CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2016 Point of Sale (POS) Pilot Event

Center for Medicare

Medicare Enrollment & Appeals Group
Medicare Drug Benefit & C&D Data Group

January 21, 2016

Highmark Inc.
Point of Sale (POS) Pilot

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January 21, 2016

Who is Highmark Health?

Highmark Health is an interdependent system designed to deliver high quality, accessible, understandable and affordable experiences, outcomes and solutions for our customers.

- Highmark Health is the parent company of **Highmark Inc., Allegheny Health Network and HM Health Solutions.**
- Highmark Health is the **third largest integrated health care delivery and financing system** in the nation.
- Highmark Health **employs more than 35,000 people** and **serves 40 million Americans** in 50 states.

Highmark Inc. and its diversified businesses and affiliates operate health insurance plans in Pennsylvania, Delaware, and West Virginia.

- Serving **5.3 million members**, Highmark Inc. is the **fourth largest Blue Cross Blue Shield-affiliated company** in the U.S. and one of the nation's **largest health insurance organizations**.
- Through a **national network** that includes United Concordia Dental, HM Insurance Group, Davis Vision and Vision Works, Highmark's diversified businesses provide dental insurance, vision care and related health products across America.
- Highmark Inc. **employs more than 7,500 people**.

Medicare Advantage

- Highmark introduced a Medicare Advantage HMO in Western PA in 1995.
- Currently, Highmark has **~317k MA members accounting for ~$4B in annual revenue**.
  - Medicare Advantage HMO: 118k
  - Medicare Advantage PPO: 199k
- Highmark also has over **40k Medicare Prescription Drug Plan (PDP) members** and **85k Medicare Supplement members**.

POS Pilot Program Overview

Drug Selection

The drugs selected for this pilot were life-sustaining medications for beneficiaries in critically ill populations. Members likely have multiple comorbidities and would have benefited the greatest from the pilot program.

