21. Pharmacy Benefits (Section 31 Pharmacy Benefits)

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

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.

UnitedHealthcare's Preferred Drug List management related savings for all Medicaid health plans in 2018 was more than ***$100 million.***

As an industry-recognized service integrator known for delivering market expertise, innovative information technology, clinical capability and scale of operations, we will deliver quality Medicaid-specific solutions for pharmacy services that meet Kentucky's needs. We will administer pharmacy benefits transparently and in compliance with all requirements in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 31.0 Pharmacy Benefits, leveraging our experience supporting our 22 Medicaid health plans in other states with included pharmacy benefits. Unlike others who may outsource pharmacy benefits and at times struggle with oversight, UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare), in partnership with our affiliate Pharmacy Benefit Manager (PBM) OptumRx, has a legacy of success with sophisticated, integrated technology that we deploy. This includes network pharmacy management, retail pharmacy network claims processing, home delivery, specialty pharmaceutical management, Medicaid reporting, state audit functions, utilization management programs, therapeutic editing, formulary management, proactive drug utilization review (ProDUR) and retrospective drug utilization review (RetroDUR), and clinical programs to address the specific needs of the Medicaid population. *Recognizing this contract could potentially extend into the 2030s, we are uniquely positioned to be the best partner for the Commonwealth to continue modernizing Kentucky's health care system.*

Our synchronized and transparent approach will add value to the health system and aligns with Kentucky's goals: providing high quality, innovative services and improving the health of individuals. Our contractual and working relationship with OptumRx is transparent, including pass-through network pricing and transparent rebate contracting, billing and collections.

Our local Kentucky licensed pharmacy director leads our program. To facilitate program management, the pharmacy director is supported by a Kentucky-based pharmacy navigation team (PNT) (pharmacist and pharmacy technician), the national UnitedHealthcare pharmacy team and OptumRx support infrastructure. A key accountability for the pharmacy director is working with the Commonwealth, contracted pharmacy network, advocate and stakeholder groups, and association partners to support and collaborate in optimizing the pharmacy program in Kentucky for enrollees and providers. Our pharmacy director will meet with DMS as necessary and is accountable for assuring appropriate PBM oversight activities for the Kentucky plan. We share DMS's interest in driving pharmacy benefit value and providing individuals a health care experience that is simple to navigate and improves health outcomes.

In Kentucky, we will deploy the PNT to support pharmacy program integration across the continuum of care management teams. The PNT comprises dedicated clinical pharmacist(s) and technician(s) that collaborate with the extended multidisciplinary care team (MCT) [e.g., physicians, care coordinators, social workers, hospital care transition staff, community health workers (CHWs), prior authorization department] via referrals and attendance on clinical rounds to address all medication-related gaps in care queries or concerns. Our PNT clinicians close gaps in care with the prescriber, pharmacy or the enrollee as appropriate. We document all interventions in our care management software tool, *CommunityCare*, which all team members

can access. Our software tool also includes the individual's refill history. This allows our team to identify and intervene if an individual has missed important medications.

Integration with OptumRx

We have developed a cohesive pharmacy solution that will unite the PBM resources of OptumRx with our own Medicaid managed care expertise. Our Kentucky-based pharmacy resources, in collaboration with our national infrastructure, are developing integrated pharmacy management processes for Kentucky. Our pharmacy department will provide a comprehensive suite of pharmacy benefit services to individuals enrolled in the program, using the same platform as UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare), creating transparency between partners and sharing data routinely as part of each individual's MCT.

A critical part of our oversight and management of the pharmacy benefit is our approach to monitor, audit and evaluate PBM services delegated to OptumRx extensively verifying that services comply with regulatory and contractual standards, including, but not limited to, oversight of OptumRx's management of the network of pharmacies and claims processing responsibilities. OptumRx submits a dashboard of both summary and detailed reports detailing service standard metrics of their delegated services, including pharmacy call-center statistics, audit results and rebate reporting, and complies with reporting requirements in Attachment C – Draft Medicaid Managed Care Contract, Section 31.17 Pharmacy Benefit Manager or Administrator Reporting Requirements. We record all pharmacy call center calls — which are trackable and retrievable for monthly reporting — and monitor them for quality (please see Attachment C.21.a.i. PBM contract). We will hold a quarterly Business Review and a Joint Oversight Committee meeting with the Kentucky pharmacy director and the Kentucky PBM account manager in attendance.

Annually, our UnitedHealthcare Community & State (Medicaid) pharmacy team (independent from OptumRx) performs an extensive audit of OptumRx delegated functions to validate compliance with contract requirements. We perform in-depth oversight and audits to verify that OptumRx achieves our rigorous performance standards and complies with contract requirements.

Network Claims Processing: We audit claims processing monthly and annually through a random sampling of a statistically valid number of claims. We review them for timeliness, prompt pharmacy payments and correct processing. Our network pharmacy audit team identifies outliers from a daily claims report in an effort to increase detection of aberrant claims and focus resources on potential abuse discovery and monetary recovery.

Fraud, Waste and Abuse Compliance: The annual review of the OptumRx Compliance Program examines each of the elements as defined by the Office of Inspector General, including governance; written policies and procedures; training and education; effective communication; monitoring and auditing; enforcement and disciplinary actions; responding to identified issues; and a comprehensive fraud, waste and abuse plan.

Pharmacy Network Credentialing: As part of our annual audit, we review pharmacy network contracts and pharmacy network claims from a random selection of national chains and independent pharmacies. This review ensures valid, up-to-date contracts are in place and claims are processed according to the contractual requirements.

Pharmacy Network Auditing: Network auditing is an important part of our pharmacy network management program. It is a contractual requirement for OptumRx inclusive of a multiphase auditing program with real-time, desk, focused and onsite capabilities.

Pharmacy Call Center Service Levels: Our PBM account manager is closely involved with the training and oversight of the pharmacy call-center staff. During the annual audit, we randomly audit calls for the quality of the response and compliance with documentation requirements.

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

Under the advisement of the Pharmacy & Therapeutics (P&T) Committee, comprised of our local health plan staff, national pharmacy team and open to participation from a local Kentucky external pharmacist and/or physician, we develop our Preferred Drug Lists (PDLs) (as well as physician administered drug list, in compliance with Attachment C – Draft Medicaid Managed Care Contract, Section 31.3 Physician Administered Drugs) to help drive generic utilization and prerequisite therapy based upon the most cost-effective treatments supported by clinical evidence. Our Kentucky chief medical officer will provide input on the PDL, as will our local health plan Kentucky-licensed pharmacy director. We combine clinical expertise and information with a rigorous design process to update our PDL quarterly with input and approval from the Commonwealth and to comply with all requirements in Attachment C – Draft Medicaid Managed Care Contract, Section 31.4 Preferred Drug List. Using our own PDL allows us to better respond to individuals' needs and efficiently implement cost-savings programs while maintaining a high quality, evidence-based medication selection, though we will comply should the DMS decide to move to a single uniform PDL.

