Texas
Medicaid Fee-For-Service (FFS)
Federal Fiscal Year (FFY) 2022
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?	194,237
2. On a monthly average, how many of your State's Medicaid beneficiaries are enrolled in managed care plan(s)?	5,167,075

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, Other, Alerts can be overridden with standard professional codes, Alerts need prior authorization (PA) to be overridden
If "Other," please explain.	Except for Med Synchronization purposes, all early refills will require an override by calling HHSC Help Desk. Early refill does not require a prior authorization request from 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.	Ad-hoc reports are run as needed.
a. How often does your State receive reports (multiple responses allowed)?	N/A
If "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

Question	Response
If "Yes," by what method does your State follow up (multiple responses allowed)?	N/A
If "Other," 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.	In normal situations only for Medication Synchronization purposes, dispensing pharmacist may override by entering a PA code. For all other reasons pharmacists must call the HHSC Help Desk. Med. Sync. override does not apply to CIIs and controlled substances containing hydrocodone.
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

Question	Response
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. Does your system have a diagnosis edit that can be utilized when processing a prescription?	No
If "Yes," please explain.	N/A
10. 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 the Texas Formulary and can be accessed via a prior authorization. The PA criteria are automated and will be approved 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 is responsible for informing the prescriber about the PDL PA failure. The prescriber may either change the prescription to a preferred drug or contact the PA call center for approval.
If "No," please explain why not.	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
If "Yes," check all that apply.	Real-time automated process
If "Other process," please explain.	N/A
If "No," please explain why not.	N/A
11. 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	quantity dispensed exceeds maximum allowed	coagulation factor IX (recombinant)	4.14%	cetirizine	5.40%
albuterol Sulfa HFA	bronchodilator agents	refill too soon	elexacaftor/tezacaftor /ivacaftor	3.38%	loratadine	3.95%
gabapentin	anticonvulsant agents	prior authorization required	bictegravir/ emtricitabine/ tenofovir	2.96%	docusate	3.85%
methylphenidate	attention deficit hyperactivity disorder agents	product/service not covered - plan/benefit exclusion	paliperidone	2.22%	aspirin	3.62%
meloxicam	antipsychotic agents	DUR reject error	adalimumab	2.12%	ergocalciferol	3.59%
hydrocodone/ acetaminophen	analgesics, narcotic agents		apixaban	1.48%	polyethylene glycol 3350	3.55%
esomeprazole	analgesics, narcotic agents		insulin glargine	1.43%	folic acid	1.81%
tramadol	NSAID		vitafol	1.35%	amoxicillin	1.75%
risperidone	proton pump inhibitor agents		insulin aspart	1.24%	ondansetron	1.66%
doxylamine/ pyridoxine	antiemetic agents		polyethylene glycol 3350	1.52%	ibuprofen	1.63%

Question	Response
12. 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 and 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. This method allows clinical issues affecting thousands of members to be addressed without the need to individually review each profile. The retrospective criteria are presented to the Texas DUR Board for review and approval prior to being mailed out. An outcome report is submitted to the state and presented to the DUR Board. The outcome report shows the dollar amount of cost saving/cost avoidance by comparing the claims from 6-month before and after intervention. Additional clinical impact is also included.
d. Does your State customize your RetroDUR vendor criteria?	Yes
2. How often does your State perform retrospective practitioner-based education?	Other
If "Other," please specify.	There is no set schedule for conducting R-DUR practitioner-based education. Per the state's requirement, vendor performs up to10 or 12 population-based interventions after which educational letters are sent to the flagged providers.
a. How often does your State perform retrospective reviews that involve communication of client-specific	Other