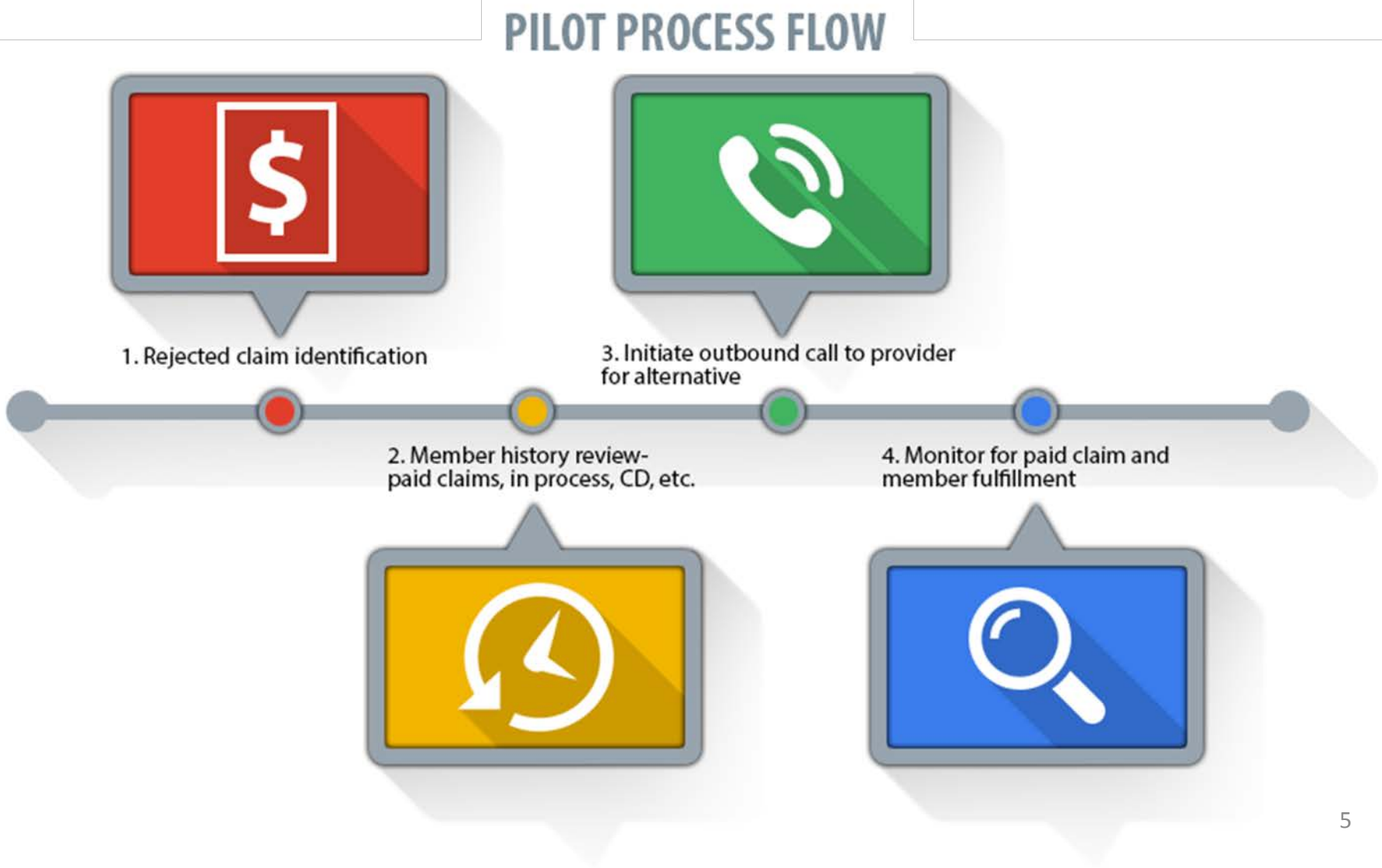
Factors Considered

Medications used for the control of COPD and asthma were selected based on a large volume of formulary exception requests. These medications are essential in the prevention of exasperations. There are formulary alternatives available to beneficiaries without restrictions. A single PPI (Dexilant) was also