

C. Technical Approach

21. Pharmacy Benefits (Section 31 Pharmacy Benefits)

a. Describe the Contractor's proposed approach to administration of pharmacy benefits and related pharmacy services, including the following in its response:

Humana operates our own URAC®-accredited pharmacy benefit manager, **Humana Pharmacy Solutions, Inc.® (HPS)**. As a PBM that exclusively serves Humana plans, HPS is deeply integrated into Humana operations, including our clinical programs. HPS has more than 20 years of experience serving the complex and special needs of the Medicaid population and brings this expertise to manage the pharmacy benefit for our Kentucky Medicaid Enrollees. Across all lines of business, **HPS provides pharmacy benefit management services for more than 10 million Enrollees, including more than 700,000 Kentucky residents.** In total, HPS manages pharmacy benefits for more than 570,000 Medicaid Enrollees, 1.3 million Commercial Enrollees, and 8.5 million Medicare Enrollees nationwide. HPS processes more than 490 million prescriptions annually (totaling \$29 billion in spending) and employs more than 7,400 associates, including 900 in-house pharmacists, who focus on supporting the overall health and well-being of our Enrollees.

HPS applies a total net cost management philosophy that encourages providers and Enrollees to choose medications with the best value while preserving high-quality care and positive outcomes. We will tailor HPS supports and services to the needs of Kentucky Enrollees, drawing upon the expertise of HPS's pharmacists serving populations like those covered in Kentucky. HPS has a proven track record of managing pharmacy costs, providing access to medications, and providing comprehensive pharmacy-related Enrollee support programs. In addition, since HPS is a subsidiary of Humana Inc., our Kentucky Medicaid plan will benefit from having full transparency into PBM costs and network financial rates. **Pass-through pricing has been, and will continue to be, a main feature of HPS's operations.** HPS has never used a spread pricing payment model for our Medicaid line of business.

Humana, including HPS, is committed to continuing and growing our partnership with the Department for Medicaid Services (DMS). We regularly collaborate with other Managed Care Organizations (MCO) and DMS to address issues affecting the efficient and economical delivery of pharmacy services to our Enrollees through monthly Kentucky Medicaid Pharmacy Director Workgroup meetings and monthly joint meetings, per Section 31.16 Kentucky Pharmacy Director Workgroup and Section 9.3 Monthly Meetings of the Draft Medicaid Contract. For example, Humana and HPS have collaborated with DMS and other MCOs to determine how to best implement Senate Bill 5 pricing requirements with limited disruption to our Enrollees or providers. We are currently working with the DMS Uniform Policy Workgroup to standardize the Kentucky Lock-In Program (KLIP) across Medicaid fee-for-service (FFS) and managed care plans.

Additional features of Humana's approach to the delivery of pharmacy services for our Medicaid Enrollees include the following:

- **Net (post-rebate) cost focus:** Wide unit cost variation exists among medications that are equally effective clinically. While some PBMs promote costlier drugs to inflate the value of their rebate "savings," Humana and HPS focus on optimizing the net (post-rebate) unit cost. This involves generic substitution for brand drug alternatives as well as extensive management of drug mix within brands and generics. While this approach will deliver a highly cost-effective mix of drugs, our benefits management rules and processes also ensure relatively costly therapies are dispensed and used when they are clinically superior. Among our plans that use a Humana-controlled formulary, we achieved a 91.7% generic dispensing ratio and an 87.3% generic dispensing ratio for our individual Medicare and Commercial plans, respectively, in 2019.

- Integration with clinical processes: As further described under sub-question I.C.21.a.i of this response, our Medicaid clinical associates work closely with HPS and their pharmacy counterparts to leverage pharmacy data and processes to drive improved treatment adherence and Enrollee health outcomes. We regularly review and institute quality and clinical initiatives that combine pharmacy and care management processes to improve management of chronic conditions and promote appropriate utilization.
- Medication therapy management: Humana provides medication therapy management services to eligible Enrollees to optimize therapeutic outcomes through improved medication use. The overall goal of the medication therapy management program is to optimize medication therapy that promotes safety, effectiveness, and cost savings, enabling our Enrollees to achieve their best health.
- Specialty pharmacy solutions through Humana Specialty Pharmacy: Humana provides a personalized approach that helps keep Enrollees using specialty pharmacy medications adherent to their therapies and manages high costs through enhanced Utilization Management (UM) protocols.
- Continuity of care: If an Enrollee transitioning to Humana from another health plan or Medicaid FFS plan is currently stabilized on medications not listed in Humana's Preferred Drug List (PDL), we will allow those Enrollees to continue receiving those medications for the first 30 days of enrollment. This 30-day period gives the provider time to prescribe an alternative medication included in the Humana PDL or to request prior authorization (PA) for the Enrollee to remain on the current drug.



ASSOCIATE SPOTLIGHT:
Joseph Vennari, PharmD,
Pharmacy Director

Joseph Vennari, PharmD, serves as the Pharmacy Director for our Kentucky Medicaid Managed Care program. He holds a Doctor of Pharmacy degree, and has served as the Director of Pharmacy Services for Kentucky health plans since 2003. In his position as Pharmacy Director, he provides oversight of Humana's Medicaid pharmacy operations in Kentucky, currently co-chairs the Pharmacy & Therapeutics Committee, provides pharmacy support for our Care Managers, works with our formulary team to review formularies and create appropriate prior authorization protocols and other edits as appropriate. He also attends all senior leadership meetings with DMS, visits facilities to develop relationships with providers and present opportunities for value-based contracting, and maintains compliance with State regulations. Dr. Vennari believes using pharmacy data, in conjunction with a multidisciplinary approach to care management, delivers the best outcomes for our Enrollees.

In 2019 (for the second consecutive year), **Humana Specialty Pharmacy** received a Specialty Pharmacy Patient Choice Award from Specialty Pharmacy Times®, the leading journal for the specialty pharmacy industry.

Our Kentucky Medicaid pharmacy operations are overseen by Joseph Vennari, PharmD. Please refer to **Attachment I.B.3-1 Resumes Staffing** of this Request for Proposal for Dr. Vennari's resume with his full credentials and experience.

a.i.

If using a Pharmacy Benefit Manager (PBM), provide a copy of the Subcontract, approach to integration with other services, as well as assuring transparency in pricing and reporting.

COPY OF PBM SUBCONTRACT

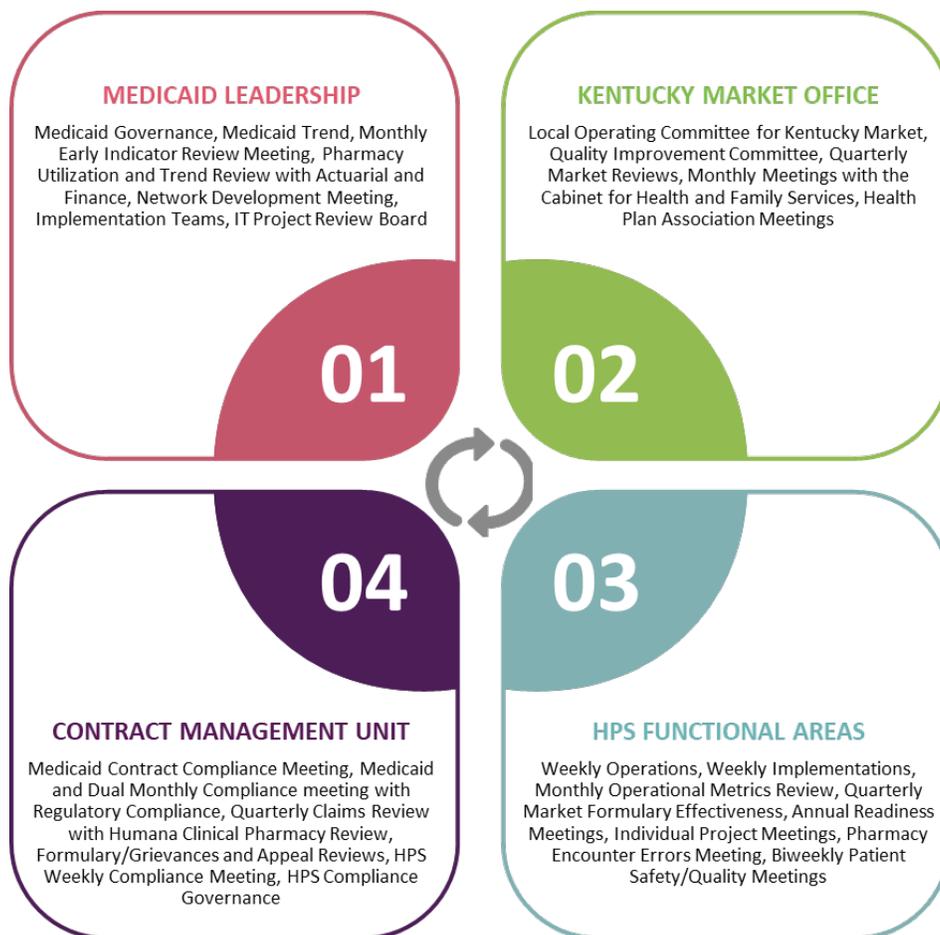
HPS is a wholly owned subsidiary of Humana Inc., which is the direct and ultimate owner of Humana Health Plan, Inc. Pursuant to Addendum 2 of the solicitation regarding attachments greater than 10 pages, we have included

the subcontract between Humana Health Plan, Inc. and HPS (**Attachment I.C.21.a.i-1 PBM Subcontract**) as a hard copy at the end of our response to I.C.21 of the RFP, as well as soft copies on our submitted flash drives.

APPROACH TO INTEGRATION WITH OTHER SERVICES

As described above, **HPS exclusively serves Humana plans**, enabling full integration with our Medicaid services. In addition to the functions carried out by HPS, our Medicaid pharmacy operations are supported by our Medicaid Senior Products area and other teams across the enterprise, including those working in the areas of compliance, consumer experience, grievances and appeals, Information Technology (IT), legal, and service operations. **Figure I.C.21-1** illustrates the multiple touchpoints between Medicaid Leadership, our Kentucky Medicaid plan, our Contract Management Unit, and HPS. Integration between our Kentucky Medicaid plan and HPS comes not only in the form of reports (which are described further below) but also through market trend meetings, local operating committees and Quality Improvement committees, delegated vendor management of HPS, and integrated and jointly-developed quality initiatives that leverage our Medicaid clinical programs and integrated pharmacy data analytics.

Figure I.C.21-1: Touchpoints between Areas with Oversight of Pharmacy Operations



The delivery of pharmacy services to our Kentucky Medicaid Enrollees is overseen by our Kentucky Pharmacy Director, Dr. Joseph Vennari. **Table I.C.21-1** summarizes his responsibilities, highlighting how his role involves collaboration with many other functional areas.

