Texas
Medicaid Fee-For-Service (FFS)
Federal Fiscal Year (FFY) 2020
Drug Utilization Review (DUR)
Annual Report

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Section I – Number of Beneficiaries

Question	Response
1. On a monthly 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?	**224,944**
2. On a monthly average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)?	**3,760,023**

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. Who processes the state's National Council for Prescription Drug Programs (NCPDP) transactions?	**POS vendor is the fiscal agent (FA)**
2. Identify your ProDUR table driven criteria source. This would be initial ratings such as drug to drug interactions, dose limits based on age and pregnancy severity.	**First Databank, Other**
Other, please specify.	Some criteria are developed inhouse.
3. When the pharmacist receives a 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)?	**Varies by Alert Type**
If "Yes" or "Varies by Alert Type,"	Alerts can be overridden ahead of time, Alerts can be overridden with standard professional codes, Alerts need PA to be overridden
Other, please explain.	N/A
4. Does your state receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail?	**No**
a. How often does your state receive reports?	**N/A**
Other, please explain.	N/A
b. If you receive reports, does your state follow up with those providers who routinely override with interventions?	**N/A**
Yes, what method does your state follow up?	N/A
Other, please explain.	N/A
No, please explain.	N/A
5. 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%**

Question	Response
b. For non-controlled drugs: when an early refill message occurs, does your state require a PA?	**No**
If "Yes" or "Dependent on medication or situation," who obtains authorization?	N/A
If "No," can the pharmacist override at the POS?	No
c. For controlled drugs: when an early refill message occurs, does your state require a PA?	**No**
If "Yes," who obtains authorization?	N/A
If "No," can the pharmacist override at the POS?	No
6. 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:	
a. Lost/stolen Rx	**No**
b. Vacation	**No**
c. Other, please explain.	**The dispensing pharmacist must call FFS Pharmacy program Help Desk and provide a reasonable explanation for an override.**
7. 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," does your state plan to implement this edit?	No
8. Does the state Medicaid program 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**
9. For drugs not on your Preferred Drug List (PDL), does your Medicaid program have a documented process (i.e. PA) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?	**Yes**
Yes, please.	Other
Other, please explain.	For drugs that are on Texas formulary and are designated as non-preferred, a PDL PA is required. When a drug is CMS rebatable but is not yet on the Texas formulary, the claim will be denied for NDC not covered and if prescriber requests coverage for medical

Question	Response
	necessity, we quickly take the necessary actions to provide access to the drug.
No, please explain.	N/A
a. Does your program provide for the dispensing of at least a 72-hour supply of a COD in an emergency situation?	**Yes**
Yes, please.	Real time automated process, Retrospective PA, Other process
Other process, please explain.	The 72-hours supply can be dispensed on drugs when a prior authorization is required. Providing 72-hours emergency supply is based on the pharmacist's professional discretion. The 72-hour supply may be repeated on the same claim if the prescriber is not reachable after the first 72-hrs but it should not be used for routine and continuous overrides of the drug prior-approval process. a 72-hour emergency supply does not count towards pharmacies 3 RX limit in FFS program.
No, please explain.	N/A
10. Please list the requested data in each category in Table 1 - Top Drug Claims Data Reviewed by the DUR Board below.	

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

Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level	Top 10 Prior Authorization (PA) Requests by Drug Class	Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD) and Age Edits (AE))	Top 10 Drug Names by Amount Paid, report at generic ingredient level	% 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, report at generic ingredient level	Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)
montelukast	leukotriene receptor antagonist agents	member enrolled in managed care	Divalproex	2.80%	cetirizine	4.62%
gabapentin	anticonvulsant agents	product/service not covered - plan/benefit exclusion	Prenatal multivitamine	2.00%	ibuprofen	3.04%
methylphenidate	attention deficit hyperactivity disorder agents	patient is not covered	elexacaftor/ tezacaftor/ ivacaftor	1.92%	amoxicillin	2.98%
albuterol	stimulants and related agents	submit bill to other processor or primary payor	insulin aspart	1.85%	loratadine	2.81%
risperidone	antipsychotic agents	prescriber is not covered	albuterol	1.73%	docusate	2.60%
dextroamphetamine /amphetamine	antiemetic agents		lisdexamfetamine	1.71%	pediatric multivitamin	2.07%
meloxicam	bronchodilator agents		insulin glargine	1.58%	polyethylene glycol 3350	2.02%
brompheniramine/ pseudoephedrine/ dextromethorphan	proton pump inhibitor agents		fluticasone	1.55%	albuterol	1.99%
esomeprazole	nsaid agents		paliperidone	1.49%	ondansetron	1.97%
doxylamine/pyridoxine	cough and cold agents		oseltamivir	1.47%	aspirin	1.94%

Question	Response
11. Section 1927(g) (A) of the Social Security Act (the 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?	**State Board of Pharmacy**

Question	Response
Other, please explain.	N/A

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 the Medicaid Management Information System (MMIS) fiscal agent?	**No**
c. Is the RetroDUR vendor the developer/supplier of your retrospective DUR criteria?	**Yes**
Please explain "Yes" or "No" response.	Conduent uses Cyberformance, a web-based tool, in order to conduct clinical analysis of drug therapy and disease states using both pharmacy and medical claims data. This method allows clinical issues affecting thousands of members to be addressed without the need to individually review each profile. The retrospective criteria are reviewed by the Texas DUR Board prior to implementation. To allow for development of physician outlier profiles based on the number of beneficiaries who are receiving sub-optimal therapy, the Prescribing physicians who treat only one or two members flagged for intervention are filtered. This approach produces a large multiplier effect for a single intervention.
d. Does your state customize your RetroDUR vender criteria?	**Yes**
2. How often does your state perform retrospective practitioner-based education?	**Other**
Other, please specify.	There is no set frequency for mailing educational letters. Per the program requirement, vendor must perform seven to ten retrospective interventions per year. Proposed intervention criteria and the educational letters that receive approval by the DUR Board, are mailed out within 1-3 months.
a. How often does your state perform retrospective reviews that involve communication of client specific information to healthcare practitioners (through messaging, fax, or mail)?	**Other**

