California

Medicaid Managed Care Organization

(with Carved-out Pharmacy Benefit)
FFY 2022 Annual Abbreviated
Drug Utilization Review Report

This Managed Care Organization (MCO) report covers the period October 1, 2021 to September 30, 2022. It is an abbreviated version of the traditional MCO survey for States that have pharmacy benefits covered through the fee-for-service (FFS) program. Coverage of the pharmacy benefit, handled through retail or mail-order dispensing, is very different from medications administered in a clinical setting. Claims for dispensed medications are routinely submitted via a real-time transaction and these transactions are subject to Prospective Drug Utilization Review edits. The MCOs covered in this survey, have only the portion of benefits for covered outpatient drugs (COD) administered in a doctor's office and/or outpatient hospital or clinic. These types of claims are generally only subject to Retrospective Drug Utilization reviews.

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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

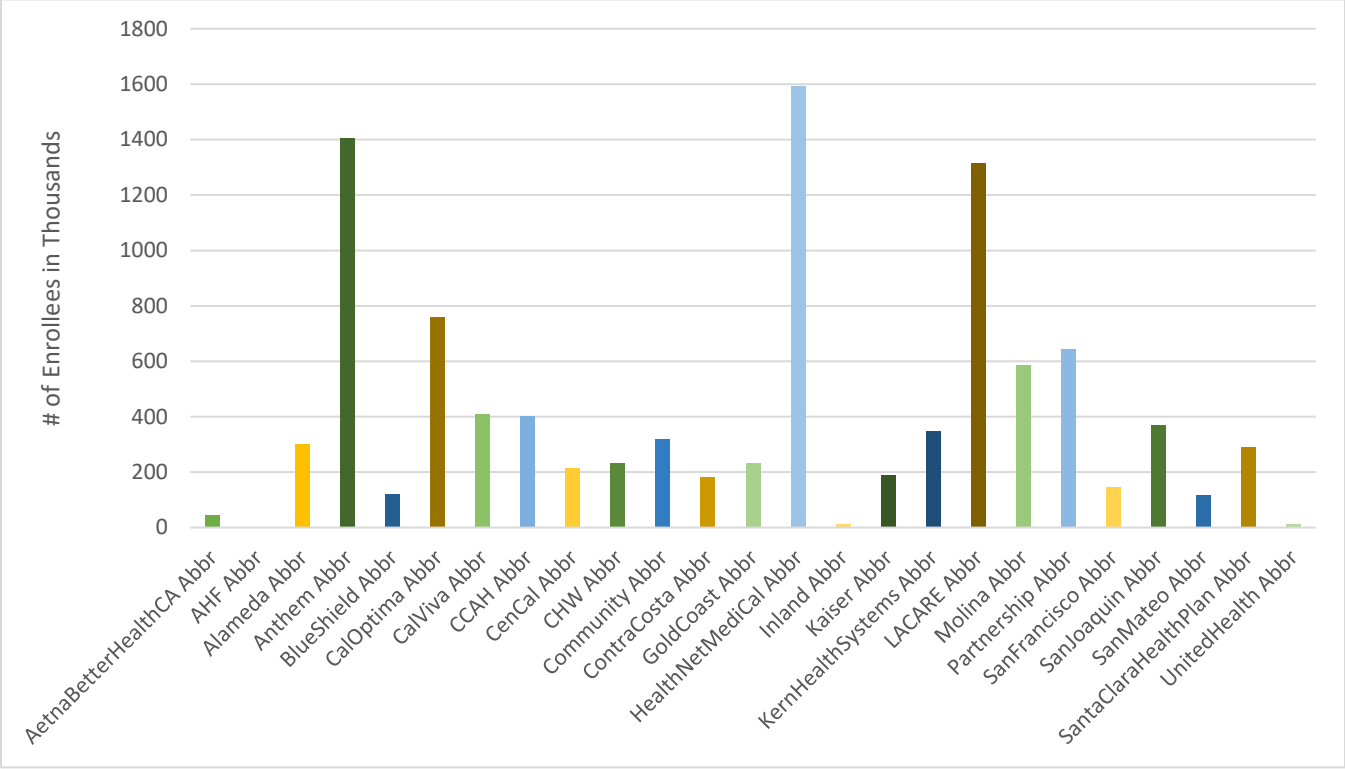

Table 1 - Number of Beneficiaries Enrolled in Each MCO

MCO Name	Number of Beneficiaries Enrolled
AetnaBetterHealthCA Abbr	44,052
AHF Abbr	453
Alameda Abbr	302,193
Anthem Abbr	1,406,056
BlueShield Abbr	121,544
CalOptima Abbr	760,089
CalViva Abbr	408,151
CCAH Abbr	403,679
CenCal Abbr	215,775
CHW Abbr	231,843
Community Abbr	320,000
ContraCosta Abbr	182,807
GoldCoast Abbr	234,065
HealthNetMediCal Abbr	1,592,853
Inland Abbr	12,652
Kaiser Abbr	188,830
KernHealthSystems Abbr	350,000
LACARE Abbr	1,316,473

MCO Name	Number of Beneficiaries Enrolled
Molina Abbr	587,385
Partnership Abbr	642,572
SanFrancisco Abbr	144,348
SanJoaquin Abbr	369,000
SanMateo Abbr	116,904
SantaClaraHealthPlan Abbr	290,261
UnitedHealth Abbr	11,820
State Totals	**10,253,805**

2. Are all Section 1927(g) of the Social Security Act (the Act) covered outpatient drugs (CODs) included in Fee-for-Service (FFS) pharmacy benefits (CODs include drugs dispensed in a pharmacy, administered in a doctor's office, outpatient hospital or clinic. Drugs reimbursed at bundled/global rate are not considered outpatient drugs)? If yes, the completion of the remaining survey is voluntary.

Figure 2 - CODs Included in FFS Pharmacy Benefits

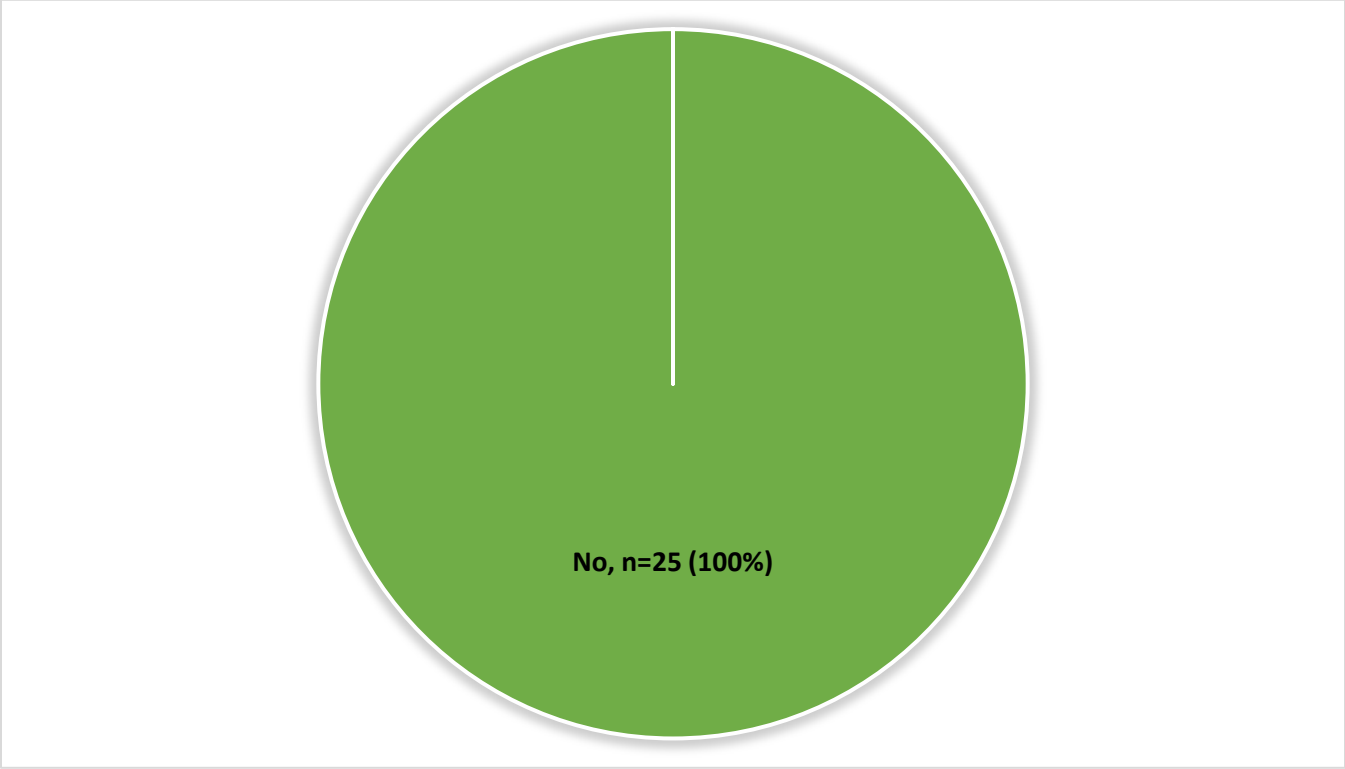

Table 2 - CODs Included in FFS Pharmacy Benefits

Response	MCO Names	Count	Percentage
No	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE	25	100.00%

Response	MCO Names	Count	Percentage
	Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr		
State Totals		**25**	**100%**

3. Please list what CODs are included in the benefits by your MCO (i.e., physician administered drugs (PAD), medication assisted treatment (MAT) at outpatient treatment programs (OTPs), and hospital outpatient drugs).

Figure 3 - CODs Included in MCO Benefits

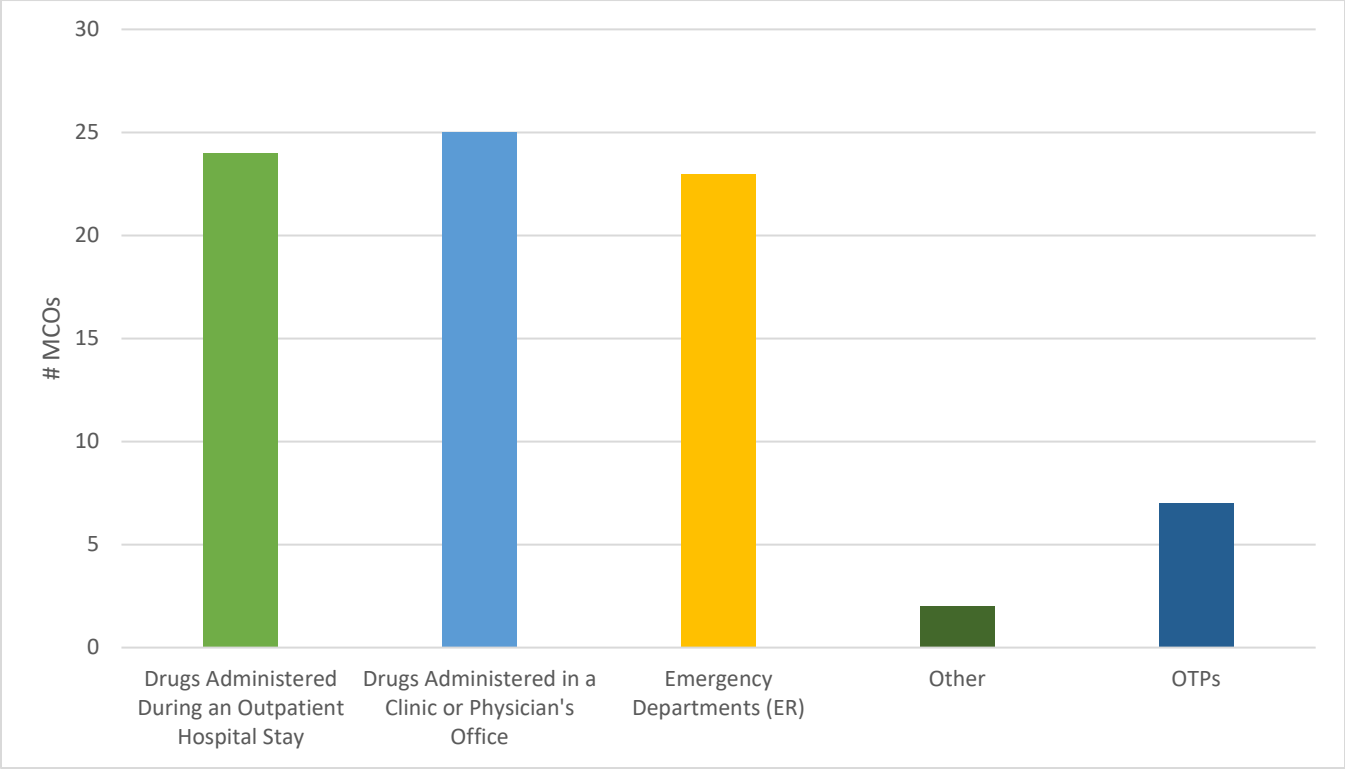

Table 3 - CODs Included in MCO Benefits

Response	MCO Names	Count	Percentage
Drugs administered during an outpatient hospital stay	AetnaBetterHealthCA Abbr, AHF Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	24	29.63%
Drugs administered in a clinic or physician's office	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield	25	30.86%

Response	MCO Names	Count	Percentage
	Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr		
Emergency Departments (ER)	AetnaBetterHealthCA Abbr, AHF Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	23	28.40%
OTPs	AHF Abbr, Anthem Abbr, CalOptima Abbr, ContraCosta Abbr, LACARE Abbr, SanJoaquin Abbr, UnitedHealth Abbr	7	8.64%
Other	ContraCosta Abbr, Molina Abbr	2	2.47%
State Totals		**81**	**100%**

If “Other,” please explain.

Table 4 - “Other” Explanations for CODs Included in MCO Benefits

MCO Name	Explanation
ContraCosta Abbr	CCHP provides substance use disorder services to Medi-Cal members who meet criteria for these service, which include Medication Assisted Treatment (MAT) services including the ordering, prescribing, administering, and monitoring of all medications for substance use disorder.
Molina Abbr	Home Health drugs (drugs billed to the plan and administered in the member's home)

4. What practices and policies does your MCO have in place to share information between providers? NOTE: It is expected that if the drug benefit is handled separately there are file transfers of the drug claim file so MCOs can coordinate that aspect of the care.

Table 5 - Explanations for MCO Policies in Place to Share Information Between Providers

MCO Name	Explanation
AetnaBetterHealthCA Abbr	Aetna Better Health of CA receives comprehensive pharmacy claims data for our members (from Medi-Cal Rx). Drug claims data are used for quality improvement and retrospective DUR activities. The pharmacy claims data are shared with providers through a secure file transfer protocol.

MCO Name	Explanation
AHF Abbr	MCO receives comprehensive claims and PA history for their Members (from Medi-Cal Rx) and uses claims data for quality improvement programs and retrospective DUR activities.
Alameda Abbr	Alameda will receive comprehensive claims and PA history for their members (from Medi-Cal RX) and use claim data for quality improvement projects and retrospective DUR activities.
Anthem Abbr	We receive comprehensive claims and PA history for our members (from Medi-Cal Rx) and can use claims data for our own quality improvement and retrospective DUR activities (Near real time Fax, Mailed Letters, Provider Phone Calls, Newsletters or other non-direct provider communications)
BlueShield Abbr	MCO provides active and ongoing reach to educate providers on common drug therapy problems with the goals of improving prescribing and dispensing practices, increasing medication compliance, and improvement of overall beneficiary health.
CalOptima Abbr	Paid outpatient pharmacy claim files are provided to our delegates on a weekly basis.
CalViva Abbr	We receive comprehensive claims and PA history for our members (from Medi-Cal Rx) and use the claims data for health plan quality improvement and retrospective DUR activities.
CCAH Abbr	MCO receives comprehensive claims and prior authorization history from FFS Program (Medi-Cal Rx) and uses claims data for care coordination, quality improvement and retrospective DUR activities. Based on the data, MCO may contact different providers, pharmacies, and members.
CenCal Abbr	CenCal Health receives daily data feeds from Medi-Cal Rx with all the claims and prior authorizations from the previous day. The data is loaded into CenCal Health's data warehouse where staff can generate reports to coordinate the care for CenCal Health members. CenCal Health also has access to a reporting suite from Medi-Cal Rx that includes controlled substance and opioid utilization reporting.
CHW Abbr	We receive comprehensive claims and PA history for our members (from Medi-Cal Rx) and use the claims data for health plan quality improvement and retrospective DUR activities.
Community Abbr	CHG receives claims and PA history from Medi-Cal Rx. This data is used for our own quality improvement and retrospective DUR activities. CHG makes information available to PCPs through the provider portal. The Member Look-up module contains prescription information for the specific member for the last year and includes the date the prescription was filled, the name and strength of the medication, the NDC number for the product dispensed, the days' supply, quantity dispensed, and who prescribed it. The Member Look-up module also shows the member's gaps in care and lists the preventive and screening services that the member needs.
ContraCosta Abbr	Comprehensive drug claim files including paid claim history reports and prior authorization history are used to create reports. These reports are used for retrospective DUR programs and quality improvement.
GoldCoast Abbr	GCHP receives daily data feeds with comprehensive claims and prior authorization history for our Members (from Medi-Cal Rx). The data is loaded into our data warehouse where staff can generate reports to coordinate the care for GCHP Members. We can use the claims data for our own quality improvement and

MCO Name	Explanation
	retrospective DUR activities. GCHP also has access to an opioid dashboard which includes controlled substance and opioid utilization claims data.
HealthNetMediCal Abbr	We receive comprehensive claims and PA history for our members (from Medi-Cal Rx) and use the claims data for health plan quality improvement and retrospective DUR activities.
Inland Abbr	IEHP receives drug information from the entity that provides the drug benefit. IEHP incorporates the drug information into the IEHP provider portal for providers to gain access to view drug claims for beneficiaries and includes pertinent medical data. Providers are also informed through provider communications about the Provider Portal to directly view drug claims with the entity that provides the drug benefit.
Kaiser Abbr	Kaiser is an integrated health care system where providers and pharmacies have access to all patient encounter/Rx data via our electronic medical record system and can engage in direct communication. In addition, Kaiser receives comprehensive claims and PA history for our Members from Medi-Cal Rx/PBM and can use claims data for quality improvement and retrospective DUR activities.
KernHealthSystems Abbr	Kern Health Systems (KHS) receives daily files consisting of claims and Prior Authorization (PA) data from Medi-Cal Rx (MCRx). KHS will then use this information in a variety of ways. They are used to share information to improve quality scores. The data is shared in collaborative methods in enhanced care management. It can be used for educational purposes when Drug Utilization Reviews find certain anomalies.
LACARE Abbr	MCP will receive comprehensive claims and PA history for their Members (from FFS Medi-Cal Rx) and has the ability to use claims data for their retrospective DUR activities and clinical programs.
Molina Abbr	Currently clinical interventions on behalf of our members are being communicated via Provider lettering. Additional modes of communication include use of Molina's Provider Portal, Provider Newsletters and Provider Blast Faxes. Providers can always request information from Molina on an ad-hoc basis if more information is desired for care of their member.
Partnership Abbr	We configure the claims data our pharmacy department receives from Medi-Cal Rx to a format that allows the data to be shared with our providers to identify potential medication related issues that can impact clinical outcomes. This data is utilized for our quality improvement and retrospective DUR activities.
SanFrancisco Abbr	SFHP receives prescription data from Medi-Cal Rx that is then analyzed for DUR reports.
SanJoaquin Abbr	HPSJ receives comprehensive claims and PA history for their members (from Medi-Cal Rx). HPSJ has quarterly JOM meetings with FQHC and hospitals where they share provider performance and quality information with provider.
SanMateo Abbr	The plan receives claims and PA history data from Medi-Cal Rx, the California Department of Health Care Services (DHCS) fee-for-service Medicaid program that handles the Medicaid pharmacy benefit. Clinical staff at the plan also have access to view data within Medi-Cal Rx's systems to see the live status of prescription claims and prior authorizations.
SantaClaraHealthPlan Abbr	The Plan receives comprehensive claims data and prior authorization (PA) history for our members from Medi-Cal Rx. The Plan uses claims data for quality improvement and retrospective DUR activities.

MCO Name	Explanation
UnitedHealth Abbr	UnitedHealthcare Community Plan receives comprehensive claims and PA history for their Members (from Medi-CalRx) and use this claims data for our own quality improvement and retrospective DUR activities.

a. Please explain the process for coordination of clinical outcomes between medical providers and pharmacy.

Table 6 - Process for Coordination of Clinical Outcomes Between Medical Providers and Pharmacy

MCO Name	Explanation
AetnaBetterHealthCA Abbr	Aetna Better Health of CA's pharmacy department communicates with plan's medical providers through newsletters and website updates, which contain guideline references. ABHCA has scheduled meetings with providers, in which the pharmacy department details appropriate communication. The Educational Outreach Programs developed by the plan's DUR Board utilize educational outreach directed to prescribers, members and/or pharmacies to correct prescribing patterns that deviate from the predetermined parameters. The 2022 Goal of the DUR Board was to conduct outreach programs targeting each of four categories over-utilization, under-utilization, patient safety, and fraud/waste/abuse issue.
AHF Abbr	Communication is provided between providers and pharmacies via bulletins, newsletters, and interdisciplinary meetings.
Alameda Abbr	We report DUR trends, Medi-Cal Rx news and state formulary changes to committee meetings such as UMC (Utilization Management Committee), HCQC (Health Care Quality Committee), and/or P&T (Pharmacy and Therapeutic Committee). Updates with coverage by Medi-Cal Rx or educational opportunities are communicated in our provider packet.
Anthem Abbr	Examples are routine/regular review at MCP DUR or MCO P&T Committees, other multi-disciplinary committees. Communication between medical providers and pharmacy via newsletters, guidelines, reviews and recommendations.
BlueShield Abbr	Clinical outcomes for high risk Medi-Cal members are reviewed at the MCO's Interdisciplinary Care Team committee with a multi-disciplinary team that coordinates care between medical providers and pharmacy.
CalOptima Abbr	Various utilization reports are reviewed at the P&T Committee. Medication information is disseminated to providers via newsletters and meetings. Guidelines are posted on the CalOptima website.
CalViva Abbr	Examples are routine/regular review at our health plan DUR or P&T Committees, other multi-disciplinary committees. Communication between medical providers and pharmacy via newsletters, guidelines, reviews and recommendations.
CCAH Abbr	MCO assists with the communication between medical providers, pharmacies, and Medi-Cal Rx to ensure members receive their medications in a timely fashion. Results from retrospective DURs are presented to MCO Pharmacy & Therapeutics (P&T) Committee/DUR Board and other internal and external multidisciplinary committees. Educational articles are sent to all providers via provider bulletin/newsletter, and shared on the website. Individualized letters may be sent via fax as appropriate.
CenCal Abbr	Retrospective DUR outreaches are coordinated at a regular cadence based on the data received from Medi-Cal Rx. All DUR provider outreaches are brought before

MCO Name	Explanation
	the CenCal Health DUR Board for approval and input for future topics are discussed with the board that is comprised of local providers. Retrospective DURs are also developed in conjunction with CenCal Health's Population Health team to address organizational initiatives. Educational articles are posted on the CenCal Health webpage that provide important clinical updates for the provider network.
CHW Abbr	Examples are routine/regular review at our health plan DUR or P&T Committees, other multi-disciplinary committees. Communication between medical providers and pharmacy via newsletters, guidelines, reviews and recommendations.
Community Abbr	Coordination of clinical outcomes between providers and pharmacy are done through P&T Committees, newsletters, providers alerts, and guidelines and recommendations posted on the CHG website.
ContraCosta Abbr	Retrospective and prospective DUR reviews are conducted with each P&T committee. Provider bulletins are sent out after each P&T committee meeting providing outreach educations and updating providers as to most recent changes and guidelines. Educational bulletins created by Medi-cal Rx are posted on the CCHP website. National guidelines are posted to the CCHP website.
GoldCoast Abbr	Retrospective DUR reviews are performed at Utilization Management (UM) and Medical Advisory Committee (MAC), and other multi-disciplinary committees. Communication between medical providers and pharmacies are provided via newsletters (quarterly pharmacy newsletter and provider operations bulletin), guidelines and clinical updates, and educational articles that are posted on the GCHP website.
HealthNetMediCal Abbr	Examples are routine/regular review at our health plan DUR or P&T Committees, other multi-disciplinary committees. Communication between medical providers and pharmacy via newsletters, guidelines, reviews and recommendations.
Inland Abbr	Medical providers are given IEHP provider portal access to view pharmacy claims and clinical notes and outcomes of beneficiaries. Providers are able to see pertinent labs as well as pharmacy claims information to coordinate timely and accessible pharmacy and medical services for beneficiaries.
Kaiser Abbr	Examples of coordination of clinical outcomes between providers and pharmacies include routine/regular review at P&T Committees or other multi-disciplinary committees. Communication between medical providers and pharmacy are conducted via guidelines, reviews and recommendations.
KernHealthSystems Abbr	This information is shared at the plan's DUR (P&T) meetings. Medication adherence cases are shared with interdisciplinary team meetings. The same data is shared at quality meetings with providers on a one-on-one basis. Provider newsletters and bulletins can communicate trends and findings at a plan level. KHS performs Medication Therapy Management (MTM) reviews and shares these suggestions/recommendations as they arise.
LACARE Abbr	Routine review of the DUR program, communication between providers and pharmacies via newsletter, website updates, faxed and mailed recommendations.
Molina Abbr	Retrospective DUR monitoring has been tasked to the MCOs post carve-out of the Pharmacy benefit, therefore information shared with Providers would include any interventions from specific rDUR reports. These interventions are communicated via Provider letters with member specific information. Provider portal and Provider Newsletters have also been used to provide more general information in regards to overall member care.

MCO Name	Explanation
Partnership Abbr	Pharmacy claims data are analyzed to identify medication safety issues and gaps in care related to control substance medications, HEDIS measures impacted by medications and pharmacy dispensing events. These results are shared with our providers who are encouraged to follow up with the pharmacies to address any identified medication related issues such as control substance safety, duplication of therapy, poly-pharmacy and medication non-adherence.
SanFrancisco Abbr	SFHP communicates with providers through a monthly provider newsletter, a quarterly Pharmacy & Therapeutics/DUR Board, and through Joint Action Committees between the plan and medical groups.
SanJoaquin Abbr	HPSJ meets with P&T Commitee quarterly. HSPJ communicates via newsletters and educational updates to both medical and pharmacy providers.
SanMateo Abbr	The plan uses available pharmacy data where applicable through the course of regular activities when health plan staff interact with providers (such as through case management, medical prior authorization review, care coordination, and other clinical outreach activities). For example, when reviewing medical drug requests and coordinating care with providers, clinical staff are able to access this information to inform next steps.
SantaClaraHealthPlan Abbr	Regular review at P&T Committee meetings. Communication between medical providers and pharmacy via newsletters, memos, and other multi-disciplinary committees.
UnitedHealth Abbr	UnitedHealthcare Community Plan utilizes this data for our quality improvement and retrospective DUR activities. The results of these activities are presented at the Health Quality and Utilization Management (HQUM) Committee, the Quality Management Committee, and the Provider Advisory Committee. UHC also educates providers of medication issues with our Provider Bulletins, alerts, and fax blasts.

b. How is quality of care for prescriptions ensured? Please explain.

Table 7 - Explanations of Methods for Ensuring Quality of Care for Prescriptions

MCO Name	Explanation
AetnaBetterHealthCA Abbr	The plan's pharmacy team evaluates multiple pharmacy-based metrics, including internal Aetna quality initiatives determined by the Aetna DUR Board. The plan's quality team tracks HEDIS MCAS measures, including but not limited to pharmacy-based measures to monitor quality outcomes.
AHF Abbr	Quality of care is ensured through QI programs, HEDIS measures, and identifying gaps in performance. Routine reviews, audits, and quality improvement programs are performed.
Alameda Abbr	Alameda reviews and monitors claims to ensure quality of care for prescriptions. These findings are reported to UMC and HCQC. Quality improvement projects are implemented to bridge any gaps in adherence and disease management.
Anthem Abbr	Examples are reviews, audits, quality improvement projects, using HEDIS measures, MCAS measures, exception criteria, to identify gaps in performance standards.

MCO Name	Explanation
BlueShield Abbr	Medi-Cal Rx will manage prospective DUR alerts. MCO will receive comprehensive claims and Prior Authorization history for their members and can use claims data for their own quality improvement and retrospective DUR activities.
CalOptima Abbr	We utilize HEDIS measures and quality improvement projects to identify gaps in performance standards.
CalViva Abbr	Examples are reviews, audits, quality improvement projects, using HEDIS measures, MCAS measures, exception criteria, to identify gaps in performance standards
CCAH Abbr	Quality of care for prescriptions are ensured by retrospective DURs, audits, HEDIS measures, MCAS measures, audits, and various quality improvement projects.
CenCal Abbr	The Medi-Cal Rx data feed is utilized by CenCal Health's Quality department to address HEDIS, MCAS, and gaps in performance measures. Controlled substance claims data is also reviewed for any signs of fraud waste and abuse.
CHW Abbr	Examples are reviews, audits, quality improvement projects, using HEDIS measures, MCAS measures, exception criteria, to identify gaps in performance standards
Community Abbr	The quality of care for prescriptions are ensured through retrospective review of claims during Interdisciplinary Care Team meetings, medication reconciliation, and HEDIS activities to help identify gaps in performance standards.
ContraCosta Abbr	Regular reviews and audits are performed to ensure quality of care of prescriptions. Clinical projects and reports are implemented to ensure HEDIS measures and MCAS measures are met. Retrospective and prospective DUR reviews are performed.
GoldCoast Abbr	We perform retrospective DUR and quality improvement projects based on HEDIS measures, MCAS measures, and gaps in performance measures. Controlled substance claims data is also reviewed for any potential signs of fraud, waste and abuse.
HealthNetMediCal Abbr	Examples are reviews, audits, quality improvement projects, using HEDIS measures, MCAS measures, exception criteria, to identify gaps in performance standards
Inland Abbr	Providers are able to view all claims data for a beneficiary in one location on the IEHP provider portal. Providers are able to coordinate care and ensure beneficiaries are not misusing or abusing medications by looking at their utilization. Providers are able to use the drug and medical claims data to ensure appropriate use of the medications.
Kaiser Abbr	Examples of ensuring quality of care for prescription include reviews, audits, quality improvement projects, using HEDIS measures, MCAS measures, and exception criteria, to identify gaps in performance standards.
KernHealthSystems Abbr	Reports are run to determine gaps or deficiencies in HEDIS/MCAS measures. Reports/audits are performed to identify issues with adherence to chronic medication regimens.
LACARE Abbr	Claims are routinely monitored for timely processing and accurate adjudication.
Molina Abbr	Quality of care is ensured by retrospective monitoring of member's drug claim history and review of pharmacy specific HEDIS measures as well as MCAS measures to identify gaps in performance.

MCO Name	Explanation
Partnership Abbr	Quality of care for prescriptions has been evaluated utilizing the medication related HEDIS measures to identify gaps in performance standards such as improving rates of appropriate pharmacotherapy for COPD exacerbations, appropriate use and adherence to asthma maintenance medications, and increasing rates of statin initiation for diabetic members when indicated.
SanFrancisco Abbr	The quality of prescriptions is ensured through reviewing applicable HEDIS and MCAS measures, in addition to QI measures determined by SFHP Health Services.
SanJoaquin Abbr	HPSJ has HEDIS measures clinical programs, MCAS measures, NCQA compliance programs, MTM, adherence programs, HEP C etc.
SanMateo Abbr	Access to data and information within Medi-Cal Rx systems, Medi-Cal Rx porvision of exception criteria reports, incorporation of Medi-Cal Rx pharmacy data into quality reporting such as inclusion in HEDIS measure calculations, staff interaction and direct line of access to Medi-Cal Rx's clinical liaison team for communication of any issues and coordination of access.
SantaClaraHealthPlan Abbr	Through reviews, audits, quality improvement projects using HEDIS and MCAS measures to identify gaps in performance standards.
UnitedHealth Abbr	The UnitedHealthcare Community Plan Quality team uses the claims data provided by Medi-CalRx to track HEDIS measure performance. The data informs Gaps in Care, appropriate opioid use, and other quality analysis. Findings are shared in the HQUM and Quality Management Committee meetings.

5. Does your MCO have a documented process (i.e., prior authorization (PA), pharmacist or technician reviews, etc.) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any COD covered under your benefit plan when medically necessary?

Figure 4 - Documented Process in Place for Beneficiaries or Prescribers to Access CODs when Medically Necessary

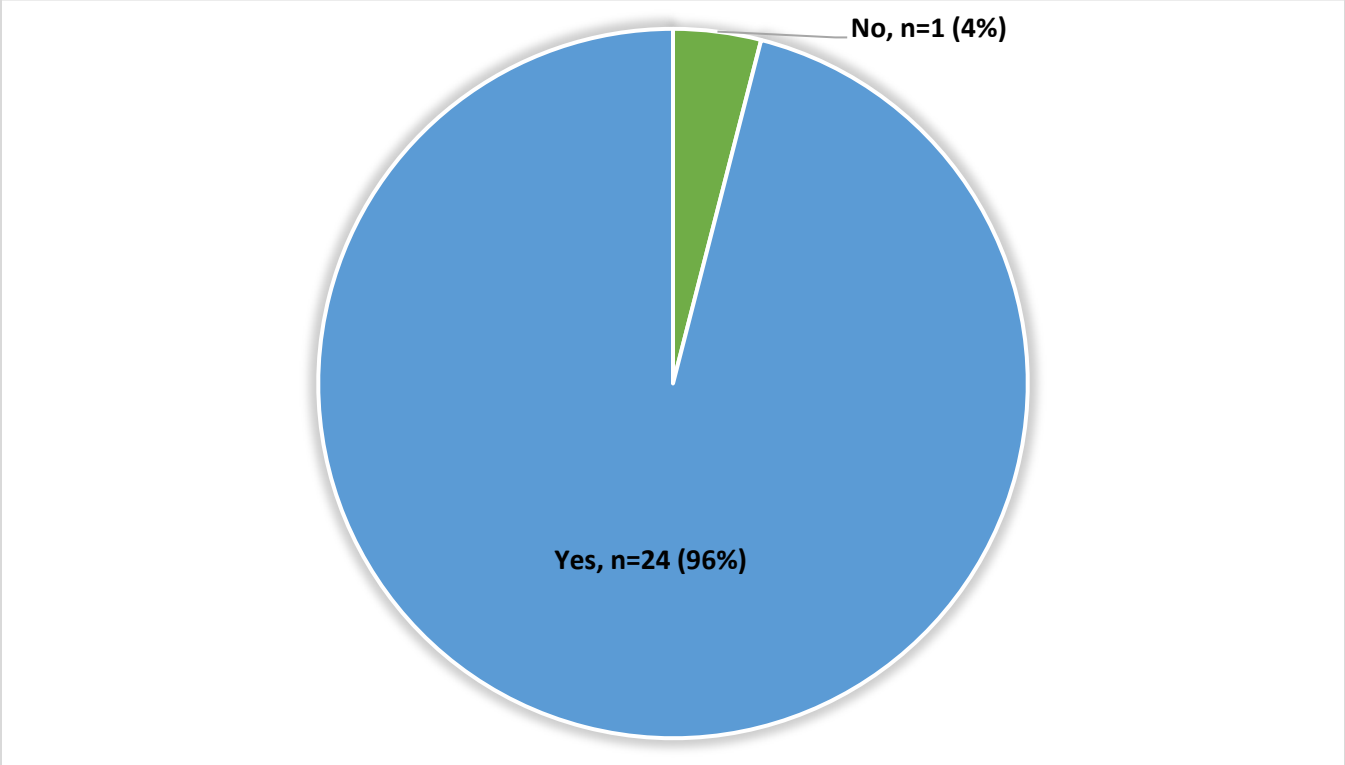

Table 8 - Documented Process in Place for Beneficiaries or Prescribers to Access CODs when Medically Necessary

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	24	96.00%
No	Kaiser Abbr	1	4.00%
State Totals		**25**	**100%**

If “Yes,” what is the PA process?

Table 9 - Explanations of PA Process

MCO Name	Explanation
AetnaBetterHealthCA Abbr	Pharmacy services administered by a provider that require a prior authorization (PA) are routed to the plan's Utilization Management (UM) services. The request is reviewed by Aetna Better Health of California's Utilization Management (UM) team using medical necessity criteria, including but not limited to those from the State/Federal regulatory agencies and internal medical clinical policy bulletins.
AHF Abbr	Providers may request authorization for any outpatient drug billed as a medical and/or institutional claim. These requests are reviewed by our Medical Director and Utilization Management team.
Alameda Abbr	UM(Utilization Management) Department and Pharmacy Department collaborate. Alameda has criteria for PAD PA. Pharmacists reviews based on medical necessity. Medical directors reviews denials and redetermination. Letters are sent to members and providers.
Anthem Abbr	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.
BlueShield Abbr	The beneficiary's physician/physician's agent may contact MCO with a medical necessity statement and any necessary documentation or relevant clinical information to support the request for coverage. After receipt of aforementioned documentation, MCO pharmacy technician reviews request in accordance with MCO's P&T approved coverage criteria and under the supervision of appropriately licensed health professionals. Requests that require further review for determination or a coverage denial are reviewed and completed by MCO DUR pharmacist or physician. Drug coverage determinations for drugs requiring prior authorization or for exceptions will be made in a timely manner, appropriate for the beneficiary's condition, not to exceed 24 hours from receipt of request. The prescribing provider is notified within 24 hours of the receipt of the drug prior authorization request. The beneficiary is notified by telephone or mail of the determination within 24 hours of receipt of a standard or urgent request.

MCO Name	Explanation
CalOptima Abbr	A list of physician-administered drugs (PAD) that require prior authorization is updated quarterly and posted on the CalOptima website. Prior authorizations for PAD are reviewed by MCO pharmacists.
CalViva Abbr	PA pharmacist or tech reviews for outpatient medical drugs administered in a physician's office or outpatient hospital stay. Drugs administered in an ED do not require PA.
CCAH Abbr	MCO reviews prior authorization requests for medical necessity for COD billed as medical claims. Pharmacy technician performs the initial review based on the PA criteria approved by MCO P&T Committee. For any requests not meeting the PA criteria, Pharmacist or Medical Director reviews for medical necessity.
CenCal Abbr	Physician administered drugs billed as a medical claim requiring prior authorization can be submitted by the requesting/servicing provider via CenCal Health Provider Portal (Treatment Authorization Request) or by faxing the CenCal Health Pharmacy Department. Clinical Review for these products is conducted by CenCal Health pharmacists and can be sent for external clinical review for initial consult in accordance with Pharmacy and Therapeutics committee approved medical criteria.
CHW Abbr	PA pharmacist or tech reviews for outpatient medical drugs administered in a physician's office or outpatient hospital stay. Drugs administered in an ED do not require PA.
Community Abbr	Contracted providers submit a COD for review through CHG. The primary review process utilizes Medi-Cal guidelines, along with the Healthcare Management Guidelines (HMG) that are developed by Milliman Care Guidelines (MCG). All information relevant to a member's care is considered when making a decision. Requests for services are reviewed for medical necessity and use the following member-based information when making a utilization management decision: benefit structure, diagnosis, severity, treatment tried/failed or contraindicated, age, comorbidities, complications, progress of treatment, the psychosocial situation, home environment, and urgency.
ContraCosta Abbr	Physician administered drugs and outpatient infusion medications are billed to CCHP as a medical benefit and are reviewed as such under the prior authorization process. These medications are billed using medical coding such as Jcodes.
GoldCoast Abbr	Some pharmacy services that are billed as a medical and/or institutional claim instead of a pharmacy claim will require a Prior Authorization (PA) for review. We have a list of injectable drugs that will require a PA to be submitted for review based on medical necessity. The UM department will review the PA and determine based on clinical guidelines whether the PA meets clinical criteria for approval, require more documentation for further review or be denied based on clinical guidelines.
HealthNetMediCal Abbr	PA pharmacist or tech reviews for outpatient medical drugs administered in a physician's office or outpatient hospital stay. Drugs administered in an ED do not require PA.
Inland Abbr	Pharmacist and pharmacy technician staff at IEHP are involved in the process to review COD medications that are not covered under Medi-Cal Rx. Physician administered drugs are reviewed to make sure beneficiaries have access to these drug when medically necessary.
KernHealthSystems Abbr	Some medical requests have a pharmacy component. The treatment is to administer a drug as opposed to some procedure, surgery, or radiologic therapy. Requests that have an aspect of pharmacotherapy that is administered in physician office, clinic, outpatient hospital, are reviewed by pharmacy for medical

MCO Name	Explanation
	appropriateness. This includes not only the drug selected, but other elements such as formulation, dosage, etc. The request is sent to the plan. Pharmacy reviews. Forwards to the Utilization Management (UM) dept for further action if necessary for determining place/facility, contract issues, etc.
LACARE Abbr	Any medical benefit will be reviewed by our utilization management department for medical necessity.
Molina Abbr	Molina Healthcare maintains a documented process for medical necessity drug prior authorization reviews for physician administered drugs covered as a medical benefit. Upon receipt of a completed request form or completion of an electronic PA, a Molina Health plan licensed designated utilization management clinician will review all criteria. Where state regulations allow, Clinical Pharmacist as well as the Medical Director, may approve requests based on medical necessity. Clinical information for determining medical necessity of coverage may include, but is not limited to: office and hospital records, a history of presenting problem, physical exam results, treatment plans and progress notes, patient psychosocial history, information on consultations with the treating practitioner, evaluations from other healthcare practitioners and providers, operative and pathological reports, rehabilitation evaluations, a printed copy of criteria related to the request, information regarding benefits for services or procedures, information regarding the local delivery system, patient characteristics and information, patient age, home environment-when applicable, information from family members and diagnosis codes.
Partnership Abbr	Partnership HealthPlan uses a documented process for prior authorizations and benefit formulary exceptions as per the PHC MCRP4068 Medical Benefit Medication TAR Policy. The PHC pharmacy department establishes coverage & prior authorization requirements for the PAD benefit. These processes are supported by prior authorization guidelines that are reviewed and approved by PHC's Pharmacy & Therapeutics committee and the Physician Advisory Committee (PAC).
SanFrancisco Abbr	Physician Administered Drugs (PADs) are approved through a Prior Authorization (PA) submitted by the provider to SFHP's Utilization Management (UM) department.
SanJoaquin Abbr	HPSJ reviews coverage policies, and pharmacy policies on a quarterly basis. Any changes to the coverage policies are presented to the HPSJ P&T Committee.
SanMateo Abbr	We follow our prior authorization review process in place for the medical benefit, which provides a channel for access to COD, such as when we determine the drug is coverable through the medical benefit, is medically necessary, and Medi-Cal Rx is unable to provide coverage for the outpatient product. This would generally apply to products that exist as outpatient covered drugs, but may also overlap with medical benefit coverage needs. We would cover based on medical necessity.and whether the requested COD is a Medicaid covered benefit.
SantaClaraHealthPlan Abbr	The Plan maintains a Medical Benefit Drug Prior Authorization Grid which includes physician administered drugs (PADs) that require PA and/or step therapy (ST). In addition, all PADs administered by non-contracted providers require PA. Providers may submit PA requests via fax or electronically through the Plan's provider portal. A pharmacist will review medical benefit drug PA requests within 24 hours for both urgent and standard requests.
UnitedHealth Abbr	UnitedHealthcare Community Plan has a PA process to assist providers in obtaining authorization for use of a medically necessary Physician Administered Drug (PAD) when billed to the medical benefit. PADs requiring prior authorization are identified

MCO Name	Explanation
	in the Prior Authorization and Notification document. The document also instructs providers on how to submit prior authorization requests. The PAD prior authorization requests are reviewed for medical necessity by appropriate clinical review staff.

If "No," please explain why there is not a process for the beneficiary to access a COD when it is medically necessary.

Table 10 - Explanations for Not Having a Process for Beneficiaries to Access CODs when Medically Necessary

MCO Name	Explanation
Kaiser Abbr	As an integrated health care system, when a patient requires access to a covered outpatient drug, Kaiser Permanente physicians will review and deem if the drug is medically necessary.

Section II - Retrospective DUR (RetroDUR)

1. Who reviews and approves the RetroDUR criteria?

Figure 5 - RetroDUR Criteria Approval/Review Source

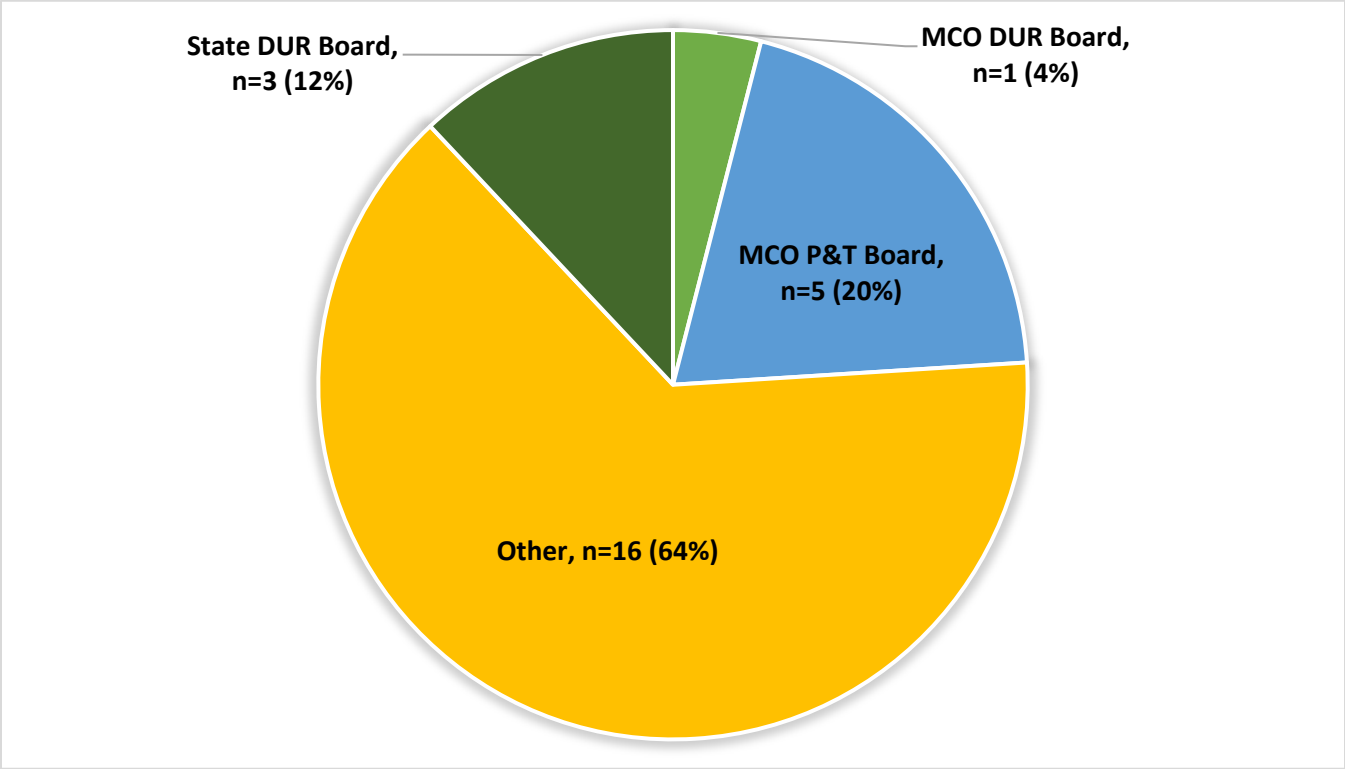

Table 11 - RetroDUR Criteria Approval/Review Source

Response	MCO Names	Count	Percentage
MCO DUR Board	CenCal Abbr	1	4.00%
MCO P&T Board	CalOptima Abbr, ContraCosta Abbr, Inland Abbr, Partnership Abbr, SanJoaquin Abbr	5	20.00%
State DUR Board	AHF Abbr, BlueShield Abbr, Community Abbr	3	12.00%
Other	AetnaBetterHealthCA Abbr, Alameda Abbr, Anthem Abbr, CalViva Abbr, CCAH Abbr, CHW Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, SanFrancisco Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	16	64.00%
State Totals		**25**	**100%**

If "Other," please explain.

Table 12 - "Other" Explanations for RetroDUR Criteria Approval/Review Source

MCO Name	Explanation
AetnaBetterHealthCA Abbr	Criteria are approved by both MCO DUR and State DUR Board.
Alameda Abbr	State DUR Board and Alameda P&T

MCO Name	Explanation
Anthem Abbr	MCO DUR and MCO P&T Board, as well as State DUR Board
CalViva Abbr	MCO DUR Board, State Pharmacy Director, and State DUR Board
CCAH Abbr	State DUR Board and MCO P&T Committee/DUR Board
CHW Abbr	MCO DUR Board, State Pharmacy Director, and State DUR Board
GoldCoast Abbr	RetroDUR activities are reviewed by the GCHP pharmacy staff, P&T committee, and State DUR Board.
HealthNetMediCal Abbr	MCO DUR Board, State Pharmacy Director, and State DUR Board
Kaiser Abbr	MCO P&T Board State DUR Board
KernHealthSystems Abbr	The RetroDUR criteria is primarily reviewed by the KHS DUR Committee. Some CA State DUR Board critieria is shared and incorporated to be implemented at the plan level. It is a combination of the MCO DUR Board and State DUR, with most emphasis on the the MCO Board.
LACARE Abbr	The Navitus Health Solutions P&T Committee and L.A. Care Health Plan PQOC Committee. State DUR Board
Molina Abbr	Collaboration between the MCO DUR Board, MCO P&T Board, MCO pharmacy manager
SanFrancisco Abbr	Both MCO P&T and DUR Board (one board provides both)
SanMateo Abbr	Retrospective criteria recommendations are provided by the State DUR Board, developed jointly by UCSF and DHCS. Final decisions to use RetroDUR criteria are made by the MCO (either by the MCO's P&T Committee, plan internal clinical workgroups, and/or plan/PBM work groups).
SantaClaraHealthPlan Abbr	State DUR Board and the Plan's P&T Committee. RetroDUR activities and interventions are presented to the Plan's P&T Committee for review.
UnitedHealth Abbr	UnitedHealthcare Community Plan works with the State DUR Board in executing required State DUR programs. For internal UHC Community Plan RDUR programs, we utilize OptumRx as our vendor for RDUR programs. Recommendations for additions or changes to the OptumRx RDUR program are made by both OptumRx and UHC Community Plan and are presented to the UHC DUR Board. OptumRx RDUR programs are reviewed by the UHC Community Plan Board annually and they make the final decision on RDUR program enrollment.

2. Summary 1 - RetroDUR Educational Outreach

RetroDUR Educational Outreach Summary is a report on retrospective profile screening and educational opportunities during the fiscal year reported. This report 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 13 - RetroDUR Educational Outreach

MCO Name	RetroDUR Educational Outreach Summary
AetnaBetterHealthCA Abbr	Aetna's 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.

MCO Name	RetroDUR Educational Outreach Summary
	Interventions and educational materials are developed for providers (Prescriber and pharmacy) and members. 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 DUR Board was to conduct outreach programs targeting each of four categories over-utilization, under-utilization, patient safety, and fraud/waste/abuse issue. Aetna has completed the following educational outreach programs in FFY22: Program Name: Valproic Acid and Fetal Health Description: Educate providers on the risks of valproic acid in persons of child bearing potential and increase the use of contraceptives in this group. Goals/Objectives: 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. Program Name: Benzo + Opioids Description: Educate the prescribers of chronic benzodiazepines the risks associated with them in members concurrently taking opioids. Goals/Objectives: Decrease the use of benzodiazepines in members taking opioids. Actions: Targeted provider faxes. Program Name: Antipsychotics and Serotonergic Antidepressants in Children Description: Educate providers by highlighting risks of concomitant medication utilization (AP + AD) and identifying members affected. Goals/Objectives: Educate providers on the 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. Actions: Targeted provider fax education; Telephonic follow-up PRN. Program Name: DM Duplicate Therapy Description: Educate providers on members receiving duplicative DM medications. Goals/Objectives: Decrease duplicate therapy in members using multiple brand antidiabetic medications or insulins Actions: Provider telephonic outreach by clinical pharmacist. Program Name: COPD Duplicate Therapy Description: Educate providers on members receiving duplicative COPD medications. Goals/Objectives: Decrease duplicate therapy in members using multiple COPD inhalers. Actions: Provider telephonic outreach by clinical pharmacist.

MCO Name	RetroDUR Educational Outreach Summary
	Program Name: 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. Goals/Objectives: 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. 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.
AHF Abbr	Educational bulletins prepared by Medi-Cal Rx are distributed to provider and pharmacy networks. MCO creates provider newsletters and educational opportunities including continuous medical education (CME) programs.
Alameda Abbr	Alameda uses the educational bulletin prepared by Medi-Cal RX and Global DUR committee to provide clinical updates to providers.
Anthem Abbr	MCPs coordinate Education and Outreach activities along with Global DUR Board and Medi-Cal Rx provider communication updates. Anthem distributes provider targeted communications for Medi-Cal Rx education and outreach via our provider portal, email blasts and/or newsletters. Providers in Anthem's network are also re-directed to Medi-Cal Rx website for educational resources such as contracted drug lists, manuals, etc.
BlueShield Abbr	The Medi-Cal Provider Education Bulletin process shares Medi-Cal Rx DUR Educational Articles with providers throughout the year. Below are links to pdfs of some of those articles and bulletins as well as the Medi-Cal Rx sites where they can be found: https://medi-calrx.dhcs.ca.gov/provider/drug-utilization-review/ https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/dur/educational-articles/dured_Professional_Organizations_Push_for_Recall_of_Buprenorphine_Dental_Warning.pdf https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/dur/educational-articles/dured_31532_Improving_the_Quality_of_Care_Legislative_Impact_on_the_Use_of_Naloxone.pdf https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/dur/educational-articles/dured_Submitting_Quality_Data_to_California_Immunization_Registry.pdf
CalOptima Abbr	Pharmacist Interventions Targeting Concurrent Opioid and Benzodiazepine Use. Targeted members over 17 years of age with concomitant opioid and benzodiazepine prescriptions. Members were separated into the naloxone or

MCO Name	RetroDUR Educational Outreach Summary
	benzodiazepine intervention groups by the pharmacist. Provider interventions consisted of a fax with outreach calls and clarification of responses as needed. o Naloxone intervention: No claim for naloxone in previous 12 months. o Benzodiazepine intervention: Diagnosis of anxiety, panic disorder, or PTSD with no pharmacy claim for a benzodiazepine alternative for that indication in the previous 12 months. There was a statistically significant association between the naloxone intervention and increase in naloxone prescribing (30 out of 75 members; p<0.0001), opioid tapering (9 out of 75 members; p=0.0032), and benzodiazepine tapering (10 out of 75 members; p=0.0015) in COB. There was a statistically significant association between the benzodiazepine intervention and benzodiazepine tapering (7 out of 31 members; p=0.0113) but no statistically significant association between the intervention and benzodiazepine alternative prescribing (3 out of 31 members; p=0.2394) in COB. Pharmacist-Driven Interventions on Pediatric Psychotropic Polypharmacy. Targeted members aged 0 to 18 years old who had concurrent use of two drugs in the same psychotropic drug class and/or exceeded the suggested number of total psychotropic medications by age per the DHCS Prescribing Standards. Pediatric members who met the criteria for polypharmacy per the DHCS Prescribing Standards based on their psychotropic pharmacy claims with remaining medication supply were classified in Group 1 or Group 2. Group 1: All pediatric members who were not in foster care were included in a general provider fax intervention. Provider outreach calls occurred as needed. Group 2: Pediatric members in foster care were included in a comprehensive medication review (CMR) provider fax intervention with specific clinical recommendations. Provider outreach call occurred as needed. There was a statistically significant association between the intervention and decrease in psychotropic polypharmacy for both Group 1 (49% decrease, p<0.0001) and Group 2 (57% decrease, p=0.0019). Prescriber Education: Opioid Prescribing Quality Measure Updates " January 2022. This educational bulletin summarizes quality measures involving use of opioids at high doses, use of opioids from multiple providers and/or pharmacies, and risk of continued opioid use. Morphine Milligram Equivalent (MME) conversion factors were also provided. Follow-Up Care for Children Prescribed ADHD Medication " September 2022 This educational bulletin summarizes the HEDIS measure for follow-up care for children newly prescribed ADHD medications within 30 days and nine months of prescription dispensing. This measure assesses the percentage of children between 6 and 12 years of age who were newly prescribed an ADHD medication and received at least 3 follow-up visits with a practitioner with prescribing authority within a 10-month period.
CalViva Abbr	Polypharmacy Prescribers of members taking 8+ medications per quarter are sent a letter with recommendations to resolve identified drug related problems. Pharmacists call prescribers to resolve these drug related problems such as therapeutic duplication, deprescribing, drug-age/drug interactions and fraud waste and abuse.

