POLICY AND PROCEDURE

DEPARTMENT: Pharmacy Operations	**REFERENCE NUMBER:** MS.PHAR.09
EFFECTIVE DATE: 10/01/2010	**P&P NAME:** Pharmacy Program
REVIEWED/REVISED DATE: 4/19/11, 5/22/11; 4/22/12; 11/14/12; 3/21/13; 2/20/14; 01/15/15; 12/1/15; 11/3/16; 5/5/17; 11/28/17; 6/25/2018; 11/20/18; 8/1/19; 8/20/20; 10/7/20; 3/15/21; 8/10/22; 6/18/24	**RETIRED DATE:**
BUSINESS UNIT: Magnolia Health Plan	**PRODUCT TYPE:** MSCAN
REGULATOR MOST RECENT APPROVAL DATE(S): 10/16/24	

SCOPE:
This policy applies to Magnolia Health Plan (Plan) Pharmacy Department, Mississippi Division of Medicaid Pharmacy and Therapeutics (P&T) Committee, Centene Pharmacy Services (CPS), Magnolia Health Plan Medical Management Department, and the Mississippi Medicaid Single Pharmacy Benefit Administrator (PBA).

PURPOSE:
To ensure that Magnolia Health Plan (Plan), Centene Pharmacy Services (CPS), and the Mississippi Medicaid Single Pharmacy Benefits Administrator (PBA), to whom pharmaceutical management has been delegated, develop and annually review and update policies and procedures for pharmaceutical management, using sound clinical evidence.

POLICY STATEMENT:
It is the policy of the Plan to have 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].

PROCEDURE:

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 the MSCAN product line(s). The scope of the program is to:

- First and foremost, align to DOM guidance and requirements for our managed care program;
- 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 and to address gaps in care or underutilization of needed medication;
- Work with the Plan Quality Department to initiate and manage programs that increase the quality of pharmaceutical care for Plan members;
- Champion and support efforts to ensure proper utilization of medications such as but not limited to opiates, supports efforts to curb opioid addiction and support education of medication-assisted treatment (MAT) in the treatment of opioid use disorders (OUD) to help member recovery;
- Champion review for fraud, waste, and abuse in our healthcare system;
- Manage and support the Beneficiary Health Management Program (BHMP).

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 Pharmacy Services Department. The Mississippi Medicaid Single PBA is responsible for implementing benefit design, the Division of Medicaid's Universal Preferred Drug List (PDL), 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.

Centene and/or its subsidiaries does not discriminate on the basis of race, color, national origin, sex, age, or disability, nor exclude from participation in, deny the benefits of, or otherwise subject to discrimination under any applicable Company health program or activity.

II. UTILIZATION MANAGEMENT GOALS AND FUNCTIONS

A. GOALS

The goals of the Plan Pharmacy Program are to:

- Promote pharmaceutical utilization to support/improve clinical outcomes and ensure all program provisions are consistent to DOM guidance and requirements;
- Continuously expand access to services and care to ensure improved patient centered health outcomes, safety and optimize patient care using evidence-based clinical guidelines;
- Monitor and evaluate the quality of the pharmacy program;
- Conduct DUR activities to monitor appropriate drug use, including but not limited to addressing gaps in care, inappropriate dosing, under or over prescribing via DOM approved DUR programs;
- Ensure there are appropriate prospective, concurrent, and retrospective DUR programs in place consistent to DOM guidance and requirements;
- Promote cost containment without compromising quality of care;
- Identify, assess and refer members who could benefit from case management/disease management or behavioral health
- Ensure confidentiality of member and practitioner information;
- Be a resource to other departments, Providers and Members regarding pharmacy benefits;
- Be a resource regarding pharmacy appeals and grievances as needed;
- Provide Provider and Member consultations related to drug therapy;
- Identify and report cases of fraud, waste, and/or abuse to appropriate departments;
- Review Members for BHMP and perform required reassessments pursuant to DOM guidance;
- Support all NCQA and HEDIS measures and requirements.

B. FUNCTIONS

The key function of the Pharmacy Program is to promote the appropriate use of the pharmacy benefit. Components of the Pharmacy Program include:

- Use of prior authorization (PA) and medical necessity (MN) criteria;
- Concurrent and retrospective DUR review;
- 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;
- BHMP initiatives and review.