chosen due to the wide range of generic alternatives available. This program also allowed the plan to educate providers on first-line use of preferred medications and reinforce the use of formulary products.

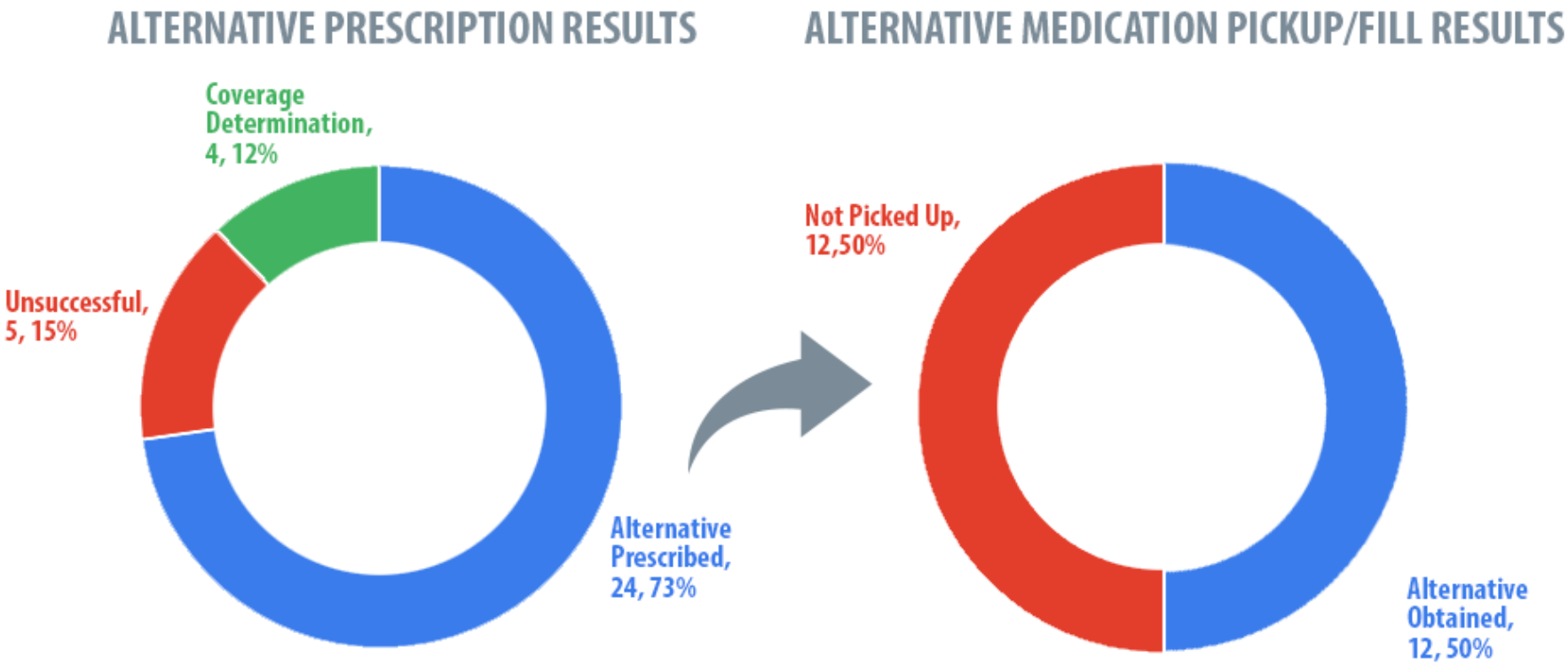
Products that were not considered include: high-risk medications, drugs with significant off-label use and opioids.

