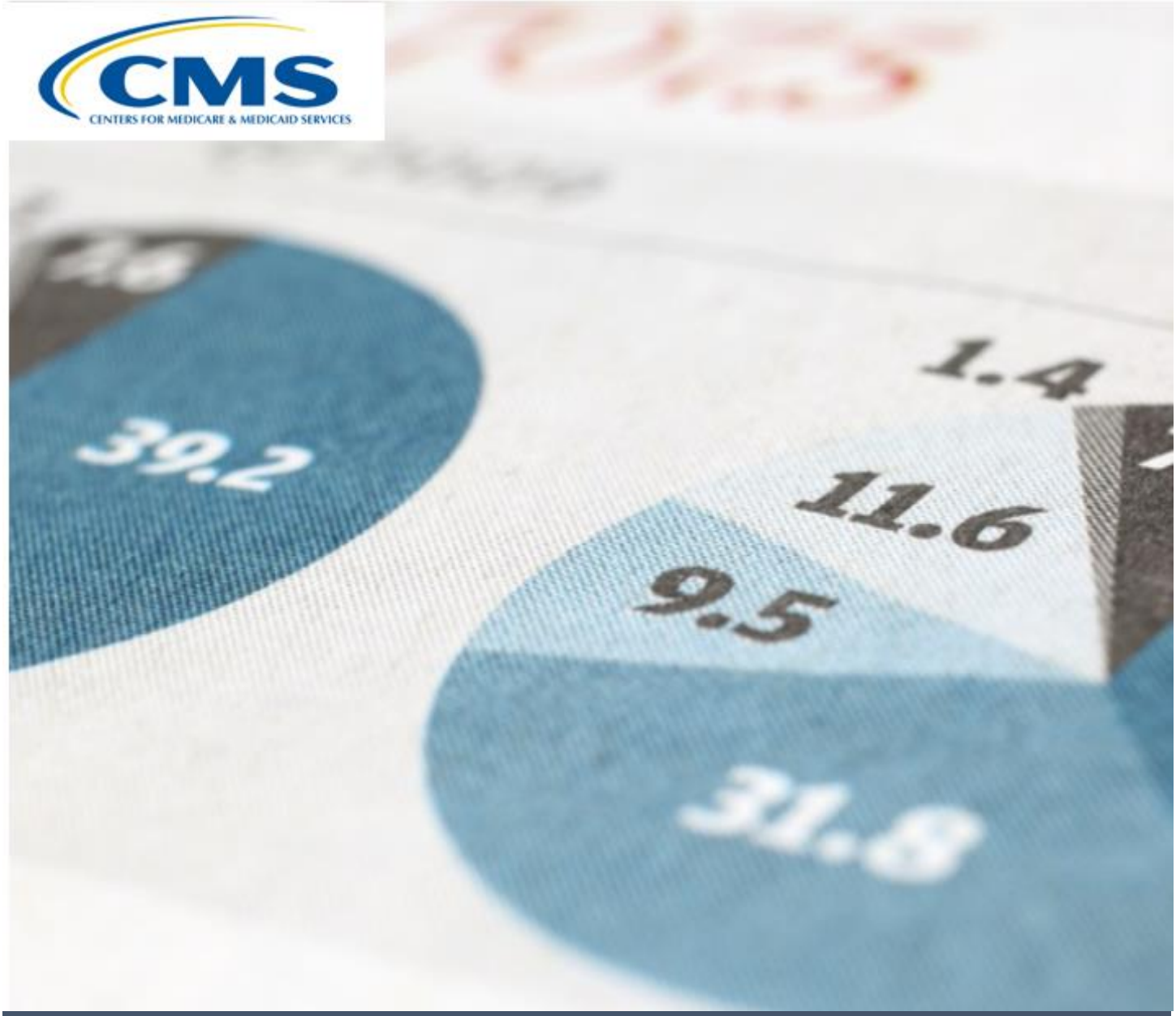

Texas
Medicaid Fee-For-Service (FFS)
2019 Drug Utilization Review (DUR)

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Texas DUR 2019 FFS Individual State Report

Section I – Number of Beneficiaries

Question	Response
1. On average, how many of your state's Medicaid beneficiaries are enrolled in your state's Medicaid Fee-For-Service (FFS) program that have a pharmacy benefit?	**767,971**
2. On average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)?	**3,835,619**

Section II - Prospective DUR (ProDUR)

Question	Response
1. Indicate the type of your pharmacy point of service (POS) vendor.	**Contractor**
a. Vendor Name	**Conduent**
b. If not state-operated, is the POS vendor also the MMIS fiscal agent or a separate PBM?	**POS vendor is a separate PBM**
2. Identify ProDUR criteria source.	**Other**
If "Other," please specify	Some of the pro-DUR criteria are from First Data Bank. Some others, such as the High Dose Acetaminophen edit, or the Antifungals Treatment Duration edit, are developed by the state.
3. Are new ProDUR criteria approved by the DUR Board?	**No**
If "No," please explain	The clinical prior authorization criteria are reviewed and approved by the DUR Board. The pro-DUR alerts are updated automatically in the claims system. Additionally, the program implements prospective claims edits for certain drugs or drug classes that are not reviewed by the DUR Board.
4. When the pharmacist receives a level-one ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?	**Yes**

Question	Response
If "varies," please explain	N/A
5. Do you receive and review follow-up reports providing individual pharmacy provider DUR alert override activity in summary and/or in detail?	**Yes**
a. If "Yes," how often do you receive reports?	**Other**
If "Other," please explain	Monthly report files are stored in document library. Staff can access and review reports as necessary.
b. If you receive reports, do you follow up with those providers who routinely override with interventions?	**No**
If "Yes," by what method do you follow up?	N/A
If "Other," please explain.	N/A
If "No," please explain	Vendor Drug Program has not conducted pharmacy audit for the FFS claims activities since 2014.
If "No," please explain	N/A
6. Early Refill	
a. At what percent threshold do you set your system to edit?	
i) Non-controlled drugs:	**75%**
ii) Schedule II controlled drugs:	**90%**
iii) Schedule III through V controlled drugs:	**90%**
b. For non-controlled drugs: When an early refill message occurs, does the state require prior authorization?	**Yes**
If "Yes" or "Dependent on medication or situation," who obtains authorization?	Pharmacist
If "No," can the pharmacist override at the point of service?	N/A
c. For controlled drugs: When an early refill message occurs, does the state require prior authorization?	**Yes**
If "Yes," who obtains authorization?	Pharmacist
If "No," can the pharmacist override at the point of service?	N/A
7. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your state's policy allow the pharmacist to override for situations such as:	

Question	Response
a. Lost/stolen Rx	**No**
b. Vacation	**No**
c. "Other," please explain.	**Dispensing pharmacist must call state pharmacy helpdesk for an override. Necessary information and reasons for early refill must be provided. For the stolen controlled substance drugs, Vendor Drug Program must either receive a police report or have the prescriber attest to that. For non-controlled prescription, the help desk staff documents the information and allows an additional prescription to be dispensed for the lost or stolen quantity.**
8. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?	**No**
If "Yes," please explain your edit.	N/A
If "No," do you plan to implement this edit?	No
9. Does the state Medicaid agency or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?	**Yes**
10. Does the state Medicaid agency have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled, chronic medication refills at the same time, the state would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?	**Yes**
11. For drugs not on your formulary, does your agency have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?	**Yes**
If "Yes," what is the preauthorization process?	Prescriber may contact Vendor Drug Program (VDP) for requested non-formulary product. Reasons for requesting a non-formulary product as well as the duration of therapy

