**Medicaid Lock-in Programs: What do they look like and do they have an impact?**

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Summary and Overview

 Medicaid lock-in programs (MLIPs) are programs administered by state Medicaid agencies in attempt to reduce prescription drug overuse and fraud. Nearly all states have some form of MLIP, but each of these programs is quite unique. While there are certainly similarities across programs in terms of criteria for enrollment or the provisions of the lock-in, each state administers its program differently and has had varying degrees of success in terms of cost and curbing fraud.

 There are a number of different terms commonly used to define or to refer to these lock-in programs: Lock-In, Safe Pharmacy, Patient Restriction & Review (PRR), or Integrity Program. The content and the availability of public information on MLIPs varies greatly from state to state, making it challenging to determine whether a state does not have a strong program or whether there is just a lack of publicly available information on the program. Kentucky and Tennessee appear to have relatively robust programs, and so these state programs were identified as a model for comparison across states.

 This report will summarize original research and existing research on key elements of MLIPs, describe available MLIP program impact data, detail a deep-dive into nine MLIPs and their associated appeal rights and data sharing provisions, and will conclude with current trends and perceptions regarding lock-in programs. Much of this information was generated by conducting original online research into state MLIPs, which is documented in the “50-state File,” the accompanying Excel file.

Program Authority and Establishment

Prescription Drug Monitoring Programs (PDMPs), or Prescription Monitoring Programs (PMPs) and Drug Utilization Review (DUR) are state-run programs which help establish patient eligibility for the lock-in programs. [Forty states](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3680126/) have PMPs, which overall cover 87% of the U.S. population. All states must have DUR programs and most states will identify and determine enrollment in lock-in programs based on DUR evaluations. Often, the state DUR board sets the criteria for beneficiary behavior and claims to be considered fraud or abuse, and then retrospective DUR will identify the specific beneficiaries eligible for the lock-in. Alternatively, Arkansas, Vermont, and North Dakota enroll based on [provider referrals.](http://www.dhhr.wv.gov/bms/Pharmacy/dur/Documents/Capsules/dur_Newsletter200140818.pdf) These states rely on physicians to identify overuse or misuse of these medications and to subsequently report these cases.

The federal authority which enables states to establish MLIPs is located at [42 CFR 431.54(e).](http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec431-54.pdf) The language is very broad, and does not explicitly define standards or set requirements. This may explain why there is such variability across state programs. It does set a requirement for appeals rights, though.

 *(e) Lock-in of beneficiaries who over-utilize Medicaid services. If a Medicaid agency finds that a beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that beneficiary for a reasonable period of time to obtain Medicaid services from designated providers only. The agency may impose these restrictions only if the following conditions are met:*

*(1) The agency gives the beneficiary notice and opportunity for a hearing (in accordance with procedures established by the agency) before imposing the restrictions.*

 *(2) The agency ensures that the beneficiary has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality.*

 *(3) The restrictions do not apply to emergency services furnished to the beneficiary.*

MLIP Details

 MLIPs vary according to their lock-in provisions, lock-in duration, enrollment criteria, and the appeals processes. This section will summarize key similarities and differences across MLIPs. The associated 50-state File has additional state-specific details which was used for these summary comparisons.

[**46 states**](http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=18019) **and the District of Columbia have MLIPs**

The handful of states that do not have MLIPs include Arizona, California, New Mexico, and South Dakota.

**Lock-in program provisions**

 [Most states'](http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=18019) MLIPs restrict beneficiaries to 1 pharmacy and 1 physician, and sometimes 1 hospital also. The programs typically explain the exceptions process for emergency situations, when beneficiaries can seek covered services from providers and hospitals outside of their lock-in providers. While many state programs do look similar, there is still considerable variation in the lock-in program provisions across certain states.

* [Florida](http://www.fdhc.state.fl.us/Medicaid/Prescribed_Drug/lockin.shtml)- beneficiaries locked-in to only 1 pharmacy
* [Missouri](http://mmac.mo.gov/participants/participant-lock-in/)- beneficiaries locked-in to either 1 physician or 1 pharmacy, or both
* [District of Columbia](http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MedicaidRegPharmacyServicesNoticeFinal.pdf)- beneficiaries locked-in to 1 pharmacy, chosen by the beneficiary from a list of 3 pharmacies

**Lock-in duration**

 The duration of most state MLIPs is 12-24 months, although the duration of some MLIPs can be quite a bit longer.