Other, please specify.	With each retrospective intervention package mailed, individual client's claims information is included.
b. What is the preferred mode of communication when performing RetroDUR initiatives?	**Mailed letters**
Other, please specify.	N/A
3. Summary 1 – RetroDUR Educational Outreach Summary Summary 1: RetroDUR Educational Outreach is a year-end summary report on retrospective screening and educational interventions. This year-end summary should be limited to the most prominent problems with the largest number of exceptions.	**Population-Based Intervention Summary** **1. Influenza Prevention was mailed out on 10/18/2019 to 3,411 physicians. This intervention focused on improving influenza vaccination, antiviral prescribing practices, and reducing the overall cost of care for patients. During the intervention. Targeted patients saw average reductions in clinical indicators by 27.5%.** **In terms of financial outcomes, the amount paid for intervention-related drugs increased by $0.65 in the post-intervention period. This yielded an overall estimated increase of $265,938.40 in intervention-related drug expenditures on an annualized basis.** **2. Diabetes Disease Management was delivered on 05/05/2020 to 930 physicians and impacted 2,715 clients. This intervention focused on improving prescription drug therapy as well as the recommended laboratory tests in patients with type I or type II diabetes. During the intervention. Targeted patients saw average reductions in clinical indicators by 22.4%.** **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 $395,111.52 in intervention-related drug expenditures on an annualized basis.** **3. Cough and Cold Remedies was delivered on 10/22/2019 to 485 physicians. This intervention focused on improving prescribing practices based on patient safety. Targeted patients saw average reductions in clinical indicators by 24.8%. In terms of financial outcomes, the amount paid for intervention-related drugs increased by $0.55 in the post-intervention period. This yielded an overall estimated increase of $95,130.20**

	in intervention-related drug expenditures on an annualized basis. **4. Anticonvulsants Drug Use Evaluation was delivered on 10/14/2019 to 337 physicians and impacted 342 clients. This intervention focused on improving prescribing practices, treatment adherence, and reducing adverse events associated with duplicative therapies, drug-drug and drug-disease interactions, etc. During the intervention. Targeted patients saw average reductions in clinical indicators by 23.4%.** **In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $1.37 in the post-intervention period. This yielded an overall estimated decrease of $192,737.08 in intervention-related drug expenditures on an annualized basis.** **5. Psychotropic Drugs in Youth was delivered on 03/23/2020 to 222 physicians and impacted 272 clients. This intervention focused on improving prescribing practices, treatment adherence, reducing duplicative therapies and drug adverse effects. During the intervention. Targeted patients saw average reductions in clinical indicators by 25.7%.** **In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $5.77 in the post-intervention period. This yielded an overall estimated decrease of $2,169,719.61 in intervention-related drug expenditures on an annualized basis.** **6. Caring for Patients with Asthma was delivered on 08/20/2020 to 134 physicians and impacted 120 Patients. This intervention focused on improving overall prescribing of the short acting and long acting bronchodilators, as well as, reducing the risk of hospitalization and emergency visits due to uncontrolled asthma symptoms. Targeted patients saw average reductions in clinical indicators by 28.9%.** **In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.82 in the post-intervention period. This yielded an overall estimated decrease of**

	$69,324.44 in intervention-related drug expenditures on an annualized basis. **7. NSAIDs intervention was mailed out on 06/24/2020 to 105 physicians and impacted 104 clients. This intervention focused on improving prescribing practices and reducing the risks associated with NSAID therapy. Targeted patients saw average reductions in clinical indicators by 32.7%.** **In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.69 in the post-intervention period. This yielded an overall estimated decrease of $10,792.98 in intervention-related drug expenditures on an annualized basis.** **8. Post-Traumatic Stress Disorder (PTSD) was delivered on 09/15/2020 to 95 physicians and impacted 74 clients. This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. During the intervention. Targeted patients saw average reductions in clinical indicators by 37.9%.** **In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.23 in the post-intervention period. This yielded an overall estimated decrease of $9,166.88 in intervention-related drug expenditures on an annualized basis.** **9. ADHD Medications was delivered on 05/18/2020 81 to 73 physicians and impacted 81 clients. This intervention focused on improving prescribing practices and reducing the risks associated with over utilization and duplicative therapies. During the intervention. Targeted patients saw average reductions in clinical indicators by 26.8%.** **In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $2.35 in the post-intervention period. This yielded an overall estimated decrease of $148,346.10 in intervention-related drug expenditures on an annualized basis.** **10. Pain Management was mailed out on 02/28/2020 to 54 physicians and impacted**

	57 clients. This intervention focused on improving prescribing practices and reducing opioid overutilization and decreasing he overall cost of care for patients. 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 $0.64 in the post-intervention period. This yielded an overall estimated decrease of $3,728.64 in intervention-related drug expenditures on an annualized basis.** **11. Opioid/Benzo/ Antipsychotics was mailed on 01/08/2020 to 9 physicians and impacted 9 clients. This intervention focused on improving prescribing practices and reducing risks associated with drug abuse, and to reduce overall cost of care for patients. During the intervention. Targeted patients saw average reductions in clinical indicators by 42.9%.** **In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $7.24 in the post-intervention period. This yielded an overall estimated decrease of $31,580.88 in intervention-related drug expenditures on an annualized basis.**

Section IV - DUR Board Activity

Question	Response
1. Summary 2 – DUR Board Activities Summary. Summary 2: DUR Board Activities Summary should be a brief descriptive on DUR activities during the fiscal year reported.	**During the FFY 2020, the Board held four quarterly meetings.** **The Board's activities consist of the following:** **1. Review drugs within each therapeutic class for preferred/non-preferred recommendations** **2. Retrospective criteria reviews on drugs or drug classes- these criteria may be used as the basis for prospective and retrospective DUR proposals. Reviewed criteria include: 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. Review of the prospective clinical prior authorization (PA) criteria proposal: Clinical prior authorizations are developed with input from State DUR staff, Medicaid managed care organizations(MCOs), and the PA vendor. Criteria are mainly based on the available references such as drug Package insert, treatment practice guidelines, etc.** **Retrospective Criteria Reviews** **During FFY 2020, the following retrospective criteria were reviewed:** **a. Atypical Antipsychotics -long-acting injectable** **b. Atypical Antipsychotics (oral)** **c. Exogenous Insulin Products** **d. Nitazoxanide (Alinia)** **e. Promethazine Use in Children < 2 Years of Age** **f. Quetiapine (low-dose)** **g. fentanyl Inhalation/oral/transdermal** **h. Gabapentin** **i. Hydrocodone Bitartrate/ Hydrocodone Polistirex** **j. Ivacaftor (Kalydeco) and Combination Therapy** **k. Topical Calcineurin Inhibitors Pimecrolimus (Elidel) Tacrolimus (Protopic)** **l. Tramadol (Ultram)** **m. Direct Oral Anticoagulants**