information to healthcare practitioners (multiple responses allowed)?	
If "Other," please specify.	There is no set frequency for mailing educational letters to prescribers. Intervention packages are sent to targeted prescribers via mail after the DUR Board approval. Each package includes a letter to the prescriber, specific client claims information, and a clinical message page explaining the standard practices guidance.
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.	For the FFY 2022, 8 retour-DUR interventions were conducted: 1. Diabetes Disease Management was mailed to 2717 providers and targeted patients had average reductions in clinical indicators of 25.2%. However, there was an estimated increase of $384,309.60 in intervention-related drug expenditures on an annualized basis. 2. Bipolar Disorder Management intervention targeted 322 providers and had a reduction/improvement in clinical indicators by 31.9%. The amount expenditure for intervention-related drugs decreased by $1,385,350.20. 3. Hypertension Management targeted 1248 providers and had average reductions/improvement in clinical indicators of 32.0%. In terms of financial outcomes, an overall decrease by $13,894.80 in intervention-related drug was reported. 4. ADHD Medication Management targeted 171 providers and had an average improvement in the clinical indicators of 27.7%. An overall $590,144.94 decrease in intervention-related drug expenditures was reported 5. Combined Use of Opioids and CNS Depressants targeted 46 providers and had improved clinical indicators by an average of 33.3%. In terms of financial outcomes, an overall estimated decrease of $15,257.28 in intervention-related drug expenditures was reported. 6. Management of Psychotropic Drugs in Pediatric Patients targeted 154 providers and had average reductions in clinical indicators of 26.4%. The Dollar amount paid for intervention-related drugs decrease by $73,418.40. 7. Heart Failure Management targeted 148 providers and had average reductions in clinical indicators of 28.5%.

	However, there was an increase in intervention-related drugs expenditure by $24,727.68. 8. Migraine Disease Management targeted 16 providers and had average reductions in clinical indicators of 37.5%. In terms of financial outcomes, this intervention yielded an overall estimated decrease of $10,273.68 in intervention-related drug expenditures.

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.	During FFY 2022, the Texas DUR Board held four quarterly meetings. Each meeting consisted of several functions: On Oct 22, 2021, the board reviewed the following drug classes for the PDL purposes: a. Androgenic agents b. Antibiotics, gastrointestinal (GI) c. Antibiotics, topical d. Antibiotics, vaginal e. Anticonvulsants f. Antiemetics/Antivertigo agents g. Antifungals, oral h. Antifungals, topical i. Antihistamines - first generation j. Antiparasitics, topical k. Antipsychotics l. Antivirals, topical m. Bone resorption suppression and related agents n. Colony stimulating factors o. Epinephrine, self-injected p. GI Motility, chronic q. Growth hormone r. Hepatitis C s. HIV / AIDS t. Hypoglycemics, insulin and related agents u. Hypoglycemics, meglitinides v. Hypoglycemics, metformin w. Hypoglycemics, sodium-glucose cotransporter-2 (SGLT2) inhibitors x. Hypoglycemics, thiazolidinediones (TZDs) y. Macrolides-Ketolides z. Opiate dependence treatments The following new products were reviewed off cycle: Benlysta Autoinjector (subcutaneous) / Immunosuppressives Benlysta Syringe (subcutaneous) / Immunosuppressives Lumakras (oral) / Oncology, oral for lung cancer Lupkynis (oral) / Immunosuppressives Truseltiq (oral) / Oncology, oral - other Zegalogue Autoinjector (subcutaneous) / Glucagon agents

Question	Response
	Zegalogue Syringe (subcutaneous) / Glucagon agents The Board voted on these proposed retro-DUR intervention criteria, and interventional letters. ADD/ADHD Management Opioid and CNS depressants Drug Use Evaluation. The clinical prior authorization criteria proposals included the followings: a. Topical antifungal for treatment of onychomycosis new criteria b. Antipsychotic agents -Lybalvi new criteria c. Cytokine and cell-adhesion molecule (CAM) - Enspryng new criteria d. Lupus, new criteria- Benslysta (safety checks) and Lupknis (safety checks) e. SGLT2- Farxiga (revised criteria) and Jardiance (revised criteria) Retrospective drug use criteria for outpatient use in Vendor Drug Program are proposals for probable future clinical prior authorizations criteria and/or claims edits criteria. The Board reviewed and approved the followings: a. Atypical antipsychotics (long-acting injectable) b. Atypical antipsychotics (oral) c. Exogenous insulin products d. Nitazoxanide (Alinia) e. Promethazine use in children less than 2 years of age f. Quetiapine (low dose) On January 21,2022, the Board reviewed these PDL therapeutic classes a. Acne agents, oral b. Acne agents, topical c. Analgesics, narcotics long d. Analgesics, narcotics short e. Angiotensin modulator combinations f. Angiotensin modulators g. Antiparkinsons agents h. Antimigraine agents, other i. Antimigraine agents, triptans j. Bladder relaxant preparations k. Glucagon agents

