U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act: Section 1004 Medicaid Drug Review and Utilization

Federal Fiscal Year 2022
Report to Congress

Executive Summary

BACKGROUND

This report to Congress fulfills the requirement of section 1902(oo)(2) of the Social Security Act (hereinafter referred to as "the Act"), as added by section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; Pub. L. 115-271), for federal fiscal year (FFY) 2022. The SUPPORT Act includes measures to combat the opioid crisis in part by reducing opioid misuse, fraud, and advancing treatment and recovery initiatives, improving prevention, protecting communities, and bolstering efforts to fight deadly illicit synthetic drug use. This report provides information to Congress concerning implementation of the Medicaid drug utilization review (DUR) provisions that were included in amendments made by section 1004 of the SUPPORT Act.

There are several DUR provisions in section 1004 of the SUPPORT Act with respect to Medicaid fee-for-service (FFS) and managed care delivery systems, which cover policy goals of protecting beneficiaries from and educating providers about opioid overutilization and addressing the clinical appropriateness of use of antipsychotic medications in children. These provisions establish drug review and utilization standards in sections 1902(a)(85) and (oo) of the Act to supplement existing requirements under section 1927(g) of the Act, in an effort to reduce opioid-related fraud and misuse. State implementation of these opioid-related strategies was required to be in place by October 1, 2019. This report specifically addresses the required implementation and states' status of these provisions, including requirements regarding opioid prescription claims review at the point of sale (POS) and retrospective reviews.

States must include information about their programs and section 1004 SUPPORT Act provisions in their annual DUR reports to the Centers for Medicare & Medicaid Services (CMS) under section 1927(g)(3)(D) of the Act. In turn, the Secretary of the Department of Health and Human Services (HHS) is required to report to Congress on the information submitted by the states, starting with information from FFY 2020 reports.[1] This report is the third annual report to Congress and addresses compliance with provisions for FFY 2022 for the reporting period October 1, 2021, to September 30, 2022.[2]

The provisions added by section 1004 of the SUPPORT Act require state Medicaid programs to have in place:

- a claims review process and safety edits (as specified by the state) for subsequent opioid fills (i.e., refills) and maximum daily morphine equivalent that exceeds state-defined limitations;
- an automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or antipsychotics;
- a program to monitor antipsychotic prescribing for children; and
- a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, prescribing health care providers, and pharmacies dispensing drugs to such individuals.

[1] https://www.medicaid.gov/medicaid/downloads/sud-prev-medicaid-drug-rev-util.pdf.
[2] https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf.

The statute also requires that states' contracts with managed care entities (MCE) include these provisions, effective October 1, 2019. Although section 1004 of the SUPPORT Act uses the term "managed care entity," CMS implementing regulations on drug utilization review at 42 C.F.R. 438.3(s) specifically address managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), and certain other entities in managed care. This report refers to these entities collectively as managed care plans (MCP).

MEDICAID DRUG UTILIZATION OVERVIEW

Medicaid DUR programs promote beneficiary safety through state-administered drug utilization management tools and systems that interface with the claims processing systems. DUR includes both prospective and retrospective reviews. Prospective DUR reviews generally occur before the pharmacy dispenses the prescription and includes a review of the new prescriptions compared to other prescriptions the beneficiary is taking. This helps to avoid drug interactions, therapeutic duplications, allergic reactions, and underdosing or overdosing. Retrospective DUR reviews generally attempt to identify patterns of prescribing or dispensing that may require the state to engage in educational interventions with prescribers, pharmacists, or beneficiaries.

There are several Medicaid-related DUR provisions for FFS programs and MCPs in the amendments made by section 1004 of the SUPPORT Act. These provisions have the goal of improving the quality of care received by Medicaid beneficiaries by reducing their exposure to hazards resulting from inappropriate prescribing, gross overuse, or inappropriate or medically unnecessary care. These basic standards implemented through Medicaid DUR programs nationwide help ensure that prescriptions are appropriate, medically necessary, and align with current standards of care.

SUMMARY OF DATA COMPILATION

Enrollee Information

States' FFY 2022 survey incorporates survey responses from all 50 states and the District of Columbia (51 states), which is included in counts of states hereafter.[3] In addition to the 51 FFS survey responses, 34 states have submitted a total of 205 Medicaid MCP DUR Annual FFY 2022 survey responses, all of which are incorporated into this report. FFY 2022 survey responses include information on 37,930,305 beneficiaries enrolled in FFS Medicaid programs, a 41% increase from FFY 2021, and 49,853,837 beneficiaries enrolled in Medicaid MCPs, a 9% decrease from FFY 2021.[4] The significant increase in beneficiaries enrolled in FFS Medicaid programs is largely due to the California and Ohio Medicaid programs excluding pharmacy benefits from their MCP contracts. At the time of the survey,

[3] The Annual DUR survey was not submitted by the State of Arizona because of the existing waiver of DUR requirements included in the states approved 1115 demonstration; however, Arizona submitted a separate survey in reference to section 1004 of the SUPPORT Act for incorporation into this report to Congress. For purposes of this report, when referencing FFY 2022 survey data, Arizona's separate survey information is included with the other 50 states.

[4] Arizona submitted separate responses for incorporation into this report to Congress for their FFS and 7 MCPs. Arizona's data includes information on 135,290 beneficiaries enrolled in FFS programs, a 6% increase from FFY 2021, and 2,104,766 beneficiaries enrolled in the state's Medicaid MCPs, a 5% increase from FFY 2021.

six states -- California, Missouri, North Dakota, Tennessee, West Virginia, and Wisconsin -- excluded their drug benefit from the MCPs' contracts and this benefit was provided through the FFS delivery system, and these states submitted an abbreviated managed care survey for each of their MCPs.[5] These reports can be accessed on Medicaid.gov.[6]

Claim Review

1. **Prospective Safety Edit Limitations for Opioid Prescriptions -** FFY 2022 survey responses confirm all Medicaid FFS programs and MCPs set early prescription refill thresholds as a way of preventing prescriptions from being overutilized. That is, enough time must have elapsed for the beneficiary to have been able to use a designated percentage of the prescription dispensed, based on the directions for taking the drug, before another prescription or refill can be obtained.

    - *Controlled Substances (CII)[7] Early Refills:* FFS surveys reported early refill thresholds ranging from 75% to 100% of a prescription being used, with a national average of 87%, before a subsequent prescription could be dispensed, which is a 1% increase from FFY 2021. MCPs reported thresholds ranging from 81% to 90% of the prescription being used, with a national average of 86% (this is consistent with FFY 2021). While CII prescriptions are not refillable, partial refills can be authorized. Additionally, early refill edits can determine when a subsequent new prescription is filled too early.
    - *Controlled Substances (CIII to CV)[8, 9, 10] Early Refills:* FFS surveys reported early refill thresholds ranging from 75% to 95% of a prescription being used, with a national average of 85%, which is consistent with FFY 2021. MCPs reported thresholds ranging from 80% to 90% of the prescription being used, with a national average of 86% (a 1% increase from FFY 2021).
    - *Quantity of Opioid Doses Dispensed:* FFY 2022 survey responses show that 100% of FFS and 93% of MCPs have safety edits[11] in place to limit the quantity dispensed of opioids.
    - *Days' Supply Limitations of Initial Opioid Prescriptions:* For FFS surveys, the

[5] In FFY 2022, Ohio submitted both MCP reports and an abbreviated MCP report because drug benefits are excluded and covered through the FFS program for one MCP, which are both incorporated into this report.
[6] Please reference the following URL throughout this report to access Medicaid.gov state specific DUR reports: https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/drug-utilization-review-annual-report/index.html.
[7] Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. Additional drugs may be also considered Schedule II as defined by state specific law.
[8] Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Additional drugs may also be considered Schedule III as defined by state-specific law.
[9] Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Additional drugs may also be considered Schedule IV as defined by state-specific law.
[10] Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Additional drugs may also be considered Schedule V as defined by state-specific law.
[11] Pharmacy safety edits are alerts generated within a pharmacy's computer system to promote the safe and effective use of medications.

average days' supply limit for an initial opioid prescription for an opioid naïve patient[12] based on FFY 2022 reported responses is 10 days, which includes a national range of five to 34 days' supply. Additionally, the average days' supply limit for an initial opioid prescription for an opioid naïve patient reported under MCP surveys is eight days, which includes a national range of five to 30 days. Both FFS and MCP median figures are consistent with FFY 2021.

- *Duplicate Opioid Therapy:* Opioid duplicate safety edits for initial and subsequent prescription fills help to avoid inappropriate or unnecessary therapeutic duplication when simultaneous use of multiple opioids is detected. FFY 2022 survey responses show that 98% of FFS and 99% of MCPs have safety edits to monitor duplicate opioid therapies dispensed, a 2% decrease for FFS and a 1% decrease for MCPs from FFY 2021.

2. **Morphine Milligram Equivalent (MME) Daily Dose -** MME is the amount of morphine, in milligrams, equivalent to the strength of the opioid dose prescribed. MME is used to assess the total daily dose of opioids dispensed to a patient and takes into account the comparative potency of different opioids and frequency of use. The calculation to determine MMEs includes drug strength, quantity, days' supply, and a defined conversion factor unique to each drug, which assesses patient risk. Using an MME approach allows comparison between the strength of different types of opioids. The 2022 Centers for Disease Control and Prevention (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain recommends that before increasing total opioid dosage to ≥50 MME/day, clinicians should pause and carefully reassess evidence of individual benefits and risks.[13] If a decision is made to increase dosage, clinicians should use caution and increase dosage by the smallest practical amount.[14]

   All FFS and MCPs limit maximum MME daily doses to reduce potential beneficiary harm, misuse, and/or diversion.[15] The median MME daily dose for FFY 2022 FFS and MCP reported responses is 90 mg/day, which includes a national range from less than 50 mg/day to greater than 200 mg/day. Additionally, 50 states (98%) FFS programs have an edit in their POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded, which is consistent with FFY 2021, and 44 states (86%) have an automated retrospective claims review process to monitor the total daily dose of MMEs for opioid

[12] Opioid naive patients are beneficiaries who have not received opioids within a specified timeframe. These patients who have not received opioids within a specified timeframe would be subjected to the days' supply limit on the opioid prescription. This limit would not apply to patients currently receiving opioids and is meant for beneficiaries who have not received opioids within this specified time period (as defined and implemented by the state). This limitation is required by regulation implementing the Medicaid DUR program under section 1927(g) of the Act, see 42 C.F.R. § 456.703(h)(1)(i)(A) at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-456/subpart-K/section-456.703.

[13] When referencing the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain throughout this report, the recommendations related to opioid dosages are not intended to be used as an inflexible, rigid standard of care; they are intended to be guideposts to help inform clinician-patient decision-making.

[14] CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm.

[15] Drug diversion refers to the illegal distribution or use of prescription drugs for purposes other than those intended by the prescribing doctor. This can occur at any point in the supply chain, from manufacturing and prescribing to dispensing and administration. U.S. Drug Enforcement Administration. Drug diversion. https://www.deadiversion.usdoj.gov.

prescriptions dispensed, which is a 25% increase compared with FFY 2021. In contrast, 211 MCPs (99%) have an edit in their POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded, and there are 199 MCPs (94%) that have an automated retrospective claims review process to monitor the total daily dose of MMEs for opioid prescriptions dispensed, which is a 6% increase compared with FFY 2021.

3. **Opioids and Concurrently Prescribed Medications -** There are 51 states (100%) with FFS programs that have prospective edits or a retrospective claims review process to monitor opioids and benzodiazepines being used concurrently, which is a 2% increase compared with FFY 2021. There were 203 (96%) MCPs that have prospective edits or a retrospective claims review process to monitor opioids and benzodiazepines being used concurrently, a 3% decrease from FFY 2021.

   Additionally, there are 51 states with FFS programs (100%) that have prospective edits or a retrospective claims review process to monitor opioids and antipsychotics being used concurrently. A total of 201 MCPs (95%) have prospective edits or a retrospective claims review process to monitor opioids and antipsychotics being used concurrently. These edits allow for the evaluation of the risk of respiratory depression and overdose. Note that MCPs in several states have antipsychotics excluded from MCP contracts and included instead in their state's FFS program, which lowers this number, but the programs are still considered compliant.[16]

4. **Retrospective Automated Claims Review -** For FFS programs, 50 states (98%) have an automated retrospective claims DUR review process to monitor opioid prescriptions exceeding state limitations, an 8% increase from FFY 2021, and 196 MCPs (93%) have an automated retrospective claims DUR review process to monitor opioid prescriptions exceeding state limitations, a 6% increase from FFY 2021. These claims reviews identify potential issues such as adverse events, inappropriate or medically unnecessary care, gross overuse, misuse, and fraud after the prescription has been dispensed. This allows for applicable actions, including opportunities for provider and beneficiary education. A lower affirmative response rate on this provision is noted because many programs surveyed stated that their review process was not automated or that they manage these reviews through other utilization management processes.

Antipsychotics in Children

According to FFY 2022 survey responses, all FFS and 99% of MCPs have established protocols for monitoring or managing the appropriate use of antipsychotic drugs in children responsible for conducting risk assessments of potential issues such as adverse effects and polytherapy (also known as polypharmacy) that refers to the simultaneous use of multiple medications by a patient to treat one or more health conditions. These findings are consistent with FFY 2021 results. Additionally, 96% of both FFS and MCPs monitor or manage antipsychotic medication for all children, including those in foster care. It is important to note that several MCPs have antipsychotics excluded from MCP contracts and included instead in their states' FFS program or have no pediatric population enrolled.

[16] MCPs in Maryland, Oregon, and Utah have these medications excluded from MCP contracts and provided by the FFS program.

Fraud, Waste and Abuse (FWA)

With respect to certain program integrity requirements in Medicaid, CMS defines fraud as any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to themselves or some other person.[17] States have flexibility to define specific parameters for reviews for FWA, which can involve practices such as doctor shopping, filling multiple prescriptions from providers, and multiple Emergency Department (ED) visits. States also have protocols for recommendation, referral, or escalation of reviews to the relevant Program Integrity/Surveillance Utilization Review unit, law enforcement, or state professional board based on patterns discovered through the state DUR process.

FFY 2022 FFS surveys indicate that all states have a process to identify possible fraudulent practices or abuse of controlled drugs by beneficiaries, consistent with FFY 2021. Additionally, all states have processes in place to identify FWA by prescribers, which is a 6% increase compared with FFY 2021, and 50 states (98%) have processes in place to identify potential fraudulent practices by pharmacies, a 4% increase from FFY 2021.

FFY 2022 survey responses show all MCPs have a process to identify possible fraudulent practices or abuse of controlled drugs by beneficiaries, which is consistent with FFY 2021. Additionally, all MCPs have processes in place to identify FWA by prescribers, which is consistent with FFY 2021, and 211 MCPs (99%) have processes in place to identify potential fraudulent practices by pharmacies, a 1% decrease from FFY 2021.

DISCUSSION, COMPLIANCE AND RECOMMENDATIONS

CMS reviewed all surveys for compliance with section 1004, which encompassed 51 FFS programs and 212 MCPs, a total of 263 surveys. Similar to how the DUR survey and reports are structured, we are reporting the information as the state reported to us, without alteration or interpretation. The information was reported to CMS either from DUR reports or through follow-up correspondence with states regarding compliance reviews based on state and MCP specific DUR responses.

The adoption of standards pertaining to Section 1004 Support Act requirements have similarly trended upwards from the initial FFY 2020 report to the current FFY 2022 report for both FFS and MCPs. According to responses received, the majority of FFS and MCPs have integrated the mandated standards. The remaining FFS programs and MCPs have indicated their plans for future implementations where additional compliance is needed for one or more provisions.

To address potential program deficits, CMS implemented compliance reviews for all noncompliance findings in state and MCP. After reviewing FFY 2022 survey responses for each FFS and MCP, CMS contacted 35 states to request supplemental data and to work with these states to address deficiencies, misinterpretations, errors, and if necessary, to implement corrective action plans for their applicable programs. States were asked to provide explanations for responses indicating noncompliance, actions taken to address the issue, dates involved in

[17] Definitions, 42 C.F.R. § 455.2. https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec455-2.pdf.

implementation, and to provide supportive materials. States were expected to correct errors and discrepancies and take steps to ensure compliance with all federal regulations. All states responded to CMS correspondence regarding compliance with applicable requirements. States either corrected the action or implemented a corrective action plan (CAP) to remediate any identified noncompliance.

CMS will continue to ensure oversight and corrective actions by states as necessary. States not taking remediation action(s) where necessary to come into compliance with amendments made by section 1004 of the SUPPORT Act and implementing regulations would be at risk of the withholding of Federal Financial Participation (FFP) pursuant to regulations in 42 C.F.R. § 430.35.

In addressing noncompliance, it is important to note that six states have categories of medications and services that are excluded from the managed care delivery system and instead are included in FFS pharmacy benefits. These "exclusions" occur when a state excludes certain medications and services from its contract with an MCP, essentially "excluding" them out from that MCP's coverage. In these instances, the MCPs are not responsible for the implementation of applicable DUR edits, reviews, and programs as they are managed by the state through the FFS program. As a result, some noncompliance of MCPs with particular requirements is difficult to evaluate and may have valid underlying rationales, including but not limited to the relevant coverage being excluded from the MCP's contractual obligations, and, therefore, the responsibility of the state and not the MCP. Ultimately, states are responsible for ensuring compliance with all applicable statutory and regulatory requirements.

FFY 2022 survey responses indicate the implementation of section 1004 of the SUPPORT Act standards were similar in states' FFS programs and MCPs. Survey responses also indicated that the majority of programs have implemented opioid edits and other standards required by the amendments made by section 1004 of the SUPPORT Act or have a plan in place to implement those standards in the near future. Variations in the methods used by states to meet the required standards were noted, and further details can be found in state-specific DUR reports on Medicaid.gov. The following are recommendations to help states and MCPs maintain or improve compliance with the amendments made by section 1004 of the SUPPORT Act.