Question	Response
	n. Complement Inhibitor and Enzyme/Protein Replacement Therapy **o. Low-Molecular-Weight Heparins (LMWHs)** **p. Nebulized Bronchodilators** **q. Hydroxymethylglutaryl-Coenzyme A (HMG-CoA) Reductase Inhibitors (Statins)** **r. Benzodiazepines (Nonsedative/ Hypnotics)** **s. Immune Globulins** **t. Oral/Rectal Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)** **u. Non-sedating Antihistamines** **v. Oral Fluoroquinolones** **w. Rifaximin (Xifaxan)** **x. Skeletal Muscle Relaxants** **y. Sickle Cell Disease Products** **Retrospective DUR Intervention Proposals- Educational letters for provider- During FFY 2020, the following retrospective intervention topics were reviewed:** **a. Opioids, Benzodiazepines, and Antipsychotics** **b. Pain Management with Opioids** **c. Diabetes Disease Management** **d. Monitoring of Psychotropic Drugs in Youth** **e. Postpartum Depression** **f. Caring for Your Patients with Asthma** **g. NSAID Drug Usage Evaluation (DUE)** **h. Pharmacotherapy of Post-Traumatic Stress Disorder** **i. Appropriate Use of Antibiotics** **j. Contraception: Drug Use Evaluation** **k. Gabapentinoid Drug Use Evaluation** **For the FFY 2020, the Board reviewed the following clinical prior authorization criteria** **a. Benjesta/Diclegis - criteria included: age check, FDA-approved diagnosis check, number of units per day** **b. Cytokine and CAM Antagonists- Rinvoq- criteria included: age check, FDA-approved diagnosis, concurrent use of methotrexate or inadequate response/intolerance to methotrexate, no evidence of contraindicated diagnosis or contraindicated drugs, number of units per day**

Question	Response
	c. Diacomet - criteria included: age check, current claim for clobazam, and diagnosis of Dravet syndrome **d. Sunosi - criteria included: age check, FDA-approved diagnosis, procedure code for CPAP/BiPAP for those with obstructive sleep apnea, no evidence of use of contraindicated drugs, quantity per day, prescriber specialty** **e. Cystic Fibrosis Agents - Trikafta- criteria included: age check, FDA- approved diagnosis/F508del gene mutation, no evidence of contraindicated diagnosis or drugs, no duplicated therapy with Kalydeco, Orkambi, or Symdeko,** **f. Inhaled antibiotics (revisions) - addition of non-CF bronchiectasis or colonization with P. aeruginosa. The Board did not approve the revisions** **g. Oxbryta - criteria included: age check, FDA-approved diagnosis, no evidence of contraindicated drugs, dose check** **h. PAH Agents- addition of oral and inhaled agents to the existing inj. agents- criteria included: FDA-approved diagnosis, and confirmed contraindication to right heart catheterization or pulmonary angiogram** **i. Monoclonal Antibody for Asthma - Fasenra and Nucalal - criteria included: age check, FDA-approved diagnosis, indications of current use of asthma controller, no evidence of contraindicated diagnosis, initial and maintenance daily doses.** **k. Ophthalmic Immunomodulators - Cequa, Restasis, Xiidra - criteria included: age check, FDA-approved diagnosis, prescriber specialty, dosing and quantity check** **l. Transthyretin Agents - Vyndamax, Vyndaqel, Tegsedi - criteria included: specialist prescribing, age check, FDA-approved diagnosis, labs, approved dose/day, no evidence of concurrent therapy with contraindicated agents.** **m. Age-Based Tricyclic Antidepressants - criteria included: aged check- The criteria did not pass the Board's approval** **n. Acthar gel (revision)- removed the non-FDA-approved indications from automatic PA approval**

Question	Response
	o. Oxervate Ophthalmic Solution - criteria included - age check, FDA-approved diagnosis, no evidence of prior treatment with cenegermin, therapy duration **p. Palforzia - criteria included: age check, FDA-approved diagnosis, evidence of epinephrine prescription, no history of uncontrolled asthma** **q. Spravato Nasal Solution - criteria included: age check, specialist prescribing, FDA-approved diagnosis, trial of 2 augmentation therapies, no evidence of contraindicated therapies, does check.**
2. Does your state have an approved Medication Therapy Management (MTM) Program?	**No**

Section V – Physician Administered Drugs (PAD)

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

Question	Response
1. ProDUR?	**No**
If "No," does your state have a plan to include this information in your DUR criteria in the future?	No
2. RetroDUR?	**No**
If "No," does your state 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 3 – Generic Drug Substitution Policies Summary 3: Generic Drug Substitution Policies should summarize factors that could affect your generic utilization percentage. In describing these factors, please explain any formulary management or cost containment measures, PDL policies, educational initiatives, technology or promotional factors, or other state specific factors that affects your generic utilization rate.	**1. Texas Government Code Sec 531.303, Generic Equivalent Authorized, requires that, unless the practitioner's signature on a prescription clearly indicates that the prescription must be dispensed as written, the dispensing pharmacies may select a generic equivalent of the prescribed drug. However, if a brand name drug is preferred on Texas formulary, the pharmacy does not have to ask for prescriber to certify medically necessary. In this case Texas Medicaid reimburses pharmacy for the brand name product without requiring a PDL prior authorization.** **2. The single formulary and PDL is still in effect in Texas. Medicaid outpatient drug formulary includes covered generic drugs. The factors that may potentially affect our generic utilization percentage include the PDL decisions within a therapeutic class. The MCOs are required to cover the same preferred brands as the FFS.**
2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your state have a more restrictive requirement?	**Yes**
If "Yes,"	PA is required, Other
Other, please explain.	For brand name drugs designated as preferred, the prescriber does not have to certify "Brand Necessary" on the prescription.

Generic Drug Utilization Data

Computation Instructions KEY

Single Source (S) – Drugs having an FDA New Drug Application (NDA), and there are no generic alternatives available on the market.

Non-Innovator Multiple-Source (N) – Drugs that have an FDA Abbreviated New Drug Application (ANDA), and generic alternatives exist on the market

Innovator Multiple-Source (I) – Drugs which have an NDA and no longer have patent exclusivity.

1. **Generic Utilization Percentage:** To determine the generic utilization percentage of all covered outpatient drugs paid during this reporting period, use the following formula:

N ÷ (***S*** + ***N*** + ***I***) × 100 = Generic Utilization Percentage

2. **Generic Expenditures:** To determine the generic expenditure percentage (rounded to the nearest $1000) for all covered outpatient drugs for this reporting period use the following formula:

$***N*** ÷ ($***S*** + $***N*** + $***I***) × 100 = Generic Expenditure Percentage

CMS has developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each NDC along with sourcing status of each drug: S, N, or I.

