Recommendations for Cost Savings Approaches
Under Texas Medicaid Pharmacy Program

Over the past several years, states throughout the country have wrestled with the rising cost of prescription drugs in their Medicaid programs. Recognizing these severe financial pressures, the National Association of Chain Drug Stores (NACDS) is committed to partnering with state Medicaid programs to implement initiatives that control prescription drug spending, maintain beneficiary access to prescription drugs and pharmacy services, and take positive steps towards improving patient adherence to their medication regimens.

Growth in Medicaid spending for the pharmacy benefit is driven primarily by the cost of prescription drugs. While Texas Medicaid has managed to successfully utilize cost containment measures over the years, there is still a need to implement additional initiatives that will further help curtail the constant rise in prescription drug costs. In Texas, some examples of additional ways to effectively control costs associated with the prescription drug spend include:

- Seeking CMS Approval to Implement Mandatory Co-Payments
- State Option to Provide Health Homes for Medicaid Enrollees with Chronic Conditions
- Prescription Drug Cost Avoidance
- Value-Based Payment Models (VBPM): Community Pharmacy

Seek CMS Approval to Implement Mandatory Co-payments
Texas Medicaid should implement mandatory copays for prescriptions dispensed to Medicaid beneficiaries to generate additional savings. Currently, many other states have co-payments and other cost sharing measures in place for prescriptions dispensed to certain Medicaid beneficiaries. Until enactment of the Deficit Reduction Act (DRA) of 2005 (P.L.109-171), pharmacies and other providers were prohibited by federal law from denying service to Medicaid beneficiaries who did not pay co-payments. However, the DRA made significant changes, and gave states the authority to both increase cost sharing amounts and make the payment of cost sharing mandatory for certain Medicaid beneficiaries.[1]

Alternative Co-payment Model: Historically, Medicaid co-payments were set to "nominal" levels of 50 cents to $4 per prescription. In addition to giving states the flexibility to mandate the payment of cost sharing, the DRA also provides the ability to change cost sharing amounts. First, the DRA gave the Secretary of Health and Human Services the authority to increase these nominal co-payment amounts at the beginning of every fiscal year based on the change in the medical care component of the consumer price index for all urban consumers (CPI-U). Second, the DRA permits states to continue to use the nominal co-payment levels that have been established for that fiscal year, or to apply tiered co-payments based on whether prescriptions are brand or generic, or preferred or non-preferred. In addition, the cost sharing imposed by

[1] Provisions of the DRA were codified as a part of the Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals, and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing Rule.

states for non-preferred drugs may vary based on an individual's family income and federal poverty level (FPL). Cost sharing amounts may be as high as 10% of the cost of the drugs for non-exempt exempt beneficiaries with a family income above 100% and below 150% of the FPL and as high as 20% of the cost of the drug for non-exempt individuals with a family income above 150% of the FPL. However, the combined total cost of premiums and cost sharing cannot exceed 5% of the individual's family income.

In addition to having the option to implement alternative cost sharing models allowed under DRA, states will also have the option to mandate cost sharing and allow providers to condition services on payment of cost sharing. However, the alternative cost sharing models as well as the authority to mandate cost sharing and deny patient services must be approved by CMS through the state plan amendment (SPA) process. CMS has released guidance to state Medicaid directors informing them of these provisions as well as provided pre-printed SPA pages that states can use to provide details on copayment structure (i.e. tiered copayments for brand vs. generic or preferred vs. non-preferred), additional exempted patient populations or populations that will have reduced cost sharing as decided by the state, excluded drug classes, and whether or not the state will allow participating providers to the right to deny services to patients for failure to meet their cost sharing obligations.[2]

Medicaid Beneficiaries Exempt from Cost Sharing: Although states now have the option to mandate co-payments, they are prohibited from imposing co-pays on the following patient populations:

- Individuals under 18 years of age that are required to be provided medical assistance including individuals who receive aid or assistance under Part B for children in foster care and individuals who receive adoption or foster care assistance under Part E without regard to age;
- Pregnant women;
- A terminally ill individual who is receiving hospice care;
- Individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the state plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- Women who are receiving medical assistance for breast or cervical cancer provision; and
- Indians if currently receiving or have ever received an item or service in any State furnished by an Indian health care provider or through referral under contract health services (CHS)[3].

