Texas
Medicaid Fee-For-Service (FFS)
Federal Fiscal Year (FFY) 2021
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?	165,221
2. On a monthly average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)?	4,574,465

Section II - Prospective DUR (ProDUR)

Question	Response
1. Indicate the type of your pharmacy point of service (POS) vendor.	Contractor
a. Vendor Name	Conduent Public Health Solutions. INC
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 (multiple responses allowed).	First Databank, Other
If "Other," please specify.	Some criteria are developed in-house.
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," check all that apply.	Alerts can be overridden ahead of time, Alerts can be overridden with standard professional codes, Alerts need prior authorization (PA) to be overridden, Other
If "Other," please explain.	With the exception of Med Synchronization purposes, all early refills will require an override by calling HHSC Help Desk. Early refill does not require a prior authorization request by prescriber.
4. Does your state receive periodic reports providing individual pharmacy providers DUR alert override activity in summary and/or in detail?	No
If "No," please explain.	Reports are run as needed (ad-hoc)
a. How often does your state receive reports (multiple responses allowed)?	N/A
If "Other," please explain.	N/A

Question	Response
b. If you receive reports, does your state follow up with those providers who routinely override with interventions?	N/A
If "Yes," by what method does your state follow up (multiple responses allowed)?	N/A
If "Other," please explain.	N/A
If "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%
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 (multiple responses allowed):	Other
If "Other," please explain.	For Med Synchronization purposes, the dispensing pharmacist may override by entering a PA code. For all the other reasons, pharmacist must call the HHSC Help Desk.

Question	Response
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
If "Yes," check all that apply.	Automatic PA based on diagnosis codes or systematic review, Other
If "Other," please explain.	The non-preferred drugs are on Texas Formulary and can be accessed via a prior authorization. The PA criteria are automated and will approve if all criteria are met. If one or more PA criteria fail, the system will prompt a message to the dispensing pharmacy about PDL PA failure. Dispensing pharmacy in turn must inform the Prescriber who may either decide to change prescription to a preferred drug, or contact the PA call center for approval. In other situations, when a drug is CMS rebatable but is not yet on Texas formulary, the claim will be denied and pharmacy will receive a "NDC Not Covered" message. If prescriber still wants coverage due to medical necessity, Medicaid program staff will quickly act to provide access.
If "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

Question	Response
If “Yes,” check all that apply.	Real-time automated process, Other process
If “Other process,” please explain.	The 72-hours supply can be dispensed when a prior authorization is required and the provider cannot be reached. Providing 72-hours emergency supply is based on the dispensing 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 for adults enrolled in Texas FFS program.
If “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

Column 1 Top 10 Prior Authorization (PA) Requests by Drug Name, report at generic ingredient level	Column 2 Top 10 Prior Authorization (PA) Requests by Drug Class	Column 3 Top 5 Claim Denial Reasons (i.e. Quantity Limits (QL), Early Refill (ER), PA, Therapeutic Duplications (TD) and Age Edits (AE))	Column 4 Top 10 Drug Names by Amount Paid, report at generic ingredient level	Column 5 % of Total Spent for Drugs by Amount Paid (From data in Column 4, determine the % of Total Drug Spend)	Column 6 Top 10 Drug Names by Claim Count, report at generic ingredient level	Column 7 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	coagulation Factor IX (recombinant)	3.70%	cetirizine	5.02%
albuterol Sulfate HFA	bronchodilator agents	submit bill to other processor or primary payor	elexacaftor/ tezacaftor/ ivacaftor	2.54%	loratadine	3.66%
gabapentin	anticonvulsant agents	product/ service not covered - plan/ benefit exclusion	bictegravir/ emtricitabine/ tenofovir	2.24%	polyethylene glycol 3350	3.14%
methylphenidate ER	attention deficit hyperactivity disorder agents	patient is not covered	prenatal vitamin with Iron and folate and DHA	1.90%	aspirin	3.09%
hydrocodone/ acetaminophen	antipsychotic agents	use primary ID	paliperidone	1.86%	multivitamin	3.04%
risperidone	analgesics, narcotic agents		lenalidomide	1.81%	docusate	2.75%
tramadol	antiemetic agents		insulin aspart	1.80%	ondansetron	1.80%
meloxicam	nsaid agents		insulin glargine	1.74%	ibuprofen	1.66%
esomeprazole	proton pump inhibitor agents		emicizumab	1.61%	folic acid	1.66%
doxylamine/ pyridoxine	androgenic agents		lurasidone	1.52%	albuterol	1.65%

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 (multiple responses allowed)?	State Board of Pharmacy
If “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 is responsible for developing retrospective intervention criteria for the intervention letters to the prescribers. Conduent uses a web-based tool 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 developed and are submitted to the Texas DUR Board for review and approval prior to deployment. 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 are not flagged for intervention. Physicians who are flagged will receive an intervention letter along with patient specific information and an intervention message page which includes helpful clinical information and resources. On the letter there is also vendor's contact information if physician wishes to further discuss the issue. These letters are for educational purposes and do not affect any future prescribing abilities for the FFS clients. Vendor
d. Does your state customize your RetroDUR vendor criteria?	Yes
2. How often does your state perform retrospective practitioner-based education?	Other

Question	Response
If "Other," please specify.	There is no set frequency for mailing educational letters to prescribers. Per the program requirement, vendor must perform seven to ten population-based retrospective interventions per year. Proposed intervention criteria and the educational letters are mailed out within 1-3 months from the DUR Board's approval.
a. How often does your state perform retrospective reviews that involve communication of client-specific information to healthcare practitioners (multiple responses allowed)?	Other
If "Other," please specify.	There is no set frequency for mailing educational letters. Intervention packages are sent to targeted prescribers every 1-3 months after the DUR Board approval and will include the letter to the prescriber, specific client's claims information, and a clinical message sheet explaining the standard treatment practices.
b. What is the preferred mode of communication when performing RetroDUR initiatives (multiple responses allowed)?	Mailed letters
If "Other," please specify.	N/A
3. Summary 1 – RetroDUR Educational Outreach RetroDUR Educational Outreach should be a year-end report on retrospective screening and educational interventions. The summary should be limited to the most prominent problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed below.	1. Appropriate Use of Antibiotics letters were mailed on 11/17/2020 to 1,288 prescribers Outcome summary- 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 23.4%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.57 in the post-intervention period. This yielded an overall estimated decrease of $228,465.12 in intervention-related drug expenditures on an annualized basis. 2. Anticonvulsant Drug Use Evaluation (DUE) intervention letters were mailed on 01/28/2021 to 320 prescribers impacting 531 FFS recipients. Outcome Summary- 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 31.1%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $12.58 in the post-intervention