MCO Name	RetroDUR Educational Outreach Summary
	Notifications with successful outcomes: Deprescribing - 1177 Drug-Age Interaction " 108 DDI " 572 FWA " 681 Opportunity to reduce cost " 251 Dup therapy - 1140 rDUR Program RxCellent CareTM program is used as a DUR rules engine to identify drug related problems, send provider intervention letters and evaluate outcomes Notifications with successful outcomes: Deprescribing " 9 Drug Age Interaction " 3 DDI " 6 FWA " 120 Dup therapy " 4 Health Benefit Ratio (HBR): Cardiac + Diabetes Our objective for this HBR clinical program is to review pharmacy claims for Chronic Care PHM members (All LOB) and perform outreach to those members with 1 or more ER/IP visits, non-adherent to medications, or both. Members are diagnosed with any of the following conditions: Type 2 Diabetes, Coronary Artery Disease, or Hypertension. The goals are to improve medication adherence, clinical outcomes (A1C reduction), and member experience, and to reduce ER/IP utilization. In 2022 our Population Health Pharmacy was able to perform outreach to 1,846 members total who were flagged for non-adherence and provide education/counseling to encourage compliance. Of those we were able to reach 449 of the members and called 38 pharmacies to assist with any medication related issues. We also contacted 67 providers offices to recommend cardiac bundle therapy, obtain refills for our members, recommend additional anti-diabetic agents and/or insulin therapy for those members with uncontrolled diabetes, and any other issues that arose. The most common barriers to adherence and interventions performed were the following: Common Barriers to Adherence: Lack of understanding therapy, lack of refills/calling in refills, Provider issues, Forgetfulness, Literacy and language barriers, Lack of counseling at pharmacy, Transportation, food among other SDOH needs. Common Interventions: Member and provider education, Faxing providers for cardiac bundle therapy, Calling pharmacy to refill medications, Pill boxes and calendar reminders as well as text reminders from pharmacy, Referral to disease and case management, Transportation line and using the find help provider portal for medically tailored meal referrals and immediate member assistance. Each

MCO Name	RetroDUR Educational Outreach Summary
	member is a unique case. We make sure to address their SDoH needs as well as their pharmacy/healthcare needs and refer to the appropriate departments. Our Health Plan's Opioid and Substance Use Disorder Program offers innovative and creative ways to curtail the opioid epidemic. We perform proactive review of addictive medications and dangerous combinations of drugs including onset and duration, promote seamless referrals to Medication Assisted Treatment (MAT) including our partnership with Bright Heart Health, improve member outcomes by preventing adverse drug events; create digital repository to follow members with Substance Use Disorder to ensure long-term follow up and recovery, continuously perform prospective and retrospective review, and proactively support at-risk members. We also incorporate a predictive analytics algorithm HALO (Health Assistance, Linkage, and Outreach) (formerly known as ORCA or Opioid Risk Classification Algorithm) to predict early signs of undiagnosed opioid misuse among our members " for early engagement, outreach, to manage/coordinate care for members at risk for or with a substance use disorder (SUD) across the prevention to recovery continuum. The goals of the program are to decrease the number of new opioid prescription starts, identify members on high-dose opioids and other risky medications, increase awareness and access to treatment for opioid use disorder, and prevent overdose. Target Population: Members taking high dose opioids and dangerous combinations of medications Referrals from Case Management, Clinical Pharmacy, Social Work, and other Population Health Teams Self-referrals from members seeking Substance Use Disorder Treatment Member Inclusion Criteria: o High morphine milligram equivalent (MME >120) o Drug combination of opioids, benzodiazepines and muscle relaxants o More than 3 providers prescribing opioids in one month Outcomes: Total # members starting October 2021 (data ending September 2022) # called 230, interventions made 73
CCAH Abbr	1. Concurrent Opioids and Benzodiazepines Retrospective DUR was performed on members who received opioids and benzodiazepines concurrently. Various analyses were performed to identify high-risk members and unsafe prescribing patterns. It was revealed that only 15% of the members were co-prescribed naloxone. The following interventions were done to improve the appropriate and effective management of patients on potentially harmful combinations of opioids and benzodiazepines, and to encourage naloxone utilization. - Educational article published in provider newsletter and bulletin: The article included a general safety alert on risks of concurrent use of opioids and

MCO Name	RetroDUR Educational Outreach Summary
	benzodiazepines, information on benzodiazepine tapering, and importance of naloxone co-prescribing for high-risk patients. - Provider letter encouraging naloxone co-prescribing: The letter was sent to 35 providers who had seven or more members on concurrent opioids and benzodiazepines, but co-prescribed naloxone to less than 50% of them. - Provider letter with information on benzodiazepine taper: The letter was sent to 44 prescribers with three or more members with concurrent opioids and benzodiazepines. - Educational article for members posted on MCO website: The article was a general safety alert on risks of taking opioid and benzodiazepine concurrently and on the importance of naloxone for opioid overdose. 2. Concurrent Opioids and Antipsychotics Retrospective DUR was performed on members who received opioids and antipsychotics concurrently. Member age, members with multiple opioids and/or multiple opioid prescribers, types of opioids as well as morphine milligram equivalents (MME) dosages were analyzed. Naloxone utilization was noted for only 24% of concurrent users. - Educational article published in provider newsletter and bulletin: The article educated providers about risks associated with concurrent use of opioids and antipsychotics, the importance of co-prescribing naloxone when appropriate, and CDC recommendations for opioid prescribing when combined use is warranted. 3. Inappropriate Use of Ivermectin for COVID-19 Treatment or Prevention MCO investigated the increase in ivermectin prescriptions in August 2021. Retrospective reports were generated and evaluated monthly from July 2021 to March 2022. The following concerning patterns with ivermectin prescriptions were identified and flagged: unusually large quantities, monthly refills implying chronic use, prescriptions by out-of-state and non-contracted providers, and prescribing by specialists outside of their usual practice. Additionally, members' history was reviewed for concurrent use of azithromycin, hydroxychloroquine, colchicine, and fluvoxamine that were often co-prescribed experimentally for COVID-19. To combat inappropriate use of ivermectin for COVID-19, the following actions were taken: - Educational article sent via fax blast to all providers: The article informed prescribers that ivermectin is neither approved nor authorized by the FDA and CDC to treat or prevent COVID-19. - Provider letter cautioning against the use of ivermectin for COVID-19: The letter was sent to 40 providers with questionable prescribing patterns. - Educational article for members on MCO website: The article cautioning against using ivermectin for treatment or prevention of COVID-19. - Outreach by care management to members with monthly prescriptions of ivermectin. - Referred identified prescribers to Special Investigations Unit, DHCS, and Quality Improvement. - Implemented prior authorization requirement for off-label prescribers.
CenCal Abbr	1. Naloxone Retrospective DUR Provider Outreach -Criteria: Identified members who received a 30-day supply of a high dose opioid in the previous 3-months, which may indicate an increased risk for overdose.

MCO Name	RetroDUR Educational Outreach Summary
	Members were selected for review if they did not receive a naloxone prescription in the previous 12-months. -Identified Member Provider Outreach: Each provider with an identified member received a letter with the background of the retrospective DUR, access to a list of their members who met the criteria, and a link to the naloxone DUR educational article on the CenCal Health Pharmacy webpage. An insert with naloxone distribution resources was also provided in the letter. The insert provided options for members to receive Naloxone outside of the pharmacy benefit, which included delivery of the Naloxone to their home. The insert was provided to increase the access of Naloxone for CenCal Health members and provide alternatives to the traditional pharmacy setting. -DUR Report Period: 03/01/2022 - 6/30/2022 = 405 members identified for provider outreach -Follow-up period: 07/01/2022 - 12/31/2022 = 108 members from the DUR reporting period did not meet the criteria, giving a 27% success rate for the outreach 2. Hypertension Medication DUR Campaign -Criteria: Identified members aged 18-65 who are diagnosed with hypertension and who have not filled their hypertension medication in the past 4 months. -Identified Member Provider Outreach: Each PCP provider with an identified member received a letter giving background on the retrospective DUR, and a list of their members that met the criteria. All the provider letters contained an informational insert promoting the coverage of blood pressure monitors through the pharmacy benefit. -DUR Report Period: 05/01/22 to 8/31/22 = 3,550 unique members identified for provider outreach -Follow-up period: 12/01/22 to 03/31/23 = 756 members from the DUR reporting period did not meet the criteria, giving a 21% success rate. 3. 2021 Immunization Updates COVID-19, Influenza, and Meningococcal Disease (Educational Article) - Summary: Each year, the California Medi-Cal Drug Use Review (DUR) program issues an annual summary of updates on immunization guidelines, products, and/or research in collaboration with the California Department of Public Health (CDPH) Immunization Branch. -Recommendations: Information on the vaccines currently available to prevent infection with SARs-CoV2, the virus that causes coronavirus disease 2019 (COVID-19). Strategies for improving (COVID-19) vaccination rates and vaccine confidence. Updated advisory committee on Immunization Practices (ACIP) recommendations for COVID-19, influenza, and meningococcal disease vaccines. 4. Improving the Quality-of-Care: Legislative Impact on the Use of Naloxone (Educational Article) -Summary: The age-adjusted opioid-related overdose death rate in California has significantly increased over the last two years, driven primarily by highly potent opioids such as illicitly manufactured fentanyl. Naloxone, a potentially life-saving

MCO Name	RetroDUR Educational Outreach Summary
	medication for opioid overdose, may be offered to individuals at risk for opioid overdose. -Recommendations: Talk to patients, caregivers, and the community about the changing illicit drug supply and risks for overdose and exposure to highly potent opioids such as illicitly manufactured fentanyl. Prescribe naloxone to individuals at risk for opioid overdose, such as those with a prior history of overdose, those with opioid use disorder, and individuals using illicit opioids and other drugs that might be mixed with illicitly manufactured fentanyl. Naloxone prescriptions can also be written directly to third party individuals who may be in a position to witness and assist a person at risk of an opioid overdose. For more information and resources about naloxone, including patient-specific materials, practice guidelines, and conversation tips, visit the Prescribe to Prevent website and review the Opioid Overdose Prevention Toolkit developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). 5. Professional Organizations Push for Recall of Buprenorphine Dental Warning (Educational Article) -Summary: The American Society of Addiction Medicine (ASAM) and ten other health professional associations called for the FDA to immediately and fully retract their Drug Safety Communication on dental problems associated with buprenorphine, which was based on 305 reported cases of dental problems since 2002. The authors note that nearly 2.4 million Americans took buprenorphine in 2019 alone (and many more than that since 2002), so it would not be possible to conclude a causal relationship between exposure to buprenorphine and dental pain, which more than 40% of Americans have experienced during the past year. -Recommendations: With over a million opioid overdoses since 1999, buprenorphine is an effective yet still underutilized tool in treating opioid use disorder (OUD), reducing mortality from opioid use disorder by over 50%. Health care providers can help alleviate patient concerns about dental problems by affirming the FDA recommendations that the benefits of buprenorphine clearly outweigh potential risks. 6. Submitting Quality Data to California Immunization Registry (educational Article) -Summary: The California Immunization Registry (CAIR2) is a secure web-based platform that allows providers and organizations to track patient immunization and tuberculosis records. The CAIR2 aims to improve vaccination rates, minimize missed immunization opportunities, and prevent administration of duplicate immunizations. Patient-specific and aggregate reports in the CAIR2 system allow for accurate assessment of vaccination coverage rates in California. Additionally, the CAIR2 provides schools and childcare facilities with accurate and complete records that are required for entry. -Recommendations: To ensure that CAIR2 contains only high-quality data, CDPH recommends the following: Train all staff to enter complete demographic and immunization information accurately into the EHR. Contact the EHR vendor as soon as possible to resolve any data accuracy or integrity issues. Configure the EHR interface properly for easy and accurate use. Drop-down menus are useful but can result in improper selection of vaccine. Implement an ongoing data monitoring process to monitor data exchange submissions via the EHR or using the Check Status' screen in CAIR2. Assign primary responsibility for monitoring to a staff member and communicate with EHR vendor if message flow is interrupted or

MCO Name	RetroDUR Educational Outreach Summary
	excess errors occur. Periodically compare selected patient records in the EHR with the same patient records in CAIR2 to make sure the information matches.
CHW Abbr	Polypharmacy Prescribers of members taking 8+ medications per quarter are sent a letter with recommendations to resolve identified drug related problems. Pharmacists call prescribers to resolve these drug related problems such as therapeutic duplication, deprescribing, drug-age/drug interactions and fraud waste and abuse. Notifications with successful outcomes: Deprescribing " 851 Drug-Age Interaction " 89 DDI " 620 FWA " 1244 Opportunity to reduce cost " 99 Dup therapy " 1509 rDUR Program RxCellent Care program is used as a DUR rules engine to identify drug related problems, send provider intervention letters and evaluate outcomes. Notifications with successful outcomes: Deprescribing " 3 FWA " 1083 Dup therapy " 2 Our Health Plan's Opioid and Substance Use Disorder Program offers innovative and creative ways to curtail the opioid epidemic. We perform proactive review of addictive medications and dangerous combinations of drugs including onset and duration, promote seamless referrals to Medication Assisted Treatment (MAT) including our partnership with Bright Heart Health, improve member outcomes by preventing adverse drug events; create digital repository to follow members with Substance Use Disorder to ensure long-term follow up and recovery, continuously perform prospective and retrospective review, and proactively support at-risk members. We also incorporate a predictive analytics algorithm HALO (Health Assistance, Linkage, and Outreach) (formerly known as ORCA or Opioid Risk Classification Algorithm) to predict early signs of undiagnosed opioid misuse among our members " for early engagement, outreach, to manage/coordinate care for members at risk for or with a substance use disorder (SUD) across the prevention to recovery continuum. The goals of the program are to decrease the number of new opioid prescription starts, identify members on high-dose opioids and other risky medications, increase awareness and access to treatment for opioid use disorder, and prevent overdose. Target Population: Members taking high dose opioids and dangerous combinations of medications

MCO Name	RetroDUR Educational Outreach Summary
	Referrals from Case Management, Clinical Pharmacy, Social Work, and other Population Health Teams Self-referrals from members seeking Substance Use Disorder Treatment Member Inclusion Criteria: o High morphine milligram equivalent (MME >120) o Drug combination of opioids, benzodiazepines and muscle relaxants o More than 3 providers prescribing opioids in one month Outcomes: Total # members starting October 2021 (data ending September 2022) # called 410, interventions made 110 Health Benefit Ratio (HBR): Cardiac + Diabetes Our objective for this HBR clinical program is to review pharmacy claims for Chronic Care PHM members (All LOB) and perform outreach to those members with 1 or more ER/IP visits, non-adherent to medications, or both. Members are diagnosed with any of the following conditions: Type 2 Diabetes, Coronary Artery Disease, or Hypertension. The goals are to improve medication adherence, clinical outcomes (A1C reduction), and member experience, and to reduce ER/IP utilization. In 2022 our Population Health Pharmacy was able to perform outreach to 2,030 members total who were flagged for non-adherence and provide education/counseling to encourage compliance. Of those we were able to reach 394 of the members and called 10 pharmacies to assist with any medication related issues. We also contacted 44 providers offices to recommend cardiac bundle therapy, obtain refills for our members, recommend additional anti-diabetic agents and/or insulin therapy for those members with uncontrolled diabetes, and any other issues that arose. The most common barriers to adherence and interventions performed were the following: Common Barriers to Adherence: Lack of understanding therapy, lack of refills/calling in refills, Provider issues, Forgetfulness, Literacy and language barriers, Lack of counseling at pharmacy, Transportation, food among other SDOH needs. Common Interventions: Member and provider education, Faxing providers for cardiac bundle therapy, Calling pharmacy to refill medications, Pill boxes and calendar reminders as well as text reminders from pharmacy, Referral to disease and case management, Transportation line and using the find help provider portal for medically tailored meal referrals and immediate member assistance. Each member is a unique case. We make sure to address their SDoH needs as well as their pharmacy/healthcare needs and refer to the appropriate departments.
Community Abbr	CHG RetroDUR educational outreach summary includes company and government updates, guidelines, recommendations, improved programs and improved access to care. We provide information that will promote improved care of our members. This includes but not limited to: 1) Continuity and promotion of flu and Covid-19 vaccinations

MCO Name	RetroDUR Educational Outreach Summary
	2) Community support for reducing high-level utilization: Asthma remediation and medically tailored meals 3) Cancer screening 4) Promoting Health Behaviors - Medication non-adherence 5) Blood lead screening 6) Buprenorphine benefits, prescribing, and DEA X-Waiver 7) Diabetes clinical program to help determine use of Continuours Glucose Monitor 8) Blood pressure monitors - information on covered BP monitors and requirements for coverage 9) Access to care information for members with substance abuse disorders 10) Emergency preparedness guidance on delivering services during emergencies 11) Ways to improve health: a. Controlling weight b. Health assessment that provides insight to potential treatments and/or practices to encourage a healthier life. c. Vaccine schedules for kids and teens d. Dental schedules for babies e. Education on common diseases, at risk populations, and their treatments 12) Clinical Guidelines and Recommendations a. Diabetes b. Hypertension c. Asthma d. COPD Guideline e. Congestive Heart Failure f. Depression
ContraCosta Abbr	Educational bulletins prepared by Medi-Cal Rx are reviewed at P&T committee and are regularly posted on the CCHP website. Provider bulletins, which are sent directly to the providers also contain educational bulletin information, updates to guidelines, and changes to pharmacy practice based on RetroDUR screenings.
GoldCoast Abbr	The plan conducted the following outreach activities during Federal Fiscal Year 2022. Educational Outreach Activities: 1. Pharmacy Newsletters: a. Dates: December 2021, March 2022, June 2022 b. Topics: Medi-Cal Rx Update, FDA New Drug Approvals, FDA Safety Labeling Changes, Drug Shortages, and FDA Drug Safety Communications 2. Provider Updates July 18, 2022: Medi-Cal Rx: Reinstatement of Edits June 9, 2022: Psychiatric Education Capacity Expansion (PECE) Psychiatry Residency and Psychiatric Mental Health Nurse Practitioner Grant Webinars June 8, 2022: All-Plan Letter 22-022, Alternative Format Selection for Members with Visual Impairment March 21, 2022: Provider Training Opportunity: Lead Poisoning Prevention in Children February 24, 2022: Postpartum Care Extension Program January 25, 2022: COVID-19 Vaccine Member Incentive Program

MCO Name	RetroDUR Educational Outreach Summary
	January 13, 2022: Managed Care Accountability Set (MCAS) Measurement Year 2021: Data Collection Effort November 17, 2021: Medi-Cal Rx Communications October 27, 2021: Adverse Childhood Experiences (ACEs) Virtual Lecture Series October 25, 2021: National Lead Poisoning Prevention Week Provider Operations Bulletins: a. Dates: November 2021, February 2022, April 2022, June 2022, August 2022 b. Topics: Medi-Cal Rx updates November 2021 " Blood Pressure Cuffs: A GCHP Covered Benefit, Great American Smokeout, New Member Incentive Program Flyer, Help Gold Coast Health Plan Members with Asthma, Talk to Youth About E-Cigarette Use, November: Diabetes Awareness Month February 2022 " Buprenorphine FDA Safety Communication, February American Heart Month, Chronic Disease Self-Management Program (CDSMP), Help Members with Asthma April 2022 " Tobacco Cessation and Counseling, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT), Tobacco Cessation " Kick It California, Smile California " Med-Cal Dental, Fluoride Varnish, Women's Health June 2022 " June: Men's Health Month, Student Behavioral Health Incentive Program (SBHIP) August 2022 " Alcohol and Drug Screening, National Immunization Awareness Month 2022, Lead Poisoning Prevention, Chronic Disease Self-Management Program (CDSMP) 3. Medi-Cal DUR Board Educational Bulletins: a) January 2022: FDA Drug Safety Communication, Jan. 12, 2022: FDA warns about dental problems with buprenorphine medicines dissolved in the mouth to treat opioid use disorder and pain b) February 2022: Professional Organizations Push for Recall of Buprenorphine Dental Warning c) March 2022: Improving the Quality of Care: Legislative Impact on the Use of Naloxone d) May 2022: Submitting Quality Data to the California Immunization Registry (CAIR2)
HealthNetMediCal Abbr	Polypharmacy Prescribers of members taking 8+ medications per quarter are sent a letter with recommendations to resolve identified drug related problems. Pharmacists call prescribers to resolve these drug related problems such as therapeutic duplication, deprescribing, drug-age/drug interactions and fraud waste and abuse. Notifications with successful outcomes Deprescribing - 6301

MCO Name	RetroDUR Educational Outreach Summary
	Drug-Age Interaction " 1121 DDI " 4113 FWA " 4854 Opportunity to reduce cost " 776 Dup therapy " 9899 rDUR Program RxCellent CareTM program is used as a DUR rules engine to identify drug related problems, send provider intervention letters and evaluate outcomes. Notifications with successful outcomes Deprescribing " 47 Drug-Age Interaction " 9 DDI " 33 FWA " 1013 Opportunity to reduce cost " 5 Dup therapy " 89 Our Health Plan's Opioid and Substance Use Disorder Program offers innovative and creative ways to curtail the opioid epidemic. We perform proactive review of addictive medications and dangerous combinations of drugs including onset and duration, promote seamless referrals to Medication Assisted Treatment (MAT) including our partnership with Bright Heart Health, improve member outcomes by preventing adverse drug events; create digital repository to follow members with Substance Use Disorder to ensure long-term follow up and recovery, continuously perform prospective and retrospective review, and proactively support at-risk members. We also incorporate a predictive analytics algorithm HALO (Health Assistance, Linkage, and Outreach) (formerly known as ORCA or Opioid Risk Classification Algorithm) to predict early signs of undiagnosed opioid misuse among our members " for early engagement, outreach, to manage/coordinate care for members at risk for or with a substance use disorder (SUD) across the prevention to recovery continuum. The goals of the program are to decrease the number of new opioid prescription starts, identify members on high-dose opioids and other risky medications, increase awareness and access to treatment for opioid use disorder, and prevent overdose. Target Population: Members taking high dose opioids and dangerous combinations of medications Referrals from Case Management, Clinical Pharmacy, Social Work, and other Population Health Teams Self-referrals from members seeking Substance Use Disorder Treatment Member Inclusion Criteria: o High morphine milligram equivalent (MME >120) o Drug combination of opioids, benzodiazepines and muscle relaxants o More than 3 providers prescribing opioids in one month

MCO Name	RetroDUR Educational Outreach Summary
	Outcomes: Total # members starting October 2021 (data ending September 2022) # called 894, interventions made 253 Health Benefit Ratio (HBR): Cardiac + Diabetes Our objective for this HBR clinical program is to review pharmacy claims for Chronic Care PHM members (All LOB) and perform outreach to those members with 1 or more ER/IP visits, non-adherent to medications, or both. Members are diagnosed with any of the following conditions: Type 2 Diabetes, Coronary Artery Disease, or Hypertension. The goals are to improve medication adherence, clinical outcomes (A1C reduction), and member experience, and to reduce ER/IP utilization. In 2022 our Population Health Pharmacy was able to perform outreach to 4,411 members total who were flagged for non-adherence and provide education/counseling to encourage compliance. Of those we were able to reach 1,000 of the members and called 48 pharmacies to assist with any medication related issues. We also contacted 129 providers offices to recommend cardiac bundle therapy, obtain refills for our members, recommend additional anti-diabetic agents and/or insulin therapy for those members with uncontrolled diabetes, and any other issues that arose. The most common barriers to adherence and interventions performed were the following: Common Barriers to Adherence: Lack of understanding therapy, lack of refills/calling in refills, Provider issues, Forgetfulness, Literacy and language barriers, Lack of counseling at pharmacy, Transportation, food among other SDOH needs. Common Interventions: Member and provider education, Faxing providers for cardiac bundle therapy, Calling pharmacy to refill medications, Pill boxes and calendar reminders as well as text reminders from pharmacy, Referral to disease and case management, Transportation line and using the find help provider portal for medically tailored meal referrals and immediate member assistance. Each member is a unique case. We make sure to address their SDoH needs as well as their pharmacy/healthcare needs and refer to the appropriate departments.
Inland Abbr	Drug Utilization Review (DUR) 1. Opioid Utilization i. Time frame: 09/01/2021 to 12/31/2021 ii. Intervention details: Targeted Medication Review (TMR) to recommend naloxone prescribing for beneficiaries at risk for opioid overdose as well as assess appropriateness of opioid regimens. iii. Result: 4.4% decrease in number of beneficiaries with MME >90, 18.5% decrease in members with concurrent use of opioid and benzodiazepine, 1.7% increase in members with concurrent use of opioid and gabapentin/pregabalin, and 8.6% decrease members with concurrent use of opioid and tramadol.

MCO Name	RetroDUR Educational Outreach Summary
	2. Controlling Blood Pressure (CBP) in African American Patient Population (IPA Focus) i. Time frame: 1/01/2022 to 2/23/2022 ii. Intervention: Targeted Medication Review (TMR) to recommend 90 day refill and adding thiazide diuretic or calcium channel blocking agent if missing therapy iii. Result: Outreached providers for a total of 222 beneficiaries. CBP rate improved from 17.84% baseline to 27.84% for the patient population over 3 months. Increased number of beneficiaries to use thiazide or calcium channel blocking agent from 35% to 50%. 3. Asthma Medication Ratio (AMR) i. Time frame: 4/22/2022 to 5/20/2022 ii. Intervention: Targeted Medication Review (TMR) to review beneficiary use of controller asthma medications iii. Results: Outreached providers for a total of 708 beneficiaries. Percent of members adherent to AMR rate increased from 14.19% to 23.34%.
Kaiser Abbr	Retro DUR educational opportunities include: Opioid utilization MED, Opioid drug trends, Opioid utilization in combination with benzodiazepine, Poly-ACH Agents " concurrent use of >=2 unique anticholinergic medications, Poly-CNS Agents " concurrent use of >=3 unique central nervous system medications, Multiple sclerosis patients on preferred highly effective disease modifying therapy.
KernHealthSystems Abbr	With the transition of the pharmacy benefit from the managed care plan to the state of California, many traditional DUR outreach efforts were modified and types of problems or issues shifted to more basic claims processing in nature. Regardless, KHS still performed DUR activities and outreach. KHS passed DHCS Educational Articles to the community providers and pharmacies. KHS also ran reports on their own and shared those as needed. With the transition of the pharmacy benefit from the managed care plans to the State of California, a number of the communications involved sharing basic DUR errors that were not previously experienced. Letters were sent to providers regarding duplication of therapy/refill too soon. Outreach to pharmacies of the same occurred via phone calls. Members were also contacted via phone, when instances of therapeutic duplication or drug interactions were identified. With the transition, DUR edits and PA requirements were relaxed. This resulted in a spike in the therapeutic duplication and drug interaction cases. It was widespread, not just limited to certain drugs or drug types.
LACARE Abbr	RETROSPECTIVE DUR EDUCATIONAL OUTREACH SUMMARY 2022 L.A. Care Health Plan provides educational bulletins to our providers based on DHCS Medi-Cal DUR Educational Articles, and Medi-Cal Global DUR Board required actions for educational bulletins. The educational articles are disseminated to providers via The Pulse, an electronic newsletter for L.A. Care's providers. The following articles were distributed to the providers: -Submitting Quality Data to the California Immunization Registry (CAIR2) - May 2022 -Improving the Quality of Care: Legislative Impact on the Use of Naloxone - March 2022 -Professional Organizations Push for Recall of Buprenorphine Dental Warning - February 2022

MCO Name	RetroDUR Educational Outreach Summary
	In addition, L.A. Care Health Plan continues to provide ongoing educational outreach for providers regarding retrospective drug utilization problems in order to improve medication use. L.A. Care Health Plan sends letters to prescribers that are identified in the RDUR program every 4 months to improve prescribing and dispensing practices, along with improving the well-being of our members. 1. Multiple Prescribers " Identifies patients who received prescriptions from 7 or more unique prescribers in the last four months. 2. Controlled Substance Monitoring " Identifies patients with potential overuse of controlled-medication, and who visit an unusually high number of prescribers, pharmacies and prescriptions for controlled medications during the last four months. 3. Duplicate Therapy " Identifies patients using 2 or more drugs in the same therapeutic class consistently during the intervention timeframe. 4. Triple Threat " Identifies patients who have concurrent use of opioids, benzodiazepines/hypnotics, and skeletal muscle relaxants in a specified time frame 5. Multiple Prescription " Identifies patients that received 13 or more prescriptions in the last four months. 6. Expanded Fraud, Waste, & Abuse " Identifies patients whose last four months of claims include medications with potential for overuse or abuse. 7. Morphine Milligram Equivalent (MME) - Identifies patients with an average 90 MME or greater per day by one or more physicians within a specific time frame.
Molina Abbr	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

MCO Name	RetroDUR Educational Outreach Summary
	evaluated members that met these requirements and letter prescribers recommending appropriate action.
Partnership Abbr	Retrospective DUR Educational interventions for FFY 2022 include the following:: 1. Prescription Claims Analysis to identify gaps and opportunities to improve outcomes: PHC's pharmacy department has been analyzing prescription claims data for diabetes and hypertension related medication to identify actionable opportunities to improve outcomes for our members with diabetes and hypertension. Raw prescription data is obtained through the Medi-Cal Rx, Magellan claims feed. The claims data is then validated against the Managed Care Pharmacy portal. The data for each of PHC's provider organizations is organized into a format that can then be stratified to allow for further evaluation such as identification of medication non-adherence, gaps in medication treatment, opportunities for dose titration, etc. The results of the analysis is shared with the individual provider organizations with an offer to tailor the data we provide to meet each provider organizations' needs. The providers are encouraged to follow up with the pharmacies to address any identified medication related issues such as duplication of therapy, poly-pharmacy and medication non-adherence. 2. Asthma Medication Ratio Provider Academic Detailing: According to the Global Initiative for Asthma (GINA) and National Institute of Health (NIH) asthma guidelines, asthma self-management education can improve adherence with asthma therapy and reduce risk for asthma exacerbations. To improve our members' adherence to their prescribed asthma therapy and to help reduce emergency room and hospital visits related to asthma, PHC contacted adult members who were recently seen in the emergency room for an asthma exacerbation to provide asthma self-management education and medication counseling. For members who were reached and provided with counseling, a fax was sent to their assigned primary care provider with their asthma related fill history and tailored recommendations from the pharmacist. 3. Pharmacotherapy for COPD exacerbation: According to the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines, providing adequate pharmacotherapy for COPD exacerbations in the form of oral corticosteroids and short acting bronchodilators can reduce the chance of subsequent and worsening exacerbations. To improve rates of appropriate pharmacotherapy for COPD exacerbations, PHC notified emergency rooms via Collective Medical, an emergency department information exchange platform, if appropriate pharmacotherapy was not dispensed for COPD exacerbations. Appropriate maintenance therapy for COPD in the form of long acting bronchodilators can reduce the risk of COPD exacerbations. For these same members, PHC also notified the assigned primary care physician of the member's emergency room visits and any gaps in GOLD recommended maintenance therapy for COPD. In addition, data for COPD exacerbations from 2021 for all PHC members was reviewed to identify which emergency rooms may be underperforming with respect to issuing appropriate pharmacotherapy for COPD exacerbations. 4. Statins for People with diabetes or cardiovascular disease: The HEDIS measure, Statin Therapy for Patient with Diabetes (SPD) - Statin Therapy, assesses the percentage of adults 40-75 years of age who have diabetes but do not have clinical ASCVD, who received statin therapy. In this subgroup of diabetic patients, the American Diabetes Association and the 2019 ACC/AHA guidelines recommend statins for primary prevention of cardiovascular disease in patients with diabetes,

MCO Name	RetroDUR Educational Outreach Summary
	based on age and other risk factors. PHC's Pharmacy department developed a triphasic telephonic member outreach project to try to increase the member's knowledge and reinforce members understanding of diabetes management with the hopes of increasing statin use. Providers were outreached for initiating statin therapy and medication management when appropriate. 5. Newsletters: The PHC Pharmacy Department publishes a newsletter for our providers and pharmacies which includes a link to the website for Medi-Cal Drug Utilization Review (DUR) Educational Articles. The link to the Medi-Cal DUR educational bulletins is provided to increase PHC providers' understanding of current treatment guidelines and recommendations on drugs, disease states, and medical conditions. The goal is to improve the quality and cost-effectiveness of prescribing and dispensing practices for our recipients.
SanFrancisco Abbr	Educational material on the SFHP website was updated in April 2022 for the following topics: emergency contraception, chronic pain, migraine, naloxone administration, pertussis, and safe medication disposal. These efforts were undertaken with the support of the qualified health educator, and final copies were translated into San Francisco Health Plan (SFHP)'s threshold languages (English, Spanish, Chinese, Vietnamese, Russian, and Tagalog). In September 2022, SFHP included information in the provider newsletter on an internal; interdisciplinary Quality Improvement (QI) workgroup that focuses on appropriate testing, medication regimen, and adherence for patients with diabetes, asthma, schizophrenia or schizoaffective disorder on antipsychotics, and major depression on antidepressants. This included the preliminary findings on health disparities by affinity group within the population of members with diabetes and asthma. For diabetes, we found members with Spanish as their primary language had lower diabetes HEDIS scores, while members age 22 to 44 had lower asthma scores. Three educational bulletins were published by DHCS during this period: "Professional Organizations Push for Recall of Buprenorphine Dental Warning," "Improving the Quality of Care: Legislative Impact on the Use of Naloxone," and "Submitting Quality Data to the California Immunization Registry (CAIR2)." All of these bulletins were communicated to providers through a short summary in the monthly provider newsletter and a link to the DHCS website. These summaries and links are also available on the SFHP provider website.
SanJoaquin Abbr	HPSJ providers educational bulletins prepared by Medi-Cal Rx and provides additional educational bulletins to Network. 2021 Immunization Updates: COVID-19, Influenza, and Meningococcal Disease Alerts, Pharmacy AnnouncementsOctober 20, 2021 Medi-Cal Rx PBM Information Alerts, Pharmacy AnnouncementsDecember 30, 2021 Submitting Quality Data to the California Immunization Registry (CAIR2) " May 2022 Pharmacy AnnouncementsMay 26, 2022 Medi-Cal Pharmacy (Rx) Update " Rejection Code 816 Alerts, Pharmacy AnnouncementsDecember 1, 2022
SanMateo Abbr	HPSM works to provide educational resources to our providers throughout various

MCO Name	RetroDUR Educational Outreach Summary
	contact points and perform targeted outreach under opportune circumstances. Information is disseminated via various modalities including letters, educational bulletins, provider newsletters, and the posting of content via our website. These materials serve to help improve provider understanding of current focus topics, relevant clinical guideline considerations when applicable, as well as general recommendations. Inclusive of aligning with the Medi-Cal Drug Utilization Review (DUR) board, focuses over this past federal fiscal year have included the following: improving COVID vaccination rates, asthma program adherence outreach, naloxone utilization in OUD, pediatric vaccination catchup recommendations, tobacco cessation treatment options, flu vaccination promotions, opioid safety recommendations, accessing coverage in transitioning to Medi-Cal Rx, and buprenorphine usage.
SantaClaraHealthPlan Abbr	Santa Clara Family Health Plan (SCFHP) conducts drug use review (DUR) programs for Medi-Cal members that identify opportunities in drug usage and patterns to provide related education to providers. Program topics are based on Healthcare Effectiveness Data and Information Set (HEDIS) metrics, Centers for Medicare and Medicaid Services (CMS) metrics, and drug trends. Between October 1, 2021 and September 30, 2022, SCFHP conducted the following retrospective DUR programs for Medi-Cal members: 1. April 2022 Provider Mailing " Opioid Use Disorder or Opioid Poisoning - Criteria: Identified members diagnosed with opioid use disorder or opioid poisoning in the last 12 months - Rationale: To prevent opioid overdose by providing available treatments and services " naloxone, medication-assisted therapy (MAT), and alternative or complementary therapies covered by the Plan 2. June 2022 Provider Mailing " Antipsychotic Use in Children and Adolescents - Criteria: Identified members under 18 years of age who were prescribed 2 or more antipsychotics and did not have an A1C/glucose test and/or LDL/cholesterol test completed in the last 12 months - Rationale: To reduce major metabolic complications with long-term consequences associated with antipsychotic use in children and adolescents Between October 1, 2021 and September 30, 2022, SCFHP sent the following educational communications to network providers: 1. October 2021 " 'Voluntary drug recall: varenicline (Chantix) lots containing nitrosamine' - Description: Informed providers that on July 2, 2021, the FDA announced that Pfizer was voluntarily recalling certain lots of the smoking cessation drug, vareciline (Chantix), due to levels of a nitrosamine impurity, called N-nitroso-varenicline, above the FDA's acceptable intake limit. N-nitroso-varenicline may be associated with a potential increased cancer risk in humans with long-term use. - Outreach Delivery Method: Provider newsletter

MCO Name	RetroDUR Educational Outreach Summary
	2. October 2021 “ 'Drug safety update: FDA requests removal of pregnancy contraindication for statins' - Description: Informed providers that on July 20, 2021, the FDA requested removal of its strongest warning against using cholesterol-lowering statin medicines in pregnant patients. However, despite the change, most patients should stop statins once they learn they are pregnant. - Outreach Delivery Method: Provider newsletter 3. December 2021 “ 'Immunization Recommendations and Coverage Details' - Description: Informed providers about recommendations, clinical guidance, and coverage details for COVID-19 vaccines, influenza vaccines, and scheduled immunizations. - Outreach Delivery Method: Provider newsletter 4. January 2022 “ 'Improving Quality of Care: Naloxone Use' - Description: Reminded providers that in order to help remove barriers and increase access to naloxone, providers are encouraged to prescribe naloxone to individuals at risk for opioid overdose, patients with high morphine milligram equivalents, and patients on both opioids and benzodiazepines. Provided a list of community resources that providers can refer patients to, such as MAT. - Outreach Delivery Method: Provider newsletter 5. February 2022 “ 'New Clinical Diabetes Program for members with A1C greater than 9%' - Description: Informed providers that the SCFHP implemented a Clinical Diabetes Program for members 18-75 years of age with diabetes and an A1C greater than 9%. Members will be proactively enrolled and followed by a SCFHP pharmacist over a 12 month period. - Outreach Delivery Method: Provider memo 6. March 2022 “ 'Professional organizations push for recall of buprenorphine dental warning' - Description: Informed providers that on January 24, 2022, a letter from the American Society of Addiction Medicine (ASAM) and 10 other health professional associations called for the FDA to retract its Drug Safety Communication on dental problems associated with buprenorphine. - Outreach Delivery Method: Provider newsletter 7. June 2022 “ 'Improving Quality Care: Naloxone Use' - Description: Informed providers that DHCS updated its article, Improving the Quality of Care: Legislative Impact on the Use of Naloxone, which was originally published on December 31, 2021. The article emphasized that the age-adjusted opioid-related death rate in California significantly increased over the last two years and encouraged providers to prescribe naloxone to patients at risk for opioid overdose and for individuals likely to witness and assist a person at risk of an opioid overdose. - Outreach Delivery Method: Provider newsletter 8. August 2022 “ 'Spirometry Testing in the Assessment and Diagnosis of COPD'

MCO Name	RetroDUR Educational Outreach Summary
	- Description: Informed providers that both the Global Initiative for Chronic Obstructive Lung Disease (GOLD) and the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) emphasize the importance of spirometry testing as a tool to diagnose chronic obstructive pulmonary disease (COPD). - Outreach Delivery Method: Provider newsletter 9. August 2022 " 'New 2022 GOLD Guidelines for Bronchodilators' - Description: Informed providers that the 2022 GOLD guidelines recommend all patients be prescribed rescue short-acting bronchodilators for immediate symptom relief and to adjust treatment as clinically appropriate if response to initial treatment is inadequate - Outreach Delivery Method: Provider newsletter 10. September 2022 " 'Flu Season is Upon Us' - Description: Provided CDC recommendations for influenza vaccines. Reminded providers that the CDC states that patients can get a COVID-19 vaccine and flu vaccine at the same time if eligible and the timing coincides. - Outreach Delivery Method: Provider newsletter
UnitedHealth Abbr	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 UnitedHealthcare Community Plan for the federal fiscal year. The total number of interventions during the federal fiscal year was 5,900 for all programs. Outcomes are evaluated 120-180 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 2,316. For those eligible interventions the number determined to be successful during the federal fiscal year was 623, yielding a success percentage of 26.90%. 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 1,337 for this program. Outcomes are evaluated 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 140. For those eligible interventions the number determined to be successful during the federal fiscal year was 1, yielding a success percentage of 0.71%. 2. Abused Meds: Early Refills (Mean Possession Ratio) This is a provider-targeted program designed to minimize the occurrence of chronic early refill of high-risk medications. The number of interventions during the federal fiscal year was 753 for this program. Outcomes are evaluated 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 127. For those eligible interventions the number determined to be successful during the federal fiscal year was 50, yielding a success percentage of 39.37%.

MCO Name	RetroDUR Educational Outreach Summary
	3. 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 645 for this program. Outcomes are evaluated 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 510. For those eligible interventions the number determined to be successful during the federal fiscal year was 170, yielding a success percentage of 33.33%. 4. 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 603 for this program. Outcomes are evaluated 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 381. For those eligible interventions the number determined to be successful during the federal fiscal year was 111, yielding a success percentage of 29.13%. 5. 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 572 for this program. Outcomes are evaluated 120 days post intervention. The number of interventions eligible for outcome evaluation during the federal fiscal year was 126. For those eligible interventions the number determined to be successful during the federal fiscal year was 60, yielding a success percentage of 47.62%.

Section III - Physician Administered Drugs

1. The Deficit Reduction Act requires collection of national drug code (NDC) numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your claims processing system been designed to evaluate the drug data supplied by the State into your RetroDUR criteria or PA reviews?

Figure 6 - Claims Processing System Designed to Evaluate State-Supplied Drug Data into RetroDUR Criteria or PA Reviews

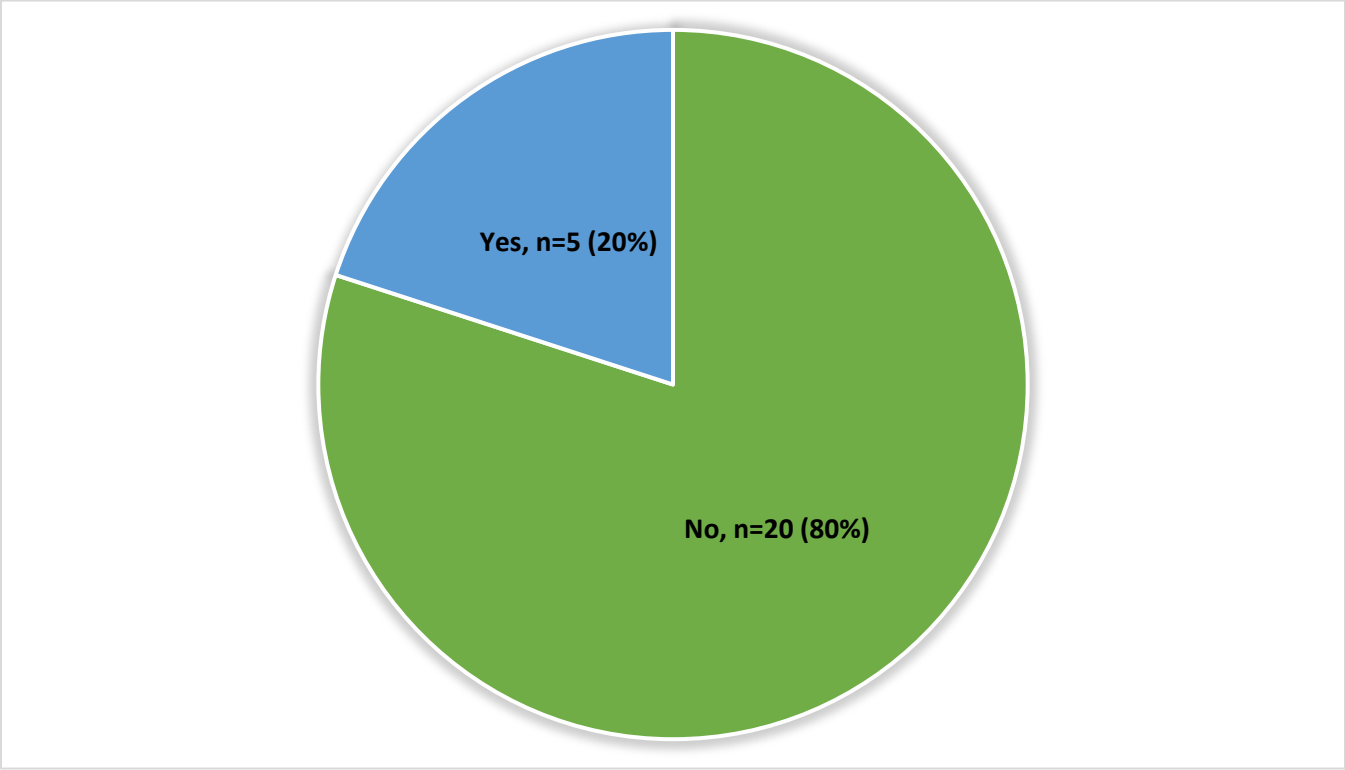

Table 14 - Claims Processing System Designed to Evaluate State-Supplied Drug Data into RetroDUR Criteria or PA Reviews

Response	MCO Names	Count	Percentage
Yes	CalOptima Abbr, CCAH Abbr, ContraCosta Abbr, Partnership Abbr, SanFrancisco Abbr	5	20.00%
No	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalViva Abbr, CenCal Abbr, CHW Abbr, Community Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	20	80.00%
State Totals		**25**	**100%**

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

Figure 7 - Future Plans to Incorporate Evaluation of State-Supplied Drug Data into RetroDUR Criteria or PA Reviews

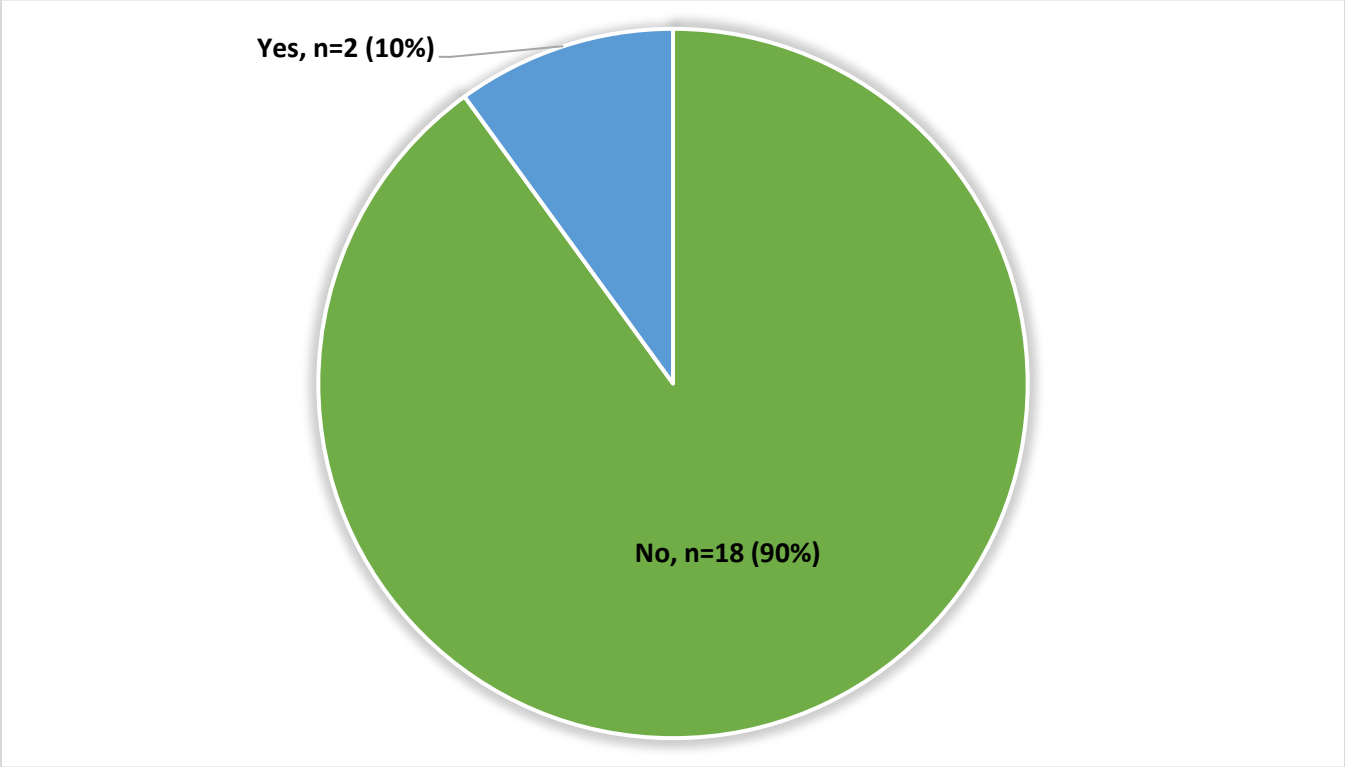

Table 15 - Future Plans to Incorporate Evaluation of State-Supplied Drug Data into RetroDUR Criteria or PA Reviews

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, UnitedHealth Abbr	2	10.00%
No	AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalViva Abbr, CenCal Abbr, CHW Abbr, Community Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr	18	90.00%
State Totals		**20**	**100%**

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

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

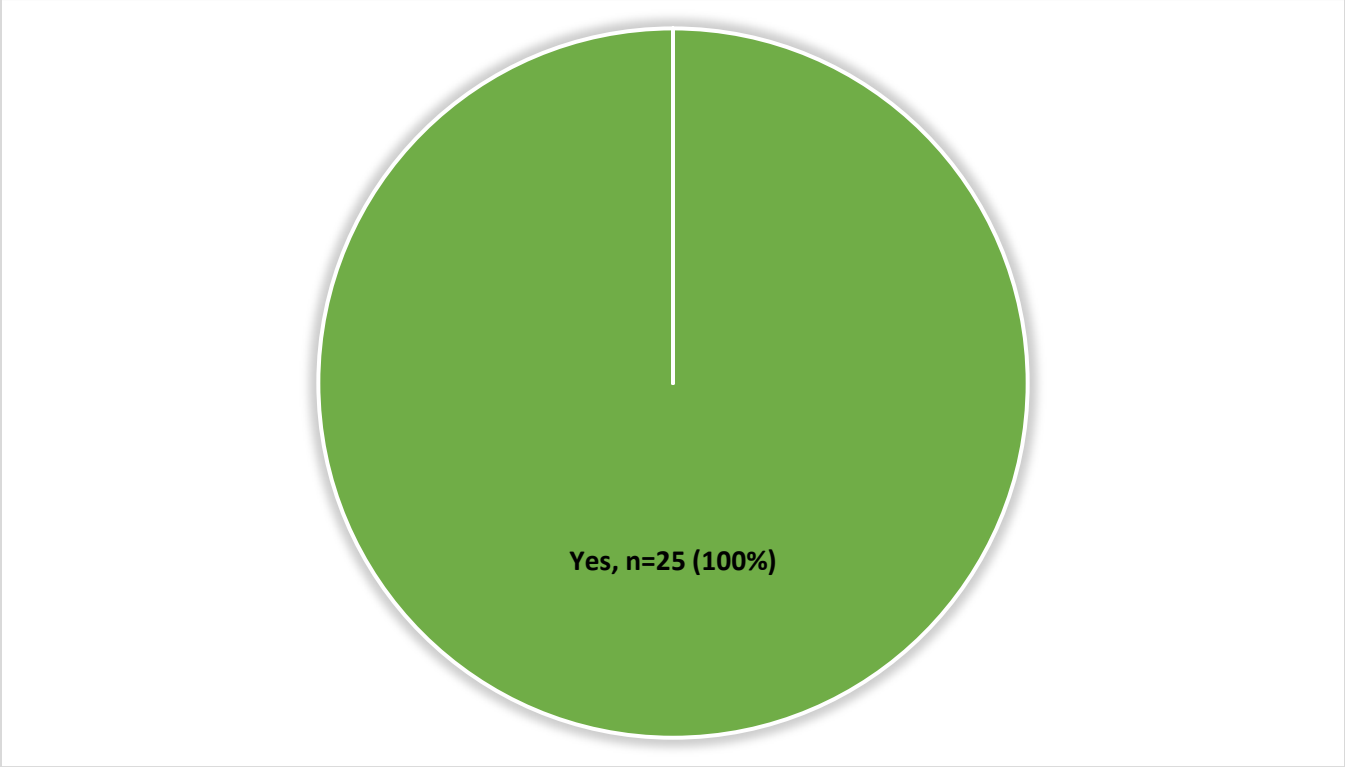

Table 16 - Documented Process in Place to Identify Potential FWA of Controlled Drugs by Beneficiaries

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

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

Figure 9 - Actions Process Initiates when Potential FWA of Controlled Drugs by Beneficiaries is Detected

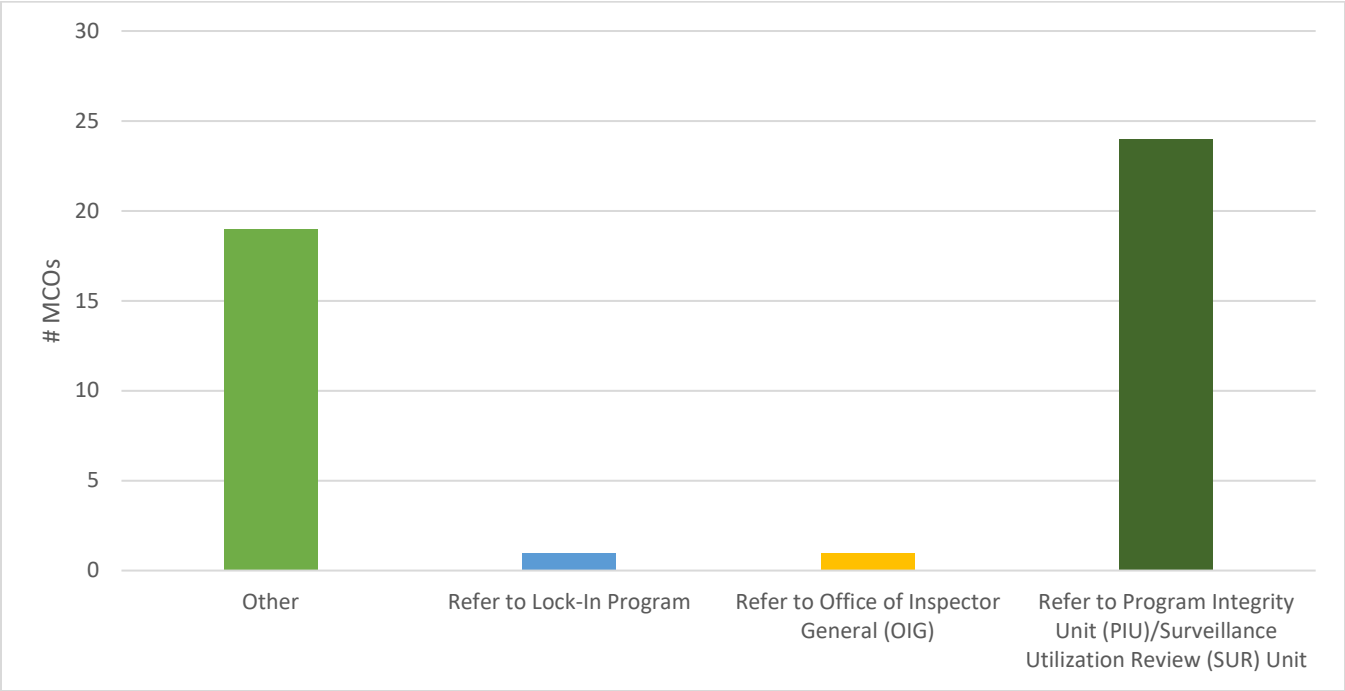

Table 17 - Actions Process Initiates when Potential FWA of Controlled Drugs by Beneficiaries is Detected

Response	MCO Names	Count	Percentage
Refer to Lock-In Program	Partnership Abbr	1	2.22%
Refer to Office of Inspector General (OIG)	CenCal Abbr	1	2.22%
Refer to Program Integrity Unit (PIU)/Surveillance Utilization Review (SUR) Unit	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	24	53.33%
Other	AetnaBetterHealthCA Abbr, Alameda Abbr, Anthem Abbr, CalOptima Abbr, CalViva Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	19	42.22%
State Totals		**45**	**100%**

If “Other,” please explain.

Table 18 - Explanations for “Other” Actions Process Initiates when Potential FWA of Controlled Drugs by Beneficiaries is Detected

MCO Name	Explanation
AetnaBetterHealthCA Abbr	The plan's Special Investigations Unit (SIU) team is required to report FWA activity to DHCS within 10 business days of the plan being aware of FWA activity.
Alameda Abbr	Alameda reports any findings of fraud, waste, and abuse that our compliance team identifies during regulatory audits or reported FWA.
Anthem Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCP first become aware of, or is on notice of, such activity.
CalOptima Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCO identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCO first become aware of, or is on notice of, such activity.
CalViva Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.
CHW Abbr	APL activity #43 Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.
Community Abbr	CHG provide fraud, waste, and abuse (FWA) reporting. This also includes referral of potential FWA to the DHCS Audits and Investigations Intake Unit. Within 10 working days of the FWA date, CHG will investigate and report the findings to DHCS.
ContraCosta Abbr	Fraud and abuse reporting is conducted and any findings of potential fraud, waste and abuse are promptly reported to the DHCS Audits and Investigations Intake Unit. Reports of suspected fraud and/or abuse are routinely conducted and reported to DHCS within 10 working days of the date CCHP is first aware of such activity.
GoldCoast Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the GCHP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date GCHP first becomes aware of, or is on notice of, such activity.
HealthNetMediCal Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.