Question	Response
	must be provided. VDP will, then, review and approve on a case-by-case basis.
If "No," please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.	N/A
a. Does your program provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation?	**Yes**
If "Yes," what is the process?	A 72-hour emergency supply of the prescribed drug should be provided by the pharmacy when a medication is needed without delay and prior authorization is not available. This applies to drugs that are non-preferred on the preferred drug list and/or drugs subject to clinical PA. The emergency override protocol applies to people enrolled in either traditional Medicaid or Medicaid managed care. Before dispensing a 72-hour emergency supply, the dispensing pharmacist should use professional judgment to determine if taking the prescribed medication jeopardizes the person's health or safety and make good faith efforts to contact the prescribing provider. A 72-hour emergency prescription will be paid in full, and it does not count toward the three-prescription limit for adults who have not already received their maximum prescriptions for the month. This procedure should not be used for routine and continuous overrides.
If "No," please explain.	N/A
12. Please list the requested data in each category in *Table 1 - Top Drug Claims Data Reviewed by the DUR Board* that follows	

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

Top 10 Prior Authorization (PA) Requests by Drug Name	Top 10 Prior Authorization (PA) Requests by Drug Class	Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications and Age Edits)	Top 10 Drug Names by Amount Paid	% of Total Spent for Drugs by Amount Paid (From data in Column 4, Determine the % of total drug spend)	Top 10 Drug Names by Claim Count	Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)
montelukast	Leukotriene Receptor Antagonists	Product/Service not Covered	lisdexamfetamine	2.23%	cetirizine	4.31%
gabapentin	ADD/ADHD	plan limitations exceeded	albuterol sulfate	2.20%	albuterol	3.58%
oseltamivir	Anticonvulsants	prior authorization required	insulin aspart	2.00%	amoxicillin	3.52%
aripiprazole	Antiemetics	early refill: overuse precaution	vitamins	1.86%	ibuprofen	3.19%
risperidone	Adrenergics, Non-catecholamines	quantity dispensed exceeds maximum allowed	antihemophilic factors	1.67%	loratadine	2.30%
methylphenidate	Inhaled beta-Adrenergics, Short-Acting		coagulation factors	1.62%	ondansetron	2.04%
mometasone	ntipsychotics, Atypical		oseltamivir	1.58%	docusate	1.69%
dexmethylphenidate	Inhaled Glucocorticoids		lurasidone	1.58%	fluticasone	1.68%
dextroamphetamine/amphetamine	NSAIDs		dornase	1.56%	azithromycin	1.63%
DOXYLAMINE SUCCINATE/VIT B6	Proton Pump Inhibitors		fluticasone	1.47%	vitamins	1.62%

Question	Response
13. Section 1927(g)(A) of the Social Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in your state has responsibility for monitoring compliance with the oral counseling requirement? Check all that apply:	**State Board of Pharmacy**
If "Other," please explain:	N/A
14. Summary 1 – Pharmacy Oral Counseling Compliance Summary 1 Pharmacy Oral Counseling Compliance reports the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid Agency,	**On Site Prospective DUR Compliance Monitoring** **Texas State Board of Pharmacy Rules and Regulations incorporate the prospective drug**

Question	Response
the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid Agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the Omnibus Budget Reduction Act (OBRA) of 1990 prospective DUR requirement. This report details state efforts to monitor pharmacy compliance with the oral counseling requirement and should describe in detail, utilizing the text box below, the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.	**use review and patient counseling provisions of OBRA '90 and make them applicable to all patients in Texas, both Medicaid and non-Medicaid. The Texas State Board of Pharmacy routinely monitors compliance and issues warnings related to violations of these requirements.** **The following is a summary of Board activities related to violations of OBRA requirements during the fiscal year (FY) 2019 (September 1, 2018 to August 31, 2019).** **FY2019** **Warning Notice** **No Oral Counseling** **31** **No Written Information** **39** **Patient Medication Record Absent or Incomplete 11** **No Drug Regimen Review** **9** **Inadequate Counseling Area** **2** **Totals** **92** **Disciplinary Actions / Complaints** **Disciplinary Actions** **In FY 2019, the Texas State Board of Pharmacy entered 36 Disciplinary Orders involving prescription counseling (16 orders on pharmacists and 20 orders on pharmacies). These orders may have involved other alleged violations as well as counseling violations (e.g., dispensing errors).** **Complaints** **In FY 2019, the Texas State Board of**

Question	Response
	Pharmacy closed 54 complaints, where the primary alleged violation involved DUR and prescription counseling violations

Section III - RETROSPECTIVE DUR (RetroDUR)

Question	Response
1. Indicate the type of vendor that performed your RetroDUR activities during the time period covered by this report.	**Company**
a. Identify, by name, your RetroDUR vendor.	**Conduent**
b. Is the RetroDUR vendor also the MMIS fiscal agent?	**No**
c. Is the RetroDUR vendor also the developer/supplier of your retrospective DUR criteria?	**Yes**
If "No," please explain	N/A
2. Who reviews and approves the RetroDUR criteria?	**State DUR Board**
"Other," please explain	N/A
3. Summary 2 – Retrospective DUR Educational Outreach Summary 2 Retrospective DUR Educational Outreach is a year-end summary report on RetroDUR screening and educational interventions. The year-end summary should be limited to the most prominent 10 problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed.	**Retrospective Drug Utilization Review (RetroDUR) Program** **Program Summary** **A proposal is developed with specific performance indicators that have been identified for the intervention. A clinical rules engine is used to identify the number of candidates with exceptions for each performance indicator. The clinical rules engine applies criteria on a focused topic for an entire member population to identify members with a specific issue. Intervention proposals are prepared and presented at quarterly DUR Board Meetings for feedback and approval.** **The intervention package delivered to providers includes a provider letter with referenced educational materials and modified patient profiles. Also included are provider messages addressing flags for each patient profile. Educational materials**

	developed by the Conduent clinical team are used to communicate prescribers on how to be more efficient and effective in their prescribing practices. **Overall Cost Savings** **The PBIs were effective in improving quality of care for Texas Medicaid recipients. The RetroDUR program administered by Conduent demonstrated net cost avoidance for FFY 2019. The overall cost savings for Texas Medicaid is $10,301,812.05.** **Population-Based Intervention Summary** **Intervention Date Recipients Pharmacies Physicians Outcomes Summary** **Antibiotics 02/22/2019 NA NA 1,528 In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $2.31 in the post-** **intervention period. This yielded an overall estimated decrease of $1,587,468.96 in intervention-related drug** **expenditures on an annualized basis.** **Medication Adherence 04/10/2019 1,069 NA 1,159 During the intervention, targeted patients saw average reductions in clinical indicators by 23.6%. In terms of** **financial outcomes, the amount paid for intervention-related drugs increased by $3.20 in the post-intervention** **period. This yielded an overall estimated increase of $3,676,983.60 in intervention-related drug expenditures** **on an annualized basis.** **Respiratory Disease 06/21/2019 1,329 NA 1,074 During the intervention, targeted patients saw average reductions in clinical indicators by 29.3%.**

