## ABOUT THE SURVEY

42 CFR 438.3(s)(4) and (5) require that each Medicaid managed care organization (MCO) must operate a drug utilization review (DUR) program that complies with the requirements described in Section 1927 (g) of the Social Security Act (the Act) and submit an annual report on the operation of its DUR program activities. Such reports are to include: descriptions of the nature and scope of the prospective and retrospective DUR programs; a summary of the interventions used in retrospective DUR and an assessment of the education program; a description of DUR Board activities; and an assessment of the DUR program's impact on quality of care.

Note: Covered Outpatient Drugs (COD) are referenced throughout this survey and refers to participating labelers in the Medicaid Drug Rebate Program (MDRP).

This report covers the period October 1, 2019 to September 30, 2020. Answering the attached questions and returning the requested materials as attachments to the report will constitute compliance with the above-mentioned statutory and regulatory requirements.

If you have any questions regarding the DUR Annual Report, please contact your state's Medicaid Pharmacy Program.

**IMPORTANT NOTE:** Adobe Acrobat Reader must be used to edit the survey. The MCO survey cannot be edited within a browser window.

Pursuant to 42 C.F.R. Subpart A, Section § 438.3 (s), Medicaid managed care programs must submit to CMS an annual report on the operation of its DUR program activities for that Federal Fiscal Year (FFY). Beginning with FFY 2020 surveys, individual managed care plan's survey results will be published online and will be publically available similar to the FFS surveys which have been published on *Medicaid.gov* since 2010. **Please confirm and acknowledge there is no proprietary or confidential information submitted in this report by checking the box below:**

- o I confirm I am aware this survey will be posted online. Confidential and proprietary information has been removed from this survey.

**PRA DISCLOSURE STATEMENT (CMS-R-153)**

This mandatory information collection (section 4401 of the Omnibus Budget Reconciliation Act of 1990 and section 1927(g) of the Social Security Act) is necessary to establish patient profiles in pharmacies, identify problems in prescribing and/or dispensing, determine each program's ability to meet minimum standards required for Federal financial participation, and ensure quality pharmaceutical care for Medicaid patients. State Medicaid agencies that have prescription drug programs are required to perform prospective and retrospective DUR in order to identify aberrations in prescribing, dispensing and/or patient behavior. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this information collection request is 0938-0659 (Expires: 11/30/2022). Public burden for all of the collection of information requirements under this control number is estimated at 64 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## I. DEMOGRAPHIC INFORMATION

**State Abbreviation:** _____

**MCO Name**: _____

**Please Note: Name above must match name entered in Medicaid Drug Program (MDP) DUR system**

**Program Type (See Appendix A)**: _____

If "Other", please specify.

_____

### Medicaid MCO Information

Identify the MCO person responsible for DUR Annual Report Preparation.

First Name: _____

Last Name: _____

Email Address: _____

Area Code/Phone Number: _____

On average, how many Medicaid beneficiaries are enrolled monthly in your MCO for this Federal Fiscal Year?

_____ Beneficiaries

## II. PROSPECTIVE DUR (ProDUR)

1. Indicate the type of your pharmacy point of service (POS) vendor and identify it by name.

   ○ State-operated
   ○ Contractor, please identify by name.

   _____

   ○ Other organization, please identify by name.

   _____

2. Identify ProDUR table driven criteria source. This would be initial ratings such as drug to drug interactions, dose limits based on age and pregnancy severity.

   - ○ First Data Bank
   - ○ Medi-Span
   - ○ MICROMEDEX
   - ○ Other, please specify.

   _____

   _____

3. When the pharmacist receives a ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "National Council for Prescription Drug Program (NCPDP) drug use evaluation codes" (reason for service, professional service and resolution)?

   - ○ Yes
   - ○ Varies by Alert Type
   - ○ No

   If "Yes" or "Varies by Alert Type", check **all** that apply.

   - ○ Alerts can be overridden ahead of time
   - ○ Alerts can be overridden with standard professional codes
   - ○ Alerts need prior authorization to be overridden.
   - ○ Other, please explain.

   _____

   _____

   _____

4. Do you receive periodic reports providing individual pharmacy provider DUR alert override activity in summary and/or in detail?

   - ○ Yes

   a. How often?
      - ○ Monthly

- ○ Quarterly
- ○ Annually
- ○ Ad hoc (on request)
- ○ Other, please explain.

_____

_____

_____

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

- ○ Yes

  By what method do you follow up?

  - ○ Contact Pharmacy
  - ○ Refer to Program Integrity (PI) for Review
  - ○ Other, please explain.

  _____

  _____

  _____

- ○ No

- ○ No, please explain.

_____

_____

_____

5. Early Refill

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

i. Non-controlled drugs:

_____ %

ii. Schedule II controlled drugs:

_____ %

iii. Schedule III through V controlled drugs:

_____ %

b. For non-controlled drugs:

When an early refill message occurs, does your MCO require prior authorization (PA)?

- ○ Yes
- ○ No
- ○ Dependent on the medication or situation

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

- ○ Pharmacist
- ○ Prescriber
- ○ Pharmacist or Prescriber

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

- ○ Yes
- ○ No

c. For controlled drugs:

When an early refill message occurs, does your MCO require PA?

- ○ Yes
- ○ No

If "Yes", who obtains authorization?

- ○ Pharmacist
- ○ Prescriber
- ○ Pharmacist or Prescriber

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

- ○ Yes
- ○ No

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

   a. Lost/stolen Rx

      - ○ Yes
      - ○ No
      - ○ Overrides are only allowed by a pharmacist through a PA

   b. Vacation

      - ○ Yes
      - ○ No
      - ○ Overrides are only allowed by a pharmacist through a PA

   c. Other, please explain.

      _____

      _____

      _____

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

   - ○ Yes
   - ○ No

   If "Yes", please explain your edits.

   _____

   _____

   _____

If "No", do you plan to implement this edit?

- ○ Yes
- ○ No

8. Does the MCO have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?

   - ○ Yes
   - ○ No

9. For drugs not on your MCO's Preferred Drug List (PDL), does your MCO have a documented process (i.e. PA) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?

   - ○ Yes

     Please check **all** that apply.

     - ○ Automatic PA based on diagnosis codes or systematic review
     - ○ Trial and failure of first or second line therapies
     - ○ Pharmacist or technician reviews
     - ○ Direct involvement with Pharmacy and/or Medical Director
     - ○ Other, please explain.

       _____

       _____

       _____

   - ○ No, please explain.

     _____

     _____

     _____

     a. How does your MCO ensure PA criteria is no more restrictive than the FFS criteria and review? Please describe the process.

_____

_____

_____

b. Does your program provide for the dispensing of at least a 72-hour supply of CODs in an emergency situation?

- ○ Yes, please check **all** that apply.
  - ○ Real time automated process
  - ○ Retrospective prior authorization
  - ○ Other process, please explain.

_____

_____

_____

- ○ No, please explain.