MCO Name	Explanation
Kaiser Abbr	Kaiser provides fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse identified to the California Department of Health Care Services (DHCS) Audits and Investigations Intake Unit as well as conducts, completes, and reports to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Kaiser first become aware of, or is on notice of, such activity.
KernHealthSystems Abbr	As outlined in an All Plan Letter (APL) 22-012, which provides guidance to the health plans, activity #43 delineates steps plans are to conduct and follow when FWA is detected. This is further stated in KHS' Policy 13.04-I.
LACARE Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCP first become aware of, or is on notice of, such activity.
Partnership Abbr	Partnership HealthPlan has established policies for reporting of FWA of controlled drugs by beneficiaries. Reports of potential fraud, waste and abuse are referred to Partnership HealthPlan's Regulatory Affairs and Compliance department (RAC) for review and investigation. RAC determines if the incident is reportable to DHCS and adheres to DHCS reporting and time requirements.
SanFrancisco Abbr	As per APL 22-012, activity 43, any identified FWA is reported back to DHCS.
SanJoaquin Abbr	The HPSJ Compliance department directs the identification, monitoring and reporting of all FWA. Detection includes but is not limited to, implementing effective internal monitoring (e.g., Hotline, Anonymous Compliance Lunch Room boxes), auditing, and data mining (FWA Detection Vendor).
SanMateo Abbr	The MCO has a documented process for FWA investigation and reporting that involves notification to MCO compliance staff of any potential FWA for investigation. Regarding controlled substances, these may stem from referrals, state provided reporting, or outlier identification via data review (based on multiple prescriber/pharmacy, level of opioid consumption in morphine equivalents, and any spikes in utilization). The MCO will also coordinate with the state, sending identified concerns to the state's Audits and Investigations Intake Unit along with preliminary MCO findings of the suspected FWA.
SantaClaraHealthPlan Abbr	Identified potential fraud, waste, or abuse of controlled drugs by beneficiaries are reviewed by the Director of Pharmacy, or designee, and forwarded to SCFHP's Compliance Department for determination of action. If SCFHP's Compliance Department agrees with the determination of potential fraud, waste, or abuse, SCFHP will forward the information to the DHCS Audits and Investigations Intake Unit and conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud, waste, or abuse within 10 business days of becoming aware of, or is on notice of, such activity.
UnitedHealth Abbr	UnitedHealthcare Community Plan provides fraud and abuse reporting, including prompt referral of any potential fraud, waste, or abuse UHC identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date UHC first becomes aware of, or is on notice of, such activity.

2. Does your MCO have a coordinated process in place, such as a lock-in program, for beneficiaries with potential FWA of controlled substances (CS)?

Figure 10 - Coordinated Process in Place for Beneficiaries with Potential FWA of Controlled Substances

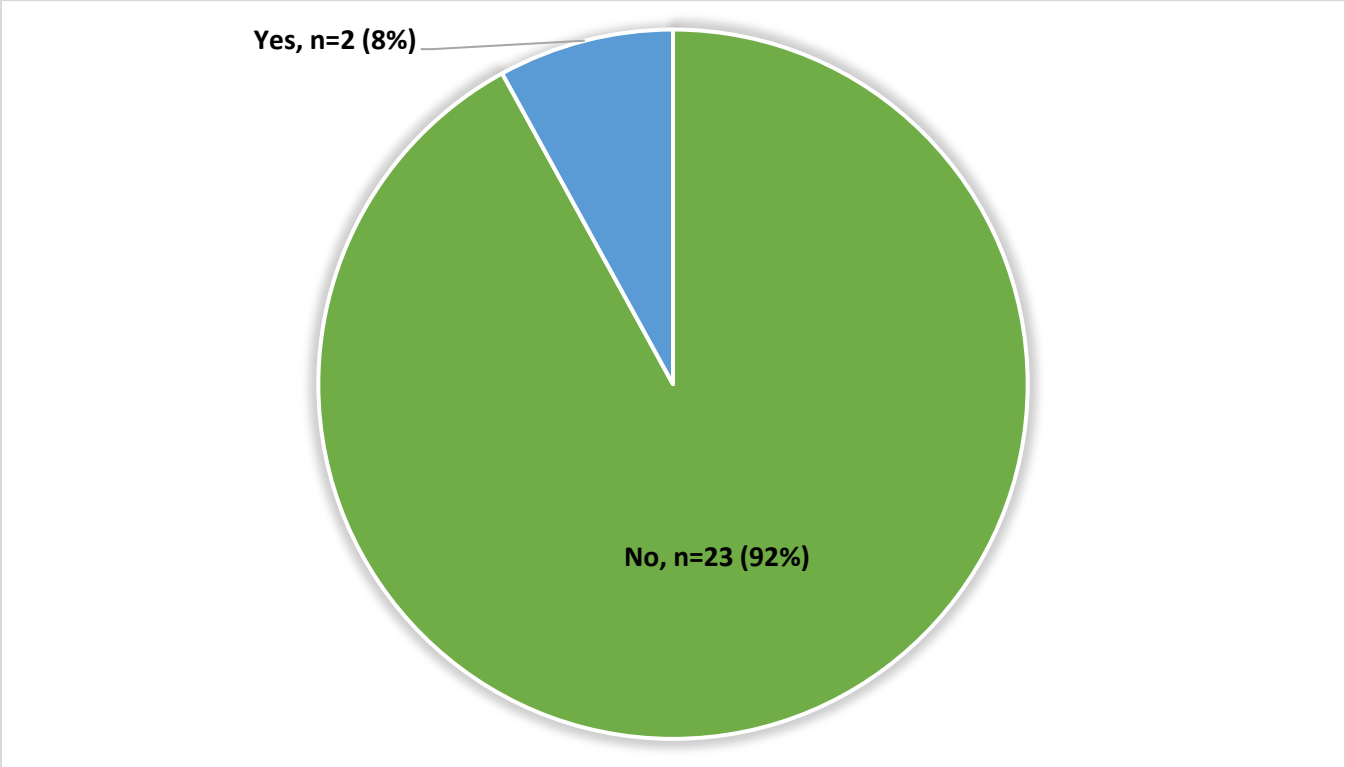

Table 19 - Coordinated Process in Place for Beneficiaries with Potential FWA of Controlled Substances

Response	MCO Names	Count	Percentage
Yes	Inland Abbr, Partnership Abbr	2	8.00%
No	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	23	92.00%
State Totals		**25**	**100%**

a. If "Yes," what criteria is used to identify beneficiaries with potential FWA of controlled substances (multiple responses allowed)?

Figure 11 - Criteria Used to Identify Beneficiaries with Potential FWA of Controlled Substances

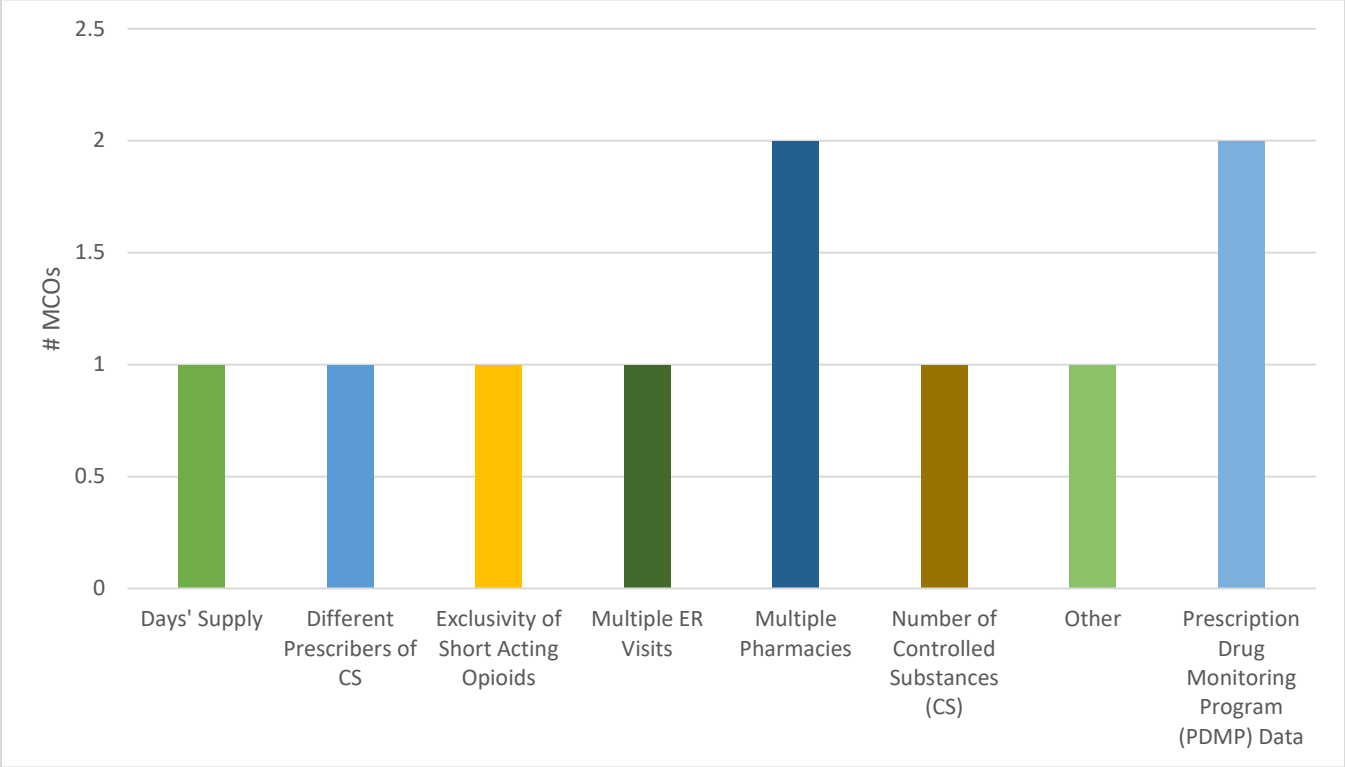

Table 20 - Criteria Used to Identify Beneficiaries with Potential FWA of Controlled Substances

Response	MCO Names	Count	Percentage
Days' supply	Inland Abbr	1	10.00%
Different prescribers of CS	Inland Abbr	1	10.00%
Exclusivity of short acting opioids	Inland Abbr	1	10.00%
Multiple ER visits	Inland Abbr	1	10.00%
Multiple pharmacies	Inland Abbr, Partnership Abbr	2	20.00%
Number of controlled substances (CS)	Inland Abbr	1	10.00%
Prescription Drug Monitoring Program (PDMP) data	Inland Abbr, Partnership Abbr	2	20.00%
Other	Partnership Abbr	1	10.00%
State Totals		**10**	**100%**

If "Other," please explain.

Table 21 - "Other" Explanations for Criteria Used to Identify Beneficiaries with Potential FWA of Controlled Substances

MCO Name	Explanation
Partnership Abbr	Between 10/1/2021 to 12/31/2021, Partnership HealthPlan used our PBM to institute a Lock-In Program for beneficiaries with potential FWA of controlled substances.

b. If "Yes," does your MCO have the capability to restrict the beneficiary to a prescriber only?

Figure 12 - Prescriber Only Restriction Capability

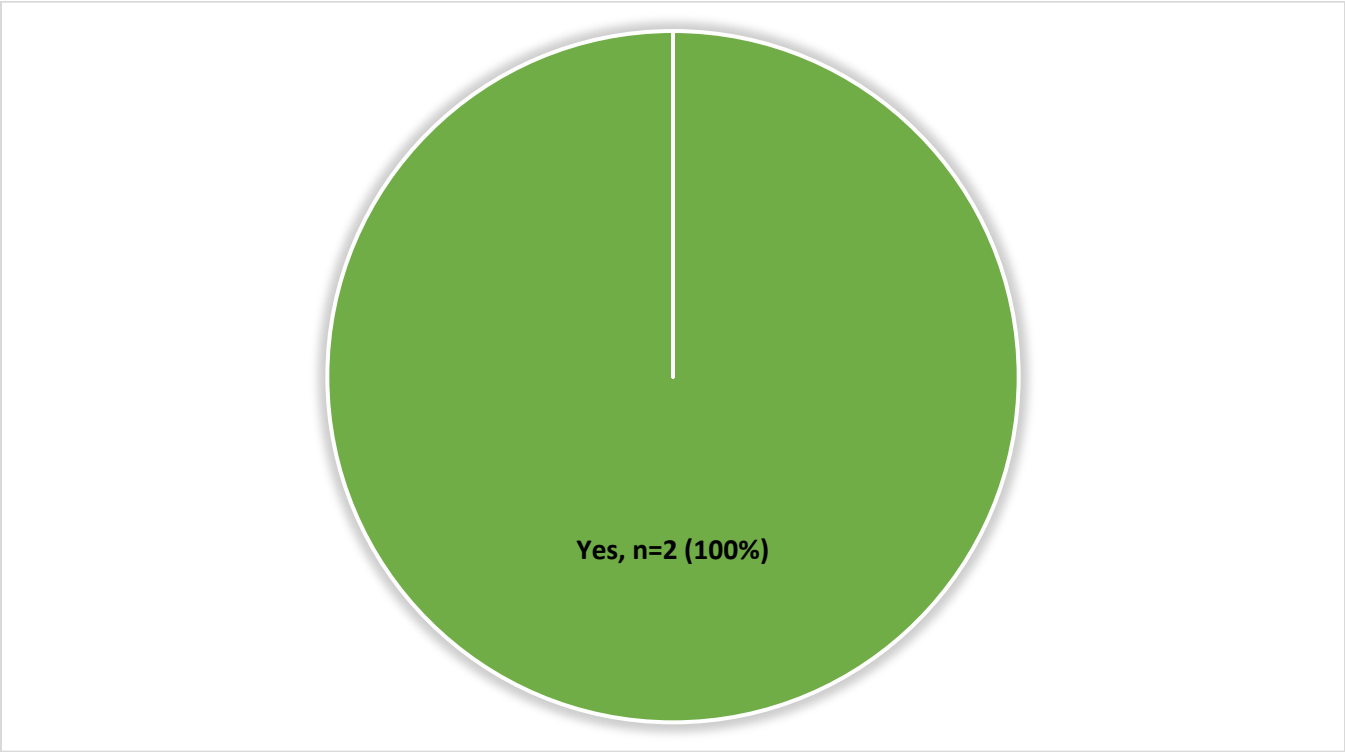

Table 22 - Prescriber Only Restriction Capability

Response	MCO Names	Count	Percentage
Yes	Inland Abbr, Partnership Abbr	2	100.00%
State Totals		**2**	**100%**

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

Figure 13 - Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers

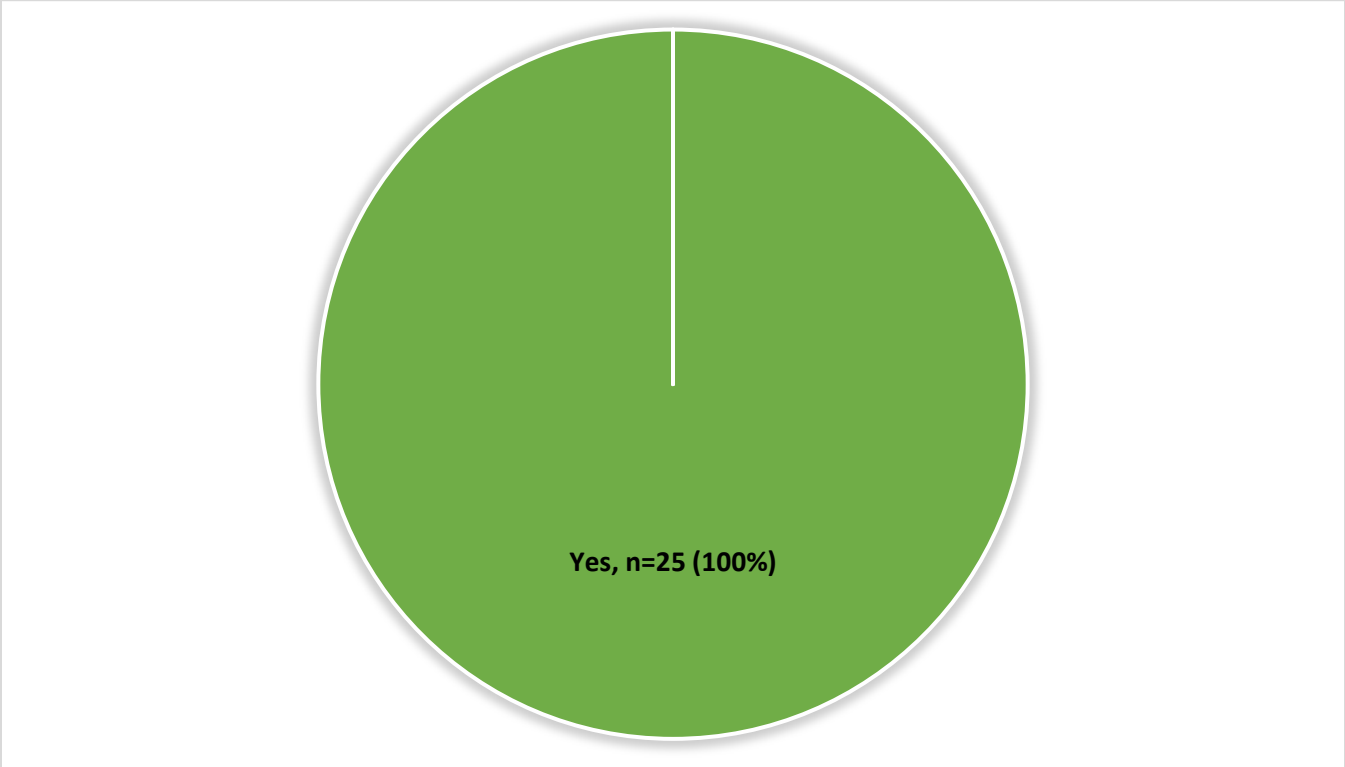

Table 23 - Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

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

Figure 14 - Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected

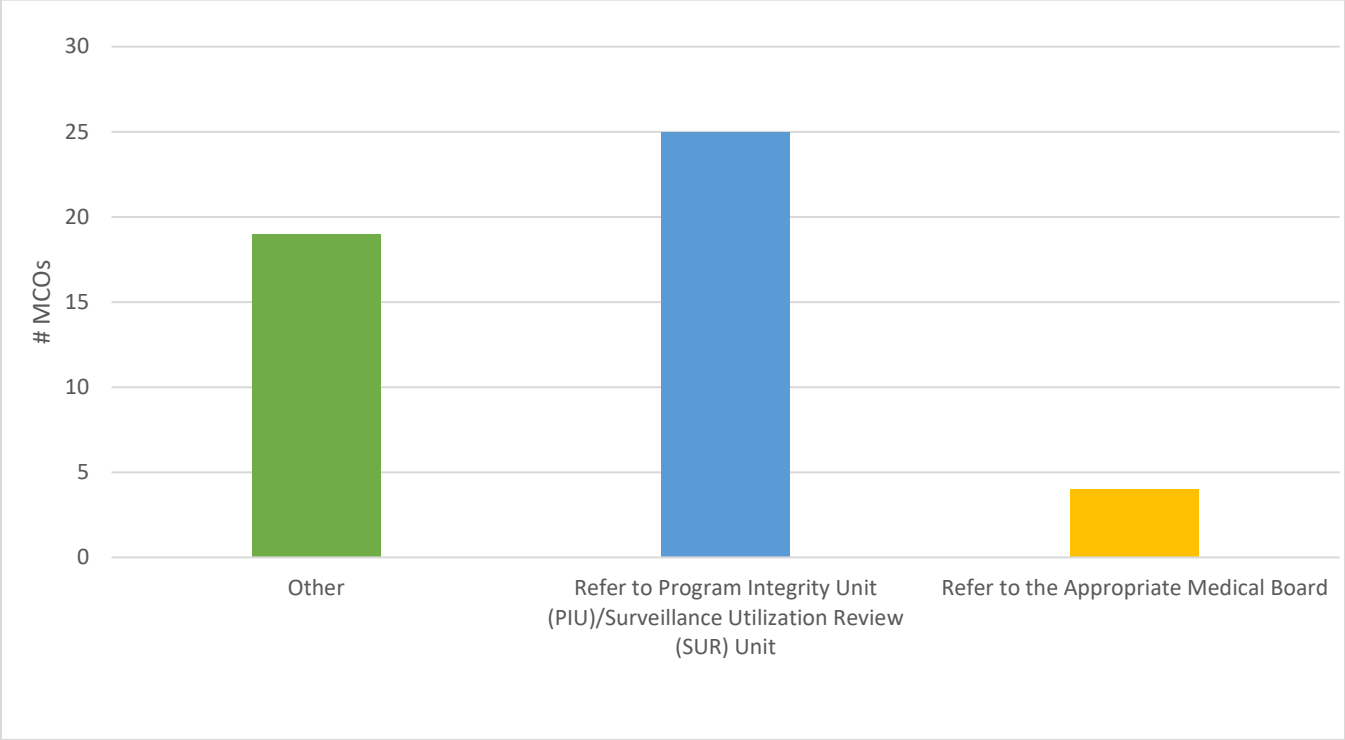

Table 24 - Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected

Response	MCO Names	Count	Percentage
Refer to Program Integrity Unit (PIU)/Surveillance Utilization Review (SUR) Unit	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	52.08%
Refer to the Appropriate Medical Board	BlueShield Abbr, CenCal Abbr, Inland Abbr, UnitedHealth Abbr	4	8.33%
Other	AetnaBetterHealthCA Abbr, Alameda Abbr, Anthem Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Partnership Abbr, SanFrancisco Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	19	39.58%
State Totals		**48**	**100%**

If “Other,” please explain.

Table 25 - “Other” Explanations for Action Initiated by Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers

MCO Name	Explanation
AetnaBetterHealthCA Abbr	The plan's Special Investigations Unit (SIU) team is required to report FWA activity to DHCS within 10 business days of the plan being aware of FWA activity.
Alameda Abbr	Alameda reports any findings of fraud, waste, and abuse that our compliance team identifies during regulatory audits or reported FWA.
Anthem Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCP first become aware of, or is on notice of, such activity.
CalOptima Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCO identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCO first become aware of, or is on notice of, such activity.
CalViva Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.
CCAH Abbr	Potential quality issues are referred to Quality Improvement.
CHW Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.
Community Abbr	CHG provide fraud, waste, and abuse (FWA) reporting. This also includes referral of potential FWA to the DHCS Audits and Investigations Intake Unit. Within 10 working days of the FWA date, CHG will investigate and report the findings to DHCS.
ContraCosta Abbr	Fraud and abuse reporting is conducted and any findings of potential fraud, waste and abuse are promptly reported to the DHCS Audits and Investigations Intake Unit. Reports of suspected fraud and/or abuse are routinely conducted and reported to DHCS within 10 working days of the date CCHP is first aware of such activity.
GoldCoast Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse GCHP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date GCHP first becomes aware of, or is on notice of, such activity.
HealthNetMediCal Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.

MCO Name	Explanation
Kaiser Abbr	Kaiser provides fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse identified to the California Department of Health Care Services (DHCS) Audits and Investigations Intake Unit as well as conducts, completes, and reports to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Kaiser first become aware of, or is on notice of, such activity.
KernHealthSystems Abbr	As outlined in an All Plan Letter (APL) 22-012, which provides guidance to the health plans, activity #43 delineates steps plans are to conduct and follow when FWA is detected. Reports are run to identify instances of FWA. This is further stated in KHS' Policy 13.04-I.
LACARE Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCP first become aware of, or is on notice of, such activity.
Partnership Abbr	Partnership HealthPlan used PBM or MediCal Rx data to identify possible FWA in prescribing practices. Reports of potential fraud, waste and abuse are referred to Partnership HealthPlan's Regulatory Affairs and Compliance department (RAC) for review and investigation. RAC determines if the incident is reportable to DHCS and adheres to DHCS reporting and time requirements. Referrals of FWA can be received from providers, pharmacies, PHC's Care Coordination department, anonymous tips, and RAC.
SanFrancisco Abbr	As per APL 22-012, activity 43, any identified FWA is provided back to DHCS.
SanMateo Abbr	The MCO has a documented process for FWA investigation and reporting that involves notification to MCO compliance staff of any potential FWA for investigation. Regarding controlled substances, these may stem from referrals (e.g., from individuals, the healthcare fraud prevention partnership group), state provided reporting, or outlier identification via pharmacy data review (based on outlier utilization, opioid prescribing amounts). The MCO will also coordinate with the state, sending identified concerns to the state's Audits and Investigations Intake Unit along with preliminary MCO findings of the suspected FWA.
SantaClaraHealthPlan Abbr	Identified prescribers are reviewed by the Director of Pharmacy, or designee, and forwarded to SCFHP's Compliance Department for determination of action. If SCFHP's Compliance Department agrees with the determination of potential fraud, waste, or abuse, SCFHP will forward the information to the DHCS Audits and Investigations Intake Unit and conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud, waste, or abuse within 10 business days of becoming aware of, or is on notice of, such activity.
UnitedHealth Abbr	UnitedHealthcare Community Plan refers potential fraud, waste, and abuse to the DHCS Audits and Investigations Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date UHC first becomes aware of such activity.

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

Figure 15 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

Table 26 - Documented Process to Identify Potential FWA of Controlled Drugs by Pharmacy Providers

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

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

Figure 16 - Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

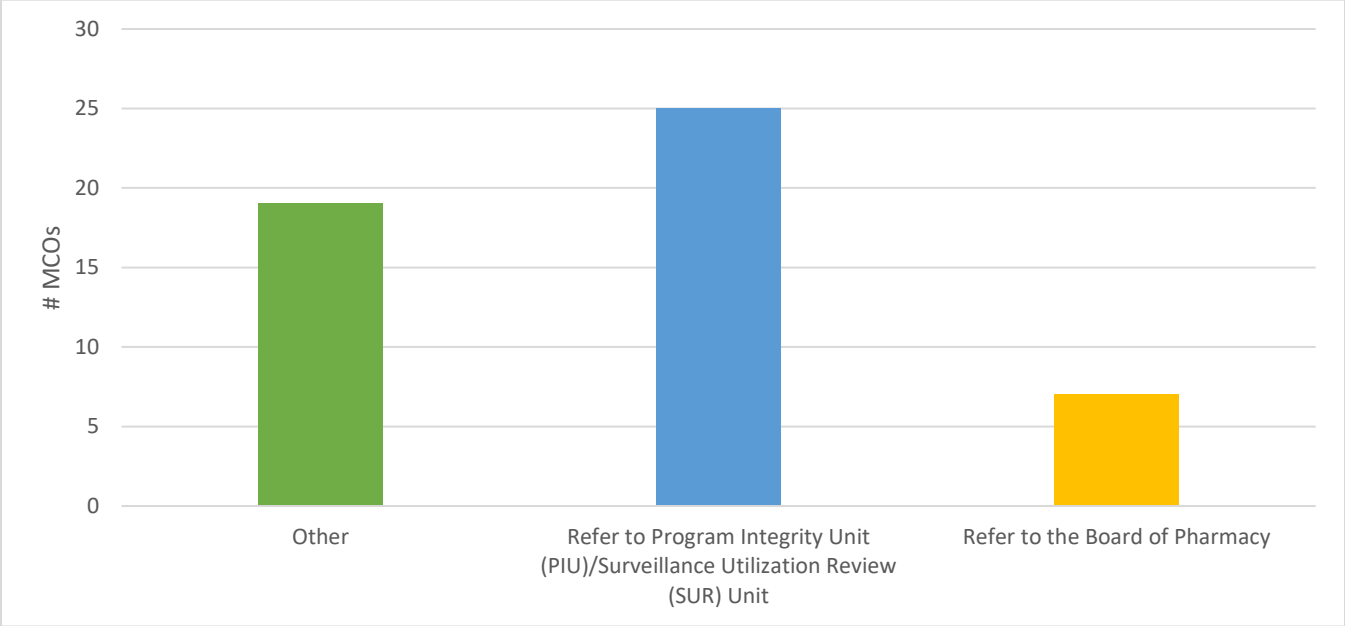

Table 27 - Actions Process Initiates when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

Response	MCO Names	Count	Percentage
Refer to Program Integrity Unit (PIU)/Surveillance Utilization Review (SUR) Unit	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	49.02%
Refer to the Board of Pharmacy	AetnaBetterHealthCA Abbr, BlueShield Abbr, CenCal Abbr, Inland Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	7	13.73%
Other	AetnaBetterHealthCA Abbr, Alameda Abbr, Anthem Abbr, CalOptima Abbr, CalViva Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	19	37.25%
State Totals		**51**	**100%**

If “Other,” please explain.

Table 28 - “Other” Explanations when Potential FWA of Controlled Drugs by Pharmacy Providers is Detected

MCO Name	Explanation
AetnaBetterHealthCA Abbr	The plan's Special Investigations Unit (SIU) team is required to report FWA activity to DHCS within 10 business days of the plan being aware of FWA activity.
Alameda Abbr	Alameda reports any findings of fraud, waste, and abuse that our compliance team identifies during regulatory audits or reported FWA.
Anthem Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCP first become aware of, or is on notice of, such activity.
CalOptima Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCO identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCO first become aware of, or is on notice of, such activity.
CalViva Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.
CHW Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.
Community Abbr	CHG provide fraud, waste, and abuse (FWA) reporting. This also includes referral of potential FWA to the DHCS Audits and Investigations Intake Unit. Within 10 working days of the FWA date, CHG will investigate and report the findings to DHCS.
ContraCosta Abbr	Fraud and abuse reporting is conducted and any findings of potential fraud, waste and abuse are promptly reported to the DHCS Audits and Investigations Intake Unit. Reports of suspected fraud and/or abuse are routinely conducted and reported to DHCS within 10 working days of the date CCHP is first aware of such activity.
GoldCoast Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse GCHP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date GCHP first becomes aware of, or is on notice of, such activity.
HealthNetMediCal Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.
Kaiser Abbr	Kaiser provides fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse identified to the California Department of Health

MCO Name	Explanation
	Care Services (DHCS) Audits and Investigations Intake Unit as well as conducts, completes, and reports to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Kaiser first become aware of, or is on notice of, such activity.
KernHealthSystems Abbr	As outlined in an All Plan Letter (APL) 22-012, which provides guidance to the health plans, activity #43 delineates steps plans are to conduct and follow when FWA is detected. Reports are run to identify instances of FWA. This is further stated in KHS' Policy 13.04-I.
LACARE Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCP first become aware of, or is on notice of, such activity.
Partnership Abbr	Partnership HealthPlan received reports from our PBM on controlled drug dispensing to identify potential FWA of controlled drugs by pharmacy providers. Partnership HealthPlan also maintains a Managing Pain Safely dashboard to monitor controlled substance dispensing data by pharmacy providers.
SanFrancisco Abbr	As per APL 22-012, activity 43, any identified FWA is provided back to DHCS.
SanJoaquin Abbr	The HPSJ Compliance department directs the identification, monitoring and reporting of all FWA. Detection includes but is not limited to, implementing effective internal monitoring (e.g., Hotline, Anonymous Compliance Lunch Room boxes), auditing, and data mining (FWA Detection Vendor).
SanMateo Abbr	The MCO has a documented process for FWA investigation and reporting that involves notification to MCO compliance staff of any potential FWA for investigation. Regarding controlled substances, these may stem from referrals (e.g., from individuals, the healthcare fraud prevention partnership group), state provided reporting, and outlier identification via pharmacy data review. The state Board of Pharmacy is notified in situations warranting notification. The MCO will also coordinate with the state, sending identified concerns to the state's Audits and Investigations Intake Unit along with preliminary MCO findings of the suspected FWA.
SantaClaraHealthPlan Abbr	Identified pharmacy providers are reviewed by the Director of Pharmacy, or designee, and forwarded to SCFHP's Compliance Department for determination of action. If SCFHP's Compliance Department agrees with the determination of potential fraud, waste, or abuse, SCFHP will forward the information to the DHCS Audits and Investigations Intake Unit and conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud, waste, or abuse within 10 business days of becoming aware of, or is on notice of, such activity.
UnitedHealth Abbr	UnitedHealthcare Community Plan refers potential fraud, waste, and abuse to the DHCS Audits and Investigations Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date UnitedHealthcare Community Plan first becomes aware of such activity.

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

Figure 17 - Documented Process to Identify Potential FWA of Non-Controlled Drugs by Beneficiaries, Prescribers, and Pharmacy Providers

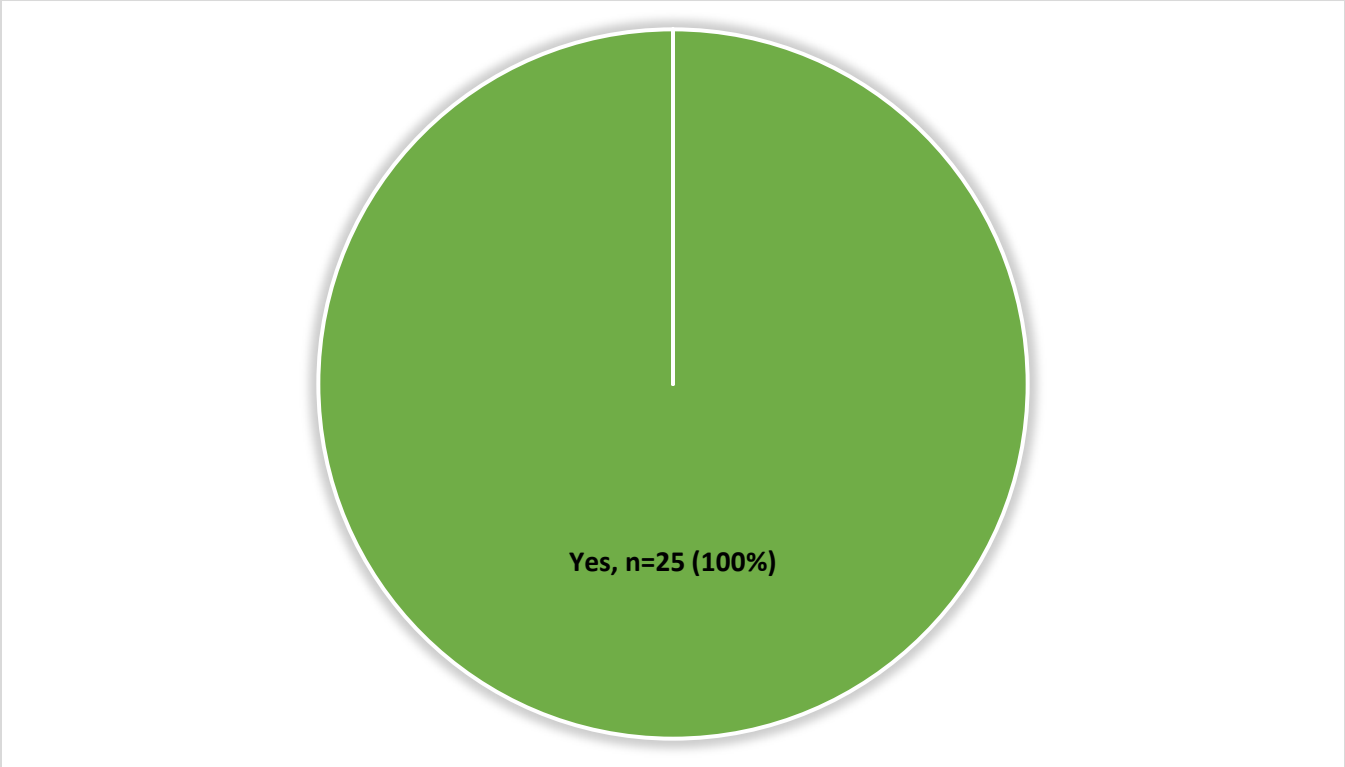

Table 29 - Documented Process to Identify Potential FWA of Non-Controlled Drugs by Beneficiaries, Prescribers, and Pharmacy Providers

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

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

Table 30 - Explanations of Program for FWA of Non-Controlled Substances by Beneficiaries, Prescribers, and Pharmacy Providers

MCO Name	Explanation
AetnaBetterHealthCA Abbr	The plan's Special Investigations Unit (SIU) team is required to report FWA activity to DHCS within 10 business days of the plan being aware of FWA activity.

MCO Name	Explanation
AHF Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCP first become aware of, or is on notice of, such activity.
Alameda Abbr	Alameda reports any findings of fraud, waste, and abuse that our compliance team identifies during regulatory audits or reported FWA.
Anthem Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCP first become aware of, or is on notice of, such activity.
BlueShield Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCO identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCP first become aware of, or is on notice of, such activity.
CalOptima Abbr	Monthly reviews for duplicate claims billed on the pharmacy and medical benefit. Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCO identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCO first become aware of, or is on notice of, such activity.
CalViva Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.
CCAH Abbr	Potential FWA is identified from retrospective DUR, and referred to Special Investigations Unit (SIU) for audit/investigation. Potential quality issues are referred to Quality Improvement.
CenCal Abbr	CenCal Health has a process that allows providers, members, and internal staff to report potential or actual FWA of non-controlled drugs by contacting the CenCal Health Compliance Department via email, mail, or anonymous hotline. Once the report is received, CenCal Health will then investigate and respond to the allegations of FWA.
CHW Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.
Community Abbr	CHG provide fraud, waste, and abuse (FWA) reporting. This also includes referral of potential FWA to the DHCS Audits and Investigations Intake Unit. Within 10 working days of the FWA date, CHG will investigate and report the findings to DHCS.
ContraCosta Abbr	Fraud and abuse reporting is conducted and any findings of potential fraud, waste and abuse are promptly reported too the DHCS Audits and Investigations Intake

MCO Name	Explanation
	Unit. Reports of suspected fraud and/or abuse are routinely conducted and reported to DHCS within 10 working days of the date CCHP is first aware of such activity.
GoldCoast Abbr	GCHP has a process that allows providers, members, and internal staff to report potential or actual FWA of non-controlled drugs by contacting the GCHP Compliance Department via email, mail, or anonymous hotline. Once the report is received, GCHP will then investigate and respond to the allegations of FWA.
HealthNetMediCal Abbr	(APL activity #43) Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse that is identified to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the health plan first become aware of, or is on notice of, such activity.
Inland Abbr	All potential fraud, waste, or abuse of non-controlled drugs by beneficiaries are sent to Compliance department for further review and investigation. Compliance department will facilitate with other departments to help review and analyze for final determination.
Kaiser Abbr	Kaiser provides fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse identified to the California Department of Health Care Services (DHCS) Audits and Investigations Intake Unit as well as conducts, completes, and reports to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Kaiser first become aware of, or is on notice of, such activity.
KernHealthSystems Abbr	As outlined in an All Plan Letter (APL) 22-012, which provides guidance to the health plans, activity #43 delineates steps plans are to conduct and follow when FWA is detected. Reports are run to identify instances of FWA. This is further stated in KHS' Policy 13.04-I.
LACARE Abbr	Providing fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse the MCP identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the MCP first become aware of, or is on notice of, such activity.
Molina Abbr	Pharmacy Services staff adhere to the Molina Healthcare compliance reporting system for reporting instances of suspected healthcare fraud, waste, and/or abuse for any drugs as well as participate in regular education concerning detection and prevention of healthcare related fraud, waste, and/or abuse (potential occurrences of member, provider, practitioner, practitioner, supplier, or employee fraud, waste, and/or abuse). Investigation and potential reporting of suspected acts of healthcare related fraud, waste, and/or abuse can be sent to the Pharmacy Director/designee, Compliance Official or Legal Department. Additional coordination may also involve Molina's Compliance Department.
Partnership Abbr	Partnership HealthPlan follows a process described in PHC policy CMP09 which outlines PHC's process to detect, prevent, investigate, and report potential or actual cases of fraud, waste or abuse by beneficiaries, prescribers, and pharmacy providers for all drugs.
SanFrancisco Abbr	The Medi-Cal Rx prescription data provided to SFHP by DHCS is analyzed for potential FWA through multiple quarterly reports. These include, but are not limited to, members with multiple providers, members with multiple pharmacies, members experiencing polypharmacy, and utilization trends by therapeutic class.

MCO Name	Explanation
SanJoaquin Abbr	The HPSJ Compliance department directs the identification, monitoring and reporting of all FWA. Detection includes but is not limited to, implementing effective internal monitoring (e.g., Hotline, Anonymous Compliance Lunch Room boxes), auditing, and data mining (FWA Detection Vendor).
SanMateo Abbr	The MCO has a documented process for FWA investigation and reporting that involves notification to MCO compliance staff of any potential FWA for investigation. For non-controlled drugs, this involves referrals (e.g., from individuals, the healthcare fraud prevention partnership group), state provided reporting, or outlier identification via pharmacy data review. The MCO will also coordinate with the state, sending identified concerns to the state's Audits and Investigations Intake Unit along with preliminary MCO findings of the suspected FWA.
SantaClaraHealthPlan Abbr	Identified potential fraud or abuse of non-controlled drugs by beneficiaries, prescribers, and pharmacy providers are reviewed by the Director of Pharmacy, or designee, and forwarded to SCFHP's Compliance Department for determination of action. If SCFHP's Compliance Department agrees with the determination of potential fraud, waste, or abuse, SCFHP will forward the information to the DHCS Audits and Investigations Intake Unit and conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud, waste, or abuse within 10 business days of becoming aware of, or is on notice of, such activity.
UnitedHealth Abbr	UnitedHealthcare Community Plan provides fraud and abuse reporting, including prompt referral of any potential fraud, waste and abuse UnitedHealthcare Community Plan identifies to the DHCS Audits and Investigations Intake Unit as well as conducting, completing, and reporting to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date UnitedHealthcare Community Plan first becomes aware of, or is on notice of, such activity. Additionally Optum Provider Behavior Operations - Drug Diversion team creates member cases for UnitedHealthcare Community Plan. As part of their drug diversion leads non- controlled substances known to be potentiators of opioids or benzodiazepines are included.

B. Prescription Drug Monitoring Program (PDMP)

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

Figure 18 - MCO has Ability to Query the State's PDMP Database

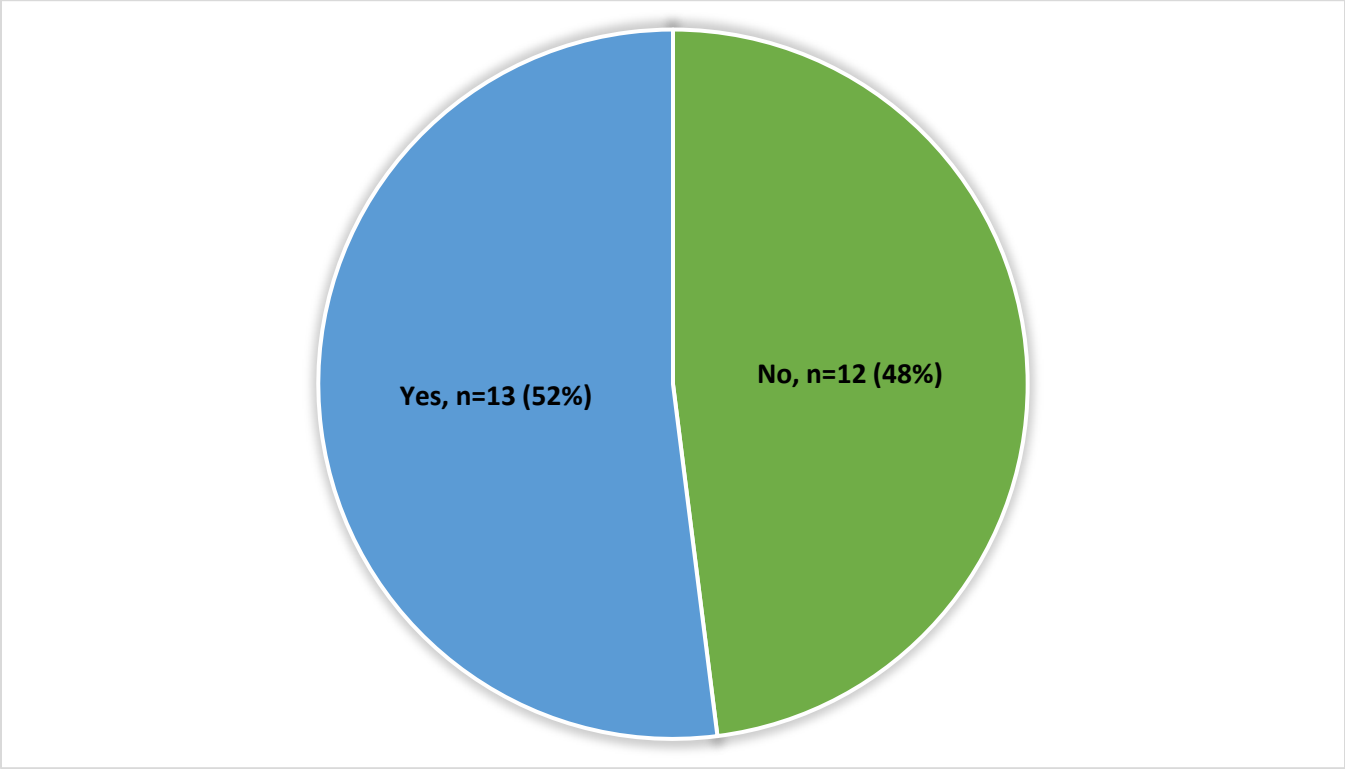

Table 31 - MCO has Ability to Query the State's PDMP Database

Response	MCO Names	Count	Percentage
Yes	Alameda Abbr, Anthem Abbr, CalOptima Abbr, CalViva Abbr, CHW Abbr, Community Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SantaClaraHealthPlan Abbr	13	52.00%
No	AetnaBetterHealthCA Abbr, AHF Abbr, BlueShield Abbr, CCAH Abbr, CenCal Abbr, ContraCosta Abbr, GoldCoast Abbr, KernHealthSystems Abbr, LACARE Abbr, SanJoaquin Abbr, SanMateo Abbr, UnitedHealth Abbr	12	48.00%
State Totals		**25**	**100%**

If "No," please explain.

Table 32 - Explanations for MCO not having the Ability to Query the State's PDMP Database

MCO Name	Explanation
AetnaBetterHealthCA Abbr	State does not permit the plan to access the PDMP.

MCO Name	Explanation
AHF Abbr	California state law does not allow for California's Medicaid program to query the CURES database.
BlueShield Abbr	Per California state law, access to California's CURES (Controlled Substance Utilization Review and Evaluation System) PDMP information can only be used by licensed health care practitioners and licensed pharmacists when providing direct patient care.
CCAH Abbr	California state law does not allow for California's Medicaid program to query the CURES database.
CenCal Abbr	According to the Prescription Drug Monitoring Program (PDMP) Training and Technical Assistance Center (TTAC), the State of California does not include the MCOs as requesters that are authorized to generate reports on the PDMP database.
ContraCosta Abbr	California's PDMP does not include MCOs as an authorized user. However, pharmacists may query the state's PDMP database
GoldCoast Abbr	According to the Prescription Drug Monitoring Program (PDMP) Training and Technical Assistance Center (TTAC), the State of California does not include the MCOs as requesters that are authorized to generate reports on the PDMP database.
KernHealthSystems Abbr	Some personnel have access to state's PDMP site. The functionality is limited to looking up a single member at a time. There is no ability currently to run sweeping reports, look up multiple members, providers, pharmacies, etc. at a time. KHS does not get a direct file dump.
LACARE Abbr	CA's PDMP does not include MCOs as an authorized user
SanJoaquin Abbr	HPSJ does not have access. California state law does not allow for California's Medicaid program to query the CURES database.
SanMateo Abbr	No, California state law does not enable California Medicaid MCOs direct access to query the CURES database.
UnitedHealth Abbr	CA's PDMP does not include MCOs as an authorized user.

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

Figure 19 - Ways the MCO has Ability to Query the State's PDMP Database

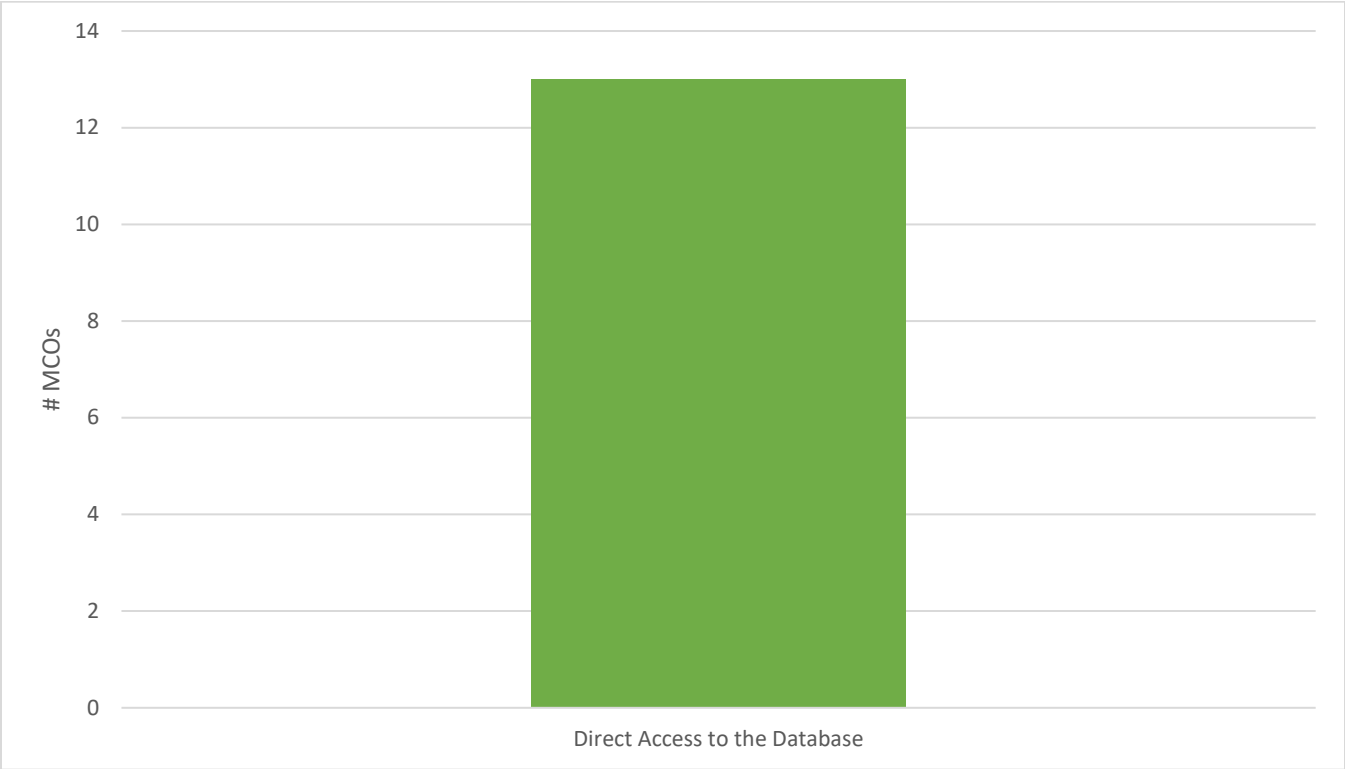

Table 33 - Ways the MCO has Ability to Query the State's PDMP Database

Response	MCO Names	Count	Percentage
Direct access to the database	Alameda Abbr, Anthem Abbr, CalOptima Abbr, CalViva Abbr, CHW Abbr, Community Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SantaClaraHealthPlan Abbr	13	100.00%
State Totals		**13**	**100%**

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

Figure 20 - Query Capability

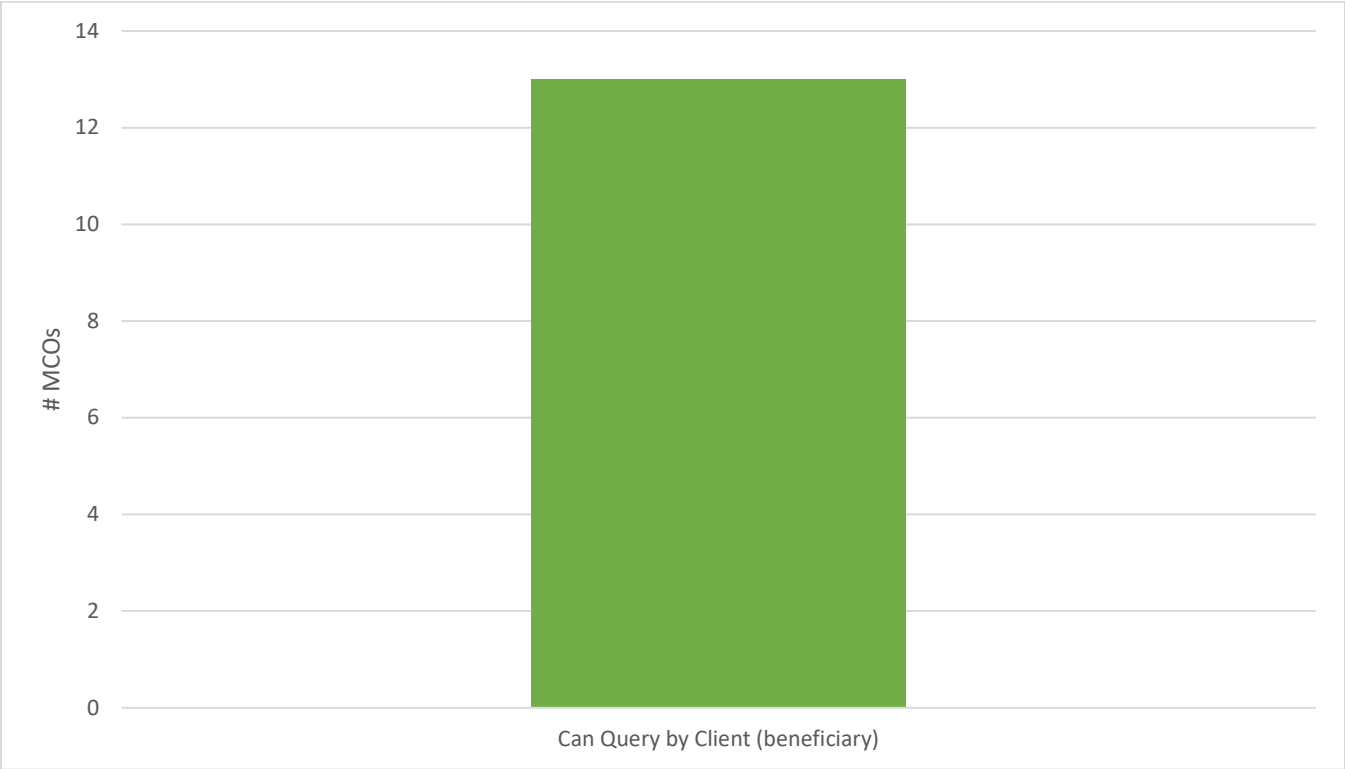

Table 34 - Query Capability

Response	MCO Names	Count	Percentage
Can query by client (beneficiary)	Alameda Abbr, Anthem Abbr, CalOptima Abbr, CalViva Abbr, CHW Abbr, Community Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SantaClaraHealthPlan Abbr	13	100.00%
State Totals		**13**	**100%**

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

Table 35 - Explanation for How MCO Program Applies Information to Control FWA of Controlled Substances

MCO Name	Explanation
Alameda Abbr	Alameda reports any findings of fraud, waste, and abuse that our compliance team identifies during regulatory audits or reported FWA. Alameda used PDMP data to help identify FWA issues, if necessary.
Anthem Abbr	We do not use the information at this time, unless a member is identified as a potential high utilizer by our case management team.
CalOptima Abbr	Used to identify potential FWA for prescriptions filled outside the PBM system.
CalViva Abbr	Review members identified for potential FWA by Care Management and Special Investigations Unit (SIU) teams.
CHW Abbr	Review members identified for potential FWA by Care Management and Special Investigations Unit (SIU) teams.

MCO Name	Explanation
Community Abbr	CHG pharmacists compares information in the PDMP database to controlled medications found in CHG's database to identify gaps or potential missing information. This helps improve patient safety and control FWA of controlled substances for the members under our care.
HealthNetMediCal Abbr	Review members identified for potential FWA by Care Management and Special Investigations Unit (SIU) teams.
Inland Abbr	MCO query by client to get the PDMP information. The information is used to look for evidence of beneficiaries who are paying cash, and for evidence of polypharmacy or polyprescriber.
Kaiser Abbr	Kaiser Permanente Medical Group physicians follow CA state law requirements and have access to all patient encounter/Rx data via our integrated health care model. A Kaiser pharmacist may use their professional judgement to query CURES when FWA is suspected.
Molina Abbr	Used for review of (Physician Administered Drugs) Prior Authorization decision making or ad-hoc as needed for FWA concerns. Any issues can be referred to our Molina SIU (Special Investigations Unit) team for potential escalation to DHCS.
Partnership Abbr	PHC Clinical Pharmacists and Medical Directors access PDMP data and Magellan data when reviewing and researching referrals for possible Fraud Waste and Abuse investigations.
SanFrancisco Abbr	When reviewing members identified through internal reporting as potential risks for FWA, SFHP pharmacists look up individual members in order to assess appropriateness of prescribing.
SantaClaraHealthPlan Abbr	The Plan's pharmacists are able to pull beneficiary controlled substance utilization reporting from California's PDMP, Controlled Substance Utilization Review and Evaluation System (CURES), as part of investigating potential FWA cases.

c. Does your State also have access to contiguous States' PDMP information?