Question	Response
	l. H. pylori treatment m. Immunomodulators, atopic dermatitis n. Intranasal rhinitis agents o. Movement disorders p. Neuropathic pain q. Oncology, oral - breast r. Oncology, oral - hematologic s. Oncology, oral - lung t. Oncology, oral - other u. Oncology, oral - prostate v. Oncology, oral - renal cell w. Oncology, oral - skin x. Phosphate binders y. Platelet aggregation inhibitors z. Potassium binders aa. Progestins for cachexia bb. Proton pump inhibitors cc. Smoking cessation dd. Stimulants and related agents Th following new brand name drugs were reviewed off cycle: a. Bylvay capsule (oral) / Bile salts b. Bylvay pellet (oral) / Bile salts c. Invega Hafyera (intramusc) / Antipsychotics d. Livmarli (oral) / Bile salts e. Loreev XR capsule ER 24H (oral) / Anxiolytics f. Lybalvi (oral) / Antipsychotics g. Miconatate OTC (topical) / Antifungals, topical h. Mucinex instasoothe cough OTC (oral) / Cough and Cold, non-narcotic i. Rezurock (oral) / Immunosupressives, oral The following retrospective intervention proposals were reviewed: i. Attention-deficit/hyperactivity disorder management ii. Management of psychotropic drugs in pediatrics iii. Opioids and central nervous system depressants DUE The following clinical prior authorization proposals were reviewed: a. Antimigraine agents, triptans- new criteria b. Bile salts

Question	Response
	i. Add Bylvay- new criteria c. Calcitonin gene-related peptide (CGRP) agents, chronic i. Add Quilpta- new criteria d. Immunomodulators, atopic dermatitis i. Add Opzelura e. Phosphate binders - revised criteria f. Pulmozyme- new criteria Retrospective drug use criteria for outpatient use in Vendor Drug Program are proposals for probable future clinical prior authorizations criteria and/or claims edits criteria. The Board reviewed and approved the followings: a. Fentanyl b. Gabapentin c. Hydrocodone Bitartrate/Hydrocodone Polistirex d. Ivacaftpor (Kalydeco) and combination therapy e. Topical Calcineurin Ihibitors- Pimecrolimus (Elidel) and Tacrolimus (Protopic) f. Tramadol On April 22, 2022, the following drug classes were reviewed for PDL purposes: a. Analgesics, narcotics long acting b. Anti-Allergens, oral c. Antibiotics, inhaled d. Anticoagulants e. Antidepressants, other f. Antidepressants, selective serotonin reuptake inhibitors (SSRIs) g. Antidepressants, tricyclic h. Antihyperuricemics i. Antivirals, oral j. Anxiolytics k. Benign prostatic hyperplasia treatments l. Beta-blockers m. Bile salts n. Bronchodilators, beta-agonists o. Chronic obstructive pulmonary disease (COPD) agents p. Cough and cold, cold q. Cough and cold, narcotic r. Cough and cold, non-narcotic s. Erythropoiesis stimulating proteins t. Glucocorticoids, inhaled

Question	Response
	u. Hemophilia treatment v. Hereditary angioedema (HAE) treatments w. Immune globulins, intravenous x. Immunomodulators, asthma y. Lincosamides/oxazolidinones/streptogramins z. Lipotropics, other aa. Lipotropics, statins bb. Multiple sclerosis agents cc. Pancreatic enzymes dd. Pediatric vitamin preparations ee. Prenatal vitamins ff. Pulmonary arterial hypertension agents, oral and inhaled gg. Sedative hypnotics hh. Sickle cell anemia treatments ii. Thrombopoiesis stimulating proteins jj. Urea cycle disorder, oral Additionally, the following new drugs were reviewed off cycle a. Dhivy tablet (oral) / Antiparkinson agents b. Eprontia solution (oral) / Anticonvulsants c. Skytrofa cartridge (subcutaneous) / Growth hormone d. Adbry (subcutaneous) / Immunomodulators, atopic dermatitis e. Tyrvaya spray (nasal) / Ophthalmics, anti-inflammatory/immunomodulators f. Vuity (ophthalmic) / Ophthalmics, glaucoma agents There were two proposals for retroDUR interventions: i. Heart failure management ii. Migraine disease management The following clinical prior authorization criteria proposals were reviewed: a. Atopic Dermatitis- add Cibinqo and Adbry b. Livmarli- new criteria for cholestatic pruritis due to Alagille syndrome c. Recorlev oral tablets- new criteria for Cushing Disease d. Tyrvaya nasal- new criteria for dry eye e. Voxzogo- new criteria for achondroplasia Retrospective drug use criteria for outpatient use in Vendor Drug Program are proposals for probable future clinical prior authorizations criteria and/or claims edits criteria. The Board reviewed and approved the followings:

