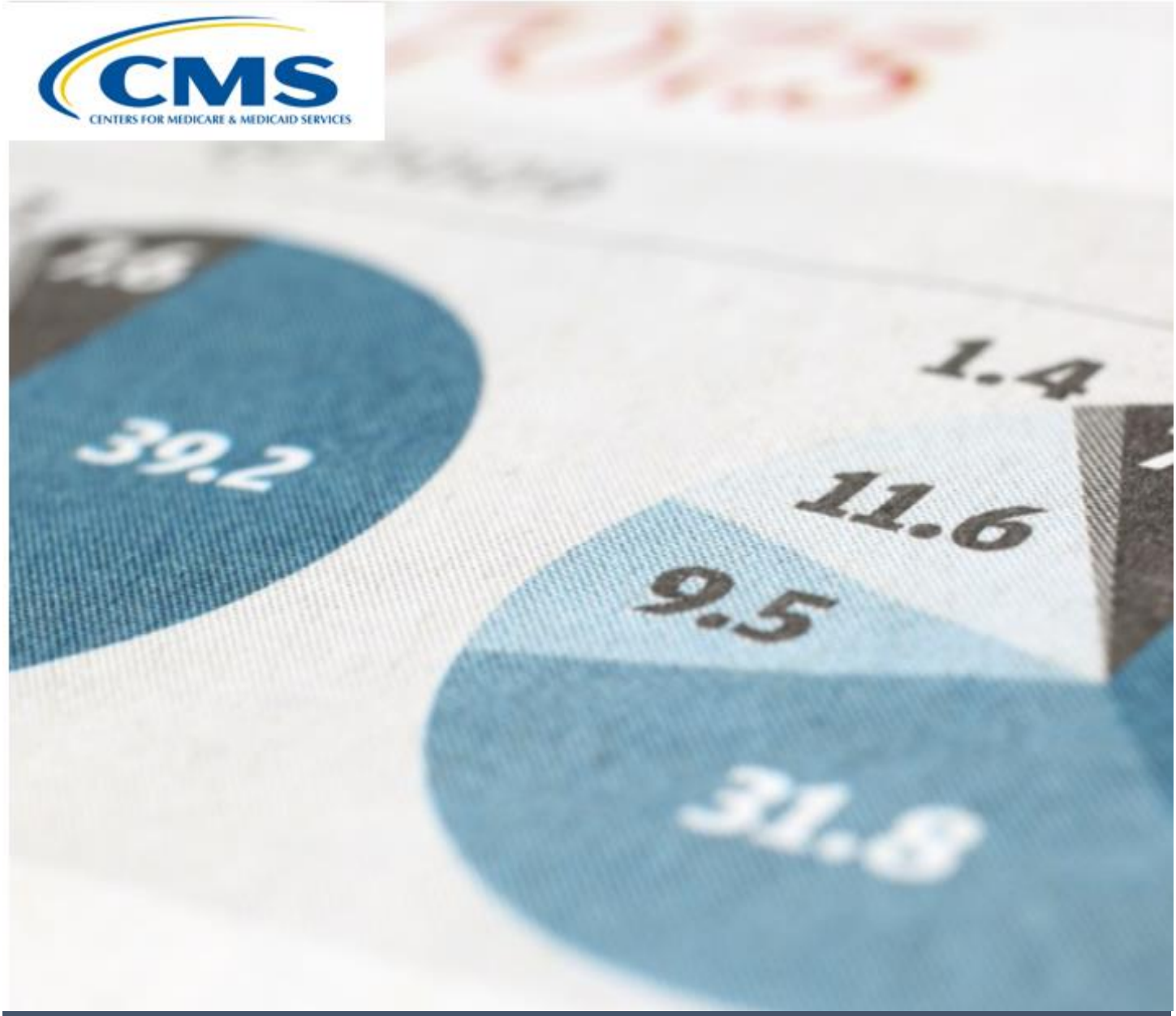

New York
Medicaid Fee-For-Service (FFS)
2019 Drug Utilization Review (DUR)

Table of Contents

Section I – Number of Beneficiaries **1**

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

2. On average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)? 1

Section II - Prospective DUR (ProDUR) **1**

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

   a. Vendor Name 1

   b. If not state-operated, is the POS vendor also the MMIS fiscal agent or a separate PBM? 1

2. Identify ProDUR criteria source. 1

3. Are new ProDUR criteria approved by the DUR Board? 1

4. When the pharmacist receives a level-one ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)? 1

5. Do you receive and review follow-up reports providing individual pharmacy provider DUR alert override activity in summary and/or in detail? 1

   a. If "Yes," how often do you receive reports? 2

   b. If you receive reports, do you follow up with those providers who routinely override with interventions? 2

6. Early Refill 2

   a. At what percent threshold do you set your system to edit? 2

   b. For non-controlled drugs: When an early refill message occurs, does the state require prior authorization? 2

   c. For controlled drugs: When an early refill message occurs, does the state require prior authorization? 2

7. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your state's policy allow the pharmacist to override for situations such as: 2

   a. Lost/stolen Rx 3

   b. Vacation 3

   c. "Other," please explain. 3

8. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early? 3

9. Does the state Medicaid agency or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)? 3

10. Does the state Medicaid agency have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled, chronic medication refills at the same time, the state would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)? 3

a. Does your program provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation? 4

Yes 4

12. Please list the requested data in each category in *Table 1 - Top Drug Claims Data Reviewed by the DUR Board* that follows 4

13. Section 1927(g)(A) of the Social Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in your state has responsibility for monitoring compliance with the oral counseling requirement? Check all that apply: 5

14. Summary 1 – Pharmacy Oral Counseling Compliance 5

Section III - RETROSPECTIVE DUR (RetroDUR) 6

a. Identify, by name, your RetroDUR vendor. 6

b. Is the RetroDUR vendor also the MMIS fiscal agent? 6

2. Who reviews and approves the RetroDUR criteria? 6

3. Summary 2 – Retrospective DUR Educational Outreach 6

Section IV - DUR BOARD ACTIVITY 8

1. Summary 3 – DUR Board Activities Report. 8

2. Does your state have an approved Medication Therapy Management Program? 14

a. Have you performed an analysis of the program's effectiveness? 14

b. Is your DUR Board involved with this program? 14

Section V - PHYSICIAN ADMINISTERED DRUGS 14

1. ProDUR? 14

2. RetroDUR? 14

Section VI - GENERIC POLICY AND UTILIZATION DATA 14

1. Summary 4 – Generic Drug Substitution Policies 14

2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your state have a more restrictive requirement? 15

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. 16

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. 16

Section VII - PROGRAM EVALUATION / COST SAVINGS / COST AVOIDANCE 16

1. Did your state conduct a DUR program evaluation of the estimated cost savings/cost avoidance? 16

2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below 17

3. The Estimated Percent Impact was generated by dividing the Grand Total Estimated Avoided Costs from Question 2 above by the Total Dollar Amount provided in Section VI, Question 4, then multiplying this value by 100. 17

4. Summary 5 – Cost Savings/Cost Avoidance Methodology 17

Section VIII - FRAUD, WASTE, AND ABUSE DETECTION 19

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS 19

1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries? 19

2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances? 19

a. What criteria does your state use to identify candidates for Lock-In? Check all that apply: 19

b. Do you have the capability to restrict the beneficiary to: 19

c. What is the usual Lock-In time period? 19

d. On average, what percentage of the FFS population is in Lock-In status annually? 19

e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review as part of Attachment 5. 19

3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers? 19

4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by pharmacy providers? 20

5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by beneficiaries? 20

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP) 20

1. Does your state have a Prescription Drug Monitoring Program (PDMP)? 20

a. Does your agency have the ability to query the state's PDMP database? 20

b. Do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing controlled substances? 21

c. Are there barriers that hinder the agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse? 21

2. Have you had any changes to your state's Prescription Drug Monitoring Program during this reporting period that have improved the agency's ability to access PDMP data? 21

