Beneficiaries

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, District of Columbia, Florida, Georgia, Illinois, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	37	74.00%
No	Connecticut, Delaware, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maryland, Missouri, Montana, Nevada, North Carolina, Rhode Island	13	26.00%
Total		50	100.00%

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

Table 99 – 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.
Alaska	The state utilizes quantity limits, days supply, therapeutic duplication, and prior authorization edits to identify/prevent potential abuse.
Arkansas	Muscle relaxers and gabapentin have recently been added to algorithms for lock-in reviews. Refill-too-soon edits, ProDUR checks, accumulation edits, quantity edits and prior authorization criteria help prevent fraud, waste and abuse by beneficiaries. Arkansas Medicaid has an internal controls and compliance group that investigate potential fraud and abuse by beneficiaries and forwards the information to the local prosecutor. If AR OMIG identifies potential fraud and abuse by beneficiaries during random sampling, information gathered is forwarded to the local prosecutor. Also, a fraud hotline and integrity reporting form are available for concerned citizens to bring attention to possible fraud, waste or abuse by a beneficiary.
California	Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working potential fraud or abuse of non-controlled drugs by beneficiaries. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and - if warranted - assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and trends.
Colorado	Retrospective DUR analysis and prior authorization are used to identify these issues. Beneficiaries are referred to the Program Integrity Unit, who works with the counties.
District of Columbia	The monthly Lock-in review process for beneficiaries includes polypharmacy defined as greater than 10 prescriptions per month including non-controlled substances
Florida	There are prescribing limits (i.e., quantity limits, duration of therapy) on non-controlled drugs based on FDA prescribing guidelines and package inserts.
Georgia	Deny claims and require prior authorization; quantity limits; refer to Program Integrity
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

State	Explanations
	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.
Maine	Referal process to identify over use and internal clinical review for placement in the lock-in program (IBM) Intensive Benefit Program
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.
Mississippi	Medicaid utilizes a maximum daily dose edit to prevent potential fraud or abuse of non-controlled drugs.
Nebraska	Early refill limits and daily quantity limits.
New Hampshire	Beneficiaries with high utilization of emergency room prescribers and pharmacies including those that paid with cash are subject to review.
New Jersey	Lock into a pharmacy and utilize negative PA. Negative PA will block payment of a prescription service. Number of referrals substantially decreased due to transition of beneficiaries to Medicaid Managed Care.
New Mexico	There is a threshold for refilling non-controlled prescriptions where 75% of the original days' supply must be used prior to dispensing a refill. If fraud, waste, or abuse by a beneficiary is determined, HSD has the authority to lock-in a member to a specified provider.
New York	Professional retro-dur case reviewers refer potential prescriber fraud cases to the DUR program. They are then forwarded to the Medicaid Office of the Inspector General (OMIG) for further review and/or possible investigation.
North Dakota	We have quantity and utilization limits on the majority (by volume of claims and dollars) of medications paid by our Medicaid program. These are in place in part to prevent fraud, waste, or abuse.
Ohio	We partner with other state agencies and investigative units to monitor potential misuse of prescriptions.
Oklahoma	We also review muscle relaxants and gabapentin claims when doing a lock in review.
Oregon	Early refill edit
Pennsylvania	Beneficiaries are placed in the Lock-In program when a pattern of fraud, waste or abuse of any medication is identified.
South Carolina	Managed by Program Integrity
South Dakota	Retrospective Drug Utilization Review, potential fraud, waste, or abuse referred to Program Integrity Unit
Tennessee	We began to look at enrollees who were using opioids and atypical antipsychotics concomitantly in March of 2019, at the angle of looking at provider types, where we identified 9 specific provider practice types. The data proved inconclusive at that time, but we will be repeating this exercise again in FF20, narrowing our review to specific atypical antipsychotic products.
Texas	The Lock-In Program makes referrals to other OIG divisions or licensing body when applicable.

State	Explanations
Utah	To prevent fraud, waste, or abuse of non-controlled substances utilization management edits are in place. These edits vary depending on the medication, include but are not limited to: quantity limits, day supply limits, and prior authorization.
Vermont	Quantity limits and early refill limits. Additional fills for lost or stolen medication requires a call to the help desk for appropriate documentation (possible PA) and override
Virginia	Refer to Program Integrity Unit
Washington	A referral would be made to the Lock-In (Patient Review and Coordination) program for assessment.
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 at minimum an approved diagnosis.
Wisconsin	Fraud and abuse must be reported regardless if the drug is a controlled or non-controlled drug. Providers may report fraud and abuse by going to the OIG fraud and abuse website or by calling the fraud and abuse hotline.
Wyoming	The DUR Manager may identify patterns of fraud, waste or abuse of non-controlled substances during retrospective analysis. When this occurs, beneficiaries are referred to the program integrity unit for further review.

If “No,” please explain.

Table 100 – Explanations of Documented Processes to Identify Possible Fraud or Abuse of Non-Controlled Drugs by Beneficiaries

State	Explanations
Connecticut	During FFY 2020 a form was created to allow the clinical pharmacist to document suspected fraud and abuse of controlled and non-controlled drugs by beneficiaries and send the referral form to the DSS program integrity unit for referral or further review.
Delaware	Polypharmacy and multiple provider.
Hawaii	Quarterly manual reviews of outlier claims with random sampling of one week of all claims at least once a year are performed by the DUR Board. No action was required. The monthly average of FFS claims paid is less than 500.
Idaho	Presently we do not have a documented process. We work very closely with Board of Pharmacy with referral going both ways (from them to us or us to them). The Board of Pharmacy also will work with the licensing agency for the prescriber if necessary.
Indiana	Pharmacies are able to supply tips on members to the fraud control line if member fraud and abuse is suspected.
Kansas	We will review this internally and work towards being able to provide a "yes" next year.
Louisiana	When potential patterns of fraud, waste, or abuse by beneficiaries are identified, the beneficiary may be referred to the Lock-in Program, and/or their prescriber may be contacted.
Maryland	The Maryland Department of Health (MDH) currently does not have a process in place that identifies and/or prevents potential fraud or abuse of non-controlled medications however, may develop one in future.
Missouri	We do not have a process in place to monitor non-controlled drugs for fraud/abuse.
Montana	We only have duplicate fill, early fill, and some quantity limit or criteria POS edits to prevent potential fraud or abuse of non-controlled drugs by beneficiaries. We do not have a retrospective review process.

State	Explanations
Nevada	Currently, the program does not include regular reviews to identify pharmacy providers for possible fraud or abuse of controlled substances. Reporting is provided to the DUR Board and regular reports are reviewed for other initiatives; any anomalies are reported to the SUR unit for investigation.
North Carolina	We do not have a process at this time.
Rhode Island	Fee for Service is routinely secondary payer.

B. Prescription Drug Monitoring Program (PDMP)

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

Figure 68 - Prescription Drug Monitoring Program

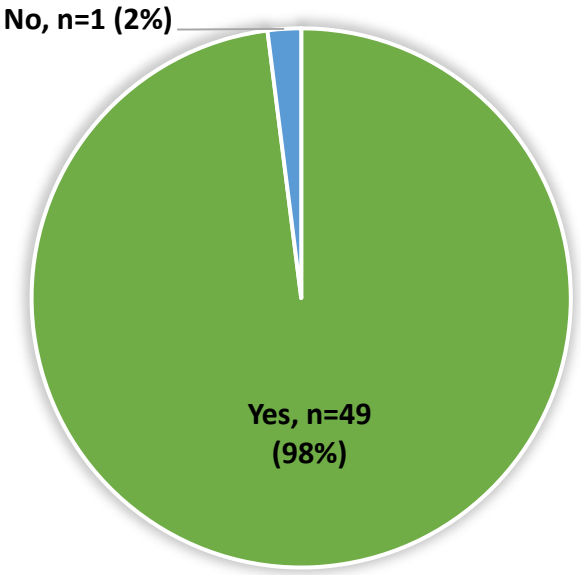

Table 101 - Prescription Drug Monitoring Program

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%
Total		50	100.00%

If the answer to question 1 is "Yes," please continue with a, b, and c.

a. Does your agency have the ability to query the state's PDMP database?

Figure 69 - Ability to Query State's PDMP Database

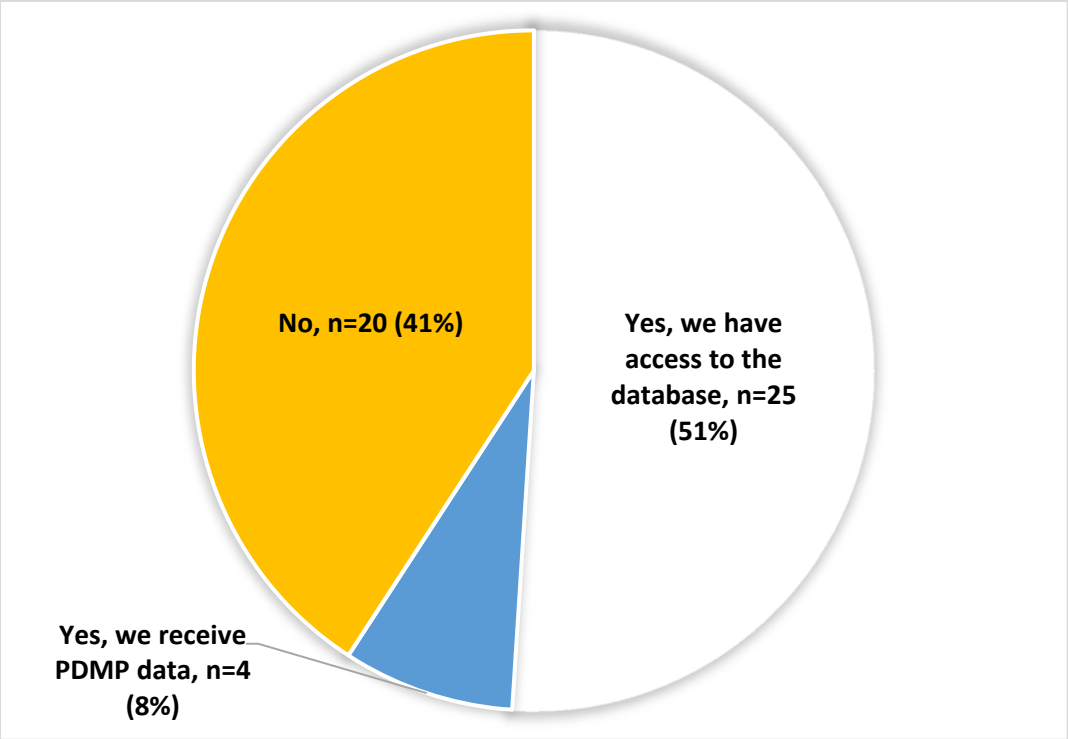

Table 102 - Ability to Query State's PDMP Database

Response	States	Count	Percentage
Yes, we have access to the database	Alabama, Alaska, Arkansas, California, Connecticut, Georgia, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Vermont	25	51.02%
Yes, we receive PDMP data	South Carolina, Tennessee, Washington, West Virginia	4	8.16%
No	Colorado, Delaware, District of Columbia, Florida, Hawaii, Indiana, Iowa, Kansas, Minnesota, Nebraska, New Hampshire, New Jersey, New York, Oregon, Rhode Island, Texas, Utah, Virginia, Wisconsin, Wyoming	20	40.82%
Total		49	100.00%

If the answer to sub-question 1 a is "Yes," please continue.

i. Please explain how the state applies this information to control fraud and abuse.

Table 103 – Explanations of Application of Information to Control Fraud and Abuse

State	Explanations
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 during case review.
Arkansas	The RDUR program is responsible for monitoring our lock-in program. When reviewing potential lock-in patients, the PDMP is used to ascertain what controlled substances were used by the beneficiary in addition to what has been billed and found on the beneficiary's Medicaid profile. Arkansas has a poisoning/overdose edit that requires a prior authorization for opioids and benzodiazepines if the beneficiary has a billed diagnosis of poisoning or overdose on their profile. The prior authorization reviewer consults the PDMP on these requests. Also, the Arkansas State Medical Board requires prescribers to access the PDMP before prescribing controlled substances.
California	The California Department of Justice has a Prescription Drug Monitoring Program (PDMP) system called the Controlled Substance Utilization Review and Evaluation System (CURES), which allows pre-registered users including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards to access timely patient controlled substance history information. Access to such information helps prescribers and pharmacists better evaluate their patients' care, allowing them to make better prescribing and dispensing decisions, and cut down on prescription drug abuse in California. Audit & Investigations, Investigations Branch (IB) uses all available information to develop and work cases, initiates audits, and assists in investigations. IB also examines PDMP information on prescribers, dispensers, and beneficiaries during the course of their usual work.
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.
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 that possible fraud and/or abuse is occurring. The PDMP is also used to identify patients who are paying cash (private pay) for controlled substance outside of the Idaho Medicaid benefit. The PDMP gives us a more complete picture of what controlled substances a beneficiary may be receiving.
Illinois	Recipient Analysis Unit staff use the PMP as a reference only in access restriction determinations. When evaluating requests for controlled substances, Prior authorization staff will check PMP. Potential fraud and abuse may be communicated to the prescriber. PMP information is used for reference to augment agency fill history information.
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	Used 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 bonafide investigation is being conducted.

State	Explanations
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.
New Mexico	Information is obtained on a case-by-case situation, of which is only accessible by a state staff pharmacist personally enrolled in the state's PDMP.
North Carolina	If supporting information is needed for an investigation, the PDMP is available.
North Dakota	Pharmacists review the PDMP data when there are calls regarding denied controlled substances or requests for coverage of medications that require prior authorization.
Ohio	Used for data mining projects with SURS.
Oklahoma	Evaluate members for the lock-in program and individual review of members to prevents excess abuse.
Pennsylvania	BPI has the ability to query the data base if abuse is suspected. If fraud is suspected, BPI would refer the pharmacy provider to MFCS. BPI is a civil agency and cannot act as an agent for MFCS.
South Carolina	For clinical considerations only, generally in regard to Lock-In.
South Dakota	The PDMP information is utilized as a reference on a case by case basis.
Tennessee	We have an agreement with the TN Department of Health, who owns the PDMP, referred to in Tennessee as the Controlled Substance Monitoring Database (CSMD), which allows TennCare to receive CSMD data, but in the agreement we are unable to use the data on an individual basis for fraud, controlled substance investigation, etc. TennCare's primary use of the information is in Dashboard benchmarking
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. The PDMP access by the Medical Director has a limited application to the control of fraud and abuse.
Washington	PDMP data is used by clinical staff performing authorization reviews. If there appears to be multiple prescribers or cash payment of controlled substances referrals are made to the Lock-In program for assessment. In the future PDMP data will be used in conjunction with our claim and encounter data to validate prescriber and pharmacy staff are monitoring activity prior to prescribing or dispensing controlled substances. Combining controlled substance transactional data from the PDMP will allow us to verify frequency of cash payment and other at risk behaviors from a client, prescriber, and pharmacy perspective and make referrals to the Lock-In program or Program Integrity for additional monitoring.
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 also have access to Border States' PDMP information?

Figure 70 - Access to Border State PDMP Information

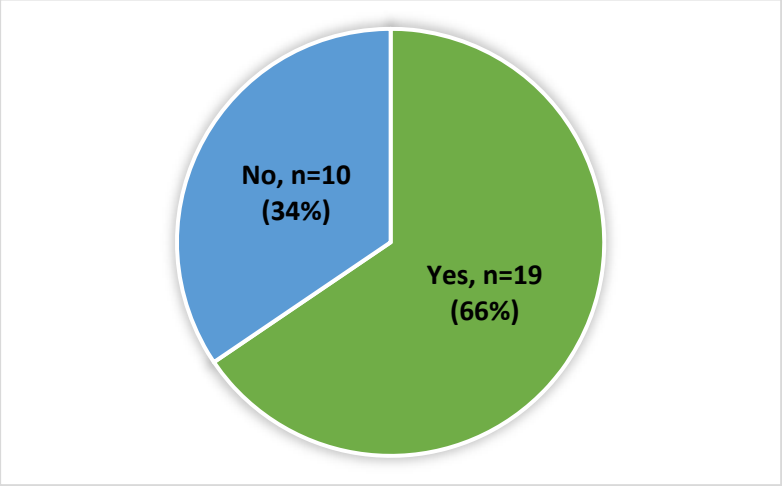

Table 104 - Access to Border State PDMP Information

Response	States	Count	Percentage
Yes	Alaska, Connecticut, Idaho, Illinois, Kentucky, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Mexico, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Vermont, Washington	19	65.52%
No	Alabama, Arkansas, California, Georgia, Louisiana, Maine, Maryland, North Carolina, North Dakota, West Virginia	10	34.48%
Total		29	100.00%

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

Figure 71 - PDMP Data Integration into POS Edit

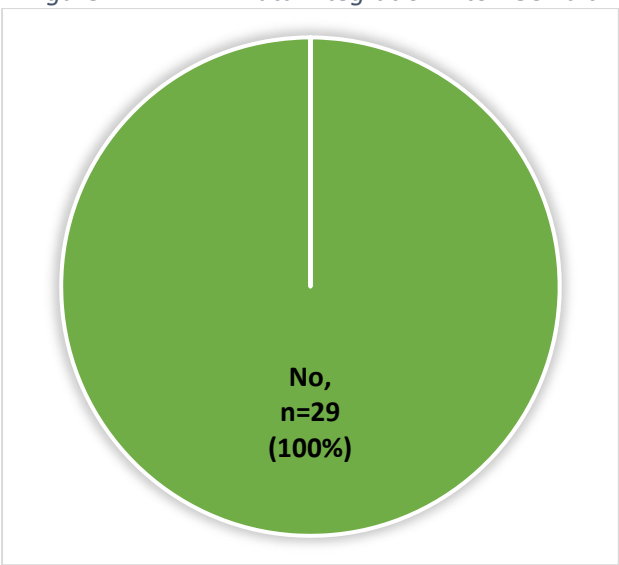

Table 105 - PDMP Data Integration into POS Edit

Response	States	Count	Percentage
No	Alabama, Alaska, Arkansas, California, Connecticut, Georgia, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Vermont, Washington, West Virginia	29	100.00%
Total		29	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 72 - Prescribers Requirement to Access the PDMP Patient History before Prescribing Controlled Substances

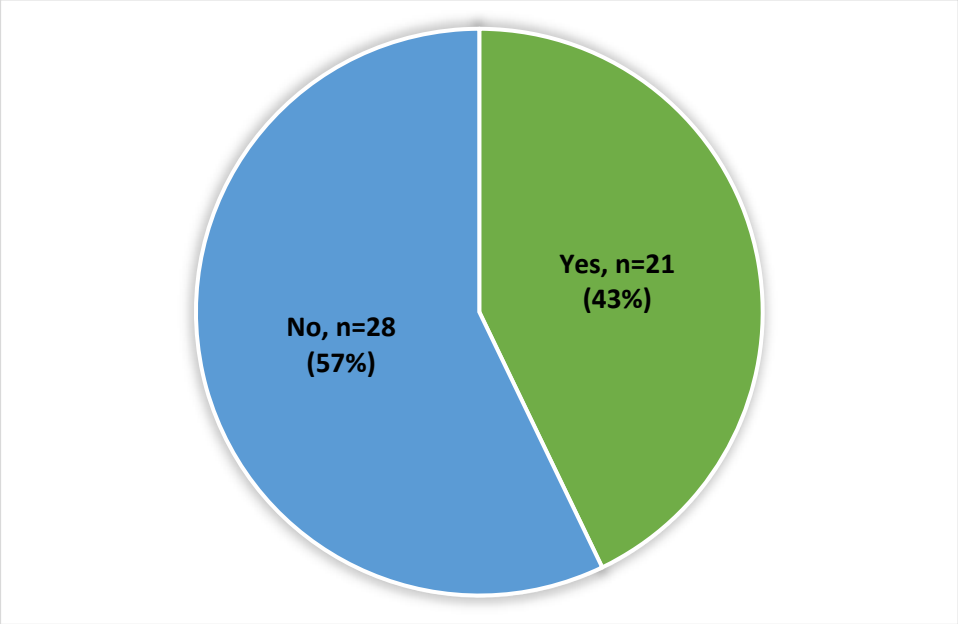

Table 106 - Prescribers Requirement to Access the PDMP Patient History before Prescribing Controlled Substances

Response	States	Count	Percentage
Yes	Connecticut, Delaware, Florida, Georgia, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wyoming	21	42.86%
No	Alabama, Alaska, Arkansas, California, Colorado, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin	28	57.14%
Total		49	100.00%

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 73 - Barriers that Hinder the Agency from Fully Accessing the PDMP

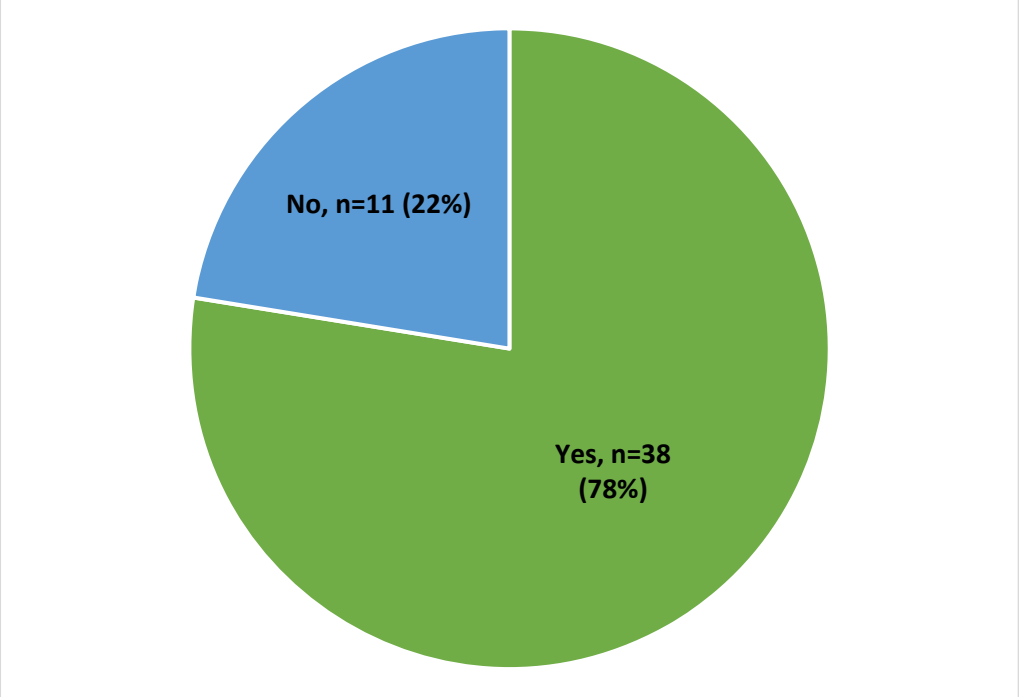

Table 107 - Barriers that Hinder the Agency from Fully Accessing the PDMP

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	38	77.55%
No	Kentucky, Louisiana, Maine, Michigan, Montana, New Mexico, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee	11	22.45%
Total		49	100.00%

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

Table 108 – Explanations of PDMP Barriers

State	Barrier Explanations
Alabama	Medicaid has limited access to PDMP as the oversight is with another State agency. Prescribers/pharmacies are not required to access prior to writing/dispensing prescriptions.
Alaska	The PDMP is not currently integrated into the Point-of-Sale system, limiting the efficiency of the pharmacist when checking previous prescription history.

State	Barrier Explanations
Arkansas	Arkansas Medicaid enrolled prescribers do not access the PDMP 100% of the time when prescribing opioids/controlled substances. Arkansas Medicaid staff does not have access to PDMP data for other states. Access to PDMP data for all states would allow Medicaid staff to more thoroughly review prior authorization requests for patients living on state boarders and those recently moving from other states.
California	The following barriers exist that hinder the agency from fully accessing the PDMP in the way it was intended: 1. Inability to access border states' PDMP information 2. Lag time for prescription data being submitted 3. Ambiguous regulations governing access to PDMP data
Colorado	The State is prohibited by legislation from accessing the PDMP. In our criteria, we highly encourage providers to access the PDMP before prescribing any opioids.
Connecticut	Access is restricted to our Medicaid Fraud Unit only.
Delaware	The barrier in Delaware is there is no direct access by the Medicaid agency to the PDMP, all requests must go through PDMP agency.
District of Columbia	The District of Columbia PDMP does include pharmacy claims data from the bordering states of MD and VA. The barrier to Medicaid access is the policy of the Department of Health (the PDMP administrator) that the PDMP can not be used by the Department of Health Care Finance (DC Medicaid) in support of the Pharmacy Lock-in Program or other pharmacy related program analyses. The PDMP Administrator has deemed such activity as inappropriate fishing for information. Currently the PDMP can only be accessed by the Medicaid Program Integrity Unit to assist with providing information in response to 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	It is legislated for prescribers and dispensers to check PDMP but access to agencies and report capability were not included. Prior to COVID, the agency access was requested.
Idaho	Can only access by specific patient and not able to look for patterns by patient, prescriber or pharmacy. There is a lag time in information available from the 6 border states. We are not able to generate aggregate reports such as cash (private pay) payments by the beneficiary or total MME over a set amount from all sources. We do not have the ability to see Outpatient Drug Treatment clinics (methadone).
Illinois	We can only view one patient at a time. Sometimes still need to re-enter patient's demographic data if checking neighboring state. Not all pharmacy data is real time as evidenced by claims filled in HFS system, but not yet visible in PDMP. HFS has no way to verify if prescriber checked ILPMP prior to writing prescription.
Indiana	Prescribers not accessing data, pharmacists not reviewing data before filling prescriptions, unable to query and monitor the database for review.
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 the patient's use of controlled substances.
Kansas	We do not have access at the State Medicaid agency, but the Kansas pharmacies/pharmacists have access. FFS and MCO Pharmacy Directors have limited access, but only on demand/individual request for data.

State	Barrier Explanations
Maryland	The FFS program must have a bonafide 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 including 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 patient under investigation for fraud and abuse.
Mississippi	The PDMP database does not utilize a unique patient identifier in its system. Currently the PDMP system requires 3 fields to identify a beneficiary (first name, last name, and DOB). If all three of these criteria do not match exactly, the system may not link profiles. This makes it difficult to match PDMP data to particular beneficiaries. An example could be if Medicaid has beneficiary listed as "Joseph Doe", but they are in the PDMP database as "Joe Doe", the two profiles may not match up even if the DOB is the same in both systems.
Nebraska	Nebraska Medicaid just obtained the ability to access the PDMP September 2019.
Nevada	Only one State employee is allowed access and none of the Managed Care Organizations have access. The Nevada PDMP only includes data on controlled substances, not all drugs. There are inconsistencies and inaccuracies in the way that data is entered by the pharmacist filling the prescription. For example, a pharmacist enters in coupon as payment method, then when contacted and asked about the coupon, the pharmacy staff has stated that it may have been entered incorrectly.
New Hampshire	The Department is prohibited by NH statute from accessing the 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.
New York	Currently the Medicaid Program is working to establish a data exchange with the Bureau of Narcotic Enforcement which operates and manages the PDMP
North Carolina	Some pharmacies have restricted internet access, delays in processing data submitted, prescribers complain of time required to log in. There are some security issues with department access to the PDMP.
North Dakota	Border states don't allow Medicaid employees to access their PDMP data.
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	Medicaid payers did not have access to the PDMP in Oregon during the reporting period (FFS still does not have access).
Rhode Island	State law requires users of the PDMP to have a DEA number.
Texas	Per the State's requirement, access to the prescription data is statutorily restricted. The information is available to practitioners and pharmacies who are inquiring about their own prescribing or dispensing history on their patients. State regulatory boards have access as well. A person who knowingly gives, permits or obtains unauthorized access to this information, is subject to criminal penalty.

State	Barrier Explanations
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 to check the PDMP prior to prescribing a controlled substance, there is no way of knowing if prescribers have access it to verify this information.
Vermont	Currently according to Vermont rule, only the medical director of the Department of Vermont Health Access as the Authority to query VPMS directly. There is no direct access by the Department of Vermont Health Access Pharmacy team to query the PDMP and there is no integration of PDMP into the POS system.
Virginia	Not allowed to access by state law
Washington	During FFY19 there were several recommendations for prescribers to review the PDMP prior to prescribing controlled substances; however WA State continues to see limited providers access the database. Much of this limitation is associated with impact to provider workflow and lack of integration into some electronic record systems.
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.
Wyoming	The Wyoming Department of Health is not allowed access by the Wyoming Board of Pharmacy due to interpretation of the statute creating 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 74 - Changes to your State's PDMP during this Reporting Period that have Improved the Agency's Ability to Access PDMP Data

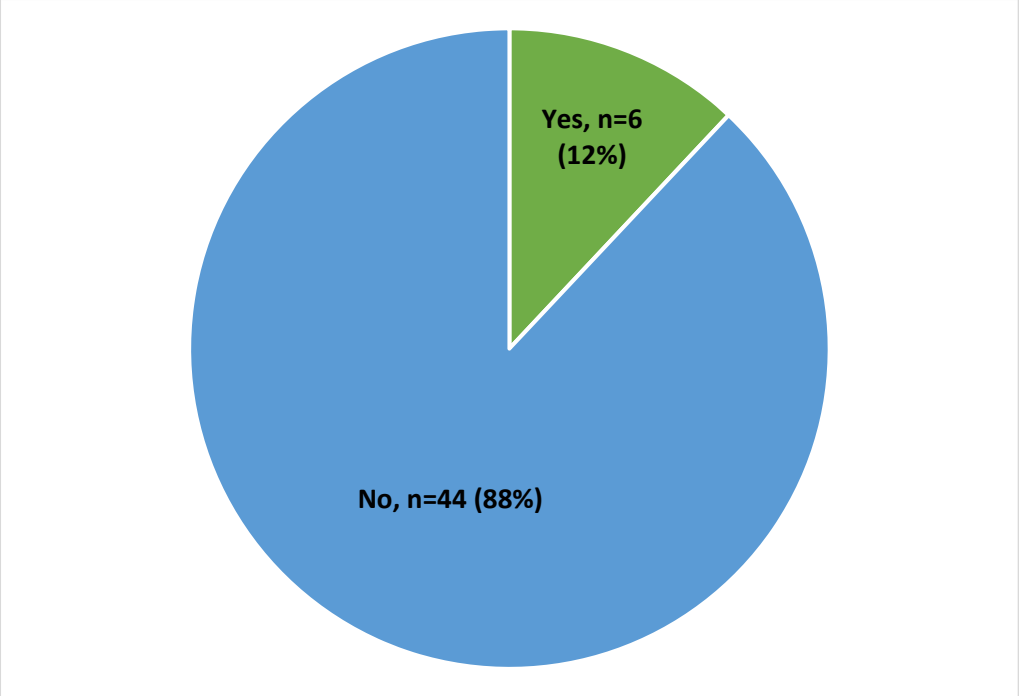

Table 109 - Changes to your State's PDMP during this Reporting Period that have Improved the Agency's Ability to Access PDMP Data

Response	States	Count	Percentage
Yes	California, Hawaii, Idaho, Illinois, Ohio, West Virginia	6	12.00%
No	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, 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, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	44	88.00%
Total		50	100.00%

If "Yes," please explain.

Table 110 - Explanations of PDMP Changes

State	Explanations
California	Effective for dates of service on or after October 2, 2018, it is now mandatory to consult the CURES 2.0 database prior to prescribing, ordering, administering, or furnishing a Schedule II - IV controlled substance.
Hawaii	Hawaii Revised Stature Section 329-38.2 Prescriptions; additional restrictions (b) No prescriber shall prescribe a schedule II, III, or IV controlled substance without first requesting, receiving, and considering records of the ultimate user from the state electronic prescription accountability system as needed to reduce the risk of abuse of or addiction to a controlled substance, as needed to avoid harmful drug interactions, or as otherwise medically necessary; provided that this subsection shall not apply to any prescription: (1) For a supply of three days or less that is made in an emergency situation, by an emergency medical provider, or in an emergency room; (2) That will be administered directly to a patient under the supervision of a health care provider licensed to practice within the State; provided that a medically-indicated query of the electronic prescription accountability system is made when the patient is initially admitted for inpatient care at a hospital; (3) That is an initial prescription for a patient being treated for post-operative pain; provided that the prescription is limited to a three-day supply with no refills; (4) For a patient with a terminal disease receiving hospice or other types of palliative care; provided that for purposes of this paragraph, "terminal disease" means an incurable and irreversible disease that will, within reasonable medical judgment, produce death within six months; (5) Prescribed while the state electronic prescription accountability system is nonfunctional;
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. State law now mandates that prescribers check PMP when writing an initial prescription for Schedule II controlled substances. Prescribers are also now automatically enrolled in PMP when applying or reapplying for state licensure. More prescribers now have direct PMP access via their medical systems' EMRs.

State	Explanations
Ohio	On January 16, 2019, four Ohio dispensaries began selling medical marijuana products. All Ohio licensed dispensaries are required to report medical marijuana dispensing to OARRS within five minutes of a sale. Beginning March 19, 2019 Naltrexone dispensing information had to be reported to OARRS. The collection of naltrexone is intended to assist prescribers and pharmacists in identifying individuals who may be receiving treatment for substance use disorder. This information can be useful for healthcare providers who are considering the use of controlled substances to treat patients.
West Virginia	We are now allowed to delegate authority to our PA vendor so that they may also review patient's 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 75 - Possession of DEA Active Controlled Substance Registrant's File to Identify Prescribers Not Authorized to Prescribe Controlled Drugs

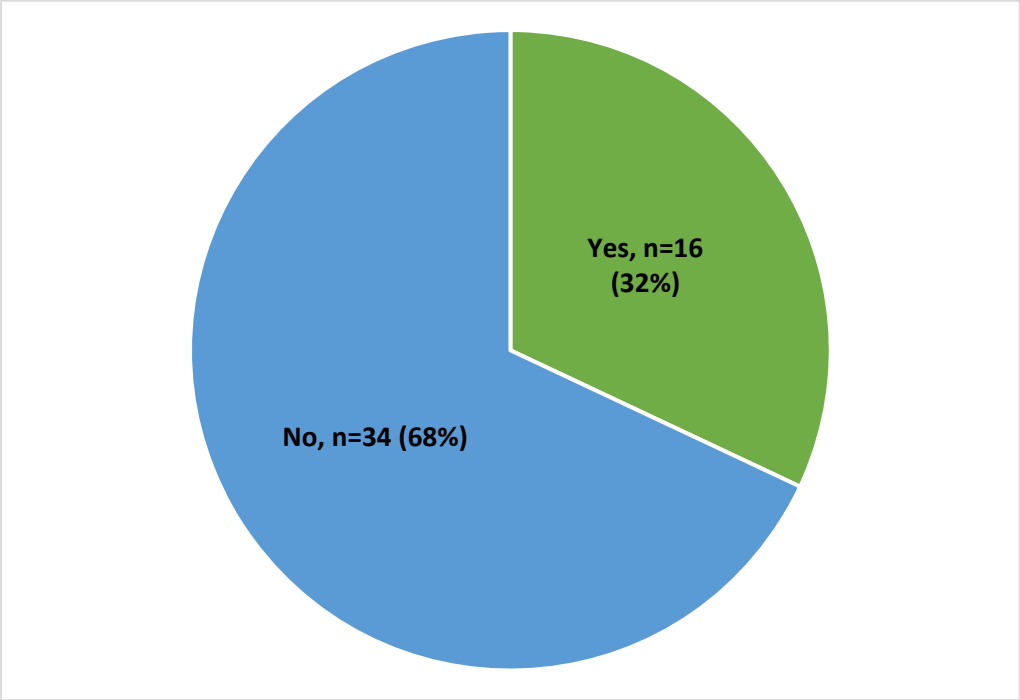

Table 111 - Possession of DEA Active Controlled Substance Registrant's File to Identify Prescribers Not Authorized to Prescribe Controlled Drugs

Response	States	Count	Percentage
Yes	Alabama, Alaska, Connecticut, Hawaii, Idaho, Illinois, Maine, Michigan, New Hampshire, North Dakota, Pennsylvania, South Carolina, South Dakota, Tennessee, Washington, West Virginia	16	32.00%
No	Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, Texas, Utah, Vermont, Virginia, Wisconsin, Wyoming	34	68.00%
Total		50	100.00%

If the answer to question 1 is "Yes," please continue

a. Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?

Figure 76 - Application of the DEA Active Controlled Substance Registrant's File to ProDUR POS Edits to Prevent Unauthorized Prescribing

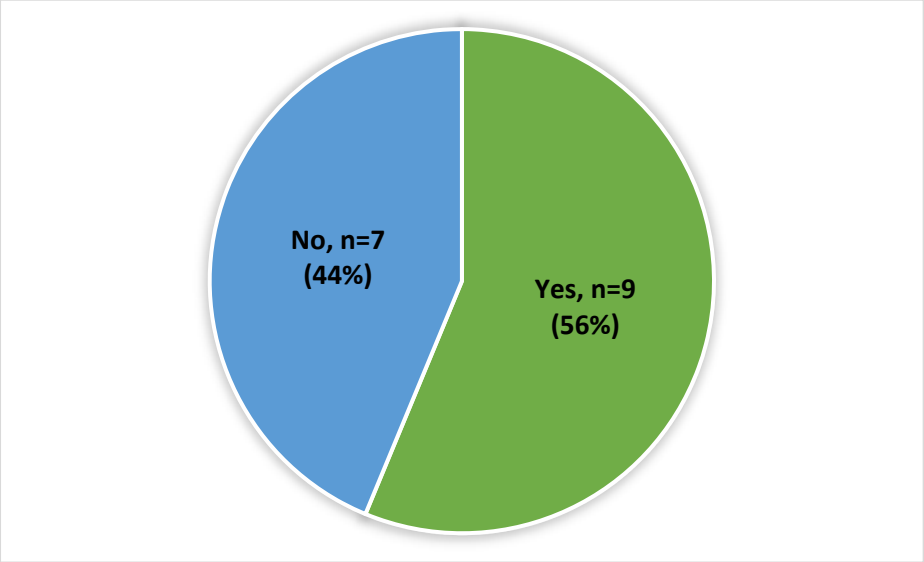

Table 112 - Application of the DEA Active Controlled Substance Registrant's File to ProDUR POS Edits to Prevent Unauthorized Prescribing

Response	States	Count	Percentage
Yes	Alabama, Connecticut, Hawaii, Maine, Michigan, North Dakota, South Carolina, South Dakota, Washington	9	56.25%
No	Alaska, Idaho, Illinois, New Hampshire, Pennsylvania, Tennessee, West Virginia	7	43.75%
Total		16	100.00%

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

Table 113 – Explanations of the Application of the DEA File to 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.
Hawaii	Any controlled substance must have a valid and active DEA number. Buprenorphine and buprenorphine combinations must have a valid and active DEA-X number. If not the case, the claim will be denied at point of sale.
Maine	Utilize the NTIS data source for claim adjudication
Michigan	The POS system has business rules that check the XDEA license eligible prescribers of office-based opioid dependency drug therapies.
North Dakota	All controlled substance prescriptions are compared to the DEA file to ensure the prescriber is licensed to prescribe that specific level of controlled substances, and the claim will deny if they are not.
South Carolina	System requires a valid DEA number in order to process the claim
South Dakota	The file is referenced during claim adjudication.
Washington	These files are loaded into the POS system and the provider is added to a network that restricts controlled substances from paying based on no DEA number being on file.

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

Figure 77 – Plans to Obtain the DEA Active Controlled Substance Registrant’s File and Apply it to POS Edits

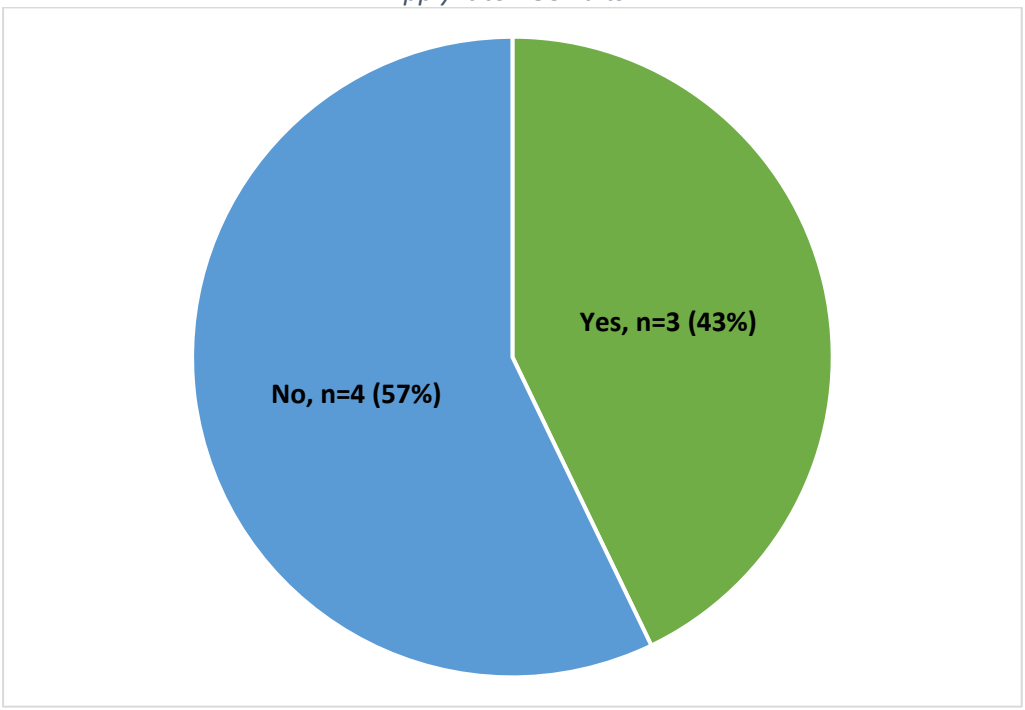

Table 114 - Plans to Obtain the DEA Active Controlled Substance Registrant's File and Apply it to POS Edits

Response	States	Count	Percentage
Yes	Alaska, Pennsylvania, West Virginia	3	42.86%
No	Idaho, Illinois, New Hampshire, Tennessee	4	57.14%
Total		7	100.00%

If "No," please explain.

Table 115 – Explanations of not obtaining the DEA Active Controlled Substance Registrant's File and Apply it to POS Edits

State	Explanations
Idaho	We have not been able to figure out how to integrate with POS edits, but are exploring.
Illinois	At this time our vendor does not offer the ability to apply this file prospectively to pharmacy claims
New Hampshire	At this time the DEA file is used in our RetroDUR review process to identify prescribers that are not authorized to prescribe controlled substances.
Tennessee	We did use this file, however found that it became problematic because the data is only updated monthly. This caused denials for some children, using C-II stimulants, and also caused denials for student physicians (residents, fellows) and we felt that it caused more harm than good at the time.

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

Figure 78 - Apply DEA File to RetroDUR Reviews

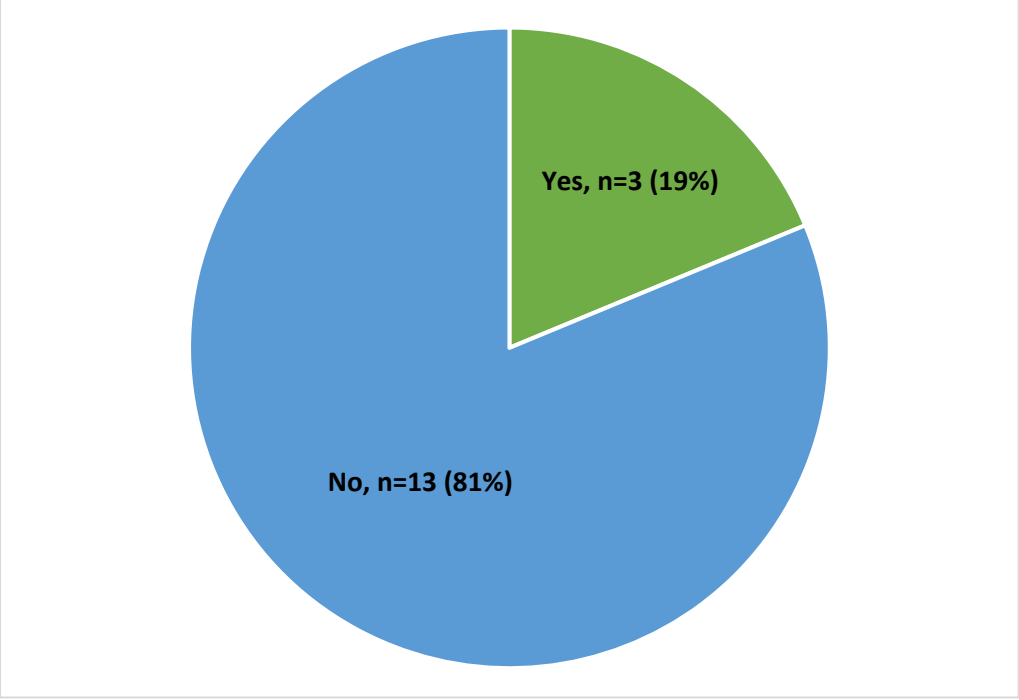

Table 116 - Apply DEA File to RetroDUR Reviews

Response	States	Count	Percentage
Yes	Maine, Michigan, New Hampshire	3	18.75%
No	Alabama, Alaska, Connecticut, Hawaii, Idaho, Illinois, North Dakota, Pennsylvania, South Carolina, South Dakota, Tennessee, Washington, West Virginia	13	81.25%
Total		16	100.00%

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

Table 117 - Explanation 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 79 - Measure in Place to either Monitor or Manage the Prescribing of Methadone for Pain Management

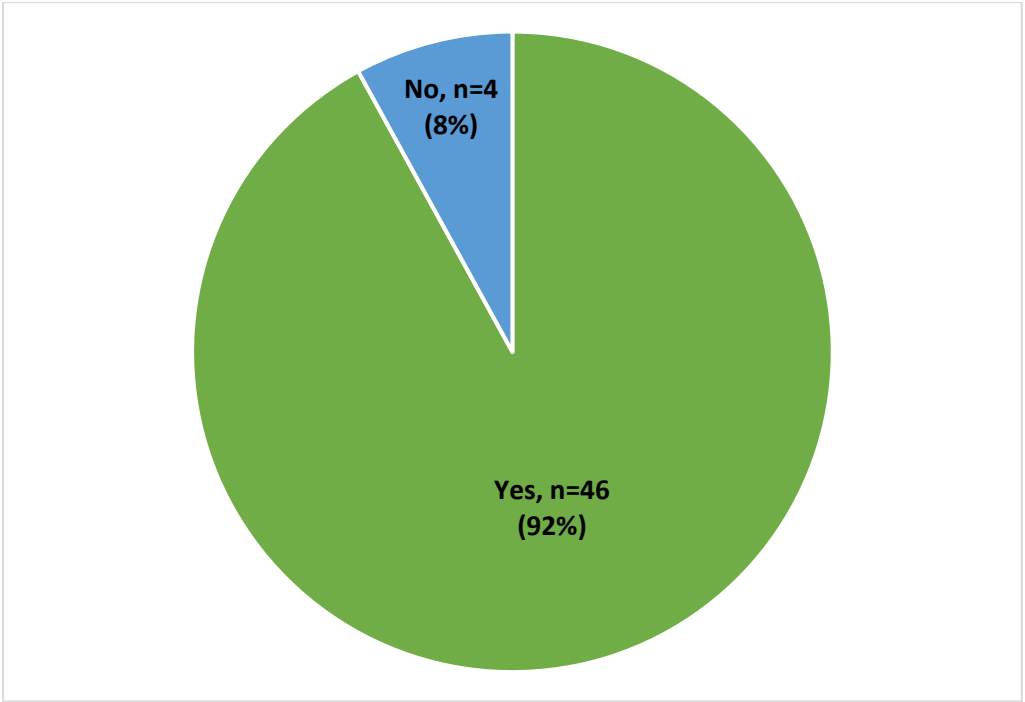

Table 118 - Measure in Place to Either Monitor or Manage the Prescribing of Methadone for Pain Management

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%
Total		50	100.00%

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

Table 119 - Explanations of Not Having a Measure in Place to either Manage or Monitor the Prescribing of Methadone for Pain Management

State	Explanations
Hawaii	The need has not occurred since 2009.
Nevada	Methadone is non-preferred in the opioid drug class on the Nevada PDL.
New Mexico	Researching possible resources to validate Registrant's DEA in order to apply to POS edits.
Rhode Island	P & T Committee determines methadone would be a preferred agent on the Preferred Drug list. Fee for Service is a secondary claim, therefore 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 80 - POS Edit in Place to Limit the Quantity Dispensed of an Initial Opioid Prescription

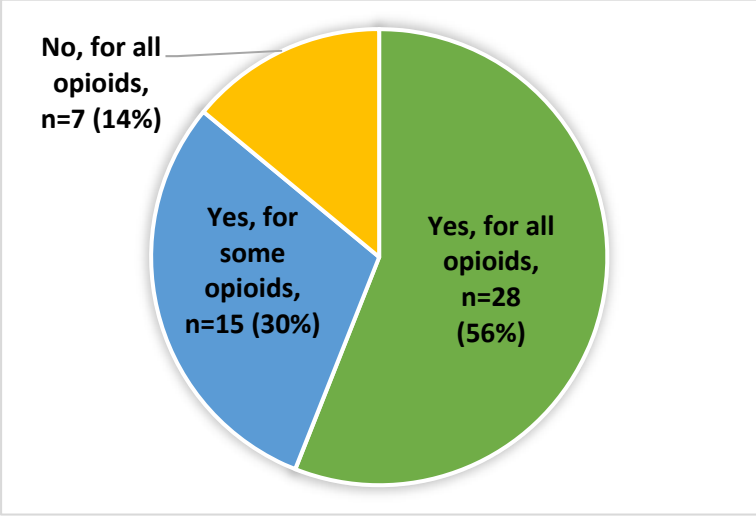

Table 120 - POS Edit in Place to Limit the Quantity Dispensed of an Initial Opioid Prescription

Response	States	Count	Percentage
Yes, for all opioids	Alabama, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Nebraska, Nevada, New York, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Utah, Virginia, Washington, Wyoming	28	56.00%
Yes, for some opioids	California, Delaware, Hawaii, Kansas, Louisiana, Michigan, Missouri, Montana, North Carolina, North Dakota, Rhode Island, South Carolina, Vermont, West Virginia, Wisconsin	15	30.00%
No, for all opioids	Alaska, Iowa, New Hampshire, New Jersey, New Mexico, Oklahoma, Texas	7	14.00%
Total		50	100.00%

Please explain answer above

Table 121 - Explanations of POS Edit in Place to Limit the Quantity Dispensed of an Initial Opioid Prescription

State	Explanations
Alabama	Short-acting opioid naive days' supply edit Quantity limits
Alaska	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	New start to opioid therapy (treatment naive) for a Medicaid beneficiary is defined as no claims for any opioid drugs for pain in the beneficiary's Medicaid drug profile in the previous 60 days. For an opioid treatment naive beneficiary, the maximum MMEs is 50 MME/day. The initial prescription for the treatment naive beneficiary for the short-acting opioid is limited to a 7-day supply with the corresponding quantity limit of up to 6 tablets or capsules per day. The new start opioid therapy rule does not apply to beneficiaries with a cancer diagnosis. All new starts for long-acting opioids require a prior authorization. Documentation of opioid tolerance must be provided. LA opioid criteria exclude current LTC-eligible beneficiaries, beneficiaries who meet the cancer diagnosis criteria, and beneficiaries who meet the NPO diagnosis criteria.
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 to quantity limits listed on the preferred drug list and are eligible for up to a 30 day supply. Dental prescriptions are limited to a three day supply of short-acting opioids.
Connecticut	CT state law requires that prescribers limit initial opioid prescriptions for patients to a 7 days' supply.
Delaware	A long-acting opioid analgesic. Initial fills of all long-acting narcotics will be limited to a 15-day supply. The first fill of a short-acting opioid prescription cannot exceed a 7-day supply.
District of Columbia	Patients who are considered acute (less than 120 days of history of opioid claims in the last 180 days) are limited to a 7 days supply with a total of 30 days per 180 day period
Florida	For opioid treatment naive recipients, the limit is 90 MME. There are also product specific limits per FDA package inserts.

State	Explanations
Georgia	Quantity level limits in place. MEDLIMIT 50 MME: For treatment naïve members, edit check for a cumulative SAO & LAO dose check for >50 MME/day. MEDLIMIT 7 DAY SUPPLY: For treatment naive members: Edit check for SAO prescriptions for >7 day supply.
Hawaii	The majority of opioids are dental prescriptions for acute pain relief and one time emergency basis. Refills are not allowed. There are quantity limits in place in the Dental formulary.
Idaho	Idaho Medicaid does not currently have a 3-7 day initial limit for opioid naive recipients. The drug specific daily and monthly quantity limit plus cumulative MME edit with all other opioids is applied.
Illinois	Monthly quantity Short-acting opioids: 186. Long-acting opioids: 124.
Indiana	60MME for new opioid utilizers of short-acting opioids only, quantity limits applied to all long-acting agents if approved via PA or for those current utilizers. Patients with cancer, sickle cell, and other terminal diagnoses associated with significant pain are not subject to the initial quantity limits for new utilizers.
Iowa	POS edit is not currently in place, but has been recommended by the DUR Commission.
Kansas	We have an initial fill limit of a 7 day supply for short-acting opioids, unless they have cancer, sickle cell anemia, or reside in a facility that a caregiver gives the medicine to the patient. Cough and cold products which contain opioids are not included in our initial quantity limit edit. Opioid Use Disorder medications do not have an initial quantity limit.
Kentucky	Short-acting opioids are subject to day supply limit; most also have a daily quantity limit. Long-acting opioid s
Louisiana	Short-acting opiates, recipient is opiate naive: 28 units within a 7 day period
Maine	initial script limits are in place as adjudication edit
Maryland	Quantity limits are in place and are expressed as a cap of 90MME/day. All opioids have quantity limits in place regardless of the patient's length of treatment or history of use of the medication. The Maryland Medicaid Opioid Drug Utilization Review Workgroup proposed recommendations located at: https://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/medicaid-opioid-response.aspx Quantity limit information is available at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf
Massachusetts	Massachusetts law established a maximum seven day supply on prescriptions for opioids when issued to an adult for the first time. The law also sets a maximum seven day supply on all opioid prescriptions for minors. A prescriber may issue a prescription for more than a seven day supply of an opioid to adult or minor patients if, in the prescriber's medical judgment, a greater supply is necessary to treat an acute medical condition, chronic pain, pain associated with a cancer diagnosis or for palliative care. In such a case, the condition must be documented in the patient's medical record and the prescriber must indicate that a non-opioid alternative was not appropriate to address the medical condition. This new law does not apply to opioid medications that are designed for the treatment of substance abuse or opioid dependence.
Michigan	Prescriptions for short acting narcotics in opioid naive patients is limited to a 7 days supply unless a prior authorization is requested with attestation that the prescription is for chronic pain.

State	Explanations
Minnesota	The quantity limit is to 7 day supply and the max units per day which is based on 90mg MME.
Mississippi	New opioid prescriptions (first opioid fill within 90 days) for opiate-naive patients must be for short-acting (SA) opioid. For new starts (first opioid fill within 90 days) a SA opioid can be filled for a maximum of two 7- day supplies in a 30 day period. Use of SA opioids for longer periods will require a manual PA.* 1. For Opioid-Naive Patients An opioid-naive patient is defined as not having filled an opioid prescription in each month of the past three months. Patients will be limited to two 7-day supplies in a rolling 30 days and less than 90 morphine equivalent daily dose (MEDD) cumulative dose for their opioid fill. Any requests for traumatic injury/postoperative use of, short-acting opioids cannot exceed a single 7-day supply without medical justification. Opioid-naive members may receive greater than any of the following: (1) Mississippi Medicaid's quantity limit (2) >90 MEDD (3) > a 7 day supply (4) additional prescriptions after the two- seven days' supply with a prior authorization when the prescriber attests to the following: a. The beneficiary's history on the Prescription Monitoring Program (PMP) has been evaluated and continues to be evaluated on a regular basis. b. (If applicable) I, the prescriber initiating or maintaining concomitant opioid and benzodiazepine therapy, acknowledge the risk of adverse events such as respiratory depression, coma, and death associated with concurrent utilization. c. (If applicable) I have informed the beneficiary about the risks of concomitant utilization of opioid and benzodiazepine therapy and the beneficiary expressed understanding of these risks. d. That the information provided is true and accurate to the best of the prescriber's knowledge. e. The prescriber understands that the Division of Medicaid (DOM) may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided f. Females of child-bearing age have been counseled on the risk of neonatal abstinence syndrome to the fetus Authorization will be issued for the requested duration (up to 90 days). 2. For Patients Routinely Using Opioids A routine opioid user is defined as having 1 opioid claim per month for the past 3 months prior to the current date of service. No PA criteria except for the following: a. Mississippi Medicaid's quantity limit (Max Unit Override PA) b. PDL Exception Request Criteria c. MEDD => 90 MEDD Cumulative Threshold- criteria applies d. When a PA is approved for => 90 MEDD, and the prescription's required quantity exceeds DOM's monthly quantity limit, the PA Unit shall issue an accompanying MAX Unit override PA.

State	Explanations
Missouri	Short-acting opioids and combination products are limited to less than or equal to a 7 days supply and less than or equal to 50 MME per day for an initial fill.
Montana	We only have quantity limits on oxycodone IR. However we have a 7-day supply limit on opioid prescriptions for opioid naive members and a cumulative opioid limit of 90 MME for all opioid prescriptions
Nebraska	Patients limited to initial prescription of 7 days. Then patients limited to a 30 day supply only.
Nevada	All opioids are limited to 60 morphine equivalents, a max of seven-day supply and a maximum of 13 fills per rolling 12 months for adults. For children under 18 years of age, the day supply is limited to three.
New Hampshire	Medicaid limits all opioid prescriptions to a 30 day supply. We do not have a lower limit for initial prescriptions.
New Jersey	Limits in place are based on total daily dosage. Claims exceeding maximum daily dosage are denied with a DUR edit. State regulations limit all initial opioid prescriptions to a 5 day supply.
New Mexico	Preparing for implementation of SUPPORT Act for FFY20.
New York	A quantity limit of a 7-day supply is a POS edit for initial opioid prescriptions for acute pain in recipients who are opioid naive. Exceptions are for recipients with a diagnosis of cancer or sickle cell disease.
North Carolina	Other than Schedule V, opioid claims are limited by daily dose, quantity dispensed, days supply, and morphine equivalency limits.
North Dakota	Immediate release opioids are limited to a 7 day supply. Extended release products do not have an initial limit because they require prior authorization which will only be approved if they have been taking medication for 90 or more days (chronic pain).
Ohio	Initial short acting opioids are limited to a 7 - day supply All long acting opioids are limited to a 34 - day supply
Oklahoma	We have an acute vs chronic opioid edit in place that allows up to 8 per day for 7 days on short acting opioids and 4 per day for long acting opioids. We do not have any system edits in place to look for an initial script. State law limits the initial rx to 7 days supply.
Oregon	Short acting opioids limited to 7 day supply limit and max 90MME for all opioids.
Pennsylvania	Pennsylvania has quantity limits on all opioids.
Rhode Island	For naive patients the quantity dispensed is based on 30 mme and 20 doses for different short acting opioids.
South Carolina	MAT products are excluded
South Dakota	Limited to seven day supply for opioid naive patients.
Tennessee	For treatment naive patients, Opioids are limited to not more than 15 days supply per 180 days, at no greater than 60MME per day. The first prescription can be filled for 5 days supply without Prior Authorization. After the initial 5 days supply has been submitted, the enrollee can fill 10 additional days supply within the 180 day period, with prior authorization required.
Texas	In the FFY 2019, the initial opioid prescription followed the same quantity limit set in the system as the max quantity limit per prescription. The implemented opioid policy only checked for daily morphine milliequivalent. In Oct. 2018 a retro-DUR intervention was conducted, and letters were sent to prescribers who wrote opioid prescriptions for more than 7 days for the initial therapy. The retro-DUR criteria were based on the current national guidelines.
Utah	Initial prescriptions for over a 7-day supply or over the cumulative MED limit (90 MME) require prior authorization. A prescription is considered initial if the drug has not been filled for the patient in the past 60 days. Subsequent prescriptions may be for a 30-day supply and do not

State	Explanations
	require prior authorization if the quantity prescribed is less than or equal to the cumulative MED limit. In addition, all initial opioid prescriptions by a dental provider are limited to a 3-day supply.
Vermont	The initial fill for all short-acting opiates will be limited to 50 Morphine Milligram Equivalents (MME) and 7-day supply for patients 18 years of age or older OR 24 MME and 3-day supply for patients 17 years of age or younger.
Virginia	There is a quantity limit currently in place to limit the quantity dispensed for all short and long acting opioids.
Washington	FFS and MCOs apply a quantity limit of 18 dosages per prescription for children (20 years of age or under) and 42 dosages per prescription for adults (21 years of age or older).
West Virginia	Short-acting opioids are limited to 4 units/day. Long-acting opioids are limited to 2 units/day.
Wisconsin	Wisconsin has some opioid quantity limits in place.
Wyoming	Initial fills are limited to 7 days supply.

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 81 - More than One Quantity Limit for Various Opioids

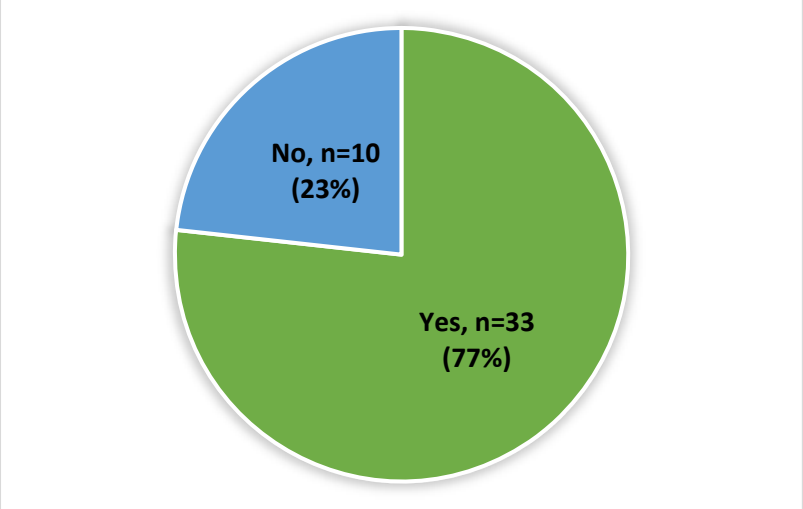

Table 122 - More than One Quantity Limit for Various Opioids

Response	States	Count	Percentage
Yes	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nebraska, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin	33	76.74%
No	District of Columbia, Maine, Massachusetts, Minnesota, Montana, Nevada, North Carolina, South Carolina, Virginia, Wyoming	10	23.26%
Total		43	100.00%

If “Yes,” please explain.

Table 123 - Explanations for More than One Quantity Limit for Various Opioids

State	Explanations
Alabama	Quantity limit is dependent on the particular product.
Arkansas	Short-acting opioids have a quantity limit of #42 for a 7-day supply (6 tablets or capsules per day) with a maximum of 50 MME/day. Beyond an initial claim for short-acting opioids, the maximum monthly quantity is #93/ 31 days and 90 MME/day. Cancer patients may receive up to #124/ 31 days of a short-acting opioid without a prior authorization needed. Long-acting opioids have individual quantity limits based on MME and typical dosing recommendations.
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 to quantity limits listed on the preferred drug list and are eligible for up to a 30 day supply. Dental prescriptions are limited to a three day supply of short-acting opioids.
Connecticut	Quantity limits are dependent on dosage form.
Delaware	DMMA limits the quantity allowed based on day supply, MME per day, as well as a global number of units per year. For example, oxycodone 15, 20, and 30MG have monthly, quarterly and yearly limits in place. All short acting opioids require an initial 7-day fill. All long acting opioids require a prior authorization
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	Acetaminophen/codeine #31, hydrocodone/acetaminophen #21, oxycodone/acetaminophen #11 for acute dental pain relief and one time emergency dental basis. Refills are not allowed.
Idaho	We apply drug specific drug quantity limits plus MME limits for all concurrent opioid prescriptions.
Illinois	Short-acting opioids: 186. Long-acting opioids: 124.
Indiana	60MME for new opioid utilizers of short-acting opioids only, quantity limits applied to all long-acting agents if approved via PA.
Kansas	We have an initial fill limit of a 7 day supply for short-acting opioids, unless they have cancer, sickle cell anemia, or reside in a facility that a caregiver gives the medicine to the patient. Cough and cold products which contain opioids are not included in our initial quantity limit edit. Opioid Use Disorder medications do not have an initial quantity limit.
Kentucky	The quantity limit for short-acting opioids is designed to limit the quantity based on the most restrictive of: morphine milligram equivalents (MME) less than or equal to 90 MME/day, the maximum daily dose in the package insert, or a maximum of 4 grams of acetaminophen (APAP). For instance, codeine/APAP 30-300 mg is limited to 12 per day, while up to 20 tablets per day of codeine sulfate are allowed. For long-acting opioids, the daily unit allowance is based on the

State	Explanations
	dosing that is contained in the package insert (e.g., 1, 2, or 3 times daily). Also, for any oral solid dosage form where a single unit is 30 MME or more (e.g., oxycodone 20 mg) a PA is required. Drug and Strength - Maximum Quantity per Day Codeine-containing products: 12 mg per 5 mL liquids - 240 mL (160 mL if w/ APAP) 15 mg - 20 tablets (12 if w/ APAP) 30 mg - 20 tablets (12 if w/ APAP) 60 mg - 10 tablets Dihydrocodeine-containing tablets (16 mg) - 12 tablets Hydrocodone-containing (including benzhydrocodone equivalent dose) products: 7.5 mg per 15 mL solution - 180 mL 10 mg per 15 mL solution - 120 mL 2.5/5/7.5 mg tablets - 12 tablets 10 mg tablets - 8 tablets Hydromorphone:1 mg per mL solution - 20 mL 3 mg suppository - 6 suppositories 2 mg tablet - 10 tablets 4 mg tablet - 5 tablets 8 mg tablet - PA required Levorphanol 2mg tablets - 4 tablets 3 mg tablets - 3 tablets Meperidine: 50 mg per 5 mL solution - 90 mL 50 mg tablet - 18 tablets 100 mg tablet - 9 tablets Morphine sulfate: 10 mg per 5 mL solution - 45 mL 20 mg per 5 mL solution - 22.5 mL 20 mg per mL solution - PA required 10 mg suppositories - 8 supp. 20 mg suppositories - 4 supp. 15 mg IR tablets - 6 tablets 30 mg IR tablets - PA required Oxycodone-containing products: 5 mg per 5 mL solution - 60 mL 2.5 mg/5mg - 12 tablets 7.5 mg - 8 tablets 10 mg - 6 tablets 15 mg - 4 tablets 20 mg & 30 mg - PA required Oxymorphone tablets: 5 mg - 6 tablets 10 mg - 3 tablets Pentazocine-containing tablets (50 mg) 4 tablets Tapentadol (Nucynta) tablets: 50 mg - 4 tablets 75 mg & 100 mg - PA required Tramadol-containing products: 37.5 mg - 8 tablets 50 mg - 8 tablets
Louisiana	Short-acting opiates, recipient is opiate naive: 28 units within a 7 day period Short-acting opiates, recipients is not opiate naive: 15 day supply Long-acting opiates: 30 day supply per 30 rolling days Liquid opioids: 180 ml or 7 day supply, whichever is less There are exemptions for certain medical conditions.
Maryland	Units per day depend on the product. Please use this link for further quantity limits: https://mmcp.health.maryland.gov/pap/docs/QL.pdf
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 an MME limit which can result in a different quantity limit for different products.
Nebraska	No more than 150 units can be dispensed in a 30 day rolling period.
New York	Quantity limits are placed on various opioids based upon the maximum dosing guidelines established by the FDA extended over a 30-day period.
North Dakota	Quantity limits are product specific.
Ohio	Short acting limited to 30MED per day for 7 days Long acting limited to 80MED per day for 34 days
Oregon	Quantity limits are set to match a maximum of 90 morphine equivalents per day. Short acting limited to 7 days supply initially. All long-acting opioids require a prior authorization.
Pennsylvania	Varies by drug
Rhode Island	Depends on the strength of the opioid.

State	Explanations
South Dakota	Quantity limits based on FDA approved dosages.
Tennessee	all opioids have different quantity limits all based on MME, not number of units.
Utah	Utah Medicaid FFS routinely reviews quantity limits of individual opioid mediations 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.
Vermont	There are quantity limits related to the potency (MME) of the medication being requested. For 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)
Washington	FFS and MCOs require an attestation form for anyone receiving chronic opioid therapy defined as Opioids exceeding 42 calendar days within a rolling 90-day period.
West Virginia	Short-acting opioids are limited to 4 units/day. Long-acting opioids are limited to 2 units/day.
Wisconsin	Wisconsin has a detailed opioid quantity limit table that is published on the pharmacy portal.

b. What is the maximum number of days' supply allowed for an initial opioid prescription?

Figure 82 - Maximum Number of Days Allowed for an Initial Opioid Prescription

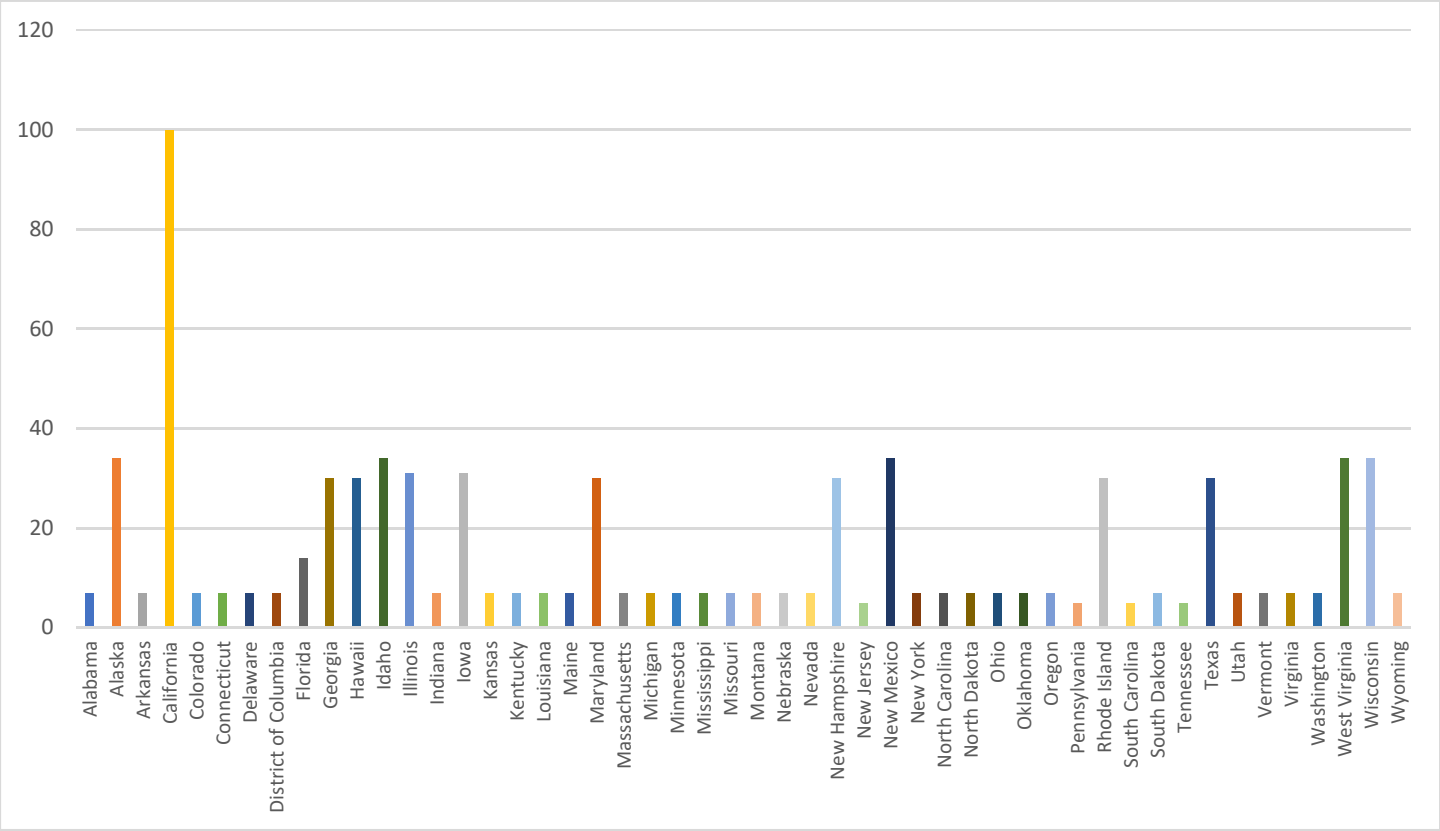

Table 124 - Maximum Number of Days Allowed for an Initial Opioid Prescription

State	Maximum Days
Alabama	7
Alaska	34
Arkansas	7
California	100
Colorado	7
Connecticut	7
Delaware	7
District of Columbia	7
Florida	14
Georgia	30
Hawaii	30
Idaho	34
Illinois	31
Indiana	7
Iowa	31
Kansas	7
Kentucky	7
Louisiana	7
Maine	7
Maryland	30
Massachusetts	7
Michigan	7
Minnesota	7
Mississippi	7
Missouri	7
Montana	7
Nebraska	7
Nevada	7
New Hampshire	30
New Jersey	5
New Mexico	34
New York	7
North Carolina	7
North Dakota	7
Ohio	7
Oklahoma	7
Oregon	7
Pennsylvania	5
Rhode Island	30
South Carolina	5
South Dakota	7
Tennessee	5
Texas	30
Utah	7
Vermont	7
Virginia	7

State	Maximum Days
Washington	7
West Virginia	34
Wisconsin	34
Wyoming	7

c. Does this days' supply limit apply to opioid prescriptions?

Figure 83 - Initial Day Limit Applies to All Opioid Prescriptions

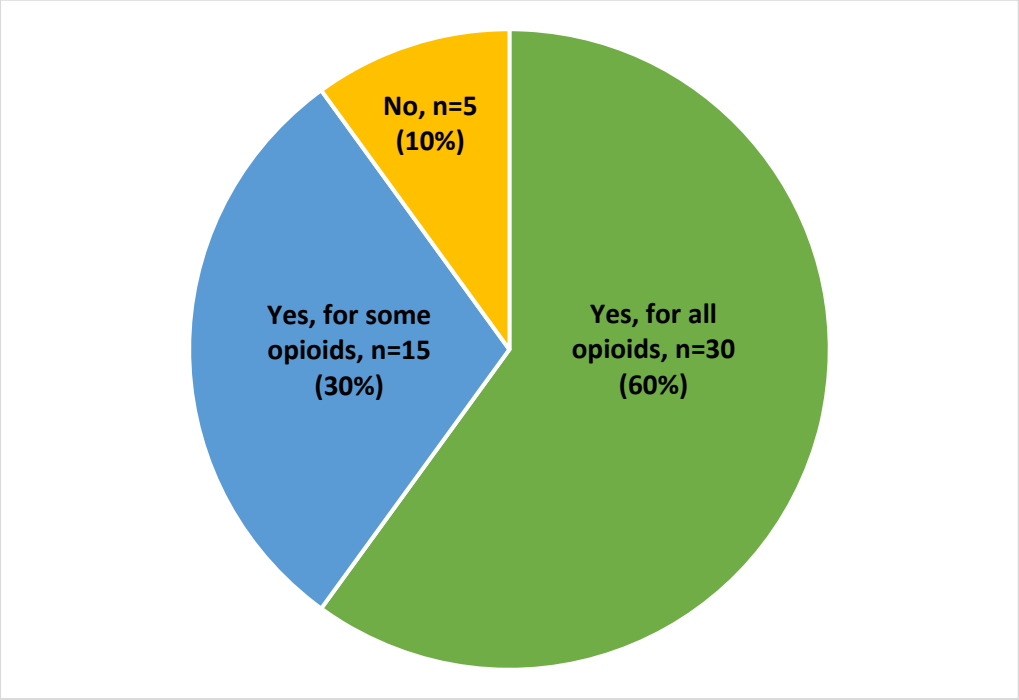

Table 125 - Initial Day Limit Applies to All Opioid Prescriptions

Response	States	Count	Percentage
Yes, for all opioids	Alabama, Alaska, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, Wyoming	30	60.00%
Yes, for some opioids	Arkansas, California, Colorado, Delaware, Florida, Kansas, Kentucky, Michigan, Mississippi, Missouri, North Dakota, Ohio, Oregon, Pennsylvania, Vermont	15	30.00%
No	Hawaii, Louisiana, Utah, Virginia, Washington	5	10.00%
Total		50	100.00%

If “No,” please explain.

Table 126 - Explanations of Different Days’ Limit to various Opioid Prescriptions

State	Explanations
Hawaii	7 days supply maximum for initial concurrent opioid plus benzodiazepine prescriptions by state law HRS Section 329-38 for non-dental use. Less than 4 day supply for dental use.
Louisiana	Short-acting opiates, recipient is opiate naive: 28 units within a 7 day period. Short-acting, recipient is not opiate naive: 15 day supply. Long-acting opiates: 30 day supply per 30 rolling days. There are exemptions for certain medical conditions.
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 60 days.
Virginia	The initial 7 days limit is for short acting opioids
Washington	Our Policy does not limit the days supply, we limit the quantity of pills per prescription, which is about a 3 day supply.

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

Figure 84 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

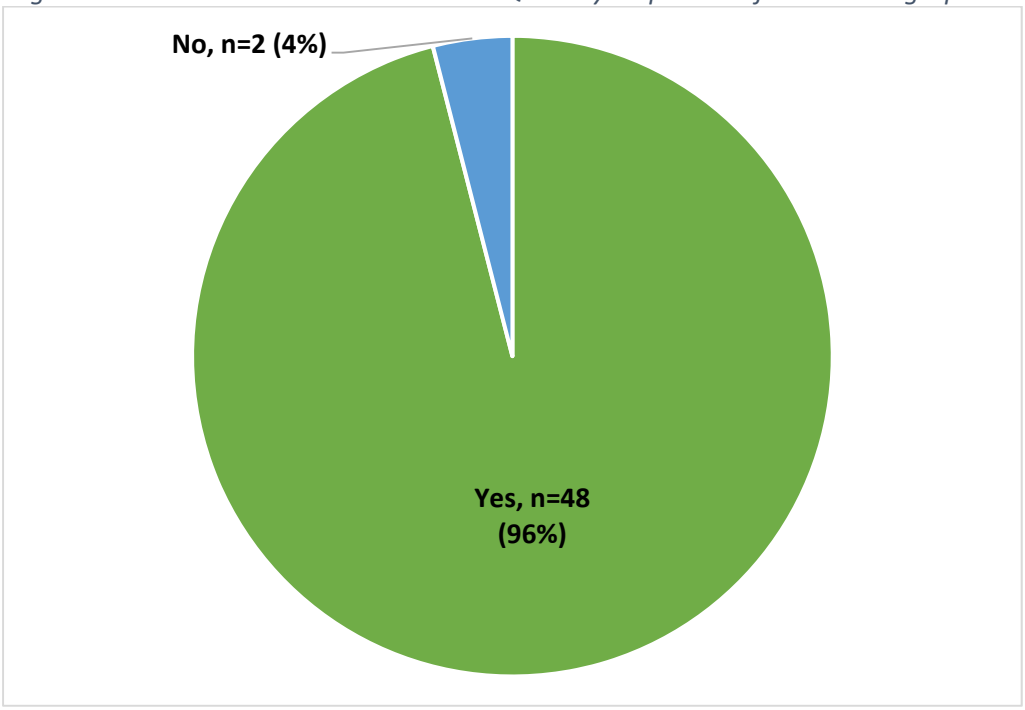

Table 127 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, 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, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	48	96.00%
No	Hawaii, Texas	2	4.00%
Total		50	100.00%

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

Figure 85 - Short-Acting Opioid Maximum Days' Supply per Prescription Limitation

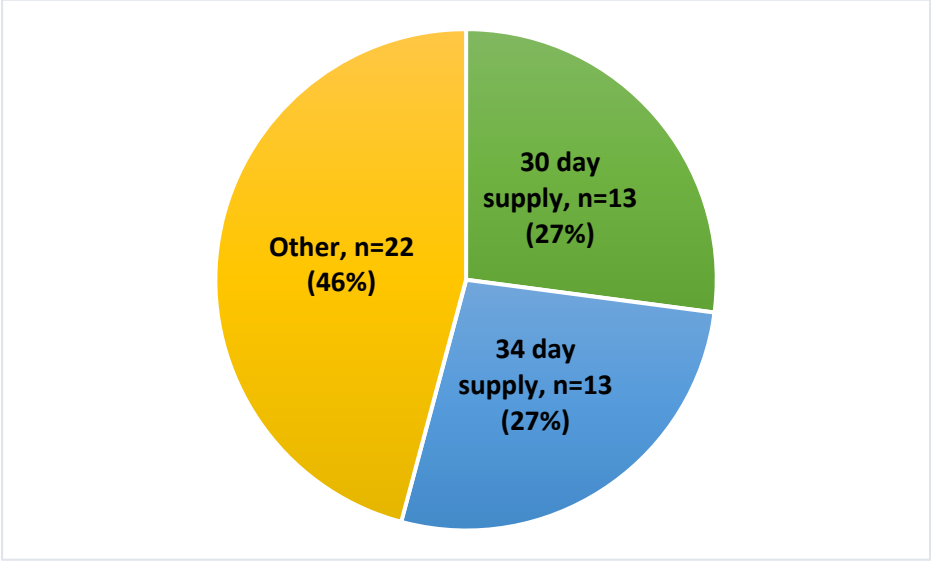

Table 128 - Short-Acting Opioid Maximum Days' Supply per Prescription Limitation

Response	States	Count	Percentage
30 day supply	Connecticut, Delaware, Georgia, Idaho, Maine, Maryland, Massachusetts, Nebraska, New Hampshire, Rhode Island, South Carolina, Utah, Vermont	13	27.08%
34 day supply	Alabama, Alaska, Kentucky, Michigan, Minnesota, Montana, New Mexico, North Carolina, North Dakota, Ohio, South Dakota, West Virginia, Wisconsin	13	27.08%
Other	Arkansas, California, Colorado, District of Columbia, Florida, Illinois, Indiana, Iowa, Kansas, Louisiana, Mississippi, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, Tennessee, Virginia, Washington, Wyoming	22	45.83%
Total		48	100.00%

If “Other,” please explain.

Table 129 - “Other” Explanation of Short-Acting Opioid Maximum Days’ Supply per Prescription Limitation

State	“Other” Explanations
Arkansas	31 days' supply
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 of short-acting opioids and require prior authorization for the fourth fill. Non-opioid naive members are limited to a 30 day supply per prescription fill. Dental prescriptions are limited to a 3 day supply of short-acting opioids for up to three fills.
District of Columbia	Patients who are considered acute (less than 120 days of history of opioid claims in the last 180 days) are limited to a 7 days supply with a total of 30 days per 180 day period
Florida	Schedule II Short Acting (SA) Narcotics: Max of 3-day supply and 2 fills per month. If "Acute Pain Exemption" on prescription Max of 7-day supply and 2 fills per month. Schedule III-V SA Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 Long Acting (LA) Narcotic every 30 days.
Illinois	31 days
Indiana	For initial utilizers of opioids, 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.
Kansas	After the first 7 days supply, prior authorization is required to exceed 14 day supply of opioid medication in last 60 days.
Louisiana	15 days
Mississippi	31
Missouri	Participants are limited to a 7 day supply on the first fill and 31 days thereafter.
Nevada	All fills are limited to seven-day supply without obtaining prior authorization.
New Jersey	On subsequent prescriptions, the limit is a 34 days supply or a maximum quantity of 100 units, whichever is greater. Quantity is dependent upon the FDA approved dosing per the manufacturer's package insert.
New York	Quantity limits are based upon FDA maximum daily doses extended for a maximum of a 30-day period.
Oklahoma	Max of 8 per day for 7 days.
Oregon	All short-acting opioids prescribed for more than 7 days require prior authorization. If approved, up to 30 days allowed at a time
Pennsylvania	All prescriptions for short-acting opioids require prior authorization after 3 days for children under 21 and after 5 days for adults. The day supply approved is determined on a case-by-case basis.
Tennessee	After the initial 5 days supply has been submitted, the enrollee can fill 10 additional days supply within the 180 day period, with prior authorization required, all at no more than 60MME per day. There are exceptions to this rule if the enrollee has burns or corrosion damage over a large percent of body area, the limit is 45 days per 90 days with a limit of 60MME per day, and this same exception is in place for those in LTC facilities, and those with sickle cell disease.
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.

State	"Other" Explanations
Washington	The maximum days' supply per prescription is 34 days; however we apply an edit based on 42 days of opioids within a rolling 90-dy period.
Wyoming	After 42 days of opioid therapy, a maximum of four short-acting tablets are allowed per day.

If "No," please explain.

Table 130 - "No" Explanation of POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

State	Explanations
Hawaii	There are no subsequent prescriptions allowed for the dental program. An annual retrospective review is done for outliers; none were found in 2019. Less than 5 have been prescribed in 2019 for the non-dental program and can be up to a 30 day supply.
Texas	In FFY 2019, only the opioid MME policy was enforced. The quantity limit for initial and subsequent fills was not implemented. The quantity limits were the same as the set maximum quantity limit per prescription.

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

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

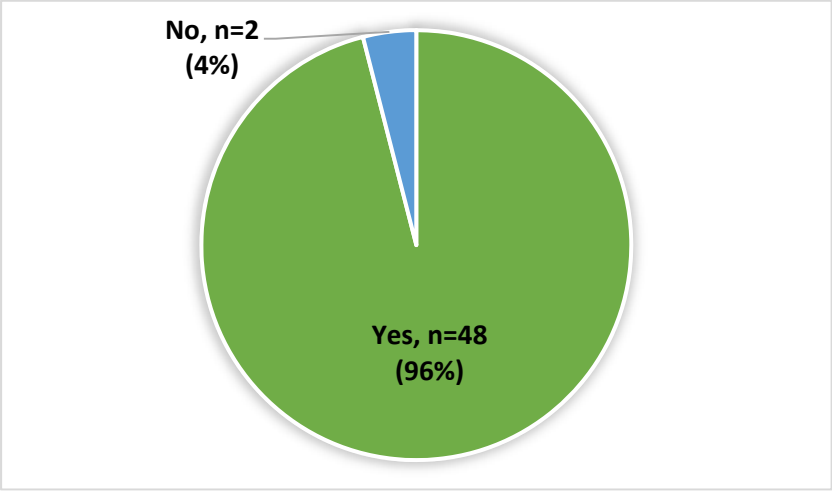

Table 131 - POS Edits In Place to Limit the Quantity Dispensed of Long-Acting Opioids

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, 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, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	48	96.00%
No	Hawaii, Texas	2	4.00%
Total		50	100.00%

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

Figure 87 - Long-Acting Opioid Maximum Days’ Supply per Prescription Limitation

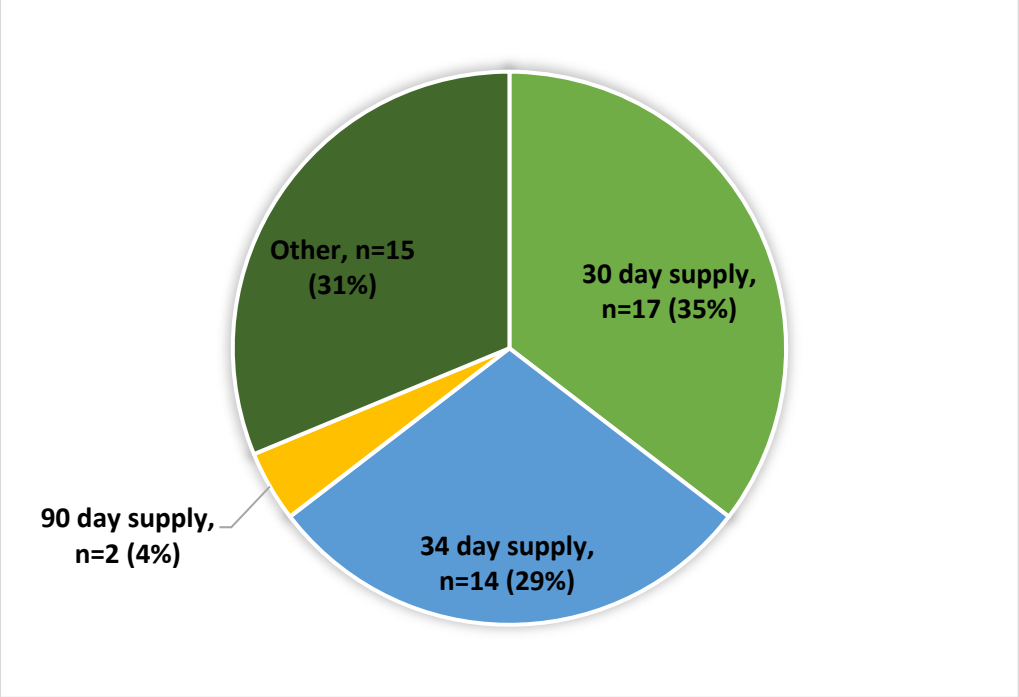

Table 132 - Long-Acting Opioid Maximum Days’ Supply per Prescription Limitation

Response	States	Count	Percentage
30 day supply	Colorado, Connecticut, Florida, Georgia, Idaho, Kansas, Louisiana, Maine, Maryland, Massachusetts, Nebraska, New Hampshire, Oregon, Rhode Island, South Carolina, Tennessee, Utah	17	35.42%
34 day supply	Alabama, Alaska, Kentucky, Michigan, Minnesota, Montana, New Mexico, North Carolina, North Dakota, Ohio, South Dakota, Virginia, West Virginia, Wisconsin	14	29.17%
90 day supply	California, Vermont	2	4.17%
Other	Arkansas, Delaware, District of Columbia, Illinois, Indiana, Iowa, Mississippi, Missouri, Nevada, New Jersey, New York, Oklahoma, Pennsylvania, Washington, Wyoming	15	31.25%
Total		48	100.00%

If “Other,” please explain.