	In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $2.96 in the post- **intervention period. This yielded an overall estimated decrease of $451,271.86 in intervention-related drug** **expenditures on an annualized basis.** **Mental Health 06/04/2019 1,273 NA 1,000 During the intervention, targeted patients saw average reductions in clinical indicators by 21.6%. In terms of** **financial outcomes, the amount paid for intervention-related drugs decreased by $3.62 in the post-** **intervention period. This yielded an overall estimated decrease of $2,554,033.05 in intervention-related drug** **expenditures on an annualized basis.** **Opioid Prescribing 10/30/2018 1,069 NA 911 During the intervention, targeted patients saw average reductions in clinical indicators by 33.1%. In terms of** **financial outcomes, the amount paid for intervention-related drugs decreased by $0.12 in the post-** **intervention period. This yielded an overall estimated decrease of $21,385.92 in intervention-related drug** **expenditures on an annualized basis** **SGAs in Youth 11/13/2018 1,48 NA 614 During the intervention ,targeted patients saw average reductions in clinical indicators by 32.0%. In terms of** **financial outcomes, the amount paid for intervention-related drugs decreased by**

	$10.97 in the post intervention **period. This yielded an overall estimated decrease of $7,899,431.18 in intervention-related drug** **expenditures on an annualized basis** **Psychotropics- Adults 04/01/2019 599 NA 503 During the intervention, targeted patients saw average reductions in clinical indicators by 27.3%.** **In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $4.34 in the post-** **intervention period. This yielded an overall estimated decrease of $1,446,548.04 in intervention-related drug** **expenditures on an annualized basis** **PPIs 01/11/2019 47 NA 44 During the intervention, targeted patients saw average reductions in clinical indicators by 39.6%.** **In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.96 in the post-** **intervention period. This yielded an overall estimated decrease of $18,656.64 in intervention-** **related drug expenditures on an annualized basis.**

Section IV - DUR BOARD ACTIVITY

Question	Response
1. Summary 3 – DUR Board Activities Report. Summary 3 DUR Board Activities Report should be a brief descriptive report on DUR Board activities during the fiscal year reported.	**DUR Board meeting dates:** **Oct. 26, 2018** **Jan. 25, 2019** **Apr. 26, 2019** **Jul. 26, 2019**

Question	Response
	DUR Board DUR activities consists of the four sessions: **1. Review drugs within each therapeutic class for preferred/non-preferred recommendations** **2. Retrospective Criteria Reviews-may be used as the basis for prospective and retrospective DUR proposals. Review is focused on criteria, such as: maximum daily dose in adults and pediatrics, Drug-Drug interaction, Therapeutic duplication, Over utilization, etc.** **3. Retrospective DUR Intervention Proposals-Educational letters for provider outreach are developed and mailed to those with outlier prescribing activities.** **4. Prospective Clinical Prior Authorization (PA) Criteria Proposal Review: Clinical prior authorizations are developed with input from State DUR staff, Medicaid Managed Care Organizations(MCOs), and the Sate's PA vendor. Criteria are mainly based on the available references such as drug Package insert, treatment practice guidelines, etc.** **In FFY 2019 the following retrospective criteria were reviewed** **1. 5-HT3 receptor antagonists** **2. Attention deficit disorder medications** **3. GLP-1 receptor agonists** **4. Oral anti-diabetic agents** **5. Pramlintide (Symlin)** **6. Substance P / Neurokinin 1 receptor antagonists** **7. 5-HT3 receptor antagonists** **8. Angiotensin II receptor blockers** **9. Angiotensin-converting enzyme inhibitors** **10. ADHD medications** **11. GLP-1 receptor agonists** **12. Oral anti-diabetic agents** **13. Serotonin 5-HT1B/1D receptor agonists** **14. Substance P / Neurokinin 1 receptor antagonists** **15. Aerosolized Agents** **16. Aerosolized Agents** **17. Aerosolized Agents** **18. Aerosolized Agents** **19. Antidepressants (oral) - other**

Question	Response
	20. Antidepressants (oral) - SSRIs **21. Fentanyl (Inhalation/Oral/Transdermal)** **22. Platelet aggregation inhibitors.** **23. Proton pump inhibitors** **24. Acetylcholinesterase Inhibitors** **25. Cyclooxygenase (COX)-2 Inhibitors** **26. Hepatitis C Direct Acting Antivirals** **27. Histamine H2-Receptor Antagonists** **28. Ketorolac** **29. Leukotriene Receptor Antagonists** **30. Mecasermin** **In FFY 2019 the following Retro-DUR intervention topics were reviewed:** **1. Management of Psychotropic Drugs in Adults- The following performance indicators were considered for intervention: High doses ADHD medications, ADHD medication without indication, High dose antidepressants, High dose second generation antipsychotics(SGA), Multiple (3 or more) oral SGA, psychotropics Polypharmacy, Lab Monitoring (glucose, lipids, and A1c) in patients taking SGA, 90-days or more of concomitant prescribing of oral and long-acting injectable** **2. Medication Adherences- The following performance indicators were considered for intervention: Antiasthmatics: Inhaled corticosteroids, Anticonvulsants, Antidepressants, Oral antidiabetics, Antihypertensives, Antilipemics, Oral second-generation antipsychotics, Inhaled COPD medications, Thyroid replacement** **3. Appropriate Use of Antibiotics- the following performance indicator was considered for intervention: High percentage of oral broad-spectrum antibiotic use.** **4. Respiratory Disease Management- the following performance indicators were considered for intervention: Overutilization of short-acting beta2-agonists (SABA) inhalers in patients with asthma, Underutilization of inhaled corticosteroids)ICS) in patients with asthma, Use of long-acting beta-agonists (LABA) inhalers without SABA inhaler in patients with asthma, Use of SABA inhaler without short-acting antimuscarinic antagonist (SAMA) inhaler in**

Question	Response
	COPD, Use of ICS without LABA inhaler in patients with COPD, Overutilization of oral glucocorticoids in patients with asthma and/or COPD, Duplicate ingredient inhalers in patients with asthma and/or COPD, History of smoking in patients with asthma and/or COPD **5. Mental Health Disorders Management- the following performance indicators were considered for intervention. Antidepressant use extended duration (greater than 12 months)) in single episode depression, Duplicative antidepressants, Increased ADE-risk of serotonin syndrome, Benzodiazepine chronic use (greater than 4 months), Sedative/hypnotics chronic use (greater than 4 months), Duplicative anxiolytics and/or sedative/hypnotics, Concomitant long-acting injectable antipsychotics with oral agents, Multiple second generation antipsychotics (SGA) (3 or more), Inadequate lab monitoring of SGAs** **6. Anticonvulsant Drug Use Review- the following performance indicators were proposed: Anticonvulsants drug-drug interactions, Increased risk of adverse drug events (ADE) with anticonvulsants, Concomitant use of anticonvulsants and contraceptives** **7. Cough and Cold Medications- the following performance indicator was considered for intervention: Members age 2 and older to less than 12 y/o with pharmacy claims for cough and cold drugs are not considered safe based on the cough and cold drugs listed on Texas Medicaid Cough and Cold Clinical Prior Authorization.** **8. ADHD Medication Management- the following performance indicators were considered for intervention: ADHD medications without indication in adults; dose consolidation for the extended-release formulations in adults; stimulants duplicate therapy; high dose ADHD medications; multiple prescribers; risk of suicide ideation with atomoxetine in youth.** **9. Influenza Prevention through Vaccination and Education-the following performance indicators were considered for intervention:**