Figure 21 - MCO Access to Contiguous States' PDMP Information

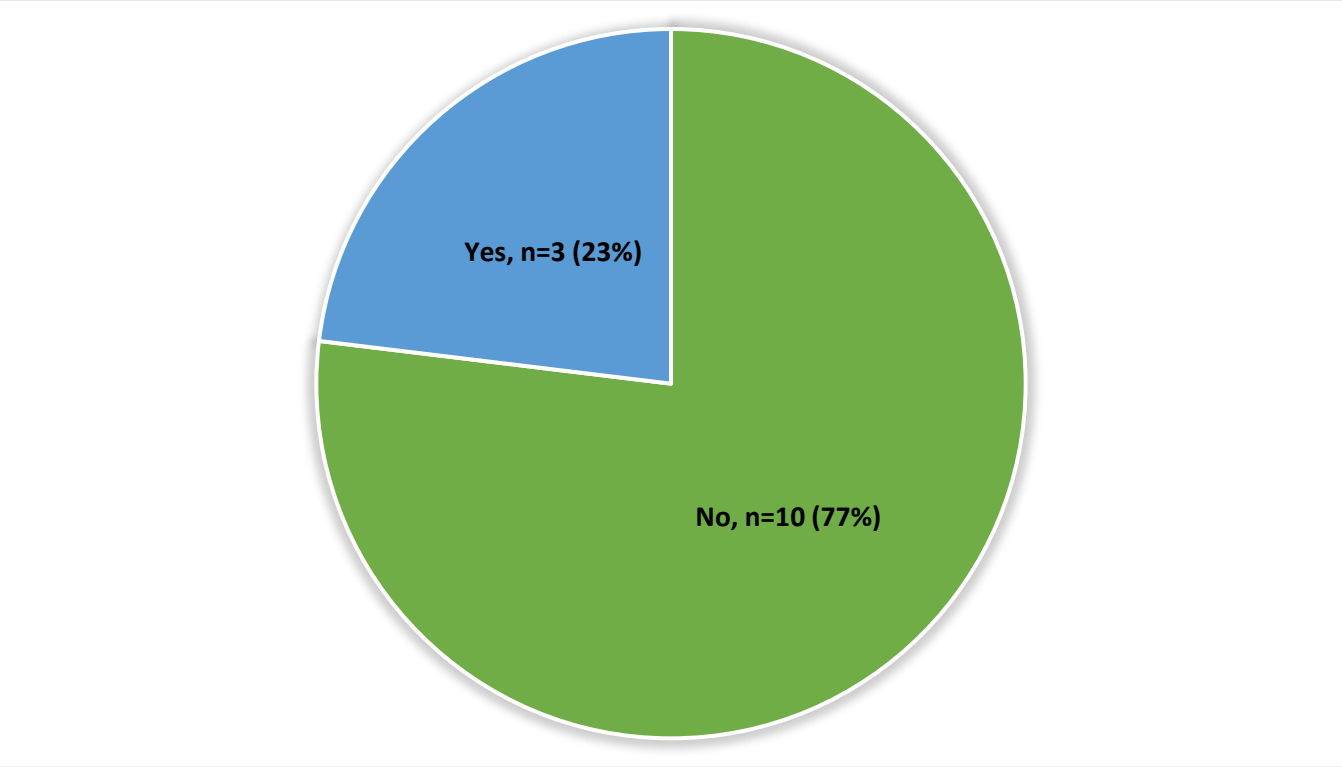

Table 36 - MCO Access to Contiguous States' PDMP Information

Response	MCO Names	Count	Percentage
Yes	Community Abbr, Inland Abbr, Partnership Abbr	3	23.08%
No	Alameda Abbr, Anthem Abbr, CalOptima Abbr, CalViva Abbr, CHW Abbr, HealthNetMediCal Abbr, Kaiser Abbr, Molina Abbr, SanFrancisco Abbr, SantaClaraHealthPlan Abbr	10	76.92%
State Totals		**13**	**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 22 - Communicated that Prescribers are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

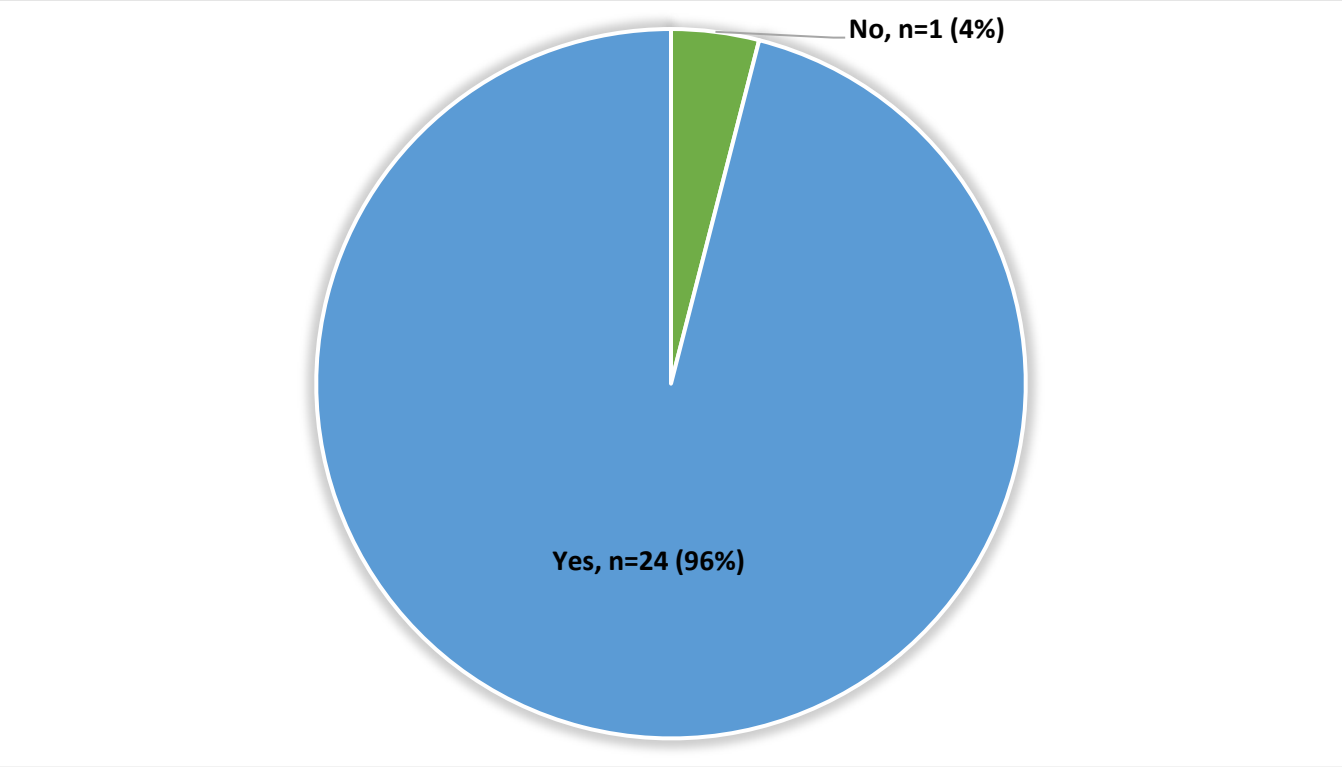

Table 37 - Communicated that Prescribers are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	24	96.00%
No	CalOptima Abbr	1	4.00%
State Totals		**25**	**100%**

If "Yes," please check all that apply.

Figure 23 - Ways MCO Has Communicated Requirement

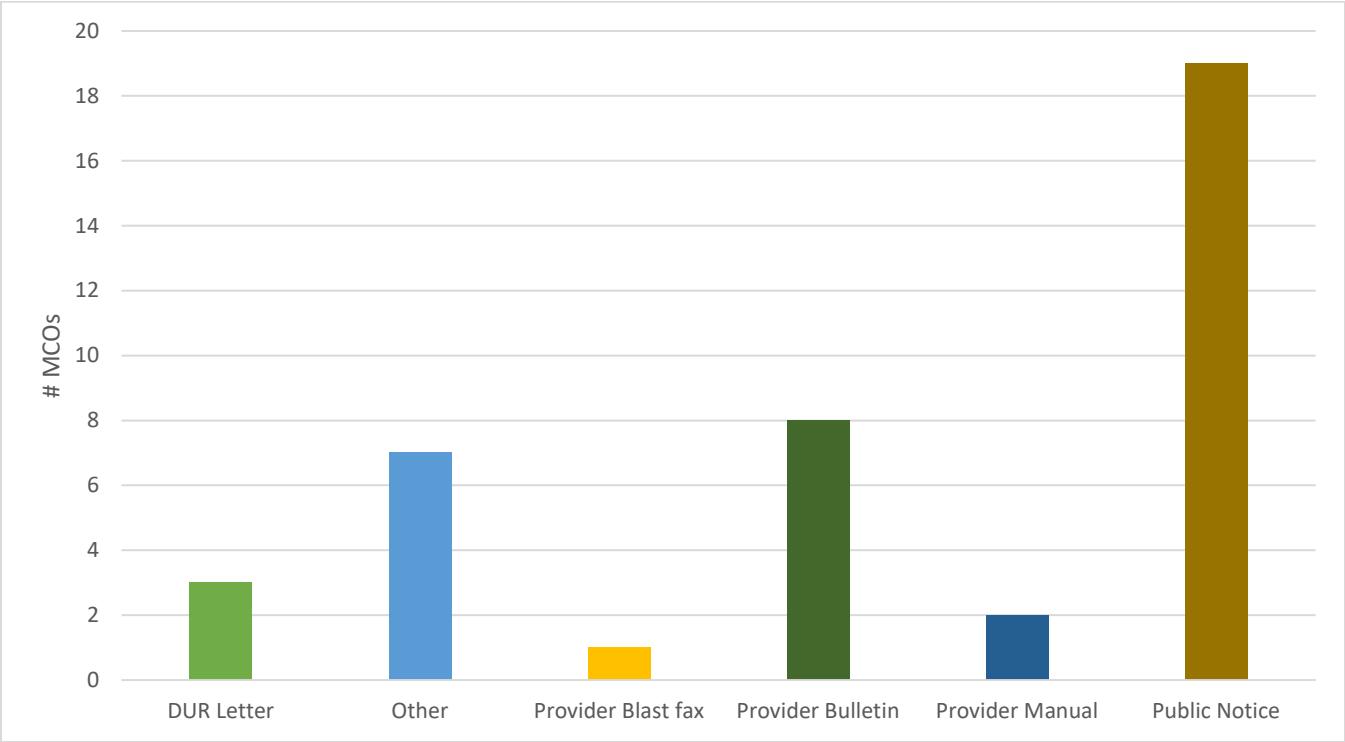

Table 38 - Ways MCO Has Communicated Requirement

Response	States	Count	Percentage
DUR letter	CenCal Abbr, GoldCoast Abbr, Inland Abbr	3	7.50%
Provider blast fax	Inland Abbr	1	2.50%
Provider bulletin	CalViva Abbr, CHW Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, Partnership Abbr, SanFrancisco Abbr	8	20.00%
Provider manual	Inland Abbr, LACARE Abbr	2	5.00%
Public notice	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CCAH Abbr, CenCal Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, Kaiser Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	19	47.50%

Response	States	Count	Percentage
Other	AHF Abbr, Alameda Abbr, Anthem Abbr, CenCal Abbr, GoldCoast Abbr, SanJoaquin Abbr, SanMateo Abbr	7	17.50%
State Totals		**40**	**100%**

If “Other,” please explain.

Table 39 - "Other" Ways MCO Has Communicated Requirement

MCO Name	Explanation
AHF Abbr	There are conditions under which a California health care practitioner is required to consult the CURES database. A health care practitioner must consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every six months thereafter. These requirements are provided, in full, at California Health and Safety Code Section 11165.4. This requirement does not apply to veterinarians or pharmacists and there are also conditions under which a health care practitioner is exempt from consulting the CURES database before prescribing, ordering, administering, or furnishing a controlled substance based on California Health and Safety Code section 11165.4
Alameda Abbr	There are conditions under which a California health care practitioner is required to consult the CURES database. A health care practitioner must consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every six months thereafter. These requirements are provided, in full, at California Health and Safety Code Section 11165.4. This requirement does not apply to veterinarians or pharmacists and there are also conditions under which a health care practitioner is exempt from consulting the CURES database before prescribing, ordering, administering, or furnishing a controlled substance. For a full list of exemptions please visit California Health and Safety Code section 11165.4(c). Additionally, the following documents may provide helpful context: The Department of Consumer Affair's (DCA) Website for CURES The DCA's flyer regarding mandatory consulting
Anthem Abbr	California Department of Justice (DOJ.ca.gov) public website; https://oag.ca.gov/cures; (Educational Bulletin in 2016 on CURES, but not recent not about the requirements. https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/dur/educational-articles/dured_24422_California_Upgrades_Prescription_Drug_Monitoring_Program_to_CURES_2.0.pdf
CenCal Abbr	Notification of the requirement was posted on the CenCal Health pharmacy webpage as a DUR educational article alert and public notice was given through the California Department of Justice public website.
GoldCoast Abbr	Notification of the requirement was posted on the GCHP pharmacy services webpage for providers as a DUR Bulletin education article alert. Public notice was also given by the California Department of Justice public website. There are conditions under which a

MCO Name	Explanation
	California health care practitioner is required to consult the CURES database. A health care practitioner must consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every six months thereafter. These requirements are provided, in full, at California Health and Safety Code Section 11165.4. This requirement does not apply to veterinarians or pharmacists and there are also conditions under which a health care practitioner is exempt from consulting the CURES database before prescribing, ordering, administering, or furnishing a controlled substance. For a full list of exemptions please visit California Health and Safety Code section 11165.4(c). Additionally, the following documents may provide helpful context: The Department of Consumer Affair's (DCA) Website for CURES The DCA's flyer regarding mandatory consulting
SanJoaquin Abbr	There are conditions under which a California health care practitioner is required to consult the CURES database. A health care practitioner must consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every six months thereafter. These requirements are provided, in full, at California Health and Safety Code Section 11165.4. This requirement does not apply to veterinarians or pharmacists and there are also conditions under which a health care practitioner is exempt from consulting the CURES database before prescribing, ordering, administering, or furnishing a controlled substance. For a full list of exemptions please visit California Health and Safety Code section 11165.4(c). Additionally, the following documents may provide helpful context: The Department of Consumer Affair's (DCA) Website for CURES The DCA's flyer regarding mandatory consulting
SanMateo Abbr	There are conditions under which a California health care practitioner is required to consult the CURES database. A health care practitioner must consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every six months thereafter. These requirements are provided, in full, at California Health and Safety Code Section 11165.4. This requirement does not apply to veterinarians or pharmacists and there are also conditions under which a health care practitioner is exempt from consulting the CURES database before prescribing, ordering, administering, or furnishing a controlled substance. For a full list of exemptions please visit California Health and Safety Code section 11165.4(c). Additionally, the following documents may provide helpful context: The Department of Consumer Affair's (DCA) Website for CURES The DCA's flyer regarding mandatory consulting

If “No,” please explain.

Table 40 - “No” Explanations for Communicating Prescribers are Required to Access the PDMP Patient History Before Prescribing Controlled Substances

MCO Name	Explanation
CalOptima Abbr	State requirement.

a. If "Yes," has your MCO specified protocols for prescribers checking the PDMP?

Figure 24 - Protocols Involved in Checking the PDMP

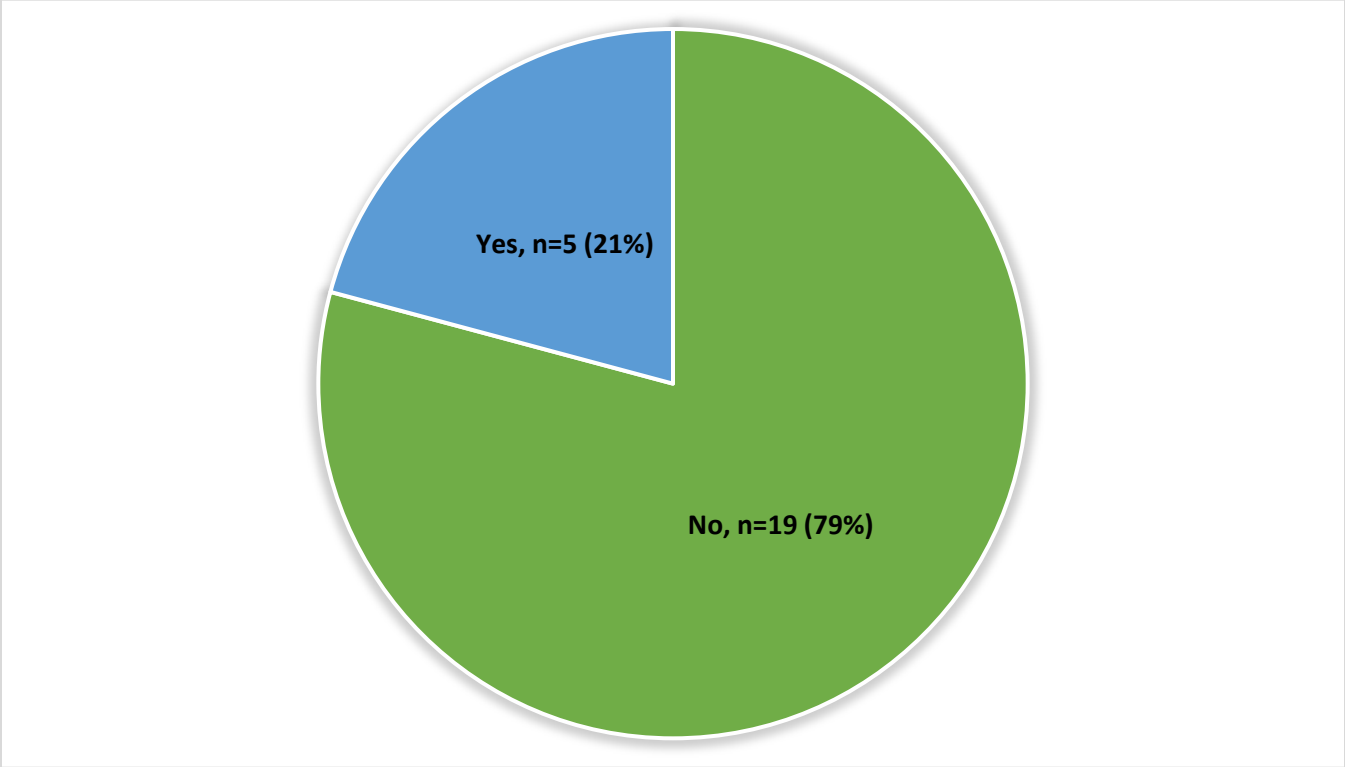

Table 41 - Protocols Involved in Checking the PDMP

Response	MCO Names	Count	Percentage
Yes	Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Partnership Abbr, SantaClaraHealthPlan Abbr	5	20.83%
No	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, UnitedHealth Abbr	19	79.17%
State Totals		**24**	**100%**

If "Yes," please explain.

Table 42 - Explanations of Protocols Involved in Checking the PDMP

MCO Name	Explanation
Kaiser Abbr	Kaiser Permanente Medical Group physicians have protocols in place to check CURES, which includes any requirements, frequency, and exemptions.
KernHealthSystems Abbr	The provider should follow CDC guidelines and CA state law as to when to check PDMP.
LACARE Abbr	Yes, per HSC 11165.4, prescribers must consult CURES the first time a patient is prescribed a controlled substance and at least every 4 months if the controlled substance remains a part of the patients treatment plan.
Partnership Abbr	Per PHC Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing MPXG5008 " Section VI, line C, 4c: when prescribing opioids, the prescriber is to check the California Department of Justice Controlled Substance

MCO Name	Explanation
	Utilization Review and Evaluation System (CURES) report at the time of writing each controlled substance prescription, or more frequently, as required by state law.
SantaClaraHealthPlan Abbr	California requires prescribers to consult the Controlled Substance Utilization Review and Evaluation System (CURES) database prior to prescribing, ordering, and administering, or furnishing a Schedule II-IV controlled substance for the first time and at least once every six months thereafter while the drug remains part of the patient's treatment.

b. If "Yes," 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 25 - Providers Having Protocols for Responses to Information from the PDMP that is Contradictory to the Information the Practitioner Expects

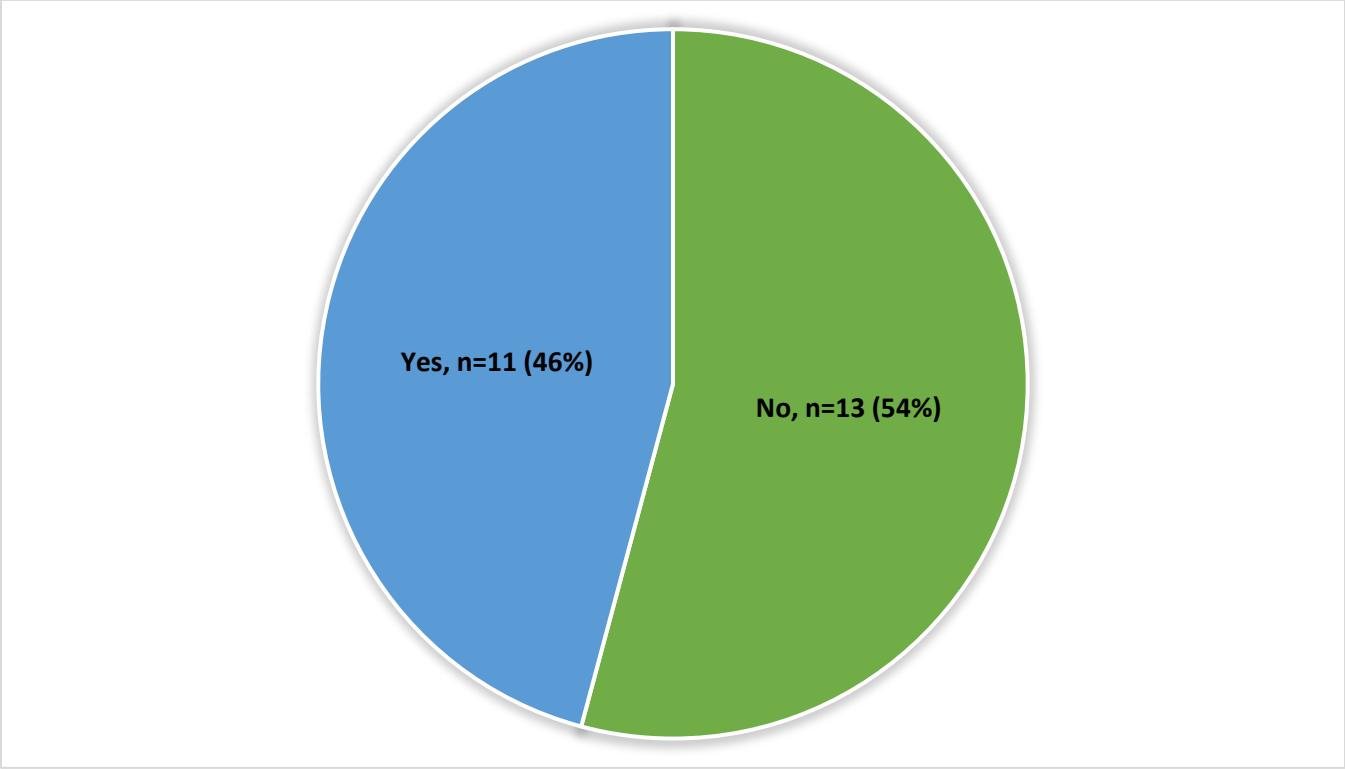

Table 43 - Providers Having Protocols for Responses to Information from the PDMP that is Contradictory to the Information the Practitioner Expects

Response	MCO Names	Count	Percentage
Yes	BlueShield Abbr, CalViva Abbr, CenCal Abbr, CHW Abbr, ContraCosta Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, SanFrancisco Abbr, SantaClaraHealthPlan Abbr	11	45.83%
No	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, CCAH Abbr, Community Abbr, GoldCoast Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanJoaquin Abbr, SanMateo Abbr, UnitedHealth Abbr	13	54.17%
State Totals		**24**	**100%**

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

Figure 26 - MCO Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check

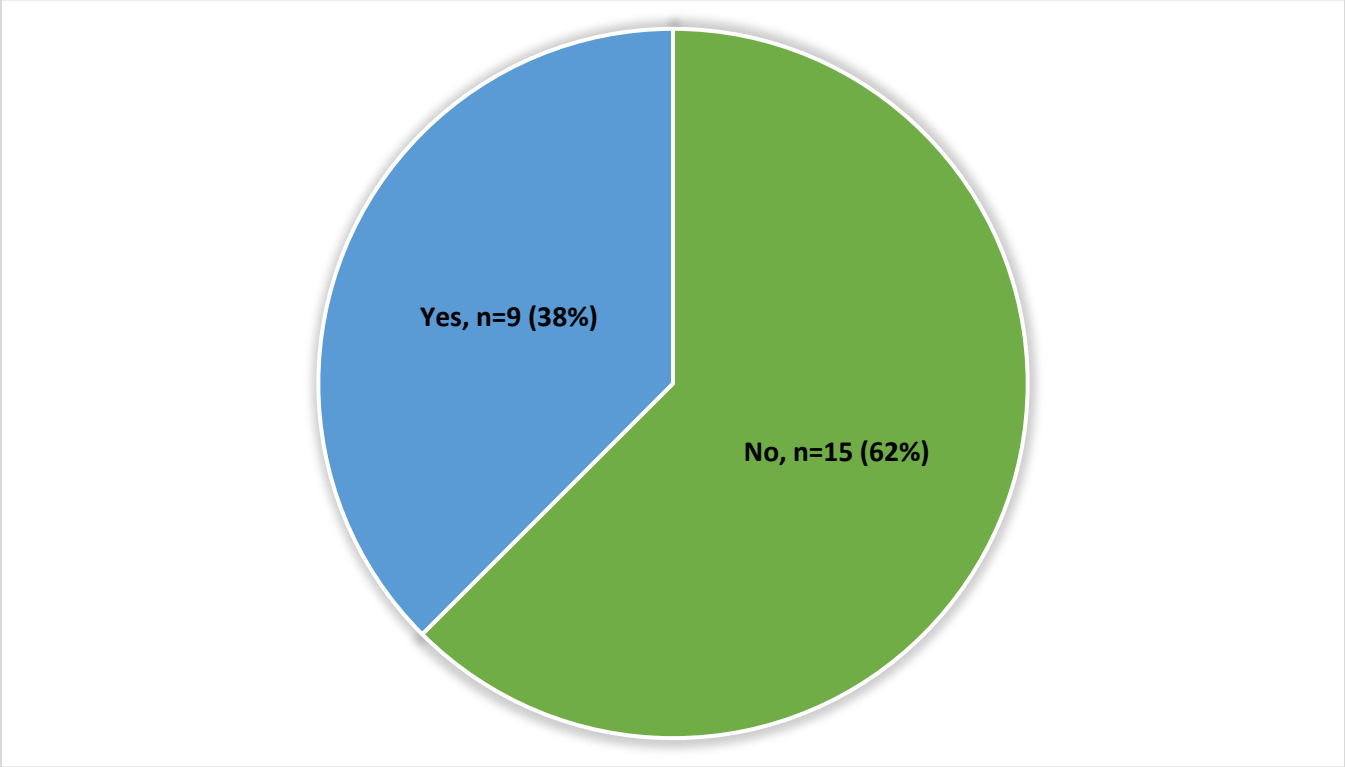

Table 44 - MCO Requires Prescriber to Document a Good Faith Effort if Unable to Conduct a PDMP Check

Response	MCO Names	Count	Percentage
Yes	CenCal Abbr, CHW Abbr, Inland Abbr, KernHealthSystems Abbr, LACARE Abbr, Partnership Abbr, SanFrancisco Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	9	37.50%
No	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalViva Abbr, CCAH Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, Molina Abbr, SanJoaquin Abbr, SanMateo Abbr	15	62.50%
State Totals		**24**	**100%**

If "No," please explain.

Table 45 - Explanations for not Requiring Prescribers to Document a Good Faith Effort

MCO Name	Explanation
AetnaBetterHealthCA Abbr	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record (11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.
AHF Abbr	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record

MCO Name	Explanation
	(11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.
Alameda Abbr	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record (11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.
Anthem Abbr	MCO does not require; state regulations require chart documentation
BlueShield Abbr	Per California state law, access to California's CURES (Controlled Substance Utilization Review and Evaluation System) PDMP information can only be used by licensed health care practitioners and licensed pharmacists when providing direct patient care.
CalViva Abbr	Magellan Rx manages the pharmacy benefit.
CCAH Abbr	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record (11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.
Community Abbr	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record (11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.
ContraCosta Abbr	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record (11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.
GoldCoast Abbr	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record (11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.
HealthNetMediCal Abbr	Magellan Rx manages the pharmacy benefit.
Kaiser Abbr	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record (11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.
Molina Abbr	There is no oversight of outpatient drug reviews as they are carved out to the state. For potential Physician Administered Drug Prior Authorization review of opioids, PDMP review is required for approval. If the Prescriber is unable to conduct a PDMP check, clinical rationale for why they could not do so would be reviewed on a case by case basis.
SanJoaquin Abbr	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record

MCO Name	Explanation
	(11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.
SanMateo Abbr	There are multiple exceptions to the mandatory consultation requirement, which are specified in California Health and Safety Code Section 11165.4(c). Only one of these exceptions requires the provider to document a reason in the patients record (11165.4(c)(5)), and this requirement to document is not contingent on a good faith effort being made.

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

Figure 27 - MCO Requires Provider to Submit Documentation

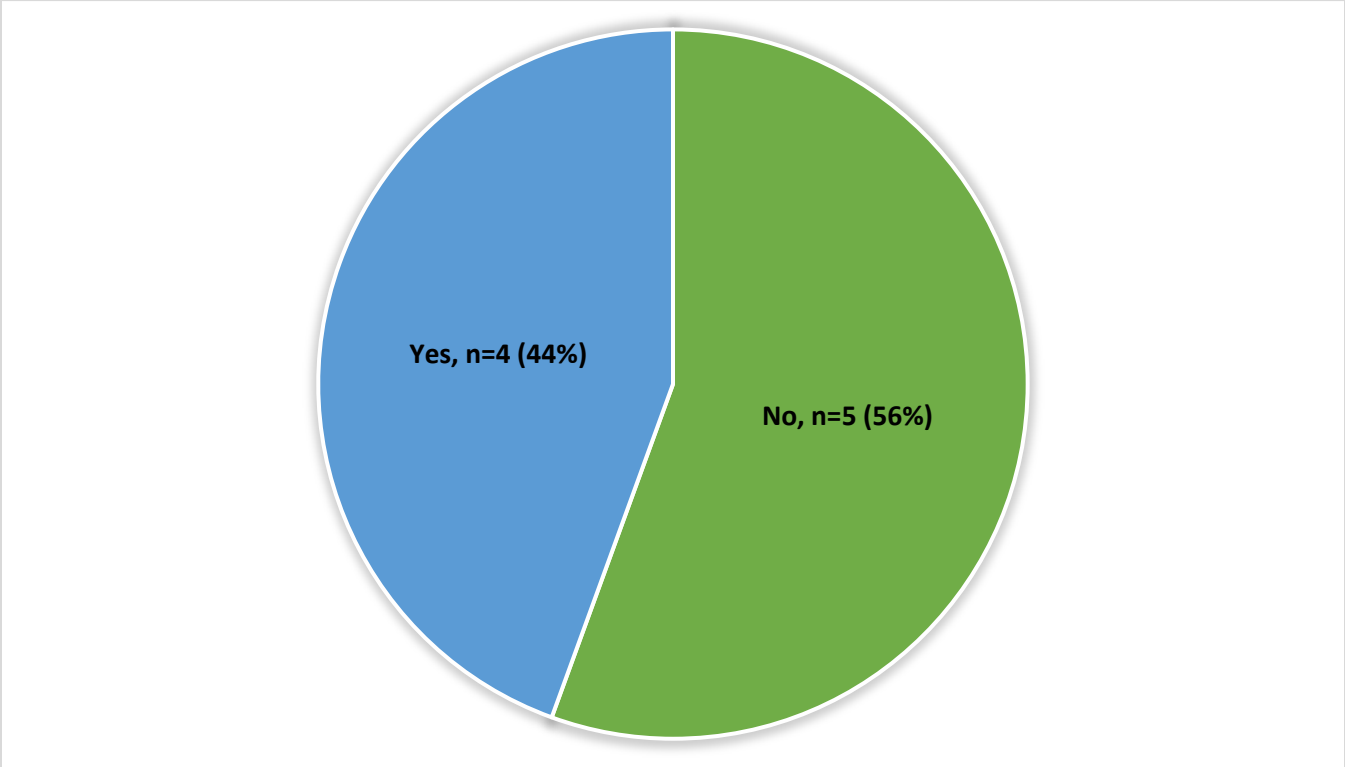

Table 46 - MCO Requires Provider to Submit Documentation

Response	MCO Names	Count	Percentage
Yes	KernHealthSystems Abbr, LACARE Abbr, SanFrancisco Abbr, UnitedHealth Abbr	4	44.44%
No	CenCal Abbr, CHW Abbr, Inland Abbr, Partnership Abbr, SantaClaraHealthPlan Abbr	5	55.56%
State Totals		**9**	**100%**

If "No," please explain.

Table 47 - Explanations for not Requiring Provider to Submit Documentation

MCO Name	Explanation
CenCal Abbr	The Refer to the Appropriate Medical Board of California requires all providers unless an exemption exists in law to query the CURES database and run a Patient Activity Report (PAR) for all Schedule II-IV controlled substances.

MCO Name	Explanation
CHW Abbr	Magellan Rx manages the pharmacy benefit.
Inland Abbr	Providers are to document the reason why they are unable to conduct a PDMP check at the time of prescribing a controlled substance in the patient's medical record for their own records and auditing purposes.
Partnership Abbr	PHC does not require the provider to submit documentation to the State, however, PHC Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing recommends utilization of Controlled Substance Utilization Review and Evaluation System (CURES) report at the time of writing each controlled substance prescription, as well as following all requirements set forth by state law.
SantaClaraHealthPlan Abbr	The Plan does not require prescribers to do this in our provider agreements. However, California Health and Safety Code 11165.4 requires that the prescriber must document the reason for not consulting the PDMP database in the patient's medical record if the CURES database was not consulted prior to prescribing, ordering, administering, or furnishing a controlled substance.

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 28 - Beneficiary Information Available to Prescribers as Close to Real-Time as Possible

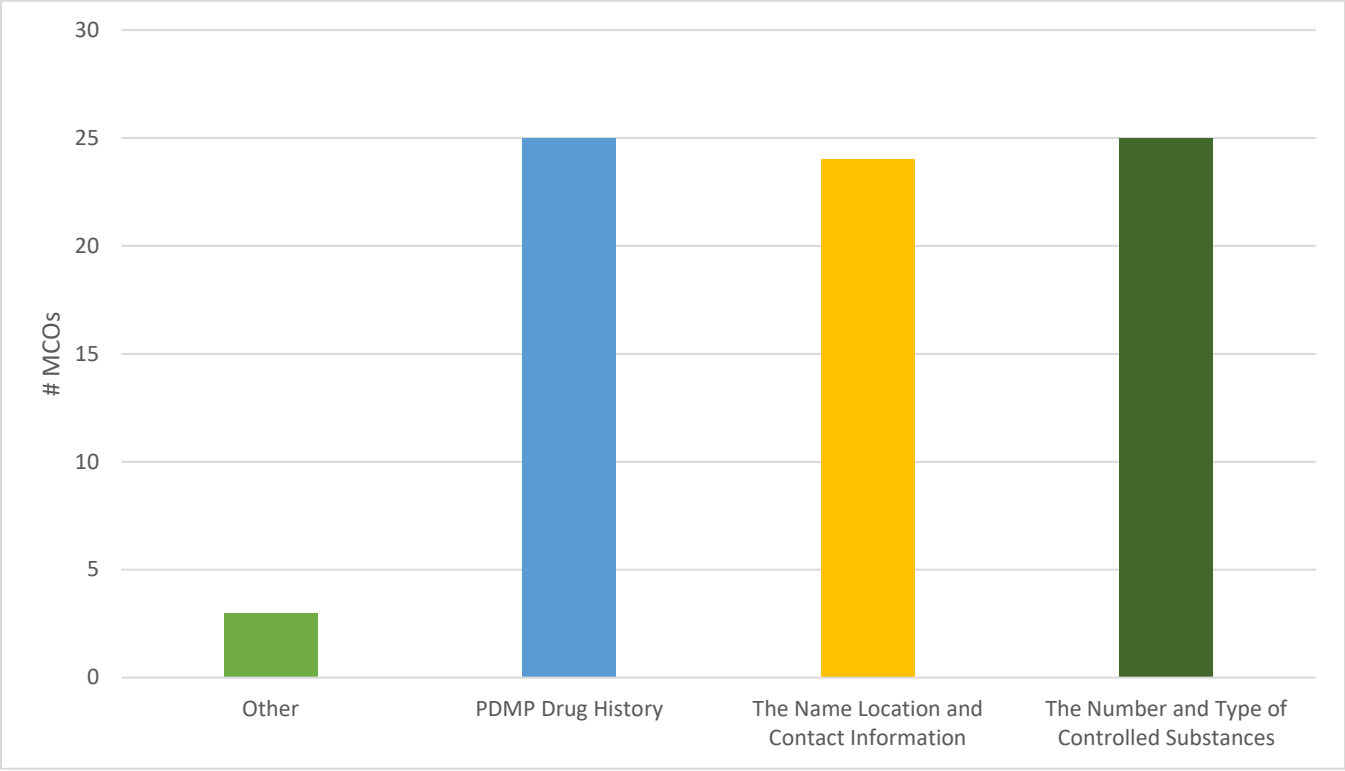

Table 48 - Beneficiary Information Available to Prescribers as Close to Real-Time as Possible

Response	MCO Names	Count	Percentage
PDMP drug history	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr,	25	32.47%

Response	MCO Names	Count	Percentage
	KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr		
The name location and contact information	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	24	31.17%
The number and type of controlled substances	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	32.47%
Other	CalViva Abbr, CHW Abbr, HealthNetMediCal Abbr	3	3.90%
State Totals		**77**	**100%**

If “Other,” please explain.

Table 49 - Other Explanation for Information Available to Prescribers with Respect to a Beneficiary as Close to Real-Time as Possible

MCO Name	Explanation
CalViva Abbr	form of payment
CHW Abbr	form of payment
HealthNetMediCal Abbr	form of payment

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

Figure 29 - Barriers Hinder MCO from Fully Accessing the PDMP to Curb FWA

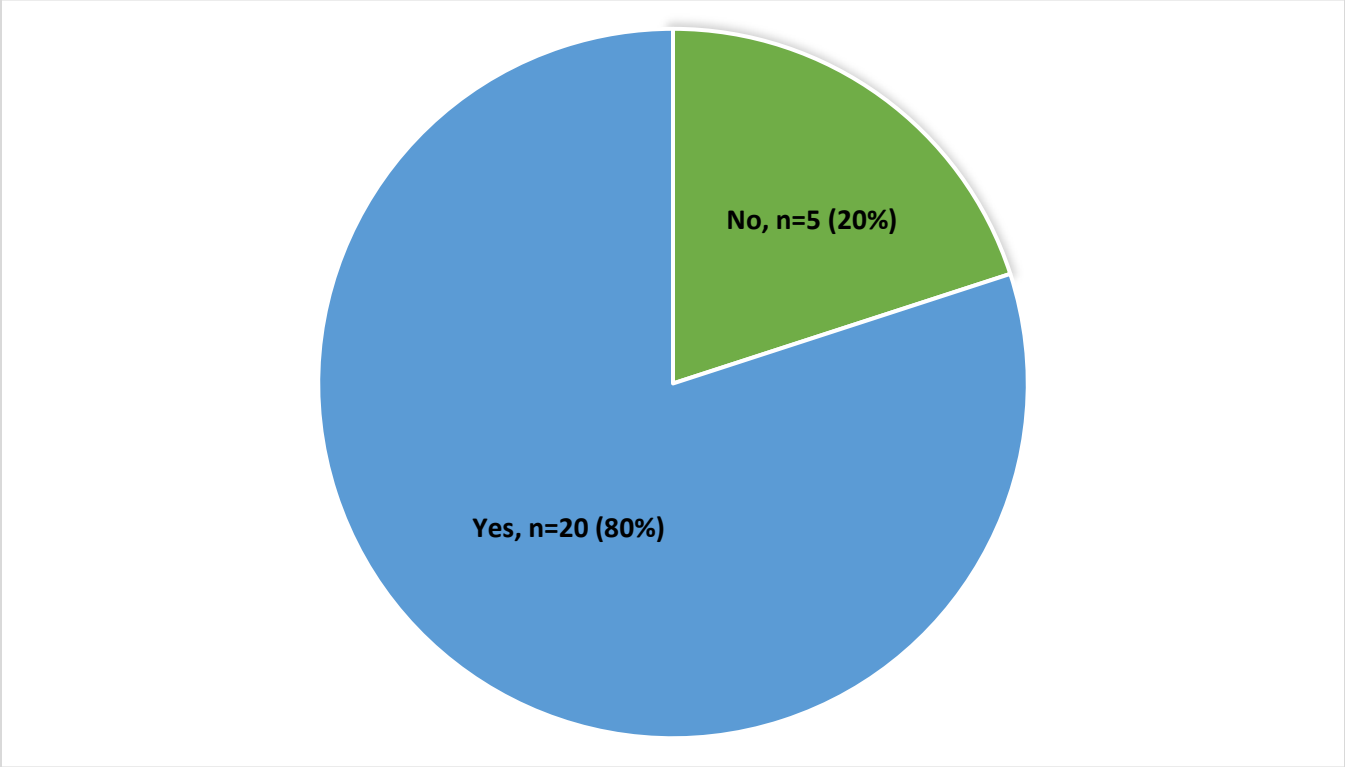

Table 50 - Barriers Hinder MCO from Fully Accessing the PDMP to Curb FWA

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, KernHealthSystems Abbr, LACARE Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	20	80.00%
No	CalOptima Abbr, Kaiser Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr	5	20.00%
State Totals		**25**	**100%**

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

Table 51 - Explanation for Barriers that Hinder MCO from Fully Accessing the PDMP to Curb FWA

MCO Name	Explanation
AetnaBetterHealthCA Abbr	Lag time in prescription data being submitted.
AHF Abbr	1. Inability to access border state PDMP information. 2. Lag time in prescription data being submitted.
Alameda Abbr	The state PDMP system does not have a direct contract with MCO plan allowing us to gather tracking data on prescriber and dispensing pharmacist checking PDMP system. PDMP does not have database to query by provider and dispensing entity. Other barriers include:

MCO Name	Explanation
	1. Inability to access border state PDMP information. 2. Lag time in prescription data being submitted
Anthem Abbr	Unlike some other states that include Medicaid as an authorized user (examples are Washington, Arkansas, and others), the California PDMP (CURES) does not include Medicaid as an authorized user. Requesting data requires any organizations not listed as an authorized user, such as Medicaid or MCOs to submit data request application as a Researcher. This additional Research requirements (establishing a principle investigator (PI) with research expertise and requirement of completion of mandatory training to conduct human subjects research), added paperwork, and added barriers that hinder our (MCO) plan from fully accessing the PDMP (CURES) data.
BlueShield Abbr	Per California state law, access to California's CURES (Controlled Substance Utilization Review and Evaluation System) PDMP information can only be used by licensed health care practitioners and licensed pharmacists when providing direct patient care. Unlike some other states that include Medicaid as an authorized user (examples are Washington, Arkansas, and others), the California PDMP (CURES) does not include Medicaid as an authorized user. Requesting data requires any organizations not listed as an authorized user, such as Medicaid or MCOs to submit data request application as a Researcher. This additional Research requirements (establishing a principle investigator (PI) with research expertise and requirement of completion of mandatory training to conduct human subjects research), added paperwork, and added barriers that hinder our (MCO) plan from fully accessing the PDMP (CURES) data.
CalViva Abbr	Some prescribers do not routinely check PDMP/CURES. Out-of-state pharmacists who do not have CA license are unable to access CURES.
CCAH Abbr	California state law does not allow for California's Medicaid program to query the CURES database.
CenCal Abbr	According to the Prescription Drug Monitoring Program (PDMP) Training and Technical Assistance Center (TTAC), the State of California does not include the MCOs as requesters that are authorized to generate reports on the PDMP database.
CHW Abbr	Some prescribers do not routinely check PDMP/CURES. Out-of-state pharmacists who do not have CA license are unable to access CURES.
Community Abbr	The state is still developing agreements between all bordering states for Interstate Data Sharing. Also, there is a lag time between prescription data being submitted and the same data being reported in the PDMP system.
ContraCosta Abbr	Unlike some other states that include Medicaid as an authorized user (examples are Washington, Arkansas, and others), the California PDMP (CURES) does not include Medicaid as an authorized user. Requesting data requires any organizations not listed as an authorized user, such as Medicaid or MCOs to submit data request application as a Researcher. This additional Research requirements (establishing a principle investigator (PI) with research expertise and requirement of completion of mandatory training to conduct human subjects research), added paperwork, and added barriers that hinder our (MCO) plan from fully accessing the PDMP (CURES) data.
GoldCoast Abbr	According to the Prescription Drug Monitoring Program (PDMP) Training

MCO Name	Explanation
	and Technical Assistance Center (TTAC), the State of California does not include the MCOs as requesters that are authorized to generate reports on the PDMP database. There's also a lag time for prescription data being submitted and there's an inability to access border states' PDMP information.
HealthNetMediCal Abbr	Some prescribers do not routinely check PDMP/CURES. Out-of-state pharmacists who do not have CA license are unable to access CURES.
Inland Abbr	Lag time in prescription data being submitted to the PDMP from pharmacies
KernHealthSystems Abbr	Lag time is a concern. Some providers and systems may not submit data as efficiently as necessary. Some pharmacies may not be able or check the PDMP prior to dispensing.
LACARE Abbr	Unlike some other states that include Medicaid as an authorized user (examples are Washington, Arkansas, and others), the California PDMP (CURES) does not include Medicaid as an authorized user. Requesting data requires any organizations not listed as an authorized user, such as Medicaid or MCOs to submit data request application as a Researcher. This additional Research requirements (establishing a principle investigator (PI) with research expertise and requirement of completion of mandatory training to conduct human subjects research), added paperwork, and added barriers that hinder our MCO plan from fully accessing the PDMP (CURES) data.
SanJoaquin Abbr	1. Inability to access border state PDMP information. 2. Lag time in prescription data being submitted
SanMateo Abbr	We believe the California CURES system (state PDMP) is continuing to evolve over time. Some barriers that currently exist include lack of direct access for payers, inability to access PDMP information from neighboring states, and prescription data lag.
SantaClaraHealthPlan Abbr	Inability to access other states' PDMP information, lag time for prescription data being submitted, unclear directives for health plans' access/use of PDMP data, out-of-state providers cannot query California's PDMP.
UnitedHealth Abbr	Unlike some other states that include Medicaid as an authorized user (examples are Washington, Arkansas, and others), the California PDMP (CURES) does not include Medicaid MCOs as an authorized user. Requesting data requires any organizations not listed as an authorized user, such as Medicaid or MCOs to submit data request application as a Researcher. This additional Research requirements (establishing a principle investigator (PI) with research expertise and requirement of completion of mandatory training to conduct human subjects research), added paperwork, and added barriers that hinder our UHC plan from fully accessing the PDMP (CURES) data.

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

Figure 30 - Changes to State PDMP That Have Improved or Detracted from the Medicaid Program's Ability to Access PDMP Data

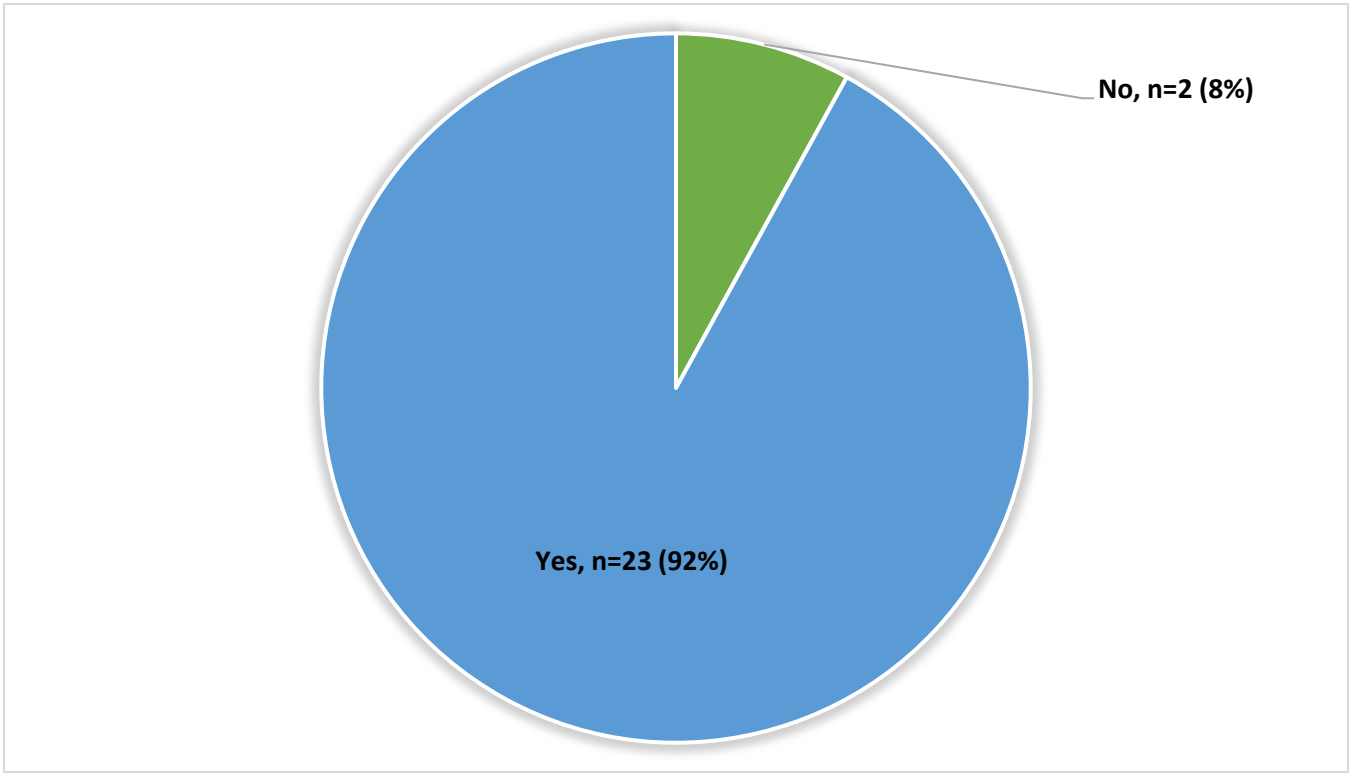

Table 52 - Changes to State PDMP That Have Improved or Detracted from the Medicaid Program's Ability to Access PDMP Data

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	23	92.00%
No	CCAH Abbr, CenCal Abbr	2	8.00%
State Totals		**25**	**100%**

If "Yes," please explain.

Table 53 - Explanations of Changes to State PDMP That Have Improved or Detracted from the Medicaid Program's ability to Access PDMP Data

MCO Name	Summary
AetnaBetterHealthCA Abbr	On August 29, 2022, the State of California - Department of Justice - Office of the Attorney General posted a bulletin on the Adoption of Updated CURES regulations. These changes improved the access to PDMP data, but Medicaid and its MCOs are still not authorized users of CURES.
AHF Abbr	August 29, 2022 Bulletin: Adoption of Updated CURES regulations. "Controlled Substance Utilization Review and Evaluation System | State of California - Department of Justice - Office of the Attorney General"
Alameda Abbr	On August 15, 2022, the California DOJ released updated CURES regulations which can be found here: https://oag.ca.gov/system/files/media/adoption-of-updated-cures-regulations.pdf
Anthem Abbr	August 29, 2022 Bulletin; Adoption of Updated CURES regulations; https;//oag.ca.gov/cures. These changes improved the access to PDMP data, but did not remove significant barrier. Medicaid and its MCOs are still not authorized users of CURES.
BlueShield Abbr	August 29, 2022 Bulletin: Adoption of Updated CURES regulations. Controlled Substance Utilization Review and Evaluation System | State of California - Department of Justice - Office of the Attorney General https://oag.ca.gov/cures These changes improved the access to PDMP data, but did not remove significant barrier. Medicaid and its MCOs are still not authorized users of CURES.
CalOptima Abbr	August 29, 2022 Bulletin: Adoption of Updated CURES regulations. Controlled Substance Utilization Review and Evaluation System | State of California - Department of Justice - Office of the Attorney General These changes improved access to PDMP data, but did not remove significant barriers. Medicaid and its MCOs are still not authorized users.
CalViva Abbr	August 29, 2022 Bulletin: Adoption of Updated CURES Regulations New User Role Added: Non-DEA Prescriber and Expanded Delegate Role allows Delegates to directly access data in CURES. These changes improved the access to PDMP data.
CHW Abbr	August 29, 2022 Bulletin: Adoption of Updated CURES Regulations New User Role Added: Non-DEA Prescriber and Expanded Delegate Role allows Delegates to directly access data in CURES. These changes improved the access to PDMP data.
Community Abbr	CURES provided an improved user interface and new system feature. New user role was added for non-DEA practitioner. Delegates can now directly access data in CURES. Interstate Data Sharing will be allowed as soon as CA DOJ finalizes Interstate Data Sharing agreements with other states (Oregon, Nevada, and Arizona). Agreement with Oregon was approved in 2023.
ContraCosta Abbr	On the August 29, 2022 Bulletin, there was an adoption of updated CURES regulations. Changes improved access to PDMP data, but Medicaid and its MCOs are still not authorized users of CURES.
GoldCoast Abbr	August 2022 bulletin: adoption of updated CURES regulations

MCO Name	Summary
HealthNetMediCal Abbr	August 29, 2022 Bulletin: Adoption of Updated CURES Regulations New User Role Added: Non-DEA Prescriber and Expanded Delegate Role allows Delegates to directly access data in CURES. These changes improved the access to PDMP data.
Inland Abbr	Pharmacy technicians have access to the state's PDMP as a delegate to an individual pharmacist.
Kaiser Abbr	Updated regulations pertaining to the Controlled Substance Utilization Review and Evaluation System (CURES) became effective on August 15, 2022. The regulations revise and add to the CURES access. These changes improved the access to PDMP data.
KernHealthSystems Abbr	California is upgrading the PDMP system so as to allow communication to neighboring states.
LACARE Abbr	August 29, 2022 Bulletin: Adoption of Updated CURES regulations. These changes improved the access to PDMP data, but did not remove significant barrier. Medicaid and its MCOs are still not authorized users of CURES.
Molina Abbr	In 2022 the Controlled Substance Utilization Review and Evaluation System (CURES) program allowed for an expanded delegate functionality which allows delegates to directly access data in CURES.
Partnership Abbr	Updated regulations expanded delegate functionality by allowing delegates to directly access CURES. These changes improved the access to PDMP data, but did not remove any significant barriers as Medicaid and its MCOs are still not authorized users of CURES.
SanFrancisco Abbr	New CURES (California PDMP) regulations were adopted in August of 2022. These included adding a new user role (non-DEA practitioner), expanded delegate role, preparations to allow interstate data sharing, new pre-approval process for law enforcement, and bona fide researcher access.
SanJoaquin Abbr	August 2022 bulletin: adoption of updated CURES regulations
SanMateo Abbr	The adoption of updated regulations pertaining to the California CURES system in August 2022. The CA DOJ has published a bulletin regarding this event which can be found in an announcement on the CURES home page at https://oag.ca.gov/cures
SantaClaraHealthPlan Abbr	The State of California Department of Justice Office of the Attorney General updated regulations to improve the access to PDMP data. However, this did not impact the Plan's previous ability to query or use PDMP data.
UnitedHealth Abbr	Changes were made to the PDMP as outlined in the August 29, 2022 Bulletin: Adoption of Updated CURES regulations. The changes improved the access to PDMP data, but did not remove the significant barrier. Medicaid and its MCOs are still not authorized users of CURES.