We use our innovative technology, such as PreCheck MyScript, to promote PDL adherence. PreCheck MyScript provides physicians a point of care solution to promote adherence to the PDL by showing the prescriber what is covered when meeting with the individual, so they can make clinically appropriate prescribing decisions. This both minimizes disruption for enrollees when picking up medications from their pharmacy (as the medication the provider prescribed is on the PDL) and improves satisfaction among enrollees, providers and pharmacists. Through *Link*, providers are able to access the *Care Provider Manual,* which offers a view of the complete PDL and PDL updates. Providers also will have access to our PDL Database Tool, which is a web-based PDL application that can be downloaded onto a smart device. Through this tool, providers can view plan-specific messaging regarding quantity limits, prior authorization requirements and step therapy.

Enrollees and their families or caregivers can easily see drugs on our PDL, which includes a wide variety of safe and clinically appropriate drugs representing the full breadth of therapeutic classes, including brand drugs and generic drugs. The PDL also includes over-the-counter medications that meet contract requirements and that extend the cost-effective range of therapeutic options for enrollees. Our *Member Handbook* provides general information for enrollees about all aspects of the pharmacy benefit, including the PDL. Our enrollee website, *myuhc.com,* includes a complete listing of our PDL (including updates and status changes) in a searchable drug database and information on the prior authorization (PA) process, additional clinical coverage information, PA criteria and PA request forms. When a drug on our PDL has a status change, enrollees are proactively notified in writing to let them know of the change, formulary alternatives available and the processes by which they can work with their prescriber to adjust therapy to a preferred medication or to initiate PA.

New medications are reviewed for inclusion on the PDL, within 75 days of market availability, as the Food and Drug Administration (FDA) approves them and they become available, unless otherwise restricted from inclusion by regulation or contract. New drugs not yet reviewed by the P&T Committee are available through the PA process. Medications included on the PDL must

demonstrate a clinically significant therapeutic advantage to current PDL agents or be new agents with no comparative products available.

The PDL will be available on *myuhc.com* and through our provider portal, in the format specified in 42 C.F.R. 438.10. We also will send the PDL to enrollees or providers in hard copy upon request. In addition to the base requirements, the PDL information will include the PDL status (preferred, non-preferred), an indication if a PA is required and information necessary to initiate a PA request or access to a non-preferred drug.

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

We will maintain a P&T Committee whose primary objective is developing and overseeing the pharmacy program to meet the prescription drug needs of Kentucky MCO enrollees. Our P&T Committee is responsible for developing the PDL, making recommendations regarding inclusions and exclusions from the PDL, and developing and recommending policies and procedures for PDL development. Dr. Jeb Teichman, our Kentucky health plan chief medical officer (CMO) and our health plan pharmacy director, who will be a licensed Kentucky pharmacist, will provide perspective on medications by offering insight on utilization management (UM) tools and coverage criteria, chairs the P&T Committee.

Committee members support the P&T Committee composition guidelines and include: our health plan chief medical officer, national, as well as local, Kentucky practitioners in family practice, behavioral health, internal medicine, obstetrics/gynecology, pediatrics and psychiatry, and pharmacists. The P&T Committee will draw upon the expertise of committee members and will include, at minimum a local Kentucky licensed physician and an experienced Kentucky licensed pharmacist who currently provide services to Kentucky Medicaid recipients. The committee also includes ad hoc specialists (e.g., gastroenterologists, endocrinologists, cardiologists, infectious disease specialists, pulmonologists, pharmacoeconomic specialists). We consult other specialties as needed, depending on the therapeutic category of the drug(s) in question.

The clinical criteria for all drugs requiring PA will be reviewed and approved by the P&T Committee and are based upon medical literature, FDA information, treatment guidelines, actively practicing consultant physicians and appropriate external organizations. In considering clinical criteria, we will monitor the introduction of new medications to the market, the utilization of high-dollar medications and treatment guidelines for conditions requiring specific treatment algorithms. Our pharmacy clinical team identifies drugs or disease states that require greater oversight due to very specific therapeutic use and potential misuse or abuse and compiles and reviews relevant data, including information on new drugs and existing treatment guidelines (e.g., whether a given drug is a first-line or second-line therapy). Based upon this research, the clinical team develops clinical criteria relating to the following:

- Clinical information such as diagnosis, lab work, list of medications previously used for the same indication including dose, duration and outcome required to support request
- PDL alternatives appropriate as first-line therapy
- Appropriate length of therapy for initial treatment and re-treatment

Fully developed PA criteria are presented to the P&T Committee, which reviews them for appropriateness and examines recommended clinical guidelines in the context of current literature and medical practice. The P&T Committee undertakes its examination of PA criteria with a goal of facilitating the appropriate use of pharmaceuticals without unnecessary obstacles to access. We also will comply with requirements regarding alignment of criteria when required

to do so, for example, with drugs to treat hepatitis C and substance use disorders (SUD). We also will be an engaged partner to collaborate with the state pharmacy team to develop criteria in the future, should that need arise.

The committee reviews updates to the PDL/formulary quarterly and as needed and undertakes review of several drugs and therapeutic classes at each quarterly meeting, resulting in a full review of all drugs and therapeutic classes throughout the course of a year. PDL additions, deletions and review of PA criteria occur on an ongoing basis. We make every effort to implement all changes on a quarterly basis. The resulting PDL includes a range of drugs in each therapeutic category and subcategory. Medications restricted from inclusion by either state or federal regulation or by our contract will not be included in the PDL.

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

DUR Program Collaboration

Our health plan chief medical officer, Dr. Jeb Teichman, will lead the UM of our pharmacy benefit services in collaboration with the dedicated health plan Kentucky licensed pharmacy director. Our pharmacy director will actively share UnitedHealthcare's Medicaid experience and serve as a subject matter expert on the health plan's behalf. The pharmacy director will provide information and collaborate with the key pharmacy stakeholders at the state (within the Medicaid pharmacy program) to provide information on our clinical initiatives challenges and successes to find important areas of collaboration with the state. Not only will we collaborate with the Commonwealth on pharmacy initiatives, we will manage pharmacy utilization through our Drug Utilization Review (DUR) program. Our Kentucky pharmacy director will act as the liaison to work collaboratively with DMS and our DUR Board (e.g., policy implementations, lock-ins) and through other meetings as directed by DMS, such as the Kentucky pharmacy director workgroup.

Drug Utilization Review Board

Monitoring Psychotropic Drugs
Antipsychotics generated at least 1,000 ProDUR flags per quarter through soft edits, warnings and prompts at the point of sale. This avoided potentially dangerous medical implications or drug interactions and we verified dispensed medications were clinically appropriate and not likely to result in adverse medical outcomes.