C. PAIN MANAGEMENT CONTROLS 21

1. Does your program obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs? 21

a. Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing? 21

b. Do you apply this DEA file to your RetroDUR reviews? 22

2. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management? 22

D. OPIOIDS 22

1. Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription? 22

a. Is there more than one quantity limit for the various opioids? 22

b. What is the maximum number of days' supply allowed for an initial opioid prescription? 22

c. Does this days' supply limit apply to opioid prescriptions? 22

2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids? 22

3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids? 23

4. Do you have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids? 23

5. Do you have POS edits to monitor duplicate therapy of opioid prescriptions? 23

6. Do you have POS edits to monitor early refills of opioid prescriptions dispensed? 24

7. Do you have comprehensive claims review automated retrospective process to monitor opioid prescriptions exceeding these state limitations? 24

8. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and benzodiazepines being used concurrently? 24

9. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and sedatives being used concurrently? 25

10. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and antipsychotics being used concurrently? 25

11. Do you have POS safety edits or perform RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis? 26

12. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines? 26

13. Do you have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)? 27

E. MORPHINE MILLIGRAM EQUIVALENT (MME) DAILY DOSE 27

1. Have you set recommended maximum MME daily dose measures? 27

2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere? 27

a. If "Yes," Please name the developer of the calculator: 28

b. If "Yes," how is the information disseminated? Check all that apply: 28

3. Do you have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded? 28

4. Do you have automated retrospective claim reviews to monitor total daily dose (MME) of opioid prescriptions dispensed? 28

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER (OUD) 28

1. Does your agency set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs? 28

2. What are your limitations on the allowable length of this treatment? 28

3. Do you require that the maximum mg per day allowable be reduced after a set period of time? 28

a. What is your reduced (maintenance) dosage? 28

b. What are your limitations on the allowable length of the reduced dosage treatment? 28
4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization? 29
5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT? 29
6. Do you have at least one naloxone opioid overdose product available without prior authorization? 29
7. Do you retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose? 29
8. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols? 29
9. Does your state agency cover methadone for a substance use disorder (i.e. Methadone Treatment Center)? 29
G. ANTIPSYCHOTICS / STIMULANTS 29
ANTIPSYCHOTICS 29
1. Do you currently have restrictions in place to limit the quantity of antipsychotics? 30
2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children? 30
a. If "Yes," do you either manage or monitor: 30
b. If "Yes," do you have edits in place to monitor (check all that apply): 30
c. Please briefly explain the specifics of your antipsychotic monitoring program(s). 30
d. If "No," do you plan on implementing a program in the future? 30
STIMULANTS 30
3. Do you currently have restrictions in place to limit the quantity of stimulants? 30
4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children? 30
a. If "Yes," Do you either manage or monitor: 31
b. If "Yes," Do you have edits in place to monitor (check all that apply): 31
c. Please briefly explain the specifics of your documented stimulant monitoring program(s) 31
d. If "No," do you plan on implementing a program in the future? 31
Section IX - INNOVATIVE PRACTICES 31
1. Summary 6 – Innovative Practices 31
Section X - E-PRESCRIBING 33
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? 33
2. Does your system use the NCPDP Origin Code that indicates the prescription source? 34
Section XI - MANAGED CARE ORGANIZATIONS (MCOs) 34
1. How many MCOs are enrolled in your state Medicaid program? 34
2. Is your pharmacy program included in the capitation rate (carved in)? 34
3. Does the state set requirements for the MCO's pharmacy benefit (e.g. same PDL, same ProDUR/RetroDUR)? 34

a. If “Yes,” please check all requirements that apply 34
b. If “Yes,” please briefly explain your policy. 34
4. Did all of your managed care plans submit their DUR reports? 34
Section XII – EXECUTIVE REPORT 35
Summary 8-Executive Report should provide a brief overview of your program. It should describe 2019 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives. 35

New York DUR 2019 FFS Individual State Report

Section I – Number of Beneficiaries

Question	Response
1. On average, how many of your state's Medicaid beneficiaries are enrolled in your state's Medicaid Fee-For-Service (FFS) program that have a pharmacy benefit?	**1,400,000**
2. On average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)?	**5,000,000**

Section II - Prospective DUR (ProDUR)

Question	Response
1. Indicate the type of your pharmacy point of service (POS) vendor.	**Contractor**
a. Vendor Name	**General Dynamics Information Technology**
b. If not state-operated, is the POS vendor also the MMIS fiscal agent or a separate PBM?	**POS vendor is the fiscal agent**
2. Identify ProDUR criteria source.	**First Databank**
If "Other," please specify	N/A
3. Are new ProDUR criteria approved by the DUR Board?	**Yes**
If "No," please explain	N/A
4. When the pharmacist receives a level-one ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?	**Varies by alert type**
If "varies," please explain	Any anti-retroviral (used in the treatment of Aids/HIV) level 1 drug interaction encountered cannot be overridden by the pharmacist and the prescriber must obtain a PA. All other level 1 ProDUR edits can be overridden by the Pharmacist.
5. Do you receive and review follow-up reports providing individual pharmacy provider DUR alert override activity in summary and/or in detail?	**Yes**

Question	Response
a. If "Yes," how often do you receive reports?	**Annually**
If "Other," please explain	N/A
b. If you receive reports, do you follow up with those providers who routinely override with interventions?	**Yes**
If "Yes," by what method do you follow up?	Other
If "Other," please explain.	Program activity that appear to have a high level of overrides are evaluated through clinical review by the DUR Board using utilization information to evaluate the effectiveness of system edits. Potential upgrades/modification of ProDUR edits may result. RetroDUR activity is evaluated by the DUR Board using "educational letters" where appropriate.
If "No," please explain	N/A
If "No," please explain	N/A
6. Early Refill	
a. At what percent threshold do you set your system to edit?	
i) Non-controlled drugs:	**75%**
ii) Schedule II controlled drugs:	**75%**
iii) Schedule III through V controlled drugs:	**75%**
b. For non-controlled drugs: When an early refill message occurs, does the state require prior authorization?	**Yes**
If "Yes" or "Dependent on medication or situation," who obtains authorization?	Prescriber
If "No," can the pharmacist override at the point of service?	N/A
c. For controlled drugs: When an early refill message occurs, does the state require prior authorization?	**Yes**
If "Yes," who obtains authorization?	Prescriber
If "No," can the pharmacist override at the point of service?	N/A
7. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your state's policy allow the pharmacist to override for situations such as:	

Question	Response
a. Lost/stolen Rx	**No**
b. Vacation	**No**
c. "Other," please explain.	**N/A**
8. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?	**Yes**
If "Yes," please explain your edit.	At the time of refill the edit allows for an existing supply of no more than 10 days of medication which is determined by a refill "look-back" of 90 days. For controlled substances, the existing supply at the time of refill must be no more than 7 days as determined by a 90 day "look back".
If "No," do you plan to implement this edit?	N/A
9. Does the state Medicaid agency or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?	**Yes**
10. Does the state Medicaid agency have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled, chronic medication refills at the same time, the state would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?	**No**
11. For drugs not on your formulary, does your agency have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?	**Yes**
If "Yes," what is the preauthorization process?	Prescribers initiate a prior authorization (PA) request by contacting the NY Medicaid pharmacy clinical call center via telephone, fax or by way of a web-based application. In certain cases, an authorized agent (i.e. nurse, medical assistant with patient medical record access) can initiate the PA process. Each drug has specific clinical information that must be provided to the clinical call center before prior

Question	Response
	authorization may be issued. In general, prescribers or an authorized agent initially speak with a Certified Pharmacy Technician (CPT) when requesting authorization. If the information provided meet the clinical criteria, a PA may be issued by the CPT. Information not meeting the criteria are referred to a pharmacist for discussion of additional supporting information. If the clinical criteria are met, a PA is issued. Further escalation to a Medical Director may be necessary for certain PA requests. The Medical Director or pharmacist may contact the prescriber's office to discuss the rationale for use of a drug when the PA criteria is not met.
If "No," please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.	N/A
a. Does your program provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation?	**Yes**
If "Yes," what is the process?	A pharmacist can request a prior authorization for medication that is urgently needed. The supply amount would be for a 3-day period only. In addition, New York Medicaid FFS and Medicaid Managed Care provide at least 5 days' coverage for emergencies, without prior authorization, for medications used to treat substance use disorders.
If "No," please explain.	N/A
12. Please list the requested data in each category in *Table 1 - Top Drug Claims Data Reviewed by the DUR Board* that follows	

