New York
Medicaid Fee-For-Service (FFS)
Federal Fiscal Year (FFY) 2021
Drug Utilization Review (DUR)
Annual Report

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Section I - Number of Beneficiaries

Question	Response
1. On a monthly 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?	1,474,000
2. On a monthly average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)?	5,492,000

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 (GDIT)
b. Who processes the state's National Council for Prescription Drug Programs (NCPDP) transactions?	POS vendor is the fiscal agent (FA)
2. Identify your ProDUR table driven criteria source. This would be initial ratings such as drug to drug interactions, dose limits based on age and pregnancy severity (multiple responses allowed).	First Databank
If "Other," please specify.	N/A
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 "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?	Varies by Alert Type
If "Yes" or "Varies by Alert Type," check all that apply.	Alerts can be overridden with standard professional codes, Alerts need prior authorization (PA) to be overridden
If "Other," please explain.	N/A
4. Does your state receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail?	Yes
If "No," please explain.	N/A
a. How often does your state receive reports (multiple responses allowed)?	Annually
If "Other," please explain.	N/A

Question	Response
b. If you receive reports, does your state follow up with those providers who routinely override with interventions?	Yes
If "Yes," by what method does your state follow up (multiple responses allowed)?	Other
If "Other," please explain.	Pharmacy provider interventions concerning potential drug related problems are communicated / addressed through the RetroDUR intervention therapeutic criteria exemption program/processes/reviews.
If "No," please explain.	N/A
5. 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 your state require a PA?	Yes
If "Yes" or "Dependent on medication or situation," who obtains authorization?	Prescriber
If "No," can the pharmacist override at the POS?	N/A
c. For controlled drugs, when an early refill message occurs, does your state require a PA?	Yes
If "Yes," who obtains authorization?	Prescriber
If "No," can the pharmacist override at the POS?	N/A

Question	Response
6. 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 (multiple responses allowed):	Other
If "Other," please explain.	Overrides are allowed by pharmacist in an emergency situation as noted in question #9.a. below.
7. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?	Yes
If "Yes," please explain your edit.	For non-controlled substances: no more than a 10 day supply (on hand) using a ninety day look back. For controlled substances: no more than a 7 day supply (on-hand) using a ninety day look back.
If "No," does your state plan to implement this edit?	N/A
8. Does the state Medicaid program 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
9. For drugs not on your Preferred Drug List (PDL), does your Medicaid program 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
If "Yes," 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
If "Other," please explain.	N/A

Question	Response
If "No," please explain.	N/A
a. Does your program provide for the dispensing of at least a 72-hour supply of a COD in an emergency situation?	Yes
If "Yes," check all that apply.	Other process
If "Other process," please explain.	If a prior authorization number has not been obtained by the prescriber and the pharmacist is unable to reach the prescriber, the pharmacist may obtain a prior authorization for up to a 72-hour emergency supply. Once a 72-hour supply prior authorization number is given and a 72-hour supply is dispensed, the prescription is no longer valid for the remaining quantity and refills. The pharmacist is expected to follow-up with the prescriber to determine future needs.
If "No," please explain.	N/A
10. Please list the requested data in each category in Table 1 - Top Drug Claims Data Reviewed by the DUR Board below.	

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

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level	Column 2 Top 10 Prior Authorization (PA) Requests by Drug Class	Column 3 Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD) and Age Edits (AE))	Column 4 Top 10 Drug Names by Amount Paid, report at generic ingredient level	Column 5 % of Total Spent for Drugs by Amount Paid (From data in Column 4, determine the % of Total Drug Spend)	Column 6 Top 10 Drug Names by Claim Count, report at generic ingredient level	Column 7 Drugs by Claim Count % of Total Claims (From data in Column 6, determine the % of Total Claims)
omeprazole	anxiolytic agents	therapeutic duplication	bictegravir/ emtricitabine/ tenofovir	3.62%	ergocalciferol	7.07%
quetiapine	proton pump inhibitor agents	drug-drug interaction	insulin glargine	2.41%	folic acid	3.00%
oxycodone	analgesics, narcotic agents	early refill: overuse precaution	sitagliptin	2.24%	atorvastatin	1.74%
pantoprazole	hypoglycemic agents	drug-disease reported precaution	paliperidone	2.13%	metformin	1.30%
aripiprazole	anticonvulsant agents	high dose alert	lacosamide	1.58%	albuterol	1.21%
oxycodone/ acetaminophen	stimulants and related agents		apixaban	1.58%	amlodipine	1.18%
zolpidem	antidepressant agents		cannabidiol (CBD)	1.35%	gabapentin	1.09%
olanzapine	bronchodilator agents		budesonide/ formoterol	1.32%	levothyroxine	0.98%
ketoconazole	attention deficit hyperactivity disorder agents		elvitegravir/ cobicistat/ emtricitabine/ tenofovir	1.32%	famotidine	0.96%
risperidone	sedative hypnotic agents		adalimumab	1.25%	divalproex	0.83%

Question	Response
11. Section 1927(g)(A) of the Social Security Act (the 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 (multiple responses allowed)?	State Board of Pharmacy
If "Other," please explain.	N/A