The UnitedHealthcare DUR Board is responsible for developing, maintaining and providing medical oversight of DUR programs used by Medicaid benefit plans issued or administered by UnitedHealthcare or its affiliates in accordance with the requirements of a DUR Board found in 1927(g) of the Social Security act relating to DUR activities. The DUR Board provides clinical support for the development, maintenance and clinical oversight of DUR programs and the pharmacy lock-in program. The purpose of the clinical support provided is to collaborate on initiatives and verify the clinical pharmacy programs improve quality of individual care by promoting enrollee safety, identifying gaps in care, and reducing the frequency of patterns of fraud, abuse, gross overuse or inappropriate or medically unnecessary care among physicians, pharmacists and enrollees.

The UnitedHealthcare DUR Board's membership includes health care professionals who have recognized knowledge and expertise on the clinically appropriate prescribing of covered outpatient drugs, the clinically appropriate dispensing and monitoring of covered outpatient drugs, drug use review, evaluation and intervention, and medical quality assurance.

Drug Utilization Review Program

Built on real-time edits and comprehensive education programs, and in compliance with CMS and Attachment C – Draft Medicaid Managed Care Contract Section 31.9 DUR Program requirements, our DUR program finds opportunities for clinical interventions and identifies contraindications, duplications or other potentially dangerous prescribing. This allows us to take immediate action by alerting the prescriber and/or pharmacist to provide individual quality care and manage total health care costs. The DUR program, including concurrent DUR and retrospective DUR programming, identifies dangerous enrollee utilization patterns or gaps in care, looks at prescribing trends outside of evidence-based guidelines for educational opportunities and looks to alert pharmacies of medication issues due to a person's use of multiple pharmacies. We can provide quarterly written reports of DUR activities to DMS upon request.

From the end of 2017 to early 2019, through our ProDUR program, we have seen:

- A 45% decrease in the number of total opioid claims
- A 58% decrease in the number of opioid users using >90 MME dose
- A 31% decrease in utilization of long-acting opioids

Prospective Drug Utilization Review

Prospective Drug Utilization Review (ProDUR) programs screen all prescriptions at the point of service to identify potential drug issues using the Medispan database. The ProDUR program consists of a series of real-time point of sale flags that check incoming prescriptions against the enrollee's prescription history looking for potential medication and/or diagnosis related conflicts. Alerts include duplicate therapy, drug-inferred health state issues, drug diagnosis cautions, drug-drug interactions, drug-duration issues, high dose utilization, drug-gender identification, drug-age issues, refill too soon flags, and regulator-specific morphine equivalent dose limits. By alerting the dispensing pharmacist during the initial prescription preparation process, we can work collaboratively with the prescriber and the individual to address and resolve the situation before the person potentially suffers harm.

During adjudication, ProDUR edits are checked simultaneously with the other plan edits. If a medication issue is encountered, ProDUR can vary the response sent to the pharmacy based upon the severity of the issue and/or how the ProDUR program is uniquely set up; the program is flexible and configurable to meet Kentucky's needs. Three options in the system flag ProDUR interventions at the point of sale:

- ***Hard edits:*** Requires a PA before the prescription will pay at the point of sale.
- ***Soft edits:*** Soft edits take the responsibility away from the prescriber. This response will require pharmacy confirmation of the prescription in the pharmacy claim submission by entering NCPDP codes (e.g., professional and results code) before a paid claim at the point of sale. This does not require a PA.
- ***Warning messages:*** Indicates a potential issue (e.g., duplication, potential interaction) along with a paid claim allowing the pharmacist to exercise professional judgment without submission of a code at the point of sale.

Our pharmacy team will present suggested changes to the type of real-time messages used at the point of sale to the DUR Board for review based upon reviewed clinical trends and clinical severity. For example, to address the opioid crisis, the DUR Board approved point-of-sale edits include opioids and benzodiazepine, opioid therapeutic duplication, and custom messaging on opioids and prenatal vitamins. Our ProDUR programs improve the quality, safety and cost

effectiveness of medication regimens by catching potential medication problems before the medication is dispensed.

Retrospective Drug Utilization (RetroDUR) Program

Our RetroDUR program is a powerful tool to monitor appropriate medication use. The RetroDUR clinical product line program focuses on medication-related concerns that may not have been addressed at the point-of-sale to effectively drive drug therapy changes, promote evidence-based prescribing or control total health care costs. We review all RetroDUR initiatives with the DUR Board for clinical merit, perceived influence and approval for implementation or continuation.

Individuals are identified daily for safety or gap in care opportunities through retrospective pharmacy and available medical claims data going back 120 days. When we identify an individual for an intervention, we send a timely fax to the prescriber for them to review and adjust therapies as appropriate. The programs include a monthly individual level detail and activity metrics/outcomes report.

RetroDUR Safety Management

Through the Safety Management Program, we target potentially inappropriate medication patterns across a broad range of drug classes for safety and to minimize potential adverse events. We analyze pharmacy and medical claims data for concerns, including the following provider-targeted programs:

- ***Duplicate therapy:*** Promotes awareness of therapeutic duplication concerns.
- ***Drug-drug interactions:*** Minimizes the occurrence of clinically significant, enrollee-specific drug-drug interactions.
- ***Drug-disease interactions:*** Minimizes the occurrence of clinically significant, enrollee-specific drug-disease interactions.
- ***Drug-age considerations:*** Minimizes the occurrence of potentially inappropriate medications in the geriatric and pediatric populations.
- ***Overutilization Day's Supply:*** Minimizes the occurrence of targeted medication use exceeding the recommended duration of therapy.
- ***Dose per Day and Average Daily Dose:*** Minimizes the occurrence of targeted medication dosing above the recommended therapeutic range.
- ***Narcotic Drug Utilization Review:*** Minimizes the occurrence of drug abuse, diversion and inappropriate use in using high-risk medications. This program identifies enrollees whose medication use shows patterns indicative of overuse, such as excessive refills, multiple prescribing physicians and pharmacies, therapeutic duplications and drug-drug interactions for opioid, benzodiazepine and muscle relaxant products.

RetroDUR Gaps in Care Programs

Through gaps in care programs, we drive quality of care by identifying and closing gaps in medication therapy for individuals with targeted disease states while improving adherence and lowering total health care costs. We analyze pharmacy and medical claims data for concerns including:

In 2018, our narcotic DUR program yielded a 62% resolution rate of inappropriate medication use patterns.

Asthma Optimization Program: Provider-targeted program designed to optimize the use of long-term controller medications as recommended by current guidelines and promote the appropriate use of short-acting beta-agonists. The program also incorporates quality measures supported by CMS, HEDIS and Pharmacy Quality Alliance.

COPD Program: Provider-targeted program designed to optimize the use of long-term controller medications as recommended and promote the appropriate use of short-acting beta-agonists in chronic obstructive pulmonary disease (COPD).

