

C.21. Pharmacy Benefits

- a. Describe the Contractor's proposed approach to administration of pharmacy benefits and related pharmacy services, including the following in its response:
 - 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.
 - ii. Methods to ensure access to covered drugs and adherence to the preferred drug list.
 - iii. Responsibilities and composition of the P&T Committee.
 - iv. Proposed DUR Program, including approaches to collaborate with the Department on pharmacy initiatives.
 - v. Proposed Maximum Allowable Cost (MAC) program.
 - vi. Approach to operation of a pharmacy call center.
- 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.
- 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.
- d. Describe the Contractor's processes and procedures to provide data and support Department-based efforts and initiatives for 340B transactions.
- e. Describe the Contractor's pharmacy Prior Authorization process, including the following as part of the response:
 - i. Transparency in communicating the conditions for coverage to providers.
 - ii. Required credentials for staff reviewing, approving and denying prior authorization requests.
 - iii. Use of pharmacy and/or medical claims history to adjudicate prior authorization requests.

Passport Highlights: Pharmacy Benefits

How We're Different	Why It Matters	Proof
Passport brings a long-standing history of Kentucky-specific benefit management services to the Commonwealth's members and providers.	Significant history of engagement with the provider and member community; Kentucky-based, provider-driven and managed health plan with a vested interest in providing friends and neighbors with the best possible health care	Continuously contracted for years to provide compliant pharmacy services in partnership with DMS.
Passport clinical outreach pharmacists are Kentuckians serving Kentuckians—Kentucky residents and licensed pharmacists with significant program tenure.	<ul style="list-style-type: none"> • Long standing members of the health care community with deep understanding of the issues facing our members including substance use disorders • In depth Kentucky-specific knowledge of member and provider challenges and opportunities 	<ul style="list-style-type: none"> • Passport pioneered significant controlled substance safety edits in 2016. Since then, these edits have been refined and coordinated with DMS fee-for-service edits implemented in 2018. • Passport efforts to monitor and manage opioid use resulted in a 22% reduction in members receiving opioids in the past 18 months.
Passport's PBM uses an integrated prescriber access point to deliver real-time benefit treatment options and integrated electronic prior authorizations (ePA).	<ul style="list-style-type: none"> • Presents alternative products that may be lower cost, available without PA, or may otherwise improve member success and medication compliance • Identifies products that do not require immediate or ongoing PA 	As demonstrated in Exhibit C.21-4 , prescribers are presented multiple drug product options as payer-suggested alternatives showing relative cost.
Exceptional adherence to the PDL ensuring the health and safety of our members.	Ensures cost-effective and clinically appropriate treatment is available to members through Passport's active PDL management in conjunction with the P&T Committee	From 2016-2019 Passport's PDL adherence rate was 99%.
Passport's encounter submission first-pass acceptance rate is greater than 99%.	Higher first-pass acceptance results in reduced re-work for DMS and its rebate vendor, delivers rebate-eligible claims for inclusion in a more timely manner, and results in faster recoupment of manufacturer payments	Passport's commitment to our partnership with DMS is demonstrated through the value we place on clean and accurate encounter claim processing. Our success is demonstrated in Exhibit C.21-9 .

Introduction

The Passport pharmacy benefit team has provided active, integrated, and effective program management of the member pharmacy benefit to the Kentucky Department for Medicaid Services (DMS) for more than 22 years. This includes working closely with our partner health systems and provider associations to constantly evaluate and improve access to needed pharmacy services. Integrating with the provider community in support of our local Pharmacy and Therapeutics (P&T) Committee, Behavioral Health Committee, Quality Medical Management Committee (QMMC), and Partnership Council in the oversight and management of the pharmacy benefit delivers an unparalleled model that integrates evidence- and outcome-based improvements and provider specialist–influenced program design.

Passport’s Pharmacy program leverages evolving technologies to improve prescriber and pharmacy provider access to medications. One way that Passport delivers effective clinical and fiscal management of the pharmacy benefit in support of DMS initiatives is through the notification of both members and pharmacies of appropriate therapeutically equivalent options in real time at the POS. This ensures access to appropriate treatment with lower program and member costs. In addition, Passport provides integrated solutions that reduce the administrative burden for prescribers by identifying preferred products and providing benefit rules and design details at the point of prescribing. Passport’s unique program ownership and partnership with local providers delivers the essential model for advancing member health through focused engagement and active education of providers, member outcome improvement, and responsible program financial and operational management.

While Passport is ultimately accountable and remains committed to compliance with all contract provisions for the oversight, activities and reporting of our Pharmacy program, we have engaged with Evolent Health (Evolent) since 2016 for their expertise in functions that include pharmacy plan design, Preferred Drug List (PDL) development, non-preferred product exceptions, prior authorization (PA) and utilization management (UM) criteria, formulary exception reviews and program audits. As a result of the recent acquisition, Evolent and the provider owners will jointly own and operate Passport. Evolent’s ownership in Passport means that a significant layer of management and oversight redundancy is eliminated, which results in greater efficiency, faster issue resolution, effective root cause analysis and business process optimization.

C.21.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.

Passport contracts with CVS/Caremark as our PBM. As the largest PBM in the nation, CVS/Caremark serves twenty-one (21) million members in thirty (30) managed Medicaid markets and is one of the largest national PBMs for Medicaid members. On behalf of Passport, CVS/Caremark contracts and manages Passport’s network of more than 1,200 pharmacies in Kentucky, and is responsible for credentialing and pharmacy provider management, processing pharmacy claims at the POS, administrative and encounter reporting, and

managing supplemental rebate agreements. The subcontract with CVS/Caremark is included with this response as **Attachment C.21-1_2016 Delegation Agreement (09-01-16)**.

Effective Oversight of PBM Responsibilities and Integration of Services

CVS/Caremark, under the direction and oversight of Passport, supports multiple integration points that enhance pharmacy services to our members, including the following:

- Claims data sharing to integrate pharmacy utilization data in care management systems.
- Integration of medical claims into the pharmacy claims processing system to electronically address UM criteria through smart PA.
- Direct connection points between our PBM and other plan services and units, such as encounters, compliance, enrollment and eligibility updates, and program integrity. PBM representatives directly support and assist all pertinent plan areas.

To ensure all PBM-delegated services remain in compliance with Passport's contract with DMS, issues impacting members are resolved, required reports are generated and distributed, and DMS inquiries are responded to within DMS-designated time frames. The Passport pharmacy team meets at least twice weekly with the CVS/Caremark account team to address these topics. In addition to these twice-weekly meetings, CVS/Caremark is held to established service-level agreements (SLAs) across several key performance metrics, including claims processing accuracy and availability, member services and encounter accuracy and timeliness. We also require CVS/Caremark to provide attestations that all Senate Bill 5 (SB5) reporting requirements are submitted completely and within defined SLAs. CVS/Caremark has a record of 100% on-time submission for all recurring SB5 reporting requirements on behalf of Passport.

Ensuring Transparency in Pricing and Reporting

As of January 1, 2020, our contractual agreement with CVS/Caremark changed to a pass-through pricing model for claims processing. Our PBM is required to provide the necessary reporting to demonstrate contract compliance with pricing transparency. This reporting will ensure appropriate reimbursement of claims to Kentucky pharmacy providers. Compliance with pass-through pricing requirements is monitored via claims-level detail reporting from our PBM. Passport's contract with CVS/Caremark requires CVS/Caremark to comply with all DMS pharmacy network requirements including prohibition of direct or indirect remuneration, membership fees and retrospective remuneration models.

C.21.a.ii. Methods to ensure access to covered drugs and adherence to the preferred drug list.

Ensuring Access to Covered Drugs and Adherence to the PDL

Passport is dedicated to maintaining quality care for our members while controlling rising costs for the Kentucky Medicaid program. Our Kentucky-based pharmacy director and clinical pharmacists, along with our Pharmacy Department, work in collaboration with our PBM, CVS/Caremark, to develop and maintain Passport's outpatient PDL. The goal of our PDL is to provide a complete list of safe and clinically effective drug products that provide high quality of care to members in a cost-effective manner.

Passport's significant experience serving Kentuckians has shown that a broad formulary that includes prescription and non-prescription drugs available over-the-counter (OTC) is essential to member health and well-being. Passport's pharmacy benefit provides the most robust coverage of OTC drugs, acknowledging that many efficacious and cost-effective drug options are available without a prescription. When reviewing the PDL and the OTC list (both available through Passport's website) it is evident that Passport places great value on appropriate access to OTC products. We review OTC drugs as we do prescription drugs, selecting products that meet safety and efficacy standards for coverage and formulary placement under the pharmacy benefit. By managing the OTC benefit through the PDL, members can obtain OTC products directly from their local pharmacy and are not restricted to access through certain online/catalog channels. Passport improves member access to necessary and appropriate medications through coverage of many cough and cold medications available as OTC products for symptomatic relief and as a deterrent to the inappropriate use of antibiotics.

As described in **Attachment C.21-2_Policy RX.059.E.KY Preferred Drug List**, a stringent process is followed for developing and implementing the PDL, including any necessary restrictions. The policy also describes the types and categories of drugs included in the PDL, explains the process used to make changes (additions and deletions) to the list, and describes how these changes are communicated to members and providers, as well as the process used for posting and distribution of the PDL to members and providers.


Our pharmacy team's expertise in developing a formulary of covered outpatient drugs is also applied in the development and maintenance of a list of covered physician-administered drugs. As many specialty pharmaceuticals have a dual-distribution model whereby medications may be available to members through both medical and pharmacy channels, it is important to have a clear method for how these drugs may be accessed, while preventing possible double-billing under both the pharmacy and medical benefit. Our UM team regularly reviews physician-administered drugs and denotes under which benefit each drug should be placed. For physician-administered or medically billed drugs, there is a clear POS message at the pharmacy to indicate how these medications should be billed so this information is clearly communicated to the providers. The pharmacy team also works with the Passport medical UM team to ensure access to these drugs, advise on reimbursement rates and comply with required claim requirements for both pharmacy and physician billed claims.

Promoting Member and Provider Adherence to the PDL

Adherence to the PDL is of the utmost importance for the health and safety of our members as well as for managing an effective and efficient pharmacy benefit design. Having a PDL that is presented in a manner that is easy to understand and navigate by members and providers is critical to PDL adherence. Our searchable online PDL (**Exhibit C.21-1a**) and its hardcopy version (**Exhibit C.21-1b**), clearly define common pharmaceutical terms, delineate brand names and generic drugs, indicate any limits or PA requirements for each prescription drug, and indicate what to do if a specific drug is not listed on the PDL. The online printable version and web-based searchable formulary are both available 24/7, allowing members and

providers to search for specific drugs, generic and therapeutic equivalents, and other formulary requirement information specific to Passport. If members do not have access to the web, they may request that a hardcopy version of the formulary be mailed to them simply by calling Member Services.

Exhibit C.21-1.a: Online Searchable PDL



You may search the Passport Health Plan drug formulary in several ways:

- Use the alphabetical list to search by the first letter of your medication.
- Type part of the generic or brand name, click Search.
- Select the Therapeutic Class of the medication you are looking for, and then select a subclass to view your results.

What if my drug is not on the formulary?

Remember, not all drugs are listed on the formulary. If Passport does not cover your drug, you have 3 options:

1. Work with your pharmacy or provider to find the preferred drug.
2. You can call Member Services at 1-800-578-0603 and ask for a list of similar drugs that are on Passport's Preferred Drug List.
3. If a drug is not covered by Passport or is not listed on our Preferred Drug List, your doctor can request an approval for it.

Can the formulary change?

Yes. Passport may add or remove drugs from the formulary during the year. To get updated information about covered drugs, please visit our website at www.passporthealthplan.com or call Member Services at 1-800-578-0603.

Therapeutic Class Search: anti-infective agents/hcv polymerase inhibitor antivirals
6 drug(s) found
To view other medications in a therapeutic class, click any class hyperlink in your search results.