Table I.C.21-1: Responsibilities of our Kentucky Pharmacy Director

Functional Area	Data and Process Flow
Medicaid Pharmacy Operations	<ul style="list-style-type: none"> • Support network development and maintenance • Formulary oversight • Support drug utilization management and PA process • Pharmacy encounters
Medicaid Reviews/Trends	<ul style="list-style-type: none"> • Local Operating Committees • Monitor and identify trend drivers • Work with markets to mitigate unfavorable trends • Lead pharmacy quality initiatives
Support Provider Satisfaction, Retention, and Relationships	<ul style="list-style-type: none"> • Joint Operating Committee performance monitoring of pharmacy and quality metrics • Provider education on Medicaid formulary and issues • Peer-to-peer collaboration
Pharmacy Issue Resolution for Markets	<ul style="list-style-type: none"> • Resolve myriad of Enrollee/provider issues • Claims, coverage, prior approvals, benefit issues • Support care management and UM pharmacy-related concerns

Pharmacy Integration with Humana’s Population Health Management (PHM) Program

Through our experience supporting Medicaid Enrollees – including Enrollees with special health care needs – we understand that pharmacy solutions are essential to improving the health of our Medicaid Enrollees. We therefore prioritize integration between HPS and our Medicaid clinical operations and our broader PHM Program, recognizing the fundamental connections between our Enrollees’ physical health, behavioral health (BH), and social needs and services and their medication use. Our clinical associates work hand-in-hand with HPS to implement quality initiatives targeting medication adherence and associated clinical outcomes, develop data-sharing infrastructure to permit our Care Managers (CM) to view pharmacy data for their assigned Enrollees, conduct post-discharge medication reconciliation for identified Enrollees, and create enterprise-wide solutions that meet the needs of our Enrollee population.

Between 2016 and 2018, use of medication-assisted treatment (MAT) among Humana Kentucky Medicaid Enrollees increased by **111%**, while the number of opioid prescriptions decreased by **19%**. Humana does not require PAs for preferred MAT products to help address opioid dependencies among our Kentucky Medicaid Enrollees.

A prime example of this collaboration is **Humana’s enterprise-wide Opioid Task Force**. Our Opioid Task Force designs and implements solutions that combat the topic of opioid misuse among Humana membership and the communities we serve. Tackling a problem with the magnitude of our nation’s opioid crisis cannot fall to one single business area, such as pharmacy; rather, it requires the input of experts from a broad range of areas. Our Opioid Task Force includes HPS, as well as associates in charge of Humana’s network operations, clinical services (including BH), digital solutions, marketing, and Enrollee education.

Our Medicaid clinical associates collaborate with HPS to develop quality and clinical initiatives targeting conditions prevalent among the Medicaid population. These initiatives are designed to improve care and reduce costs through better adherence, safety, and dosing efficacy. To support the delivery of targeted interventions and education for Enrollees with polypharmacy, suboptimal medication management, or other similar issues, we made recent investments to integrate pharmacy data into **our integrated clinical platform, Clinical Guidance eXchange (CGX)**. CGX’s functionality enables direct management of BH, social, and physical health services, enhancing our ability to document gaps in care, automate care planning, monitor plan compliance, and proactively address co-occurring needs and



changes in condition. This integration provides our CMs with insight into all of our Enrollees’ conditions and needs, including their pharmacy benefit. When one of our targeted drug utilization review (DUR) programs identifies that an Enrollee has a potential medication adherence issue, our care management team will receive an alert via CGX, enabling further follow up and intervention and **avoiding potentially preventable emergency department (ED) visits and inpatient admissions**. In addition, we leverage our pharmacy systems to promote improved clinical outcomes. Our proprietary point of care system, **IntelligentRx**, integrates with the provider’s electronic health record (EHR) system to provide pharmacy benefit information at point of care, can provide **real-time UM authorization (“Fast Pass”)**, offers personalized formulary alternatives, and includes DUR capabilities to ensure patient safety and help to prevent adverse drug events.

In addition, we are introducing medication therapy management to our Medicaid plans. We will alter our successful medication therapy management program from our other lines of business to meet the needs of our Medicaid Enrollees, including targeting those conditions most prevalent among the Medicaid population. Our medication therapy management program will include the implementation of targeted medication reviews by our network providers, addressing areas such as adherence, safety, and dosing efficacy. **Between January and November 2019, we completed 548 comprehensive medication reviews for our Illinois duals demonstration Enrollees, encompassing 65% of identified Enrollees**, after making at least two attempts to complete comprehensive medication review for each identified Enrollee. We will make at least one attempt per quarter among our Kentucky Medicaid Enrollees to complete a comprehensive medication review for as long as they met eligibility criteria for the program.

Conditions targeted by our Kentucky Medicaid medication therapy management program include:

- Depression
- Asthma
- Diabetes
- Hepatitis C
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Dyslipidemia
- End-stage renal disease

In addition, we have recently introduced several pharmacy quality initiatives targeting our Medicaid Enrollees nationwide. We have summarized these in **Table I.C.21-2**.

Table I.C.21-2: Pharmacy Quality Initiatives for Humana Medicaid

Condition	Quality Indicator	Initiatives
Depression	<ul style="list-style-type: none"> • Antidepressant medication management 	<ul style="list-style-type: none"> • Notify providers of their patient population with schizophrenia or depression who are irregularly taking antipsychotic or antidepressant medications
Schizophrenia	<ul style="list-style-type: none"> • Adherence to antipsychotic medications for individuals with schizophrenia • Diabetes and cardiovascular disease screening and monitoring for people with schizophrenia or bipolar disorder 	<ul style="list-style-type: none"> • Notify providers of their patient population with schizophrenia or depression who are irregularly taking antipsychotic or antidepressant medications • Send Enrollee and provider letters if claims for diabetes screening and monitoring have not been received within the appropriate timeframe
Acute bronchitis	<ul style="list-style-type: none"> • Avoidance of antibiotic treatment in adults with acute bronchitis 	<ul style="list-style-type: none"> • Administer provider education campaign regarding appropriate antibiotic use • Perform retrospective DUR initiative targeting acute bronchitis
Asthma	<ul style="list-style-type: none"> • Medication management for people with asthma • Asthma medication ratio 	<ul style="list-style-type: none"> • Send Enrollee and provider letters if medication adherence is below 75% or medication ratio is below 0.50

Table I.C.21-2: Pharmacy Quality Initiatives for Humana Medicaid

Condition	Quality Indicator	Initiatives
Opioid use disorder	<ul style="list-style-type: none"> • Use of opioids at high dosage • Use of opioids from multiple prescribers 	<ul style="list-style-type: none"> • Implement Opioid Predictive Model to identify and intervene with Enrollees at risk of opioid use disorder • Administer provider and Enrollee call campaign to encourage prescription of naloxone as a rescue medication along with opioid prescription • Apply point of sale (POS) hard edits to limit opioid day supply, limit opioid dose to less than 100 milligrams, or restrict use of multiple providers/pharmacies without PA • Apply POS soft edits to request pharmacist review when an Enrollee has an overlap of opioid, benzodiazepine, and muscle relaxant medications, or is filling a prescription for an opioid dose greater than 90 milligrams
Antipsychotic use	<ul style="list-style-type: none"> • Use of multiple concurrent antipsychotics in children and adolescents • Metabolic monitoring for children and adolescents on antipsychotics • Use of first-line psychosocial care for children and adolescents on antipsychotics 	<ul style="list-style-type: none"> • Apply a POS hard edit to prevent dispensing of an antipsychotic medication to a pediatric Enrollee with two or more antipsychotic medications without PA • Administration of a BH DUR program targeting antipsychotics and other BH medications, accompanied by a CGX alert when the DUR program identifies an Enrollee as having potentially unsafe medication use • Send letters to Enrollees and providers if claims have not been received for psychosocial care and metabolic monitoring
Attention Deficit Hyperactivity Disorder (ADHD)	<ul style="list-style-type: none"> • Follow-up care for children prescribed ADHD medication 	<ul style="list-style-type: none"> • Send Enrollee letter after first fill of medication to educate on appropriate follow up with provider • Send Enrollee and provider letters if claim for follow-up care has not been received in the appropriate timeframe • Provider education campaign on appropriate ADHD prescribing

Humana will continue to align with DMS-sponsored clinical criteria, pharmacy-based programs, and other initiatives as directed by DMS, in accordance with Section 31.5 Alignment of Clinical Criteria and Pharmacy Based Programs and Initiatives of the Draft Medicaid Contract.

ASSURING TRANSPARENCY IN PRICING AND REPORTING

HPS will continue our commitment to transparency in pricing and reporting per requirements outlined in Sections 31.14 PBM Pricing Transparency and 31.17 Pharmacy Benefit Manager or Administrator Reporting Requirements of the Draft Medicaid Contract. HPS’s reimbursement from Humana Health Plan, Inc. is provided through an administrative fee, based on 30-day equivalent prescriptions. HPS and Humana Health Plan, Inc. renegotiate administrative rates annually. Humana’s direct relationship with HPS ensures that barriers such as PBM firewalls do not impede reporting or coordination activities. Humana reports all requested data directly to DMS.

HPS’s contract with Humana Health Plan, Inc. ensures full transparency through the following mechanisms:

- **Pass-through pricing:** HPS will continue to use a **pass-through pricing model** that ensures there is no difference in pharmacy claim payment amounts between HPS and the retail pharmacy and Humana Health Plan, Inc. to HPS. HPS has always used a pass-through pricing model for our Medicaid line of business.