* [Pennsylvania](http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/s_001848.pdf)- 5 years
* [Tennessee-](http://www.tn.gov/sos/rules_all/2014/1200-13-13.20140101.pdf) lock-in status can be discontinued after 6 months if the beneficiary meets all applicable requirements

 Additionally, many states have a set time period for the initial lock-in, but will then review the beneficiary’s case to determine if an additional lock-in period is necessary. For example, in Missouri the Surveillance and Utilization Review System Unit will review cases between 12 months and 24 months after the start of the initial lock-in to determine if another 12-24 month lock-in is appropriate.

**Enrollment criteria**

 The criteria for lock-in enrollment is publicly available for many states. There is significant variability in how states decide to enroll individuals in the MLIP. Typically, enrollment is based on a combination, in a given time period, of:

* The number of prescriptions filled
* The number of pharmacies visited
* The number of prescribers

A few examples of state criteria for lock-in enrollment:

* [Nevada-](http://www.nga.org/files/live/sites/NGA/files/pdf/MedicaidStateRequirementsAndOptionsChart.pdf) 2+ prescribers and 2+ pharmacies and 5+ controlled substances (3+ are opioids) within 45 days
* [Arkansas-](http://www.sos.arkansas.gov/rulesRegs/Arkansas%20Register/2006/mar_2006/016.06.05-100.pdf) uses an unspecified computerized algorithm followed by a manual review process
* [Massachusetts](http://www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-pharmacy.pdf)- More than 11 prescriptions (including fills and refills) of Schedule II-IV substances from 4+ prescribers or filled by 4+ pharmacies in 90 days.

**Appeals process**

 Most states will explicitly describe the beneficiary’s appeal rights in the notification letter sent to the beneficiary, which states they have been identified for the MLIP. Some states send a warning letter to the beneficiary, in an attempt to give the beneficiary time to change his/her behavior and potentially avoid the lock-in, whereas other states simply send the notification letters with the lock-in effective date included. The notification letter may specify a 10 or 30 day window of time in which the beneficiary can file a grievance. The notification letter may also allow beneficiaries to select a pharmacy or provider for the lock-in on their own or from a list, or the letter may have a pharmacy and provider already selected.

**MLIP program impact**

There is limited peer-reviewed and published research on the public health and cost impact of MLIPs. However, many state programs have done evaluations of their programs, and have made these assessments and results public. Each evaluation measures the impact slightly differently, over different time periods, and each state has a different program, so it is difficult to generalize based on an individual state’s impact data.

**Louisiana-** A 1998 study published in *Value in Health* found that [Louisiana MLIP](http://www.valueinhealthjournal.com/article/S1098-3015%2810%2975696-5/pdf) increased single pharmacy prescriptions, reduced polypharmacy, reduced use of Schedule II narcotics, significantly lower prescription costs. There was no impact on medications for chronic disease management. Monthly [pharmacy expenditures decreased](http://www.ucdmc.ucdavis.edu/iphi/Programs/OOD/resources/CDC%20Opioid%20Project_Final%20Report.pdf) from $300-400 before intervention to $225-250 for physician-pharmacy lock-in and $300 for pharmacy-only lock-in.

**Oklahoma-** A 2009 study published in*Journal of the Oklahoma State Medical Association* found that Oklahoma MLIP decreased in narcotic prescriptions, reduced polypharmacy, reduced multiple physicians, reduced emergency care, saved $606 per enrollee per year. No impact on medications for chronic [disease management](http://www.cdc.gov/homeandrecreationalsafety/pdf/PDO_patient_review_meeting-a.pdf).

**Wisconsin-** A 2010 study on the Wisconsin MLIP published in*Journal of Hospital Marketing & Public Relations* didn’t actually look at program impact, but only evaluated the automated, electronic system that identifies overutilizers. They found the [tool improved accuracy](http://www.ncbi.nlm.nih.gov/pubmed/20054735) and that the # of pharmacies visited was the best predictor of controlled substance abuse.

**Connecticut-** Connecticut Drug Utilization Review Board (DUR) looked at MLIP savings to the state- saved $3.7 million in 2009, $2.4 million in 2011. Savings of prospective DUR during 2011 estimated at [$16.4 million.](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Downloads/DURSurvey2011-StateXIIExecutiveSummarySurvey01152013.pdf)

**Iowa-** Iowa Medicaid Integrity Program- MLIP saves [$2 million](http://www.ucdmc.ucdavis.edu/iphi/Programs/OOD/resources/CDC%20Opioid%20Project_Final%20Report.pdf) per year.