To ensure that the above patient populations are not inappropriately charged co-pays, once these individuals have been identified and verified by the state, it is the state's responsibility to update all claims databases accordingly. As a result, when pharmacy claims are adjudicated,

[2] The CMS guidance can be found at http://www.cms.gov/smdl/downloads/SMD061606.pdf . The preprinted SPA pages can be found at http://www.cms.gov/smdl/downloads/6042Preprint.pdf.
[3] American Recovery and Reinvestment Act of 2009 (ARRA) Section 5006(a)

claims for these patients should be returned to the pharmacy with zero-dollar copays, therefore removing any instances where the pharmacy is tasked with trying to identify exempted patients and delaying services to these patients when visiting the pharmacy.

Impact of Uncollected Co-payments: Seeking CMS approval to implement mandatory co-payments will shift liability from the state to the patient to cover the cost of prescription drugs. However, it is important to keep in mind the impact of uncollected co-payments on pharmacies. The Medicaid pharmacy reimbursement structure in every state assumes that the co-payment has been collected, and the pharmacy's reimbursement is reduced by that amount. These systems are in place even though Medicaid providers have historically been able to collect only 50 percent of all co-payments assessed. Many community pharmacies, especially those located in low-income urban and remote rural areas where many Medicaid beneficiaries live, incur significant losses each year because they are unable to collect co-payments.

In addition to losses suffered by community pharmacies, it is important to note that when payment of cost sharing is optional for Medicaid beneficiaries, they lose their effectiveness in controlling utilization and influencing cost effective choices. A Medicaid beneficiary facing a higher co-payment for the use of an expensive brand-name drug, will be more likely to declare an inability to afford the higher co-payment, rather than opt for a lower-cost generic drug with a much lower co-payment. Cost sharing can encourage the use of equally effective, lower cost therapies, such as generic drugs. Without mandating the payment of co-payments, states are limiting their own ability increase generic utilization and manage prescription drug costs.

State Option to Provide Health Homes for Medicaid Enrollees with Chronic Conditions

The Patient Protection and Affordable Care Act (P.L.111-148) includes a series of grants and pilot programs aimed at improving health care quality and controlling costs through the use of coordinated care models. For example, Section 2703, State Option to Provide Health Homes for Enrollees with Chronic Conditions, provides states the option to create a health home for Medicaid beneficiaries with chronic conditions. Services provided to patients enrolled in the health home would include a comprehensive set of medical services such as care coordination and comprehensive care management.

As a part of the provisions under Section 2703, the Secretary of Health and Human Services started awarding planning grants to those states who are interested in developing a health home as a part of their Medicaid program. In addition to planning grants, those states that are approved for implementation of the health home will receive 90% federal medical assistance percentage (FMAP) for health home services provided during the first two years that the State Medicaid Plan amendment is in effect. As of August 2019, there are 21 states and the District of Columbia with a total of 36 approved Medicaid Health Homes.[4]

As an avenue to increasing medication adherence, coordinated care models can improve patient care by promoting safe and effective medication use. Community pharmacists are uniquely qualified and positioned to reduce the problem of poor medication adherence. As a trusted member of the healthcare team, community pharmacists collaborate with others to positively address patient

[4] https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-map.pdf.

outcomes and mitigate rising healthcare costs.[5] Healthcare spending on non-optimal medication therapy (estimated at $528.4 billion per year)[6] and medication nonadherence (estimated at $100-290 billion per year and attributed to 10% of hospitalizations)[7] could be significantly decreased with the development of more purposeful policies and programs that fully leverage patient touch points in the community setting that fully utilize the skillset of community pharmacists. With the adoption of a medical home and through coordinated efforts with other healthcare providers, Texas Medicaid can improve health outcomes and reduce the use of more costly medical interventions such as hospitalizations and emergency room visits which will result in greater savings to the state.

Prescription Drug Cost Avoidance

Problems states face in ensuring that Medicaid is the payer of last resort fall into two categories: problems verifying whether beneficiaries have private health coverage and problems collecting payments or "pay-and-chase" when such coverage exists. On the basis of Medical Expenditure Panel Survey data from calendar year 2016, an average of 8% of respondents who reported having Medicaid coverage also reported having private health coverage at the same time. In addition, the average amount of costs recovered through pay and chase programs is 17%, which does not include the cost to administer the program. By implementing a cost avoidance program which utilizes access to real-time eligibility information, the costs of administering a pay-and-chase program is mitigated and the cash flow remains with state Medicaid agencies.