Piloted Drugs	
COMBIVENT RESPIMAT INHAL SPRAY	XOPENEX HFA 45 MCG INHALER
BREO ELLIPTA 100-25 MCG INH	PROVENTIL HFA 90 MCG INHALER
DEXILANT DR 60 MG CAPSULE	DULERA 200 MCG/5 MCG INHALER
ANORO ELLIPTA 62.5-25 MCG INH	TUDORZA PRESSAIR 400 MCG INH
FLOVENT HFA 110 MCG INHALER	STIOLTO RESPIMAT INHAL SPRAY

POS Pilot Program Overview (cont.)



POS Pilot Program Results



***Notes*

- 33 cases reviewed throughout the entire pilot program
- 24 (73%) cases resulted in formulary alternatives being prescribed

- In 12 (50%) cases where an alternative was prescribed, the member obtained the alternative from the pharmacy
- In 12 (50%) cases, the member did not pick up the alternative medication as prescribed

POS Pilot Program Results (cont.)

SUCCESSES

Medication Access

- Certain beneficiaries received an alternative medication that was necessary and timely

Stakeholder Engagement

- Stakeholders were receptive to the plan sponsor taking a more active role in ensuring beneficiaries have access to medication
- Provider offices were willing to prescribe formulary alternatives upon notification or submit coverage determinations in instances where the formulary alternative was not deemed to be appropriate
- Pharmacies were willing to provide information regarding prescription pick-up

CHALLENGES

Resources

- While the outreach process produced very positive results, the process was highly labor intensive to perform and costly to the plan sponsor when compared to the standard coverage determination process
  - For example, on average 5-6 cases were reviewed a week, which resulted in 12-15 hours of reject reviews, phone calls, etc.

Communication

- Rarely could a provider be reached directly, which required multiple calls to each provider, increasing time requirements
- Coordination with unknown beneficiary supplemental coverage, such as PA prescription assistance program – PACE

Medication Adherence

- In a number of cases, the most challenging aspect related to the beneficiaries was picking up their prescriptions

POS Pilot Program Results (cont.)

Operational Considerations When Considering Policy Change/ Expanded Scope

- Education and awareness of the provider to the formulary alternatives - critical to success
- Cost effectiveness and sustainability
  - Operationalizing the program on a large scale would require a substantial increase in clinical and member experience staff
- Finding ways by which the member experience is improved through facilitating the process between the provider and plan to obtain prescribed medications, or an alternative, in a timely manner
- Employing creative solutions to increase the rate of medication pick-up and adherence to the prescribed medication regimen
  - Leverage e-Prescribing technology to facilitate delivery of formulary and utilization management information to the provider, at the time of prescribing
- Plan sponsors engaging pharmacies and providers would create the best opportunity for the beneficiaries to have access to their medications.
  - All three parties would need to have a vested interest to ensure successful program results have meaningful outcomes for the beneficiaries.
  - For example, pharmacies are best equipped to affect changes to a prescribed medication. Formulary alternatives are included in reject messages, delivered to the pharmacy. Pharmacists at the POS are in an optimal position to facilitate a discussion with the provider and beneficiary. If a change to the medication is appropriate, the pharmacist can immediately fill the new prescription and provide to the beneficiary.
  - A pay-by-performance program may adequately incentivize pharmacies and providers to participate.

Martin's Point Health Care
Part D Point of Sale (POS) Pilot

Jody McDaniel

Supervisor, Medicare Part D Operations

January 21, 2016

Case Data

- Pilot ran from August 2015 to December 2015
- Total of 294 cases measured during the 10/26/2015 to 12/22/2015 time period:

# of Cases Worked	# of Cases MPGA was ABLE to Approve Coverage	# of Cases MPGA was UNABLE to Resolve
294	193	101

  - Currently the Plan's outreach to providers, pharmacies and Pharmacy Help Desk is resulting in **66%** of rejected B vs. D claims being resolved at POS during the 10/26/2015 to 12/22/2015 timeframe.