Table 1 – Top Drug Claims Data Reviewed by the DUR Board

Top 10 Prior Authorization (PA) Requests by Drug Name	Top 10 Prior Authorization (PA) Requests by Drug Class	Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications and Age Edits)	Top 10 Drug Names by Amount Paid	% of Total Spent for Drugs by Amount Paid (From data in Column 4, Determine the % of total drug spend)	Top 10 Drug Names by Claim Count	Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)
omeprazole	ataractic - traquilizers	drug/pregnancy Alert	insulin glargine	2.27%	ergocalciferol	5.16%
quetiapine	opiod analgesics	drug-drug interaction	sitagliptin	1.71%	folic acid	2.41%
methylphenidate	anti-ulcer/gastrointestinal preps	therapeutic duplication severity 1	paliperidone	1.70%	atorvastatin	1.25%
oxycodone	Antivirals	early refill: overuse precaution	bictegrav/emtricit/tenof alefen	1.64%	albuterol	1.17%
oxycodone/apap	Anticonvulsants	drug-disease reported precaution	elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide	1.55%	metformin	1.02%
aripiprazole	diabetic agents		lurasidone	1.30%	amlodipine	0.95%
zolpidem	CNS stimulants		rufinamide	1.19%	gabapentin	0.93%
pantoprazole sodium	Antidepressants		dolutegravir	1.19%	levothyroxine	0.84%
risperidone	amphetamine		budesonide/ formoterol	1.18%	divalproex sodium	0.73%
clonazepam	Miscellaneous		aripiprazole	1.16%	risperidone	0.71%

Question	Response
13. Section 1927(g)(A) of the Social Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in your state has responsibility for monitoring compliance with the oral counseling requirement? Check all that apply:	**State Board of Pharmacy, Other**
If "Other," please explain:	State Educational Department through the Office of Professional Discipline which performs on-site inspections.
14. Summary 1 – Pharmacy Oral Counseling Compliance Summary 1 Pharmacy Oral Counseling Compliance reports the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid Agency,	**The State Education Department through the Office of Professional Discipline incorporates observation of counseling in their routine inspections of pharmacies. Office of Professional Discipline reviews counseling procedures whenever noncompliance is**

Question	Response
the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid Agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the Omnibus Budget Reduction Act (OBRA) of 1990 prospective DUR requirement. This report details state efforts to monitor pharmacy compliance with the oral counseling requirement and should describe in detail, utilizing the text box below, the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.	**brought to their attention.**

Section III - RETROSPECTIVE DUR (RetroDUR)

Question	Response
1. Indicate the type of vendor that performed your RetroDUR activities during the time period covered by this report.	**Company**
a. Identify, by name, your RetroDUR vendor.	**Health Information Designs**
b. Is the RetroDUR vendor also the MMIS fiscal agent?	**No**
c. Is the RetroDUR vendor also the developer/supplier of your retrospective DUR criteria?	**Yes**
If "No," please explain	N/A
2. Who reviews and approves the RetroDUR criteria?	**State DUR Board**
"Other," please explain	N/A
3. Summary 2 – Retrospective DUR Educational Outreach Summary 2 Retrospective DUR Educational Outreach is a year-end summary report on RetroDUR screening and educational interventions. The year-end summary should be limited to the most prominent 10 problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed.	**criteria type criteria number Description # recipients mailed letters Responses** **DD 3592 Concurrent opioids & benzodiazepines SUPPORT Act 282 659 80** **DD 10890 Concurrent opioids & antipsychotics SUPPORT Act 206 489 38** **TA 9237 Cholesterol guidelines in diabetic patients age 40-75 195 302**

	21 **TA 3739 Immediate-release opioids for pain management 166 265** **31** **DD 3093 Concurrent CNS stimulants & serotonergic agents 96 220 43** **TD 454 Duplicate therapy of atypical antipsychotics 84 169 13** **DD 10670 Concurrent opioids & gabapentin (>900mg/day) 91 183 14** **DD 10899 Concurrent opioids & pregabalin 100 169** **27** **TA 8807 PPI's & risk of osteoporosis 116 150 14** **DB 3232 Antipsychotic use in diabetic patients 72 147 12** **Total Top 10 1408 2753 293** **Total all letters 3713 6381 668** **Key: TA, therapeutic appropriateness; DD, drug-drug interaction; TD, therapeutic duplication; DB, drug-drug marker and/or diagnosis** **Results** **Provider Responses to Intervention Letters** **A total of 6,381 DUR educational intervention letters were mailed to prescribers during FFY 2019 and 668 responses were received for a response rate of 10%. A summary of all coded responses from prescribers is listed in the table below.** **Prescriber Response Total** **MD UNAWARE OF WHAT OTHER MD PRESCRIBING 8** **PT IS NO LONGER UNDER THIS MD's CARE 70** **MD SAYS PROB INSIGNIFICANT NO CHG THX**

	246 **MD WILL REASSESS AND MODIFY DRUG THERAPY 122** **MD TRIED TO MODIFY THERAPY, PT NON-COOPERATIVE 19** **PATIENT DECEASED 4** **PATIENT WAS NEVER UNDER MD CARE 36** **HAS APPT TO DISCUSS THERAPY 21** **MD DID NOT RX DRUG ATTRIBUTED TO HIM. 41** **TRIED TO MODIFY THERAPY, SX RECURRED 37** **MD SAW PATIENT ONLY ONCE IN ER OR AS ON-CALL MD 58** **MD RESPONSE FORM RETURNED BLANK 4** **RPH WILL COUNSEL PT ON NEXT VISIT 1** **PT NO LONGER USES PHARM / OR SEES MD 1** **TOTAL OF ALL RESPONSES 668** **Response Rate 10%** **Conclusion** **For FFY 2019, a total of 2,753 intervention letters for the top 10 criteria alerts were mailed to prescribers, with a response rate of 11%. There was also a 10% physician response rate for all criteria alerts, and 28% of prescribers who responded to the letters indicated that some positive action had been or would be taken to address the drug therapy issue identified in the intervention letter.**

Section IV - DUR BOARD ACTIVITY

Question	Response
1. Summary 3 – DUR Board Activities Report. Summary 3 DUR Board Activities Report should be a brief descriptive report on DUR Board activities during the fiscal year reported.	**During the period of October 1, 2018 to November 30, 2019 the DUR Board held three meetings: February 14, 2019, May 16, 2019 and September 19, 2019. The following discussions and resolutions took place during the following meetings:** **February 14, 2019** **Drug Cap Review of Remicade (infliximab)** **The Board was apprised of the expenditures for Remicade as this product was identified**

Question	Response
	as piercing the State's Medicaid Drug Cap. State legislation requires that the absence of positive rebate negotiations for products identified as piercing the Drug Cap requires the Commissioner of Health to direct the Drug Utilization Review (DUR) Board to perform a drug review with the intent of suggesting a targeted supplemental rebate from the manufacturer. A product review of Remicade (infliximab) was presented emphasizing its place in therapy, indications, and utilization data. A cost comparison of the biosimilar products to Remicade were outlined. The Board decided upon a supplemental rebate target amount and recommended that value to the Commissioner of Health. Drug Utilization Review : Concurrent use of opioids with gabapentin/pregabalin A drug utilization review of the concurrent use of opioids with gabapentinoids was presented which demonstrated safety concerns with the gabapentinoid doses being used. The Board made three recommendations:1) PA requirement for gabapentin doses >900mg per day and pregabalin doses > 150 mg per day in patients currently on an opioid dose > 50 morphine milligram equivalent /day. 2) PA requirement for concurrent opioid use beyond 7-day supply in patients established on a gabapentinoid. 3) Dose limitations for pregabalin IR and ER, 4) Intervention letter to prescribers highlighting safety concerns associated with concurrent use of opioids and gabapentinoids. Prevention of Migraine Headaches and Concurrent use of Triptans A drug utilization review was conducted on the prevention of migraine headaches and the concurrent use of triptans. The data showed that there may be some overutilization of triptans by way of utilizing different strengths or agents to receive dosage units above the programs monthly quantity limits. Utilization of Systemic Immunomodulators A drug utilization analysis was presented to