By accessing real-time patient eligibility from payer sources, Texas Medicaid will be able to identify other pharmacy coverage that a patient may have and avoid Medicaid claims representing millions of dollars, an immediate savings for states and managed care programs. The prospective cost avoidance savings identified would be in addition to states' current pay-and-chase programmatic efforts. Over time, prescription cost avoidance will mitigate the need for existing retrospective pay and chase models used for pharmacy services.

Value-Based Payment Models (VBPM): Community Pharmacy

Among options to help control prescription drug spending and related medical condition costs, it is imperative that patients maintain access to their medications and the professionals who can best ensure medications are used correctly. Any effort to improve quality and reduce costs over the long term will be difficult to achieve if patients do not take their medications appropriately and/or their adherence is poor. By allowing patients to use the provider of their choice for medication-related needs, avoidable medical condition costs can be greatly minimized. **(See Attachment 1 for Examples of VBPM in Pharmacy)**

As VBPM continue to evolve, NACDS encourages Texas Medicaid to consider the benefits of coordinated care programs and VBPMs. Successful outcomes for value-based models and other coordinated care programs will be dependent on ensuring multiple provider types are able to

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[5] Accreditation Council for Pharmacy Education (ACPE); "Accreditation Standards and Key Elements for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree;" Accessed July 2018. https://www.acpe-accredit.org/pdf/Standards2016FINAL.pdf.

[6] Watanabe JH, McInnis T, Hirsch JD; "Cost of Prescription- Drug Related Morbidity and Mortality;" *Annals of Pharmacotherapy*; March 26, 2018. http://journals.sagepub.com/doi/10.1177/1060028018765159

[7] Rosenbaum L, Shrank WH; "Taking Our Medicine - Improving Adherence in the Accountability Era;" *New England Journal of Medicine*; August 22, 2013. Shrank WH, Polinski JM; "The Present and the Future of Cost-Related Non-Adherence in Medicare Part D;" J Gen Intern Med 30(8):1045–6. Pretorius RW, et al. "Reducing the Risk of Adverse Drug Events in Older Adults;" *American Family Physician*; March 1, 2013. https://www.aafp.org/afp/2013/0301/p331.html .

provide disease state management, medication management, and preventive services to beneficiaries.[8] Considering the growing evidence that pharmacists are uniquely positioned to improve medication management across the care continuum and provide a range of health services in the community and as part of care teams, NACDS advocates for the expansion of community pharmacy inclusion in VPB models.

Improved care coordination and chronic care management are the cornerstones of VBPMs, and medication management is central to both objectives. While VBPM have primarily focused on physicians and hospitals, they are now expanding to include more providers. The goal of VBPM is to align performance and health outcomes with compensation by assessing performance using quality and health metrics, and to provide tools and programs to improve patient health outcomes. Value-based payment model reform has the potential to improve outcomes, enhance care coordination, and create more system efficiencies and the contribution of community pharmacy in helping achieve the goal of VBPM is extremely promising.

Pharmacy Product Reimbursement Should not be Included in Value-Based Payment Models: When establishing value-based agreements, both private sector and public-sector healthcare payors should recognize the cost savings and patient care benefits of pharmacist provided services and recommendations for cost-effective prescription drug treatment. Payors should also recognize that services provided by community pharmacists help to lower prescription drug costs and reduce overall healthcare costs by decreasing the use of more costly services such as avoidable emergency room visits and hospitalizations. However, in considering VBPM as a cost saving initiative, it is important to ensure that pharmacists can provide the greatest value to patients and reimburse pharmacies accordingly for the innovative services provided by community pharmacists to the extent pharmacists can provide those services under state law. Furthermore, this reimbursement should be based on the other valuable services that pharmacists provide and not in any way be tied to or negatively impact pharmacies' reimbursement (product and/or dispensing fees) for prescription drugs.

Making product reimbursement dependent on value-based rate is inappropriate. In the pharmacy setting, all drugs dispensed are rightfully purchased and paid for by the pharmacy. At the time that the drug is dispensed, there is no way for the pharmacists to determine or predict if the desired outcome will be reached. Because of the inability to adequately determine the outcomes of any prescribed regimen, placing value-based rates on prescription drug reimbursement would place pharmacies at a potential financial loss for prescription drugs dispensed if the desired outcome is not attained. Therefore, VBPM should apply to the other services that are provided and not to prescription drug reimbursement. In addition, all metrics and outcomes goals should be focused on modifiable measures where pharmacies can be more influential on the outcome of those measures, such as medication adherence, and not on measures that are beyond the control of the pharmacists.