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

Figure 31 - Data or Privacy Breaches of PDMP or PDMP Data During This Reporting Period

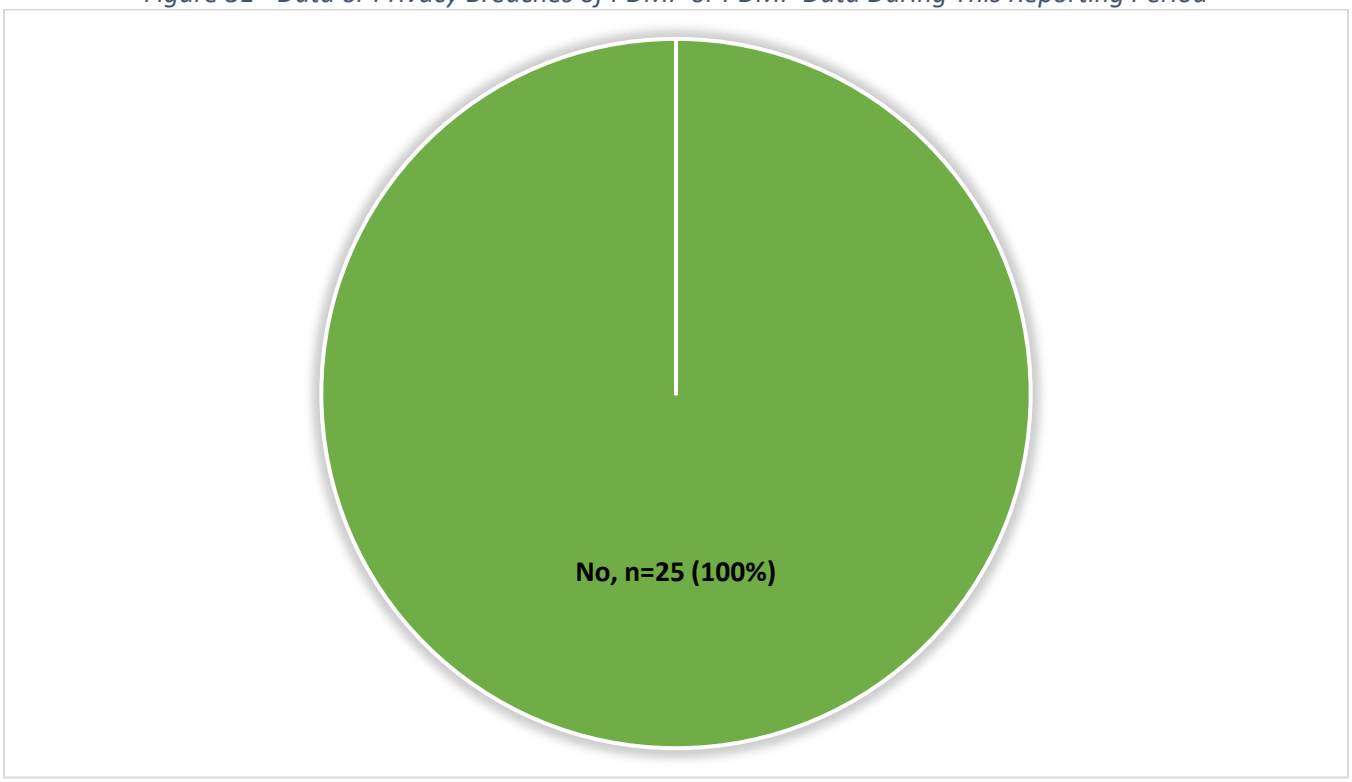

Table 54 - Data or Privacy Breaches of PDMP or PDMP Data During This Reporting Period

Response	MCO Names	Count	Percentage
No	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

C. Opioids

1. Does your MCO coordinate with the entity that provides the drug benefits to monitor opioid prescriptions (duplicate therapy, early refills, quantity limits, etc.)?

Figure 32 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioid Prescriptions

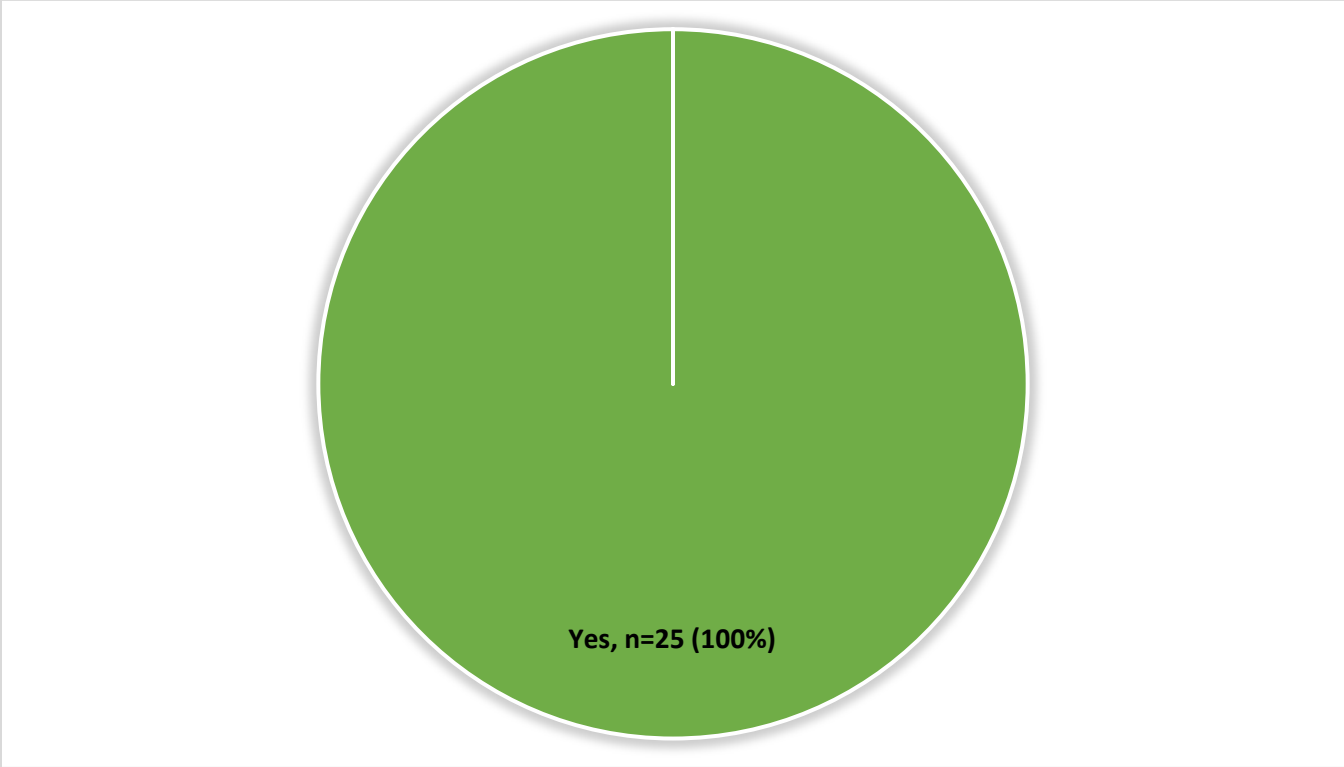

Table 55 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioid Prescriptions

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

Please explain above response.

Table 56 - Explanations for Monitoring Opioid Prescriptions

MCO Name	Explanation
AetnaBetterHealthCA Abbr	As of 1/1/2022 the Pharmacy benefit has been carved out to FFS.

MCO Name	Explanation
	Medi-Cal Rx Provider Manual - Controlled Substance Policy: Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days supply of 35 days. A PA will be required for claims submitted for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s): Dosage Form, Allowable Daily Limit: Solid Dosage Forms, 8 each; Liquid Dosage Forms, 60 mL; Transdermal Dosage Forms, 1 each. NOTE: These limits do not apply to buprenorphine products. Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill: Maximum Quantity Per Fill Subsequent Fill(s): Dosage Form, Allowable Per Fill Limit: Solid Oral " Immediate Release, 120 each; Solid Oral " Extended Release, 90 each; Oral Liquids, 180 mL; Parenterals, 100 mL; Transdermal Dosage Forms, 10 each. NOTE: These limits do not apply to buprenorphine products. As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products) in the past 120-day period.
AHF Abbr	Controlled Substance Policy states claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A prior authorization will be required for claims submitted for greater than (>) 35 days. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply.
Alameda Abbr	Medi-cal Rx has a provider manual in section 15.1.3 which addresses duplicate therapy, early refills and quantity limits. Medi-cal Rx is in charge of managing the formulary. Controlled Substance Policy Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days.

MCO Name	Explanation
	A PA will be required for claims submitted for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. For additional information on what constitutes a new-start, please see note below in Table 15.1.3-1. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-1: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill shown in Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products) Alameda also monitors utilization of opioids.
Anthem Abbr	Yes, per Medi-Cal Rx Provider Manual; 15.1.3 Controlled Substance Policy Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A PA will be required for claims submitted for greater than or equal to 35 days. NOTE; This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products.

MCO Name	Explanation
	New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. For additional information on what constitutes a new-start, please see note below in Table 15.1.3-1. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits; Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each; These limits do not apply to buprenorphine products. Table 15.1.3-; Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill shown in Table 15.1.3-; Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE; These limits do not apply to buprenorphine products. Table 15.1.3-; Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE; New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products).
BlueShield Abbr	MCO follows state regulatory guidance as noted below: https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf 15.1.3 Controlled Substance Policy Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A PA will be required for claims submitted for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products.

MCO Name	Explanation
	New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. For additional information on what constitutes a new-start, please see note below in Table 15.1.3-1. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-1: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill shown in Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products).
CalOptima Abbr	Medi-Cal Rx Provider Manual 15.1.3 Controlled Substance Policy Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A PA will be required for claims submitted for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply.

MCO Name	Explanation
	For additional information on what constitutes a new-start, please see note below in Table 15.1.3-1. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-1: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill shown in Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products).
CalViva Abbr	Medi-Cal Rx Provider Manual 15.1.3 Controlled Substance Policy Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A PA will be required for claims submitted for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. For additional information on what constitutes a new-start, please see note below in Table 15.1.3-1. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction).

MCO Name	Explanation
	Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-1: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill shown in Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products) in the past 120-day period.
CCAH Abbr	Medi-Cal Rx limits new-start opioid claims to a 7 day supply, and subsequent fills are restricted to maximum days' supply of 35 days and specific quantity limits. A warning message is sent to the pharmacy when 90 Morphine Milligram Equivalent (MME) threshold has been exceeded, and claims will deny and require a PA when exceeding 500 MME. Early refill tolerance is set at 90%, indicated by a number of days.
CenCal Abbr	CenCal Health receives daily claims data feeds and reviews internal reports on the concomitant use of opioids and antipsychotics and benzodiazepines. CenCal Health also has access to an opioid dashboard that allows us to review members by their morphine milligram equivalent (MME) or identify members with multiple prescribers.
CHW Abbr	Medi-Cal Rx Provider Manual 15.1.3 Controlled Substance Policy Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A PA will be required for claims submitted for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply.

MCO Name	Explanation
	For additional information on what constitutes a new-start, please see note below in Table 15.1.3-1. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-1: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill shown in Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products) in the past 120-day period.
Community Abbr	Controlled Substance Policy Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A prior authorization will be required for claims submitted for greater than (>) 35 days. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each NOTE: These limits do not apply to buprenorphine products.

MCO Name	Explanation
	Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill shown in Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products).
ContraCosta Abbr	Provider Manual 15.1.3 Controlled Substance Policy Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A PA will be required for claims submitted for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. For additional information on what constitutes a new-start, please see note below in Table 15.1.3-1. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-1: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s)

MCO Name	Explanation
	Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill shown in Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products)
GoldCoast Abbr	Yes, GCHP receives daily claims data feeds and reviews an opioid dashboard that allows us to monitor concurrent use of opioids and antipsychotics and benzodiazepines. DHCS' pharmacy benefit program called Medi-Cal Rx has outlined their Controlled Substance Policy Claims in their Medi-Cal Rx Provider Manual (https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf). 15.1.3 Controlled Substance Policy Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A PA will be required for claims submitted for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. For additional information on what constitutes a new-start, please see note below in Table 15.1.3-1. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each NOTE: These limits do not apply to buprenorphine products.

MCO Name	Explanation
	Table 15.1.3-1: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill shown in Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products).
HealthNetMediCal Abbr	Medi-Cal Rx Provider Manual 15.1.3 Controlled Substance Policy Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A PA will be required for claims submitted for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. For additional information on what constitutes a new-start, please see note below in Table 15.1.3-1. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each NOTE: These limits do not apply to buprenorphine products. Table 15.1.3-1: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill shown in Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE: These limits do not

MCO Name	Explanation
	apply to buprenorphine products. Table 15.1.3-2: Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products) in the past 120-day period.
Inland Abbr	Entity that providers the drug benefits provides Opioid Utilization reports to monitor opioid prescriptions utilization such as multiple prescribers and pharmacies.
Kaiser Abbr	Kaiser Permanente receives comprehensive daily claims data and opioid dashboard for our Members from Medi-Cal Rx/PBM to monitor opioid prescriptions. Medi-Cal Rx has a Controlled Substance Policy for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days supply of 35 days. A PA will be required for claims submitted for greater than (>) 35 days. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to maximum daily quantity limits. Claims submitted for subsequent fill(s) for opioids will be restricted to maximum quantities per fill. CDC guidelines are used to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply).
KernHealthSystems Abbr	MCRx provides an opioid dashboard. Additionally, they provide reports of utilization. KHS also receives daily claim feeds the the plan can use for their own reporting purposes. Standard DUR reports identifying typical elements such as refill too soon, therapeutic duplications, high quantity are some examples. KHS Policy 13.04-I addresses this.
LACARE Abbr	Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A PA will be required for claims submitted

MCO Name	Explanation
	for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: Maximum Quantity Per Day Limit(s) New-Start and Subsequent Fill(s) Dosage Form Allowable Daily Limit Solid Dosage Forms 8 each Liquid Dosage Forms 60 mL Transdermal Dosage Forms 1 each NOTE: These limits do not apply to buprenorphine products. Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill: Maximum Quantity Per Fill Subsequent Fill(s) Dosage Form Allowable Per Fill Limit Solid Oral " Immediate Release 120 each Solid Oral " Extended Release 90 each Oral Liquids 180 mL Parenterals 100 mL Transdermal Dosage Forms 10 each NOTE: These limits do not apply to buprenorphine products. Maximum Quantity Per Fill Subsequent Fill(s) As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products)
Molina Abbr	Yes, according to the Medi-Cal RX Provider Manual (Section 15.1.3 Controlled Substance Policy), outpatient claims for all controlled drug products including opioids will have limits (e.g. maximum day supply, new start restrictions, dosage forms, allowable daily limits, MME threshold etc.)
Partnership Abbr	PHC coordinated with Medimpact and now Magellan to receive and review pharmacy data for opioid prescription claims which we use for monitoring purposes.
SanFrancisco Abbr	Yes, SFHP has access to the DHCS opioid report and also receives raw pharmacy claims data which is used to create an in-house opioid database.
SanJoaquin Abbr	HPSJ receives comprehensive claims and PA history for their members (from Medi-Cal Rx). HPSJ monitors opiate prescriptions through a combination of data from Medi-Cal Rx and HPSJ.
SanMateo Abbr	The MCO has access to monitor opioid data via the pharmacy claims and PA data files sent by Medi-Cal Rx, as well as access to an opioid dashboard in Medi-Cal Rx

MCO Name	Explanation
	systems. The claim system opioid restrictions such as limits are known and publicly available in the state's Medi-Cal Rx provider manual. The MCO is connected to the state via their clinical liaison team and is able to coordinate issues regarding opioid claims.
SantaClaraHealthPlan Abbr	Per Medi-Cal Rx Provider Manual (section 15.1.3 Controlled Substance Policy): Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days' supply of 35 days. A PA will be required for claims submitted for greater than 35 days. This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. Claims submitted for all injectable forms of opioids will require a PA. This does not apply to buprenorphine products (indicated for pain or addiction). Claims submitted for new-start and subsequent fill(s) for opioids will be restricted to the following maximum daily quantity limits: solid dosage forms (8 each/day), liquid dosage forms (60mL/day), transdermal dosage forms (1/day). Claims submitted for subsequent fill(s) for opioids will be restricted to the following maximum quantities per fill: solid oral immediate release (120 each), solid oral extended release (90 each), oral liquids (180mL), parenterals (100mL), transdermal dosage forms (10 each). These limits do not apply to buprenorphine products. As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products) in the past 120-day period. The submission of DUR codes will not be allowed to override ER reject(s) for opioids. The above limitations, with the exception of the maximum quantity per day outlined above and the 90 percent refill threshold mentioned above, will not apply to the following beneficiaries: - In LTC facilities - In hospice - Receiving palliative or end-of-life care - With a diagnosis of sickle-cell disease - In treatment for active cancer-related pain

MCO Name	Explanation
UnitedHealth Abbr	Using claims information provided by Medi-CalRx, UHC can monitor opioid prescription claims. Opioid claim edits are as outlined in the Controlled Substance Policy of the Medi-CalRx Provider Manual section 15.1.3. This section of the provider manual outlines the following requirements and limitations: 1. Claims for all controlled drug products, including opioids (DEA Schedule II-V) have a maximum days' supply of 35 days. 2. A PA will be required for claims submitted for greater than (>) 35 days. This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. 3. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. 4. Claims submitted for all injectable forms of opioids require a PA. 5. Table 15.1.3-1 outlines Maximum Quantity per Day Limits for New Start and Subsequent Fills of solid, liquid, and transdermal dose forms. 6. Table 15.1.3-2 outlines Maximum Quantity per Fill or Subsequent Fills for solid oral immediate release, solid oral extended release, oral liquid, parenteral, and transdermal dose forms. 7. A 90 percent refill threshold 8. Uses CDC guidelines to establishes Morphine Milligram Equivalent (MME) thresholds and actions. For example, a warning message will be returned on the claim when the providers exceed the 90 MME threshold. When 500 MME has been exceeded the claim will deny and require PA. MME thresholds are cumulatively applied across all concurrent opioid prescriptions. The policy also outline if the limitations apply to buprenorphine products or specific populations. The above limitations, with the exception of the maximum quantity per day outlined in Table 15.1.3-1 of the policy and the 90 percent refill threshold do not apply to beneficiaries in LTC facilities; in hospice; receiving palliative or end of life care; with a diagnosis of sickle cell disease; or in treatment for active cancer related pain.

2. Does your MCO have a comprehensive automated retrospective claim reviews process to monitor opioid prescriptions exceeding State defined limitations?

Figure 33 - Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions in Excess of State Limitations

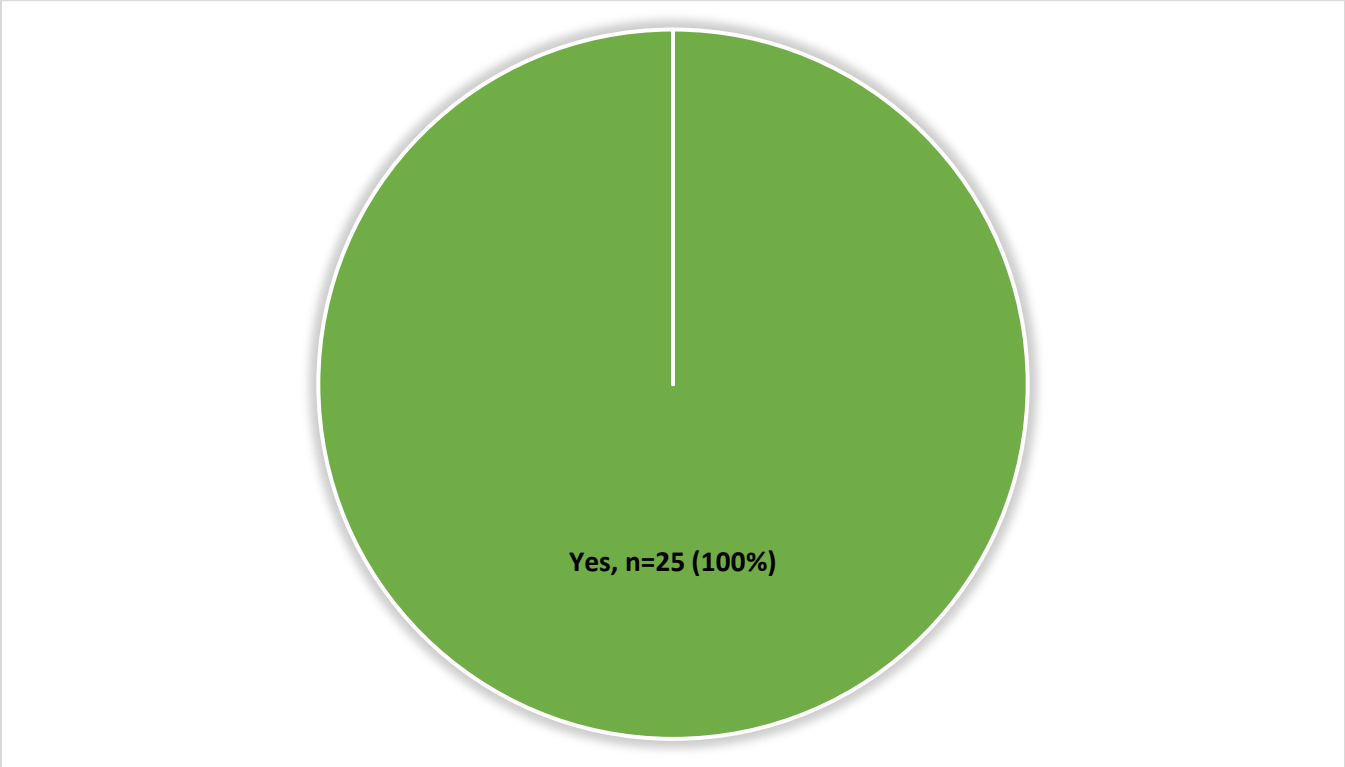

Table 57 - Automated Retrospective Claim Reviews to Monitor Opioid Prescriptions in Excess of State Limitations

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

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

Table 58 - Scope and Nature of Retrospective Reviews for Opioid Prescription Monitoring

MCO Name	Retrospective Review Details
AetnaBetterHealthCA Abbr	Medi-Cal Rx (FFS) provides claims data that Aetna Better Health of California uses to monitor opioid utilization. FFS shares trend overviews on aggregate opioid utilization with the MCOs in the quarterly DUR Board Meetings. The plan reviews the presented data in consideration for development of future educational outreach programs.

MCO Name	Retrospective Review Details
AHF Abbr	Medi-Cal Rx MCO Opioid Dashboard Aggregate quarterly report Opioid Dashboard Plan Specific Data Educational Bulletin Educational Bulletin, Newsletters Provider letters Provider letters
Alameda Abbr	Alameda has monthly retrospective DUR program in monitoring opioid over-utilization . Alameda has the plan own opioid dashboard to present to HCQC and UMC. Alameda looks at the quarterly DUR packet and compare this data with our DUR data. Alameda has its own dashboard, reports to HCQC and UMC and provide academic detailing to providers and members.
Anthem Abbr	Yes, 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.
BlueShield Abbr	Quarterly automated retrospective DUR reports look back 6 months to identify potentially at-risk members based on 1) Opioid Dosage 2) Multiple Providers 3) Multiple Pharmacies 4) Concurrent Use of Opioid and Benzodiazepine 5) Concurrent Use of Opioid and Antipsychotic. At-risk members are case reviewed, and prescriber and member outreach is conducted if deemed appropriate.
CalOptima Abbr	We have a plan-specific opioid dashboard provided by the state and we review the quarterly state DUR Board Meeting aggregate Opioid Dashboard report.
CalViva Abbr	We utilize the Opioid dashboard from Magellan to identify members who are on opioids. From those members, we run pharmacy drug claims for all opioid prescriptions and proactively outreach to those members who exceed state defined limitations.
CCAH Abbr	MCO performs retrospective DUR based on pharmacy claims data sent by Medi-Cal Rx. Average MME per day is calculated to assess the member's risk for adverse drug event. Members with opioid prescriptions from multiple prescribers are identified and analyzed for potential FWA. Prescribing patterns are reviewed for providers with multiple members on opioids 90 MME or greater.
CenCal Abbr	CenCal Health reviews members with an MME value of 120 or higher. Members identified by this method can be addressed through a retrospective DUR outreach or through individual case management.
CHW Abbr	We utilize the Opioid dashboard from Magellan to identify members who are on opioids. From those members, we run pharmacy drug claims for all opioid prescriptions and proactively outreach to those members who exceed state defined limitations.
Community Abbr	CHG does retrospective review of claims during Interdisciplinary Care Team meetings, opioid overdose reviews, and 4x4x4 fraud, waste, and abuse monitoring. A part of this review include monitoring appropriate use of opioid by reviewing opioid quantity.
ContraCosta Abbr	ii. A retrospective review of all opioid claims (using the registry) is also performed on a monthly basis through a clinical pharmacist driven claims review process that utilizes internal reporting and analytical tools. The retrospective process reviews

MCO Name	Retrospective Review Details
	opioid claims for potential dosing aberrancies and ensures that submitted treatment/taper plans are clinically appropriate. Results from the retrospective review are used to improve the overall quality of the CCHP opiate program.
GoldCoast Abbr	The plan does have an automated retrospective review to identify utilization that exceeds CDC prescribing guidelines which is part of an opioid utilization report that we receive from the PBM that's contracted with DHCS. We are able to access an opioid dashboard created by Magellan Medicaid Administration which contains pharmacy claim information pertaining to opioids. The retrospective reviews also requires additional manual review by a pharmarcist.
HealthNetMediCal Abbr	We utilize the Opioid dashboard from Magellan to identify members who are on opioids. From those members, we run pharmacy drug claims for all opioid prescriptions and proactively outreach to those members who exceed state defined limitations.
Inland Abbr	MCO has built a retrospective claims review process that includes diagnosis of opioid overdose using medical claims data to identify beneficiaries that are potentially at risk for misuse and abuse.
Kaiser Abbr	Kaiser utilizes a comprehensive and unique approach in managing opioids. In addition to the automated prospective edits set at the PBM level, Kaiser employs real-time review in managing potential overuse of opioid medications. Kaiser's pharmacists also review alerts at point of sale for high MME >=90, refill-too-soon alerts of 90%, safety edits (e.g. Opioid+BZD, Opioid+Amphetamines, Opioid+Z-drugs, Opioid+SMRs), duplicate claims, and quantity limits. The local Controlled Substances Committees typically meet either weekly, monthly, or quarterly and physician and pharmacist members conduct patient care reviews of patients identified through the retrospective reports of patients on opioids at an average of = or > 90 MME/day over each quarter. KP P&T Committee also reviews reports, including opioid + benzo, opioid + antipsych, opioid nave fill, and MME >=50 quarterly.
KernHealthSystems Abbr	MCRx provides an opioid dashboard. Additionally, they provide reports of utilization. KHS also receives daily claim feeds the the plan can use for their own reporting purposes. This is discussed in KHS Policy 13.04-I.
LACARE Abbr	Identifies patients with an average 90 MME or greater per day by more than one prescriber & pharmacy within a specific timeframe Potentiator medications are also identified; however, they are not factored into the MME Patients who have been prescribed potentiator medications will have them listed in their patient profiles as additional information. A tally of naloxone fills are also listed on the patient's profile, if any MCO has the ability to pull data from the Opioid Dashboard for opioid prescriptions
Molina Abbr	During the DUR Board meeting, DHCS provides a quarterly report of their aggregate Opioid Dashboard report for all MCO's to review. Additionally, DHCS has provided an Opioid Dashboard platform for MCO use. This dashboard continues to be refined with MCO feedback on better development to assist with monitoring and surveillance of retrospective claim reviews of opioids.

MCO Name	Retrospective Review Details
	Additionally, Molina runs a report quarterly for members who are filling opioids above the state MME limit of 90. 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.
Partnership Abbr	Our Managing Pain Safely program monitors daily MED and new start days supply. In addition we use Magellan pharmacy claims data to review opioid utilization for high dose MED and duration of therapy for new starts.
SanFrancisco Abbr	On a quarterly basis, SFHP reviews opioid prescriptions using an internal dashboard, which tracks daily MMEs, prescribers, drug choice, OUD diagnosis, concomitant use, and more. We also review the state dashboard on opioids which is provided to us.
SanJoaquin Abbr	HPSJ has an Opioid Dashboard, HPSJ routinely sends out educational bulletin and provider alerts
SanMateo Abbr	Medi-Cal Rx provides opioid dashboard reporting access along with the sharing of pharmacy claims and PA data. In addition to educational bulletins and provider letters from the state, the MCO utilizes also provides educational content to providers and members, targeting specific individuals as deemed appropriate based on opioid utilization to conduct outreach, such as the communication of information on the dangers of long-term opioid use.
SantaClaraHealthPlan Abbr	The Plan reviews the Medi-Cal Rx Opioid Dashboard report quarterly to determine if any interventions need to be made.
UnitedHealth Abbr	UnitedHealthcare Community Plan utilizes information from the Opioid Dashboards to inform utilization within our member population. UHC also utilized claims data from Medi-CalRx to enroll in the Abused Medications Program through OptumRx. This RDUR program 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).

3. Does your MCO coordinate with the entity that provides the drug benefits to monitor opioids and benzodiazepines being used concurrently?

Figure 34 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Benzodiazepines Used Concurrently

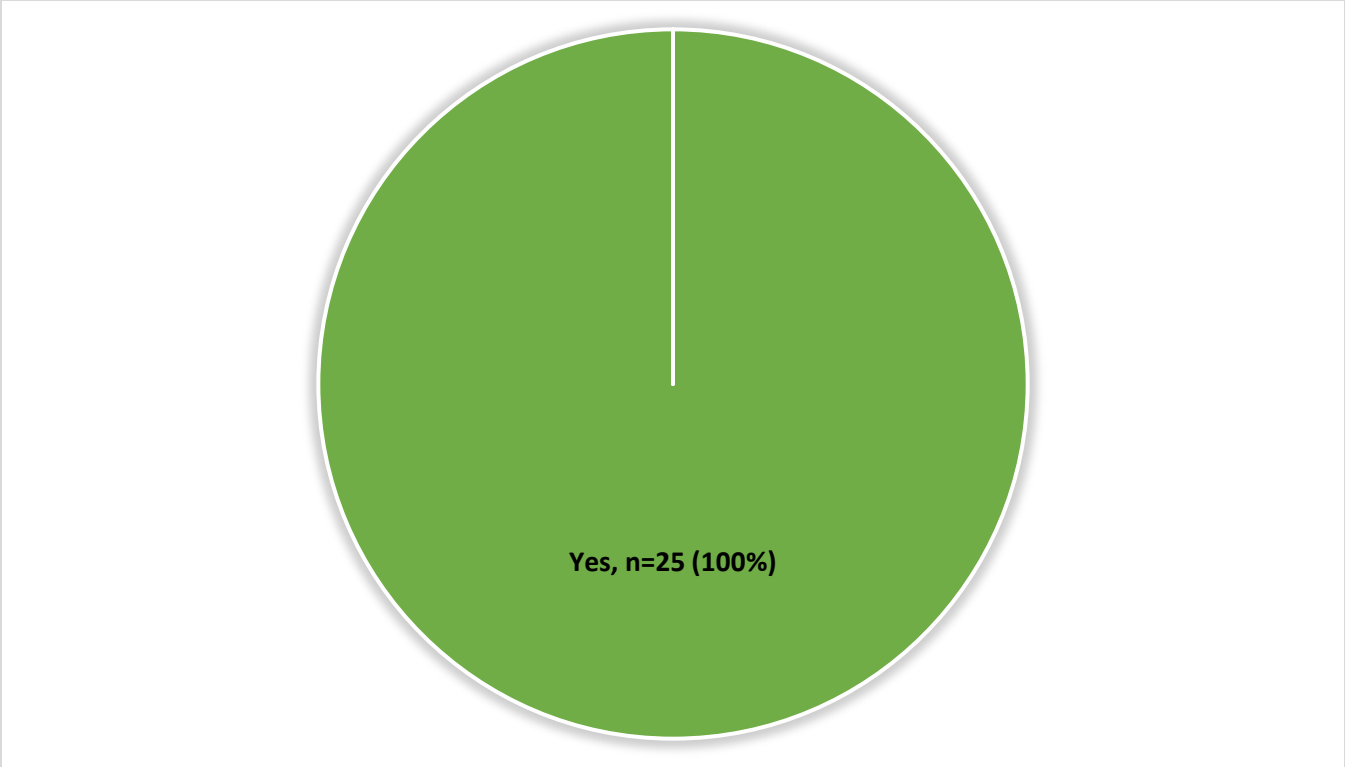

Table 59 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Benzodiazepines Used Concurrently

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

If "Yes," please check all that apply.

Figure 35 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Benzodiazepines Used Concurrently

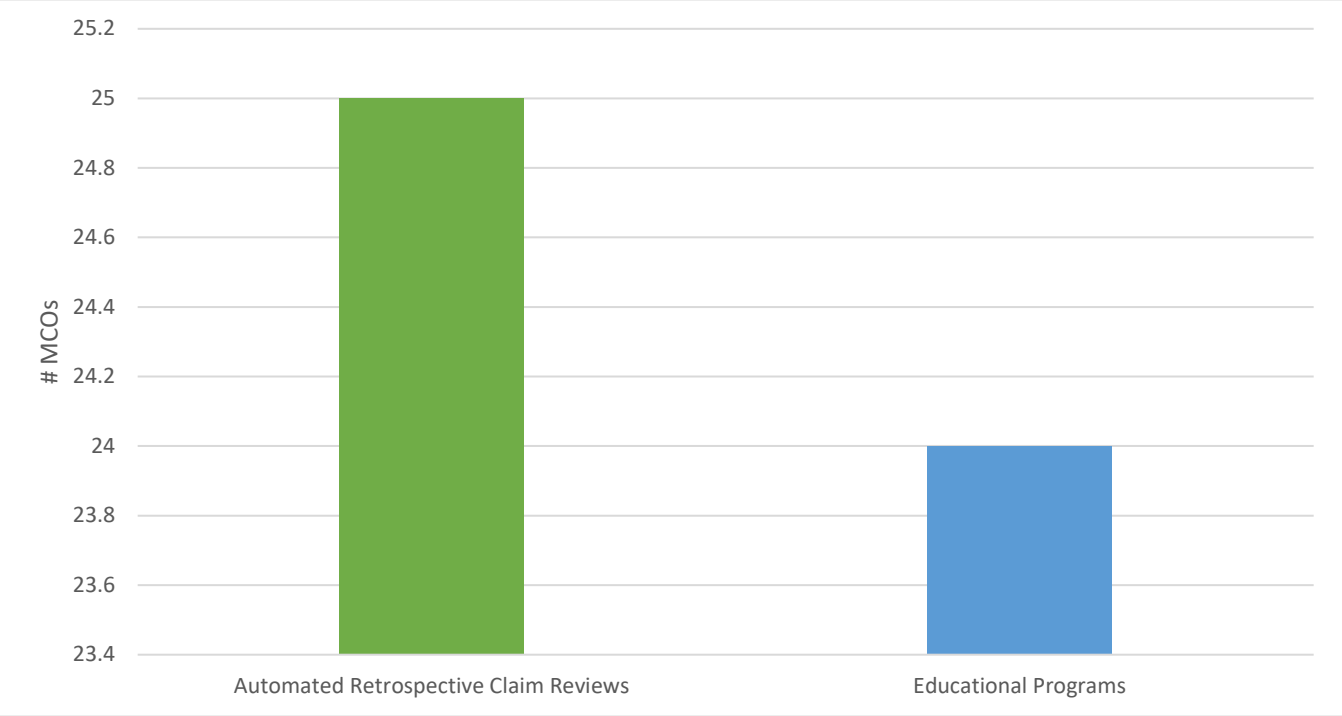

Table 60 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Benzodiazepines Used Concurrently

Response	MCO Names	Count	Percentage
Automated retrospective claim reviews	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	51.02%
Educational programs	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	24	48.98%
State Totals		**49**	**100%**

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

Table 61 - Explanations of Scope and Nature of Reviews and Edits to Monitor Opioids and Benzodiazepines Being Used Concurrently

MCO Name	Explanation
AetnaBetterHealthCA Abbr	Aetna Better Health of California's DUR Board has Educational Outreach Programs, including Benzo+Opioid that educates the prescribers of chronic benzodiazepines of the risks associated with them in members also taking opioids. Additionally, the plan's Care Management (CM) team reviews an internal Opioid Use Disorder (OUD) Risk Report which is built using retrospective pharmacy and medical claims data. The report risk stratifies members on multiple factors, including opioid utilization and concomitant therapy (opioid + benzo). The CM team conducts member outreach to the risk stratified populations to assess overall health and coordinate care. Medi-Cal Rx provides an opioid dashboard that Aetna Better Health of California can access to monitor plan's opioid utilization.
AHF Abbr	Medi-Cal Rx MCO Opioid Dashboard Aggregate quarterly report Opioid Dashboard Plan Specific Data Educational Bulletin Educational Bulletin, Newsletters Provider letters Provider letters
Alameda Abbr	Alameda monitors quarterly use concurrent use of opioid and benzodiazepines with specific attention to chronic users. These findings are sent to the providers along with some resources which includes opioid and benzodiazepines safety, OUD treatment and safely tapering opioid and benzodiazepine when necessary. In addition, Alameda provides provider maps, non-opioid alternatives, and MAT. Alameda has its own dashboard, reports to board committees, and provide academic detailing to providers and members.
Anthem Abbr	Medi-Cal Rx (Opioid dashboard, aggregate quarterly DUR report, Educational bulletins, provider educational interventions, letters, letter templates on https;//medi-calrx.dhcs.ca.gov/home/. MCO's monitor via Opoiod dashboard data, DUR and P&T reviews, other multi-disciplinary committe reviews, provider communications, educational bulletins, provider educational interventions, academic detailing, letters and meetings.
BlueShield Abbr	The following describes the coordination between Medi-Cal Rx and MCO: Medi-Cal Rx 1. Opioid dashboard, aggregate quarterly DUR report 2. Educational bulletins 3. Provider educational interventions, Letters, Letter templates (on website) MCO 1. Opioid Dashboard plan specific data

MCO Name	Explanation
	MCO DUR, P&T reviews, other multidisciplinary committee reviews, provider communications 2. Educational bulletins 3. Provider educational interventions, Academic detailing, Letters, Meetings
CalOptima Abbr	Opioid dashboard plan-specific data reviews, MCO retrospective DUR reviews, educational newsletters and member-specific provider communications.
CalViva Abbr	We utilizes monthly DUR reports to identify members who are on opioids and benzodiazepines. Members are outreached to by a pharmacist to discuss potential drug interactions, adverse effects and to recommend alternatives. Provider education is offered to avoid concurrent prescribing of opioids and benzodiazepines.
CCAH Abbr	MCO performs retrospective DUR based on pharmacy claims data sent by Medi-Cal Rx. Analysis is performed based on member's age, presence of naloxone claim, number of prescribers per member, prescriber specialty and county. Top utilizers and prescribers with highest number of members are reviewed in detail. Educational articles are included in the provider newsletter and member website, and letters are sent to selected providers via fax.
CenCal Abbr	CenCal Health retrospectively monitors the concomitant use of opioids and benzodiazepines. CenCal Health provides educational materials for providers on CenCal Health's website and through educational DUR outreaches. There are also periodic retrospective DUR provider outreaches identifying members that are currently receiving concomitant treatment.
CHW Abbr	We utilizes monthly DUR reports to identify members who are on opioids and benzodiazepines. Members are outreached to by a pharmacist to discuss potential drug interactions, adverse effects and to recommend alternatives. Provider education is offered to avoid concurrent prescribing of opioids and benzodiazepines.
Community Abbr	CHG does retrospective review of claims during Interdisciplinary Care Team meetings, opioid overdose reviews, and 4x4x4 fraud, waste, and abuse monitoring. Results are summarized to CHG's Pharmacy and Therapeutics Committee.
ContraCosta Abbr	Both Medi-cal Rx and CCHP distribute educational bulletins, provider education, interventions and outreach letters. Medi-cal Rx uses an opioid dashboard with an aggregate quarterly DUR report. CCHP uses multiple opioid specific reports based on paid claims data to monitor opioids and perform interventions. Retrospective DUR is performed, P&T committee reviews the DUR and provider bulletins are sent out.
GoldCoast Abbr	Per Medi-Cal Rx: Claims for all controlled drug products, including opioids (DEA Schedule II-V) will have a maximum days supply of 35 days. A PA will be required for claims submitted for greater than (>) 35 days. NOTE: This limit does not apply to new-start opioid prescriptions, new-start benzodiazepine prescriptions, or buprenorphine products. New-start opioid claims will be restricted to a 7 days supply or a maximum quantity of 30 solid dosage units (each) or 240 mL for liquids and new-start benzodiazepine claims will be limited to a 30 days supply. All new-start (the absence of any Benzodiazepine therapy in the past 90 days) Benzodiazepine claims will be limited to a maximum of a 30 days supply. Exemptions: Beneficiaries with documented history or submitted diagnosis of seizure disorders.

MCO Name	Explanation
	The following describes the coordination between Medi-Cal Rx and MCO: Medi-Cal Rx provides the opioid dashboard data, aggregate quarterly DUR report, educational bulletins, provider educational interventions, letters, and letter templates (on the website). The MCO reviews the opioid dashboard plan specific data, performs further reviews at the MCO P&T committee and other multidisciplinary committees, generate provider communications, educational bulletins, provider educational interventions, academic detailing, letters, and meetings.
HealthNetMediCal Abbr	We utilizes monthly DUR reports to identify members who are on opioids and benzodiazepines. Members are outreached to by a pharmacist to discuss potential drug interactions, adverse effects and to recommend alternatives. Provider education is offered to avoid concurrent prescribing of opioids and benzodiazepines.
Inland Abbr	Entity that provides the drug benefits works with MCO to identify count of members who concurrently use benzodiazepines and opioids through automated retrospective claims review that are summarized in the opioid dashboard. All controlled substances including benzodiazepines and opioids have a maximum days supply of 35 days. A PA is required for claims submitted greater than 35 days.
Kaiser Abbr	Kaiser utilizes a comprehensive and unique approach in managing opioids. In addition to the automated prospective edits set at the PBM level, Kaiser employs real-time review in managing potential overuse of opioid medications. Kaiser's pharmacists review alerts at point of sale for high MME >=90, refill-too-soon alerts of 90%, safety edits (e.g. Opioid+BZD, Opioid+Amphetamines, Opioid+Z-drugs, Opioid+SMRs), duplicate claims, and quantity limits. The local Controlled Substances Committees typically meet either weekly, monthly, or quarterly and physician and pharmacist members conduct patient care reviews of patients identified through the retrospective reports of patients on opioids at an average of = or > 90 MME/day over each quarter. KP P&T Committee also reviews reports including opioid + benzo, opioid + antipsych, opioid nave fill, and MME >=50 quarterly. Medi-Cal Rx provides an opioid dashboard and quarterly DUR report for MCO plans to review. Bulletins, letters, and letter templates for provider education and intervention are also shared with plans.
KernHealthSystems Abbr	As part of the SUPPORT Act, KHS runs reports/audits to identify potential inappropriate therapies. If identified, a provider is sent a letter indicating such. The CDC guidelines are referenced and monitoring tools are available. Providers are asked to provide treatment plans to reduce or eliminate utilization. If not clinically appropriate, the providers are asked to state that fact, giving supporting rationale as to why the reduction or deprescribing would not be appropriate for the particular member. KHS Policy 13.04-I addresses the type of monitoring and reporting conducted to identify these cases.
LACARE Abbr	Identifies patients who have concurrent use of opioids, benzodiazepines/hypnotics and skeletal muscle relaxants in a specific timeframe This combination of drugs can be subject to abuse as it produces euphoric sensations similar to heroin Using these medications together has led to many reported overdoses and emergency room visits in the past decade

MCO Name	Explanation
	MCO has the ability to pull data from the Opioid Dashboard for concomitant drugs: opioids and benzodiazepines
Molina Abbr	Using claims data by Medi-Cal RX, Molina runs a quarterly report of members who are taking benzodiazepines and opioids concomitantly. Letters to Providers will be sent to members who may require intervention (e.g. also using a muscle relaxer). Molina's Q2 2022 Provider Newsletter included Clinical Practice Guidelines on Opioid Safety. Copies could be requested or viewed directly on the Molina website. Resources included information such as Opioid Tapering Resources (CHCF, CSAM, CDC) as well as a PDMP link and fact sheet regarding members who may be on substances that may increase risk of opioids-such as benzodiazepines.
Partnership Abbr	We coordinated with Medimpact and now Magellan to receive this data which is utilized by PHC's Managing Pain Safely program to monitor concurrent utilization of benzodiazepines and opioids. PHC's Managing Pain Safely dashboard provides member level information on concurrent utilization of benzodiazepines and opioids as well as the specific time period of the concurrent utilization. Between 10/1/2021 to 12/31/2021, our TAR process evaluated use of concurrent utilization of benzodiazepines and opioids. As part of our required DUR activities, PHC distributes DHCS DUR education bulletins and alerts in our quarterly provider newsletter.
SanFrancisco Abbr	Concomitant use of opioids and benzodiazepines is monitored using an internal opioid dashboard report. We also have access to the state dashboard. Appropriate dosing recommendations are communicated through SFHP's external provider website resources, as well as through provider education through DHCS.
SanJoaquin Abbr	HPSJ has an Opioid Dashboard, HPSJ routinely sends out educational bulletin and provider alerts
SanMateo Abbr	Medi-Cal Rx provides opioid dashboard reporting access along with the sharing of pharmacy claims and PA data. In addition to educational bulletins and provider letters from the state, the MCO utilizes also provides educational content to providers and members, targeting specific individuals as deemed appropriate based on utilization to conduct outreach. Where warranted, we refer providers to educational content such as resources on the MCO's website on best practices for titration/tapering of opioids and benzodiazepines.
SantaClaraHealthPlan Abbr	Medi-Cal Rx provides an opioid dashboard, an aggregate quarterly DUR report, educational bulletins, and provider educational interventions and letters/letter templates. The Plan reviews the opioid dashboard and quarterly DUR report from Medi-Cal Rx, shares any findings with the P&T Committee and other multidisciplinary committees, as appropriate. The Plan also conducts provider educational interventions when necessary and publishes educational articles in the provider newsletter.
UnitedHealth Abbr	UnitedHealthcare Community Plan utilizes information from the Opioid Dashboards to inform utilization within our member population. Provider education bulletins are published and stored on our provider website to assist providers with opioid and benzodiazepine tapering. The claims data received from Medi-CalRx is used as part of the OptumRx Abused Medications Program. This program notifies prescribers via fax/mail when a member is receiving an opioid and a benzodiazepine concurrently. Results of this automated review are discussed at the Health Quality and Utilization Management (HQUM) Committee and the Quality Management Committee meetings.

4. Does your MCO coordinate with the entity that provides the drug benefits to monitor opioids and sedatives being used concurrently?

Figure 36 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Sedatives Being Used Concurrently

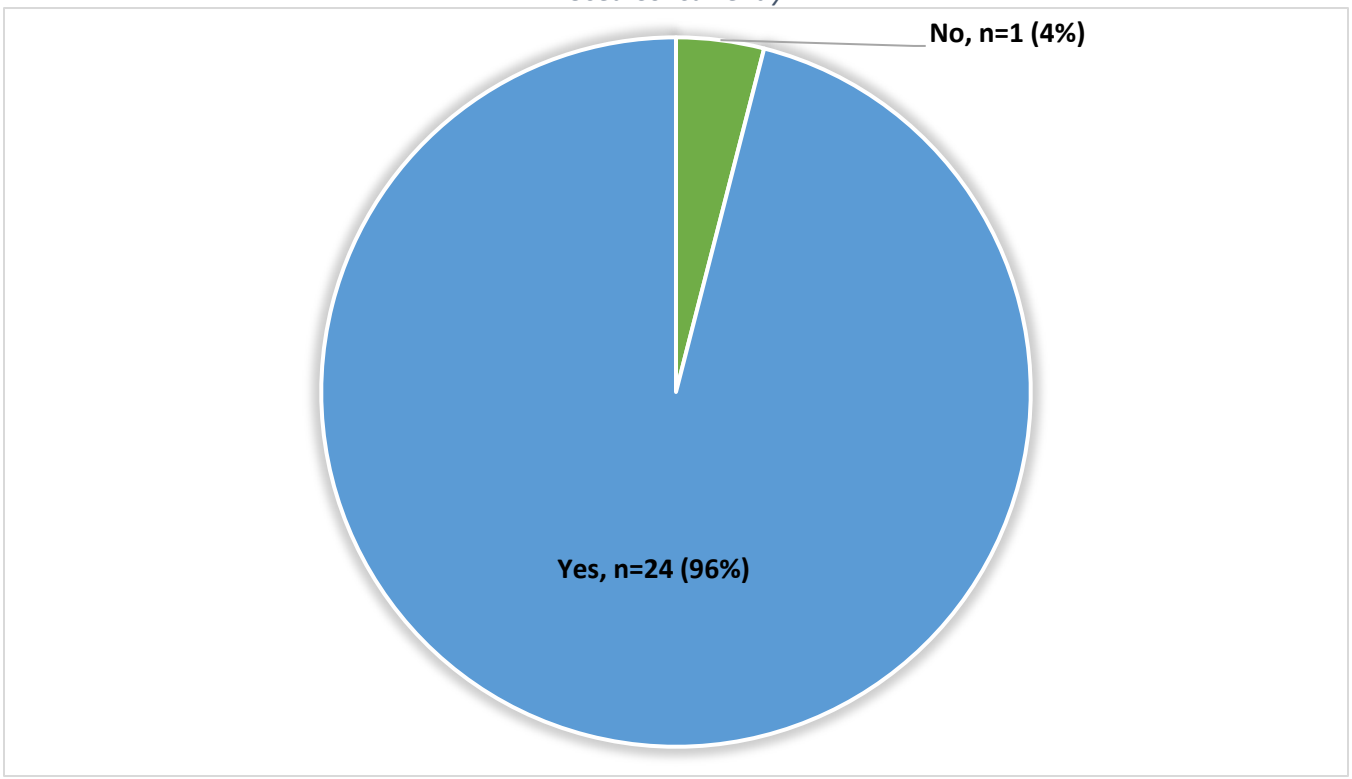

Table 62 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Sedatives Being Used Concurrently

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	24	96.00%
No	CenCal Abbr	1	4.00%
State Totals		**25**	**100%**

If "Yes," please check all that apply.

Figure 37 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Sedatives Being Used Concurrently

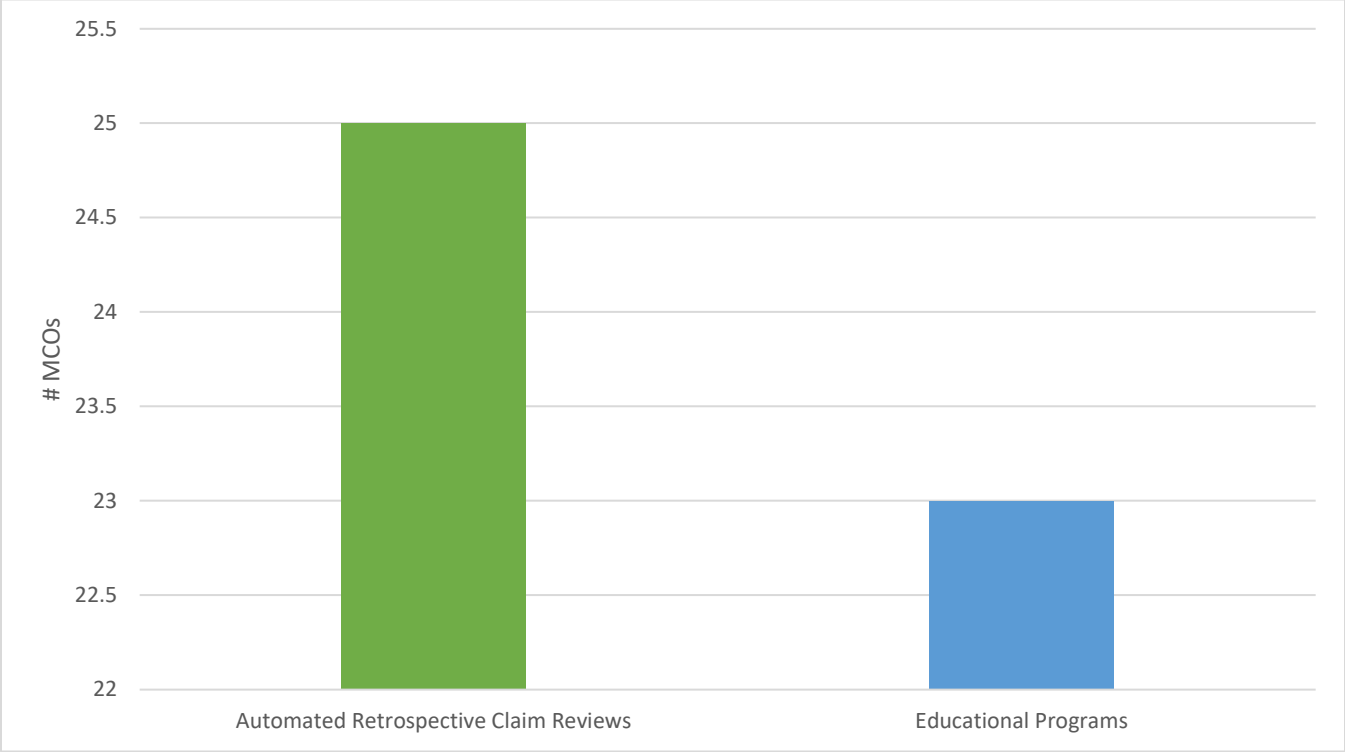

Table 63 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Sedatives Being Used Concurrently

Response	MCO Names	Count	Percentage
Automated retrospective claim reviews	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	52.08%
Educational programs	AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	23	47.92%
State Totals		**48**	**100%**

If "Yes," please explain response above and detail the scope and nature of these reviews and edits.