Question	Response
	Members with an influenza antiviral prescription who did not receive an influenza vaccine, Members who received more than 1 influenza antiviral prescription. **In FFY 2019, the Board reviewed the following clinical prior authorizations (PA)** **1. Calcitonin gene-related peptide receptor (CGRP) Antagonist- new criteria - approval criteria include: medication prescribed by or in consultation with a neurologist, age 18 and older, diagnosis of episodic or chronic migraines (verified manually with chart notes detailing number of migraine and headache days per month on average), history of a 30-day trial of 2 or more migraine prophylactic therapies in the last 365 days, quantity requested is equal or more than 2 per month.** **2. Cytokine and CAM antagonists, addition of Olumiant criteria- approval criteria include: age requirement, diagnosis of Rheumatoid Arthritis, prior use of TNF-blockers, no claims for JAK inhibitors or DMARD or potent immunosuppressants. no recent claims for OAT3 inhibitors, no recent diagnosis of GI perforation, thrombosis or malignancies, no severe renal impairment, no active serious infections; daily dose of 1 table per day.** **3. Epidiolex oral solution- approval criteria include: age equal or more than 2 years of age, diagnosis of Lennox-Gastaut syndrome or Dravet syndrome in the last 730 days** **4. Orilissa (elagolix)- approval criteria include: age equal or more than 18 years, diagnosis of endometriosis found in the last 730 days, claim for an NSAID and 1 claim for an oral contraceptive found in the last 180 days, no diagnosis of osteoporosis found in the last 365 days, no claims for a strong OATP-1B1 inhibitor found in the last 90 days, dosing does not exceed maximum recommended** **5. Arikayce (amikacin liposome inhalation suspension)- approval criteria include: appropriate age, diagnosis of MAC lung disease, therapy with at least 2 recommended initial drug therapy, concurrent use with the 2 initial therapy drugs.**

Question	Response
	6. HAE Agents- approval criteria include: age requirement, stable therapy (defined as 2 claims for the requested agent or a diagnosis of HAE in the past 730 days. **7. Inhaled ABX: Approval criteria include: Client meets age requirement, diagnosis of CF found** **9. Cytokine & CAM Antagonists, addition of Skyrizi criteria- approval criteria included: age requirement, diagnosis of moderate-severe plaque psoriasis; no history of active infection.** **10. Motegrity (prucalopride)- approval criteria included: age requirement, diagnosis of chronic idiopathic constipation found, no diagnosis of GI obstruction, quantity of 1 tablet per day** **11. Skeletal Muscle Relaxants- approval criteria included: age requirements, no more than 60 days therapy in the last 90 days**
2. Does your state have an approved Medication Therapy Management Program?	**No**
a. Have you performed an analysis of the program's effectiveness?	**N/A**
"Yes," please provide a brief summary of your findings.	N/A
b. Is your DUR Board involved with this program?	**N/A**
If the answer to question 2 is "No," are you planning to develop and implement a program?	No

Section V - PHYSICIAN ADMINISTERED DRUGS

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

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

Section VI - GENERIC POLICY AND UTILIZATION DATA

Question	Response
1. Summary 4 – Generic Drug Substitution Policies Summary 4 Generic Drug Substitution Policies summarizes factors that could affect your generic utilization percentage. Please explain and provide details.	**Texas Administrative Code Rule (TAC Rule) 355.8546 -Brand-Name Drugs** **(a) Physicians who want a brand name drug dispensed on a prescription for a multisource drug must handwrite the phrase "Brand necessary" on the face of the prescription. This procedure enables payment for the drug at the more expensive brand name acquisition cost. To indicate this certification (override) on the pharmacy claim form, the pharmacy provider must enter "1" in the field for "Dispense as Written." For telephone orders involving physician overrides, a written prescription must be obtained from the prescribing physician within 30 days from the time the order was placed.** **(b) A physician override for a prescription is valid only for the life of the prescription. The life of the prescription is defined as the original dispensing and any authorized refills, not to exceed eleven refills or a twelve-month supply. The physician override cannot be forwarded or transferred to any other prescription for the same drug.** **(c) A pharmacy provider that dispenses a brand drug that is subject to a generic reimbursement and bills HHSC for the service must accept Medicaid reimbursement as payment in full. No additional dispensing fee or product cost amounts may be billed to the Medicaid recipient.** **Single PDL** **HHSC requires the MCOs to follow the same preferred drug list (PDL) as approved by the state. The PDL medications are recommended by the Texas Drug Utilization Review Board for their clinical significance and cost effectiveness.**
2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically	**No**

Question	Response
Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your state have a more restrictive requirement?	
If “Yes,” check all that apply.	N/A
Other, please explain.	N/A

Table 2 - Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	58,736	641,022	43,168
Total Reimbursement Amount Less Co-Pay	$32,042,000	$14,188,000	$8,341,000

Question	Response
3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Number of Generic Claims	641,022
Total Number of Claims	742,926
Generic Utilization Percentage	86.28%
4. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period using the computation instructions in Table 2 - Generic Drug Utilization Data.	
Generic Dollars	$14,188,000
Total Dollars	$54,571,000
Generic Expenditure Percentage	26.00%

Section VII - PROGRAM EVALUATION / COST SAVINGS / COST AVOIDANCE

Question	Response
1. Did your state conduct a DUR program evaluation of the estimated cost savings/cost avoidance? If "Yes," identify, by name and type, the institution that conducted the program evaluation.	**Yes**
Institution Type	Company
Institution Name	Conduent and Health Informaton Design (HID)
2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below	

	Data
ProDUR Total Estimated Avoided Costs	$11,459,369.00
RetroDUR Total Estimated Avoided Costs	$10,301,812.05
Other Cost Avoidance	$17,779.80
Grand Total Estimated Avoided Costs	$21,778,960.85

Question	Response
3. The Estimated Percent Impact was generated by dividing the Grand Total Estimated Avoided Costs from Question 2 above by the Total Dollar Amount provided in Section VI, Question 4, then multiplying this value by 100. Estimated Percent Impact	**39.91%**
4. Summary 5 – Cost Savings/Cost Avoidance Methodology Summary 5 Cost Savings/Cost Avoidance Methodology includes program evaluations/cost savings estimates prepared by state or contractor.	**Retro-DUR cost savings mythology Pharmacy claims data is mapped to allow CyberFormance, a web-based interactive data management system, to analyze and interpret data for FFS and 20 different MCOs. The medical claims data is mapped to evaluate up to two years of patient medical history for the RetroDUR interventions. Conduent delivers interventions to prescribers based on clinical performance indicators. Prescribers are mailed intervention letters based on the number of patients with identified clinical indicators. Target Prescribers are those that were identified and received intervention**

	materials. Control prescribers are those prescribers that prescribed the intervention drugs, but did not receive intervention materials. **When seven months of data have been received post-intervention Conduent prepares an outcome report. The analysis identifies all patients who had a prescription for an intervention drug for either the target or control group of prescribers. The number of patients treated and the total cost for intervention drugs are determined for the 6-month pre-intervention period and for a 6-month post-intervention period.** **Total drug costs can be defined as the total amount of paid intervention drug claims for the above time periods for the prescribers in the control and target groups. The number of panel patients is calculated by counting the distinct number of patients per month prescribed an intervention drug. Medicaid patients that did not have an intervention drug claim were not counted in the prescriber's panel.** **Average cost per patient per month (PPPM) is calculated by dividing the total dollars paid for drug claims during the analysis time period by the total number of Medicaid panel patients during the respective time period.** **The change in the control group is calculated by comparing the post-intervention per patient per month cost by the pre-intervention. This provides the expected change in costs for all patients for the intervention drugs. This amount represents the estimated amount paid per targeted provider per patient in the absence of the intervention (i.e., estimated paid amount). The estimated paid amount PPPM is then subtracted from the actual Intervention target group average cost PPPM to estimate the average cost savings PPPM.** **6-Month Total Savings is the Intervention Average Cost Savings PPPM multiplied by the total number of targeted patients served over the 6-** **month time frame.** **Pro-DUR cost savings methodology** **The data used for this analysis was sourced by the RxPert prior authorization processing**

