# POLICY AND PROCEDURE

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| **PRODUCT TYPE:** MSCAN and CHIP | **REFERENCE NUMBER:** MS.PHAR.09 |

**SCOPE:**

Centene Corporation Pharmacy Department, Magnolia Health Plan (Plan) Pharmacy Department, Plan Pharmacy and Therapeutics (P&T) Committee, and Envolve, Inc. (Envolve)

**PURPOSE:**

To describe the Plan Pharmacy Program.

**POLICY:**

It is the policy of the Plan to develop and maintain a comprehensive, high quality pharmacy program that complies with the Mississippi Pharmacy Practice Act and the Mississippi Board of Pharmacy rules and regulations as well as all requirements found in the Social Security Act section 1927 and all changes made to the Covered Outpatient Drug Section of the Patient Protection and Affordable Care Act (PPACA) found in 42 C.F.R. Part 447 [CMS 2345-FC].

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# Magnolia Health Plan

# Pharmacy Program Description

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## I. INTRODUCTION

### A. PURPOSE

The purpose of the Plan Pharmacy Program is to provide access to pharmaceutical services to our members, and to ensure that these services are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and meet professionally recognized standards of pharmaceutical care. In addition, the Plan Pharmacy Program seeks to educate providers regarding the cost effective usage of drugs and to provide useful feedback about current prescribing patterns to improve the quality of patient care.

### B. SCOPE

The Pharmacy Program applies to all Plan members, including both MSCAN and CHIP product lines. The scope of the program is to:
* Ensure that pharmacy benefit services provided are medically necessary;
* Promote safe and cost-effective drug therapy;
* Manage pharmacy benefit resources effectively and efficiently while ensuring that quality care is provided;
* Ensure that members can easily access prescription services;
* Actively monitor utilization to guard against over-utilization of services and fraud or abuse;

### C. AUTHORITY

Centene Corporation is a fully integrated government services managed care company with health plans in several states. Due to differences in state regulations, Centene's Board of Directors delegates' responsibility to the Plan President/CEO who coordinates the provision of pharmacy services with Centene's contracted pharmacy benefit manager (PBM), Envolve Pharmacy Solutions. In turn, Envolve is contractually responsible for implementing Centene's Pharmacy Program including benefit design, the Division of Medicaid's Universal Preferred Drug List (UPDL), drug utilization review (DUR), the prior authorization (PA) process, pharmacy network management, pharmacy claims processing, pharmacy help desk, customer service functions, clinical reviews, and reporting. Magnolia Health Plan nor Envolve Pharmacy solutions shall develop and use its own PDL. Envolve shall not require or restrict members to utilize a pharmacy that ships, mails, or delivers prescription drugs or devices. Envolve is not authorized to negotiate rebates for preferred products listed on the aforementioned PDL, and all Medicaid

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outpatient drug claims, including Provider-administered drugs, must be exempt from such rebate agreements.

## II.   UTILIZATION MANAGEMENT GOALS AND FUNCTIONS

### A.   GOALS
The goals of the Plan Pharmacy Program are to:
- Monitor and evaluate the quality of the pharmacy program;
- Conduct DUR activities to monitor appropriate drug use,
- Promote cost containment without compromising quality of care;
- Identify, assess and refer members who could benefit from case management/disease management;
- Ensure confidentiality of member and practitioner information;
- Ensure timely reviews of requests for drug therapy exceptions to UPDL positioned drugs; and
- Ensure timely responses to appeals and grievances.

