Medicaid Drug Utilization Review
State Comparison/Summary Report FFY 2017
Annual Report

Prescription Drug Fee-For-Service Programs

October 2018

Executive Summary of 2017 State Medicaid DUR Annual Reports

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

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

On February 8th, 2018, the Centers for Medicare & Medicaid Services (CMS) sent the FFY 2017 Medicaid DUR Annual Reporting tool to states for completion. Below is a brief summary of the findings.

I. **Demographics – Page 1**

All states including the District of Columbia submitted a 2017 Medicaid DUR Annual Report, with the exception of Arizona because almost all of its beneficiaries are enrolled in managed care organizations (MCOs). The information reported is focused primarily on Medicaid Fee-For-Service DUR activities. States are not currently required to submit an annual report on the specifics of MCO DUR activities.

II. Prospective DUR (ProDUR) – Page 1

ProDUR functions are done at the point-of-sale (POS) when the prescription is being filled at the pharmacy. Fourty-five states (90%) contract with an outside vendor to process their POS claims. Thirty-seven states (74%) use First Data Bank as their ProDUR criteria source. All states set early refill thresholds as a way of preventing prescriptions from being refilled too soon. States reported thresholds ranging from 70% to 93%, with an average of 79% of the prescription being used before a non-controlled prescription could be refilled. For controlled drugs, the range reported is 70% to 100%, with an average of 84% of the prescription being used before the prescription could be refilled.

Section 1927(g)(A) of the Act requires that the pharmacist offer patient counseling when dispensing a prescription. Forty-four states (88%) report that the Board of Pharmacy has responsibility for monitoring compliance with this requirement.

III. Retrospective DUR (RetroDUR) – Page 12

RetroDUR allows states to examine drug claims to identify patterns of abuse or misuse. These functions reside primarily with a contractor in 36 states and with an academic organization in 9 states. The DUR Board identifies those categories of prescription claims to be examined to screen for patterns of fraud, abuse, gross overuse, or medically unnecessary care and then takes corrective actions. In 43 states (86%), the DUR Board approves the RetroDUR criteria to be followed by the contracted organization.

IV. DUR Board Activity – Page 15

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

V. Physician Administered Drugs – Page 18

To date, 12 states (24%) for the Prospective DUR and 24 states (48%) for the Retrospective DUR have designed or redesigned their Medicaid Management Information System (MMIS) systems to incorporate Physician Administered Drugs (those drugs paid through the physicians and hospitals programs) into their DUR criteria.

VI. Generic Policy and Utilization Data – Page 19

All states reported generic utilization percentages for all covered outpatient drugs reimbursed during the 2017 reporting period. The average percentage generic utilization was 83%, which accounts for an average of 21% of the total dollars reimbursed by Medicaid for drugs during the reporting period.

VII. Program Evaluation /Cost Savings/Avoidance – Page 23

Based on states' reported estimates, DUR activities saved on the average about 20% on drug cost savings/cost avoidance compared to the total Medicaid drug spend.

VIII. Fraud, Waste and Abuse Detection – Page 28

A. Lock- In Programs – Page 28

Almost all Medicaid agencies, except Arkansas and Florida, have a Lock-In or Patient Review and Restriction Program in which the state identifies potential fraud or misuse of controlled drugs by a beneficiary. Lock-In programs restrict beneficiaries whose utilization of medical services is documented as being excessive. Beneficiaries are restricted to specific provider(s) in order to monitor services being utilized and reduce unnecessary or inappropriate utilization. In addition, 25 states (50%) have a documented process in place that identifies potential fraud or misuse of non-controlled drugs by a beneficiary.

Thirty-seven states (74%) have a process to identify potential fraudulent practices by prescribers and thirty-five states (70%) have a process to identify potential fraudulent practices by pharmacies. These processes trigger actions such as denying claims written by that prescriber or claims submitted by that pharmacy, alerting the state Integrity or Compliance Unit to investigate, or referring to the appropriate licensing Board or another state governmental agency (e.g. Attorney General, OIG and DEA) for follow-up.

B. Prescription Drug Monitoring Programs – Page 36

Prescription Drug Monitoring Programs (PDMPs) are statewide electronic databases that collect designated data on controlled substances that are dispensed in the state. Depending on the state, physicians and pharmacists have access to these databases to identify prescribers and patients that are engaging in potential fraud or misuse of controlled substances. In 2017, forty-nine states (98%) reported having a PDMP in their state. Thirty states (61%) have some ability to query the PDMP database, while the remaining nineteen states (39%) do not have the ability to do so. Only 15 states (31%) require that prescribers access the patient history in the database prior to prescribing restricted (controlled) substances. As of the close of this reporting period, only Missouri report to be states that are not implementing a PDMP. While 20 states (41%) report that they also have access to Border States PDMPs, thirty-four states (69%) indicated that they face a range of barriers that hinder their ability to fully access and utilize the database to curb abuse.

C. Pain Management Control – Page **40**

Sixteen states (32%) reported that they obtained the Drug Enforcement Administration (DEA) Active Controlled Substance Registrant's File in order to identify those prescribers not authorized to prescribe controlled drugs. Forty-three states (86%) reported having measures in place to either monitor or manage the prescribing of methadone for pain management.

D. Opioids – Page 43

Forty states (80%) have edits in place to limit the quantity of short-acting opioids and thirty-nine states (78%) have edits in place to limit the quantity of long-acting opioids.

E. Morphine Equivalent Daily Dose (MEDD) – Page 48

Twenty-four states (48%) have set recommended Morphine Equivalent Daily Dose (MEDD) screens. The state limits the amount of products containing morphine or morphine derivatives that a patient may receive in a specific time frame in order to reduce potential abuse or diversion. Twenty-four states (48%) report that they give providers information on how to calculate the MEDD.

F. Buprenorphine and Buprenorphine/naloxone combinations – Page 50

Forty-four states (88%) set limits on the daily milligrams of buprenorphine that can be prescribed. Details on the limit amounts, length of treatment and maintenance dosing can be found in the report.

G. Antipsychotics/Stimulants – Page 53

Forty-three states (86%) have programs in place to either manage or monitor the appropriate use of antipsychotic medications in children. Thirty-seven of these states (86%) monitor all children, not just those children in foster care or a subset of children specified by a young age limit. The 43 states have provided a brief synopsis of the specifics of their programs. Delaware, Montana and Oregon only monitors children in foster care. It should be noted that some states have legislation in place that prohibits any restriction being placed on the prescribing of medications used to treat mental or behavioral health conditions. Forty-eight states (96%) have restrictions or special programs in place to monitor/control the use of stimulants.

IX. Innovative Practices – Page 61

Thirty-nine states (78%) listed in the full report have submitted Innovative Practices that they initiated. These can be found in the individual state reports in Attachment 6.

X. E-Prescribing – Page 62

Twenty-four states (48%) have the capability to enable the prescriber to access patient data history and pharmacy coverage limitations prior to prescribing for a specific patient. Electronic prescribing helps to improve the quality of the prescribing process and helps providers identify drugs that have lower-cost generics or are more cost effective.

XI. Managed Care Organizations (MCOs) – Page 63

States are currently not required to report on the nature and scope of DUR activities in their MCOs, even though more states are moving their beneficiaries into MCOs[1]. Thirty-eight states (76%) have MCOs. Seventeen states (45%) report that prescription coverage is included (carved-in) to the capitation rate. Twenty states (53%) report the agency sets requirements for the MCO pharmacy benefit. Thirty-four states (89%) require their MCOs to have a targeted intervention program (i.e. CMC/ Lock-In) for the misuse or abuse of controlled substances. Lastly, only 14 states (37%) require their MCOs to monitor or report their MCO DUR activities.

1. In the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) published on May 6, 2017, CMS finalized that states require MCOs to operate DUR programs that comply with Section 1927(g) of the Social Security Act as well as have the MCOs provide a detailed report of their DUR program activities to the state on an annual basis.

Medicaid Fee for Service Program Drug Utilization Review Annual Report

Comparison/Summary Report FFY 2017

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I. DEMOGRAPHIC INFORMATION

49 States plus DC completed the FFY 2017 Medicaid DUR Annual Report. AZ has the majority of its Medicaid population in Managed Care Organizations (MCOs); therefore, the state is not currently required to submit an annual DUR report.

II. PROSPECTIVE DUR (ProDUR)

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

Answer	State	Number of States (Percentage)
State-operated	MN, ND, SD, WA	4 (8%)
Contractor	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WI, WV, WY	45 (90%)

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

State	Note
*OR	Hewlett Packard Enterprise Services operates the POS claims system and Prospective DUR services. Oregon State University (OSU)/Oregon Health Sciences University (OHSU) College of Pharmacy is subcontracted to operate the Retrospective DUR services.
*OH	Goold Health Systems through June 11, 2017 Goold Health Systems Change Healthcare beginning June 12, 2016 to present
*VA	For FFY 2017 - the vendor was Xerox/Conduent For today - the vendor is Magellan
*IL	State-operated through 3/2017, then state operated using a Pharmacy Benefits Management System (PBMS) to process claims. Claims configuration changes are made by state staff and PBMS staff.
*CO	Xerox up to 02/25/2017; Magellan after 02/25/2017

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

Answer	State	Number of States (Percentage of 46 States)
Yes	AL, CA, CO, CT, DE, HI, KS, LA, MO, MS, MT, NC, NJ, NM, NY, OK, PA, RI, TX, VA, WI, WV	22 (48%)
No	AK, AR, DC, FL, GA, IA, ID, IL, IN, KY, MA, MD, ME, MI, NE, NH, NV, OH, OR, SC, TN, UT, VT, WY	24 (52%)

II-3. Identify the prospective DUR criteria source.

Answer	State	Number of States (Percentage)
First Data Bank	AK, AL, AR, CA, CO, CT, DC, DE, FL, HI, ID, KS, KY, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NY, OK, OR, PA, RI, SC, SD, TN, VA, WI, WV	37 (74%)
Medi-Span	GA, IA, IN, NV, UT, WA, WY	7 (14%)
Other	IL, LA, ME, OH, TX, VT	6 (12 %)

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

State	Explanation
IL	First Databank until March 26, 2017 and then Medi-Span from March 27, 2017 through September 30, 2017
LA	First DataBank is the data source. The prospective DUR criteria source is the result of collaboration by pharmacists at LDH, Molina Medicaid Solutions, and the University of Louisiana-Monroe.
ME	Medispam, Clinical Literature, CMS and FDA alerts and other State programs.
OH	First Data Bank through June 2016 Medispan beginning June 12, 2016 to present.
TX	Some of the pro-DUR criteria are from First Data Bank and some others, such as the high acetaminophen dose or Antifungals prescription treatment Duration limit are set by the state.
VT	Medispan FDA Safety Alerts Clinical Literature

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

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

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

State	Explanation
AR	New ProDUR criteria for new drugs to system are automatically updated as new drugs are added to the system.
CA	The DUR Board advises and makes recommendations regarding prospective DUR criteria; however, final approval is made by DHCS.
GA	Criteria is from Medi-Span
IA	This is a collaborative effort between the State, POS Contractor and DUR. Most new proposed criteria are reviewed by the DUR.
ID	The DUR Board reviews; however, they do not approve or disapprove any vendor criteria.
MD	Although the DUR Board does not review and approve all new prospective DUR criteria, a summary of prospective DUR alerts is reviewed and discussed at all DUR meetings. Individual criteria may be recommended by the Board for implementation. All new severity level 1 drug intervention criteria is automatically implemented by the point of sale (POS) vendor as it becomes available from First Data Bank.
MI	MDHHS and the DUR Board reviewed the ProDUR criteria when the First DataBank (FDB) criteria were first implemented. After that, the DUR Board felt comfortable with the completeness of the First DataBank ProDUR criteria.
MN	Informational edits are not reviewed by the DUR Board. High dose or quantity limit edits which cause the claim to reject are reviewed by the DUR Board.
MO	Automatic updates are made from First Databank which are incorporated in our DUR criteria.
ND	The DUR Board meets quarterly so their responsibility is to review all new retrospective DUR criteria.
NE	Prospective DUR criteria are developed jointly by DHHS, the POS vendor and the DUR Program.
NV	Medispan provides the criteria, the DUR Board does not review or approve the new criteria.
OK	Guidelines have been approved, and new criteria are updated as it comes from FDB as long as it meets the set parameters.
OR	No; DUR criteria are updated by FDB. There is an ability to modify how the alerts are responded to (override required or information only), but not to change the criteria itself.
RI	The prospective DUR criteria is auto loaded from First Data Bank.
SD	DUR Board reviews retrospective claims data
TN	It's difficult to review or to approve all new ProDUR edits, since they are all standard within the FDB or Medispan drug databases. The Board does approve custom or non-industry standard criteria when the Board has seen issues in claims that are presented.
WA	Standard automated DUR criteria which are overridable by pharmacists with the use of submitted DUR Conflict, Intervention, and Outcome codes are provided through the Medispan drug file and applied by the OptumRx claim processing system. These DUR criteria are not reviewed by the DUR Board. Active DUR criteria in the form hard stops for prior authorization requirements (including clinical criteria for appropriateness of therapy, quantity and dosing limits, step therapy, etc..) applied by the State are reviewed by the Board on a case by case basis. Federal rule already requires the state to use medically accepted indications as a standard for prior authorization criteria, and those criteria based strictly on medically accepted indications are not always reviewed by the DUR Board. The DUR Board reviews those active Prospective DUR criteria which represent predetermined standards more stringent than medically accepted indication alone, such as clinical step therapies not dictated by labeling, requirements for certain prescriptions to be written in consultation with a specialist, or quantity and dose limits established for patient safety.

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

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

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

Answer	State	Number of States (Percentage)
Monthly	AL, CT, DC, KY, MA, MS, MT, NC, ND, NE, NH, NM, OH, VA	14 (28%)
Quarterly	AK, DE, GA, HI, MI, NV, NY, OK, OR, SC, UT, VT	12 (24%)
Annually	CA, LA, PA, RI, SD, TN, TX	7 (14%)
Never	AR, CO, FL, IA, ID, IL, IN, KS, MD, ME, MN, MO, NJ, WA, WI, WV, WY	17 (34%)

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

State	Explanation
AR	AR Medicaid Pharmacy Program has not requested the ProDUR contractor to provide ProDUR response reports on individual pharmacy providers. Instead, the Program requested the contractor to provide reports on the drugs with the highest number of overrides (therapeutic duplication (TD), early refill (ER), drug-drug interaction (DD)) involved in ProDUR alerts to drill down for the reasons for the overrides. It was found that the vast majority of the ProDUR overrides were for the 2 drug classes that have Therapeutic Duplication approval criteria built into the point of sale prior authorization algorithm. The prior authorization approval criteria is criteria that has been approved by the DUR Board. For example, in the TD ProDUR overrides in the opioid algorithms, the approval criteria will allow for one SA opioid for break-through pain along with one LA opioid; in the C-II stimulant algorithms, the approval criteria will allow one SA C-II stimulant for one booster dose with one LA C-II stimulant for ADHD. 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. The ProDUR vendor, Magellan, is also the vendor that assists the Program with development and implementation of PA criteria. The Program was able to implement a hard edit on the ProDUR ER of non-controlled drugs if pharmacy tried to fill earlier than 75% of days' supply expended. In addition, we were able to place an additional "accumulation" edit on all drugs (controlled drugs and non-controlled drugs) that were filled early (e.g., 7 days early, which is at the 75% level that is set for almost all drugs and does not require a PA if filled at 75%). The "accumulation" edit will allow the beneficiary to only "accumulate" a total of 15 days' supply filled "early" on each drug entity (same drug/same strength/same dosage form) during a 180 day look-back period to decrease/stop excessive stockpiling/abuse of drugs. Although we have the ProDUR alert level set at the highest severity level to avoid false positive messages, for example, the ProDUR edits for drug-drug interactions that were overridden were actually not drug-drug combinations that were contraindicated in the medical literature. The researched literature only said to "dispense with caution", which leaves it up to the professional judgment of the pharmacist filling the prescription. It was 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.
CO	Ad hoc reporting is conducted for individual pharmacy provider activity
FL	The Bureau of Medicaid Program Integrity reviews the pharmacy provider activity, not Pharmacy policy.
IA	We do not allow overrides at the pharmacy level. Individual pharmacy claim activity is reviewed bimonthly, by the top 100 pharmacies by paid amount and top 100 pharmacies by prescription count.
ID	No individual pharmacy provider reports are generated currently.
IL	The MMIS system in place during FFY17 did not have this capability. The new PBMS rejects claims instead of sending informational soft edits for ProDur.
IN	The claims processing system has logic in place to determine appropriate pharmacy provider submissions of conflict, intervention, and outcome codes. We continue to evaluate the utility of this type of reporting.
KS	Our MCOs manage any provider/pharmacy outlier usage and alert the state when/as needed.
MD	Reports are generated and reviewed ad hoc or as necessary.
ME	Currently we do not allow pharmacies to override conflict code/interventions they are soft messaging back to the pharmacies
MN	We can get information from data warehouse queries.
MO	We can request reports as needed, but do not do so on a scheduled basis.
NJ	Prospective DUR alerts cannot be overridden by the pharmacy provider.
WA	Washington Medicaid considers potential misuse of submitted DUR codes to be an issue of fraud and abuse, rather than a clinical issue, and defers review of submitted DUR codes to the SURS/ audit function as permitted under 42 CFR 456.714, and limits the review activities of DUR staff to those that focus on what constitutes appropriate and medically necessary care. Use of DUR codes is not specifically followed up on in reporting across all pharmacy providers, but are reviewed for accuracy and appropriateness during individual pharmacy audits.
WI	Wisconsin is currently in the process of modifying the DUR alerts. After completion of this work, Wisconsin will need to evaluate and revise the prospective DUR reports.
WV	They are received upon request.
WY	We have reviewed in the past and not found the information to be actionable.

