Florida

Medicaid Managed Care Organization (MCO) FFY 2022 Drug Utilization Review (DUR) Annual Report

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Section I - Demographic Information

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

Figure 1 - Number of Beneficiaries Enrolled in Each MCO

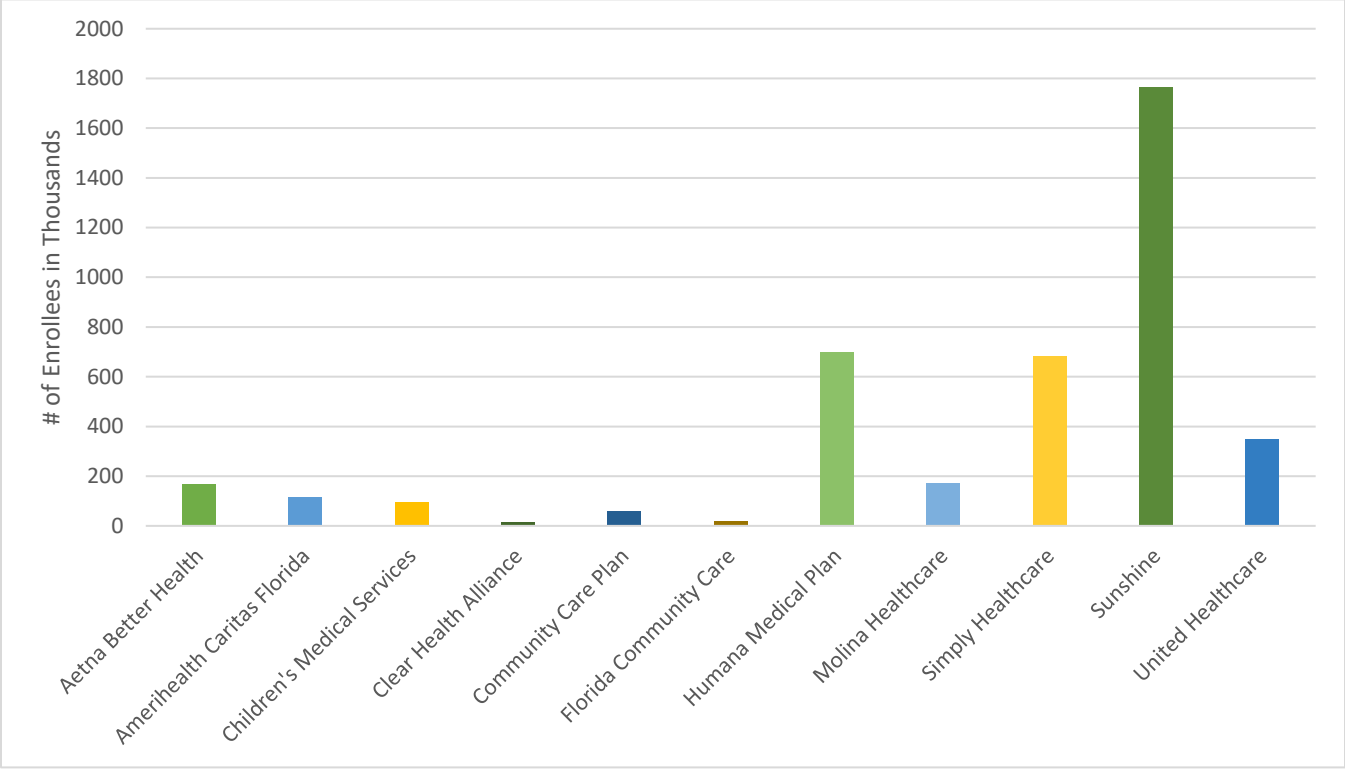


Table 1 - Number of Beneficiaries Enrolled in Each MCO

MCO Name	Number of Beneficiaries Enrolled
Aetna Better Health	166,585
Amerihealth Caritas Florida	115,558
Children's Medical Services	94,447
Clear Health Alliance	12,918
Community Care Plan	60,000
Florida Community Care	19,011
Humana Medical Plan	697,991
Molina Healthcare	170,000
Simply Healthcare	683,445
Sunshine	1,763,769
United Healthcare	349,492
State Totals	**4,133,216**

Section II - Prospective DUR (ProDUR)

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

Figure 2 - Pharmacy POS Type of Vendor

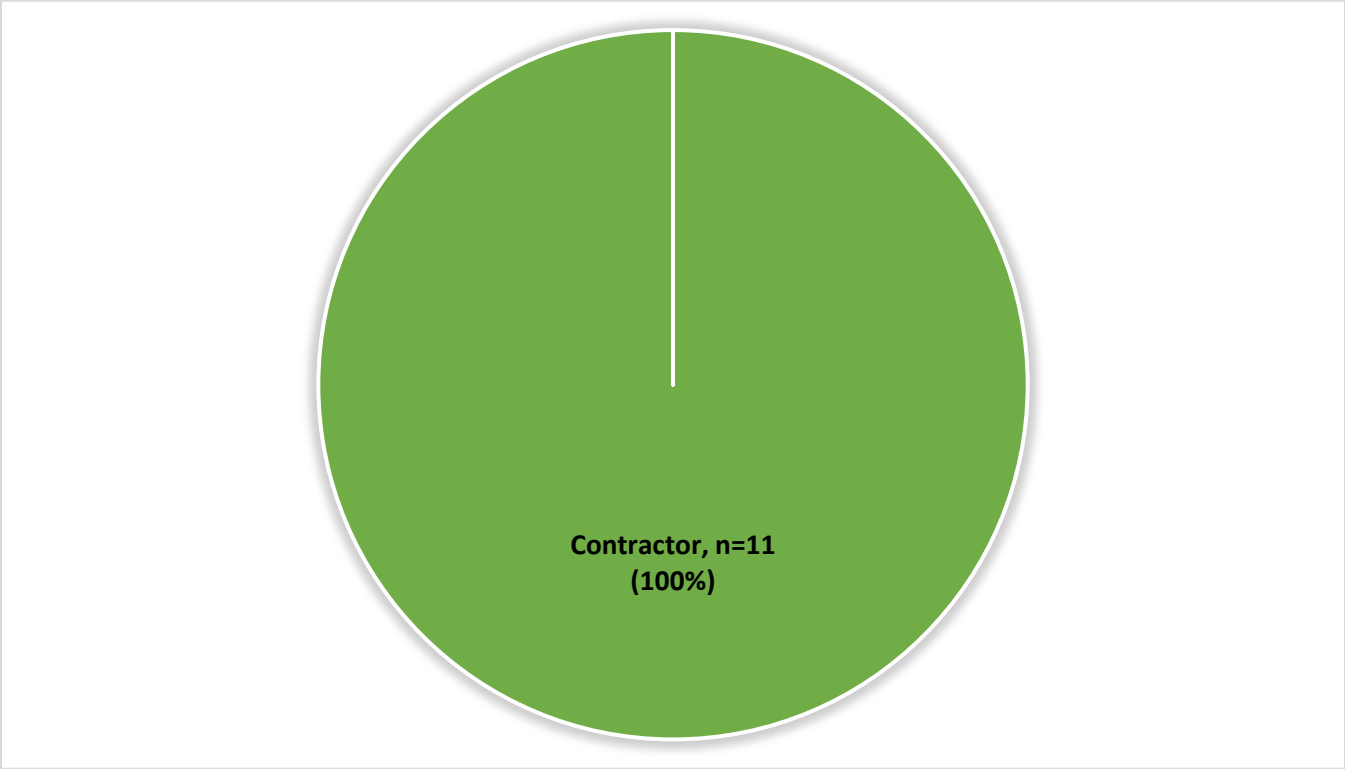


Table 2 - Pharmacy POS Type of Vendor

Response	MCO Names	Count	Percentage
Contractor	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

Table 3 - Pharmacy POS Vendor Name

Response	MCO Names	Count	Percentage
CVS/Caremark	Aetna Better Health, Children's Medical Services, Florida Community Care, Molina Healthcare, Sunshine	5	45.45%
IngenioRx	Clear Health Alliance, Simply Healthcare	2	18.18%
OptumRx	United Healthcare	1	9.09%
PerformRx	Amerihealth Caritas Florida	1	9.09%
Prime Therapeutics/Magellan Rx Management	Community Care Plan	1	9.09%
SS&C	Humana Medical Plan	1	9.09%
State Totals		**11**	**100%**

2. Identify ProDUR table driven criteria source (multiple responses allowed).

Figure 3 - Prospective DUR Criteria Source

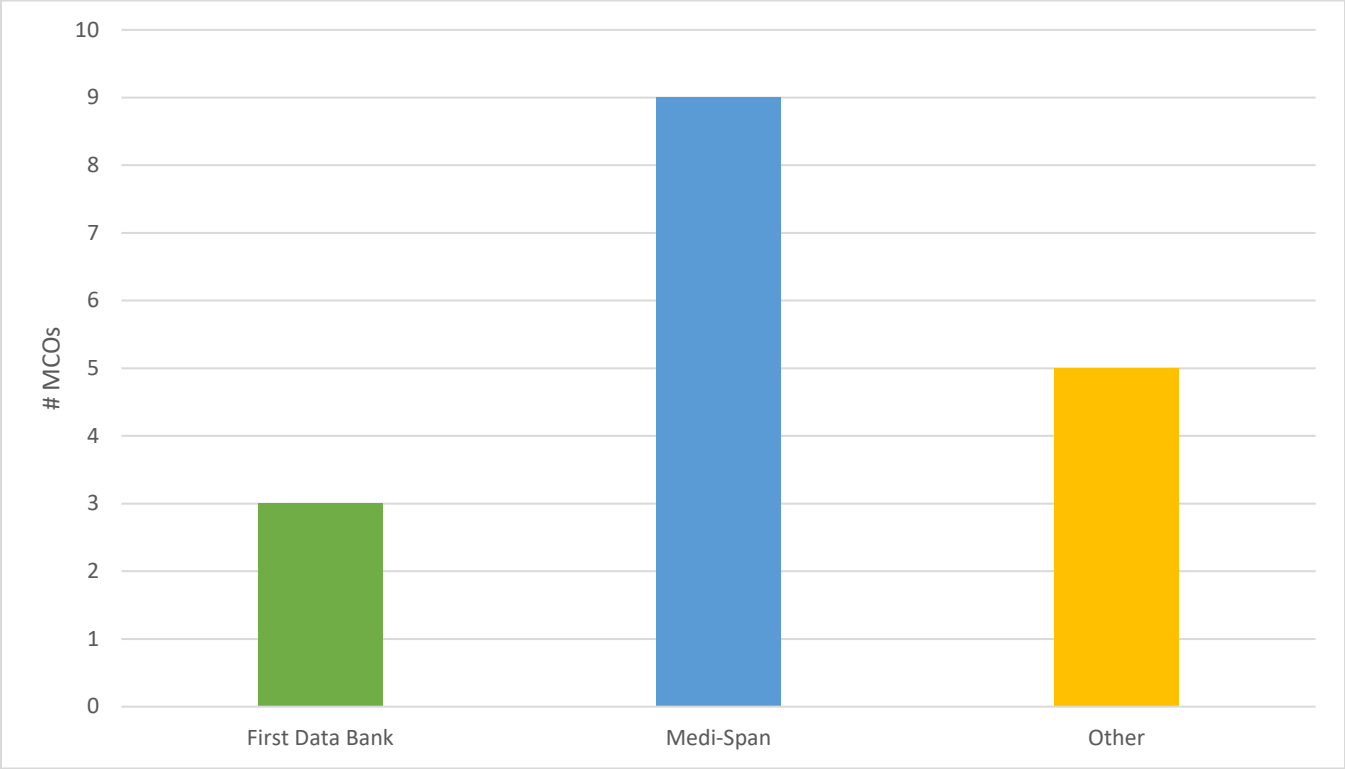


Table 4 - Prospective DUR Criteria Source

Response	MCO Names	Count	Percentage
First Data Bank	Amerihealth Caritas Florida, Community Care Plan, Humana Medical Plan	3	17.65%
Medi-Span	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	52.94%
Other	Aetna Better Health, Children's Medical Services, Community Care Plan, Molina Healthcare, Sunshine	5	29.41%
State Totals		**17**	**100%**

If "Other," please specify.

Table 5 - "Other" Explanations for Prospective DUR Criteria Source

MCO Name	Explanation
Aetna Better Health	CMS Medicare Part D Guidance, recommendations from P&T Committee and/or DUR Board may also create criteria.
Children's Medical Services	CVS/Caremark
Community Care Plan	CCP also uses ProDUR criteria provided by the Agency for Healthcare Administration (AHCA).
Molina Healthcare	Molina National Pharmacy & Therapeutics Committee
Sunshine	CVS Caremark

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

Figure 4 - ProDUR Alert Message for Pharmacist Override using "NCPDP Drug Use Evaluation Codes"

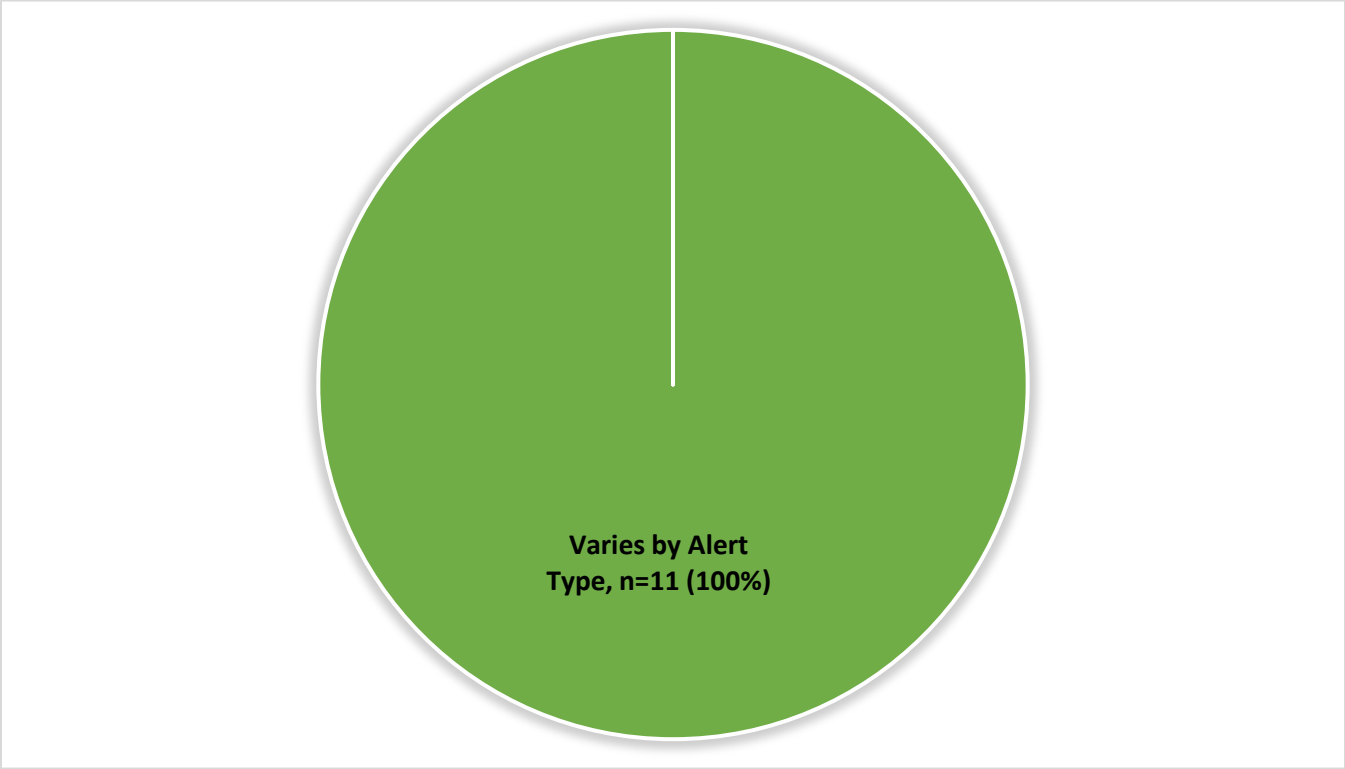


Table 6 - ProDUR Alert Message for Pharmacist Override using "NCPDP Drug Use Evaluation Codes"

Response	MCO Names	Count	Percentage
Varies by Alert Type	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

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

Table 7 - ProDUR Alert Types for Pharmacist Override

Response	MCO Names	Count	Percentage
Alerts can be overridden ahead of time	Molina Healthcare	1	4.00%
Alerts can be overridden with standard professional codes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	40.00%
Alerts need prior authorization (PA) to be overridden	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical	9	36.00%

Response	MCO Names	Count	Percentage
	Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare		
Other	Aetna Better Health, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Molina Healthcare	5	20.00%
State Totals		**25**	**100%**

If "Other," please explain.

Table 8 - Explanation for "Other" ProDUR Alert Types for Pharmacist Override

MCO Name	Explanation
Aetna Better Health	Some alerts are educational messages only and require no code entry to continue claim processing.
Clear Health Alliance	some edits require a phone call to the health plan.
Florida Community Care	Most edits are just a warning to the pharmacist and result in a message that alerts the pharmacist to the edit but will not cause the claim to reject or a soft-reject that can be overridden by the pharmacy submitting an appropriate override code with the corresponding Reason for Service Code. Few edits result in a hard-reject and require pharmacist to call into Pharmacy Help Desk to override.
Humana Medical Plan	'-Soft denials allow for PPS codes to override the alert reject at the pharmacy. - Hard denials will need to have clinical documentation provided to Humana Clinical Pharmacy Review for clinical review and coverage determination.
Molina Healthcare	Most edits are just a warning to the pharmacist and result in a message that alerts the pharmacist to the edit but will not cause the claim to reject or a soft-reject that can be overridden by the pharmacy submitting an appropriate override code with the corresponding Reason for Service Code. Few edits result in a hard-reject and require pharmacist to call into Pharmacy Help Desk to override.

4. Does your MCO receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail?

Figure 5 - Receives Periodic Reports Providing Individual Pharmacy Providers DUR Alert Override Activity

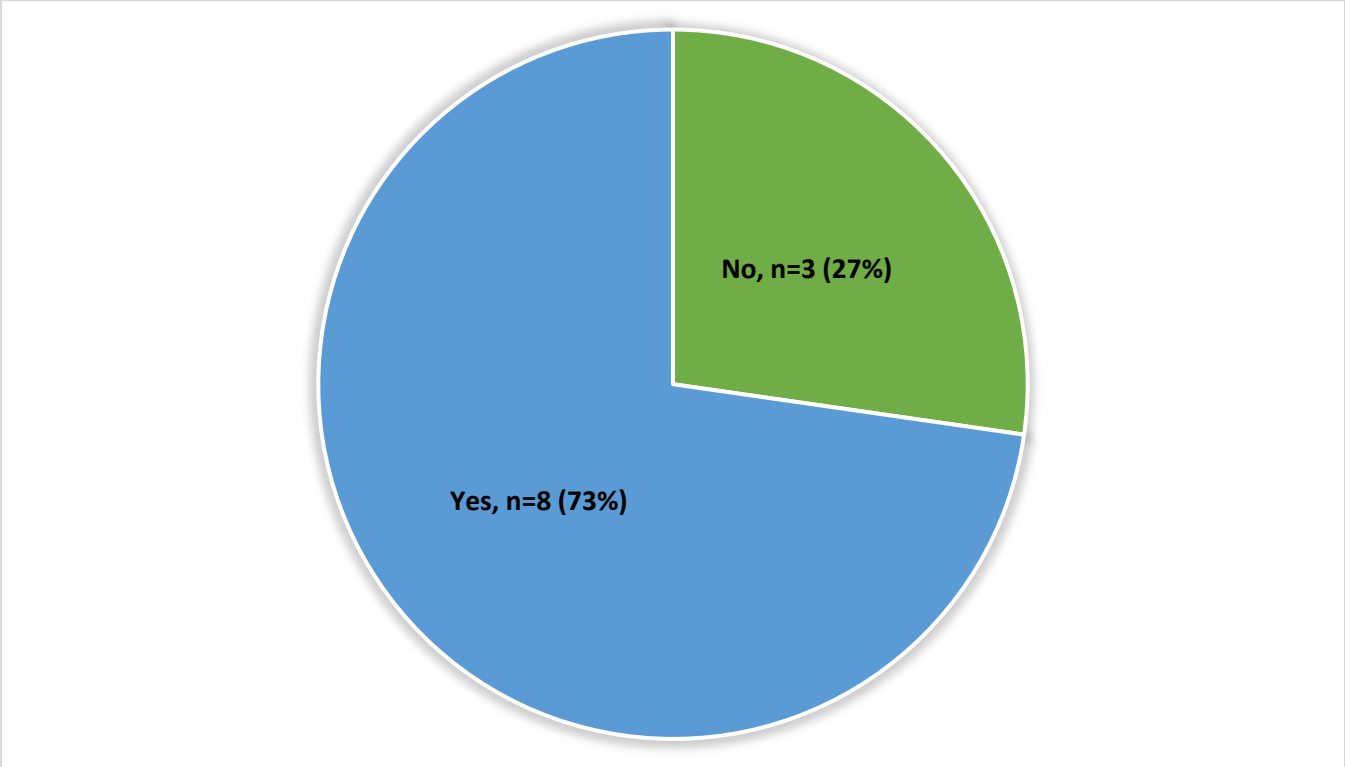


Table 9 - Receives Periodic Reports Providing Individual Pharmacy Provider DUR Alert Override Activity

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, United Healthcare	8	72.73%
No	Children's Medical Services, Community Care Plan, Sunshine	3	27.27%
State Totals		**11**	**100%**

a. If "Yes," how often does your MCO receive reports (multiple responses allowed)?

Figure 6 - Frequency of Reports Providing Individual Pharmacy Provider DUR Alert Override Activity

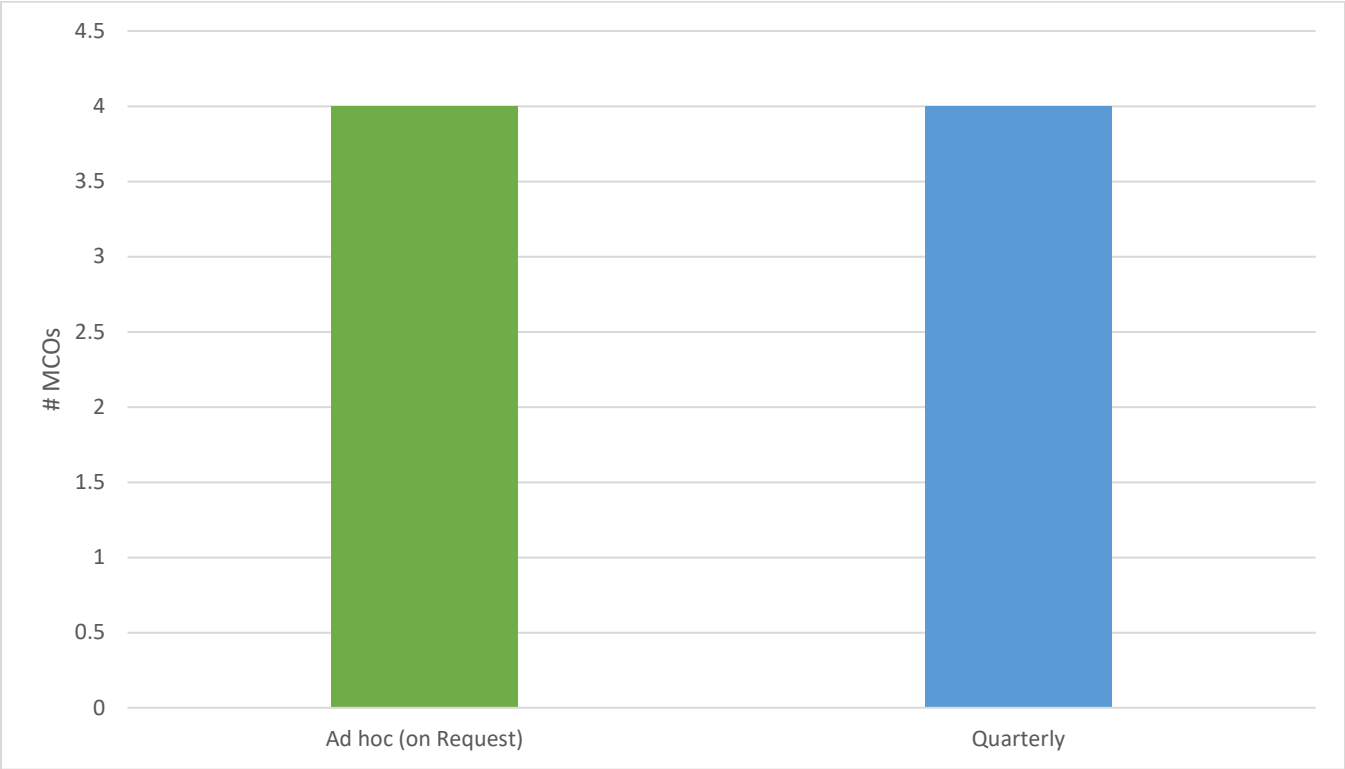


Table 10 - Frequency of Reports Providing Individual Pharmacy Provider DUR Alerts Override Activity

Response	MCO Names	Count	Percentage
Ad hoc (on request)	Amerihealth Caritas Florida, Clear Health Alliance, Humana Medical Plan, Simply Healthcare	4	50.00%
Quarterly	Aetna Better Health, Florida Community Care, Molina Healthcare, United Healthcare	4	50.00%
State Totals		**8**	**100%**

b. If "Yes," does your MCO follow up with those providers who routinely override with interventions?

Figure 7 - Follow up with Providers who Routinely Override with Interventions

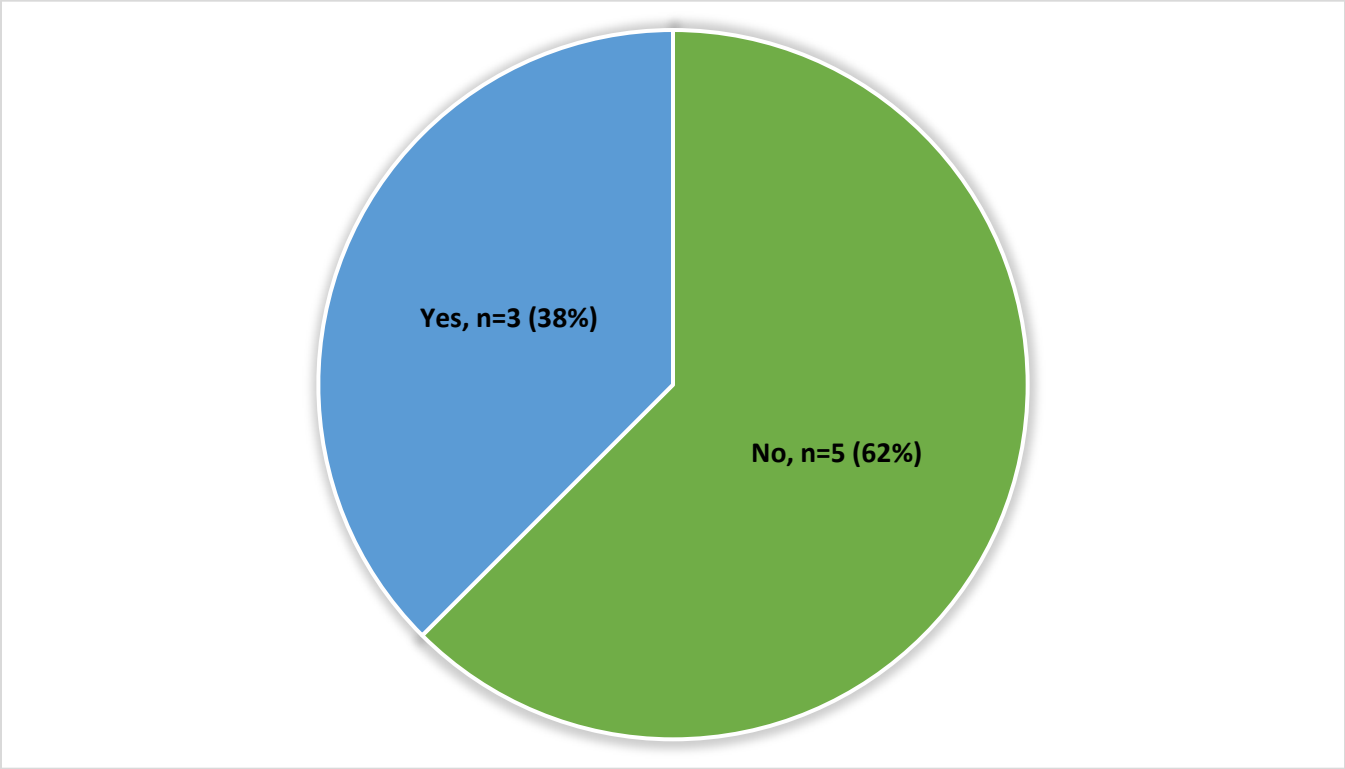


Table 11 - Follow up with Providers who Routinely Override with Interventions

Response	MCO Names	Count	Percentage
Yes	Clear Health Alliance, Simply Healthcare, United Healthcare	3	37.50%
No	Aetna Better Health, Amerihealth Caritas Florida, Florida Community Care, Humana Medical Plan, Molina Healthcare	5	62.50%
State Totals		**8**	**100%**

If "Yes," by what method does your MCO follow up (multiple responses allowed)?

Figure 8 - Follow-up Methods with Providers who Routinely Override with Interventions

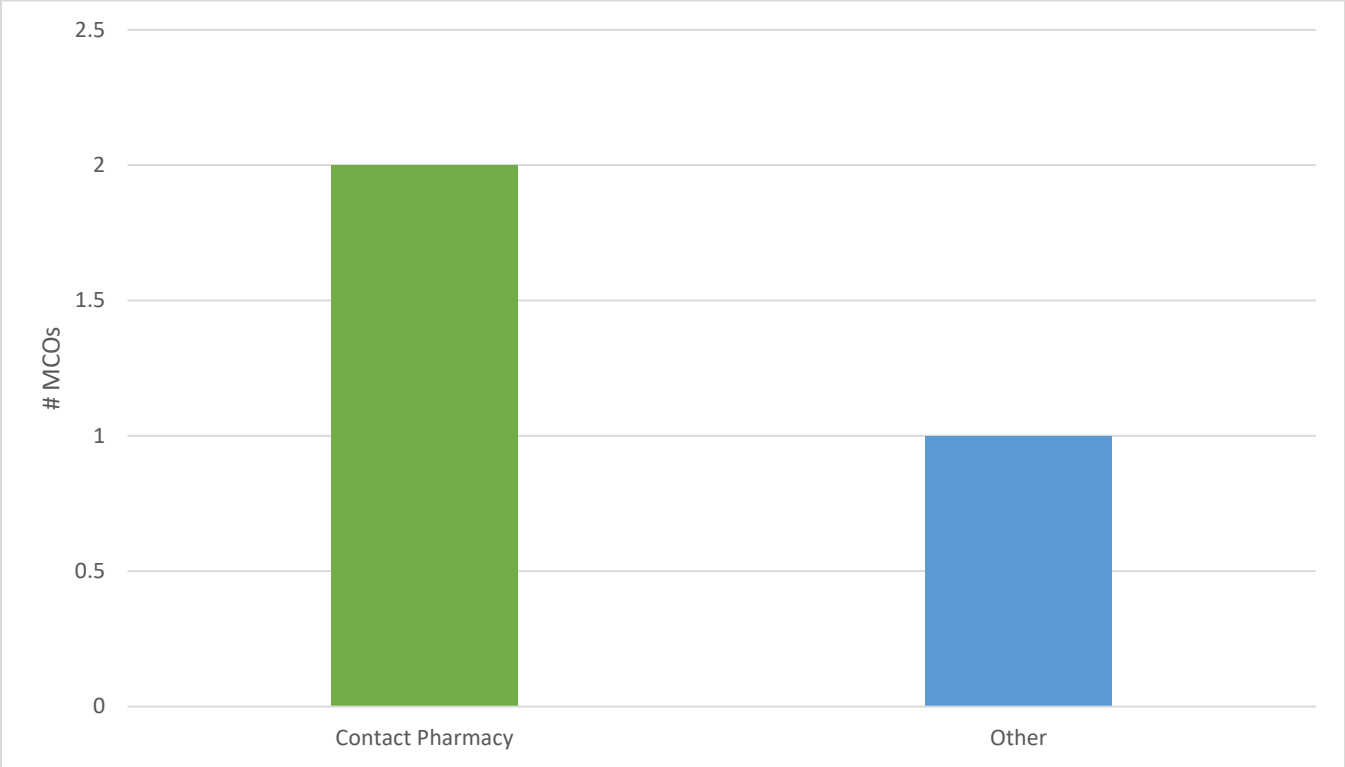


Table 12 - Follow-up Methods with Providers who Routinely Override with Interventions

Response	MCO Names	Count	Percentage
Contact Pharmacy	Clear Health Alliance, Simply Healthcare	2	66.67%
Other	United Healthcare	1	33.33%
State Totals		**3**	**100%**

If "Other," please explain.

Table 13 - "Other" Explanations for Follow-up Methods for Providers who Routinely Override with Interventions

MCO Name	Explanation
United Healthcare	The DUR alert override data is routinely reviewed to identify outliers. The method of follow up is handled on a case by case basis depending on the situation. For instance, if a pharmacy chain is identified as having multiple pharmacies with high override rates, the chain will be referred to the Network Relations team to address. Other cases might require FWA referral or individual pharmacy outreach.

If "No," please explain.

Table 14 - "No" Explanations for Receiving Periodic Reports Providing Individual Pharmacy Provider DUR Alert Override Activity

MCO Name	Explanation
Children's Medical Services	We do not routinely follow-up with pharmacy providers regarding their override activity. The trends are monitored at the POS/PBM edit level.
Community Care Plan	The contracted PBM manages the MCO's pharmacy network and reviews the pharmacy providers prospective DUR activities but do not send reports to MCO.

MCO Name	Explanation
Sunshine	Sunshine does not routinely follow-up with pharmacy providers overriding interventions. DUR intervention codes and trends are monitored at the edit level via POS detailed reports that are obtained monthly.

5. Early Refill

a. At what percent threshold does your MCO set your system to edit?

Figure 9 - Non-Controlled Drugs Early Refill Percent Edit Threshold

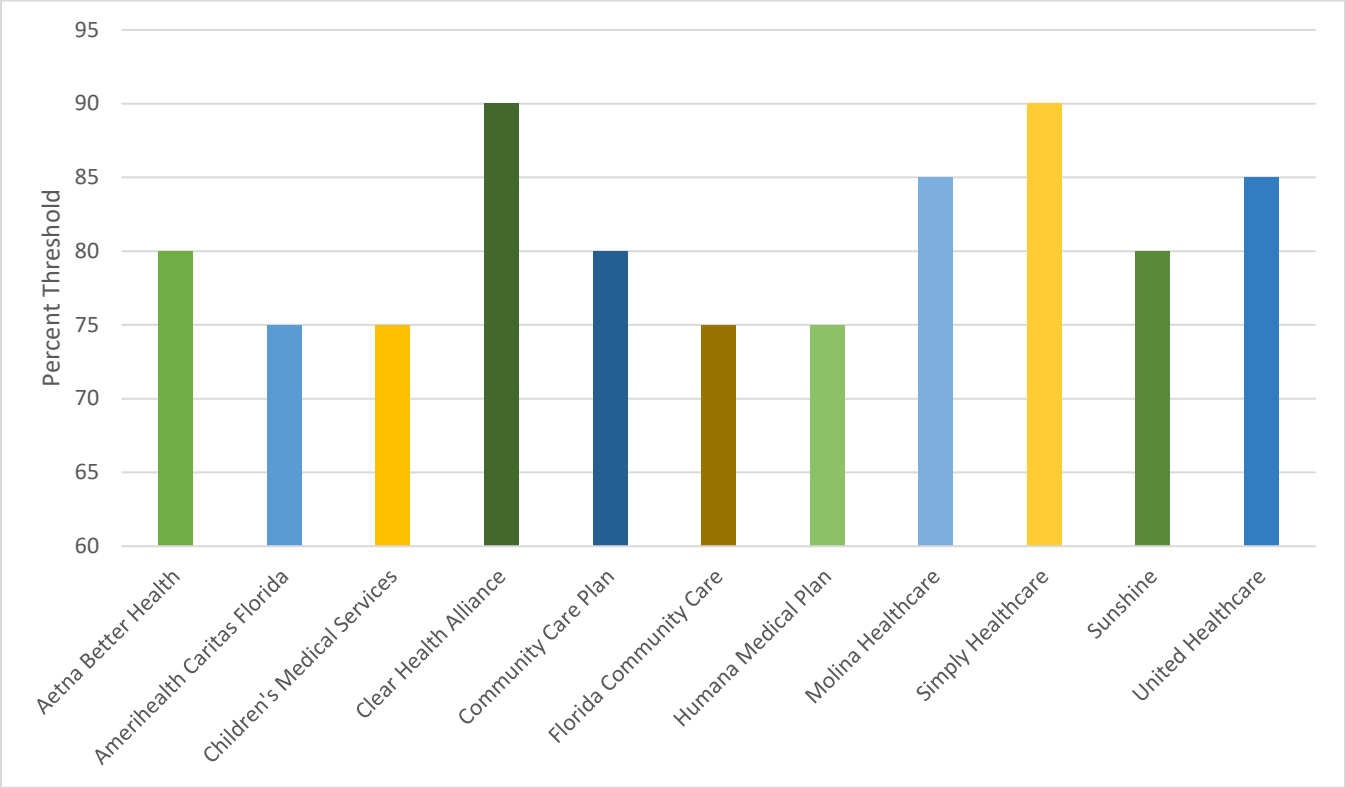


Figure 10 - Schedule II Controlled Drugs Early Refill Percent Edit Threshold

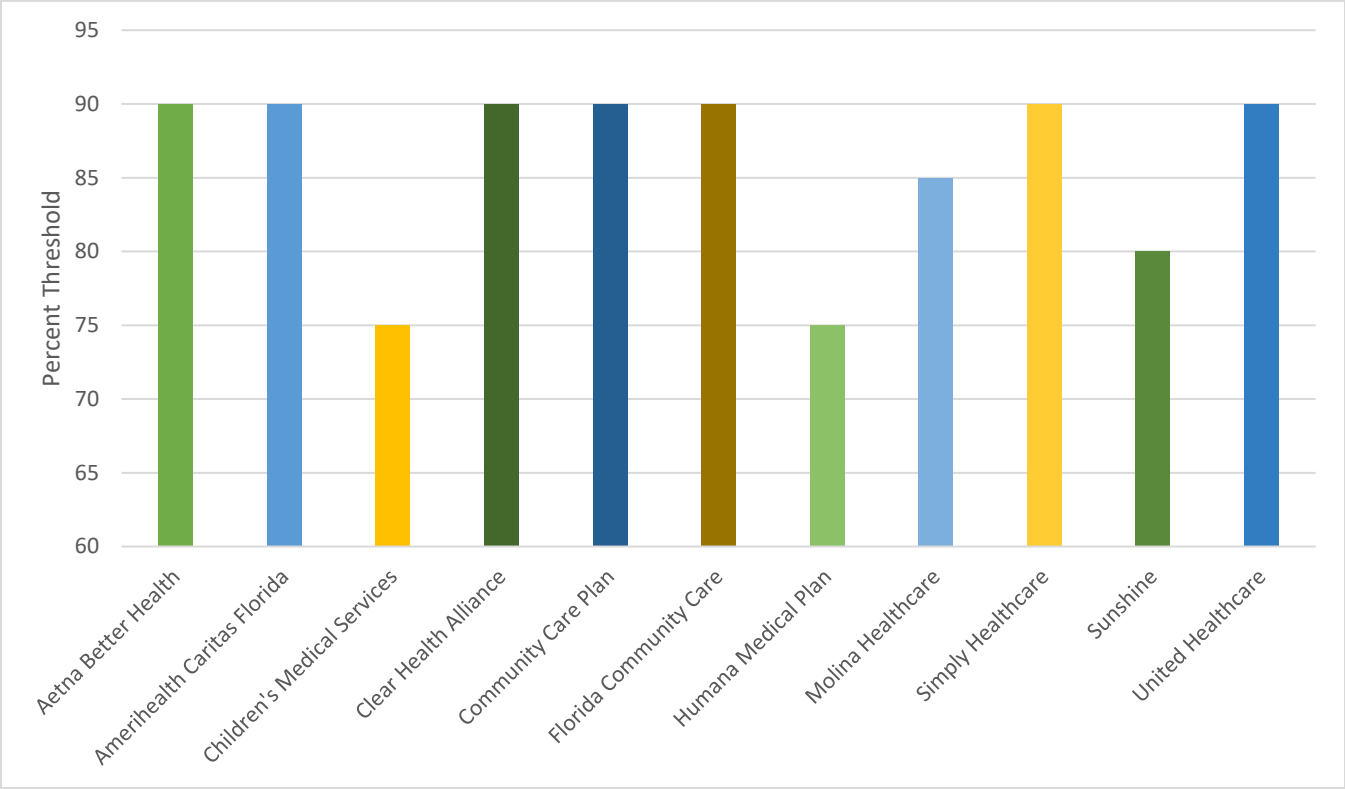


Figure 11 - Schedule III through V Controlled Drugs Early Refill Percent Edit Threshold

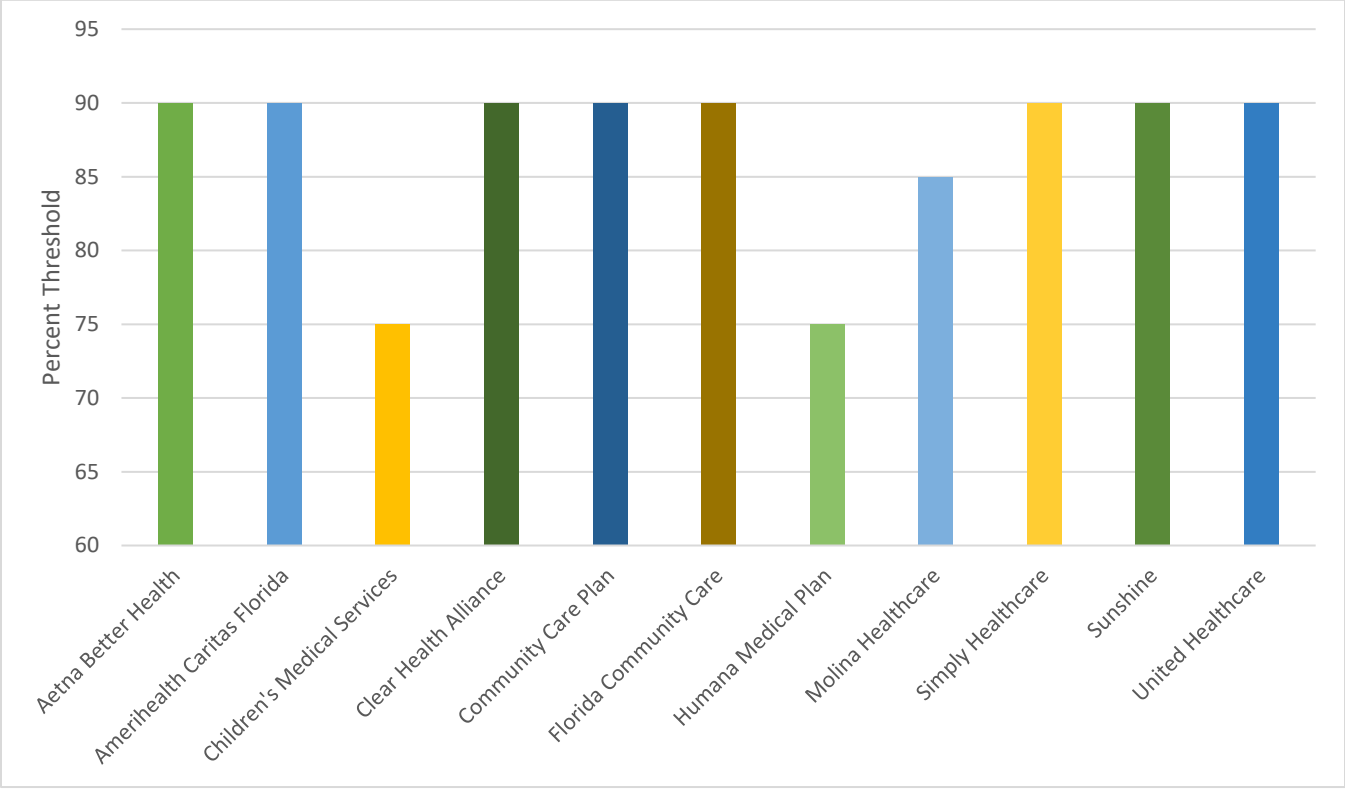
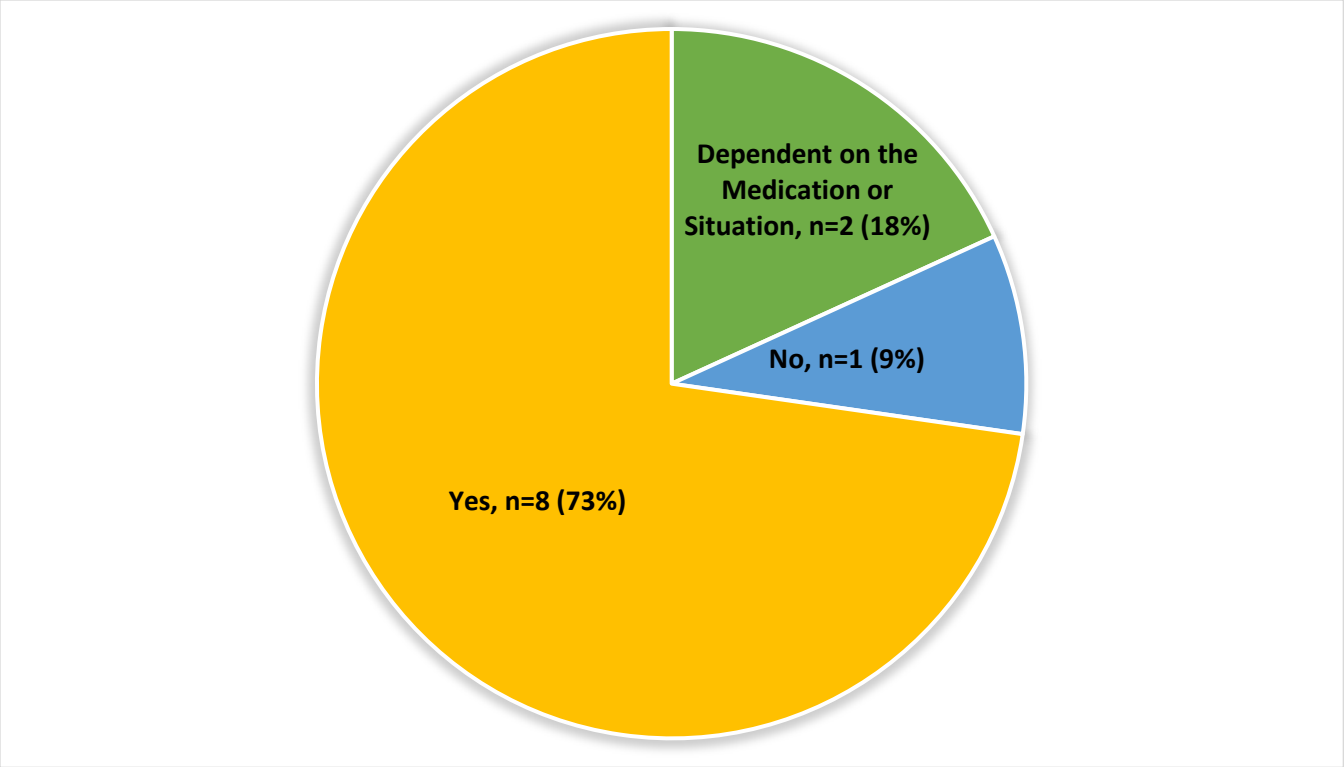


Table 15 - Early Refill Percent Threshold for Non-controlled and Controlled Drugs

MCO Name	Non-controlled Drugs	Schedule II Controlled Drugs	Schedule III through V Controlled Drugs
Aetna Better Health	80.00%	90.00%	90.00%
Amerihealth Caritas Florida	75.00%	90.00%	90.00%
Children's Medical Services	75.00%	75.00%	75.00%
Clear Health Alliance	90.00%	90.00%	90.00%
Community Care Plan	80.00%	90.00%	90.00%
Florida Community Care	75.00%	90.00%	90.00%
Humana Medical Plan	75.00%	75.00%	75.00%
Molina Healthcare	85.00%	85.00%	85.00%
Simply Healthcare	90.00%	90.00%	90.00%
Sunshine	80.00%	80.00%	90.00%
United Healthcare	85.00%	90.00%	90.00%

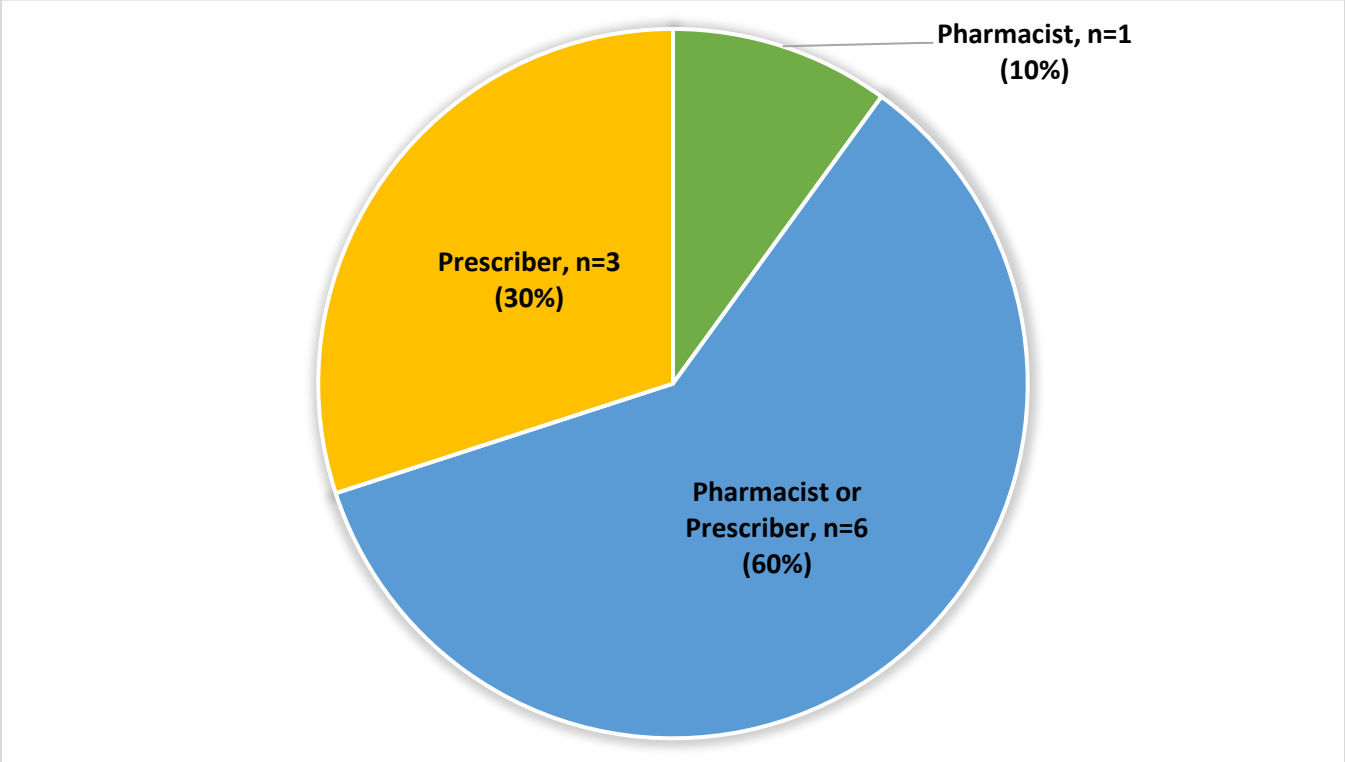
b. For non-controlled drugs, when an early refill message occurs, does your MCO require PA?

Figure 12 - Non-Controlled Drugs Early Refill Requirement for Prior Authorization



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

Figure 13 - Non-Controlled Drugs Early Refill Authorization Sources



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

Figure 14 - Non-Controlled Drugs, Pharmacist May Override at Point of Service

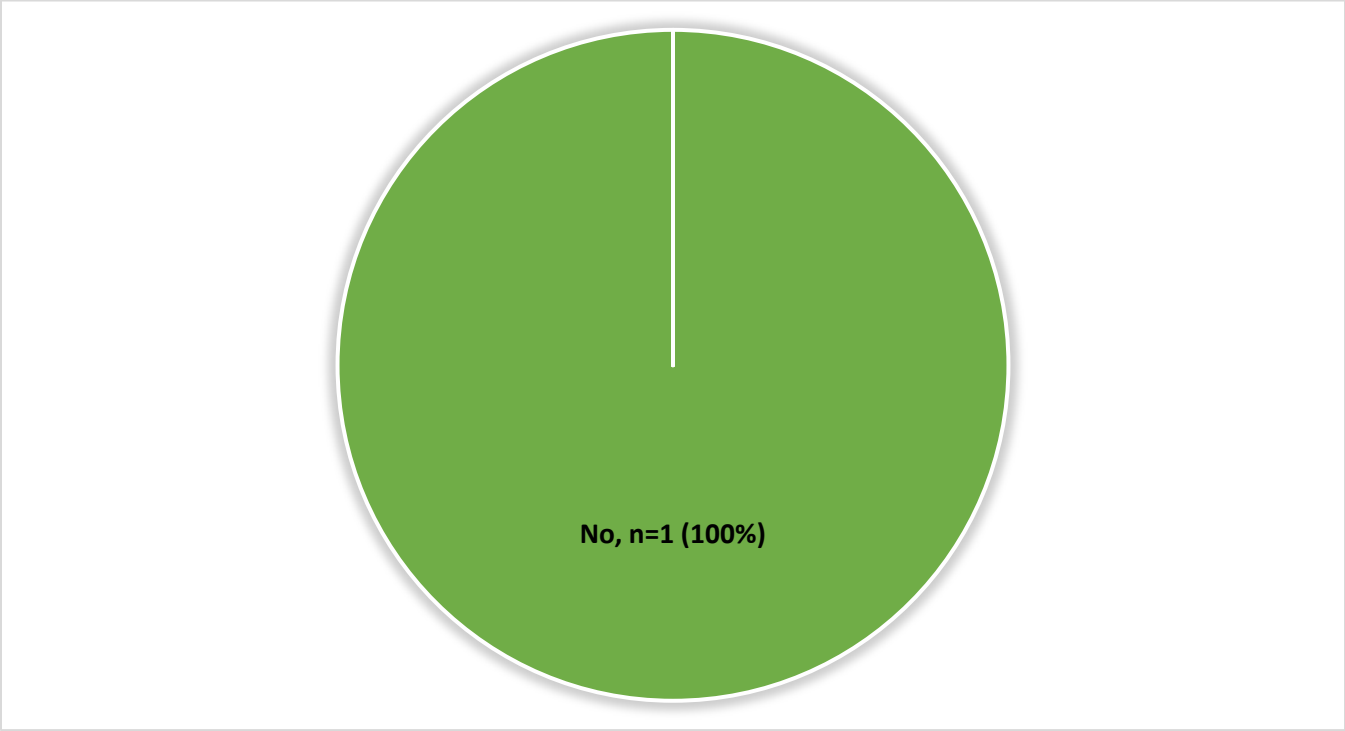
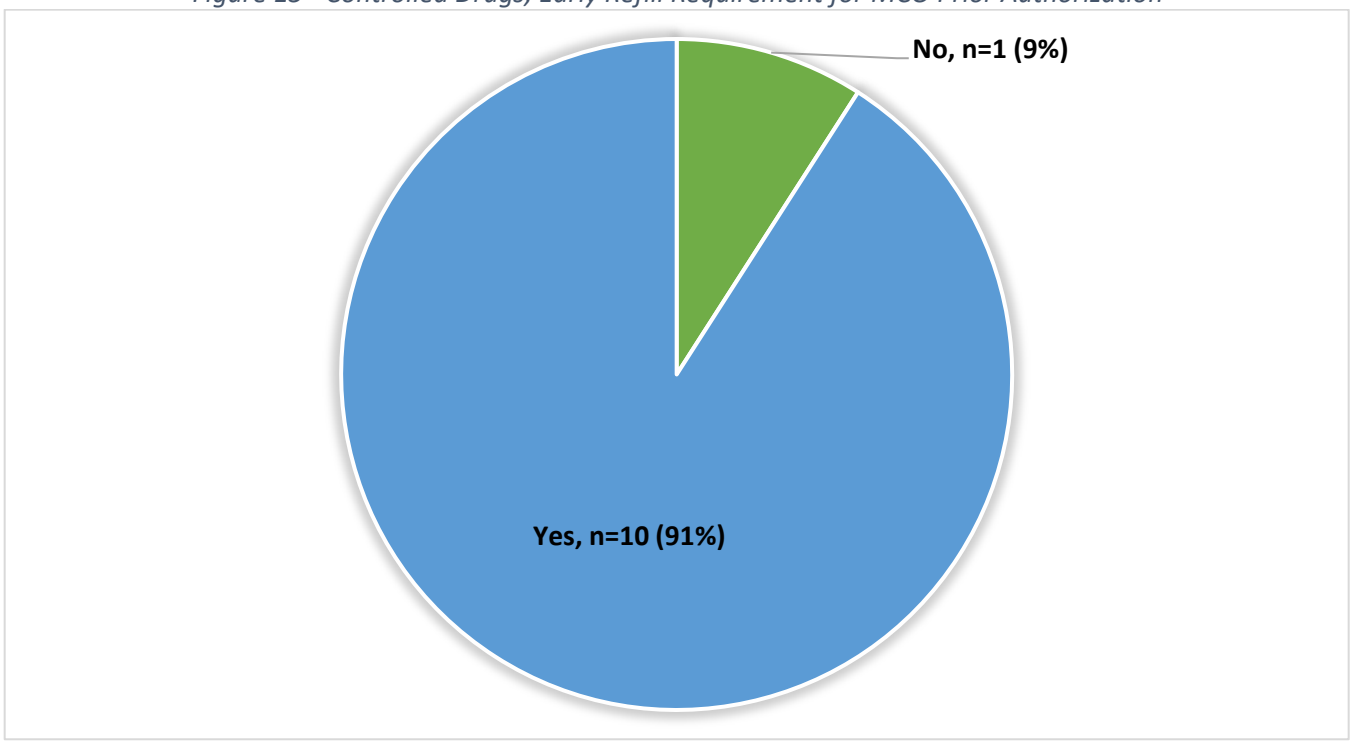


Table 16 - Non-Controlled Drugs Early Refill Requirement and Authorization Source for Prior Authorization

MCO Name	Non-controlled Early Refill Prior Authorization?	If "Yes," who obtains authorization (Pharmacist, Prescriber or Either)?	If "No," can pharmacist override at the point of service?
Aetna Better Health	Yes	Prescriber	
Amerihealth Caritas Florida	Yes	Pharmacist or Prescriber	
Children's Medical Services	Yes	Pharmacist or Prescriber	
Clear Health Alliance	Yes	Prescriber	
Community Care Plan	No		No
Florida Community Care	Dependent on the medication or situation	Pharmacist	
Humana Medical Plan	Yes	Pharmacist or Prescriber	
Molina Healthcare	Dependent on the medication or situation	Pharmacist or Prescriber	
Simply Healthcare	Yes	Prescriber	
Sunshine	Yes	Pharmacist or Prescriber	
United Healthcare	Yes	Pharmacist or Prescriber	

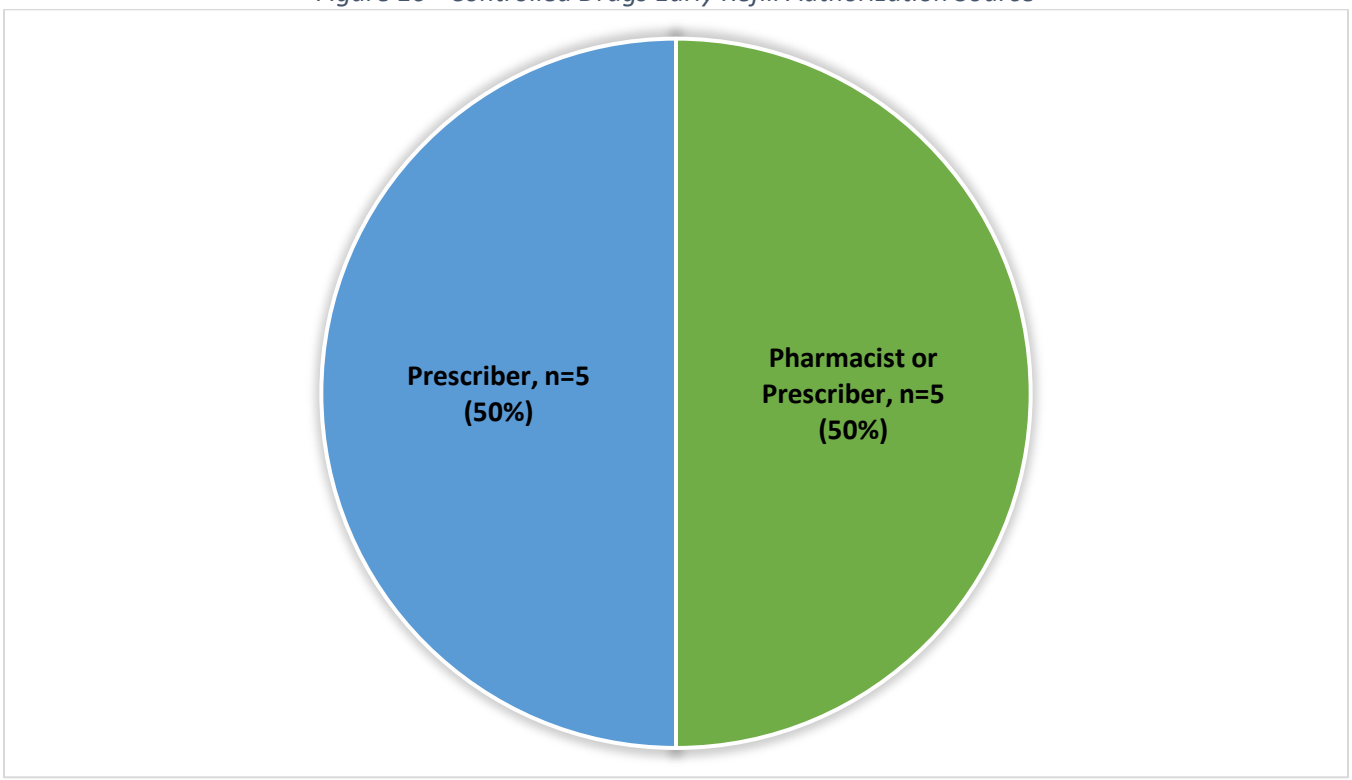
c. For controlled drugs, when an early refill message occurs, does your MCO require PA?

Figure 15 - Controlled Drugs, Early Refill Requirement for MCO Prior Authorization



If "Yes," who obtains authorization?

Figure 16 - Controlled Drugs Early Refill Authorization Source



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

Figure 17 - Controlled Drugs, Pharmacist Override at Point of Service

Table 17 - For Controlled Drugs, Early Refill Requirement and Authorization Source for Prior Authorization

MCO Name	Controlled Drugs Early Refill Requirement for Prior Authorization?	If "Yes," who obtains authorization? (Pharmacist, Prescriber or Either)	If "No," can pharmacist override at the point of service?
Aetna Better Health	Yes	Prescriber	
Amerihealth Caritas Florida	Yes	Pharmacist or Prescriber	
Children's Medical Services	Yes	Pharmacist or Prescriber	
Clear Health Alliance	Yes	Prescriber	
Community Care Plan	No		No
Florida Community Care	Yes	Pharmacist or Prescriber	
Humana Medical Plan	Yes	Prescriber	
Molina Healthcare	Yes	Pharmacist or Prescriber	
Simply Healthcare	Yes	Prescriber	
Sunshine	Yes	Pharmacist or Prescriber	
United Healthcare	Yes	Prescriber	

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

Figure 18 - Policy Allows Pharmacist Overrides for an Early Refill

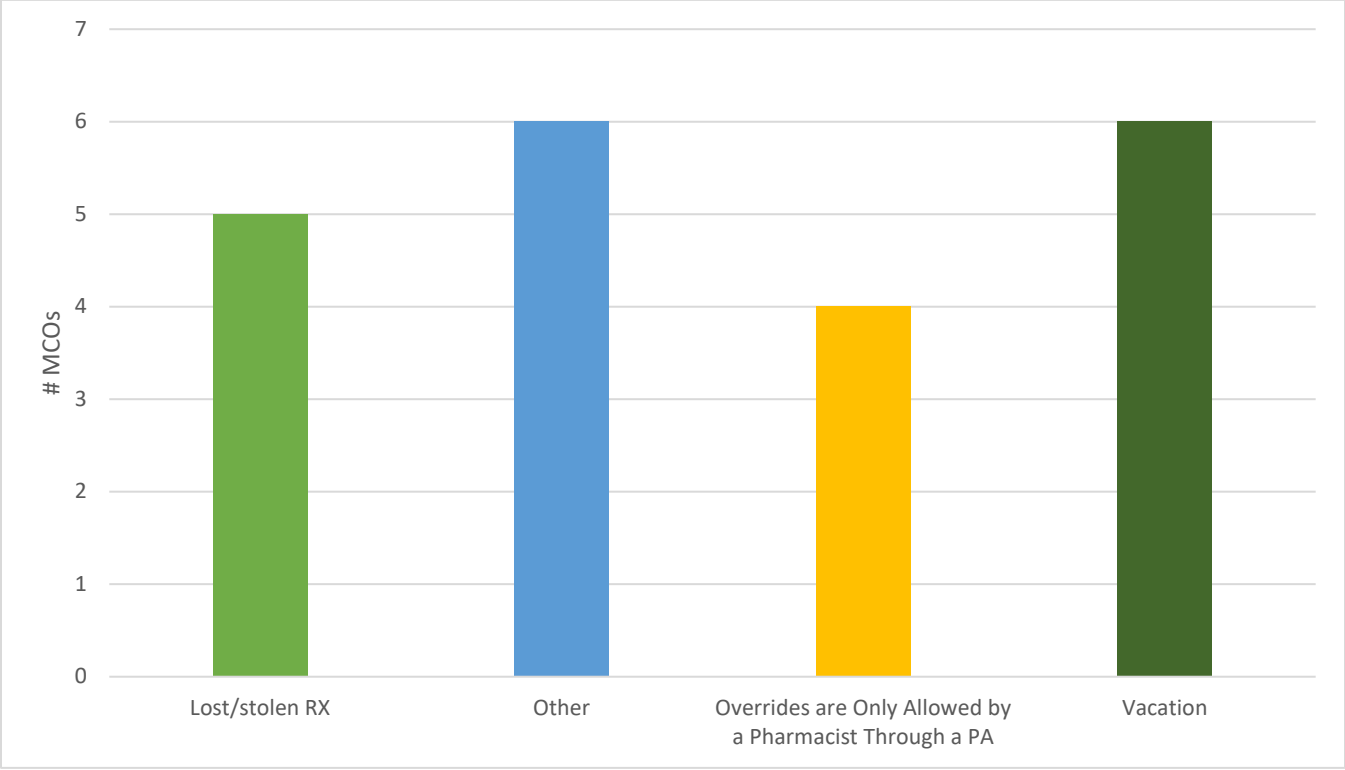


Table 18 - Policy Allows Pharmacist Overrides for an Early Refill

Response	MCO Names	Count	Percentage
Lost/stolen RX	Aetna Better Health, Clear Health Alliance, Florida Community Care, Molina Healthcare, Simply Healthcare	5	23.81%
Overrides are only allowed by a pharmacist through a PA	Children's Medical Services, Clear Health Alliance, Simply Healthcare, Sunshine	4	19.05%
Vacation	Aetna Better Health, Clear Health Alliance, Florida Community Care, Molina Healthcare, Simply Healthcare, United Healthcare	6	28.57%
Other	Aetna Better Health, Amerihealth Caritas Florida, Community Care Plan, Humana Medical Plan, Molina Healthcare, United Healthcare	6	28.57%
State Totals		**21**	**100%**

If "Other," please explain.

Table 19 - "Other" Explanations for Allowing Pharmacist Overrides for an Early Refill

MCO Name	Explanation
Aetna Better Health	Lost/spilled Rx override: Members are allowed 1 lost/spilled Rx override per medication per 365 days. Controlled and specialty drugs require PA for override, and Hep C drugs are excluded from override.

MCO Name	Explanation
	Stolen Rx override: Members are allowed 1 stolen Rx override per medication per 365 days. Controlled drugs require a PA with signed police report. Vacation Rx override: Members are allowed 1 vacation Rx override per medication per 365 days. Controlled and specialty medications require PA (documentation of travel must be submitted). Any request for greater than a 34-day supply for Medicaid requires PA with documentation of travel. Any vacation override request for over 3 months should be sent to MD for final review and recommended for denial. Disaster/emergency override: During declared states of emergency, the refill too soon edit logic can be overrode so that claims will be able to process by entering a DUR code.
Amerihealth Caritas Florida	Pharmacist must call the plan for an override on all of the above situations, with the exception of an increase in dose. For a dosage increase, the pharmacist must enter an authorization code, and the system will recalculate the day supply based on the new directions. If the member is still not due for the medication, the system will provide the pharmacy a new refill date.
Community Care Plan	Members are instructed to contact the health plan when they need extra medication fills for vacations or have lost/stolen medications. CCP will contact the PBM to proactively have the system set up to allow the claims to pay. This will allow members to have less medication related delays at the pharmacy.
Humana Medical Plan	Prior Authorization is required.
Molina Healthcare	The dispensing pharmacists can call the Molina pharmacy help desk for verbal overrides/authorizations. This is done per member per case after eligibility and benefit allowances are reviewed.
United Healthcare	The Pharmacy can call the PBM help desk to receive a vacation override for the member . Member is limited to one vacation override per drug/year.

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

Figure 19 - System Accumulation Edit for Prevention of Early Prescription Filling

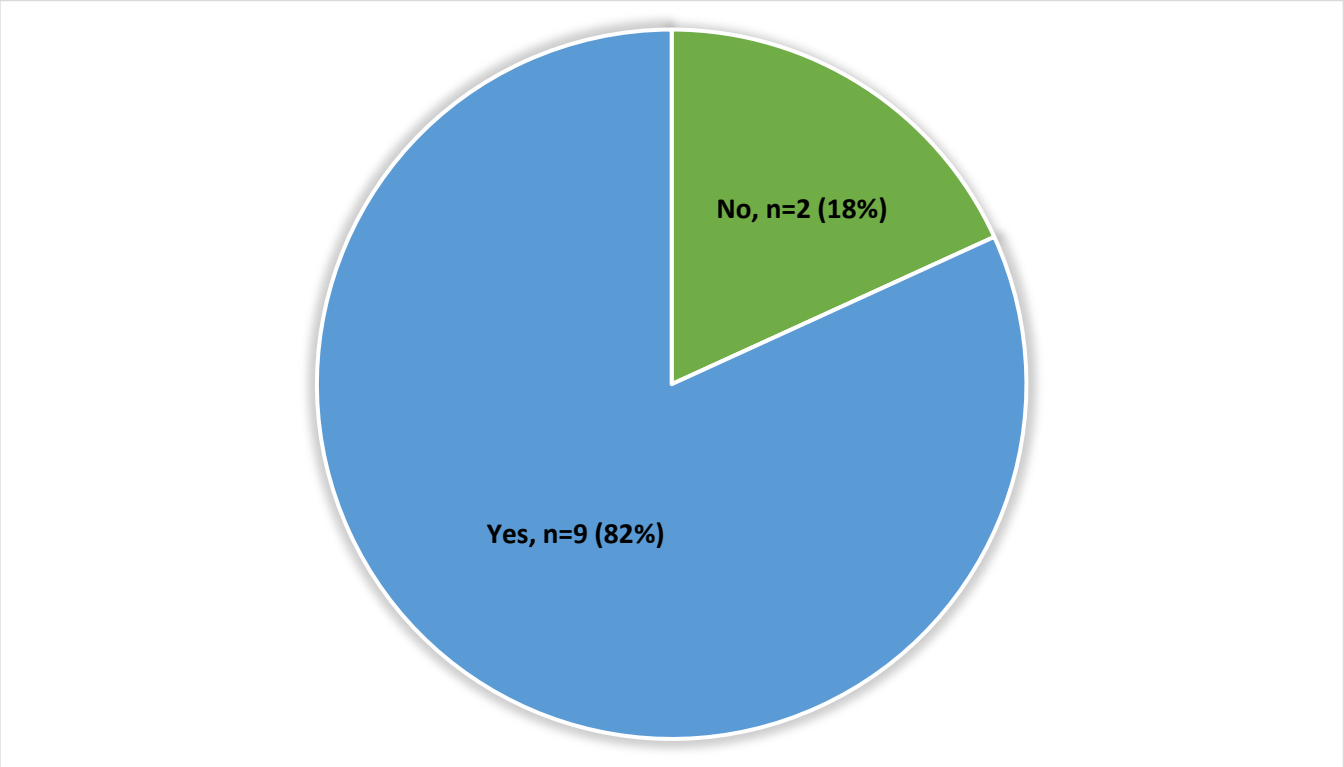


Table 20 - System Accumulation Edit for Prevention of Early Prescription Filling

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine	9	81.82%
No	Amerihealth Caritas Florida, United Healthcare	2	18.18%
State Totals		**11**	**100%**

If "Yes," please explain your edit.

Table 21 - Explanations for System Accumulation Edit for Prevention of Early Prescription Filling

MCO Name	Explanation
Aetna Better Health	Certain classes have accumulation edits (proton pump inhibitors, skeletal muscle relaxants, and controlled substances) in alignment with state PDL requirements. The edits count refills over a particular time frame to prohibit a total accumulation amount.
Children's Medical Services	Adjudication has two refill too soon edits that work in partnership and use the exact match of a drug's GPI to prevent members from obtaining more medication than they should. The Refill Threshold Percentage and DUR setups calculate the next estimated refill date based on the previous Date of Fill and Day's Supply of a dispensed drug. The system will not allow a refill until that specific amount of days has passed
Clear Health Alliance	We have quantity limits that limit members to a certain amount of medication per month, and refill too soon edits. We also review prior requests for early refills before approving.

MCO Name	Explanation
Community Care Plan	Over a period of 180 days the prescription cannot be more than 15 days early. If more than 15 days early the claim will reject to prevent accumulation.
Florida Community Care	Adjudication has two refill too soon edits that work in partnership and use the exact match of a drug's GPI to prevent members from obtaining more medication than they should. The Refill Threshold Percentage and DUR setup calculate the next estimated refill date based on the previous Date of Fill and Days Supply of a dispensed drug. The system will not allow a refill until that specific amount of days has passed.
Humana Medical Plan	Including but not limited to: Morphine equivalent dose; APAP (do not allow more than 4MG daily); Limit on the number of controlled prescriptions per month.
Molina Healthcare	Adjudication has two refill too soon edits that work in partnership and use the exact match of a drug's GPI to prevent members from obtaining more medication than they should. The Refill Threshold Percentage and DUR setup calculate the next estimated refill date based on the previous Date of Fill and Days Supply of a dispensed drug. The system will not allow a refill until that specific amount of days has passed
Simply Healthcare	We have quantity limits that limit members to a certain amount of medication per month, and refill too soon edits. We also review prior requests for early refills before approving.
Sunshine	Sunshine's adjudication system has two refill too soon edits that work in partnership and use the exact match of a drug's GPI to prevent members from obtaining more medication than they should. The Refill Threshold Percentage and DUR setup calculate the next estimated refill date based on the previous Date of Fill and Day's Supply of a dispensed drug. The system will not allow a refill until that specific amount of days has passed.

If “No,” does your MCO plan to implement this edit?

Figure 20 - Plans to Implement a System Accumulation Edit

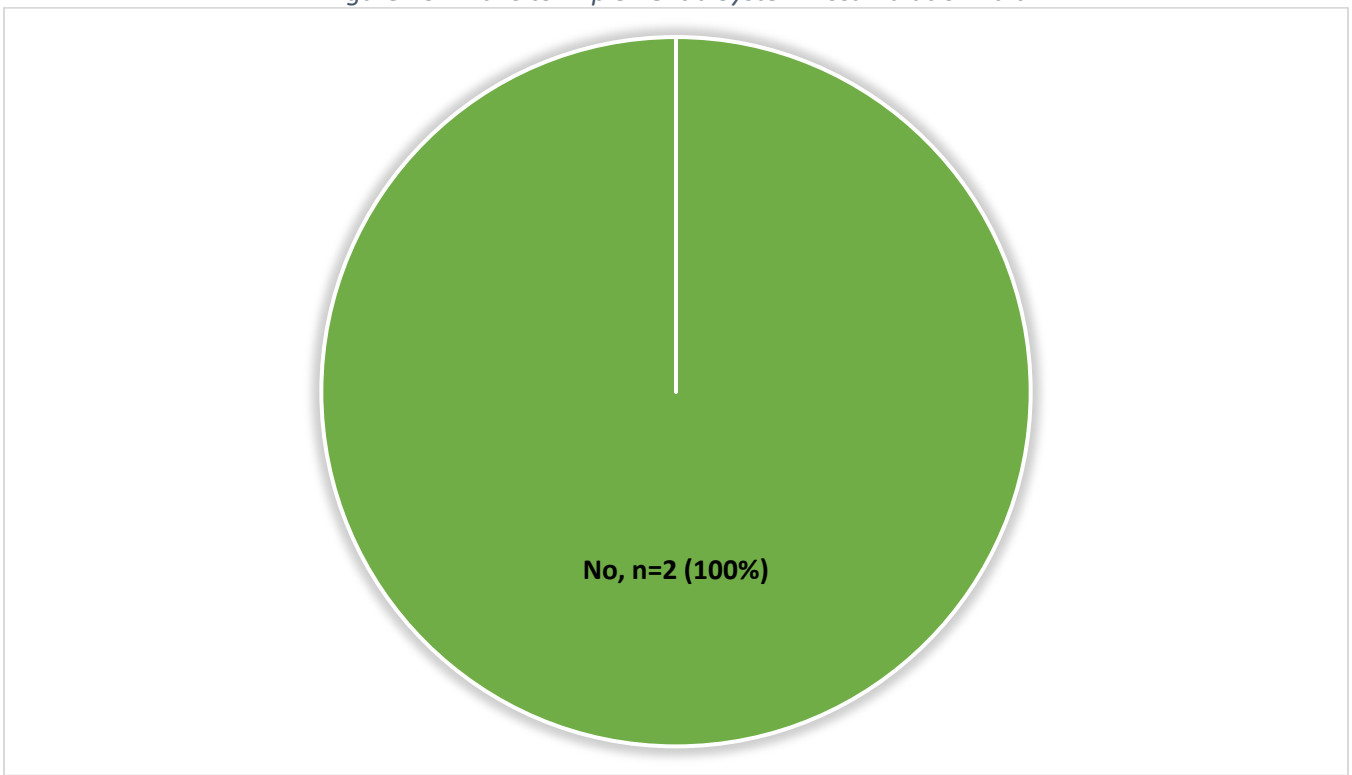


Table 22 - Plans to Implement a System Accumulation Edit

Response	MCO Names	Count	Percentage
No	Amerihealth Caritas Florida, United Healthcare	2	100.00%
State Totals		**2**	**100%**

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

Figure 21 - MCO Policy Prohibiting Auto-Refill at the POS

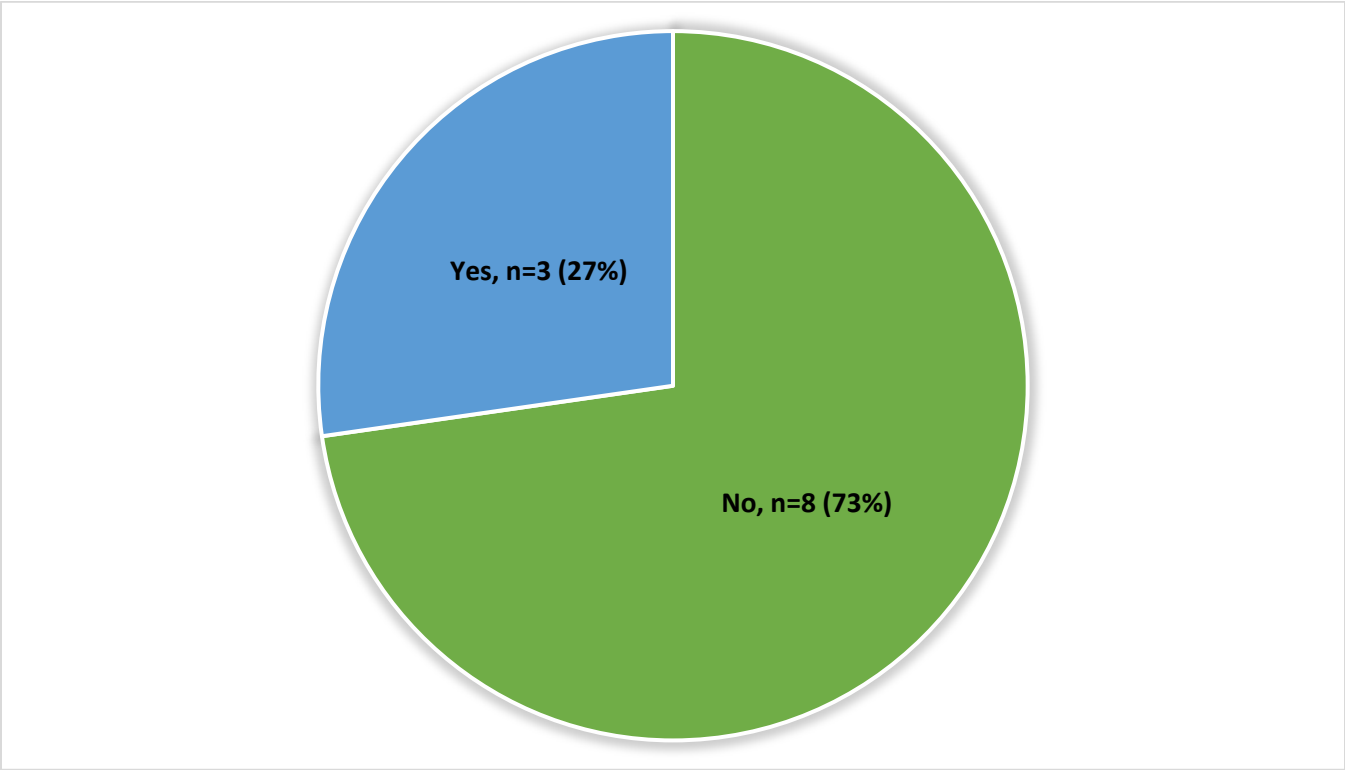


Table 23 - MCO Policy Prohibiting Auto-Refill at the POS

Response	MCO Names	Count	Percentage
Yes	Amerihealth Caritas Florida, Community Care Plan, United Healthcare	3	27.27%
No	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine	8	72.73%
State Totals		**11**	**100%**

9. Does your system have a diagnosis edit that can be utilized when processing a prescription?

Figure 22 - System Having a Diagnosis Edit That Can be Utilized When Processing Prescription

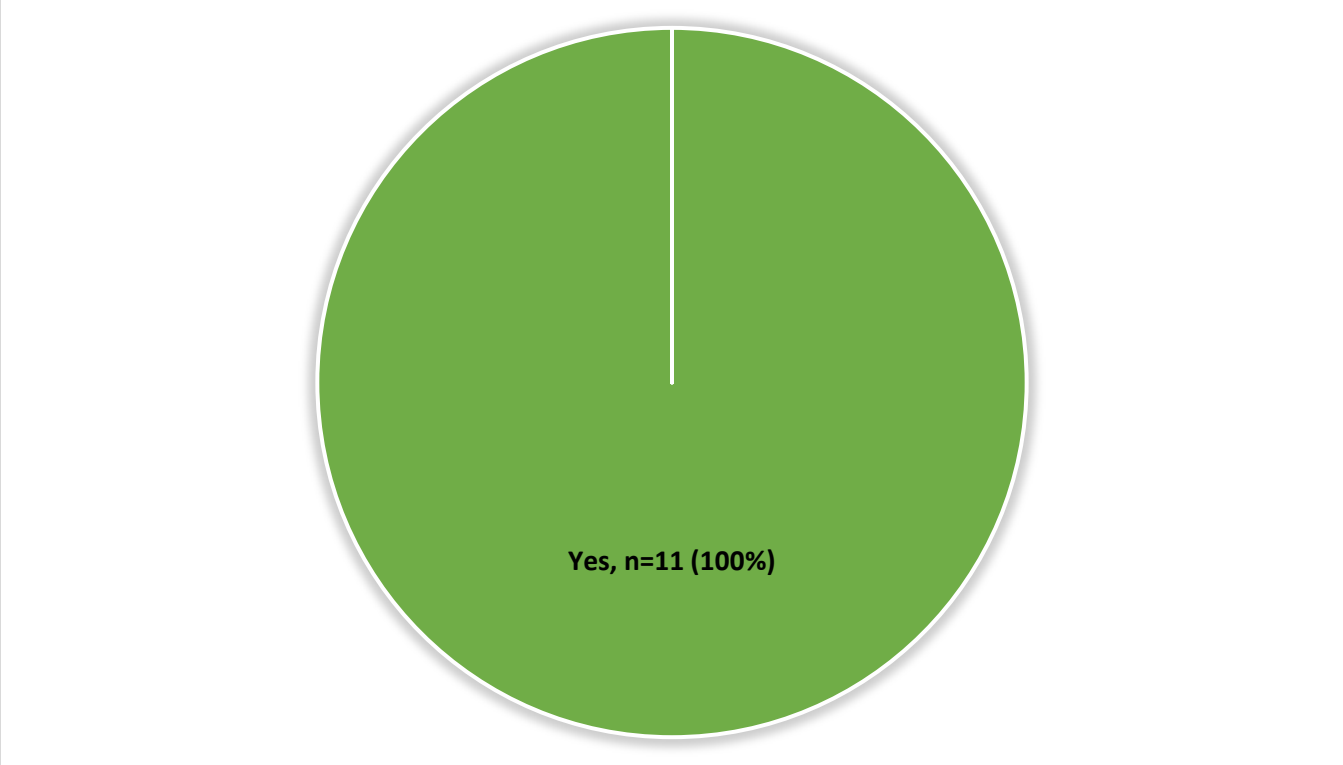


Table 24 - System Having a Diagnosis Edit That Can be Utilized When Processing Prescription

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," please explain.

Table 25 - Explanations for System Having a Diagnosis Edit That Can be Utilized When Processing Prescription

MCO Name	Explanation
Aetna Better Health	Some medications and DUR edits also automatic coding in place that searches for the presence of a diagnosis code in the member's medication history. If certain diagnoses codes are found, then those medications will automatically pay through smart PA edits. There is also coding in place for some medications that allows the pharmacist to enter a diagnosis code at point of sale to allow a prescription claim to process if appropriate (e.g., MAT therapy).
Amerihealth Caritas Florida	YES A diagnosis code can be submitted on certain prescriptions to allow the prescription to process without a prior authorization requirement or to override certain DUR edits
Children's Medical Services	Adjudication system is able to systematically review for diagnosis codes programmed to allow for successfully paying a claim without any human intervention.
Clear Health Alliance	Our system has the capability to review a diagnosis code and pay a claim according to AHCA automated prior authorization and bypass list requirements.

MCO Name	Explanation
Community Care Plan	Diagnosis codes are sent to the PBM daily and this information is on the members file in advance in most cases. At POS if the prescribing physician wrote the diagnosis on the script, then the PBM will accept the pharmacist/provided information and allow an override. AHCA POS diagnosis edits are allso
Florida Community Care	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary."
Humana Medical Plan	Yes - Drug-disease interaction edits utilize ICD-10 codes from medical history, Opioid edits infer exclusions for sickle cell, cancer based on medical claims, ICD-10 and pharmacy claims drug lists. Custom functionality to utilize medical claims and pharmacy claims to apply exclusions across all duplicate therapy, drug-drug interaction edits.
Molina Healthcare	The DUR Diagnosis edit "messages" the pharmacist when contraindications based on diagnosis is identified. The edit identifies contraindications based on the member's diagnosis. These contraindications are classified as either absolute, potential or precautionary."
Simply Healthcare	Our system has the capability to review a diagnosis code and pay a claim according to AHCA automated prior authorization and bypass list requirements.
Sunshine	Adjudication system is able to systematically review for diagnosis codes programmed to allow for successfully paying a claim without any human intervention.
United Healthcare	UnitedHealthcare Community Plan aligns required diagnosis edits on products/drug classes as outlined by the State Medicaid Prescription program specified by the Agency for Healthcare Administration (AHCA) Examples of medications where this is utilized are : HIV agents, ADHD and specific Diabetic Agnets (GLP-1 class). Appropriate diagnosis per ICD-10 codes must be included on the prescription for the prescription to process by the pharmacist- otherwise a prior authorization is required.

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

Figure 23 - Documented Process for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) when Medically Necessary

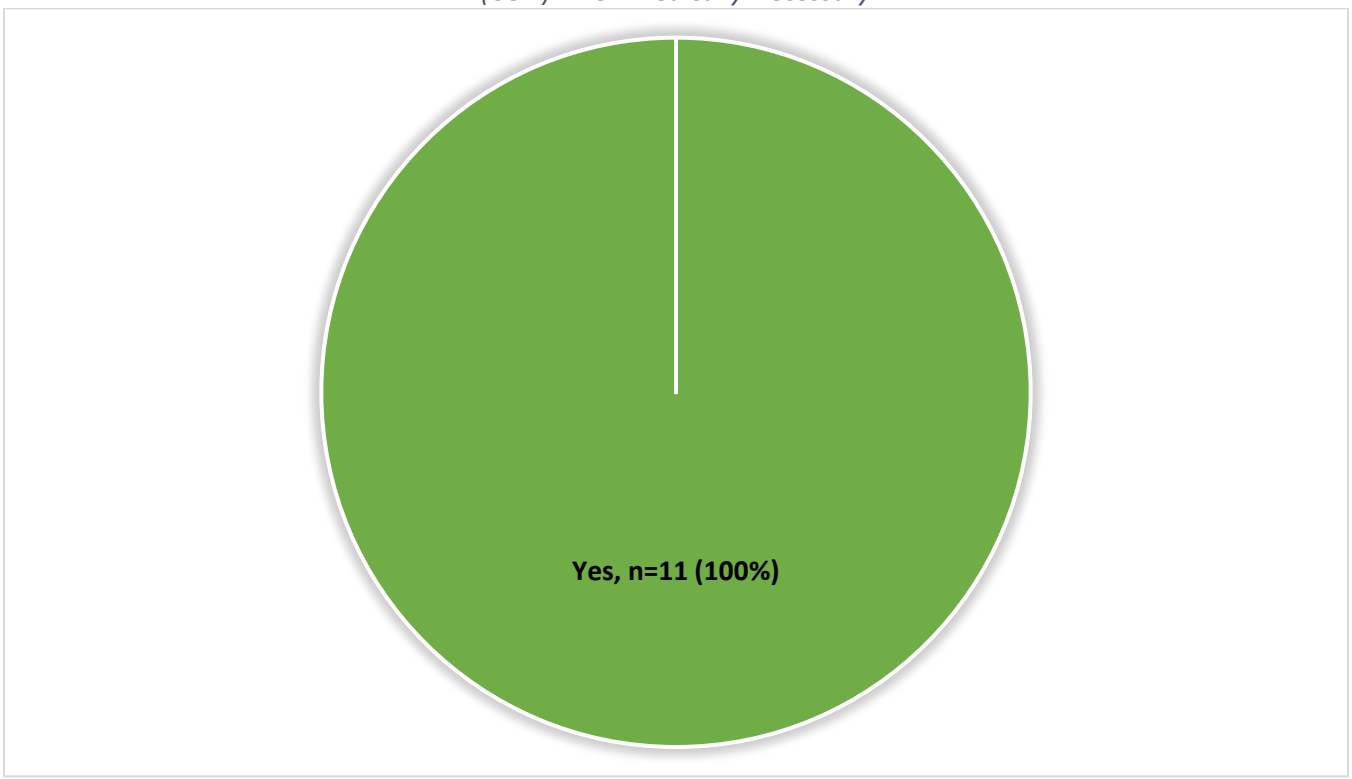


Table 26 - Documented Process for Beneficiaries or their Prescribers to Access Any Covered Outpatient Drug (COD) when Medically Necessary

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," please check all that apply.

Figure 24 - Documented Process in Place for Beneficiaries to Access Any Covered Outpatient Drug (COD) When Medically Necessary

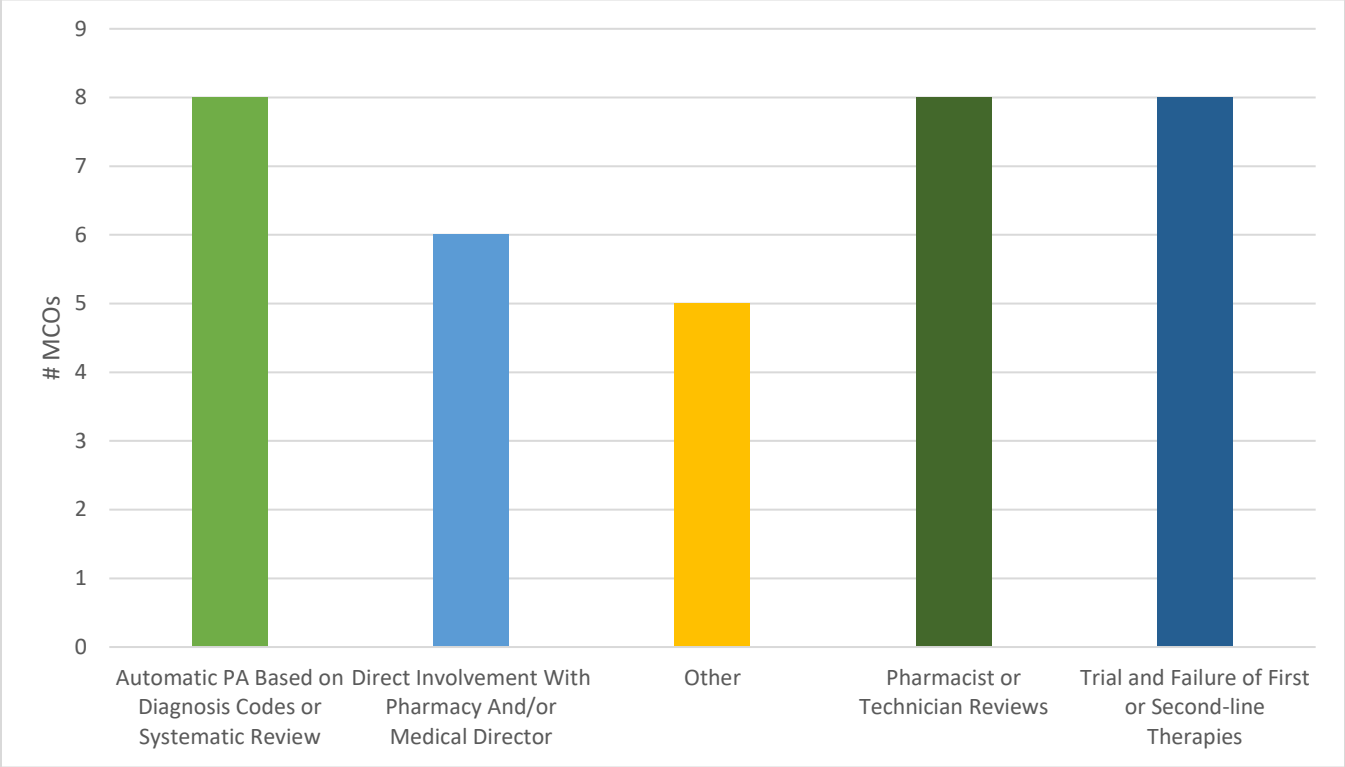


Table 27 - Documented Process in Place for Beneficiaries to Access Any Covered Outpatient Drug (COD) When Medically Necessary

Response	MCO Names	Count	Percentage
Automatic PA based on diagnosis codes or systematic review	Aetna Better Health, Children's Medical Services, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Sunshine, United Healthcare	8	22.86%
Direct involvement with Pharmacy and/or Medical Director	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Florida Community Care, Molina Healthcare, Sunshine	6	17.14%
Pharmacist or technician reviews	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Sunshine	8	22.86%
Trial and failure of first or second-line therapies	Aetna Better Health, Children's Medical Services, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Sunshine, United Healthcare	8	22.86%
Other	Clear Health Alliance, Community Care Plan, Molina Healthcare, Simply Healthcare, United Healthcare	5	14.29%
State Totals		**35**	**100%**

If “Other,” please explain.

Table 28 - Explanations for “Other” Processes in Place for Beneficiaries to Access Any Covered Outpatient Drug When Medically Necessary

MCO Name	Explanation
Clear Health Alliance	The claim denies at point of sale. Provider may request a PA to consider coverage based on medical necessity. The provider may need to submit clinical documentation to support the PA request. The PA reviewer uses the medical necessity criteria to evaluate the PA request.
Community Care Plan	CCP follows the State's PDL and drug criteria, CCP has a step-therapy prior authorization approval process for medications excluded from the preferred drug list. Medications listed on the preferred drug list (at least two within similar drug class or for similar medical indication) must be used before the non-preferred alternative is approved unless contraindicated in the Food and Drug Administration labeling. A drug may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides additional written medical or clinical documentation that the product is medically necessary because: a) There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative; b) The alternatives have been ineffective in the treatment of the beneficiary's disease; or c) Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective, or the number of doses have been ineffective.
Molina Healthcare	Molina offers a Medicaid Formulary Exception Review process. The member or provider may request medication coverage for products that are not on the formulary. Criteria for approval may include: a) Request is for a FDA approved indication, AND b) Member has tried and failed preferred formulary alternatives OR c) Member has a documented allergy to the available formulary alternatives in the class, OR d) Member has demonstrated an adverse reaction to the available formulary alternatives, OR e) The formulary drug is contraindicated for the member's diagnosis
Simply Healthcare	The claim denies at point of sale. Provider may request a PA to consider coverage based on medical necessity. The provider may need to submit clinical documentation to support the PA request. The PA reviewer uses the medical necessity criteria to evaluate the PA request.
United Healthcare	Authorization for non-preferred medications are reviewed and approvable when shown to be medically necessary. Medical necessity is established when the drugs offerred on the Preferred Drug List (PDL) are not appropriate to treat the member due to contraindication or intolerances. A formal prior authorization process is in place that validates the member's diagnosis to identify appropriate use and rationale when the preferred drugs are inappropriate.

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

Table 29 - How MCO Ensures PA Criteria is No More Restrictive than FFS Criteria and Review

MCO Name	Description
Aetna Better Health	The MCO utilizes the same PA criteria as FFS for any non-preferred medications that have set criteria and prior authorization forms available on the Agency for Health Care Administration (AHCA) Pharmacy Policy website at https://ahca.myflorida.com/medicaid/Prescribed_Drug/drug_criteria.shtml. Once a PA

MCO Name	Description
	is submitted to the MCO, the clinical reviewers have 24 hours to review the PA request and provide a decision. This is the same PA review time frame that is used by FFS.
Amerihealth Caritas Florida	AmeriHealth Caritas Florida (ACFL) is required by its contract with the State of Florida Agency for Health Care Administration (AHCA) to provide coverage of outpatient drugs in accordance with the policies and procedures established by the AHCA Pharmacy Policy Unit. AHCA's Pharmacy Policy Unit oversees pharmaceutical coverage and maintains the Medicaid Preferred Drug List and determines prescription drug criteria, prior authorization requirements and drug limitations. By contract requirement, ACFL only utilizes the PA criteria established by AHCA.
Children's Medical Services	The MCO utilizes the same FFS criteria when evaluating medical necessity requests and other coverage determination requests. The MCO website links directly to the FFS website which houses the FFS criteria in order to indicate that the criteria used for coverage determination reviews is consistent. Further, staff members are trained to use the FFS criteria and any "decision tools" used to help staff members review coverage requests use the FFS criteria.
Clear Health Alliance	We follow all AHCA mandated clinical criteria and PDL for drugs requiring a prior authorization. When permitted, if the State does not maintain applicable PA Criteria for a particular drug, we follow our criteria which is based upon official compendia and clinical practice guidelines.
Community Care Plan	The PBM clinical pharmacist and when needed the in-house MCO clinical pharmacist will review for medical necessity using the AHCA criteria. Following the States drug criteria allows for avoiding being more stringent.
Florida Community Care	PA criteria aligns with AHCA policies and MCO reviews/approves updates to PA criteria at least quarterly
Humana Medical Plan	We utilize the state specific criteria provided by ACHA.
Molina Healthcare	Molina Healthcare of Florida utilizes FFS criteria as published or provided from the State Agency
Simply Healthcare	We follow all AHCA mandated clinical criteria and PDL for drugs requiring a prior authorization. When permitted, if the State does not maintain applicable PA Criteria for a particular drug, we follow our criteria which is based upon official compendia and clinical practice guidelines.
Sunshine	The MCO utilizes the same FFS criteria when evaluating medical necessity requests and other coverage determination requests. Team members are trained to use the FFS criteria and any "decision tools" used to help staff members review coverage requests use the FFS criteria.
United Healthcare	The MCO aligns and operationalizes in accordance with all state-mandated prior authorization criteria. In addition the MCO aligns with all fee-for-service prior authorization review criteria and procedures including turn around time (TAT) and provision of emergency supply of eligible medications for members . Where no policy exists, the FDA indications as identifies in the package insert are utilized.