Question	Response
	assess if products in the systemic immunomodulator class were being used for FDA approved indications. The data identified 5 top agents all of which were used for FDA-approved indications. **Review of Clinical Edits** **Drug utilization data illustrating the role of current pharmacy criteria/intervention initiatives developed for the Medicaid Program (FFS and MC) and their effects on the use of opioids for pain management was presented to the Board. The data demonstrated a downward trend in opioid use for the Medicaid Program for the periods State Fiscal Year (SFY) 2014 through SFY 2018. In addition, data was presented illustrating the use of medications for opioid dependence within the Medicaid Program (FFS and MC). The data showed an increase in members utilizing buprenorphine containing products. The presentation summarized for the Board the benefits legislative initiatives and pharmacy management programs had on the use of opioids in the Medicaid Program.** **May 16, 2019** **Preferred Drug Program** **A clinical and financial review of products being added or moved between the preferred and non-preferred sections of the Preferred Drug List (PDL) were outlined for the Board. The therapeutic classes reviewed for PDL status. The categories reviewed were as follows: Tetracyclines, Anticonvulsants, Anti-Migraine agents, CNS Stimulants, Movement Disorder Agents, Multiple Sclerosis Agents, Growth Hormones, Colony Stimulating Factors, Erythropoiesis Stimulating Agents, Immunosuppressives, Anti-hyperuricemics, Anticholinergics/COPD Agents. Suggested changes to the PDL by the Department of Health were recommended by the Board.** **September 19, 2019** **Drug Cap Update** **A Drug Cap update was presented as an overview for the Board focusing on pharmacy**

Question	Response
	expenditures for SFY 2019 and projections for SFY 2020. Based upon projections, pharmacy expenditures are expected to exceed the States Medicaid Drug Cap. **Support for Patients and Communities Act (The SUPPORT ACT)** **The Board was provided a dissertation on the Support for Patients and Communities (SUPPORT) Act went into effect October 1, 2019. The report focused on section 1004 of the Act which is specific to Medicaid review and utilization. The SUPPORT ACT effects both Medicaid and Managed Care Entities. Specific DUR provisions become effective on October 1, 2019 and it was reported that provisions of the ACT are in place for FFS. Early indications suggest that the provisions are in place for the Managed Care Plans after a review of their CMS Annual DUR Survey for compliance.** **Opioid Utilization as it Relates to the SUPPORT ACT** **A review was presented to the Board to illustrate the tools currently used by the New York Medicaid Program to comply with the standards of the SUPPORT ACT. Focus was placed on the prospective (ProDur) and retrospective (RetroDur) initiatives as applied to opioid utilization within the Medicaid Program. Point of service edits (ProDur initiative) have impacted opioid utilization which have led to a decrease in opioid use from SFY 2014 to the present. Retrospective evaluations (RetroDur initiative) identify drug therapy concerns involving opioids. Targeted educational letters are then sent to Medicaid providers (prescribers and pharmacists). Trends involving suspected fraud and abuse with opioids are then extracted and sent to the Office of the Medicaid Inspector General for review. After the presentation the Board acted on opioid utilization as related to the SUPPORT ACT by recommending that a prior authorization be required for opioid-naive patients exceeding a morphine milligram equivalent (MME) of 90 mg per day.** **Antipsychotic Utilization in Children as**

Question	Response
	Related to the SUPPORT ACT **A drug utilization review was presented evaluating the concurrent use of antipsychotics and opioid medications in children in both the Medicaid and Managed Care programs. Utilization data was inclusive of age, metabolic monitoring and poly pharmacy and included the foster care children population. Clinical monitoring criteria from the ProDur and RetroDur programs were identified as being consistent with the positions of the FDA, CMS, and the requirements of the SUPPORT ACT. At the conclusion of the presentation the Board recommended that a targeted educational letter be sent to prescribers regarding antipsychotic therapy and metabolic monitoring for patients less than 21 years of age. A second recommendation by the Board required prior authorization for patients less than 21 years of age when there is concurrent use of two or more different oral antipsychotics for greater than 90 days.** **Concurrent Utilization of Opioids and Antipsychotics as related to the SUPPORT ACT** **A second drug utilization review was conducted with the purpose of evaluating the concurrent use of antipsychotics, opioid medications and benzodiazepine agents in conjunction with the mental health treatment and the coordination of care of recipients within the Medicaid FFS and MC populations. Once again, the current clinical criteria edits and programs (ProDur and RetroDur) utilized by the Medicaid FFS program illustrated consistency with the positions of the FDA and CMS as they pertained to opioid and antipsychotics monitoring. The review concluded that the aspects of the ProDur and RetroDur programs should continue to be used to monitor the concurrent use of these agents with the Medicaid Program. The Board recommended that a targeted educational letter be sent to prescribers highlighting the SUPPORT ACT requirements addressing the concurrent use of antipsychotic and opioid medications and**

Question	Response
	the importance for mental health treatment and coordination of care. **Leukotriene Modifier Utilization in the Treatment of Asthma** **A third drug utilization review was presented which reviewed the use of leukotriene modifiers in patents being treated for asthma. Current treatment modalities from both the Global Initiative of Asthma and the National Heart, Lung and Blood institute served as guidelines. Data presented reflected the utilization of leukotriene modifiers with and without a diagnosis of asthma. Combined therapies with and without short acting beta agonists, with inhaled corticosteroids as well as with inhaled corticosteroids and long acting beta agonists were identified. The review concluded that 2.4% of Medicaid members with asthma using leukotriene modifiers did not have a claim for another agent used to treat. The Board recommended that a targeted educational letter be sent to prescribers regarding leukotriene modifier use relative to as asthma treatment guidelines.** **Clinical Editing Updates** **An update on clinical editing with respect to anti-retroviral (ARV) agents and associated drug interactions was presented. It was explained that the current coding system to categorize drug to drug interactions (DDI) based on severity of clinical significance has changed resulting in interactions of level 1 severity not being captured and reported properly. To compensate, point-of-service edits have been enhanced to report ARV-ARV interactions as level 1. As a result, select ARV-ARV drug interactions previously masked by the change in severity level coding are now able to be identified using point-of-service edits. The process of updating ARV-ARV drug interactions using point-of-service editing will continue as new ARVs or post marketing drug interaction data become available.**

Question	Response
2. Does your state have an approved Medication Therapy Management Program?	**No**
a. Have you performed an analysis of the program's effectiveness?	**N/A**
"Yes," please provide a brief summary of your findings.	N/A
b. Is your DUR Board involved with this program?	**N/A**
If the answer to question 2 is "No," are you planning to develop and implement a program?	No

Section V - PHYSICIAN ADMINISTERED DRUGS

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

Question	Response
1. ProDUR?	**No**
If "No," do you have a plan to include this information in your DUR criteria in the future?	No
2. RetroDUR?	**No**
If "No," do you have a plan to include this information in your DUR criteria in the future?	No

Section VI - GENERIC POLICY AND UTILIZATION DATA

Question	Response
1. Summary 4 – Generic Drug Substitution Policies Summary 4 Generic Drug Substitution Policies summarizes factors that could affect your generic utilization percentage. Please explain and provide details.	**New York Generic Substitution Policies** **Medicaid generic substitution policy is aligned with Article 137 of New York State Education Law, which states that a pharmacist must substitute a less expensive drug product containing the same active ingredients, dosage form and strength as the drug product prescribed, ordered or demanded. provided that the following conditions are met:** **The prescription meets the requirements of subdivision six of section sixty-eight hundred ten of this article and the prescriber does not prohibit substitution, or in the case of oral prescriptions, the prescriber must expressly state whether substitution is to be permitted or prohibited. Any oral prescription that does not include such an express statement shall**

