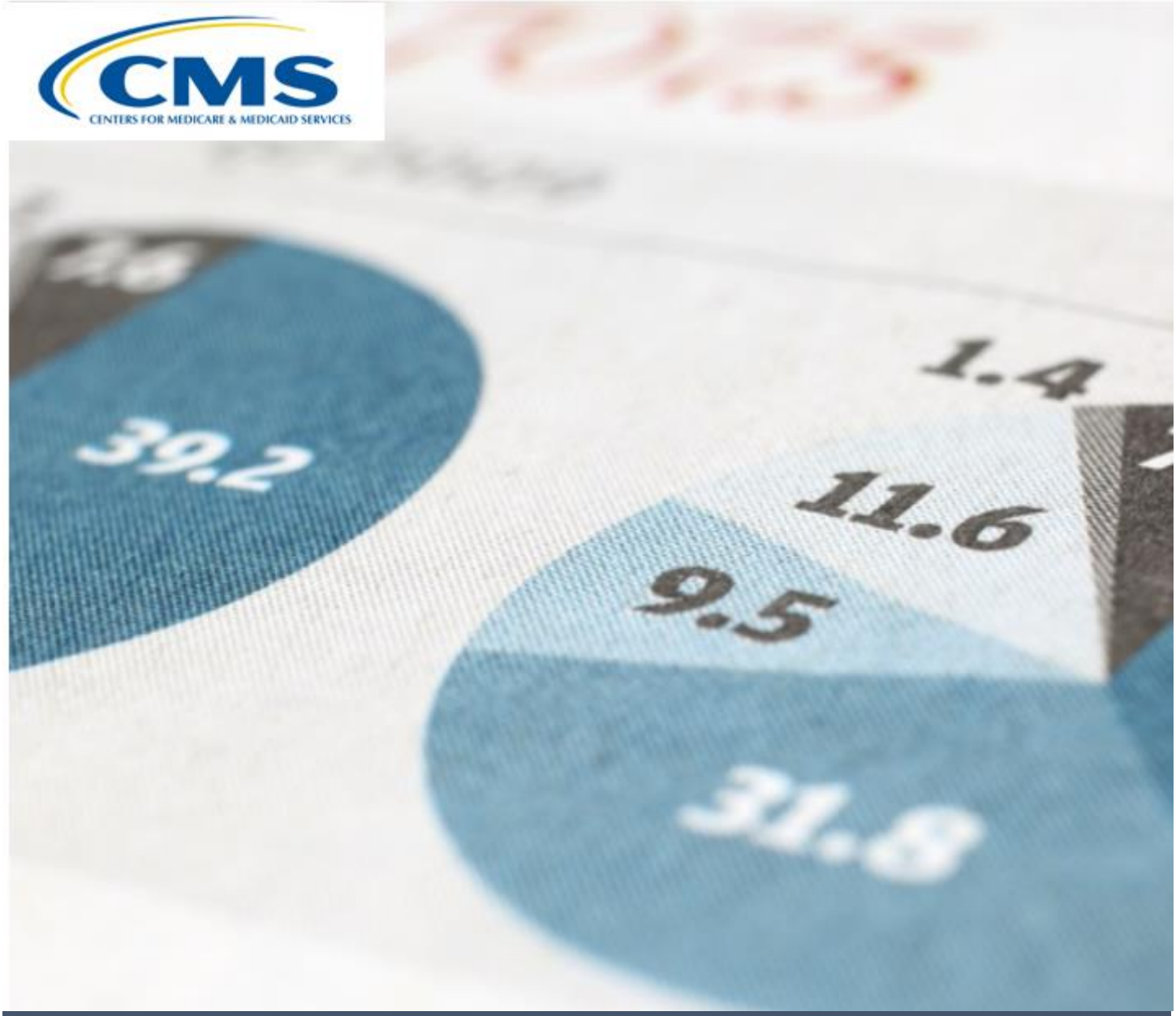

Delaware
Medicaid Fee-For-Service (FFS)
2019 Drug Utilization Review (DUR)

Table of Contents

Delaware DUR 2019 FFS Individual State Report

Section I – Number of Beneficiaries

Question	Response
1. On average, how many of your state's Medicaid beneficiaries are enrolled in your state's Medicaid Fee-For-Service (FFS) program that have a pharmacy benefit?	**35,500**
2. On average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)?	**199,877**

Section II - Prospective DUR (ProDUR)

Question	Response
1. Indicate the type of your pharmacy point of service (POS) vendor.	**Contractor**
a. Vendor Name	**DXC Technology**
b. If not state-operated, is the POS vendor also the MMIS fiscal agent or a separate PBM?	**POS vendor is the fiscal agent**
2. Identify ProDUR criteria source.	**First Databank**
If "Other," please specify	N/A
3. Are new ProDUR criteria approved by the DUR Board?	**Yes**
If "No," please explain	N/A
4. When the pharmacist receives a level-one ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service and resolution)?	**Yes**
If "varies," please explain	N/A
5. Do you receive and review follow-up reports providing individual pharmacy provider DUR alert override activity in summary and/or in detail?	**Yes**
a. If "Yes," how often do you receive reports?	**Monthly**
If "Other," please explain	N/A

Question	Response
b. If you receive reports, do you follow up with those providers who routinely override with interventions?	**Yes**
If "Yes," by what method do you follow up?	Contact Pharmacy
If "Other," please explain.	N/A
If "No," please explain	N/A
If "No," please explain	N/A
6. Early Refill	
a. At what percent threshold do you set your system to edit?	
i) Non-controlled drugs:	**83%**
ii) Schedule II controlled drugs:	**90%**
iii) Schedule III through V controlled drugs:	**90%**
b. For non-controlled drugs: When an early refill message occurs, does the state require prior authorization?	**Yes**
If "Yes" or "Dependent on medication or situation," who obtains authorization?	Pharmacist or Prescriber
If "No," can the pharmacist override at the point of service?	N/A
c. For controlled drugs: When an early refill message occurs, does the state require prior authorization?	**Yes**
If "Yes," who obtains authorization?	Pharmacist or Prescriber
If "No," can the pharmacist override at the point of service?	N/A
7. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your state's policy allow the pharmacist to override for situations such as:	
a. Lost/stolen Rx	**No**
b. Vacation	**No**
c. "Other," please explain.	**Overrides by pharmacist are allowed for changes in direction with a prior authorization or entry of Submission Clarification code of 5.**
8. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?	**Yes**
If "Yes," please explain your edit.	Delaware posts an audit on claims If the accumulative refills are greater than 4 in 120 days post the audit. Early refill date: From