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

Answer	State	Number of States (Percentage of 33 States)
Yes	AK, AL, CA, DC, DE, KY, LA, MA, MI, NC, ND, NE, SC, SD, UT	15 (45%)
No	CT, GA, HI, MS, MT, NH, NM, NV, NY, OH, OK, OR, PA, RI, TN, TX, VA, VT	18 (55%)

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

Answer	State	Number of States (Percentage of 15 States)
Contact pharmacy	AK, CA, DC, LA, MA, ND, NE, SD	8 (53%)
Refer to Program Integrity for Review	DE, NC, SC	3 (20%)
Other(explain)	AL, KY, MI, UT	4 (27%)

If the answer to c) above is "Other," please explain.

State	Explanation
AL	Alabama has an Academic Detailing Program that provides scheduled face to face visits to providers.
KY	Both - contact pharmacy and refer to program integrity
MI	Contact the pharmacy and if appropriate refer to Program Integrity for Review
UT	Contact method is situationally specific

d) If the answer to (b) above is “No,” please explain why you do not follow-up with providers.

State	Explanation
CT	Interventions have not been performed based on review of the monthly report.
GA	While the functionality to override is present, we currently do not require soft edit overrides.
HI	Quality of the reporting is not specific to provider. Due to a very small FFS population a manual quarterly review is done by claims review, not provider review.
MS	Staff's time is concentrated on review of other issues programs such as CMS covered outpatient reimbursement changes and resultant claims reprocessing, the Complex Pharmacy Care program, managed care organization implementation pharmacy related issues, etc.
MT	We believe that when pharmacists intervene it speaks of appropriate therapy.
NH	NH has not found any trend in this information to follow-up with providers.
NM	System edit overrides are allowed through the Conduent Help Desk at this time. Follow-up is only on a case by case situation
NV	We have not implemented a process yet.
NY	Program activity that appears to have a high level of overrides is evaluated through a clinical review of utilization and system edits by the DUR board and a potential upgrade/modification of ProDUR edits, RetroDUR edits or both
OH	We can look at this in the future
OK	Edits are educational and allow the pharmacist to use their clinical judgment.
OR	Our system is designed to require the pharmacy to enter a reason code when overriding the Early Refill ProDUR alert. Since we have this information provided on the claim, we can verify the reason for the override and do not need to contact the pharmacy.
PA	If the conflict is significant and pharmacists are overriding routinely, then the Department recommends to DUR Board a hard stop prior authorization requirement.
RI	Fee for Service is routinely secondary payer.
TN	Again, the edits are industry standard, and not every pharmacist using their professional judgment will agree that it is an issue that is necessary to contact a prescriber. We haven't had the staff or resources to make this type of review a priority.
TX	Since the removal of the Field Pharmacist position as a result of the Agency's Sunset review in 2014, Vendor Drug Program has not audited pharmacies' activities.
VA	Plan to monitor with the new POS system.
VT	Policy allows the pharmacist to override the interventions as allowed by NCPDP format. This is used to alert the pharmacist of potential DDD, Therapy conflicts and other requirements.

II-7. Early Refill:

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

Category	Number of States	Percentage Threshold		
		Average	Minimum	Maximum
Non-controlled drugs:	50	79%	70%	93%
Controlled drugs:	50	84%	70%	100%

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

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

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

Answer	State	Number of States (Percentage of 35 states)
Pharmacist	OK, TX, WA	3 (8.5%)
Prescriber	ID, NY, TN	3 (8.5 %)
Either	AK, AL, AR, CO, CT, DC, DE, FL, GA, HI, IL, IN, KY, MA, MD, ME, MN, MO, MS, MT, NM, NV, PA, SC, UT, VA, VT, WV, WY	29 (83%)

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

Answer	State	Number of States (Percentage of 15 states)
Yes	CA, KS, LA, MI, NC, ND, NE, OR, RI, WI	10 (67%)
No	IA, NH, NJ, OH, SD	5 (33%)

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

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

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

Answer	State	Number of States (Percentage of 41 states)
Pharmacist	OK, TX, WA, WI	4 (10%)
Prescriber	CT, DE, FL, HI, ID, IN, KS, KY, NY, PA, TN	11 (27%)
Either	AK, AL, AR, CO, DC, GA, IL, MA, MD, ME, MI, MN, MO, MS, MT, ND, NE, NM, NV, SC, SD, UT, VA, VT, WV, WY	26 (63%)

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

Answer	State	Number of States (Percentage of 9 states)
Yes	CA, LA, NC, OR, RI	5 (56%)
No	IA, NH, NJ, OH	4 (44%)

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

a) Lost/stolen Rx

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

b) Vacation

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

c) Other

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

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

State	Explanation
AK	Lost/Stolen only in the event a police report has been filed and upon coordination/approval from the prescriber.
CA	The pharmacist can override the early refill DUR alert message if medically necessary.
DE	Change in directions can have pharmacist override
KS	Spilled Medications
LA	Other situations may be overridden using the pharmacist's professional judgment.
ME	Nursing home admissions
MO	All early refill denials require the pharmacist to contact the helpdesk for individual override each time the edit posts.
NC	Change of Therapy
ND	Prescription must be 60% utilized.
NE	Lost or stolen controlled substances require a prior authorization.
NH	NH allows for other early refills reasons such as increased/variable dose, transitioning to facility, school/daycare supply and destroyed.
NM	The pharmacy must contact the state of New Mexico or Conduent Help Desk for approval prior to overriding.
OR	N/A
SC	Therapeutic duplication/dosing titration (increase/decrease)
SD	Situational
TX	For any early refill reasons, the State requires a phone call from dispensing pharmacy to the Pharmacy Help Desk and a HHSC clinical staff will review the claim and evaluate reasons for early refill. If necessary, the clinical staff may reach out to the prescribing provider for further explanation.
WA	Washington State has two levels of early refill rejection, one of which is a 'hard' edit requiring authorization, the other being a 'soft' DUR edit overridable by pharmacists. 'Soft' early refill edits occur at an ingredient level and are primarily information regarding what a client has filled at pharmacies other than the pharmacy submitting the current claim. 'Hard' early refill edits are specific to the particular pharmacy and prescription being filled, and require authorization. Pharmacists can self-authorize some early refill situations. They may use an override for lost or stolen prescriptions once per drug per client in a six month

	period. Additional instances of loss require an active request of authorization from the state. The state does not allow early refill overrides for vacations. Pharmacists may also self-authorize early refills in situations where the early refill is erroneously triggered by situations where separate supplies are needed for separate locations, such as a home supply and a school supply. Early refill may also be overridden when the pharmacy is aware that the patient is being actively monitored by the prescriber.
WI	Dose change, member misunderstood directions from prescriber and natural disaster.

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

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

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

State	Explanation
AK	The edit allows for 7 day accumulation over a 120 day look-back period.
AL	Claims that exceed, or result in, the accumulation of more than 7 days' worth of medication in a 120â€□day time period will deny at the point of sale (POS).
AR	The Refill Too Soon logic is an Early Refill Accumulation Limit that allows a beneficiary, who fills prescriptions early, a maximum accumulation of 15-days' supply filled early during a 180-day look-back period of time. The Refill Too Soon (RTS) Logic applies to both controlled drugs and non-controlled drugs. The RTS logic is not based on the prescription number; the RTS logic identifies the same drug/same strength/same dosage form and adds up the days' supply for each time the drug is filled early during the look-back period. The RTS logic starts with the date of service on the incoming claim and looks back 180 days for the number of days filled early during that time period. Once the beneficiary has reached an accumulation of 15 days' supply filled early for same drug/same strength/same dosage form in the previous 180 days, the drug cannot be filled early again until the oldest "early" fill is outside of the date range.
CO	A cumulative 20 days are allowed over a 180-day period
DE	If the accumulative refills are greater than 4 in a 120 day time period, post the audit
FL	Certain classes have accumulation edits (proton pump inhibitors, skeletal muscle relaxants, controlled substances). The edit counts refills over a particular time frame to prohibit a total accumulation amount.
GA	Refill-too-soon edit, which allows patients to only obtain next fill if 75% of previous fill would be completed by that time.
ID	The pharmacy claims system is set to look at a maximum quantity per day as well as a rolling accumulation edit to not allow for early refills.
IL	Refill too soon edit where early refill days accumulate from month to month and refill tolerance must be met based on day supply on hand.
IN	The claims processing system will evaluate the days supply for historical claims against the days supply of new claims. If the new claim's daily dose has increased, the system will calculate the next date of fill automatically based on remaining supply. If the new daily dose has not increased, the system will calculate the next date of fill based on the remaining supply from all historical claims.
KY	The system does have this capability and Kentucky currently uses a three (3) day tolerance per month.
LA	We have accumulation edits on hydrocodone and on proton pump inhibitors. Both edits require clinical override from our prior authorization center.
MI	MI has refill tolerance and dispensing fee accumulation edits to prevent patients from continuously filling prescriptions early.
ND	Max 15 days accumulation in 180 days for non-controlled. Max 10 days accumulation in 180 days for controlled.
NM	An exception code posts to the pharmacy indicating the date when the medication can be refilled.

NY	The enhanced edit denies a claim if more than a 10-day supply of medication is remaining of the cumulative amount that has been dispensed over the previous 90 days, and will augment current editing where claims are denied when less than 75% of the previously dispensed amount has been used (the more stringent rule will apply). Members may, with prescriber intervention, have the ability to refill their prescription(s) early through the process of prior authorization, allowing for ample supply of their medication(s) on hand.
OK	Cumulative Early Refill edit is triggered when the member has received early refills for the medication in the past 240 days and the combined extra days' supply of the early fills is equal to 110% or more of the days' supply on the current claim being submitted. The edit is set up for stimulant medications only.
RI	Only allow one original and five refills per prescription.
SC	75% fill non control 85% control
WV	The edit keeps members from getting a thirteen month supply in 12 months by not allowing them to refill their prescriptions early each month, based on the total number of units obtained during a rolling 12-month period.
WY	For each claim that is filled, the number of days that claim is filled early will be added to the day supply submitted on the claim and the refill tolerance will be calculated on that accumulated total.

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

Answer	State	Number of States (Percentage of 29 states)
Yes	DC, MA, MD, ME, MS, MT, NC, NE, SD, UT, VT	11 (38%)
No	CA, CT, HI, IA, KS, MN, MO, NH, NJ, NV, OH, OR, PA, TN, TX, VA, WA, WI	18 (62%)

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

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

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

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

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

Answer	State	Number of States (Percentage)
Medicaid agency	AK, CO, CT, FL, HI, KS, MI, SC, TN	9 (18%)
State Board of Pharmacy	AK, AL, AR, CA, DC, DE, FL, GA, IA, ID, IN, KS, KY, LA, MA, MD, ME, MI, MN, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	44 (88%)
Other- please explain	IL, MO, NY	3 (6 %)

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

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

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

Answer	State	Number of States (Percentage)
Yes	AK, AL, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WA, WV, WY	46 (92%)
No	AR, MA, PA, WI	4 (8%)

III. RETROSPECTIVE DUR (RetroDUR)

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

Answer	State	Number of States (Percentage)
Company	AK, AL, AR, CT, DC, DE, FL, GA, HI, IA, ID, IN, KS, KY, LA, MD, ME, MI, MN, MO, NC, ND, NH, NJ, NM, NV, PA, RI, SC, SD, TN, TX, VA, VT, WI, WV	36 (72%)
Academic institution	CA, CO, MA, MS, OH, OK, OR, UT, WY	9 (18%)
Other organization	IL, MT, NE, NY, WA	5 (10 %)

Organization by Name and Type

Organization	State (* served by more than one organization)
Company	
Change HealthCare	IA, ME, PA, VT
Conduent	DC, HI, MN, MO, NM, TX, VA
Health Information Design	AL, AR, CT, DE*, KS, MD, ND, NY*, RI, SD*, WI, WV
Magellan	AK, FL, ID, KY, MI, NC, NH, SC, TN
Molina Medicaid Solution	LA, NJ
Mountain Pacific Quality Health	MT
NorthStar HealthCare Consulting	GA
OptumRx	IN, NV
Academic Institution	
(OSU) College of Pharmacy, Drug Use Research & Management Program	OR
State University of NY at Buffalo	NY*
SD State University College of Pharmacy	SD*
University of California, San Francisco (UCSF)	CA
University of Cincinnati	OH
University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences	CO
University of Illinois College of Pharmacy Staff	IL
University of Massachusetts Medical School	MA
University of Mississippi School of Pharmacy	MS
University of Oklahoma College of Pharmacy, Pharmacy Management Consultants	OK
University of Utah College of Pharmacy Drug Regimen Review Center (DRRC)	UT
University of Wyoming, School of Pharmacy	WY
Health Information Design (10/1/2016 - 12/31/2016).	DE*
DXC Technology (01/01/2017-09/30/2017)	
Other Organization	
Nebraska Pharmacists Association	NE
Washington State Health Care Authority	WA

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

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

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

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

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

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

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

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

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

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

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

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

IV. DUR BOARD ACTIVITY

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

Answer	Number of States	Percentage
Yes	50	100%

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

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

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

Answer	State	Number of States (Percentage of 19 states)
Yes	FL, IN, MA, ME, MS, UT, VT	7 (37%)
No	CA, DC, MO, ND, NY, OK, OR, PA, TX, WA, WV, WY	12 (63%)

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

State Findings

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

Answer	State	Number of States (Percentage of 19 states)
Yes	MA, ME, MO, WV	4 (21%)
No	CA, DC, FL, IN, MS, ND, NY, OK, OR, PA, TX, UT, VT, WA, WY	15 (79%)

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

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

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

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

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

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

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

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

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

Answer	State	Number of States (Percentage of 43 states)
Yes	CA, CO, DC, MA, MD, MS, ND, OK, UT, VA, VT, WY	12 (28%)
No	AK, AL, AR, CT, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MT, NC, NE, NH, NJ, NM, NV, NY, OH, PA, RI, SC, SD, TX, WA, WV	31 (72%)

V. PHYSICIAN ADMINISTERED DRUGS

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

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

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

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

Answer	State	Number of States (Percentage of 38 states)
Yes	CA, CO, DC, ID, IL, MS, ND, NV, OR, SC, SD, UT, VA, VT, WV	15 (39%)
No	AL, AR, FL, GA, IA, IN, KS, LA, MD, MN, MT, NC, NE, NH, NM, NY, OH, OK, RI, TN, TX, WI, WY	23 (61%)

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

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

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

Answer	State	Number of States (Percentage of 26 states)
Yes	CO, DC, ID, IL, MS, NC, VA, WV	8 (31%)
No	AL, AR, DE, IA, IN, KS, MD, MT, NE, NJ, NM, NY, OK, RI, TN, TX, WI, WY	18 (69%)

VI. GENERIC POLICY AND UTILIZATION DATA

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

Answer	Number of States	Percentage
Yes	50	100%

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

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

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

Answer	State	Number of States (Percentage of 44 states)
Require that a MedWatch Form be submitted	AK, AL, AR, CT, DE, IA, ID, IN, KS, MD, ME, MI, MS, ND, SC, SD, TN, WV, WY	19 (43%)
Require medical reason for override accompany prescription	AL, DE, ID, KS, MO, MS, MT, ND, NV, OK, SC, SD, UT, WV	14 (32%)
Prior authorization is required	AK, AL, AR, CO, DC, DE, GA, IA, ID, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, ND, NH, NJ, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, WI, WV, WY	39 (89%)
Other – please explain	CA, CT, ID, ME, MI, NC, NE, UT, WA, WI	10 (23%)

If the response is “Other,” please explain.