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.	Kepro / Health Information Designs (HID)
b. Is the RetroDUR vendor the Medicaid Management Information System (MMIS) fiscal agent?	No
c. Is the RetroDUR vendor the developer/supplier of your retrospective DUR criteria?	Yes
Please explain "Yes" or "No" response.	Kepro updates and maintains the RetroDUR clinical criteria. The criteria is updated at least once a month in consideration of new clinical information.
d. Does your state customize your RetroDUR vendor criteria?	Ad hoc based on state-specific needs
2. How often does your state perform retrospective practitioner-based education?	Monthly
If "Other," please specify.	N/A
a. How often does your state perform retrospective reviews that involve communication of client-specific information to healthcare practitioners (multiple responses allowed)?	Monthly
If "Other," please specify.	N/A
b. What is the preferred mode of communication when performing RetroDUR initiatives (multiple responses allowed)?	Mailed letters
If "Other," please specify.	N/A

3. Summary 1 – RetroDUR Educational Outreach RetroDUR Educational Outreach should be a year-end report on retrospective screening and educational interventions. The summary should be limited to the most prominent problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed below.	Drug to Drug Interaction - Concurrent gabapentinoids & CNS depressants: 567 members selected for intervention; 1,252 intervention letters mailed; 32 responses. Therapeutic Appropriateness -Chronic use of proton pump inhibitors: 556 members selected for intervention; 694 intervention letters mailed; 22 responses. Drug to Drug Interaction - Concurrent opioids & gabapentin (>900mg/day): 231 members selected for intervention; 481 intervention letters mailed; 17 responses. Drug to Diagnosis - Antipsychotic use in convulsive disorders: 160 members selected for intervention; 361 intervention letters mailed; 11 responses. Therapeutic Appropriateness -Multi-class polypsychopharmacy: 162 members selected for intervention; 311 intervention letters mailed; 10 responses. Drug to Drug Interaction - Concurrent opioids & benzodiazepines SUPPORT Act: 142 members selected for intervention; 307 intervention letters mailed; 9 responses. Therapeutic Duplication - Duplicate therapy of atypical antipsychotics: 159 members selected for intervention; 265 intervention letters mailed; 14 responses. Therapeutic Appropriateness - Immediate-release opioids for pain management: 170 members selected for intervention; 263 intervention letters mailed; 11 responses. Drug to Drug Interaction - Concurrent opioids & antipsychotics SUPPORT Act: 116 members selected for intervention; 253 intervention letters mailed; 1 response. Therapeutic Appropriateness - Cholesterol guidelines in diabetic patients age 40-75: 157 members selected for intervention; 236 intervention letters mailed; 7 responses.

Section IV - DUR Board Activity

Question	Response
1. Does your state have an approved Medication Therapy Management (MTM) Program?	No
2. Summary 2 – DUR Board Activities DUR Board Activities Summary should be a brief descriptive on DUR activities during the fiscal year reported.	There were four DUR Board meetings held during the reporting period. Meeting dates and activities are as follows: November 5, 2020 The DUR Board reviewed clinical and financial information, and recommended drugs to be preferred or non-preferred in the following therapeutic classes: 1. ARBs Combinations 2. Antimigraine Agents - Acute Treatment 3. Antipsychotics - Second Generation 4. Multiple Sclerosis Agents 5. Gastrointestinal Antibiotics 6. Immunomodulators - Systemic The DUR Board reviewed the following topics and recommended clinical criteria and/or interventions to ensure appropriate drug utilization: 1. Opioids used for the treatment of acute pain and morphine milligram equivalent (MME) parameters. The DUR Board recommendation: Prior authorization required when initiating therapy with a short-acting opioid (SAO) at equal to or greater than 50 morphine milligram equivalents (MME) per day. Note: This was a reduction from greater than 90 MME per day. Exceptions for patients with cancer, sickle cell disease or receiving hospice care 2. Long-Acting Injectable Antipsychotic utilization as related to the SUPPORT Act. Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. The outcome of the DUR as to continue to monitor the use of oral and injectable antipsychotics across the entire Medicaid population. February 11, 2021 The DUR Board reviewed the following drugs/drug classes currently subject to the Clinical Drug Review Program (CDRP)

Question	Response
	and recommended changes to the clinical criteria or other drug utilization review interventions to ensure appropriate utilization: 1. Palivizumab (Synagis) 2. Sodium Oxybate (Xyrem) 3. Somatropin (Serostim) 4. Anabolic Steroids 5. Fentanyl Mucosal Agents 6. Growth Hormones For all but one of the therapeutic classes / drugs reviewed, the DUR Board determined that the existing clinical criteria was appropriate, and the products would remain subject to the CDRP. The one change to the existing clinical criteria was for growth hormone class as follows: Prior authorization required when prescribed for members 18 years of age or older. Note: This was a reduction of age from 21 years or older. The DUR Board was provided updates on the following topics: 1. Drug Cap Initiative 2. Pharmacy Benefit Carve-Out from Managed Care May 13, 2021 The DUR Board reviewed clinical and financial information, and recommended drugs to be preferred and non-preferred drugs in the following therapeutic classes: 1. Non-Steroidal Anti-inflammatory Drugs (NSAIDs) 2. Antibiotics, Inhaled 3. Triglyceride Lowering Agents 4. Antimigraine Agents, Other 5. Colony Stimulating Factors 6. Anti-inflammatories/Immunomodulators, Ophthalmic 7. Fluoroquinolones, Otic 8. Antihyperuricemics July 15, 2021 The DUR Board reviewed clinical and financial information,