Question	Response
	date of service plus (days' supply 83% for non-controls and 90% for controls)
If "No," do you plan to implement this edit?	N/A
9. Does the state Medicaid agency or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS (i.e. must obtain beneficiary's consent prior to enrolling in the auto-refill program)?	**Yes**
10. Does the state Medicaid agency have any policy that provides for the synchronization of prescription refills (i.e. if the patient wants and pharmacy provider permits the patient to obtain non-controlled, chronic medication refills at the same time, the state would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?	**No**
11. For drugs not on your formulary, does your agency have a documented process (i.e. prior authorization) in place, so that the Medicaid beneficiary or the Medicaid beneficiary's prescriber may access any covered outpatient drug when medically necessary?	**Yes**
If "Yes," what is the preauthorization process?	Drugs not listed on our formulary require prior authorization. In those cases, the provider will submit a prior authorization through our portal, fax, or telephone. Upon receipt of the prior authorization, the Pharmacist will consider available drug information such as the FDA package insert, clinical trials, other available therapies, as well as patient need, history, and appropriateness in determining coverage status for that specific patient.If the request is for a multisource drug, use of the generic version is required, or a Med Watch form showing a contraindication to generic would need to be provided. Medicaid has a universal form for non- formulary related denials to address cost threshold, quantity limitation, and nonspecific prior authorization denials.
If "No," please explain why there is not a process for the beneficiary to access a covered outpatient drug when it is medically necessary.	N/A

Question	Response
a. Does your program provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation?	**Yes**
If "Yes," what is the process?	Pharmacy manual allows a Pharmacist to dispense a 72 hours supply or 10 units with guarantee of payment. A look back of 120 days is required to establish a new start. Pharmacy submits the claim for less than or equal to 72-hour supply.
If "No," please explain.	N/A
12. Please list the requested data in each category in *Table 1 - Top Drug Claims Data Reviewed by the DUR Board* that follows	

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

Top 10 Prior Authorization (PA) Requests by Drug Name	Top 10 Prior Authorization (PA) Requests by Drug Class	Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications and Age Edits)	Top 10 Drug Names by Amount Paid	% of Total Spent for Drugs by Amount Paid (From data in Column 4, Determine the % of total drug spend)	Top 10 Drug Names by Claim Count	Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)
Lantus Solostar 100 u/ml	Insulins	Claim failed a ProDUR alert	Genvoya	3.21%	Docusate 100 MG Capsule	2.02%
Levemir Flextouch	Anticonvulsants	Member services covered by MCO plan	Mavyret 100-40 MG Tablet	3.04%	Loratadine 10 MG Tablet	1.93%
Novolog 100 Unit/ML Flexpen	Adrenergics, aromatic, non-catecholamine	Drug covered by medicare D - FFS	Biktarvy 50-200-25 MG Tablet	2.64%	Cetirizine 10 MG Tablet	1.57%
Humalog 100un/ml Kwikpen	Opioid analgesics	Member not eligible	Vivitrol 380 MG	2.30%	Daily Multivitamin Tablets	1.44%
Omeprazole Delayed Release 40 MG Capsule	Antipsychotics - Atypical	Members benefit package does not include this med	Revlimid 25 MG Capsule	2.03%	Vitamin D3 Oral 1000 IU Tablet	1.30%
Dextroamphetamine/Amphetamine ER 30 MG Capsule 24H	Direct factor XA inhibitors		Lantus Solarstar 100 UNIT/ML	1.81%	Albuterol HFA Inhalalation 90 MCG	1.26%
Dextroamphetamine/Amphetamine 30 MG Tablet	Proton pump inhibitors		Novolog 100 UNIT/ML Flexpen	1.65%	Polyethylene Glyclol 3350 Powder	1.14%
Xarelto 20 MG Tablet	Anticonvulsants-Benzodiazepine Type		Banzel 400 MG Tablet	1.60%	Aspirin 81 MG Tablet	1.07%

Top 10 Prior Authorization (PA) Requests by Drug Name	Top 10 Prior Authorization (PA) Requests by Drug Class	Top 5 Claim Denial Reasons Other Than Eligibility (i.e. Quantity Limits, Early Refill, PA, Therapeutic Duplications and Age Edits)	Top 10 Drug Names by Amount Paid	% of Total Spent for Drugs by Amount Paid (From data in Column 4, Determine the % of total drug spend)	Top 10 Drug Names by Claim Count	Drugs by Claim Count % of Total Claims (From data in Column 6, Determine the % of total claims)
Oxycodone/Acetaminophen 10-325 MG Tablet	Opioid withdrawal therapy agents, opioid-type		Humalog 100 UNIT/ML Kwikpen	1.53%	Fluticasone Proprionate Nasal 50 MCCG Spray	1.04%
Eliquis 5 MG Tablet	Anti-anxiety-benzodiazepines		Triumeq 600-50-300 MG Tablet	1.40%	Omeprazole 40 MG Capsule	0.86%

Question	Response
13. Section 1927(g)(A) of the Social Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in your state has responsibility for monitoring compliance with the oral counseling requirement? Check all that apply:	**State Board of Pharmacy**
If "Other," please explain:	N/A
14. Summary 1 – Pharmacy Oral Counseling Compliance Summary 1 Pharmacy Oral Counseling Compliance reports the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid Agency, the State Board of Pharmacy, or other entity responsible for monitoring pharmacy activities. If the State Medicaid Agency itself monitors compliance with these requirements, it may provide a survey of a random sample of pharmacies with regard to compliance with the Omnibus Budget Reduction Act (OBRA) of 1990 prospective DUR requirement. This report details state efforts to monitor pharmacy compliance with the oral counseling requirement and should describe in detail, utilizing the text box below, the monitoring efforts that were performed and how effective these efforts were in the fiscal year reported.	**In Delaware, enforcement of the oral counseling requirement has been overseen by the state Board of Pharmacy. The oral requirement to counsel is on all prescriptions dispensed in Delaware. The state Board of Pharmacy performs this check. The rules and definitions that surround patient counseling in Delaware are available via the following link http://regulations.delaware.gov/AdminCode/title24/2500.shtml. The Division of Medicaid and Medical Assistance team does not perform random audits on the oral counseling. Audits have been performed on signature logs for dispensing. These logs serve a dual purpose not only for a dispensing record, but for the offer to counsel. Delaware Medicaid has a working relationship with the Board of Pharmacy where concerns that arise from our investigations can be reported and further reviewed for disciplinary action.**