Diabetes Program: Provider-targeted program designed to optimize the management of diabetes by identifying and closing the gap for people with diabetes not on a statin and people with diabetes and hypertension not on certain anti-hypertensive agents.

Cardiovascular Program: Provider-targeted program designed to optimize the management of those individuals with certain cardiovascular diagnoses by identifying and closing the gap for:

- Coronary heart disease and ischemic vascular disease enrollees not on a statin or an appropriate dose of a statin
- Congestive heart failure enrollees not on beta-blocker, appropriate beta-blocker, angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker or angiotensin receptor-neprilysin inhibitor
- Myocardial infarction enrollees not on a beta-blocker
- Atrial fibrillation enrollees not on an anti-thrombin agent

Appropriate Medication Use and Adherence

As compared to non-adherent enrollees, enrollees who consistently take their medications have lower likelihood of hospitalization, ED visits and condition-specific health care costs. The Medication Adherence program we will bring to our Kentucky MCO Program uses a data-driven approach to identify individuals who need help taking medications as prescribed across multiple drug classes. By identifying non-adherent enrollees, engaging early and staying connected — we can help individuals stay on track with their health and medications. In turn, this can lead to better outcomes and lower overall health care costs. OptumRx uses claims data and advanced analytics to identify individuals taking medications at crucial points in their therapy. Once identified, we actively support our enrollees though a series of outreach initiatives including:

In 2018, a 34-year-old male enrollee with diabetes type 2, dialysis and visual impairment was hospitalized for hypoglycemia. His clinical pharmacist spoke with the individual and his caregiver and found that he was using insulin vials, but had difficulty measuring the correct dose. The clinical pharmacist recommended insulin pens, as the dose is dialed by pen clicks and the individual can count the number of clicks to get the correct dosage. The clinical pharmacist spoke to the enrollee's doctor and assisted in obtaining a PA for the pens. The enrollee has had no further hospitalizations due to hypoglycemia for over 6 months.

New to Therapy Letter: Educating people on new prescriptions and their disease, including the importance of medication adherence.

Primary Medication Non-adherence: Faxes/mailings are sent to providers alerting them if their enrollee did not start their new therapy

Early Refill Reminder: Interactive voice response (IVR) calls reminding enrollees to refill their medications, typically 3 days prior to refill date, with an option to be transferred to their last dispensing pharmacy to refill

Late to Refill: IVR calls include barrier survey and tips to address barriers that people may be facing, with an option to be transferred to their last dispensing pharmacy to refill

Additionally, if we recognize an individual is still non-adherent, we send educational letters about the importance of adherence with tips on how to remember to take their medication, fax or mailings to their provider alerting them of the non-adherence, and IVR calls with barrier surveys and tips to address barriers. The calls offer

people the option to connect with a live OptumRx pharmacist for telephonic consultation and collects barrier information that will be reported.

Our team of clinical pharmacists is working to facilitate access to Medication Assisted Treatment (MAT) medications. The team does a rapid review of rejected claims for individuals new to MAT and works with the prescribers to assist in removing barriers so enrollees can receive medications. To date, we have reached prescribers on behalf of 753 individuals across 13 of our Medicaid health plans, and have shown a 52% MAT utilization success rate, with plans to expand across all Medicaid states.

Multidisciplinary Care Team (MCT) Coordination: As a member of the PNT, our Kentucky health plan clinical pharmacist will work collaboratively with the extended clinical team (physicians, care coordinators, social workers, CHWs, PA department) via referrals and attendance on clinical rounds to address all medication related gaps in care queries or concerns. Our clinical pharmacist then closes gaps in care with the prescriber, pharmacy or enrollee as appropriate. The clinical pharmacist also attends meetings to help support new initiatives, provides education on drug-related topics, solves or prevents drug therapy issues and decreases the total cost of care for enrollees related to drug therapy. We document all interventions in our care management tool, *CommunityCare*, which all MCT members can access. *CommunityCare* also includes the enrollee's drug history file. This allows our team members to identify and intervene if an individual has missed important medications and supports our MCTs staying up-to-date on all aspects of an enrollees' care.

Text Message Reminders: Recognizing the importance of technology as a method of communication, enrollees, parents or guardians may sign up through the enrollee portal to receive daily or monthly text messages with reminders to take or administer medications at the appropriate time.

Administrative Pharmacy Lock-In Program

Through our administrative lock-in program across 22 states, we have seen a:

- 56% decrease in the number of utilizers using three or more pharmacies to fill opioids
- 55% decrease in the number of utilizers using three or more prescribers for opioids.

Our administrative lock-in program is an integral component of our fraud, waste and abuse (FWA) program, protects the integrity of health services provided to our enrollees, and supports the overall quality management program at UnitedHealthcare. Our goal is to help the enrollee use their benefits in a safe and effective manner. The program identifies enrollees who demonstrate overutilization of services, exhibit abusive conduct or have fraudulently abused their medical benefits. The KASPER system will be an important part of lock-in program management in Kentucky. This program allows us to limit an enrollee to one pharmacy, enabling the pharmacist(s) to know all the medications the enrollee is receiving, resulting in increased enrollee safety by reducing potential interactions or overdoses of medication.

SUPPORT Act and Opioid Management

The Kentucky UnitedHealthcare Community Plan will implement a Comprehensive Opioid Misuse Prevention Program within the pharmacy benefit. This program minimizes inappropriate opioid use, ensures dispensing in line with the Centers for Disease Control and Prevention (CDC) guidelines, complies with the federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) ACT, and identifies areas for targeted interventions to reduce inappropriate supply. Our targeted pharmacy strategies (e.g., morphine milligram equivalent [MME] limits, quantity edits, and drug utilization reviews) are designed to minimize early exposure, prevent inappropriate utilization, and ensure opioid dispensing in line

with CDC guidelines. We closely monitor trends and continue to innovate and quickly implement new strategies to prevent misuse.

We use Prospective Drug Utilization Review (ProDUR) to identify fill patterns misaligned with state and CDC guidelines, and use real-time, point-of-sale (POS) edits to inform pharmacists of the need to review. Such edits include prior authorization for long-acting opioids, a cumulative MME limit of 90 and new to therapy edits that limit members to a maximum of a seven day supply and less than 50 MME for their first fill. We have implemented alerts that identify potentially inappropriate drug combinations (e.g., concurrent use of opioids and benzodiazepines), and prompt safety messaging for opioids and prenatal vitamins, which may indicate inappropriate use among pregnant members.

We also utilize retrospective DUR (rDUR) to minimize the occurrence of drug abuse, diversion and inappropriate use by monitoring utilization behaviors and identifying opportunities for intervention. This is a provider-targeted program designed to identify members whose opioid medication use shows patterns indicative of overuse (i.e., excessive refills, multiple prescribing physicians and pharmacies, high MME doses, therapeutic duplications, concurrent use of opioids and antipsychotics, and concurrent use of opioids and benzodiazepines).

v. Proposed Maximum Allowable Cost (MAC) program.