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

Figure 25 - Program Provides for the Dispensing of at least a 72-hour Supply of a COD in Emergency Situations

Table 30 - Program Provides for the Dispensing of at least a 72-hour Supply of a COD in Emergency Situations

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," please check all that apply.

Figure 26 - Process for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations

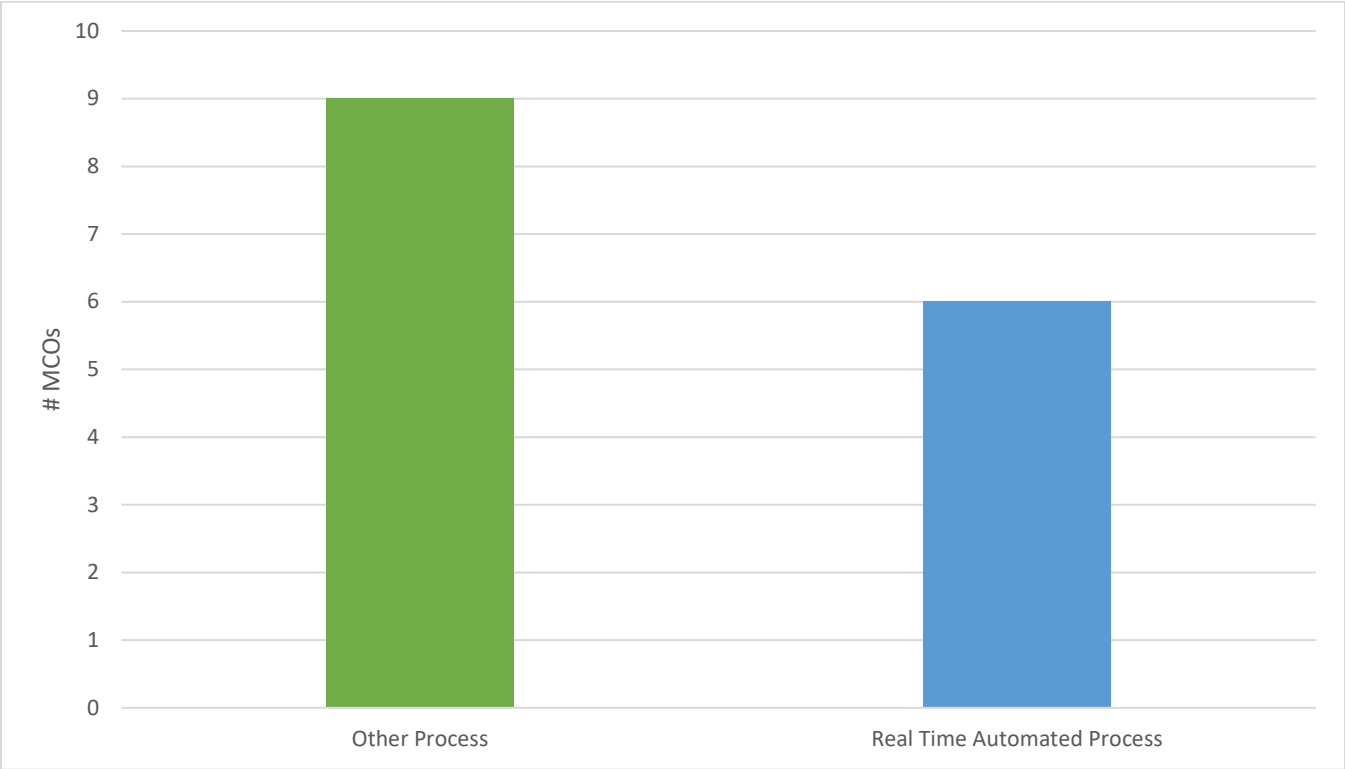


Table 31 - Process for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations

Response	MCO Names	Count	Percentage
Real time automated process	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Florida Community Care, Molina Healthcare, Sunshine	6	40.00%
Other process	Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	60.00%
State Totals		**15**	**100%**

If "Other process," please explain.

Table 32 - Explanations of "Other Process" for the Dispensing of at least a 72-Hour Supply of CODs in Emergency Situations

MCO Name	Explanation
Children's Medical Services	The beneficiary would contact the MCO and the MCO will place an override providing a 72-hour supply for the emergency situation.
Clear Health Alliance	Pharmacist may override the claim at POS 2 times per month per drug for a 72-hour supply of medication. The dispensing pharmacist can enter a one-time code at POS to attest to an emergency situation or call our pharmacy help desk to assist with an override.
Community Care Plan	Pharmacies must offer the recipient a 3-day supply for a timely refill at the POS denial, unless one of the following exceptions apply: The attempt to refill is early; OR The rejection is due to an error that only the pharmacist can correct; OR

MCO Name	Explanation
	There are clinical issues that must be resolved; OR The individual is not eligible for Medicaid; OR There would be a medical danger, if a temporary supply is dispensed. If a pharmacist contacts the Ombudsman line requesting assistance with a 3-day override, the Ombudsman pharmacist will assist. (Note: only pharmacists can request this override.) Information from the recipient notification pamphlet: If the pharmacist tells me Medicaid will not cover my prescription, when will I get a three (3) day supply of my medicine? ' If your prescription was for a refill of the exact prescription that Medicaid paid for last month; OR ' The pharmacist believes you should receive the medication to prevent serious or permanent harm to your health; OR ' The pharmacist believes that, if you do not receive your prescription, you could be hospitalized or need emergency treatment or you have a serious contagious disease. The three (3) day supply can be repeated one time.
Florida Community Care	There is a process in place to provide the dispensing of at least a 72 hour supply in emergency situations. This is handled by the account teams and driven in one of the 3 ways below: - Customer Care enters an emergency override - Point of sale reject with Pharmacy Help Desk number for override - Point of sale reject with override code for pharmacy to enter the override
Humana Medical Plan	If a prescription is presented in which the eligibility of the individual or the coverage of the product cannot be obtained, an emergency supply of medication (i.e. 48-72 hour supply) will be provided to the member subject to the pharmacist's professional judgement.
Molina Healthcare	There is a process in place to provide the dispensing of at least a 72-hour supply in emergency situations. This is could also be handled by the PBM service teams and driven in one of the 3 ways below: - Customer Care enters an emergency override - Point of sale reject with Pharmacy Help Desk number for override - Point of sale reject with override code for pharmacy to enter the override
Simply Healthcare	Pharmacist may override the claim at POS 2 times per month per drug for a 72-hour supply of medication. The dispensing pharmacist can enter a one-time code at POS to attest to an emergency situation or call our pharmacy help desk to assist with an override.
Sunshine	The member would contact the MCO and the MCO will place an override providing a 72-hour supply for the emergency situation.
United Healthcare	Florida allows for 72 hour supply for emergency situations per state regulations

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

*Table 33 - Top Drug Claims Data Reviewed by the DUR Board**

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name	Column 2 Top 10 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	Column 5 Top 10 Drug Names by Claim Count
Oxycodone	Opioids	Prior Authorization Required	Adalimumab	Albuterol
Albuterol	Adhd Agents/ stimulants	Refill Too Soon	Paliperidone	Amoxicillin
Semaglutide	Anticonvulsants	Plan Limitations Exceeded	Somatropin	Atorvastatin
Methylphenidate	Proton Pump Inhibitor Agents	Ndc Not Covered	Lurasidone	Gabapentin
Omeprazole	Acne Therapy	Submit Bill To Other Processor Or Primary Payor	Bictegrav/emtricit/ tenofov Ala	Fluticasone
Hydrocodone - Acetaminophen	Antidiabetic Agents		Bictegravir/ emtricitabine/tenofovir	Ibuprofen
Pregabalin	Sympathomimetics		Lisdexamfetamine	Cetirizine
Dextroamphetamine/ amphetamine	Muscle Relaxants		Dulaglutide	Montelukast
Oxycodone - Acetaminophen	Diabetic Supplies		Insulin Glargine	Humira(cf) Pen
Dupilumab	Eczema Agents		Elexacaftor/tezacaftor/ ivacaftor	Dextroamphetamine/ amphetamine

* This table has been developed and formulated using weighted averages to reflect the relative beneficiary size of each reporting MCO. Drug names are reported at the generic ingredient level.

Section III - Retrospective DUR (RetroDUR)

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

Figure 27 - Operation and Oversight of RetroDUR Reviews

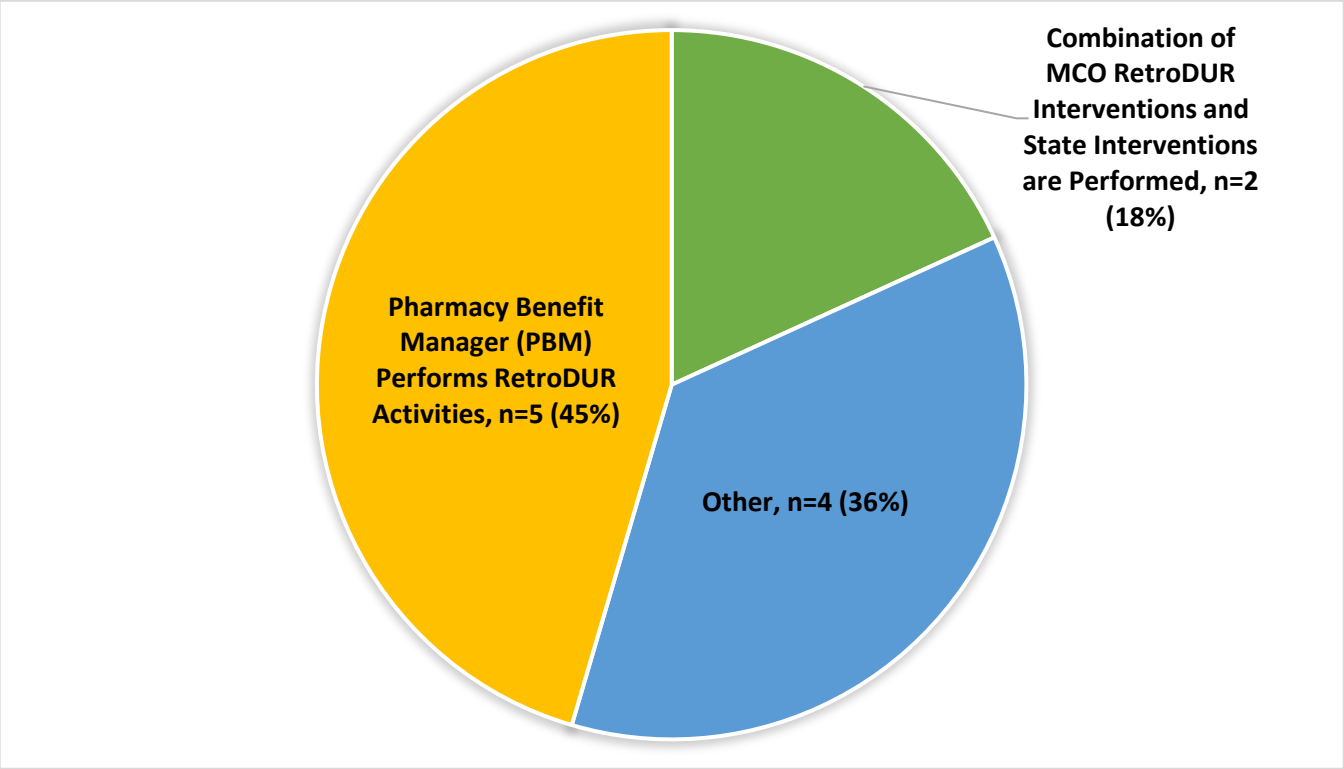


Table 34 - Operation and Oversight of RetroDUR Reviews

Response	MCO Names	Count	Percentage
Combination of MCO RetroDUR interventions and State interventions are performed	Amerihealth Caritas Florida, Humana Medical Plan	2	18.18%
Pharmacy Benefit Manager (PBM) performs RetroDUR activities	Clear Health Alliance, Community Care Plan, Florida Community Care, Simply Healthcare, United Healthcare	5	45.45%
Other	Aetna Better Health, Children's Medical Services, Molina Healthcare, Sunshine	4	36.36%
State Totals		**11**	**100%**

If "Other," please explain.

Table 35 - "Other" Explanations for Operation and Oversight of RetroDUR Reviews

MCO Name	Explanation
Aetna Better Health	Aetna combines state, MCO and PBM activities into our RetroDUR program activities.
Children's Medical Services	Combination of MCO and PBM execute RetroDUR activities.
Molina Healthcare	CVS/Caremark is delegated to retrospective activities involving safety and monitoring system activities. CVS/Caremark utilizes it's own criteria for identification of members

MCO Name	Explanation
	and/or prescribers that are high-risk based on their proprietary algorithm for claims data mining
Sunshine	Combination of MCO and PBM execute RetroDUR activities.

2. Identify the vendor, by name and type, that performed your RetroDUR activities during the time period covered by this report.

Figure 28 - Type of Vendor that Performed RetroDUR Activities

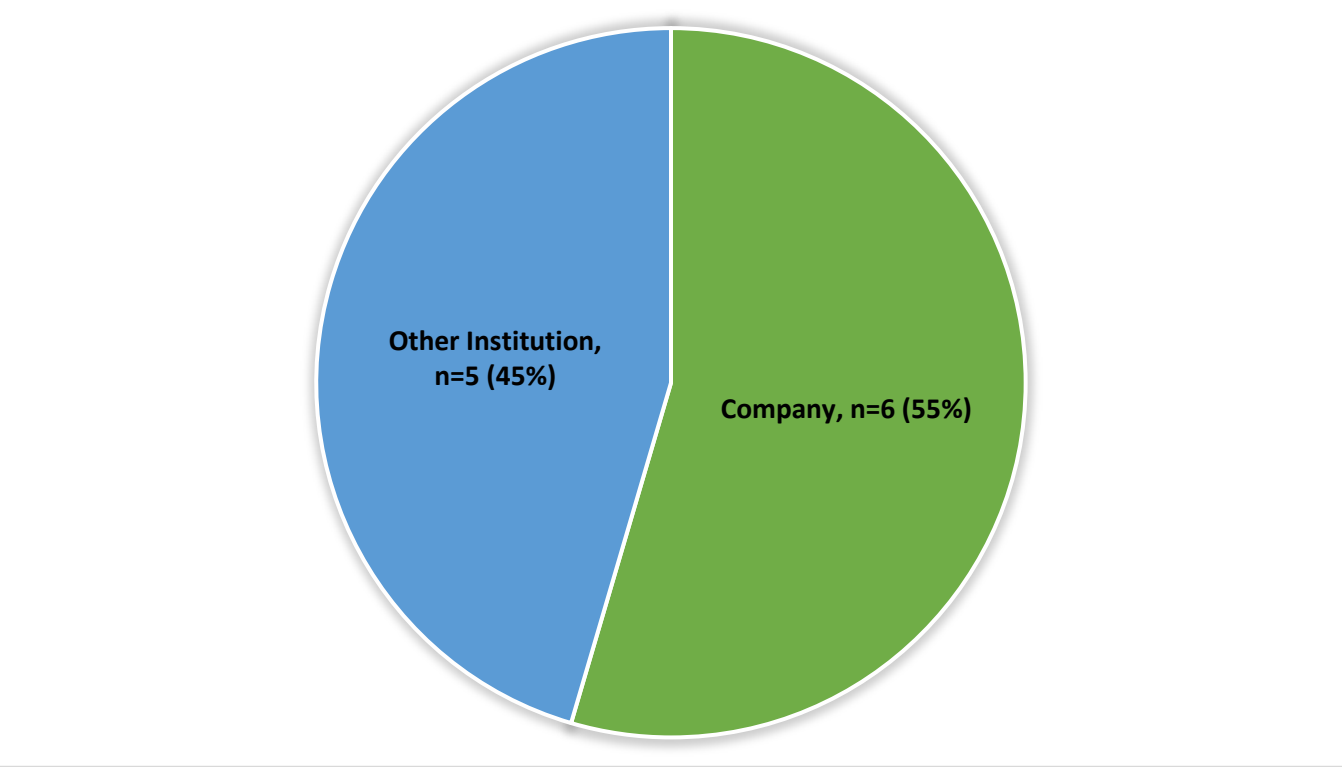


Table 36 - Type of Vendor that Performed RetroDUR Activities

Response	MCO Names	Count	Percentage
Company	Children's Medical Services, Clear Health Alliance, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine	6	54.55%
Other Institution	Aetna Better Health, Amerihealth Caritas Florida, Community Care Plan, Humana Medical Plan, United Healthcare	5	45.45%
State Totals		**11**	**100%**

Table 37 - Vendor Names

Response	MCO Names	Count	Percentage
CVS/Caremark - PBM	Children's Medical Services, Sunshine	2	18.18%
CVSHealth	Florida Community Care	1	9.09%
CVS Health	Molina Healthcare	1	9.09%
IngenioRx	Clear Health Alliance, Simply Healthcare	2	18.18%
Magellan Rx with Prime Therapeutics	Community Care Plan	1	9.09%

Response	MCO Names	Count	Percentage
MCO) - Florida True Health, Inc. d/b/a Prestige Health Choice Florida True Health, Inc. d/b/a AmeriHealth Caritas, Florida PBM - PerformRx	Amerihealth Caritas Florida	1	9.09%
OptumRX	United Healthcare	1	9.09%
State FFS Agency and internal DUR review function of MCO P&T Committee	Humana Medical Plan	1	9.09%
The Pharmacy Director, P&T Committee and DUR Board, and CVS/Caremark all contribute to RetroDUR activities.	Aetna Better Health	1	9.09%
State Totals		**11**	**100%**

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

Figure 29 - RetroDUR Vendor is the Developer/Supplier of Retrospective DUR Criteria

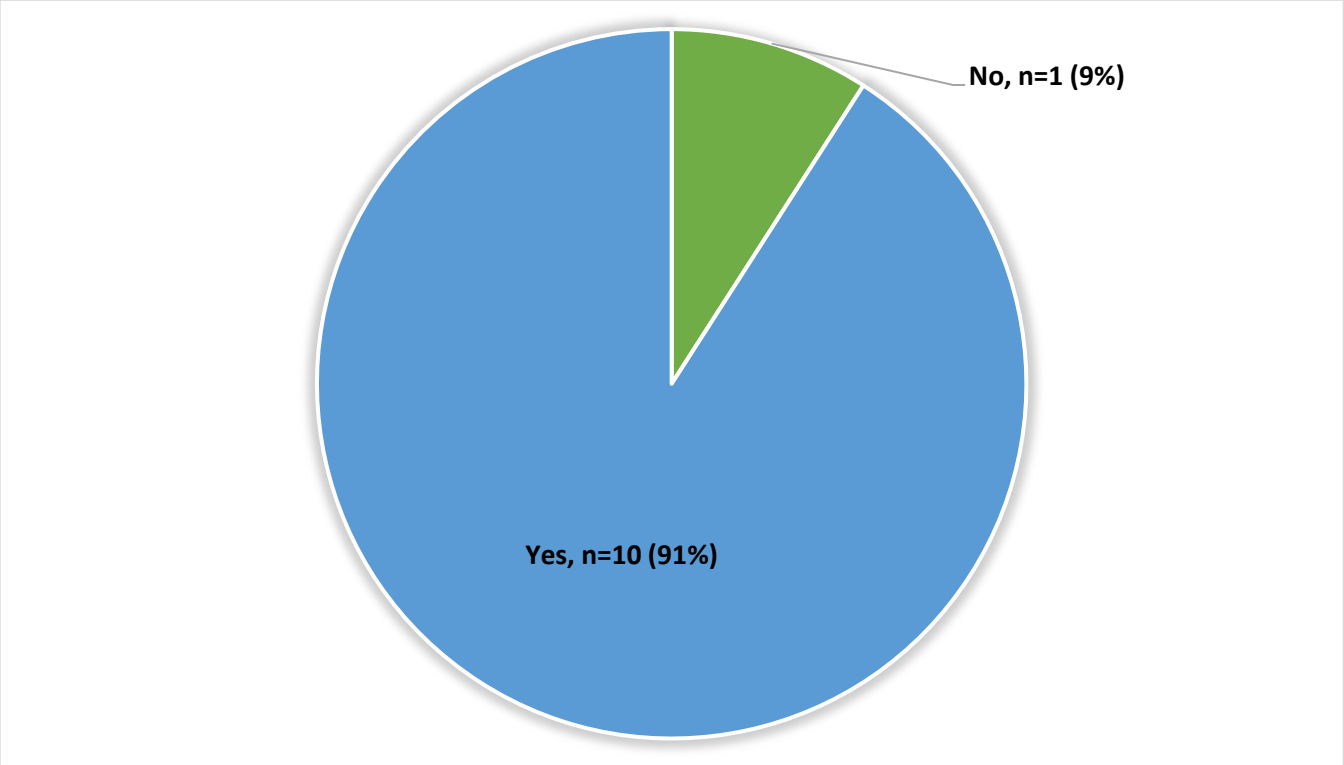


Table 38 - RetroDUR Vendor is the Developer/Supplier of Retrospective DUR Criteria

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Amerihealth Caritas Florida	1	9.09%
State Totals		**11**	**100%**

If "Yes," please explain.

Table 39 - "Yes" Explanations for RetroDUR Vendor Developer/Supplier of Retrospective DUR Criteria

MCO Name	Explanation
Aetna Better Health	The PBM develops the criteria for the RetroDUR activities that the PBM performs. The FL Medicaid retrospective DUR criteria are developed by the state DUR Board in collaboration with the Agency for Health Care Administration (AHCA). Aetna develops the criteria executed at the Aetna P&T Committee and DUR Board.
Children's Medical Services	The MCO works closely with the RetroDUR vendor to select programs that meet the rDUR criteria
Clear Health Alliance	IngenioRx develops retroDUR programs and criteria specifically geared toward Medicaid populations. Each program available is presented to the plan, and it is able to opt into programs that fit its needs and membership.
Community Care Plan	The PBM conducts active surveillance of prescription activities and identifies prescribing patterns based on current clinical best practices as it relates to chronic conditions. The PBM also creates and develops RetroDUR initiatives based on information from Medicaid boards like AHCA. The PBM provides CCP Pharmacy Director with a list of identified RetroDUR options quarterly. The selected RetroDUR initiatives are investigated by the PBM clinical Pharmacists team, and the results are shared and discussed with CCP.
Florida Community Care	Some edits are maintained through Medispan and CVS Caremark offers other edits that are built by a clinical development team. These edits are reviewed at least annually and then go to a P&T team for final review.
Humana Medical Plan	State FFS Agency and internal DUR review function of Humana Pharmacy Solutions P&T Committee.
Molina Healthcare	CVS Health is delegated to perform retrospective activities involving safety and monitoring system activities. CVS Health utilizes its own criteria for identification of members and/or prescribers that are high-risk based on their proprietary algorithm for claims data mining.
Simply Healthcare	IngenioRx develops retroDUR programs and criteria specifically geared toward Medicaid populations. Each program available is presented to the plan, and it is able to opt into programs that fit its needs and membership.
Sunshine	The MCO works closely with the RetroDUR vendor to select programs that meet the rDUR criteria as well as selecting some of the State criteria provide during the public DUR meetings.
United Healthcare	OptumRx performs RDUR activities with oversight from UnitedHealthcare Community Plan. RDUR criteria is developed and maintained through OptumRx, the criteria utilized for their programs are created and approved through their own quality committee.

If "No," please explain.

Table 40 - "No" Explanations for RetroDUR Vendor Developer/Supplier of Retrospective DUR Criteria

MCO Name	Explanation
Amerihealth Caritas Florida	The MCO in conjunction with its PBM develops the retrospective DUR criteria in accordance with state and federal guidelines.

b. Does your MCO customize your RetroDUR vendor criteria?

Figure 30 - MCO Customizes RetroDUR Vendor Criteria

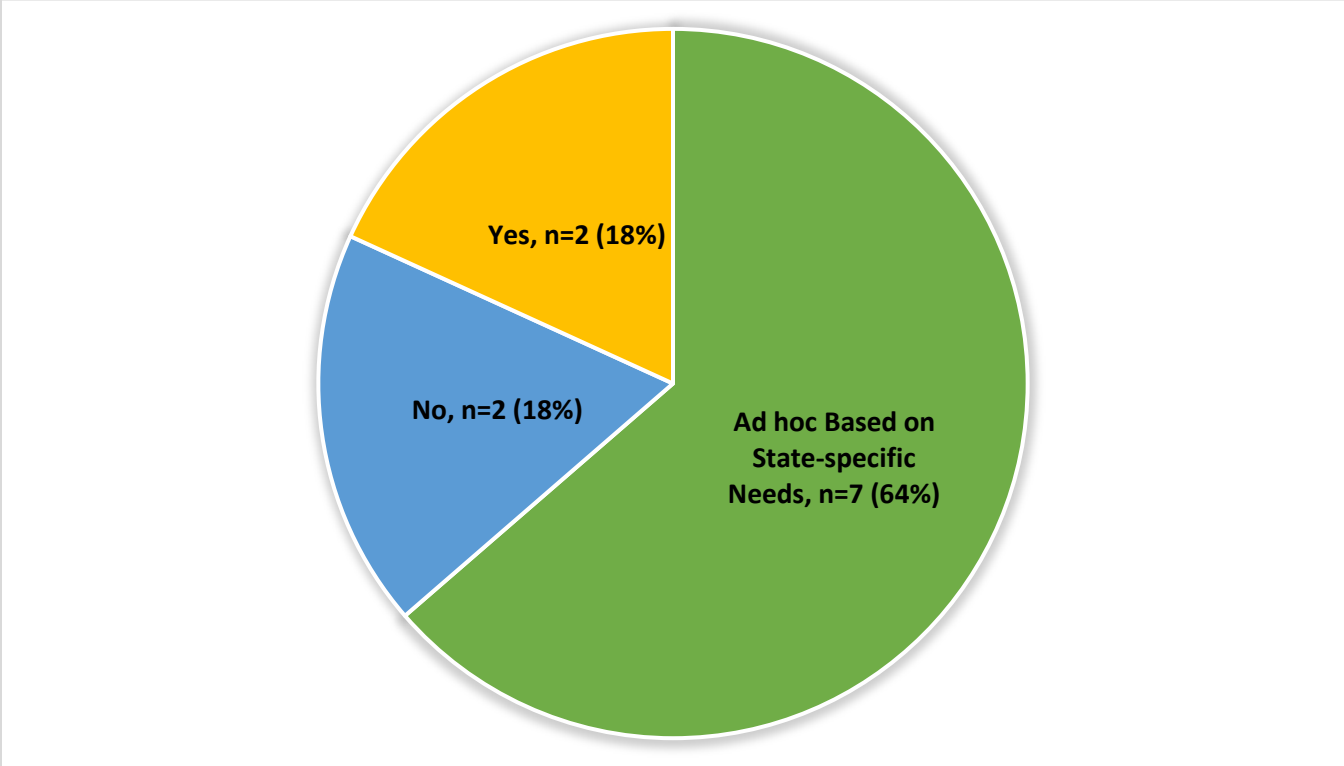


Table 41 - MCO Customizes RetroDUR Vendor Criteria

Response	MCO Names	Count	Percentage
Yes	Children's Medical Services, Sunshine	2	18.18%
Ad hoc based on State-specific needs	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Simply Healthcare, United Healthcare	7	63.64%
No	Florida Community Care, Molina Healthcare	2	18.18%
State Totals		**11**	**100%**

3. Who reviews and approves your MCO RetroDUR criteria?

Figure 31 - RetroDUR Criteria Approval/Review Sources

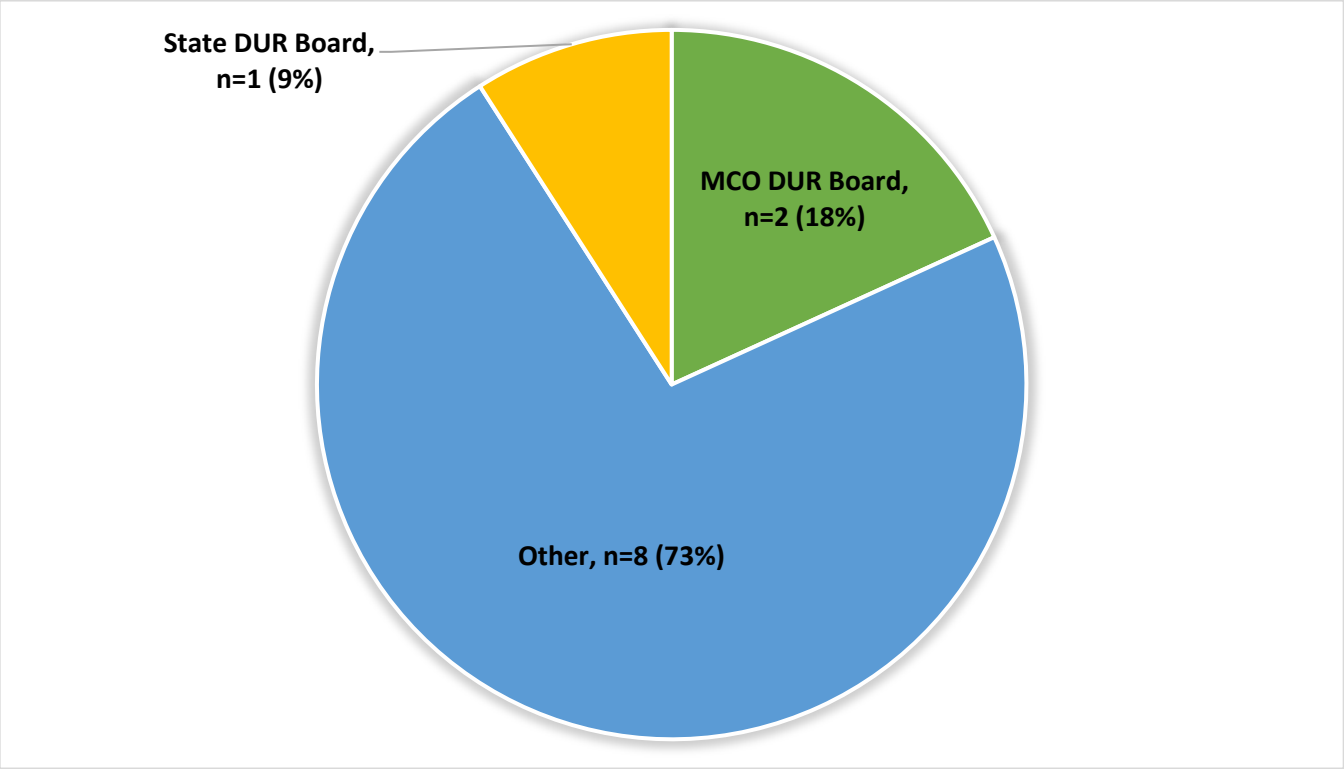


Table 42 - RetroDUR Criteria Approval/Review Sources

Response	MCO Names	Count	Percentage
MCO DUR Board	Children's Medical Services, Sunshine	2	18.18%
State DUR Board	Amerihealth Caritas Florida	1	9.09%
Other	Aetna Better Health, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, United Healthcare	8	72.73%
State Totals		**11**	**100%**

If "Other," please explain.

Table 43 - "Other" Explanations RetroDUR Criteria Approval/Review Sources

MCO Name	Explanation
Aetna Better Health	The FL Agency for Health Care Administration (AHCA) has a DUR Board that reviews and approves the RetroDUR criteria for the state Medicaid program. The MCO aligns with the AHCA DUR program edits if able to be coded in the pharmacy system. Aetna's RetroDUR program is overseen by the P&T Committee and Pharmacy Director. RetroDUR activities, such as modification to the formulary and institution of prior authorization or other utilization controls on a drug, are conducted through the actions of the P&T Committee. RetroDUR programs offered by our PBM partner are reviewed and approved by the Pharmacy Director. The DUR Board may also conduct RetroDUR functions as part of educational intervention programs for our prescribers, pharmacies, and/or members.

MCO Name	Explanation
Clear Health Alliance	Our DUR Board functions are handled by three committees which include Pharmacy Quality Programs (PQP), P&T, and Value Assessment (VAC) committees. PQP provides feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request. P&T Committee reviews and approves policies so they are optionally available for each business unit to use (or not) according to their business needs. VAC decides to adopt a PA and makes drug list (PDL) decisions. State mandated criteria, PDL, and policies take priority over internal committee recommendations.
Community Care Plan	Magellan Rx and Community Care Plan Pharmacy Director.
Florida Community Care	The RetroDUR programs are reviewed on at least an annual basis internally (CVS Pharmacists) and then externally by a Physician Specialist in that disease state and not reviewed by the CVS P&T Committee
Humana Medical Plan	State FFS Agency and internal DUR review function of Humana Pharmacy Solutions P&T Committee.
Molina Healthcare	Molina reviews the internal Retro DUR program- both internal and delegated activities on an annual basis. The delegated activities to CVS Health are reviewed in the following manner- reviewed on at least an annual basis internally (CVS Pharmacists) and then externally by a Physician Specialist in that disease state and not reviewed by the CVS P&T Committee
Simply Healthcare	Our DUR Board functions are handled by three committees, which include Pharmacy Quality Programs (PQP), P&T, and Value Assessment (VAC) committees. PQP provides feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request. P&T Committee reviews and approves policies so they are optionally available for each business unit to use (or not) according to their business needs. VAC decides to adopt a PA and makes drug list (PDL) decisions. State mandated criteria, PDL, and policies take priority over internal committee recommendations.
United Healthcare	Recommendations for additions or changes to the OptumRx RDUR program are made by both OptumRx and UnitedHealthcare Community Plan and are presented to the UHC DUR Board. OptumRx RDUR programs are reviewed by the UnitedHealthcare Community Plan Board annually and they make the final decision on RDUR program enrollment.

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

Figure 32 - Frequency of Retrospective Practitioner-Based Education

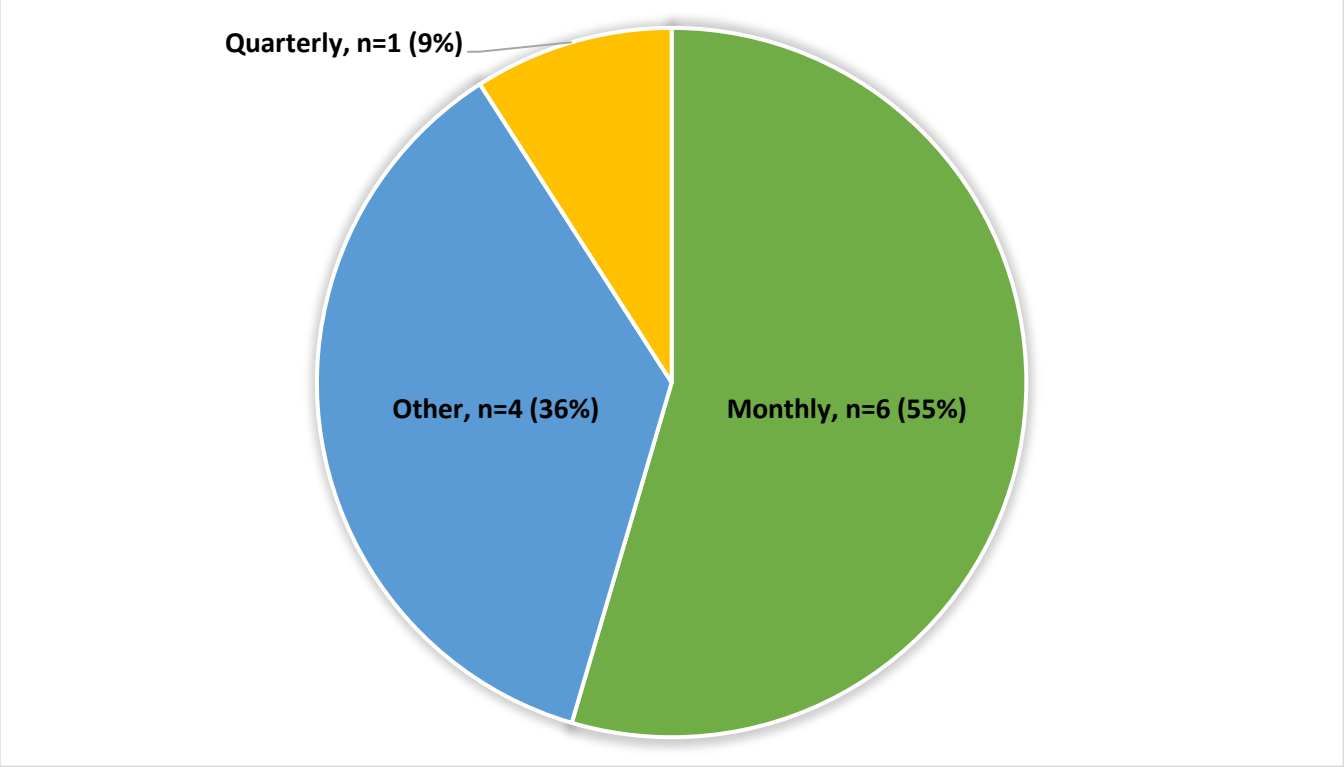


Table 44 - Frequency of Retrospective Practitioner-Based Education

Response	MCO Names	Count	Percentage
Monthly	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Humana Medical Plan, Simply Healthcare, Sunshine	6	54.55%
Quarterly	Community Care Plan	1	9.09%
Other	Amerihealth Caritas Florida, Florida Community Care, Molina Healthcare, United Healthcare	4	36.36%
State Totals		**11**	**100%**

If "Other," please specify.

Table 45 - "Other" Frequency of Retrospective Practitioner-Based Education

MCO Name	Explanation
Amerihealth Caritas Florida	As part of the Drug Therapy Management (DTM) Program practitioner-based education is completed each time a pharmacist reviews a medication profile and identifies a medication-related problem that requires provider intervention. Reviews are conducted weekly
Florida Community Care	Monthly, Quarterly, & Daily
Molina Healthcare	Monthly, quarterly, daily
United Healthcare	Daily

a. How often does your MCO perform retrospective reviews that involve communication of client-specific information to healthcare practitioners (multiple responses allowed)?

Figure 33 - Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners

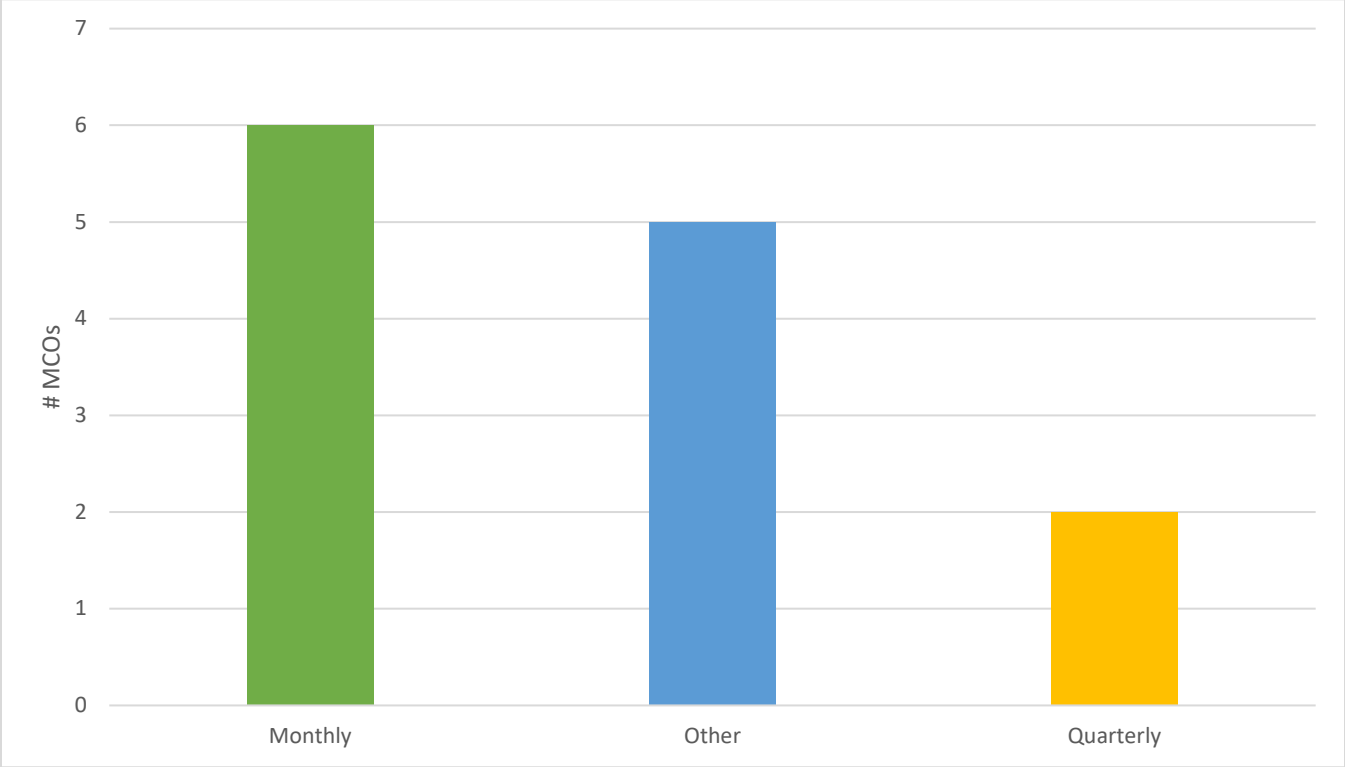


Table 46 - Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners

Response	MCO Names	Count	Percentage
Monthly	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Molina Healthcare, Simply Healthcare, Sunshine	6	46.15%
Quarterly	Community Care Plan, Molina Healthcare	2	15.38%
Other	Amerihealth Caritas Florida, Florida Community Care, Humana Medical Plan, Molina Healthcare, United Healthcare	5	38.46%
State Totals		**13**	**100%**

If "Other," please specify.

Table 47 - "Other" Explanations for Frequency of Retrospective Reviews that Involve Communication of Client-Specific Information to Healthcare Practitioners

MCO Name	Explanation
Amerihealth Caritas Florida	As a part of the DTM program,practitioner-based education is completed each time a pharmacist reviews a medication profile and identifies a medication related problem. Communication to the provider will occur through phone, fax or mail weekly.
Florida Community Care	Monthly, Quarterly, & Daily
Humana Medical Plan	All of our RDUR programs provide monthly intervention communication to providers, except

MCO Name	Explanation
	one RDUR program (Opioid High Dose) involves weekly communication to provider.
Molina Healthcare	Daily also
United Healthcare	Daily

b. What is the preferred mode of communication when performing RetroDUR initiatives (multiple responses allowed)?

Figure 34 - Preferred Mode of Communication When Performing RetroDUR Initiatives

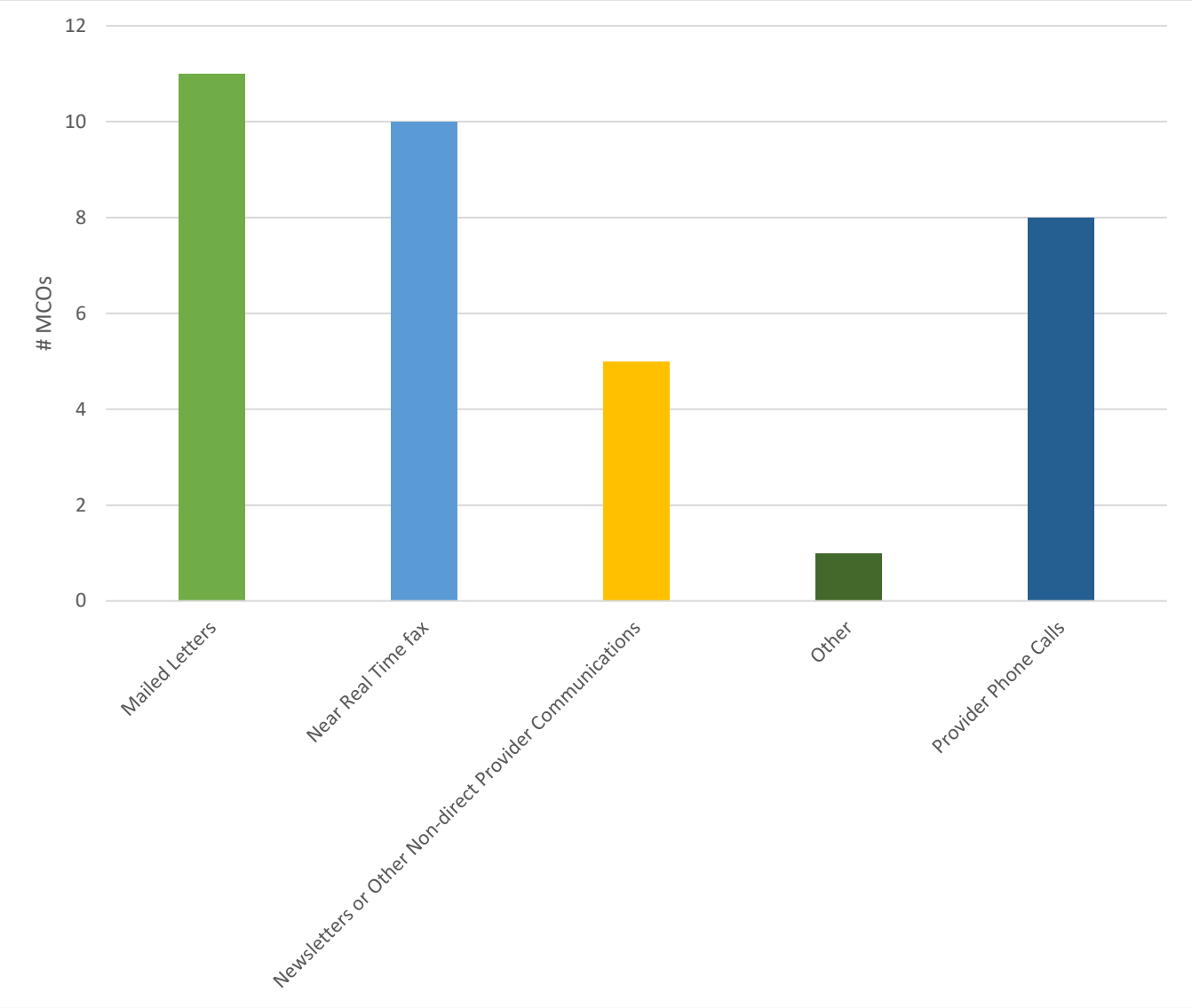


Table 48 - Preferred Mode of Communication When Performing RetroDUR Initiatives

Response	MCO Names	Count	Percentage
Mailed letters	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	31.43%

Response	MCO Names	Count	Percentage
Near real time fax	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	28.57%
Newsletters or other non-direct provider communications	Aetna Better Health, Clear Health Alliance, Molina Healthcare, Simply Healthcare, United Healthcare	5	14.29%
Provider phone calls	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine	8	22.86%
Other	Aetna Better Health	1	2.86%
State Totals		**35**	**100%**

If "Other," please specify.

Table 49 - "Other" Explanations for Preferred Mode of Communication When Performing RetroDUR Initiatives

MCO Name	Explanation
Aetna Better Health	Health plan provider websites

5. Summary 1 - RetroDUR Educational Outreach

RetroDUR Educational Outreach Summary should be a year-end summary 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.

Table 50 - RetroDUR Educational Outreach

MCO Name	RetroDUR Educational Outreach Summary
Aetna Better Health	Aetna has independently and/or in partnership with our Pharmacy Benefits Manager (PBM), CVS Health, completed the following Educational Outreach Programs (EOPs). 1. Valproic Acid and Fetal Health Description: Educate providers on the risks of valproic acid in persons of childbearing potential and increase the use of contraceptives in this group. Goals/ Objective: Decrease the use of Valproic acid in persons of childbearing potential and increase the use of identified contraception in Valproic acid users Actions: Targeted provider faxes Implementation: 4Q21 Outcomes: 59 members were targeted for outreach. 6 of these members termed at follow up. 16 of the outreached members had valproic acid discontinued by the prescriber. 35 members continued valproic acid only. 1 member continued valproic acid + contraceptive. 1 member continued contraceptive only. 2. Benzodiazepine + Opioids Description: Educate the prescribers of chronic benzos to risks associated with them in members also taking opioids Goals/ Objective: Decrease the use of benzo in members taking opioids Actions: Targeted provider faxes Implementation: 1Q22

MCO Name	RetroDUR Educational Outreach Summary
	Outcomes: 113 members were targeted for outreach. 11 of these members termed at follow up. 72 members had no change. 6 members had the benzo discontinued by prescriber. 8 members had both the benzo and opioid discontinued. 16 members had the opioid discontinued. 29% discontinued concurrent therapy. 3. Antipsychotics and Serotonergic antidepressants in children v 2.0 Description: Educate providers via fax highlighting risks of concomitant medications and identifying members affected. Goals/ Objective: Educate providers about need to attempt counseling and caregiver education before prescribing antidepressants when a member is already on an antipsychotic. Reduce frequency of co-prescribing these drug classes in this age group. The antidepressant classes addressed in this program were SNRIs, SSRIs, and TCAs. Actions: Targeted provider fax education. Telephonic follow up as needed. Implementation: 4Q21 Outcomes: 60 members were identified for the program. 11 members discontinued the combination therapy at 3 months. There was an 18% reduction in members receiving concomitant therapy at 3 months. There were 15 members who discontinued the combination therapy at 6 months. There was an 25% reduction in members receiving concomitant therapy at 6 months. There were 45 members receiving concomitant therapy after 6 months. There was a 25% change in members receiving combo therapy. There were 56 providers identified to the program. After intervention, there were 36 providers still prescribing antipsychotic + antidepressants. There was a 36% reduction in the number of original providers prescribing the combo. There were 73 provider faxes sent for the initiative in FL. 52 of those faxes (71%) were sent successfully. 4. Diabetes Mellitus Duplicate Therapy Description: Educate providers on members receiving duplicative diabetes mellitus medications. Goals/ Objective: Decrease duplicate therapy in members using multiple brand diabetic medications or insulins Actions: Provider telephonic outreach by clinical pharmacist. Implementation: monthly Outcomes: 19 members were impacted by this program. There wee 29 provider telephonic outreach attempts, and 0 successful faxes sent. There were 4 case manager outreaches. At 3 months post-outreach, there were 13 members not on duplicate therapy, which is a success rate of 68%. 5. COPD ICS Monotherapy Description: Educate providers on members receiving suboptimal COPD therapy with ICS Monotherapy. Goals/ Objective: Decrease use of ICS monotherapy in members with COPD and history of exacerbation in previous six months Actions: Provider fax followed by clinical pharmacist outreach to non-responders Implementation: monthly Outcomes: 1 member identified. Member was unable to be reached 6. COPD Duplicate Therapy Description: Educate providers on members receiving duplicative COPD medications. Goals/ Objective: Decrease duplicate therapy in members using multiple COPD inhalers

MCO Name	RetroDUR Educational Outreach Summary
	Actions: Provider telephonic outreach by clinical pharmacist Implementation: monthly Outcomes: 15 members were impacted. There were 24 provider telephonic outreach attempts. 3 faxes were successfully sent. There were 0 case manager outreaches. At 3 months post outreach, there were 11 members not on duplicate therapy. The program had a success rate of 73% in FL. 7. Hospital Readmission Reduction Program (HRRP) Description: Educate members and provider of appropriate medication use for members with a recent hospital discharge of high risk, high cost and problem prone disease states. Goals/ Objective: Provide clinical pharmacist medication review and reconciliation after hospital discharge to prevent potentially avoidable readmissions Actions: Medication review and reconciliation. Collaboration with CM. Member outreach. Implementation: monthly Outcomes: From October 1, 2021, through September 30th, 2022, there were 323 members impacted by this program in FL. Of the 323 impacted members, 30 members were readmitted to the hospital within 30 days of discharge (there was a 9.3% hospital readmission rate). There were 293 members that were not readmitted within 30 days. The estimated savings associated with preventing hospital readmissions for these members was $409,768. 8. Case Manager (CM) Referral Program Description: Educate members, case managers, and providers on appropriate medication use in members with complicated chronic disease and/or drug regimens. Goals/ Objective: CMs to refer medically complex members identified as having medication care issues to the clinical pharmacist for medication review and recommendations. Actions: Medication review and reconciliation. Collaboration with CM. Member and provider outreach. Implementation: 2Q22 Outcomes: 8 members were referred by case management to the clinical pharmacist for medication review and reconciliation. The estimated cost savings associated with the referral of these members in FL was $38,691. 9. Montelukast Black Box Warning (BBW) Description: Education prescribers on the Montelukast BBW and increased risk of suicidality in members under 18 on Montelukast. Goals/ Objective: Reduce number of at-risk members under 18yrs on Montelukast. Actions: Targeted provider faxes. Follow up telephonic interventions by clinical pharmacist. Implementation: July 2021. Initiative is still ongoing. Outcomes: 18 members were identified. 17 members were successfully faxed and were eligible for program inclusion. 12 members filled Montelukast when reviewed at follow up. 10. Readmission Avoidance Program (RAP) Description: Educate members and provider of appropriate medication use for members with a recent hospital discharge of high risk, high cost and problem prone disease states.

MCO Name	RetroDUR Educational Outreach Summary
	Goals/ Objective: Provide clinical pharmacist medication review and reconciliation after hospital discharge to prevent potentially avoidable readmissions. Actions: Medication review and reconciliation. Collaboration with CM. Member outreach Implementation: monthly Outcomes: There were 13 total cases (interventions) with 10 distinct members identified. There were 49 total outreaches with 6 member contacts and 9 provider contacts. Overall, there were 106 interventions made with 0 success stories.
Amerihealth Caritas Florida	AmeriHealth Caritas FL has implemented the below listed Behavioral Health HEDIS Drug Therapy Management Programs focused on optimizing medication regimens for members and improving health outcomes especially related to the appropriate use and monitoring of antipsychotic and antidepressant medications. The clinical pharmacy team performs targeted medication reviews to ensure medication adherence and appropriate medication monitoring for the following four (4) DTM programs listed below: Antidepressant Medication Management (AMM) Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Below is a summary of program outcomes for 4Q2021: AMM Members enrolled: 409 Members saved (Acute Phase): 201 Save % (Acute Phase): 49% Members saved (Continued Phase): 149 Save % (Continued Phase): 36% SAA Members enrolled: 177 Members saved: 81 Save %: 46% SSD Members enrolled: 143 Members saved: 69 Save %: 48% APM Members enrolled: 137 Members saved: 40 Save %: 29% Below is a summary of program outcomes for 1Q through 3Q 2022: AMM Members enrolled: 417 Members saved (Acute Phase): 177 Save % (Acute Phase): 43% Members saved (Continued Phase): 119 Save % (Continued Phase): 29%

MCO Name	RetroDUR Educational Outreach Summary
	SAA Members enrolled: 162 Members saved: 35 Save %: 22% SSD Members enrolled: 245 Members saved: 155 Save %: 63% APM Members enrolled: 178 Members saved: 46 Save %: 26%
Children's Medical Services	RetroDUR educational outreach 1) Retrospective Safety Review: Critical Drug-Drug Interactions a. This program reviews POS Drug-Drug Interactions alerts to address issues that were not addressed at the point of sale within 72 hours of adjudication. A phone call or fax is sent to the provider alerting them of this safety issue. Number of interventions are the number of provider outreaches. Number of responses are positive responses from providers. i. Number of Interventions: 503 ii. Number of responses: 79 2) Respiratory DUR is a monthly initiative that aims to improve asthma control by notifying providers when members may need intervention due to potential overutilization of rescue inhalers (Short-Acting Beta-Agonists, SABA). Prescribing providers are faxed a letter recommending reassessing, adjusting, or initiating an inhaled corticosteroid (ICS) based on the member's fill history. a. SABA Overutilization: i. Number of Interventions: 204 ii. Number of responses: 157 b. ICS Initiation: i. Number of Interventions: 52 ii. Number of responses: 13
Clear Health Alliance	Summary 1 Retrospective DUR Educational Outreach Summary FL CHA 2022 DUR Date Range 10/1/21 9/30/22 Adherence/HIV Adherence - HIV Compliance # Cases- 3945 # Unique Members- 3945 # Prescriber Messages Generated & Sent- 2

MCO Name	RetroDUR Educational Outreach Summary
	# Member Messages Generated & Sent- 4162 New Start/New Start Depression # Cases- 1282 # Unique Members- 1282 # Prescriber Messages Generated & Sent- 1226 # Member Messages Generated & Sent- 233 # Positive Outcomes- 628 % Positive Impact- %52.65 Adding Therapy/Needs Follow-Up - Asthma # Cases- 1096 # Unique Members- 1096 # Prescriber Messages Generated & Sent- 966 # Member Messages Generated & Sent- 517 # Positive Outcomes- 137 % Positive Impact- %77.41 Adherence/Adherence - Hypertension # Cases- 1075 # Unique Members- 1075 # Prescriber Messages Generated & Sent- 941 # Member Messages Generated & Sent- 559 # Positive Outcomes- 259 % Positive Impact- %28.1 Adherence/Adherence - ACE/ARB # Cases- 1024

MCO Name	RetroDUR Educational Outreach Summary
	# Unique Members- 1024 # Prescriber Messages Generated & Sent- 927 # Member Messages Generated & Sent- 563 # Positive Outcomes- 244 % Positive Impact- %27.24 Adherence/Adherence - Depression # Cases- 993 # Unique Members- 993 # Prescriber Messages Generated & Sent- 938 # Member Messages Generated & Sent- 528 # Positive Outcomes- 216 % Positive Impact- %25.72 Adherence/Adherence - Statins # Cases- 939 # Unique Members- 939 # Prescriber Messages Generated & Sent- 860 # Member Messages Generated & Sent- 518 # Positive Outcomes- 257 % Positive Impact- %30.53 Adherence/Adherence - Diabetes # Cases- 637 # Unique Members- 637 # Prescriber Messages Generated & Sent- 567 # Member Messages Generated & Sent- 329 # Positive Outcomes- 180

MCO Name	RetroDUR Educational Outreach Summary
	% Positive Impact- %32.32 Polypharmacy/Polypharmacy - 10 drugs # Cases- 501 # Unique Members- 501 # Prescriber Messages Generated & Sent- 0 # Member Messages Generated & Sent- 576 # Positive Outcomes- 368 % Positive Impact- %69.57 Asthma/Asthma Controller Proportion # Cases- 492 # Unique Members- 492 # Prescriber Messages Generated & Sent- 426 # Member Messages Generated & Sent- 220 # Positive Outcomes- 99 % Positive Impact- %21.96
Community Care Plan	The RetroDUR examines claims data to identify clinical care gaps, patterns of FWA, overuse, and medically unnecessary care. Magellan utilizes a technology platform called FirstIQ for clinical management decision support designed to perform menu-driven inquiries into specific data. The results of these queries can be used to produce reports, files for further analysis, and graphs for use in monitoring pharmacy program's, and economic trends. Magellan then uses DUR programs to identify, and ultimately correct, potentially dangerous prescribing. Magellan performs the RetroDUR activities per CCP's direction. There were several clinical areas reviewed for RetroDUR. Some of the areas were: Non-compliance with inhaled corticosteroids 10-day gap, Concurrent use of opioids and antipsychotics, Non-compliance with atypical antipsychotics oral and intravenous 10-day gap, and Antiretroviral non-compliance 5-day gap. The PBM team outreached to 90 providers regarding corticosteroids, 38 providers regarding concurrent use of opioids and antipsychotics, 47 prescribers for non-adherence with oral or IV antipsychotics, and 20 prescribers for the Antiretroviral drugs noncompliance 5-day gap. Each provider received a letter identifying the member in their care that was noted with medication adherence concerns or drug combination concerns. A total of 505 letters were sent to prescribers

MCO Name	RetroDUR Educational Outreach Summary
	regarding the various RetroDUR initiatives. For the non-adherence to oral and IV antipsychotics and antiretroviral noncompliance 5-day gap 68 providers were sent letters, 8.8% responded, and 8.8% of letters were returned mail. For the Noncompliance with corticosteroids group and concurrent use of opioids and antipsychotics a total of 101 letters were sent with a 7% response rate, 6% of letters were returned mail, and 93% did not respond. In some of the other RetroDUR categories 336 letters were sent with an 11% response rate from prescribers, 6% were returned mail, and 89% did not respond. The providers who replied, provided one of the following responses: "will discuss drug therapy with members", " will assess and modify medications" or "no longer my patient." Lack of a response may not necessarily indicate a failed attempt. Some providers may make modifications that may not be captured during the PBM surveillance time. but may be noted in the recycling of the initiative.
Florida Community Care	Point-of-Sale Safety Review delivers real-time/concurrent safety alerts to dispensing pharmacies when a prescription is being processed. These alerts prompt the dispensing pharmacist to take an action that will avoid a potential safety concern. The pharmacist may consult with the prescriber, counsel the plan member or choose not to fill the prescription to avoid a negative clinical outcome. POS has various targeting edits, including, but not limited to controlled substance edits. Top 10 Intervention Types: 1. Therapeutic Duplication 2. Drug-Drug Interaction 3. Refill Too Soon 4. Underuse Precaution 5. Ingredient Duplication 6. Apparent Drug Misuse 7. Drug-Disease Precaution 8. Low Dose Alert 9. High Dose Alert 10. Opioid-Benzo Drug Interaction *Requires an attachment*
Humana Medical Plan	RDUR Programs: 1. Antipsychotic Use in Dementia: Description: Patients 65 and older with dementia, on prescription fills for antipsychotic medications, without the evidence of psychotic disorder or related condition. Intervention/Communication: Provider Letter to Physician 2. Polyphamacy: Antidepressant and/or Antipsychotic Description: 1. Multi-Class Polypharmacy: Patients on at least 14 consecutive days of concurrent possession of 4 or more different medications from 2 or more therapeutic classes prior to and on the cutoff date. (Drug Classes: FGA, SGA, SSRI, SNRI, BZD) 2. Single Class Polypharmacy: Patients on at least 14 consecutive days of concurrent possession of 2 or more different medications from 1 or more therapeutic classes prior to and on the cutoff date. (SSRI and SNRI)" Intervention/Communication: Provider Letter to Physician 3. Suboptimal Dosing: Antidepressant Description: Identify and notify providers of patients on suboptimal therapeutic dosing of

MCO Name	RetroDUR Educational Outreach Summary
	antidepressant (SSRIs and SNRIs) Intervention/Communication: Provider Letter Physician 4. Adherence: Antidepressant and Antipsychotic Description: Identify and notify providers of patients non-adherent (<85%) to antidepressant and antipsychotics Intervention/Communication: Provider Fax to Physician 5. Opioid High-Dose: Description: Patients who have an average Morphine Equivalent Dosage (MME) between 90-119 mg over 30 days to 6 months Intervention/Communication: Provider Letter to Physician
Molina Healthcare	In 2022 Molina provided retrospective DUR education outreach for multiple safety programs. The two most prominent are the lettering of providers to alert them of their members utilizing high dose opioids potentially without access to naloxone and lettering of prescribers of members that are actively receiving antipsychotic therapy without having a history of metabolic monitoring. The Molina Healthcare, Inc. confidential drug utilization review program provides educational information concerning potentially serious drug safety concerns. Our goal is to facilitate optimal, safe, effective, and high-quality drug therapy. Based on the FDA published recommendations stating that for naloxone use should be discussed with all patients prescribed opioids and considered for prescribing for patients at increased risk for opioid overdose, Molina evaluated members that met these requirements and lettered prescribers with multiple members effected. Education to all providers regarding the utilization of naloxone as well as other harm reduction strategies was given by live webinars and website enduring digital media. The other prominent education intervention in 2022 was the lettering of prescribers with members found to have a gap in care. This initiative was to educate providers to increase metabolic screening for those members utilizing antipsychotic agents. Molina members 18 years of age and younger utilizing antipsychotic therapy that did not have a claim within the last 12 months for metabolic screening were found within reporting. Metabolic adverse effects, including alterations in glucose metabolism, lipid abnormalities, and weight gain, are of great concern for patients treated with antipsychotic medications. These metabolic effects may occur in any patient but are particularly concerning in children and adolescents. Molina evaluated

MCO Name	RetroDUR Educational Outreach Summary
	members that met these requirements and letter prescribers recommending appropriate action. The Retrospective Drug Utilization Review of the Safety and Monitoring Program focuses on therapeutic categories with the potential for high abuse and acetaminophen (APAP) toxicity: Narcotic / Narcotic combination drugs (e.g., fentanyl, hydrocodone/APAP), Anti-anxiety and sedative hypnotic agents (e.g., diazepam, triazolam), Non-benzodiazepine sedatives / hypnotics (e.g., zolpidem, zaleplon), Other drugs with abuse potential (e.g., cyclobenzaprine, gabapentin), CNS Stimulants (e.g., methylphenidate, modafinil) and Other Controlled Substances (e.g., dronabinol, testosterone). For all members identified as needing an intervention, prescribers of the targeted therapeutic category are sent a letter on their patients that meet criteria indicative of potential misuse or abuse of prescription medications in the specified therapeutic categories. The letter outlines the goals of the program and the clinical issues involved. An integrated member drug history profile (member case file) is included and shall contain the following: Prescription claims information, including medication, dose, prescriber and pharmacy, Prescriber fax back response formand any responses from prescribers are tracked within the Safety and Monitoring System.
Simply Healthcare	Date Range 10/1/21 9/30/22 New Start/New Start Depression # Cases- 17813 # Unique Members- 17813 # Prescriber Messages Generated & Sent- 16359 # Member Messages Generated & Sent- 2854 # Positive Outcomes- 8656 % Positive Impact- %56.76 Adherence/Adherence - Depression

MCO Name	RetroDUR Educational Outreach Summary
	# Cases- 11722 # Unique Members- 11722 # Prescriber Messages Generated & Sent- 9904 # Member Messages Generated & Sent- 4787 # Positive Outcomes- 2249 % Positive Impact- %25.08 Adherence/Adherence - ACE/ARB # Cases- 10896 # Unique Members- 10896 # Prescriber Messages Generated & Sent- 9120 # Member Messages Generated & Sent- 4991 # Positive Outcomes- 2180 % Positive Impact- %24.76 Adherence/Adherence - Statins # Cases- 10426 # Unique Members- 10426 # Prescriber Messages Generated & Sent- 8700 # Member Messages Generated & Sent- 4576 # Positive Outcomes- 1936 % Positive Impact- %23.91 Adherence/Adherence - ADHD Rx # Cases- 10298

MCO Name	RetroDUR Educational Outreach Summary
	# Unique Members- 10298 # Prescriber Messages Generated & Sent- 0 # Member Messages Generated & Sent- 10335 # Positive Outcomes- 729 % Positive Impact- %9.61 Adding Therapy/Needs Follow-Up - BH Meds # Cases- 9433 # Unique Members- 9433 # Prescriber Messages Generated & Sent- 0 # Member Messages Generated & Sent- 9488 # Positive Outcomes- 3882 % Positive Impact- %53.94 Adding Therapy/Needs Follow-Up - Asthma # Cases- 8895 # Unique Members- 8895 # Prescriber Messages Generated & Sent- 7659 # Member Messages Generated & Sent- 3607 # Positive Outcomes- 698 % Positive Impact- %68.04 Adherence/Adherence - Hypertension # Cases- 8805

MCO Name	RetroDUR Educational Outreach Summary
	# Unique Members- 8805 # Prescriber Messages Generated & Sent- 7344 # Member Messages Generated & Sent- 3774 # Positive Outcomes- 1589 % Positive Impact- %23.06 Adherence/Adherence - Asthma # Cases- 8727 # Unique Members- 8727 # Prescriber Messages Generated & Sent- 7238 # Member Messages Generated & Sent- 3993 # Positive Outcomes- 995 % Positive Impact- %16.82 Adherence/Adherence - Diabetes # Cases- 8573 # Unique Members- 8573 # Prescriber Messages Generated & Sent- 7081 # Member Messages Generated & Sent- 3737 # Positive Outcomes- 1620 % Positive Impact- %23.88
Sunshine	1) Retrospective Safety Review: Critical Drug-Drug Interactions a. This program reviews POS Drug-Drug Interactions alerts to address issues that were not addressed at the point of sale within 72 hours of adjudication. A phone call or fax is sent to the provider alerting them of this safety issue. Number of interventions are the number of provider outreaches. Number of responses are positive responses from providers. i. Number of Interventions: 14,826 ii. Number of responses: 2,436

MCO Name	RetroDUR Educational Outreach Summary
	2) Controlled substances, and inappropriate use and misuse a. This program reduces instances of fraud, waste, and abuse of controlled substances through regular claims monitoring and timely interventions. i. Number of Interventions: 3,953 ii. Number of responses: 1,051 3) The Antipsychotic Drug Utilization Review Program is meant to address risk factors associated with psychotropics, optimize their use, and enhance coordination of care between a member's PCP and his/her prescriber. Health plan pharmacists perform a retrospective review of members on select antipsychotics at an increased risk of a drug- or disease-related adverse event. Once these members are identified, the health plan sends letters to their providers with a brief description of both the potential concern and a recommended action to optimize care. i. Number of members: 1,913 ii. Number of letters mailed: 2,486 4) Antipsychotics and uncontrolled diabetes switch to antipsychotic with fewer metabolic side effects. i. Number of members: 182 ii. Number of successful interventions: 89 5) Antipsychotics and active cardiac disease switch to antipsychotic with fewer cardiac side effects i. Number of members: 71 ii. Number of successful interventions: 34 6) Antipsychotic drug-drug interactions remove interacting drug or switch to safer alternative i. Number of members: 57 ii. Number of successful interventions: 31 7) Respiratory DUR is a monthly initiative that aims to improve asthma control by notifying providers when members may need intervention due to potential overutilization of rescue inhalers (Short-Acting Beta-Agonists, SABA). Prescribing providers are faxed a letter recommending reassessing, adjusting, or initiating an inhaled corticosteroid (ICS) based on the member's fill history. a. SABA Overutilization: i. Number of Interventions: 1,408 ii. Number of responses: 985 b. ICS Initiation: i. Number of Interventions: 551 ii. Number of responses: 130
United Healthcare	The RetroDUR Educational Summary below includes the top 5 programs and/or programs where the total number of interventions in the program represent greater than 5% of the total overall interventions of RetroDUR interventions executed by OptumRx for programs enrolled in by UnitedHealthcare Community Plan for the federal fiscal year (this does not include state specific initiatives). The total number of interventions during the federal fiscal year was 124,605 for all programs. Outcomes are evaluated 120-180 days post

MCO Name	RetroDUR Educational Outreach Summary
	intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 54,640. For those eligible interventions the number determined to be successful during the federal fiscal year was 10,324, yielding a success percentage of 18.89%. 1. Abused Meds: Drug-Drug Interactions/Overlap (Concurrent Therapy) This is a provider-targeted program designed to minimize the occurrence of drug-drug interactions and concurrent use of high-risk medications. This includes interventions for opioid therapeutic duplication, concurrent use of opioids with benzodiazepines and muscle relaxants, and concurrent use of opioids with benzodiazepines, antipsychotics, MAT, and opioid potentiators (stimulants, sedatives, etc.). The number of interventions during the federal fiscal year was 47,470 for this program. Outcomes are evaluated 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 6,307. For those eligible interventions the number determined to be successful during the federal fiscal year was 96, yielding a success percentage of 1.52%. 2. Safety Management: Drug-Disease Interaction This is a provider-targeted program designed to minimize the occurrence of clinically significant, patient-specific drug-disease interactions. The number of interventions during the federal fiscal year was 15,867 for this program. Outcomes are evaluated 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 12,690. For those eligible interventions the number determined to be successful during the federal fiscal year was 2,771, yielding a success percentage of 21.84%. 3. Abused Meds: Dose Per Day This is a provider-targeted program designed to enhance provider awareness of appropriate opioid medication dose based on approved prescribing information. The number of interventions during the federal fiscal year was 13,870 for this program. Outcomes are evaluated 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 2,551. For those eligible interventions the number determined to be successful during the federal fiscal year was 1,188, yielding a success percentage of 46.57%. 4. Abused Meds: Morphine Equivalent Dose (MED) This is a provider-targeted program designed to minimize the occurrence of high daily doses of opioid analgesics. The number of interventions during the federal fiscal year was 7,604 for this program. Outcomes are evaluated 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 1,652. For those eligible interventions the number determined to be successful during the federal fiscal year was 745, yielding a success percentage of 45.10%. 5. Gaps in Care: Diabetes The purpose of this program is to optimize the management of diabetes by identifying and closing the gap for members with diabetes not on a statin and with diabetes and hypertension not on certain anti-hypertensive agents. The number of interventions during the federal fiscal year was 7,318 for this program. Outcomes are evaluated 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 6,818. For those eligible interventions the number determined to be successful during the federal fiscal year was 1,484, yielding a success percentage of 21.77%.

Section IV - DUR Board Activity

1. Does your MCO utilize the same DUR Board as the State FFS Medicaid program or does your MCO have its own DUR Board?

Figure 35 - MCO Utilizes the Same DUR Board as the State FFS Program or Has Own DUR Board

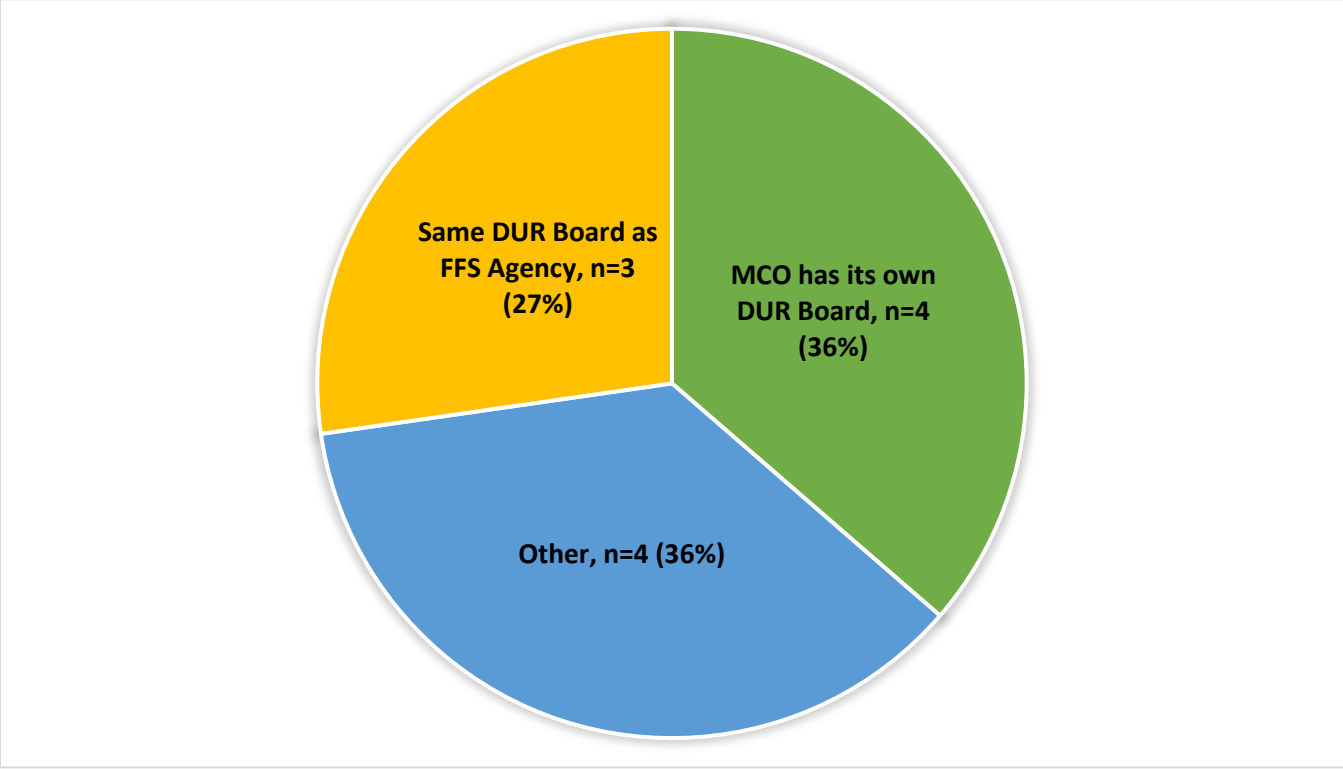


Table 51 - MCO Utilizes the Same DUR Board as the State FFS Program or Has Own DUR Board

Response	MCO Names	Count	Percentage
MCO has its own DUR Board	Children's Medical Services, Molina Healthcare, Sunshine, United Healthcare	4	36.36%
Same DUR Board as FFS agency	Amerihealth Caritas Florida, Community Care Plan, Florida Community Care	3	27.27%
Other	Aetna Better Health, Clear Health Alliance, Humana Medical Plan, Simply Healthcare	4	36.36%
State Totals		**11**	**100%**

If "Other," please explain.

Table 52 - "Other" Explanations for MCO not Utilizing the Same DUR Board as the State FFS Program or its Own DUR Board

MCO Name	Explanation
Aetna Better Health	The FL Agency for Health Care Administration (AHCA) has a DUR Board that reviews and approves the RetroDUR criteria for the state Medicaid program. The MCO aligns with the AHCA DUR program edits if able to be coded in the pharmacy system. Aetna's RetroDUR program is overseen by the P&T Committee and Pharmacy Director. RetroDUR activities, such as modification to the formulary and institution of prior authorization or other utilization controls on a drug, are conducted through the actions of

MCO Name	Explanation
	the P&T Committee. RetroDUR programs offered by our PBM partner are reviewed and approved by the Pharmacy Director. The DUR Board may also conduct RetroDUR functions as part of educational intervention programs for our prescribers, pharmacies, and/or members.
Clear Health Alliance	Clear Health Alliance follows the State Medicaid Agency's Preferred Drug List (PDL) based on state DUR Board directive. Retrospective DUR programs are presented and approved by the Pharmacy Quality Programs Committee. One purpose of the committee is to provide feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request.
Humana Medical Plan	MCO uses states FFS agency recommendations, and any additional reviews are completed by internal DUR review function of Humana Pharmacy Solutions P&T Committee.
Simply Healthcare	FL Simply follows the State Medicaid Agency's Preferred Drug List (PDL) based on state DUR Board directive. Retrospective DUR programs are presented and approved by the Pharmacy Quality Programs Committee. One purpose of the committee is to provide feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request.

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

Figure 36 - MCO has a Medication Therapy Management Program

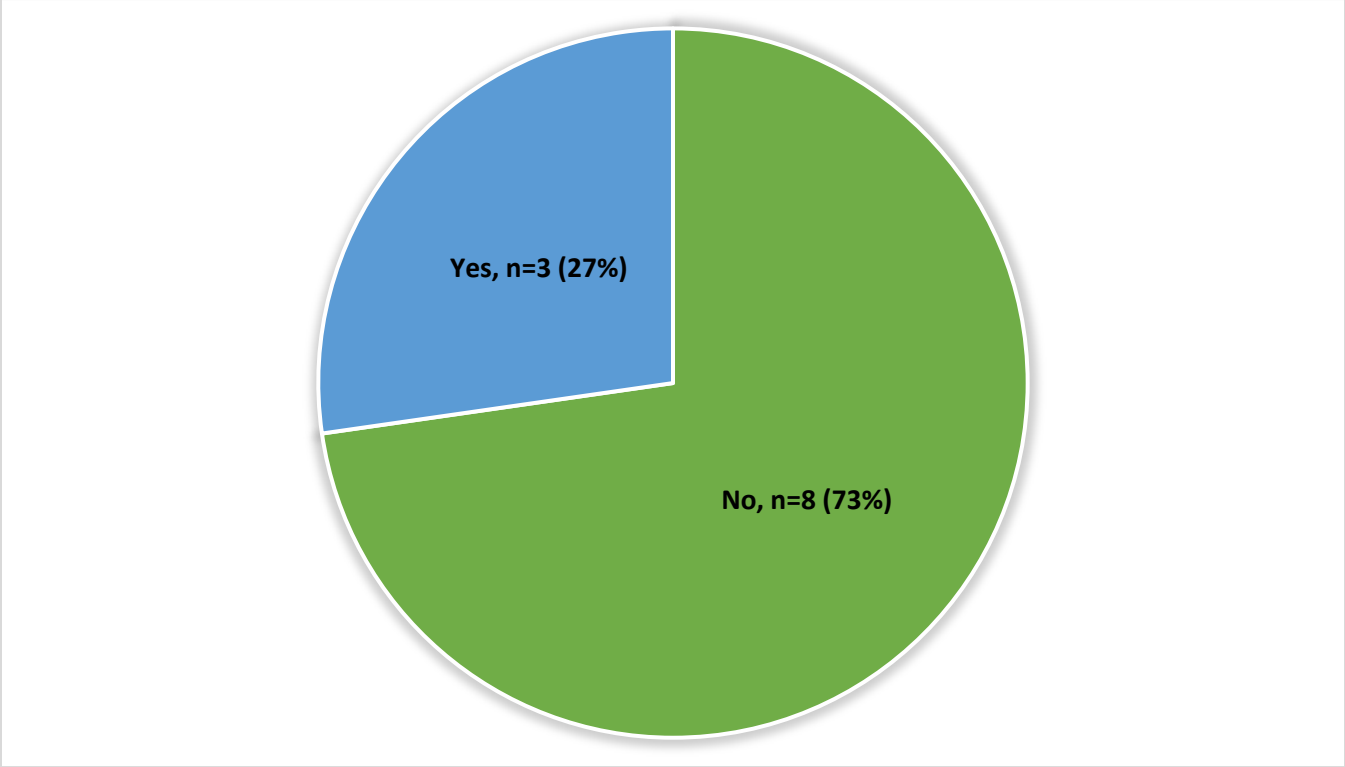


Table 53 - MCO has a Medication Therapy Management Program

Response	MCO Names	Count	Percentage
Yes	Amerihealth Caritas Florida, Community Care Plan, Florida Community Care	3	27.27%

Response	MCO Names	Count	Percentage
No	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	8	72.73%
State Totals		**11**	**100%**

3. Summary 2 - DUR Board Activities

DUR Board Activities Summary should include a brief descriptive report on DUR activities during the fiscal year reported.

Table 54 - DUR Board Activities

MCO Name	DUR Board Activities Summary
Aetna Better Health	The FL Agency for Health Care Administration (AHCA) has a DUR Board that meets quarterly to review and approve the RetroDUR criteria for the state Medicaid program. The MCO aligns with the AHCA PDL, PA criteria, and DUR program edits if able to be coded in the pharmacy system. Aetna's DUR Board meets quarterly and held four meetings during this reporting period. The Pharmacy and Therapeutics (P&T) Committee has long been established and meets quarterly, holding four meetings during the reported year. It is the P&T Committee that oversees much of the functions requested in this attachment and as such have been included here. The DUR Board is responsible for the following functions: Monitor and review the DUR Program activities, including those actions undertaken by the Pharmacy and Therapeutics Committee Oversee and approve member and provider Educational Outreach Programs (EOP) proposals prepared by the EOP Work Group EOPs are approved by the DUR Board and will have the following characteristics: Established predetermined criteria, e.g. desired drug utilization pattern Utilize retrospective drug reviews against predetermined criteria Develop process to correct a prescribing or drug utilization patterns identified as suboptimal through EOP, including metrics to be captured Educational pieces directed to prescribers, members and/or pharmacies Monitoring and measurement of responses to educational outreach Reported outcomes metrics, e.g. % change in response, cost saving/cost avoidance EOPs and other Actions overseen by the DUR Board during this reporting period included: Reviewed the outcomes report on program and educational campaigns run earlier in the year (FFY21) Developed and approved the DUR educational outreach goals for 2022. Approved new POS edits for duplicate short-acting stimulants Approved new POS edits for duplicate long-acting stimulants Approved re-issuing campaign to educate providers on the risks of valproic acid in persons of childbearing potential and increase the use of contraceptives in this group. Approved re-issue of Provider Educational campaign for prescribers on the montelukast BBW and increased risk of suicidality in members under 18 on montelukast. Approved re-issue with revisions to the AMR campaign Approved new campaign on safety of Melatonin in kids Approved new POS edits for sedatives and opioids

MCO Name	DUR Board Activities Summary
	Approved reissue of a previous high dose opioid prescribers' intervention. Approved reissuing Academic detailing to educate prescribers on risks of co-prescribing antipsychotics and SSRI, SNRI, or TCA antidepressants for members ages 5-17. Approved continuing provider educational program using telephonic consultation and educational faxes to resolve instances of ICS monotherapy in members with COPD. Approved continuing the educational programs using telephonic consultation and educational faxes for members and prescribers with COPD taking Daliresp (Roflumilast) without a long-acting bronchodilator; Member consultations with aim to assess and discuss adherence to COPD plan of care including medication review, smoking cessation, and preventative vaccinations (pneumococcal and influenza) as appropriate. Approved continuing educational campaign to reduce the incidence of members receiving duplicate therapy from multiple COPD inhalers, outreaching to prescribers to optimize therapy. Approved educational campaign to reduce the incidence of members receiving duplicate diabetes therapy, outreaching to prescribers to optimize therapy. Prescriber Newsletter articles were approved/provided on the following topics: - Biosimilar and Interchangeable Insulins - Melatonin Safety in Kids - Ivermectin for Covid-19 - DKA risks with SGLT-2 - Metabolic Monitoring The Pharmacy and Therapeutics Committee is responsible for the following major functions: Maintain the Drug Formularies to promote safety, effectiveness, and affordability according to the Formulary Principles Maintain Formulary Principles that guide the management of the Drug Formularies Review new drugs, drug classes, new clinical indications, therapeutic advantages, new chemical entities, and new safety information Review the Drug Formularies and therapeutic classes at least annually Review and update Prior Authorization (PA) coverage guidelines at least annually and as new pharmaceutical information becomes available. Policies are shared regularly with providers in a plan newsletter During this reporting period the P&T Committee completed the review of 33 drug classes using RetroDUR analysis to make modifications to 64% of those classes, to optimize formulary offerings for highest clinical value. These adjustments included changes to the preferred drugs in class, addition of quantity limits for safety and to avoid overutilization, age edits to assure appropriate utilization by formulation and drug. Also, 169 clinical prior authorization coverage guidelines were reviewed: 7 new guidelines were created following a review of ProDUR messages and RetroDUR utilization analysis, based on nationally accepted treatment recommendations for the drugs/drug classes in question. 147 guidelines were renewed or revised/updated based on RetroDUR analysis of utilization patterns, changes to the formulary for preferred products, and updates to treatment recommendations for the conditions managed by those agents. 15 guidelines were retired A summary of P&T decisions and activities is share at each DUR Board meeting.

MCO Name	DUR Board Activities Summary
Amerihealth Caritas Florida	AmeriHealth Caritas FL (ACFL) is required by its contract with the State of Florida Agency for Health Care Administration (AHCA) to provide coverage of outpatient drugs in accordance with the policies and procedures established by the AHCA Pharmacy Policy Unit. AHCA's Pharmacy Policy Unit oversees pharmaceutical coverage and reimbursement policy, clinical criteria, and monitors pharmaceutical utilization. The unit also oversees the State's Pharmaceutical and Therapeutics Committee and Drug Utilization Review Board and maintains the Medicaid Preferred Drug List and determines prescription drug criteria, prior authorization requirements and drug limitations. Any prospective and retrospective DUR activity conducted by AHCA's DUR Board is used to generate the opportunities that are listed in the committee's final PDL recommendations. some PDL additions/deletions made during the reporting period by the AHCA DUR Board are listed below. Drug Change: Status Before Meeting PDL Status After Meeting Comment ACNE AGENTS, TOPICAL CLINDAMYCIN PHOSPHATE GEL (TOPICAL) Non-PDL PDL ANDROGENIC AGENTS, ORAL TLANDO (ORAL) NA Non-PDL ANGIOTENSIN MODULATORS BENAZEPRIL HCTZ (ORAL) Non-PDL PDL QUINAPRIL HCTZ (ORAL) Non-PDL PDL TELMISARTAN (ORAL) Non-PDL PDL TELMISARTAN HCTZ (ORAL) Non-PDL PDL ANTICHOLINERGICS / ANTISPASMODICS DARTISLA (ORAL) NA Non-PDL GLYCOPYRROLATE SOLUTION (ORAL) Non-PDL PDL HYOSCYAMINE SULFATE DROPS (ORAL) PDL Non-PDL ANTICONVULSANTS ZONISADE (ORAL) NA Non-PDL ANTIDEPRESSANTS, OTHER: AUVELITY (ORAL) NA Non-PDL "ANTIDIURETIC HORMONE REPLACEMENT, ORAL & NASAL" VASOSTRICT (INTRAVENOUS) NA Non-PDL ANTIMIGRAINE AGENTS, OTHER AJOVY (SUBCUTANEOUS) Non-PDL PDL AJOVY AUTOINJECTOR (SUBCUTANEOUS) Non-PDL PDL "AJOVY AUTOINJECTOR 3-PK (SUBCUTANEOUS)" Non-PDL PDL ANTIMYCOBACTERIUM AGENTS MYCOBUTIN (ORAL) Non-PDL PDL RIFABUTIN CAPSULE (ORAL) PDL Non-PDL ANTIPSORIATICS, TOPICAL VTAMA (TOPICAL) NA Non-PDL ZORYVE (TOPICAL) NA Non-PDL BPH TREATMENTS: ENTADFI (ORAL) NA Non-PDL COLONY STIMULATING FACTORS FYLNETRA (SUBCUTANEOUS) NA Non-PDL ROLVEDON SYRINGE (SUBCUTANEOUS) NA Non-PDL DRUG CLASS DRUG NAME "PDL STATUS BEFORE MEETING" PDL STATUS AFTER MEETING COLONY STIMULATING FACTORS STIMUFEND SYRINGE (SUBCUTANEOUS) NA Non-PDL CYTOKINE AND CAM ANTAGONISTSSPEVIGO (INTRAVENOUS) NA Non-PDL GLUCAGON AGENTS DIAZOXIDE SUSPENSION (ORAL) PDL Non-PDL PROGLYCEM SUSPENSION (ORAL) Non-PDL PDL GLUCOCORTICOIDS, INHALED ALVESCO (INHALATION) PDL Non-PDL FLOVENT DISKUS (INHALATION) Non-PDL PDL H. PYLORI TREATMENT TALICIA (ORAL) PDL Non-PDL

MCO Name	DUR Board Activities Summary
	HYPOGLYCEMICS, INSULIN AND RELATED AGENTS BASAGLAR TEMPO PEN (SUBCUTANEOUS) NA Non-PDL HUMALOG TEMPO PEN (SUBCUTANEOUS) NA Non-PDL LYUMJEV TEMPO PEN (SUBCUTANEOUS) NA Non-PDL IDIOPATHIC PULMONARY FIBROSIS PIRFENIDONE (ORAL) Non-PDL PDL IMMUNOMODULATORS, ASTHMA TEZSPIRE SYRINGE (SUBCUTANEOUS) NA Non-PDL IMMUNOMODULATORS, ATOPIC DERMATITIS TACROLIMUS (AG) (TOPICAL)Non-PDL PDL TACROLIMUS (TOPICAL) Non-PDL PDL IMMUNOMODULATORS, TOPICAL HYFTOR (TOPICAL) NA Non-PDL INTRANASAL RHINITIS AGENTS RYALTRIS (NASAL) NA Non-PDL KERATOLYTICS SALICYLIC ACID GEL (TOPICAL) Non-PDL PDL METHOTREXATE METHOTREXATE PF VIAL (AG) (INJECTION) Non-PDL PDL MULTIVITAMINS DERMACINRX MULTITAM (ORAL) NA Non-PDL PHOSPHATE BINDERS CALCIUM ACETATE CAPSULE (ORAL) PDL Non-PDL CALCIUM ACETATE TABLET OTC (ORAL) Non-PDL PDL RENVELA TABLET (ORAL) Non-PDL PDL PHOSPHATE BINDERS "SEVELAMER CARBONATE TABLET (AG) (ORAL)" PDL Non-PDL SEVELAMER CARBONATE TABLET (ORAL) PDL Non-PDL SKELETAL MUSCLE RELAXANTS BACLOFEN SOLUTION (AG) (ORAL) Non-PDL PDL NORGESIC (ORAL) NA Non-PDL STIMULANTS AND RELATED AGENTS "METHYLPHENIDATE ER (RELEXXII) (AG) (ORAL)" NA Non-PDL RELEXXII (ORAL)NA Non-PDL XELSTRYM (TRANSDERMAL) NA Non-PDL VASODILATORS, CORONARY "ISOSORBIDE DINTRATE/HYDRALAZINE (ORAL)" NA Non-PDL ACNE AGENTS, TOPICAL: TWYNEO CREAM (TOPICAL) NA Non-PDL ANALGESICS, NARCOTICS SHORT: SEGLENTIS (ORAL) NA Non-PDL ANTICOAGULANTS: XARELTO SUSPENSION (ORAL) PDL Non-PDL ANTIDEPRESSANTS, OTHER: ZULRESSO (INJECTION) NA Non-PDL ANTIDEPRESSANTS, SSRIs PAROXETINE SUSPENSION (ORAL) PDL Non-PDL SERTRALINE CAPSULE (ORAL) PDL Non-PDL ANTIEMETIC/ANTIVERTIGO AGENTS: ALOXI (INTRAVEN) Non-PDL PDL BARHEMSYS VIAL (INTRAVENOUS) NA Non-PDL PALONOSETRON (AG) (INTRAVENOUS) PDL Non-PDL PALONOSETRON (INTRAVENOUS) PDL Non-PDL SCOPOLAMINE (TRANSDERM) PDL Non-PDL TRANSDERM-SCOP (TRANSDERM) Non-PDL PDL Auto-PA ANTI-ULCER PROTECTANTS: CARAFATE SUSPENSION (ORAL) Non-PDL PDL CARAFATE TABLET (OR) CARAFATE TABLET (ORAL) Non-PDL PDL SUCRALFATE SUSPENSION (AG) (ORAL) PDL Non-PDL SUCRALFATE SUSPENSION (ORAL) PDL Non-PDL ANXIOLYTICS LOREEV XR CAP ER 24H (ORAL) NA Non-PDL

MCO Name	DUR Board Activities Summary
	BETA-BLOCKERS COREG CR (ORAL) Non-PDL PDL NADOLOL (ORAL) Non-PDL PDL NEBIVOLOL (ORAL) Non-PDL PDL COLONY STIMULATING FACTORS RELEUKO SYRINGE (SUBQ) Prospective DUR: ACFL's benefits system is configured in accordance with state requirements and DUR Board policies to identify cases where there may be potential errors or harm. The requirements include that during the claims adjudication process, prospective DUR relies on computerized algorithms to perform key checks including drug interactions, duplications or contraindications with the patient's disease state or condition. Prospective DUR activities include: a. Clinical abuse/misuse b. Drug-disease contraindications (when a prescribed drug should not be used with certain c. diseases) d. Drug dosage modification e. Drug-drug interactions (when two or more different drugs interact and alter their intended f. effects, often causing adverse events) g. Drug-patient precautions (due to age, allergies, gender, pregnancy, etc.) h. Formulary substitutions (e.g., therapeutic interchange, generic substitution) i. Inappropriate duration of drug treatment Pharmacists have the opportunity to resolve these potential problems before the patient receives the medication. Analysis of these interventions helps ACFL and the state DUR Board to determine retrospective targets for the future. RetroDUR: Reports and member profiles are reviewed retrospectively to determine opportunities for member or provider outreach activities as well as referring a member to a disease therapy management program. In addition, retrospective analysis of these edits, may result in the plan making a request to the State to consider further review for potential modifications to these edits. ACFL's DUR program is conducted for the ongoing periodic systematic review of drug utilization and prescribing patterns to ensure prescriptions for outpatient medications for members are appropriate, medically necessary, and not likely to result in adverse medical effects. On a quarterly basis, clinical pharmacists review claims history data to evaluate member drug utilization, physician prescribing patterns, and pharmacy dispensing patterns to detect episodes of drug-related problems, target therapeutic categories for intervention, and identify inappropriate and/or unnecessary usage patterns. In accordance with state DUR Board policy, during the Retrospective DUR process the presence and/or frequency of the following are evaluated: a. Drug-drug interactions b. Drug-disease interactions c. Polypharmacy d. Overdosing and under dosing e. Excessive duration of therapy f. Potential therapeutic failures

MCO Name	DUR Board Activities Summary
	g. Duplicate therapy h. Fraud and abuse i. Failure to substitute therapeutic equivalents j. Failure to substitute generic drugs k. Over-utilization and under-utilization l. Compliance m. Top Drugs Report Outliers are identified and subsequent intervention recommendations are determined to promote the quality of pharmaceutical care and improve member outcomes. As a result, prescribers and network pharmacists are educated on how to identify and reduce the frequency and patterns of fraud, abuse, overuse, and the inappropriate or non-medically necessary use of medications. In addition, utilization patterns, prior authorization statistics, PMPM changes, cost-saving opportunities, and future initiatives that will enhance the MCO's clinical programs are discussed and evaluated. Prescribers and network pharmacists are made aware of any policy changes through the MCO's formulary and other routine mailings, as appropriate. ACFL follows state policy to notify network providers of the DUR Board changes and recommendations made to the PDL via provider newsletters and with Education alerts placed on the ACFL Provider webpage and notify providers who may prescribe or are currently prescribing a drug that is being deleted from the Agency's Medicaid PDL within thirty (30) days of ACFL being notified of the change by the Agency. In addition, ACFL provides a link to the Agency's formulary website on its Member and provider webpage@ https://www.amerihealthcaritasfl.com/provider/find-provider/index.aspx . This link directs members and providers to the State's PDL, prior authorization forms, and drug criteria for medications that require prior authorization When unique prescribing patterns are detected upon review of the claims data, ACFL may bring recommendations to the FFS DUR Board for consideration and the MCO's Quality Committee for review. For example, age and quantity limits are recommended based on a review of the claims data and peer reviewed literature. In addition, step therapies are suggested to the Board when the data suggests clinically appropriate alternatives should be tried prior to more costly alternatives. These state DUR policies are used to identify members who may benefit from Drug Therapy Management. These members are considered for enrollment into the Drug Therapy Management program where comprehensive medication reviews are completed telephonically with the consenting members. Written and telephonic interventions are made to providers to discuss suggested clinical actions such as discontinuing medications or adding any necessary medications based on patient mix.
Children's Medical Services	There were 7 DUR MCO Board meetings: 10/18/2021 11/29/2021 2/28/2022 3/14/2022 5/23/2022 6/27/2022 9/26/2022

MCO Name	DUR Board Activities Summary
	Prospective DUR - POS review: During the reporting period, all cDUR messaging at the point of sale (POS) was reviewed in the Pharmacy Drug Utilization Meeting. Edit types reviewed included the following: Apparent Drug Misuse Cumulative APAP Check Cumulative Morphine Equivalent Dose Dose Check Multiplier Drug Age Precaution Drug-Disease Precaution Drug-Drug Interaction Drug-Gender Drug-Pregnancy Excessive Controlled Substances: Multiple Drugs, Number of Therapies Excessive Duration High Dose Ingredient Duplication Low Dose Therapeutic Duplication Underuse Precaution Buprenorphine-opioid concurrent use Opioid claim >7 day supply in a nave member Opiate/Benzodiazepines Drug Interaction - Refill Too Soon - Multiple Pharmacies - Multiple Prescribers - Duplicate Long Acting Opioids All conflicts identified were determined to be appropriate. Retrospective DUR: To act as a safety net for situations that may have a negative clinical impact on a member. Retail and mail prescriptions are reviewed daily for serious drug-to-drug interactions and the prescriber is notified within 72 hours of claim processing. Providers are sent therapeutic alerts via fax with patient profile requesting a response for an appropriate intervention. Goal: Increase Member Safety Increase Prescriber Engagement Reduce Medication Error
Clear Health Alliance	Florida CHA Retrospective Drug Utilization Review (RDUR) analysis is performed through a review of administrative pharmacy claims each day, week, and/or month. RDUR letters are faxed or mailed to targeted prescribers and members to identify gaps in care, discuss adherence and identify cases of potential under-and over-utilization, drug abuse or misuse, and/or improve formulary compliance. Some of these identified members are referred to the

MCO Name	DUR Board Activities Summary
	Lock-in program or to a pharmacist for further evaluation or clinical intervention. Additionally, our Clinical Pharmacy Care Center, composed of pharmacists and pharmacy technicians conduct retrospective outreaches to members and providers. Examples of these programs include evaluation of medications for polypharmacy and age appropriateness, new start and adherence education, and opioid/controlled substance management programs. State-specific program results are shared with the health plan leaders at a minimum of a quarterly basis. RDUR details are also presented during plan-specific Quality Management meetings and/or DUR Committee meetings. Retrospective DUR programs are presented and approved by the Pharmacy Quality Programs Committee. One purpose of the committee is to provide feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request. PQP Committee interventions approved on the following dates: 10/19/2021: No Medicaid 02/15/2022: Accordant New Conditions: Adding 3 new conditions (pulmonary arterial hypertension, juvenile idiopathic arthritis, and inclusion body myositis) to the existing 19 specialty conditions that our vendor, Accordant, currently manages through the Specialty Condition Management (SCM) enhanced program. Follow-up Care for Children Prescribed ADHD Medication (ADD): New provider outreach to ensure appropriate monitoring and follow-up for children that are new starts on ADHD medications. 05/17/2022: Medicaid Program Message Consolidation: Adding medication review rules to Medicaid rule set and retire separate faxes for certain programs.
Community Care Plan	The Drug Utilization Review (DUR) board is operated by the States Agency for Healthcare Administration (AHCA). This DUR committee meets 4 times per year to review and approve all DUR program policies and procedures for the State of Florida Medicaid program. All MCO's contracted with the State are required to follow the AHCA Preferred drug list, prior authorization criteria when available and DUR program edits. The DUR Board reviews and approves drug utilization criteria and the standards for both the RetroDUR and ProDUR reviews. Drug utilization reports and meeting schedules can be viewed at the ahca.myflorida website.
Florida Community Care	SUMMARY 2 DUR Board Activities Report, FFY 2022 (10/1/21 9/30/22)

MCO Name	DUR Board Activities Summary
	CVS Caremark conducted four P&T committee meetings between 10/1/21 -9/30/22 o 10/27/21 o 2/23/22 o 6/1/22 o 8/10/22 List additions/deletions to DUR Board approved criteria o For prospective DUR, list problem type/drug combinations added or deleted. Medi-Span handles most of the POS Safety DURs. They are a third-party vendor, so they have their own review processes. CVS Caremark has no influence or visibility to their clinical activities and vice versa. Additions to internally developed programs include: - No new prospective interventions developed internally in 2022 o For retrospective DUR, list therapeutic categories added or deleted – Added maribavir - anticonvulsant drug interaction program – Added statins-protease inhibitor drug interaction program – Added toremifine - SSRI drug interaction program – Added levoketoconazole - ziprasidone drug interaction program – Added PCSK9 duplicate therapy program – Added duplicate therapy narcolepsy agents program – Added drugs that can worsen dry-eye disease – Added Uceris (budesonide) duration of therapy program – Added appropriate use of Vtama (tapinarof) in plaque psoriasis – Added duplicate therapy testosterone program – Added duplicate therapy antiandrogen program – Added mavacamten-CYP inducers drug interaction program – Added anti-Parkinson agents MAO inhibitor drug interaction program – Added inappropriate use of GLP-1 agonists for weight loss program – Added use of stimulants with benzodiazepine/non-benzodiazepine program – Added inappropriate use of stimulants in patients > 17 years program – Added capotegravir/rilpivirine vs rifamycin drug interaction program – Added NNRTI - PPI drug interaction program – Added daridorexant antiretroviral drug interaction program – Added fluoroquinolone use in patients with diabetes program – Added atogepant- CYP3A inhibitors drug interaction program – Added atorvastatin protease inhibitor drug interaction program – Added doxepin isocarboxazid or tranylcypromine drug interaction program – Added specific anticoagulant celecoxib drug interaction program – Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens. o Some prospective DURs are developed by third-party vendors (e.g., Medi- Span or First Databank safety alerts) and have no influence upon internally developed retrospective DURs. Internally developed prospective programs have different scopes than retrospective programs; hence have little influence on each other. o In developing the Retrospective DUR programs, CVS Caremark looks for drug interactions that are classified as "high severity" or "contraindicated" by industry databases (e.g., Micromedex, Facts & Comparisons) or the FDA (if operationally feasible). The Board gets ideas from daily healthcare news feeds as well as FDA safety alerts.