**North Carolina-** North Carolina Department of Health and Human Services- [$5.2 million](http://www.ncdhhs.gov/pressrel/2012/2012-05-14_pills_off_streets.htm) in program savings in the first year, and 2 million fewer narcotic analgesic pills prescribed to the program’s 2,000 beneficiaries.

**Washington**- [37% decrease](http://www.ucdmc.ucdavis.edu/iphi/Programs/OOD/resources/CDC%20Opioid%20Project_Final%20Report.pdf) in physician visits, 33% reduction in ED visits, 24% decrease in number of prescriptions, almost cut number of narcotic prescriptions in half (average of 3.07 prescriptions to 1.63). Saved $120 million through 2012. Return on investment= $12 for every $1 invested.

**Missouri-** saved $1.8-$10.9 million/year, [$6.8-$41.3 million](http://www.cdc.gov/homeandrecreationalsafety/pdf/PDO_patient_review_meeting-a.pdf) in 2012 dollars.

**Hawaii-** restricted 270 patients between 1977-1983 and saved $900,000 or [$2 million](http://www.ucdmc.ucdavis.edu/iphi/Programs/OOD/resources/CDC%20Opioid%20Project_Final%20Report.pdf) in 2012 dollars.

**Ohio-** PRR [reduced monthly dosages](http://www.cdc.gov/homeandrecreationalsafety/pdf/PDO_patient_review_meeting-a.pdf) of narcotics by 41% and sedatives by 36%.

**Florida**- MLIP saved [$12.5 million](http://www.ucdmc.ucdavis.edu/iphi/Programs/OOD/resources/CDC%20Opioid%20Project_Final%20Report.pdf) from 2002-2005.

**West Virginia**- average savings of $48 per member per month, [saved WV $264,000](http://www.dhhr.wv.gov/bms/Pharmacy/dur/Documents/Capsules/dur_Newsletter200140818.pdf) over 6 months.

**Alaska-** Alaska’s Care Management program can accommodate 300 beneficiaries and saves [$4.5 million/year](http://dhss.alaska.gov/Commissioner/Documents/mrag/Sept/MRAG-Innovations-Revised-9-15-2014.pdf).

**ADOPT study**- This study used a modeling approach (Approaches to Drug Overdose Prevention Analytical Tool- ADOPT) to look at effectiveness of PRR programs. Estimate PRR program costs $300,000 annually plus $200 per beneficiary enrolled. Plus very good overview of current PRR/lock-in programs. [http://www.ucdmc.ucdavis.edu/iphi/Programs/OOD/resources/CDC%20Opioid%20Project\_Final%20Report.pdf](http://www.ucdmc.ucdavis.edu/iphi/Programs/OOD/resources/CDC%20Opioid%20Project_Final%20Report.pdf%22%20%5Ct%20%22_blank)

State Lock-in Program Deep Dive

 Kentucky and Tennessee were identified as having robust MLIPs with a considerable amount of publicly available data. As such, the lock-in programs of Kentucky and Tennessee were researched more thoroughly in order to establish a set of best practices for MLIPs. These programs were then compared to a handful of other states, also those which had publicly available data. The comparison states include Maryland, Massachusetts, Missouri, Alaska, District of Columbia, Kansas, and Oklahoma. These states also have publicly available information regarding their lock-in programs, and they represent a good variety of programs. See the chart below for the details on each of these programs. Note that not all states had the same type of information and data publicly available, but all available information was gathered and is included in the chart below, with links to references following the chart.