- States should continue to upgrade existing systems from manual to automated retrospective claims review to increase compliance and detect high doses of opioids in a timely and efficient manner.
- States should consider beneficiary specific clinical circumstances when performing reviews.
- In operating their DUR programs, states must adhere to all required federal DUR minimum standards.[18]
- States should continue to strategize to increase access to substance use disorder treatment, such as medications for opioid use disorder (MOUD) and accompanying

[18] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-456/subpart-K/section-456.703

behavioral therapies.

- When certain medications are excluded from MCP contracts and instead included in FFS programs, states should ensure appropriate data sharing between FFS and managed care programs.

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1. Introduction

This report to Congress on state Medicaid Drug Review and Utilization Programs fulfills requirements added by section 1004 of the SUPPORT Act. In particular, section 1902(oo)(2) of the Act, as added by section 1004 of the SUPPORT Act, requires the Secretary of HHS to report annually to Congress on the most recent information submitted by states on their implementation of the DUR requirements added by section 1004 of the SUPPORT Act. This report is based on state activity concerning opioid-related DUR throughout FFY 2022.

Within state Medicaid programs, DUR involves the structured, ongoing review of prescribing by health care providers, dispensing by pharmacists and beneficiary use of medication. DUR encompasses a comprehensive review of beneficiaries' medication use to help ensure appropriate medication decision-making and promote positive outcomes. Potentially inappropriate prescriptions, unexpected and potentially troublesome prescribing or dispensing patterns, and other issues can be identified and addressed through prospective and retrospective DUR activities.

Prospective DUR occurs at the point of dispensing when a pharmacist submits a prescription transaction. The pharmacist will review the specific criteria of the prescription for appropriateness and will also consider all other patient medication use and medical history. This process may be guided by systematic and automated messages sent to the pharmacist, determined by algorithms operating within the electronic claims processing logic. These algorithms are determined by the claim payer organization, including state Medicaid programs. In some cases, the algorithms will require modifications to the original prescription prior to adjudicating the claim. In other cases, algorithms require beneficiary counseling on important interactions, provider override, prior authorization, therapy change or can be designed to prevent the pharmacist from dispensing the prescription entirely. Prospective DUR is an important tool for state Medicaid programs to ensure medication use is appropriate prior to the beneficiary acquiring a medication.

Retrospective DUR occurs after claims have been processed and prescriptions have been dispensed to the beneficiary. Individual prescriptions, or a beneficiary's entire medication history over a period of time, including aggregate dosing or concurrent use of multiple medications, may be analyzed for appropriateness. Any potential inappropriate use may be flagged and associated with patients, prescribers, or pharmacies. Once the issue is identified via retrospective DUR, state Medicaid programs have multiple intervention options to follow up, including, but not limited to, directly contacting beneficiaries or the prescribers of their medication to request or recommend a specific clinical action be taken; providing clinical education to the provider(s); notifying prescribers of beneficiary medications of other prescribers to avoid duplicate or conflicting medications; alerting the Program Integrity Unit (PIU); or restricting beneficiaries to a single prescriber or pharmacy.

Often, prospective and retrospective review activities are synergistic; information gleaned through retrospective DUR claims review can be used to shape effective safety edits that are implemented through prospective DUR, better enabling prescribers and pharmacists to investigate prescription concerns prior to dispensing the medication to the beneficiary. From prospective alerts (which

can incorporate information from the beneficiary claims data), potential issues can be identified to help promote the appropriate prescribing and dispensing of outpatient drugs to beneficiaries. DUR programs play a key role in helping health care systems understand, interpret, and improve the prescribing, administration, and use of medications.

Consistent with section 1927(g)(3)(D) of the Act, CMS requires each state Medicaid program to submit to CMS an annual survey on the operation of its Medicaid DUR program with respect to the FFS delivery system, including information on prescribing patterns, cost savings generated by the state's DUR program, and the state's DUR programs overall operations, including any new or innovative practices. States are required to report on the nature and scope of the prospective and retrospective DUR programs, including a summary of the interventions used in retrospective DUR, an assessment of the education programs deployed, a description of DUR Board activities, as well as an overall assessment of the DUR programs impact on quality of care and cost savings generated from their DUR programs. Additionally, 42 C.F.R. § 438.3(s)(4) and (5) require state contracts for any MCP that cover covered outpatient drugs[19], to require the MCP to operate a DUR program that complies with section 1927(g) of the Act and 42 C.F.R. part 456, subpart K, and to submit detailed information about its DUR program activities annually.

Section 1004 of the SUPPORT Act included measures to combat the opioid crisis, in part, by reducing opioid related abuse and misuse through important opioid specific DUR standards within states' Medicaid FFS programs and MCPs. Consistent with section 1927(g) of the Act, section 1004 of the SUPPORT Act aims to improve the quality of care received by Medicaid beneficiaries by reducing their exposure to hazards resulting from inappropriate prescribing, gross overuse, or inappropriate or medically unnecessary care. These requirements added by section 1004 supplement preexisting DUR standards under section 1927(g) of the Act. States were required to implement section 1004 standards by October 1, 2019. Additionally, states must submit, annually as part of the DUR report under section 1927(g)(3)(D) of the Act, information on activities conducted on their implementation of requirements added by section 1004 of the SUPPORT Act, starting with information collected by CMS from states in 2021, regarding their FFY 2020 activities. In turn, the Secretary of HHS is required to report to Congress on the information submitted by the states, starting with information from states' FFY 2020 DUR reports. This report represents information submitted by the states with information from FFY 2022.

CMS organized this report around these strategic provisions in section 1004 of the SUPPORT Act, with each section identified below detailing specific aspects of states' compliance with requirements:

- Claims review involving prospective safety edits and retrospective reviews monitoring the use of opioids.
- Monitoring the use of antipsychotic medication use in children.
- Identification of FWA of controlled substances.

[19] Covered outpatient drug (COD) are drugs which are treated as a prescribed drug for the purposes of section 1905(a)(12) of the Act, a drug which may be dispensed only upon a prescription (except as provided in paragraphs (2) and (3) of this definition). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-I

This document reports on both FFS programs and MCP responses from the DUR survey regarding section 1004 of the SUPPORT Act implementations. Detailed responses from each state are available in reports on Medicaid.gov. Additionally, as 35 states have multiple MCPs, responses throughout the report are identified as the representative state and total MCPs responding as follows: State (Count of MCPs), i.e., Minnesota (9) represents 9 MCPs in the State of Minnesota responding to a particular question. Individual state MCP reports, attachments, and responses throughout the report can be found on Medicaid.gov.

In reviewing the report, for context on Medicaid populations in FFY 2022 for Medicaid pharmacy benefits, approximately 42% of all Medicaid beneficiaries were enrolled in FFS state Medicaid programs, a 13% increase from FFY 2021, and the other 58% were enrolled in Medicaid MCPs, a 13% decrease from FFY 2021. This shift from MCP to FFS for pharmacy benefits, in part, was related to the California Medicaid program excluding their pharmacy benefits from MCPs and instead including this benefit in their FFS program. There are 51 FFS programs (inclusive of the 50 states and the District of Columbia) and 212 MCPs (inclusive of 35 states) included in this report. Additionally, California, Missouri, North Dakota, Tennessee, West Virginia, and Wisconsin exclude pharmacy benefits from their MCPs and covered this benefit entirely through their FFS program. The MCPs do not administer pharmacy benefits in these six states and only the FFS report from these six states are included in this report.

2. Claims Review

Amendments made by section 1004 of the SUPPORT Act require states have in place: prospective safety edits for opioid prescriptions and an automated claims review process that identifies when an individual enrolled under the Medicaid state plan (or under a waiver of the state plan) is prescribed an opioid in excess of any limitation that may be established by the state.

In implementing the amendments made by section 1004 of the SUPPORT Act, CMS interpreted "safety edits" to refer to the prospective DUR review specified in section 1927(g)(2)(A) of the Act and 42 C.F.R. § 456.703. Prospective safety edits provide for identifying potential problems at POS to engage patients, prescribers, and pharmacists about identifying and mitigating possible opioid misuse and overdose risk at the time of dispensing. The POS safety edits provide real-time information to the pharmacist prior to the prescription being dispensed to a patient but do not necessarily prevent the prescription from being dispensed. When a safety edit is generated, the pharmacist receives an alert. Action is required, as dictated by good clinical practice and the state's predetermined standards, to resolve the alert before the prescription can be dispensed.

A claims review automated process, which CMS interpreted to refer to a retrospective DUR review as defined in section 1927(g)(2)(B) of the Act and 42 C.F.R. § 456.703, provides for additional examination of claims data to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. Retrospective reviews involve reviews of patient drug and disease history, clinician prescribing history, and pharmacy dispensing history information that is generated from claims data after prescriptions have been dispensed to the beneficiary. For many retrospective reviews, to promote appropriate prescribing and utilization of medications, claims data are evaluated against state determined criteria on a regular basis to

identify potential population-wide issues with medication prescriptions based on patterns and do not focus on particular, individual prescriptions. After these reviews, prescribers who are contacted as a result of retrospective DUR review findings often have the opportunity to review prescriptions and diagnosis history and make changes to their prescribing practices and/or individual patient therapies based on the retrospective review intervention. Retrospective claims reviews provide access to more comprehensive information relevant to the prescriptions and services that are being furnished to beneficiaries and better enable and encourage prescribers and pharmacists to minimize opioid risk in their patients while assuring appropriate pain care.

The purpose of the safety edits and claims reviews is to prompt prescribers and pharmacists to conduct additional safety reviews to determine if the patient's opioid use is appropriate and medically necessary and is intended to help protect beneficiaries from serious potential consequences of overutilization, including misuse, opioid use disorder (OUD), overdose and increased side effects. In addition to the risk of OUD, misuse, and diversion, opioids can have side effects, including respiratory depression, confusion, tolerance, and physical dependence. Each state is permitted to specify its safety edits and automated claims review process, with the detailed design and implementation specifications left to the state's discretion to meet state-specific needs.

CMS published final regulations in December 2020[20] that implemented the opioid-related requirements established by amendments made by section 1004 of the SUPPORT Act and further implemented pre-existing DUR provisions under section 1927(g) of the Act in an effort to reduce prescription-related fraud, misuse, and abuse.

Consistent with the Act and federal regulations within 42 C.F.R. § 456.703(h), claims review limitations implemented by states were defined to include:

- Prospective safety edits (as designed and implemented by the state) on early fills on subsequent opioid prescriptions, quantity limits for initial and subsequent fills, the days' supply for initial prescriptions filled for patients not currently receiving opioid therapy, and therapeutically duplicative initial and subsequent fills.
- Prospective safety edits (as designed and implemented by the state) on the maximum daily morphine equivalent for treatment of pain for initial and subsequent fills.
- Retrospective claims review automated process (and, at the option of the state, prospective safety edits) that monitors when an individual is concurrently prescribed opioids and benzodiazepines or antipsychotics.
- Retrospective claims review automated processes (as designed and implemented by the state) that indicate prescription fills of opioids in excess of the foregoing limits to provide for ongoing review of opioid claims data to identify patterns of fraud, abuse, and excessive utilization.

These safety edits and claims review limitations implemented by states are intended to protect Medicaid patients from serious consequences of opioid overutilization, dependence, overdose,

[20] CMS 2482-F, Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability (TPL) Requirements. https://www.federalregister.gov/documents/2020/12/31/2020-28567/medicaid-program-establishing-minimum-standards-in-medicaid-state-drug-utilization-review-dur-and

dangerous interactions, increased side effects, and additive toxicity (i.e., additive side effects). States are required to ensure that opioid reviews consistent with current clinical practice are included within their DUR programs pursuant to 1927(g)(2)(C) and 42 C.F.R. § 456.703(f). States are encouraged to develop prospective and retrospective drug review parameters consistent with current clinical practice and to address medical practice patterns in the state, to help meet the health care needs of their Medicaid patient population. Additionally, none of the required safety reviews prohibit the exercise of clinical judgment by a provider regarding the most appropriate care and treatment for any patient. In some cases safety edits may prevent the fulfilment of inappropriate or harmful prescriptions supporting provider clinical decision making. These reviews serve to ensure safety standards and protocols are met but they do not prohibit a provider from exercising their clinical judgement and discretion to determine the most appropriate care and treatment for any beneficiary based on their unique circumstance.

Additionally, the above described DUR requirements added to section 1902(oo) of the Act by section 1004 of the SUPPORT Act do not apply to individuals who are receiving hospice or palliative care, individuals receiving treatment for cancer, residents of a long-term care facility, a facility described in section 1905(d) of the Act (that is, an intermediate care facility for those with intellectual disabilities), or of another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy, and other individuals the state elects to treat as exempt from such requirements. States have considerable flexibility with DUR reviews to address complex patient populations, and the exclusion at 42 C.F.R. § 456.703(h)(2) specifies that states are not required to implement the otherwise applicable opioid DUR requirements with respect to these populations.

States are expected to consult national guidelines and are encouraged to work with their pharmacy and therapeutics (P&T) and DUR committees to identify other clinically appropriate patient populations, such as sickle cell crisis patients, for possible exclusion from the safety reviews specified in 42 C.F.R. § 456.703(h)(1)(i) through (vii) to avoid impeding critical access to needed medication when managing specific complex disease states.

The following sections provide the survey results for state Medicaid programs related to these safety edits and claims reviews on opioid prescriptions.

2.1. Prospective Safety Edit Limitations for Opioid Prescriptions

Amendments made by section 1004 of the SUPPORT Act require states to have in place prospective safety edits (as specified by the state) for subsequent fills for opioids that indicate when an individual enrolled under the state plan (or under a waiver of the state plan) is prescribed a subsequent fill of opioids in excess of any limitation that may be identified by the state. Consistent with amendments made by section 1004 of the SUPPORT Act and pre-existing DUR requirements under section 1927(g)(2)(A) of the Act, state-identified limitations must include safety edits on opioid prescriptions, as specified below, to identify patterns of fraud, abuse, excessive utilization, or inappropriate or medically unnecessary care, or prescribing or billing practices that indicate inappropriate or excessive utilization among physicians, pharmacists and

individuals receiving Medicaid benefits (see 42 C.F.R. § 456.703(h)(1)):

- Early fills on subsequent opioid prescriptions;
- Quantity limits for initial and subsequent fills;
- Days' supply for initial prescriptions filled for patients not currently receiving opioid therapy; and
- Therapeutically duplicative fills for initial and subsequent fills.

These safety edits reinforce efforts to combat the nation's opioid crisis and help ensure DUR opioid reviews are consistent with current clinical practice. They are intended to protect Medicaid patients from serious consequences of overutilization, including overdose, drug interactions, increased side effects, and additive toxicity (additive side effects). In addition, overutilization of opioids may serve as an indication for potential OUD and the need for increased monitoring and coordination of care.

2.1.1. Early Refills for Subsequent Prescription Fills

Amendments made by section 1004 of the SUPPORT Act require that states establish safety edits to alert the dispenser before a prescription is filled prior to the previous supply being completed for an opioid product, based on the days' supply provided at the most recent fill. These early fill safety edits on opioids are intended to protect beneficiaries from adverse events associated with using opioid medication beyond the prescribed dose schedule. Monitoring for possible early refills for an individual also minimizes the extent to which extra opioids might be dispensed and thus subject to possible diversion to other individuals.

Depending on state specific designs, a prior authorization may be required to be submitted by the prescriber or pharmacist to override an early refill alert and adjudicate the claim. Prior authorization is an additional administrative step where the prescriber is required to provide supplementary information to justify the necessity for an override of a prospective edit, such as early refill. Alternatively, in some states, the early refill percent threshold may be overridden via the claims adjudication process by the pharmacist using standardized codes. These codes are entered onto the claim to indicate, based on the pharmacist's review, that the prescription can be filled. In these instances, if the pharmacist overrides the early refill alert, the claim will be adjudicated, and the prescription can be dispensed to the beneficiary.

In consideration of clinical recommendations to limit opioid use to only when necessary and as prescribed, safety edits for early refills help ensure that opioid prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results and accomplish the purposes of the DUR program under section 1927(g) of the Act and of the amendments made by section 1004 of the SUPPORT Act.

Under the Controlled Substances Act (CSA), the Drug Enforcement Administration (DEA) classifies drugs into schedules based on their medical value and potential for misuse. Currently, there are five schedules for controlled drugs, schedules I through V. Schedule I drugs have no medical value and high potential for misuse, while schedule II through V substances all have some medical value but differ in ranking depending on their potential for misuse (from high to

low, respectively).

Early refill is defined as when the patient requests a refill prior to the date when they are eligible based on the directions of the prescription and quantity prescribed and are designed to minimize the excessive use, waste, and stockpiling of prescription medications. Based on FFY 2022 survey responses, as seen in Table 1, for FFS programs, the early refill percent for schedule II drugs ranged between 75% and 100%, and for schedules III through V, the early refill percent ranged between 75% and 95%. For MCPs, the average early refill percent for schedule II drugs ranged between 81% and 90%, and for schedules III through V, early refill percent ranged between 80% and 90%.