Conclusion

[8] Choudhry NK, Fischer MA, Smith BF, et al; "Five Features of Value-Based Insurance Design Plans Were Associated with Higher Rates of Medication Adherence"; *Health Affairs*; March 2014. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0060; Roebuck MC; "Medical Cost Offsets from Prescription Drug Utilization Among Medicare Beneficiaries"; J Manag Care Spec Pharm. 2014;20(10):994-995. doi:10.18553/jmcp.2014.20.10.99.

NACDS believes that there are appropriate, effective, and long-term approaches to cutting Medicaid prescription drug costs. Each of the abovementioned initiatives is long-term cost-saving approaches that have been proven to be cost effective in other states. We strongly urge Texas Medicaid program to consider these approaches that have proven so successful elsewhere before making changes to the Medicaid program that could negatively impact the quality of care beneficiaries receive.

ATTACHMENT 1

Examples of Value-based Models in Pharmacy

1. Wellmark Blue Cross Blue Shield Value Based Pharmacy Program (VBPP)

Payor: Medicare, Medicaid, and Commercial

Background: In July 2016, Wellmark identified high performing independent and chain pharmacies in Iowa and South Dakota to participate in a new value-based model, focused on better serving patients with asthma, diabetes, hyperlipidemia, and depression. Goals of this program include ensuring that the patient is on the right drug and is adherent, and in the longer-term, to reduce emergency department visits, hospital readmissions, and total cost of care.

Program Details: For inclusion in the network, participating pharmacies must offer multiple clinical services (e.g. year-round immunization program, comprehensive medication reviews, health screenings, and medication synchronization appointments). Participating pharmacies are also required to formally document services delivered and actively communicate information to patients' providers, provide adequate space for private or semi-private consultations, develop a service plan based on community-specific needs, establish formal immunization protocol and/or collaborative practice agreement(s), and ongoing pharmacist training.

Eligible members for the program include those with ≥1 chronic medication or diagnosed with a chronic condition. Example metrics to evaluate pharmacy performance vary by disease state and include:

- Diabetes – blood sugar control and blood pressure control
- Depression - readmissions
- Cardiovascular risk - cholesterol goals, is patient on correct statin intensity?
- Asthma - assess how often patient is utilizing rescue inhaler

Payment Structure: Wellmark's VBPP network is structured outside of the Pharmacy Benefit Manager (PBM) relationship. VBPP payment structure is per member per month (PMPM) with bonuses. Bonus from shared savings is received based on Wellmark's evaluation of costs.

Preliminary Results: As of July 2018, researchers are collecting and analyzing VBPP data to determine the impacts of this program. However, the **Continuous Medication Monitoring (CoMM) pharmacy pilot**, which informed the creation of the ongoing Wellmark VBPP model, had significant results. Specifically, the CoMM pilot was designed to assess the effects of continuous medication monitoring (CoMM) on total costs of care, proportion of days covered (PDC) rates and the use of high-risk medications by elderly patients. The pilot results demonstrated lower total costs of care and meaningfully better medication adherence. *Per member per month (PMPM) costs were approximately $300 lower for patients who received medications only from the pharmacy offering the CoMM program as compared to patients receiving medications from other pharmacies.* This pilot validated that paying pharmacists to proactively address the safety, effectiveness, and adherence of medications at the time of dispensing can support optimization of medication therapy and decrease costs.[9]

2. Wisconsin Pharmacy Quality Collaborative (WPQC)[10]

Payors: Medicaid, Medicare Part D, Medicare, Commercial, and SeniorCare

Background: Established in 2008, the WPQC is an initiative of the Pharmacy Society of Wisconsin (PSW), which connects community pharmacists with patients, physicians, and health plans to improve the quality and reduce the cost of medication use across Wisconsin. In 2012 the PSW received a $4.1 million Health Care Innovation Award from the Centers for Medicare & Medicaid Services (CMS) to expand the WPQC statewide. Currently, over 500 pharmacists are actively certified through WPQC. Current health plan partners include the Wisconsin Medicaid and SeniorCare programs and the United Way of Dane County, representing approximately 20% of the state population, or over 1 million Wisconsin lives.