Question	Response
	not be filled; and **The substituted drug product is contained in the list of drug products established pursuant to paragraph (o) of subdivision one of section two hundred six of the public health law; and** **The pharmacist shall indicate on the label affixed to the immediate container in which the drug is sold or dispensed, the name and strength of the drug product and its manufacturer unless the prescriber specifically states otherwise. The pharmacist shall record on the prescription form the brand name or the name of the manufacturer of the drug product dispensed.** **Effective March 27, 2016, practitioners were mandated to electronically prescribe both controlled and non-controlled substances. Education Law 6810 allows the prescriber to electronically sign and insert an electronic direction to dispense the drug as written.** **New York State Medicaid administers a Dispense Brand when Less Expensive than Generic cost containment initiative which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent. Except for drugs subject to the Dispense Brand when Less Expensive than Generic program, State law excludes Medicaid coverage of brand name drugs when the Federal Food and Drug Administration (FDA) has approved a generic product, unless a prior authorization is received. Prescriptions for brand-name drugs, where an A-rated generic equivalent is available, require that the prescriber obtain prior authorization for the brand name drug.**
2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your state have a more restrictive requirement?	**Yes**
If "Yes," check all that apply.	Prior authorization is required
Other, please explain.	N/A

Question	Response

Table 2 - Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	458,137	5,668,813	371,502
Total Reimbursement Amount Less Co-Pay	$359,542,203	$126,645,210	$142,858,136

Question	Response
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.	
Number of Generic Claims	5,668,813
Total Number of Claims	6,498,452
Generic Utilization Percentage	87.23%
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.	
Generic Dollars	$126,645,210
Total Dollars	$629,045,549
Generic Expenditure Percentage	20.13%

Section VII - PROGRAM EVALUATION / COST SAVINGS / COST AVOIDANCE

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

Question	Response
If "Yes," identify, by name and type, the institution that conducted the program evaluation.	
Institution Type	Company
Institution Name	Health Information Design
2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below	

	Data
ProDUR Total Estimated Avoided Costs	$53,118,347.00
RetroDUR Total Estimated Avoided Costs	$2,259,237.00
Other Cost Avoidance	$20,100,000.00
Grand Total Estimated Avoided Costs	$75,477,584.00

Question	Response
3. The Estimated Percent Impact was generated by dividing the Grand Total Estimated Avoided Costs from Question 2 above by the Total Dollar Amount provided in Section VI, Question 4, then multiplying this value by 100. Estimated Percent Impact	**12.00%**
4. Summary 5 – Cost Savings/Cost Avoidance Methodology Summary 5 Cost Savings/Cost Avoidance Methodology includes program evaluations/cost savings estimates prepared by state or contractor.	**ProDur cost savings/cost avoidance is calculated by the Department of Health (DOH). It is determined by calculating the number of ProDUR edit override rejections encountered by pharmacists and multiplying that by the average cost per claim. There was a total of 1.7 million rejected pharmacist override attempts for FFY 2019. Cost per claim was determined by dividing the total claim expenditures (less rebates) by the number of claims for FFY 2019 which yielded a cost per claim of $30.58. Total estimated cost savings/avoidance from the ProDUR Program amounted to $53.1 million dollars.** **Retro DUR savings is determined by the contracted vendor, Health Information Designs (HID). Total savings was calculated at $2.3 million. Rebate amounts were not**

	included since the vendor does not have access to that data. **To determine the impact of RetroDUR intervention letters on overall drug expenditures, total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. HID then compared drug expenditures and utilization in the targeted intervention population for the pre- and post-intervention timeframes with a comparison group to determine the estimated impact of the RetroDUR intervention letters.** **The comparison group consisted of a random group of recipients who were not chosen for RetroDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods.** **For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RetroDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the RetroDUR intervention letters. Recipients were analyzed based on whether a single or duplicate intervention existed (a duplicate intervention being the occurrence of at least two RetroDUR intervention letters on the same recipient within FFY 2019). The pharmacy claims costs were compared for the pre- and post-intervention periods. To evaluate the impact of changes over time, such as manufacturer drug price changes or policy changes, the intervention group for each case was compared to a similar comparison group. Anything that happens to one group will also affect the other group and negate any effects.** **Other cost savings/avoidance were achieved during the State's Fiscal Year (SFY) 2018-2019. Cost savings/avoidance for the Preferred Drug Program totaled $8.1 million, the Brand less than Generic Program $4.3 million and savings attributed to the Lock-in Program $7.8 million.**

Section VIII - FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

Question	Response
1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Deny claims and require prior authorization, Refer to Lock-In Program, Refer to Office of Inspector General
"Other," Please explain	N/A
2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances? If the answer to question 2 is "Yes," please continue	**Yes**
a. What criteria does your state 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**
"Other," please explain	N/A
b. Do you have the capability to restrict the beneficiary to:	
i. Prescriber only	**Yes**
ii. Pharmacy only	**Yes**
iii. Prescriber and Pharmacy	**Yes**
c. What is the usual Lock-In time period?	**Lock-in time period is based on number of offences**
"Other," please explain	N/A
d. On average, what percentage of the FFS population is in Lock-In status annually?	**0.1000%**
e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review as part of Attachment 5.	**$7.80**
3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers?	**Yes**

Question	Response
If "Yes," what actions does this process initiate? Check all that apply:	Other
"Other," please explain	Professional retro-dur case reviewers refer potential prescriber fraud cases to the DUR program. They are then forwarded to the Medicaid Office of Inspector General for further review and/or possible investigation.
"No," please explain	N/A
4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by pharmacy providers?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Other
"Other," please explain	Professional retro-dur case reviewers refer potential prescriber fraud cases to the DUR program. They are then forwarded to the Medicaid Office of the Inspector General (OMIG) for further review and/or possible investigation.
"No," please explain	N/A
5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by beneficiaries?	**Yes**
"Yes," please explain your program for fraud, waste, or abuse of non-controlled substances.	Professional retro-dur case reviewers refer potential prescriber fraud cases to the DUR program. They are then forwarded to the Medicaid Office of the Inspector General (OMIG) for further review and/or possible investigation.
"No," please explain	**N/A**

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

Question	Response
1. Does your state have a Prescription Drug Monitoring Program (PDMP)? If the answer to question 1 is "Yes," please continue with a, b, and c.	**Yes**
a. Does your agency have the ability to query the state's PDMP database? If the answer to sub-question 1 a is "Yes," please continue.	**No**

Question	Response
i. Please explain how the state applies this information to control fraud and abuse.	N/A
ii. Do you also have access to Border States' PDMP information?	N/A
iii. Do you also have PDMP data (i.e. outside of MMIS, such as a controlled substance that was paid for by using cash) integrated into your POS edits?	N/A
b. Do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing controlled substances?	**Yes**
c. Are there barriers that hinder the agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?	**Yes**
"Yes," please explain the barriers (i.e. lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).	Currently the Medicaid Program is working to establish a data exchange with the Bureau of Narcotic Enforcement which operates and manages the PDMP
2. Have you had any changes to your state's Prescription Drug Monitoring Program during this reporting period that have improved the agency's ability to access PDMP data?	**No**
"Yes," please explain.	N/A

C. PAIN MANAGEMENT CONTROLS

Question	Response
1. Does your program obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs? If the answer to question 1 is "Yes," please continue.	**No**
a. Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?	**N/A**
If "Yes," please explain how information is applied.	N/A
If "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?	N/A
If "No," please explain	N/A

Question	Response
b. Do you apply this DEA file to your RetroDUR reviews?	**N/A**
If "Yes," please explain how it is applied.	N/A
2. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?	**Yes**
If "No," please explain why you do not have a measure in place to either manage or monitor the prescribing of methadone for pain management.	N/A

D. OPIOIDS

Question	Response
1. Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription? If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue.	**Yes, for all opioids**
Please explain answer above.	A quantity limit of a 7-day supply is a POS edit for initial opioid prescriptions for acute pain in recipients who are opioid naive. Exceptions are for recipients with a diagnosis of cancer or sickle cell disease.
a. Is there more than one quantity limit for the various opioids?	**Yes**
"Yes," please explain	Quantity limits are placed on various opioids based upon the maximum dosing guidelines established by the FDA extended over a 30-day period.
b. What is the maximum number of days' supply allowed for an initial opioid prescription?	**7**
c. Does this days' supply limit apply to opioid prescriptions?	**Yes, for all opioids**
"No," please explain	N/A
2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?	**Yes**
If "Yes," what is your maximum days' supply per prescription limitation?	Other