Resources

MPGA Roles involved in Pilot:

- Supervisor, Part D Operations (3-4 hours per week)
- Health Benefits Advisor - GA Part D (15 hours per week)
- Clinical Pharmacist (1-2 hours total)
- Manager, Strategic Programs (1 hour per week)

PBM Roles involved in Pilot (6 hours per week):

- Clinical Advisor, Clinical Account Services
- Strategic Account Executive
  Health Plans East
- Director, Strategic Accounts
  Health Plans East
- Clinical Pharmacist

Process

- Pulled all Prior Auth requests to see what drugs have Prior Auth requests and are approved 90-100% of the time
  - Outcome: **Ondansetron** and **Pantoprazole** were identified to be the highest requested and approved Prior Auth drugs

- Outreach at Point of Sale from the pharmacist to the Pharmacy Help Desk – PBM added a rejection message to call the Pharmacy Help Desk with the phone number
  - Outcome: Pharmacist can answer a few determining questions to see if the claim should pay under B or D for Ondansetron. **Ipratropium and Albuterol were also identified as highly requested/approval drugs that could follow the same process.**

Case Example

- Female member received rejection on 12/30/2015.
- Health Benefits Advisor saw rejection on daily report.
- Health Benefits Advisor reached out to the pharmacy and provided the Pharmacy Help Desk phone number and questions to expect.
- Pharmacy contacted the Pharmacy Help Desk and obtained override on 12/31/2015.
- Health Benefits Advisor reached back out to the pharmacy to verify member picked up the prescription. Member had received her prescription, and no Coverage Determination was needed.

Lessons Learned

- Pharmacies and Pharmacy Help Desk were not educated fully on this process (B vs. D), causing beneficiaries to still experience issues with POS rejections as well as long wait times for pharmacies reaching out to the help desk.
  - Outcome: Working with PBM Strategic Account Manager to better educate network pharmacies
- Centers for Medicare and Medicaid Services suggested that we add a process to reach out to pharmacy, post-paid claim, to track if members are picking up these prescriptions.
- We added calls back to the pharmacies once the B vs. D decision was made to ensure members had picked up their medication. We have found 2 outcomes:
  - Members that received paid claims were picking up their medications.
  - Many members on Ondansetron were filling through the Healthy Saver Pharmacy Program, and paid claims were being reversed.** **This would take our 66% of final approved determinations to 49% of resolved rejected claims.**

***The Healthy Saver Program is a pharmacy discount program designed to save customers money on generic prescriptions, certain diabetic supplies and more. This is a program run by one of our network pharmacy partners and claims do not process under Plan.*

How does the pilot compare to existing B vs. D and Coverage Determination processes?

- Enhanced communication internally and with members, pharmacies and prescribers
- More proactive identification and outreach
- Enhanced and consistent processes and measurement

Other Ideas

- We indentified Glyburide as a potential opportunity
  - CMS has suggested that we use this as the formulary exception drug to target and build a process around POS rejections for this drug
    - Work with PBM has begun to build this process
    - Conversations have also occurred with PBM around Pantoprazole outreach as this is the other highest prior authorization request that is always approved when requested by a beneficiary but is not a non-formulary drug
    - Clinical guidance around what outreach would include was supplied to the PBM clinical team
    - Planned formulary education opportunity with network providers

Other Ideas (cont.)

- Partnering with Preferred Pharmacy
  - Half of all prescriptions go through our preferred pharmacy
  - Biweekly operational check-in conference calls with preferred pharmacy account team to discuss service issues
  - Rejected claims oversight: Observing spikes in POS rejections for specific drugs (B vs. D, flu vaccine, etc.) and providing additional education around claims processing
  - Reaching out to pharmacies on a case-by-case basis to walk them through the process as re-education

Other Potential Improvements to Prescriber Awareness of Formulary Product

- Provided guidance to PBM around improved education to network pharmacies and the Pharmacy Help Desk
- Provided PBM with the Glyburide and Pantoprazole clinical alternatives and QTY limit discussions with providers from our Manager of Clinical Rx Programs
- Tracking and trending prescribing providers and outreaching when appropriate
  - Targeted lettering campaigns
  - Targeted outbound calls to high-volume prescribers

PerformRx, LLC
Point of Sale (POS) Pilot

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Manager, Pharmacy Prior Authorization