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.	**DXC Technology**
b. Is the RetroDUR vendor also the MMIS fiscal agent?	**Yes**
c. Is the RetroDUR vendor also the developer/supplier of your retrospective DUR criteria?	**Yes**
If "No," please explain	N/A
2. Who reviews and approves the RetroDUR criteria?	**State DUR Board**
"Other," please explain	N/A
3. Summary 2 – Retrospective DUR Educational Outreach Summary 2 Retrospective DUR Educational Outreach is a year-end summary report on RetroDUR screening and educational interventions. The year-end summary should be limited to the most prominent 10 problems with the largest number of exceptions. The results of RetroDUR screening and interventions should be included and detailed.	**For FFY 2019, Delaware Medicaid continued to operate under a Medicaid Management Information System (MMIS) and third-party vendor contracts. Delaware designed an improved electronic drug utilization review process and a concurrent review functionality that accounts for both pharmacy and medical claim types in the drug utilization review process for the Fee for Service (FFS) program. This continues to benefit the providers of the program by providing a holistic view of drug utilization issues.** **Retrospective DUR is frequently used as a means of reviewing potential interventions and providing provider outreach to improve outcomes. For example, a review of Therapeutic Duplication (TD) errors was used to identify patients receiving duplication of therapy within the laxative drug class in long term and assisted living facilities. This commonly occurs due to patients seeing multiple providers who are not aware of the patient's other medications. The providers that were identified received targeted outreach with the goal of improving client care, reducing pill burden and preventing unnecessary expenditures for the State**

	In FFY 2019, top ten alerts selected for review was from alert category from in high dose (HD), therapeutic duplication (TD), drug - disease (MC), based on DUR boards primary focus on Mental health and long -term care medication management aligned with clinical recommendation. **Therapeutic duplication in the following drug classes Laxative and Cathartics (client taking greater than two different drugs with different mechanism of action), Atypical antipsychotics (review of profiles with duplicate agents, dose titration, use of submission clarification code 5 to bypass TD edit) , Insulins (category in top 10 drug expenditure by state, re view of claims optimal formulation) and Selective Serotonin reuptake inhibitors (SSRI).** **High dose alerts selected for intervention in drug class categories, Aniticonvulsants, SSRIs, Atypical antipsychotics aligned with FDA approved dosing by indication, and age.** **Drug disease reported contraindication in Anticonvulsants, Antipsychotics, SSRIs and Cardiovascular therapeutic categories. Identifying client with contraindicated diagnosis obtained from client disease profile, based on severity provider is sent an alert.** **Provider education topics from reviewing retrospective claims intervention alerts and promote better health outcomes. For example, a review of Therapeutic Duplication (TD) errors was used to identify patients receiving duplication of therapy within the laxative drug class in long term and assisted living facilities. This commonly occurs due to patients seeing multiple providers who are not aware of the patient's other medications. The providers that were identified received targeted outreach with the goal of improving client care, reducing pill burden and preventing unnecessary expenditures for the State.** **TD alerts within the antipsychotic drug class, led to targeted outreach to providers, educating providers on frequent medication review, and integration of non-pharmacological counseling to achieve better health outcomes. Additionally, allowed the**

	state to facilitate provider engagement to promote mental health care, increased patient compliance with therapy, and optimize financial outcomes. Due to the nature of the condition being treated, clients on antipsychotics are often prescribed successive agents and even strengths within the same drug to find the best treatment option. **Another method through which Delaware performs RetroDUR to improve client health and fiscal responsibility is through Pharmacy provider outreach using blast faxes to registered pharmacies, bulletins to providers, and notifications on Healthcare Portal. For example, Alprazolam due to abuse potency, and dependence concerns from chronic use, was changed to a non-preferred requiring Prior authorization. A survey from Department of public health, found accidental overdose deaths had a mixture of Opioids, benzodiazepines and other synthetics agents. To drive awareness, Delaware prospectively and retrospectively communicated to our providers the rationale behind the decision and necessary information such as options for transitioning their patients to less risky agents, conversion off these medications with no qualifying diagnosis.** **In FFY 2019, Delaware continued to closely monitor and provide outreach to assist in educating providers on safe opioid prescribing. For example, auto-generated letters were sent to 28 providers in FFY 2019 when their patient reached the threshold of greater than 90 MME. The numbers of providers targeted represent a significant decrease from previous FFY 2018 and indicates an overall reduction of patients receiving high total daily doses of morphine milliequivalents.**

Section IV - DUR BOARD ACTIVITY

Question	Response
1. Summary 3 – DUR Board Activities Report. Summary 3 DUR Board Activities Report should be a brief descriptive report on DUR Board activities during the fiscal year reported.	**During the Federal Fiscal Year 2019, Delaware continued to have combined DUR and the Pharmacy and Therapeutic (P&T) committee meetings. By having one cohesive board, Delaware facilitates broad ranging discussions on drug utilization, drug coverage policies and feedback from the community. The Board's executive sessions focus on financial issues with open dialogue between all members. The annual DUR/P&T Meeting occurred September 19, 2019. Both managed care organizations' pharmacy directors, which represent 85% of the Medicaid population in Delaware, participated in the DUR/P&T committee meeting.** **During the FFY 2019 the board met 3 times. Members are non-paid volunteers who often also serve in several different capacities for multiple professional organizations, so scheduling conflicts do occur. When scheduling conflicts occur and board members were not present for the meetings, they were contacted both prior and post meeting for feedback on the topics presented.** **Delaware protects our clients by implementing software DUR warnings directly into our system from our drug database vendor, FDB. We balance the need for alerting providers with important warnings on medications while attempting to prevent warning overload and the increased likelihood such alerts will be disregarded. With that balance in mind we directly adopt all severity warnings 1 (major) and 2 (moderate) into our system.** **The following are several areas where new warnings have been adopted:** **Drug Drug interactions:** **Providing appropriate warnings to providers for the many novel antineoplastic agents that were released in FFY 2019 was one area of particular importance. Although these agents provide hope for better patient**