Table 133 - “Other” Explanation of Long-Acting Opioid Maximum Days’ Supply per Prescription Limitation

State	”Other” Explanations
Arkansas	31 days' supply
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.
District of Columbia	Patients who are considered acute (less than 120 days of history of opioid claims in the last 180 days) are limited to a 7 days supply with a total of 30 days per 180 day period
Illinois	31 days
Indiana	For initial utilizers, PA is required. For current opioid utilizers, day supply is limited to 34 as a non-maintenance medication, along with applicable quantity limits.
Iowa	Up to a 31 day supply is allowed.
Mississippi	Maximum days supply is 31 days versus 30 days due to monthly limit on number of prescriptions. Maximum monthly limit for 31 days supply is 62 units (tablets/capsules).
Missouri	31 days' supply
Nevada	Recipients can get up-to 34-day supply with an approved prior authorization (PA). A recipient limited to a seven-day supply without a PA.
New Jersey	On subsequent prescriptions, the limit is a 34 days supply or a maximum quantity of 100 units, whichever is greater. Quantity is dependent upon the FDA approved dosing per the manufacturer's package insert.
New York	Quantity limits are based upon FDA maximum daily doses extended for a maximum of a 30-day period.
Oklahoma	Max of 4 per day for 30 days
Pennsylvania	All long acting opioids require prior authorization for all beneficiaries. The day supply approved is determined on a case-by-case basis
Washington	The maximum days' supply per prescription is 34 days; however we apply an edit based on 42 days of opioids within a rolling 90-dy period.
Wyoming	Long-acting opioids are limited to a maximum of 120 MED per day.

If “No,” please explain.

Table 134 - “No” Explanation of Long-Acting Opioid Maximum Days’ Supply per Prescription Limitation

State	Explanations
Hawaii	No long-acting opioids are on the dental formulary. Less than 10 opioid prescriptions was paid in 2019 for the non-dental program. Refills were appropriate with no subsequent claims when reviewed retrospectively by the DUR Board.
Texas	The POS quantity limit for the long-acting opioids is the same as maximum quantity limit per prescription.

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

Figure 88 - Measures other than Restricted Quantities and Days' Supply in Place to either Monitor or Manage the Prescribing of Opioids

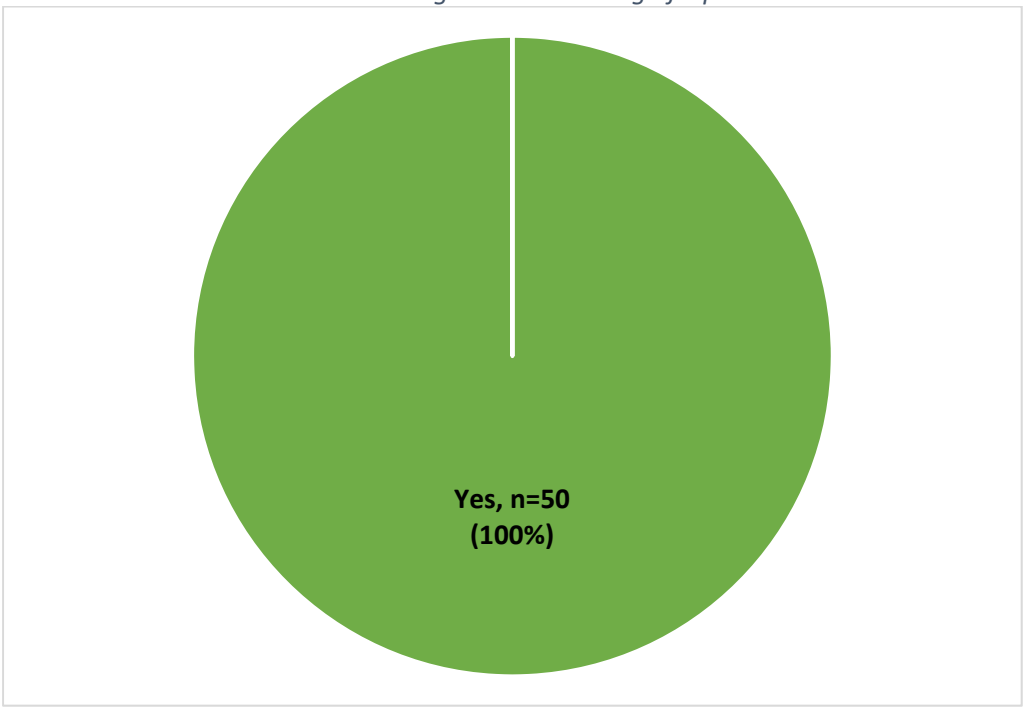

Table 135 - Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, 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%
Total		50	100.00%

If “Yes,” check all that apply:

Figure 89 - Measures other than Restricted Quantities and Days’ Supply in Place to Either Monitor or Manage the Prescribing of Opioids

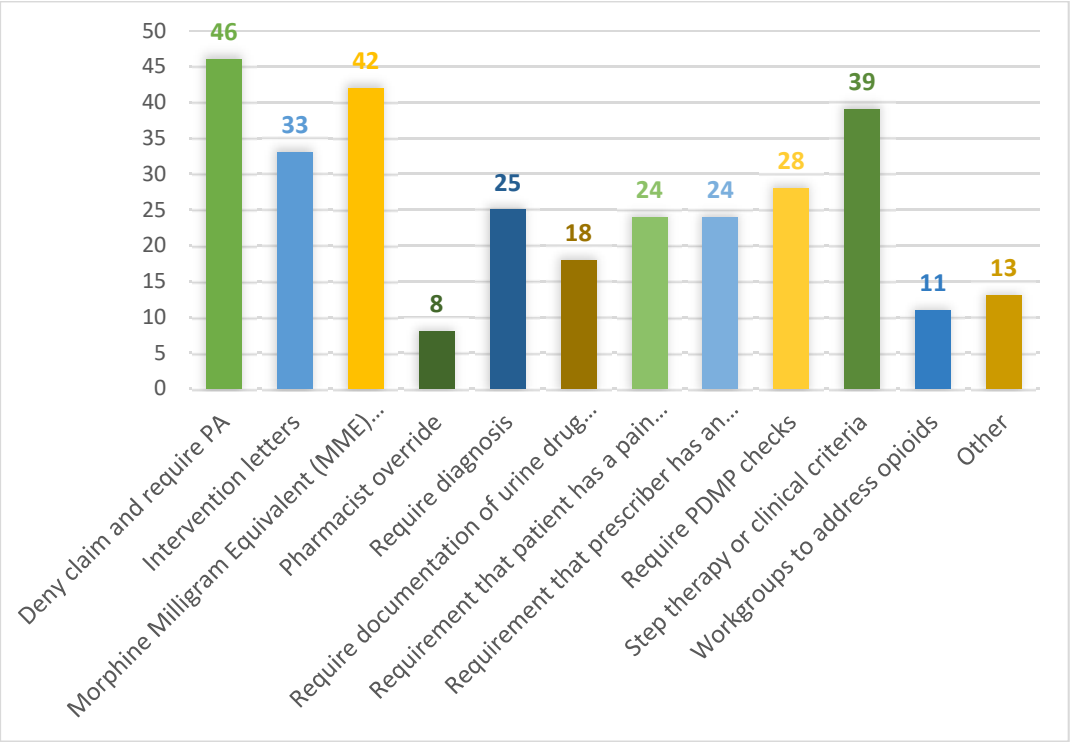

Table 136 - Measures other than Restricted Quantities and Days’ Supply in Place to either Monitor or Manage the Prescribing of Opioids

Response	States	Count	Percentage
Deny claim and require PA	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, 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, West Virginia, Wisconsin	46	14.79%
Intervention letters	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, Wisconsin, Wyoming	33	10.61%
Morphine Milligram Equivalent (MME) daily dose program	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri,	42	13.50%

Response	States	Count	Percentage
	Montana, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wyoming		
Pharmacist override	Alabama, Georgia, Idaho, North Carolina, Utah, Vermont, West Virginia, Wisconsin	8	2.57%
Require diagnosis	Alabama, Alaska, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, Washington	25	8.04%
Require documentation of urine drug screening results	Alabama, Alaska, Delaware, District of Columbia, Georgia, Illinois, Kansas, Kentucky, Maine, Maryland, Michigan, Montana, North Dakota, Ohio, Oregon, Pennsylvania, Virginia, Washington	18	5.79%
Requirement that patient has a pain management contract or Patient-Provider agreement	Alabama, Alaska, Delaware, Georgia, Hawaii, Illinois, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Tennessee, Texas, Utah, Virginia, Washington, West Virginia	24	7.72%
Requirement that prescriber has an opioid treatment plan for patients	Alabama, Alaska, Colorado, Delaware, District of Columbia, Florida, Georgia, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Montana, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Tennessee, Utah, Virginia, Washington, West Virginia	24	7.72%
Require PDMP checks	Alabama, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Virginia, Washington, Wyoming	28	9.00%
Step therapy or clinical criteria	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	39	12.54%
Workgroups to address opioids	Alabama, California, Idaho, Illinois, Massachusetts, Michigan, Missouri, Rhode Island, South Carolina, South Dakota, Utah	11	3.54%
Other	Arkansas, Colorado, Hawaii, Indiana, Kansas, Louisiana, Maryland, Nebraska, Nevada, New Mexico, South Dakota, Vermont, West Virginia	13	4.18%
Total		311	100.00%

Please provide details on these opioid prescribing controls in place.

Table 137 – Detail for Opioid Prescribing Controls in Place

State	Explanations
Alabama	RDUR criteria; RDUR intervention letters; max quantity limits; prior authorization for non-preferred opioids; therapeutic duplication edit
Alaska	The opioid prescribing controls are integrated into the point-sale-system and reviewed by the DUR committee.
Arkansas	Both short-acting and long-acting opioids are on the PDL with preferred agents. Opioid naive patients may receive short-acting opioids only. Long-acting opioids require a prior authorization with the exception of long-term care beneficiaries, cancer patients or beneficiaries identified as NPO. Continuation of coverage without an additional PA request requires a paid claim for an opioid on the beneficiary profile in the previous 60 days.
California	Deny claim and require PA - Restrictions that may deny claim and require PA include, but are not limited to, age restrictions and duration of therapy restrictions. Intervention letters - In FFY 2019, intervention letters were sent to prescribers for the following topics: 1. Patients at high-risk for adverse events associated with the use of certain opioid medications in combination with benzodiazepines and other CNS depressants 2. Patients with at least one paid claim > 120 mg MME/day 3. Patients under 18 years of age with a paid claim for tramadol and/or codeine Morphine Milligram Equivalent (MME) daily dose program - For the treatment of chronic pain, dose is to not exceed 500 MME/daily without an approved Treatment Authorization Request. This safety edit assists in identifying members at potentially high-clinical risk who may benefit from close monitoring and care coordination. Require PDMP checks - Assembly Bill 2760 (Wood, Chapter 324) was signed into law in 2018 and became effective on January 1, 2019. California prescribers are now required to offer a prescription to a patient for either naloxone or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of opioid-induced respiratory depression, as a rescue medication when one or more of the following conditions are present: 1. The prescription dosage for the patient is greater than or equal to 90 mg MME/day 2. An opioid medication is prescribed concurrently with a prescription for a benzodiazepine. 3. The patient presents with an increased risk for overdose, including a history of overdose, a history of substance use disorder, or a risk for returning to a high dose of opioid medication to which the patient is no longer tolerant. The bill also requires a prescriber, consistent with the existing standard of care, to provide education on overdose prevention and the use of naloxone or other similar drug approved by the FDA to a patient and his or her designee or, if the patient is a minor, to the patient's parent or guardian. Workgroups to address opioids - California has a Prescription Drug Overdose Prevention Initiative. The goals of the initiative include increasing the number of active buprenorphine prescribers, increasing the number of naloxone claims, decreasing all-cause overdose mortality, reducing the concomitant use of benzodiazepines and opioids, and reducing opioid claims > 90 mg MEDD.
Colorado	Prescriptions are limited to 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. Prior authorization is required for members receiving long-term therapy with an opioid medication who are newly started on a sedative

State	Explanations
	benzodiazepine medication, or for members receiving long-term therapy with a sedative benzodiazepine medication who are newly started on an opioid medication. Prescriber opioid treatment plans are documented as part of provider-to-provider telephone consultations that are required for certain opioid prior authorizations.
Connecticut	These are the other measures that are used to restrict access to opiates.
Delaware	Prior Authorization criteria contain the following question, verification of prescribing profile using PDMP. Verification of first line drug therapies used controlled an d non controlled based on diagnosis provided. Pain assessment and contract certification.
District of Columbia	Prior authorization is required for all opioid prescriptions and the request must provide attestation from the prescriber that the PDMP was accessed before the prescription was written since DC does not have mandatory PDMP check currently in legislation. The PA form requires the initial diagnosis, periodic documentation of urine drug screening results and encourages the implementation of a pain management contract for long term opioid therapy. A MME daily dose program is in place with a dosage calculator built into the claims adjudication process to alert the pharmacist if the daily limit of 90 MME is exceeded. Clinical criteria allows for the exclusion of patients with a history of malignancies, sickle cell disease, palliative and end of life care.
Florida	Schedule II Short Acting (SA) Narcotics: Max of 3-day supply and 2 fills per month. If "Acute Pain Exemption" on prescription Max of 7-day supply and 2 fills per month. Schedule III-V SA Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 Long Acting (LA) Narcotic every 30 days. Opioid prescribing trends and potential fraud and/or abuse are identified via automated claims review by the DUR Board. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
Georgia	See above
Hawaii	These POS edits apply to Oxycontin prior authorization criteria , including provider specialty, diagnosis, dosage per day. Prior authorization criteria for over 160mg per day and non-cancer pain are age, pregnancy, strenght and total daily doasage, docuemtned failure or non-tolerance of at least one other long acting opioid analgesic.
Idaho	Pharmacist override exists only for edits not involving doses, quantities or MME limits. For example general edits like a drug interaction override is allowed. Claims are denied at POS and a PA is required for quantities, MME, therapy duplication and non-preferred drugs. Intervention letters are done through the DUR Board on focused topics. The Morphine Milligram Equivalent (MME) daily dose program is an automated edit that adds up all opioid MME for all drugs and doses and denies for a cumulative MME exceeding 90 MME. Step therapy or clinical criteria are done at each drug GCN or class level for preferred status, prior drug trials and indication. The State has two major workgroups assigned to ensure appropriate opioid use . 1. Idaho Opioid Misuse and Overdose Strategic Plan Working Group with work groups for specific goals including opioid prescribing, patient, prescriber and public education; improvement in PDMP use: and Opioid Use Disorder treatment. Idaho Medicaid Pharmacists and our Medical Director are directly involved with this group and its specific subgroups. 2. Governor's Opioid and Substance Use Disorder Advisory Group.
Illinois	Only 1 short-acting opioid or one long-acting opioid allowed at a time Group accumulation edit counts all short-acting opioid units per rolling 31 days in order to limit to 186 units per 31 days. Another group accumulation edit counts all long-acting opioid units per

State	Explanations
	rolling 31 days in order to limit to 124 units per 31 days. Then the 90% tolerance is applied to all opioid refills. All long-acting opioids require prior approval. Patients flagged via the Four Prescription Policy with first request receive short-term approval if appropriate. If patient has used opioids 3 or more months, the prescriber must fill out a pain management program form with medical justification. If approved, at approval expiration, must justify medical need for continued therapy. The methadone pain management program requires additional safety monitoring, including submission of recent urine drug screen. All chronic opioid use requires use of short acting narcotics and/or preferred long-acting opioids first. Exceptions may be made for patients with cancer who may require a long and a short acting agent. All patients in the pain management program must have a patient-provider pain contract and pain diagnosis for which opioid therapy is appropriate. State law requires PDMP check for the first Schedule II prescription. The prescriber notes date PDMP checked on the Four Prescription Policy pain management program forms. All prescribers within the pain program receive an intervention letter/response with recommendations after review of submitted pain forms. The Illinois Governor's Opioid Prevention and Intervention Task Force works with the Illinois Opioid Crisis Response Advisory Council to implement the State Opioid Action Plan. HFS is a member of the Task Force. More information is available at https://www.dhs.state.il.us/page.aspx?item=93882.
Indiana	Doctor-shopping edit evaluating number of prescribers; restrictions for concurrent use with benzodiazepines, carisoprodol products, buprenorphine, or buprenorphine/naloxone; current utilizers limited to one long-acting and one short-acting opioid product.
Iowa	Prior authorization (PA) in required for non-preferred opioids, allowing the pharmacist to review and determine if therapy is appropriate. MME is in place, requiring PA for MME > 120 mg/day (will decrease to 90 MME/day in the fall). Any opioid requiring PA must document patient has a pain management contract with the provider in addition, the prescriber must document the PMP has been reviewed.
Kansas	We have a clinical prior authorization (PA) in place for opioids products used for pain management. This PA includes many other factors. The website for this PA is https://www.kdheks.gov/hcf/pharmacy/PA_Criteria/Opioid_PA_Criteria.pdf For opioid drug renewal requests, urine screens and checking PDMP are a provider attestation on the PA form, not a requirement. We have a policy in place that requires following this PA and also sent provider bulletins about this policy and PA criteria. The bulletin links are below: https://www.kmap-state-ks.us/Documents/Content/Bulletins/18027%20-%20General%20-%20Opioid_2.pdf https://www.kmap-state-ks.us/Documents/Content/Bulletins/18101%20-%20General%20-%20Opioid_2.1.pdf https://www.kmap-state-ks.us/Documents/Content/Bulletins/18112%20-%20General%20-%20Opioid_2.3.pdf
Kentucky	Please see opioid criteria available online at: https://kyportal.magellanmedicaid.com/public/client/static/kentucky/documents/KY-ProviderNotice-231-20181010.pdf

State	Explanations
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.
Maine	See all the items listed above, these are all used as controls on prescribing of opiates.
Maryland	Providers must obtain a prior authorization every six months to prescribe long-acting opioids, fentanyl products, methadone for paina nd opioids greater than 90milligram 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.
Massachusetts	https://masshealthdruglist.ehs.state.ma.us/MHDL/pubtheradetail.do?id=8
Michigan	These ProDUR point-of-sale edits prevent claims hitting these additional safety edits from processing. In essence they trigger a comprehensive medical necessity prior authorization review to occur to further evaluate the opioid treatment plan for safety and appropriateness and provide an opportunity to recommend a naloxone prescription for individuals at risk for opioid overdose. The prior authorization reviews provide opportunity for State staff to acquire additional details on utilization and prescribing trends to further monitor and manage the prescribing of opioids in our program. The Medicaid Opioid Workgroup reviews other State Best Practices, utilization trends, and policies and evaluates opportunities for modification of the program to better monitor and manage the prescribing of opioids. Our comprehensive RetroDUR opioid review monitors for trends and targets prescribers of the highest risk Medicaid beneficiaries with additional education and resources to manage the safe and appropriate prescribing of opioids and referral options for MAT and additional behavioral health support services.
Minnesota	If the opioid claim is greater than 90mg MME, then the claims rejects at POS. Prior authorization is required which includes a pain management plan that is signed by the patient.
Mississippi	DOM implemented opioid prescribing criteria that sets cumulative MME limits to 90 and prohibits concomitant use with benzodiazepines. Interventional letters were mailed prior to the implementation of the criteria.
Missouri	MO HealthNet utilizes clinical edits. These edits look for appropriate diagnosis, duplicate therapy, quantity and day supply limits, and accumulative MME limits. When participants do not meet the clinical criteria, claims are denied and require a clinical review.
Montana	Quantity per day limits on IR oxycodone. Limits on # of prescribers of opioids. Limit on # LA opioid prescription. 90MME limit. Provider attestation of risk vs benefit analysis, OUD analysis, failure of taper, failure of alternate therapy, offer of Narcan, etc to keep legacy patient on greater than 90mme.
Nebraska	Non-preferred opioids require PA. Some medications have daily quantity limits.
Nevada	All of the following criteria must be met in order for a recipient to exceed the number of seven-day prescriptions, to exceed the seven-day limit or to exceed the 60 mg morphine equivalents or less per day; if the recipient has chronic pain or requires extended opioid therapy and is under the supervision of a licensed prescriber, if 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.

State	Explanations
New Hampshire	All opioid prescriptions require prior authorization. In addition, NH has a daily MME edit of 100mg. When a beneficiary exceeds 100mg MME prior authorization is triggered, even if the beneficiary already had a prior authorization in place for opioids. Step therapy requirements clinical criteria are all included in the prior authorization process.
New Jersey	Initial fills of high dose opioids require a PA to confirm diagnosis and titration of dosage. Beneficiaries on short-acting opioids 90 days or more require prior authorization to obtain justification of continued use.
New Mexico	System edits in process to follow CDC guidelines.
New York	Claims are subject to a PA where the State's Medicaid Management Administrator reviews the prescribing with the prescriber. Physicians are required to refer to the States PDMP listing prior to writing prescriptions for opioids.
North Carolina	Prior approval is required for greater than 5 days supply for acute pain and 7 days supply for postoperative pain. Prior approval requests should include the beneficiary's diagnosis and reason for exceeding dose per day limits and duration (days supply) limits.The prescribing clinician shall review the North Carolina Medical Board statement on use of controlled substances for the treatment of pain (https://www.ncmedboard.org/resourcesinformation/professional-resources/laws-rules-position-statements/positionstatements/Policy_for_the_use_of_opiates_for_the_treatment_of_pain), and is adhering as medically appropriate to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent,(d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate. The prescribing clinician shall check the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System. (https://northcarolina.pmpaware.net/login). The prescribing clinician shall review the CDC Guideline for Prescribing Opioids for Chronic Pain . (https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm).
North Dakota	Pain contracts and opioid treatment plans are required for any dosages above 90 MME or with concurrent benzodiazepines.
Ohio	Initial short acting opioids limited to 30MED per day for a 7- day supply. All long acting opioids require a PA and are limited to 80MED per day for a 34- day supply. A diagnosis is required as well as a list of non-pharmacological treatment tried, a list of non-opioid analgesics tried, and a list of concurrent therapies. The clinical criteria require that prescribers review PDMP. The prescriber must discuss benefits and risks of opioid therapy with patient and provide a current treatment plan and demonstrated adherence to treatment plan.
Oklahoma	MME is limited to 90 MME per day. PA/override requests for MME quantities greater than the 90 MME limit, require documentation that prescriber has a tapering plan in place; cancer, hemophilia, and sickle cell diagnosis are excluded. Quantity limits were updated in November 2018 to limit short acting opioids to 8 per day for 7 days.
Oregon	Limit SAO to 7 day supply and require PA for all LAO SAO Criteria: https://www.orpdl.org/durm/PA_Docs/short_acting_opioid_analgesics.pdf LAO Criteria: https://www.orpdl.org/durm/PA_Docs/opioids_long_acting.pdf

State	Explanations
Pennsylvania	The prior authorization guidelines can be found at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Clinical-Guidelines.aspx
Rhode Island	Auto deny long acting opioids and require a PA, which requires the prescriber to provide a diagnosis for the particular drug requested. Use of the Morphine Milligram Equivalent daily dose program for naive patients requesting certain short acting opioids. The provider contract requires them to follow state law which says they need to check the PDMP before prescribing. Currently working on more projects to add additional requirements to manage the prescribing of opioids.
South Carolina	90MME, diagnosis for terminal illness (products indicated for the management of breakthrough pain in patients with cancer who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain), State law requires providers verify Medicaid members' controlled substance prescription history before issuing prescriptions for opioids, SC Behavioral Health Coalition is multi-sector coalition is an important outgrowth of the valuable work of the SC Institute of Medicine and Public Health's Behavioral Health Task Force, the SC House Opioid Study Committee, and the Governor's Opioid Crisis Task Force that each provided a set of recommended actions to improve the care and outcomes of South Carolinians suffering with mental illness and/or substance use disorders, Birth Outcomes Initiative (BOI), MAT Telehealth and others address OUD/SUD/Screening/Interventions and Linkage to care.
South Dakota	A multi-agency state work group addresses opioid utilization for all residents to include Medicaid recipients. Peer to peer contact by a Medicaid physician for high opioid utilizers.
Tennessee	In addition to the information described above for non-chronic use, those who are chronic users are limited to 200MME per
Texas	During FFY 2019, the opioid policy allowed for up to 90 morphine milliequivalent (MME) per day; cancer related pain or hospice/palliative care were exempt. The authorization duration was for 6 months. In addition to MME level, There were additional clinical PAs for opioids such as: - Opioid Overutilization criteria deny claims and require a PA for short-acting opioid overutilization, diagnosis of substance use disorder, doctor shoppers and pharmacy shoppers - Fentanyl Agents clinical prior authorization criteria deny for the unsafe starting dose in fentanyl naive patients and documented drug-drug interactions. -Oxycodone ER Agents clinical criteria include appropriate daily dose for non-cancer pain and, for the high dose formulation, justification for highly dose, use of alternative pain therapy, client-prescriber pain management agreement, and appropriate daily dose. - Combination of opioids, benzodiazepines with or without muscle relaxants would deny for more than 14-day therapy overlap of these agents.
Utah	MME Daily Dose Program Implementation date of January 2019 - Initial opioid limits were 90MME for opioid naive and 180MME for opioid experienced individuals. The opioid experienced MME was reduced every 6 months to achieve a common 90 MME for all opioid prescriptions. The gradual MME reduction occured in 6 month increments as Medicaid worked closely with prescribers to taper members, if clinically appropriate.
Vermont	The initial fill for all short-acting opiates will be limited to 50 Morphine Milligram Equivalents (MME) and 7-day supply for patients 18 years of age or older OR 24 MME and 3-day supply for patients 17 years of age or younger
Virginia	* The prescriber has checked the Virginia's Prescription Monitoring Program (PMP) database on the date of the request to rule out use of other opioids or dangerous combinations (such as opioids and benzodiazepines). Document the date of the last opioid Rx, the date of the last

State	Explanations
	benzodiazepine Rx. If benzodiazepine filled in past 30 days, prescriber attests that patient has been counseled on warnings associated with combined use and Naloxone has been prescribed; AND * Document the Morphine Milligram Equivalents (MME) per day from the PMP site. If MME ≥ 90, prescriber attests to the following: patient's long term opioid therapy will be managed, VA BOM Regulations for Opioid Prescribing has been reviewed, Naloxone has been prescribed and acknowledges the warnings associated with high dose opioid therapy including fatal overdose and that therapy is medically necessary for the patient; AND * For female patients between 18-45 years of age, the prescriber has discussed risk of neonatal abstinence syndrome and provided counseling on contraceptives options; AND * Attestation from the prescriber that a signed physician/patient treatment plan/agreement with goals addressing the benefits and harm of opioids has been established; AND * The prescriber has ordered and reviewed a urine drug screen (UDS) or serum blood medication level prior to initiating opioid treatment. For renewals - Prescriber has ordered and reviewed a UDS or serum blood medication level at least every 3 months for the 1st year of treatment and at least every 6 months thereafter to ensure adherence.
Washington	Requests to exceed 42 days of opioid use within a rolling 90-day period require a chronic attestation to be submitted from the prescriber. The prescriber must attest that the client meets the following: A. on-going clinical need for chronic opioid use B. non-pharmacologic therapies have been used C. tried a short-acting opioid for at least 42 days D. conduct periodic pain assessments E. screened for mental health disorders, substance use disorder, naloxone use F. conduct periodic urine drug screens G. checked the PDMP to determine if the patient is receiving other opioid therapy H. discussed with my patient the realistic goals of pain management therapy I. confirmed that my patient understands and accepts these conditions
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 SEMP (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 Early Refill hard alert for certain opioid prescriptions dispensing that requires a prior authorization from a specialized call center. Wisconsin has a monthly opioid script limit that limits the dispensing of opioids to five per month. Wisconsin has a Therapeutic Duplication alert for opioids and a Patient Age alert for tramadol, codeine and hydrocodone cough syrups that a dispensing pharmacist may override. In addition, Wisconsin has a number of retrospective intervention letters addressing opioid prescribing issues, including the pharmacy Lock-In program.

State	Explanations
Wyoming	Intervention letters are sent when a prescriber indicates on the prior authorization form that the PDMP has not been checked recently. MME daily dose limits are applied to long-acting narcotic claims. Step therapy is required to get to non-preferred short and long-acting opioids. State law requires that prescribers check the PDMP prior to prescribing controlled substances the first time and on a regular basis during ongoing treatment.

5. Do you have POS edits to monitor duplicate therapy of opioid prescriptions?

Figure 90 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

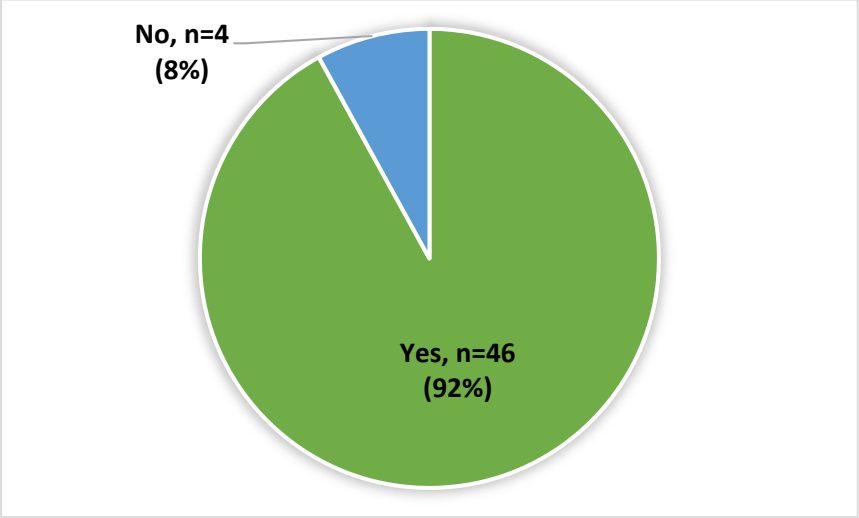

Table 138 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, 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, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	46	92.00%
No	Colorado, New Mexico, Oregon, Texas	4	8.00%
Total		50	100.00%

Please explain.

Table 139 - Explanations of POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

State	Explanations
Alabama	Therapeutic duplication edit
Alaska	There is a point-of-sale prescription lookback and produr edits identify duplicate therapy.
Arkansas	Arkansas Medicaid has a maximum quantity edit for short-acting opioids of #93 over a rolling 31 days. This edit would allow multiple short-acting opioids to be billed, but a total for all claims cannot exceed 93 pills in a 31 day rolling timeframe. Opioid claims will deny at POS if the beneficiary has a billed claim of a buprenorphine product in the previous 90 days.
California	POS edits are in place to monitor duplicate therapy of opioid prescriptions that do not have an approved Treatment Authorization Request.
Colorado	Duplicate therapy limitations, including limit of one long-acting opioid (including different strengths) and one short-acting opioid (including different strengths) for concomitant use, are managed by limiting prior authorization approval on file for opioid medications prescribed.
Connecticut	Same day/duplicate fills are not allowed and will trigger early refill notifications. Additionally, there are ProDUR alerts triggered by duplication of ingredient.
Delaware	Duplicate claims are identified by comparing drug in history to current having the same generic sequence number, in same therapeutic class with overlapping day supply. Claim is flagged for Pharmacy verification, a prior authorization is required to override or use of submission clarification code of 5 for therapeutic change by prescriber.
District of Columbia	Claims for concurrent use of opioid prescriptions including short and long acting opioids as well as for more than one short-acting opioid are denied at the PS and require clinical review and prior authorization.
Florida	Narcotics: Max of 14-days of therapy per month. Restricts recipients to no more than 1 LA Narcotic every 30 days.
Georgia	Members are limited to 5 narcotic (opioid pain relievers) fills per 30 days. Treatment naive members: Edit checks for a LAO with no paid claim for a SAO. Purpose is to verify patient receives IR prior to ER use. MME limits in place for overall opioid use.
Hawaii	First Data Bank updated edits for therapeutic categories
Idaho	ProDUR edit plus cumulative MME total for all opioids.
Illinois	Duplicate therapy edit for short-acting narcotics and a duplicate therapy edit for long-acting narcotics
Indiana	System monitors for more than one long-acting and one short-acting agent in current utilizers and requires PA if more are present.
Iowa	Soft edits are used to message pharmacies.
Kansas	Concurrent opioid use is limited to one short-acting opioid and one long-acting opioid, with the exception of the following scenario: We allow for the main opioid prescriber plus an intermittent prescriber for a surgical/trauma type situation where increased opioid use would be needed. *The prescriber has to have reviewed controlled substance prescriptions in the Prescription Drug Monitoring Program (PDMP) a.k.a K-TRACS. *Prescriber must attest that the patient has been counseled on potential respiratory depression. *Cumulative opioid dose must not exceed 90 MME per day. *Total day supply for the requested medication must not exceed 21 days (3 weeks).
Kentucky	Yes, an NCPDP 88 duplicate therapy denial will present when there are overlapping days supply of 2 opioids in therapeutic class 40 or an opioid and a buprenorphine-containing product. Prior authorization is required.

State	Explanations
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.
Maine	ProDUR messaging sent to the Pharmacy
Maryland	The Therapeutic Duplication (TD) outcomes override POS edit is in place to monitor duplicate opioid prescriptions.
Massachusetts	1. Claims for any combination of the following long-acting agents: Arymo ER, Belbuca, buprenorphine transdermal, Conzip, Embeda, fentanyl transdermal system, hydrocodone ER capsule, hydromorphone ER, Hysingla ER, levorphanol tablet, methadone injection, methadone oral, MorphaBond ER, morphine ER capsule (Avinza, Kadian), morphine CR tablet, Nucynta ER, oxycodone ER tablet, oxymorphone ER oral, tramadol ER, or Xtampza ER, and there is greater than 2 months of duplicate claims in POPS history, the claim will usually reject at the pharmacy as prior authorization required. 2. Claims for any combination of the following short-acting, opioid powders, and combination product agents: Abstral, acetaminophen/codeine, apomorphine powder, benzhydrocodone/acetaminophen, Buprenex, buprenorphine powder, butalbital/acetaminophen/caffeine/codeine, butalbital/aspirin/caffeine/codeine, butorphanol nasal spray, carisoprodol/aspirin/codeine, cocaine powder, codeine, codeine powder, dihydrocodeine/acetaminophen/caffeine, dihydrocodeine/aspirin/caffeine, fentanyl buccal tablet, fentanyl powder, fentanyl transmucosal system, hydrocodone powder, hydrocodone/acetaminophen, hydrocodone/ibuprofen, hydromorphone, hydromorphone powder, Lazanda, levorphanol powder, meperidine, methadone powder, morphine IR, morphine sulfate powder, Nucynta, Oxaydo, oxycodone IR, oxycodone powder, oxycodone/acetaminophen, oxycodone/aspirin, oxycodone/ibuprofen, oxymorphone IR oral, pentazocine/naloxone, Prialt, Subsys, sufentanil powder, tramadol IR, tramadol/acetaminophen or Xartemis XR and there is greater than 2 months of duplicate claims in POPS history, the claim will usually reject at the pharmacy as prior authorization required.
Michigan	The POS therapeutic duplication edit denies and requires a call center override. Provider level overrides are not permitted on this edit.
Minnesota	If it is the same drug, strength, and dose form of the opioid, then the claim rejects as a duplicate claim.
Mississippi	POS edits capture duplicate opioid prescriptions. Incoming claims for short acting and long acting opioids are checked. If MME for an overlapping claim in history is >/= 90 MME per day, the edits cause a denial of the claim and requires a Clinical review of the claim.
Missouri	We allow one short acting opioid at a time. We also have an accumulative MME edit and evaluate the total therapy when the MME limit is exceeded.
Montana	Rx system will recognize same drug and strength and deny for duplicate.
Nebraska	Drug-drug alerts are sent to pharmacies with each fill.
Nevada	Pro-DUR edits are in place to monitor duplicate therapy.
New Hampshire	POS edits will deny opioid prescriptions for therapeutic duplication. If the prescription is medically necessary and clinically appropriate the pharmacy can request an over-ride.
New Jersey	DUR edits deny a claim if 2 or more short-acting or long-acting opioid prescriptions are requested.

State	Explanations
New Mexico	Currently have a pay and report Therapeutic Duplicate ProDur Alert in place that list submission of duplicate opioid prescriptions.
New York	The Medicaid Program has a POS edit which indicates to a pharmacist when a therapeutic duplicate, of any medication being entered, exists on a recipient undergoing a medication order entry process. PA required for more than 4 opioid prescriptions within a 30-day period except for treatment of sickle cell disease or cancer. PA required for initiation of opioid therapy for patients on opioid dependence therapy. PA required for any additional long acting opioid for patients currently on long acting opioid therapy except for treatment of sickle cell disease or cancer.
North Carolina	DUR Alerts for Therapeutic Duplication and Ingredient Duplication. The MME limit is cumulative for all opioid prescriptions.
North Dakota	We limit patients to one short acting and one long acting at a time. All long acting opioids and any cumulative dosages greater than 90 MME require prior authorization.
Ohio	DUR edits to monitor duplicate therapy.
Oklahoma	Limited to one short acting and one long acting opioid.
Oregon	Morphine equivalents and quantity limits are per opioid drug claim and do not look across multiple agents.
Pennsylvania	Therapeutic duplication POS edits apply to all opioid claims. When therapy duplication is identified, the incoming duplicate drug claim denies at the POS and requires review for medical necessity.
Rhode Island	ProDUR edits in place for duplicate therapy.
South Carolina	Yes, FDB monitors for TD/DDI, etc
South Dakota	Allow one short acting and one long acting.
Tennessee	Yes, duplicate therapy ProDUR edits will trigger with multiple opioids, and the use of multiple opioids is also controlled via the benefit limit for non-chronic users and PA's required. For chronic users, ProDUR edits would be triggered, however the enrollees benefit allows up to 200MME, so with the hard duplicate therapy edit, if the enrollee is below 200MME, the enrollee/practitioner can acquire coverage with PA submitted via CoverMyMeds or a call to the call center.
Texas	Though a POS edit for duplicative opioid therapy is not in place, Texas-licensed pharmacies are required to report all dispensed CII - CV records to the Texas Prescription Monitoring Program (PMP) within 1 business day. Mandatory PDMP review by both prescribers and pharmacists started in FFY 2020. Also, the cumulative daily MME does not allow the combination daily dose exceeding 90 MME.
Utah	Opioid prescriptions within the same class and dose will hit a refill too soon edit if filled before 100% is exhausted. The system will allow opioids of different class or dose to fill concurrently.
Vermont	There is an edit in the POS alerting the pharmacist of the duplicate.
Virginia	There is a ProDUR edit for duplication of therapy for opioids
Washington	For acute use POS adds the prescriptions to verify if they exceed the allowed number of doses based on the client's age. For chronic use (exceeding 42 days in a rolling 90 day period) only the opioids approved through the attestation prior authorization process will pay; all others will reject 75 for prior authorization required.
West Virginia	We allow long-acting to be used with short-acting but cannot have multiple of either. Edit will fire that requires override by the pa vendor RDTP (SEV 1 EDIT).
Wisconsin	Wisconsin has a prospective DUR alert for therapeutic duplication in certain therapeutic drug classes including opioid analgesics.

State	Explanations
Wyoming	Medicaid clients are allowed one long-acting and one short-acting medication at a time.

6. Do you have POS edits to monitor early refills of opioid prescriptions dispensed?

Figure 91 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

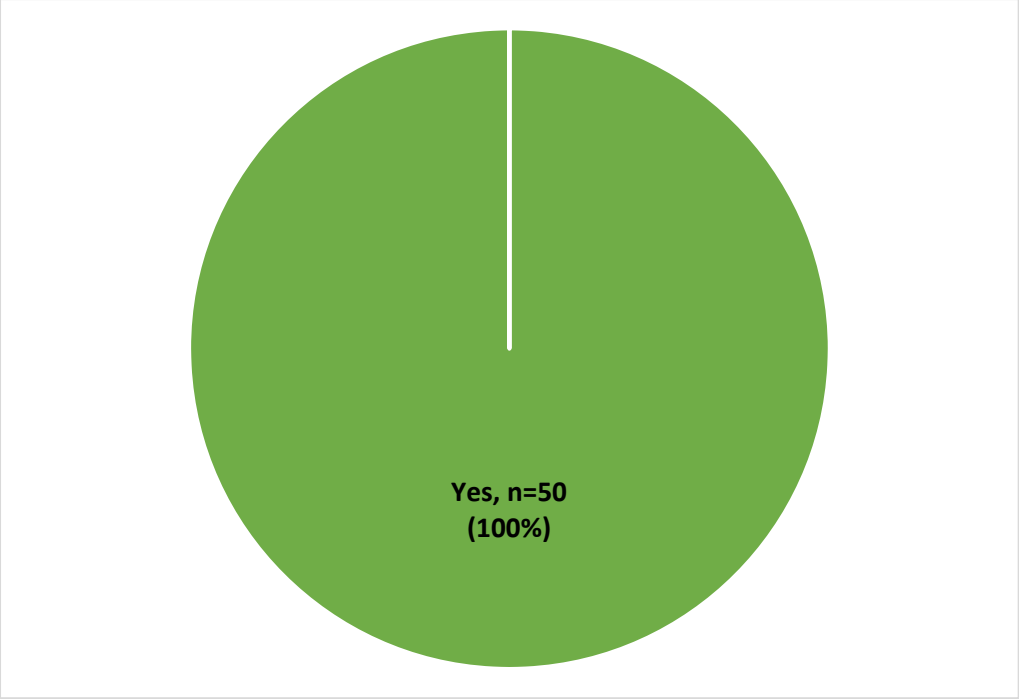

Table 140 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

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%
Total		50	100.00%

Please explain.

Table 141 - Explanation for POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

State	Explanations
Alabama	Early refill edit; 75% threshold for Schedule II controlled drugs; 85% threshold for opioid agonists and partial agonists
Alaska	There is a point-of-sale prescription lookback and produr edits identify duplicate therapy.
Arkansas	POS edits include refill-too-soon logic that requries at least 75% of dispensed medications to be utilized before a refill would be allowed. Also an accumulation edit for controlled drugs will allow an extra 7-days' supply accumulation through early fills in the previous 180 day period. If a beneficiary refills a prescription when 75% of the previous fill has been utilized (which would equate to approximately 7 days early), then refills for subsequent months until that 7 days early in 180 falls off must be filled on time.
California	POS edits are in place to monitor early refills of opioid prescriptions that do not have an approved Treatment Authorization Request.
Colorado	All opioid claims are subject to 85% early refill tolerance and a cumulative total of twenty early refill days over a 180 day period.
Connecticut	Claims < 15 Day Supply, or if the pharmacy is out of state, require that 85 % of the days' supply on the previous prescription be used before allowing the current claim to pay. Claims > or =15 Days of Supply require that 93 % of the days' supply on the previous prescription be used before allowing the current claim to pay.
Delaware	Early refill opioid claims denied if less than 90% day supply is calculated.
District of Columbia	The POS system denies claims for opioid prescriptions submitted prior to a 80% tolerance threshold and requires that a prior authorization be placed to allow that early fill claim to be paid.
Florida	The early refill percent threshold is set at 90% for opioid prescriptions.
Georgia	Early refill edit in place. Members are limited to 5 narcotic (opioid pain relievers) fills per 30 days
Hawaii	75% for scheduled III and IV substances and 87% for scheduled II substances.
Idaho	ProDUR edit for early refill. Also the MME edit is set up so if early refill then both original fill and refill will count toward cumulative MME limit. If over 90 then will deny.
Illinois	HFS has a refill-too-soon threshold of 90% for Schedule II-V controlled substances. Prior authorization is required for all early refills.
Indiana	Early refill is monitored and PA is required if 85% of supply is not exhausted
Iowa	Hard edit in place to block early refill. The pharmacist does not have the ability to override the claim at the POS.
Kansas	We have the soft edit set at 80% for all prescriptions, but FFS was not able to have the specific hard stop edit in place when this PA and policy was implemented. A PA is required to refill sooner than at the 90% refill limit and that hard stop edit is not in place.
Kentucky	90% of the days supply from the previous dispense must be used up or the claim will deny based on the duplicate opioid therapy edit described above.
Louisiana	Opioid prescriptions deny edit before 90% used or 2 days early.
Maine	Accumulator edits are in place to minimize early refill use and require prior authorization.
Maryland	Early Refill is a hard stop edit and requires a call to the POS vendor's call center for an override.
Massachusetts	POS rules will not allow less than 85% of days supply utilized. Prior Authorization is required to override.
Michigan	The POS system requires 90% of the opioid claim to be utilized otherwise the claim will deny. No provider level overrides are allowed. The call center must review and approve. For beneficiaries enrolled in our Benefits Monitoring Program (BMP), the POS system requires 95% of the opioid claim to be utilized before a refill is allowed.

State	Explanations
Minnesota	CS are set at the 85% refill too soon threshold.
Mississippi	Depending on the scheduling classification of opioids (II,III,IV), for those agents where refills are permitted, an 85% threshold is set in our system before a refill is allowed.
Missouri	Our early refill edit limits opioids to be filled at 85% and is not overridable by the pharmacist though the POS system.
Montana	Rx system will deny same drug and strength as refill too soon if >10% remaining.
Nebraska	Yes, 30 day supply only.
Nevada	Refill limits are set to 90% of previous fill must be used.
New Hampshire	POS edits will deny opioid prescriptions for early refill. If the prescription is medically necessary and clinically appropriate the pharmacy can request an over-ride.
New Jersey	Early refill edits deny claims for opioid prescriptions that have not exceeded 85% completion.
New Mexico	All prescriptions are subject to a 75% utilization early refill POS edits. Planning to change to 90% refill threshold for opioids in FFY20.
New York	Early refills of opioid prescriptions are denied if the remaining amount is greater than a 7-day supply of an opioid medication which has been obtained over a period of 90 days.
North Carolina	Early Refill Edit hits for claims with less than 85% consumption.
North Dakota	Early refill edit set at 87% and accumulation edit set at 10 days of accumulation in 180 day lookback.
Ohio	Early refill edits in point of sale. The pharmacy cannot override this and needs to call the helpdesk if an override is required.
Oklahoma	early refill threshold set at 90% for opioids.
Oregon	Early refill threshold set at 80%
Pennsylvania	A hard edit on early refills of all opioids at less than 85% requires prior authorization by the prescriber.
Rhode Island	ProDUR edits in place to monitor early refills.
South Carolina	Yes, Prescription edits limit refill of Control Medications - 85% of control medications must be exhausted prior to a prescription refill. Claim will reject/deny NCPDP early refill and cannot be overridden by Pharmacy (Federal/State laws apply example: Authorization for Emergency Dispensin Dispensers shall pull all original controlled substances prescriptions and document any early refill information in full detail; including, but not limited to, the date, time, reason for early refill, and

State	Explanations
	the pharmacist signature associated with the transaction. Compliance with this Order supersedes any conflicting requirement of Regulation 61-4. Schedule II Medications In the case of an emergency situation, a pharmacist may dispense a controlled substance listed in Schedule II upon receiving oral authorization of a prescribing individual practitioner, provided that: 1.In the case of an emergency situation, a pharmacist may dispense a controlled substance listed in Schedule II upon receiving oral authorization of a prescribing individual practitioner, provided that: 2.The quantity prescribed and dispensed is limited to the amount adequate to treat the patient during the emergency period (dispensing beyond the emergency period shall be pursuant to a written prescription signed by the prescribing individual practitioner); 3.The prescription shall be immediately reduced to writing by the pharmacist and shall contain all information requested in 1003, except for the signature of the prescribing individual practitioner; 4.If the prescribing individual practitioner is not known to the pharmacist, he or she shall make a reasonable effort to determine that the oral authorization came from a registered individual practitioner, which may include a callback to the prescribing individual practitioner using his or her phone number as listed in the telephone directory and/or other good faith efforts to insure his or her identity; and 5.Within 72 hours after authorizing an emergency oral prescription, the prescribing individual practitioner shall cause a written prescription for the emergency quantity prescribed to be delivered to the dispensing pharmacist. In addition to conforming to the requirements of 1003, the prescription shall have written on its face, "Authorization for Emergency Dispensing," and the date of the oral order. The written prescription may be delivered to the pharmacist in person or by mail; however, if delivered by mail, it shall be postmarked within the 72-hour period. Upon receipt, the dispensing pharmacist shall attach this prescription to the oral emergency prescription, which had earlier been reduced to writing. The pharmacist shall notify the Bureau Director if the prescribing individual practitioner fails to deliver a written prescription to him or her; failure of the pharmacist to do so shall void the authority conferred by this paragraph to dispense without a written prescription of a prescribing individual practitioner.
South Dakota	We edit all claims for early refill.
Tennessee	The early refill edit is not only for opioids, but is for all controlled substances. The refill percent threshold for non-controlled substances is 85%, so for a 30-day supply, the prescription cannot be refilled until the 26th day. For all controlled substances, the refill percent threshold is 95%, so any additional fills cannot be filled until the 30th day for a 30-day supply.
Texas	Claims for all controlled substances require a 90% utilization of prior fill before the next a refill is allowed.
Utah	Opioid prescriptions have a refill tolerance of 100%. The claim will not fill early unless 100% of the opioid day supply has been used.
Vermont	A refill is allowed based on the days supply remaining. In general if a prescription is for 14-39 days supply 85 % has to be used before a refill is allowed. In early 2020 we began applying a cumulative days supply edit.
Virginia	There is an early refill edit with a percent threshold for schedule II controlled drugs of 90%.
Washington	All prescriptions must show that 75% of the medication has been used based on the quantity and days' supply submitted on the claim. If a prescription is filled prior to exhausting 75% of the medication the claim will reject NCPDP edit 79 refill too soon.

State	Explanations
West Virginia	Early refill edit is set at 85% which can be overridden by rational drug therapy program (prior authorization vendor).
Wisconsin	Wisconsin has a prospective DUR alert for early refill. This alert requires pharmacies to call into a specialized call center to obtain a policy override before the opioid prescription can be dispensed. All opioid prescriptions are monitored by a prospective early refill alert or a quantity limit alert.
Wyoming	Scheduled drugs II-V require 90% of the days supply to be used before a refill or new claim for the same medication will be allowed. 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 all subsequent claims, and the 90% refill tolerance will be calculated on that accumulated total.

7. Do you have comprehensive claims review automated retrospective process to monitor opioid prescriptions exceeding these state limitations?

Figure 92 - Claims Review Automated Retrospective Process to Monitor Opioid Prescriptions Exceeding State Limitations

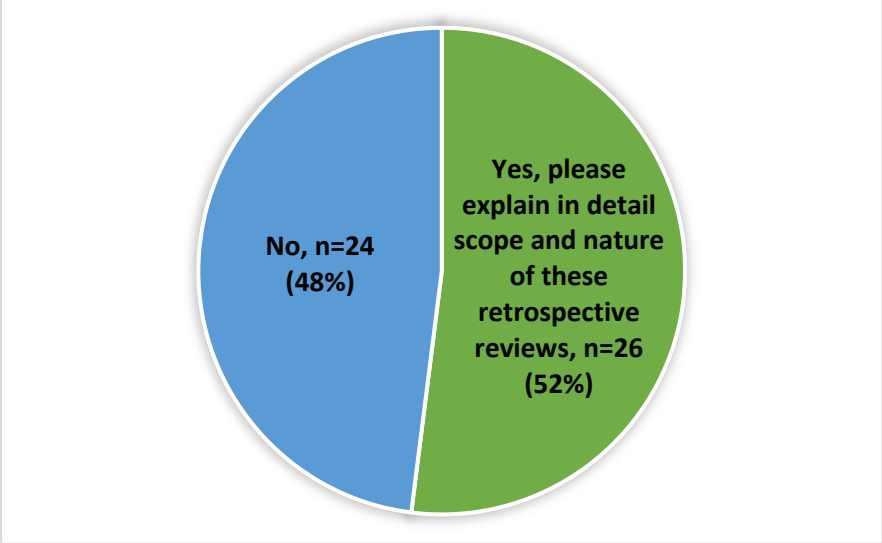

Table 142 - Claims Review Automated Retrospective Process to Monitor Opioid Prescriptions Exceeding State Limitations

Response	States	Count	Percentage
Yes, please explain in detail scope and nature of these retrospective reviews	Alaska, Arkansas, Colorado, District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, Kentucky, Maryland, Michigan, Nebraska, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Wisconsin	26	52.00%
No	Alabama, California, Connecticut, Delaware, Idaho, Illinois, Kansas, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oklahoma, Rhode Island, Texas, Washington, West Virginia, Wyoming	24	48.00%
Total		50	100.00%

Please explain in detail the scope and nature of these claims review automated retrospective processes.

Table 143 - Scope and Nature of Claims Review Automated Retrospective Process

State	Scope and nature of these retrospective reviews
Alabama	Alabama Medicaid has prospective edits.
Alaska	The opioid report generated is reviewed with the DUR committee quarterly
Arkansas	Our POS edits which include maximum quantities and MME restrictions for opioids are so strict that very few beneficiaries will have claims that exceed our limitations which mirror the CDC recommendations. The RDUR program does mointor for over-utililzation, multiple physicians/pharmacies, opioids with benzodiazpines, opioids with antipsychotics, and opioids with polypharmacy including benzodiazepines, muscle relaxers, gabapentin and sedative hypnotics.
California	While there is regular, comprehensive claims review to monitor opioid prescriptions exceeding these state limitations, the review process is not automated.
Colorado	Retrospective review is conducted on a case-by-case basis at the claims level as part of a prior authorization requirement triggered by MME > 200mg or the 4th fill of an opioid for a previously opioid naive member or the 4th fill of an opioid prescribed by a dental provider. Prescribers also receive letters when concomitant use of an opioid and benzodiazepine is identified.
Connecticut	Claims review automated retrospective processes were established during FFY 2020 to monitor opioid prescriptions exceeding state limitations set prospectively.
Delaware	Claims denied and overridden are flagged for review, for potential prescriber score card report generation, and provider education. The population mix of predominately with other insurance and Medicaid as secondary posse a challenge to enforcement of policies. Individual provider outreach is done to educate providers when patient's dose exceeds state limits
District of Columbia	There is a manual monthly claims review to identify top prescribers, pharmacies and beneficiaries displaying prescribing and utilization patterns that exceed program policy parameters. These opioid focused reports are shared with the DHCF Program Integrity staff at a monthly meeting.
Florida	Opioid prescribing trends and potential fraud and/or abuse are identified via automated claims review by the DUR Board. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
Georgia	We have the ability to retrospectively monitor opioid use in patients.
Hawaii	Quarterly review of control substances, assess for patient access, outliers and trends, policy amendments as needed. Patient profile review for detail if needed.
Idaho	The State does not have an automated retrospective process, but has employed a quarterly retrospective reporting package to look at all members exceeding limitations.
Illinois	The automated retrospective process to date selects 300 patients based on Medispan criteria, not just opioid prescriptions. HFS periodically reviews impact of opioid edits to determine whether edit changes are needed.
Indiana	Opioid claims are reviewed annually for MME limits, quantity, number of utilizers, and concurrent utilization with other therapies.
Iowa	A monthly early refill report is generated for review consistent with SUPPORT Act requirements effective October 2019.
Kansas	All claims must be within edit limits or meet the clinical PA criteria for claims to pay.

State	Scope and nature of these retrospective reviews
Kentucky	A quarterly report is provided to KY Medicaid by Magellan to identify potential opioid over-utilization. This includes high MME, opioids used with drugs that potentiate overdose (e.g., antipsychotics, benzodiazepines, gabapentin, sedative hypnotics), change in dosage and top prescribers and pharmacies.
Louisiana	We are expecting to implement this during FFY20.
Maine	Claims exceeding State limitations are evaluated through the PA process with clinical review. Those found in excess or abusing the process are enetered into the Intensive Benefit Management Program
Maryland	The Retrospective DUR (RDUR) vendor, Health Information Design, LLC (HID), monitors criteria to look at over-utilization of opioids as part of the Corrective Managed Care program, and performs interventions monthly. Additionally, HID has pre-built RDUR criteria that identifies duplicate use of short acting opioids, duplicate use of long acting opioids, inappropriate use of opioids based on diagnosis. This criteria is activated and monitored with the monthly claims data evaluation through RxExplorer system. Case by Case basis If approved by the DUR Board, HID performs an intervention with this criteria. HID has R-DUR criteria to identify participants receiving greater than or equal to 50mg MME, with a comment that the MME is 90mg. This criteria has been in place since 2016. The criteria remains active. On case by case basis If approved by the DUR Board, HID performs an intervention with this criteria.
Massachusetts	Process is not automated, however opioid prescriptions exceeding state limitations under specific conditions require prior authorization and review by a Therapeutic Class Management Group
Michigan	We have standard RetroDUR reports that monitor monthly opioid MME trends (e.g. under 90, 90 to 120, and greater than 120. Our contracted lead academic detailing pharmacist manually reviews the high MME utilizers each month and performs additional outreach and education to the prescribers using our standard High MME education packet.
Minnesota	There is nothing automated. All drugs that exceed state opioid prescription limits which is 90mg MME require prior authorization so these prescriptions have already gone through the prior authorization review process.
Mississippi	Any opioid prescriptions that fall outside of the approved opioid criteria require a prior authorization and ProDUR review before the prescription can be filled.
Missouri	All claims that exceed the ProDUR limits for opioid prescriptions are thoroughly reviewed in the prospective process. Claims are reviewed in aggregate semi-annually to detect and address potential utilization issues and the ProDUR edits are updated accordingly.
Montana	As we deny claims that exceed these limitations at point of sale and require prior authorization, all claims that exceed these limitations have been authorized.
Nebraska	Drug alert is sent to the pharmacies with each fill.
Nevada	RetroDUR is a manual review process and opioid reports are presented to the DUR Board.
New Hampshire	The state has a MME limit implemented which requires a prior authorization for all claims above an MME of 100.
New Jersey	A comprehensive claims review to monitor opioid prescriptions retrospectively was started 4th quarter of CY2019.

State	Scope and nature of these retrospective reviews
New Mexico	Plan to develop comprehensive claims review automated processes with the new MMIS implementation.
New York	Opioid claims are reviewed retrospectively by pharmacy academia from the State University of New York at Buffalo. Ad Hoc reviews by the DUR Board using drug utilization presentations by pharmacy academia from the State University of New York at Buffalo are used by the Board in identifying the effectiveness of the State limitations. Targeted educational letters, stricter point of service edits or additional edits would be a determination of the DUR Board.
North Carolina	NC has automated reports on drugs hitting the Early Refill Edit.
North Dakota	RetroDUR criteria continue to be used for opioid monitoring, although with all of the limits, the volume of patients that trigger these exceptions is lower.
Ohio	High quantity/day supply algorithm that will identify opioids where the quantity and day supply do not match. Maximum daily dose exceeded. These claims will have been through prior authorization. High quantity dispensed. These claims would have been through prior authorization.
Oklahoma	We did not have an automated process for review during this FFY.
Oregon	We track currently enrolled FFS patients who have a current PA for an opioid prescription and at least one of the following criteria: 90 Morphine Milligram Equivalents (MMEs) cumulative daily dose Concurrent paid claims for short- and long-acting opioids Concurrent paid claims for > 2 unique opioids Multiple paid claims for early opioid fills 3 unique denied claims for opioid prescriptions Patients are prioritized based on the number of inclusion criteria met. Higher priority patients meet more inclusion criteria. Individual patient profiles are reviewed and the prescriber is lettered with a clinical recommendation. Patients excluded from the report: Patients with a malignant cancer diagnosis or claim for palliative care Patients with a diagnosis of sickle cell disease in the past year Patients with currently active TPL or Medicare coverage Patients previously reviewed with this initiative in the last 6 months
Pennsylvania	Prior authorization is required for all opioids. The RetroDUR program is used to look at concurrent use with other CNS depressants.
Rhode Island	Not at this time.
South Carolina	Yes
South Dakota	We conduct retro DUR for all claims.
Tennessee	Yes. All claims are denied if over 200 MME for chronic opioid users, or after the first 5-day fill a no greater than 60 MME for non-chronic opioid users. These limits are set in TennCare Rules (approved via the State legislature), so there are no exceptions with prior authorization. The only way for an enrollee to pass the benefit limits would be via appeal and this would include a hearing in front of an Administrative Law Judge.
Texas	A one-time retro-DUR intervention was conducted in October 2018 and intervention letters were sent to prescribers whose patients received more than 3 different opioid agents within 60 days (excluding cancer patients).

State	Scope and nature of these retrospective reviews
Utah	Retrospective review of claims identifies prescriptions that exceeded the MME threshold in a designated time period. Claims are evaluated by member prescription profile and provider prescribing patterns for opioids. Next, peer-to-peer outreach is done to encourage a decrease in the prescribing of high dose opioids with the following goals: 1) Educate health care providers on the availability of non-pharmacologic and non-opioid pain options and selected opioid use disorder treatments; 2) Provide health care providers with resources on both Medicaid and CDC web sites; 3) Educate providers on Utah Medicaid opioid policies.
Vermont	Prior Authorization would be required and approved on a case by case basis by the state for prescriptions in excess of the state limitations. Additionally 2 team care reports are generated on a quarterly basis and are used as a retrospective process to monitor opioid prescriptions and potential misuse. 1. Controlled Substance Claims that denied at the pharmacy for Refill Too Soon or for CII drugs, therapy duplication 2. Prescribers that wrote members a prescription for a controlled substance including MAT therapy (all claims, both paid and denied). Includes the ability to sort and monitor at the pharmacy level as well.
Virginia	Every quarter we review members utilizing opioids chronically and that have high risk activity (e.g., opioid/substance abuse, high MME, ER visits) and see if they are getting naloxone along with the opioid. We also review quarterly as part of the SUPPORT Act members on concurrent opioids and benzodiazepine therapy and concurrent opioids and antipsychotics.
Washington	In 2017 Washington Apple Health (Medicaid) created a dashboard to monitor the Initial Opioid Policy which included the limits for acute use and transition to chronic use or subsequent fills. Unfortunately the staff position that supported this work was temporary and based on grant funding. For FFY2019 the dashboard that was previously used to support retrospective review of opioids was not refreshed with current data. Washington Apple Health (Medicaid) is developing reports to measure the SUPPORT Act requirements and will be regularly monitoring opioid use. These reports will include measures looking at MME, co-prescribing, concurrent opioid use with medication assistance treatment drugs, benzodiazepines, sedative hypnotics, and other medications with psychotropic affects. These reports will be reviewed by client, prescriber, and pharmacy.
West Virginia	We have prospective edits in place that prevent members from exceeding state limitations. Retrospective review cannot access PDMP.
Wisconsin	Although Wisconsin has not officially established state opioid limits, Wisconsin is doing a claims review of high dose opioids where the MME is greater than or equal to 250 MMEs. Prescriber letters are sent and peer to peer outreach calls are being performed.
Wyoming	Retrospective reviews are done approximately annually, however, the process is not automated. As all prescriptions exceeding state limitations require prior authorization, and PDMP data is not available, regular retrospective review is not necessary.

8. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and benzodiazepines being used concurrently?

Figure 93 - POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Benzodiazepines Being Used Concurrently

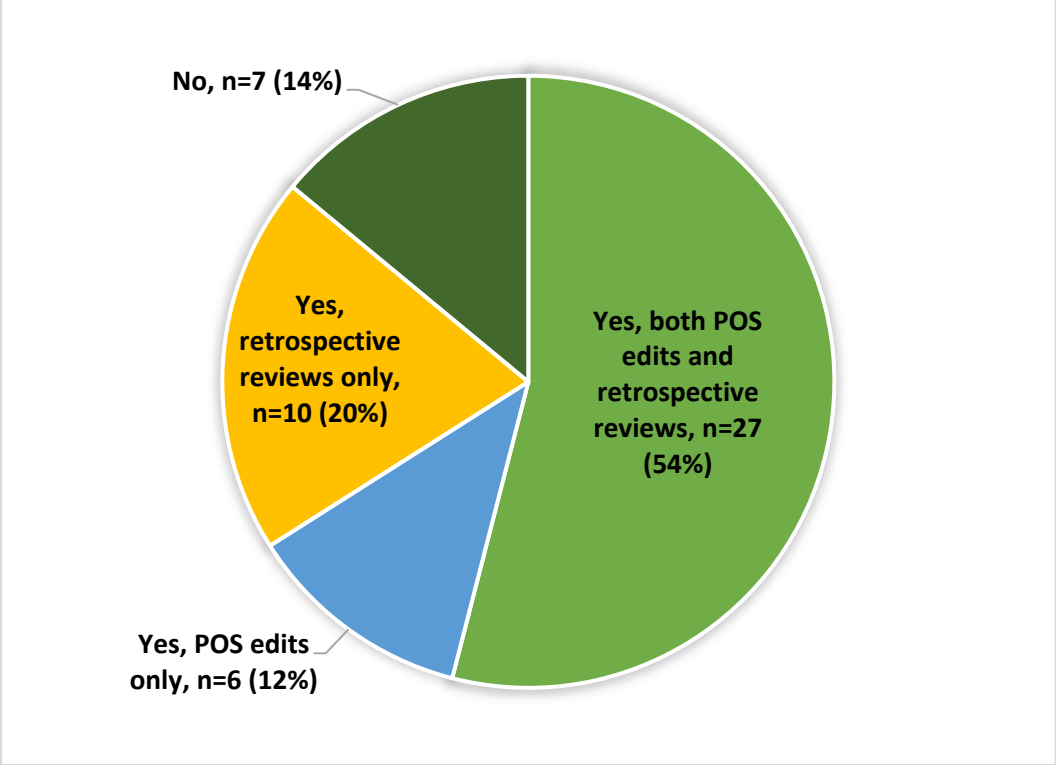

Table 144 - POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Benzodiazepines Being Used Concurrently

Response	States	Count	Percentage
Yes, both POS edits and retrospective reviews	Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New York, North Carolina, North Dakota, Ohio, South Dakota, Utah, Vermont, West Virginia	27	54.00%
Yes, POS edits only	Delaware, Nebraska, Tennessee, Texas, Virginia, Wyoming	6	12.00%
Yes, retrospective reviews only	Alabama, Hawaii, Illinois, Kentucky, Michigan, Oregon, Pennsylvania, Rhode Island, South Carolina, Wisconsin	10	20.00%
No	Kansas, Maryland, New Hampshire, New Jersey, New Mexico, Oklahoma, Washington	7	14.00%
Total		50	100.00%

If “Yes,” please explain in detail scope and nature of reviews and edits for Opioids and Benzodiazepines Being Used Concurrently

Table 145 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Benzodiazepines Being Used Concurrently

State	Explanations
Alabama	SUPPORT Act of 2018 RDUR criteria
Alaska	Point-of-Sale overrides are available when the pharmacist contacts the prescriber to discuss potential interactions. A report with concurrent use is reviewed by the DUR committee.
Arkansas	Arkansas Medicaid has edits in place that manage the use of benzodiazepines and opioids in patients with poisoning/overdose diagnoses 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. Anyone with these billed diagnoses will need a prior authorization for using benzodiazepines or opioids excluding patients with a billed diagnosis of cancer in the last year. The RDUR program reviews the utilization of concomitant opioid and benzodiazepine usage and provides education with intevention 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. Two mailings on this topic were initiated in FFY2019 after retrospective reviews showed beneficiaries with concurrent use of opioids, benzodiazepines, and additional medications with CNS depressant properties.
Colorado	Prior authorization is required for members receiving long-term therapy with an opioid medication who are newly started on a benzodiazepine medication, or for members receiving long-term therapy with a benzodiazepine medication who are newly started on an opioid medication. 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	This RDUR criteria is designed to target recipients who receive any benzodiazepine (30-day supply in 90 days) concurrently with any opioid (30-day supply in 90 days). An occurrence of any negating diagnosis and/or drug below would negate the criteria from selecting those recipients. Negating medications /diagnoses include antineoplastic agents, malignancy diagnoses, sickle cell, and palliative care. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention annually.
Delaware	Prior authorization for all long acting and high dose opiates can only be approved if the member is not receiving a benzodiazepine. With exception of certain diagnosis such as Seizures disorder.
District of Columbia	The claims review process includes monthly reports to identify trends on concomitant use of benzodiazepines and opioids. DUE edits include BENZODIAZEPINES/OPIOIDS (COUGH AND COLD), BENZODIAZEPINES/OPIOIDS (IMMEDIATE RELEASE0, BENZODIAZEPINES/OPIOIDS 9EXTENDED RELEASE), LEVOMETHADONE, METHADONE FOR MAT/BENZODIAZEPINES. Top prescribers, pharmacies and beneficiaries are identified and tracked for utilization and prescribing patterns that exceed policy parameters.
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. The DUR Board did a retrospective review of the soft edit and voted to move to a hard edit to be deployed in FFY20.

State	Explanations
Georgia	Members filling opioid and benzos will trigger POS message that this combination is not recommended. See RDUR section previously for more details on retrospective claims.
Hawaii	Annual review of opioids and benzodiazepines being used concurrently, assess for patient access, outliers and trends, policy amendments as needed. Patient profile review for detail if needed.
Idaho	FDB ProDUR edits and RetroDUR reviews.
Illinois	We have reviewed patients receiving benzodiazepines with opioids concurrently to determine types of medications, regimens, and durations of concomitant use. Additionally, when prior authorization requests are received for an opioid or for a benzodiazepine, and a benzodiazepine or opioid are noted in the medication claims history, the prescriber is reminded of the FDA black box warning regarding potentially fatal respiratory depression with concomitant use and encouraged to consider tapering of one of the agents and/or prescribing naloxone since the patient is at higher risk for potentially fatal respiratory depression
Indiana	Claims are reviewed annually for concurrent utilization. In addition, prior authorization with prescriber attestation is required for concurrent use in new starts.
Iowa	Soft edits are in place, messaging pharmacies. Additionally, a retrospective report is generated identifying members with concurrent use of an opioid and benzodiazepine consistent with SUPPORT Act requirements effective October 2019.
Kentucky	A quarterly report is provided to KY Medicaid by Magellan to identify potential opioid over-utilization. This includes high MME, opioids used with drugs that potentiate overdose (e.g., antipsychotics, benzodiazepines, gabapentin, sedative hypnotics), change in dosage and top prescribers and pharmacies. Of note, benzodiazepines are only available for 60 days (per rolling 365 days) without a prior authorization. Must have a qualifying diagnosis to continue.
Louisiana	POS edit: Pharmacy claims for an opioid will deny if there is an active claim on the recipient's 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. Retrospective reviews: 92 interventions were mailed to prescribers regarding recipients who had concurrent prescriptions for opioids and benzodiazepines in FFY19.
Maine	ProDUR messaging is sent to the Pharmacy and RetroDUR analysis are done
Massachusetts	All benzodiazepines (with the exception of clobazam, diazepam rectal gel, diazepam nasal spray, midazolam nasal spray and injectable products) will require prior authorization if used concomitantly with an opioid for 60 out of the past 90 days under the Concomitant Opioid and Benzodiazepine Initiative.
Michigan	Concurrent utilization reports of opioids and benzodiazepines are reviewed regularly. In addition, our WholeHealthRx program performs academic detailing outreach to prescribers of members taking opioids in doses greater than or equal to 90 MME concurrently with benzodiazepines.
Minnesota	FDB drug-drug interactions are used in ProDUR informational edits. DHS can elect to choose a population-based intervention with this criteria
Mississippi	Monthly Retro-DUR analysis and education letters are mailed to identified prescribers.
Missouri	We have two retrospective interventions in place to monitor concurrent use of opioids and benzodiazepines. The first, in compliance with the SUPPORT act, identifies all patients with current drug claims for an opioid in the past 30 days and then flags and sends educational material to providers of those patients who are using benzodiazepines concurrently for at least 7 of those days. The same intervention utilizes the same patient pool and flags and sends materials

State	Explanations
	to those providers whose patients concurrently use benzodiazepines, antipsychotics and the identified opioids. We have a second intervention evaluating the use of opioids and benzodiazepines concurrently for an extended duration. Patients with current opioid claims for the past 60 days and 30 days of overlapping benzodiazepines are identified, and their providers receive educational materials. We also send drug-drug interactions between benzodiazepines and opioids from FDB to the pharmacy for review at POS along with a POS edit to monitor concurrent utilization of benzodiazepines and opioids.
Montana	We prospectively limit benzodiazepines when used with methadone. We retrospectively outreach to providers who prescribe benzodiazepine and/or opioids to members who receive both.
Nebraska	Drug-drug alerts are sent to the pharmacies with each fill.
Nevada	ProDUR edits are in place to warn of combination of opioids and benzodiazepines. The RetroDUR program includes initiatives to address the combination of opioids and benzodiazepines.
New York	In 2014 NY Medicaid put into place an edit requiring a prior authorization for claims submitted with concurrent use of opioids and benzodiazepines. Claims of concurrent use of opioids and benzodiazepines are retrospectively reviewed by pharmacy academia at the State University of New York at Buffalo. Ad Hoc reviews by the DUR Board using drug utilization presentations by pharmacy academia at the State University of New York at Buffalo are used by the Board in identifying the effectiveness of those edit. Targeted educational letters, stricter point of service edits or additional edits would be a determination of the DUR Board.
North Carolina	NC has an edit for concurrent use of opioids and benzodiazepines. NC also does retrospective DUR reviews of concurrent use.
North Dakota	Long acting opioids greater than 90 MME per day or immediate release opioids that are greater than 15 MME per dose require prior authorization for concurrent use with benzodiazepines.
Ohio	We have a prospective edit in place that alerts the pharmacist that an opioid is being dispensed in combination with a benzodiazepine. We also have performed a retrospective DUR intervention for members who were taking an opioid together with a benzodiazepine and sedative hypnotic.
Oregon	Prior authorization criteria for benzodiazepines and opioids restrict concurrent use
Pennsylvania	Prior authorization is required on all opioids. The RetroDUR program is used to look at concurrent use with other CNS depressants.
Rhode Island	DUR Board
South Carolina	Retro DUR reporting can capture claims for both concomitant use of opioids and benzodiazepines FDB edits identify DDI/TD, etc.
South Dakota	For claims reviewed during retrospective DUR process educational letters are sent to providers involved with the recipients care. For ProDUR edits a message is returned to the pharmacy identifying concomitant opioid and benzodiazepine utilization.
Tennessee	Prior to 2014, Tennessee did not cover BZO for adults. When mandated in 2014, our criteria for approval was so stringent, 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 not 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. We are not allowed as mentioned earlier to use the PDMP data for the purposes of

State	Explanations
	enforcement with individuals, but the retrospective review from the PDMP showed us that we have very little BZO coverage, and even less for BZO and Opioid concomitant usage.
Texas	An overlap of benzodiazepines and opioids claims that is 14 days or higher will be denied will require a prior authorization.
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 a long-acting opioid will reject.
Vermont	There are edits in the POS that alert the pharmacist of the overlap. DUR Board Meeting February 19, 2019 Retrospective Drug Utilization Review Data presentation: Co-prescribing of Opiates and Benzodiazepines Chronic pain is among the most common reasons for visits to primary care and opioid use/misuse is an epidemic in the US population. Anxiety disorders are also common, and many patients are prescribed benzodiazepines to mitigate symptoms. Both opioids and benzodiazepines have addiction potential, are highly desirable street drugs and are commonly diverted to those in whom use is not intended. Use of the combination frequently results in respiratory depression, over-sedation, accidental injuries and death. A study of 1220 patients with noncancer pain on long-term opioids who also used benzodiazepines were found to have greater pain severity, prescription of higher doses of opioids, substance abuse and greater mental health comorbidities. Even short-term use of either class of medication can lead to addiction and substance abuse. Change Healthcare used paid, non-reversed Medicaid pharmacy and medical claims date from calendar year 2017 and 2018, excluding members with Part D, VMAP and Healthy Vermonters coverage. They identified members, excluding those with a cancer diagnosis, who were prescribed an opioid for at least 90 days within a 180-day span, and examined how many were given an overlapping prescription for a benzodiazepine along with continued use of the opioid. Total members on 90 or more days of opioids 2805 Total members on 90 or more days of opioids with overlapping benzo 1115 (40%) Total members on 90 or more days of opioids and no benzo 1690 (60%) Total ED or Inpatient admissions 1204 Total Members with ED or Inpatient Admission 444 Number of prescriptions where prescriber was the same23034 Number of prescriptions where prescriber was different 11279 Different prescriber 627 members Same prescriber 667 members Of the 1115 members with an overlapping benzodiazepine, 804 members had > 30 days of overlap (72%), and 311 members had an overlap of 30 days or less (28%). Below is the

State	Explanations
	breakdown of the benzos filled. Please note that the same member may have filled more than one medication/strength and would therefore be counted twice. Recommendation: A substantial number of members on chronic opioids were also prescribed benzodiazepines chronically, despite the risks. As well, the prescribers were discordant in a large number of members, raising the question of whether the prescriber of the benzodiazepine was aware of the chronic opioid use. Of the 2805 members on chronic opioids, 16% (444) had an ED or hospital admission, raising concerns about the effects of the medications. No specific diagnoses of falls or accidents were noted, however. Generalized education to the provider community of the prevalence of co-prescribing and reminders of the dangers of combined therapy may be warranted. Public Comment: No public comment. Board Decision: The Board unanimously approved the above recommendation. They asked for follow up looking at the average daily dose to see if low doses of either the benzo or opiates are being prescribed. They also wanted to look further into the diagnoses of the ED visits to see if drug interactions are listed.
Virginia	As part of the Service Authorization process: the prescriber must enter on the opioid service authorization fax form the patient's last fill date of Benzodiazepine prescription from the prescription monitoring program (PMP). The opioid service authorization fax form then asks: -- If benzodiazepine filled in past 30 days, does the prescriber attest that he/she has counseled the patient on the FDA black box warning on the dangers of prescribing Opioids and Benzodiazepines including fatal overdose, has documented that the therapy is medically necessary, and has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines per the Board of Medicine Opioid Prescribing Regulations? Also: First Data Bank's ProDUR edits
West Virginia	Yes we have both. For POS a warning fired but does not stop a claim from going through. Retrospectively there is a flag which prompts review by the RetroDur Board.
Wisconsin	Wisconsin has developed educational letters to inform prescribers when a member is receiving opioids and benzodiazepines concurrently. The letter discusses the clinical concern as well as recommending consideration of naloxone prescribing.
Wyoming	Concurrent use of an opioid and a benzodiazepine is not allowed. Claims are denied at point of sale. As we do not have access to the PDMP, no retrospective claims review is completed.

If “No,” please explain.

Table 146 - Explanations of not Having POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Benzodiazepines Being Used Concurrently

State	Explanations
Kansas	The edits were not in place in FFY 2019. A POS edit and retrospective review was required in policy, effective 10.01.2019, (SUPPORT Act effective date) but our Fiscal Agent had delays due to being in a KMMS build, which delayed implementation.
Maryland	The POS system has pay and report messaging on claims to monitor opioids and benzodiazepines when used concurrently since Oct. 1, 2019 as part of the SUPPORT ACT (HR-6) mandates. HID has RDUR claims review criteria to identify and monitor opioids and benzodiazepines in both populations, Fee-for-Service (FFS) and MCOs since Oct. 1, 2019. as part of the SUPPORT ACT (HR-6) mandates. Since antipsychotics and benzodiazepines are carved out of the MCO benefit and paid FFS, this program covers all Medicaid beneficiaries.
New Hampshire	A POS edit to begin denying overlapping claims at point of sale (POS) for Benzodiazepine and Opioid therapy (excluding acute therapy), as a hard edit, Prior Authorization (PA) required, when the recipient is Benzodiazepine / Opioid treatment naive is in the process of being implemented. If the recipient is Benzodiazepine /Opioid experienced the edit will allow an additional two-month soft edit, which allows pharmacist to enter appropriate DUR codes via POS with messaging. The third fill of concomitant therapy will deny for a hard edit, PA required. Please note that the prior authorization logic will impact Benzodiazepine therapy only. Recipients with an approved seizure diagnosis will be excluded from the logic.
New Jersey	In compliance with the SUPPORT ACT, a retrospective review is conducted to monitor concurrent use of opioids and benzodiazepines as of 4th quarter CY2019.
New Mexico	Quarterly retrospective review/reports in process.
Oklahoma	ProDUR edits at POS to alert pharmacist and Retrospective review of claims to identify outliers set up to begin FFY2020.
Washington	In FFY 19 WA Medicaid did not have prospective or regularly scheduled retrospective review of concurrent use of opioids or benzodiazepines; only case-by-case ad-hoc review was completed for individual clients begin considered for the Lock-In program. Washington Apple Health (Medicaid) is developing reports to measure the SUPPORT Act requirements and will be regularly monitoring opioid use. These reports will include measures looking at MME, co-prescribing, concurrent opioid use with medication assistance treatment drugs, benzodiazepines, sedative hypnotics, and other medications with psychotropic affects. These reports will be reviewed by client, prescriber, and pharmacy.

9. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and sedatives being used concurrently?

Figure 94 - POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Sedatives Being Used Concurrently

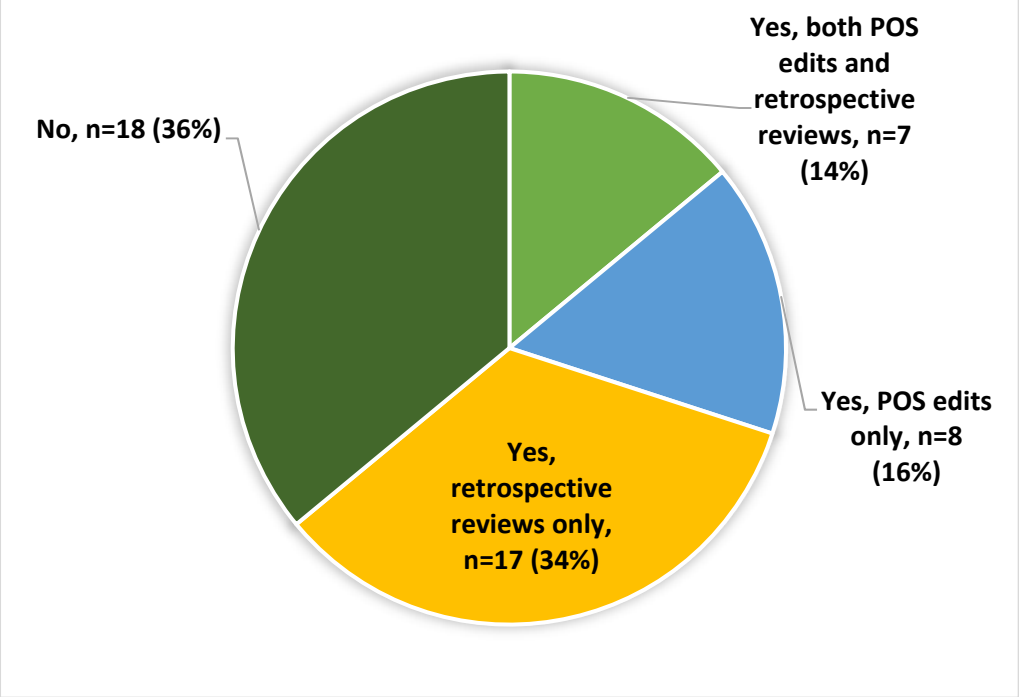

Table 147 - POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Sedatives Being Used Concurrently

Response	States	Count	Percentage
Yes, both POS edits and retrospective reviews	Idaho, Minnesota, New York, North Carolina, Ohio, Pennsylvania, South Carolina	7	14.00%
Yes, POS edits only	California, District of Columbia, Maine, Nebraska, Nevada, Vermont, Virginia, West Virginia	8	16.00%
Yes, retrospective reviews only	Alabama, Alaska, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Michigan, North Dakota, Oregon, Rhode Island, South Dakota, Tennessee, Utah, Wisconsin, Wyoming	17	34.00%
No	Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kansas, Massachusetts, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New Mexico, Oklahoma, Texas, Washington	18	36.00%
Total		50	100.00%

If "Yes," please explain in detail scope and nature of reviews and edits for Opioids and Sedatives Being Used Concurrently.

Table 148 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Sedatives Being Used Concurrently

State	Explanations
Alabama	SUPPORT Act of 2018 RDUR criteria
Alaska	Reviewed quarterly with the DUR committee meetings.
Arkansas	The RDUR program reviews for concomitant utilization of opioids and sedative hypnotics (benzodiazepines and non-benzos). Intervention letters are mailed to affected providers. Quarterly provider memos posted on the contractor website and Arkansas Medicaid website caution providers about concomitant usages of opioids and benzodiazepines. Gabapentin, muscle relaxers and non-benzo sedative hypnotics will be added to the memo soon.
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.
District of Columbia	DUE edits include SLEEP DRUGS, TRANQUILIZERS/OPIOIDS, ANTIPSYCHOTICS, PHENOTHIAZINES/OPIOIDS, MUSCLE RELAXANTS/OPIOIDS and others. THese edits require submission of professional codes by the dispensing pharmacist to allow successful claim adjudication.
Florida	The DUR Board did a retrospective review of concomitant use of non-benzodiazepine (Non-BZD) sedatives and opioids. The DUR Board voted to create a hard edit for recipients on concomitant therapy. The edit will start with the Non-BZD sedative treatment naive recipients. Treatment naive is defined by the recipient having no paid claims for Non-BZD in the prior 60 days. An additional 2 month soft edit will be provided for Non-BZD sedative treatment experienced recipients with POS messaging advising the third fill of concomitant therapy will deny for a prior authorization. The prior authorization would be required for the Non-BZD sedative only. The hard edit includes long acting opiates only to allow for acute treatment of pain with short acting opiates. Seizure recipients, cancer/palliative care, Sickle Cell and Long-Term Care Facility (LTCF) recipients are excluded from the hard edit. The edit is to be deployed in FFY20.
Georgia	We have the ability to monitor retrospectively and take action as needed.
Idaho	FDB ProDUR edits and RetroDUR reviews.
Kentucky	A quarterly report is provided to KY Medicaid by Magellan to identify potential opioid over-utilization. This includes high MME, opioids used with drugs that potentiate overdose (e.g., antipsychotics, benzodiazepines, gabapentin, sedative hypnotics), change in dosage and top prescribers and pharmacies. Of note, sedative hypnotics are only available for 60 days (per rolling 365 days) without a prior authorization.
Louisiana	Retrospective reviews: 27 interventions were mailed to prescribers regarding recipients who had concurrent prescriptions for opioids and sedatives in FFY19.
Maine	ProDUR messaging is sent to the Pharmacy
Maryland	Our RDUR vendor has criteria which they monitor on an ongoing basis.
Michigan	Routine utilization reviews are performed to look at concurrent use of opioids and all potentiators which includes sedatives.
Minnesota	FDB drug-drug interactions are used in ProDUR informational edits. DHS can elect to choose a population-based intervention with this criteria.