January 21, 2016

PerformRx Overview

- Over **4.9 Million Lives** in **17 States** and the **District of Columbia**
- Managed ***Medicare Part D*** Clients Since Program Inception in 2006
- Extensive ***Managed Care, Commercial, State/Federal*** and ***Employer Experience***
- Impactful **Clinical Programs** Driving Quality and Financial Outcomes
- **Flexible Service Options** and **Collaborative PBM Model**

urac
ACCREDITED
Pharmacy Benefit Management
Expires 11/01/2016

URAC Accredited* for *PBM & DTM Services

urac
ACCREDITED
Drug Therapy Management
Expires 04/01/2018

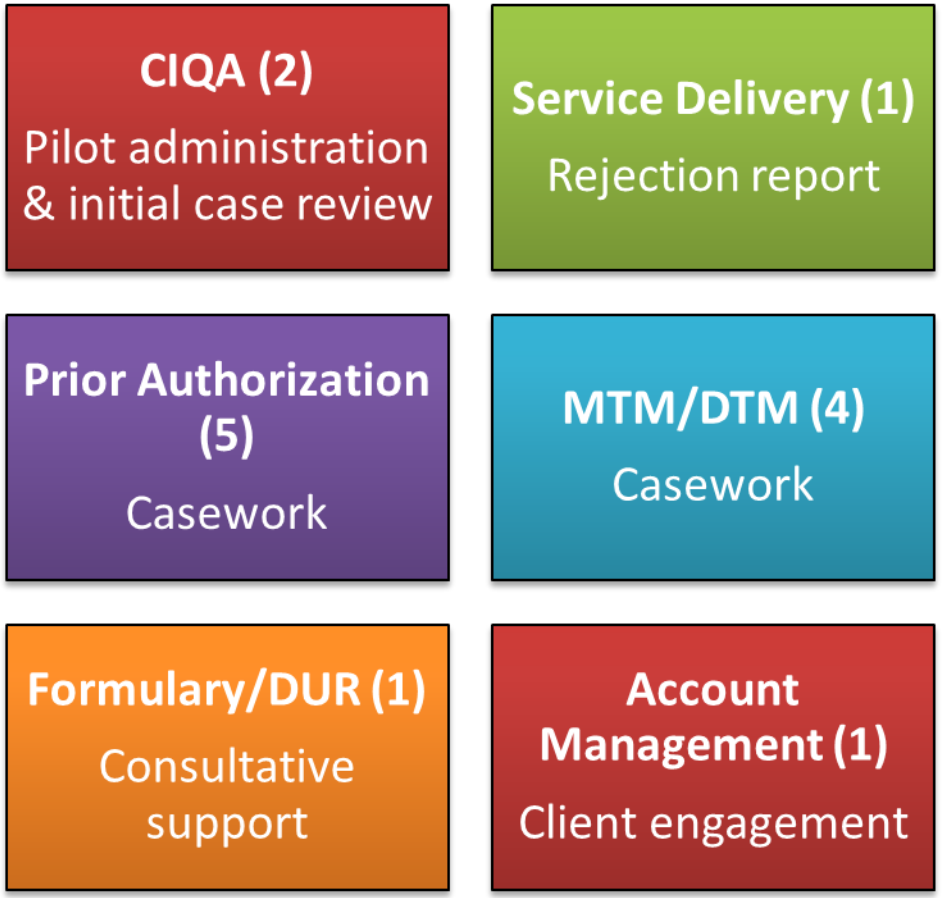
Process Development

Initial development of process – Two weeks

Process refinement from CMS feedback & pilot experience – Four weeks

Time Investment

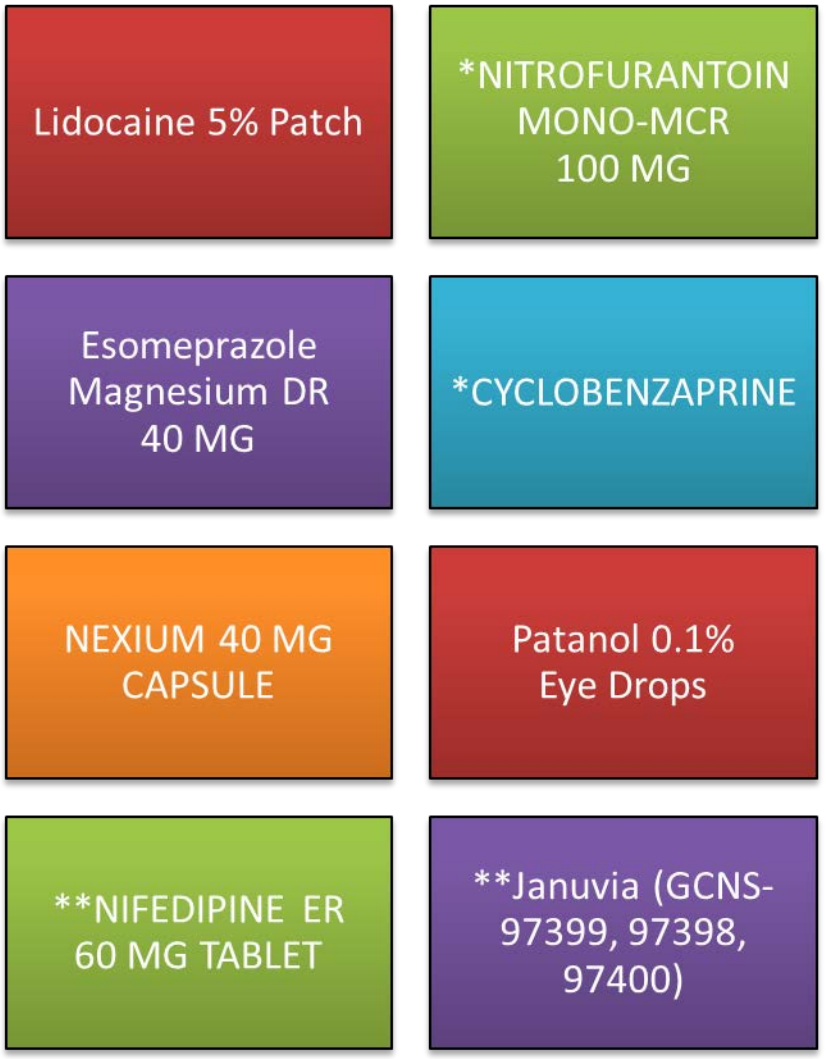
- Pharmacist: 30 min per case
- Technician: 10 min per case
- Research and Reporting: 30 min per day
- Administration: 4 hours per week



