

**Molina Healthcare, Inc.**

**Pharmacy Benefit Manager Oversight and  
Surveillance Program Description**



## Revision History

Version Number	Date of Change	Purpose of Change	Author
V1.0	6/17/2019	Initial document	Jason Barretto

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## **Pharmacy Benefit Manager Oversight and Surveillance Program**

Molina administers pharmacy benefits and related services in accordance with Commonwealth and federal contracts and all applicable and federal laws and regulations. Although our dedicated pharmacy staff performs most of these services, some are delegated to a Pharmacy Benefit Manager (PBM). We require the PBM to meet all applicable contract requirements and performance standards under its contract with Molina and by extension, Molina's Commonwealth and federal contracts. Molina's dedicated in-house pharmacy team is charged with contractual oversight of the PBM. We verify that contractual obligations are being met in three cycles:

- During benefit and Preferred Drug List (PDL) configuration, testing, and maintenance
- Through ongoing claims surveillance using pharmacy claims and encounter data
- During an annual contract audit conducted by an independent third party

This PBM Oversight and Surveillance Program description provides a detailed description of all three cycles of our PBM oversight program to drive accountability and transparency.

### **Benefit/PDL Setup and Maintenance**

Molina collaborated with the PBM to design a best in class benefit/PDL configuration validation and testing process. Prior to any changes going live in the PBM's claim adjudication platform, Molina performs a thorough testing process. We execute validation of the systems configuration and performance to ensure it meets our intent and contractual obligations. We compare our PDL/ formulary data files to the files in the configured PBM system through algorithms to verify accuracy. Any variances identified are sent to the PBM for correction. **Molina does not allow the PBM to make any changes to the PBM's claim adjudication platform without our explicit written consent and approval.**

In validating appropriate set-up and configuration, Molina examines the following scenarios:

1. Formulary Status
  - a. Preferred
  - b. Non-preferred
2. Prior Authorization Status
  - a. Step Therapy
  - b. Prior Authorization Required
  - c. Automatic Prior Authorization
3. Utilization Management Status
  - a. Maximum Daily Dose
  - b. Quantity Over Time
  - c. Age Limitation
  - d. Drug Utilization Review
  - e. Gender Restrictions

*Process Summary*

For PDL/formulary changes, Molina will notify the PBM, in writing, of all necessary changes and provide a target date for completion as well as an effective date. The PBM will provide detailed test claim data files that Molina will systemically review using an algorithm to ensure claims will adjudicate with the appropriate formulary, prior authorization, and utilization management status before and after the target effective date. Molina will identify outliers and provide them to the PBM for correction. Molina requires all corrections to be completed by the PBM prior to the targeted completion date.

**Ongoing Claims Surveillance**

Surveillance of our claims and encounters is the process where Molina systemically audits every paid, reversed, and rejected transaction. Detailed algorithms flag outliers for further review and validation by Molina’s team of pharmacy data analysts. False negatives prompt refinement of the algorithm and Molina sends true errors to the PBM for confirmation and resolution. Molina requires that the PBM respond to these within one business day and any resolution is to be completed within 24 hrs. All human or systemic errors impacting at least one of Molina’s Enrollees or providers or Molina’s financials/compliance requires a written corrective action plan.

The table below includes the current oversight and monitoring scenarios.

Indicator	Description
1. Formulary drug not paying - Validation of reject code 70	To ensure that covered items do not reject as non-formulary, claims are validated against our PDL/formulary data files. Claims for drugs on the PDL/formulary should not reject for “70 – Drug not covered”, else they are flagged.
2. Non-formulary drug paying–	To ensure non-covered items are not paid, all paid claims are validated against our PDL/formulary data files. If they are not on the PDL/formulary, they are flagged.
3. Prior Authorization (PA) drug paying without a PA – Validation of reject code 75	To ensure proper clinical review, claims requiring PA should not pay without the presence of an approved override. Claims for items that require PA that do not have a clinical override present should reject for “75 – PA Required” or else they are flagged.
4. Non-PA drug not paying	Claims for drugs do not require a PA authorization should not reject for “75 – PA Required” or else they are flagged.
5. Drug paying for greater than allowed quantity over time edit	To ensure Enrollee safety, claims quantity and days supply are validated against formulary utilization limits. Claims that pay for drugs that exceed the quantity over time edit are flagged.
6. Drug paying when Enrollee under minimum age edit	To ensure Enrollee safety, the Enrollee’s date of birth is compared to the age minimum set by the FDA for the specific drug reviewed. Claims for Enrollees who do not meet the age minimum should reject or else they are flagged.
7. Drug paying when Enrollee over maximum age edit	To ensure Enrollee safety, the Enrollee’s date of birth is compared to the age maximum set by the FDA for the specific drug reviewed. Claims for Enrollees who exceed the age maximum should reject or else they are flagged.
8. Drug paying when exceeding maximum quantity edit	To ensure Enrollee safety, claims quantity and days supply are validated against formulary utilization limits. Claims exceeding the maximum daily dose limit should reject or else they are flagged.
9. Drug paying with incorrect gender restriction edit	To ensure Enrollee safety, the gender code on the claim is validated against the gender restriction code on the formulary file. Claims where the gender does not match should reject or else they are flagged.