Question	Response
	outcomes, many providers may not be informed of risks associated with various drug interactions. For example, providers will receive alerts on claims for Lobrena when the client is on a concurrent CYP3A4 inhibitor or inducer. **Agents to treat multiple sclerosis was another class that saw a surge in novel therapies during FFY 2019. Again, the newness of the agents and their unique mechanisms of action could potentially place clients in danger due to provider lack of familiarity. For example, claims for Mayzent will also be flagged for providers in cases where the client is on a concurrent CYP3A4 inhibitor or inducer.** **Drug Pregnancy warnings:** **These warnings are one of the most important tools we utilize in Delaware to ensure the safety of this group of our clients. While providers may be aware of classic medications to avoid in pregnancy, the risk of novel medications inadvertently being provided to our pregnant clients is avoided by the direct implementation of drug-pregnancy severity 1 and 2 warnings from the FDB files. An example that best highlights this situation are the new tetracycline antibiotics Xerava, Nuzyra, and Seysara. While pharmacists will know to avoid doxycycline in pregnant patients, they may not even know that Nuzyra is in the tetracycline class and carries the identical risk** **Additionally, since the board had previously decided to change Alprazolam to a non-preferred status on February 1, 2019, this topic was revisited at the September 2019 meeting. It was reported that there had been very little provider or member negative experience from this change. Members who were previously identified as using alprazolam were grandfathered to continue use until appropriate replacement therapy could be identified and implemented. A subsequent review of the Prescription**

Question	Response
	Monitoring Program also saw very little increase in cash payment for alprazolam during the month of February despite the change to non-preferred. Additionally, the claims data for alprazolam for the year was reviewed by the Board at the annual P &T meeting, and a decrease in the overall number of alprazolam claims was noted. **Building on this success, the DUR board further discussed of requiring a diagnosis code for all benzodiazepines and a list of valid appropriate codes was distributed to the advisory committee for their input. Fee for service claims can be monitored for diagnosis codes for claims analysis purposes but claims without a code will not currently deny avoiding creating a barrier to patient access. Therapeutic duplications in this class are being reviewed for all clients.**
2. Does your state have an approved Medication Therapy Management Program?	**No**
a. Have you performed an analysis of the program's effectiveness?	**N/A**
"Yes," please provide a brief summary of your findings.	N/A
b. Is your DUR Board involved with this program?	**N/A**
If the answer to question 2 is "No," are you planning to develop and implement a program?	No

Section V - PHYSICIAN ADMINISTERED DRUGS

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

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

Section VI - GENERIC POLICY AND UTILIZATION DATA

Question	Response
1. Summary 4 – Generic Drug Substitution Policies Summary 4 Generic Drug Substitution Policies summarizes factors that could affect your generic utilization percentage. Please explain and provide details.	**In federal fiscal year 2019, DMMA policy goals encourage generic usage unless there is a price guarantee offered by the labeler, regardless of the federal rebate, to lessen the cost burden on the MCOs and to be more supportive of generic substitution.** **Previously, when the net price of the brand product was more cost effective, DMMA selected the brand as preferred. In general, we limit brand multi-sourced products as preferred in Delaware, however there are a few drug classes where it has been deemed necessary. In these cases, prescribers are made aware of these drugs by the brand name product being listed as preferred on the PDL and the type being bolded to notate the brand name is preferred over the generic. Delaware utilizes NADAC pricing.** **Delaware Medicaid continues to mandate generic dispensing on all drug categories except for members with a seizure diagnosis and drugs deemed to be narrow therapeutic index medications. All other instances of brand name dispensing when generics are available require prior authorization. For members with a seizure diagnosis, the provider includes the diagnosis on the prescription and the pharmacy submits the diagnosis code in the corresponding NCPDP field which will override the need for any paper prior authorization to be submitted. Our state law requires that a doctor must write Brand Medically Necessary on the face of prescriptions for brand name but Medicaid takes additional steps to ensure the medical necessity of a brand name dispensing. If a patient requests brand and the pharmacy submits a DAW code of two, this code is automatically rejected in our point of sale system.** **Delaware also continues to mandate that a Med Watch form be submitted as the prior authorization for brand name multi-sourced medications. First and foremost, Med Watch forms are detailed descriptions of the generic**

Question	Response
	product failed and the type of failure that occur. Using this form means that a generic must be tried prior to the request for a brand name product. A minimum of a two-week trial period is required unless an objective adverse event occurs that necessitates the medication being stopped. The Med Watch form must be completely filled out with the National Drug Code (NDC) and lot number. Along with this required information, the physician must document a valid side effect or lack of efficacy that occurred with the member utilizing a generic. The majority of Med Watch forms submitted to Delaware Medicaid do not meet our criterion as they lack information, have too short of a trial period, or listed symptoms that cannot be linked to the generic product itself. Delaware has had this policy requiring the Med Watch form to deter brand name dispensing of multi-source drugs for many years and continues to find it to be effective in decreasing unnecessary and costly use of brand name products
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 is required
Other, please explain.	N/A

Table 2 - Generic Drug Utilization Data

	Single Source (S) Drugs	Non-Innovator (N) Drugs	Innovator Multi-Source (I) Drugs
Total Number of Claims	8,609	87,248	5,709
Total Reimbursement Amount Less Co-Pay	$3,892,702	$1,554,719	$848,886

Question	Response
3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in Table 2 – Generic Drug Utilization Data.	
Number of Generic Claims	87,248
Total Number of Claims	101,566
Generic Utilization Percentage	85.90%
4. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period using the computation instructions in Table 2 - Generic Drug Utilization Data.	
Generic Dollars	$1,554,719
Total Dollars	$6,296,306
Generic Expenditure Percentage	24.69%

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

	Data
ProDUR Total Estimated Avoided Costs	$949,535.00
RetroDUR Total Estimated Avoided Costs	$0.00
Other Cost Avoidance	$192,144.00
Grand Total Estimated Avoided Costs	$1,141,679.00