Question	Response
	period. This yielded an overall estimated decrease of $1,022,386.56 in intervention-related drug expenditures on an annualized basis. 3. Benzodiazepine Anxiolytics and Controlled Sedative Hypnotics intervention letters were mailed on 06/15/2021 to 38 providers. Outcome Summary: During the intervention, targeted patients saw average reductions in clinical indicators by 35.3%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $1.77 in the post-intervention period. This yielded an overall estimated decrease of $38,529.36 in intervention-related drug expenditures on an annualized basis. 4. Contraceptive DUE intervention letters were mailed on 11/19/2020 to 1158 prescribers. Outcome Summary: During the intervention, targeted patients saw average reductions in clinical indicators by 28.1%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $4.12 in the post-intervention period. This yielded an overall estimated decrease of $921,075.44 in intervention-related drug expenditures on an annualized basis 5. Depression Disease Management intervention letters were mailed on to 635 providers. Outcome Summary: During the intervention, targeted patients saw average reductions in clinical indicators by 27.8%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.10 in the post-intervention period. This yielded an overall estimated decrease of $19,291.80 in intervention-related drug expenditures on an annualized basis. 6. Gabapentinoids DUE intervention letters were mailed on 10/23/2020 to 334 providers. Outcome Summary: During the intervention, targeted patients saw average reductions in clinical indicators by 23.0%. In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.65 in the post-intervention period. This yielded an overall estimated decrease of $82,303.06 in intervention-related drug expenditures on an annualized basis.

Question	Response
	7. Hyperlipidemia Disease Management intervention letters were mailed on 08/31/2021 to 1224 providers. Outcome Summery: 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 $0.68 in the post-intervention period. This yielded an overall estimated decrease of $133,362.12 in intervention-related drug expenditures on an annualized basis. 8. influenza Prevention intervention letters were mailed on 01/08/2020. Outcome Summery: During the intervention, targeted patients saw average reductions in clinical indicators by 41.4%. In terms of financial outcomes, the amount paid for intervention-related drugs increased by $5.23 in the post-intervention period. This yielded an overall estimated increase of $9,006.06 in intervention-related drug expenditures on an annualized basis. 9. Opioid Management intervention letters were mailed to 64 providers. During the intervention, targeted patients saw average reductions in clinical indicators by 43.1%. Outcome Summery: In terms of financial outcomes, the amount paid for intervention-related drugs decreased by $0.72 in the post-intervention period. This yielded an overall estimated decrease of $5,595.84 in intervention-related drug expenditures on an annualized basis. 10. Psychotropic Drugs in Youth intervention letters were mailed on 03/18/2021 to 154 providers. Outcome Summary: 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 decreased by $3.16 in the post-intervention period. This yielded an overall estimated decrease of $719,759.52 in intervention-related drug expenditures on an annualized basis.

Section IV - DUR Board Activity

Question	Response
1. Does your state have an approved Medication Therapy Management (MTM) Program?	No
2. Summary 2 – DUR Board Activities DUR Board Activities Summary should be a brief descriptive on DUR activities during the fiscal year reported.	In FFY 2021, four scheduled meetings were held. These meetings are opened to the public. The board's activities are typically consisting of the following: 1. Hearing public testimonies on drugs scheduled for review. 2. Making recommendations for preferred drug list. 3. Review and approval of prospective clinical prior authorizations on drugs or drug classes. 3. Review and approval of retrospective DUR criteria on drug or drug classes. These criteria may be used as the basis for future prospective and retrospective DUR proposals. 4. Review of the proposed retrospective DUR intervention criteria and letters. On October 23, 2020, meeting, the Board's activities included: Review of the following therapeutic categories and single drugs for PDL recommendations: Androgenic agents, Antibiotics (gastrointestinal), Antibiotics (topical), Antibiotics (vaginal, Antiemetics or Antivertigo agents, Antifungals (oral); Antifungals (topical), Antihistamines (first generation), Antiparasitics (topical), Antipsychotics, Antivirals (topical), Bone resorption suppression and related agents, Colony stimulating factors, Epinephrine (self-injected), GI motility (chronic), Growth hormone, Hepatitis C agents, Hypoglycemics (incretin mimetics or enhancers), Hypoglycemics (insulin and related), Hypoglycemics (meglitinides), Hypoglycemics (metformin), Hypoglycemics (SLGT2), Hypoglycemics (TZD), Macrolides and Ketolides, Opiate dependence treatments, Tetracyclines, Benzefoam foam, Dupixent pen, Nexlizet, Voltaren gel, and Dayvigo Retrospective intervention proposals on the following topics: Anticonvulsants Drug Use Evaluation (DUE); Comprehensive opioid management; Management of psychotropic drugs in youth Prospective prior authorization proposals (clinical edits) included: new criteria for Evrysdi (oral solution); Calcitonin