State	Explanations
Nebraska	Drug-drug alerts are sent to the pharmacies with each fill.
Nevada	ProDUR edits are in place to warn of the combination of opioids and sedatives being used concurrently.
New York	A POS drug to drug interaction warning will alert pharmacists of the concurrent use of opioids and sedatives on a patient. Claims involving the concurrent use of sedatives and opioids are retrospectively reviewed by pharmacy academia at the State University of New York at Buffalo. Ad Hoc reviews by the DUR Board using drug utilization presentations by pharmacy academia at the State University of New York at Buffalo assess the degree of concern. Targeted educational letters, stricter point of service edits or additional edits are a determination of the DUR Board.
North Carolina	NC has an edit for concurrent use of opioids and benzodiazepines. NC also does retrospective DUR reviews of concurrent use.
North Dakota	RetroDUR criteria are in place to identify excessive concurrent use of sedatives and opioids.
Ohio	We have a prospective edit in place that alerts the pharmacist that an opioid is being dispensed in combination with a sedative. We also have performed a retrospective DUR intervention for members who were taking an opioid together with a sedative and benzodiazepine.
Oregon	A POS edit evaluates for history of opioid use of more than 7 days within the last 90-day period. Opioid claims of more than 7 days stop for review and utilization of concurrent sedatives is evaluated before approval. A POS edit evaluated utilization of sedatives for more than 30 days. Utilization of benzodiazepines or sedatives for insomnia beyond 30 days stops for review and utilization of concurrent opioids is evaluated before the claim can be paid. In addition, we identify patients who have been prescribed both an opioid and another sedating medication within the past 120 days and an informational/educational letter is sent to prescribers notifying them of at least one the following circumstances: Prescriptions were written for opioids and sedatives (including benzodiazepines or antipsychotics) which overlap by at least 7 days written by more than a single unique provider Prescriptions were written for opioids and sedatives (including benzodiazepines or antipsychotics) from 3 or more unique providers in the past 120 days Prescriptions were written for members with a history of sedative poisoning or adverse events within the past 2 years The following individuals are excluded from the review if they meet any of the following criteria: They are a patient not currently enrolled in Medicaid They are a provider who has been messaged for the same patient within the past 6 months The prescriber of the most recent sedative or opioid prescription will receive the provider letter.
Pennsylvania	Prior authorization is required on all opioids and concurrent use with sedatives is evaluated during the medical necessity review. The RetroDUR program is used to look at concurrent use with other CNS depressants.
Rhode Island	DUR Board
South Carolina	Retro DUR reporting can capture claims for both concomitant use of opioids and sedatives FDB edits identify DDI/TD, etc.
South Dakota	We do regular ICER checks for concomitant use of opioids and sedatives
Tennessee	We are not aware of a standard ProDUR edit addressing the concomitant use of opioids and sedatives (we are having to assume that "sedatives" could be referring to hypnotic drugs, carisoprodol, and other CNS depressants). We do address this issue in retrospective reviews of controlled substance prescribing of practitioners in an algorithm that takes into account not only opioids + BZO, but also opioids + carisoprodol, opioids + stimulants, opioids + hypnotics and combinations of these, for example the "Trinity" of opioids + BZO + carisoprodol.

State	Explanations
Utah	Retrospective queries are performed evaluating the concurrent use of opioids and sedatives. Provider outreach is made for identified patients who are prescribed both an opioid and a sedative to: 1) Educate on danger of prescribing together (respiratory depression); 2) Discourage co-prescribing; 3) Benchmarking against peers.
Vermont	Currently there are POS edits in place for soft messaging with concurrent use of CNS depressants
Virginia	First Data Bank's ProDUR edits
West Virginia	At the POS level there is a SEV 2 which can be overridden at the retail level. There is no retrospective review for this currently.
Wisconsin	Wisconsin has developed educational letters to inform prescribers when a member is receiving opioids and benzodiazepines concurrently. A number of sedatives are a benzodiazepine. Wisconsin has a retrospective review of members receiving multiple CNS depressants, including opioids and sedatives.
Wyoming	Retrospective review of this combination is reviewed on occasion with comparative prescriber reports completed.

If "No," please explain.

Table 149 - Explanations of not Having POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Sedatives Being Used Concurrently

State	Explanations
Colorado	Prior authorization is required for members receiving long-term therapy with an opioid medication who are newly started on a sedative benzodiazepine medication, or for members receiving long-term therapy with a sedative benzodiazepine medication who are newly started on an opioid medication. No other POS edits are in place for opioids and sedative medications used in combination. An ad hoc retrospective DUR analysis was conducted to evaluated utilization of opioids in combination with sedative medications in August 2019. Opioid use and opioid use disorder (OUD) diagnoses in combination with benzodiazepine and non-benzodiazepine sedative use were evaluated in patients <65 years and >65 years of age. Retrospective review of concomitant use of sedative medications and opioids is also evaluated as part of peer-to-peer prescriber consult services for members exceeding opioid consult limitations.
Connecticut	RDUR criteria will be implemented during FFY 2020.
Delaware	State send clinical severity level alerts of High and medium to pharmacies to avoid Alert fatigue as recommended by Provider feedback. Based on adverse code of minor these combinations did not set alerts on this combination to avoid alert fatigue in the pharmacies.
Hawaii	Claim count is less than 500 per month. Will implement.
Illinois	For FFY19 our new system did not have the drug interaction edit turned on. This was not a retrospective review conducted during FFY19.
Indiana	The current focus has been around concurrent opioid and benzodiazepine utilization. The office will continue to review edits for opioids and the potential for edits around other sedatives.
Iowa	It can be taken as a topic to a future DUR meeting for discussion and consideration of appropriate initiatives.

State	Explanations
Kansas	We have not formally addressed this combination at this time. However, our Opioid Products for Pain Management PA has the following provider education language: • Provider attests to limiting and avoiding where possible the concurrent use of CNS depressants, especially benzodiazepines, when prescribing opioids. • Before starting & periodically, an evaluation of risk factors for opioid related harms should be done. * Prescriber must attest to reviewing K-TRACS prior to writing every new opioid prescription.
Massachusetts	Hypnotic benzodiazepines are included in the Concomitant Opioid and Benzodiazepine Initiative.
Mississippi	The POS edits are separate rules for Opioids and sedatives except for benzodiazepines. Our Retro-DUR analysis only included BZD sedatives but not other types of sedatives (ex. Z drugs).
Missouri	MO HealthNet does not currently have anything in place.
Montana	Currently we are only doing provider outreach for members receiving opioids and benzodiazepines or sedating antipsychotics.
New Hampshire	A POS edit to begin denying overlapping claims at point of sale (POS) for Benzodiazepine and Opioid therapy (excluding acute therapy), as a hard edit, Prior Authorization (PA) required, when the recipient is Benzodiazepine / Opioid treatment naive is in the process of being implemented. If the recipient is Benzodiazepine /Opioid experienced the edit will allow an additional two-month soft edit, which allows pharmacist to enter appropriate DUR codes via POS with messaging. The third fill of concomitant therapy will deny for a hard edit, PA required. Please note that the prior authorization logic will impact Benzodiazepine therapy only. Recipients with an approved seizure diagnosis will be excluded from the logic.
New Jersey	Retrospective reviews to monitor concurrent use of opioids and sedatives was implemented 4th quarter of CY2019.
New Mexico	Quarterly retrospective review/reports in progress.
Oklahoma	We did not have edits in place during this FFY.
Texas	Sedatives Hypnotics for Adults criteria logic does not check for combination of opioids and sedatives. However, if benzodiazepines are prescribed for sedation, there is another clinical PA requirement which denies a 14 day or more overlapping combination of opioids and benzodiazepines. Also, in the Sedatives Hypnotics for Adults PA criteria, a diagnosis of drug abuse, including opioid abuse disorder, will lead to PA denial.
Washington	In FFY 19 WA Medicaid did not have prospective or regularly scheduled retrospective review of concurrent use of opioids or sedatives; only case-by-case ad-hoc review was completed for individual clients begin considered for the Lock-In program. Washington Apple Health (Medicaid) is developing reports to measure the SUPPORT Act requirements and will be regularly monitoring opioid use. These reports will include measures looking at MME, co-prescribing, concurrent opioid use with medication assistance treatment drugs, benzodiazepines, sedative hypnotics, and other medications with psychotropic affects. These reports will be reviewed by client, prescriber, and pharmacy.

10. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and antipsychotics being used concurrently?

Figure 95 - POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Antipsychotics Being Used Concurrently

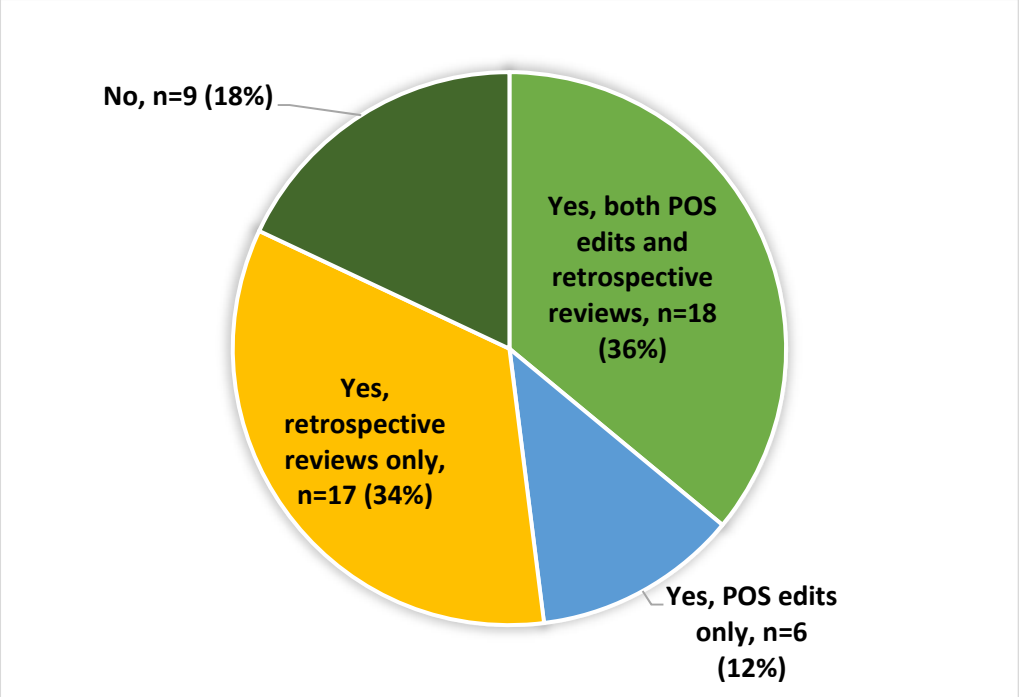

Table 150 - POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Antipsychotics Being Used Concurrently

Response	States	Count	Percentage
Yes, both POS edits and retrospective reviews	Alaska, Connecticut, District of Columbia, Florida, Indiana, Iowa, Minnesota, Missouri, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Virginia, West Virginia	18	36.00%
Yes, POS edits only	California, Colorado, Delaware, Georgia, Massachusetts, Nebraska	6	12.00%
Yes, retrospective reviews only	Alabama, Arkansas, Hawaii, Idaho, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Montana, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Wisconsin, Wyoming	17	34.00%
No	Illinois, Kansas, Maine, New Jersey, New Mexico, Ohio, Texas, Vermont, Washington	9	18.00%
Total		50	100.00%

If “Yes,” please explain in detail scope and nature of reviews and edits for Opioids and Antipsychotics Being Used Concurrently.

Table 151 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Antipsychotics Being Used Concurrently

State	Explanations
Alabama	SUPPORT Act of 2018 RDUR criteria
Alaska	Point-of-Sale overrides are available when the pharmacist contacts the prescriber to discuss potential interactions. A report with concurrent use is reviewed by the DUR committee.
Arkansas	The RDUR program reviews for concomitant utilization of opioids and antipsychotics. Intervention letters are sent to corresponding prescribers. So far, response by prescribers to this intervention has been minimal. Verbiage of the prescriber intervention letter--Section 1004 of the 2019 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) adds a requirement for State Medicaid plans to conduct a claims review automated process to monitor recipients concurrently prescribed opioids and antipsychotics. States have been advised by the Center for Medicaid and CHIP Services that patients receiving this combination of medications benefit from increased coordination of care. Your patient was prescribed at least one opioid and one antipsychotic during the time frame reviewed.
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	Due to the risk of increased sedation with concomitant use, pharmacy claims for members receiving an opioid and quetiapine in combination require entry of POS DUR service codes (Reason for Service, Professional Service, Result of Service) in order to override an opioid-quetiapine drug-drug interaction.
Connecticut	This RDUR criteria is designed to target recipients who receive any opioid (1-day supply in 90 days) concurrently with any antipsychotic (30 days' supply in 90 days). An occurrence of any negating diagnosis and/or drug below would negate the criteria from selecting those recipients. Negating medications /diagnoses include antineoplastic agents, malignancy diagnoses, sickle cell, and palliative care. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them regarding the concurrent therapy. Additionally, we perform this review as a targeted intervention annually.
Delaware	There are prospective drug clinical alerts that must be addressed and overridden at the pharmacy to allow the fill. Based on adverse code of minor these combinations did not set alerts on this combination to avoid alert fatigue in the pharmacies.
District of Columbia	Claims process includes monthly reports to identify trends on concomitant use of antipsychotics and opioids. DUE edits include ANTICHOLINERGICS/SELECT ANTIPSYCHOTICS, SELECT PHENOTHIAZINES, SELECTED ANTIPSYCHOTICS, TRAMADOL (IR), ANTIPSYCHOTICS, PHENOTHIAZINES/OPIOIDS, SELECTED ANTIPSYCHOTICS THAT PROLONG QT
Florida	The DUR Board did a retrospective review of concomitant use of opioids and antipsychotics. In response to the SUPPORT Act, the Agency proceeded with deployment of a soft edit for individuals prescribed opioids and antipsychotics concomitantly. The pharmacist will have the capability to enter approved DUR intervention codes to allow claim payment. Cancer, Sickle Cell and LTCF recipients will be excluded from the edit.

State	Explanations
Georgia	Member filling an opioid and antipsychotic will trigger POS message "Antipsych + Opioid-monitor use".
Hawaii	Annual review of opioids and antipsychotics being used concurrently, assess for patient access, outliers and trends, policy amendments as needed. Patient profile review for detail if needed.
Idaho	The DUR Board has an annual review that includes * the number of beneficiaries receiving both drug classes concurrently * number of days of combination therapy * number of pediatric vs adult patients * drugs from both classes with highest incidence in combination use * evaluation of whether the same or different prescribers are prescribing component of combinations An Educational Letter with response request is sent to both the prescriber and dispensing pharmacy.
Indiana	Claims for concurrent opioids and antipsychotics will prompt a message to pharmacies notifying them of the concurrent utilization. Reports will be reviewed annually of claims with concurrent utilization.
Iowa	Soft edits are in place, messaging pharmacies. Additionally, a retrospective report is generated identifying members with concurrent use of an opioid and antipsychotic consistent with SUPPORT Act requirements effective October 2019.
Kentucky	A quarterly report is provided to KY Medicaid by Magellan to identify potential opioid over-utilization. This includes high MME, opioids used with drugs that potentiate overdose (e.g., antipsychotics, benzodiazepines, gabapentin, sedative hypnotics), change in dosage and top prescribers and pharmacies.
Louisiana	Retrospective reviews: 13 interventions were mailed to prescribers regarding recipients who had concurrent prescriptions for opioids and antipsychotic agents in FFY19.
Maryland	Our RDUR vendor has criteria which they monitor on an ongoing basis.
Massachusetts	HR6 coding is in place to capture opioids and antipsychotics being used concurrently when there are paid claims for at least 60 days of concurrent therapy out of the last 90 days of an opioid agent with an antipsychotic agent.
Michigan	Concurrent use of opioids and antipsychotics is included in our comprehensive review of opioids each quarter.
Minnesota	FDB drug-drug interactions are used in ProDUR informational edits. DHS can elect to choose a population-based intervention with this criteria.
Mississippi	We integrated a retrospective review of concomitant use of opioids and antipsychotics into a quarterly report on beneficiaries at high risk for opioid overdose of misuse. A special report on the concomitant use of opioids and antipsychotics was also conducted to examine this issue.
Missouri	Our retrospective intervention, in compliance with the SUPPORT act, identifies all patients with current drug claims for an opioid in the past 30 days and then flags and sends educational material to providers of those patients who are using antipsychotics concurrently for at least 7 of those days. We also send drug-drug interactions between antipsychotics and opioids from FDB to the pharmacy for review at POS along with a POS edit to monitor concurrent utilization of antipsychotics and opioids.
Montana	We are doing educational outreach to providers who are prescribing either an opioid or a sedating antipsychotic for a member who is receiving both. This education details the risks of prescribing multiple sedating medications as well as the increased risk of OUD in patients with other mental health issues.

State	Explanations
Nebraska	Drug-drug alerts are sent to the pharmacies with each fill.
Nevada	POS claims are edited with ProDUR edits set to warn pharmacists of the combination of opioids and antipsychotics. RetroDUR activities include letters and information to prescribers for the combination of opioids and antipsychotics.
New Hampshire	Concurrent use of opioids and antipsychotics is included in our comprehensive review of opioids each quarter.
New York	A POS drug to drug interaction warning will alert pharmacists of the concurrent use of opioids and antipsychotics on a patient. Retrospective claims for the concurrent use of opioids and antipsychotics are reviewed by pharmacy academia from the State University of New York at Buffalo. Ad Hoc reviews by the DUR Board using drug utilization presentations by pharmacy academia from the State University of New York at Buffalo assess the concern. Targeted educational letters, stricter point of service edits or additional edits would be a determination of the DUR Board. To date Board actions have targeted educational letters to providers addressing concurrent use of opioids and antipsychotics and the importance of mental health treatment and coordination of care as outlined by the SUPPORT ACT.
North Carolina	NC has an edit for concurrent use of opioids and antipsychotics. NC also does retrospective DUR reviews of concurrent use.
North Dakota	We have RetroDUR criteria that will allow us to message prescribers and pharmacists regarding the combination, and we have ProDUR edits to limit the frequency of quetiapine being used with opioids.
Oklahoma	ProDUR edits at POS to alert pharmacist and Retrospective review of claims to identify outliers set up to begin FFY2020.
Oregon	See question #9 response. The retroDUR lettering process includes antipsychotics.
Pennsylvania	Prior authorization is required on all opioids. The RetroDUR program is used to look at concurrent use with other CNS depressants.
Rhode Island	DUR Board
South Carolina	RetroDUR reporting can capture claims for both concomitant use of opioids and antipsychotics FDB edits identify DDI/TD, etc.
South Dakota	For claims reviewed during retrospective DUR process educational letters are sent to providers involved with the recipients care. For ProDUR edits a message is returned to the pharmacy identifying concomitant opioid and antipsychotic utilization.
Tennessee	Not aware of a standard POS ProDUR edit yet for concurrent use of opioids and antipsychotics (APsy). We did present a retrospective study to the DUR Board in March of 2019 where we looked at the types of prescribers who were prescribing the antipsychotic to those adult enrollees who were also chronic opioid users. Our main focus during the review was the possibility of the APsy being prescribed by a practitioner not in the same practice as the opioid prescriber, and not knowing about the opioid, as the APsy prescriber would not be legally bound to check the PDMP prior to writing for an APsy. We did not find significant results about any specific provider type or practice type, and found that polypharmacy was existing in all types. We did find that 7.22% of all adult chronic APsy users were also found to be concomitant chronic opioid users. We plan to follow up with looking specifically at quetiapine, also by looking at children under 21
Utah	Retrospective queries are performed evaluating for the chronic use of opioids (> 30 days) with antipsychotics. Provider outreach is made for identified patients who are prescribed both an opioid and an antispychotic to: 1) Educate on the increased sedative affect of using both together; 2) Identify non-adherence to the antipsychotic.

State	Explanations
Virginia	DMAS has a new ProDUR edit that soft messages the pharmacy when concurrent opioid and antipsychotic therapy are being used and mentions to offer naloxone. DMAS also runs a report quarterly to monitor opioids and antipsychotics being used concurrently.
West Virginia	At the POS level there is a SEV 2 which can be overridden at the retail level. There is no retrospective review for this currently. However, we are in the process of developing this to flag in order to allow for review by the RetroDUR board.
Wisconsin	Wisconsin has a retrospective review of concurrent utilization of opioids and antipsychotics on an ongoing periodic basis.
Wyoming	An intervention letter is sent to antipsychotic providers when their patient has also received an opioid prescription from another prescriber.

If "No," please explain.

Table 152 - Explanations of not Having POS Edits in Place or a Retrospective Claims Review to Monitor Opioids and Antipsychotics Being Used Concurrently

State	Explanations
Illinois	For FFY19 our new system did not have the drug interaction edit turned on. This was not a retrospective review conducted during FFY19.
Kansas	The edits were not in place in FFY 2019. A retrospective review was required in policy, effective 10.01.2019, (SUPPORT Act effective date) but our Fiscal Agent had delays due to being in a KMMS build, which delayed implementation.
Maine	Currently being developed.
New Jersey	In compliance with the SUPPORT ACT, a retrospective review is conducted to monitor concurrent use of opioids and antipsychotics as of 4th quarter CY 2019.
New Mexico	Quarterly retrospective review/reports in process.
Ohio	We did not have this is place during FFY19 however, in January 2020 we did review profiles at our DUR Committee meeting for members taking opioids together with antipsychotics.
Texas	In FFY 2019, the retrospective review for concurrent prescribing of antipsychotics and opioids was not implemented.
Vermont	In June 2020 we completed a retrospective DUR in compliance with the SUPPORT act. We also anticipate POS changes by end of 2020 for POS edits for concurrent use of opioids and antipsychotics.
Washington	In FFY 19 WA Medicaid did not have prospective or regularly scheduled retrospective review of concurrent use of opioids or antipsychotics; only case-by-case ad-hoc review was completed for individual clients begin considered for the Lock-In program. Washington Apple Health (Medicaid) is developing reports to measure the SUPPORT Act requirements and will be regularly monitoring opioid use. These reports will include measures looking at MME, co-prescribing, concurrent opioid use with medication assistance treatment drugs, benzodiazepines, sedative hypnotics, and other medications with psychotropic affects. These reports will be reviewed by client, prescriber, and pharmacy.

11. Do you have POS safety edits or perform RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?

Figure 96 - POS Safety Edits or Perform RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

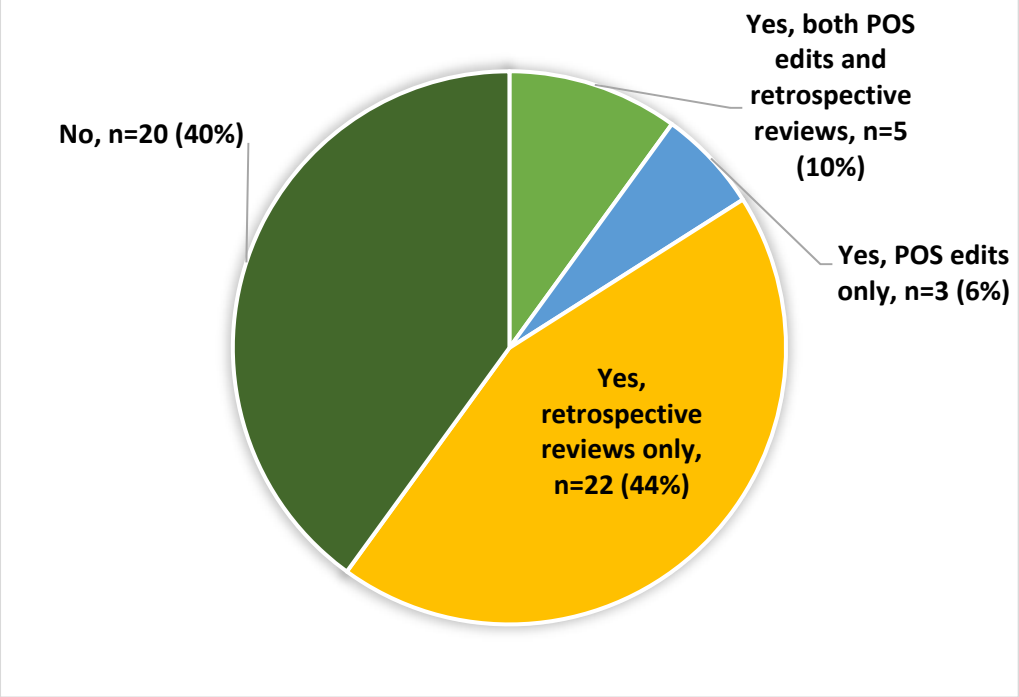

Table 153 - POS Safety Edits or Perform RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

Response	States	Count	Percentage
Yes, both POS edits and retrospective reviews	Arkansas, Florida, Montana, New York, North Dakota	5	10.00%
Yes, POS edits only	District of Columbia, Louisiana, New Jersey	3	6.00%
Yes, retrospective reviews only	Alabama, California, Colorado, Connecticut, Idaho, Maine, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Mexico, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, West Virginia, Wisconsin	22	44.00%
No	Alaska, Delaware, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, Oklahoma, Rhode Island, Utah, Vermont, Washington, Wyoming	20	40.00%
Total		50	100.00%

If “Yes,” retrospective reviews are performed, please indicate how often

Figure 97 – How often Retrospective Reviews are Performed for Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

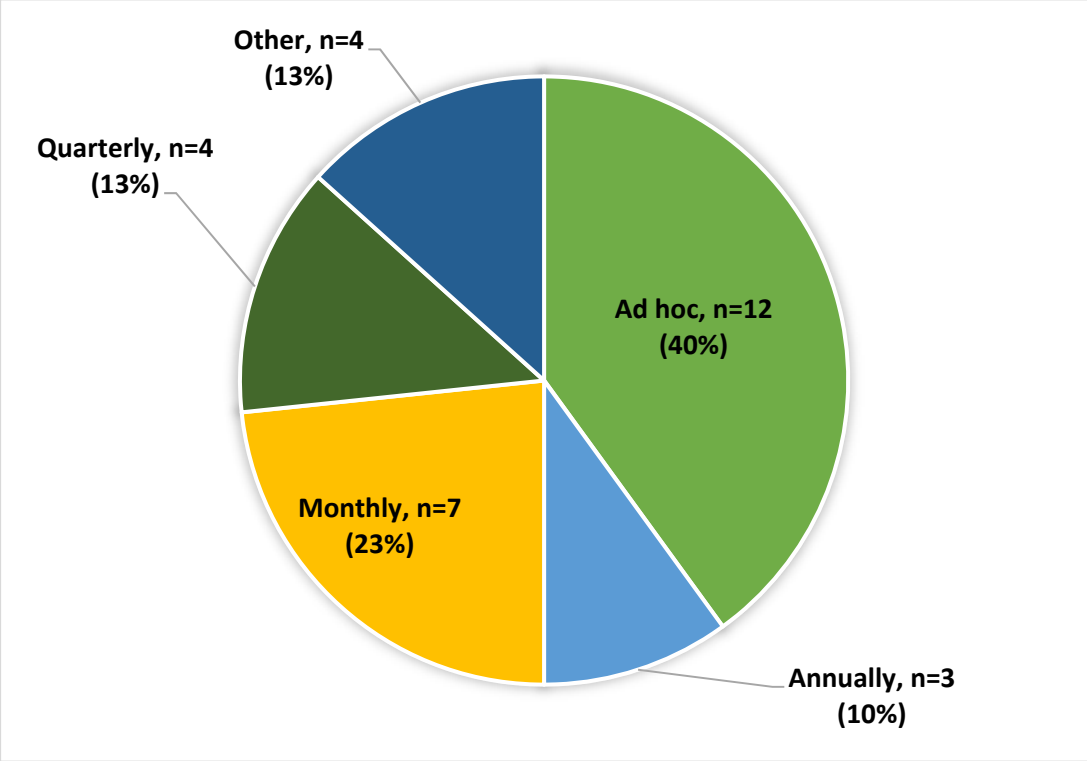

Table 154 - How often Retrospective Reviews are Performed for Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

Response	States	Count	Percentage
Ad hoc	California, Colorado, Idaho, Massachusetts, Michigan, Nevada, New Jersey, New Mexico, New York, Oregon, South Carolina, Tennessee	12	40.00%
Annually	Connecticut, Maine, Texas	3	10.00%
Monthly	Alabama, District of Columbia, Maryland, Pennsylvania, South Dakota, West Virginia, Wisconsin	7	23.33%
Quarterly	Florida, Mississippi, Ohio, Virginia	4	13.33%
Other	Arkansas, Louisiana, Montana, North Dakota	4	13.33%
Total		30	100.00%

If “Other,” please specify.

Table 155 - Explanations of How often Retrospective Reviews are Performed for Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

State	Explanations
Arkansas	Opioid use disorder and opioid poisoning diagnosis have been added to lock-in review for beneficiares at risk for fraud, waste and abuse. Prescribers are notifed when their patient has been locked into a pharmacy. The lock-in algorithm report is run monthly with potential lock-in beneficiaries reviewed manually from the identified list by the lock-in/RDUR team.
Louisiana	We are under the impression that we are prohibited by federal law (42 CFR Part 2) from RetroDUR activity that would identify these recipients.
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.
North Dakota	RetroDUR criteria exist to identify inappropriate medication combinations and our RetroDUR process is monthly, but not all exception criteria are selected monthly. Also, routine review of opioid poisonings is done to identify patients that may need special medication history reviews.

Please explain nature and scope of edits, reviews and/or provider education reviews performed for Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis.

Table 156 - Explanations of Nature and Scope of Edits, Reviews and/or Provider Education Reviews Performed for Beneficiaries with a Diagnosis History of Opioid Use Disorder (OUD) or Opioid Poisoning Diagnosis

State	Explanations
Alabama	Ad hoc reporting, also
Arkansas	POS edits have been in place since March 2018 with a 90 day look-back which was changed to a 365-day look-back in November 2018 for a billed diagnosis of poisoing or overdose when a claim for an opioid or benzodiazepine has been submitted. Claims of opioids or benzos for beneficiaries with the diagnosis will deny and require the prescriber to request a prior authorization. We have found that most beneficiaries do not inform their providers of the recent event/hospitalization. Diagnoses included are poisoning for opioids, narcotics, barbiturates, benzodiazepines or unspecified drug or substance. Cancer patients are exempt from the poisoning diagnosis check.
California	Retrospective reviews of beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis are performed annually and on an ad-hoc basis. For FFY 2019, provider education efforts included sending educational outreach letters to all prescribers of opioids to beneficiaries with at least one paid claim greater than or equal to 120 morphine mg equivalents per day. Patient profiles included outpatient office visits, emergency department visits, and inpatient hospitalizations where a diagnosis of opioid use disorder and/or opioid poisoning was indicated.
Colorado	Retrospective pharmacy claims analysis is performed ad hoc to evaluate members with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis.
Connecticut	This RDUR criteria is designed to target recipients who receive any controlled substance with a diagnosis of medication related poisoning (including illicit substance poisoning) within the previous 180 period. During monthly profile reviews, if recipients are selected for this intervention, their prescriber(s) will receive intervention letters educating them about the poisoning and continued use of controlled substances. Additionally, we perform this review as a targeted intervention annually.

State	Explanations
District of Columbia	POS DUE edits including: LEVOMETHADONE, METHADONE FOR MAT/BENZODIAZEPINES, BUPRENORPHINE AND METHADONE FOR MAT/SLEEP DRUGS, TRANQUILIZERS, BUPRENORPHINE AND METHADONE FOR MAT/ANTIPSYCHOTICS, METHADONE (NON MAT)/SELECTED ANTIPSYCHOTICS, PHENOTHIAZINES
Florida	Opioid prescribing trends and potential fraud and/or abuse are identified via automated claims review by the DUR Board. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
Idaho	Focused reviews have been done to review the number of patients with OUD diagnoses receiving buprenorphine-based therapy.
Louisiana	POS safety edits: Although OUD / opioid poisoning diagnoses are not parameters to trigger the edits, beneficiaries with these diagnoses are included in POS safety edits if the parameters are met. RetroDUR: We are under the impression that we are prohibited by federal law (42 CFR Part 2) from RetroDUR activity that would identify these recipients.
Maine	We currently are not looking at members with opiate poisoning diagnosis with the DUR, this is looked at through the Care Management program with the ER initiative.
Maryland	On a monthly basis, participants with a history of opioid use disorder with claims for opioids during the retrospective look back period are identified and educational intervention letters are sent to corresponding prescribers and pharmacy providers on record to alert them to the drug therapy issue.
Massachusetts	Direct outreach to prescribers bi-weekly for members who exceed clinical thresholds .
Michigan	Our DUR Board has been monitoring MAT utilization trends each quarter for several years, including review of patient demographics, (e.g. ages, gender, race) to identify disparities along with diagnoses and concurrent utilization. Any concerning utilization trends are reviewed further by our contracted academic detailing pharmacist and additional education is performed to the prescriber for cases where naloxone education may be warranted.
Mississippi	This information is included in a quarterly Retro-DUR report for beneficiaries at high risk for opioid overdose/misuse.
Montana	We educate providers prior to paying for buprenorphine products for members they are treating for OUD. This education follows SAMHSA guidelines for MAT prescribing.
Nevada	RetroDUR activities include letters and information to prescribers providing for members with opioid use disorder and who are receiving an opioid.
New Jersey	Prior authorization of MAT products were removed as of 4/1/2019. Pharmacy claims for opioids are denied if a member has a medical claim history of opioid use disorder diagnosis.
New Mexico	An educational intervention newsletter on Opioid Prescribing Recommendations was performed. An intervention targeting providers prescribing codeine or tramadol in children and adolescents targeted 38 patients and 20 providers informing them of the new FDA restrictions on use in children.
New York	PA is required for initiation of opioid therapy for patients on established opioid dependence therapy. Retrospective claims are reviewed monthly by SUNY at Buffalo academia. Ad Hoc drug utilization reviews are employed as a means of identifying clinical issues pertaining to concurrent use of opioids on patients established on opioid dependence therapy. Targeted educational letters, stricter point of service edits or additional edits would be a determination of the DUR Board.

State	Explanations
North Dakota	Concurrent use of buprenorphine and other OUD treatment medications with opioids will not be approved for payment except in situations where it is appropriate and only after both prescribers confirm their awareness and agreement for the duration (e.g. patient goes in for surgery).
Ohio	We have a Coordinated Services Program that identifies members with a diagnosis of a history of opioid use disorder or opioid poisoning diagnosis for enrollment criteria in the program.
Oregon	Some of these patients may be included in initiative described in #7 but don't have any specific initiative targeting these patients. RetroDUR process - Anyone with a substance use diagnosis (including opioid use disorder or opioid poisoning) and who is prescribed an opioid or medication assisted treatment is included for evaluation in the pharmacy lock-in program if they visit multiple pharmacies.
Pennsylvania	The RetroDUR program is used to review beneficiary profiles with a history of OUD.
South Carolina	Ad Hoc reporting can be utilized to identify medical claims for ICD codes associated with prior history of OUD (F11.10, F11.20) and Poisoning (T40.0X1;T40.1X1; T40.2X1; T40.3X1; T40.4X1; T40.601and T40.691)
South Dakota	RDUR criteria is built to check for beneficiaries with OUD or opioid poisoning that are currently taking opioids
Tennessee	Per our TennCare Rules, and as voted on and approved by the DUR Board, any TennCare enrollee who has a diagnosis of poisoning by an illicit substance is enrolled in the Pharmacy Lock-In program and is also subjected to "PA Status", where every fill of every controlled substance requires Prior Authorization. We have conducted the diagnosis searches for the past 3 years about every 9 months.
Texas	In Oct. 2018 a retro-DUR intervention, prescribers received intervention letters for prescribing opioid to patient with history of OUD.
Virginia	We review quarterly members on chronic opioids and also with high risk activity which includes opioid use disorder and see if they are getting a claim for naloxone as well. We also have lettered prescribers on high risk for an opioid overdose and NO naloxone claims.
West Virginia	Reviewed monthly at RetroDUR meetings. It is limited to the Lock-in portion.
Wisconsin	Diagnosis information of opioid use disorder and opioid poisoning are utilized in retrospective profile review for lock-in and regular monthly DUR activities.

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

Figure 98 – Plans to Implement a RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

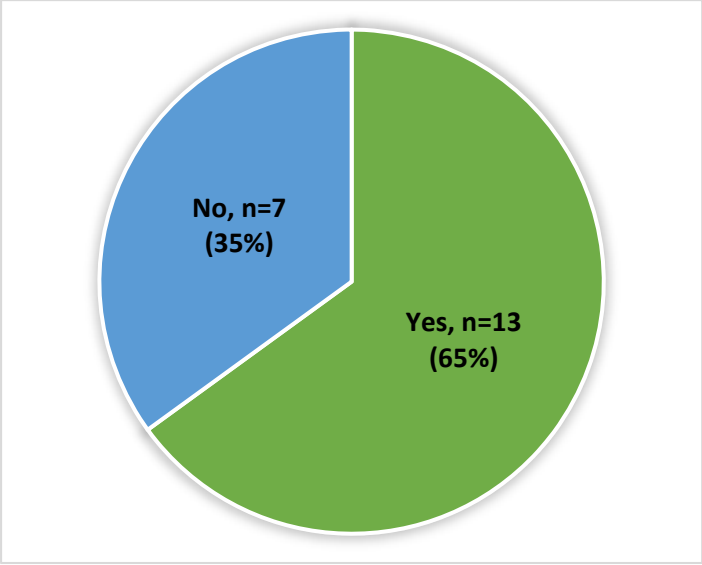

Table 157 - Plans to Implement a RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

Response	States	Count	Percentage
Yes	Alaska, Delaware, Georgia, Hawaii, Illinois, Kentucky, Nebraska, New Hampshire, North Carolina, Oklahoma, Utah, Washington, Wyoming	13	65.00%
No	Indiana, Iowa, Kansas, Minnesota, Missouri, Rhode Island, Vermont	7	35.00%
Total		20	100.00%

Please explain.

Table 158 – Explanation on Implementing a RetroDUR Activity and/or Provider Education in Regard to Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

State	Explanations
Alaska	Alaska Medicaid is exploring data capabilities with our SURS team.
Delaware	There are ongoing Statewide collaborative between department of Public Health (DPH) and Substance Abuse and Mental Health (DSAMH) to develop ways of data transfer of system alerts of Opioid Use Disorder (OUD), outreach and intervention alert mechanism for referral to specialized care.
Georgia	Planning on implementing.
Hawaii	Claim count is less than 500 per month. Will implement.

State	Explanations
Illinois	In the future we will review system capability to identify beneficiaries with a diagnosis history of OUD or opioid poisoning who are prescribed opioids. We will inform the opioid prescriber about risks of opioid use in the patient and remind of need for naloxone therapy for the patient.
Indiana	RetroDUR disclosures of this nature would violate substance abuse confidentiality regulations 42 CFR Part 2.
Iowa	This topic has not been discussed with the DUR Commission at this point nor was it included in the SUPPORT Act guidance provided by CMS. It can be taken as a topic to a future DUR meeting for discussion and consideration of appropriate initiatives.
Kansas	The majority of our beneficiaries are provided for under our Managed Care Organizations and they are required to address the SUD and Social Determinants of Health needs of their members. Many of the FFS beneficiaries reside in facility settings.
Kentucky	Will consider access to diagnosis information to facilitate review of opioid poisoning and OUD. Have not seen a lot of OUD (based on MAT utilization) in the FFS population.
Minnesota	There are no plan to implement this but it may be considered again.
Missouri	MO HealthNet currently has safety edits in place for participants actively receiving MAT.
Nebraska	As part of a future State DUR Board project, if alert comes across, will contact prescriber.
New Hampshire	A RetroDUR program will be developed to address this.
North Carolina	NC will be adding a new claims edit to identify beneficiaries who have a history of OUD or opioid poisoning diagnosis.
Oklahoma	We have plans to look into this further after FFY21 when we implement the new guidelines of HR6 surrounding OTPs.
Rhode Island	Refer prescribers to the CDC guidelines for prescribing opioids for chronic pain.
Utah	Implemented in 2021.
Vermont	We are planning to present this subject to the DUR Board for as a possible retro/dur activity
Washington	Effective November 2019 WA Medicaid implemented an update opioid policy aligned with the requirements of the SUPPORT Act. As such, retrospective reports are being developed to allow review of OUD, medications used to treat OUD, and co-prescribing with opioids or other risk factors for this population. These reports and services will be reviewed by client, prescriber, and pharmacy.
Wyoming	Data has been reviewed with a small amount of utilization in this population. Data will be monitored regularly.

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

Figure 99 - Develop and Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

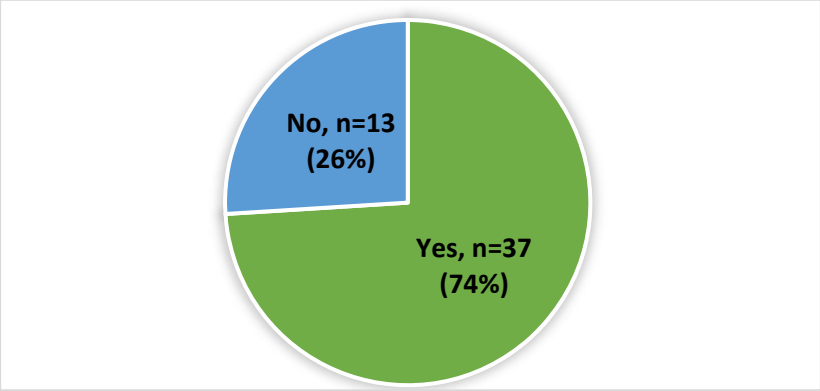

Table 159 - Develop and Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Washington, West Virginia	37	74.00%
No	District of Columbia, Maryland, Missouri, Nebraska, New Hampshire, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Virginia, Wisconsin, Wyoming	13	26.00%
Total		50	100.00%

If "Yes," please check all that apply:

Figure 100 - Pain Management / Opioid Prescribing Guidelines Provided

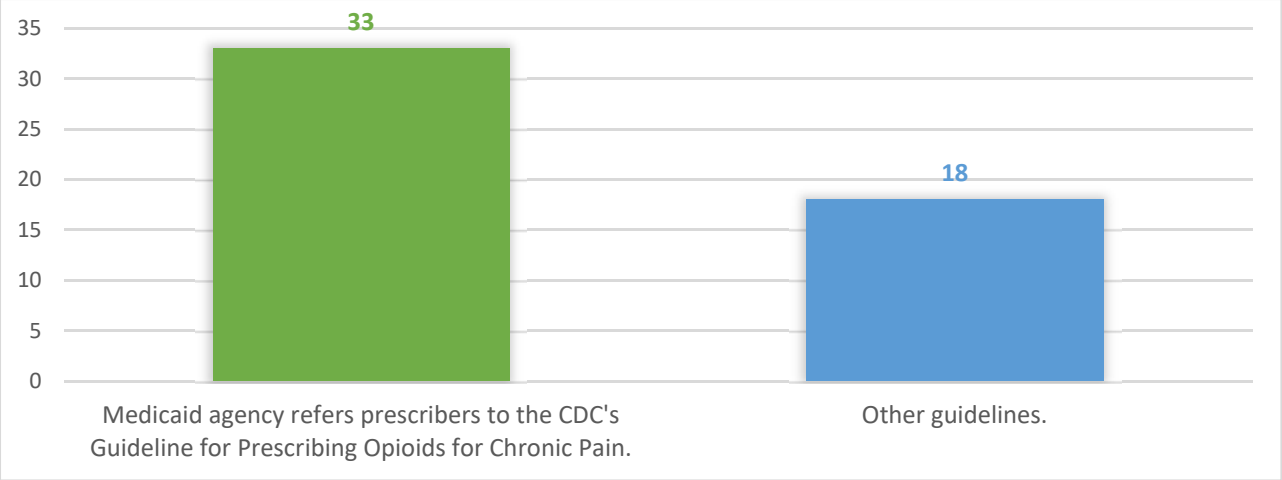

Table 160 - Pain Management / Opioid Prescribing Guidelines Provided

Response	States	Count	Percentage
Medicaid agency refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain.	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Washington, West Virginia	33	64.71%
Other guidelines.	Alabama, Alaska, Arkansas, California, Colorado, Idaho, Illinois, Kansas, Minnesota, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Utah, Washington, West Virginia	18	35.29%
Total		51	100.00%

Please identify the "other" guidelines.

Table 161 – "Other" Explanations of Pain Management / Opioid Prescribing Guidelines Provided

State	"Other" Explanations
Alabama	Also, we provide the HHS Guidelines for Reduction and Discontinuation of Opioids on the Agency's website.
Alaska	Washington State AMDG guidelines
Arkansas	Opioid dose conversion calculator is located on the contractor website for access by prescribers. Beginning FFY2020, CDC guidelines will be included on each quarterly provider memo. Also the contractor is developing a references tab on their website to list mutliple useful links to CDC guidelines, SAMHSA website and MME dosing conversion. Clinical correspondence with a provider on an opioid PA request will have a reference to the CDC 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.
Idaho	Appropriate use guidelines are provided on all opioid related PA forms and on the published preferred drug list.
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 prescriber is referred to the DUR Board Education Web page for the following: CDC guideline for prescribing opioids for chronic pain, FDA warnings about concomitant benzodiazepines and narcotics, CDC/Surgeon General recommendations for naloxone use, 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.

State	"Other" Explanations
Kansas	Our provider bulletins have CDC links as well as state specific opioid prescribing guidelines based upon DUR Board approved criteria: https://www.kmap-state-ks.us/Documents/Content/Bulletins/18027%20-%20General%20-%20Opioid_2.pdf https://www.kmap-state-ks.us/Documents/Content/Bulletins/18101%20-%20General%20-%20Opioid_2.1.pdf https://www.kmap-state-ks.us/Documents/Content/Bulletins/18112%20-%20General%20-%20Opioid_2.3.pdf Our Clinical PA has the following guidance for providers, in addition to the PA criteria: GENERAL CRITERIA FOR OPIOID MEDICATION USE: • Prescriber must attest to reviewing K-TRACS prior to writing every new opioid prescription. • Prescriber should calculate total MME per day for concurrent opioid medications. • Initial use of immediate-release opioids is required before use of ER/LA opioids. • Provider attests to limiting and avoiding where possible the concurrent use of CNS depressants, especially benzodiazepines, when prescribing opioids. • Before starting & periodically, an evaluation of risk factors for opioid related harms should be done. • Non-opioid ancillary treatments (e.g., NSAIDs, acetaminophen, antidepressants) and non-pharmacological treatments should be tried first unless contraindicated. • Prescriber has screened patient for depression and substance use disorder. • New dosage forms or strengths to agents listed can be added as they become available. • Drug must not exceed maximum FDA approved dosage. • Physician must consider use of opioids and Neonatal Opioid Withdrawal Syndrome if patient is pregnant.
Minnesota	Minnesota has their own guidelines which are similar to the CDC's Guidelines. http://mn.gov/dhs/opioid-guidelines/
New York	New York State offers licensed prescribers an Opioid Prescribing Training Program available at no charge to prescribers and is accredited for continuing education. The program covers 8 topics required per legislation. New York Medicaid, through its Medicaid Physician Education Program (PEP), offers visits by pharmacy educators detailing the use of agents for the treatment of chronic non-cancer pain using on-site education sessions. Educational modules are available using key messages to succinctly deliver prescribing tips. Modules are accredited by the Accreditation Council for Continuing Education. In addition, the State Medicaid Program's Physician Education Program uses the CDC guidelines on the web site as an additional reference.
North Carolina	The prescribing clinician shall review the North Carolina Medical Board statement on use of controlled substances for the treatment of pain (https://www.ncmedboard.org/resourcesinformation/professional-resources/laws-rules-position-statements/positionstatements/Policy_for_the_use_of_opiates_for_the_treatment_of_pain).

State	"Other" Explanations
Ohio	Take Charge Ohio Healthcare professionals. Available at http://www.takechargeohio.org/. Accessed October 19, 2018. OARRS guidelines. Available at https://www.ohiopmp.gov/. Accessed August 2, 2020. US Department of Health and Human Services. Available at https://www.hhs.gov/opioids/prevention/safe-opioid-prescribing/index.html. Accessed August 2, 2020. Beginning December 2018, the state medical board set new rules for treating subacute and chronic pain. Available at https://med.ohio.gov/Publications/Recent-News/newly-adopted-rule-effective-122318. Accessed August 2, 2020. Prior to increasing the opioid dosage to a daily average of 50 MED or greater, the prescriber shall complete and document certain criteria in the patient's record as listed in the rule. Prior to increasing the opioid dosage to a daily average of 80 MED or greater, the prescriber shall complete and document certain criteria in the patient's record as listed in the rule. The prescriber shall not prescribe a dosage that exceeds an average of 120 MED per day. This prohibition shall not apply in certain circumstances as listed in the rule.
Oregon	Oregon Opioid Prescribing Guidelines: http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/task-force.aspx
Pennsylvania	The Department has coordinated with other state agencies to develop Pennsylvania opioid prescribing guidelines to be used by all payers in the state.
Texas	With the initial communication regarding Opioid morphine milliequivalent policy, VDP provided the information from the CDC guidelines. Also, with the retro-DUR intervention letters, the reference to the CDC guidelines was provided.
Utah	Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain : Utah Department of Health, Utah Medical Association 2018
Washington	In addition to the CDC's guidelines WA Medicaid directs providers to recommendations from the Agency Medical Directors Group (AMDG) and the Bree Collaborative.
West Virginia	We have a SEMP (Safe and Effective Management of Pain) Program which offers guidance. More information about the program is below and can be found on the website www.semppguidelines.org "A geographically and professionally diverse expert panel of West Virginia professionals was formed with intention of creating guidelines for the safe and effective overall management of pain, which build upon the 2016 CDC Chronic Pain OPIOID Guidelines. These PAIN management guidelines intend to build upon the 2016 OPIOID guidelines of the CDC by providing a risk reduction strategy for the appropriate use of all pain treatments, and secondly, to provide pain management clinical treatment algorithms, similar to such for the treatment of hypertension, diabetes, and so on, in order to safely and effectively manage the pain of and improve the lives of West Virginians and beyond"

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

Figure 101 - A Drug Utilization Management Strategy That Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

Table 162 - A Drug Utilization Management Strategy That Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

Response	States	Count	Percentage
Yes	Alaska, California, Connecticut, Delaware, District of Columbia, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Dakota, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin	32	64.00%
No	Alabama, Arkansas, Colorado, Georgia, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Dakota, Virginia, Washington, Wyoming	18	36.00%
Total		50	100.00%

For “Yes,” please explain

Table 163 – Explanation of a Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use to Prevent Opioid Misuse and Abuse

State	Explanation
Alaska	We currently have at lest one abuse deterent formulation on the PDL, as per the recommendation of the Pharmacy and Therapeutics committee.
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 require prior authorization, as all long acting opioids. When a provider wishes to utilize an abuse-deterrent opioid agent, the prior authorization request will go through the review process and would be approved in appropriate cases.
District of Columbia	Abuse deterrent products are preferred on PDL
Florida	To receive an abuse deterrent opioid system requires recipients to have 2 fills of a 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.
Illinois	Embeda is preferred.
Indiana	Abuse deterrent opioids are available 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 an abuse deterrent opioid preferred on the PDL.
Kansas	Several abuse deterrent opioids have preferred status on our preferred drug list (PDL).
Kentucky	Yes, Embeda was present on the preferred drug list during FFY2019
Louisiana	There are abuse deterrent opioid agents present on the preferred drug list.
Maine	Abuse deterrent formulations are available as preferred products on the MaineCare PDL.
Maryland	The FFS program 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 a preferred abuse deterrent opioid agent.
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.
Missouri	MO HealthNet does have an abuse deterrent opioid with preferred status on our preferred drug list.
Montana	Yes we have an abuse deterrent opioid with preferred status on our PDL per DUR Board request.
Nebraska	In FFY 2018 started the use of Embeda, Hysingla, and Butrans as preferred agents.
Nevada	The preferred drug list contains a drug class specific to abuse deterrent opioids. Members do not have to try a non-abuse deterrent opioid prior to gaining access to abuse deterrent 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 State's Preferred Drug List. Opioid antagonists (Narcan Nasal spray, naloxone and naltrexone), and injectable opioid dependence agents (Vivitrol and Sublocade) are preferred. Oral or trans-mucosal opioid dependent agents (buprenorphine and Suboxone) are preferred but require a PA for initiation of opioid therapy for patients on established opioid dependence therapy.
North Dakota	All extended release products require prior authorization, but those available as first line in that category includes at least one abuse deterrent opioid.

State	Explanation
Oklahoma	We have abuse deterrent medications in tier 2 of the class. AutoPA after trial of an immediate release medication.
Rhode Island	The presence of an abuse deterrent opioid with preferred status on the preferred drug list.
South Carolina	Yes, currently one preferred abuse deterrent on PDL- Other products (Non Preferred) are available via Prior Authorization (documentation of clinical rationale)
Tennessee	We did in FFY19, but we do not now at this time. TennCare's sole preferred long acting morphine was Embeda, which has since been terminated from the marketplace by the drug manufacturer and is no longer available. We made the choice to Embeda preemptively because there was a push via the legislature for TennCare to have a tamper-resistant product on our PDL. We also made Embeda as sole preferred due to the excellent contracting opportunity that was presented to us at that time.
Texas	There is at least one opioid abuse deterrent on the preferred list of narcotic analgesics.
Utah	Abuse deterrent formulations have preferred status on the PDL.
Vermont	ORAL, ABUSE-DETERRENT FORMULATIONS EMBEDA (morphine sulfate/naltrexone hydrochloride) Capsules (QTY LIMIT=2 capsules/day) Was preferred on the PDL as of 7/12/2019
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 Milligram Equivalent (MME) Daily Dose

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

Figure 102 - State Recommended Maximum MME Daily Dose Measures

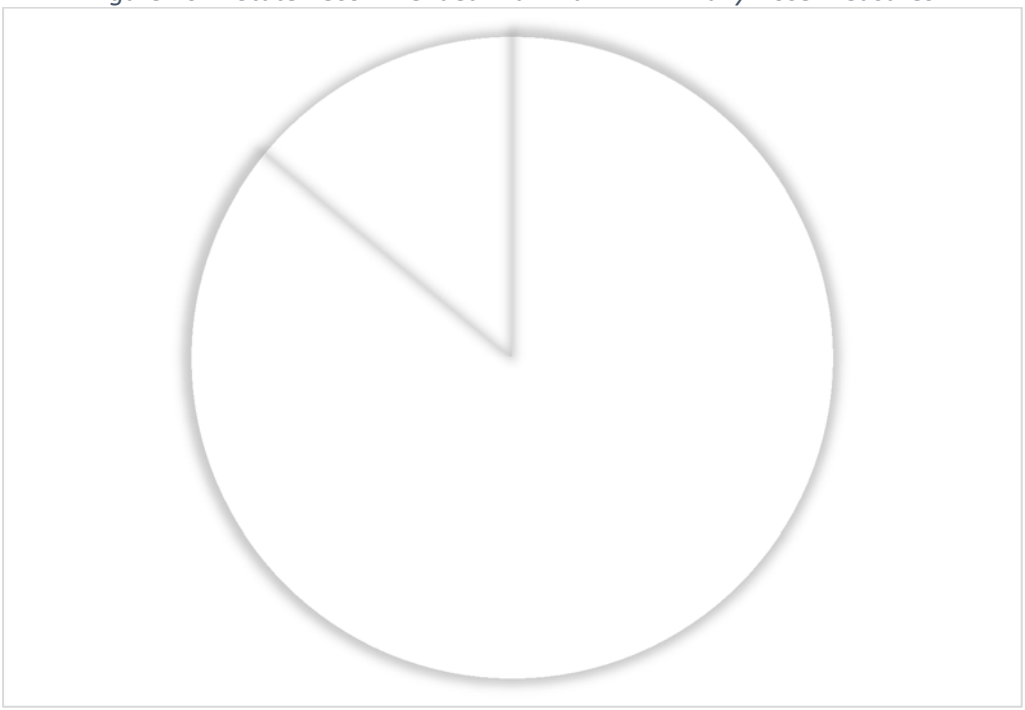

Table 164 - State Recommended Maximum MME Daily Dose Measures

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, 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 York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wyoming	43	86.00%
No	Hawaii, Illinois, New Jersey, New Mexico, Rhode Island, Washington, Wisconsin	7	14.00%
Total		50	100.00%

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

Figure 103 - Maximum Morphine Equivalent Daily Dose Limit in Milligrams

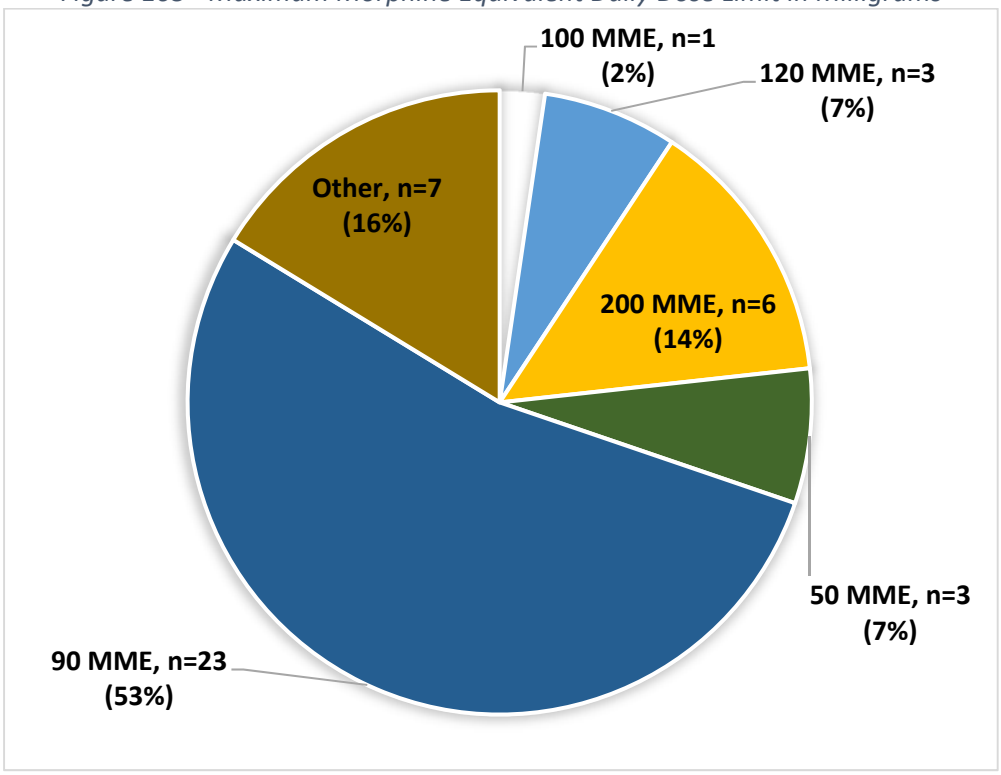

Table 165 - Maximum Morphine Equivalent Daily Dose Limit in Milligrams

Response	States	Count	Percentage
100 MME	New Hampshire	1	2.33%
120 MME	Massachusetts, Michigan, Wyoming	3	6.98%
200 MME	Colorado, Georgia, Kentucky, Missouri, Nebraska, Tennessee	6	13.95%
50 MME	Pennsylvania, Vermont, West Virginia	3	6.98%
90 MME	Arkansas, Connecticut, Delaware, District of Columbia, Florida, Idaho, Iowa, Kansas, Louisiana, Maryland, Minnesota, Mississippi, Montana, New York, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Utah, Virginia	23	53.49%
Other	Alabama, Alaska, California, Indiana, Maine, Nevada, Ohio	7	16.28%
Total		43	100.00%

If “Other” (mg per day)

Table 166 – Other Maximum Morphine Equivalent Daily Dose Limit in Milligrams

State	Other MME
Alabama	250mg
Alaska	250mg
California	500mg
Indiana	60mg
Maine	30mg
Nevada	60mg
Ohio	30mg

b. If “Yes,” please explain nature and scope of dose limit.

Table 167 - Explanations for Nature and Scope of Maximum Morphine Equivalent Daily Dose Limit

State	Explanations
Alabama	Began with a cumulative MME edit "phase-in" period for 3 months. Claims that exceed the cumulative daily MME limit of 250 MME per day will deny at the POS. The Agency will continue to phase down to a goal of 90 MME per day.
Alaska	A reduction of 50 MME every six moths to a goal of 90MME as recommended by the CDC and interdisciplinary licensing board.
Arkansas	Effective February 14, 2018, the maximum MME/day was decreased for opioid naive patients to 50 MME/day and limited to #42 pills for a 7 days' supply of short-acting opioids. On November 14, 2018, the maximum daily dose limit for opioid experienced patients was decreased to 90 MME/day with a quantity limited to #93 per 31 days with patients having certain cancer diagnoses being exempt from the edit. This edit is additive for all opioid drug claims with overlapping days' supply including long-acting and short-acting opioids.
California	For the treatment of chronic pain, dose is to not exceed 500 MME/daily without an approved treatment authorization request. This safety edit assists in identifying members at potentially high-clinical risk who may benefit from close monitoring and care coordination.
Colorado	Prior authorization involving prescriber-to-prescriber consult is required for members' prescriptions that exceed the MME limit. An opioid prescribing plan and recommendations for

State	Explanations
	tapering are documented as part of this consult and approval may be placed to allow for tapering.
Connecticut	The maximum MME is defined as exceeding 630 MME in a rolling 120-day window. Patients who exceed these limits will require prior authorization unless their diagnosis is of cancer or sickle cell and their prescriber is in a hematology/oncology taxonomy.
Delaware	Delaware follows the most recent CDC recommendations. When the dose is above the current recommended dose, physicians receive written notification in order to reduce patient risk by encouraging re-evaluation of the necessity of the higher dose. The 90 MME limit is also part of the clinical criteria for approval of PA. The 90 MME limit has been in place since July 1, 2018, however Delaware would further re-evaluate this limit if new recommendations for lower doses are released.
District of Columbia	All patients are limited to 90 MME per day and 7 days supply limit. Acute patients with less than 120 days of opioid utilization in the last 180 days are also limited to 30 days treatment per 180 days.
Florida	Applies only to treatment naive recipients defined as not receiving opioid prescriptions in previous 60 days. An edit for all opioid recipients is set to deploy in FFY20.
Georgia	In response to the growing opioid crisis, the Centers for Disease Control and Prevention (CDC) published guidelines for the use of opioids in chronic, non-cancer pain in 2016. In the Guidelines for Prescribing Opioids for Chronic Pain, the CDC recommends careful justification for titrating opioid doses above an average of 90 morphine milligram equivalents (MME) per day to avoid potential overdose. In an effort to reduce the risk of opioid-related harms while preserving access to appropriate pain treatment, Georgia Medicaid Fee-For-Service (FFS) implemented a prior authorization for cumulative morphine milligram equivalent (MME) doses exceeding 210 MME per day.
Idaho	Edit implemented in July 2017. When a new prescription comes in the edit looks at the cumulative daily MME of currently received prescriptions plus the new prescription and will deny claim if all drugs and doses added together exceed the 90 MME at that point in time. A prior authorization is required for override to allow dispensing.
Indiana	Current limit applies to new starts. Indiana Medicaid anticipates adding tapering requirements and limits to current utilizers in the future.
Iowa	We are in the process of tapering to a maximum of 90 MME per day. Currently, MME is set at 120 mg per day, with 90 MME per day going into effect Fall of 2020.
Kansas	All opioids have an MME limit unless the MME does not apply to that drug and then a Maximum daily dose limit is set, except for claims for patients with cancer, sickle cell anemia, or palliative care.
Kentucky	200 morphine milligram equivalents (MME) is our ceiling in the POS system, which allows only one MME value cut off. Our quantity limits for individual agents (e.g., oxycodone and hydrocodone/APAP) are configured to allow around 90 MME/day, so this is effectively the limit

State	Explanations
	as a PA would be required if a claim for another opioid of a different kind or strength were submitted due to a therapeutic duplication hard stop. During FFY 2019, the urine drug screening criteria were modified to align with 201 KAR 9:260: 1. Require UDS results dated within the past 30 days for ALL new chronic opioid (e.g., beyond 45 days of treatment) requests UNLESS the member is in a long-term care or skilled nursing facility. Note: UDS is not required for acute prescribing. 2. If the member is NOT in a long-term care or skilled nursing facility, require prescriber to document risk assessment and provide most recent UDS results dated within: a. 1 year if considered 'low risk' b. 6 months if considered 'moderate risk' c. 3 months if considered 'high risk'
Louisiana	Each time an opioid prescription claim is submitted for a recipient, the MME per day for all active opioid prescriptions for that recipient is calculated and limited to a maximum of 90 MME per day. There are exemptions to the edits for maximum daily MME limits for opioids: cancer, palliative care, sickle cell crisis, and burn diagnosis (second and third degree). Authorization to increase the maximum prescribed MME limit for a recipient may be approved by the PA unit prior to the initiation of the edit.
Maine	The State of Maine has had 30MME in place for many years and has successfully decreased overall opiate utilization per member drastically since FFY 2013.
Maryland	Maryland Medicaid set the maximum morphine equivalent daily dose limit at 90MME in keeping with the published CDC guidelines in FFY 2018. Anyone exceeding a MEDD of 90mg is required to obtain a prior authorization. While patients with sickle cell anemia or patients in Hospice are excluded from the prior authorization process, the program recommends they be kept on the lowest effective dose for the short duration required to minimize the risk of harm.
Massachusetts	Prior Authorization for MME 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 120 MEDD. Prescribers are referred to CDC tapering tools for assistance.
Minnesota	A POS edit is used which compares the quantity per day limit and quantity per prescription limit against the values in the MMIS drug table. These values are based on a daily max of 90 MME. If either of the values are over, then claim rejects and a prior authorization is required for the high dose opioid claim to adjudicate.
Mississippi	This limit aligns with CDC guidelines and applies to all opioid prescriptions excluding those beneficiaries with an active cancer diagnosis or sickle cell disease.
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. April 4, 2019 the MME limit was reduced to 200 MME per day. The initial prescription of an opioid is limited to 50 MME on the initial fill of 7 day and 90 MME thereafter.
Montana	We started our opioid MME limits at 180 and have gradually lowered them to our final 90MME limit. This applies to opioid naive and non-opioid naive members. Providers with members already over our limits were given time (variable depending on how high the dose was to start)

State	Explanations
	to taper. Providers who could not taper their patients successfully could request a prior authorization to remain at a dose over our limits.
Nebraska	Cumulative of all long acting and short acting products and cough and cold medications. Being tapered throughout 2020.
Nevada	The MME limit applies to all oral opioid products.
New Hampshire	NH Medicaid selected the daily MME at 100 to be consistent with the administrative prescribing rules published by the licensing boards (Medical, Nursing and Dental) that fall under the Office of Professional Licensure and Certification (OPLC). NH has an accumulative POS edit and place that will deny opioid claims for beneficiaries that exceed the 100mg MME unless there is a prior authorization in place.
New York	On September 19, 2019 the DUR Board determined that a prior authorization will be required for opioid naive patients exceeding a morphine milligram equivalent (MME) of 90 mg per day. System methodology is expected to be put in place at a later date. Exceptions would be for patient therapy for Cancer or Sickle Cell Disease.
North Carolina	Beneficiaries requiring more than 90 MME (cumulative for all opioids) are required to meet prior authorization requirements.
North Dakota	The 90 MME limit is based on total daily dose of both IR and ER products, and can be exceeded through prior authorization, which then must be renewed yearly.
Ohio	30 MME for short acting opioids 80 MME for long acting opioids
Oklahoma	Opioid MME daily totals greater than 90 will require prior authorization with patient-specific, clinically significant reasoning why the member requires greater than 90 MME per day. Members with diagnosis of cancer, sickle cell, and/or hemophilia are excluded from the MME limit.
Oregon	Tapering legacy patients already established on treatment and limiting new starts to not exceed this maximum MME
Pennsylvania	The limit is a threshold for prior authorization. Doses greater than 50 MME/day require prior authorization.
South Carolina	Opioid Quantity Limits Prescribers must limit the initial prescribing of opioid medications for the treatment of acute or post-operative pain to the lowest effective dose and for a quantity no more than necessary for the expected duration of pain. Providers must not exceed a five-day supply or 90 morphine milligram equivalents (MMEs) daily, except in the cases of chronic pain, cancer pain, pain related to sickle cell disease, hospice care, palliative care or medication-assisted treatment for substance use disorder. If, in a prescriber's clinical judgement, an initial supply of more than five days or 90 MMEs is medically necessary, the prescriber must document that need in the patient's medical record.
South Dakota	Doses exceeding 90 MME require PA.
Tennessee	Our limit for non-chronic users is 15 days per 180 days with no greater than 60 MME per day. Non-chronic use is defined as 90 days supply within the past 180 calendar days. The only exceptions to this limit are patients with sickle-cell disease, corrosive or other burns over a significant part of the body, and those in LTC facilities, and with these exceptions the limit is 45 days supply per 90 days at no greater than 60 MME per day. For chronic users, the limit is 200 MME per day.
Texas	In FFY 2019, all clients, except for clients with cancer or patients in hospice or palliative care, were subject to a 90 MME per day dosing. Prescription above this limit would require a prior authorization. The prior authorization duration was for 6 months.

State	Explanations
Utah	A morphine equivalent daily (MED) limit was implemented on January 1, 2019 for adjudication of all opioid claims for the treatment of non-cancer pain. Two sets of daily MED thresholds were established, a threshold of 90 MED for opioid naive individuals who have not had a claim for an opioid in the last 90 days, and 180 MED for opioid experiencedindividuals who had a claim for an opioid in the last 90 days. The higher MED threshold will be reduced over time, every 6 months, to achieve one common MED standard, 90 MME, for all Utah Medicaid members. The MED will be gradually reduced for opioid experienced based on the following timeline: January 1, 2019 : MED 180; July 1, 2019 : MED 150; January 1, 2020 : MED 120; July 1, 2020 : MED 90.
Vermont	The initial fill for all short-acting opiates will be limited to 50 Morphine Milligram Equivalents (MME) and 7-day supply for patients 18 years of age or older OR 24 MME and 3-day supply for patients 17 years of age or younger.
Virginia	A service authorization is required for any cumulative opioid prescription exceeding 90 morphine milligram equivalents (MME) per day. Quantity limits apply to each drug. The service authorization fax form also mentions and provides a link to alternative therapy to schedule II opioids. The service authorization fax form states: Alternative Therapy to Schedule II Opioids. Based on the Virginia Board of Medicines Opioid Prescribing Regulations, Opioids are NOT recommended as first line treatment for acute or chronic pain. For additional information please see: VA Board of Medicine Regulations. Preferred Pain Relievers available without SA include NSAIDS topical and oral, SNRIs, Tricyclic Antidepressants, Gabapentin, Pregabalin capsules, Baclofen, Capsaicin topical cream 0.025% and Lidocaine 5% Patch. Consider alternative therapies to Schedule II opioid drugs due to their high potential for abuse and misuse.
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 SEMP (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.
Wyoming	The MME limit is applied to long-acting opioids only.

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

Table 168 - Explanations of the Measure or Program Utilized for Maximum Morphine Equivalent Daily Dose Limit

State	Explanations
Hawaii	To be set in FFY 2020. Pain management has not been an issue since 20009. FDA approved quantity edits for excessive quantities per First Data Bank are POS edits.
Illinois	The MME edit is in the process of being implemented. The initial planned MME edits will be 120 MME for chronic opioid users and 90 MME for new opioid users. Until the MME edit is live, HFS will continue to use quantity limits for short and long-acting opioids.
New Jersey	MME initiative was implemented starting October 2019.
New Mexico	A report and POS edit is in progress for FFY 2020 to identify claims exceeding 90 MME.
Rhode Island	Partial plan in place for naive patients.
Washington	Our limits were not in place during FFY 2019. Effective November 2019, WA Medicaid's fee-for-service and contracted Managed Care plans updated the Opioid policy to include a high dose attestation for a single or combined dose exceeding 120 MME a day and a prior authorization for medical necessity for single or combined doses of 200 MME or above.
Wisconsin	Wisconsin has a prospective DUR alert for claims with 90MME or greater. This alert notifies the pharmacy the claim is a high dose opioid and recommends the dispensing of naloxone. Wisconsin also monitors these drugs through edits, such as quantity limits, early refill and therapeutic duplication prospective DUR alerts. Wisconsin performs retrospective reviews of all

	Explanations
	opioids used at 250MME or greater and use of opioids at 50MME or greater with concomitant benzodiazepine. 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 104 - Provides Information to Your Prescribers on How to Calculate the Morphine Equivalent Daily Dosage or Provides a Calculator Developed Elsewhere?

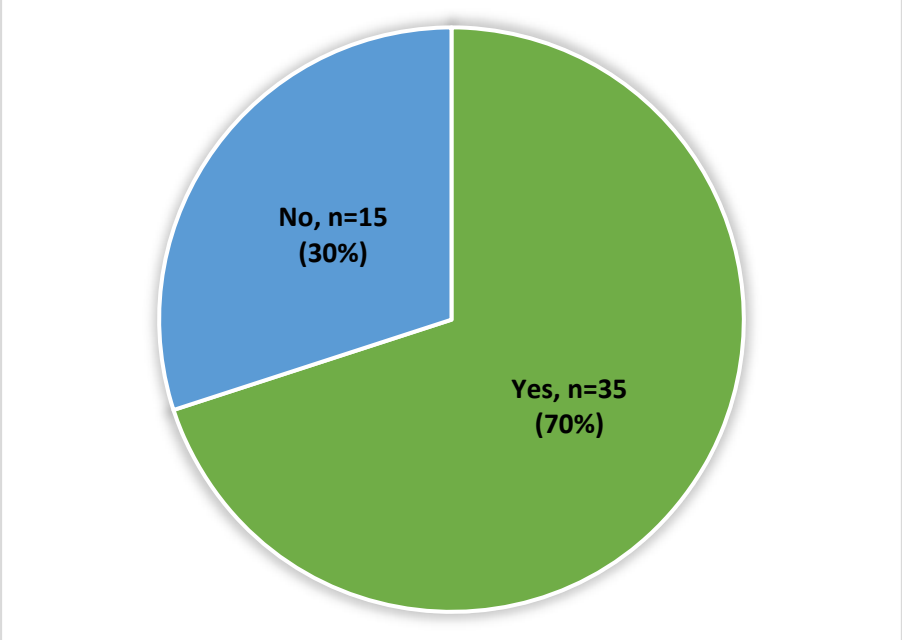

Table 169 - Provides Information to Your Prescribers on How to Calculate the Morphine Equivalent Daily Dosage or Provides a Calculator Developed Elsewhere

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia	35	70.00%
No	Delaware, Georgia, Hawaii, Idaho, Kentucky, Louisiana, Minnesota, Missouri, New Mexico, New York, Oklahoma, Pennsylvania, South Dakota, Wisconsin, Wyoming	15	30.00%
Total		50	100.00%

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

Figure 105 - Name of the Developer of the Calculator

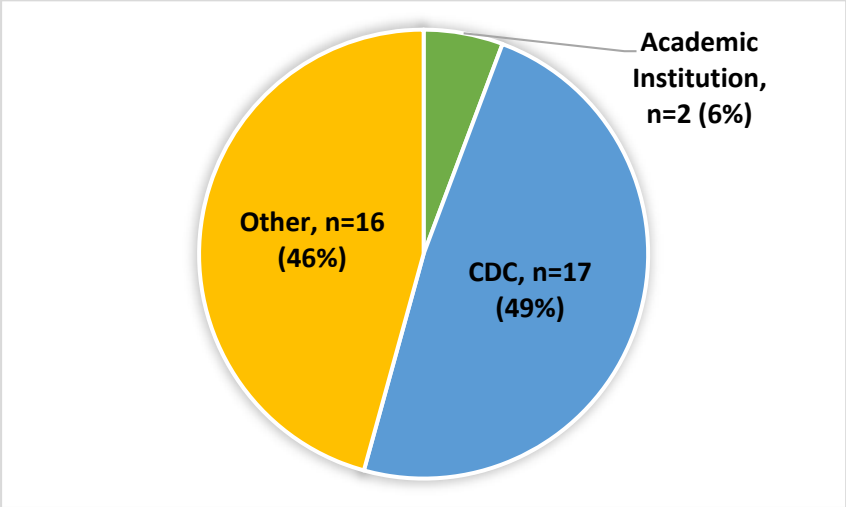

Table 170 - Name of the Developer of the Calculator

Response	States	Count	Percentage
Academic Institution	Mississippi, Oregon	2	5.71%
CDC	Alabama, California, Connecticut, District of Columbia, Florida, Illinois, Iowa, Maine, Maryland, Michigan, Nevada, New Jersey, Rhode Island, Texas, Utah, Vermont, West Virginia	17	48.57%
Other	Alaska, Arkansas, Colorado, Indiana, Kansas, Massachusetts, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, South Carolina, Tennessee, Virginia, Washington	16	45.71%
Total		35	100.00%

If "Other," please specify

Table 171 – Other Explanations for the Developer of the Calculator

State	Explanations
Alaska	Washington AMDG and the Alaska state PDMP website provides additional resources for online and mobil
Arkansas	Developed by HP Enterprise Services then updated by Magellan
Colorado	Washington State Agency Medical Directors' Group
Indiana	Drug Utilization Review Board Newsletter, posted electronically, provides opiate conversion charts.
Kansas	We have MME and dose limits on the PA table plus a provider bulletin with the CDC link.
Massachusetts	MassHealth distributed a prescriber letter re Updated Opioid High Dose Limits with an MEDD table.
Montana	We provide the CDC calculaor and one from Washington state (agencymeddirectors.wa.gov)
Nebraska	Nebraska Pain Management Guidance Document
New Hampshire	The calculator is courtesy of the Washington State Agency Medical Directors' Group.
North Carolina	NC has a table, not a calculator.

State	Explanations
North Dakota	Agency Medical Directors' Group - Washington State
Ohio	Take Charge Ohio. OARRS guidelines Available at https://www.ohiopmp.gov/. Accessed August 2, 2020
South Carolina	Magellan
Tennessee	We list the MME calculations on our website, and on all opioid P.A. forms.
Virginia	SA form states for prescriber to provide pts Daily MME from PMP (http://virginia.pmpaware.net/login)
Washington	WA Medicaid created our own opioid calculator using the CDC and AMDG MME conversion factors.

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

Figure 106 - Information Dissemination Routes

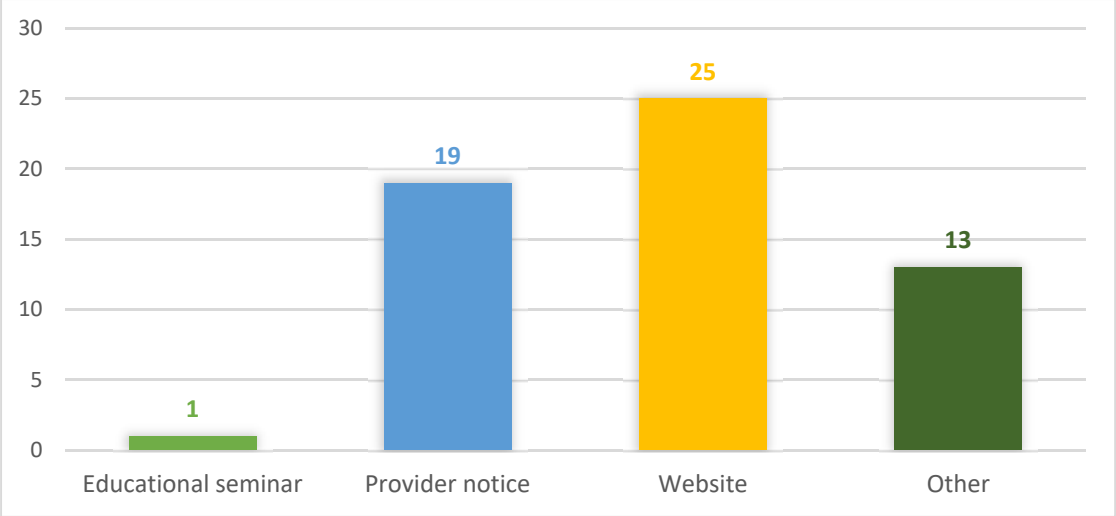

Table 172 - Information Dissemination Routes

Response	States	Count	Percentage
Educational seminar	Maine	1	1.72%
Provider notice	Alabama, California, District of Columbia, Florida, Kansas, Maine, Massachusetts, Mississippi, Montana, Nevada, New Jersey, Ohio, Rhode Island, Texas, Utah, Vermont, Virginia, Washington, West Virginia	19	32.76%
Website	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, District of Columbia, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Montana, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Tennessee, Vermont, Virginia, Washington	25	43.10%
Other	Alabama, Alaska, California, Colorado, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, Oregon, South Carolina, Utah, Virginia	13	22.41%
Total		58	100.00%

If “Other,” please explain.

Table 173 - “Other” Explanations for Information Dissemination Route

State	“Other” Explanations
Alabama	Academic Detailers
Alaska	Website, prior authorization form, and criteria documents.
California	In February 2019, the Medi-Cal DUR program published an educational bulletin - Clinical Review Update: Morphine Equivalent Daily Dose - 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	The link to the MME calculator is on preferred drug list. There is also a link on the Colorado State Department's pain management resources and opioid use web page.
Massachusetts	Direct mail to prescribers.
Michigan	Provided on the prior authorization fax form and RetroDUR education packets to prescribers associated with members with daily MME 90 or above.
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
New Hampshire	There is a link to the calculator on Magellan's State of NH web portal, https://newhampshire.magellanmedicaid.com/portal/spring/public/nhportalpublic?execution=e1s1.
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
South Carolina	SCRIPTS (PDMP) contains calculator, Vendor (Magellan) also has access to MME calculations via the Call Center. Additional information/resources can be found tipSC (opioid conversion fact charts, other opioid related issues/articles and CME) https://msp.scdhhs.gov/tipsc/
Utah	Quarterly Medicaid Information Bulletins and targeted peer to peer work provide education on MME calculations.
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 MME daily dose prescribed has been exceeded?

Figure 107 - Edit in POS System that Alerts the Pharmacy Provider that the Morphine Equivalent Daily Dose Prescribed has been Exceeded

Table 174 - Edit in POS System that Alerts the Pharmacy Provider that the Morphine Equivalent Daily Dose Prescribed has been Exceeded

Response	State	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	39	78.00%
No	California, Connecticut, Georgia, Hawaii, Illinois, Nebraska, New Jersey, New Mexico, New York, Rhode Island, Washington	11	22.00%
Total		50	100.00%

If “Yes,” do you require prior authorization if the MME limit is exceeded?

Figure 108 - Prior Authorization Required if MME Limit is Exceeded

Table 175 - Prior Authorization Required if MME Limit is Exceeded

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wyoming	38	97.44%
No	Wisconsin	1	2.56%
Total		39	100.00%

4. Do you have automated retrospective claim reviews to monitor total daily dose (MME) of opioid prescriptions dispensed?

Figure 109 - Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

Table 176 - Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

Response	State	Count	Percentage
Yes	Colorado, Delaware, Florida, Indiana, Iowa, Kentucky, Maine, Maryland, Michigan, Mississippi, Missouri, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Dakota, Utah, Virginia, Wisconsin	20	40.00%
No	Alabama, Alaska, Arkansas, California, Connecticut, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Kansas, Louisiana, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Washington, West Virginia, Wyoming	30	60.00%
Total		50	100.00%

Please explain.

Table 177 - Explanations for Automated Retrospective Claim Reviews to Monitor Total Daily Dose (MME) of Opioid Prescriptions Dispensed

State	Explanations
Alabama	n/a
Alaska	Retrospective reviews of total daily dose MME is review by the DUR committee.
Arkansas	Our strict prospective edits prevent claims from processing at POS with > 90 MME/day.
California	We have completed several retrospective claim reviews to monitor total daily dose (MME) of opioid prescriptions dispensed, but they are not automated.
Colorado	Magellan Health, Inc., the point of service vendor, calculates the cumulative MME across opioid prescription claims processed for individual members.
Connecticut	Retrospective MME criteria was created during FFY 2020 to target any patient receiving > 472.5 MME in 90 days.
Delaware	Automated high dose edit, overuse alert is set on claim to dispensing Pharmacies on targeted narcotics medications, identified through manual MME calculation.
District of Columbia	Retrospective claims reviews developed manually and are monitored on a monthly basis.
Florida	The retrospective claim review to monitor total daily dose (MME) of opioid prescriptions is reviewed by the DUR Board quarterly.
Georgia	n/a
Hawaii	If identified as a paid claim on quarterly reviews, the claim will be manually reviewed. Otherwise, at least an annual review will be done.
Idaho	We perform restrospective reviews to evaluate total MMEs, but it is not automated.
Illinois	We have conducted a retrospective review to calculate MME for patients who filled in a given time period. Our MMIS is not automated to calculate total daily dose (MME).
Indiana	Claims exceeding limit are reviewed both prospectively and retrospectively.
Iowa	A retrospective report is generated for review, consistent with SUPPORT Act requirements effective October 2019.. If issues are identified, it is referred to the DUR Commission for discussion and next steps, such as provider education.
Kansas	This is a hard edit and therefore is required for claims to pay and is only overridden if a PA is approved.
Kentucky	Magellan has developed an opioid overutilization report which is reviewed each quarter. It contains several views of opioid users including by MME, ranked by pharmacy/patient/prescriber, concurrent use of potentiators, naloxone coverage. The report is run and reviewed quarterly.
Louisiana	We are expecting to implement a retrospective DUR activity in FFY20, however the proposed activity is is not an automated claim review.
Maine	Report analysis is done on all members above 30MME,
Maryland	During retrospective reviews, the RDUR program is able to identify patients who are receiving greater then 50MME as well as participants receiving over 90MME daily.
Massachusetts	We use claim edits to monitor daily MME, however no automated review. Reports are produced ad-hoc.
Michigan	Our comprehensive quarterly opioid trend report includes the accumulated MME of each member. The report provides claim and member detail if further investigation is required.
Minnesota	Prior authorization is required for of any prescription where the opioid per day exceeds 90mg MME.

State	Explanations
Mississippi	A monthly retrospective DUR mailing is sent to providers with beneficiaries above 50 MME opioid dosing. MME values are also included in the quarterly report on beneficiaries at high risk for opioid misuse or abuse.
Missouri	We do have an automated retrospective claims review process in place to monitor daily MME on opioid prescriptions. Our multi-faceted approach combines monthly MME reporting identifying individuals over the set limits, combined with our retrospective, population-based interventions targeting safe opioid utilization. Our retrospective intervention identifies members over the maximum cumulative daily MME, which is currently set at >/=300MME per day and educates providers on how to obtain prior approval for continued use, or how to safely taper the current opioid dose. We mailed to providers last in November of 2018. The state uses the retrospective lettering process to communicate MME changes to providers and will continue this process as the target MME limit is reduced over time.
Montana	We do not review these retrospectively because we deny them prospectively and require prior authorization so any paid claims have already been reviewed and approved.
Nebraska	None yet.
Nevada	The retrospective claim review is a manual review process through the retroDUR program and DUR meeting presentations.
New Hampshire	A hard edit prospective DUR of MME over 100 has been implemented. All claims of MME over 100 reuired a prior authorization.
New Jersey	Retrospective reviews to monitor MME are currently manually reviewed.
New Mexico	There is a “soft” pay and report POS edit set up for FFY 2020 to comply.
New York	Retrospective claims are reviewed monthly by pharmacy academia at the State University of New York at Buffalo. Where appropriate, utilization reviews are prepared by pharmacy academia at the State University of New York at Buffalo as a means of identifying clinical issues regarding the total daily dose (MME) of opioid prescriptions dispensed.
North Carolina	NC Tracks monitors the total MME of all opioid prescriptions concurrently dispensed. Prior authorization is required for greater than 90 MME This is also monitored in various reports reviewed by the DUR Board.
North Dakota	Our RetroDUR exception criteria includes MME review.
Ohio	We have automated claim reviews that monitor high quantity/day supply of opioids. We also monitor MME threshold through reporting.
Oklahoma	MME edit calculates cumulative MME of members claims for active medications.
Oregon	NA
Pennsylvania	The current system does not have the capability to calculate total daily MME.
Rhode Island	DUR Board
South Carolina	MME established at 90MME effective 7/1/2019- Prior to the implementation, claims were analyzed for those exceeding the 90MME threshold. The State will be running analysis for claims exceeding 90MME for next steps
South Dakota	MME is regularly monitored
Tennessee	We are working on this. We have asked our PBM Vendor, OptumRx, for a system enhancement that will accumulate MME use, but it is not ready as of yet.