Indicator	Description
10. Drug with incorrect NCPDP rejection code	For each of the scenarios listed above, to ensure proper NCPDP reject code and messaging at the POS, claims reject codes and messaging are verified against the formulary and matched for compliance. Non-matched claims are flagged.
11. Drug paying with incorrect cost share	To ensure accuracy of Enrollee cost sharing responsibility, paid claims copay and deductible are validated against the contracted benefit design. Claims cost share should never exceed the indicated limits, else they are flagged.
12. DESI drugs paying inappropriately	To ensure Enrollee safety, DESI 5 and 6 drugs are not covered by Molina. To ensure these drugs are not paid for, all paid claims are validated against a list of known DESI 5 and 6 drugs. If there is a paid claim for a DESI 5 or 6 drug the claim will be flagged.
13. Prompt pay	To ensure prompt payment to providers, an algorithm is used to compare claims data against encounters data, any transaction with a paid date greater than the Commonwealth's payment timeliness requirement is flagged.
14. Plan paid accuracy	Validate that the contract pricing and lesser of logic (AWP, MAC, U&C or Submitted Amount) are triggering correctly at the POS as contractually required.

### **Annual Contract Audit using an independent third party**

Annually, through a request for proposal (RFP) process, Molina selects an independent third party auditor to review our PBM contract and validate the performance in five key areas: (1) discounts and fees, (2) rebates, (3) PDL/Formulary adherence (4) pass-through pricing, and (5) the PBM's retail pharmacy network agreement. The entire process—starting with the selection of the auditor to the final audit report—typically takes six months, but can take as much as nine months.

#### **1. *PBM Contract Pricing Audit* -**

- a. The relevant PBM contract provisions will be reviewed and the following will be independently verified by conducting an audit on 100% of the Plan Year pharmacy claims data for Molina's Medicare, Medicaid, and marketplace lines of businesses.
  - i. Aggregate discount guarantees (Maximum Allowable Cost (MAC) and non-MAC)
  - ii. Drug level guarantees (if applicable)
  - iii. Dispensing fee guarantees
  - iv. Transactional administrative fees (per claim)
  - v. Duplicate claims
- b. If underperformance / discrepancies are identified, they will be documented in the final audit report. Otherwise, contract compliance will be reported in the final audit report.

#### **2. *Rebate Program Audit* -**

##### **a. *Accuracy of Rebate Invoicing***

- i. Select a five-manufacturer contract sampling and review per line of business (Medicare, Medicaid, and Marketplace)
- ii. Travel onsite to the PBM's location to ensure rebates were invoiced at the rate specified in the manufacturer / PBM contract. Confirm all other related rebate remuneration was also invoiced.

- iii. While onsite, note all rebate eligible products listed in the manufacturer / PBM contract. Confirm all rebate contracted products that Molina did not collect rebates for were either: 1) not on Molina's formulary/PDL or 2) had no utilization.
- iv. Aside from confirming that entire products were not omitted from rebates, confirm that no lingering claims were excluded by cross-referencing the Rebate Detail File with the Claim File.
- v. Compare the Wholesale Acquisition Cost (WAC) on the Rebate Detail File to the WAC reported by an independent database (Medi-span).

**b. Rebate Collections**

- i. Reconcile the Rebate Detail File with the Invoice Summary
- ii. From this point forward, audit 100% of rebates
- iii. Receive a statement of rebate collections from the PBM by manufacturer and quarter and reconcile this "Rebate Collection Report" with the Invoice Summary

**c. Rebate Distributions**

- i. Request and review a summary of all other manufacturer revenues received by the PBM driven by Molina claims data. Molina performs this oversight to ensure that all contractually defined manufacture revenues are administered as per terms of PBM agreement.
- ii. If the PBM is reclassifying a subset of rebates, the auditor will review the PBM contract in detail to confirm that language exists in the contract protecting Molina from this practice.
- iii. Apply the contracted rebate allocation percentage to the audited total dollars of rebates collected by the PBM and confirm this was the total amount received by Molina in rebate payments.

**d. Guarantee Performance**

- i. Identify any rebate guarantees in Molina's contract with the PBM and independently calculate the rebate guarantee using the Claims File.
- ii. Ensure Molina has received at least this amount in rebate payments.

**e. Direct and Indirect Remuneration (DIR) Accuracy**

- i. Tie the sum of rebates received and expected to receive from the DIR submitted to CMS.

**3. Formulary Adherence Audit -**

- a. The relevant National Drug Code (NDC) level formulary information will be collected and reviewed at the state level for Medicare, Medicaid, and Marketplace lines of businesses. This includes both standard formulary offerings and custom formulary offerings. Assuming formulary information is provided at the NDC level, 100% of the Plan Year pharmacy claims will be audited for accuracy. Specifically, the following will be reviewed:
  - i. Proper drug tiering
  - ii. Preferred / non-preferred status
- b. The following summarizes the number of formularies that are considered in-scope:
  - i. Medicare:
    - 1. Standard / State: 3
    - 2. Custom: 0
  - ii. Medicaid:
    - 1. Molina developed PDL: 7

2. State PDL: 2
      3. Consensus formularies: 2
    - iii. Marketplace:
      1. Standard: 0
      2. Custom: 9
  - c. If discrepancies are identified, they will be documented in a final audit report. Otherwise, contract compliance will be reported in the final audit report.
4. ***PBM Pass-Through Pricing Audit –***
  - i. A random sample of 30 claims will be chosen and PBM pharmacy remittance records will be collected, reviewed, and validated with pharmacy claims data.
  - ii. If discrepancies are identified, they will be documented in a final audit report. Otherwise, contract compliance will be reported in the final audit report.
5. ***Retail Pharmacy Network Agreement Audit –***
  - i. Review PBM network agreements for the top seven utilized retail pharmacy chains, two of which must be independent retail pharmacies. Collect PBM provided aggregate guarantee reconciliations for each pharmacy chain and conduct a comparison to each contract for compliance.
  - ii. If the comparison identifies discrepancies, these discrepancies will be documented in a final audit report. Otherwise, contract compliance will be reported in the final audit report.

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