Results

Brand Name <small>Generic Name</small>	Therapeutic Class <small>Sub-Class</small>	Dose/Strength	Status	Notes & Restrictions
EPLUSA ORAL TABLET 400-100 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> <u>ANTIVIRALS</u>	TABLET 400-100 MG	NP Non-Preferred	<div style="display: flex; flex-direction: column; gap: 5px;"> <div>QL Quantity Limit more info</div> <div>PA Prior Auth more info</div> <div>SP Specialty Product more info</div> </div>
HARVONI ORAL TABLET 90-400 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> <u>ANTIVIRALS</u>	TABLET 90-400 MG	NP Non-Preferred	<div style="display: flex; flex-direction: column; gap: 5px;"> <div>QL Quantity Limit more info</div> <div>PA Prior Auth more info</div> <div>SP Specialty Product more info</div> </div>
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> <u>ANTIVIRALS</u>	TABLET 400-100 MG	G Generic	<div style="display: flex; flex-direction: column; gap: 5px;"> <div>QL Quantity Limit more info</div> <div>PA Prior Auth more info</div> <div>SP Specialty Product more info</div> </div>
SOVALDI ORAL TABLET 400 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> <u>ANTIVIRALS</u>	TABLET 400 MG	NP Non-Preferred	<div style="display: flex; flex-direction: column; gap: 5px;"> <div>QL Quantity Limit more info</div> <div>PA Prior Auth more info</div> <div>SP Specialty Product more info</div> </div>
VIEKIRA PAK ORAL TABLET THERAPY PACK 12.5-75-50 &250 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> <u>ANTIVIRALS</u>	TABLET THERAPY PACK 12.5-75-50 &250 MG	NP Non-Preferred	<div style="display: flex; flex-direction: column; gap: 5px;"> <div>QL Quantity Limit more info</div> <div>PA Prior Auth more info</div> <div>SP Specialty Product more info</div> </div>
VOSEVI ORAL TABLET 400-100-100 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> <u>ANTIVIRALS</u>	TABLET 400-100-100 MG	NP Non-Preferred	<div style="display: flex; flex-direction: column; gap: 5px;"> <div>QL Quantity Limit more info</div> <div>PA Prior Auth more info</div> <div>SP Specialty Product more info</div> </div>

Exhibit C.21-1.b: Print-Version PDL

ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS		
ANTI-INFLAMMATORY AGENTS		
<i>cromolyn sodium soln nebu 20 mg/2ml</i>	1	
ANTI-ASTHMATIC - MONOCLONAL ANTIBODIES		
XOLAIR INJ 75/0.5	2	QL (6 syringes / 28 days), PA
XOLAIR INJ 150MG/ML	2	QL (6 syringes / 28 days), PA
XOLAIR SOL 150MG	2	QL (6 syringes / 28 days), PA
BRONCHODILATORS - ANTICHOLINERGICS		
ATROVENT HFA AER 17MCG	2	
INCRUSE ELPT INH 62.5MCG	2	
<i>ipratropium bromide inhal soln 0.02%</i>	1	
LONHALA MAGN SOL 25MCG	3	PA
SPIRIVA AER 1.25MCG	3	QL (1 inhaler / 30 days), PA; PA applies to 18 years of age and older
SPIRIVA CAP HANDIHLR	3	QL (1 box / 30 days), ST
SPIRIVA SPR 2.5MCG	3	QL (1 inhaler / 30 days), PA; PA applies to 18 years of age and older
TUDORZA PRES AER 400/ACT	3	ST
YUPELRI SOL	3	QL (30 vials / 30 days), PA
LEUKOTRIENE MODULATORS		
<i>montelukast sodium chew tab 4 mg (base equiv)</i>	1	QL (30 tabs / 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy **OTC** - Over the counter 28

Ensuring timely communication of any PDL changes is also a critical component of PDL adherence. Upon approval of any PDL additions, deletions or changes to criteria such as restrictions or limitations that apply to the use of certain pharmaceuticals, controlled substance safety edits or quantity limit updates, the changes are programmed in the PBM’s claims processing system and uploaded into Passport’s online searchable formulary in the format specified in 42 C.F.R. 438.10. Removals from the PDL are not implemented until members and providers have received at least a thirty (30) day advance notice of the change. Members affected by a formulary change are often “grandfathered” for a period to allow additional time to work with the provider to find a preferred formulary alternative or to submit a PA to continue to receive the medication. Members may also be grandfathered indefinitely.

Passport notifies prescribers, pharmacies and members of PDL changes via the following methods:

- **Pharmacy News bulletins** to pharmacies and prescribers, detailing all PDL changes, process and procedure updates, and other operational information, as illustrated in **Exhibit C.21-2**. The newsletter is posted to the Passport website, delivered to providers electronically via Passport’s eNews delivery, and can be faxed or mailed upon request. An abbreviated version is faxed to the pharmacy network via CVS/Caremark. In addition, printed copies are hand-delivered and reviewed with providers and pharmacies by Passport’s clinical outreach pharmacists. Both the content included in our newsletters and the methods for delivery are unique to Passport.

Exhibit C.21-2: Passport Pharmacy Newsletter

PHARMACY NEWS PASSPORT HEALTH * PLAN

SUPPORTING OUR PROVIDER PARTNERS THROUGH COMMUNICATION AND COLLABORATION.

DATE DECEMBER 2019
ISSUE 4

HELPFUL NUMBERS FOR PROVIDERS
CVS: 1-888-512-8935
Primary: 004336
Secondary Commercial: 013089
Secondary Part D: 012114
Passport Pharmacy Services:
1-844-380-8831

Passport Advantage
BIN: 004336
PCN: MEDDAVDV

HELPFUL NUMBERS FOR MEMBERS
Passport Health Plan
1-800-578-0603

WEBSITE
www.passporthealthplan.com

NEW IN THIS ISSUE

- Inhaler Updates
- Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Update
- New Prior Authorization or Step Additions
- Prior Authorization or Step Removals
- Formulary Changes
- P&T Committee Review
- New Generics
- Line Extension Products
- Thank you!

Inhaler Updates

Effective **December 2019**, both the generic Advair Diskus products and Trelegy Ellipta will move to a preferred status and no longer require a prior authorization. In addition, all generic albuterol HFA inhalers will no longer require a prior authorization (Proair Respiclick will not be affected by this change). Both changes were reviewed and approved by the Pharmacy and Therapeutics Committee following the November 2019 meeting.

Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Update

Effective **February 3, 2020**, Januvia (sitagliptin), Janumet (sitagliptin/ metformin), and Janumet XR will become non-preferred. Current utilizers who are adherent to therapy within the last 60 days will not be affected by this change at this time. All new utilizers will need to have a prior authorization submitted for any of the DPP-4 inhibitors. The prior authorization criteria will require a diagnosis of type 2 diabetes, a previous trial and failure of metformin, as well as a trial and failure of a SGLT2 (Steglatro) with certain exceptions. DPP-4 inhibitors have not demonstrated the same efficacy as other oral diabetes medications. These medications also are not known to demonstrate the same positive side effects such as weight loss and cardiovascular benefits as other oral diabetes medications. Formulary updates are intended to align with the most recent diabetes guidelines published in January 2019 by the American Diabetes Association. These changes were reviewed and approved by the Pharmacy and Therapeutics Committee following the November 2019 meeting.

The above message was provided by the Kentucky Department for Medicaid Services.

Prenatal Products Update

Effective **October 15, 2019**, various prenatal vitamin products will be moving to a non-formulary status. Those members utilizing these products will continue to have coverage for the remainder of their pregnancy or a minimum of nine months from the effective date. A variety of prenatal vitamin products will remain on tier 1 and 2 as preferred products, see table below for medications remaining on formulary. This change was reviewed and approved by the Pharmacy and Therapeutics Committee following the August 2019 meeting.

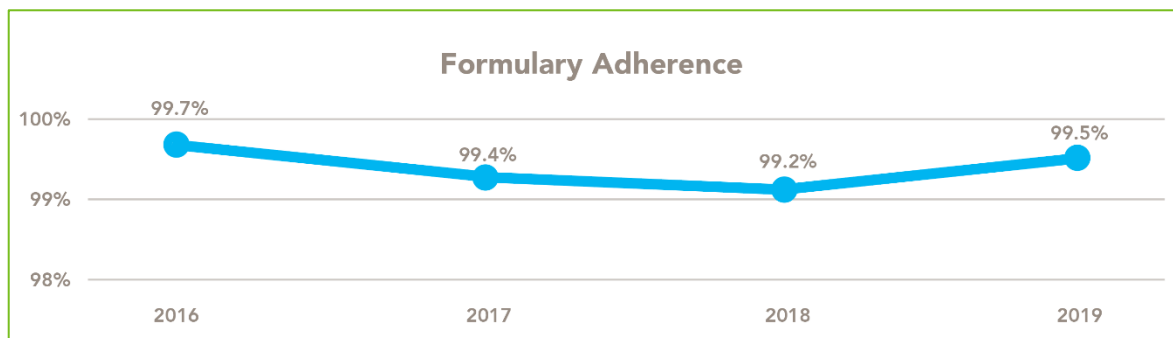
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- **POS system messaging** to prescribers and pharmacists is used for PDL changes and ongoing education. Not only is the type of UM messaged (PA, Quantity Limits (QL), etc.), but formulary alternatives and requirements for step therapy are often included. Exact quantity limitations are populated so that this can be clearly communicated to the member and prescriber. In addition, notification of upcoming PDL changes can be communicated through soft messaging, prior to a hard-edit implementation.
- **A personalized letter** to affected members for any formulary changes to a drug’s coverage status is mailed at least thirty (30) days prior to the change. These letters include what action is needed to continue taking the medication. This allows members to work with their provider to either submit a PA or move to one of the listed formulary alternatives. A protected health information (PHI)-redacted copy of this letter is also posted to Passport’s website so that members and providers can easily view recent PDL changes and specifics around each change. This redacted letter is found in the Preferred Drug List section of the website under “Preferred Drug List Notifications.”

- **Our web-based searchable formulary** is updated in near real time and can be accessed by visiting passporthealthplan.com. An online printable formulary that is updated quarterly is also available on the website. Members may request that a hard copy be mailed to them by calling Member Services.
- **All pharmacists and technicians on the Pharmacy Services team** are educated on any PDL changes following each P&T Committee meeting. The Passport pharmacy team offers direct access for members and providers to ensure that any pharmacy-related questions or concerns are immediately addressed and resolved in a timely manner by our Kentucky-based staff. There is a Passport-specific email address and phone number for contacting a Passport-designated team of pharmacy technicians and pharmacists.

As demonstrated in **Exhibit C.21-3**, Passport’s continued formulary adherence success for the past four (4) years has been nearly 100%. Our success in consistently achieving a high rate of PDL adherence is the outcome of our collective Pharmacy program. Members, providers and pharmacies are well-informed of PDL drugs through communications, claims processing, self-service tools and engagement. The Passport pharmacy team monitors PDL utilization monthly and analyzes trends to continually maintain and improve PDL adherence in consultation with local providers.

Exhibit C.21-3: Annual Formulary Adherence Rate Trend



Enhanced Pharmacy Benefit Access for Prescribers

Passport wants members to have convenient access to affordable medications. Through our partnership with CVS/Caremark, providers have enhanced visibility into our member’s Passport prescription benefit via CVS/Caremark’s real-time benefit check (RTBC) across all key points of care. Real-time benefits further build on connections with electronic health records (EHR) by means of desktop Electronic Medical Records (EMR), bringing the CVS/Caremark POS system closer to true, seamless interoperability.

At the Point of Prescribing

With RTBC, the provider will have member-specific information available at their fingertips prior to writing a prescription, including the following:

- The cost of a selected drug based on the Passport’s Medicaid prescription drug benefit structure

- Up to five (5) clinically appropriate therapeutic alternatives, which may also be lower cost to the member and the plan, generated from CVS/Caremark’s database of drug classes, mapped for clinical substitution and specific to the Passport’s PDL
- Restrictions on the selected drug, such as PA, step therapy requirements or quantity limits
- Pharmacy network enrollment status

This integration into the prescribing workflow improves timely member access to medications by removing the typical prescribe–process–deny–request PA–dispense cycle that can often cause access issues. Increasing connectivity through interoperability, eliminating blind spots, and providing transparent access to information at critical decision points will help our members get the medications they need faster, more easily, and more affordably, enabling them to be more engaged in their own care and benefits.

CVS/Caremark, using their proprietary technology and data-sharing capabilities, can connect providers with real-time information through integration with e-prescribing software with Passport’s PDL file and member benefit structure to promote more informed decision-making and coordinated care. This creates an opportunity for lower drug costs for the member and a better overall member experience. With the RTBC solution, all available information is integrated into the e-prescribing workflow as seen in **Exhibit C.21-4**, enabling prescribers to see formulary options and be more informed about member benefits. If the selected drug has any restrictions, prescribers may submit an electronic PA request through the Passport Pharmacy Portal. This technology will improve timely member access to medications by avoiding potential barriers in the dispensing process.

Exhibit C.21-4: Example Preliminary Patient Estimate

Preliminary Patient Estimate
for *Pharmacokinetics* seen on 4/27/2018

Prescriptions using VALUE PLAN (CVS CAREMARK...)

<input type="radio"/> ethacrynic acid (EDECIN) 25 MG tablet CVS Pharmacy # 775 - HA... , 30 tablet, 30 days	\$310 \$10.33/day
Payer-Suggested Alternatives	
<input checked="" type="radio"/> FUROSEMIDE 40 MG tablet CVS Pharmacy # 775 - ... , 30 tablet, 30 days	\$4 \$0.13/day
<input type="radio"/> TORSEMIDE 20 MG tablet CVS Pharmacy # 775 - ... , 30 tablet, 30 days	\$20 \$0.66/day
<input type="radio"/> BUMETANIDE 1 MG tablet CVS Pharmacy # 775 - ... , 30 tablet, 30 days	\$26 \$0.87/day

Patient portion (per fill): \$4

At the Pharmacy

This integrated technology includes the RxSavings Finder, which enables the pharmacist to see the same list of clinically appropriate formulary alternatives at the POS, allowing them to engage members and inform

them about potentially lower-cost alternatives, based on formulary coverage. If the member’s prescribed drug is not on the formulary, the pharmacist will be able to request a prescription change from the provider at the click of a button.

Empowering Passport Members

Providing transparent access to members regarding their drug coverage is our top priority. Passport recognizes that access to medications, understanding a medication regime and medication adherence are key to a healthy member population. We provide tools and outreach to members through multiple modalities. For example, the updated PDL is available on the plan website in both a searchable and a printable format. The PDL will indicate the current formulary tier and any UM requirements, including age and quantity limitations. In addition, through the Check Drug Cost tool on Caremark.com and the Caremark app (see **Exhibit C.21-5**), members can access Passport plan-specific information such as the following:

- Whether a medication is covered by Passport
- Whether any out-of-pocket costs apply, and fill options for up to five (5) clinically appropriate, therapeutic alternatives, if available
- Coverage restrictions, such as PA or quantity limits
- Comparison of savings based on filling options, such as ninety (90) day supplies and mail service

Exhibit C.21-5: Check Drug Cost Tool

The screenshot displays the CVS Caremark member dashboard for a user named Robert. At the top, there is a navigation bar with links for Profile, Help Center, Español, Change Text Size (with three 'A' icons), and Log Out. The CVS Caremark logo is on the left, and utility links for Message Center, Check Drug Cost & Coverage, and Pharmacy Locator are on the right. A main navigation bar includes Home, Prescriptions, Plan & Benefits, and Health Resources. The main content area features a welcome message: "Welcome to your dashboard, Robert. Access everything you need — prescription refills, plan info, drug cost comparisons, and recent orders — all right here." Below this is a section titled "Your prescriptions" with the text "You don't have any Rx that are available for refill." and a link "View all prescriptions >". A highlighted box contains the "Add a new medication" section, which includes an icon of a pill bottle and a magnifying glass, and the text: "Start by comparing brand-name and generic medications. We'll show you the best value, including how much you'll pay and how much your plan will pay." Below this text is a link "Check drug costs >".