Question	Response
	and recommended drugs to be preferred and non-preferred drugs in the following therapeutic classes: 1. Anticonvulsants, Other 2. Antipsychotics, Injectable 3. Multiple Sclerosis Agents 4. Other Agents for Attention Deficit Hyperactivity Disorder (ADHD) 5. Actinic Keratosis Agents 6. Glucocorticoids, Oral 7. Phosphate Binders/Regulators 8. Anticholinergics/COPD Agents More information regarding DUR Board Meetings can be found at: https://www.health.ny.gov/health_care/medicaid/program/dur/index.htm New RetroDUR criteria (e.g., drug interactions, diagnosis alerts, contraindications, therapeutic appropriateness, overutilization, underutilization, adherence, etc.) was added to the program for the drugs listed: October 2020: alpelisib, upadacitinib, binimetinib, cobimetinib, selumetinib, capmatinib, enasidenib, everolimus, fedratinib, gilteritinib, midostaurin, regorafenib, sorafenib, idelalisib, duvelisib, November 2020: istradefylline, diroximel, diroximel/dimethyl fumarate, apalutamide, darolutamide, entrectinib, ivosidenib, vorinostat, trifluridine/tipiracil, selinexor, tazemetostat, venetoclax, topotecan, celecoxib oral solution, forfivo XL December 2020: cenobamate, ibrutinib, enasidenib, Panobinostat, capecitabine, abiraterone, abiraterone micronized, bicalutamide, enzalutamide, flutamide, nilutamide, fluticasone/umeclidinium/vilanterol January 2021: duloxetine, pexidartinib, fostemsavir, pralsetinib, rucaparib, temozolomide, gabapentin IR, gabapentin/pregabalin February 2021: osilodrostat, budesonide/glycopyrrolate/formoterol, procarbazine, mitotane, olaparib, talazoparib, ixazomib, bexarotene, hydroxyurea, decitabine/cedazuridine, March 2021: amifampridine, acalabrutinib, afatinib, alectinib, avapritinib, axitinib, bosutinib, brigatinib, cabozantinib,

Question	Response
	ceritinib, crizotinib, dasatinib, rosuvastatin sprinkle April 2021: brigatinib, opicapone, guselkumab May 2021: viloxazine, seckinumab, erlotinib, gefitinib, ibrutinib, imatinib, lapatinib, lenvatinib, lorlatinib, neratinib, nilotinib, erdafitinib June 2021: vibegron, pralsetinib, monetelukast, budesonide inhalation powder, ciclesonide, fluticasone HFA, fluticasone diskus, mometasone inhalation, budesonide/formoteol, mometasone inhalantion aerosol, fluticasone/salmeterol July 2021: rosuvastatin/ezetimibe, capmatinib, ivosidenib August 2021: ozanimod, ponesimod September 2021: vorinostat, serdexmethylphenidate/dexmethylphenidate, elexacaftor/tezacaftor/ivacaftor, exenatide/exenatide ER, fesoterodine

Section V - Physician Administered Drugs (PAD)

The Deficit Reduction Act required 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 MMIS been designed to incorporate this data into your DUR criteria for:

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

Section VI - Generic Policy and Utilization Data

Question	Response
1. Summary 3 – Generic Drug Substitution Policies Generic Drug Substitution Policies should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, preferred drug list (PDL) policies, educational initiatives, technology or promotional factors, or other state-specific factors that affects your generic utilization rate.	The Brand Less than Generic Program is a 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. Generic drugs included in this program require prior authorization. Once it is determined that the generic drug is more cost-effective than the brand name equivalent, the prior authorization requirement is removed for the generic 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 (PA) is required
If "Other," please explain.	N/A

Generic Drug Utilization Data

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 Expenditure Percentage:** 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.

Table 2 – Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	523,896	8,841,499	343,907
Total Reimbursement Amount Less Co-Pay	$453,441,024	$155,584,883	$97,604,816

Question	Response
3. Indicate the generic utilization percentage for all covered outpatient drugs (COD) paid during this reporting period, using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Number of Generic Claims	8,841,499
Total Number of Claims	9,709,302
Generic Utilization Percentage	91.06%

Question	Response
4. How many innovator drugs are the preferred product on your state PDL when multi-source drugs are available based on net pricing and rebates (i.e. brand preferred over generic)?	35
5. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Generic Dollars	$155,584,883
Total Dollars	$706,630,723
Generic Expenditure Percentage	22.02%
6. Does your state have any policies related to Biosimilars? Please explain.	None during this reporting period.

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? If "Yes," identify, by name and type, the institution that conducted the program evaluation.	Yes
Institution Type	Company
Institution Name	ProDUR: State. RetroDUR: Kepro. Other Cost Avoidance: Magellan Medicaid Administration
2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below.	