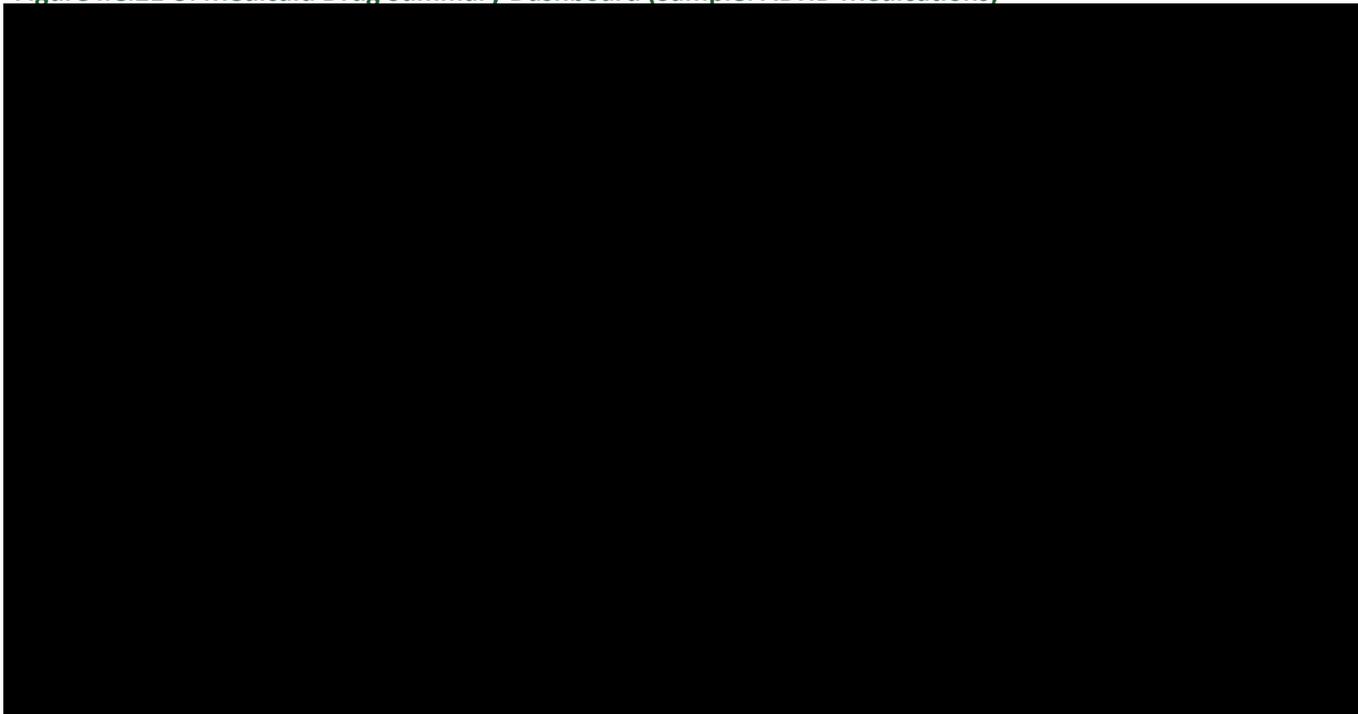
- **Transparency in network contract rate and Maximum Allowable Cost (MAC) changes:** HPS will comply with Senate Bill 5 requirements by submitting any network contract rate changes greater than 5% to the Commonwealth for approval prior to implementation and will submit any planned MAC changes seven days prior to implementation. If DMS decides to decline the proposed MAC rate within 30 days of submission, HPS will then revert back to the old rate and batch rework the impacted claims and adjust the payment to impacted pharmacies.
- **Rate reporting:** HPS provides Humana Health Plan, Inc. with reports that provide claims-level detail, providing the basis for comparison of rates paid by HPS to the pharmacies with rates paid by Humana Health Plan, Inc. to HPS. We will provide both summary and claims-level detailed reports at the request of DMS.
- **Fees as a condition of claims payment or network inclusion:** HPS does not impose direct or indirect remuneration fees, membership fees, or the like on a pharmacy as a condition of claims payment or network inclusion, nor does HPS does also not utilize retrospective remuneration models, including Generic Effective Rates.
- **Claims processing:** Nothing shall preclude the reprocessing of claims due to claims adjudication errors of HPS.
- **Monthly dashboard:** HPS provides a monthly dashboard to Humana Health Pan, Inc., reporting pharmacy costs across regions, cohorts, provider groups, and drugs classes (**Figure I.C.21-2**). In addition, this dashboard allows us to analyze data by drug class and prescribers and to identify Enrollees and prescribers with outlying drug utilization patterns.

Figure I.C.21-2: Monthly Medicaid Key Metrics Dashboard



An example of a drug summary report – specific to ADHD medications – is displayed in **Figure I.C.21-3**.

Figure I.C.21-3: Medicaid Drug Summary Dashboard (Sample: ADHD Medications)



a.ii. Methods to ensure access to covered drugs and adherence to the preferred drug list.

ACCESS TO COVERED DRUGS

We ensure access to covered drugs through use of our Formulary Management system and PA processes and will comply with requirements set forth in Sections 31.2 Covered Outpatient Drugs and 31.4 Preferred Drug List of the Draft Medicaid Contract.

Formulary Management

Our Formulary Management system maintains information at several drug levels and stores plan-specific covered drugs and UM requirements, including our PDL. This includes, but is not limited to, non-preferred and clinical PA, step therapy, quantity limits, and age limits. This system feeds directly into our claims processing system, which also applies safety and other edits unique to the formulary. We process all HPS pharmacy claims through this system, enabling the seamless and accurate application of our Kentucky formulary and PDL in the Kentucky Medicaid program and ensuring our Enrollees receive covered drugs in a timely manner. We can quickly and easily update our Formulary Management system as clinical guidance, clinical appropriateness, and Enrollee needs evolve.

Preferred Drug List

Our administration of the PDL allows access to all non-preferred covered drugs through a structured PA process. Our Pharmacy & Therapeutics (P&T) Committee ensures our PDL is not more restrictive than Medicaid FFS coverage of outpatient drugs and advises on the development of our PDL. Our PDL is updated weekly, with additions made on a rolling basis as new drugs are introduced to the market to ensure prompt access for our Enrollees. We monitor news about new drugs and drug formulations through our review of the drug pipeline, Pink Sheets, and announcements from the U.S. Food and Drug Administration (FDA) and drug manufacturers and will review new drugs and drug formularies within 90 days of market availability. Once the P&T Committee approves new medications, we can add them to the formulary as early as their initial release date, based upon urgency of need and alternatives currently on the PDL.

ADHERENCE TO THE PREFERRED DRUG LIST

We closely monitor PDL adherence among our Kentucky Medicaid providers and take adherence into account when identifying needed improvements to the PDL. For example, if we identify a drug that is highly utilized and not on the PDL, our P&T Committee reviews this drug at the next meeting to see if it should be added to the PDL to promote administrative simplification and Enrollee access.

Humana's PDL indicates whether the drug is preferred or non-preferred and (if PA is required) the information that must be submitted by the prescriber in order to initiate a request for PA or access to a non-preferred drug. We maintain a brand name exception process for prescribers to pursue when they request brand name products due to medical necessity.

We achieved
99.6% PDL
adherence among
our Kentucky
Medicaid
providers in 2019.

Access to Humana's PDL

Our providers and Enrollees can access a searchable version of our PDL at any time through our secured site for providers and Enrollees; we update the PDL weekly. In addition, our PDL is available on Humana's public website in both English and Spanish; an updated version is available on a monthly basis. Enrollees and providers can request a hard copy of the PDL at any time via mail without charge and view the PDL on our website. We also send mailings to impacted Enrollees conveying any removal of drugs from the PDL.

We educate all providers on our PDL and the PA process during our mandatory provider orientation. To ensure awareness of the PDL and PA process among our Enrollees, we include a detailed description in our Enrollee handbook (touching on topics including the PDL, alternative drugs, generic versus brand name drugs, PA, and appeals), and our CMs educate engaged Enrollees on the pharmacy PA process, as it applies to their medication therapy.

In addition to easily accessing a searchable or static version of our PDL through our secured and public sites, Humana has introduced a dynamic, integrated platform that leverages proprietary software to simplify the prescribing and PA process for our Enrollees and providers. Through our **proprietary IntelligentRx system**, providers using a major EHR or eRx vendor that is part of the SureScripts network can view our formulary (including any PA requirements) and their Enrollees' medication history directly in their EHR or eRx system prior to prescribing. Through comprehensive integrations with leading EHR systems – including DrFirst, Allscripts, Epic, Cerner, Athena, and eCW (which will be added this year) – providers can also view real-time clinical information about coverage, formulary alternatives, and safety alert messaging through our **Real-Time Benefit** program. In addition to encouraging use of preferred drugs, IntelligentRx permits our providers to anticipate and comply with PA requirements prior to submitting a prescription, allowing our Enrollees to receive necessary medications more quickly.

MANAGING CHANGES TO THE PDL

Each week, Humana receives data on new drugs from First Databank. Our P&T Committee – further described under sub-question I.C.21.a.iii below – evaluates these data to determine which drugs to cover and which drugs should require PA. After these decisions are finalized, our Clinical Formulary Administration team operationalizes these updates via our Centralized Formulary, which serves as Humana's formulary system of record, and via RxNova, our pharmacy claims processing system. After updates have been completed in both systems, the Clinical Formulary Administration Team conducts testing to ensure correct claims adjudication for the newly added or adjusted drugs.

Before making any changes to the PDL, we conduct an analysis of how these disruptions will affect our Enrollees and prescribers so that we may anticipate and account for their impact on those we serve. We notify impacted Enrollees and prescribers **at least 30 days** before implementing the change. In addition, we share a list of all impacted Enrollees with our care management team. Our CMs use this list to identify those impacted Enrollees who are enrolled in care management and subsequently contact them to discuss the process for switching to a formulary alternative and to help them contact the responsible prescriber, as needed.

The Enrollee story contained in the text box below illustrates Humana’s ability to be flexible and fast-acting in delivering medically necessary services and covered drugs to our Enrollees, even when a drug has newly entered the market.



**Enrollee Story Spotlight:
Innovative Gene Therapy Treatment Approved for Rare Pediatric Genetic Disease**

In May 2019, the U.S. FDA approved Zolgensma, the first gene therapy treatment (and now the most expensive on the market at over \$2 million per patient) for pediatric patients under the age of two years old with spinal muscular atrophy (SMA), the leading genetic cause of infant mortality. Within the first week of approval by the FDA, a physician at the University of Florida Health Gene Therapy Center submitted a request to Humana to cover Zolgensma for a patient enrolled in our Florida Medicaid plan.

Humana determined this request was clinically appropriate and medically necessary, approving this drug to be fully covered for the child. We guided her mother through the entire process to ensure this life saving treatment was available for her daughter. This remarkable therapy will provide families with a level of unprecedented hope that Humana is committed to providing.

a.iii. Responsibilities and composition of the P&T Committee.

P&T COMMITTEE RESPONSIBILITIES

With more than 20 years of experience developing PDLs, including 11 years of Medicaid drug list development experience, Humana’s P&T committee is responsible for:

- Formulary development, including reviewing and making decisions about the appropriate use of drugs, biologics, and select non-drug pharmacy-related products
- Clinical edits, including quantity limits, generic substitution, and therapeutic interchange
- Drug utilization reviews, including setting clinical criteria for the approval of drugs and reviewing policies that guide exceptions and other UM processes
- Enrollee programs, including alignment with DMS-sponsored clinical criteria, pharmacy-based programs, and other DMS and Humana initiatives

Our P&T Committee meets at least quarterly, while subcommittees (further described below) meet on a weekly or monthly basis.

The Role of the P&T Committee in Formulary Management

Our P&T Committee evaluates pharmaceutical products using various sources of clinical information, including FDA approval information, peer-reviewed medical literature, evidence-based effectiveness studies, and clinical practice guidelines (CPG), to create and evolve evidence-based PDLs that produce a positive, cost-effective outcomes. Sources used for these evidence-based medicine determinations include, but are not limited to, the following:

- Nationally-recognized compendia, including American Hospital Formulary Service® Drug Information, Truven Health Analytics Micromedex, DRUGDEX®, Elsevier’s Gold Standard Clinical Pharmacology, National Comprehensive Cancer Network Drugs and Biologics Compendium™, and Wolters Kluwer Clinical Drug Information Lexi-Drugs
- Evidence ratings accepted in compendia
- Supporting literature, such as journals and CPGs

- Pharmaceutical market reports, including those published by the Institute for Clinical and Economic Review, IPD Analytics, FirstWord Pharma, FiercePharma, and Datamonitor Healthcare

The P&T Committee follows specific state and federal regulations about medication coverage for Kentucky Medicaid Enrollees. In addition to reviewing these sources and requirements, the P&T Committee considers all available treatment options and the likelihood of off-label utilization prior to decisions regarding inclusion on the formulary.