_____

_____

_____

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

Column 1 – Top 10 PA Requests by Drug Name, report at generic ingredient level (*See Appendix B for the list of Drug Names*)
Column 2 – Top 10 PA Requests by Drug Class (*See Appendix C for Drug Class names*)
Column 3 – Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD), and Age Edits (AE) (*See Appendix D for the list of Denial Reasons*)
Column 4 – Top 10 Drug Names by Amount Paid, report at generic ingredient level (*See Appendix B for the list of Drug Names*)
Column 5 – From Data in column 4, determine the Percentage of Total Drug Spend
Column 6 – Top 10 Drug Names by Claim Count, report at generic ingredient level (*See Appendix B for the list of Drug Names*)
Column 7 – From Data in Column 6, determine the Percentage of Total Claim

## Table 1: Top Drug Claims Data Reviewed by the DUR Board

| Column 1<br>**Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level** | Column 2<br>**Top 10 Prior Authorization (PA) Requests by Drug Class** | Column 3<br>**Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications, Age Edits)** | Column 4<br>**Top 10 Drug Names by Amount Paid, report at generic ingredient level** | Column 5<br>**% of Total Spent for Drugs by Amount Paid (From data in Column 4, Determine the % of total drug spend)** | Column 6<br>**Top 10 Drug Names by Claim Count, report at generic ingredient level** | Column 7<br>**Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)** |
|---|---|---|---|---|---|---|
| | | | | % | | % |
| | | | | % | | % |
| | | | | % | | % |
| | | | | % | | % |
| | | | | % | | % |
| | | | | % | | % |
| | | | | % | | % |
| | | | | % | | % |
| | | | | % | | % |

## III. RETROSPECTIVE DUR (RetroDUR)

1. Please indicate how your MCO operates and oversees RetroDUR reviews?

   - ○ State-operated interventions
   - ○ Managed Care executes its own RetroDUR activities
   - ○ Pharmacy Benefit Manager (PBM) performs RetroDUR activities
   - ○ Combination of MCO RetroDUR interventions and state interventions are performed
   - ○ Other, please explain.

   _____

   _____

   _____

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

   - ○ Company
   - ○ Academic Institution
   - ○ Other Institution

   a. Identify, by name, your RetroDUR vendor.

   _____

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

   i. Yes, please explain.

   _____

   _____

   _____

   ii. No, please explain.

_____

_____

_____

c. Do you customize your RetroDUR vender criteria?
   - ○ Yes
   - ○ No
   - ○ Ad hoc based on state-specific needs

3. Who reviews and approves the RetroDUR criteria?

- ○ State DUR Board
- ○ MCO DUR Board
- ○ PBM performs RetroDUR and has a RetroDUR Board
- ○ PBM Pharmacy and Therapeutics (P&T) Board also functions as a DUR Board
- ○ State Pharmacy Director
- ○ Other, please explain.

_____

_____

_____

4. How often does your MCO perform retrospective practitioner based education?

- ○ Monthly
- ○ Bi-monthly
- ○ Quarterly
- ○ Other, please specify: _____

a. How often do you perform retrospective reviews that involves communication of client specific information to healthcare practitioner (through messaging, fax, or mail)? Check **all** that apply.

   - ○ Monthly
   - ○ Bi-monthly
   - ○ Quarterly

○ Other, please specify: _____

b. What is the preferred mode of communication when performing RetroDUR initiatives (check all that apply)?

○ Mailed letters
○ Provider phone calls
○ Near real time fax
○ Near real time messaging
○ Other new technologies such as apps or Quick Response (QR) codes
○ Focused workshops, case management or WebEx training
○ Newsletters or other non-direct provider communications
○ Other, please specify:

_____

_____

5. **Summary 1: RetroDUR Educational Outreach**

Summary 1: RetroDUR Educational Outreach is a year-end summary report on RetroDUR screening and educational interventions. The summary should be limited to the most prominent problems with the largest number of exceptions. The results of retrospective DUR screening and interventions should be included and detailed below.

_____

_____

_____

_____

_____

_____

## IV. DUR BOARD ACTIVITY

1. Does your MCO utilize the same DUR Board as the state Fee-For-Service (FFS) Medicaid Program or does your MCO have its own DUR Board?

○ Same DUR Board as FFS agency

- ○ MCO has its own DUR Board
- ○ Other, please explain.

_____

_____

_____

2. **Summary 2: DUR Board Activities Report**

Summary 2: DUR Board Activities Report should be a brief descriptive report on DUR activities during the fiscal year reported. Please provide a detailed summary below:

- Indicate the number of DUR Board meetings held.
- List additions/deletions to DUR Board approved criteria:
  - For ProDUR, list problem type/drug combinations added or deleted.
  - For RetroDUR, list therapeutic categories added or deleted.
- Describe Board policies that establish whether and how results of ProDUR screening are used to adjust RetroDUR screens.
- Describe policies that establish whether and how results of RetroDUR screening are used to adjust ProDUR screens.
- Describe DUR Board involvement in the DUR education program (i.e. newsletters, continuing education, etc.).
- Describe policies adopted to determine mix of patient or provider specific intervention types (i.e. letters, face-to-face visits, increased monitoring).

_____

_____

_____

_____

_____

_____

2. Does your MCO have a Medication Therapy Management (MTM) Program?

- ○ Yes

○ No

## V. PHYSICIAN ADMINISTERED DRUGS (PAD)

The Deficit Reduction Act requires collection of national drug code (NDC) numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your pharmacy system been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

   ○ Yes
   ○ No

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

   ○ Yes
   ○ No

2. RetroDUR?

   ○ Yes
   ○ No

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

   ○ Yes
   ○ No

## VI. GENERIC POLICY AND UTILIZATION DATA

1. **Summary 3: Generic Drug Substitution Policies**

   Summary 3: Generic Drug Substitution Policies summarizes should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, PDL policies, educational initiatives, technology or promotional factors, or other state specific factors that affects your generic utilization rate.

_____

_____

_____

_____

_____

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

   ○ Yes
   ○ No

   If "Yes", check **all** that apply.

   ○ Require that a MedWatch Form be submitted
   ○ Require the medical reason(s) for override accompany the prescription(s)
   ○ PA is required
   ○ Other, please explain.

   _____

   _____

   _____

**Table 2: Generic Drug Utilization**

**Computation Instructions**

**KEY**

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

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

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

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

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

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

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

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I, which can be found at Medicaid.gov (Click on the link "an NDC and Drug Category file [ZIP]," then open the Medicaid Drug Product File 4th Qtr. 2020 Excel file).

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

| | **Single Source (S) Drugs** | **Non-Innovator (N) Drugs** | **Innovator Multi Source(I) Drugs** |
|---|---|---|---|
| **Total Number of Claims** | | | |
| **Total Reimbursement Amount Less Co-Pay** | | | |

3. Indicate the generic utilization percentage for all CODs paid during this reporting period, using the computation instructions in **Table 2: Generic Utilization Data**.

   Number of Generic Claims _____

   Total Number of Claims _____

   Generic Utilization Percentage _____%

4. How many multi source drugs have the innovator as the State's preferred drug product based on net pricing?

   _____

5. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all COD claims paid during this reporting period using the computation instructions in

   **Table 2: Generic Utilization Data**.

   Generic Dollars: $_____

   Total Dollars: $_____

   Generic Expenditure Percentage: _____%

6. Does your MCO have any policies related to Biosimilars? Please explain.

   _____

_____

_____

## VII. FRAUD, WASTE, AND ABUSE DETECTION (FWA)

### A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

1. Do you have a documented process in place that identifies potential FWA of controlled drugs by **beneficiaries**?

   ○ Yes
   ○ No

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

   ○ Deny claims and require PA
   ○ Refer to Lock-In Program
   ○ Refer to Program Integrity Unit (PIU)/Surveillance Utilization Review (SUR) Unit
   ○ Refer to Office of Inspector General (OIG)
   ○ Other, please explain.

   _____

   _____

   _____

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

   ○ Yes
   ○ No

   If "No", skip to question 3.

   If "Yes", please continue.

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

- ○ Number of controlled substances (CS)
- ○ Different prescribers of CS
- ○ Multiple pharmacies
- ○ Number days' supply of CS
- ○ Exclusivity of short acting opioids
- ○ Multiple ER visits
- ○ PDMP data
- ○ Same FFS state criteria is applied
- ○ Other, please explain.