Table 1 FFS and MCP Early Refill Percent Safety Edit for Controlled Drugs

State	FFS		MCP (Average by State)*	
	Schedule II Controlled Drugs**	Schedule III - V Controlled Drugs	Schedule II Controlled Drugs***	Schedule III - V Controlled Drugs
Alabama	75%	75%	N/A	N/A
Alaska	93%	75%	N/A	N/A
Arizona	85%	85%	85%	85%
Arkansas	90%	90%	90%	90%
California	90%	90%	N/A	N/A
Colorado	85%	85%	88%	83%
Connecticut	93%	93%	N/A	N/A
Delaware	90%	90%	83%	83%
District of Columbia	80%	80%	81%	81%
Florida	90%	90%	86%	87%
Georgia	85%	85%	90%	88%
Hawaii	90%	90%	83%	83%
Idaho	75%	75%	N/A	N/A
Illinois	90%	90%	82%	82%
Indiana	85%	85%	86%	85%
Iowa	90%	90%	90%	90%
Kansas	90%	80%	90%	90%
Kentucky	90%	80%	90%	80%
Louisiana	90%	90%	90%	90%
Maine	85%	85%	N/A	N/A
Maryland	85%	85%	86%	86%
Massachusetts	85%	85%	82%	80%
Michigan	90%	90%	90%	90%
Minnesota	85%	85%	86%	86%
Mississippi	85%	85%	85%	85%
Missouri	85%	85%	N/A	N/A
Montana	90%	90%	N/A	N/A
Nebraska	90%	90%	90%	90%
Nevada	90%	90%	90%	90%
New Hampshire	80%	80%	83%	83%

State	FFS		MCP (Average by State)*	
	Schedule II Controlled Drugs**	Schedule III - V Controlled Drugs	Schedule II Controlled Drugs***	Schedule III - V Controlled Drugs
New Jersey	85%	85%	88%	88%
New Mexico	90%	75%	85%	85%
New York	75%	75%	83%	83%
North Carolina	85%	85%	85%	85%
North Dakota	87%	87%	N/A	N/A
Ohio	90%	90%	87%	86%
Oklahoma	90%	90%	N/A	N/A
Oregon	80%	80%	84%	84%
Pennsylvania	85%	85%	85%	85%
Rhode Island	85%	85%	87%	83%
South Carolina	100%	85%	84%	84%
South Dakota	85%	85%	N/A	N/A
Tennessee	95%	95%	N/A	N/A
Texas	90%	90%	86%	86%
Utah	85%	85%	86%	86%
Vermont	85%	85%	N/A	N/A
Virginia	90%	75%	87%	87%
Washington	75%	75%	84%	84%
West Virginia	85%	85%	N/A	N/A
Wisconsin	80%	80%	N/A	N/A
Wyoming	90%	90%	N/A	N/A
National Average	**87%**	**85%**	**86%**	**86%**

* 35 states have submitted 212 Medicaid MCP DUR Annual FFY 2022 survey responses. States that do not have MCPs or have pharmacy benefits excluded from MCP contracts are noted by N/A on the chart above.

** While CII prescriptions are not refillable, partial refills can be authorized. Additionally, early refill edits can determine when a subsequent prescription is filled too early.

*** Ibid.

As shown in Tables 2 and 3 below, based on FFY 2022 survey responses, 100% of FFS and MCPs have safety edits or retrospective reviews to monitor early refills of opioid prescriptions dispensed. Additionally, several programs (51% of FFS, and 49% of MCPs) indicated having both safety edits and automated retrospective reviews on opioid early refill claims.

Table 2 FFS Safety Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

Response	States	Total	Percent of Total
Yes, Automated Retrospective Claims Review Process	Tennessee	1	2%

Response	States	Total	Percent of Total
Yes, Both Safety Edits and Automated Retrospective Claims Review Process	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Iowa, Kansas, Louisiana, Maryland, Mississippi, Nebraska, New York, North Carolina, North Dakota, Oregon, South Dakota, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin	26	51%
Yes, Safety Edits	Arizona, Arkansas, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Virginia, Wyoming	24	47%
National Totals		**51**	**100%**

Table 3 MCP Safety Edits to Monitor Early Refills of Opioid Prescriptions Dispensed

Response	States (Count of MCPs)	Total	Percent of Total
Yes, Automated Retrospective Claims Review Process	Florida (1), Minnesota (3)	4	2%
Yes, Both Safety Edits and Automated Retrospective Claims Review Process	Arizona (6), Colorado (2), Delaware (1), District of Columbia (2), Florida (4), Hawaii (2), Illinois (2), Indiana (1), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (3), Massachusetts (1), Michigan (5), Minnesota (3), Mississippi (2), Nebraska (2), Nevada (2), New Jersey (3), New York (7), North Carolina (2), Ohio (3), Oregon (21), Pennsylvania (5), Rhode Island (1), South Carolina (1), Texas (1), Virginia (3), Washington (3)	104	49%
Yes, Safety Edits	Arizona (1), Arkansas (4), Delaware (1), District of Columbia (2), Florida (6), Georgia (3), Hawaii (4), Illinois (4), Indiana (4), Maryland (6), Massachusetts (4), Michigan (4), Minnesota (3), Mississippi (1), Nebraska (1), Nevada (2), New Hampshire (3), New Jersey (2), New Mexico (3), New York (7), North Carolina (3), Ohio (2), Pennsylvania (3), Rhode Island (2), South Carolina (4), Texas (15), Utah (4), Virginia (3), Washington (2)	103	49%
National Totals		**211***	**100%**

* While there was a total of 212 MCPs, the New York MCP "Healthfirst" reported that opioids are excluded from MCP contracts and handled by the state's FFS program. This resulted in MCP counts for some questions related to opioids having a national total of 211.

2.1.2. Quantity of Prescription Dispensed for Initial and Subsequent Prescription Fills

Dose optimization is a method to consolidate the quantity of medication dispensed to the smallest amount required to achieve the desired daily dose and regimen. With these edits, states use maximum dosing and schedules to establish quantity limits for the quantity of opioids that are allowed per day without triggering the safety edit. Minimizing the medication burden (e.g., number of tablets or capsules that must be taken) improves patient compliance with taking medication as directed. Dosage optimization seeks to prospectively identify patients who have been prescribed multiple units of a dosage formulation (e.g., tablets, capsules, etc.) per day of a lower strength medication meant to be taken together to achieve higher dose, when a higher strength of medication is already available (e.g., the patient is prescribed two, 5 mg tablets, when a 10 mg strength is available in one tablet). Performing this intervention with medications that are available in multiple strengths can also yield significant drug cost savings.

When implementing section 1927(g)(1) of the Act and the amendments made by section 1004 of the SUPPORT Act, states were required to establish safety edits to implement quantity limits on initial and subsequent fills, as designed and identified by the state per 42 C.F.R. § 456.703(h)(1)(i)(B). States are encouraged to take clinical indications and dosing schedules into account when establishing quantity limits to restrict the quantity of opioids per day to help ensure dose optimization and minimize potential for waste and diversion.

Consistent with the requirements added by section 1004 of the SUPPORT Act, FFY 2022 responses indicate that almost all programs have safety edit(s) in place to limit the quantity dispensed of an initial opioid prescription, whether it is a quantity edit to limit short-acting opioids, long-acting opioids, or both. Pursuant to DEA Regulations found at 21 C.F.R. § 1306.24 (c)(1), not more than a 34-day supply or 100 dosage units, whichever is less, of a controlled substance listed in Schedule III, IV, or V should be dispensed on a labeled prescription at one time. FFY 2022 survey responses show that 100% of FFS and 93% of MCPs have safety edits in place to limit the quantity dispensed of opioids to specific quantities. These edits were established taking clinical indications and dosing schedules into account to restrict the number of opioids to the lowest quantity per day to ensure dose optimization and to minimize potential for waste and diversion. FFS and MCPs that have safety edits in place to limit the quantity of short-acting opioids are shown in Tables 4 and 5. The MCPs that responded “No,” did not have safety edits to limit the quantity of opioids dispensed, but reported having other measures in place, including safety edits based upon days’ supply or total morphine milligram equivalent (MME) daily dose, or prior authorizations.

Table 4 FFS Safety Edits in Place to Limit the Quantity Dispensed of Opioids

Response	States	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	51	100%
National Totals		**51**	**100%**

Table 5 MCP Safety Edits in Place to Limit the Quantity Dispensed of Opioids

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (18), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (5), Utah (4), Virginia (6), Washington (5)	196	93%
No	Florida (1), Oregon (3), Texas (11)	15	7%
National Totals		**211***	**100%**

* While there was a total of 212 MCPs, the New York MCP "Healthfirst" reported that opioids are excluded from MCP contracts and handled by the state's FFS program. This resulted in MCP counts for some questions related to opioids having a national total of 211.

As shown in Table 6 and 7, FFY 2022 survey responses show that 24% of FFS and 13% of MCPs have safety edits in place to limit the quantity dispensed of short-acting opioids to specific quantities.

Table 6 FFS Safety Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

Response	States	Total	Percent of Total
Yes	Arizona, California, Indiana, Louisiana, Mississippi, Nebraska, Oklahoma, Rhode Island, South Carolina, Utah, West Virginia, Wisconsin	12	24%
Other*	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wyoming	39	76%
National Totals		**51**	**100%**

* As there are no specific federal requirements for short and long-acting drugs, there is discretion how this edit is applied. Program details can be found on Medicaid.gov.

Table 7 MCP Safety Edits in Place to Limit the Quantity Dispensed of Short-Acting Opioids

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (1), Arkansas (1), Delaware (1), District of Columbia (1), Indiana (2), Louisiana (3), Massachusetts (1), Mississippi (2), Nebraska (2), New York (3), Ohio (1), Oregon (3), Pennsylvania (1), South Carolina (1), Utah (3)	26	13%
Other*	Arizona (6), Arkansas (3), Colorado (2), Delaware (1), District of Columbia (3), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (3), Iowa (2), Kansas (3), Kentucky (6), Louisiana (2), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (9), Mississippi (1), Nebraska (1), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (11), North Carolina (5), Ohio (4), Oregon (15), Pennsylvania (7), Rhode Island (3), South Carolina (4), Texas (5), Utah (1), Virginia (6), Washington (5)	170	87%
National Totals		**196**	**100%**

*As there are no specific federal requirements for short and long-acting drugs, there is discretion how this edit is applied. Program details can be found on Medicaid.gov.

Long-acting opioids often have higher doses or potency, and patient safety may require extra scrutiny via safety edits compared to short-acting opioids; long-acting opioids are generally recommended only in specific circumstances.[21] State responses in Tables 8 and 9 show that

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almost all programs (94% of FFS and 98% of MCPs) have safety edits in place to limit the quantity dispensed of long-acting opioids.

Table 8 FFS Safety Edits to Limit the Quantity Dispensed of Long-Acting Opioids

Response	States	Total	Percent of Total
Yes	California, Indiana, Louisiana, Mississippi, South Carolina, South Dakota, West Virginia	7	14%
No	Arizona, Rhode Island, Washington	3	6%
Other*	Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin, Wyoming	41	80%
National Totals		**51**	**100%**

*As there are no specific federal requirements for short and long-acting drugs, there is discretion how this edit is applied. Program details can be found on Medicaid.gov.

Table 9 MCP Safety Edits to Limit the Quantity Dispensed of Long-Acting Opioids

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Florida (1), Indiana (2), Louisiana (2), Massachusetts (1), Mississippi (2), New York (3), Pennsylvania (1), South Carolina (1), Utah (3)	16	8%
No	Arizona (1), Minnesota (1), Pennsylvania (1)	3	2%
Other*	Arizona (6), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (9), Georgia (3), Hawaii (6), Illinois (6), Indiana (3), Iowa (2), Kansas (3), Kentucky (6), Louisiana (3), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (8), Mississippi (1), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (11), North Carolina (5), Ohio (5), Oregon (18), Pennsylvania (6), Rhode Island (3), South Carolina (4), Texas (5), Utah (1), Virginia (6), Washington (5)	177	90%
National Totals		**196**	**100%**

Fact Sheet for Prescribing Opioids for Pain. https://www.cdc.gov/overdose-prevention/?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-providers-a.pdf

*As there are no specific federal requirements for short and long-acting drugs, there is discretion how this edit is applied. Program details can be found on Medicaid.gov.

2.1.3. Days' Supply

Consistent with section 1927(g)(1) of the Act and the amendments made by section 1004 of the SUPPORT Act as implemented in CMS 2482-F, states are required to establish safety edit limitations on the days' supply for an initial opioid prescription fill for beneficiaries who have not filled an opioid prescription within a defined period of time, as specified by the state. Patients who have not received an opioid prescription within a specified timeframe determined by the state are referred to as opioid naïve and would be subjected to the days' supply limit on an opioid prescription. In most cases, "days' supply" is calculated by dividing the dispensed quantity of medication by the amount of the medication to be taken by the patient in one day per the prescribers' instructions. In other circumstances, "days' supply" means how many days the supply of dispensed medication is intended to last. While the amendments made by section 1004 of the SUPPORT Act mention limits on subsequent fills of opioids, consistent with section 1927(g) of the Act, this safety edit was also implemented on initial fills of opioids through rulemaking, to help avoid excessive utilization by opioid naïve beneficiaries, with its attendant risk of adverse effects.

The 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain recommends that clinicians maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute, subacute, and chronic pain if benefits are anticipated to outweigh risks to the patient.[22] Clinical evidence cited by the CDC 2022 Clinical Practice Guideline for Prescribing Opioids for Pain review found that opioid use for acute pain is associated with long-term opioid use, and that a greater amount of early opioid exposure is associated with greater risk for long-term use. An expected physiologic response in patients exposed to opioids for more than a few days is physical dependence, and the chances of long-term opioid use begin to increase after just 3 days of use and rise rapidly thereafter.[23] Limiting days for which opioids are prescribed for opioid naïve patients could minimize the need to taper opioids.[24]

State responses in Tables 10 and 11 show that almost all programs (96% in FFS and 99% in MCPs) have safety edits in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients. FFY 2022 survey responses show that programs vary in whether the initial day supply limit applies to all or just select opioid prescriptions or if other special considerations are made. Further details can be found in state specific reports on Medicaid.gov.

[22] Guideline: Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1
[23] Shah A., Hayes C.J., Martin B.C. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. Morbidity and Mortality Weekly Report 2017; 66:265–269 [Accessed February 11, 2019, at http://dx.doi.org/10.15585/mmwr.mm6610a1].
[24] Ibid.

Table 10 FFS Days' Supply Limitation of an Initial Opioid Prescription for Opioid Naive Patients*

Response	States	Total	Percent of Total
Yes, For All Opioids	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin, Wyoming	39	76%
Yes, For Some Opioids	Hawaii, Kansas, Louisiana, Michigan, Montana, New Mexico, New York, Oklahoma, Rhode Island, Utah	10	20%
No	North Carolina**, West Virginia***	2	4%
National Totals		**51**	**100%**

* States are required to establish safety edit limitations on the days' supply for an initial opioid prescription fill for beneficiaries who have not filled an opioid prescription within a defined period of time, as specified by the state.
**Based upon data collected in FFY 2022, North Carolina responded "No" to this question, but the explanation section clarified that North Carolina FFS has a Days' Supply limitation for drugs that are DEA Scheduled II-IV.
***Based on data collected in FFY 2022, West Virginia Medicaid limits quantity dispensed but not days' supply.

Table 11 MCP Days' Supply Limitation of an Initial Opioid Prescription for Opioid Naïve Patients

Response	States (Count of MCPs)	Total	Percent of Total
Yes, For All Opioids	Arizona (3), Arkansas (4), Colorado (1), Delaware (1), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (3), Indiana (4), Iowa (2), Kentucky (6), Louisiana (3), Maryland (7), Massachusetts (3), Michigan (6), Minnesota (7), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (10), North Carolina (5), Ohio (5), Oregon (19), Pennsylvania (6), Rhode Island (1), South Carolina (5), Texas (14), Utah (2), Virginia (5), Washington (5)	171	81%
Yes, For Some Opioids	Arizona (4), Colorado (1), Delaware (1), Florida (1), Illinois (3), Indiana (1), Kansas (3), Louisiana (2), Maryland (2), Massachusetts (1), Michigan (3), Minnesota (2), New York (4), Oregon (2), Pennsylvania (2), Texas (2), Utah (2), Virginia (1)	37	18%
No	Massachusetts (1), Rhode Island (2)	3	1%

Response	States (Count of MCPs)	Total	Percent of Total
National Totals		**211***	**100%**

* One New York MCP responded the state excluded opioids from the MCP contract which subsequently removed them from the denominator

FFY 2022 survey responses displayed in Table 12 show that each program has varied maximum number of days allowed for an initial opioid prescription for an opioid naïve patient. FFS programs range from 5-34 days allowed, with a national average of 10 days. The MCPs range from 5-30 days allowed for an initial opioid prescription with a national average of 8 days.

Table 12 FFS/MCP Maximum Number of Days Allowed for an Initial Opioid Prescription for an Opioid Naïve Patient

State	FFS Maximum Days	MCP Maximum Days * (State Average)
Alabama	7	N/A
Alaska	34	N/A
Arizona	5	5
Arkansas	7	7
California	7	N/A
Colorado	7	7
Connecticut	7	N/A
Delaware	7	6
District of Columbia	7	7
Florida	14	6
Georgia	7	7
Hawaii	30	11
Idaho	7	N/A
Illinois	7	11
Indiana	7	7
Iowa	7	7
Kansas	7	7
Kentucky	7	7
Louisiana	7	7
Maine	7	N/A
Maryland	7	7
Massachusetts	7	7
Michigan	7	7
Minnesota	7	7
Mississippi	7	7
Missouri	7	N/A
Montana	7	N/A
Nebraska	7	7
Nevada	7	7

State	FFS Maximum Days	MCP Maximum Days * (State Average)
New Hampshire	34	25
New Jersey	5	5
New Mexico	7	7
New York	7	7
North Carolina	N/A	6
North Dakota	7	N/A
Ohio	7	7
Oklahoma	7	N/A
Oregon	7	7
Pennsylvania	5	5
Rhode Island	30	30
South Carolina	5	7
South Dakota	7	N/A
Tennessee	5	N/A
Texas	10	10
Utah	7	7
Vermont	7	N/A
Virginia	7	7
Washington	7	7
West Virginia	N/A	N/A
Wisconsin	34	N/A
Wyoming	7	N/A
National Average	**10**	**8**

* Thirty-five states have submitted 212 Medicaid MCP DUR Annual FFY 2022 survey responses. California, Missouri, North Dakota, Tennessee, Wisconsin, and West Virginia have their covered outpatient drugs excluded from MCP contracts and managed by their FFS program.

In addition to safety edits on days' supply and quantity limits, states may establish other reasonable and appropriate drug utilization management reviews that assist in safe administration of prescribed medications, including, but not limited to, concurrent use of opioids with other medications, interactions between patients' medical conditions and opioid use, and the number of unique prescribers and pharmacies used by a patient to obtain opioids.