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| --- | --- | --- | --- | --- | --- |
| State | Lock-in Criteria | Duration | Lock-in Description | Data/Party Access | Appeal Rights |
| Kentucky | Beneficiary received services from at least 5 different providers, received at least ten 10 different prescription drugs, and received prescriptions from at least 3 pharmacies;ORBeneficiary had at least 4 hospital ED visits for a non-emergency condition; ORBeneficiary received services from at least 3 different hospital ERs for a non-emergency condition. | 24 months, can be extended | Establishes a medical home for beneficiary- locked into 1 PCP, 1 pharmacy, 1 controlled substances provider, and sometimes 1 hospital (for non-emergency care) | The State of Kentucky’s program integrity area has access to a database of all controlled substance prescriptions filled in Kentucky (eKASPER system). KY has strong collaboration between its Medicaid Fraud Control Unit, Department of Medicaid Services’ Division of Program Integrity and the Kentucky’s Cabinet for Health and Family Services Office of Inspector General. They hold quarterly meetings with KY’s MCO to review fraud cases. | Beneficiary can appeal within 30 days of notification letter. Once in Lock-in, beneficiary can seek services from outside provider if the PCP sends a completed Lock-in Recipient Referral form to the referred provider. |
| Tennessee | Criteria for “appropriate” for lock-in or “potentially appropriate” for lock-in. There’s a long list of over 10 potential criteria, including identification of fraud by OIG, an enrollee arrested for a drug-related offense, or one of the following within 90 days: controlled substance prescriptions from 3+ prescribers and 3+ pharmacies, OR the prescriptions were filled at 2+ pharmacies and writtenduring 3+ ED visits, etc. | 6 month minimum, must meet requirements to be removed from lock-in. The Bureau of TennCare or Managed Care Contractor (MCC) reviews member claims to determine lock-in duration. | Pharmacists verify TennCare coverage for prescriptions for TennCare enrollees. If PBM denies coverage because it isn’t the enrollee’s lock-in pharmacy, the PBM will send the enrollee a letter, which describes the right to appeal. The Bureau implements and maintains the TennCare lock-in program. | Those who can conduct prescription drug monitoring activities: the Bureau of TennCare, the MCCs, Pharmacy Benefits Managers (PBMs), TennCare OIG. | The Bureau or MCC will notify enrollee of determination for lock-in program- explaining the program, reason for lock-in status, effective date, and appeal information.  |
| Maryland | 6+ opioid prescriptions and 3+ providers within one month; OR 2+ opiates each for at least 360 doses in 3 months | 6, 12, 18, or 24 months | Recipient Corrective Managed Care Program- locked into 1 pharmacy | Maryland’s Corrective Managed Care Program monitors appropriate use of controlled substances, conducting monthly review to identify members who are receiving multiple controlled substances, visiting multiple prescribers and/orvisiting multiple pharmacies. Member information is shared with prescribers, pharmacy providers and PCPs in order to prevent any abusive behavior. Pharmacies and prescribers are first asked to intervene. | Beneficiaries have the right to appeal a lock-in decision. |
| Massachusetts | More than 11 prescriptions (including fills and refills) of Schedule II-IV substances from 4+ prescribers or filled by 4+ pharmacies in 90 days. | 12 months | MassHealth Controlled Substances Management Program- restricted to 1 pharmacy, except for rare and emergency situations | Members can be identified by the Recipient Eligibility Verification System (REVS) as participants. When members goes to a pharmacy with MassHealth card, REVS will alert pharmacy of the member’s restriction. | Members are notified that they have met the criteria, and are advised that they may request a letter of exemption from their PCP, or they can directly appeal the decision. |
| Missouri | Missouri Medicaid Audit and Compliance (MMAC) reviews beneficiary utilization for abuse- look at # prescribing providers, # pharmacies, # refills, # ED visits, and types of services received. Physicians can refer. | Surveillance and UtilizationReview System Unit will review cases between 12 months and 24 months post-lock in to determine if another 12-24 month lock-in is appropriate. | Beneficiary can be restricted to a physician/clinic, pharmacy, or both. |  | Members can choose their lock-in provider- free choice of participating Missouri Medicaid providers. Division of Medical Services will designate a provider if a beneficiary does not. Beneficiary has right to a fair hearing.  |
| Alaska | (1) a referral is made to the department indicating a beneficiary used medical item or service at a frequency not medically necessary; (2) the recipient receives prescriptions from one or more providers in total average daily doses that exceed those recommended; (3) in 3 consecutive months, uses a medical item or service with a frequency exceeding 2 standard deviations from the mean.  | 12 month maximum. Can be renewed annually. | Beneficiary is locked into 1 physician, 1 pharmacy. | The state’s fiscal agent, First Health Services Corporation, administers the lock-in program. | The department will first offer the recipient the opportunity for a fair hearing . If the recipient does not request hearing after 30 days, their choice of providers can be restricted. |
| District of Columbia | 3+ controlled substance prescriptions/month, 3+ controlled substances, 10+ prescriptions/month, OR 3+ pharmacies/month. The DUR board develops the guidelines for inclusion in lock-in. | 12 months, then DUR Board re-reviews case | Locked into 1 pharmacy- beneficiary gets to pick from 3 choices. Does not apply in emergency situations |  | DHCF sends notice to beneficiary 15 days prior to effective date. The notice includes appeals rights information. Beneficiary must request hearing within 15 days. |
| Kansas | DUR sets dosage limitations. There is a 6 month narcotic utilization limit. If beneficiary use is above the limit, beneficiary will be evaluated for the lock-in program- a review nurse will look at each case. Each case takes 40 hours to review, admin costs of $2,000. 2+ pharmacies, 2+ providers, 5+ controlled substances (3+ are opioids) within 45 days | 24 months | Locked into a combination of 1 pharmacy, 1 physician, 1 ED. |  | Members are sent a warning letter, and if behavior doesn't change in 60 days, they are locked-in. Members can respond with a grievance within 30 days of receiving the letter. |
| Oklahoma | Medicaid usage above the statistical norm, during a 12-month period. Oklahoma Health Care Authority (OHCA) medical consultants review cases. | Usage reviewed after 24 months | Locked into 1 primary physician and/or 1 pharmacy. Does not apply to emergency care.  |  | Beneficiary will receive notice of the need to select a primary physician and/or pharmacy and of their opportunity for a fair hearing.  |