Question	Response
	a. Benzodiazepines (nonsedative/hypnotics) b. Complement Inhibitor and Enzyme/ Protein Replacement Therapy c. Direct oral anticoagulants d. Hydroxy-Methylglutaryl Coenzyme A Reductase Inhibitors e. Ivacaftor (Kalydeco) and Combination Therapy (Resubmission from the January Meeting) f. Low Molecular-Weight Heparins g. Nebulized Bronchodilators On July 22, 2022, The DUR Board Reviewed the following PDL therapeutic classes a. Alzheimer's agents b. Antihistamines, minimally sedating c. Antihypertensives, sympatholytics d. Calcium channel blockers e. Cephalosporins and related antibiotics f. Cytokine and cell adhesion module (CAM) antagonists g. Fluoroquinolones, oral h. Glucocorticoids, oral i. Immunomodulators, Lupus j. Immunosuppressives, oral k. Iron, oral l. Leukotriene modifiers m. Nonsteroidal anti-inflammatory drugs (NSAIDs) n. Ophthalmic antibiotics o. Ophthalmic antibiotic-steroid combinations p. Ophthalmics for allergic conjunctivitis q. Ophthalmics, anti-inflammatories r. Ophthalmics, anti-inflammatory/immunomodulator s. Ophthalmics, glaucoma agents t. Otic antibiotics u. Otic anti-infectives and anesthetics v. Penicillins w. Progestational agents x. Rosacea agents, topical y. Skeletal muscle relaxants z. Steroids, topical high aa. Steroids, topical low bb. Steroids, topical medium cc. Steroids, topical very high dd. Ulcerative colitis agents

Question	Response
	ee. Uterine disorder treatments As well as the following brand name drugs were reviewed off cycle: a. Twyneo, cream (topical)/ Acne Agents, topical b. Seglentis (oral) / Analgesics, narcotics short c. Livtencity (oral)/ Antivirals, orals d. Releuko, syringe (subcutaneous)/ Colony Stimulating Factors e. Releuko, vial (injection) / Colony Stimulating Factors f. Ibsrela, tablet (oral) / Gastrointestinal(GI) Motility, chronic g. Takhzyro, syringe (subcutaneous)/ Heridatry Angioedema (HAE) Treatments h. Triumeq Pediatric (PD), tablet, suspension (oral) / HIV / AIDs i. Zimhi (injection) / Opiate Dependence Treatments Potential RetroDUR interventions was reviewed i. Influenza Prevention: vaccination and education Clinical Prior authorization proposals: a. Allergen Extracts- Oralair revised criteria b. Fintepla (fenfluramine)- new criteria c. Gastrointesinal Mobility- new criteria for Ibsrela d. Monoclonal Antibody Agents- new criteria for Xolair e. Sodium-glucose cotransporter-2 (SGLT2) - Farxiga and Jardiance revised criteria Retrospective drug use criteria for outpatient use in Vendor Drug Program are proposals for probable future clinical prior authorizations criteria and/or claims edits criteria. The Board reviewed and approved the followings: a. Fluoroquinolones (oral) b. Hepatitis C (new criteria) c. Immune globulins d. Non-sedating antihistamines e. Non-steroidal anti-inflammatory drugs f. Rifaximin (Xifaxan) g. Sickle cell disease products h. Skeletal muscle relaxants

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.	Generic utilization percentage is affected by the preferred brand name drugs. Due to the Federal and state rebate policies, the brand names that are less costly when compared to their generic formulations, are moved to preferred list. Texas has a single-PDL policy and the MCOs are required to implement the same preferred drug and PDL PA criteria. Therefore, the MCOs generic utilization is directly impacted by the state's PDL policies.
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.	Other, Prior Authorization (PA) is required
If “Other,” please explain.	If brand name drug has a preferred status, the prescriber does not need to write "Brand name Necessary".