MCO Name	DUR Board Activities Summary
	Additionally, we find interventions by reviewing the current medical literature. When we identify a potential intervention that can be operationalized, we develop the algorithm and send it to one of our internal Medical Directors for review. An example of a current program is Opioid Use and the Potential Risk of Neonatal Abstinence Syndrome. Describe DUR Board involvement in the DUR education program (i.e., newsletters, continuing education, etc.) Also, describe policies adopted to determine mix of patient or provider specific. o The CVS Caremark P&T Committee is not a part of the State's DUR Board and does not have direct involvement in the DUR education program through the review of newsletters or continuing education.
Humana Medical Plan	Most DUR activities are managed by the FFS DUR Board. The MCO DUR Board meets regularly throughout the year as part of a larger committee and multiple small subcommittees. The board consists of pharmacists and physician members of various specialties and makes decisions on drug utilization review programs and requirements. 12 monthly meetings are held and 52 weekly subcommittee meetings. For Florida Medicaid, the MCO DUR Board is limited to issues permitted by the state to be managed by the MCO. A prospective DUR reasonable quantity limit edit has been implemented for drugs that have a high risk of fraud waste and abuse. Policies and corresponding edits are reviewed no less than annually for continued need and effectiveness of criteria/edit. Policies regarding edits are posted to an external web and communications are sent to providers and members as needed for negative impacts.
Molina Healthcare	Molina Healthcare, Inc. held four drug utilization review meetings during FFY 2022 (October 2021, January 2022, April 2022, and July 2022) During FFY 2022 the following prospective DUR activities occurred. The evaluation of the configuration for triple therapy (opioid, benzodiazepine, carisoprodol) avoidance has demonstrated a 65.12% reduction in triple therapy concurrent utilization since May of 2019 when the coding was first implemented enterprise wide. Dr. Mario San Bartolome created an enduring education video on naloxone prescribing for providers that can be found on Molina websites. This video was first provided live to Ohio providers by webinar on December 1, 2021 During the October 2021 meeting is was determined, during the course of annual physician administered drug utilization review that there was value and risk avoidance by adding prior authorization to the following HCPC codes within the medical channel: C9062, J0185, J0630, J7333, J9246, Q5111, S0189 and remove the following HCPC codes from prior authorization

MCO Name	DUR Board Activities Summary
	requirement: J0895, J1230, J1570, J1652, J1955, J8521. The evaluation of claim edits based on drug label and compendia support were reviewed the following is a summary of those activities: 59 proposed edits for a JW waste policy, Botulinum- deny for benefit exclusion policy, 1 edit to deny for duplication of services, 5 edits to deny for administration frequency great than FDA label, 4 edits to deny for quantities limits above FDA label, 2 edits to deny for inappropriate provider specialty During the January 2022 DUR meeting the COVID vaccines and treatment utilization was reviewed. Data was reviewed to ensure access to care was available to members for all COVID needs. The Molina Smart Fill program was reviewed during that same meeting to evaluate the number of utilizers effected, how often they converted to a maintenance dose and how often the member moved to a new dose or new medication. The Smart Fill program is targeted to therapies with high incidence of adverse events during the initial titration period. Providing members with only a small supply reduces the incidence of wastage and members having conflicting dosages available that could lead to errors. During the April 2022 DUR meeting we reviewed in depth of overdose interventions. From November of 2019 to November of 2020, we saw an increase of 28.9 % in overdose deaths. 11 of 18 states are above the national average. When evaluating what drugs are leading to overdose deaths- the top offenders are all opioids, synthetic opioids, methadone, and psychostimulants. Based on this data reporting was created to allow for targeted interventions by different staffing models that created hierarchy of risk members for overdose based on opioid use. The reporting evaluated chronic opioid utilizers with or without a diagnosis for opioid use disorder and did or did not have medication assisted therapy use in their record. This reporting will be used synergistically with the behavioral health team to target interventions for the substance user disorder program on a moving forward. During the July 2022 DUR meeting the evaluation of the success of the prescriber education campaign for metabolic monitoring for those members on antipsychotic medications was conducted. The reporting demonstrated that about 17% of those people who had not had

MCO Name	DUR Board Activities Summary
	metabolic screening became compliant after the letters were sent out. The data also showed an overall DUR compliance rate has gone up from 31% to 34%. The committee reviewed the Covered California's Proposal for the Quality Transformation Initiative (QTI) and discussed potentially programming that could supporting increasing measures.
Simply Healthcare	Simply - Florida Retrospective Drug Utilization Review (RDUR) analysis is performed through a review of administrative pharmacy claims each day, week, and/or month. RDUR letters are faxed or mailed to targeted prescribers and members to identify gaps in care, discuss adherence and identify cases of potential under-and over-utilization, drug abuse or misuse, and/or improve formulary compliance. Some of these identified members are referred to the Lock-in program or to a pharmacist for further evaluation or clinical intervention. Additionally, our Clinical Pharmacy Care Center, composed of pharmacists and pharmacy technicians conduct retrospective outreaches to members and providers. Examples of these programs include evaluation of medications for polypharmacy and age appropriateness, new start and adherence education, and opioid/controlled substance management programs. State-specific program results are shared with the health plan leaders at a minimum of a quarterly basis. RDUR details are also presented during plan-specific Quality Management meetings and/or DUR Committee meetings. Retrospective DUR programs are presented and approved by the Pharmacy Quality Programs Committee. One purpose of the committee is to provide feedback and approve newly proposed pharmacy quality or cost of care interventions or changes to existing interventions upon request. PQP Committee interventions approved on the following dates: 10/19/2021: No Medicaid changes 02/15/2022: Accordant New Conditions: Adding 3 new conditions (pulmonary arterial hypertension, juvenile idiopathic arthritis, and inclusion body myositis) to the existing 19 specialty conditions that our vendor, Accordant, currently manages through the Specialty Condition Management (SCM) enhanced program.

MCO Name	DUR Board Activities Summary
	Follow-up Care for Children Prescribed ADHD Medication (ADD): New provider outreach to ensure appropriate monitoring and follow-up for children that are new starts on ADHD medications 05/17/2022: Medicaid Program Message Consolidation: Adding medication review rules to Medicaid rule set and retire separate faxes for certain programs.
Sunshine	There were 7 DUR MCO Board meetings: 10/18/2021 11/29/2021 2/28/2022 3/14/2022 5/23/2022 6/27/2022 9/26/2022 Prospective DUR - POS review: During the reporting period, all cDUR messaging at the point of sale (POS) was reviewed in the Pharmacy Drug Utilization Meeting. Edit types reviewed included the following: Apparent Drug Misuse Cumulative APAP Check Cumulative Morphine Equivalent Dose Dose Check Multiplier Drug Age Precaution Drug-Disease Precaution Drug-Drug Interaction Drug-Gender Drug-Pregnancy Excessive Controlled Substances: Multiple Drugs, Number of Therapies Excessive Duration High Dose Ingredient Duplication Low Dose Therapeutic Duplication Underuse Precaution Buprenorphine-opioid concurrent use Opioid claim -7 day supply in a nave member Opiate/Benzodiazepines Drug Interaction - Refill Too Soon - Multiple Pharmacies - Multiple Prescribers - Duplicate Long Acting Opioids

MCO Name	DUR Board Activities Summary
	All conflicts identified were determined to be appropriate. Retrospective DUR: To act as a safety net for situations that may have a negative clinical impact on a member. Retail and mail prescriptions are reviewed daily for serious drug-to-drug interactions and the prescriber is notified within 72 hours of claim processing. Providers are sent therapeutic alerts via fax with patient profile requesting a response for an appropriate intervention. Goal: Increase Member Safety Increase Prescriber Engagement Reduce Medication Error
United Healthcare	DUR Board Summary Write-Up 1. DUR Board meetings held between 10/01/2021 and 09/30/2022 a. The UnitedHealthcare Community Plan DUR Board Meetings: i. 3/31/2022 ii. 09/26/2022 2. Additions/deletions to DUR Board approved criteria. a. For prospective DUR, list problem type/drug combinations added or deleted. i. Approval to add Concurrent Drug Utilization Review (CDUR) soft edits at the point of sale for the following CDUR types and classes: 1. Therapeutic Duplication: Barbiturates, Alpha-1 Blockers, and Mood Stabilizers 2. Drug Interactions: Clonidine + Beta Blocker, Anti-Rejection Immunosuppressants, and Opioid+ Skeletal Muscle Relaxants 3. Cumulative High Dose: Metformin and Benzodiazepines ii. Approval to add Concurrent Drug Utilization Review (CDUR) message only edit at the point of sale for the following CDUR types and classes: 1. Drug Interactions: Oral Contraceptive + Anti-Infective b. For retrospective DUR, list therapeutic categories added or deleted. i. Gained approval for a member targeted letter campaign focusing on member awareness of risks associated with prolonged use of PPIs and/or sedatives. ii. Gained approval to ask OptumRx to re-evaluate triggers within the OptumRx RDUR Safety Management Program based on a comprehensive evaluation. 3. Describe Board policies that establish whether and how results of prospective DUR screening are used to adjust retrospective DUR screens. a. The UnitedHealthcare Community Plan evaluates the trends in the ongoing CDUR programs at the point of sale and are completed by the DUR Team at minimum once yearly. Outlier medication related problems within each service are evaluated for possible recommendation for addition to the existing RDUR program triggers employed by OptumRx. The DUR Team brings these recommendations to the DUR Board committee for review and final approval to place the recommendation with OptumRx. 4. Also, describe policies that establish whether and how results of retrospective DUR screening are used to adjust prospective DUR screens.

MCO Name	DUR Board Activities Summary
	a. The UnitedHealthcare Community Plan evaluates the trends in the ongoing RDUR programs we are enrolled in through OptumRx and are completed by the DUR Team at minimum once yearly. Outlier medication related problems within each service are evaluated for possible inclusion in the custom CDUR soft edit program. The DUR Team brings these recommendations to the DUR Board committee for review and final approval. Examples of this during FFY 21-22 was the inclusion of anti-rejection immunosuppressants interaction to the CDUR soft edit program, both of which came from evaluations of RDUR medication-related problem trends. 5. Describe DUR Board involvement in the DUR education program (e.g., newsletters, continuing education, etc.). a. The UnitedHealthcare Community Plan evaluates the need for educational programs on an ongoing basis and the type of program implementation done is decided on a case-by-case basis. During the evaluation of CDUR and RDUR program trends and the larger healthcare landscape, opportunities are identified that would be well suited for a broader education of the prescribing network and are recommended to the DUR Board. Most often this takes the form of educational newsletters. 6. Also, describe policies adopted to determine mix of patient or provider specific intervention types (e.g., letters, face-to-face visits, increased monitoring) a. The UnitedHealthcare Community Plan's standard intervention types are prescriber facing and usually take the form of letters/faxes or provider newsletters. The addition of programs that include other intervention types like face-to-face visits or monitoring or referrals are discussed on a case-by-case basis with the DUR Board. b. The OptumRx Adherence Program includes member and provider facing interventions. The program includes member mailings and member IVR calls connecting members to pharmacists for consultation if desired. c. A member targeted letter campaign was approved during this FFY 21-22 focusing on member awareness of risks associated with prolonged use of PPIs and/or sedatives and to provide education to assist in conversations with their prescribing provider.

Section V - Physician Administered Drugs (PAD)

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

1. ProDUR?

Figure 37 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

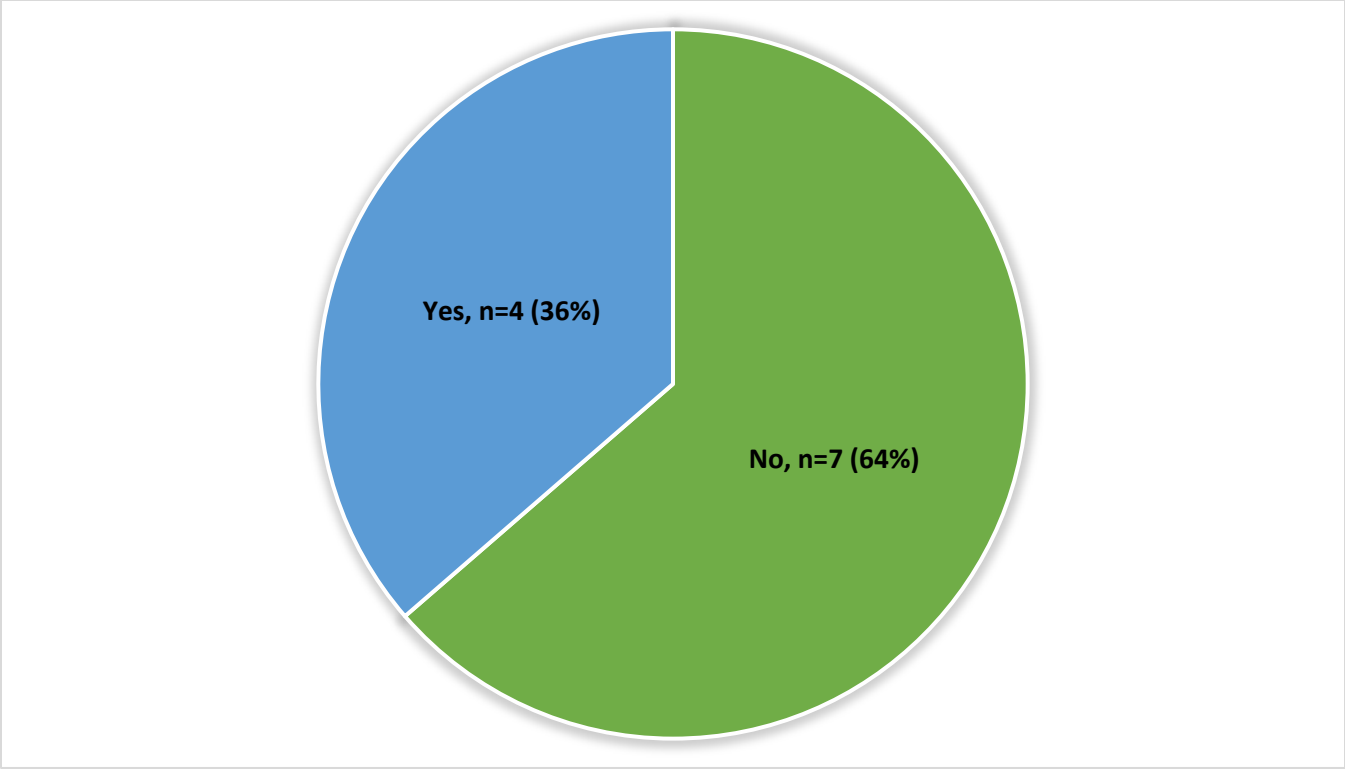


Table 55 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

Response	MCO Names	Count	Percentage
Yes	Clear Health Alliance, Community Care Plan, Molina Healthcare, Simply Healthcare	4	36.36%
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Florida Community Care, Humana Medical Plan, Sunshine, United Healthcare	7	63.64%
State Totals		**11**	**100%**

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

Figure 38 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

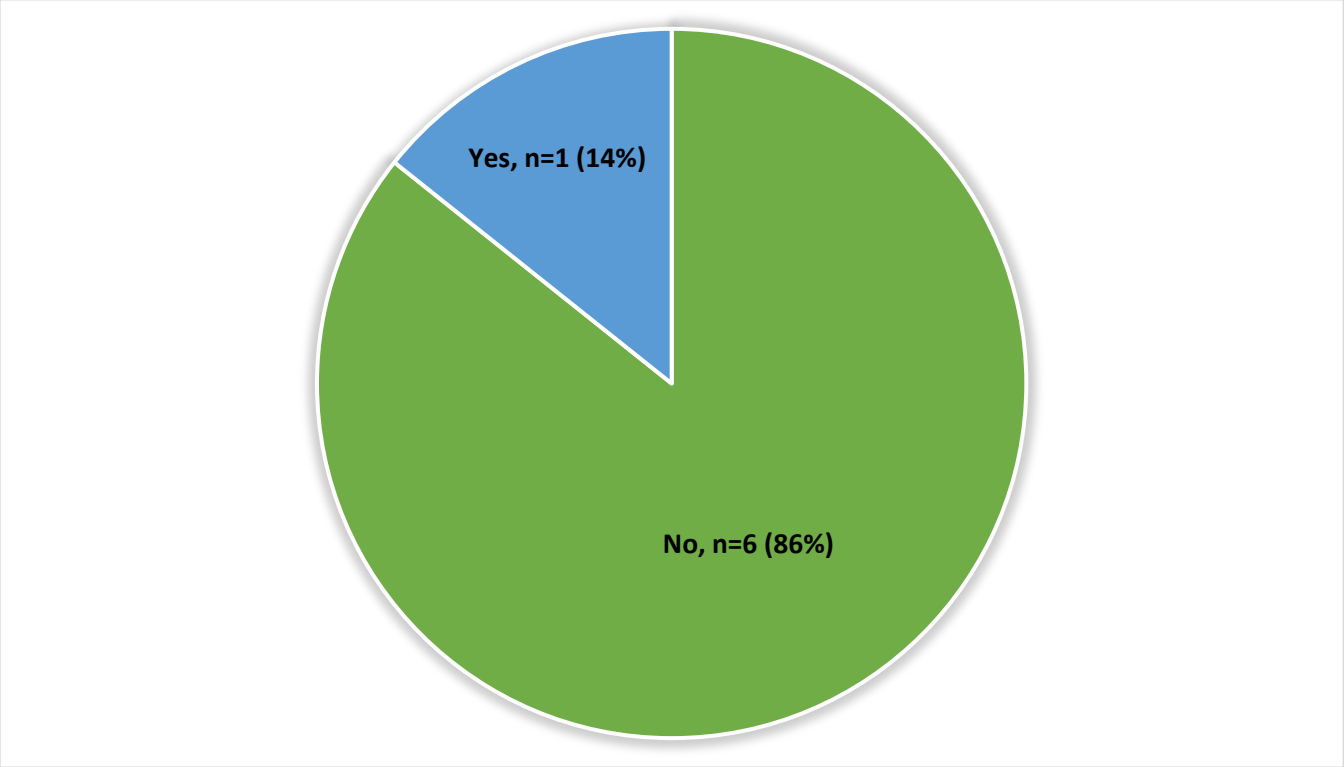


Table 56 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for ProDUR

Response	MCO Names	Count	Percentage
Yes	United Healthcare	1	14.29%
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Florida Community Care, Humana Medical Plan, Sunshine	6	85.71%
State Totals		**7**	**100%**

2. RetroDUR?

Figure 39 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

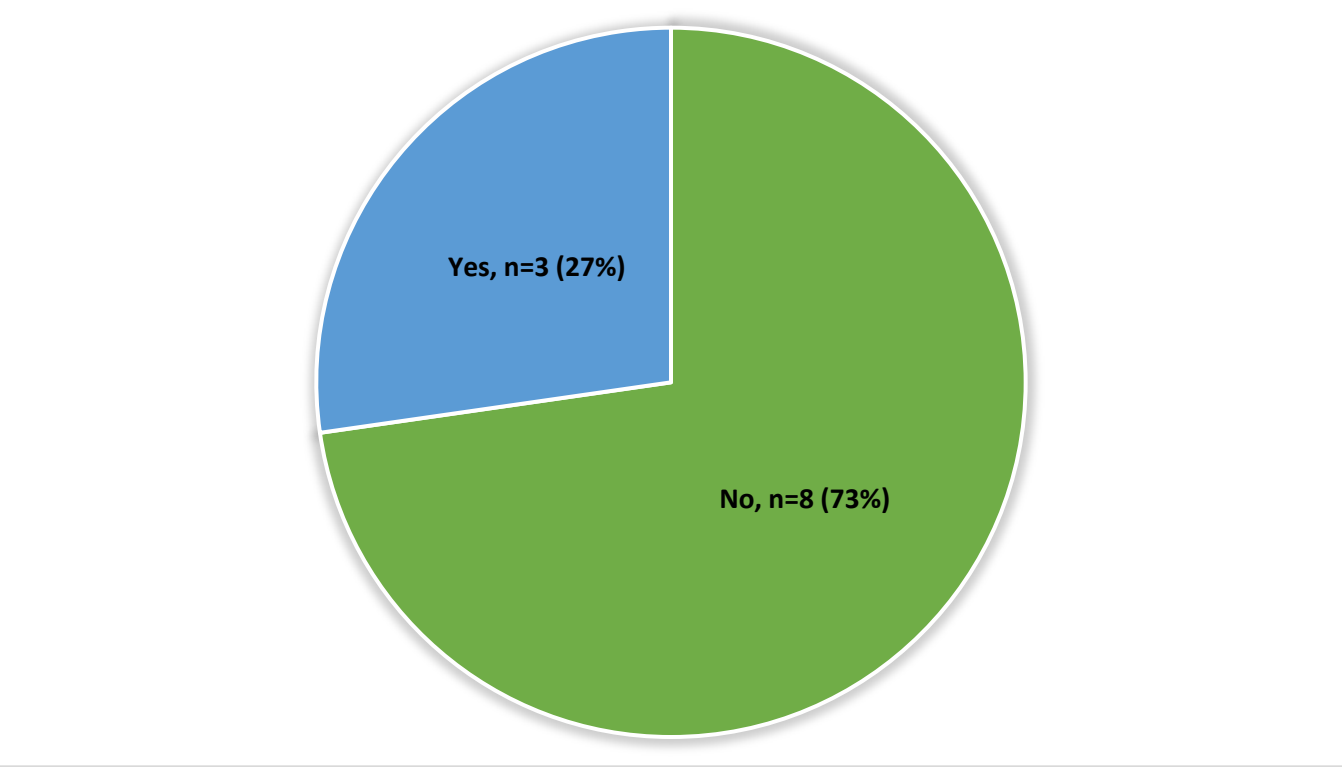


Table 57 - Incorporation of NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

Response	MCO Names	Count	Percentage
Yes	Clear Health Alliance, Molina Healthcare, Simply Healthcare	3	27.27%
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Community Care Plan, Florida Community Care, Humana Medical Plan, Sunshine, United Healthcare	8	72.73%
State Totals		**11**	**100%**

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

Figure 40 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

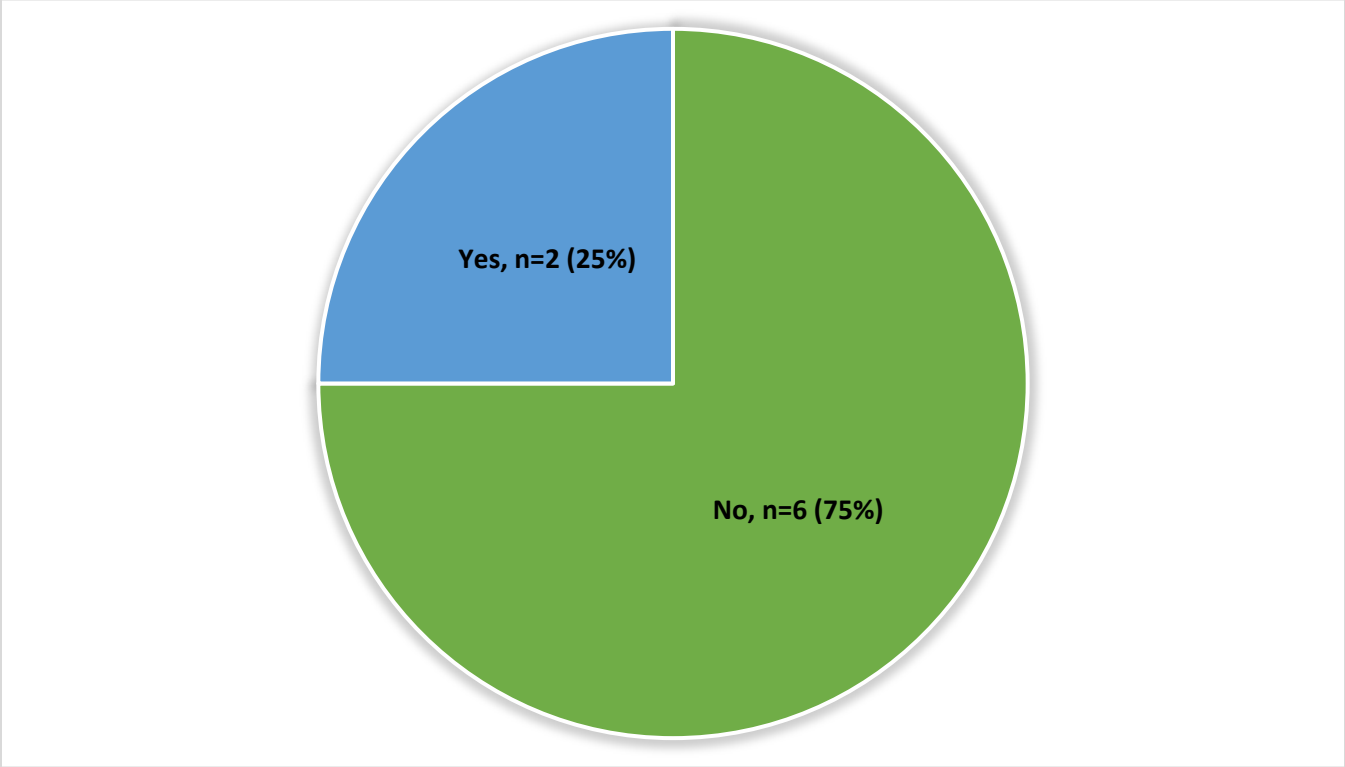


Table 58 - Future Plans to Incorporate NDCs for Covered Outpatient Physician Administered Drugs into DUR Criteria for RetroDUR

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, United Healthcare	2	25.00%
No	Amerihealth Caritas Florida, Children's Medical Services, Community Care Plan, Florida Community Care, Humana Medical Plan, Sunshine	6	75.00%
State Totals		**8**	**100%**

Section VI - Generic Policy and Utilization Data

1. Summary 3 - Generic Drug Substitution Policies

Generic Drug Substitution Policies Summary 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 affect your generic utilization rate.

Table 59 - Generic Drug Substitution Policies

MCO Name	Generic Drug Substitution Policies Summary
Aetna Better Health	AETNA BETTER HEALTH of Florida Policy. Policy Name: Generic Substitution Policy Number: 7600.11 Effective Date: 03/01/2017 PURPOSE: The purpose of the Generic Substitution policy is to provide guidelines for the safe and efficacious use of therapeutically equivalent generic drugs when commercially available and medically appropriate. STATEMENT OF OBJECTIVE: The objectives of the generic substitution policy are to: Manage members' pharmacy benefit effectively in the interest of patient safety Provide designations of acceptable therapeutically equivalent generic substitutions Provide guidelines for reviewing requests for exceptions to the drug substitution policy LEGAL/CONTRACT REFERENCE: Applicable federal and state laws regarding confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA]) Current pharmacy benefits manager agreements, addenda, amendments, letters of understanding, and data licensing agreements Federal and state laws, rules, and regulations concerning the practice of pharmacy, third party administration, Medicaid laws, rules, and regulations Client agreement National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans FOCUS/DISPOSITION: Aetna Better Health mandates generic substitution for applicable members whenever a generic equivalent to a brand name drug is available. Only drugs listed in Orange Book Annual Edition (28th Edition) with the following designations may be substituted: AA, AB, AN, AO, AP, and AT. Drugs listed on the Statewide Medicaid Managed Care MMA program preferred brands list are excluded from this policy. Practitioners/providers may request an exception to the generic substitution policy by submitting documentation of adverse effects caused by the generic alternative (see the Exceptions section). Scope

MCO Name	Generic Drug Substitution Policies Summary
	This policy applies to Aetna Better Health's Medicaid members who are enrolled and eligible to receive pharmacy benefits on the date of service. Responsibilities The Pharmacy Management department, under the direction of the Aetna Medicaid pharmacy director, is responsible for overseeing Aetna Better Health's generic substitution policy. The Pharmacy Prior Authorization department, under the direction of the Aetna Medicaid pharmacy director, chief medical officer, or designated medical director, is responsible for reviewing requests for exceptions to the generic substitution requirement. Exceptions Aetna Better Health may grant an exception to the generic substitution requirement upon review of documentation of adverse effects caused by the generic alternative. To request an exception, a practitioner/provider must fax to the Pharmacy Prior Authorization department a completed copy of one of the following: Florida Healthy Kids: submit the standard MedWatch form (the FDA-required form used to document and report adverse effects) available on the FDA's website Statewide Medicaid Managed Care MMA Program: submit multisource brand drug prior authorization form available on the Department's website The request form must include the following information: The member's name and identification number Prescribing practitioner/provider's name, address, and telephone number Brand/generic name, strength, and directions for use of requested drug Member diagnosis Clinical information, as appropriate Requests for exceptions will be reviewed by the Pharmacy Prior Authorization department. Criteria for reviewing exception requests include: Documented therapeutic failure of an equivalent generic drug Documented allergic reaction to a component of the generic product Documented adverse event attributed to a component of the generic product If criteria for approval are met, the request will be approved and the requesting practitioner will be notified no later than twenty-four (24) calendar hours from receipt of the completed request, or sooner, if required by state regulatory requirements. If criteria for approval are not met, the request will be reviewed by the Aetna Medicaid chief medical officer or designated medical director for medical necessity. If the request for exception is denied, the denial will be communicated to the prescribing practitioner/provider by fax no later than twenty-four (24) calendar hours from receipt of the completed request, or sooner if required by state regulatory requirements. Both the practitioner/provider and member will also be notified of the reason for denial and an explanation of the appeal process with instructions on how to request an expedited appeal. OPERATING PROTOCOLS:

MCO Name	Generic Drug Substitution Policies Summary
	Systems Pharmacy benefits manager's (PBM's) proprietary clinical authorization system Paid claims files from the pharmacy benefits manager Measurement Exceptions approved, denied, and reasons for decision (measured monthly) Reports Approved and denied exceptions reviewed by Aetna Medicaid Pharmacy Management (reported monthly) Safety and/or efficacy issues reported to the Aetna Medicaid Pharmacy Management for review as they occur INTER-/INTRA-DEPENDENCIES: Internal Case Management Chief medical officer or designee Information Technology Medical Management Member Services Network Services Pharmacy director External Client Federal and state regulators Mail service pharmacy Members Participating pharmacies Participating prescribing providers Pharmacy benefits manager Regulatory bodies Aetna Better Health
Amerihealth Caritas Florida	Drug coverage is determined by the state's single preferred drug list which is provided at an NDC level. Therefore, Mandatory Generic Logic is currently not utilized for ACFL. ACFL is required to manage the Florida Agency for Health Care Administration (AHCA) state-mandated Prescription Drug List (PDL). The AHCA PDL dictates which NDC's of a particular drug are preferred and non-preferred. The MCO does not have ability to substitute a generic drug if the AHCA PDL mandates the brand formulation of the drug is preferred. In the event a brand name drug is not on the AHCA PDL, in order for the member to receive the brand formulation, when medically necessary, the prescriber must request a prior authorization by doing the following: Write in his/her own handwriting on the valid prescription that the "Brand Name is Medically Necessary" (pursuant to s. 465.025, F.S.); and Submit a completed "Multisource Drug and Miscellaneous Prior Authorization" form to the Managed Care Plan indicating that the enrollee has had an adverse reaction to a

MCO Name	Generic Drug Substitution Policies Summary
	generic drug or has had, in the prescriber's medical opinion, better results when taking the brand name drug.
Children's Medical Services	To minimize cost, generic utilization shall be promoted by Children's Medical Services. The FDA requires that generic drugs have the same quality, strength, purity and stability profile as their brand name counterparts. I. Medicaid coverage of brand-name drugs may be excluded when an A-rated generic drug is available, unless a prior authorization is obtained or the brand-name drug is Children's Medical Services' preferred drug. II. Requests for brand-name drugs when an A-rated generic drug is available and is not Children's Medical Services' preferred drug shall be reviewed for approval. The PDL is a small part of a broader formulary system that encompasses not only drug selection but also utilization management ("UM") tools such as prior authorizations ("PA"), step therapy ("ST"), quantity limits ("QL"), age limits ("AL") and generic substitution. To ensure that Children's Medical Services Health Plans, Inc. and its affiliates and subsidiaries (collectively, "Children's Medical Services" or the "Company") complies with state Medicaid regulations regarding PDLs, PA, ST, QL, AL, and generic substitution, Children's Medical Services conforms its policies to reflect these regulations.
Clear Health Alliance	The Florida Managed Medical Assistance (MMA) Program -policy addresses generic drug substitution practices which follow the Statewide Medicaid Managed Care-Managed Medical Assistance (SMMC-MMA) contract requirements with the Agency for the Healthcare Administration. The Managed Care Plan may make available generic drugs in a therapeutic category that is not on the Agency's Medicaid PDL, unless a brand-name drug containing the same active ingredient is on the Agency's Medicaid PDL. The Managed Care Plan shall make available those brand name drugs that are not on the Agency's Medicaid PDL, when medically necessary, if the prescriber: 1.Writes in his/her own handwriting on the valid prescription that the "Brand Name is Medically Necessary" (pursuant to s. 465.025 F. S.:) and 2.Submits a completed "Multisource Drug and Miscellaneous Prior Authorization" form to the Managed Care Plan indicating that the enrollee has had an adverse reaction to a generic drug or has had, in the prescriber's medical opinion, better results when taking the brand-name drug. The plan may not pay for the generic version of a product if the Brand is preferred on the Agency's PDL.
Community Care Plan	Community Care Plan follows the State's PDL and criteria on filling generic medications. There are no restrictions on filling generic unless it's Non-PDL or there is a brand preferred product. In this instance the generic product would not pay at point of sale and the brand would. BRAND NAME MEDICALLY NECESSARY: If the provider writes a prescription for a brand name product and there is a generic available (with an applicable SMAC or FUL), the provider must complete a Miscellaneous Prior Authorization form and a Request for Multi-Source Brand Drug form. The completed Multi-Source Brand Drug form describing the problem and difference in therapeutic response and the Miscellaneous Prior Authorization form should be faxed to Magellan Rx/Prime Therapeutics at the fax number listed on the forms. The same forms are required for brand name medically necessary continuation of therapy requests.

MCO Name	Generic Drug Substitution Policies Summary
Florida Community Care	FCC follows the state-mandated preferred drug list (PDL). The PDL does include a subset of branded products that are preferred over the generic as applicable which can affect the generic utilization percentage. There are a variety of branded products covered by the state as defined on the weekly PDL document provided to the plans.
Humana Medical Plan	Humana's Non Formulary Exception process allows for brands to be covered if the drug is being prescribed for a compendia supported indication and the prescriber provides one of the following: - Provision of sound clinical rationale as to why the covered formulary bioequivalent would not be appropriate. - Provision of sound clinical rationale that supports failure of the covered formulary bioeqivalent and explains why the same effect would not occur with the brand. Humana's Plan Preferred Brand Non-Formulary Exception process allows generics to be covered if the drug is being prescribed for a compedia supported indication and the prescriber inidicates one of the following: -Member has a true allergy to the brand name product with patient specific rationale/documentation -Preferred brand is on backorder which is verified on credible website.
Molina Healthcare	A. The Molina Healthcare Inc National Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available. 1. Generic drugs with an "A" rating from the FDA are considered therapeutically equivalent to corresponding brand drugs. Generic Drugs are less costly than brand drugs and play a vital role in the clinical management of patients within a managed health care setting 2. FDA approved Orange Book "A" or "AB" rated generic drugs shall be dispensed by the pharmacist whenever available. 3. Providers are encouraged to write ''DAW" only when medically necessary. 4. The Pharmacy and Therapeutics Committee recognizes that certain medications possess narrow dose response characteristics. The following drugs are not recommended to be generically substituted: Tegretol, Carbatol, Lanoxin/Digitek, Synthroid/Levoxyl/Armour Thyroid, Dilantin, Sandimmune/ Neoral/Sangcya and Coumadin. 5. Members may request for a brand name medication. Such requested brand name medications are subject to the prior authorization process when: a. A therapeutically equivalent generic is available. b. The medication is not an NTI drug, and c. Not explicitly list on the Preferred Drug List as a covered medication
Simply Healthcare	The Florida Managed Medical Assistance (MMA) Program -policy addresses generic drug substitution practices which follow the Statewide Medicaid Managed Care-Managed Medical Assistance (SMMC-MMA) contract requirements with the Agency for the Healthcare Administration. The Managed Care Plan may make available generic drugs in a therapeutic category that is not on the Agency's Medicaid PDL, unless a brand-name drug containing the same active ingredient is on the Agency's Medicaid PDL. The Managed Care Plan shall make available those brand name drugs that are not on the

MCO Name	Generic Drug Substitution Policies Summary
	Agency's Medicaid PDL, when medically necessary, if the prescriber: 1.Writes in his/her own handwriting on the valid prescription that the "Brand Name is Medically Necessary" (pursuant to s. 465.025 F. S.:) and 2.Submits a completed "Multisource Drug and Miscellaneous Prior Authorization" form to the Managed Care Plan indicating that the enrollee has had an adverse reaction to a generic drug or has had, in the prescriber's medical opinion, better results when taking the brand-name drug. The plan may not pay for the generic version of a product if the Brand is preferred on the Agency's PDL.
Sunshine	Pursuant to s. 409.912(5) the Florida Agency for Health Care Administration (AHCA) administers the Medicaid prescribed drug program. The agency is also responsible for the review of drug options to ensure its PDL offers an array of choices for prescribers within each therapeutic class. Sunshine Health (SH), through its pharmacy benefit manager ,CVS/Caremark, makes available those drugs and dosage forms listed on the Agency's Medicaid PDL. SH may make available generic drugs in a therapeutic category that are not on the Agency's Medicaid PDL, unless a brand-name drug containing the same active ingredient is on the Agency's Medicaid PDL. If a physician/clinician provider feels a brand name drug is medically necessary, the physician/clinician can ask for a prior authorization (PA). The PDL is a small part of a broader formulary system that encompasses not only drug selection but also utilization management ("UM") tools such as prior authorizations ("PA"), step therapy ("ST"), quantity limits ("QL"), age limits ("AL") and generic substitution. To ensure that Centene Health Plans, Inc. and its affiliates and subsidiaries (collectively, "Centene" or the "Company") complies with state Medicaid regulations regarding PDLs, PA, ST, QL, AL, and generic substitution, Centene conforms its policies to reflect these regulations. To minimize cost, generic utilization shall be promoted by Centene. The FDA requires that generic drugs have the same quality, strength, purity and stability profile as their brand name counterparts. SH shall cover those brand name drugs not on the Agency's PDL, when medically necessary, if the prescriber: 1. Writes in his/her own handwriting on the valid prescription that the "Brand Name is Medically Necessary," (pursuant to s. 465.025, F.S.); and 2. Submits a completed "Multisource Drug and Miscellaneous Prior Authorization" form indicating that the member has an adverse reaction to a generic drug or has had, in the prescriber's medical opinion, better results when taking the brand-name drug. PROCEDURE: 1. The prescriber requests coverage for a specific, multi-source, brand name product by submitting a written or faxed request to the Centene Pharmacy Services Prior Authorization department. 2. The prescriber must write in his/her own handwriting "Brand Name is Medically Necessary" on the prescription. A pre-printed box or signature line is not accepted. 3. Centene Pharmacy Services PA team will review the request and respond to the prescriber within 24 hours. NOTE: In accordance with the Hernandez Settlement Agreement, SH will allow up to a 3 day supply if the situation is an emergency in the opinion of the on-site pharmacist, or the medication is an ongoing therapy, except ongoing therapy shall not serve as a reason for dispensing under this agreement if there are indications that the member already has the medication, or the rejection is due to an

MCO Name	Generic Drug Substitution Policies Summary
	error that could be corrected during that visit, or there are clinical issues that must be resolved prior to dispensing the medication, or the member is no longer eligible with SH. 4. Coverage will be granted for all requests showing that a patient is unable to take the generic version of a product. 5. Appeals of denials will be forwarded to the health plan for review and final determination will be made by the health plan pharmacist or medical director. If SH does not grant PA, we will notify member and physician/clinician provider and provide information regarding the appeal process.
United Healthcare	The purpose of the UnitedHealthcare Community Plan Generic Substitution Policy is to define the process of ensuring cost-effective generic drugs, or authorized brand alternatives (ABA) included in the preferred drug lists and covered by the pharmacy benefits of UnitedHealthcare Community Plan. The Florida Agency for Health Care Administration Pharmacy and Therapeutics committee determines which drugs are included in preferred drug lists and the PBM reviews the Medispan data base and generic pipeline report frequently to determine when generic drugs become available and if they are determined to be an authorized brand alternative (ABA) by the U.S. Food and Drug Administration. The Florida Agency for Health Care Administration reserves the right to implement a brand over generic strategy if, economically, the brand with a rebated discount is more cost effective than the generic equivalent. The PDL will define Brand over generic strategies and POS messaging will reflect this preference to direct pharmacy claims processing to the appropriate product. The PBM programs the point-of-sale (POS) system to reject multi-source brand drugs as non-preferred when equivalent generic drugs become available as directed by The Florida Agency for Health Care Administration. If the FDA identifies the equivalent generic drug as an ABA that does not lead to a corresponding multisource code (MSC) change, The Florida Agency for Health Care Administration will review the new product to identify if it provides an opportunity to manage towards a new lower cost alternative in the class. If identified as a lower cost opportunity, and directed by the Agency,UnitedHealthcare Community Plan will work with the PBM to adjust the coding to prefer national drug codes (NDC) of the ABA and reject the NDC of the brand name drugs as non-preferred. When adjudicated, the POS system reject claims for non-preferred multi-source brand drugs with a preferred ABA with a rejection message that indicates a generic substitution is required. If a prior authorization is in place for a non-preferred drug that has an ABA become available, UnitedHealthcare Community Plan will work with the PBM to update those authorizations to allow the new ABA NDC to process and subsequently remove the NDC for the brand product leading to a POS reject for processed claims with a rejection message indicating generic substitution is required as directed by The Florida Agency for Health Care Administration The Prescriber can request coverage of a multi-source brand product if it is not on the preferred drug list by contacting the Pharmacy Prior Authorization Team via fax, telephone, or electronic prior authorization. The prescriber must provide documentation explaining the reason for the brand drug, and the Pharmacy Prior Authorization Team processes the request in accordance with coverage review guidelines for non-preferred drugs.

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

Figure 41 - More Restrictive MCO Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

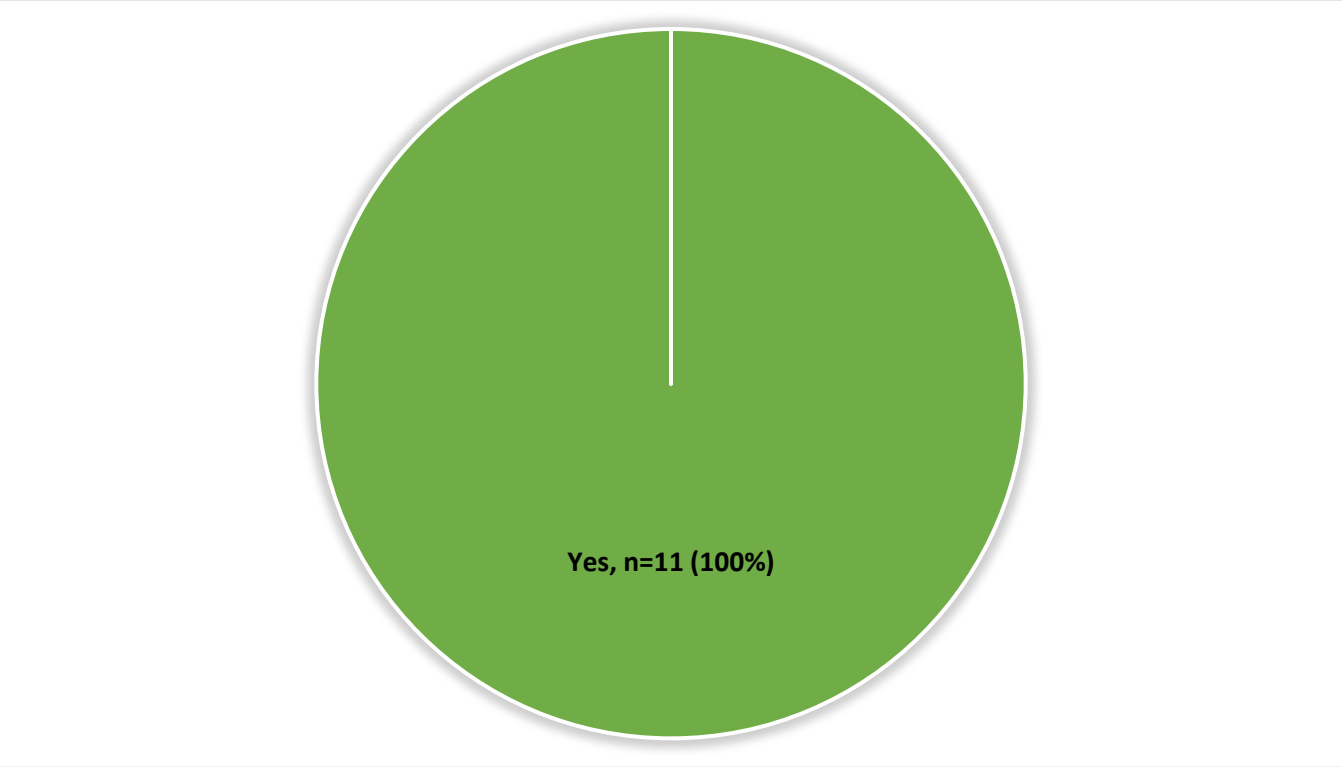


Table 60 - More Restrictive MCO Requirements than the Prescriber Writing in His Own Handwriting "Brand Medically Necessary" for a Brand Name Drug

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," check all that apply.

Figure 42 - Additional Restrictive MCO Requirements for Dispensing a Brand Name Drug

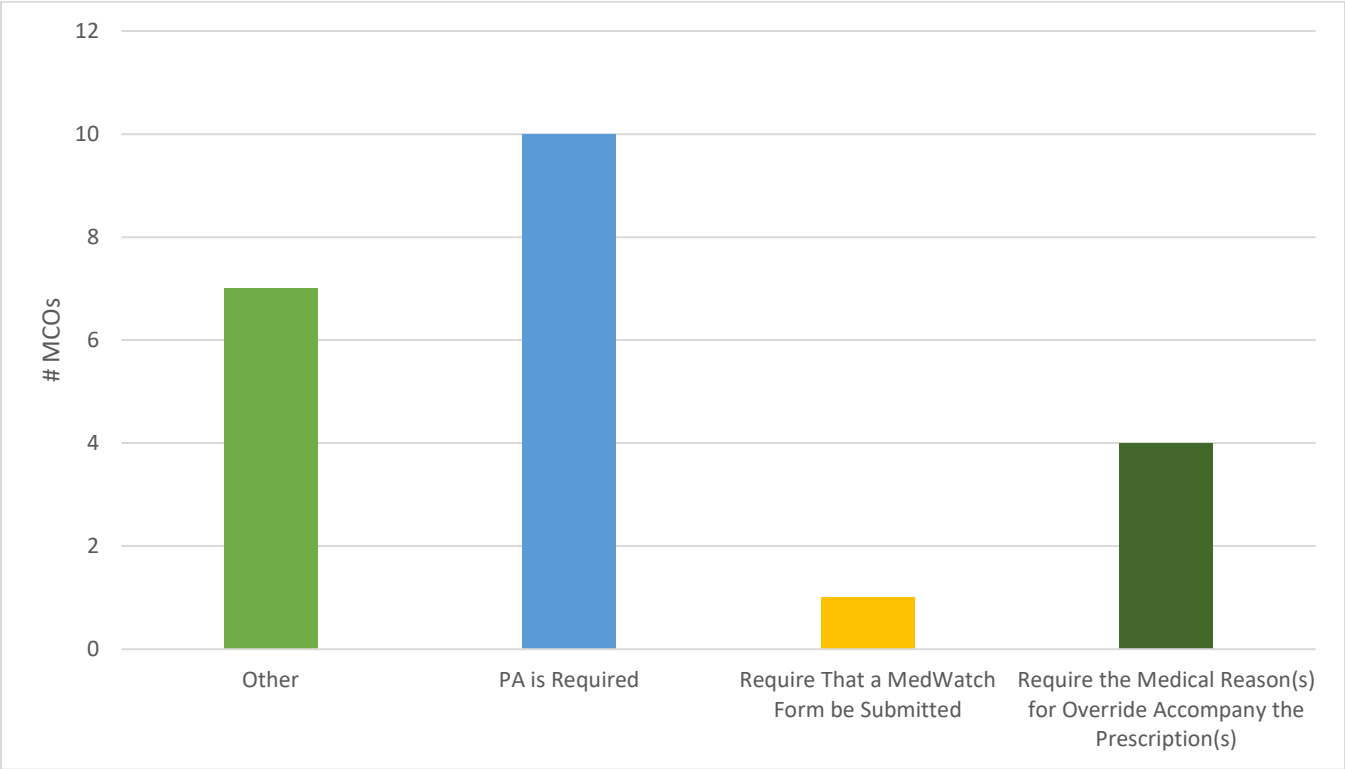


Table 61 - Additional Restrictive MCO Requirements for Dispensing a Brand Name Drug

Response	MCO Names	Count	Percentage
PA is required	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	45.45%
Require that a MedWatch Form be submitted	Aetna Better Health	1	4.55%
Require the medical reason(s) for override accompany the prescription(s)	Amerihealth Caritas Florida, Clear Health Alliance, Molina Healthcare, Simply Healthcare	4	18.18%
Other	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Humana Medical Plan, Molina Healthcare, Sunshine, United Healthcare	7	31.82%
State Totals		**22**	**100%**

If "Other," please explain.

Table 62 - "Other" Explanations for Additional Restrictive MCO Requirements for Dispensing a Brand Name Drug

MCO Name	Explanation
Aetna Better Health	If the requested brand product is one of the preferred brand products on the state Medicaid PDL, then no PA is required and the brand formulation of the drug must pay (the generic will deny at point of sale).

MCO Name	Explanation
Amerihealth Caritas Florida	Although PA is required, ACFL requirements for prior authorization may not be more restrictive than state guidelines.
Children's Medical Services	Prescriber must indicate "Brand Medically Necessary" on the prescription.
Humana Medical Plan	If generic only is covered and member and provider requests brand, they would go through our Non Formulary exception process.
Molina Healthcare	The decision to approve a brand name version will be evaluated on a case-by-case basis. The approval for brand version may be contingent upon prior trials of a maximum of two (2) available generically manufactured products and/or other generically available product within the same therapeutic class if appropriate. See previous explanation for generic drug substitution policies.
Sunshine	Prescriber must indicate "Brand Medically Necessary" on the prescription.
United Healthcare	Prior authorization is required for brand name drugs only if the brand name drugs are not preferred drugd in the preferred drug list (PDL) identified by the Florida Agency for Healthcare Administration

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.

Figure 43 - Total Single Source (S) Drug Claims by MCO

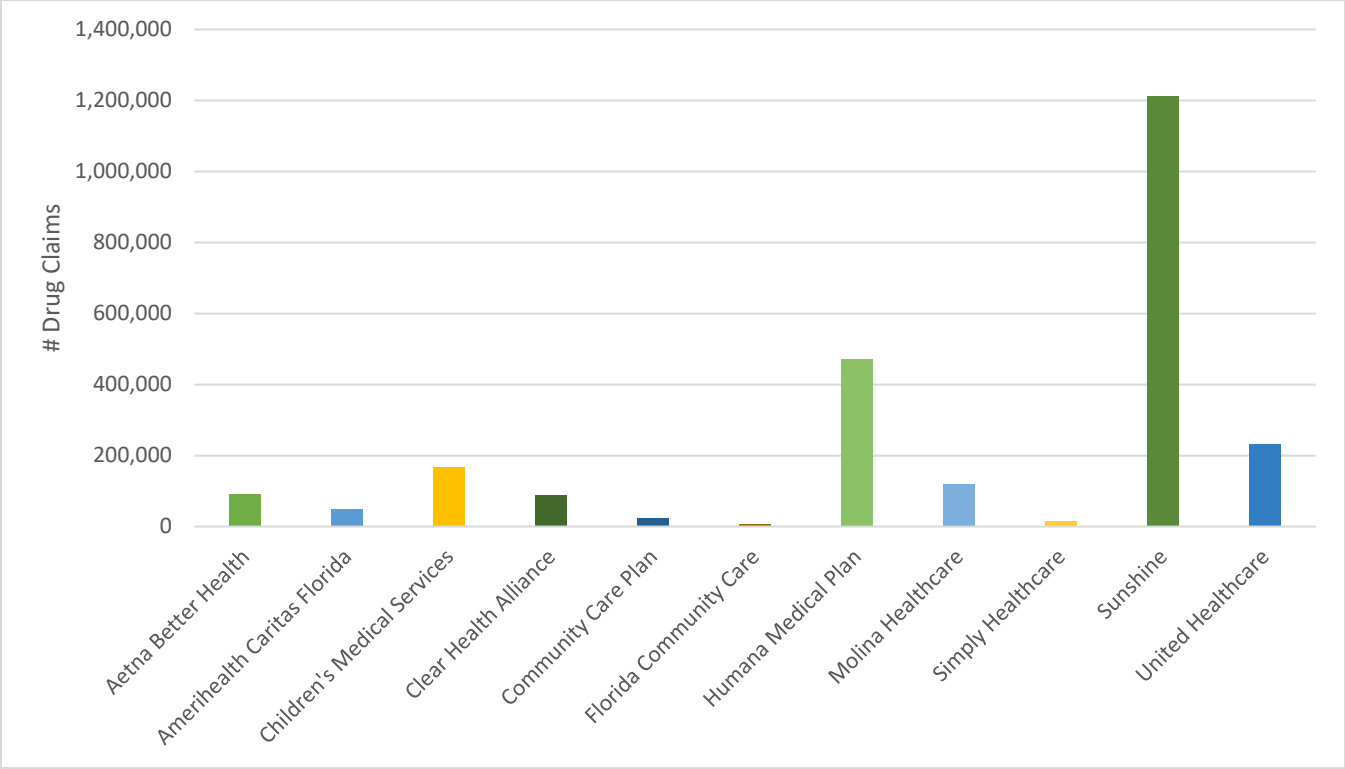


Figure 44 - Total Non-Innovator (N) Drug Claims by MCO

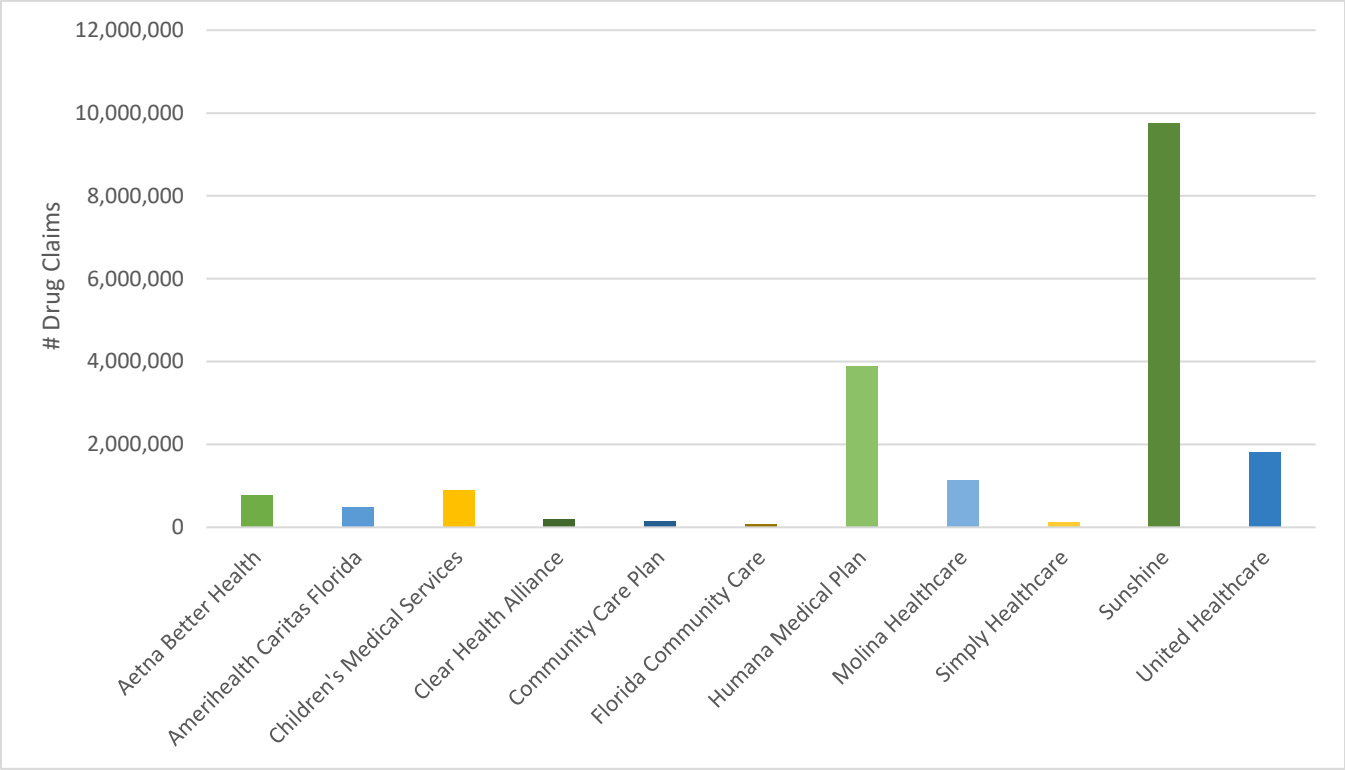


Figure 45 - Total Innovator Multi-Source (I) Drug Claims by MCO

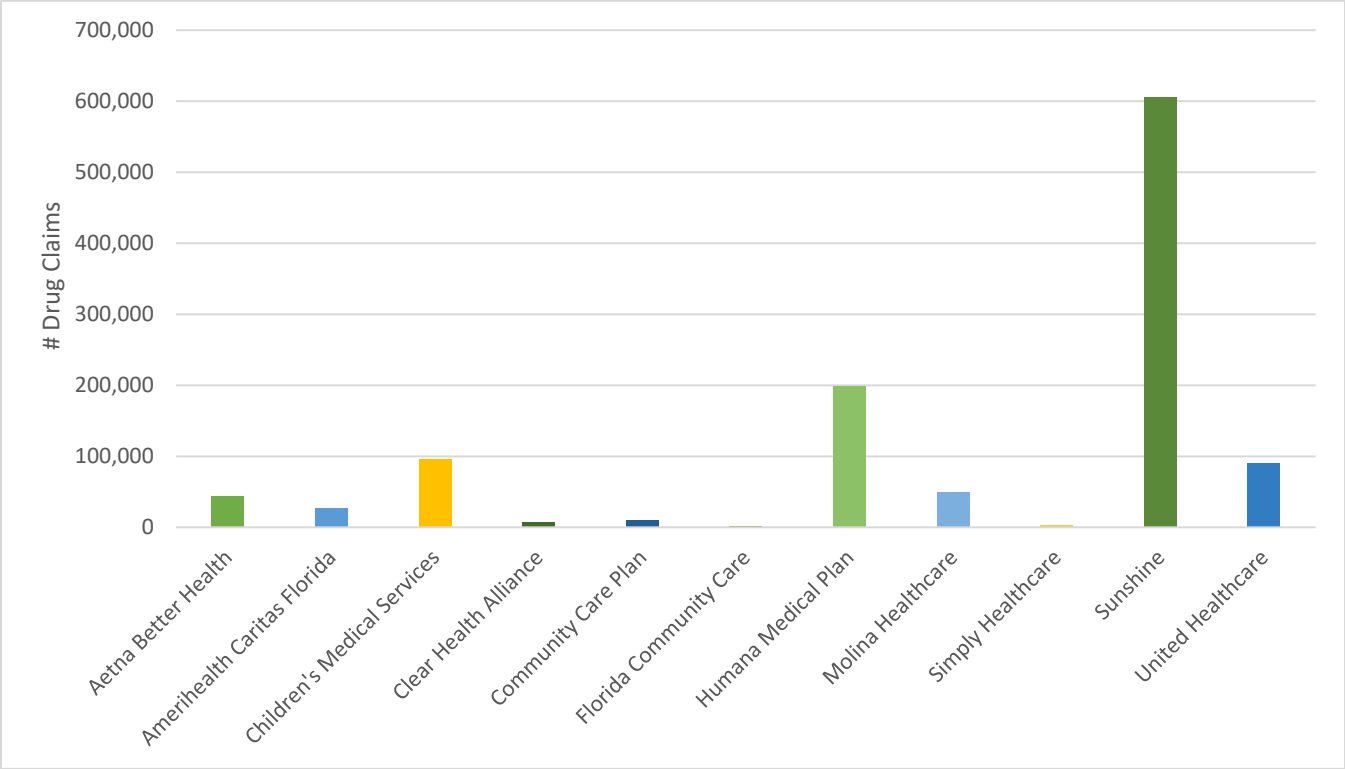


Table 63 - Generic Drug Utilization Data: Single Source Innovator(S), Innovator Multiple-Source (I), Non-Innovator Multiple-Source (N)

MCO Name	"S" Drug Claims	"N" Drug Claims	"I" Drug Claims
Aetna Better Health	92,489	779,025	43,319
Amerihealth Caritas Florida	50,548	490,437	26,509
Children's Medical Services	167,997	896,207	96,067
Clear Health Alliance	87,950	201,615	7,820
Community Care Plan	23,750	158,152	10,010
Florida Community Care	7,836	84,581	1,826
Humana Medical Plan	471,628	3,884,982	198,750
Molina Healthcare	120,794	1,136,851	48,800
Simply Healthcare	14,111	116,052	3,678
Sunshine	1,212,972	9,757,369	605,555
United Healthcare	231,210	1,820,669	90,004
State Totals	**2,481,285**	**19,325,940**	**1,132,338**

3. Indicate the generic utilization percentage for all CODs paid during this reporting period.

Figure 46 - Generic Utilization Percentage

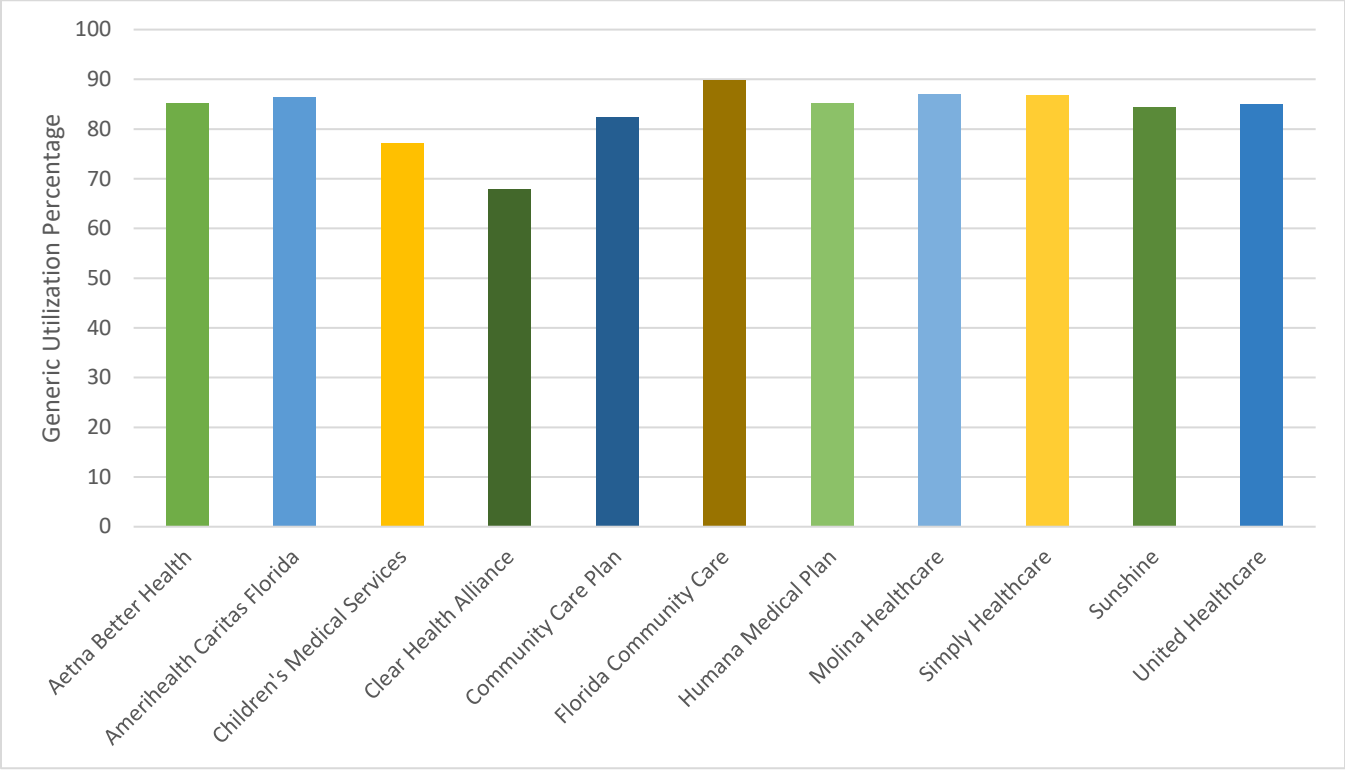


Table 64 - Generic Utilization Percentage

MCO Name	Generic Utilization Percentage
Aetna Better Health	85.15%
Amerihealth Caritas Florida	86.42%

MCO Name	Generic Utilization Percentage
Children's Medical Services	77.24%
Clear Health Alliance	67.80%
Community Care Plan	82.41%
Florida Community Care	89.75%
Humana Medical Plan	85.28%
Molina Healthcare	87.02%
Simply Healthcare	86.71%
Sunshine	84.29%
United Healthcare	85.00%
State Average	**83.37%**

4. How many innovator drugs are the preferred product instead of their multi-source counterpart based on net pricing (i.e. brand name drug is preferred over equivalent generic product on the PDL)?

Figure 47 - Innovator Drugs That Are The Preferred Product Instead Of Their Multi-Source Counterpart Based On Net Pricing

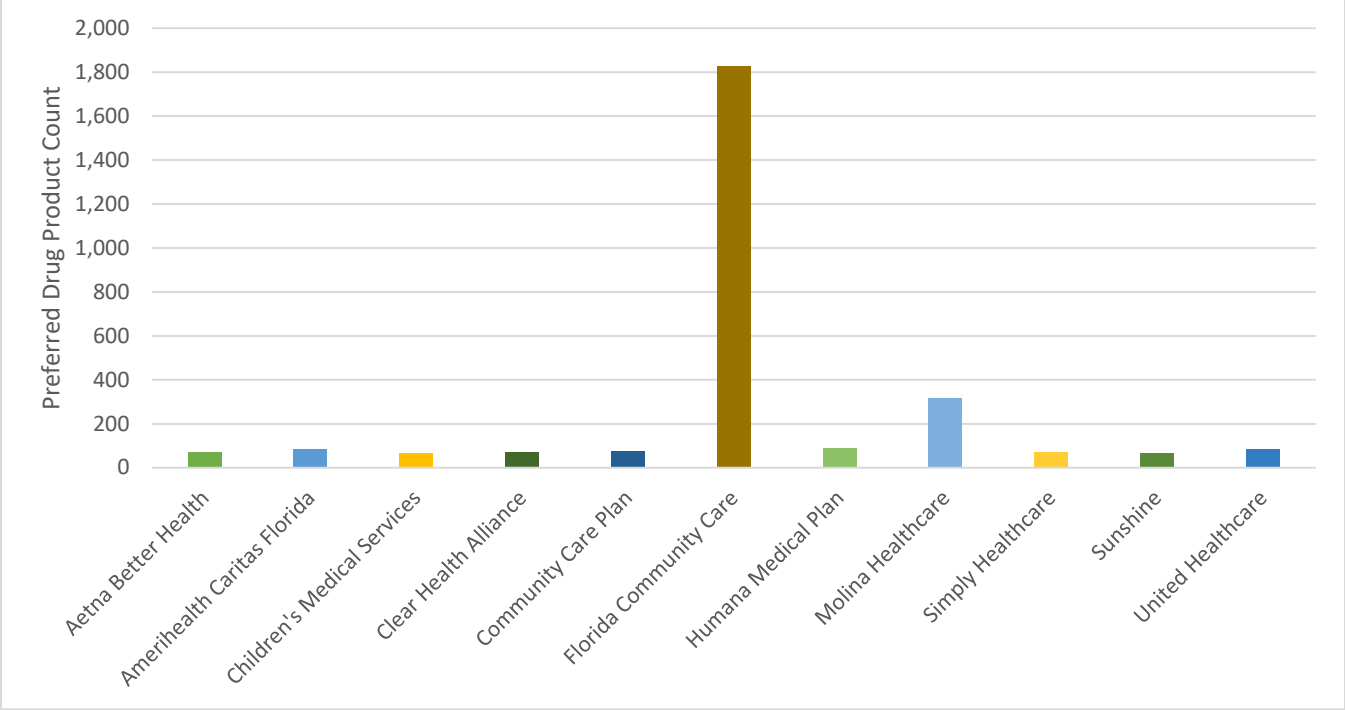


Table 65 - Innovator Drugs That Are The Preferred Product Instead Of Their Multi-Source Counterpart Based On Net Pricing

MCO Name	Preferred Drug Product Count
Aetna Better Health	69
Amerihealth Caritas Florida	83
Children's Medical Services	68
Clear Health Alliance	69

MCO Name	Preferred Drug Product Count
Community Care Plan	73
Florida Community Care	1,826
Humana Medical Plan	89
Molina Healthcare	318
Simply Healthcare	69
Sunshine	68
United Healthcare	83

5. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period.

Figure 48 - Percentage Dollars Paid for Generic CODs

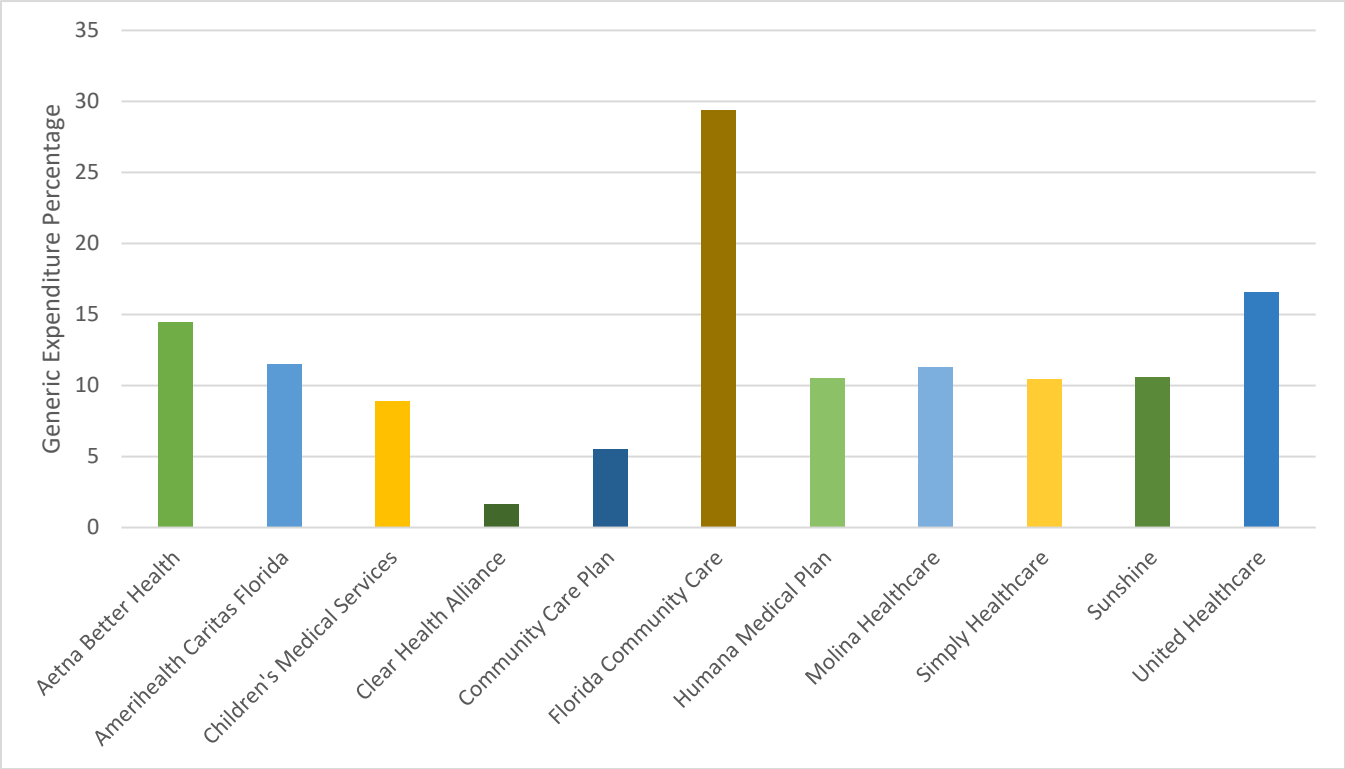


Table 66 - Percentage Dollars Paid for Generic CODs

MCO Name	Generic Expenditure Percentage
Aetna Better Health	14.47%
Amerihealth Caritas Florida	11.54%
Children's Medical Services	8.93%
Clear Health Alliance	1.64%
Community Care Plan	5.55%
Florida Community Care	29.40%
Humana Medical Plan	10.55%
Molina Healthcare	11.31%

MCO Name	Generic Expenditure Percentage
Simply Healthcare	10.44%
Sunshine	10.61%
United Healthcare	16.60%
State Average	**11.91%**

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

Table 67 - Explanations for MCO Policies Related to Biosimilars

MCO Name	Explanations
Aetna Better Health	No specific policy. Each biosimilar is reviewed at time of its approval and/or market availability for possible PDL inclusion in much the same way a new generic for a tradition medication is evaluated.
Amerihealth Caritas Florida	No. Since ACFL formulary is based on the AHCA state PDL no such policies have been developed.
Children's Medical Services	The MCO does not have any policies related to Biosimilars. Biosimilars are monitored and evaluated for PDL inclusion by MCO as they become available.
Clear Health Alliance	We follow agency criteria for biosimilar coverage, if there is no agency directive, we cover biosimilar agents in the same manner as the reference product. The biosimilar agents are specifically called out in the clinical criteria. Biosimilar agents are at parity with the reference agents with regard to allowed indications.
Community Care Plan	Community Care Plan has a biosimilars policy. Certain biosimilars that have been shown to be effective substitutes for the brand drugs have been identified as preferred products. These products are currently drugs like Neupogen and Neulasta. The PBM sends the PA request to CCP clinical pharmacist to review for appropriate indication for substitution. The pharmacist will contact the providers office by phone to request biosimilar substitution. As new biosimilars come into the marketplace CCP tracks them with the assistance of the PBM to determine if product should be added to the list.
Florida Community Care	There is no policy currently for biosimilars developed by AHCA.
Humana Medical Plan	There aren't any specific Biosimilar policies. Biosimilar reviews would follow other processes for review such as the Non Formulary Exception process and the process for reviewing policies that AHCA creates.
Molina Healthcare	A biosimilar is highly similar version of a brand name biological drug that meets strict controls for structural, pharmaceutical, and clinical consistency. A biosimilar manufacturer must demonstrate that there are no meaningful clinical differences (i.e., safety and efficacy) between the biosimilar and the reference product. Clinical performance is demonstrated through human pharmacokinetic (exposure) and pharmacodynamic (response) studies, an assessment of clinical immunogenicity, and, if needed, additional clinical studies. As costs for biological specialty drugs continue to rise, the growing biosimilar market will benefit providers and patients by broadening biological treatment options and expanding access to these medications at lower costs.

MCO Name	Explanations
	Molina Healthcare, Inc. continues to be committed to continually reevaluating preferred strategies and applying innovative cost-controls to ensure patients receive safe, effective, and quality healthcare. This commitment includes potentially creating a preference for biosimilars when value can be added without compromising Member satisfaction and safety.
Simply Healthcare	We follow agency criteria for biosimilar coverage, if there is no agency directive, we cover biosimilar agents in the same manner as the reference product. The biosimilar agents are specifically called out in the clinical criteria. Biosimilar agents are at parity with the reference agents with regard to allowed indications.
Sunshine	The MCO does not have any policies related to Biosimilars. Biosimilars are monitored and evaluated for PDL inclusion by MCO as they become available.
United Healthcare	UnitedHealcare Communite Plan aligns policies according to state guidance related to biosimilar coverage. Biosimilars are defined by State of Florida Agency for Healthcare Administration via the preferred drug list (where covered) prior authroization or fee schedule as defined by the State of Florida.

7. Does your Medicaid program provide coverage of over-the-counter medications when prescribed by an authorized prescriber?

Figure 49 - Medicaid Program Providing Coverage of Over-the-Counter Medications When Prescribed by an Authorized Prescriber

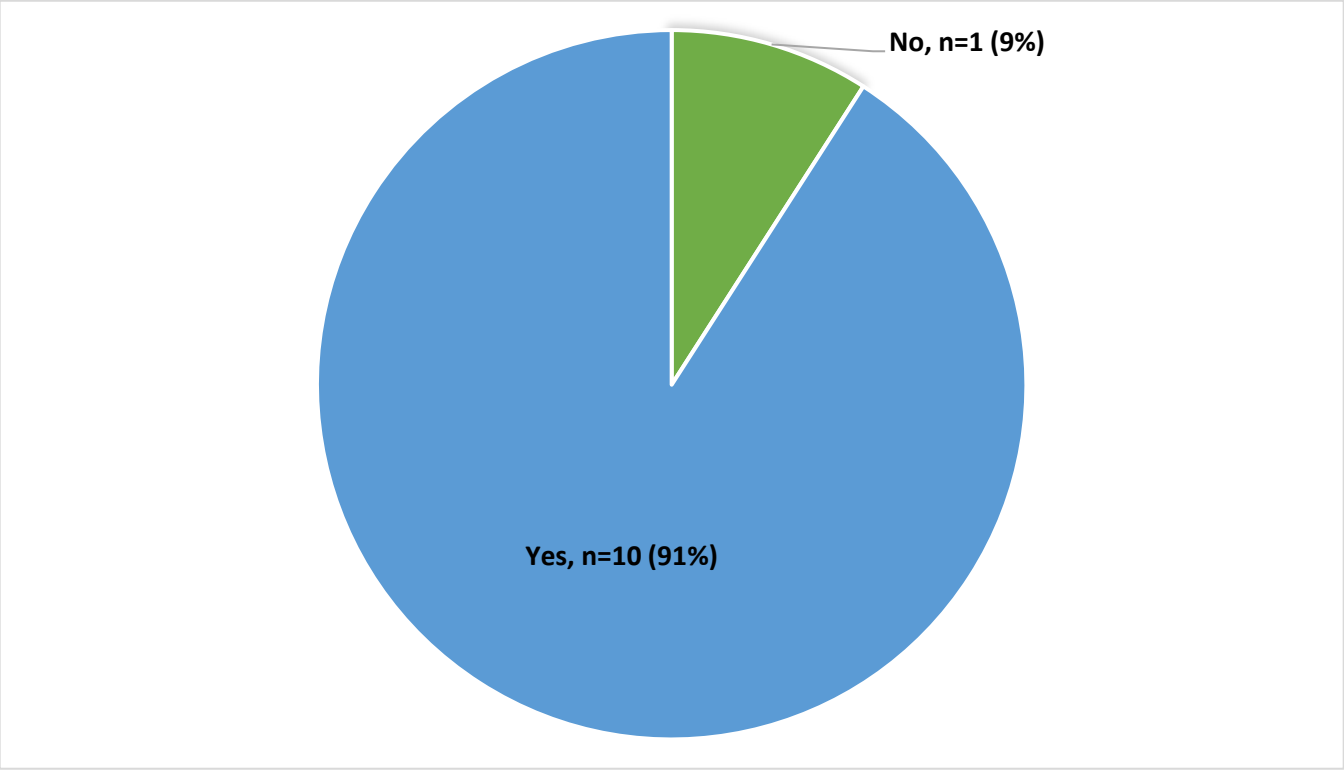


Table 68 - Medicaid Program Providing Coverage of Over-the-Counter Medications When Prescribed by an Authorized Prescriber

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Florida Community	10	90.91%

Response	MCO Names	Count	Percentage
	Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare		
No	Community Care Plan	1	9.09%
State Totals		**11**	**100%**

If "No," please explain why not.

Table 69 - Explanations for Medicaid Program Not Providing Coverage of Over-the-Counter Medications When Prescribed by an Authorized Prescriber

MCO Name	Explanations
Community Care Plan	OTC medications that are on the PDL are payable at the pharmacy via prescription. If the medication is not on the PDL it will not pay. CCP is working on providing OTC benefits for members.

Section VII - Fraud, Waste and Abuse Detection (FWA)

A. Lock-in or Patient Review and Restriction Programs

1. Does your MCO have a documented process in place that identifies potential FWA of controlled drugs by beneficiaries?

Figure 50 - Documented Process in Place to Identify Potential FWA of Controlled Drugs by Beneficiaries

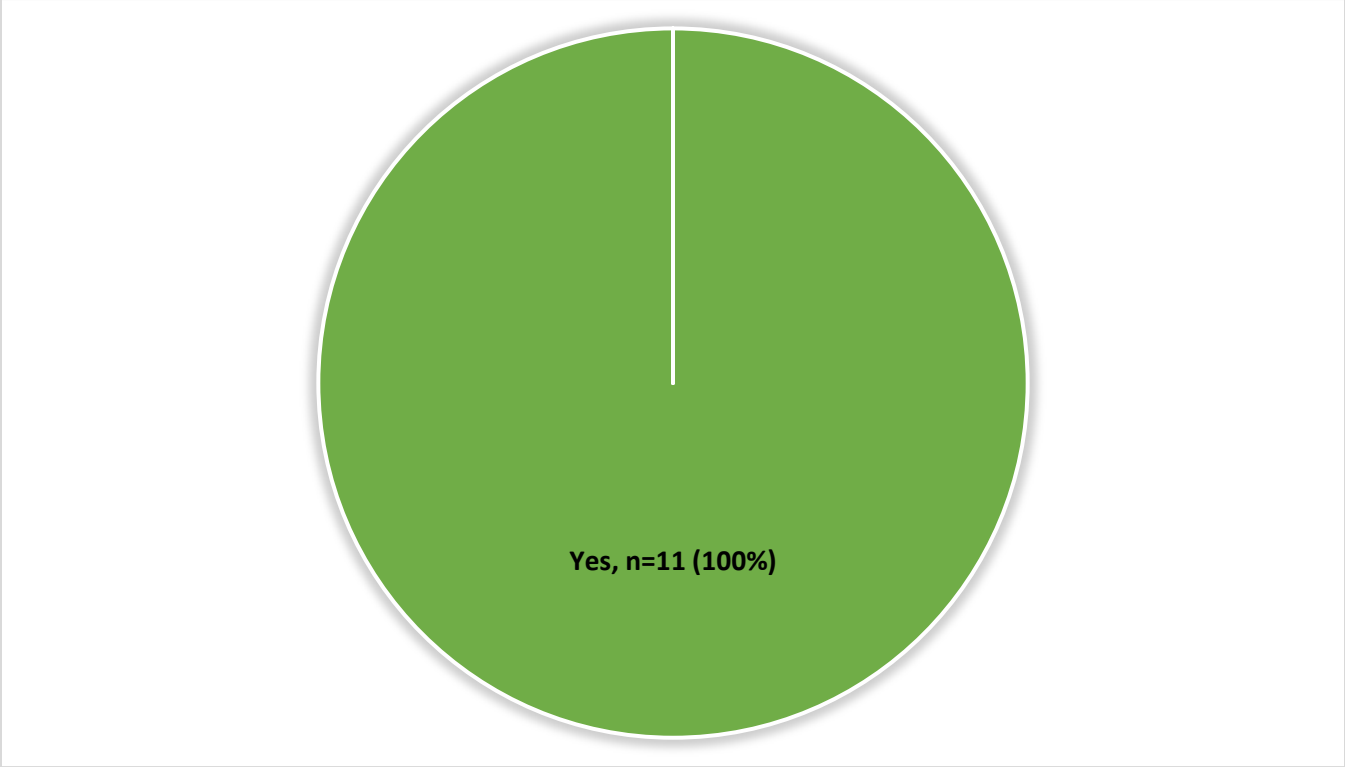


Table 70 - Documented Process in Place to Identify Potential FWA of Controlled Drugs by Beneficiaries

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," what actions does this process initiate (multiple responses allowed)?

Figure 51 - Actions Process Initiates when Potential FWA of Controlled Drugs by Beneficiaries is Detected

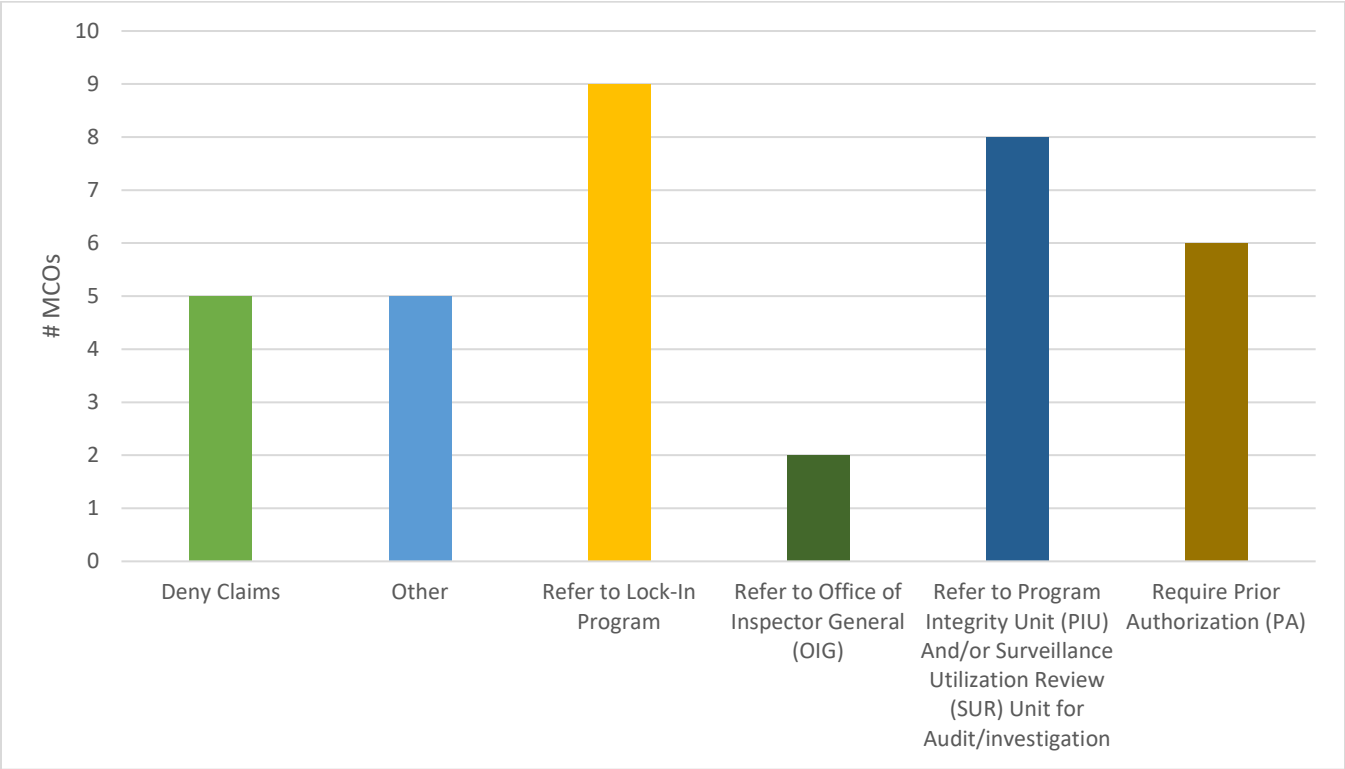


Table 71 - Actions Process Initiates when Potential FWA of Controlled Drugs by Beneficiaries is Detected

Response	MCO Names	Count	Percentage
Deny claims	Aetna Better Health, Clear Health Alliance, Community Care Plan, Florida Community Care, Simply Healthcare	5	14.29%
Refer to Lock-In Program	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	25.71%
Refer to Office of Inspector General (OIG)	Aetna Better Health, United Healthcare	2	5.71%
Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Florida Community Care, Simply Healthcare, Sunshine, United Healthcare	8	22.86%
Require prior authorization (PA)	Aetna Better Health, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare	6	17.14%
Other	Amerihealth Caritas Florida, Community Care Plan, Humana Medical Plan, Molina Healthcare, United Healthcare	5	14.29%
State Totals		**35**	**100%**

If “Other,” please explain.

Table 72 - Explanations for “Other” Actions Process Initiates when Potential FWA of Controlled Drugs by Beneficiaries is Detected

MCO Name	Explanation
Amerihealth Caritas Florida	Our Program Integrity's Special Investigation Unit submits referrals on suspected FWA to the Agency for Health Care Administration Medicaid Program Integrity. For credible allegations of fraud, referrals are sent to the Office of Attorney General Medicaid Fraud Control Unit. Additional referrals may also be submitted to internal Quality Management Department and DEA.
Community Care Plan	The pharmacy audits are conducted by the PBM. The pharmacy audit program consists of claim check reviews, desktop and onsite audits. Through predictive analytics and a number of proprietary and customized rule sets, Conduent's FWA Detection System will identify, and report claims discrepancies. Some of the criteria include but not be limited to: claims volume, DAW submissions, incorrect prescriber submissions, incorrect day supply, max dose limits, controlled substance utilization. The audit process includes extensive monitoring and auditing of provider usage and claims to help identify and eliminate pharmacy billing errors, ensure pharmacy compliance with regulatory and contractual requirements, and to identify opportunities for additional controls and education.
Humana Medical Plan	Abuse- those that meet criteria are reviewed for the lock in program. If fraud is suspected a referral would also be sent over to Special Investigations Unit department.
Molina Healthcare	The Safety and Monitoring Solutions Program by CVS Caremark identifies members of who utilize multiple pharmacies, prescribers, and hospitals for controlled substances. The cases are sent to Molina after prescriber communication is deemed ineffective. Molina clinical team reviews and determines if lock-in is necessary.
United Healthcare	Beneficiary may be referred to the state medicaid agency or law enforcement if the Refer to Program Integrity Unit case warrants the referral

2. Does your MCO have a lock-in program for beneficiaries with potential FWA of controlled substances?

Figure 52 - Lock-In Program

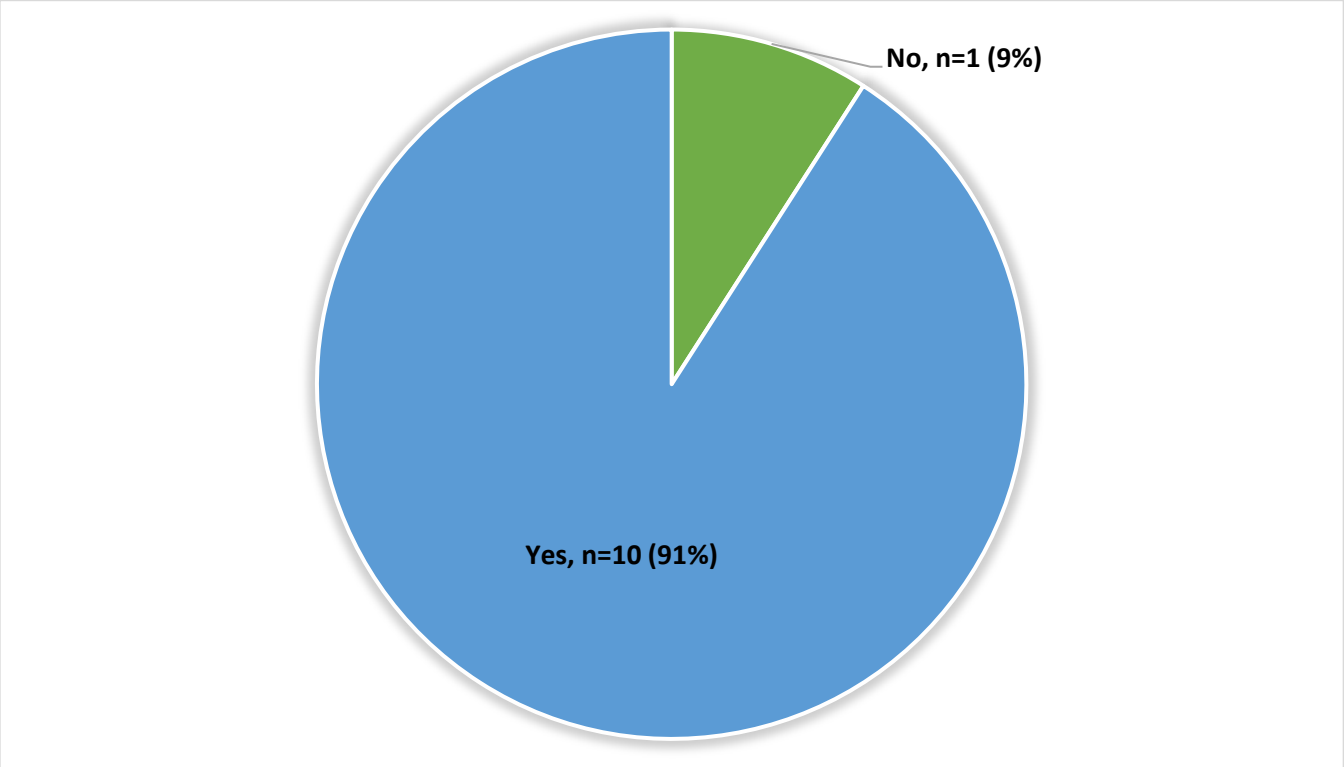


Table 73 - Lock-In Program

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Children's Medical Services	1	9.09%
State Totals		**11**	**100%**

a. If "Yes," what criteria does your MCO use to identify candidates for lock-in (multiple responses allowed)?

Figure 53 - Lock-In Program Candidate Identification Criteria

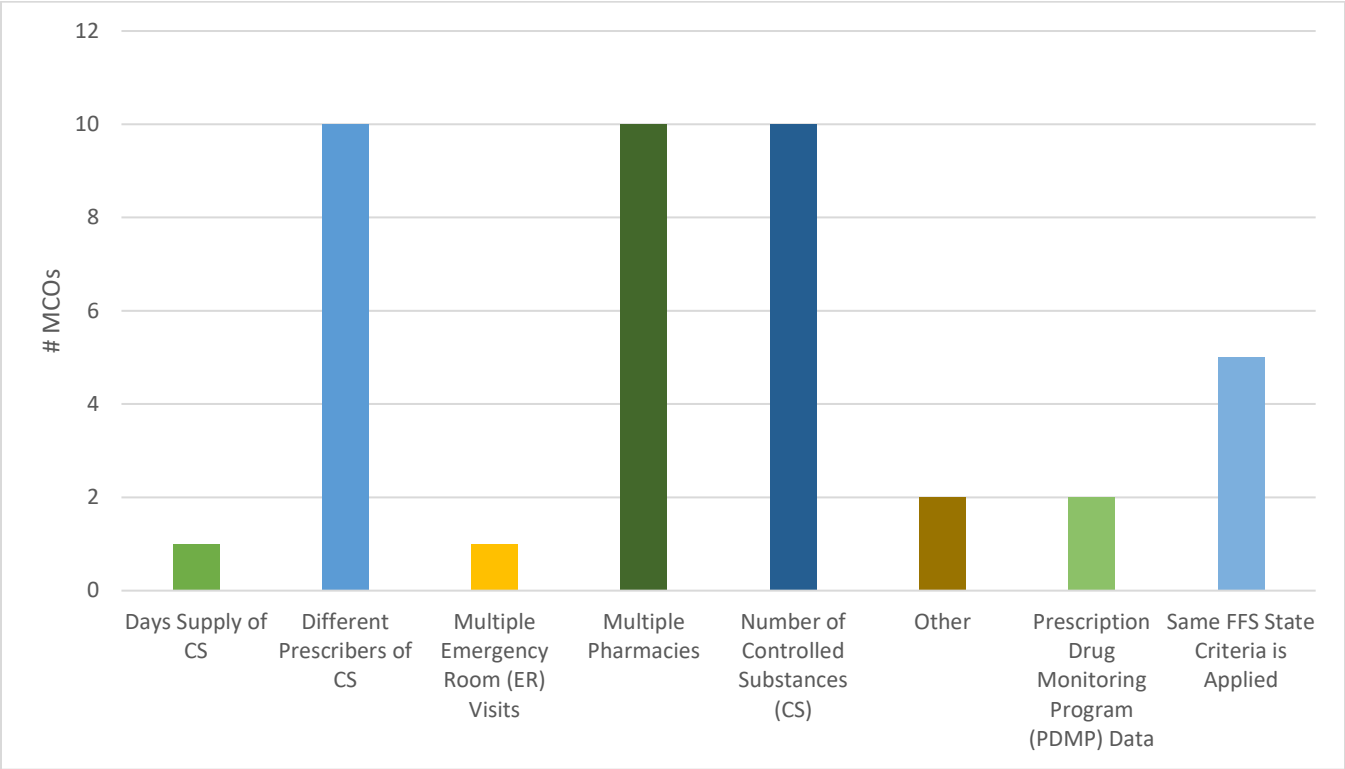


Table 74 - Lock-In Program Candidate Identification Criteria

Response	MCO Names	Count	Percentage
Days supply of CS	Amerihealth Caritas Florida	1	2.44%
Different prescribers of CS	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	24.39%
Multiple emergency room (ER) visits	Aetna Better Health	1	2.44%
Multiple pharmacies	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	24.39%
Number of controlled substances (CS)	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	24.39%
Prescription Drug Monitoring Program (PDMP) data	Amerihealth Caritas Florida, Florida Community Care	2	4.88%
Same FFS State criteria is applied	Aetna Better Health, Florida Community Care, Molina Healthcare, Sunshine, United Healthcare	5	12.20%
Other	Humana Medical Plan, United Healthcare	2	4.88%
State Totals		**41**	**100%**

If "Other," please explain.