State	Explanations
Texas	In FFY 2019, an automated retrospective claims reviews for total daily MME was not implemented. The prospective check and PA requirement for total daily MME is a good safeguard against prescribing above the designated MME.
Utah	Weekly reports are run retrospectively to monitor total daily dose (MME) or prescriptions dispensed.
Vermont	We do not have an automated process but we do perform Retro Dur analysis. DUR Board Meeting May 7, 2019 Data presentation: Evaluation of Opioid Prescribing for Chronic Pain Chronic opioid use has become endemic and the societal problems of substance abuse and deaths related to opioids are devastating in the United States. Patients can become addicted to opioids very quickly, even at low doses. Although overdose may occur at any opioid dose, higher doses are associated with higher risk of overdose and death. Opioid doses greater than or equal to 100 morphine milligram equivalents (MME) per day increase overdose risk by nine times compared with dosages between 0 and 20 MME. It has been well identified that for many types of pain, opioids are not necessary or, in some cases, particularly effective. National efforts to stem the prescriptions of opioids are underway, including better patient and physician education around pain management, prescription drug monitoring programs and quantity limits on narcotics. Problems of diversion, misuse, selling and stockpiling narcotics are well known issues that plague the use of these medications today. Change Healthcare used paid, non-reversed Medicaid pharmacy claims from calendar year 2017 and compare them with those of calendar year 2018, excluding members with Part D, VMAP and Healthy Vermonters coverage. They identified members on any opioid medication (short or long acting) for greater than 90 days and stratify into those on a combined daily dose of greater than or equal to 100MME, greater than or equal to 200MME and greater than or equal to 300MME, excluding members with diagnoses of cancer or mat. They also looked at the prescribing patterns geographically. Number of members on any opioid medication (short or long acting) for greater than 90 days within the selected year. Stratification of members above by MME Members with 2 different distinct short acting opioids with no long acting opioid on file. These are members that had 90-day supply or greater within the calendar year with at least 30 days overlap of both opioids. Members on 2 different distinct long- acting opioids. As above, these members had 90 -day supply or greater within the calendar year with at least a 30 day overlap of both opioids Geographic breakdown of average MME for members on opioids for greater than 90 days Recommendation: Additional data will be collected. For members on 2 different short acting opioids, the medications being used in this situation will be determined. A detailed look at the member profiled should be completed for those identified as being on 2 different long acting opioids. Member count and MME count per member will be analyzed to determine if only a select few members are bringing up the averages. Public Comment: No public comment. Board Decision: The Board unanimously approved the above recommendation.
Virginia	We review members on chronic opioids and with high risk activity that includes being on high total daily doses for MME quarterly and present to each DUR Board meeting.
Washington	Effective November 2019, WA Medicaid's fee-for-service and contracted Managed Care plans updated the Opioid policy to include a high dose attestation for a single or combined dose exceeding 120 MME a day and a prior authorization for medical necessity for single or combined doses of 200 MME or above. Once implemented both MME limits will use an automated

State	Explanations
	retrospective claims review to calculate the total daily MME dose and will include the total in the message back to the billing pharmacy.
West Virginia	We use MME to filter members for some Retrospective reviews. Members who receive an opioid equivalent to 50 MME or greater and also receive a benzodiazepine are flagged for review for higher risk of respiratory failure. High Average Daily Dose: 120 morphine milligram equivalents or more per day over the past 90 days (members with a cancer diagnosis are excluded) are flagged for review in the lock-in program.
Wisconsin	Wisconsin performs a retrospective claims review if a member's MME in a month is 250 MMEs or greater and sends prescriber letters. Wisconsin performs targeted interventions when a member is receiving a benzodiazepine and has 50 MMEs or greater, the prescriber is sent a retrospective letter informing them of a clinical concern.
Wyoming	MME Calculation happens prospectively at point of sale with prior authorization required for anything exceeding limits.

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

Table 178 - 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, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, 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, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	42	84.00%
No	Hawaii, Kansas, New Mexico, Rhode Island, South Carolina, South Dakota, Texas, Wisconsin	8	16.00%
Total		50	100.00%

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

Figure 111 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

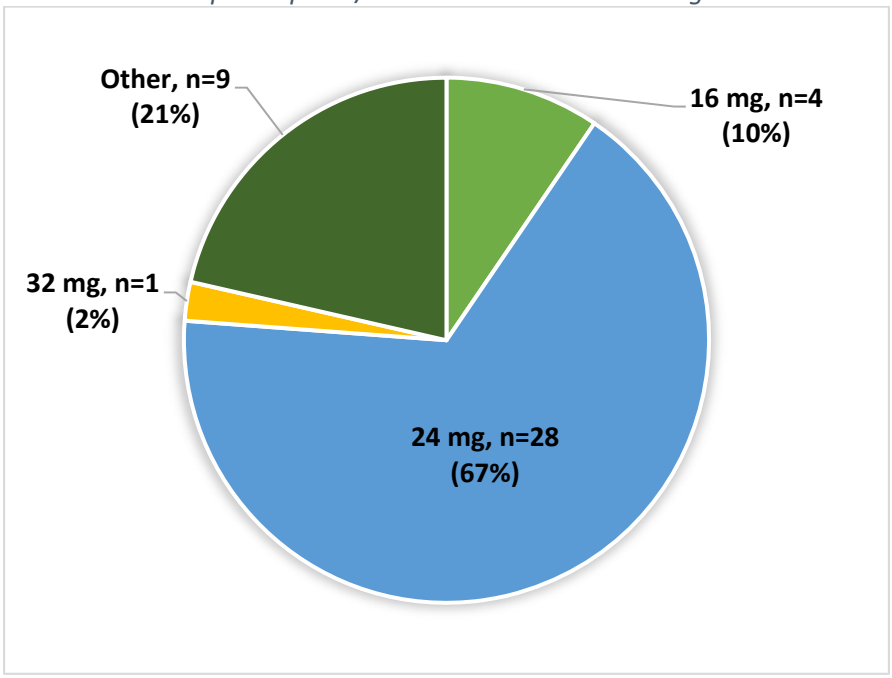

Table 179 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	State	Count	Percentage
16 mg	Maine, Oklahoma, Vermont, Wyoming	4	9.52%
24 mg	Alaska, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Utah, Virginia, West Virginia	28	66.67%
32 mg	Washington	1	2.38%
Other	Alabama, California, Connecticut, Illinois, Maryland, New Hampshire, North Carolina, Ohio, Tennessee	9	21.43%
Total		42	100.00%

If "Other," please explain.

Table 180 - "Other" Explanations for TotalMilligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

State	"Other" Explanations
Alabama	Per CMS Guidance, the Agency sets the total mg/day for buprenorphine and buprenorphine/naloxone combination drugs at 24mg/day. Bunavail is not approved for > 12.6mg/day and Zubsolv is not approved for > 17.1mg/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.
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 24mg. 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.
Maryland	Maryland Medicaid employs varying quantity limits based on the drug and dosage form for buprenorphine and buprenorphine-naloxone combination products. Quantity limits are available at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf
New Hampshire	Buprenorphine/naloxone combination drugs that exceed 16mg/day of buprenorphine will deny for prior authorization required.
North Carolina	Override is needed to exceed 16 mg; limited to maximum of 24 mg. No ability to exceed 24mg.
Ohio	After 90 days of 24mg per day, required to taper to 16mg per day. A PA is required to exceed these limitations.
Tennessee	16mg per day for the first 6 months of therapy, and 8mg per day thereafter with no time limitation.

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

Figure 112 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

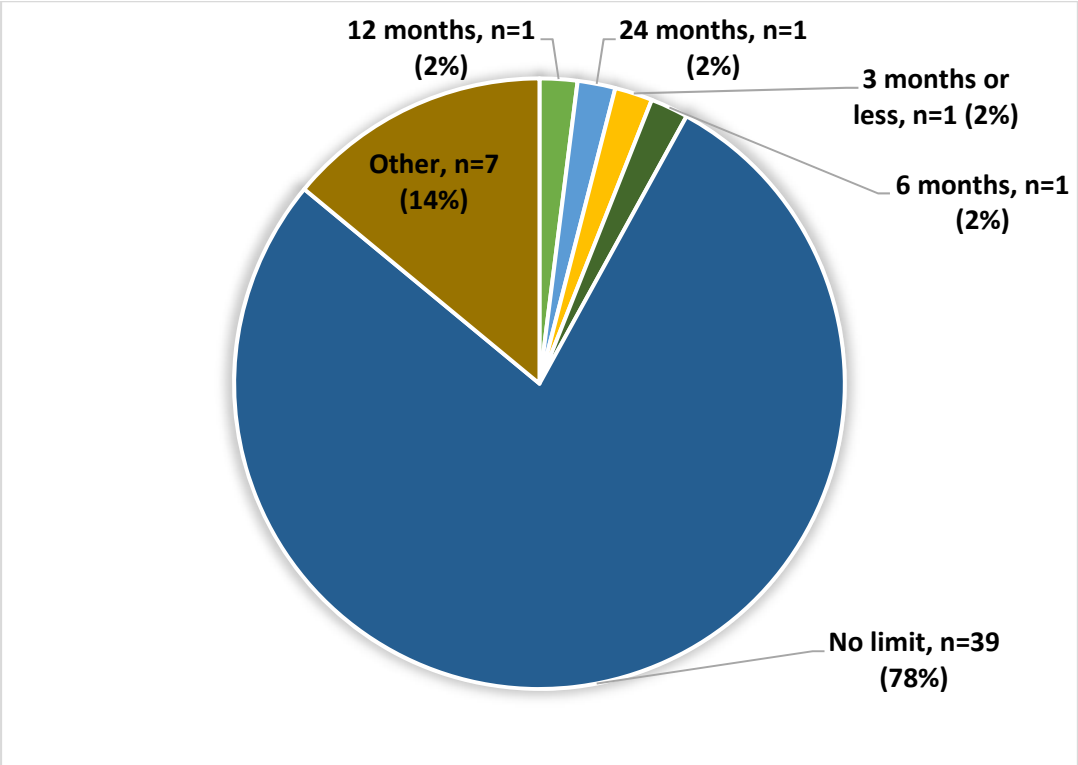

Table 181 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

Response	States	Count	Percentage
12 months	Nebraska	1	2.00%
24 months	Wyoming	1	2.00%
3 months or less	Mississippi	1	2.00%
6 months	Tennessee	1	2.00%
No limit	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Wisconsin	39	78.00%
Other	Kansas, Michigan, Ohio, Oregon, Virginia, Washington, West Virginia	7	14.00%
Total		50	100.00%

If “Other,” please explain.

Table 182 – “Other” Explanations for Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

State	“Other” Explanations
Kansas	We only have a PA on Subutex. We do not have an allowable length set for Subutex. All other OUD drugs do not have POS hard edits. Subutex has a PA required due to its being single agent Buprenorphine that is highly abused. Other PA criteria are required for Subutex use.
Michigan	12 months initially then renewal requests are evaluated on a case by case basis.
Ohio	After 90 days of 24mg per day, required to taper to 16mg per day. A PA is required to exceed these limitations
Oregon	No PA required and no limit on duration for buprenorphine/naloxone combination products that do not exceed an average daily dose of 24 mg per day of buprenorphine
Virginia	Length of Authorization: 3 Months (Initial SA), 6 months (Maintenance SA)
Washington	For buprenorphine/naloxone combination therapy there is no limit for the allowable length of treatment. Buprenorphine monotherapy is approved only for clients who experienced a documented allergic reaction or for pregnant clients and is allowed through the estimated delivery date; if the client will be breastfeeding and additional authorization is allowed for up to twelve months post-delivery.
West Virginia	We allow a one-time-only 24 mg initiation dose with a limit if 60-days.

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

Figure 113 - Maximum Milligrams per Day Reduction after a Set Period of Time

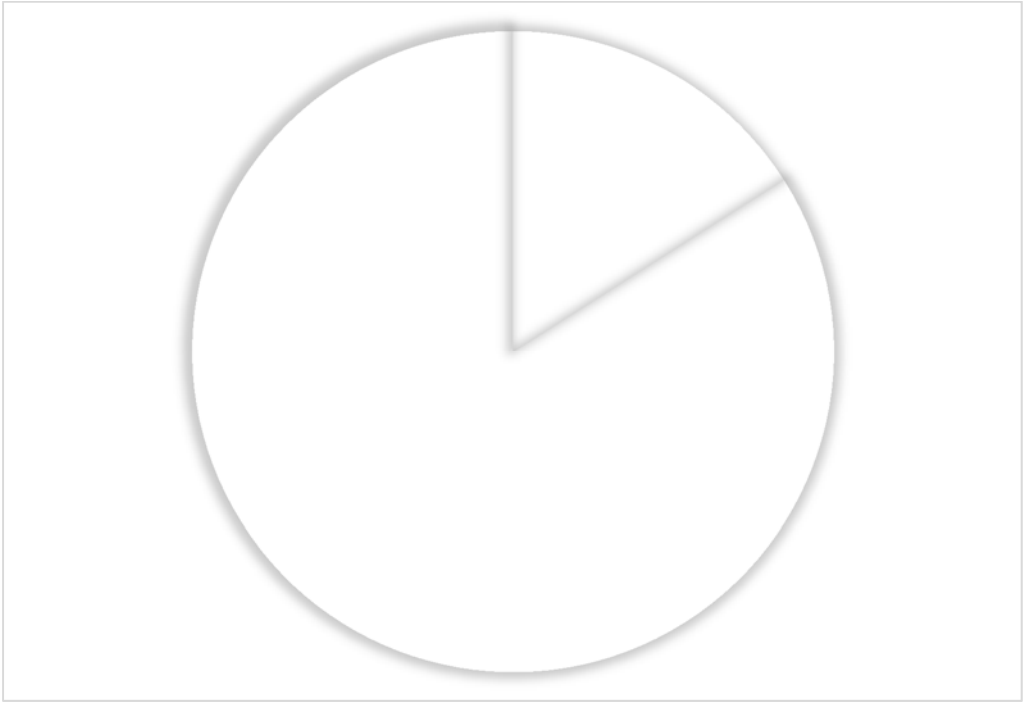

Table 183 - Maximum Milligrams per Day Reduction after a Set Period of Time

Response	States	Count	Percentage
Yes	Iowa, Maine, Michigan, Mississippi, Ohio, 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, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, Wisconsin	42	84.00%
Total		50	100.00%

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

Figure 114 - Reduced (Maintenance) Dosage

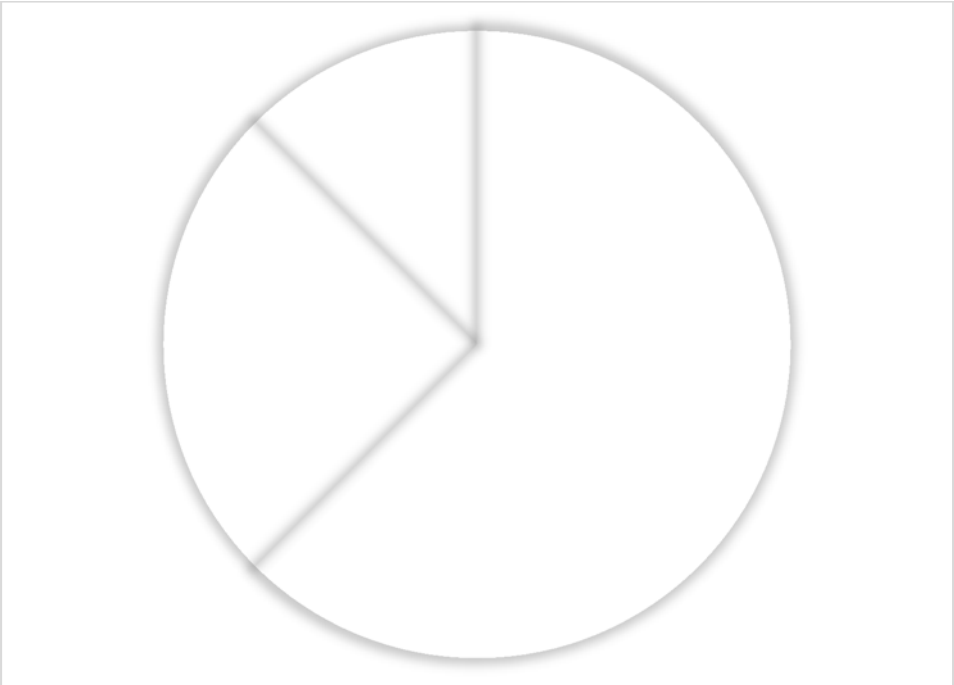

Table 184 - Reduced (Maintenance) Dosage

Response	States	Count	Percentage
16 mg	Iowa, Maine, Mississippi, Ohio, West Virginia	5	62.50%
8 mg	Tennessee, Wyoming	2	25.00%
Other	Michigan	1	12.50%
Total		8	100.00%

If "Other," please explain.

Table 185 – "Other" Explanations for Reduced (Maintenance) Dosage

State	"Other" Explanations
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 115 - Limitations on the Allowable Length of the Reduced Dosage Treatment of Buprenorphine/Naloxone Combination Drugs

Table 186 - Limitations on the Allowable Length of the Reduced Dosage Treatment on Buprenorphine/Naloxone Combination Drugs

Response	States	Count	Percentage
No limit	Iowa, Maine, Mississippi, Ohio, Tennessee, West Virginia, Wyoming	7	87.50%
Other	Michigan	1	12.50%
Total		8	100.00%

If “Other,” please explain.

Table 187 – “Other” Explanations for Limitations on the Allowable Length of the Reduced Dosage Treatment on Buprenorphine/Naloxone Combination Drugs

State	“Other” Explanations
Michigan	Allowed length of coverage and tapering was required based on an individualized care plan during FFY2019.

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

Figure 116 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

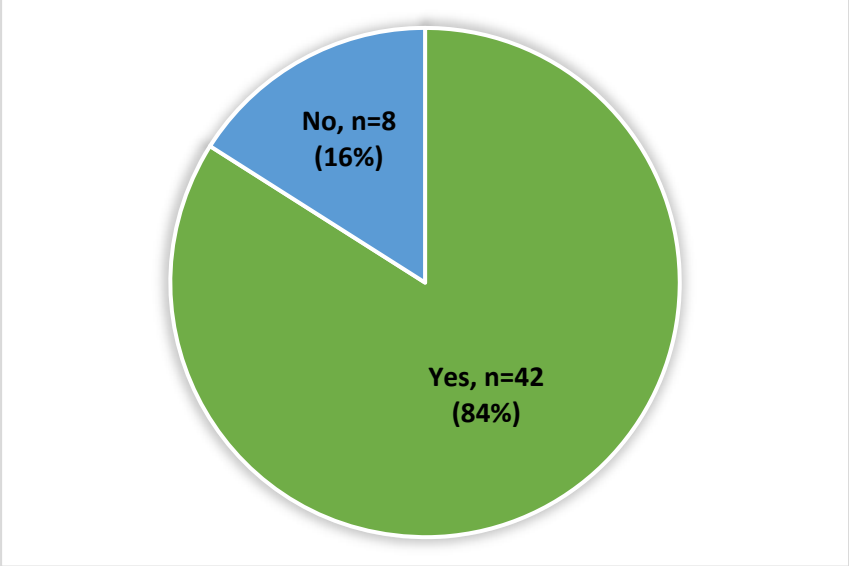

Table 188 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

Response	States	Count	Percentage
Yes	Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, 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, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	42	84.00%
No	Alabama, Colorado, Indiana, Iowa, Michigan, Tennessee, Texas, Wyoming	8	16.00%
Total		50	100.00%

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

Figure 117 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any form of MAT

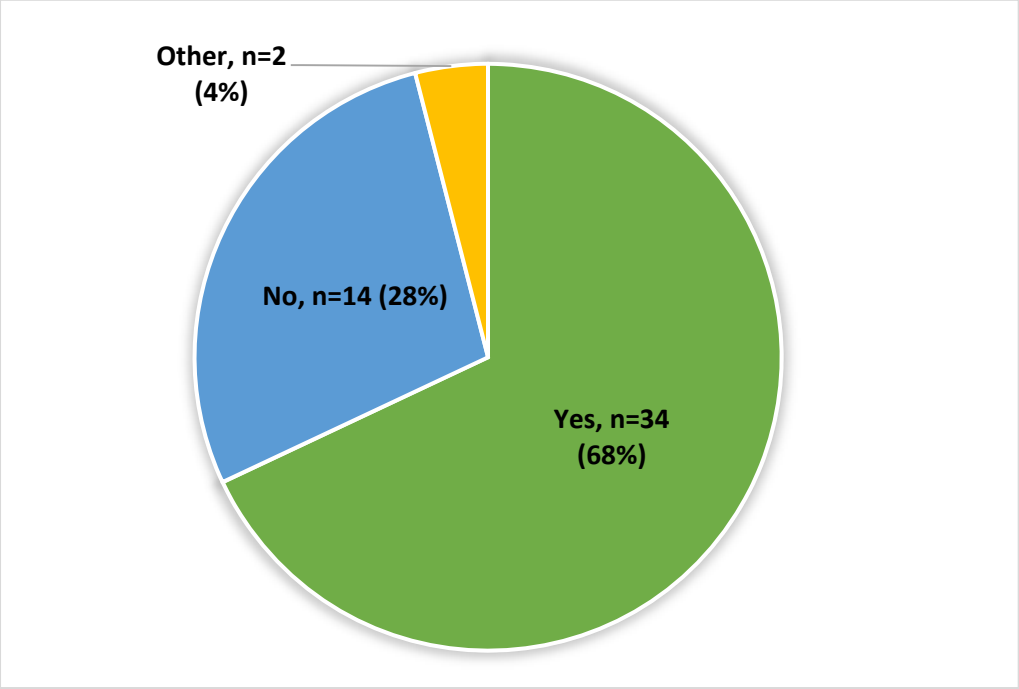

Table 189 - Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any form of MAT

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, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia, Wyoming	34	68.00%
No	Alabama, California, Connecticut, Delaware, Florida, Hawaii, Iowa, Minnesota, Nevada, New Mexico, North Carolina, Oregon, Utah, Washington	14	28.00%
Other	Kansas, Wisconsin	2	4.00%
Total		50	100.00%

If “Other,” please explain.

Table 190 – “Other” Explanations for Edits in Place to Monitor Opioids Being Used Concurrently with any Buprenorphine Drug or any form of MAT

State	“Other” Explanations
Kansas	only for Subutex, with the PA edit
Wisconsin	Wisconsin monitors concurrent use of opioids and MAT treatments through retrospective claims reviews, including lock-in reviews.

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

Figure 118 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with any Buprenorphine Drug or any form of MAT

Table 191 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with any Buprenorphine Drug or any form of MAT

Response	States	Count	Percentage
Yes	District of Columbia, Louisiana, Maryland, Ohio, Rhode Island, Vermont, Virginia	7	20.59%
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 Carolina, South Dakota, Tennessee, Texas, West Virginia, Wyoming	27	79.41%
Total		34	100.00%

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

Figure 119 - Naloxone Opioid Overdose Product Available without Prior Authorization

Table 192 - 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, 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	Iowa	1	2.00%
Total		50	100.00%

7. Do you retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?

Figure 120 - Retrospectively Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

Table 193 - Retrospectively Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

Response	States	Count	Percentage
Yes	Alabama, Alaska, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Kentucky, Michigan, Nevada, North Carolina, Oregon, Pennsylvania, South Dakota, Tennessee, Virginia, Wyoming	19	38.00%
No	Arkansas, District of Columbia, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin	31	62.00%
Total		50	100.00%

Please explain.

Table 194 – Explanations for Retrospectively Monitoring and Managing Appropriate Use of Naloxone to Persons at Risk of Overdose

State	Explanations
Alabama	Retrospective audits reviewing naloxone use.
Alaska	Utilization is reviewed by the DUR committee quarterly.
Arkansas	Prospectively, there is an edit to monitor appropriate use of Naloxone/Opioids. When a second Naloxone claim is billed to Medicaid within a 90 day period, the next opioid claim will deny and require a prior authorization initiated by the prescriber. This specific criterion will exclude terminal cancer patients with a billed diagnosis in the last 365 days. Currently, retrospective monitoring is not done.
California	There have been multiple retrospective reviews to identify persons at risk of overdose. Provider outreach to prescribers is ongoing and information has been provided to these prescribers regarding appropriate use of naloxone. Assembly Bill 2760 (Wood, Chapter 324) was signed into law in 2018 and became effective on January 1, 2019. California prescribers are now required to offer a prescription to a patient for either naloxone or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of opioid-induced respiratory depression, as a rescue medication when one or more of the following conditions are present: 1. The prescription dosage for the patient is greater than or equal to 90 mg MME/day. 2. An opioid medication is prescribed concurrently with a prescription for a benzodiazepine. 3. The patient presents with an increased risk for overdose, including a history of overdose, a history of substance use disorder, or a risk for returning to a high dose of opioid medication to which the patient is no longer tolerant. The bill also requires a prescriber, consistent with the existing standard of care, to provide education on overdose prevention and the use of naloxone or other similar drug approved by the FDA to a patient and his or her designee or, if the patient is a minor, to the patient's parent or guardian.
Colorado	Recommendations to prescribe naloxone to members who are prescribed opioids are communicated peer-to-peer by contracted opioid consultation service providers as part of the retrospective opioid use process.
Connecticut	This RDUR criteria is designed to target recipients receiving opioids who also have specific risk factors for opioid overdose and who did not, within the last 6 months, receive a prescription for naloxone.
Delaware	Naloxone is dispensed at no cost to patient, no copayment and can be prescribed at the discretion of the Pharmacist based on total daily dose of 90MME or greater. Retrospective analysis of claims is reviewed for over dispensing by provider time.
District of Columbia	Program is scheduled to be implemented next fiscal year.
Florida	Opioid prescribing trends and potential fraud and/or abuse are identified via automated claims review by the DUR Board. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
Georgia	Not at the moment, but this is currently being discussed for implementation.
Hawaii	Retrospective annual review of naloxone has found no use for 2019.
Idaho	Our efforts have been directed at ensuring and encouraging concomitant prescribing of naloxone for those at risk. These are based on reviews ensuring at least one concurrent naloxone prescription within the last year for beneficiaries receiving over 90 daily cumulative MME.

State	Explanations
Illinois	State law mandates availability of medications for opioid use disorder and opioid overdose without prior authorization, thus HFS does not manage naloxone use. Naloxone is recommended for patients on chronic opioid therapy as appropriate within the Pain Management Program in the Four Prescription Policy.
Indiana	We are currently evaluating the need for this monitoring and assessment with prescribers.
Iowa	This topic has not been discussed with the DUR Commission. However prior authorization is required for a patient requiring more than 2 doses of naloxone per 365 days. This results in actively engaging the prescriber of the medication to encourage their closer monitoring of the patient. This topic can be taken to a future meeting for additional consideration of initiatives.
Kansas	We have not addressed this part of OUD yet.
Kentucky	Magellan has developed an opioid overutilization report which is reviewed each quarter. It contains several views of opioid users including by MME, ranked by pharmacy/patient/prescriber, concurrent use of potentiators, naloxone coverage. The report is run and reviewed quarterly.
Louisiana	We are under the impression that we are prohibited by federal law (42 CFR Part 2) from retrospective DUR activity that would identify these recipients.
Maine	Currently done on the medical claims side not through the DUR
Maryland	The FFS program does not currently monitor this retrospectively.
Massachusetts	Naloxone is available without prior authorization
Michigan	Naloxone utilization is also included in our comprehensive opioid review.
Minnesota	Currently, this is not monitored.
Mississippi	We have no process in place at this time.
Missouri	MO HealthNet did not monitor for this time period, but has since implemented this.
Montana	We prospectively require providers who are prescribing MAT or opioids over the MME limits to attest that they have reviewed the risk of overdose with their patients and have offered a naloxone prescription.
Nebraska	At time of dispensing, patient counseling is offered.
Nevada	RetroDUR activities include review of high-dose opioids without naloxone rescue.
New Hampshire	Prior authorizations for buprenorphine and opioid products require attestation by the prescriber that a prescription for naloxone is provided.
New Jersey	Monitoring the use of naloxone for members at risk of overdose did not occur during this reporting period. Monitoring started October 2019.
New Mexico	There is a proDUR edit in process for FFY 2020/2021.
New York	This responsibility lies with the Department of Health through the Opioid Overdose Prevention program established in law April 1, 2006. (https://www.health.ny.gov/diseases/aids/consumers/prevention/opioidprevention/factsheet.htm). Eligible providers must establish and maintain a record keeping system and must report administrations of opioid antagonists to the NYS Department of Health.
North Carolina	NC monitors utilization of naloxone retrospectively and reminds pharmacies of the standing order for naloxone.
North Dakota	We will work with our RetroDUR vendor to ensure exception criteria is developed.
Ohio	We do not retrospectively monitor at this time. We do refer to the prescribing guidelines that speak to when naloxone should be prescribed.
Oklahoma	We encourage prescribers to follow guidelines when prescribing opioids. This includes the prescribing naloxone with the opioid script.

State	Explanations
Oregon	For some patients, but not comprehensively - we retrospectively identify patients at high risk of overdose based on dose, number of prescribed drugs, concurrent sedatives and send provider letters recommending prescription of naloxone if appropriate for patients who do not have evidence of a naloxone prescription based on claims history.
Pennsylvania	The RetroDUR program is used to review beneficiary profiles with a prescription for MAT but no naloxone in claims history.
Rhode Island	State law addresses prescribers as being appropriate for prescribing of naloxone with an opioid.
South Carolina	Not currently, On June 5, 2016, S.C. Code Ann. 44-130-40 was amended to allow pharmacists to dispense Naloxone pursuant to a written joint protocol issued by the South Carolina Board of Medical Examiners and the South Carolina Board of Pharmacy without requiring a patient-specific written order or prescription. Additionally, Naloxone was added to the FFS PDL July 1, 2016
South Dakota	RDUR criteria monitors for appropriate dispensing and utilization of naloxone
Tennessee	We have presented a retrospective study on our naloxone use and the use of naloxone in general to our DUR Board, in June of 2017. Our plans for a follow-up retrospective analysis for September, 2019 was not performed as we were not able to meet due to our inability to meet quorum.
Texas	In FFY 2019, state did not conduct retrospective monitoring on appropriate use of naloxone.
Utah	Not implemented at this time.
Vermont	Naloxone is available at various sites around the state through a program with the Vermont Department of Health so that people have various ways of obtaining Narcan. This information would not show up in claims data. The Health Department has partnered with a growing number of community-based organizations to distribute overdose rescue kits containing naloxone. Individuals can get naloxone as well as prevention and overdose response training designed and approved by the Health Department at these distribution sites. Standing Order A standing order from the Commissioner of Health has been in effect since August 2016. The standing order allows any pharmacy to sell naloxone to any person who wants to have it, without a prescription. The order allows insurers and Medicaid to cover the cost so people do not have to pay out of pocket. The current order is effective through August 2021. Vermont Law for Health Care Professionals (18 VSA 4240 (c)) (link is external) This law allows health care professionals acting in good faith to prescribe, dispense and distribute an opioid antagonist to a person who is at risk of overdose or to a family member, friend or other person in a position to help so long as the recipient of the opioid antagonist has completed a prevention and treatment training program approved by the Vermont Department of Health. Unless acting recklessly, with gross negligence or intentional misconduct, a health professional who prescribes, dispenses or distributes an opioid antagoinist under this section shall be immune from civil or criminal liability, regardless of whether the opioid antagonist was administered by or to the person for whom it was provided. https://www.healthvermont.gov/emergency/injury/opioid-overdose-prevention https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Naloxone_Data_Brief_0.pdf
Virginia	DMAS runs a report quarterly looking at members on chronic opioids and that are at a high risk for possible overdose and monitor how many of those members are getting naloxone and how many are not getting naloxone.

State	Explanations
Washington	In FFY 19 WA Medicaid did not have prospective or regularly scheduled retrospective review of concurrent use of opioids and naloxone; only case-by-case ad-hoc review was completed for individual clients being considered for the Lock-In program. Washington Apple Health (Medicaid) is developing reports to measure the SUPPORT Act requirements and will be regularly monitoring opioid use and other medications used concurrently. These reports will include measures looking at MME, co-prescribing, concurrent opioid use with medication assistance treatment drugs, benzodiazepines, sedative hypnotics, and other medications with psychotropic affects. In addition a naloxone indicator will be included in each report to show if the client is receiving naloxone medication. A review of number of clients prescribed and dispensed naloxone will be included in the prescriber and pharmacy reports.
West Virginia	Currently we are not retrospectively monitoring appropriate use of naloxone however we may have the capability to do so.
Wisconsin	Wisconsin has a prospective DUR alert when a claim has an MME of 90 or greater. The alert recommends the dispensing of naloxone.
Wyoming	Program integrity reviews naloxone claims regularly.

8. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?

Figure 121 - States Allow Pharmacists to Dispense Naloxone Prescribed Independently or By Collaborative Practice Agreements, Standing Orders, or Other Predetermined Protocols

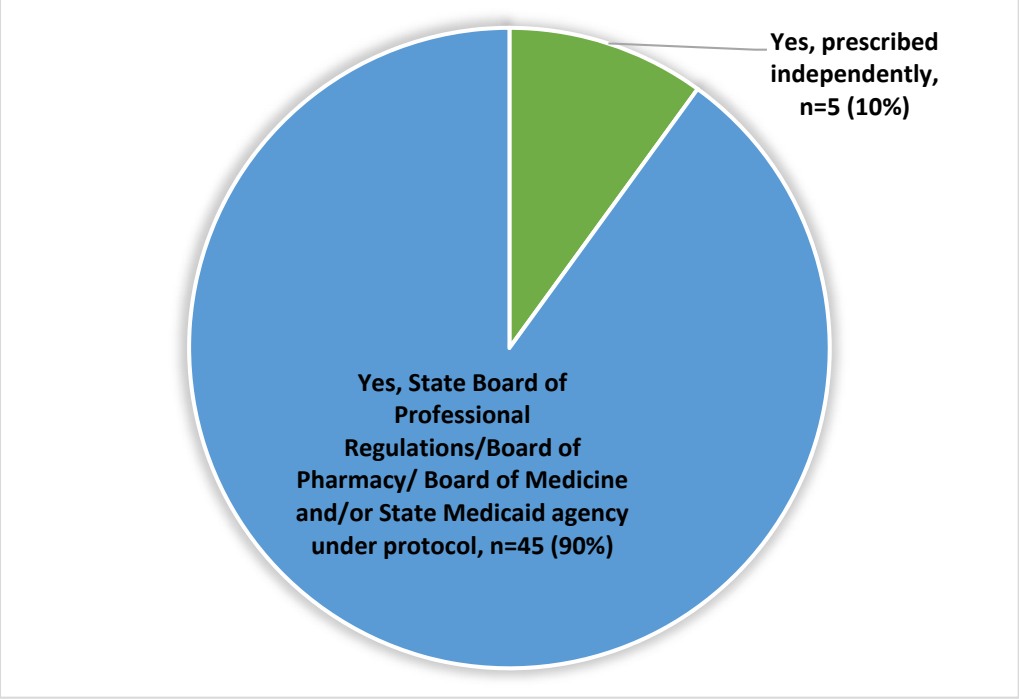

Table 195 - States Allow Pharmacists to Dispense Naloxone Prescribed Independently or By Collaborative Practice Agreements, Standing Orders, or Other Predetermined Protocols

Response	States	Count	Percentage
Yes, prescribed independently	Alaska, Connecticut, Idaho, New Mexico, Wyoming	5	10.00%
Yes, State Board of Professional Regulations/Board of Pharmacy/ Board of Medicine and/or State Medicaid agency under protocol	Alabama, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, 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, West Virginia, Wisconsin	45	90.00%
Total		50	100.00%

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

Figure 122 - State Agency Coverage for Methadone for a Substance Use Disorder

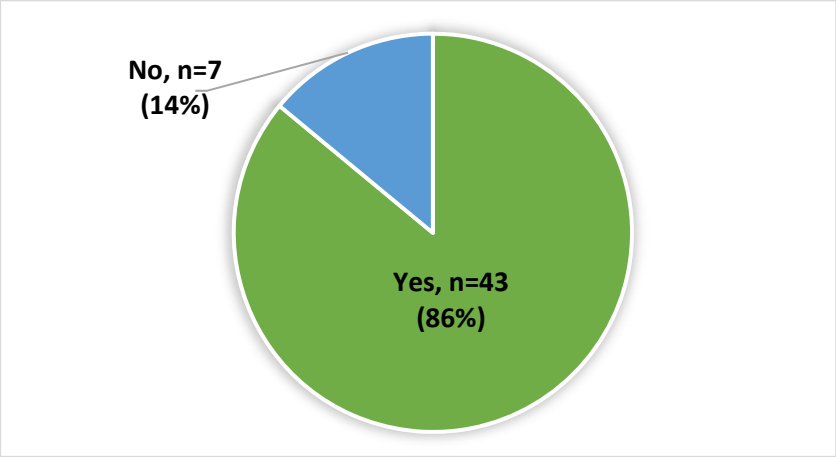

Table 196 - State Agency Coverage for Methadone for a Substance Use Disorder

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, 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, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin	43	86.00%
No	Kansas, Louisiana, Nebraska, North Dakota, Oklahoma, West Virginia, Wyoming	7	14.00%
Total		50	100.00%

G. Antipsychotics / Stimulants

Antipsychotics

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

Figure 123 - Restrictions to Limit Quantity of Antipsychotics

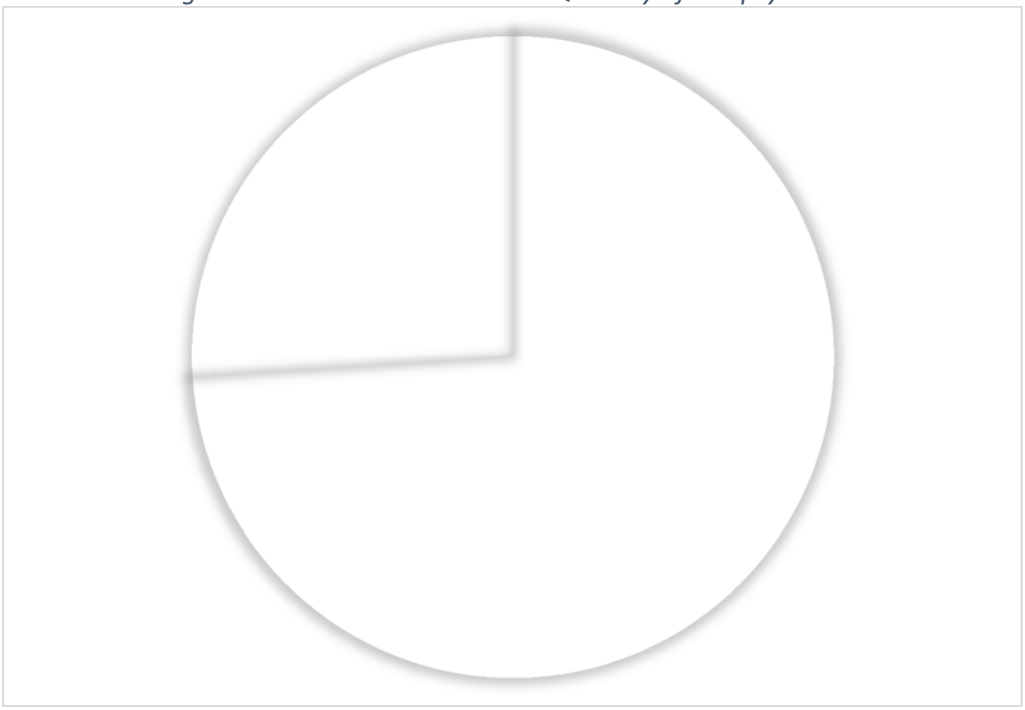

Table 197 - Restrictions to Limit Quantity of Antipsychotics

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Vermont, Virginia, Washington, Wyoming	37	74.00%
No	California, Louisiana, Massachusetts, Michigan, Montana, New Mexico, Oregon, Rhode Island, Tennessee, Texas, Utah, West Virginia, Wisconsin	13	26.00%
Total		50	100.00%

Please explain.

Table 198 - Explanations of Restrictions to Limit Quantity of Antipsychotics

State	Explanations
Alabama	Prior authorization is required for all antipsychotics. 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. Metabolic monitoring is required for children (< 6 years of age) and must be documented on the PA request form.
Alaska	N/A
Arkansas	Oral antipsychotics have maximum dose edits for adults and children with children having specific maximum doses based on age. All new starts of an antipsychotic agent for patients <18 require a prior authorization review by a clinical pharmacist, and any requests for patients <10 require a review by our state clinical pharmacists and chief psychiatrist. A signed guardian informed consent form and metabolic labs are required for children. A therapeutic duplication edit allows a maxiumum of two oral antipsychotic agents or one oral antipsychotic agent and one long-acting injection without an additional TD prior authorization. All new starts for a long-acting injection require a prior authorization. and all LAIs have continuation criteria if the beneficiary remains stable and complaint. Oral and injection antipsychotics are both on our PDL.
California	An approved Treatment Authorization Request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 - 17 years of age. An approved Treatment Authorization Request is also required for beneficiaries residing in skilled nursing facilities (SNFs).
Colorado	Antipsychotic medications also have age limitations.
Connecticut	A quantity limit of 240 units is used.
Delaware	Prior authorization is required if the drug is not FDA approved for the child's age. Claims for doses above normal limits will reject and require prior authorization. We also edit for Therapeutic duplication.
District of Columbia	Injectable antipsychotics are available thru pharmacies enrolled in the Mental Health Network. Some products require a clinical PA as well.
Florida	There are 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	Therapeutic duplication and age edits for the non-dental program. Non-formulary for dental program. Hawaii law requires that Medicaid cover therapeutic agents approved by the FDA for the treatment of mental and emotional conditions. Thus MQD retains or may establish prior authorization requirements or other restrictions for non-FDA approved indications, or for FDA approved agents for non-mental and non- emotional disorders.
Idaho	Limit dose per day. Age limit per FDA approved labeling. Specifically do not allow for less than 6 years without a PA.
Illinois	Group accumulators on long-acting injectable antipsychotics and high dose override for some of the antipsychotics that overrides the Medispan programmed high dose. Also prior authorization is required for use of antipsychotic medications for long-term care residents and for long acting atypical antipsychotics.
Indiana	Age limitations, duplicate therapy edits, low-dose edits, 15-day initial supply limits, and quantity limits.
Iowa	N/A. Quantity limits are only restriction

State	Explanations
Kansas	We have multiple concurrent use limits, dose limits, age limits, and provider type/or in consultation with a psychiatrist, neurologist, or developmental/behavioral pediatrician.
Kentucky	Dose accumulations for many atypical agents.
Louisiana	Louisiana does not limit the quantity of antipsychotics. However, safety edits are in place at POS and include age-maximum dose limits, diagnosis requirements, and therapeutic duplication. Additionally, preauthorization is required for behavioral health agents for recipients less than 6 years old.
Maine	Require prior authorization for use under age 5, for multiple anti-psychotics concurrently, and routinely review metabolic monitoring during use .
Maryland	Antipsychotic Peer Review Program (APRP) and Peer Review Program (PRP) To support providers who prescribe this drug class, the Maryland Medicaid Pharmacy Program (MMPP) has established two programs. These are the Peer Review Program (PRP) and the Tier 2 & Non Preferred (Tier 2 & NP) Antipsychotic Review Program. Non-preferred and Tier 2 clinical criteria. For additional information, please refer to The Program also employs clinical criteria and dose optimization requirements. https://mmcp.health.maryland.gov/pap/Pages/Antipsychotics-Review-Programs.aspx
Massachusetts	Prior authorization is required for polypharmacy with two or more antipsychotics. PA criteria requires documentation of treatment-resistant diagnoses, complete treatment plan including dose, frequency and indication for each antipsychotic, psychiatrist involvement (either as the prescriber or consult notes from the past year) and additional rational for use (cross-taper planned that will result in only one antipsychotic, discharged on polypharmacy after a recent psychiatric hospitalization, or failed trail with two antipsychotics as monotherapy). Dosing is generally managed and monitored with only quantity limits.
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 through FFS.
Minnesota	These limits are based on maximum FDA approved dose per day.
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.
Nevada	Children under age 18 years-old are allowed one antipsychotic without prior authorization.
New Hampshire	Quantity is limited to a 34 day supply.
New Jersey	Maximum daily dose edits are in place for antipsychotics.
New Mexico	Only allow a 34-day supply.
New York	Maximum daily limits have been placed on the following antipsychotics: paliperidone ER; quetiapine; quetiapine ER based upon tablet strength.
North Carolina	Antipsychotics have edits that require Prior Authorization, check for concomitant use, check for quantity limits, daily dose, and maximum quantity.

State	Explanations
North Dakota	We have therapeutic duplication edits to prevent excessive concurrent utilization of antipsychotics.
Ohio	Quantity limits and day supply limits exist
Oklahoma	Prior authorization for members younger than five years of age are reviewed by an OHCA-contracted child psychiatrist. QLs in place bases on FDA approved dosing.
Oregon	N/A
Pennsylvania	Prior authorization and quantity limits.
Rhode Island	n/a
South Carolina	Examples include but not limited to: Prior Authorizations for indication/age as well as edits to identify TD (therapeutic duplication), Overuse
South Dakota	Multiple antipsychotics require PA
Tennessee	N/A. We would like to adhere strictly to quantity limits for APsy, however it would be extremely disruptive to the therapy of our enrollees, who are among the most vulnerable population served by our State. Many of our APsy are used for the worst of the worst cases, and doses have been necessarily and appropriately pushed higher than manufacturer's recommendations.
Texas	N/A
Utah	Comprehensive pediatric antipsychotic policy was implemented effective October 1, 2019. This program includes: 1. age edits, 2. dose edits, 3. metabolic monitoring, 4. diagnosis codes, and 5. quality measure (HEDIS) assessment.
Vermont	Quantity Limits are in place. We also apply Prior Authorization and manage this class on the Preferred Drug List, Antipsychotics are a managed class on the PDL and PA criteria, including dose limitations, for preferred and non -preferred products. Link to the website: https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria
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	For clients 17 years of age and younger WA Medicaid applies age/dose limits to second generation antipsychotics. These limits are set by the Pediatric Mental Health guidelines and all requests to exceed the established thresholds must have a Second Opinion (SON) Review by the Agency's contracted mental health specialist (Seattle Children's).
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 nine years of age who are on an antipsychotic.
Wyoming	Dose is limited to maximum dose in the FDA approved label.

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

Figure 124 - Program in Place for Either Managing or Monitoring Appropriate Use of Antipsychotic Drugs in Children

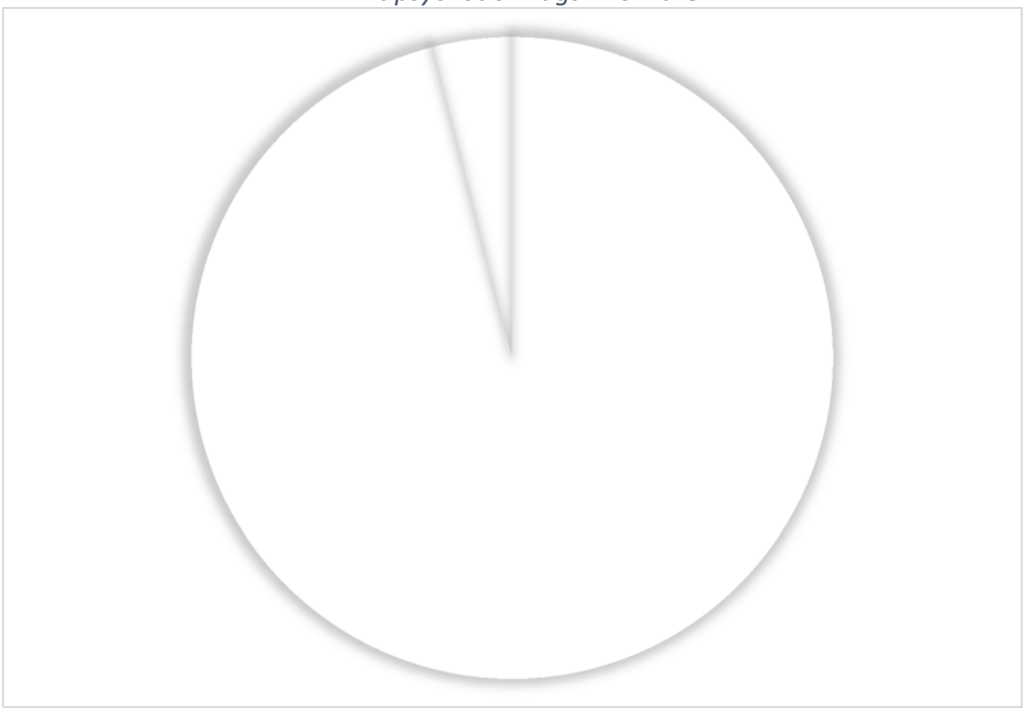

Table 199 - Monitoring Program in Place for Either Managing or Monitoring Appropriate Use of Antipsychotic Drugs in Children

Response	States	Count	Percentage
Yes	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, 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	Hawaii, New Hampshire	2	4.00%
Total		50	100.00%

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

Figure 125 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

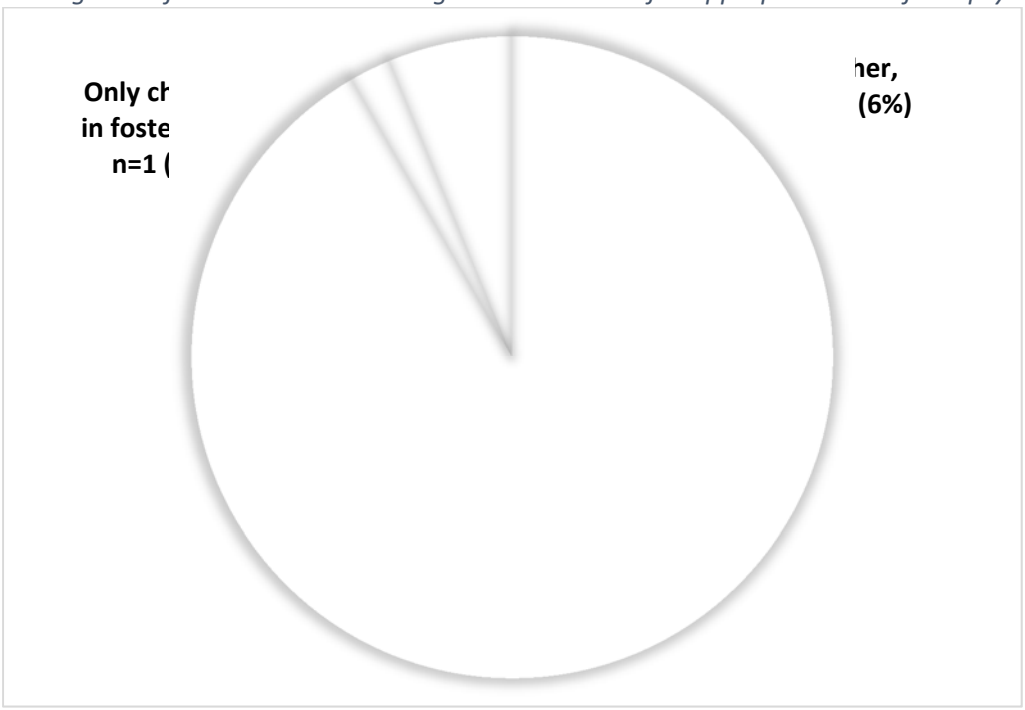

Table 200 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

Response	States	Count	Percentage
All children	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	44	91.67%
Only children in foster care	Oregon	1	2.08%
Other	Illinois, New Mexico, Wisconsin	3	6.25%
Total		48	100.00%

If “Other,” please explain.

Table 201 - “Other” Explanations for Either Managing or Monitoring Categories for Appropriate Use of Antipsychotic Drugs in Children

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	All children including foster children prescribed antipsychotics are identified that have no lab claims for metabolic monitoring and prescribers are notified.
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 (check all that apply):

Figure 126 - Antipsychotic Edits in Place to Monitor for Appropriate Use in Children

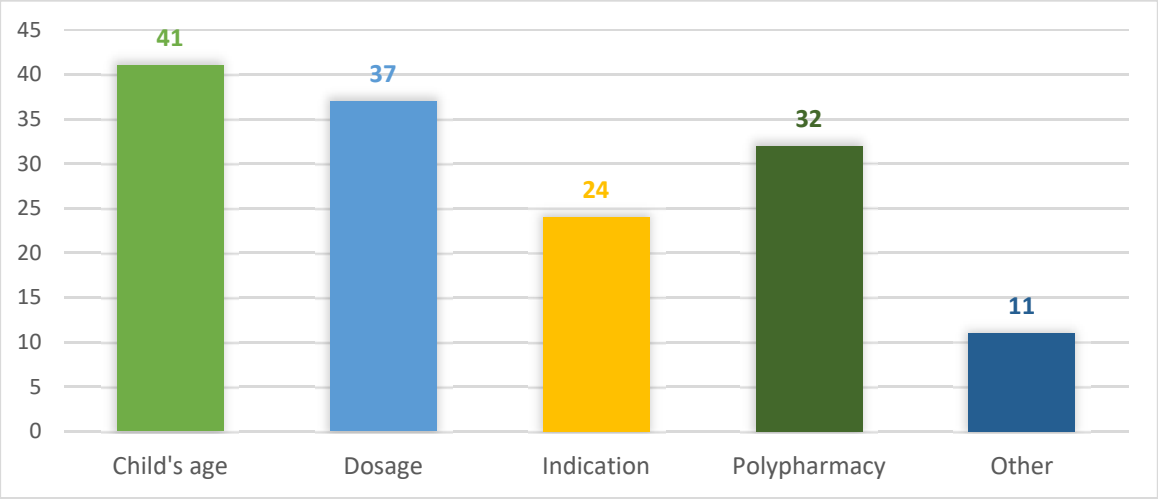

Table 202 - Antipsychotic Edits in Place to Monitor for Appropriate Use in Children

Response	States	Count	Percentage
Child's age	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	41	28.28%
Dosage	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana,	37	25.52%

Response	States	Count	Percentage
	Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming		
Indication	Alabama, Arkansas, California, Colorado, Connecticut, Florida, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Montana, Nevada, New York, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington	24	16.55%
Polypharmacy	Alaska, Arkansas, California, Connecticut, District of Columbia, Florida, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New York, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	32	22.07%
Other	Illinois, Kansas, Louisiana, Maine, Massachusetts, New Mexico, North Carolina, Ohio, Oregon, Rhode Island, Washington	11	7.59%
Total		145	100.00%

If “Other,” please explain.

Table 203 - “Other” Explanations for Antipsychotic Edits in Place to Monitor for Appropriate Use in Children

State	“Other” Explanations
Illinois	Prior authorization for atypical antipsychotics in children < 8 years of age reviews appropriate indication, non-pharmacologic therapy use, and step therapy pre-use of antipsychotics.
Kansas	multiple concurrent drug use and provider type- either at POS or via the PA process
Louisiana	Safety edits are in place at POS and include age-maximum dose limits, diagnosis requirements, and therapeutic duplication. Additionally, preauthorization is required for behavioral health agents for recipients less than 6 years old.
Maine	metobolic monitoring is required and prior authorization if not seen in the members medical claims data.
Massachusetts	Use of behavioral health medications in children, including antipsychotics, 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 antipsychotics) across all behavioral health classes. Also for all children less than 18 years of age, PA is required for polypharmacy with two or more antipsychotics. Additionally, PA is required for antipsychotics for all children less than six years of age.
New Mexico	RetroDUR interventions to identify children prescribed antipsychotics from non-HIS prescribers that require metabolic monitoring.
North Carolina	Require Prior Authorization, check for concomitant use, and quantity limits.
Ohio	We have edits in place that monitor any medication that has a drug interaction when taken with an antipsychotic.
Oregon	No pharmacy POS edits, but monitoring is performed retrospectively
Rhode Island	No edits in place.
Washington	For clients 17 years of age and younger WA Medicaid also applies edits for therapy duplication.

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

Table 204 - Explanations of the specifics for the state Antipsychotic Monitoring Program for Appropriate Use in Children

State	Explanations
Alabama	Prior authorization is required for all antipsychotics. 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. 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	Maximum daily dose edits are in place for beneficiaries < 18 years of age which are specific to different age groups. For all new starts on an antipsychotic agent, children <18 years of age require a prior authorization request which is reviewed by a pharmacist and children <10 years of age also require a consultation with our psychiatrist with submitted chart notes, signed informed consent, and metabolic lab work. Once approved, POS approval criteria requires metabolic lab tests every 6 months for beneficiaries between 10 and 17 years of age. Beneficiaries < 10 years of age do not have POS approval criteria but require a prior authorization once the previous approval ends reviewed by a pharmacist and chief psychiatrist with current chart notes and updated labs every 6 months.
California	An approved Treatment Authorization Request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 - 17 years of age. In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health Division, and California Department of Social Services (CDSS) continue to collaborate on a Quality Improvement Project - Improving the Use of Psychotropic Medication among Children and Youth in Foster Care. The purpose of this program is to reduce the rate of antipsychotic polypharmacy, improve the rate of compliance with age-specific antipsychotic dose recommended guidelines, and improve the rate of children and youth in foster care with at least one psychotropic medication who have an annual metabolic risk assessment. The goals are to reduce polypharmacy and improve compliance with dosing guidelines and annual metabolic risk assessment.
Colorado	Edits are in place to identify doses exceeding maximum and off-label uses based on atypical antipsychotic indications for use and patient age, and require prior authorization potentially involving a child/adolescent psychiatrist consult. Retrospective DUR analysis is conducted and letters are sent to providers regarding pediatric members' use of antipsychotic medications.
Connecticut	Connecticut currently has approximately 40 individual RDUR criteria used to monitor and manage antipsychotic medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly and 1,000 patient profiles are reviewed each month. While there are 12 targeted interventions that occur annually for the pediatric population, antipsychotic medication targeted review and intervention occur at least four times a year. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
Delaware	Delaware monitor all children but in addition we do targeted intervention in the foster care population. 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	Explanations
District of Columbia	Monthly reports monitors opioids and antipsychotics including pediatric patients for age, and dosage limits and poly pharmacy issues. Also POS DUE edits include - ANTICHOLINERGICS/SELECT ANTIPSYCHOTICS, SELECT PHENOTHIAZINES, SELECTED ANTIPSYCHOTICS, TRAMADOL (IR), ANTIPSSYCHOTICS, PHENOTHIAZINES/OPIOIDS, SELECTED ANTIPSYCHOTICS THAT PROLONG QT
Florida	The clinical pharmacist is required to review submissions 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 a Atypical Antipsychotic PA Form. The requests are reviewed on a case-by-case basis by a clinical pharmacist.
Idaho	Targeted DUR interventions for all children less than 6 years old. Currently in process of implementing a specific PA form for that age group which will include an attestation that 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 dose, 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 clinical PA in place and have done a claims review for this drug class as part of preparations for our Mental Health Medication Advisory Committee meetings.
Kentucky	Prospective review at point of sale which requires an indication submitted on claim, in medical history or via PA process. Edit which creates a hard stop/PA required when more than 2 antipsychotics are used concurrently based on pharmacy claims data. Dose accumulations for many atypical agents.
Louisiana	Safety edits are in place at POS and include age-maximum dose limits, diagnosis requirements, and therapeutic duplication. Additionally, preauthorization is required for behavioral health agents for recipients less than 6 years old.
Maine	The DUR sent out over 1800 letters to providers in FFY 2019 regarding the appropriate need for metabolic monitoring with the use of atypical antipsychotics. The communication included monitoring of weight and metabolic parameters including blood pressure, A1c, fasting glucose and fasting lipid profile in accordance with the ADA screening guidelines. The letters also described a process where baseline parameters would be obtained then at 12 weeks follow up labs would be required. Providers that were surveyed were given 20 weeks to obtain and submit the baseline and follow up numbers for review, if this information was not received than further antipsychotic use would require prior authorization to assure proper monitoring. In its review, 30% of members lack proper documentation of routine monitoring.
Maryland	In October 2011 Maryland Medicaid established the peer review program for mental health drugs. This peer reviewed authorization process informs clinicians of relevant pharmacologic and non-pharmacologic information for decision making and ensures the appropriate use while

State	Explanations
	limiting adverse sequelae in the program's vulnerable pediatric population. The program initially addressed the use of antipsychotics in participants under the age of 5 years. During FFY 2013, the program was expanded to include all participants less than 10 years of age. As of January 2014, the program encompasses all participants less than 18 years of age.
Massachusetts	PA criteria varies by restriction but generally requires documentation of a complete treatment plan including the name dose and frequency of all behavioral health medications with associated diagnosis or target symptom, a comprehensive treatment plan including non-pharmacologic interventions, psychiatrist involvement (either as the prescriber or consult notes from the past year). For antipsychotic polypharmacy additional requirements include two failed trials with antipsychotic mono-therapy and if treatment beyond one year, rational for continued use of polypharmacy (e.g., previous efforts to reduce/simplify the antipsychotic regimen in the past 24 months resulted in symptom exacerbation, family/caregiver does not support the antipsychotic regimen change at this time due to risk of exacerbation, other significant barrier for antipsychotic therapy discontinuation. Dosing is generally managed and monitored through quantity limits. All member cases (PAs) evaluated through the initiative are evaluated on a case-by-case basis to determine if there are additional high-risk factors for additional, individualized case review by multidisciplinary team (psychiatrists, pharmacists, social worker). This comprehensive review evaluates all aspects of the child's case (diagnosis, medication regimen and indications, dosing, drug-drug and drug-disease interactions, non-pharmacologic and psycho social services, pharmacy and medical claims history, context of care, custody status, etc). For cases where the team identifies unnecessary or redundant medication use or if the team has other concerns, a peer-to-peer discussion may be required between the member's prescriber and a psychiatrist associated with the initiative.
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. We also have a Foster Children Psychotropic Medication Oversight Unit that monitors informed consents, utilization trends and performs psychiatrist to prescriber education/outreach if any concerning utilization trends are identified (e.g. multiple concurrent antipsychotics).
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 criteria regarding psychotropic drug use in youth.
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	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 no more than 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. Dose and indication are also reviewed. Case management is provided for all foster children taking psychotropics. These are reviewed for dosage, quantity, 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	Recipients under 18 years old are limited to a single anti-psychotic without PA. Children under 18 years of age are allowed one product from three of the following classes (antipsychotic, sedative/hypnotic, anticonvulsant, antidepressant or benzodiazepine) without prior

State	Explanations
	authorization. The fourth medication requires prior authorization and two or more medications within the same class require prior authorization. All antipsychotics for children under six years of age require prior authorization.
New Jersey	As of 10/1/2019, maximum daily dose edits were updated to apply to antipsychotic drugs in children.
New Mexico	Require glucose and lipid monitoring for children on second generation antipsychotics.
New York	Point of service prior authorization if established DUR clinical criteria is not met as previously cited above. Step therapy trial with at least two different antidepressant agents when a Second-Generation Antipsychotic is used in the treatment of a major depressive disorder in the absence of other psychiatric co-morbidities. F/Q/D requirements for the following agents: paliperidone ER, quetiapine, quetiapine ER, quetiapine XR. Dose optimization.
North Carolina	The NC Medicaid Outpatient Pharmacy antipsychotic monitoring programs are A+KIDS, ASAP and select Behavioral Health (BH) Clinical Edits. A+KIDS - The objective of the A+KIDS program is improvement in adherence to recommended safety monitoring parameters when any antipsychotics is prescribed for beneficiaries aged 0 - 17. Documentation of safety monitoring measures is requested for any of the following occurrences: the antipsychotic is prescribed for an indication that is not approved by the FDA; the antipsychotic is prescribed at a higher dosage than approved by the FDA for a specific indication; or the prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents. A+KIDS targets metabolic adverse effects. ASAP - The objective of the ASAP program is improvement in adherence to recommended safety monitoring parameters when an antipsychotics is prescribed for beneficiaries aged 18 and over. Documentation of safety monitoring measures is requested for any of the following occurrences: the antipsychotic is prescribed for an indication that is not approved by the FDA; the antipsychotic is prescribed at a higher dosage than approved by the FDA for a specific indication; or the prescribed antipsychotic will result in the concomitant use of two or more antipsychotic agents. The ASAP program is implemented for atypical antipsychotics, targets metabolic adverse effects and is exempted for beneficiaries with any psychosis diagnosis. Behavioral Health Clinical Edits - These POS clinical edits include atypical antipsychotics triggers. For an atypical antipsychotic claim, if the dosage and quantity prescribed exceeds the FDA approved maximum dosage, dosage frequency or meets the definition of in class therapeutic duplication, the claim denies. To override the edit, the pharmacist can contact the prescriber to obtain clinical rationale for the therapy issue identified by the edit. These utilization management edits are implemented for pediatrics and adults.
North Dakota	Age edits are in place on antipsychotics to prevent use outside of FDA approved use. Maximum dose limitations and diagnosis edits are set so dosages don't exceed compendia supported use and diagnoses are FDA label or compendia supported.

State	Explanations
Ohio	Prospective edits to monitor dose, day supply and polypharmacy. Soft DUR drug-drug interactions messaging.
Oklahoma	Educational mailings to prescribers of psychotropic drugs used in children. Particularly when prescribers deviate from evidence-based norms in patient population. Academic Detailing
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 the use of an antipsychotic drug and stimulant in children. Critieria is monitored monthly. If a reviewer identifies an issue a letter is sent to the prescriber.
South Carolina	Claims/PA edits for products (indication/dose/quantity). RetroDUR "runs" have also been run for polypharmacy.
South Dakota	Prescriptions for all children under six years of age require prior authorization and consultation with a psychiatrist. Use of multiple agents in all children requires PA and consultation with a psychiatrist. P&T Committee is currently working to identify additional criteria that may be effective in decreasing the use of antipsychotics in children.
Tennessee	Our APsy monitoring program is not managed or governed by the DUR Board, and is instead managed via TennCare's Mental Health unit, the Department of Health and Vanderbilt University.
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	Comprehensive pediatric antipsychotic policy was implemented effective October 1, 2019. This program includes: 1. age edits, 2. dose edits, 3. metabolic monitoring, 4. diagnosis codes, and 5. quality measure (HEDIS) assessment.
Vermont	We participate in a multi-departmental Psychotherapeutic Monitoring Committee which looks at children in and out of foster care, reviewing utilization trends of all psychotherapeutic drugs. The Committee refers issues to DVHA or the DUR Board as necessary for action, and also performs outreach and education. SUMMARY Objective: The primary goal of this study was to estimate and analyze PMQIC common measures in Vermont Medicaid pharmacy program over time for federal fiscal years (FFY) from 2013 through 2020. Method: Pharmacy claims for psychotropic medications paid by the Department of Vermont Health Access (DVHA), Vermont Medicaid pharmacy program, with dates of services between April 1, 2013 and March 31, 2019 were analyzed. The study examined the PMQIC common measures on a semiannual basis for the following 12 six-month periods: 2nd half of FFY 2013, 1st and 2nd halves of FFY 2014, 1st and 2nd halves of FFY 2015, 1st and 2nd halves of FFY 2016, 1st

State	Explanations
	and 2nd halves of FFY 2017, 1st and 2nd halves of FFY 2018, 1st and 2nd halves of FFY 2019, and 1st half of FFY 2020. The study estimated and evaluated the following nine PMQIC common measures: 1) Percentage of children in foster care on any psychotropic medication, 2) Percentage of children in foster care on a specific class of medication, 3) Percentage of children in foster care on more than one psychotropic medication from the same class simultaneously for 90 days or more (defined above as co-pharmacy), 4) Percentage of children in foster care on 2 psychotropic medications; 3 psychotropic medications and 4 plus psychotropic medications (regardless of their drug class) simultaneously for 90 days or more, 5) Percentage of children in foster care < 6 years old on any psychotropic medication, 6) Percentage of children in foster care < 6 years on 2; 3 and 4 plus psychotropic medications (regardless of their drug class) simultaneously for 90 days or more, 7) Percentage of children in foster care < 6 years old on any antipsychotic medication, 8) Percentage of children in foster care on more than one antipsychotic simultaneously for 45 days or more, 9) Percentage of children in foster care who are continuously on an antipsychotic for more than 1 year. The study also estimated the above-mentioned measures for non-foster care children as a comparison group. The study reviewed trends for both foster care and non-foster care groups of children over the mentioned time frames. The study also estimated the common measures for different age and gender groups.
Virginia	ALL antipsychotics for children 0 to 17 years of age (preferred and nonpreferred) require the submission of a Clinical Service Authorization.
Washington	In collaboration with The Pediatric Mental Health Advisory Group and the Drug Utilization Review Board, HCA has established pediatric mental health guidelines to identify children who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers. For antipsychotics exceeding the established thresholds for age/dose, therapy duplications, or included in polypharmacy (defined as the use of five or more psychotropic medications) a SON review is required.
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 Medicaids consultant psychiatrist.
Wisconsin	Wisconsin monitors the use of antipsychotic drugs in young children (less than 9 years of age) 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. In addition, Wisconsin monitors the use of multiple antipsychotics in all children 18 years of age and younger. Contracted child psychiatrist reviews the doses the child is on and perform peer to peer outreach calls when needed to discuss a specific case with the prescriber. Wisconsin has retrospective DUR criteria to review antipsychotic drug prescribing that are not indicated for use in children.
Wyoming	Children aged 5 and under require prior authorization for all antipsychotics. Additionally, children under age 9 require prior authorization for Latuda and Saphris, and all children under age 18 require prior authorization for Fanapt. Dosage is limited to the maximum dose in FDA

State	Explanations
	approved labeling. Prior authorization is required for use of an injectable and oral dosage form concurrently. A retrospective review of children is regularly completed for polypharmacy. Any child receiving 5 or more mental health drugs from any class is referred to Seattle Children's for independent review.

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

Figure 127 - Future Monitoring Program for Appropriate Use of Antipsychotic Drugs in Children

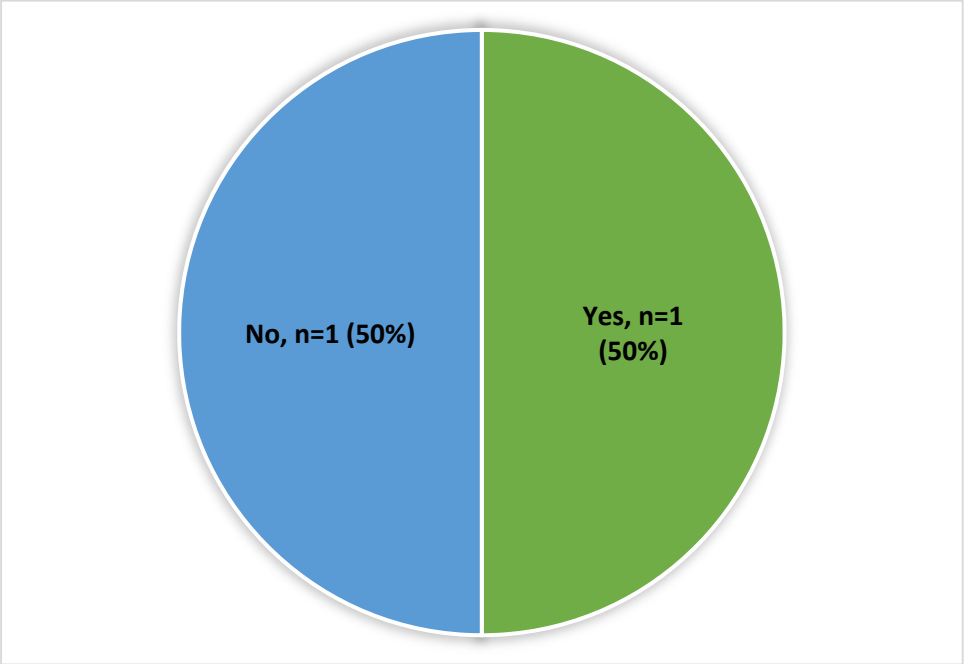

Table 205 - Future Monitoring Program for Appropriate Use of Antipsychotic Drugs in Children

Response	States	Count	Percentage
Yes	New Hampshire	1	50.00%
No	Hawaii	1	50.00%
Total		2	100.00%

If "Yes," when do you plan on implementing a program?

Table 206 - Explanations for Implementing a Program to Monitor Appropriate use of Antipsychotic Drugs in Children

State	Explanations
New Hampshire	Program will be implemented in FFY2020

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

Table 207 - Explanations for not Implementing a Program to Monitor Appropriate use of Antipsychotic Drugs in Children

State	Explanations
Hawaii	Services are rendered elsewhere. The majority of children prescribed antipsychotic 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 and 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 optimal results". For those outside of the program, an annual review of age and drug found no occurrence in 2019.

Stimulants

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

Figure 128 - Restrictions in Place to Limit the Quantity of Stimulants

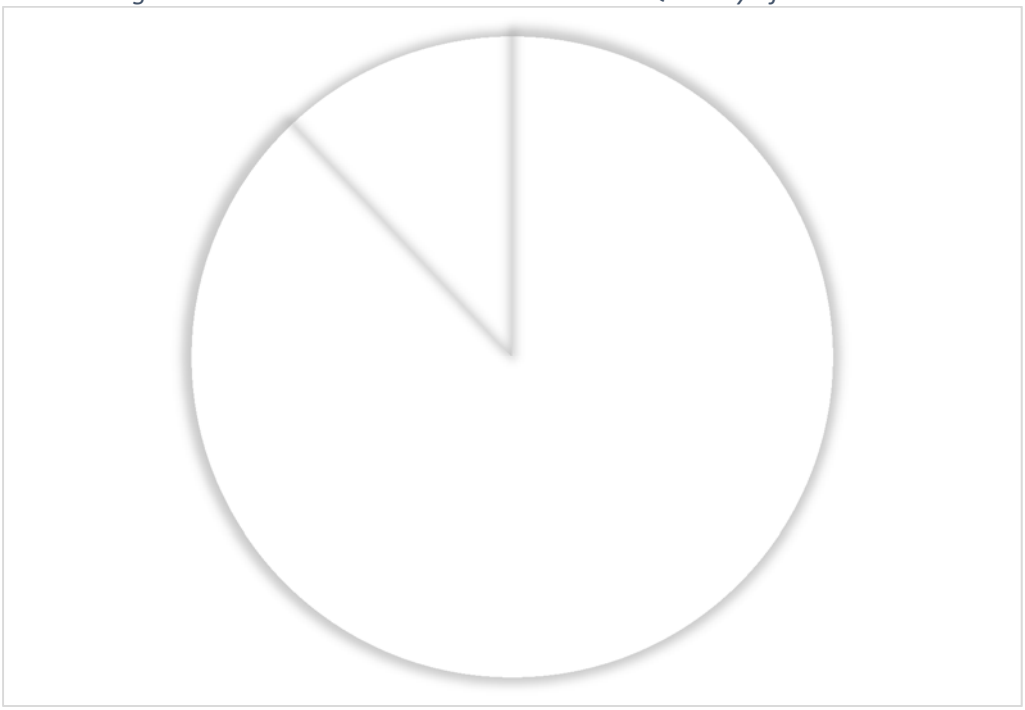

Table 208 - Restrictions in Place to Limit the Quantity of Stimulants

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 Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	88.00%
No	California, Louisiana, Maryland, Rhode Island, Texas, Utah	6	12.00%
Total		50	100.00%

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

Figure 129 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

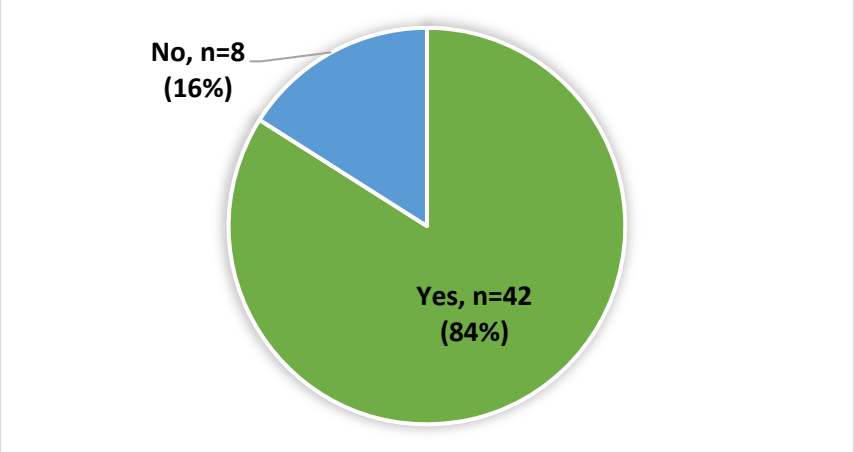

Table 209 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

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 Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	42	84.00%
No	Alaska, District of Columbia, Hawaii, Maryland, New Mexico, South Dakota, Tennessee, Utah	8	16.00%
Total		50	100.00%

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

Figure 130 – Categories of Children Either Managing or Monitoring the Appropriate Use of Stimulant Drugs

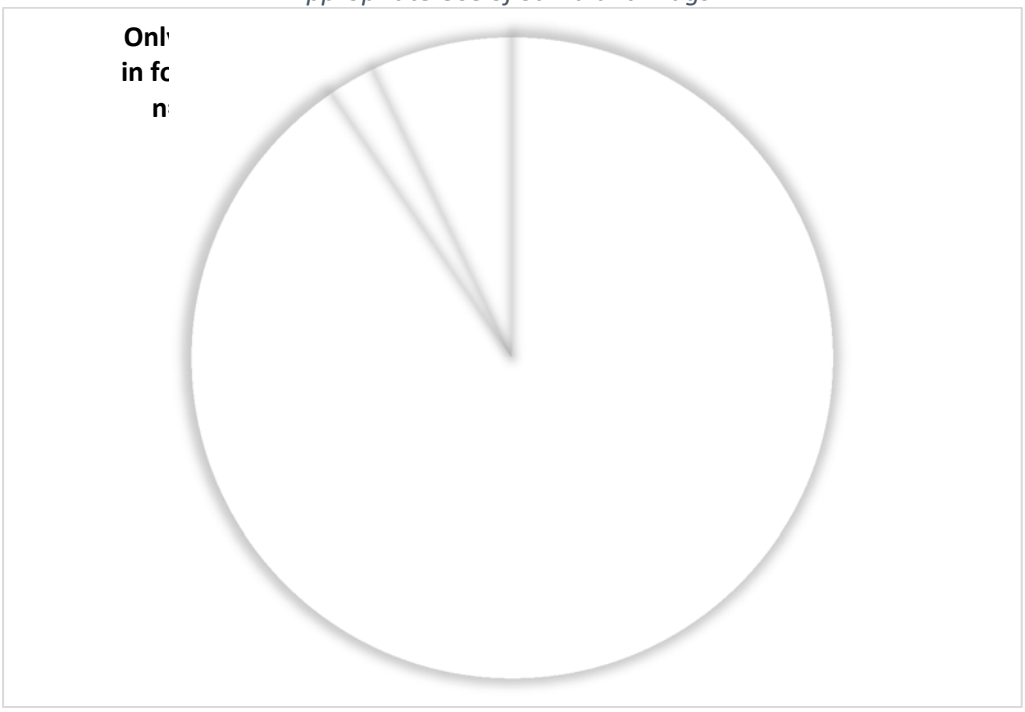

Table 210 - Categories of Children Either Managing or Monitoring the Appropriate Use of Stimulant Drugs

Response	States	Count	Percentage
All children	Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	38	90.48%
Only children in foster care	Montana	1	2.38%
Other	Illinois, Massachusetts, Wisconsin	3	7.14%
Total		42	100.00%

If “Other,” please explain.

Table 211 - “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. DocAssist referral by prior authorization staff to address stimulant use in younger children. Child psychiatrists from DocAssist review specific cases and discussed cases with prescriber.
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.
Wisconsin	Wisconsin has a quantity limit and diagnosis restriction for all stimulants both for children and adults.

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

Figure 131 - Edits in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

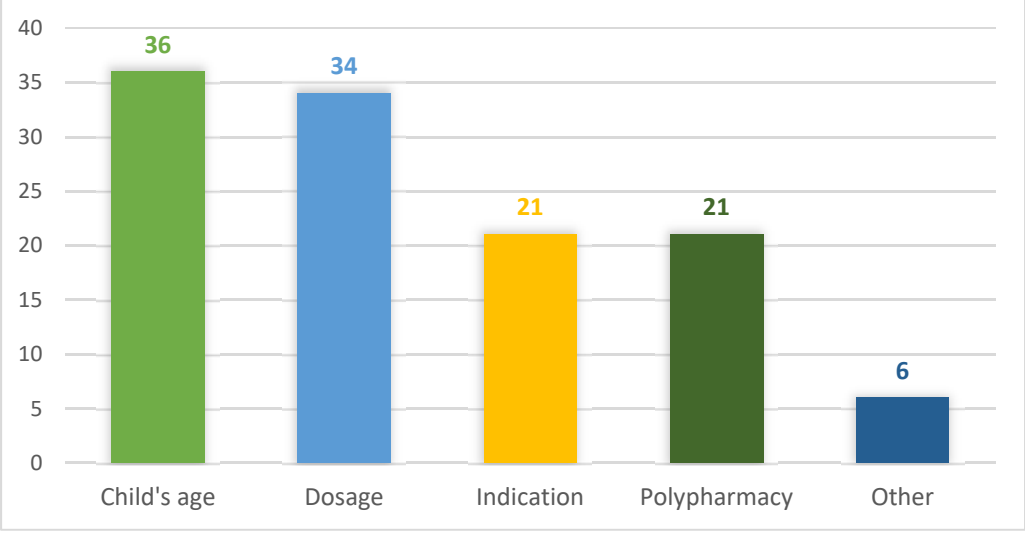

Table 212 - Edits in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

Response	States	Count	Percentage
Child's age	Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, Wyoming	36	30.51%
Dosage	Alabama, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Vermont, Virginia, Washington, West Virginia, Wyoming	34	28.81%
Indication	California, Colorado, Connecticut, Florida, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Missouri, Montana, Nevada, New York, North Dakota, South Carolina, Texas, Vermont, Virginia, Washington, Wisconsin	21	17.80%
Polypharmacy	Arkansas, Connecticut, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Montana, New York, North Carolina, North Dakota, Ohio, Texas, Vermont, Virginia, Washington, West Virginia	21	17.80%
Other	Kansas, Louisiana, Massachusetts, Ohio, Rhode Island, Washington	6	5.08%
Total		118	100.00%

If “Other,” please explain.

Table 213 - “Other” Explanations to Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

State	“Other” Explanation
Kansas	Must be prescribed by or in consultation/collaboration with a child and adolescent psychiatrist, pediatric neurologist, or developmental-behavioral pediatrician. Either an edit or via the PA process.
Louisiana	Preauthorization is required for ADHD agents for recipients less than 6 years old. POS edits include diagnosis requirement, therapeutic duplication of short acting ADHD agents, of long acting ADHD agents, and ADHD agents from different prescribers.
Massachusetts	PA criteria varies by restriction, but polypharmacy generally requires documentation of a complete treatment plan including the name dose and frequency of all behavioral health medications with associated diagnosis or target symptom, a comprehensive treatment plan including non-pharmacologic interventions, psychiatrist involvement (either as the prescriber or consult notes from the past year), trial with stimulant monotherapy and rationale for the stimulant polypharmacy. PA criteria for children less than three years of age requires an appropriate diagnosis and clinical rationale for use of the stimulant in a very young child. Dosing is generally managed and monitored through quantity limits

State	"Other" Explanation
Ohio	We have edits in place that monitor any medication that has a drug interaction when taken with a stimulant.
Rhode Island	No edits
Washington	For client 17 years of age and younger WA Medicaid also applies edits for therapy duplication.

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

Table 214 - Explanations of the specifics for the state Stimulant Monitoring Program for Children

State	Explanations
Alabama	All stimulants have quantity limits.
Arkansas	All stimulant requests for children 4 years old and younger require a manual review PA by the Medicaid Pharmacy Program psychiatrist. Therapeutic duplication edits are in place. The criterion allows concurrent therapy for children <18 years of age for both a long-acting agent and a short-acting agent as a booster dose. The criterion allows only one tablet per day for the booster dose of the short-acting agent if there is an overlap in the days' supply between the long-acting agent and the short-acting agent. Generic Strattera will process without a PA, but also carries therapeutic duplication edits with CII stimulants. All CII stimulants have quantity/dosing edits. CII stimulants are on the Arkansas Medicaid PDL. All patients 18 years and older prescribed CII stimulants will need a PA submitted by their provider with documentation of medical necessity.
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 are in place to identify when maximum doses are exceed and off-label uses based on stimulant indications or use and patient age and may require prior authorization and a child/adolescent psychiatrist prescriber consult. Retrospective DUR analysis is also conducted and letters are sent to providers regarding the use of stimulant medications in the pediatric population.
Connecticut	Connecticut currently RDUR criteria used to monitor and manage stimulant medication in all children, including foster care children, enrolled in the Medicaid program. Retrospective review of the pediatric population occurs monthly and 1,000 patient profiles are reviewed each month. While there are 12 targeted interventions that occur annually for the pediatric population, stimulant medication targeted review and intervention occur at least once a year. These interventions include selection and review of patients, targeted intervention letters mailed to selected patient prescribers, and outcomes reporting to the DUR Board.
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 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 limitations 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	Medicaid pharmacist review of those not meeting (falling out of) specified PA (edit) criteria.

State	Explanations
Illinois	All attention deficit hyperactivity medications (ADHD) in children less than 6 years of age require a special prior authorization request form. Form is available at https://www.illinois.gov/hfs/SiteCollectionDocuments/ADHDkids6122916HFSWEB007R416007.pdf
Indiana	Stimulants require prior authorization when used in duplication or when a drug-specific quantity and age limits have been exceeded.
Iowa	Age - ProDUR age edit on stimulants claim rejects for: amphetamines (excluding Adderall XR and Dexedrine ER) < 3 years of age; Dexmethylphenidate, methylphenidate, atomoxetine, Adderall XR and Dexedrine ER < 6 years of age. Dosage - Prior authorization is required for stimulants above the set quantity limit. Additionally, prescribers are required to check the Iowa PMP for any stimulant that requires PA.
Kansas	We have a clinical PA in place and have done a claims review for this drug class as part of preparations for our Mental Health Medication Advisory Committee meetings.
Kentucky	Prospective review at point of sale which requires an indication submitted on claim, in medical history or via PA process. Edit which creates a hard stop/PA required when more than 1 short- and 1 long- acting stimulant are used concurrently based on pharmacy claims data. Dose accumulations for all stimulants and age limits corresponding to the FDA approval on newer formulations.
Louisiana	Preauthorization is required for ADHD agents for recipients less than 6 years old. 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	All member cases (PAs) evaluated through the initiative are evaluated on a case-by-case basis to determine if there are additional high-risk factors for additional, individualized case review by multidisciplinary team (psychiatrists, pharmacists, social worker). This comprehensive review evaluates all aspects of the child's case (diagnosis, medication regimen and indications, dosing, drug-drug and drug-disease interactions, non-pharmacologic and psychosocial services, pharmacy and medical claims history, context of care, custody status, etc.). For cases where the team identifies unnecessary or redundant medication use or if the team has other concerns, a peer-to-peer discussion may be required between the member's prescriber and a psychiatrist associated with the initiative.
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. Specific to Foster Children, our Psychotropic Medication Oversight Unit regularly monitors stimulant usage and performs additional education/outreach if warranted with prescribers via our contract psychiatrist.
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 and indication edits follow FDA approved or compendia supported diagnoses.
Missouri	For children 0 to 6 years old, stimulants deny at point of sale and must be reviewed by a clinical consultant for approval or denial. For children 6 to 18 years old, stimulants will auto approve as long as they have an appropriate diagnosis on file and the dose does not exceed recommended maximum limitations.