Table 2 - Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	38,367	489,370	27,923
Total Reimbursement Amount Less Co-Pay	$23,278,906	$11,125,955	$5,709,095

Question	Response
3. Indicate the generic utilization percentage for all CODs paid during this reporting period, using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Number of Generic Claims	489,370
Total Number of Claims	555,660
Generic Utilization Percentage	88.07%
4. How many multi-source drugs have the innovator as the preferred drug product based on net pricing?	**39**
5. Indicate the percentage dollars paid for generic CODs in relation to all COD claims paid during this reporting period using the computation instructions in Table 2: Generic Drug Utilization Data.	
Generic Dollars	$11,125,955
Total Dollars	$40,113,956
Generic Expenditure Percentage	27.74%

Question	Response
6. Does your state have any policies related to Biosimilars? Please explain.	**No, biosimilars are subject to the same PDL and clinical prior authorization criteria as the original single sours products.**

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; KePro
2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below.	

	Data
ProDUR Total Estimated Avoided Costs	$6,787,550.00
RetroDUR Total Estimated Avoided Costs	$1,879,216.49
Other Cost Avoidance	$7,071.36
Grand Total Estimated Avoided Costs	$8,673,837.85

Question	Response
3. Estimated Percent Impact	**21.62%**
4. Summary 4 – Cost Savings/Cost Avoidance Methodology Summary 4 Cost Savings/Cost Avoidance Methodology includes program evaluations/cost savings estimates prepared by the state or contractor.	**RetroDUR Program Summary** **RetroDUR report provides an analysis estimating the cost savings generated by eleven RetroDUR Population-Based Interventions (PBIs) delivered to Texas Medicaid providers for the period of October 1, 2019 through September 30, 2020.** **PBIs are developed to target a specific disease state or drug-use evaluation. 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 the quarterly DUR Board Meetings for feedbacks and approval. The intervention packages are delivered to outlier providers. The package includes a provider letter with referenced**

	educational materials and modified patient profiles. If a provider replies to any of the intervention letters, the vendor will provide the necessary response. An analysis of the intervention outcomes is completed 6 months post-intervention. Total Paid 6-month pre and post total drug costs can be defined as the total amount of paid intervention-related drug claims for a time period for the prescribers in the control and target groups. The target group consisted of those prescribers who had prescribed intervention-related drug therapy to more than two Medicaid patients. The control group consisted of all other prescribers who prescribed intervention-related drug therapy agents in the designated time periods. **Average Number of Panel Patients per Month - during the 6-month pre and post time periods, the number of unique Medicaid patients with a drug claim submitted using a respective provider number is captured each month. Medicaid patients that did not have a drug claim were not counted in the prescriber's panel. The monthly numbers are summed then divided by six to calculate the monthly average. By evaluating all patients seen by a specific physician, changes in prescribing patterns can be evaluated on existing and new patients. Average Cost per Patient per Month 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.** **6-Month and 12-Month Total Savings - the Intervention Average Cost Savings per Patient per Month is multiplied by the total number of targeted patients served over the 6-month time frame. 6-Month State General Revenue Funds Savings= 6-Month Total State Savings X 0.4001. Total State Savings = 6-Month State General Revenue Funds Savings X 2. The estimated cost savings calculated is $1,879,216.49** **ProDUR Program Summary** **KePro (HID) provides the Prior Authorization Services for the VDP fee-for-service population. In general, prescribers must**

	obtain prior authorization for all non-preferred drugs in each drug class on the preferred drug list (PDL). In addition, some drugs are subject to clinical edits prior to authorization for dispensing. Due to the high percentage of automated decisions made by RxPert, a high percentage of prior authorizations are obtained at point-of-sale (POS) without requiring a call to the HID call center for approval. Working from criteria supplied by HHSC, the RxPert system provides a determination as to whether it is appropriate for the client to receive the requested drug. **Prior authorization denial activities across all request methods (including duplicates) are used for the estimated cost savings calculation.** **Total cost saving= total cost savings for unique denials with subsequent therapy + total cost savings for unique denials without follow-up approval and substitution therapy.** **Total Cost Savings for Unique Denials with Substitute Therapy: SUM (Estimated Denial Cost per unique denial: 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: 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. **Total Cost savings associated with ProDUR was $6,787,550** **The Lock-In Program receives referrals from the public, providers, Managed Care Organizations (MCOs) and law enforcement officials via the Waste, Abuse, Fraud Electronic Referral System (WAFERS). Each referral is reviewed for lock-in criteria match. In addition, the Lock-In Program makes referrals to the Office of Inspector General (OIG) internal divisions, law enforcement and Child and Adult Protective Services and other state agencies as appropriate.** **The cost avoidance associated with the Lock-in program in FFS was 7,071.36.**

Section VIII – Fraud, Waste, and Abuse Detection

A. Lock-In or Patient Review and Restriction Programs

Question	Response
1. Does your state 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?	Deny claims, Refer to Lock-In Program, Refer to Office of Inspector General (OIG), Other
Other, please explain.	The Lock-In Program receives referrals from the public, providers, Managed Care Organizations (MCOs) and law enforcement officials via the Waste, Abuse, Fraud Electronic Referral System (WAFERS). Each referral is reviewed for lock-in criteria match. In addition to the Office of Inspector General (OIG) , the Lock-In Program makes referrals to the internal divisions, law enforcement and Child and Adult Protective Services and other state agencies as appropriate.
2. Does your state have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances? If "Yes," please continue.	**Yes**
a. What criteria does your state use to identify candidates for Lock-In?	**Number of controlled substances (CS), Different prescribers of CS, Multiple pharmacies, Number days' supply of CS, Multiple ER visits, Other**
Other, please explain.	1. Treatment that exceeds therapeutic daily Morphine Equivalent Dose (MED) Prescription combination with abuse potential 2. Overlapping or duplicative psychotropic prescriptions from 2 or more unaffiliated prescribers; 3. ER visits or hospitalizations due to suicide attempt; poisoning or overdose of drugs (intentional self-harm) 4. A diagnosis of alcohol or drug abuse including non-therapeutic, recreational or illegal drug use 5. Two or more occurrences of violating a pain contract with the same prescriber or with different prescriber(s) 6. Conviction of a crime related to restricted medications within the past year (e.g., forgery, theft, distribution or Medicaid fraud)
b. Does your state have the capability to restrict the beneficiary to:	

Question	Response
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.	The Lock-In time periods are cumulative eligibility time frames of 36-months, 60-months and Lifetime determined on a case by case basis.
d. On average, what percentage of the FFS population is in Lock-In status annually?	**0.0024%**
e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review.	**$7,071.36**
3. Does your state have a documented process in place that identifies possible FWA of controlled drugs by prescribers?	**Yes**
Yes, what actions does this process initiate?	Other
Other, please explain.	The Lock-In Program makes referrals to other OIG divisions, law enforcement or licensing body when applicable. Lock-In may refer a provider within the OIG for a preliminary investigation. If findings merit a full-scale investigation, an initial notification is made to the Medicaid Fraud Control Unit (MFCU). If criminal elements are identified, MFCU and OIG coordinate on the case. The OIG may also close and refer a case to a board/licensing body.
No, please explain.	N/A
4. Does your state have a documented process in place that identifies potential FWA of controlled drugs by pharmacy providers?	**Yes**
Yes, what actions does this process initiate?	Other
Other, please explain.	The Lock-In Program makes referrals to other OIG divisions, law enforcement or licensing body when applicable. If Lock-In refers a provider within the OIG for investigation there is a preliminary investigation. If findings merit a full-scale investigation, an initial notification is made to the Medicaid Fraud Control Unit (MFCU). If criminal elements are identified, MFCU and OIG coordinate on the case. The OIG may also close and refer a case to a board/licensing body.