_____

_____

_____

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

i. Prescriber only

- ○ Yes
- ○ No

ii. Pharmacy only

- ○ Yes
- ○ No

iii. Prescriber and pharmacy

- ○ Yes
- ○ No

c. On average, what percentage of your Medicaid MCO population is in Lock-In status annually?

_____ %

3. Do you have a documented process in place that identifies possible FWA of controlled drugs by **prescribers**?

○ Yes

What actions does this process initiate? Check **all** that apply.

- ○ Deny claims written by this prescriber
- ○ Refer to Program Integrity Unit
- ○ Refer to the appropriate Medical Board
- ○ Other, please explain.

_____

_____

_____

○ No, please explain.

_____

_____

_____

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

○ Yes

What actions does this process initiate? Check **all** that apply.

- ○ Deny claims
- ○ Refer to Program Integrity Unit
- ○ Refer to the Board of Pharmacy
- ○ Other, please explain.

_____

_____

_____

○ No, please explain.

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

   ○ Yes

   Please explain your program for FWA of non-controlled substances.

   ○ No, please explain.

## B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

***Note:*** *Section 5042 of the SUPPORT for Patients and Communities Act requires states to report metrics in reference to their state's PDMP. CMS has included questions to reference these metrics to help establish processes to be in compliance with provisions outlined in Section 5042 and CMS reporting, beginning in FFY 2023. Please complete applicable questions below in this section of the survey.*

1. Does your state have a PDMP?

   ○ Yes
   ○ No, please explain and go to Section C.

_____

_____

_____

If "Yes", please continue.

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

- ○ Yes, receive PDMP data
  - ○ Daily
  - ○ Weekly
  - ○ Monthly
  - ○ Other _____
- ○ Yes, have direct access to the database
  - ○ Can query by client
  - ○ Can query by prescriber
  - ○ Can query by dispensing entity
- ○ No

If "Yes", please continue.

i. Please explain how your program applies this information to control FWA of controlled substances.

_____

_____

_____

ii. Does your MCO have access to border states' PDMP information?

- ○ Yes
- ○ No

iii. Are there barriers that hinder your MCO from fully accessing the

PDMP that prevent the program from being utilized the way it was intended to be to curb FWA?

○ Yes, please explain the barriers that exist.

_____

_____

_____

○ No

iv. Do you also have PDMP data integrated into your POS edits?

○ Yes
○ No

2. Do you or the professional board require prescribers (in your provider agreement) to access the PDMP patient history before prescribing controlled substances?

○ Yes
○ No

If "Yes", please continue.

a. Are there protocols involved in checking the PDMP?

○ Yes, please explain.

_____

_____

_____

○ No

b. Are providers required to have protocols for responses to information from the PDMP that is contradictory to the direction that the practitioner expects from the client?

- ○ Yes
- ○ No

c. If a provider is not able to conduct PDMP check, do you require the prescriber to document a good faith effort, including the reasons why the provider was not able to conduct the check?

- ○ Yes
- ○ No, please explain.

_____

_____

_____

If "Yes", do you require the provider to submit, upon request, documentation to the MCO?

- ○ Yes
- ○ No, please explain.

_____

_____

_____

3. Does your MCO require pharmacists to check the PDMP prior to dispensing?

- ○ Yes
- ○ No, please explain.

_____

_____

_____

If "Yes", are there protocols involved in checking the PDMP?

- ○ Yes, please explain.

_____

_____

_____

○ No

4. In the State's PDMP system, which of the following pieces of information with respect to a beneficiary, is available to prescribers as close to real-time as possible? Check **all** that apply.
   - ○ PDMP drug history
   - ○ The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period.
   - ○ The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills
   - ○ Other, please explain.

     _____

     _____

     _____

5. Please specify below the following information for the 12-month reporting period for this survey. Note: Mandatory reporting will be required in FFY2023 under Section 1927(g)(3)(D) of the Act.

   a. The percentage of covered providers who checked the prescription drug history of a beneficiary through a PDMP before prescribing a controlled substance to such an individual:

      _____%.

   b. Average daily MME prescribed for controlled substances per covered individuals: _____MMEs

   c. Average daily MME prescribed for controlled substances per covered individuals who are receiving opioids.

      _____MMEs

d. Please complete Tables 3, 4, 5 and 6 below. Specify the controlled substances prescribed based on claim count (by generic ingredient(s)) and within each population during this FFY reporting period.

**Table 3: Opioid Controlled Substances by Population**

| Population | Top 3 Opioid Controlled Substances Prescribed Based On Claim Count (Generic Ingredient) within Each Population | Total Number of Beneficiaries Within Each Population | Number of Beneficiaries in Each Population/ Month Receiving Controlled Substances | Percentage of Population Receiving Controlled Substances (Auto Calculate) |
|---|---|---|---|---|
| 0-18 yrs | | | | |
| | | | | |
| | | | | |
| 19-29 yrs | | | | |
| | | | | |
| | | | | |
| 30-39 yrs | | | | |
| | | | | |
| | | | | |
| 40-49 yrs | | | | |
| | | | | |
| | | | | |
| 50-59 yrs | | | | |
| | | | | |
| | | | | |
| 60-69 yrs | | | | |
| | | | | |
| | | | | |
| 70-79 yrs | | | | |
| | | | | |
| | | | | |
| 80+ yrs | | | | |
| | | | | |
| | | | | |
| Individuals with Disabilities Utilizing State Eligibility Categories | | | | |
| | | | | |
| | | | | |

**Table 4: Top Sedative/Benzodiazepines Controlled Substances by Population**

- When listing the controlled substances in different drug categories, for the purpose of Table 4 below, please consider long and short acting benzodiazepines to be in the same category.

| Population | Top 3 Sedative/ Benzodiazepine Controlled Substances Prescribed Based On Claim Count (Generic Ingredient) within Each Population | Total Number of Beneficiaries within Each Population | Number of Beneficiaries in Each Population/ Month Receiving Sedative/ Benzodiazepine Controlled Substances | Percentage of Population Receiving Sedative/ Benzodiazepine Controlled Substances (Auto Calculate) |
|---|---|---|---|---|
| 0-18 yrs | | | | |
| | | | | |
| | | | | |
| 19-29 yrs | | | | |
| | | | | |
| | | | | |
| 30-39 yrs | | | | |
| | | | | |
| | | | | |
| 40-49 yrs | | | | |
| | | | | |
| | | | | |
| 50-59 yrs | | | | |
| | | | | |
| | | | | |
| 60-69 yrs | | | | |
| | | | | |
| | | | | |
| 70-79 yrs | | | | |
| | | | | |
| | | | | |
| 80+ yrs | | | | |
| | | | | |
| | | | | |
| Individuals with Disabilities Utilizing State Eligibility Categories | | | | |
| | | | | |
| | | | | |

**Table 5: Top Stimulant/ADHD Controlled Substances by Population**

- When listing the controlled substances in different drug categories, for the purpose of Table 5 below, please consider long and short acting ADHD medications to be in the same category.

| Population | Top 3 Stimulant/ADHD Controlled Substances Prescribed Based On Claim Count (Generic Ingredient) within Each Population | Total Number of Beneficiaries within Each Population | Number of Beneficiaries In Each Population/ Month Receiving Stimulant/ADHD Controlled Substances | Percentage of Population Receiving Stimulant/ADHD Controlled Prescriptions (Auto Calculate) |
|---|---|---|---|---|
| 0-18 yrs | | | | |
| | | | | |
| | | | | |
| 19-29 yrs | | | | |
| | | | | |
| | | | | |
| 30-39 yrs | | | | |
| | | | | |
| | | | | |
| 40-49 yrs | | | | |
| | | | | |
| | | | | |
| 50-59 yrs | | | | |
| | | | | |
| | | | | |
| 60-69 yrs | | | | |
| | | | | |
| | | | | |
| 70-79 yrs | | | | |
| | | | | |
| | | | | |
| 80+ yrs | | | | |
| | | | | |
| | | | | |
| Individuals with Disabilities Utilizing State Eligibility Categories | | | | |
| | | | | |
| | | | | |