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 4, then multiplying this value by 100. Estimated Percent Impact	**18.13%**
4. Summary 5 – Cost Savings/Cost Avoidance Methodology Summary 5 Cost Savings/Cost Avoidance Methodology includes program evaluations/cost savings estimates prepared by state or contractor.	**Delaware has continued to take a conservative approach in estimating our cost savings due to pro-DUR. While early refill denials could be considered, we have always deemed these savings to be more of cost deferral rather than cost avoidance. The refill percentage in Delaware is set at and for prior authorization claims we even tighten this percentage more by the date range and quantity for which the drug is approved. The two edits that Delaware uses to calculate cost savings are therapeutic duplication and dose optimization. The list of medications that hit for these two edits are extensive and have produced cost savings on the unnecessary dispensation of additional products or additional units of medication.** **Fee for service compromises about 15% of the Medicaid population, of which approximately a quarter of that population transitions to an MCO administered benefit. The tracked and reported savings for therapeutic duplication and dose optimization appears slightly higher than last year's result. At point of sale, therapeutic duplication within classes is the best way to proactively prevent duplicate therapy and unnecessary expenditures. In federal fiscal year 2019, the estimated therapeutic duplication alerts for FFS deferred the dispensing of 7,737 units with an estimated savings of $949,535 .** **Delaware has a long-standing history of maximizing dose optimization since its implementation in February 2005. Setting optimal dose edits ensures that the member receives a dose that maximizes compliance and therapeutic appropriateness, and as a result, decreases expenditures for the state**

	by dispensing the minimum units and beneficial healthcare outcomes which drive future cost savings. One current trend that continues to be identified in Delaware by the dose optimization audit are those healthcare providers who prescribe an FDA approved drug for once daily dosing to be dosed multiple times per day. Research has continued to indicate that there is no benefit from more than once daily dosing. For FFY 2019, of the FFS claims that dispositioned by edit quantity units billed outside the limits, the drug class of proton pump inhibitors were the predominant result. **Utilizing dose optimization produces savings and does not sacrifice level of member care; in fact, dose optimization reduces the dosing frequency or number of units taken; therefore, improving patient compliance. Even for products that are indicated with a dosing range such as once to twice daily, Delaware utilized the once daily regimen first and needs to see failure before twice daily dosing would be considered for approval. It is estimated during federal fiscal year 2019, Delaware's dose optimization edits prevented over 42,729 units of medication from being dispensed resulting in an estimated savings of $192,144. Delaware continues to review each drug as it enters the market and add it to the dose optimization list when appropriate**

Section VIII - FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTION PROGRAMS

Question	Response
1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Deny claims and require prior authorization, Refer to Lock-In Program, Refer to Program Integrity Unit/Surveillance Utilization Review (SURS unit)

Question	Response
"Other," Please explain	N/A
2. Do you have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances? If the answer to question 2 is "Yes," please continue	**Yes**
a. What criteria does your state use to identify candidates for Lock-In? Check all that apply:	**Number of controlled substances (CS), Different prescribers of CS, Multiple pharmacies, Number days' supply of CS, Exclusivity of short acting opioids**
"Other," please explain	N/A
b. Do you have the capability to restrict the beneficiary to:	
i. Prescriber only	**Yes**
ii. Pharmacy only	**Yes**
iii. Prescriber and Pharmacy	**Yes**
c. What is the usual Lock-In time period?	**Other**
"Other," please explain	Lock in period does not have an end date but can be reviewed at the member's request
d. On average, what percentage of the FFS population is in Lock-In status annually?	**0.1000%**
e. Please provide an estimate of the savings attributed to the Lock-In program for the fiscal year under review as part of Attachment 5.	**$0.00**
3. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Refer to Program Integrity Unit, Refer to the appropriate Medical Board
"Other," please explain	N/A
"No," please explain	N/A
4. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by pharmacy providers?	**Yes**
If "Yes," what actions does this process initiate? Check all that apply:	Refer to Program Integrity Unit, Refer to Board of Pharmacy
"Other," please explain	N/A
"No," please explain	N/A

Question	Response
5. Do you have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by beneficiaries?	**No**
"Yes," please explain your program for fraud, waste, or abuse of non-controlled substances.	N/A
"No," please explain	**Polypharmacy and multiple provider.**

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

Question	Response
1. Does your state have a Prescription Drug Monitoring Program (PDMP)? If the answer to question 1 is "Yes," please continue with a, b, and c.	**Yes**
a. Does your agency have the ability to query the state's PDMP database? If the answer to sub-question 1 a is "Yes," please continue.	**No**
i. Please explain how the state applies this information to control fraud and abuse.	N/A
ii. Do you also have access to Border States' PDMP information?	N/A
iii. Do you also have PDMP data (i.e. outside of MMIS, such as a controlled substance that was paid for by using cash) integrated into your POS edits?	N/A
b. Do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing controlled substances?	**Yes**
c. Are there barriers that hinder the agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?	**Yes**
"Yes," please explain the barriers (i.e. lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).	The barrier in Delaware is there is no direct access by the Medicaid agency to the PDMP, all requests must go through PDMP agency.
2. Have you had any changes to your state's Prescription Drug Monitoring Program during this reporting period that have improved the agency's ability to access PDMP data?	**No**
"Yes," please explain.	N/A

C. PAIN MANAGEMENT CONTROLS

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

D. OPIOIDS

Question	Response
1. Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription? If the answer to question 1 is "Yes, for all opioids" or "Yes, for some opioids," please continue.	**Yes, for some opioids**
Please explain answer above.	A long-acting opioid analgesic. Initial fills of all long-acting narcotics will be limited to a 15-day supply. The first fill of a short-acting opioid prescription cannot exceed a 7-day supply.
a. Is there more than one quantity limit for the various opioids?	**Yes**

Question	Response
"Yes," please explain	DMMA limits the quantity allowed based on day supply, MME per day, as well as a global number of units per year. For example, oxycodone 15, 20, and 30MG have monthly, quarterly and yearly limits in place. All short acting opioids require an initial 7-day fill. All long acting opioids require a prior authorization
b. What is the maximum number of days' supply allowed for an initial opioid prescription?	**7**
c. Does this days' supply limit apply to opioid prescriptions?	**Yes, for some opioids**
"No," please explain	N/A
2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?	**Yes**
If "Yes," what is your maximum days' supply per prescription limitation?	30 day supply
"Other," please explain	N/A
If "No," please explain	N/A
3. Do you currently have POS edits in place to limit the quantity dispensed of long-acting opioids?	**Yes**
If "Yes," what is your maximum days' supply per prescription limitation?	Other
"Other," please explain	Total dose of opioid cannot exceed 90mg MME per 24 hours. Total quantity dispensed limits in place based on units per day, units per month and units per year.
If "No," please explain	N/A
4. Do you have measures other than restricted quantities and days' supply in place to either monitor or manage the prescribing of opioids?	**Yes**
If "Yes," check all that apply:	Deny claim and require PA, Intervention letters, Morphine Milligram Equivalent (MME) daily dose program, Step therapy or clinical criteria, Requirement that patient has a pain management contract or Patient-Provider agreement, Requirement that prescriber has an opioid treatment plan for patients, Require documentation of urine drug screening results, Require diagnosis
Please provide details on these opioid prescribing controls in place.	Prior Authorization criteria contain the following question, verification of prescribing profile using PDMP. Verification of first line drug therapies used controlled an d non