Question	Response
"Other," please explain	Quantity limits are based upon FDA maximum daily doses extended for a maximum of a 30-day period.
If "No," please explain	N/A
3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids?	**Yes**
If "Yes," what is your maximum days' supply per prescription limitation?	Other
"Other," please explain	Quantity limits are based upon FDA maximum daily doses extended for a maximum of a 30-day period.
If "No," please explain	N/A
4. Do you have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?	**Yes**
If "Yes," check all that apply:	Deny claim and require PA, Intervention letters, Step therapy or clinical criteria, Require PDMP checks
Please provide details on these opioid prescribing controls in place.	Claims are subject to a PA where the State's Medicaid Management Administrator reviews the prescribing with the prescriber. Physicians are required to refer to the States PDMP listing prior to writing prescriptions for opioids.
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.	N/A
5. Do you have POS edits to monitor duplicate therapy of opioid prescriptions?	**Yes**
Please explain	The Medicaid Program has a POS edit which indicates to a pharmacist when a therapeutic duplicate, of any medication being entered, exists on a recipient undergoing a medication order entry process. PA required for more than 4 opioid prescriptions within a 30-day period except for treatment of sickle cell disease or cancer. PA required for initiation of opioid therapy for patients on opioid dependence therapy. PA required for any additional long acting opioid for patients currently on long acting opioid therapy except for treatment of sickle cell disease or cancer.

Question	Response
6. Do you have POS edits to monitor early refills of opioid prescriptions dispensed?	**Yes**
Please explain	Early refills of opioid prescriptions are denied if the remaining amount is greater than a 7-day supply of an opioid medication which has been obtained over a period of 90 days.
7. Do you have comprehensive claims review automated retrospective process to monitor opioid prescriptions exceeding these state limitations?	**Yes, please explain in detail scope and nature of these retrospective reviews**
Please explain	Opioid claims are reviewed retrospectively by pharmacy academia from the State University of New York at Buffalo. Ad Hoc reviews by the DUR Board using drug utilization presentations by pharmacy academia from the State University of New York at Buffalo are used by the Board in identifying the effectiveness of the State limitations. Targeted educational letters, stricter point of service edits or additional edits would be a determination of the DUR Board.
8. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and benzodiazepines being used concurrently?	**Yes, both POS edits and retrospective reviews**
If "Yes," Please explain in detail scope and nature of reviews and edits.	In 2014 NY Medicaid put into place an edit requiring a prior authorization for claims submitted with concurrent use of opioids and benzodiazepines. Claims of concurrent use of opioids and benzodiazepines are retrospectively reviewed by pharmacy academia at the State University of New York at Buffalo. Ad Hoc reviews by the DUR Board using drug utilization presentations by pharmacy academia at the State University of New York at Buffalo are used by the Board in identifying the effectiveness of those edit. Targeted educational letters, stricter point of service edits or additional edits would be a determination of the DUR Board.
If "No," Please explain	N/A

Question	Response
9. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and sedatives being used concurrently?	**Yes, both POS edits and retrospective reviews**
If "Yes," Please explain in detail scope and nature of reviews and edits.	**A POS drug to drug interaction warning will alert pharmacists of the concurrent use of opioids and sedatives on a patient. Claims involving the concurrent use of sedatives and opioids are retrospectively reviewed by pharmacy academia at the State University of New York at Buffalo. Ad Hoc reviews by the DUR Board using drug utilization presentations by pharmacy academia at the State University of New York at Buffalo assess the degree of concern. Targeted educational letters, stricter point of service edits or additional edits are a determination of the DUR Board.**
If "No," Please explain	**N/A**
10. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and antipsychotics being used concurrently?	**Yes, both POS edits and retrospective reviews**
If "Yes," Please explain in detail scope and nature of reviews and edits.	A POS drug to drug interaction warning will alert pharmacists of the concurrent use of opioids and antipsychotics on a patient. Retrospective claims for the concurrent use of opioids and antipsychotics are reviewed by pharmacy academia from the State University of New York at Buffalo. Ad Hoc reviews by the DUR Board using drug utilization presentations by pharmacy academia from the State University of New York at Buffalo assess the concern. Targeted educational letters, stricter point of service edits or additional edits would be a determination of the DUR Board. To date Board actions have targeted educational letters to providers addressing concurrent use of opioids and antipsychotics and the importance of mental health treatment and coordination of care as outlined by the SUPPORT ACT.
If "No," Please explain	N/A

Question	Response
11. Do you have POS safety edits or perform RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?	**Yes, both POS edits and retrospective reviews**
If "Yes," retrospective reviews are performed, please indicate how often.	Ad hoc
"Other," please specify.	N/A
Please explain nature and scope of edits, reviews and/or provider education reviews performed.	PA is required for initiation of opioid therapy for patients on established opioid dependence therapy. Retrospective claims are reviewed monthly by SUNY at Buffalo academia. Ad Hoc drug utilization reviews are employed as a means of identifying clinical issues pertaining to concurrent use of opioids on patients established on opioid dependence therapy. Targeted educational letters, stricter point of service edits or additional edits would be a determination of the DUR Board.
If "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?	N/A
If "No," Please explain.	N/A
12. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?	**Yes**
If "Yes," please check all that apply	Your state Medicaid agency refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain., Other guidelines.
Please identify the "other" guidelines.	New York State offers licensed prescribers an Opioid Prescribing Training Program available at no charge to prescribers and is accredited for continuing education. The program covers 8 topics required per legislation. New York Medicaid, through its Medicaid Physician Education Program (PEP), offers visits by pharmacy educators detailing the use of agents for the treatment of chronic non-cancer pain using on-site education sessions. Educational modules are available using key messages to succinctly deliver prescribing tips. Modules are accredited by the Accreditation Council for Continuing Education. In addition, the State Medicaid Program's Physician Education Program uses the CDC guidelines on the web site as an additional

Question	Response
	reference.
Please explain why no guidelines are offered.	N/A
13. Do you have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?	**Yes**
"Yes," please explain	New York has abuse deterrent products available on the preferred section of the State's Preferred Drug List. Opioid antagonists (Narcan Nasal spray, naloxone and naltrexone), and injectable opioid dependence agents (Vivitrol and Sublocade) are preferred. Oral or trans-mucosal opioid dependent agents (buprenorphine and Suboxone) are preferred but require a PA for initiation of opioid therapy for patients on established opioid dependence therapy.

E. MORPHINE MILLIGRAM EQUIVALENT (MME) DAILY DOSE

Question	Response
1. Have you set recommended maximum MME daily dose measures?	**Yes**
If "Yes," please continue	
a. What is your maximum morphine equivalent daily dose limit in milligrams?	**90 MME mg per day**
i. If "Other", please specify	**N/A mg per day**
b. Please explain nature and scope of dose limit.	**On September 19, 2019 the DUR Board determined that a prior authorization will be required for opioid naive patients exceeding a morphine milligram equivalent (MME) of 90 mg per day. System methodology is expected to be put in place at a later date. Exceptions would be for patient therapy for Cancer or Sickle Cell Disease.**
If "No," please explain the measure or program you utilize.	**N/A**
2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?	**No**

Question	Response
a. If "Yes," Please name the developer of the calculator:	**N/A**
If "Other," please specify	N/A
b. If "Yes," how is the information disseminated? Check all that apply:	**N/A**
If "Other," please explain	N/A
3. Do you have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?	**No**
If "Yes," do you require prior authorization if the MME limit is exceeded?	N/A
4. Do you have automated retrospective claim reviews to monitor total daily dose (MME) of opioid prescriptions dispensed?	**Yes**
Please explain	Retrospective claims are reviewed monthly by pharmacy academia at the State University of New York at Buffalo. Where appropriate, utilization reviews are prepared by pharmacy academia at the State University of New York at Buffalo as a means of identifying clinical issues regarding the total daily dose (MME) of opioid prescriptions dispensed.