State survey responses in Tables 13 and 14 show that all programs (100% of FFS and MCPs) have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids. Further details can be found in state specific reports on Medicaid.gov.

Table 13 FFS Measures Other Than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	51	100%
National Totals		**51**	**100%**

Table 14 MCP Measures Other Than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	211	100%
National Totals		**211***	**100%**

* One New York MCP responded that the state excluded opioids from the MCP contract which subsequently removed them from the denominator

Table 15 FFS Measures Other Than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States	Total	Percent
Deny claim and require PA	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin	48	94%
Intervention letters	Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, Wisconsin, Wyoming	35	69%
MME daily dose program	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	50	98%
Pharmacist override	Alabama, Georgia, Idaho, Louisiana, Massachusetts, Mississippi, Nebraska, North Carolina, South Carolina, Utah, West Virginia, Wisconsin	12	24%
Require diagnosis	Alabama, Alaska, Arizona, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington	34	67%
Require documentation of urine drug screening results	Alabama, Alaska, Delaware, Georgia, Illinois, Kansas, Kentucky, Maine, Maryland, Michigan, Montana, Ohio, Oregon, Pennsylvania, Virginia, Washington	16	31%

Response	States	Total	Percent
Requirement that patient has a pain management contract or Patient-Provider agreement	Alabama, Alaska, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia	28	55%
Requirement that prescriber has an opioid treatment plan for patients	Alabama, Alaska, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Kansas, Maine, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Utah, Virginia, Washington, West Virginia	25	49%
Require Prescription Drug Monitoring Program (PDMP) checks	Alabama, California, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	37	73%
Step therapy or clinical criteria	Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	42	82%
Workgroups to address opioids	Alabama, Alaska, California, Delaware, Idaho, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Missouri, South Carolina, South Dakota, Utah	14	27%
Other	Arizona, Colorado, District of Columbia, Idaho, Illinois, Indiana, Kansas, Louisiana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, West Virginia	15	29%

Table 16 MCP Measures Other Than Restricted Quantities and Days' Supply in Place to Either Monitor or Manage the Prescribing of Opioids

Response	States (Count of MCPs)	Total	Percent
Deny claim and require PA	Arizona (7), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (5), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Maryland (8), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (4), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (19), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (15), Utah (4), Virginia (6), Washington (5)	202	96%

Response	States (Count of MCPs)	Total	Percent
Intervention letters	Arizona (4), Arkansas (4), Colorado (1), Delaware (2), District of Columbia (2), Florida (8), Georgia (3), Hawaii (3), Illinois (3), Indiana (4), Kansas (2), Louisiana (5), Maryland (4), Massachusetts (2), Michigan (3), Minnesota (4), Mississippi (3), Nebraska (2), Nevada (4), New Hampshire (2), New Jersey (2), New Mexico (2), New York (9), North Carolina (3), Ohio (4), Oregon (14), Pennsylvania (4), Rhode Island (2), South Carolina (3), Texas (5), Utah (2), Virginia (5), Washington (3)	123	58%
Morphine Milligram Equivalent (MME) daily dose program	Arizona (7), Arkansas (4), Colorado (2), Delaware (1), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (13), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (2), South Carolina (5), Texas (15), Utah (4), Virginia (6), Washington (5)	206	98%
Pharmacist override	Arizona (4), Arkansas (3), Colorado (2), Delaware (1), Florida (7), Hawaii (4), Illinois (2), Indiana (2), Kansas (1), Kentucky (6), Louisiana (1), Maryland (3), Massachusetts (3), Michigan (6), Minnesota (5), Mississippi (2), Nebraska (2), Nevada (1), New Hampshire (1), New Jersey (3), New Mexico (1), New York (7), North Carolina (3), Ohio (2), Oregon (16), Pennsylvania (2), Rhode Island (1), South Carolina (2), Texas (1), Utah (2), Virginia (3), Washington (5)	104	49%
Require diagnosis	Arizona (7), Arkansas (3), Delaware (2), District of Columbia (2), Florida (10), Georgia (2), Hawaii (4), Illinois (3), Indiana (5), Kansas (2), Kentucky (4), Louisiana (3), Maryland (6), Massachusetts (3), Michigan (5), Minnesota (5), Mississippi (1), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (4), New Mexico (2), New York (8), North Carolina (3), Ohio (4), Oregon (16), Pennsylvania (7), Rhode Island (3), South Carolina (4), Texas (12), Utah (3), Virginia (6), Washington (4)	152	72%
Require PDMP checks	Arizona (5), Arkansas (1), Colorado (1), Delaware (2), District of Columbia (4), Florida (10), Georgia (2), Hawaii (3), Illinois (3), Indiana (1), Iowa (2), Kansas (3), Kentucky (6), Louisiana (2), Maryland (8), Massachusetts (1), Michigan (5), Minnesota (5), Mississippi (2), Nebraska (1), Nevada (3), New Hampshire (3), New Jersey (2), New Mexico (2), New York (7), North Carolina (3), Ohio (5), Oregon (7), Pennsylvania (7), Rhode Island (1), South Carolina (3), Texas (1), Utah (3), Virginia (6), Washington (5)	125	59%

Response	States (Count of MCPs)	Total	Percent
Requirement that patient has a pain management contract or Patient-Provider agreement	Arizona (4), Colorado (1), Delaware (2), District of Columbia (3), Florida (9), Georgia (1), Hawaii (3), Illinois (3), Indiana (1), Iowa (2), Kansas (3), Louisiana (4), Maryland (8), Massachusetts (3), Michigan (5), Minnesota (4), Nebraska (2), New Hampshire (3), New Jersey (1), New Mexico (1), New York (5), North Carolina (2), Ohio (3), Oregon (7), Pennsylvania (4), Rhode Island (2), South Carolina (3), Utah (3), Virginia (5), Washington (4)	101	48%
Requirement that prescriber has an opioid treatment plan for patients	Arizona (5), Colorado (1), Delaware (2), District of Columbia (3), Florida (9), Georgia (2), Hawaii (3), Illinois (2), Indiana (3), Kansas (2), Kentucky (6), Maryland (5), Massachusetts (2), Michigan (5), Minnesota (4), Mississippi (1), Nebraska (2), Nevada (3), New Hampshire (2), New Jersey (2), New Mexico (1), New York (5), North Carolina (2), Ohio (4), Oregon (8), Pennsylvania (6), Rhode Island (1), South Carolina (4), Texas (2), Utah (3), Virginia (6), Washington (4)	110	52%
Step therapy or Clinical criteria	Arizona (6), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (3), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (4), Maryland (7), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (13), North Carolina (5), Ohio (5), Oregon (19), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (15), Utah (4), Virginia (6), Washington (5)	201	95%
Workgroups to address opioids	Arizona (4), Arkansas (1), Delaware (1), Florida (2), Georgia (1), Hawaii (2), Illinois (2), Indiana (1), Kansas (1), Louisiana (2), Maryland (4), Michigan (2), Minnesota (2), Mississippi (1), Nebraska (1), Nevada (2), New Jersey (1), New Mexico (2), New York (5), North Carolina (2), Ohio (2), Oregon (11), Pennsylvania (4), South Carolina (3), Texas (3), Utah (2), Virginia (1), Washington (2)	67	32%
Other	Arkansas (3), Colorado (1), Delaware (2), Florida (5), Georgia (2), Hawaii (2), Illinois (3), Indiana (4), Kansas (2), Kentucky (2), Louisiana (4), Maryland (2), Massachusetts (3), Michigan (4), Minnesota (4), Mississippi (2), Nebraska (1), Nevada (3), New Hampshire (1), New Jersey (2), New Mexico (2), New York (7), North Carolina (2), Ohio (2), Oregon (6), Pennsylvania (4), Rhode Island (2), South Carolina (2), Texas (6), Utah (3), Virginia (2), Washington (1)	91	43%

2.1.4. Therapeutic Duplication

When implementing section 1927(g)(1) of the Act and section 1004 of the SUPPORT Act, in accordance with the requirements finalized in CMS 2482-F, states are required to establish safety edits to alert the dispenser to potential therapeutic duplication before a prescription is filled for an opioid product that is in the same therapeutic class as an opioid product currently being prescribed for the beneficiary. Prescriptions for multiple opioids and multiple strengths of opioids increase the supply of opioids available for diversion and misuse, as well as the opportunity for self-

medication and dose escalation.[25]

Some patients, especially those living with multiple chronic conditions, may consult multiple physicians, which can put them at risk of receiving multiple medications in the same therapeutic class for the same diagnosis.[26] In some instances, the side-effects produced by overmedication due to the duplication of prescriptions within the same therapeutic class are more serious than the original condition.[27] Opioid duplicate safety edits for initial and subsequent prescription fills help to avoid inappropriate or unnecessary therapeutic duplication when simultaneous use of multiple opioids is detected. These types of safety alerts can also help to identify when prescription drugs are being misused or if patients are moving from provider to provider to obtain multiple prescriptions for their drug(s) of choice. States must also determine what constitutes therapeutic duplication as opposed to appropriate care. For example, a common clinical therapy regimen for patients with chronic pain may include a patient using both an extended-release opioid and an immediate-release opioid for breakthrough pain. States may choose to not define this as therapeutic duplication.

FFY 2022 survey responses shown in Tables 17 and 18 that the majority of programs (98% of FFS and 99% of MCPs) have safety edits to monitor duplicate therapy of opioid prescriptions dispensed. FFY 2022 FFS responses indicating compliance with this requirement decreased by 2% compared with from FFY 2021, and MCP responses decreased by 1%. This excludes regimens that include a single extended-release product and a breakthrough short-acting agent.

Table 17 FFS Safety Edits to Monitor Duplicate Therapy of Opioid Prescriptions

Response	States	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	98%
No	New Mexico*	1	2%
National Totals		**51**	**100%**

*In explanation for responding No, New Mexico FFS reported: *"There is not a therapeutic duplication edit*

[25] Manchikanti, Laxmaiah, et al. "Opioid Epidemic in the United States." Pain Physician, U.S. National Library of Medicine, July 2012, www.ncbi.nlm.nih.gov/pubmed/22786464.
[26] Ibid.
[27] "Therapeutic Duplication." Journal of the American Medical Association, vol. 160, no. 9, 1956, p. 780., doi:10.1001/jama.1956.02960440052016.

for opioids, but there is a therapeutic duplication edit at POS that will capture opioid duplication".

Table 18 MCP Safety Edits in Place to Monitor Duplicate Therapy of Opioid Prescriptions

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	210	99%
No	Michigan (1)*	1	1%
National Totals		**211**	**100%**

*One MCP in Michigan sets safety edits related to the MME Cumulative Daily Dose.

2.2. Morphine Milligram Equivalent (MME) Daily Dose

Amendments made by section 1004 of the SUPPORT Act require state DUR programs to include safety edit limits (as specified by the state) on the maximum daily morphine equivalent (MME) that can be prescribed to an individual enrolled under the state plan (or under a waiver of the state plan) for treatment of chronic pain (as designed and implemented by the state) that indicate when an individual enrolled under the plan (or waiver) is prescribed the morphine equivalent for such treatment in excess of any threshold identified by the state.[28] Section 1004 of the SUPPORT Act specifically addresses MME limitations in the context of chronic pain. According to the CDC, acute pain is usually sudden in onset and time limited (defined in the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain as having a duration of <1 month) and often is caused by injury, trauma, or medical treatments such as surgery. For example, acute pain can be caused by a broken bone after an automobile accident, surgery, or a wisdom tooth extraction. Unresolved acute pain or subacute pain can evolve into chronic pain.[29] Chronic pain typically lasts >3 months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause.[30] Regarding chronic pain, the CDC indicates clinicians should: discuss with patients the realistic benefits and known risks of opioid therapy, work with patients to establish treatment goals for pain and function, and consider how opioid therapy will be discontinued if benefits do not outweigh the risks.[31]

[28] Section 1902(oo)(1)(A)(i)(II) of the Act, as added by section 1004 of the SUPPORT for Patients and Communities Act.
[29] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.
DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1
[30] Ibid.
[31] Ibid.

MME safety edits include an MME threshold amount to meet statutory requirements, to assist in identifying patients at potentially high clinical risk who may benefit from closer monitoring and care coordination. Calculating the total daily dosage of opioids helps identify patients who may benefit from closer monitoring, tapering of opioids, prescribing of a medication for the reversal of opioid overdoses such as naloxone, or other measures to reduce risk of respiratory failure. Many patients do not experience benefit in pain or function from increasing opioid dosages to ≥50 MME/day but are exposed to progressive increases in risk as dosage increases. Therefore, before increasing total opioid dosage to ≥50 MME/day, clinicians should pause and carefully reassess evidence of individual benefits and risks. If a decision is made to increase dosage, clinicians should use caution and increase dosage by the smallest practical amount.[32] HHS's Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics,[33] is also a valuable resource for considering how best to taper and/or discontinue usage in a thoughtful manner consistent with best clinical practices.

The MME/day metric is often used as a gauge for the overdose potential of the amount of opioid that is being given at a particular time. In 42 C.F.R. § 456.703(h)(1)(ii), states are required to implement prospective safety edit limitations for opioid prescriptions, as specified by the state, on the maximum daily MME for treatment of pain, for initial and subsequent prescription refills.

When states implement the maximum daily MME limits, this does not mean to suggest rapid discontinuation of opioids already prescribed at higher dosages, rather the MME/day metric is often used as a gauge of the overdose potential of the amount of opioid that is being given at a particular time.[34] When implementing this safety edit, we noted in the final rule that HHS does not recommend opioids be tapered rapidly or discontinued suddenly due to the significant risks of opioid withdrawal. The Food and Drug Administration (FDA) issued a safety announcement on tapering in April 2019, noting concerns about safely decreasing or discontinuing doses of opioids in patients who are physically dependent after hearing reports about serious harm.[35] Additionally, states were reminded that clinical resources, including, for example, the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain, recommend caution when prescribing opioids for chronic pain in certain circumstances and recommend that primary care practitioners reassess evidence of individual benefits and risks when increasing doses, and subsequently justifying decisions by thoroughly documenting the clinical basis for prescribing in the patient's medical record.[36, 37]

FFY 2022 survey responses shown in Tables 19 and 20 that a majority of programs (98% of FFS and 99% of MCPs) have safety edits in place to alert the pharmacy provider if the MME daily dose

[32] Ibid.
[33] https://www.hhs.gov/system/files/Dosage_Reduction_Discontinuation.pdf .
[34] Ibid.
[35] "FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering." Food and Drug Administration. Available at https://www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes.
[36] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1.
[37] Ibid.

prescribed has been exceeded.

Table 19 FFS Safety Edits to Alert the Pharmacy Provider that the MME Daily Dose Prescribed Has Been Exceeded

Response	States	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	50	98%
No	Wisconsin*	1	2%
National Totals		**51**	**100%**

*In the explanation for responding "No", Wisconsin FFS clarified that: "Wisconsin does not have a prospective alert to the pharmacy provider regarding a daily MME dose. Wisconsin has a prospective DUR alert for claims with 90 MME or greater. This alert notifies the pharmacy the claim is a high dose opioid and recommends the dispensing of naloxone. Wisconsin also monitors opioids in the prospective system and alerts the pharmacy provider regarding quantity limits, early refill, therapeutic duplication, etc."

Table 20 MCP Safety Edits to Alert the Pharmacy Provider that the MME Daily Dose Prescribed Has Been Exceeded

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	211	99%
No	Pennsylvania (1)*	1	1%
National Totals		**212**	**100%**

*One MCP in Pennsylvania requires Prior Authorization for doses exceeding daily quantity limits.

Tables 21 and 22 show the median MME daily dose for FFY 2022 reported responses was 90 mg/day for both FFS and MCPs. For both FFS and MCPs, responses ranged from less than 50 mg/day to greater than 200 MME. Overall, all FFS and MCPs, have established MME limits in FFY 2022, consistent with FFY 2021.

Table 21 FFS Maximum Morphine Equivalent Daily Dose Limit in Milligrams

Response	States	Total	Percent of Total
Less Than 50 MME	Maine, Ohio	2	4%
50 MME	Georgia, Pennsylvania, West Virginia	3	6%
90 MME	Arizona, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Idaho, Illinois, Iowa, Kansas, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia	31	60%
100 MME	Mississippi, New Hampshire	2	4%
120 MME	Hawaii, Massachusetts, Wyoming	3	6%
200 MME	Alabama, Colorado, Kentucky, Tennessee, Washington	5	10%
Greater Than 200 MME	California	1	2%
Other	Alaska, Indiana, Nevada, Wisconsin	4	8%
National Totals		**51**	**100%**

Table 22 MCP Maximum Morphine Equivalent Daily Dose Limit in Milligrams

Response	States (Count of MCPs)	Total	Percent of Total
Less Than 50 MME	Massachusetts (1), Ohio (1), Pennsylvania (1)	3	1%
50 MME	Arizona (1), Florida (1), Georgia (1), Pennsylvania (6)	9	4%
80 MME	Ohio (3)	3	1%
90 MME	Arizona (5), Arkansas (4), Colorado (1), Delaware (2), District of Columbia (4), Florida (9), Georgia (2), Hawaii (3), Illinois (4), Indiana (2), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (8), Massachusetts (3), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Jersey (5), New Mexico (3), New York (10), North Carolina (5), Ohio (1), Oregon (20), Rhode Island (3), South Carolina (4), Texas (15), Utah (4), Virginia (6)	166	79%
100 MME	New Hampshire (3)	3	1%
120 MME	Hawaii (3), Washington (5)	8	4%

Response	States (Count of MCPs)	Total	Percent of Total
200 MME	Colorado (1), Florida (1), Illinois (2), Maryland (1), Massachusetts (1), New York (4), Oregon (1)	11	5%
Greater Than 200 MME	South Carolina (1)	1	1%
Other	Arizona (1), Indiana (3), Nevada (1), Texas (1)	6	3%
National Totals		**210**	**100%**

Automated retrospective claims reviews may detect high doses of opioids and allow for the program to follow up on prescription trends or issues found on prescriptions that have already been dispensed. As depicted in Tables 23 and 24, FFY 2022 survey responses show that a majority of programs have automated retrospective claims review to monitor total daily MME dose of opioid prescriptions dispensed (86% in FFS, and 94% in MCPs). These reviews also assist in determining overall trending of prescriptions in the state by MME.