A comprehensive and informed pharmacy network is a vital component of the UnitedHealthcare pharmacy benefits program. Reasonable compensation to the pharmacy network for the services provided is an essential component of our pharmacy network strategy, and includes a Maximum Allowable Cost (MAC) program for the reimbursement of generic drugs. We set individual prices for pharmaceutical equivalents, updated to respond to market changes in pricing and acquisition costs, and support adoption of new product introductions. Our MAC pricing provides continuous competitive unit cost discounts and promotes high substitution levels per generic category and rapid adoption of generics for brands coming off patent. We price products not on the MAC list at average wholesale price (AWP) less the network discount. This method results in controlled, discounted pricing for generic products.

We derive our MAC prices from a number of elements to reflect market availability, wholesale price index and usual and customary pricing in the market. There is no simple formula for these calculations. The process is refined and unique to provide fair pricing for customers and pharmacies. The input data reflects a dynamic marketplace and the calculations yield a fair generic price in a market fluid in both acquisition cost and supply. Our ability to administer pricing according to industry dynamics will be especially valuable as some of the highest used brand-name drugs continue going off patent over the next several years. We apply the dynamic pricing of our MAC program to provide even greater savings when combined with UnitedHealthcare PDL/formulary strategies designed to drive towards utilization of generic products. Our MAC pricing program provides the comprehensive product coverage of 91% to 93% of generic products to optimize unit cost discounts and daily pricing updates to support adoption of new products and reflect changes in pharmacy acquisition costs.

We are sensitive to the market dynamics of acquisition price changes and supply issues for our network pharmacies. To respond to marketplace changes, we monitor prices through multiple independent sources, including manufacturers, pharmacies and wholesalers. In particular, we update prices in response to patent expiration and market availability and inflation or deflation of the price of a particular product. As frequency of MAC price updates depend on market conditions, changes may take place as needed, which can be daily. We complete monthly review of all pricing for products to assure rational pricing.

Our network team captures questions and concerns from contracted retail pharmacies regarding MAC pricing. We have a MAC appeal process for such concerns. Our MAC team reviews all inquiries and often provides recommendations on how to lower acquisition costs for specific drugs by using more effective acquisition strategies. We routinely monitor pricing activity in the wholesale channel, expansion and contraction in the sourcing of products, new generic additions, and other factors to determine appropriate reimbursements to pharmacies.

vi. Approach to operation of a pharmacy call center.

Our toll-free pharmacy call center is staffed 24 hours a day, seven days a week. We train pharmacy call-center staff on how to assist network pharmacies with questions about electronic transmission of prescription claims and the appropriate steps to take when escalation of the issue is needed. We record all pharmacy call center calls and make them available for quality review; they are trackable and retrievable upon request from DMS. In compliance with requirements 31.15, we forward escalated issues that cannot be resolved by the OptumRx call center relating to Kentucky pharmacies to the OptumRx Kentucky PBM account manager who works to resolve the issue in partnership with the Kentucky pharmacy director. To achieve full compliance with accreditation standards and regulatory requirements, the Kentucky pharmacy director and oversight staff monitor and audit service standard requirements for the 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.

UnitedHealthcare, with OptumRx, owns and develops our own claims processing system, which meets requirements in Attachment C – Draft Medicaid Managed Care Contract, Section 31.8 Pharmacy Claims Payment Administration. RxClaim, the software suite behind our claims processing and related services uses NCPDP processing standards. RxClaim is available for claims submissions 24 hours a day, seven days a week, outside of scheduled downtime for updates. We regularly schedule updates to all of the components of this system to remain up-to-date regarding industry standards, regulatory compliance and recent trends or demands in technology to verify compliance with dispensing fee requirements. The primary purpose of these updates is to meet the needs of our providers by offering innovative, differentiating products and services. We communicate these scheduled updates to providers. Updates occur six times per year (approximately every 2 months) and are scheduled with exact dates for deployment of each new release.

System Capacity and Transactions

We can handle a virtually limitless amount of transactions. We can add additional computer processing units, including additional servers, to meet expanding peak volumes, if necessary. Factors in processing transaction volumes depend on demographics associated utilization rate, and size of the processing platform. With these factors in mind, larger volumes can be processed but with a reduction in response time without increasing the platform capacity.

OptumRx processes more than 81 million electronic transactions per month on average.

Experience with Direct Adjudication Model

Our flexible systems and procedures accommodate client specific benefit structures, DUR criteria, formulary setup, MAC pricing and other benefit design parameters. Our client management and information systems teams are also adept at integrating our systems and procedures with those of our customers to achieve seamless connectivity and operations. Some of our key claims adjudication capabilities include:

- Performing automatic group, enrollee, physician and drug verification for eligibility
- Editing and screening for clinical and utilization management
- Preventing adverse events through a customized system
- Processing electronic, paper, retail and home delivery claims
- Integrating drug utilization data for reports
- Maintaining data confidentiality
- Integrating administration of medical and pharmacy benefits
- Handling a variety of clinical and administrative benefit designs
- Enabling real time eligibility update capabilities
- Coordinating benefits
- Offering around the clock availability of the claims system

Handling Misdirected Claims (claims not covered under the contract)

Our claims system includes various edits and checks that verify claim and enrollee eligibility (including misdirected claims) to protect the appropriate adjudication of electronically submitted claims. These system edits compare submission date with eligibility and coordination of benefits markers to help us prevent misdirection of claims among primary and secondary payers. They provide for hard and soft edits that, based upon qualifying events, can reject a claim or send standard NCPDP rejection codes messages or custom-defined messages to pharmacies.

When the system identifies a misdirected (not covered) electronic claim, it rejects the claim. If the electronic claim has been accepted and later determined to be in error, we to reverse the claim and appropriately re-bill under the appropriate payer. For misdirected paper claims, we may contact the individual and instruct them to resubmit the claim under the appropriate payer.

Timeline for Claims Adjudication and Payment

The claims adjudication timeline depends on the individual pharmacy and how quickly they submit a claim for processing. Our standard claims adjudication timeline is as follows:

- ***Day 1:*** The pharmacy fills the prescription and submits the claim for processing. We receive and adjudicate the claim.
- ***Day 2:*** We extract the claim from our claims processing system and send it to the payment system for approval and payment processing. We then add the approved claim to the scheduled batch file for check production.
- ***Days 3-7:*** We complete claim payment in the payment system, add it to the pharmacy check cycle or electronic file transfer and release it to the pharmacy.

Dispersed payments (checks) must be deposited within 90 days, or they are automatically canceled (voided).