**Table 6: Populations on 2 or more Controlled Substances in Different Drug Categories**

- When listing the controlled substances in different drug categories, for the purpose of Table 6 below, please consider long and short acting opioids to be in the same category. Please follow this approach for long and short acting ADHD medications and benzodiazepines in this table as well.

| Population | Total Number of Beneficiaries within Each Population | Number of Beneficiaries in Each Population/ Month Receiving 2 or more Controlled Substances in Different Drug Categories | Number of Beneficiaries in Each Population/ Month Receiving 3 or more Controlled Substances in Different Drug Categories | Percentage Of Population Receiving 2 or more Controlled Substances (Auto Calculate) |
|---|---|---|---|---|
| 0-18 yrs | | | | |
| | | | | |
| | | | | |
| 19-29 yrs | | | | |
| | | | | |
| | | | | |
| 30-39 yrs | | | | |
| | | | | |
| | | | | |
| 40-49 yrs | | | | |
| | | | | |
| | | | | |
| 50-59 yrs | | | | |
| | | | | |
| | | | | |
| 60-69 yrs | | | | |
| | | | | |
| | | | | |
| 70-79 yrs | | | | |
| | | | | |
| | | | | |
| 80+ yrs | | | | |
| | | | | |
| | | | | |
| Individuals with Disabilities Utilizing State Eligibility Categories | | | | |
| | | | | |
| | | | | |

i. If there is additional information you want to provide for the previous 12-month reporting period, please explain below.

_____

_____

_____

ii. If any of the information requested is not being reported above, please explain below.

_____

_____

_____

6. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?

○ Yes
○ No

If "Yes", please summarize the breach, the number of individuals impacted, a description of the steps the State has taken to address each such breach, and if law enforcement or the affected individuals were notified of the breach.

_____

_____

_____

## C. OPIOIDS

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

○ Yes, for **all** opioids
○ Yes, for some opioids
○ No for **all** opioids

Please explain responses above.

_____

_____

_____

If "No", skip to question 1b.

a. Is there more than one quantity limit for various opioids? Additionally, please explain ramifications when addressing COVID-19 if applicable.

O Yes, please explain.

_____

_____

_____

O No

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

_____# of days

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

O Yes, for **all** opioids
O Yes, some opioids
O No

Please explain response above.

_____

_____

_____

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

   ○ Yes

   What is your maximum days' supply per prescription limitation?

   ○ 30-day supply
   ○ 34-day supply
   ○ 90-day supply
   ○ Other, please explain.

   _____

   _____

   _____

   ○ No, please explain.

   _____

   _____

   _____

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

   ○ Yes

   What is your maximum days' supply per prescription limitation?

   ○ 30-day supply
   ○ 34-day supply
   ○ 90-day supply
   ○ Other, please explain.

   _____

   _____

   _____

- ○ No, please explain.

_____

_____

_____

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

   - ○ Yes
   - ○ No

   If "Yes", please check **all** that apply.

   - ○ Pharmacist override
   - ○ Deny claim and require PA
   - ○ Intervention letters
   - ○ Morphine Milligram Equivalent (MME) daily dose program
   - ○ Step therapy or Clinical criteria
   - ○ Requirement that patient has a pain management contract or Patient-Provider agreement
   - ○ Requirement that prescriber has an opioid treatment plan for patients
   - ○ Require documentation of urine drug screening results
   - ○ Require diagnosis
   - ○ Require PDMP checks
   - ○ Workgroups to address opioids
   - ○ Other, please specify.

   _____

   Please provide details on these opioid prescribing controls in place.

   _____

If "No", 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 opioids.

5. Do you have POS edits to monitor duplicate therapy of opioid prescriptions? This excludes regimens that include a single extended release product and a breakthrough short acting agent.

   ○ Yes
   ○ No

   Please explain response above.

6. Do you have POS edits and automated retrospective claim reviews to monitor duplicate therapy of opioid prescriptions dispensed?

   ○ Yes, POS edits
   ○ Yes, automated retrospective claim reviews
   ○ Yes, both POS edits and automated retrospective claim reviews
   ○ No

   If any response is "Yes", please explain scope and nature.

If "No", please explain.

7. Do you have POS edits and automated retrospective claim reviews to monitor early refills of opioid prescriptions dispensed?

   - ○ Yes, POS edits
   - ○ Yes, automated retrospective claim reviews
   - ○ Yes, both POS edits and automated retrospective claim reviews
   - ○ No

   If any response is "Yes", please explain scope and nature of reviews and edits.

   If "No", please explain.

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

   - ○ Yes, please explain in detail the scope and nature of these retrospective reviews.

_____

_____

_____

○ No, please explain.

_____

_____

_____

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

   ○ Yes, POS edits
   ○ Yes, automated retrospective claim reviews
   ○ Yes, both POS edits and automated retrospective claim reviews

   Please explain the above response and detail the scope and nature of these reviews and edits. Additionally, please explain any potential titration processes utilized for those patients chronically on benzodiazepines and how the state justifies pain medications, i.e. Oxycodone/APAP, for breakthrough pain without jeopardizing patient care (i.e. quantity limits/practitioner education titration programs).

   _____

   _____

   _____

   ○ No, please explain.

   _____

   _____

   _____

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

    ○ Yes, POS edits

- ○ Yes, automated retrospective claim reviews
- ○ Yes, both POS edits and automated retrospective claim reviews

Please explain above response and detail the scope and nature of reviews and/or edits.

_____

_____

_____

- ○ No, please explain.

_____

_____

_____

11. Do you currently have POS edits in place or an automated retrospective claims review to monitor opioids and antipsychotics being used concurrently?

- ○ Yes, POS edits
- ○ Yes, automated retrospective claim reviews
- ○ Yes, both POS edits and automated retrospective claim reviews

Please explain above response and detail the scope and nature of reviews and/or edits.

_____

_____

_____

- ○ No, please explain.

_____

_____

_____

12. Do you have POS safety edits or perform RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?

    - ○ Yes, POS edits
    - ○ Yes, RetroDUR activity and/or provider education
    - ○ Yes, both POS edits and RetroDUR activity and/or provider education
    - ○ No

    If "Yes, RetroDUR activity and/or provider education," please continue.

    a. Please indicate how often.

        - ○ Monthly
        - ○ Quarterly
        - ○ Semi-Annually
        - ○ Annually
        - ○ Ad hoc
        - ○ Other, please specify.

        _____

        _____

        _____

    b. Please explain the nature and scope of edits, reviews and/or provider education reviews performed.

        _____

        _____

        _____

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

- ○ Yes, when do you plan on implementing?

  _____

- ○ No, please explain.

  _____

  _____

  _____

13. Does your MCO program develop and provide prescribers with pain management or opioid prescribing guidelines?

    - ○ Yes
    - ○ No

    If "Yes", please check **all** that apply.

    - ○ Your prescribers are referred to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain
    - ○ Other guidelines, please identify.

      _____

      _____

    - ○ No guidelines are offered, please explain.

      _____

      _____

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

    - ○ Yes, please explain.