Question	Response
No, please explain.	N/A
5. Does your state have a documented process in place that identifies and/or prevents potential FWA of non-controlled drugs by beneficiaries?	**Yes**
Yes, please explain your program for FWA of non-controlled substances.	Referrals are made to the OIG-Lock-In Program, OIG-Investigations and Reviews, law enforcement, and Texas Department of Family and Protective Services as appropriate. Upon referral through the Waste, Abuse and Fraud Electronic Referral System (WAFERS), the Lock-In Program restricts referred Medicaid recipients to a provider and/or pharmacy. In addition, managed care organizations make referrals to the Lock-In Program
No, please explain.	N/A

B. Prescription Drug Monitoring Program (PDMP)

Note: Section 5042 of the SUPPORT for Patients and Communities Act requires states to report metrics in reference to their state's PDMP. CMS has included questions to reference these metrics to help your state establish processes to be in compliance with provisions outlined in Section 5042 and CMS reporting, beginning in FFY 2023.

Question	Response
1. Does your Medicaid program have the ability to query the state's PDMP database?	**No**
Yes, receive PDMP data.	N/A
Other, please explain.	N/A
Yes, have direct access to the database.	N/A
No, please explain.	Texas Law prohibits access to PDMP database
If "Yes," please continue. a. Please explain how the state applies this information to control FWA of controlled substances.	**N/A**
b. Does your state also have access to Border States' PDMP information?	**N/A**
c. Does your state also have PDMP data integrated into your POS edits?	**N/A**
2. Does your state or your professional board require prescribers to access the PDMP patient history before prescribing controlled substances?	**Yes**
No, please explain.	N/A
If "Yes," please continue.	Yes

Question	Response
a. Are there protocols involved in checking the PDMP?	
Yes, please explain.	Prescribers are required to check the Texas Prescription Monitoring Program (PMP) before prescribing opioids, benzodiazepines, barbiturates, or carisoprodol per House Bill 3285 effective in the 86th Legislature. Practitioners are not required to check the PMP before ordering controlled substances in the inpatient setting. The mandate applies to outpatient and discharge prescriptions. Patients diagnosed with cancer and terminally ill under hospice care are exempt. The prescriber must clearly note in the prescription record that the patient has this diagnosis or that the patient is receiving hospice care. Prescribers are not subject to the mandate if unique circumstances outside of the prescriber's control prohibit access to the PMP after a good faith attempt to comply.
b. Are providers required to have protocols for responses to information from the PDMP that is contradictory to the direction that the practitioner expects from the client?	**No**
c. If a provider is not able to conduct PDMP check, does your state require the prescriber to document a good faith effort, including the reasons why the provider was not able to conduct the check?	**Yes**
No, please explain.	N/A
If "Yes," does your state require the provider to submit, upon request, documentation to the State?	No
No, please explain.	The state does not require the provider to submit upon request documentation to the state.
3. Does the State require pharmacists to check the PDMP prior to dispensing?	**Yes**
No, please explain.	N/A
If "Yes," are there protocols involved in checking the PDMP?	Yes

Question	Response
Yes, please explain.	All Texas-licensed pharmacies are required to report all dispensed controlled substances records to the Texas Prescription Monitoring Program (PMP) no later than the next business day after the prescription is filled. The reporting requirement applies to all Schedule II, III, IV, and V controlled substances. Pharmacists and prescribers (other than a veterinarian) will be required to check the patient's PMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. Pharmacists and prescribers are encouraged to check the PMP to help eliminate duplicate and overprescribing of controlled substances, as well as to obtain critical controlled substance history information.
4. In the State's PDMP system, which of the following pieces of information with respect to a beneficiary is available to prescribers as close to real-time as possible?	**PDMP drug history, The number and type of controlled substances prescribed to and dispensed to the beneficiary during at least the most recent 12-month period., The name, location, and contact information, or other identifying number, such as a national provider identifier, for previous beneficiary fills**
Other, please explain.	N/A
a. Are there barriers that hinder the Medicaid agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb FWA?	**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).	Health plans access to PMP is prohibited by law.
5. Have you had any changes to your state's PDMP during this reporting period that have improved the Medicaid program's ability to access PDMP data?	**No**
Yes, please explain.	N/A
6. In this reporting period, have there been any data or privacy breaches of the PDMP or PDMP data?	**No**
If "Yes," please summarize the breach, the number of individuals impacted, a description of the steps the State has taken to address each such breach, and if law	N/A

Question	Response
enforcement or the affected individuals were notified of the breach.	

C. Opioids

Question	Response
1. Does your state 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.	**Yes, for all opioids**
Please explain answer above.	For the initial opioid prescription the quantity is for 10 days supply.
a. Is there more than one quantity limit for various opioids? Additionally, please explain ramifications when addressing COVID-19 if applicable?	**No**
Yes, please explain.	N/A
b. What is the maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?	**10**
c. Does this days' supply limit apply to all opioid prescriptions?	**Yes, for all opioids**
Please explain above response.	The 10-day limit only applies to the initial opioid prescriptions for an opioid-naive client. A person is considered "opioid-naive" if the person has taken opioids for a duration that is less than or equal to seven days in the last 60 days.
2. For subsequent prescriptions, does your state have POS edits in place to limit the quantity dispensed of short-acting (SA) opioids?	**No**
Yes, what is your maximum days' supply per prescription limitation?	N/A
Other, please explain.	N/A
No, please explain.	There is no a quantity limit for the refills or subsequent prescriptions because the patient is not considered opioid naive. However, the maximum daily MME will be at a 90 MME limit.
3. Does your state currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?	**No**