Table 23 FFS Automated Retrospective Claims Review to Monitor Total Daily MME Dose of Opioid Prescriptions Dispensed

Response	State	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, Wyoming	44	86%
No*	Kentucky, Massachusetts, Nebraska, New Jersey, New York, Pennsylvania, West Virginia	7	14%
National Totals		**51**	**100%**

*CMS continues to monitor state specific trends and will follow up with these programs for compliance.

Table 24 MCP Automated Retrospective Claims Review to Monitor Total Daily MME Dose of Opioid Prescriptions Dispensed

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (3), Colorado (2), Delaware (2), District of Columbia (2), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (4), Michigan (9), Minnesota (8), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (13), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (6), Rhode Island (3), South Carolina (5), Texas (14), Utah (4), Virginia (5), Washington (4)	199	94%
No*	Arkansas (1), District of Columbia (2), Massachusetts (1), Minnesota (1), New York (2), Pennsylvania (2), Texas (2), Virginia (1), Washington (1)	13	6%
National Totals		**212**	**100%**

*CMS continues to monitor state specific trends and will follow up with these programs for compliance.

2.3. Opioids and Concurrently Prescribed Medications

Section 1902 of the Act, as amended by section 1004 of the SUPPORT Act, requires states to have an automated process for claims review (as designed and implemented by the state) that monitors when an individual enrolled under the state plan (or under a waiver of the state plan) is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.[38] This requirement is consistent with the requirement in section 1927(g)(1)(A) of the Act that state DUR programs must ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. The concurrent use of opioids with benzodiazepines and/or antipsychotics significantly increases the risk of adverse effects, including undesirable changes in mental status or overdose. Using automated retrospective claims review, concurrent use of opioids and benzodiazepines and/or opioids and antipsychotics can be reduced, as can potential complications resulting from the medications. The requirement for a retrospective automated claims review added by section 1004 of the SUPPORT Act does not preclude the state from also establishing a prospective safety edit system to provide additional information to patients and providers at the POS about concurrent utilization alerts.

Opioid and Benzodiazepines Concurrent Fill Reviews: In 2016, the FDA added a boxed warning to prescription opioid analgesics, opioid-containing cough products, and benzodiazepines with information about the serious risks associated with using these medications concurrently.[39]

[38] Section 1902(oo)(1)(A)(i)(III) of the Act, as added by section 1004 of the SUPPORT for Patients and Communities Act.

[39] The 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain recommends that clinicians avoid prescribing benzodiazepines concurrently with opioids whenever possible. https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w

Studies show that people concurrently using both opioids and benzodiazepines are at higher risk of visiting the emergency department (ED) or being admitted to a hospital for a drug-related emergency.[40] Due to the heightened risk of adverse events associated with the concurrent use of opioids and benzodiazepines, such as an additive sedative effect and increased risk for respiratory depression, physicians should avoid the initial combination of opioids and benzodiazepines by offering alternative approaches.[41] This review alerts providers when these drugs have been prescribed concurrently to assist in avoiding and mitigating these associated risks.

Opioid and Antipsychotic Concurrent Fill Reviews: This review is supported by the FDAs warning of increased risk of respiratory and Central Nervous System (CNS) depression with concurrent use of opioid and CNS depressants such as antipsychotics or sedatives, including extreme sleepiness, slowed or difficult breathing, and unresponsiveness or the possibility that death can occur. Despite the risks, patients may benefit from concurrent opioid and antipsychotic therapy with the appropriate coordination of care and drug monitoring. Additionally, improving treatment of comorbid mental health disorders is an important consideration when trying to reduce the overall negative impacts of OUD, and determining the best approach for pain management.

As the Pain Management Task Force (PMTF)[42] report noted, "the occurrence of pain and mental health comorbidities, including depression, [post-traumatic stress disorder] (PTSD), and [substance use disorder] (SUD), is well documented," and it is established that "[p]sychosocial distress can contribute to pain intensity, pain-related disability, and poor response to treatment."[43] Evidence indicates that optimizing mental health and pain treatment can improve outcomes in both areas for patients seen in primary and specialty care settings. Untreated psychiatric conditions may increase the risk of both unintentional and intentional medication adverse events, OUD, and overdose.[44] Given the intersection between psychiatric/psychological symptoms and chronic pain, it is important that the behavioral health needs of patients with pain are appropriately and carefully evaluated and treated with the co-occurring chronic pain condition.[45] A patient's unique presentation and circumstances should be considered when prescribing opioids and antipsychotics. This review encourages coordination of care for patients taking antipsychotic and opioid medication concurrently.

[40] Benzodiazepines and Opioids, https://nida.nih.gov/research-topics/opioids/benzodiazepines-opioids.
[41] "Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines." MLN Matters Number: SE19011. Available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE19011.pdf.
[42] The Pain Management Best Practices Inter-Agency Task Force was convened by the U.S. Department of Health and Human Services in conjunction with the U.S. Department of Defense and the U.S. Department of Veterans Affairs with the Office of National Drug Control Policy to address acute and chronic pain in light of the ongoing opioid crisis. The Task Force mandate is to identify gaps, inconsistencies, and updates and to make recommendations for best practices for managing acute and chronic pain. The 29-member Task Force included federal agency representatives as well as nonfederal experts and representatives from a broad group of stakeholders.
[43] Pain Management Best Practices Inter-Agency Task Force. "Pain Management Best Practices." Available at https://www.hhs.gov/opioids/prevention/pain-management-options/index.html.
[44] Ibid.
[45] Ibid.

2.3.1. Concurrent Opioids and Benzodiazepines

DUR safety edits can detect if a patient has active prescriptions of both opioids and benzodiazepines and generate an alert for the pharmacist. Based upon the review, the pharmacist may counsel the patient on the interaction, alert prescribers of the concurrent medications, suggest a therapy change, or take no action. Automated retrospective claims reviews may detect the same scenario and allow for the program to follow up.

In consideration of clinical recommendations to limit opioid interactions with certain other drugs and to assess the clinical benefits and harms of opioid treatment on an ongoing basis, states were required to establish retrospective reviews on individuals concurrently prescribed opioids and benzodiazepines to ensure at-risk individuals are receiving appropriate treatment that is not likely to result in adverse medical results. The requirement for a retrospective automated claims review added by section 1004 of the SUPPORT Act did not preclude states from also establishing a prospective safety edit to provide additional information to patients and providers at the POS about concurrent utilization alerts.

FFY 2022 survey responses show that most programs have safety edits or a retrospective claims review process to monitor opioids and benzodiazepines being used concurrently (100% of FFS, and 96% of MCPs) as shown in Tables 25 and 26. There were 13 FFS (25%) programs that only had prospective safety edits in place. There were 35 MCPs (17%) that only had prospective safety edits in place and 8 MCPs (4%) without either reviews or edits on benzodiazepine and opioid interactions. Of those 8 MCPs, Maryland (3), Michigan (4), and Utah (1) specified their programs have opioids or benzodiazepines excluded from MCP contracts and instead are provided by the FFS program. Overall, from FFY 2021 to FFY 2022, FFS programs remained consistent (100%) as MCPs showed a decrease (3%) with their opioid and benzodiazepine concurrent utilization reviews.

Table 25 FFS Safety Edits or Retrospective Claims Review to Monitor Opioids and Benzodiazepines Used Concurrently

Response	States	Total	Percent of Total
Yes, Automated Retrospective Claims Review	Alabama, Hawaii, Michigan, New Mexico, Washington, Wisconsin	6	12%
Yes, Both Safety Edits and Automated Retrospective Claims Review	Alaska, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia	32	63%
Yes, Safety Edits	Arizona, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Nebraska, New Hampshire, New Jersey, Oklahoma, South Carolina, Tennessee, Wyoming	13	25%
National Totals		**51**	**100%**

* CMS is continuing to work with programs and follow up regarding compliance as DUR survey responses were not provided, need clarification or additional information and state action is needed.

Table 26 MCP Safety Edits or Retrospective Claims Review to Monitor Opioids and Benzodiazepines Used Concurrently

Response	States (Count of MCPs)	Total	Percent of Total
Yes, Automated Retrospective Claims Review Process	Maryland (4), Massachusetts (1), Michigan (2), Minnesota (1), Nebraska (1), Ohio (1), Oregon (6), Utah (1), Virginia (1), Washington (1)	19	9%
Yes, Both Safety Edits and Automated Retrospective Claims Review Process	Arizona (7), Arkansas (3), Colorado (2), Delaware (2), District of Columbia (2), Florida (9), Georgia (2), Hawaii (5), Illinois (4), Indiana (2), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (2), Massachusetts (2), Michigan (3), Minnesota (7), Mississippi (3), Nebraska (2), Nevada (4), New Hampshire (2), New Jersey (5), New Mexico (3), New York (13), North Carolina (5), Ohio (4), Oregon (15), Pennsylvania (5), Rhode Island (3), South Carolina (3), Texas (6), Utah (1), Virginia (4), Washington (3)	149	70%
Yes, Safety Edits*	Arkansas (1), District of Columbia (2), Florida (2), Georgia (1), Hawaii (1), Illinois (2), Indiana (3), Massachusetts (2), Minnesota (1), New Hampshire (1), New York (1), Pennsylvania (3), South Carolina (2), Texas (10), Utah (1), Virginia (1), Washington (1)	35	17%
No**	Maryland (3), Michigan (4), Utah (1)	8	4%
National Totals		**211**	**100%**

* CMS is continuing to work with programs and follow up regarding compliance as DUR survey responses were not provided, need clarification or additional information, and state action is needed.
** Maryland (7), Michigan (4), and Utah (1) have benzodiazepines excluded from MCP contracts and provided by the FFS program.

2.3.2. Concurrent Opioids and Antipsychotics

Safety edits can detect if a patient has active prescriptions of both opioids and antipsychotics and require review by the pharmacist. The pharmacist will review the patient's medical history and determine if there is a safety concern with concurrent use. If so, the pharmacist may alert the prescribers, suggest a therapy change, or counsel the patient on risks such as respiratory depression, extreme sleepiness, slowed or difficult breathing, unresponsiveness or increased risk of death. Automated retrospective claims reviews may detect such scenarios and allow for the program to follow up.

The requirement for retrospective automated claims review on concurrently prescribed opioids and antipsychotics, as added by section 1004 of the SUPPORT Act, did not preclude states from also establishing a prospective safety edit to provide additional information to patients and

providers at the POS. As such, many states implemented both prospective safety edits and retrospective claims reviews (49% of FFS and 47% of MCPs).

Tables 27 and 28 show that FFY 2022 survey responses indicate a large majority of programs have safety edits in place or automated retrospective claims reviews to monitor opioids and antipsychotics being used concurrently (100% of FFS and 95% of MCPs). There were 11 FFS states (22%) and 37 MCPs (18%) that indicated only safety edits were implemented. Note that 9 MCPs (Maryland (3), Michigan (4), Oregon (1), and Utah (1)) have antipsychotics excluded from the MCP contracts and instead provided in their FFS program. Overall, from FFY 2021 to FFY 2022, both FFS and MCPs increased compliance rates with opioid and antipsychotic concurrent utilization reviews.

Table 27 FFS Safety Edits or Retrospective Claims Review to Monitor Opioids and Antipsychotics Being Used Concurrently

Response	States	Total	Percent of Total
Yes, Automated Retrospective Claims Review	Alabama, Hawaii, Louisiana, Michigan, Montana, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Washington, Wisconsin, Wyoming	15	29%
Yes, Both Safety Edits and Automated Retrospective Claims Review	Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Nevada, New York, North Carolina, North Dakota, Oklahoma, South Dakota, Vermont, Virginia, West Virginia	25	49%
Yes, Safety Edits*	Arizona, Colorado, Georgia, Illinois, Maine, Massachusetts, Nebraska, New Hampshire, New Jersey, South Carolina, Tennessee	11	22%
National Totals		**51**	**100%**

* CMS continues to monitor state specific trends and will follow up with these programs for compliance.

Table 28 MCP Safety Edits or Retrospective Claims Review to Monitor Opioids and Antipsychotics Being Used Concurrently

Response	States (Count of MCPs)	Total	Percent of Total
Yes, Automated Retrospective Claims Review Process	Arizona (4), Hawaii (2), Illinois (2), Indiana (1), Kansas (2), Louisiana (3), Maryland (6), Michigan (4), Minnesota (3), Mississippi (1), Nebraska (2), Nevada (1), New Jersey (2), New York (1), North Carolina (1), Ohio (1), Oregon (16), Pennsylvania (3), Texas (2), Utah (2), Virginia (3), Washington (2)	64	30%

Response	States (Count of MCPs)	Total	Percent of Total
Yes, Both Safety Edits and Automated Retrospective Claims Review Process	Arizona (3), Arkansas (3), Colorado (1), Delaware (1), District of Columbia (2), Florida (9), Georgia (2), Hawaii (3), Illinois (3), Indiana (1), Iowa (2), Kansas (1), Kentucky (6), Louisiana (2), Massachusetts (3), Michigan (1), Minnesota (6), Mississippi (2), Nebraska (1), Nevada (3), New Hampshire (1), New Jersey (3), New Mexico (2), New York (10), North Carolina (4), Ohio (4), Oregon (4), Pennsylvania (3), Rhode Island (3), South Carolina (3), Texas (3), Utah (1), Virginia (2), Washington (2)	100	47%
Yes, Safety Edits*	Arkansas (1), Colorado (1), Delaware (1), District of Columbia (2), Florida (2), Georgia (1), Hawaii (1), Illinois (1), Indiana (3), Massachusetts (2), New Hampshire (2), New Mexico (1), New York (3), Pennsylvania (1), South Carolina (2), Texas (11), Virginia (1), Washington (1)	37	18%
No	Maryland (3)**, Michigan (4)**, Oregon (1)**, Pennsylvania (1)***, Utah (1)**	10	5%
National Totals		**211**	**100%**

* CMS continues to monitor state specific trends and will follow up with these programs for compliance.
** 9 MCPs (Maryland (3), Michigan (4), Oregon (1), and Utah (1)) have antipsychotics excluded from MCP contracts and instead provided in FFS program.
*** Pennsylvania (1) stated they have no current plans to implement this edit as this MCP works closely with their regional behavioral health and would collaborate with them on implementation of this edit.

2.4. Automated Claims Review

In accordance with the amendments made by section 1004 of the SUPPORT Act and the requirements in the CMS 2482-F final rule, states must have in place a claims automated review process (as designed and implemented by the state) that indicates when an individual enrolled under the state plan (or under a waiver of the state plan) is prescribed opioids in excess of limitations identified by the state. In these ongoing, comprehensive reviews of opioid claims data, states should continuously monitor opioid prescriptions including: overrides of safety edits by the prescriber or pharmacist on initial fill days' supply for opioid naïve patients, quantity limits, therapeutically duplicative fills, early refills, and maximum daily MME limitations on opioids prescriptions.

These are important reviews regarding prescription data in the state, which aim to detect patterns in prescribing, dispensing, and administering drugs. Based on current trends in medication use, prospective standards, and provider or beneficiary educational interventions can be developed to prevent the recurrence of inappropriate medication use or misuse. Outcomes of these reviews may aid prescribers in improving the care of their patients, either individually or within a certain target population via provider education. For example, a retrospective DUR review may be the identification of a group of patients whose therapy does not meet approved guidelines or an identification of beneficiaries who could benefit from co-prescribing naloxone. Additionally,

these opioid claims review are necessary to allow states to monitor the opioid prescriptions beneficiaries are receiving, and then determine and refine future potential prospective DUR safety edits, based on the findings of the claims review. These DUR reviews play a key role in helping programs understand, interpret, and improve the prescribing, administration, and use of opioids.

Based on 42 C.F.R. § 456.703(h)(1)(iii), states are required to conduct retrospective claims review automated processes that indicate prescription fills in excess of the prospective safety edit limitations specified by the state under 42 C.F.R. § 456.703(h)(1)(i) or (h)(1)(ii) to provide for the ongoing review of opioid claims data to identify patterns of fraud, abuse, excessive utilization, inappropriate or medically unnecessary care, or prescribing or billing practices that indicate misuse or provision of inappropriate or medically unnecessary care among prescribers, pharmacists and individuals receiving Medicaid benefits.

In addition to opioid claims data, states should consider incorporating other available records to provide for the ongoing periodic reviews of opioid claim data and other records in their retrospective claims review automated processes, including but not limited to prescription histories, diagnoses, medical records, and prescription drug monitoring program (PDMP) files, when available. While prospective DUR safety edits are employed for screening prescription drug claims to identify prescription problems prior to the dispensing of the prescription to the patient, automated retrospective reviews of claims data, guided by algorithmic logic determined by each state Medicaid program, identifies patterns of unsafe or inappropriate use, fraud, waste, abuse, or medically unnecessary care based on ongoing and periodic examination and reviews of claims data for prescriptions that were already dispensed.

In these ongoing, comprehensive reviews of opioid claim data, states should continuously monitor opioid prescriptions, including overrides of safety edits by the prescriber or pharmacist on initial fill days' supply for opioid naïve patients, quantity limits, therapeutically duplicative fills, early refills and maximum daily MME limitations on opioids prescriptions. Through ongoing monitoring and observation of trends over time, these reviews will allow for regular updates to safety edits in an evolving pain treatment landscape.

When asked if state programs have a comprehensive automated retrospective claims review process to monitor opioid prescriptions exceeding restricted quantity, days' supply, and/or duplicate therapy limitations, FFY 2022 survey responses show many states made progress from last year for both FFS and MCPs. Tables 29 and 30 indicated approximately 98% of FFS and 93% of MCPs' compliance with having automated retrospective claims review to monitor opioid prescriptions exceeding state defined limitations for FFY 2022. Many of the remaining FFS programs and MCPs surveyed said either their review process was not automated, the programs have prospective safety edits in place, or they were using prior authorization reviews to manage this requirement.