Table 75 - "Other" Explanations for Lock-In Program Candidate Identification Criteria

MCO Name	Explanation
Humana Medical Plan	The MCO will also review dx. history for Drug Abuse or Overdose within the last 365 days to determine need for lock in.
United Healthcare	Additional information as identified by the State of FL Agency for Healthcare Administration- inclusive of known fraud or emergency room visits for narcotic poisoning or overdose

b. If "Yes," does your MCO have the capability to restrict the beneficiary to:

i. Prescriber only

Figure 54 - Prescriber Only Restriction Capability

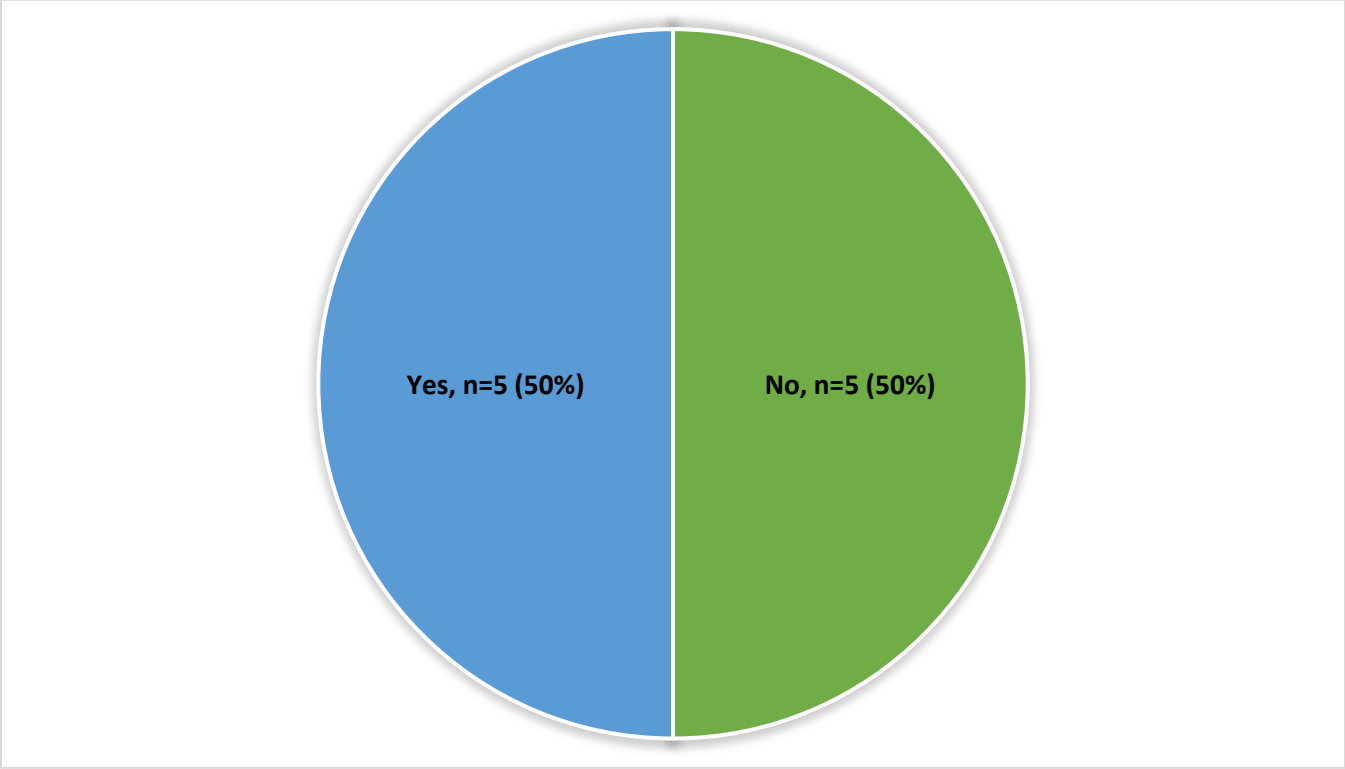


Table 76 - Prescriber Only Restriction Capability

Response	MCO Names	Count	Percentage
Yes	Clear Health Alliance, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	5	50.00%
No	Aetna Better Health, Amerihealth Caritas Florida, Community Care Plan, Florida Community Care, Molina Healthcare	5	50.00%
State Totals		**10**	**100%**

ii. Pharmacy only

Figure 55 - Pharmacy Only Restriction Capability

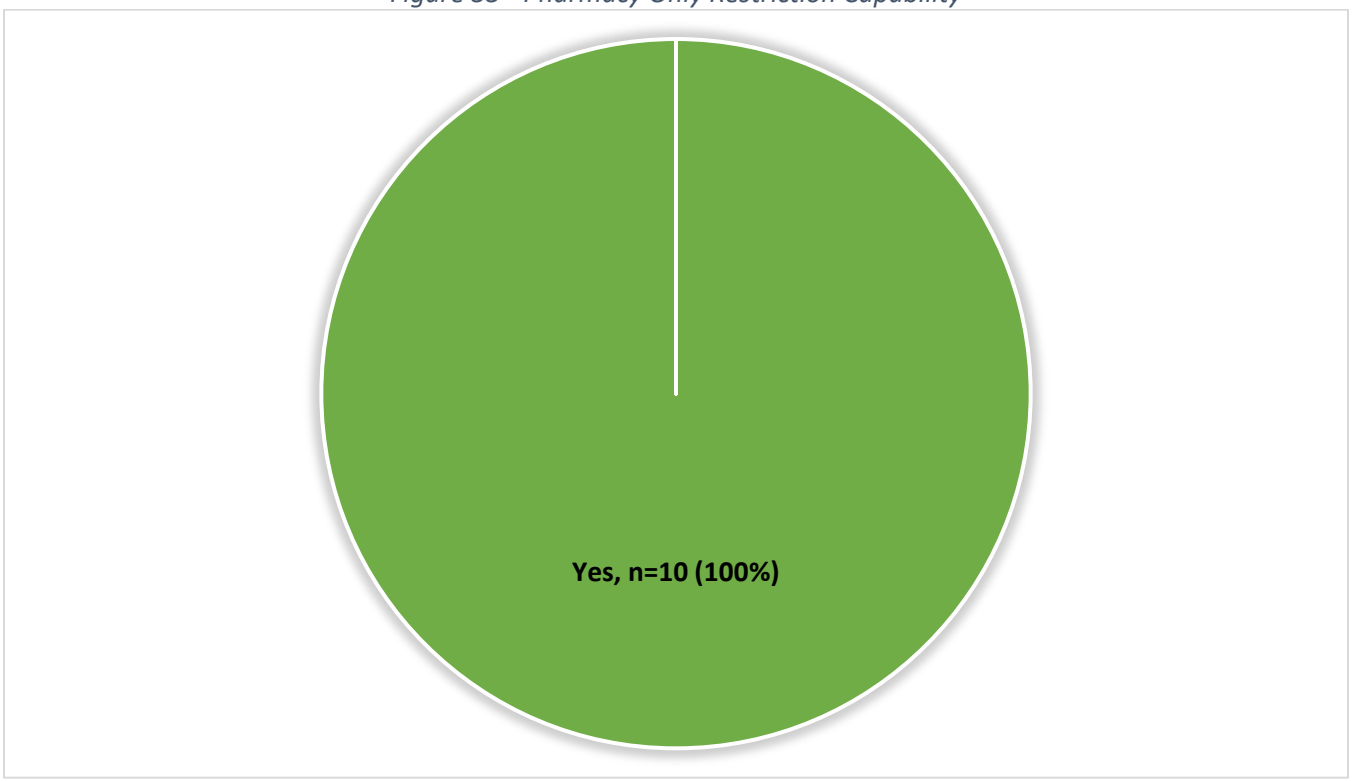


Table 77 - Pharmacy Only Restriction Capability

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	100.00%
State Totals		**10**	**100%**

iii. Prescriber and Pharmacy

Figure 56 - Prescriber and Pharmacy Restriction Capability

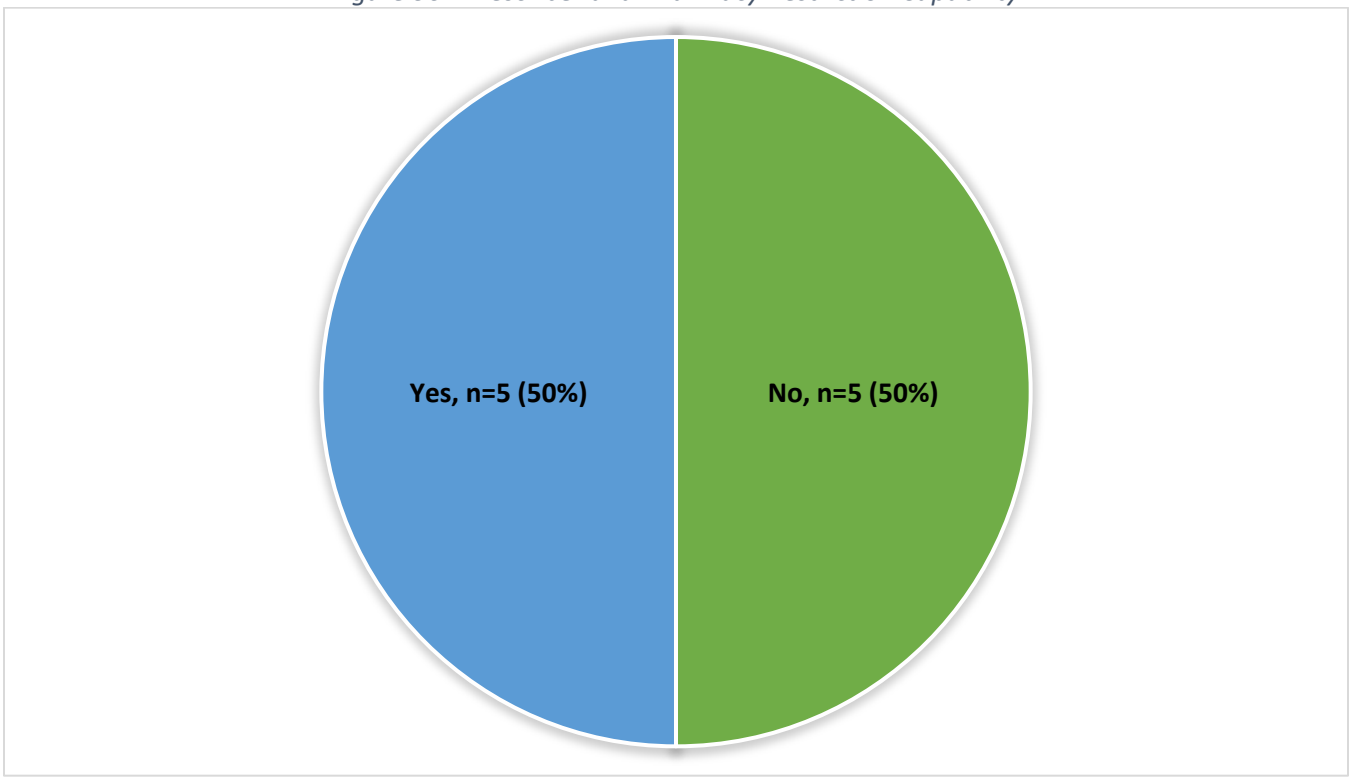


Table 78 - Prescriber and Pharmacy Restriction Capability

Response	MCO Names	Count	Percentage
Yes	Clear Health Alliance, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	5	50.00%
No	Aetna Better Health, Amerihealth Caritas Florida, Community Care Plan, Florida Community Care, Molina Healthcare	5	50.00%
State Totals		**10**	**100%**

c. If "Yes," what is the usual lock-in time period?

Figure 57 - Lock-In Time Period

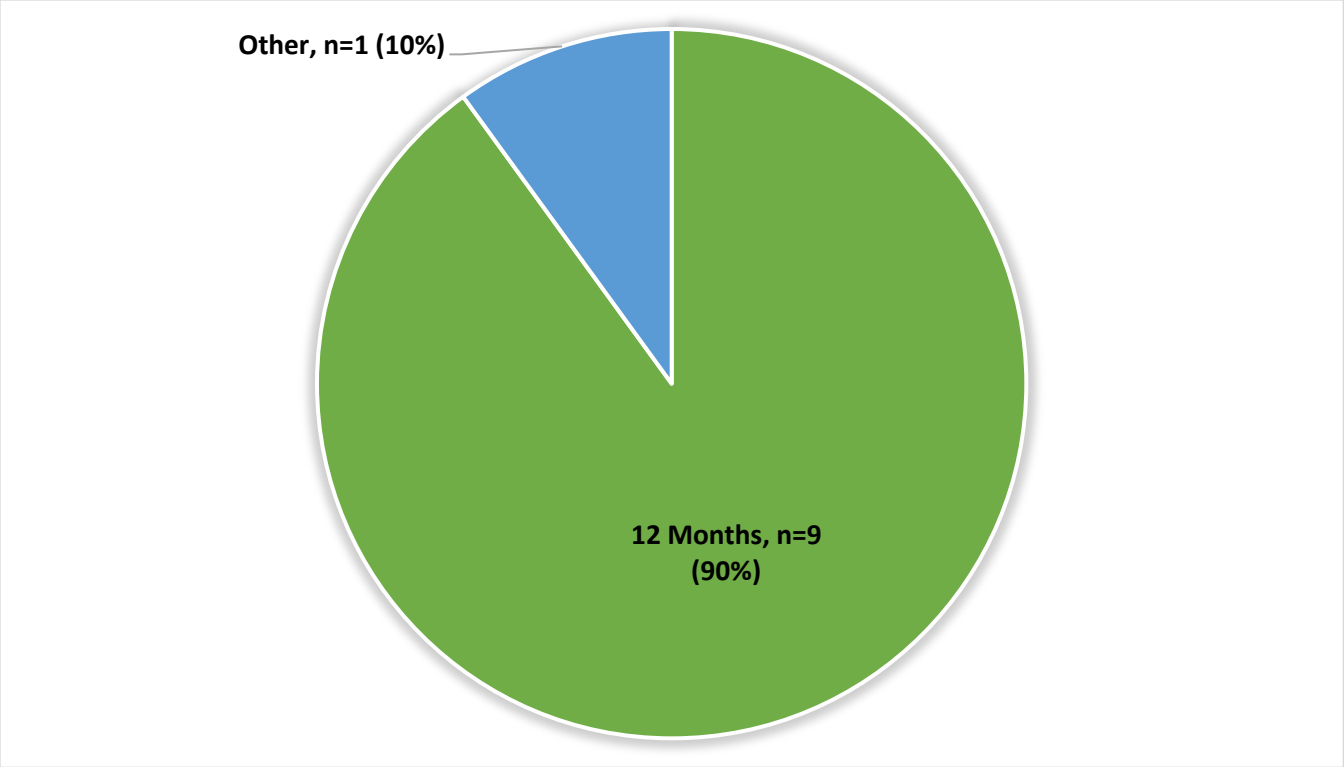


Table 79 - Lock-In Time Period

Response	MCO Names	Count	Percentage
12 months	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	90.00%
Other	Humana Medical Plan	1	10.00%
State Totals		**10**	**100%**

If "Other," please explain.

Table 80 - "Other" Explanations for Lock-In Time Period

MCO Name	Explanation
Humana Medical Plan	Pharmacy Lock-In time period is 12 months. Currently, the Prescriber Lock-In capability has not been approved by the state, therefore, is not utilized.

d. If "Yes," on average, what percentage of your Medicaid MCO population is in lock-in status annually?

Figure 58 - Percentage of Medicaid MCO Population in Lock-In Status Annually

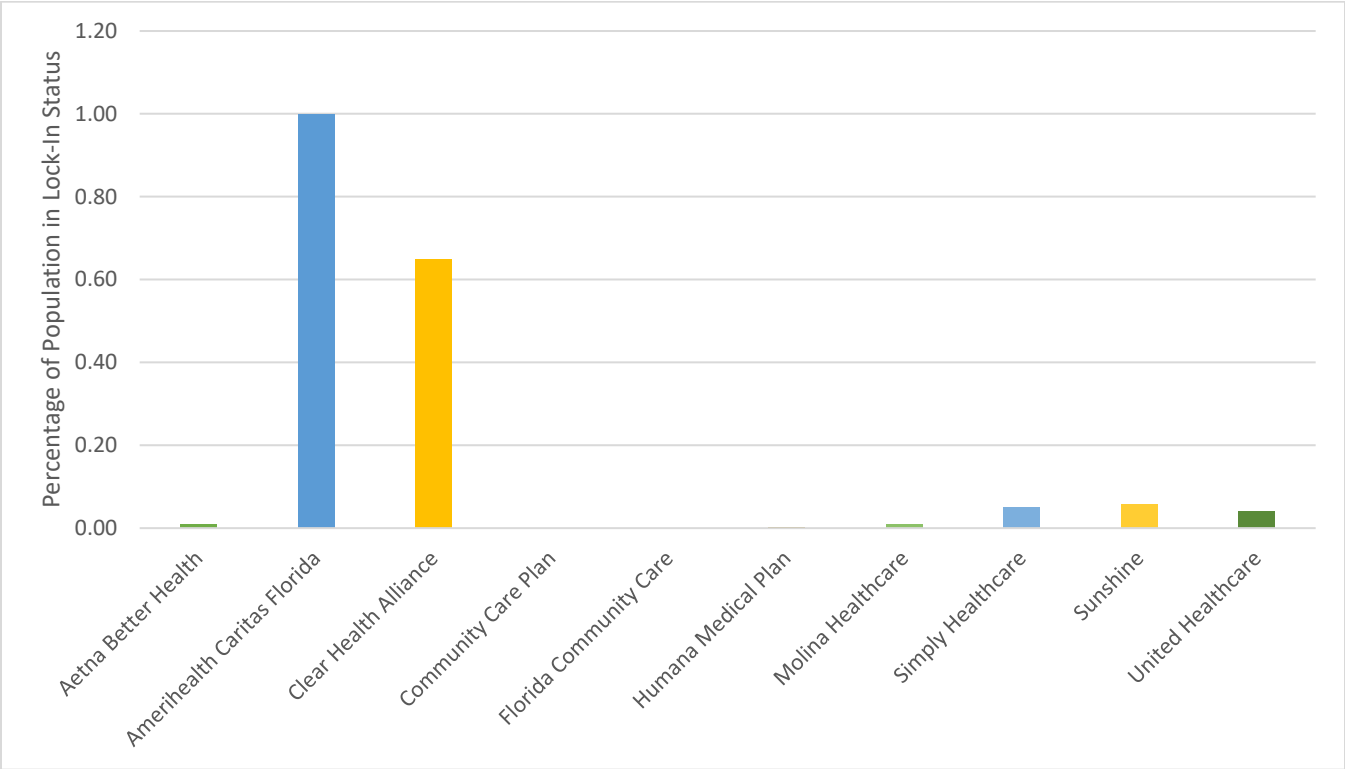


Table 81 - Percentage of Medicaid MCO Population in Lock-In Status Annually

MCO Name	Percentage
Aetna Better Health	0.01%
Amerihealth Caritas Florida	1%
Clear Health Alliance	0.65%
Community Care Plan	0%
Florida Community Care	0%
Humana Medical Plan	0%
Molina Healthcare	0.01%
Simply Healthcare	0.05%
Sunshine	0.06%
United Healthcare	0.04%

e. If "Yes," please provide an estimate of the savings attributed to the lock-in program for the fiscal year under review.

Figure 59 - Estimate of Savings Attributed to the Lock-In Program for the Fiscal Year Under Review

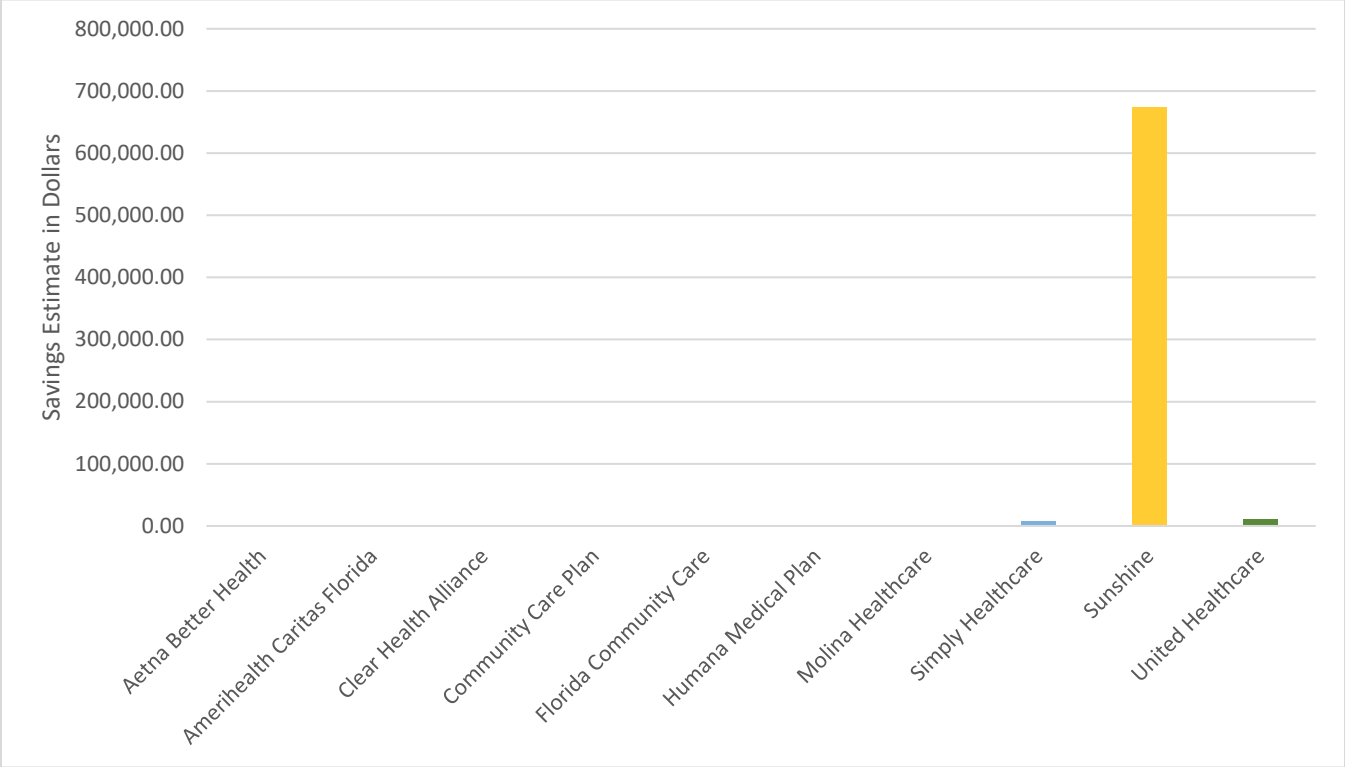


Table 82 - Estimate of Savings Attributed to the Lock-In Program for the Fiscal Year Under Review

MCO Name	Savings Estimate
Aetna Better Health	$0.00
Amerihealth Caritas Florida	$0.00
Clear Health Alliance	$0.00
Community Care Plan	$0.00
Florida Community Care	$0.00
Humana Medical Plan	$0.00
Molina Healthcare	$1.00
Simply Healthcare	$6,905.00
Sunshine	$674,040.00
United Healthcare	$10,080.00

3. Does your MCO have a documented process in place that identifies potential FWA of controlled drugs by prescribers?

Figure 60 - Documented Process to Identify Potential FWA of Controlled Drugs by Prescribers

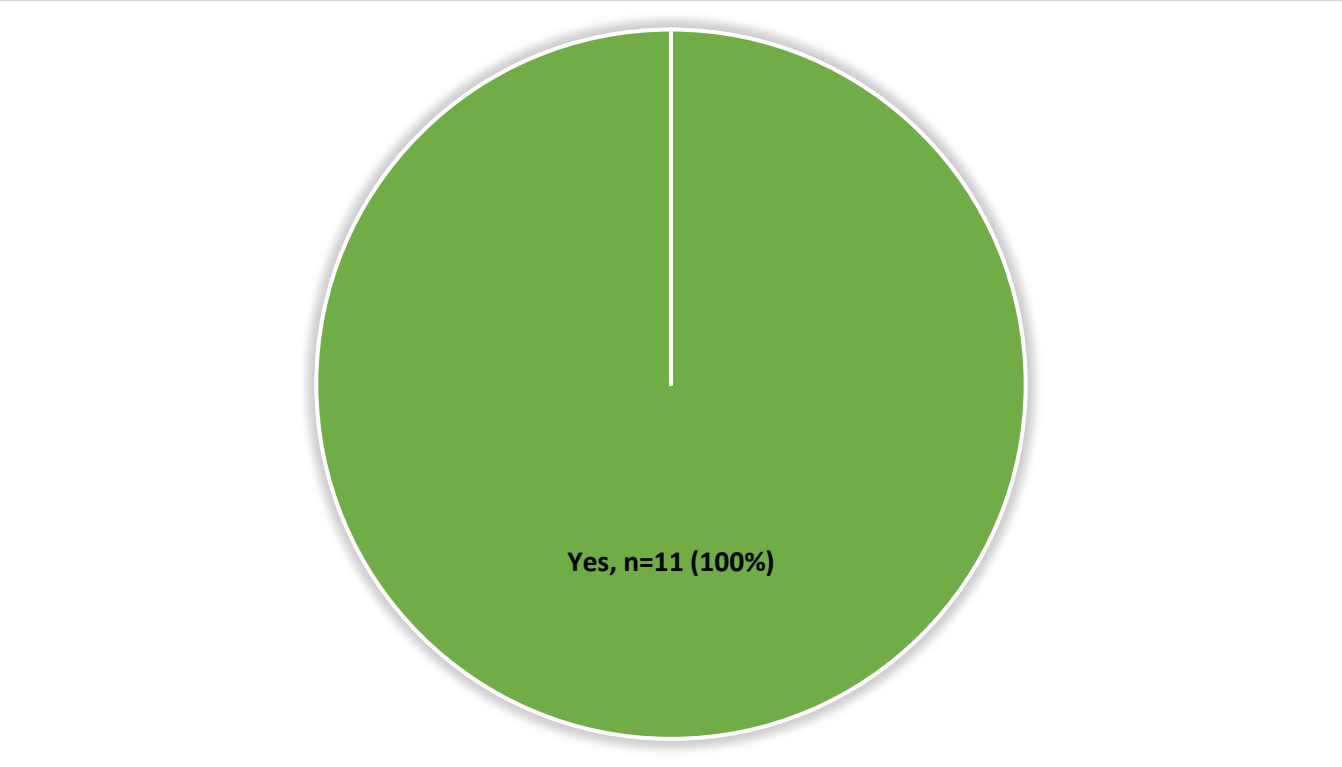


Table 83 - Documented Process to Identify Potential FWA of Controlled Drugs by Prescribers

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," what actions does this process initiate (multiple responses allowed)?

Figure 61 - Actions Process Initiates when Potential FWA of Controlled Drugs by Prescribers is Detected

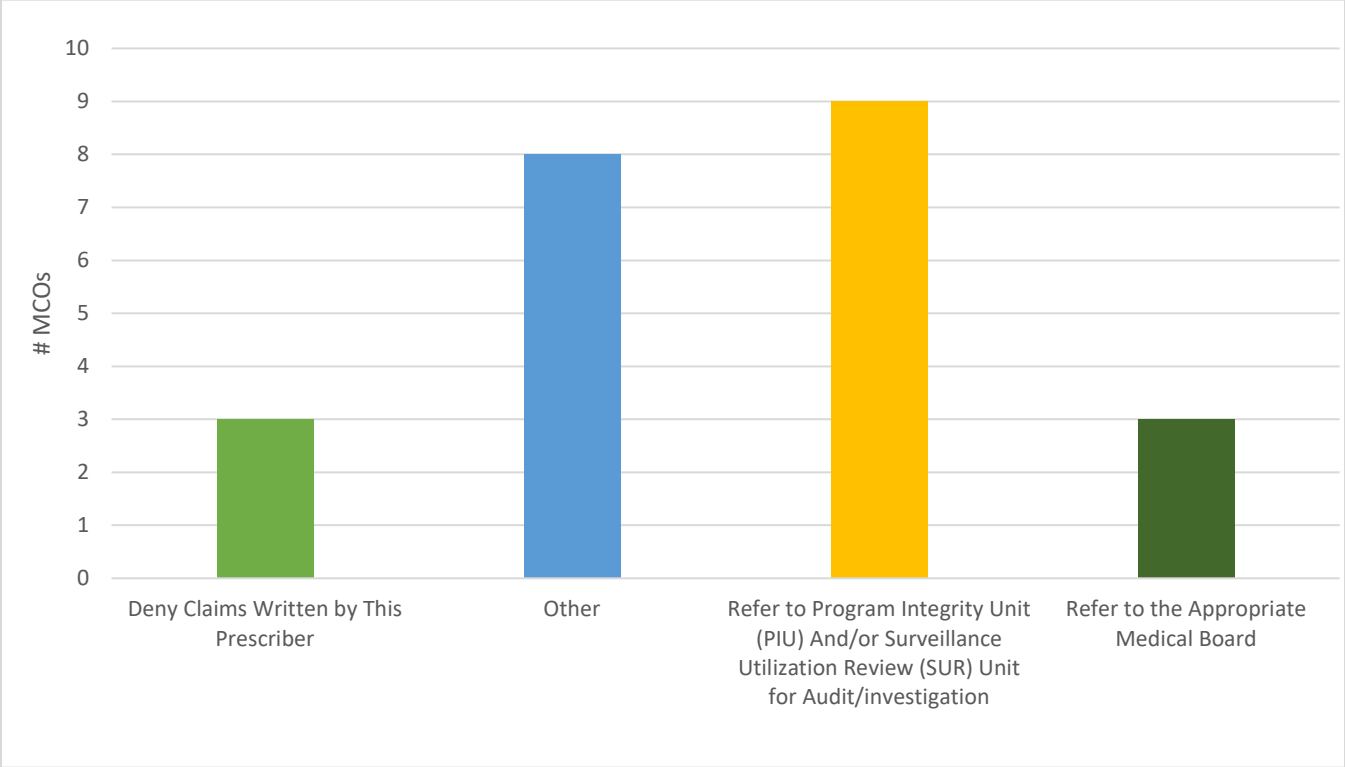


Table 84 - Actions Process Initiates when Potential FWA of Controlled Drugs by Prescribers is Detected

Response	MCO Names	Count	Percentage
Deny claims written by this prescriber	Aetna Better Health, Community Care Plan, Simply Healthcare	3	13.04%
Refer to Program Integrity Unit (PIU) and/or Surveillance Utilization Review (SUR) Unit for audit/investigation	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Simply Healthcare, Sunshine, United Healthcare	9	39.13%
Refer to the appropriate Medical Board	Aetna Better Health, Amerihealth Caritas Florida, United Healthcare	3	13.04%
Other	Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Sunshine	8	34.78%
State Totals		**23**	**100%**

If "Other," please explain.

Table 85 - "Other" Explanations for Action Initiated by Documented Process to Identify Potential FWA of Controlled Drugs by Prescribers

MCO Name	Explanation
Amerihealth Caritas Florida	Our Program Integrity's Special Investigation Unit submits referrals on suspected FWA to the Agency for Health Care Administration Medicaid Program Integrity. For credible

MCO Name	Explanation
	allegations of fraud, referrals are sent to the Office of Attorney General Medicaid Fraud Control Unit. Additional referrals may also be submitted to internal Quality Management Department and DEA.
Children's Medical Services	Other- The plan will have claims denied written by a prescriber if the prescriber is an excluded provider on the state's list and/or on the Office of Investigator General (OIG) exclusion list. The Plan may terminate a contracted prescriber if fraud or abuse of controlled drugs is identified and confirmed. The Plan is evaluates the implementation of prescriber blocks on pharmacy claims when fraud or abuse is identified and confirmed by a non-participating provider. Centene's FWA team in combination with CVS and Centene's Special Investigations Unit (SIU) team work to identify fraudulent providers and initiate appropriate investigations and resulting actions. The Plan implements pre-pay edits on the medical side (which may indirectly affect medication utilization).
Clear Health Alliance	Our PBM performs audits on retail pharmacies looking for issues with claim submissions such as patients getting multiple fills of same medication with different dose. Faxes are sent to prescribers when questionable scenarios arise and in most cases, the prescriber denies approving multiple fills. Prescriber notices are sent if the audit finds any potential fraud or abuse and further action may be taken; including, referral of situations of potential fraud or abuse to our Special Investigative team for further review/action. Upon receipt of referrals, the Special Investigation team opens and completes a comprehensive investigation and makes required referrals to the applicable State if potential fraud or abuse is identified. In addition, any prescribers on a sanctioned/excluded provider list will not have any claims adjudicated and will deny at the point of service.
Community Care Plan	The CCP Compliance & SIU (CSIU) team receive information from various sources regarding suspected FWA activities. The CSIU team will open an investigation and review all available data collected within and outside of CCP. Based on the CSIU team investigation they will follow directives from the State Agencies policies and procedures for reporting FWA activities. The Compliance & SIU team communicate directly with the PBM on cases where prescribers or pharmacies may be under investigation for FWA activities. PBM's are directed to deny prescriber activities or are out on notice that provider is under investigation.
Florida Community Care	CVS Caremark performs audits on retail pharmacies looking for issues with claim submissions such as patients getting multiple fills of same med with different dose. Faxes are sent to prescribers when questionable scenarios arise and in most cases the prescriber denies approving multiple fills. CVS Caremark will send notices if the audit finds any potential Fraud or Abuse and further action may be taken. In addition to this review, FCC conducts pharmacy claims review with pharmacy and FWA/SIU representation to identify potential fraud or abuse of controlled drugs by high-risk prescribers.
Humana Medical Plan	Refer to Special Investigations Unit for further review.
Molina Healthcare	CVS Caremark performs audits on retail pharmacies looking for issues with claim submissions such as patients getting multiple fills of same med with different dose. Faxes are sent to prescribers when questionable scenarios arise and in most cases the prescriber denies approving multiple fills. CVS Caremark will send notices if the audit finds any potential Fraud or Abuse and further action may be taken.
Sunshine	Sunshine Health Plan will have claims denied written by a prescriber if the prescriber is an excluded provider on the state's list and/or on the Office of Investigator General (OIG) exclusion list. The Plan may terminate a contracted prescriber if fraud or abuse of controlled drugs is identified and confirmed. The Plan is evaluates the implementation of

MCO Name	Explanation
	prescriber blocks on pharmacy claims when fraud or abuse is identified and confirmed by a non-participating provider. Centene's FWA team in combination with CVS and Centene's Special Investigations Unit (SIU) team work to identify fraudulent providers and initiate appropriate investigations and resulting actions. The Plan implements pre-pay edits on the medical side (which may indirectly affect medication utilization).

4. Does your MCO have a documented process in place that identifies potential FWA of controlled drugs by pharmacy providers?

Figure 62 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

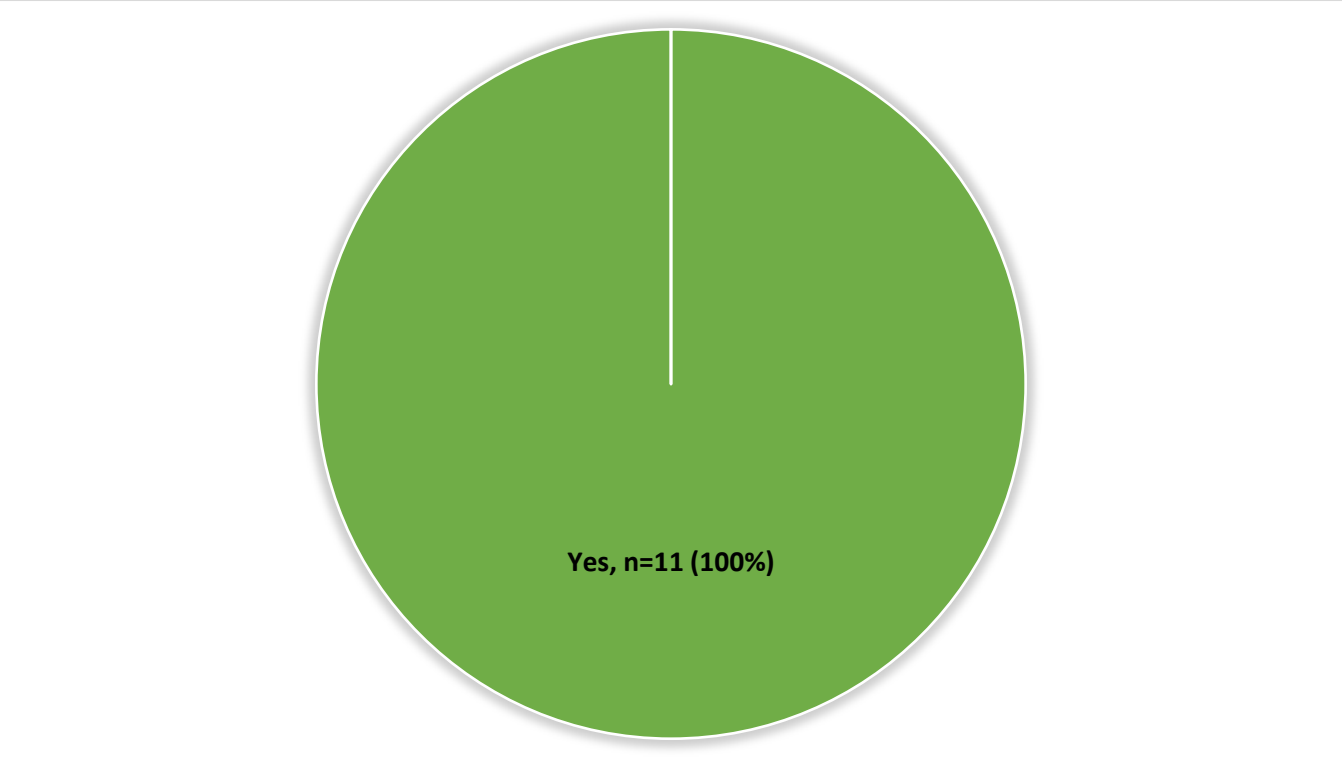


Table 86 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," what actions does this process initiate (multiple responses allowed)?

Figure 63 - Actions when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

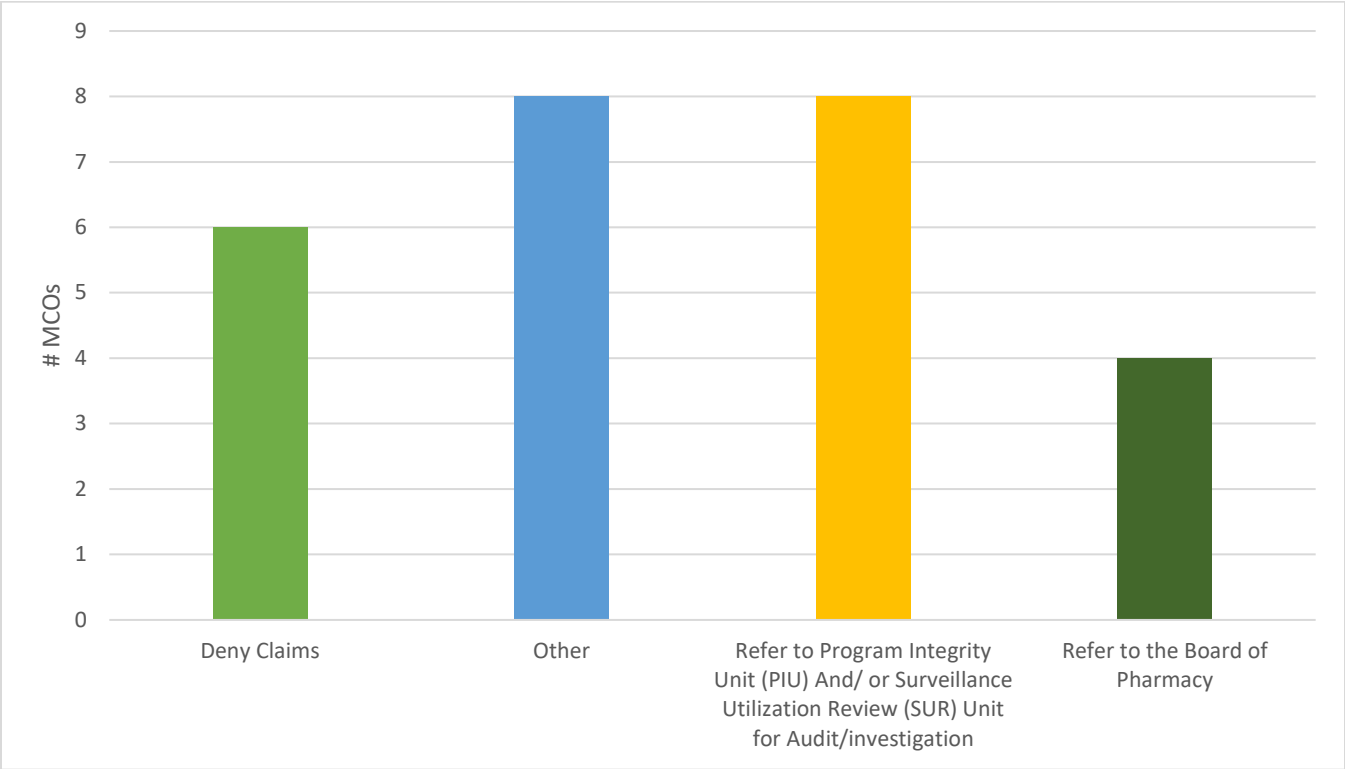


Table 87 - Actions when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

Response	MCO Names	Count	Percentage
Deny claims	Children's Medical Services, Clear Health Alliance, Community Care Plan, Simply Healthcare, Sunshine, United Healthcare	6	23.08%
Refer to Program Integrity Unit (PIU) and/ or Surveillance Utilization Review (SUR) Unit for audit/investigation	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Florida Community Care, Simply Healthcare, Sunshine, United Healthcare	8	30.77%
Refer to the Board of Pharmacy	Amerihealth Caritas Florida, Children's Medical Services, Sunshine, United Healthcare	4	15.38%
Other	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Sunshine	8	30.77%
State Totals		**26**	**100%**

If "Other," please explain.

Table 88 - "Other" Explanations when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

MCO Name	Explanation
Aetna Better Health	Pharmacy providers/network are delegated to our affiliate CVS Caremark who has responsibility of monitoring pharmacies for FWA activities. CVS Caremark provides to Aetna a weekly tracking log of investigative audits where Aetna has exposure. These are

MCO Name	Explanation
	jointly reviewed with the opportunity for SIU to open a case/investigation as needed. The primary method for identifying fraud as well as waste and abuse is through reviewing Aetna claims monthly for FWA trends, meeting with Aetna SIU and other Aetna resources monthly to review findings. Audit team looks at current outliers or drugs subject to FWA billing (examples: high volumes of controlled substances, lidocaine ointment, topicals, etc.) As plans address these drugs, we look for the next trend, using their FWA reports, reviewing for outlier pharmacies, outlier reporting etc. Identifying FWA and reporting to Aetna SIU is an ongoing function. Auditors are in place to identify suspect claims which can be escalate on an ad hoc basis.
Amerihealth Caritas Florida	Our Program Integrity's Special Investigation Unit submits referrals on suspected FWA to the Agency for Health Care Administration Medicaid Program Integrity. For credible allegations of fraud, referrals are sent to the Office of Attorney General Medicaid Fraud Control Unit. Additional referrals may also be submitted to internal Quality Management Department and DEA.
Children's Medical Services	The Plan may initiate an onsite and/or an investigative audit. The Plan may place a pharmacy on payment suspension, which would deny payment of claims but continue to allow claims to adjudicate while the pharmacy undergoes an investigative audit. The Plan may place a pharmacy on adjudication suspension, which would prevent claims from processing while the pharmacy undergoes an investigative audit. The Plan will deny claims processed by a pharmacy if the pharmacy is required to be excluded per the FL AHCA monthly or quarterly Ineligible Provider Reports. The plan will also deny FL Medicaid claims from a pharmacy that has an active exclusion (no waiver) on the Office of Investigator General (OIG) or the System for Award Management (SAM) exclusion list. The Plan may terminate the pharmacy from the network when audit findings identify fraud or abuse.
Community Care Plan	The CCP Compliance & SIU (CSIU) team follow the State Agencies policies and procedures for reporting and acting on FWA activities. The Compliance & SIU team communicate directly with the PBM on cases where prescribers or pharmacies may be under investigation for FWA activities. PBM is notified and in some case advised to deny activities of a provider under investigation or withhold payment from a pharmacy. The CSIU team can obtain ad hoc reports from the PBM regarding in network pharmacies. The PBM also has a SIU team. The PBM provides the CCP CSIU team with a quarterly AHCA FWA report. CSIU follows all directives provided by the agency on these matters.
Florida Community Care	VS Caremark performs audits on retail pharmacies looking for issues with claim submissions such as patients getting multiple fills of same med with different dose. Faxes are sent to prescriber when questionable scenarios arise and in most cases the prescriber denies approving multiple fills. CVS Caremark will send notices if the audit finds any potential Fraud or Abuse and further action may be taken. In addition to this review, FCC conducts a monthly pharmacy claims review with pharmacy and FWA/SIU representation to identify potential fraud or abuse of controlled drugs by high-risk pharmacy providers.
Humana Medical Plan	Refer to Special Investigations Unit for further review.
Molina Healthcare	CVS Caremark performs audits on retail pharmacies looking for issues with claim submissions such as patients getting multiple fills of same med with different dose. Faxes

MCO Name	Explanation
	are sent to prescribers when questionable scenarios arise and in most cases the prescriber denies approving multiple fills. CVS Caremark will send notices if the audit finds any potential Fraud or Abuse and further action may be taken.
Sunshine	Sunshine Health Plan may place a pharmacy on payment suspension, which would deny payment of claims but continue to allow claims to adjudicate while the pharmacy undergoes an investigative audit. The Plan may place a pharmacy on adjudication suspension, which would prevent claims from processing while the pharmacy undergoes an investigative audit. The Plan may deny claims written by this pharmacy if the pharmacy is on the state or OIG exclusion lists. The Plan may terminate the pharmacy from the network when audit findings identify fraud or abuse. Centene's FWA team in combination with CVS and Centene's Special Investigations Unit (SIU) team work to identify fraudulent pharmacies and initiate appropriate investigations and resulting actions.

5. Does your MCO have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by beneficiaries, prescribers, and pharmacy providers?

Figure 64 - Documented Process to Identify Potential Fraud or Abuse of Non-Controlled Drugs by Beneficiaries, Prescribers, and Pharmacy Providers

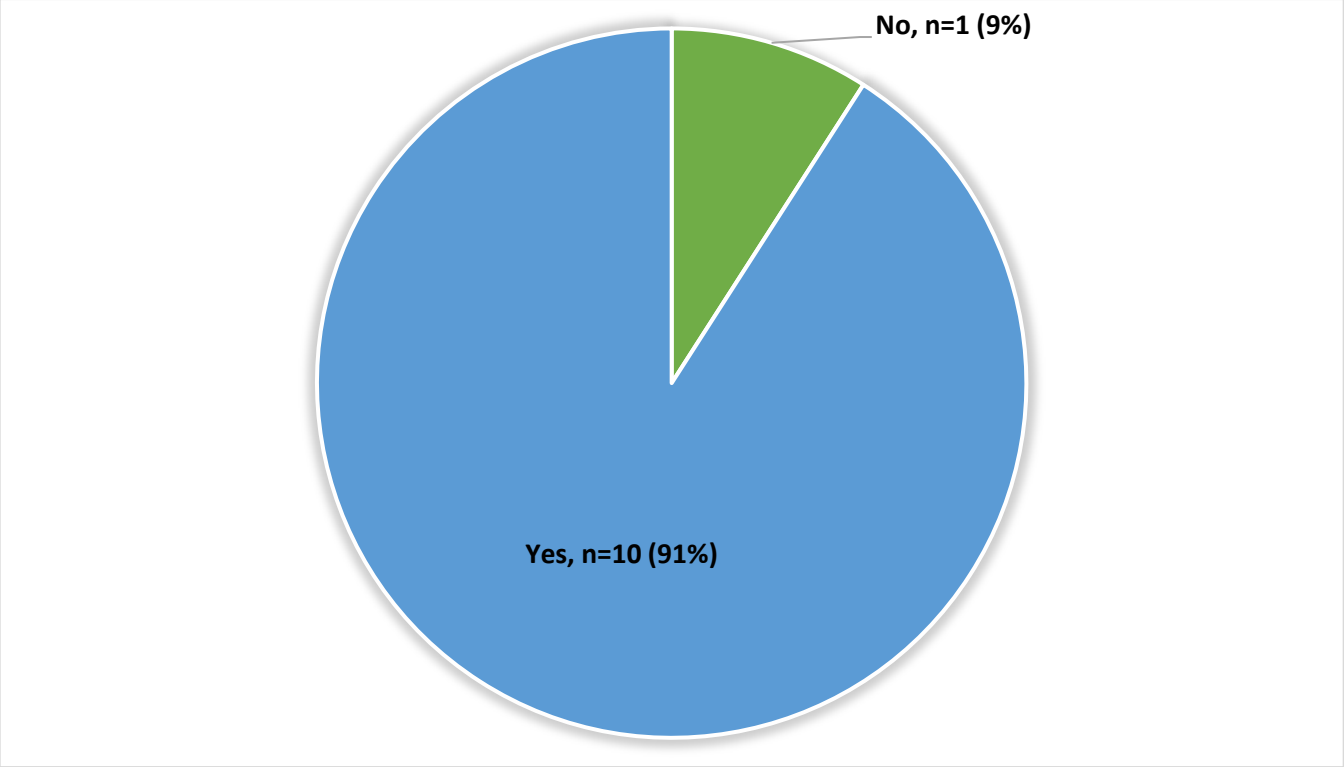


Table 89 - Documented Process to Identify Potential Fraud or Abuse of Non-Controlled Drugs by Beneficiaries, Prescribers, and Pharmacy Providers

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%

Response	MCO Names	Count	Percentage
No	Humana Medical Plan	1	9.09%
State Totals		**11**	**100%**

If "Yes," please explain your program for FWA of non-controlled substances.

Table 90 - Explanations of Program for FWA of Non-Controlled Substances by Beneficiaries, Prescribers, and Pharmacy Providers

MCO Name	Explanation
Aetna Better Health	Aetna uses both refill too soon logic and cumulative refill too soon logic to prevent overfilling or stock piling of medications. Certain medications may require diagnosis code in the medical claims history from the prescriber for claims to pay at the point of sale. Quantity limits on either total daily dose, amount per fill or duration of use are employed for other medications to limit utilization the medically appropriate quantities and durations of use. The same FWA auditing that occurs for controlled substances also occurs for non-controls, Statistical reviews are completed on pharmacies with claims volume more than $1,000 and/or 100 or more claims submitted each quarter. Analysis filtering data help identify outliers requiring further examination. This process summarizes pharmacy trends that indicate pharmacy deviations such as: Higher percentage of claims for a narrow set of higher costing NDC numbers Percentage of refilled claims Total number of claims Percentage of high dollar claims Average prescriptions per member per month
Amerihealth Caritas Florida	STARS Sentinel, which allows the investigators and data analysts to run reports to assist in identifying potential fraud, waste, or abuse. In addition to the data mining tool, SIU and data analyst staff initiate projects to expand and strengthen the identification of potential FWA of for controlled and non-controlled drugs.
Children's Medical Services	Children's Medical Services utilizes a multi-faceted collaborative approach to detect, prevent and remedy Fraud, Waste, and Abuse (FWA). Primary sources for evaluation and detection of fraud or abuse include internal and external referrals as well as proactive data mining. Member fraud and abuse referrals are commonly received from internal departments such as customer service or pharmacy operations. As part of our proactive data mining efforts, Children's Medical Services uses a variety of reports/tools and participates in meaningful collaborations in order to focus our fraud and abuse detection efforts. Specifically, Children's Medical Services utilizes these reports, tools and collaboration opportunities to conduct additional internal analyses in order to identify outlier beneficiaries that may require additional investigation or a more focused audit. All cases of suspected beneficiary fraud or abuse are referred to Children's Medical Services' Special Investigations Unit (SIU) for further investigation and/or reporting to government agencies. Once a determination has been made that a beneficiary has engaged in FWA, remedial actions are identified which may include law enforcement actions and/or termination of the member from the plan upon approval by the state agency.
Clear Health Alliance	We have a comprehensive approach to combat Fraud Waste and Abuse (FWA). Our multi-faceted approach reduces needless costs while promoting appropriate medication use. The following describes our programs administered at Point of Sale (POS) as well as retrospectively. Our Retail Network Audit program fights FWA by finding discrepancies, deterrence messaging, and educating pharmacies as appropriate. Our FWA collaborates with network pharmacies to communicate issues and provide the necessary support to resolve FWA concerns. Suspected FWA may result in suspension of pharmacy payment

MCO Name	Explanation
	and adjudication ability until confirmed. Confirmed FWA may result in termination from the network. An internal review committee will make final decisions on terminations. Timely notifications to prescribers and members impacted by a termination ensure continuity of care. Initiation of FWA investigations may result from tips, desk audit/review or onsite audits. Our compound management program employs adjudication logic for compounded products allowing only safe and effective FDA approved ingredients and rejecting claims for non-approved ingredients. The compound high dollar cost limit program targets compounds costing more than $100 (varies by state) resulting in a POS reject that requires further review prior to payment. Medical device management directs devices to the medical benefit except for spacers, glucometers, and diabetic supplies. The non-compound high-cost program targets max allowed cost for claims specific to the average cost of the GPI14, allowing further management of increasing spend. Claims submitted for more than assigned value will reject for further review before determining coverage. The Non-FDA approved drug block program ensures only FDA approved drugs are covered. Our Special Investigation Team investigates referrals in addition to conducting proactive reviews of data analysis on all outlier medications.
Community Care Plan	The pharmacy audit program consists of claim check reviews, desktop and onsite audits. Through predictive analytics and a number of proprietary and customized rule sets, Conduent's FWA Detection System will identify, and report claims discrepancies. Criteria can include but is not limited to claims volume, DAW submissions, incorrect prescriber submissions, incorrect day supply, max dose limits, controlled substance utilization. The audit process includes extensive monitoring and auditing of provider usage and claims data.
Florida Community Care	FCC conducts pharmacy claims review with pharmacy and FWA/SIU representation to identify potential fraud or abuse of non-controlled drugs by beneficiaries
Molina Healthcare	Molina leverages utilization management tools to mitigate fraud, waste and abuse. These utilization management strategies include quantity limits, medical necessity review, age limits, duration limits and specialty prescriber requirements.
Simply Healthcare	We have a comprehensive approach to combat Fraud Waste and Abuse (FWA). Our multi-faceted approach reduces needless costs while promoting appropriate medication use. The following describes our programs administered at Point of Sale (POS) as well as retrospectively. Our Retail Network Audit program fights FWA by finding discrepancies, deterrence messaging, and educating pharmacies as appropriate. Our FWA collaborates with network pharmacies to communicate issues and provide the necessary support to resolve FWA concerns. Suspected FWA may result in suspension of pharmacy payment and adjudication ability until confirmed. Confirmed FWA may result in termination from the network. An internal review committee will make final decisions on terminations. Timely notifications to prescribers and members impacted by a termination ensure continuity of care. Initiation of FWA investigations may result from tips, desk audit/review or onsite audits. Our compound management program employs adjudication logic for compounded products allowing only safe and effective FDA approved ingredients and rejecting claims for non-approved ingredients. The compound high dollar cost limit program targets compounds costing more than $100 (varies by state) resulting in a POS reject that requires further review prior to payment. Medical device management directs devices to the medical benefit except for spacers, glucometers, and diabetic supplies. The non-compound high-cost program targets max allowed cost for claims specific to the average cost of the GPI14, allowing further management of increasing spend. Claims submitted for more than assigned value will reject for further review before determining coverage. The Non-FDA approved drug block program ensures only FDA approved drugs

MCO Name	Explanation
	are covered. Our Special Investigation Team investigates referrals in addition to conducting proactive reviews of data analysis on all outlier medications.
Sunshine	Sunshine Health Plan utilizes a multi-faceted collaborative approach to detect, prevent and remedy Fraud, Waste, and Abuse (FWA). Primary sources for evaluation and detection of fraud or abuse include internal and external referrals as well as proactive data mining. Member fraud and abuse referrals are commonly received from internal departments such as customer service or pharmacy operations. As part of our proactive data mining efforts, Centene uses a variety of reports/tools and participates in meaningful collaborations in order to focus our fraud and abuse detection efforts. Specifically, Centene utilizes these reports, tools and collaboration opportunities to conduct additional internal analyses in order to identify outlier beneficiaries that may require additional investigation or a more focused audit. All cases of suspected beneficiary fraud or abuse are referred to Centene's Special Investigations Unit (SIU) for further investigation and/or reporting to government agencies. Once a determination has been made that a beneficiary has engaged in FWA, remedial actions are identified which may include law enforcement actions and/or termination of the member from the plan upon approval by the state agency.
United Healthcare	UnitedHealthcare Community Plan follows standard vendor oversight procedures which includes ensuring the Pharmacy Benefit Manager (PBM) follws the standard Anti-Fraud plan for pharmacy providers. UnitedHealthcare Community Plan has a documented process that the health plan follows related to monitoring fraud,waste and abuse related to beneficiaries and prescribers.

If “No,” please explain why not.

Table 91 - Explanations for Not Having a Documented Process to Identify Potential Fraud or Abuse of Non-Controlled Drugs by Beneficiaries, Prescribers, and Pharmacy Providers

MCO Name	Explanation
Humana Medical Plan	Our lock in program is only for controlled medication. Our audit targeting is done at the pharmacy level and their dispensing outliers for waste and/or abuse, but it's not specific to beneficiary patterns. Any evidence of fraud or potential fraud is referred to Special Investigations Unit.

B. Prescription Drug Monitoring Program (PDMP)

1. Does your MCO have the ability to query the State's PDMP database?

Figure 65 - MCO Has Ability to Query the State's PDMP database

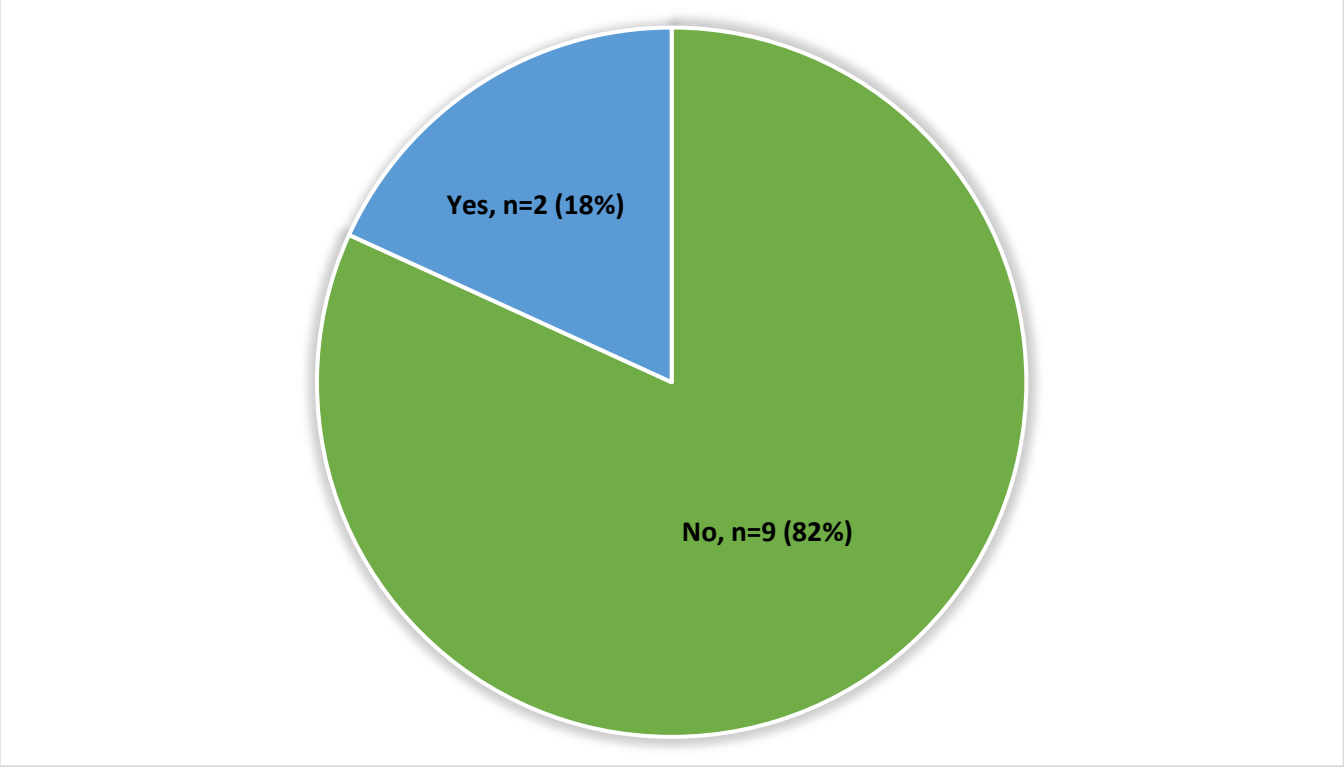


Table 92 - MCO Has Ability to Query the State's PDMP Database

Response	MCO Names	Count	Percentage
Yes	Amerihealth Caritas Florida, Florida Community Care	2	18.18%
No	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	81.82%
State Totals		**11**	**100%**

If "No," please explain.

Table 93 - Explanations for MCO Not Having the Ability to Query the State's PDMP Database

MCO Name	Explanation
Aetna Better Health	The state does not permit the MCO to access the PDMP.
Children's Medical Services	N/A - we do not have access to PDMP data
Clear Health Alliance	Although MCO as an entity has no access to the state PDMP, our local and state licensed Pharmacy Director can query as needed.
Community Care Plan	The PDMP allows access to pharmacies, Pharmacist and prescribers that work with controlled substances. MCO's are not given access. Although we do not have direct access CCP has implemented a process via the PBM to have in- network pharmacies sign a yearly affidavit declaring that they check e-forcse when processing controlled substance

MCO Name	Explanation
	prescriptions. This has been added to the annual pharmacy audit process conducted by the PBM.
Humana Medical Plan	It is a FL law that pharmacists and prescribers have access to the system for controlled substance prescribing.
Molina Healthcare	Molina follows state regulations around privacy and requirements for direct member care providers to leverage PDMP databases. Currently Molina does not have the ability to query the State's PDMP database.
Simply Healthcare	Although MCO as an entity has no access to the state PDMP, our local and state licensed Pharmacy Director can query as needed.
Sunshine	The MCO does not have access to PDMP data.
United Healthcare	Only dispensing pharmacists and licensed prescribers can currently access the state PDMP per FL statute.

a. If "Yes," please check all applicable ways your MCO accesses the PDMP database.

Figure 66 - Ways the MCO Has the Ability to Query the State's PDMP Database

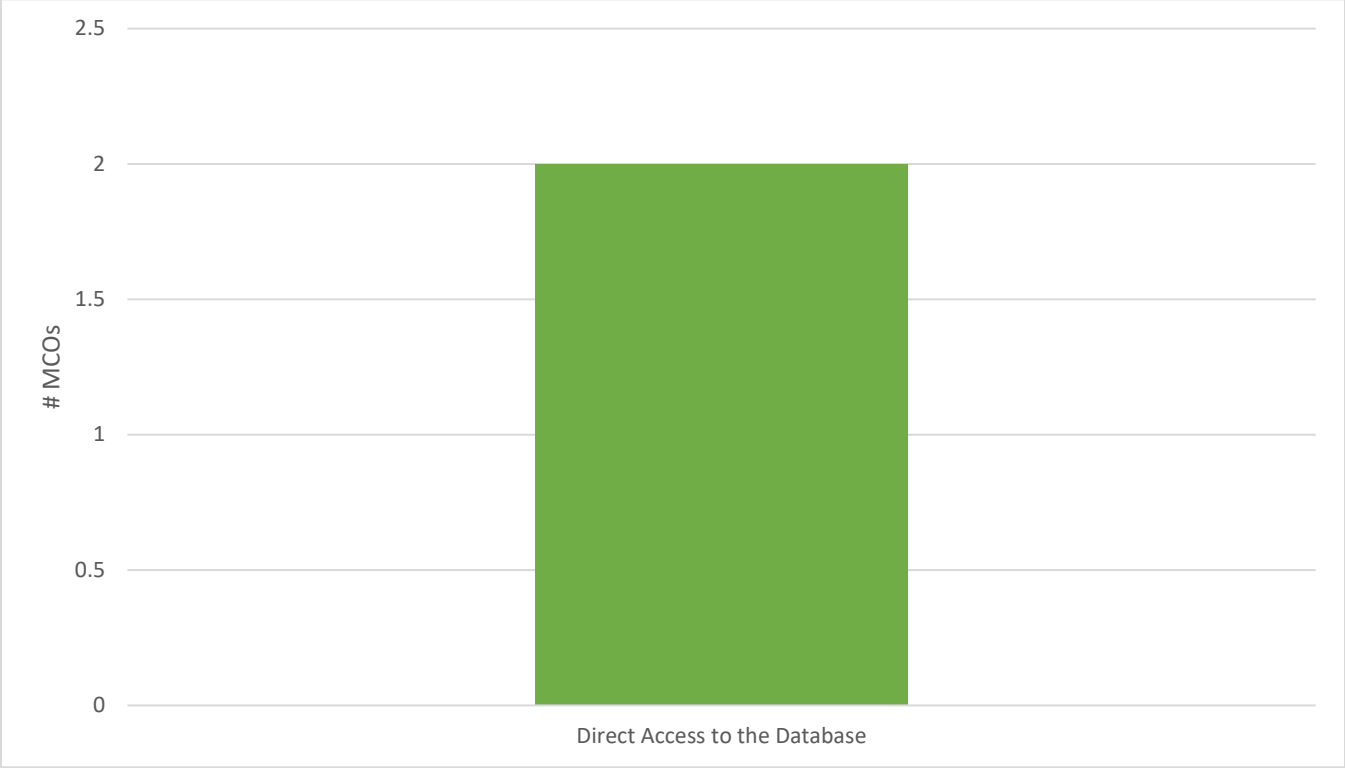


Table 94 - Ways the MCO Has the Ability to Query the State's PDMP Database

Response	MCO Names	Count	Percentage
Direct access to the database	Amerihealth Caritas Florida, Florida Community Care	2	100.00%
State Totals		**2**	**100%**

i. If "Direct access to the database," please specify your query capability (multiple responses allowed).

Figure 67 - Query Capability

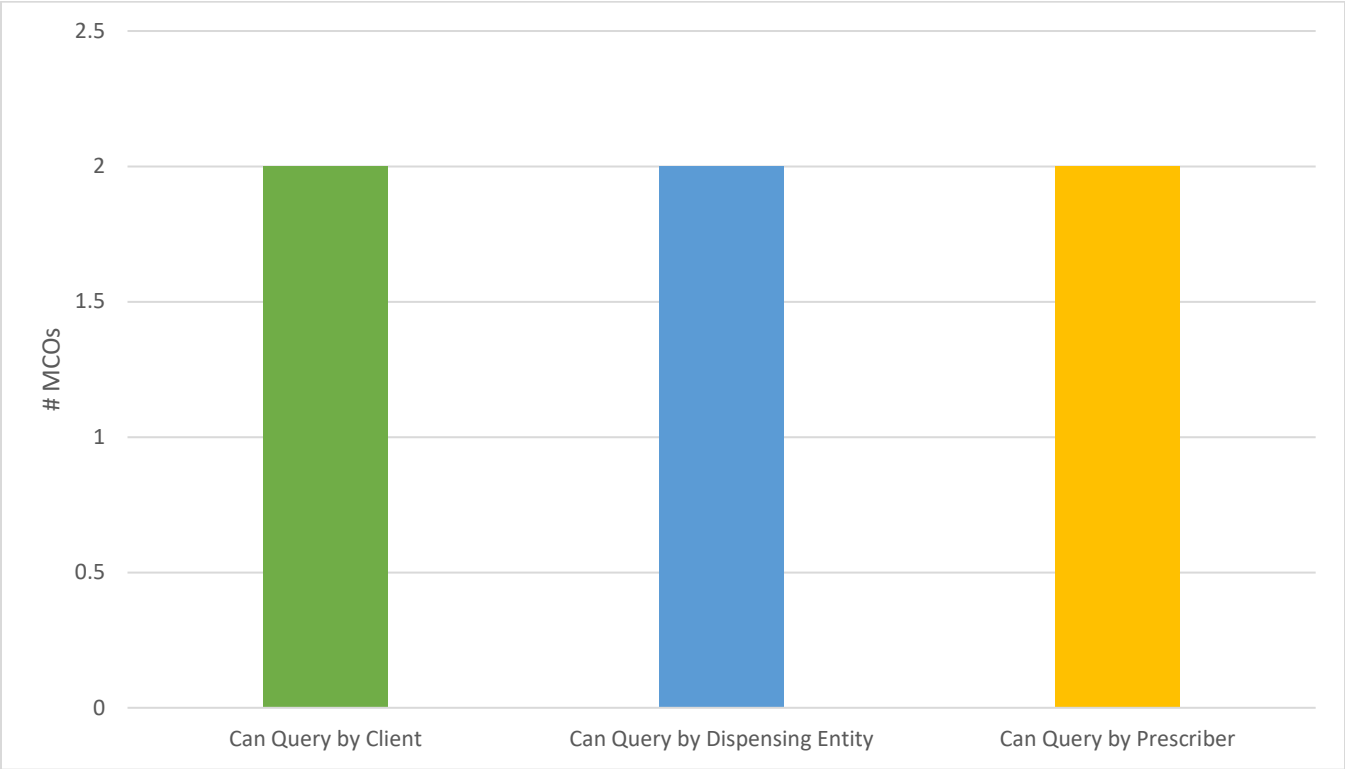


Table 95 - Query Capability

Response	MCO Names	Count	Percentage
Can query by client	Amerihealth Caritas Florida, Florida Community Care	2	33.33%
Can query by dispensing entity	Amerihealth Caritas Florida, Florida Community Care	2	33.33%
Can query by prescriber	Amerihealth Caritas Florida, Florida Community Care	2	33.33%
State Totals		**6**	**100%**

b. If "Yes," please explain how your MCO program applies this information to control FWA of controlled substances.

Table 96 - Explanation for How MCO Program Applies Information to Control FWA of Controlled Substances

MCO Name	Explanation
Amerihealth Caritas Florida	During Pharmacy claims review for reconsideration, if potential claims is identify, the PDMP data is forwarded to plan's FWA team for further investigation.
Florida Community Care	FCC pulls queries on an as needed basis when questions arise regarding utilization of multiple prescriber, multiple pharmacy, or other potential FWA concerns regarding controlled substances

c. If "Yes," does your MCO have access to contiguous States' PDMP Information?

Figure 68 - MCO Access to Contiguous States' PDMP Information

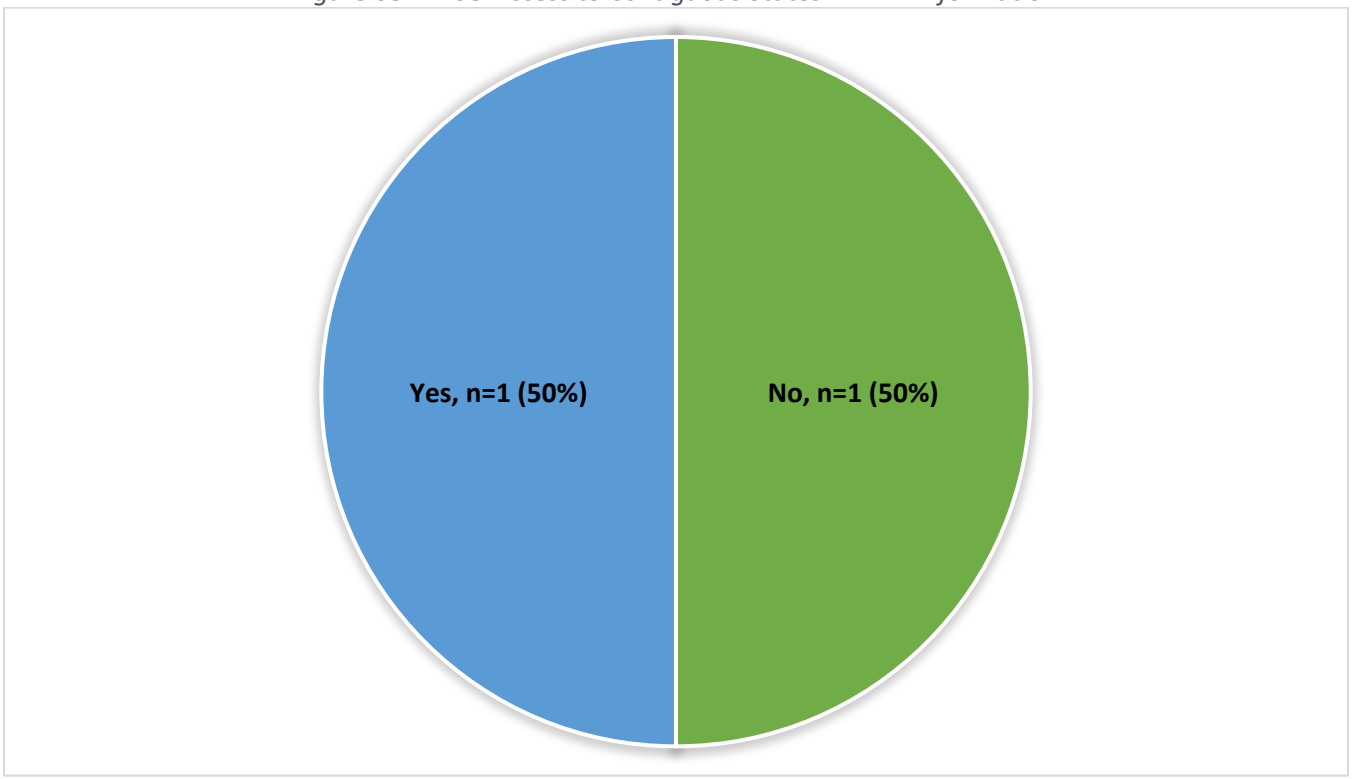


Table 97 - MCO Access to Contiguous States' PDMP Information

Response	MCO Names	Count	Percentage
Yes	Amerihealth Caritas Florida	1	50.00%
No	Florida Community Care	1	50.00%
State Totals		**2**	**100%**

d. If "Yes," does your MCO also have PDMP data integrated into your POS edits?

Figure 69 - MCO Has PDMP Data Integrated into POS Edits

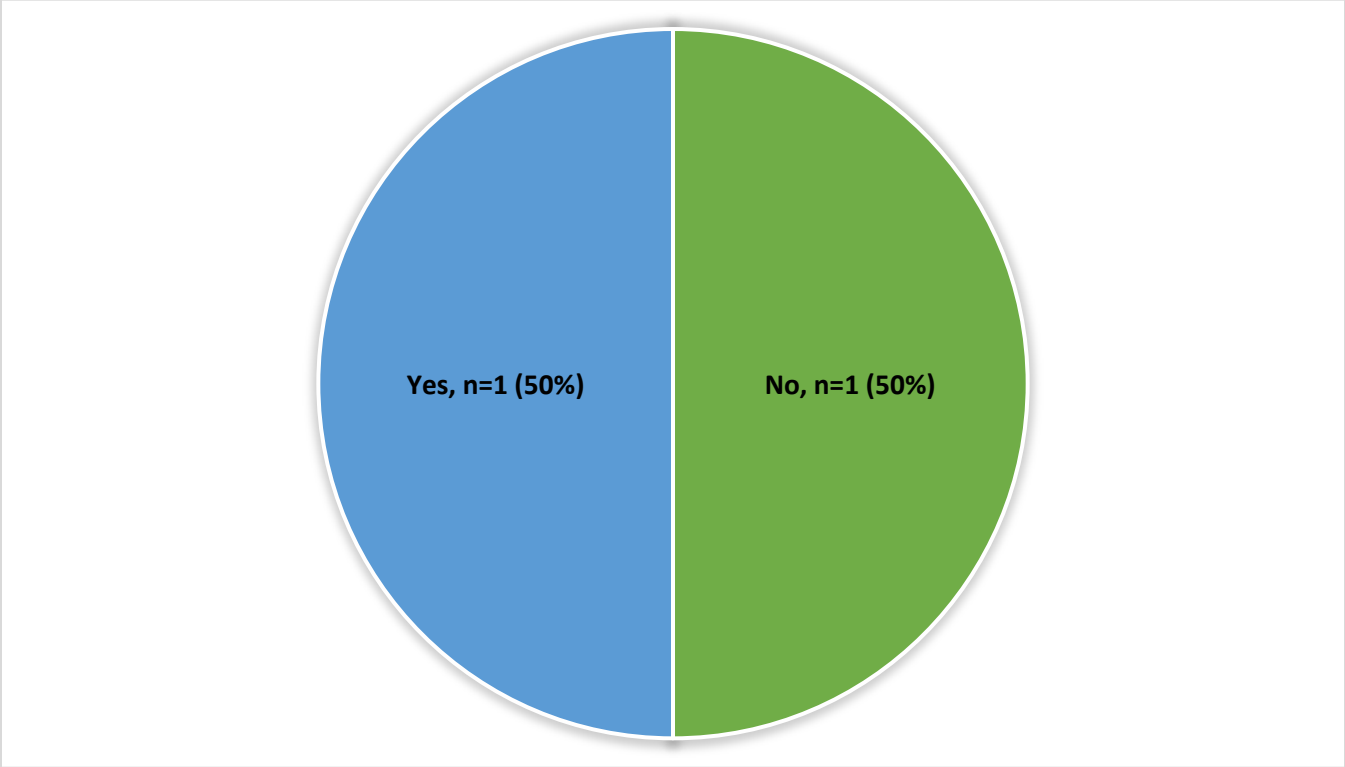


Table 98 - MCO Has PDMP Data Integrated into POS Edits

Response	MCO Names	Count	Percentage
Yes	Florida Community Care	1	50.00%
No	Amerihealth Caritas Florida	1	50.00%
State Totals		**2**	**100%**

2. Have you communicated to prescribers who are covered providers that as of October 1, 2021, they are required to check the PDMP before prescribing controlled substances to beneficiaries who are covered individuals?

Figure 70 - Communicated that Prescribers are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

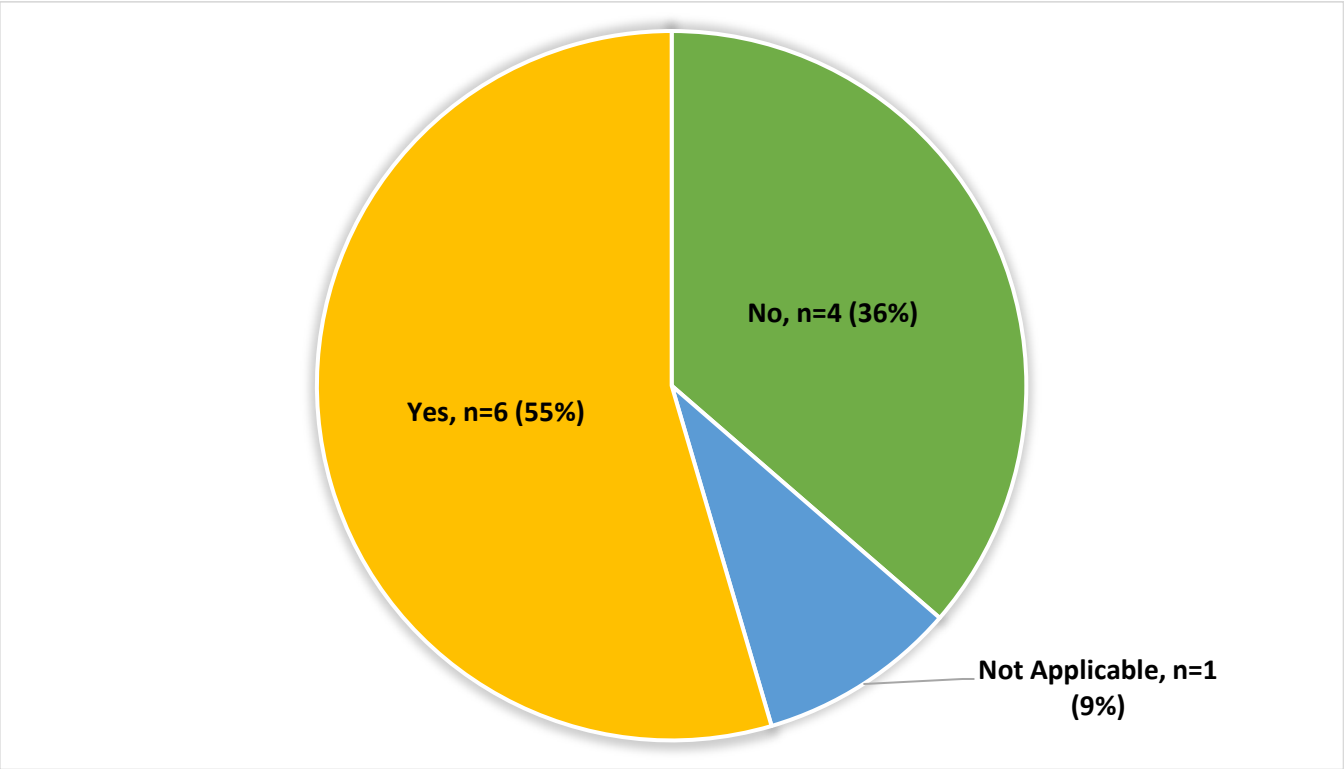


Table 99 - Communicated that Prescribers are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Children's Medical Services, Florida Community Care, Humana Medical Plan, Sunshine, United Healthcare	6	54.55%
No	Clear Health Alliance, Community Care Plan, Molina Healthcare, Simply Healthcare	4	36.36%
Not Applicable	Amerihealth Caritas Florida	1	9.09%
State Totals		**11**	**100%**

If "Yes," check all that apply.

Figure 71 - Ways MCO Has Communicated Requirement

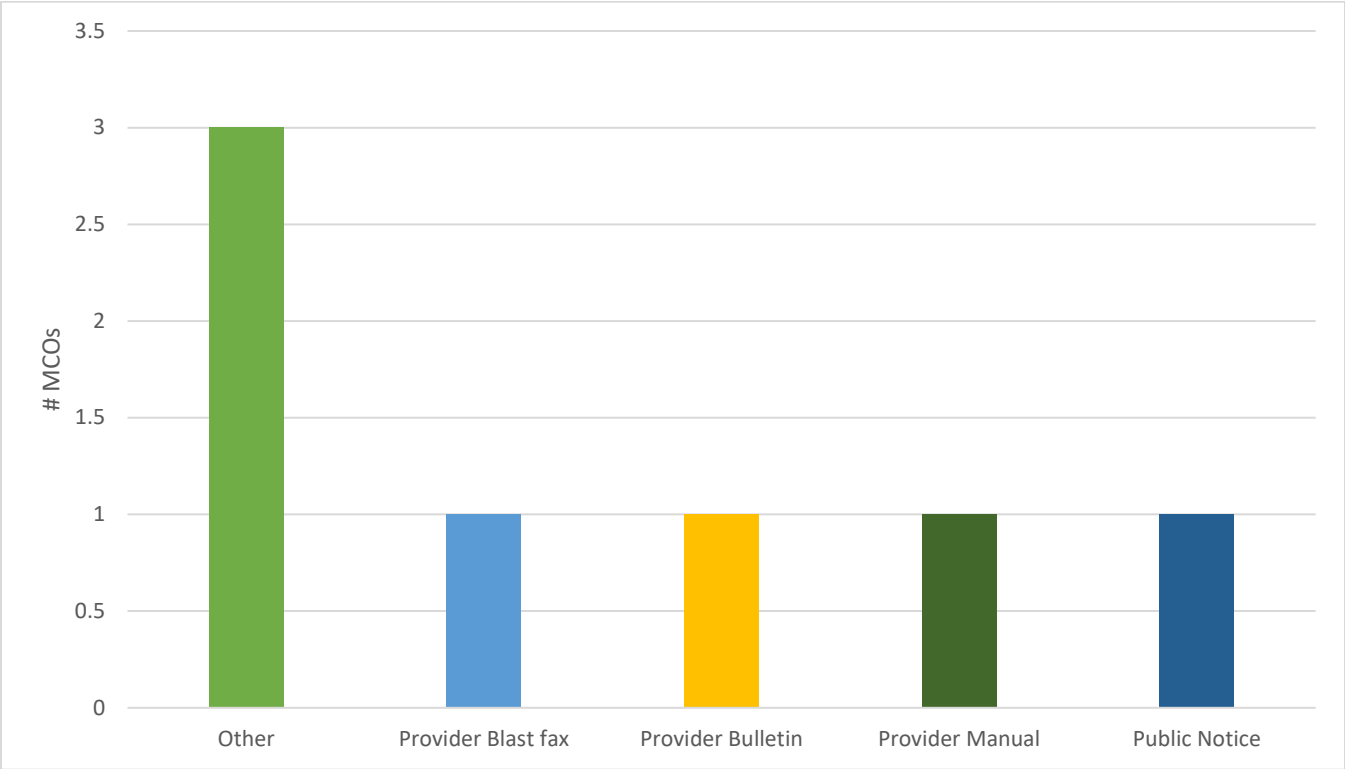


Table 100 - Ways MCO Has Communicated Requirement

Response	States	Count	Percentage
Provider blast fax	Humana Medical Plan	1	14.29%
Provider bulletin	Humana Medical Plan	1	14.29%
Provider manual	Florida Community Care	1	14.29%
Public notice	United Healthcare	1	14.29%
Other	Aetna Better Health, Children's Medical Services, Sunshine	3	42.86%
State Totals		**7**	**100%**

If "Other," please explain.

Table 101 - "Other" Ways MCO Has Communicated Requirement

MCO Name	Explanation
Aetna Better Health	Some of the state PA criteria (e.g., the Opioid PA form) asks prescribers if they have reviewed the PDMP prior to prescribing the medication as required by FL statute. If the prescriber says "no," the form asks them to explain why.
Children's Medical Services	The requirement is a part of the prior authorization form for opioids.
Sunshine	The requirement is a part of the prior authorization form for opioids.

If “Not applicable,” please explain.

Table 102 - “Not Applicable” Explanations for Communicating to Prescribers they are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

MCO Name	Explanation
Amerihealth Caritas Florida	AmeriHealth Caritas FL (ACFL) does not mandate in its provider agreement that providers access the PDMP as this is a requirement of Florida's EFORSCE program which indicates "A prescriber or his or her designee must consult the PDMP to review their patient's controlled substance dispensing history prior to prescribing a controlled substance in Schedules II-V, as defined in section 893.03, F.S., for patients age 16 and older." However, ACFL's provider agreements do require providers to follow state and federal laws, which include section 893.03, F.S

If “No,” please explain.

Table 103 - “No” Explanations for Communicating to Prescribers they are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

MCO Name	Explanation
Clear Health Alliance	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient age 16 or older unless a statutory exemption applies. The prior authorization criteria for opiates requires that the prescriber check the PDMP, and asks for an explanation why the PDMP wasn't reviewed.
Community Care Plan	CCP did not reach out to prescribers because this practice is part of the prescribers DEA licensure responsibilities. The PDMP questions noted in the previous survey FFY 2021 did not address provider notification as a required activity. CCP 's providers operation team will notify providers moving forward.
Molina Healthcare	Molina relies on language within the prior authorization criteria set for short and long acting opioids that requires prescribers to review the PDMP prior to prescribing. The criteria set is what the Health Plan utilization management pharmacists use to review cases. If prescriber does not complete this step, it may be grounds for prior authorization to be denied.
Simply Healthcare	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient aged 16 or older unless a statutory exemption applies. The prior authorization criteria for opioids requires prescribers to check the PDMP and asks for an explanation why the PDMP wasn't reviewed.

a. Has your MCO specified protocols for prescribers checking the PDMP?

Figure 72 - Protocols Involved in Checking the PDMP

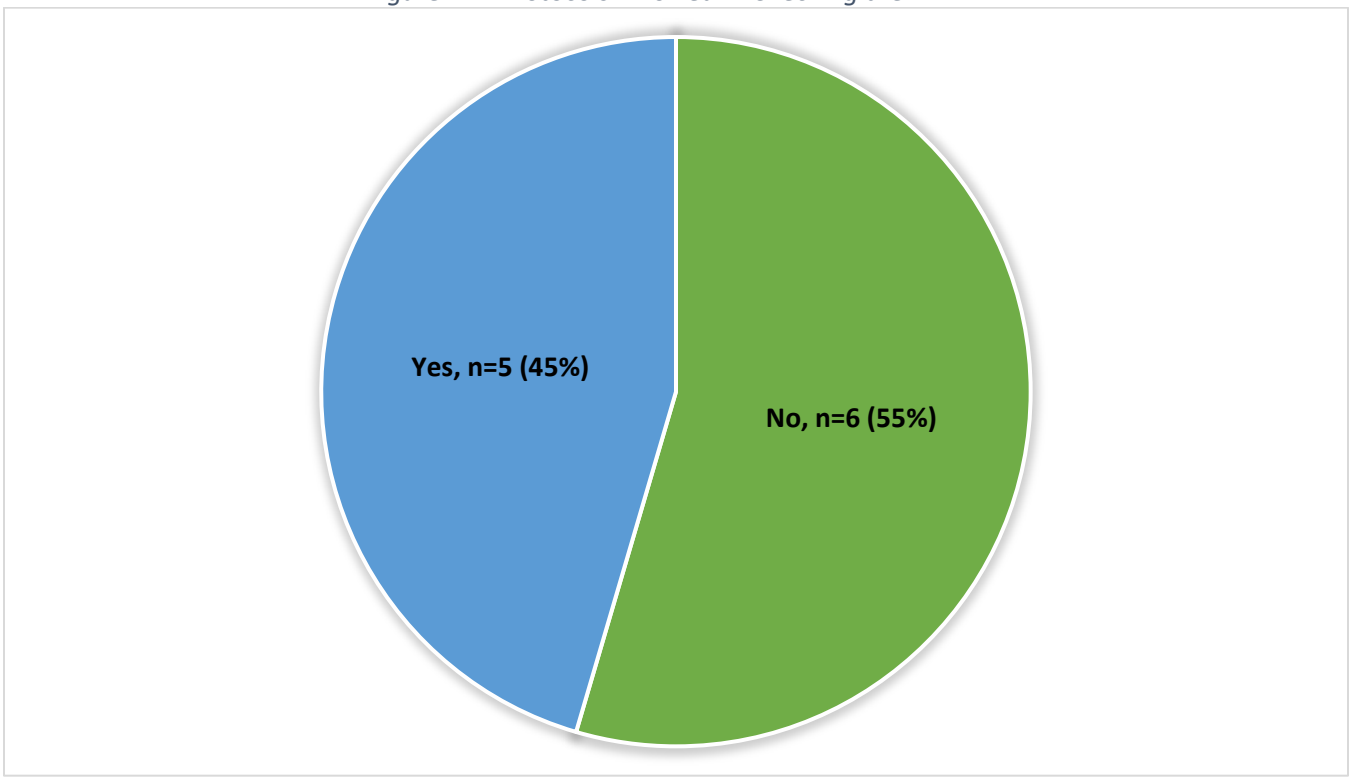


Table 104 - Protocols Involved in Checking the PDMP

Response	MCO Names	Count	Percentage
Yes	Clear Health Alliance, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare	5	45.45%
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Community Care Plan, Sunshine, United Healthcare	6	54.55%
State Totals		**11**	**100%**

If “Yes,” please explain.

Table 105 - Explanations of Protocols Involved in Checking the PDMP

MCO Name	Explanation
Clear Health Alliance	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient age 16 or older unless a statutory exemption applies. The prior authorization criteria for opiates requires that the prescriber check the PDMP, and asks for an explanation why the PDMP wasn't reviewed.
Florida Community Care	Each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient age 16 or older unless a statutory exemption applies. Statutory exemptions include:

MCO Name	Explanation
	If the patient is less than 16 years of age Drug being prescribed is a nonopioid schedule V System is not operational Requestor has technological or electrical failure Failure to consult in the PDMP may result in a non-disciplinary citation by the regulatory board.
Humana Medical Plan	Pharmacies are required in the contract to follow all state and federal laws for checking the PDMP. In Florida, it is a state law for a pharmacist to abide by this rule.
Molina Healthcare	Molina relies on language within the prior authorization criteria set for short and long acting opioids that requires prescribers to review the PDMP prior to prescribing. The criteria set is what the Health Plan utilization management pharmacists use to review cases. If prescriber does not complete this step, it may be grounds for prior authorization to be denied.
Simply Healthcare	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient aged 16 or older unless a statutory exemption applies. The prior authorization criteria for opioids requires prescribers to check the PDMP and asks for an explanation why the PDMP wasn't reviewed.

b. Do providers have protocols for responses to information from the PDMP that is contradictory to information that the practitioner expects to receive, based on information from the client (example: when a provider prescribing pain management medication finds medications for opioid use disorder (OUD) during a PDMP check, when client denies opioid use disorder)?

Figure 73 - Providers Having Protocols for Responses to Information from the PDMP that is Contradictory to the Information the Practitioner Expects

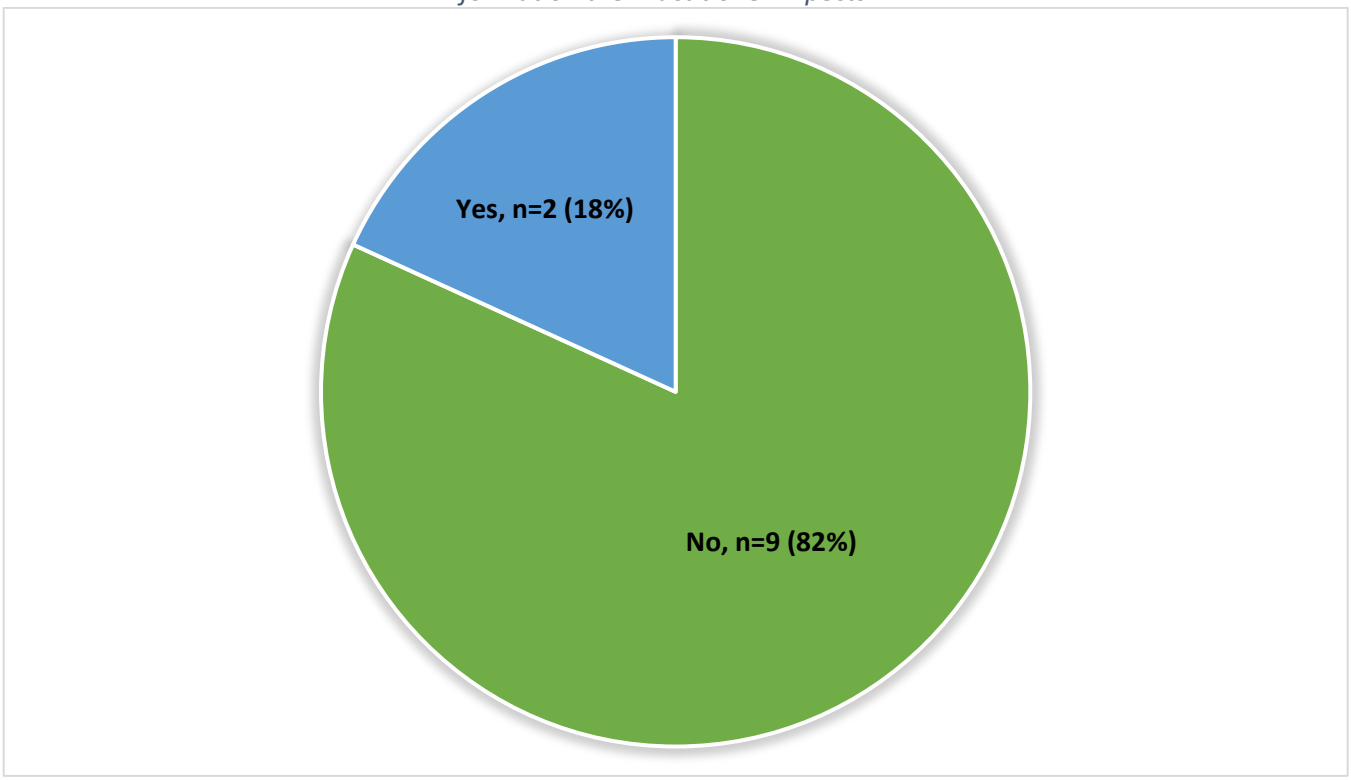


Table 106 - Providers Having Protocols for Responses to Information from the PDMP that is Contradictory to the Information the Practitioner Expects

Response	MCO Names	Count	Percentage
Yes	Florida Community Care, Molina Healthcare	2	18.18%
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	9	81.82%
State Totals		**11**	**100%**

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

Figure 74 - MCO Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check

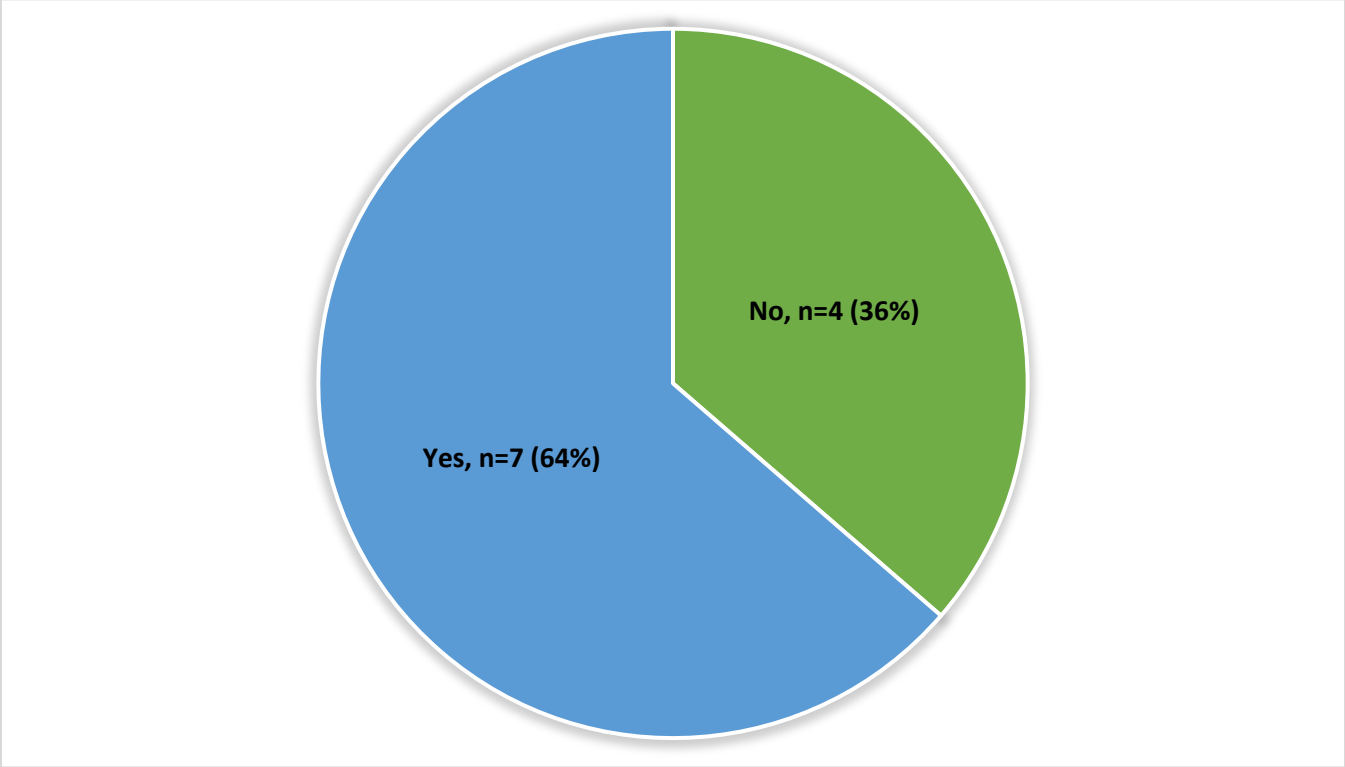


Table 107 - MCO Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine	7	63.64%
No	Amerihealth Caritas Florida, Community Care Plan, Humana Medical Plan, United Healthcare	4	36.36%
State Totals		**11**	**100%**

If “No,” please explain why not.

Table 108 - Explanations for not Requiring Prescribers to Document a Good Faith Effort

MCO Name	Explanation
Amerihealth Caritas Florida	AmeriHealth Caritas FL (ACFL) does not mandate in its provider agreement that providers access the PDMP as this is a requirement of Florida's EFORSCE program which indicates "A

MCO Name	Explanation
	prescriber or his or her designee must consult the PDMP to review their patient's controlled substance dispensing history prior to prescribing a controlled substance in Schedules II-V, as defined in section 893.03, F.S., for patients age 16 and older." However, ACFL's provider agreements do require providers to follow state and federal laws, which include section 893.03, F.S
Community Care Plan	CCP does not monitored this process and expects the prescribers to follow the requirements provided the State for appropriate use of E-forcse. Prescribers are expected to follow the rules of prescribing only a 3-day supply of controlled substance and documenting in the patients record the reason they did not use PDMP.
Humana Medical Plan	Pharmacies are required in the contract to follow all state and federal laws for checking the PDMP. In Florida, it is a state law for a pharmacist to abide by this rule.
United Healthcare	The requirement to check the PDMP is done at the point of prescribing and MCOs do not have access to review PDMP information to further evaluate prescribing.

If “Yes,” does your MCO require the provider to submit, upon request, documentation to the MCO?