Welcome, Robert! [Profile](#) | [Help Center](#) | [Español](#) | [Change Text Size](#) A A A | [Log Out](#)

CVS caremark Message Center Check Drug Cost & Coverage Pharmacy Locator

[Home](#) [Prescriptions](#) [Plan & Benefits](#) [Health Resources](#)

Welcome to your dashboard.
Access everything you need — prescriptions, drug cost comparisons, and recent orders — all right here.

Your prescription
You don't have any Rx that are active.

Add a new medication
Start by comparing medications to show you the best value and how much your plan will pay.

[Check drug costs](#)

- Plan Summary
- Check Drug Cost & Coverage**
- Pharmacy Locator
- Print Member ID Card
- Prescription Savings Guide
- Covered Drug List (Formulary)
- Print Plan Forms
- Specialty Pharmacy
- Prior Authorization

[View all prescriptions](#)

Check Drug Cost

Price varies by person and location.
Find out if your medication is covered and what it will cost based on your benefit plan. We'll show you lower-cost options, if available.
Please keep in mind that the price shown may not accurately reflect what you will pay at the pharmacy. Your actual price may vary depending on your benefit plan design, deductibles, previous payments, pharmacy-specific pricing, future claims and prior authorizations.

[Price a new drug](#) | [Price a past search](#) | [Price a previously filled prescription](#)

Enter 3 or more letters of the drug's name, then select from the suggested options.

- Metformin Er Gastric 500mg Tabletergr24h
- Metformin Er Gastric 1000mg Tabletergr24h
- Metformin Er Osmotic 500mg Tablet Er 24
- Metformin Er Osmotic 1000mg Tablet Er 24
- Metformin Hcl Er 500mg Tablet Er 24h
- Metformin Hcl Er 750mg Tablet Er 24h
- Metformin Hcl 100% Powder
- Metformin Hcl 500mg/5ml Solution
- Metformin Hcl 500mg Tablet
- Metformin Hcl 850mg Tablet
- Metformin Hcl 1000mg Tablet

The screenshot displays a search results page for 'Metformin Hcl Er 500mg Tablet Er 24h'. At the top, it shows the search criteria and options to 'Print these search results' or 'New Search'. Below this is a summary table with columns for Patient, Pharmacy, and Dosage. The patient is Robert Dizenzo (DOB: 11/14/1975), the pharmacy is Kroger Pharmacy 24327 (2710 West Broadway St, Louisville, KY 40211, (502) 778-3348), and the dosage is 'Most common dosage'. There is an 'Edit this information' link. Below the table, there are tabs for 'Mail: common dosage', 'Store pickup: 90-day dosage', and 'Store pickup: common dosage' (which is selected). A 'Best Value' badge is present. The main content area shows 'Generic Metformin Hcl Er 500mg Tablet Er 24h' with a 30-day supply, store pickup, and 60 tablets. It lists the same pharmacy information and an 'Edit' link. To the right, a 'Your Best Value' box shows a cost of '\$2.68 for 1 month', with a note that the member pays 100% of the cost and the plan pays \$0.00 per 1 month. It includes a 'See cost details' link, a note to talk to a doctor, and a note that online ordering is unavailable.

Members can use this information to request a different medication or have a conversation about their prescription options with their prescriber or pharmacist. Member-specific benefit information is securely integrated within the tool, and the Passport Pharmacy Services team can assist members with cost and coverage questions. The Passport Pharmacy Services team is available through a direct phone number for members, providers and internal Passport departments (e.g., Member Services, Care Coordination) to resolve questions or issues related to the pharmacy benefit. This includes, but is not limited to, overrides, PDL changes and drug coverage inquiries.

Our clinical pharmacy program includes member outreach through automated calls, mailings and live calls from the Passport team. We engage members, as well as their entire care team, to improve member adherence to new and existing medication therapy. Examples of interventions include the following:

- Counseling members on how to overcome adherence barriers, such as transportation, low health literacy and proper medication administration
- Contacting the dispensing pharmacy to synchronize fills of chronic medications, initiate auto-refill enrollments and provide med-minder pill boxes
- Optimizing dosing and reducing complexity of medication regimen, collaborating with other health care providers as necessary

Through this outreach, members are more educated on disease management, have a better understanding of formulary medications and feel empowered to adhere to their medication therapy.

Interdisciplinary Care Team Approach to Addressing Safety and Improving Outcomes

Kailyn* was stratified into Passport’s Complex Care program with type 2 diabetes, high cholesterol, and high blood pressure. Upon completion of a comprehensive needs assessment, our RN Care Advisor referred Kailyn to our clinical pharmacy team for review of her medications. Our clinical pharmacist identified numerous issues with her medication regimen, including two high-risk medications, non-adherence to pravastatin for high cholesterol and metformin for type 2 diabetes, potential duplication of therapy used to treat high blood pressure, and potential barriers for Kailyn due to high copays.

In coordination with the Care Advisor, our clinical pharmacist outreached the prescribing provider to discuss her concerns and to address the cost barriers for Kailyn that will inevitably lead to low adherence. As a result of the conversation, the provider changed the high-risk medications, discontinued one of the duplicate high blood pressure medications, and switched two medications to alternatives with lower member cost share. The Care Advisor and clinical pharmacist worked together to educate Kailyn on her new regimen. As a result, Kailyn was able to pay for and manage her medications and with support from her care team, she successfully graduated from the program.

*Member name changed for privacy

Improving Member Access Through Integration of our Clinical Pharmacy Team and Care Coordination

The clinical pharmacy team identifies members who are at risk for medication non-adherence and provides subsequent outreach. Our dynamic adherence modeling incorporates several key variables, including timing and cadence of pharmacy claims, utilization patterns, adherence calculations and member attributes. Results of the modeling include a prioritized list of potentially non-adherent members receiving medications to treat diabetes, hypertension, cholesterol, asthma, depression and other behavioral health disorders. The stratification criteria changes throughout the year to target members who are most impactful and to allow for data-driven recommendations.

The clinical pharmacy program allows pharmacists to directly interact with care management nurses (Care Advisors) to assist with pharmacy-related issues and subsequently reach out to the member and provider to provide education and recommendations, as needed. Through our proprietary, comprehensive care management platform, IdentifiSM, both pharmacists and nurses have access to both pharmacy and medical claims to identify and address non-adherence, gaps in care through the review of diagnoses, opportunities to move to a preferred drug on the PDL, etc. Pharmacists and nurses may make referrals to each other, as necessary, when interacting with members and providers, to ensure members are receiving the best, most appropriate care possible (see callout box above).

Our clinical pharmacists address medication adherence by supporting members engaged in care management or transition care programs. During medication reviews, pharmacists conduct



medication reconciliation, assess clinical appropriateness of therapy, identify opportunities to improve medication cost-effectiveness, review potential drug safety issues, and support members through education and self-management tools. Pharmacists also support members' access to care when a member is at risk for non-adherence to a critical medication. Using pharmaceutical manufacturer and other published patient assistance program information, our pharmacists refer members to qualifying patient assistance programs that may provide coverage of additional medication therapies not covered under the Commonwealth Medicaid benefit.

Our Rx Clinical Outreach program, previously called CHOICES, which began in 2004, provides direct clinical and educational support for providers and pharmacies across the Commonwealth. Our field-based team consists of two experienced, Kentucky-licensed pharmacists who have over sixty-seven (67) years' combined pharmacy experience and 19 years of experience at Passport. Our clinical outreach pharmacists have previously managed and operated a family-owned independent pharmacy, managed multiple pharmacy locations as district managers, and have over fifteen (15) years of experience with Durable Medical Equipment (DME), specialty, and infusion billing and coding. Their expertise has proven to be valuable to providers, pharmacies, Passport and DMS through their efforts to provide the following services covering all Medicaid regions throughout the Commonwealth:

- Provide pharmacy benefit education, such as on formulary changes, ahead of implementing changes to provide clinical solutions and minimize member and provider disruption
- Educate and train provider staff on the PA process to alleviate administrative burden
- Support clinical pharmacy initiatives by discussing member-specific care gaps, adherence barriers and other quality concerns in person with the prescribing provider and/or primary care physician
- Educate providers on the appropriate use of opioids and other controlled substances
- Outreach to specialists to solicit feedback and expertise on potential formulary changes to help develop recommendations for coverage and drug policies
- Collaborate with pharmacies to determine accuracy in manufacturer/wholesaler shortages, expediting resolution to limit barriers to accessing needed medication
- Assist with fraud, waste and abuse (FWA) issues
- Facilitate connections between providers and other plan representatives, such as population health managers, care managers, behavioral health managers and provider representatives
- Assist with escalated claim resolution to resolve medication access issues
- Serve as a direct pharmacy point-of-contact for providers and pharmacies

Our clinical outreach pharmacists use data analytics to identify pharmacies and providers requiring education and outreach based on many factors, including utilization of controlled substances, volume of members with multiple chronic conditions, prescribing habits and outliers, and providers who will be impacted by upcoming formulary changes. In addition, the clinical outreach pharmacists will regularly visit

provider offices and pharmacies with an overall high volume of members or by request from the provider or pharmacist. Key performance measures of our Clinical Outreach program are shown in **Exhibit C.21-6**.

Exhibit C.21-6: 2019 Clinical Outreach Program Metrics

2019 Rx Clinical Outreach Program	# Outreach Visits
Provider Visits	3,728
Pharmacy Provider Visits	693
Total Outreach Visits	4,421
# Members Who Received at Least One Prescription from a Visited Provider	112,769
# Visits by Discussion Topic <i>(Not all-inclusive list of topics discussed)</i>	
Quality Measures	73
FWA and/or Controlled Substances	185
Diabetic Medications	224

Ensuring Access to Medications for a Foster Care Member

When a foster care member was abruptly relocated to Florida to live with grandparents, her medications were left behind. The member was unable to obtain refills locally, as there were no Kentucky Medicaid pharmacy providers nearby. Our clinical outreach pharmacist, in collaboration with the Passport foster care specialist, immediately engaged with an independent pharmacy in Kentucky to facilitate refills of the needed medications. The pharmacy contacted the provider for the prescriptions, filled the prescriptions and shipped the medications overnight to the member, resulting in no interruption in care.

C.21.a.iii. Responsibilities and composition of the P&T Committee.

P&T Committee—Pharmacy Program Oversight

The mission of the P&T Committee is to advise on the establishment and maintenance of the PDL, including restrictions and preferences, which promotes clinically appropriate, cost-effective drug therapy and drug monitoring programs as documented in **Attachment C. 21-3_Policy RXOPS.051.E.KY Pharmacy and Therapeutics Advisory Committee**. The P&T Advisory Committee is a subcommittee of the QMMC, which is the functional Quality Improvement Committee (QIC) at Passport. The P&T committee and QMMC both report up to the Partnership Council and the Board of Directors.

All current physician and pharmacist P&T committee members are Kentucky-based, and all are Kentucky-licensed providers who provide services to Passport members on a daily basis. The committee composition includes a primary care physician, pediatrician, psychiatrist, asthma and respiratory specialist, and oncologist. In addition, on an ad hoc basis, leveraging our close relationships with the provider community, the pharmacy team will engage other specialists throughout the Commonwealth to assist with formulary development. This may involve review of medications to treat conditions such as HIV/AIDS, Hepatitis C, infectious disease, substance use disorder and diabetes.



This inclusive and diverse committee provides direct member care in facilities such as family health centers and pediatric medical homes, treating some of our most vulnerable members such as those in foster care and those with multiple chronic medical conditions. For formulary changes related to behavioral health medications, all proposed recommendations are vetted and discussed with our Behavioral Health Advisory Committee in addition to the P&T committee.

Passport Pharmacy Program Governance

Full governance of our Pharmacy program, represented in **Exhibit C.21-7**, is structured to develop and promote strategies that enhance member and population health outcomes, while optimizing cost-effective drug therapies. Collectively, the talented and experienced individuals who comprise the governance of Passport's Pharmacy program help support the physical, behavioral and social needs of our members. The Partnership Council is the ultimate governing body that oversees the Pharmacy program, including the P&T Advisory Committee.



Exhibit C.21-7: Passport Pharmacy Program Governance



- **The P&T Advisory Committee** advises on the PDL, clinical guidelines for pharmaceutical treatment, and drug monitoring programs in accordance with Kentucky Administrative Regulations (KAR) Title 907. Recommendations from the Behavioral Health Advisory Committee are also reviewed. Once approved by the P&T Committee, all recommendations are submitted to the QMMC for review.
 - The P&T Committee is chaired by a Kentucky-licensed physician and is composed of actively practicing Kentucky-licensed pharmacists, physicians and other health care professionals from various practice areas including, but not limited to the following:
 - Pharmacy
 - Family Practice
 - Internal Medicine
 - Pediatrics
 - Behavioral Health
 - Member Advocacy
 - Gastroenterology (ad hoc)
 - Cardiology (ad hoc)
 - Allergy/Immunology
 - Oncology

- **The QMMC** provides direction to and oversight of those management and subcommittee functions responsible for the provision of clinical care and services. The QMMC reviews recommendations made by the P&T Committee and approves recommendations to be forwarded to the Partnership Council for final approval. Recommendations not accepted and other concerns from QMMC are sent back to the P&T Committee for further review and discussion.
- **The Partnership Council** is a nonprofit organization established to broadly represent Medicaid providers and health plan client members to ensure constituencies have a voice in determining the policies and procedures of the Kentucky Managed Care program. The Partnership Council provides final approval of recommendations submitted by the P&T Committee. Recommendations not accepted and other concerns are sent back to the P&T Committee for further review and discussion.