We are able to process batch electronic media and paper claims submitted directly for processing. Paper claims can include (but not limited to) those submitted in situations when the enrollee has to visit an out-of-network pharmacy in an emergency. We will submit paper claims on the NCPDP Universal Claim Form version D.0, and we will:

- Process and adjudicate paper claims within 10 days of receipt
- Assign batch claims within 24 hours of receipt
- Maintain electronic backup of batch claims for the duration of the contract
- Adjudicate electronic batch claims through the same processing logic as the POS claim

Pharmacy Network Dispensing Fee

UnitedHealthcare is developing and contracting with a pharmacy network specific to the Kentucky MCO program. As part of our network contract and in compliance with 18 RS HB 200, Medicaid Benefits, section (16), for POS/retail claims, we will pay an additional dispensing fee of $2.00 without reduction of any kind or for any reason. Through our routine network performance oversight process, we will assure that the additional dispensing fee amount is in addition to the dispensing fee paid to pharmacies for POS/retail claims as calculated or determined by contractual provisions negotiated directly with the dispensing pharmacy or any entity who contracts on behalf of the dispensing pharmacy. Additionally, we understand that DMS has ability to set, create, approve or change reimbursement rates.

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.

We will report timely drug utilization data that is necessary for DMS to bill manufacturers for rebates in accordance with section 1927 (b) (1) (A) of the Social Security Act and any Kentucky supplemental rebate program no later than 45 days after the end of each quarterly rebate period, or as required by DMS. Complete and accurate encounters (in a format determined by DMS) are critical for the Commonwealth to collect rebates and routinely monitor pharmacy encounter data. Through our high quality encounter data collection and submission process, we test all data provided to the Commonwealth for accuracy, completeness, logic, consistency and timeliness. We receive paid claims weekly from OptumRx and load the data into our vendor database using automated processes that verify an absence of duplicate files, confirm compliance with the expected check postdate range and verify file arrival and loading per the established schedule. These processes also screen for sudden changes in file size or error rate that may indicate a vendor issue, enabling us to initiate expedited research and resolution of the problem.

We submit extracted encounter files from the vendor database into our National Encounter Management Information System (NEMIS) to DMS, and upload the appropriate response files into NEMIS. NEMIS is our strategic, internally developed encounter data submission and reporting system. It initiates submission, tracks responses and provides error correction and resubmission of Medicaid encounters. We use statistical reports to compare vendor inbound claims against submitted encounters and the subsequent responses. With internal control numbers (ICNs) applied to each claims encounter, we analyze encounter errors and work with appropriate internal and external teams to resolve issues. We will provide detailed claim information requested by DMS or its contractors to support rebate dispute and resolution activities.

Florida has similar pharmacy utilization data submission requirements to those required under the Kentuckycontract. For 2018, in Florida, we achieved an over ***99% submission rate within seven days of adjudication, an over 99% acceptance rate and more than 99% encounter completeness.*** We have established systems and dedicated analyst staff in place to provide solid, reliable encounter reporting built on sound, accurate data. To help assure DMS is able to collect all applicable rebates, we will provide an encounters team contact within UnitedHealthcare who will engage the pharmacy operations benefit system-coding expert to help resolve rebate issues and manufacturer disputes resulting from our encounters and drug utilization files.

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

To support DMS's processes and procedures for 340B claim data, the OptumRx claim system identifies 340B claims in real time, prospectively and retrospectively through claim submission requirements in our network pharmacy contracts. For any 340B claim utilization submitted by a pharmacy, our contracts require the 340B claim dispensing pharmacy to comply with the point of sale clarification code use to flag drugs purchased through the 340B program. The contracts require 340B claims to be submitted as 340B pharmacy claims as described by NCPDP, and similarly physician administered 340B drug claims are required to include a UD modifier on the claims as part of the encounter. In the encounter submission process (in a format determined by DMS) we will use this claim information to identify pharmacy encounters that are 340B claims to support DMS's rebates submission obligations related to 340B drug claims.

To support for DMS's efforts and initiatives for 340B transactions, network configuration requirements and oversight procedures will include requirements to verify we do not reimburse a 340B entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in prescription volume that are not 340B entities. We will not assess any fee, charge-back, or other adjustment upon the 340B entity on the basis that the 340B entity participates in the program set forth in 42 U.S.C. §256b.

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

Our prior authorization (PA) system is seamlessly integrated into our claims processing platform, enabling network pharmacies to process claims within seconds after an approval by PA staff and is fully compliant with requirements in Attachment C – Draft Medicaid Managed Care Contract, Section 31.12 Pharmacy Prior Authorizations. We issue all PA decisions within 24 hours of receipt and track our performance to verify we consistently meet this time frame. ***Our national average turnaround for all Medicaid programs we administer today is less than eight hours.***

Promoting the PDL and Appropriate Prescribing: The prescribing provider must initiate all requests for authorization of medications — including non-PDL medications via telephone, fax, mail, web-based entry or electronic medical record (EMR) integration PA submission. Incoming PA requests are subject to a clinical review.

Clinical PA Review Process: We route all incoming PA requests for all submission channels (e.g., web-based, fax, phone) to our pharmacy prior notification service for entry into the prior authorization system (PAS). The PAS facilitates clinical review by walking the reviewer (a physician, registered pharmacist or technician) through the clinical criteria relevant to the request, including appropriate medical necessity information from the requesting prescriber. Our PA process also includes a brand name exceptions process when a generic version of the drug is preferred. All clinical PA review criteria are evidence-based and follow best clinical practice standards and other national standards.

Step Therapy: Our key clinical management strategies include step therapy, another form of PA that focuses on specific drugs and drug classes to promote utilization of effective, safe, clinically appropriate and less costly first-line medications by requiring prior use of the preferred product(s). This strategy ultimately improves behavior patterns and enrollee and physician awareness of appropriate drug use and influences physician-prescribing patterns. Submitted prescriptions that fail to meet step therapy criteria are rejected and may be subject to clinical review and medical necessity determination (e.g., certain diabetic medications). For example, the step therapy requirement to use guideline supported first-line therapy metformin before sitagliptin.

Temporary Medication Supply Process: In situations where we cannot reach the prescribing physician for a prescription requiring a PA, pharmacists at the point of service who determine that there is an urgent need for a temporary supply or an exception, have the authority to initiate an override without contacting us. The ***pharmacist may dispense a 72-hour emergency supply of the prescription,*** with a point of sale entry of a temporary supply override. If the prescribed amount is more than a 72-hour supply, but is packaged so that it must be dispensed intact (e.g., an inhaler), the pharmacist will dispense the packaged drug and UnitedHealthcare will compensate the pharmacy for the complete package, even if it exceeds a calculated 72 hour supply, making sure the enrollee has immediate access to needed medications.

Grievances and Appeals: We offer providers opportunities for review — either case review or peer-to-peer review — before the formal appeal process. If a formal appeal is necessary, enrollees and their authorized representatives (e.g., caregiver or prescriber) are able to file a grievance or appeal related to PAs denied after our final review in accordance with the requirements in Attachment C – Draft Medicaid Managed Care Contract, Section 24.2 Enrollee Grievance and Appeal Policies and Procedures.