Figure 75 - MCO Requires Provider to Submit Documentation

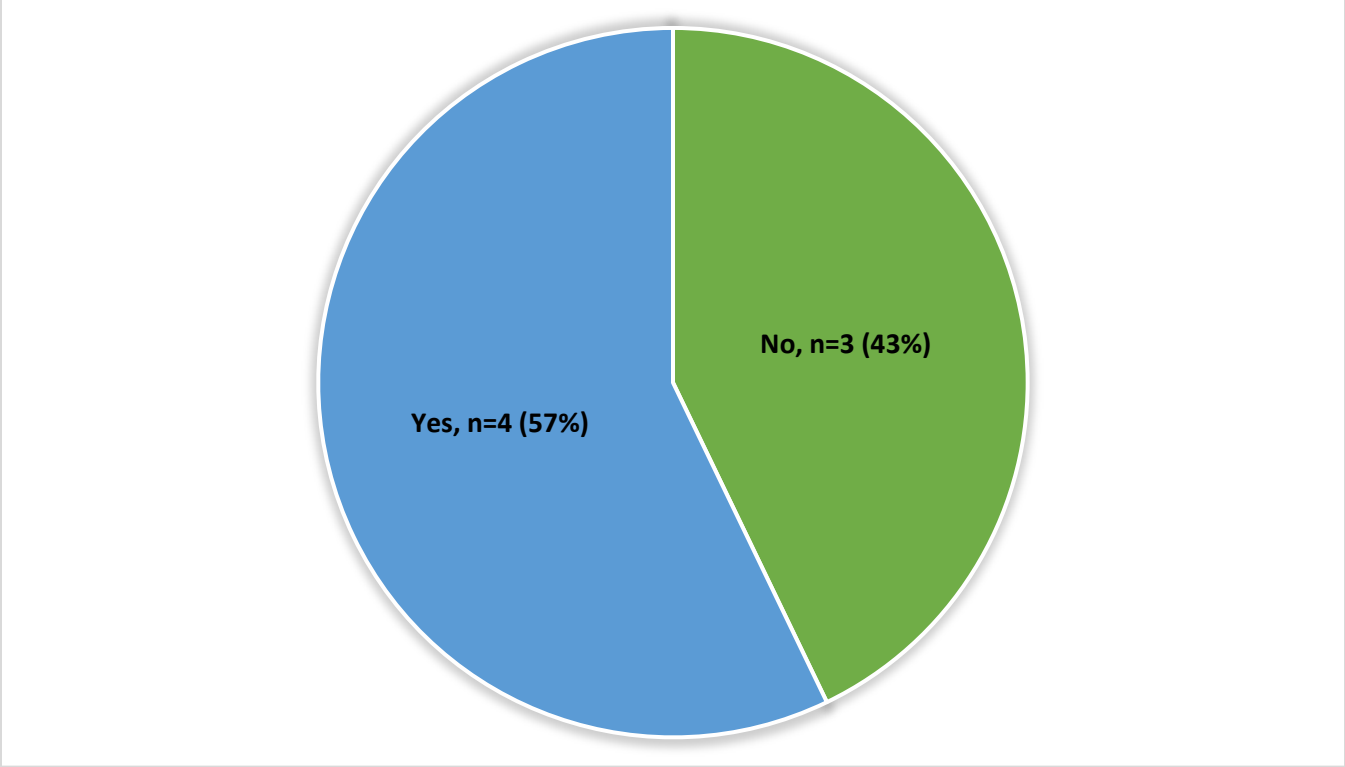


Table 109 - MCO Requires Provider to Submit Documentation

Response	MCO Names	Count	Percentage
Yes	Children's Medical Services, Florida Community Care, Molina Healthcare, Sunshine	4	57.14%
No	Aetna Better Health, Clear Health Alliance, Simply Healthcare	3	42.86%
State Totals		**7**	**100%**

If "No," please explain.

Table 110 - Explanations for not Requiring Provider to Submit Documentation

MCO Name	Explanation
Aetna Better Health	Some of the state PA criteria (e.g., the Opioid PA form) asks prescribers if they have reviewed the PDMP prior to prescribing the medication as required by FL statute. If the prescriber says "no," the form asks them to explain why. There is no stated requirement that the provider must submit documentation to the MCO upon request.
Clear Health Alliance	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient age 16 or older unless a statutory exemption applies. The prior authorization criteria for opiates requires that the prescriber check the PDMP, and asks for an explanation why the PDMP wasn't reviewed.
Simply Healthcare	The DOH requires each prescriber and dispenser or his or her designee has a duty to consult the PDMP system to review a patient's controlled substance dispensing history each time a controlled substance is prescribed or dispensed to a patient aged 16 or older unless a statutory exemption applies. The prior authorization criteria for opiates requires that the prescriber check the PDMP and asks for an explanation why the PDMP wasn't reviewed.

3. In the State's PDMP system, which of the following beneficiary information is available to prescribers as close to real-time as possible (multiple responses allowed)?

Figure 76 - Beneficiary Information Available to Prescribers as Close to Real-Time as Possible

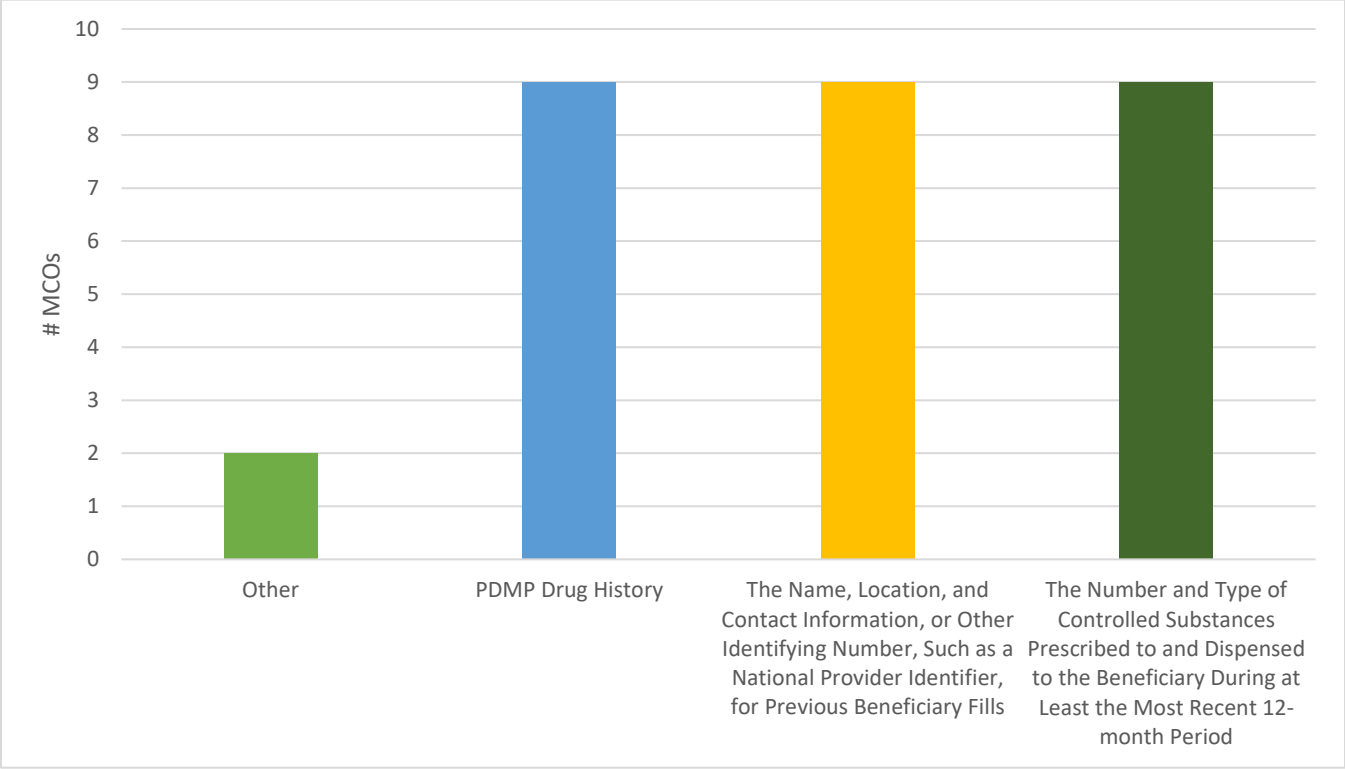


Table 111 - Beneficiary Information Available to Prescribers as Close to Real-Time as Possible

Response	MCO Names	Count	Percentage
PDMP drug history	Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	9	31.03%
The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills	Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	9	31.03%
The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period	Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	9	31.03%
Other	Aetna Better Health, Molina Healthcare	2	6.90%
State Totals		**29**	**100%**

If “Other,” please explain.

Table 112 - Other Explanation for Information Available to Prescribers with Respect to a Beneficiary as Close to Real-Time as Possible

MCO Name	Explanation
Aetna Better Health	The MCOs in FL do not have access to the PDMP, so unable to describe was is available to prescribers.
Molina Healthcare	unaware as health plans do not have access to State PDMP

a. Are there barriers that hinder your MCO from fully accessing PDMP that prevent the program from being utilized the way it was intended to be to curb FWA?

Figure 77 - Barriers Hinder MCO from Fully Accessing the PDMP to Curb FWA

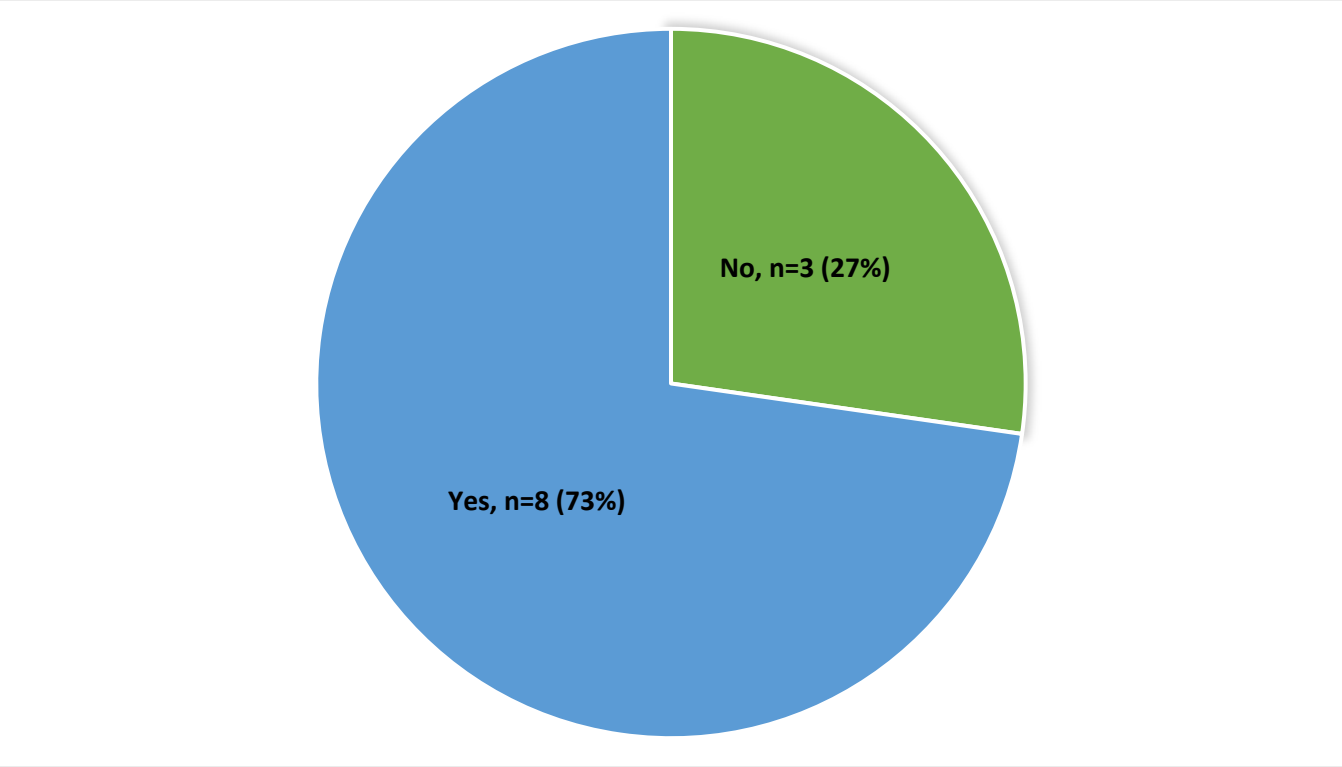


Table 113 - Barriers Hinder MCO from Fully Accessing the PDMP to Curb FWA

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	8	72.73%
No	Amerihealth Caritas Florida, Florida Community Care, Humana Medical Plan	3	27.27%
State Totals		**11**	**100%**

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

Table 114 - Explanation for Barriers that Hinder MCO from Fully Accessing the PDMP to Curb FWA

MCO Name	Explanation
Aetna Better Health	FL has not given MCOs the ability to access the PDMP system.
Children's Medical Services	MCOs are not provided with direct access to the state's PDMP. Access to the PDMP would allow MCOs the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA.
Clear Health Alliance	the MCO as an entity has no access to the state PDMP; however, our local and state licensed Pharmacy Director can query as needed.
Community Care Plan	Pharmacist that dispense in a facility with DEA license seem to be the only Rph's in the State of Florida that can access E-forcse. As a pharmacist in MCO access was denied.
Molina Healthcare	Health Plans do not have the ability to query the State PDMP at this time

MCO Name	Explanation
Simply Healthcare	The MCO as an entity has no access to the state PDMP; however, our local and state licensed Pharmacy Director can query as needed.
Sunshine	MCOs are not provided with direct access to the state's PDMP. Access to the PDMP would allow MCOs the ability to conduct retrospective reviews on prescriber, dispensing, and utilization behavior that would help to curb FWA.
United Healthcare	The pharmacy contracts require compliance with all state and federal laws which the State of Florida identifies in PDMP monitoring Only licensed prescribers and dispensing pharmacists are permitted to access the PDMP therefore hindering the monitoring of prescribers and members by the MCO.

4. Have any changes to your State's PDMP during this reporting period improved or detracted from the Medicaid program's ability to access PDMP data?

Figure 78 - Changes to State PDMP That Have Improved or Detracted from the Medicaid Program's Ability to Access PDMP Data

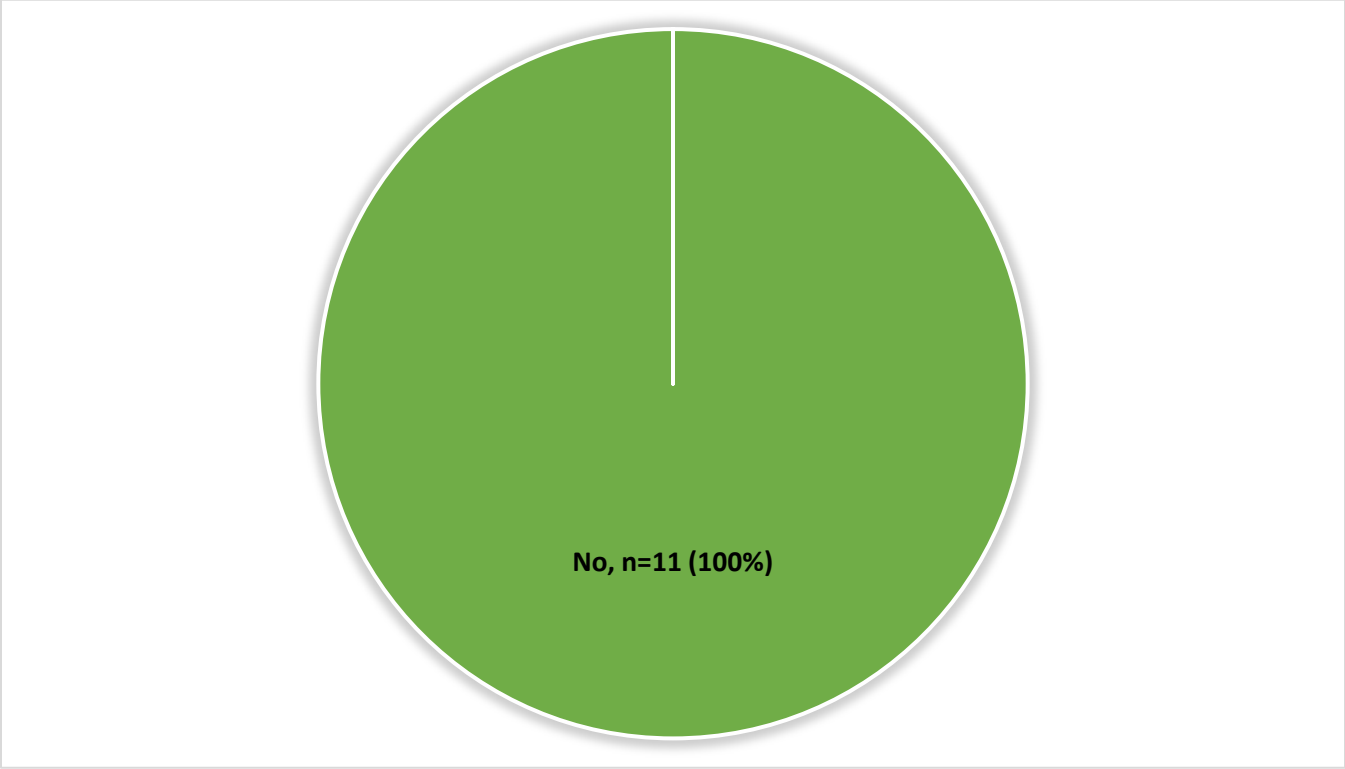


Table 115 - Changes to State PDMP That Have Improved or Detracted from the Medicaid Program's Ability to Access PDMP Data

Response	MCO Names	Count	Percentage
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

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

Figure 79 - Data or Privacy Breaches of PDMP or PDMP Data During This Reporting Period

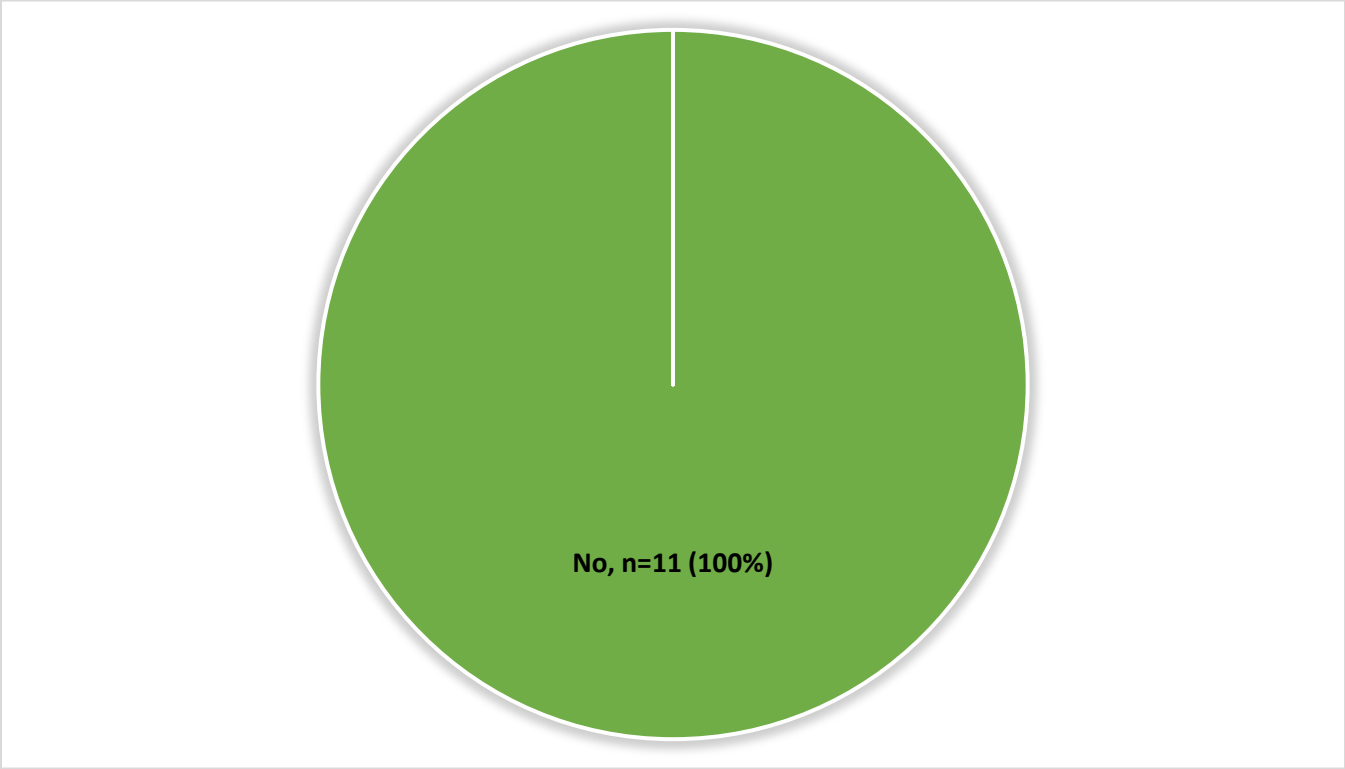


Table 116 - Data or Privacy Breaches of PDMP or PDMP Data During This Reporting Period

Response	MCO Names	Count	Percentage
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

C. Opioids

1. For your program, is this category of medications carved out and handled by the State?

Figure 80 - Opioid Category of Medications Carved Out and Handled by the State

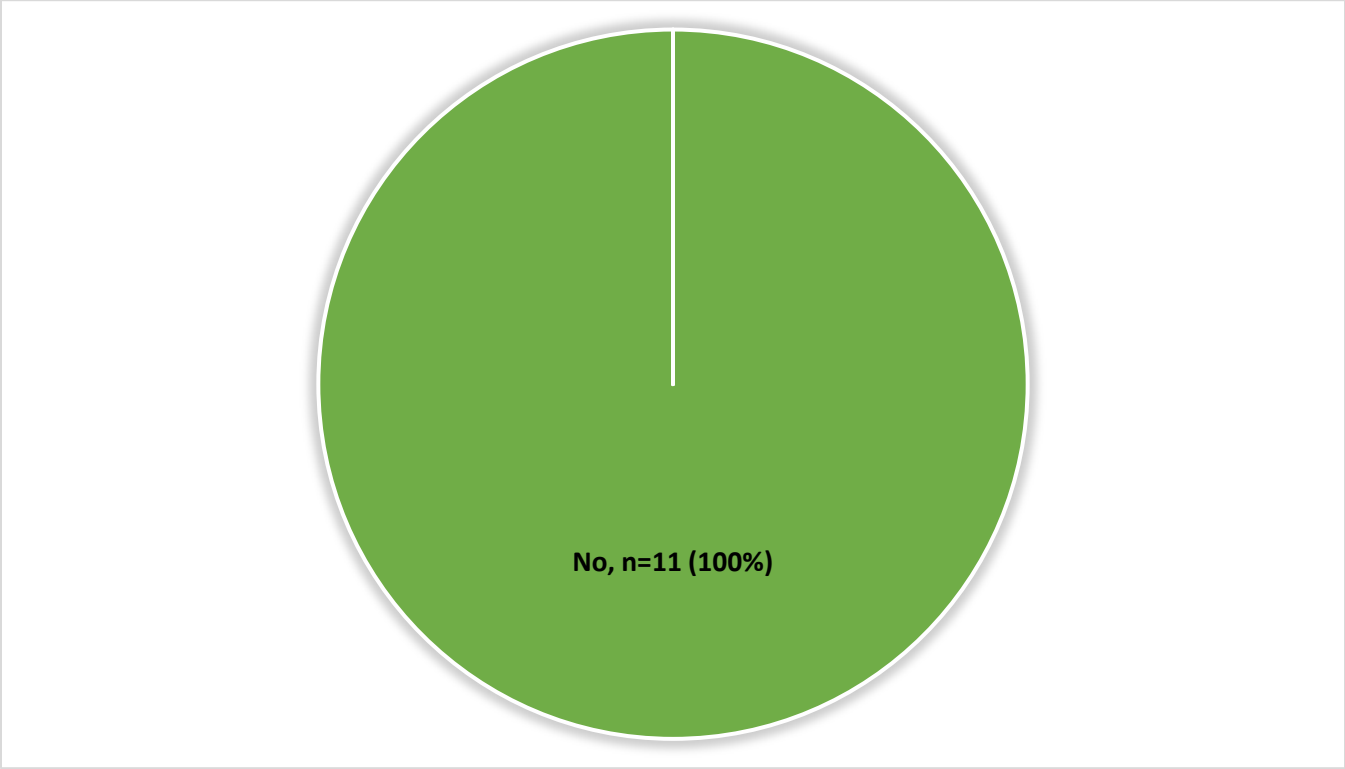


Table 117 - Opioid Category of Medications Carved Out and Handled by the State

Response	MCO Names	Count	Percentage
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

2. Does your MCO currently have a POS edit in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients?

Figure 81 - POS Edit in Place to Limit the Days' Supply Dispensed of an Initial Opioid Prescription for Opioid Naïve Patients

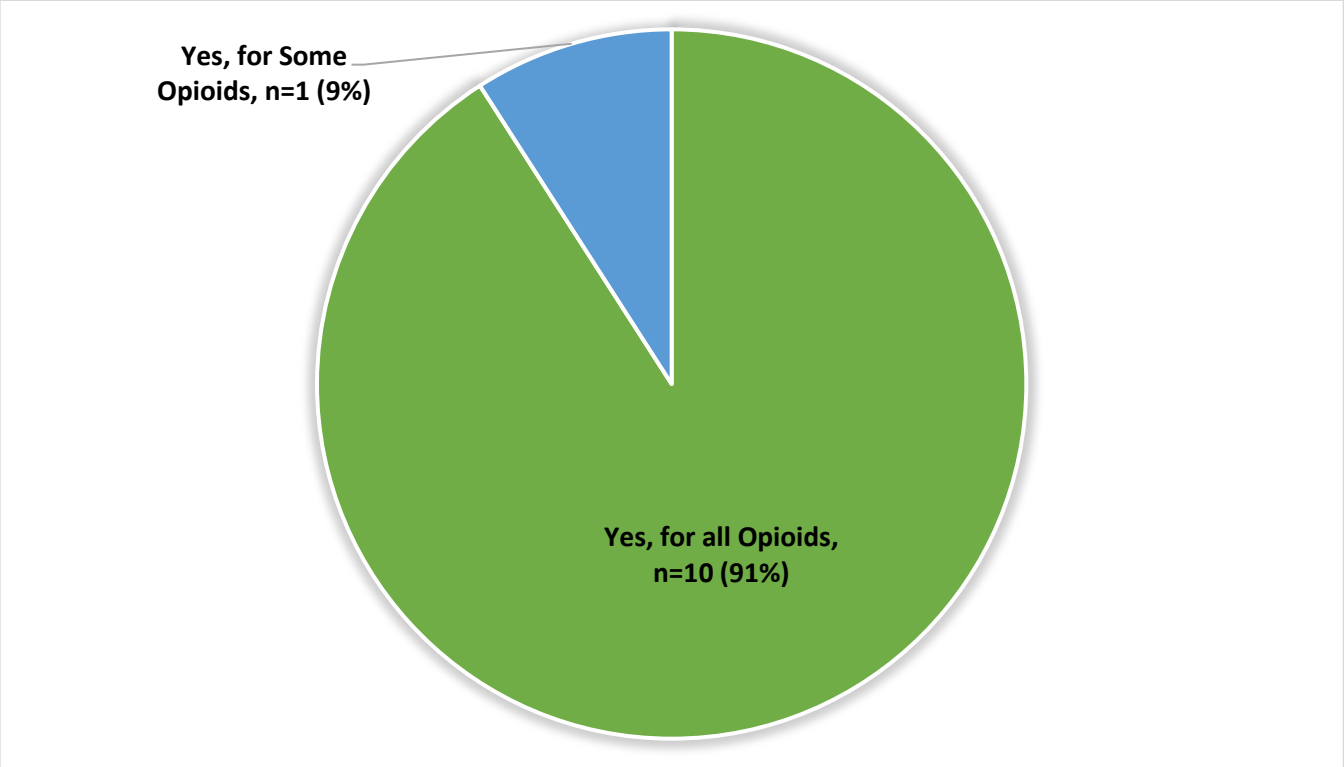


Table 118 - POS Edit in Place to Limit the Days' Supply Dispensed of an Initial Opioid Prescription for Opioid Naïve Patients

Response	MCO Names	Count	Percentage
Yes, for all opioids	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine	10	90.91%
Yes, for some opioids	United Healthcare	1	9.09%
State Totals		**11**	**100%**

a. If "Yes, for all opioids" or "Yes, for some opioids," what is your maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?

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

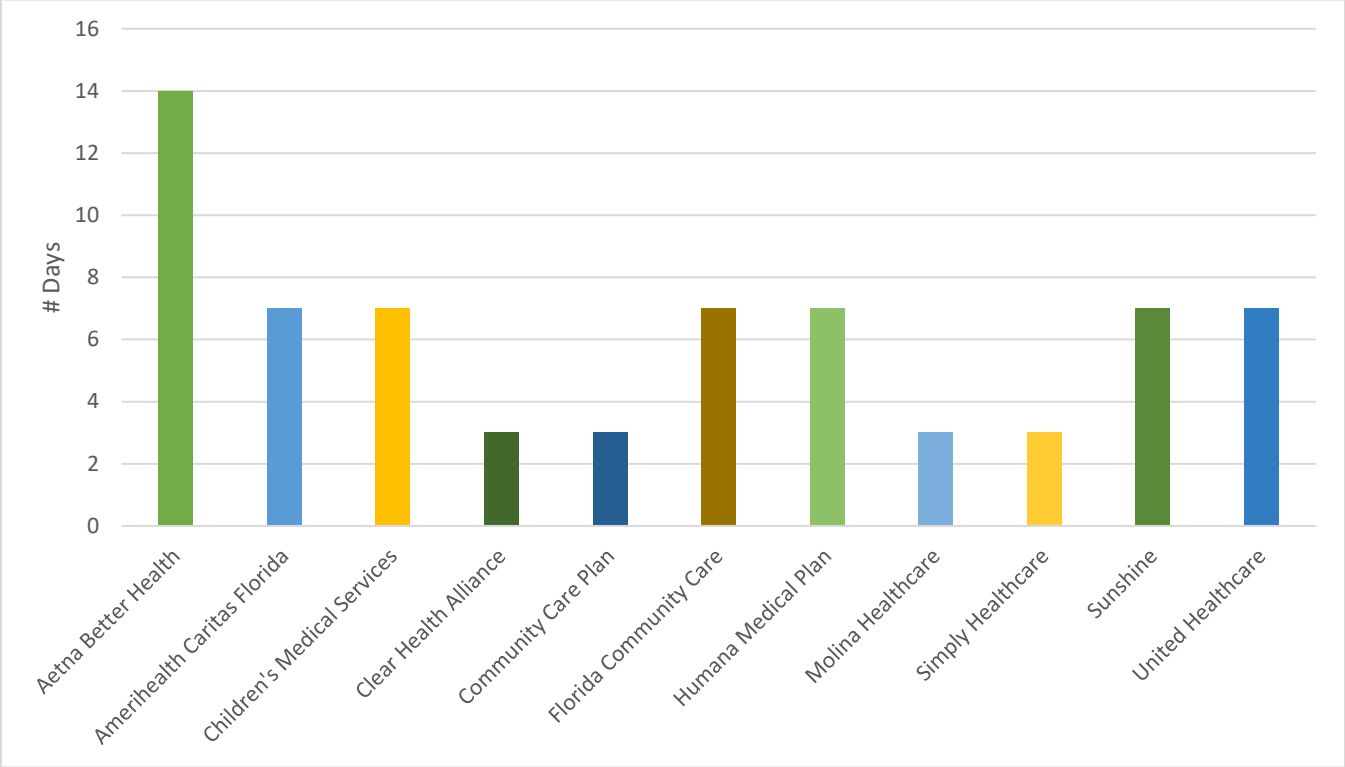


Table 119 - Maximum Number of Days Allowed for an Initial Opioid Prescription for Opioid Naïve Patients

MCO Names	Response (Days)
Aetna Better Health	14
Amerihealth Caritas Florida	7
Children's Medical Services	7
Clear Health Alliance	3
Community Care Plan	3
Florida Community Care	7
Humana Medical Plan	7
Molina Healthcare	3
Simply Healthcare	3
Sunshine	7
United Healthcare	7
State Totals	**68**

3. Does your MCO have POS edits in place to limit the quantity dispensed of opioids?

Figure 83 - POS Edits in Place to Limit the Quantity Dispensed of Opioids

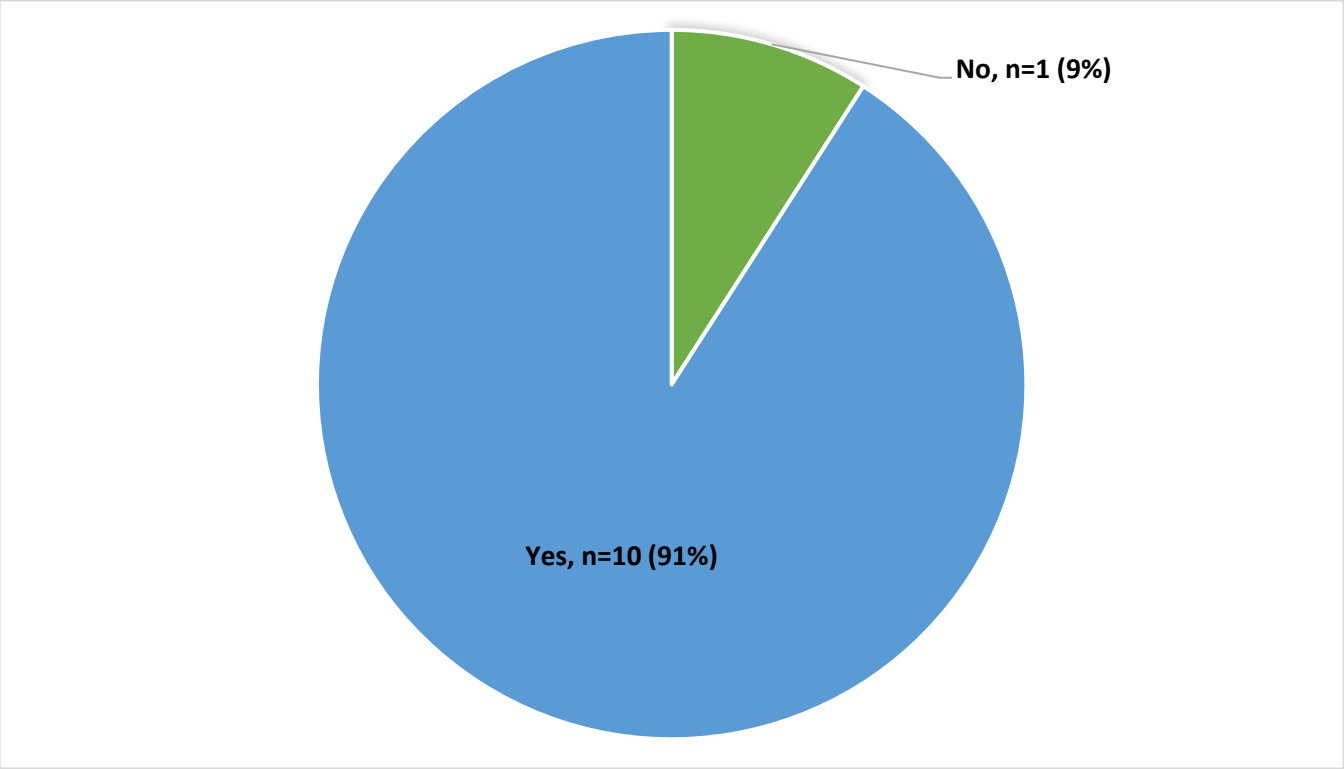


Table 120 - POS Edits in Place to Limit the Quantity Dispensed of Opioids

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Molina Healthcare	1	9.09%
State Totals		**11**	**100%**

If “No,” please explain why not.

Table 121 - Explanations for Not Having POS Edits in Place to Limit the Quantity Dispensed of Opioids

State	Explanation
Molina Healthcare	Point of sale edits will stop any opioid products (short or long acting or in combination) when the daily cumulative total reaches 90 MME. Also, per plan design, the maximum day supply is 34 days. Quantity limits do not apply when a patient has a diagnosis of palliative care, hospice, sickle cell disease, or cancer

a. If "Yes," does your MCO have POS edits in place to limit the quantity dispensed of short-acting (SA) opioids?

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

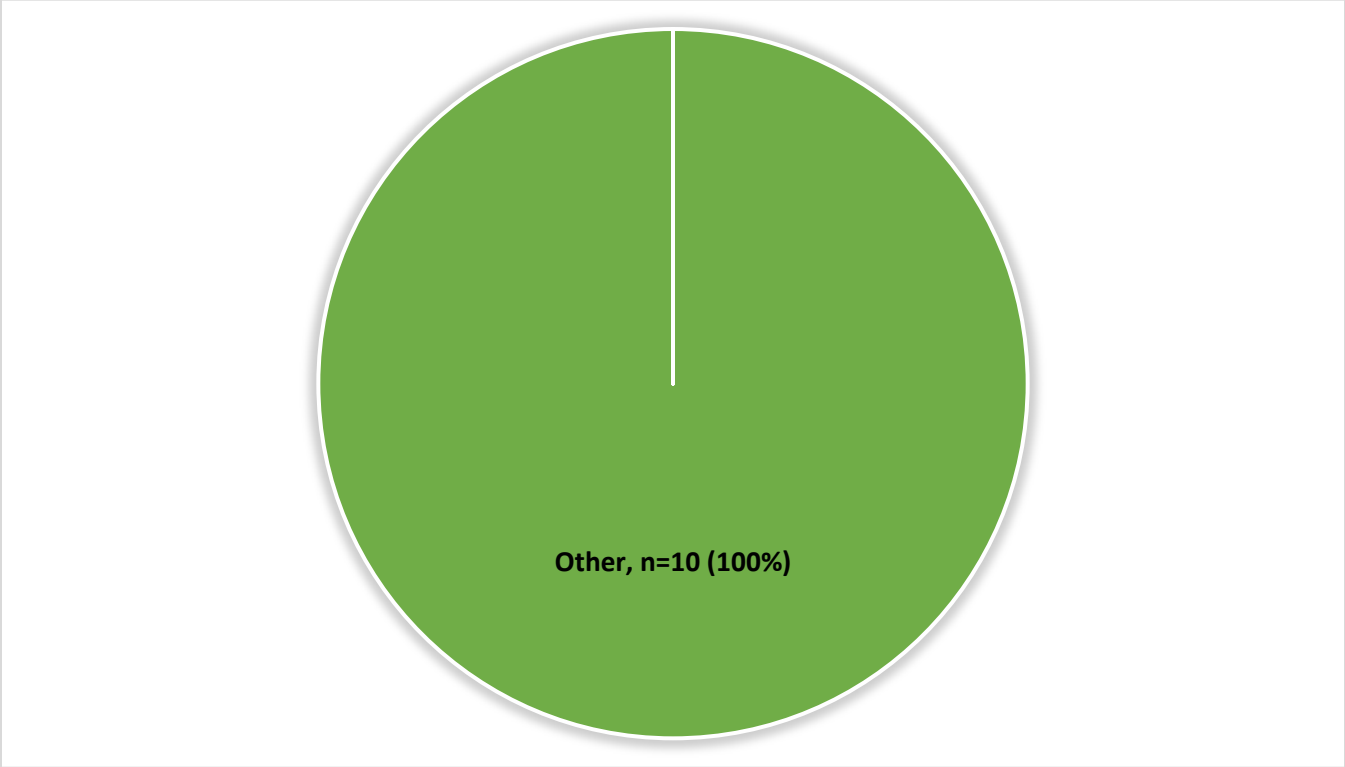


Table 122 - POS Edits in Place to Limit the Quantity Dispensed of Short-Acting (SA) Opioids

Response	MCO Names	Count	Percentage
Other	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	10	100.00%
State Totals		**10**	**100%**

If "Other," please explain

Table 123 - "Other" Explanations for POS Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

MCO Name	Explanation
Aetna Better Health	Schedule II Short Acting (SA) Narcotics: Max of 3-day supply and 2 fills per month. If "Acute Pain Exemption" is written on prescription, then max of 7-day supply and 2 fills per month. Schedule III-V SA Narcotics: Max of 14-days of therapy per month.
Amerihealth Caritas Florida	ACFL has implemented pharmacy point of sale safety edits including: an early refill threshold of 90% for all medications including controlled substances; 7-day supply limit for all short acting opioid containing products. Note: Schedule CII short acting opioid medications are limited to a 3-day supply, and up to a maximum of 7 days if a prescriber indicates "Acute Pain exemption" on the prescription o Schedule CIII to CV medications will be limited to a maximum 7-day supply. Short acting opioids are limited to a 7 day supply Short acting opioids are limited to 2 fills in a 27 day period Long acting opioids are limited to 1 fill in a 27 day period

MCO Name	Explanation
	*excluding recipients with a diagnosis of Cancer, Sickle Cell, or CNMP (chronic non-malignant pain)
Children's Medical Services	Quantity limits are in place for short-acting opioids and the limitations are drug specific.
Clear Health Alliance	C II Opioids: We follow AHCA PDL opioid POS edits. For new prescriptions, there is a 3-day supply limit per fill, a maximum of two-3-day supplies per 30 days, or a 7-day supply limit with proper documentation on the prescription, or a maximum of two 7-day supplies per 30 days. Exceptions for: Members with certain documented conditions such as cancer-related pain, or Sickle Cell. Other conditions reviewed on a case-by-case basis. CIII - IV Opioids: For new prescriptions, there is a 14-day supply limit per 30 days. Limits are waived for members with certain diagnosis codes.
Community Care Plan	CCP's PBM follows the AHCA weekly comprehensive drug list "summary of limitations" for quantity limits and have the AHCA parameters set of for POS activity. Based on the type of opioid and strength, the SA opioid may have a 30-day quantity limit identified in the weekly PDL (ex/Oxycodone ir). Additional info For Schedule II: Maximum day supply = 3 Maximum of two 3-day supplies per 30 days For Schedule II with 'Acute Pain Exemption' on Rx: Maximum day supply = 7 Maximum of two 7-day supplies per 30 days For Schedule III-V: Maximum days supply = 14 Maximum of 14 day supply per 30 days *excluding recipients with a diagnosis of Cancer, Sickle Cell, or CNMP (chronic non-malignant pain)
Florida Community Care	Other. Yes, adherence to State SDL guidance; Quantity limits are in place for SA opioids dependent on the medication and its MME value.
Humana Medical Plan	Limits are based on AHCAs summary of limitatons for Short acting opioids.
Simply Healthcare	C II Opioids: We follow AHCA PDL opioid POS edits. For new prescriptions, there is a 3-day supply limit per fill, a maximum of two-3-day supplies per 30 days, or a 7-day supply limit with proper documentation on the prescription, or a maximum of two 7-day supplies per 30 days. Exceptions for: Members with certain documented conditions such as cancer-related pain, or Sickle Cell. Other conditions reviewed on a case-by-case basis. CIII - IV Opioids: For new prescriptions, there is a 14-day supply limit per 30 days. Limits are waived for members with certain diagnosis codes.
Sunshine	Quantity limits are in place for short-acting opioids and the limitations are drug specific.
United Healthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of short acting opioids. All opioid naive members are limited to a 90 MME cumulative maximum of short-acting and long-acting opioids. In addition, UnitedHealthcare also implements product specific quantity limit on our short-acting opioid products for all members. Each quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.

b. Does your MCO currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?

Figure 85 - POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

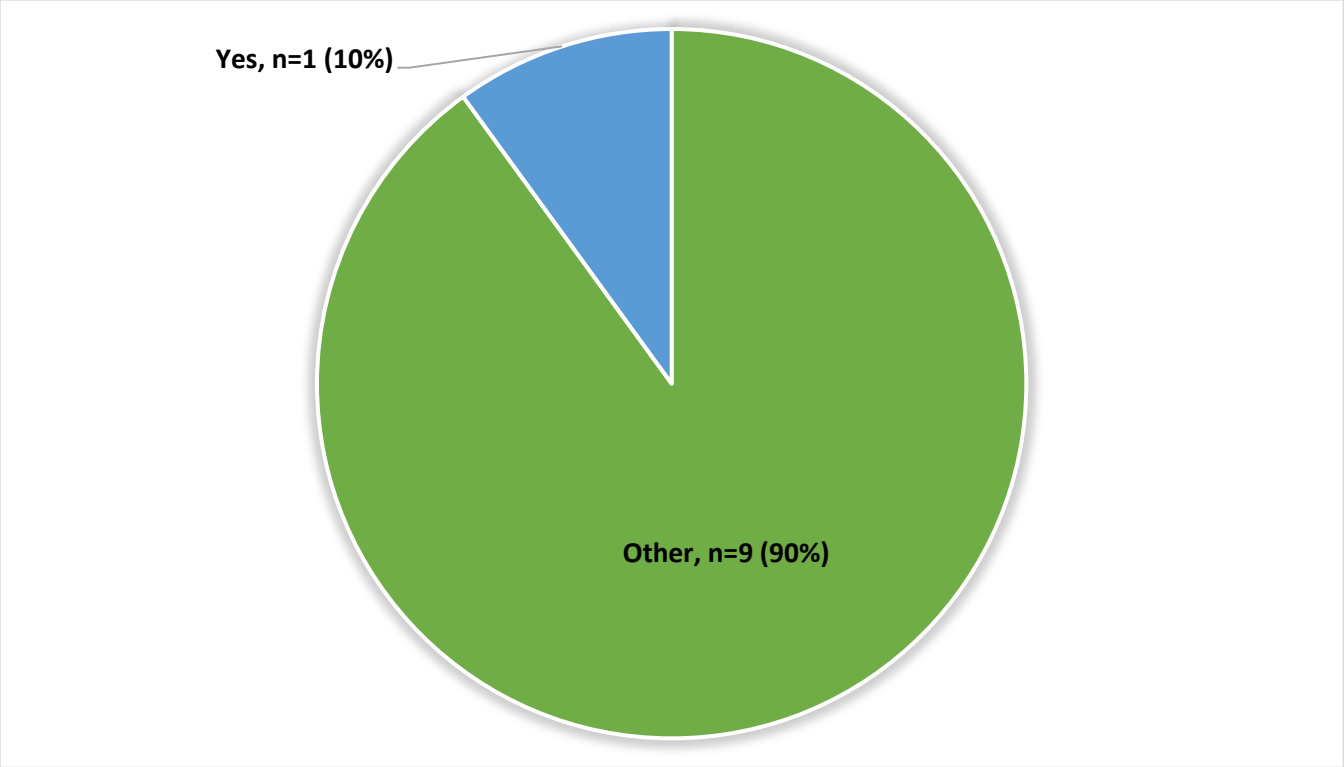


Table 124 - POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

Response	MCO Names	Count	Percentage
Yes	Humana Medical Plan	1	10.00%
Other	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Simply Healthcare, Sunshine, United Healthcare	9	90.00%
State Totals		**10**	**100%**

If "Yes," please specify limit as # of units.

Figure 86 - Limits for Quantity Dispensed of Long-Acting Opioids

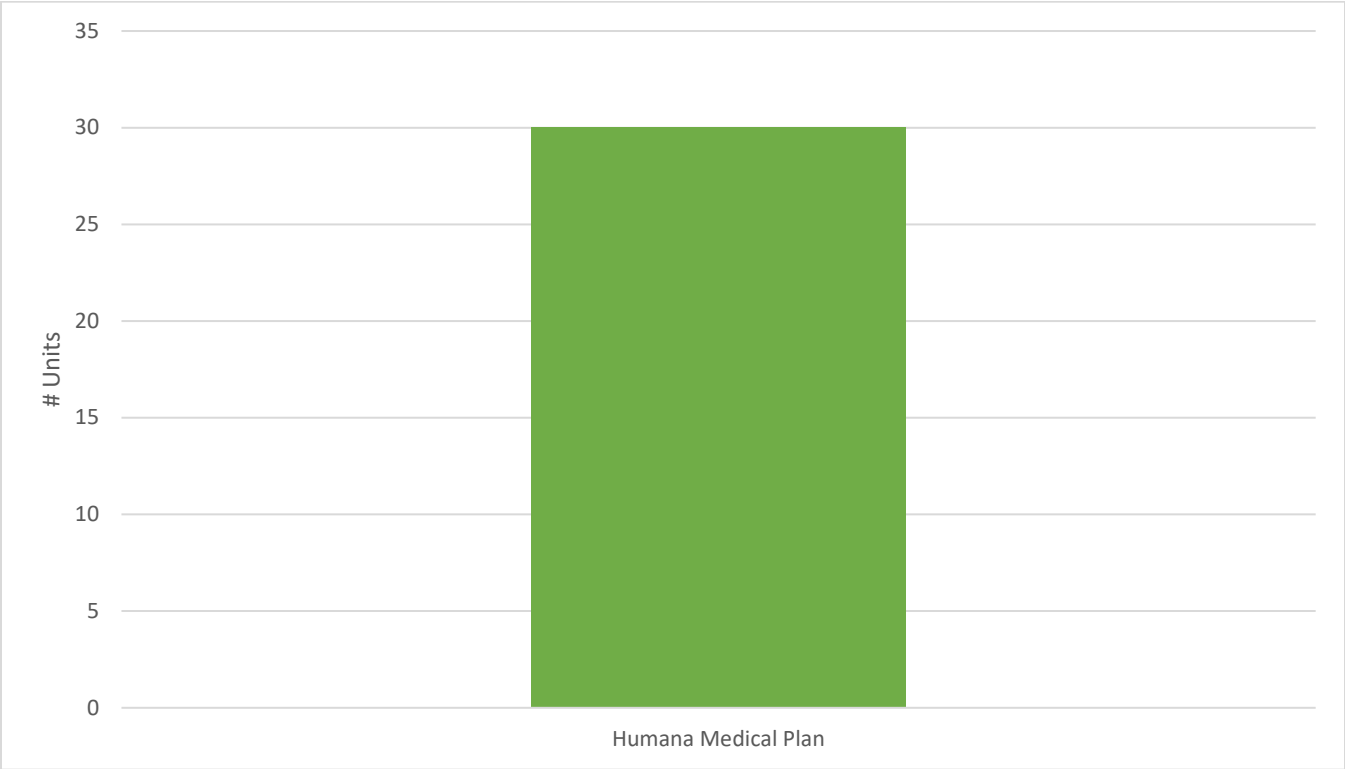


Table 125 - Limits for Quantity Dispensed of Long-Acting Opioids

MCO Names	Units
Humana Medical Plan	30
State Totals	**30**

If "Other," please explain.

Table 126 - "Other" Explanations for POS Edits in Place to Limit the Quantity Dispensed of Long-Acting Opioids

MCO Name	Explanation
Aetna Better Health	Yes, 30 day supply. Dosing frequency per day varies by opioid medication and aligns with state PDL requirements.
Amerihealth Caritas Florida	Varies based on the products being dispensed based on state quantity limits guidelines
Children's Medical Services	Quantity limits are in place for long-acting opioids and the limits are drug specific.
Clear Health Alliance	Quantity limits for LAO are per the AHCA PDL requirements and summary of drug limitations.
Community Care Plan	CCP's PBM follows the AHCA weekly comprehensive drug list "summary of limitations" for quantity limits and have the AHCA parameters set of for POS activity. Based on the type of opioid, dosage form and strength.
Florida Community Care	Other. Yes, adherence to State SDL guidance.
Simply Healthcare	Quantity limits for LAO are per the AHCA PDL requirements and summary of drug limitations.
Sunshine	Quantity limits are in place for long-acting opioids and the limits are drug specific.

MCO Name	Explanation
United Healthcare	UnitedHealthcare Community Plan does have point-of-sale edits in place to limit the quantity dispensed of long-acting opioids. All opioid naive members are limited to a 90 MME cumulative maximum of short-acting and long-acting opioids. Each opioid quantity limit is drug specific and determined utilizing FDA-based dosing schedules and dose optimization or by utilizing FDA maximum doses, where applicable.

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

Figure 87 - Have Measures Other Than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

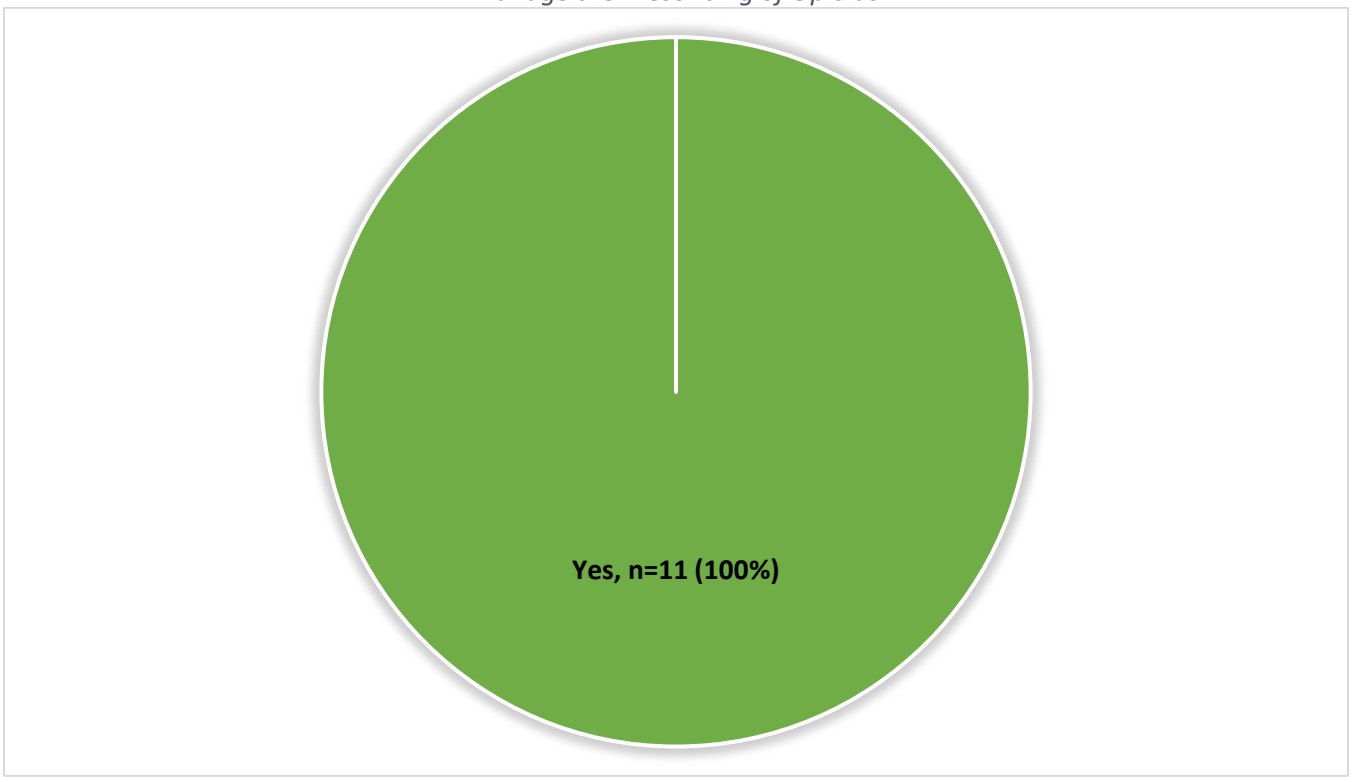


Table 127 - Have Measures Other Than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," check all that apply.

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

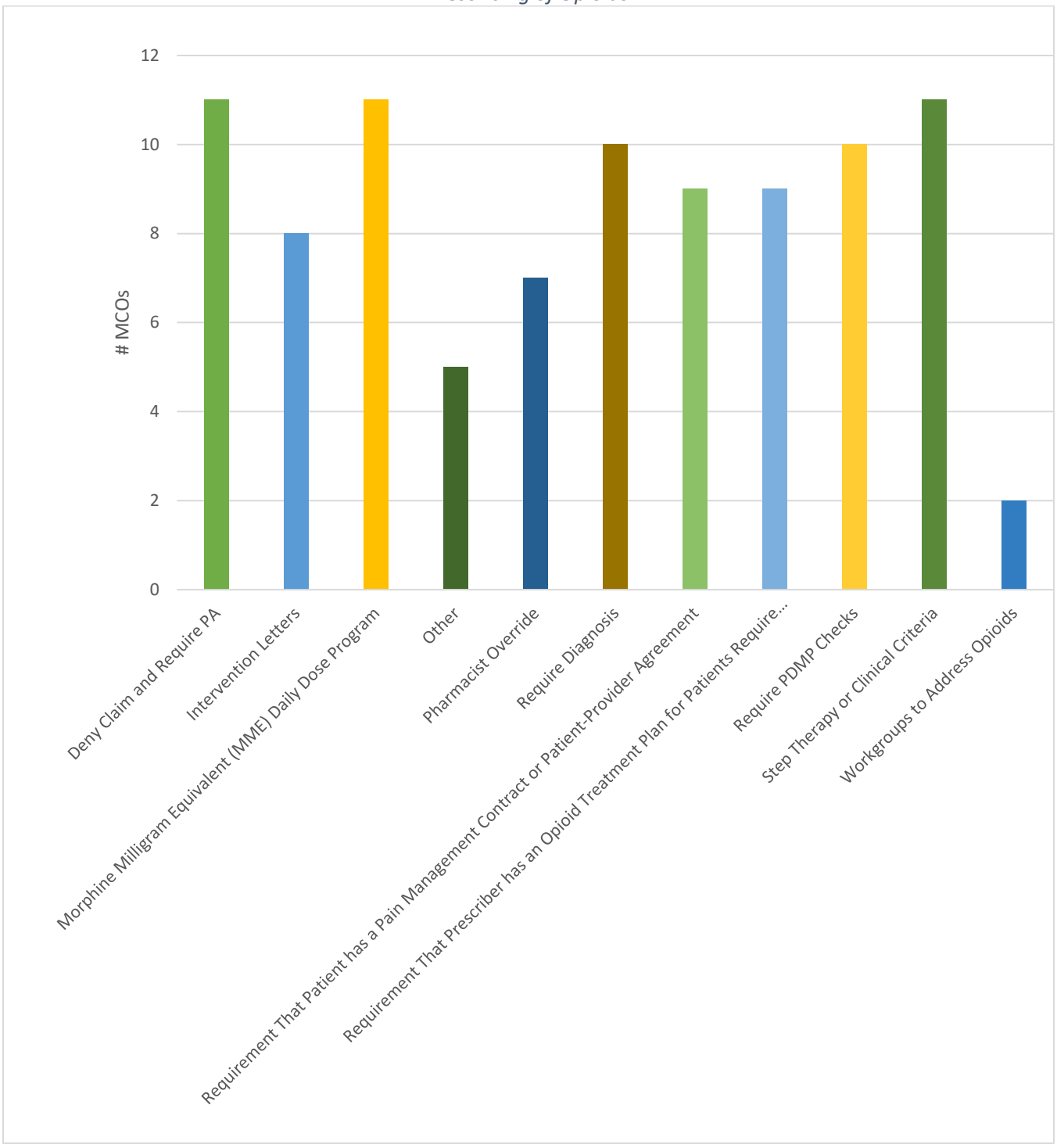


Table 128- Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	MCO Names	Count	Percentage
Deny claim and require PA	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care	11	11.83%

Response	MCO Names	Count	Percentage
	Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare		
Intervention letters	Children's Medical Services, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	8	8.60%
Morphine Milligram Equivalent (MME) daily dose program	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	11.83%
Pharmacist override	Children's Medical Services, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	7	7.53%
Require diagnosis	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	10	10.75%
Requirement that patient has a pain management contract or Patient-Provider agreement	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	9	9.68%
Requirement that prescriber has an opioid treatment plan for patients Require documentation of urine drug screening results	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	9	9.68%
Require PDMP checks	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	10.75%
Step therapy or Clinical criteria	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	11.83%
Workgroups to address opioids	Florida Community Care, Humana Medical Plan	2	2.15%
Other	Children's Medical Services, Community Care Plan, Florida Community Care, Molina Healthcare, Sunshine	5	5.38%
State Totals		**93**	**100%**

If "Other," please specify.

Table 129 - "Other" Explanations for Measures other than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

MCO Name	Explanation
Children's Medical Services	Our Excessive Controlled substance edit is intended to capture multiple controlled substance claims (for the same drug) within the past 30 days. Once triggered, it would require the Pharmacists to override the edit for the prescription to pay. Certain edits will deny the claim and request that a prior authorization be submitted. These edits are Buprenorphine-Opioid, which restricts the use of an opioid prescription being filled while buprenorphine or buprenorphine/naloxone is being used to treat opioid dependence, and Ingredient Duplication, which reviews for same generic ingredients in more than one drug prescribed. Our MME edit also limits initial opioid fills to a seven day supply. Our Step Therapy ensures that short acting opioids are tried and failed before long acting opioids.
Community Care Plan	CCP follows AHCA guidance and DUR edits and knows that Medicaid prescribers are required to follow State guidance related to prescribing opioids and should have treatment plans in place, which may include a pain management contract with the patient.
Florida Community Care	Med D Program
Molina Healthcare	Medical records must document the clinical rationale for high dose of opioids in the member and medical records documenting titration of medication up to current dose.
Sunshine	Our Excessive Controlled substance edit is intended to capture multiple controlled substance claims (for the same drug) within the past 30 days. Once triggered, it would require the Pharmacists to override the edit for the prescription to pay. Certain edits will deny the claim and request that a prior authorization be submitted. These edits are Buprenorphine-Opioid, which restricts the use of an opioid prescription being filled while buprenorphine or buprenorphine/naloxone is being used to treat opioid dependence, and Ingredient Duplication, which reviews for same generic ingredients in more than one drug prescribed. Our MME edit also limits initial opioid fills to a seven day supply. Our Step Therapy ensures that short acting opioids are tried and failed before long acting opioids.

5. Does your MCO 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.

Figure 89 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

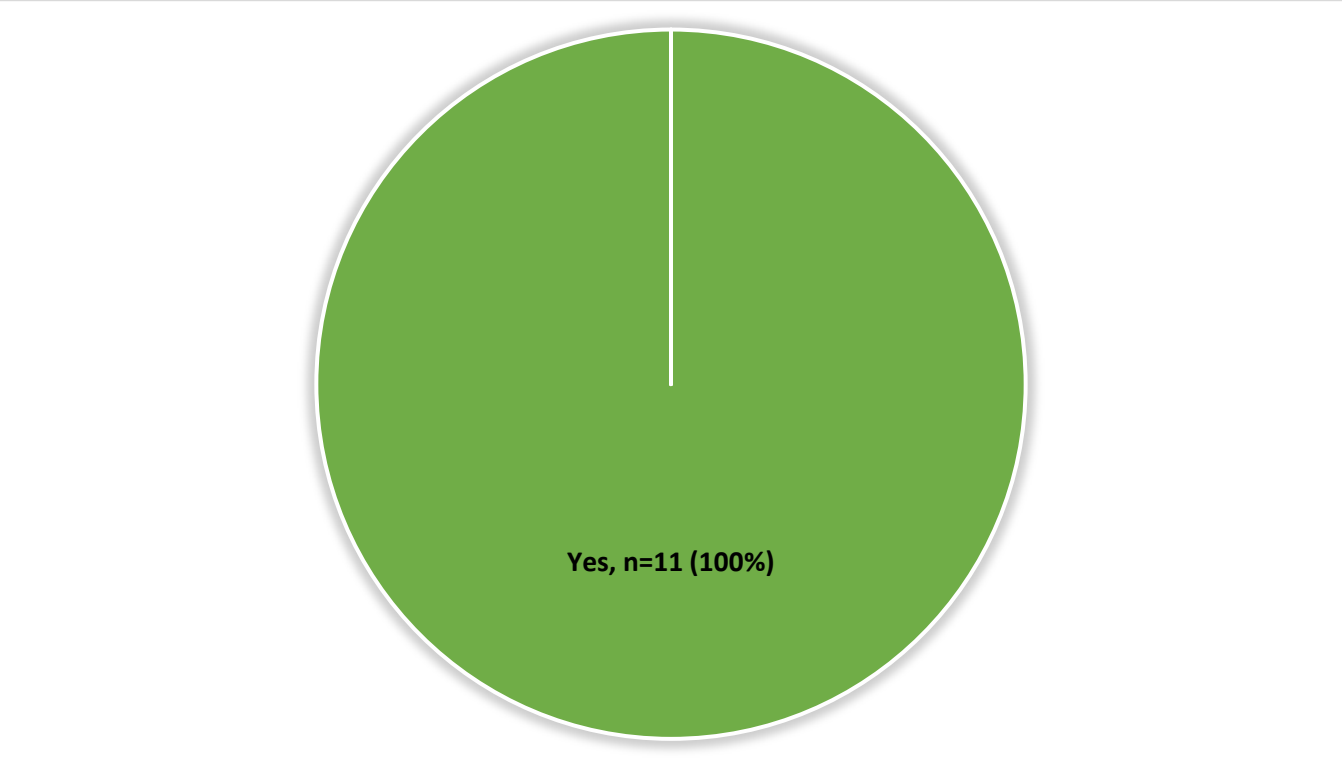


Table 130 - POS Edits to Monitor Duplicate Therapy of Opioid Prescriptions

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

6. Does your MCO have POS edits to monitor early refills of opioid prescriptions dispensed?

Figure 90 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

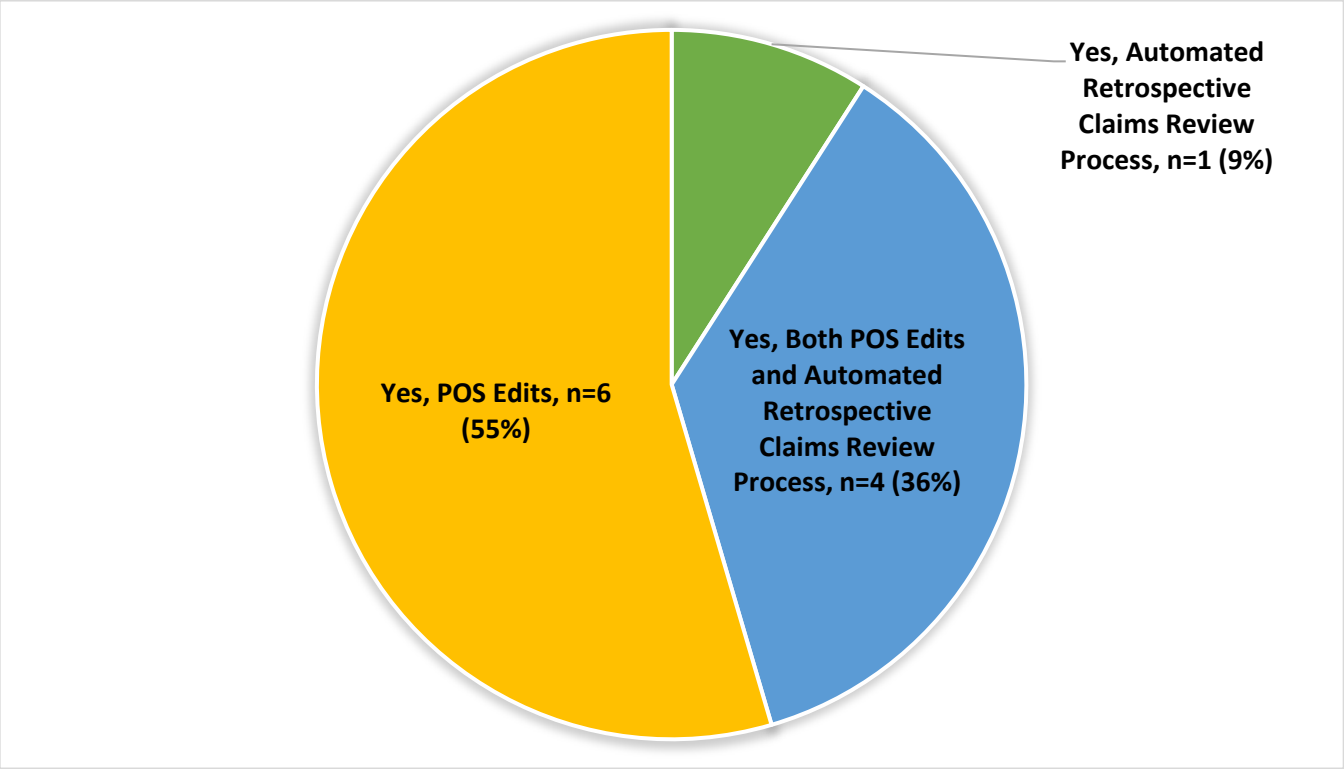


Table 131 - POS Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

Response	MCO Names	Count	Percentage
Yes, automated retrospective claims review process	Humana Medical Plan	1	9.09%
Yes, both POS edits and automated retrospective claims review process	Aetna Better Health, Amerihealth Caritas Florida, Community Care Plan, United Healthcare	4	36.36%
Yes, POS edits	Children's Medical Services, Clear Health Alliance, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine	6	54.55%
State Totals		**11**	**100%**

7. Does your MCO have comprehensive automated retrospective claim reviews to monitor opioid prescriptions exceeding program limitations (early refills, duplicate fills, quantity limits and days' supply)?

Figure 91 - Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions in Excess of Program Limitations

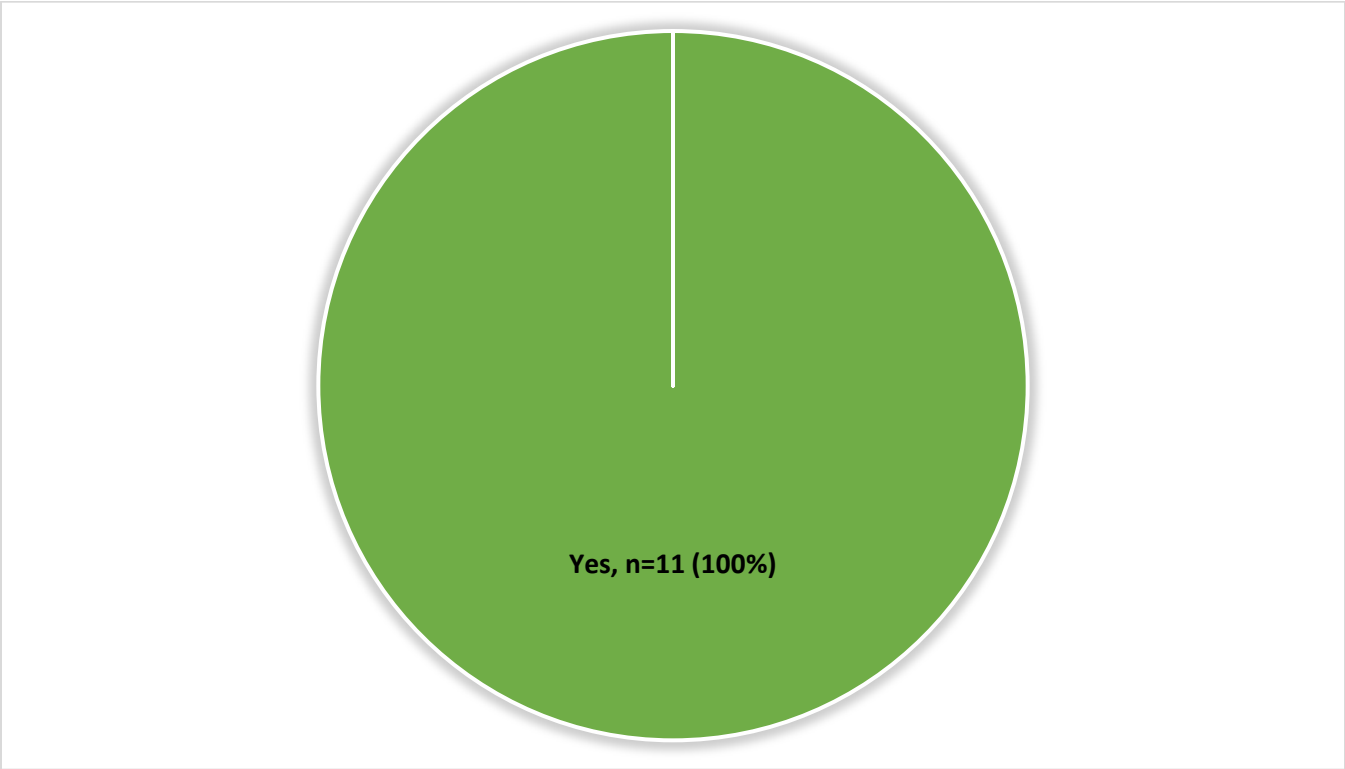


Table 132 - Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions in Excess of Program Limitations

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," please explain in detail scope, nature, and frequency of these retrospective reviews.

Table 133 - Scope, Nature, and Frequency of Retrospective Reviews of Opioid Prescription Monitoring in Excess of Program Limitations

MCO Name	Retrospective Review Details
Aetna Better Health	In each of these instances the claims system would utilize a look back of member's claims history and where limitation is exceeded would result in a hard reject at POS. This would then require prior authorization or medical necessity to exceed the limit and continue processing the prescription as a paid claim. The prescription claim would only be paid if medical necessity was demonstrated per approved guidelines and the prior authorization was approved. This would happen every time an opioid prescription exceeded set limitations.

MCO Name	Retrospective Review Details
Amerihealth Caritas Florida	Members exceeding any opioid related limitations would require prior authorization and pharmacist review. Plan's PBM provides reporting for potential member lock in. The plan then reviews and monitors those individuals that have been placed in the lock in program.
Children's Medical Services	Core SMS checks for excessive opioid utilization (GPI-65) via cumulative morphine milligram equivalent (cMME) across multiple drugs and prescriptions. This edit will identify all active opioid prescriptions in a member's drug profile and convert the opioid dose to the equivalent dose of morphine. On a quarterly basis, clinical pharmacists will evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity.
Clear Health Alliance	Our retrospective claims review process is automated. Within this process, providers are notified of members who exceed the MME thresholds. Our clinical rules regularly examine pharmacy claims to identify members that meet program criteria.
Community Care Plan	CCP's PBM has monitoring parameters for reports and edits in place that follow AHCA guidance provided in the WCDL under " automated PA logic." PBM POS edits identify early refills, quantity and days' supply limits. Edits like the Short -acting before long-acting; looks back 60 days to see if patient has had at least a 14-day supply in total of a SA opioid before allowed to fill a LA opioid. Members having a diagnosis of CA, SCD or LTC are excluded from this edit. The PBM provides monthly and quarterly opioid reports which allow for identifying potential lock-in candidates, average daily MME's, prescriber avg MME's prescribed, and pharmacies filling these prescriptions. CCP has created an in-house tool to assist with tracking and identifying candidates for lock-in program.
Florida Community Care	The CVS Caremark Safety and Monitoring Solution (SMS) helps identify potential unsafe and at risk opioid use by reviewing claims through an automated series of edits that identify members with high-cost drug use patterns suggesting potential abuse or misuse. A clinical pharmacist then conducts an analysis of the generated profiles, which are stratified by risk score. Based on that analysis, if a potential case of at risk opioid prescribing is identified, we will send a letter to the appropriate prescriber(s) alerting them to the issue, and will conduct follow-up activities on the targeted participants for up to six months.
Humana Medical Plan	Opioid High-Dose: Patients who have an average Morphine Equivalent Dosage (MME) between 90-119 MG over 30 days to 6 months Communication/Intervention: Provider letter to Physician
Molina Healthcare	The CVS Caremark Safety and Monitoring Solution (SMS) helps identify potential unsafe and at risk opioid use by reviewing claims through an automated series of edits that identify members with high-cost drug use patterns suggesting potential abuse or misuse. A clinical pharmacist then conducts an analysis of the generated profiles, which are stratified by risk score. Based on that analysis, if a potential case of at risk opioid prescribing is identified, we will send a letter to the appropriate prescriber(s) alerting them to the issue, and will conduct follow-up activities on the targeted participants for up to six months.
Simply Healthcare	Our retrospective claims review process is automated. Within this process, providers are notified of members who exceed the MME thresholds. Our clinical rules regularly examine pharmacy claims to identify members that meet program criteria.

MCO Name	Retrospective Review Details
Sunshine	Core SMS checks for excessive opioid utilization (GPI-65) via cumulative morphine milligram equivalent (cMME) across multiple drugs and prescriptions. This edit will identify all active opioid prescriptions in a member's drug profile and convert the opioid dose to the equivalent dose of morphine. On a quarterly basis, clinical pharmacists will evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity.
United Healthcare	UnitedHealthcare Community Plan is enrolled in the Abused Medications Program through OptumRx, this is a RDUR program that notifies providers via fax/mail on a daily basis of chronic early refill of opioids, therapeutic duplication of short + short acting opioids and therapeutic duplication of long + long acting opioids, and high daily doses of opioids (over cumulative 90 MME and number of units per day).

8. Does your MCO currently have POS edits in place or automated retrospective claim reviews to monitor opioids and benzodiazepines being used concurrently?

Figure 92 - POS Edits or Automated Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Used Concurrently

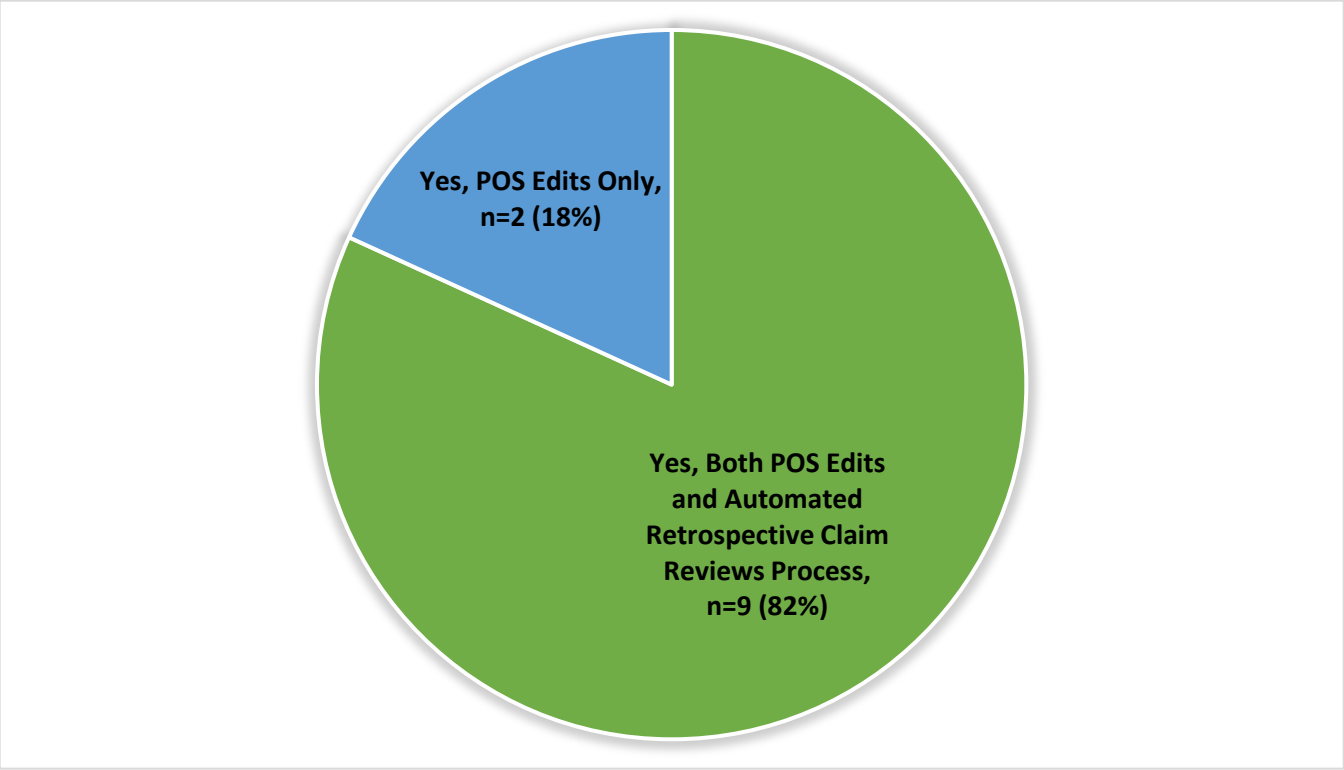


Table 134 - POS Edits or Automated Retrospective Claim Reviews to Monitor Opioids and Benzodiazepines Used Concurrently

Response	MCO Names	Count	Percentage
Yes, both POS edits and automated retrospective claim reviews process	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	81.82%

Response	MCO Names	Count	Percentage
Yes, POS edits only	Amerihealth Caritas Florida, Humana Medical Plan	2	18.18%
State Totals		**11**	**100%**

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

Table 135 - Explanations of Scope and Nature of Reviews and Edits for Opioids and Benzodiazepines Being Used Concurrently

MCO Name	Explanation
Aetna Better Health	There is a concomitant benzo/opioid point of sale edit in place for long-acting opioids and benzodiazepine overlapping therapy. The edit will fire a DUR reject error with a message for drug duplication toxicity warning for overlapping benzo and LA opioid therapy for any combination of opioids and benzodiazepines. This edit can be overridden by the pharmacist by entering a DUR code if appropriate. Members with cancer, sickle cell, or seizure diagnoses in the past 730 days or members with a LTC indicator or patient residence 03 are exempt from edit requirements.
Amerihealth Caritas Florida	Claims for opioids and benzodiazepines prescribed concurrently will populate a Soft Error informing the pharmacist of a potential drug drug interaction
Children's Medical Services	Children's Medical Services' Opioid/Benzodiazepine edit is a message only edit intended to identify members who are receiving concurrent therapy with opioid and benzodiazepine medications. Children's Medical Services utilizes the PBM's Safety and Monitoring retrospective DUR program around high risk drug classes including controlled substances and reduces instances of fraud, waste, and abuse through regular claims monitoring and timely interventions. Opioid and Benzodiazepine concurrent usage is one of the drug interactions captured which would result in a targeted letter outreach to the provider identifying therapeutic concern(s) and requests a physician response.
Clear Health Alliance	both POS edits and automated retrospective claims review process. RDUR process that will identify members receiving opioids and benzodiazepines. Messages are sent to providers. We also have AHCA PDL opioid and benzodiazepine DUR edit.
Community Care Plan	Magellan Rx/Prime Therapeutics (PBM) has POS edits in place based on the AHCA guidance. The PBM sends out provider notices as part of the RetroDUR activities to notify them of the potential problems associated with these concurrent therapies. At POS the dispensing pharmacist will receive an alert about the combination. The pharmacist is allowed to override this combination twice with in180 days at the third override request a PA will be required and the PBM clinical pharmacist will then review the clinical information provided by the prescriber to assess why both therapies are needed.
Florida Community Care	Yes.-POS. The POS programs trigger at the pharmacy and the pharmacist reviews the clinical issue and uses his/her professional judgement to decide whether a call to the physician is warranted. Yes- Retrospective reviews. Claims are retrospectively reviewed to target members utilizing both medications and their prescribers are sent a fax to recommend tapering and discontinuation of one or both meds or switching one or both to a safer alternative; either one, if medically appropriate. Our Prescription Safety Management program reviews higher risk member utilization of all controlled substances, including concurrent use of opioids and benzodiazepines, for

MCO Name	Explanation
	potential intervention including prescriber lettering and/or additional enhanced interventions and restrictions.
Humana Medical Plan	Point of sale edits are implemented, that include concurrent opioid and benzodiazepine use. Safety alert will trigger when this combination occurs. There are additional safety edits designed to notify the dispensing pharmacist when a patient is taking (1) a long-acting opioid in combination with a benzodiazepine, 2) combination of opioid/benzodiazepine/muscle relaxant, or 3) duplicate therapy of multiple benzodiazepine products.
Molina Healthcare	The POS programs trigger at the pharmacy and the pharmacist reviews the clinical issue and uses his/her professional judgement to decide whether a call to the physician is warranted. Concurrent therapy edit for Opioids and Benzodiazepines will reject at POS and allows pharmacists to override. Yes- Retrospective reviews. Claims are retrospectively reviewed to target members utilizing both medications and their prescribers are sent a fax to recommend tapering and discontinuation of one or both meds or switching one or both to a safer alternative; either one, if medically appropriate. Our Prescription Safety Management program reviews higher risk member utilization of all controlled substances, including concurrent use of opioids and benzodiazepines, for potential intervention including prescriber lettering and/or additional enhanced interventions and restrictions.
Simply Healthcare	Both POS edits and automated retrospective claims review process. RDUR process that will identify members receiving opioids and benzodiazepines. Messages are sent to providers. We also have AHCA PDL opioid and benzodiazepine DUR edit.
Sunshine	Sunshine Health Plan's Opioid/Benzodiazepine edit is a message only edit intended to identify members who are receiving concurrent therapy with opioid and benzodiazepine medications. Centene's utilizes the PBM's Safety and Monitoring retrospective DUR program around high risk drug classes including controlled substances and reduces instances of fraud, waste, and abuse through regular claims monitoring and timely interventions. Opioid and Benzodiazepine concurrent usage is one of the drug interactions captured which would result in a targeted letter outreach to the provider identifying therapeutic concern(s) and requests a physician response
United Healthcare	"1. UnitedHealthcare Community Plan has a Drug- Drug Interaction CDUR soft reject edit for Opioid + Benzodiazepine when the two medications are found to have overlapping days supply. The dispensing pharmacist is required to enter the appropriate NCPDP codes to override the reject and obtain a paid claim. No prior authorization is required for this approach. 2. Retrospective Review: As part of their Abused Medications Program, OptumRx notifies prescribers via fax/mail when a member is receiving an opioid and a benzodiazepine concurrently. "

9. Does your MCO currently have POS edits in place or automated retrospective claim reviews to monitor opioids and sedatives being used concurrently?

Figure 93 - POS Edits or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently

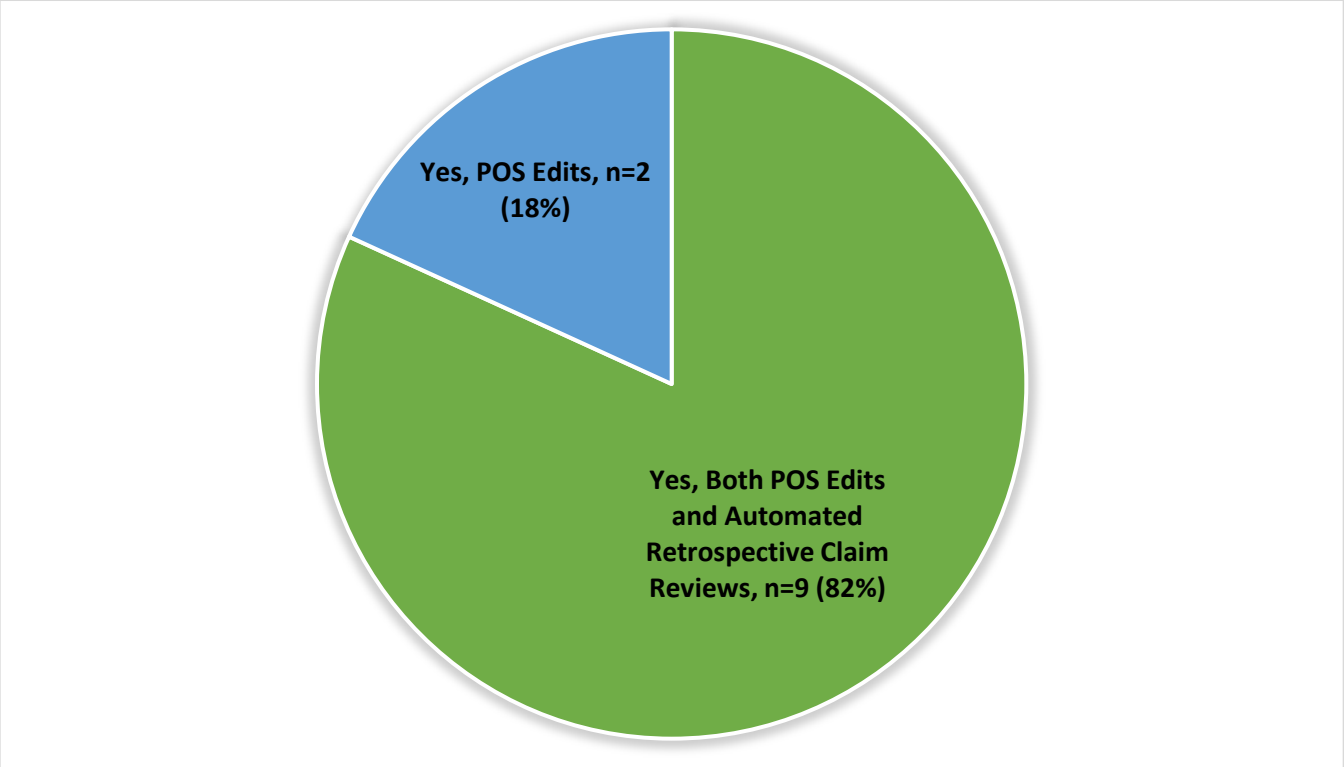


Table 136 - POS Edits or Automated Retrospective Claim Reviews to Monitor Opioids and Sedatives Being Used Concurrently

Response	MCO Names	Count	Percentage
Yes, both POS edits and automated retrospective claim reviews	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	81.82%
Yes, POS edits	Amerihealth Caritas Florida, Humana Medical Plan	2	18.18%
State Totals		**11**	**100%**

10. Does your MCO currently have POS edits in place or an automated retrospective claims review process to monitor opioids and antipsychotics being used concurrently?

Figure 94 - POS Edits or Automated Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently

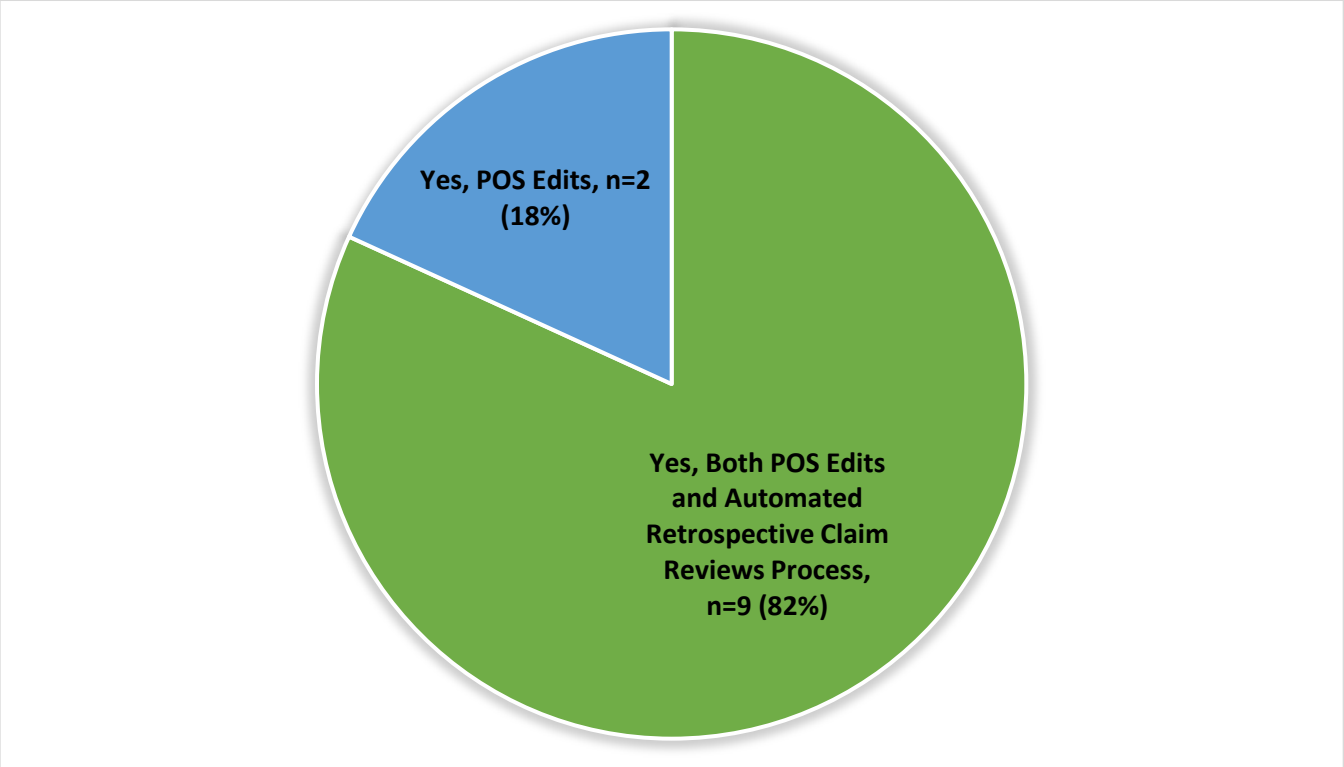


Table 137 - POS Edits or Automated Retrospective Claim Reviews to Monitor Opioids and Antipsychotics Being Used Concurrently

Response	MCO Names	Count	Percentage
Yes, both POS edits and automated retrospective claim reviews process	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	81.82%
Yes, POS edits	Amerihealth Caritas Florida, Humana Medical Plan	2	18.18%
State Totals		**11**	**100%**

11. Does your MCO have POS safety edits or perform automated respective claims reviews and/or provider education regarding beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis (multiple responses allowed)?

Figure 95 - POS Safety Edits, Automated Retrospective Claims Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

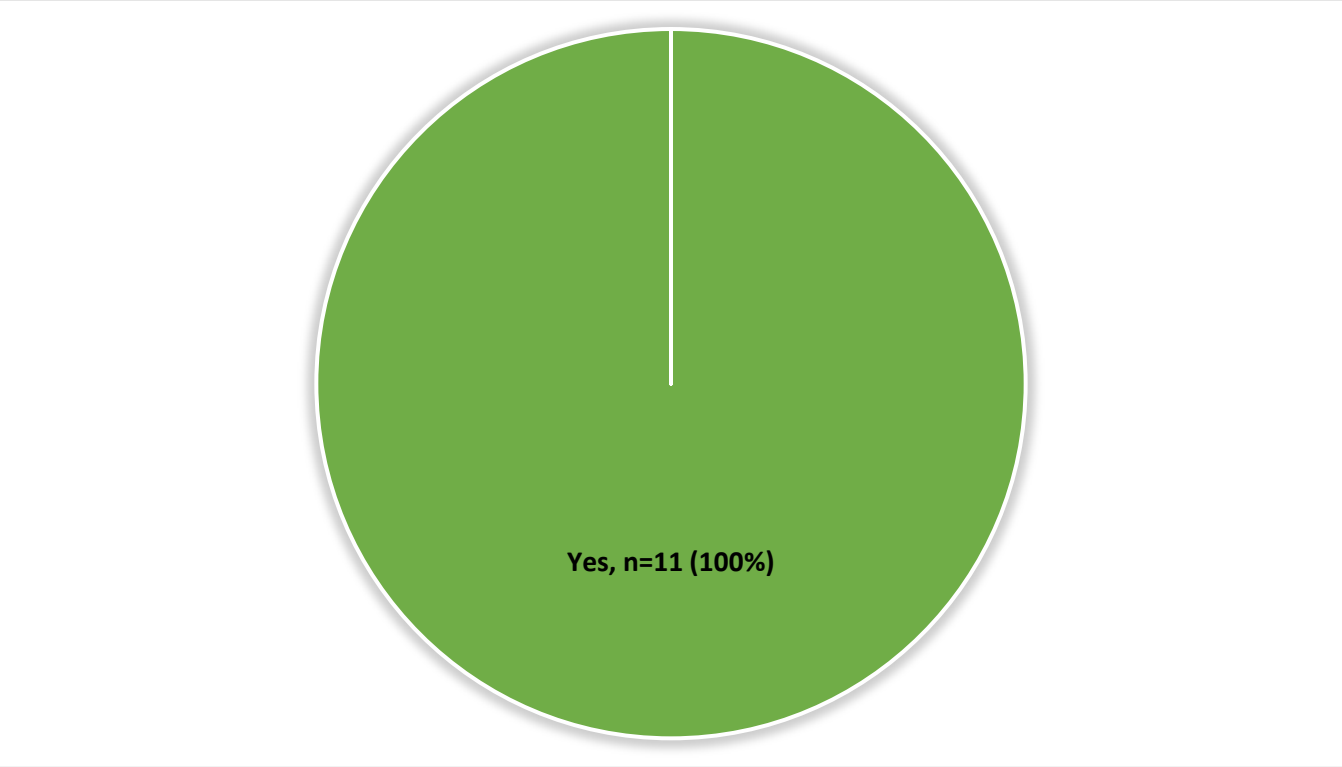


Table 138 - POS Safety Edits, Automated Retrospective Claims Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," please check all that apply.

Figure 96 - POS Safety Edits, Automated Retrospective Claims Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

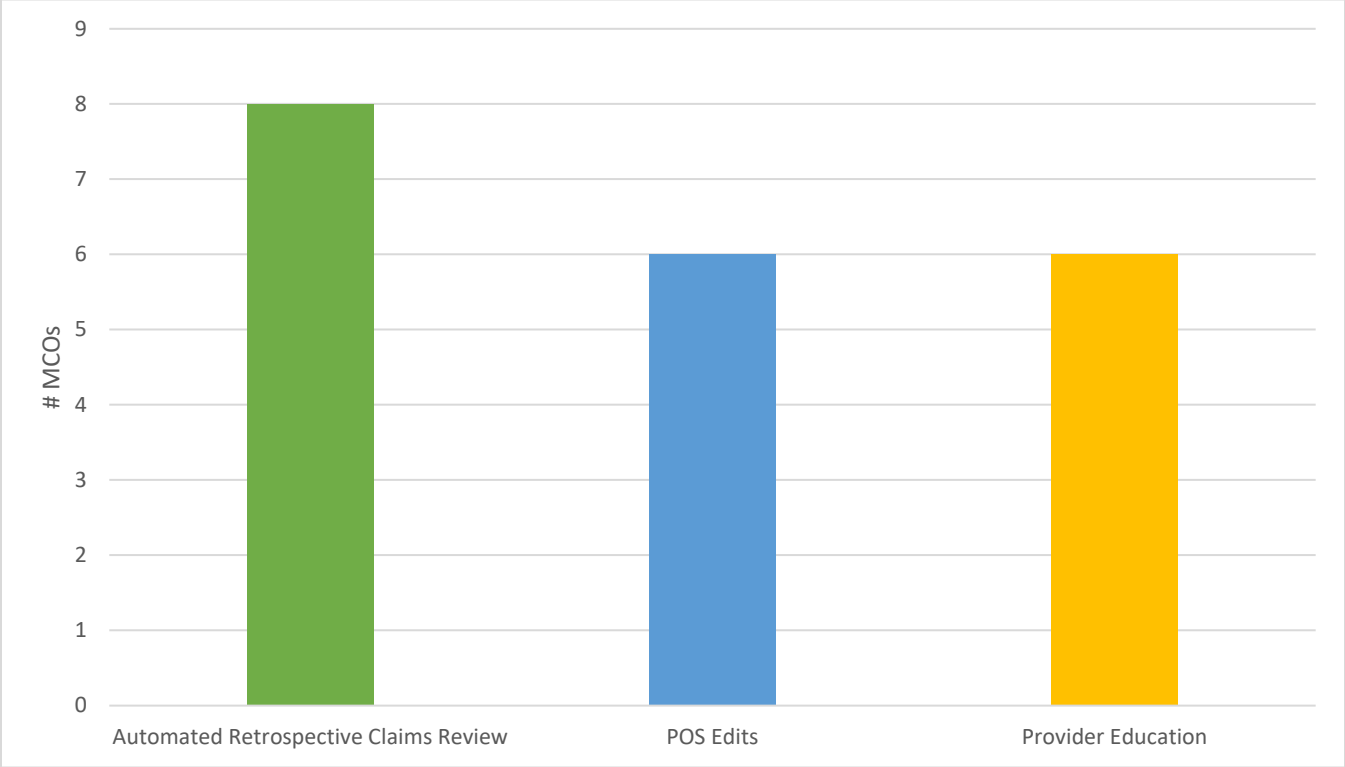


Table 139 - POS Safety Edits, Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

Response	MCO Names	Count	Percentage
Automated retrospective claims review	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	8	40.00%
POS edits	Amerihealth Caritas Florida, Children's Medical Services, Community Care Plan, Florida Community Care, Humana Medical Plan, Sunshine	6	30.00%
Provider education	Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Molina Healthcare, Simply Healthcare, Sunshine	6	30.00%
State Totals		**20**	**100%**

If "Automated retrospective claim reviews" and/or "Provider education," please indicate how often.

Figure 97 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

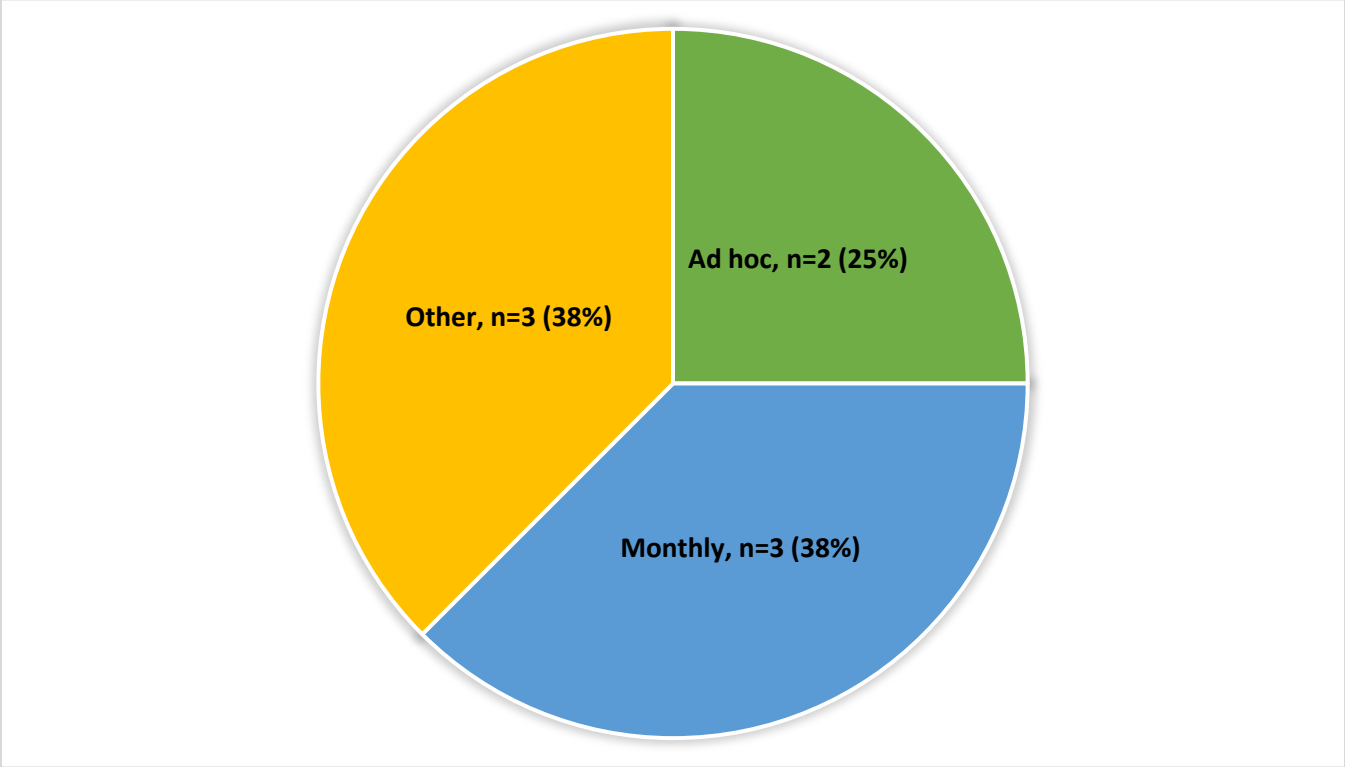


Table 140 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

Response	MCO Names	Count	Percentage
Ad hoc	Children's Medical Services, Sunshine	2	25.00%
Monthly	Aetna Better Health, Clear Health Alliance, Simply Healthcare	3	37.50%
Other	Amerihealth Caritas Florida, Molina Healthcare, United Healthcare	3	37.50%
State Totals		**8**	**100%**

If "Other," please specify.