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 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. PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

The Centene P&T Committee presents policies, procedures and lists of pharmaceuticals and seeks feedback and input from the practitioners who are participating on the committee. Those participating practitioners are also involved in the development of pharmaceutical procedures that are used throughout the organization. The Plan Pharmacy program will always default to DOM guidance and requirements in lieu of any company offered program or criteria to remain compliant to DOM contractual requirements.

V. UTILIZATION MANAGEMENT TECHNIQUES

A. Pharmaceutical management policies include the following:

- The criteria used to adopt pharmaceutical management procedures. In particular, criteria used when constructing the formulary or preferred status, show how decisions are made about:
  - Classes of pharmaceuticals
  - Classes preferred or covered at any level
  - Exception processes available to members for obtaining non-covered drugs
  - Considerations regarding limiting access to drugs in certain classes

B. Within each class of pharmaceuticals:

- The drugs preferred or covered at any level
- The criteria for prior authorization of any drug
- Exceptions process available to members
- Substitutions made automatically or with physician permission
- Evidence showing how preferred-status pharmaceuticals can produce similar or better results for a majority of the population as compared to other pharmaceuticals in the same class

C. A process that uses clinical evidence from appropriate external organizations.

This evidence includes relevant findings of the Food and Drug Administration, Centers for Drug Evaluation and Research, drug manufacturer dossiers, the Academy of Managed Care Pharmacy, and others. In addition, clinical review using peer-reviewed journals, medical specialty guidelines, and authoritative compendia is performed for determination of pharmaceutical coverage positioning.

VI. CLINICAL PHARMACIST RESPONSIBILITIES

The Health Plan Pharmacist is responsible for the oversight of the Pharmacy Program, attending the DOM P&T and DUR Committee Meetings, and works closely with the Plan CEO and the Single PBA to ensure all contractual and regulatory obligations of the pharmacy program are met. Responsibilities include working with CPS, DOM, and Single PBA staff to:

- Review policies to assure compliance with state rules and regulations;
- Review clinical drug criteria, used in the PA and MN review process, for appropriateness as approved by the DOM P&T Committee;
- Review policies and procedures developed by the corporate liaison from the Pharmacy Solutions Group and make suggestions for changes consistent with state regulations;
- Support resolution of 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;
- 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.

VII. REVIEW OF PROGRAM ELEMENTS

A. DRUG UTILIZATION REVIEW (DUR) PROGRAM

The Single PBA is responsible for the prospective DUR program to provide a review of drug therapy at Point of Sale (POS) before each prescription is given to the recipient. Screening should be performed for potential drug problems due to therapeutic duplication, drug-disease, contraindications, drug-drug interactions, duration of

therapy, and clinical misuse. Inappropriate therapy should trigger edits and each edit should have its own separate denial code and description including, but not limited to: early refill, duration of therapy, therapeutic duplication, pregnancy precaution, quantity limit (excluding opioids), quantity limit for long-acting opioids, quantity limit for short acting opioids, diagnosis code required on selected agents, drug interactions, age limit, and dose limits.
The Plan Pharmacy Program, in conjunction with DOM, administers a retrospective DUR program, utilizing the standards, criteria, protocols and procedures approved by the DOM DUR Committee, and in accordance with applicable state and federal requirements, NCQA standards and recognized medical practice standards.

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. PA guidelines generally require that certain conditions be met before coverage of drug therapy can be authorized.

This process is administered by the Single PBA, in accordance with applicable state and federal requirements, NCQA standards and recognized high quality practice standards. The Single PBA will conduct the prior authorization process for covered outpatient drugs in accordance with section 1927(d)(5),and are required to provide a determination 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.
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C. APPEALS AND GRIEVANCES

The Single PBA will be responsible for the appeals process for the benefit of Plan 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. UNIVERSAL PREFERRED DRUG LIST (PDL)

The PDL is a listing of covered pharmacy services approved by the DOM P&T Committee. The PDL is posted on the MS-DOM website 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 criteria, and step therapy protocols. The availability of the current formulary is communicated to members and providers no less than annually through the newsletter, plan website, or other materials such as the annual member welcome packet or provider email notice. Major changes in drug coverage and pharmaceutical management edits are communicated to members and prescribers by direct mail (e.g. fax, email, mail) as needed.