Prior Authorization Simplification

We are committed to simplifying the administrative processes for providers when requesting PAs and avoiding disruption in the enrollee's care by making our process as streamlined and convenient as possible. Providers will have the option to use the designated Kentucky Medicaid pharmacy universal form. In addition to submitting PA requests toll-free via telephone or fax to the PA call center, prescribers can also use our streamlined online submission option. Prior authorization requests can be submitted 24 hours a day, seven days a week through the provider portal, *UHConline.com*, which allows enrolled providers to submit, view and manage pharmacy PAs. Prescribers can also check the status of a PA request online or by calling the pharmacy call center or the toll-free PA call center. Should the provider call the toll-free line, PAs will be processed immediately and in real-time.

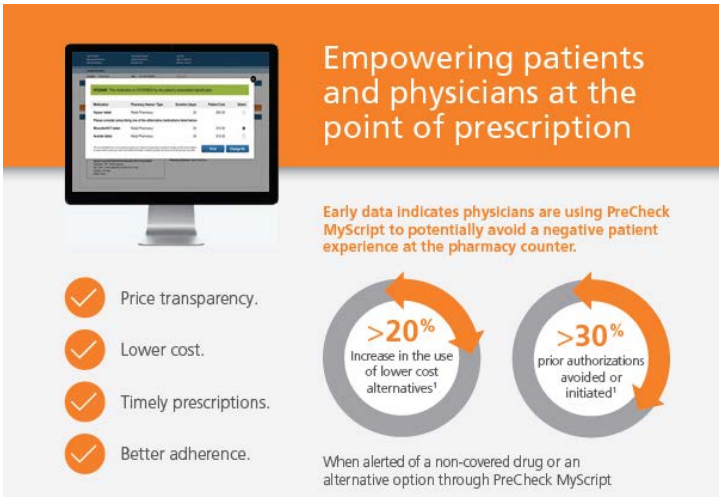

Figure 4. PreCheck MyScript applies the analysis of real time trial claims to provide enrollee- and plan- specific cost and benefit information, considering elements such as coinsurance, deductibles, drug alternatives and plan design. Prescribers can easily see where clinical programs such as PA are required and submit documentation directly within the medical record before the individual even leaves the physician's office.

PreCheck MyScript: In 2017, we introduced PreCheck MyScript as the first health plan to offer this innovative pharmacy solution to all providers in our network. The tool is embedded into a provider's existing electronic medical record workflow and provides precise, real-time prescription coverage details based upon an enrollee's prescription benefits, details of formulary coverage (including preferred or lower-cost drugs) and point-of-sale alerts. PreCheck MyScript automates and simplifies the electronic PA process. All PA activities and decisions are documented in PreCheck MyScript and are available for immediate review at DMS's request.

Other Tools Supporting Pharmacy Prior Authorization

ePrescribing: SureScripts® is the nation's largest e-prescription network and connects prescribers (when they sign up) in all 50 states through their choice of e-prescribing software to the nation's leading payers, chain pharmacies and independent pharmacies.

Pharmacy Service Line: Our pharmacy services PA team supports pharmacy coverage reviews after business hours, holidays and weekends. This single point of contact assists all providers (including pharmacies) with claim adjudication, PAs, clinical criteria, claims payment and other provider questions.

Provider Relations Department: Provider relations service representatives can educate prescribers about where to find information on PAs, and can provide PA criteria upon request.

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

We provide several options to make sure providers have quick and easy access to information on conditions for coverage.

Preferred Drug List (PDL): The PDL identifies all PDL drugs and those that are subject to PA. We distribute quarterly notifications of changes to the PDL, including additions and deletions.

UnitedHealthcare Online: All our prescribers have access to the UnitedHealthcare online provider portal 24 hours a day, seven days a week. This interactive website offers links to the *Care Provider Manual* and a downloadable Prior Notification Request form that prescribers can use to fax in PA requests. Our *Care Provider Manual* includes all PA criteria, guidelines and information on PA processes.

Routine Provider Communications: All prescriber communications indicate our preferred drug alternatives and suggest conferring with our PA call center for prescribers who feel that a non-preferred medication is medically necessary.

PreCheck MyScript provides prescription clarity upfront by giving prescribers enrollee-specific pharmacy information at the point of prescribing and is available 24 hours a day, seven days a week. The primary benefits include more accurate price transparency, faster prescription processing, less administrative waste, improved satisfaction and most importantly better health outcomes. Prescribers can access PreCheck MyScript through two ways:

- PreCheck MyScript is integrated with the EMR enabling prescribers to see enrollee-specific eligibility and plan information automatically. This integration helps to achieve a greater transparency into actual enrollee-specific pricing and formulary information at the point of prescribing. The prescriber is able to write the prescription while accessing the EMR without disrupting their workflow.
- All prescribers have access to our provider portal *Link,* which allows access to PreCheck MyScript and may view the enrollee's specific cost and coverage information.

PreCheck MyScript reduces administrative burden by providing real-time accurate data at time of prescribing and requires less time spent on pharmacy transactions, encouraging more patient time.

"It cuts down on the phone calls from pharmacies and frustrated patients."

— Provider using PreCheck My Script

PreCheck MyScript offers a number of additional advantages including:

- Quick and efficient prescription transactions (an average response time of less than two seconds) that provide information about formulary coverage, PA requirements, clinically

appropriate alternatives, in-network pharmacy options and enrollee cost information in an easily accessible format

- The potential to reduce overall volume of PAs and calls to the pharmacy call center
- Point-of-prescribing transparency enabling both prescriber and individual to understand alternative, clinically appropriate therapies to lower enrollee costs and to potentially help avoid unnecessary PA
- Streamlined PA processes and reduced claims rejections, which can lead to faster access to prescriptions and less frustration at the pharmacy counter
- Reduced compliance risk through lowered costs and the promotion of better engagement between the enrollee and prescriber

Our development plans for PreCheck MyScript include an initiative to proactively deliver clinical messaging including alerts that indicate gaps-in-care, formulary changes or the availability of specific pharmaceutical programs. For example, a clinical alert may be triggered indicating an opioid intervention, or clinical insights typically done when the prescription is filled (ProDUR review) for medication safety issues such as drug-drug, drug-age, drug-gender or other possible issues can now be caught at the point of prescribing. These and other additional clinical alerts and messaging are in development.

Prior Authorization Efficiencies: With PreCheck MyScript, doctors can easily see when a PA is required and submit the PA through their EMR. Physicians are able to spend more time with enrollees thanks to faster and fewer PAs or rejected claims. ***As much as 30% of PAs may be avoided with the information provided within the tool.***

PreCheck MyScript Savings
Saves individuals an average of $80 per fill.