The Committee may render decisions through motions or may play an advisory role, depending on the issue at hand. Ultimately, the goal of the Committee is to confirm that proper decisions are made regarding drug access, safety, effectiveness, and the overall value of the benefit as it pertains to drugs, biologics, and select non-drug products.

Figure I.C.21-4 illustrates our formulary management process, including how decisions of the P&T Committee are implemented.

P&T Subcommittees

Our P&T Subcommittees, responsible for clinical drug and drug policy decisions, convene on a weekly or monthly basis. The higher frequency of these meetings allows us to more quickly make clinical drug and/or drug policy decisions in response to changes in state or federal policy, the introduction of a new drug to the market, a drug going off patent, or price changes. The P&T Committee may review and/or vote to amend or revise P&T Subcommittee decisions. The responsibilities of the weekly and monthly P&T Subcommittees include:

- Reviewing clinical information for drugs, drug classes, and alternative treatment
- Articulating tier placement or formulary placement for FDA-approved prescription drug products, as necessary
- Formulating clinical criteria (including PA criteria) used by the Humana Clinical Pharmacy Review team, and revising criteria as necessary
- Formulating quantity limits for some prescription drugs, as necessary

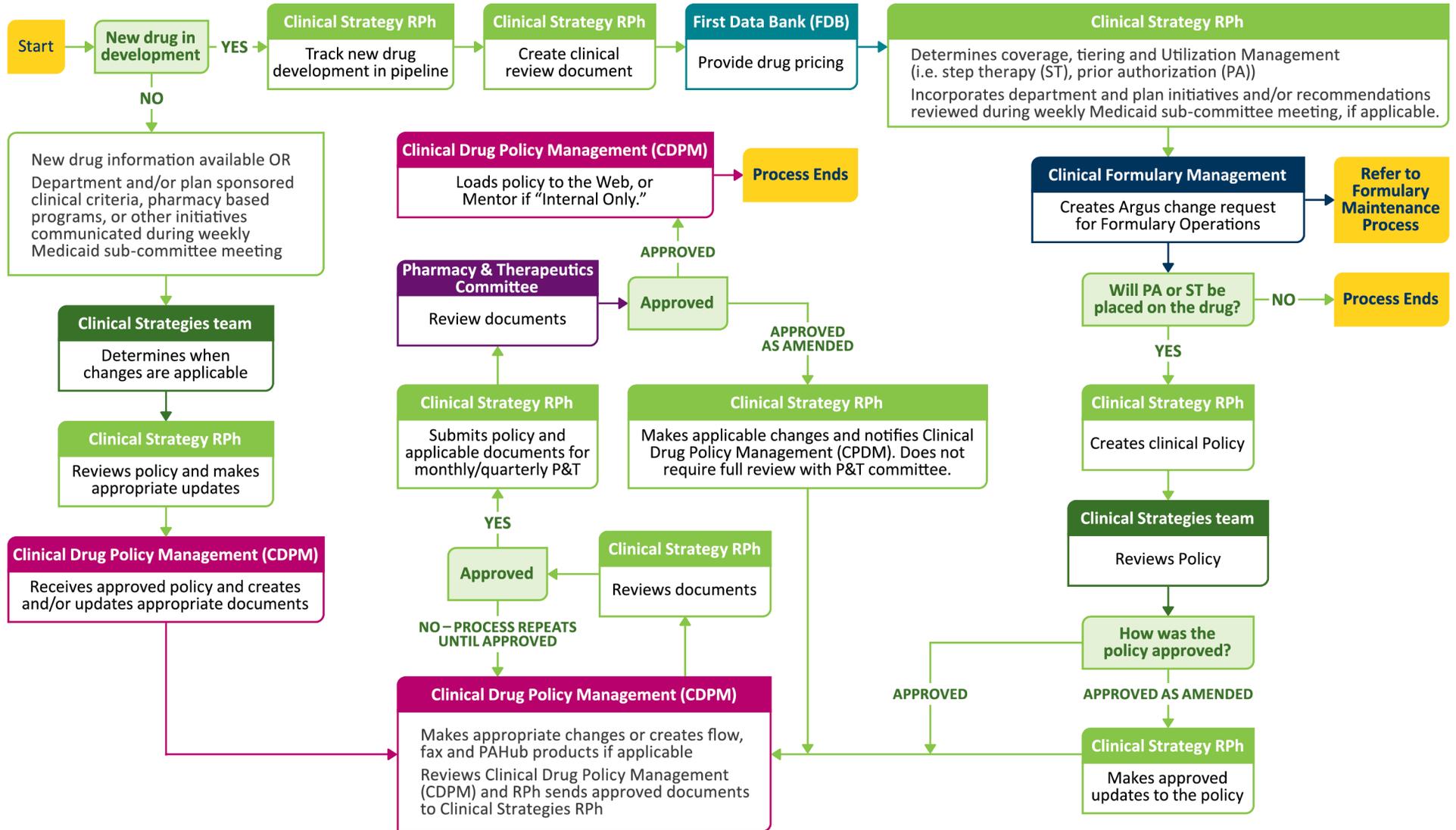
To guide the development of our Medicaid PDLs and Medicaid-specific policies, we will introduce a **Medicaid Subcommittee** to our P&T Committee. This Subcommittee will meet monthly, with ad hoc meetings held on an as-needed basis, and will include one BH provider (at a minimum), alongside physical health practitioners and pharmacists. Our Kentucky Medicaid Medical Director, Lisa Galloway, MD, and our Kentucky Medicaid Pharmacy Director, Dr. Joseph Vennari, will play an active role in this Subcommittee.

Communication of the P&T Committee's Activities with Providers, Enrollees, and Other Humana Business Units

The minutes of our P&T Committee meetings formally document its activities. The minutes include presentation summaries, positions, motions, and decisions regarding coverage, policies, PA, step therapy, and quantity limits. These minutes are shared with other Humana operational areas that are responsible for building and enforcing the intent of the decision. These decisions may include, but are not limited to, the addition of new drugs, changes in clinical edits, or changes in policy. Humana Clinical Pharmacy Review (responsible for pharmacy utilization management) and our formulary operations team are given the opportunity to provide feedback to the P&T Committee on issues of coding and the clinical relevancy of policy changes. The P&T Committee and its subcommittees use this feedback to refine existing policies.

To ensure awareness of P&T Committee decisions among external audiences, we publish the minutes of P&T Committee meetings on our public P&T Committee webpage. In addition, Humana business units assist in crafting specific messages regarding any changes to clinical policy or the formulary that affect our Enrollees, providers, and other stakeholders. For example, our Kentucky care management teams assist our Enrollees engaged in care management in contacting their provider if the formulary status of one of their prescribed drugs has changed.

Figure I.C.21-4: Pharmacy Benefits P&T Committee Process



COMPOSITION OF THE P&T COMMITTEE

Our P&T Committee is chaired by the medical director of the P&T Committee, Charles Stemple, DO, and our Director of Pharmacy and Therapeutics, Jay McKnight, PharmD. The co-chairs designate voting members of our P&T Committee. Our P&T Committee policy states that a majority of the voting members must be practicing physicians and/or practicing pharmacists and must be chosen from various clinical specialties and with such experience to adequately represent the needs of Enrollees, including those with special needs. In addition, we require all physician and pharmacist P&T Committee members to be licensed in the United States or one of its territories and to be free of conflict of interest with any P&T agenda or pharmaceutical manufacturers.

HPS's P&T Committee is made up of four practicing pharmacists and eight practicing physicians, including both Humana associates and external members. Today, two of our P&T pharmacists and one physician are experts in the care of the disabled and elderly. We include (at a minimum) one Kentucky licensed physician and one Kentucky licensed pharmacist who is actively providing services to Kentucky Medicaid recipients on the P&T Committee.

In addition to the P&T Committee members, other individuals frequently attend the P&T Committee to serve as consultants on specific issues. For example, Matt Ruble, MD, a Humana Behavioral Health Medical Director, regularly attends to provide input on topics such as psychotropic medications.

a.iv.

Proposed DUR Program, including approaches to collaborate with the Department on pharmacy initiatives.

Our Kentucky Medicaid DUR program (including prospective, concurrent, and retrospective reviews) seeks to ensure our Kentucky Enrollees receive safe, high-quality, cost-effective medication therapy while minimizing the frequency of inappropriate or medically unnecessary care, as well as fraud, waste, and abuse (FWA). This program is designed to advance therapeutic outcomes and improve the quality of pharmaceutical care through the delivery of appropriate and medically necessary prescriptions that are not likely to cause adverse medical results. Our prospective DUR edits are designed and implemented to assist a pharmacist's daily practice. Our edits (such as appropriate age, maximum dosage, minimum dosage, and therapeutic duplication) provide an additional layer of patient safety by assessing a prescription's dosage and directions and reviewing patient claims history for possible drug interactions or duplicate therapy. We evaluate appropriate medication use through the use of quantity limits and dose accumulation edits, as well as PA. As we adjudicate all pharmacy claims using the same system, regardless of the source (retail or specialty), we can integrate DUR accordingly. A team of licensed clinical pharmacists is dedicated to our DUR program.



PROSPECTIVE REVIEWS AT THE POINT OF CARE

Our prospective DUR program, powered by IntelligentRx and our **One Medication List (OML)** tool, ensures we can prevent an ineffective or even harmful adverse event by identifying and resolving the event before the Enrollee receives the medication. Our proprietary IntelligentRx solution supplies prescribers with a wealth of actionable information at the point of care and prior to fulfilling a prescription, including adverse drug alerts. When a provider enters a prescription or PA request into a system with access to the IntelligentRx service, the system automatically reviews the Enrollee's pharmacy claims to assess possible adverse drug events and other safety concerns severe enough to deny a claim at the point of sale. If an adverse event is identified, an alert is sent to the provider prior to writing the prescription, allowing the provider to select a safe formulary alternative from a customized list delivered by IntelligentRx.

Providers connected to our provider portal, Availity, can access Enrollee profiles populated by our OML tool. These Enrollee profiles compile information from pharmacy claims and information logged by our CMs and Enrollees about over-the-counter drug and supplement use to document an individual Enrollee's medication

use, drug allergies, and immunizations. Together with IntelligentRx, OML will give our providers powerful insights and tools to decrease the prescribing of duplicate medications and prevent potentially dangerous drug-drug interactions.