E. SAFETY ISSUES

The Single PBA has the responsibility for real time adjudication of drug claims and to generate electronic alerts to dispensing pharmacies via standard point of sale (POS) messaging when potential drug conflicts exist consistent to DOM guidance. . The PBA uses a passive notification to augment the dispensing pharmacy's internal DUR dispensing application and to avoid interruption or delays in drug therapy. The Plan will work with the Single PBA to identify and notify members and providers of Class I, II, and III drug alerts and drug recalls which have the potential to cause health problems. Voluntary 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.

F. EXCEPTIONS

The DOM P&T Committee reviews and makes determinations on PDL placement and clinical criteria. This information is shared on our website and will be provided in any prior authorization adverse determination to direct to next steps as appropriate to receive the medication. A pharmacist or appropriate practitioner at the state-mandated Single PBA reviews the exception requests received within turnaround times and against specific criteria following any DOM guidance. Prescribers and members are notified of denials, and that an appeal process is available. For this reason, the Single PBA, who is delegated the responsibility of completing the reviews, is held to strict protocols regarding the timeliness of clinical reviews. A 72-hour supply policy is in place to allow for interim therapy while awaiting a PA or MN determination for drug coverage. The dispensing pharmacist will be allowed to dispense a 72-hour supply of medication when a member presents a prescription to the pharmacy that requires PA or MN review. In addition, if a member tries to obtain a non-PDL drug after hours or on holidays, the member is allowed a 72-hour supply until single PBA Call Center resumes normal business hours.

G. CONTINUITY OF CARE

The Continuity of Care (COC) process, through use of the Single PBA, promotes the appropriate, safe, and effective transition of medications, when applicable, for new members on a non-preferred prescription medication to a preferred PDL prescription medication, as follows:

- For new members who are currently on a non- preferred medication(s) when becoming part of the Plan, the PBA system will be programmed to look back 90 days on claims history as provided by the Mississippi Division of Medicaid (DOM), utilizing current PDL 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.
- At the discretion of the Single PBA as reviewed on a case-by-case basis, the Single PBA 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) notifying the prescribing provider or pharmacist that the member has filled a non-preferred prescription and the recommendation made to switch to a preferred PDL agent. If the provider wishes to keep the member on the current non-preferred medication, the provider should submit a Prior Authorization or Medical Necessity request to the Single PBA for approval. The request will be reviewed based on the criteria established by the DOM P&T Committee, PDL, 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

SUPPORT/HELP: N/A

REGULATORY REPORTING REQUIREMENTS: Mississippi Division of Medicaid

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc	Added continuity of care language.	4/19/11
Annual review	Annual review	5/22/11
Annual review	Annual review; replaced VP, Medical Management, with Chief Medical Director for approval	4/22/12

Ad Hoc	November review for NCQA; add second approver;	11/14/12
Annual review	Added the following to Behavioral Health Medications: Anti-Seizures, Antianxiety, Mood Stabilizers	03/21/13
Annual Review	Annual Review	02/20/14
Annual Review	Annual Review; added Universal Preferred Drug List language (UPDL)	01/15/15
Annual Review	Annual Review; replaced Plan Pharmacist with VP, Pharmacy	12/01/15
Annual Review	Annual Review; replaced US Script with Envolve	11/03/16
Ad Hoc	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
Annual Review	Updated to include in Scope and Authority: Regulatory statutes and Rebate exclusion	11/28/17
Ad Hoc	Change Plan P&T Committee to DOM P&T Committee in G. Continuity of Care	06/25/18
Annual Review	Annual Review	11/20/18
Annual Review	Annual Review; updated Corporate, DOM, and Plan P&T Committee meeting criteria; added timelines for the appeals process; added section on Utilization Management Techniques.	8/1/19
Annual Review	Annual Review; updated drug recall process.	8/20/20
Ad Hoc	Updated language for 24 hour TAT on PA determinations and removed CHIP business line.	10/7/20
Annual Review	Updated language to include Rx Advance, future PBMs, and/or future claim processing vendors. PBM activities must follow the Magnolia/MS-DOM contract and PDL criteria. Providers must be credentialed with the MS-DOM. Updated language for safety issues to clarify the passive notifications for DUR edits.	3/15/21
Annual Review	Updated language to include CPS as the responsible party for PA reviews and clarification for PBM responsibilities. Added clarification for rebates and COC.	8/10/22
Annual Review	Updated template to reflect the implementation of the Mississippi Medicaid Single PBA. Changes will be effective 7/1/24.	6/18/24

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.