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 of Total Drug Expenditure:** 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	19,919.00	291,236.00	10,137.00
Total Reimbursement Amount Less Co-Pay	$16,773,952.13	$6,164,260.99	$2,193,660.92

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	291,236
Total Number of Claims	321,292
Generic Utilization Percentage	91%

Question	Response
4. How many innovator drugs are the preferred product instead of their multi-source counterpart based on net pricing (i.e. brand name drug is preferred over equivalent generic product on the PDL)?	91
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	$6,164,261
Total Dollars	$25,131,874
Generic Expenditure Percentage	25%
6. Does your State have any policies related to Biosimilars? Please explain.	Biosimilars are reviewed for the PDL purposes.

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	KePro for the Pro-DUR and Conduent for Retro-DUR, Lock-in for the other cost avoidance
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	$6,214,625.00
RetroDUR Total Estimated Avoided Costs	$1,679,302.02
Other Cost Avoidance	$751.00
Grand Total Estimated Avoided Costs	$7,894,678.02

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.	31.41%
4. Does your Medicaid program provide coverage of over-the-counter medications when prescribed by an authorized prescriber?	Yes
If "No," please explain why not.	N/A

5. 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.	For the Pro-DUR - we only consider the cost savings/avoidance associated with the clinical and PDL prior authorizations. The data used for this analysis was sourced by the RxPert prior authorization processing system and the PCRA vendor. The total cost savings =Total Cost Savings for Unique Denials with Substitute Therapy + Total Cost Savings for Unique Denials without Follow-Up Approval or Substitute Therapy. Total Cost Savings for Unique Denials with Substitute Therapy= Total number of non-duplicate denied prior authorization requests for the time frame, where the client had a paid claim within 7 days of the original denied request for a drug within the same HIC3 category Total Cost Savings for Unique Denials without Follow-Up Approval or Substitute Therapy= Total number of non-duplicate denied prior authorization requests for the time frame, where the client did not have a prior authorization approval within 7 days of the original denied request and the client did not have a paid claim within 7 days of the original denied request for a drug within the same HIC3 category. For the RDUR savings The Sourse Data: The Conduent RetroDUR program receives outpatient pharmacy claims data from Conduent Pharmacy PBM daily. Accenture provides eligibility data daily and medical data weekly. Further, updated Texas Medical Board Provider files are received from Conduent Pharmacy PBM monthly. Target Prescribers are those that were identified and received intervention materials. Control prescribers are those prescribers that prescribed the intervention drugs but did not receive intervention materials. When seven months of data have been received post-intervention, Conduent prepares an outcome report. The analysis identifies all patients who had a prescription for an intervention drug for either the target or control group of prescribers. The number of patients treated and the total cost for intervention drugs are determined for the 6-month pre-intervention period and for a 6-month post-intervention period.

Question	Response
	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 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 = the Intervention Average Cost Savings PPPM x total number of targeted patients served over the 6-month time frame. 6-Month State General Revenue Funds Savings = the 6-Month Total State Savings x by 0.400 Total State Savings = 6-Month State General Revenue Funds Savings x 2. Lock-in did not provide cost saving methodology for the lock-in savings.

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
If "No," please explain why not.	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.	N/A
b. Does your State have the capability to restrict the beneficiary to:	
i. Prescriber only	Yes
ii. Pharmacy only	Yes
iii. Prescriber and Pharmacy	No
c. What is the usual lock-in time period?	Other
If "Other," please explain.	The Lock-In Program 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?	0.1100%
e. Please provide an estimate of the savings attributed to the lock-in program for the fiscal year under review.	$750.00