CONCURRENT REVIEWS

Our POS, concurrent DUR process identifies potential drug therapy problems prior to dispensing the drug to the Enrollee at the pharmacy. We apply this process every time the pharmacist fills a prescription to assist in the evaluation of an Enrollee’s planned drug therapy. Our online DUR program performs real-time editing of drug therapy prior to prescription dispensing at the POS, with an average of 150 edits per second for each submitted claim. Customized for each population we serve, these edits include eligibility, pharmacy, physician, drug, benefits, and authorizations. Our clinical edits, including appropriate age, incorrect drug dosage or duration of drug treatment, drug contraindications and interactions, and therapeutic duplication supply an additional layer of Enrollee safety by assessing a prescription’s dosage and directions and reviewing patient claims history for possible safety concerns prior to dispensing.

Humana’s One Medication List tool connects multiple users and systems (including CMs, pharmacists, providers, and Enrollees) to a single source of truth for medication list information, comprising both pharmacy claims and information recorded by Centers for Medicare and Medicaid Services (CMS) and Enrollees themselves.

When our system identifies any drug inconsistencies, potential drug interactions, and/or compliance issues, the dispensing pharmacies receive an alert or error code within the claims adjudication system. These messages enable pharmacists to educate Enrollees and consult physicians (when appropriate) prior to dispensing the drug to an Enrollee. Online messages also alert the pharmacist to check for other potential problems, such as early refills, excessive drug use, and therapeutic duplications. Quantity limits, dose accumulation edits, and clinical PA also serve as POS safeguards against inappropriate medication use. For example, when we identify a claim that exceeds customized opioid threshold limits for morphine milligram equivalents (MME) per day, we send an alert to the pharmacist via the claims adjudication system. This alert prompts them to follow up with the Enrollee or provider to resolve the identified issue prior to issuing the medication. Once resolved, the pharmacist must enter a pharmacy professional service code to complete the transaction.

Table I.C.21-3 provides examples of safety edits in place for Humana’s Kentucky Medicaid plan. We will comply with all opioid prescribing guidelines mandated by DMS, and we will continue to adjust these edits to meet shifting trends in prescribing and medication use.

Table I.C.21-3: Example Safety Edits in Place for Humana’s Kentucky Medicaid Plan

Initiative	Logic	Edit
Morphine-equivalent dosing	Morphine milligram equivalents > 50mg - 250mg	Soft edit (pharmacy professional service code eligible)
Morphine-equivalent dosing	Morphine milligram equivalents > 250mg	Hard denial
Opioid naïve	> 7-day supply, with no claims in 108 days	Soft edit
Opioid/benzodiazepine (double threat)	2-way edit: overlap in opioid and benzodiazepine	Soft edit
Benzodiazepine/stimulant	2-way edit: overlap in stimulant and benzodiazepine	Soft edit
Opioid 30-day	Opioid > 30-day supply	Hard denial
Benzodiazepine 30-day	Benzodiazepine > 30-day supply	Hard denial
Antipsychotic use in persons with dementia	Enrollee > 65 years old with a diagnosis of dementia who is filling an antipsychotic medication	Hard denial

Initiative	Logic	Edit
Antipsychotic use in children	Enrollee between ages of 1 and 17 who has at least 1 day from 2 or more drugs within the same therapeutic classes in the last 14 days	Hard denial
Drug-to-drug interaction	2-way edit: overlap in drugs (examples: opioid combinations, opioid agonists, anticonvulsants/benzodiazepines, non-barbiturate hypnotics)	Soft edit or hard denial, depending on drugs involved and/or dosing
Duplicate therapy	2-way edit: overlap in drugs (examples: HMG-CoA reductase inhibitors, proton-pump inhibitors, selective serotonin)	Soft edit or hard denial, depending on drugs involved and/or dosing

RETROSPECTIVE REVIEWS

Our Kentucky Medicaid retrospective DUR program (staffed by a Process Manager and a Clinical Pharmacist) assesses both drug use in individual patients and prescribing and dispensing patterns among prescribers and contracted pharmacies. In compliance with State and federal regulations (including 42 U.S.C. § 1396r-8 and 42 C.F.R. part 456, subpart K, section 456.709), we have designed our retrospective DUR process to review claims and other electronic data to identify overutilization, non-compliance, underutilization, drug-drug interactions, drug-disease contraindications, therapeutic duplication, and misuse of controlled substances. Our reviews also determine whether service delivery occurred as prescribed and in compliance with Humana policies and procedures.

In addition to conducting all reviews mandated by DMS, our Patient Safety and Clinical team reviews quality measures, patient outcomes, and other data sources to identify potential areas of focus for retrospective reviews. Retrospective reviews typically review 90-120 days of claims and electronic data, with variation by review topic. When our DUR program identifies a potential problem, we initiate outreach to the Enrollee, care management team, prescriber, and/or pharmacy. This outreach may take the form of a notification letter, telephonic outreach by an HPS representative, or peer-to-peer review with our Kentucky Medicaid Medical Director.

We have implemented several routine, retrospective interventions to target providers who are over-prescribing opioids. Between 2016 and 2018, our opioid utilization interventions have reduced the number of Humana Enrollees filling opioid prescriptions **in excess of 100 MMEs by 29.2%** and the number of Enrollees filling a benzodiazepine prescription **while in possession of an opioid by 31.9%**.

Examples of Historic Retrospective DUR Interventions

Inappropriate Off-Label Use of Namenda (to treat signs of dementia) in Persons Ages 26 and Younger:

To address inappropriate, off-label use of Namenda (memantine) in Enrollees ages 26 and younger, Humana issued provider and Enrollee letters upon identification of inappropriate off-label use and implemented a POS edit. These interventions resulted in a **66% reduction in paid claims** for Namenda among Enrollees ages 26 and younger.

Chronic High Dose Acetaminophen:

Acetaminophen is effective and safe when taken as directed; however, consuming more than directed can lead to liver damage. To drive awareness and promote education on safe acetaminophen use, Humana issued letters to providers found to be prescribing doses of acetaminophen exceeding the FDA-recommended daily dose of four grams for 30 days within a six-month period. This intervention led to a **69% decrease in prescriptions** for doses greater than four grams.¹

¹ <https://www.chpa.org/Acetaminophen.aspx>

Retrospective DUR for Psychotropic Medications

To address the high rate of psychotropic usage among Kentucky's adults and children, our BH DUR program will include a targeted psychotropic DUR for our Kentucky Medicaid plan. Misuse of psychotropic drugs exposes Enrollees to unnecessary side effects and often leads to deterioration of medical and cognitive status. We have designed several policies and procedures for the monitoring of psychotropic drugs to ensure their appropriate use among adults and children. Our BH DUR program for our Kentucky Medicaid plan has been closely modeled after our BH DUR program in our Florida Medicaid program, the results of which are summarized in the text box below. In our PDL and UM processes, we will implement peer-reviewed clinical practice guidelines for psychotropic medication use. If we identify patterns outside of these parameters through our DURs, we will conduct a peer-to-peer discussion with the responsible prescriber. For example, an analysis of psychotropic prescribing data for our Kentucky Medicaid Enrollees revealed that the top 10 prescribers of psychotropic medications accounted for 32.7% of total psychotropic prescription volume. This indicated a need to target these providers with interventions to understand and work to reduce any inappropriate prescribing. Through our DUR program, we apply advanced analytics and clinical review to identify claims-based, medication-related issues for Enrollees receiving psychotropic medications, focusing on the following challenges:

- Medication adherence for Enrollees taking medications that require consistent, ongoing use
- Sub-therapeutic dosing of psychotropic medications that require therapeutic dosing
- Polypharmacy of psychotropic medications
- Potential cases of uncoordinated prescribing when multiple clinicians are involved in treatment
- Possible fraudulent or abusive prescription patterns
- Outlier Enrollee cases that may indicate potential medication utilization safety concerns
- Inappropriate use of psychotropic medications in the presence of underlying medical conditions
- Use of antipsychotic medications in Enrollees with dementia
- Use of antipsychotic medications in pediatric Enrollees

Humana will offer a psychiatric consultation service for PCPs and OB/GYNs offering care to our Kentucky Medicaid Enrollees. Through this service, providers can receive a consultation from a psychiatrist, equipping them to deliver BH services in line with their professional capacity, including systematic and evidence-based screenings, and treatment for mild or moderate BH conditions (including medication management, as appropriate), without further referral.

Addressing Psychotropic Use in Humana's Florida Medicaid Program

We achieved the following results among our Florida Medicaid network providers who received a BH DUR intervention targeting psychotropic medications in fiscal year 2018:

- 11% improvement in the Average Proportion of Days Covered ratio among Enrollees whose prescribers were targeted for intervention, indicating improved medication adherence
- 58% of prescribers that received an intervention for suboptimal dosing changed their behavior
- 67% of prescribers that received an intervention for polypharmacy changed their behavior

APPROACHES TO COLLABORATE WITH THE DEPARTMENT ON PHARMACY INITIATIVES

Humana will continue to partner with DMS on pharmacy initiatives. In addition to learning about pharmacy initiatives through the Kentucky Medicaid Pharmacy Director Workgroup meeting, the monthly joint meeting, and other DMS forums, Humana will continue to identify trends among our Medicaid Enrollees and suggest potential initiatives on which Humana, DMS, and other MCOs can collaborate.

To date, Humana has partnered with DMS on initiatives including KLIP. As of January 2020, Humana has 48 Enrollees participating in KLIP for pharmacy utilization. In addition to seeking DMS approval on KLIP procedures,

Humana is working with DMS to determine ways to improve the operations and effectiveness of KLIP, including standardization of KLIP across Medicaid FFS and managed care programs.

In addition, Humana will collaborate with DMS on related universal policy implementations (including buprenorphine provider programs). We will also partner with DMS if regulations are changed to require a uniform PDL or formulary. We have experience implementing a State-mandated formulary and PDL through our Florida Medicaid plan and can share with DMS best practices and lessons learned from this experience to inform uniform policy implementation in Kentucky.

a.v. Proposed Maximum Allowable Cost (MAC) program.

The strategic goal of Humana's MAC program is to ensure reimbursement of a fair and market-competitive amount that derives pricing based on current relevant generic drug acquisition data. This aligns with DMS's requirement (per Section 31.13 Maximum Allowable Cost of the Draft Medicaid Contract) to promote generic utilization and cost containment. Our MAC program includes the following key operational elements.