Program Details: WPQC is a network of pharmacies with pharmacists who provide medication therapy management (MTM) services, such as comprehensive medication reviews (CMRs) to complex, high-risk patients. This model leverages pharmacists to reduce medication complexity and errors, improve adherence, and empower patients to safely manage their medication regimens. WPQC and its health plan partners facilitate the provision of MTM services for patients taking multiple medications to treat chronic conditions, those at risk of falls and adverse drug events (ADEs), and those recently discharged from the hospital. The UWDC CMR program supports community and senior center case managers to identify older adults at risk of falls and ADEs and intervene by scheduling WPQC- provided CMRs and offering home falls safety assessments. Services can also be provided at the pharmacy or the patient's residence. Similarly, a partnership in Milwaukee between WPQC pharmacies and UniteMKE trains community health workers in medication adherence screening. The community health workers then make CMR referrals to WPQC pharmacies.

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[9] Pilot: While some of the pharmacy services promoted and measured are different between the current Wellmark Blue Cross Blue Shield VBPP and the CoMM pilot, in the CoMM, pharmacists assessed each of the medications being dispensed, identified, and resolved any medication-related problems, and then documented their actions. Examples of drug therapy problems include doses too high or low, duplicate therapy, omissions in drug therapy, etc. Doucette, William R, et al.; "Pharmacy performance while providing continuous medication monitoring."; *Journal of the American Pharmacists Association*; Volume 57, Issue 6, 692-697. https://www.japha.org/article/S1544-3191(17)30788-4/fulltext

[10] http://www.pswi.org/wpqc
http://www.pswi.org/WPQC/About-WPQC/About-WPQC
https://www.dhs.wisconsin.gov/publications/p01558.pdf
http://www.pswi.org/WPQC/WPQC-Payers/Benefits-to-Payers

Eligible patients must meet at least one of the following criteria to receive WPQC CMR services: take four or more prescription medications to treat/prevent two or more chronic conditions, diagnosis of diabetes, have multiple prescribers, or low health literacy. Patients also qualify for a CMR in the 14 days following discharge from a hospital or long-term care facility to prevent a readmission to the hospital. Additionally, a referral from a prescriber automatically qualifies any patient covered by a participating health plan for WPQC services.

Preliminary Results: In 2016, the Wisconsin Department of Health Services Division of Health Care Access and Accountability completed an evaluation of the project work. The evaluation showed that patients who received a CMR at some point prior to hospitalization exhibited a decrease of $524 in inpatient costs per hospitalized patient in comparison with a control group that had not received a CMR. This finding suggests that CMRs provided through WPQC may have been impacting health care utilization between 2012-15. Results from the pilot phase of WPQC (2008-2010), which included Unity Health Insurance and Group Health Cooperative of South-Central Wisconsin showed:

1) 10:1 Return on Investment (ROI) for services which directly impacted medication cost;
2) ROI was maintained at 2.5:1 when combining services which directly impacted medication cost and comprehensive medication reviews; and
3) Facilitating the use of health plan formularies to ensure the least expensive equivalent medication, pharmacists can save payers and patients 3-4 times the cost of medications.

Payment Structure: Compensation for the CMR service is provided by participating health plans on a fee-for-service basis and includes one initial visit and three follow-up visits with the pharmacist annually at no cost to the patient.

3. Community Care of North Carolina – Enhanced Pharmacy Services Network[11]

Payor: Medicare and Medicaid Innovation Grant

Background: In 2014, Community Care of North Carolina (CCNC) was awarded a 3-year grant from the CMS Center for Medicare & Medicaid Innovation (CMMI) to test payment reform in community pharmacies for Medicaid, Medicare, and dually eligible Medicare-Medicaid and NC Health Choice beneficiaries by using a collaborative care model where community pharmacy is part of the medical home team.

Program Details: Participating pharmacies are given access to CCNC information that allows pharmacists to review prescription claims data, adherence data, and population management tools. Pharmacies are allowed to participate in the CPESN-NC framework as long as they deliver enhanced

[11] https://www.communitycarenc.org/
https://www.cpesn.com/
https://issuu.com/iowapharmacyassociation/docs/2016q2_journal_web
https://cpesn.com/payors

services, document interventions, and meet minimum established criteria. CPESN-NC pharmacies must provide a proactive waste management program that prevents medication waste by verifying patient need prior to each fill, patient counseling and adherence coaching, and assistance with medication reconciliation especially after hospital discharge.