Cost Avoidance	Cost in Dollars
ProDUR Total Estimated Avoided Costs	$138,200,000.00
RetroDUR Total Estimated Avoided Costs	$5,800,000.00
Other Cost Avoidance	$16,200,000.00
Grand Total Estimated Avoided Costs	**$160,200,000.00**

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 5, then multiplying this value by 100.	22.67%
4. Summary 4 – Cost Savings/Cost Avoidance Methodology Cost Savings/Cost Avoidance Methodology Summary should include program evaluations/cost savings estimates prepared by the state or contractor.	ProDUR: To estimate the impact of ProDUR, the total number of ProDUR claim alerts/conflicts not overridden (i.e. number of alerts/conflicts minus the number of overrides) was multiplied by the average cost per claim (without factoring in any federal or supplemental rebates). RetroDUR: To estimate the impact of RetroDUR, the total drug utilization in the targeted intervention population was evaluated six months before and six months after intervention letters were mailed. Kepro then compared drug expenditures and utilization in the targeted intervention population for the

Question	Response
	pre- and post- intervention timeframes with a comparison group to determine the estimated impact of the Retro DUR intervention letters. The comparison group consisted of a random group of recipients who were not chosen for RDUR intervention letters. For a recipient to be included in the analysis for either the intervention or comparison groups, he or she had to have at least one claim for any drug in the pre and post-intervention periods. For the purpose of this report, recipients were analyzed using 180 days of claims data before and after the RDUR intervention date. In addition, a null period of 14 days was included in the post-analysis period to allow for delivery and circulation of the 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 RDUR intervention letters on the same recipient within FFY 2021). 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 Avoidance: Attributed to the Preferred Drugs Program (i.e. Preferred Drug List and promoting the most cost effective products in a class in consideration of supplemental rebates and market share savings) and the Brand Less than Generic Program (i.e., promoting the utilization of a multi-source brand name product when less expensive than the generic [net of all rebates]). Estimates based on State Fiscal Year 2020 - 20201 (April 1, 2020 - March 31, 2021). Lock In Program: New York State's Office of the Medicaid Inspector General (OMIG) provides savings estimate amount attributed to the restricted recipient program. OMIG's Lock-In program data encompasses statistics from both Managed Care and Fee-For-Service (FFS). A FFS only savings estimate is difficult to ascertain as beneficiaries often move between Managed Care and FFS (see VIII. Fraud, Waste and Abuse Detection, Lock-in or Patient Review and Restriction Programs section for cost savings estimate which is not included here).

Section VIII - Fraud, Waste and Abuse Detection

A. Lock-In or Patient Review and Restriction Programs

Question	Response
1. Does your state 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 (multiple responses allowed)?	Deny claims, Require prior authorization (PA), Refer to Lock-In Program, Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation, Refer to Office of Inspector General (OIG)
If "Other," please explain.	N/A
2. Does your state have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances? If "Yes," please continue.	Yes
a. What criteria does your state use to identify candidates for Lock-In (multiple responses allowed)?	Number of controlled substances (CS), Different prescribers of CS, Multiple pharmacies, Days' supply of CS, Exclusivity of short acting opioids, Multiple emergency room (ER) visits
If "Other," please explain.	N/A
b. Does your state 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?	As determined by the state on a case-by-case basis
If "Other," please explain.	N/A
d. On average, what percentage of the FFS population is in Lock-In status annually?	0.10%
e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review.	$94,800,000.00

Question	Response
3. Does your state have a documented process in place that identifies possible FWA of controlled drugs by prescribers?	Yes
If "Yes," what actions does this process initiate (multiple responses allowed)?	Deny claims written by this prescriber, Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation, Refer to the appropriate Medical Board
If "Other," please explain.	N/A
If "No," please explain.	N/A
4. Does your state have a documented process in place that identifies potential FWA of controlled drugs by pharmacy providers?	Yes
If "Yes," what actions does this process initiate (multiple responses allowed)?	Deny claim, Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation, Refer to Board of Pharmacy
If "Other," please explain.	N/A
If "No," please explain.	N/A
5. Does your state have a documented process in place that identifies and/or prevents potential FWA of non-controlled drugs by beneficiaries, prescribers, and pharmacy providers?	Yes
If "Yes," please explain your program for FWA of non-controlled substances.	ProDUR editing and RetroDUR case reviews (i.e. therapeutic duplication and over utilization).
If "No," please explain.	N/A

B. Prescription Drug Monitoring Program (PDMP)

Question	Response
1. Does your Medicaid program have the ability to query the state's PDMP database?	No
If "Yes, receive PDMP data" specify frequency.	N/A
If "Other," please explain.	N/A
If "Yes, have direct access to the database," specify access method.	N/A
If "No," please explain.	n/a
If "Yes," please continue. a. Please explain how the state applies this information to control FWA of controlled substances.	N/A
b. Does your state also have access to border states' PDMP information?	N/A
c. Does your state also have PDMP data integrated into your point of sale (POS) edits?	N/A
2. Does your state or your professional board require prescribers to access the PDMP patient history before prescribing controlled substances?	Yes
If "No," please explain.	N/A
If "Yes," please continue. a. Are there protocols involved in checking the PDMP?	Yes
If "Yes," please explain.	Practitioners are required to check the PDMP database prior to prescribing any controlled substance listed on schedule II, II or IV.
b. Are providers required to have protocols for responses to information from the PDMP that are contradictory to the direction that the practitioner expects from the client?	Yes

Question	Response
c. If a provider is not able to conduct PDMP check, does your state require the prescriber to document a good faith effort, including the reasons why the provider was not able to conduct the check?	Yes
If "No," please explain.	N/A
If "Yes," does your state require the provider to submit, upon request, documentation to the State?	Yes
If "No," please explain.	N/A
3. Does the State or professional board require pharmacists to check the PDMP prior to dispensing?	Yes
If "No," please explain.	N/A
If "Yes," are there protocols involved in checking the PDMP?	No
If "Yes," please explain.	N/A
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 (multiple responses allowed)?	The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period.
If "Other," please explain.	N/A
a. Are there barriers that hinder the Medicaid agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb FWA?	Yes
If "Yes," please explain the barriers (i.e. lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).	Data sharing or access to information for Medicaid members only.