State	Explanations
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.
Nevada	Prior authorization is required for all stimulant use for children. More than one agent including more than one long-acting agent requires prior authorization and clinical justification.
New Hampshire	Dosage and quantity per day is reviewed on all claims.
New Jersey	Pharmacy claims exceeding the set maximum daily dosage deny at POS for all stimulants drugs in children and adults.
New York	Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication for beneficiaries <18 years of age and beneficiaries 18 years of age and older. Confirm diagnosis that supports the concurrent use of a Second- Generation Antipsychotic and a CNS stimulant for patients<18 years of age. PA requirement required for initial prescriptions for stimulant therapy for beneficiaries less than 3 years of age. Quantity limits based on daily dosage as determined by FDA labeling. Patient-specific considerations for drug selection include treatment of excessive sleepiness associated with shift work sleep disorder, narcolepsy, or as an adjunct to standard treatment for obstructive sleep apnea.
North Carolina	Edits are in place to limit quantities based on maximum daily dose approved by the FDA and FDA approved pediatric age ranges. ProDUR edits limit claims from multiple pharmacies and concurrent use of drugs from the same drug class.
North Dakota	We have an edit in place to identify when children are prescribed their 5th psych medication.
Ohio	Prospective edits to monitor dose, day supply and polypharmacy. Soft DUR drug-drug interactions messaging.
Oklahoma	Children under 5 require psychiatric consultation. 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	DUR Board reviews patients on stimulants.
South Carolina	Claims edits/Prior authorization for age/dose/indication in children. In addition, criteria in place for products for Narcolepsy in adults.
Texas	The criteria for the stimulants is a part of the Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD) Medications clinical prior authorization. The clinical criteria are divided into 4 sections: the immediate release (IR)stimulants, the extended release (ER) stimulants, the nonstimulants (except clonidine ER), and clonidine ER. For the IR formulation, we check for age, diagnosis, no diagnosis of substance abuse disorder, maximum daily dose based on the FDA approved indications or the national peer-reviewed guidelines, and no concomitant use of two or more IR formulations. For the ER formulation the criteria check for a minimum age of 6, diagnosis of ADD/ADHD, no diagnosis of substance use disorder found, maximum daily does based on the FDA approved indications or the national, peer reviewed guidelines, and no concomitant use of two or more ER

State	Explanations
	formulations. For clients older than 19 years of age, client must have a documented diagnosis of ADD/ADHD. The concomitant use of and IR and an ER formulation, as well as, the concomitant use of either of the above formulations with a non-stimulant is permitted.
Vermont	We participate in a multi-departmental Psychotherapeutic Monitoring Committee which looks at children in and out of foster care, reviewing utilization trends of all psychotherapeutic drugs. The Committee refers issues to DVHA or the DUR Board as necessary for action, and also performs outreach and education.
Virginia	*All stimulants (preferred and non-preferred) require the submission of Clinical Service Authorization if prescribed for a child less than four or an adult eighteen years and older. Stimulants prescribed for children under the age of four (4) must be prescribed by pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician or in consultation with one of these specialists. The patient must have a diagnosis of ADHD. The prescriber must have reviewed the Virginia PMP on the date of the request. The prescriber has ordered and reviewed a urine drug screen (UDS) prior to initiating treatment with the requested stimulant within 30 days of this request and a copy of the most recent UDS is attached. (The urine drug screens MUST check for benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates). For maintenance: the practitioner must have checked the PMP at least every three months after the initiation of treatment. The practitioner has ordered and reviewed a random urine drug screen at least every six months. The practitioner has regularly evaluated the patient for stimulant and/or other substance use disorder, and, if present, initiated specific treatment, consulted with an appropriate health care provider, or referred the patient for evaluation for treatment if indicated.
Washington	In collaboration with The Pediatric Mental Health Advisory Group and the Drug Utilization Review Board, HCA has established pediatric mental health guidelines to identify children who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers. For stimulants exceeding the established thresholds for age/dose, therapy duplications, or included in polypharmacy (defined as the use of five or more psychotropic medications) a SON review is required.
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 shortacting 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	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, 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. Wisconsin also has a quantity limit for all stimulant drugs.
Wyoming	Prior authorization is required for children under the age of 4. Dosages are limited to the maximum dose in FDA approved labeling.

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

Figure 132 - Future Implementation of a Stimulant Monitoring Program for Children

Table 215 - Future Implementation of a Stimulant Monitoring Program for Children

Response	States	Count	Percentage
Yes	Alaska, District of Columbia, Maryland, New Mexico, South Dakota, Tennessee, Utah	7	87.50%
No	Hawaii	1	12.50%
Total		8	100.00%

If “Yes,” when do you plan on implementing a program?

Table 216 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Stimulant Drugs in Children

State	Explanations
Alaska	Yes future. Alaska medicaid currently requires diagnosis codes for all stimlulants age 21 and up.
District of Columbia	Program is scheduled for implementation in the next fiscal year.
Maryland	TBD
New Mexico	This will be part of the new MMIS replacement implementation in FFY 2021 or 2022.
South Dakota	Currently being reviewed by the P&T Committee for appropriate edit recommendations.
Tennessee	Unsure. However it is in planning stages today, not DUR Board related, and prompted via legislation
Utah	The program to monitor and manage the appropriate use of stimulant drugs in children begins 2020.

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

Table 217 - Explanations for not Implementing a Program to Monitor the Appropriate Use of Stimulant Drugs in Children

State	Explanations
Hawaii	Like antipsychotics, services are rendered elsewhere. The majority of children prescribed antipsychotic 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 and 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 optimal results". For those outside of the program, an annual review of age and drug found no occurrence in 2019.An annual review of age and drug found no occurrence in 2019.

IX - Innovative Practices

1. Summary 6 - Innovative Practices

Summary 6 - Innovative Practices should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing).

Table 218 - Summary 6 - Innovative Practices

State	Explanations
Alabama	Innovative Practices for Federal Fiscal Year 2019 The Alabama Medicaid Agency has several innovative practices that improve the administration of the Drug Utilization Review (DUR) program. In addition to a DUR program that consists of Prospective and Retrospective DUR, Academic Detailing and continuous education for providers, the following other practices were implemented during the FFY 2019. Increase the refill tolerance threshold for agonist and partial agonist opioids from 75% to 85% of the original days' supply Add Xofluza to the Preferred Drug List (PDL) as a preferred agent Require PA for ritonavir (generic Norvir); DAW Code of 9 allowed for brand Norvir Require PA for tobramycin/dexamethasone ophthalmic drops (generic Tobradex), albuterol HFA (generic ProAir HFA and Proventil HFA), and fluticasone/salmeterol inhalation device (generic Advair Diskus) ; DAW Code of 9 allowed for Tobradex, ProAir HFA, Proventil HFA, and Advair Diskus. Remove PA from budesonide respules (generic Pulmicort); brand Pulmicort Respules will require PA Include the Growth Hormone Agents in the Preferred Drug List (PDL). Preferred agents will be preferred with clinical criteria Begin with a Cumulative Daily Morphine Milligram Equivalent (MME) edit phase-in period for 3 months. Claims that exceed the cumulative daily MME limit of 250 MME will be denied at the Point of Sale (POS). Remove PA from dexmethylphenidate IR (generic Focalin) and dextroamphetamine/amphetamine Er (generic Adderall XR); brand Focalin and brand Adderall XR will require PA Include the Calcitonin Gene-Related Peptide Receptor Antagonists (Antimigraine Agents) in the Preferred Drug List (PDL). Preferred agents will be preferred with clinical criteria. Implement hard edit on Cumulative Daily MME claims exceeding 250 MME/day. A phase-in period for claims exceeding 200 MME/day, but less than 250 MME/day, will also be implemented In cases of cost-effectiveness, the Alabama Medicaid Agency sometimes allows for reimbursement of certain brand named medications while requiring prior authorization for the generic alternative. In these cases, a Dispense as Written (DAW) code of 9 must be utilized when dispensing the preferred brand named medication. A DAW Code of 9 indicates that substitution is allowed by the prescriber but Alabama Medicaid requests the brand product be dispensed.
Alaska	Innovative Practices for FFY 2019 In FFY 2019, the Alaska Medicaid Drug Utilization Review (DUR) committee and the State of Alaska Medicaid program implemented a morphine milligram equivalent (MME) limit. The initial MME threshold was set at a cumulative 300 MME/day and a prospective edit was deployed in the

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	pharmacy point-of-sale (POS) system. A threshold reduction of 50 MME/day will occur every six months to a notification goal of 90 MME/day or as set by the DUR Committee based on statewide rules. Regimens exceeding the set MME threshold will require a prior authorization. Since the implementation of this edit, we have seen not only a reduction of total MME, but also a reduction in the number of opioids being prescribed. Prospective system edits were also put into place for interacting opioids and benzodiazepines and opioids and antipsychotics. The pharmacist is able to override these drug to drug interaction edits after documenting consultation with the prescriber. Electronic prior authorization (ePA) was implemented in FFY 2019. Approximately 40% of claims are being processed through this platform, thus reducing the time for prior authorizations to be approved or denied. It also has reduced the amount of phone calls and faxes that the call center receives. Most pharmacies using the new ePA platform are accessing it through CoverMyMeds.
Arkansas	ARKANSAS INNOVATIVE PRACTICES FFY2019 FFY2019 has been a year of transition. Arkansas was fortunate to have a long-standing pharmacy director and a long-standing DUR coordinator with almost 30 years of Medicaid experience between them. But our pharmacy director moved to a new job in October 2018, and our DUR coordinator retired in December 2018. Their departure has left an experience gap that we are filling. Two members of the clinical review staff assumed those roles. Movement into those new roles left vacancies in our clinical pharmacist staff. We were fortunate to hire two new clinical pharmacists as state employees and two new clinical pharmacists as Magellan employees. These extra pharmacist positions were needed to move our program forward with more clinical reviews. With this in mind, our innovative practices were limited for FFY2019. COLLABORATION WITH ARKANSAS DEPARTMENT OF HEALTH (ADH) HIV ELIMINATION TASK FORCE--ADH has made a campaign to eliminate HIV in Arkansas by 2030. To work toward this goal, ADH enacted a task force consisting of healthcare providers from around the state, members of clergy, Department of Corrections, AR Department of Human Services (Medical Services Division), legislators and HIV survivors. The task force meets monthly to brainstorm ideas on reaching our goal. Diagnosis and treatment in our rural areas seem to be two major concerns along with pricing of HIV medications. The task force has 4 subcommittees focusing on diagnosing, treating, preventing and responding to outbreaks. Our Medicaid program as part of the AR Department of Human Services (DHS) participates in the treatment subcommittee. Our participation ensures our Medicaid population is represented. HCV AFFINITY GROUP--ADH and DHS have partnered in an affinity group for HCV elimination along with multiple other states. Our state group had been meeting monthly until COVID-19. ADH has been extremely busy with testing and tracking COVID-19. But we continue to have monthly meetings with the other states facilitated by HHS and Mission Analytics Group. We are making strides to improve access to services for Arkansans. RELATIONSHIP WITH ADH SECRETARY OF HEALTH--DHS has developed a good relationship with physicians and staff at ADH. Many of the physicians involved with ADH specialize in infection control. DHS has consulted with these physicians on multiple issues affecting Medicaid including RSV prophylaxis and the addition of HIV medications to the preferred drug list. The health department's support of our Medicaid program has been invaluable. Also, the Secretary of Health has been added as an ex-officio member of our DUR board in an advisory role. Having the Secretary of Health attend as a board member has been extremely helpful and informational.

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	LAB DATA INTEGRATION In FFY2019, our contractor's software was updated to allow lab data integration from multiple laboratory services (currently Quest Diagnostics and LabCorp). This integrated lab data has multiple positive impacts on our program. Any provider that uses our contracted lab services will automatically have clients' labs sent to Medicaid. Quick access to labs will allow our pharmacists to have another tool for making clinical judgement on prior authorization requests. Medications that previously required a manual review can be updated to an Auto-PA status allowing for a claim to process at POS if predetermined lab values and/or billed clinical diagnoses are found on the client's profile. For example, preferred erythropoiesis stimulating agents which were previously manually reviewed may process at POS if a client has a hemoglobin level less than or equal to 10 g/dL in the previous 30 days. Conversely, the lab integration data can be used at POS for claims that did not require a PA in the past, but the need for increased monitoring is warranted. This addition to our available resources doesn't have the potential for great cost savings, but it does save valuable pharmacist and prescriber time during the prior authorization review process. PDL CLASSES REVIEWED During FFY2019, multiple drug classes were re-reviewed for the preferred drug list and for potential state supplemental rebate. Those classes included opioid use disorder treatments, cystine depleting agents, second generation antidepressants, bowel preps, beta blockers, and proton pump inhibitors. The new drug class to the PDL was oral antipsychotics which has increased our cost avoidance. RETROSPECTIVE DRUG UTILIZATION REVIEW Our RDUR program reviewed over 1000 charts per month for possible intervention letters and 300 profiles for potential pharmacy lock-in. Some of the more interesting and possibly most impactful topics for review included the use of antipsychotics for an off-label diagnosis, concomitant opioid and antipsychotic usage, use of benztropine without a diagnosis of tardive dyskinesia or extrapyramidal symptoms, and appropriate use of antiepileptics. Over the next year, we hope to grow the RDUR program and provide more educational material to prescribers and pharmacists. PASSEs Beginning March 1, 2019, Arkansas moved away from 100% FFS. Currently, the state has 3 MCOs which are referred to as the PASSEs (Provider-led Arkansas Shared Savings Entity). Most states have MCOs; so, adding MCOs to our program is not innovative. The difference with our program pertains to the type of clients included and the level of care. Currently, Arkansas has only about 45,000 lives involved with the 3 MCOs. The clients included are mental health patients with behavioral health issues or developmental/intellectual disabilities. The program has clients divided into 3 tiers based on the level of care needed. Clients placed in tiers 2 or 3 are moved from FFS to the MCOs as they require more care than a tier 1 client. The goals of this program are to improve the health of Arkansans who need intensive levels of specialized care, allow for better coordination of care for all community-based services, and link providers of physical health care with specialty providers.
California	The Medi-Cal DUR Program plays an integral role in the Department of Health Care Services' Strategy for Quality Improvement in Healthcare initiative. DHCS continues to collaborate statewide to prevent prescription drug overdose, including with the state's Prescription Drug

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	Overdose Prevention Initiative. The overarching strategy for this initiative includes safe prescribing, access to treatment, naloxone distribution, a public education campaign, and data informed and driven interventions. The goals of the initiative include increasing the number of active buprenorphine prescribers, increasing the number of naloxone claims, decreasing all-cause overdose mortality, reducing the concomitant use of benzodiazepines and opioids, and reducing opioid claims > 90 mg MEDD. The DUR program also helped disseminate important materials and resources developed elsewhere in the state, including the California Health Care Foundation's Opioid Safety Toolkit, information about the Naloxone Distribution Project (NDP), a project funded by SAMHSA and administered by DHCS to combat opioid overdose-related deaths throughout California, and resources available from the California State Board of Pharmacy, including a no-cost webinar that fulfills the training requirement for pharmacists to furnish naloxone to patients without a prescription and a revised training guide entitled Opioid Safety: Focus on Furnishing Naloxone - A Guide for California Community Pharmacists. In addition, California Assembly Bill 2760 (Wood, Chapter 324) was signed into law in 2018 and became effective on January 1, 2019. AB 2760 requires California prescribers to offer a prescription to a patient for either naloxone or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of opioid-induced respiratory depression, as a rescue medication under certain conditions. In order to continue addressing polypharmacy of CNS depressants, the DUR Board had previously recommended that the additive toxicity (AT) alert be updated to reflect only additive toxicity effects from multiple CNS depressants, including opioids, benzodiazepines, skeletal muscle relaxants, other sleep drugs and tranquilizers (non-benzodiazepine), antipsychotic medications, and other selected psychotropic medications with CNS depressant properties. In FFY 2019, gabapentinoids were added to the list of drugs that could generate an AT alert and, as a result, gabapentin was the top drug to generate AT alerts in FFY 2019. Both independently and in collaboration, the DUR Board continues to evaluate opioid pharmacy claims data in order to: 1) characterize the nature and magnitude of opioid use in the Medi-Cal fee-for-service population and 2) develop effective policies and programs to reduce the adverse impact of opioid abuse.
Colorado	Prospective DUR Innovative Practices: Removal of prior authorization requirements for smoking cessation products Addition of pharmacists as enrolled providers Allowance of coverage for pharmacist prescriptions for smoking cessation products (including OTC patch, gum, and lozenge products) Allowance of coverage for pharmacist prescriptions for select OTC pediatric cough and cold products Addition of 12-month supply coverage allowance for contraceptive medications Development of an ongoing quarterly process for identifying cost savings opportunities with favored coverage of certain multi-source brand medications Streamlined claims configuration for opioid naive edit to enhance application of opioid naive policy limitations in the claims system Implementation of quantity and days supply limits for dental opioid prescriptions Implementation of quantity limit restrictions and prior authorization requirements for twice daily proton pump inhibitor dosing

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	Retrospective DUR Innovative Practices: The following is a summary of four retrospective DUR ad-hoc module analyses completed during FFY 2019: 1. Evaluation of Utilization Related to Select HEDIS Measures: Summary: A) Antibiotics Utilization in Medication Population and PharMetrics Claims Population: For those members under 35 years of age, the percent of antibiotics of concern were <40% whereas for those 35 years of age and older, the percent of antibiotics of concern was approximately greater than or equal to 40%. Data suggests that the most common antibiotic of concern based on number of scripts was azithromycin and clarithromycin followed by the use of amoxicillin clavulanate and fluoroquinolones. The penicillin class as a whole (not including amoxicillin clavulanate) was the most common other antibiotic based on number of scripts. Additional analysis demonstrated that there has been small decreases in the percentage of antibiotics of concern within the Colorado Medicaid population. From 2016 to 2018, the overall percentage of antibiotics of concern within the Colorado Medicaid population decreased from 43.1% to 40.6%. Additionally, the percentage of antibiotics of concern were comparable or slightly higher in 2016 and 2017 versus a nationally representative commercially insured population (PharMetrics). B) Appropriate Treatment for Children with Upper Respiratory Infection: Overall, Colorado Medicaid members achieved about 90% or better in terms of the appropriate treatment for children with upper respiratory infections. Colorado Medicaid members have small improvements across the 2016-2018 years in the appropriate treatment of antibiotics for children with URI moving from 89.0% to 91.6%. The percentage of appropriate treatment was slightly higher in the PharMetrics populations. However, the 2016 Colorado Medicaid level of appropriate treatment for children with upper respiratory infections was slightly higher compared to the 2016 NCQA national population. Among the antibiotics used inappropriately for treatment of pediatric URI, amino-penicillins (amoxicillin) was prescribed the most across 2016-2018 with a decreasing trend. Physicians, physician assistants, and nurse practitioners had the largest contribution in inappropriate treatment for children with URI; however, there was a decreasing trend over the years. The most common comorbid diseases among inappropriately treated children with URI were disease of the respiratory system. C) Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: Compared to the 2016 National standards and the PharMetrics-Medicaid population, the Colorado Medicaid beneficiaries have a higher rate of avoidance of antibiotic treatment in adults with acute bronchitis. There was an increase in the rate of appropriate treatment for the PharMetrics-Commercial and PharMetrics-Medicaid population from 2016 to 2017. However, the rate of appropriate treatment for Colorado Medicaid beneficiaries have only increased slightly from 46.76% to 49.56% from 2016 to 2018. Among the antibiotics used inappropriately for treatment of adults with bronchitis, macrolides (azithromycin) was prescribed the most across 2016-2018 with a decreasing trend. Physicians, physician assistants, and nurse practitioners had the largest contribution in inappropriate treatment for adults with bronchitis; however, there was a decreasing trend over the years. The most common comorbid diseases among inappropriately treated children with URI were disease of the respiratory system. Recommendations: Despite incremental improvements from 2016 to 2018 in the Colorado Medicaid population for all three HEDIS antibiotics measures evaluated, the two HEDIS measures

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	with larger opportunity for further improvement are the overall percentage of antibiotic prescriptions deemed to be antibiotics of concern, (~40% in 2018) and the proportion of encounters where antibiotic treatment was avoided for adults with acute bronchitis (considered as appropriate treatment only 49% of the time). We recommend the following policy implementations to the Department based on our findings: With the advent of the cough/flu/cold season, the findings from our analysis need to be provided to prescribers on either the Department website or newsletter highlighting the importance of avoiding these antibiotics of concern when considering viral URIs. In the case of fluoroquinolones, consideration should be given to a prior authorization for acute bronchitis and acute bacterial exacerbation of chronic bronchitis. 2. Antiretroviral Utilization and Adherence Investigations for HIV Treatment and Pre-Exposure Prophylaxis: Summary: The key findings from included that only a small number of CO Medicaid HIV-diagnosed members were identified as taking multiple single antiretroviral regimens (i.e. not on any combination ARTs). We identified only a small number of members diagnosed with HIV who were taking multiple single ARTs but were not on any combination ART pills. The members who were taking multiple single ARTs were different from the majority of members with an HIV diagnosis who were taking one combination ART; they were older and appeared to have more complex disease when compared to those taking one combination ART. With regards to adherence, it was observed that over 6-month and 12-month periods relatively low levels of HIV-diagnosed members achieving at least 80% days covered (i.e. good adherence). Over 6 months, 46% of those taking one combination ART achieved good adherence whereas only 34% of Group 3 and 40% of Group 2 achieved good adherence. Over 12 months, good adherence fell to only 31% of those taking one combination ART and only 19% of Group 3 and 28% of Group 2. After adjusting for baseline demographics and clinical characteristics, these adherence comparisons between those on the group taking three concomitant single therapies (Group 3) and the group taking at least two concomitant therapies (Group 2) versus one combination ART (Group 1) were statistically significant. Another finding was that across all groups of HIV-diagnosed members, the ART regimen adherence levels appeared low. Statistical significant differences were not able to be detected across short-run proxy measures of burden for those considered good versus poor adherers to ART regimens. However, the trends in in-patient days as well as in-patient related paid costs suggested that good adherence to ART may have lower burden compared to poor adherence to ART. Recommendations: It is recommended that CO Medicaid consider prior authorization for medications indicated for PrEP to optimize the public health benefits of its use while bearing in mind the resource utilization, cost, and potential unintended consequences of open access to such interventions. Considerations for prior authorization could include attestation of safe-sex practices and potential drug screens before approval. Approvals should be re-evaluated annually for renewal of the prior authorization. For CO Medicaid members with a diagnosis with HIV, low levels of good adherence to ART regimens were observed. An additional observation was that the small minority of HIV-diagnosed members who were taking multiple single pill ARTs (no combination ARTs) appeared to be associated with even poorer adherence compared to those on combination ART. Although poor adherence was not statistically associated with short-run proxies of burden, the literature suggests poor ART adherence is associated with poor long-run outcomes. Therefore, it is recommend that CO Medicaid consider interventions that increase the adherence to ART regimens for all combination and single pill formulations. Furthermore, for

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	those not on combination ART regimens, consideration should be given toward policies that nudge members toward combination ART regimens. 3. Benzodiazepine Use Population Analysis with Select Sub-Analyses: Summary: It was observed that among the CO Medicaid population in the calendar year of 2018, approximately 45,000 members had at least one claim for a benzodiazepine (BZD). Of that 45,000, approximately 5,000 had a diagnosis of any seizure disorder within the 2017 or 2018 calendar years and were excluded from subsequent analyses. Of the ~40,000 who remained without a seizure disorder, the majority were female sex (~67%) and identified as white (~48%) or multiple (~35%) with regard to race/ethnicity. Evaluation of characteristics of monthly use of benzodiazepines revealed that a large portion of the <65 years of age population ~65% are receiving <20% of the days in the year filled. This may be representative of the mental health indications that BZDs are used for and the guidance suggesting short-term prescriptions be used. Also, BZDs are used as needed in many cases and if used sparingly, a prescription may last a member far longer than the days supplied billed for with the claim. We defined chronic user of BZDs as having >60% of days supplied in the measurement year of a BZD and found that ~15% met this definition. We further investigated a high potency BZD group, which was determined by identifying the dosage forms that are higher than the recommended starting dose range for any indication. Using this definition, we found that more members identified as chronic users were receiving high potency BZDs. This finding matches our hypothesis since many of the high potency BZDs identified are extended release formulations and less appropriate for initiating a member on a BZD or as needed use. Our findings on quantities dispensed per day shows that the vast majority (>98%) of members were receiving 4 or less dosage forms per day of a BZD. Members receiving more than 4 dosage forms per day may be receiving BZDs inappropriately or necessitate a change in dosage forms to reduce as needed medications. Also, members may have prescriptions for days supplied that are written differently than the intended use of that medication. For these reasons, we support a recommendation that has impacts an estimated <500 members in a one-year time period. we found approximately ~7% of the <65 years old BZD population were receiving two or more BZDs concomitantly during the measurement year. Multiple BZD therapy increases risks of all adverse events and while cross-tapering may be an appropriate transition from one BZD to another, chronic use of multiple BZDs would rarely be appropriate. Estimated impact related to this is ~2,800 members per year. A very high percentage of members in the <65 years old BZD group (~35%) were found to be receiving a non-BZD and what we classified as an other BZD. The other BZD group is all BZDs except for the sleep-indicated BZDs (temazepam, triazolam, etc). The drug interaction between a BZD and a non-BZD is listed as Major with fair evidence supporting increased central nervous system depression and respiratory depression. Despite the strong drug interaction, the combination appears to be widely prescribed. CO Medicaid currently requires a prior authorization for sleep indicated BZDs and non-BZDs as described in the Sedative-Hypnotic PDL class, but this is not currently inclusive of our defined other BZD group. The ~35% of our BZD group <65 years old members taking the combination of an other BZD and a non-BZD may be further broken down by dose and other risk factors to give more information and provide lesser impact policy recommendations. Sub-groups of members within the BZD group who have had a diagnosis of either major depressive disorder (MDD) or generalized anxiety disorder (GAD) were analyzed. These were combined as clinical considerations for BZD use in members with either diagnosis. There are other mental health indications that BZDs would be used for, on a temporary basis, but guidance with MDD and GAD are clear and relatively homogenous across sources. The first-line standard of care

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	for MDD and GAD is a Selective Serotonin Reuptake Inhibitor (SSRI) or a Serotonin Norepinephrine Reuptake Inhibitor (SNRI) and short-term BZD only (<30 days), if indicated. Out of the ~11,000 that are included in the <65 years old MDD/GAD subgroup, a little more than half (~51%) are found to be taking a BZD only and no SSRI/SNRI at the index point used of the first BZD claim of the measurement period. A little less than half (~49%) had SSRI/SNRI claims. The members in the BZD-only group could have trialed SSRI/SNRIs appropriately in the past and be on other psychotropic medication treating anxiety (second and third line options), which may be appropriate depending on other comorbidities and tolerance to SSRI/SNRIs. For a member to be chronically taking a BZD for solely MDD/GAD diagnosis and not be concomitantly prescribed a SSRI/SNRI is likely inappropriate. Data also suggests that many providers are following guidelines based on the combination therapy at initial claim, then a low incidence of BZD-only prescribing after that and a portion (~15% of initial 49% of MDD/GAD prescribed both SSRI/SNRI and BZD) falling in to the SSRI/SNRI-only group. Recommendations: Consider prior authorization for members without seizure disorder who are receiving >4 dosage forms of a BZD dispensed per day for new start prescriptions. Allow members who have been receiving >4 dosage forms per day to continue to receive their prescribed amount, with recommendations to taper to 4 or less dosage forms per day. Consider prior authorization for second unique BZD claim (i.e. not a different dose of initial BZD with population exclusion for seizure disorder. Use RDUR letter program to identify members who are receiving an other BZD and a non-BZD and provide that information to the provider. This could be a graphical comparative letter or traditional letter. The CO-DUR team can work with inclusion criteria to identify the most chronic, high-risk users of this group to target for letter intervention. Solicit feedback from the DUR Board regarding other BZD and non-BZD combination prescribing. Considerations may include, but not be limited to; prior authorization required, additional risk factors, and/or grandfathering of current combination users. Require prior authorization for members with MDD/GAD diagnosis who are receiving a BZD and not taking an SSRI/SNRI to ensure that MDD/GAD is being treated per guidance. RDUR letters may be used for this population also. 4. Analysis of opioid prescriber consult service with respect to clinical pain management outcomes and claims utilization: Summary: For this analysis, the CO-DUR team divided all of the consults that were conducted between February 2017 and April 2019 and split them into 3 groups depending on their type. The three groups identified are high dose, opioid naive, and provider requested. The largest group of consults was the opioid naive group with 268 total consults, followed by high dose opioids with 78 total consults, and 18 provider requested consults. Different sets of outcomes were measured in each opioid naive and high dose opioid group as the goals of the consult are different for each setting. Both outcome sets include concomitant high risk medication prescribing. A duration of opioid therapy was measured in the opioid naive group and a decrease of MME with total dosage count was measured in the high dose group. An outcome of atypical opioid proportion prescribed was also measured in the high dose group. The high dose group and the opioid naive groups were then used to conduct two separate investigations. One investigation looked at the outcome set six months before and six months after the consult index time. The other investigation looked at the outcome set 3 months before and 3 months after the consult index time. Our findings show a similar sex and other measured demographic breakdown amongst opioid naive and high dose opioid groups. The provider-requested consult group is small and has slightly different demographic distributions. For the high dose group the findings are positive for

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	MME<200 and reduction of proportion of atypical opioid prescribed in both the 3 month and the 6 month test groups. As the consultant routinely recommends atypical opioids, we wrongly hypothesized that the proportion would go up. In both the 3 and 6 month high dose the number of ED visits remained about the same. A decrease in this number is a central goal of opioid policy as a surrogate marker of overdose visits. While there was an absolute decrease in the number of high-risk medications prescribed with the high dose group in the 3 and 6 month sub-groups, this did not approach statistical significance. With the nature of high risk concomitant prescribing with opioids, all reductions may be clinically significant. Data shows absolute reductions in MME and total dose counts, with statistical findings in both groups. There is some heterogeneity of members who may have had a decrease in MME, but an increase in dosage forms prescribed. Those particular members are being prescribed more dosage forms of a lower dosage opioid and the result in the data, the percent change is positive for this reason. With some control for outliers, this would likely be negative as hypothesized. For the opioid naive portions of the module, a positive and statistically significant decrease in high risk concomitant prescribing at both 3 and 6 month sub-groups. Policy limiting these high risk combinations are not yet implemented, but the RDUR program has been providing letters to providers regarding the 3 part combination of an opioid, a BZD, and a skeletal muscle relaxant for the past year. Strong warnings from the CDC and other entities plus our own local RDUR projects may influence some of these results. Hospital and ED visits significantly decreased in the opioid naive group for the 3 and 6 month tests. Many of the members included in the opioid naive group may have received their acute opioid prescription immediately following a hospitalization or ED visit, which could have influenced this reduction. Data depicts that the percentage of members who remained on an opioid at monthly intervals in each 3 and 6 month sub-groups of the opioid naive group. The other comparison group was sampled from pre-naive policy historical data. This comparison shows a similar graphically comparative rate of decrease of opioid prescription at timepoints from the index fill. Notably, the percent of members still receiving opioid prescription at the first timepoint of 30 days on both 3 and 6-month cohorts is less than the historical comparator. Recommendations: Continue, and if possible, expand the pain management consult service. Future potential triggers may include combination opioid and benzodiazepine prescribing as well as risk factor stratification.
Connecticut	Retrospective DUR Innovative Practices Pediatric Reviews There are approximately 800,000 patients enrolled in the Connecticut Medical Assistance Program and approximately half of those patients are under the age of eighteen. Beginning July 2010, the Connecticut Medical Assistance Program began performing Retrospective Drug Utilization Review (RDUR) on the Pediatric population in addition to the reviews performed on the adult population. 1,000 monthly reviews are performed on the adult population and 1,000 monthly reviews are performed on the pediatric population. Pediatric Reviews Examples of pediatric reviews performed during FFY 2019 include; therapeutic duplication of mental health medications, pediatric psychotropic medication monitoring guidelines (stimulants, antipsychotics, antidepressants), HEDIS/NCQA criteria for use of atypical antipsychotics, fluoroquinolone criteria review, overutilization and appropriate age use for antihistamines and inhaled steroids, and pediatric psychotropic medication maximum dosing guidelines.

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	Adult Reviews Adult drug utilization review has been the foundation of the RDUR program in Connecticut. Select topics of review during FFY 2019 for the adult population included; underutilization of lipid lowering agents, review of patients receiving triple antipsychotic therapy, review of patients who received a diagnosis of a medication related poisoning and continue to receive medications that caused the poisoning, overutilization of narcotics, therapeutic duplication of long acting opioids, concurrent use of pure opioid agonists with opioid antagonists/partial agonists, low dose quetiapine used off label for sedation/sleep, nonadherence to anticonvulsant therapy, fluoroquinolone utilization review and targeted interventions of FDA warnings associated with use, risk of using 1st generation antihistamines in the elderly population, a targeted review of patients receiving chronic opioid therapy with specific risk factors for overdose who did not have a naloxone prescription, and therapeutic duplication of benzodiazepines. Lock-In Program Approximately 5,000 patients are flagged by the lock-in criteria for review each month and 800 patients are reviewed during each monthly cycle. The goal of restricting a patient to a single pharmacy is to ensure that patients have access to medication they need while reducing the harm associated with over utilizing controlled substances. Fraud Hotline The Fraud Hotline at the Department of Social Services (DSS) is a proactive approach to handling complaints regarding fraud and abuse from the community. Complaints received by the fraud hotline are sent to the pharmacy unit at DSS to determine if patients should be placed into selected review for further action. Retrospective DUR Innovative Practices Established during FFY 2019 During the first quarter of FFY 2019, the DUR Board began tracking naloxone utilization, as well as buprenorphine product utilization (indicated for Medication Assisted Treatment) as part of the quarterly opioid utilization report. Additionally, the DUR Board approved criteria to target patient's prescribers who are prescribing opioids where there is an absence of a naloxone prescription in the patient's record. During December 2018, the DUR Board approved a newsletter covering Influenza epidemiology, etiology, and the Advisory Committee on Immunization Practices (ACIP) recommendations for seasonal flu vaccination. During March 2019, the DUR Board approved a newsletter covering the topic of recent FDA warnings regarding fluoroquinolones. In tandem with the newsletter, new retrospective criteria targeting the adult and pediatric populations were approved by the Board which targets patients receiving prescriptions for fluoroquinolone antibiotics. During the months of March and May 2019, targeted RDUR interventions were performed on the pediatric population which reviewed NCQA/HEDIS recommendations for use of antipsychotics in the pediatric population. In line with the SUPPORT Act requirements to have a program in place to monitor the use of antipsychotics in this population, the DUR Board proactively approved these new criteria during the last quarter of 2018. The NCQA/HEDIS criteria are new additions to the criteria library used to review and send educational interventions for all recipients in the pediatric population, including foster care children. During June 2019, the DUR Board approved a newsletter covering the topic of Ixode scapularis tickborne illnesses transmitted to humans in the northeast. 5 pathogens are commonly

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	transmitted by I. scapularis in the northeast; Borrelia burgdorferi (B. burgdorferi), Anaplasma phagocytophilum (A. phagocytophilum), Babesia microti (B.microti), Borrelia miyamotoi (B.miyamotoi), and Powassan virus. Etiology, epidemiology, diagnosis, and treatment of these infections were covered in the June newsletter. During July 2019, a specialty mailer was developed and sent out targeting prescribers of patients receiving opioids who were at high risk of overdose who did not have a naloxone prescription on file. Patients were defined as high risk of opioid overdose if they: Received opioids at a dosage of 50 MME per day or greater; Have respiratory conditions such as chronic obstructive pulmonary disease (COPD) or obstructive sleep apnea (regardless of opioid dose); Have been prescribed benzodiazepines (regardless of opioid dose). Have a non-opioid substance use disorder, report excessive alcohol use, or have a mental health disorder (regardless of opioid dose); Use heroin, illicit synthetic opioids or misusing prescription opioids; Use other illicit drugs such as stimulants, including methamphetamine and cocaine, which could potentially be contaminated with illicit synthetic opioids like fentanyl; Received treatment for opioid use disorder, including medication-assisted treatment with methadone, buprenorphine, or naltrexone. During September 2019, the DUR Board approved a newsletter covering the etiology, epidemiology, diagnosis and treatment of the measles virus. Herd immunity was discussed and Connecticut specific information regarding school vaccination exemption rates were included in the newsletter to help spread awareness of required immunity in order for populations to be protected from the virus. Prospective DUR Innovative Practices Established during FFY 2019 Effective February 1, 2019, buprenorphine buccal film (Belbuca) and buprenorphine transdermal patch (Butrans) no longer require prior authorization (PA). On December 1, 2016, the Department of Social Services (DSS) implemented Prior Authorization for all long acting sustained release opioid medications. Belbuca and Butrans are considered safe and effective alternatives to other long acting opioids for the treatment of chronic pain. Buprenorphine in either form is less addictive, poses a much lower overdose risk, and has significantly fewer side effects as compared to other long acting opioids. For these reasons, DSS decided to no longer require PA for Belbuca or Butrans but recommend that prescribers reserve these products for use in patients where alternative treatment options (e.g. non-opioid analgesics or immediate release opioids) have proven ineffective, not, not tolerated, or would be otherwise inadequate to provide insufficient management of pain. In August 2019, the Department of Social Services (DSS) selected a date of 10/16/2019 to implementing a new prior authorization for short acting opioid agents. Prior authorization is required for prescriptions for long acting opioid agents. The new prior authorization for short acting opioid claims in which the days' supply exceeds 7 days and/or the patient's cumulative morphine milligram equivalence (MME) exceeds 630 over the past 120-day window.
Delaware	Delaware state with two managed care organization, managing ninety percent of population and other ten percent in FFS, has always been a state with a significant number of clinical edits and audits to ensure drugs are used according to proper clinical guidelines and eliminate unnecessary expenditures. Delaware monitors the pharmacy encounters submitted by managed care companies to analyze their compliance with clinical protocols and state policies. Monthly reports are used to track and compile results of efficiencies and inefficiencies in the programs. Results are

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	also used to validate state system checks for possible enhancement aligned with business process upgrades. Quarterly meetings are held between the managed care, the fee for service pharmacists and the state Pharmacy Director to discuss areas of improvement; address new and upcoming policy changes; and trouble shoot challenges that need to be discussed and resolved to improve the quality of care, improve outcomes for our members and save program drug cost. This open dialogue and forum allow each payer to implement systematic policy changes together, with no disruption to the provider community. Consistent timelines for policy implementations and shared solutions keep members and providers informed and avoids ser vice disruption and less chaotic in care delivery and consistent information that impact our community. House Bill 331 was signed into law on September 4, 2018 to amend Title 16 of Delaware Code relating to benzodiazepine and non-benzodiazepine hypnotics. The bill requires non-institutional pharmacies to distribute educational pamphlets for consumers whenever a benzodiazepine or non-benzodiazepine hypnotic is dispensed. The pamphlets address the following: misuse and abuse by adults and children; risk of dependency and addiction; proper storage and disposal; addiction support and treatment resources; and a telephone helpline. Additionally, the bill also requires that consent be obtained from a parent or guardian in writing, prior to prescribing a benzodiazepine or non-benzodiazepine hypnotic to a minor, with only a few narrow exceptions. This effort represents a huge step in educating patients on the potential risks of this class of medications that continue to contribute to overdose deaths and drug addiction in Delaware. In February 2019, alprazolam was changed to a non-preferred status to discourage inappropriate use of benzodiazepines. DMMA had very little provider or member negative experience from this change. Members who were previously identified as using alprazolam were grandfathered to continue use. This project was implemented through collaboration with the department of Public health and Substance Abuse and Mental health. Throughout FFY 2019, Delaware continued to address the opioid crisis effecting the state and has made great strides to improve treatment options and limit opioid use in Delaware. As part of the ongoing effort to improve treatment outcomes the maximum allowable daily dose without a prior authorization of buprenorphine/naloxone products was increased to 24mg/day decreasing the administrative effort for their treatment to be approved. Additionally, to help decrease the risk of opioid overdoses, any prescription dispensed at 90MME or greater should have a prescription of naloxone rescue preparation and for Medicaid patients receiving a naloxone prescription as a rescue medication there is no copay. Through collaboration between Medicaid and Department of services for children, youth and their families, In order to monitor and manage the appropriate use of mental health medications such antipsychotic medications use in children enrolled under the State plan, ensuring metabolic monitoring is been documented, no duplicate therapies, and medication therapy monitoring. To address the low response rate to paper mailings of retrospective drug utilization letters, Delaware has developed an innovative system that automatically generates a Prescriber Notices Letter weekly to detail alerts that were overridden by the Pharmacy and set to be paid for each prescriber. The letters will be available as a secure message on the portal, and an email notice will be sent indicating the letter is available to download. Copies of generated letters are data stored and can be retrieved for faxing. This creates a cost saving for the state through elimination of returned mailings due to wrong addresses because of relocation and allows the easy and timely retrieval of the alert by the provider improving patient care. The state can develop targeted alert

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	combination based on topic of interest within a specified period of focus, the letters generated from dispensed prescriptions is stored in document repository for audit purposes. Provider specific letters can be collated for prescriber rating among peers.
District of Columbia	PHARMACY LOCK-IN REVIEW The DUR Board engages in an in-depth review of Lock-in program candidates presented during monthly meetings as grand round case studies. Prior to each meeting individual candidate profiles are thoroughly reviewed and vetted by the by the Medicaid pharmacy staff led by the MTM clinical pharmacist and FFS PBM contractor who provides detailed reporting on pharmacy and medical claims, diagnoses, and any mitigating circumstances that might influence the decision to restrict a beneficiary to a single pharmacy provider. The proactive outreach efforts and meticulous documentation of patient and provider encounters by the MTM pharmacist allow the DUR Board members to confidently approve and recommend candidates to the Lock-in program knowing that those FFS beneficiaries who simply require re-engagement with their care providers and/or additional counseling from a pharmacist on drug dosing or avoidance of adverse effects had received the help they needed instead of assignment to a non-productive punitive lock-in period. SUBOXONE PRESCRIBER PANEL In response to the growing opioid epidemic legislation was passed in the District in 2018 mandating the removal of prior authorization requirements for access to Medication Assisted Therapy (MAT) including medications. Because only DATA waivered providers may prescribe buprenorphine containing products, a pharmacy POS solution to accurately identifying these providers was needed. Working with the FFS PBM contractor and Medicaid pharmacy staff, the Board explored possible solutions to satisfy both the new District legislative mandate as well as the existing federal DEA requirements. A special subpanel of pre-screened and verified DATA-waivered providers was created within the POS adjudication system which allowed claims from these empaneled providers to pay without the prior authorization requirement previously established to verify DATA-waivered status. OPTIMIZING TREATMENT OF SICKLE CELL DISEASE The Board continued the collaboration with Dr. James Taylor, Director of the Howard University Center of Excellence that was established in 2017 to ensure that DC Medicaid beneficiaries receive the most appropriate level of treatment of sickle cell disease. Dr. Taylor serves in a voluntary consultative basis to keep Board members apprised of best practices and to share recommendations for evidenced-based management of sickle cell disease patients which include: patient engagement and education; use of hydroxyurea where appropriate and at the correct dosing levels; and how to conduct an individual patient risk/benefit analysis of short and long acting opiate use with consistent monitoring of pain relief and/or drug misuse. He conducted an in-depth review of the new and emerging pharmacological and gene therapies indicated for the advanced treatment and/or potential cure of the disease that affects a significant percentage of the Medicaid population and affects the quality of life of patients and strains the resources of the program. The Board authorized an educational intervention consisting of a physician mailing with cover letter and patient profiles with targeted opiate claims that took place over 2018-19. This intervention was aimed at those prescribers treating patients with sickle cell disease and is designed to determine opportunities for improving the safety and efficacy of drug therapy and to reduce hospitalizations for sickle cell crises. It was anticipated that providing prescribers with

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	information pertaining to their patient's sickle cell therapy would encourage review of current therapy. As a result, short acting opiate utilization saw a decrease, while long acting opiate therapy was initiated or titrated in a clinically appropriate manner.
Florida	Florida Medicaid Pharmacy Program Drug Utilization Review Annual Report: FFY19 Innovative Practices Narrative The point-of-sale (POS)/prospective drug utilization review (ProDUR) system provides the Florida Agency for Health Care Administration (Agency) with the ability to meet an important objective; that is, to minimize potential drug interactions and drug-induced illness or side effects. Adverse reactions from drugs occur more frequently when a recipient visits more than one physician and/or more than one pharmacy to obtain medication. Averting adverse drug effects may result in the prevention of subsequent physician visits, hospitalizations, or additional drug therapy. Magellan Medicaid Administration has brought this technology to the Drug Utilization Review (DUR) Board which allows the Board to make recommendations for edits to address the therapeutic appropriateness of drug regimens to the Agency for implementation via the POS system. These system edits encourage providers to prescribe medications appropriately, which is the primary goal of this Board. The Agency continues to automate many prior authorizations. Automated prior authorizations (AutoPA's) look for information in the patient's clinical record such as historic ICD-9 codes or current ICD-10 codes or CPT codes that may be a diagnosis marker and provides the ability to systematically make a decision whether to deny or pay claims during adjudication. AutoPA's may also look for a drug or a drug combination in the patient's clinical records/drug history to pay or deny claims. In addition, AutoPA's may also include a review of submitted claims data, pharmacy information, prescriber information, number of pharmacies in a patient history or number of prescribers in history, accumulated drug days supply, accumulated dose and accumulated drug quantities. The DUR Board works collaboratively with the Pharmaceutical and Therapeutics (P&T) Committee to ensure Florida Medicaid recipients receive optimized drug therapy. The DUR Board makes recommendations for the P&T Committee to consider and the P&T Committee will frequently refer utilization questions to the DUR Board for follow up. A report from the other Committee is a standing agenda item at each of these meetings.
Georgia	-Continued to establish a more robust prospective drug utilization review (ProDUR) process for drugs covered under the Provider Administered Drug List (PADL). Previously, drug products were added to the PADL by individual requests which made formulary decisions driven by clinical and cost-related factors more burdensome due to an imminent need of the requested product by one or more plan participants at the time of request. To ensure clinically appropriate cost-containment strategies were applied to provider administered drugs, DCH began proactively evaluating drugs that met criteria for inclusion on the PADL. This ongoing comprehensive evaluation incorporates data provided by clinical and financial vendors regarding cost-effective strategies which may include prior authorization criteria creation/implementation and solicitation of supplemental rebates. Representatives for the state presented the program's progress at the twenty-ninth annual American Drug Utilization Review Symposium (ADURS) on February 23, 2018,

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	providing an overview of program details and offering ideas and solutions to other state Medicaid programs wishing to implement similar ProDUR programs for provider administered drugs. -Continued to strengthen measures for curbing opioid abuse and misuse, the details for which have been provided in previous sections. -Created a Hemlibra treatment form, which allowed for the evaluation of all Hemlibra requests in a more streamlined manner on a case-by-case basis.
Hawaii	None available.
Idaho	During Federal Fiscal Year 2019, Idaho Medicaid's Pharmacy Program began several innovative practices in State Rule Changes, Unique DUR Interventions and around prior authorization and clinical management. State Rule Changes Cash Payment Prohibition for Controlled Substances: In the 2019 Idaho State Legislative Session a new rule was passed that prohibits pharmacy providers from accepting cash (private payment) as payment for controlled substances from persons known to be Medicaid participants. Historically, as Idaho Medicaid implemented quantity and MME edits, the work around for beneficiaries and their prescribers was to write separate prescriptions for the beneficiary to pay out of pocket for drug supplies exceeding Medicaid limits. Similarly, prescribers would also write prescriptions for drugs denied through the prior authorization process for indication or non-preferred status. This circumvented many of the safety and other evidence-based usage guidelines implemented by the Medicaid program. The implemented state rule discourages pharmacies from filling these separate prescriptions by allowing the beneficiary to pay cash. Implementation meant working with providers to help with tapering plans and in some cases allowing previously denied medications to be supplied on a temporary basis to allow realistic timelines for changes in long-term therapy. Education and one-on-one provider interaction was successful for implementation and ensuring good pharmaceutical care. Establishment of a Three-Month Maintenance Supply Drug List: Prior to a rule change in the 2019 State Legislative Session, there were only a few drugs which were listed by name available for dispensed quantities over a one-month supply. During the session a new rule which allows a set list of maintenance drugs to be dispensed for a three-month supply after the beneficiary has been maintained on the same strength and dose of a medication for 60 days. Rather than list each drug class separately requiring frequent rule changes, the rule allows the Pharmacy and Therapeutics Committee to recommend to the Director of Health and Welfare which drug classes are to be on the list. This action has supported patient medication adherence. This has been particularly important in a rural state like Idaho where some beneficiaries must travel far distances to a pharmacy which is especially difficult during inclement weather. DUR Interventions The Drug Utilization Review Board completed several unique drug utilization interventions to improve patient safety with better efficacy outcomes. Butalbital and Drug Over-Use Headaches: The Pharmacy program worked with a local neurologist headache specialist who had observed a high number of medication overuse headaches referred to him by patients receiving butalbital in high doses for extended periods of time. Prior authorization requirements were established for new starts of butalbital with requirements for trial and failure or contraindication to triptans, NSAIDs and acetaminophen prior to starting butalbital. A limit of 12 tablets monthly was instituted. Current patients were granted prior authorizations for 3 months and education was provided to prescribers on medication overuse headaches and butalbital tapering guidelines.

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	Naloxone intervention letter directly to pharmacists: The DUR Board implemented a direct to pharmacist intervention for patients on high dose opioids. Idaho pharmacists have authority to independently prescribe naloxone, are aware if and when naloxone has been dispensed and usually have an established relationship with the patient. The program ran a report of all patients who were receiving total opioids exceeding 90 MME daily and had not received a prescription of naloxone within the last 90 days. Individual pharmacies received an educational letter, a list of specific patients and copies of educational pamphlets as well as links to both professional and patient information. Prior Authorization and Clinical Management Genomic Testing. Idaho Medicaid pharmacists have done prior authorization of physician administered drugs for almost 10 years. During the reporting period for this annual report, the pharmacy program also added prior authorization of drug-related genomic tests. These tests are highly marketed to providers as screening tests to determine which drugs to prescribe. The pharmacy program reviews requests for CPT 81225 (CYP2C9), CPT 81226 (CYP2D6), and CPT 81227 (CYP2C19). The purpose of the test must be patient and drug class specific, choice of drug must be tied to test result including reasoning for not using a preferred agent, and the specific genomic test must be included in the drug package insert or other high-quality evidence must validate necessity and correlation between the test and the drug desired. Methadone Case Management: When the pharmacy program implemented a 90 MME edit it was noted that the highest MME daily doses usually involved methadone. The program began a case management program where a specific pharmacist works one on one with prescribers to taper and either decrease the dose of methadone or switch to safer opioid alternatives. This was one area where it was identified that a lot of private pay (cash) payment was occurring. Extra effort went into stopping cash payment on methadone and temporarily paying for higher doses while working with patients and prescribers to taper to acceptable daily doses.
Illinois	Illinois Medicaid continues to focus on controlling Medicaid drug spending while ensuring Medicaid participants have access to the most cost-effective, clinically appropriate therapies. Illinois Medicaid routinely reviews processes to improve the care of Medicaid patients, maximize cost containment, and streamline operations. Provider education is also a key part of facilitating appropriate therapeutic care. The following innovative practices are highlighted for FFY19. Illinois Public Act 100-138 amended the Illinois Insurance Code to allow all providers of prescription coverage to provide synchronization of prescription medication refills. Effective August 8, 2019, Fee-for-Service permits synchronization of prescription drug refills one time per maintenance medication per year. A specific clarification code is required on the prescription claim. No participant copay is required for the synchronized prescriptions. Compound drugs, partial fill/completions and controlled substances are not eligible for medication synchronization. Adherence evaluation continued in FFY19 for steroid-containing inhalers for the management of asthma, metformin, direct acting oral anticoagulants, and medications for the treatment of cystic fibrosis and hepatitis C. Prescriber peer consultation for Attention Deficit Hyperactivity Disorder (ADHD) medications in children via University of Illinois Department of Child and Adolescent Psychiatry DocAssist

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	program continues for children who exceed the HFS modified version of the Washington state Medicaid ADHD medication limits based on age and dose. Provider outreach to prescribers of chronic benzodiazepine medication use for the management of anxiety in the absence of first-line therapies, such as selective serotonin re-uptake inhibitors (SSRIs). During FF19, at least 77 faxes regarding inappropriate benzodiazepine therapy were sent to prescribers. Participant specific recommendations were included. The advent of prescriber message capability in the new PBMS prior authorization system decreased the number of unique benzodiazepine faxes sent. The new HFS prior authorization system facilitated adjudication of 3,733 prior authorizations for benzodiazepines for 2,469 participants from 1,891 prescribers. The adjudicating pharmacist now notes recommendations regarding benzodiazepine therapy and/or tapers in the determination letters, rather than in the special benzodiazepine faxes. Increasing shift of patients from Fee-for-Service Medicaid to Medicaid Managed Care may also have decreased the number of prior authorization requests for benzodiazepines under the Four Prescription Policy. The pain management program continues to ensure appropriate pain management with opioids. During FFY19, there were a total of 1,776 pain forms sent to prescribers: 1,513 initial pain program forms, 230 renewal pain management program forms, 27 initial methadone pain management program forms, and 6 methadone renewal pain management program forms. Since launch of the new PBMS prior authorization system, faxes are faxed back by the provider directly into the program. It is not feasible to extract information about the number of returned forms. There has been an overall decrease in forms sent, in part because many more Fee-for-Service participants transitioned to Medicaid Managed Care. The FFS HFS Medication Review and Academic Detailing and Prior Authorization staff participated in several UIC College of Pharmacy grant initiatives targeting live prescriber and pharmacist education during FFY19. These providers serve many HFS participants. Staff underwent the National Resource Center for Academic Detailing (NARCAD) training during FFY19. Prescriber education informed about the CDC Guideline for Prescribing Opioids for Chronic Pain and the Illinois Prescription Monitoring Program in the Chicagoland and southern Illinois regions. Pharmacist education at Chicagoland pharmacies informed about the State of Illinois naloxone standing order to enhance naloxone use and availability in the community.
Indiana	On November 1, 2009, the fee-for-service (FFS) pharmacy program implemented an automated prior authorization (PA) tool known as SmartPA. On May 24, 2013, OptumRx (previously known as Catamaran) became the pharmacy benefit manager and implemented SilentAuth. SilentAuth is an automated PA tool that executes real-time prior authorization decisions by utilizing highly sophisticated clinical PA edits supported by the member's medical profiles and pharmacy claims data. This results in quicker PA determinations for Medicaid members, with less intervention on the part of both the pharmacy and the prescribing provider. On July 1, 2019, the FFS pharmacy program removed fibrosis requirements from its carved-out hepatitis C prior authorization. While this started at the end of this report's reporting period, this decision to remove fibrosis was reviewed and approved prior to the July 1, 2019 start date. With the removal of fibrosis, the prior authorization now assesses a diagnosis of chronic hepatitis C and appropriate genotype for the agent reviewed.

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	On May 24, 2013, OptumRx implemented near real-time faxed retro-DUR interventions. These retro-DUR interventions evaluate claims as they happen and send DUR Board-approved interventions to prescribers to address as the potential concern occurs. During the reporting period, two new interventions were implemented to address the long-term use of benzodiazepines and the long-term use of sedative hypnotics. The Office collaborated with OptumRx and managed care to continue to drive opioid criteria to address overuse and misuse. All new starts require prior authorization when exceeding a 7-day supply or a total of 14 days in a 45-day period. New opioid starts also require prior authorization when exceeding 60 milligrams of morphine equivalents (MME) or when requesting a long-acting opioid. Current opioid utilizers will require prior authorization when utilizing more than one long-acting and one short-acting agent. Members with a diagnosis of cancer or sickle-cell disease are excluded from these requirements. All utilizers require prior authorization when used in combination with a buprenorphine product indicated for medication-assisted treatment, a benzodiazepine product, or a carisoprodol product, or when the limit of opiate prescribers has been exceeded. Concurrent opioids and benzodiazepines require faxed documentation that the prescriber understands the risk of utilizing both agents together in addition to diagnosis(es) and previous treatments trialed.
Iowa	Developed a handbook for the MCOs as a supplement to their Iowa Health Link contract to provide additional specifics on the DUR program and provide MCO requirements and guidelines for collaboration. The handbook outlines requirements of the DUR program and clearly defines expectations for the FFS and MCO programs for ProDUR, RetroDUR, and educational initiatives.
Kansas	2019 INNOVATIVE PRACTICE NARRATIVE Below are two key updates to the drug program for the 2019 Federal Fiscal Year. DUR Program New-to-market medications for Kansas Medicaid beneficiaries may be subject to Advanced Medical Hold Manual Review (AMHMR). Previously, new-to-market medications required clinical approval based upon package insert guidelines for coverage determination on a case-by-case basis. Effective December 1, 2018, new-to-market drugs required a drug use review based upon the Advanced Medical Hold Manual Review (AMHMR) criteria that were approved by the Drug Utilization Review (DUR) Board in October 2018 and revised on April 10, 2019. An AMHMR PA may be in effect from the time the drug is placed on AMHRM until its review by the Kansas Medicaid DUR Board, at which time formal permanent PA criteria may/will be established. The AMHMR PA criteria are listed in the link below: https://www.kdheks.gov/hcf/pharmacy/download/Advanced_Medical_Hold_Manual_Review_APPROVED_PA_Criteria.pdf PDL Program The PDL Consent Agenda Item pre-approval management tool for the PDL Program was further expanded as shown in Criteria #5 below. Consent Agenda Item Pre-Approval Reference Guide New Consent Agenda Item Pre-Approval Criteria General Examples of Each Approval Type PDL Comm. Approval Dates DUR Board Approval Dates 1. New drug is a different dose form than current PDL drug. (Examples: Cap, tablet, gel, cream) 9/13/2017 10/11/2017

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	2. New drug device is a change from current PDL drug. (Example: Spiriva® Handihaler to Spiriva® Respimat®) 9/13/2017 10/11/2017 3. New drug change in strength or added strengths of Current PDL Drug (Example: 5mg, 10mg) 9/13/2017 10/11/2017 4. New drug is an addition of IR, now ER (or vice versa). (Example: Seroquel®, Seroquel XR®) 9/13/2017 10/11/2017 5. New Drug is a stereochemical, prodrug, or active ingredient moiety of a Current PDL Drug in the same PDL Class/Category (Examples: Zyrtec & Xyzal, Emend PO & Emend IV, Diovan & Prexxartan) 3/13/2019 4/10/2019 Any drug that is added to the PDL between PDL meetings will be listed on the next PDL meeting agenda. These drugs are listed under Old Business - Consent Agenda Items. A vote is taken to "formally" approve the drugs listed in this section.
Kentucky	1. Opening Access to Medication-Assisted Treatment (MAT) -October 2018: preferred buprenorphine-containing MAT prior authorization will be bypassed at POS when certain conditions are met and for a limited duration: https://kyportal.magellanmedicaid.com/public/client/static/kentucky/documents/KY-ProviderNotice-231-20181010.pdf -February 2019: preferred buprenorphine-containing MAT can be obtained without a prior authorization: https://kyportal.magellanmedicaid.com/public/client/static/kentucky/documents/KY-ProviderNotice-234-20190221.pdf 2. Refined urine drug screen policy to align with KY regulations Previous class criteria for opioids regarding urine drug screens (UDSs): -Require UDS results dated within the past 30 days for ALL new chronic opioid (e.g., beyond 45 days of treatment) requests. Note: UDS is not required for acute prescribing. -UDS results within the past 30 days required for ALL renewal requests for chronic use of an opioid. New criteria for opioids regarding urine drug screens (UDSs): 1. Require UDS results dated within the past 30 days for ALL new chronic opioid (e.g., beyond 45 days of treatment) requests UNLESS the member is in a long-term care or skilled nursing facility. Note: UDS is not required for acute prescribing. 2. If the member is NOT in a long-term care or skilled nursing facility, require prescriber to document risk assessment and provide most recent UDS results dated within: a. 1 year if considered low risk b. 6 months if considered moderate risk c. 3 months if considered high risk 3. Expanded the preferred drug list with the addition of the following class(es): -Bile Salts
Louisiana	Louisiana Department of Health established a Hepatitis C treatment partnership with Asegua Therapeutics. A maximum expenditure cap is used with intention to treat 10,000 persons with

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	hepatitis C, including 7,000 to 8,000 Medicaid recipients, within 18 months. The implementation date was July 15, 2019. Sofosbuvir/velpatasvir (authorized generic Epclusa), became the preferred agent in the direct acting antiviral agents for Hepatitis C category, and is over 95% effective in the treatment of hepatitis C. This program made this agent available through a seamless process using the normal supply chain. The other agents in this category are non-preferred and can be obtained through the prior authorization process (treatment failure with the preferred agent, allergies, etc.)
Maine	Metabolic Monitoring The DUR sent out over 1800 letters to providers in FFY 2019 regarding the appropriate need for metabolic monitoring with the use of atypical antipsychotics. The communication included monitoring of weight and metabolic parameters including blood pressure, A1c, fasting glucose and fasting lipid profile in accordance with the ADA screening guidelines. The letters also described a process where baseline parameters would be obtained then at 12 weeks follow up labs would be required. Providers that were surveyed were given 20 weeks to obtain and submit the baseline and follow up numbers for review, if this information was not received than further antipsychotic use would require prior authorization to assure proper monitoring. In its review, 30% of members lack proper documentation of routine monitoring. Opiate Limits MaineCare members are allowed over a rolling 12-month period up to a 15-day supply of an opiate without prior authorization after an initial 7-day limit on short acting opiates. Members requiring longer than 15 days require a PA for continuation of therapy and providers may provide medical necessity. Members may be eligible for up to three prior authorizations of up to 14-day supplies of opiates during the 12-month period. MaineCare members that are in Hospice care or are being treated for a diagnosis of cancer will be exempt from these limits. Providers are required to indicate on the prescription these exceptions and the pharmacies utilize the CA or HO diagnosis code when transmitting the claims for processing. Post-surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the Surgeon. Members that require additional opiates after the initial 8 week limits listed above are considered chronic users and further communications will be sent to providers on developing criteria requiring other potential treatment options or monitoring programs PCM Program The MaineCare Pharmacy Care Management (PCM) program for Fiscal Year 2019, enrolled an additional 838 members to total 3658 members since program initiation (including Pilot). Our program has been designed to assure that the right patients are receiving the right medication for the right condition. We confirm that medication prescribing comports with FDA approval for the condition it is being used for as well as that it is being taken by the correct type of patient. Our program educates patients on new medications so that they are aware of how to take their medications, the importance of being compliant with the dosing schedule, and what they can expect in terms of outcomes and adverse reactions. This program tracks patient adherence to medication regimens by measuring Medication Possession Ratio. At the conclusions of Fiscal Year 2019, the PCM program included 1434 members being actively followed (others have stopped medications, lost eligibility or required no further monitoring for various reasons). Looking at the 4th quarter alone, after an in-depth initial review for each new

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	member (assessing prescription claims history along with previous prior authorization requests), an additional 653 follow-up reviews were completed on existing PCM patients. All follow-up reviews begin by researching all prescription fills and prior authorization requests since the previous review to determine what, if any, contact and follow-up is needed with the patient and/or provider. Resultant of these reviews, MaineCare PCM contacted providers (prescribers and pharmacies) via telephone or fax a total of 230 times and contacted patients via telephone 51 times during the 4th quarter alone. Medication cost abatement readily occurs when a lower cost regimen is selected, a dose decrease occurs, or medication discontinuation ensues following a consult with our pharmacist. Treatment adherence is tracked in real time using established methods and also include assessment of medication possession ratio. We strive to achieve the highest treatment medication adherence to ensure maximal benefit from the treatment selected. Utilization information is continually monitored to assess the impact of the PCM program on all aspects of the patient's care including aggregate spend. This not only includes the direct cost of medications but other utilization measures such as emergency room visits, hospital stays, and laboratory services, amongst others. Hepatitis C Value-based Authorizations Hepatitis C is a serious illness that can lead to cirrhosis, liver cancer and death. It is the leading indication for liver transplants in the United States. Once again, further medication development and release occurred throughout Fiscal Year 2019 to further advance this field. Cures are possible with oral regimens that range from 8-24 weeks for most patients. However, the cost for treating this disease is staggering with hepatitis C drugs rising quickly to one of the top 5 categories in cost for almost every state Medicaid program. Despite the release now of multiple therapies and some relief in the form of cost competition and supplemental rebates, the cost remains high. Maine has taken a multi-pronged approach to managing these medications--balancing evidence-based science with cost to try to allow as many as possible to access this important category of medications. In addition to being expensive, the clinical care of Hepatitis C is complex. There are now over 25 regimens recommended by the AASLD/IDSA guidelines for the treatment of hepatitis C. The choice is based on the genotype of the virus as well as patient factors, such as prior treatments and the presence of cirrhosis. Given the continued high cost of treatment, it is critical that the correct therapy is chosen and that adherence be monitored. An incorrect choice of regimen or lack of adherence that results in an unsuccessful treatment course is not only costly, it makes the next attempt at cure potentially both less likely and more expensive. The most cost effective, clinically correct choice is to make sure the patient is cured with the first treatment course by ensuring that the correct treatment is chosen, the patient is ready for treatment and likely to be compliant and then monitoring for that compliance. Finally, it is critical that Maine ensures it pays the lowest net cost for the correct therapeutic regimen. The introduction of multiple new therapies has created options for treatment and options for price negotiation. In many circumstances, the guidelines offer as many as 4 clinically acceptable, equally efficacious regimens. Through its membership in the SSDC drug pool, Maine has been able to consider offers from all of the labelers of the major hepatitis C direct-acting antivirals. However, sorting through these offers and making sure the best overall value is obtained for this category has required complex modelling and consideration of the prevalence of the various genotypes and clinical scenarios to arrive at the most clinically effective as well as the most cost effective regimen for each of the various clinical circumstances. Using the AASLD/IDSA guidelines as a source of evidence-based practice and considering the various offers available via complex clinical/fiscal models allowed determination of the best value for each unique clinical situation and helped to determine which agents would be placed in a preferred position on the

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	preferred drug list and in which circumstance each was the best value (considering both efficacy and cost). The next hurdle was providing information to providers in an easy to use format so that they could see which choice of drug regimen in each unique clinical circumstance was the most cost effective. It is not as simple as choosing only preferred drugs. There are some complex situations where the use of a non-preferred drug is the most cost-effective choice for MaineCare as well as the right choice for the member. In this type of circumstance, the occasional use of a non-preferred drug to meet a specific clinical need is authorized. To meet this complex challenge, Maine worked with its DUR Board to develop a prior authorization form that helps lead the provider to the most clinically effective, cost-effective choice based on net pricing to the State of Maine. Considering the genotype, prior therapy and level of cirrhosis, a provider can work through the form to determine the clinically appropriate choice as well as the choice that represents the best value to the State. For cases that don't fall easily into the choices provided, MaineCare also offers expert oversight of the hepatitis therapies, when needed. This from was again updated during Fiscal Year 2019 to include the newest therapy options and changes to preferred regimens. Finally, the Pharmacy Care Management Program allows a pharmacist to interact with the member and provider on an ongoing basis to help ensure the medication is taken, monitored appropriately and to collect follow-up information on outcomes. The PCM program has continued to track adherence (at the end of Fiscal Year 2019, Hepatitis C adherence was measured at 95.3% based on a medication possession ratio of 0.8 or higher), as well as cure rates by receiving post-treatment viral loads from providers. During Fiscal Year 2019, cure rates based on Genotype and Fibrosis Level (degree of liver damage) ranged from 80% in the most diseased/difficult to treat members to 100% in the more common and less diseased groups. By synthesizing complex clinical and fiscal data into an easy to follow authorization form, Maine has made it easier for providers to choose the most cost-effective, clinically appropriate therapy the first time rather than asking for a therapy only to be told no and that another therapy is more cost-effective. By making the right choice easy to find, Maine is helping providers to navigate a complex therapeutic landscape to enable members access to these breakthrough therapies.
Maryland	Summary 6 - Innovative Practices Live Continuing Education Programs Annually, MMPP has sponsored a live continuing education program. In FFY 2019, MMPP sponsored its tenth (10th) live continuing education program HIV Management in Primary Care on Saturday, October 27, 2018. The program awarded four (4) Continuing Medical Education (CME) credits for prescribers and four (4) Continuing Education (CE) credits for pharmacists. Response to the program was overwhelmingly positive. The Department plans to continue this service to the healthcare community. Clinical Criteria Expansion In FFY 2019, MMPP continued to update its website to include clinical criteria for additional medications. The clinical criteria are based on FDA approved indications and exist to ensure appropriate utilization of medications with limited indications. The list of medications for which

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	prior authorization is required is updated regularly and can be found at: https://mmcp.health.maryland.gov/pap/Pages/Clinical-Criteria.aspx Dose Optimization and Quantity Limits Many drugs have flat pricing across dosage strengths; however, there are products with significant price disparities between dosage forms. In an effort to reduce waste and improve prescribing practices, dose optimization and quantity limits continue to be utilized. Medical necessity overrides are available with prior authorization. The most recent list of dose optimization quantity limits can be found at: https://mmcp.health.maryland.gov/pap/docs/QL.pdf Online Formulary hosting for Maryland Medicaid and HealthChoice MCOs The MMPP has maintained an electronic database with FFS and MCO formulary information since 2007. This program, which is free for providers and participants, provides updated information on the formulary status of medications. During FFY 2019, the use of Formulary Navigator allowed real time access to information for Maryland Medicaid providers for all nine MCO and FFS formulary information. This user-friendly platform allows searches by drug name (brand or generic), therapeutic class or alphabetical listing. Additionally, products are now displayed with drug strength/formulation, and multiple flags (prior authorization, quantity limits, criteria for use) are available to guide prescribing and facilitate access to medications for patients. Corrective Managed Care Program The Corrective Managed Care (CMC) Program has been instituted by the Maryland Medicaid Pharmacy Program to monitor and promote appropriate use of controlled substances. Through a monthly review, the state identifies Maryland Medicaid participants who appear to be on duplicate drug therapy, visit multiple prescribers writing for similar medications, and/or patronize multiple pharmacies. Intervention letters are mailed to prescribers and pharmacy providers in an effort to alert them to potential drug therapy concerns. If there continues to be overutilization of a substance by a participant after intervention letters are mailed, a participant can be locked-in to a single pharmacy. Under a Lock-In pharmacy agreement, the participant will be required to fill the related medications at one mutually agreed upon pharmacy. The CMC Program utilizes the Corrective Managed Care Advisory Committee, which is a sub-committee of the DUR Board, to assist with the review of individual participants and help set policy regarding efforts to reduce the potential misuse of controlled substances. The Committee meets just prior to the regular quarterly DUR Board meeting and includes all members of the DUR Board. For those participants where contact with prescribers through means of intervention letters has not changed behavior, the CMC Advisory Committee reviews each participant's drug and diagnosis history profile. The Committee then advises the MMPP on recommended corrective action, which may include lock-in further provider education or continued follow-up. Specific criteria have been approved by the CMC Advisory Committee, which allow some participants to be automatically restricted to a single pharmacy without prior CMC review. Criteria are based on the number of claims for controlled substances in their recent history and the number of prescribers and pharmacies utilized. In addition, some criteria used to screen patients for potential misuse have been modified to allow for follow-up 3 months after initial

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	letters are mailed to providers. In the past, follow-up was not performed until 6 months after letters were initially mailed to providers. On April 1, 2016 (FFY 2016), a Unified CMC program was initiated that expanded CMC lock-in participation to all Medicaid participants included in the MCO programs. The program was expanded to create a minimum standard for monitoring of controlled substances by participants. The pharmacy program and MCO programs provided input on the final criteria that will be utilized by all parties when reviewing participant prescription claims. In addition to providing optimal care for all Medicaid participants, the unified program prevents the enrollment into a program that may not provide this oversight and allow potential fraud or abuse of controlled substances to occur without any corrective actions. Under the new program, if a lock-in participant switches between any Medicaid program, the lock-in information is maintained for the full lock-in term of 24 months. The goal of the CMC program is to educate providers when patients appear to be over-utilizing controlled substances while ensuring that participants have access to appropriate medications they need and reducing adverse outcomes associated with over-utilizing controlled substances. Opioid Drug Utilization Review During FFY 2017, the Maryland Medicaid Pharmacy Program worked with the Maryland HealthChoice MCOs to create prior authorization criteria for opioids as part of the Maryland Department of Health's initiative to combat the national opioid epidemic. The criteria is part of a minimum standard across all plans to assure safe and appropriate use of opioids in the Medicaid population. Prior authorization is required for all long-acting opioids, fentanyl, methadone for pain and any opioid prescription that results in a dose exceeding 90 morphine milligram equivalents per day. In addition, a standard 30-day quantity limit for all opioids is set at or below 90 morphine milligram equivalents per day. Exceptions to these standards include participants with a diagnosis of cancer (treatment within the past 2 years), sickle cell anemia or those receiving palliative care or in hospice care. These minimum standards continued to be utilized through FFY2019 and monitoring of the program has shown improved prescribing of opioids without restricting access for Medicaid recipients. Program details, forms and educational resources are available at: https://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/medicaid-opioid-response.aspx Automated Prior Authorization System The Prospective DUR vendor, Conduent State Healthcare, LLC, utilizes an automated prior authorization program for selected medications which require prior authorizations. Pharmacy claims can be automatically authorized if specific criteria are met at the point of service. This eliminates the need for the provider to call for an authorization if the participant meets the criteria for approval. The Conduent automated prior authorization system is made up of two components known as SmartPA and SmartFusion. A brief description is below. SmartPA - A clinical rules-based system that allows flexibility when determining prior authorization acceptance or denial. It produces the prior authorization that can be saved within the system. It has help desk tracking, support, and reporting capabilities.

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	SmartFusion - The call center solution for providing call center representatives access to the SmartPA rules engine via a window on certain claim processing screens. This system is used to determine pre-authorizations for rules based in SmartPA. Antipsychotic Review Programs The use of antipsychotic agents in children and adolescents has increased substantially over the past decade. There is increased public scrutiny, controversy and debate regarding the increasing use of the antipsychotic agents in children and the lack of data on long-term effects. The long-term efficacy and safety of these agents in the pediatric population has not been well-established for any given clinical indication. For these reasons, and in order to promote evidenced based, cost-effective prescribing of antipsychotic medications for all Medicaid participants, the State of Maryland Medicaid Pharmacy Program (MMPP) established two new programs, the first one is The Peer Review Program for Mental Health Drugs. The program began in October 2011 and initially addressed the use of antipsychotics in Medicaid patients under five years of age. During FFY 2013, all children under age 10 required prior authorization. As of January 2014 (FFY 2014), the program expanded to include all patients less than 18 years of age. In partnership with the Behavioral Health Administration (BHA) and the University of Maryland (UMD) Division of Child and Adolescent Psychiatry and School of Pharmacy, the program's goal is to ensure that members of this vulnerable population receive optimal treatment in concert with appropriate non-pharmacologic measures in the safest manner possible. The second program, implemented in 2013, the MMPP, with the assistance of the University of Maryland, established the Antipsychotic Prescription Review Program (APRP) as another avenue to promote evidenced based, cost-effective prescribing. Through this program, the APRP retrospectively reviews paid antipsychotic claims and identifies outlying prescribing patterns. Subsequently, APRP contacts the prescribers associated with the above claims with the goal of improving their prescribing practices. Hepatitis C Peer Review Program While coverage of Hepatitis C agents is provided by MCOs and the Medicaid FFS program, during FFY 2015, the MMPP partnered with the MCOs in the State of Maryland to standardize treatment options for this disease state. Through a joint program, managed through the University of Maryland School of Pharmacy (UMSOP), clinical guidelines have been developed to address the growing use of Hepatitis C agents. These guidelines are updated as new information becomes available and serve as a guide for the FFS program and all nine MCOs. During FFY2019, the Department expanded coverage to include fibrosis scores of F1 (mild/portal or periportal fibrosis w/o septa) and greater; patients < 21 years were approved with a status F0; patients > 21 years old with a score of F0 was approved for treatment if they presented with a viral condition (e.g. HIV) which was known to accelerate hepatic disease progression. Additionally, drugs such as daclatasvir/sofosbuvir, Technivie and Viekira XR were removed from the criteria as they were discontinued due to low utilization.

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	Full program details, including recommended treatment plans, medication guidelines and prior authorization forms, are available at: https://mmcp.health.maryland.gov/pap/pages/Hepatitis-C-Therapy.aspx Substance Use Disorder Carve-Out program Beginning January 1, 2015, the Maryland Department of Health initiated a carve-out program to provide all substance use disorder medications to Medicaid participants. Through this program, the MMPP standardized coverage and criteria for use of medication assisted treatment, including buprenorphine-containing products, disulfiram, acamprosate, naltrexone (oral and injectable), varenicline, bupropion SR and nicotine replacement products. Effective October 1, 2018, Lucemyra (lofexidine) was added to the program. Criteria for use, quantity limits/dose optimization and copayment for participants were implemented with this program. Treatment guidelines are based off of the FDA-approved indications as well as CMS recommendations for comprehensive patient-care. In addition to medication assisted treatment for substance use disorders, the MMPP also provided coverage of naloxone for opioid overdose/reversal for all Medicaid participants and community members who were certified to administer the medication. Program details are available at: https://mmcp.health.maryland.gov/pap/docs/Substance%20Use%20Disorder%20%20Medication%20Clinical%20Criteria%20Final%20updated%20Aug2018.pdf
Massachusetts	MASSHEALTH INNOVATIVE PRACTICES FFY2019 Provider Outreach Programs The goal of this program is to identify high cost medications / disease states that are also associated with considerable non-adherence. The measure utilized within the programs will be the medication possession ration (MPR). Examples of such programs include the following: Synagis/RSV Prophylaxis Hepatitis C Agents Each individual program follows a similar model whereby a consultant pharmacist or pharmacy associate monitors medication claims/MPR for the select members. If a lapse or potential lapse in medication claims is identified, a consultant pharmacist conducts telephonic outreach to the prescriber. Prior Authorization determinations are adjusted on a case by case basis when indicated. These interactions are monitored, and outcomes of the interventions are reviewed periodically. CAR-T Monitoring Program Following the initial approval of CAR-T therapies in late 2017, a monitoring program was created with several aims. First, the manufacturer of one agent Kymriah (tisagenlecleucel) offered to reimburse the provider for the cost of the drug if treatment was unsuccessful at 30 days post-treatment. A mechanism was needed to ensure that the plan would not pay for medication is this scenario. In addition, the monitoring program follows plan members at specified points post-treatment to verify treatment response and better understand the long-term impact of therapy.

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	Zolgensma (onasemnogene abeparvovec-xioi) Monitoring Program Following approval of Zolgensma (onasemnogene abeparvovec-xioi) in May of 2010 a monitoring program was created with the aim of following plan members at specified points post-treatment to verify treatment response and better understand the long-term impact of therapy. Complex Opioid / Therapeutic Case Management Workgroup A biweekly meeting occurs with a multidisciplinary team involving clinical consultant pharmacists, physician advisor, psychiatry consultant and pain specialist (as needed). The intent of these meetings is to discuss and develop action plans for members on complex opioid regimes including high dose and duplicative therapies. Polypharmacy with other classes associated with abuse and diversion (e.g., benzodiazepines, stimulants) are considered in the evaluation. Opioid Dose Accumulator and Concomitant Opioid Benzodiazepine initiatives In 2019, point of sale coding was developed to identify and monitor members receiving multiple opioids and accumulate those different products into a cumulative daily dose. Secondarily, coding was developed to monitor members receiving opioids in combination with benzodiazepines. Compounding Program and Monitoring Periodic monitoring of high cost compounding ingredients is performed to ensure clinically appropriate and lowest cost ingredients are used. If an ingredient has been identified and determined not to be medically necessary, it may be subject to prior authorization. Hepatitis C Medications Following the Food and Drug Administration (FDA)-approval of Sovaldi (sofosbuvir) in late 2013, all prior authorization (PA) requests for hepatitis C regimens have been reviewed by Drug Utilization Review (DUR) to promote selection of the most cost-effective regimen. Several other products, Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Daklinza (daclatasvir), Epclusa (velpatasvir/sofosbuvir), Viekira Pak (ombitasvir/paritaprevir/ritonavir/dasabuvir), Vosevi (sofosbuvir/velpatasvir/voxilaprevir), and Zepatier (elbasvir/grazoprevir) were also included in the prescriber outreach to discuss treatment alternatives following their FDA-approvals. At the time a PA request for one of the above products is received by the DUR, a DUR clinical pharmacist may contact the prescriber to discuss an alternative, more clinically appropriate and/or more cost-effective regimen. If the prescriber agrees to switch the member to the suggested regimen, prescriber may resubmit the PA request for that regimen and receive an approval. Pediatric Behavioral Health Medication Initiative / Therapeutic Case Management Workgroup A multidisciplinary Pediatric Behavioral Health Medication Initiative (PBHMI) Therapeutic Class Management (TCM) workgroup was created consisting of pharmacists, psychopharmacology consultant, child psychiatrists, and a social worker. Retrospective case review is conducted on a daily basis and cases are discussed weekly among workgroup members to provide an increased level of clinical expertise and prescriber outreach as appropriate. Member cases reviewed by the workgroup include those with a recent psychiatric hospitalization, age less than three years, behavioral health regimens with six or more medications, and use of select high-risk agents in certain age groups (e.g., antipsychotics in children less eight years). Workgroup responsibilities include clinical discussions regarding treatment plans, prescriber outreach to encourage evidence-based prescribing practices, and referral of members to a behavioral health program that assists in integrating care and providing psychosocial interventions.

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	Pharmaceutical Pipeline Monitoring and Budget Impact Forecasting Prospective monitoring of the pharmaceutical pipeline is essential to anticipate new medications and their impact on pharmacy programs from both a formulary perspective and a budgetary perspective. The pipeline pharmacist continuously tracks agents in development, reporting on the potential place in therapy, the anticipated FDA approval date, and potential impact to the plan membership. In 2019 this process evolved to consider pipeline agents within therapeutic classes to project the impact of competing products coming to market. In addition, the pipeline pharmacist uses available clinical and economic data to predict the cost of the new agent, adoption by providers and patients, and the potential budgetary impact to the plan. Based on this information, the program can successfully organize, prioritize, and determine appropriate management strategies for emerging therapies, as well as allocate budgetary resources appropriately. Accountable Care Organization Care Referrals In 2018, MassHealth enrolled most plan members into Accountable Care Organizations with the goal of providing coordinated high-quality care. To support the success of this model efforts were taken to identify at risk members for the ACO to facilitate intervention. Members referred to ACO case managers included those with diabetes, respiratory disorders and pediatric members receiving psychiatric medications. Reasons for referral included suboptimal medication adherence and lack of access to community services and supports. Special Populations Extended Scope and Services Community Case Management (CCM) The special populations pharmacist maintains a direct means of expedited communication between MassHealth DUR and CCM. The CCM pharmacist tracks PA denials and approvals, reports trends and provide recommendations to MassHealth based on findings. Provider outreach involving medication related consultations, discharge consultations, and medication reconciliation ensure continuity of care among this at-risk population. Division of Children and Families (DCF) The special populations pharmacist maintains a direct means of expedited communication between MassHealth and DCF nurse case managers and social workers for medication-related inquiries. The special populations pharmacist also facilitates procurement and appropriate utilization of medications through collaboration with DCF providers. Enhanced Coordination of Benefits (ECOB) The special populations pharmacist maintains a direct means of expedited communication between MassHealth DUR and ECOB health benefits coordinators to ensure appropriate use of third-party liability and pharmacy billing for members. Automated PA -Point of Sale (POS) Rules As the Drug Utilization Review (DUR) program reviews new medications, performs evidence-based medicine reviews and executes quality assurance analyses, updates to the PA process are required. These updates require the creation or update of a clinical guideline used for reviewing PA requests. Each clinical guideline that is created requires the development of a point of sale (POS) rule. These POS rules are decision algorithms designed to evaluate clinical criteria at the time the prescription is processed at the pharmacy level and bypassing the PA submission process. When a prescription is processed through the MassHealth Pharmacy Online Processing System (POPS), the software automatically searches medication history, diagnosis, or procedure codes from the MassHealth medical and pharmacy claims database. If all criteria are met, the medication will adjudicate at the pharmacy without a requirement for PA submission.

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	Special Projects Changes in Medical and Pharmacy Utilization Following Initiation of Clozapine in Adults with Treatment-Resistant Schizophrenia in a Medicaid Population. This project has led to a better understanding of the financial and clinical outcomes after clozapine use. An Observational Case-Control Study of Risk Factors for Overdose in Members of a State Medicaid Program Prescribed Concurrent Benzodiazepines and Opioids. This project has led to a better understanding of risk factors for overdose in this patient population. An evaluation of a multidisciplinary pediatric behavioral health medication initiative workgroup's interventions on medication prescribing in a population of Medicaid patients. This project has led to a better understanding of the impacts of interventions by child adolescent psychiatrists to improve the medication regimens of pediatric members being treated for behavioral health indications. Effectiveness of ledipasvir/sofosbuvir and predictors of treatment failure in members with hepatitis C genotype 1 infection: A retrospective cohort study in a Medicaid population. This project has led to a better understanding of the predictors of treatment failure in those patients with hepatitis C infection. Impact of sequential opioid dose reduction interventions in a state Medicaid program between 2002 and 2017. This project has led to a better understanding of the impact of opioid dose reductions in the MassHealth pharmacy program over a 15-year period. MassHealth Acute Hospital Carve-Out Drugs List This MassHealth Acute Hospital Carve-Out Drugs List section of the MassHealth Drug List (MHDL) applies to participating in-state MassHealth Acute Hospital providers, and as applicable to out-of-state MassHealth acute hospital providers pursuant to 130 CMR 450.233(D). This List identifies the current list of Adjudicated Payment Amount per Discharge (APAD) Carve-Out Drugs and Adjudicated Payment per Episode of Care (APEC) Carve-Out Drugs for purposes of Sections 5.B.8.b and 5.C.9 of the current MassHealth Acute Hospital Request for Applications for in-state acute hospitals (Acute Hospital RFA), and regulations at 130 CMR 450.233(D) for out-of-state acute hospitals. The hospital must obtain prior authorization (PA) from MassHealth for the APAD Carve-Out Drugs and APEC Carve-Out Drugs on this list, and the associated treatment will be subject to monitoring, as indicated below. Other requirements also apply. This list, and the PA and other requirements, may be updated from time to time. APAD and APEC drugs include Car-T Therapies, Spinal Muscular Atrophy Gene Therapy, and FDA-Approved New to Market Drugs and Biologics that are not listed on the MassHealth Drug List are evaluated on a case by case basis.
Michigan	Michigan Medicaid has been leading the way to control healthcare spending for years. We were one of the first states in the nation to implement supplemental rebate contracting to create a preferred drug list (PDL). Michigan Medicaid also employs an aggressive reimbursement pricing algorithm, quantity limits, clinical edits and a maximum allowable cost (MAC) program. As part of their DUR program, Michigan Medicaid conducts academic detailing activities utilizing the WholeHealthRx program to educate prescribers on current evidence-based guidelines and prescribing patterns for behavioral health medications.