State	Explanation
CA	If a brand name drug does not appear on the Medi-Cal List of Contract Drugs, an approved Treatment Authorization Request may be required before dispensing.
CT	A BMN PA is required unless the brand name drug is on the PDL. A DAW-1 submitted on electronic prescriptions is acceptable.
ID	Must fail two generic products
ME	Maine does not allow DAW 1 for prescriptions as everything is driven by the MaineCare PDL
MI	Selected drug classes determined by the state legislature are exempt from prior authorization.
NC	If the brand name is non-preferred on the PDL then prior authorization is required.
NE	Prescriber must complete an MC-6 form, which declares that the brand name medication is medically necessary.
UT	Utah Medicaid requires preauthorization, including a medical reason, for override of non-preferred drugs. State statute requires generic substitution unless the brand name version presents a financial benefit to the state (UCA 58-17b-606). For mental health drugs, non-preferred medications can be filled without prior authorization at point of sale if the prescriber writes out "Dispense as Written" on the face of the prescription.
WA	Washington Medicaid allows a brand to be dispensed without authorization when prescribed Dispense as Written, but will only reimburse the dispensing pharmacy the same amount it would for the generic equivalent. If the pharmacy wishes to receive higher reimbursement for the brand, they must request authorization. When authorization is requested the State contacts the prescriber to review the medical necessity for use of the branded product over a generic alternative."
WI	Wisconsin has identified select drugs that do not require a prior authorization (i.e. anticonvulsants, thyroid replacement drugs).

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

State	Generic Utilization Percentage
CA	70%
DC	73%
TX	76%
CT	77%
FL	77%
NC	77%
VT	77%
MD	78%
NJ	78%
AL	80%
NV	80%
ME	81%
AK	81%
AR	81%
SC	81%
MO	81%
WI	81%
WY	81%
MS	82%
CO	82%
NH	82%
SD	82%
NM	82%
ID	82%
OK	82%
TN	83%
UT	83%
MI	83%
ND	84%
IA	84%
MN	84%
WV	84%
GA	84%
MA	84%
MT	85%

NY	85%
IL	85%
IN	86%
LA	86%
OH	87%
KY	88%
VA	88%
KS	90%
WA	90%
OR	91%
NE	91%
PA	91%
RI	91%
HI	94%
DE	97%

Average 83%

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

State	Percentage Dollars Paid for Generics in relation to Total Drug Spend
NH	4%
WA	6%
DC	6%
CA	8%
FL	8%
NJ	9%
SC	10%
MD	13%
NV	14%
GA	14%
MI	14%
CT	15%
TN	15%
ME	15%
MA	16%
NC	16%
MS	17%
VT	17%
WI	17%
PA	18%
TX	18%
WV	18%
WY	18%
AL	18%
CO	19%
ID	19%
KY	19%
AK	19%
AR	21%
IN	21%
IL	22%
OH	22%
SD	22%
MT	23%
HI	23%
RI	23%
LA	23%

UT	23%
KS	24%
MN	24%
NM	24%
OK	25%
MO	25%
IA	26%
VA	28%
OR	33%
ND	34%
NE	36%
NY	44%
DE	88%
Average	**21%**

VII. PROGRAM EVALUATION/COST SAVINGS/COST AVOIDANCE

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

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

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

Answer	State	Number of States (Percentage)
Company	AK, AL, AR, CT, DC, DE, FL, GA, IA, ID, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, NC, ND, NH, NJ, NM, NV, PA, RI, SC, SD, TN, TX, VA, VT, WI, WV	36 (72%)
Academic institution	CA, MA, OK, OR, WY	5 (10%)
Other institution	CO, HI, IL, MT, NE, NY, OH, UT, WA	9 (18%)

Organization Name and Type

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

Change Healthcare and University of Wyoming School of Pharmacy	WY*
DXC Technologies and Oregon State University (OSU) College of Pharmacy, Drug Use Research & Management Program	OR*

Other Organization

Illinois Department of Healthcare and Family Services (HFS) Bureau of Professional and Ancillary Services (BPAS) and Change Healthcare for SMAC	IL*
Hawaii State Medicaid DUR Coordinator	HI
Health Information Designs (HID) reports on cost savings analysis associated with pharmacy claims prior authorization activities. Conduent reports on the cost savings analysis associated with the pharmacy claims Retro-DUR intervention savings.	TX*
Molina Healthcare (ProDUR) and Health Information Designs (RetroDUR)	WV*
MN does internally except for RetroDUR	MN
Not applicable	PA
NYS Dept. of Health evaluates ProDUR and Health Information Designs, LLC evaluates RetroDUR.	NY*
Pro: Change Healthcare, Retro: University of Cincinnati	OH*
ProDUR- Magellan; retroDUR- Conduent	DC*
Prospective DUR cost savings estimate was conducted by DXC. Retrospective DUR cost savings estimate was conducted by HID.	CT*
RetroDUR cost savings conducted by HID.	AL
The State conducted analysis	CO
Washington State Health Care Authority	WA

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

State	ProDUR Total Estimated Avoided Costs	RetroDUR Total Estimated Avoided Costs	Other Cost Avoidance	Grand Total Estimated Avoided Costs
AK	$ 6,404,355	$ -	$ -	$ 6,404,355
AL	$ -	$ 808,454	$ -	$ 808,454
AR	$ 112,041,156	$ 1,150,26	$ 75,822,972	$ 189,014,854
CA	$ 172,247,763	$ -	$ -	$ 172,247,763
CO	$ 13,545,000	-	-	$ 13,545,000
CT	$ 61,143,434	$ 5,683,077	-	$ 66,826,511
DC	$ 117,578,863	$ 30,447	$ -	$ 117,609,310
DE	$ 626,110	$ -	$ -	$ 626,110
FL	$ 369,436,264	$ 103,935	$ 4,863,673	$ 374,403,872
GA	$ 85,844,155	-	-	$ 85,844,155
HI	$ 1,000	$ 13,600	$ -	$ 14,600
IA	$ -	$ 13,217	$ -	$ 13,217

ID	$ 13,197,096	$ 7,528,429	$ -	$ 20,725,525
IL	$ 28,372,286	$ -	$ 51,431,047	$ 79,803,333
IN	$ 121,920,000	-	-	$ 121,920,000
KS	$ 116,574	$ 33,578	$ 131,872	$ 282,024
KY	$ 44,978,640	$ 21,849	$ 11,367,810	$ 56,368,299
LA	$ 31,163,598	$ 693,588	$ -	$ 31,857,186
MA	$ 249,878,714	$ -	$ 4,795,977	$ 254,674,691
MD	$ 48,997,842	$755, 426	$ -	$ 49,753,268
ME	$ 1,934,752	$ -	$ 33,049,727	$ 34,984,479
MI	$ 388,576,412	$ 9,985	$ -	$ 388,586,397
MN	$ 44,679,511	$ 1,146,907	$ -	$ 45,826,418
MO	$ 71,105,538	$ 1,206,739	$ -	$ 72,312,277
MS	$ 13,707,860	$ -	$ -	$ 13,707,860
MT	$ 29,084,792	$ 92,922	$ 23,361,499	$ 52,539,213
NC	$ 393,710,000	$ 110,000	$ 108,470,000	$ 502,290,000
ND	$ -	$ 415,854	$ -	$ 415,854
NE	$ 30,991,912	$ 216,694	$ 2,498	$ 31,211,104
NH	$ 1,584,970	$ 105,591	$ 441,924	$ 2,132,486
NJ	$ 7,875,283	$ -	$ -	$ 7,875,283
NM	$ 3,713,180	$ -	$ -	$ 3,713,180
NV	$ 168,602,165	$ -	$ -	$ 168,602,165
NY	$ 54,399,333	$ 3,620,049	$ -	$ 58,019,382
OH	$ 8,596,979	$ -	$ -	$ 8,596,979
OK	$ 9,123,271	$ 19,742,868	$ (4,403,168)	$ 24,462,970
OR	$ 98,739	$ 454,517	$ 18,571,713	$ 19,124,969
PA	$ -	$ -	$ -	$ -
RI	$ 2,987,470	$ (113,646)	$ -	$ 2,873,824
SC	$ 20,777,913	$ 11,139,073	$ 14,959,200	$ 43,876,186
SD	$ -	$ 258,599	$ -	$ 258,599
TN	$ -	$ 536,658	$ 391,308	$ 927,996
TX	$ 18,071,015	$ 6,772,429	$ -	$ 24,843,444
UT	$ 12,646,835	$ 1,184,254	$ 291,728	$ 14,144,817
VA	$ 23,423,053	$ 58,911	$ 6,746,828	$ 30,228,793
VT	$ 1,289,050	$ -	$ 9,178,317	$ 10,467,367
WA	$ 26,502,898	$ -	$ 7,026,439	$ 33,529,337
WI	$ -	$ 1,180,997	$ -	$ 1,180,997
WV	$ 16,200,318	$ 2,057,835	$ 110,513	$ 18,368,666
WY	$ 24,617,271	$ 716,463	$ -	$ 25,333,734
Average	$ 57,035,867	$ 1,463,197	$ 7,969,823	$ 65,663,546

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

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

State	Percent Impact of Cost Savings/Avoidance Compared to Total Drug Spend
AL	0%
IA	0%
PA	0%
SD	0%
TN	0%
WI	0%
CO	1%
HI	1%
ND	1%
OH	3%
NJ	4%
OK	4%
AK	5%
CA	5%
CT	5%
MO	5%
NM	5%
VT	6%
NH	7%
MD	8%
WV	9%
WA	10%
UT	11%
GA	12%
TX	12%
IL	14%
ME	14%
OR	14%
MS	15%
MN	21%
VA	22%
MT	23%
ID	24%
KS	24%
NY	24%
DE	27%
NC	27%
SC	30%
IN	36%
MI	36%

LA	42%
MA	42%
RI	43%
AR	45%
DC	52%
WY	52%
NV	55%
NE	65%
KY	71%
FL	73%
Average	**20%**

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

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

VIII. FRAUD, WASTE AND ABUSE DETECTION

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

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

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

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

Answer	State	Number of States (Percentage of 48 states)
Deny claims and require prior authorization	CO, CT, DC, DE, GA, ID, IL, IN, KY, MA, ME, MI, MO, MT, ND, NE, NJ, OR, TN, UT, VT, WV	22 (46%)
Refer to lock-in program	AK, AL, CO, CT, DC, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NJ, NM, NV, OH, OK, OR, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	42 (88%)
Refer to Program Integrity Unit	AK, AL, CO, CT, DC, DE, GA, IA, IN, KY, ME, MI, MS, MT, NC, ND, NE, NJ, NV, NY, OH, OK, PA, RI, SD, TX, UT, VA, VT, WV, WY	31 (65%)
Other (e.g. SURS, Office of Inspector General)	AK, AL, CA, GA, IN, KY, MD, MI, MN, MS, MT, NC, NH, NJ, PA, SD, TN, TX, VA, VT, WI	21 (44%)

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

State	Explanation
AK	SURS, MFCU
AL	Refer to MFCU if necessary.
CA	22CCR 50793 details available utilization restrictions when the Department has determined that a beneficiary is misusing or abusing Medi-Cal benefits. Audit & Investigations, Investigations Branch (IB) is responsible for working

	beneficiary cases. IB has an intake process for complaints which entails an initial case review and if warranted, assignment of a case to an investigator. Subsequent actions are dependent upon the outcome of IB's investigation.
GA	Refer to Office of Inspector General
IN	Submit to FSSA Bureau of Investigations for member investigation
KY	Board of Pharmacy, Audit Vendors, Surveillance Utilization Review System (SURS), Special Investigative Unit (SIU), Attorney General (AG), Office of Inspector General (OIG)
MD	SURS, OIG
MI	The Office of Inspector General performs SURS for both providers and beneficiaries.
MN	Questionable utilization is referred to the SURS program and they determine the action from there.
MS	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.
MT	We follow a member through a fraud review determination and when fraud may be occurring the member is referred to the Division of Criminal Investigation
NC	All potential beneficiary fraud and abuse leads are referred by Program Integrity to the beneficiary's county Department of Social Services for further investigation and disposition.
NH	The Program Integrity Unit performs this function and maintains the lock-in program.
NJ	A Surveillance and Utilization Review (SURS) reporting tool is used by the Data Mining Unit within the Medicaid Fraud Division to look for unusual patterns in claim reimbursement from providers
PA	Refer to OIG for criminal investigation.
SD	Medicaid Fraud Control Unit
TN	Referrals are made to OIG, which is responsible for investigation and law enforcement for TennCare enrollee fraud, abuse and Doctor Shopping.
TX	Referrals are made to Law Enforcement and Child and Adult Protective Services as appropriate.
VA	Java- Server Utilization Review System (JSURS) identified members to review for enrollment in DMAS Client Medical Management Program (Lock- In program)
VT	Referrals to law enforcement
WI	The Office of the Inspector General (OIG) has department wide responsibility for auditing the use of department funds in support of the department's commitment to be an effective steward of the public resources DHS is instructed to manage. OIG, which reports directly to the DSH Secretary, conducts audits of providers who receive department funds, performs internal audits of department programs and operations and investigates allegations of fraud, waste and abuse of DHS resources by contractors, providers and members. OIG is responsible for working with DHS programs, divisions and partners to develop policies and practices to prevent fraud, waste and abuse.