Metrics: PreCheck MyScript may increase a prescriber's likelihood to switch to a lower cost medication as much as 20% while accessing the EMR. Adherence rates may also be affected as much as 4%, with clients experiencing an average cost savings of $415 per medication switch. Some additional indicators of PreCheck MyScript's value include:

- An average of 30 minutes in time savings for physicians and office staff
- An average of three minutes in time savings for pharmacies per prescription
- Physician and office staff savings when a PA is required or the drug is rejected
- A potential 19% reduction in cost for physicians and office staff
- As much as an $0.88 pharmacist and retail pharmacy savings per script when a PA is required or the drug is rejected
- A 23% reduction in retail pharmacy administrative cost

***UHC On Air*:** UHC On Air offers providers access to pharmacy information, including PDL and PA education that can be accessed anywhere, anytime, from any device. UHC On Air is accessed through the *Link* secure portal. Once inside the tool, providers can log in to stay up to date with pharmacy information in Kentucky.

Targeted Fax Blasts: We use fax blasts to inform pharmacies of the latest pharmacy program and PDL information in a manner convenient to them.

Provider Bulletins: We post all necessary and informational pharmacy messages (e.g., PDL updates) and education on *UHCprovider.com*, with the same messages sent via mail and fax.

Provider Training: To deliver the best care to enrollees, we want to make certain our pharmacists are educated on all of our policies and procedures. As part of implementation and readiness activities, we will provide training sessions on our pharmacy program, including sessions on our transition processes, member and provider services, how to contact the pharmacy call center, PDL and PA criteria information, and pharmacy clinical programs.

Training content will be specific to the Kentucky MCO population, and we will distribute it to all individuals attending the orientation training sessions we will host and conduct prior to and following program implementation. We will post all training materials, including the *Care Provider Manual* and reference guides, to our website so they are accessible to providers and pharmacies at any time.

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

The pharmacy team that manages and processes PA requests is staffed with licensed pharmacy technicians, pharmacists and physicians. Active licensure is required as part of the hiring process. Our in-depth training program for the PA staff confirms that they thoroughly understand the PA process. To facilitate continual improvement in management of our PA processes we use a thorough internal audit and coaching feedback model.

Prior authorization requests are submitted to the UnitedHealthcare pharmacy Prior Notification Service and managed via and an electronic PA management system. The system facilitates clinical review by walking the reviewer (a pharmacy technician, a pharmacist or medical director) through the clinical criteria relevant to the request, including appropriate medical necessity information from the requesting prescriber. The appropriate clinical reviewer, under the direction of the registered medical director, makes decisions.

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

Our claims processing system's capabilities verify appropriate utilization of medications while reducing provider and enrollee disruption through two of our enhanced and innovative approaches, Diagnosis-to-Drug Match Verification and Silent Authorization.

Diagnosis-to-Drug Match Verification helps validate that individuals are prescribed appropriate medications for medical conditions. The verification checks that the prescription use matches the FDA-approved use, is supported by current medical literature and aligns with state Medicaid rules by using the ICD-10 diagnosis code on the prescription form or stored in claims history. If the enrollee's medical file supports the appropriate ICD-10 for the medication, then the prescription will process automatically without the need for a PA to verify the diagnosis.

Silent Authorization applies enrollee-specific metrics contained in their claims data (e.g., enrollee demographics, claim history, diagnoses) to automate the PA process. This point of sale technology automates the clinical intent of the PA edit and reviews the claim without human intervention. This speeds the PA review process and reduces the number of manual PA requests, resulting in decreased enrollee disruption due to a PA requirement. Once the targeted drug is approved by Silent Authorization, a PA is generated into the enrollee's profile and the claim pays at the pharmacy. This occurs because the system can evaluate both appropriate pharmacy claims history and diagnostic (ICD-10) information, and if that information is available in the system the claim automatically meets the authorization requirements. If the drug cannot be approved because the appropriate information is not available, the claim will reject for "PA Required" and the existing standard PA process is enacted.

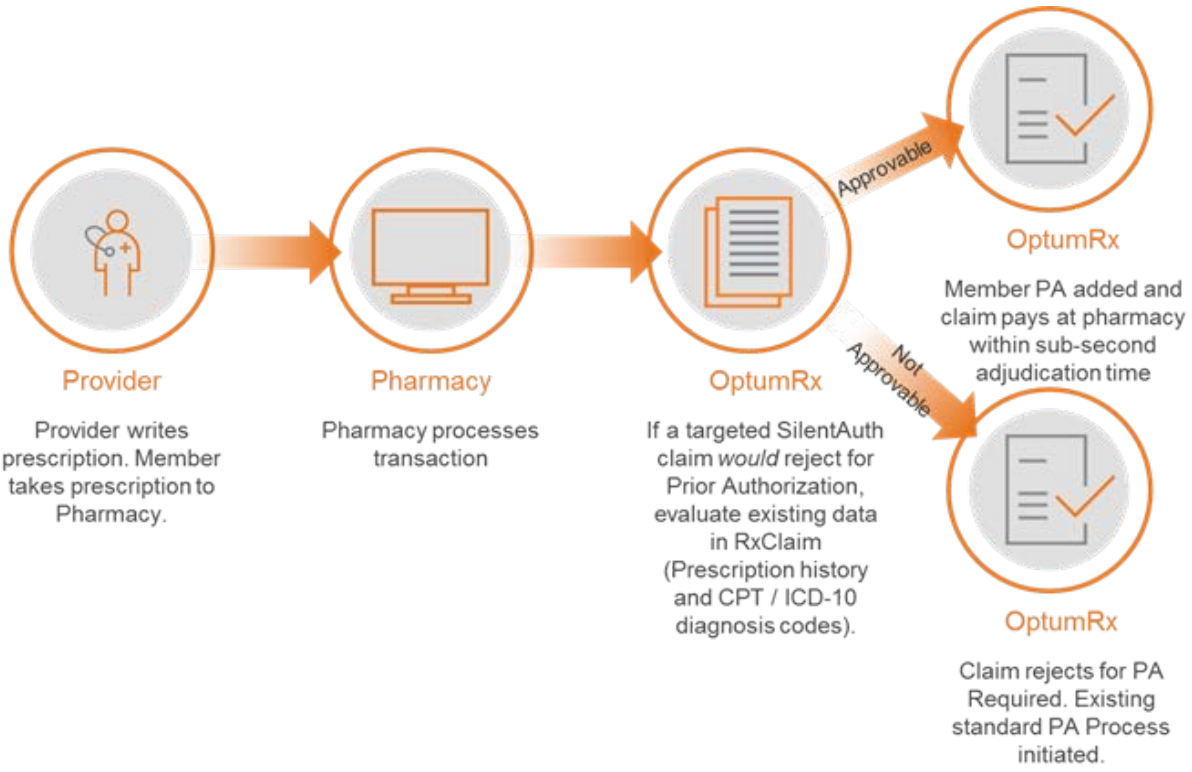

Figure 5. Our Silent Authorization technology helps to automate the PA process using claims data, relieving administrative burden by streamlining the process.

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