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER (OUD)

Question	Response
1. Does your agency set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?	**Yes**
If "Yes," please specify the total mg/day:	24 mg
If "Other," please explain	N/A
2. What are your limitations on the allowable length of this treatment?	**No limit**
If "Other," please explain	N/A
3. Do you require that the maximum mg per day allowable be reduced after a set period of time? If "Yes," please continue	**No**
a. What is your reduced (maintenance) dosage?	**N/A**
If "Other," please explain	N/A
b. What are your limitations on the allowable length of the reduced dosage treatment?	**N/A**

Question	Response
If "Other," please explain	N/A
4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?	**Yes**
5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?	**Yes**
"Other," please explain	N/A
If "Yes," can the POS pharmacist override the edit?	No
6. Do you have at least one naloxone opioid overdose product available without prior authorization?	**Yes**
7. Do you retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?	**No**
Please explain	This responsibility lies with the Department of Health through the Opioid Overdose Prevention program established in law April 1, 2006. (https://www.health.ny.gov/diseases/aids/consumers/prevention/opioidprevention/factsheet.htm). Eligible providers must establish and maintain a record keeping system and must report administrations of opioid antagonists to the NYS Department of Health.
8. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?	**Yes, State Board of Professional Regulations/Board of Pharmacy/ Board of Medicine and/or State Medicaid agency under protocol**
9. Does your state agency cover methadone for a substance use disorder (i.e. Methadone Treatment Center)?	**Yes**

G. ANTIPSYCHOTICS / STIMULANTS

ANTIPSYCHOTICS

Question	Response
1. Do you currently have restrictions in place to limit the quantity of antipsychotics?	**Yes**
Please explain	Maximum daily limits have been placed on the following antipsychotics: paliperidone ER; quetiapine; quetiapine ER based upon tablet strength.
2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?	**Yes**
a. If "Yes," do you either manage or monitor:	**All children**
"Other," please explain	N/A
b. If "Yes," do you have edits in place to monitor (check all that apply):	**Child's age, Dosage, Indication, Polypharmacy**
"Other" Please explain	N/A
c. Please briefly explain the specifics of your antipsychotic monitoring program(s).	**Point of service prior authorization if established DUR clinical criteria is not met as previously cited above.** **Step therapy trial with at least two different antidepressant agents when a Second-Generation Antipsychotic is used in the treatment of a major depressive disorder in the absence of other psychiatric co-morbidities.** **F/Q/D requirements for the following agents: paliperidone ER, quetiapine, quetiapine ER, quetiapine XR.** **Dose optimization.**
d. If "No," do you plan on implementing a program in the future?	**N/A**
If "Yes," when do you plan on implementing a program?	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.	N/A

STIMULANTS

Question	Response
3. Do you currently have restrictions in place to limit the quantity of stimulants?	**Yes**
4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?	**Yes**

Question	Response
a. If "Yes," Do you either manage or monitor:	**All children**
"Other," please explain	N/A
b. If "Yes," Do you have edits in place to monitor (check all that apply):	**Child's age, Dosage, Indication, Polypharmacy**
"Other," please explain	N/A
c. Please briefly explain the specifics of your documented stimulant monitoring program(s).	**Confirm diagnosis of FDA-approved, compendia-supported, and Medicaid covered indication for beneficiaries <18 years of age and beneficiaries 18 years of age and older.** **Confirm diagnosis that supports the concurrent use of a Second- Generation Antipsychotic and a CNS stimulant for patients<18 years of age.** **PA requirement required for initial prescriptions for stimulant therapy for beneficiaries less than 3 years of age.** **Quantity limits based on daily dosage as determined by FDA labeling.** **Patient-specific considerations for drug selection include treatment of excessive sleepiness associated with shift work sleep disorder, narcolepsy, or as an adjunct to standard treatment for obstructive sleep apnea.**
d. If "No," do you plan on implementing a program in the future?	**N/A**
If "Yes," when do you plan on implementing a program?	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children	N/A

Section IX - INNOVATIVE PRACTICES

Question	Response
1. Summary 6 – Innovative Practices Summary 6 - Innovative Practices should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing).	**During the time period being reviewed the NY BLTG (Brand Less than Generic) Program has been updated 8 times in an effort to capitalize on brand pricing being lower than the generic equivalent.** **Effective 11-29-18 a PA was required for all compounded products for topical use to**

Question	Response
	ensure that both Federal and State regulations are adhered to and that said therapy has FDA and compendia support. **The States Preferred Diabetic Supply program expanded coverage in the area of continuous glucose monitors and insulin pumps for diversity of its patient population.** **On 12-06-18 the recommendations of the DUR Board from their 9-20-18 meeting was put into place through the update of the States Prior Authorization Program.** **On 1-1-19 arrangements were made with a State MCO plan that did not cover family planning and reproductive health to now cover those services for their recipients.** **As an added effort to curtail the prescribing of opiates for pain management, New York Medicaid was able to create a tool to aid selection of non-opioid options for pain management with links to resources for the treatment of substance use disorder. This webpage development for non-opioid alternative treatment options became available 1-9-19.** **Effective 4-8-19, NY Medicaid issued a beneficial change for recipient coverage of contraceptive prescription drugs. The change allows for a written contraception order for family planning to be filled 12 times within one year. This was a change from the previous allowance of a one-time supply in a 12-month period or 5 times in a 6-month period.** **On 6-6-19 the DUR Board recommendations from their 2-14-19 meeting was put into place; an update of the States Prior Authorization Program, a drug cap review of the product Remicade was performed, requirement for prescriber intervention for the initiation of gabapentin or pregabalin on patients with concurrent use of an opioid, require prescriber intervention for continuation of opioid therapy beyond seven days in patients established on gabapentin or pregabalin, send a targeted educational letter to prescribers highlighting safety concerns associated with opioids and the concurrent use with gabapentin and**

Question	Response
	pregabalin. **A system's edit relating to the dispensing of vaccines through the Vaccines for Children Federal Program was put into effect on 5-23-19. The new edit assures that vaccines obtained through the Federal Program, dispensed to children at or under the age of 19, will no longer be allowed to be billed to NY Medicaid.** **DUR Board recommendations from their -19 meeting were put into effect on 8-25-19 with an update of the States Prior Authorization Program.** **A system's edit was put into effect on 9-12-19 which validates ingredient cost for 340B claims.** **On 11-21-19 the DUR Board recommendations from their 9-19-2019 meeting were put into effect; Prior authorization requirement for opioid-naive patients exceeding the morphine milligram equivalent (MME) of 90 mg per day, send targeted educational letters to prescribers regarding antipsychotic therapy and metabolic monitoring for patients less than 21 years, prior authorization required for patients less than 21 years of age when there is concurrent use of two or more different oral antipsychotics for more than 90 days, send targeted educational letter highlighting the SUPPORT ACT, send targeted educational letters to prescribers regarding leukotriene modifiers use relative to asthma treatment guidelines.**

Section X - E-PRESCRIBING

Question	Response
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?	**No**

Question	Response
If "Yes," do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?	N/A
If "Yes," please explain the evaluation methodology. **Summary 7 –E-Prescribing Activity** should explain the evaluation methodology utilized in evaluate the effectiveness of providing drug information and medication history prior to prescribing.	N/A
If "No," are you planning to develop this capability?	No
If "No," please explain	E Prescribing activity is monitored by the State's Bureau of Narcotic Enforcement (BNE). Evaluation of E prescribing activity is handled on a statewide basis.
2. Does your system use the NCPDP Origin Code that indicates the prescription source?	**Yes**

Section XI - MANAGED CARE ORGANIZATIONS (MCOs)

Question	Response
1. How many MCOs are enrolled in your state Medicaid program?	**19**
2. Is your pharmacy program included in the capitation rate (carved in)?	**Yes**
If "Partial," please specify the drug categories that are carved out.	N/A
3. Does the state set requirements for the MCO's pharmacy benefit (e.g. same PDL, same ProDUR/RetroDUR)?	**Yes**
a. If "Yes," please check all requirements that apply	**Formulary Reviews, No state PDL**
b. If "Yes," please briefly explain your policy.	**Managed care plans mimic the therapeutic categories on the FFS formulary but do not require that the formulary drugs in each therapeutic category are exact. Rules and Regulations of the distinct plans regarding PA requirements, appeals etc. will remain as that of each plan.**
If "No," do you plan to set standards in the future?	N/A
If "No," please explain	N/A
4. Did all of your managed care plans submit their DUR reports?	**Yes**
If "No," please explain.	N/A