Question	Response
	gene related peptide receptor (CRGP) antagonists, acute; new criteria for Nurtec and Ubrelvy; New criteria for Oriahnn (capsules); revised criteria for Vyvanse capsules and chewable tablets; new criteria for Wakix (tablets); new criteria for Xywav (oral solution) Retrospective drug use criteria for outpatient use included: document updates on anti-diabetic agents (oral); document updates on attention deficit disorder/attention deficit hyperactivity disorder; document updates on glucagon peptide like 1 receptor agonists; document updates on pramlintide; document updates on serotonin 5HT3 receptor antagonists for nausea and vomiting (oral); document update on substance P/neurokinin1 receptor antagonists. On the January 22, 2021 meeting, the board reviewed the following therapeutic categories and single drugs for PDL recommendations: Acne agents, oral, Acne agents, topical, Analgesics, narcotics long, Analgesics, narcotics short, Angiotensin modulator combinations, Angiotensin modulators, Antimigraine agents, other, Antimigraine agents, triptans, Antiparkinson agents, Bladder relaxant preparations, Glucagon agents, H. pylori treatment, Immunomodulators, atopic dermatitis, Intranasal rhinitis agents, Movement disorders, Neuropathic pain, Oncology (oral) for Breast cancer, Oncology (oral) for Hematologic; Oncology (oral) for Lung, Oncology (oral) for Other, Oncology (oral) for prostate, Oncology (oral) for Renal cell, Oncology (oral) for Skin, Phosphate binders, Platelet aggregation inhibitors, Progestins for cachexia, Proton pump inhibitors, Smoking cessation, Stimulants and related agents, Airduo Digihaler, inhaled, Armonair Digihaler, Bafiertam Capsule Dr, Breztri Aerosphere HFA AER AD, Diclotrex Kit, Enbrel Vial , Enspryng, Hemady , Kesimpta , Semglee Retrospective intervention criteria included the followings: Benzodiazepine anxiolytics and controlled sedative/hypnotics DUE; Major depressive disorder (MDD) management Prospective prior authorization (clinical edits) proposals included: New criteria for Apokyn and Kynmobi (dopamine agonists); new criteria for Evrysdi (oral solution); New criteria for Govovri and Osmolex (Amantadine extended-release

Question	Response
	agents); New criteria for Hemady (Dexamethsone)new criteria Retrospective drug use criteria for outpatient use included the followings: document updates on angiotensin converting enzyme (ACE) inhibitors; document updates on angiotensin II receptor blockers; document updates on platelet aggregation inhibitors; document updates on proton pump inhibitors; document updates on sedative and hypnotics; document updates on serotonin 5 HT1B1D receptor agonists On the April 23, 2021 meeting, the board reviewed the following therapeutic categories and single drugs for DPL recommendations: Anti-allergens, oral, Antibiotics (inhaled), Anticoagulants, Antidepressants, other, Antidepressants, selective serotonin reuptake inhibitors (SSRIs), Antidepressants, tricyclic, Antihyperuricemics, Antivirals (oral), Anxiolytics, Benign prostatic hyperplasia treatments, Beta blockers, Bile salts, Bronchodilators, beta agonist, Chronic obstructive pulmonary disease agents, Cough and cold, Erythropoiesis stimulating proteins, Glucocorticoids, inhaled, Hemophilia treatment, Hereditary angioedema (HAE) treatments, Hypoglycemics, incretin mimetics and enhancers, Immune globulins, intravenous, Immunomodulators, asthma, Lincosamides and oxazolidinones and streptogramins, Lipotropics, other, Lipotropics, statins, Multiple sclerosis agents, Pancreatic enzymes, Pediatric vitamin preparations, Prenatal vitamins, Pulmonary arterial hypertension agents, oral and inhaled, Sedative hypnotics, Sickle cell anemia treatments, Thrombopoiesis stimulating proteins, Urea cycle disorder (oral), Dificid suspension Antibiotics, gastrointestinal, Nyvepria, Ibupak kit, Venngel one Kit, Pataday extra strength, Eysuvis (ophthalmic), Impeklo lotion, Retrospective intervention proposals on the following topics: Diabetes disease management; Dyslipidemia disease management; Influenza prevention: vaccination and education Prospective prior authorization (clinical edits) Proposals included the followings: Anxiolytic and sedative and hypnotics; Criteria revision for sedative and hypnotics for adults (added PA criteria for Belsomra and Dayvigo to the

Question	Response
	existing document); HAE agents criteria revision (added PA criteria for Orladeyo); Hyperlipidemia agents, Formerly was titled as Protein Convertase Subtilisin Kexin type 9 agents (added Juxtapid to the criteria guide document); Multiple sclerosis agents criteria for safety checks. Retrospective drug use criteria for outpatient use review: aerosolized agents metered dose inhalers (MDIs) criteria document updated: anticholinergic drugs criteria document update; aerosolized agents MDIs criteria document update: anti-inflammatory drugs criteria document update; Aerosolized agents MDIs: beta2 agonists (long acting) criteria document update; aerosolized agents MDIs: beta2 agonists (short acting) criteria document updated; Antidepressant drugs, other criteria document updated; Antidepressant drugs (SSRIs) criteria document update On July 23, 2021, the board reviewed the following therapeutic categories and single drugs for PDL recommendations: Alzheimers agents, Antihistamines, minimally sedating, Antihypertensives, sympatholytic, Calcium channel blockers, Cephalosporins and related antibiotics, Cytokine and cell adhesion module antagonists and related agents, Fluoroquinolones, oral, Glucocorticoids, oral, Immunosuppressives, oral, Iron, oral, Leukotriene modifiers, Nonsteroidal anti-inflammatory drugs (NSAIDs), Ophthalmic antibiotics, Ophthalmic antibiotic and steroid combinations, Ophthalmics for allergic conjunctivitis, Ophthalmics, anti inflammatories, Ophthalmic, anti inflammatories and immunomodulators, Ophthalmics, glaucoma agents, Otic antibiotics, Otic anti-infectives and anesthetics, Penicillins, Platelet aggregation inhibitors, Progestational agents, Rosacea agents, topical, Skeletal muscle relaxants, Steroids, topical, Ulcerative colitis agents, Hetlioz liquid (oral), Ponvory starter pack (oral), Ponvory tablet, Qelbree, Tepmetko tablet, Trilociclo kit, Ukoniq, Vesicare LS (oral) Retrospective DUR intervention proposals: Bipolar disorder disease management; Hypertension disease management. Prospective prior authorization (clinical edits) proposals: Addition of Qelbree to the Attention Deficit and Attention Deficit Hyperactivity Disorder criteria guide; addition of

Question	Response
	Ponvoy to the Multiple sclerosis agents for safety checks; Phosphate Binders criteria revisions; Sedative and Hypnotics criteria revisions on Hetlioz Retrospective drug use criteria for outpatient use document review and updates for the followings: Acetylcholinesterase inhibitors; Cyclooxygenase 2 inhibitors; Histamine H2 receptor antagonists; Ketorolac (oral); Leukotriene receptor antagonists; Mecasermin; Memantine