Supporting the activities of the P&T Committee is one of the roles of members of the pharmacy team, pharmacy director and chief medical officer. These valuable resources are responsible for the operational and administrative management of the Pharmacy program and serve as a liaison to pharmacies, members and our PBM.

Passport's Kentucky-based clinical outreach pharmacists are also responsible for providing direct contact and education to providers, pharmacies and members. Not only does their work with the pharmacy team, care coordinators and community providers throughout the Commonwealth improve health literacy and compliance rates in Kentucky, but they also serve as part of a feedback loop with the provider community. Through the feedback our pharmacists obtain, we can report on practice trends, educate on new evidence-based therapies, and address medication-related access issues.

Clinical Outreach Pharmacists and endocrinologist collaborate on treating members with diabetes

Clinical Outreach Pharmacist outreached to an endocrinologist in rural KY to gather feedback about treating members with diabetes. This feedback was used in constructing formulary and drug policy updates for antidiabetic medications and approved at the following P&T meeting.

Responsibilities of the P&T Committee

The P&T Advisory Committee meets at least quarterly and provides recommendations to the QMMC and the Partnership Council for final approval on the development and implementation of policies related to pharmaceutical management. The committee reviews and advises on which medications should be included on the PDL. In addition, the committee serves in an advisory capacity to the Partnership Council on matters pertaining to treatment protocols and guidelines for drug utilization, prescribing, dispensing and administration of drugs, and the use of accepted and investigational drugs and medication-related supplies for member care and treatment. The committee reviews clinical safety edits to ensure the safe and appropriate use of medications such as controlled substances and products with significant Food and Drug

Administration (FDA) warnings. Final decisions made by the P&T Committee are posted on our website at: passporthealthplan.com/pharmacy/pharmacy-news/.

Activities related to formulary management are outlined in the Preferred Drug List Decision Making Process (Policy RX.059). This policy encompasses the following as relates to the management of Passport's PDL:

- New-to-market drugs for coverage and PDL placement
- Addition of new generics entities to the Passport PDL
- Generic substitution of drug products
- Coverage for OTC products
- Self-injectable medications covered under the pharmacy benefit
- Design and implementation of step-therapy drug protocols
- Design and implementation of drug therapeutic protocols
- PA of pharmaceuticals
- Class I, class II and voluntary drug withdrawal notification
- Process for communicating pharmacy procedures and changes to providers
- Requirements for dispensing emergency supplies of pharmaceuticals

C.21.a.iv. Proposed DUR Program, including approaches to collaborate with the Department on pharmacy initiatives.

Maintaining a Compliant and Effective Drug Utilization Review Program

Passport's multifaceted Drug Utilization Review (DUR) program ensures that prescriptions are appropriate, medically necessary and unlikely to result in adverse health outcomes. Through prospective and retrospective DUR, our programs provide the control necessary to achieve optimal UM and enhanced financial control. Passport's DUR program supports appropriate prescribing practices by facilitating the following:

- Promoting member safety, including reviews for mental health/substance use, narcotic drugs and morphine equivalent dose (MED) limits
- Proactively addressing medication interactions
- Ensuring adherence to approved treatment protocols
- Managing spend by shifting utilization to more cost-effective clinically appropriate drugs
- Retrospectively reviewing member utilization and prescribing practices

Integrated, Collaborative and Compliant DUR Program

There are specific policies for all DUR edits, ensuring UM pharmacists and physicians appropriately and uniformly review PA requests for possible exceptions to these edits. While most DUR edits use pharmacy claims data, many Passport DUR edits incorporate medical claims data to identify specific diagnoses (e.g.,

cancer) that may exclude certain predefined drug products from specific edits. Our PBM's pharmacy claims system reviews drug and medical claims data to identify specific historical drug products and/or medical conditions that may warrant an exception to an edit (e.g., oncology medications).

Passport pioneered many significant controlled substance safety edits in 2016. Since then, these edits have been refined and coordinated with DMS fee-for-service edits implemented in 2018. Passport extended these edits to address both acute and chronic opioid use and limit daily MED and prescription-days supply. These edits reflect Kentucky Board of Medical Licensure guidance with respect to promoting safety and curbing abuse potential associated with acute opioid prescribing. In the last eighteen (18) months, we have seen a reduction of approximately twenty-two percent (22%) in total opioid users.

Fighting the Opioid Crisis

Passport efforts to monitor and manage opioid use resulted in a 22% reduction in members receiving opioids in the past 18 months.

Passport also implemented novel proton pump inhibitor (PPI) safety edits to limit the duration of use for these medications, aligning with the American College of Gastroenterology guidelines.

Custom compound edits are also in place to combat potential fraud, waste and abuse that has been identified in this area. The maximum dollar threshold for compounds prepared for adults is \$50, while the maximum dollar threshold for compounds prepared for pediatric members is \$100. Clinically appropriate, medically necessary compounds that exceed these limits may be approved through a PA request to allow access to therapy, while monitoring the utilization of compounds, specifically topical.

The Passport pharmacy director regularly attends the monthly Kentucky Pharmacy Workgroup meetings to collaborate with DMS and the other managed care organizations (MCOs) to resolve issues of concern such as opioid stewardship, psychotropic medication use in the pediatric population, Pharmacy Lock-In Program redesign and antibiotic stewardship. Passport looks forward to continuing to work together with DMS to solve pharmacy-related health care issues that affect the Commonwealth.

Our DUR program complies with the requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K.

Prospective Drug Utilization Review (Pro-DUR)

Pro-DUR employs an automatic, system-driven DUR performed on all prescriptions. The program, implemented through CVS/Caremark's single-platform POS information system, can perform up to five hundred (500) edits on every prescription to help ensure each meets administrative, plan design and member safety criteria. The POS system screens for indicators such as therapeutic duplicates, potential drug-to-drug and drug-to-allergy interactions, plan design compliance and

Approval of DUR Custom Edits

All Passport DUR custom edits are evaluated and approved through the Passport P&T Committee.

evidence of over-utilization—for example, early refill requests or an unusual delay between the prescription date and the date CVS/Caremark received it. **Exhibit C.21-8**, provides additional detail on the goal of some of the more frequently used edits.

Exhibit C.21-8: Passport Sample Pro-DUR Edits and Goals

Pro-DUR Edit	Goal of Edit
Step Therapy: Prerequisite	Prevents a medication from processing if a predetermined therapy has not been used prior to the object medication prescribed.
Step Therapy: Preclusive	Prevents a medication from processing if a contraindicated medication is present in the member’s claims history.
Possible Drug Misuse	Indicates a pattern of drug use by a member in a manner that is significantly different than that prescribed.
Drug-to-Drug Interaction	Prevents a medication from processing if an interaction between two or more medications in the member profile is identified.
Duplicate Drug Therapy	Prevents a medication from processing by completing a comparison of new prescriptions against duplicate or similar pharmacological action medications in the member profile.
Too-Early Refill or Overutilization	Prevents improper frequency of refilling a prescription.
Insufficient and Inadequate Dosage	Prevents processing of a medication when strength and dose requests are inconsistent with predetermined standard parameters.
Excessive Utilization	Prevents processing of a medication when strength and dose requests exceed predetermined standard parameters.
Drug to Age	Analyzes the prescription appropriateness for age (elderly or pediatric).
Controlled Substance Edits	Limits chronic opioid users (those who have been on therapy for ninety [90] days or more) to a daily MED of eighty (80) and limits new opioid users to a daily MED of fifty (50) and no more than a seven (7) days’ supply. In addition, claims for an extended-release opioid formulation require a history of therapy with an immediate-release opioid product.
PPI Safety Edits	Limits PPI therapy to a cumulative duration of twelve (12) weeks of therapy per year for members age three (3) and older.
Apparent Drug Misuse	Messages the pharmacist when four (4) or more claims for the same controlled substance are prescribed within ninety (90) days.
Excessive Controlled Substances	Returns a soft reject requiring the pharmacist to enter an override if one of the following occurs: (1) Concurrent use of five (5) or more unique controlled substances within a class of drugs (same GPI 2) within the previous thirty (30) days, or (2) Prescriptions for eight (8) or more claims for the same controlled substance (GPI 10) within the previous thirty (30) days.
Cumulative Acetaminophen Check	Returns a soft reject when the cumulative acetaminophen dose across all prescriptions exceeds 4,000 mg per day.

Pro-DUR Edit	Goal of Edit
Dose Check Multiplier	Identifies doses of medications that greatly exceed (5 times) the FDA-approved maximum dose.
Multiple Pharmacies	Returns a soft reject requiring the pharmacist to enter an override if there are multiple prescriptions within the same drug class (GPI 2) filled at four (4) or more pharmacies.
Buprenorphine with Opioid	Identifies opioid use after the patient has begun opioid use disorder treatment with a buprenorphine product and returns a soft reject. After reviewing the patient’s medication history, the pharmacist will have the option of: (1) filling the Rx as written based on his/her professional judgment or (2) contacting the prescriber to determine a further course of action.
Duplicate Long-Acting Opioids	Returns a soft reject when prescribed drugs have the same therapeutic effect as medication(s) the patient is currently taking.
Opioid-Benzodiazepine Drug Interaction	Returns a soft reject requiring the pharmacist to enter an override when interacting drug combinations are identified.
90-Day Limit for Short-Acting Opioids	Prevents short-acting opioid use beyond ninety (90) days. Returns a hard reject for a prescription that exceeds ninety (90) days of a short-acting opioid within a rolling consecutive 180-day period.
Opioid-Carisoprodol Drug Interaction	Returns a hard reject requiring a PA when interacting drug combinations are identified.
Short-Acting Stimulants	Prevents concurrent use of two (2) or more short-acting stimulants. Returns a hard reject requiring PA when concurrent use is identified.
Compound Edits	Prevents use of ingredients commonly used for topical pain compounds, such as ketamine, baclofen and gabapentin. Prevents compounds prepared for adults from exceeding \$50 and compounds prepared for pediatric members from exceeding \$100. Returns a hard reject if this edit hits, which requires a PA.
Antipsychotics Under 6 Years of Age	Returns a hard reject requiring PA when an antipsychotic medication is filled for a member under the age of six (6) years.
Attention Deficit Hyperactivity Disorder (ADHD) Medications Under 4 Years of Age	Returns a hard reject requiring PA when an ADHD medication is filled for a member under the age of four (4) years.

Each time a prescription is entered into the POS system, it is reviewed against the member’s integrated prescription history for potential interactions with medications previously dispensed at any retail network pharmacy, via mail order, or any out-of-network pharmacy when the member has submitted a paper claim for reimbursement. For certain appropriate edits, medical claims history is reviewed to determine if the

member has a specific ICD-10 diagnosis code that will meet the edit requirements. Based on the results of the DUR process, safety alerts are automatically triggered that immediately notify the pharmacist of any issues or concerns through claim response messaging. Alert messaging is customized to meet specific Passport requirements and to supplement National Council for Prescription Drug Programs Inc. (NCPDP) standardized messaging. These supplemental messages may include “ICD-10 required” messages for atypical antipsychotics, information for the dispensing pharmacist to review concerning interaction details, preferred drug options and many others. With timely DUR results that include actionable information, adverse medication reactions can be mitigated, and pharmacists can appropriately provide counsel to Passport members to help improve member care and health outcomes, while also helping contain overall health care costs.

Any utilization management issue detected in the POS system during adjudication is documented and logged in the system. Pharmacists also have the option to manually override select DUR edits if deemed clinically appropriate or following consultation with the prescriber, thereby ensuring our members access to necessary medications and allowing physicians and pharmacists to apply their clinical judgment and knowledge when prescribing and dispensing medications. For drugs with step therapy, the POS system offers the ability to look back for previous therapies. If the required prerequisite product is present, the system will allow a claim to process if history supports an adequate trial of a preferred therapy. This integrated electronic review decreases the need for PAs by evaluating known historical data and ensures member access to medications in a more timely manner.

The CVS/Caremark Safety Review solution acts as a safety net for serious drug interactions by further reviewing retail mail-order prescriptions (mail at retail dispensing) within 72 hours after the claim adjudicates. Claims are evaluated for potential safety issues not addressed at the point of dispensing. If a potential DUR event is discovered, prescribers receive actionable member-specific communications identifying the clinical issue and providing suggestions for improving medication therapy. This early retrospective intervention may allow for a change in the prescription before the member picks up the identified prescription, resulting in increased member safety, less member disruption and earlier savings capture.

Mitigating Possible Drug-to-Drug Interactions

Over the course of 1 year (October 2018 to September 2019) providers received nearly 5,600 communications for more than 3,500 unique Passport members.

Retrospective Drug Utilization Review

Safety and Monitoring Solutions, part of CVS/Caremark’s real-time surveillance and dynamic trend management capabilities, helps identify potential FWA among members, physicians and prescribers, which in turn supports improved member safety and cost savings. Claims are reviewed through an automated series of edits, benchmarks and algorithms. Passport members with high-cost drug use patterns that may suggest potential abuse or misuse are identified. A clinical pharmacist then conducts an analysis of the generated profiles, which are stratified by risk score using CVS/Caremark’s proprietary, evidence-based medication standards. If a potential case of fraud or misuse is identified, in addition to referring cases to

CVS/Caremark's fraud investigation unit for further monitoring and intervention of at-risk cases, a letter is sent to the appropriate prescriber(s), alerting them to the issue and describing that follow-up activities will be conducted for up to nine (9) months.