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

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CO, CT, DC, DE, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	46 (92%)
No	CA, FL, IA, SD	4 (8 %)

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

Answer	State	Number of States (Percentage of 46 states)
Number of controlled substances (CS)	AK, AL, AR, CO, DC, DE, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, NC, ND, NH, NJ, NM, NV, NY, OH, OK, OR, PA, SC, TX, UT, VA, VT, WA, WI, WV, WY	40 (87%)
Different prescribers of CS	AL, AR, DC, DE, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	43 (93%)
Multiple pharmacies	AK, AL, AR, DC, DE, GA, HI, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	43 (93%)
Number days' supply of CS	AL, AR, CT, GA, KS, LA, MD, MI, MO, ND, NM, NY, OK OR, PA, TX, UT, VT, WI, WV	20 (43%)
Exclusivity of short-acting opioids	GA, KS, MD, NM, NY, OK, PA, VT	8 (17%)
Multiple ER visits	AK, AL, CO, GA, ID, IL, IN, KS, KY, ME, MI, MN, MO, MT, ND, NE, NH, NJ, NY, OK, OR, PA, TN, TX, UT, VA, VT, WA, WI, WV	30 (65%)
Other	AL, AR, CT, IL, IN, LA, MI, NE, NV, OR, PA, SC, TN, TX, VA, VT, WA	17 (37%)

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

Answer	State	Number of States (Percentage of 46 states)
prescriber only		0 (0 %)
pharmacy only	AR, CT, DC, DE, MA, MD, NH, NJ, NV, OH, OR, RI, SC, TN, WV, WY	16 (35%)
Both prescriber and pharmacy	AK, AL, CO, GA, HI, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NM, NY, OK, PA, TX, UT, VA, VT, WA, WI	30 (65%)

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

Answer	State	Number of States (Percentage of 46 states)
6 months	AK, SC	2 (4%)
12 months	AL, CT, DC, ID, MA, MS, MT, NH, RI, UT, VA, WV, WY	13 (28%)
Other	AR, CO, DE, GA, HI, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, NC, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, TN, TX, VT, WA, WI	31 (67%)

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

State	Explanation
AR	The Lock-in review criteria includes looking for medication poisoning diagnoses in Medicaid diagnosis history. Beneficiary is re-reviewed by the Lock-in committee yearly.
CO	Initial 3 month time period followed by re-evaluation. Lock-in statistics for reporting are anticipated to be available for the 2017/2018 FFY reporting period.
DE	Lock in does not have an end date, but can be reviewed at the member's request.
GA	9-12 months
HI	There has been no usual "lock-in" time period since 2009 when the ABD population moved into managed care plans. No one has been "locked-in" since 2009.
IL	The initial FFS client lock-in is for 12 months. All subsequent lock-ins for same recipient are implemented for 24 months.
IN	2 years, and then re-evaluation for graduation or re-enrollment
KS	Two Years
KY	Twenty-four (24) months initial lock-in period with annual reviews thereafter for appropriateness of continuance in the program.
LA	24 months
MD	24 months
ME	Varies on severity and also dependent of review of urinalysisand medical chart notes
MI	2 years
MN	Initial 24 months with the possibility of a 36 month renewal.
MO	Participants are locked in for a period of 24 months of eligibility.
NC	24 months
ND	Until a subsequent review shows that the patient is properly utilizing services and their lock-in doctor agrees the patient should be removed from the lock-in program.
NE	Each patient enrolled in Restricted Services is evaluated every 24 months for necessity of Restricted Services.
NJ	Time period is decided on a case by case basis.
NM	The time period is determined on case by case situations.
NV	Indefinite, we do not have a process for review to remove from lock-in.
NY	Two years of lock-in for the first offense. Thereafter, for a continuation (due to continued abuse or overuse while restriction/lock-in still in place) or re-restriction/lock-in, the second term would be three years, and the third time or more would be six years.
OH	24 months
OK	24 months for new lock-in referrals, then reviewed yearly.
OR	18 months
PA	5 years as approved by CMS in 1985 audit of PA's Lock-In Program.
TN	Indefinite. All enrollees are given at least one chance per year to be unlocked.
TX	Lock-in periods are: 36 months for the first lock-in 60 months for the 2nd lock-in lifetime for the 3rd lock-in
VT	2 years
WA	2 years for the first lock-in period, 3 years for the second, and 6 years for each subsequent lock in period
WI	2 years

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

State	Percentage of the FFS population in lock-in status annually
CO	0.000%
HI	0.000%
KY	0.000%
MS	0.000%
NE	0.000%
NH	0.000%
NM	0.000%
OR	0.000%
MD	0.001%
TX	0.001%
MO	0.002%
AL	0.010%
NV	0.010%
OH	0.010%
LA	0.012%
AR	0.014%
MI	0.017%

NY	0.018%
CT	0.050%
WV	0.060%
IL	0.080%
PA	0.080%
WA	0.090%
DC	0.100%
KS	0.100%
WY	0.100%
ND	0.140%
IN	0.190%
AK	0.200%
DE	0.200%
GA	0.200%
ID	0.200%
NC	0.200%
MN	0.220%
RI	0.300%
TN	0.300%
OK	0.329%
UT	0.360%
MT	0.400%
ME	0.500%
WI	0.500%
MA	1.000%
NJ	1.000%
SC	1.000%
VA	1.000%
VT	1.000%
Average	**0.217%**

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

State	Estimate of the savings attributed to the lock-in program for the fiscal year under review
AK	$-
CO	$-
DE	$-
GA	$-
HI	$-
ID	$-
IN	$-
KS	$-
KY	$-
ME	$-
MN	$-
MS	$-
ND	$-
NE	$-
NH	$-
NM	$-
VA	$-
VT	$-
WI	$-
RI	$792
OR	$3,271
DC	$4,818
WY	$6,835
OH	$10,000
MD	$10,173

LA	$11,200
AL	$22,885
MI	$29,680
NJ	$65,000
WV	$110,513
AR	$131,665
SC	$135,878
OK	$156,348
TX	$201,135
MA	$218,950
CT	$230,805
UT	$291,728
TN	$391,308
NV	$411,152
MT	$865,771
IL	$896,411
NY	$4,470,000
MO	$7,280,679
WA	$13,971,910
NC	$30,200,000
PA	$38,515,800
Average	**$2,144,450**

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

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

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

Answer	State	Number of States (Percentage of 37 states)
Deny claims written by this prescriber	CA, GA, IN, MA, MI, NJ, TN, VT, WA, WV	10 (27%)
Refer to Program Integrity Unit	AL, CA, CO, CT, DC, DE, GA, IA, IL, IN, KS, KY, MA, ME, MI, MO, MS, NC, ND, NJ, OH, OK, PA, RI, SD, TN, UT, VA, VT, WA, WV, WY	32 (86%)
Refer to the appropriate Medical Board	AL, DC, DE, GA, IA, IL, IN, KS, KY, MA, ME, MI, MS, NC, ND, NJ, OK, PA, SD, TN, VT, WA, WV, WY	24 (65%)
Other - please explain:	AL, CA, GA, IL, KS, MD, MI, MN, MS, NC, NE, NY, PA, SC, TN, VT, WA	17 (46%)

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

State	Explanation
AL	Refer to MFCU if necessary.
CA	Propose new policy such as quantity restrictions, and further review by Audit & Investigations, Investigations Branch (IB) and Medical Review Branch (MRB).
GA	Refer to office of Inspector General
IL	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.
KS	Referrals are sometimes made to the Attorney General's Office.
MD	SURS, OIG
MI	Prescribers may be suspended or sanctioned and prescriptions written by these prescribers would then be denied at point-of-sale.
MN	Refer to DHS's Office of Inspector General based on hotline tips. Also direct referrals from anyone including law enforcement, state agencies, & local advocates.
MS	Refer to DEA
NC	An audit of specific claims would be performed.
NE	Program Integrity Unit is reviewing reports produced through the data warehouse of outliers for further review.
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
PA	Refer to MFCS and initiate payment suspension if appropriate.
SC	Program integrity monitors
TN	Refer to TennCare's Provider Review Committee, which is the body that reviews and has the authority to terminate a provider's Medicaid ID
VT	Refer to Medicaid Fraud and Residential Abuse unit
WA	Items A, B, and C are not applicable in every case. All three may be pursued, but only a single action may be taken in some cases.

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

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

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

Answer	State	Number of States (Percentage of 35 states)
Deny claim	GA, IN, KY, LA, MA, MD, ME, MI, MO, NJ, WV	11 (31%)
Refer to Program Integrity Unit	AL, CA, CO, CT, DC, DE, GA, IA, IL, IN, KY, MA, ME, MI, MO, MS, NC, ND, NJ, OH, OK, PA, RI, SD, UT, VA, WA, WV,WY	29 (83%)
Refer to Board of Pharmacy	AL, DC, DE, GA, IA, IL, IN, KY, MA, ME, MI, MS, NC, ND, NJ, OK, PA, SD, WV, WY	20 (57%)
Other - please explain:	CA, GA, IL, IN, KY, MD, MI, MN, MO, MS, NC, NE, NY, PA, SC	15 (43%)

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

State	Explanation
CA	Propose new policy such as quantity restrictions, and further review by Audit & Investigations, Investigations Branch (IB) and Medical Review Branch (MRB).
GA	Refer to Office of Inspector General
IL	Refer to Provider Analysis Unit for evaluation. Also report to the Illinois Department of Financial and Professional Regulation, which issues professional licenses.
IN	Audit recoupment, Prepayment review program
KY	Desk audits are conducted by a vendor.
MD	OIG conducts audits of Maryland pharmacies to ensure compliance with regulations for all medications for Medicaid. Also, a compliance pharmacist performs desktop audits to identify potential fraud, waste or abuse.
MI	Pharmacies may be suspended or sanctioned which results in denial of claims submitted by the pharmacy at point-of-sale.
MN	Refer to DHS's Office of Inspector General based on hotline tips. Also direct referrals from anyone including law enforcement, state agencies, & local advocates.
MO	Review of requests for opioid authorization overrides.
MS	Refer to Mississippi Attorney General's Medicaid Fraud Control Unit
NC	An audit of specific claims would be performed.
NE	Program Integrity Unity is reviewing reports produced through the data warehouse of outliers for further review.
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
PA	Refer to MFCS
SC	Program Integrity Monitors

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

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

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

State	Explanation
AL	Through eligibility and URC, recipients are referred to MFCU.
CA	Audit & Investigations, Investigations Branch (IB) uses all available information to develop and work cases, initiates audits, and assists in investigations, including review of claims data and trends of non-controlled drugs.
CO	Retrospective DUR analysis and prior authorization are used to identify these issues.
CT	The quality assurance program at DSS performs random claims samples of controlled and non-controlled drugs to identify anomalies in payment and claims processing.
GA	Retrospective analyses of potential fraud/abuse on a case-by-case basis.
HI	Prior authorization requests are reviewed for greater than established quantity limits and early refills.
IA	If fraud or abuse of a non-controlled substance is identified, the member would be referred to Program Integrity for further investigation.
IL	Recipient and Provider Analysis Units looks at correlating diagnoses to support use of all medications and medical benefits by beneficiaries. We also look to see if alternative services to drug therapy are ordered for recipients such as physical therapy, specialty providers, assistive devices etc. that would indicate standards of care being provided. We will also contact ordering

	provider to validate need. If fraud or abuse of non-narcotics are suspected we work together with appropriate unit(s) to implement cost avoidance measures such as quantity limits and product cost reduction.
KY	Refill too soon, ProDUR checks, desk audits, RetroDUR audits, quantity limits, accumulation edits, and other general DUR activities or system edits.
LA	Point of Sale edits.
MA	MassHealth monitors through Quantity Limits and Dose Limits
ME	Review and referral system to identify over use and internal clinical review for placement within the lock-in program.
MI	Beneficiaries with high utilization of emergency room prescribers and pharmacies including those that paid with cash are subject to review.
MN	Questionable utilization is referred to the SURS program and they determine the action from there.
MT	We run a statistical report that reviews usage for controlled substances
NE	Each month, patients utilizing multiple providers are evaluated for abuse of any medication.
NJ	Lock into a pharmacy and utilize negative PA. Negative PA will block payment of a prescription service.
NY	Professional RetroDUR case reviewers refer potential prescriber fraud cases to the DUR program, from which they are forwarded to the Office of the Medicaid Inspector General (OMIG) for further review and/or possible investigation.
OK	Muscle relaxants claims are considered when locking members in.
PA	Review for the Lock-In Program includes all medications. Recipients may be restricted for fraud, waste or abuse of non-controlled substances.
SC	Program Integrity Monitors
UT	The DRRC has algorithms to identify recipients who may be misusing or abusing non-controlled drugs. See Appendix.
WA	Washington Medicaid does not differentiate between controlled and non-controlled substances for its lock-in program. Although it is usually controlled substances which most easily result in a client be placed in lock-in, any documentable fraud, abuse, or even unintentional misuse of the prescription drug benefit can lead to placement.
WI	Fraud and abuse must be reported regardless if the drug is a controlled drug or non-controlled drug. Providers may report fraud and abuse by going to the OIG fraud and abuse website or by calling the fraud and abuse hotline.
WV	Our early refill edit and quantity limit edit protect against a member obtaining more than 12 months supply of any drug in a year. Drugs requiring a PA typically require a minimum an approved diagnosis.

VIII B. PRESCRPTION DRUG MONITORING PROGRAM (PDMP)

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

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

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

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

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

Answer	State	Number of States (Percentage of 49 states)
Yes	AK, CT, DE, KS, KY, MA, NC, ND, NY, PA, SC, TN, VA, VT, WV	15 (31%)
No	AL, AR, CA, CO, DC, FL, GA, HI, IA, ID, IL, IN, LA, MD, ME, MI, MN, MS, MT, NE, NH, NJ, NM, NV, OH, OK, OR, RI, SD, TX, UT, WA, WI, WY	34 (69%)

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

State	Explanation
AK	Under state statute the practitioner or the practitioners agent must check the PDMP prior to dispensing, prescribing, or administering schedule 2 or 3 controlled substances with a few exceptions outlined in AS 17.30.200.
CT	State law requires all prescribers to review a patient's controlled substance history report if writing for more than a 72 hour supply. The provider agreement with the agency requires prescribers to adhere to all state laws and regulations.
DE	For prior authorization requests for controlled substances, the prescriber must indicate on the prior authorization form that the PDMP was checked.
KS	We incorporated this into our Long-Acting Opioid prior authorization criteria.
KY	Prescribers must attest to the fact that the PDMP was consulted prior to particular drugs being approved.
MA	Medicaid check MassPAT for outlier behavior episodically and develops corrective action
NC	For treatment of opioid dependence, prescribers are required to access the PDMP patient history before a PA will be granted.
ND	Require prescribers to access and review PDMP before approving prior authorizations on narcotics.
NY	In NYS, all prescribers writing a prescription for a Schedule II-IV controlled substance have a mandatory duty to consult the Prescription Monitoring Program Registry, with limited exceptions. The mandatory duty to consult the PDMP provision affords practitioners with current, patient-specific controlled substance prescription information intended to inform the practitioner of controlled substance utilization by their patient at the point of prescribing.
PA	Prescribers are required to query the PDMP for an existing patient when the following clinical situations apply: 1. For each patient the first time the patient is prescribed a controlled substance by the prescriber for purposes of establishing a baseline and a thorough medical record; or 2. If a prescriber believes or has reason to believe, using sound clinical judgment, that a patient may be abusing or diverting drugs; or 3. Each time a patient is prescribed an opioid drug product or benzodiazepine by the prescriber.
SC	Pescriber or authorized agent requited to check PDMP for Medicaid beneficiaries prior to prescribing control substance (II-IV) . Failure to perform an evaluation of SCRIPTS may result in recoupment of monies paid for office visit
TN	Providers are to check the PDMP as part of the PA criteria for certain medications (including controlled substances) in an effort to control fraud and abuse.
VA	Service Authorizations
VT	Vermont providers are required to register for the VPMS and are mandated to use it in the following circumstances. 1. At least annuallyfor patients who are receiving ongoing treatment with an opioid Schedule II, III, IV. 2. When starting a patient ojn a schedule II, III, IV for non-pallative long term therapy. 3. The first time the provider prescribes to treat chronic pain. 4. Prior to writing a replacement prescription for a Schedule II, III, IV. 5. In the future, the Department of Health may promulgate rules that require practioners to check the VPMS in additional circumstances. 4289. Standards and guidelines for health care providers and dispensers (a) Each professional licensing authority for health care providers shall develop evidence-based standards to guide health care providers in the appropriate prescription of Schedules II, III, and IV controlled substances for treatment of chronic pain and for other medical conditions to be determined by the licensing authority. The standards developed by the licensing authorities shall be consistent with rules adopted by the Department of Health. (b)(1) Each health care provider who prescribes any Schedule II, III, or IV controlled substances shall register with the VPMS by November 15, 2013. (2) If the VPMS shows that a patient has filled a prescription for a controlled substance written by a health care provider who is not a registered user of VPMS, the Commissioner of Health shall notify the applicable licensing authority and the provider by mail of the provider's registration requirement pursuant to subdivision (1) of this subsection. (3) The Commissioner of Health shall develop additional procedures to ensure that all health care providers who prescribe controlled substances are registered in compliance with subdivision (1) of this subsection. (c) Each dispenser who dispenses any Schedule II, III, or IV controlled substances shall register with the VPMS. (d) Health care providers shall query the VPMS with respect to an individual patient in the following circumstances: (1) at least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance;(2) when starting a patient on a Schedule II, III, or IV controlled substance for nonpalliative long-term pain therapy of 90 days or more; (3) the first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat chronic pain; and (4)

	prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance pursuant to section 4290 of this title. (e) The Commissioner of Health shall, after consultation with the Unified Pain Management System Advisory Council, adopt rules necessary to effect the purposes of this section. The Commissioner and the Council shall consider additional circumstances under which health care providers should be required to query the VPMS, including whether health care providers should be required to query the VPMS when a patient requests renewal of a prescription for an opioid Schedule II, III, or IV controlled substance written to treat acute pain. (f) Each professional licensing authority for dispensers shall adopt standards, consistent with rules adopted by the Department of Health under this section, regarding the frequency and circumstances under which its respective licensees shall:(1) query the VPMS; and (2) report to the VPMS, which shall be no less than once every seven days. (g) Each professional licensing authority for health care providers and dispensers shall consider the statutory requirements, rules, and standards adopted pursuant to this section in disciplinary proceedings when determining whether a licensee has complied with the applicable standard of care. (Added 2013, No. 75, 11.)
WV	If the PDMP indicates that a member is obtaining a controlled substance by more than one payer source the matter is referred to the Medicaid Fraud unit. Information obtained through this query may also be used when evaluating a request for prior authorization.