### B.   FUNCTIONS
The key function of the Plan Pharmacy Program is to promote the appropriate use of the pharmacy benefit.  Components of the Pharmacy Program include:
- Use of PA and medical necessity (MN) criteria, concurrent and retrospective DUR, and edits related to maximum dosing, early refills, age and gender, quantity limits, maximum approved costs, duplicate therapy, adverse reactions and prescriber restrictions;
- Analysis of utilization data;
- Develop, review and update policies and procedures that govern the various aspects of the pharmacy benefit;
- Identify opportunities to improve quality of care and services;
- Interface with other Plan departments including Medical Management, Member Services, Provider Services, and Quality Improvement to support opportunities for case management, disease management, and member and provider education;
- Provide feedback to providers who demonstrate inappropriate prescribing patterns that deviate from recognized practice standards and guidelines;

## III.  ACCOUNTABILITY AND ORGANIZATIONAL STRUCTURE

The Plan's Board of Directors has the ultimate authority and responsibility for the Pharmacy Program.  The Board delegates the responsibility for the

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oversight of the Pharmacy Program to the Plan's President/CEO and Chairman of the Centene Corporation Quality Improvement (QI) Council. The Pharmacy Program activities are integrated with the Plan's Utilization Management (UM) and Quality Improvement (QI) Programs. The utilization and quality issues and trends identified as part of the Pharmacy Program are reported to the Plan QI Committee.

## IV. HEALTH PLAN PHARMACY AND THERAPEUTICS COMMITTEE

### A. MEMBERSHIP

The Vice President of Medical Affairs, the Chief Medical Officer or the Medical Director at the Plan or his/her designee will chair the Plan's P&T Committee. The VP of Pharmacy will serve as the Secretary of the committee. The P&T Committee addresses quality and utilization issues related to provision of the pharmacy benefit. Voting members of the Committee will include community based practitioners and pharmacists representing various clinical specialties that adequately represent the needs of Plan members. The community-based practitioners must be independent and free of conflict with respect to the health plan and pharmaceutical manufacturers. P&T Committee meetings will be held at least quarterly.

### B. RESPONSIBILITIES AND FUNCTIONS OF THE PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

The responsibilities of the P&T Committee may include, but are not limited to, the following:

- All medication reviews shall be processed by the MS-DOM and the MS-DOM will issue guidance as to what changes are made to the UPDL
- Assist in quality improvement programs that employ drug use evaluation (DUE);
- Review the policies and procedures for PBM activities, such as PA's, MN criteria, step therapies, age and gender restrictions, quantity limitations, mandatory generics and other activities that affect access, and make recommendations for changes as appropriate;
- Review the administrative policies and procedures
- Review of individual provider prescribing for appropriate drug utilization. Egregious prescribing patterns will be reported to the QI Department for consideration of the appropriateness of Plan provider credentialing;

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- Review of state regulations to ensure compliance with all mandates and requirements;
- Review of complaints/appeals and grievances pertaining to the pharmacy benefit;
- Provide oversight of the designated PBM, Envolve, to ensure that pharmacy providers contracted for provision of pharmacy services are in compliance with their contracts, and that UPDL programming and other delegated responsibilities are being applied and administered in accordance with the MS-DOM P&T recommendations;
- Review of provider requests for additions, deletions or changes to the UPDL, and forward such requests to the MS-DOM for their decision and guidance. Review and approve the Pharmacy Program Description at least annually;

## V. CLINICAL PHARMACIST RESPONSIBILITIES

The VP of Pharmacy is responsible for the oversight of the Pharmacy Program and successful operation of the Plan P&T Committee in conjunction with the VP of Medical Affairs, the Chief Medical Officer, or the Medical Director. Responsibilities include:

- Review policies to assure compliance with state rules and regulations;
- Review clinical drug criteria, used in the PA and MN review process, for appropriateness and present them to the Plan P&T Committee for review and approval;
- Review policies and procedures and make suggestions for changes consistent with Plan P&T Committee recommendations and state regulations.
- Provide oversight of the designated PBM, Envolve, and their delegated responsibilities and programming as it applies to PA, MN, and other pharmacy management edits;
- Provide a point of contact for providers calling in with questions about the Pharmacy Program and educate providers on Pharmacy Program to promote provider satisfaction;
- Call providers as necessary to discuss Pharmacy Program issues and complaints.
- Review and analyze pharmacy cost and utilization reports and report on trends and initiatives for cost-containment;