The following criteria is employed to help identify at-risk members:

- Controlled substance claims, which identifies the total number of continuous and concurrent (two [2] or more at the same time) targeted drugs
- Prescribers, which identifies an unusually high number of concurrent controlled substance prescribers
- Pharmacies, which identifies the total number of distinct pharmacies that have filled targeted drugs
- Excessive utilization, which identifies members who exceed the recommended utilization for targeted drug classes
- High cumulative daily dosage, which evaluates acetaminophen and morphine equivalent
- Geographic distribution of prescribers and pharmacies, which identifies patterns that indicate a member could be doctor- or pharmacy-shopping to avoid detection
- High total claim cost, which identifies potential misuse or abuse based on targeted drug costs

Collaborating with DMS on Controlled Substance DUR Initiatives

In serving our mission, we work collaboratively with DMS on pharmacy-related initiatives. One example is the multiple discussions we have had with DMS regarding the Pharmacy Lock-In Program over the last several years. We commit to working with DMS on enhancing this program to ensure the safety of our members. As it stands today, Passport's Pharmacy Lock-In Program continues to follow 907 KAR 1:677 and is designed for members to receive necessary medical and pharmacy benefits at the appropriate time through a structured delivery model.

Inappropriate use or abuse of pharmacy and/or medical benefits may include:

- Multiple prescriptions from different prescribers and/or pharmacies
- Reports of fraud, abuse or misuse from law enforcement agencies, practitioners, Office of the Inspector General, pharmacies and Passport staff

Under the Pharmacy Lock-In Program, a member's medical and pharmacy claims history and diagnoses are reviewed for possible overutilization. Members who meet the established criteria are locked into a designated single controlled substance prescriber and pharmacy for twelve (12) months. We work with the member's designated providers (i.e., primary care providers, controlled substance prescribers and pharmacies) and provide written notice of lock-in status. Our dedicated coordinators educate members on the appropriate use of plan benefits and connect them with our Care Advisors for condition management. As part of the program, Passport regularly reviews members' medical and pharmacy claims records to determine if they are adhering to plan benefits or if they should maintain lock-in status for another twelve (12)-month period. Should they retain lock-in status, Passport's Care Advisors continue the

care management program to help members improve their health and learn to comply with established plan guidelines. The Pharmacy Services team may modify a provider designation when:

- The designated provider withdraws or is terminated from participation in the Medicaid program
- The Pharmacy Lock-In team determines that it is in the best interest of the lock-in recipient to change the designated provider
- The member relocates outside the designated provider’s geographic area.

Passport continually seeks ways to collaborate with DMS on DUR initiatives. We worked with CVS/Caremark to further enhance and customize opioid edits in its POS system to more accurately reflect Kentucky Board of Medical Licensure guidance with respect to promoting safety and curbing the abuse potential in acute opioid prescribing. As a result, Passport implemented the following controlled substance smart claim edits:

- A maximum MED of 80 MED per day
- New opioid users (those without a history of an opioid in pharmacy claims) are limited to a maximum of seven (7) days of therapy with a maximum MED of fifty (50) MED per day
- Claims for an extended release opioid formulation require a history of therapy with an immediate release opioid product
- Pharmacy and medical claims history are used to determine if a member has had a claim for an oncology drug or an oncology or palliative care ICD-10 code, respectively, and if claims history shows either of these, the member is not subject to the controlled substance edits, and the claim will adjudicate
- If the claim does not meet the automatic smart edit criteria, then the drug(s) will reject for PA, allowing for a manual review to still be performed

Promoting Member Safety

In 2019, Passport enrolled 625 members in the Pharmacy Lock-In Program, bringing total lock-in enrollment to 1,431.

As a result, Passport helps more members improve their health, lower pharmacy costs and decrease unnecessary utilization.

The above edit enhancements were introduced in the same timeframe that DMS introduced a similar controlled substance safety edit for the fee-for-service program. This created an opportunity for both DMS and Passport to implement a DUR edit that was aligned in both the type of edits and timing of implementation.

Passport complies with all DUR reporting requirements as defined by federal and state regulations as demonstrated in the annual report recently submitted to DMS.

C.21.a.v. Proposed Maximum Allowable Cost (MAC) program

Administering the Maximum Allowable Cost Program

The Commonwealth has a key advantage in choosing Passport to continue its current role because it provides a fully compliant MAC solution within the program. Passport’s MAC program is administered by its

PBM, CVS/Caremark. The analytical process to establish a MAC occurs at a product level for generics and multisource brand products. This process involves a review of marketplace dynamics, including new generic launches, generic exclusivity status, the number of available generic vendors, product availability and different pricing sources. Pricing sources may include Medi-Span (or any other similar nationally recognized reference), wholesalers, MAC lists published by the Centers for Medicare & Medicaid Services (CMS) and retail pharmacies via invoices, if provided. These factors are all taken into consideration when establishing a MAC price.

Typically, products with limited competition due to exclusivity, supply issues, etc., will have less competitive MAC price points than products with an abundance of generic vendors available. MAC prices are subject to change as often as weekly, based on marketplace trends and dynamics and to meet Passport's commitments. New, bioequivalent (i.e., A-rated) generic products will be added to the MAC list for the CVS/Caremark generic pricing program applicable to Passport not more than thirty (30) days after they are readily available from more than two (2) generic vendors. As a measure of completeness and accuracy in the program, during 2019, eighty-six percent (86%) of Passport pharmacy claims were paid using MAC reimbursement rates.

CVS/Caremark pharmacy providers may access the pharmacy portal to obtain MAC prices and submit MAC appeals. The MAC program complies with all applicable federal and state requirements related to pharmacy claim pricing. In 2019, ninety-nine percent (99%) of all MAC appeals were reviewed within the required ten (10) days of an appeal being filed.

CVS/Caremark has a Kentucky-specific policy and procedure in place to comply with all aspects of Kentucky government code KRS 304.17A-162. This policy includes all requirements specific to the code and has been approved by the Kentucky Department of Insurance. More recently, Passport and CVS/Caremark worked closely with DMS and contracted consultants to develop a mutually agreeable process to comply with the Senate Bill 5 (SB5) requirement to request approval from DMS in advance of any proposed change of over five percent (5%) for a given product's reimbursement to a pharmacy provider licensed in the Commonwealth.

C.21.a.vi. Approach to operation of a pharmacy call center.

Managing Passports Pharmacy Call Center Operations

Passport's Pharmacy Services Call Center (PSCC) is already in place and meets or exceeds the requirements of this RFP. Our call center is readily available to respond to phone, email and fax inquiries from providers, pharmacies, members, Passport Member Services and the CVS/Caremark Customer Care team accurately, appropriately and in full compliance with state and federal law. Our PSCC is available Monday to Friday, 8 a.m. to 7 p.m. EST at 844-380-8831. For calls that come in outside of normal business hours, a prerecorded message that is available in both English and Spanish, providing the caller with the option to leave a

voicemail or to be routed to the CVS/Caremark Customer Care Service Center, which operates twenty-four (24) hours a day, seven (7) days per week. All email requests receive an initial receipt confirmation. Non-urgent email requests are received, reviewed, researched and followed up on by a lead pharmacy coordinator in an average of two (2) hours or less.

Caller inquiries are authenticated prior to the release of any PHI. All calls are recorded, tracked and documented in a HIPAA-compliant manner.

Both Passport's PSCC representatives and CVS/Caremark's help desk staff assist callers with inquiries pertaining to:

- Retail pharmacy claim inquiries
- PA status
- Drug coverage inquiries
- Plan design education
- Coinsurance questions
- Plan benefit overrides
- Escalated member requests
- UM process (authorizations), including initiating the exceptions process
- Ordering a refill for an existing, unexpired, mail-order prescription
- Finding the location of an in-network pharmacy and conducting a pharmacy proximity search based on zip code
- Determining potential drug-drug interactions
- Determining a drug's common side effects
- Formulary, including determining the availability of generic substitutes
- Claims submission, processing and payment, including:
 - Stage in the process
 - Amount approved
 - Amount paid
 - Member cost
 - Date paid, if applicable
- Formulary transition process
- How to access the grievance, coverage determination (including exceptions) and appeals processes

Passport's PSCC representatives clearly and comprehensively document all communication with callers under each member's unique profile in its proprietary Identifi system.

Assisting Members with Special Communication Needs

We ensure members with special communication needs have access to the exceptional service and information provided by our PSCC at no cost. Services for non-English speaking members are provided through our designated translation service vendor, Language Services Associates. Our PSCC utilizes TTY/TDD for members who may be hard of hearing or deaf.

Passport Pharmacy Services Call Center Training and Monitoring

Our PSCC is designed to be flexible in its staffing model to be staffed with the appropriate number of pharmacy technicians for effective servicing with acceptable response times. The model is structured based on historical call volumes and from forecasting the potential needs of our Passport members, providers and pharmacies. The staffing model is reviewed and updated annually.

The Passport Pharmacy Services team receives comprehensive new hire and ongoing training to support our members, providers and prescribers compliantly and in a timely fashion. Upon hire and annually thereafter, all Pharmacy Services staff complete online training that covers topics such as:

- Essentials of Ethics and Compliance
- Compliance—PHI, HIPAA and Compliance
- Compliance—FWA
- Insider Trading

Newly hired PSCC representatives are trained for six (6) to eight (8) weeks. Typically, our initial new hire PSCC representative training occurs on-site at our offices in Louisville, Kentucky. Representatives are provided with the tools and systems training needed to be successful in their roles and must complete activities that demonstrate proficiencies under the direct observation and guidance of their direct supervisor prior to working on their own. Training activities include:

- Problem-based learning to ensure that each trainee can explain the benefit plans, resolve issues and answer questions from providers, medical staff, pharmacies and Passport members
- Role-playing customer service calls so that each trainee understands and appreciates the experience of both sides of the calls that come into the Passport PSCC
- Orientation and training for the following systems:
 - Coverage determinations using MHK (Medical House of Knowledge, formerly known as MedHok®)
 - Call tracking database using Identifi, a proprietary management information system

Delivering an Exceptional Provider Experience

In 2019, Passport's Pharmacy Services Call Center quality monitoring score exceeded an average of ninety-nine percent (99%).

- Claims processing system using RxClaim
- Commercial plans and benefits using BARI (Benefits and Rate Information), a proprietary Pharmacy Services tool
- Medicare plans and benefits using BARI

Annual and ongoing training includes role-specific professional development and annual benefit training in addition to regular coaching and feedback.

Call Monitoring Quality Assurance

We have established high expectations for our PSCC representatives because they can directly impact a member or provider's experience and satisfaction with our plan. The Pharmacy Training and Quality Manager and the Pharmacy Coordinator Manager regularly monitor and evaluate PSCC performance on an ongoing basis. They utilize a standard evaluation form that is based on a set of call quality monitoring guidelines. These guidelines provide a detailed explanation of each competency that is measured as well as specific examples and explanations for the call center representative to understand why each competency is important. Examples of the competencies measured include correct member verification, voice presentation and caller advocacy (e.g., acknowledgment of issue, desire to help, empathy communicated, first-call resolution, professionalism and call documentation according to procedure).

We also review call center performance through call monitoring and monthly performance metrics to identify trends and opportunities for process or training improvements.

C.21.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.

Passport's Claims Payment Administration Process and Oversight

Passport maintains compliance with all prompt pay statutes, regulations and the Patient Protection and Affordable Care Act (PPACA) rebate requirements. The established requirements include provisions to pursue payments from third parties first so that Medicaid is always the payor of last resort.

We have clearly defined and executed processes in place with CVS/Caremark to ensure compliance with both federal and state regulations with regards to claims payment, accounts receivable and federal rebates so that:

- Claims, including adjustments, are processed completely and accurately
- Pharmacy and member reimbursement payments are requested, received and distributed completely, accurately and in a timely manner
- Rebates are processed and invoiced completely and accurately

Proven Interface with DMS systems

Passport has successfully interfaced with DMS, subcontractors and providers for many years to exchange data needed to administer our program. Data exchanges with DMS, providers and subcontractors occur through dedicated point-to-point connectivity or via secure virtual private online networks. Passport receives electronically transmitted member eligibility data and prescriber files from DMS, which allows the POS system to:

- Process claims for eligible members within DMS-required timeframes
- Appropriately assign copays, as applicable
- Validate that prescribers have active Kentucky Medicaid IDs
- Validate that pharmacies have active Kentucky Medicaid IDs

High-Volume, Flexible and Customizable POS

CVS/Caremark's POS system has processed millions of claims and can adjudicate a claim in less than one (1) second, including mail-order claims and batch electronic claim files. The historical reliability and system up time are excellent as well. The POS system is available twenty-four (24) hours a day, seven (7) days a week, with an average availability for pharmacy providers to submit and process claims of 99.9%. **Exhibit C.21-9** illustrates the Passport pharmacy transactions completed during the first quarter of 2019.