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

Answer	State	Number of States (Percentage of 49 states)
Yes	CT, ID, IL, IN, KS, KY, MA, MI, MS, MT, ND, NM, NV, NY, OH, PA, SC, TN, VA, VT	20 (41%)
No	AK, AL, AR, CA, CO, DC, DE, FL, GA, HI, IA, LA, MD, ME, MN, NC, NE, NH, NJ, NV, OK, OR, RI, SD, TX, UT, WA, WI, WV, WY	29 (59%)

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

Answer	State	Number of States (Percentage of 49 states*)
Yes	AK, AL, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, MA, MD, MI, MN, NC, NE, NH, NJ, NV, OK, OR, RI, SC, TN, TX, UT, VA, WA, WI, WV, WY	34 (69%)
No	AR, CA, DE, KY, LA, ME, MS, MT, ND, NM, NY, OH, PA, SD, VT	15 (31%)

*MO have no PDMP

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

State	Explanation
AK	Under current law, access to PDMP information is on an individual case basis. Data submission lag is present; data submission requirement is weekly.
AL	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.
CO	The State is prohibited by legislation from accessing the PDMP.
CT	Access is restricted to our Medicaid Fraud Unit only.

DC	The Department of Health as the PDMP administrator does not allow the Medicaid program "warrantless" access to the PDMP even in support of the Medicaid Lock-in Program. Access may be granted to the Medicaid Program Integrity Unit only to assist in providing information in active fraud or criminal investigations.
FL	Medicaid does not have access to PDMP.
GA	No funding and legal concerns about who can access the data. Prescribers and pharmacies also do not access data like they should, although this seems to be trending in the right direction.
HI	No time resource is available within the agency to utilize PDMP.
IA	Medicaid agency is not granted access to the PMP. The PMP is only available to authorized healthcare practitioners to review their patients' use of controlled substances.
ID	Lag time can occur between dispensing and data being submitted to PDMP by other States. Can only do by patient and not generate reports for trends, etc.
IL	Need to view one patient at a time and re-enter data if checking neighboring state. Not all pharmacies submit data in a timely manner as evidenced by claims filled, but not yet visible in PDMP. No way to verify if prescriber checked ILPMP prior to writing prescription.
IN	Lag time in prescription data being submitted, prescribers not accessing, pharmacists not accessing before filling script
KS	Our Medicaid SURS team is not able to pull data in real time, but the Kansas pharmacies/pharmacists are able to pull the data in real time. Our K-TRACS (PDMP) system is a good program.
MA	No aggregate data 42CFR part 2 Methadone maintenance is not uploaded to MassPAT DUR Program does not have access
MD	The FFS program must have a bona fide formal investigation to access the PDMP. Requests must be approved by the MDH Secretary. Information is obtained through the MDH's PDMP program. This may lead to a lagtime between request and receipt of information. Also, technical issues include system downtime maintenance and delay of claims submission by providers.
MI	Discussions have been ongoing to increase the Agency's ability to access the PDMP. System improvements are improving lag time and data availability.
MN	Only SURS can access for a unique recipient that is under investigation. DHS Pharmacy & Health Plan Policy Staff cannot access the information.
NC	Many pharmacies have restricted internet access, delay in processing data submitted, prescribers complain of time required to log in.
NE	Nebraska Medicaid does not have the legal authority to access PDMP data.
NH	Legislation as written does not allow NH State Medicaid Program staff to access data.
NJ	NJ PDMP grants access to prescribers and pharmacists who are licensed by the State of New Jersey and in good standing with their respective licensing boards. Licensed pharmacy staff conducting DUR is considered unauthorized users since they are not directly delivering healthcare.
NV	Only the State staff have access to the data. Contractors for the State are not allowed to access the PMP unless they have responsibility for direct patient care. Unable to query by prescriber.
OK	The agency has very limited 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.
OR	Payers do not have access to the PDMP in Oregon
RI	State law requires the user of the PDMP have a DEA number.
SC	PDMP constantly working to address issues which may contribute to barriers - some of the issues have been updating data timely, limited information and access to system
TN	Only being able to pull data for one patient at a time and not being able to pull data for multiple patients at once, or being able to pull a prescribers data.
TX	The Statuary law prohibits access to prescription data.
UT	Providers are not required to check the Controlled Substance Database before providing prescriptions to a patient. Utah Medicaid is limited by State Statute in how it may access and use data from the PDMP.
VA	Not allowed to access by state law
WA	Washington State continues to struggle with uptake of PDMP usage by prescribers.
WI	The PDMP is managed by a different agency.
WV	Access to the PDMP is limited to one person at our department and queries are capable of only pulling up one member at a time.
WY	The current interpretation of the PDMP law has resulted in the Board of Pharmacy denying access to the agency for any purpose. This is new in the last year.

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

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

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

State	Explanation
AK	Granted limited access.
AR	The Medicaid Pharmacy Program was given access to the PDMP July 2017.
IL	ILPMP continues to expand the number of neighboring states' data that is visible. More prescribers now have access due to linkage directly to several medical systems' EMRs
MI	The PDMP system was enhanced April 1, 2017 to improve data availability and reporting capabilities.
MS	Have executed a memorandum of agreement with State Board of Pharmacy for Medicaid to obtain all PMP claims for Medicaid beneficiaries each month for use in Retro-DUR program.
PA	Clinical staff in the Department's FFS Medicaid Program now have access to the PDMP. The MA MCO clinicians do not have access to the PDMP.
SC	updates more frequently, working to expand information (MME/reporting)
TX	The Texas State Board of Pharmacy announced that effective September 1, 2017, the Texas-licensed pharmacies are required to report all dispensed controlled substances records to the Texas Prescription Monitoring Program (PMP) no later than the next business day after the prescription is filled. This was a change from previous requirement which allowed for seven days for information to be sent to the Texas PMP.
VT	We are currently in the midst of transition, having just migrated to a new system on the 15th of June, 2017. This will greatly improve the interface and functionality to providers and others utilizing the system.

VIII C. Pain Management Controls

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

Answer	State	Number of States (Percentage)
Yes	NJ, OH, TN, TX	4 (8 %)
No	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NM, NV, NY, OK, OR, PA, RI, SC, SD, UT, VA, VT, WA, WI, WV, WY	46 (92%)

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

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

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

Answer	State	Number of States (Percentage of 16 states)
Yes	AL, CT, ME, MI, MO, ND, SC, WA	8 (50%)
No	AK, ID, MS. NH, PA, UT, WV, WY	8 (50%)

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

State	Explanation
AL	Claims are denied for controlled drugs prescribed by a provider not on the DEA file.
CT	The information is applied at the point of sale.
ME	We utilize the NTIS DEA file in adjudication of claims
MI	The POS system has business rules that check the XDEA license eligible prescriber of office-based opioid dependency drug therapies.
MO	If a DEA is submitted which is inactive or restricted, the claim is denied at POS.
ND	If no active DEA number, claims for controlled substances are denied.
SC	System requires valid DEA number in order for claim to be paid via ProDUR edit
WA	During automated prescriber file loads, providers without DEA numbers are identified and added to restricted prescriber networks which do not allow the dispensing of Schedule II medications written by the provider.

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

Answer	State	Number of States (Percentage 34 states)
Yes	DC, IA, MA, MD, NJ, SD	6 (18%)
No	AR, CA, CO, DE, FL, GA, HI, IL, IN, KS, KY, LA, MN, MT, NC, NE, NM, NV, NY, OH, OK, OR, RI, TN, TX, VA, VT, WI	28 (82%)

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

Answer	State	Number of States (Percentage)
Yes	IA, ME, MI, NH	4 (8 %)
No	AK, AL, AR, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, K,S, KY, LA, MA, MD, MN, MO, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	46 (92%)

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

State	Explanation
IA	Claims are blocked at the point of sale for prescribers not authorized to prescribe controlled substances.
ME	Deny claim and require PA Quantity Limits Morphine Equivalent Daily dose.
MI	Our vendor's RetroDUR system loads the DEA registrant file and can be queried for reports as needed, including prescribers without a valid DEA but prescribing controlled substances, etc.
NH	The DEA file is used to identify prescribers not authorized to prescribe control substance medications.

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

Answer	State	Number of States (Percentage)
Yes	AK, AL, AR, CA, CO, CT, DC, DE, FL, IA, ID, IL, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NY, OH, OK, OR, PA, SC, TN, TX, UT, VA, VT, WA, WI, WV, WY	43 (86 %)
No	GA, HI, NM, NV, RI, SD	6 (12%)
Other	IN	1 (2 %)

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

Answer	State	Number of States (Percentage of 43 states)
Pharmacist override	ID, KY, MO	3 (7%)
Deny claim and require PA	AK, AL, AR, CA, CT, DC, DE, FL, IA, ID, IL, KS, KY, LA, MA, MD, ME, MI, MO, MS, NC, ND, NE, NH, NJ, NY, OH, OR, PA, SC, TN, TX, UT, VA, VT, WI, WV	37 (86%)
Quantity limits	AK, AL, DC, DE, ID, KS, LA, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NY, OH, OK, OR, PA, TN, TX, UT, VA, VT, WA, WV, WY	30 (70%)
Intervention letters	CT, DE, IA, ID, IL, MD, MI, MO, NC, ND, NH, WI	12 (28%)
morphine equivalent daily dose program	AR, CO, CT, ID, LA, MA, MD, MN, MO, OR, PA, TN, VA, WA, WV, WY	16 (37%)
step therapy or clinical criteria	AK, AL, DC, DE, FL, ID, IL, KY, MA, MD, MI, MO, MT, ND, NE, NH, NY, OK, OR, PA, TN, TX, UT, WA, WV	25 (58%)

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

State	Explanation
IN	Indiana law requires methadone to be dispensed only for the treatment of pain in an outpatient setting. Prior authorization is required if the member is over the established dosing limit or has greater than four prescribers of opiates.
NV	Methadone is non-preferred on our PDL. We are looking at ways to better control it's use.
HI	No FFS recipient since 2009 has been in need of pain management program. This is an issue for our managed care plans and will be explored in 2018.
NM	Nothing in lieu of at this time, but the topic is under consideration.
RI	Pharmacy and Therapeutic Committee determines methadone will be a preferred agent. FFS is secondary claim. Primary insurance makes that determination.
GA	Quantity limits.
SD	Reviewing as a part of a broader opioid management program.

VIII D. OPIOIDS

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

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

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

State	Number of unit(s) per day
AK	Varies based on medication: up to 8 units/day
AL	2
AR	6
CA	Short-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
CO	4 units/day
DC	7
DE	4 units for acute pain and 2 units a day for chronic pain

FL	12
GA	Varies; 5 opioid fills per 30 days
IA	varies by drug
ID	Specific to each drug
IL	6
IN	60 MME for new opiate utilizers units/day
KS	other- drug specific
KY	N/A
LA	4
MD	Units per day depends on the product and dosage form (reference: https://mmcp.health.maryland.gov/pap/docs/QL.pdf)
ME	15 day limit with continuation requiring PA for additional units and clinical rationale for long term use
MI	6
MO	24
MS	2
MT	8 oxycodone/day
NC	120 MME
ND	Limit qty/day on all short-acting opioids and the quantity varies by drug and strength
NE	5
NH	The edit is on 30 days supply and not by unit per day.
NV	60 mg morphine eq
NY	6
OH	Based on MED or APAP dose
OK	4
OR	90 mme
PA	Varies by drug
SC	4
SD	30 days supply
TN	N/A
UT	Variable, based upon drug-specific FDA-approved dosing
VA	4
VT	Dependent on medication requested
WI	16
WV	4
WY	4

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

Answer	State	Number of States (Percentage of 41 states)
30 day supply	AL, AR, DE, FL, GA, ID, KY, MD, ME, MT, NE, NH, OK, OR, SC, SD, WI, WY	18 (44%)
90 day supply		0 (0%)
Other, please explain	AK, CA, CO, DC, IA, IL, IN, KS, MI, MO, MS, NC, ND, NV, NY, OH, PA, TN, UT, VA, VT, WV	24 (59%)

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

State	Explanation
AK	34 day supply
CA	Short-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
CO	Implemented 08/01/2017, the opioid native policy limits days supply of short-acting opioids to 7 days (8 tabs/caps per day) for members who have not had an opioid claim within 365 days. For non-native members it is 30 days.
DC	7 days supply
IA	up to a 31 day supply
IL	- 30-day supply - Only 1 short-acting opioid allowed at a time. - Patients flagged via the Four Rx Policy with first request receive short-term approval if appropriate. If patient has used opioids 3 or more months the prescriber must fill out pain manage
IN	For initial utilizers of opiates, a 7 day supply followed by an additional 7 day supply in a rolling 45 day period is permitted without prior authorization.
KS	driven by drug-specific individual quantity limits
LA	7 day supply within a 30 day period for opioid native patients. 15 day supply within a 30 day period for patients who are not opioid native.
MI	34 days supply
MO	Opiate native participants are limited to 7 days on the first fill. All other claims are limited to 31 days.
MS	Maximum days supply is 31 days versus 30 due to monthly limit on number of prescriptions. Maximum monthly limit for 31 days supply is 62 units. (tablets/capsules).
NC	Up to a 7-day supply (without a prior authorization) and then up to 34-day supply with a prior authorization.
ND	34 days max for all products unless primary insurance allows > 34 days or if product package size / dosing often results in > 34 days (e.g. insulins).
NV	7 days
NY	90-day supply limit; Limited to a total of four (4) opioid prescriptions every 30 days; Exemption for diagnosis of cancer or sickle cell disease CLINICAL CRITERIA (CC); For opioid: Native patients - limited to a 15 days supply for all initial opioid prescriptions, except for patients with diagnosis of sickle cell disease or cancer; Medical necessity rationale for opioid therapy is required for patients on established buprenorphine opioid dependence therapy; PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy.
OH	34 days
PA	Prior authorization is required for short acting opioids after 3 days for children under 21 and after 7 days for adults.
TN	Different quantities based on whether the enrollee is a chronic or non-chronic user. If non-chronic, the enrollee is limited to 15 days supply, no greater than 40 (will be increased to 60) MEDD, per 90 days. Exceptions are: active metastatic disease (no limit per 90 days), Sickle Cell, corrosive/burns, Enrollees in skilled LTC facility are limited to 45 days supply per 90 days. All claims are limited to a maximum of 30 days supply.
UT	7 day initial fill, 30 days thereafter
VA	7 days
VT	7-day supply for initial fill, 30 day limit overall for IR products. 50 MME limit for adults, 24 MME limit for children effective 7/1/17
WV	34 day supply

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

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

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

Answer	State	Number of States (Percentage of 39 states)
2 units/day	AL, AR, GA, IA, ID, IN, KY, LA, MD, ME, MI, MS, MT, ND, NE, NV, OH, OR, PA, SC, TN, VT, WA, WV	24 (62%)
3 units/day	AK, CA, DE, FL, IL KS, MA, NC, NH, NJ, NY, OK, SD, UT, VA	15 (38%)

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

Answer	State	Number of States (Percentage of 39 states)
30 day supply	AL, AR, FL, GA, ID, KY, MA, MT, NE, NH, OK, OR, SC, SD, TN, UT, VT	17 (44%)
90 day supply		0 (0%)
Other, please explain	AK, CA, DE, IA, IL, IN, KS, LA, MD, ME, MI, MS, NC, ND, NJ, NV, NY, OH, PA, VA, WA, WV	22 (56%)

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

State	Explanation
AK	34 day supply
CA	Long-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
DE	All long acting opioids require prior authorization. Specific clinical reviews allow for individual entry. Routinely the authorization is for 1 year. If there is any concern, the authorized quantities are limited to one month at a time.
IA	Up to a 31 day supply
IL	- 30-day supply - Only 1 long-acting opioid allowed at a time - Patients flagged via the Four Rx Policy with first request receive short-term approval if appropriate. Prescriber must complete pain management program forms with medical justification and if
IN	Quantity limits placed on certain long-acting opioid products for a maximum quantity of each agent per month.
KS	driven by drug-specific individual quantity limits
LA	15 day supply within a 30 day period.
MD	Quantity limits are set at or below 90 milligram morphine equivalents and a 30 day supply.
ME	15 day limit similar to short acting opioids
MI	34 days supply with specific quantity limitations on certain long-acting narcotics such as fentanyl patches and ER oxycodone.
MS	Maximum days supply is 31 days versus 30 due to monthly limit on number of prescriptions. Maximum monthly limit for 31 days supply is 62 units. (tablets/capsules).
NC	Up to a 7-day supply (without a prior authorization) and then up to 34-day supply with a prior authorization.
ND	VIII-D2 is yes, but 96a doesn't give proper choices. We limit all long acting products to no more than FDA approved dosing. 34 days max is our entire program max (unless primary insurance allows > 34 days)
NJ	30 day or 100 units whichever is greater
NV	7 days without a PA if below 60mg morphine eq.
NY	90-day supply; Hydromorphone ER, oxymorphone ER- Maximum 4 (four) units per day, 120 units per 30 days; Morphine ER (MS Contin 100mg only) - Maximum 4 units per day, up to 3 times a day, maximum 120 units per 30 days All other long acting opioids are either 2 or 3 times a day.
OH	34 days
PA	All long acting opioids require prior authorization for all beneficiaries. The day supply approved is determined on a case-by-case basis.