Question	Response
5. Have you had any changes to your state's PDMP during this reporting period that have improved the Medicaid program's ability to access PDMP data?	No
If "Yes," please explain.	N/A
6. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?	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.	N/A

C. Opioids

Question	Response
1. Does your state currently have a POS edit in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients?	Yes, for some opioids
Please explain response above.	Initial prescription for short acting opioid for a opioid-naive patient is limited to a 7 day supply. Prior authorization (PA) is required for initiation of long-acting opioid therapy for an opioid-naive patient.
If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue. a. What is the maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?	7
b. Does your state have POS edits in place to limit days' supply of subsequent opioid prescriptions? If "yes," please indicate your days' supply limit.	30-day supply
If "Other", please specify.	N/A

Question	Response
c. Please explain above response.	Yes. Quantity limits are based on FDA maximum daily doses in the product labeling extended to a thirty day supply.
2. Does your state have POS edits in place to limit the quantity dispensed of short-acting (SA) opioids?	Other
If "Yes," please specify limit as # of units.	N/A
If "No," or "Other" please explain.	Initial prescription for opioid-naive patients limited to a 7-day supply. Prior Authorization (PA) required for initiation of opioid therapy for patients on established opioid dependence therapy. PA required for use if greater than or equal to 90 MME of opioid per day for management of non acute pain (greater than 7 days). PA is required for opioid-naive patients for prescription requests if greater than or equal to 50 MME per day.
3. Does your state currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?	No
If "Yes," please specify limit as # of units.	N/A
If "No," or "Other" please explain.	Yes. Quantity limits are based on FDA maximum daily doses in the product labeling extended to a thirty day supply.
4. Does your state 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, MME daily dose program, Step therapy or clinical criteria, Require diagnosis, Require PDMP checks
If "Other," please specify.	N/A
Please provide details on these opioid prescribing controls in place.	Four prescription limit every thirty days. Initial prescription for opioid naive members limited to a seven day supply and equal to or less than 50 morphine milligram equivalents per day. Morphine milligram equivalent maximum equal to or greater than 90 morphine milligram equivalents .
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

Question	Response
5. Does your state 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
Please explain above response.	The pharmacy would receive a therapeutic duplication (TD) warning. The therapeutic duplication edit checks the therapeutic class of the new drug against the classes of the member's current, active drugs already dispensed.
6. Does your state have POS edits to monitor early refills of opioid prescriptions dispensed?	Yes
Please explain answer above.	Prior authorization required for an early refill. The decision to honor a member's request for authorization of a replacement supply is based on the professional judgement of the prescriber. An early refill (if granted) may be approved for up to a 30-day supply of medication.
7. Does your state have comprehensive automated retrospective claim reviews to monitor opioid prescriptions exceeding these state limitations (early refills, duplicate fills, quantity limits and days' supply)?	Yes
If "Yes," please explain in detail scope, nature, and frequency of these retrospective reviews.	The RetroDUR program maintains criteria to identify the incidence of therapeutic duplications. If inappropriate drug therapy is identified, an intervention letter is sent to prescribers and/or pharmacists detailing the potential drug therapy problem. In addition to the RetroDUR process, targeted educational letters can also be used for select clinical issues through the actions of the DUR Board.
If "No," please explain.	N/A

Question	Response
8. Does your state currently have POS edits in place or automated retrospective claim reviews to monitor opioids and benzodiazepines being used concurrently?	Yes, both POS edits and automated retrospective claim reviews
Please explain 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).	POS: Prior authorization required. RetroDUR: The Retro DUR program maintains criteria to identify co-administration of opioids and benzodiazepines. If inappropriate drug therapy is identified, an intervention letter is sent to prescribers and/or pharmacists detailing the potential drug therapy problem. In addition to the RetroDUR process, targeted educational letters can also be used for select clinical issues through the actions of the DUR Board.
If "No," please explain.	N/A
9. Does your state currently have POS edits in place or automated retrospective claim reviews to monitor opioids and sedatives being used concurrently?	Yes, both POS edits and automated retrospective claim reviews
If "Yes," please explain above and detail scope and nature of reviews and edits.	POS: The pharmacy would receive a drug-drug interaction (DD) warning. The drug-drug interaction edit matches the new drug against the member's current, active drugs to identify clinically relevant interactions. RetroDUR: The Retro DUR program maintains criteria to identify co-administration of opioids and sedative. If inappropriate drug therapy is identified, an intervention letter is sent to prescribers and/or pharmacists detailing the potential drug therapy problem. In addition to the RetroDUR process, targeted educational letters can also be used for select clinical issues through the actions of the DUR Board.
If "No," please explain.	N/A