- Establishing MAC prices: We calculate MAC prices on a weekly basis based upon acquisition pricing available from several leading national generic drug wholesalers and external, publicly available acquisition pricing data, including National Average Drug Acquisition Cost (NADAC) data and other available Medicaid benchmark pricing information. We communicate any increases in MAC reimbursements to all network pharmacies through our secured pharmacy portal and via fax blasts, as required.
- Senate Bill 5 Maximum Allowable Pricing Compliance: Maintaining compliance with the requirements of Senate Bill 5 has been a key priority for Humana's network and pricing strategy for our Kentucky Medicaid plan. Humana has demonstrated the ability to quickly adapt to new operational and reporting requirements as the Commonwealth has increased its oversight of drug pricing for the Medicaid program. To date, **Humana has met or exceeded all requirements of Senate Bill 5**, including contractual and drug level approvals for all pricing changes greater or equal to five percent, as well as full pricing list approvals for all MAC pricing currently used in the Medicaid program. In addition, Humana has received approval regarding the file layout of the new monthly MAC file reporting requirements that are being implemented in early 2020.
- Monitoring of the generic pipeline: Our pricing teams strive to react quickly to market events that may impact product pricing and availability, including new generic drug launches, drug shortages, and changes in the generic manufacturing market. Our MAC program is coordinated with the HPS clinical team, which is responsible for monitoring generic launches. This team tracks whether the launch is exclusive or competitive, and (if competitive) how many manufacturers will enter the market at launch. This allows our MAC team to lower costs by putting the newly-launched drug on MAC in a timely manner. Upon the launch of a multisource generic launch, Humana's goal is to add the new drug to MAC within 14 to 45 days of product launch. For example, we added generic Lyrica to MAC on September 1, 2019, 41 days after a competitive launch in which with several manufacturers came to market shortly after the initial launch. Similarly, we responded quickly to the launch of Advair, which was launched on February 8, 2019, became multi-sourced on February 12, 2019, and was added to MAC 21 days after launch on March 1, 2019.
- Keeping generic pricing aligned with the generic acquisition market: We reference several wholesalers, as well as NADAC, to adjust MAC prices up or down to reflect the generic acquisition market.
- Sources for establishing MAC prices: Humana verifies wholesaler availability and published acquisition costs from leading national wholesalers, including AmerisourceBergen, Anda, Cardinal, McKesson, and NADAC.
- MAC appeal process: Humana has implemented a robust process to receive, investigate, and respond to pharmacy pricing appeals from network pharmacy partners and has experience complying with state-specific regulations covering MAC pricing. We maintain a dedicated e-mail account and fax number for inquiries about MAC. In addition, the appeals form can be found on Humana's pharmacy portal. We will respond within five business days with our final decision. Our final decision is based upon our review of the

generic acquisition market, including but not limited to wholesaler availability, acquisition price, and NADAC data.

In addition to monitoring the new generic pipeline, our network pricing team also ensures that MAC pricing is adjusted appropriately upwards when market events such as drug recalls, drug shortages, or generic manufacturer pricing increases are found within the generic drug supply chain. In 2019, Humana increased or removed from MAC pricing more than 90 generic medications related to pricing events. An example of such an event was a series of drug recalls within the statin class, including Valsartan and Losartan. These recalls drove significant issues of availability and pricing instability. After the FDA recalled a subset of lots for Valsartan on November 20, 2018, Humana monitored inventories from multiple national wholesalers weekly, and increased reimbursement as inventories were depleted throughout 2019.

a.vi. Approach to operation of a pharmacy call center.

PHARMACY TECHNICAL HELP DESK

Our pharmacy technical help desk provides quick, accurate responses to pharmacy inquiries, including issues regarding claims and eligibility. The pharmacy technical help desk uses a single, integrated call center with associates based in multiple locations, allowing for disaster recovery in the event of a natural disaster. The call center is toll-free, open 24 hours a day, seven days a week, 365 days a year and consistently meets federal call center compliance standards, in addition to meeting DMS’s requirements outlined in Section 31.15 Pharmacy Call Center Services of the Draft Medicaid Contract. Our pharmacy technical help desk uses an Integrated Voice Response system to support call routing and provide upfront information. The caller can opt to speak directly with a live representative by selecting the corresponding option on the first menu.

Our pharmacy technical help desk handles calls concerning:

- Eligibility
- “Refill too soon” alerts
- Miscellaneous processing questions
- Authorization requests
- “Claim exceeding plan limitations” alerts
- DUR questions
- Copay inquiries

Staffing and Training

The pharmacy technical help desk employs approximately 160 customer service representatives. At a minimum, a new customer service representative receives more than 150 hours of training. All customer service representatives receive another 68 hours of training each year. Training programs for new customer service representatives include a trainer-facilitated classroom curriculum with call/system simulation exercises. New customer service representatives are observed for an extended period of time before being placed on the floor.

Training topics for customer service representatives include:

- Use of telephonic equipment
- Call flow and customer care techniques
- Core system usage (RxNova Connect)
- Pharmacy claims processing standards
- Customer-specific procedural information

Simulations used during training include role plays of standardized call handling routines, as well as use of the RxNova Connect’s “Contextual Help” and/or intranet reference material. Customer service representatives take phone calls in a controlled environment before being assigned as part of the regular staff schedule. This step occurs in a training room with a trainer and peer mentors available to supervise and provide guidance in call handling.

Quality monitoring of our pharmacy technical help desk includes a combination of observation, silent monitoring, and side-by-side sessions. Call performance is evaluated based on standardized criteria, including validation, accuracy of information, customer care, and closing. Each call is randomly monitored and scored based on these standard criteria, and feedback is provided to the participating customer service representative. The help desk monitors at least 10 calls per month per associate and compares these calls against these standard criteria. In addition, call scores are tracked over time and utilized in the annual performance appraisal process for all customer service representatives.

VENDOR PERFORMANCE MONITORING

We conduct daily, monthly, and quarterly monitoring of technical help desk performance as follows:

- **Daily:** Humana receives a daily call center report from the technical help desk, providing the previous day's results. Once received, the team inputs the daily metrics into our call center dashboard. If any metric falls below the CMS threshold, the technical help desk is required to provide justification within the e-mail communicating the daily call center report. This justification is then documented by our Vendor Management team within the "Missed Metric" portion of our call center dashboard. If the technical help desk repeatedly fails to adhere to performance standards, our Vendor Management team holds a meeting with help desk managers to discuss an action plan to achieve compliance.
- **Monthly:** On the first day of each month, the technical help desk shares the previous month's overall results. This information is also imported into the dashboard used by our Governance, Risk, and Compliance program. The dashboard indicates whether the technical help desk has met the performance standard for each metric. Any substandard performance is subsequently addressed with the technical help desk managers.
- **Quarterly:** Humana accesses CMS's Health Plan Management System's website each quarter to extract call data and statistics. Average hold times and disconnect rates are compared to the standards for each contract. Our Vendor Management team discusses any calls that were not completed successfully or had unprofessional behavior with the technical help desk managers.

In 2019, our pharmacy technical help desk answered 888,667 calls. During this time period, the call center surpassed both the URAC and Service Level Agreement (SLA) standards for the abandonment rate (1.10% as compared to a standard of 5%) and average speed of answer of 14 seconds (compared to a standard of 30 seconds).

With DMS's approval, Humana will provide a pharmacy call center quality assurance program. We will make our pharmacy technical call center monitoring results available to DMS on a monthly basis.

b.

Describe the Contractor's pharmacy claims payment administration, including an overview of the Point of Sale (POS) system and processes for complying with dispensing fee requirements.

OVERVIEW OF THE POINT OF SALE SYSTEM

All pharmacy claims, regardless of the source (retail or specialty), are processed, adjudicated, and paid through our online, real-time POS system. Our POS system complies with all requirements described in Section 31.8 Pharmacy Claims Payment Administration of the Draft Medicaid Contract, including the following requirements.

- 24 hours per day, seven days per week operations, except for any downtime pre-approved by DMS
- Flexibility to add, change, or remove claim adjudication processing rules to accommodate state and federal required changes within 30 days, unless otherwise approved
- Ability to apply an Internal Control Number to each claim and its supporting documentation to track claims, conduct research, perform reconciliations, and support audits



We bring a tradition of excellence to POS claims processing. **Our system processed more than 490 million claims in 2019.** Humana adjudicates more than 99% of pharmacy claims electronically in real time at the POS. We process all National Council for Prescription Drug Programs (NCPDP) D.0 standard claims within one second of processing time. In 2019, our POS system experienced no downtime, delivering 100% availability to our Enrollees and providers. In 2018, our system delivered 99.98% availability, with only one unexpected outage that lasted 107 minutes and affected only a portion of incoming claims. **Figure I.C.21-5** illustrates our POS system.

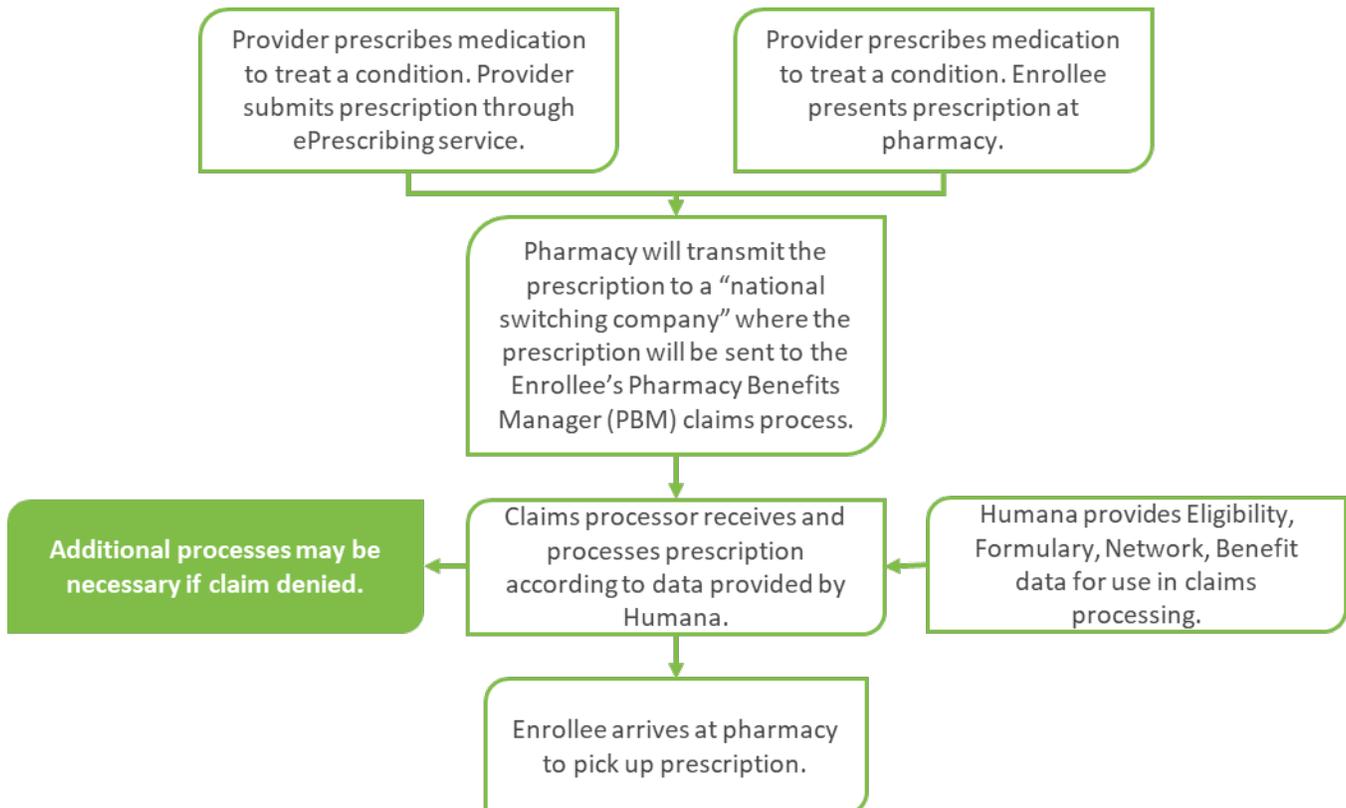
In addition to electronic claims, we offers providers the option to submit claims through batch electronic media and paper. We currently process less than 1% of pharmacy claims manually, including when Enrollees submit a paper claim at an out-of-network pharmacy. In 2019, 99.99% of the more than 3.6 million Humana Medicaid pharmacy claims were submitted electronically. We process clean manual claims in our system within 24 hours of receipt. Our Compliance and Pharmacy departments are dedicated to claims accuracy, early issues detection, and daily claims monitoring for both electronic and manual claims.