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

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

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

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

State	Explanation
CT	Retrospectively we have criteria to identify the concurrent use of opioids and benzodiazepines together but there is nothing at POS to identify and monitor the use of these medications.
DC	ProDUR soft edits
DE	Prior authorization for all long-acting, high-dose opioids is only approved if the member is not receiving a benzodiazepine.
FL	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.
ID	Use FDB edit to monitor
IN	Retrospective DUR established to monitor concurrent claims for opioids and benzodiazepines. A near real-time letter is faxed to the prescriber notifying them of the combination therapy and risks associated with this therapy.
KY	Standard ProDUR system edits require a pharmacist intervention for this combination.
MT	We limit benzodiazepines when used with methadone
NH	When a long acting narcotic is prescribed and approved for coverage, benzodiazepines can not be dispensed for the length of the prior authorization of the long acting narcotic without review/approval.
NY	PA required for initiation of opioid therapy in patients currently on benzodiazepine therapy
OR	Prior authorization criteria for benzodiazepines and opioids restrict concurrent use
PA	While there was no hard edit in the claims system to prevent concomitant claims, concomitant use was addressed through the prior authorization process required for all opioids.
TN	Benzos are denied and require PA if enrollee is using an opioid concomitantly, and vice versa.
TX	The "Combination of Alprazolam, Carisoprodol, and Hydrocodone" edit, was implemented effective 2013. This edit denies claims for combination of alprazolam, carisoprodol, and hydrocodone with a 14-day overlapping days supply. In 2016, this edit title was changed to the "Opiate/Benzodiazepine/Muscle Relaxant Combinations" which denies claims if any combination of drugs in these classes are dispensed with a14-day overlapping days supply. The edit excluded rectal diazepam and clobazam from benzodiazepines as well as muscle relaxant agents indicated for spasticity.
VA	First Data Bank's Alert Space ProDUR edits
WY	Concurrent use of opioids and benzodiazepines requires prior authorization.

VIII E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

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

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

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

AR	CO	DE	ID	IN	LA	MA	MD	ME	MI	MN	NC	ND	NV	OH	OK	OR	PA	TN	VA	VT	WA	WV	WY
250	300	120	90	60	90	120	90	30	120	120	120	90	60	80	120	90	50	200	120	50	120	50	120

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

State	Explanation
AK	No formal system edit for a set maximum recommendation in FFY2017. Alaska Professional Boards have adopted Washington State Agency Medical Directors' Group Guidelines. Prior Authorization criteria and guidance references caution when using in excess of 100 MME
AL	Placed max units manually.
CA	All opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.
CT	Effective 9/1/2016 we implemented a MEDD informational alert message at point of sale.
DC	The MME program will be implemented in Summer of 2018
FL	A limitation will be implemented in March of 2018.
GA	We are moving in the direction of implementing a max MED in the future. Currently, our QLLs vary not based on MED.
HI	FDA approved quantity edits for excessive quanatity per First Data Bank.
IA	Currently, individual opioids have set quantity limits. A recommendation has been made by the DUR to implement an initial 200 MME/day edit with a gradual reduction to 90 MME/day. The edit will be implemented in the upcoming months.
IL	No MEDD used.
KS	For the time period of this report, there were only quantity and day supply limits.
KY	ProDUR edits for quantity per day. Plan to implement morphine equivalent daily dose edit in FFY 2018.
MO	We did not have a MEDD policy in effect for FFY17, however we recently made changes to our opioid edits to lower the MEDD.
MS	Approved by DUR Board in September 2016. Prospective edits to 90 MME being programmed.
MT	We plan to set the maximum at 180MEDD in July 2018
NE	The DUR Board made specific recommendations to limit opioid use and those limits are in the planning stages of implementation.
NH	MME of 100 went into effect 1/15/2018 to follow Board of Medicine regulations.
NJ	ProDUR editing is utilized. MME conversion used in RetroDUR letters to prescribers March 2018.
NM	Topic is under consideration.
NY	The NYS DURB has recommended quantity/ frequency/ duration limits to promote the safe and clinically effective use of opioids in the New York State Medicaid Program. The process examines FDA recommended dosages and considers equivalent MED levels. The combined efforts of the Medicaid Prescriber Education Program (MPEP), the Drug Information Response Center (DIRC) and Retrospective Drug Utilization Review (RetroDUR) program promotes the clinical effectiveness and medical appropriateness of opioid utilization by way of point-of-sale (POS) prospective edits, RetroDUR evaluations and the application of educational interventions for prescribers and pharmacists. In addition, on March 27, 2016 New York State began mandatory e-prescribing controlled substances.
RI	Partially in place for native patients.
SC	MME is being established and will be required across FFS and MCO's
SD	No MED measures
TX	Maximum quantity limit per each prescription claim is in place for opioids.
UT	Drug-specific FDA-dose limits

WI	Wisconsin monitors these drugs through edits such as quantity limits and early refill alerts. Wisconsin has also looked at specific drugs through retroDUR and targeted interventions. Prescribers identified during these processes receive a letter which alerts them to the clinical concern.

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

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

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

Answer	State	Number of States (Percentage of 24 states)
Website	AK, CO, CT, DC, IA, MA, ME, NC, NH, NV, OR, TN, WA, WV	14 (58%)
Provider notice	MI	1 (4%)
Educational seminars		0 (0%)
Other, please explain	AR, CA, ID, IN, MD, MS, ND, VA, VT	9 (38%)

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

State	Explanation
AR	The MME reduction began Nov. 2016 at 300 MME/day and reduced by 50 MME every 6 months (Nov and May) until findal MME of 90 MME/day on Nov. 14, 2018. Prescribers receive a letter with list of patients exceed MME 2 months before next MME reduction, and receive Provider Memo, and is posted on website.
CA	The Medi-Cal DUR program published an educational bulletin entitled, "Clinical Review: Morphine Equivalent Daily Dose to Prevent Opioid Overuse" to the Medi-Cal DUR website. This bulletin defined morphine equivalent daily dose (MEDD) and provided evidence to support using MEDD as an indicator of potential dose-related risk for prescription opioid overdose. The bulletin provided links to several online MEDD calculators, as well as additional resources to providers. The bulletin was also emailed to all providers who subscribe to the Medi-Cal Subscription Service.
ID	Targeted letters to prescribers based on RetroDUR activity
IN	Drug Utilization Review Board Newsletter, posted electronically, provides opiate conversion charts.
MD	Maryland Medicaid utilizes multiple sources of education, including website, provider notice and educational seminar.
MS	RetroDUR notices to providers
ND	Limit of 90 is for immediate release products only. PRN doses limited to 15% of current extended release narcotic dosage. Providers are referred to a variety of website calculators
VA	A Medicaid Memo was posted to the state website with a blast email sent to those enrolled in the service. A patient specific letter was sent to those prescribers whose patients had received a prescription above the new limit.
VT	Provider notice and website

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

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

VIII F. BUPRENORPHINE and BUPRENORPHINE/NALOXONE COMBINATIONS

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

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

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

Answer	State	Number of States (Percentage of 44 states)
12mg	DE	1 (2%)
16mg	GA, ME, MT, OH, PA, TN, TX, VA, VT, WY	10 (23%)
24mg	AK, AL, AR, CO, DC, FL, IA, ID, IN, KY, LA, MI, MN, NC, ND, NE, NH, NV, NY, OK, OR, UT, WA	23 (52%)
other, please explain	CA, CT, IL, KS, MA, MD, MO, MS, NJ, WV	10 (23%)

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

State	Explanation
CA	There is a maximum quantity of four dosage units per day, regardless of strength. The maximum allowable total daily dose is 48 mg.

CT	An Informational alert is set at point of sale for any buprenorphine prescription that exceeds 24 mg per day.
IL	Buprenorphine tablets total mg/day is 24 mg. A group accumulator edit allows up to 93 units per month of any buprenorphine and/or buprenorphine/naloxone combination claims. If prior authorization is requested, the regimen, PMP, and submitted clinical notes are reviewed.
KS	24mg for Suboxone and Subutex, 17.1mg for Zubsolv, or 12.6mg for Bunavail
MA	32mg
MD	The Maryland Medicaid Pharmacy Program utilizes quantity limits that vary by drug and dosage form for buprenorphine and buprenorphine-naloxone combination products. Quantity limits may be found online at https://mmcp.health.maryland.gov/pap/docs/QL.pdf
MO	The first 180 days are limited to 32mg/day.
MS	Step down therapy; up to 24 mg/day during induction and stabilization phase (month 1-2), up to 16 mg/day during maintenance phase (months 3 and beyond).
NJ	32 mg
WV	24 mg is allowed once per lifetime and only for 60 days after which the dose must be reduced to 16 mg or less.

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

Answer	State	Number of States (Percentage)
6 months	GA, MO, OR, TN	4 (8%)
12 months	NE	1 (2%)
no limit	AK, AL, AR, CA, CO, CT, DC, DE, FL, ID, IL, KS, KY, MA, MD, MN, MS, MT, ND, NH, NJ, NM, NV, NY, OH, OK, PA, RI, SC, SD, TX, UT, VT, WA, WI	35 (70%)
other, please explain	HI, IA, IN, LA, ME, MI, NC, VA, WV, WY	10 (20%)

If “Other”, please explain.

State	Explanation
HI	No pain management has been required since 2009.
IA	24mg/d for a maximum of 3 months
IN	Buprenorphine/naloxone prior authorizations are granted every 6 months with a maximum 34-day supply if all criteria are met. Buprenorphine prior authorizations are granted for a 34-day supply if all criteria are met.
LA	3 months
ME	2 years without a PA if within dosing limits
MI	The initial authorization is for 12 months, then renewal requests are evaluated on a case by case basis.
NC	Approve for up to 12 months, then PA must be renewed.
VA	3 months
WV	At 16 mg and below there is no time limit. An initial dose of 24 mg is allowed once in a lifetime and is permitted for 60 days if needed.
WY	Up to 16mg/day is allowed for the first two years. After two years, a maximum of 8mg/day is allowed

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

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

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

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

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

State	Explanation
ME	looking at reduction in MG over a time period and PA submission.
MI	Tapering required based on an individualized care plan.
MS	Step down therapy; up to 24 mg/day maximum during induction and stabilization phase (month 1-2), up to 16 mg/day maximum during maintenance phase (months 3 and beyond).
MT	As low as possible for each member

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

Answer	State	Number of States (Percentage of 11 states)
6 months	TN	1 (9%)
no limit	DE, IA, LA, MO, MS, MT, WV, WY	8 (73%)
other, please explain	ME, MI	2 (18%)

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

State	Explanation
ME	as indicated in previous answer
MI	These are reviewed on a case by case basis.

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

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

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

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

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

Answer	State	Number of States (Percentage of 33 states)
Yes	DC, MD, RI, VA, VT	5 (15%)
No	AK, AR, CO, DE, GA, ID, IL, IN, KS, KY, LA, MA, ME, MO, MS, MT, ND, NE, NH, NJ, NY, OK, PA, SC, TN, TX, UT, WY	28 (85%)

VIII G. ANTIPSYCHOTICS/STIMULANTS

VIII-G1. ANTIPSYCHOTICS

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

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

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

Answer	State	Number of States (Percentage of 43 states)
only children in foster care	DE, MT, OR	3 (7%)
all children	AK, AL, AR, CA, CO, CT, FL, GA, IA, ID, IN, KY, LA, MA, MD, ME, MI, MN, MO, MS, NC, NE, NV, NY, OH, OK, PA, RI, SC, SD, TN, TX, VA, VT, WA, WV, WY	37 (86%)
other, please explain	IL, KS, WI	3 (7%)

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

State	Explanation
IL	Prior authorization is required for all children under the Department of Child and Family Services 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.
KS	adults and children
WI	7 years of age or younger.

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

Answer	State	Number of States (Percentage of 43 states)
Child’ Age	AK, AR, CA, CO, CT, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, NE, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA, VT, WA, WI, WV, WY	41 (95%)
Dosage	AR, CA, CO, CT, FL, GA, ID, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, NE, NY, OH, OK, OR, RI, SD, TN, TX, VA, VT, WA, WI, WV, WY	33 (77%)
Polypharmacy	AK, AL, AR, CA, CO, CT, FL, GA, IA, ID, IN, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NV, NY, OH, OR, RI, SC, SD, TN, TX, VA, WA, WI, WV, WY	35 (81%)