Question	Response
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)?	Refer to the appropriate Medical Board, Other, Deny claims written by this prescriber
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 (MIFU). 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 why not.	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, Other, Refer to Board of Pharmacy
If "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 will be a preliminary investigation. If findings merit 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 coordinate on the case. The OIG may also close and refer a case to a board/licensing body.
If "No," please explain why not.	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. FFS uses the same process to identify or report FWA of non-controlled drugs by providers or beneficiaries.
If "No," please explain why not.	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 "No," please explain.	Texas law does not permit Texas Medicaid Program to access the PDMP portal.
If "Yes," please continue. a. How does your State access the PDMP database (multiple responses allowed)?	N/A
If "Receive PDMP data" please indicate how often (multiple responses allowed).	N/A
If "Other," please explain.	N/A
If "Direct access to the database," please specify (multiple responses allowed).	N/A
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 contiguous States' PDMP information?	N/A

Question	Response
c. Does your State also have PDMP data integrated into your point of sale (POS) edits?	N/A
2. Have you communicated to prescribers who are covered providers that as of October 1, 2021, they are required to check the PDMP before prescribing controlled substances to beneficiaries who are covered individuals?	No
If "Not applicable," or "No," please explain.	The Agency did not send notification to the prescribers. The State Board of Pharmacy oversaw managing the regulation and published information regarding PDMP.
If "Yes," please check all that apply.	N/A
If "Other," please explain.	N/A
If "Yes," please continue. a. Has the State specified protocols for prescribers checking the PDMP?	N/A
If "Yes," please explain.	N/A
b. Do providers have protocols for responses to information from the PDMP that is contradictory to information that the practitioner expects to receive, based on information from the client (example: when a provider prescribing pain management medication finds medications for opioid use disorder (OUD) during a PDMP check, when client denies opioid use disorder)?	N/A
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?	N/A
If "No," please explain why not.	N/A
If "Yes," does your State require the provider to submit, upon request, documentation to the State?	N/A
If "No," please explain.	N/A

Question	Response
3. In the State's PDMP system, which of the following beneficiary information is available to prescribers as close to real-time as possible (multiple responses allowed)?	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, PDMP drug history
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
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 the prescription data is statutorily restricted. The information is available to practitioners and pharmacies who are inquiring about their own prescribing or dispensing history on their patients. State regulatory boards have access as well. A person who knowingly gives, permits or obtains unauthorized access to this information, is subject to criminal penalty.
4. Have any changes to your State's PDMP during this reporting period improved or detracted from the Medicaid program's ability to access PDMP data?	No
If "Yes," please explain.	N/A
5. 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
If "No," please explain why not.	N/A
If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue. If the answer to question 1 is "No," please skip to 1b. a. What is the maximum number of days allowed for an initial opioid prescription for an opioid naïve patient?	10
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
If "No," please explain.	The days' supply limit on the subsequent opioid prescriptions or refills will be based on the maximum quantity per prescription set in the claims system for each opioid product.
2. Does your State have POS edits in place to limit the quantity dispensed of opioids?	Yes
If "No," please explain why not.	N/A
If "Yes," please continue. a. 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 calculated at a 10-day supply limit and 90 MME level. The quantity for subsequent short-acting opioid (for non-native patient) will be based on the 90 MME per day levels and the maximum quantity for that NDC set in the claims system.

Question	Response
b. 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 only approved for subsequent prescribing or for non-native patients. The quantity limit would be based on the maximum quantity set in the claims system. However, the 90 MME per day limit will be applied.
3. 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, Require diagnosis, Step therapy or clinical criteria
If "Other," please specify.	N/A
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
4. 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
If "No," please explain why not.	N/A
5. Does your State have POS edits to monitor early refills of opioid prescriptions dispensed?	Yes, both POS edits and automated retrospective claims review process
If "No," please explain why not.	N/A

Question	Response
6. 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.	Texas conducts periodic retrospective claim review and interventions which include the criteria for opioid overutilization. Prescribers whose opioid prescribing appears to exceed the set parameters will be flagged. and will receive educational intervention letters. The criteria parameters may differ for members depending on the patient's disease condition. For example, those with diagnosis of cancer, sickle cell, or hospice and palliative care may be allowed to have access to more prescriptions and higher quantities.
If "No," please explain why not.	N/A
7. 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
If "Yes," 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-benzodiazepine combination as well as antipsychotics- opioid combination are conducted regularly.
If "No," please explain why not.	N/A
8. 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 "No," please explain why not.	N/A