Table 64 - Explanations of Scope and Nature of Reviews and Edits to Monitor Opioids and Sedatives Being Used Concurrently

MCO Name	Explanation
AetnaBetterHealthCA Abbr	Aetna Better Health of California receives an internal monthly Retrospective Drug Utilization Review (retroDUR) report that provides pharmacy claim level data on members taking both opioid(s) and sedatives. The report is available to both the pharmacy and nurse care management teams for monitoring and tracking. Medi-Cal Rx provides an opioid dashboard that Aetna Better Health of California can access to monitor plan's opioid utilization. Additionally, the State shares trends overviews on aggregate opioid utilization with the MCOs in the quarterly DUR Board Meetings. Plan reviews the presented data in consideration for development of future educational outreach programs.
AHF Abbr	Medi-Cal Rx MCO Opioid Dashboard Aggregate quarterly report Opioid Dashboard Plan Specific Data Educational Bulletin Educational Bulletin, Newsletters Provider letters Provider letters
Alameda Abbr	Medi-Cal RX does opioid dashboard aggregate review and also provide educational bulletin and provider letters. Alameda supports academic detailing as needed based on Medi-Cal RX opioid dashboard, educational bulletin and provider letters.
Anthem Abbr	Medi-Cal Rx (Opioid dashboard, aggregate quarterly DUR report, Educational bulletins, provider educational interventions, letters, letter templates on https;//medi-calrx.dhcs.ca.gov/home/. MCO's monitor via Opoiod dashboard data, DUR and P&T reviews, other multi-disciplinary committe reviews, provider communications, educational bulletins, provider educational interventions, academic detailing, letters and meetings.
BlueShield Abbr	The following describes the coordination between Medi-Cal Rx and MCO: Medi-Cal Rx 1. Opioid dashboard, aggregate quarterly DUR report 2. Educational bulletins 3. Provider educational interventions, Letters, Letter templates (on website) MCO 1. Opioid Dashboard plan specific data MCO DUR, P&T reviews, other multidisciplinary committee reviews, provider communications 2. Educational bulletins 3. Provider educational interventions, Academic detailing, Letters, Meetings
CalOptima Abbr	Opioid dashboard plan-specific data reviews, MCO retrospective DUR reviews, educational newsletters and member-specific provider communications.
CalViva Abbr	We utilizes monthly DUR reports to identify members who are on opioids and sedatives. Members are outreached to by a pharmacist to discuss potential drug

MCO Name	Explanation
	interactions, adverse effects and to recommend alternatives. Provider education is offered to avoid concurrent prescribing of opioids and sedatives.
CCAH Abbr	MCO has access to automated retrospective report provided by Medi-Cal Rx. Aggregated data is reviewed by the State DUR Board, and educational articles published by Medi-Cal Rx are shared on MCO website.
CHW Abbr	We utilizes monthly DUR reports to identify members who are on opioids and sedatives. Members are outreached to by a pharmacist to discuss potential drug interactions, adverse effects and to recommend alternatives. Provider education is offered to avoid concurrent prescribing of opioids and sedatives
Community Abbr	CHG does retrospective review of claims during Interdisciplinary Care Team meetings, opioid overdose reviews, and 4x4x4 fraud, waste, and abuse monitoring. Results are summarized to CHG's Pharmacy and Therapeutics Committee.
ContraCosta Abbr	Both Medi-cal Rx and CCHP distribute educational bulletins, provider education, interventions and outreach letters. Medi-cal Rx uses an opioid dashboard with an aggregate quarterly DUR report. CCHP uses multiple opioid specific reports based on paid claims data to monitor opioids in combination with sedatives and perform interventions. Retrospective DUR is performed, P&T committee reviews the DUR and provider bulletins are sent out. CCHP sends quarterly letters to providers prescribing the combination of opioids and sedatives (benzodiazepines or muscle relaxants) to their patients.
GoldCoast Abbr	The following describes the coordination between Medi-Cal Rx and MCO: Medi-Cal Rx provides the opioid dashboard data, aggregate quarterly DUR report, educational bulletins, provider educational interventions, letters, and letter templates (on the website). The MCO reviews the opioid dashboard plan specific data, performs further reviews at the MCO P&T committee and other multidisciplinary committees, generate provider communications, educational bulletins, provider educational interventions, academic detailing, letters, and meetings.
HealthNetMediCal Abbr	We utilizes monthly DUR reports to identify members who are on opioids and sedatives. Members are outreached to by a pharmacist to discuss potential drug interactions, adverse effects and to recommend alternatives. Provider education is offered to avoid concurrent prescribing of opioids and sedatives.
Inland Abbr	Entity that provides the drug benefits works with MCO to identify count of members who concurrently use sedatives such as hypnotics and opioids through automated retrospective claims review that are summarized in the opioid dashboard. All controlled substances including benzodiazepines and opioids have a maximum days supply of 35 days. A PA is required for claims submitted greater than 35 days.
Kaiser Abbr	Kaiser utilizes a comprehensive and unique approach in managing opioids. In addition to the automated prospective edits set at the PBM level, Kaiser employs real-time review in managing potential overuse of opioid medications. Kaiser's pharmacists review alerts at point of sale for high MME >=90, refill-too-soon alerts of 90%, safety edits (e.g. Opioid+BZD, Opioid+Amphetamines, Opioid+Z-drugs, Opioid+SMRs), duplicate claims, and quantity limits. The local Controlled Substances Committees typically meet either weekly, monthly, or quarterly and physician and pharmacist members conduct patient care reviews of patients identified through the retrospective reports of patients on opioids at an

MCO Name	Explanation
	average of = or > 90 MME/day over each quarter. KP P&T Committee also reviews reports including opioid + benzo, opioid + antipsych, opioid nave fill, and MME >=50 quarterly. Medi-Cal Rx provides an opioid dashboard and quarterly DUR report for MCO plans to review. Bulletins, letters, and letter templates for provider education and intervention are also shared with plans.
KernHealthSystems Abbr	As part of the SUPPORT Act, KHS runs reports/audits to identify potential inappropriate therapies. If identified, a provider is sent a letter indicating such. The CDC guidelines are referenced and monitoring tools are available. Providers are asked to provide treatment plans to reduce or eliminate utilization. If not clinically appropriate, the providers are asked to state that fact, giving supporting rationale as to why the reduction or deprescribing would not be appropriate for the particular member. KHS Policy 13.04-I addresses the type of monitoring and reporting conducted to identify these cases.
LACARE Abbr	Identifies patients who have concurrent use of opioids, benzodiazepines/hypnotics and skeletal muscle relaxants in a specific timeframe This combination of drugs can be subject to abuse as it produces euphoric sensations similar to heroin Using these medications together has led to many reported overdoses and emergency room visits in the past decade MCO has the ability to pull data from the Opioid Dashboard for concomitant drugs: opioids and sedatives
Molina Abbr	Medi-Cal RX has provided a Opioid Dashboard platform for MCO use which allows for review of opioid and sedative use. This dashboard continues to be refined with MCO feedback on better development to assist with monitoring and surveillance of retrospective claim reviews of opioids.
Partnership Abbr	PHC's Managing Pain Safely dashboard allows our plan to monitor increasing utilization of benzodiazepines, muscle relaxants, and opioids which require additional review. As part of our required DUR activities, PHC distributes DHCS DUR education bulletins and alerts in our quarterly provider newsletter.
SanFrancisco Abbr	Concomitant use of opioids and sedatives is monitored using an internal opioid dashboard report. We also have access to the state dashboard. Appropriate dosing recommendations are communicated through SFHP's external provider website resources, as well as through provider education through DHCS.
SanJoaquin Abbr	HPSJ has an Opioid Dashboard, HPSJ routinely sends out educational bulletin and provider alerts
SanMateo Abbr	Medi-Cal Rx provides opioid dashboard reporting access along with the sharing of pharmacy claims and PA data. In addition to educational bulletins and provider letters from the state, the MCO utilizes also provides educational content to providers and members, targeting specific individuals as deemed appropriate based on utilization to conduct outreach. Where warranted, we refer providers to educational content such as guideline resources on the MCO's website that include recommendations on concurrent opioid/sedative use.
SantaClaraHealthPlan Abbr	Medi-Cal Rx provides an opioid dashboard, an aggregate quarterly DUR report, educational bulletins, and provider educational interventions and letters/letter templates. The Plan reviews the opioid dashboard and quarterly DUR report from Medi-Cal Rx, shares any findings with the P&T Committee and other

MCO Name	Explanation
	multidisciplinary committees, as appropriate. The Plan also conducts provider educational interventions when necessary and publishes educational articles in the provider newsletter.
UnitedHealth Abbr	UnitedHealthcare Community Plan utilizes information from the Opioid Dashboards to inform utilization within our member population. Provider education bulletins are published and stored on our provider website to assist providers with opioid tapering. The claims data received from Medi-CalRx is used as part of the OptumRx Abused Medications Program. This program notifies prescribers via fax/mail when a member is receiving an opioid and a sedative concurrently.

If "No," please explain.

Table 65 - Explanations for not Coordinating with the Entity that Provides Drug Benefits to Monitor Opioids and Sedatives Being Used Concurrently

MCO Name	Explanation
CenCal Abbr	CenCal Health currently looks at the concomitant use of opioid with benzodiazepines, antipsychotic, and medication assisted treatment (MAT). Further development of the program will be needed to include the review of sedatives, with the possibility of a future retrospective DUR using the claims data.

5. Does your MCO coordinate with the entity that provides the drug benefits to monitor opioids and antipsychotics being used concurrently?

Figure 38 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Antipsychotics Being Used Concurrently

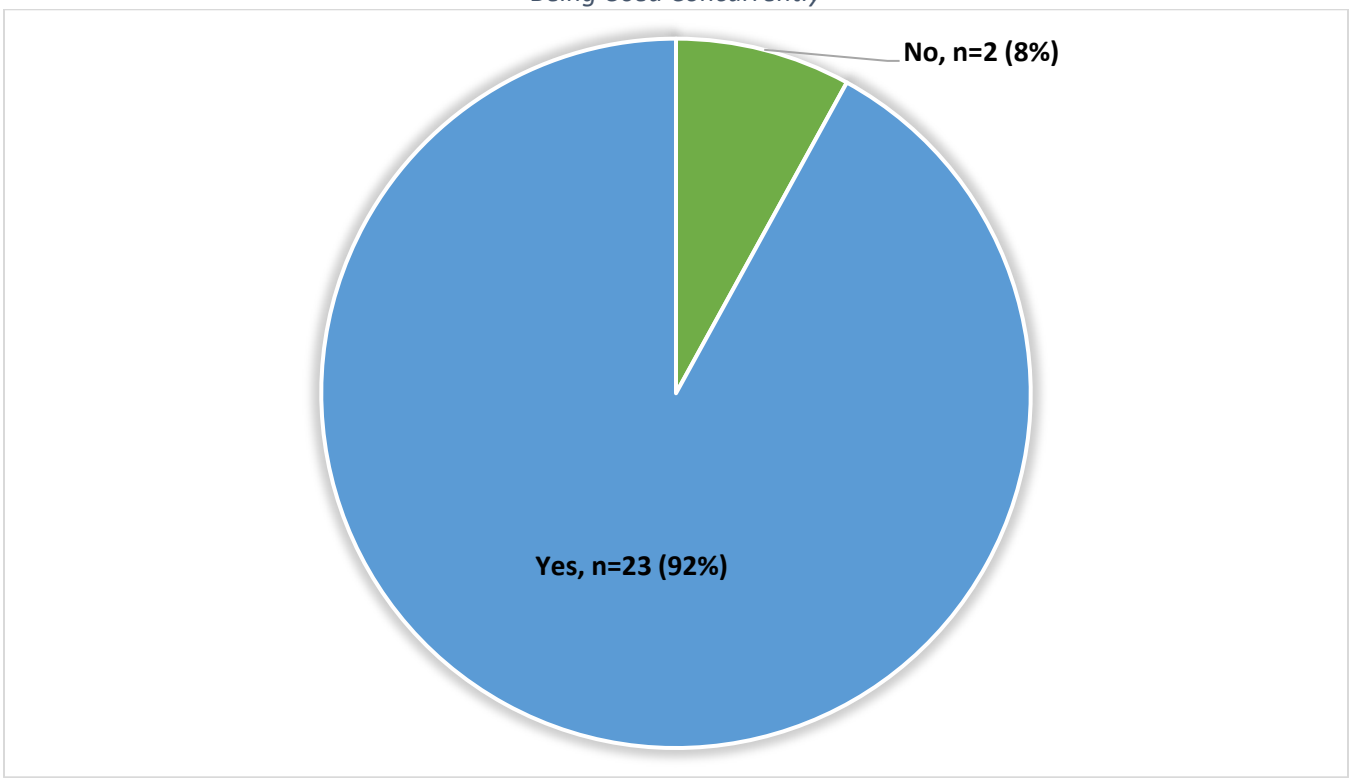

Table 66 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Antipsychotics Being Used Concurrently

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	23	92.00%
No	Inland Abbr, Partnership Abbr	2	8.00%
State Totals		**25**	**100%**

If "Yes," please check all that apply.

Figure 39 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Antipsychotics Being Used Concurrently

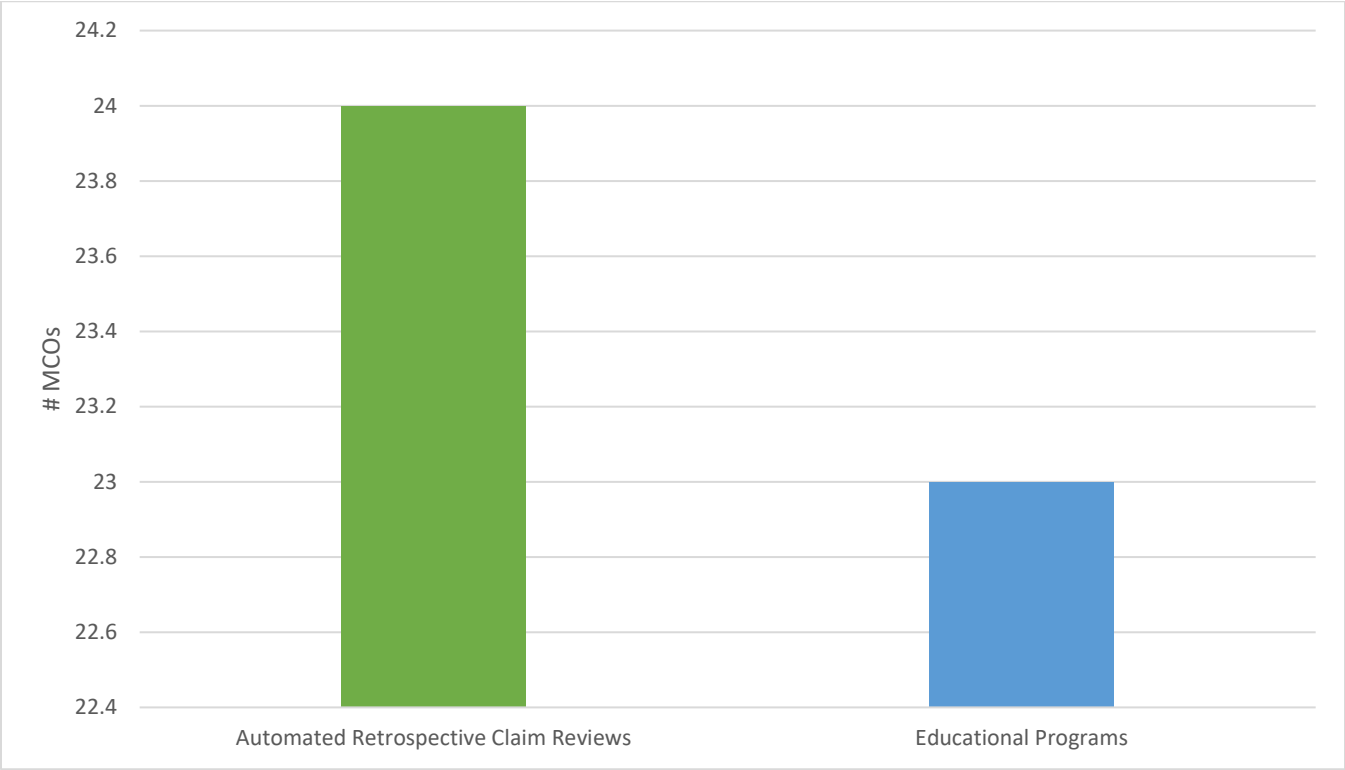

Table 67 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor Opioids and Antipsychotics Being Used Concurrently

Response	MCO Names	Count	Percentage
Automated retrospective claim reviews	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr,	24	51.06%

Response	MCO Names	Count	Percentage
	KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr		
Educational programs	AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	23	48.94%
State Totals		**47**	**100%**

If "Yes," please explain response above and detail the scope and nature of reviews and edits.

Table 68 - Explanations of Scope and Nature of Reviews and Edits to Monitor Opioids and Antipsychotics Being Used Concurrently

MCO Name	Explanation
AetnaBetterHealthCA Abbr	Aetna Better Health of California receives an internal monthly Retrospective Drug Utilization Review (retroDUR) report that provides pharmacy claim level data on members taking both opioid(s) and antipsychotic(s). The report is available to both the pharmacy and nurse care management teams for monitoring and tracking. Medi-Cal Rx provides an opioid dashboard that Aetna Better Health of California can access to monitor plan's opioid utilization. Additionally, the State shares trends overviews on aggregate opioid utilization with the MCOs in the quarterly DUR Board Meetings. Plan reviews the presented data in consideration for development of future educational outreach programs.
AHF Abbr	MCO attends State DUR meeting and distributes bulletins to provider and pharmacy network. Educational programs include continuous medical education and provider newsletters.
Alameda Abbr	Alameda monitors quarterly use concurrent use of opioid and anti-psychotics with specific attention to chronic users.
Anthem Abbr	Medi-Cal Rx (Opioid dashboard, aggregate quarterly DUR report, Educational bulletins, provider educational interventions, letters, letter templates on https;//medi-calrx.dhcs.ca.gov/home/. MCO's monitor via Opoiod dashboard data, DUR and P&T reviews, other multi-disciplinary committe reviews, provider communications, educational bulletins, provider educational interventions, academic detailing, letters and meetings.
BlueShield Abbr	The following describes the coordination between Medi-Cal Rx and MCO: Medi-Cal Rx 1. Opioid dashboard, aggregate quarterly DUR report 2. Educational bulletins 3. Provider educational interventions, Letters, Letter templates (on website)

MCO Name	Explanation
	MCO 1. Opioid Dashboard plan specific data MCO DUR, P&T reviews, other multidisciplinary committee reviews, provider communications 2. Educational bulletins 3. Provider educational interventions, Academic detailing, Letters, Meetings
CalOptima Abbr	Opioid dashboard plan-specific data reviews, MCO retrospective DUR reviews, educational newsletters and member-specific provider communications.
CalViva Abbr	Health Net utilizes monthly DUR reports to identify members who are on opioids and antipsychotics. Members are outreached to by a pharmacist to discuss potential drug interactions, adverse effects and to recommend alternatives. Provider education is offered to avoid concurrent prescribing of opioids and antipsychotics.
CCAH Abbr	MCO performs retrospective DUR based on pharmacy claims data sent by Medi-Cal Rx. Analysis is performed based on member age, MME, multiple opioid prescriptions, presence of naloxone claim, and number of prescribers per member. Top utilizers and prescribers with highest number of members are reviewed in detail. Educational article is shared in the provider newsletter.
CenCal Abbr	CenCal Health retrospectively monitors the concomitant use of opioids and antipshychotics. Periodic retrospective DUR provider outreaches are done identifying members that are currently receiving concomitant treatment.
CHW Abbr	Health Net utilizes monthly DUR reports to identify members who are on opioids and antipsychotics. Members are outreached to by a pharmacist to discuss potential drug interactions, adverse effects and to recommend alternatives. Provider education is offered to avoid concurrent prescribing of opioids and antipsychotics.
Community Abbr	CHG does retrospective review of claims during Interdisciplinary Care Team meetings, opioid overdose reviews, and 4x4x4 fraud, waste, and abuse monitoring. Results are summarized to CHG's Pharmacy and Therapeutics Committee.
ContraCosta Abbr	Both Medi-cal Rx and CCHP distribute educational bulletins, provider education, interventions and outreach letters. Medi-cal Rx uses an opioid dashboard with an aggregate quarterly DUR report. CCHP uses multiple opioid specific reports based on paid claims data to monitor opioids in combination with antipsychotics and perform interventions. Retrospective DUR is performed, P&T committee reviews the DUR and provider bulletins are sent out.
GoldCoast Abbr	The following describes the coordination between Medi-Cal Rx and MCO: Medi-Cal Rx provides the opioid dashboard data, aggregate quarterly DUR report, educational bulletins, provider educational interventions, letters, and letter templates (on the website). The MCO reviews the opioid dashboard plan specific data, performs further reviews at the MCO P&T committee and other multidisciplinary committees, generate provider communications, educational bulletins, provider educational interventions, academic detailing, letters, and meetings.
HealthNetMediCal Abbr	Health Net utilizes monthly DUR reports to identify members who are on opioids and antipsychotics. Members are outreached to by a pharmacist to discuss potential drug interactions, adverse effects and to recommend alternatives.

MCO Name	Explanation
	Provider education is offered to avoid concurrent prescribing of opioids and antipsychotics.
Kaiser Abbr	Kaiser utilizes a comprehensive and unique approach in managing opioids. In addition to the automated prospective edits set at the PBM level, Kaiser employs real-time review in managing potential overuse of opioid medications. Kaiser's pharmacists review alerts at point of sale for high MME >=90, refill-too-soon alerts of 90%, safety edits (e.g. Opioid+BZD, Opioid+Amphetamines, Opioid+Z-drugs, Opioid+SMRs), duplicate claims, and quantity limits. The local Controlled Substances Committees typically meet either weekly, monthly, or quarterly and physician and pharmacist members conduct patient care reviews of patients identified through the retrospective reports of patients on opioids at an average of = or > 90 MME/day over each quarter. KP P&T Committee also reviews reports including opioid + benzo, opioid + antipsych, opioid nave fill, and MME >=50 quarterly. Medi-Cal Rx provides an opioid dashboard and quarterly DUR report for MCO plans to review. Bulletins, letters, and letter templates for provider education and intervention are also shared with plans.
KernHealthSystems Abbr	As part of the SUPPORT Act, KHS runs reports/audits to identify potential inappropriate therapies. If identified, a provider is sent a letter indicating such. The CDC guidelines are referenced and monitoring tools are available. Providers are asked to provide treatment plans to reduce or eliminate utilization. If not clinically appropriate, the providers are asked to state that fact, giving supporting rationale as to why the reduction or deprescribing would not be appropriate for the particular member. KHS Policy 13.04-I addresses the type of monitoring and reporting conducted to identify these cases.
LACARE Abbr	MCO has the ability to pull data from the Opioid Dashboard for concomitant drugs: opioids and antipsychotics
Molina Abbr	Medi-Cal RX has provided a Opioid Dashboard platform for MCO use which allows for review of opioid and antipsychotic use. This dashboard continues to be refined with MCO feedback on better development to assist with monitoring and surveillance of retrospective claim reviews of opioids.
SanFrancisco Abbr	Concomitant use of opioids and antipsychotics is monitored through the state provided opioid reporting. Appropriate dosing recommendations are communicated through SFHP's external provider website resources, as well as through provider education through DHCS.
SanJoaquin Abbr	HPSJ has an Opioid Dashboard, HPSJ routinely sends out educational bulletin and provider alerts
SanMateo Abbr	Medi-Cal Rx provides opioid dashboard reporting access along with the sharing of pharmacy claims and PA data. In addition to educational bulletins and provider letters from the state, the MCO utilizes also provides educational content to providers and members, targeting specific individuals as deemed appropriate based on utilization to conduct outreach. Regarding concurrent antipsychotic use, the MCO collaborates with behavioral health pharmacy staff from the county who review and work closely with behavioral health practitioners on utilization.

MCO Name	Explanation
SantaClaraHealthPlan Abbr	Medi-Cal Rx provides an opioid dashboard, an aggregate quarterly DUR report, educational bulletins, and provider educational interventions and letters/letter templates. The Plan reviews the opioid dashboard and quarterly DUR report from Medi-Cal Rx, shares any findings with the P&T Committee and other multidisciplinary committees, as appropriate. The Plan also conducts provider educational interventions when necessary and publishes educational articles in the provider newsletter.
UnitedHealth Abbr	UnitedHealthcare Community Plan utilizes information from the Opioid Dashboards to inform utilization within our member population. Provider education bulletins are published and stored on our provider website to assist providers with opioid tapering. The claims data received from Medi-CalRx is used as part of the OptumRx Abused Medications Program. This program notifies prescribers via fax/mail when a member is receiving an opioid and an antipsychotic concurrently.

If “No,” please explain.

Table 69 - Explanations for not Coordinating with the Entity that Provides Drug Benefits to Monitor Opioids and Antipsychotics Being Used Concurrently

MCO Name	Explanation
Inland Abbr	Entity that provides the drug benefits works with MCO does not identify count of members who concurrently use antipsychotics and opioids in the opioid utilization dashboard. MCO has own internal report that identifies members who are concurrently use antipsychotics and opioids.
Partnership Abbr	PHC will be exploring processes to identify opioids and antipsychotics being used concurrently, and will develop appropriate interventions.

6. Does your MCO have safety edits or perform automated retrospective claims reviews and/or provider education regarding beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis?

Figure 40 - MCO has POS Safety Edits or Performs Automated Retrospective Claims Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

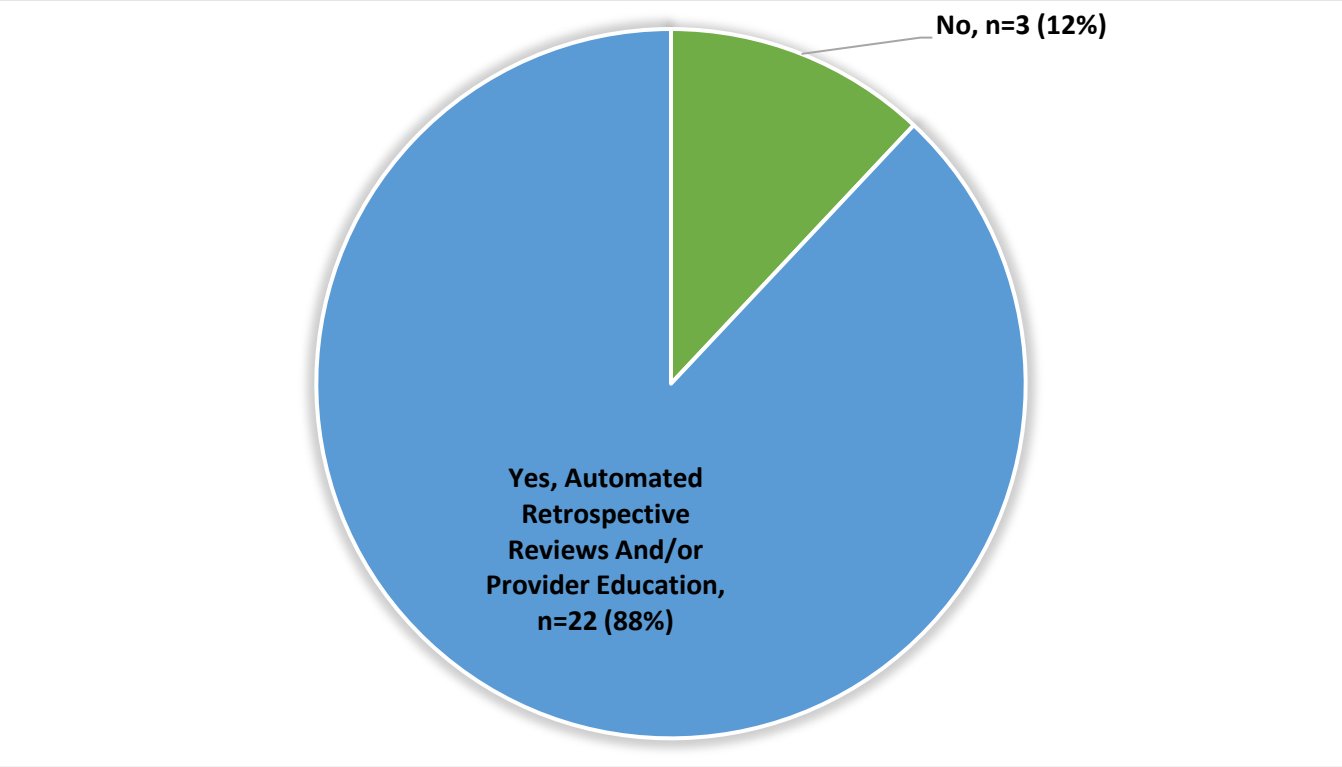

Table 70 - MCO has POS Safety Edits or Performs Automated Retrospective Claims Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

Response	MCO Names	Count	Percentage
Yes, automated retrospective reviews and/or provider education	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, CalViva Abbr, CCAH Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	22	88.00%
No	BlueShield Abbr, CalOptima Abbr, CenCal Abbr	3	12.00%
State Totals		**25**	**100%**

a. If "Yes, automated retrospective claim reviews" and/or "Yes, provider education," please indicate how often.

Figure 41 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

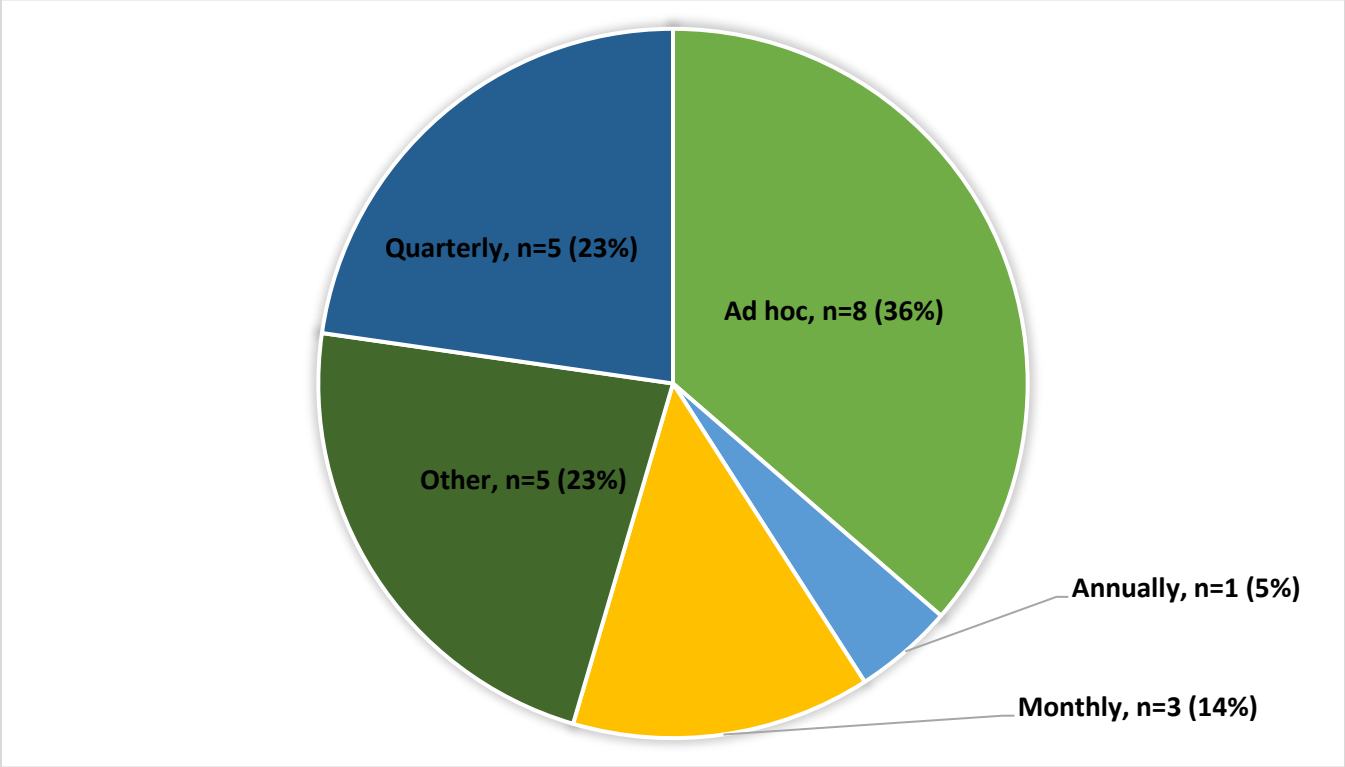

Table 71 - Frequency of Automated Retrospective Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

Response	MCO Names	Count	Percentage
Ad hoc	AHF Abbr, Anthem Abbr, CCAH Abbr, GoldCoast Abbr, LACARE Abbr, Partnership Abbr, SanJoaquin Abbr, SanMateo Abbr	8	36.36%
Annually	SantaClaraHealthPlan Abbr	1	4.55%
Monthly	AetnaBetterHealthCA Abbr, KernHealthSystems Abbr, Molina Abbr	3	13.64%
Quarterly	Alameda Abbr, Community Abbr, ContraCosta Abbr, Inland Abbr, SanFrancisco Abbr	5	22.73%
Other	CalViva Abbr, CHW Abbr, HealthNetMediCal Abbr, Kaiser Abbr, UnitedHealth Abbr	5	22.73%
State Totals		**22**	**100%**

If "Other," please specify.

Table 72 - "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
CalViva Abbr	Monthly retrospective claims review and ad-hoc provider education
CHW Abbr	Monthly retrospective claims review and ad-hoc provider education

MCO Name	Explanation
HealthNetMediCal Abbr	Monthly retrospective claims review and ad-hoc provider education
Kaiser Abbr	Information provided through our integrated medical record system - KP HealthConnect.
UnitedHealth Abbr	Daily

b. If "Yes, automated retrospective claim reviews" and/or "Yes, provider education," please explain nature and scope of edits, reviews and/or provider education reviews performed.

Table 73 - Explanations of Nature and Scope of Edits, Reviews and/or Provider Education Reviews Performed Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning Diagnosis

MCO Name	Explanation
AetnaBetterHealthCA Abbr	The plan's Care Management (CM) team monthly reviews the internal Opioid Use Disorder (OUD) Risk Report built from retrospective pharmacy and medical claims. The report risk stratifies members on multiple factors, including but not limited to opioid overdose history, opioid use disorder history, and concurrent opioid and benzodiazepine medication utilization. The CM team conducts member outreach to the risk stratified populations to assess overall health and coordinate care. Medi-Cal Rx provides an opioid dashboard that Aetna Better Health of California can access to monitor plan's opioid utilization. Additionally, the State shares trends overviews on aggregate opioid utilization with the MCOs in the quarterly DUR Board Meetings. Plan reviews the presented data in consideration for development of future educational outreach programs.
AHF Abbr	Provider education reviews are performed based on recommendations by state's DUR Board and continuing medical education requirements.
Alameda Abbr	Alameda reviews members with opioid toxicity and concurrent use of opioid and benzodiazepines quarterly.
Anthem Abbr	Yes, 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.
CalViva Abbr	Our Health Plan utilizes claims data to identify members who have a diagnosis of opioid use disorder (OUD) and/or opioid poisoning. Members are referred to our telehealth medication-assisted treatment (MAT) provider, Bright Heart Health for care. Reports are generated on a monthly basis for pharmacist review. Pharmacists outreach to members and/or provider if necessary for education.
CCAH Abbr	MCO performs retrospective review of Emergency Department and hospital inpatient claims associated with opioid poisoning diagnosis. Members' claims history is reviewed for opioids, concurrent benzodiazepines, antidepressants, antipsychotics, buprenorphine, naltrexone, and naloxone. Members receiving opioids from multiple prescribers are reviewed in detail.
CHW Abbr	Our Health Plan utilizes claims data to identify members who have a diagnosis of opioid use disorder (OUD) and/or opioid poisoning. Members are referred to our telehealth medication-assisted treatment (MAT) provider, Bright Heart Health for care. Reports are generated on a monthly basis for pharmacist review. Pharmacists outreach to members and/or provider if necessary for education.

MCO Name	Explanation
Community Abbr	CHG does retrospective review of claims during Interdisciplinary Care Team meetings, opioid overdose reviews, and 4x4x4 fraud, waste, and abuse monitoring. Results are summarized with CHG's Pharmacy and Therapeutics Committee.
ContraCosta Abbr	CCHP uses multiple opioid specific reports based on paid claims data to monitor opioids in combination with sedatives and perform interventions. Retrospective DUR is performed, P&T committee reviews the DUR and provider bulletins are sent out. CCHP sends quarterly letters to providers prescribing the combination of opioids and benzodiazepines or muscle relaxants to their patients.
GoldCoast Abbr	GCHP has provided ad hoc provider education in the past regarding OUD or opioid poisoning diagnosis as necessary. Additionally, the Plan is part of a county workgroup that addresses these issues which regularly provide training and educational opportunities. Gold Coast Health Plan also provides care management and assists in arranging healthcare and mental health services with local agencies.
HealthNetMediCal Abbr	Our Health Plan utilizes claims data to identify members who have a diagnosis of opioid use disorder (OUD) and/or opioid poisoning. Members are referred to our telehealth medication-assisted treatment (MAT) provider, Bright Heart Health for care. Reports are generated on a monthly basis for pharmacist review. Pharmacists outreach to members and/or provider if necessary for education.
Inland Abbr	Provider education is provided via academic detailing on safe opioid prescribing topics including but not limited to, drug-drug interactions, use of opioids at high dosage, and the importance of naloxone prescribing. Beneficiaries identified with a diagnosis of opioid use disorder or opioid poisoning diagnosis will have Nurse Case Managers outreach and counsel Member for potential benefits through Member for potential multi-disciplinary Medication Assisted Treatment (MMAT). MMAT will have a provider to prescribe Medication Assisted Treatment (MAT) and a behavioral health provider to provide counseling to the member.
Kaiser Abbr	The local Controlled Substances Committees typically meet either weekly, monthly, or quarterly and physician and pharmacist members conduct patient care reviews of patients identified through the Drug Use Management reports of patients on opioids at an average of = or > 90 MME/day over each quarter and/or on concurrent opioids plus benzodiazepines and non-benzodiazepine sedative-hypnotics.
KernHealthSystems Abbr	As part of the SUPPORT Act, KHS runs reports/audits to identify potential inappropriate therapies. If identified, a provider is sent a letter indicating such. The CDC guidelines are referenced and monitoring tools are available. Providers are asked to provide treatment plans to reduce or eliminate utilization. If not clinically appropriate, the providers are asked to state that fact, giving supporting rationale as to why the reduction or deprescribing would not be appropriate for the particular member. KHS Policy 13.04-I addresses the type of monitoring and reporting conducted to identify these cases.
LACARE Abbr	MCO has the ability to pull data from the Opioid Dashboard for opioid related conditions.
Molina Abbr	Molina's use of the platform ImpactPro is refreshed monthly and identifies members with: a diagnosis of opioid use disorder, fill of MAT drugs, or opioid poisoning overdose (by diagnosis or drug history). Members are then stratified by risk score alongside other parameters assessing clinical risk or impactable opportunities allowing prioritization of interventions to the highest risk members.

MCO Name	Explanation
	Molina's Q2 2022 Provider Newsletter included Clinical Practice Guidelines on Opioid Safety. Copies could be requested or viewed directly on the Molina website. Resources included information such as CDC guidance on opioids, CME courses for safer opioid use and information on MAT drugs, Opioid Tapering Resources (CHCF, CSAM, CDC) as well as a PDMP link and fact sheet to view members who may be on substances that may increase risk of opioids-such as benzodiazepines.
Partnership Abbr	PHC's Managing Pain Safely dashboard maintains data for beneficiaries receiving medication-assisted treatment. PHC's Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing (MPXG5008) includes Emergency Department Guidelines which address screening for Substance Use Disorder and initiating medication-assisted treatment. The Clinical Practice Guidelines also include PHC Recommendations for Safe Use of Opioid Medications: Primary Care & Specialist Prescribing Guidelines which addresses treatment of acute pain in members with opioid use disorder. Clinical Practice Guidelines are policies that are reviewed and approved by PHC's Internal Quality Improvement Committee and Physician Advisory Committee
SanFrancisco Abbr	Diagnosis of OUD is tracked and included in the SFHP opioid dashboard. On a quarterly basis, members with OUD are evaluated to see which members are on prescription opioids, what their daily MME is, if they have buprenorphine prescribed, if they have naloxone prescribed, and is they have an concomitant use of CNS depressant medications.
SanJoaquin Abbr	HPSJ has an Opioid Dashboard, HPSJ routinely sends out educational bulletin and provider alerts
SanMateo Abbr	We work in partnership with county behavioral health and recovery services to support an integrated approach to OUD and SUD treatment, which involves facilitating access to treatment, sharing pharmacy data, and working with providers to communicate utilization concerns as warranted.
SantaClaraHealthPlan Abbr	A retrospective DUR program is performed annually to identify members diagnosed with opioid use disorder or opioid poisoning in the last 12 months. Members' primary care providers are mailed letters that include education about available treatments and services to prevent opioid overdose " naloxone, medication-assisted therapy (MAT), and alternative or complementary therapies covered by the Plan.
UnitedHealth Abbr	UnitedHealthcare Community Plan has enrolled in the Abused Meds program through OptumRx that identifies members with a diagnosis of opioid poisoning and a subsequent fill of an opioid analgesic and notifies prescribers via fax/mail of the members in which they have written opioid prescriptions for. The notification recommends considering prescribing naloxone for the member.

If "No," does your MCO plan on implementing automated retrospective claim reviews and/or provider education regarding beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?

Figure 42 - Plans to Implement Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

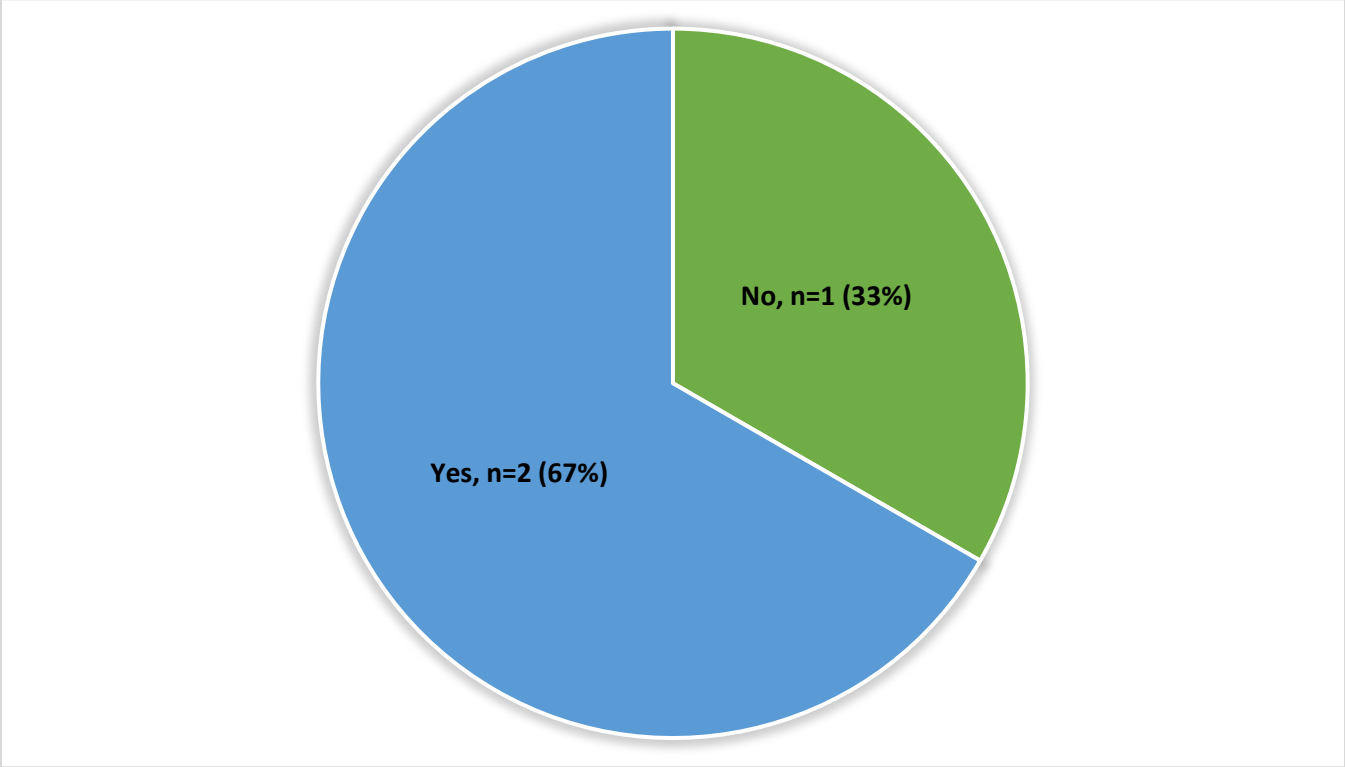

Table 74 - Plans to Implement Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

Response	MCO Names	Count	Percentage
Yes	BlueShield Abbr, CalOptima Abbr	2	66.67%
No	CenCal Abbr	1	33.33%
State Totals		**3**	**100%**

If "Yes," when does your MCO plan on implementing?

Table 75 - "Yes" Explanations for Plans to Implement Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis History of OUD or Opioid Poisoning in the Future

MCO Name	Explanation
BlueShield Abbr	Opioid poisoning diagnosis is currently flagged and may be discussed with providers under our current program, the Patient Review and Coordination (PRC) program. An OUD diagnosis flag and concomitant opioid and medication-assisted therapy flag will be implemented by Q3 of 2023. The program does not have a specific task for targeting OUD or opioid poisoning diagnosis directly, but rather discussing when discovered and necessary as part of case management.
CalOptima Abbr	In the next year.

If "No," please explain.

Table 76 - "No" Explanations for Plans to Implement Automated Retrospective Claim Reviews and/or Provider Education Regarding Beneficiaries with a Diagnosis or History of OUD or Opioid Poisoning in the Future

MCO Name	Explanation
CenCal Abbr	CenCal Health does not have a program in place currently, but CenCal Health is exploring options for identifying members through medical claims data to distribute provider education to the network.

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

Figure 43 - Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

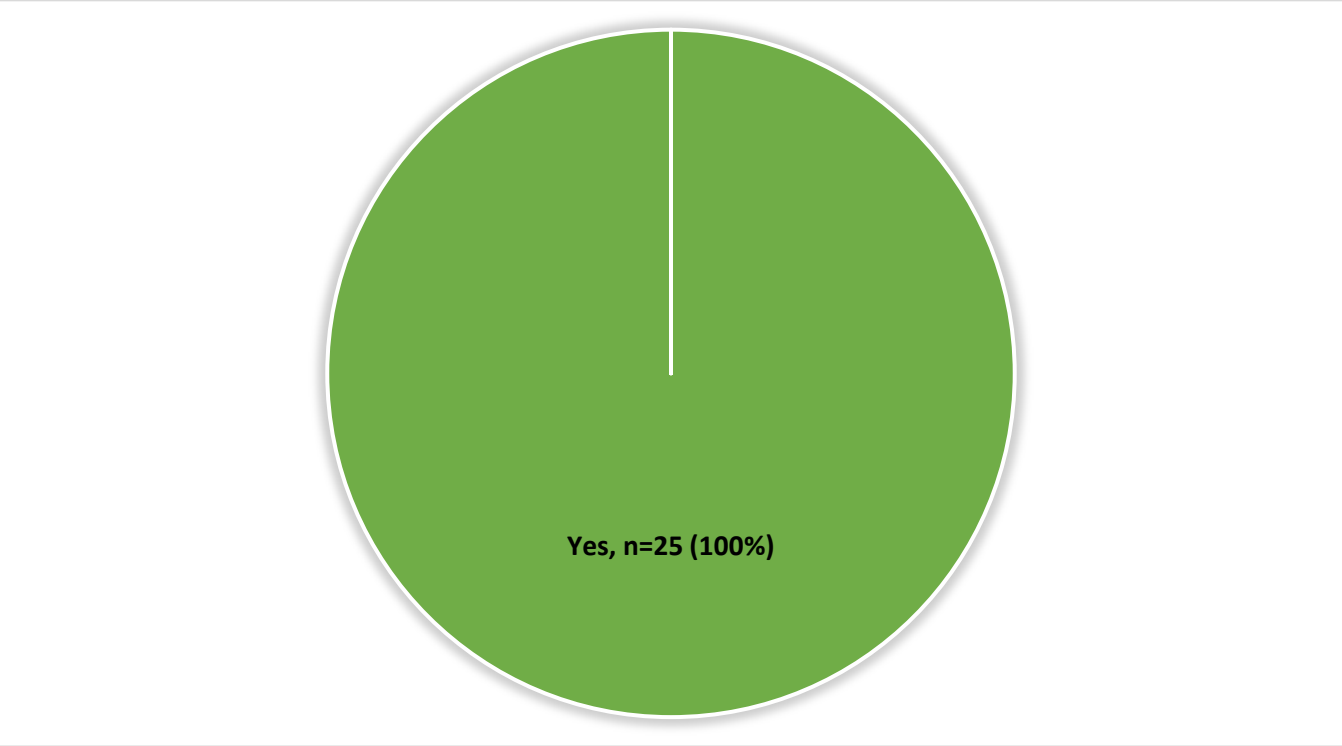

Table 77 - Provide Prescribers with Pain Management or Opioid Prescribing Guidelines

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

If "Yes," please check all that apply.

Figure 44 - Pain Management / Opioid Prescribing Guidelines Provided

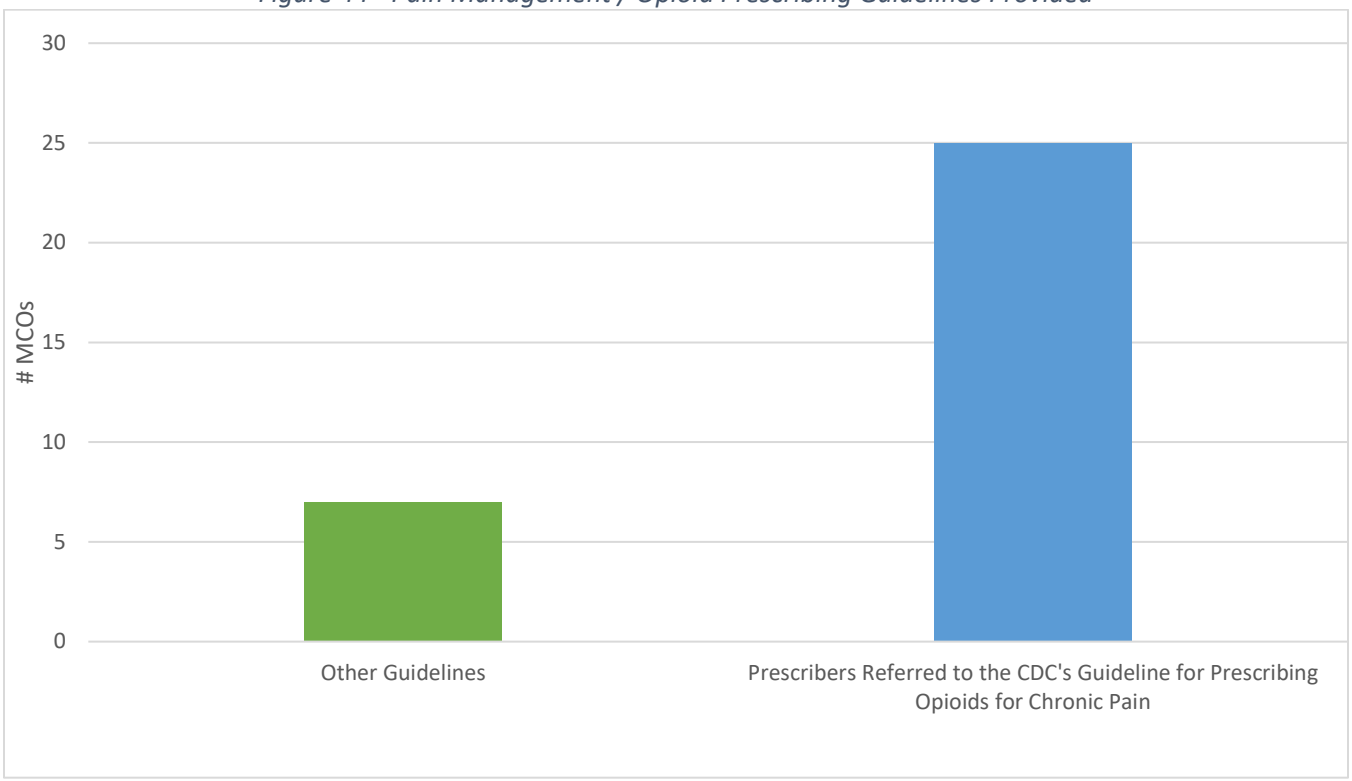

Table 78 - Pain Management / Opioid Prescribing Guidelines Provided

Response	MCO Names	Count	Percentage
Prescribers referred to the CDC's Guideline for Prescribing Opioids for Chronic Pain	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	78.12%
Other guidelines	AetnaBetterHealthCA Abbr, Anthem Abbr, Kaiser Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, UnitedHealth Abbr	7	21.88%
State Totals		**32**	**100%**

If "Other guidelines," please identify.

Table 79 - "Other Guidelines" Provided

MCO Name	Explanation
AetnaBetterHealthCA Abbr	Medi-Cal Rx uses CDC guidelines to establish the Opioids policy.
Anthem Abbr	Medi-Cal Rx uses CDC guidelines to establish the Opioids policy.

MCO Name	Explanation
Kaiser Abbr	Appropriate opioid prescribing guidelines developed and championed by TPMG and SCPMG physician experts and leaders. Approved by the TPMG and SCPMG Pharmacy and Therapeutics Committee.
LACARE Abbr	The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine (2015).
Molina Abbr	Molina's Q2 2022 Provider Newsletter included Clinical Practice Guidelines on Opioid Safety. Copies could be requested or viewed directly on the Molina website. Resources included information such as CDC guidance on opioids, CME courses for safer opioid use and information on MAT drugs, Opioid Tapering Resources (CHCF, CSAM, CDC) as well as a PDMP link and fact sheet to view members who may be on substances that may increase risk of opioids-such as benzodiazepines.
Partnership Abbr	In addition to the CDC guidelines, PHC's Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing (MPXG5008) uses several other resources including guidelines from: the American Pain Society Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review; Washington State Agency Medical Directors' Group (AMDG)-Cautious Evidence-Based Opioid Prescribing; and Substance Abuse and Mental Health Services Administration (SAMHSA).
UnitedHealth Abbr	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 Prescriber Reference Guide to provide our prescribers with information regarding 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) - Inter-agency 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

D. Morphine Milligram Equivalent (MME) Daily Dose

1. Does your MCO coordinate with the entity that provides the drug benefit to monitor MME total daily dose of opioid prescriptions dispensed?

Figure 45 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor MME Total Daily Dose of Opioid Prescriptions Dispensed

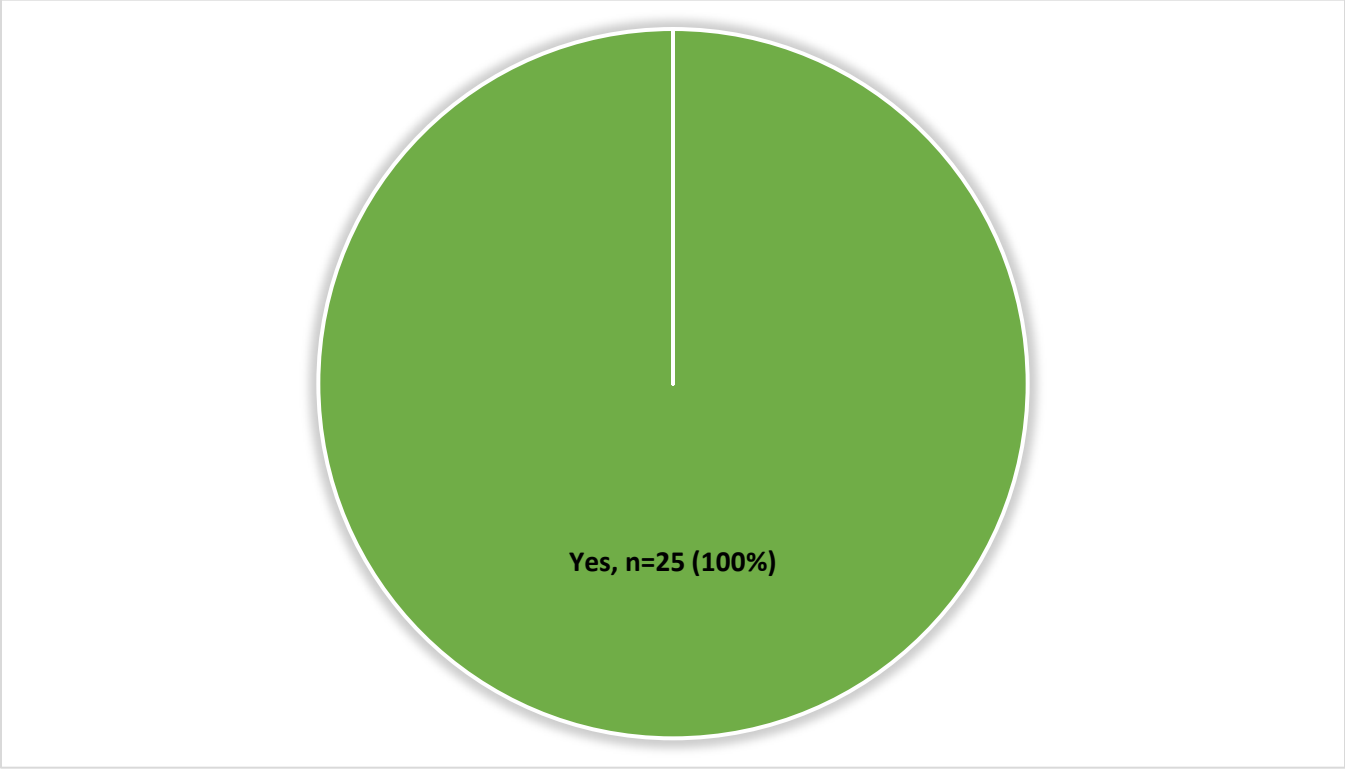

Table 80 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor MME Total Daily Dose of Opioid Prescriptions Dispensed

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

Please explain.