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

State	Explanation
AK	Monitor atypical antipsychotics for children.
AL	PA is required for all antipsychotics (brand and generic; atypical and typical). 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) and must be documented on the PA request form.
AR	All children < 10 years of age, for all "new starts" on an antipsychotic agent, including a change in the chemical entity for children currently on an antipsychotic agent, require a manual review prior authorization. All documentation, chart notes, signed informed consent, and required lab work must be submitted to the Medicaid Pharmacy Program and the data will be reviewed by the Medicaid Pharmacy Program child & adolescent psychiatrist. All requests to add a second antipsychotic agents for all children < 18 years of age also require a manual review prior authorization. The Medicaid Pharmacy Program psychiatrist will determine approval or denial

	of the PA request and will respond to the prescriber's request. The dose edits for each drug are determined by the child's age. Any request to exceed the dose for age requires a manual review prior authorization as noted above.
CA	An approved Treatment Authorization Request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 ~17 years of age. In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health Division, and California Department of Social Services (CDSS) continue to collaborate on a Quality Improvement Project entitled, "Improving the Use of Psychotropic Medication among Children and Youth in Foster Care." The purpose of this program is to reduce the rate of antipsychotic polypharmacy, improve the rate of compliance with age-specific antipsychotic dose recommended guidelines, and improve the rate of children and youth in foster care with at least one psychotropic medication who have an annual metabolic risk assessment. The goals are to reduce polypharmacy and improve compliance with dosing guidelines and annual metabolic risk assessment.
CO	Prior authorization is required for members under approved age or over approved dose. There is RDUR monitoring and provider letters are sent. Complex cases are referred to child and adolescent psychiatry telephone consult service.
CT	HID performs 1,000 RetroDUR reviews for the pediatric population each month and the majority of the criteria used to review the pediatric population have to do with mental health drugs. An additional program exists and is administered by the Department of Children and Families for children in foster care only. The Psychotropic Medication Advisory Committee (PMAC) oversee the use of psychotropic medications in the foster care population and have specific edits, maximum doses, monitoring guidelines, etc. associated with prescribing of these medications. Some of the criteria used for the pediatric RetroDUR program have been adopted from the PMAC criteria.
DE	Age 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 to reduce unnecessary therapy in the foster care population.
FL	Florida continues to perform second medical review. The second medical review is performed by a board certified child psychiatrist. The psychiatrist review is required for all children under six and select children over six depending on antipsychotic selection and dosage.
GA	Require the use of an atypical antipsychotic form, which delineates important parameters such as use of psychiatrist, age of patient, off-label use of atypical agents, patient medication and family history, medical necessity of medication, etc.
IA	Age edit on risperidone for members less than five (5) years of age. Age edit on all other antipsychotics for members less than six (6) years of age. Duplicate therapy edit on all antipsychotics for members 0 through 17 years of age. A 30 day grace period is allowed to allow transition between antipsychotic medications.
ID	Targeted DUR interventions for foster children and children < or = 5 years.
IL	"Prior authorization required for atypical antipsychotics in children < 8 years of age.
IN	Antipsychotics require prior authorization when used in duplication, low doses, or when a drug-specific quantity limit has been exceeded.
KS	We have dosing limits and multiple-drug use limits in place for children and for adults.
KY	A diagnosis-driven prior authorization is required for all second generation antipsychotics. There are max daily dosing edits and checks or therapeutic duplication (e.g., not more than one antipsychotic at a time).
LA	Requirements for antipsychotics include appropriate diagnosis, therapeutic duplication (3rd agent), dose and age limit, and clinical preauthorization for age < 6 years.
MA	Behavioral health medication polypharmacy: pharmacy claims for 4 or more behavioral health medications (i.e., alpha2 agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines, buspirone, cerebral stimulants, hypnotics, and mood stabilizers) filled within a 60-day period Antipsychotic polypharmacy: overlapping pharmacy claims for 2 or more antipsychotics for a 60 days within a 90 day period Any pharmacy claim for an antipsychotic, antidepressant, atomoxetine, benzodiazepine, buspirone, or mood stabilizer for members less than 6 years old
MD	In October 2011, MMPP established the peer review program for mental health drugs. This peer reviewed authorization process informs clinicians of relevant pharmacologic and non-pharmacologic clinical information for decision making and ensures the appropriate use while limiting adverse sequela in Medicaid's valuable pediatric population. The program initially addressed the use of antipsychotics in participants < 5 years of age. During FFY 2013, all participants < 10 years of age required prior authorization. As of January 2014, the program was expanded to include all participants < 18 years of age.
ME	PA requirements limiting age, length of therapy and well as metabolic monitoring requirements.
MI	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 consultant intervention with the most exception providers or specific educational topics.
MN	Monthly the DHS Children's Division receives reports that identifies children on multiple psychotropic drugs, lack of monitoring, and high dose.
MO	For children 0 to 5 years old, atypical antipsychotics deny at point of sale and must be reviewed by a clinical consultant for approval or denial. For children 5 to 9 years old, all new and non-adherent requests for atypical antipsychotics will deny at point of sale and must be reviewed by a clinical consultant for approval or denial. For children 5 to 9 years old, that are already established along with children 9 to 18 years old atypical antipsychotics will approve as long as they are on only 1 atypical, have appropriate diagnosis, dose does not exceed recommended maximum doses and are adherent to therapy 60 of the most recent 90 days. Requests that are reviewed by a clinical

	consultant require submission of at least the past 6 months of progress notes from the prescribing provider, results of a baseline fasting lipid profile and fasting glucose, BMI%tile and notation of any evidence-based behavioral therapy that the participant is or will be participating in.
MS	Electronic PA age edits, quantity limits for all beneficiaries, diagnosis edit for adults and polypharmacy edit for children.
MT	We require atypicals to be prescribed by a psychiatrist for those under six. We provide pharmacy case management for foster children
NC	In April 2011, the N.C. Division of Medical Assistance partnered Community Care of North Carolina to implement a registry to document the use of anti-psychotic therapy in N.C. Medicaid and N.C. Health Choice beneficiaries ages 0 through 17. A+KIDS was created due to well-documented safety concerns and limited information about the efficacy of using anti-psychotic agents in children. A+KIDS encourages the use of appropriate baseline and follow-up monitoring parameters to facilitate the safe and effective use of anti-psychotics in this population.
NE	Minimum age limits, quantity limits, daily dose limits and a review by a board-certified child and adolescent psychiatrist is required for requests outside of these limits.
NV	Children 7-17 are allowed one drug from each class (antidepressant, antianxiety, antipsychotic, anticonvulsant) without PA up to three medications total. The fourth needs PA.
NY	DUR Board recommended drug-specific minimum age parameters have been established. (Automatic bypass for established therapy.). Fee for service diagnosis parameters for second-generation antipsychotics in the pediatric population. Diagnosis requirement for the initial prescription for patients between minimum age (as defined by the DURB for the FFS population) and 18 years of age. (Automatic bypass for established therapy.). Prescriber involvement required for utilization of 3 or more different oral SGAs for greater than 180 days.
OH	Retrospective review of claims
OK	Educational mailings to prescribers of psychotropic drugs used in children particularly when prescribers deviate from evidence based norms in patient population.
OR	Review all children in Foster Care annually and when there are changes to their prescribed medications.
PA	A prescription for either a preferred or non-preferred Antipsychotic regardless of quantity limit when prescribed for a child under 18 years of age requires prior authorization.
RI	HID has specific RDUR criteria that identifies use of psychotropic drugs and stimulants in children. Criteria is monitered monthly. If a reveiwer identifies an issue a letter is sent to the prescriber.
SC	For children < 6- Pyschosocial treatment in place, Psych prescriber or MD in consult with Psych, developmentally appropriate psych assessment with diagnosis and treatment plans in place, one antipsychotic (exception-tapering while titrating, informed consent
SD	Child Protective Services
TN	All antipsychotics require prior authorization, with specific clinical criteria for each product to be met to qualify for use.
TX	"Vendor Drug does not have antipsychotic monitoring program. The antipsychotics claims for the fee-for-service (FFS) Medicaid clients are subject to a clinical edit as well as an annual retrospective DUR intervention. The clinical edit criteria and the retro-DUR are applied to all ages. The clinical edit checks for age appropriateness, denies the use of antipsychotics as monotherapy for treatment of insomnia or major depressive disorder, and it denies the concomitant use of more than two different antipsychotics. The MCOs are required to follow the same antipsychotics clinical edit criteria approved and implemented by the HHSC Vendor Drug Program. The HHSC requires the MCOs to perform Psychotropic Medication Utilization Review (PMUR). The MCOs must do a retrospective assessment of prescribing patterns for psychotropic medications to help identify Medicaid beneficiaries under the age of 18 whose psychotropic medication utilization fall outside of the following minimum parameters.
VA	Service authorizations are required for the use of antipsychotics in children under the age of 18.
VT	a) PA process for all antipsychotics for children b) 18 years or less PA for diagnosis and max daily dose c) less than 5 years of age PA is reviewed by Medical Director. d) Non-specialists have access to Psychiatrists at University of Vermont for psychiatric consultation
WA	The agency maintains dose limits stratified by patient age, limitations against ongoing duplication, and polypharmacy. These limits have been recommended by a Pediatric Mental Health Workgroup and approved by the DUR Board. Exceeding any of these review thresholds triggers a required consultation through our Second Opinion Network program, in which pediatric psychiatrists engage in a one-on-one consultation with the prescriber.
WI	Wisconsin monitors the use of antipsychotic drugs in young children through prior authorization (PA). The PA process is intended to scrutinize the prescribing of antipsychotic drugs for mood disorders and the monitoring of metabolic effects of this class of drugs. Child psychiatrists who are contracted with the state perform peer to peer outreach when needed.
WV	A PA is required for all children < 18 years of age.
WY	Age and dosage limits are set in the claims system as appropriate. Polypharmacy may be reviewed by child psychiatrists under contract with Seattle Children's Hospital.

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

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

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

State	Explanation
AL	Children are monitored under current program.
GA	Already have a program in place; plan on continuing current program.
HI	FFS is not in need of one because other programs cover and monitor antipsychotropic drugs for children (DOH CAMHD and Medicaid managed care plans).
NJ	There are guidelines provided by the New Jersey Department of Children and Families for the use of psychotropic medications in children.
NM	A DUR intervention was delivered to identify children who require metabolic monitoring of atypical antipsychotics on 3/27/18 identifying children in 2017.
UT	Utah Medicaid has focused on other issues in FY 2017, but may explore antipsychotic drug use in children in the future.
VA	Already implemented.
WI	The State of Wisconsin already has a program in place to monitor the appropriate use of antipsychotic drugs in children.
WY	N\A

VIII-G2. STIMULANTS

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

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

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

Answer	State	Number of States (Percentage of 48 states)
children	SC	1 (2%)
adults	DE, GA, IA, NJ, NM, RI	6 (13%)
both	AK, AL, AR, CA, CO, CT, DC, FL, HI, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, ND, NE, NH, NV, NY, OH, OK, OR, PA, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	41 (85%)

b) Please briefly explain your program.

State	Explanation
AK	Quantity limits are established.
AL	Stimulants are included in the Preferred Drug List (PDL) and have maximum quantity limits.
AR	All requests for a stimulant for an adult require a manual review prior authorization and prescriber must submit chart notes, test results, and letter explaining medical necessity of receiving the stimulant. All C-III stimulants require manual review prior authorization for any request. All C-II stimulants have dose and quantity edits on each strength drug. C-II stimulants are part of the PDL so there are "preferred" agents, however all PA criteria still apply to the preferred agents. C-II stimulants have criteria algorithms for the preferred agents that will allow 1 dose or unit of a short-acting agent as a "booster" dose for concurrent therapy with one long-acting agent.
CA	The use of stimulants for Medi-Cal beneficiaries is restricted to use in Attention Deficit Disorder in individuals from 4 years through 16 years of age only. Any use outside of these restrictions requires an approved Treatment Authorization Request.
CO	Stimulants are managed on the PDL. Addtionally, there is RDUR monitoring and provider letters are sent. Complex cases are referred to child and adolescent psychiatry telephone consult service.
CT	HID performs 1,000 RetroDUR reviews for the adult and pediatric populations each month and the majority of the criteria used to review the pediatric population have to do with mental health drugs, including stimulants. An additional program exists and is administered by the Department of Children and Families for children in foster care only. The Psychotropic Medication Advisory Committee (PMAC) oversee the use of psychotropic medications in the foster care population and have specific edits, maximum doses, monitoring guidelines, etc. associated with prescribing of these medications. Some of the criteria used for the pediatric RetroDUR program have been adopted from the PMAC criteria. Additionally, stimulant use is also reviewed during the monthly RetroDUR adult reviews.
DC	Clinical criteria is applied to the entire class of ant-hyperkinesis drugs. Prior authorization is required to determine appropriate prescribing for beneficiary age, diagnosis and concomitant drug use.
DE	Adults are required to try and fail a long acting agent with less abuse potential before another agent will be considered.
FL	High dose limitation are placed on all stimulants. A close prior authorization review is preformed on all children less than six.
GA	Stimulant use in adult population requires prior authorization.
HI	ICD-10 and age requirement are drug specific.
IA	Require PA for members 21 years of age and older. Documentation diagnosis of ADHD meets the DSM-V criteria and is confirmed by a standardized rating scale. Symptoms must have been present before 12 years of age and there must be a clear evidence of clinically significant impairment in two or more environments (social, academic, or occupational). Prescriber must also review the patient's use of controlled substances on the Iowa PMP website and document the date reviewed on the PA form.
ID	All products have age and Quantity Limits. Adults must have documented diagnosis of ADHD and any Adults with any substance abuse diagnosis can not receive medication.
IL	All attention deficit hyperactivity medications (ADHD) in children less than 6 years of age require a special prior authorization request form. Medications for ADHD are allowed for clients who are 6 through 18 years of age. Adults (19 years and older) require prior authorization for ADHD medications. Implemented a pilot program with IL Medicaid DocAssist to address stimulant use in younger children. Child psychiatrists from Docassist reviewed

	specific cases and discussed cases with prescriber. Pharmacy will evaluate benefit of expanding to wider age groups.
IN	Stimulants require prior authorization when used in duplication or when a drug-specific quantity limit has been exceeded.
KS	We have stimulant PA criteria and dosing limits for both children and adults.
KY	A diagnosis-driven prior authorization is required on all stimulants. There are also max dose per day edits and therapeutic duplication edits (not more than one (1) long acting agent).
LA	Stimulants are reviewed in the retrospective DUR program for stimulant-induced insomnia and use in young children. Prospective edits include duplication of therapy with stimulants and with narcolepsy agents, diagnosis requirement, and clinical preauthorization for young children.
MA	Behavioral health medication polypharmacy: pharmacy claims for 4 or more behavioral health medications (i.e., alpha2 agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines, buspirone, cerebral stimulants, hypnotics, and mood stabilizers) filled within a 60-day period Cerebral stimulant polypharmacy: overlapping pharmacy claims for 2 or more cerebral stimulants (immediate-release and extended-release formulations of the same chemical entity are counted as one) for a 60 days within a 90 day period
ME	manage daily dosing requirements
MI	Prior authorization required for members over the age of 18 years and under the age of 6 years.
MN	MN has quantity limits in place.
MO	Under 6 years old requires prior authorization. 6 to 18 years old requires appropriate diagnosis on file and within approved dosage limitations for it to approve transparently. Greater than 18 years of age requires prior authorization.
MS	Electronic PA age edits and quantity limits for all beneficiaries and diagnosis edit for adults.
MT	We use SmartPA to prevent overuse
ND	First fill limitation (14 days initial supply), only one long acting and one short acting allowed concurrently and they must be the same molecule (e.g. they can't be on dexmethylphenidate extended release and methylphenidate immediate release concurrently), FDA max doses and age limits.
NE	Non-preferred drugs require review for compliance and doses are monitored. Edits are in place to prevent use of more than one stimulant and high doses in children.
NH	Stimulants require a prior authorization for all adults and is required for children for non-preferred medications only.
NJ	A PA is required to obtain a diagnosis from the prescriber for clinical criteria and medical necessity evaluation.
NM	Stimulants require prior authorization for those 18 years of age or older.
NV	PA criteria for both adults and children established by the DUR Board.
NY	Quantity limits for patients less than 18 years of age include: Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration); Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 90 days. Concerta 36mg not to exceed 2 units daily. Quantity limits for patients 18 years of age and older include: Short-acting CNS stimulants: not to exceed 3 dosage units daily with maximum of 30 days; Long-acting CNS stimulants: not to exceed 1 dosage unit daily with maximum of 30 days. Concerta 36mg not to exceed 2 units daily. For patients 18 years of age and older: a 90-day supply may be obtained with confirmation of FDA approved, Compendia supported or Medicaid covered diagnosis.
OH	Quantity limits on stimulants
OK	Under Age of 5 requires a psychiatrist consult, over age 21 must fill out Prior Authorization. Quantity limits in placed based on FDA approved dosing.
OR	Doses exceeding quantity limits require prior authorization and prescribing by a specialist
PA	A prescription for a preferred or non-preferred Stimulant and Related Agent for a recipient under 4 years of age or for a recipient 18 years of age or older requires prior authorization.
RI	Prior authorization program.
SC	many medications are not approved for children < 6, polypharmacy/duplication of therapy is also assessed
SD	Quantity Limits
TN	PA required for all adults, and PA required for children under the age of 21 for stimulants over 70 mg per day.
TX	HHSC has a clinical prior authorization (PA) for all stimulants and non-stimulants used for treatment of ADD/ADHD. The PA criteria screen for age limit, ADD/ADHD diagnosis codes for adults, concomitant use of two short acting or two long acting products, and a history of drug abuse. The edit criteria information is shared with the managed care organizations (MCOs). The MCOs may choose to implement in full or a less stringent version of these criteria.
UT	Utah has PA criteria for off-label use in children, and for any use in adults.
VA	Each product will require a service authorization if the age is outside of the FDA/Package Insert age. May approve if patient has been evaluated by a specialist (i.e. psychiatrist, neurologist, developmental/behavioral pediatrician, or pediatrician). If patient is over 18 years old then the patient must have a confirmed diagnosis of ADHD/ADD or other FDA approved indication. Managed by P&T Committee criteria.
VT	Certain Stimulants require PA and/or quantity limits
WA	Program for children is the same as described for antipsychotics above. Adults have maximum dose limits as well as expedited authorization requirements for validation of diagnosis.