_____

_____

○ No

## D. MORPHINE MILLIGRAM EQUIVALENT (MME) DAILY DOSE

1. Have you set recommended maximum MME daily dose measures?

   ○ Yes
   ○ No

   If "Yes", please continue.

   a. What is your maximum MME daily dose limit in milligrams?

      ○ Less than 50 MME, please specify: _____ mg per day
      ○ 50 MME
      ○ 70 MME
      ○ 80 MME
      ○ 90 MME
      ○ 100 MME
      ○ 120 MME
      ○ 200 MME
      ○ Greater than 200 MME, please specify. _____ mg per day
      ○ Other, please specify. _____ mg per day

   b. Please explain nature and scope of dose limit (i.e. who does the edit apply to? Does the limit apply to **all** opioids? Are you in the process of tapering patients to achieve this limit)?

      _____

      _____

      _____

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

_____

_____

_____

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

   ○ Yes
   ○ No

   If "Yes", do you require PA if the MME limit is exceeded?

   ○ Yes
   ○ No

3. Do you have automated retrospective claim reviews to monitor total daily dose (MME) of opioid prescriptions dispensed?

   ○ Yes, please explain.

   _____

   _____

   _____

   ○ No, please explain.

   _____

   _____

   _____

## E. OPIOID USE DISORDER (OUD) TREATMENT

1. Do you have utilization controls (i.e. PDL, PA, QL) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?

   ○ Yes, please explain.

_____

_____

_____

○ No

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

○ Yes
○ No

If "Yes", please specify the total mg/day.

○ 12 mg
○ 16 mg
○ 24 mg
○ 32mg
○ Other, please explain.

_____

_____

_____

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

○ No limit
○ 3 months or less
○ 6 months
○ 12 months
○ 24 months
○ Other, please explain.

_____

_____

_____

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

   ○ Yes
   ○ No

   If "Yes", please continue.

   a. What is your reduced (maintenance) dosage?

      ○ 8 mg
      ○ 12 mg
      ○ 16 mg
      ○ Other, please explain.

      _____

      _____

      _____

   b. What are your limitations on the allowable length of the reduced dosage treatment?

      ○ 6 months
      ○ 12 months
      ○ No limit
      ○ Other, please explain.

      _____

      _____

      _____

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

   ○ Yes
   ○ No

6. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?

   ○ Yes
   ○ No
   ○ Other, please explain.

   _____

   _____

   _____

   If "Yes", can the POS pharmacist override the edit?

   ○ Yes
   ○ No

7. Is there at least one formulation of naltrexone for OUD available without PA?

   ○ Yes
   ○ No

8. Do you have at least one naloxone opioid overdose product available without PA?

   ○ Yes
   ○ No

9. Do you retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?

   ○ Yes
   ○ No

   Please explain above response.

   _____

   _____

   _____

10. Does your MCO allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?

    ○ Yes, please explain.

    _____

    _____

    _____

    ○ No

## F. OUTPATIENT TREATMENT PROGRAMS (OTP)

1. Does your MCO cover OTPs that provide both services, Behavioral Health (BH) and MAT through OTPs?

    ○ Yes
    ○ No, please explain.

    _____

    _____

    _____

    If "Yes", is a referral needed for OUD treatment through OTPs?

    ○ Yes, please explain.

    _____

    _____

    _____

    ○ No, please explain.

_____

_____

_____

2. Does your MCO cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?

   - ○ Yes
   - ○ No, please explain.

   _____

   _____

   _____

3. Does your MCO cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?

   - ○ Yes
   - ○ No, please explain.

   _____

   _____

   _____

4. Does your MCO cover Methadone for SUD (i.e. OTPs, Methadone Clinics)?

   - ○ Yes
   - ○ No

## G. ANTIPSYCHOTICS /STIMULANTS

### ANTIPSYCHOTICS

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

   - ○ Yes

○ No

Enter restrictions other than quantity limits below, or N/A.

_____

_____

_____

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

○ Yes
○ No

If "No", skip to question 2.d.

If "Yes", please continue.

a. Do you either manage or monitor?

○ Only children in foster care
○ **All** children
○ Other, please explain.

_____

_____

_____

b. Do you have edits in place to monitor (check **all** that apply)?

○ Child's Age
○ Dosage
○ Indication
○ Polypharmacy
○ Other, please explain.

_____

_____

_____

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

_____

_____

_____

If "No", please continue.

d. Do you plan on implementing a program in the future?

○ Yes, please specify when.

_____

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

_____

_____

_____

**STIMULANTS**

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

○ Yes
○ No

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

○ Yes
○ No

If “No”, skip to question 4.d.

If “Yes”, please continue.

a. Do you either manage or monitor?

- ○ Only children in foster care
- ○ **All** children
- ○ Other, please explain.

_____

_____

_____

b. Do you have edits in place to monitor (check **all** that apply)?

- ○ Child’s Age
- ○ Dosage
- ○ Indication
- ○ Polypharmacy
- ○ Other, please explain.

_____

_____

_____

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

_____

_____

_____

If “No”, please continue.

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

○ Yes, please specify when.

_____

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

_____

_____

_____

## VIII. INNOVATIVE PRACTICES

1. Does your MCO participate in any demonstrations or have any waivers to allow importation of certain drugs from Canada or other countries that are versions of FDA-approved drugs for dispensing to Medicaid Beneficiaries?

○ Yes, please explain.

_____

_____

_____

○ No

2. **Summary 4: Innovative Practices**

Have you developed any innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MMEs, Value Based Purchasing)? Please describe in detailed narrative below any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs (i.e. disease management, academic detailing, automated prior authorizations, continuing education programs).

## IX. EXECUTIVE SUMMARY

**Summary 5: Executive Summary**

Please include a general overview and summary of program highlights from FFY 2019 as well as objectives, tools and outcomes of initiatives accomplished, as well as goals for FFY 2020. Include a summary of program oversight and initiatives.

# APPENDIX A: MCO PROGRAM TYPES

## DEFINITIONS OF MANAGED CARE PROGRAM TYPES

A managed care program is defined by the set of benefits covered and the type of participating managed care plans (e.g., MCOs, PHPs, PACE, etc.) or providers (e.g., PCCM providers).

| Managed Care Program Type | Definition |
|---|---|
| Comprehensive MCO | Comprehensive Managed Care Organization: A program in which the State contracts with managed care plans to cover all acute and primary medical services; some also cover behavioral health, dental, transportation and long term care. Entities that qualify as MCOs include Health Maintenance Organizations (HMOs) and Health Insuring Organizations (HIOs in California).<br><br>If the comprehensive MCO also covers long-term services and supports, the program type should be Comprehensive MCO + MLTSS.<br><br>When certain benefits, such as behavioral health, dental, or transportation, are carved out of the comprehensive MCO program and covered through a limited benefit program (i.e. a Prepaid Inpatient Health Plan or Prepaid Ambulatory Health Plan), enrollees in such limited benefit plans should be reported in separate programs of the appropriate type (e.g., BHO (PIHP and/or PAHP), Dental PAHP, or Non-Emergency Medical Transportation, or an MLTSS-only program when only LTSS and no other services are covered.<br><br>Individual beneficiaries can be enrolled in only one comprehensive MCO program (either a comprehensive MCO or a comprehensive MCO+MLTSS) as of the July 1 point in time. |
| Comprehensive MCO + MLTSS | Comprehensive Managed Care Organization + Managed Long-Term Services and Supports: A program in which plans cover comprehensive acute and outpatient benefits as defined above, where the same plan also covers long-term services and supports (LTSS).<br><br>Individual beneficiaries can be enrolled in only one comprehensive MCO program (either a comprehensive MCO or a comprehensive MCO+MLTSS). |
| BHO Only (PIHP and/or PAHP) | Behavior Health Organizations Only (Prepaid Inpatient Health Plan and/or Prepaid Ambulatory Health Plan): A program specializing in behavioral health (mental health and/or substance use disorder) services. Services are covered on a prepaid basis. |