Table 29 FFS Comprehensive Claims Review Automated Retrospective Process to Monitor Opioid Prescriptions Exceeding State Limitations

Response	States	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	98%
No*	Massachusetts	1	2%
National Totals		**51**	**100%**

*As of 6/2023, the Massachusetts DUR program was set up an automatically run report to monitor for how many opioid claims have been overridden early, approved for duplication, and exceeding quantity limits.

Table 30 MCP Comprehensive Claims Review Automated Retrospective Process to Monitor Opioid Prescriptions in Excess of State Limitations

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (4), Iowa (2), Kansas (2), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (6), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (11), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (13), Utah (2), Virginia (5), Washington (5)	196	93%
No*	Indiana (1), Kansas (1), Minnesota (3), New York (3), Pennsylvania (1), Texas (3), Utah (2), Virginia (1)	15	7%
National Totals		**211**	**100%**

* CMS continues to monitor state specific trends and will follow up with these programs for compliance.

3. Antipsychotics in Children

Under the amendments made by section 1004 of the SUPPORT Act, states must have a program, designed and implemented by the state, to monitor and manage the appropriate use of antipsychotic medications by children enrolled under the state plan, or under a waiver of the state plan, including any Medicaid expansion group for Children's Health Insurance Program (CHIP).[46] Antipsychotic medications are increasingly used for a wide range of clinical indications in diverse populations, including privately and publicly insured youth.[47]

Antipsychotics' adverse metabolic effects have heightened concern over increases in prescribing to youth, including off-label prescribing and polytherapy of multiple antipsychotics.[48] Studies have raised concerns regarding the long-term safety and effectiveness of antipsychotics in this broadened population. Studies in adults have found that antipsychotics can cause serious side effects. Long-term safety and efficacy for off-label utilization in children is also a particular concern.[49] Some of the most concerning effects include uncontrollable movements and tremors, an increased risk of diabetes, substantial weight gain, changes in sexual function, abnormal lactation, and elevated cholesterol, triglycerides, and prolactin.[50] Children appear to be at higher risk than adults for a number of adverse effects, such as extrapyramidal symptoms (movement disorders) and metabolic and endocrine abnormalities (conditions that disrupt the body's natural processes). Additionally, some studies suggest that antipsychotic treatment may be associated with increased mortality among children and youths, and the distal benefit/risk ratio for long-term off-label treatment remains to be determined.[51, 52]

Based on clinical recommendations to monitor and manage the appropriate use of antipsychotic medications by children, and to assess the clinical benefits and harms of treatment on an ongoing basis, these monitoring programs ensure children are receiving appropriate treatment that is not likely to result in adverse medical results. As implemented by 42 C.F.R. § 456.703(h)(1)(v), states are required to implement programs to monitor and manage the appropriate use of antipsychotic medications by children enrolled under the state plan, including any Medicaid expansion groups for CHIP. These monitoring provisions are not meant to prohibit the exercise of clinical judgment by a provider regarding the best or most appropriate care and treatment for any patient, and states are expected to consult national guidelines and are encouraged to work with their P&T and DUR committees to identify clinically appropriate safety edits and reviews. Additionally, state DUR programs could consider including reviews on children for additional concerns, such as for polytherapy (therapy that uses more than one medication), inappropriate utilization, or off-label utilization of other medications as well. The following sections provide the survey results for state Medicaid programs related to antipsychotic medication use in children.

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[46] Section 1902(oo)(1)(B) of the Act, as added by section 1004 of the SUPPORT for Patients and Communities Act.
[47] Crystal, Stephen et al. "Broadened use of atypical antipsychotics: safety, effectiveness, and policy challenges."
Health affairs (Project Hope) vol. 28,5 (2009): w770-81. doi:10.1377/hlthaff.28.5.w770.
[48] Ibid.
[49] Ibid.
[50] Marder SR, et al. Physical health monitoring of patients with schizophrenia. Am J Psychiatry. 2004;161(8):1334.
[51] https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2717966
[52] https://www.healthline.com/health/consumer-reports-antipsychotics-children#1

3.1 Programs to Monitor and Manage Antipsychotics in Children

Pursuant to section 1927(g) of the Act and to the amendments made by section 1004 of the SUPPORT Act, as implemented by 42 C.F.R. § 456.703(h)(1)(v), states are required to implement programs to monitor and manage the appropriate use of antipsychotic medications by children.

Tables 31 and 32 show that all FFS (consistent with FFY 2021) and 88% of MCPs have a program in place for managing and monitoring appropriate use of antipsychotic drugs in children. Twenty-three MCPs indicated they do not have a program in place as they have no children beneficiaries, or these medications are excluded from MCP contracts and provided by the FFS program.

Table 31 FFS Program in Place for Managing and Monitoring Appropriate Use of Antipsychotic Drugs in Children

Response	States	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	51	100%
National Totals		**51**	**100%**

Table 32 MCP Program in Place for Managing and Monitoring Appropriate Use of Antipsychotic Drugs in Children

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (3), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (3), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (7), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (16), Utah (3), Virginia (6), Washington (5)	187	88%
No*	District of Columbia (1), Florida (1), Maryland (6), Michigan (1), Oregon (14), Pennsylvania (1), Utah (1)	25	12%
National Totals		**212**	**100%**

* MCPs in Maryland (6), Oregon (14), and Utah (1) have these medications excluded from the MCP contracts and provided by the FFS program. The MCPs in Florida (1) and Pennsylvania (1) have no children enrolled. One MCP in District of Columbia plans to develop criteria in FY2023 and implement them in FY2024. One MCP in Michigan has implemented a program to monitor appropriate use of antipsychotics in children for FY2023.

As shown in Tables 33 and 34, 96% of FFS and MCPs manage and monitor antipsychotic medication use in all children. For 2 FFS programs (Illinois and Oregon) that selected "other," all indicated some degree of monitoring and managing antipsychotic medication in children. Of the 6 MCPs that selected "other", these MCPs had antipsychotics excluded from the MCP contracts, did not have all types of children enrolled in their program, or had monitoring restricted to certain ages.

Table 33 FFS Categories of Children Managed and Monitored for Appropriate Use of Antipsychotic Drugs

Response	States	Total	Percent of Total
All Children	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	49	96%
Other*	Illinois, Oregon	2	4%
National Totals		**51**	**100%**

**CMS continues to monitor state specific trends and will follow up with these programs for compliance.

Table 34 MCP Categories of Children Managed and Monitored for Appropriate Use of Antipsychotic Drugs

Response	States (Count of MCPs)	Total	Percent of Total
All Children	Arizona (6), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (2), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (3), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (2), New York (15), North Carolina (5), Ohio (4), Oregon (4), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (16), Utah (3), Virginia (6), Washington (5)	180	96%
Only Children in Foster Care*	New Mexico (1)	1	1%
Other**	Arizona (1), District of Columbia (1), Ohio (1), Oregon (3)	6	3%
National Totals		**187**	**100%**

*CMS continues to monitor state specific trends and will follow up with these programs for compliance.
**One MCP from Arizona requires Prior Authorization for Antipsychotics for Children 6 and Under. One MCP from the District of Columbia does not include any foster children and monitors all children. One MCP from Ohio monitors appropriate use of antipsychotic drugs for adults and all children. MCPs from Oregon report that antipsychotics are excluded from MCP contracts and instead provided by FFS programs.

3.2. Types of Safety Edits in Place to Monitor Antipsychotic Utilization in Children

Antipsychotic drug monitoring by state programs helps to prevent adverse outcomes in the pediatric population. States have a variety of safety edits in place to monitor antipsychotic drug use in children, including edits to monitor a child's age, dosage, indication, and polypharmacy. FFY 2022 survey responses shown in Tables 35 and 36 that various antipsychotic safety edits are in place to monitor for appropriate use in children including child's age (84% of FFS, and 61% of MCPs:), dosage (86% of FFS, and 71% of MCPs), indication (67% of FFS, and 49% of MCPs), and polypharmacy (78% of FFS, and 65% of MCPs).

Table 35 FFS Antipsychotic Safety Edits in Place to Monitor for Appropriate Use in Children*

Response	States	Total	Total Percent
Child's Age	Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	43	84%
Dosage	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	44	86%
Indication	Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington	34	67%
Polypharmacy	Alabama, Alaska, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming	40	78%
Other**	Arkansas, Delaware, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Michigan, Mississippi, New Mexico, North Carolina, Ohio, Oregon, Tennessee, Washington	16	31%

* A program may select multiple answers to this question.
** Access state specific reports at Medicaid.gov

Table 36 MCP Antipsychotic Safety Edits in Place to Monitor for Appropriate Use in Children*

Response	States (Count of MCPs)	Total	Total Percent
Child's Age	Arizona (7), Arkansas (4), Delaware (2), District of Columbia (2), Florida (7), Georgia (2), Hawaii (1), Illinois (5), Indiana (4), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (1), Massachusetts (5), Michigan (2), Minnesota (7), Mississippi (1), Nebraska (2), Nevada (3), New Hampshire (2), New Jersey (3), New Mexico (2), New York (12), North Carolina (3), Ohio (2), Pennsylvania (7), South Carolina (3), Texas (14), Virginia (6), Washington (5)	130	61%
Dosage	Arizona (6), Arkansas (4), Colorado (1), Delaware (2), District of Columbia (3), Florida (9), Georgia (3), Hawaii (5), Illinois (5), Indiana (5), Kansas (3), Kentucky (5), Louisiana (5), Massachusetts (4), Michigan (3), Minnesota (6), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (10), North Carolina (5), Ohio (4), Oregon (2), Pennsylvania (7), Rhode Island (2), South Carolina (5), Texas (16), Virginia (5), Washington (5)	150	71%
Indication	Arizona (5), Arkansas (3), Colorado (1), Delaware (2), District of Columbia (1), Florida (4), Georgia (1), Hawaii (3), Illinois (2), Indiana (3), Kansas (2), Kentucky (6), Louisiana (5), Massachusetts (2), Michigan (3), Minnesota (3), Mississippi (2), Nebraska (3), Nevada (1), New Hampshire (3), New Jersey (4), New Mexico (2), New York (8), North Carolina (5), Ohio (2), Oregon (2), Pennsylvania (4), South Carolina (3), Texas (13), Virginia (4), Washington (2)	104	49%
Polypharmacy	Arizona (6), Arkansas (4), Colorado (1), Delaware (2), District of Columbia (3), Florida (9), Georgia (3), Hawaii (5), Illinois (3), Indiana (5), Iowa (2), Kansas (2), Louisiana (3), Maryland (1), Massachusetts (5), Michigan (2), Minnesota (6), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (3), New Mexico (1), New York (13), North Carolina (4), Ohio (5), Oregon (1), Pennsylvania (6), Rhode Island (1), South Carolina (4), Texas (15), Utah (2), Virginia (4), Washington (5)	138	65%
Other**	Arizona (3), Arkansas (3), Colorado (2), District of Columbia (2), Florida (7), Georgia (2), Hawaii (3), Illinois (4), Indiana (4), Kansas (2), Kentucky (1), Louisiana (2), Maryland (2), Michigan (7), Minnesota (3), Mississippi (2), Nebraska (1), Nevada (1), New Hampshire (3), New Jersey (3), New Mexico (1), New York (5), North Carolina (2), Ohio (2), Oregon (4), Pennsylvania (3), Rhode Island (2), South Carolina (1), Texas (4), Utah (1), Virginia (2), Washington (4)	88	42%

* A program may select multiple answers to this question.
** Access state-specific reports at Medicaid.gov

4. Fraud, Waste and Abuse (FWA) Detection

Consistent with section 1927(g) of the Act, the amendments made by section 1004 of the SUPPORT Act have the goal of improving the quality of care received by Medicaid beneficiaries by reducing their exposure to hazards resulting from the inappropriate prescribing, gross overuse, or medically unnecessary care. In this context, strategies to ensure the appropriate use of opioids are now being implemented in clinical settings, health care systems, and public health agencies. Efforts to prevent harm associated with overuse and misuse of opioids must be integrated to ensure patients are receiving appropriate pain care.

Pursuant to the amendments made by section 1004 of the SUPPORT Act, states must have in place a process (as designed and implemented by the state) that identifies potential fraud or abuse of controlled substances by individuals enrolled under the state plan (or under a waiver of the state plan), health care providers prescribing drugs to individuals so enrolled, and pharmacies dispensing drugs to individuals so enrolled. Additionally, states should identify inappropriate or medically unnecessary care or prescribing or billing practices that indicate abuse or provision of inappropriate or medically unnecessary care among prescribers, pharmacists, and individuals receiving Medicaid benefits. In implementing this requirement, states could operate this process in a coordinated fashion with other state program integrity (PI) efforts and have the flexibility to define specific parameters for DUR reviews for fraud and misuse of controlled drugs, as well as, protocols for recommendation, referral, or escalation of reviews to the relevant PI or Surveillance Utilization Review (SUR) unit, law enforcement, or state professional board, based on patterns discovered through the proposed DUR process. Existing state initiatives can also work synergistically to help reduce fraud and misuse related to opioids. For example, patient review and restriction (PRR) programs (lock-in programs)[53] and PDMPs[54] also play an important role in detecting and preventing opioid-related fraud and misuse. Lock-in programs, also called PRR or drug management programs, are meant to prevent "doctor shopping," the practice of going to several doctors or pharmacies to fill multiple prescriptions for opioids or other controlled substances for illicit sale or misuse. Such programs are used primarily to restrict overutilization and diversion of medications.

PDMPs are database tools utilized by state, federal, and/or law enforcement entities depending on how the program is designed for clinical patient management, as well as reducing prescription drug fraud, misuse, and diversion. Depending on state specific designs, PDMPs collect electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners. In some states, data is monitored and analyzed to support states' efforts in education, research, enforcement, and/or misuse prevention.[55]

[53] Programs may require beneficiaries to receive all prescriptions through one pharmacy, have all prescriptions written by one prescriber, receive health care services from one clinical professional, or all three, depending on how the program is designed.
[54] Office of National Drug Control Policy. Prescription Drug Monitoring Program. Prescription Drug Monitoring Program, April 2011. https://www.ncjrs.gov/pdffiles1/ondcp/pdmp.pdf.
[55] https://doi.org/10.1111/coep.12607.

Additionally, PDMPs can be used to monitor controlled substance use by health care providers, including prescribers and pharmacists, in the prevention of FWA. The following sections provide the survey results for state Medicaid programs related to the potential FWA of controlled substances.

4.1. FWA of Beneficiaries

Based on FFY 2022 survey responses, Tables 37 and 38 show all FFS and MCPs have a documented process in place that identifies potential fraud or abuse of controlled drugs by a beneficiary.

Table 37 FFS Process in Place to Identify Potential Fraud or Abuse of Controlled Drugs by Beneficiaries

Response	States	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	51	100%
National Totals		**51**	**100%**

Table 38 MCP Process in Place to Identify Potential Fraud or Abuse of Controlled Drugs by Beneficiaries

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	212	100%
National Totals		**212**	**100%**

4.2. Patient Review and Restriction (PRR) Programs

A PRR program plays an important role in preventing opioid related FWA. This program, upon

state review, may elect to restrict patients whose utilization of medical services is documented as being potentially unsafe, excessive, or could benefit from increased coordination of care. In some instances, PRR programs may be used to restrict a patient to a single prescriber and/or a single pharmacy to monitor services being utilized and reduce unnecessary or inappropriate utilization. FFY 2022 survey responses in Tables 39 and 40 show that 92% of FFS, consistent with FFY 2021, and 96% of MCPs have a PRR program for beneficiaries with potential misuse of controlled substances. FFY 2022 survey responses show a 4% increase within MCPs from FFY 2021.

Table 39 FFS Patient Review and Restriction Program

Response	States	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	47	92%
No	California, Florida, Iowa, South Dakota	4	8%
National Totals		**51**	**100%**

Table 40 MCP Patient Review and Restriction Program

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (16), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	204	96%
No	Arkansas (1), Florida (1), Kentucky (1), Oregon (5)	8	4%
National Totals		**212**	**100%**

Potential FWA of controlled substances by beneficiaries may be detected through either manual or algorithmic review of claims data. There are many patient indicators and use patterns that may be concerning or could possibly be indicative of misuse. These include, but are not limited to, seeing multiple prescribers for opioids, using multiple pharmacies, frequently using small amounts of short-acting opioids, and/or frequently visiting EDs seeking opioids. Beneficiary

criteria for PRR programs in FFY 2022 survey responses, shown in Tables 41 and 42, are identified through multiple resources. Top criteria include beneficiaries using multiple prescribers of controlled substances (88% in FFS, and 92% in MCPs) and multiple pharmacies to obtain controlled substances (88% in FFS, and 91% in MCPs). FFY 2022 responses for FFS show a 10% decrease for multiple prescribers and 8% decrease for multiple pharmacies and for MCPs show a 5% decrease for multiple prescribers and 5% decrease in multiple pharmacies.