Question	Response
10. Does your state currently have POS edits in place or automated retrospective claim reviews to monitor opioids and antipsychotics being used concurrently?	Yes, both POS edits and automated retrospective claim reviews
If "Yes," please explain in detail scope and nature of reviews and edits.	POS: The pharmacy may receive a drug-drug interaction (DD) warning. The drug-drug interaction edit matches the new drug against the member's current, active drugs to identify clinically relevant interactions. RetroDUR: The Retro DUR program maintains criteria to identify co-administration of opioids and antipsychotics. If inappropriate drug therapy is identified, an intervention letter is sent to prescribers and/or pharmacists detailing the potential drug therapy problem. In addition to the RetroDUR process, targeted educational letters can also be used for select clinical issues through the actions of the DUR Board.
If "No," please explain.	N/A
11. Does your state have POS safety edits or perform automated retrospective claim reviews and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis (multiple responses allowed)?	Yes, POS edits, Yes, automated retrospective claim reviews, Yes, provider education
If "Yes, automated retrospective claim reviews" and/or "Yes, provider education," please indicate how often.	Ad hoc
If "Other," please specify.	N/A
If "Yes," please explain nature and scope of edits, reviews and/or provider education reviews performed.	POS: The pharmacy would receive a drug-disease contraindication (DC) warning. The drug-disease contraindications edit determines whether the new drug is potentially harmful to the individual's disease condition. The active drugs on drug history determine the member's disease condition(s). RetroDUR: The Retro DUR program maintains criteria to associated with a history of substance abuse or dependence or substance use disorder. If inappropriate drug therapy is identified, an intervention letter can be sent to prescribers and/or pharmacists detailing the potential drug therapy problem.

Question	Response
If "No," does your state plan on implementing POS edits, automated retrospective claim reviews and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?	N/A
If "Yes," when does your state plan on implementing?	N/A
If "No," please explain.	N/A
12. Does your state Medicaid program develop and provide prescribers with pain management or opioid prescribing guidelines?	Yes
If "Yes," please check all that apply.	Your state Medicaid program refers prescribers to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain.
If applicable, please identify the "other" guidelines.	N/A
If "No," please explain why no guidelines are offered.	N/A
13. Does your state 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
If "Yes," please explain.	Abuse deterrent agents listed as preferred on preferred drug list.
14. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency?	No
If "Yes," please explain.	N/A

D. 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
If "Less than 50 MME," please specify the amount in mg per day.	N/A mg per day
If "Greater than 200 MME," please specify the amount in mg per day.	N/A mg per day
If "Other," please specify the amount in mg per day.	N/A 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?).	Prior authorization required in opioid-naive patients for prescription requests equal to or greater than 50 MME per day. Prior authorization required for the management of non-acute pain (greater than 7 days) if the dose is equal to or greater than 90 MME of opioid per day. Exceptions for diagnosis of cancer or sickle cell disease, or hospice program.
If "No," please explain the measure or program you utilize.	N/A
2. Does your state have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?	Yes
If "Yes," does your state require PA if the MME limit is exceeded.	Yes

Question	Response
3. Does your state have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed?	No
Please explain.	The RetroDUR criteria identifies doses > 100 mg morphine equivalents per day and includes information indicating that higher doses of opioids may increase risk for opioid-related adverse effects and overdose, members may benefit from a change of opioid regimen or substitution with non-opioid analgesics, discontinuation or opioid tapering may decrease risks and guidelines recommend tapering when risks outweigh benefits.
4. Do you provide information to your prescribers on how to calculate the MME daily dosage or do you provide a calculator developed elsewhere? If "Yes," please continue.	No
a. Please name the developer of the calculator.	N/A
If "Other," please specify.	N/A
b. How is the information disseminated (multiple responses allowed)?	N/A
If "Other," please explain.	N/A

E. Opioid Use Disorder (OUD) Treatment

Question	Response
1. Does your state have utilization controls (i.e. preferred drug list (PDL), prior authorization (PA), quantity limit (QL)) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?	Yes
If "Yes," please explain.	Quantity Limits for all products based units per day extended to a thirty days supply. For buprenorphine sublingual (SL): six tablets dispensed as a two-day supply; not to exceed 24 mg per day Prior authorization required for initiation of opioid therapy for members on established opioid dependence therapy. Prior Authorization required for initiation of a central nervous system stimulant for members established on opioid dependence therapy.
2. Does your Medicaid program 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
3. What are your limitations on the allowable length of this treatment?	No limit
If "Other," please explain.	N/A
4. Does your state 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
If "Other," please explain.	N/A

Question	Response
5. Does your state have at least one buprenorphine/naloxone combination product available without PA?	Yes
6. Does your state currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?	Yes
If "Other," please explain.	N/A
If "Yes," can the POS pharmacist override the edit?	No
7. Is there at least one formulation of naltrexone for OUD available without PA?	Yes
8. Does your state have at least one naloxone opioid overdose product available without PA?	Yes
9. Does your state retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?	Yes
If "No," please explain.	N/A
10. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid program 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 program under protocol

F. Outpatient Treatment Programs (OTP)

Question	Response
1. Does your state cover OTPs that provide Behavioral Health (BH) and MAT services?	Yes
If "No," please explain.	N/A
If "Yes," is a referral needed for OUD treatment through OTPs?	No
Please explain.	Members have open access to outpatient services / outpatient treatment programs. State law prohibits prior approval for these services across public and commercial insurance programs that are regulated by New York State.
2. Does your state Medicaid program cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?	Yes
If "No," please explain.	N/A
3. Does your state Medicaid program cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?	Yes
If "No," please explain.	N/A
4. Does your state Medicaid program cover Methadone for a substance use disorder (i.e. OTPs, Methadone Clinics)?	Yes