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	Several new edits were implemented to address both acute and chronic pain management consistent with the CDC guidelines. Opioid naive beneficiaries have the initial fill of an opioid prescription limited to a 7-day supply and to dosages less than 50 MEDD. Additionally, an accumulation edit was implemented to determine the total MEDD of all opioid prescriptions for an individual. This edit is being phased in to minimize the impact to the community. The initial implementation set the maximum accumulated doses at 500 MEDD with the goal of lowering the edit's threshold down to 90 MEDD. MI Medicaid is also utilizing the WholeHealthRx academic detailing program to provide educational outreach to prescribers to provide guidance on how to better treat acute pain with fewer opioids. The DUR Board closely monitored the increasing utilization of gabapentin. With growing concerns of over-prescribing, the Board recommended that the daily dosage be limited to 3600mg. Dosages exceeding 3600mg require a prior authorization. On October 1, 2018, Michigan Medicaid expanded the coverage of hepatitis C medications to patients with F1 liver scarring. Prior to that date, coverage had been limited to more advanced liver scarring of stages F2-F4. Two new technological enhancements were made this year. A web-based drug lookup tool was implemented that allows providers as well as beneficiaries to determine drug coverage for the FFS program. Also, an electronic PA (ePA) tool was implemented to ease the administrative burden on prescribers. The tool integrates the clinical decision tree and preferred alternatives during the prior authorization process. This increases compliance with our preferred products. Overall, it improves the user experience for the provider community and reduces the prior authorization turnaround time.
Minnesota	There are no innovative practices to report.
Mississippi	I. The Division of Medicaid's opioid related prospective point-of-sale (POS) safety edits were implemented August 1, 2019. Prior to the POS implementation of the hard edits, MS-DUR consistently mailed letters to prescribers per DUR Board recommendations for several years. These letters identified the prescribers' patients who were receiving concomitant benzodiazepine therapy and /or whose MME was =/> 90. The POS safety edits are as follows except for those beneficiaries with certain diagnoses (cancer, sickle cell disease) as recommended by the DUR Board: 1) Duplicate fill and early fill alerts: In addition to duplicate fill and early fill alerts on all opioids, new opioid prescriptions for opiate-naive patients must be for a short-acting (SA) opioid. SA opioid prescriptions for opiate-naive patients are limited to both day supply allowed per prescription fill and number of times the prescription can be filled per month in accordance with current DUR Board recommendations. 2) Quantity limits: Monthly quantity limits for all opioids. 3) Dosage limits: Maximum daily dosage limits for all opioids in accordance within the FDA approved indications or compendia supported guidelines. 4) MME limitations of =/90: Daily opioid doses, whether individual and/or cumulative daily sum of all opioid prescriptions for the patient, in excess of the Morphine Milligram Equivalents (MME) as recommended by the DUR Board will require prior authorization (PA) with documentation that the benefits outweigh the risks and that the patient has been counseled about the risks of overdose and death. 5) Concomitant use of opioids and benzodiazepines will require PA

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	Medicaid worked to align the opioid initiatives with the CDC's guidelines, the Mississippi State Board of Medical Licensure prescribing regulations, the Governor's Opioid and Heroin Task Force recommendations, and Medicaid requirements under section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and the Communities Act (SUPPORT Act). This effort, along with extensive efforts to educate providers prior to the implementation and affect prescribing patterns, resulted in minimal provider and beneficiary disruption upon implementation of the initiatives. II. Pharmacy Stakeholders Collaborative - The Division of Medicaid began meeting with the 5 pharmacy member organizations in Mississippi (Mississippi Pharmacists Association, Mississippi Society of Health-System Pharmacists, Magnolia State Pharmaceutical Society, Mississippi Independent Pharmacies Association, and Mississippi College of Clinical Pharmacists) to foster the expansion of clinical services pharmacists provide in Mississippi. The collaborative developed a list of priority areas for cultivating pharmacist provided care. Some of the identified areas include reimbursement of pharmacists for vaccine administration and coordination of patient care upon discharge from the hospital between an institutional pharmacist and a community pharmacist (pharm-to-pharm care coordination). The collaborative was able to meet with Medicaid's Medical Advisory Committee to present their proposal. Medicaid's Executive Director also visited a high-performing community pharmacy to get a first-hand view of the scope of services pharmacists can provide. III MCOs increased involvement in DUR Activities - Mississippi Medicaid continues to work to incorporate its three managed care organizations into DUR activities. During the past year, each MCO was invited to present at multiple DUR Board meetings regarding specific patient management services they provide. These presentations focused on the management of patients at risk of preterm birth and the management of patients with COPD. Through this sharing of knowledge, Medicaid and the MCOs were able to learn from each other and identify "best practices" that could be incorporated across all programs. This sharing of knowledge also allowed for the identification of potential barriers to effective patient management and the collaborative development of strategies to potentially overcome these barriers. The MCOs have also been more involved in helping Medicaid identify potential DUR projects that impact all pharmacy programs.
Missouri	Atypical Antipsychotic Usage in Children - MO HealthNet (MHD) in partnership with the Department of Mental Health and the Children's Division within the Department of Social Services, implemented revised clinical criteria for use of the atypical antipsychotics in children in January 2016. We are using a combination of prior authorization and clinical review, along with retrospective case review to ensure appropriate utilization among our youth participants. Our initial focus was on children under 9 years of age in foster care, but our criteria changes and reviews apply to therapy for all children covered by MO HealthNet. In April 2017, MHD began reminding ALL prescribers of atypical antipsychotics in children of the need for metabolic monitoring, and that the division would require documentation in the near future, prior to authorizing continued therapy. This initiative was anticipated to be fully in place by August 2017, however MHD ran into issues being able to check for metabolic monitoring transparently. The issues involved FQHCs being able to bundle bill and MHD being unable to distinguish metabolic monitoring claims within the bundle bill and that there were some providers who did finger sticks in their offices but MHD does not cover a claim for finger stick metabolic monitoring. Discussions

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	are ongoing around these issues. The Children Division under the Department of Social Services, The Department of Mental Health and MHD have had ongoing meetings regarding Psychotropic Prescribing for children under the age of 9 which has led to the establishment of a Center of Excellence to provide additional review specifically for our foster children. High Quality and Cost-Effective Health Care (Direct Care Pro) - Direct Care Pro is a highly innovative Medication Therapy Management (MTM) tool. This application utilizes the pharmacist-patient relationship, focusing on quality of care, wellness initiatives and cost containment. This web-based system assists pharmacists and other appropriate healthcare providers to maintain standards of care for participants' multiple chronic diseases and co-morbidities by utilizing nationally recognized, evidence-based treatment standards. The statewide rollout of this tool started in summer 2010 by delivering actionable clinical information at the point-of-service, empowering pharmacists to provide clinical education to their patients. As of August 2016, there were over 150 pharmacy sites with over 200 pharmacists set up with MTM access to perform encounters. To date, over 8,600 encounters have been performed. Clinical Editing/Prior Authorization (SmartPATM) - SmartPATM employs a highly sophisticated clinical rules engine that uses algorithmic criteria derived from best practices and evidence-based medical information to allow transparent approval of service and product requests. It streamlines the prior authorization process for all stakeholders - physicians, allied health professionals and participants - as it adjudicates prior authorizations in real time. All providers who participate in MO HealthNet's fee-for-service program are subject to clinical editing and prior authorization requirements. Smart MedPATM technology was implemented in July 2006 utilizing the same clinical rules engine used for SmartPATM. SmartPATM and Smart MedPATM process precertifications for pharmacy, durable medical equipment, radiology and optical services. MHD has started including behavioral health services in the Smart MedPA TM rules engine to ensure appropriate utilization and efficient use of funds. As of August 2019 there are over 300 Pharmacy edits and 38 Durable Medical Equipment Rules. In the pharmacy program transparency rates exceed 90% for certain rules with an overall transparency average of 82%. Long Acting Reversible Contraceptives (LARCs) - The 2017 Missouri legislative session passed legislation in the attempt to deal with the high number of MHD abandoned non-oral Long Acting Reversible Contraceptives (LARCs) in provider's offices. If the LARC was dispensed from a pharmacy, it cannot be returned to the pharmacy. The legislation allowed for a MHD participant abandoned unit to be utilized for another MHD participant. A prescription paid under one MHD participant being utilized by another MHD participant would create an audit nightmare and have incorrect information or no information regarding the LARC in MHD medical profiles. MHD changed its policy where LARCs were no longer allowed to be dispensed by a pharmacy and medical providers needed to obtain the LARC from the pharmaceutical company or wholesaler and bill MHD the LARC as a pharmacy claim. Should the unit become abandoned the provider has 90 days to return it to the manufacturer or wholesaler for credit. Advisory Council on Rare Diseases and Personalized Medicine - The 2018 Missouri legislative session passed legislation that established an 'Advisory Council on Rare Diseases and Personalized Medicine' within the MO HealthNet Division. The advisory council shall serve as an expert advisory committee to the drug utilization review board, providing necessary consultation to the board when the board makes recommendations or determinations regarding beneficiary access to drugs or biological products for rare diseases, or when the board itself determines that it lacks the specific scientific, medical, or technical expertise necessary for the proper performance of its responsibilities and such necessary expertise can be provided by experts outside the board. The advisory council meets quarterly and has reviewed a number of rare disease medications including unique insight into the treatment and care of these rare and ultra-rare diseases that would not be available to state staff without the council.

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	Alternative Pain Management Therapies - In 2019 MO HealthNet implemented the coverage of alternative pain management therapies, including acupuncture, chiropractic services, and physical therapy. These services are covered as an alternative to opioids for chronic pain. While the program is still in its infancy, the goals of the program are to reduce the need for chronic opioids when participants are suffering from chronic pain. The services are available to FFS and MCO participants.
Montana	Pharmacy Case Management Program The primary goal of the pharmacy case management program is to share information with all providers of care to enable individual /multiple providers the opportunity to manage drug therapy based on all the information available. The Medicaid program allows for this sharing of information by virtue of the benefit and that all the data resides in mostly one repository. By having first-hand knowledge of all the medications, providers, pharmacies, and other medical services that have been provided to the member, a more goal-oriented approach can be made for each member. After a case is chosen for review, a case management pharmacist then makes phone appointments with the providers involved to discuss utilization issues, counter-detailing, and cost appropriateness. This program also defines a mechanism for reimbursement of the provider's participation in the telephone conference by virtue of a CPT code. Cases are chosen for review by several methods: Selection by the Pharmacy Case Management Clinician via retrospective DUR, referral from the Drug Prior Authorization Unit during prospective DUR, or referral from outside sources including the Team Care (lock-in) program director, Medicaid Pharmacy Program Officer, case workers, or other members of the patient's health care team (i.e. retail pharmacist or physician). Medicaid drug claims data in conjunction with diagnoses information is then reviewed by a pharmacist. Medication review may include any/all of the following parameters: Possible medication over-usage, medication duplication, potential drug-drug interactions, drug-disease indications, identification of multiple pharmacies or providers, and potential cost savings recommendations. If an intervention is deemed appropriate, a copy of the patient's medication profile, diagnosis profile, and letter requesting a telephone conference is mailed to the prescribing physician(s). This information indicates all medications, physicians, pharmacies and diagnoses that have been documented through Montana Medicaid within a selected time period. It also indicates the reason for patient selection. A telephone conference is scheduled to discuss recommendations with the physician. Often times, a physician will fax documentation resulting in a positive outcome for the patient in lieu of a telephone conference. If necessary, cases may be referred to the DUR Board for further review and recommendations. Information on how to bill for the telephone conference is sent to the provider after the interface, and all patients involved in the case management are tracked within the internal MARS database tracking system. These cases are also viewable by drug PA staff for cross-referencing relevant data with the prior authorization process. Pharmacy case management was expanded in FFY 2008 to include academic detailing of selected topics (i.e. Suboxone best-practice guidelines.) Face-to-face education of prescribers has been effective in changing prescribing practices of targeted drugs to be consistent with the medical evidence, support patient safety, and to be cost-effective choices.

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	The process has been extremely successful in engaging providers to be part of the solution in dealing with the increasing complexity and cost associated with current drug therapies. Psychotropic Medication Usage Oversight among Children in Foster Care The pharmacy case management program continues to assist in the oversight of psychotropic medication use in the Montana Medicaid foster care population. Clinical case management staff has met with stakeholders for input including the medical directors of child and adolescent psychiatric treatment facilities and community-based psychiatric services in Montana. Based on current psychiatric treatment guidelines and input from the profession, foster care members meeting specific clinical criteria undergo case review by a clinical pharmacist, who works with providers following the same protocols established by the pharmacy case management program previously described. Case management staff are currently working with stakeholders and providing educational presentations at various Montana conferences such as the Foster Resource Conference, Child Abuse and Neglect Conference, MSFAPA Conference, and the upcoming Youth Summit. The development of an educational brochure for CPS Workers, Foster Parents and children, and psychotropic medication education packet for foster parents has also been accomplished. Various successes have been realized; including increased laboratory monitoring and appropriate indication for atypical antipsychotic medication, medication dose decrease and/or discontinuation, and increased continuity of care between providers of care for the foster care population. Development of a Prior Authorization Required Process for Medications without prospective DUR edits In an effort to combat significant medication overuse/abuse and support patient safety, the pharmacy case management program worked with the department to develop and implement a process for a provider-driven PA required process managed through the point-of-sale system. This process is for medications normally not requiring prior authorization and members for this program are referred on a case-by-case basis. Implementation of a Drug Not Covered Status in the Medicaid POS system prevents a member from receiving a selected medication or complete therapeutic class of medications each time a claim is submitted, unless a prior authorization is granted per instructions developed by the provider and the case management pharmacist. Currently approximately 300 members are enrolled and managed through this program. This has been an effective means to provide a higher level of management for those members who even the lock-in program cannot prevent overuse and misuse of medications. Case Management for Hepatitis C Medications The pharmacy case management program has been intimately responsible for managing the approval process for the new generation of medications to treat Hepatitis C. This has promoted the utilization of appropriate therapy through telephonic prescriber outreach by a clinical case management pharmacist and resulted in considerable cost savings to the Medicaid program. In coordination with the state, the criteria for treatment has changed and our staff has been able to help guide providers to better treatment outcomes for the increased population receiving antivirals treating/curing Hepatitis C. Case Management for Hereditary Angioedema Medications Significant cost savings were found by working with patients and providers to increase use of attack logs, awareness of acute vs prophylactic medication need, and utilization management by

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	the CM pharmacist that promoted better patient understanding of their disease. This effort reduced the anticipated amount of emergency department visits by coordinating care between the patient and their providers in addition to helping patients and their families understand the nature and progression of HAE. Case Management of Idiopathic Thrombocytopenic Purpura (ITP) By correctly identifying the need/indication for drug therapy with providers and then working out appropriate dosing with them for their patients, significant cost savings were found in addition to enhanced management of chronic therapy needs. Case Management of Cystic Fibrosis (CF) Working with providers and their CF patients, we have been able to reduce disease exacerbations, increase drug compliance, potentially lower drug resistance rates with appropriate antibiotic use, and lower overall treatment costs related to all these efforts. Case Management of Opioid Use Disorder (OUD) Our pharmacy team has worked with almost all providers of Medication Assisted Treatment (MAT) in Montana that use Suboxone or Sublocade for their patients. Combining our CM efforts with the prior authorization of both agents, we have been able to decrease the number of concomitant opioids, benzodiazepines, and tramadol medication use in Medicaid members receiving MAT therapy. This has also diminished the risk of overdose in this population by restricting their access to other opioid medications while receiving MAT therapy. The teams are also actively involved in both state and local taskforces working to help manage opioid use disorder and to be active within our communities as a resource to help manage patient care. Case Management of Eosinophilic Asthma Our CM efforts have established procedures for appropriate use of medications indicated for this condition and we have increased adherence rates to appropriately prescribed medications by our follow up and treatment protocols. Case Management of Pseudobulbar Affect (PBA) Diagnosis of this condition and its treatment can often be difficult, the medications are not highly effective, and patients are often left on therapy without evidence of success. Our CM team, using DUR Board approved protocols, evaluates diagnosis and patient need to start therapy and then follows up with providers to establish continued efficacy in relation to baseline metrics. This utilization effort not only sets up appropriate use but reduces costs in situations where the medication is not indicated or does not provide a benefit for a patient. Automated Prior Authorizations Our PA staff continues to work with the State and their contracted vendor to improve automatic prior authorizations where appropriate and the appropriate algorithms can be managed. Through weekly meetings and constant communication, any issues with these are resolved almost immediately, and without disruption to patient care.
Nebraska	Nebraska Medicaid worked collaboratively with the managed care organizations to improve both prospective and retrospective drug utilization review. The DUR program included the identification of drug utilization trends by the managed care organizations where clinical best practices could be encourage or where prescribing trends identified potential patient risk. Drug utilization trends were presented to the State DUR Board for consideration and recommendation

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	of further data review. In this manner national trends along with Nebraska specific state-wide drug utilization was considered in identifying DUR projects.
Nevada	The Nevada Medicaid Drug Use Review Board continually evolves in order to meet the needs of the recipients while making the practice of medicine fair and efficient for providers. In order to optimize time and the effectiveness of the board, the following lists some of the innovative practices of the Nevada Medicaid Drug Use Review Board. In a further attempt to quell opioid use in the Nevada Medicaid population, the Board voted during the October 18, 2018 meeting to reduce the max day supply of opioids in children to a three-day supply. Members under the age of 18 are able to fill up to 13 three-day prescriptions in any rolling 12-month period for prescriptions of 60 morphine milligram equivalent (MME) or less per day without prior authorization. Prior authorization requires the recipient have chronic pain or requires an extended opioid therapy, is under the supervision of a licensed prescriber, the pain cannot be controlled through the use of non-opioid therapy, the lowest effective dose is requested and a pain contract is on file. During the January 24, 2019 DUR Board Meeting, the Board elected to adopt prior authorization for all outpatient oral oncology agents. Prior authorization criterion includes either an approved diagnosis by the FDA or supporting compendia and the requested dose must be appropriate for the diagnosis and recipient's age, among other requirements. This criterion reduces the risk of off-label use of oncology agents. The January 24, 2019 DUR Board Meeting also led to more stringent criteria for compounded medications. Monitoring of compounded medications revealed pharmacies dispensing medication combinations without proven safety and efficacy data. The prior authorization requirement was revised to apply to all compounded medications from the previously allowed $200 per prescription limit. Compounded medications are approved if shown safe and effective and no commercial product is available, among other criteria.
New Hampshire	New Hampshire FFS Medicaid program continuously monitors Hepatitis C medication guidelines and recommendations to allow coverage for additional Hepatitis C patients to be eligible for coverage. Specialty medications for oncology and HIV are covered without restriction but are monitored for potential cost saving initiatives. New Hampshire continues to review current programs such as: Maximum Allowable Cost (MAC) program, dose optimization, quantity limits, clinical edits and RetroDUR programs for potential cost savings. To address the opioid epidemic a cumulative Morphine Milligram Equivalent (MME) program was implemented in FFY 2018. All claims for members over a cumulative MME of 100, require prior authorization. Hospice, cancer, end-of-life and sickle cell patients are exempt from the prior authorization requirement. Continuous monitoring of members who exceed the MME limit is conducted and reviewed at each monthly meeting with the PBM. To improve access for treatment of Substance Use Disorder, New Hampshire does not require prior authorization for medication-assisted treatment (MAT) with brand and generic buprenorphine/naloxone SL tablets and film if the daily dose is 16mg or less. To ensure appropriate use of single agent buprenorphine SL, a prior authorization is required for all doses.
New Jersey	In FFY 2019, the State continued its focus on managing the opioid epidemic. In addition to having a real-time Medical Exception Process (MEP) in place that prospectively monitors opioid drug utilization, the Division of Medical Assistance and Health Services (DMAHS) announced its

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	Morphine Milligram Equivalency (MME) protocol to its pharmacy provider community, both in FFS and managed care, in July 2018. The MME initiative was implemented effective October 2019. In FFY 2019, the DMAHS also turned its focus to the issue of auto-refills and their suspected negative fiscal impact on the NJFC Medicaid program. The DMAHS is familiar with difficulties encountered when attempting to identify auto-refills that are not medically necessary. The DMAHS worked closely with its managed care partners to communicate auto-refill guidelines in October 2019. The guidance listed below represents a consensus regarding what is determined necessary for pharmacies to appropriately implement an auto-refill policy: - The participation of a beneficiary in an auto-refill program should be authorized by the participant, responsible party or caregiver every twelve (12) months subject to verification with the prescriber. - Written authorizations shall be retained on file by the pharmacy for no less than ten (10) years. - Automatic enrollment in an electronic refill program is not considered acceptable. - Auto-refilling of prescription drugs should be limited to maintenance drugs. Maintenance drugs are prescriptions commonly used to treat medical conditions that are considered chronic or long-term. Examples of maintenance drugs include, but are not limited to, drugs prescribed for the medical management of hypertension, heart disease, asthma and diabetes. - Pharmacies are responsible for ensuring that prescriptions filled under their auto-refill program are medically necessary. Verification of the continued use of a prescription drug during the authorization period should be conducted to ensure beneficiaries are appropriately dispensed prescribed medications. - A nurse or other authorized agent of a facility may initiate requests for prescription auto-refills for beneficiaries residing in a skilled nursing facility as ordered by a properly credentialed healthcare provider. Auto-refilling of unit-dose medications is permitted for beneficiaries residing in a skilled nursing facility. - Pharmacies with an auto-refill program shall reverse any payments for prescriptions not received by a beneficiary or responsible party within fourteen (14) days. The State continues to prospectively manage drug utilization through its MEP. The MEP performs utilization reviews, including but not limited to therapeutic duplication, drug-drug interactions, maximum daily dosage and durations of drug use. In our FFY18 Narrative, the DMAHS recognized the cost effectiveness of encouraging utilization of metformin as first-line treatment for Type 2 diabetes after diet and exercise. A NJDURB educational Newsletter highlighting the clinical and fiscal benefits of prescribing metformin was communicated to prescribers in November 2018 to encourage changes to treatment plans developed to treat Type 2 diabetes. An initial retrospective review of metformin utilization after the Newsletter was communicated did not reveal any significant changes in utilization. The State will continue its monitoring effort to report any subsequent changes in utilization. The Governor approved family planning legislation to increase access to NJFC Medicaid family planning services for individuals not currently eligible for other NJFC Medicaid programs which became effective October 1, 2019. Plan First benefits are limited to family planning pharmacy services, including oral contraceptives, Long-Acting Reversible Contraception (LARC), over the counter condoms, spermicides, diaphragms , Plan B contraception and HPV vaccines.

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New Mexico	In order to improve the administration of the DUR program, the appropriateness of prescription drug uses, and help control costs, the following educational newsletters and interventions were developed and carried out for FFY 2019: Provider education newsletters are sent to providers to assist them in caring for their patients. An influenza newsletter was mailed to prescribing practices and pharmacies with a summary of the CDC flu vaccination recommendations and a summary on the use of antiviral medications. Also, a newsletter was mailed on the Herpes Zoster Vaccination to provide information on the vaccine to prevent occurrences of the disease. Another newsletter was mailed on Monitoring for Metabolic Adverse Effects of Second-Generation Antipsychotics (SGAs) to educate providers regarding guideline recommendations for appropriate metabolic monitoring of patients receiving SGAs. This newsletter was followed by an intervention targeting providers prescribing SGAs. Monitoring continued on the use of opioids, benzodiazepine anxiolytics, and controlled sedative hypnotics to address the best practices on preventing drug overdose deaths due to increased use of opioids, especially high doses, longer courses of treatment, and use with benzodiazepines. A newsletter was mailed out on Opioid Prescribing Recommendations and another on the Guidance for Opioid-Based Treatment of Opioid Use Disorder to show the clinical effectiveness of treating opioid use disorder with medication and counseling. Another intervention on the use of Codeine and Tramadol in Youth provided information to targeted providers on the increased risk of adverse events, including alternative treatments for cough and cold symptoms, and the pharmacologic pain treatment guidelines from the World Health Organization (WHO).
New York	During the time period being reviewed the NY BLTG (Brand Less than Generic) Program has been updated 8 times in an effort to capitalize on brand pricing being lower than the generic equivalent. Effective 11-29-18 a PA was required for all compounded products for topical use to ensure that both Federal and State regulations are adhered to and that said therapy has FDA and compendia support. The States Preferred Diabetic Supply program expanded coverage in the area of continuous glucose monitors and insulin pumps for diversity of its patient population. On 12-06-18 the recommendations of the DUR Board from their 9-20-18 meeting was put into place through the update of the States Prior Authorization Program. On 1-1-19 arrangements were made with a State MCO plan that did not cover family planning and reproductive health to now cover those services for their recipients. As an added effort to curtail the prescribing of opiates for pain management, New York Medicaid was able to create a tool to aid selection of non-opioid options for pain management with links to resources for the treatment of substance use disorder. This webpage development for non-opioid alternative treatment options became available 1-9-19. Effective 4-8-19, NY Medicaid issued a beneficial change for recipient coverage of contraceptive prescription drugs. The change allows for a written contraception order for family planning to be filled 12 times within one year. This was a change from the previous allowance of a one-time supply in a 12-month period or 5 times in a 6-month period. On 6-6-19 the DUR Board recommendations from their 2-14-19 meeting was put into place; an update of the States Prior Authorization Program, a drug cap review of the product Remicade was

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	performed, requirement for prescriber intervention for the initiation of gabapentin or pregabalin on patients with concurrent use of an opioid, require prescriber intervention for continuation of opioid therapy beyond seven days in patients established on gabapentin or pregabalin, send a targeted educational letter to prescribers highlighting safety concerns associated with opioids and the concurrent use with gabapentin and pregabalin. A system's edit relating to the dispensing of vaccines through the Vaccines for Children Federal Program was put into effect on 5-23-19. The new edit assures that vaccines obtained through the Federal Program, dispensed to children at or under the age of 19, will no longer be allowed to be billed to NY Medicaid. DUR Board recommendations from their -19 meeting were put into effect on 8-25-19 with an update of the States Prior Authorization Program. A system's edit was put into effect on 9-12-19 which validates ingredient cost for 340B claims. On 11-21-19 the DUR Board recommendations from their 9-19-2019 meeting were put into effect; Prior authorization requirement for opioid-naive patients exceeding the morphine milligram equivalent (MME) of 90 mg per day, send targeted educational letters to prescribers regarding antipsychotic therapy and metabolic monitoring for patients less than 21 years, prior authorization required for patients less than 21 years of age when there is concurrent use of two or more different oral antipsychotics for more than 90 days, send targeted educational letter highlighting the SUPPORT ACT, send targeted educational letters to prescribers regarding leukotriene modifiers use relative to asthma treatment guidelines.
North Carolina	These are some of the articles from our North Carolina Medicaid Pharmacy Newsletter to describe innovative practices that have improved the administration of the DUR program, the appropriateness of prescription drug use, or have helped to control costs. February 2019 Pharmacy Newsletter NC Medicaid Managed Care PHP Contracts Awarded On Feb. 4, 2019 NC Medicaid Managed Care PHP Contracts Awarded On Feb. 4, 2019, the North Carolina Department of Health and Human Services (NC DHHS) announced the selection of Prepaid Health Plans (PHPs) that will participate in Medicaid managed care when the program launches in November 2019. The Department awarded contracts to five entities: Statewide PHP contracts were awarded to the following entities which will offer Standard Plans in all regions in North Carolina: AmeriHealth Caritas North Carolina, Inc. Blue Cross and Blue Shield of North Carolina UnitedHealthcare of North Carolina, Inc. WellCare of North Carolina, Inc. A regional PHP contract was awarded to Carolina Complete Health, a provider-led entity, which will offer plans in Regions 3 and 5. In 2015, the NC General Assembly directed the transition of Medicaid to a managed care structure. In managed care, NC DHHS will oversee all aspects of the Medicaid and NC Health Choice programs. However, PHPs will directly manage certain health services which include pharmacy, assume financial risk and contract with providers to provide services for beneficiaries. About 1.6 million Medicaid and NC Health Choice beneficiaries will enroll in a Standard Plan, which will

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	provide integrated physical health, behavioral health and pharmaceutical services. To ease the transition to Medicaid Managed Care, Standard Plans will launch in two phases. The first phase will launch in November 2019 for beneficiaries in the following 27 counties: Alamance, Alleghany, Ashe, Caswell, Chatham, Davidson, Davie, Durham, Forsyth, Franklin, Granville, Guilford, Johnston, Nash, Orange, Person, Randolph, Rockingham, Stokes, Surry, Vance, Wake, Warren, Watauga, Wilkes, Wilson and Yadkin. Standard Plans will launch in the remaining 73 NC counties in February. 2020. In the coming months, the NC DHHS will work with each PHP to implement managed care consistent with the NC DHHS's expectations as outlined in the PHP RFP. Over the summer and fall, the PHPs will complete a readiness review to demonstrate their ability to meet state, federal and contractual requirements. Once implemented, the PHPs will be subject to rigorous oversight by the NC DHHS to ensure strong provider networks, a full range of benefits, accountability for quality and outcomes, a positive beneficiary experience and timely payments to providers among aspects of a successful managed care program. A fact sheet with more information can be found at https://files.nc.gov/ncdhhs/medicaid/Medicaid-Factsheets-PHP-2.4.19.pdf. For additional information about Medicaid Transformation, please visit https://ncdhhs.gov/medicaidtransformation April 2019 Pharmacy Newsletter Insulin Products Added to Unbreakable Package List Insulin Products Added to Unbreakable Package List Billing inaccurate package sizes creates extra costs and delays for the NC Medicaid and NC Health Choice (NCHC) programs when collecting drug rebates from manufacturers. Providers should bill the quantity that matches the package size for the NDC billed. If a different package size is used for the refill, the prescription must be updated to match the drug dispensed with the drug on the label, as is also required by law. The NC Medicaid Outpatient Pharmacy Program accepts metric decimal quantities. To assist providers in billing correct quantities, an edit is in place in NCTracks to deny claims billed with inaccurate units for certain medications. Effective immediately, covered insulin cartridges and pens will be added to the unbreakable package edit list in addition to insulin vials. May 2019 Pharmacy Newsletter State Maximum Allowable Cost (SMAC) Update North Carolina Medicaid outpatient pharmacy reimbursement methodology as approved by the Centers of Medicare and Medicaid Services (CMS) includes the use of a State Maximum Allowable Cost (SMAC) rate for generic drugs with A-rated equivalents and, in the great majority of cases, generic drugs marketed by at least two labelers. The SMAC reimbursement is based on the application of a percentage factor applied to the lowest priced generic drug. In cases where the calculated SMAC rate, based on the primary percentage factor, results in a price less than the cost of the second lowest generic drug, at least an additional 10 percent margin is added to the cost of the second-lowest generic drug to determine the SMAC

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	rate. The SMAC pricing factor is established by NC Medicaid and may change as deemed appropriate. For generic drugs with only one supplier, the SMAC rate is calculated using the actual acquisition cost and average wholesale price of the generic drug. A minimum reimbursement of 20 percent above actual acquisition is guaranteed for these drugs. In most cases, SMAC rates are substantially higher than this 20 percent, which allows the state and pharmacies to share in the cost savings of using the generic product. Generic drugs on the SMAC list must be in adequate supply. Drug shortage information is verified through national pharmacy websites as well as through information provided by national drug wholesalers. North Carolina Medicaid has contracted with Myers and Stauffer to provide assistance in maintaining the SMAC list and rates for generic drugs. Myers and Stauffer routinely reviews and updates the SMAC rates to reflect changes in drug availability and current pricing. New drugs are also added to the SMAC list as they are identified. July 2019 Pharmacy Newsletter Clinical Coverage Policy Update for 340B Pharmacy Providers Pharmacy providers should be aware that the Division of Health Benefits recently updated Outpatient Pharmacy - Clinical Coverage Policy No. 9 regarding billing guidelines for 340B drug claims submitted as a pharmacy point-of-sale (POS) claim. 340B providers must be listed on the HRSA website found at http://www.hrsa.gov/opa/. 340B providers must submit POS claims with an "8" in the basis of cost determination field (NCPDP D.0 field 423-DN) AND a "20" in the submission clarification field (NCPDP D.0 field 420-DK) to indicate they are dispensing a 340B product. This will eliminate duplicate discounts as the claims will be pulled from rebate collections. 340B providers must submit the actual purchased drug price in the usual and customary charge field. Providers who maintain two separate inventories - one for eligible 340B prescriptions and a purchased inventory for non-340B prescriptions - may not dispense a 340B program purchased drug and bill Medicaid or NC Health Choice the calculated Medicaid price for non-qualified 340B prescriptions. Hemophilia drugs: 340B providers may submit the state upper limit established for a 340B purchased hemophilia drug. Please note that Clinical Coverage Policy No. 9 was updated on July 22, 2019. Prior to this update the policy allowed for submission of POS claims with an "8" in the basis of cost determination field (NCPDP D.0 field 423-DN) OR a "20" in the submission clarification field (NCPDP D.0 field 420-DK). The updated policy requires use of both indicators. Previously, providers were instructed to submit both the actual purchased drug price AND the dispensing fee in the usual and customary charge field. Per the updated policy, only the actual purchased drug price should be submitted in the usual and customary charge field.

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	The referenced clinical coverage policy can be found at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/pharmacy-services-clinicalcoverage-policies August 2019 Pharmacy Newsletter Influenza Vaccine and Reimbursement Guidelines for 2019-2020 for N.C. Medicaid Effective January 1, 2016, NC Medicaid began reimbursing pharmacies for covered vaccines, including influenza vaccines, as permitted by G.S. 90-85.15B when administered to NC Medicaid beneficiaries 19 years of age and older by an immunizing pharmacist. The Composition of the trivalent influenza vaccines for the 2019-2020 influenza season is: A/Brisbane/02/2018 (H1N1) pdm09-like virus (updated) A/Kansas/14/2017 (H3N2)-like virus (updated) B/Colorado/06/2017-like (Victoria lineage) virus Quadrivalent (four-component) vaccines, which protect against a second lineage of B viruses, are recommended to contain the three recommended viruses above plus B/Phuket/3073/2013-like (Yamagata lineage) virus. For further details on the 2019-2020 influenza vaccine, visit the Centers for Disease Control (CDC) Flu Season web page. Influenza vaccine and administration fee rates for pharmacists are the same as for other providers. Refer to the Physician Administered Drug Program (PDP) fee schedule on DHB's PDP web page for more information. September 2019 Pharmacy Newsletter Statewide Transition to Managed Care on Feb. 1, 2020 The NC Department of Health and Human Services (DHHS) announced on September 3, 2019 that it will extend open enrollment for Medicaid beneficiaries and move to a statewide transition to managed care on February 1, 2020. There are five NC Medicaid managed care prepaid health plans. Attention: All Providers Procedures for Prior Authorization (PA) of Synagis (palivizumab) for Respiratory Syncytial Virus Season 2019/2020 The clinical criteria used by NC Medicaid for the 2019/2020 Respiratory Syncytial Virus (RSV) season are consistent with guidance published by the American Academy of Pediatrics (AAP): 2018 - 2021 Report of the Committee on Infectious Diseases, 31th Edition. This guidance for Synagis use among infants and children at increased risk of hospitalization for RSV infection is available online by subscription. The coverage season is November 1, 2019, through March 31, 2020. Providers are encouraged to review the AAP guidance prior to the start of the RSV season. September 2019 3 On February 1, 2020, NC Medicaid will transition from fee-for-service to Medicaid Managed Care statewide. Coverage of Synagis will transition to the managed care Prepaid Health Plan (PHP) selected by or assigned to the beneficiary. Beginning February 1, 2020, providers will only use the documentforsafety.org web-based process to submit a PA request for coverage of Synagis or complete a dose request to obtain the medication for beneficiaries with traditional Medicaid fee-for-service (now known as Medicaid Direct) coverage.

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	Much of the cost containment results from clinical criteria, Prior Authorization of medications, PDL placement, monitoring new high cost specialty drugs and ensuring they are used appropriately, the lock-in program, and ensuring beneficiaries have access to SUD treatments. The implementation of managed care will give our beneficiaries access to enhanced services,
North Dakota	During FFY 2019, the state implemented prior authorization requirements to limit the concomitant utilization of the antipsychotic quetiapine and opioids to patients that have exhausted other treatment options for the patient's diagnoses for use. Information required for prior authorization approval includes a request be submitted from the provider of each agent that provided the patient's diagnosis for use of each agent; documentation of other agents previously tried and failed for that diagnosis; confirmation that the provider monitors the PDMP; and attestations that the provider has counseled the patient on the known risks of utilizing opioid analgesics in combination with antipsychotics, as well as established a realistic treatment plan for the patient in which the patient will be monitored for drug abuse and effectiveness of therapy. The state also made efforts to reduce overutilization and improving therapeutically appropriate use of antipsychotics through educational letters, provider profiling, face-to-face academic detailing interventions, and claims processing edits requiring appropriate age and diagnosis for use. Also during FFY 2019, the state has also restructured the prior authorization criteria for long-acting opioid analgesic agents by categorizing the agents as either partial agonists/antagonists, full-agonists with an abuse deterrent formulation, and full agonists without an abuse deterrent formulation. Each of these categories has preferred and nonpreferred agents and their own subset of prior authorization criteria that promotes the utilization of the partial agonists/antagonists or agents with an abuse-deterrent formulation, while limiting the use of agents without an abuse deterrent formulation. Other areas of focus for North Dakota during FFY 2019 included increasing appropriate use of agents for the treatment of opioid dependence by implementing claims processing edits that check for medication adherence; improving medication adherence with select high-cost medications by implementing claims processing edits checking for medication adherence; eliminating the need for prior authorization on medications that just require a covered indication by incorporating claims processing edits that look for covered ICD-10 codes (ICD-10s provided by prescriber and input by the pharmacy when processing the claim); and reducing short-acting beta agonist inhaler overutilization through intervention letters and by implementing claims processing edits that look for appropriate maintenance therapy. Steroid/Long Acting Beta Agonist products are used off-label in urgent care practices for cough/bronchitis. Diagnosis was applied to these products to decrease off label use outside of COPD and Asthma. An underutilization edit was developed to send information messages back to pharmacies on number of missed days within past 6 months for all drugs defined as maintenance drugs by FirstDataBank. The underutilization edit also includes an option to reject a claim at point of service for drugs that would be unsafe to continue at same dose or without intervention by pharmacy or prescriber, including long acting opioids.

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Ohio	The Ohio Department of Medicaid (ODM) has been particularly assertive in responding to the opiate crisis in Ohio. ODM responses have included coverage of medication-assisted-treatment (MAT) (following current evidence-based guidelines), expanding treatment and integrating physical health and substance use disorder delivery systems, innovation in the delivery of care, and collaboration with other state agencies to reduce prescribing and misuse of prescription opioids. Continuing its assertive response to the opioid crisis in Ohio, ODM supported best-evidence treatment guidelines for the utilization of Medication Assisted Treatment (MAT) by removing the administrative barriers to MAT such as prior authorization. ODM, both fee for service and managed care, eliminated prior authorization on all brand and generic forms of oral short acting buprenorphine-containing products for all prescribers of MAT. Updates were also made to Managed Care Provider Agreements. There was a change from Spread Pricing to Pass-Through Model, pricing schedule transparency, subcontracting relationships and delegation, and specialized pharmacies. In an effort to increase transparency, ODM posts quarterly pharmacy dashboards to make aggregate prescription drug spending data publicly available, including number of prescriptions, cost per prescription, and total quarterly spending. MCPs are now required to develop a medication therapy management program to promote the safe and effective use of medications, including over-the-counter medications, vitamins, and herbal supplements. ODM expanded this requirement to include opioids, pediatrics, and behavioral health medications. These changes allow pharmacists to play a more active role in disease management. In an effort to provide additional coverage to members with Hepatitis C, ODM removed the fibrosis score requirements on Hepatitis C drugs. In an ongoing effort to manage costs, during this timeframe several new algorithms were implemented for claims review process. These additional reviews help detect fraud, waste, and abuse while also resulting in cost savings for the department.
Oklahoma	Introduction Academic Detailing (AD) combines evidence-based guidelines with standards of care and presents them to prescribers in a non-biased manner. AD programs are typically designed to provide a link between the prescriber and an educator with positive health outcomes. While not specifically designed to be a tool of cost containment, traditionally AD programs save $2 for every dollar spent. In November 2015, PMC assisted OHCA in securing ongoing funding for the AD program through the Health Service Initiative under the Children's Health Insurance Program (CHIP). AD topics are chosen based on OHCA budgetary impact, prevalence of prescribing, sub-optimal prescribing trends, and volume of prior authorization (PA) requests. AD visits began in January 2016 and completed topics have included the following: Diagnosis and Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) Use of Atypical Antipsychotic Medications (Second-generation Antipsychotics, SGAs) Treatment of Upper Respiratory Infections Research Method

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	SoonerCare providers with high prescribing volume were identified. Prior authorization submissions for targeted categories were reviewed. Program material was developed from current targeted drug category clinical practice guidelines. AD sessions were performed by a clinical pharmacist with one to eight participants. AD sessions were geared towards potential benefits of guideline implementation. Program satisfaction survey questionnaires were completed by participants. Research Goals The research goals are to increase awareness and initiation of evidence-based guidelines for treatment to improve patient outcomes and decrease over-prescribing and overuse of high dollar medications options. Program Objectives Program objectives include educational outreach to providers indicating appropriate treatment options, identifying barriers to guideline implementation, and decreasing potentially inappropriate prescribing. Simply knowing what medications are recommended and readily available without a prior authorization can help with unnecessary paper work for office staff for both providers and payers, saving time and money. Collaborative efforts between providers and AD facilitator clinical pharmacists can improve patient care. Education on the topics of treatment guidelines, dosing regimens, monitoring, adverse events, and prior authorization criteria can ease the burden for primary care providers within these drug categories. Therapy Evaluations AD was initiated in 2015 in the SoonerCare program and reviewed for the subsequent two fiscal years. The pilot program data collected focused on changes to the following outcomes: Medication prescription patterns, utilization, and cost of targeted therapeutic medications Number of targeted therapeutic medication prior authorization petitions submitted and subsequent burden to the health care system Increased knowledge of evidence-based prescribing practices Evaluation of AD program acceptance and perceived value from participants Academic Detailing Data Academic detailing (AD) involves educational outreach to providers on a chosen topic impacting members covered through SoonerCare. The program has addressed Attention-deficit/hyperactivity disorder (ADHD), use of atypical antipsychotic medications, and most recently, antibiotic (ABX) usage. The College of Pharmacy analyzed Oklahoma SoonerCare claims to investigate antibiotic prescribing trends. Providers were identified to receive AD if three or more of the following were true: Having a 50% or more increase in number of ABX claims from 2016 to 2017 Having 50% more ABX claims than the average for their prescriber specialty Being 1 of the top 50 prescribers of ABX across the entire state Being 1 of the top 200 prescribers of ABX for both 2016 and 2017 Data is continuously compiled for review and educational opportunities for improvement. Collected data for FFY 2019 focused on changes in prescribing patterns, utilization, and use of specific therapeutic agents. During FFY 2019 more than 150 providers received ABX-AD visits and nearly 30,000 members were impacted by the program. Specific educational focus was given to treatment of upper respiratory infections as this is the area with the highest degree of inappropriate antibiotic prescribing for pediatric patients. AD providers had larger percentage

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	improvements in hospitalizations and length of stays, occurring up to 14 days after the initial antibiotic medication, compared to non-AD controls, representing a significant clinical improvement. Changes in Academic Detailing Outcomes AD Providers Non-AD Controls Patient Utilization Change Change Hospitalizations -50.5% -25.0% Length of Stay -53.0% -10.1% *negative indicates improvement Providers express a high degree of satisfaction with the program as evidenced by cumulative satisfaction survey results. More than 96% of providers describe the program as easily understood, clearly presented, and evidence-based. When asked about the impact on their practice, more than 82% say they will make practice changes as a result, recommend the program to colleagues, and participate in future topics. With the clinical success of the program to date, associated prescription cost savings of well over $200,000, and recently demonstrated reductions in hospital utilization, further program material for additional drug categories will be created with more providers being reached. Academic Detailing Analysis Summary The research analysis indicates providers who participated in the program will likely continue to use AD services given their positive assessment and corresponding changes in prescribing patterns. Interventions have shown a trend toward meaningful benchmarks in costs, prior authorizations, and program application. With the success of the pilot, further program material for additional drug categories will be created with more providers being reached. Future adult AD topics are anticipated to align with current changes to Medicaid drug utilization requirements and may include use of opioids, both alone and in combination with benzodiazepines, or SGAs. An expansion of pediatric SGA-AD to additional SGA prescribers is also anticipated.
Oregon	Adherence Monitoring in Schizophrenia Patients: Implemented of a retrospective initiative to identify schizophrenia patients who are non-adherent to routine antipsychotic therapy, and notify their prescribing provider when they miss a medication refill. Expert Consultation for Long-term Antipsychotics in Children: RetroDUR program which provides new start patients access to care coordination and referral for expert consultation by psychiatrists with the Oregon Prescription Access Line for Kids (OPAL-K) program. Profiles of children who are less than 10 years of age and prescribed long-term antipsychotic therapy are referred to OPAL-K for peer-to-peer provider consultation so experts can then coordinate with prescribing providers in order to improve patient care.

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Pennsylvania	FFS does not have specific innovative practices to report during the FFY2019 time period. FFS Pharmacy Program clinicians stay abreast of new clinical information and develop strategies as opportunities are identified to ensure the health and safety of Pennsylvania's MA beneficiaries.
Rhode Island	Retrospective DUR Innovative Practices Established during FFY 2019 During FFY 2019, targeted and specialty mailings for the FFS population included; concurrent use of an atypical antipsychotic and a stimulant, concurrent use of benzodiazepines and opiates, atypical antipsychotic use and risk of metabolic syndrome, triple use of antipsychotics, oxycontin/long acting oxycodone mailer, and review of opioid MME criteria. The DUR Board implemented a new topic titled ADURS topics a few years ago and continued to report on this topic into FFY 2019. The purpose of this topic is to discuss issues or concerns that are brought up on the ADURS list serve and to ultimately determine if these issues are a concern for the RI FFS population. Some of the ADURS topics that were discussed during FFY 2019 include; SUPPORT Act (HR-6), Exondys utilization, MME comparison to other FFS programs, Spravato review, and Medication Assisted Treatment (MAT). Additionally, during FFY 2019, the DUR Board began tracking naloxone utilization and biologic agent utilization on a quarterly basis. Prospective DUR Innovative Practices Established during FFY 2019
South Carolina	CMS Annual DUR 2019 South Carolina Innovative Practices The South Carolina Department of Health and Human Services (SCDHHS), in its continuing efforts to purchase the most health for our citizens at the least possible cost to the taxpayer, routinely evaluates the services provided through the South Carolina Healthy Connections Medicaid program and the related provider payments issued for delivering those services. As a result of these efforts, several benefit and reimbursement changes were implemented. More details related to these changes are available at the SCDHHS website and in the Medicaid Provider Guides at www.scdhhs.gov Below are several of those initiatives: MAT providing in OTPs (Opioid Treatment Programs): In January 2019, the South Carolina Department of Health and Human Services (SCDHHS) will began to enroll opioid treatment programs (OTPs) in the Medicaid provider network and begin to reimburse for medication-assisted treatment (MAT) provided in OTPs. The addition of this benefit will make the full spectrum of pharmacotherapies approved for the treatment of opioid use disorder (OUD) available to Medicaid members. Additional details regarding the enrollment procedures for OTPs will be provided this month. 340B Reimbursement: SCDHHS has identified the need to provide additional guidance in more accurately identifying claims for drugs purchased through the 340B program to ensure the appropriate treatment of these claims related to Medicaid rebates. Guidance was provided to Pharmacy providers billing the FFS benefit indicating providers must submit a value of 20 in the Submission Clarification Code field (420-DK) for 340B drugs. Providers should continue to submit the actual acquisition cost of the medication, plus a 340-dispensing fee of $10.50, as the usual and customary charge.

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	Initiation of MAT in Emergency Departments: A pilot program, funded by SCDHHS, has created programs at three coastal hospitals to allow for initiation of MAT in emergency departments, when indicated. Working through clinicians at MUSC and in partnership with the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS), this program brings the most evidence-based treatment to patients who present to an emergency department, which is often the first point of health care contact for individuals suffering from OUD. SCDHHS and MUSC plan to expand this program into other parts of the state in 2019. The Hepatitis C program continued to remain carved out with coverage for F0-F4. Approximately 1100 members' received approval for treatment during SFY 2019. The SC Telehealth Initiative which offers technology based education and training programs, consultative support and co-management for health care providers treating HIV/HCV patients in rural and underserved areas continues to be a invaluable resource http://titan.med.sc.edu/mission.asp The South Carolina Behavioral Health Coalition is an unprecedented alliance of public and private agencies, organizations and healthcare providers collectively committed to improving the mental health and well-being of everyone in our state. This multi-sector coalition is an important outgrowth of the valuable work of the SC Institute of Medicine and Public Health's Behavioral Health Task Force and the SC House of Representatives Opioid Abuse Prevention and Study Committee that each provided a set of recommended actions to improve the care and outcomes of South Carolinians suffering with mental illness and/or substance use disorders. Established in 2017, the South Carolina Behavioral Health Coalition (SCBHC) creates the structure and platform for all partners to work collectively toward the shared goals and mission. https://www.scha.org/members/member-initiatives/behavioral-health-coalition South Carolina Birth Outcomes Initiative (BOI) is an effort by the South Carolina Department of Health and Human Services (SCDHHS), South Carolina Hospital Association, Blue Cross Blue Shield of South Carolina, South Carolina Department of Health and Environmental Control (DHEC), March of Dimes and over 100 stakeholders to improve the health outcomes for all moms and babies. Recent efforts have included: SBIRT focused on preventing Neonatal Abstinence Syndrome; MAiN Managing Abstinence in Newborns https://www.scdhhs.gov/organizations/south-carolina-birth-outcomes-initiative SC MAT ECHO: This project is one component of a large, multi-faceted, statewide approach to reducing the deadly impact of opioid abuse and overdose on the citizens of South Carolina.SC MAT ACCESS is charged with helping to expand access to medication assisted treatments (known as MAT) for opioid addiction. https://scmataccess.org/PracticeSupport/WhatIsMatAccessEcho
South Dakota	IHS claims moved to POS. Allows for prospective and retrospective DUR.
Tennessee	As stated previously, TennCare has 2 different committees, and PDL and drug coverage is within the responsibility of the Pharmacy Advisory Committee (PAC), and the DUR Board has responsibility for ProDUR, Retrospective DUR, which can also translate to fraud, abuse and misuse of prescription claims paid for by the State. Both FFY2019 and also into FFY2020 (reported next year), were very difficult periods for Tennessee's DUR Program and DUR Board, as we struggled throughout the period with a lack of physician members on the DUR Board and were not able to achieve quorum and thereby there was little activity.

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	Although we have reported in past years several activities that we believed qualified as "Innovative" practices, including: Review of Opioids written by Dental Providers, A Review of Opioid Engagement Strategies re: Neonatal Abstinence Syndrome with the MCO's, Review of utilization of "Me-Too" products and Antihelmentics for pinworms, and many other subjects. TennCare has taken the presentation from one of our MCO's on Opioid Engagement strategies with NAS, and has formalized this process with committee work from all three MCO's, and this program has been a great start with collaboration that we haven't had in the past. BUT, this work is not in relation to the DUR Board or TennCare's DUR program. 2 presentations that TennCare made to the DUR Board that were valuable and could be considered as innovative during FY2019 were: -- Opioid/Antipsychotic Concomitant use, presented on March 4, 2019, looked at enrollees using both opioids and antipsychotics chronically, and the goal was to investigate to see if there was any problematic provider types. The overall concern was whether psychiatric nurse practitioners in solo practice had prescription writing habits that were outliers compared to physicians. We looked at 9 different provider types: all different combinations of specialists, group practices, solo practices, large Behavioral Health organizations, and solo psych nurse practices. In summary, we did not find any significance or outlying results from any particular practice type. --We presented to the DUR Board, a retrospective study on TennCare's use of rifaximin, and were concerned with the increase in use, and were concerned that the product was being used widely for IBS-D. We found just the opposite, that it was being used for encephalopathy with acute liver failure, but in most cases was not being used with lactulose as indicated and as in the studies. As of June 2020, our Board is now staffed again, and we plan to be much more functional and innovative in years FY20 and beyond.
Texas	Multiple Formulary and DUR innovative projects were initiated during FFY 2019 1. In April 2019 Vendor Drug Program (VDP) initiated the project to allow pharmacists to receive reimbursement for the administration of certain long-acting injectable antipsychotic medications, opioid antagonists, and influenza vaccines to members. Implementation date was Sep. 1, 2020, SPA is pending CMS approval. 2. In June 2019 developed the PDL compliance standards and reports to properly monitor the use of non-preferred drugs by the MCOs. The PDL Compliance Report will be used by VDP's Pharmacy Benefit Oversite (PBO) team for review of the MCO PDL compliance. PBO developed compliance metrics for the drug classes and liquidated damages for MCO noncompliance. 3. In Aug. 2019, VDP initiated a project to allow patient access to non-preferred drugs when prescribed for treatment of conditions associated with Stage 4 advanced, metastatic cancer. This PDL exemption criteria was implemented in January 2020. 4. In Aug. 2019 VDP initiated the provision to exempt opioid prescriptions from counting towards 3 RX/month limit for FFS members. This policy is only applied when opioids are prescribed for the treatment of acute pain. The implementation date was set for Sep. 2020. 5. In Aug. 2019 VDP initiated the project to move all drugs in the Opiate Dependence Treatment class to preferred status. Implemented January 2020.

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	6. In Aug. 2019 VDP initiated coverage of any prescription drug for the Medicaid STAR Kids population including drugs from manufacturers that have not entered into a federal rebate agreement with CMS. VDP, also, removed prior authorization requirement for non-preferred drugs and prohibited step therapy protocols for this population. The implementation date will be on Dec. 31, 2020. 7. In Aug. 2019 VDP initiated the project that allows HHSC to enter into value-based agreements with drug manufacturers based on the outcome data or other metrics to which HHSC and the drug manufacturer agree in writing. SPA is pending CMS approval. 8. In Aug. 2019, the project for automated submission of formulary Certificate on Information (COI) documents was initiated. 9. In Aug. 2019 VDP initiated the project to evaluate the prescribing practices for opioids and assess the extent by which prescribers align their practices with the guidelines set forth by the CDC. In addition to the projects listed above, VDP developed the following new clinical prior authorizations: Urea Cycle Disorder Agents in April 2019, Calcitonin Gene-Related Peptide Receptor (CGRP) Antagonists in Oct. 2018. Furthermore, HHSC has developed multiple training opportunities for physicians, nurses, pharmacists, and other healthcare professionals.
Utah	In FFY 2019 the Utah Medicaid Pharmacy Program launched multiple peer-to-peer programs. The first peer-to-peer program was focused to decrease the opioid burden through a focused provider engagement outreach. The primary goals for this program was the following: - Track health care provider prescribing patterns for opioids and identify the number of patients exceeding the Medicaid Morphine Milligram (MME) limit, aligned with CDC guidelines. - Educate health care providers on the availability of non-pharmacologic and non-opioid pain options and selected opioid use disorder treatments. - Provide health care providers with resources on both Medicaid and CDC web sites. This focused outreach was in addition to the MME point of sale edit that was implemented January 1, 2019. Two sets of daily MME thresholds were established, a threshold of 90 MME for opioid naive individuals who have not had a claim for an opioid in the last 90 days, and 180 MME for opioid experienced individuals who have had a claim for an opioid in the last 90 days. The higher MME threshold would be reduced over time to achieve one common MME standard for all Utah Medicaid members, 90 MME. The gradual MME reduction will occur every 6 months as Medicaid continues to work closely with prescribers. The second peer-to-peer program launched was focused telephonic outreaches to dispensing pharmacies in alignment with the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act requirements. Education and resources were provided to dispensing pharmacies regarding patients use of concurrent opioids and benzodiazepines. Following education points were reviewed during these outreach calls with dispensing pharmacists: - The importance of routinely checking the controlled substance database with every opioid prescription. - Proactively counseling patients regarding the risks of respiratory depression from the concurrent use.

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	- Proactively offer, counsel, and educate on appropriate naloxone use. - Proactively outreach to prescriber to consider safer alternative combinations. The third peer-to-peer program that is planned to launch on October 1, 2019 is antipsychotic use in pediatric Medicaid Recipients. This program would monitor and manage antipsychotic medications prescribed to members 19 years of age and younger. Peer to peer educational interventions, aligned with the American Academy of Child and Adolescent Psychiatry, would address the following: - Use of other first-line available services (psychosocial counseling and safer medication alternatives) prior to initiation of antipsychotic medication. - Dosing of antipsychotic medication following the start low and go slow approach - Careful and frequent monitoring of side-effects related to antipsychotic medication use o Metabolic screening, Body Mass Index (weight gain), Movement disorder assessments - Use of multiple concurrent antipsychotic medications Future prospective work would include the following: - Diagnosis code requirement on all prescription claims for antipsychotic medications. Prescribers must include the diagnosis codes with each prescription for an antipsychotic medication given to a child 19 years of age and younger. Pharmacies will be required to enter the diagnosis code into the point of sale system when processing a claim for an antipsychotic medication. Retrospective peer-to-peer outreach will address off-label use of antipsychotic medications in this vulnerable population. - High dose limits for antipsychotic medications will be established in the pharmacy point of sale system. Very high doses of antipsychotic medications have not been proven effective in children, and may be associated with a greater incidence of adverse effects, including movement disorders. Claims for antipsychotic medications submitted to Utah Medicaid that exceed the preestablished limits will reject at the pharmacy point of sale and require a prior authorization.
Vermont	Hepatitis C Drugs Direct Acting Antivirals are very effective drugs and although still expensive, competition has driven the cost down considerably. We continue to see a significant financial impact of these drugs and more people will continue to be treated for Hepatitis C Virus (HCV). There were two Direct Acting Antivirals (DAA) for treating Hepatitis C on the top 10 list by Gross Spend, Mavyret and Epclusa. Harvoni is no longer a preferred drug and was replaced by Mavyret toward the end of Calendar Year 2018 and into CY2019. Mavyret is very effective, can be used for all genotypes, typically has an eight-week course of therapy versus 12 weeks for some other DAA agents, and has an overall lower cost of treatment. In January 2018 the requirement for a Fibrosis Score=2 or more was removed, and in February 2019 we removed several other requirements which opened the door for broader access to treatment for Hepatitis C infected patients. DAA's continue to rank high on our top therapeutic categories by gross spend list. These drugs are a focus of Pharmacy Care Management services (explained below) to facilitate adherence and patient follow-up to enable the best clinical outcomes. DVHA's fiscal year runs from July through June. In SFY2018, 806 prescriptions were dispensed compared to SFY2019 when 799 prescriptions were dispensed. In SFY2018, 267 unique members were treated versus 348 members in SFY2019 representing a 30% increase in members treated. In SFY2019, DVHA had approximately $11.6 million in gross spend on Hep C drugs compared to $11.9 million the year before. Although the Hepatitis C antiviral drug prescription count and gross spend declined in SFY2019 the data is misleading, and the number of patients treated is going up over time. The decrease in

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	prescriptions is due to a change in our policy of requiring two 14-day prescriptions as a starting course of therapy to one 28-day prescription late in 2018 which decreases the overall prescription count but not the number of capsules or tablets dispensed. In addition, our preferred product Mavyret has a lower wholesale acquisition cost, so payments to the pharmacy are lower overall, thus overall and PMPM spend looks lower on a gross basis. Pharmacy Care Management (PCM) Program In late SFY 2017, DVHA, in collaboration with Change Healthcare, implemented the Pharmacy Care Management (PCM) Program. The goal of the program is to mitigate the impact of high-cost specialty drugs on pharmaceutical expenditures while ensuring that the full value of these medications in improving patient outcomes and reducing medical expenditures can be realized. Conditions typically targeted in this program include cancer, hepatitis C, cystic fibrosis, and autoimmune diseases. Achieving the program's goal requires focused and attentive oversight and management of both the drugs and the patients receiving them to ensure that patients are not only prescribed the optimal drug for their specific condition, but that they are taking the drug as prescribed and are receiving the appropriate monitoring, testing and follow-up care. The PCM pharmacist provides direct outreach to prescribers and pharmacies to discuss the goals of therapy as well as the appropriateness of drug, dose, and duration of therapy and follow up. The pharmacist works directly with prescribers to choose the most cost-effective treatment regimens for each patient with consideration of age, gender, co-morbidities and, when pertinent, biologic and genetic markers. In addition, they communicate directly with pharmacies to ensure that the medications are dispensed to the patients at the correct times and are billed appropriately. Prescribers are notified when a patient demonstrates poor adherence. The Vermont Medicaid Pharmacy Care Management Program documented savings of $942,360 for DVHA during State Fiscal Year 2019. The PCM program currently has 380 active member enrollments. PCM interventions may not always result in direct drug cost avoidance however they are in place to encourage adherence and ultimately improve member outcomes and avoid future health spending. The program continues to grow, identifying new members and including more specialty medications as they come to market and usage increases. Treatment of Opioid Use Disorder and Opioid Utilization DVHA continues to see the highest spending on drugs used to treat Opioid-Use Disorder (OUD), namely opioid partial agonists. In both SFY 2018 and 2019, opioid partial agonists including Suboxone rank the highest by both spend and utilization. The number of claims for all buprenorphine containing drugs increased by 7% for SFY2019 and increased a total of 15.3% for the last two fiscal years supporting the trend toward more patients with Opiate Use Disorder accessing treatment. This trend is in part due to the effort to reduce provider burden and better support the treatment of OUD. The Department of Vermont Health Access (DVHA) removed prior authorization (PA) requirements for our preferred product, Suboxone Film when the maximum daily dose does not exceed 16mg, effective 10/12/18. At the same time, we have seen the number of members using short-acting opioids decrease by 38% and those using chronic opioids decrease by 44% over the last two fiscal years. The number of prescriptions for short-acting and long-acting opioids declined by 35% and 38% respectively. There continues to be a significant focus on initiatives to tackle the opioid crisis. Vermont has put into place better prescribing guidelines, edits, and rules limiting the quantities of opioids that are

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	prescribed. Educational initiatives and awareness around treating chronic pain differently without the use of opioids is also a contributing factor. Vermont is recognizing and treating opioid addiction as a chronic medical condition. This has expanded access for those who seek treatment and, in some counties, greatly decreased wait times for those patients. Vermont's successful Hub and Spoke program for opioid addiction continues to be a valuable resource for improved access and treatment.
Virginia	The DUR Board has been focused on compounded prescriptions in terms of safety, efficacy and effectiveness as well as cost. At the May 10, 2018 meeting the Board made the recommendation to change the maximum per compound drug to $250 and $500 maximum for all compounds per 30 days. This will include oral and topical compounds. In order for the service authorization to be approved, the prescriber would be required to submit peer review studies of the compounded products safety and effectiveness. Compound claims over these limits will be forwarded to the DMAS physicians for review and approval/denial. This change to the compounded prescription edit was implemented on November 26, 2018 and the DUR Board continues to monitor the results. The compound prescription edit has caused a significant decrease in the number of compounded claims and the total cost on compounded prescriptions per quarter. In order to align with the Virginia Board of Medicine Regulations governing prescribing of opioids, DMAS made the following changes effective July 1, 2017: Service Authorizations are required for all long acting opioids, service authorizations are required for all short acting opioids prescribed for greater than 7 days' supply or two prescriptions for a 7 day supply in a 60 day period. Virginia Board of Medicine requires limit of treatment for acute pain with opioids to a 7 day supply and all post-op pain to no more than a 14 days' supply. In addition, DMAS has further lowered the morphine milligram equivalents (MME) from 120 to 90 MME. Service authorizations are required for any cumulative opioid prescriptions exceeding 90 MME per day. Quantity limits apply to each drug. DMAS has implemented new edits and reports to meet the requirements for the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT Act. The DUR Board reviews each quarter concurrent use of opioids and benzodiazepines, concurrent use of opioids and antipsychotics, and opioid use with high risk factors and no naloxone use or with naloxone use. DMAS also has ProDUR edits in place that sends the pharmacist a soft message in reference to the potential risk of concurrent opioids with benzodiazepines and concurrent opioids with antipsychotics. Moreover, DMAS has implemented an edit to notify the pharmacist when an opioid naïve member is trying to fill an opioid prescription and sends a message back alerting of the potential risk and to offer naloxone. DMAS continued the CNS behavioral pharmacy program which the DUR Board began in 2007. In 2008 and 2009 the CNS contract was renewed for one additional year. In 2009, the DUR Board reviewed the percentage of all patients on behavioral health medications; children taking atypical antipsychotics; and, antipsychotic medication utilization in children ages 0 to 5. During FFY 2010, the DUR Board decided to monitor all children under age 6 who are new to atypical antipsychotic therapy on a quarterly basis, which was later changed to a monthly basis. During FFY 2011, the DUR Board decided to implement a Service Authorization (SA) requirement for the use of atypical antipsychotics in children under the age of six years of age based on the following criteria: a. The drug must be prescribed by a pediatric psychiatrist or pediatric neurologist or the prescriber must supply proof of a psychiatric consultation AND, b. The recipient must have an appropriate diagnosis AND, c. The recipient must be participating in a behavioral management program AND,

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	d. Written, informed consent for the medication must be obtained from the parent or guardian. A pediatric psychiatrist was contracted to review service authorization requests for the antipsychotics in children under the age of six that do not meet the approved criteria and provide peer to peer consultations with the prescribing providers. For requests that do not meet the criteria, the SA contractor will authorize a SA for a period of 30 days so that the child will receive the medication while requests are reviewed. This program was implemented on December 1, 2011. In FFY 2014, the program was expanded to require prior authorization requests for children ages 0 to 12 years. The program continued in FFY 2019 to include all children ages 0 to 17 years and the board continues to monitor. The DUR Board has also begun to review more closely the physician administered drugs as well as the specialty drugs. Magellan Rx Management along with DMAS work together to create clinical service authorization criteria for several of these drugs which get reviewed at the DUR Board Meetings. Clinical criteria for physician administered drugs reviewed during FFY 2019 DUR Board meetings were: • Crysvita® (burosumab-twza) • Ilumya™ (tildrakizumab-asmn) • Imlygic® (talimogene laherparepvec) • Immune Globulins • Mozobil® (plerixafor) • Onpattro™ (patisiran) • Soliris® (eculizumab) Also, Magellan Rx Management has added member lab value data which allows Magellan to execute RetroDUR algorithms with Fee-For-Service (FFS) or Managed Care Organization (MCO) data. The availability of lab results mitigates the outreach required to ask physicians to validate a test result or ask if a lab test had been done recently. The addition of the lab results information through this new process has potential to greatly improve RetroDUR capabilities and will help to better engage prescribers by not asking for information that we should already have. The DUR Board actively monitors new drugs to the market and evaluates the need for utilization management through Service Authorizations (SA). During FFY 2019, the DUR Board recommended that DMAS require prescribing providers to submit an SA for the use of the following drugs based on FDA approved labeling effective for: • Ajovy™ (fremanezumab-vfrm) • Balversa™ (erdafitinib) • Braftovi™ (encorafenib) • Copiktra™ (duvelisib) • Daurismo™ (glasdegib) • Delstrigo™ (doravirine/lamivudine/ tenofovir disoproxil fumarate) • Doptelet® (avatrombopag) • Dovato® (dolutegravir and lamivudine) • Galafold™ (migalastat) • Libtayo® (cemiplimab-rwlc) • Lorbrena® (lorlatinib) • Mektovi® (binimetinib)

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	• Mulpleta® (lusutrombopag) • Nucala® prefilled autoinjector and syringe (mepolizumab) • Orilissa™ (elagolix) • Pifeltro™ (doravirine) • Piqray® (alpelisib) • Poteligeo® (mogamulizumab-kpkc) • Symtuza™ (darunavir/ cobicistat/ emtricitabine/ tenofovir alafenamide) • Talzenna™ (talazoparib) • Tibsovo® (ivosidenib) • Vitrakvi® (larotrectinib) • Vizimpro® (dacomitinib) • Vyndaqel®/Vyndamax™ (tafamidis meglumine)/(tafamidis) • Xospata® (gilteritinib)
Washington	Hepatitis C Elimination Strategy In September 2018, the Governor of Washington State issued a directive, Eliminating Hepatitis C in Washington by 2030 through combined public health efforts and a new medication purchasing approach. This directive was a public health effort led by the Washington State Department of Health (DOH) to work together with the Washington State Health Care Authority (HCA) to create an elimination strategy around Hepatitis C. The DOH focused on identifying, screening, and linking patients with Hepatitis C to care while the HCA issued request for proposals for joint purchasing of Hepatitis C medications to cut costs and boost access. HCA explored an innovative purchasing strategy primarily focused on a subscription model. Contract negotiations with manufacturers not only included purchasing strategies but bonafides that were approved by CMS such as increasing screening and providing linkage to care by medical case managers and prescribing authority granted to registered pharmacists under collaborative practice agreements to help increase access in rural areas. Implemented Single PDL In FFY 2019, Washington Apple Health (Medicaid) continued to implement the single Apple Health Preferred Drug List (AHPDL) and added 267 new drug classes. The goal of the AHPDL is to align the fee-for-service and Managed Care Organizations (MCOs) providing guidance on which drugs are preferred and non-preferred as well as help provide cost savings for the State. MCOs who administer managed Medicaid benefits are no longer allowed to negotiate supplemental rebate agreements and must adhere to those processes and procedures set forth by the Washington State Health Care Authority (HCA). Washington Apple Health (Medicaid) participates in The Optimal PDL $olution (TOP$) purchasing pool to help manage and negotiate rebates. Through the TOP$ program, Washington Apple Health (Medicaid) is able to make decisions on which drugs will be the most cost effective for the State. Washington Apple Health (Medicaid) works collaboratively with the MCOs in creating clinical policies for the AHPDL through an extensive review process that allows for feedback from the MCOs that may include clinical appropriateness and configuration of various pharmacy processing systems. The clinical criteria created applies to the fee-for-service (FFS) and all contracted Managed Care pharmacy programs.
West Virginia	The following is a summary of the innovative (or new) practices implemented in WV during FFY2019: 1. Development of new Hospital-Based Presumptive Eligibility Reports (HBPE) in our MMIS system which would allow for higher Federal Match. Members enrolled with a PE rate code that

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	resulted from the ACA and who were later included as expansion members under any other Medicaid Expansion Rate Code may be accounted for in order to claim the higher matching Federal rate. 2. Helped the MCOs to strengthen their PADs federal rebate collections through improved data integrity monitoring, sharing of the crosswalk and the formulation of reject reports. 3. Developed customized 340B reports to educate providers and strengthen compliance with 340B billing requirements. 4. WV Medicaid continued our efforts to better manage Hepatitis C in our State both from a clinical and financial standpoint. In September 2019 we removed all fibrosis requirements from our prior authorization criteria and in combination with various stakeholders throughout the State we have encouraged development of robust consulting programs, such as WVHAMP. This program is modeled on a successful endeavor from our neighboring state of Kentucky, with the goal of expanding access to skilled practitioners and adherence to treatment guidelines. 5. In 2019, WV Medicaid contracted with one of our in-State universities (Marshall University) for retrospective review. Because they are a first-time provider of RetroDUR services, we have had the opportunity to work very closely with them in developing their electronic algorithms to efficiently identify clinical and lock-in related issues. The electronic program they are using has been developed to provide unique screens according to whether a clinical or lock-in review is being performed. This allows us to focus on drug classes, MME, and other variables as needed.
Wisconsin	Diabetes Medication and Renal Dosing The Wisconsin Drug Utilization Review (DUR) Board developed an intervention letter to address the use of appropriate dosing of renally adjusted diabetes medications in members with a diagnosis of chronic kidney disease. Members included in the intervention were those who were on metformin, a metformin combination product, or an SGLT2 inhibitor for at least 30 days and who also had a diagnosis of chronic kidney disease within the last 90 days. Intervention letters were sent to providers who had members exceeding the recommended maximum daily dose for their documented stage of renal disease. There were 266 members identified with 102 members receiving doses exceeding the recommended dose. Letters were sent to 105 prescribers in November 2018. A post intervention analysis of prescriber responses was conducted. Twenty-four responses were received and 18 of the responses included prescriber comments. Prescriber comments were generally positive, and many clarified the renal function status of the member. Claims history for all 102 members was reviewed. Of note were 12 members with either dosage changes or diagnosis updates. Several members had medications changes or no new claims in the system. The responses provided by the prescriber and changes in claims data indicate that most providers are appropriately monitoring and adjusting these medications based on renal function. Diazepam and Alprazolam Benzodiazepine Intervention The Wisconsin Drug Utilization Review (DUR) Board developed an intervention to address the use of chronic, high-dose benzodiazepines. The intervention consisted of two parts. The first part of the intervention included peer-to-peer phone calls between a ForwardHealth psychiatrist consultant and select benzodiazepine prescribers. Calls were made to prescribers with members receiving either 20 mg per day of diazepam or 10 mg per day of alprazolam for greater than six months. The intent of the conversations was to gather information regarding prescriber attitudes

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	toward prescribing high dose benzodiazepines and barriers to initiating deprescribing. The conversations revealed several themes including: difficulties with inheriting members who are already stable on a high dose benzodiazepine, prescriber does not consider high dose chronic benzodiazepine use to be problematic, concerns about adverse consequences associated with tapering, and unawareness of deprescribing strategies. Of note, primary care providers and mid-level practitioners often expressed difficulties with initiating deprescribing. The calls revealed that prescribers would benefit from additional information through a retrospective letter intervention to address this issue. The second part of the intervention consisted of letters sent to prescribers of high dose alprazolam and diazepam. Prescribers were identified who had members taking at least 3 mg of alprazolam daily or 10 mg of diazepam daily for at least six months. Two letters were developed, one for alprazolam and one for diazepam. The letters focused on the addictive properties of the medications and the risk of adverse reactions in the aging population. Also included in the letter was an extensive list of references, including guidelines for the treatment of anxiety disorders and strategies for deprescribing benzodiazepines. Letters were sent in October 2019. Seventy-five prescribers received the alprazolam letter and 17 prescribers received the diazepam letter. A post intervention analysis of prescriber responses and member claims was conducted. A ForwardHealth psychiatrist consultant made follow-up peer to peer outreach calls to several prescribers who continued to have a high volume of qualifying members. The calls included discussions of appropriate techniques for deprescribing of benzodiazepines as well as addressing barriers to deprescribing. The DUR Board plans to further address this issue with a provider newsletter which is currently being developed. Of note, portions of the intervention discussed above occurred outside of FFY 2019.
Wyoming	Wyoming Medicaid utilizes the Pharmacy Care Management (PCM) program which is an innovative, client-focused, pharmacist-driven practice that leverages techniques not feasible for a traditional prior authorization program. The PCM program supports the provider/patient relationship, promotes adherence, and augments existing care management efforts. The program strives to provide oversight and to maximize the value of the use of highly complex and/or high-cost drugs to achieve the best results possible from the treatment plan. Wyoming Medicaid clients receiving complex and/or high-cost drugs are proactively identified through pharmacy claims data and the prior authorization process. The PCM team initially reviews the dosing and duration of the requested medication, reviews the client profile and verifies eligibility for enrollment into the PCM program. Following the review, PCM program enrollment letters are sent to the provider and the client. Based on profile and prior authorization reviews, the PCM team will contact the client to confirm the medication has been received; to verify the anticipated start date of treatment; to discuss the appropriate use of the drug; to educate the client on potential adverse effects; to reiterate the importance of adherence, drug storage and dosing issues; and to provide any other pertinent education regarding the prescribed medication. The PCM team communicates with the client throughout the course of treatment. Once the client initiates drug therapy, the PCM team contacts the client prior to each anticipated refill to confirm the client has requested a refill of the medication and to verify the number of doses the client has remaining. During the phone interventions, the PCM pharmacist also addresses specific concerns or questions the client may have related to each specific clinical situation. The goal is to detect barriers to compliance and to proactively collaborate with both the client and provider to maximize the clinical effectiveness of the targeted therapy. Towards the end of the treatment course, the PCM team contacts the client to verify the number of remaining doses and anticipated

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	end date. If applicable, the team also verifies that lab appointments are scheduled and monitors the client until the lab results are received. Since implementing this program, Wyoming Medicaid hepatitis C clients have had access to a healthcare team focused on adherence, communication, education, avoidance of inappropriate use and treatment success. For disease states like Hepatitis C with the potential for cure, the importance of adherence is emphasized to obtain the highest likelihood of benefit from medication. The PCM team is uniquely positioned, being part of the claims processing team, to serve as a resource to help ensure timely intervention regarding compliance issues. The program has: reduced medication errors. For example, a prescription for Mavyret written for a quantity of 21 for a 21 day supply instead of a quantity of 84 for a 28 day supply. The team caught the error prior to being sent to the client; therefore, avoiding possible sub-therapeutic treatment. increased adherence by calculating refill dates, reviewing billed claim dates of service, and conducting medication received confirmation calls on a timely basis. worked with providers to extend approval end dates to account for treatment start dates. confirmed "cure" rates by tracking clients until final labs are conducted and requesting SVR12 results. increased client compliance/access by working with respective staff on eligibility issues during entire course of treatment. assisted State staff on additional length of treatment requests by providing information regarding client adherence during initial treatment.

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

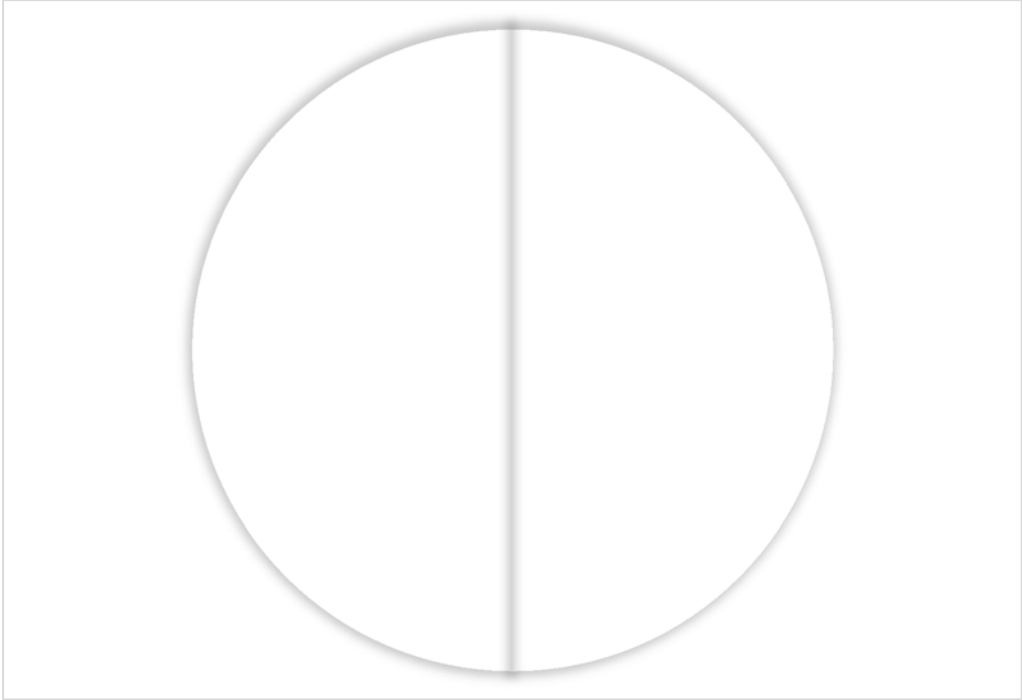

Table 219 – MMIS or Vendor Ability to Electronically Provide Patient Drug History Data and Pharmacy Coverage Limitations to a Prescriber Prior to Prescribing Upon Inquiry

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, Oklahoma, South Dakota, Texas, Vermont, Virginia, West Virginia, Wyoming	25	50.00%
No	Alaska, California, Colorado, Delaware, District of Columbia, Hawaii, Illinois, Kansas, Kentucky, Maryland, Massachusetts, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Washington, Wisconsin	25	50.00%
Total		50	100.00%

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

Figure 134 - Methodology to Evaluate the Effectiveness of Providing Drug Information and Medication History Prior to Prescribing

Table 220 - 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, Nevada, New Mexico, Virginia	8	32.00%
No	Alabama, Georgia, Idaho, Indiana, Iowa, Louisiana, Maine, Minnesota, Mississippi, Montana, New Hampshire, Oklahoma, South Dakota, Texas, Vermont, West Virginia, Wyoming	17	68.00%
Total		25	100.00%

If “Yes,” please explain the evaluation methodology in Summary 7.

Summary 7 - E-Prescribing Activity should explain the evaluation methodology utilized in evaluate the effectiveness of providing drug information and medication history prior to prescribing.

Table 221 - Summary 7 - E-Prescribing Activity

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Arkansas	E-Prescribing Activity for FFY 2019 Arkansas Medicaid first implemented ePrescribing in 2008. E-Prescribing in Arkansas was implemented with SureScripts/RxHub. It offered physicians access to the beneficiary's drug plan information in real time during the office visit. Automation of the outpatient prescribing process offers many potential benefits to different healthcare stakeholders, especially patients, physicians, and pharmacy providers, because the processes employed by e-prescribing allows the creation of an informed prescription that takes into consideration patient plan coverage, formulary preferences, and medication history. Putting formulary and eligibility information at a physician's fingertips eliminates many of the questions that often require pharmacists to place multiple telephone calls to a physician's office. This improves beneficiary care and saves time for both beneficiaries and providers. The MMA, Inc. E-Prescribing program supports a model for beneficiary demographics, eligibility, PDL/Formulary, and medication history. MMA, Inc. sends beneficiary, formulary and medication history files to SureScripts/RxHub weekly. Program capabilities include: 1) Prescriber requests for beneficiary eligibility using an ASC X12 270 format. SureScripts/RxHub will validate the transaction format and locate the beneficiary based on MMA, Inc. demographics file and unique identifiers of the beneficiary to determine if the requested beneficiary information is housed and available. SureScripts/RxHub responds back to the requesting prescriber with the beneficiary's eligibility response (ASCX12 271). 2) Drug Coverage Information. The prescriber can locate the beneficiary's PDL/Formulary information in their practice management system. Magellan creates an NDC level file using the industry standard. This contains multiple levels of drug coverage information including formulary status and coverage lists. The coverage lists contain information regarding Prior Authorization, Age Limits, Gender Limit, and Quantity Limit. A resource link can also be accessed through the coverage lists. The resource link is drug specific and conveys a web address/URL that contains additional drug specific coverage detail. After receiving formulary files, SureScripts/RxHub will validate it to NCPDP specifications and provide the Arkansas Medicaid coverage information to the prescriber's practice management system. 3) Prescriber requests for beneficiary medication history from SureScripts/RxHub using the NCPDP SCRIPT 8.1 format. Magellan will return one year of Medication History (MedHx) to Surescripts and ultimately to the EMR/EHR vendor using the SCRIPT standard transaction set for MedHx record delivery. 4) Real-time electronic scripts. Once all validation is completed, SureScripts/RxHub forwards a real-time electronic copy of the prescriber's prescription to the identified pharmacy. 5) Pharmacy approvals. The pharmacy submits the claim using the NCPDP origin code to MMA Inc. for adjudication. The original code identifies the claim as an electronic prescription.