Question	Response
	controlled based on diagnosis provided. Pain assessment and contract certification.
If "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.	N/A
5. Do you have POS edits to monitor duplicate therapy of opioid prescriptions?	**Yes**
Please explain	Duplicate claims are identified by comparing drug in history to current having the same generic sequence number, in same therapeutic class with overlapping day supply. Claim is flagged for Pharmacy verification, a prior authorization is required to override or use of submission clarification code of 5 for therapeutic change by prescriber.
6. Do you have POS edits to monitor early refills of opioid prescriptions dispensed?	**Yes**
Please explain	Early refill opioid claims denied if less than 90% day supply is calculated.
7. Do you have comprehensive claims review automated retrospective process to monitor opioid prescriptions exceeding these state limitations?	**No**
Please explain	Claims denied and overridden are flagged for review, for potential prescriber score card report generation, and provider education. The population mix of predominately with other insurance and Medicaid as secondary posse a challenge to enforcement of policies. Individual provider outreach is done to educate providers when patient's dose exceeds state limits
8. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and benzodiazepines being used concurrently?	**Yes, POS edits only**
If "Yes," Please explain in detail scope and nature of reviews and edits.	Prior authorization for all long acting and high dose opiates can only be approved if the member is not receiving a benzodiazepine. With exception of certain diagnosis such as Seizures disorder.
If "No," Please explain	N/A

Question	Response
9. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and sedatives being used concurrently?	**No**
If "Yes," Please explain in detail scope and nature of reviews and edits.	**N/A**
If "No," Please explain	**State send clinical severity level alerts of High and medium to pharmacies to avoid Alert fatigue as recommended by Provider feedback. Based on adverse code of minor these combinations did not set alerts on this combination to avoid alert fatigue in the pharmacies.**
10. Do you currently have POS edits in place or a retrospective claims review to monitor opioids and antipsychotics being used concurrently?	**Yes, POS edits only**
If "Yes," Please explain in detail scope and nature of reviews and edits.	There are prospective drug clinical alerts that must be addressed and overridden at the pharmacy to allow the fill. Based on adverse code of minor these combinations did not set alerts on this combination to avoid alert fatigue in the pharmacies.
If "No," Please explain	N/A
11. Do you have POS safety edits or perform RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?	**No**
If "Yes," retrospective reviews are performed, please indicate how often.	N/A
"Other," please specify.	N/A
Please explain nature and scope of edits, reviews and/or provider education reviews performed.	N/A
If "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?	Yes
If "No," Please explain.	There are ongoing Statewide collaborative between department of Public Health (DPH) and Substance Abuse and Mental Health (DSAMH) to develop ways of data transfer of system alerts of Opioid Use Disorder (OUD), outreach and intervention alert mechanism for referral to specialized care.

Question	Response
12. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?	**Yes**
If "Yes," please check all that apply	Your state Medicaid agency refers prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain.
Please identify the "other" guidelines.	N/A
Please explain why no guidelines are offered.	N/A
13. Do you have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?	**Yes**
"Yes," please explain	Abuse deterrent medications do require prior authorization, as all long acting opioids. When a provider wishes to utilize an abuse-deterrent opioid agent, the prior authorization request will go through the review process and would be approved in appropriate cases.

E. MORPHINE MILLIGRAM EQUIVALENT (MME) DAILY DOSE

Question	Response
1. Have you set recommended maximum MME daily dose measures?	**Yes**
If "Yes," please continue	
a. What is your maximum morphine equivalent daily dose limit in milligrams?	**90 MME mg per day**
i. If "Other", please specify	**N/A mg per day**
b. Please explain nature and scope of dose limit.	**Delaware follows the most recent CDC recommendations. When the dose is above the current recommended dose, physicians receive written notification in order to reduce patient risk by encouraging re-evaluation of the necessity of the higher dose. The 90 MME limit is also part of the clinical criteria for approval of PA. The 90 MME limit has been in place since July 1, 2018, however Delaware would further re-evaluate this limit if new recommendations for lower doses are released.**
If "No," please explain the measure or program you utilize.	**N/A**

Question	Response
2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?	**No**
a. If "Yes," Please name the developer of the calculator:	**N/A**
If "Other," please specify	N/A
b. If "Yes," how is the information disseminated? Check all that apply:	**N/A**
If "Other," please explain	N/A
3. Do you have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?	**Yes**
If "Yes," do you require prior authorization if the MME limit is exceeded?	Yes
4. Do you have automated retrospective claim reviews to monitor total daily dose (MME) of opioid prescriptions dispensed?	**Yes**
Please explain	Automated high dose edit, overuse alert is set on claim to dispensing Pharmacies on targeted narcotics medications, identified through manual MME calculation.

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

Question	Response
1. Does your agency set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?	**Yes**
If "Yes," please specify the total mg/day:	24 mg
If "Other," please explain	N/A
2. What are your limitations on the allowable length of this treatment?	**No limit**
If "Other," please explain	N/A
3. Do you require that the maximum mg per day allowable be reduced after a set period of time? If "Yes," please continue	**No**
a. What is your reduced (maintenance) dosage?	**N/A**
If "Other," please explain	N/A

Question	Response
b. What are your limitations on the allowable length of the reduced dosage treatment?	**N/A**
If "Other," please explain	N/A
4. Do you have at least one buprenorphine/naloxone combination product available without prior authorization?	**Yes**
5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug or any form of MAT?	**No**
"Other," please explain	N/A
If "Yes," can the POS pharmacist override the edit?	N/A
6. Do you have at least one naloxone opioid overdose product available without prior authorization?	**Yes**
7. Do you retrospectively monitor and manage appropriate use of naloxone to persons at risk of overdose?	**Yes**
Please explain	Naloxone is dispensed at no cost to patient, no copayment and can be prescribed at the discretion of the Pharmacist based on total daily dose of 90MME or greater. Retrospective analysis of claims is reviewed for over dispensing by provider time.
8. Does your State Board of Professional Regulations/Board of Pharmacy/Board of Medicine and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?	**Yes, State Board of Professional Regulations/Board of Pharmacy/ Board of Medicine and/or State Medicaid agency under protocol**
9. Does your state agency cover methadone for a substance use disorder (i.e. Methadone Treatment Center)?	**Yes**