	system and the PCRA vendor. **statistics associated with prior authorization activity for the specified time frame (October 1, 2018 to September 30, 2019).** **Total Denials** **152,618** **Total Unique Clients** **38,006** **Total Unique Denials** **56,923** **Total Unique Denials with Follow-Up Approval** **10,341** **Total Unique Denials with Substitute Therapy** **13,157** **Total Unique Denials without Follow-Up Approval or Substitute Therapy** **33,425** **Total Unique Prescribers** **16,710** **Total Denials: Total number of denied prior authorization requests for the time frame across all request methods (includes duplicates)** **Total Unique Clients: Total number of unique client IDs associated with all denied prior authorization requests** **Total Unique Denials: Total number of non-duplicate denied prior authorization requests for the time frame across all request methods (duplicate defined as the same client ID and GCN within 7 days of the initial denied request)** **Total Unique Denials with Follow-Up Approval: Total number of non-duplicate denied prior authorization requests for the time frame, where an approved prior authorization request was granted for the same client ID and GCN within 7 days of the initial denied request** **Substitute Therapy: A drug in the HIC3 category for the drug specified on the original denied request** **Notes:** **Drugs that were already being taken 45 days prior to the request were excluded as substitute therapy** **Substitute therapy was not evaluated for Synagis or Increlex requests; these drugs do**

	not have available alternatives **Total Unique Denials with Substitute Therapy: Total number of non-duplicate denied prior authorization requests for the time frame, where the client had a paid claim within 7 days of the original denied request for a drug within the same HIC3 category** **Total Unique Denials without Follow-up Approval or Substitute Therapy: Total number of non-duplicate denied prior authorization requests for the time frame, where the client did not have a prior authorization approval within 7 days of the original denied request and the client did not have a paid claim within 7 days of the original denied request for a drug within the same HIC3 category** **Total Unique Prescribers: Total number of unique prescribers associated with all denied prior authorization requests** **Cost Savings Statistic Value** **Total Cost Savings for Unique Denials with Substitute Therapy** **$1,718,374** **Total Cost Savings for Unique Denials without Follow-Up Approval or Substitute Therapy** **$9,740,995** **Overall Cost Savings** **$11,459,369** **Total Cost Savings for Unique Denials with Substitute Therapy: Total dollar amount for all unique denied prior authorization requests with a substitute therapy within 7 days of the original denial for a drug within the same HIC3 category.** **Calculation: SUM (Estimated Denial Cost per unique denial minus Reimbursement amount of substitute therapy within 7 days of unique denial) where Estimated Denial Cost is the aggregated cost per unit for all paid claims for the same GCN within the specified time frame times the number of units for the denied request. If there were no paid claims for the GCN, then the cost per unit was established by looking for paid claims at the HICL sequence number or HIC3 category until paid claims were found to calculate an aggregated cost per unit. When no paid claims were found to calculate the**

	aggregated cost per unit, no cost savings were associated with the original denied request. **Total Cost Savings for Unique Denials without Follow-Up Approval or Substitute Therapy: Total dollar amount for all unique denied prior authorization requests without a prior authorization approval or a substitute therapy within 7 days of the original denial for a drug within the same HIC3 category. Calculation: SUM all Estimated Denial Cost per unique denial where Estimated Denial Cost is the aggregated cost per units for all paid claims for the same GCN within the specified time frame times the number of units for the denied request. If there were no paid claims for the NDC, then the cost per unit was established by looking for paid claims at the HICL sequence number or HIC3 category until paid claims were found to calculate an aggregated cost per unit. When no paid claims were found to calculate the aggregated cost per unit, no cost savings were associated with the original denied request.** **Cost Savings Associated with PDL and Clinical Edit Prior Authorizations, and Other Denials: Table 5 shows the cost savings by prior authorization type during the specified time frame. The table includes unique denied prior authorization requests with a substitute therapy and unique denied requests without a substitute therapy and also shows values for prior authorization requests that did not hit either a PDL or clinical edit due to validation errors.** **PA Type With Substitute Therapy Without Substitute Therapy** **PDL $687,522 $2,826,762** **Clinical Edit $556,430 $4,425,677** **PDL and Clinical Edit $473,886 $2,487,691** **Validation Error $1,295,073 $2,624,678** **With Substitute Therapy: Total cost savings for unique denials with substitute therapy**

	Without Substitute Therapy: Total cost savings for unique denials without substitute therapy and another prior authorization approval **Validation Error: Cost savings associated with prior authorization requests that were denied as a result of not passing validation. As these requests never hit criteria, savings cannot be measured under a specific PA type. These requests may have denied for any number of reasons. Even though the associated claims for these PAs did not hit criteria, data for follow up claims can be reviewed to determine if there were any substitutions. This data is included for reference purposes since the PA denials do attribute to savings outside of the PA Type and are included in the savings shown in other tables in this Estimated Cost Savings report.** **Cost avoidance associated with FFS Lock-In Program was 17,779.80. Please refer to the Lock-In section for more information.** **The total Dollar amount spent reported in section VI, Question 4, does not include payments for covered non-drug products such as diabetes supplies.**

Section VIII - FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

Question	Response
1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Refer to Lock-In Program, Refer to Office of Inspector General
"Other," Please explain	N/A
2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances? If the answer to question 2 is "Yes," please continue	**Yes**
a. What criteria does your state use to identify candidates for Lock-In? Check all that apply:	**Number of controlled substances (CS), Different prescribers of CS, Multiple**

Question	Response
	pharmacies, Number days' supply of CS, Other
"Other," please explain	In addition to the boxes checked above, the following are criteria for identifying candidates for Lock-In: Treatment that exceeds therapeutic daily Morphine Equivalent Dose (MED) Prescription combination with abuse potential Overlapping or duplicative psychotropic prescriptions from 2 or more unaffiliated prescribers. ER visits or hospitalizations due to suicide attempt, poisoning or overdose of drugs (intentional self-harm) A diagnosis of alcohol or drug abuse including non-therapeutic, recreational or illegal drug use Two or more occurrences of violating a pain contract with the same prescriber or with different prescriber(s) Conviction of a crime related to restricted medications within the past year (e.g., forgery, theft, distribution or Medicaid fraud)
b. Do you have the capability to restrict the beneficiary to:	
i. Prescriber only	**Yes**
ii. Pharmacy only	**Yes**
iii. Prescriber and Pharmacy	**Yes**
c. What is the usual Lock-In time period?	**Other**
"Other," please explain	Initial lock-in status period is a minimum of 36 months. Second lock-in status period will be additional 60 months. Third lock-in status period will be for the duration of eligibility and all subsequent periods of eligibility.
d. On average, what percentage of the FFS population is in Lock-In status annually?	**0.0016%**
e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review as part of Attachment 5.	**$17,779.80**
3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Other