Exhibit C.21-9: Volume of POS Transactions Completed by Passport

Passport Health Plan Name	Oct-2019	Nov-2019	Dec-2019	Average per Month	Rolling 13-Month Total
NEW RXS	277,206	254,264	266,817	260,785	3,390,206
REFILL RXS	162,960	150,823	158,756	160,441	2,085,736
TOTAL NON PDL RXS	11,328	8,506	7,442	7,015	91,196
% NON PDL RXS	2.57%	2.10%	1.75%	1.66%	1.67%
PSYCH RXS	95,442	85,543	88,922	89,758	1,166,849
% PSYCH RXS	21.68%	21.12%	20.89%	21.31%	21.31%
NON PDL PSYCH RXS	1,508	1,356	1,412	823	10,700
% NON PDL PSYCH RXS	0.34%	0.33%	0.33%	0.20%	0.20%
# PSYCH UTILIZERS	44,681	42,324	42,621	43,052	559,675
% PSYCH UTILIZERS	15.04%	14.31%	14.66%	14.33%	14.32%
% PSYCH UTILIZERS/RX UTILIZERS	40.22%	39.13%	38.65%	39.70%	39.68%
# PSYCH RXS/MEMBER	0.32	0.29	0.31	0.30	0.30
# PSYCH RXS/PSYCH UTILIZER	2.14	2.02	2.09	2.09	2.08
# RXS/MEMBER LESS PSYCHS	1.16	1.08	1.16	1.10	1.10
% MEMBERS ON MEDS LESS PSYCHS	22.36%	22.26%	23.27%	21.77%	21.77%
PSYCH COST/PSYCH UTILIZER	\$91.38	\$81.95	\$82.35	93.70	\$93.82
# PROVIDER PRESCRIBED OTCS	56,213	51,218	53,172	51,919	674,948
# CONTROLLED RXS	48,221	43,402	44,988	45,156	587,027
# BRAND RXs*	42,207	36,221	36,439	40,475	526,170
% BRAND	9.59%	8.94%	8.56%	9.61%	9.61%
# GENERIC RXs*	397,959	368,866	389,134	380,752	4,949,772
% GENERIC	90.41%	91.06%	91.44%	90.39%	90.39%

The POS system has the flexibility for modifications to customize parameters for Passport, including eligibility, PDL logic and benefit design that support best practices and regulatory mandates. This includes:

- ICD-10 requirements for select drugs to facilitate appropriate use
- Use of ICD-10 codes, medical data and pharmacy claims history to reduce prescriber burden and process claims using smart PA edits
- Programming to restrict certain prescription classes to designated prescribers (in an effort to maintain member access to pharmaceuticals while containing costs)

- Assigning members in our lock-in program to one controlled substance prescriber (in compliance with state regulatory requirements)

Complying with Claims Payments and Accounts Receivable

CVS/Caremark's state-of-the-art POS claims processing system performs eligibility verification, claim adjudication, provider validation, duplicate claims edits and concurrent DUR edits online, in real time, for all prescriptions. As each claim is processed, CVS/Caremark's POS system assigns an internal control number (ICN) to each claim and its supporting documentation. This unique number is used to cross reference the ICN for tracking claims, research, reconciliation or audit purposes while safeguarding HIPAA information in the most stringent manner to protect the confidentiality of our members' PHI. All claims determinations, such as paid, rejected or reversed, are tracked to provide a full claims transaction history.

Passport pharmacy claims are adjudicated and paid in accordance with prompt pay statutes and regulations, including 42 CFR 447.45, KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-13542 C.F.R. 447.46, 42 C.F.R. 447.45, KRS 304.17A-700-730, KRS 205.593, KRS 304.14-135, and KRS 304.99-123. Under these regulations, all clean pharmacy claims, paper or electronic, are to be paid within thirty (30) days. CVS/Caremark's claims processing system performs eligibility verification, claim adjudication, provider validation, duplicate claims edits and concurrent DUR edits online, in real time. System edits, applied at the POS, act as an automated management tool to monitor and help ensure compliance with program parameters before a prescription is dispensed. Few other vendors can provide as stringent a set of online electronic claims verification and authorization edits combined with extensive pharmacy desk audit and field audit capabilities.

Claims Payment Is a Passport Priority

On average, claims are paid within eleven (11) calendar days.

One hundred percent (100%) of all claims are paid within twenty-one (21) calendar days of receipt.

CVS/Caremark enters paper claims into its adjudication system within ten (10) business days of receipt. The claims adjudication system then automatically performs a series of edits against specific plan design parameters on each claim processed. The system rejects ineligible or duplicate claims automatically and prevents overrides based on access code levels. Claims containing invalid provider numbers are rejected with appropriate messaging to the provider as to the reason for the rejection. The claims adjudication process passes the claim through the system to a separate business function to generate the paper claim reconciliation statement and reimbursement check. Claim transactions for pharmacy services are in the NCPDP B1/B2 format.

CVS/Caremark electronically adjudicates 100% of all claims received, including paper claims. Algorithms that capture performance objectives, guidelines and measurement mechanisms in overseeing the claims process are maintained to track both turnaround times and the volume of claims processed and suspended. With

complete and accurate information, CVS/Caremark commits to processing all claims submitted in accordance with DMS requirements.

Adjustments, recoupments, manual payments and other required identifying accounts receivable and claim information is also captured and acted upon, as appropriate. Claim records, including all adjustments and reversals from overpayments, are reported to DMS at the conclusion of each financial cycle with the status as of the closing date of the financial period.

Streamlined Claims Adjudication Process for Pharmacies

Our pharmacy claims adjudication process has been streamlined to ease administrative duties for pharmacies and get needed medications to members faster and more accurately. We use best practices and follow NCPDP standards and guidelines. Pharmacies submit POS claims using the HIPAA-compliant industry standard format. Batch claims as well as post adjudication claims reporting also use the prevailing NCPDP standards. Passport member ID cards display a Medicaid-specific BIN/PCN and group number to properly inform pharmacy providers where to submit a Medicaid claim to Passport.

Upon receipt of a prescription claim, the POS system automatically checks against a series of edits. These include, but are not limited to, the following:

- Validation of required and complete claim elements
- Confirmation of member eligibility
- Validation of the pharmacy National Provider Identifier and pharmacy network status
- Verification of the prescriber National Provider Identifier and provider network status
- Confirmation that the claim complies with the benefit plan parameters, including plan formulary
- Determination of member copay, if any
- Defined claims adjustments

As POS and batch claims are processed, CVS/Caremark's POS system assigns an ICN to each claim and to its supporting documentation within twenty-four (24) hours. This unique number is used to cross-reference the ICN for tracking claims, research, reconciliation or audit purposes while safeguarding HIPAA information in the most stringent manner to protect the confidentiality of our members' PHI. Claims that are rejected for payment include specific NCPDP D.0 reject messages to inform the provider of the reason for the claim reject. The Passport PSCC and CVS/Caremark help desk staff are available to resolve any claim rejects with the pharmacy provider.

CVS/Caremark maintains an electronic back-up of all POS and batch claims as well.

The CVS/Caremark POS system has the capability to add, change or remove claim adjudication processing rules to accommodate required state and federal changes within thirty (30) days for standard requests. Expedited requests are deployed with reduced turnaround times. A recent example of complying with this requirement involved the implementation of new dispensing fee requirements on July 1, 2018 that paid pharmacies an additional two-dollar (\$2) dispensing fee on paid claims.

CVS/Caremark uses sophisticated algorithms and real-time claims surveillance to automatically identify and notify account teams of potential issues during claims adjudication, allowing for more timely resolution of potential issues.

CVS/Caremark developed a series of rule-based and machine-learning algorithms to detect potential issues with benefit or plan set-ups during claims adjudication. These algorithms are run multiple times a day to identify potential issues. We test for outliers against benchmarks specific to each plan or group set-up, including formulary mismatches such as

- Copay changes/differentials
- PA requirements
- Network changes
- High dollar claims
- Variations in reject rates by reject type
- Other outliers based on plan type, with similar rules developed for other clients

Automated triggers (alerts) are sent to account teams for claims requiring specific review. CVS/Caremark also has developed same-day reporting tools that lets account teams review claims transaction patterns for paid and rejected claims, including comparisons against benchmarks and prior history, to review suspect claims and drill into claim line detail.

In the event that the claims processing system experiences downtime or there is an unexpected upward trend in denied claim rates, the CVS/Caremark account team is immediately notified and in turn notifies the Passport Pharmacy Services team of the service disruption. Upon notification, Passport and CVS/Caremark identify the current and potential level of member disruption resulting from the claims processing issue and prepare to notify DMS within twenty-four (24) hours if the potential impact is greater than one hundred (100) member claims.

C.21.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

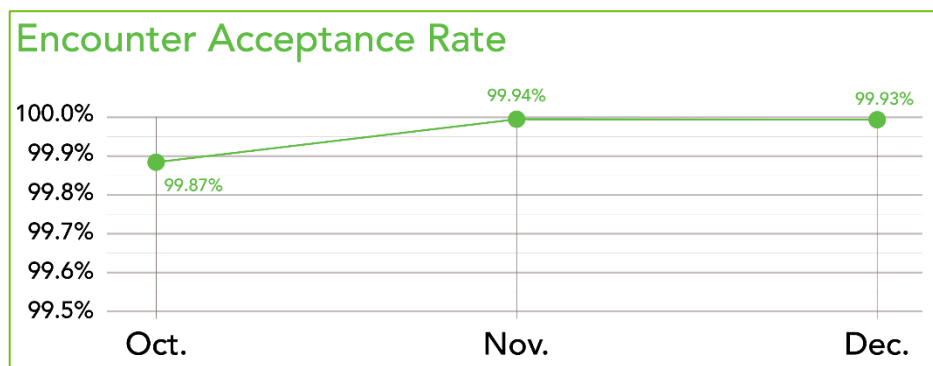
Passport Support for the Department's Rebate Operations

Passport has a long history of working with DMS to provide rebate data, resolve disputes and ensure that the Department rebate realization is maintained. Passport is committed to continued compliance with the Affordable Care Act and 42 C.F.R. 438.3(s), which require states to collect CMS-level rebates on all Medicaid MCO utilization. In support of this requirement, Passport's PBM enforces POS edits that ensure manufacturer rebate-eligible, covered outpatient drugs are paid as covered products. Other product utilization, including insulin, diabetic testing supplies and eligible medical pharmacy claims such as biologicals or provider-administered product claims, will contain valid national drug codes (NDCs) and any required HCPCS codes (e.g., J-Code, Q-Code, etc.), units dispensed or administered, strength, date of service,

paid date and amount paid by Passport. By enforcing data collection and validation during claim adjudication, Passport delivers clean encounter data to DMS for use in drug rebate administration.

To facilitate DMS’ access to rebates, Passport provides DMS with encounter data in accordance with Section 1927(b)(1)(A) of the Social Security Act in compliance with the Department’s Medicaid Managed Care Contract. This commitment includes oversight and review of PBM-submitted data that is compliant with required state drug utilization data and adheres to NDC-specific unit of measure guidance and CMS-suggested claim level data fields. Passport’s PBM submits program encounters directly to DMS on a weekly basis, and all encounters are submitted within thirty (30) days of successful claim adjudication. Passport has a long history of providing prescription and medical drug data to DMS, delivering an encounter acceptance rate of 99+% on the first submission, as shown in **Exhibit C.21-10**. This high first-pass compliance rate reduces rework and corrections, provides timely claim level drug utilization for aggregation and invoicing activities, and allows DMS to invoice manufacturers in the earliest possible quarterly billing cycle.

Exhibit C.21-10: Encounter Acceptance Rate



Encounter record content provides utilization data that includes the total number of units of each dosage form, strength and package size by NDC, claim date of service, claim paid date and total amount paid for each covered outpatient drug dispensed to Passport members. Passport also reports any other data DMS deems necessary for rebate collection. Claim detail and supporting data is submitted for outpatient prescribed drugs, including diabetic testing supplies and insulin. All reports are provided within required timeframes in the DMS-prescribed formats and timeframe.

Passport is aware that disputes are a tactic deployed by manufacturers to reduce or delay payment to the Commonwealth. We are committed to helping DMS to resolve Medicaid Drug Rebate Program disputes using established efficient processes and in accordance with Commonwealth and federal guidelines. Passport works in close partnership with PBM and DMS resources to address all manufacturer disputes.

As we become aware of rebate disputes from the Commonwealth, we immediately engage our PBM and the provider, as necessary, to resolve claim issues so that a the Commonwealth or their designee has sufficient time to review and submit a dispute response to the manufacturer within sixty (60) days as required. Passport reviews disputed information for pharmacy claims with its PBM and will direct them to take any

necessary steps to request that a pharmacy resubmit and correct the claim. Additionally, we ensure the Commonwealth's access to network pharmacy providers for verifying information submitted on claims.

The Passport team commits to delivering all files and reports necessary to facilitate the invoicing and collection of drug rebates and to assisting in the timely and complete resolution of drug rebate disputes with the manufacturer, working as a partner with DMS should any future changes occur to the program or product coverage, Commonwealth assumption of the PDL or the Medicaid Drug Rebate Program.

C.21.d. Describe the Contractor's processes and procedures to provide data and support Department-based efforts and initiatives for 340B transactions

Passport Support of DMS-Based Efforts and Initiatives for 340B Transactions

Passport and CVS/Caremark maintain system capability to appropriately identify 340B transactions in real time, prospectively and retrospectively, and provide appropriate 340B identifiers on all encounter claims. We leverage our combined experience, industry best practices and close monitoring of Health Resources & Services Administration and CMS guidance to support and maintain compliance with DMS 340B initiatives and federal regulations.

The pharmacy network provider manual includes the requirements for pharmacies to identify 340B-purchased drugs using the available NCPDP fields when submitting a claim for payment. Pharmacy POS 340B claims are identified by the submission of "20" in the Submission Clarification Code field (420-DK) and require submission of the actual acquisition cost of the drug product. In addition, 340B status is assigned to claims submitted by covered entity-owned pharmacies. These claims are identified via the NCPDP DataQ pharmacy provider database, where the submitting provider's 340B status is coded as "38" or "39." Claims coming from a CVS/Caremark-owned mail or specialty pharmacy are not included in this definition. Passport is already compliant with 340B processing procedures and submission of claim level indicators, supporting the DMS 340B program policy going into effect on April 1, 2020. Passport currently accepts and stores NCPDP Submission Clarification Code values as well as the Claim Modifier Code value of unit dose as an indicator of 340B status for drugs billed through the medical benefit.