WI	Wisconsin has both documented restrictions and special programs to monitor, manage or control the use of stimulants. These include: diagnosis restrictions- allowed diagnoses are ADHD and narcolepsy; Prior authorization-required for non-preferred stimulants on the Preferred Drug List; System edits for early refill that can be overridden in certain circumstances by calling a specialized pharmacy call center. Children's Mental Health work group has focused on stimulant use; Interventions have included several targeted mailings to prescribers as well as peer to peer outreach from consultant child psychiatrists.
WV	A PA is required for adults eighteen (18) years of age or older. Requests for IR + ER combination therapy must be for the same active ingredient in the same salt form, if available. Non-preferred agents require a thirty (30) day trial of at least one preferred agent in the same subclass and with a similar duration of effect, unless one (1) of the exceptions on the PA form is present. NOTE: Non-preferred agents will NOT be "grandfathered" for adults. Children under the age of 18 may continue their current therapy until the end of the school year after which they will be required to switch to a preferred agent.
WY	Children under age 18 have dosage limits applied in the claims system. Adults over age 18 must meet DSM-V critieria for ADHD in addition to dosage limits.

IX. INNOVATIVE PRACTICES

The 39 states listed below have initiated innovative practices during the past year. A description of their innovative practice can be found in Attachment 6 of the individual state report: Drug Utilization Review Annual Report | Medicaid.gov

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

X. E-PRESCRIBING

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

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

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

Answer	State	Number of States (Percentage of 24 states)
Yes	AR, CT, DE, FL, MI, MO, NM, TX	8 (33%)
No	AL, GA, IA, ID, IN, KS, LA, ME, MN, MS, MT, NH, OK, UT, WV, WY	16 (67%)

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

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

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

Answer	State	Number of States (Percentage of 26 states)
Yes	CO, DC, MA, MD, ND, NJ, NV, SD, TN, VA, VT, WA	12 (46%)
No	AK, CA, HI, IL, KY, NC, NE, NY, OH, OR, PA, RI, SC, WI	14 (54%)

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

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

XI. MANAGED CARE ORGANIZATIONS (MCOs)

XI-1. Does your state have MCOs?

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

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

Answer	State	Number of States (Percentage of 38 states)
Yes	DE, HI, IL, KS, KY, LA, MA, MN, ND, NE, NJ, NM, NV, NY, OH, PA, VA	17 (45%)
No	CO, GA, MO, TN, WV	5 (13%)
Partial	CA, DC, FL, IA, IN, MD, MI, MS, NH, OR, RI, SC, TX, UT, WA, WI	16 (42%)

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

State	Explanation
CA	Selected HIV/AIDS/Hepatitis B treatment drugs; Selected alcohol and heroin detoxification and dependency treatment drugs; Selected coagulation factors; and Selected drugs used to treat psychiatric conditions (including antipsychotics and MAO inhibitors)
DC	HIV antiretrovirals
FL	Hemophilia, Spinraza and Exondys
IA	ANTIHEMOPHILIA FACTOR AGENTS
IN	Healthy Indiana Plan (HIP) 2.0, Hoosier Healthwise, and Hoosier Care Connect (HCC) are carved-in. Fee-for-service members are carved-out.
MD	During FFY2017, antiretrovirals for the treatment of HIV/AIDS, mental health medications and substance use disorder products were carved out of the MCO benefit and paid FFS.
MI	Mental health drugs, substance abuse treatment, hemophilia drugs, HIV, hepatitis C and drugs for rare metabolic diseases.
MS	Beneficiaries diagnosed with hemophilia are carved out and enrolled in FFS. A Member must be disenrolled from the Contractor (MCO) and enrolled in FFS if the Member is diagnosed with hemophilia. The category of hemophilia products are not included in the MCO capitation rate.
NH	Medications to treat Hepatitis C and Hemophilia, also Carbiglu and Ravicti.
OR	Mental Health Drugs are carved out to FFS
RI	Stop loss arrangement for Hepatitis C drugs.
SC	HCV
TX	For the FFY 2017, direct acting Hepatitis C treatment agents and Orkambi for treatment of Cystic Fibrosis were carved out.
UT	Benzodiazepines, buprenorphine, buprenorphine/naloxone combination products, and those used to treat epilepsy, psychosis, ADD, ADHD, organ transplant, and hemophilia.
WA	Hemophillia factor product for maintenance use in outpatient setting, HCV treatment, dental prescriptiongs, prescriptions written in locations where clients are allowed to self refer out of network (such as Family Planning clinics and the health department).
WI	Managed Care Organizations carve-out drugs and provider-administered drugs in Wisconsin by specific program. In FFY 2017 the carve-out program was FamilyCare. FamilyCare is a long-term care program which helps frail elders and adults with disabilities get the services they need to remain in their homes.

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

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

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

Answer	State	Number of States (Percentage of 20 states)
Formulary Reviews	CA, DC, DE, FL, IL, KS, MD, MI, NE, NJ, NY, OH, PA, TX, UT, WA	16 (80%)
same PDL	DE, FL, IA, KS, MS, NE, TX, UT, WV	9 (45%)
same RetroDUR	CO, FL, IA, UT	4 (20%)
same ProDUR	FL, IA, KS, MS, UT	5 (25%)

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

State	Explanation
CA	"Medi-Cal MCOs are required to provide a pharmacy benefit that is comparable to the Medi-Cal FFS pharmacy program and their preferred drug lists (PDLs) are required to be comparable to the Medi-Cal List of Contract Drugs. While all drugs included on the Medi-Cal List of Contract Drugs do not need to be included on the MCOs' PDLs, comparable means that the drugs on the PDLs must have the same mechanism of action sub-class within all major therapeutic categories of drugs included in the Medi-Cal List of Contract Drugs.
CO	Starting 07/01/2017 the State began requiring reporting of certain RDUR activities for MCO pharmacy benefit
DC	At contract initiation and with any formualry changes, MCOs must submit additions/deletions to District for review and approval.
DE	MCOs must follow the State Medicaid PDL to a 95% compliance rate
FL	MCO plans criteria, edits, etc. cannot be more restrictive than the Agency.
IA	MCO Pharmacy representatives are required to attend meetings of the DUR and P&T Committee. One MCO representative is a non-voting member of the DUR as of August 2017.
IL	MCO shall provide coverage of drugs in all classes of drugs for which the Department's FFS program provides coverage.
KS	The State determines the PDL and PAs to present to the DUR Board. The MCOs can request proposals, but the State makes the final decisions.
MD	A comprehensive drug use management program has been in place for several years which evaluates each MCO drug benefits, including: P&T Committee management and procedure, formulary content/management, prior authorizaiton procedures and criteria, generic substitution, drug utilization review and disease management programs. A review and assessment of each MCO Drug Utilization Management Program is conducted annually.
MI	The MCO contract requires that the plan's formulary include coverage available for all outpatient covered drugs identified on the Fee-For-Service Michigan Pharmaceutical Product List and also that plan's can be no more restrictive than the Department's approved MCO Common Formulary.
MS	MCOs have been required to reimburse at same amount or higher than FFS. As of January 2015, MCOs were required to use Universal Preferred Drug List and same clinical criteria.

NE	The MCOs must provide coverage for all therapeutic classes of drugs covered by the Nebraska Medicaid pharmacy benefit. The MCOs must cover medications that meet the definition of outpatient pharmacy services eligible for Medicaid coverage as defined under Section 1927 of the Social Security Act. The MCOs must follow the Nebraska Medicaid PDL. Preferred drugs must be adjudicated as payable without prior authorization, unless they are subject to clinical or utilization edits, as defined by MLTC. The PDL is subject to change on an ongoing basis. The MCOs must submit all proposed formulary changes, excluding formulary expansion changes, to MLTC for review and written approval prior to the implementation of such changes. The MCOs may utilize prior authorizations and additional edits for psychotropic drugs prescribed to youth, at a minimum, following MLTC guidelines as provided. If appropriate, the MCOs must ensure a review of the prior authorization request by a State-licensed child and adolescent psychiatrist. The MCOs must develop and maintain DUR programs, including prospective and retrospective DUR programs. The guidelines for these programs must be submitted to MLTC for review and approval a minimum of 60 calendar days prior to the contract's start date or intended implementation of any changes. The MCOs must: i. Establish and maintain retrospective DUR exception criteria. ii. Conduct drug criteria analysis and generate and review member and provider profiles. iii. Develop a case tracking system and project reports. iv. Implement prescriber and pharmacy educational intervention program. v. Conduct prescriber and pharmacy assessment/evaluation of educational intervention program. vi. Submit an analysis of cost outcomes and an evaluation of the effectiveness of the prescriber and pharmacy educational interventions to members, prescribers, and pharmacies. vii. Use results of reviews to inform MTM education and outreach needs. viii. Perform, at a minimum, one (1) retrospective DUR intervention each quarter of the contract year. ix. Submit quarterly to MLTC the documentation needed to support preparation of MLTC's annual CMS DUR report. b. The MCOs shall nominate a non-voting staff member to attend the Nebraska Drug Utilization Review Board meetings, which occur six (6) times a year, for the term of this contract. The MCOs shall obtain MLTC's written approval of the nominee.
NJ	MCOs contractually required to comply with NJ DURB standards
NY	Plans establish their own formularies and prior authorization processes. Plan formularies must include all categories of prescription drugs on the NYS Medicaid fee-for-service list of reimbursable drugs.
OH	70% agreement on PDL
PA	The requirements for the outpatient drug services provided by the Medicaid MCOs are defined in Exhibit BBB of the HealthChoices Agreement. The amount, duration, and scope of covered outpatient drugs must be consistent with coverage under the Fee-For-Service Program. The Department reviews and approves all MCO formularies, prior authorization policies and drug utilization management programs prior to implementation.
TX	Managed Care Organizations must follow the Texas Formulary and Preferred Drug List. Under Texas Government Code § 533.005 (a)(23)(D)(i), the MCO may not negotiate rebates with drug companies for pharmaceutical products. HHSC or its designee will negotiate rebate agreements. The MCO's DUR program must comply with 42 U.S.C. Â§ 1396r-8 and 42 C.F.R. part 456, subpart K. There are a few pro-DUR PA criteria that the MCOs are required to follow the same as the DUR Board approved and HHSC implemented. For all the other clinical prior authorization criteria, the MCOs may choose to implement as approved by the DUR Board or a less stringent criteria version.
UT	same or less restrictive PDL and DUR
WA	The state selectively limits the pharmacy benefit. Review and approval by the state of all MCO formularies is required, according to standards of adequacy set out in contract. Generally MCOs are allowed to manage their own formularies after approval, but the state does dictate coverage in some specific areas to ensure consistent quality of care to clients. Currently the state is proscriptive with the plans in coverage criteria for antipsychotics and medication assisted SUD treatments.
WV	Pharmacy has been carved out, so all MCO members must follow our criteria.

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

Answer	State	Number of States (Percentage of 18 states)
Yes	LA, MA, MN, ND, NV, VA	6 (33%)
No	GA, HI, IN, KY, MO, NH, NM, OR, RI, SC, TN, WI	12 (67%)

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

Answer	State	Number of States (Percentage of 38 states)
Yes	CA, CO, DC, DE, HI, IA, KS, LA, MD, MI, NE, PA, TX, UT	14 (37%)
No	FL, GA, IL, IN, KY, MA, MN, MO, MS, ND, NH, NJ, NM, NV, NY, OH, OR, RI, SC, TN, VA, WA, WI, WV	24 (63%)

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

State	Explanation
CA	MCOs are required to submit Policies and Procedures for DUR and treatment outcomes system to optimize the quality of pharmacy services. The DUR review includes: -Range and type of drugs taken by members -General drug utilization patterns of the plan -List of pharmacy interventions for Quality Improvement Projects (e.g., Asthma, Diabetes, HTN, etc.) -DUR alert/edit program to detect drug-drug interactions, high dose alert, etc., in order to alert dispensing pharmacy -Pharmacy service and drug utilization encounter data, including all pharmacy claims, which are provided to the state on a monthly basis
CO	Starting 07/01/2017 the MCOs implemented processes to begin reporting certain RDUR activities to the State.
DC	MCO Pharmacy Directors will be invited to participate in quarterly DUR Board meetings to report on DUR activities and targeted program statistics beginning in FY18 under the new MCO contracts.
DE	The MCOs report their activities as part of their state specific P & T meetings. There is also an exchange of informal reports.
HI	The review process is in development: 1. data from template will be general retroDUR and comparison across managed care plans. 2. subjective DUR examples will be basis for best practices and basic guidelines.
IA	MCOs submit their DUR activities to the state on a quarterly basis which are reviewed by the state and DUR Coordinator.
KS	The MCOs submit monthly reports regarding PDL and DUR activities. In addition the MCOs present an annual report to the DUR Board.
LA	We have a monthly report that addresses DUR activities initiated by MCOs.
MD	Through the annual MCO Drug Utilization Management assessment, each MCO is required to report all DUR policies and procedures as well as specific documents related to oversight of the drug use evaluation process and maintenance of patient confidentiality. The assessment also requires reporting of types of prospective and retrospective programs, including any program specifically related to the use of controlled substances by participants.
MI	MCOs are contractually required to provide details about their DUR activities upon request and starting FY2018 MCOs must report in accordance with new Federal requirements
NE	Monthly reports are filed with the state and the MCOs report at the DUR Board meetings.
PA	The MCOs are required to submit an annual DUR Report to the Department.
TX	The MCOs report on the number and the nature of their retro-DUR activities. They are not required to report on the financial outcomes of those activities. For the pro-DUR activities (clinical prior authorizations), the MCOs submit their requests to the Vendor Drug Program for consideration of DUR Board review. All clinical prior authorizations approval before implementing a retro-DUR intervention. They are required to report on which clinical prior authorizations they've implemented, the impact of those clinical PA's on claims, and a breakdown of prior authorization requests, denials, and appeals.
UT	Each MCO completes this survey, which is then attached to the Fee For Service survey (which you are currently reading) as Appendix 2

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

Answer	State	Number of States (Percentage of 24 states)
Yes	FL, IL, KY, MA, MN, MS, ND, NH, NJ, NM, NV, NY, OH, OR, RI, SC, VA, WA, WI	19 (79%)
No	GA, IN, MO, TN, WV	5 (21%)

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

State	Explanation
GA	The State does not plan to develop a program requiring MCOs to report their DUR activities in the future. The MCOs operate independently and report their DUR activities in ways they see fit without intervention from the State.
IN	The office continues to evaluate the effectiveness of this type of reporting.
MO	Our MCOs do not provide pharmacy benefits at this time.
TN	TennCare is 100% managed care, but pharmacy is totally carved out for covered outpatient drugs. The MCO does not pay for any Covered Outpatient Drugs for Tennessee Medicaid enrollees.
WV	MCOs no longer manage the pharmacy benefit in WV.

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

Answer	State	Number of States (Percentage of 38 states)
Yes	CO, DC, DE, GA, HI, IA, IL, IN, KS, KY, LA, MA, MD, MI, MN, MO, MS, ND, NE, NH, NJ, NM, NV, NY, OH, OR, PA, RI, SC, TX, UT, VA, WA, WV	34 (89%)
No	CA, FL, TN, WI	4 (11%)

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

State	Explanation
CA	Some of the MCOs have Lock In programs, however not all of the MCOs have verified programs.
FL	Plans have the flexibility to have a pharmacy Lock In program.
TN	TennCare is 100% managed care, but pharmacy is totally carved out for covered outpatient drugs. The MCO does not pay for any Covered Outpatient Drugs for Tennessee Medicaid enrollees.
WI	The FamilyCare Partnership contract does not establish requirements for a Lock-In or CMC program.

Unlike previous years, we are unable to post the individual state reports on Medicaid.gov. If you have any question regarding an individual state report or for detailed state information, please direct your inquiries to the respective state Medicaid pharmacy directors.