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 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, preferred drug list (PDL) policies, educational initiatives, technology or promotional factors, or other state-specific factors that affects your generic utilization rate.	Texas Government Code Sec 531.303, Generic Equivalent Authorized, requires that, unless the practitioner's signature on the 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. The single formulary and PDL policy is in effect in Texas Medicaid. Medicaid outpatient drug formulary includes covered generic drugs. The factors that may potentially affect generic utilization include the PDL decisions within a therapeutic class. HHSC requires the MCOs to cover the same preferred brands as was approved by HHSC.
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,” check all that apply.	Prior Authorization (PA) is required, Other
If “Other,” please explain.	For the brand name drugs designated as preferred on Texas formulary, prescriber does not have to write "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:

$$N \div (S + N + I) \times 100 = \text{Generic Utilization Percentage}$$

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

$$\$N \div (\$S + \$N + \$I) \times 100 = \text{Generic Expenditure Percentage}$$

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	23,929	331,529	15,188
Total Reimbursement Amount Less Co-Pay	$19,080,300	$7,274,933	$3,605,234

Question	Response
3. Indicate the generic utilization percentage for all covered outpatient drugs (COD) paid during this reporting period, using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Number of Generic Claims	331,529
Total Number of Claims	370,646
Generic Utilization Percentage	89.45%

Question	Response
4. How many innovator drugs are the preferred product on your state PDL when multi-source drugs are available based on net pricing and rebates (i.e. brand preferred over generic)?	57
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	$7,274,933
Total Dollars	$29,960,466
Generic Expenditure Percentage	24.28%
6. Does your state have any policies related to Biosimilars? Please explain.	Biosimilars are subject to the same PDL and clinical policies and criteria as the original single source 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 for RDUR interventions cost savings; KePro for PDL and clinical PA cost savings
2. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below.	

Cost Avoidance	Cost in Dollars
ProDUR Total Estimated Avoided Costs	$6,370,064.00
RetroDUR Total Estimated Avoided Costs	$3,179,775.00
Other Cost Avoidance	$9,011.00
Grand Total Estimated Avoided Costs	**$9,558,850.00**

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 5, then multiplying this value by 100.	31.90%
4. Summary 4 – Cost Savings/Cost Avoidance Methodology Cost Savings/Cost Avoidance Methodology Summary should include program evaluations/cost savings estimates prepared by the state or contractor.	Retro-DUR Cost saving Methodology Pharmacy claims data is mapped to allow R-DUR data management system to analyze and interpret data. The medical claims data is mapped to evaluate up to two years of patient medical history for the Retro-DUR interventions. Vendor 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

Question	Response
	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, vendor 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. 6-Month State General Revenue Funds Savings equals the 6-Month Total State Savings multiplied by 0.400 Total State Savings equals 6-Month State General Revenue Funds Savings multiplied 2. Pro-DUR Cost Saving Methodology Vendor provides the prior authorization services for the Vendor Drug Program (VDP). Prescribers must obtain PA for all non-preferred drugs. In addition to the PDL PAs, some drugs may be subject to one or more clinical PAs or edits.

Question	Response
	The PA system permits for automated processing of PAs and a large percentage of PAs are obtained at point-of-sale (POS) without requiring a phone call. The overall cost saving is calculated by adding the cost savings for unique denials with subsequent substitution to a preferred drug to the cost savings for unique denial without subsequent follow up approval or substitution therapy. Total cost savings for unique denial with subsequent substitution therapy is estimated by calculating 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. Total cost savings for unique denial without subsequent follow up approval or substitution is estimated by calculating 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. Lock-In Program Methodology The Lock-In program receives referrals from the public, providers, managed care organizations (MCOs) and the law enforcement officials. The Waste, Abuse, Fraud Electronic Referral System (WAFER) is available to the public for this purpose. Each referral is reviewed for lock-in criteria match. The estimated cost savings are based on the dollar amount would have been spent For the FFY 2021, there were 4 FFS members in the lock-in program with an estimated savings of $9,011.04. A cost saving methodology was not provider by the reporting party.

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 (multiple responses allowed)?	Deny claims, Refer to Lock-In Program, Refer to Office of Inspector General (OIG)
If "Other," please explain.	N/A
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 (multiple responses allowed)?	Number of controlled substances (CS), Different prescribers of CS, Multiple pharmacies, Multiple emergency room (ER) visits, Other
If "Other," please explain.	-Treatment that exceeds therapeutic daily Morphine equivalent dose (MED) -Any prescription combination with abuse potential -Member had two of more occurrences of violating a pain contact with the same prescriber or with different prescribers -Member had conviction due to crime related to restricted medications within the past year (theft, distribution, or Medicaid Fraud) -The member required emergency room visit or hospitalization due to a suicide attempt, poisoning or overdose of drugs or medications, or there was a diagnosis of alcohol or drug abuse (including non-therapeutic, recreational, or illegal drug use).
b. Does your state 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

Question	Response
If "Other," please explain.	The lock-in time periods are cumulative eligibility time frames of 36-months, 60-months, and lifetime depending on a case by case basis.
d. On average, what percentage of the FFS population is in Lock-In status annually?	0.00%
e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review.	$9,011.00
3. Does your state have a documented process in place that identifies possible FWA of controlled drugs by prescribers?	Yes
If "Yes," what actions does this process initiate (multiple responses allowed)?	Deny claims written by this prescriber, Refer to the appropriate Medical Board, Other
If "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 prescriber to 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.
If "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
If "Yes," what actions does this process initiate (multiple responses allowed)?	Deny claim, Refer to Board of Pharmacy, Other
If "Other," please explain.	The lock-in program makes referral to other OIG divisions, law enforcement, or licensing body when applicable. If lock-in refers a provider within the OIG for investigation, there will be a preliminary investigation. If findings merits a full-scale investigation, an initial notification will be made to the Medicaid Fraud Control Unit (MFCU). If criminal elements are identified, MFCU and OIG coordinated on the case. The OIG may also close and refer a case to a board/licensing body.
If "No," please explain.	N/A