| Managed Care Program Type | Definition |
|---|---|
| | |
| Dental only (PAHP) | A Prepaid Ambulatory Health Program (PAHP) that only provides dental services. |
| MLTSS Only | Managed Long Term Services and Supports Only: A program only covering long term services and supports. |
| Other PHP | Other Prepaid Health Plan: A program covering a limited set of services through PIHPs or PAHPs not otherwise included above. Examples include disease management and pharmacy benefits. |
| PACE | Programs of All-Inclusive Care for the Elderly: A program that provides prepaid, capitated comprehensive medical and social services in an adult day health center, supplemented by in-home and referral services according to a participant's needs. To qualify, individuals must: (1) be 55 years of age or older, (2) meet a nursing home level of care, and (3) live in a PACE organization service area. |
| PCCM | Primary Care Case Management: A managed care arrangement in which primary care providers contract with the state to provide a core set of case management services to the enrollees assigned to them and to serve as the enrollees' home for medical care, in exchange for a monthly case management fee. All other services are reimbursed on a FFS basis. Primary Care Providers (PCPs) can include primary care physicians, clinics, group practices and nurse practitioners, among others. In general, we would only expect case management and physician services to be covered under capitation for PCCM programs. |
| PCCM entity | Primary Care Case Management entity: In addition to providing primary care case management services for the State, a PCCM entity is an organization that provides any of the following functions: (1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line; (2) Development of enrollee care plans; (3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program; (4) Provision of payments to FFS providers on behalf of the State; (5) Provision of enrollee outreach and education activities; (6) Operation of a customer service call center; (7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement; (8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; (9) Coordination with behavioral health systems/providers; and/or (10) Coordination with long-term services and supports systems/ providers. |

| Managed Care Program Type | Definition |
|---|---|
| Non-Emergency Medical Transportation (NEMT) | A program that covers transportation to and from medically necessary health care services in which these services are paid for on a per capita basis (the state pays the transportation broker based on the number of people served, not the amount of service or trips that each individual receives). Do not report transportation programs in which individual trips are reimbursed on a FFS basis. |

## MANAGED CARE PLAN CROSSWALK

The table below provides a crosswalk for plan types to program types.

| Managed Care Plan Type | Managed Care Program Type |
|---|---|
| Comprehensive MCO | • Comprehensive MCO<br>• Comprehensive MCO +MLTSS (if benefits include LTSS) |
| Traditional PCCM Provider | • PCCM |
| Enhanced PCCM Provider | • PCCM |
| HIO | • Comprehensive MCO |
| Medical-only PIHP (risk or non-risk/non-comprehensive/with inpatient hospital or institutional services) | • Other PHP |
| Medical-only PAHP (risk or non-risk/non-comprehensive/no inpatient hospital or institutional services) | • Other PHP |
| Long Term Care (LTC) PIHP | • MLTSS Only |
| Mental Health (MH) PIHP | • BHO (PIHP and/or PAHP) |
| Mental Health (MH) PAHP | • BHO (PIHP and/or PAHP) |
| Substance Use Disorders (SUD) PIHP | • BHO (PIHP and/or PAHP) |
| Substance Use Disorders (SUD) PAHP | • BHO (PIHP and/or PAHP) |
| Mental Health (MH) and Substance Use Disorders (SUD) PIHP | • BHO (PIHP and/or PAHP) |
| Mental Health (MH) and Substance Use Disorders (SUD) PAHP | • BHO (PIHP and/or PAHP) |
| Dental PAHP | • Dental |
| Transportation PAHP | • NEMT |
| Disease Management PAHP | • Other PHP |
| PACE | • PACE |
| Pharmacy PAHP | • Other PHP |
| Accountable Care Organization | • Comprehensive MCO<br>• Other PHP<br>• PCCM |
| Health/Medical Home | • PCCM |

| | |
|---|---|
| Integrated Care For Dual Eligibles | • Comprehensive MCO + MLTSS,<br>• MLTSS Only<br>(if benefits cover LTSS) |
| Unknown – it is not yet known how PCCM entities will be reported in T-MSIS. | • PCCM entity |

# APPENDIX B: DRUG NAMES

Abacavir/Dolutegravir/Lamivudi
Accolate
Accupril
Acetaminophen
Acitretin
Acyclovir
Adalimumab
Aflibercept
Albuterol
Albuterol Sulfate/Ipratropium Bromide
Alendronate Sodium
Allopurinol
Alprazolam
Ambrisentan
Amiodarone Hydrochloride
Amitriptyline
Amlodipine
Amlodipine Besylate/Benazepril Hydrochloride
Amoxicillin
Amoxicillin/Potassium Clav
Amoxicillin; Clavulanate Potassium
Amphetamine
Androgens
Antihemophilic Factors
Anti-Inhibitor Coagulant Comp.
Apixaban
Apraclonidine
Argatroban
Aricept
Aripiprazole
Asenapine Maleate
Aspirin
Atazanavir
Atenolol
Atomoxetine
Atorvastatin
Azithromycin
Bacitracin/Neomycin/ Polymyxin B
Baclofen
Beclomethasone
Benazepril Hydrochloride
Benzonatate
Benztropine Mesylate

Bevacizumab
Brexipiprazole
Brimonidine Tartrate
Budesonide
Budesonide/ Formoterol
Buprenorphine
Buprenorphine Hcl/Naloxone Hcl
Bupropion
Buspirone Hydrochloride
Canagliflozin
Carbamazepine
Carbidopa/ Levodopa
Carisoprodol
Carvedilol
Celecoxib
Cephalexin
Cetirizine
Chlorthalidone
Cholecalciferol
Cinacalcet Hcl
Ciprofloxacin
Citalopram
Clindamycin
Clobazam
Clobetasol Propionate
Clonazepam
Clonidine
Clopidogrel Bisulfate
Coagulation Factors
Contraceptives
Corticotropin
Cyanocobalamin
Cyclobenzaprine
Cyclosporine
Darbepoetin Alfa In Polysorbat
Darunavir Ethanolate
Darunavir/Cobicistat
Deferasirox
Deferoxamine
Deserasirox
Desogestrel/ Ethinyl Estradiol
Dexlansoprazole

Dexmethylphenidate
Dextroamphetamine/Amphetamine
Diazepam
Diclofenac
Dicyclomine Hydrochloride
Digoxin
Diltiazem Hydrochloride
Dimethyl Fumarate
Diphenhydramine
Divalproex Sodium
Docusate
Dolutegravir
Donepezil
Dornase
Dorzolamide Hydrochloride/Timolol Maleate
Doxazosin Mesylate
Doxycycline
Drospirenone/ Ethinyl Estradiol
Duloxetine
Eculizumab
Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate
Elbasvir/Grazoprevir
Elviteg/Cob/Emtri/Tenofo Disop
Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Alafenamide
Emtricita/Rilpivirine/Tenof Df
Emtricitabine/Tenofovir Alafenamide
Enalapril Maleate
Enoxaparin Sodium
Entecavir
Epoetin Alfa
Ergocalciferol
Escitalopram
Esomeprazole
Estradiol
Etanercept
Estrogens
Everolimus
Exenatide
Ezetimibe
Famotidine
Fenofibrate