Table 41 FFS Patient Review and Restriction Program Beneficiary Identification Criteria*

Response	States	Total	Total Percent
Different Prescribers of Controlled Substances	Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	88%
Exclusivity of Short-Acting Opioids	Arkansas, Delaware, Georgia, Maryland, Michigan, New York, Pennsylvania, Utah	8	16%
Multiple ER Visits	Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia	33	65%
Multiple Pharmacies	Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	45	88%
Days' Supply of Controlled Substances	Alabama, Arkansas, Connecticut, Delaware, Georgia, Kansas, Louisiana, Maryland, Michigan, Missouri, New York, Oklahoma, Oregon, Pennsylvania, South Carolina, Utah, Virginia, West Virginia, Wisconsin	19	37%

Response	States	Total	Total Percent
Number of Controlled Substances	Alabama, Alaska, Arizona, Arkansas, Colorado, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	41	80%
PDMP Data	Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Kansas, Michigan, Mississippi, Montana, Nevada, North Dakota, Utah, Virginia, West Virginia	16	31%
Other**	Arizona, Arkansas, Connecticut, District of Columbia, Idaho, Illinois, Indiana, Maine, Mississippi, Montana, Nebraska, Nevada, Ohio, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin	19	37%

* A program may select multiple answers to this question.
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Table 42 MCP Patient Review and Restriction Program Beneficiary Identification Criteria*

Response	States (Count of MCPs)	Total	Total Percent
Different Prescribers of Controlled Substances	Arizona (7), Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (3), Ohio (5), Oregon (13), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (15), Utah (4), Virginia (6), Washington (4)	195	92%
Exclusivity of Short-Acting Opioids	Delaware (1), Indiana (1), Kansas (1), Maryland (1), Michigan (1), Minnesota (2), Nebraska (1), New Hampshire (1), New Jersey (1), New York (1), Pennsylvania (3), Texas (1), Virginia (1), Washington (1)	17	8%
Multiple ER Visits	Arizona (2), Arkansas (1), Colorado (2), Delaware (1), District of Columbia (1), Florida (1), Georgia (2), Hawaii (2), Illinois (4), Indiana (4), Kansas (3), Kentucky (2), Louisiana (1), Maryland (1), Massachusetts (3), Michigan (9), Minnesota (9), Mississippi (1), Nebraska (1), Nevada (1), New Hampshire (3), New Jersey (3), New Mexico (3), New York (12), Ohio (2), Pennsylvania (7), Rhode Island (1), South Carolina (1), Texas (14), Utah (4), Virginia (3), Washington (3)	107	50%

Response	States (Count of MCPs)	Total	Total Percent
Multiple Pharmacies	Arizona (7), Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (8), Minnesota (9), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (3), Ohio (5), Oregon (13), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (15), Utah (4), Virginia (6), Washington (4)	192	91%
Days' Supply of Controlled Substances	Arizona (3), Delaware (1), Florida (1), Georgia (1), Hawaii (2), Illinois (3), Indiana (1), Kansas (2), Louisiana (3), Maryland (2), Massachusetts (1), Michigan (1), Minnesota (3), Nevada (1), New Hampshire (2), New Jersey (1), New Mexico (2), New York (4), North Carolina (1), Ohio (1), Oregon (7), Pennsylvania (5), South Carolina (3), Texas (13), Virginia (2), Washington (2)	68	32%
Number of Controlled Substances	Arizona (7), Arkansas (3), Colorado (2), Delaware (2), District of Columbia (4), Florida (10), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (3), Ohio (5), Oregon (12), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (15), Utah (4), Virginia (5), Washington (4)	193	91%
PDMP Data	Arizona (5), District of Columbia (1), Florida (2), Hawaii (1), Illinois (4), Indiana (2), Kansas (3), Michigan (4), Minnesota (9), Mississippi (2), New Mexico (3), Ohio (1), Pennsylvania (1), Texas (1), Utah (3), Virginia (5), Washington (3)	50	24%
Same FFS State Criteria Is Applied	Arizona (6), District of Columbia (3), Florida (5), Hawaii (2), Indiana (2), Kansas (2), Louisiana (3), Maryland (7), Massachusetts (3), Michigan (5), Minnesota (5), Nevada (1), New Hampshire (2), New York (4), North Carolina (5), Ohio (1), Oregon (3), Pennsylvania (3), South Carolina (2), Texas (3), Utah (4), Virginia (5), Washington (2)	78	37%
Other**	Arizona (1), Arkansas (2), Delaware (2), District of Columbia (1), Florida (2), Georgia (1), Hawaii (3), Illinois (3), Indiana (1), Kansas (2), Kentucky (1), Louisiana (2), Maryland (1), Massachusetts (2), Michigan (3), Minnesota (1), Mississippi (2), Nebraska (1), Nevada (1), New Jersey (2), New York (7), North Carolina (3), Ohio (4), Oregon (14), Pennsylvania (6), Rhode Island (3), South Carolina (3), Texas (12), Washington (2)	88	42%

* A program may select multiple answers to this question.
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State Medicaid programs have a variety of mechanisms for recourse once a beneficiary has been detected for potential FWA. Interventions may include denying claims, PRR programs, DUR-related education and notification to prescribers, and/or requiring prior authorization for all

controlled substance claims. FFY 2022 survey responses depicted in Tables 43 and 44 show potential recourses to initiate multiple actions such as PRR programs (86% of FFS and 90% of MCPs), alerting the PIU (78% of FFS and 67% of MCPs), denying claims (59% of FFS, and 47% of MCPs), and/or requiring prior authorization (51% of FFS and 51% of MCPs).

Table 43 FFS Actions when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected*

Response	States	Total	Total Percent
Deny Claims	Alaska, Arkansas, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, South Carolina, Texas, Utah, Vermont, Virginia, West Virginia	30	59%
Refer to PRR Program	Alabama, Alaska, Arizona, Arkansas, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	44	86%
Refer to Office of Inspector General (OIG)	Arizona, Arkansas, Indiana, Kentucky, Maine, Maryland, Michigan, Minnesota, New Mexico, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Wisconsin	17	33%
Refer to PIU and/or SUR Unit for Audit/Investigation	Alabama, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia, Wyoming	40	78%
Require Prior Authorization	Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New York, North Dakota, Oregon, South Carolina, Tennessee, Vermont, Virginia, West Virginia	26	51%
Other**	Alaska, California, Connecticut, Florida, Indiana, Mississippi, Montana, New Hampshire, New Jersey, North Carolina, Utah, Vermont, Virginia	13	25%

* A program may select multiple answers to this question.
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Table 44 MCP Actions when Potential Fraud or Abuse of Controlled Drugs by Beneficiaries is Detected*

Response	States (Count of MCPs)	Total	Total Percent
Deny Claims	Arizona (5), Arkansas (4), Colorado (2), District of Columbia (2), Florida (5), Georgia (2), Hawaii (2), Illinois (5), Indiana (3), Kansas (2), Louisiana (2), Maryland (7), Massachusetts (1), Michigan (3), Minnesota (4), Mississippi (1), Nevada (1), New Hampshire (1), New Jersey (3), New Mexico (3), New York (5), North Carolina (2), Ohio (2), Oregon (4), Pennsylvania (3), Rhode Island (1), South Carolina (2), Texas (13), Utah (3), Virginia (5), Washington (1)	99	47%
Refer to PRR Program	Arizona (7), Arkansas (3), Colorado (1), Delaware (2), District of Columbia (4), Florida (9), Georgia (3), Hawaii (5), Illinois (6), Indiana (5), Iowa (1), Kansas (3), Kentucky (5), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (14), North Carolina (5), Ohio (5), Oregon (9), Pennsylvania (8), Rhode Island (3), South Carolina (4), Texas (16), Utah (4), Virginia (6), Washington (5)	191	90%
Refer to Office of Inspector General (OIG)	Arizona (1), Arkansas (3), District of Columbia (1), Florida (2), Georgia (1), Hawaii (2), Illinois (3), Indiana (3), Kansas (2), Louisiana (1), Maryland (6), Massachusetts (1), Michigan (7), Minnesota (3), Mississippi (2), Nebraska (1), New Jersey (2), New York (4), North Carolina (1), Ohio (2), Oregon (1), Pennsylvania (3), Rhode Island (1), Texas (5), Utah (3), Virginia (3), Washington (1)	65	31%
Refer to PIU and/or SUR Unit for Audit/ Investigation	Arizona (5), Arkansas (3), Delaware (2), District of Columbia (2), Florida (8), Georgia (2), Hawaii (5), Illinois (3), Indiana (4), Iowa (1), Kansas (2), Kentucky (2), Louisiana (4), Maryland (7), Massachusetts (4), Michigan (9), Minnesota (5), Mississippi (2), Nebraska (2), Nevada (2), New Hampshire (3), New Jersey (5), New Mexico (2), New York (11), North Carolina (5), Ohio (3), Oregon (10), Pennsylvania (7), Rhode Island (3), South Carolina (3), Texas (5), Utah (4), Virginia (5), Washington (2)	142	67%
Require Prior Authorization	Arizona (4), Arkansas (2), Colorado (2), District of Columbia (3), Florida (6), Georgia (1), Hawaii (2), Illinois (5), Indiana (2), Kansas (2), Kentucky (6), Louisiana (2), Maryland (7), Michigan (5), Minnesota (5), Mississippi (2), Nebraska (1), Nevada (1), New Hampshire (1), New Jersey (4), New Mexico (3), New York (4), North Carolina (2), Ohio (2), Oregon (5), Pennsylvania (2), Rhode Island (1), South Carolina (2), Texas (13), Utah (4), Virginia (6), Washington (2)	109	51%

Response	States (Count of MCPs)	Total	Total Percent
Other**	Arizona (1), Arkansas (2), Colorado (1), District of Columbia (3), Florida (5), Hawaii (3), Illinois (2), Indiana (2), Iowa (1), Kansas (3), Louisiana (3), Maryland (6), Massachusetts (1), Michigan (3), Minnesota (2), Mississippi (1), Nebraska (1), New Hampshire (1), New Jersey (2), New Mexico (1), New York (3), North Carolina (2), Ohio (2), Oregon (8), Pennsylvania (3), Rhode Island (2), South Carolina (2), Texas (8), Virginia (3), Washington (1)	78	37%

* A program may select multiple answers to this question.
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4.3. FWA of Prescribers

Potential FWA of controlled substances by prescribers may be detected through either manual or algorithmic review of claims data. FFY 2022 survey responses shown in Tables 45 and 46 that all FFS and MCPs have a documented process in place that identifies possible FWA of controlled drugs by prescribers. Those FFS programs without a documented program to detect FWA of controlled substances review claims data through their prior authorization process and other established state review initiatives, including their program integrity unit to identify outlying prescribers. Once identified, these programs will provide case management and/or forward these outlying prescribers to their state PIU, SUR Unit, medical board, and/or to the DEA for action.

Table 45 FFS Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers

Response	States	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	51	100%
National Totals		**51**	**100%**

Table 46 MCP Documented Process to Identify Possible FWA of Controlled Drugs by Prescribers

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (8), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	212	100%
National Totals		**212**	**100%**

State Medicaid programs have a variety of mechanisms for recourse once a prescriber has been detected for potential FWA. FFY 2022 survey responses show potential recourse may initiate multiple actions, as seen in Tables 47 and 48. The top action for both the FFS and MCPs are to alert their PIU and/or SUR Unit for audit/investigation (88% of FFS and 83% of MCPs). Another action initiated by these programs is to alert the appropriate Medical Board (61% of FFS and 40% of MCPs).

Table 47 FFS Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected*

Response	States	Total	Total Percent
Deny Claims Written by this Prescriber	California, Connecticut, Florida, Georgia, Illinois, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Dakota, Oregon, South Carolina, Texas, Utah, Vermont, West Virginia	19	37%
Refer to PIU and/or SUR Unit for Audit/ Investigation	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	45	88%
Refer to the Appropriate Medical Board	Alabama, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, West Virginia, Wyoming	31	61%

Response	States	Total	Total Percent
Other**	Alaska, Arizona, Arkansas, California, Connecticut, Illinois, Kansas, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Montana, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, Vermont, Washington, Wisconsin	24	47%

* A program may select multiple answers to this question.
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Table 48 MCP Actions Process Initiates when Possible FWA of Controlled Drugs by Prescribers is Detected*

Response	States (Count of MCPs)	Total	Total Percent
Deny Claims Written by this Prescriber	Arizona (5), Arkansas (2), Colorado (1), District of Columbia (3), Florida (3), Georgia (3), Hawaii (3), Illinois (3), Indiana (3), Kansas (1), Kentucky (1), Louisiana (1), Maryland (5), Massachusetts (1), Michigan (6), Minnesota (5), Mississippi (1), Nebraska (1), New Hampshire (1), New Jersey (3), New Mexico (2), New York (6), North Carolina (1), Ohio (1), Oregon (5), Pennsylvania (3), South Carolina (1), Texas (2), Utah (2), Virginia (2), Washington (3)	80	38%
Refer to PIU and/or SUR Unit for Audit/ Investigation	Arizona (7), Arkansas (4), Colorado (1), Delaware (2), District of Columbia (4), Florida (9), Georgia (3), Hawaii (6), Illinois (5), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (8), Massachusetts (4), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (3), New Hampshire (2), New Jersey (5), New Mexico (3), New York (12), North Carolina (5), Ohio (3), Oregon (11), Pennsylvania (6), Rhode Island (3), South Carolina (4), Texas (7), Utah (4), Virginia (5), Washington (4)	175	83%
Refer to the Appropriate Medical Board	Arizona (3), Arkansas (2), Colorado (1), Delaware (1), District of Columbia (1), Florida (3), Georgia (1), Hawaii (3), Illinois (2), Indiana (4), Kansas (2), Kentucky (2), Louisiana (3), Maryland (4), Massachusetts (2), Michigan (5), Minnesota (7), Mississippi (2), Nebraska (2), Nevada (1), New Hampshire (1), New Jersey (3), New Mexico (1), New York (7), North Carolina (1), Ohio (2), Oregon (1), Pennsylvania (3), Rhode Island (1), South Carolina (2), Texas (3), Utah (2), Virginia (4), Washington (2)	84	40%

Response	States (Count of MCPs)	Total	Total Percent
Other**	Arkansas (3), Delaware (1), District of Columbia (2), Florida (8), Georgia (3), Hawaii (4), Illinois (3), Indiana (3), Iowa (1), Kansas (2), Louisiana (2), Maryland (7), Massachusetts (3), Michigan (6), Minnesota (2), Mississippi (2), Nebraska (1), Nevada (2), New Hampshire (2), New Jersey (3), New Mexico (2), New York (9), North Carolina (3), Ohio (4), Oregon (13), Pennsylvania (5), Rhode Island (2), South Carolina (5), Texas (13), Utah (3), Virginia (4), Washington (3)	126	59%

* A program may select multiple answers to this question.
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4.4. FWA of Pharmacy Providers

Potential FWA of controlled substances by pharmacies may be detected through either manual or algorithmic review of claims data. FFY 2022 survey responses show that most programs (98% of FFS and 99% of MCPs) have a documented process in place that identifies possible FWA of controlled drugs by pharmacies, as shown in Tables 49 and 50. Those FFS programs without a documented program to detect FWA of controlled substances review claims data and heavily rely on safety edits and prior authorization processes to help detect pharmacies committing potentially fraudulent activities, in addition to working collaboratively with their PI and SUR units. The majority of these FFS programs also limit pharmacist overrides, which prevent these providers from most forms of fraud or misuse of controlled drugs.

Table 49 FFS Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers

Response	States	Total	Percent of Total
Yes	Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming	50	98%
No*	Nevada	1	2%
National Totals		**51**	**100%**

* Response in the FFY 2022 report for NV confirms implementation in FFY 2023 for compliance.

Table 50 MCP Documented Process to Identify Possible Fraud or Abuse of Controlled Drugs by Pharmacy Providers

Response	States (Count of MCPs)	Total	Percent of Total
Yes	Arizona (7), Arkansas (4), Colorado (2), Delaware (2), District of Columbia (4), Florida (11), Georgia (3), Hawaii (6), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (9), Massachusetts (5), Michigan (9), Minnesota (9), Mississippi (3), Nebraska (3), Nevada (4), New Hampshire (3), New Jersey (5), New Mexico (3), New York (15), North Carolina (5), Ohio (5), Oregon (21), Pennsylvania (7), Rhode Island (3), South Carolina (5), Texas (16), Utah (4), Virginia (6), Washington (5)	211	99%
No*	Pennsylvania (1)	1	1%
National Totals		**212**	**100%**

*Response in the FFY 2022 report for PA indicates compliance.

State Medicaid programs have a variety of mechanisms for recourse once a pharmacy has been detected for potential fraud, waste, or misuse of controlled substances. FFY 2022 survey responses show potential recourse may initiate multiple actions, as seen in Tables 51 and 52. The top action for both the FFS and MCPs are to alert their PI unit and/or SUR Unit for audit/investigation (90% of FFS and 81% of MCPs). Another action initiated by these programs is to alert the State Board of Pharmacy (59% of FFS and 45% of MCPs).