Question	Response
5. Does your state have a documented process in place that identifies and/or prevents potential FWA of non-controlled drugs by beneficiaries, prescribers, and pharmacy providers?	Yes
If "Yes," please explain your program for FWA of non-controlled substances.	Texas Administrative Code (TAC) 370.502 describes managed care organizations (MCOs) responsibilities in developing a plan to prevent and reduce waste, abuse, and fraud (WAF) and submit that plan annually to the Health and Human Services Commission (HHSC), Office of Inspector General (OIG) for approval. The plan must include information about the procedures for detection and investigation of possible acts of WAF by providers and recipients and the follow up process once the detection is made. Also, a description of MCO's internal procedure for referring possible acts of WAF to MCO's Special Investigative Unit (SIU) and the mandatory reporting of possible acts of WAF by providers or recipients to the HHSC-OIG. Further more, the plan must include a description of the MCOs procedures for educating recipients and providers and training personnel to prevent WAF, as well as, a process flow diagram, or chart outlining the organizational arrangement of the MCO's personnel responsible for investigation and reporting of WAF, and any advertising and marketing materials utilized by the MCOs must be completed and accurately reflect the information about the MCO.
If "No," please explain.	N/A

B. Prescription Drug Monitoring Program (PDMP)

Question	Response
1. Does your Medicaid program have the ability to query the state's PDMP database?	No
If "Yes, receive PDMP data" specify frequency.	N/A
If "Other," please explain.	N/A
If "Yes, have direct access to the database," specify access method.	N/A
If "No," please explain.	Texas law does not allow the Texas Medicaid program to access the PDMP at this time.

Question	Response
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 point of sale (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
If "No," please explain.	N/A
If "Yes," please continue. a. Are there protocols involved in checking the PDMP?	Yes
If "Yes," please explain.	Per House Bill 3285, 86th Legislature, prescribers are required to check the Texas Prescription Monitoring Program (PMP) before prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. 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 are contradictory to the direction that the practitioner expects from the client?	No

Question	Response
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
If "No," please explain.	N/A
If "Yes," does your state require the provider to submit, upon request, documentation to the State?	No
If "No," please explain.	Texas law requires the prescriber to make and document a good faith attempt to comply but is unable to access the PMP because of circumstances outside the control of the prescriber. HHSC does not require provider's document submission.
3. Does the State or professional board require pharmacists to check the PDMP prior to dispensing?	Yes
If "No," please explain.	N/A
If "Yes," are there protocols involved in checking the PDMP?	Yes
If "Yes," please explain.	Pharmacists must report every controlled substance dispensed to an outpatient, including occasional or sporadic dispensing. Reporting must be done within one day of dispensing. On days when there is no dispensing of any reportable drug, the pharmacy will file a 'zero report'.
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 (multiple responses allowed)?	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
If "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

Question	Response
If "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).	Access to PMP is statutory restricted. Texas Medicaid does not have access to PMP
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
If "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 enforcement or the affected individuals were notified of the breach.	N/A

C. Opioids

Question	Response
1. Does your state currently have a POS edit in place to limit the days' supply dispensed of an initial opioid prescription for opioid naïve patients?	Yes, for all opioids
Please explain response above.	Yes, the Opioid Clinical Policy is applied to opioid prescriptions for opioid naive patients to limit the days-supply, the type of opioid prescribed for opioid navie patient (short acting vs. long-acting), and the exemption criteria.
If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue. a. What is the maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?	10

Question	Response
b. Does your state have POS edits in place to limit days' supply of subsequent opioid prescriptions? If "yes," please indicate your days' supply limit.	No
If "Other", please specify.	N/A
c. Please explain above response.	The day's supply limit on the subsequent opioid prescriptions or refills will be based on the maximum quantity per prescription set in the claims system and it may vary for each drug.
2. Does your state have POS edits in place to limit the quantity dispensed of short-acting (SA) opioids?	Other
If "Yes," please specify limit as # of units.	N/A
If "No," or "Other" please explain.	The quantity limit for a short-acting opioid, if written for an opioid naive patient, will be the calculated at a10-days supply limit and a 90-days MME level. The quantity for subsequent short-acting opioid (for non-naive patient) will be based on the 90 MME per day levels and the maximum quantity for that drug/NDC set in the claims system.
3. Does your state currently have POS edits in place to limit the quantity dispensed of long-acting (LA) opioids?	Other
If "Yes," please specify limit as # of units.	N/A
If "No," or "Other" please explain.	Per the Opioid Clinical Policy, long-acting opioids prescriptions are approved for subsequent prescribing (for non-naive patients) . The only limit to subsequent prescriptions would be based on the 90 MME per day limit and the maximum quantity for that drug/NDC set in the claims system.

Question	Response
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," check all that apply.	Deny claim and require PA, Intervention letters, MME daily dose program, Step therapy or clinical criteria, Require diagnosis, Require PDMP checks
If "Other," please specify.	N/A
Please provide details on these opioid prescribing controls in place.	HHSC implements multiple prior authorization criteria to manage the opioid prescriptions. The purpose of these PAs is to reduce opioid overutilization as well as to monitor inappropriate behaviors such as doctor shopping/pharmacy shopping, etc. Also, a number of population-based retro-DUR interventions are performed annually. These are intended to fulfill the requirement for federal SUPORT Act and to reduced inappropriate prescribing. Educational letters along with patient's specific claim information are mailed to prescribes identified through these RDUR monitoring. In addition, the Opioid Clinical Policy is in place to monitor daily cumulative MME levels. A daily MME level above 90 will trigger the system to stop the claim and require a prior authorization. For clients with certain diagnosis, including cancer, sickle cell, hospice care, the daily MME level does not apply.
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

Question	Response
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.	Per the Opioid Clinical Policy cumulative opioid dosing for any combinations of opioids must be less than 90 MME. In addition, the Opioid Overutilization PA criteria checks for doctor/pharmacy shopping, and for the number prescriptions/claims during a set time period (i.e. for clients with diagnosis of cancer, sickle cell, or palliative/hospice care, the client can receive no more than 3 prescriptions (of different opioids), or no more than 4 claims in the last 60 days. For any other conditions, the client can receive no more than 2 different prescriptions or no more than 3 claims in the last 60 days.)
6. Does your state have POS edits to monitor early refills of opioid prescriptions dispensed?	Yes
Please explain answer above.	An early refill is triggered if client did not complete 90% refill threshold for opioids. It will trigger the system to reject that claim and message the dispensing pharmacy to contact HHSC Help Desk and provide justification for early refill.
7. Does your state have comprehensive automated retrospective claim reviews to monitor opioid prescriptions exceeding these state limitations (early refills, duplicate fills, quantity limits and days' supply)?	Yes
If "Yes," please explain in detail scope, nature, and frequency of these retrospective reviews.	The retrospective claim reviews are in place to monitor opioid claims. Periodic retroDUR intervention topics on the opioid utilization include the criteria for opioid overutilization and will flag prescribers whose opioid prescribing appears to exceed the set parameters. The parameters may differ depending on the patient's disease condition. For example those with diagnoses of cancer, sickle cell, or hospice or palliative care may be allowed to have access to more prescriptions and higher quantities.
If "No," please explain.	N/A