Section XII – EXECUTIVE REPORT

Question	Response
Summary 8-Executive Report should provide a brief overview of your program. It should describe 2019 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.	**Prospective and Retrospective Review Programs** **The New York State Medicaid DUR Program is composed of two separate but complementary components: The Prospective Drug Utilization Review (ProDUR) Program and the Retrospective Drug Utilization Review (RetroDUR) Program. During the reporting period for Federal Fiscal Year (FFY) 2019, there were $1.7 million on-line claim rejections where pharmacists encountered dispensing issues that were avoided due to ProDUR safety edits. The estimated ProDUR cost avoidance for FFY 2019 amounted to $ 53.1 million dollars. The types of on-line claim rejections encountered during the review period (October 1, 2018 through September 30, 2019) encompass four general categories: early fill, drug-drug interactions, therapeutic duplication, prescriber notification. The RetroDUR Program is designed to improve prescribing trends by alerting providers through education, to problems identified by the RetroDUR process. The Medicaid RetroDUR Program uses intervention letters, based on DUR Board approved criteria. The RetroDUR review volume is 500 cases per month. Interventions may include referral to the Office of the Medicaid Inspector General (OMIG). During the reporting period (October 1, 2018 through September 30, 2019) the computer-based clinical criteria identified approximately 6,000 Medicaid members who met criteria for intervention letters. The DUR Program's RetroDUR vendor, Health Information Designs, Inc. (HID), confirmed potential drug therapy problems for 2,707 members, and a case was created for each member. Clinical pharmacists from the State University of New York at Buffalo reviewed member cases. These reviewers determine whether interventions are appropriate. During the review period, 6,381 alert letters were mailed to prescribers. Approximately**

Question	Response
	10% of the prescribers voluntarily replied to the program intervention letters. HID evaluated total drug expenditures and claims for the 6 months prior to and 6 months after the alert letters were mailed. HID found that the intervention group had a decrease of 10.58% in pharmacy claims cost following the RetroDUR intervention letters; whereas, the comparison group had a decrease of 2.61%. The total RetroDUR cost avoidance, calculated by the RetroDUR vendor was estimated at $2.3 million dollars. By notifying either prescribing providers (which provided most of the savings) or pharmacy providers, of the potential for inappropriate drug utilization, actions may be taken by the providers that result in a decrease in inappropriate utilization. The total DUR cost avoidance combines ProDUR and RetroDUR costs. In FFY 2019 the DUR program's ProDUR cost avoidance was calculated to be $53.1 million dollars. The RetroDUR cost avoidance was estimated at $2.3 million dollars. This resulted in an estimated total cost avoidance of $55.4 million dollars . The FFS spend, net of all rebates, for the reporting period for all drugs was $198.7 million dollars. The estimated DUR cost avoidance therefore represents twenty-seven and nine tenths percent (27.9%) of the total net spend. **DUR Educational Program** **In addition to the monthly RetroDUR intervention letters referenced previously in this report under the directions of the vendor, Health Information Designs, targeted educational letters are also sent to providers for select clinical issues through the actions of the Drug Utilization Review Board. The Board addresses provider-specific clinical matters identified from utilization reviews presented to the Board. Two such reviews focused on gabapentinoids and the use of hydroxyurea in Sickle Cell disease where letters were sent to 19,726 and 766 prescribers respectively.** **Preferred Drug and Brand Less Than Generic Programs** **New York Medicaid belongs to a multi-state Medicaid pharmaceutical purchasing pool**

Question	Response
	administered by the vendor, Magellan Medicaid Administration Inc (MMAI). The pool provides advantages of supplemental rebates for select drug classes managed by the member states. The review of this information is the responsibility of the New York State Medicaid Drug Utilization Review Board (DURB). The Board's review of the select drug classes is based upon clinical and financial information which determine the degree of potential savings. This information is used during the DURB's review of the State's formulary drug listing. This listing consists of preferred and non-preferred drugs for each therapeutic drug category. Based upon clinical drug updates and/or financial information provided by the MMAI, drugs may be moved from preferred to non-preferred status and visa-versa, within each therapeutic drug category. Managing the PDL in this way, the State's DURB can take advantage of financial incentives while invoking clinical best practices using additional mechanisms such as -prior authorization- and -step therapy. Both of those instruments serve as additional attempts by the DUR Board in guiding physician best prescribing practices while incurring potential cost savings. Available dollar savings for the State's fiscal achievements are recorded yearly. For State Fiscal Year 2019 (April 1, 2018 to March 31, 2019) the State's Preferred Drug Program savings amounting to $8.1 million. An additional program offering the potential for cost savings is the Brand less than Generic Program (BLTG). For State Fiscal Year 2019 (April 1, 2018-March 31, 2019) the BLTC program estimated savings amounting to $4.3 million. **Initiatives and Improvements** **During Federal Fiscal Year 2019 the New York Medicaid Program underwent additional changes and updates as the program continues to adapt to the ever-changing needs of the State's beneficiaries. The responsiveness of current practices along with program costs are routinely reviewed for practicality, adherence to the most up-to-**

Question	Response
	date clinical practices, potentials for program abuse and the need to change with the changing times. The current changes to the 2019 program are as follows: **Effective 11-2018 a PA was required for all compounded products for topical use to ensure that both Federal and State regulations are adhered to and that said therapy has FDA and compendia support.** **The States Preferred Diabetic Supply program expanded coverage in the area of continuous glucose monitors and insulin pumps for diversity of its patient population.** **New York Medicaid was able to create a tool to aid selection of non-opioid options for pain management with links to resources for the treatment of substance use disorder. This webpage development for non-opioid alternative treatment options became available in January of 2019.** **Effective 4-2019, NY Medicaid issued a beneficial change for recipient coverage of contraceptive prescription drugs. The change allows for a written contraception order for family planning to be filled 12 times within one year. This was a change from the previous allowance of a one-time supply in a 12-month period or 5 times in a 6-month period.** **On 6-2019 the DUR Board recommendations were put into place as follows; an update of the States Prior Authorization Program, a drug cap review of the product Remicade, requirement for prescriber intervention for the initiation of gabapentin or pregabalin on patients with concurrent use of an opioid, requiring prescriber intervention for continuation of opioid therapy beyond seven days in patients established on gabapentin or pregabalin, sending targeted educational letters to prescribers highlighting safety concerns associated with opioids and the concurrent use of gabapentin and pregabalin.** **A system's edit relating to the dispensing of vaccines through the Vaccines for Children Federal Program was put into effect on 5-2019. The new edit assures that vaccines obtained through the Federal Program, dispensed to children at or under the age of**

Question	Response
	19, cannot be billed to NY Medicaid. **A system's edit was put into effect on 9-19 which validates ingredient cost for 340B claims.** **On 11-2019 the DUR Board's following recommendations from their September 2019 meeting were put into effect; Prior authorization requirement for opioid-naive patients exceeding the morphine milligram equivalent (MME) of 90 mg per day, send targeted educational letters to prescribers regarding antipsychotic therapy and metabolic monitoring for patients less than 21 years, prior authorization required for patients less than 21 years of age when there is concurrent use of two or more different oral antipsychotics for more than 90 days, send targeted educational letter highlighting the SUPPORT ACT, send targeted educational letters to prescribers regarding leukotriene modifiers use relative to asthma treatment guidelines.** **Managed Care Oversight** **On 1-2019 arrangements were made with a State MCO plan that did not cover family planning and reproductive health to allow for coverage of those services for family beneficiaries.** **Medicaid Managed Care plans meet quarterly with the Medicaid Formulary and Operation Systems Implementation Unit to discuss statewide initiatives and major program changes.** **Routine meetings are held every first and third quarter to discuss each plans adherence to NY Medicaid's formulary requirements for beneficiaries.** **Medicaid Managed Care formularies are reviewed each second and fourth quarter for agents that are not considered Covered Outpatient Drugs. If found the respective plan is required to remove them from coverage for Medicaid beneficiaries. In addition, clinical criteria evaluations are conducted on MAT/SUD, HCV, opioids and smoking cessation agents. In addition, new pipeline drugs are introduced for discussion.**