Table 141 - "Other" Explanations for Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

MCO Name	Explanation
Amerihealth Caritas Florida	Extension information is provided on Plan website and, thus, is ongoing and always available. https://www.amerihealthcaritasfl.com/provider/resources/behavioral-health-substance-use.aspx
Molina Healthcare	Safety and Monitoring programs review higher risk member utilization of all controlled substances for potential intervention including prescriber lettering (SMS). During the course of member case interventions, prescribers may respond with diagnosis or history of OUD or opioid poisoning.
United Healthcare	Daily

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

Figure 98 - Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

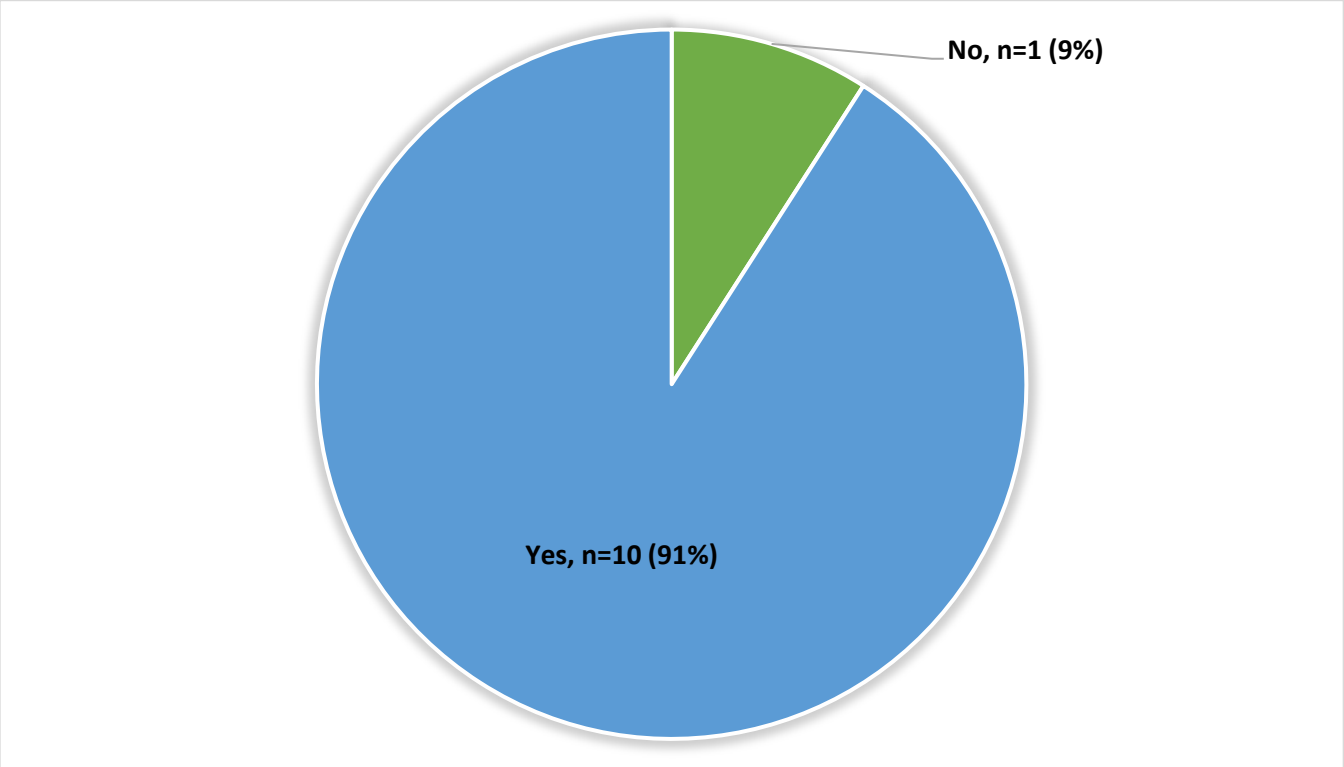


Table 142 - Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Community Care Plan	1	9.09%
State Totals		**11**	**100%**

If "Yes," please check all that apply.

Figure 99 - Pain Management / Opioid Prescribing Guidelines Provided

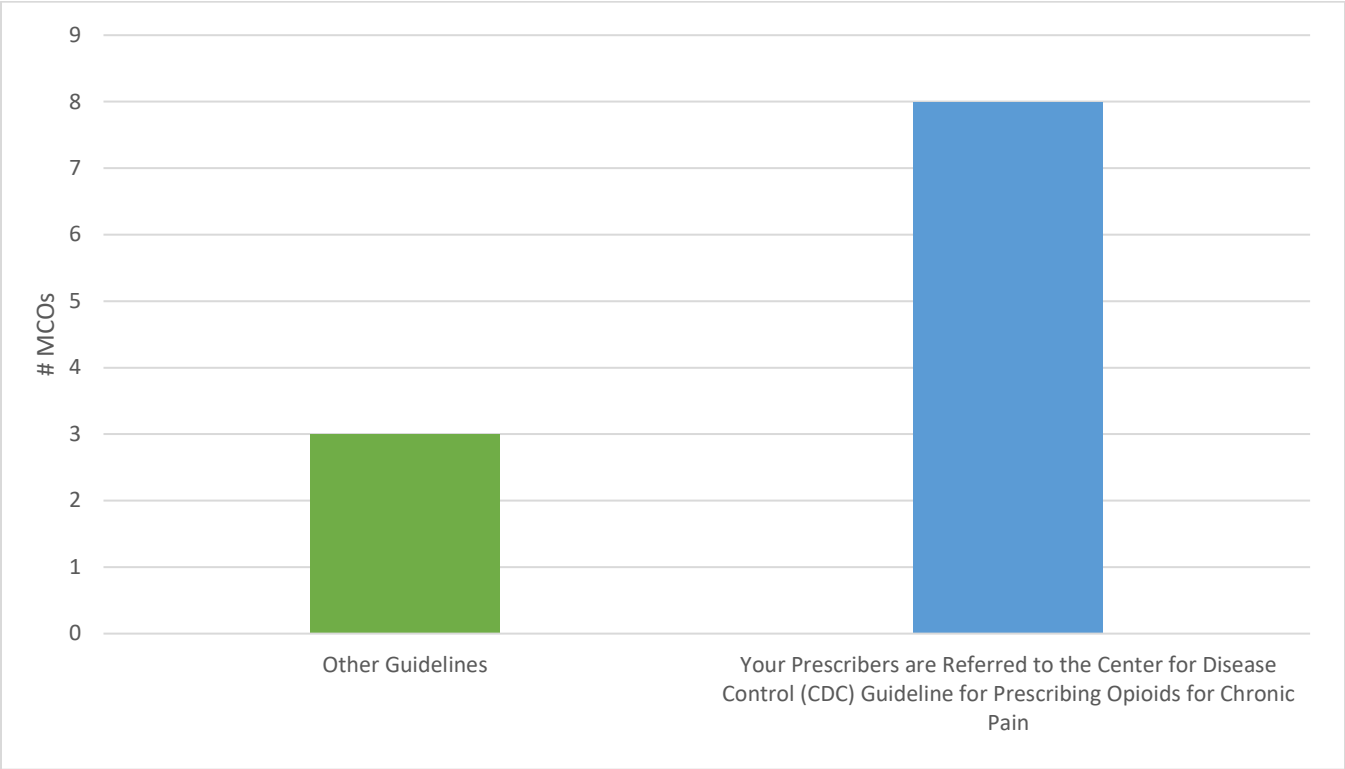


Table 143 - Pain Management / Opioid Prescribing Guidelines Provided

Response	MCO Names	Count	Percentage
Your prescribers are referred to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	8	72.73%
Other guidelines	Amerihealth Caritas Florida, Molina Healthcare, United Healthcare	3	27.27%
State Totals		**11**	**100%**

If "Other guidelines," please identify.

Table 144 - "Other Guidelines" Provided

MCO Name	Explanation
Amerihealth Caritas Florida	Prescribers are referred to the CDC's guideline for Prescribing Opioids for Chronic Pain and Other guidelines include Substance Abuse and Mental Health Services Administration (SAMHSA)
Molina Healthcare	Opioid prescribing guidelines are posted on our Provider website portal at Molinahealthcare.com. Additionally we refer providers to the CDC's guideline for prescribing opioids for chronic pain. For the Prescription Safety Management Program, targeted prescribers are provided with retrospective DUR interventions that involve targeted lettering communications to prescribers that reference the CDC opioid guidelines and other relevant standards (e.g., PQA quality measures).
United Healthcare	"UnitedHealthcare Community Plan has created a opioid resource section on our provider facing website. One page PDF resources range in topic from naloxone coverage to treatment alternatives for common pain conditions. We developed and posted an Opioid

MCO Name	Explanation
	Prescriber Reference Guide to provide our prescribers with information regarding our point of sale DUR edits, retrospective DUR programs, and utilization management edits. We also provide links to external resources and guidelines including: 1. Agency for Healthcare Research and Quality (AHRQ) - Interagency Guideline on Prescribing Opioids for Pain. 2. Centers for Disease Control and Prevention - CDC Guideline for Prescribing Opioids for Chronic Pain 3. Centers for Disease Control and Prevention - CDC Opioid Overdose Guideline Resources"

If “No,” please explain why no guidelines are offered.

Table 145 - Explanations for not Offering Pain Management / Opioid Prescribing Guidelines

MCO Name	Explanation
Community Care Plan	CCP does provide links for prescriber's education related to opioids on its website. Prescriber are expected to follow State provided resources (ER prescribing of pain medications) and other clinical pain management guidelines such as the CDC and world health organization (WHO) guidelines. CCP will contact and educate prescribers as needed based on the monthly and quarterly Opioid reports. Prescribers identified as prescribing high MME's in the reports are researched for practice specialty and EPIC clinical notes are reviewed to understand the prescriber, to gather members history, and need for the medication. If areas of concern are noted the provider may receive a letter.

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

Figure 100 - Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use

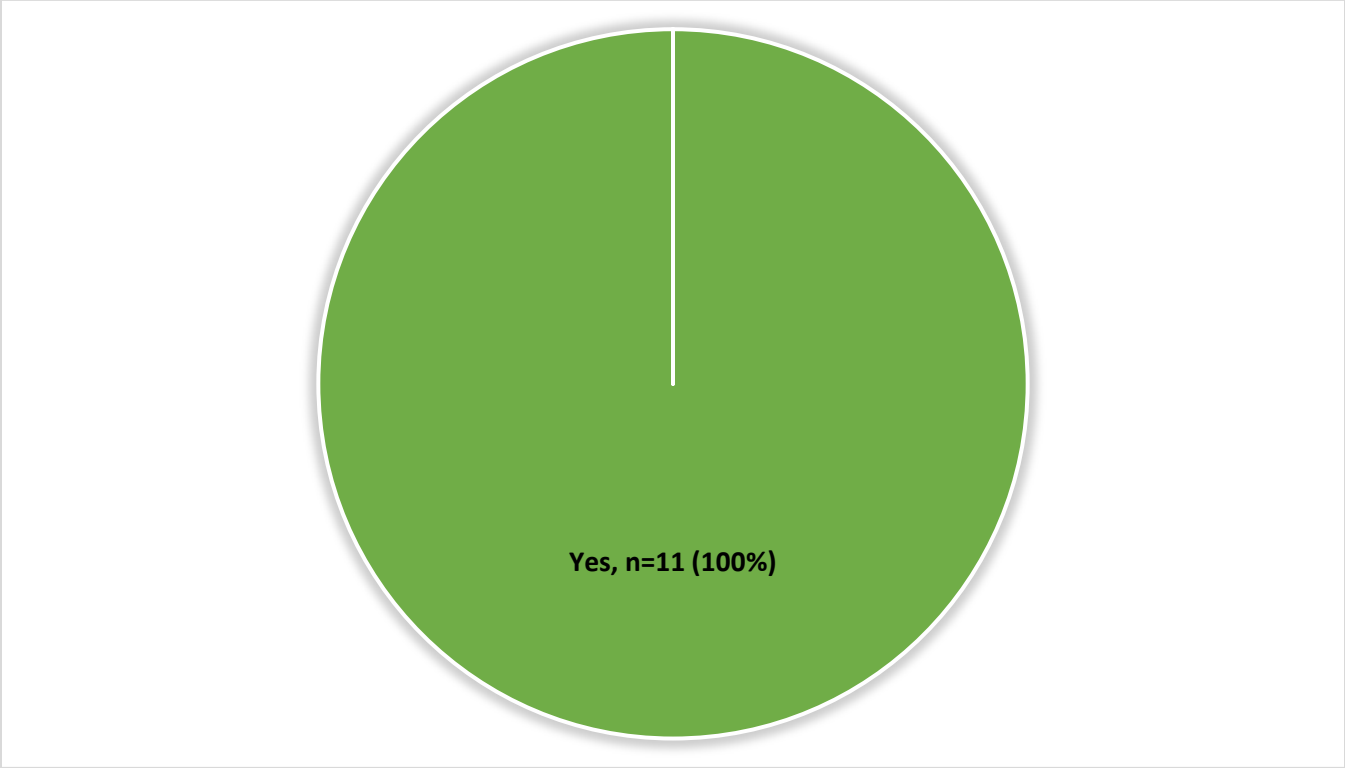


Table 146 - Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," please explain.

Table 147 - "Yes" Explanation for Drug Utilization Management Strategy that Supports Abuse Deterrent Opioid Use

MCO Name	Explanation
Aetna Better Health	There is a short acting before long acting narcotic and abuse deterrent narcotic POS edit in place. To receive an Abuse Deterrant Narcotic (ADN), the system requires members to have 2 fills of a short acting narcotic within 60 days or a fill of another ADN within 60 days.
Amerihealth Caritas Florida	Abuse deterrent opioids are available as preferred agents on the preferred drug list
Children's Medical Services	An abuse-deterrent opioid product is available as a preferred agent.

MCO Name	Explanation
Clear Health Alliance	The AHCA preferred drug list and opioid policy steers treat-naive members to short-acting opioids before the use of long acting. Abuse deterrent Long-acting opioids are preferred for a new start on long-acting opioids.
Community Care Plan	CCP follow AHCA's weekly comprehensive drug list (PDL) . The formulary currently has Xtampza ER available with automated PA logic.
Florida Community Care	CVS Caremark's UM criteria assures proper coverage of opioids consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines that include the presence of an abuse deterrent opioids as preferred status when clinically appropriate. We follow the state of FL mandated PDL.
Humana Medical Plan	For Schedule II: Maximum day supply = 3 Maximum of two 3-day supplies every 30 days For Schedule II with 'Acute Pain Exemption' on Rx: Maximum day supply = 7 Maximum of two 7-day supplies every 30 days For Schedule III-V: Maximum days supply = 14 Maximum of 14 day supply every 30 days *excluding recipients with a diagnosis of Cancer, Sickle Cell, CNMP (chronic non-malignant pain) or LTC (Long term care coverage indicator
Molina Healthcare	Molina's clinical criteria assures proper coverage of opioids consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines that include the presence of an abuse deterrent opioids as preferred status when clinically appropriate.
Simply Healthcare	The AHCA preferred drug list and opioid policy steers treat-naive members to short-acting opioids before the use of long acting. Abuse deterrent Long-acting opioids are preferred for a new start on long-acting opioids.
Sunshine	An abuse-deterrent opioid product is available as a preferred agent.
United Healthcare	The MCO aligns with utilization management edits as defined by the State Regulator. MAT medication used to treat OUD are managed using the preferred drug list (PDL), point of sale coding requirements, diagnosis to drug match, quantity limits and prior authorization when identified by state criter for use.

14. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency?

Figure 101 - COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

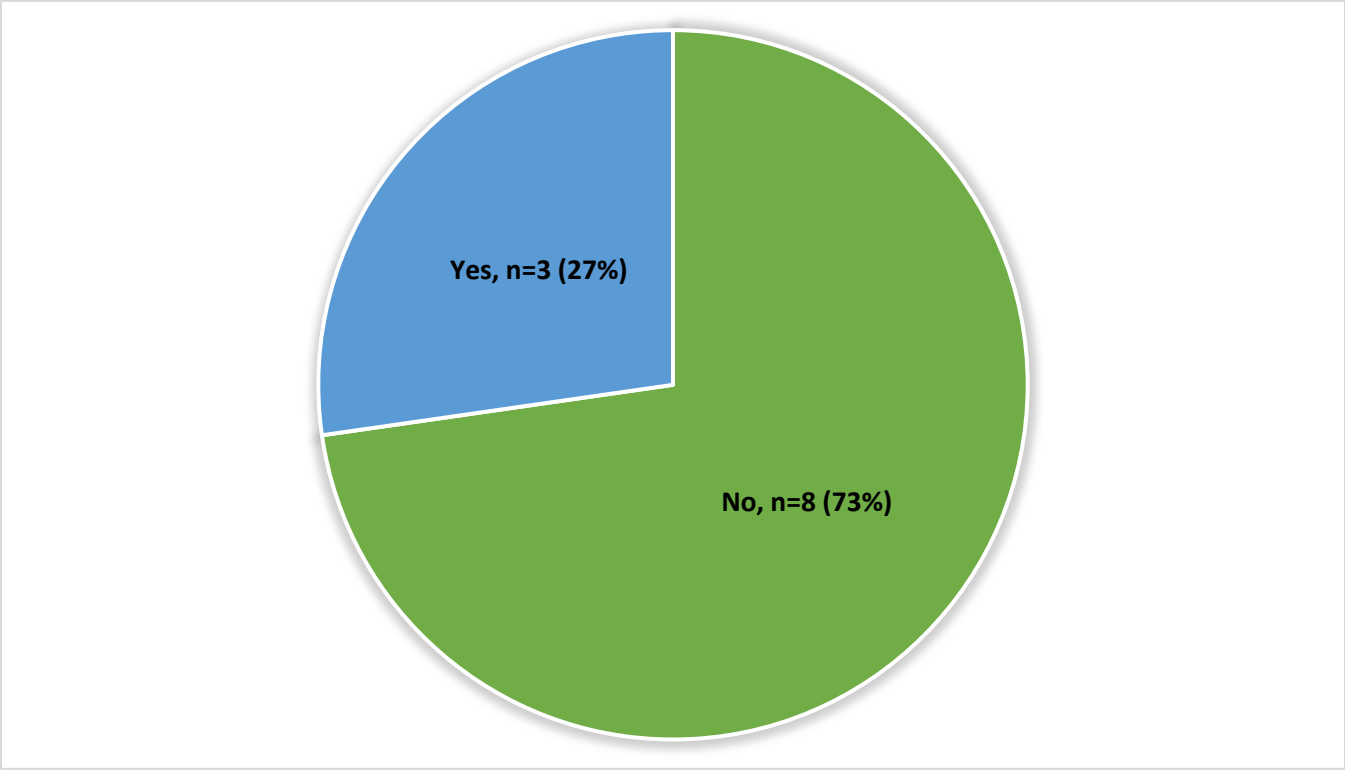


Table 148 - COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

Response	MCO Names	Count	Percentage
Yes	Children's Medical Services, Humana Medical Plan, Sunshine	3	27.27%
No	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Florida Community Care, Molina Healthcare, Simply Healthcare, United Healthcare	8	72.73%
State Totals		**11**	**100%**

If "Yes," please explain.

Table 149 - "Yes" Explanations for COVID-19 Ramifications on Edits and Reviews on Controlled Substances During the Public Health Emergency

MCO Name	Explanation
Children's Medical Services	There was one edit placed during the period of 03/10/2020 through 05/31/2021 where members were allowed an SCC13 to override refill too soon on all drugs except C2 and pharmacies were only allowed to use this override 3 times. This override allowance would have helped members to secure their medication supply earlier than their standard time during COVID restrictive timeframes.

MCO Name	Explanation
Humana Medical Plan	Multiple edits based on daily usage, script limit, and state mandates.
Sunshine	There was one edit placed during the period of 03/10/2020 through 05/31/2021 where members were allowed an SCC13 to override refill too soon on all drugs except C2 and pharmacies were only allowed to use this override 3 times. This override allowance would have helped members to secure their medication supply earlier than their standard time during COVID restrictive timeframes.

D. Morphine Milligram Equivalent (MME) Daily Dose

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

Figure 102 - MCO Recommended MME Daily Dose Measures

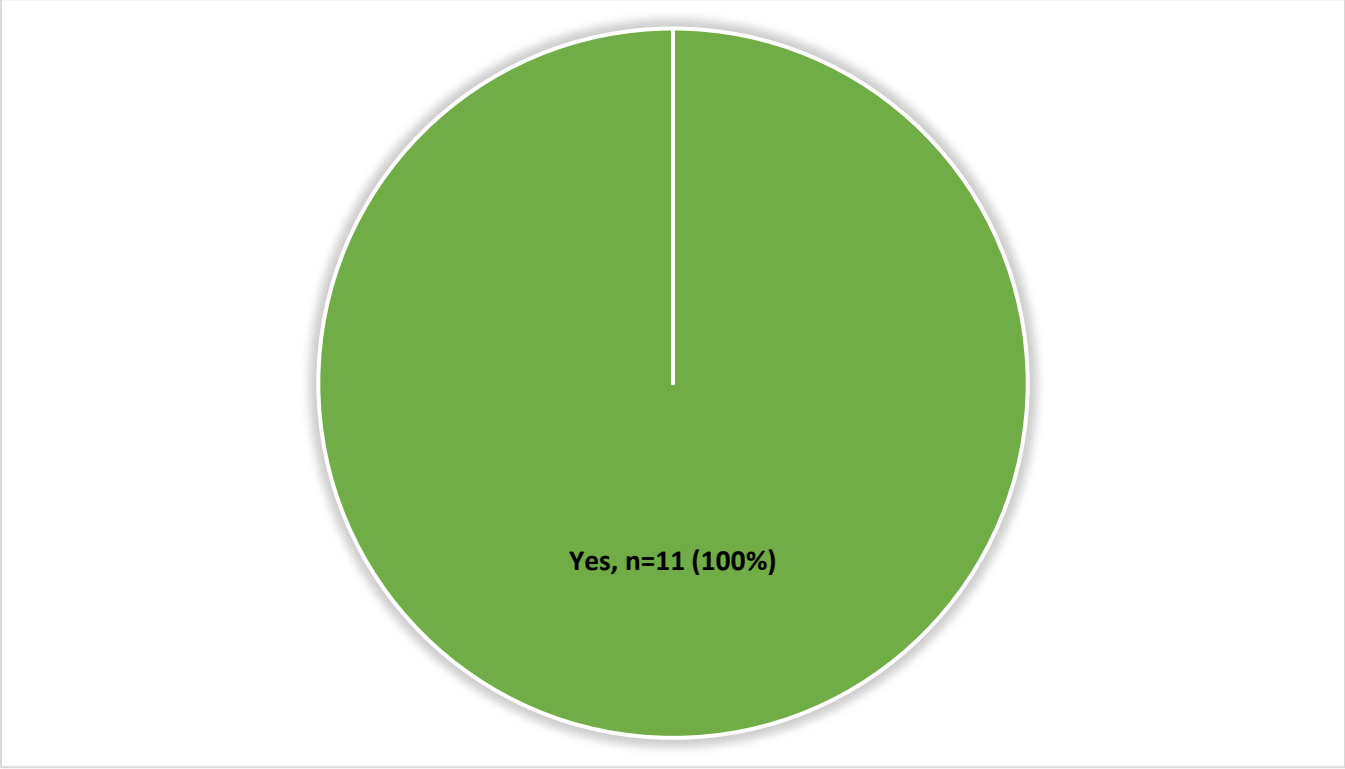


Table 150 - MCO Recommended MME Daily Dose Measures

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

a. If "Yes," what is your maximum MME daily dose limit in milligrams?

Figure 103 - Maximum MME Daily Dose Limit in Milligrams

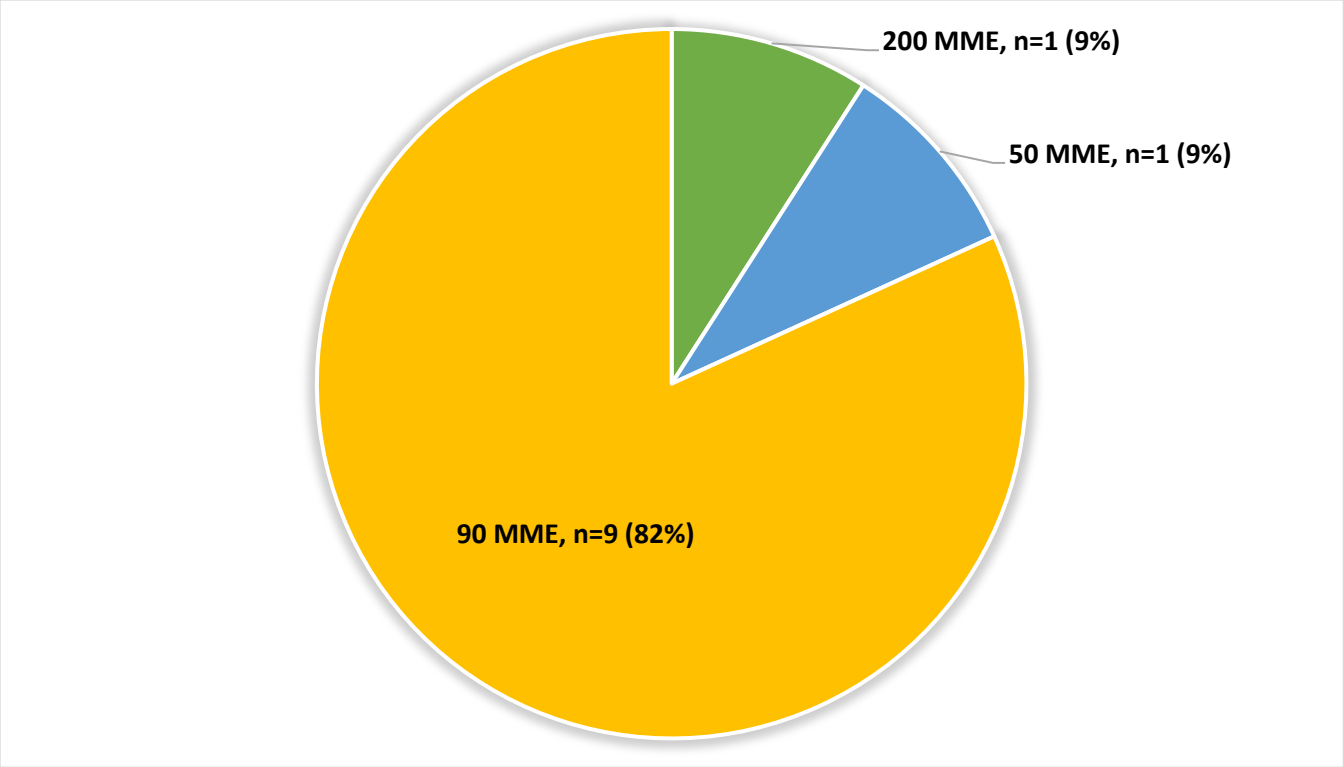


Table 151 - Maximum MME Daily Dose Limit in Milligrams

Response	MCO Names	Count	Percentage
200 MME	Florida Community Care	1	9.09%
50 MME	Community Care Plan	1	9.09%
90 MME	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	81.82%
State Totals		**11**	**100%**

b. If "Yes," 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?).

Table 152 - Explanations for Nature and Scope of Maximum MME Daily Dose Limit

MCO Name	Explanation
Aetna Better Health	The 90 MME daily limit applies only to treatment naive members who are defined as not receiving opioid prescriptions in the previous 60 days. If a member tries to exceed the 90 MME daily limit, a reject will occur and a prior authorization will be required. For opioid treatment experienced (tolerant) members, the daily MME limit is 50 MME. Opioid tolerant is defined as having a paid opioid claim within 60 days of the incoming claim. The 50 MME edit is a soft edit that can be bypassed by entering a DUR service code if appropriate. There is no specific process for tapering and this is left at the prescriber's discretion on what is best for the medical needs of their patients.

MCO Name	Explanation
Amerihealth Caritas Florida	For any opioid nave (defined as a member with no opioids in the previous 60 days) will be limited to 90 MME. *Cancer, sickle cell, and chronic nonmalignant pain (CNMP) patients are excluded from this edit.
Children's Medical Services	The 90 MME edit applies to all Medicaid recipients with the exception of those diagnosed with cancer, sickle cell disease, or those residing in an LTC facility who present to the pharmacy with a new prescription for an opioid (opioid naiive). The edit applies to all opioids outlined in the AHCA auto-PA logic. After the initial fill of 90 MME, opioid tolerant members are encouraged to decrease to a maximum of 50 MME via a POS edit denying if above the limitation of 50 MME. Pharmacists may override the denial at POS using SCC codes.
Clear Health Alliance	This was implemented for new start patients and applies to all drugs.
Community Care Plan	CCP follows the opioid edits for 50MME and 90 MME's provided by AHCA. Which applies to all opioids. Both of these edits look back 60 days in the patient's history for another or the same prescribed opioid and 365 days for a diagnosis associated with exclusion from the edit. These MME's thresholds help to identify potentially opioid naive patients or non-chronic opioid users to ensure they do not exceed these daily MME's that have been shown to increase risk of addiction and fatalities by respiratory depression.
Florida Community Care	The MME limits may apply to all lines of business and all opioids. We do not have a tapering process in place.
Humana Medical Plan	Morphine miligram equivalent limits are applied to all opioids. For Florida Medicaid doses with a morphine milligram equivalent (MME) greater than 50 MG and less than 250 MG are PPS eligible. Doses with a morphine milligram equivalent (MME) or where the daily cumulative morphine equivalent dose (MED) is greater than 250 MG a clinical review/prior authorization is required.
Molina Healthcare	In evaluating PA requests for doses above 90 MME, Molina will be looking for supporting documentation including, but not limited to, pain consultation supporting the dose requested, signed and dated patient prescriber agreement, and medical records documenting treatment plan including rationale for the high dose and titration to current dose and plan. This edit does not apply to opioid prescriptions issued by a practitioner who orders an opioid to be wholly administered in a hospital, nursing home, hospice facility, or residential care facility.
Simply Healthcare	This was implemented for new start patients, all drugs.
Sunshine	The 90 MME edit applies to all Medicaid recipients with the exception of those diagnosed with cancer, sickle cell disease, or those residing in an LTC facility who present to the pharmacy with a new prescription for an opioid (opioid naiive). The edit applies to all opioids outlined in the AHCA auto-PA logic. After the initial fill of 90 MME, opioid tolerant members are encouraged to decrease to a maximum of 50 MME via a POS edit denying if above the limitation of 50 MME. Pharmacists may override the denial at POS using SCC codes.
United Healthcare	In Florida a single PDL is utilized across the Managed Medicaid MCOs and the utilization management strategy of the opioid class is managed by the state. The state of Florida currently uses a 90 MME maximum dose limit for opioid naive members only (no opioids in the last 60 days)- the edit does not apply to members outside of this definition. Members with a cancer, sickle cell, non-malignant chronic pain, or palliative care diagnosis are excluded from the cumulative MME edit at the point of sale. The prior authorization criteria for this edit ensures that the providers are properly monitoring

MCO Name	Explanation
	through attestation of non-opioid trial and failure, PDMP checks, urine drug screens, and opioid treatment agreements. UnitedHealthcare Community Plan is unable to implement a cumulative MME strategy that applies to all members at the point of sale that we have deployed in other states because the state manages this class.

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

Figure 104 - Edit in POS System that Alerts the Pharmacy Provider that the MME Daily Dose has been Exceeded

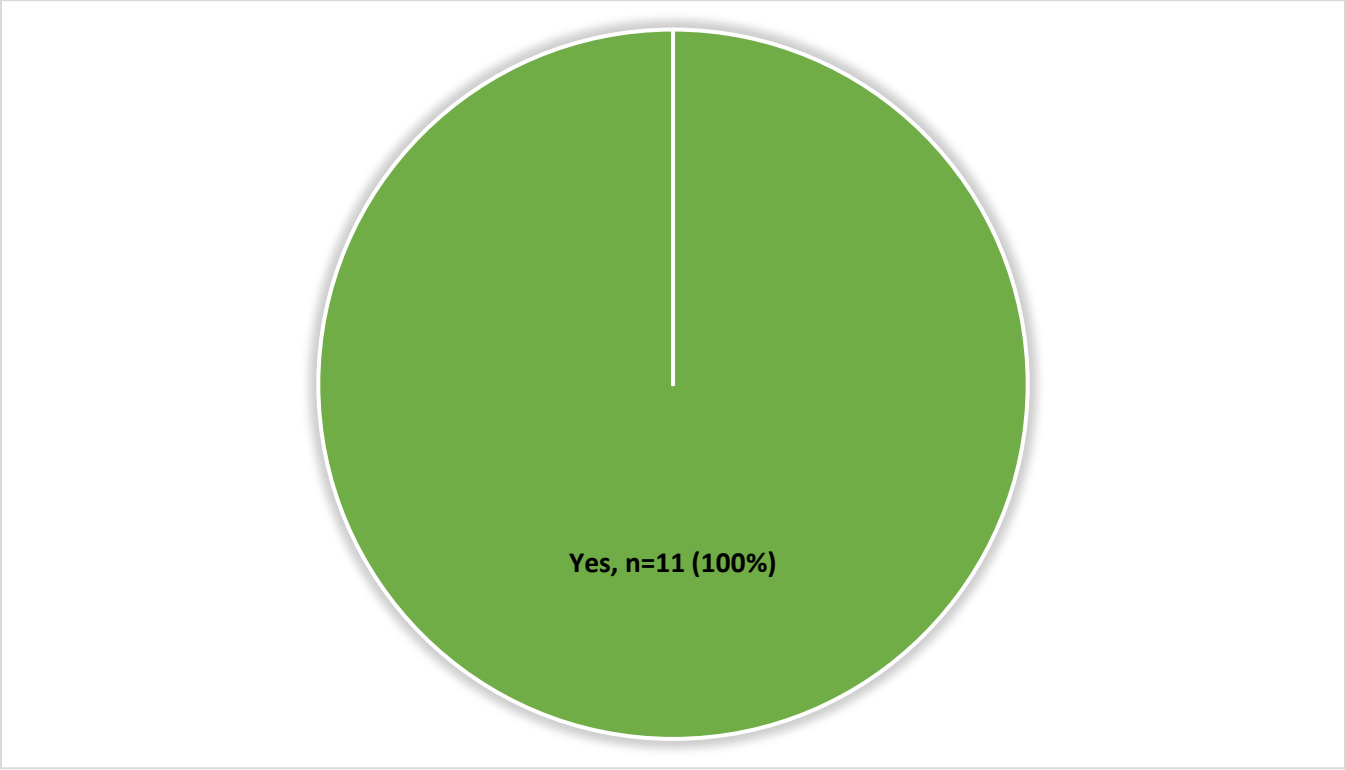


Table 153 - Edit in POS System that Alerts the Pharmacy Provider that the MME Daily Dose has been Exceeded

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," does your MCO require PA if the MME limit is exceeded?

Figure 105 - Prior Authorization Required if MME Limit is Exceeded

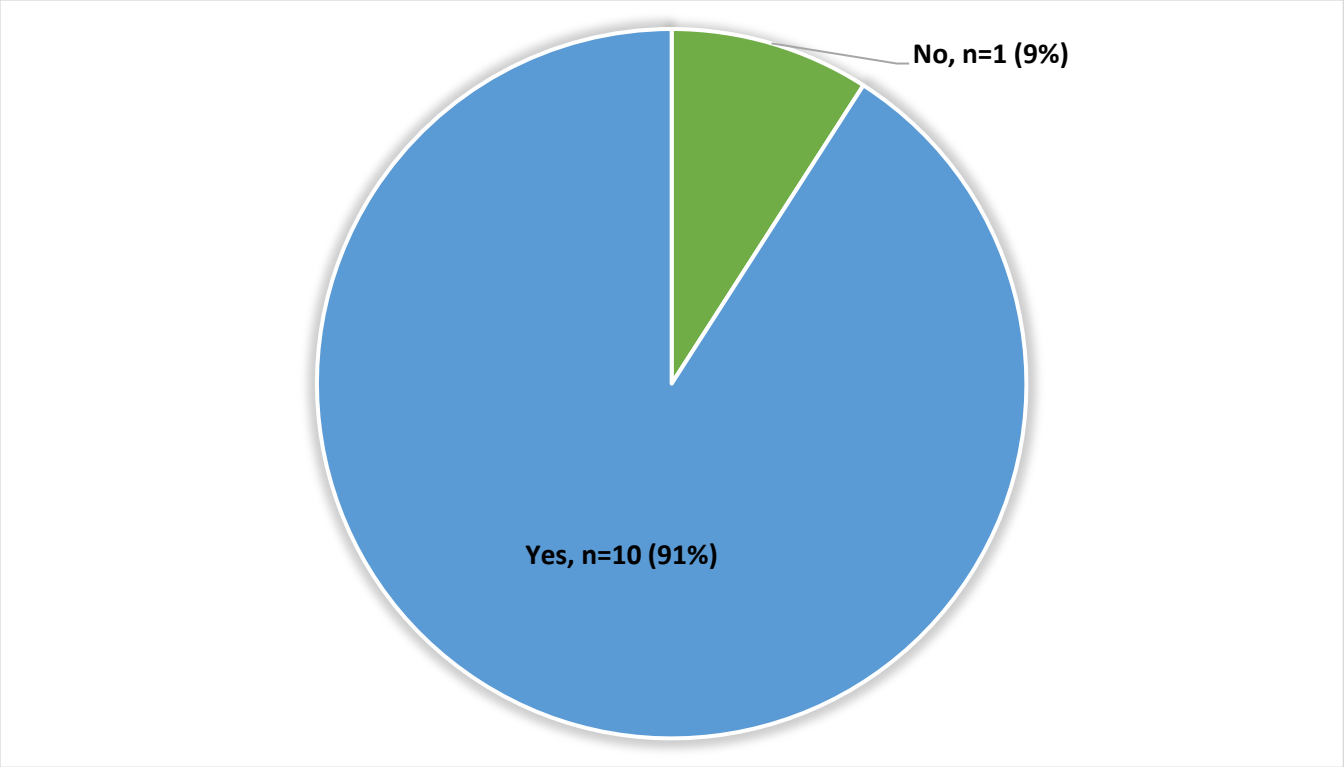


Table 154 - Prior Authorization Required if MME Limit is Exceeded

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Community Care Plan	1	9.09%
State Totals		**11**	**100%**

3. Does your MCO have an automated retrospective claims review to monitor the MME total daily dose of opioid prescriptions dispensed?

Figure 106 - MCO Has Automated Retrospective Claim Reviews to Monitor MME Total Daily Dose

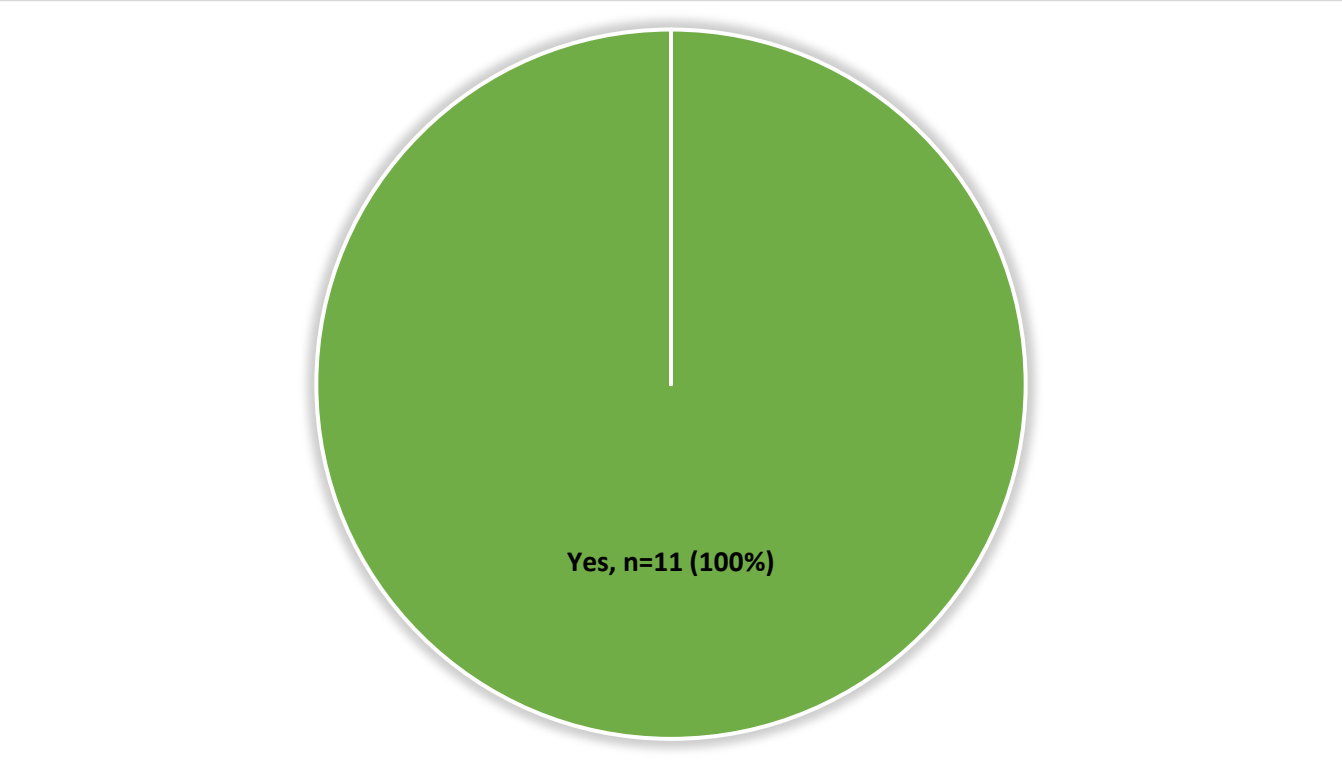


Table 155 - MCO Has Automated Retrospective Claim Reviews to Monitor MME Total Daily Dose

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

4. Does your MCO provide information to your prescribers on how to calculate the MME daily dosage or does your MCO provide a calculator developed elsewhere?

Figure 107 - Provide Information to Prescribers to Calculate the MME Daily Dosage or Provide a Calculator Developed Elsewhere

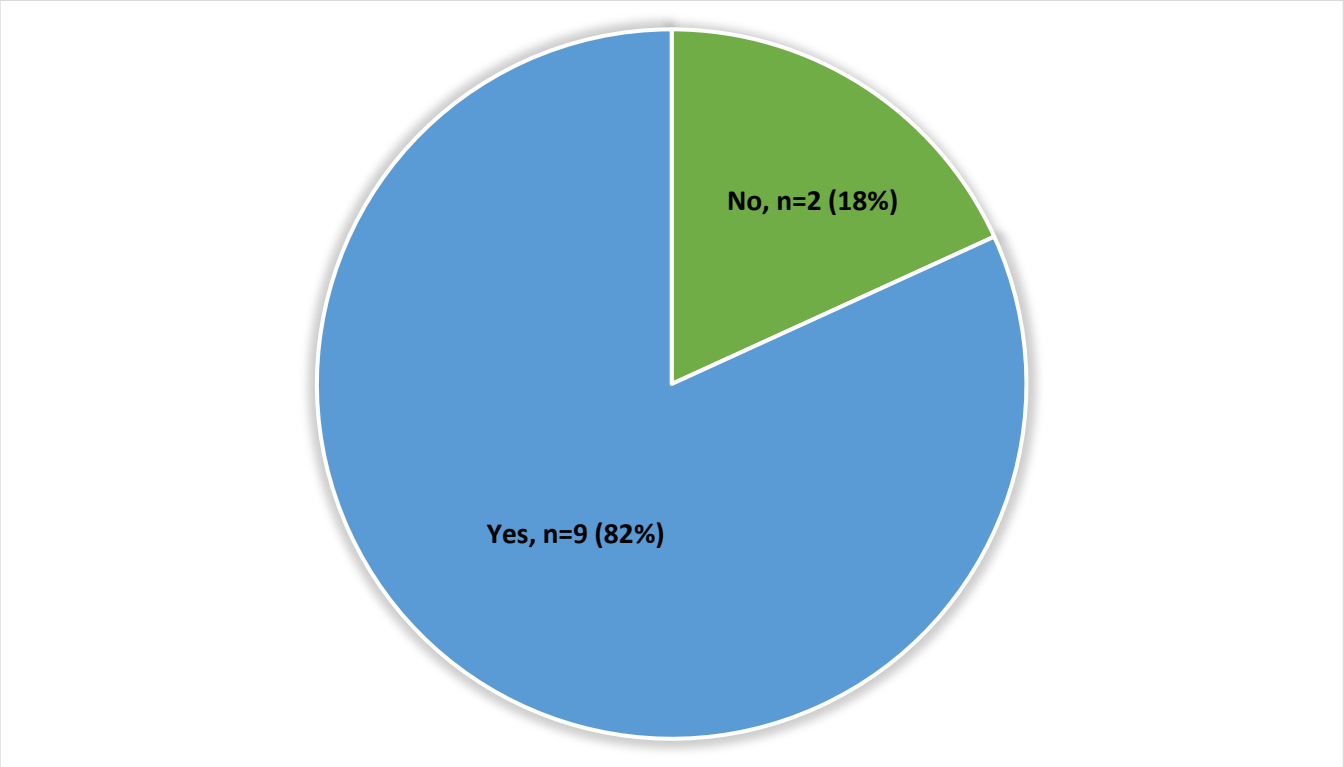


Table 156 - Provide Information to Prescribers to Calculate the MME Daily Dosage or Provide a Calculator Developed Elsewhere

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, United Healthcare	9	81.82%
No	Children's Medical Services, Sunshine	2	18.18%
State Totals		**11**	**100%**

a. If "Yes," please name the developer of the calculator.

Figure 108 - Developer of the MME Daily Dosage Calculator

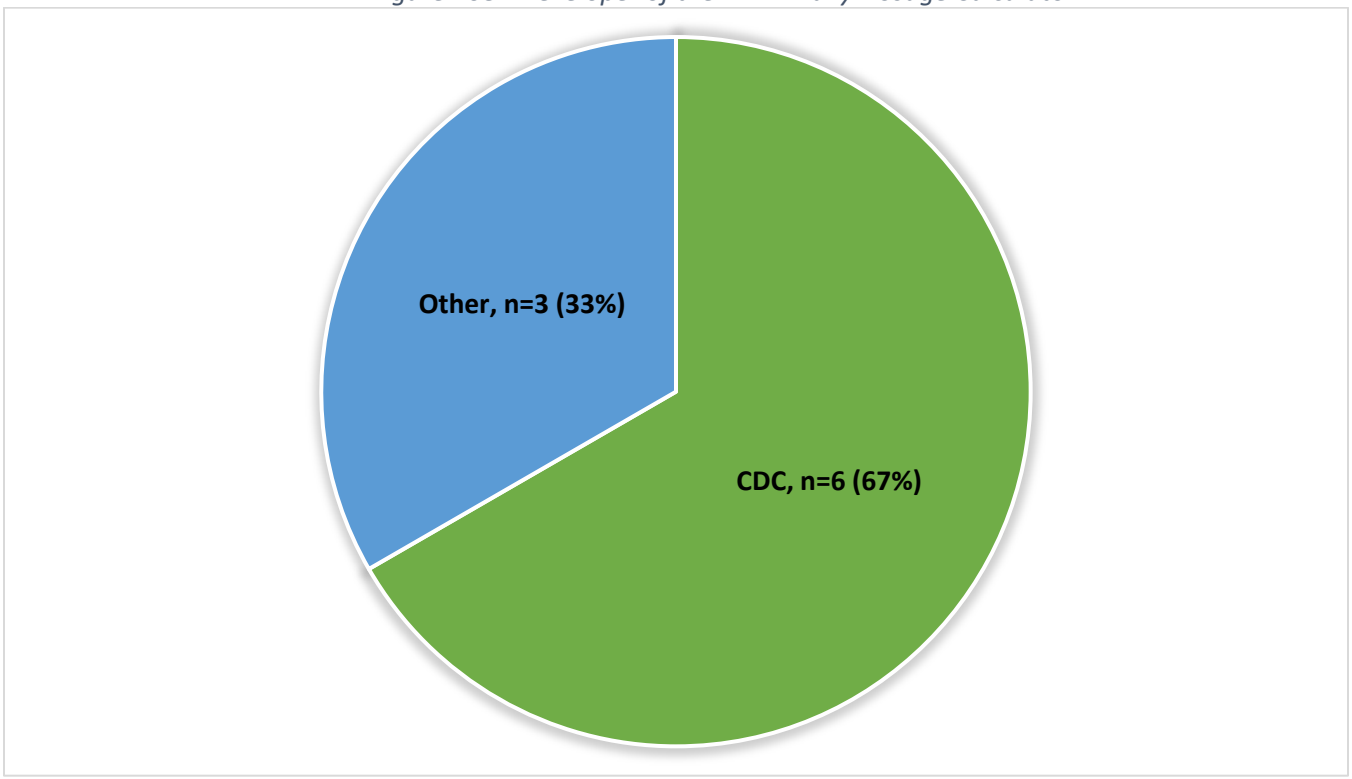


Table 157 - Developer of the MME Daily Dosage Calculator

Response	MCO Names	Count	Percentage
CDC	Aetna Better Health, Amerihealth Caritas Florida, Florida Community Care, Humana Medical Plan, Molina Healthcare, United Healthcare	6	66.67%
Other	Clear Health Alliance, Community Care Plan, Simply Healthcare	3	33.33%
State Totals		**9**	**100%**

If "Other," please specify.

Table 158 - "Other" Explanation for Developer of the MME Daily Dosage Calculator

MCO Name	Explanation
Clear Health Alliance	Our PBM, IngenioRx uses the logic as defined by CMS to calculate MME for each member and/or prescriber.
Community Care Plan	Agency Medical Directors Group website
Simply Healthcare	Our PBM, IngenioRx uses the logic as defined by CMS to calculate MME for each member and/or prescriber. MME is calculated for the prescriber and the prescribers are sent an opioid prescriber summary.

b. If "Yes," how is the information disseminated (multiple responses allowed)?

Figure 109 - Information Dissemination Routes

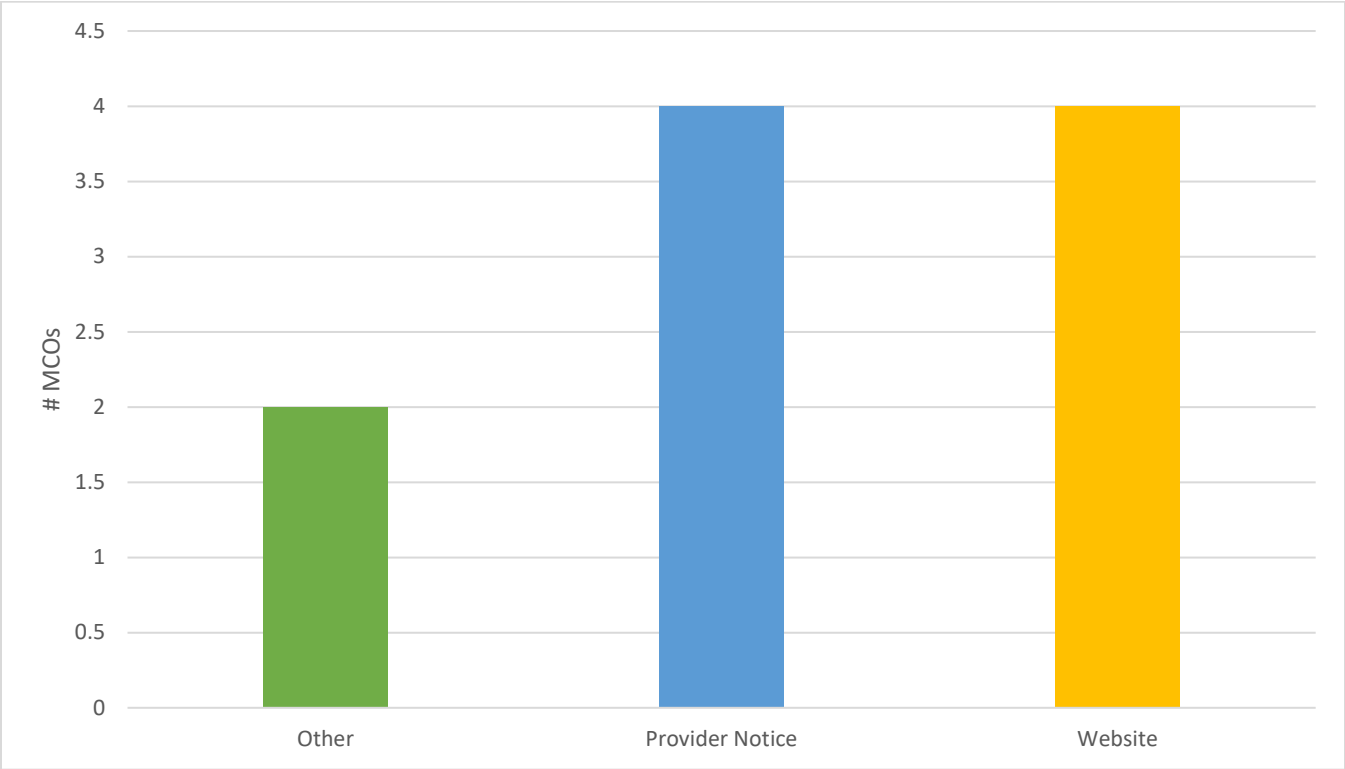


Table 159 - Information Dissemination Routes

Response	MCO Names	Count	Percentage
Provider notice	Clear Health Alliance, Florida Community Care, Molina Healthcare, Simply Healthcare	4	40.00%
Website	Amerihealth Caritas Florida, Community Care Plan, Humana Medical Plan, United Healthcare	4	40.00%
Other	Aetna Better Health, Humana Medical Plan	2	20.00%
State Totals		**10**	**100%**

If "Other," please explain.

Table 160 - "Other" Explanations for Information Dissemination Routes

MCO Name	Explanation
Aetna Better Health	Educational letter is sent to providers each year who have written scripts exceeding 90 MME/day providing them with means to access the CDC website. Providers also receive information/recommendations and their prescribing profile on opioids/benzodiazepines as compared to their peer prescribing group
Humana Medical Plan	Point of Prescribing Alert

E. Opioid Use Disorder (OUD) Treatment

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

Figure 110 - MCO Has Utilization Controls to Monitor/Manage Prescribing of MAT Drugs for OUD

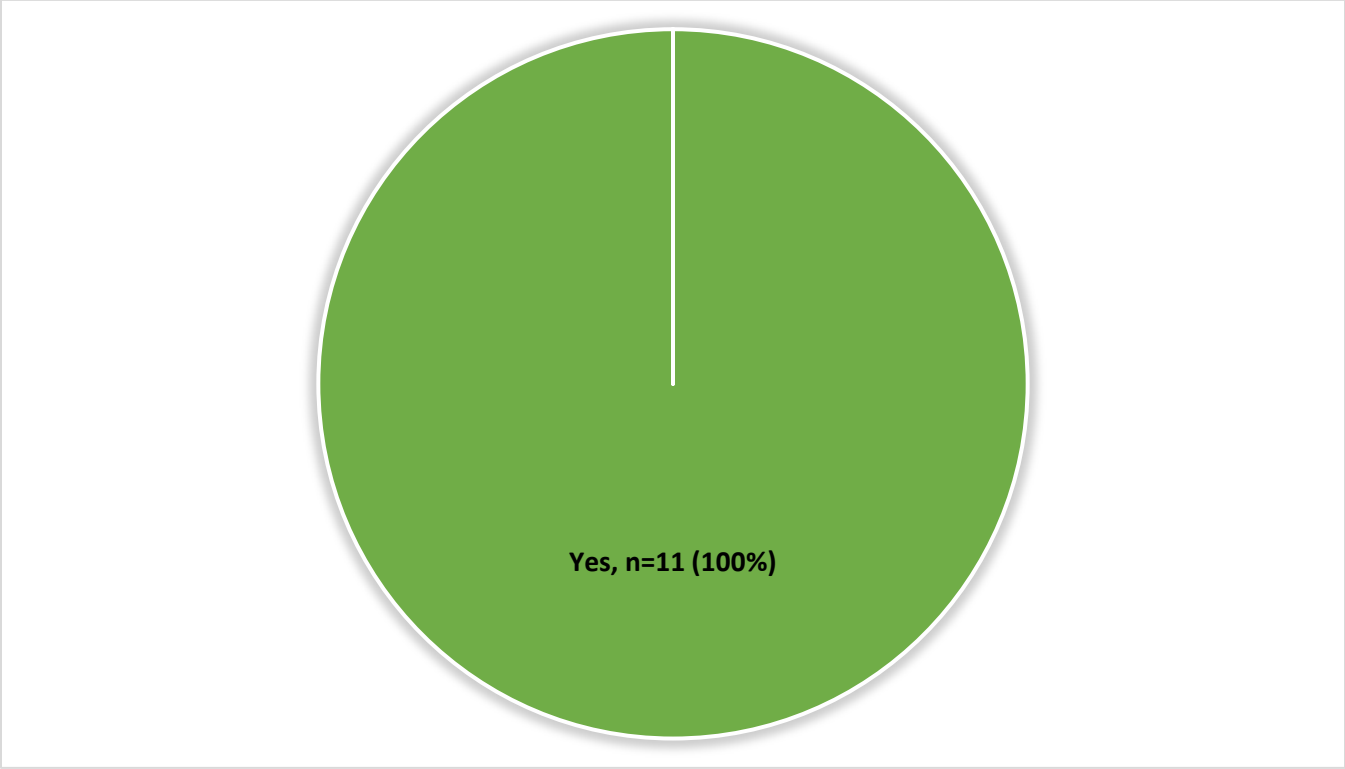


Table 161 - MCO Has Utilization Controls to Monitor/Manage Prescribing MAT Drugs for OUD

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If "Yes," please explain.

Table 162 - Explanation for MCO Utilization Controls to Monitor/Manage Prescribing of MAT Drugs for OUD

MCO Name	Explanation
Aetna Better Health	The state DUR Board reviews MAT criteria, utilization, and induction therapy. Prescribers initiating patients on MAT are able to prescribe a 30 day supply of buprenorphine sublingual tablets, buprenorphine/naloxone sublingual tablets, Suboxone film, or Zubsolv sublingual tablets for induction therapy without prior authorization. A complete prior authorization submission will be required beyond the 30 days. In addition, an edit was deployed to allow access to buprenorphine products by way of automation logic, that allows MAT therapy if a recipient has a diagnosis of OUD and pregnancy within the past 365 days of the incoming claim. The edit deployed in 1Q 2020.

MCO Name	Explanation
Amerihealth Caritas Florida	MAT requires prior authorization, there are preferred and non-preferred products, Quantity Limits, and Age Limits are also in place. However, as of 9/15/202, Preferred MAT drugs will pay at point-of-sale (POS) for members 16 years of age or older when a diagnosis of opioid use disorder is provided on the prescription, and the pharmacy submits that diagnosis with the claim at POS.
Children's Medical Services	There is an Age Limit (16 years old and older) for MATs and a QL for Buprenorphrine/Naloxone combination drugs
Clear Health Alliance	There are age limits, quantity limits, and auto-PA
Community Care Plan	CCP's PBM follow the AHCA edits provided in the weekly comprehensive drug list (PDL). The "summary of limitations" provides daily maximum tabs/mg/vials etc. guidance. The "automated PA logic" section defines the ProDUR steps to be taken to deny or allow adjudication.
Florida Community Care	Yes, quantity limits adherence per state PDL/SDL guidance.
Humana Medical Plan	Yes. We have age mins (where applicable) and QLs, as well as representative agents that are covered on the PDL. We purposely do NOT add PA (i.e. we are less restrictive than the state in some instances) on MAT drugs for OUD in accordance with Opioid Task Force recommendations.
Molina Healthcare	quantity limits
Simply Healthcare	There are age limits, quantity limits, auto-PA.
Sunshine	There is an Age Limit (16 years old and older) for MATs and a QL for Buprenorphrine/Naloxone combination drugs.
United Healthcare	MAT medications used to treat OUD are managed using the FL Preferred Drug List (PDL), prior authorization where appropriate, as outlined by the state of FL Agency for HealthCare Administration , along with quantiy limits

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

Figure 111 - MCO Sets Total Milligram per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

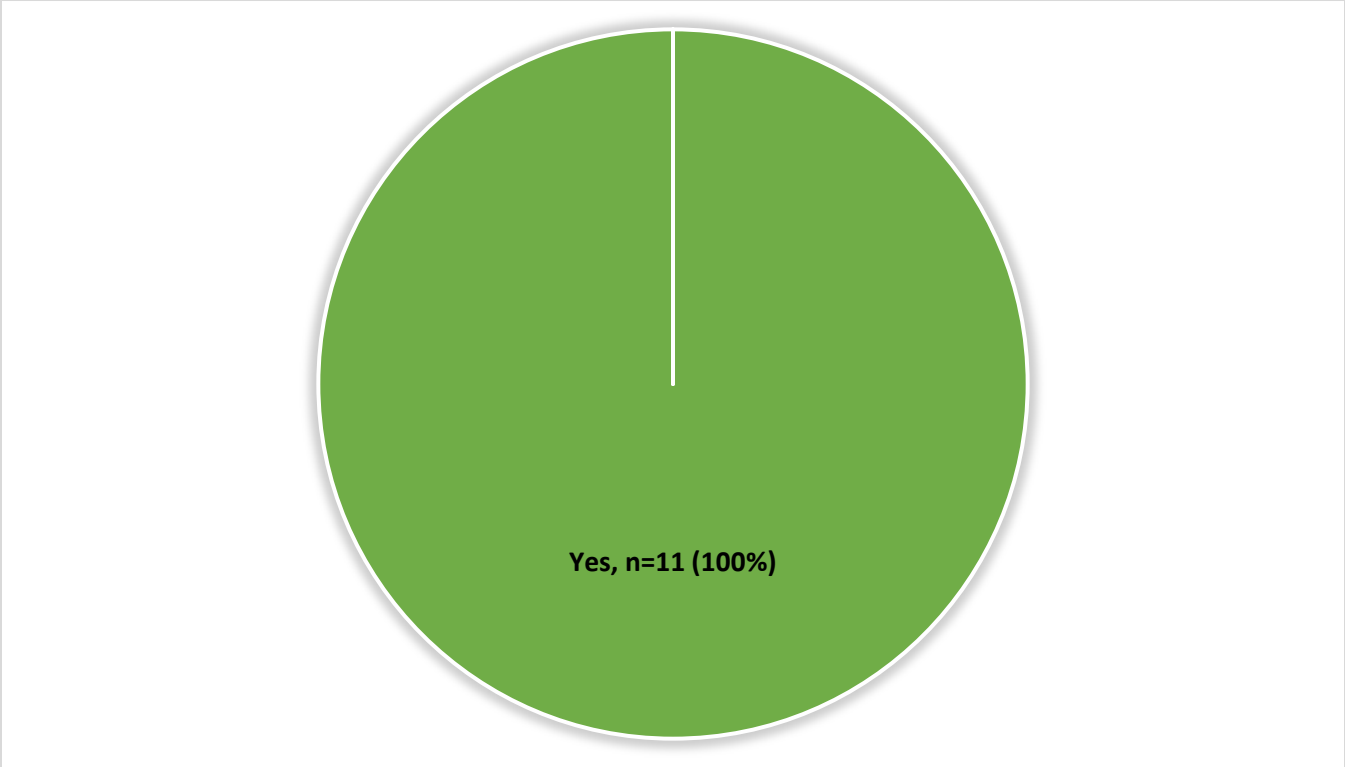


Table 163 - MCO Sets Total Milligram per Day Limits on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

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

Figure 112 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

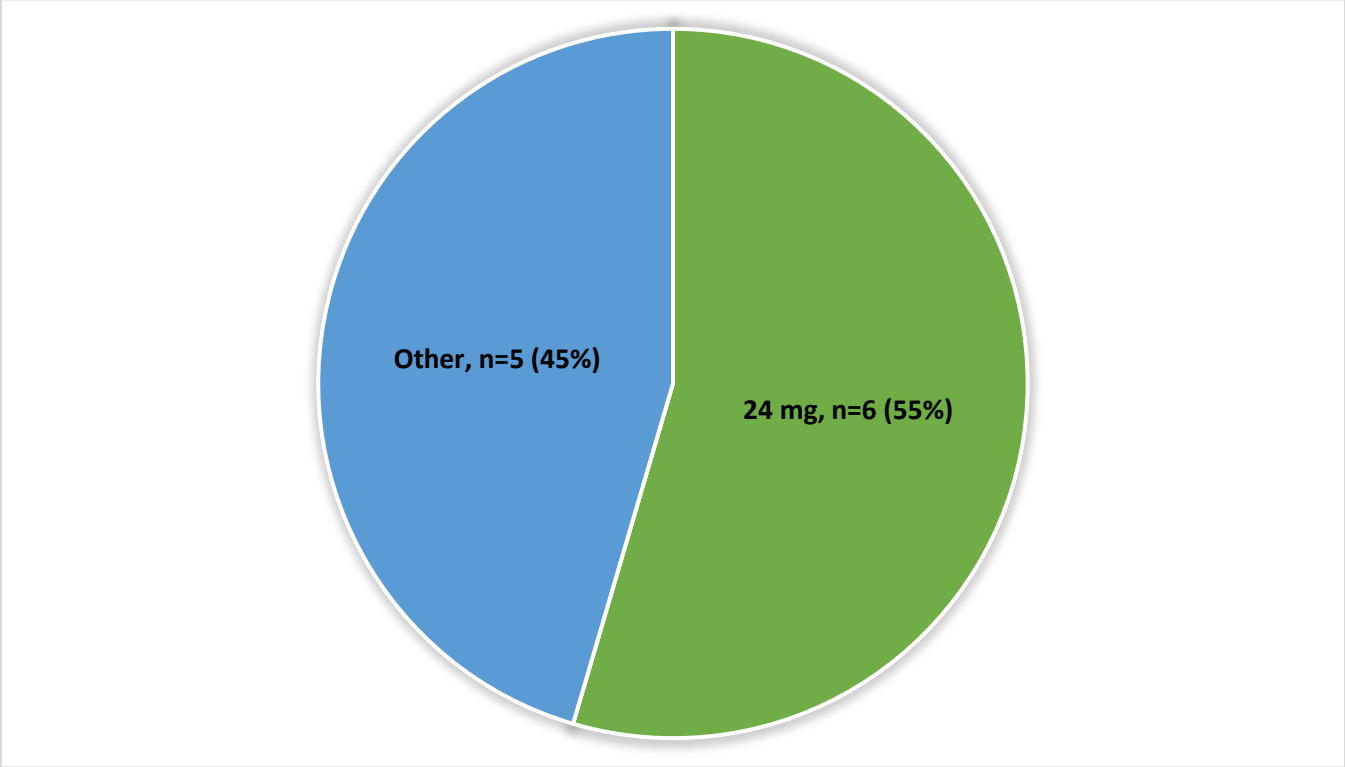


Table 164 - Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

Response	MCO Names	Count	Percentage
24 mg	Aetna Better Health, Children's Medical Services, Florida Community Care, Humana Medical Plan, Sunshine, United Healthcare	6	54.55%
Other	Amerihealth Caritas Florida, Clear Health Alliance, Community Care Plan, Molina Healthcare, Simply Healthcare	5	45.45%
State Totals		**11**	**100%**

If "Other," please explain.

Table 165 - "Other" Explanations for Total Milligrams/Day Limit on the Use of Buprenorphine and Buprenorphine/Naloxone Combination Drugs

MCO Name	Explanation
Amerihealth Caritas Florida	Buprenorphine, buprenorphine / naloxone products intended for the treatment of substance use disorder are limited to 3 tabs/fills per day. Quantity Limits, and Age Limits are also in place.
Clear Health Alliance	3 units per day
Community Care Plan	CCP follows the buprenorphine and buprenorphine naloxone daily dosing guidance provided by the AHCA weekly comprehensive drug list summary of limitations. Limitations are based on the drugs formulation.

MCO Name	Explanation
Molina Healthcare	AHCA FL defines as maximum of 3 sublingual film/tabs per day and minimum age of 16. So it varies by strength.
Simply Healthcare	3 units per day

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

Figure 113 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

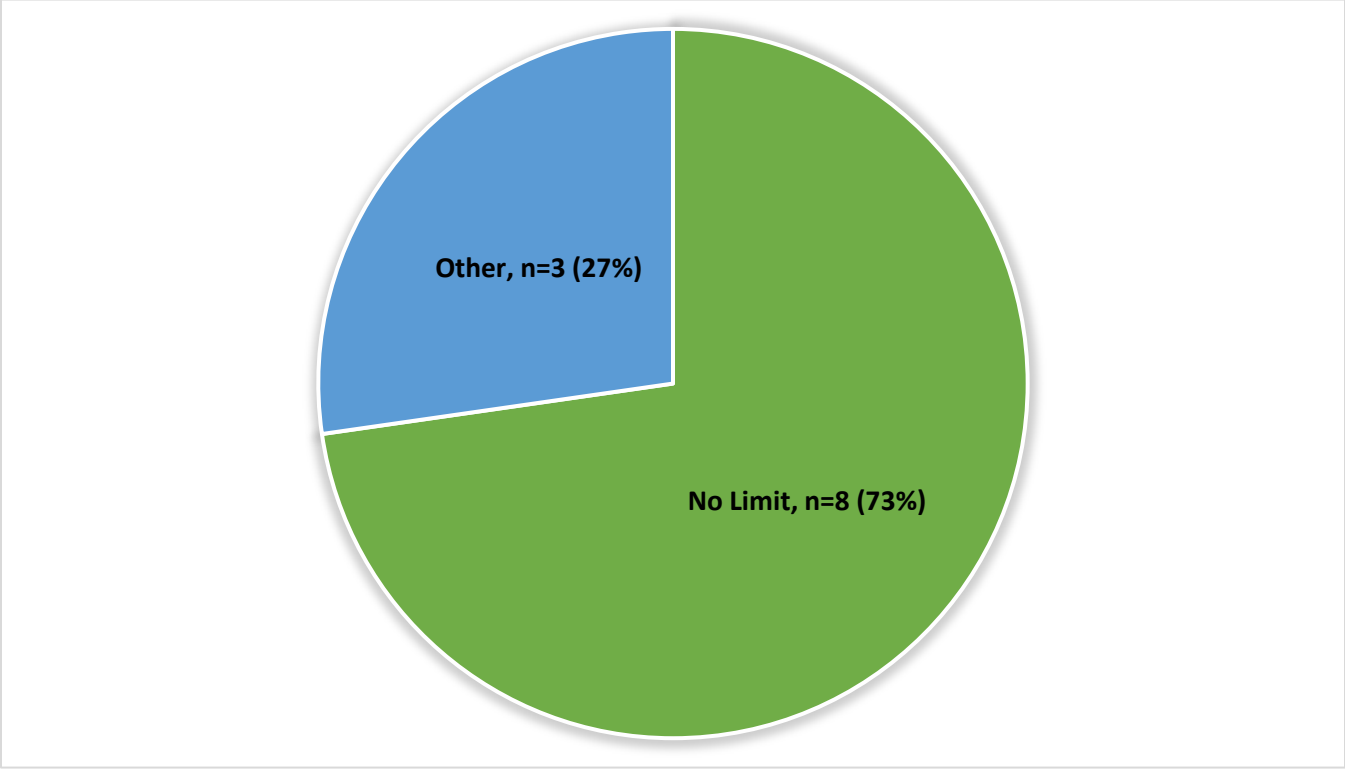


Table 166 - Limitations on Allowable Length of Treatment of Buprenorphine/Naloxone Combination Drugs

Response	MCO Names	Count	Percentage
No limit	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Simply Healthcare, Sunshine	8	72.73%
Other	Florida Community Care, Molina Healthcare, United Healthcare	3	27.27%
State Totals		**11**	**100%**

If "Other," please explain.

Table 167 - "Other" Explanations for Limitations on Length of Treatment

MCO Name	Explanation
Florida Community Care	Buprenorphine combination products have an initial quantity limit only, therefore if a patient is filling at or below the quantity limit, there will be no limitations on the allowable length of treatment. The buprenorphine monoproduct PA will be approved for 12 months if a patient is pregnant or breastfeeding, or 3 months if being used for induction therapy and the patient is not pregnant or breastfeeding. Patients may go through the PA process again if more monoproduct is needed after the duration of approval for the PA has expired.

MCO Name	Explanation
Molina Healthcare	Buprenorphine combination products have an initial quantity limit only, therefore if a patient is filling at or below the quantity limit, there will be no limitations on the allowable length of treatment. The buprenorphine monoproduct PA will be approved for 12 months if a patient is pregnant or breastfeeding, or 3 months if being used for induction therapy and the patient is not pregnant or breastfeeding. Patients may go through the PA process again if more monoproduct is needed after the duration of approval for the PA has expired
United Healthcare	There are no durations of limit to therapy- State of FL Agency for HealthCare Administration provides guidance for utilization and parameters . Example: MAT in Pregnancy- Buprenorphine. Diagnosis and gestational age requirements facilitates bypass logic at point of sale allow for Rx oversight for 1 year without prior authorization.

4. Does your MCO require that the maximum mg per day allowable be reduced after a set period of time?

Figure 114 - Maximum Milligrams per Day Reduction After a Set Period of Time

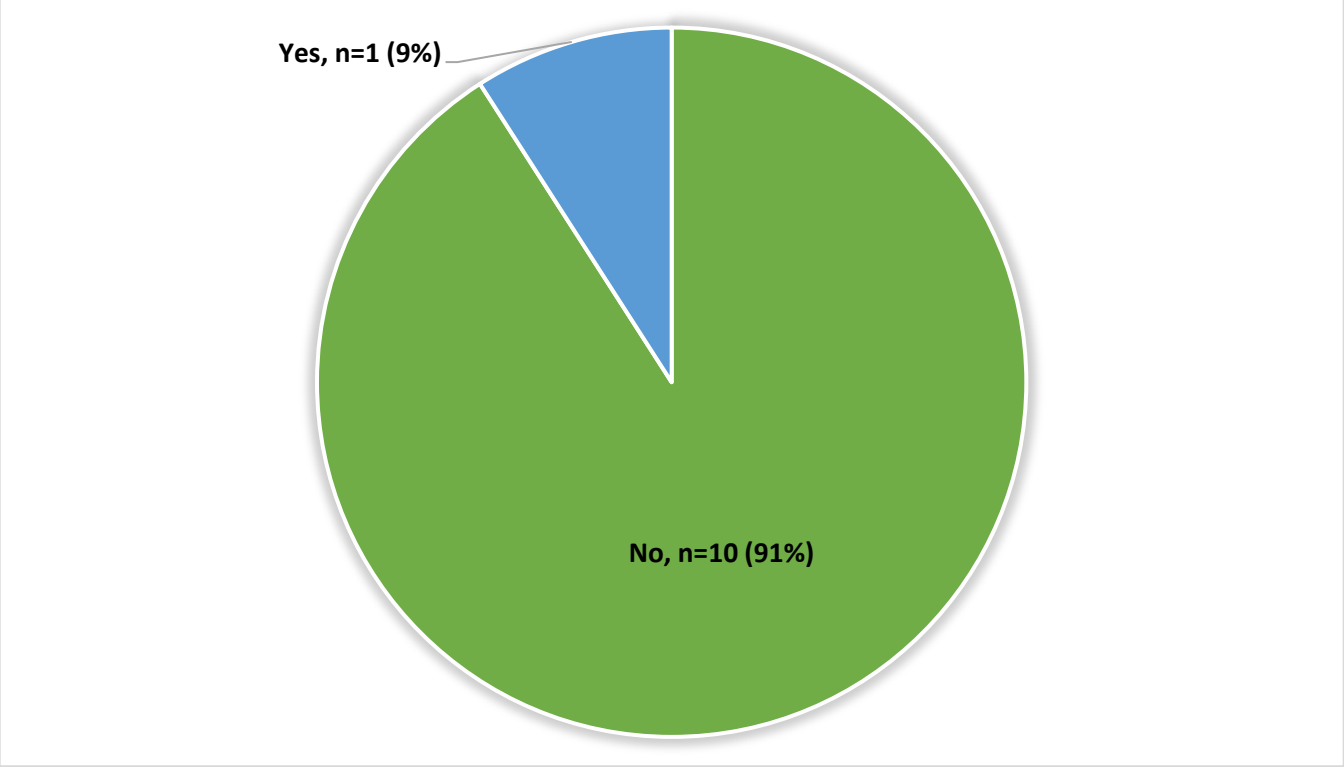


Table 168 - Maximum Milligrams per Day Reduction After a Set Period of Time

Response	MCO Names	Count	Percentage
Yes	Community Care Plan	1	9.09%
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
State Totals		**11**	**100%**

a. If "Yes," what is your reduced (maintenance) dosage?

Figure 115 - Reduced (Maintenance) Dosage

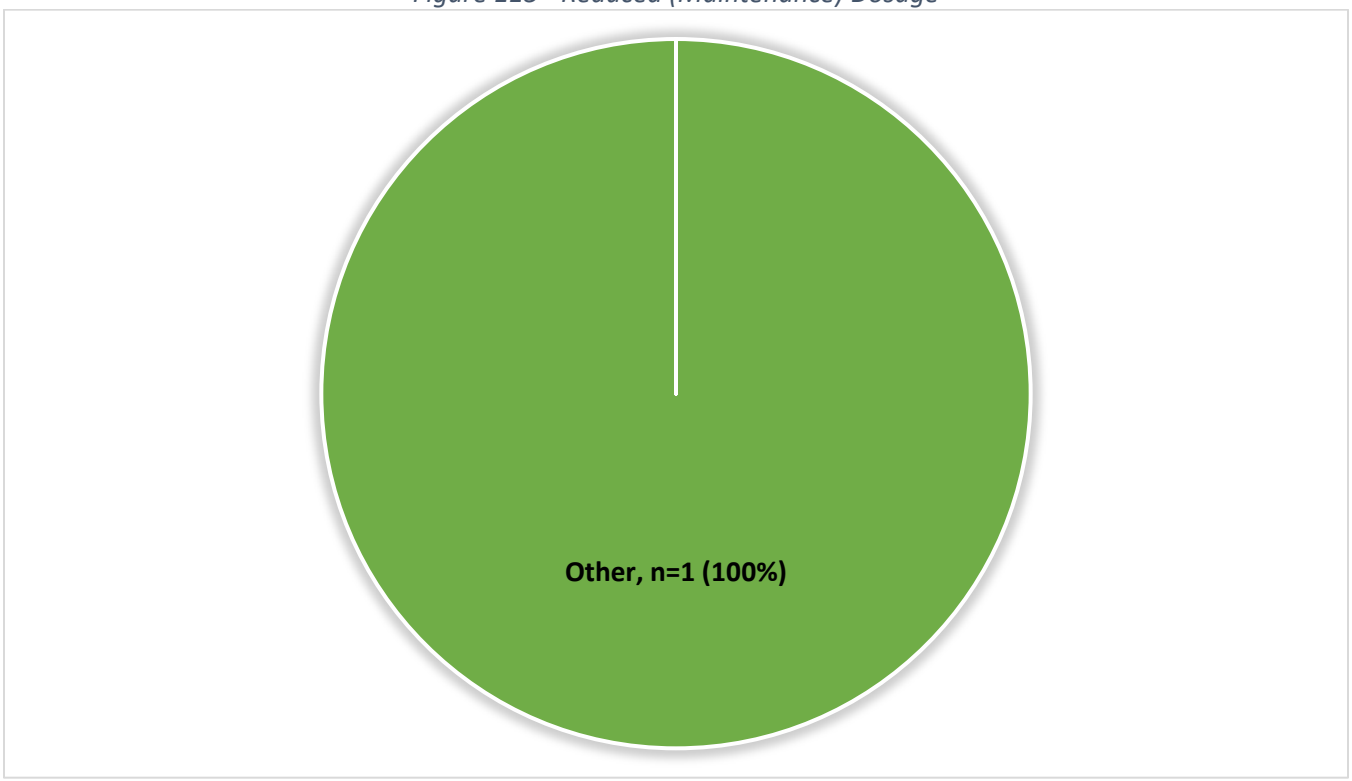


Table 169 - Reduced (Maintenance) Dosage

Response	MCO Names	Count	Percentage
Other	Community Care Plan	1	100.00%
State Totals		**1**	**100%**

If "Other," please explain.

Table 170 - "Other" Explanations for Reduced (Maintenance) Dosage

MCO Name	Explanation
Community Care Plan	We follow the states weekly comprehensive drug list directives. Buprenorphine sublingual (SL) tablets have a minimum age requirement of 16; Max of 3 SL tablets/tabs/films per day. Maximum of 7 days of induction therapy every 60 days (may approve a second 7-day induction therapy)

b. If "Yes," what are your limitations on the allowable length of the reduced dosage treatment?

Figure 116 - Limitations on the Allowable Length of the Reduced Dosage Treatment

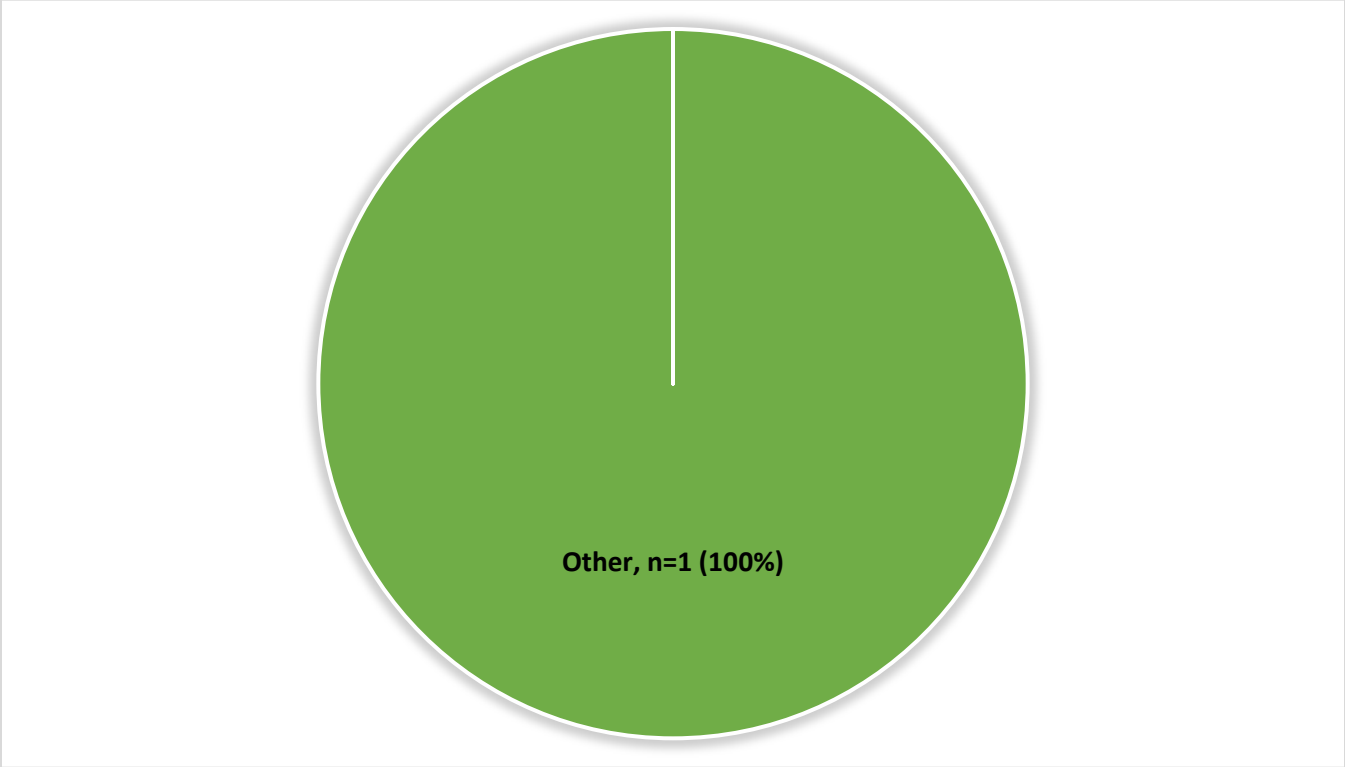


Table 171 - Limitations on the Allowable Length of the Reduced Dosage Treatment

Response	MCO Names	Count	Percentage
Other	Community Care Plan	1	100.00%
State Totals		**1**	**100%**

If "Other," please explain.

Table 172 - "Other" Explanations for Limitations on the Allowable Length of the Reduced Dosage Treatment

MCO Name	Explanation
Community Care Plan	3 months

5. Does your MCO have at least one buprenorphine/naloxone combination product available without PA?

Figure 117 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

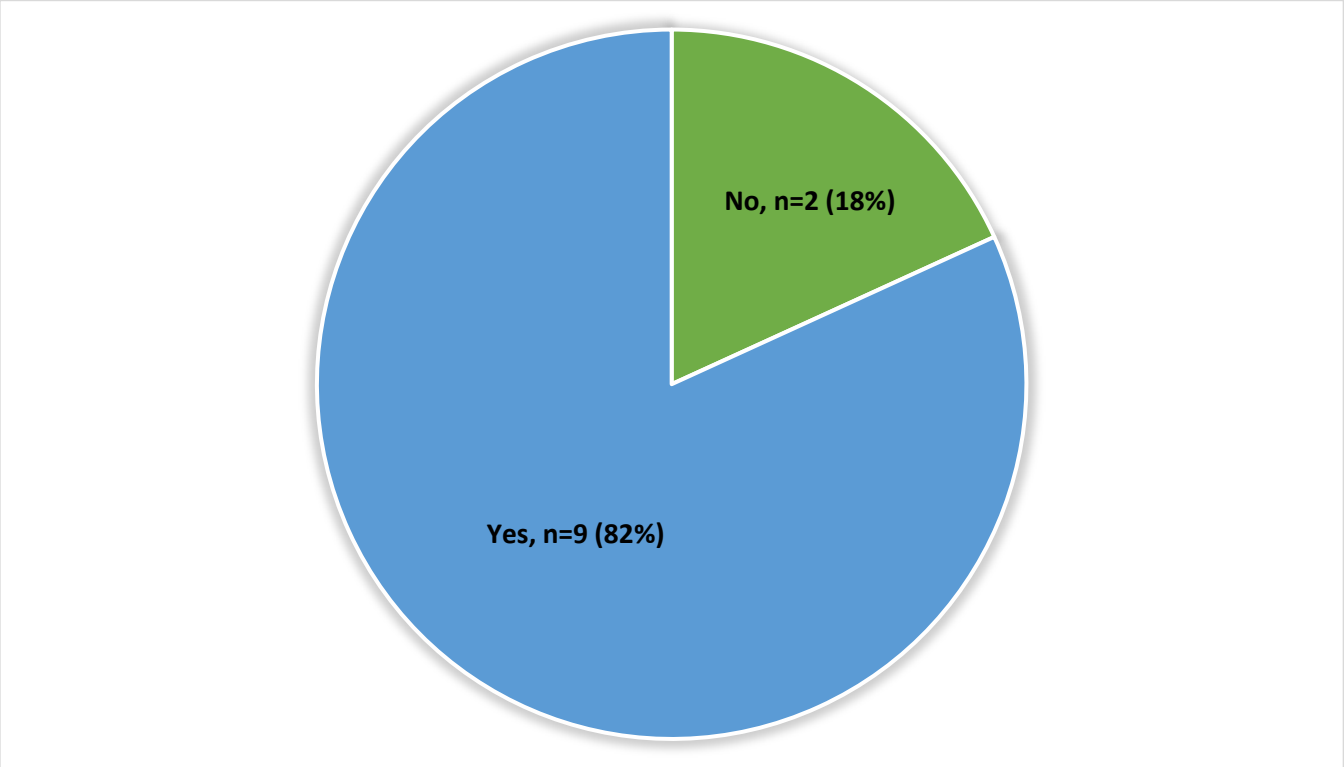


Table 173 - Buprenorphine/Naloxone Combination Product Available Without Prior Authorization

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Simply Healthcare, Sunshine, United Healthcare	9	81.82%
No	Amerihealth Caritas Florida, Molina Healthcare	2	18.18%
State Totals		**11**	**100%**

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

Figure 118 - Edits in Place to Monitor Opioids Being Used Concurrently with Any Buprenorphine Drug or Any Form of MAT

Table 174 - Edits in Place to Monitor Opioids Being Used Concurrently with Any Buprenorphine Drug or Any Form of MAT

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

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

Figure 119 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with Any Buprenorphine Drug or Any Form of MAT

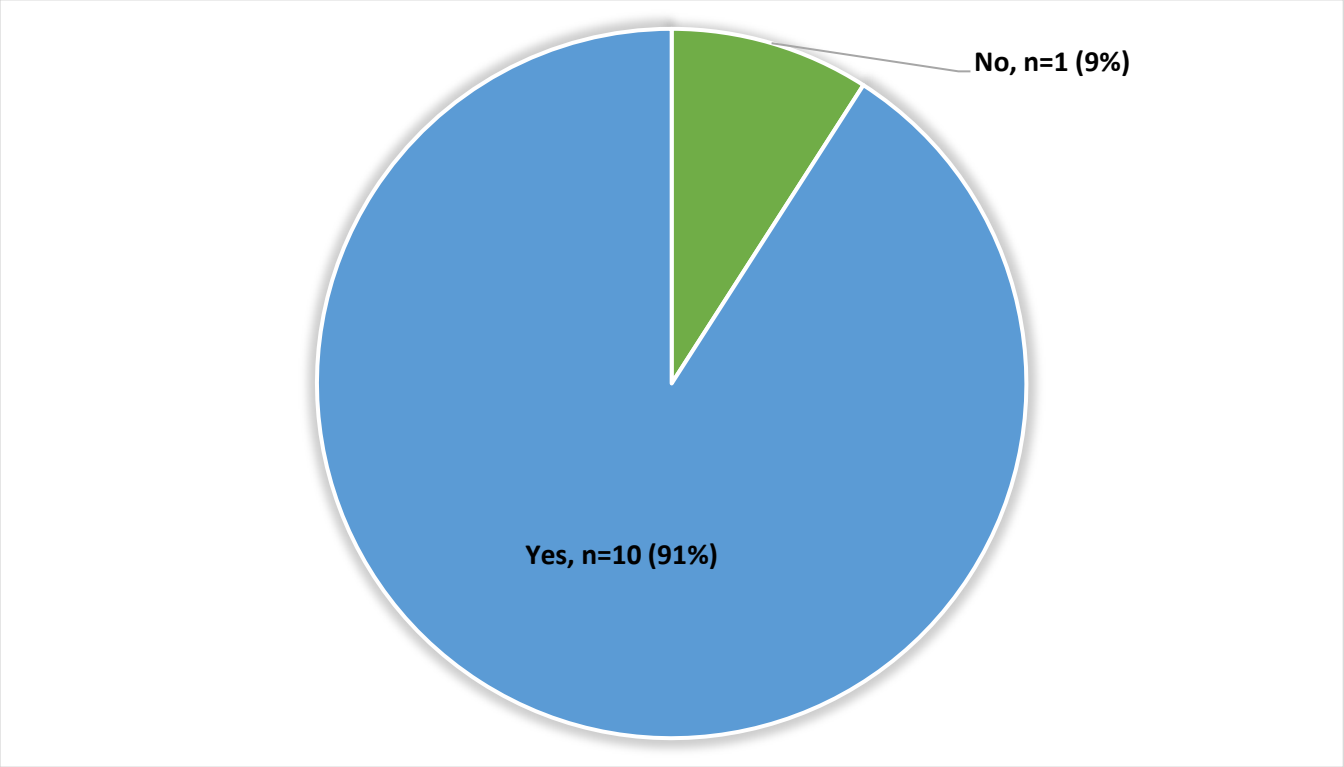


Table 175 - POS Pharmacist Override Edit for Opioids Being Used Concurrently with Any Buprenorphine Drug or Any Form of MAT

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Amerihealth Caritas Florida	1	9.09%
State Totals		**11**	**100%**

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

Figure 120 - Formulation of Naltrexone for OUD Available Without PA

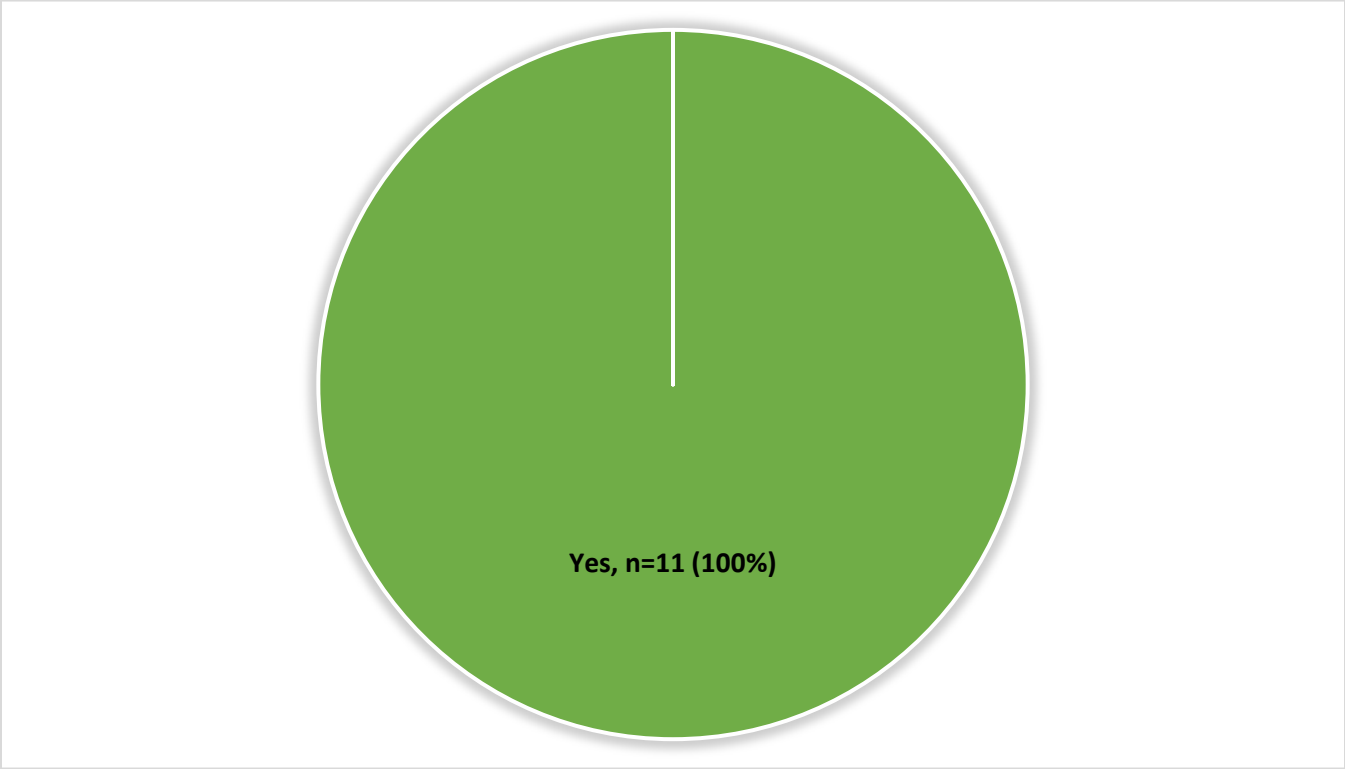


Table 176 - Formulation of Naltrexone for OUD Available Without PA

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

8. Does your MCO have at least one naloxone opioid overdose product available without PA?

Figure 121 - Naloxone Opioid Overdose Product Available Without PA

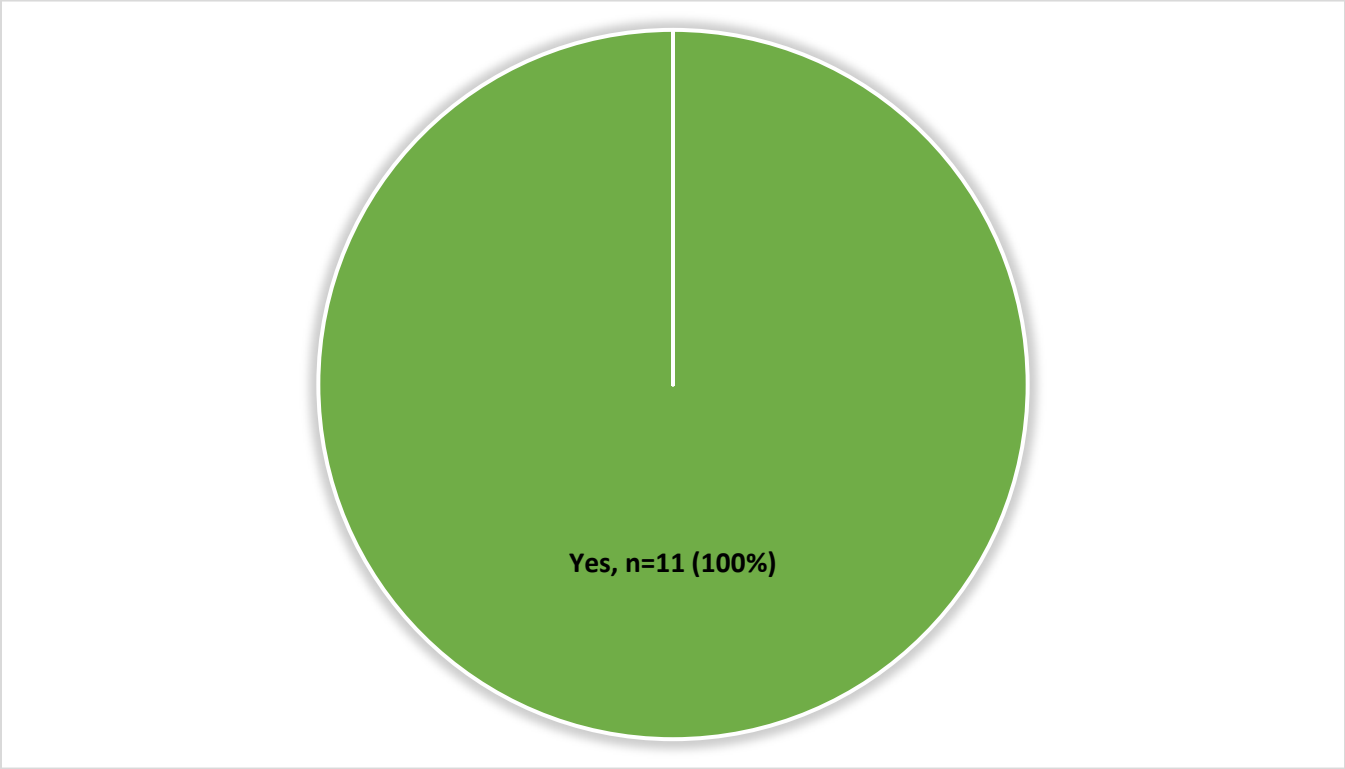


Table 177 - Naloxone Opioid Overdose Product Available Without PA

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

9. Does your MCO monitor and manage appropriate use of naloxone to persons at risk of overdose?

Figure 122 - Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

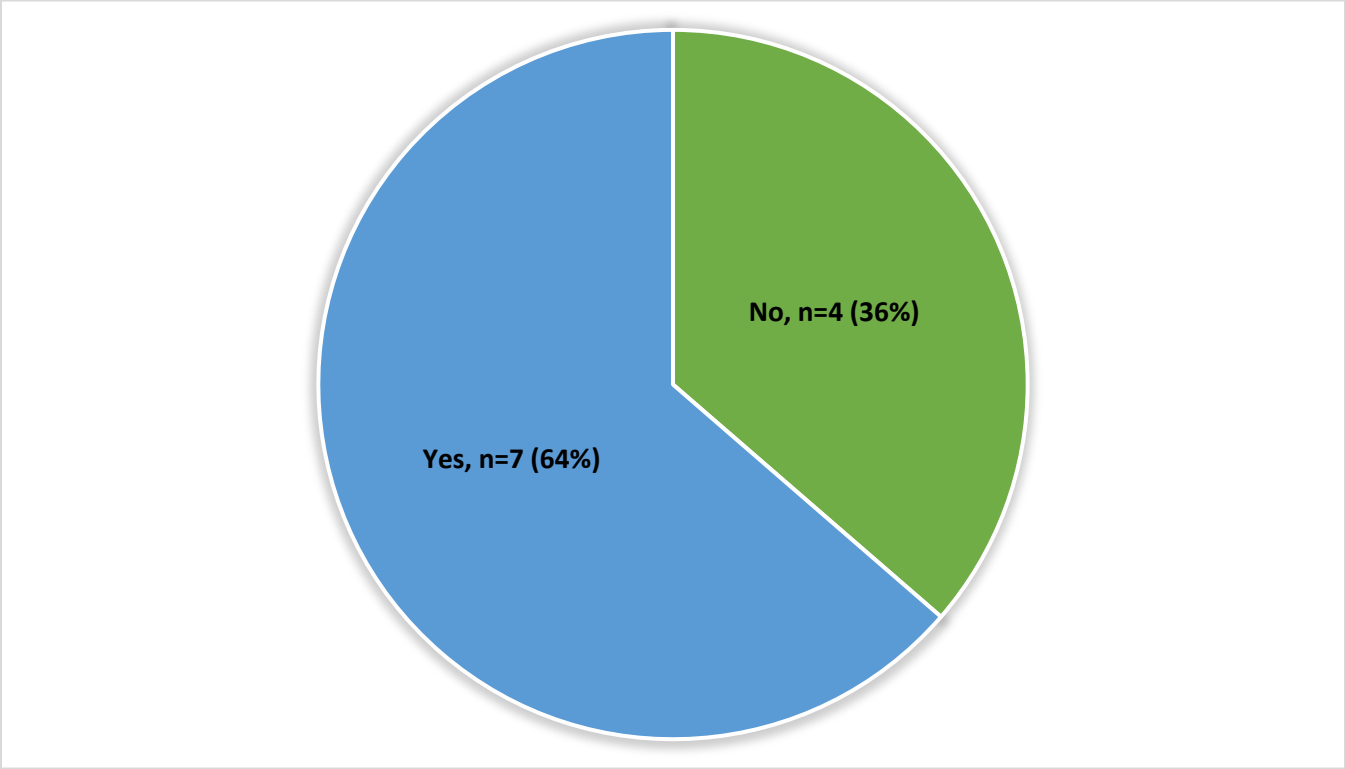


Table 178 - Monitor and Manage Appropriate Use of Naloxone to Persons at Risk of Overdose

Response	MCO Names	Count	Percentage
Yes	Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, United Healthcare	7	63.64%
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Sunshine	4	36.36%
State Totals		**11**	**100%**

If "No," please explain why not.