Question	Response
8. Does your state currently have POS edits in place or automated retrospective claim reviews 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 (excluding clonazepam and rectal dosage form of diazepam) with a 14-day overlap. In response to a part of the Federal Support Act, the retro-DUR review and intervention for opioid -benzodiazepines combination, as well as, antipsychotics-opioids combination are conducted regularly.
If "No," please explain.	N/A
9. Does your state currently have POS edits in place or automated retrospective claim reviews to monitor opioids and sedatives being used concurrently?	Yes, both POS edits and automated retrospective claim reviews
If "Yes," please explain above and detail scope and nature of reviews and edits.	The program uses a POS edit to deny sedative claim to those with diagnosis of SUD, but it does not deny concurrent use with opioids if diagnosis of SUD is not found. For the FFY 2021, also, a retrospective DUR intervention was completed that included concurrent prescribing of sedatives and opioids.
If "No," please explain.	N/A
10. Does your state currently have POS edits in place or automated retrospective claim reviews to monitor opioids and antipsychotics being used concurrently?	Yes, automated retrospective claim reviews
If "Yes," 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.
If "No," please explain.	N/A

Question	Response
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 (multiple responses allowed)?	Yes, POS edits
If "Yes, automated retrospective claim reviews" and/or "Yes, provider education," please indicate how often.	N/A
If "Other," please specify.	N/A
If "Yes," please explain nature and scope of edits, reviews and/or provider education reviews performed.	All the POS clinical PA criteria will reject claims for opioids if the diagnosis of OUD is found. Also, the retro-DUR interventions on opioids will target prescribers writing opioid prescriptions for clients with OUD diagnosis.
If "No," does your state plan on implementing POS edits, 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
If "Yes," when does your state plan on implementing?	N/A
If "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 check all that apply.	Your state Medicaid program refers prescribers to the Center for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain.
If applicable, please identify the "other" guidelines.	N/A
If "No," please explain why no guidelines are offered.	N/A

Question	Response
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
If "Yes," please explain.	Currently, the out-patient pharmacy formulary includes XTAMPZA ER (oxycodone) as a preferred agent.
14. Were there COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency?	No
If "Yes," please explain.	N/A

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
If "Less than 50 MME," please specify the amount in mg per day.	N/A mg per day
If "Greater than 200 MME," please specify the amount in mg per day.	N/A mg per day
If "Other," please specify the amount in mg per day.	N/A mg per day
b. Please explain nature and scope of dose limit (i.e. Who does the edit apply to? Does the limit apply to all opioids? Are you in the process of tapering patients to achieve this limit?).	The 90 MME daily dose is cumulative and is applied to all opioids and is calculated for both for initial and subsequent therapies. For those who may require a tapering plan, provider may develop and manage patient-specific course of therapy. A prescriber may request for a tapering plan through prior authorization process on a case-by-case basis. Prior authorization approval lasts for 6 months. Clients with documented diagnosis of cancer, sickle cell, or hospice/palliative care are exempt.
If "No," please explain the measure or program you utilize.	N/A

Question	Response
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.	Prior to processing an incoming claim, the system checks cumulative daily MME levels of the existing claims and if the dose is above 90 MME per day, it will reject the incoming claim for prior authorization. System does not send messages to the prescriber in near real time.
4. Do you provide information to your prescribers on how to calculate the MME daily dosage or do you provide a calculator developed elsewhere? If "Yes," please continue.	Yes
a. Please name the developer of the calculator.	CDC
If "Other," please specify.	N/A
b. How is the information disseminated (multiple responses allowed)?	Other
If "Other," please explain.	A link to the CDC's calculation page is included on Opioid Policy Criteria guide document.

E. Opioid Use Disorder (OUD) Treatment

Question	Response
1. Does your state have utilization controls (i.e. preferred drug list (PDL), prior authorization (PA), quantity limit (QL)) to either monitor or manage the prescribing of Medication Assisted Treatment (MAT) drugs for OUD?	Yes
If "Yes," please explain.	There is a clinical prior authorization for buprenorphine agents with the following checks: Age, diagnosis of opioid dependency, concurrent therapy with opioids. For single-ingredient buprenorphine prescriptions, approval is granted only if the client is pregnant or is intolerant to naloxone. All MAT therapy drugs are preferred on the PDL.
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
If "Other," please explain.	N/A
3. What are your limitations on the allowable length of this treatment?	No limit
If "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
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

Question	Response
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
If "Other," please explain.	N/A
If "Yes," can the POS pharmacist override the edit?	No
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
If "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
If "No," please explain.	N/A
If "Yes," is a referral needed for OUD treatment through OTPs?	Yes
Please explain.	Narcotic treatment centers (NTCs) are required to provide or offer referrals to patients for the following services: social and human services, mental health services, educational and vocational services, family counseling, and HIV/AIDS counseling/prevention/risk-reduction education. Texas residents of 18 years of age and older who have been diagnosed with moderate to severe opioid use disorder in the at least 12 months in a row are eligible for MAT services. Financial eligibility is based on the patient's income and expenses, and some out-of-pocket expenses may apply. Eligible residents may receive medication-assisted treatment services by calling their local narcotic treatment center 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
If "No," please explain.	N/A
3. Does your state Medicaid program cover naltrexone for diagnoses of OUD as part of a comprehensive MAT treatment plan?	Yes
If "No," please explain.	N/A

Question	Response
4. Does your state Medicaid program cover Methadone for a substance use disorder (i.e. OTPs, Methadone Clinics)?	Yes

G. Psychotropic Medication

Antipsychotics

Question	Response
1. Does your state currently have restrictions in place to limit the quantity of antipsychotic drugs?	Yes
Please explain restrictions or N/A.	The POS criteria limits the number of antipsychotics prescribed concomitantly. 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
If "Other," please explain.	N/A
b. Does your state have edits in place to monitor (multiple responses allowed):	Child's age, Indication, Polypharmacy, Other
Specify child's age limit in years.	6
If "Other," please explain.	Children 3 years of age and older may receive certain atypical antipsychotics only for the FDA approved indications, such as autism. For antipsychotic therapy, patients 6 and older may receive up to two different antipsychotics for the appropriate indications. The prior authorization criteria will reject the antipsychotic claim if only given for insomnia, or for major depressive disorder treatment without concurrent antidepressant therapy.