Table 51 FFS Actions Process Initiates when Possible FWA of Controlled Drugs by Pharmacy Providers is Detected*

Response	States	Total	Total Percent
Deny Claim	California, Connecticut, Delaware, Florida, Georgia, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Dakota, Oregon, South Carolina, Texas, Vermont, West Virginia	20	39%
Refer to Board of Pharmacy	Alabama, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wyoming	30	59%

Response	States	Total	Total Percent
Refer to PIU and/or SUR Unit for Audit/ Investigation	Alabama, Alaska, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming	46	90%
Other**	Alaska, Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Michigan, Minnesota, Mississippi, Montana, New Hampshire, New Jersey, North Carolina, Pennsylvania, Tennessee, Texas, Washington, Wisconsin	23	45%

* A program may select multiple answers to this question.
** Access state specific reports at Medicaid.gov

Table 52 MCP Actions Process Initiates when Possible FWA of Controlled Drugs by Pharmacy Providers is Detected*

Response	States (Count of MCPs)	Total	Total Percent
Deny Claims	Arizona (5), Arkansas (2), Colorado (1), District of Columbia (3), Florida (6), Georgia (3), Hawaii (4), Illinois (3), Indiana (4), Iowa (1), Kentucky (6), Louisiana (4), Maryland (3), Massachusetts (3), Michigan (5), Minnesota (6), Nebraska (1), Nevada (1), New Hampshire (3), New Jersey (3), New Mexico (3), New York (5), North Carolina (3), Ohio (2), Oregon (10), Pennsylvania (1), Rhode Island (1), South Carolina (1), Texas (12), Utah (2), Virginia (2), Washington (3)	112	53%
Refer to PIU and/or SUR Unit for Audit/ Investigation	Arizona (7), Arkansas (3), Colorado (1), Delaware (2), District of Columbia (3), Florida (8), Georgia (3), Hawaii (5), Illinois (6), Indiana (5), Iowa (2), Kansas (3), Kentucky (6), Louisiana (5), Maryland (6), Massachusetts (3), Michigan (9), Minnesota (8), Mississippi (2), Nebraska (3), Nevada (3), New Hampshire (3), New Jersey (5), New Mexico (3), New York (10), North Carolina (5), Ohio (3), Oregon (18), Pennsylvania (6), Rhode Island (3), South Carolina (4), Texas (6), Utah (4), Virginia (5), Washington (3)	171	81%

Response	States (Count of MCPs)	Total	Total Percent
Refer to the Board of Pharmacy	Arizona (3), Arkansas (1), Colorado (1), Delaware (1), District of Columbia (1), Florida (4), Georgia (1), Hawaii (3), Illinois (1), Indiana (3), Kansas (1), Kentucky (6), Louisiana (1), Maryland (3), Massachusetts (2), Michigan (5), Minnesota (7), Mississippi (1), Nebraska (2), Nevada (1), New Hampshire (2), New Jersey (3), New Mexico (3), New York (3), North Carolina (3), Ohio (3), Oregon (13), Pennsylvania (5), Rhode Island (2), South Carolina (1), Texas (3), Utah (2), Virginia (3), Washington (2)	96	45%
Other**	Arizona (1), Arkansas (3), Delaware (2), District of Columbia (2), Florida (8), Georgia (2), Hawaii (5), Illinois (3), Indiana (3), Kansas (2), Louisiana (4), Maryland (6), Massachusetts (4), Michigan (9), Minnesota (6), Mississippi (2), Nevada (2), New Hampshire (3), New Jersey (4), New Mexico (2), New York (14), North Carolina (2), Ohio (5), Oregon (5), Pennsylvania (6), Rhode Island (3), South Carolina (4), Texas (13), Utah (3), Virginia (5), Washington (3)	136	64%

* A program may select multiple answers to this question.
** Access state specific reports at Medicaid.gov

5. Managed Care Compliance

Consistent with section 1902(oo)(1)(A)(ii) of the Act, as added by section 1004 of the SUPPORT Act, states must ensure that their contracts with their MCPs under section 1903(m) of the Act, require that the contracted MCP has in place opioid safety edits, automated claims review processes, a program to monitor antipsychotic medications in children, and fraud and abuse identification requirements. State implementation of these DUR provisions in contracts was required by October 1, 2019.

This section provides the survey results for state Medicaid programs related to MCP compliance with the relevant provisions added by section 1004 of the SUPPORT Act.

FFY 2022 survey responses shown in Table 53 reflects that 90% of state Medicaid programs that utilize a managed care delivery system updated their MCP contracts to comply with Section 1004 of the SUPPORT Act.

Table 53 MCP Contract Compliance for Section 1004 of the SUPPORT Act*

Response	States	Total	Percent of Total
Yes, Contracts are Updated to Address Each Provision	Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia	37	90%
No, Contracts Not Updated**	Missouri, New York, North Carolina, Wisconsin	4	10%
National Totals		**41**	**100%**

* Not all states have managed care delivery systems that utilize MCPs.
** Missouri and Wisconsin excluded covered outpatient drugs from MCP contracts and instead provided them through their FFS program; therefore, an MCP contract amendment is not required. New York indicates that MCPs are required to comply with all applicable state and federal laws and regulations under the provisions of Section 35.1 of the contract, which would include compliance with the SUPPORT Act. NY indicated that the SUPPORT ACT contract language will be added in a forthcoming amendment. North Carolina indicates the contracts do not have specific language regarding the SUPPORT Act, but they require that their MCPs follow all CMS guidance, SSA, and other federal and state laws and regulations.

The majority of states (98%) reported they are monitoring MCP compliance with provisions added by Section 1004 of the SUPPORT Act, as shown in Table 54.

Table 54 State Reported Compliance with Federal Law in Monitoring MCP Compliance with Section 1004 of the SUPPORT Act*

Response	States	Total	Percent of Total
Yes, State is Complying with Federal Law and Monitoring MCP Compliance with Section 1004 of the SUPPORT Act Provisions	Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia,	40	98%
No**	Missouri, Wisconsin	1	2%
National Totals		**41**	**100%**

*Note: Not all states have managed care delivery systems that utilize MCPs.
**Missouri and Wisconsin have their covered outpatient drugs excluded from MCP contracts and provided instead by their FFS program.

6. Discussion and Recommendations

The SUPPORT Act includes measures to address the opioid crisis in part by reducing prescription opioid fraud and misuse by advancing treatment and recovery initiatives, improving treatment, protecting communities, and bolstering illicit drug use prevention efforts. Section 1004 of the SUPPORT Act addresses FFS and MCP policy goals of protecting beneficiaries from and educating providers about opioid misuse and overutilization, addressing the clinical appropriateness of the use of antipsychotic medications in children, and bolstering Program Integrity activities. State implementation of these standards was required by October 1, 2019, and states included information about their implementation in their FFY 2020, 2021, and 2022 annual DUR reports or, in the case of Arizona, through a separate Section 1004 report.

The survey question responses for the following topics have been included in this report:

- Prospective claim safety edits, including on initial prescription fill days' supply for beneficiaries without recent history of opioid therapy, quantity limits for initial and subsequent fills, therapeutically duplicative fills, and early fills on opioid prescriptions at point of dispensing to determine appropriate opioid use.
- Safety edit limits (as specified by the state) on the maximum daily MME that can be prescribed to a beneficiary.
- Retrospective reviews and, at the option of the state, prospective safety edits monitoring the use of opioids concurrently with benzodiazepines and/or antipsychotics.
- Claims review automated process that indicates prescription fills of opioids in excess of these limitations to provide for the ongoing periodic reviews of opioid claims data.
- Monitoring the use of antipsychotic medication use in children.
- Identification of FWA of controlled substances.

Variations in the methods used by states to meet the required standards were noted, and further details can be found in state specific reports on Medicaid.gov.

Broadly, the implementation of standards related to these provisions were similar in states' FFS and MCPs. As seen below in Tables 55 and 56, the majority of programs have already implemented the standards required by amendments made by section 1004 of the SUPPORT Act or have a plan in place to implement those standards in the near future. State survey question responses included in the FFY 2020, 2021, and 2022 annual DUR reports for both FFS and MCPs have been combined to allow for comparison of progress by states.

Table 55 National FFS Improvements in Implementing Selected DUR Safety Reviews

Provision	FFS FFY 2020	FFS FFY 2021	FFS FFY 2022
Process to Identify FWA in Beneficiaries	100%	100%	100%
Opioid/Benzodiazepine Safety and/or Retrospective Edits	98%	98%	100%
Opioid/Antipsychotic Safety and/or Retrospective Edits	92%	96%	100%
Duplicate Opioid Therapy Edits	100%	100%	98%*

Provision	FFS FFY 2020	FFS FFY 2021	FFS FFY 2022
MME Limits	98%	100%	98%**
Program in Place to Manage/Monitor Antipsychotic Use in Children	100%	100%	100%
Contract Updates Between State and their MCPs Addressing Provisions in Section 1004 of the SUPPORT Act	97%	100%	90%***

*Reference Table 17.
**Reference Table 19.
***Responses for states with pharmacy benefit excluded from MCP contracts and provided by the FFS program lower this number. Reference Table 53.

Table 56 National MCP Improvements in Implementing Selected DUR Safety Reviews

Provision	MCP FFY 2020	MCP FFY 2021	MCP FFY 2022
Process to Identify FWA in Beneficiaries	99%	100%	100%
Opioid/Benzodiazepine Safety and/or Retrospective Edits	90%	99%	96%*
Opioid/Antipsychotic Safety and/or Retrospective Edits	82%	100%	95%*
Duplicate Opioid Therapy Edits	95%	100%	99%**
MME Limits	99%	100%	99%***
Program in Place to Manage/Monitor Antipsychotic Use in Children	77%*	100%	88%*

* Following CMS oversight in reaching out to MCPs, it was determined that MCP compliance is much higher than this number appears. MCPs indicated it was because these medications were excluded from MCP contracts, restricted to FFS programs, or the monitoring and managing was handled through the FFS program.
**Reference Table 18.
***Reference Table 20.

The following are recommendations to help states and MCPs more effectively implement the prospective safety edits and retrospective claims reviews required under the amendments made by section 1004 of the SUPPORT Act.

States Should Continue to Upgrade Existing Systems from Manual to Automated Retrospective Claims Review to Increase Compliance and Detect High Doses of Prescribed Opioids in a Timely and Efficient Manner.

FFY 2022 survey responses show greater compliance as compared to FFY 2021, within FFS and MCPs implementing automated retrospective claims review. For FFS programs, 50 states (98%) have an automated retrospective claims DUR review process to monitor opioid prescriptions exceeding state limitations, a 25% increase from FFY 2020, and 196 MCPs (93%) have an automated DUR respective claims review process to monitor opioid prescriptions exceeding state limitations, a 6% increase from FFY 2021. Amendments made by section 1004 of the SUPPORT Act require

automated retrospective claims review to detect high doses of opioids and program follow up on prescription trends or issues found on prescriptions that have already been dispensed. States should continue to update systems and automations to enhance claim processing and clinical reviews.

States Should Consider Beneficiaries Specific Clinical Circumstances When Performing Reviews.

To enhance state clinical reviews, pursuant to the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain, a multimodal and multidisciplinary approach to pain management attending to the physical health, behavioral health, long-term services, and supports, and expected health outcomes and well-being of each person is critical.[56] Flexibility to meet the care needs and the clinical circumstance of a specific patient is paramount. The use of electronic health records and web-based technologies has resulted in the widespread use of feedback interventions to monitor and operationalize patient specific clinical circumstances.[57] The updated 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain were developed to 1) ensure a clinical tool to improve communication between clinicians and patients and empower them to make informed, person-centered decisions related to pain care together; 2) improve the safety and effectiveness of pain treatment; mitigate pain; improve function and quality of life for patients with pain; and 3) reduce risks associated with opioid pain therapy, including OUD, overdose, and death.[58]

In Operating Their DUR Programs, States Must Adhere to All Required Federal DUR Minimum Standards.

We acknowledge that other initiatives, which many states may be already undertaking, work synergistically with the SUPPORT Act requirements to further help reduce fraud and misuse related to opioids. In addition to codifying the SUPPORT Act requirements, additional minimum DUR standards were implemented at 42 C.F.R. § 456.703(h)(1)(vii) to prevent opioid related overdoses. States should take the necessary steps to ensure compliance with these additional provisions, which include prospective safety edits, retrospective claims review automated processes, or a combination of these approaches as determined by the state, to identify when:

1) A beneficiary is prescribed an opioid after the beneficiary has been prescribed one or more medications for opioid use disorder (MOUD) or has been diagnosed with an OUD, within a timeframe specified by the state, in the absence of a new indication to support utilization of opioids (such as new cancer diagnosis or entry into hospice care). For the FFY 2022 DUR report, 82% of FFS programs and 87% of MCPs reported having edits in place to monitor when opioids are being used concurrently with any buprenorphine drug or any form of MOUD. Given the critical importance of ensuring safe and effective treatment for individuals receiving MOUD, there remains a significant opportunity to enhance these monitoring

[56] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.
[57] Dowding D, Randell R, Gardner P, Fitzpatrick G, Dykes P, Favela J, et al. Dashboards for Improving Patient Care: Review of the Literature. Int J Med Inform. 2015;84(2):87–100.
[58] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

protocols further. Implementing these safeguards, improving data analytics, and increasing provider education would strengthen efforts to optimize beneficiary care; and

2) A beneficiary could be at high risk of opioid overdose and should be considered for co-prescription or co-dispensing of any FDA-approved opioid antagonist/reversal agent. For the FFY 2022 DUR report, 76% of FFS programs and 70% of MCPs reported having processes in place to monitor and manage dispensing of naloxone to persons at risk. Ensuring that naloxone is readily available to patients at risk of opioid overdose is a critical public health measure. As a life-saving medication, naloxone can rapidly reverse the effects of opioid overdose, preventing death and enabling individuals to seek further treatment and recovery.

States Should Continue to Strategize to Increase Access to Substance Use Disorder Treatment, such as Medications for Opioid Use Disorder (MOUD) and Accompanying Behavioral Therapies.

States should consider removing prior authorization for MOUD as a critical step towards removing barriers to access and availability and reducing burdens on providers.[59] Prior authorization can create unnecessary delays and barriers for beneficiaries in urgent need of treatment, potentially leading to interruptions in care and worsening health outcomes. Most recently, a 2025 analysis found that Medicaid managed care programs with prior authorization requirements for buprenorphine have lower OUD treatment engagement rates.[60] Removing prior authorization would streamline the prescribing process for health care providers, allowing them to focus on individual beneficiary care rather than navigating an approval process. Ensuring MOUD is readily available without delays is critical for promoting better outcomes for those seeking recovery.

For FFY 2022, 46 states (92%) and 173 MCPs (84%) have at least one buprenorphine/naloxone combination product (which is used for induction and maintenance treatment for individuals with OUD) available without prior authorization.

Other policies can also be implemented to prevent opioid misuse and overdose, such as working with PDMPs to track prescribing patterns and identify potential misuse and improving access to mental health services for beneficiaries with or at risk for substance use disorders. Ultimately, a multifaceted approach is necessary to prevent and address this public health crisis effectively.

When Certain Medications are Excluded from MCP Contracts and provided by FFS Programs, States Should Ensure Appropriate Data Sharing with MCPs.

In states where some medical benefits are covered by MCPs, but some or all medications are covered through the FFS program, appropriate data sharing between the MCP and FFS program

[59] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on the Examination of the Integration of Opioid and Infectious Disease Prevention Efforts in Select Programs. Opportunities to Improve Opioid Use Disorder and Infectious Disease Services: Integrating Responses to a Dual Epidemic. Washington (DC): National Academies Press (US); 2020 Jan 23. Available from: https://www.ncbi.nlm.nih.gov/books/NBK555809 / doi: 10.17226/25626.

[60] Stewart M, Feltus S, Andrews C, Hodgkin D, Thomas C, Horgan C, Predictors of Medicaid Managed Care Plan Performance on Opioid Use Disorder Treatment Quality Metrics, Drug and Alcohol Dependence, Volume 274, 2025, 112742, ISSN 0376-8716, https://doi.org/10.1016/j.drugalcdep.2025.112742

should exist to allow clinical teams from each program to have the full picture of medication use, avoid inappropriate duplication of therapy, inappropriate concurrent therapies, or drug-drug interactions, and protect beneficiaries' health.

While there has been continued improvement in many of these initiatives, there is still room for additional enhancements to reach a point where all FFS programs and MCPs have fully implemented DUR standards required by the amendments made by section 1004 of the SUPPORT Act and by section 1927(g) of the Act and implementing regulations. As a result of data-related nuances, some aspects of compliance are difficult to determine. Additionally, some states have initiatives beyond what is required and have been engaged in a number of activities related to the opioid crisis for several years.

For FFY 2022, CMS contacted applicable states, including their MCPs, to address program deficits. After reviewing FFY 2022 results for each FFS and MCP, CMS implemented additional compliance reviews addressing all specific noncompliance findings in FFS programs and MCPs, with 23 FFS findings and 110 MCPs findings in 35 states. CMS reached out to these states to request additional supplemental information and data to enable CMS to better identify and work with these states to address deficiencies, misinterpretations, and errors and, if necessary, to address issues through corrective action plans for their applicable FFS and/or MCPs. States were asked to provide explanations for responses indicating noncompliance, actions taken to address the issue, and any dates involved in implementation, including supportive materials. States were expected to correct actual errors and discrepancies and take steps to ensure compliance with all federal regulations. All states responded to CMS' noncompliance correspondence. States either corrected the action immediately or implemented a corrective action plan (CAP) to remediate their noncompliance.

Based on this current report to Congress, and our evaluations of the submissions, CMS will continue to conduct oversight and request corrective actions by states where necessary to come into compliance with federal requirements.

Appendix A – Acronyms

AK	Alaska
AL	Alabama
AR	Arkansas
AZ	Arizona
CA	California
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
C.F.R.	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CNS	Central Nervous System
CO	Colorado
CSA	Controlled Substances Act
CT	Connecticut
DC	District of Columbia
DE	Delaware
DEA	Drug Enforcement Administration
DUR	Drug Utilization Review
ED	Emergency Department
FDA	Food and Drug Administration
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FL	Florida
FWA	Fraud, Waste and Abuse
GA	Georgia
HHS	Department of Health and Human Services
HI	Hawaii
IA	Iowa
ID	Idaho
IL	Illinois
IN	Indiana
KS	Kansas
KY	Kentucky
LA	Louisiana
MA	Massachusetts
MCP	Managed Care Plan
MD	Maryland
ME	Maine

MI	Michigan
MME	Morphine Milligram Equivalent
MN	Minnesota
MO	Missouri
MOUD	Medications for Opioid Use Disorder
MS	Mississippi
MT	Montana
NC	North Carolina
ND	North Dakota
NE	Nebraska
NH	New Hampshire
NJ	New Jersey
NM	New Mexico
NV	Nevada
NY	New York
OEOCR	Office of Equal Employment Opportunity & Civil Rights
OH	Ohio
OIG	Office of Inspector General
OK	Oklahoma
OR	Oregon
OUD	Opioid Use Disorder
PA	Pennsylvania
PDMP	Prescription Drug Monitoring Program
PI	Program Integrity
PIU	Program Integrity Unit
PMTF	Pain Management Task Force
POS	Point of Sale
PRR	Review and Restriction Program
RI	Rhode Island
SC	South Carolina
SD	South Dakota
SUD	Substance Use Disorder
SUR	Surveillance Utilization Review Unit
TN	Tennessee
TPL	Third Party Liability
TX	Texas
UT	Utah
VA	Virginia
VBP	Value-Based Purchasing
VT	Vermont

WA	Washington
WI	Wisconsin
WV	West Virginia
WY	Wyoming