Preliminary Results: Outcomes from this grant have not been published yet. Based upon preliminary results, high-risk Medicaid patients supported by CPESN pharmacies are:

- 45% less likely to have an inpatient hospitalization admission,
- 35% less likely to have a preventable hospital admission or readmission,
- 15% less likely to experience an emergency department visit,
- 25% more likely to engage their primary care provider (PCP), and
- 20% more adherent to their medications.

Primary goals of this grant were to improve quality and reduce costs while enhancing the ability of the primary care provider (PCP) to improve care outcomes for patients with chronic diseases.

Payment Structure: The payment structure is per member per month (PMPM) based on the patient risk or complexity and pharmacy performance score. Pharmacy performance score is based upon the following metrics: risk-adjusted total cost of care, risk-adjusted inpatient hospitalizations, risk-adjusted emergency department visits, adherence to antihypertensive medications, adherence to statins, adherences to DM medications, and patients' adherence to multiple chronic medications. Payment is based on current Medicare Chronic Care Management codes.

Patients must have high preventable risks. For example, a patient with high preventable risk is a 55-year-old with diabetes and high cholesterol who has a history of two previous ER visits and is nonadherent to their cholesterol medication. A pharmacist can help this patient become more adherent to the cholesterol medication and reduce the likelihood of a $3,000 or significantly higher ER visit.

4. ***Inland Empire Health Plan (IEHP) Pharmacy P4P Program***[12]

Payors: Medi-Cal and Medicare

Background: In 2013, IEHP, a Medi-Cal and Medicare health plan that provides managed care for more than 1.2 million California residents, developed the IEHP Pharmacy Pay-For-Performance (P4P) Program – one of the first programs of its kind – designed to improve pharmacy services through IEHP's 450 community pharmacy providers. The main focus of the program aimed to validate the roles of community pharmacies in promoting healthcare quality and define a pharmacy payment model for outcome-based services while improving members' health, reducing costs, and increasing the plan's star rating. IEHP has a Pharmacy Quality Star Ratings system created to help IEHP members locate high-quality pharmacies based on data collected. The searchable system displays the rating of each participating pharmacy. The ratings range from 1 to 5 stars, with 5 stars being the best.

[12] https://ww3.iehp.org/en/providers/pharmaceutical-services/pharmacy-p4p-program

Program Details: The initiative began with a focus on pharmacist review of member's Proportion of Days Covered (PDC), which is a measure of medication adherence. Pharmacists worked to achieve members' adherence goal of PDC ≥ 80%. In a later phase, the Pharmacy Home Program began, which provided reimbursement for pharmacies that reached PDC member adherence goals and included medication therapy management (MTM) services to provide care for diabetes, high blood pressure, high cholesterol, and/or asthma. The most recent phase of the program, Safe Rx Network, commenced with a focus on medication safety, and requires pharmacists to review all relevant drug utilization review (DURs) alerts, and determine the most appropriate interventions. DUR alerts and appropriate intervention can mitigate the risk of adverse or medication-related events. There are four DUR alert categories in the program: drug-drug interactions, high dose exceeding maximum recommended dose, therapeutic and ingredient duplication, and high-risk medications for the elderly. To evaluate the program, IEHP measures DUR interventions, percentage (%) of total processed claims with safety DUR alerts, and percentage (%) of overall inappropriate claims avoided. IEHP is preparing to expand their quality-focused initiatives with a Point-of-Care (POC) MTM Pharmacy Program with expected launch date in 2019.

Preliminary Results: Prior to current phase of the DUR program, pharmacists were able to significantly increase medication adherence rates. Likewise, based on current DUR program data collection and calculations, overridden DUR alerts are trending down from baseline. Therefore, pharmacists are intervening on DUR alerts more often: this process helps to optimize medication therapy and ensure that only safe and effective medications reach patients.

Payment Structure: Pharmacies are paid a certain amount of dollars per prescription claim that is processed with an overridden DUR alert providing that a payable PSC code is included. The P4P payment per claim will be determined based on final paid prescription volume. Furthermore, there is a bonus payment associated with not filling a prescription after receiving a DUR notification or alert. A pharmacy will receive bonus payment if the percentage of paid prescription volume associated with overridden DUR alerts of the total paid prescription is lower than IEHP threshold. Pharmacies can also earn payment for participating in a Text Message Incentive Program. Monetary support will be allocated to encourage pharmacies to implement a text message system to provide notification to IEHP members. For pharmacies to meet the requirement for opt-in, IEHP members much opt-in >50%. Pharmacies may also earn payment based on member satisfaction survey results.