Fentanyl
Ferrous Sulfate
Filgrastim
Finasteride
Fingolimod
Fluconazole
Fluoxetine
Fluticasone
Fluticasone Propionate/ Salmeterol Xinafoate
Fluticasone/Salmeterol
Fluticasone/Vilanterol
Folic Acid
Furosemide
Gabapentin
Gemfibrozil
Glatiramer
Glimepiride
Glipizide
Glyburide
Guanfacine
Guanfacine Hcl Er
Haloperidol
Hctz
Heparin
Hydralazine Hydrochloride
Hydrochlorothiazide
Hydrochlorothiazide/ Lisinopril
Hydrochlorothiazide/ Losartan Potassium
Hydrochlorothiazide/ Triamterene
Hydrochlorothiazide/Valsartan
Hydrocodone
Hydrocodone /Apap
Hydrocortisone
Hydromorphone
Hydroxychloroquine Sulfate
Hydroxyprogesterone
Hydroxyzine
Ibuprofen
Imatinib Mesylate
Immune Globulins
Infliximab
Insulin Aspart
Insulin Detemir

Insulin Glargine
Insulin Human
Insulin Lispro
Ipratropium
Ipratropium/Albuterol
Irbesartan
Isosorbide Mononitrate
Ketoconazole
Lacosamide
Lamotrigine
Lansoprazole
Latanoprost
Ledipasvir/Sofosbuvir
Lenalidomide
Leuprolide Acetate
Levalbuterol Hcl
Levetiracetam
Levocetirizine Dihydrochloride
Levofloxacin
Levothyroxine
Lidocaine
Linaclotide
Linagliptin
Lipase/Protease/Amylase
Liraglutide
Lisdexamfetamine
Lisinopril
Lithium
Loratadine
Lorazepam
Losartan
Lovastatin
Lumacaftor/Vacaftor
Lurasidone
Magnesium
Meclizine Hydrochloride
Meloxicam
Memantine Hydrochloride
Metformin
Metformin Hydrochloride/ Sitagliptin Phosphate
Methocarbamol
Methotrexate
Methylcellulose (4000 Mpa.S)
Methylphenidate
Methylprednisolone
Metoprolol
Metronidazole
Mirtazapine
Mometasone
Mometasone/Formoterol
Montelukast
Morphine
Mupirocin
Naloxone
Naltrexone
Naltrexone Microspheres
Naproxen
Natalizumab
Nebivolol Hydrochloride
Nicotine Patch
Nifedipine
Nitrofurantoin
Nitroglycerin
Nivolumab
Nortriptyline Hydrochloride
Olanzapine
Olmesartan Medoxomil
Olopatadine
Omalizumab
Omega-3-Acid Ethyl Esters
Omeprazole
Ondansetron
Oseltamivir
Oxybutynin
Oxycodone
Oxycodone/Apap
Palbociclib
Paliperidone
Palivizumab
Pantoprazole Sodium
Paroxetine
Pegfilgrastim
Pioglitazone
Polyethylene Glycol 3350
Potassium
Pravastatin Sodium
Prednisolone
Prednisone
Pregabalin
Progesterone

Promethazine
Promethazine Hydrochloride
Propranolol
Quetiapine
Raltegravir Potassium
Ramipril
Ranitidine
Ranitidine Hcl
Retinoids
Rifaximin
Risperidone
Risperidone Microspheres
Ritonavir
Rituximab
Rivaroxaban
Ropinirole Hydrochloride
Rosuvastatin
Rufinamide
Sertraline
Sertraline Hydrochloride
Sevelamer Hcl
Simvastatin
Sitagliptin
Sitagliptin Phos/Metformin Hcl
Sodium Chloride
Sofosbuvir/Velpatasvir
Solifenacin Succinate
Somatropin
Spironolactone
Sulfamethoxazole/ Trimethoprim
Sumatriptan
Tacrolimus
Tamsulosin Hydrochloride
Temazepam
Tenofovir Disoproxil Fumarate
Terazosin
Teriflunomide
Testosterone
Thyroid
Timolol
Tiotropium
Tizanidine
Topiramate
Tramadol
Trastuzumab

Trazodone
Treprostinil Sodium
Triamcinolone
Ustekinumab
Valacyclovir
Valsartan
Varenicline
Vedolizumab
Venlafaxine
Verapamil
Vitamins
Warfarin
Zolpidem

# APPENDIX C: DRUG CLASSES

| Drug Class | Description |
|---|---|
| **Analgesics** | Drugs that relieve pain. There are two main types: non-narcotic analgesics for mild pain, and narcotic analgesics for severe pain. |
| **Antacids** | Drugs that relieve indigestion and heartburn by neutralizing stomach acid. |
| **Antianxiety Drugs** | Drugs that suppress anxiety and relax muscles (sometimes called anxiolytics, sedatives, or minor tranquilizers). |
| **Antiarrhythmics** | Drugs used to control irregularities of heartbeat. |
| **Antibacterials** | Drugs used to treat infections. |
| **Antibiotics** | Drugs made from naturally occurring and synthetic substances that combat bacterial infection. Some antibiotics are effective only against limited types of bacteria. Others, known as broad spectrum antibiotics, are effective against a wide range of bacteria. |
| **Anticoagulants and Thrombolytics** | Anticoagulants prevent blood from clotting. Thrombolytics help dissolve and disperse blood clots and may be prescribed for patients with recent arterial or venous thrombosis. |
| **Anticonvulsants** | Drugs that prevent epileptic seizures. |
| **Antidepressants** | There are three main groups of mood-lifting antidepressants: tricyclics, monoamine oxidase inhibitors, and selective serotonin reuptake inhibitors (SSRIs). |
| **Antidiarrheals** | Drugs used for the relief of diarrhea. Two main types of antidiarrheal preparations are simple adsorbent substances and drugs that slow down the contractions of the bowel muscles so that the contents are propelled more slowly. |
| **Antiemetics** | Drugs used to treat nausea and vomiting. |
| **Antifungals** | Drugs used to treat fungal infections, the most common of which affect the hair, skin, nails, or mucous membranes. |
| **Antihistamines** | Drugs used primarily to counteract the effects of histamine, one of the chemicals involved in allergic reactions. |
| **Antihypertensives** | Drugs that lower blood pressure. The types of antihypertensives currently marketed include diuretics, beta-blockers, calcium channel blocker, ACE (angiotensin- converting enzyme) inhibitors, centrally acting antihypertensives and sympatholytics. |
| **Anti-Inflammatories** | Drugs used to reduce inflammation - the redness, heat, swelling, and increased blood flow found in |

| Drug Class | Description |
|---|---|
| | infections and in many chronic noninfective diseases such as rheumatoid arthritis and gout. |
| **Antineoplastics** | Drugs used to treat cancer. |
| **Antipsychotics** | Drugs used to treat symptoms of severe psychiatric disorders. These drugs are sometimes called major tranquilizers. |
| **Antipyretics** | Drugs that reduce fever. |
| **Antivirals** | Drugs used to treat viral infections or to provide temporary protection against infections such as influenza. |
| **Barbiturates** | See "sleeping drugs." |
| **Beta-Blockers** | Beta-adrenergic blocking agents, or beta-blockers for short, reduce the oxygen needs of the heart by reducing heartbeat rate. |
| **Bronchodilators** | Drugs that open up the bronchial tubes within the lungs when the tubes have become narrowed by muscle spasm. Bronchodilators ease breathing in diseases such as asthma. |
| **Cold Cures** | Although there is no drug that can cure a cold, the aches, pains, and fever that accompany a cold can be relieved by aspirin or acetaminophen often accompanied by a decongestant, antihistamine, and sometimes caffeine. |
| **Corticosteroids** | These hormonal preparations are used primarily as anti-inflammatories in arthritis or asthma or as immunosuppressives, but they are also useful for treating some malignancies or compensating for a deficiency of natural hormones in disorders such as Addison's disease. |
| **Cough Suppressants** | Simple cough medicines, which contain substances such as honey, glycerine, or menthol, soothe throat irritation but do not actually suppress coughing. They are most soothing when taken as lozenges and dissolved in the mouth. As liquids they are probably swallowed too quickly to be effective. A few drugs are actually cough suppressants. There are two groups of cough suppressants: those that alter the consistency or production of phlegm such as mucolytics and expectorants; and those that suppress the coughing reflex such as codeine (narcotic cough suppressants), antihistamines, dextromethorphan and isoproterenol (non-narcotic cough suppressants). |
| **Cytotoxics** | Drugs that kill or damage cells. Cytotoxics are used as antineoplastics (drugs used to treat cancer) and also as immunosuppressives. |
| **Decongestants** | Drugs that reduce swelling of the mucous membranes that line the nose by constricting blood vessels, thus relieving nasal stuffiness. |