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- Monitor practitioner prescribing patterns and suggest corrective action, as appropriate, for providers identified with prescribing concerns related to the provision of quality care;
- Serve as a liaison between the Plan Pharmacy Department and other Plan departments and provide support to the Medical Management staff in the performance of their responsibilities;

## VI. REVIEW OF PROGRAM ELEMENTS

## A. DRUG UTILIZATION REVIEW (DUR) PROGRAM

The Pharmacy Program administers a retrospective drug utilization review program, delegated to the PBM, Envolve, utilizing the standards, criteria, protocols and procedures approved by the Plan P&T Committee, and in accordance with applicable state and federal requirements, NCQA standards and recognized medical practice standards. DUR projects are agreed upon by the mutual consent of the Plan Pharmacy Department and Envolve. Once established, Envolve provides the Plan a list of members whose prescription history deviates from the protocols of the retrospective DUR initiatives. The goals of the DUR program include but are not limited to:

- Identify and analyze prescribing patterns, and share the information with the appropriate providers to impact prescribing, dispensing, and overall drug utilization practices;
- Identify changes in pharmacotherapy that will improve member outcomes;
- Identify poly-pharmacy, educate prescribers and share information with multiple prescribers;
- Identify medication non-adherence and report incidences to prescribers or case managers as appropriate;
- Identify and address potential member, prescriber, or pharmacy provider fraud and abuse.

## B. PRIOR AUTHORIZATIONS

The PA process was developed to promote the most appropriate utilization of selected high risk and/or high cost medications, and those subject to a high potential for abuse. This process is delegated to Envolve Pharmacy Solutions, and administered in accordance with applicable state and federal requirements, NCQA standards and recognized high quality practice standards. Envolve Pharmacy Solutions shall conduct the prior authorization process for

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covered outpatient drugs in accordance with section 1927(d)(5), and are required to provide a response to a prior authorization request for a covered outpatient drug within 24 hours of the request and the dispensing of at least a 72 hour supply of a covered outpatient drug in an emergency situation. PA criteria are consistent with review of current pharmaceutical and medical literature, peer reviewed journals, and professional standards of practice. PA guidelines generally require that certain conditions be met before coverage of drug therapy can be authorized.

Envolve supplies the Plan, on a daily basis, member specific adverse coverage determinations for prior authorization or medical necessity reviews. Denials are only made by Mississippi licensed physicians, as required by the CAN Contract, Section 5 (J) (1). The plan then sends letters to members advising of a denial for drug coverage, language on their appeal rights, and referral of the member back to the prescriber for requests for UPDL alternative therapy. Envolve advises prescribers by fax of adverse coverage determinations with suggestions for UPDL alternative therapy.

## C. APPEALS AND GRIEVANCES

The Plan will maintain an internal appeals process for the benefit of its members and will provide members affected by an adverse coverage decision with a written explanation on how to access the appeals options. Providers may also appeal an unfavorable coverage decision on behalf of members.

## D. UNIVERSIAL PREFERRED DRUG LIST (UPDL)

The UPDL is a listing of covered pharmacy services approved by the MS-DOM P&T Committee. The UPDL is posted on the MS-DOM web site and can be downloaded and printed for future reference. It includes information on pharmaceutical management procedures, explanations of drug therapy limitations, mandatory generic substitution, PA, and step therapy protocols. Magnolia Health Plan uses the most current version of the Mississippi Medicaid Program Preferred Drug List, as required by the Division of Medicaid Contract, Section 5 (F).