Throughout 2019, Passport observed that brand claims submitted with the Submission Clarification Code increased by a multiple of 1.7 compared to 2018. This increase demonstrates both our pharmacy network's improved compliance with DMS 340B claim requirements as well as our ability to track and monitor activity across the network. The benefits to DMS include improved pharmacy encounter accuracy resulting in a decreased risk of submitting 340B-eligible claims for pharmaceutical manufacturer rebates.

A benefit of our locally based clinical outreach pharmacists is to analyze 340B claim activity for individual 340B pharmacies and educate pharmacies on proper 340B claim submission. Our clinical outreach pharmacists also collaborate with pharmacies to identify and select the lowest cost therapies for the Medicaid program.



As a leading provider in 340B management programs, CVS/Caremark has experience in administering programs that optimize the prospective and retrospective identification of 340B-eligible claims. Passport and CVS/Caremark are prepared to collaborate with DMS on how best practices implemented in hospitals and health systems to maximize 340B capture can be applied to the Kentucky Medicaid program.

CVS/Caremark complies with all Commonwealth pharmacy network requirements, as required in the Prescription Benefit Management Services Agreement Participating Customer Agreement. This includes excluding pharmacy network contract terms that lower reimbursement or apply other fees for pharmacies listed as a contracted pharmacy for a 340B-covered entity. Passport and CVS/Caremark do not discriminate against any 340B entities and allows Passport members to receive services from pharmacies that are contracted or owned by 340B-covered entities.

Passport's years of experience with the 340B program and close provider and pharmacy relationships offer a distinct advantage to the Commonwealth. Passport understands the complexities of the 340B program, including identifying eligible prescriptions or medical services, the implications and issues contract pharmacies bring to administering the program, and the risk to drug rebate collections through improper or inappropriate exclusion of claims. Passport's solution lets the plan work collaboratively with DMS, health systems and their contract and closed-door pharmacies to ensure that 340B impacts to the state result in capturing lowest cost position qualification and reimbursement data.

C.21.e. Describe the Contractor's pharmacy Prior Authorization process, including the following as part of the response:

- i. Transparency in communicating the conditions for coverage to providers.

Passport's Comprehensive Prior Authorization Program

Passport's PA program, developed in partnership with the P&T Committee, Behavioral Health Committee and clinical pharmacists, assures that member access to medically necessary prescriptions is available through the use of evidence-based criteria, best clinical practice standards and patient safety interventions in full compliance with state and federal laws and all requirements set forth by the Commonwealth.

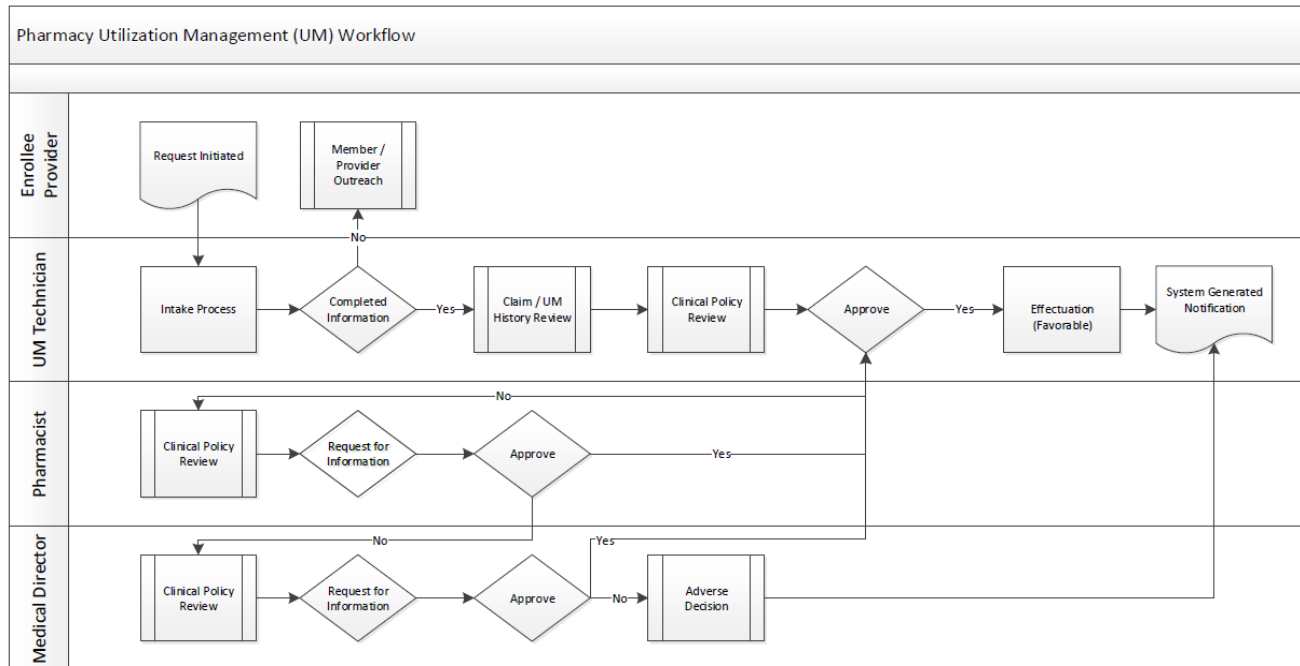
PA may be required for medications that are:

- Outside the recommended age, dose or gender limits
- Duplication in therapy (i.e., another drug currently used within the same class)
- New to the market and not yet reviewed by Passport's P&T Advisory Committee
- Prescribed for off-label use or outside of certain diseases or specialties

- Non-preferred products

The flow chart in **Exhibit C.21-11** illustrates our PA process upon submission of a written, telephonic (fax) or electronic PA (ePA) request(s) for medications requiring PA by the prescribing practitioner.

Exhibit C.21-11: Passport’s Prior Authorization Process



Transparency and Access to Drug Coverage Conditions and Criteria

Our website includes several resources to help guide members and providers to identify which medications require PA (**Exhibit C.21-12**), access universal and drug-specific PA request forms, and obtain instructions on how to submit PA requests. Drug-specific PA request forms (**Exhibit C.21-13**) have been created for the most common types of PA requests and contain the complete criteria or conditions for coverage that need to be met for the member to obtain medication approval.

We also recognize the need for members and prescribers to assess medication appropriateness using unconventional methods at times. Passport encourages the collaboration between our market physicians and medical directors as we offer the opportunity for peer-to-peer discussions to our providers.

Health care is an evolving field, where partnership and collaboration between providers leads to improved quality of care for members. Passport’s clinical outreach pharmacists have developed lasting relationships with prescribers in their regions. These relationships allow for improved communication with offices through routine office detailing. Furthermore, these providers have the cellphone numbers of our clinical outreach pharmacists so they can assist when an issue arises between regularly scheduled visits. This

program provides a direct channel to the Passport Pharmacy Services team so that member medication access concerns can be immediately triaged and resolved.

Exhibit C.21-12: Passport Searchable Formulary

PASSPORT
HEALTH ★ PLAN

You may search the Passport Health Plan drug formulary in several ways:

- Use the alphabetical list to search by the first letter of your medication.
- Type part of the generic or brand name, click Search.
- Select the Therapeutic Class of the medication you are looking for, and then select a subclass to view your results.

What if my drug is not on the formulary?

Remember, not all drugs are listed on the formulary. If Passport does not cover your drug, you have 3 options:

1. Work with your pharmacy or provider to find the preferred drug.
2. You can call Member Services at 1-800-578-0603 and ask for a list of similar drugs that are on Passport's Preferred Drug List.
3. If a drug is not covered by Passport or is not listed on our Preferred Drug List, your doctor can request an approval for it.

Can the formulary change?

Yes, Passport may add or remove drugs from the formulary during the year. To get updated information about covered drugs, please visit our website at www.passportthehealthplan.com or call Member Services at 1-800-578-0603.

Therapeutic Class Search: anti-infective agents/hcv polymerase inhibitor antivirals
6 drug(s) found
To view other medications in a therapeutic class, click any class hyperlink in your search results.

Results

Brand Name <small>Generic Name</small>	Therapeutic Class <small>Sub-Class</small>	Dose/Strength	Status	Notes & Restrictions
EPCLUSA ORAL TABLET 400-100 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> ANTIVIRALS	TABLET 400-100 MG	NP PA SP	QL more info PA more info SP
HARVONI ORAL TABLET 90-400 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> ANTIVIRALS	TABLET 90-400 MG	NP PA SP	QL more info PA more info SP
SOFOSBUVIR-VELPATASVIR ORAL TABLET 400-100 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> ANTIVIRALS	TABLET 400-100 MG	G NP PA SP	QL more info PA more info SP
SOVALDI ORAL TABLET 400 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> ANTIVIRALS	TABLET 400 MG	NP PA SP	QL more info PA more info SP
VIEKIRA PAK ORAL TABLET THERAPY PACK 12.5-75-50 &250 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> ANTIVIRALS	TABLET THERAPY PACK 12.5-75-50 &250 MG	NP PA SP	QL more info PA more info SP
VOSEVI ORAL TABLET 400-100-100 MG	ANTI-INFECTIVE AGENTS <u>HCV POLYMERASE INHIBITOR</u> ANTIVIRALS	TABLET 400-100-100 MG	NP PA SP	QL more info PA more info SP

We recognize the burden that PA forms can have on physician offices and staffing. As a result, our clinical outreach pharmacists have worked directly with market physicians to gain feedback on PA forms and related materials for years. This collaboration allows Passport to focus on updating and creating new content for these forms, resulting in more efficient and comprehensive submissions by the prescribing offices. In addition, our clinical outreach pharmacists proactively reach out to many of our provider partners in advance of a new PA or formulary change to help ensure that providers are aware in advance of the change, thereby minimizing member disruption.

Exhibit C.21-13: Passport Drug Specific Prior Authorization Request Form

PASSPORT HEALTH ★ PLAN		Passport Health Plan Pharmacy Benefit Management - Medicaid Phone: 844.380.8831 Fax: 844.802.1406			
LYRICA					
<input type="checkbox"/> Standard Request <input type="checkbox"/> Expedited Request		If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision.			
Demographics					
Patient Information		Prescriber Information			
Patient Name:		Prescriber Name:			
DOB:	Age:	NPI#:	Specialty:		
Health Plan ID#:		Phone:	Fax:		
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:		
Medication Information					
Drug Requested: Lyrica	Strength: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 75mg <input type="checkbox"/> 100mg <input type="checkbox"/> 150mg <input type="checkbox"/> 200mg <input type="checkbox"/> 225mg <input type="checkbox"/> 300mg	Directions:	Quantity Dispensed: Day Supply:		
<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy		Start Date: _____ If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.			
Clinical Information					
Diagnosis: _____		ICD-10 Code: _____			
Does patient have a seizure disorder or epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> If yes, please provide documentation (chart notes or specific dates) of other agents being used in conjunction with Lyrica					
Does patient have diabetic peripheral neuropathy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> If yes, please provide documentation (chart notes or specific dates that include the daily dosage) of previous trial and failure or contraindication to gabapentin AND a tricyclic antidepressant (TCA)					
Does patient have post-herpetic neuralgia? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> If yes, please provide documentation (chart notes or specific dates that include the daily dosage) of previous trial and failure or contraindication to gabapentin AND a tricyclic antidepressant (TCA)					
<input type="checkbox"/> Date of initial onset of symptoms					
Does patient have trigeminal neuralgia pain? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> If yes, please provide documentation (chart notes or specific dates that include the daily dosage) of previous trial and failure or contraindication to carbamazepine AND gabapentin					
Does patient have neuropathic pain due to a spinal cord injury? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> If yes, please provide documentation (chart notes or specific dates that include the daily dosage) of previous trial and failure or contraindication to gabapentin AND a tricyclic antidepressant (TCA)					
Does patient have Fibromyalgia? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> If yes, please provide documentation (chart notes or specific dates that include the daily dosage) of previous trial and failure or contraindication to gabapentin AND a tricyclic antidepressant (TCA) AND duloxetine (Cymbalta)					
History of Medications Used to Treat Above Condition					
Medication	Strength	Directions	Start Date	End Date	Reason for Discontinuing

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Passport’s PA program allows multiple submission methods and access points that providers can use to submit requests, provide information and receive a determination response to their request. This multichannel stream of information exchange supports our goal of ensuring timely determinations with no disruption of member access to care. Electronic prescribing (ePrescribing) support and ePA functionality are two important tools that reduce the need for PA requests and reduce demands on submitting providers.

Although ePrescribing functionality and the sharing of member formularies have been available for some time, Passport members benefit from RTBC through the presentation of alternative preferred or PA-exempt drug products. This also includes the presentation of generic products that can reduce member cost-sharing or copay expense in an effort to promote member adherence to therapy. This is a benefit to both the member and the provider because the provider can easily assess alternative therapies that are covered with

no PA requirement. If the provider chooses a preferred alternative, this allows for immediate coverage of the medication for the member, eliminating the need to complete the PA process.

The ePA program engages customized algorithms (**Exhibit C.21.14**) through an online PA submission tool that allows us to optimize our members’ best health through:

- Increased efficiency and turnaround times due to decreased PA handling time
- Real-time prescriber notification if an authorization has been approved
- Reduction of incomplete request submissions
- Elimination of illegible orders from being submitted and possibly delayed
- Supported verification of a member’s plan eligibility
- Attachment feature that allows uploading of documents to the member’s electronic profile
- Prevention of authorizations being placed for polypharmacy

Exhibit C.21-14: Electronic Prior Authorization Algorithm Examples

RxDiclegis_MedicaidV1

Rx-Diclegis_Medicaid V1

Is the patient pregnant? : Yes

Has the patient failed a nonpharmacologic method to manage nausea and vomiting during pregnancy? : Yes ?

