MCO Contract: Section 31.0 Pharmacy Benefits
Summary of Modifications to MCO Contract

Section 31.0, Pharmacy Benefits, of the MCO contract has been extensively revised to increase accountability of the Contractor and to modify requirements to be more specific to MCO contracts than to direct contracts with Pharmacy Benefit Managers. Requirements were updated to address compliance with SB 5, increase transparency, cooperate with DMS on ensuring compliance, and provide necessary reporting. Below is a detailed listing of modifications:

- Added specificity of the definition of "pharmacy benefits" to increase clarity on utilization management, appropriate use of pharmaceuticals, and reporting responsibilities.
- Clarified the language applied to a PBM as well as a PBA or related subcontractor.
- Streamlined language by referencing sections of the Social Security Act and the Code of Federal Regulations. This added clarity and removed the opportunity for the language as crafted in the Contract to carry a different meaning or interpretation from the federal requirements.
- Added referenced to Kentucky statute specific to SB5 to require compliance with all requirements and not only those outlined in the Contract.
- Improved contractual requirements on claims processing and other requirements to ensure the state can claim and maximize rebates on physician administered drugs.
- Strengthened Pharmacy and Therapeutics Committee (P&T) requirements through the following
  - Removed the requirement for the MCOs to duplicate their national P&T Committee meeting by creating a KY P&T Committee. However, KY practicing provider participation in the committee was ensured.
  - Specified the MCOs' P&T Committee must meet quarterly vs "throughout the year as necessary."
  - After discussions with DMS, clarified the Open Meeting Law requirements previously stated in the Contract applied only to the Commonwealth's P&T and not the MCOs' P&T.
- Improved the cycle in which drugs are reviewed for preferred drug list status. The prior cycle was once every 3 years, but was revised to be annually. This is more in line with national best practices and allows for increased responsiveness to clinical study developments, new drug indications, additional safety concerns, pricing changes, rebate enhancements, etc.
- Added requirements that new drugs must be reviewed for preferred drug list placement within 75 days of market availability.
- Ensured availability of the preferred drug list to enrollees and providers.
- Modified requirements to re-inforce that at the direction of DMS, the plans (and hence the MCOs) would have to align coverage, prior authorization criteria, and processes with those of DMS.
- Recommended the claims and systems-specific level that apply to pharmacy and non-pharmacy claims be moved to system requirements that apply across all claims processing activities.
- Increased requirements around the information that must be on the enrollee's ID card to ensure availability of information necessary for pharmacies to process pharmacy claims.
- Required MCO compliance with the relatively new federal clarification of drug utilization review activities and reporting the state must ensure.
- Added pharmacy rebate language to ensure MCOs comply should the state aggregate MCO claims into a supplemental rebate program.
- Modified language that was limiting and stood to cause problems with EPSDT requirements such as requiring use for FDA approved indications only versus use based on evidence.

- Clarified that prior authorizations cannot be denied by a pharmacy technician. A registered pharmacist must make any denial decisions.
- Added requirements for disclosure of all terms and conditions it has with its PBM.
- The PBM must use a pass through model for payments to the pharmacies (no "spread pricing" arrangements).
- Added transparency reporting to reflect what was actually paid to the pharmacy.
- Removed the MCO/PBM's ability to charge hidden feeds (direct and indirect remuneration fees, generic effectiveness rates, etc.)
- Requires participation in meetings with DMS pharmacy staff as well as the pharmacy leadership of the other plans.
- Removed previous barriers to receiving both summary and claim-level detailed pharmacy reports from the MCO/PBM.