G. ANTIPSYCHOTICS / STIMULANTS

ANTIPSYCHOTICS

Question	Response
1. Do you currently have restrictions in place to limit the quantity of antipsychotics?	**Yes**

Question	Response
Please explain	Prior authorization is required if the drug is not FDA approved for the child's age. Claims for doses above normal limits will reject and require prior authorization. We also edit for Therapeutic duplication.
2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children?	**Yes**
a. If "Yes," do you either manage or monitor:	**All children**
"Other," please explain	N/A
b. If "Yes," do you have edits in place to monitor (check all that apply):	**Child's age, Dosage**
"Other" Please explain	N/A
c. Please briefly explain the specifics of your antipsychotic monitoring program(s).	**Delaware monitor all children but in addition we do targeted intervention in the foster care population. Ages on the atypical antipsychotic agents are set to the FDA approved indications. Synergy is also achieved in Delaware by the Department of Family Services working with Medicaid on foster children to reduce unnecessary therapies. Doses are edited based on FDA approved doses.**
d. If "No," do you plan on implementing a program in the future?	**N/A**
If "Yes," when do you plan on implementing a program?	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.	N/A

STIMULANTS

Question	Response
3. Do you currently have restrictions in place to limit the quantity of stimulants?	**Yes**
4. Do you have a documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?	**Yes**
a. If "Yes," Do you either manage or monitor:	**All children**
"Other," please explain	N/A
b. If "Yes," Do you have edits in place to monitor (check all that apply):	**Child's age, Dosage**
"Other," please explain	N/A

Question	Response
c. Please briefly explain the specifics of your documented stimulant monitoring program(s).	**Ages on stimulant agents are set to the FDA approved indications. Doses are edited based on FDA approved doses and Pro-DUR edits are in place to monitor for therapeutic duplication within the stimulant class of medications. Synergy is also achieved in Delaware by the Department of Family Services working with Medicaid on foster children to reduce unnecessary therapies.**
d. If "No," do you plan on implementing a program in the future?	**N/A**
If "Yes," when do you plan on implementing a program?	N/A
If "No," please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children	N/A

Section IX - INNOVATIVE PRACTICES

Question	Response
1. Summary 6 – Innovative Practices Summary 6 - Innovative Practices should discuss development of innovative practices during the past year (i.e. Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MME, and Value Based Purchasing).	**Delaware state with two managed care organization, managing ninety percent of population and other ten percent in FFS, has always been a state with a significant number of clinical edits and audits to ensure drugs are used according to proper clinical guidelines and eliminate unnecessary expenditures. Delaware monitors the pharmacy encounters submitted by managed care companies to analyze their compliance with clinical protocols and state policies. Monthly reports are used to track and compile results of efficiencies and inefficiencies in the programs. Results are also used to validate state system checks for possible enhancement aligned with business process upgrades.** **Quarterly meetings are held between the managed care, the fee for service pharmacists and the state Pharmacy Director to discuss areas of improvement; address new and upcoming policy changes; and trouble shoot challenges that need to be discussed and resolved to improve the quality of care, improve outcomes for our members and save program drug cost. This**

Question	Response
	open dialogue and forum allow each payer to implement systematic policy changes together, with no disruption to the provider community. Consistent timelines for policy implementations and shared solutions keep members and providers informed and avoids ser vice disruption and less chaotic in care delivery and consistent information that impact our community. **House Bill 331 was signed into law on September 4, 2018 to amend Title 16 of Delaware Code relating to benzodiazepine and non-benzodiazepine hypnotics. The bill requires non-institutional pharmacies to distribute educational pamphlets for consumers whenever a benzodiazepine or non-benzodiazepine hypnotic is dispensed. The pamphlets address the following: misuse and abuse by adults and children; risk of dependency and addiction; proper storage and disposal; addiction support and treatment resources; and a telephone helpline. Additionally, the bill also requires that consent be obtained from a parent or guardian in writing, prior to prescribing a benzodiazepine or non-benzodiazepine hypnotic to a minor, with only a few narrow exceptions. This effort represents a huge step in educating patients on the potential risks of this class of medications that continue to contribute to overdose deaths and drug addiction in Delaware. In February 2019, alprazolam was changed to a non-preferred status to discourage inappropriate use of benzodiazepines. DMMA had very little provider or member negative experience from this change. Members who were previously identified as using alprazolam were grandfathered to continue use. This project was implemented through collaboration with the department of Public health and Substance Abuse and Mental health.** **Throughout FFY 2019, Delaware continued to address the opioid crisis effecting the state and has made great strides to improve treatment options and limit opioid use in Delaware. As part of the ongoing effort to**

Question	Response
	improve treatment outcomes the maximum allowable daily dose without a prior authorization of buprenorphine/naloxone products was increased to 24mg/day decreasing the administrative effort for their treatment to be approved. Additionally, to help decrease the risk of opioid overdoses, any prescription dispensed at 90MME or greater should have a prescription of naloxone rescue preparation and for Medicaid patients receiving a naloxone prescription as a rescue medication there is no copay. **Through collaboration between Medicaid and Department of services for children, youth and their families, In order to monitor and manage the appropriate use of mental health medications such antipsychotic medications use in children enrolled under the State plan, ensuring metabolic monitoring is been documented, no duplicate therapies, and medication therapy monitoring.** **To address the low response rate to paper mailings of retrospective drug utilization letters, Delaware has developed an innovative system that automatically generates a Prescriber Notices Letter weekly to detail alerts that were overridden by the Pharmacy and set to be paid for each prescriber. The letters will be available as a secure message on the portal, and an email notice will be sent indicating the letter is available to download. Copies of generated letters are data stored and can be retrieved for faxing. This creates a cost saving for the state through elimination of returned mailings due to wrong addresses because of relocation and allows the easy and timely retrieval of the alert by the provider improving patient care. The state can develop targeted alert combination based on topic of interest within a specified period of focus, the letters generated from dispensed prescriptions is stored in document repository for audit purposes. Provider**

Question	Response
	specific letters can be collated for prescriber rating among peers.