Has the patient had an adequate trial of both of the following with an inadequate response or a contraindication to therapy? OTC pyridoxine AND Alternate antiemetic (see tool tip) : Yes ?

Rx-Celecoxib_MedicaidV1

Rx-Celecoxib_MedicaidV1

Does the patient have a diagnosis of rheumatoid arthritis, osteoarthritis, juvenile rheumatoid arthritis, primary dysmenorrhea, or ankylosing spondylitis? : Yes No

Has the patient had a documented trial and failure or intolerance to at least TWO of the following agents for at least 4 weeks each (see tool tip):

1. meloxicam
2. diclofenac
3. etodolac
4. oxaprozin
5. naproxen
6. meclufenamate
7. nabumetone :

Yes No or Unknown ?

Is the request for brand Celebrex or generic celecoxib? : Generic Celocoxib

How Each Process Within the Structure of Prior Authorization Is Conducted

All PA activities and decisions are documented in our online PA support system, an end-to-end solution that provides system-generated deadlines and automated communication services, ensuring compliance with all turnaround times. Here is how it works:

- **PA request is submitted.** Our online searchable formulary can be accessed to determine if a specific medication requires PA by visiting passporthealthplan.com/pharmacy. If a PA is required, a physician, nurse practitioner or pharmacist completes and submits the online prescription drug PA

submission form located on our pharmacy portal at passporthealthplan.com/pharmacy/pharmacy-portal-2. The form may also be accessed at passporthealthplan.com/pharmacy and submitted via fax. Passport accepts the DMS universal PA form for any request and does not require providers to complete a Passport-specific form.

- **PA request is received.** Upon receipt of a PA request, the certified pharmacy technician creates an order in the PA system.
- **PA request is evaluated using evidence-based criteria.** The pharmacy technician evaluates the individual drugs and/or drug formulations on the PA request against Passport’s clinical authorization criteria as developed by the P&T Advisory Committee and the Partnership Council. The criteria utilized is derived from one (1) or more of the following:
 - Evidence-based guidelines provided by non-biased resources from government agencies, such as the Agency for Healthcare Review and Quality, the American Society of Clinical Oncologists or the American Academy of Pediatrics
 - Published FDA approval indications for therapy
 - Federal and/or state regulatory requirements
 - Drug compendia, such as American Hospital Formulary Service-Drug Information, Gold Standard Clinical Pharmacology, DrugDex or “Facts and Comparisons”
 - Current medical literature and peer-reviewed, non-biased publications based on an appropriate scientifically designed study protocol with validated outcome endpoints that detail best clinical practice standards or other national standards of care

Pharmacy UM staff have access to real-time pharmacy claims data in addition to medical claim history, which assists in the PA evaluation process. Additional information may be requested via fax or telephone from the prescribing provider. If the request does not meet Passport’s clinical authorization criteria, it is forwarded to a licensed pharmacist and/or a licensed medical director for review and decision.

- **PA determination is rendered.**
 - **REQUEST APPROVED.** If a PA request meets Passport-approved clinical criteria and is approved by the pharmacy technician, pharmacist or medical director, the prescriber and/or pharmacist are immediately notified of the approval via fax, and the prescription can be filled. This may include approval for a therapeutic alternative or for a different dose than requested. As required in provisions of the Omnibus Budget and Reconciliation Act (OBRA 90) mandate, approval decisions are communicated to the prescribing practitioner within twenty-four (24) hours of initial case receipt via fax.
 - **REQUEST DENIED.** Requests not meeting Passport-approved clinical criteria are immediately electronically forwarded from the pharmacy technician to a pharmacist and/or medical director for medical necessity review. If the pharmacist or medical director, after their review, determines that the clinical criteria have not been met, they may deny the PA request. All denial decisions issued through the Passport pharmacy benefit are made by a licensed pharmacist and/or medical director. As required in provisions of the OBRA 90 mandate, denial decisions are communicated to the prescribing practitioner within twenty-four (24) hours of initial case receipt via fax. A denial letter is also mailed to the member. The denial notification includes the

explanation of the specific reason or missing item required for approval, a summary of the criteria used, the availability of a physician to discuss the decision (peer review) with the requesting provider and an explanation of the appeal process. Access to the complete clinical policy used for review is also available to the provider by request.

- Member and provider appeals to adverse benefit determinations are processed in accordance with DMS state requirements and in compliance with Section 24.2 Enrollee Grievance and Appeals Policies and Procedures and Section 27.10 Provider Grievances and Appeals of our contract with DMS.

As noted above, PA decisions are made and communicated to the requesting provider within twenty-four (24) hours of the initial request, including weekends, as required by the provisions of OBRA 1990 mandate, Section 1927 of the Social Security Act and other federal regulations. In the event a prescription is for a drug awaiting PA and Passport cannot reach the prescribing provider, the dispensing pharmacist, using his/her clinical judgment to avoid harm or injury to the member, is allowed to dispense a seventy-two (72)-hour emergency supply of medication using an override code in the claims system until the final PA determination is made. Should the drug product packaging require that it be dispensed in a quantity greater than what a seventy-two (72)-hour supply would provide, the pharmacist may dispense the packaged drug, and Passport will approve the claim with the submission of the permitted override code.

Additionally, Passport's online PA system has extensive reporting capabilities to provide quality assurance of the PA review process. This includes the reporting timeliness of review and determination to comply with required DMS turnaround timeframes.

C.21.e.ii. Required credentials for staff reviewing, approving and denying prior authorization requests.

Required Credentials for Prior Authorization Staff

Passport recognizes and agrees with the use of certified, credentialed and licensed staff in supporting key impactful clinical support areas such as PA. Passport's current PA review, approval, denial and reconsideration processes comply with the requirements in this RFP. Our UM staff includes certified pharmacy technicians, pharmacists and medical directors who support both pharmacy and medical UM development and operational functions. Denials may only be issued by licensed pharmacists or medical directors. The pharmacist team consists of individuals with many years of UM/MCO experience. In addition, a number of pharmacists are NABP credentialed, with board certification in geriatric pharmacy or working as board-certified pharmacotherapy specialists. The medical director's team has a broad spectrum of specialties, from internal medicine to pediatrics, and specialty practice areas such as family medicine, emergency medicine, anesthesiology and endocrinology. Passport's integrated pharmacy model brings clinical pharmacy expertise to optimally manage cost and utilization of both the pharmacy spend as well as trend-driving physician-administered specialty medications. The integration between medical and pharmacy also allows for monitoring of claims processing and the avoidance of potential double-billing under the two (2) benefits.

Passport is unique in that there is extensive coordination between the disciplinary teams within the plan, both before and after PA determinations are made. The director of pharmacy and Passport-designated clinical pharmacists work directly with foster care specialists, pediatric nurses and clinical outreach pharmacists who are embedded in offices or out in the field working directly with members and providers. Medication concerns and/or questions are relayed through our pharmacist/pharmacy technician managed via a dedicated UM email inbox, as well as phone calls and face-to-face visits from our clinical outreach pharmacists. This approach allows for timely resolution of all medication concerns, which then leads to easier and faster discharges from facilities. This allows the focus to remain on recovery, better adherence and earned trust between members and their care providers.



C.21.e.iii. Use of pharmacy and/or medical claims history to adjudicate prior authorization requests.

Utilizing Pharmacy and/or Medical Claims History to Adjudicate Prior Authorization Requests

Our PA process also incorporates auto-adjudication claims logic for select therapeutic classes. Auto-adjudication (sometimes called a smart PA) utilizes a member's claim history and information provided on a prescription or medical claim, such as an ICD-10 diagnosis code. These member health conditions and diagnoses are provided daily in files sent to the PBM that are uploaded to the claims processing system. This allows for automatic medication approval and mitigates potential disruption to therapy. In addition to using prescription drug claims to automate authorization of non-preferred PDL drugs when the member has a trial of preferred agents in his/her claim history, Passport deploys product- or condition-specific automated authorization evaluations. For example, we have deployed auto-adjudication logic to support quick and necessary access to medication-assisted therapy for substance abuse disorder, such as:

- Buprenorphine waiver of PA for treatment of opioid dependence or withdrawal in pregnancy
 - Medical claims history determines if a member has a certain ICD-10 code. This is provided as part of a medical claims integration with the claims processor system for any drug use complicating the pregnancy diagnosis. If a diagnosis is not found within this automatic medical claim lookback at POS, then the pharmacy may enter the ICD-10 code so that the claim will bypass the PA requirement and adjudicate.
 - This allows the member to receive up to a fourteen (14)-day supply of bridge therapy while she works with the provider to submit a PA (if required) for longer-term use.
 - If the claim does not meet the automatic smart edit criteria, then the drug will reject for PA, allowing for a manual review to still be performed.
- Vivitrol dispensing with opioid dependence diagnosis
 - Medical claims history determines if a member has an ICD-10 code for any opioid dependence diagnosis. The ICD-10 code is determined through the medical claims integration with the claims processor system, as described above. When an appropriate ICD-10 code is identified, then the claim will bypass the PA requirement.

- If a diagnosis is not found through the automatic medical claims lookback at POS, then the pharmacy is prompted to manually enter an ICD-10 code, if provided on the prescription, at the POS so that the claim will bypass the PA requirement and adjudicate.

Additional examples of custom edits that automate the PA process and align our efforts as a health plan to reduce provider burden, reduce FWA and improve overall program compliance with PDL options and clinical initiatives are as follows:

- Grandfathering for protected drug classes
 - Prior claims history determines if a member has been adherent with select classes of drugs, such as antipsychotics, within the last ninety (90) days. If a claim is found for a thirty (30)-day supply within the last ninety (90) days, the medication will continue to pay, even if the drug was subject to a PA review and the approval had expired.
 - This promotes continuation of therapy and adherence to medications that are benefiting the member's condition. It also reduces the burden on local physician offices in having to submit additional PA requests.
 - If a member is no longer adherent, this gives the physician an opportunity to work with the member, as his/her medication will no longer continue to process unless a new authorization is obtained.
- Controlled substance edits
 - Prior claims history is used to calculate the member's MED and then stratify him/her into one (1) of three (3) groups: new opioid users, existing opioid users or oncology or hospice. ICD-10 codes provided as part of medical claims integration for any hospice- or oncology-related diagnosis (or entered at the pharmacy for one of these diagnoses) will remove the member from the PA requirements associated with this edit.
 - Members identified as new may not exceed seven (7) days of therapy or fifty (50) MED per day. Members identified as existing must not exceed eighty (80) MED per day. Additionally, an immediate-release product is required before an extended-release product may be obtained for all utilizers.
 - Passport's edits accurately reflect Kentucky Board of Medical Licensure guidance with respect to promoting safety and curbing abuse potential with acute opioid prescribing. These DUR edits and policies fall in line with acute pain management treatment recommendations and are in accordance with numerous state-level prescribing restrictions of opioids and controlled substances.

If a claim evaluated for smart PA does not meet the automatic approval criteria, the drug will reject for PA. This prescription claim rejection is accompanied by the specific denial reason and supplemental messaging indicating how the provider may request a standard PA review.

Providers may submit requests for physician-administered drugs as well as outpatient-dispensed medications through our web-based portal or by fax, phone, email and mail. Web-based submissions are available via a PA and formulary exception link on Passport's website. Prescribing providers may submit PA requests utilizing our Passport Pharmacy Portal ePA solution, which allows them to respond to online question sets based on evidence-based medical policy and clinical practice standards, receive the status of the submitted PA or non-preferred exception request in real time, and submit additional supporting

documentation, as necessary. Upon approval, the pharmacy UM system has real-time connectivity with our claim processor to automate direct PA entry and record verification through an automated test claim function.

Conclusion

Passport has transformed to meet the changes of the Medicaid Managed Care Program alongside DMS. We have stayed informed and collaborated with DMS to ensure our processes, procedures, technology and workflows have been adaptable, scalable and, most importantly, compliant as requirements evolve to meet the health care needs of Kentuckians, while also addressing the changing social determinants of health.



Passport takes pride in employing Kentuckians who live and work in the same area as the members they serve. The length of tenure of our employees ensures that our members are receiving the best care possible from knowledgeable and seasoned staff who will be by their side for years to come. Our ability to quickly implement regular provider feedback is due to the collaboration between our internal Passport teams and our rapport with community providers. The fact that we are a homegrown health plan allows us to focus on our members and avoid complicated processes.

We can stay one step ahead of our competitors because our clinical model incorporates local providers in our decision-making as they are a critical part of our DNA. Passport employs clinical outreach pharmacists who travel to provider offices and pharmacies throughout the Commonwealth to educate on PDL changes, gain feedback and collaborate to improve the program. Our UM techniques are unlike any other plan due to the level of collaboration that we achieve by embedding our nurses, pharmacists and staff in the community and the direct channels we have to our medical and pharmacy teams.

Passport continues to transform and will bring the benefits of this evolution to DMS. Under the recently announced acquisition, Passport will further leverage the innovations, technologies and experience Evolent brings, with less redundancy and more efficiency to help deliver pharmacy benefits to health plan members so that they may live the healthiest and most active and productive life possible. We will continue to comply with all provisions of the MCO and Kentucky SKY contracts as we continue to serve them in the future.

Passport has been honored to serve the Kentucky Medicaid and foster care populations for 22 years and will continue to comply with all provisions of the Medicaid Managed Care Contract and Appendices (including Kentucky SKY) as we continue to serve them in the future.