Table 179 - Explanation for Not Monitoring and Managing Appropriate use of Naloxone to Persons at Risk of Overdose

MCO Name	Explanation
Aetna Better Health	A high-level overview of MCO retrospective trends is shared with the plans at the AHCA Medicaid quarterly DUR Board meetings. Topics reviewed include opioid claims utilization, top opioid prescribers including specialty and region, top opioid recipients, Narcan/naloxone utilization, and overdose data if available.
Amerihealth Caritas Florida	The use of Naloxone is managed according to agency DUR Board and state board of pharmacy dispensing edits and guidelines to ensure members have open access to medication use for treatment of opioid overdose.
Children's Medical Services	This will be evaluated and implemented as needed and dependent on resources
Sunshine	This will be evaluated and implemented as needed and dependent on resources.

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

Figure 123 - MCO Allows Pharmacists to Dispense Naloxone Prescribed Independently or by Collaborative Practice Agreements, Standing Orders, Or Other Predetermined Protocols

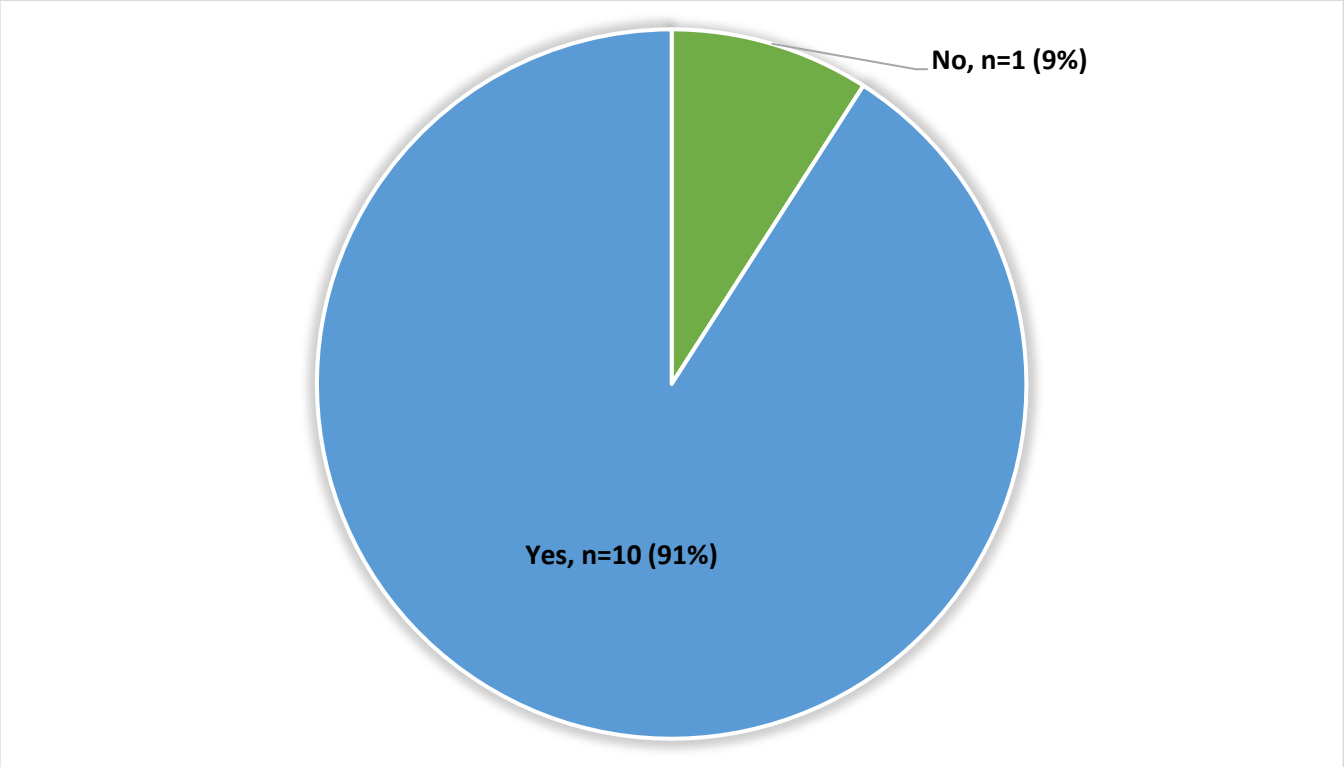


Table 180 - MCO Allows Pharmacists to Dispense Naloxone Prescribed Independently or by Collaborative Practice Agreements, Standing Orders, Or Other Predetermined Protocols

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Florida Community Care	1	9.09%
State Totals		**11**	**100%**

If "Yes," please explain.

Table 181 - Explanation for MCO Allowing Pharmacists to Dispense Naloxone Prescribed Independently or By Collaborative Practice Agreements, Standing Orders, Or Other Predetermined Protocols

MCO Name	Explanation
Aetna Better Health	There is a standing order through the state of FL Department of Health that is on file at all FL pharmacies that allows naloxone to be dispensed.
Amerihealth Caritas Florida	There is a standing order authorizing pharmacists who maintain a current active license for practicing in a pharmacy located in Florida that maintains a current active pharmacy permit to dispense naloxone to emergency responders for administration to persons exhibiting signs of opioid overdose. Emergency responders include law enforcement officers, firefighters, paramedics and emergency medical technicians.

MCO Name	Explanation
Children's Medical Services	Each pharmacy chain may have their own protocol, but in general, the pharmacy can dispense Narcan/Naloxone under a protocol physician. This prescription can be created with this protocol physician to be submitted to the plan. Claims will pay, only if an RX is written under a provider's NPI.
Clear Health Alliance	Yes, if allowed by state law
Community Care Plan	CCP follows the State guidelines.
Humana Medical Plan	Humana recognizes all valid prescriptions.
Molina Healthcare	CVS Health supports consistent prescriber editing for all lines of business (Commercial, Medicaid and Medicare Part D). These system edits ensure the following: The prescriber is valid, active and authorized by state and federal regulatory agencies to prescribe medicine The prescriber has a Type 1 NPI which must be submitted on the prescription claim. No other form of prescriber identification will be accepted. Any claim submitted with an invalid NPI will reject For controlled substance prescribing, a prescriber must have an active DEA identifier in good standing and have the authority to prescribe a controlled substance in a given DEA drug class schedule (2, 2N, 3, 3N, 4, 5). Note: Pharmacy claims electronically submitted according to the NCPDP standard may be processed using NCPDP Submission Clarification Codes (SCC) to allow accountable pharmacies to override claim rejections for failed validations of the prescriber or the prescriber's license. When a SCC override is used, the accountable pharmacies are certifying they have validated that the prescriber is active and valid and can prescribe medications. This SCC override process is subject to audit.
Simply Healthcare	Pursuant to state law.
Sunshine	Each pharmacy chain may have their own protocol, but in general, the pharmacy can dispense Narcan/Naloxone under a protocol physician. This prescription can be created with this protocol physician to be submitted to the plan. Claims will pay, only if an RX is written under a provider's NPI.
United Healthcare	Based on state defined requirements, the process for submitting a claim prescribed by a pharmacist or via collaborative practice agreement is the same as other claims. Florida statute allows pharmacists to dispense emergency opioid antagonist therapy pursuant to a prescription or to a patient with opioids for a auto-injection delivery or intransal application system. Product must be appropriately stored and labelled with instructions for use.

F. Outpatient Treatment Programs (OTP)

1. Does your MCO cover OTPs that provide behavioral health (BH) and MAT through OTPs?

Figure 124 - MCO Covers OTPs That Provide BH and MAT Through OTPs

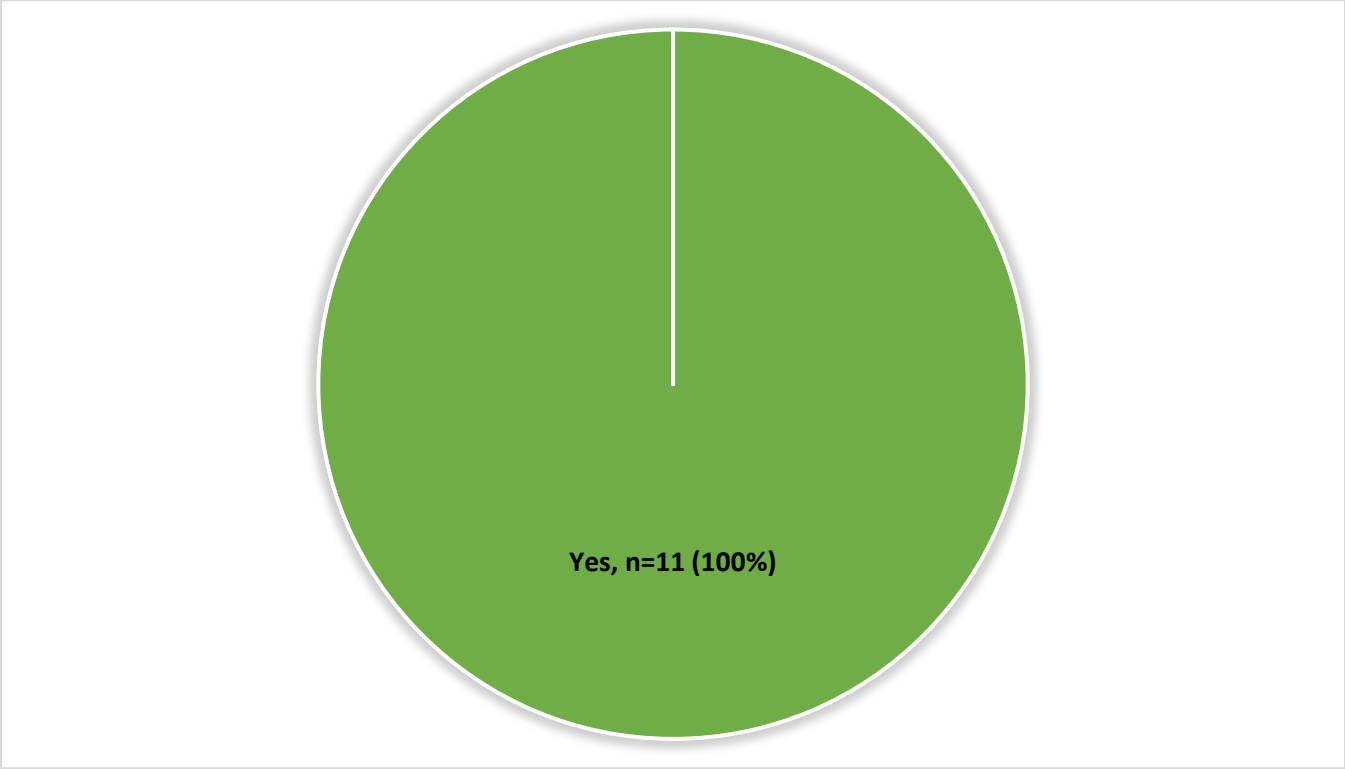


Table 182 - MCO Covers OTPs That Provide BH and MAT Through OTPs

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

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

Figure 125 - Referral Required for OUD Treatment Through OTPs

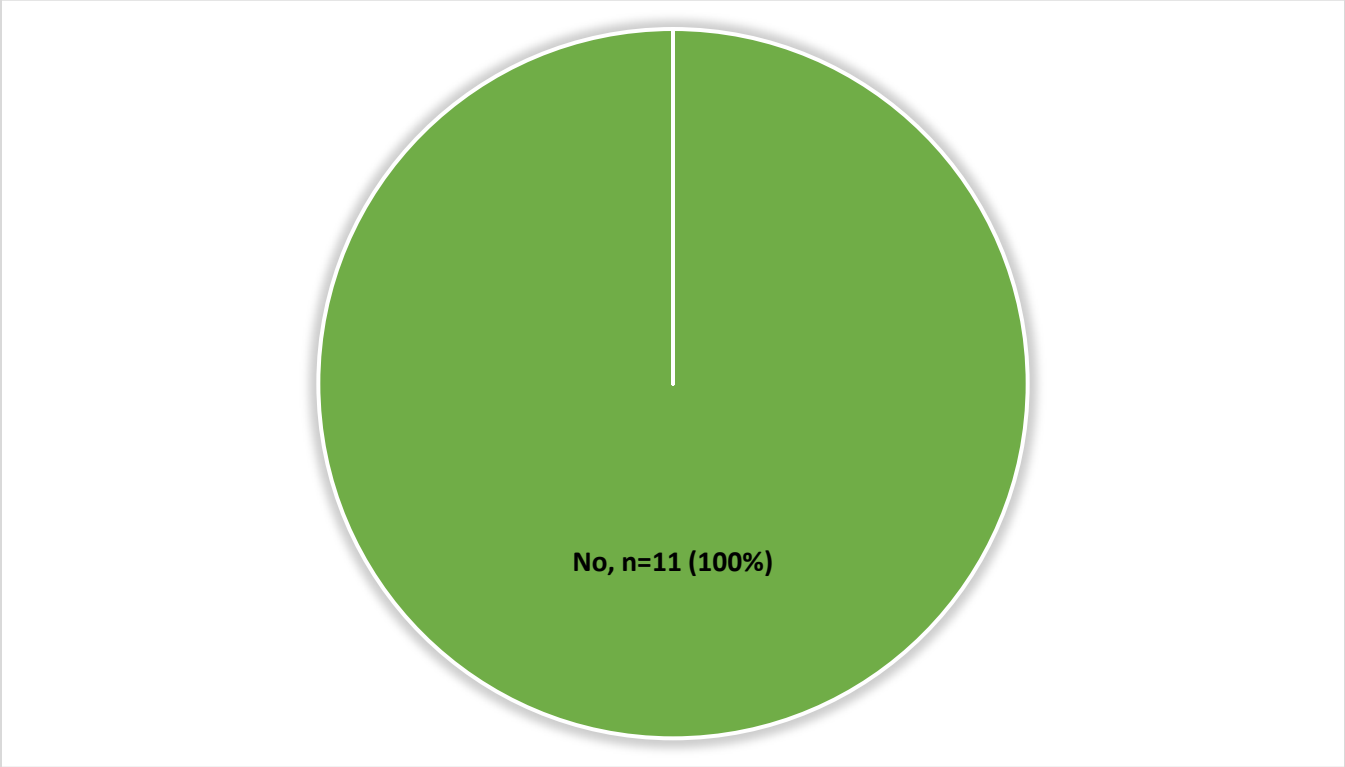


Table 183 - Referral Required for OUD Treatment Through OTPs

Response	MCO Names	Count	Percentage
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

If “No,” please explain.

Table 184 - Explanation for Not Requiring Referrals for OUD Treatment Through OTPs

MCO Name	Explanation
Aetna Better Health	Members can access OUD treatment from an outpatient provider without a referral. Certain outpatient services for substance use disorder require a prior authorization (intensive outpatient).
Amerihealth Caritas Florida	Referrals are not required to ensure there are no barriers to treatment.
Children's Medical Services	The MCO does not require a referral for OUD treatment through OTPs.
Clear Health Alliance	no referral is required.
Community Care Plan	Depends on where the member is linked to for assistance. But member can go to walk in facilities that we have in our plan. Memorial MAT program is one of the OTP walk in options.
Florida Community Care	FCC considers this to fall under Mental Health parity.

MCO Name	Explanation
Humana Medical Plan	Humana does not require a referral for MAT treatment for members, as to avoid the potential for a referral being seen as a barrier to receiving BH services and MAT treatment.
Molina Healthcare	Referral is not needed
Simply Healthcare	Referral is not required.
Sunshine	The MCO does not require a referral for OUD treatment through OTPs.
United Healthcare	Members may also self- refer

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

Figure 126 - MCO Covers Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a MAT Treatment Plan

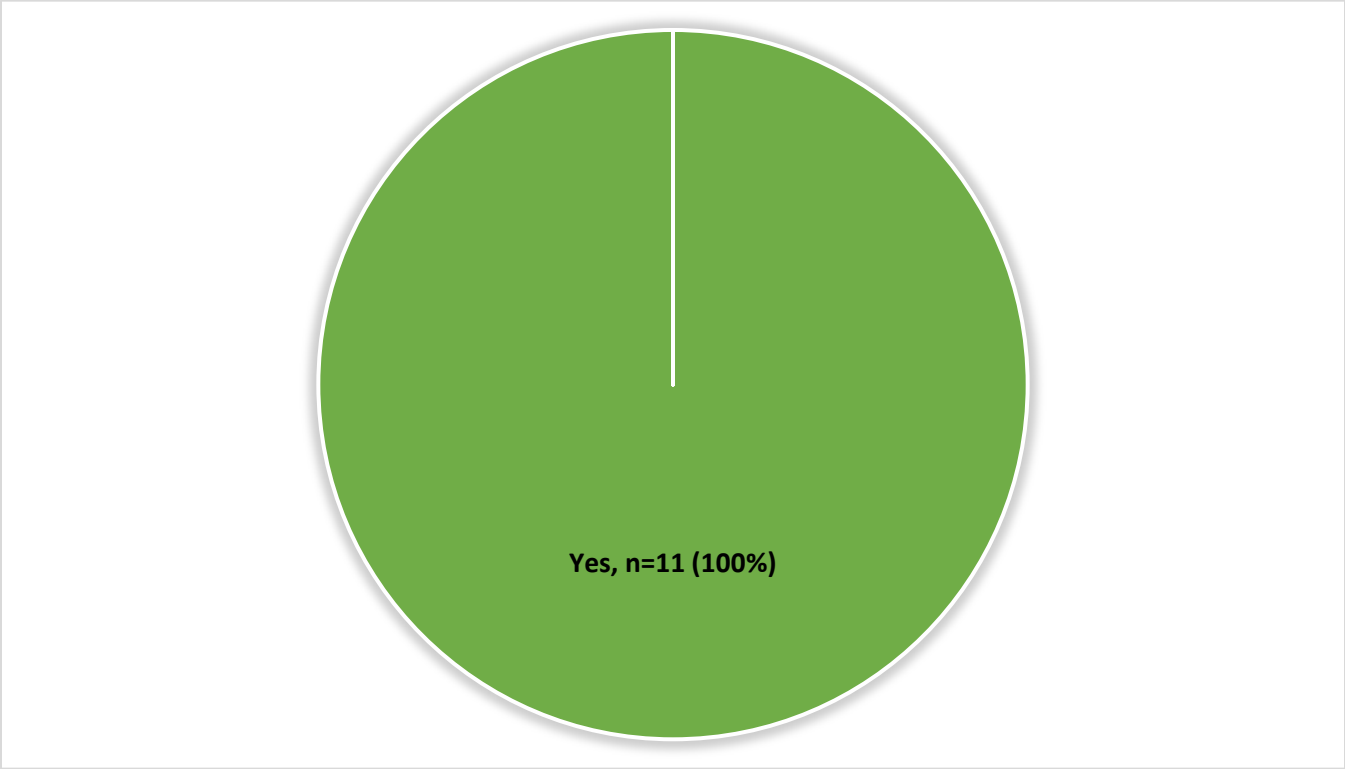


Table 185 - MCO Covers Buprenorphine or Buprenorphine/Naloxone for Diagnoses of OUD as Part of a MAT Treatment Plan

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

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

Figure 127 - MCO Covers Naltrexone for Diagnoses of OUD as Part of a MAT Treatment Plan

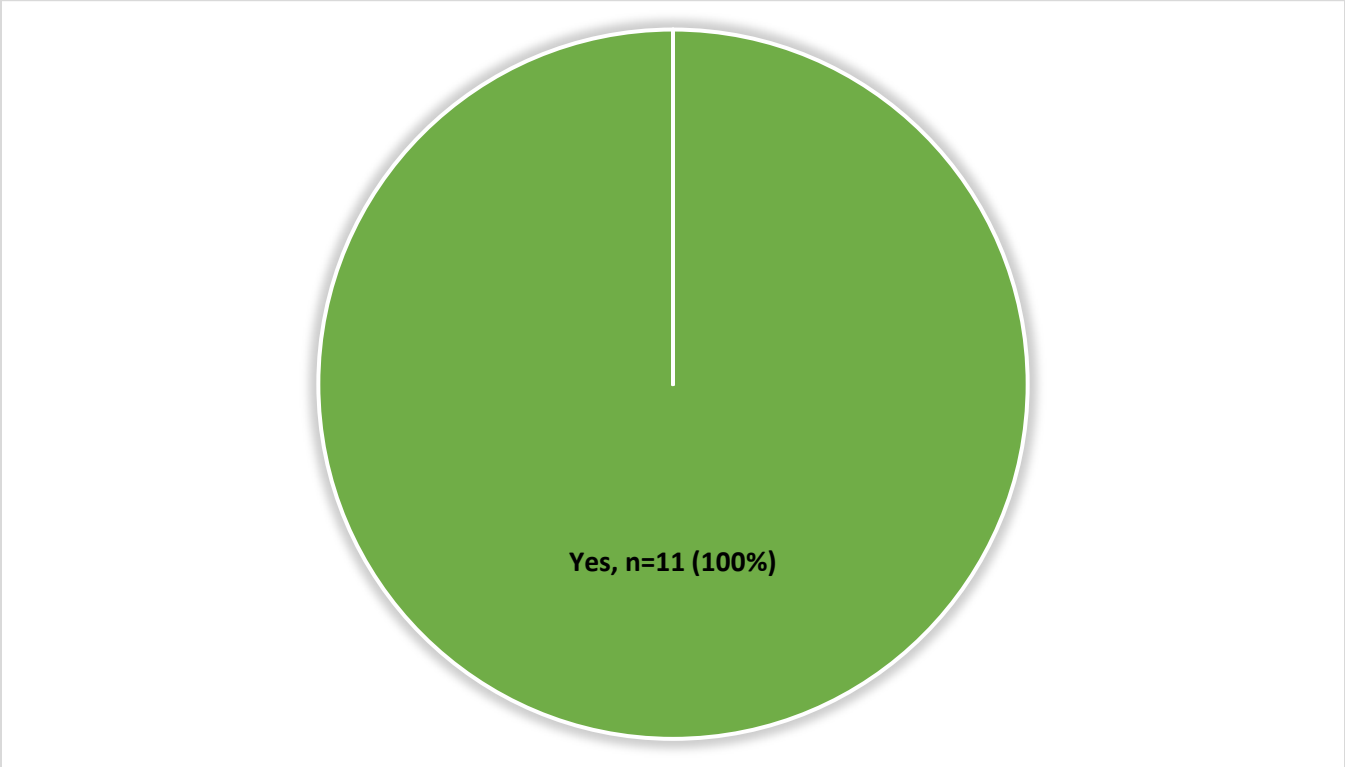


Table 186 - MCO Covers Naltrexone for Diagnoses of OUD as Part of a MAT Treatment Plan

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

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

Figure 128 - MCO Covers Methadone for Substance Use Disorder

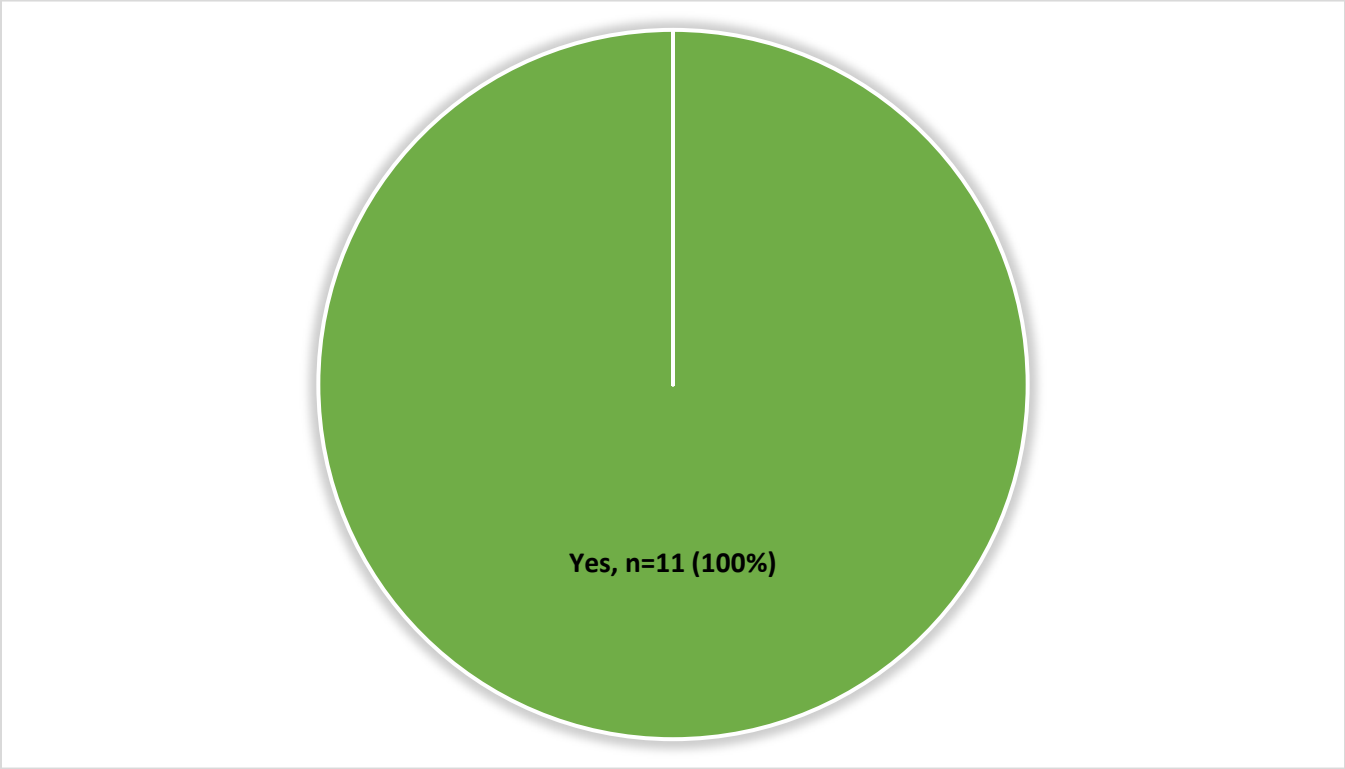


Table 187 - MCO Covers Methadone for Substance Use Disorder

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

G. Psychotropic Medication For Children

Antipsychotics

1. Does your MCO currently have restrictions in place to limit the quantity of antipsychotic drugs?

Figure 129 - Restrictions to Limit Quantity of Antipsychotics

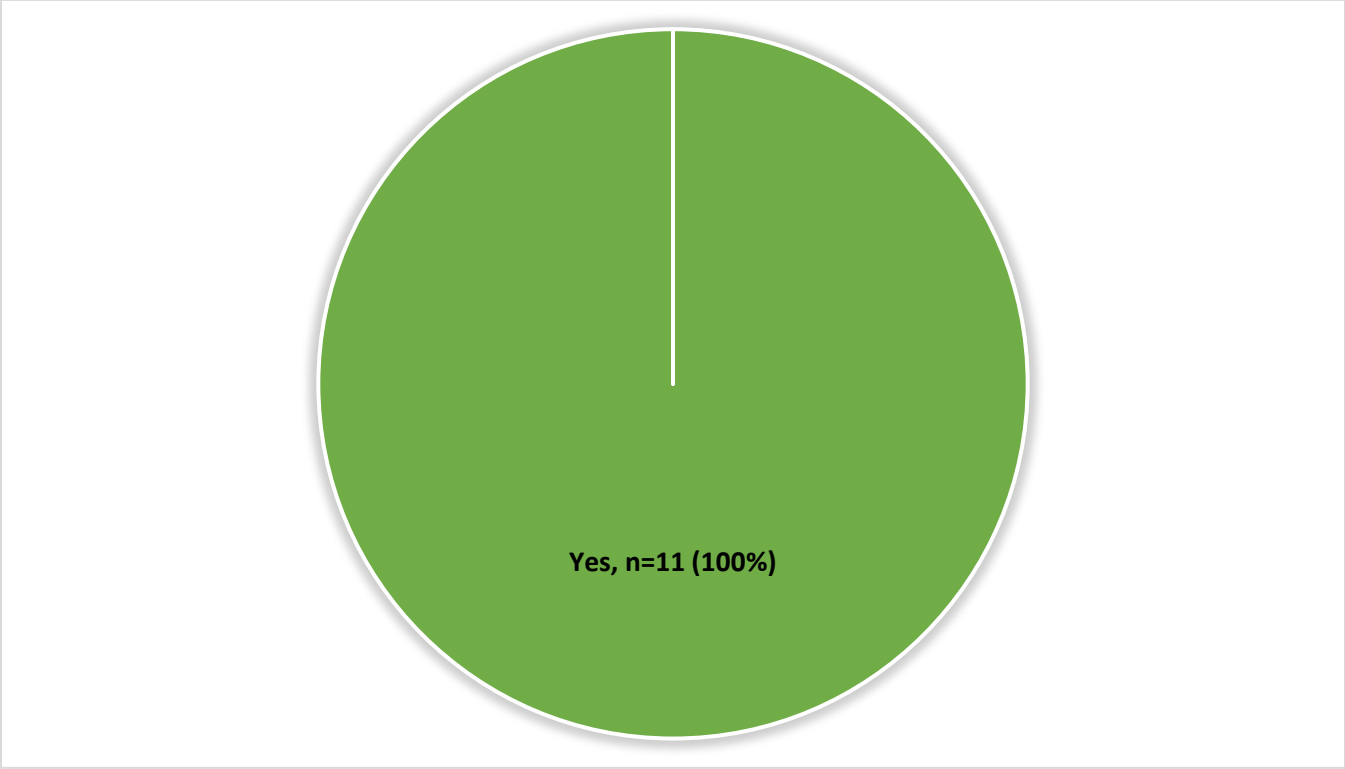


Table 188 - Restrictions to Limit Quantity of Antipsychotics

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

Please explain restrictions or N/A.

Table 189 - Explanations of Restrictions to Limit Quantity of Antipsychotics

MCO Name	Explanation
Aetna Better Health	Quantity limits align with state PDL requirements and FDA package inserts.
Amerihealth Caritas Florida	There are age limits and quantity limits in place.
Children's Medical Services	Utilization management edits are in place (qty limits, age)
Clear Health Alliance	We have a polypharmacy edit those alerts pharmacies to the use of more than one antipsychotic agent.
Community Care Plan	CCP follows the guidance of the State related to children and antipsychotics therapy.

MCO Name	Explanation
Florida Community Care	Aligns with requirements under State of FL PDL
Humana Medical Plan	Duplicate therapy edit to meet AHCA requirements to intercept either a duplicative oral antipsychotic fill or an oral antipsychotic with an LAI via Auto PA logic
Molina Healthcare	Quantity limits are in place that align with the AHCA FL weekly drug file
Simply Healthcare	A Polypharmacy edit that alerts pharmacies to the concurrent use of more than one antipsychotic agent.
Sunshine	Utilization management edits are in place (qty limits, age)
United Healthcare	Point of sale FDA cumulative max dose, DUR, High dose soft reject edit on antipsychotics . This edit requires dispensing pharmacist at point of sale to enter an appropriate NCPDP code to override the rejection and obtain a paid claim. State of Florida Agency for HealthCare Administration additionally defines prior authorization parameters and guidelines for polypharmacy of antipsychotic therapy, min age limits, and maximum daily doses for age.

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

Figure 130 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antipsychotic Drugs in Children

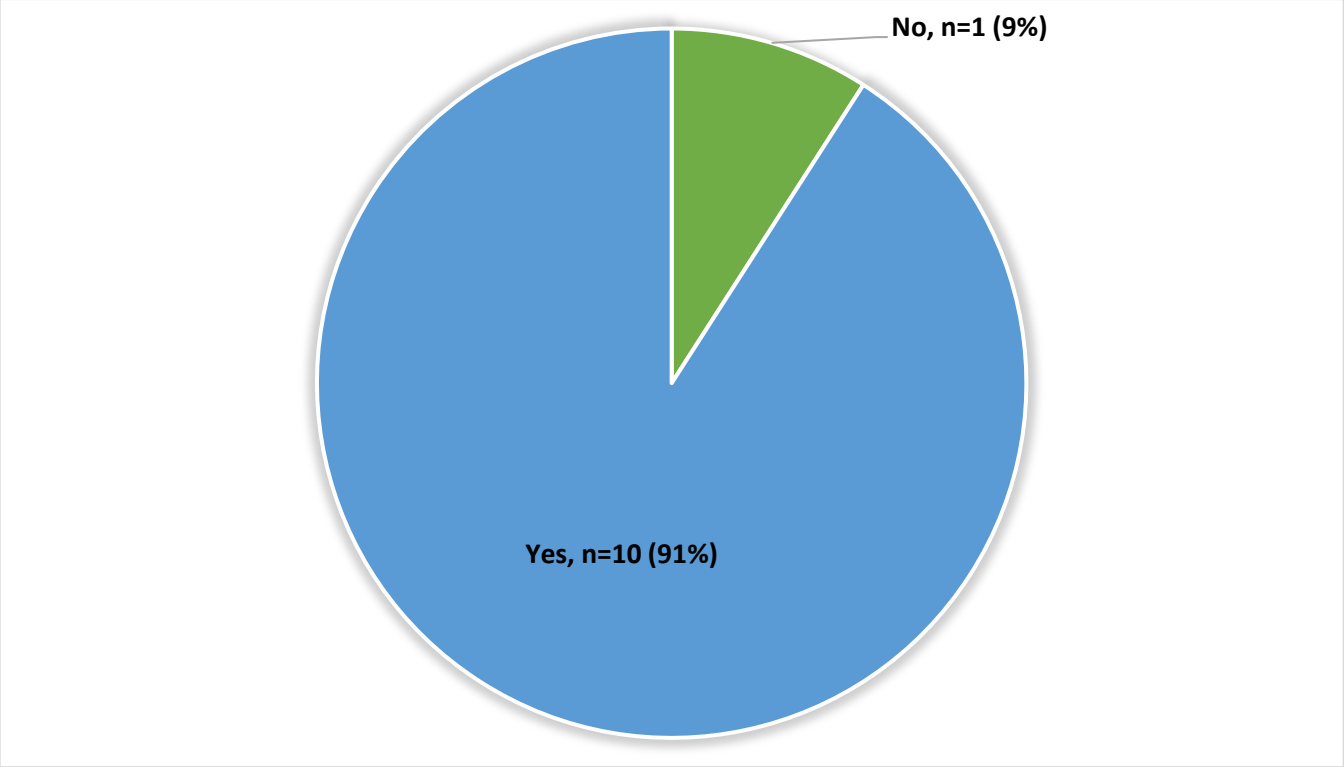


Table 190 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antipsychotic Drugs in Children

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care	10	90.91%

Response	MCO Names	Count	Percentage
	Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare		
No	Florida Community Care	1	9.09%
State Totals		**11**	**100%**

a. If "Yes," does your MCO either manage or monitor:

Figure 131 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

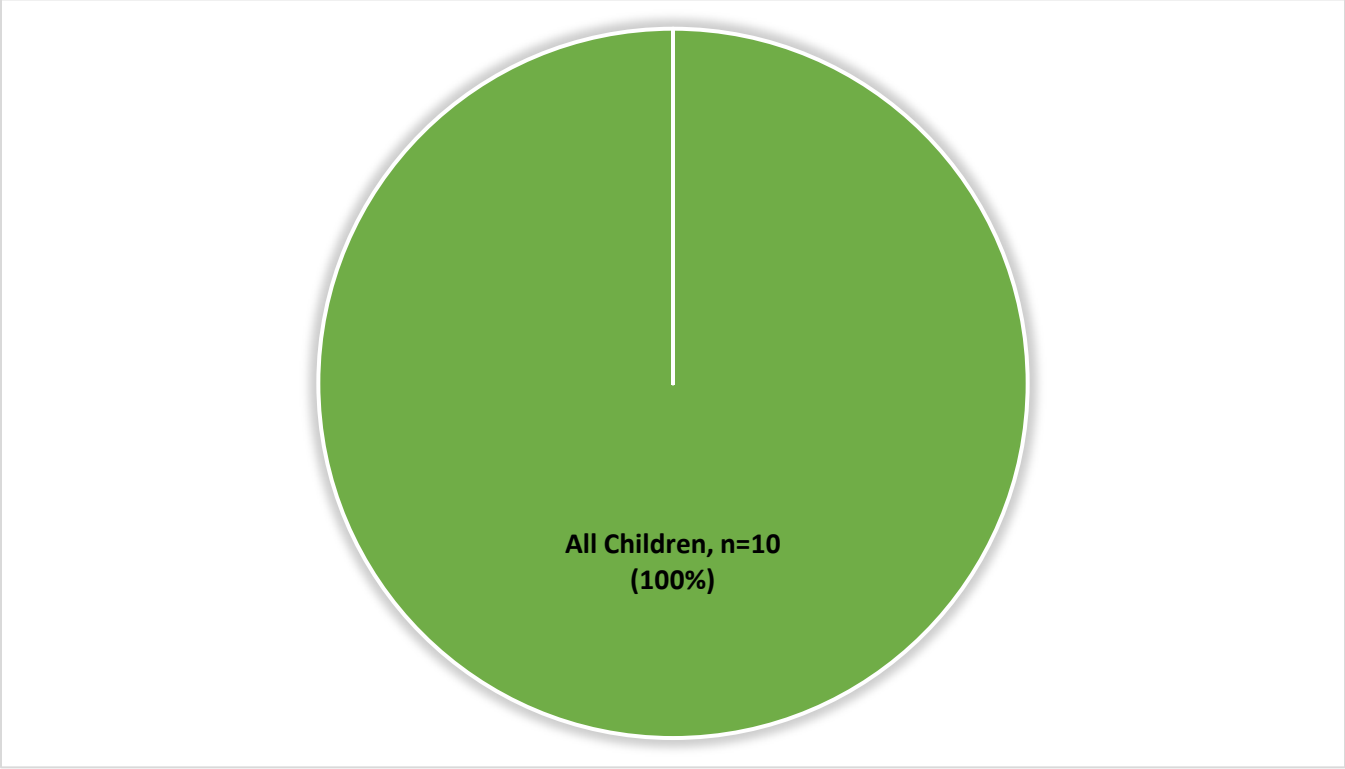


Table 191 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

Response	MCO Names	Count	Percentage
All children	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	100.00%
State Totals		**10**	**100%**

b. If "Yes," does your MCO have edits in place to monitor (multiple responses allowed):

Figure 132 - Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

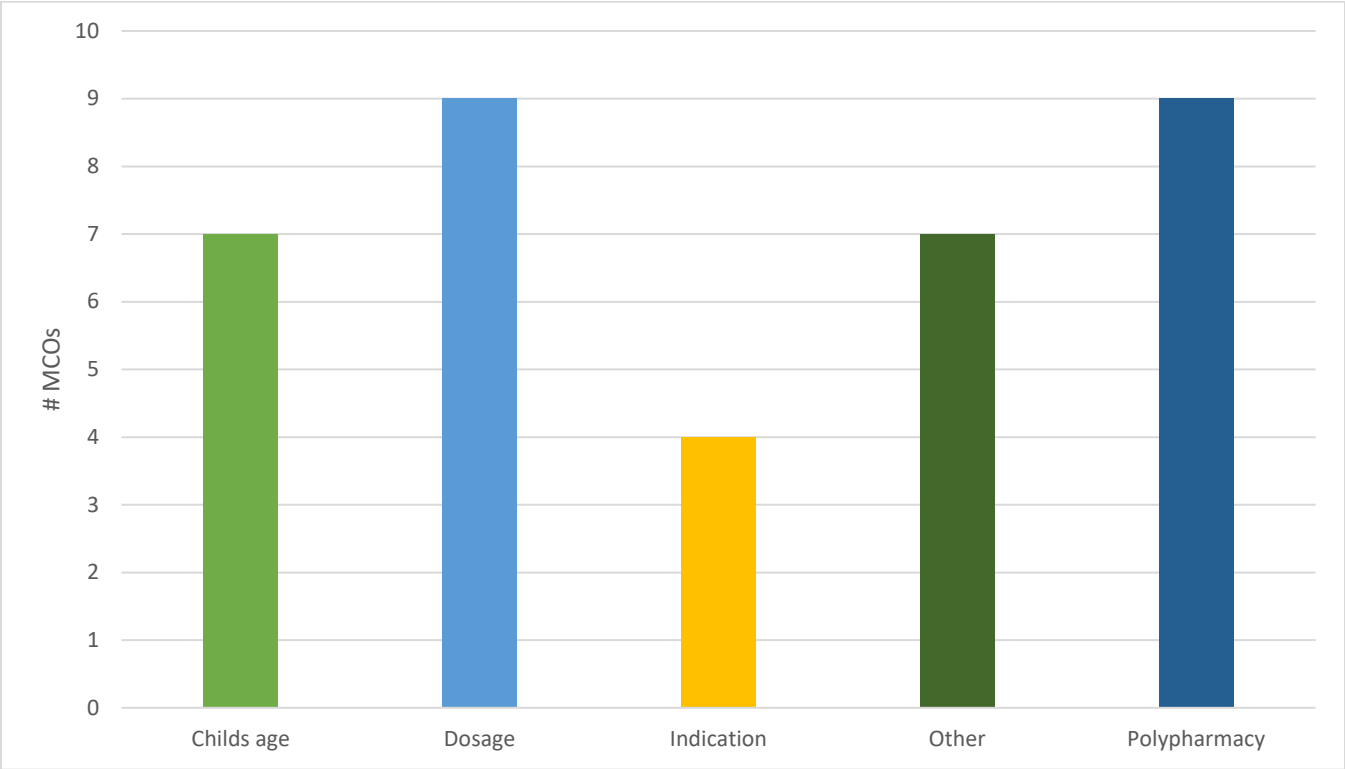


Table 192 - Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

Response	MCO Names	Count	Percentage
Childs age	Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine	7	19.44%
Dosage	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	25.00%
Indication	Aetna Better Health, Community Care Plan, Humana Medical Plan, Molina Healthcare	4	11.11%
Polypharmacy	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	25.00%
Other	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Simply Healthcare, Sunshine, United Healthcare	7	19.44%
State Totals		**36**	**100%**

If "Child's age," please specify age limit in years.

Table 193 - Child's Age Limits for Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

MCO Name	Age Limit in Years
Children's Medical Services	18

MCO Name	Age Limit in Years
Clear Health Alliance	6
Community Care Plan	6
Humana Medical Plan	17
Molina Healthcare	17
Simply Healthcare	6
Sunshine	18

If "Other," please explain.

Table 194 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Antipsychotic Drugs in Children

MCO Name	Explanation
Aetna Better Health	Prior Authorization requirements also include metabolic monitoring and assessment for tardive dyskinesia. Concurrent anti-psychotics are permitted for cross-tapering to change therapeutic agent. The FL Medicaid plan follows state PA criteria for antipsychotics. The state has separate criteria for antipsychotic use for children under age 6 and children ages 6 to under 18.
Amerihealth Caritas Florida	The plan sets minimum age limits and maximum doses based on the member's age or age range based on state guidelines.
Children's Medical Services	ProDUR edit screening for overlapping therapy of an opioid and antipsychotic therapy. POS pharmacist is requested to review clinical necessity. If needed, an override is entered at POS utilizing SCC/PAMC codes.
Clear Health Alliance	appropriate diagnosis
Simply Healthcare	Age limits depend upon product selected.
Sunshine	ProDUR edit screening for overlapping therapy of an opioid and antipsychotic therapy. POS pharmacist is requested to review clinical necessity. If needed, an override is entered at POS utilizing SCC/PAMC codes.
United Healthcare	In addition to edits that monitor dosage, indication, and polypharmacy (therapeutic duplication), UnitedHealthcare Community Plan has edits in place that monitor age based on FDA labeling for each individual product and not as a specific age across all products.

c. If "Yes," please briefly explain the specifics of your documented antipsychotic monitoring program(s).

Table 195 - Explanations of Specifics of Documented Antipsychotic Monitoring Program(s)

MCO Name	Explanation
Aetna Better Health	Pro-DUR program where all anti-psychotics for members under age 18 require prior authorization for medical necessity. Prior authorization must be renewed every 6 months thereafter if continuation is required.
Amerihealth Caritas Florida	Requests outside of the age range and/or maximum dose would require a medical necessity review. Appropriate metabolic monitoring related to use of antipsychotic medications in the pediatric population is addressed through the Drug Therapy Management program.
Children's Medical Services	The Pediatric Antipsychotic Utilization program identifies potential drug therapy issues including excessive dose and multiple medication therapy for children 10 and under in the Medicaid population. Recommendations are suggested to the provider via outreach. For all beneficiaries, if two or more antipsychotics are being use for greater than 90 days, a letter is sent to their provider. Additionally the retrospective safety review (RSR) program will specifically flag interactions between antipsychotics and opioids. The point of sale reports will generate clinically relevant alerts as well related to antipsychotics.

MCO Name	Explanation
Clear Health Alliance	We have Protocols to monitor the use of antipsychotic medications including: the oversight of the use of antipsychotics used in children under the age of six; Adults or children receiving more than one antipsychotic medication (polypharmacy); Program monitors for medication adherence of antipsychotic in those who have less than 80% PDC of their antipsychotic medications (18 and older), as well monitoring for Gaps in care of those who are receiving antipsychotic medications but have not had a diabetes or lipid screen; a fax is generated and sent to the prescribers of antipsychotic medications to inform of identified drug therapy issue and encourages the physician to follow up with the member. Antipsychotic for monitoring for children less than 18 years of age. Outreach to providers of children being prescribed antipsychotic medications as first line and have not received psychosocial care as first line therapy. We also have a prior authorization for antipsychotic use in children under 18 years of age. Requires a specialist consult to prescribe these drugs.
Community Care Plan	The age limit will depend on the product. CCP follows the States guidance and required documentation for children prescribed antipsychotics. The PBM enforces this at POS. CCP requires the Medicaid prescribers to use the forms provided by the State for prescribing antipsychotics to children under the age of 6 and between the ages of 6 and <18, prescribing stimulants <6 years and etc. The CCP clinical pharmacist will contact parents to discuss medications compliance, follow up appointments with prescribers, side effect monitoring, answer questions and provide medication education.
Humana Medical Plan	Drug-age contraindication edits Multiple concurrent antipsychotic use edits We apply the age, gender, and QL edits as described in the Summary of Drug Limitations directly from the state's website. We also manage these drugs through applying drugs that are applicable to the AHCA Informed Consent table, which will give a hard rejection that requires all patients <13 and their guardians to complete the informed consent process to pay a claim. As defined by AHCA per Florida Statute F.S. 409.912(16), "antipsychotics, antidepressants, anti-anxiety, and mood stabilizers (anticonvulsants and ADHD medications not included)" must be added to the AHCA Informed Consent drug table. Powered by Humana Pharmacy Solutions' proprietary IntelligentRx solution we deploy prospective DUR edits and override alerts for all our members to prescribers and pharmacies. These are designed and implemented to assist evaluation of a members planned drug therapy before a medication is dispensed. Our edits such as drug-drug interaction, therapeutic duplication, drug-disease edits for these drug classes e.g. anticonvulsants, antipsychotics, antidepressants, benzodiazepines, barbiturates, non-benzodiazepine sedatives, provide an additional layer of patient safety by reviewing patient claims history for possible inappropriate, unnecessary or unsafe prescribing.
Molina Healthcare	Specifically evaluating the utilization of antipsychotic utilization in children less than 18 years of age, Molina reviewed claims for those members who are younger than the FDA label or compendium supported age limit. These members were referred to case management. Claims were also reviewed for utilization of multiple antipyschotic therapies concurrently. Any member found to have 2 or more antipsychotic claims paid within the same 30 days were referred to a clinician to evaluate the appropriateness of the prescriber specialty and review of medication history. Anything that did not align with the medical record was referred to case management.
Simply Healthcare	We have Protocols to monitor the use of antipsychotic medications including: the oversight of the use of antipsychotics used in children under the age of six; Adults or children receiving more than one antipsychotic medication (polypharmacy); Program monitors for medication adherence of antipsychotic in those who have less than 80% PDC

MCO Name	Explanation
	of their antipsychotic medications (18 and older), as well monitoring for Gaps in care of those who are receiving antipsychotic medications but have not had a diabetes or lipid screen; a fax is generated and sent to the prescribers of antipsychotic medications to inform of identified drug therapy issue and encourages the physician to follow up with the member. Antipsychotic for monitoring for children less than 18 years of age. Outreach to providers of children being prescribed antipsychotic medications as first line and have not received psychosocial care as first line therapy. We also have a prior authorization for antipsychotic use in children under 18 years of age. Requires a specialist consult to prescribe these drugs.
Sunshine	The Pediatric Antipsychotic Utilization program identifies potential drug therapy issues including excessive dose and multiple medication therapy for children 10 and under in the Medicaid population. Recommendations are suggested to the provider via outreach. For all beneficiaries, if two or more antipsychotics are being use for greater than 90 days, a letter is sent to their provider. Additionally the retrospective safety review (RSR) program will specifically flag interactions between antipsychotics and opioids. The point of sale reports will generate clinically relevant alerts as well related to antipsychotics.
United Healthcare	"1. Prior authorization is required when an antipsychotic is being utilized for age below a set minimum, a dosage above the limits set by the state on the PDL or summary of drug limitations, or if utilizing 3 or more antipsychotics for more than 30 days in the last 60 day period. 2. UnitedHealthcare Community Plan also has a drug interaction soft reject edit at the point of sale on antipsychotics concurrently used with opioids. The edit require the dispensing pharmacist at the point of sale to enter an appropriate NCPDP code to override the reject and obtain a paid claim. 3. Retrospective DUR programs: OptumRx runs multiple safety management RDUR programs that include antipsychotic medications. These RDUR programs send faxes to prescribers within 24 hours of the identified medication related problem. Antipsychotics are included in our Drug-Age, Dose-Per Day, Therapeutic Duplication, Drug-Drug Interaction, Drug-Disease Interaction, Concurrent Use of multiple CNS active medications, and Concurrent Use of opioids with antipsychotics programs. "

d. If "No," does your MCO plan on implementing an antipsychotic monitoring program in the future?

Figure 133 - Future Plans to Implement an Antipsychotic Monitoring Program

Table 196 - Future Plans to Implement an Antipsychotic Monitoring Program

Response	MCO Names	Count	Percentage
No	Florida Community Care	1	100.00%
State Totals		**1**	**100%**

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

Table 197 - Explanations for not Implementing a Program to Monitor Appropriate Use of Antipsychotic Drugs in Children

MCO Name	Explanation
Florida Community Care	As a Long Term Care plan, our population is restricted to beneficiaries age 18 and above. We have no population of children.

Stimulants

3. Does your MCO currently have restrictions in place to limit the quantity of stimulant drugs?

Figure 134 - Restrictions in Place to Limit the Quantity of Stimulant Drugs

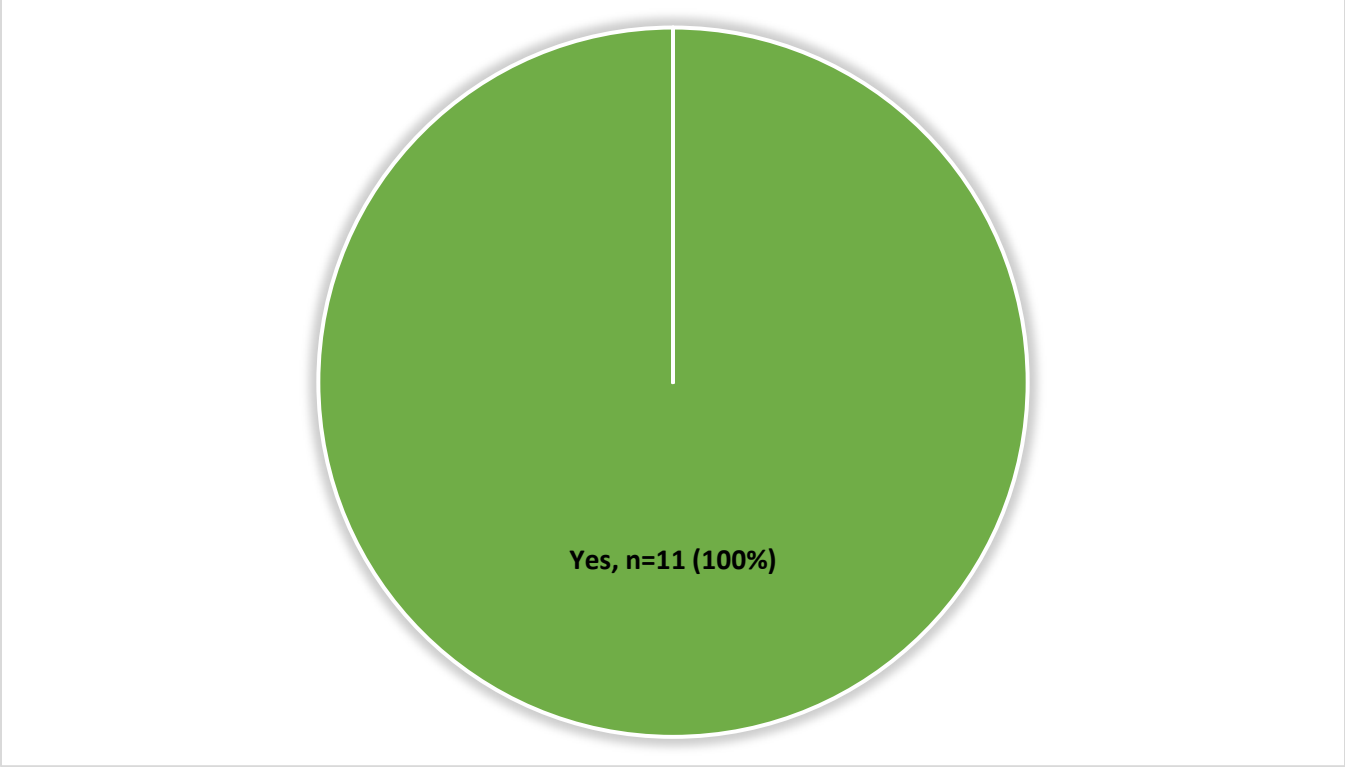


Table 198 - Restrictions in Place to Limit the Quantity of Stimulant Drugs

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

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

Figure 135 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

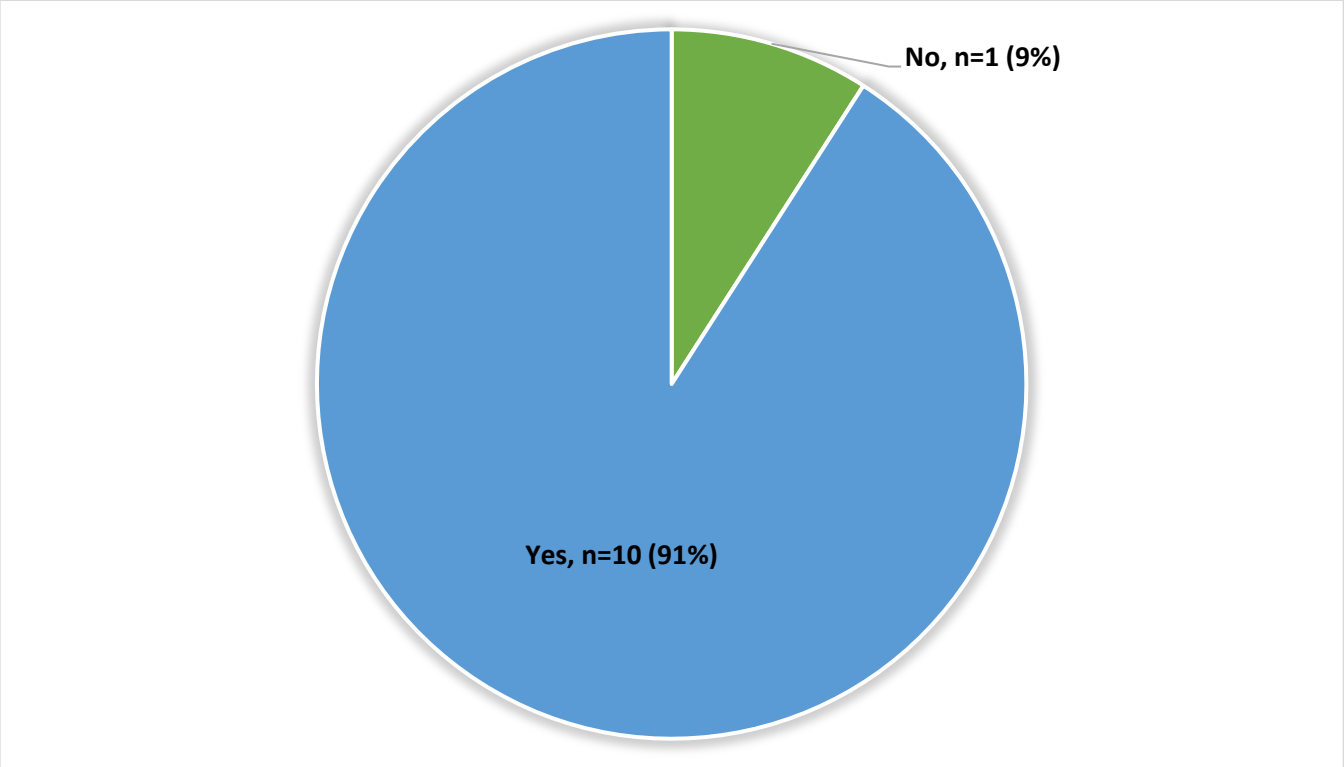


Table 199 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Florida Community Care	1	9.09%
State Totals		**11**	**100%**

a. If "Yes," does your MCO either manage or monitor:

Figure 136 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs

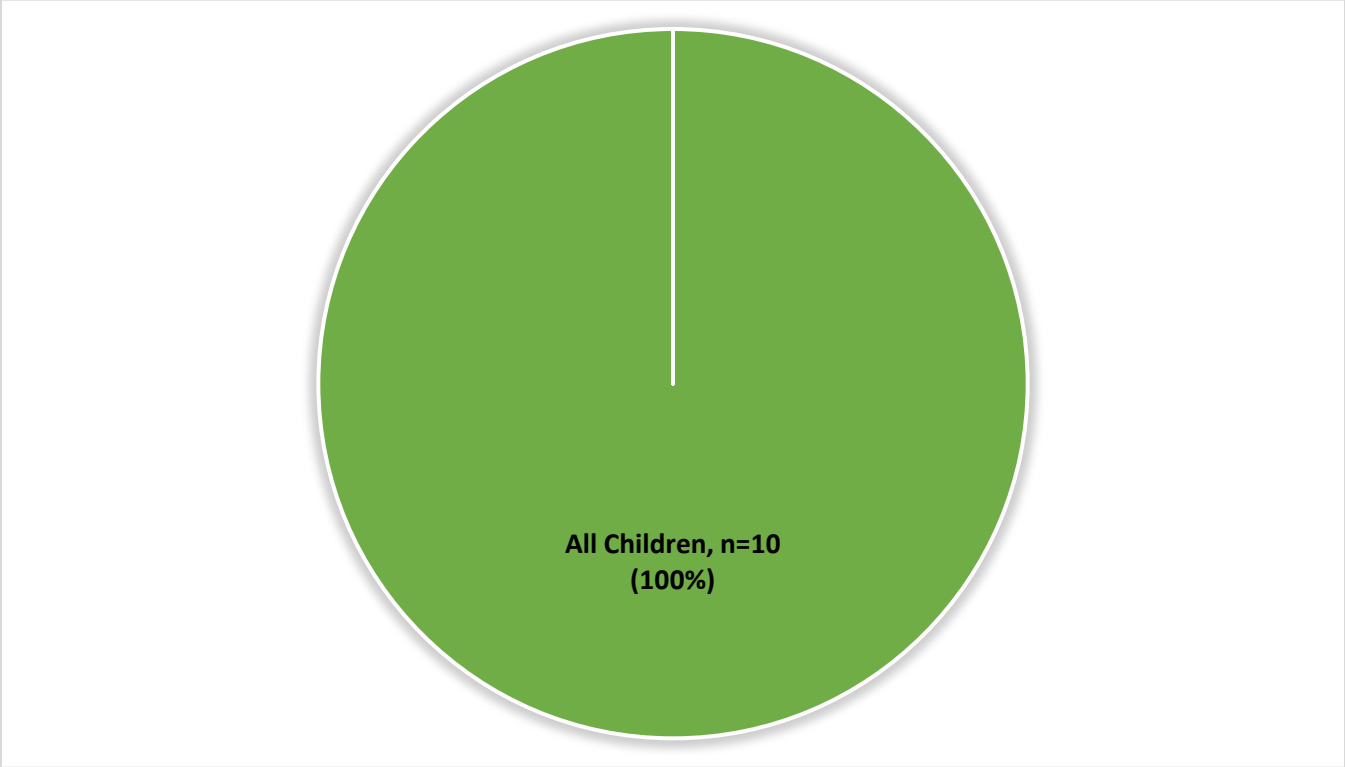


Table 200 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs

Response	MCO Names	Count	Percentage
All children	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	100.00%
State Totals		**10**	**100%**

b. If "Yes," do you have edits in place to monitor (multiple responses allowed):

Figure 137 - Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

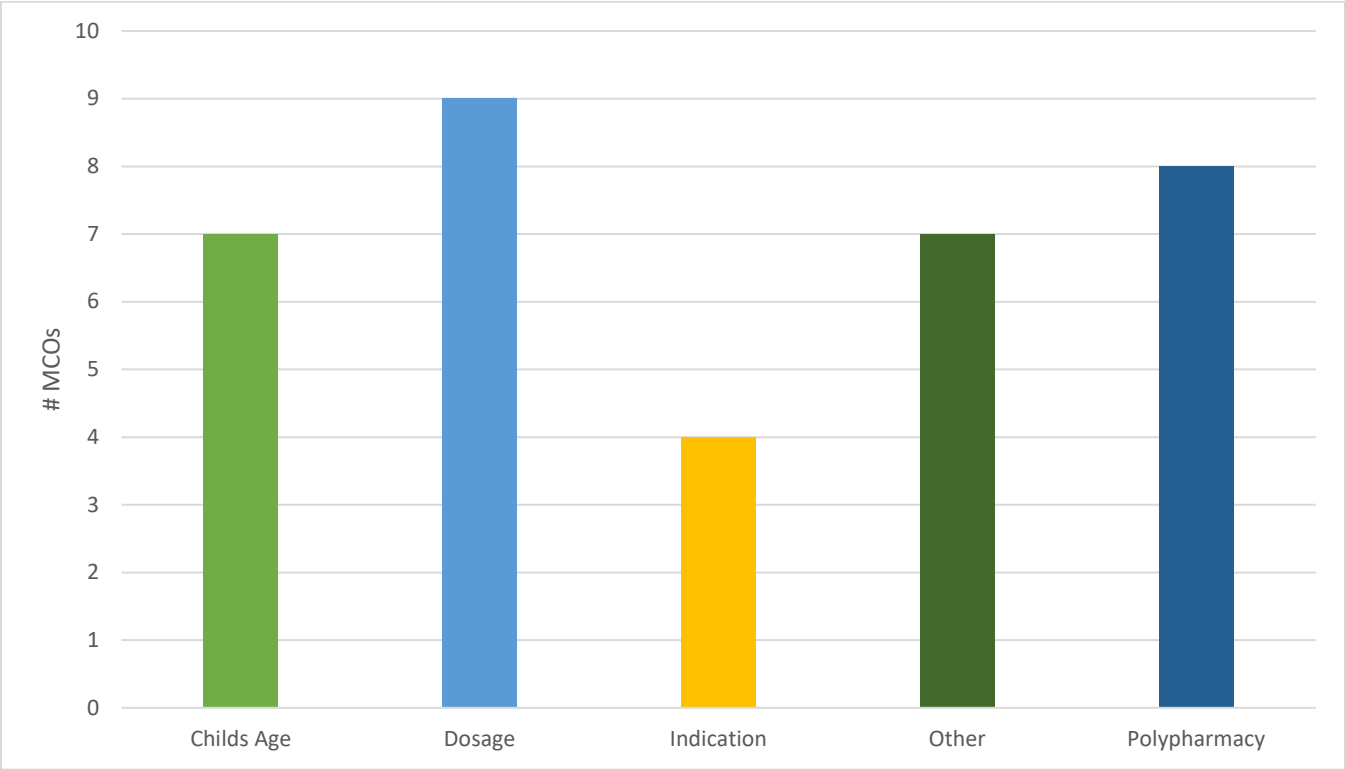


Table 201 - Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

Response	MCO Names	Count	Percentage
Childs Age	Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine	7	20.00%
Dosage	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	25.71%
Indication	Children's Medical Services, Community Care Plan, Molina Healthcare, Sunshine	4	11.43%
Polypharmacy	Aetna Better Health, Children's Medical Services, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	8	22.86%
Other	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Simply Healthcare, Sunshine, United Healthcare	7	20.00%
State Totals		**35**	**100%**

If "Child's age," please specify age limit in years.

Table 202 - Child's Age Limits for Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

MCO Name	Age Limit in Years
Children's Medical Services	18

MCO Name	Age Limit in Years
Clear Health Alliance	3
Community Care Plan	6
Humana Medical Plan	13
Molina Healthcare	17
Simply Healthcare	3
Sunshine	18

If "Other," please explain.

Table 203 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Stimulant Drugs in Children

MCO Name	Explanation
Aetna Better Health	Stimulants have a minimum age limit of 3 years. Quantity limits vary depending on child's age.
Amerihealth Caritas Florida	The plan sets minimum age limits and maximum doses based on the member's age or age range in accordance with state guidelines.
Children's Medical Services	Automated edit screening for overlapping therapy of an opioid and stimulant therapy. POS pharmacist is requested to review clinical necessity. If needed, an override is entered at POS utilizing SCC/PAMC codes for a maximum of 2 times. Beyond 2 overrides in 180 days, a manual prior authorization is required.
Clear Health Alliance	Age limits depend on products selected.
Simply Healthcare	Age limits depend upon product selected.
Sunshine	Automated edit screening for overlapping therapy of an opioid and stimulant therapy. POS pharmacist is requested to review clinical necessity. If needed, an override is entered at POS utilizing SCC/PAMC codes for a maximum of 2 times. Beyond 2 overrides in 180 days, a manual prior authorization is required.
United Healthcare	In addition to edits that monitor dosage, indication, and polypharmacy (therapeutic duplication), UnitedHealthcare Community Plan has edits in place that monitor age based on FDA labeling for each individual product and not as a specific age across all products.

c. If "Yes," please briefly explain the specifics of your documented stimulant monitoring program(s).

Table 204 - Explanations of Specifics of Documented Stimulant Monitoring Program(s)

MCO Name	Explanation
Aetna Better Health	State removed formal PA criteria for stimulant medications, but still has age limits and quantity limits in place that MCO follows. Some specific drugs also have individual auto PA edits (smart PAs). For example, there is an automated PA edit in place for Jornay PM. There is also a DUR edit in place to monitor for overlapping stimulant and benzodiazepine therapy.
Amerihealth Caritas Florida	Requests outside of the age range/maximum dose would require a medical necessity review.
Children's Medical Services	Claims are retrospectively reviewed to target member fraud, waste, and abuse of controlled substances; including Stimulants. Members with elevated risk are reviewed by clinicians for targeted prescriber letter interventions and follow-up.
Clear Health Alliance	Prospective Interventions: Point of sale pharmacy programming is in place to ensure the correct age and dosage is prescribed. Also, duplication of therapy edits are in place to identify potential polypharmacy. Retrospective Interventions: We have protocols that support a multimodal approach to ensure optimal ADHD medication management. Our protocols identify members taking ADHD medications without an approved FDA diagnosis, educate providers on the risk of cardiovascular events associated with use of

MCO Name	Explanation
	stimulants in children with a past medical history of cardiac conditions, identify members that are taking multiple stimulant or ADHD medications prescribed by multiple prescribers (polypharmacy), identify members without an initial trial of monotherapy or psychosocial counseling (i.e. behavior therapy); ADHD therapy without behavioral health follow up visits in past 1 month, 3 months or 6 months. ADHD New Start therapy provides medication education of new stimulant or ADHD medications and IVR calls to encourages follow up with the prescriber within 30 days of being prescribed new ADHD medication; Identify members less than 6 years of age taking stimulants with outreach to providers to promote evidence-based treatment with the use of stimulants or other ADHD therapies initiated in young children
Community Care Plan	CCP's PBM follows the States edits for the use of stimulants, antipsychotics and antidepressants in children. CCP's PBM has edits in place to identify appropriate age, days supply, QL, maximum dosage, therapy duplication, polypharmacy, and other safety edits. CCP clinical pharmacist outreaches to the parents of members on stimulants to ensure that the member is tolerating the medicine, to remind parents to have a follow up with provider, and to educate on side effects and answer questions.
Humana Medical Plan	Duplicate therapy
Molina Healthcare	Utilization management is in place that align with FDA label or compendium supported literature to ensure proper utilization of therapies. Management includes quantity limits, age limits and duration limits that align with FDA label or compendium supported literature.
Simply Healthcare	Prospective Interventions: Point of sale pharmacy programming is in place to ensure the correct age and dosage is prescribed. Also, duplication of therapy edits are in place to identify potential polypharmacy. Retrospective Interventions: We have protocols that support a multimodal approach to ensure optimal ADHD medication management. Our protocols identify members taking ADHD medications without an approved FDA diagnosis, educate providers on the risk of cardiovascular events associated with use of stimulants in children with a past medical history of cardiac conditions, identify members that are taking multiple stimulant or ADHD medications prescribed by multiple prescribers (polypharmacy), identify members without an initial trial of monotherapy or psychosocial counseling (i.e. behavior therapy); ADHD therapy without behavioral health follow up visits in past 1 month, 3 months or 6 months. ADHD New Start therapy provides medication education of new stimulant or ADHD medications and IVR calls to encourages follow up with the prescriber within 30 days of being prescribed new ADHD medication; Identify members less than 6 years of age taking stimulants with outreach to providers to promote evidence-based treatment with the use of stimulants or other ADHD therapies initiated in young children.
Sunshine	Claims are retrospectively reviewed to target member fraud, waste, and abuse of controlled substances; including Stimulants. Members with elevated risk are reviewed by clinicians for targeted prescriber letter interventions and follow-up.
United Healthcare	"1. Prior authorization is required when a stimulant is being utilized for an age below a set minimum or a dosage above the limits set by the state on the PDL or summary of drug limitations. 2. UnitedHealthcare Community Plan also has a therapeutic duplication soft reject edit at the point of sale on stimulants, and an FDA cumulative max dose high dose soft reject edit at the point of sale on stimulants. Both edit require the dispensing pharmacist at the

MCO Name	Explanation
	point of sale to enter an appropriate NCPDP code to override the reject and obtain a paid claim. 3. Retrospective DUR programs: OptumRx runs multiple safety management RDUR programs that include stimulant medications. These RDUR programs send faxes to prescribers within 24 hours of the identified medication related problem. Stimulants are included in our Drug-Age, Dose-Per Day, Therapeutic duplication, Drug-Drug Interaction, Drug-Disease Interaction, and Concurrent Use of multiple CNS active medications programs, and Concurrent Use of opioids with opioid potentiators (i.e. stimulants) programs."

d. If “No,” does your MCO plan on implementing a stimulant monitoring program in the future?

Figure 138 - Future Plans to Implement a Stimulant Monitoring Program

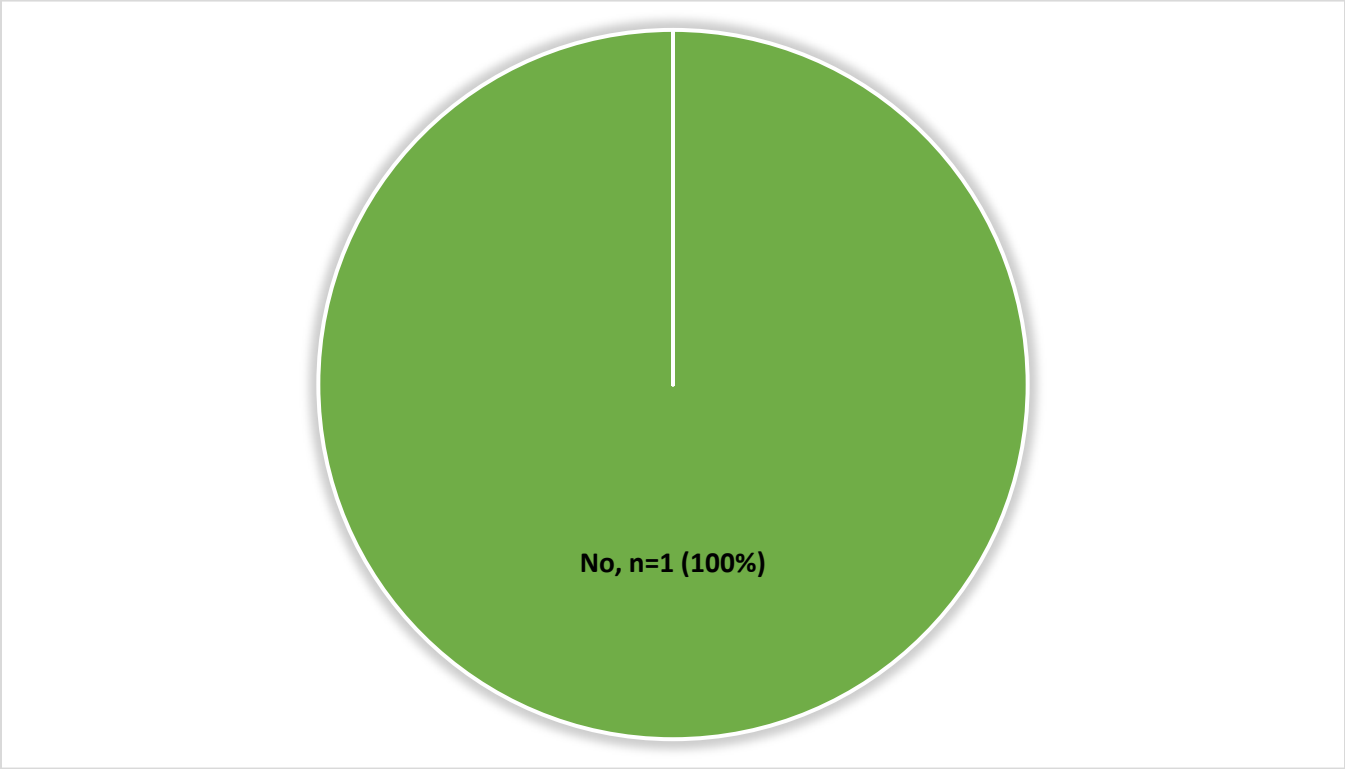


Table 205 - Future Plans to Implement a Stimulant Monitoring Program

Response	MCO Names	Count	Percentage
No	Florida Community Care	1	100.00%
State Totals		**1**	**100%**

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

Table 206 - Explanation for Not Implementing a Program to Monitor Use of Stimulant Drugs in Children

MCO Name	Explanation
Florida Community Care	As a Long Term Care plan, our population is restricted to beneficiaries age 18 and above. We have no population of children.

Antidepressants

5. Does your MCO have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children?

Figure 139 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antidepressant Drugs in Children

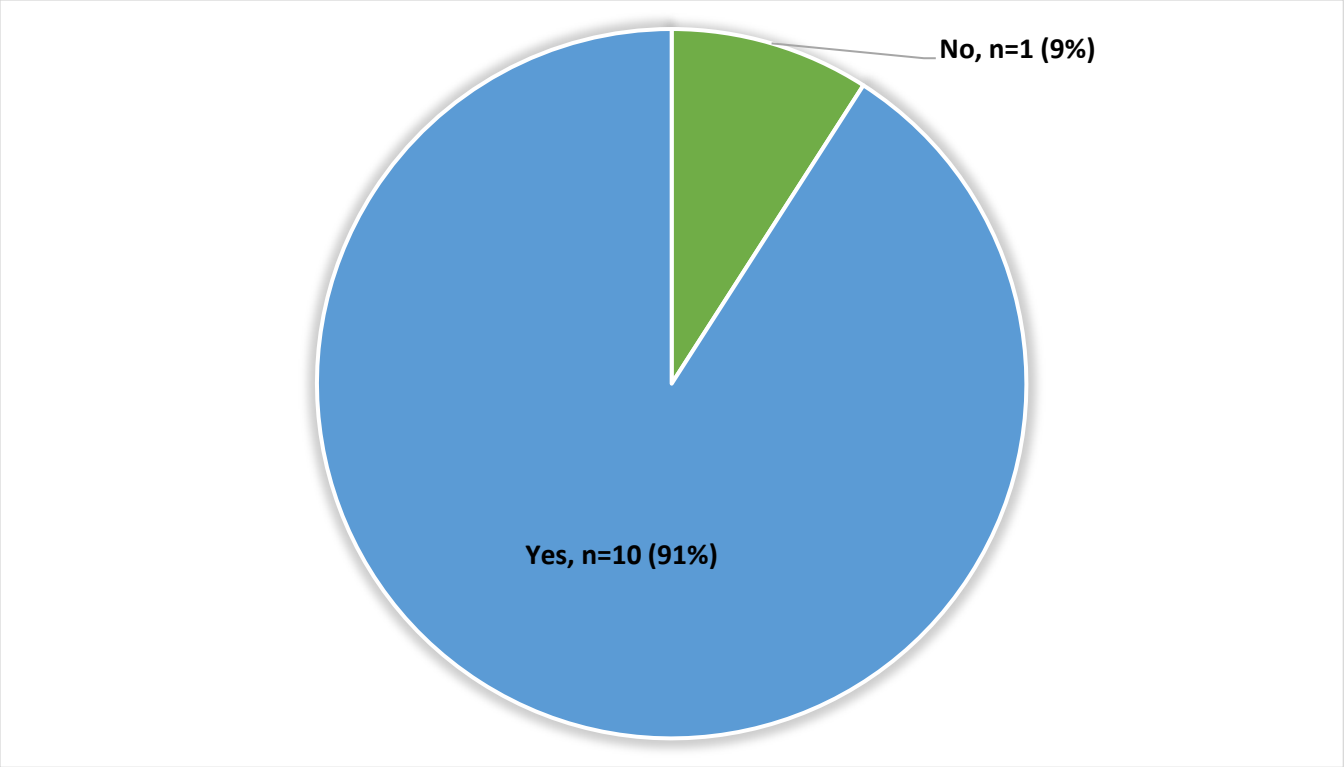


Table 207 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antidepressant Drugs in Children

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Florida Community Care	1	9.09%
State Totals		**11**	**100%**

a. If "Yes," does your MCO either manage or monitor:

Figure 140 - Categories of Children Either Managed or Monitored for Appropriate Use of Antidepressant Drugs

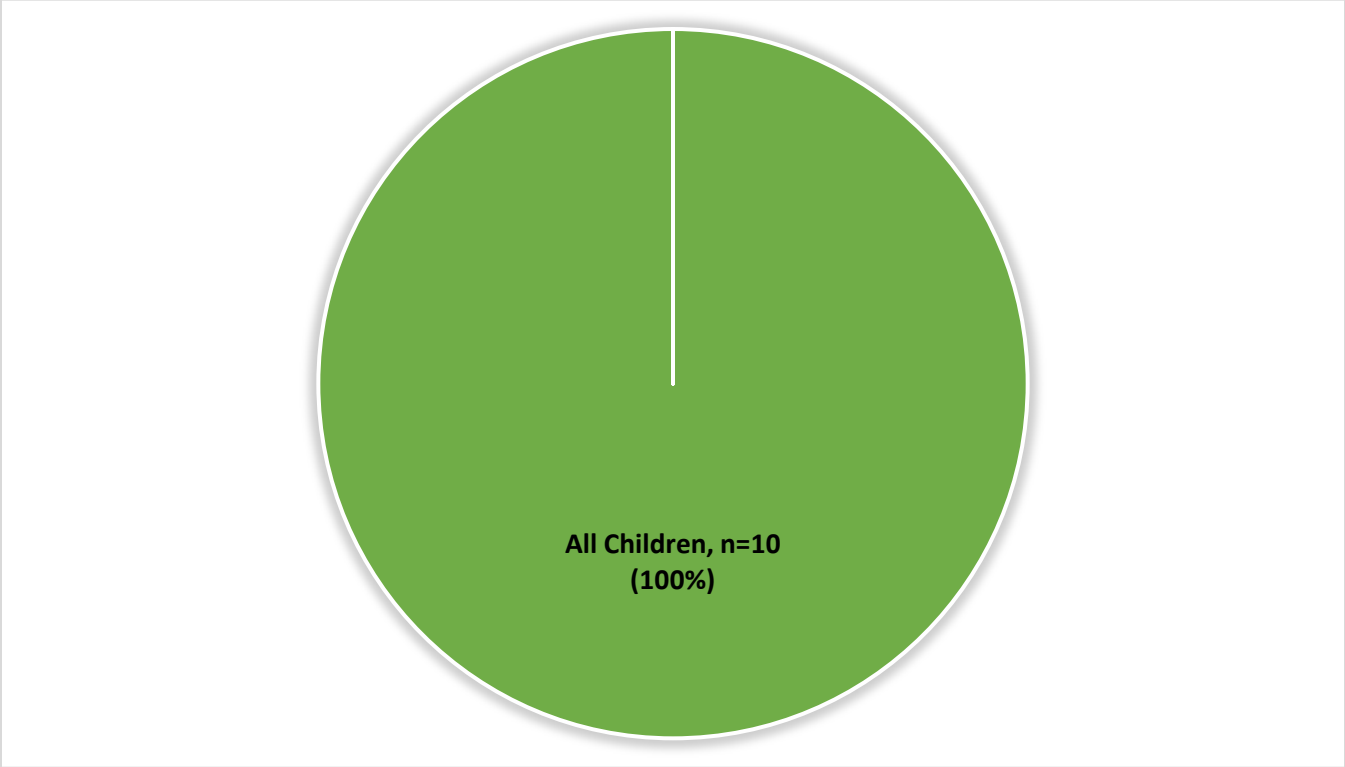


Table 208 - Categories of Children Either Managed or Monitored for Appropriate Use of Antidepressant Drugs

Response	MCO Names	Count	Percentage
All children	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	100.00%
State Totals		**10**	**100%**

b. If "Yes," does your MCO have edits in place to monitor (multiple responses allowed):

Figure 141 - Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

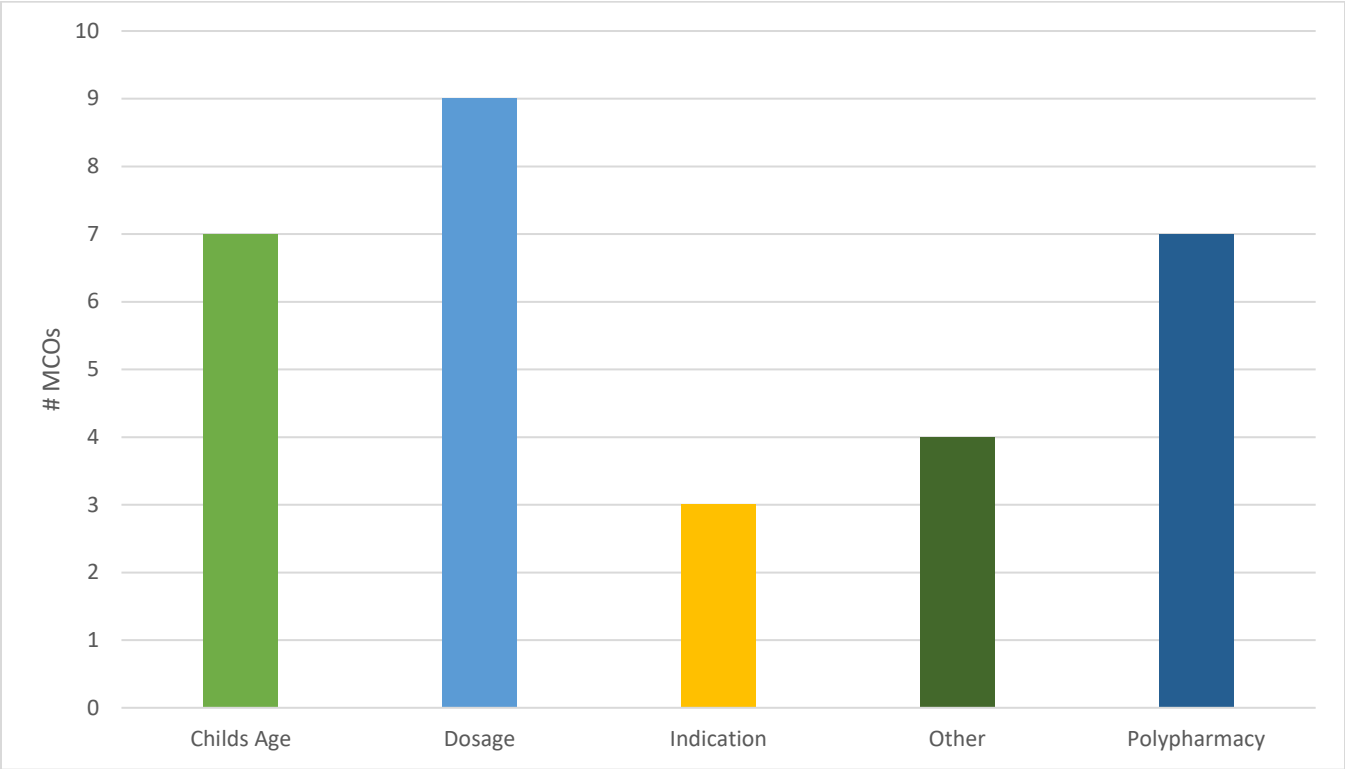


Table 209 - Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

Response	MCO Names	Count	Percentage
Childs Age	Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine	7	23.33%
Dosage	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	30.00%
Indication	Community Care Plan, Humana Medical Plan, Molina Healthcare	3	10.00%
Polypharmacy	Aetna Better Health, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, United Healthcare	7	23.33%
Other	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Simply Healthcare	4	13.33%
State Totals		**30**	**100%**

If "Child's age," please specify age limit in years.

Table 210 - Child's Age Limits for Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

MCO Name	Age Limit in Years
Children's Medical Services	18
Clear Health Alliance	6
Community Care Plan	6

MCO Name	Age Limit in Years
Humana Medical Plan	13
Molina Healthcare	17
Simply Healthcare	6
Sunshine	18

If "Other," please explain.

Table 211 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Antidepressant Drugs in Children

MCO Name	Explanation
Aetna Better Health	Age limits and quantity limits vary by medication. There is specific PA criteria for children under age 6.
Amerihealth Caritas Florida	The plan sets minimum age limits and maximum doses based on the member's age or age range in accordance with state guidelines.
Clear Health Alliance	Age and Quantity limits depend on the product selected.
Simply Healthcare	Quantity and Age limits depend on the product selected.

c. If "Yes," please briefly explain the specifics of your documented antidepressant monitoring program(s).

Table 212 - Explanations of Specifics of Documented Antidepressant Monitoring Program(s)

MCO Name	Explanation
Aetna Better Health	Current Aetna program monitors all children on SSRI/SNRI antidepressant in combination with anti-psychotic. MCO also aligns with the state age limits and quantity limits for antidepressants. There is an automated PA edit in place for step therapy with Trintellix.
Amerihealth Caritas Florida	Requests outside of the age range/maximum dose would require a medical necessity review.
Children's Medical Services	Appropriate utilization management is in place that aligns with the FDA approved label, duration limits, and age restrictions for antidepressants. MCO also ensures that that any state guidance on age and QL limits are followed and in place. Any requests outside of these limits are managed through override or PA requests
Clear Health Alliance	Our Child Age appropriateness program identifies children less than 6 years of age who are being prescribed antidepressants- we perform provider outreach to discuss the child's current antidepressant therapy, with a goal of establishing with the provider a plan to have the child discontinued off any inappropriate antidepressant therapy. Our Polypharmacy program identifies children/adolescents receiving multiple antidepressant drugs -2 or more from multiple prescribers, we also identify children/adolescents receiving multiple psychotropic medications in combination with antidepressants drugs being prescribed by multiple providers (if the child is receiving any combination of 4 or more psychotropic meds including antidepressants)we perform outreach to all prescribing providers, identify a decision maker for the member's therapy and assist in coordinating members care when uncoordinated.
Community Care Plan	CCP PBM follows the guidance of the State provided in the weekly comprehensive drug list. The PBM monitors for age limitations, dosage, QL, days supply, polypharmacy and etc. Clinical pharmacist will contact parents to discuss medications compliance, follow up appointments with prescribers, side effect monitoring, answer questions and provide medication education.
Humana Medical Plan	We apply the age, gender, and QL edits as described in the Summary of Drug Limitations directly from the state's website. We also manage these drugs through applying drugs

MCO Name	Explanation
	that are applicable to the AHCA Informed Consent table, which will give a hard rejection that requires all patients <13 and their guardians to complete the informed consent process to pay a claim. As defined by AHCA per Florida Statute F.S. 409.912(16), "antipsychotics, antidepressants, anti-anxiety, and mood stabilizers (anticonvulsants and ADHD medications not included)" must be added to the AHCA Informed Consent drug table. Powered by Humana Pharmacy Solutions' proprietary IntelligentRx solution we deploy prospective DUR edits and override alerts for all our members to prescribers and pharmacies. These are designed and implemented to assist evaluation of a members planned drug therapy before a medication is dispensed. Our edits such as drug-drug interaction, therapeutic duplication, drug-disease edits for these drug classes e.g. anticonvulsants, antipsychotics, antidepressants, benzodiazepines, barbiturates, non-benzodiazepine sedatives, provide an additional layer of patient safety by reviewing patient claims history for possible inappropriate, unnecessary or unsafe prescribing.
Molina Healthcare	Utilization management is in place that align with FDA label or compendium supported literature to ensure proper utilization of therapies. Management includes quantity limits, age limits and duration limits that align with FDA label or compendium supported literature. Specifically evaluating the utilization of mood stablilizer utilization in children less than 18 years of age, Molina reviewed claims for those members who are younger than the FDA label or compendium supported age limit. These members were referred to case management. Claims were also reviewed for utilization of multiple mood stabilizer therapies concurrently. Any member found to have 2 or more mood stabilizer claims paid within the same 30 days were referred to a clinician to evaluate the appropriateness of the prescriber specialty and review of medication history. Anything that did not align with the medical record was referred to case management.
Simply Healthcare	Our Child Age appropriateness program identifies children less than 6 years of age who are being prescribed antidepressants- we perform provider outreach to discuss the child's current antidepressant therapy, with a goal of establishing with the provider a plan to have the child discontinued off any inappropriate antidepressant therapy. Our Polypharmacy program identifies children/adolescents receiving multiple antidepressant drugs -2 or more from multiple prescribers, we also identify children/adolescents receiving multiple psychotropic medications in combination with antidepressants drugs being prescribed by multiple providers (if the child is receiving any combination of 4 or more psychotropic meds including antidepressants)we perform outreach to all prescribing providers, identify a decision maker for the member's therapy and assist in coordinating members care when uncoordinated. (ProDUR response needed)
Sunshine	Appropriate utilization management is in place that aligns with the FDA approved label, duration limits, and age restrictions for antidepressants. MCO also ensures that that any state guidance on age and QL limits are followed and in place. Any requests outside of these limits are managed through override or PA requests
United Healthcare	"1. Prior authorization is required when an antidepressant is being utilized for an age below a set minimum or a dosage above the limits set by the state on the PDL or summary of drug limitations. 2. UnitedHealthcare Community Plan also has a therapeutic duplication soft reject edit at the point of sale on antidepressants, and an FDA cumulative max dose high dose soft reject edit at the point of sale on antidepressants Both edit require the dispensing pharmacist at the point of sale to enter an appropriate NCPDP code to override the reject and obtain a paid claim.

MCO Name	Explanation
	3. Retrospective DUR programs: OptumRx runs multiple safety management RDUR programs that include antidepressant medications. These RDUR programs send faxes to prescribers within 24 hours of the identified medication related problem. Antidepressants are included in our Drug-Age, Dose-Per Day, Therapeutic duplication, Drug-Drug Interaction, Drug-Disease Interaction, and Concurrent Use of multiple CNS active medications programs. "

d. If “No” or “Covered through the FFS benefit,” does your MCO plan on implementing an antidepressant monitoring program in the future?

Figure 142 - Future Plans to Implement an Antidepressant Monitoring Program

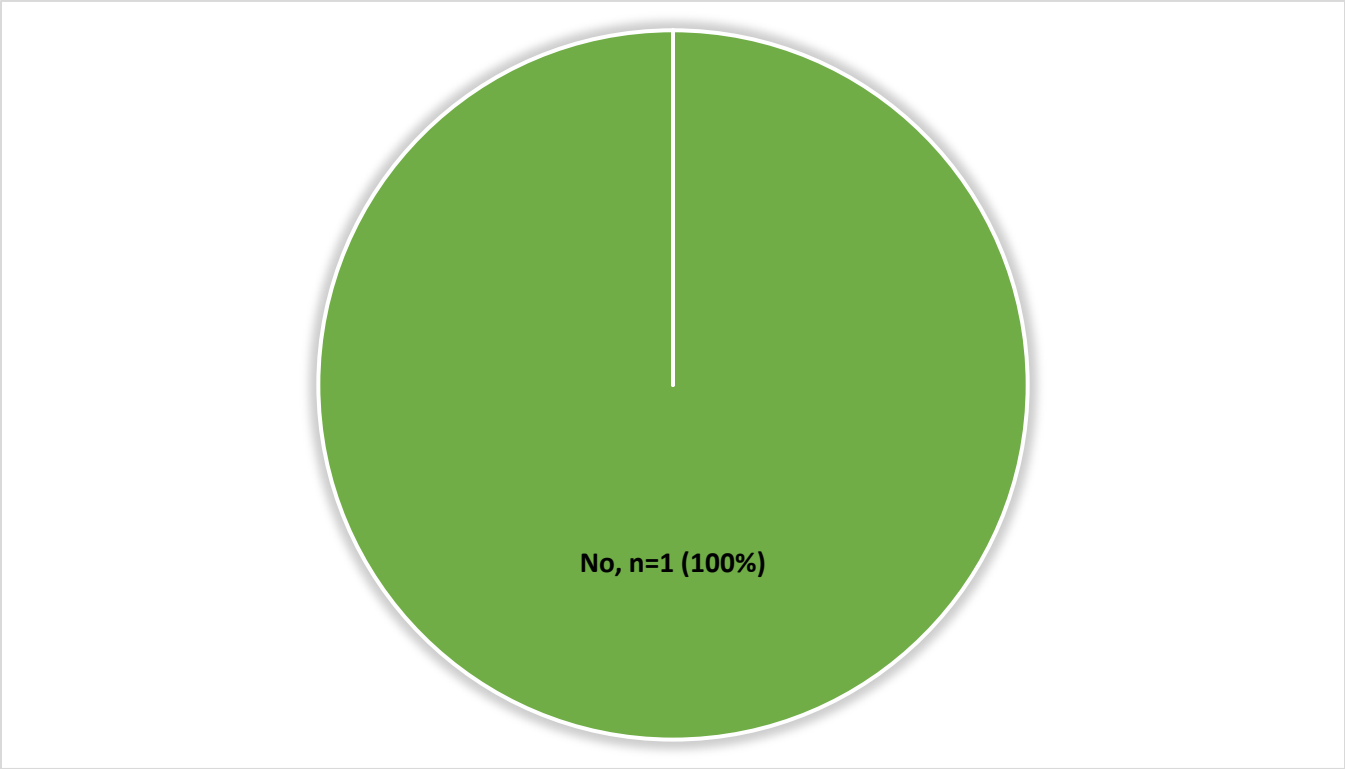


Table 213 - Future Plans to Implement an Antidepressant Monitoring Program

Response	MCO Names	Count	Percentage
No	Florida Community Care	1	100.00%
State Totals		**1**	**100%**

If “No,” please explain why you will not be implementing a program to monitor the appropriate use of antidepressant drugs in children.

Table 214 - Explanation for Not Implementing a Program to Monitor Use of Antidepressant Drugs in Children

MCO Name	Explanation
Florida Community Care	As a Long Term Care plan, our population is restricted to beneficiaries age 18 and above. We have no population of children.