Question	Response
9. 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 "No," please explain why not.	N/A
10. Does your State have POS safety edits or perform automated retrospective claims reviews and/or provider education regarding beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?	Yes
If "No," please explain why not.	N/A
If "Yes," check all that apply.	POS edits, Automated retrospective claims review, Provider education
If "Automated retrospective claim reviews" and/or "Yes, provider education," please indicate how often.	Other
If "Other," please specify.	The POS clinical PA criteria will reject claims for opioids if diagnosis of OUD is found. Also, the retro-DUR interventions on Opioids include performance indicators to target providers 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 regarding 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 why not.	N/A
11. 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

Question	Response
If "No," please explain why no guidelines are offered.	N/A
12. 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 (extended-release oxycodone) as a preferred agent.
If "No," please explain.	N/A
13. 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

Question	Response
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 claims system does a retrospective review to check for cumulative 90 MME level. The daily 90 MME level is applied to all opioids and is calculated for both initial therapies as well as subsequent therapies. For those who may require a daily dose tapering plan, provider may develop and manage patient-specific course of therapy. 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 disease, or hospice/palliative care are exempt from opioid criteria.
If "No," please explain why not.	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
If "No," please explain why not.	N/A
3. Does your State have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed?	Yes
If "No," please explain why not.	N/A
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 the 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 drugs PA will approve if the client is pregnant or is intolerant to naloxone. All MAT therapy drugs are given a preferred status on the PDL.
If "No," 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 drugs PA will approve if the client is pregnant or is intolerant to naloxone. All MAT therapy drugs are given a preferred status 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 "No," please explain why not.	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 monitor and manage appropriate use of naloxone to persons at risk of overdose?	Yes
If "No," please explain why not.	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 why not.	N/A
If "Yes," is a referral needed for OUD treatment through OTPs?	No

Question	Response
Please explain.	There are no prior authorizations or referrals required for Opioid Use Disorder (OUD) treatment.
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
4. Does your State Medicaid program cover Methadone for a substance use disorder (i.e., OTPs, Methadone Clinics)?	Yes
If "No," please explain why not.	N/A

G. Psychotropic Medication For Children

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 quantity limit on the antipsychotic prescriptions is based on the maximum quantity per claim set in the claims system. The clinical prior authorization limits the number of antipsychotics prescribed to 2 different antipsychotics (chemically different drugs) at any given time. Prior authorization is required for more than two antipsychotics prescribed concurrently.

Question	Response
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, Dosage, Indication, Polypharmacy
Specify child's age limit in years.	6
If "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 only for the FDA approved indications, such as autism. For antipsychotic therapy, 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 only given for insomnia, or for major depressive disorder treatment without concurrent antidepressant therapy.
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
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) formulations. Combination of an IR and an ER stimulant, as well as any combination of IR or ER stimulants with one or more non-stimulants are approved. For clients aged 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:	All children
If "Other," please explain.	N/A
b. Does your State have edits in place to monitor (multiple responses allowed):	Dosage, Indication, Polypharmacy
Specify child's age limit in years.	N/A
If "Other," please explain.	N/A
c. Please briefly explain the specifics of your documented antidepressant monitoring program(s).	At this time, the antidepressants are subject to the PDL prior authorization but there are no clinical prior authorizations criteria set up in the automated PA system. Texas FFS also conducts retro-DUR intervention on the topic of appropriate use of antidepressants for all age groups and will include performance indicators such as appropriate age, diagnosis, polypharmacy, etc. In the FFY 2022, Texas FFS did not conduct an intervention on this topic.
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:	All children
If "Other," please explain.	N/A
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.	Managing/monitoring is not specific to just for children. Antianxiety and sedatives are managed through claims edits such as 90% early refill threshold, Anxiolytics/Sedative and Hypnotics clinical prior authorizations, as well as retrospective DUR education intervention letters sent to the prescribers.
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/sedative/Hypnotics but not just for children.
c. Please briefly explain the specifics of your documented antianxiety/sedative monitoring program(s).	All the anxiolytic and sedative/hypnotics that are classified as controlled substances are subject to 90% refill threshold; benzodiazepines that are approved for epilepsy, or certain muscle disorders are exempt from this restriction. Refill claim will be denied if submitted prior to 90% of the previous claim's day supply. The clinical prior authorization criteria include age check, diagnosis check, and diagnosis of substance use disorder (SUD) safety check. The duration of PA for diagnosis of anxiety is short termed to give the providers the opportunity to reevaluate continued therapy.
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).	1. The antipsychotic prior authorization was automated in Texas Medicaid, fee-for-service and managed care. 2. In December 2021, Texas conducted a competitive procurement and issued a Request for Proposals (RFP) seeking a pharmaceutical manufacturer, through a Value Based Rebate Subscription Model, to provide an unlimited supply of one DAA medication to improve awareness, screening, diagnosis, and treatment of the Hepatitis C Virus for Texas Medicaid clients.