State	Explanations
	The transaction activity of the e-prescribing program is routinely monitored. SureScripts/RxHub provides monthly reports of the number of inquiries for eligibility, medication history and formulary. In addition, MMA Inc. provides daily and monthly reports of the prescribers that are using the application. Number of prescribers that are e-prescribing = 9,350 % e-prescriptions to total prescriptions = 66% Rx_Origin Claims % of Claims Unique Prescribers Paid_Amount RX_Origin_Description 0 8,529 0.2% 1,174 $908,557.66 Not Specified 1 898,994 17% 9,864 $68,429,240.65 Written Prescription 2 336,107 6% 8,278 $30,802,203.70 Telephone Prescription 3 3,571,694 66% 9,350 $259,050,087.74 Electronic 4 329,640 6% 6,242 $49,127,061.87 Facsimile 5 240,161 4% 7,318 $30,129,817.30 Pharmacy Total 5,385,125 100% 12,054 $438,446,968.92
Connecticut	At the end of 2009, the State of Connecticut Department of Social Services became a certified payer in the Surescripts network. Through the Surescript network, the e-Prescribing technology is securely linked to the Connecticut Medicaid Management Information System (MMIS). Surescripts electronically routes up-to-date patient eligibility, medication history, and information about how the different pharmacy programs cover specific medications. Connecticut currently allows providers who currently use an approved e-Prescribing system access to Medical Assistance Program client's eligibility, formulary, and medication claims history for: Medicaid Fee-For-Service -- HUSKY A and HUSKY C HUSKY B (SCHIP) Medicaid Low Income Adults (Medicaid LIA) HUSKY D, The State has seen the e-prescribing initiative widely accepted in the Medicaid community. The State of Connecticut is reporting the following averages for e-prescribing activity in 2019: Formulary downloads: Total: 1,164,713 Monthly average: 97,059 Eligibility requests: Total: 10,523,690 Monthly average: 876,974 Medication History requests: Total requests:4,983,825 Monthly average: 415,319 Pharmacy program benefits information is updated weekly for download. The types of pharmacy program benefits information available through e-Prescribing is summarized below:

State	Explanations
	Prior Authorization All current medications requiring prior authorization (PA) will be identified for the provider at the time of prescribing. Preferred Drug List (PDL) Alternatives Providers will have access to the PDL formulary real-time. Providers will be able to identify which drugs are non-preferred and require PA. Preferred alternatives will be identified by drug name (not strength or dosage form) and the provider will be able to decide to either prescribe the preferred agent or to begin the prior authorization process in order to obtain coverage for the non-preferred drug. Resource Links Web links will be tied to specific drugs in each formulary. The web link for Prior Authorization forms will be provided for all drugs that currently require PA including Non-Preferred Drug (PDL), Optimal Dose, and Synagis. Coverage Text Message Text messages will be available to providers and allow specific messages to be conveyed about particular drugs. Examples include drugs that require diagnosis for coverage and drugs that are limited to once daily dosing. Quantity Limits Drugs that are limited by either quantity or days' supply are visible real-time. Age Limits Drugs where age restrictions are applicable for coverage will be visible real-time. Benefit Co-Pay Co-pay information will be identified for all State programs where co-pays are in effect. This includes the HUSKY B and Charter Oak programs (tiered-co-pays based on generic and brand drugs). Co-pay amounts identified are only an estimate of the client's liability. Actual co-pay determination will be finalized during claims submission from the pharmacy. The State of Connecticut is currently working on future enhancements for e-prescribing. This includes changes required for the implementation of New Script version 2017071 which is scheduled for implementation Jan 2020. Additional reporting is also defined to identify the relative cost savings achieved through the e-prescribing project.
Florida	Florida Medicaid Pharmacy Program Drug Utilization Review Annual Report: FFY19 E-Prescribing Activity Summary In 2007, the Florida Legislature implemented electronic prescribing (e-prescribing), pursuant to Section 408.0611, Florida Statutes, (F.S.). The law states the following : Florida Statutes, 408.0611 Electronic prescribing clearinghouse. (1) It is the intent of the Legislature to promote the implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies in order to prevent prescription drug abuse,

State	Explanations
	improve patient safety, and reduce unnecessary prescriptions. To that end, it is the intent of the Legislature to create a clearinghouse of information on electronic prescribing to convey the process and advantages of electronic prescribing; to provide information regarding the availability of electronic prescribing products, including no-cost or low-cost products; and to regularly convene stakeholders to assess and accelerate the implementation of electronic prescribing. (4) Pursuant to s. 408.061, the agency shall monitor the implementation of electronic prescribing by health care practitioners, health care facilities, and pharmacies. By January 31 of each year, the agency shall report on the progress of implementation of electronic prescribing to the Governor and the Legislature. Information reported pursuant to this subsection shall include federal and private sector electronic prescribing initiatives and, to the extent that data is readily available from organizations that operate electronic prescribing networks, the number of health care practitioners using electronic prescribing and the number of prescriptions electronically transmitted. On July 1, 2010, the Florida Agency for Health Care Administration (Agency) implemented the participation of Florida Medicaid in the Surescripts pharmacy network enabling providers to access Florida Medicaid prescription drug claims data using any Surescripts certified e-prescribing tool. The data feed is real time, and provides recipient eligibility status, preferred drug information, plan limitations, and medication histories. The Agency's objective is to prevent medication errors and curb prescription fraud and abuse by giving providers actionable information at the time of prescribing. The Magellan Medicaid Administration e-prescribing program supports a model for recipient demographics, eligibility, and medication history. Magellan Medicaid Administration sends recipient eligibility, medication history files to SureScripts/RxHub weekly. Program capabilities include: Prescriber requests for recipient eligibility using an ASC X12 270 format. SureScripts/RxHub will validate the transaction format and locate the recipient based on Magellan Medicaid Administration's demographics file and unique identifiers of the recipient to determine if the requested recipient information is housed and available. SureScripts/RxHub responds back to the requesting prescriber with the recipient's eligibility response (ASCX12 271). Prescriber requests for recipient medication history from SureScripts/RxHub using the NCPDP SCRIPT 8.1 format. This request can be limited to specific date ranges, or if no date is entered, defaults to the entire drug history (a rolling maximum of 13 months) for the recipient. SureScripts/RxHub validates the recipient elements on the request against a stored PBM dataset. Magellan Medicaid Administration supplies the recipient medication history and SureScripts/RxHub completes interaction/DUR checks. The recipient medication history from Magellan Medicaid Administration is routed to the requesting prescriber through SureScripts/RxHub. The transaction activity of the e-prescribing program is routinely monitored. SureScripts/RxHub provides monthly reports of the number of inquiries for eligibility, medication history and formulary. In addition, Magellan Medicaid Administration provides daily and monthly reports of the prescribers that are using the application. The Agency provides a single point of access for e-prescribing information referred to as the Florida Electronic Prescribing Clearinghouse. It is designed to meet the requirements of Section 408.0611, F.S., and provides information on developments and trends in e-prescribing in the state. The website contains annual e-prescribing reports as well as quarterly metrics on the status of e-prescribing adoption in Florida. , Selected metrics from these reports for 2019 include the following:

State	Explanations
	Through the 3rd quarter of 2019, there were an average of 10, 879,800 electronic prescriptions per month. The number of Medicaid medication record requests (for specific patient information such as eligibility, benefits or medication history) averaged 505,420 per month for the first 3 quarters of 2019. This was an increase from 2018 when the number of Medicaid medication requests averaged 439,713 per month. The annual e-prescribing rate increased 75.9% from 1.6% of Florida prescriptions in 2007 to 77.5% as of the 3rd quarter of 2019. The percentage of health care professionals who are e-prescribing (e-prescribers) at the end of the 3rd quarter of 2019 was 73.9%. This figure demonstrated an increase of 1 percentage point compared to prior quarter. Reference: 1Online Sunshine, Official Internet Site of the Florida Legislature. The 2019 Florida Statutes, 408.0611 Electronic prescribing clearinghouse. Available at: http://www.leg.state.fl.us/STATUTES/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0408/Sections/0408.0611.html Accessed: January 8, 2020. Agency for Health Care Administration Florida's Annual Electronic Prescribing Reports, Florida ePrescribing Report 2019 Available at: https://ahca.myflorida.com/SCHS/ePrescribing/docs/Florida2019ePrescribeReport.pdf Accessed: February 13, 2020. Agency for Health Care Administration ePrescribing Dashboard. Quarterly Metrics Summary and Data Charts 2019. Available at: https://ahca.myflorida.com/SCHS/ePrescribing/docs/2019eprescribemetrics3Q.pdf Accessed: January 8, 2020.
Michigan	MDHHS and Magellan implemented e-prescribing with SureScripts/RxHub that offers physicians access to the beneficiary's drug plan information in real time during the office visit. The e-prescribing program supports a model for beneficiary demographics, eligibility, PDL/Formulary, and medication history. Magellan sends beneficiary, formulary and medication history files to SureScripts/RxHub weekly. The transaction activity of the e-prescribing program is routinely monitored. Magellan provides daily and monthly reports of the prescribers that are using the application. MDHHS requires pharmacy providers to submit the NCPDP Origin Code on all claims. This allows the number of prescriptions processed via e-prescribing to be monitored. During FFY 2019 MI achieved the greatest increase thus far with 65% of all claims received as e-prescribed by 69% of all prescribers.
Missouri	E-prescribing ability is located within the CyberAccess provider tool and is hosted by SureScripts. Utilization is monitored on a monthly CyberAccess report. During FFY19 via CyberAccess, there were 927,344 user log ins, 1,181,529 patient history checks, 311,370 medical rule checks, 718 medical help tickets, 83,362 medical pre-certification submitted, 2,883 behavioral health evaluation forms submitted, 15,156 behavioral heal rule checks, 4,897 behavioral health pre-certification submitted, 290 lab data checked, 2,668 clinical traits checked, 12,385 drug rules checked, 4,432 drug help tickets, 0 e-prescriptions, 137 faxed prescriptions, 78 printed prescriptions, 92,758 transfer to RBM, 74,159 ER visits page accessed, 1,388 hospice lock in page accessed.
Nevada	As of September 2019, approximately 59% of all prescriptions are transmitted through an ePrescribing platform. This trend continues to grow into FFY2020. As of September 2019, approximately 40% of

State	Explanations
	prescribers have adopted an ePrescribing tool. There were a total of 3,024,742 eligibility checks and a total of 3,784,107 medication history transaction requests between October 1, 2018 and September 30, 2019. Cost-savings evaluation was not performed for this period. In FFY20, an ePA tool should be available to providers. This tool works with ePrescribe and will increase the number of electronic prescriptions.
New Mexico	FFY 2019 Total Prescription Benefit Requests 1,259,992 Total Prescriptions Routed Electronically 578,894 Total Paid Prescriptions Claims 389,202 Total Denied Prescriptions Claims 340,096 Percentage of Total Prescriptions Represented Electronically 42.99% Percentage of Electronic Prescription with Paid Claims 36.38%
Virginia	Virginia Medicaid first implemented e-prescribing on February 1, 2018. Electronic prescribing (e-Prescribing) is the use of an automated data entry system to generate a prescription, replacing the use of handwritten prescriptions. Automation of the outpatient prescribing process benefits different healthcare stakeholders, especially members, physicians, health plans, pharmacy benefit managers, and employers. Electronic prescriptions are computer-generated prescriptions created by the doctor and sent directly to the member's pharmacy of choice. E-Prescribing applications that are certified by SureScripts allow new prescription orders and refill authorizations from the prescriber to be sent directly to the computers of the selected pharmacies. The process is a simple one. Instead of writing the prescription on a piece of paper, the prescriber enters it directly into an automated data entry system. The prescription is then sent electronically from the prescriber's automated data entry system to the pharmacy's computer using a private, secure, and closed network. The e-Prescribing process eliminates the need for the member to take a hard copy of the script to the pharmacy, saving time and facilitating prescription accuracy. Magellan Rx Management has contracted with the industry leader in e-Prescribing, SureScripts. Magellan Rx Management has a strong relationship with the industry's largest e-Prescribing vendor serving the provider, prescriber, and Pharmacy marketplace through health information exchange (HIE). SuperScripts is the leader in providing Accredited Standards Committee (ASC) X12 270/271 and NCPDP compliant electronic prescription transactions, and their presence in the market gives Magellan Rx Management customers and ASC's members access to numerous pharmacy providers and most of the industry practice management vendors that have been actively involved in electronic prescribing. General information on activated pharmacies within Virginia may be found at www.surescripts.com. Physicians interested in automating the prescribing process must utilize an e-Prescribing or Electronic Medical Record (EMR) system that has been certified to connect to the Pharmacy Health Information Exchange, operated by SureScripts. The Application provides the prescribers: • The ability to request and receive prescription history from Magellan (NCPDP SCRIPT XML 10.6 format). • The ability to request and receive eligibility and formulary information from Magellan (Eligibility/Formulary). SureScripts

State	Explanations
	Magellan builds the e-Prescribing application in accordance with the SureScripts Implementation Guidelines and the NCPDP SCRIPT, ANSI ASC X12 standards. The prescribers access the electronic prescription information and route prescriptions using the SureScripts network. SureScripts provides physicians with electronic access to their patients' prescription benefit and prescription history, which helps to improve safety. SureScripts conducts certification to ensure all the requirements are met. Key Architecture Considerations The Application uses the Fusion Middleware tool set to develop various reusable services. 1. Oracle Service Bus (OSB) will be used for all the proxy Services interfacing the VPN Gateway and F5. OSB provides embedded service management capabilities that provide optimized governance of all messaging. 2. Oracle SCA Components will be used to implement the Business Logic of the real-time Interfaces. 3. The Batch interfaces will be developed using the Informatica tool set and/or PL/SQL. Technical Services • OSB will receive the Eligibility and prescription History Requests. • The BPEL Composite i. Validates the Request using EDIFECS XEngine validation tool. ii. Transforms the request message. iii. Perform the preprocessing tasks, Eligibility checks and other database calls and gets the required fields for transformation. iv. Generates the Response message. v. Publish the Eligibility and Claims History Response back to OSB. vi. Publish Report messages to ODS reporting database. • OSB will publish the response out. Databases FirstRx The FirstRx application database has all the data required for the e-Prescribing application. The BPEL Service Composites call the FirstRx database for a subset of data for the Eligibility and medication History transactions, that is needed to generate the response back to the requestor. The FirstRx is also the source for the Batch interfaces. ODS The Operational Data Store (ODS) database houses the data required for generating the transaction reports for the Business entities. Member Roster and Formulary

State	Explanations
	• The Member Roster is the Master Patient Index file containing the Patient demographics which is sent daily to SureScripts. SureScripts uses this information to route the requests to the appropriate services. • The Formulary file is sent once every week to SureScripts. This helps prescriber vendors maintain compliance with weekly downloading of the PBM formulary files. The formulary information is made available to physicians. LAN to LAN Gateway The SureScripts and the Magellan data centers are connected to each other by VPN tunnels. The table below shows the e-prescribing activity for FFY 2019. FFY 2019 had 47% of all claims received as e-prescribed by 69% of all prescribers. FFY Nbr e-Prescribed Paid Claims Total Paid Claims % of Total Paid Claims Nbr e-Prescribers Total Unique Prescribers % Total Prescribers 2019 306,281 653,060 47% 15,902 23,042 69%

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

Figure 135 - Future Development of an Electronic Portal to Provide Patient Drug History and Pharmacy Coverage Limitations

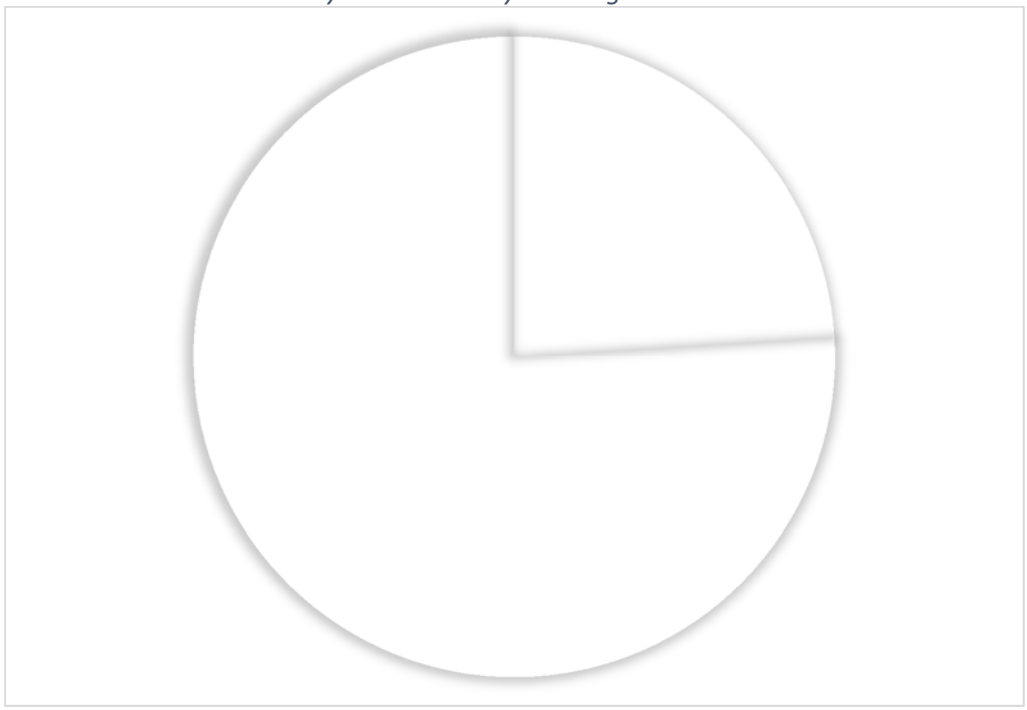

Table 222 - Future Development of an Electronic Portal to Provide Patient Drug History and Pharmacy Coverage Limitations

Response	States	Count	Percentage
Yes	Colorado, Maryland, Massachusetts, North Carolina, North Dakota, Tennessee	6	24.00%
No	Alaska, California, Delaware, District of Columbia, Hawaii, Illinois, Kansas, Kentucky, Nebraska, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Washington, Wisconsin	19	76.00%
Total		25	100.00%

If "No," please explain.

Table 223 - Explanations for not Developing an Electronic Portal to Provide Patient Drug History and Pharmacy Coverage Limitations

State	Explanations
Alaska	The MMIS contract expires in two years. An evaluation can be made at the time of a new contract.
California	Current system does not allow for this capability.
Delaware	In Federal Fiscal year 2019, eighty five percent of the population resided in two managed care organizations while 15% of the population remained in fee-for-service. Of the 15%, the majority of these FFS clients were transitioning into a managed care plan within 60 days. As a state with a mixture of FFS & MCO lives, Delaware has a unified PDL designed to streamline consistent drug status and maximize savings for the program. Both programs (FFS & MCO) strive to align drug policies, by mirroring the claims editing of FFS with encounters. This allows for the provider community to providing quality care for Medicaid beneficiaries with the least amount of disruption of treatment. To address the low response rate from providers to paper mailing of retrospective drug utilization letters, Delaware uses an innovative system of automatically generating Retro-DUR alerts to prescribers utilizing information within the system. Copies of the letters generated this way are data stored and may be retrieved for faxing when necessary or upon provider request. This system has served as a cost saving for the state through elimination of returned mail due to wrong addresses when an office relocation has occurred. It also guarantees the providers have access and receive these alerts. Delaware has continued to run all drug encounters through established edit/audit rules to track the MCO's management of the drug benefit. DMES generates a monthly report that allows a side-by-side comparison of our two MCOs. This report is utilized to analyze both MCO efficiency and compliance with all existing state policies. Delaware continues to make adjustments to our system as we work to improve the integration between our Medicaid system the MCOs systems. Delaware uses numerous platforms to report our successes, gain insight and discuss challenges with other states so that we can learn from each other and move forward with innovation. Legislative mandates continue to guide Delaware as a state in addressing clinical concerns highlighted by data such as rate of unplanned pregnancies and opioid overdose-related death analyses across multiple agencies. The data continues to shed light onto areas of possible improvement through collaboration with Substance abuse and mental health divisions, department of Public Health and other state organizations. Going forward, Delaware will be continuing to collaborate with various areas of Pharmacy practice to close the gap in Vaccination

State	Explanations
	hesitancy, by allowing additional Pharmacy practice areas vaccinate with an administration fee equal to the dispensing fee. The small size of the state and client mix pose some limitations to innovation, but we continue to gain collaborative engagement with different stakeholders to ensure our vulnerable population has a voice and is represented where needed. Ultimately, the goal is to provide all clients with the level of care they need and deserve.
District of Columbia	Provisions to address access to patient drug history data and pharmacy coverage limitations are scheduled to be included in upcoming vendor solicitations
Hawaii	Direct inquiries are available with medical FFS contractor for the small FFS population.
Illinois	HFS will pursue the capability when it is made available from our vendor.
Kansas	We have a website that providers can use to find specific drug coverage through pharmacy and medical benefit plans. Evaluation of rejected and then paid claims may help us to create this analysis in the future.
Kentucky	Cost is prohibitive, small FFS population.
Nebraska	No back and forth in systems yet available.
New Jersey	No plan to develop e-prescribing capability since 95% of beneficiary population is enrolled in MCOs.
New York	E Prescribing activity is monitored by the State's Bureau of Narcotic Enforcement (BNE). Evaluation of E prescribing activity is handled on a statewide basis.
Ohio	No plans at this time
Oregon	We do not currently have plans to implement e-prescribing.
Pennsylvania	The FFS MMIS vendor provides the patient drug history and drug coverage information to Surescripts. Prescribers can access this information via their own EHR/ePrescribing software. FFS supports ePrescribing, but does not supply an ePrescribing portal for prescribers.
Rhode Island	Not at this time.
South Carolina	SureScripts was previously utilized by the State previously, as a method to inquire on patient history/pharmacy coverage. However, the cost/fee associated for each inquiry was outweighing any perceived benefit. Other alternatives may be entertained in the future.
Utah	Change Healthcare system does not support e-prescribing.
Washington	N/A
Wisconsin	Wisconsin is in a multi-year MMIS system upgrade. This change is not in the current systems work plan.

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

Figure 136 - System Use of the NCPDP Origin Code that Indicates the Prescription Source

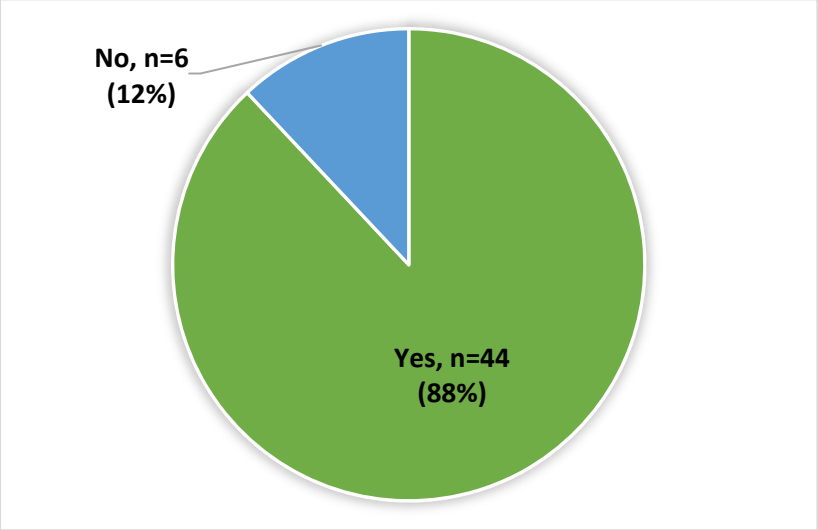

Table 224 - System Use of the NCPDP Origin Code that Indicates the Prescription Source

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%
Total		50	100.00%

XI - Managed Care Organizations (MCOs)

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

Figure 137 - Number of MCOs Enrolled in State Medicaid Program

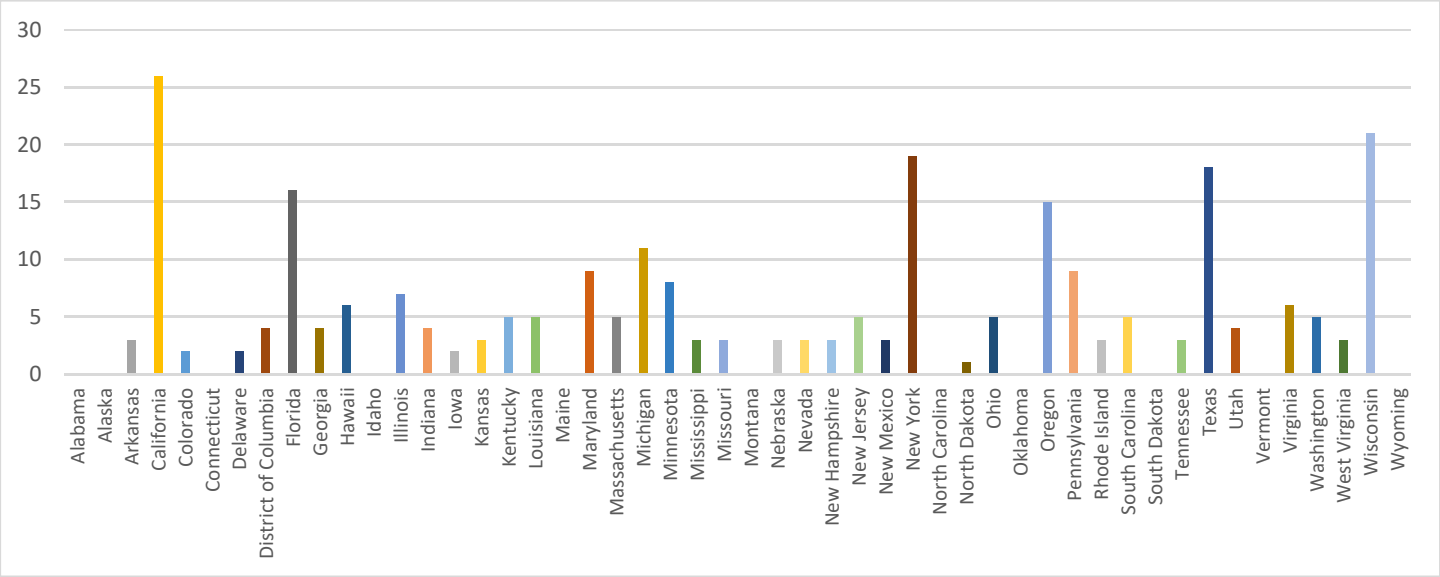

Table 225 - Number of MCOs Enrolled in State Medicaid Program

State	Number of MCOs
Alabama	0
Alaska	0
Arkansas	3
California	26
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

State	Number of MCOs
Minnesota	8
Mississippi	3
Missouri	3
Montana	0
Nebraska	3
Nevada	3
New Hampshire	3
New Jersey	5
New Mexico	3
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	18
Utah	4
Vermont	0
Virginia	6
Washington	5
West Virginia	3
Wisconsin	19
Wyoming	0

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

Figure 138 - Pharmacy Program Included in the Capitation Rate (Carved In)

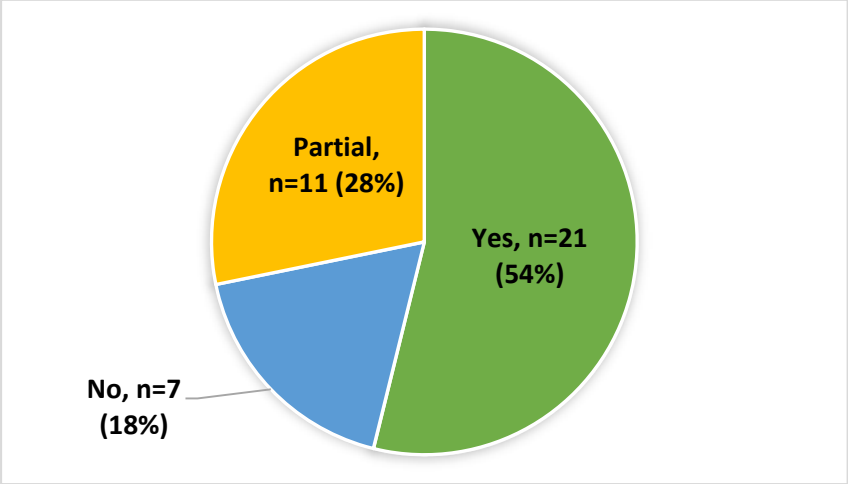

Table 226 - Pharmacy Program Included in the Capitation Rate (Carved In)

Response	States	Count	Percentage
Yes	Delaware, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Texas, Utah, Virginia	21	53.85%
No	Arkansas, Colorado, Missouri, Nevada, Tennessee, West Virginia, Wisconsin	7	17.95%
Partial	California, District of Columbia, Florida, Indiana, Maryland, Michigan, Mississippi, Oregon, Rhode Island, South Carolina, Washington	11	28.21%
Total		39	100.00%

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

Table 227 - Drug Categories that are Carved Out of the Capitation Rate

State	Drug Categories
California	Carved out drugs have some variation from plan to plan, but in general include: 1. Selected HIV/AIDS/Hepatitis B treatment drugs; 2. Selected alcohol and heroin detoxification and dependency treatment drugs; 3. Selected coagulation factors; and 4. Selected drugs used to treat psychiatric conditions (including antipsychotics and MAO inhibitors)
District of Columbia	HIV treatment antiretrovirals are carved out of the MCO coverage responsibility.
Florida	Hemophilia (Spinraza and Exondys are billed by the MCO plans as of 01/01/19)
Indiana	Hepatitis C agents, cystic fibrosis agents, clotting factor agents, muscular dystrophy agents, and spinal muscular atrophy agents are carved-out.
Maryland	During FFY 2019, then following drug categories were carved out of the MCO benefit and paid FFS: antiretrovirals for the treatment of HIV/AIDS, mental health medications, and substance use disorder products. Additionally, specific medications were carved out. Lucemyra was carved out effective 10/1/2018. Spinraza and Cinryze were carved out effective 1/1/2019.
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 hemohilia. 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.
Oregon	Mental health drugs carved out to FFS only
Rhode Island	Stop loss arrangement for Hepatitis C drugs.
South Carolina	7/1/2015 HCV (Hepatitis C- transitioned back 7/1/2020).

State	Drug Categories
Washington	As of July 2018 all prescriptions paid through the pharmacy point-of-sale (POS) systems were carved out of the capitated rate and paid to the MCO on a monthly basis based on the total paid from the MCOs submitted and accepted pharmacy encounters. In addition to POS claims the following drugs are excluded from the MCO rate when administered in a physician or outpatient hospital setting: 1. Hemophiliac Products : Blood factors VII, VIII and IX, anti-inhibitor, and all FDA approved products labeled with an indication for use in treatment of hemophilia and von Willebrand disease when distributed for administration in the Enrollee's home or other outpatient setting; 2. axicabtagene ciloleucel, as marketed under the brand name Yescarta ; 3. burosumab-twza, as marketed under the brand name Crysvita ; 4. cerliponase alfa, as marketed under the brand name BrineuraTM; 5. edaravone, as marketed under the brand name RadicavaTM; 6. eteplirsen, as marketed under the brand name Exondys 51TM; 7. nusinersen, as marketed under the brand name Spinraza ; 8. pegvaliase-pqpz, as marketed under the brand name Palynziq TM; 9. tisagenlecleucel-t, as marketed under the brand name KymriahTM; and 10. voretigene neparvovec-rzyl, as marketed under the brand name LuxturnaTM

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

Figure 139 - State Mandating Requirements for the MCO's Pharmacy Benefit

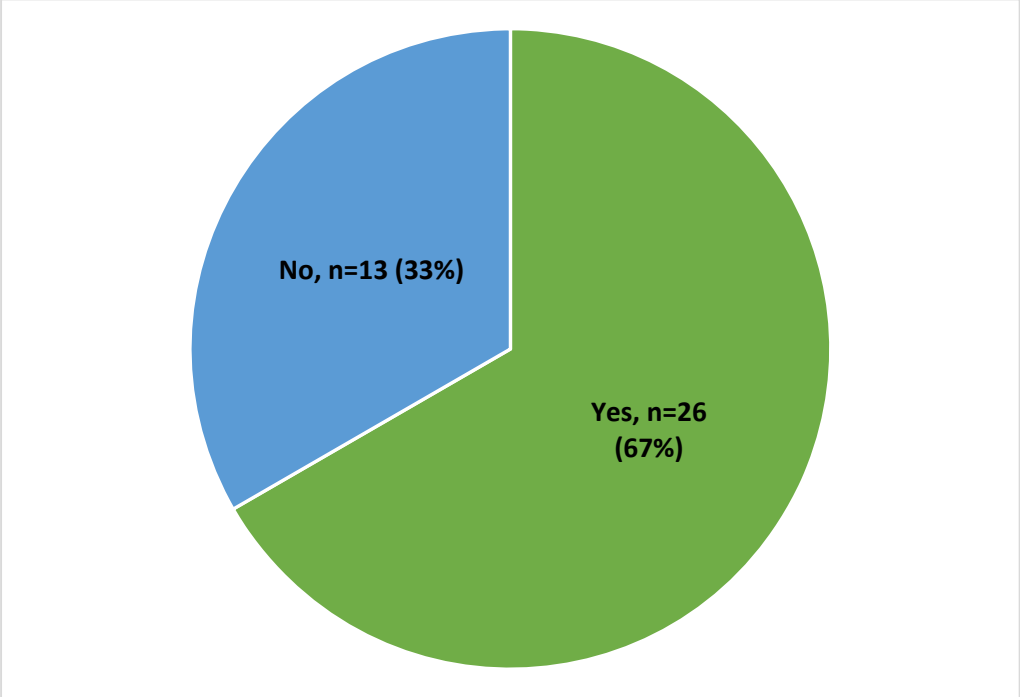

Table 228 - State Mandating Requirements for the MCO's Pharmacy Benefit

Response	States	Count	Percentage
Yes	Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Illinois, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Ohio, Pennsylvania, Texas, Virginia, Washington, West Virginia	26	66.67%
No	Georgia, Hawaii, Indiana, Kentucky, Missouri, Nevada, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Wisconsin	13	33.33%
Total		39	100.00%

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

Figure 140 - State Requirements for the MCO's Pharmacy Benefit

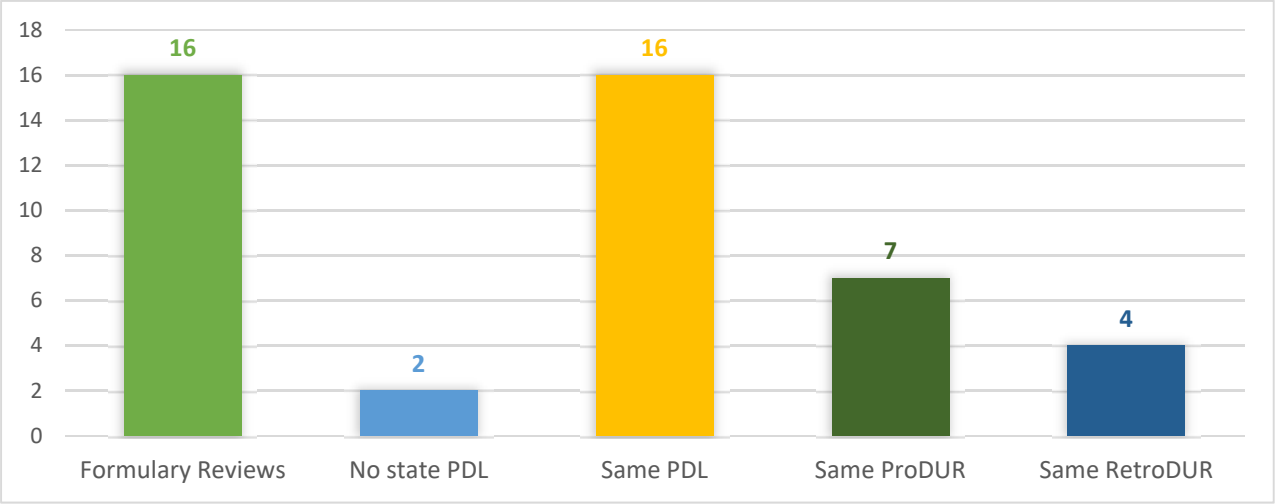

Table 229 - State Requirements for the MCO's Pharmacy Benefit

Response	States	Count	Percentage
Formulary Reviews	Arkansas, California, Colorado, District of Columbia, Florida, Illinois, Maryland, Michigan, Nebraska, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Texas, Washington	16	35.56%
No state PDL	District of Columbia, New York	2	4.44%
Same PDL	Arkansas, Delaware, Florida, Iowa, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, Nebraska, New Hampshire, North Dakota, Texas, Virginia, Washington, West Virginia	16	35.56%
Same ProDUR	Arkansas, Florida, Iowa, Louisiana, Massachusetts, Mississippi, New Jersey	7	15.56%
Same RetroDUR	Florida, Iowa, Louisiana, North Dakota	4	8.89%
Total		45	100.00%

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

Table 230 - Policy Explanations for State Requirements for the MCO's Pharmacy Benefit

State	Explanations
Arkansas	The MCOs must cover all federal Food and Drug Administration (FDA) approved drugs for enrolled members, as set forth in the SSA and must cover all therapeutic classes of drugs covered by the Arkansas Medicaid pharmacy benefit and must follow the Arkansas Medicaid Preferred Drug List (PDL). Drugs on the PDL must be covered without prior authorization unless they are subject to clinical or utilization edits. For those drugs not on the Arkansas PDL but that are covered by the SSA, the MCOs may require prior authorization. Prior authorization criteria cannot be more restrictive than the Arkansas Medicaid Fee For Service Program. The MCOs must develop and maintain a Drug Utilization Review (DUR) program that complies with the DUR program standards as described in the Act including prospective DUR, retrospective DUR, educational program, and the DUR Board. MCOs must have a RDUR program, but they are not required to have the same RetroDUR program as the FFS program. The formulary must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) or Drug Utilization Review (DUR) Committee, and the DUR committee must meet at least biannually which is less strict than FFS. The MCOs must provide DHS with a detailed description of its DUR program activities annually and it must complete and submit the annual Drug Utilization Review (DUR) Annual Report, as required by CMS.
California	Medi-Cal MCOs are required to provide a pharmacy benefit that is comparable to the Medi-Cal FFS pharmacy program and their preferred drug lists (PDLs) are required to be comparable to the Medi-Cal List of Contract Drugs. While all drugs included on the Medi-Cal List of Contract Drugs do not need to be included on the MCOs' PDLs, comparable means that the drugs on the PDLs must have the same mechanism of action sub-class within all major therapeutic categories of drugs included in the Medi-Cal List of Contract Drugs. Starting in FFY 2018, the DUR Board expanded to become the Global Medi-Cal DUR Board, with MCO representatives now included as Board members. MCOs utilize the Global Medi-Cal DUR Board and educational components of the Medi-Cal DUR program. However, MCOs maintain their current proprietary claims processing procedures and protocols and MCPs individually administer the systematic components related to the prospective and retrospective DUR processes. As is the case with the Fee-For-Service (FFS) program, MCOs are not required to implement all DUR Board recommended actions, nor are they required to mirror the Medi-Cal DUR activities.
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	State contracts with a vendor to manage supplemental drug rebates through multistate drug consortium contract. PDL review and files exchange is in collaboration with MCOs
District of Columbia	MCO formularies are reviewed quarterly and on an ad hoc basis as pharmacy benefit changes (additions, deletions, quantity limits, step therapy) are proposed monthly.
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 Department's FFS program provides coverage. Each MCO is responsible for conducting ProDUR and RetroDUR.
Iowa	MCOs are required to follow the same PDL, same ProDUR edits, and RetroDUR initiatives.

State	Explanations
Kansas	The MCOs must implement the FFS PDL and FFS Clinical Prior Authorization criteria and forms. The MCOs MAC cannot be lower than the State MAC. The State Medicaid Agency determines the reimbursement methodology for the MCOs, for both pharmacy and medical drug benefits.
Louisiana	A Single PDL was implemented across FFS and MCOs on May 1, 2019. Prior Authorization criteria has been aligned over time. DUR is directed by a DUR Board comprised of participating Medicaid physician and pharmacy providers and one each MCO Medical Director, MCO Behavioral Health Medical Director and MCO Pharmacy Director to align initiatives and criteria. Each plan follows directives of the DUR Board for prospective criteria, however safety edits such as quantity limits are allowed to be implemented by the plan if they are in accordance with FDA guidelines. Each plan adheres to the schedule of retrospective reviews determined by the DUR and are allowed to implement additional retrospective reviews when approved by Medicaid pharmacy staff. Educational objectives are supported by the University of Louisiana at Monroe College of Pharmacy. MCOs are allowed to bring additional educational initiatives to the DUR Board and Pharmacy staff for considerations.
Maryland	A comprehensive drug use management program has been in place for several years which evaluates each MCO drug benefit including P &T Committee management and procedures, formulary content/management, prior authorization procedures and criteria, generic substitution, drug utilization reviews 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. Please consider modifying this question to account for partial Preferred Drug Lists.
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). In addition, the MCOs can only be less restrictive than the MDHHS approved MCO Common Formulary.
Minnesota	DHS has developed a uniform non-preferred PDL drug prior authorization used by both FFS and MCOs. If the MCO chooses, they can develop their own PA criteria but the criteria cannot disadvantage the preferred drug.
Mississippi	MCOs have been required to reimburse at the same amount or higher than FFS. As of January 2015, MCOs were required to use Universal Preferred Drug List and same clinical criteria.
Nebraska	MCO's will utilize our PDL and Formulary.
New Hampshire	The MCO's are required to follow the State PDL. For drug classes not managed by the State PDL, the MCO's can set their own policies and coverage criteria. The State requires review and approval of drug coverage policies and prior authorization criteria.

State	Explanations
New Jersey	Each MCO submits proposed formulary and drug coverage changes to Division for review and approval on a quarterly basis. The prospective and retrospective DUR standards established by the MCO must be consistent with those same standards established by the Medicaid Drug Utilization Review Board (DURB). DMAHS approves the effective date for implementation of any DUR standards by the MCO.
New York	Managed care plans mimic the therapeutic categories on the FFS formulary but do not require that the formulary drugs in each therapeutic category are exact. Rules and Regulations of the distinct plans regarding PA requirements, appeals etc. will remain as that of each plan.
North Dakota	Starting in October 2017, the MCO was required to follow our PDL. The RetroDUR has been done within the state RetroDUR process - fully integrated.
Ohio	There is a 70% agreement on the PDL that the managed care plans 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 are required to follow the single formulary and PDL. Also the state does not allow MCO's clinical PA criteria to be more stringent than what the DUR Board has approved. The MCOs are required to follow the same Specialty Drug List (SDL) as the state designates.
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	In January 2018 Washington Medicaid began implementing a single Apple Health Preferred Drug List (AHPDL) to be used by the fee-for-service (FFS) program and all five contracted Managed Care plans (MCO). The AHPDL initially included approximately 25 drug class with additional classes being added overtime (October 2018, April 2019, and July 2019). The FFS and MCO programs are required to use the AHPDL drug statuses, prior authorization requirements, and drug policies. The MCOs may continue to apply their own quantity limits and corporate drug policies when a shared policy has not been developed. For all drugs paid through the pharmacy benefit and not included on the AHPDL, MCOs must have a wrap-around formulary and submit any requested changes to Washington Medicaid for review and approval.
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 141 - State Plan to Set MCO Pharmacy Benefit Standards in the Future

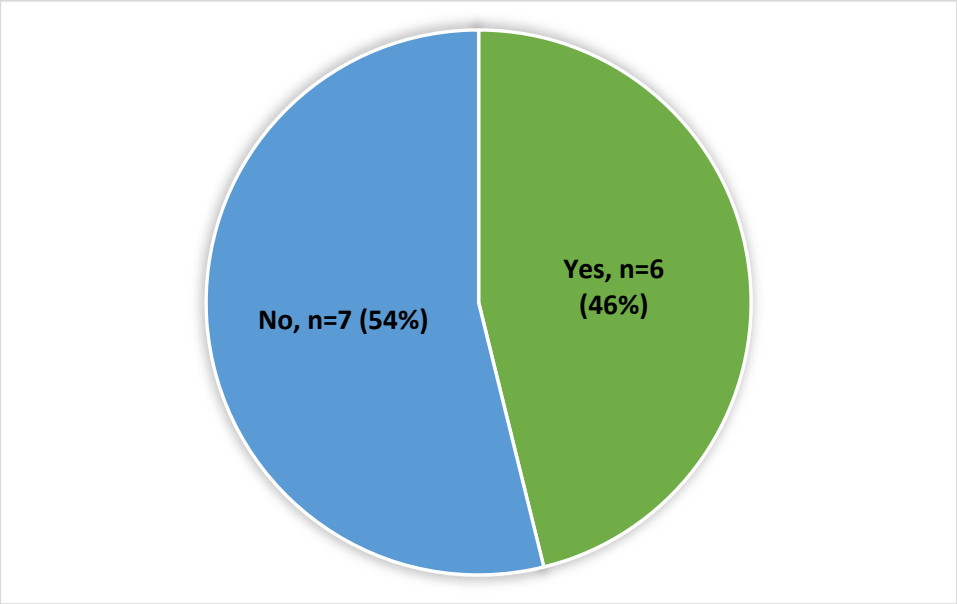

Table 231 - State Plan to Set MCO Pharmacy Benefit Standards in the Future

Response	States	Count	Percentage
Yes	Georgia, Hawaii, Kentucky, Nevada, Oregon, Utah	6	46.15%
No	Indiana, Missouri, New Mexico, Rhode Island, South Carolina, Tennessee, Wisconsin	7	53.85%
Total		13	100.00%

If “No,” please explain.

Table 232 - Explanations for State Plan to Set MCO Pharmacy Benefit Standards in the Future

State	Explanations
Indiana	Establishing requirements such as these would require substantial contract changes and negotiations.
Missouri	Pharmacy benefits are carved out of Managed Care.
New Mexico	MCOs are monitored to provide coverage at no less than Fee-For-Service.
Rhode Island	Not at this time.
South Carolina	Coverage/Benefit requirements are set, however, the State allows the MCO to manage coverage rules, prior authorization requirements and preferred drug classifications - with a few exceptions: Tobacco Cessation, MAT (Medication Assisted Treatment) and HCV (Hepatitis C: carved out 7/1/2015 and transitioned back to MCO's 7/1/2020).
Tennessee	Since our pharmacy program is carved out, the MCO's do not have a pharmacy benefit for TennCare members. So the MCO's do not have a PDL for TennCare members.
Wisconsin	Pharmacy is carved-out in Wisconsin.

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

Figure 142 - Managed Care Plans Submission of DUR Reports

Table 233 - Managed Care Plans Submission of DUR Reports

Response	States	Count	Percentage
Yes	Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington	37	94.87%
No	West Virginia, Wisconsin	2	5.13%
Total		39	100.00%

If "No," please explain.

Table 234 - Explanations for Managed Care Plans Not Submitting DUR Reports

State	Explanations
West Virginia	Pharmacy is carved out, therefore the MCOs do not perform DUR
Wisconsin	Wisconsin is submitting the FFS report and some of the MCOS are still in the process of completing their report and sending it to us for submission to CMS.

XII - Executive Report

1. **Summary 8 - Executive Report** should provide a brief overview of your program. It should describe 2019 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.

Table 235 - State Executive Summaries

State	Executive Summaries
Alabama	The Alabama Medicaid Drug Utilization Review (RDUR) report in its entirety serves as the summary for the RDUR Program for the Alabama Medicaid Agency covering Federal Fiscal Year (FFY) 2019.
Alaska	Executive Summary for Annual DUR report for FFY 2019 The Alaska Medicaid Drug Utilization Review (DUR) committee met for four scheduled meetings in FFY 2019. The committee strives to ensure recipients have access to medically necessary pharmaceutical therapies to yield the best clinical outcomes while concomitantly considering the fiscal and time impact on the users of the system. The interdisciplinary nature of the DUR committee provides for consideration of a breadth of perspectives, as does the members' varied practice locations around the state. Prescription drug costs have steadily risen over the past several years despite many older medications now having generic equivalents in the market place. The committee is dedicated to help promote safe and effective use of medications by approving prospective claims processing edits that are reasonable and sensible. Reaching out to providers by varied means and educating them of the edits has been a challenge. Advances in FFY 2019 will aid in solving these challenges. The committee continues to utilize and explore expanded opportunities for electronic educational communication avenues as alternatives to paper mailings. Prospective Drug Utilization Review (ProDUR) The generic utilization from FFY 2018 (81.3%) to FFY 2019 (81.9%) experienced a 0.6% increase, which contributes to a grand total of an 8.5% increase since FFY 2012. The generic expenditure for FFY 2018, as a percent of total costs, was 19.3%. In FFY 2019, this number decreased to 17.9%. The influencing factors can be attributed to the constant focus on new clinical edits and diligence to promote the utilization of equally effective generic therapies while maintaining a high standard of care. Coupled to this, however, is the dilution of generic drug cost savings from steadily rising branded drug costs with no generic equivalent. Maintaining the stability of the program without negatively impacting patient care, or outcomes, is primarily addressed by incorporating new edits at the point of sale. Therapeutic duplication, refill too soon, drug disease interaction, drug/drug interaction, drug/pregnancy interaction, drug to age, quantity limit, and prior authorization edits are valuable tools that aided in safety, appropriate utilization, and cost containment successes during FFY 2019. High cost specialty medications for infectious disease, oncology, hematology, and immunology in particular continue to increase the criticality of the DUR committee's decisions. In light of increasing costs, ensuring rational, evidence-based utilization of medications across the spectrum is imperative. Resource consideration coupled with sound clinical decisions is essential to the sustainability of Medicaid pharmacy programs in this new pharmaceutical era. Retrospective Drug Utilization (RetroDUR)

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	The RetroDUR portion of the committee meetings during FFY 2019 relied primarily on the review of aggregate claims data. Various educational means were employed, including sending informational letters to prescribers. The committee members are very passionate about sharing information within the medical community; communicating meaningful information can be a challenge when the reviews are limited to the Medicaid claims. The committee continues to explore other communication channels to provide meaningful education to prescribers and providers around the state. Conclusion In FFY2019 the DUR committee reviewed issues with respect to therapeutic appropriateness, overutilization, therapeutic duplication, drug-disease and drug-drug interactions, inappropriate dosing and duration. The committee addressed these issues through the utilization of quantity limits, prior authorization, point-of-sale edits, and educational materials. These initiatives have translated into an increase in appropriate drug utilization, prevention of waste, and promotion of cost saving options while maintaining positive outcomes. The committee will continue to focus on appropriate drug utilization, safety and efficacy issues, maintaining accessibility, diversion control, and use their professional knowledge of unique Alaskan healthcare delivery challenges when applying standards and interventions on behalf of the Alaska Medicaid Pharmacy program for the delivery of quality care to beneficiaries.
Arkansas	ARKANSAS EXECUTIVE SUMMARY FFY2019 AR Medicaid Pharmacy Program has an extensive list of drugs that require prior approval (PA) to override established clinical criteria edits and drug claim edits. Although patient safety and appropriate drug utilization to protect the vulnerable, promote better health, and provide improved outcomes are the focus when developing clinical algorithms and drug claim edits, generally the end result is cost containment or cost avoidance for the pharmacy program. The clinical criteria edits may use either point of sale (POS) clinical approval algorithms or a clinical manual review PA for approval of a particular drug. If a client does not meet the established prior approval criteria, the prescriber may submit a request in writing to provide additional documentation to substantiate the medical necessity of the client receiving the drug in question, or the prescriber may change the drug to an alternative drug that does not require prior approval. Drug claim edits are limitations placed on drugs or drug classes using gender, age, daily dose, monthly quantity allowed, quantity allowed per claim, or accumulation quantity edits that allow up to a certain quantity over a period of time. In addition to clinical edits and claim edits, AR Medicaid Pharmacy Program has a preferred drug list (PDL) and the drugs may be listed as preferred status, preferred status with criteria, non-preferred status, and non-preferred status with criteria. The non-preferred drugs on the Preferred Drug List will deny at point of sale and require an approved manual review authorization in order for the claim to pay. The prescribing provider must submit a request in writing explaining the medical necessity for the client to receive the non-preferred drug over the preferred drug(s), or the prescriber can change the prescription to a preferred drug as an alternative drug that does not require a prior approval.

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	Our process requires that we review the new drug file every week prior to the drug file being accepted into the system program. New drugs are reviewed and decisions are made whether to develop a clinical edit proposal for review at an upcoming DUR Board meeting, such as for a new drug that may have the potential for inappropriate use and/or abuse, or a new drug that has been approved by the FDA and it carries an excessively high price tag and yet the evidence for the drug does not show that a clinical benefit has been established for the drug, or a new drug was approved by the FDA and although is very inexpensive as a generic drug in other countries it carries an excessively high price tag in the US and the evidence does not support that this new drug is more effective than other generic drugs available in the drug class. The Pharmacy Program staff continue to search for and identify various issues in client profiles, such as inappropriate utilization, billing errors, excessive quantities & doses written for and dispensed, and over-utilization of medications in a particular drug class. These issues could also indicate the potential of prescription-medication fraud and abuse so it is essential to address these issues when possible by preventing the opportunity, such as developing some type of clinical edit proposal, implementing quantity edits, accumulation edits, and the elimination of early refills that could allow a client to stock-pile medication or allow the client to accumulate excessive extra doses of medications. The Pharmacy Program staff use an evidence-based approach for developing proposals for the DUR Board to review and approve at the quarterly meetings, including clinical PA criteria algorithms and drug claim edits (quantity edits, dose edits, cumulative quantity edits, age, or gender edits) that will support appropriate and safe prescription drug use. Although it is important for the AR Medicaid Pharmacy Program to conserve program funds using these types of drug claim edits and prior authorization criteria, the success of the AR Medicaid Pharmacy Program is not measured by cost savings or cost avoidance alone. The evidence-based approach to safe and clinically appropriate use of prescription drugs is a strong foundation on which we have built our pharmacy program so that we may protect the vulnerable, promote better health, and provide improved outcomes in a cost-effective manner. FFY2019 INFORMATION: FFY2019 was interesting for the Arkansas Medicaid pharmacy program. The program had a change in staffing with a new pharmacy director and new DUR coordinator and subsequently 2 new clinical pharmacists that are state employees and 2 new clinical pharmacists that are Magellan employees. Our program definitely had a huge learning curve, but this change allowed a reconfiguration of the pharmacy program. ADDITION OF MCOs: One significant change to the Medicaid pharmacy program was the addition of three MCOs. Previously, Arkansas was 100% FFS. In March 2019, the Medicaid program started the PASSEs (Provider-led Arkansas Shared Savings Entity). The goal of the PASSE system is to monitor client's health care needs, keep them healthy, and help them reach goals. Currently, the PASSE system contains approximately 45,000 Medicaid clients with complex behavior health, developmental, or intellectual disabilities. The goal of improved client health is facilitated by care coordination. The PASSEs cover all required services for the members, including pharmacy. To ensure communication and oversight, each PASSE must have a non-voting member for the FFS DUR board, and a representative from the Medicaid Pharmacy Program must be a voting member for each PASSE's board.

State	Executive Summaries
	ARKANSAS DRUG UTILIZATION REVIEW BOARD (DUR) AND DRUG REVIEW COMMITTEE (DRC): In an effort to bring healthcare professionals with differing backgrounds and experiences, we have increased the number of members for each board. We have expanded our DUR board by an additional physician and pharmacist for a total of 11 members. The diversity of our board is imperative in making appropriate clinical decisions for our program. Our board contains a psychiatrist, an addiction specialist, a gerontologist, a pediatrician, an independent retail pharmacist, a clinical pharmacist with hospital experience, a pharmacist in academia, a pharmacist with third party experience, and a retail pharmacist from our local children's hospital. We are currently looking for possibly a consultant pharmacist and an oncologist. The DRC reviews placement of drug classes on our preferred drug list (PDL). We have expanded our DRC by an additional pharmacist for a total of 7 members. We currently have a pharmacist in hospital management, a pharmacist with clinical hospital experience, a pharmacist in academia, a pharmacist with RDUR, retail, and corrections experience, a psychiatrist, a pediatrician, and a general practitioner. The variety in this committee is imperative as we review therapeutic classes reviewing clinical efficacy and safety data for PDL placement. FFY2020 GOALS: FFY2020 goals include tracking response and expenditures for our Cystic Fibrosis population as well as our Hemophilia population. An additional goal includes developing a plan for decreasing concomitant usage of opioids, benzodiazepines, muscle relaxers, gabapentin and sedative hypnotics by our FFS and MCO clients.
California	The purpose of Drug Utilization Review (DUR) is to improve the quality and cost-effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. California's Medi-Cal DUR program is the responsibility of the Department of Health Care Services (DHCS), and includes prospective DUR reviews, retrospective DUR reviews, and educational interventions for providers and pharmacies. During federal fiscal year (FFY) 2019, California's Global Medi-Cal DUR Board (the Board) included ten pharmacists and six physicians, meeting OBRA 1990 requirements. The Board held four meetings in FFY 2019, with each meeting divided up into two distinct sections: 1) old business and follow-ups; and 2) new business that included placeholders for updates from DHCS and the DUR Board, drug utilization reports, prospective and retrospective DUR reviews, and descriptions of educational bulletins and/or alerts. The Board is responsible for advising and making recommendations to DHCS for the Medi-Cal population. Over the course of FFY 2019 the Board reviewed prospective DUR criteria for 55 drugs and comprehensively reviewed the status of ingredient duplication (ID) and therapeutic duplication (TD) alerts for lithium and quetiapine. In addition, retrospective DUR criteria for Hepatitis C Virus (HCV) medications and gabapentinoids, as well as all medications that became available on the Medi-Cal Contract Drugs List in FFY 2018 were presented to the Board. A total of seven educational bulletins and alerts were published on the Medi-Cal website in order to educate and inform Medi-Cal providers and beneficiaries on timely and relevant topics related to medication use. A total of five educational mailings were sent to selected prescribers to improve the quality of care for Medi-Cal beneficiaries. Finally, in FFY 2018, the Board continued to

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	collaborate with key state agencies and national experts, and actively worked to incorporate a variety of Medi-Cal MCP best practices across multiple plans into the Board meeting agenda. This Annual Report was prepared through a collaborative effort between the California Department of Health Care Services, the Global Medi-Cal Drug Use Review Board, DXC Technology, Inc., and the University of California, San Francisco.
Colorado	The Colorado DUR Program is now in the seventh year of collaboration with Skaggs School of Pharmacy and Pharmaceutical Science (SSPPS). The DUR program continues to contract with a pain management specialist and a child and adolescent psychiatrist for teleconsultation services. In addition to the sub-contracted specialists, there are two clinical faculty members, an administrative faculty member, an analyst, and a pharmacy outcomes researcher involved in DUR-related analyses and subsequent policy recommendations to the Department. One clinical faculty member serves as a clinical consultant and SSPPS liaison for the Department as well as point person for contract deliverables. Policy in the areas of opioid utilization were measured and modified to further enhance management of opioid medications and target areas of potentially inappropriate opioid utilization. In alignment with requirements included in the SUPPORT for Patients and Communities Act, the Department implemented opioid policies and systems edits for concomitant opioid and benzodiazepine use, quantity and days supply limits for dental opioid prescriptions, and concomitant opioid and antipsychotic medication use. The DUR Board was consulted for opioid policy input, as well as public stakeholders including persons with disabilities, patient advocates, and pain management specialists. Consideration for opioid policy development is ongoing and will likely focus on opportunities for managing inappropriate or high risk concomitant prescribing and evaluation of naloxone prescribing practices during the upcoming fiscal years. Additional medication management and policy-related changes made during the reporting fiscal year include removal of prior authorization requirements for smoking cessation products, addition of pharmacists as enrolled providers, allowance of coverage for pharmacist prescriptions for smoking cessation products, addition of 12-month supply coverage allowance for contraceptive medications, implementation of quantity limit restrictions for twice daily proton pump inhibitor dosing, and implementation of claims dollar amount limitations for all 340B claims. The Department also development and implemented an ongoing quarterly process for identifying cost savings opportunities with favored coverage of certain multi-source brand medications. DUR Board meeting agendas have been very full as Colorado's P&T processes have been adding many drug classes to the State's Preferred Drug List (PDL). New PDL classes added during FFY 2019 include Hereditary Angioedema Agents, Prenatal Vitamins, CGRP Inhibitors, Lipotropic and Bile Salt Agents, Parkinson's Disease Agents, Ophthalmic Glaucoma Agents, Topical Steroids, Rosacea Agents, Phosphate Binders, and Benign Prostatic Hyperplasia Agents. The DUR Board continues to have high quality discussion leading to high quality recommendations made to the Department. Meetings continue to occur at a quarterly frequency and last approximately 4-5 hours. The Department Pharmacy Office is in the process of expanding utilization management for physician administered drugs billed through the medical benefit. When this change happens, there will likely be DUR Board involvement in the processes for developing terms of management.
Connecticut	Objectives for the operations of the Connecticut Medical Assistance Drug Utilization Review (DUR) Board during federal fiscal year 2019 include: (1) maintain a DUR Board with membership that meets OBRA 1990 requirements; (2) continue prospective DUR criteria review and

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	evaluation, (3) conduct focused retrospective analyses of claims data to study drug utilization in the Connecticut Medical Assistance Program including the fee-for-service population and to (4) guide the development and implementation of educational interventions to improve drug use in this population. From 10/01/2018 to 9/30/2019 the DUR Board was comprised of six pharmacists and three physicians. Four DUR Board meetings were held during FFY 2019. Twenty-four targeted retrospective analyses were reviewed and approved by the DUR Board and conducted during FFY 2019. All the retrospective evaluations included mailing of recipient specific educational intervention letters to prescribers. Recipient specific educational intervention letters highlight a drug therapy concern and are sent to prescribers with a complete recipient drug and diagnosis history profile along with a response form. An additional 12 retrospective analyses for the pharmacy lock-in program were conducted during FFY 2019. The Pharmacy Lock-In Program is ongoing and HID was required to review 800 lock-in profiles monthly. A summary report of the activities of the regular DUR and Lock-In Program during FFY 2019 is included within the report. For the future, the DUR Board aims to accomplish the following: (1) provide recommendations to help improve drug therapy in the Connecticut Medical Assistance Program population, (2) analyze the utility and effectiveness of existing prospective DUR criteria and retrospective interventions for the fee-for-service population and patients taking medications reimbursed fee-for-service, (3) recommend and review prescriber interventions and educational programs and (4) serve in an advisory role for the development and management of a Pharmacy Lock-In Program. Cost Savings analyses of both prospective and retrospective DUR are reported and can be found in Attachment 5 of the CMS Report. The reported cost savings for Retrospective DUR during FFY 2019 from HID was $3,864,173. The reported cost savings for Prospective DUR during FFY 2019 was $95,702,538.
Delaware	In Federal Fiscal year 2019, eighty five percent of the population resided in two managed care organizations while 15% of the population remained in fee-for-service. Of the 15%, the majority of these FFS clients were transitioning into a managed care plan within 60 days. As a state with a mixture of FFS & MCO lives, Delaware has a unified PDL designed to streamline consistent drug status and maximize savings for the program. Both programs (FFS & MCO) strive to align drug policies, by mirroring the claims editing of FFS with encounters. This allows for the provider community to providing quality care for Medicaid beneficiaries with the least amount of disruption of treatment. To address the low response rate from providers to paper mailing of retrospective drug utilization letters, Delaware continues to utilize MMIS to automatically generating Retro-DUR alerts to prescribers utilizing Pharmacy and medical information within the system. Provider specific letters with a compilation of clients is generated for portal retrieval, copies of the letters generated are data stored in document repository available for retrieval for faxing upon provider request. This system has served as a cost saving for the state through elimination of returned mail due to wrong addresses when an office relocation has occurred. It also guarantees the providers have access and receive these alerts. Delaware has continued to run all drug encounters through established edit/audit rules to track the MCO's management of the drug benefit aligned with Delaware State policies. MMIS

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	generates a monthly report that tracks submitted encounter acceptance rate of our two MCOs. This report is utilized to analyze both MCO efficiency and compliance with all existing state policies and to identify potential modification. Delaware continues to adjust our system as we work to improve the integration between our Medicaid system the MCOs systems. Delaware uses numerous platforms to report our successes, gain insight and discuss challenges with other states so that we can learn from each other and move forward with innovation. Legislative mandates continue to guide Delaware as a state in addressing clinical concerns highlighted by data such as rate of unplanned pregnancies and opioid overdose-related death analyses across multiple agencies. The data continues to shed light onto areas of possible improvement through collaboration with Substance abuse and mental health divisions, department of Public Health, Prescription monitoring program, and other state organizations. Going forward, Delaware will be continuing to collaborate with various areas of Pharmacy practice to close the gap in Vaccination hesitancy, by allowing additional Pharmacy practice areas vaccinate with an administration fee equal to the dispensing fee. The small size of the state and client mix pose some limitations to innovation, but we continue to gain collaborative engagement with different stakeholders to ensure our vulnerable population has a voice and is represented where needed. Ultimately, the goal is to provide all clients with the level of care they need and deserve.
District of Columbia	The District of Columbia Drug Utilization Review Board (Board) dealt with several important issues during FY19. Pharmacy Lock-in The Fee for Service Lock-in Program has developed into a robust process led by the District's Medication Therapy Management (MTM) certified clinical pharmacist. Potential lock-in candidates were presented to Board members at each monthly meeting for approval of pharmacy lock-in restriction after a thorough vetting process. Appropriate candidates not meeting lock-in criteria were referred to MTM for care management and follow-up. Lock-in criteria and recipient rosters were shared with the Medicaid managed care plans to coordinate movement of beneficiaries among the individual plans and the FFS program. Lock-in program participants completing their pharmacy restriction period continue to receive MTM outreach encounters. MANAGED CARE DUR ACTIVITY OVERSIGHT The DUR Board established its oversight responsibilities over the Managed Care plans' drug utilization activities and underscored its role in establishing a coordinated approach to ensuring the all Medicaid beneficiaries receive medications that are appropriately prescribed, are safe and efficacious and are cost effective through proactive avoidance of fraud, waste and abuse practices. The DUR Board identified District pharmacy priorities and invited the Pharmacy Director from each Medicaid Managed Care plan to participate in a dedicated Board meeting each quarter to present the managed care plan's current policies on the selected priority. Interactive discussion on best practices lead to establishment of goals and timelines for alignment of policies to achieve parity across the managed care and FFS populations. Board oversight focused on opiate utilization reduction strategy, coordination between the FFS and Managed Care plan Lock-in programs, removal of barriers to access to MAT medications for beneficiaries and providers and review of clinical criteria for MAT medications. Relevant provisions of the SUPPORT Act were thoroughly reviewed and discussed with all Managed Care partners to assure understanding and that adherence to each pharmacy requirement was implemented accordingly.

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	EMERGING THERAPIES Rising concern over the potential budget impact of new extremely costly medications to treat several rare but quality of life impacting health conditions demanded a great deal of attention. The Board was tasked with development of drug specific prior authorization criteria and forms designed to help educate the prescriber on FDA approved indications and required laboratory or genetic testing. Evaluation of some of the emerging therapies, especially gene-therapy treatment, seemed to straddle the boundaries between medical and pharmacy benefit coverage and required extensive research and review of current literature and other resources. Board members continue to be actively involved in providing recommendations for ProDUR edits that are designed for minimizing potential adverse effects that might be discovered during monthly utilization review of the patient profiles. Individual Board members shared their subject matter expertise at the meetings and provided updates via email when clinically significant information became available between scheduled meeting dates. SUMMARY It is anticipated that increasing numbers of drugs will come to market having more narrow therapeutic indications, complex dosing regimens and high costs. The on-going work of the DUR Board to detect inappropriate prescribing and promote safe and effective medication utilization will become even more important and will help shape prospective clinical criteria and future POS edit design. The District of Columbia Drug Utilization Review Board looks forward to another challenging and productive year and welcomes the expanded oversight of the managed care enrolled Medicaid beneficiary population.
Florida	Executive Summary Drug Utilization Review Program Overview Magellan provides electronic claims processing and a pharmacy claims management system incorporating on-line point-of-service (POS) and prospective drug utilization review (ProDUR) for the Florida Medicaid Fee-for-Service (FFS) Program. The primary objective of the ProDUR program is to improve the quality of care for recipients by reducing the potential for drug interactions as well as adverse drug reactions. Additional goals include conserving program funds and expenditures, as well as maintaining program integrity by controlling problems of fraud and benefit abuse. The operation of the retrospective drug utilization review (RetroDUR) program is a shared responsibility of Magellan and the Agency. The goal of the RetroDUR program is to promote appropriate medication prescribing by identifying patterns of potentially inappropriate prescribing or medication use. Once these patterns are reviewed and studied, potential interventions to address the issue are presented to the DUR Board for consideration. An analysis of the impact of planned interventions is created and agreed upon interventions are then communicated to physicians and/or pharmacists to improve prescribing and patient outcomes. Prospective Drug Utilization Review Program (ProDUR) ProDUR encompasses the detection, evaluation, and counseling components of predispensing drug therapy screening. The ProDUR system of Magellan assists the pharmacist in these functions by addressing nine different situations in which potential drug problems may exist. ProDUR is performed prior to dispensing and helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may have been previously unavailable. Because Magellan's ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by

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	previously dispensed medications can be detected. ProDUR recognizes that pharmacists utilize their education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid pharmacists in their professional duties. For certain edits, as determined by the DUR Board, ProDUR edits may be overridden by the pharmacist in such cases where the pharmacist, either alone, or in consultation with prescriber has determined the accuracy and safety of the prescription. To accomplish the override, the provider must input the Reason for Service, Professional Service and Result of Service Codes in the appropriate fields. In other situations, as deemed appropriate by the DUR Board, no override of the ProDUR edit can be accomplished at the POS and a prior authorization must be obtained before the medication can be dispensed. This action adds an extra layer of safety in situations where the risks are known to be substantial or the prescribed therapy falls outside of nationally accepted standards of care. Magellan's ProDUR system assists the pharmacist with the detection, evaluation, and counseling components of pre-dispensing drug therapy screening by addressing nine drug therapy problem types in which potential medication problems may exist. The screening types identified by Florida Medicaid's FFS ProDUR criteria are: Excessive Daily Dose (HD) Alert occurs when the calculated dose per day of a drug exceeds the recommended daily dosage. The criteria for excessive daily dose are age specific. Insufficient Daily Dose (LD) Alert occurs when the calculated dose per day of a drug is less than the minimum recommended daily dosage. The criteria for insufficient daily dose are age specific. Early Refill (ER) Alert occurs when a prescription is refilled before 80 percent of the previously filled prescription's days' supply has elapsed. Therapeutic Duplication (TD) Alert occurs when a drug that is to be dispensed is in the same therapeutic class as another drug filled within the previous six weeks. Drug-Drug Interactions (DD) Alert occurs when a drug that is to be dispensed may interact with a previously filled drug (within the previous six weeks) from any participating pharmacy. Alerts are sent to pharmacies only on the most clinically significant drug interactions. Ingredient Duplication (ID) Alert occurs when a drug that is to be dispensed shares a common ingredient with a previously filled drug from any pharmacy. Drug to Gender (SX) Drug to Gender alerts occur when the drugs with risks of harm to a particular gender, or drugs not indicated to a specific gender are being prescribed. Drug-Age Contraindication (PA) Drug Age Contraindication alerts occur when a drug is dispensed that is not recommended for use in the age group of the patient. Age alerts can occur when the patient is too old for the given medication, is too young for the given medication, or is not within the recommended age range for this medication. Underutilization (LR) Underutilization alerts occur when patients have waited to refill their maintenance medications beyond the specified days' supply of the previous fill. ProDUR Cost Savings ProDUR cost savings are calculated by tracking claims that receive ProDUR alerts to determine if the pharmacy providers dispensed these prescriptions. Cost savings are reported from the cost of claims generating an alert, which were reversed by the pharmacist and not dispensed, and on claims that denied and were not overridden. Retrospective Drug Utilization Review (RetroDUR) The goal of the Florida Medicaid FFS RetroDUR Program is to promote appropriate prescribing and medication use. The RetroDUR utilization analysis, as described below, provides information that assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians and pharmacists to potential drug therapy problems, identifies opportunities to improve drug therapy, and makes recommendations to avoid drug therapy problems. Utilization Analysis

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	The operation of the retrospective drug utilization review (RetroDUR) program is a shared responsibility of Magellan and the Agency. The RetroDUR program examines patterns of drug therapy utilization to detect potentially inappropriate prescribing or to examine prescribing patterns that are outside the established standard of care based on national guidelines or accepted standards of practice. The RetroDUR review process emphasizes medication classes where there is high utilization and/or high risk associated with those classes of medications. Recent updates to standards of practice, in the form of published peer-reviewed guidelines, as well as important safety communications from the US Food and Drug Administration (FDA) service are utilized to ensure timely reviews of important therapeutic issues affecting Florida Medicaid FFS recipients. Utilizing pharmacy claims history, medical claims history and diagnostic information captured on medical claims, Magellan is able to provide a robust analysis of utilization and identify areas of concern. These analyses are presented to the DUR Board quarterly, along with background information and details of currently accepted medical guidelines, to help guide recommendations for specific interventions or edits that may be appropriate to implement based on the RetroDUR findings. Impact analyses are performed regarding specific recommendations and the DUR Board is informed prior to the implementation of any such edits. A follow-up post edit implementation analysis is performed after a specified time interval and these results are presented to the DUR Board as well to ensure the intended outcomes of the edit are being met and resulting in improved quality of care for Florida Medicaid FFS recipients. Depending on the clinical situation, communication to prescribers and/or pharmacies may be accomplished through posting a banner message on the AHCA website or by direct mailings to specific providers who were identified as part of the RetroDUR process. Specific drug classes that will be reviewed at upcoming quarterly Pharmacy & Therapeutics (P & T) meetings are examined for recommendations by the DUR Board to serve the state collaboratively along with the members of the P & T committee. In this capacity, the DUR Board serves to provide advisory input to the P & T committee based on drug utilization patterns that are examined and reviewed as part of the RetroDUR process. RetroDUR Cost Analysis The provision of high quality drug therapy not only results in improved patient health but may also result in program cost savings. It is important to quantify the effect of interventions on the cost of drug therapy. Magellan performs a post-edit implementation analysis for all RetroDUR interventions. This analysis examines any changes in number of claims, number of recipients or potential cost savings that may have occurred as a result of the intervention. Cost savings may vary due to a variety of factors including the particular class of medication, the intervention selected, the lag time before the recipient's next physician visit when changes in drug therapy may occur or changing patient demographics. Some interventions based on RetroDUR review emphasize the need to increase spending on a particular class of medications in order to improve adherence. Improved adherence for many classes of medications has been shown to improve outcomes and lessen other, long-term medical expenditures. RetroDUR initiatives in FFY 2019 demonstrated cost savings as documented below: Minimum age limit of 18 years of age on opiate containing cough and cold preparations: $98.48 savings. Minimum age limit of 6 years of age on oral codeine preparations: $1,205.24 savings. Zolpidem step therapy edit: $7,144.92 savings. Maximum daily dose in antidepressant therapy: $15,673.92 savings. Polypharmacy in Tumor Necrosis Factor (TNF) inhibitors: $12,669,526.64 savings.
Georgia	The Drug Utilization Review Board (DUR Board, DURB or Board) continued its service to the Georgia Department of Community of Health (GDCH or DCH) in an advisory capacity. In this role, the DUR Board made recommendations related to the safe and effective use of medications for

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	Medicaid Fee-for-Service members to the Department. During Federal Fiscal Year 2019 (FFY2019), the DUR Board was comprised of physicians and pharmacists from a variety of backgrounds located throughout the State of Georgia. The primary responsibility and charge to the Board was the continuing development and modification of the State of Georgia's Preferred Drug List (PDL) and Providers' Administered Drug List (PADL) for the Medicaid Fee for Service (FFS) program. Additionally, the Board offered its expertise to assist the State with development of prior authorization criteria, drug utilization reviews, increasing generic utilization, and advising on conditions for claims processing. Board Meetings follow parliamentary procedures and have a standing order of business, specifically: Call to Order Comments from the Department Approval of Minutes External Comments Session Executive Session New Drug Reviews Class Reviews Clinical Utilization Reviews Utilization Trend Review Drug Information Review Future Agenda Items Future Meeting Dates Boards' Recommendations Adjournment The clinical review of information includes input from several sources: NorthStar HealthCare Consulting (NHC) (review of medical literature including controlled clinical trials as well as clinical guidelines, drug safety alerts, generic availability report, new medication pipeline report); the pharmaceutical manufacturers (verbal presentations via the manufacturers' forum and written materials via electronic submission); external comments at the meetings; and the DUR Board members through their independent research and clinical expertise. Additionally, the Board sought clinical input from practicing clinical experts when supplemental information was needed. Drug classes previously reviewed by the Board are reconsidered on an annual basis. New market entrants that are subject to the outpatient drug benefit are reviewed after 6 months of market availability. During FFY2019, the DURB researched, reviewed and made PDL/PADL recommendations for the following drugs: Aimovig Crysvita Mircera Rhopressa Trogarzo Vyzulta Fasenra Lokelma

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	Lucemyra Orilissa Solosec Zemdri Ajovy Delstrigo Doptelet Emgality Ilumya Jivi Mulpleta Olumiant Pifeltro Xofluza Nuzyra Yupelri Zolgensma In addition to the drug classes which the new drugs above belonged to, the DURB also researched, reviewed and made PDL/PADL recommendations on the following therapeutic classes: Anticonvulsants Antihyperuricemics Antipsychotics Colony Stimulating Factors COPD Agents Glucocorticoids, Inhaled Ophthalmics, Anti-Inflammatory/Immunomodulator
Hawaii	As Medicaid provides 1/4 of the State of Hawaii's population with health care, the diverse demographics and extensive rural areas are major factors when considering DUR. FFS has less than 1% of the Medicaid population in the non-dental program. The FFS dental program can service 350,000 but realizes 62,000 eligibles: children have full dental care and adults have only emergency care. The dental formulary DUR highlights are to improve prescribing on common drug therapy problems due to available inventory and increasing antibiotic costs, provide for patient access in rural areas (silver diamine fluoride) and neighboring island, improving prescribing or dispensing practices of controlled substances and increasing patient medication compliance. The plan is to shift all of managed care dental to FFS drug coverage in the future. The non-dental program is for organ and tissue transplant, foster children out-of-state, breast and cervical cancer and ITOP drug coverage. By Hawaii law, Medicaid is not allowed to prior authorize any medications to treat the human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, or who is a patient in need of transplant immunosuppressives, approved by the United States Food and Drug Administration and that are eligible for Omnibus Budget Reconciliation Rebates Act (OBRA), that are necessary to treat the condition. (This shall not apply to Medicaid managed care medical plans.) Program demographics result in less than 500 claims per month in FFY 2019 and allows manual review of random claims sampling as needed, quarterly or at least annually for the majority of DUR.

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	Managed care plans have been included in the Hepatitis C, naloxone and Synagis reviews. Hepatitis C DUR showed decrease need: 1 claim for FFS and 142 claims for managed care for FFY 2019. After the fibrosis score changed to F0, claims slightly increased (not like the warehousing effect of Harvoni and F3 changing to F1 in FFY 2017). Currently count and cost are 1/5 of FFY 2017. Manual retroDUR for patient, prescriber, pharmacy, drug, etc. found no issue. Naloxone DUR found 0 FFS claims and a slowly increasing number of claims for managed care (which is extremely low). Formulary access and media education to the public were available but not the demand for the medication. Shared Synagis updates were from an annual state initiative by local pediatricians tailored to our Hawaii population and longer season. Collaboration within the medical community continues to be outstanding. Psychotropic use remains low due to the population served. DUR found no outlier on the few claims. Annual DUR reviews on patient drug profiles for the transplant program identified appropriate prescribing and utilization at the transplant centers. Patients are in the program 1 year pre-transplant and usually 1 year post-transplant, returning back to managed care. Other annual DURs were performed without need for new initiatives or improvements. Rewriting Hawaii's state plan amendment for reimbursement and updates plus preparing for the SUPPORT Act consumed time usually spent on DUR in FFY 2019 and prepared for FFY 2020.
Idaho	During Federal Fiscal Year 2019 the activities of the Idaho DUR Board were coordinated by Magellan RX Management. This has developed into a great partnership between Magellan and the staff clinical pharmacists at Idaho Medicaid. The staff is able to identify areas of concern and quality improvement opportunities. Magellan is able to pull data and profiles and the state staff is able to complete the profile reviews. The Department operates its own internal call center to manage the prior authorization program. The DUR Board is involved in outcome studies to review PDL changes and impact of prior authorization criteria. Idaho feels fortunate to be able to ensure appropriate utilization without legislative restriction on any of the high expenditure drug classes. Being able to include physician administered drugs in the prior authorization process by pharmacists has added consistency to the quality use of drugs across the whole program. This has been especially advantageous for many of the high cost specialty drugs to be able to use pharmacist knowledge for coverage decisions. During the time period of this report, 24 unique RetroDUR Studies were completed with follow-up. These studies were strongly correlated with Pharmacy and Therapeutics Committee current focus and included educational interventions to both prescribers and pharmacies. Emphasis has been put on evaluation and intervention in opioid analgesics in chronic non-malignant pain, benzodiazepine use and treatment of opioid use disorder. Several of these studies are ongoing and a quarterly update is done at each and every DUR meeting. All DUR studies have included insufficient dose, high dose, incorrect duration, overutilization, underutilization, therapeutic duplication, drug/drug interactions and drug disease contraindications. Generic utilization for the Idaho Medicaid Pharmacy Program is currently at 82.79%. Our program is a strong believer in using therapeutically equivalent drugs that have the least net price which in some cases may be brand over generic, particularly when a drug first goes generic or when there are supplemental rebates involved. We typically cost avoid approximately $ 1.5

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	million per quarter by preferring brand over generic when fiscally advantageous. We closely watch these agents and when the generic is less costly net of all rebates, we flip to preferring the generic. Net Cost Savings for Prospective DUR was $ 19,997,476 and for Retrospective DUR was $ 3,00,268 with most of the Retro DUR cost avoidance being due to tight controls. Innovative practices during this time period include state rule changes for disallowing private (cash) pay for recipients and improving availability of 3 month supply for maintenance drugs; unique PA studies for butalbital and drug overuse headaches and direct pharmacist intervention for naloxone; and prior authorization of genomic testing and case management of methadone usage. Idaho Medicaid ensures appropriate drug utilization through the Drug Utilization Review Board, the Pharmacy and Therapeutics Committee and an extensive prior authorization system including an automated PA system at point of sale. The Department puts emphasis on evidence based drug information and utilizes that information for the 80 plus drug classes in the preferred drug list as well as the development of therapeutic prior authorization criteria.
Illinois	Throughout FFY19, the Illinois Department of Healthcare and Family Services continued to strive to ensure the efficient operation of the Pharmacy Program, in part, by protecting against reimbursement for unnecessary or inappropriate services. During FFY19 staff continued to adjust processes to the new Pharmacy Benefit Management System (PBMS) for claims processing. The more efficient processes and increased shift of participants from Fee-for-Service to Managed Care, allowed staff to focus more on identifying and communicating adherence issues as medication utilization was reviewed. It also allowed direct-one-on-one academic detailing of prescribers about opioid use for chronic pain and the Illinois Prescription Monitoring Program. Pharmacists were detailed regarding the naloxone standing order. The University of Illinois Department of Child and Adolescent Psychiatry DocAssist program continued to serve as a resource for review of stimulant use in children and for peer-to-peer consultation with prescribers to improve prescribing. The ketorolac duration limit of 5 days with a 20-tablet maximum quantity per fill will help ensure appropriate and safe use. The Four Prescription Policy criteria focused on metformin as first-line therapy will help adherence with evidence-based standards for diabetes management. Improvement in steroid inhaler efficacy will be helped by incorporation of spacer device/valved holding chamber into the Inhaled Corticosteroid Prescription Request Form. Opioid-related edits were discussed as part of implementation of the Support for Patients and Communities Act requirements. During FFY19, focus continued on reduction of overutilization of narcotic agents, benzodiazepines, medications for mental health issues, specialty medications, immunosuppressant medications, antiviral medications, and biological products. Cost savings have been realized as a result of improved utilization management of covered medications. The Four Prescription Policy continues to require prior authorization when more than four prescriptions are dispensed within a 30-day period. The Four Prescription Policy facilitates review of participants' entire medication regimen and where possible and clinically appropriate, reduces duplication, unnecessary medications, polypharmacy, etc. The prior authorization review process increased identification of opportunities to improve efficacious drug therapy. The process also facilitated one-on-one participant-specific provider education regarding appropriate drug therapy. The RetroDUR system stimulated retrospective review of metformin underdosing. Retrospective review of gabapentin use identified need for more prescriber information to assess appropriateness of therapy. The Illinois DUR Board also reviewed the following topics: spacer device/valved holding chamber utilization with inhalers,

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	RetroDur 300 issues, adherence with medications for the treatment of hepatitis C infection, and naloxone utilization from 2016 through 2019. To ensure more efficient use of staff resources, links to materials helpful for prescribers were posted, for example, the FDA Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS), Opioid Analgesic REMS Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain, The Department of Health and Human Services' Five-point strategy to combat the opioid crisis, FDA Animal Veterinary Resources for veterinarians who stock and administer opioids, Opioid analgesics REMS patient counseling guide, the Surgeon General's Advisory on naloxone and opioid overdose, the Illinois Department of Public Health Naloxone page, and the Centers for Disease Control and Prevention (CDC) opioid prescribing guideline factsheet and mobile application. Web sites continue to be maintained to provide information about DUR Board activities, DUR educational materials, as well as prior authorization criteria and forms.
Indiana	The State of Indiana is committed to operating a Medicaid DUR program that has a positive impact upon quality of care as well as upon pharmacy and medical expenditures. Prospective DUR (pro-DUR) and retrospective DUR (retro-DUR) each serve a unique purpose in providing practitioners and pharmacists with specific, focused, and comprehensive drug information available from no other source. For FFY 2019, the total estimated savings for the Indiana Medicaid pro-DUR program was approximately $26.7 million. OptumRx modified the reporting for the pro-DUR program this year to remove duplicates and better capture actual outcomes of pro-DUR. The retro-DUR estimated savings were $9,221,082.75 in FFY 2019 due to one retro-DUR focusing on opioid-use reduction in the entire Medicaid population. One retro-DUR initiative is not yet complete and savings will be provided in FFY 2020. The total savings was estimated at approximately $36 million. The cost to administer both programs is $0.30 million, which results in a net savings of approximately $35.7 million. In FFY 2013, the State of Indiana transferred the management of the pharmacy benefit to OptumRx (previously Catamaran). OptumRx manages both the pro-DUR and retro-DUR programs, which were previously split between two contractors. OptumRx began the first real-time faxed prescriber retro-DUR intervention on August 1, 2014. Additional information regarding the specifics of the implemented retro-DUR programs can be found in Section 3, Summary 2. The Indiana Medicaid Pharmacy program initiated several updates to prior authorization criteria as well as new utilization edits during FFY 2019. The Mental Health Quality Advisory Committee advised the DUR Board in regards to updates involving all mental health prior authorization criteria to provide streamlined, guideline-centered requirements. New SilentAuth prior authorization criteria were updated and implemented for targeted immunomodulators, opiates, duplicate sedative hypnotic/benzodiazpines, antiseizure agents, monoclonal antibodies for the treatment of respiratory conditions, Multiple Sclerosis, and COX II inhibitors and select non-steroidal anti-inflammatory agents (NSAIDs). within the reporting period. New prior authorization (hard edit) criteria were implemented for hepatitis C agents, cystic fibrosis agents, Synagis®, pumonary antihypertensive agents, Dificid®, Spinraza®, Lucemyra®, carisoprodol and combination agents, human parathyroid hormone agents, testosterones, growth hormone, Neudexta®, ophthalmic anti-inflammatory agents/immunomodulator type, Lyrica® CR, NSAID step therapy, topical Doxepin®, allergy specific immunotherapy, topical steroids, Vynaqel® and

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	Vyndamax®, Corlanor®, PCSK9 inhibitors, bone formation stimulating agents, and muscular dystrophy agents. The Indiana Medicaid DUR program remains beneficial to the state, the provider community, and the beneficiary population served. The Office of Medicaid Policy and Planning (OMPP) will continue to utilize and improve the retro-DUR and pro-DUR program through review of guideline-based care with the DUR Board.
Iowa	On April 1, 2016, Iowa Medicaid transitioned from 100 percent fee-for-service (FFS) to providing coverage through Managed Care Organizations (MCOs) for roughly 90 percent of its population. While this transition occurred over four years ago, the DUR program continues to evolve with the addition of Managed Care (MC). Overall, the program produced a net cost savings of ($262,086.77) versus a net cost savings of ($265,136.59) in FFYE 2018. The difference in savings over the prior FFY is due to the small population remaining in the FFS program and the small problem-focused study conducted based on claims review. Patient-focused review saw a savings of $1,317.31 versus a savings of $4,863.41 in FFYE 2018. This decrease in savings is due to the cost of the particular drug(s) involved in the therapeutic or cost-saving interventions and the small population remaining in FFS. Total cost savings for the problem-focused studies for FFYE 2019 is $6,595.92 versus $0 in FFYE 2018. The FFS program conducted a small problem-focused study based on review of prescriber claims from the Prevalence Report, as reviewed by the DUR Commission and DUR staff.
Kansas	KANSAS MEDICAID (Executive Summary) Kansas Medicaid continues to monitor for patient safety and cost-effective drug use. Two common management tools used are the Preferred Drug List (PDL) Program, which includes a Consent Agenda Item Process and the Drug Utilization Review (DUR) Program which includes Step Therapy and Advanced Medical Hold Manual Review components. We continue to update clinical prior authorization criteria to be compatible with disease state clinical guidelines. Disease activity scales/scores are incorporated into the criteria to evaluate the effectiveness of drug therapy. We continue to work with providers and PhRMA representatives for a better patient and provider experience. The DUR portion of the 2018 SUPPORT Act involved increased communication with many stakeholders, particularly Opioid Use Disorder specialty providers. We maintain quarterly meetings with the state pharmacy associations. The NADAC lesser of reimbursement methodology continues to be a well-received change to the program. In general, FFS and the Managed Care Organizations (MCOs) are both under the direction of the State, so this provides greater consistency throughout the drug program. The result is a better patient and provider experience. Additionally, we continue to improve and expand our website content for greater benefit to providers, our MCOs, and the public. http://www.kdheks.gov/hcf/pharmacy/default.htm

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	Lastly, Kansas Medicaid started a new MCO contract period, effective 01/01/2019. Two of the previous MCOs (Sunflower Health Plan and UnitedHealthcare) were awarded the contract and were joined by Aetna Better Health of Kansas. We conducted our annual oversight review of key pharmacy program areas and made recommendations for any areas that needed improvements. We have a strong drug program because the MCOs, FFS, and State work closely together on common goals. Weekly and monthly, joint and individual entity, conference calls and emails help to keep an open line of communication.
Kentucky	Kentucky Medicaid Fee-for-Service Pharmacy Program Drug Utilization Review Annual Report: FFY18 Attachment 8 - Executive Summary This DUR program annual report encompasses the drug utilization review activities and outcomes that have occurred during FFY 2018. Included are ProDUR alerts and intervention statistics, and RetroDUR alerts and intervention statistics. I. Drug Utilization Review Program Overview Magellan Medicaid Administration (MMA) provides electronic claims processing and a pharmacy claims management system incorporating on-line point-of-service (POS) and prospective drug utilization review (ProDUR) for the Kentucky Medicaid Fee-for-Service (FFS) Program. The primary objective of the ProDUR program is to improve the quality of care for recipients, to conserve program funds and expenditures, and to maintain program integrity by controlling problems of fraud and benefit abuse. On March 1, 2009 MMA began providing retrospective drug utilization review (RetroDUR) for the Commonwealth of Kentucky Medicaid FFS Pharmacy Program. The goal of this program is to promote appropriate medication prescribing by: Identifying patterns of potential inappropriate prescribing or medication use, Alerting physicians and/or pharmacists to potential drug therapy problems, and Recommending future corrective actions to avoid identified problems. II. Prospective Drug Utilization Review Program (ProDUR) The POS/ProDUR system provides Kentucky Medicaid with the ability to meet an important objective: to minimize potential drug interactions and drug-induced illness or side effects. Adverse reactions from drugs occur more frequently when a recipient visits more than one physician and/or more than one pharmacy to obtain medication. The POS/ProDUR system provides the dispensing pharmacist with access to a comprehensive patient/drug incompatibility database. Averting adverse drug effects may result in the prevention of subsequent physician visits, hospitalizations or additional drug therapy. ProDUR achieves this objective by: Reviewing all claims for therapeutic appropriateness before a medication is dispensed,

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	Reviewing eight (8) weeks of the recipient's available drug claims and medical histories for incompatible or duplicative therapy, and Focusing on those recipients at the highest level of risk for harmful outcome. The primary focus of the Kentucky Medicaid FFS ProDUR program is to enhance the quality of patient care through appropriate drug therapy. The ProDUR system provides information that may have been previously unavailable, enabling the dispensing pharmacist to review comprehensive medical and drug histories. The system identifies potentially severe adverse consequences of drug therapy prior to dispensing. The dispensing pharmacist can use the therapeutic situations identified by the system to intervene via patient counseling and consultation with the prescribing physician. ProDUR messages are presented to the pharmacist as an informational tool that can enhance the pharmacist's ability to assure rational, effective and safe drug therapy. The ProDUR system was designed to function as an adjunct to the pharmacist's education and professional judgment and not to overwhelm the pharmacist with excessive alerts. Kentucky Medicaid's FFS ProDUR criteria are designed to be clear, concise, and clinically significant. Kentucky Medicaid's FFS ProDUR system assists the pharmacist with the detection, evaluation, and counseling components of pre-dispensing drug therapy screening by addressing six drug therapy problem types in which potential medication problems may exist. The screening types identified by Kentucky Medicaid's FFS ProDUR criteria are: 1. Excessive Drug-Dosage (HD) - Alert occurs when the calculated milligram dose per day of a drug exceeds the recommended daily dosage. The criteria for excessive daily dose are age specific. This alert is also referred to as Min-Max Dose. 2. Insufficient Daily Dose (LD) - Alert occurs when the calculated milligram dose per day of a drug is less than the minimum recommended daily dosage. The criteria for insufficient daily dose are age specific. This alert is also referred to as Min-Max Dose. 3. Early Refill (ER) - Alert occurs when a prescription is refilled before 90% of the previously filled prescription's days' supply has elapsed. 4. Therapeutic Duplication (TD) - Alert occurs when a drug that is to be dispensed is in the same therapeutic class as another drug filled within the previous eight weeks. 5. Drug-Drug Interactions (DD) - Alert occurs when a drug that is to be dispensed may interact with a previously filled drug from any participating pharmacy. Alerts are sent to pharmacies only on the most clinically significant drug interactions. 6. Ingredient Duplication (ID) - Alert occurs when a drug that is to be dispensed shares a common ingredient with a previously filled drug from any pharmacy. III. ProDUR Cost Savings ProDUR cost savings are calculated by tracking claims that receive ProDUR alerts to determine if the pharmacy providers dispensed these prescriptions. Cost savings are reported from the cost

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	of claims generating an alert, which were reversed by the pharmacist and not dispensed, and on claims that denied and were not overridden. Exact duplicate paid claims (DPC) are not included in ProDUR cost savings, because the Kentucky Medicaid FFS program denies these claims outside of the ProDUR environment. IV. Retrospective Drug Utilization Review (RetroDUR) The goal of the Kentucky Medicaid FFS RetroDUR Program is to promote appropriate prescribing and medication use. The RetroDUR utilization analysis, as described below, provides information that assists in the identification of patterns of inappropriate prescribing and/or medication use, alerts physicians and pharmacists to potential drug therapy problems, identifies opportunities to improve drug therapy, and makes recommendations to avoid drug therapy problems. Utilization Analysis MMA began providing RetroDUR services to Kentucky Medicaid on March 1, 2009. The operation of the RetroDUR program is a shared responsibility of MMA, the Kentucky Cabinet for Health and Family Services and the Drug Management Review Advisory Board (DMRAB). Specific drug classes that have been reviewed are targeted for focused review under the RetroDUR program at least quarterly. MMA then applies the specified criteria established to the prescription drug and health claims files and identifies medication regimens that are not congruent to the criteria established. Copies of individual medication profiles that are not consistent with the criteria are generated by MMA and sent to clinical reviewers for in-depth review. If, based on the professional judgment of the clinical reviewers or the MMA Kentucky Medicaid Clinical Manager, an aberrant pattern of prescribing and/or utilization is indeed present, an educational letter is sent to the prescribing physician and/or the dispensing pharmacist informing the provider of the suspected problem. MMA produces and mails provider letters documenting the therapeutic effects of the RetroDUR program and tracks provider responses and cost savings associated with the interventions. RetroDUR Cost Analysis The provision of high quality drug therapy not only results in improved patient health but may also result in program cost savings. It is important to quantify the effect of interventions on the cost of drug therapy. MMA uses a cost savings model developed by the Institute for Pharmacoeconomics of the Philadelphia College of Pharmacy and Science to quantify cost savings. When fully applied, the cost savings model has the ability to capture not only savings that are a direct result of the RetroDUR letter intervention process, but also savings due to indirect effects. Indirect effects arise when a prescriber applies changes in prescribing triggered by a letter intervention involving one patient to other patients in his/her practice. The model also takes into account the impact of prescription drug inflation, new drugs introduced into the market, and changes in utilization rates, recipient numbers and demographics. The cost savings analysis in this report was calculated based on changes in the prescription drug costs for those patients whose profiles were identified through the RetroDUR program. Cost savings are tracked over a twelve (12) month period. Changes in prescription drug costs are totaled to yield overall cost savings for the review period. Monthly cost savings may vary due to a variety of factors, including: - the class selection and problem type chosen for review,

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	- intervention letter dissemination after the RetroDUR profile run and/or tracking through the First IQ system, - the lag time before the next physician visit when changes in drug therapy may be made, and/or - the incremental educational and familiarity impact on the prescriber after receiving intervention letters. Month-by-month cost savings for all active interventions (i.e. interventions which have not completed twelve (12) consecutive months of review/tracking) vary with intensity of intervention activity. Intervention letters sent during the past fiscal year have not all completed follow-up review for one year. Consequently, the cumulative cost savings effect of intervention letters mailed during FFY 2019 will not be known until the end of FFY 2020.
Louisiana	Executive Report This annual report represents a summary of the Louisiana Medicaid Pharmacy Benefits Management (LMPBM) program's drug utilization review (DUR) activities under the direction of the Louisiana Department of Health (LDH). A commitment to improving the quality of patient health care was demonstrated during the FFY 2019. In February 2015 approximately 90 percent of Louisiana Medicaid lives moved to managed care. Those lives remain in the managed care as do the lives of the Medicaid expansion population. Louisiana expanded Medicaid beginning July 1, 2016. Beginning in FFY17 through the current time, Louisiana has included five managed care organizations (MCOs) in the Medicaid arena. During this period, LDH established a Single Preferred Drug List across all MCOs and Medicaid Fee for Service (FFS). FFS continues to review incoming claims for appropriateness at the Point of Sale and has updated prior authorization criteria. Louisiana has modified existing retrospective drug utilization review (DUR) criteria to address the shift in population demographics. Education. Under the direction of the LDH, the University of Louisiana at Monroe (ULM) College of Pharmacy publishes a series of educational articles are published in the Provider Update newsletters (Appendix A). This monthly newsletter is available for viewing on the lamedicaid.com webpage. Prospective DUR interventions. Prospective DUR screening occurs every time a pharmacist processes a prescription, before the prescription is dispensed to the patient, to assure safe and medically necessary drug use. Clinical alerts and edits address current disease-focused categories such as behavioral health and pain disorders. Pharmacy cost avoidance attributed to the use of the prospective interventions during FFY19 $37,568,155. Retrospective DUR interventions. The Louisiana Drug Utilization Review (LADUR) program provides retrospective clinical interventions in the form of mailings to prescribers and pharmacists and occur after prescriptions are dispensed. These interventions make accessible current pertinent information to the provider concerning the patient and are often derived from nationally-recognized disease management guidelines, potentially improving the recipients' disease management and quality of life. In FFY19, LADUR interventions addressed issues in the following categories:

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	Diabetes management Asthma management Heart failure management management Sleep disorders Hepatitis C treatment Behavioral health Depressive disorders Sickle cell disorder Hypertension Pharmacy cost analysis for LADUR interventions during FFY19 projected to $23,308 increase in expenditures in the targeted drug classes (Figure 7). Drug expenditure increases were observed 1) for disease management drug initiation recommendations, indicating successful clinical interventions, and 2) for drugs increasing in cost despite decreased utilization. The LADUR program effectively assists in overall pharmacy cost containment. Cost analysis does not include potential savings in other categories such as hospitalizations or physician visits. LADUR program acceptance and approval by the provider community is evident by numerous positive responses along with a response rate of 10 percent.
Maine	The Maine Medicaid program, known as MaineCare, oversees the pharmacy benefit program and the Drug Utilization Review Committee (DUR). The DUR was formed in accordance with the Omnibus Budget Reconciliation Act of 1990. The purpose is to review drugs that will become part of the preferred drug list (PDL) and assist the Department to make decisions on the structure of the PDL based on clinical and financial reviews. For FFY 2019, the DUR reviewed 78 New Drugs, 7 revised clinical criteria, looked at 43 Therapeutic Class reviews, 16 Quantity Limits on new or established drugs, in determining placement of medications on the State's Preferred Drug List. Overall, 7 FDA safety alerts were reviewed and recommendations were made when appropriate. The DUR continued its review of narcotic utilization and co-prescribing, substance abuse prescribing, assessed the use of appropriate asthma controller medications, the use of statins in diabetic patients, continuous use and adherence of antidepressant medications, chronic triptan use and assessed members on Vivitrol compliance with long-term use. The DUR did a variety of educational outreach to providers or review of prescriber activity with the Department in which the collected information provided multiple analysis for the DUR to review. As a result of the reviews mentioned above the DUR has recommended changes to PA requirements for these categories of drugs and in some cases has implemented new PA requirements. The DUR will continue to monitor these categories of drugs and provide recommendations to the Department to improve patient care and educate prescribers. The Department continue to work with the DUR on retro and prospective reviews and analysis to continue to improve the pharmacy program for MaineCare, including its new Pharmacy Care Management Program (PCM) as described in the Innovative Practices section of the Report.
Maryland	Section XII Executive Report FFY 2019 The objectives for the operation of the Maryland Medicaid Drug Utilization Review (DUR) Board during Federal Fiscal Year (FFY) 2019 include: 1. Continue to review and evaluate prospective DUR criteria alerts; 2. Conduct focused retrospective analyses of claims data to study drug utilization in the Maryland Medicaid fee-for-service population; 3. Guide the development and implementation of educational interventions to improve drug use in this population; and 4. Maintain a DUR Board with membership that meets OBRA 1990 requirements.