Mood Stabilizers

6. Does your MCO have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children?

Figure 143 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

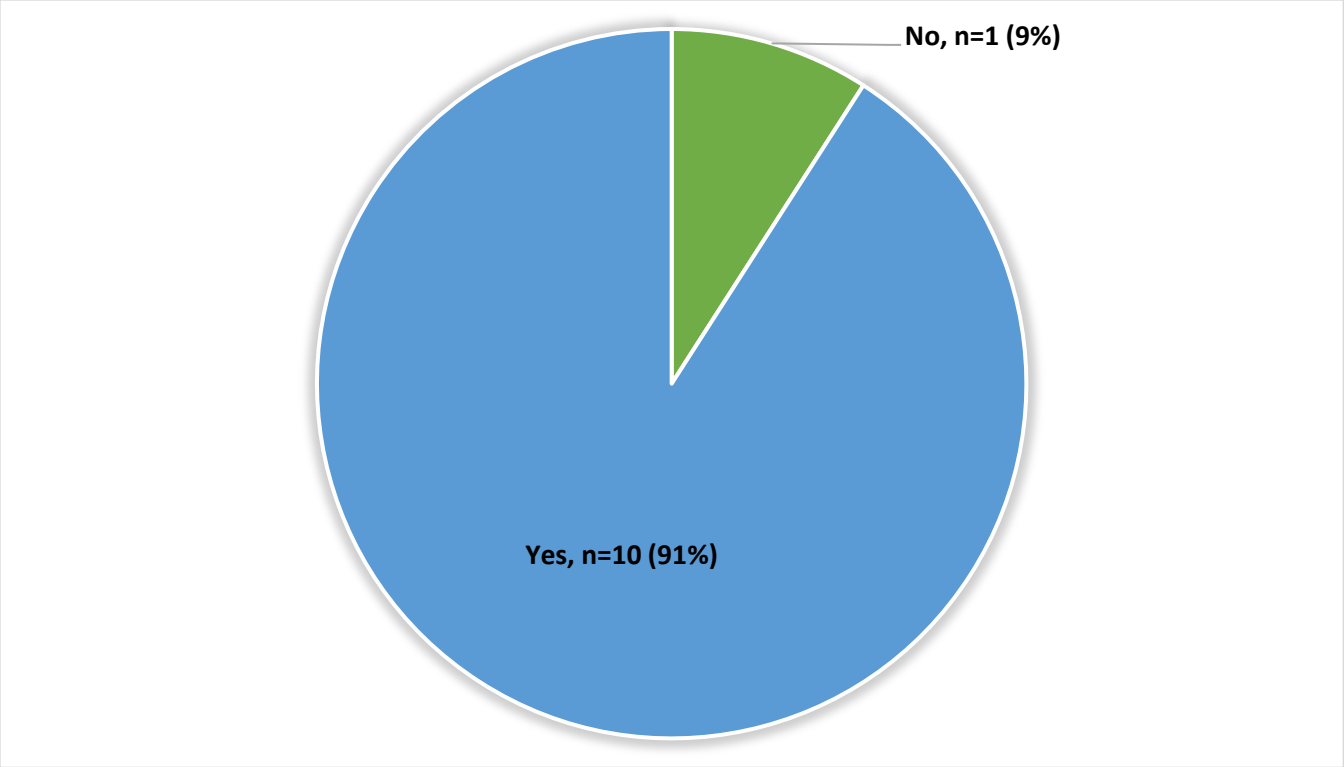


Table 215 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Florida Community Care	1	9.09%
State Totals		**11**	**100%**

a. If "Yes," does your MCO either manage or monitor:

Figure 144 - Categories of Children Either Managed or Monitored for Appropriate Use of Mood Stabilizing Drugs

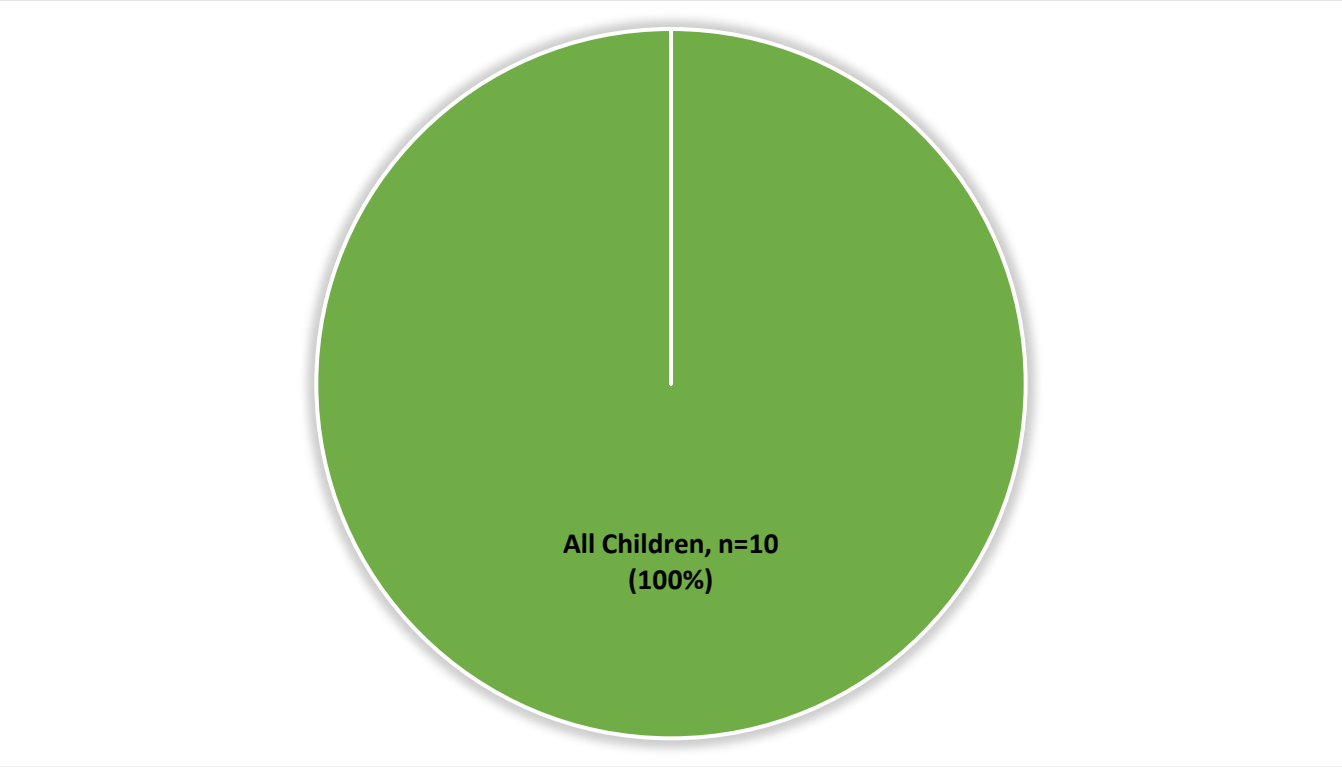


Table 216 - Categories of Children Either Managed or Monitored for Appropriate Use of Mood Stabilizing Drugs

Response	MCO Names	Count	Percentage
All children	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	100.00%
State Totals		**10**	**100%**

b. If "Yes," does your MCO have edits in place to monitor (multiple responses allowed):

Figure 145 - Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

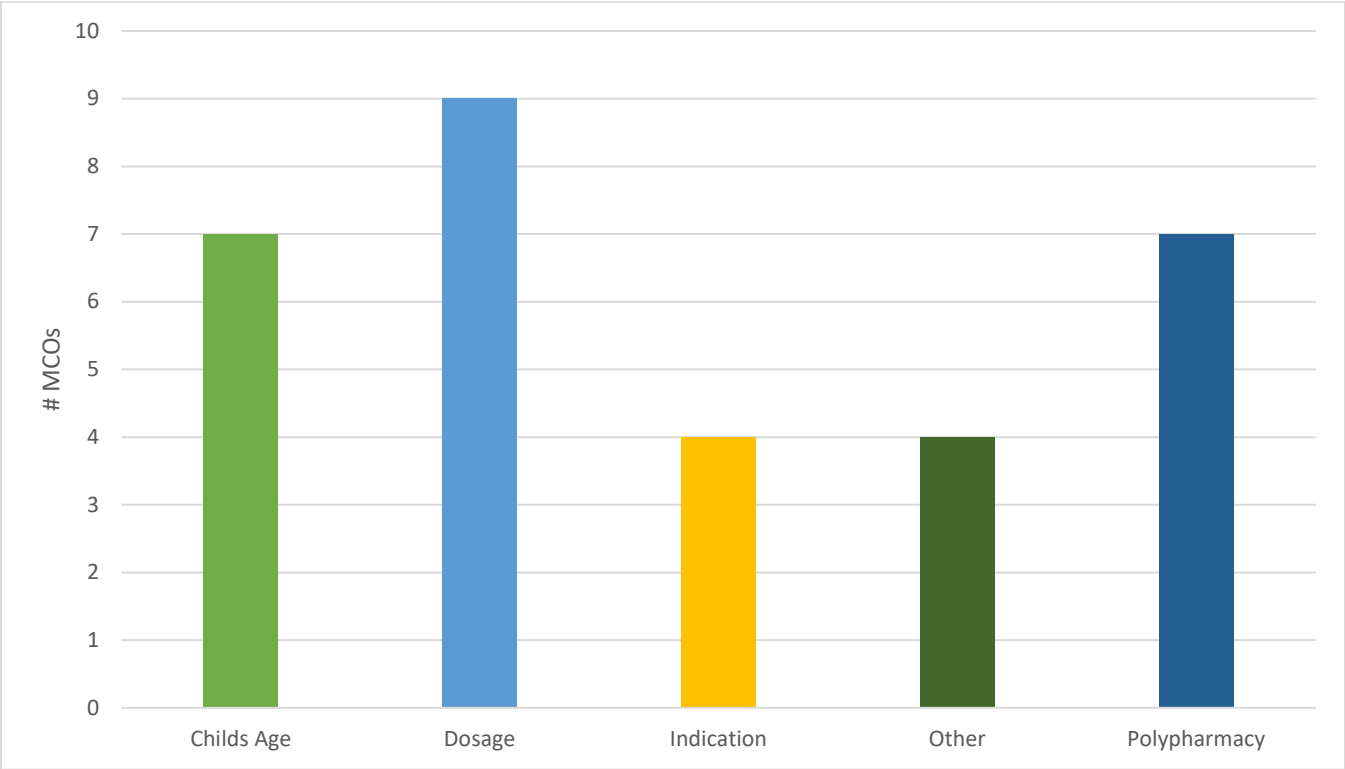


Table 217 - Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

Response	MCO Names	Count	Percentage
Childs Age	Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine	7	22.58%
Dosage	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	9	29.03%
Indication	Aetna Better Health, Community Care Plan, Humana Medical Plan, Molina Healthcare	4	12.90%
Polypharmacy	Aetna Better Health, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, United Healthcare	7	22.58%
Other	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Simply Healthcare	4	12.90%
State Totals		**31**	**100%**

If "Child's age," please specify age limit in years.

Table 218 - Child's Age Limits for Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

MCO Name	Age Limit in Years
Children's Medical Services	18
Clear Health Alliance	6
Community Care Plan	6

MCO Name	Age Limit in Years
Humana Medical Plan	13
Molina Healthcare	17
Simply Healthcare	6
Sunshine	18

If "Other," please explain.

Table 219 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Mood Stabilizing Drugs in Children

MCO Name	Explanation
Aetna Better Health	There are different PA criteria for children under age 6 and children ages 6-18. Prior Authorization requirements also include metabolic monitoring and assessment for tardive dyskinesia. Concurrent anti-psychotics are permitted for cross-tapering to change therapeutic agent.
Amerihealth Caritas Florida	The plan sets minimum age limits and/or maximum doses based on the member's age or age range in accordance with state guidelines.
Clear Health Alliance	Age and Quantity limits depend on the product selected.
Simply Healthcare	Quantity and Age limits depend on product selected.

c. If "Yes," please briefly explain the specifics of your documented mood stabilizer monitoring program(s).

Table 220 - Explanations of Specifics of Documented Mood Stabilizer Monitoring Program(s)

MCO Name	Explanation
Aetna Better Health	Quantity limits align with state PDL requirements and FDA package inserts. The FL Medicaid plan follows state PA criteria for antipsychotics. The state has separate criteria for antipsychotic use for children under age 6 and children ages 6 to under 18. The Pro-DUR program mandates that all anti-psychotics for members under age 18 require prior authorization for medical necessity. Prior authorization must be renewed every 6 months thereafter if continuation is required.
Amerihealth Caritas Florida	Requests outside of the age range/maximum dose would require a medical necessity review
Children's Medical Services	Appropriate utilization management is in place that aligns with the FDA approved label, duration limits, and age restrictions for mood stabilizers. MCO also ensures that that any state guidance on age and QL limits are followed and in place. Any requests outside of these limits are managed through override or PA requests
Clear Health Alliance	Our Polypharmacy program identifies children receiving multiple psychotropic medications in combination with mood stabilizer meds drugs being prescribed by multiple providers (if the child is receiving any combination of 4 or more psychotropic meds including mood stabilizer meds)we perform outreach to all prescribing providers, identify a decision maker for the member's therapy and assist in coordinating members care when found uncoordinated.
Community Care Plan	CCP PBM follows the guidance of the State provided in the weekly comprehensive drug list. Ages may vary based on the product prescribed.
Humana Medical Plan	We apply the age, gender, and QL edits as described in the Summary of Drug Limitations directly from the state's website. We also manage these drugs through applying drugs that are applicable to the AHCA Informed Consent table, which will give a hard rejection that requires all patients <13 and their guardians to complete the informed consent process to pay a claim. As defined by AHCA per Florida Statute F.S. 409.912(16), "antipsychotics, antidepressants, anti-anxiety, and mood stabilizers (anticonvulsants and

MCO Name	Explanation
	ADHD medications not included)" must be added to the AHCA Informed Consent drug table. Powered by Humana Pharmacy Solutions' proprietary IntelligentRx solution we deploy prospective DUR edits and override alerts for all our members to prescribers and pharmacies. These are designed and implemented to assist evaluation of a members planned drug therapy before a medication is dispensed. Our edits such as drug-drug interaction, therapeutic duplication, drug-disease edits for these drug classes e.g. anticonvulsants, antipsychotics, antidepressants, benzodiazepines, barbiturates, non-benzodiazepine sedatives, provide an additional layer of patient safety by reviewing patient claims history for possible inappropriate, unnecessary or unsafe prescribing.
Molina Healthcare	Utilization management is in place that align with FDA label or compendium supported literature to ensure proper utilization of therapies. Management includes quantity limits, age limits and duration limits that align with FDA label or compendium supported literature. Specifically evaluating the utilization of mood stablilizer utilization in children less than 18 years of age, Molina reviewed claims for those members who are younger than the FDA label or compendium supported age limit. These members were referred to case management. Claims were also reviewed for utilization of multiple mood stabilizer therapies concurrently. Any member found to have 2 or more mood stabilizer claims paid within the same 30 days were referred to a clinician to evaluate the appropriateness of the prescriber specialty and review of medication history. Anything that did not align with the medical record was referred to case management.
Simply Healthcare	Our Polypharmacy program identifies children receiving multiple psychotropic medications in combination with mood stabilizer meds drugs being prescribed by multiple providers (if the child is receiving any combination of 4 or more psychotropic meds including mood stabilizer meds)we perform outreach to all prescribing providers, identify a decision maker for the member's therapy and assist in coordinating members care when found uncoordinated (ProDur response needed)
Sunshine	Appropriate utilization management is in place that aligns with the FDA approved label, duration limits, and age restrictions for mood stabilizers. MCO also ensures that that any state guidance on age and QL limits are followed and in place. Any requests outside of these limits are managed through override or PA requests
United Healthcare	"1. Prior authorization is required when a mood stabilizer is being utilized for an age below a set minimum or a dosage above the limits set by the state on the PDL or summary of drug limitations. 2. Retrospective DUR programs: OptumRx runs multiple safety management RDUR programs that include mood stabilizer medications. These RDUR programs send faxes to prescribers within 24 hours of the identified medication related problem. Mood stabilizers are included in our Drug-Age, Dose-Per Day, Therapeutic Duplication, Drug-Drug Interaction, Drug-Disease Interaction, and Concurrent Use of multiple CNS active medications programs."

d. If "No" or "Covered through the FFS benefit," does your MCO plan on implementing a mood stabilizer monitoring program in the future?

Figure 146 - Future Plans to Implement a Mood Stabilizer Monitoring Program

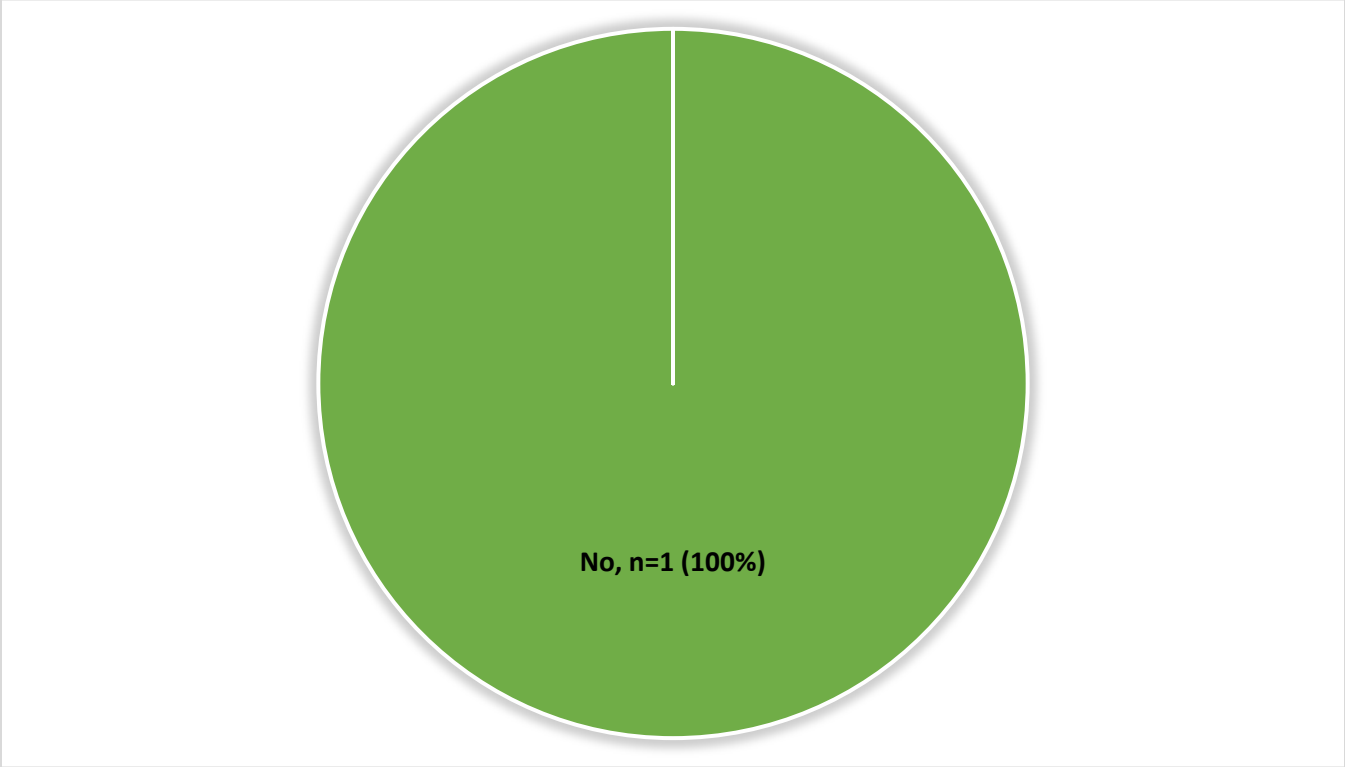


Table 221 - Future Plans to Implement a Mood Stabilizer Monitoring Program

Response	MCO Names	Count	Percentage
No	Florida Community Care	1	100.00%
State Totals		**1**	**100%**

If "No," please explain why you will not be implementing a program to monitor the appropriate use of mood stabilizing drugs in children.

Table 222 - Explanation for Not Implementing a Program to Monitor Use of Mood Stabilizing Drugs in Children

MCO Name	Explanation
Florida Community Care	As a Long Term Care plan, our population is restricted to beneficiaries age 18 and above. We have no population of children.

Antianxiety/Sedatives

7. Does your MCO have a documented program in place to either manage or monitor the appropriate use of antianxiety/sedative drugs in children?

Figure 147 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

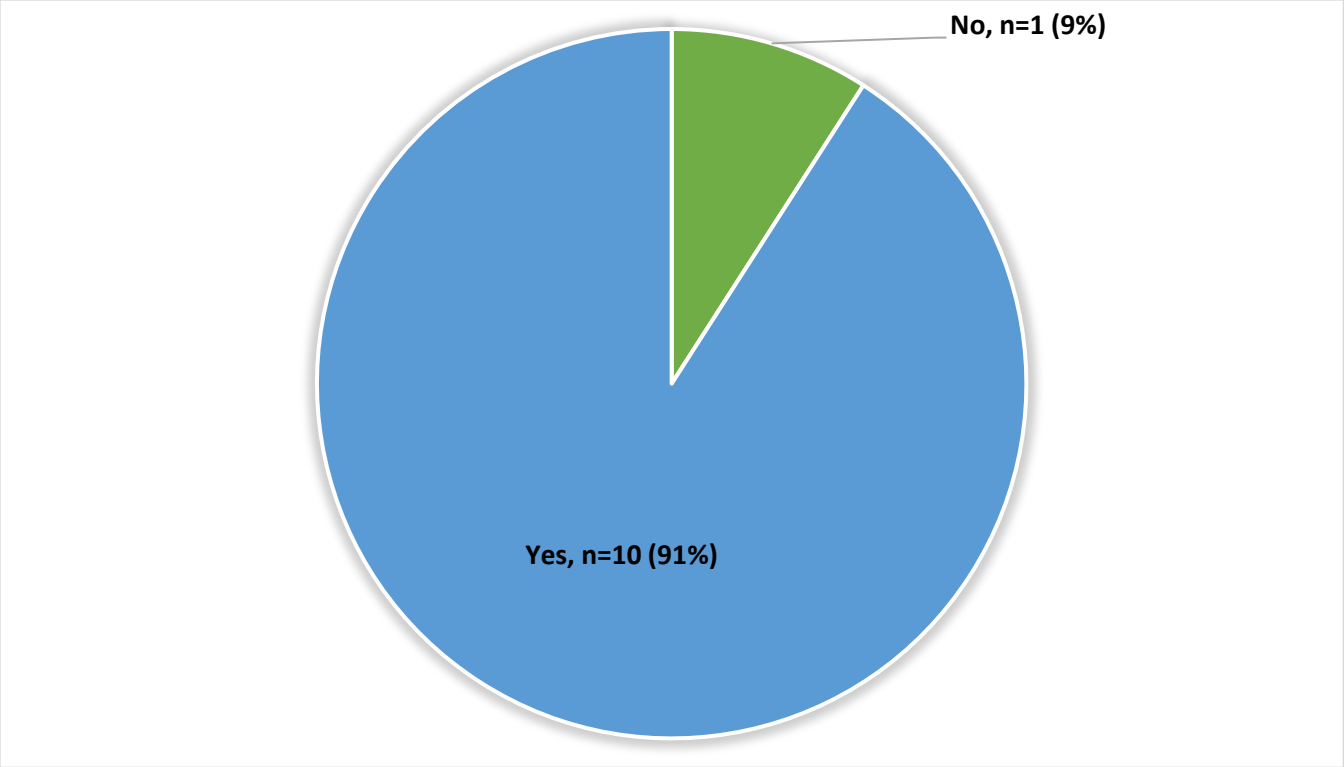


Table 223 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

Response	MCO Names	Count	Percentage
Yes	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	90.91%
No	Florida Community Care	1	9.09%
State Totals		**11**	**100%**

a. If "Yes," does your MCO either manage or monitor:

Figure 148 - Categories of Children Either Managed or Monitored for Appropriate Use of Antianxiety/Sedative Drugs

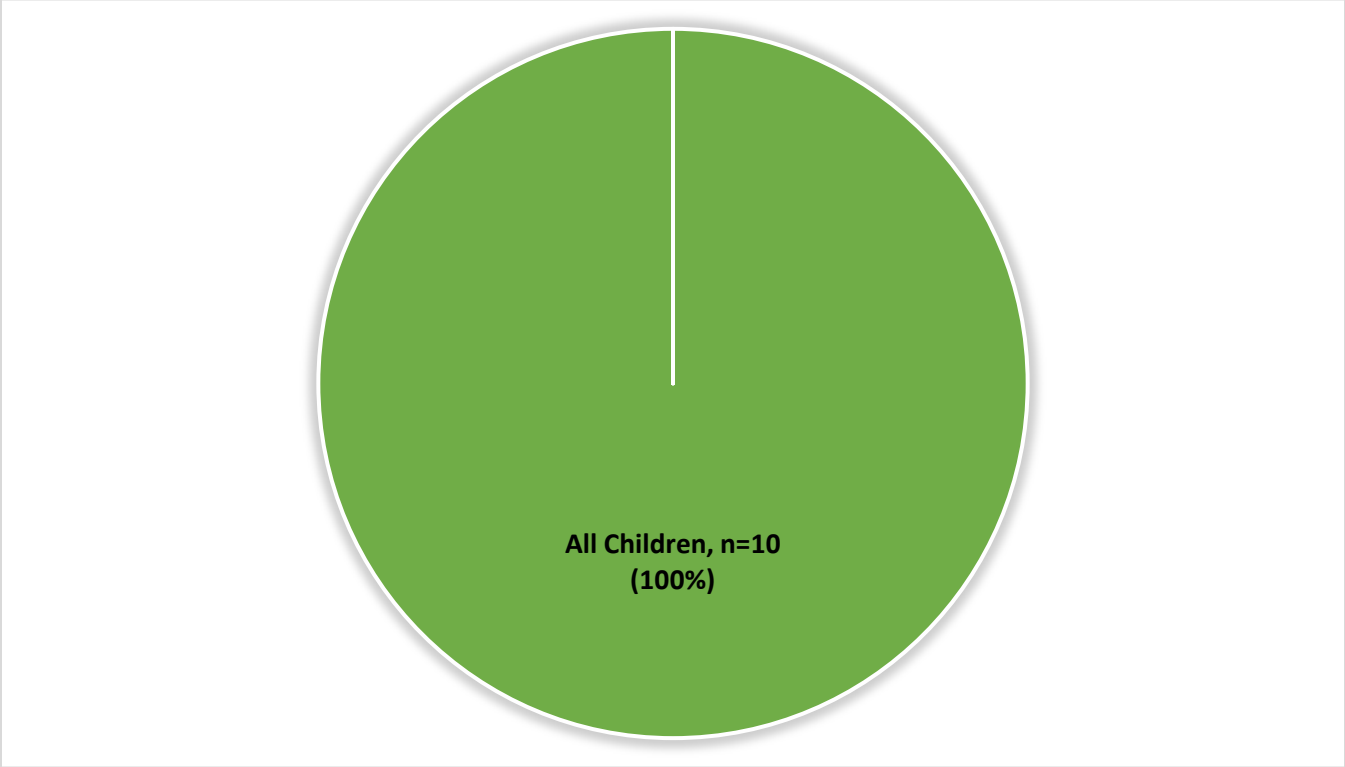


Table 224 - Categories of Children Either Managed or Monitored for Appropriate Use of Antianxiety/Sedative Drugs

Response	MCO Names	Count	Percentage
All children	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	10	100.00%
State Totals		**10**	**100%**

b. If "Yes," does your MCO have edits in place to monitor (multiple responses allowed):

Figure 149 - Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

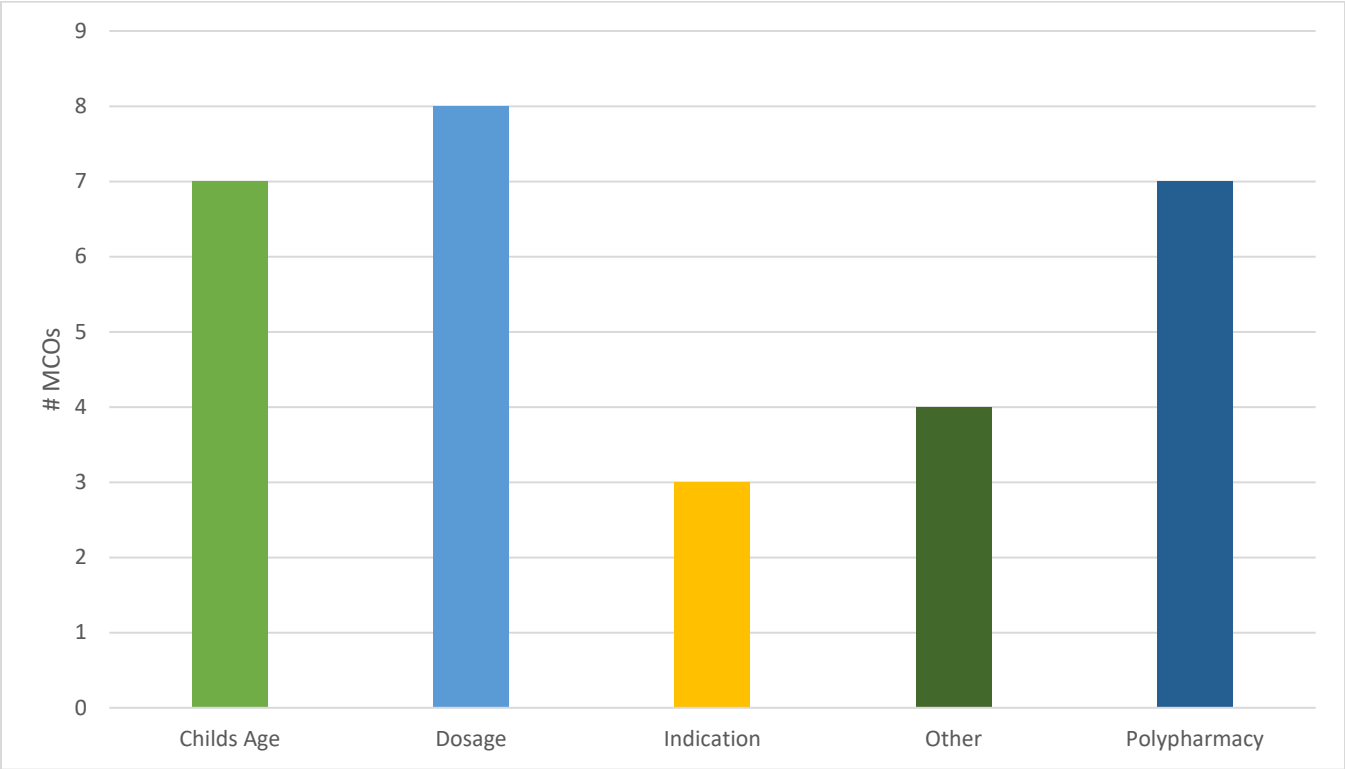


Table 225 - Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

Response	MCO Names	Count	Percentage
Childs Age	Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine	7	24.14%
Dosage	Aetna Better Health, Children's Medical Services, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Sunshine, United Healthcare	8	27.59%
Indication	Community Care Plan, Humana Medical Plan, Molina Healthcare	3	10.34%
Polypharmacy	Aetna Better Health, Clear Health Alliance, Community Care Plan, Humana Medical Plan, Molina Healthcare, Simply Healthcare, United Healthcare	7	24.14%
Other	Aetna Better Health, Amerihealth Caritas Florida, Clear Health Alliance, Simply Healthcare	4	13.79%
State Totals		**29**	**100%**

If "Child's age," please specify age limit in years.

Table 226 - Child's Age Limits for Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

MCO Name	Age Limit in Years
Children's Medical Services	18
Clear Health Alliance	6
Community Care Plan	6
Humana Medical Plan	13

MCO Name	Age Limit in Years
Molina Healthcare	17
Simply Healthcare	18
Sunshine	18

If "Other," please explain.

Table 227 - "Other" Explanations for Edits in Place to Monitor the Appropriate Use of Antianxiety/Sedative Drugs in Children

MCO Name	Explanation
Aetna Better Health	Age limits and quantity limits vary by medication.
Amerihealth Caritas Florida	The plan sets minimum age limits and/or quantity limits in accordance with state guidelines.
Clear Health Alliance	Quantity and Age limits depend on the product selected.
Simply Healthcare	Age limits depend on the product selected.

c. If "Yes," please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).

Table 228 - Explanations of Specifics of Documented Antianxiety/Sedative Monitoring Program(s)

MCO Name	Explanation
Aetna Better Health	MCO aligns with the state age limits and quantity limits for antianxiety/sedative drugs in children. There are also automated PA edits in place to monitor for overlapping use of these products. There is an overlapping stimulant/benzodiazepine DUR edit and a benzodiazepine/long-acting opioid DUR edit in place for all members including children.
Amerihealth Caritas Florida	Requests outside of the age range and/or quantity limit would require a medical necessity review.
Children's Medical Services	Appropriate utilization management is in place that aligns with the FDA approved label, duration limits, and age restrictions for antianxiety/sedatives. MCO also ensures that that any state guidance on age and QL limits are followed and in place. Any requests outside of these limits are managed through override or PA requests.
Clear Health Alliance	Our Polypharmacy program identifies children/adolescents receiving multiple antianxiety/sedative drugs 2 or more from multiple prescribers, we also identify children receiving multiple psychotropic medications in combination with antianxiety/sedative drugs being prescribed by multiple providers (if the child is receiving any combination of 4 or more psychotropic meds including antianxiety/sedative meds)we perform outreach to all prescribing providers, identify a decision maker for the member's therapy and assist in coordinating members care when found uncoordinated.
Community Care Plan	CCP PBM follows the guidance of the State provided in the weekly comprehensive drug list. The PBM monitors for age limitations, dosage, QL, days supply, polypharmacy and etc. Age may vary based on the product.
Humana Medical Plan	We apply the age, gender, and QL edits as described in the Summary of Drug Limitations directly from the state's website. We also manage these drugs through applying drugs that are applicable to the AHCA Informed Consent table, which will give a hard rejection that requires all patients <13 and their guardians to complete the informed consent process to pay a claim. As defined by AHCA per Florida Statute F.S. 409.912(16), "antipsychotics, antidepressants, anti-anxiety, and mood stabilizers (anticonvulsants and ADHD medications not included)" must be added to the AHCA Informed Consent drug table. Powered by Humana Pharmacy Solutions' proprietary IntelligentRx solution we deploy prospective DUR edits and override alerts for all our members to prescribers and pharmacies. These are designed and implemented to assist evaluation of a members

MCO Name	Explanation
	planned drug therapy before a medication is dispensed. Our edits such as drug-drug interaction, therapeutic duplication, drug-disease edits for these drug classes e.g. anticonvulsants, antipsychotics, antidepressants, benzodiazepines, barbiturates, non-benzodiazepine sedatives, provide an additional layer of patient safety by reviewing patient claims history for possible inappropriate, unnecessary or unsafe prescribing.
Molina Healthcare	Utilization management is in place that align with FDA label or compendium supported literature to ensure proper utilization of therapies. Management includes quantity limits, age limits and duration limits that align with FDA label or compendium supported literature.
Simply Healthcare	Our Polypharmacy program identifies children/adolescents receiving multiple antianxiety/sedative drugs 2 or more from multiple prescribers, we also identify children receiving multiple psychotropic medications in combination with antianxiety/sedative drugs being prescribed by multiple providers (if the child is receiving any combination of 4 or more psychotropic meds including antianxiety/sedative meds)we perform outreach to all prescribing providers, identify a decision maker for the member's therapy and assist in coordinating members care when found uncoordinated. (ProDUR response needed)
Sunshine	Appropriate utilization management is in place that aligns with the FDA approved label, duration limits, and age restrictions for mood stabilizers. MCO also ensures that that any state guidance on age and QL limits are followed and in place. Any requests outside of these limits are managed through override or PA requests
United Healthcare	"1. Prior authorization is required when an antianxiety or sedative medication is being utilized for an age below set minimums or a dosage above the limits set by the state on the PDL or summary of drug limitations. 2. UnitedHealthcare Community Plan also has a therapeutic duplication soft reject edit at the point of sale on antianxiety/sedatives, and an FDA cumulative max dose high dose soft reject edit at the point of sale on antianxiety/sedatives. Both edits require the dispensing pharmacist at the point of sale to enter an appropriate NCPDP code to override the reject and obtain a paid claim. 3. Retrospective DUR programs: OptumRx runs multiple safety management RDUR programs that include antianxiety/sedative medications. These RDUR programs send faxes to prescribers within 24 hours of the identified medication related problem. Antidepressants are included in our Drug-Age, Dose-Per Day, Therapeutic duplication, Drug-Drug Interaction, Drug-Disease Interaction, and Concurrent Use of multiple CNS active medications programs, Concurrent Use of opioids with benzodiazepines, and Concurrent Use of opioids with opioid"

d. If "No" or "Covered through the FFS benefit," does your MCO plan on implementing an antianxiety/sedative monitoring program in the future?

Figure 150 - Future Plans to Implement an Antianxiety/Sedative Monitoring Program

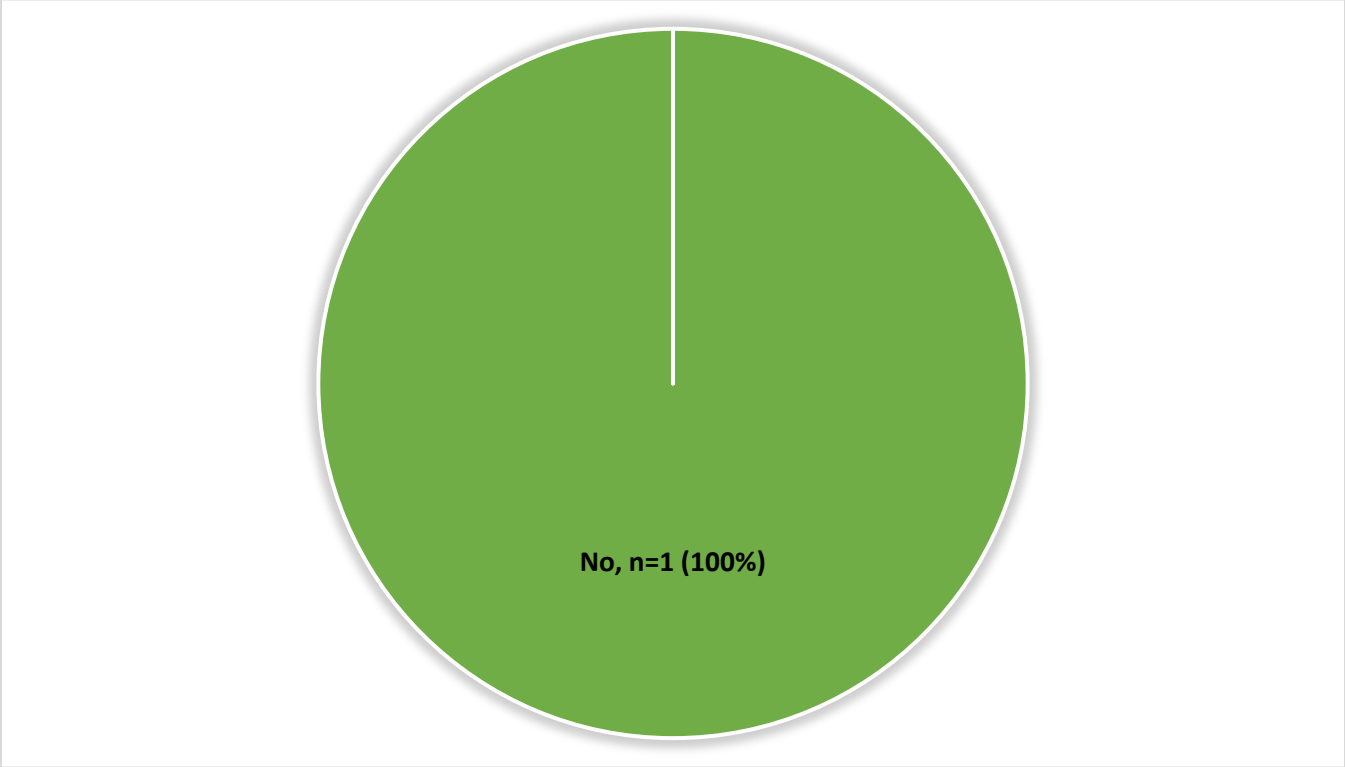


Table 229 - Future Plans to Implement an Antianxiety/Sedative Monitoring Program

Response	MCO Names	Count	Percentage
No	Florida Community Care	1	100.00%
State Totals		**1**	**100%**

If "No," please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.

Table 230 - Explanation for Not Implementing a Program to Monitor Use of Antianxiety/Sedative Drugs in Children

MCO Name	Explanation
Florida Community Care	As a Long Term Care plan, our population is restricted to beneficiaries age 18 and above. We have no population of children.

Section VIII - Innovative Practices

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

Figure 151 - Demonstrations or Waivers to Allow Importation of Certain Drugs from Canada or Other Countries that are Versions of FDA-Approved Drugs for Dispensing to Medicaid Beneficiaries

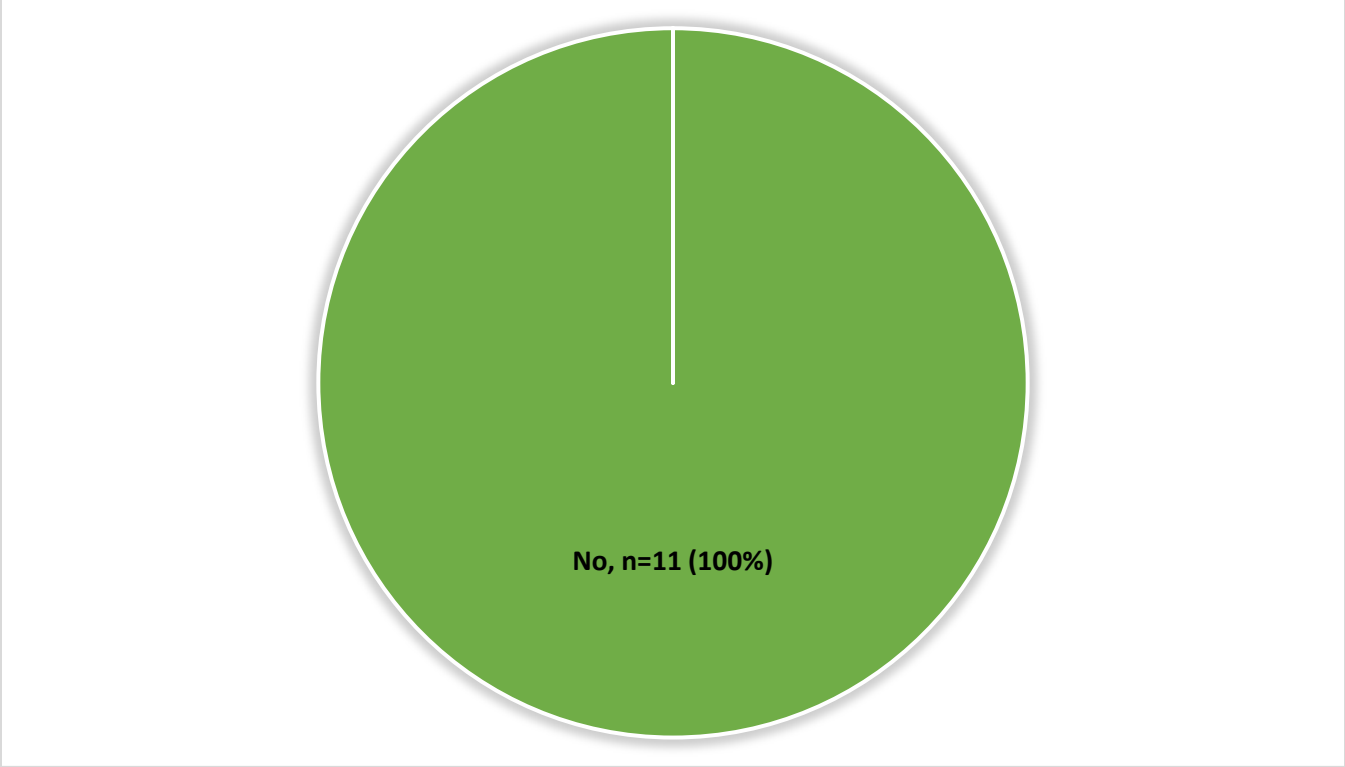


Table 231 - Demonstrations or Waivers to Allow Importation of Certain Drugs from Canada or Other Countries that are Versions of FDA-Approved Drugs for Dispensing to Medicaid Beneficiaries

Response	MCO Names	Count	Percentage
No	Aetna Better Health, Amerihealth Caritas Florida, Children's Medical Services, Clear Health Alliance, Community Care Plan, Florida Community Care, Humana Medical Plan, Molina Healthcare, Simply Healthcare, Sunshine, United Healthcare	11	100.00%
State Totals		**11**	**100%**

2. Summary 4 - Innovative Practices

Innovative Practices Summary should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MMEs, and Value Based Purchasing).

Table 232 - Innovative Practices

MCO Name	Innovative Practices Summary
Aetna Better Health	In accordance with the FL state DUR Board, several state-specific DUR edits were implemented as auto PA edits at the point of sale during the DUR survey timeframe.

MCO Name	Innovative Practices Summary
	Educational Outreach Programs (EOPs) these programs focus on identifying and correcting suboptimal prescribing patterns through educational interventions. These may include letters/faxes to prescribers or pharmacies about certain prescribing patterns of concern and providing information on possible actions. EOPs deployed during time frame included the following topics: valproic acid and fetal health, benzodiazepines + opioids, antipsychotics and antidepressants in children, diabetes duplicate therapy, COPD ICS monotherapy, COPD duplicate therapy, hospital readmission reduction program, case manager referral program, Montelukast black box warning, and readmission avoidance program. Safety and Monitoring Solutions: FWA program that monitors for high cost and utilization of controlled substances by members. Member profiles are reviewed by CVS clinicians and letters are sent to prescribers based on the number of opioid claims, combinations of buprenorphine and opioids or benzodiazepines and opioids, and the geographic distribution of pharmacies and prescribers. Reports sent to plan monthly: Safety and Monitoring Solutions Outcomes (financial), Safety and Monitoring Solutions Detail (includes member information) Retrospective Safety Review: Claims evaluated by CVS clinical pharmacist within 72 hours after adjudication for issues not addressed at point of sale, such as drug-drug interactions. The patient's profile is faxed to the prescriber with a request for a response. In severe cases, the pharmacist calls the pharmacy and prescriber. Reports sent to plan quarterly: Retrospective Safety Review Activity, Retrospective Safety Review Outcomes (financial), Retrospective Safety Review Activity Detail (member information) Clinical Pharmacy Advisor Support identifying gaps in care (all plans): Faxes are sent to prescribers when a gap in the drug regimen is identified, such as patients with diabetes who do not have a statin or whose antihypertensive is not an ACE or ARB, patients receiving a SABA but no inhaled corticosteroid, or patients receiving methotrexate without folic acid. Reports sent to plan: Closing Gaps in Medication Therapy Outcomes Report (financial sent quarterly), Closing Gaps in Medication Therapy Activity Report (monthly), Closing Gaps in Medication Therapy Activity Detail Report (monthly) The pharmacy lock-in program was updated and reimplemented at the FL plan in March 2021. Each month, members are reviewed to determine if they meet state-defined criteria that is designed to identify those at risk of abusing or misusing controlled substances. Members are reviewed by a multidisciplinary team comprised of a pharmacist, behavioral health liaison, medical directors, nurses, and case management staff. A decision is made on whether to lock in a member to a specific pharmacy or to simply monitor the member moving forward. During this DUR survey reporting period, approximately 75 members were reviewed for lock-in eligibility at the FL plan.
Amerihealth Caritas Florida	AmeriHealth Caritas FL (ACFL) continued its drug therapy management programs with a focus on behavioral health to engage members and providers to manage the patient's health in a collaborative approach. Such measures included: Antidepressant Medication Management (AMM) Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

MCO Name	Innovative Practices Summary
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)" ACFL must follow the requirements of the preferred drug list and clinical prior authorization criteria determined by the state, including automated prior authorizations. However, ACFL provides strategic clinical feedback to the state and has provided recommendations for criteria for non-formulary medications for consideration at the state's quarterly DUR Board and P&T Committee Meetings. ACFL offers resources and an e-learning tool on the plan's website for the plan's providers related to opioid use. These resources include information regarding issues related to opioid use disorder and the CDC Guideline for Prescribing Opioids for Chronic Pain for clinicians treating adult patients for chronic pain in outpatient settings. ACFL has developed an Opioid Blueprint designed to meet the unique needs and challenges of Medicaid members who may confront a myriad of challenges including those related to social determinants of health which make opioid dependencies more difficult to overcome and require more comprehensive support.
Children's Medical Services	Children's Medical Services (CMS) is continuously looking to drive innovation to support our beneficiaries. The focus of innovation has come from various drug utilization review (DUR) projects throughout the year. DUR projects were targeted to improve quality of care for members, improve prescribing, and control costs. Over the last year, there has been intensive focus on the sickle cell membership. The goal was to identify adherence issues and any gaps precluding the member/caregiver from obtaining their prescriptions. The pharmacy team took a interdisciplinary approach including the member's care coordinator to discuss any barriers. Those barriers were then researched with the drive to resolve the members issues/concerns. Due to these efforts, a text campaign has been launched providing alerts and information about their condition, refill reminders, reminders on the importance on taking their therapy, and tips on prevention. Tracking and outcomes will be monitored over the next year for initiative success. Another ongoing initiative throughout the year for Medicaid that was implemented was regarding Morphine Milligram Equivalence (MME). Medicaid members were identified on a quarterly basis if they have prescription fills with a morphine milligram equivalent (MME) of 90mg or greater within the past 90 days. Prescriber outreach is then conducted to alert them and educate them using The Centers for Disease Control and Prevention (CDC) Guidelines for Prescribing Opioids for Chronic Pain. Further efforts have been implemented to lower the MME limit to 50 for treatment experienced members. The claim will reject at the POS, whereby the pharmacist may override the rejection if clinically appropriate. Overall, these Medicaid focused projects and initiatives have contributed to better quality care for the members of the health plan, cost savings in certain situations, and improved clinical care through internal and prescriber clinical education.
Clear Health Alliance	This year we implemented programs to improve medication safety and cost-effective care. A new retrospective rule was implemented into the Controlled Substances Utilization Monitoring (CSUM) program, a provider-facing outreach program, to support

MCO Name	Innovative Practices Summary
	the company's response to uptick in overdose deaths across the country and promote use of naloxone for patients at increased risk for overdose. The clinical rule identifies members who had an overdose and filled an opioid medication prior to the overdose to inform the provider of their members increased risk.
Community Care Plan	Community Care Plan (CCP) in an effort to meet the PDMP requirements has acquired the help of its PBM (Magellan Rx/Prime Therapeutics) to help with ensuring that pharmacies are using the PDMP when filling scheduled II, III. IV and V controlled substance. The PBM currently conducts annual audits for HSA and other areas and agreed to add an affidavit to be signed by the Pharmacy indicating that they use the PDMP process before filling opioid prescriptions. CCP has also completed a text messaging campaign for Medicaid members (all text messaging was previously approved by AHCA before initiation of the campaign) to help resolve denied medication claims issues. The text messaging campaign was successful in engaging some members and providing them with another way to communicate with the CCP for medication related issues. The campaign looked at unresolved pharmacy medication claims that persisted for greater than a week. The goal is to have this text message trigger in real time to the member after x denials are noted. This process will help CCP resolve medication related issues faster for members, improve member to CCP pharmacy communication and improve patient satisfaction. CCP initiated pharmacy access to CGM's and certain diabetic supplies in 2022. This allowed for adult members to obtain CGM's since the DME only allowed them for members under the age of 21. This change also allowed members to obtain needles and syringes in addition to lancets and test strips. Some members had to wait for shipments from DME facilities. This new process has provided a cost savings, improved convenience and has improved patient satisfaction. In addition, CCP has initiated some new automated processes for its MTM outreach with the help of the CCP Medical Economics team. This process will allow the system to identify MTM eligible members and open assessment for the pharmacist automatically and send notifications. This will save the pharmacist time in the preparation for MTM reviews. MTM outreach allows the pharmacy team to follow up on Retro DUR concerns or potentially identify new ones, provide medication education, review medication safety and identify and address areas that technology cannot like SDoH's. These are just a few on the many innovative processes that CCP has developed in 2022.
Florida Community Care	FCC draws on the expertise of case managers assigned to each member to help manage and best understand needs and appropriate care on an individual basis. This individualized care has improved the administration of the overall benefit and helps ensure appropriate care is provided while helping to control costs. In 2021, FCC initiated a medication therapy management program for qualified members, to assist in DUR administration of prescription drug use and medication adherence, as well as Retrospective Drug Utilization Review (rDUR) with a new targeted intervention program inclusive of all members utilizing the pharmacy benefit. For 2022, the rDUR program added therapeutic categories enhancing safety and monitoring of drug interaction, drug/age or drug/disease state contraindication or precaution based on industry databases or the FDA.
Humana Medical Plan	Retrospective DUR campaigns: 1. Concurrent use of opioids and gabapentinoids - provider education/outreach recommending evaluation of concurrent therapy

MCO Name	Innovative Practices Summary
	2. Asthma in children - provider education/outreach to recommend prescribing short acting beta-2 agonist in children who are chronically utilizing inhaled corticosteroids. Enhanced point of sale safety edits functionality to provide custom exclusions based on medical claims, utilizing ICD-10, CPT codes, HCPCS and pharmacy claims drugs to infer conditions
Molina Healthcare	During the course of 2022, Molina Healthcare Drug utilization review board began evaluating utilization of physician administered drugs through data mining of medical claim authorization and claim submissions. This enabled the committee to evaluate the need for utilization management reviews for medical necessity in this benefit. The Molina DUR Board evaluated the drug product parallel to the process utilized as the Molina Healthcare Pharmacy and Therapeutics Committee. Drugs were evaluated for any new clinical data, safety information, evidence-based clinical guidelines and practice trends that may impact previous drug utilization management decisions. This thorough process allowed Molina to reduce the amount of manual administrative burden for all key stakeholders. Within 2022 Molina Healthcare DUR Board was able to refine and create a high risk pool of members in order to facilitate case management referrals for therapy safety oversight. Specifically evaluating the utilization of antipsychotic utilization in children less than 18 years of age, Molina reviewed claims for those members who are younger than the FDA label or compendium supported age limit. These members were referred to case management. Claims were also reviewed for utilization of multiple antipyschotic therapies concurrently. Any member found to have 2 or more antipsychotic claims paid within the same 30 days were referred to a clinican to evaluate the appropriateness of the prescriber specialty and review of medication history. Anything that did not align with the medical record was referred to case managment. Within 2022 Molina Healthcare implemented a complex condition management program within some populations to a delegated to a vendor in order to support members with chronic rare diseases. This program educates members, supports the prescribers treatment plan and connects members with resources necessary to treat their condition. This program has shown improvement in clinical metrics specific to each condition as well as improvement in medical healthcare costs.

MCO Name	Innovative Practices Summary
Simply Healthcare	This year we implemented programs to improve medication safety and cost-effective care. A new retrospective rule was implemented into the Controlled Substances Utilization Monitoring (CSUM) program, a provider-facing outreach program, to support the company's response to uptick in overdose deaths across the country and promote use of naloxone for patients at increased risk for overdose. The clinical rule identifies members who had an overdose and filled an opioid medication prior to the overdose to inform the provider of their members increased risk. Additionally, we limited the initial dispensing of a select group of topical medications to the smallest container size for treatment nave members to alleviate medication waste and excessive costs.
Sunshine	Sunshine Health Plan is continuously looking to drive innovation to support our beneficiaries. The focus of innovation has come from various drug utilization review (DUR) projects throughout the year. DUR projects were targeted to improve quality of care for members, improve prescribing, and control costs. Over the last year, due to the increasing use of behavioral health medications, namely antipsychotics, Sunshine has become laser focused on the use and safety of these medications within our membership. The following DUR reviews were added to address the growing concerns: Antipsychotics and uncontrolled diabetes switch to antipsychotic with fewer metabolic side effects, Antipsychotics and active cardiac disease switch to antipsychotic with fewer cardiac side effects, Antipsychotic drug-drug interactions remove interacting drug or switch to safer alternative. Another ongoing initiative throughout the year for Medicaid that was implemented was regarding Morphine Milligram Equivalence (MME). Medicaid members were identified on a quarterly basis if they have prescription fills with a morphine milligram equivalent (MME) of 90mg or greater within the past 90 days. Prescriber outreach is then conducted to alert them and educate them using The Centers for Disease Control and Prevention (CDC) Guidelines for Prescribing Opioids for Chronic Pain. Further efforts have been implemented to lower the MME limit to 50 for treatment experienced members. The claim will reject at the POS, whereby the pharmacist may override the rejection if clinically appropriate. Overall, these Medicaid focused projects and initiatives have contributed to better quality care for the members of the health plan, cost savings in certain situations, and improved clinical care through internal and prescriber clinical education.
United Healthcare	Concurrent Drug Utilization Review: Improving Effectiveness of Point-of-Sale Edits UnitedHealthcare Community Plan utilizes point-of-sale soft rejects to alert pharmacists when members are receiving medications that may have medication safety issues including therapeutic duplication concerns. In order to ensure our members have access to the medications they need, the pharmacist may override the reject at the point-of-sale by entering appropriate National Council for Prescription Drug Programs (NCPDP) codes. UnitedHealthcare Community Plan continuously monitors the effectiveness of these point-of-sale edits to ensure they continue to be beneficial to our pharmacy partners in prioritizing our members' safety and care. Biannual concurrent drug utilization review effectiveness evaluations are conducted to assess the performance of all

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	UnitedHealthcare Community Plan point-of-sale edits including claims data, override rates, claims to member ratios, and pharmacy and prescriber activity. UnitedHealthcare Community Plan has therapeutic duplication soft edits implemented for antidepressants and proton pump inhibitor + H2 receptor antagonist. As part of the biannual concurrent drug utilization review effectiveness evaluation of therapeutic duplication point-of-sale edits, it was identified that the total claims and override rates for therapeutic duplication of these classes were consistently high quarter over quarter. After reviewing point-of-sale edit data more closely, it was identified that these therapeutic duplications were likely due to members weaning off and/or tapering on to a new antidepressant and members taking a PPI and H2 receptor antagonist concurrently for a short duration of time. UnitedHealthcare Community Plan has an additional point-of-sale therapeutic duplication edit option called the Overlap Service. Overlap can be utilized when a member is taking two or more medications for a specified amount of time within a specified lookback period. By transitioning antidepressant and PPI + H2 receptor antagonist therapeutic duplication edits to the Overlap service, these drugs can now be used concurrently for up to 60 days within the last 90 days before triggering the soft reject requiring an NCPDP code override at the point-of-sale thus decreasing point-of-sale abrasion and burden. The transition of therapeutic duplication of antidepressant and PPI + H2 receptor antagonist edits to the Overlap service occurred 5/16/2022. From 1Q2022 to 3Q2022, the percentage of claims hitting the therapeutic duplication of antidepressant soft edit in UnitedHealthcare Community Plan of Florida decreased by 55.9%. From 1Q2022 to 3Q2022, the percentage of claims hitting the therapeutic duplication of proton pump inhibitor + H2 receptor antagonist soft edit in UnitedHealthcare Community Plan of Florida decreased by 59.0%. The overall decrease in total claims rejecting at the point of sale for therapeutic duplication of these drug classes proves that these members are using these drugs concurrently for a short period of time, likely due to switching between agents, and point of sale burden on the pharmacies has decreased. In addition United Healthcare Community Plan implemented a Valu-Based provider program with independent pharmacies in the plan network- assisting in managing adherence with Diabetes and Hypertension- along with aiding in identifying through our pharmacies members with social determinants of health challenges, and supporting HEDIS metrics via collaboration with the MCO

Section IX - Executive Summary

1. Summary 5 - Executive Summary

Executive Summary should include a general overview and summary of program highlights from FFY 2021 as well as objectives, tools and outcomes of initiatives accomplished, and goals for FFY 2022.

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Aetna Better Health	For Aetna Better Health of FL, most of the pharmacy benefit (preferred drug list, UM edits, DUR edits, PA criteria) is dictated by the Agency for Healthcare Administration (AHCA). Formulary and DUR program changes are communicated to the health plans at the quarterly P&T and DUR quarterly committee meetings, and these meetings are run by the AHCA pharmacy team and their PBM (Magellan). In addition to the state P&T and DUR meetings, Aetna also maintains its own P&T and DUR meetings quarterly. Aetna uses various tools to ensure appropriate drug utilization and prevent over and underutilization of medications for our members. These include the three elements of the Drug Utilization Review (DUR) program as outlined by the Centers for Medicare and Medicaid Services (CMS): Retrospective (RetroDUR), Prospective (ProDUR) and Educational Outreach Program (EOP). The Aetna DUR Program functions are completed through the actions of either the Pharmacy and Therapeutics (P&T) Committee or by the DUR Board. The Aetna P&T Committee determines the formulary status of medications (for health plans that can follow the national recommendations) and any utilization controls that may be implemented to assure appropriate utilization of medications. The committee can also recommend specific educational programs regarding appropriate medication use and request specific monitoring of drug utilization. Each year, the Aetna P&T Committee reviews all drug classes for optimization and the entire formulary. During this report period that included Drugs grouped into 33 drug classes and updates to preferred products, quantity limits, age edits or POS DUR edits to 64% of those. Additionally, 169 clinical coverage guidelines were reviewed/developed to assure appropriate utilization of those drugs requiring clinical prior authorization. The goal for 2023 is to continue to adjust the formulary and its utilization management edits to provide the highest clinical value, high clinical outcome/efficacy for the lowest net cost. This includes improving persistence and adherence to chronic medications in some cases and minimizing overutilization of medications in others. Although Aetna Better Health of FL utilizes the AHCA P&T for formulary decisions, the pharmacy director still reviews the Aetna recommendations for any suggestions that can be presented to the state for review. The Aetna DUR Board oversees the development and implementation of Educational Outreach Programs (EOP). These education programs focus on correcting over/under or mis-utilization of medications through educational interventions. Interventions and educational materials are developed for providers (Prescriber and pharmacy) and members. Aetna also partners with our Pharmacy Benefit Manager (PBM) to utilize their clinical program offerings to further assure safe and effective medication utilization.

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	EOP are approved by the DUR Board and have the following characteristics: Utilizes retrospective drug views against predetermined criteria. Developed to correct a prescribing or drug utilization patterns identified as suboptimal Utilize educational outreach directed to prescribers, members and/or pharmacies to correct prescribing patterns that deviate from the predetermined parameters. Monitor and measure response to educational outreach The 2022 Goal of the Aetna DUR Board was to conduct outreach programs targeting each of four categories over-utilization, under-utilization, patient safety, and fraud/waste/abuse issue. In this instance programs in each category were developed, approved, and executed in FFY22. Each program produced a positive outcome and met its clinical objective as defined in the DUR Board approved program. Additionally, the Board oversaw the creation of 5 provider newsletter articles on a variety of topics. These were designed to update providers on key drug therapy topics such as update treatment guidelines for biosimilars and generic/interchangeable insulins, melatonin safety in children, DKA in SGLT2 users, metabolic monitoring, and COVID related matter. The 2023 Goal is two programs in each of the categories of 2022 and to incorporate specific health equity elements into at least one if not more educational campaigns.
Amerihealth Caritas Florida	AmeriHealth Caritas FL has implemented the below listed Behavioral Health HEDIS Drug Therapy Management Programs focused on optimizing medication regimens for members and improving health outcomes especially related to the appropriate use and monitoring of antipsychotic and antidepressant medications. The clinical pharmacy team performs targeted medication reviews to ensure medication adherence and appropriate medication monitoring for the following four (4) DTM programs: Antidepressant Medication Management (AMM) Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) ACFL's Program Integrity's Special Investigation Unit continues to monitor provider and member activity related to the pharmacy benefit. The team submits referrals on suspected FWA to the Agency for Health Care Administration Medicaid Program Integrity. For credible allegations of fraud, referrals are sent to the Office of Attorney General Medicaid Fraud Control Unit. Additional referrals may also be submitted to internal Quality Management Department and DEA. Members exceeding any opioid related limitations would require prior authorization and pharmacist review. This FWA program helps ACFL to ensure the maintenance of provider and member compliance. ACFL also has a member lock in program where the plan's PBM provides reporting for potential member lock in. The plan then reviews the report in conjunction with the Florida Prescription Drug Monitoring Program (PDMP) to determine those individuals to place in a 12 month lock in. ACFL continues to monitor lock in member activity for an additional 12 months post-lock in to identify any member gaps or recurrence and to ensure member compliance. During the reporting period there was no need for repeated member lock in, resulting in improve member compliance.

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	ACFL must follow state PDL and drug criteria. However, the plan has implemented a process whereas, on a quarterly basis, clinical pharmacists review claims history data to evaluate member drug utilization, physician prescribing patterns, and pharmacy dispensing patterns to detect episodes of drug-related problems, target therapeutic categories for intervention, and identify inappropriate and/or unnecessary usage patterns. The team uses the outcomes of this research as well as peer reviewed literature to bring recommendations to the state Agency FFS DUR Board for consideration and the State MCO's Quality Committee for review. For example, recommendations may include but are not limited to age and quantity limits, step therapies, or clinically appropriate and cost-effective alternative medications. As a result of these recommendations, multiple clinical criteria changes were adopted by the state DUR Board and posted to the state's website. During the reporting period. ACFL implemented system changes to the provider medication search tool that is available on the plan's website to improve the current prior authorization submission process. To facilitate member and provider awareness of COVID related resources, ACFL conducted member and provider outreach which included expanding access to vaccines at both provider offices and pharmacies as well as providing incentives for members who obtained their COVID vaccine. ACFL also posted an FAQ on the plan's website to alert members how to identify COVID symptoms and appropriate follow up steps and available resources for care. ACFL also worked with pharmacies to assist with claims processing issues unique to COVID related care. For 2023, ACFL is looking to consider expansion of its DTM programs as well as continuing to support state DUR Board recommendations. In addition, for the purpose of avoiding gap in therapy and member non-adherence, ACFL is exploring the opportunity to implement a case management transition of care program.
Children's Medical Services	Children's Medical Services continues to provide quality medications reviews with our Drug Utilization Review (DUR) program. Drug Utilization Review (DUR) is performed for covered drugs to assure that prescriptions are appropriate, medically necessary, and are not likely to result in adverse medical results. The DUR Program is made-up of prospective drug utilization review and retrospective drug utilization review. Emphasis is placed on the quality of care of members not only through DUR, but also quality initiatives which include, but are not limited to, member and prescriber outreach. Throughout this year, there has been intensive focus on sickle cell, epilepsy and asthma management. The underutilization of the drugs in these disease states have been a focus of gaps in therapy. The pharmacy team has been partnering with providers and members regarding initiating therapy for these members to decrease disease burden, hospitalizations, and overall cost of care. These programs are outcomes driven as interdisciplinary teams are engaged and collaborating to ensure the success of our efforts. Our prospective programs also assist in ensuring that prescription drug claims at the point of dispensing are evaluated for patient safety. Our relationship with our pharmacy benefit manager (PBM) provides us the tools to ensure that clinical quality is applied to each medication before dispensed. For those medications dispensed with potential concern, our retrospective programs are designed to follow up with the prescribers. As we

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	continue to enact The SUPPORT ACT, we continually evaluate for new opportunities to provide additional care for its members. Overall, Children's Medical Services is committed to providing a robust DUR program for both our members and prescribers. We look forward to continued success in the future years.
Clear Health Alliance	Clear Health Alliance, through our PBM IngenioRx, provides electronic claims processing and a pharmacy claims management system incorporating on-line point-of-service (POS) and prospective drug utilization review (ProDUR) for the Medicaid Pharmacy Program. The primary objective of the ProDUR program is to improve the quality of care for recipients, to conserve program funds and expenditures, and to maintain program integrity. IngenioRx provides retrospective drug utilization review (RDUR) for the Medicaid Pharmacy Program to promote appropriate medication prescribing by identifying patterns of potential inappropriate prescribing or medication use, alerting physicians and/or pharmacists to potential drug therapy problems and recommending future corrective action. Our Concurrent DUR process follows the NCPDP ProDUR standard formats for conflict, intervention, and outcome. The program reviews all prescriptions, compares them to patient demographics, and checks for potential clinical conflicts that may result if the prescription is dispensed. These include drug-drug interactions, drug-allergy conflicts, drug-disease conflicts, early refills, therapeutic duplication, maximum daily dose, minimum daily dose, under-utilization, over-utilization, drug-age conflicts, drug-gender conflicts, and drug-pregnancy conflicts. The Drug Interaction rule identifies potential problems with conflicting drug therapies, by comparing incoming NDC to a table of interacting drug identifiers, the POS claims processing system identifies other drugs that interact and reviews the patient profile for current interacting drugs. Table safety edits relating drug-drug interactions are clinically classified at three levels. Level 3 - "No Response", is of mild severity, probably resulting in little potential participant harm. No message is given but recorded for reporting purposes only. Level 2 - "Advisory", alerts the pharmacist of potential for a serious drug-drug interaction. Level 1 - "Very Severe", means potential for a high risk of harm and rejects the claim for clinical review by the dispensing pharmacist who may enter an override response code. The Drug-Allergy Conflicts rule identifies potential problems based on patient reported allergies. An incoming NDC is compared to a drug-allergy combination table and POS claims processing system identifies allergies conflicting and reviews the patient profile. The Cumulative Early Refill rule identifies a patient who has more than an adequate supply remaining for their prescription. An incoming NDC is matched to current drugs on the patient profile for the same therapy. If a cumulative remaining day's supply is greater than 25 percent of the maximum days' supply any previous claims, a reject for early refill will occur. Exceptions are made to standardize the minimum and maximum days' supply allowed. In mail service, if an order is received with approximately 30 days remaining before the criteria edit will pass, we may hold the prescription until the system permits processing rather than return the prescription request to the member. The member receives hold notification and when it will process. If the days' supply remaining is longer than 30 days, the mail service pharmacy will place the prescription on the member's profile and notify the member via letter of the date on which the member may call to fill the prescription. The Therapeutic Duplication rule identifies the dispensing of two or more drugs within same therapeutic category for same patient. An incoming NDC is matched to similar current therapy on the patient profile. If similar therapy exists, a therapy duplication message is sent. The POS claims processing system will exclude

MCO Name	Executive Summary
	similar therapy where appropriate. When therapeutic duplication is identified, the claim rejects. After performing a clinical review, which may include prescriber consultation, the dispensing pharmacist can enter response codes and proceed with dispensing as appropriate. The Drug Exceeding Maximum Daily Dose rule identifies a prescription being filled for more than the recommended daily dose. Daily dose is calculated by dividing quantity by days' supply and compared to a recommended daily dose table. A warning message is returned if the calculated dose is greater than the table maximum. The Drug-Age Conflict rule identifies drugs being inappropriately prescribed based on the patient's age. An incoming claim is matched to the Drug-Age Conflict table and POS claims processing system compares patient to target age. When the patient's age is outside the target range, a warning is sent. The Drug-Gender Conflict rule identifies drugs being inappropriately prescribed based on patient gender. An incoming NDC is matched to the Drug-Gender table and POS claims processing system compares to patient gender. When the gender rule is violated, POS claims processing system sends a warning message to the dispensing pharmacy. The Drug-Pregnancy rule identifies drugs contraindicated for use by pregnant women. The incoming NDC is matched to a table with drug-pregnancy contraindications and the patient's profile is reviewed to determine patient's age and gender. Also, patient's profile is reviewed if an inferred pregnancy diagnosis drug marker exists. If criteria are met, a warning message is sent. The Duration of Therapy rule identifies drugs being used beyond the manufacturer's recommendations for length of therapy and a warning message is sent, or a prior authorization is required if exceeded. The Proactive PA rule incorporates medical claims data into PA criteria, but not concurrent DUR edits. This proactive PA program captures ICD-10 diagnosis data from medical claims and routes it automatically to the pharmacy claims processing system to determine whether pharmacy claims may seamlessly POS process. RDUR analysis is performed through review of administrative claims each day, week, and/or month. RDUR letters are faxed or mailed to targeted prescribers and members to identify gaps in care, discuss adherence and identify cases of potential under-and over-utilization, drug abuse or misuse, and/or formulary compliance. Some identified members are referred to the Lock-in program or to a pharmacist for further evaluation or clinical intervention. Plan-specific RDUR results are shared with health plan leaders on an ad-hoc basis or at a minimum of quarterly on a scheduled basis. RDUR details are also presented during plan-specific Quality Management meetings and/or DUR Committee meetings. Retrospective Safety Review provides a prescriber fax within 72 hours of a claim adjudicating. The purpose is to identify members receiving 2 drugs concurrently that are known to cause a clinically significant drug interaction or contraindication. Significant interactions targeted in this program are identified through review of Micromedex and Facts & Comparisons, focusing on members receiving 2 interacting drugs for > 7-day overlap (or 2 interacting antibiotics for > 5-day overlap). Edits may be automated (no pharmacist review) or manual (requires pharmacist clinical review). Prescribers have access Clear Health Alliance's formulary, clinical edits and safety alerts on most handheld devices and desktop applications. Formulary/PDL information is accessible via the web, enabling easy access to drug information. Providers can verify formulary/PDL status, view alternative and generic substitutions, check quantity limits, and look up prior authorization requirements when making prescribing decisions. We also offer real time pharmacy benefit check to our e-prescribing process, allowing prescribers the most appropriate and cost-effective medication options based on patient-specific pharmacy benefits. This capability can be integrated into EMRs across the United States.

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	Clear Health Alliance can quickly and efficiently respond to global emergencies and drug shortages to continue support of members and remain focused on providing affordable, quality services to meet member needs. Utilization Management Response is specific to the circumstances and may include, as appropriate: flexible working environments for employees, relaxing refill-too-soon rules to allow a member to refill a prescription early if needed, encouraging 90/100-day (or other) fills of medication at home delivery or retail pharmacies, providing delivery services through many retail pharmacies, waiving proof of delivery signature at POS if necessary, and extending the duration of member's PAs for select therapies to help avoid the need for providers to re-evaluate. To help prevent drug shortages and stock piling IngenioRx' s clinical services team closely monitors drug shortages via FDA and ASHP vendors. Shortages are evaluated on a drug-by-drug basis, and we take action to help ensure members have access to drugs with limited supply. Our Specialty Pharmacy receives a weekly file for all drugs that are on shortage, backorder, etc. Several actions ensure members do not experience gaps in therapy. First, conduct a check of other fulfillment sites to determine available stock; and if so, route the order to a fulfillment site that has the drug. When applicable, system configuration edits are updated to allow a seamless experience for the member and prescriber based on review and scope of the shortage, such as revising quantity limits for drugs related to specific circumstances as needed. If it's a larger shortage and no sites have stock, the IngenioRx pharmacy team will connect with the prescriber to find an alternative (different dosage form, different drug, etc.). All shortage work is prioritized by the member's need date.
Community Care Plan	Community Care Plan (CCP) continues to work hard on improving its behavioral health (BH) program since it brought it in-house to manage in Jan 2021. This HEDIS year 2022 CCP received a score of 5 in the BH category and continues to partner with community organizations to create consistent continuity of care and profoundly impact members lives. CCP started a robust managed care pharmacy residency program in 2022 and is seeking accreditation for it in 2023. CCP has partnered with Memorial Health System, Broward Health System, Foundation for Sickle Cell Disease Research and Nova Southeastern University and will be the 2nd in the State of Florida to seek accreditation through ASHP. There are currently very few managed care pharmacy residency programs in general, and only two recognized in Florida. CCP is one of the two. CCP initiated a J-code review process with the PBM Magellan Rx/Prime therapeutics MedPharm team in an effort to improve patient safety and monitor cost. This process has allowed more visibility into what doctors are prescribing and ensuring correct clinical indications for use, proper dosing, and that appropriate clinical monitoring is occurring. This process has been going well, with an increase in dosing interventions and product recommendations noted. CCP Clinical programs: In 2022 CCP pharmacy team with the help of the quality team and medical economics team were able to create a tool that identifies the members in the different clinical programs that will be in the HEDIS measure as a denominator. This tool has significantly improved productivity and efficiency in member outreach efforts. Attention Deficit Hyperactivity Disorder (ADHD)Outreach- In 2022- The outreach efforts for this population was greatly improved and we reach 69% of this targeted population which improved our HEDIS scores.

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	Antidepressant Medication Management (AMM) Outreach- In 2022 - We reached 62% of our member this year which was a great improvement over last year's data. These efforts contributed to the HEDIS BH score of 5. Medication Therapy Mangement (MTM) - In 2022 we outreached to 362 members. Data analysis is consistently showing a reduction in per member per month (PMPM) spend. As part of the MTM process CCP has started to conduct MTM reviews for members post hospitalization. This process started in late 2021 which allows the clinical pharmacy team to conduct medication reconciliation reviews to MTM eligible members that are hospitalized at the time of an attempted MTM review. These members are tracked on our daily hospital bed census report until they are discharged. The pharmacist helps with medication reconciliation, safety, education, and serves as a reminder for members to keep or make follow up appointments post hospitalization with their provider(s). In summary, all of the clinical programs and new initiatives discussed here are just a few of the many exciting things happing in CCP. We are proud to work hard to create tools that can improve members health and overall lives. In 2023 we will continue to grow and identify new ways to be outstanding in what we do.
Florida Community Care	Overall, FCC is mandated to utilize the state-approved Medicaid preferred drug list and its associated utilization management edits and prior authorization criteria. As the FCC population grew through FFY 2021, we saw an increase in utilization of the pharmacy benefit. Based on the assignment of our care managers to each member and pharmacy benefit oversight, FCC has maintained focus on appropriate drug utilization and disease state management while ensuring cost effective care. The objective of FFY 2022 was a quality improvement of the pharmacy benefit program. In 2021, there was a concentrated focus on the initiation and implementation of the medication therapy management (MTM) program for qualified members, and for 2022 updates to MTM's Targeted Intervention Program were made enhancing the Retrospective Drug Review (rDUR) program that is inclusive of all members utilizing the pharmacy benefit. These enhancements, as well as coding of additional safety and smart edits for both prospective drug review (proDUR) and rDUR, help to further ensure appropriate medication utilization. FCC continues the evolution of the monthly pharmacy claims review process to identify possible issues or areas of concern for members, prescribers, or pharmacy partners.
Humana Medical Plan	I. Executive Summary The primary mission of the Drug Utilization Review (DUR) program is to ensure that Humana members receive safe, high-quality, cost-effective medication therapy while minimizing inappropriate and/or medically unnecessary care, fraud, waste and abuse. The Drug Utilization Review (DUR) Program is developed in accordance with Humana's overall vision and in conjunction with the Florida Medicaid Fee-for-Service (FFS) program to provide quality healthcare services and prescription drug benefits for its Medicaid members. The main goal of the DUR Program is to monitor medication utilization and to promote quality improvement, appropriate medication use, and reduce unnecessary healthcare spend across all lines of business (i.e. government-sponsored plans, employer groups and individual plans). This ties in with Humana's main goal of:

MCO Name	Executive Summary
	To help our members achieve life-long well being II. Program Content The Program uses a variety of approaches that utilize prospective (before), concurrent (during) and retrospective (after) strategies. The DUR program uses various interventions in the different time frames of before, during and after medication has been dispensed and taken. The scope of DUR focuses on implementing focused interventions to increase appropriate medication use regarding three calls to action: 1. Add medication when treatment is suboptimal, 2. Discontinue medication when treatment is inappropriate/likely to cause harm, and 3. Modify medication dose when medication is overdosed/likely to cause harm. III. Overview- Drug Utilization Review The Drug Utilization Review (DUR) program is structured into three separate programs that may be used individually or in combination to form an optimal screening environment. The DUR program may be prospective, concurrent, or retrospective. Drug Utilization Review (DUR) program is designed to advance therapeutic outcome and improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and that they are not likely to cause adverse medical results. One of Humana's goals as a Pharmacy Benefit Manager (PBM) is to assure that beneficiaries receive safe, high quality, cost-effective medication therapy while minimizing the frequency of inappropriate/medically necessary care, fraud, waste, and abuse. To achieve this goal, drug or drug classes are reviewed to identify safety concerns, over/under-utilization, or abuse. The Pharmacy and Therapeutics Committee (P&T) considers these reviews and makes DUR recommendations. If it is determined by the P&T Committee utilization management (UM) should be applied, appropriate criteria for exceptions to UM criteria are determined by the P&T Committee with input from providers, drug manufacturers, peer-reviewed medical literature, standard compendia, and other experts. Electronic edits are in place to promote appropriate medication therapy. Clinical edits and tools such as prior authorization, step therapy and quantity limits and are commonly used to perform DUR. These edits help prevent patients from taking drugs that may have harmful interactions, prevent patients from receiving higher than recommended doses of a medication, notifying patients of lower cost alternative medications, and providing other safety and efficacy safeguards. Humana DUR is structured as a series of separate programs. Retrospective Drug Utilization Review (RDUR) The operation of the retrospective drug utilization review (RDUR) program is a shared responsibility of Humana and the Agency for Health Care Administration (AHCA). The RDUR program examines patterns of drug therapy utilization to detect potentially inappropriate prescribing or to examine prescribing patterns that are outside the established standard of care based on national guidelines or accepted standards of practice. RDUR is designed to assess the frequency of adverse drug events (ADEs) caused by:

MCO Name	Executive Summary
	Over utilization, non-compliance (or underutilization) Drug-drug interactions Drug-disease interactions Therapeutic duplication Misuse of controlled substances RDUR includes an evaluation of therapy and intervention, where necessary. Retrospective evaluations may involve assessment of drug use in individual patients or analysis of prescribing and dispensing patterns. The evaluation can then prompt various strategies for intervention with the patient, provider or both. Communication with these parties occurs through various channels including: Humana's Your Practice (physician focus) Transcend-Insights Health Systems Evaluation can also result in changes to drug use policy. Prior authorization and quantity limits may be considered and if not already implemented. Other resources within Humana such as Clinical Condition Centers and Disease Management may be consulted for unique and tailored strategies. The RDUR evaluation can also lead to concurrent DUR strategies such as on-line messaging and prospective DUR strategies disease specific guidance for medication use. Prospective Drug Utilization Review (PDUR) Prospective DUR attempts to guide patients toward effective medication use prior to claims being adjudicated for a particular drug. This activity has the capability of enabling beneficial outcomes informing patients about. How to prevent or minimize the severity of their condition. How best to use their medication if prescribed. How to report adverse effects. What therapeutic options should be tried first based on evidence. Concurrent Drug Utilization Review (CDUR) Concurrent DUR edits are used during the processing of prescription drug claims. Messaging at the point of service enables the pharmacists to evaluate and decide on courses of action prior to dispensing a prescription. Some concurrent DUR edits may be solely for messaging, others may also prevent adjudication of claims unless certain criteria are addressed. Activity in RDUR may prompt changes in concurrent DUR. Examples of DUR are: Drug-drug interaction (DDI) Drug-age interaction Drug-allergy contraindications Preferred product Duplicate therapy monitoring Minimum and maximum dosage ranges Maximum daily dose Maximum daily consumption (DACON)
Molina Healthcare	The Molina Healthcare, Inc. Drug Utilization Review (DUR) Board acts as an advisory board to the Molina National Pharmacy & Therapeutics (P&T) Committee for all drug utilization program

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	activities. Drug utilization review program activities help to ensure that prescriptions for outpatient drugs are appropriate, medically necessary, and not likely to result in adverse medical consequences. The Molina DUR Board leverages professional medical protocols and data analytics to assist in reviewing trends of prescribing and dispensing of prescriptions over time. The DUR Board met quarterly (October 2021, January 2022, April 2022, and July 2022) to review and make recommendations on prospective and retrospective drug utilization management criteria, and to identify and develop educational initiatives to improve prescribing or dispensing practices. Periodically, the DUR Board evaluates the established criteria and their usage as well as the educational initiatives and recommends changes to the Molina Healthcare, Inc. National P&T Committee. Molina DUR Board recurring agenda for retrospective DUR review includes but is not limited to, top 10 pharmacy prior authorizations by drug name and by drug class, top 5 denial reasons, top 10 drug names by amount paid, percentage of total spend for drugs by amount paid, top 10 drug names by claim count and drugs by claim count percentage of total claims. This agenda item has evolved during the past year to have a greater robust evaluation of utilization management (UM) requests. Starting in January of 2021, the DUR Board started evaluating the top fifty requested UM products by volume. These UM requests reflect coverage for formulary exceptions, prior authorizations, age limits, or quantity limits. By evaluating all causes of UM exception requests the DUR Board was able to focus on areas to improve efficacy and ensure alignment with clinical best practices. This review enhancement resulted in formulary strategy recommendations presented to the National P&T Committee to improve the benefit. Within the fiscal year, the DUR Board continued to monitor an enhanced targeted therapeutic duplication program. This program prospectively identifies targeted therapeutic duplication at point-of-sale based on overlapping fills of separate products. Due to the potentially inappropriate clinical use and associated safety risks, such claims will reject for further clinical review via prior authorization. The following classes were proposed as targeted for implementation: antidepressants, hormonal agents, phosphate binders, antihistamines, hematopoietic (CSFs), respiratory agents, lipid-lowering agents, skeletal muscle relaxants, anti-hypertensives, immune globulins, stimulants, anti-retroviral, immunomodulatory agents, urinary antispasmodics,

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	benzodiazepines, migraine agents, diabetes agents, non-steroidal anti-inflammatory drugs, gastroesophageal reflux drugs and opioids. After consultation with clinical specialist within therapeutic classes, enhancements were made within classes to address specific drug needs. During DUR Board activities in 2022 Molina Healthcare was able to expand the education opportunities to providers for members at elevated risk for potential overdose. This letter campaign targeted prescribers of members with high opioid utilization and lack of a historical claim for naloxone. The second letter campaign to educate providers was an initiative to increase metabolic screening for those members utilizing antipsychotic agents. Molina members 18 years of age and younger utilizing antipsychotic therapy that did not have a claim within the last 12 months for metabolic screening was flagged and the corresponding prescriber received a letter alerting them of the gap in care. Delegation of the Retrospective Safety Activity Review and the Safety and Monitoring System to CVS Caremark, a pharmacy benefit manager (PBM) continued into 2022 and is leveraged for real-time feedback to prescribers of high-risk utilization at point of sale. The Safety and Monitoring Program continued in 2022 and focuses on therapeutic categories with the potential for high abuse and acetaminophen (APAP) toxicity: Narcotic / Narcotic combination drugs (e.g., fentanyl, hydrocodone/APAP), Anti-anxiety and sedative hypnotic agents (e.g., diazepam, triazolam), Non-benzodiazepine sedatives / hypnotics (e.g., zolpidem, zaleplon), Other drugs with abuse potential (e.g., cyclobenzaprine, gabapentin), CNS Stimulants (e.g., methylphenidate, modafinil) and Other Controlled Substances (e.g., dronabinol, testosterone). For all members identified as needing an intervention, prescribers of the targeted therapeutic category are sent a letter on their patients that meet criteria indicative of potential) is included and shall contain the following: Prescription claims information, including medication, dose, prescriber and pharmacy, Prescriber fax back response form and Any responses from prescriber(s) are tracked within the Safety and Monitoring system. In 2021, there were 7,232 members targeted for interventions in this program with 1,317prescriber responses. The Molina DUR Board evaluated several drug products that had FDA accelerated approval withdrawn in 2022, provided custom education to providers to mitigate member impact of the

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	final decisioning. As an advisory board to Molina Healthcare, Inc. National P&T Committee, the Molina DUR Board does not review prior authorization criteria but reviews the efficacy of the criteria through the market scan standing agenda items as stated above. The Molina National P&T Committee was developed to assist Molina Health Plans with managing pharmacy resources and to improve the overall satisfaction of Molina Health Plans' members and providers. It seeks to ensure Molina Health Plans' members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The National P&T Committee oversees, standardizes, and coordinates Pharmacy policies and procedures, formularies, and Pharmacy Program activities for Molina Health Plans. The Committee serves as an advisory body in making recommendations to Molina Health Plans. Molina Health Plans have final responsibility for modifying, documenting, and implementing the recommendations as needed to meet state regulatory guidelines, state contract requirements and documented state health plan business needs. On an annual basis, the P&T Committee objectively reviews all formularies, for the upcoming plan year. The P&T Committee reviews clinical coverage and utilization management criteria for new FDA approved drugs, new clinical indications for existing drugs, and new line extensions. They also review new clinical data, safety information, evidence-based clinical guidelines and practice trends that may impact previous drug utilization management decisions. The P&T Committee oversight includes prior authorization, step therapy, quantity limits, generic substitutions, medical exception protocols to allow coverage for non-formulary drugs, other drug utilization management activities that affect access, and providing drug utilization evaluations and intervention recommendations to Molina Health Plans .
Simply Healthcare	Simply Health, through our PBM IngenioRx, provides electronic claims processing and a pharmacy claims management system incorporating on-line point-of-service (POS) and prospective drug utilization review (ProDUR) for the Medicaid Pharmacy Program. The primary objective of the ProDUR program is to improve the quality of care for recipients, to conserve program funds and expenditures, and to maintain program integrity. IngenioRx provides retrospective drug utilization review (RDUR) for the Medicaid Pharmacy Program to promote appropriate medication prescribing by identifying patterns of potential inappropriate prescribing or medication use, alerting physicians and/or pharmacists to potential drug therapy problems and recommending future corrective action.

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	Our Concurrent DUR process follows the NCPDP ProDUR standard formats for conflict, intervention, and outcome. The program reviews all prescriptions, compares them to patient demographics, and checks for potential clinical conflicts that may result if the prescription is dispensed. These include drug-drug interactions, drug-allergy conflicts, drug-disease conflicts, early refills, therapeutic duplication, maximum daily dose, minimum daily dose, under-utilization, over-utilization, drug-age conflicts, drug-gender conflicts, and drug-pregnancy conflicts. The Drug Interaction rule identifies potential problems with conflicting drug therapies, by comparing incoming NDC to a table of interacting drug identifiers, the POS claims processing system identifies other drugs that interact and reviews the patient profile for current interacting drugs. Table safety edits relating drug-drug interactions are clinically classified at three levels. Level 3 - "No Response", is of mild severity, probably resulting in little potential participant harm. No message is given but recorded for reporting purposes only. Level 2 - "Advisory", alerts the pharmacist of potential for a serious drug-drug interaction. Level 1 - "Very Severe", means potential for a high risk of harm and rejects the claim for clinical review by the dispensing pharmacist who may enter an override response code. The Drug-Allergy Conflicts rule identifies potential problems based on patient reported allergies. An incoming NDC is compared to a drug-allergy combination table and POS claims processing system identifies allergies conflicting and reviews the patient profile. The Cumulative Early Refill rule identifies a patient who has more than an adequate supply remaining for their prescription. An incoming NDC is matched to current drugs on the patient profile for the same therapy. If a cumulative remaining day's supply is greater than 25 percent of the maximum days' supply any previous claims, a reject for early refill will occur. Exceptions are made to standardize the minimum and maximum days' supply allowed. In mail service, if an order is received with approximately 30 days remaining before the criteria edit will pass, we may hold the prescription until the system permits processing rather than return the prescription request to the member. The member receives hold notification and when it will process. If the days' supply remaining is longer than 30 days, the mail service pharmacy will place the prescription on the member's profile and notify the member via letter of the date on which the member may call to fill the prescription. The Therapeutic Duplication rule identifies the dispensing of two or more drugs within same therapeutic category for same patient. An incoming NDC is matched to similar current therapy on the patient profile. If similar therapy exists, a therapy duplication message is sent. The POS claims processing system will exclude similar therapy where appropriate. When therapeutic duplication is identified, the claim rejects. After performing a clinical review, which may include prescriber consultation, the dispensing pharmacist can enter response codes and proceed with dispensing as appropriate. The Drug Exceeding Maximum Daily Dose rule identifies a prescription being filled for more than the recommended daily dose. Daily dose is calculated by dividing quantity by days' supply and compared to a recommended daily dose table. A warning message is returned if the calculated dose is greater than the table maximum. The Drug-Age Conflict rule identifies drugs being inappropriately prescribed based on the patient's age. An incoming claim is matched to the Drug-Age Conflict table and POS claims processing system compares patient to target age. When the patient's age is outside the target range, a warning is sent. The Drug-Gender Conflict rule identifies drugs being inappropriately prescribed based on patient gender. An incoming NDC is matched to the Drug-Gender table and POS claims processing system compares to patient gender. When the gender rule is violated, POS claims processing system sends a warning message to the dispensing pharmacy. The Drug-Pregnancy rule identifies drugs contraindicated for use by

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	pregnant women. The incoming NDC is matched to a table with drug-pregnancy contraindications and the patient's profile is reviewed to determine patient's age and gender. Also, patient's profile is reviewed if an inferred pregnancy diagnosis drug marker exists. If criteria are met, a warning message is sent. The Duration of Therapy rule identifies drugs being used beyond the manufacturer's recommendations for length of therapy and a warning message is sent, or a prior authorization is required if exceeded. The Proactive PA rule incorporates medical claims data into PA criteria, but not concurrent DUR edits. This proactive PA program captures ICD-10 diagnosis data from medical claims and routes it automatically to the pharmacy claims processing system to determine whether pharmacy claims may seamlessly POS process. RDUR analysis is performed through review of administrative claims each day, week, and/or month. RDUR letters are faxed or mailed to targeted prescribers and members to identify gaps in care, discuss adherence and identify cases of potential under-and over-utilization, drug abuse or misuse, and/or formulary compliance. Some identified members are referred to the Lock-in program or to a pharmacist for further evaluation or clinical intervention. Plan-specific RDUR results are shared with health plan leaders on an ad-hoc basis or at a minimum of quarterly on a scheduled basis. RDUR details are also presented during plan-specific Quality Management meetings and/or DUR Committee meetings. Retrospective Safety Review provides a prescriber fax within 72 hours of a claim adjudicating. The purpose is to identify members receiving 2 drugs concurrently that are known to cause a clinically significant drug interaction or contraindication. Significant interactions targeted in this program are identified through review of Micromedex and Facts & Comparisons, focusing on members receiving 2 interacting drugs for > 7-day overlap (or 2 interacting antibiotics for > 5-day overlap). Edits may be automated (no pharmacist review) or manual (requires pharmacist clinical review). Prescribers have access Simply Health's formulary, clinical edits and safety alerts on most handheld devices and desktop applications. Formulary/PDL information is accessible via the web, enabling easy access to drug information. Providers can verify formulary/PDL status, view alternative and generic substitutions, check quantity limits, and look up prior authorization requirements when making prescribing decisions. We also offer real time pharmacy benefit check to our e-prescribing process, allowing prescribers the most appropriate and cost-effective medication options based on patient-specific pharmacy benefits. This capability can be integrated into EMRs across the United States. Simply Health can quickly and efficiently respond to global emergencies and drug shortages to continue support of members and remain focused on providing affordable, quality services to meet member needs. Utilization Management Response is specific to the circumstances and may include, as appropriate: flexible working environments for employees, relaxing refill-too-soon rules to allow a member to refill a prescription early if needed, encouraging 90/100-day (or other) fills of medication at home delivery or retail pharmacies, providing delivery services through many retail pharmacies, waiving proof of delivery signature at POS if necessary, and extending the duration of member's PAs for select therapies to help avoid the need for providers to re-evaluate. To help prevent drug shortages and stock piling IngenioRx' s clinical services team closely monitors drug shortages via FDA and ASHP vendors. Shortages are evaluated on a drug-by-drug basis, and we take action to help ensure members have access to drugs with limited supply. Our Specialty Pharmacy receives a weekly file for all drugs that are on shortage, backorder, etc. Several actions ensure members do not experience gaps in therapy. First, conduct a check of other fulfillment sites to determine available stock; and if so, route the order to a fulfillment site that has the drug. When applicable, system configuration edits are

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	updated to allow a seamless experience for the member and prescriber based on review and scope of the shortage, such as revising quantity limits for drugs related to specific circumstances as needed. If it's a larger shortage and no sites have stock, the IngenioRx pharmacy team will connect with the prescriber to find an alternative (different dosage form, different drug, etc.). All shortage work is prioritized by the member's need date.
Sunshine	Sunshine Health (SH) is committed to providing appropriate, high quality, and cost effective medication therapy to all SH members. SH works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. SH covers prescription medications and certain over-the-counter (OTC) medications when ordered by a physician/clinician. Prescribed drug services will include all prescription drugs listed in the Agency's Medicaid Preferred Drug List (PDL). See s. 409.91195, F.S. and s. 409.912(8), F.S. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage, and maximum quantities. Sunshine Health Prior Authorization, step-edit therapy, protocols and the Preferred Drug List (PDL) are no more restrictive than those posted on the AHCA web-site. SH monitors ongoing prescribing of medications for clinical appropriateness. SH reviews prescribing retrospectively to review for both safety and efficacy. SH in congruency with Centene Pharmacy Services to review for disease management, fraud and abuse (i.e. Coordinated Services Program), and prescriber profiling. Prescriber or member outreach may occur based on prescribing/dispensing patterns. SH routinely monitors for drug use review (DUR) opportunities and takes action as needed. The standard prospective (pDUR) and retrospective Drug Use Review (rDUR) programs are delegated to the designated pharmacy benefit manager (PBM), CVS Caremark, utilizing the standards, criteria, protocols and procedures established by the mutual agreement of the Centene Corporate Pharmacy and Therapeutics Committee, SH, and Centene Pharmacy Services, and in accordance with applicable state and federal requirements and NCQA standards. The DUR program is submitted for review and approval to the Centene Corporate and Health Plan Pharmacy and Therapeutics Committees annually. The DUR program is designed to alert prescribers and/or dispensing pharmacists by identifying overuse, underuse, inappropriate or medically unnecessary care, and to address safety concerns associated with specific drugs, including the potential for drug interactions. The DUR program also functions to identify opportunities to improve the quality of care for patients including adherence to prescribed therapy and improvements in the medication regimen consistent with the patient's diagnoses or conditions. The results of any rDUR programs may also be used to initiate additional claims review and analysis at the plan. In addition, follow-up studies may be performed to assess the impact and outcomes of rDUR interventions. SH's prospective DUR program is administered by CVS utilizing the RxClaims electronic claims system. Our Point of Sale (POS) Safety Review utilizes a series of alerts designed to check the plan member's prescription history for possible drug conflicts and safety issues. When a claim is adjudicated, the CVS Caremark systems evaluate the complete patient drug history and send real time alerts to the dispensing pharmacist every time a safety issue is triggered. SH's Pharmacy Program staff uses an evidence-based approach for developing proposals for the DUR Board to review and approve at the quarterly meetings, including clinical PA criteria algorithms and drug claim alerts (quantity, dose, age, or gender) that will support appropriate and safe prescription drug use.

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	SH's pharmacy lock-in program is in place to detect and prevent abuse of the pharmacy benefit, as defined by specific criteria designed to identify potential misuse or abuse of prescription medications in specific therapeutic categories with the potential for high abuse, by restricting members to one specific pharmacy for a defined period of time (12 months). SH's policy is to monitor and control suspected abuse of the pharmacy benefit by members, as identified and confirmed through analysis and audit by the pharmacy department. SH's purpose is transforming the health of the community, one person at a time. Our mission is to ensure better health outcomes at lower costs.
United Healthcare	The purpose of the UnitedHealthcare Community Plan's DUR Board is to provide clinical support for the development, maintenance, and clinical oversight of drug utilization review programs administered by UnitedHealthcare Community Plan or its affiliates. The purpose of the clinical support provided is to ensure that the clinical pharmacy programs improve quality of patient care by promoting patient safety and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and health plan members. The UnitedHealthcare Community Plan's DUR Board also develops initiatives that support the medical management strategies for customers in pharmacy benefit plans issued or administered by UnitedHealthcare Community Plan or its affiliates. The UnitedHealthcare Community Plan DUR program and policy reviews are designed to assure that the clinical programs and related materials are consistent with published clinical evidence and UnitedHealthcare Community Plan medical management policies and initiatives. The DUR program consists of four major components: retrospective DUR, prospective DUR, pharmacy lock-in programs, and formulary and utilization management strategies overseen by the P&T Committee. UnitedHealthcare Community Plan's retrospective DUR is carried out by OptumRx who reviews pharmacy claims data for our focused drug classification interventions or targeted DURs. As we identify potentially adverse patterns, we work with OptumRx to implement existing or new interventions that may yield improved outcomes and cost savings. On an ongoing basis, OptumRx performs targeted retrospective DURs based on claims data spanning time frames of one day to six months. DUR-identified physicians are sent a fax/letter describing the medication related problem or gaps in care and profiles of affected members. During the FFY 21-22 OptumRx ran 14 retrospective DUR programs in Florida including: drug interaction alerts, polypharmacy drug disease interactions, age prescription monitoring, average daily dose/dose per day monitoring, polypharmacy therapeutic duplication, days supply monitoring, concurrent use, high-risk/narcotic medication drug utilization review, gaps in care cardiovascular, gaps in care diabetes, gaps in care asthma, gaps in care COPD, gaps in care HIV, and gaps in care sickle cell disease. Overall, the RDUR interventions that went out during FFY 21-22 resolved 18.9% of identified medication related problems or gaps in care. UnitedHealthcare Community Plan of Florida is also enrolled in an OptumRx adherence program to address adherence in the following drug classes: antiretrovirals (HIV), respiratory agents, hypertension agents, and diabetes agents. This program includes provider and member targeted interventions via fax/mail letters and interactive voice response (IVR) calls. The primary member identification targets for the program include initiation of a new medication to encourage adherence from the start, refill reminders when a member is overdue for a refill to encourage continuous adherence, and those with PDC (Proportion of Days Covered) below the threshold for the drug class (<90% PDC for antiretrovirals, 80% PDC for all other classes) to offer counseling and identify barriers to adherence. Interventions are assessed

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	for success (PDC > 80% or > 90%) 180-days post-intervention. Overall, 8,604 members have been included in the outcomes analysis in 2022 with 4,252 (49.42%) becoming adherent in the post-intervention period with a pre-intervention PDC of 64.98% and post-intervention PDC of 95.71%. UnitedHealthcare Community Plan's prospective DUR is also carried out by OptumRx who utilizes their electronic claims system in conjunction with the Medispan database of identified drug therapy problems to define prospective/concurrent DUR edits. Any prescription that triggers one of our prospective DUR edits will be flagged. Based on the specific messaging or criteria programmed in the system, the real-time message sent to the dispensing pharmacist may indicate a hard reject of the prescription requiring prior authorization, a soft reject of the prescription requiring the pharmacist to enter appropriate NCPDP codes, or it may be a warning along with a paid claim that will prompt interaction and discussion with the member to determine the appropriateness of the medication being requested. The determination of which edits are flagged as hard, soft, or a message only warning are managed and maintained through the UnitedHealthcare DUR Board committee. During FFY 21-22 the following additional new point of sale CDUR soft edits were implemented: therapeutic duplication edits on bladder antispasmodics, barbiturates, and alpha-1 blockers; drug-drug interaction on warfarin+ interacting anti-infectives, clonidine+ beta-blockers, and anti-rejection immunosuppressants+ interacting medications; and cumulative high dose edits on metformin. In addition, the state of Florida also implemented diagnosis exclusions for cancer, sickle cell, and seizures from their opioid+ benzodiazepine drug-drug interaction edit. Therapeutic duplication, drug-drug interaction, and cumulative high dose CDUR soft edits were evaluated during FFY 21-22, results showed that 53%, 42%, and 76% of the respective identified issues were resolved and were not overridden by the point-of-sale pharmacist. All the prospective utilization management tools adhere to contractual requirements. UnitedHealthcare Community Plan's pharmacy lock-in program continued during FFY 21-22. The High Prescription Utilization Program identifies and manages members that meet criteria indicative of potential misuse or abuse of prescription medications in specific therapeutic categories with the potential for high abuse, (e.g. narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances, etc.) in order to minimize the occurrence of drug abuse and diversion of these medications. UnitedHealthcare Community Plan's pharmacy lock-in averaged a quarter over quarter program enrollment of 158 members. The program adheres to all criteria and program components that are contractually required. The UnitedHealthcare Prior Notification Service (PNS) is charged with utilization review of specific medications to ensure that the use of these medications is consistent with clinical guidelines. In their review, the PNS follows criteria established by UHC's P&T Committee that are consistent with FDA indications, medical literature, and current medical practice. Medications targeted for utilization review include specialty products, second-line pharmaceuticals and branded therapeutic alternatives. The prior authorization process steers prescribers to high-quality cost-effective therapies, while still allowing the prescribing of non-preferred alternatives on a case-by-case basis as a member's care warrants. The prior authorization program adheres to all criteria and program components that are contractually required. The goals for the DUR Board and DUR Program in FFY 22-23 include the following:

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	1. The continued evaluation and enhancement of the custom CDUR soft edit program by adding new edits and developing detailed reporting for all current implementations. 2. The continued evaluation of RDUR program intervention and rule sets focusing on effectiveness, clinical importance, and provider intervention fatigue. 3. To work with our PBM partner to implement electronic medical record direct messaging RDUR programs