Question	Response
Yes, what is your maximum days' supply per prescription limitation?	N/A
Other, please explain.	N/A
No, please explain.	The 10-day supply does not apply to the long-acting opioids because they re not approved for initial opioid therapy for an opioid naive client. A long-acting prescription for an opioid naive patient will require a prior authorization.
4. Does your state have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?	**Yes**
If "Yes,":	Deny claim and require PA, Intervention letters, MME daily dose program, Step therapy or Clinical criteria, Require diagnosis, Require PDMP checks
Other, please specify.	N/A
Please provide details on these opioid prescribing controls in place.	There are multiple PAs in place for opioids. The purpose of these PAs is to reduce overutilization as well as inappropriate prescribing behaviors. The population-based retrospective interventions are performed annually and are intended to flag patterns of opioid abuse and gross overuse. Educational letters are mailed to the prescribers. The opioid policy is set to monitor daily MME levels for all opioids. For clients with certain diagnosis, including Cancer, sickle cell, or in-hospice care, the 90 MME is not applicable. For the rest, a daily dose above 90 MME requires a prior authorization.
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. Does your state have POS edits to monitor duplicate therapy of opioid prescriptions? This excludes regimens that include a single extended-release product and a breakthrough short acting agent?	**Yes**
Please explain above response.	The cumulative opioid dosing for any combinations opioid prescriptions must be less than 90 MME. In addition, the Opioid Overutilization PA criteria dictate how many claims or how much

Question	Response
	opioids a client can receive: if client has a diagnosis of sickle cell, cancer, palliative care or hospice care, the client can have less than 3 different opioids in the last 60 days, or less than 4 opioid claims in the last 60 days, or less than a 90 day supply of opioids in the last 60 days. For any other conditions, the client can have less than 2 different opioids in the last 60 days, or less than 3 opioid claims in the last 60 days, or less a 90 day supply of opioids in the last 60 days.
6. Does your state have POS edits and automated retrospective claim reviews to monitor early refills of opioid prescriptions dispensed?	**Yes, POS edits**
If any response is "Yes," please explain scope and nature of reviews and edits in place.	The daily cumulative opioid dosing for any combinations opioid prescriptions must be at 90 MME or less. In addition, the Opioid Overutilization PA criteria dictates how many claims or how much opioids a client can receive: if client has a diagnosis of sickle cell, cancer, palliative care or hospice care, the client can have less than 3 different opioids in the last 60 days, or less than 4 opioid claims in the last 60 days, or less than a 90 day supply of opioids in the last 60 days. For any other conditions, the client can have less than 2 different opioids in the last 60 days, or less than 3 opioid claims in the last 60 days, or less a 90 day supply of opioids in the last 60 days.
If "No," please explain.	N/A
7. Does your state have a comprehensive automated retrospective claims review process to monitor opioid prescriptions exceeding these state limitations?	**Yes**
Yes, please explain in detail scope and nature of these retrospective reviews.	The system monitors opioid claims for appropriate utilization based on the 90% threshold limit.
No, please explain.	N/A

Question	Response
8. Does your state currently have POS edits in place or automated retrospective claims review to monitor opioids and benzodiazepines being used concurrently?	**Yes, both POS edits and automated retrospective claim reviews**
Please explain above response and detail the scope and nature of these reviews and edits. Additionally, please explain any potential titration processes utilized for those patients chronically on benzodiazepines and how the state justifies pain medications, i.e. Oxycodone/APAP, for breakthrough pain without jeopardizing patient care (i.e. quantity limits/practitioner education titration programs).	The POS edit checks for concurrent claims for opioid and benzodiazepine with a 14-day overlap. Rectal diazepam and clobazam will be excluded from the edit. In response to one of the requirements from the Federal Support Act, a retro-DUR review and intervention for Opioid,-Benzodiazepines combination, as well as, Antipsychotic - opioids combination was conducted in April of 2020.
No, please explain.	N/A
9. Does your state currently have POS edits in place or automated retrospective claims review to monitor opioids and sedatives being used concurrently?	**No**
Please explain above and detail scope and nature of reviews and edits.	N/A
No, please explain.	The program uses a POS edit to deny sedative claim to those with substance use disorder diagnosis but it does not deny concurrent use of opioid - sedatives if diagnosis of SUD is not found. for the FFY 2020, retrospective claims review for combination of opioids and sedatives was not conducted.
10. Does your state currently have POS edits in place or automated retrospective claims review to monitor opioids and antipsychotics being used concurrently?	**Yes, Automated retrospective claim reviews**
Please explain in detail scope and nature of reviews and edits.	A retrospective intervention is performed annually which monitors for concurrent use of opioids and antipsychotics.
No, please explain.	N/A
11. Does your state have POS safety edits or perform automated retrospective claim reviews and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?	**Yes, POS edits**
If "Yes, Automated retrospective claims reviews and/or "provider education," please indicate how often.	N/A

Question	Response
Other, please specify.	N/A
Please explain nature and scope of edits, reviews and/or provider education reviews performed.	N/A
If "No," does your state plan on implementing automated retrospective claim reviews and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?	N/A
Yes, when does your state plan on implementing?	N/A
No, please explain.	N/A
12. Does your state Medicaid program develop and provide prescribers with pain management or opioid prescribing guidelines?	**Yes**
If "Yes," please.	Your state Medicaid program refers prescribers to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain.
Other guidelines, please identify.	N/A
If "No," please explain why no guidelines are offered.	N/A
13. Does your state 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.	Formulary coverage of Embeda (abuse deterrent formulation).

D. 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**
Less than 50 MME, please specify.	N/A mg per day
Greater than 200 MME, please specify.	N/A mg per day

Question	Response
b. Please explain nature and scope of dose limit (i.e. who does this edit apply to? Does the limit apply to all opioids? Are you in the process of tapering patients to achieve this limit?).	**The 90 ME daily dose is applied to all prescription opioids either for initial or for the subsequent therapies. For those who may require a tapering plan, providers would determine the development and management of a person specific course of therapy to help manage withdrawal symptoms. A prescriber may request a tapering plan through the pharmacy prior authorization process on a case-by-case basis. Prior authorization approval lasts for six-months.** **Clients are exempt if documented diagnosis of cancer, sickle cell, or hospice/palliative care is found.**
If "No," please explain the measure or program you utilize.	N/A
2. Does your state have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?	**Yes**
If "Yes," does your state require PA if the MME limit is exceeded.	Yes
3. Does your state have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed?	**Yes**
Please explain.	The system monitors for cumulative daily MME levels of 90 MME. The claim that cause this MME limit to exceed will be denied.
4. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere? If "Yes," please continue.	**No**
a. Please name the developer of the calculator:	**N/A**
Other, please specify.	N/A
b. How is the information disseminated?	**N/A**
Other, please explain.	N/A

E. Opioid Use Disorder (OUD) Treatment

Question	Response
1. Does your state have utilization controls (i.e. PDL, PA, QL) to either monitor or manage the prescribing	**Yes**