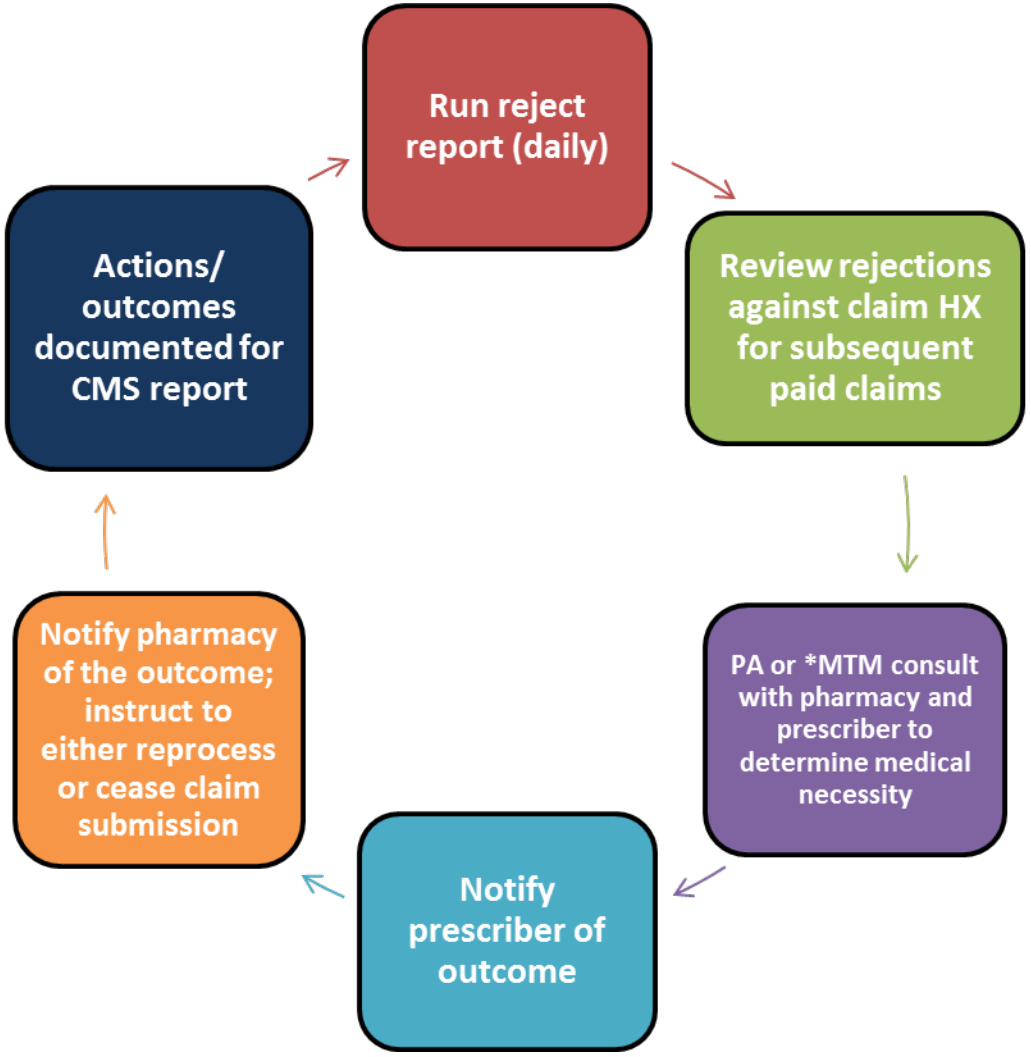
Target Drug Selection

Selection Considerations

- Beneficiaries from one plan contract
- Frequently rejected drugs between 6/1/15 and 8/31/15
- Most requested drugs at coverage determination level
- Products overturned on redetermination
- *Intersection with Star Ratings goals high risk medications (HRM)
- **Additional drugs added 10/1-10/4

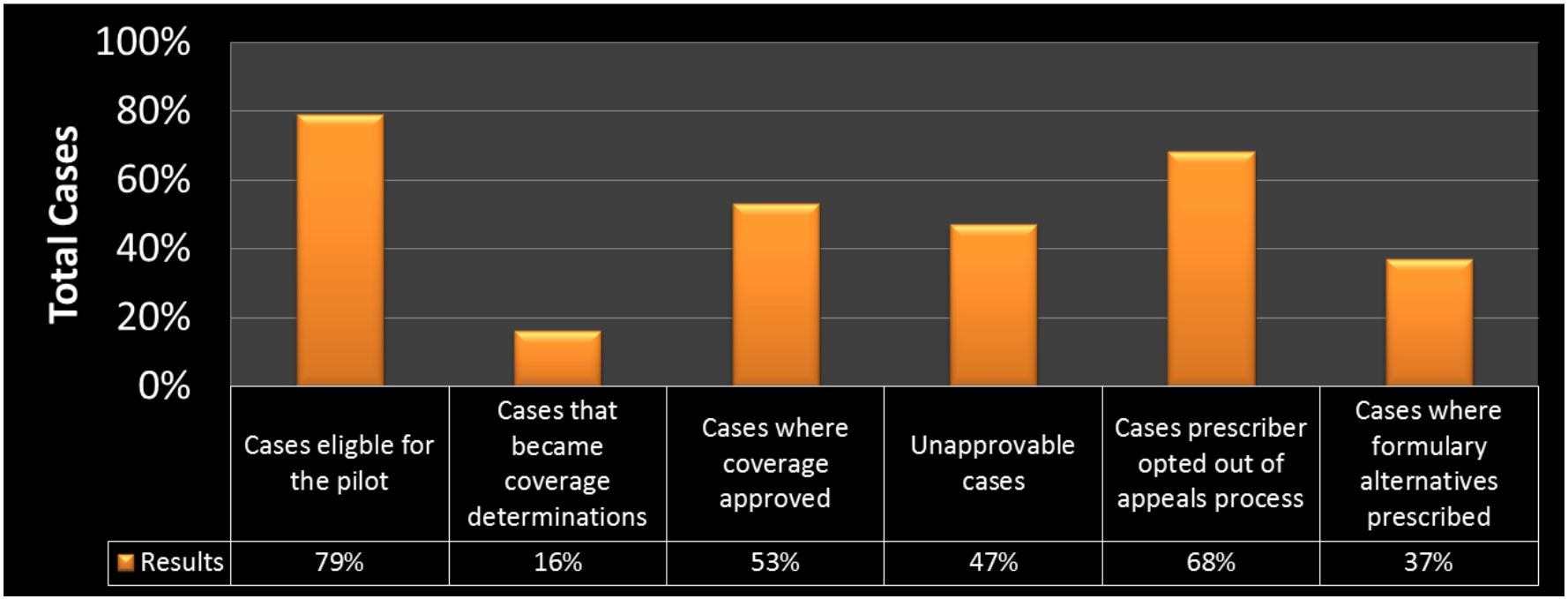


POS Process Defined



- Simple workflow
- Limited disruption to plan or beneficiary
- Calls to pharmacies to:
  - Confirm **validity** of claims
  - Instruct pharmacies to **stop submitting** un-approvable claims
- Calls to prescribers to:
  - Explain criteria
  - Offer to initiate coverage process
  - Determine medical necessity
  - *MTM processed HRM cases
  - PA processed all other cases