G. Psychotropic Medication

Antipsychotics

Question	Response
1. Does your state currently have restrictions in place to limit the quantity of antipsychotic drugs?	Yes
Please explain restrictions or N/A.	Frequency and quantity limits in place for the following products: asenapine, lumateperone, paliperidone, paliperidone, quetiapine, and quetiapine ER.
2. Does your state have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children? If "Yes," please continue.	Yes
a. Does your state either manage or monitor:	All children
If "Other," please explain.	N/A
b. Does your state have edits in place to monitor (multiple responses allowed):	Child's age, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	5
If "Other," please explain.	N/A

Question	Response
c. Please briefly explain the specifics of your documented antipsychotic monitoring program(s).	Prior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling. Prior authorization is required for patients less than 21 years of age when there is concurrent use of 2 or more different oral antipsychotics for greater than 90 days. Prior authorization is required for patients 21 years of age or older when 3 or more different oral second-generation antipsychotics are used for more than 180 days. Confirm diagnosis of FDA-approved or compendia-supported indication PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age. Require confirmation of diagnosis that supports the concurrent use of a Second-Generation Antipsychotic and a CNS Stimulant for patients <18 years of age. For all Second-Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required.
If “No,” does your state plan on implementing an antipsychotic monitoring program in the future.	N/A
If “Yes,” please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children.	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. Does your state currently have restrictions in place to limit the quantity of stimulant drugs?	Yes
4. Does your state have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children? If "Yes," please continue.	Yes
a. Does your state either manage or monitor:	All children
If "Other," please explain.	N/A
b. Does your state have edits in place to monitor (multiple responses allowed):	Child's age, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	3
If "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 less than 18 years of age. Prior authorization is required for initial prescriptions for stimulant therapy for beneficiaries less than 3 years of age. Require confirmation of diagnoses that support concurrent use of CNS Stimulant and Second Generation Antipsychotic agent.
If "No," does your state plan on implementing a stimulant monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.	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

Antidepressants

Question	Response
5. Does your state have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children? If "Yes," please continue.	Yes
a. Does your state either manage or monitor:	Other
If "Other," please explain.	The RetroDUR criteria is not specific to children as it monitors for appropriate use over all ages. See additional information in "c." below.
b. Does your state have edits in place to monitor (multiple responses allowed):	Child's age, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	0
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antidepressant monitoring program(s).	The RetroDUR process monitors for appropriate use of antidepressants. The criteria addresses drug-drug, drug-disease interactions, under over utilization, and therapeutic duplication. Some criteria include references to children including that antidepressant-containing medications may increase the risk of suicidal thinking and behaviors (suicidality) in children, adolescents, and young adults. Patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior especially during the initial months of drug therapy, or at times of dose changes.
If "No," does your state plan on implementing an antidepressant monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antidepressant drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antidepressant drugs in children.	N/A

Mood Stabilizers

Question	Response
6. Does your state have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children? If "Yes," please continue.	Yes
a. Does your state either manage or monitor:	Other
If "Other," please explain.	The RetroDUR criteria is not specific to children as it monitors for appropriate use over all ages. See additional information in "c." below.
b. Does your state have edits in place to monitor (multiple responses allowed):	Child's age, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	0
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented mood stabilizer monitoring program(s).	The RetroDUR process monitors for appropriate use of antidepressant drugs. The RetroDUR criteria is not specific to children as it monitors for appropriate use over all ages. The criteria addresses drug-drug, drug-disease interactions, under utilization, over utilization, and therapeutic duplication.
If "No," does your state plan on implementing a mood stabilizer monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of mood stabilizing drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of mood stabilizing drugs in children.	N/A

Antianxiety / Sedatives

Question	Response
7. Does your state have a documented program in place to either manage or monitor the appropriate use of antianxiety/sedative drugs in children? If "Yes," please continue.	Yes
a. Does your state either manage or monitor:	Other
If "Other," please explain.	The RetroDUR criteria is not specific to children as it monitors for appropriate use over all ages. See additional information in "c." below.
b. Does your state have edits in place to monitor (multiple responses allowed):	Child's age, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	0
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).	The RetroDUR process monitors for appropriate use of antianxiety/sedatives. The RetroDUR criteria is not specific to children as it monitors for appropriate use over all ages. The criteria addresses drug-drug, drug-disease interactions, under utilization, over utilization, and therapeutic duplication.
If "No," does your state plan on implementing an antianxiety/sedative monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.	N/A

Section IX - Innovative Practices

Question	Response
1. Does your state 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?	No
If "Yes," please explain.	N/A
2. Summary 5 – Innovative Practices Innovative Practices Summary should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and 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 PA, continuing education programs).	Development of an automated prospective physician administered drug (PAD) management program in an effort to align with management programs currently used within the pharmacy program. Pharmacy benefit for managed care members moving into the fee-for-service program (the scheduled implementation was 4/1/2021 and was moved to 4/1/2023). Drug Cap initiative which allows the negotiation for supplemental rebates across the fee-for-service and managed care populations for products identified as contributing to pharmacy spend above the projected expenditure threshold. High Cost Drug initiative which allows the negotiation for supplemental rebates across the fee-for-service and managed care populations on newly launched drugs meeting certain criteria: 1) a brand name drug or biologic that has a launch wholesale acquisition cost of thirty thousand dollars or more per year or course of treatment, or 2) a biosimilar drug that has a launch wholesale acquisition cost that is not at least fifteen percent lower than the referenced brand biologic at the time the biosimilar is launched, or 3) a generic drug that has a wholesale acquisition cost of one hundred dollars or more for a thirty day supply or recommended dosage approved for labeling by the federal Food and Drug Administration, or 4) a brand name drug or biologic that has a wholesale acquisition cost increase of three thousand dollars or more in any twelve-month period, or course of treatment if less than twelve months. During the reporting period, there were twenty-two Drug Cap or High Cost Drug supplemental rebate contracts executed or renewed.