## E. SAFETY ISSUES

The Plan designates real time adjudication of drug claims and the identification of potential adverse drug events to the Envolve PBM processing application. Envolve uses a passive system for point of dispensing communications and sends on-line alerts to dispensing pharmacies that identify and classify potential drug-drug interactions by severity. Envolve also identifies and notifies

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the Plan and pharmacy providers of Class I drug alerts and drug recalls which have the potential to cause serious health problems. When a high level of concern for safety is identified, Envolve supplies the Plan with a list of members that may be affected. After notification, it is the Plan's responsibility to notify members and document such outreach. Class II and III alerts are evaluated according to their potential to cause harm and generally pose minimal risks to a patient's health, but may be acted on if judged appropriate. (See USS.PHARM.02)

## F. EXCEPTIONS

The Plan P&T Committee must review for clinical appropriateness, the Envolve policies and procedures assuring timely access to both UPDL and non-UPDL drug products. For this reason, Envolve is held to strict protocols regarding the timeliness of clinical reviews. Magnolia Health Plan authorizes pharmacies to provide a 72-hour supply of medication while awaiting a PA or medical necessity (MN) determination for drug coverage. The dispensing pharmacist will be allowed to dispense a 72-hour (or more) supply of medication when a patient presents a prescription to the pharmacy that requires PA or MN review.

## G. CONTINUITY OF CARE

The Continuity of Care (COC) process is to promote the appropriate, safe, and effective transition of medications, when applicable, for new members on a prescription medication not on the Universal Preferred Drug List (UPDL) to a prescription medication on the UPDL, as follows:

- For new members who are currently on a non- preferred medication(s) when becoming part of the Plan, the Envolve PBM system will be programmed to look back 90 days on claims history as provided by the Mississippi Division of Medicaid (DOM), utilizing current UPDL criteria. If the member has had a prescription filled/refilled at any time during the previous 90 days, the member will be allowed to fill the prescription an additional 90 calendar days without requiring a prior authorization or disruption. In the event that no history exists (i.e., new Medicaid member, or member has received samples prior to receipt of a prescription), the provider shall attest to the member's stability on the prescribed drug in place of a history during the previous 90 days. Attestation when no history exists must be stated on the prior authorization request.

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At the discretion of the Plan as reviewed on a case-by-case basis, the Plan may allow members, if under the age 21 and on Behavior Health prescription drugs, to fill such prescriptions for an additional 12-month period without requiring a prior authorization or disruption. Once the prior authorization period has ended and the prescription medication is attempted to be refilled, a verbal notification, point of sale (POS) message, or a letter will be generated (if available) by the Plan notifying the prescribing provider or pharmacist that member has filled a prescription not on the UPDL and the recommendation made to switch to a UPDL agent. If the provider wishes to keep the member on the current non-UPDL medication, the provider should submit a Prior Authorization or Medical Necessity request to Plan's pharmacy benefit manager (PBM), Envolve, for approval. The request will be reviewed based on the criteria established by the Plan's P&T Committee as well as any specific clinical information that the prescriber has submitted.

**REFERENCES:** Current NCQA Standards and Guidelines

CCO Contract Section 5.F. Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices

**ATTACHMENTS:** N/A

**DEFINITIONS:** N/A

| REVISION LOG: | DATE |
|---|---|
| Added continuity of care language. | 4/19/11 |
| Annual review | 5/22/11 |
| Annual review; replaced VP, Medical Management, with Chief Medical Director for approval | 4/22/12 |
| November review for NCQA; add second approver; | 11/14/12 |
| Added the following to Behavioral Health Medications: Anti-Seizures, Antianxiety, Mood Stabilizers | 03/21/13 |
| Annual Review | 02/20/14 |
| Annual Review; added Universal Preferred Drug List language | 01/15/15 |

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| (UPDL) | |
|---|---|
| Annual Review; replaced Plan Pharmacist with VP, Pharmacy | 12/01/15 |
| Annual Review; replaced US Script with Envolve | 11/03/16 |
| Added MS CAN and CHIP as applied business lines to the Pharmacy Program definition; Mississippi Medicaid Program Preferred Drug List current link added to D. Universal Preferred Drug List; changed denial language in B. Prior Authorization | 05/05/17 |
| Updated to include in Scope and Authority: Regulatory statutes and Rebate exclusion | 11/28/17 |

## POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.


Director of Pharmacy: _____ Approval on file: _____

Chief Medical Director: _____ Approval on file: _____