PROCESSES FOR COMPLYING WITH DISPENSING FEE REQUIREMENTS

To operationalize the dispensing fee requirements of Kentucky Medicaid, Humana will include a reference to the State-mandated dispensing fee in all pharmacy agreements. This fee will be captured as an incremental dispense fee, outside of the amount listed within the dispense fee reimbursement category of the terms sections of the agreement.

As part of the pharmacy contract maintenance process within our claims system, we will add the State incremental dispense fee (\$2) into the pharmacy’s contracted dispense fee. This will allow the combined amount to be reflected on the provider record used in the claims adjudication system and will ensure that the combined dispensing fee is paid during each claim adjudication without imposing additional claims submission requirements on network pharmacies.

Figure I.C.21-5: Point of Sale Claims Processing Workflow



c.

Describe the Contractor's processes and procedures to provide timely, accurate and complete data to support the Department's rebate claiming process and ensure the Department maintains current rebates levels.

Humana is committed to continue providing timely, accurate, and complete data to support the Department's rebate claiming process and ensure the Department maintains its current rebate levels. Our Pharmacy Encounter team creates an NCPDP encounter data file from a daily feed of paid claims that is sent to our Enterprise Data Warehouse, ensuring all required fields are completed and in the required format. This file is submitted to the Department each week, including total amount paid and indication of 340B status to support correct rebate claiming. Encounters are submitted within 30 days of claim adjudication. This automated process ensures timeliness, accuracy, and completeness in our encounter submissions and allows prompt receipt of rebates by the Department. Any denied encounter is reviewed and resubmitted within 30 days.

In 2019, we submitted more than 4.7 million pharmacy encounters for our Kentucky Medicaid Enrollees, achieving a 99.8% acceptance rate.

We have established a robust daily monitoring and tracking process to ensure that we consistently uphold standards of accuracy, completeness, and timeliness in support of the Department's rebate claiming process:

- **Timeliness:** We track timely submission of pharmacy encounter data through our monthly Timeliness Audit report and trend our compliance month by month in our Timeliness Metric report
- **Accuracy:** We track the accuracy of our encounter submissions through our Encounter Submission and Error Tracking report, which identifies the volume of errors in our encounter submissions and trends our performance to identify improvement opportunities
- **Completeness:** We monitor that we are submitting an encounter for every pharmacy claim through a completeness report

REBATES FOR DRUGS COVERED UNDER THE MEDICAL BENEFIT

Our process for the submission of encounters for drugs covered under the medical benefit replicates that of drugs covered under the pharmacy benefit. Any encounter that contains a J-code is submitted to the Department in the required encounter files, ensuring the timeliness and accurate submissions that we have achieved for encounters covered under the pharmacy benefit.

DISPUTE RESOLUTION

HPS will fully assist the Department in resolving any manufacturer disputes, including providing additional claims information as requested, making needed corrections, and re-submitting encounter data to the Department. Candace Richardson and Courtney Hood, members of Humana's pharmacy encounters team, are the main points of contact for the Department on issues related to encounters and rebates.

d.

Describe the Contractor's processes and procedures to provide data and support Department-based efforts and initiatives for 340B transactions.

Our processes and procedures related to 340B transactions will comply with all requirements of Section 31.11 340B Transactions of the Draft Medicaid Contract, as well as the guidelines of DMS's **340B Policy and Procedures Manual**, with an effective date of April 1, 2020. Humana recognizes the importance of minimizing duplicate discounts that can occur if the Commonwealth seeks a federal drug rebate on a drug that was purchased under the 340B Drug Pricing Program. We have therefore designed our provider education, claims processing, and encounter reporting processes (as described below) to support the Department in their efforts to ensure accurate rebate collection.

As part of Humana's pharmacy network application process, we require pharmacies to disclose their participation in the 340B program. After 340B participation is confirmed, we include terms and operational requirements within the agreement to ensure pharmacies are appropriately indicating 340B status on claims submitted to Humana (where appropriate). We work with our network pharmacies to complete any necessary contract addendums to permit them to dispense 340B medications.

COLLECTING AND PROVIDING DATA TO SUPPORT DEPARTMENT-BASED EFFORTS FOR 340B TRANSACTIONS

Our systems capture 340B claims both in real time and retrospectively. We have developed an end-to-end audit process to ensure we identify and record 340B-eligible claims. We transmit all data on 340B transactions to DMS via encounter files, including physician-administered drugs (with the exception of inpatient hospital drug encounters). The 340B indicators and UD modifiers on these files ensure encounters are not inappropriately submitted for a rebate.

We also review information received from drug manufacturers as part of the rebate reconciliation process. This review identifies claims not flagged as 340B-eligible during the initial claims adjudication process that may, in fact, be 340B-eligible. We audit these claims to confirm their 340B status and re-adjudicate (if necessary) to ensure accurate rebate submissions and to support DMS-based efforts and initiatives targeting 340B transactions.

PROVIDER EDUCATION

Humana is committed to implementing appropriate provider education in support of the Department-based efforts and initiatives for 340B transactions. This education is aimed at supporting proper dispensing, billing, and participation under the 340B program with the goal of ensuring accurate, complete, and timely 340B encounter reporting. Our provider education mechanisms include:

- **Onboarding training:** We educate our pharmacists on proper dispensing procedures under Section 340B of the Public Health Service Act during our onboarding provider training, offered at the beginning of each contract.
- **Annual training:** We will add information about the 340B program to the annual training required of all Humana network providers, including pharmacies.
- **Provider manual:** We include details on Kentucky-specific 340B processes in our pharmacy Provider Manual, available at any time without a login through our public website. This includes a description of those codes that should be used when dispensing medications acquired under the 340B program. For Kentucky Medicaid, pharmacy providers are instructed to use a submission clarification code (42Ø-DK) field with a value of 20.
- **Website:** We will design and maintain a dedicated page on our website that contains education about the 340B program, how to participate in the program, and how to properly submit claims for Kentucky Medicaid Enrollees.
- **Provider newsletter:** To promote awareness among our provider network of the changes in DMS policy, our first quarter 2020 Kentucky Medicaid provider newsletter will include education on the new 340B Policies and Procedures Manual.
- **Provider and pharmacy call centers:** Our pharmacies and providers can contact our pharmacy technical help desk for additional support in complying with 340B policies and procedures, including support to ensure correct claims submission.

e.

Describe the Contractor's pharmacy Prior Authorization process, including the following as part of the response:

Humana views PA as an essential quality of care tool. Our process aims to ensure Enrollee safety and the appropriate use of drugs (relative to existing standards of care) while decreasing inappropriate utilization and unnecessary costs. Our PA program adheres to requirements of section 1927(d)(5) of the Social Security Administration (SSA) and to DMS requirements outlined in Section 31.12 Pharmacy Prior Authorizations of the Draft Medicaid Contract.

e.i.

Transparency in communicating the conditions for coverage to providers.

Humana is committed to making information about drug coverage clear, consistent, and transparent for our providers (including our network pharmacies) and Enrollees. In addition to making this information easily accessible to our providers through our website, we have designed our PA process to be transparent from the time of the initial request (whether electronically, via phone, or via fax) to the approval or denial of the request by Humana Clinical Pharmacy Review personnel.

Our Humana Clinical Pharmacy Review Call Center handles inquiries related to clinical processes, including requests for authorizations and clinical overrides. Staffed by pharmacists, Pharmacy Inbound Contact Representatives and UM Administration Coordinators, the HCPR Call Center operates from 8:00 A.M. to 6:00 P.M. Eastern Standard Time (EST), Monday through Friday, with a voicemail and call-back option for after-hours inquiries.

PROVIDER COMMUNICATION AND EDUCATION

Through three decades of experience managing pharmacy benefits, Humana has identified several effective methods to educate our network, disseminate information, and ensure transparency in communicating the conditions for coverage to providers. These include:

- **Orientation:** Our provider orientation – required for all network providers – includes education on our PDL.
- **Website:** Our providers can access our Kentucky Medicaid PDL (and all other PDLs) through our public website and can log into our secure site to access a searchable PDL that provides all coverage conditions.
- **Provider Relations:** We train our Provider Relations Team to educate our providers on coverage provisions and our pharmacy PA process. Providers can contact our HCPR call center or their assigned Provider Relations representative for questions regarding the pharmacy PA process and conditions for coverage.
- **Provider newsletter:** Humana publishes a newsletter providing updates on news and tools that make it easier for providers to do business with Humana. These newsletters contain articles on topics such as updates on PAs and referrals (including changes to clinical criteria or the PDL); updates to our claims policies and code edits; highlights of policies affecting healthcare providers and their patients; newly released state and federal guidance/requirements; and announcements of online tools, presentations, and webinars.
- **Reference guide:** All network providers are furnished with a reference guide describing Humana's PA process including online, fax, and telephonic methods to submit PA requests (see **Attachment I.C.21.e.i-1 – Prescriber Quick Reference Guide**).
- **PA request denials:** When PA requests are denied, Humana sends a formal denial letter along with educational materials to reinforce coverage conditions.
- **Clinical alerts:** When our DUR process detects an inappropriate medication combination, drug-disease interaction, or other issue that prohibits dispensing, we provide a clinical alert via IntelligentRx to educate the provider about the identified issue, assist in identifying a formulary alternative, and avoid similar issues in the future.

Transparency in Communicating Decisions of our P&T Committee

As described above, minutes of Humana’s P&T Committee meetings are published publicly on our P&T Committee webpage. To ensure that our Kentucky Medicaid providers are aware of these decisions, we publish a summary of any PDL changes or new policies impacting Kentucky Medicaid on our public website and confirm that the PDL and clinical criteria on our website and provider portal are updated accordingly.