Section X - Managed Care Organizations (MCOs)

Question	Response
1. How many MCOs are enrolled in your state Medicaid program? If "Zero" or "None", please skip the rest of this section.	16
2. Is your pharmacy program included in the capitation rate (carved in)?	Yes
Please specify the drug categories that are carved out.	N/A
3. Contract updates between state and MCOs addressing DUR provisions in Section 1004 Support for Patients and Communities Act are required based on 1902(oo). If covered outpatient drugs are included in an MCO's covered benefit package, has the State updated their MCOs' contracts for compliance with Section 1004 of the SUPPORT for Patients and Communities Act?	No, contracts are not updated
If "Yes," please specify effective date.	N/A
If "No, contracts are not updated," please explain.	Medicaid Managed Organizations (MCOs) are required to comply with all applicable state and federal laws and regulations under the provisions of Section 35.1 of the contract, which would include compliance with the SUPPORT Act. We have surveyed our contracted MCOs and have verified that all are in compliance with the SUPPORT Act. Specific SUPPORT ACT contract language will be amended to the contract in a forthcoming amendment
a. Is the state complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions?	Yes, state is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions
If "Yes," state is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions. Please explain monitoring activities.	The State staff monitor activities (i.e. ProDUR editing and/or RetroDUR interventions) and verify /confirm compliance with SUPPORT Act provisions.
If "No," please explain.	N/A

Question	Response
4. Does the state set requirements for the MCO's pharmacy benefit (i.e. same preferred drug list, same ProDUR/RetroDUR)?	Yes
a. If "Yes," check all that apply.	Formulary Reviews, No State PDL
b. Please briefly explain your policy.	MCOs establish their own formularies and prior authorization processes. MCO formularies must include all categories of medications on the FFS list of reimbursable drugs. MCO formulary reviews, by the State staff, occur at least twice a year.
If "No," does your state plan to set standards in the future?	N/A
If "No," please explain.	N/A
5. Is the RetroDUR program operated by the state or by the MCOs or does your state use a combination of state interventions as well as individual MCO interventions?	State uses a combination of state interventions as well as individual MCO interventions
6. Indicate how the State oversees the FFS and MCO RetroDUR programs? Please explain oversight process.	State staff continually evaluate of retrospective pharmacy claims data (FFS and MCO) by State staff. MCO data is included in retrospective review of pharmacy and medical claims information. MCO data / information, specific to each MCO's member population, is provided to the MCO upon DUR Board review inclusive of any DUR Board clinical criteria recommendations.
7. How does the state ensure MCO compliance with DUR requirements described in Section 1927(g) of the Act and 42 CFR part 456, subpart K?	State staff monitor MCO drug utilization data, policies and coverage parameters. The MCOs submitted formulary coverage and prior authorization information on a quarterly basis. MCO drug utilization is compared to fee-for-service data to identify areas for which each drug utilization could be improved across the MCO and FFS programs / benefits.
8. Did all of your managed care plans submit their DUR reports?	Yes
If "No," please explain.	N/A

Section XI - Executive Summary

Question	Response
1. Summary 6 – Executive Summary Executive Summary should provide a brief overview of your program. It should describe FFY 2021 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.	The DUR Program is composed of three main components, Prospective Drug Utilization Review (ProDUR) Program, Retrospective Drug Utilization Review (RetroDUR) Program and the DUR Board The ProDUR Program is a point-of-service monitoring system that analyzes pharmacy claims during the claims adjudication process. The system can identify drug related problems such as therapeutic duplication, drug-disease contraindications, drug interactions, incorrect dosage or duration of treatment, drug allergy, overutilization, and underutilization. The RetroDUR Program is designed to improve prescribing trends by alerting providers through provider education. The Program uses predetermined clinical criteria to generate case reviews of select members using claims data. The NYS Medicaid DUR Board is comprised of health care professionals and financial experts appointed by the Commissioner and their responsibilities include: The establishment and implementation of medical standards and criteria for the retrospective and prospective DUR Program. The development, selection, application, and assessment of educational interventions for prescribers and pharmacists to improve care. The collaboration with managed care organizations to address drug utilization concerns and to implement consistent management strategies across the fee-for-service and managed care pharmacy benefits. The review of therapeutic classes subject to the Preferred Drug Program. The DUR Program continues to help to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical consequences. The DUR Program continues to focus innovate practices including the development of a physician/practitioner administered drug (PAD) management program and the transition of the pharmacy benefit for managed care members into the fee-for-service program.

Question	Response
	The DUR Program has proven to be an asset in the efforts of New York Medicaid to protect and improve the health of it's members. The Department will continue to enhance the ProDUR and RetroDUR Programs and work cooperatively with the DUR Board to develop and implement medication management processes that improve patient outcomes and reduce unnecessary medication costs.