Question	Response
of Medication Assisted Treatment (MAT) drugs for OUD?	
Yes, please explain.	**There is a prior authorization for buprenorphine agents with the following checks: age, diagnosis of opioid dependence, and concurrent therapy with opioids. Single ingredient buprenorphine products are approved for treatment of opioid dependence if client is pregnant or is intolerant to naloxone.** **OUD treatment drugs are all preferred. Single ingredient buprenorphine and methadone are for covered treatment under the long-acting narcotics and are subject to both clinical and PDL prior authorizations.**
2. Does your Medicaid program 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
Other, please explain.	N/A
3. What are your limitations on the allowable length of this treatment?	**No limit**
Other, please explain.	N/A
4. Does your state require that the maximum mg per day allowable be reduced after a set period of time? If "Yes," please continue.	**No**
a. What is your reduced (maintenance) dosage?	**N/A**
Other, please explain.	N/A
b. What are your limitations on the allowable length of the reduced dosage treatment?	**N/A**
Other, please explain.	N/A
5. Does your state have at least one buprenorphine/naloxone combination product available without PA?	**No**
6. Does your state 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

Question	Response
7. Is there at least one formulation of naltrexone for OUD available without PA?	**Yes**
8. Does your state have at least one naloxone opioid overdose product available without PA?	**Yes**
9. Does your state retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?	**Yes**
No, please explain.	N/A
10. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid program 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 program under protocol**

F. Outpatient Treatment Programs (OTP)

Question	Response
1. Does your state cover OTPs that provide Behavioral Health (BH) and MAT services?	**Yes**
No, please explain.	N/A
If "Yes", is a referral needed for OUD treatment through OTPs?	Yes
Please explain.	Texas residents 18 and older with moderate to severe opioid use disorder for at least 12 months in a row are eligible for MAT services. Financial eligibility is based on income and expenses, and some out-of-pocket expenses may be needed. Eligible residents may receive Medication-Assisted Treatment Services by calling their local narcotic treatment center provider or call the outreach, screening, assessment and referral center for their region.
2. Does your state Medicaid program cover buprenorphine or buprenorphine/naloxone for diagnoses of OUD as part of a comprehensive MAT treatment plan through OTPs?	**Yes**
No, please explain.	N/A

Question	Response
3. Does your state Medicaid program cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?	**Yes**
No, please explain.	N/A
4. Does your state Medicaid program cover Methadone for a substance use disorder (i.e. OTPs, Methadone Clinics)?	**Yes**

G. Antipsychotics / Stimulants

Antipsychotics

Question	Response
1. Does your state currently have restrictions in place to limit the quantity of antipsychotics?	**Yes**
Please explain restrictions or N/A.	The POS PA criteria limits the number of antipsychotics prescribed concurrently. The criteria allows for up to two different antipsychotics (that are not the same in chemical formulations). combination of various strengths and dosage forms of the same drug is permitted.
2. Does your state have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children? If "Yes," please continue.	**Yes**
a. Does your state either manage or monitor:	**All children**
Other, please explain.	N/A
b. Does your state have edits in place to monitor:	**Child's age, Indication, Polypharmacy**
Other please explain.	N/A
c. Please briefly explain the specifics of your documented antipsychotic monitoring program(s).	**children 3 years of age and older may receive certain atypical antipsychotics for the FDA approved indications (such as autism). Patients 6 years of age and older may receive up to two different antipsychotics for the appropriate indications. The prior authorization criteria will reject the antipsychotic claim if the only diagnosis found is insomnia. or if the diagnosis is major depression but without concurrent therapy with an antidepressants.**
If "No," does your state plan on implementing a program in the future.	N/A

Question	Response
Yes, please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children.	N/A
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. Does your state currently have restrictions in place to limit the quantity of stimulants?	**Yes**
4. Does your state have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children? If "Yes," please continue.	**Yes**
a. Does your state either manage or monitor:	**All children**
Other, please explain.	N/A
b. Does your state have edits in place to monitor:	**Child's age, Dosage, Indication, Polypharmacy**
Other, please explain.	N/A
c. Please briefly explain the specifics of your documented stimulant monitoring program(s).	**The POS PA criteria allows children who are 3 years of age and older to receive prescriptions for amphetamine sulfate, amphetamine/dextroamphetamine, dextroamphetamine, dexmethylphenidate, Evekeo tablets, methylphenidate, Procentra, or Zenzedi, or non-stimulants or a combination of these two (two short acting stimulants are not allowed without a PA). Children who are 6 years of age alder may receive long-acting, short-acting, or a combination of the two (multiple short acting or long-acting prescriptions are not permitted without a PA). Adults may receive stimulants for up to 90-days without a documented diagnosis. After 90 days, the claim will require a PA if an appropriate diagnosis is not documented in the system. The maximum daily dose is either based on the FDA approved dosing regiment or based on the Texas Department of Family and Protective Services guideline.**
If "No," does your state plan on implementing a program in the future?	N/A

Question	Response
Yes, please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.	N/A
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. Does your state participate in any demonstrations or have any waivers to allow importation of certain drugs from Canada or other countries that are versions of FDA-approved drugs for dispensing to Medicaid beneficiaries?	**No**
Yes, please explain.	N/A
2. Summary 5 – Innovative Practices Summary 5: 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).	**Dental Managed Care Organization (DMO)- This project is to establish a mechanism to provide DMOs with the necessary data to perform retrospective reviews. Dental managed care organizations (DMOs) will be required to adhere to the uniform Opioid Policy for Medicaid. One of the requirement is to perform retrospective drug utilization reviews to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. If outlier prescribing patterns are identified, a review must be conducted and, if necessary, an intervention, such as a letter or phone call to the prescriber or a peer-to-peer review.** **Texas Medicaid continues to implement retrospective claims review on various drugs or drug classes in order to improve on the providers' prescribing behaviors. Retrospective DUR Interventions for the FFY 2020 were as follows.** **1. Influenza Prevention was mailed out on 10/18/2019 to 3,411 physicians. This intervention focused on improving prescribing practices and increased flu vaccination.** **2. Cough and Cold Remedies was delivered on 10/22/2019 to 485 physicians. This intervention focused on improving prescribing practices and reducing overutilization of these products in pediatrics.** **3. Anticonvulsants was delivered on 10/14/2019 to 337 physicians and impacted 342 clients. This intervention focused on improving prescribing practices and educing the overall cost of care for patients through improved treatment adherence.** **4. Post-Traumatic Stress Disorder (PTSD) was**

Question	Response
	a newly developed R-DUR intervention. This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. **5. Pain Management was mailed out on 02/28/2020. This intervention focused on improving prescribing practices and reducing the overall cost of care for patients. 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 $0.64 in the post-intervention period. This yielded an overall estimated decrease of $3,728.64 in intervention-related drug expenditures on an annualized basis.** **6. Opioid/Benzo/ Antipsychotics was mailed on 01/08/2020. This intervention focused on improving prescribing practices and reducing the overall cost of care for patients.** **Several formulary coverage restrictions were removed to accommodate issues related to the COVID-19 drug shortage.** **In FFY 2020, four new therapeutic classes were reviewed by the DUR Board: Glucagon Agents, Immunomodulators, Asthma, Sickle Cell Agents, and Rosacea Agents, Topical.**