Question	Response
c. Please briefly explain the specifics of your documented antipsychotic monitoring program(s).	Antipsychotic clinical prior authorization is an automated process. System approves children age 6 and older for diagnoses such as psychosis/ schizophrenia, bipolar disorder. For diagnoses such as depression for which antipsychotics are appropriate as adjunct therapy, the system automatically approves when evidence of antidepressant therapy is found. The system also approves up to two different antipsychotics.
If "No," does your state plan on implementing an antipsychotic monitoring program in the future.	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antipsychotic drugs in children.	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. Does your state currently have restrictions in place to limit the quantity of stimulant drugs?	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
If "Other," please explain.	N/A
b. Does your state have edits in place to monitor (multiple responses allowed):	Child's age, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	3
If "Other," please explain.	N/A

Question	Response
c. Please briefly explain the specifics of your documented stimulant monitoring program(s).	The POS automated PA process approves claims for FDA approved diagnosis, for children older than 3 years of age. For dosing, VDP uses either the FDA approved dosing or the Texas Health and Human Services (HHS) Psychotropic Medication Utilization Parameters maximum recommended daily dose. Additionally, the system checks for concurrent therapy of two or more immediate release (IR) or extended release (ER). Combination of a IR and an ER stimulants, as well as, any combination of IR or ER stimulants with one or more non-stimulants are approved. For clients age 19 or older, a diagnosis of ADD/ADHD must be documented for approval after the initial approval for the first 90-days therapy.
If "No," does your state plan on implementing a stimulant monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of stimulant drugs in children.	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

Antidepressants

Question	Response
5. Does your state have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children? If "Yes," please continue.	Yes
a. Does your state either manage or monitor:	Other
If "Other," please explain.	The antidepressant monitoring is done for all age groups through a retrospective DUR review and educational intervention.

Question	Response
b. Does your state have edits in place to monitor (multiple responses allowed):	Other
Specify child's age limit in years.	N/A
If "Other," please explain.	There are no POS prospective edits or prior authorization in place for antidepressants to monitor for age, dose, indications, etc. However, in FFY 2021,there were multiple performance indicators which were selected for retrospective intervention which applied to clients of all ages with diagnosis of depression and/or who received antidepressants. Targeted prescribers received educational intervention letters.
c. Please briefly explain the specifics of your documented antidepressant monitoring program(s).	Major Depressive Disorder Management was one of the interventions performed in FFY 2021. The performance indicators selected for this intervention included: medication therapy that lasted less than 6 months. Medication therapy that lasted longer than 12 months for a single episode, Antidepressants for children and adolescents (excluding fluoxetine age 8-18 years and escitalopram for ages 12-17 years), Duplicative therapy, antidepressant adherence, and antidepressants dose consolidation (excluding pediatric patients)
If "No," does your state plan on implementing an antidepressant monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antidepressant drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antidepressant drugs in children.	N/A

Mood Stabilizers

Question	Response
6. Does your state have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children? If "Yes," please continue.	Yes
a. Does your state either manage or monitor:	Other
If "Other," please explain.	Mood stabilizers are reviewed as a part of the retrospective intervention review criteria for topics such as Antipsychotic Drug Use Evaluation, or Bipolar Disease Management. The criteria are applied to all age groups.
b. Does your state have edits in place to monitor (multiple responses allowed):	Other
Specify child's age limit in years.	N/A
If "Other," please explain.	All the above options may be included for consideration for the retro-DUR criteria and interventions.
c. Please briefly explain the specifics of your documented mood stabilizer monitoring program(s).	As a part of the retrospective DUR program, multiple safety criteria are included, such as, Lithium monitoring (serum levels, renal function, and thyroid function), use of an antidepressant in the absence of a mood stabilizer/atypical antipsychotic, medication non-adherence with antipsychotics or mood stabilizers.
If "No," does your state plan on implementing a mood stabilizer monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of mood stabilizing drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of mood stabilizing drugs in children.	N/A

Antianxiety / Sedatives

Question	Response
7. Does your state have a documented program in place to either manage or monitor the appropriate use of antianxiety/sedative drugs in children? If "Yes," please continue.	Yes
a. Does your state either manage or monitor:	Other
If "Other," please explain.	claims for all age groups are subject to the anxiolytics/sedatives/hypnotics prior authorization and retrospective intervention criteria.
b. Does your state have edits in place to monitor (multiple responses allowed):	Other
Specify child's age limit in years.	N/A
If "Other," please explain.	All the above are included in the monitoring of anxiolytics/sedatives/hypnotics.
c. Please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).	The clinical prior authorization criteria included are: age check, diagnosis check, and diagnosis of substance use disorder (SUD) safety check. The duration of PA is short termed to give the providers the opportunity to reevaluate continued therapy. The retrospective review also checks for chronic use and use in patients with a history of SUD, duplicative therapy, high dose, and use of controlled sedatives/hypnotics in youth.
If "No," does your state plan on implementing an antianxiety/sedative monitoring program in the future?	N/A
If "Yes," please specify when you plan on implementing a program to monitor the appropriate use of antianxiety/sedative drugs in children.	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antianxiety/sedative 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
If "Yes," please explain.	N/A
2. Summary 5 – Innovative Practices Innovative Practices Summary should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing). Please describe in detailed narrative below any innovative practices that you believe have improved the administration of your DUR program, the appropriateness of prescription drug use and/or have helped to control costs (i.e., disease management, academic detailing, automated PA, continuing education programs).	In FFY 2021, Vendor Drug Program implemented many innovative practices. Below are some examples. 1. During the late spring and summer of 2021, VDP coordinated with the MCOs for reopening of the RSV season in all the state's health regions. Prior authorization for prophylactic therapy was not required for those whose approval was established and had received palivizumab during the 2020-2021 regular season. HHSC sent notifications to the prescribers and pharmacies. 2. On February 1, 2021, HHSC began using a browser-based submission portal for drug manufacturers or labelers to submit request for coverage of their drugs. 3. In November 2020, Texas Medicaid began to provide coverage of all drugs used to treat opioid use disorder (OUD) as per SEC. 1006.(b) of the SUPPORT Act. 4. On December 2020, HHSC began offering the COVID-19 vaccine as a pharmacy benefit in Medicaid (fee for service and managed care) and CHIP. 5. HHSC resumed quarterly Specialty Drug List (SDL) in July 2021. This legislatively required process was suspended due to concerns of drug shortage during COVID-19 public health emergency. 6. In July 2021, all Sickle Cell treatment agents were given preferred status. The DUR Board recommended preferring all medications after consideration for the medical complexity of the disease, the available treatment options, and public testimony.