**KY-** <http://chfs.ky.gov/NR/rdonlyres/DBE43DFD-E1E0-4306-8284-73A1A6918FAB/0/providerletterrechanges.pdf>

 <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/downloads/kyfy09comppireport.pdf>

 [http://chcmedicaid-kentucky.coventryhealthcare.com/web/groups/public/@cvty\_medicaid\_kentucky/documents/document/c070034.pdf](http://chcmedicaid-kentucky.coventryhealthcare.com/web/groups/public/%40cvty_medicaid_kentucky/documents/document/c070034.pdf)

**TN-** <http://www.tn.gov/sos/rules_all/2014/1200-13-13.20140101.pdf>

**MD-** <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/downloads/dur-wi-stcsfinal.pdf>

 <http://www.nga.org/files/live/sites/NGA/files/pdf/MedicaidStateRequirementsAndOptionsChart.pdf>

**MA-** <http://www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-pharmacy.pdf>

 <http://www.mass.gov/eohhs/provider/insurance/masshealth/pharmacy/controlled-substances-management-prog.html>

**MO-** <http://www.sos.mo.gov/adrules/csr/current/13csr/13c70-4.pdf>

 <http://mmac.mo.gov/participants/participant-lock-in/>

**AK-** <http://www.legis.state.ak.us/basis/folioproxy.asp?url=http://wwwjnu01.legis.state.ak.us/cgi-bin/folioisa.dll/aac/query=%5bJUMP:%27Title7Chap105!2C+a!2E+4%27%5d/doc/%7B@1%7D?firsthit>

 <http://dpaweb.hss.state.ak.us/main/manual/medical/fm/fammed.pdf>

**DC-** <http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MedicaidRegPharmacyServicesNoticeFinal.pdf>

**KS-** [http://www.kdheks.gov/hcf/legislative/download/2010Testimony/JCHPO%20Rx%20controlled%20substance%20question%20- %20January%202010%20-%20v2%20aa.pdf](http://www.kdheks.gov/hcf/legislative/download/2010Testimony/JCHPO%20Rx%20controlled%20substance%20question%20-%09%20January%202010%20-%20v2%20aa.pdf)

**OK-** <http://www.okhca.org/providers.aspx?id=8738&terms=lock%20in>

 <http://www.okdhs.org/library/policy/oac317/030/03/0014000.htm>

Other Relevant Information and Current Trends

**Ethical considerations**

There have been concerns that these lock-in programs are too restrictive, that they do not help the underlying substance use problem the beneficiary may have, or that the programs are punishing the beneficiary without providing any help. A few state programs have acknowledged this concern and have actually designed their programs around seeing MLIPs as [an opportunity vs. a punishment](http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=18019) to provide targeted care to people who have issues with drug abuse.