Pilot Successes



- Working directly with CMS:
  - Getting immediate **feedback**
  - **Creativity** encouraged & our ideas taken seriously
  - **Flexibility** to apply new techniques & timelines
- Looking at the process from a different point of view
- Demonstrating a benefit to beneficiaries and plans when **pharmacies** know our decisions

Pilot Challenges

- Process is **time** and **labor intensive** with limited automation
- Getting clinical information from prescribers in a **reasonable** amount of time
- Allotting extra time for pilot participants because it is **not in the current staffing model**
- Making quick changes to our prior authorization system (**PerformPA®**) to separate pilot cases from coverage determinations
- Value limited in the **4th quarter** because of low volume of rejections

Benefit of the Process Over Coverage Determinations

- Process is a "***nice to have***" way to boost member and provider **satisfaction**
- Talking to pharmacies **prevents** subsequent, **unnecessary** claim **rejections**
- Most helpful to beneficiaries **transitioning** to a new plan or benefit design
- Immediate health benefit for drugs that **prevent hospitalization** and "**clinically fragile**" drugs

Improving Prescriber Awareness of Formulary Drugs

- CMS and sponsors could investigate programs to **increase prescriber accountability** to prevent unnecessary POS rejections
  - Apply **greater emphasis** on **point of care coordination** to lessen the need for a retrospective POS process
  - Enforce adoption of **existing e-prescribing standards** (NCPDP Formulary Benefits 1.0) with prescribers and point of care software vendors
  - **Monitor rejections** at the **prescriber level** to identify gaps in formulary awareness

Final Thoughts and Recommendations

What type of program do we recommend?	• **Voluntary**
Should there be exclusions?	• Limit to **Part D drugs** & exclude demonstration plans
Which drugs should be included?	• Allow **plan choice** of drugs and disease states (like MTM) • Drugs that prevent hospitalization • "**Clinically fragile**" drugs • Not necessary for HEP C and other high-cost specialty drugs
When would this have the greatest benefit?	• When **beneficiaries** are **new** to a plan or benefit design • If applied year-round some prescribers may expect Medicare plans to initiate all coverage determinations
Who else should be included?	• **Pharmacy involvement** critical to the success of our pilot and missing link in coverage determinations
Who is best suited to do the work?	• Organization(s) that process **coverage determinations** and contract with **network pharmacies**
Are there any competing priorities or contradictory programs?	• Consider **intersection points** (MTM, rejected claims, POS pilot, star ratings) to determine **potential impacts** and/or contradictions

CVS Health
Point of Sale (POS) Pilot

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January 21, 2016

CVS Health

- CVS Caremark Part D Services, LLC (CVS/caremark®), a subsidiary of CVS Health, manages relationships with 44 health plan clients with more than 11.6 million Medicare members.
- These relationships include contracts with MAPD and PDP health plans using CVS/caremark® as their PBM.
- In addition, SilverScript is a CVS Health company with more than 5.1 million members of individual PDP members and Employer Group Waiver Plans.

Improving the Beneficiary Experience at Point of Sale: Opportunities

- Can the intervention occur at point of sale (POS)?
  - Smart edits
- Can we improve the current process from reject to coverage determination?
  - Proactive prescriber outreach

Improving the Beneficiary Experience at Point of Sale: Options

- Target drugs with simple criteria
  - Smart edits
    - Drugs with limited approvable diagnosis codes
  - Proactive outreach for non-formulary drugs
    - Drugs with clear and limited formulary alternatives

Successes

- Proactive outreach may not have resulted in coverage determination requests, but more beneficiaries received appropriate formulary alternatives
  - ~50% more beneficiaries received drug or appropriate formulary alternatives in the proactive outreach groups vs. the control group
  - Including formulary alternatives on fax forms resulted in more prescribing of formulary alternatives
- Anticipate that smart edits that can leverage ePrescribing diagnosis codes may allow some claims with utilization management to pay

Difficulties

- Proactive Outreach
  - Difficult to engage the prescriber office with phone outreach
    - No rejects were resolved with a phone call
    - Prescriber offices still requested fax forms
- Smart Edits
  - Approval would only apply to the current prescription
  - May cause confusion if the claim rejects when a new prescriber does not include a diagnosis code/a different diagnosis code

Potential Benefits

- The most impactful interventions need to occur at point of prescribing
- Improving the use of appropriate formulary alternatives provides better value to the beneficiary