| Drug Class | Description |
|---|---|
| **Diuretics** | Drugs that increase the quantity of urine produced by the kidneys and passed out of the body, thus ridding the body of excess fluid. Diuretics reduce water logging of the tissues caused by fluid retention in disorders of the heart, kidneys, and liver. They are useful in treating mild cases of high blood pressure. |
| **Expectorant** | A drug that stimulates the flow of saliva and promotes coughing to eliminate phlegm from the respiratory tract. |
| **Hormones** | Chemicals produced naturally by the endocrine glands (thyroid, adrenal, ovary, testis, pancreas, parathyroid). In some disorders, for example, diabetes mellitus, in which too little of a particular hormone is produced, synthetic equivalents or natural hormone extracts are prescribed to restore the deficiency. Such treatment is known as hormone replacement therapy. |
| **Hypoglycemics (Oral)** | Drugs that lower the level of glucose in the blood. Oral hypoglycemic drugs are used in diabetes mellitus if it cannot be controlled by diet alone, but does require treatment with injections of insulin. |
| **Immunosuppressives** | Drugs that prevent or reduce the body's normal reaction to invasion by disease or by foreign tissues. Immunosuppressives are used to treat autoimmune diseases (in which the body's defenses work abnormally and attack its own tissues) and to help prevent rejection of organ transplants. |
| **Laxatives** | Drugs that increase the frequency and ease of bowel movements, either by stimulating the bowel wall (stimulant laxative), by increasing the bulk of bowel contents (bulk laxative), or by lubricating them (stool-softeners, or bowel movement-softeners). Laxatives may be taken by mouth or directly into the lower bowel as suppositories or enemas. If laxatives are taken regularly, the bowels may ultimately become unable to work properly without them. |
| **Muscle Relaxants** | Drugs that relieve muscle spasm in disorders such as backache. Antianxiety drugs (minor tranquilizers) that also have a muscle-relaxant action are used most commonly. |
| **Sedatives** | Same as Antianxiety drugs. |
| **Sex Hormones (Female)** | There are two groups of these hormones (estrogens and progesterone), which are responsible for development of female secondary sexual characteristics. Small quantities are also produced in males. As drugs, female sex hormones are used to treat menstrual and |

| Drug Class | Description |
|---|---|
| | menopausal disorders and are also used as oral contraceptives. Estrogens may be used to treat cancer of the breast or prostate, progestins (synthetic progesterone to treat endometriosis). |
| **Sex Hormones (Male)** | Androgenic hormones, of which the most powerful is testosterone, are responsible for development of male secondary sexual characteristics. Small quantities are also produced in females. As drugs, male sex hormones are given to compensate for hormonal deficiency in hypopituitarism or disorders of the testes. They may be used to treat breast cancer in women, but either synthetic derivatives called anabolic steroids, which have less marked side- effects, or specific anti-estrogens are often preferred. Anabolic steroids also have a "body building" effect that has led to their (usually nonsanctioned) use in competitive sports, for both men and women. |
| **Sleeping Drugs** | The two main groups of drugs that are used to induce sleep are benzodiazepines and barbiturates. All such drugs have a sedative effect in low doses and are effective sleeping medications in higher doses. Benzodiazepines drugs are used more widely than barbiturates because they are safer, the side-effects are less marked, and there is less risk of eventual physical dependence. |
| **Tranquilizer** | This is a term commonly used to describe any drug that has a calming or sedative effect. However, the drugs that are sometimes called minor tranquilizers should be called antianxiety drugs, and the drugs that are sometimes called major tranquilizers should be called antipsychotics. |
| **Vitamins** | Chemicals essential in small quantities for good health. Some vitamins are not manufactured by the body, but adequate quantities are present in a normal diet. People whose diets are inadequate or who have digestive tract or liver disorders may need to take supplementary vitamins. |
| **Other** | Please specify. |

# APPENDIX D: DENIAL CODES

| |
|---|
| ACCUMULATION REFILL TOO SOON |
| AGE |
| BRAND REQUEST |
| CLAIM REQUIRES AN APPROVED TREATMENT AUTHORIZATION REQUEST (TAR) |
| CLAIM SUBMITTED DOES NOT MATCH PA |
| COMPLIANCE MONITORING/EARLY OR LATE REFILL |
| CUMULATIVE EARLY REFILL |
| DAILY DOSE EXCEEDED |
| DAYS SUPPLY |
| DRUG COVERED BY MEDICARE PART D |
| DRUG LIST INITIATIVE THRESHOLD |
| DRUG-DISEASEREPORTED PRECAUTION |
| DRUG-DRUG INTERACTION |
| DUPLICATE CLAIM |
| DUR REJECT ERROR |
| EARLY REFILL: OVERUSE PRECAUTION |
| ELIGIBILITY |
| EXCEEDS ALLOWABLE PLAN DAYS SUPPLY |
| FILLED AFTER COVERAGE TERMINATED |
| HIGH DOSE ALERT |
| M/I DAYS SUPPLY |
| M/I DIAGNOSIS CODE |
| M/I OTHER COVERAGE CODE |
| M/I PRESCRIBER |
| MD MUST CALL FOR A PRIOR AUTHORIZATION |
| MEMBER ENROLLED IN MANAGED CARE |
| MEMBERS BENEFITS PACKAGE DOES NOT INCLUDE THIS MEDICATION |
| NDC NOT CONSISTENT WITH ANY BILLED DIAGNOSIS |
| NDC NOT COVERED |
| NDC VS DIAGNOSIS RESTRICTION |
| NO REBATE |
| NON-COVERED AND NON-REBATE PRODUCTS |
| NON-MATCHED PRESCRIBER ID |

| |
|---|
| NON-PREFERRED DRUG |
| OVER UTILIZATION PRECAUTION |
| PATIENT IS NOT COVERED |
| PDL |
| PHARMACY MAINTENANCE SUPPLY REQUIRED FOR DRUG |
| PLAN LIMITATIONS EXCEEDED |
| PRESCRIBER IS NOT COVERED |
| PRIOR AUTHORIZATION REQUIRED |
| PRODUCT/SERVICE NOT COVERED – PLAN/BENEFIT EXCLUSION |
| PRODUR ALERT |
| PROVIDER NOT ENROLLED IN BENEFIT PLAN |
| BILL MEDICARE |
| QUANTITY DISPENSED EXCEEDS MAXIMUM ALLOWED |
| REFILL EXCEEDS MAX. ALLOWABLE REFILLS |
| REFILL TOO SOON |
| REPORTED DISEASE |
| SERVICE NOT COVERED |
| SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYOR |
| TAMPER PROOF PAD REQD |
| THERAPEUTIC DUPLICATION |
| UNDER UTILIZATION PRECAUTION |