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)?	Partial
Please specify the drug categories that are carved out.	There are some drugs that are considered as non-risk for the MCOs. These include: antihemophilic treatment agents, direct acting antivirals for treatment of hepatitis C, gene-based Duchene muscular dystrophy treatment, gene-based therapy for retinitis pigmentosa, immunotherapy for certain types of lymphoma
3. Contract updates between state and MCOs addressing DUR provisions in Section 1004 Support for Patients and Communities Act are required based on 1902(oo). 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
If "Yes," please specify effective date.	08/14/2020
If "No, contracts are not updated," please explain.	N/A
a. Is the state 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
If "Yes," state is complying with Federal law and monitoring MCO compliance on SUPPORT for Patients and Communities Act provisions. Please explain monitoring activities.	The MCOs 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 activities, as provided for under 42 C.F.R. 438.3(s)
If "No," please explain.	N/A

Question	Response
4. Does the state set requirements for the MCO's pharmacy benefit (i.e. same preferred drug list, same ProDUR/RetroDUR)?	Yes
a. If "Yes," check all that apply.	Same PDL
b. Please briefly explain your policy.	The state sets some requirements for the MCOs pharmacy benefits: Single PDL Single Formulary POS clinical PA criteria must not be more astringent than what the HHSC DUR Board has approved.
If "No," does your state plan to set standards in the future?	N/A
If "No," please explain.	N/A
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 uses a combination of state interventions as well as individual MCO interventions
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 by mailing the educational letters. The outcome reports for these interventions are submitted to the state for approval. For the MCOs the 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 their DUR programs during a Readiness Review and MCOs annual submission of a detailed reports, their DUR activities are evaluated every two years through an Operation Review.
8. Did all of your managed care plans submit their DUR reports?	Yes
If "No," please explain.	N/A

Section XI - Executive Summary

Question	Response
1. Summary 6 – Executive Summary Executive Summary should provide a brief overview of your program. It should describe FFY 2021 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.	Texas Medicaid conducts a robust and productive DUR program. Texas Medicaid implements a single formulary and PDL policy with all the contracted MCOs. In the FFY 2021, there were 17 MCOs contracted with Texas Medicaid. Vendor Drug Program (VDP) is responsible for managing the out-patient pharmacy formulary for members enrolled in Medicaid and CHIP as well as the state operated CHSCN program, Healthy Texas Women Program, and Kidney Health Program. In addition to the formulary and PDL, VDP is responsible for developing the prospective clinical prior authorization criteria proposals and the retrospective DUR intervention criteria proposals. These proposals are submitted to the DUR Board during the Board's regular meetings. The Board holds 4 quarterly meetings each year and makes recommendations on the proposals for PDL, prospective clinical PAs, retrospective drug use criteria, and retrospective interventions. HHSC implements the PDL decisions twice per calendar year, in January and in July. The PDL decisions from January and April DUR meetings are implemented in July. The PDL decisions from July and October meetings are implemented in January of the following year. In the FFY 2021, there were several significant additions to the PDL classes. In October 2020, the oral oncology drugs for treatment of prostate, breast, hematology, lung, prostate, renal, skin and other types of cancers were reviewed for the first time. All the reviewed drugs in these classes were given preferred status. Similarly, in the January 2021 Board meeting, anticonvulsants, HIV/AIDS, Antihemophilia, and multiple sclerosis drugs were reviewed for the first time and all were given preferred status. Finally, in response to the public and provider's request, HHSC granted preferred status to all sickle cell treatment agents. DUR Board also reviewed and voted on several new clinical prior authorization criteria proposals including Evrysdi, Orihann, Calcitonin gene-related peptide receptor (CGRP) antagonist for treatment of acute migraine, Wakix, Xyway in October 2021, Amantadine extended-release agents, Hemady, Dopamine agonists, Apokyn and Kynmobi, and Multiple Sclerosis agents (safety checks) in 2021.

Question	Response
	Of the several Board-approved retrospective DUR interventions proposals, Benzodiazepine Anxiolytics and Controlled Sedative Hypnotics Drug Use Evaluation, Comprehensive Opioid Management, and Psychotropic drugs in Youth worth mentioning. The total estimated cost savings/cost avoidance reported for the FFY 2021 is largely associated with the PDL and clinical PA implementations and the retro-DUR interventions. In FFY 2021, the total cost saving was $9,558,850. A small portion of this was from the state's FFS Lock-In program. VDP has several prospective and retrospective DUR policies and criteria in place for managing prescriptions for opioids and psychotropics (antipsychotics, antidepressants, anxiolytics, and simulants). through clinical edits, . These edits and interventions are intended to target overutilization, duplicative therapies, doctor/pharmacy shoppers, and medication treatment adherence. During the FFY 2021, HHSC implemented several innovative practices, including the reopening of intersessional RSV prophylaxis throughout all Texas Health regions, coverage of COVID-19 vaccines in out-patient pharmacy, and coverage of all OUD treatment drugs as per SEC. 1006.(b) of the SUPPORT Act.