Question	Response
"Other," please explain	Medicaid Waste, Abuse, and Fraud Policy The OIG has the responsibility to identify and investigate cases of suspected waste, abuse, and fraud in Medicaid and other health and human services programs. This responsibility, granted through state and federal law, gives the OIG the authority to pursue administrative sanctions and to refer cases to prosecutors, licensure and certification boards, and other agencies. Additionally, Texas Medicaid is required to disenroll or exclude any provider who has been disenrolled or excluded from Medicare or any other state health-care program.
"No," please explain	N/A
4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by pharmacy providers?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Refer to Board of Pharmacy, Other
"Other," please explain	Pharmacy Audits All pharmacies enrolled with VDP are subject to periodic audits. These may result from internal Texas HHSC auditors working with the Texas HHSC Inspector General (IG) or the Federal Medicaid Integrity Contractors working through the Centers for Medicare and Medicaid Services. • Refer to 1 TAC Section 354.1891 - Vendor Drug Providers Subject to Audit Pharmacy claims are sampled and reviewed for accuracy and compliance with state and federal laws and policies that govern the pharmacy programs. Any audit findings, derived by following procedures that are developed from accepted and approved audit standards, may subject the pharmacy provider to recoupment. The auditors determine the amount of overpayment in a sample set of claims and then apply a statistical extrapolation formula to estimate the overpayment across the universe of claims the pharmacy provider or supplier submitted over the selected audit period. Audits determine the pharmacy provider's compliance with federal and state laws, policies, procedures, and limitations. Claims

Question	Response
	transactions selected for audit are compared with documentation on the corresponding prescriptions, invoices, pharmacy daily logs, pharmacy delivery logs, etc. Overpayments are considered exceptions subject to restitution to HHSC. The audit process begins with an engagement letter, or notice of intent to audit, sent to the pharmacy provider. The letter includes the dates of the audit period and the proposed audit date. A request is made that pharmacy staff provide ample room and proper atmosphere for the auditor to conduct the audit. On-site audit time periods vary between 1 and 3 days. At the end of examination of material relevant to the audit, an oral exit interview is conducted. The auditors then deliver the draft audit report listing findings, if any, to the pharmacy contact - usually the owner or the pharmacist-in-charge. The pharmacy then has 15 days to provide additional documentation and a response to the draft audit report. The response may include a management rebuttal to address any findings. A final audit report will be issued.
"No," please explain	N/A
5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by beneficiaries?	**Yes**
"Yes," please explain your program for fraud, waste, or abuse of non-controlled substances.	The Lock-In Program makes referrals to other OIG divisions or licensing body when applicable.
"No," please explain	**N/A**

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

Question	Response
1. Does your state have a Prescription Drug Monitoring Program (PDMP)? If the answer to question 1 is "Yes," please continue with a, b, and c.	**Yes**
a. Does your agency have the ability to query the state's PDMP database?	**No**

Question	Response
If the answer to sub-question 1 a is "Yes," please continue.	
i. Please explain how the state applies this information to control fraud and abuse.	N/A
ii. Do you also have access to Border States' PDMP information?	N/A
iii. Do you also have PDMP data (i.e. outside of MMIS, such as a controlled substance that was paid for by using cash) integrated into your POS edits?	N/A
b. Do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing controlled substances?	**No**
c. Are there barriers that hinder the agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?	**Yes**
"Yes," please explain the barriers (i.e. lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).	Per the State's requirement, access to the prescription data is statutorily restricted. The information is available to practitioners and pharmacies who are inquiring about their own prescribing or dispensing history on their patients. State regulatory boards have access as well. A person who knowingly gives, permits or obtains unauthorized access to this information, is subject to criminal penalty.
2. Have you had any changes to your state's Prescription Drug Monitoring Program during this reporting period that have improved the agency's ability to access PDMP data?	**No**
"Yes," please explain.	N/A

C. PAIN MANAGEMENT CONTROLS

Question	Response
1. Does your program obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?	**No**

Question	Response
If the answer to question 1 is "Yes," please continue.	
a. Do you apply this DEA file to your ProDUR POS edits to prevent unauthorized prescribing?	**N/A**
If "Yes," please explain how information is applied.	N/A
If "No," do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?	N/A
If "No," please explain	N/A
b. Do you apply this DEA file to your RetroDUR reviews?	**N/A**
If "Yes," please explain how it is applied.	N/A
2. Do you have a measure (i.e. prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?	**Yes**
If "No," please explain why you do not have a measure in place to either manage or monitor the prescribing of methadone for pain management.	N/A

D. OPIOIDS

Question	Response
1. Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription? If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue.	**No, for all opioids**
Please explain answer above.	In the FFY 2019, the initial opioid prescription followed the same quantity limit set in the system as the max quantity limit per prescription. The implemented opioid policy only checked for daily morphine milliequivalent. In Oct. 2018 a retro-DUR intervention was conducted, and letters were sent to prescribers who wrote opioid prescriptions for more than 7 days for the initial therapy. The retro-DUR criteria were based on the current national guidelines.
a. Is there more than one quantity limit for the various opioids?	**N/A**
"Yes," please explain	N/A

Question	Response
b. What is the maximum number of days' supply allowed for an initial opioid prescription?	**30**
c. Does this days' supply limit apply to opioid prescriptions?	**Yes, for all opioids**
"No," please explain	N/A
2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?	**No**
If "Yes," what is your maximum days' supply per prescription limitation?	N/A
"Other," please explain	N/A
If "No," please explain	In FFY 2019, only the opioid MME policy was enforced. The quantity limit for initial and subsequent fills was not implemented. The quantity limits were the same as the set maximum quantity limit per prescription.
3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids?	**No**
If "Yes," what is your maximum days' supply per prescription limitation?	N/A
"Other," please explain	N/A
If "No," please explain	The POS quantity limit for the long-acting opioids is the same as maximum quantity limit per prescription.
4. Do you have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?	**Yes**
If "Yes," check all that apply:	Deny claim and require PA, Intervention letters, Morphine Milligram Equivalent (MME) daily dose program, Step therapy or clinical criteria, Requirement that patient has a pain management contract or Patient-Provider agreement, Require diagnosis
Please provide details on these opioid prescribing controls in place.	During FFY 2019, the opioid policy allowed for up to 90 morphine milliequivalent (MME) per day; cancer related pain or hospice/palliative care were exempt. The authorization duration was for 6 months. In addition to MME level, There were additional clinical PAs for opioids such as: - Opioid Overutilization criteria deny claims and require a PA for short-acting opioid overutilization, diagnosis of substance use disorder, doctor shoppers and pharmacy shoppers

Question	Response
	- Fentanyl Agents clinical prior authorization criteria deny for the unsafe starting dose in fentanyl naive patients and documented drug-drug interactions. -Oxycodone ER Agents clinical criteria include appropriate daily dose for non-cancer pain and, for the high dose formulation, justification for highly dose, use of alternative pain therapy, client-prescriber pain management agreement, and appropriate daily dose. - Combination of opioids, benzodiazepines with or without muscle relaxants would deny for more than 14-day therapy overlap of these agents.
If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.	N/A
5. Do you have POS edits to monitor duplicate therapy of opioid prescriptions?	**No**
Please explain	Though a POS edit for duplicative opioid therapy is not in place, Texas-licensed pharmacies are required to report all dispensed CII - CV records to the Texas Prescription Monitoring Program (PMP) within 1 business day. Mandatory PDMP review by both prescribers and pharmacists started in FFY 2020. Also, the cumulative daily MME does not allow the combination daily dose exceeding 90 MME.
6. Do you have POS edits to monitor early refills of opioid prescriptions dispensed?	**Yes**
Please explain	Claims for all controlled substances require a 90% utilization of prior fill before the next a refill is allowed.
7. Do you have comprehensive claims review automated retrospective process to monitor opioid prescriptions exceeding these state limitations?	**No**
Please explain	A one-time retro-DUR intervention was conducted in October 2018 and intervention letters were sent to prescribers whose patients received more than 3 different opioid agents within 60 days (excluding cancer patients).