Table 81 - Explanations for Monitoring MME Total Daily Dose of Opioid Prescriptions Dispensed

MCO Name	Explanation
AetnaBetterHealthCA Abbr	State aggregate data are presented at quarterly DUR Board meetings. Data monitored: total claims (claims count) by MME (<30, 30-49, 50-89, 90-120, >120).
AHF Abbr	plan specific opioid dashboard has information in already formatted pie charts. State aggregate pie charts presented at DUR Board meetings MME <30, 30-49, 50-89, 90-120, >120. Future: >400, >500
Alameda Abbr	Alameda monitors opioid over-utilization monthly with the breakdown of MME as follows: 50-89 MME, 90-119 MME, 120-199 MME, 200-299 MME, 300-399 MME, >400 MME.
Anthem Abbr	State aggregate data presented at quarterly DUR Board meetings Monitor total claims (claims count) by MME and days supply <30, 30-49, 50-89, 90-120, >120
BlueShield Abbr	State aggregate data is presented at quarterly DHCS DUR Board meetings that monitors total claims (claims count) by MME and days supply: <30, 30-49, 50-89, 90-120, >120 (In the future, will include >400, >500) MCO will review MME data and information on pharmacy claims shared by DHCS. MCO conducts the Patient Review and Coordination (PRC) program, which is an automated retrospective DUR report that look back 6 months to identify potentially at-risk members based on: 1) Opioid Dosage (MME>=500), 2) Multiple Providers, 3) Multiple Pharmacies, 4) Concurrent Use of Opioid and Benzodiazepine (MME >=50), and 5) Concurrent Use of Opioid and Antipsychotic (MME >=50).
CalOptima Abbr	State aggregate data are presented at quarterly DUR Board meetings. Monitor total claims (claims count) by MME and days supply.
CalViva Abbr	State aggregate data presented at quarterly DUR Board meetings Monitor total claims (claims count) by MME and day supply <30, 30-49, 50-89, 90-120, >120 (In future >400, >500)
CCAH Abbr	MCO performs retrospective DUR based on pharmacy claims data sent by Medi-Cal Rx. Average MME per day is calculated to assess the member's risk for adverse drug event. Members with opioid prescriptions from multiple prescribers are identified and analyzed for potential FWA. Prescribing patterns are reviewed for providers with multiple members on opioids 90 MME or greater.
CenCal Abbr	CenCal Health has access to an opioid dashboard which allows for the review of the total MME for each member under CenCal Health's benefit.
CHW Abbr	State aggregate data presented at quarterly DUR Board meetings Monitor total claims (claims count) by MME and day supply <30, 30-49, 50-89, 90-120, >120 (In future >400, >500)
Community Abbr	State aggregated data is presented at quarterly DUR Board meetings and shared with the plan. The data includes the following MME: MME <30, 30-49, 50-89, 90-

MCO Name	Explanation
	120, >120. There were discussions to include MME >400 and MME >500 in the future.
ContraCosta Abbr	The California state aggregate data presented at quarterly DUR Board meetings monitor total claims by MME and days supply, for example <30, 30-49, 50-89, 90-120, >120. In the future, >400 and >500 MME will be monitored. CCHP commercial members are monitored for MME levels >90.
GoldCoast Abbr	State aggregate data is presented at quarterly DUR Board meetings. Monitor total claims (claims count) by MME and days supply (<30, 30-49, 50-89, 90-120, >120 MME). Per Medi-Cal Rx Controlled Substance Policy: As of October 1, 2019, DHCS will utilize current CDC guidelines to establish a maximum Morphine Milligram Equivalent (MME) at which the POS system will return a message to the pharmacy provider, notifying the provider of the excessive dose risk. A warning message will be returned to providers when 90 MME threshold has been exceeded. The message will provide a warning of CDC recommendation for maximum MME. When 500 MME has been exceeded, the claim will deny and require a PA. The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an Early Refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30 days supply). NOTE: New-start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS (cough preparations containing opioids are excluded from this look back). Chronic use is defined as the presence of 90 days of any opioid therapy (including long-acting, short-acting, and buprenorphine products) in the past 120-day period. The limitations will not apply to the following beneficiaries: LTC facilities, In hospice, Receiving palliative or end-of-life care, With a diagnosis of sickle-cell disease, In treatment for active cancer-related pain.
HealthNetMediCal Abbr	State aggregate data presented at quarterly DUR Board meetings Monitor total claims (claims count) by MME and day supply <30, 30-49, 50-89, 90-120, >120 (In future >400, >500)
Inland Abbr	Entity that provides the drug benefits works with MCO to identify count of members with opioid claims and their average MME through automated retrospective claims review that are summarized in the opioid dashboard.
Kaiser Abbr	State aggregate data is presented at quarterly DUR Board meetings where total claims (claims count) are monitored by MME and days supply (e.g. <30, 30-49, 50-89, 90-120, >120).
KernHealthSystems Abbr	As part of the SUPPORT Act, KHS runs reports/audits to identify potential inappropriate therapies. If identified, a provider is sent a letter indicating such. The CDC guidelines are referenced and monitoring tools are available. Providers are asked to provide treatment plans to reduce or eliminate utilization. If not clinically appropriate, the providers are asked to state that fact, giving supporting rationale as to why the reduction or deprescribing would not be appropriate for the particular member. KHS used to have their own specific MME value. After the transition of the pharmacy benefit, the state's FFS thresholds are referenced. These

MCO Name	Explanation
	include categories of MME dosages that include: <30, 30-49, 50-89, 90-120, and >120.
LACARE Abbr	State aggregate data presented at quarterly DUR Board meetings Monitor total claims (claims count) by MME and days supply <30, 30-49, 50-89, 90-120, >120 Use state aggregate data and if needed, able to monitor Magellan opioid dashboards (In future >400, >500)
Molina Abbr	State aggregate data is presented at quarterly DUR Board meetings which monitor total claims (claims counts) by MME and days supply <30, 30-49, 50-89, 90-120, >120. In the future, MME greater than 400 and 500 will also be presented.
Partnership Abbr	Opioid prescription data is obtained through the Medi-Cal Rx, Magellan claims feed. This data is integrated into PHC's Managing Pain Safely dashboard to monitor MME total daily dose of opioid prescriptions dispensed.
SanFrancisco Abbr	The average daily MME for every patient on opioid medications is evaluated on a quarterly basis using the SFHP internal opioid dashboard.
SanJoaquin Abbr	HPSJ has an opioid dashboard that monitors beneficiaries taking opiates with an aveage daily dose exceeding MME 90
SanMateo Abbr	We have access to Medi-Cal Rx's opioid dashboard information where they provide information based on MME consumption thresholds (e.g., <30 MME, 90-120, > 120, etc...).
SantaClaraHealthPlan Abbr	State aggregate data presented at quarterly DUR Board meetings. Monitor total claims (claims count) by MME and days supply <30, 30-49, 50-89, 90-120, >120.
UnitedHealth Abbr	The State presents aggregate data quarterly DUR Board meetings. The data presented and monitored includes total claims (claims count) by MME and days' supply (<30, 30-49, 50-89, 90-120, >120). UnitedHealthcare Community Plan uses utilization and claims data provided by the state for the Abused Medications Program. The Abused Medications Program is a RDUR program that notifies the prescribers of medication related issues including when individuals are receiving a high daily dose of opioids defined by the program as 90 MME.

E. Opioid Use Disorder (OUD) Treatment

1. Does your MCO coordinate with the entity that provides the drug benefit to monitor and manage appropriate use of naloxone to persons at risk of overdose?

Figure 46 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor and Manage Use of Naloxone

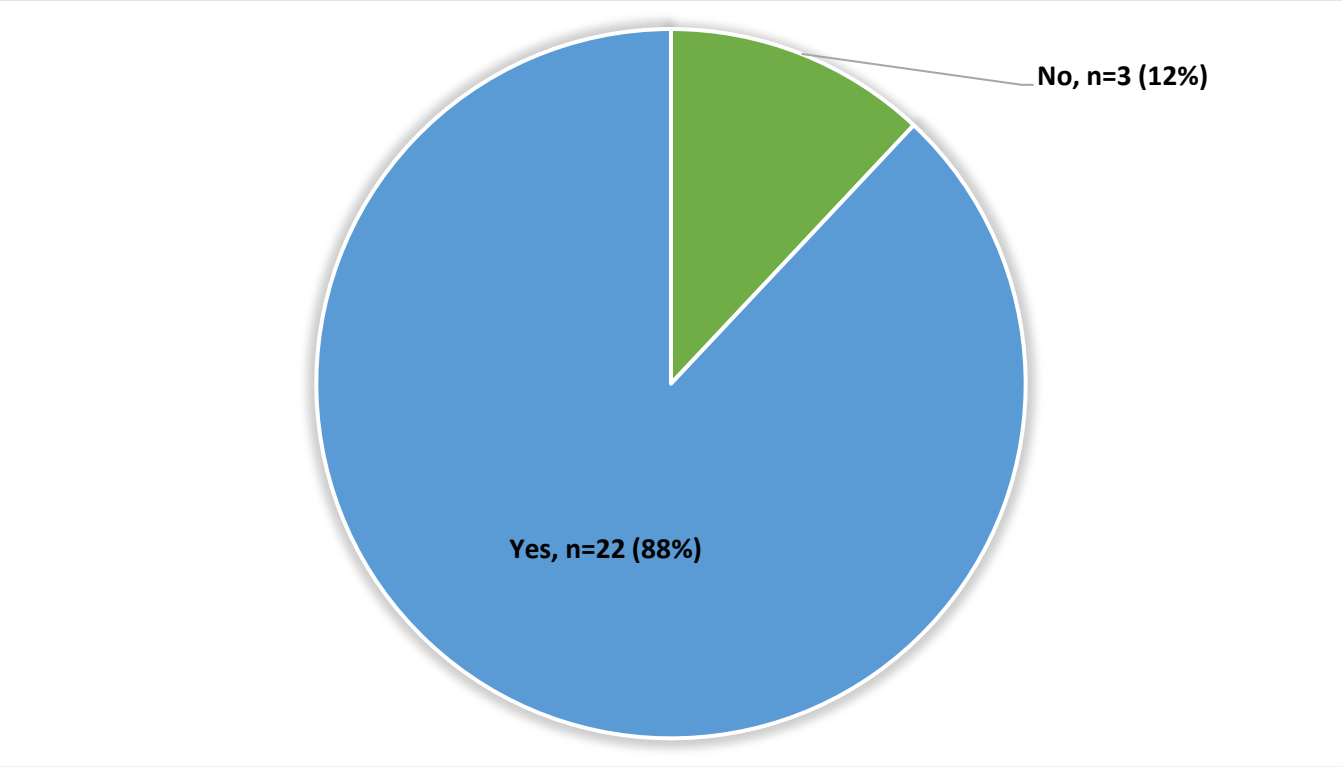

Table 82 - MCO Coordinates with the Entity that Provides Drug Benefits to Monitor and Manage Use of Naloxone

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, AHF Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	22	88.00%
No	Alameda Abbr, Inland Abbr, Partnership Abbr	3	12.00%
State Totals		**25**	**100%**

Please explain above response.

Table 83 - Explanations for Monitoring and Managing Use of Naloxone

MCO Name	Explanation
AetnaBetterHealthCA Abbr	The plan's Care Management (CM) team reviews an internal Opioid Use Disorder (OUD) Risk Report built from retrospective pharmacy and medical claims. The report risk stratifies members on multiple factors, including but not limited to opioid overdose history, opioid use disorder history, and concurrent opioid and benzodiazepine medication utilization. Naloxone utilization is also tracked. The CM team conducts member outreach to the risk stratified populations to assess overall health and coordinate care. Medi-Cal Rx provides an opioid dashboard that Aetna Better Health of California can access to monitor plan's opioid utilization. The state also sent out educational outreach letters that aimed to inform health care providers and pharmacies about the importance of prescribing/furnishing naloxone to patients at high risk for overdose.
AHF Abbr	MCO reviews opioid and naloxone claims to identify persons at risk of overdose, monitor and manage appropriate use.
Alameda Abbr	Alameda implemented a monitoring program for chronic use of opioid without naloxone on 1/2023.
Anthem Abbr	We monitor pharmacy claims of at least 50 mg of daily dose of morphine equivalent (MED) opioids without claim for naloxone. Prescriber outreach, when appropriate, for identified gaps in care.
BlueShield Abbr	MCO reviews opioids and naloxone claims data to identify persons at risk of overdose. As part of the Patient Review and Coordination (PRC) program, prescriber outreach and education may be conducted to ensure appropriate prescribing of naloxone for members at high risk of overdose.
CalOptima Abbr	MCO reviews opioid and naloxone pharmacy claims data to identify beneficiaries in need of naloxone prescriptions.
CalViva Abbr	Our Health Plan runs naloxone prescription reports on a monthly basis. Members who are on high doses of opioids receive education on naloxone and promotes carrying of naloxone. Providers and pharmacies are contacted on behalf of members who request naloxone. Provider education material is created to encourage co-prescribing of opioids and naloxone.
CCAH Abbr	MCO performs retrospective DUR based on pharmacy claims data sent by Medi-Cal Rx. Naloxone claims are reviewed while performing other retrospective DURs, such as members with high MME total daily dose of opioids or concurrent opioid and benzodiazepines. If members at high risk of overdose are not co-prescribed naloxone, MCO sends educational materials to the provider.
CenCal Abbr	CenCal Health reviews members on high potency opioids who have not received a prescription of Naloxone in the past 12-monhts. This review included an outreach to providers with identified members and educational materials on the options for members to access naloxone in the communities that CenCal Health serves.
CHW Abbr	Our Health Plan runs naloxone prescription reports on a monthly basis. Members who are on high doses of opioids receive education on naloxone and promotes carrying of naloxone. Providers and pharmacies are contacted on behalf of members who request naloxone. Provider education material is created to encourage co-prescribing of opioids and naloxone.

MCO Name	Explanation
Community Abbr	CHG does retrospective review of claims during Interdisciplinary Care Team meetings, opioid overdose reviews, and 4x4x4 fraud, waste, and abuse monitoring. A part of this review include history of naloxone fills.
ContraCosta Abbr	Yes, opioid and naloxone claims data are used to identify persons at risk of an overdose
GoldCoast Abbr	GCHP reviews opioids and naloxone claims data to identify persons at risk of overdose, monitor and manage appropriate use.
HealthNetMediCal Abbr	Our Health Plan runs naloxone prescription reports on a monthly basis. Members who are on high doses of opioids receive education on naloxone and promotes carrying of naloxone. Providers and pharmacies are contacted on behalf of members who request naloxone. Provider education material is created to encourage co-prescribing of opioids and naloxone.
Inland Abbr	Entity that provides the drug benefits works with MCO does not identify count of members naloxone use for persons at risk of overdose. MCO has own internal report that monitors members who meet CDC guideline criteria recommendation for naloxone.
Kaiser Abbr	Our clinicians are prescribing, and if a pharmacist determines that naloxone is warranted, since we are an integrated system, pharmacists are able to contact the provider directly. In addition, our clinicians have a protocol to dispense naloxone with narcotics/benzos/etc.
KernHealthSystems Abbr	As part of the SUPPORT Act, KHS runs reports/audits to identify potential inappropriate therapies. If identified, a provider is sent a letter indicating such. The CDC guidelines are referenced and monitoring tools are available. Providers are asked to provide treatment plans to reduce or eliminate utilization. If not clinically appropriate, the providers are asked to state that fact, giving supporting rationale as to why the reduction or deprescribing would not be appropriate for the particular member.
LACARE Abbr	MCO has the ability to review opioids and naloxone claims data to identify persons at risk of overdose
Molina Abbr	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.
Partnership Abbr	We plan to review naloxone claims to promote appropriate use of naloxone as well as provide best practices to our medical and pharmacy providers for prescribing and furnishing naloxone.
SanFrancisco Abbr	Members with opioid use or a diagnosis of OUD are included in the internal opioid dashboard and evaluated for whether or not they have a recent prescription for naloxone.
SanJoaquin Abbr	HPSJ reviews opioid and naloxone claims to identify persons at risk of overdose, monitor and manage appropriate use.

MCO Name	Explanation
SanMateo Abbr	We have access to Medi-Cal Rx pharmacy data on opioid and naloxone use. As mentioned above, we work in partnership with county behavioral health and recovery services to support an integrated approach to OUD and SUD treatment, which involves facilitating access to treatment, sharing pharmacy data, and working with providers to communicate utilization concerns as warranted. Where applicable, this involves monitoring, prescribing, and managing naloxone use.
SantaClaraHealthPlan Abbr	The Plan reviews opioid and naloxone claims data to identify members at risk of overdose.
UnitedHealth Abbr	UnitedHealthcare Community Plan reviews opioids and naloxone claims data to identify persons at risk of overdose.

F. Outpatient Treatment Programs (OTP)

1. Does your program cover medications used for OUD through OTPs?

Figure 47 - Program Covers Medications Used for OUD through OTPs

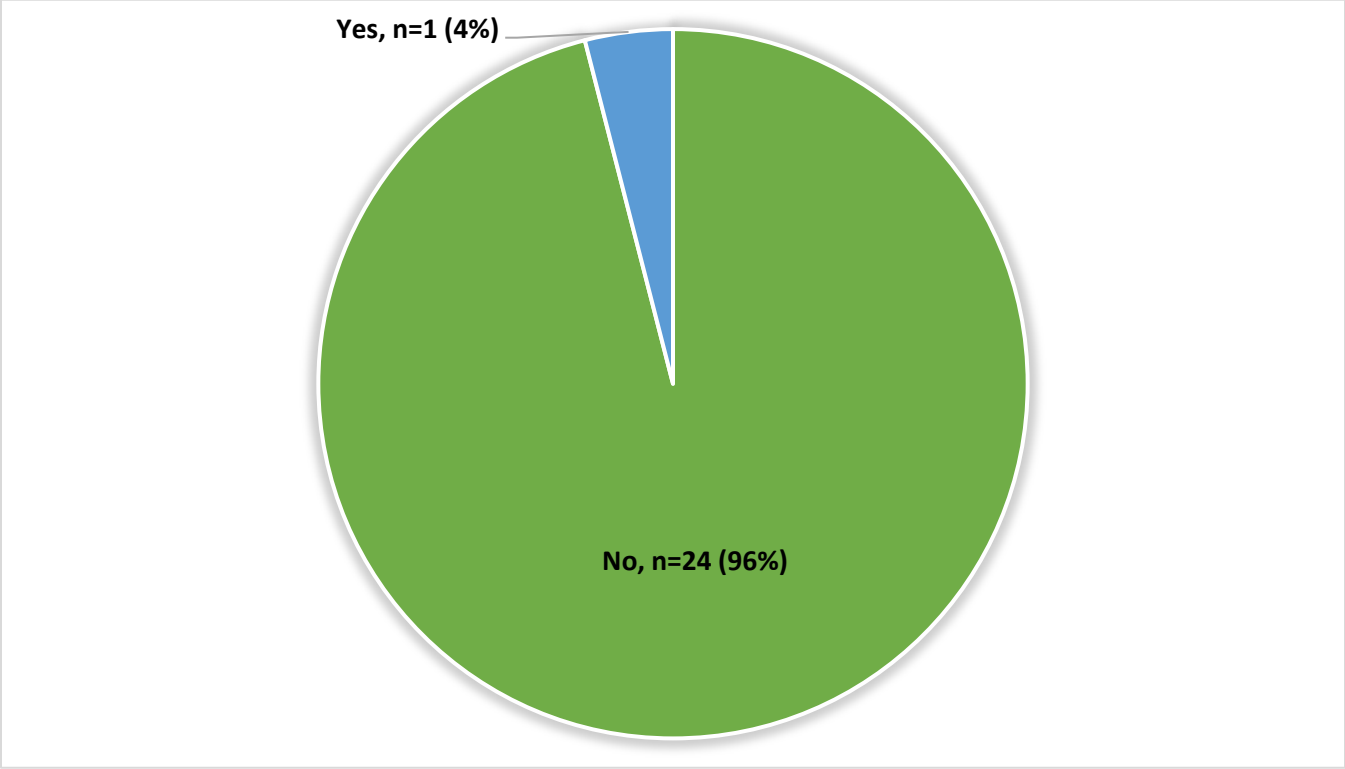

Table 84 - Program Covers Medications Used for OUD through OTPs

Response	MCO Names	Count	Percentage
Yes	ContraCosta Abbr	1	4.00%
No	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr,	24	96.00%

Response	MCO Names	Count	Percentage
	Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr		
State Totals		**25**	**100%**

If "Yes," please explain how MAT drugs are billed through OTPs.

Table 85 - Explanations for Billing MAT Drugs Through OTPs

MCO Name	Explanation
ContraCosta Abbr	The county provides substance use disorder services to Medi-Cal members who meet medical necessity rules. Members who are identified for substance use disorder treatment services are referred to their county department for treatment.

G. Psychotropic Medication for Children

Antipsychotics

1. Does your MCO coordinate with the entity that provides the drug benefit to either manage or monitor the appropriate use of antipsychotic drugs in children?

Figure 48 - MCO Coordinates with the Entity Providing Drug Benefits to Either Manage or Monitor the Appropriate Use of Antipsychotic Drugs in Children

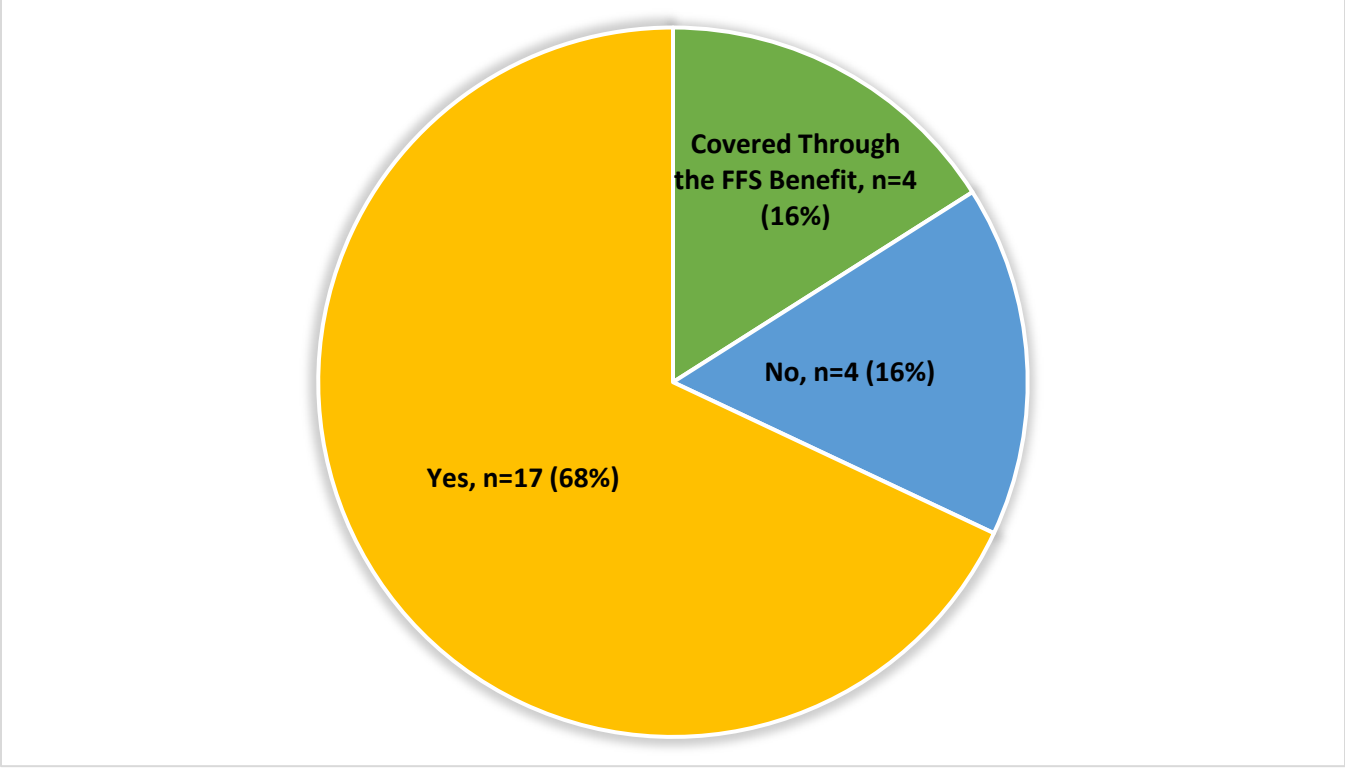

Table 86 - MCO Coordinates with the Entity Providing Drug Benefits to Either Manage or Monitor the Appropriate Use of Antipsychotic Drugs in Children

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CCAH Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, Kaiser Abbr, KernHealthSystems Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	17	68.00%
Covered through the FFS benefit	CalViva Abbr, CHW Abbr, HealthNetMediCal Abbr, Partnership Abbr	4	16.00%
No	AHF Abbr, CenCal Abbr, Inland Abbr, LACARE Abbr	4	16.00%
State Totals		**25**	**100%**

a. If "Yes," do you either manage or monitor:

Figure 49 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

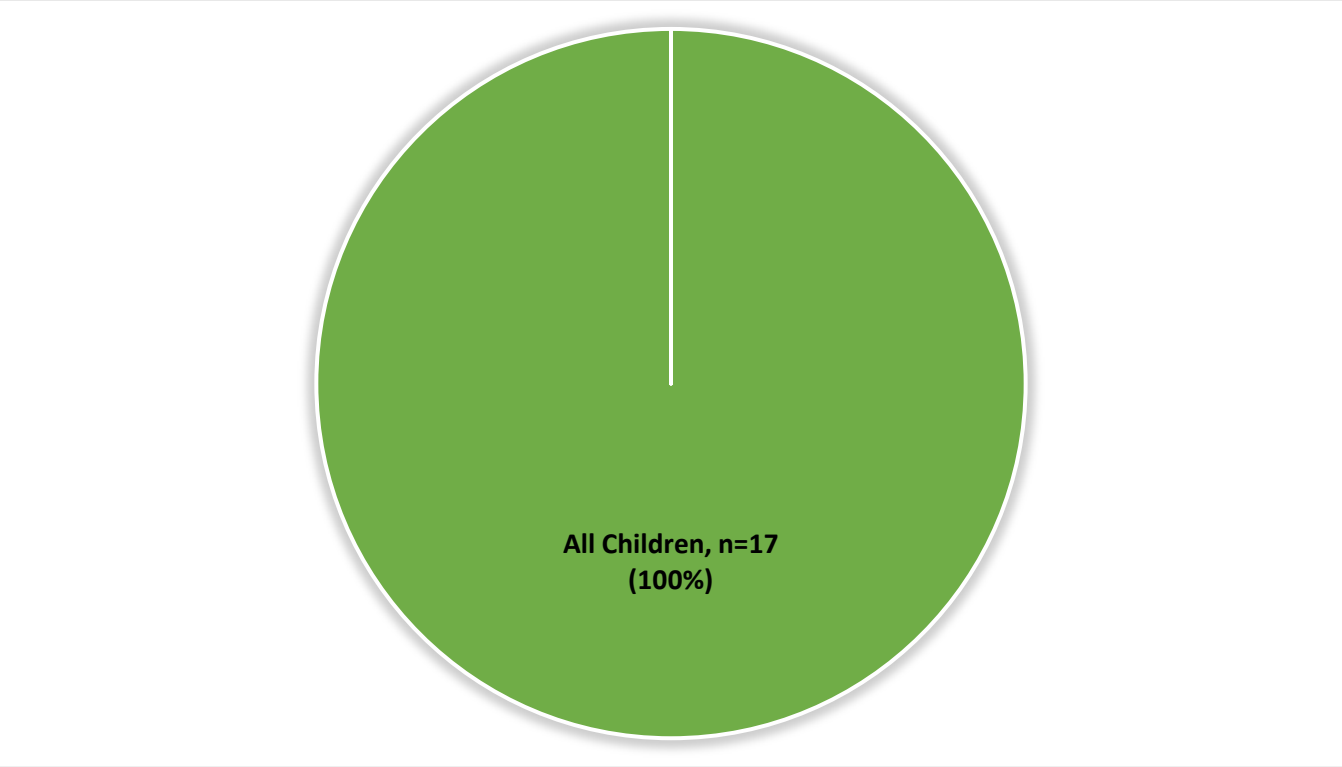

Table 87 - Categories of Children Either Managed or Monitored for Appropriate Use of Antipsychotic Drugs

Response	MCO Names	Count	Percentage
All children	AetnaBetterHealthCA Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CCAH Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, Kaiser Abbr, KernHealthSystems Abbr, Molina	17	100.00%

Response	MCO Names	Count	Percentage
	Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr		
State Totals		**17**	**100%**

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

Table 88 - Explanations of Specifics of Documented Antipsychotic Monitoring Program(s)

MCO Name	Explanation
AetnaBetterHealthCA Abbr	These medications are carved out to FFS. Our health plan is provided pharmacy claims data by FFS, which the plan's CM team can retrospectively review through a search query tool, to manage members appropriately. The plan has an automated internal monthly retrospective drug utilization (retroDUR) review report that monitors antipsychotic utilization in members who are 18 years old or below. The report is available to both the pharmacy and nurse care management teams for monitoring and tracking. Aetna DUR Board has an Educational Outreach Program called "Antipsychotics and Serotonergic Antidepressants in Children" that educates providers about the need to attempt counseling and caregiver education before prescribing antidepressants when a member is already on an antipsychotic. The goal of this program is to reduce the frequency of co-prescribing these drug classes in this age group.
Alameda Abbr	Alameda monitors children use of anti-psychotic quarterly with information on the drug, diagnosis and provider. We report these findings to UMC and HCQC.
Anthem Abbr	Routinely (quarterly, ad hoc) review claims and monitor, report to plan's P&T, DUR or Quality Committee.
BlueShield Abbr	Starting in September 2022, MCO staff perform an automated, monthly retrospective pharmacy claims analysis to identify all Medi-Cal members 18 years of age and under with a paid pharmacy claim for one or more antipsychotic medication(s) within the prior 6-month period. To the extent possible, the report will also flag members who had received concomitant prescriptions for opioids with antipsychotics.
CalOptima Abbr	Identified children receiving prescriptions for antipsychotic medications with a focus on polypharmacy utilizing the state's prescribing guidelines. Prescribers were provided with member-specific data and recommendations to reduce polypharmacy.
CCAH Abbr	MCO performs retrospective DUR based on pharmacy claims data sent by Medi-Cal Rx. The analysis includes member age distribution, members with multiple antipsychotics, top prescribers, and prescriber specialty. A subgroup analysis is performed for foster care children.
Community Abbr	CHG does retrospective review of claims during Interdisciplinary Care Team meetings. CHG review children prescribed antipsychotics and evaluate for appropriateness.
ContraCosta Abbr	Reports are run to monitor antipsychotic use in all children equal to and below the age 21 years old. If any inappropriate use is detected, the MCO will alert and outreach to providers to cease inappropriate use.
GoldCoast Abbr	GCHP reviews claims from daily data feed, perform retrospective DUR ad hoc, and monitor for any inappropriate utilization and report to UM and/or QI committees if

MCO Name	Explanation
	appropriate. In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health Division, and California Department of Social Services (CDSS) continue to collaborate on a Quality Improvement Project entitled, Improving the Use of Psychotropic Medication among Children and Youth in Foster Care. The purpose of this program is to reduce the rate of antipsychotic polypharmacy, improve the rate of compliance with age-specific antipsychotic dose recommended guidelines, and improve the rate of children and youth in foster care with at least one psychotropic medication who have an annual metabolic risk assessment. The goals are to reduce polypharmacy and improve compliance with dosing guidelines and annual metabolic risk assessment.
Kaiser Abbr	Appropriate prescribing is managed through our integrated medical record system (KP HealthConnect). Kaiser retrospectively reviews for trends and reports out to our P&T on a quarterly basis. Monitoring includes: Indication and concurrent use of 2 or more antipsychotics.
KernHealthSystems Abbr	As part of the SUPPORT Act, KHS runs reports/audits to identify potential inappropriate therapies. If identified, a provider is sent a letter indicating such. Providers are asked to provide treatment plans to reduce or eliminate utilization. If not clinically appropriate, the providers are asked to state that fact, giving supporting rationale as to why the reduction or deprescribing would not be appropriate for the particular member.
Molina Abbr	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 members that met these requirements and letter prescribers recommending appropriate action. Additionally, specifically evaluated 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 antipsychotic 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.
SanFrancisco Abbr	An approved Prior Authorization request is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 “ 17 years of age. In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health Division, and California Department of Social Services (CDSS) continue to collaborate on a Quality Improvement Project entitled, Improving the Use of Psychotropic Medication among Children and Youth in Foster Care. The purpose of this program is to reduce the rate of antipsychotic polypharmacy, improve the rate of compliance with age-specific antipsychotic dose as recommended by the guidelines, and improve the rate of children and youth in foster care with at least one psychotropic

MCO Name	Explanation
	medication who have an annual metabolic risk assessment. The goals are to reduce polypharmacy and improve compliance with dosing guidelines and annual metabolic risk assessment.
SanJoaquin Abbr	HSPJ reviews claims and monitors anti-psychotic use is children on an ad hoc basis. reports are sent to P&T.
SanMateo Abbr	We have access to Medi-Cal Rx pharmacy data and open communication channels via the clinical liaison team at Medi-Cal Rx. The MCO also has a partnership with county behavioral health and recovery services where we coordinate with behavioral health pharmacy staff from the county whom work within MCO systems, enabling them to see and monitor antipsychotic utilization. They have direct channels of communication with behavioral health providers and work closely with these practitioners on utilization to support proper antipsychotic utilization in children.
SantaClaraHealthPlan Abbr	A retrospective DUR program is performed annually to identify members under 18 years of age who were prescribed 2 or more antipsychotics and did not have an A1C/glucose test and/or LDL/cholesterol test completed in the last 12 months. The rationale of this program is to reduce major metabolic complications with long-term consequences associated with antipsychotic use in children and adolescents.
UnitedHealth Abbr	Using claims data provided by Medi-CalRx, our PBM partner OptumRx runs multiple safety management RDUR programs that include anti-psychotic medications. These RDUR programs notify prescribers via fax/mail 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.

c. If you do not have a documented antipsychotic monitoring program in place, does your MCO plan on implementing a program in the future?

Figure 50 - Future Plans to Implement an Antipsychotic Monitoring Program

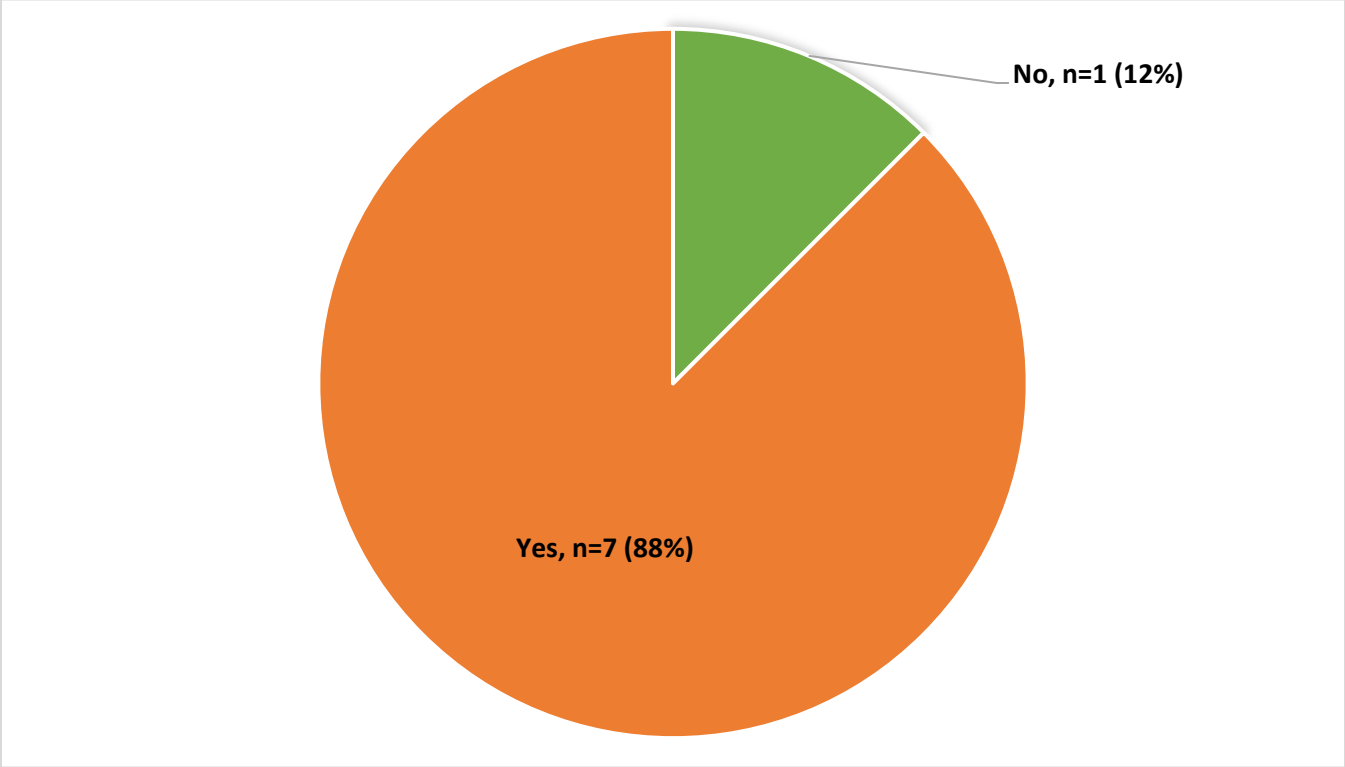

Table 89 - Future Plans to Implement an Antipsychotic Monitoring Program

Response	MCO Names	Count	Percentage
Yes	CalViva Abbr, CenCal Abbr, CHW Abbr, HealthNetMediCal Abbr, Inland Abbr, LACARE Abbr, Partnership Abbr	7	87.50%
No	AHF Abbr	1	12.50%
State Totals		**8**	**100%**

If "Yes," please specify when.

Table 90 - When MCOs Plan to Implement a Program to Monitor Appropriate Use of Antipsychotic Drugs in Children

MCO Name	Explanation
CalViva Abbr	01/01/2024
CenCal Abbr	04/01/2023
CHW Abbr	01/01/2024
HealthNetMediCal Abbr	01/01/2024
Inland Abbr	01/01/2022
LACARE Abbr	01/01/2024
Partnership Abbr	04/01/2023

If you do not plan to implement an antipsychotic monitoring program in the future, please explain why your MCO will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

Table 91 - Explanations for not Implementing a Program to Monitor Appropriate Use of Antipsychotic Drugs in Children

MCO Name	Explanation
AHF Abbr	Our plan does not enroll children.

Stimulants

2. Does your MCO coordinate with the entity that provides the drug benefit to either manage or monitor the appropriate use of stimulant drugs in children?

Figure 51 - MCO Coordinates with the Entity Providing Drug Benefits to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

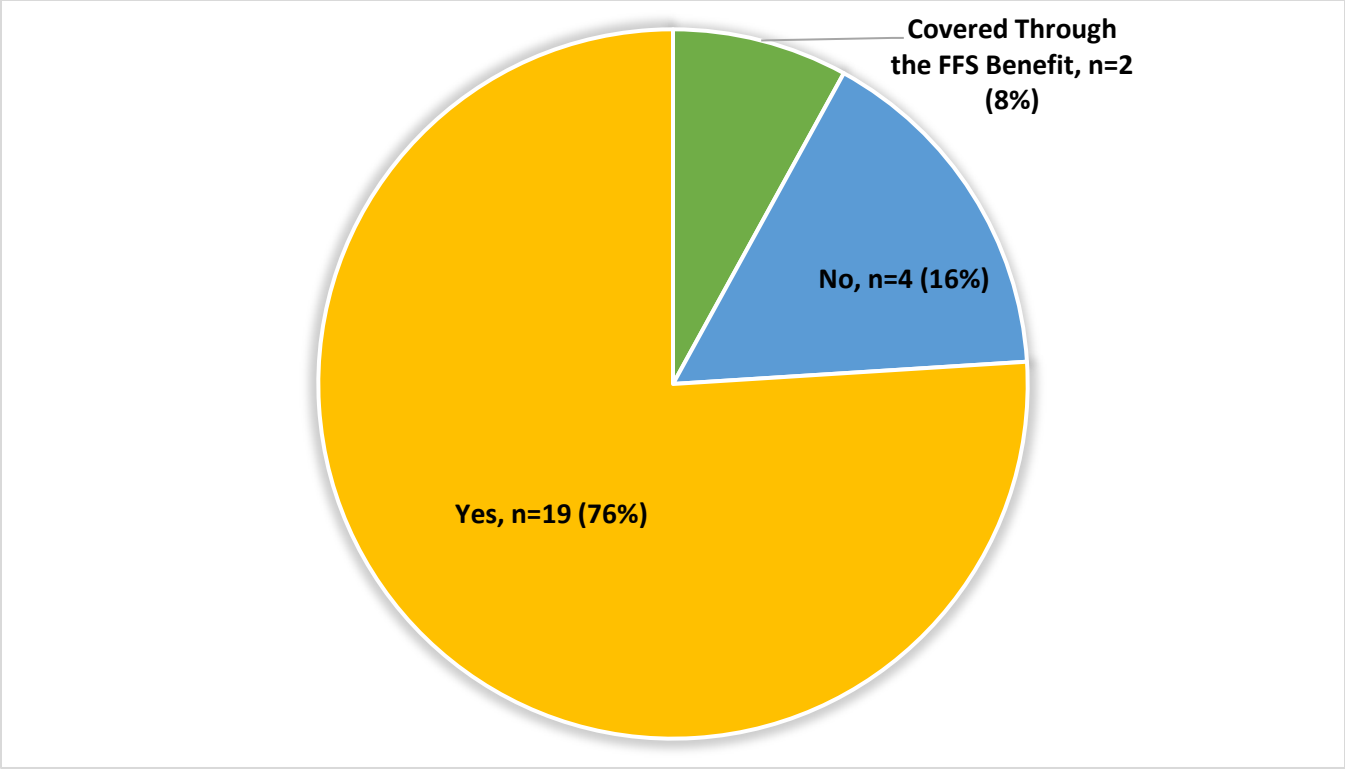

Table 92 - MCO Coordinates with the Entity Providing Drug Benefits to Either Manage or Monitor the Appropriate Use of Stimulant Drugs in Children

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, Anthem Abbr, BlueShield Abbr, CalViva Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	19	76.00%

Response	MCO Names	Count	Percentage
Covered through the FFS benefit	Alameda Abbr, CalOptima Abbr	2	8.00%
No	AHF Abbr, CCAH Abbr, CenCal Abbr, Inland Abbr	4	16.00%
State Totals		**25**	**100%**

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

Figure 52 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs

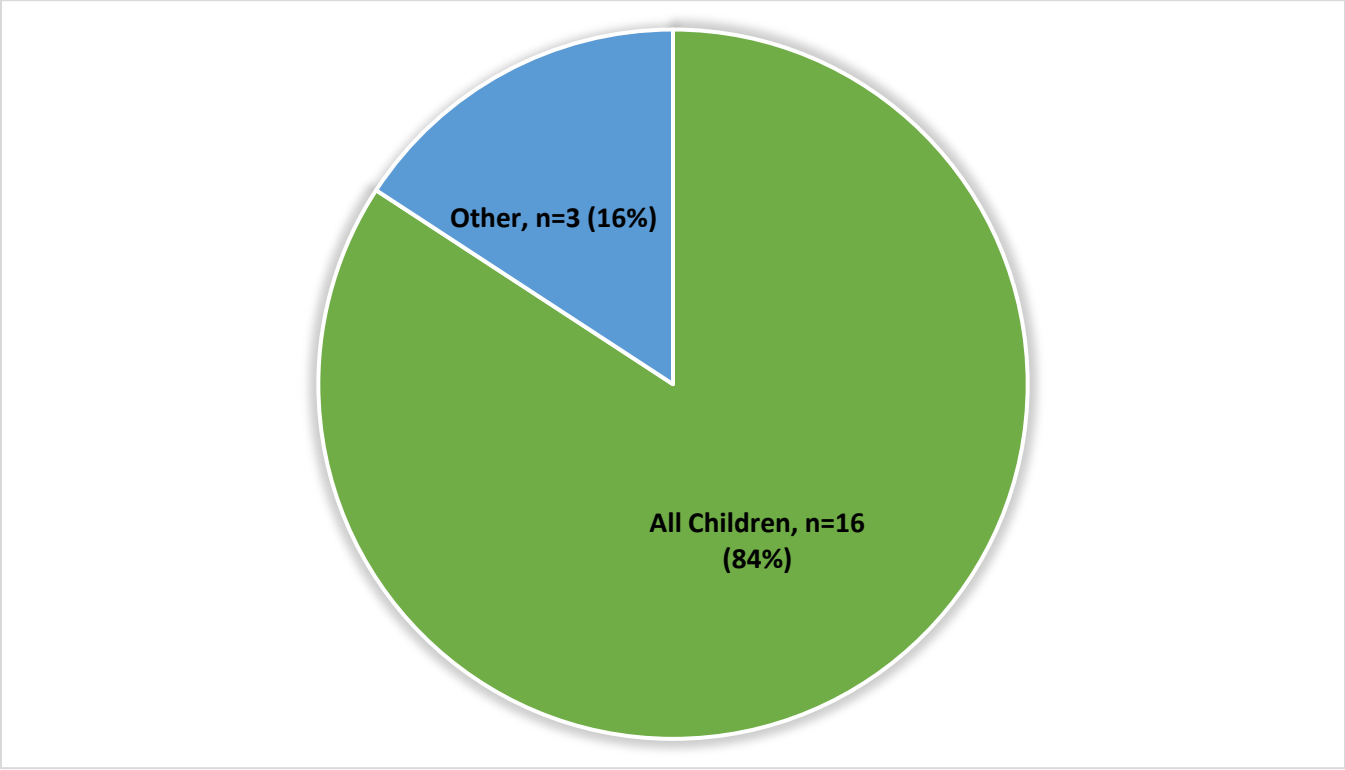

Table 93 - Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs

Response	MCO Names	Count	Percentage
All children	AetnaBetterHealthCA Abbr, Anthem Abbr, BlueShield Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	16	84.21%
Other	CalViva Abbr, CHW Abbr, HealthNetMediCal Abbr	3	15.79%
State Totals		**19**	**100%**

If "Other," please explain.

Table 94 - "Other" Explanations for Categories of Children Either Managed or Monitored for Appropriate Use of Stimulant Drugs

MCO Name	Explanation
CalViva Abbr	Our health plan Quality Improvement (QI) team monitors the appropriate use of stimulant drugs through the HEDIS metric Follow-Up Care for Children Prescribed ADHD medication for all Medi-Cal members. This ensures that children have timely and routine follow-up care for children prescribed ADHD medications and signifies that children are being monitored or managed appropriately.
CHW Abbr	Our health plan Quality Improvement (QI) team monitors the appropriate use of stimulant drugs through the HEDIS metric Follow-Up Care for Children Prescribed ADHD medication for all Medi-Cal members. This ensures that children have timely and routine follow-up care for children prescribed ADHD medications and signifies that children are being monitored or managed appropriately.
HealthNetMediCal Abbr	Our health plan Quality Improvement (QI) team monitors the appropriate use of stimulant drugs through the HEDIS metric Follow-Up Care for Children Prescribed ADHD medication for all Medi-Cal members. This ensures that children have timely and routine follow-up care for children prescribed ADHD medications and signifies that children are being monitored or managed appropriately.

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

Table 95 - Explanations of Specifics of Documented Stimulant Monitoring Program(s)

MCO Name	Explanation
AetnaBetterHealthCA Abbr	The quality team monitors the HEDIS measures associated with stimulant utilization, such as ADD (Follow-Up Care for Children Prescribed ADHD Medication) through the internal monthly Gaps In Care Report. The team evaluates the need to develop provider or member outreach programs by monitoring the measures' outcomes.
Anthem Abbr	Routinely (quarterly, ad hoc) review claims and monitor, report to plan's P&T, DUR or Quality Committee.
BlueShield Abbr	Starting in September 2022, MCO staff perform an automated, monthly retrospective pharmacy claims analysis to identify all Medi-Cal members 18 years of age and under with a paid pharmacy claim for one or more stimulant medication(s) within the prior 6-month period.
CalViva Abbr	On a monthly basis, our analytics team will use Pharmacy data to identify members (ages 6 to 12) that have been either newly prescribed a medication for ADHD, or have been prescribed the medication for at least 7 months. We work with MHN, our Behavioral Health department, to identify prescribers in the MHN and HN network. For those prescribed by an MHN provider, the MHN clinical team will conduct live outreach to Medi-Cal members. MHN's QI team will also call all the prescribing physicians, educate them about the importance of the measure, and share the member list.
CHW Abbr	On a monthly basis, our analytics team will use Pharmacy data to identify members (ages 6 to 12) that have been either newly prescribed a medication for ADHD, or have been prescribed the medication for at least 7 months. We work with MHN, our Behavioral Health department, to identify prescribers in the MHN and HN network. For those prescribed by an MHN provider, the MHN clinical team will conduct live outreach to Medi-Cal members. MHN's QI team will also call all the prescribing

MCO Name	Explanation
	physicians, educate them about the importance of the measure, and share the member list.
Community Abbr	CHG does retrospective review of claims during Interdisciplinary Care Team meetings. CHG reviews the number of stimulant drug claims, number of prescribers, prescriber specialty, prior authorization, refill too soon overrides, and diagnosis codes.
ContraCosta Abbr	Reports are run to monitor stimulant use in all children equal to and below the age 21 years old. If any inappropriate use is detected, the MCO will alert and outreach to providers to cease inappropriate use via our internal mental health physician. Peer-to-peer outreach from physician to physician will help communicate any inappropriate use and recommendations to correct any abuse.
GoldCoast Abbr	GCHP reviews claims from daily data feed, perform retrospective DUR ad hoc, and monitor for any inappropriate utilization and report to UM and/or QI committees if appropriate.
HealthNetMediCal Abbr	On a monthly basis, our analytics team will use Pharmacy data to identify members (ages 6 to 12) that have been either newly prescribed a medication for ADHD, or have been prescribed the medication for at least 7 months. We work with MHN, our Behavioral Health department, to identify prescribers in the MHN and HN network. For those prescribed by an MHN provider, the MHN clinical team will conduct live outreach to Medi-Cal members. MHN's QI team will also call all the prescribing physicians, educate them about the importance of the measure, and share the member list.
Kaiser Abbr	Appropriate prescribing is managed through our integrated medical record system (KP HealthConnect).
KernHealthSystems Abbr	As part of the SUPPORT Act, KHS runs reports/audits to identify potential inappropriate therapies. If identified, a provider is sent a letter indicating such. T Providers are asked to provide treatment plans to reduce or eliminate utilization. If not clinically appropriate, the providers are asked to state that fact, giving supporting rationale as to why the reduction or deprescribing would not be appropriate for the particular member.
LACARE Abbr	Letter to provider encourages providing follow-up care after prescribing ADHD medication. Calls are made to parents/ guardians of patients prescribed ADHD medications advising them the importance of follow-up appointments.
Molina Abbr	In 2021 prior to the pharmacy benefit being carved-out, CVS/Caremark which was Molina's PBM at the time ran a Safety and Monitoring System. This program allowed for real-time feedback to prescribers of high-risk utilization at point of sale for members of all ages including children. The Safety and Monitoring Program focused on therapeutic categories with the potential for high abuse including CNS Stimulants (e.g., methylphenidate, modafinil). 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 form and any responses from prescriber(s) are tracked within the Safety and Monitoring system.

MCO Name	Explanation
	After the pharmacy benefit was carved-out on 1/1/2022, Molina prioritized ongoing monitoring of federally mandated retrospective DUR reports (e.g. SUPPORT Act). Additionally, in 2022, Molina's Impact Pro platform continued to identify pediatric members with one or more occurrences of stimulant abuse. These members were then stratified by risk score alongside other parameters assessing clinical risk or impactable opportunities with prioritization of interventions to the highest risk members. Continued enhancements of rDUR reporting at the end of 2022 into 2023 include monitoring of members of all ages who are visiting multiple pharmacies (3 or more) for controlled drugs, including stimulants. Outcomes from this report are provided to our Care Management team for applicable member facing intervention as needed.
Partnership Abbr	PHC uses pharmacy claim data from Magellan to obtain a weekly report of members 6 to 12 years of age that were newly dispensed an ADHD medication within the preceding week. PHC utilizes this report to send faxes to prescribers alerting them of their patient filling a new ADHD medication at the pharmacy, and to inform them of the importance of follow-up care within 30 days of starting ADHD medication treatment.
SanFrancisco Abbr	Our Retro-DUR program has evaluated stimulant use in children and provided education to pediatricians supporting follow-up visits and behavioral health escalation.
SanJoaquin Abbr	HSPJ reviews claims and monitors stimulant use is children on an ad hoc basis. reports are sent to P&T.
SanMateo Abbr	We have access to Medi-Cal Rx pharmacy data and open communication channels via the clinical liaison team at Medi-Cal Rx. The MCO also has a partnership with county behavioral health and recovery services where we coordinate with behavioral health pharmacy staff from the county whom work within MCO systems, enabling them to see and monitor stimulant utilization. They have direct channels of communication with many providers and work closely with them to support proper stimulant utilization in children.
SantaClaraHealthPlan Abbr	The Plan completes ad hoc review of claims and reports utilization to the Plan's P&T Committee. Stimulants are covered under FFS.
UnitedHealth Abbr	Using claims data provided by Medi-CalRx, our PBM partner OptumRx runs multiple safety management RDUR programs that include stimulant medications. These RDUR programs notify prescribers via fax/mail 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, Concurrent Use of multiple CNS active medications programs and Concurrent use of opioids with an opioid potentiator (e.g. stimulant) programs.

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

Figure 53 - Future Plans to Implement a Stimulant Monitoring Program

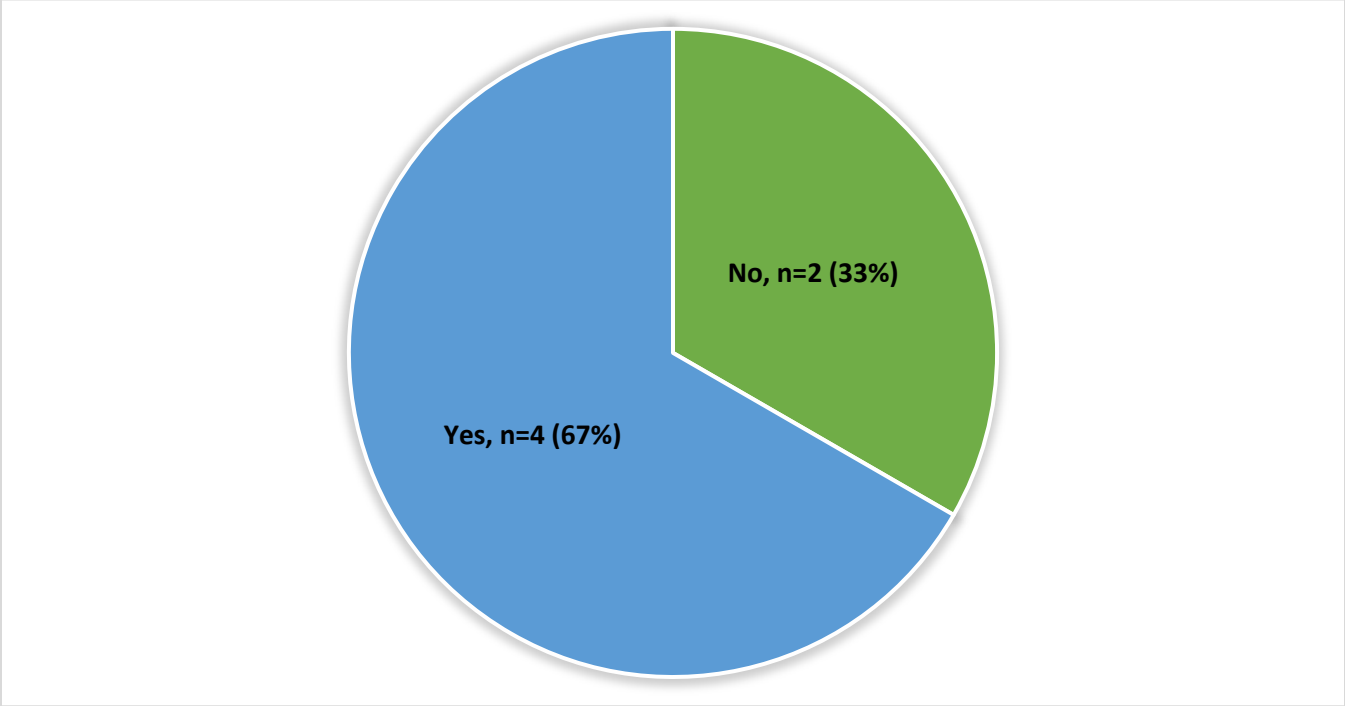

Table 96 - Future Plans to Implement a Stimulant Monitoring Program

Response	MCO Names	Count	Percentage
Yes	Alameda Abbr, CalOptima Abbr, CCAH Abbr, CenCal Abbr	4	66.67%
No	AHF Abbr, Inland Abbr	2	33.33%
State Totals		**6**	**100%**

If "Yes," please specify when.

Table 97 - When MCOs Plan to Implement a Program to Monitor the Appropriate Use of Stimulant Drugs in Children

MCO Name	Explanation
Alameda Abbr	05/01/2023
CalOptima Abbr	In the next year.
CCAH Abbr	03/01/2023
CenCal Abbr	04/01/2023

If you do not plan to implement a stimulant monitoring program in the future, please explain why your MCO will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

Table 98 - Explanation for Not Implementing a Program to Monitor Use of Stimulant Drugs in Children

MCO Name	Explanation
AHF Abbr	Our plan does not enroll children.
Inland Abbr	MCO is currently reviewing and assessing clinical program priorities based on the focus and needs of the overall MCO.

Antidepressant/Mood Stabilizers/Antianxiety/Sedatives

3. Does your MCO coordinate with the entity that provides the drug benefit to either manage or monitor the appropriate use of other psychotropic medication (antidepressants, mood stabilizers, antianxiety/sedative) in children?