* “Team Care” in Montana MLIP- enrollees are “clients” and they get locked into a multidisciplinary, coordinated medical home for 24 months. Montana wanted the program to be a positive and patient-centered service so that enrollees may be more likely to adhere to the lock-in restrictions and have positive outcomes following the lock-in period.
* Kentucky’s MLIP creates a medical home for the beneficiary. Although this is quite similar to what other state programs are doing, this terminology seems to have a more positive connotation. Framing the program in a way that is positive and something good for the beneficiary may enhance program compliance, as well as public support for the program.

 **Medicaid Managed Care Organization (MCO) involvement**

 In addition to state Medicaid agencies administering lock-in programs, many MCOs administer lock-in programs in the states they serve as well. Some states may even defer lock-in responsibility to MCOs. A number of MCOs have public reports or information regarding their administration of state lock-in programs. [CoventryCares](http://chcmedicaid-kentucky.coventryhealthcare.com/web/groups/public/%40cvty_medicaid_kentucky/documents/document/c070034.pdf) of Kentucky and [WellCare](https://www.wellcare.com/WCAssets/southcarolina/assets/sc_medicaid_provider_manual_01_2013.pdf) in South Carolina are both MCOs with public information on the lock-in programs they administer in their states. Additionally, [WellPoint](http://www.nga.org/files/live/sites/NGA/files/pdf/MedicaidStateRequirementsAndOptionsChart.pdf), which has MCOs in many states, describes its programs across states, including how many members are in the lock-in programs, as they adhere to state-specific lock-in requirements.

 In 2014, the National Association of Medicaid Directors published a [report](file:///C%3A%5CUsers%5CMegan%5CDesktop%5CCE%5C%E2%80%A2%09http%3A%5Cmedicaiddirectors.org%5Csites%5Cmedicaiddirectors.org%5Cfiles%5Cpublic%5Cnamd_rx_abuse_report_october_2014.pdf) on state Medicaid initiatives to prevent prescription drug abuse. The report describes the challenges of coordination between the state Medicaid agency and the MCOs. The report also details a number of recommendations for how to improve this coordination, and a number of best practices for how to successfully implement and administer a lock-in program.

**Other: Useful reports and PDMP interstate sharing**

 In 2011, CMS published a 50 State Drug Utilization Review (DUR) Report. The [report](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Downloads/DURSurvey2011-StateXIIExecutiveSummarySurvey01152013.pdf) describes pharmacy programs by state, including information regarding state DUR activity as well as some detail on pharmacy lock-in programs.

 In 2012, CMS published a [report](http://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaidintegrityprogram/downloads/drugdiversion.pdf) on state Medicaid program strategies to reduce prescription drug diversion. The report describes existing federal and state partnerships to address drug diversion, the impact of the Affordable Care Act on state authority to combat fraud and abuse, and finally outlines elements of a robust state prescription drug control program.

 In 2012, the CDC published a [report](http://www.cdc.gov/homeandrecreationalsafety/pdf/PDO_patient_review_meeting-a.pdf) on Patient Review & Restriction Programs, which was the end result of expert panel meetings on this topic. The report describes current practices and includes suggestions for program improvement. The report also explains the need for more thorough program evaluation to determine lock-in best practices.

 In 2014, the Office of Inspector General (OIG) published a [report](http://oig.hhs.gov/oei/reports/oei-02-11-00170.pdf) on utilization patterns among Part D beneficiaries for HIV drugs, finding that 1,600 beneficiaries had questionable utilization patterns. OIG recommends that CMS limit the number of pharmacies and providers from which beneficiaries can access these HIV drugs, and also to expand the monitoring system to capture questionable utilization of other drugs as well. OIG is essentially recommending a lock-in program for Medicare Part D.

 Work by the National Alliance for Model State Drug Laws (NAMDL) [tracks state efforts](http://www.namsdl.org/library/3AE3E0FA-E4DB-E415-17C028403C62BD73/) to broaden access to prescription monitoring program (PMP) data. An example includes a recent Illinois initiative to allow freestanding emergency centers to be included as entities that can access the PMP data.

 NAMDL also [monitors state activity](http://www.namsdl.org/prescription-monitoring-programs.cfm) regarding interstate sharing of PMP data. A number of states engage in interstate sharing with other PMPs and authorized users in other states, including Tennessee, Kentucky, New York, and Vermont. Utah, Massachusetts, and Maryland share data with PMPs in other states.