Question	Response
8. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and benzodiazepines being used concurrently?	**Yes, POS edits only**
If "Yes," Please explain in detail scope and nature of reviews and edits.	An overlap of benzodiazepines and opioids claims that is 14 days or higher will be denied will require a prior authorization.
If "No," Please explain	N/A
9. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and sedatives being used concurrently?	**No**
If "Yes," Please explain in detail scope and nature of reviews and edits.	**N/A**
If "No," Please explain	**Sedatives Hypnotics for Adults criteria logic does not check for combination of opioids and sedatives. However, if benzodiazepines are prescribed for sedation, there is another clinical PA requirement which denies a 14 day or more overlapping combination of opioids and benzodiazepines.** **Also, in the Sedatives Hypnotics for Adults PA criteria, a diagnosis of drug abuse, including opioid abuse disorder, will lead to PA denial.**
10. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and antipsychotics being used concurrently?	**No**
If "Yes," Please explain in detail scope and nature of reviews and edits.	N/A
If "No," Please explain	In FFY 2019, the retrospective review for concurrent prescribing of antipsychotics and opioids was not implemented.
11. Do you have POS safety edits or perform RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?	**Yes, retrospective reviews only**
If "Yes," retrospective reviews are performed, please indicate how often.	Annually
"Other," please specify.	N/A
Please explain nature and scope of edits, reviews and/or provider education reviews performed.	In Oct. 2018 a retro-DUR intervention, prescribers received intervention letters for prescribing opioid to patient with history of OUD.

Question	Response
If "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?	N/A
If "No," Please explain.	N/A
12. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?	**Yes**
If "Yes," please check all that apply	Your state Medicaid agency refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain., Other guidelines.
Please identify the "other" guidelines.	With the initial communication regarding Opioid morphine milliequivalent policy, VDP provided the information from the CDC guidelines. Also, with the retro-DUR intervention letters, the reference to the CDC guidelines was provided.
Please explain why no guidelines are offered.	N/A
13. Do you have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?	**Yes**
"Yes," please explain	There is at least one opioid abuse deterrent on the preferred list of narcotic analgesics.

E. MORPHINE MILLIGRAM EQUIVALENT (MME) DAILY DOSE

Question	Response
1. Have you set recommended maximum MME daily dose measures?	**Yes**
If "Yes," please continue	
a. What is your maximum morphine equivalent daily dose limit in milligrams?	**90 MME mg per day**
i. If "Other", please specify	**N/A mg per day**
b. Please explain nature and scope of dose limit.	**In FFY 2019, all clients, except for clients with cancer or patients in hospice or palliative care, were subject to a 90 MME per day dosing. Prescription above this limit would require a prior authorization. The prior authorization duration was for 6 months.**
If "No," please explain the measure or program you utilize.	**N/A**

Question	Response
2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?	**Yes**
a. If "Yes," Please name the developer of the calculator:	**CDC**
If "Other," please specify	N/A
b. If "Yes," how is the information disseminated? Check all that apply:	**Provider notice**
If "Other," please explain	N/A
3. Do you have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?	**Yes**
If "Yes," do you require prior authorization if the MME limit is exceeded?	Yes
4. Do you have automated retrospective claim reviews to monitor total daily dose (MME) of opioid prescriptions dispensed?	**No**
Please explain	In FFY 2019, an automated retrospective claims reviews for total daily MME was not implemented. The prospective check and PA requirement for total daily MME is a good safeguard against prescribing above the designated MME.

F. BUPRENORPHINE, NALOXONE, BUPRENORPHINE/NALOXONE COMBINATIONS and METHADONE for OPIOID USE DISORDER (OUD)

Question	Response
1. Does your agency set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?	**No**
If "Yes," please specify the total mg/day:	N/A
If "Other," please explain	N/A
2. What are your limitations on the allowable length of this treatment?	**No limit**
If "Other," please explain	N/A
3. Do you require that the maximum mg per day allowable be reduced after a set period of time? If "Yes," please continue	**No**

Question	Response
a. What is your reduced (maintenance) dosage?	**N/A**
If "Other," please explain	N/A
b. What are your limitations on the allowable length of the reduced dosage treatment?	**N/A**
If "Other," please explain	N/A
4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?	**No**
5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?	**Yes**
"Other," please explain	N/A
If "Yes," can the POS pharmacist override the edit?	No
6. Do you have at least one naloxone opioid overdose product available without prior authorization?	**Yes**
7. Do you retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?	**No**
Please explain	In FFY 2019, state did not conduct retrospective monitoring on appropriate use of naloxone.
8. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?	**Yes, State Board of Professional Regulations/Board of Pharmacy/ Board of Medicine and/or State Medicaid agency under protocol**
9. Does your state agency cover methadone for a substance use disorder (i.e. Methadone Treatment Center)?	**Yes**

G. ANTIPSYCHOTICS / STIMULANTS

ANTIPSYCHOTICS

Question	Response
1. Do you currently have restrictions in place to limit the quantity of antipsychotics?	**No**

Question	Response
Please explain	N/A
2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?	**Yes**
a. If "Yes," do you either manage or monitor:	**All children**
"Other," please explain	N/A
b. If "Yes," do you have edits in place to monitor (check all that apply):	**Child's age, Indication, Polypharmacy**
"Other" Please explain	N/A
c. Please briefly explain the specifics of your antipsychotic monitoring program(s).	**VDP has a clinical prior authorization in place for all antipsychotics. The approval criteria include: appropriate age, approved diagnosis, no mono-therapy for either insomnia or major depressive disorder, and no concomitant use of more than two different antipsychotics at any given time (the incoming claim will deny if more than two antipsychotics with different ingredients found in patient's claims history)**
d. If "No," do you plan on implementing a program in the future?	**N/A**
If "Yes," when do you plan on implementing a program?	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.	N/A

STIMULANTS

Question	Response
3. Do you currently have restrictions in place to limit the quantity of stimulants?	**No**
4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?	**Yes**
a. If "Yes," Do you either manage or monitor:	**All children**
"Other," please explain	N/A
b. If "Yes," Do you have edits in place to monitor (check all that apply):	**Child's age, Indication, Polypharmacy**
"Other," please explain	N/A
c. Please briefly explain the specifics of your documented stimulant monitoring program(s).	**The criteria for the stimulants is a part of the Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD) Medications clinical prior authorization. The**

Question	Response
	clinical criteria are divided into 4 sections: the immediate release (IR)stimulants, the extended release (ER) stimulants, the nonstimulants (except clonidine ER), and clonidine ER. **For the IR formulation, we check for age, diagnosis, no diagnosis of substance abuse disorder, maximum daily dose based on the FDA approved indications or the national peer-reviewed guidelines, and no concomitant use of two or more IR formulations.** **For the ER formulation the criteria check for a minimum age of 6, diagnosis of ADD/ADHD, no diagnosis of substance use disorder found, maximum daily does based on the FDA approved indications or the national, peer reviewed guidelines, and no concomitant use of two or more ER formulations. For clients older than 19 years of age, client must have a documented diagnosis of ADD/ADHD. The concomitant use of and IR and an ER formulation, as well as, the concomitant use of either of the above formulations with a non-stimulant is permitted.**
d. If "No," do you plan on implementing a program in the future?	**N/A**
If "Yes," when do you plan on implementing a program?	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children	N/A

Section IX - INNOVATIVE PRACTICES

Question	Response
1. Summary 6 – Innovative Practices Summary 6 - Innovative Practices should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing).	**Multiple Formulary and DUR innovative projects were initiated during FFY 2019** **1. In April 2019 Vendor Drug Program (VDP) initiated the project to allow pharmacists to receive reimbursement for the administration of certain long-acting injectable antipsychotic medications, opioid antagonists, and influenza vaccines to members. Implementation date was Sep. 1,**