Figure 54 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Other Psychotropic Medication in Children

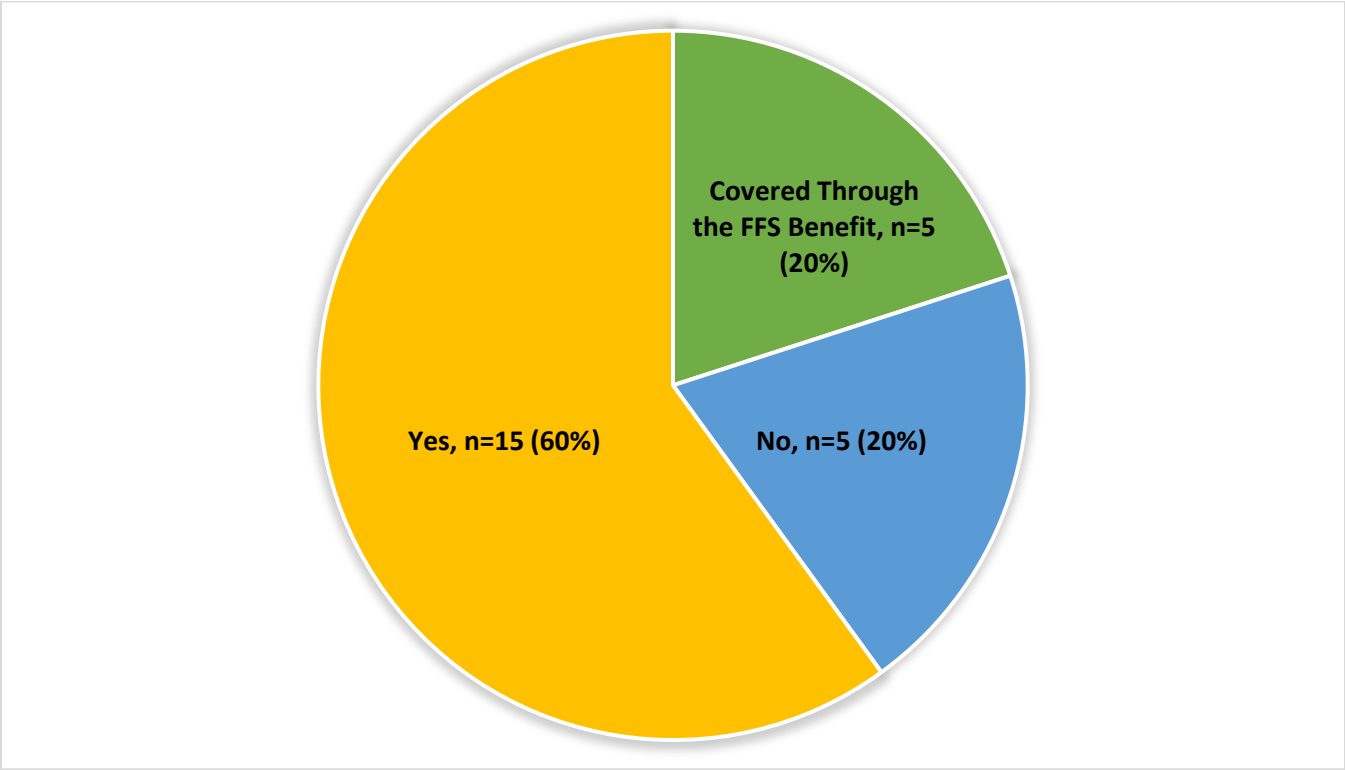

Table 99 - Documented Program in Place to Either Manage or Monitor the Appropriate Use of Other Psychotropic Medication in Children

Response	MCO Names	Count	Percentage
Yes	AetnaBetterHealthCA Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, Kaiser Abbr, KernHealthSystems Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	15	60.00%
Covered through the FFS benefit	Alameda Abbr, CalViva Abbr, CHW Abbr, HealthNetMediCal Abbr, Partnership Abbr	5	20.00%
No	AHF Abbr, CCAH Abbr, CenCal Abbr, Inland Abbr, LACARE Abbr	5	20.00%
State Totals		**25**	**100%**

If "Yes," check all that apply.

Figure 55 - Categories of Psychotropic Medication Managed or Monitored for Appropriate Use in Children

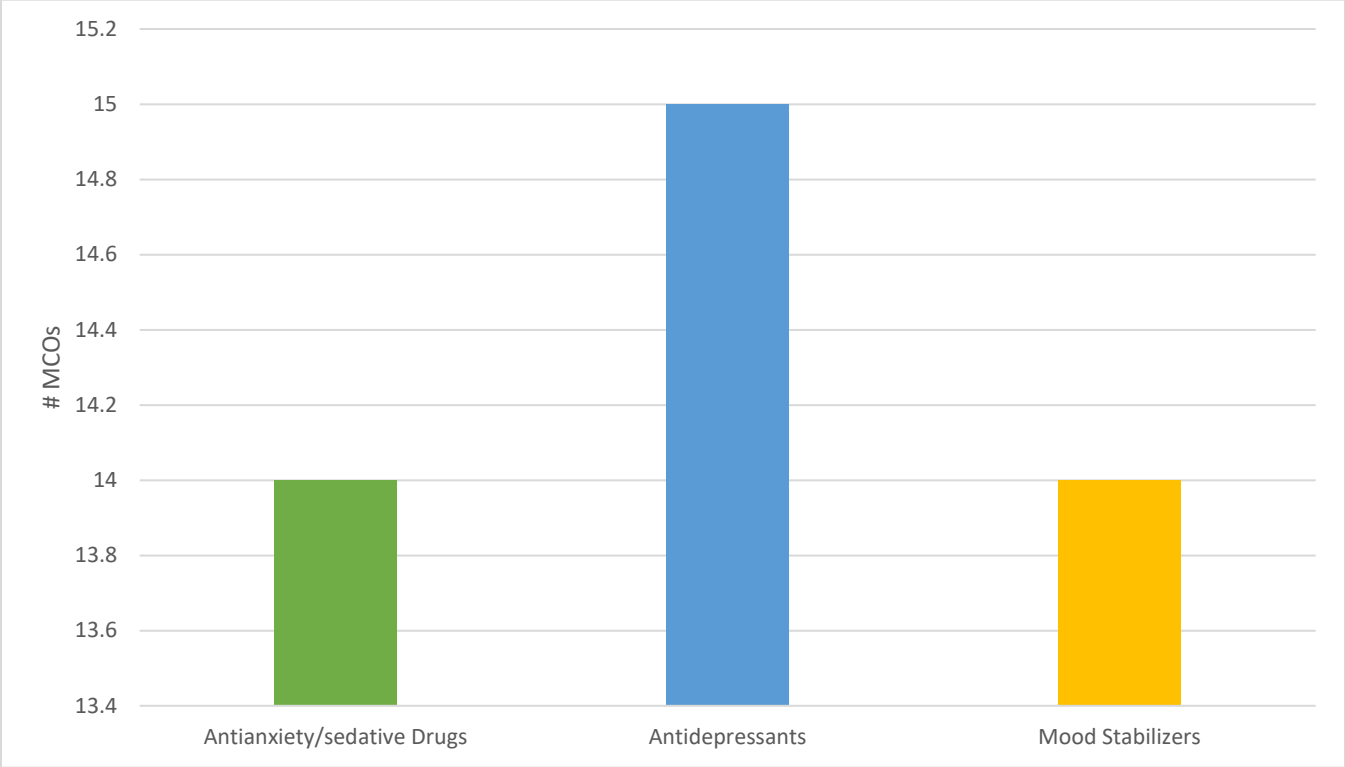

Table 100 - Categories of Psychotropic Medication Managed or Monitored for Appropriate Use in Children

Response	MCO Names	Count	Percentage
Antianxiety/sedative drugs	Anthem Abbr, BlueShield Abbr, CalOptima Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, Kaiser Abbr, KernHealthSystems Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	14	32.56%
Antidepressants	AetnaBetterHealthCA Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, Kaiser Abbr, KernHealthSystems Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	15	34.88%
Mood stabilizers	Anthem Abbr, BlueShield Abbr, CalOptima Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, Kaiser Abbr, KernHealthSystems Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	14	32.56%

Response	MCO Names	Count	Percentage
State Totals		**43**	**100%**

a. If "Yes," does your MCO either manage or monitor (multiple responses allowed):

Figure 56 - Categories of Children Either Managed or Monitored for Appropriate Use of Psychotropic Medication

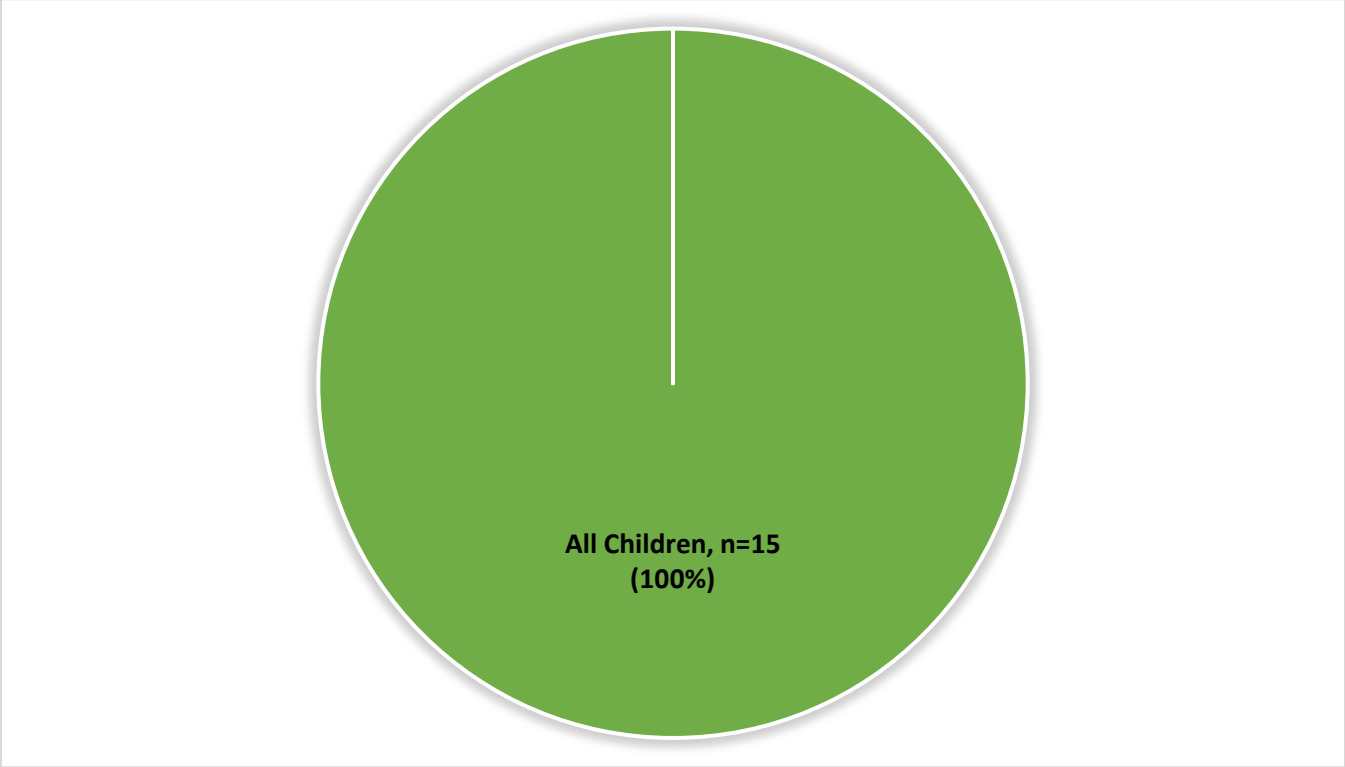

Table 101 - Categories of Children Either Managed or Monitored for Appropriate Use of Psychotropic Medication

Response	MCO Names	Count	Percentage
All children	AetnaBetterHealthCA Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, Kaiser Abbr, KernHealthSystems Abbr, Molina Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	15	100.00%
State Totals		**15**	**100%**

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

Table 102 - Explanations of Specifics of Documented Monitoring Program(s)

MCO Name	Explanation
AetnaBetterHealthCA Abbr	These medications are carved out to FFS. Our health plan is provided pharmacy claims data by FFS, which the plan's CM team can retrospectively review through a search query tool, to manage members appropriately. Aetna DUR Board has an Educational Outreach Program called "Antipsychotics and Serotonergic Antidepressants in Children" that educates providers about the need

MCO Name	Explanation
	to attempt counseling and caregiver education before prescribing antidepressants when a member is already on an antipsychotic. The goal of this program is to reduce the frequency of co-prescribing these drug classes in this age group.
Anthem Abbr	Routinely (quarterly, ad hoc) review claims and monitor, report to plan's P&T, DUR or Quality Committee
BlueShield Abbr	Starting in September 2022, MCO staff perform an automated, monthly retrospective pharmacy claims analysis to identify all Medi-Cal members 18 years of age and under with a paid pharmacy claim for one or more mood stabilizers, sedative, antianxiety and/or anti-depressant medication within the prior 6-month period.
CalOptima Abbr	Identified children receiving prescriptions for psuchotropic medications with a focus on polypharmacy utilizing the state's prescribing guidelines. Prescribers were provided with member-specific data and recommendations to reduce polypharmacy.
Community Abbr	CHG does retrospective review of claims during Interdisciplinary Care Team meetings. CHG reviews the number of psychotropic medication claims, number of prescribers, prescriber specialty, prior authorization, refill too soon overrides, and diagnosis codes.
ContraCosta Abbr	Reports are run to monitor psychotropic medication use in all children equal to and below the age 21 years old. If any inappropriate use is detected, the MCO will alert and outreach to providers to cease inappropriate use via our internal mental health physician. Peer-to-peer outreach from physician to physician will help communicate any inappropriate use and recommendations to correct any abuse.
GoldCoast Abbr	GCHP reviews claims from daily data feed, perform retrospective DUR ad hoc, and monitor for any inappropriate utilization and report to UM and/or QI committees if appropriate. In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health Division, and California Department of Social Services (CDSS) continue to collaborate on a Quality Improvement Project entitled, Improving the Use of Psychotropic Medication among Children and Youth in Foster Care. A set of guidelines was developed by CDSS and DHCS regarding the use of psychotropic medication with children and youth in foster care in 2018. The California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, jointly released by the CDSS and DHCS, is a statement of best practice for the treatment of children and youth in out of home care. These children and youth may require psychotropic medications. Depending on the nature, severity and persistence of their symptoms, medication may be indicated as part of an initial treatment plan (as with ADHD, major depression, psychosis and disabling anxiety); may be considered only after appropriate psychosocial interventions are employed (as with moderate anxiety/depression); or may not be indicated at all (as with learned defiance and predatory aggression). When psychotropic medication is indicated, it should be used in conjunction with psychosocial interventions. The exception is when psychosocial interventions have been effective and are therefore terminated but continued use of medication is necessary to prevent the recurrence of symptoms.
Kaiser Abbr	Appropriate prescribing is managed through our integrated medical record system (KP HealthConnect).
KernHealthSystems Abbr	As part of the SUPPORT Act, KHS runs reports/audits to identify potential inappropriate therapies. If identified, a provider is sent a letter indicating such. Providers are asked to provide treatment plans to reduce or eliminate utilization. If

MCO Name	Explanation
	not clinically appropriate, the providers are asked to state that fact, giving supporting rationale as to why the reduction or deprescribing would not be appropriate for the particular member.
Molina Abbr	In 2021 prior to the pharmacy benefit being carved-out, CVS/Caremark which was Molina's PBM at the time ran a Safety and Monitoring System. This program allowed for real-time feedback to prescribers of high-risk utilization at point of sale for members of all ages including children. The Safety and Monitoring Program focused on therapeutic categories with the potential for high abuse including 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), and CNS Stimulants (e.g., methylphenidate, modafinil). 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 form and any responses from prescriber(s) are tracked within the Safety and Monitoring system. In 2022, Molina's Impact Pro platform continued to identify pediatric members who filled three or more prescriptions of psychotropic medications such as lithium, MAO inhibitors, SSRIs, tetracyclics or tricyclic antidepressants. These members were then stratified by risk score alongside other parameters assessing clinical risk or impactable opportunities with prioritization of interventions to the highest risk members.
SanFrancisco Abbr	SFHP has a dashboard report where members' average PDC can be reviewed for all medication classes. This report can be narrowed by age and allows us to review all members 18 years-of-age and younger on psychotropic medications.
SanJoaquin Abbr	HSPJ reviews claims and monitors use in children on an ad hoc basis. reports are sent to P&T.
SanMateo Abbr	We have access to Medi-Cal Rx pharmacy data and open communication channels via the clinical liaison team at Medi-Cal Rx. The MCO also has a partnership with county behavioral health and recovery services where we coordinate with behavioral health pharmacy staff from the county whom work within MCO systems, enabling them to see and monitor psychotropic medication utilization. They have direct channels of communication with many providers and work closely with them to support proper psychotropic medication utilization in children.
SantaClaraHealthPlan Abbr	The Plan completes ad hoc review of claims and reports utilization to the Plan's P&T Committee. These drugs are covered under FFS.
UnitedHealth Abbr	Using claims data provided by Medi-CalRx, our PBM partner OptumRx runs multiple safety management RDUR programs that include antidepressant, mood stabilizers, and anti-anxiety/sedative medications. These RDUR programs notify prescribers via fax/mail 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, Concurrent Use of opioids with benzodiazepines, and Concurrent Use of opioids with opioid

MCO Name	Explanation
	potentiators (e.g. sedatives) programs, and Concurrent Use of multiple CNS active medications programs.

c. If you do not have a documented monitoring program in place, does your MCO plan on implementing a program in the future?

Figure 57 - Future Plans to Implement a Psychotropic Medication Monitoring Program

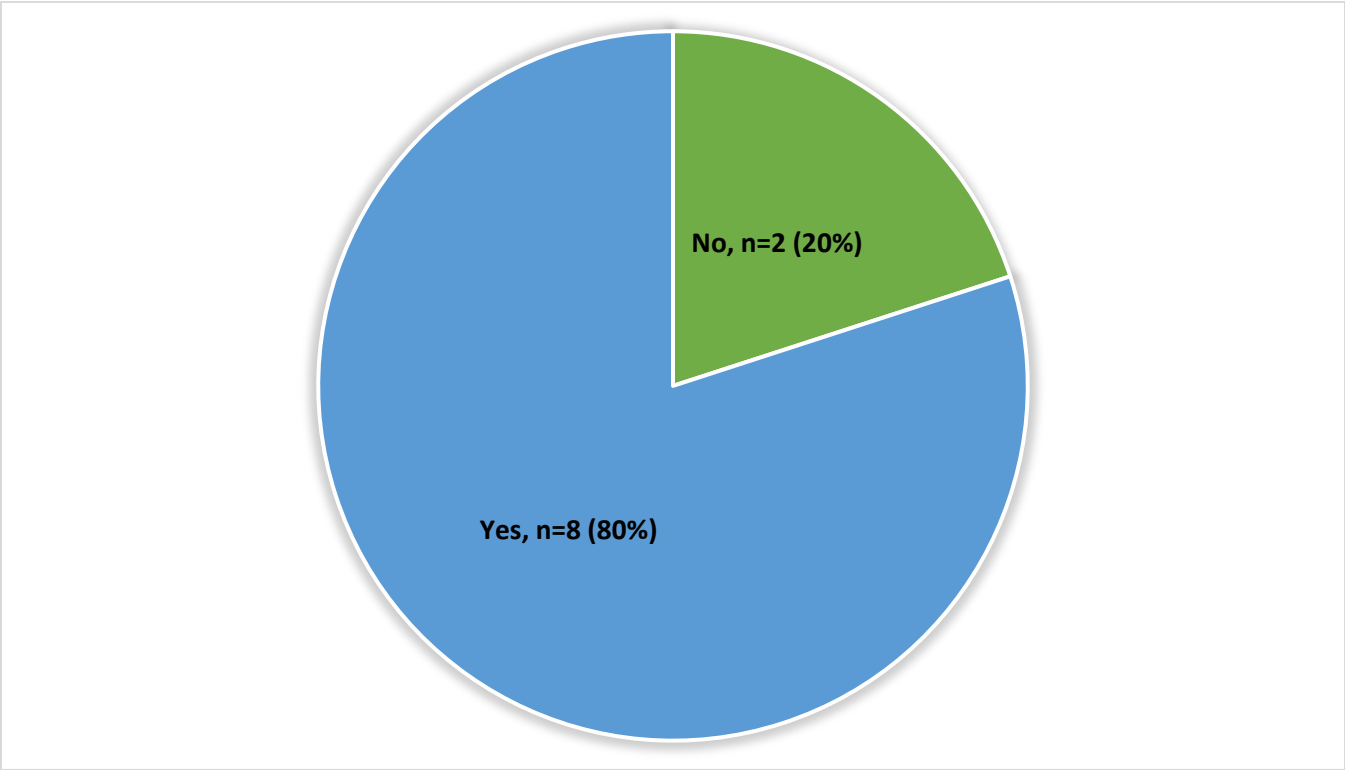

Table 103 - Future Plans to Implement a Psychotropic Medication Monitoring Program

Response	MCO Names	Count	Percentage
Yes	Alameda Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, HealthNetMediCal Abbr, LACARE Abbr, Partnership Abbr	8	80.00%
No	AHF Abbr, Inland Abbr	2	20.00%
State Totals		**10**	**100%**

If "Yes," please specify when.

Table 104 - When MCOs Plan to Implement a Program to Monitor the Appropriate Use of Psychotropic Medication in Children

MCO Name	Explanation
Alameda Abbr	Alameda plans to implement this on 5/1/23.
CalViva Abbr	01/01/2024
CCAH Abbr	Started in FFY 2023
CenCal Abbr	04/01/2023
CHW Abbr	01/01/2024

MCO Name	Explanation
HealthNetMediCal Abbr	01/01/2024
LACARE Abbr	We are currently working on implementing a program by 1/1/24.
Partnership Abbr	04/01/2023

If you do not plan to implement a monitoring program in the future, please explain why you will not be implementing a program to monitor the appropriate use of drugs in children.

Table 105 - Explanation for Not Implementing a Program to Monitor Use of Psychotropic Medication in Children

MCO Name	Explanation
AHF Abbr	Our plan does not enroll children.
Inland Abbr	MCO is currently reviewing and assessing clinical program priorities based on the focus and needs of the overall MCO.

Section V - 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 58 - 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

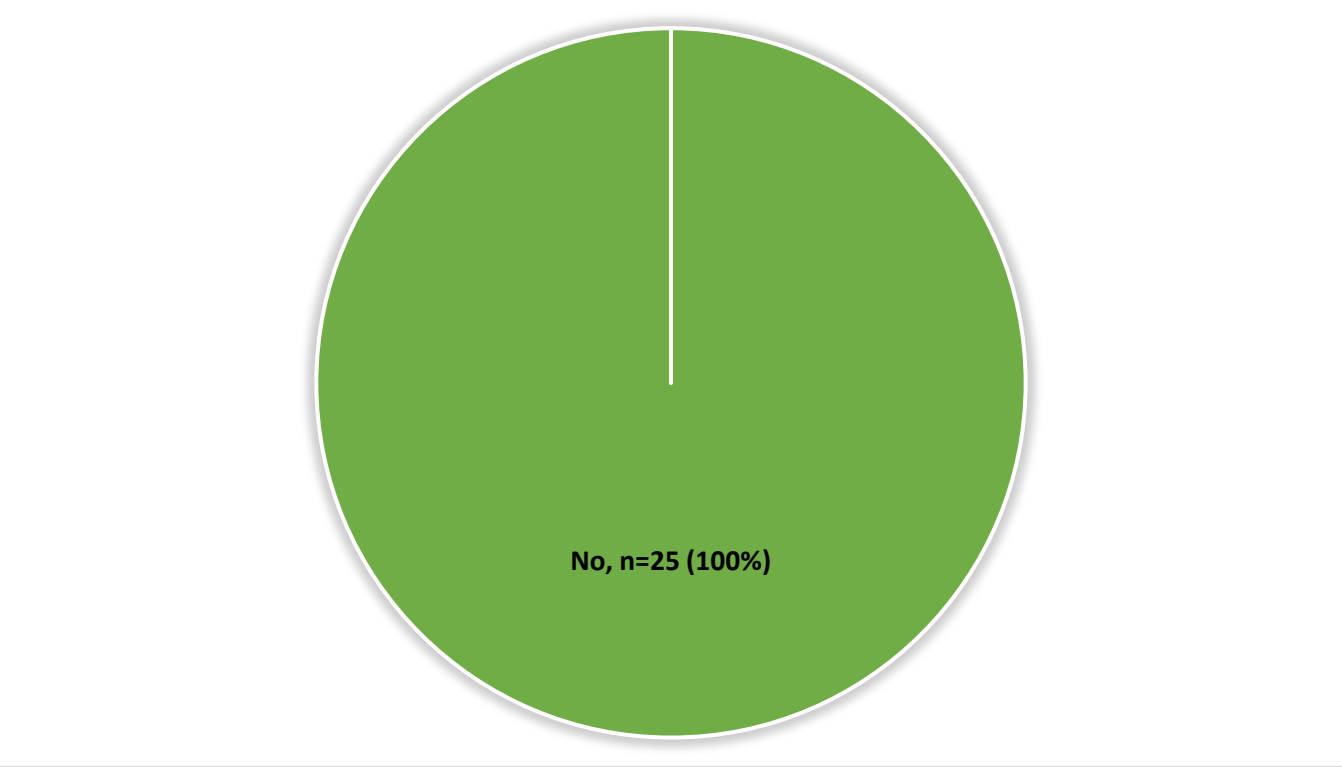

Table 106 - Demonstrations or Waivers to Allow Importation of Certain Drugs from Canada or Other Countries that are Versions of FDA-Approved Drugs for Dispensing to Medicaid Beneficiaries

Response	MCO Names	Count	Percentage
No	AetnaBetterHealthCA Abbr, AHF Abbr, Alameda Abbr, Anthem Abbr, BlueShield Abbr, CalOptima Abbr, CalViva Abbr, CCAH Abbr, CenCal Abbr, CHW Abbr, Community Abbr, ContraCosta Abbr, GoldCoast Abbr, HealthNetMediCal Abbr, Inland Abbr, Kaiser Abbr, KernHealthSystems Abbr, LACARE Abbr, Molina Abbr, Partnership Abbr, SanFrancisco Abbr, SanJoaquin Abbr, SanMateo Abbr, SantaClaraHealthPlan Abbr, UnitedHealth Abbr	25	100.00%
State Totals		**25**	**100%**

2. Summary 2 - Innovative Practices

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

Table 107 - Innovative Practices

MCO Name	Innovative Practices Summary
AetnaBetterHealthCA Abbr	CM Referrals to Pharmacy Care management team identifies members with clinical medication management needs. Members are referred by their CM to the Population Health Clinical Pharmacist for medication review with member consultation and provider outreach as identified. Quality - automated member outreach (After September 2022) The plan's quality team initiated multiple automated member outreach campaigns for pharmacy HEDIS measures, such as Antidepressant Medication Management (AMM) and Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA), to improve clinical outcomes and follow-up. Planned automated member outreach campaigns are as follows: Statin Therapy for Patients With Cardiovascular Disease and Diabetes (SPC/SPD).
AHF Abbr	MCO has developed several innovative practices including enhanced care management, medication therapy management, and targeted medication reviews by clinical pharmacists.
Alameda Abbr	Opioid stewardship Academic Detailing 1. Member Outreach a. High risk: Members greater than 120 MME b. Rising risk: Members on 50-119MME for the last 3 months i. List was created and handouts were distributed yet. c. Distributing educational handouts: Opioid safety guide for patient and caregiver, treating pain without opioids, medications for opioid dependence, member specific provider maps 2. Provider outreach a. Created a list of mailings to providers with members who has: i Chronic Opioid and Benzodiazepine Co-use ii. Rising risk list: 50-119 MME for 3 consecutive months iii. High risk list: 120+ MME for 3 consecutive months iv. Opioid and Benzodiazepine ER list b. Provider will receive: Opioid safety guide for patient and caregiver, treating pain without opioids, medications for opioid dependence, opioid/benzodiazepine tapering tool, non-opioid drug alternatives. Antibiotic Stewardship 1. Continued quarterly update on antibiotic over-utilization pre and post-carveout 2. Send educational intervention if needed. So far, our network has been great with antibiotics.

MCO Name	Innovative Practices Summary
	Opioid Dashboard 1. Created an interactive opioid dashboard to present to the UM committee and HCQC with a lookback period of 2 years looking at opioid over-utilization, co-use of antipsychotic/benzodiazepines/opioids, ER use of opioid/benzodiazepines, and children on antipsychotics Educational Handout 1. Warfarin Handout on safety and monitoring protocols for Health Education Outreach 1. Notify members and providers for CGM conversion for Type 1 Diabetes to Medi-Cal RX 2. Notify members and providers for Enteral formula coverage to Medi-Cal RX Asthma Affinity 1. January " March 2022: Group 3 Outreach (AMR 0.2-0.29) " 35 members a. 12 live calls, 7 members agreed to survey b. Total of 14 interventions for 7 members (e.g., transportation, asthma education, smoking cessation help offered, behavioral health care referral through Beacon Health offered) 2. Presented in CMS and CHIP Services Improving Asthma Control Affinity Group State Spotlights Webinar with DHCS introduction Tobacco Cessation 1. Collaborating with local pharmacies for smoking cessation opportunities (e.g., Haller's Pharmacy) Biosimilar Optimization 1. Pharmacy held collaborative meetings w/ providers to review biosimilar utilization and opportunities to optimize a. Between the months of July 2020 to May 2021, the biosimiliar utilization average was 54.1% b. Between the months of July 2020 to Sep 2021, the biosimiliar utilization average was 67.1% 2. Discussed timelines to transition and barriers that would interfere with conversion Transition of care The Alameda Alliance for Health (AAH) is restructuring its Transition of Care (TOC) Program with AAH's Case Management Disease Management (CMDM) Department in order to help better meet the needs of AAH's highest tier risk members. Health education 1. Health coaching for members with asthma and diabetes re: condition self-management 2. Training for Case Management staff re: Tobacco Cessation best practices for intervention and medications

MCO Name	Innovative Practices Summary
	Reports 1. Top 50 Medi-Cal Drugs by Volume and By Cost (newest report, not being used yet) 2. TOC Medi-Cal High risk members report (to be used in new upcoming workflow, not being used yet) 3. Reinstatement 11 STC Denied Claims Report 4. Top 50 Prescribers Report By Volume and Cost 5. Biosimilar utilization
Anthem Abbr	No
BlueShield Abbr	Care Transition Intervention program: In Q1 of 2022, a pilot readmission reduction program was established in San Diego, CA to help reduce the rate of hospital readmissions using a well-studied, widely implemented, and proven Transition of Care (TOC) model. MCO pharmacists worked closely with the assigned Transition Coach to conduct a medication reconciliation with members post hospital discharge. This program has been expanded to multiple hospitals and provider groups in San Diego County.
CalOptima Abbr	The Post-Myocardial (MI) Discharge Medication Review Program targets adult Medi-Cal CalOptima Health Community Network members discharged from an inpatient facility post-MI. A CalOptima Health clinical pharmacist conducts a comprehensive medication review to optimize medication management and reduce medication discrepancies. In addition, the pharmacist identifies members who are missing appropriate statin and beta blocker therapy in alignment with HEDIS SPC and PBH measures. Program data: October 2021- September 2022. 3 call attempts are made to each member before a review is finalized and faxed to PCP. 45 medication reviews completed for 43 unique members. 26 of 45 medication reviews involved a successful member consultation. Common interventions tracked: o Initiating medications (statin, beta-blocker, GLP-1 agonist, SGLT-2 inhibitor, aspirin, nitroglycerin). o Modifying medications (increase statin intensity, switch formulations or combine medications to reduce pill burden and copays). o Discontinuing medications (lack of appropriate indication, drug/disease interactions). Takeaways: o Most members are not aware of medication indications post-discharge. o Members have communicated that they do not know what to do when their discharge medications reject at the pharmacy. o Members often have misconceptions about their condition. o Members typically have medication-related questions but have not had an opportunity to see their PCP or Cardiologist. o Other success stories involve the pharmacist counseling members who would have otherwise been taking their old dose or the wrong frequency of their medication.

MCO Name	Innovative Practices Summary
CalViva Abbr	Our Health Plan created a monthly report that identifies members who have gone to the Emergency Room (ER) with a diagnosis of opioid use disorder, opioid withdrawal or opioid poisoning. Members are proactively outreached to in order to get member help with seeing a provider on a regular basis or refer to Bright Heart Health (BHH) for MAT therapy. BHH coordinates Substance Use Disorder (SUD) services with County Mental Health. Goals are to decrease ER usage and lowering opioid usage in our member population.
CCAH Abbr	1. Diabetes Therapy Management Program Diabetes Therapy Management Program was established by the MCO's pharmacists to help control costs due to uncontrolled diabetes. The pharmacists collaborated with a Primary Care Provider (PCP) for better medication management of members with uncontrolled diabetes. The pharmacists reviewed members whose A1C was above 9% and provided dose optimization recommendations, suggested regimen simplification, identified gaps in therapy, screened for drug duplications, and referred members to relevant health programs. MCO pharmacists also advised on how to improve medication adherence using motivational interviewing techniques. A total of 18 member cases were reviewed and change in A1C was assessed after six months. Among the 11 members who returned for routine lab work and follow-up, 82% of the members had improved control of their diabetes (decrease in A1C values) while 18% showed no improvement. Of the 82% that had an improvement in A1C, 56% reached the goal of A1c less than or equal to 9%. After program completion, the provider expressed satisfaction with the collaboration and indicated the desire to continue. 2. Supporting Medi-Cal Rx Transition For beginning of 2022, MCO focused on supporting the pharmacy benefit transition from MCO to Fee-For-Service Program Medi-Cal Rx. For the first three months, the pharmacists and pharmacy technicians screened all denied claims and prior authorization requests processed by Medi-Cal Rx for potential medication access issues. Based on the data, the team initiated outreaches to pharmacies, prescribers, and Medi-Cal Rx to resolve the issues, and educated providers about Medi-Cal Rx. In total, 2786 claims were reviewed, outreaches were performed to 565 providers regarding 664 prescriptions of concern. By performing proactive outreaches based on daily claims and prior authorization data, issues were addressed earlier to ensure members' access to medications. Any concerning trends or questions were escalated to Medi-Cal Rx and DHCS.
CenCal Abbr	-Medical Pharmacy Benefit Physician Administered Drug Program: Due to the shifting costs on the Medical Benefit, increasing availability of Biosimilar products, and a commitment to providing CenCal Health members with access to high-quality health care, CenCal Health implemented updates to the review and approval processes of certain Physician Administered Drugs (PADs). The program goal was to optimize appropriate use, clinical expertise, and cost management of the complex specialty pharmacy space. In FFY22 CenCal Health implemented the third phase of this program with the review of rare and orphan physician administered drugs. This phase was implemented to address the challenges health plans and members experience with these types of medications. Member's receiving these medications often have

MCO Name	Innovative Practices Summary
	disease burden, comorbidities, and mental health issues. Gaining access to the medications requires them to navigate PA and benefit structures, and in some cases the medications must be administered at a center of excellence outside of their area. CenCal Health challenges include the surge in high-cost drug approvals, and lack of guidelines and literature to support the use of these products. With the implementation of the program all rare and orphan drugs with an annual cost of greater than $300,000 per year will be run through the program. All prior authorization requests for these agents go straight to specialty matched physician review. The goal of the program is to enhance the review process for these complex therapies with the support of a specialty-matched physician to evaluate the appropriateness of the therapy. All decisions for these cases are based on current guidelines for the requested medications and recommendations are evidence-based and literature supported. The ability to streamline these cases allows for internal case conferences and care coordination for the member receiving the treatment. -Blood Pressure Monitor Provider and Member Outreach: CenCal Health identified that many of the plan's hypertensive members were not regularly checking their blood pressure at home. To increase the use of blood pressure monitors by hypertensive members a provider and member outreach campaign was created. The goal of the outreach was to educate providers and members on the coverage of blood pressure monitors on the pharmacy benefit. A letter documenting the benefit went out to hypertensive members and to providers that were identified as part of a DUR outreach for members who had not had a fill of their hypertension medication in the past 4 months. Since the distribution of the letters, CenCal Health has had 454 unique members fill blood pressure monitors on the pharmacy benefit. That number is more than double what CenCal Health had in the previous 6-month period before the outreach took place. -Provider Asthma Management Webinar: CenCal Health continues to work to improve asthma medication ratios for our members. On a yearly basis CenCal Health provides a provider webinar on asthma management. The provider webinar is comprised of two sections with a local Allergist going over asthma in the primary care setting and a plan pharmacist reviewing medications and delivery devices. The section on asthma in the primary care setting included discussion around COVID-19 and the effect on asthmatic members. The goal of the webinar is to provide primary care providers with the most up to date information on the treatment of asthma. All providers that attend the webinar are eligible to receive continuing education credits.
CHW Abbr	Our Health Plan created a monthly report that identifies members who have gone to the Emergency Room (ER) with a diagnosis of opioid use disorder, opioid withdrawal or opioid poisoning. Members are proactively outreached to in order to get member help with seeing a provider on a regular basis or refer to Bright Heart Health (BHH) for MAT therapy. BHH coordinates Substance Use Disorder (SUD) services with County Mental Health. Goals are to decrease ER usage and lowering opioid usage in our member population.
Community Abbr	Minimize Fraud, Waste and Abuse of Controlled Substances:

MCO Name	Innovative Practices Summary
	Community Health Group (CHG) ran reports to identify patients at risk for potential fraud, waste and abuse. Patients who met our internal 4x4x4 (4 controlled substances, 4 pharmacies, 4 prescribers) criteria were identified and offered care coordination services if needed. A pharmacist reviews patient's claim history and pertinent clinical notes to determine potential drug seeking patterns or gaps in care. Depending on results, the pharmacist can refer the member to case management, compliance, or behavioral health. The member can also be added to CHG's internal watch list because they required additional pharmacist intervention, pharmacist monitoring, or additional support from case management. CHG pharmacists receive a weekly report of members who experience an overdose of opioids, synthetic narcotics, unspecified narcotics, and/or benzodiazepines (BZD). A pharmacist reviews patient's claim history and pertinent clinical notes to determine potential drug seeking patterns or gaps in care (e.g. naloxone prescription filled). Depending on results, the pharmacist can refer the member to case management, compliance, or behavioral health. Disease Management: Asthma Remediation CHG Pharmacists collaborated with CHG's Health Education Department to provide comprehensive disease management. Members who have poorly controlled asthma and hospitalization/ER/Urgent Care visits qualify for the program. The members received a home evaluation to reduce asthma triggers. CHG pharmacists worked up the members and conduct a video call to assess for adherence, knowledge of disease, proper use, medication efficacy, medication side effects, and drug-drug interactions. MOM's Meal CHG Pharmacists collaborated with CHG's Health Education Department to provide comprehensive disease management. Members who qualify for the program receive medically tailored meals and are followed by the CHG Pharmacists and Health Education Department. Members receive a medication reconciliation, nutritional education, adherence checks, and disease education.
ContraCosta Abbr	Hepatitis C Adherence: Overview: Successful Hepatitis C treatment results in a sustained virologic response (SVR), which is tantamount to virologic cure and reduces further transmission to the population. SVR confers a >70% reduction in liver cancer, and a 90% reduction in the risk of liver related mortality and liver transplantation. In ~95%+ cases SVR is achieved after receiving and completing oral Hepatitis C treatment. Depending on the medication, treatment is completed in 2-3 months of oral therapy. By monitoring HepC medication adherence, sending appropriate reminders to patients, and outreaching to providers, CCHP is able to increase the number of cured patients and reduce transmission. Methods: Monitoring: TAP3409 HCV Med Adherence report is monitored each month for potential patients that are late to fill their prescriptions

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	Reminders to patients: Phone calls encourage and remind members to continue to fill their medications. If there are obstacles such as prior authorization extensions, CCHP works to address them. Outreach to providers: Often, there are patients that due to lifestyle complications (homelessness, drug use, rehab, no phone contact) are unable to adhere or be reminded. We outreach to providers to consider re-starting therapy. Progress: This program is ongoing from 2016. There are several excel spreadsheets with details as to completed members, reminders sent, and interventions made. -Since Jan 2022: 116 members have been tracked to completion, 11 members have been contacted several times, 2 separate providers outreached and attempted several times Concurrent Benzodiazepine-Opioid Use: Overview: In response to the opioid epidemic, one of CCHP's goal has been to limit and reduce the number of members on a concurrent benzo and opioid regimen. The concurrent use of benzodiazepine and opioids can increase the risk of respiratory depression. Providers are often unaware that members are on an opioid or benzodiazepine before they prescribe additional agents. By informing providers that they have prescribed these risky medications to their patient, they are made more aware of it and will take steps to taper one of the agents. Method: Template letters are sent out quarterly to providers. These letters also include confidential and specific information to the providers telling them exactly what they prescribed and which of their patients is concurrently using benzodiazepines and opioids. Progress: -In April 2018, 369 members and 1,512 prescriptions were for either a benzodiazepine or opioid used in combination. -For February 2022, there are 174 members and 614 prescriptions -Overall, this is a 52% drop in total members on concurrent medications, and an almost 60% drop over 4 years in prescriptions written. -Whether this is a direct result of these benzo-opioid letters or can be attributed to the work of the RMC pain specialist team is difficult to delineate. -Since Jan 2022: 57 letters to providers have been sent High Prescription Utilizers (>15 Rxs) Overview: When patients are using a high number (>15) of prescription drugs each month it makes it hard to manage their health care. It also makes it harder for doctors to keep error-free medical records. Having a pharmacist review all of these patients' medications and perform medication-therapy-management (MTM) and conveying those suggestions to the patient can help to streamline a members treatment regimen. Method: Each month, a high prescription utilizer report is run. A pharmacist reviews the medications for the following: All medications are being used correctly and effectively Check for drug-to-drug interactions Present ways to simplify your medication regimen

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	Ways to monitor your medications to be sure you're getting the most out of your medications Then, personalized recommendations are made over the phone to the member and a letter is sent out summarizing these recommendations. Contact numbers for Case management referrals are also included in these letters. Progress: This is our newest project that began Feb 2022. Outreach to 9 members has occurred. Our future goals are to reduce overutilization of medically unnecessary drugs or spot potential interactions and side effects that may be occurring. In addition, educational outreach is empowering to members who then have the knowledge to make suggestions to their physicians. Concurrent Opioid and Antipsychotic Use Overview: CCHP will monitor the concurrent usage of opioids and antipsychotics for CCHP members 21 years old and under. CCHP will analyze this data and watch for members who are being prescribed this combination of medications. Methods: Monitoring: TAP4849 CCHP Members on Opioids and Antipsychotics report is generated each month for members 21 years old or younger with a minimum of 10 prescription days. These monthly reports are gathered and the data is analyzed. Outreach to providers: If it is deemed necessary, CCHP pharmacy department will outreach to prescribers regarding suspicious concurrent opioid and antipsychotic use situations. Progress: This program began in January 2022. So far, there have not been any situations of concurrent opioid and antipsychotic usage.
GoldCoast Abbr	Blood Pressure Monitor and Cuff Workgroup: Blood pressure monitors and cuffs became a pharmacy benefit under Medi-Cal Rx starting 6/1/22. We reviewed the current utilization of BP monitors and cuffs as a medical and pharmacy benefit. We identified qualifying members who could benefit from a BP monitor and our Care Management team reached out to these members to promote the benefit. We also had our health education team promote the benefit for our members enrolled in the Chronic Disease Self-Management Program. We also worked on developing handouts, educational materials and a provider toolkit to help promote the benefit.
HealthNetMediCal Abbr	Our Health Plan created a monthly report that identifies members who have gone to the

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	Emergency Room (ER) with a diagnosis of opioid use disorder, opioid withdrawal or opioid poisoning. Members are proactively outreached to in order to get member help with seeing a provider on a regular basis or refer to Bright Heart Health (BHH) for MAT therapy. BHH coordinates Substance Use Disorder (SUD) services with County Mental Health. Goals are to decrease ER usage and lowering opioid usage in our member population.
Inland Abbr	During the calendar year 2022, IEHP continued to engage in major efforts to transform the Pharmacy department now that Medi-Cal Rx has been implemented. IEHP has spent most of the year shifting pharmacy staff members to more clinical activities. To highlight this years clinical activities and future goals to help improve appropriateness of drug use and help control costs: 1. Enhanced Care Management (ECM): IEHP pharmacy team members conduct annual and post-discharge medication reviews in collaboration with interdisciplinary team members to provide a whole person care approach to beneficiaries not delegated to IPA. ECM workflow process has been standardized and is now fully integrated throughout Riverside and San Bernardino County 2. Integrated Transition Care Team - IEHP has pharmacy team members as part of the newly designed Integrated Transitional Care (ITC) Team designed to provide Population Health Management related to transitional care services. A pilot team that includes pharmacy and care manager has been created with the goal to promote continuity of coverage for beneficiaries. During the pilot phase, work flow processes will be developed. After the pilot phase, ITC team will expand its staff and become fully implemented in 2023. 3. Drug Utilization Review (DUR) and Targeted Medication Review (TMR): IEHP streamlined the process to quickly identify members not meeting MCAS metrics. Provider letter generation has become more automated so that outreach to providers can for various MCAS metrics can be more frequent. IEHP are now able to outreach providers on all pharmacy related MCAS measures on a quarterly basis. 4. Disease Management: IEHP has redesigned the Comprehensive Medication Management (CMM) program to work with local pharmacies to provide clinical services to beneficiaries to manage chronic conditions. The program currently provides clinical services for asthma, but the disease management program plans to expand to other disease states in 2023 including hypertension and diabetes. 5. Opioid Related Efforts: IEHP continues to raise awareness to opioid related medications including safe opioid prescribing and furnishing of naloxone through academic detailing of providers. IEHP has also helped provide fentanyl test strips to various local locations to help promote safe use and monitoring of opioid medications. IEHP pharmacy department has made significant achievements in 2022 to help improve appropriate drug use and continues to further develop its clinical activities in the Riverside and San Bernardino county area to meet the needs of the beneficiaries.

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Kaiser Abbr	Kaiser continues to advance innovative processes through our integrated service model. In the last year, we have leveraged our internal analytic capabilities because of the carveout to FFS. For example, we developed a new initiative that focuses on initial higher risk opioid prescribing. The initiative recommends avoidance of prescribing 1 initial opioid prescription(s) for >7 cumulative days' supply during the measurement year due to an increased risk of chronic use, misuse, and potential overdose.
KernHealthSystems Abbr	KHS developed a couple of new programs to enhance appropriate drug use, and continued or enhanced previous programs that were producing effective results. One of the new programs developed was designed to help improve member understanding and adherence to best practices for asthma management. Pharmacy teamed up with the Quality Improvement and Health Education Depts. to engage with pediatric members identified with asthma who were not utilizing the maintenance/controller inhalers. The pharmacist spoke with the member and caregiver to illustrate the importance of the controller inhaler and its role in managing asthma. Issues with over reliance on rescue inhalers was discussed. Proper inhaler technique was reviewed. Management tools such as peak flow meters and spacers were discussed. KHS assisted in getting these devices to the member to improve their asthma management. Another area the plan concentrated on was more actively bringing the member into accountability and have them more actively taking responsibility of their health and driving the preventive efforts. This was done by an incentive program. The Plan initiated a COVID-19 vaccine incentive program on September 1, 2021 for all members eligible to receive the vaccine. The program for all members ended on March 31, 2022. The Plan also provided incentives to in network primary care providers who showed an increase in their patients' vaccine rates during this program. The member incentive program was continued for members who were classified as high-risk based on age and if they had a chronic condition beginning April 1, 2022 through December 31, 2022. The high-risk program included an incentive for the COVID-19 booster. The Plan conducted a robust outreach campaign that consisted of text messages, robocalls, website content, social media posts, member newsletter articles, and was promoted through our Member Services Call Center staff. The Plan saw a 32% increase in vaccinations and boosters attributed to these programs. Kern Health Systems continues to see value in its Transition of Care (TOC) model in which a local pharmacy works with the discharge of members to ensure that not only medications are available upon discharge, but that the appropriate and medically necessary medications are available. The pharmacy works with the provider and the plan to arrange for formulary medications and if formulary medications are not available to adequately manage the condition, to assist in the prior authorization process. This TOC also looks for therapeutic duplication and interacting meds and works to de-prescribe where appropriate.

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	Other programs include participating in complex case rounds and also in Interdisciplinary Care Teams for Enhanced Care Management. Both involve having active pharmacist input on severe and complex cases. The pharmacist shares their expertise and perspective with physicians, nurses, social workers, etc. to provide the best health outcomes for the member reviewed.
LACARE Abbr	LA Care Health Plan's pharmacy department has developed innovative practices and programs in ambulatory care and community pharmacy practice. Our primary focus with these programs is to decrease unnecessary high-cost associated spending due to uncontrolled chronic disease states. Ambulatory Care Pharmacist Program In 2019, we launched a new initiative to encourage collaboration with our medical groups to directly manage chronic disease states (e.g., diabetes, hypertension, hyperlipidemia, etc.), to improve overall quality and efficiency of the care delivered while reducing healthcare costs. In this pilot program, an ambulatory care pharmacist is dispatched to partnered clinics to directly manage high risk patients in specified chronic disease states to decrease provider burden and to increase access to care. The pharmacist practices under a collaborative practice agreement, which allows a clinical pharmacist to manage patients' medications, including initiation, modification, and discontinuation of drug therapy as clinically appropriate and according to current practice guidelines. This program tracks several different clinical outcomes as well as medication-related interventions. The ambulatory care pharmacist directly manages appropriateness of prescription drug use in managing L.A. Care members with diabetes, hypertension, and hyperlipidemia. In targeting high-risk members, the goal is to prevent further complications of chronic disease states and to provide and also empower the members to know the resources available to them in order to control their disease states. The program includes a total of 3 federally qualified health centers: Wilmington Community Clinic, Watts Community Health Center, and APLA Health Center. This program has yielded A1c reduction, as well as produce interventions for medication-related problems identified. Of those members with follow up A1cs, they were able to achieve 3.1% A1c reduction, on average. California Right Meds Collaborative Program In 2019, we also partnered with the California Right Meds Collaborative (CRMC), an initiative of the University of Southern California (USC) School of Pharmacy, to develop a network of pharmacies that will deliver Comprehensive Medication Management (CMM) services to address the high burden of chronic disease states in L.A. County. Community pharmacists, who are on the front line of patient care, are one of the most accessible health care providers, and well positioned to provide chronic disease state management. One of the barriers that existed and was identified was a lack of payment for quality services. Pharmacies need reasonable payment/incentives in order to provide sustainable CMM. Payers should not pay for CMM services that do not have a high probability of delivering the results needed for targeted high-risk populations to improve clinical health outcomes. Thus, LA Care utilized an innovative approach and created a value-based payment model for pharmacists to improve patient health outcomes and access to care by providing

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	comprehensive medication management services at the community pharmacy level. The Pharmacy Department worked with Navitus in creating a mechanism to process payments to community pharmacists for CMM services. Community pharmacists participating in the program provided comprehensive medication management for chronic disease states through telehealth, telephonic appointments, in-person, as well as home-visitations. These pharmacists worked to manage disease states as well as assess appropriateness of prescription drug use by being directly involved with the medication management for members. In September 2022, we had 535 members, 16 pharmacies, and 21 clinics/provider partners participating in CRMC. Data up to January 2023 demonstrated an average A1c reduction of 2.8% for members who completed at least 5 or more visits with a CRMC pharmacist and an average 14.4 point reduction in systolic blood pressure for members with a baseline blood pressure above 140/90 mmHg. Vaccine Clinics To prepare for the 2022 flu season, L.A. Care Health Plan partnered with Blue Shield Promise Health Plan to host 4 vaccination clinics throughout L.A. county. This was the first year we transitioned to indoor vaccine clinics since the start of the COVID-19 pandemic. The clinics provided flu and COVID-19 vaccinations for all community members, regardless of insurance status. This year we provided 315 flu and 177 COVID-19 vaccines. The vaccine clinics are an interdepartmental effort with Health Education, the Community Resource Centers, Marketing, and Pharmacy to reduce hospitalizations and complications from flu and COVID-19.
Molina Abbr	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

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	compendium supported age limit. These members were referred to case management. Claims were also reviewed for utilization of multiple antipsychotic 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. 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.
Partnership Abbr	Prescription Claims Analysis to identify gaps and opportunities to improve outcomes: PHC's pharmacy department has been analyzing prescription claims data for diabetes and hypertension related medication to identify actionable opportunities to improve outcomes for our members with diabetes and hypertension. Prescription data is obtained through the Medi-Cal Rx Magellan daily claims feed and can be validated against the Managed Care Pharmacy portal when necessary. For the analysis, the data for a provider organizations is organized into a format that can then be stratified to different medication issues such as medication non-adherence, gaps in care, suboptimal dosing, etc. The results of the analysis is shared with the individual provider organizations with guidance on closing gaps and addressing the identified issues. The providers are encouraged to follow up with the pharmacies to address any identified medication related issues such as duplication of therapy, poly-pharmacy and medication non-adherence. Pharmacotherapy for COPD exacerbation: According to the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines, providing adequate pharmacotherapy for COPD exacerbations in the form of oral corticosteroids and short acting bronchodilators can reduce the chance of subsequent and worsening exacerbations. To improve rates of appropriate pharmacotherapy for COPD exacerbations, PHC pharmacists provided member specific medication notes and recommendations in the Collective Medical platform when appropriate pharmacotherapy was not dispensed after an ED discharge for COPD exacerbations. Appropriate maintenance therapy for COPD in the form of long acting bronchodilators can reduce the risk of COPD exacerbations. For these same members, PHC also notified the assigned primary care physician of the member's emergency room visits and any gaps in GOLD recommended maintenance therapy for COPD. In addition, data for COPD exacerbations from

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	2021 for all PHC members was reviewed to identify which emergency rooms may be underperforming with respect to issuing appropriate pharmacotherapy for COPD exacerbations. Statins for People with diabetes or cardiovascular disease: The HEDIS measure, Statin Therapy for Patient with Diabetes - Statin Therapy, assesses the percentage of adults 40-75 years of age who have diabetes but do not have clinical ASCVD, who received statin therapy. In this subgroup of diabetic patients, the American Diabetes Association and the 2019 ACC/AHA guidelines recommend statins for primary prevention of cardiovascular disease in patients with diabetes, based on age and other risk factors. PHC's Pharmacy department developed a triphasic telephonic member outreach project to try to increase the member's knowledge and reinforce members understanding of diabetes management with the hopes of increasing statin use. Providers were outreached for initiating statin therapy and medication management when appropriate.
SanFrancisco Abbr	Starting in June of 2022, the SFHP clinical pharmacist in charge of DUR has hosted a biweekly internal workgroup meeting. This workgroup includes stakeholders from multiple positions within Health Services and Business Analytics departments, such as Quality Improvement, Behavioral Health, Care Management, and Population Health. The goal of these meetings has been to collaborate to focus and align quality improvement efforts. During this year, we have used HEDIS (Healthcare Effectiveness Data and Information Set) measures to identify four areas of intervention: comprehensive diabetes care (CDC), asthma medication ratio (AMR), antidepressant medication management (AMM), adherence to antipsychotic medications for individuals with schizophrenia (SAA), asthma medication ratio (AMR). First, member demographic data was analyzed to determine any possible under-served communities. Demographic information analyzed included: age group, ethnicity, spoken language, medical group, PCP/Non-PCP visit count, in patient visit count, and ED visit count. Initial results on identified under-served groups in the CDC and AMM measures were communicated to providers in a September provider newsletter. These meetings are ongoing, and we expect to have further results and materials created during FFY 2023.
SanJoaquin Abbr	The Health Plan developed several programs in the measure period. One of the innovative programs that we developed is the Hepatitis C Adherence Program and the Antidepressant Medication Management (AMM) Program.
SanMateo Abbr	- Evolving management of drugs under the medical benefit to support proper access to drugs via the medical benefit, including coordinating coverage across payer entities, such as Medi-Cal Rx. - Implementing thoughtful pharmacy coverage design to accommodate the transition from a Medicare-Medicaid benefit design into two separate payer entities, allowing for greater coverage through supplemental benefits to support access.

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	- Integrating the dental benefit as part of the MCO's coverage offering as a Medicaid plan, with pharmaceutical support involving information sharing of pharmaceutical utilization and coordination of with MCO dental staff to support the overall implementation of this new benefit.
SantaClaraHealthPlan Abbr	In federal fiscal year 2022, Santa Clara Family Health Plan completed the following initiatives to promote appropriate and effective medication use to improve patient safety: 1. Developed a pharmacist-run comprehensive clinical diabetes program enrolling members with uncontrolled diabetes (A1C > 9%) and following them over a 1 year time frame. This clinical program utilizes a Whole Person Care (WPC) approach " besides disease state and medication review, pharmacists conduct social needs screenings to identify barriers related to social determinants of health and refer to the Plan's Case Management if needed. 2. Implemented a COVID-19 Vaccine Reward Program at SCFHP's Blanca Alvarado Community Resource Center (CRC) - SCFHP Medi-Cal members were eligible to receive a $50 gift card for getting their first or second doses or first booster of a COVID-19 vaccine at one of the CRC's vaccine clinics, offered in partnership with Bay Area Community Health.
UnitedHealth Abbr	In conjunction with San Diego's TB Elimination Initiative(TBEI) Community of Practice, UnitedHealthcare Community Plan provided education and materials to the network of Clinic and medical group of CMO's, resulting in increased screening for latent TB and embedded treatment protocols within EMR's. Most notable, through our outreach, UCSD joined the TBEI and Healthy San Diego appointed a representative from Quality and Health Education to attend TBEI Community of Practice meetings. UHC participated with Liver Coalition on drafting and promoting Hep C elimination actions from the Board of Supervisors, including needle exchanges and education to providers regarding testing and treatment. UHC worked with the Liver Coalition to ensure Hep C treatment regimens were available to San Diego residents. One innovative practice initiated during this time was including a behavioral health clinician on our inpatient concurrent review rounds. When a patient was presented with SUD or AUD or co-morbidities this behavioral health clinician reached out to the member post discharge to attempt to facilitate therapy, psychiatry consultation and treatment or referral to County BH as appropriate. Through this manner we were able to engage members who otherwise would not have chosen to pursue treatment.