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	During FFY 2019, the DUR Board was comprised of six (6) pharmacists and five (5) physicians. Four (4) DUR Board meetings were held during FFY 2019. The meetings were held on the first Thursday of the months of March, June, September and December. Approximately 97% of Maryland Medicaid participants were enrolled in the managed care program known as HealthChoice during FFY 2019. There were nine (9) managed care organizations who participated in the HealthChoice Program during this timeframe. Mental health drugs, including many anticonvulsant agents, antiretroviral agents and substance use disorder medications are carved out of the managed care pharmacy benefits and are paid fee-for-service. As a result of this, the transition to managed care resulted in the need to integrate all prescription claims through a common source. The Department of Health (MDH) implemented and continues to maintain an electronic claims management pharmacy processing system which includes Coordinated Prospective Drug Utilization Review (Coordinated ProDUR). The Coordinated ProDUR system transmits an alert to the pharmacy submitting the claim at the time of claim adjudication regarding any identified drug therapy issue. The contract for maintaining the electronic claims management pharmacy processing system, along with Coordinated ProDUR, is administered by Conduent Government Healthcare Solutions. Conduent continues to enhance and maintain Coordinated ProDUR and provides the DUR Board with quarterly prospective DUR message summary reports for prescription claims reimbursed by the Maryland Medicaid Pharmacy Program. For FFY 2019, these reports include all claims for fee-for-service participants and claims for medications included on the Mental health drugs, substance use disorder drugs, as well as claims for antiretroviral medications for HealthChoice participants. The Maryland Medicaid Pharmacy Program (MMPP) conducts focused retrospective DUR analyses. Data evaluations, educational interventions and clinical support services are provided by Health Information Designs, LLC. (HID). MMPP, with recommendations from the DUR Board, implements educational and administrative interventions with the objectives of encouraging appropriate medication use and improving clinical outcomes among Maryland Medicaid participants. Thirteen (13) retrospective analyses were conducted during FFY 2019. All of these retrospective evaluations included the mailing of participant specific educational intervention letters to prescribers and pharmacy providers. Participant specific educational intervention letters highlight a drug therapy concern and are sent to prescribers and pharmacy providers with a complete participant drug and diagnosis history profile along with a response form. In the survey Section VI. Generic policy and utilization data, sub question 3, we have reported generic utilization percentage of 78%, however several brand drugs are preferred over their generic counterparts due to the availability of supplemental rebates and lower net cost. Taking into account the preferred brands, a generic use rate of 83% was calculated. There has been increased public scrutiny, controversy and debate regarding the increasing use of antipsychotic agents in children. As a response to this, MMPP established a new program, The Peer Review Program for Mental Health Drugs. The program began in October 2011 and initially addressed the use of antipsychotics in Medicaid patients under five years of age. In partnership with the Behavioral Health Administration (BHA) and the University of Maryland (UMD) Division of Child and Adolescent Psychiatry and School of Pharmacy, the program's goal is to ensure that

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	members of this vulnerable population receive optimal treatment in concert with appropriate non-pharmacologic measures in the safest manner possible. During FFY 2014, the program expanded to include all patients under 18 years of age. In 2013, the MMPP, with the assistance of the University of Maryland, established the Antipsychotic Prescription Review Program (APRP) as another avenue to promote evidenced based, cost-effective prescribing. Through this program, the APRP retrospectively reviews paid antipsychotic claims and identifies outlying prescribing patterns. Subsequently, APRP contacts the prescribers associated with the above claims with the goal of improving their prescribing practices. Beginning in FFY2016, a Unified Corrective Managed Care Lock-In Program was initiated. This program sets minimum standards across all HealthChoice MCO programs, as well as the fee-for-service program, regarding monitoring for potential fraud and/or inappropriate use of controlled substances. During FFY 2017, the Maryland Medicaid Pharmacy Program worked with the Maryland HealthChoice MCOs to create prior authorization criteria for opioids as part of the Maryland Department of Health's initiative to combat the national opioid epidemic. The criteria is part of a minimum standard across all plans to assure safe and appropriate use of opioids in the Medicaid population. Prior authorization is required for all long-acting opioids, fentanyl, methadone for pain and any opioid prescription that results in a dose exceeding 90 morphine milligram equivalents per day. In addition, a standard 30-day quantity limit for all opioids is set at or below 90 morphine milligram equivalents per day. Exceptions to these standards include participants with a diagnosis of cancer (treatment within the past 2 years), sickle cell anemia or those receiving palliative care or in hospice care. Program details, forms and educational resources are available at: https://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/medicaid-opioid-response.aspx In the future, the DUR Board aims to accomplish the following: 1. Provide recommendations to MMPP to improve drug therapy in the Maryland Medicaid population; 2. Analyze the utility and effectiveness of existing prospective DUR criteria and retrospective interventions for the fee-for-service population and patients taking medications reimbursed fee-for-service; 3. Recommend and review prescriber interventions and educational programs; and 4. Serve in an advisory role for MMPP in the continued management of a Participant Corrective Managed Care (Pharmacy Lock-In) Program.
Massachusetts	Centers for Medicare Medicaid Services Annual DUR Report FFY 2019 Massachusetts Medicaid Program Executive Summary

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	The University of Massachusetts Medical School administers the Massachusetts Drug Utilization Review Program for MassHealth (Massachusetts Medicaid). The Massachusetts Drug Utilization Review (DUR) program was established in response to the requirements of the Omnibus Budget and Reconciliation Act of 1990 (OBRA90). The main goal of the DUR program is to ensure that Medicaid recipients are receiving appropriate, medically necessary, prescription drug therapy. To achieve this goal, three program s have been implemented. Prospective DUR (proDUR): Prior to dispensing prescription medication, the pharmacist is required to screen for possible drug therapy problem s including incorrect dosing, over/under utilization, drug- drug interactions, drug- disease interactions, duplicate therapy, and possible abuse. The process of a drug requiring a prior authorization approval prior to dispensing of the drug is also part of proDUR. Retrospective DUR (retroDUR): This program occurs after the prescription is dispensed and targets patterns involving the prescriber, pharmacists, and Medicaid recipients. Under the advice of the DUR Board and MassHealth, educational interventions are executed to promote proper use of prescription medications. Such interventions include providing education material to pharmacists, providers, and members. The Drug Utilization Review (DUR) Board: The Massachusetts DUR Board was established in response to OBRA90 regulations. Its responsibilities include advising MassHealth on clinical guidelines for medications and case reviews. The DUR Board is made up of physicians and pharmacists currently practicing in Massachusetts.. MassHealth has required representatives of all MCOs to attend Quarterly Board Meetings and monthly Clinical Workgroup Meetings. Conduent is the claims processor for the MassHealth FFS/PCC plans and administers the Point of Sale rules (SmartPA) and internal prior authorization evaluation tools (SmartFusion) for the MassHealth Pharmacy Program. In order to provide the most cost effective, sustainable pharmacy benefit, MassHealth has designated preferred drugs within certain therapeutic classes (MassHealth ACPP/MCO Uniform Preferred Drug List.) 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.
Michigan	Michigan Medicaid ensures appropriate drug utilization through the Drug Utilization Review Board, the Pharmacy and Therapeutics Committee and an extensive prior authorization system including an automated PA system at point of sale. The Department puts emphasis on evidence based drug information for the development of therapeutic prior authorization criteria. This DUR program annual report encompasses the drug utilization review activities and program statistics for FFY 2019. The Medicaid enrollment has shown steady growth in recent years but declined slightly during FFY 2019 with an average total enrollment of 2,576,663, a 1.7% decrease from FFY 2018. Approximately 72% of the Medicaid beneficiaries are enrolled in Managed Care Organizations

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	(MCOs). The remaining 28% are in Fee-for-Service (FFS). The DUR Board reviews prescribing patterns for both the FFS patient population as well as for the therapeutic classes covered through a carve-out program for the Managed Care population. Full coverage of Medicaid Health Plan (MHP) Carve-Out medications is provided by FFS. The MHP Carve-Out medications include antidepressants, antipsychotics, CNS stimulants, anticonvulsants, antiretroviral agents, hemophilia products, hepatitis C medications and various orphan drugs for rare diseases. The costs of the carve-out medications are tremendous. Michigan utilizes a couple novel approaches to manage the high costs of hemophilia and psychotropic medications. The hemophilia assay management program has been very successful at managing the variable quantities of these products in addition to monitoring the number of doses on hand thus keeping the overall costs in check. The Michigan Public Acts 248 and 250 currently prohibit Michigan Medicaid from prior authorization of psychotropic medications. To help contain the cost of these medications and ensure safe prescribing for the beneficiaries, Michigan Medicaid utilizes an academic detailing program, called Whole Health Rx, to identify prescribing patterns that are inconsistent with evidence based, best practice guidelines. The program then reaches out to the primary care or behavioral health provider to engage in a personalized consultation. While the DUR Program addresses patient safety, Michigan believes safe and effective pharmaceutical prescribing results in cost effective medicine. The Michigan Medicaid program aggressively addresses pharmacy expenditures through the Maximum Allowable Cost (MAC) and NADAC pricing algorithms, use of quantity limits, e-prescribing and the supplemental rebate contracting. During FFY 2019, the DUR Board reviewed a number of analyses targeting appropriate prescribing patterns and recommended guidelines including the prescribing patterns of Medication Assisted Treatments (MATs) for opioid addiction, gabapentin, naloxone, migraine treatments, asthma and COPD treatments, influenza vaccinations and antiviral utilization trends. E-prescribing was initiated for Michigan Medicaid in September 2008. This on-going program increases prescription drug safety by reducing errors due to handwriting issues and by giving prescribers the opportunity to review a patient's medication history prior to ordering a new drug. Utilization of electronic prescriptions continues to grow among Michigan Medicaid prescribers. In 2019, the number of prescribers using e-prescribing rose to 69% compared to 30% in 2009 when the program began. Implementation of the technological enhancements web-based drug lookup and electronic prior authorization (ePA) applications provide easier access to drug coverage information and improve the prior authorization experience for the provider community. Michigan, like all states, is faced with the challenge of providing coverage to as many Medicaid members as possible in the most cost-efficient manner. Each year Michigan Medicaid strives to enhance their program to maximize cost containment as well as operational efficiencies and best clinical practices.
Minnesota	There are 1.2 million average monthly enrollees. Minnesota Medicaid enrollment mix is approximately twenty percent in Fee-for Service (FFS) and eighty percent in Prepaid Health Plan (PPHP) or managed care organizations (MCO). There are no PPHP carve-out of drugs. A uniform

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	preferred drug list (PDL) became effective July 2019. MCO criteria for non-preferred drugs cannot disadvantage preferred drugs. MCO may also use the same criteria as FFS Medicaid. Managed Care Organizations (MCO): This is the second federal fiscal year (FFY) where Minnesota Medicaid MCOs, BluePlus, HealthPartners, HennepinHealth, IMCare, Medica, PrimeWest, SouthCountry, and UCare will be included in the Medicaid State Annual DUR survey to CMS. Three MCOs, BluePlus, UCare, and HealthPartners, comprise about eighty four percent of MCO covered lives. Three pharmacy benefit management (PBM) companies, BlueCross Prime, ExpressScripts, and MedImpact serve approximately 90% of the MCO covered lines. Pharmacy representatives from each MCO meet routinely with the Medicaid pharmacy staff. The Annual DUR Survey requirement has been included in the meeting agendas. Changes in the uniform POS DUR opioid edits including the max morphine equivalent per day, currently set at 90MME, and the initial opioid prescription limit of a 7-day supply edit are examples of previous year's discussions to ensure that the same parameters/limits for opioids are used across FFS and all MCOs to eliminate patients choosing one MCO over another because of their opioid benefit management. Fee-for-Service (FFS): The FFS DUR Board met quarterly where a meeting's agenda consisted of (1) ProDUR criteria (performed in-house through DHS MMIS claims adjudication) and (2) RetroDUR criteria for retrospective population based mailing proposals (contracted with Conduent Government Health Care Solution) and (3) post intervention outcome assessments. Based on the RetroDUR contractor's annual program assessment, the average FFS per member per month was $65.87 and the amount paid per user month was $98.38. Psychotropic drugs had the highest drug spend, CNS drugs were second, and antihyperglycemic drugs (used to treat diabetes mellitus) were fourth. RetroDUR interventions are selected where they offer the greatest potential for clinical indicator changes usually because of the large number of occurrences per clinical indictors. During FFY 2019, there were a total of 7,499 provider letters mailed regarding 15,875 patients. Quarterly RetroDUR population-based mailings for FFY 2019 included Psychotropic Drugs in Adults, (12/2018), Polypharmacy (2/2019), Proton Pump Inhibitors (5/2019), and Management of Diabetes Mellitus (8/2019). Improvement in clinical indicators outcomes were Psychotropic Drugs in Adults - 17%; Polypharmacy - 12%; Proton Pump Inhibitors - 25%; and Management of Diabetes Mellitus -23%. Psychotropic Drugs in Children: Two additional mailings during FFY 2019 were completed to address the use of psychotropic drugs in children (mailed 3/2018 and 9/2019). The criteria included (I) monitoring of second generation antipsychotics for changes in lipids and glucose as well as (II) multiple (2 or more) oral SGAs and (III) polypharmacy defined as 3 or more psychotropic medications. The average number of prescribers mailed a letter was 818 and average patient count per mailing was 2,580. Improvement in clinical indicators averaged 24% for the two mailings. Opioids: There were no new ProDUR edits nor RetroDUR opioid specific mailings for FFY 2019. The Opioid Prescribing Improvement Program (OPIP) was established by the Minnesota

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	Legislature in 2015 to reduce opioid dependency and misuse in Minnesota related to opioid prescriptions. As a result, the OPWG (Opioid Prescribing Workgroup), (1) created opioid prescribing guidelines for the three pain phases: acute, post-acute, and chronic pain, (2) developed patient and provider education materials, and (3) delivered prescriber report cards with peer comparisons on 7 opioid prescribing metrics. Prescribers exceeding an established threshold on 5 of the 7 metrics will be required to complete a quality improvement project. Baseline reporting occurred summer and December of 2019 to 16,000 FFS and MCO prescribers. The quality improvement part of the program will begin fall 2020. DHS pharmacy unit continues to have a nonvoting representative participate in the OPWG meetings.
Mississippi	The primary focus for this past year was the implementation of Medicaid's Opioid Initiatives. Our approach in Mississippi was unique from most other states. We chose to implement all of our opioid initiatives at one time. In order to make this implementation successful, much work had to take place prior to implementation. The Division of Medicaid worked with the MS Board of Medical Licensure to ensure our initiatives aligned with their recommendations. Beginning in 2017, MS DUR began sending out provide educational letters to prescribers that had written opioids at high doses or those that had written concomitant opioid/benzodiazepine prescriptions. These letters informed prescribers of the CDC recommendations and alerted them that Medicaid would be implementing opioid initiatives in the near future. These letters began a process of provider education and behavior change. In the development of the initiatives, multiple meetings were held between Medicaid, their fiscal agent (Conduent), and MS DUR to walk through the logic of each edit and test the impact each edit would have of beneficiary care. In the 2 months immediately prior to implementation of the Opioid Initiatives, MS DUR identified all beneficiaries that had been chronically receiving opioids whose care would be impacted by the Opioid Initiatives. Letters were sent to their providers alerting them to the potential disruption in care which allowed providers to submit any needed prior authorization requests prior to the implementation of the Opioid Initiatives. Medicaid also chose to work with state medical and pharmacy associations to distribute member education of the Opioid Initiatives prior to implementation. Although Medicaid chose to undertake a very long and arduous path in the implementation of its Opioid Initiatives, the work paid off in the end. Medicaid received no pushback from the state medical and pharmacy associations. Minimal beneficiary disruption was noted and the prior authorization units were not overwhelmed when the implementation took place. Implementing all edits at the same time also minimized the number of times providers had to adapt to new Medicaid requirements.
Missouri	Incorporating increasing levels of technology throughout Missouri's health care system increases efficiency, coordination and transparency; decreases errors and reduces administrative costs. CyberAccessSM is a web-based HIPAA-compliant tool providing health care providers with access to MO HealthNet patient data. It is the first step toward a comprehensive electronic health record for MO HealthNet participants and allows access to medical, procedural and pharmacy paid claims data for participants for the past two years. In addition to the participant health information, a health care provider with prescribing privileges can submit an electronic prescription and access the clinical rules engine to request precertification of medical procedures and prior authorization for prescription drugs when needed. CyberAccessSM allows providers to view the MO HealthNet participant's claims history from all providers to determine the most appropriate course of treatment. MO HealthNet participants, health care providers, Missourians and the state of Missouri benefit from the use of

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	this tool. More than 22,000 MO HealthNet providers and allied health professionals use this web-based portal to access electronic health records for MO HealthNet patients. Treating providers can view a patient's medical history including diagnoses, procedures and prescribed medications. Providers can electronically submit prescriptions, request pre-certification for imaging procedures, durable medical equipment, inpatient hospital stays and optical services within the tool. CyberAccessSM improves the efficiency of health care delivery by using a rules-based engine to determine if a requested drug or procedure meets the appropriate clinical criteria. All of these tasks are performed in a secure environment and the entire system is Health Insurance Portability and Accountability Act (HIPAA) compliant. The tool now includes lab and clinical trait data imported from provider medical records, as well as increased functionality to allow physicians to input notes and E-prescribe. MO HealthNet maintains active provider outreach activities to encourage providers to sign up for and utilize the CyberAccessSM tools. Numerous pharmacy program initiatives include protecting patient safety by assessing utilization of psychotropic medications. A number of psychotropic clinic edits are inplace to reduce the inappropriate use of these medications and to improve patient outcomes and quality of care. An initiative specifically to address potentially inappropriate 'off-label' usage of atypical antipsychotics in pediatric participants, is entering its second year. Next steps for MO HealthNet are to require prescribers to submit diagnosis codes for pediatric psychotropic medications. In December 2016, the Pharmacy Program implemented updated criteria to provide greater access to the full range of Opiate Dependence Agents, as well as access to Narcan (Naloxone) for opioid reversal. Missouri has also opened up access to alternative pain management therapies, including acupuncture, chiropractic services, and physical therapy, along with reducing burdens for participants to receive non-opioid analgesics. Additionally, since February 2011, MO HealthNet Division has covered smoking cessation for all eligible participants, and all products are Open Access without restrictions. Like many States, MO HealthNet has developed criteria for Hepatitis C Therapy with the 'direct-acting-agents'. A clinical consultant reviews every request for HCV therapy, utilizing all available data to deliver an individualized response. The MO HealthNet Pharmacy Program's goal is the continued provision of quality, cost-effective health care for Missouri's most vulnerable citizens.
Montana	Refer to sections 3.3 and 9.1 for detailed descriptions of Case Management activities including disease state management and educational outreach. In addition, we continued to taper down our MME limits from 180 in FFY2018 to 150 and then 120 in FFY2019. This was completed in FFY2020 at 90MME. We created an automatic prior authorization process for our opioid use disorder preferred treatment to minimize patient and provider burden while still ensuring providers were adhering to SAMHSA guidelines and also that these members did not continue to receive opioids. Providers may sign a one-time detailed attestation that they are adhering to SAMHSA buprenorphine treatment guidelines for all Medicaid members and that they are informing the member that they will no longer be able to receive opioids through Montana Medicaid. The provider is then placed on a list in an automated algorithm so when a member receives a prescription for an approved dose of a preferred buprenorphine product from that provider, the prescription will automatically approve and pay. This approval of the initial buprenorphine fill triggers a lock-out of opioids for that member.
Nebraska	The Nebraska Medicaid DUR Board program goals are to improve the quality of pharmacy services and to ensure rational, cost-effective medication therapy for Nebraska Medicaid recipients. DUR Board members assess the utilization, quality, medical appropriateness and cost of prescribed medication through the evaluation of claims data. The Program works in partnership with the pharmacy claims processor, managed care organizations and staff at

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	Nebraska Medicaid. Activities of the DUR Board include monthly retrospective DUR profile reviews which are either patient specific or therapeutic/problem-focused; monitoring clinical literature and national trends or drug utilization recommendations including prospective DUR criteria, prior authorization criteria, and changes in clinical criteria for high risk drug categories. Recommendations from the Nebraska Medicaid DUR Board are made to the Medicaid Department for consideration and implementation. During FFY 2019 there was a focus on safe and appropriate use of opioids, either alone or in combination with benzodiazepines. Prospective edits were put into place to prevent overuse along with outreach to providers regarding appropriate use. Retrospective DUR projects examine claims data and identify patients who are not receiving optimal drug therapy and providers were contacted. Clinical criteria for Hepatitis C treatment was also reviewed and prior authorization criteria changed to align with literature. In FFY 2019, the retrospective projects addressed guideline compliance in order to improve a patient's health. Quarterly newsletters focused on safe use of opioids along with information useful to providers regarding high risk medications such as stimulants.
Nevada	The Drug Use Review Board (DUR) is a requirement of the Social Security Act, Section 1927 and operates in accordance with Nevada Medicaid Services Manual, Chapter 1200, Prescribed Drugs, and Nevada Medicaid Operations Manual Chapter 1200. The DUR Board consists of no less than five members and no more than ten members appointed by the State Director of Health and Human Resources. Members must be licensed to practice in the State of Nevada and either an actively practicing physician or an actively practicing pharmacist. The DUR Board meets quarterly to monitor drugs for: therapeutic appropriateness, over or under-utilization, therapeutic duplications, drug-disease contraindications and quality care. The DUR Board does this by establishing prior authorization and quantity limits to certain drugs/drug classes based on utilization data, experience, and testimony presented at the DUR Board meetings. This includes retrospective evaluation of interventions, and prospective drug review that is done electronically for each prescription filled at the Point of Sale (POS). During the Federal Fiscal Year 2019, the DUR Board was comprised of five physicians (1 pain specialist, 1 psychiatrist, 1 neurologist, 1 internal medicine and 1 family practice physician) and five pharmacists (2 hospital pharmacists and 3 ambulatory care pharmacists) from various backgrounds and locations around the State of Nevada. Other non-voting members who contribute to Board discussions include employees from DHCFP, a Deputy Attorney General and representatives from the contractors for MMIS and PBM services. The three managed care organizations also participate, and each have non-voting representation on the Board. The public is welcome to provide testimony to the board before they vote on topics. Clinical reviews and proposed prior authorization criteria for the Board are supplied by OptumRx. Additional input is provided by pharmaceutical manufacturers, members of the public and the DUR Boards unique experiences and research. All DUR Board meeting information is posted on the fiscal agent's website for the public before each meeting. This includes all clinical drug reviews, meeting materials and proposed criteria.
New Hampshire	During FFY 2019 the New Hampshire Medicaid population was managed under 3 managed care organizations and the fee-for-service program. New Hampshire's expanded population was transitioned from the 6 qualified health plans to the managed care organizations. The third managed care organization was added on September 1, 2019. Hepatitis C treatments were carved back into the managed care organizations and Zolgensma was carved out of the managed care organizations effective September 1, 2019

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	In developing DUR programs for the Fee-for-Service program, the criteria is built on maintaining quality of care, effective provider outreach and upholding standards of care while managing cost. The development of therapeutic prior authorization criteria is based on evidence-based drug information. The ProDUR program is updated, as new medications are available, to monitor duplicate therapy, drug-drug, proper dosing and drug-disease initiatives to assist pharmacy providers in reducing negative patient outcomes. The RetroDUR program continues to develop clinically relevant programs to educate providers on the most up to date information. New Hampshire reviews all therapeutic classes, including non controlled substance classes, for fraud and abuse. New Hampshire Medicaid's DUR program ensures appropriate access to medications while providing clinically sound interventions. While the DUR Program addresses patient safety, New Hampshire believes safe and effective pharmaceutical prescribing results in cost effective medicine. The New Hampshire Medicaid program aggressively addresses pharmacy expenditures through the Maximum Allowable Cost (MAC) and NADAC pricing algorithms, use of quantity limits, e-prescribing and the supplemental rebate contracting.
New Jersey	The following is a summary of the NJFC DUR process for Federal Fiscal Year 2019 including the New Jersey Drug Utilization Review Board (NJDURB), the Prospective Drug Utilization Review (PDUR) and Retrospective Drug Utilization Review (RDUR) activities. Managed Care Organizations (MCOs) participating in the NJFC Medicaid Program are responsible for coverage and payment of all pharmacy claims, including those for members enrolled in Managed Long-Term Services and Supports (MLTSS), with the exception of methadone prescribed for the treatment of substance use disorders. The DUR activities of the Board pertain to fee-for-service (FFS) pharmacy activities in FFY19 for NJFC Medicaid beneficiaries not transitioned to MLTSS and residing in long-term-care or receiving institutional care, and those transitioning from FFS to managed care. Prior to July 1, 2019, certain pharmacy encounters were carved out of MCO capitation payments, including high-cost drugs prescribed for the treatment of hemophilia, HIV, angioedema, Pompe disease, cystic fibrosis, Duchenne muscular dystrophy, Spinal Muscular Atrophy (SMA) and Gaucher's disease. Beginning July 1, 2019, DMAHS implemented a High-Cost Drugs Risk Corridor program for the non-dual eligible/non-Managed Long-Term Services and Supports (MLTSS) managed care population to mitigate the unpredictable catastrophic claim risks associated with a predefined list of High-Cost Drugs, excluding hemophilia drugs. A risk corridor payment or recoupment amount is determined by DMAHS and paid in lump sum by DMAHS to the MCO, based on the difference between the actual incurred costs and a predetermined benchmark for the MCO's risk corridor eligible claims. Additional information regarding the terms of the risk corridor payment provision are included in the State's NJ FamilyCare contract found at: https://www.nj.gov/humanservices/dmahs/info/resources/care/hmo-contract.pdf. NJFC managed care contract requires that MCOs establish and maintain a DUR program that satisfies the minimum requirements for PDUR and RDUR described in Section 1927(g) of the SSA, as amended by OBRA 1990. The MCOs are required to submit to DMAHS an annual DUR report, similar to that required by CMS for the FFS program. The PDUR and RDUR standards established by the MCO are consistent with the standards established by the NJDURB for the FFS program.

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	These standards include therapeutic duplication, drug-drug interactions, maximum daily dosage and therapy duration. In addition, the Board works to develop measures to ensure consistency in the drug protocols used by the MCOs when prior authorizing prescription drugs. The recommendations of the Board pertaining to both FSS and MCO drug utilization managements are reviewed and approved by both the Commissioner of Health and Commissioner of Human Services. During FFY 2019, DXC Technologies paid 6,134,274 NJFC Medicaid FFS pharmacy claims totaling $250,270,105 and 25,575,660 MCO pharmacy encounters totaling 1,498,549,828. Combined, 31,709,934 FFS claims and pharmacy encounters were paid totaling $1,748,819,933. 82% of FFS claims or 6.0% of FFS pharmacy payments were for non-innovator drugs while 87% of encounter claims or 18% of MCO payments were for non-innovator drugs. Regardless of payer, 87% of paid claims or 17% of claim payments were for non-innovator drugs. In addition, the FFS claim adjudication process monitored PDUR conflicts including, but not limited to, severe drug-drug interactions, therapeutic duplication, duration of therapy and maximum daily dosage. For FFY 2019, the estimated FFS DUR savings was $8,823,525. Critical to our FFS PDUR program is the State's Medical Exception Process (MEP). The MEP is a prior authorization process which functions within the framework of DUR standards recommended by the NJDURB and approved by the New Jersey Departments of Health and Human Services. The MEP is a clinically-based DUR process not influencing,in any way product selection by prescribers. Instead, the MEP prior authorizes certain FFS claims and is an effective tool for determining if drugs are being properly prescribed, providing cost savings by ensuring that prescriptions are clinically appropriate. The NJDURB is a Nine (9) member board consisting of practicing practitioners and pharmacists representing several major specialties. The Board meets quarterly in an open public forum. Updated information regarding Board membership, meeting schedules, NJDURB educational newsletters and annual reports may be found at: www.nj.gov/humanservices/dmahs/boards/durb/. In FFY19, the Board reviewed and/or recommended the following DUR protocols: - Calcitonin gene-related peptide antagonists for migraine - Dupilumab - Cannabidiol (Epidiolex) - Pancreatic enzymes; - Pregabalin; - CGRP antagonists (erenumab, fremanezumab, and galcanezumab); - Gout products (febuxostat, lesinurad, peglogicase); - Hereditary Angioedema (HAE) products; - Urea Cycle Disorder products; - Chelating agents (penicillamine and trientine); - Onasemnogene abeparvovec-xioi (Zolgensma); - Naltrexone (Vivitrol) injection; and - Morphine Milligram Equivalents (MMEs) for short-acting and long-acting opioids. Final details regarding the MME protocols approved by the Departments of Health and Human Services are being shared as part of this Summary. The State's MME protocols include a MME daily dosage not to exceed 50 MMEs for an opioid naive patient and a MME daily dosage not to exceed 120 MMEs for an opioid tolerant patient. Exclusions from the protocol include patients

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	diagnosed with cancer or sickle cell anemia, as well as hospice patients and those patients receiving palliative end of life care. The protocol also requires prior authorization for the concomitant use of opioids and benzodiazepines. An educational newsletter encouraging the prescribing of metformin as first line treatment for Type 2 diabetes was distributed in November 2018.
New Mexico	The State of New Mexico is committed to operating a Medicaid DUR program that has a positive impact upon quality of care as well as upon pharmacy and medical expenditures. Pro-DUR and Retro-DUR each serve a unique purpose in alerting practitioners and pharmacists with specific, focused, and comprehensive drug information. For FFY 2019, the total estimated new savings for Pro-DUR and Retro-DUR programs for New Mexico was $4,287,169.93. The Retro-DUR estimated savings were $136,330.93%u202c while the Pro-DUR estimated savings were $4,150,839. The New Mexico DUR program remains beneficial to the State, provider community, and the population it serves.
New York	Prospective and Retrospective Review Programs The New York State Medicaid DUR Program is composed of two separate but complementary components: The Prospective Drug Utilization Review (ProDUR) Program and the Retrospective Drug Utilization Review (RetroDUR) Program. During the reporting period for Federal Fiscal Year (FFY) 2019, there were $1.7 million on-line claim rejections where pharmacists encountered dispensing issues that were avoided due to ProDUR safety edits. The estimated ProDUR cost avoidance for FFY 2019 amounted to $ 53.1 million dollars. The types of on-line claim rejections encountered during the review period (October 1, 2018 through September 30, 2019) encompass four general categories: early fill, drug-drug interactions, therapeutic duplication, prescriber notification. The RetroDUR Program is designed to improve prescribing trends by alerting providers through education, to problems identified by the RetroDUR process. The Medicaid RetroDUR Program uses intervention letters, based on DUR Board approved criteria. The RetroDUR review volume is 500 cases per month. Interventions may include referral to the Office of the Medicaid Inspector General (OMIG). During the reporting period (October 1, 2018 through September 30, 2019) the computer-based clinical criteria identified approximately 6,000 Medicaid members who met criteria for intervention letters. The DUR Program's RetroDUR vendor, Health Information Designs, Inc. (HID), confirmed potential drug therapy problems for 2,707 members, and a case was created for each member. Clinical pharmacists from the State University of New York at Buffalo reviewed member cases. These reviewers determine whether interventions are appropriate. During the review period, 6,381 alert letters were mailed to prescribers. Approximately 10% of the prescribers voluntarily replied to the program intervention letters. HID evaluated total drug expenditures and claims for the 6 months prior to and 6 months after the alert letters were mailed. HID found that the intervention group had a decrease of 10.58% in pharmacy claims cost following the RetroDUR intervention letters; whereas, the comparison group had a decrease of 2.61%. The total RetroDUR cost avoidance, calculated by the RetroDUR vendor was estimated at $2.3 million dollars. By notifying either prescribing providers (which provided most of the savings) or pharmacy providers, of the potential for inappropriate drug utilization, actions may be taken by the providers that result in a decrease in inappropriate utilization. The total DUR cost avoidance combines ProDUR and RetroDUR costs. In FFY 2019 the DUR program's ProDUR cost avoidance was calculated to be

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	$53.1 million dollars. The RetroDUR cost avoidance was estimated at $2.3 million dollars. This resulted in an estimated total cost avoidance of $55.4 million dollars . The FFS spend, net of all rebates, for the reporting period for all drugs was $198.7 million dollars. The estimated DUR cost avoidance therefore represents twenty-seven and nine tenths percent (27.9%) of the total net spend. DUR Educational Program In addition to the monthly RetroDUR intervention letters referenced previously in this report under the directions of the vendor, Health Information Designs, targeted educational letters are also sent to providers for select clinical issues through the actions of the Drug Utilization Review Board. The Board addresses provider-specific clinical matters identified from utilization reviews presented to the Board. Two such reviews focused on gabapentinoids and the use of hydroxyurea in Sickle Cell disease where letters were sent to 19,726 and 766 prescribers respectively. Preferred Drug and Brand Less Than Generic Programs New York Medicaid belongs to a multi-state Medicaid pharmaceutical purchasing pool administered by the vendor, Magellan Medicaid Administration Inc (MMAI). The pool provides advantages of supplemental rebates for select drug classes managed by the member states. The review of this information is the responsibility of the New York State Medicaid Drug Utilization Review Board (DURB). The Board's review of the select drug classes is based upon clinical and financial information which determine the degree of potential savings. This information is used during the DURB's review of the State's formulary drug listing. This listing consists of preferred and non-preferred drugs for each therapeutic drug category. Based upon clinical drug updates and/or financial information provided by the MMAI, drugs may be moved from preferred to non-preferred status and visa-versa, within each therapeutic drug category. Managing the PDL in this way, the State's DURB can take advantage of financial incentives while invoking clinical best practices using additional mechanisms such as -prior authorization- and -step therapy. Both of those instruments serve as additional attempts by the DUR Board in guiding physician best prescribing practices while incurring potential cost savings. Available dollar savings for the State's fiscal achievements are recorded yearly. For State Fiscal Year 2019 (April 1, 2018 to March 31, 2019) the State's Preferred Drug Program savings amounting to $8.1 million. An additional program offering the potential for cost savings is the Brand less than Generic Program (BLTG). For State Fiscal Year 2019 (April 1, 2018-March 31, 2019) the BLTC program estimated savings amounting to $4.3 million. Initiatives and Improvements During Federal Fiscal Year 2019 the New York Medicaid Program underwent additional changes and updates as the program continues to adapt to the ever-changing needs of the State's beneficiaries. The responsiveness of current practices along with program costs are routinely reviewed for practicality, adherence to the most up-to-date clinical practices, potentials for program abuse and the need to change with the changing times. The current changes to the 2019 program are as follows: Effective 11-2018 a PA was required for all compounded products for topical use to ensure that both Federal and State regulations are adhered to and that said therapy has FDA and compendia support. The States Preferred Diabetic Supply program expanded coverage in the area of continuous glucose monitors and insulin pumps for diversity of its patient population. New York Medicaid was able to create a tool to aid selection of non-opioid options for pain management with links to resources for the treatment of substance use disorder. This webpage development for non-opioid alternative treatment options became available in January of 2019.

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	Effective 4-2019, NY Medicaid issued a beneficial change for recipient coverage of contraceptive prescription drugs. The change allows for a written contraception order for family planning to be filled 12 times within one year. This was a change from the previous allowance of a one-time supply in a 12-month period or 5 times in a 6-month period. On 6-2019 the DUR Board recommendations were put into place as follows; an update of the States Prior Authorization Program, a drug cap review of the product Remicade, requirement for prescriber intervention for the initiation of gabapentin or pregabalin on patients with concurrent use of an opioid, requiring prescriber intervention for continuation of opioid therapy beyond seven days in patients established on gabapentin or pregabalin, sending targeted educational letters to prescribers highlighting safety concerns associated with opioids and the concurrent use of gabapentin and pregabalin. A system's edit relating to the dispensing of vaccines through the Vaccines for Children Federal Program was put into effect on 5-2019. The new edit assures that vaccines obtained through the Federal Program, dispensed to children at or under the age of 19, cannot be billed to NY Medicaid. A system's edit was put into effect on 9-19 which validates ingredient cost for 340B claims. On 11-2019 the DUR Board's following recommendations from their September 2019 meeting were put into effect; Prior authorization requirement for opioid-naive patients exceeding the morphine milligram equivalent (MME) of 90 mg per day, send targeted educational letters to prescribers regarding antipsychotic therapy and metabolic monitoring for patients less than 21 years, prior authorization required for patients less than 21 years of age when there is concurrent use of two or more different oral antipsychotics for more than 90 days, send targeted educational letter highlighting the SUPPORT ACT, send targeted educational letters to prescribers regarding leukotriene modifiers use relative to asthma treatment guidelines. Managed Care Oversight On 1-2019 arrangements were made with a State MCO plan that did not cover family planning and reproductive health to allow for coverage of those services for family beneficiaries. Medicaid Managed Care plans meet quarterly with the Medicaid Formulary and Operation Systems Implementation Unit to discuss statewide initiatives and major program changes. Routine meetings are held every first and third quarter to discuss each plans adherence to NY Medicaid's formulary requirements for beneficiaries. Medicaid Managed Care formularies are reviewed each second and fourth quarter for agents that are not considered Covered Outpatient Drugs. If found the respective plan is required to remove them from coverage for Medicaid beneficiaries. In addition, clinical criteria evaluations are conducted on MAT/SUD, HCV, opioids and smoking cessation agents. In addition, new pipeline drugs are introduced for discussion.
North Carolina	The Drug Utilization Review Board is advisory to the Division of Health Benefits (formerly Division of Medical Assistance) and is comprised of six physicians and six pharmacists. During the FFY 2019, CSRA was the fiscal agent. CSRA provided prospective DUR reporting and Magellan Health Services, through a contract with CSRA, provided Retrospective DUR reporting. In this advisory role, the Board meets in person quarterly, reviews Prospective DUR and Retrospective DUR data and makes recommendations related to the safe and effective use of medications for the Medicaid beneficiaries in North Carolina. The cost savings analysis was performed by CSRA and Magellan Health Services. A primary objective of the Board is to review data retrospectively and make recommendations for lettering prescribers and pharmacies that provide services to beneficiaries. In 2018 and 2019 some of the retrospective drug utilization categories worth highlighting included: concurrent

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	benzodiazepine and opioid use, clozapine utilization, ADHD medication use by age, pediatric opioid utilization, opioid dependence treatment trend, monitoring of lithium levels, fluoroquinolone use in diabetic patients, fibromyalgia diagnosis and opioid utilization and no history of non-opioid utilization, migraine diagnosis with opioid utilization and no history of triptan utilization, benzodiazepine utilization without SSRI utilization without panic attacks, and opioids and antipsychotics. Additionally, an edit was added to our claims processing system for concurrent utilization of opiates and antipsychotics. This is in addition to the edit already in existence for concurrent utilization of opiates and benzodiazepines. Of interest, NC Medicaid Managed Care PHP Contracts were awarded On Feb. 4, 2019. The following is a list of Prepaid Health Plans (PHPs) that will participate in Medicaid managed care when the program launches. Statewide PHP contracts were awarded to the following entities which will offer Standard Plans in all regions in North Carolina: AmeriHealth Caritas North Carolina, Inc. Blue Cross and Blue Shield of North Carolina UnitedHealthcare of North Carolina, Inc. WellCare of North Carolina, Inc. A regional PHP contract was awarded to Carolina Complete Health, a provider-led entity. Until the transition takes place, NC Medicaid remains 100% FFS. Additionally, DHB continues to administer the lock-in program locking in approximately 600 beneficiaries per month for a 2 year period. DHB continues to use clinical criteria for approval of opiates, both preferred and non-preferred. Prior Authorization Criteria and policy changes are reviewed by the Pharmacy and Therapeutics(P&T) committee and the Physician's Advisory Group (PAG). Placement of drugs on the PDL is reviewed initially by the PAG and final recommendations are made by the PDL Committee. For quick access to additional information regarding pharmacy services, go to: https://www.nctracks.nc.gov/content/public/providers/pharmacy.html.
North Dakota	Program highlights for FFY2019 included implementing a number of requirements to promote safe and appropriate use of opioid agents by limiting concurrent utilization with opioids and quetiapine, restructuring prior authorization criteria for long-acting opioids to encourage the use of abuse-deterrent formulations, and implementing claims processing edits that check for medication adherence with opioid dependence treatments. Notable improvements to the FFS program included incorporating numerous claims processing edits that eliminated prior authorization requirements for medications that only require a covered indication and promoted medication adherence for opioid dependence agents, as well as select high-cost medications. Initiatives taken during FFY2019 included efforts to reduce overutilization and improving therapeutically appropriate use of antipsychotics using academic detailing, provider education and profiling, and claims processing edits requiring appropriate age and diagnosis for use. The state also made efforts to reduce overutilization of rescue inhalers though provider education and implementing claims processing edits looking for appropriate maintenance therapy. The North Dakota Medicaid FFS program continued to improve its prior authorization program by adding 17 new prior authorization criteria for drugs/drug classes that were high cost and/or had more affordable alternatives with comparable or equivalent efficacy available.

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	The state, with their RetroDUR vendor, manages the Retrospective DUR programs for both the FFS and Expansion patient populations to ensure uniformity of the RDUR review and lettering process for all patients enrolled in North Dakota Medicaid. The DUR Board voted to approve and add 317 new RetroDUR criteria spanning 18 different therapeutic drug categories. Despite reviewing the same average number of monthly RetroDUR profiles as was done during FFY2018, the North Dakota Retrospective DUR program resulted in an estimated cost avoidance of $1,545,834 in FFY2019, which was an additional $594,823 of cost savings from FFY2018. During FFY 2019, North Dakota continued to work towards maximum efficiencies in our pharmacy program, working within the restrictions of no prior authorization allowed for six of the highest cost categories (antipsychotics, stimulants for ADHD, anticonvulsants, anti-neoplastics, anti-retrovirals, and antidepressants). The single PDL approach continued throughout FFY 2019 while working with our managed care partner to ensure appropriate prior authorization criteria for medications not on the PDL as well as improved prospective DUR edits for narcotics in the managed care population.
Ohio	During FFY19, there were several enhancements made to the Ohio Medicaid Pharmacy program including innovative initiatives, improvements, and increased oversight of managed care partners. As an overview, ODM's Drug Utilization Review (DUR) Board is made up of 4 Pharmacists and 4 Physicians who meet on a quarterly basis. ODM also has a DUR Committee made up of 7 pharmacists who meet monthly. The Committee reviews patient profiles and makes recommendations to the Board. In FFY 2019, the DUR Committee met 11 times and the DUR Board met 4 times. RetroDUR interventions included members taking opioids with a benzodiazepine and sedative hypnotic medication, members not adherent to non-insulin antidiabetic medications, members taking insulin without a claim for glucose test strips, members who received Tamiflu but did not get a flu shot, and members not adherent to atypical antipsychotic medications. In FFY 2019, ProDUR Savings totaled approximately $29 million and The Ohio Department of Medicaid's generic drug utilization increased to 88.3%. ODM has been assertive in responding to the opiate crisis in Ohio by removing administrative barriers, such as prior authorization, for Medication Assisted Treatment (MAT). In conjunction with eliminating prior authorization for all forms of oral short acting buprenorphine-containing products, ODM and the MCPs implemented a retrospective drug utilization review (DUR) process aimed at identifying any potential prescribers/providers who deliver services consistent with clinical standards of care. In addition, ODM also published minimum standards for Ohio Medicaid Managed Care Plan compliance with requirements in the federal Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Public Law 115-271) which included the following: 1. Safety edits and claims review automated process for opioid refills above a state-defined limitation; 2. Safety edits and claims review automated process for a state-defined maximum daily morphine equivalent for treatment of chronic pain; 3. Claims review automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or antipsychotics; 4. Program to monitor and manage the appropriate use of antipsychotic medications by Medicaid children;

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	5. Process that identifies potential fraud or abuse of controlled substances by Medicaid members, enrolled prescribers, and enrolled dispensing pharmacies. ODM's contracted managed care plans submitted documentation to the state on how they intended to meet or exceed these standards by October 1, 2019. The DUR program continues to safeguard the health of Medicaid consumers, to assess the appropriateness of drug therapy, and to reduce the frequency of fraud, abuse and gross overuse.
Oklahoma	Prospective Drug Utilization Review (DUR) Monitoring Monitoring of prospective DUR is done by the clinical staff of Pharmacy Management Consultants in the form of issuing overrides for early refills and review of alert information generated by the fiscal agent. Retrospective Drug Utilization Review (RetroDUR) Screening The retrospective educational outreach summary includes the FFY 2019 year-end summary report on RetroDUR screening and educational interventions. The table lists the top 10 problems with the largest number of exceptions. DUR Board Activities During FFY 2019 the DUR Board met 9 times. Meetings were held in October, November, and December 2018, and in February, March, April, June, July, and September of 2019. In accordance with state legislative mandate, 35 speakers addressed the DUR board during public comment. DUR Board topics include Product-Based Prior Authorization (PBPA) and Criteria-Based Prior Authorization (CBPA) categories and or product additions, changes, and reviews. There were 88 additions to the CBPA program and 40 changes in FFY2019. There were 26 additions to the Product Based Prior Authorization (PBPA) program and 15 categories additional categories updated. Retrospective DUR activities included: SoonerPsych Program: Atypical Antipsychotic Medication Appropriate Diagnosis, Polypharmacy, Metabolic Monitoring, and Adherence; Chronic Medication Adherence Program: Maintenance Diabetes and Cardiovascular Medication Prescriber Mailing Update; Overview of U.S. Food and Drug Administration (FDA) Safety Alerts; Academic Detailing Program Update; Narrow Therapeutic Index (NTI) Drug List; Review of Prenatal Vitamins (PV); Long-Acting Beta2-Agonist Utilization: Pediatric Members; Use of Angiotensin Converting Enzyme Inhibitor (ACEI)/Angiotensin Receptor Blocker (ARB) Therapy in Patients with Diabetes and Hypertension (HTN) Mailing Update. Annual Reviews were presented or made available to the DUR Board for 99 CBPA categories or medications and 34 PBPA categories. Cost Savings Estimates Cost savings/cost avoidance are provided within
Oregon	Drug Use Review (DUR) within the Division of Medical Assistance Programs is a program designed to measure and assess the proper utilization, quality, therapy, medical appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program includes, but is not limited to, education in relation to over-utilization, under-utilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse. The DUR Board's priorities focused on prior authorization criteria, drug use evaluations, etc.

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Pennsylvania	The emphasis of Pennsylvania's drug utilization review (DUR) program is to promote patient safety through an increased review and awareness of outpatient prescribed drugs to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. Pennsylvania employs a combination of prospective and retrospective DUR initiatives for a comprehensive approach to pharmacy utilization management. The prospective DUR component includes a combination of alerts transmitted to the dispensing pharmacist at the point of sale and clinical prior authorization required at the point of sale which is reviewed by the Pennsylvania clinical staff for medical necessity determination. The retrospective DUR component supports the overarching goal of patient health and safety by focusing on a retrospective review of patients' drug claims against specific criteria, identifying common drug therapy concerns such as inappropriate use of drugs, medically unnecessary care, and increased risk for drug interactions, and providing for educational interventions that promote effective prescribing practices in a factual and unobtrusive manner. Through the RetroDUR, the Department provides prescribing providers with a comprehensive drug history profile for their patient and specific recommendations which enable them to consider medically appropriate actions such as identifying and discontinuing unnecessary prescriptions, reducing quantities of medications prescribed, or switching to safer drug therapies. Outcomes include enhanced therapy compliance and reductions in utilization of other medical services like emergency rooms and hospital stays, combined with reductions in drug abuse and diversions, all of which contribute to cost savings without compromising access or quality of care.
Rhode Island	Introduction Retrospective Drug Utilization Review (RDUR) seeks to assist prescribers by calling their attention to potential concerns with an individual recipient's drug therapy that could lead to possible adverse effects or undesirable outcomes. Pharmacy claims data are evaluated on an ongoing basis and run against criteria to generate educational intervention letters that are then sent to prescribers. The specific potential therapy issue is noted in the letter and the letter is sent, along with a complete drug history and available diagnosis history, to the prescriber for review. Rhode Island DUR Program Description Rhode Island has an active RDUR program that alerts prescribers of potential drug therapy issues for the Medical Assistance (Medicaid) population. The Rhode Island RDUR program alerts prescribers to potential issues related to the following: Drug-disease conflicts Drug-drug interactions Overutilization Underutilization (non-adherence) Clinical or therapeutic appropriateness Therapeutic duplication Each month, pharmacy claims data and available diagnosis data are evaluated against a database of several thousand criteria that look for potential drug therapy concerns. Approximately 1,000 drug and diagnosis history profiles for individual recipients are reviewed by a clinical pharmacist. In addition, approximately 200 recipients are screened each month specifically to evaluate for potential overutilization of controlled substances. Specific recipients are selected for intervention based on the clinical review. Educational intervention letters are then generated and mailed to their prescribers along with a complete drug history and a response form that asks the prescriber to indicate any action taken in response to the letter. Responses to the letters are voluntary and give feedback to the

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	program as to how prescribers may be adjusting therapy, if required, based on the intervention letters. A response rate of approximately 22 percent has been observed from prescribers who have received educational intervention letters. If a prescriber receives a letter addressing a specific drug therapy issue for a recipient, the same letter for that prescriber will not be sent again for an additional 6 months. However, prescribers may receive additional letters within that 6-month time period for the same recipient if other drug therapy concerns are noted. After the 6-month period, the same criteria may be evaluated against the recipient's data and a second letter may be mailed. Changes in utilization and criteria exceptions are evaluated on an ongoing basis and are discussed at DUR Board meetings. For example, for those recipients who are selected for overuse of controlled substances, each case is reviewed again after 6 months to determine if the initial letter had an impact on reducing overutilization. The Rhode Island Drug Utilization Review Board works closely with the Rhode Island Department of Human Services and their contracted vendors to develop criteria and focus on specific areas of concern with regard to recipient drug therapy. For Federal Fiscal Year 2019 (FFY 2019), the DUR Board continues to monitor recipient adherence to maintenance drug therapy and to alert prescribers to potential drug interactions. In addition, overutilization of controlled substances and therapeutic duplication are other areas that were targeted by the DUR program during FFY 2019.
South Carolina	2019 CMS Annual DUR SC Executive Summary The South Carolina Department of Health & Human Services Annual Drug Utilization Review Program Executive Summary 2019. The South Carolina Department of Health & Human Services strives to provide beneficiaries with access to medications necessary to achieve an optimum level of health, while concurrently managing both the utilization and clinically appropriate pharmaceutical products. The State continues to identify opportunities to purchase the most health for the citizens in need at the least cost possible to the taxpayer. The Prescription Preferred Drug List is a cornerstone of managing the pharmacy program, by driving utilization to clinically viable cost savings alternatives, as well as by garnering supplemental rebate revenues. Utilization control measures have been incorporated to ensure processes are in place to steer providers to evidence- based, cost effective and outcomes based pharmaceutical use. In addition to the methods listed above, the Prospective and Retrospective DUR Interventions programs assist in a more active role in the management of beneficiaries' medication regimens. Additional items of note for 2019: Over recent years, the SCDHHS has engaged in a number of efforts to address the opioid crisis within South Carolina's Medicaid population. These policy changes and benefit enhancements, coordinated through the South Carolina Opioid Emergency Response Team, have contributed to improvements in opioid prescribing, but also highlighted the need for continued focus on ensuring that treatment for OUD is available SCDHHS has engaged in an aggressive campaign of provider education to address the inappropriate use of opioids, named Timely Information for Providers in South Carolina (tipSC). Working with physicians, pharmacists and other experts from the Medical University of South Carolina (MUSC), tipSC develops and disseminates targeted, practical information to help

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	prescribers make safe prescribing decisions. To encourage participation, these educational programs offer continuing education credit for providers. These materials are available at https://msp.scdhhs.gov/tipsc/. The South Carolina Department of Health and Human Services (SCDHHS) is transitioning to a new Medicaid Management Information System (MMIS). The project includes various system and services modules that will replace the current MMIS. The modules in the replacement MMIS (RMMIS) are the accounting and finance module, administrative services organization (ASO), business intelligence system (BIS), dental administrative services organization (DASO), electronic visit verification (EVV) module, pharmacy benefits administrator (PBA) and the third-party liability (TPL) module.
South Dakota	Executive Summary October 1st, 2018 to September 30, 2019 All drug treatments carry the possibility of adverse effects and drug-induced disease. This risk grows as patients receive additive therapies for multiple medical conditions. Drugs prescribed for one medical condition may worsen other medical conditions or lead to adverse effects that require additional medical therapy. Physicians and pharmacists can minimize the danger of the adverse effects and drug-induced diseases by continuously reviewing drugs prescribed to their patients but few are able to do so even though inappropriate drug therapy endangers their patients' health and well-being. Patients that are cared for by a variety of physicians, including specialty physicians, could be at higher risk of adverse effects since physicians may not know other medications that patients are prescribed by other physicians. A timely warning to the physician and pharmacy, therefore, can potentially prevent unnecessary disease, complications, hospitalizations, and needless treatments. By providing this vital monitoring service, the South Dakota Drug Evaluation and Education Program (DEEP) provides an added margin of safety for Medicaid recipients in the state. The DURbase3 program retrospectively reviews recipients' prescription drug claims against Health Information Designs; (HID) proprietary set of criteria specifically reviewed and selected by the physician and pharmacist experts who are members of DEEP's Evaluation Committee. Cases of potentially inappropriate drug therapy are identified in an Initial Criteria Exception Report. These selected cases are then quantified with a proprietary risk' score system. The calculated risk score is used to quantify the increased morbidity and hospitalization of each identified patient. Based upon this calculated risk, a clinical review is made by the physician and pharmacist experts on potential therapy improvements. The physician and pharmacist committee decide which prescribers and pharmacists need an Alert Letter sent to them. These Alert Letters highlight the patients; particular situations and list all drugs prescribed to them over the last eighteen months. The information is provided to the prescribers as well as the pharmacies will enable them to consider modifying prescribed therapies. Therapy improvements are not dependent upon receiving Alert Letter responses back from the prescribers; however, the responses are used to potentially alter risk criteria. These Alert Letters may recommend for the physicians or pharmacists to consider discontinuing unnecessary prescriptions, reducing the quantity of medications prescribed, addition of medications for disease indications with no current therapy, or switching to safer therapeutic options.

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	There were a total of 2264 number of Alert Letters sent during the year, 1299 letters to physicians and 965 letters to pharmacists. Allowing for 180 days between letter mailing and evaluation of those recipients that were intervened on, HID found the intervention group had a decrease of 3.53% in pharmacy claims cost following the RDUR intervention letters, whereas the comparison group had an increase of 6.60%. These changes resulted in an estimated cost savings of $399.54 per recipient who received an intervention during FFY 2019. This led to a total estimated cost savings of $133,846.
Tennessee	Throughout FFY19, TennCare's DUR Board was not as active as in the past due to quorum issues, and two of the four quarterly meetings were cancelled due to lack of attendance. We feel that the role of the DUR Board and Tennessee's DUR program is to prospectively and retroactively review prescription claims, and upon seeing trends, make recommendations related to the safe and effective use of medications for our citizens to the Bureau. During FFY19, the DUR Board was not able to meet quorum for two quarterly meetings, mostly due to the inability to identify and retain physician providers to serve as Board members. The 11-member DUR Board "officially" had 5 actively practicing physicians, 5 actively practicing pharmacists and one actively practicing mid-level nurse practitioner, however, during FFY19, one of the physicians, a long-standing member with a Specialty of Emergency Medicine was abroad most of the year working in Haiti. One physician, another Emergency Medicine physician found out after accepting the position that his employer did not allow him to participate. Another physician, who specializes in psychiatry did not show up for meetings, and also a physician who with a neurology specialty in a pain management practice did not show up, and never responded to emails and meeting announcements. Of our 5 pharmacist DUR board members, four were available for the most part, however one member, who was sponsored by a large pharmacy chain from their Specialty Pharmacy division, was no longer working for the company, and we were not notified of this fact. The mid-level nurse practitioner, from a large teaching hospital was at one time working in the hospital's pain management area and is now working with patients who have undergone a bone marrow transplant, and this person was not active with the Board in FFY19. Although Tennessee has worked throughout all of 2019 and into 2020 to implement a new PBM vendor, during 2019, our PBM vendor was Magellan Medicaid Administrators. Dr. Justin Johnson was the vendor's DUR Pharmacist and prepared and presented for all meetings, and the individual at TennCare with overall DUR responsibility was Ray McIntire, D.Ph., and Director of Pharmacy Operations. These individuals worked collaboratively with Dr. Victor Wu, TennCare's Chief Medical Officer, Dr. David Collier, M.D., TennCare's Associate Medical Director, and Dr. Renee Williams-Clark, PharmD, TennCare's Chief Pharmacy Officer. As stated previously past yearly CMS report, the DUR Board has been involved in several aspects of fraud and abuse monitoring of TennCare enrollees and prescribers and are of great importance in assisting the TennCare Pharmacy team with our program integrity efforts. During the two quarterly meetings that we were able to make quorum, we continued to review drug classes and make recommendations to our P&T, known in Tennessee as PAC (Pharmacy Advisory Committee), and these class reviews are retrospective reviews based on pharmacy claims data, merged with medical data and including data from the State of Tennessee's PDMP.

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	Board Meetings are held quarterly, follow parliamentary procedures and have a standing order of business, specifically: Call to Order Approval of Minutes TennCare Update presented by Dr. Wu or Dr. Collier TennCare Pharmacy Update presented by Dr. Williams-Clark Follow Up on Old Business Class Review (if presented) New Business Review of TennCare Population Trends Review of TennCare Drug Utilization Trends Review of Pharmacy Lock-In Review of DUR Activities Review of Provider Practice Activities Future Meeting Dates Adjournment The Bureau of TennCare continues to appreciate the time and efforts of the DUR Board members. The Bureau appreciates their support, and in our FY20 report next year, Tennessee will report how changes will be/have been made to alleviate quorum issues, and at the same time how these changes will promote further involvement with TennCare's MCO partners. We expect to see much more success from the DUR Board, and Tennessee's DUR program in the years to come.
Texas	Texas Vendor Drug Program (VDP) provides access to outpatient covered drugs to members enrolled in various government healthcare programs. VDP manages the drug formulary and the preferred drug list (PDL) and the Specialty Drug List (SDL). The manages drug utilization through various DUR methodologies including implementation of a single formulary and PDL. VDP also develops clinical criteria on certain drugs. These criteria are set based on drug's potential for abuse or inappropriate prescribing. Both the PDL recommendations and the clinical criteria are reviewed by the DUR Board. The Texas DUR Board consists of medical professionals such as practicing physicians, pharmacists, academia as well as patient advocacy representative, and two members representing the managed care organizations. DUR Board meets every quarterly to review and make recommendations on proposed prospective and retrospective criteria on prescription claims. In the FFY 2019, the Board met 4 times. The following prospective clinical prior authorization criteria were reviewed by the Board: Calcitonin gene-related peptide receptor (CGRP) Antagonist, Cytokine and CAM antagonists - addition of Olumiant and Skyrizi, Epidiolex oral solution, Arikayce, HAE Agents, Inhaled ABX, Motegrity (prucalopride), Skeletal Muscle Relaxants. For the retrospective intervention, the Board approved the following topics: Management of Psychotropic Drugs in Adults; Medication Adherences; Appropriate Use of Antibiotics; Respiratory Disease Management; Mental Health Disorders Management; Anticonvulsant Drug Use Review; Cough and Cold Medications; Members age Influenza Prevention.

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	The estimated total cost savings/cost avoidance associated with the prospective claims review and the clinical and PDL PA and the retrospective interventional letters was $21, 760,000.00. The Texas Office of Inspector General (OIG) is responsible to identify and investigate suspected waste, abuse, and fraud in Medicaid and other health and human services programs. Medical and Pharmacy services and claims are reviewed, and suspected cases are referred to prosecutors, licensure and certification boards, and other agencies. For the FFY 2019, there were only 6 FFS members in the Lock-in program. Members will remain in Lock-in when transitioned from FFS to one of the MCOs. The estimated cost avoidance associated with the FFS Lock-in is reported as around $17,800.00 In the FFY 2019, several innovative projects were initiated, though the implementation dates fall outside of that fiscal year. These initiatives include the project to allow pharmacists to receive reimbursement for the administration of certain long-acting injectable antipsychotic medications, opioid antagonists, and influenza vaccines to members; the PDL compliance standards and reports to properly monitor the use of non-preferred drugs by the MCOs; a project to allow patient access to non-preferred drugs when prescribed for treatment of conditions associated with Stage 4 advanced, metastatic cancer; the provision to exempt opioid prescriptions from counting towards 3 RX/month limit for FFS members. This policy is only applied when opioids are prescribed for the treatment of acute pain; the project to move all drugs in the Opiate Dependence Treatment class to preferred status; coverage of any prescription drug for the Medicaid STAR Kids population including drugs from manufacturers that have not entered into a federal rebate agreement with CMS; removal of prior authorization requirement for non-preferred drugs and prohibited step therapy protocols for this population; value-based agreements with drug manufacturers based on the outcome data or other metrics to which HHSC and the drug manufacturer agree in writing; automated submission of formulary Certificate on Information (COI) documents was initiated; monitor and evaluate the prescribing practices for opioids in accordance with the CDC guidelines. HHSC also provides learning opportunities through continuous education (CE) credit offers for providers. VDP strives to further align its DUR programs with the guidance from the CMS and in accordance with federal and state laws in the coming years.
Utah	Utah Medicaid has been continuously implementing new pharmacy system edits to improve efficiencies in cost and care for Medicaid recipients of Utah. Areas of concentration have been reducing the use of opioid medications, concurrent utilization of opioids and benzodiazepines, and antipsychotic medication use in children and adolescents. Peer-to-peer programs were launched with the primary goals of educating and providing resources to health care providers in the areas of concentration that were previously mentioned. For the reduction in opioid use and antipsychotic medication use in children and adolescents, telephonic outreaches were conducted to provide patient-focused discussions and education around Medicaid policies and procedures. The telephonic conversation was followed with a prescriber letter, which summarized the points of the conversation. Generally, interactions were positive and well-received, and providers thanked us for the outreach. For the peer-to-peer concurrent utilization of opioid and benzodiazepine program, outreaches were conducted to dispensing pharmacists. Once again, these telephonic outreaches were focused on providing resources and educating around Medicaid policies and procedures. Due to the positive response from health care providers, this same outreach method will be used for other high-risk medication interventions. Utah Medicaid continues to enhance the prior authorization quality improvement project whereby standardizing the pharmacy prior authorization format, developing many new to market prior authorizations in addition to simplifying forms, if clinically appropriate, to

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	therapeutic categories such as Hepatitis C medications. Overall, each prior authorization created is supported with robust clinical and operational criteria. These continued efforts have improved the efficiency of the prior authorization team.
Vermont	The Department of Vermont Health Access (DVHA) assists members in accessing clinically appropriate health services efficiently and effectively and collaborates with other health care system entities in applying evidence-based practices to the Medicaid program. In support of Department goals, the pharmacy benefits program goal is to ensure that members receive medically necessary medications in the most efficient and cost-effective manner possible. With ongoing fiscal challenges facing the state, at stake is preserving, to the greatest extent possible, the benefits that have evolved in Vermont's programs. The DVHA Pharmacy Unit is responsible for managing and overseeing the pharmacy benefits programs for members enrolled in the Medicaid program. This encompasses but is not limited to processing pharmacy claims, making drug coverage determinations, managing drug appeals and exception requests, managing federal, state and supplemental drug rebate programs, resolving drug-related pharmacy and medical provider issues, overseeing and managing the Drug Utilization Review Board (DURB) and the Preferred Drug List (PDL), and assuring compliance with state and federal pharmacy and pharmacy-benefits regulations. In addition, the pharmacy program staff manages drug spend and routinely analyzes national and DVHA-specific drug trends and drug utilization. The pharmacy benefits program strives to deliver high-quality customer service, optimal drug therapy for DVHA members, and successful management of drug utilization and costs. Change Healthcare (CHC), DVHA's contracted Prescription Benefit Manager (PBM) since January 1, 2015, provides many clinical and operational support services, in addition to managing a provider call center in South Burlington, Vermont. In SFY2019 (July 2018-June 2019) total gross drug spend was $198.8 million and paid prescription claims totaled 2,010,107 for all programs. Specialty drugs represented 25.5% of DVHA's overall drug spend and the average specialty drugs cost was $7,004 per prescription. This year we continue to report improvements in clinical and utilization measures for Hepatitis C treatment, treatment of Opioid Use Disorder and improving trends in opioid utilization. We also provide an update on our Pharmacy Care Management (PCM) program which is focused on high cost specialty drug clinical management and has been both clinically and financially successful. Other areas of focus in FFY2019 included: - Establishing a medication management program with our Federally Qualified Health Centers - Vermont's recognition of pharmacists as providers and DVHA's inclusion of pharmacists as a provider type in the new Provider Management Module under development in FFY2019, with planned enrollments in FFY2020. - DVHA's evaluation of value-based purchasing in pharmacy including consideration of value-based supplemental rebate agreements - Evaluation of the current structure of the 340B program and planned changes for FFY2020 - Collaboration with Vermont's Department of Health on issues on common scope and interest including asthma, tobacco cessation, and substance use disorders to assure alignment and improve clinical outcomes for Medicaid members.
Virginia	EXECUTIVE SUMMARY VIRGINIA MEDICAID - FFY 2019

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	The Medicaid Drug Utilization Review (DUR) Annual Report Survey reports on each State's operation of its Medicaid DUR program. Areas include prospective DUR (ProDUR) and retrospective DUR programs (RetroDUR), retrospective DUR intervention summary, educational program assessment, DUR Board activities, impact on quality of care, and program cost savings. DUR programs assist health care providers to evaluate drug therapies and ensure the appropriate prescribing of drugs while improving the health of their patients and preventing disease. The systematic review of drug therapy is essential to improving drug safety and reducing issues such as polypharmacy. While the DUR Program addresses patient safety, Virginia believes safe and effective pharmaceutical prescribing results in cost effective medicine. The Virginia Medicaid program aggressively addresses pharmacy expenditures through the use of quantity limits and dose optimization (dose consolidation). The incorporation of service authorizations and step therapy has further guided prescribing practices to control drug spending. During federal fiscal year 2019, the DUR Board approved clinical edits for Ajovy™, Balversa™, Braftovi™, Copiktra™, Daurismo™, Delstrigo™, Doptelet®, Dovato®, Galafold™, Libtayo®, Lorbrena®, Mektovi®, Mulpleta®, Nucala® prefilled autoinjector and syringe, Orilissa™, Pifeltro™, Piqray®, Poteligeo®, Symtuza™, Talzenna™, Tibsovo®, Vitrakvi®, Vizimpro®, Vyndaqel®, Vyndamax™ and Xospata®. The DUR Board has also begun to review more closely the physician administered drugs as well as the specialty drugs. Magellan Rx Management along with DMAS work together to create clinical service authorization criteria for several of these drugs which get reviewed at the DUR Board Meetings. Clinical criteria for physician administered drugs reviewed during FFY 2019 DUR Board meetings were Crysvita®, Ilumya™, Imlygic®, Immune Globulins, Mozobil®, Onpattro™ and Soliris®. The most significant achievement for Virginia Medicaid during FFY 2019 is that DMAS has implemented several new edits and reports to meet the requirements for the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT Act. The DUR Board reviews each quarter concurrent use of opioids and benzodiazepines, concurrent use of opioids and antipsychotics, and opioid use with high risk factors and no naloxone use or with naloxone use. DMAS also has ProDUR edits in place that sends the pharmacist a soft message in reference to the potential risk of concurrent opioids with benzodiazepines and concurrent opioids with antipsychotics. Moreover, DMAS has implemented an edit to notify the pharmacist when an opioid naïve member is trying to fill an opioid prescription and sends a message back alerting of the potential risk and to offer naloxone. DMAS has further lowered the morphine milligram equivalents (MME) from 120 to 90 MME with quantity limits that apply to each opioid drug. DMAS also has several edits already in place to monitor and limit antipsychotic medication use in children. In addition, DMAS has sent out several RetroDUR letters to prescribers in reference to the SUPPORT Act. Virginia Medicaid has added member lab value data which allows Magellan to execute RetroDUR algorithms with Fee-For-Service (FFS) or Managed Care Organization (MCO) data. The availability of lab results mitigates the outreach required to ask physicians to validate a test result or ask if a lab test had been done recently. The addition of the lab results information through this new process has potential to greatly improve RetroDUR capabilities and will help to better engage prescribers by not asking for information that we should already have.

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	The DUR Board has been focused on compounded prescriptions in terms of safety, efficacy and effectiveness as well as cost. At the May 10, 2018 meeting the Board made the recommendation to change the maximum per compound drug to $250 and $500 maximum for all compounds per 30 days. This will include oral and topical compounds. In order for the service authorization to be approved, the prescriber would be required to submit peer review studies of the compounded products safety and effectiveness. Compound claims over these limits will be forwarded to the DMAS physicians for review and approval/denial. This change to the compounded prescriptions edit was implemented on November 26, 2018 and the DUR Board continues to monitor the results. The compound prescription edit has caused a significant decrease in the number of compounded claims and the total cost on compounded prescriptions per quarter. Virginia Medicaid first implemented e-prescribing on February 1, 2018. Electronic prescribing (e-Prescribing) is the use of an automated data entry system to generate a prescription, replacing the use of handwritten prescriptions. Automation of the outpatient prescribing process benefits different healthcare stakeholders, especially members, physicians, health plans, pharmacy benefit managers, and employers. FFY 2019 had 47% of all claims received as e-prescribed by 69% of all prescribers. Virginia Medicaid realized cost avoidance related to prospective DUR alerts totaling $13,281,889 in FFY 2019. Virginia Medicaid also administers dose optimization and quantity limit programs that saved $1,467,976. The total cost avoidance, attributed to RetroDUR, during FFY 2019 was $427,395. Virginia Medicaid's overall DUR Program savings in FFY 2019 was $15,177,260.
Washington	Pharmacy Services The Washington State Health Care Authority (HCA) is the designated state agency for administration of Medicaid in Washington State, otherwise known as Washington Apple Health (Medicaid). The Pharmacy Services section at HCA manages the pharmacy benefit by using a multi-component integrated system of utilization management and utilization review activities. Washington Apple Health (Medicaid) receives advisory support in prospective and retrospective drug utilization review though the P&T Committee and DUR Board. The P&T Committee provides advisory support for three state agencies regarding the administration of the Washington State Preferred Drug List (WA-PDL). The same members of the P&T Committee serve as the DUR Board for Medicaid and provide advisory support for administration of the Apple Health Preferred Drug List (AHPDL). The DUR board does not have set policies on what types of interventions need to be adopted however if identified they are determined on a topic-by-topic basis Although Washington Apple Health (Medicaid) is shifting towards a single Preferred Drug List, there is some overlap with drug classes between the WA-PDL and AHPDL. Implementation of AHPDL Implementation of the AHPDL continued in FFY 2019 and 267 new drug classes were added to the AHPDL. Products on the AHPDL are designated a preferred or non-preferred status with the addition of prior authorization and quantity limits if necessary. Some drugs on the AHPDL have PA requirements that may be self-authorized by a pharmacist with use of expedited authorization (EA) codes. Clinical criteria for drug products listed on the AHPDL are created in-house by Washington State Medicaid staff and go through an extensive review process that involves collaboration with the Managed Care Organizations (MCOs). Clinical criteria are presented to the DUR board for input and guidance. Medicaid staff routinely perform retrospective DUR data analysis to determine areas that may need intervention. Possible

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	interventions may include: changing drugs that are preferred or non-preferred, creation of new clinical policies, updating current clinical policies, or implementing new drug classes. Once the AHPDL is fully implemented, drug classes are scheduled to be reviewed annually where retrospective DUR data will be presented to the DUR board for recommended changes to the AHPDL. MCOs that administer Managed Medicaid benefits are required to follow the coverage of drugs in classes included on the AHPDL. Hepatitis C Elimination The directive ordered by the Governor of Washington State for Eliminating Hepatitis C made Washington the first state in the nation to have a public health and purchasing approach to eliminating Hepatitis C. This innovative approach aims to eliminate Hepatitis C by 2030 but also lower pharmacy costs for the State. It is a multi-agency effort that includes collaboration with various state agencies and stakeholders such as the Department of Health, Department of Labor and Industries, Department of Corrections, Department of Social and Health Services, MagellanRx, Center of Evidence Based Policy, Oregon Health Sciences University, Moda Health and the manufacturer who will be selected after the request for proposals (RFPs) process. HCA is responsible for exploring an innovative purchasing strategy, which is focused on a subscription model approach. Opioid Monitoring Washington Apple Health (Medicaid) began efforts to address the opioid epidemic in April 2019 before passage of the SUPPORT Act. Quantity limits of 18 dosages per prescription for children (20 years of age and younger) and 42 dosages per prescription for adults (21 years of age and older) were applied to Fee-for-Service and the MCOs. FFS and MCOs require an attestation form for anyone receiving chronic opioid therapy defined as opioids exceeding 42 calendar days within a rolling 90-day period. Measures that are in place to monitor or manage the prescribing of opioids includes prior authorization, patient-provider agreements, requirement for prescriber to have an opioid treatment plan for patients, documentation of urine drug screening results, and PDMP checks. In FFY 2019, Washington Apple Health (Medicaid) did not have prospective or regularly scheduled retrospective review of concurrent use of opioids with benzodiazepines, sedatives, or antipsychotics however, ad-hoc reviews were completed for individual clients being considered for the Lock-In program. In November 2019, Washington Apple Health (Medicaid) will implement an updated opioid policy aligned with requirements of the SUPPORT Act, which includes retrospective reporting and MME limits. Many of the requirements listed in the SUPPORT Act are currently in place for Washington Apple Health (Medicaid) with the exception of the reporting requirements and MME limits. Program Integrity Program integrity is an integrated system of activities designed to ensure compliance with federal, state, and agency statutes, rules, regulations, and policies. It includes reasonable and consistent oversight of the Washington Apple Health program (Medicaid). Through teamwork within HCA and with its partners, program integrity: 1. Supports awareness and responsibility for administering public funds. 2. Encourages compliance where providers and managed care entities are able to self-disclose improper payments. 3. Holds managed care entities accountable to have systems in place to prevent improper billing and payments. 4. Recognizes areas of vulnerabilities that adversely affect Apple Health programs. 5. Ensures providers meet program participation requirements.

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	6. Ensures clients meet program eligibility requirements. 7. Ensures Apple Health is the payor of last resort, except for an eligible client covered under Indian Health Service (IHS), IHS is the payor of last resort. 8. Investigates all leads and referrals to determine evidence of potential fraud, waste or abuse. 9. Conducts activities to detect and prevent fraud, waste and abuse, and identify any associated improper payments. Activities include but are not limited to: a. Running data analytics and algorithms b. Creating provider utilization profiles c. Conducting audits and clinical reviews d. Investigating potential credible allegations of fraud e. Applying payment suspensions f. Performing provider terminations g. Reporting individual and entity exclusions h. Invoking managed care entity sanctions i. Conducting provider outreach and education j. Implementing payment system edits k. Maintaining program policies and rules l. Complying with federal initiatives Patient Review and Coordination Program The Patient Review and Coordination (PRC) Program is a federal and state requirement of Medicaid that focuses on the health and safety of clients. It is used by both Fee-For-Service and the MCOs to control the overutilization and inappropriate use of medical services by clients, by allowing restrictions of clients to certain providers. Many of the clients are seen by several different providers, have a high number of duplicative medications, use several different pharmacies, and have high emergency room usage. Based on clinical and utilization findings, clients are placed in the PRC program for at least two years. Clients can be assigned to one primary care provider, one pharmacy, one hospital for nonemergency care, one narcotic prescriber or any combination of these providers. The assigned provider will coordinate the client's medical needs, and monitor and educate clients about the appropriate use of services. Office of Professional Rates (Pharmacy Rates, 340B Administration, and Federal Rebate) Management of costs within the pharmacy benefit are handled by fiscal staff who develop, apply and enforce policies such as the State Maximum Allowable Cost program to ensure the agency pays for prescriptions in the most cost effective manner as well as maintain 340B purchasing strategies and collection of federal rebates.
West Virginia	Cost Savings: The Pharmaceutical and Therapeutics Committee (P&T) and the Drug Utilization Review Board work closely together to curb rising pharmaceutical costs. Their efforts helped to generate a total of $ 486,703,537.52 in rebates in FFY2019, of which $ 45,459,502.98 were from negotiated supplemental rebates. An additional $ 9,058,595.22 was saved through our SMAC program. PDL Compliance: The P&T Committee reviewed all available rebates and worked diligently to prefer drugs which possessed favorable therapeutic profiles at the lowest Guaranteed Net Unit Price (GNUP). In addition, the DUR Board developed prior authorization criteria that was meant to encourage clinically appropriate prescribing, and which resulted in an overall 91.3% compliance rate to the PDL.

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	Cost Avoidance: The RetroDUR Program is an important component of the overall DUR program, both as a watchdog for inappropriate prescribing and monitoring operation of the claims processing system. In March of 2019 WV Medicaid awarded a contract to Marshall University to perform Retrospective DUR review. At the time, Marshall was a first-time provider of RetroDUR services, and so there has been a significant amount of time and effort spent on data integration and development of their DUR algorithms to better service our needs. According to their own cost-savings analysis, the Marshall University RetroDUR coalition estimates that they generated $726,694 in savings for the State of West Virginia. $500,658 of these savings were attributed to their monthly clinical reviews and $ 226,036 to efficient management of the Lock-in program. The vast majority of these savings were seen as a result of decreased emergency room visits. Reduction in claims and overall medical charges were also calculated as determinants of savings within their analysis. An independent actuarial review of the POS pharmacy benefit carve out from managed care was completed in 2019 and confirmed substantial savings: https://dhhr.wv.gov/bms/News/Documents/WV%20BMS%20Rx%20Savings%20Report%202019-04-02%20-%20FINAL.pdf
Wisconsin	BACKGROUND The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires that, effective January 1, 1993, each State establishes a Medicaid Drug Utilization Review (DUR) Program. The program must include both prospective and retrospective DUR to assure that prescriptions are appropriate, medically necessary, and are not likely to result in adverse medical results. To accomplish this objective, the law requires Medicaid DUR programs to screen, based upon explicit criteria, for therapeutic problems specified in the law (for example, drug-drug interactions, incorrect dosage and duration of therapy, therapeutic duplication), to develop and implement interventions to change drug use behavior, and to assess the outcome of the intervention. Section 1927 (g) (3) (D) of the Social Security Act requires each State to submit an annual report on the operation of its Medicaid Drug Utilization Review (DUR) program. Such reports are to include: descriptions of the nature and scope of the prospective and retrospective DUR programs; a summary of the interventions used in retrospective DUR and an assessment of the education program; a description of DUR Board activities; and an assessment of the DUR program's impact on quality of care as well as any cost savings generated by the program. HISTORY OF WISCONSIN DRUG UTILIZATION REVIEW PROGRAM The state agency in the Wisconsin Department of Health Services responsible for benefits administration is the Division of Medicaid Services (DMS), which established a Medicaid Evaluation and Decision Support Drug Utilization Review (DUR) Project. Since September 1996, the primary contractor for the DUR Project has been DXC Technology (formerly, Hewlett Packard Enterprise (HPE)). From July 1, 2009, DXC administered the Wisconsin retrospective DUR activities through a subcontract Health information Designs (HID). SUMMARY OF PROSPECTIVE DUR ACTIVITIES The State of Wisconsin utilizes an on-line, real-time, prospective DUR program that began in FFY 2002. Prior to that, Wisconsin relied on pharmacists to provide these services. SUMMARY OF RETROSPECTIVE DUR ACTIVITIES

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	Monthly DUR reviews are performed following receipt of paid claims tape. Interrogation of drug claims against DUR Board-approved criteria generates patient profiles that are individually reviewed for clinical significance by the pharmacy staff of HID. Criteria are developed jointly by HID and are reviewed and approved by the DUR Board and recommended DMS for approval. If a potential drug problem is discovered, intervention letters are sent to all providers who prescribed a drug relevant to the identified problem. DUR BOARD ACTIVITIES The DUR Board meets quarterly. Materials are sent to Board members between meetings for review and action. Activities of the DUR Board include review and approval of DUR criteria, review and approval of educational material and interventions, and review of other recommendations to the DMS on drug-related issues. COST SAVINGS A cost savings analysis of member's drug costs before and after a retrospective DUR letter intervention are reflected in Attachment 5 prepared by HID. CONCLUSION The State of Wisconsin is in compliance with the DUR program requirements specified in OBRA '90 and the reporting requirements established by CMS. In FFY 2019, the opioid SUPPORT Act requirements was a significant focus for Wisconsin's DUR activity and submission of the State Plan Amendment regarding these requirements.
Wyoming	In FFY2019, the Wyoming Drug Utilization Review (DUR) program conducted prospective and retrospective reviews resulting in a total estimated cost avoidance of more than $30 Million. Generic medications accounted for 84% of claims and 34% of expenditures. Appropriate utilization of narcotics continued to be a major focus of discussion and education. In addition to ongoing education programs, comparative prescriber reports were completed detailing use of opioids in combination with gabapentin and stimulants, as well as three-year controlled substance prescribing trends. Appropriate use of Suboxone was a significant topic of discussion with modifications made to dosing and duration limits.