Section X – Managed Care Organizations (MCOs)

Question	Response
1. How many MCOs are enrolled in your state Medicaid program? If "Zero" or "None", please skip the rest of this section.	**17**
2. Is your pharmacy program included in the capitation rate (carved in)?	**Yes**
Please specify the drug categories that are carved out.	N/A
3. If covered outpatient drugs are included in an MCO's covered benefit package, has the State updated their MCOs' contracts for compliance with Section 1004 of the SUPPORT for Patients and Communities Act?	**Yes, contracts are updated to address each provision**
Yes, contracts are updated to address each provision. Please specify effective date:	08/14/2020
No, contracts are not updated, please explain.	N/A
a. Is the state complying with Federal law and monitoring MCO compliance on the SUPPORT for Patients and Communities Act provisions?	**Yes, state is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions**
Yes, state is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions. Please explain monitoring activities.	The MCO DUR programs are initially assessed through a Readiness Review. Once operational, the MCO must submit an annual report to HHSC Vendor Drug Program (VDP) providing a detailed description of its DUR program activities, as provided for under 42 C.F.R. 438.3(s).
No, please explain.	N/A
4. Does the state set requirements for the MCO's pharmacy benefit (i.e. same PDL, same ProDUR/RetroDUR)?	**Yes**
a. If "Yes," please explain.	**Same PDL**
b. Please briefly explain your policy.	**The state sets some requirement for the MCO's pharmacy benefits:** **Single PDL** **Single Formulary** **POS clinical PA criteria must not be more stringent than the what the Board has approved.**
If "No," does your state plan to set standards in the future?	N/A
No, please explain.	N/A

Question	Response
5. Is the RetroDUR program operated by the state or by the MCOs or does your state use a combination of state interventions as well as individual MCO interventions?	**State operated**
6. Indicate how the State oversees the FFS and MCO RetroDUR programs? Please explain oversight process.	**The FFS retro-DUR vendor provides periodic reports on their activities. The topics and the criteria for these retro-DUR interventions are developed by the vendor and upon approval by the DUR Board, the vendor will implement. The outcome report for each intervention is submitted to the state for approval.** **For the MCO retro-DUR activities, periodic reports from individual MCOs are submitted to the HHSC MCO Contract Oversight team.**
7. How does the state ensure MCO compliance with DUR requirements described in Section 1927(g) of the Act and 42 CFR part 456, subpart K?	**In addition to the assessment of MCO DUR programs during a Readiness Review and each MCO's annual submission of a detailed report of their DUR activities, MCO DUR programs are evaluated every two years during through an Operational Review**
8. Did all of your managed care plans submit their DUR reports?	**Yes**
No, please explain.	N/A

Section XI – Executive Summary

Question	Response
Summary 6: Executive Summary Summary 6: Executive Summary should provide a brief overview of your program. It should describe 2020 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) manages coverage of outpatient drugs for members enrolled in Medicaid, CHIP, CHSCN Program, Health Texas Women Program, and Kidney Health Program. VDP manages the drug formulary and the preferred drug list (PDL) for Medicaid program, as well as, the Specialty Drug List (SDL). Texas Medicaid implements and shares a single formulary and PDL policy with all the contracted MCOs. Currently, there are 17 MCOs contracted with Texas Medicaid. Texas Medicaid has over 90% of the members enrolled in one of the managed care organizations.** **VDP works with the MCOs in developing proposals for clinical prior authorization criteria. The proposals are presented at the quarterly DUR Board meetings for approval. VDP, also develops retrospective-DUR programs for the FFS members, however, the MCOs are not required to follow the same Retro-DUR interventional topics. In FFY 2020, The Board approved the clinical PA criteria for the following drugs:** **Benjesta/Diclegis, Cytokine and CAM Antagonists- Rinvoq; Diacomet; Sunosi; Trikafta; Oxbryta; PAH Agents- addition of oral and inhaled agents to the existing inj. agents; Fasenra and Nucalal, Cequa; Restasis, Xiidra; Vyndamax, Vyndaqel, Tegsedi; Acthar gel (revision)- removed the non-FDA approved indications; Oxervate; Palforzia; Spravato Nasal Solution.** **In FFY 2020, the Board reviewed retrospective Criteria for the following drugs: Atypical Antipsychotics-long-acting injectable; Atypical Antipsychotics (oral); Exogenous Insulin Products; Nitazoxanide (Alinia); Promethazine Use in Children < 2 Years of Age; Quetiapine (low-dose); fentanyl Inhalation/oral/transdermal; Gabapentin; Hydrocodone Bitartrate/ Hydrocodone Polistirex; Ivacaftor (Kalydeco) and Combination Therapy; Topical Calcineurin Inhibitors Pimecrolimus (Elidel) Tacrolimus (Protopic) ; Tramadol (Ultram); Direct Oral**

Question	Response
	Anticoagulants; Complement Inhibitor and Enzyme/Protein Replacement Therapy; Low-Molecular-Weight Heparins (LMWHs); Nebulized Bronchodilators; Hydroxy-Methylglutaryl Coenzyme A (HMG-CoA) Reductase Inhibitors (Statins); Benzodiazepines (Nonsedative/ Hypnotics); Immune Globulins; Oral/Rectal Nonsteroidal Anti-Inflammatory Drugs (NSAIDs); Non-sedating Antihistamines; Oral Fluoroquinolones; Rifaximin (Xifaxan); Skeletal Muscle Relaxants; Sickle Cell Disease Products **In FFY 2020, the following retrospective intervention topics were reviewed: Opioids, Benzodiazepines, and Antipsychotics; Pain Management with Opioids; Diabetes Disease Management; Monitoring of Psychotropic Drugs in Youth; Postpartum Depression; Caring for Your Patients with Asthma; NSAID Drug Usage Evaluation (DUE); Pharmacotherapy of Post-Traumatic Stress Disorder; Appropriate Use of Antibiotics; Contraception: Drug Use Evaluation; Gabapentinoid Drug Use Evaluation.** **There were a few innovative practices initiated in FFY 2020 including the monitoring of opioid claims prescribed by dentists.** **The program also, added PDL review of several new therapeutic categories for the first time. Those included the Anticonvulsants, the Glucagon Agents, the Immunomodulators for Asthma the Sickle Cell Anemia Treatments, and the Rosacea Agents, Topical.** **The total cost savings/cost avoidance was $8, 673, 837. 85.**