Question	Response
	2020, SPA is pending CMS approval. **2. In June 2019 developed the PDL compliance standards and reports to properly monitor the use of non-preferred drugs by the MCOs. The PDL Compliance Report will be used by VDP's Pharmacy Benefit Oversite (PBO) team for review of the MCO PDL compliance. PBO developed compliance metrics for the drug classes and liquidated damages for MCO noncompliance.** **3. In Aug. 2019, VDP initiated a project to allow patient access to non-preferred drugs when prescribed for treatment of conditions associated with Stage 4 advanced, metastatic cancer. This PDL exemption criteria was implemented in January 2020.** **4. In Aug. 2019 VDP initiated the provision to exempt opioid prescriptions from counting towards 3 RX/month limit for FFS members. This policy is only applied when opioids are prescribed for the treatment of acute pain. The implementation date was set for Sep. 2020.** **5. In Aug. 2019 VDP initiated the project to move all drugs in the Opiate Dependence Treatment class to preferred status. Implemented January 2020.** **6. In Aug. 2019 VDP initiated coverage of any prescription drug for the Medicaid STAR Kids population including drugs from manufacturers that have not entered into a federal rebate agreement with CMS. VDP, also, removed prior authorization requirement for non-preferred drugs and prohibited step therapy protocols for this population.** **The implementation date will be on Dec. 31, 2020.** **7. In Aug. 2019 VDP initiated the project that allows HHSC to enter into value-based agreements with drug manufacturers based on the outcome data or other metrics to which HHSC and the drug manufacturer agree**

Question	Response
	in writing. SPA is pending CMS approval. **8. In Aug. 2019, the project for automated submission of formulary Certificate on Information (COI) documents was initiated.** **9. In Aug. 2019 VDP initiated the project to evaluate the prescribing practices for opioids and assess the extent by which prescribers align their practices with the guidelines set forth by the CDC.** **In addition to the projects listed above, VDP developed the following new clinical prior authorizations: Urea Cycle Disorder Agents in April 2019, Calcitonin Gene-Related Peptide Receptor (CGRP) Antagonists in Oct. 2018.** **Furthermore, HHSC has developed multiple training opportunities for physicians, nurses, pharmacists, and other healthcare professionals.**

Section X - E-PRESCRIBING

Question	Response
1. Does your MMIS or pharmacy vendor have a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?	**Yes**
If "Yes," do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?	No
If "Yes," please explain the evaluation methodology. **Summary 7 –E-Prescribing Activity** should explain the evaluation methodology utilized in evaluate the effectiveness of providing drug information and medication history prior to prescribing.	N/A
If "No," are you planning to develop this capability?	N/A
If "No," please explain	N/A
2. Does your system use the NCPDP Origin Code that indicates the prescription source?	**Yes**

Section XI - MANAGED CARE ORGANIZATIONS (MCOs)

Question	Response
1. How many MCOs are enrolled in your state Medicaid program?	**18**
2. Is your pharmacy program included in the capitation rate (carved in)?	**Yes**
If "Partial," please specify the drug categories that are carved out.	N/A
3. Does the state set requirements for the MCO's pharmacy benefit (e.g. same PDL, same ProDUR/RetroDUR)?	**Yes**
a. If "Yes," please check all requirements that apply	**Formulary Reviews, Same PDL**
b. If "Yes," please briefly explain your policy.	**The MCOs are required to follow the single formulary and PDL. Also the state does not allow MCO's clinical PA criteria to be more stringent than what the DUR Board has approved. The MCOs are required to follow the same Specialty Drug List (SDL) as the state designates.**
If "No," do you plan to set standards in the future?	N/A
If "No," please explain	N/A
4. Did all of your managed care plans submit their DUR reports?	**Yes**
If "No," please explain.	N/A

Section XII – EXECUTIVE REPORT

Question	Response
Summary 8-Executive Report should provide a brief overview of your program. It should describe 2019 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.	**Texas Vendor Drug Program (VDP) provides access to outpatient covered drugs to members enrolled in various government healthcare programs. VDP manages the drug formulary and the preferred drug list (PDL) and the Specialty Drug List (SDL). The manages drug utilization through various DUR methodologies including implementation of a single formulary and PDL. VDP also develops clinical criteria on certain drugs. These criteria are set based on drug's potential for abuse or inappropriate prescribing. Both the PDL recommendations and the clinical criteria are reviewed by the**

Question	Response
	DUR Board. **The Texas DUR Board consists of medical professionals such as practicing physicians, pharmacists, academia as well as patient advocacy representative, and two members representing the managed care organizations. DUR Board meets every quarterly to review and make recommendations on proposed prospective and retrospective criteria on prescription claims.** **In the FFY 2019, the Board met 4 times.** **The following prospective clinical prior authorization criteria were reviewed by the Board:** **Calcitonin gene-related peptide receptor (CGRP) Antagonist, Cytokine and CAM antagonists - addition of Olumiant and Skyrizi, Epidiolex oral solution, Arikayce, HAE Agents, Inhaled ABX, Motegrity (prucalopride), Skeletal Muscle Relaxants.** **For the retrospective intervention, the Board approved the following topics: Management of Psychotropic Drugs in Adults; Medication Adherences; Appropriate Use of Antibiotics; Respiratory Disease Management; Mental Health Disorders Management; Anticonvulsant Drug Use Review; Cough and Cold Medications; Members age Influenza Prevention.** **The estimated total cost savings/cost avoidance associated with the prospective claims review and the clinical and PDL PA and the retrospective interventional letters was $21, 760,000.00.** **The Texas Office of Inspector General (OIG) is responsible to identify and investigate suspected waste, abuse, and fraud in Medicaid and other health and human services programs. Medical and Pharmacy services and claims are reviewed, and suspected cases are referred to prosecutors, licensure and certification boards, and other agencies.** **For the FFY 2019, there were only 6 FFS members in the Lock-in program. Members will remain in Lock-in when transitioned from FFS to one of the MCOs. The estimated cost avoidance associated with the FFS Lock-in is**

Question	Response
	reported as around $17,800.00 **In the FFY 2019, several innovative projects were initiated, though the implementation dates fall outside of that fiscal year. These initiatives include the project to allow pharmacists to receive reimbursement for the administration of certain long-acting injectable antipsychotic medications, opioid antagonists, and influenza vaccines to members; the PDL compliance standards and reports to properly monitor the use of non-preferred drugs by the MCOs; a project to allow patient access to non-preferred drugs when prescribed for treatment of conditions associated with Stage 4 advanced, metastatic cancer; the provision to exempt opioid prescriptions from counting towards 3 RX/month limit for FFS members. This policy is only applied when opioids are prescribed for the treatment of acute pain; the project to move all drugs in the Opiate Dependence Treatment class to preferred status; coverage of any prescription drug for the Medicaid STAR Kids population including drugs from manufacturers that have not entered into a federal rebate agreement with CMS; removal of prior authorization requirement for non-preferred drugs and prohibited step therapy protocols for this population; value-based agreements with drug manufacturers based on the outcome data or other metrics to which HHSC and the drug manufacturer agree in writing; automated submission of formulary Certificate on Information (COI) documents was initiated; monitor and evaluate the prescribing practices for opioids in accordance with the CDC guidelines.** **HHSC also provides learning opportunities through continuous education (CE) credit offers for providers.** **VDP strives to further align its DUR programs with the guidance from the CMS and in accordance with federal and state laws in the coming years.**