AUTOMATED PRIOR AUTHORIZATION REQUESTS

A key aspect of our commitment to transparency in coverage decisions is our electronic PA process. Through our participation in the SureScripts network, our formulary and Enrollees’ medication history are available through every major EHR and eRx vendor. In addition, our system is comprehensively integrated with DrFirst, Allscripts, Epic, Cerner, and Athena (with another system, eCW, to be added this year). This integration supports **IntelligentRx’s Real-Time Benefit program**, through which a provider using a compatible EHR system can obtain information about drugs that require PA prior to prescribing, in addition to real-time clinical information about coverage, formulary alternatives, and safety alert messaging. With this information, the prescriber and Enrollee can discuss which drug is the most appropriate option prior to submission of the electronic PA request, avoiding delays at the POS due to a lack of PA approval or a hard edit. Approximately 73% of Humana’s provider network use EHR systems to submit requests for pharmaceuticals.

Humana recently partnered with Epic to integrate IntelligentRx directly into Epic’s e-prescribing workflow. This advanced interoperability will promote provider use of IntelligentRx, allowing more seamless integration of benefits, our PDL, and safety information into prescribing practices and emphasizing full transparency into Humana’s conditions for coverage.

For drugs requiring PA, prescribers can enter all necessary information through IntelligentRx. If the request meets all clinical PA criteria, it will auto-approve. If the request does not auto-approve, the prescriber can submit the request electronically via the platform operated by CoverMyMeds. Prescribers who do not use IntelligentRx can also submit electronic requests via the CoverMyMeds platform. **CoverMyMeds feeds directly into PA Hub (our automated PA system)**, enabling swift review of PA requests and ensuring our reviewers approve or deny requests within the required 24-hour timeframe. Humana engages in outreach and education activities with our pharmacy network and physician network to encourage use of these innovative and effective online PA systems.



PA reviews may also be initiated when a pharmacist enters a claim at the POS into the claims adjudication system. Our POS claims adjudication system, with the integration of IntelligentRx, is capable of supplying real-time POS authorization using pharmacy and medical claims data and clinical criteria. When the PA request is not approved, IntelligentRx provides a message to the pharmacist with an error code and the reason for the denial.

MANUAL PRIOR AUTHORIZATION REQUESTS AND DETERMINATIONS

Recognizing the varied capabilities and readiness of providers to use EHR and other technologies, we offer other avenues for submitting PA requests, including via a toll-free telephone call to Humana Clinical Pharmacy Review and fax. We offer our providers the option to use the designated Kentucky Medicaid pharmacy universal form or a DMS-approved, Humana-specific form. Prescribers receive a determination notification within 24 hours of submission. We notify providers submitting fax requests of the approval or denial via fax. If the request is denied, the Enrollee who is the subject of the request also receives a mailed letter communicating the result.

Our UM reviewers use our automated PA system, PA Hub, to review and approve PA requests. By applying PA Hub to our reviews, we ensure both uniformity in decision-making and adherence to the approved criteria. If the initial review indicates that the request does

In 2019, we achieved **100 percent** compliance with PA request timeliness standards for our Illinois Duals Demonstration plan and **99 percent** compliance with timeliness standards for our Florida Medicaid plan.

not meet PA criteria or requires additional review, we forward the request to a Humana Clinical Pharmacy Review pharmacist for further review, leading to an approval or denial. Only Medical Directors and Humana Clinical Pharmacy Review pharmacists have authority to deny a PA request. All communications of adverse benefit determinations include the reason for the denial. Upon request, a Kentucky Medicaid Medical Director will undertake a peer-to-peer review with the requesting prescriber to provide full transparency into the decision-making process.

In the event a prescription is waiting on PA approval due to additional information needed from the prescriber (and Humana Clinical Pharmacy Review will therefore exceed the 24-hour determination timeframe), we enable a 72-hour emergency fill if the dispensing pharmacist deems the medication necessary to avoid imminent harm or injury to an Enrollee. Once approval is received and the pharmacy fills the rest of the claim, pharmacists are instructed to subtract the emergency supply from the remainder of the prescription. If the physician prescribes an amount that is more than a 72-hour supply but is packaged so that it must be dispensed intact, the pharmacist may dispense the packaged drug and quantity even if it exceeds a calculated 72-hour supply.

e.ii. Required credentials for staff reviewing, approving and denying prior authorization requests.

Our Humana Clinical Pharmacy Review team is dedicated to reviewing, approving, and denying PA requests. **The Humana Clinical Pharmacy Review team is supported by 67 pharmacists and 750 non-clinical associates (i.e., Pharmacy Inbound Contact Representatives and UM Administration Coordinators).**

The clinical pharmacists who staff our Humana Clinical Pharmacy Review team are required to have a bachelor's degree, an active license, and a pharmacy degree from an accredited college of pharmacy. Our Pharmacy Inbound Contact Representatives, who are responsible for capturing clinical information from callers and electronic fax, must have a high school diploma or equivalent, along with one year of customer service experience.

Entries by our Pharmacy Inbound Contact Representatives are automatically reviewed by PA Hub. If the necessary information is present and meets all criteria, the request is approved. If information is still needed or PA Hub cannot approve the request, the request is then routed to a pharmacist to review and approve or deny the request. Only licensed pharmacists and Medical Directors are able to deny requests.

We regularly monitor the quality of decision making and criteria application skills of our Humana Clinical Pharmacy Review pharmacists. Our inter-rater reliability approach evaluates the consistency with which our pharmacist reviewers apply criteria in reviewing, approving, and denying PA requests. We conduct case-based inter-rater reliability assessments every quarter to measure congruence between pharmacist reviewers. We aim for 90% congruence between pharmacist reviewers. If the group of pharmacist reviewers fails to meet the established goals, a performance improvement plan will be developed and implemented, followed by retesting, as applicable. If an individual fails to meet the established goal, their leader develops and implements an individual performance improvement plan. In addition, HCPR uses inter-rater reliability results to review and improve upon existing policies and/or processes.

e.iii. Use of pharmacy and/or medical claims history to adjudicate prior authorization requests.

Our PA request adjudication process (for both auto-approvals and manual reviews) includes review of pharmacy and/or medical claims history. By incorporating pharmacy and medical claims history into our PA review process, we promote patient safety, deliver faster service to our Enrollees, and reduce administrative burden on prescribers and pharmacies. Below, we describe how we use pharmacy and/or medical claims history when prospectively reviewing PA requests at the point of care, processing PA requests at the point of sale, and/or

when our Humana Clinical Pharmacy Review associates are manually reviewing PA requests or conducting peer-to-peer reviews.

- **Point of care:** When the PA request cannot be approved due to lack of medical necessity, IntelligentRx’s algorithms supply **personalized formulary alternatives** using the Enrollee’s pharmacy and medical claims history, including identified diagnoses. By generating these alternatives at the point of care – before the prescription is issued – we expedite the process for identifying an alternative treatment and dispensing an appropriate drug to the Enrollee.
- **Point of sale:** IntelligentRx enables **real-time UM authorization, or “Fast Pass.”** This means that an Enrollee’s clinical diagnosis and current medication use and regimens are factored into our PA review process, both allowing **auto-approval** of the claim at the POS and preventing the dispensing of medications that may lead to drug-to-disease interaction or that violate another customized safety rule (as described below in Tables I.C.21-4 and I.C.21-5). If the request cannot be auto-approved, a list of personalized formulary alternatives is again generated, using the Enrollee’s pharmacy and medical claims history.
- **Manual reviews:** When manually reviewing the PA request, our HCPR pharmacists combine the information submitted by the requesting prescriber with the Enrollee’s pharmacy and medical claims history to assess the claims for medical necessity or possible safety concerns and render a determination.
- **Peer-to-peer reviews:** In addition to the claims data and other information captured by the reviewing pharmacist, our Medical Directors can access our integrated clinical platform, CGX, to view additional Enrollee history prior to conducting a peer-to-peer review. These data both inform the review and provide additional context for the discussion.

Through Humana’s pharmacy POS claims adjudication system and integration with IntelligentRx, we have multiple DUR edits in place to ensure safety and appropriateness in the medications dispensed to our Enrollees. IntelligentRx’s rules engine contains several features that draw upon our Enrollees’ medical and pharmacy claims history. These include those the safety edits described in **Table I.C.21-4** and the soft rejection edits described in **Table I.C.21-5**.

Table I.C.21-4: Drug Utilization Safety

DUR Type	Pharmacy Information	Example
Drug-drug interactions	Identifies significant interaction with active medication in patient history, including medication name.	Selective serotonin reuptake inhibitors/monoamine oxidase inhibitors
Drug-age interaction	Identifies safety risk related to use of specific medication for patient’s age	Adderall for age younger than 6
Drug-disease interaction	Identifies safety risk when medication is contraindicated for a patient’s disease state. Disease may be inferred or identified via medical claims.	Disease: Congenital long QT syndrome
Drug-gender interaction	Alert of safety risk related to use of specific medication for reported gender	Makena
Maximum dose	Identifies safety risk when dosage exceeds First Data Bank (FDB) maximum adult daily dose. Ratio of exceeding FDB maximum dosing is specific to the medication.	Digoxin daily
Morphine equivalent dosing (MED): High dose	Identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 100 milligram MED per day will trigger this error code.	MS contin 30 mg twice daily plus Percocet 5/325 two tablets every four hours as needed

Table I.C.21-4: Drug Utilization Safety

DUR Type	Pharmacy Information	Example
MED: Overuse	Identifies patients at greater risk of overdose or inappropriate opioid utilization. Dosing greater than 250 mg MED per day and/or more than four providers and more than four pharmacies.	MS contin 100 mg three times daily
Plan limitations exceeded: Accumulation	Identifies the potential for an overdose resulting in single or multiple medications and cumulative doses that exceed safe daily maximums.	Acetaminophen dose greater than 4 grams per day
Therapeutic duplication	Identifies duplication with active medication in patient history, including medication name	Two prescriptions for different angiotensin receptor blockers

We instruct pharmacists who receive one of error codes in Table I.C.21-5 to apply their clinical judgment in reviewing the alert, recommending therapy changes, and overriding the alert (when clinically appropriate) using a pharmacy professional service code.

Table I.C.21-5: Soft Rejection Edits

NCPDP Error Code	NCPDP Description
88: DUR reject code	This drug interacts with patient’s other drug(s)
88: DUR reject error	This drug may duplicate current patient therapy
88: DUR reject error 922: Morphine equivalent dose exceeds limit	Cumulative morphine equivalent dose exceeds limits
AG: Exceeds opioid initial fill limits 925: Initial fill days’ supply exceeds limit	Days’ supply limitation for product/service

We regularly monitor pharmacy trends to determine additional opportunities to improve IntelligentRx’s functionality and the value it delivers to our Enrollees and providers. For example, we have added edits that draw upon Enrollees’ medical and pharmacy claims history to promote appropriate opioid and antipsychotic use, in response to trend seen in our own membership and across the Commonwealth. These edits were further detailed in **Table I.C.21-3** in sub-question I.C.21.a.iv of this response.