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
If "Partial, "please check what categories of medications are carved out and handled by your FFS program (multiple responses allowed):	N/A
If "Other," please specify the drug categories.	N/A
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 why not.	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 why not.	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 requirements for the MCOs pharmacy benefits: Single PDL Single Formulary POS clinical PA criteria must not be more stringent 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 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 by mailing the educational letters. The outcome reports for these interventions are submitted to the state for approval. 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 C.F.R. § 456, subpart K?	In addition to the assessment of their DUR programs during a Readiness Review and MCOs annual submission of 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 why not.	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 implements single formulary and PDL. Vendor Drug Program (VDP) is responsible for managing the out-patient pharmacy formulary for Medicaid and CHIP and some of the state-operated programs such as Children with Special Healthcare Needs (CSHCN) Program, The Healthy Texas Women Program, and Kidney Health Program. Managed Care Organizations (MCOs) are required to cover the same formulary for their Medicaid and CHIP members. In addition to formulary management, VDP maintains the Preferred Drug List (PDL) and Specialty Drug List (SDL). MCOs may ask their providers to send prescriptions from the SDL to the MCO's specialty pharmacy network. HHSC typically publishes the SDL in March and Sept which is intended for use by MCOs and their contracted PBMs. VDP publishes the preferred drug list (PDL) twice per year. The PDL therapeutic classes are reviewed by the Texas DUR Board. The Board holds four quarterly meetings each year and makes recommendations on the PDL drugs. The PDL review decisions from January and April are implemented in July and the decisions from July and October are implemented in January of the following year. PDL and criteria for PDL PAs are mandatory for all the MCOs. VDP also manages prospective clinical prior authorization criteria, and retrospective DUR intervention criteria and policies. VDP solicits the MCOs for the clinical PA criteria. The criteria proposals are submitted to the DUR Board for approval during the Board's regular meetings. Most of these PAs are not mandated for the MCOs and once approved by the Board, the MCOs and their PBMs may choose to implement as approved by the Board or a less stringent version. In FFY 2022, there were no significant changes to the PDL policies and therapeutic classes. Any COVID-19 pandemic related PDL exemptions were removed in Late summer in 2021 however, the program continued with removing non-preferred status in response to any drug shortages afterward. VDP also remained vigilant against any intersessional RSV outbreaks and granted access to prophylaxis therapy in any regions reported with an uptick in viral activity. The total estimated cost savings/cost avoidance reported

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	for FFY 2022 is associated with the PDL and clinical PA implementations and the retro-DUR interventions. In FFY 2022, the total cost saving was $7,894,678. Regarding Opioids over utilization and Opioid Use Disorder (OUD) therapies, VDP has implemented several prospective and retrospective DUR policies and criteria for managing prescriptions for opioids and psychotropic medications. These edits and interventions are intended to target overutilization, duplicative therapies, doctor/pharmacy shoppers, and medication treatment adherence. VDP continually uses innovative practices to improve and enhance access to care issues. Below are some instances: 1. The antipsychotic prior authorization was automated in Texas Medicaid, fee-for-service and managed care. 2. In December 2021, Texas conducted a competitive procurement and issued a Request for Proposals (RFP) seeking a pharmaceutical manufacturer, through a Value Based Rebate Subscription Model, to provide an unlimited supply of one DAA medication to improve awareness, screening, diagnosis, and treatment of the Hepatitis C Virus for Texas Medicaid clients.