Section X - E-PRESCRIBING

Question	Response
1. Does your MMIS or pharmacy vendor have a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?	**No**
If "Yes," do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?	N/A
If "Yes," please explain the evaluation methodology. **Summary 7 –E-Prescribing Activity** should explain the evaluation methodology utilized in evaluate the effectiveness of providing drug information and medication history prior to prescribing.	N/A
If "No," are you planning to develop this capability?	No
If "No," please explain	In Federal Fiscal year 2019, eighty five percent of the population resided in two managed care organizations while 15% of the population remained in fee-for-service. Of the 15%, the majority of these FFS clients were transitioning into a managed care plan within 60 days. As a state with a mixture of FFS & MCO lives, Delaware has a unified PDL designed to streamline consistent drug status and maximize savings for the program. Both programs (FFS & MCO) strive to align drug policies, by mirroring the claims editing of FFS with encounters. This allows for the provider community to providing quality care for Medicaid beneficiaries with the least amount of disruption of treatment. To address the low response rate from providers to paper mailing of retrospective drug utilization letters, Delaware uses an innovative system of automatically generating Retro-DUR alerts to prescribers utilizing information within the system. Copies of the letters generated this way are data stored and

Question	Response
	may be retrieved for faxing when necessary or upon provider request. This system has served as a cost saving for the state through elimination of returned mail due to wrong addresses when an office relocation has occurred. It also guarantees the providers have access and receive these alerts. Delaware has continued to run all drug encounters through established edit/audit rules to track the MCO's management of the drug benefit. DMES generates a monthly report that allows a side-by-side comparison of our two MCOs. This report is utilized to analyze both MCO efficiency and compliance with all existing state policies. Delaware continues to make adjustments to our system as we work to improve the integration between our Medicaid system the MCOs systems. Delaware uses numerous platforms to report our successes, gain insight and discuss challenges with other states so that we can learn from each other and move forward with innovation. Legislative mandates continue to guide Delaware as a state in addressing clinical concerns highlighted by data such as rate of unplanned pregnancies and opioid overdose-related death analyses across multiple agencies. The data continues to shed light onto areas of possible improvement through collaboration with Substance abuse and mental health divisions, department of Public Health and other state organizations. Going forward, Delaware will be continuing to collaborate with various areas of Pharmacy practice to close the gap in Vaccination hesitancy, by allowing additional Pharmacy practice areas vaccinate with an administration fee equal to the dispensing fee. The small size of the state and client mix pose some limitations to innovation, but we continue to gain collaborative engagement with different stakeholders to ensure our vulnerable population has a voice and is represented where needed. Ultimately, the goal is to provide all clients with the level of care they need and deserve.

Question	Response
2. Does your system use the NCPDP Origin Code that indicates the prescription source?	**Yes**

Section XI - MANAGED CARE ORGANIZATIONS (MCOs)

Question	Response
1. How many MCOs are enrolled in your state Medicaid program?	**2**
2. Is your pharmacy program included in the capitation rate (carved in)?	**Yes**
If "Partial," please specify the drug categories that are carved out.	N/A
3. Does the state set requirements for the MCO's pharmacy benefit (e.g. same PDL, same ProDUR/RetroDUR)?	**Yes**
a. If "Yes," please check all requirements that apply	**Same PDL**
b. If "Yes," please briefly explain your policy.	**State contracts with a vendor to manage supplemental drug rebates through multistate drug consortium contract. PDL review and files exchange is in collaboration with MCOs**
If "No," do you plan to set standards in the future?	N/A
If "No," please explain	N/A
4. Did all of your managed care plans submit their DUR reports?	**Yes**
If "No," please explain.	N/A

Section XII – EXECUTIVE REPORT

Question	Response
Summary 8-Executive Report should provide a brief overview of your program. It should describe 2019 highlights of the program, FFS initiatives, improvements, program oversight of managed care partners when applicable, and statewide (FFS and MCO) initiatives.	**In Federal Fiscal year 2019, eighty five percent of the population resided in two managed care organizations while 15% of the population remained in fee-for-service. Of the 15%, the majority of these FFS clients were transitioning into a managed care plan within 60 days. As a state with a mixture of FFS & MCO lives, Delaware has a unified PDL designed to streamline consistent drug status and maximize savings for the program. Both programs (FFS & MCO) strive to align drug policies, by mirroring the claims editing of FFS**

Question	Response
	with encounters. This allows for the provider community to providing quality care for Medicaid beneficiaries with the least amount of disruption of treatment. **To address the low response rate from providers to paper mailing of retrospective drug utilization letters, Delaware continues to utilize MMIS to automatically generating Retro-DUR alerts to prescribers utilizing Pharmacy and medical information within the system. Provider specific letters with a compilation of clients is generated for portal retrieval, copies of the letters generated are data stored in document repository available for retrieval for faxing upon provider request. This system has served as a cost saving for the state through elimination of returned mail due to wrong addresses when an office relocation has occurred. It also guarantees the providers have access and receive these alerts.** **Delaware has continued to run all drug encounters through established edit/audit rules to track the MCO's management of the drug benefit aligned with Delaware State policies. MMIS generates a monthly report that tracks submitted encounter acceptance rate of our two MCOs. This report is utilized to analyze both MCO efficiency and compliance with all existing state policies and to identify potential modification. Delaware continues to adjust our system as we work to improve the integration between our Medicaid system the MCOs systems.** **Delaware uses numerous platforms to report our successes, gain insight and discuss challenges with other states so that we can learn from each other and move forward with innovation.** **Legislative mandates continue to guide Delaware as a state in addressing clinical concerns highlighted by data such as rate of unplanned pregnancies and opioid overdose-related death analyses across multiple agencies. The data continues to shed light onto areas of possible improvement through collaboration with Substance abuse and mental health divisions, department of Public Health, Prescription monitoring program, and**

Question	Response
	other state organizations. Going forward, Delaware will be continuing to collaborate with various areas of Pharmacy practice to close the gap in Vaccination hesitancy, by allowing additional Pharmacy practice areas vaccinate with an administration fee equal to the dispensing fee. **The small size of the state and client mix pose some limitations to innovation, but we continue to gain collaborative engagement with different stakeholders to ensure our vulnerable population has a voice and is represented where needed. Ultimately, the goal is to provide all clients with the level of care they need and deserve.**