Implications for Managed Care Pharmacy from the CY 2021 and 2022 Medicare Advantage and Part D Proposed Rule

March 23, 2020

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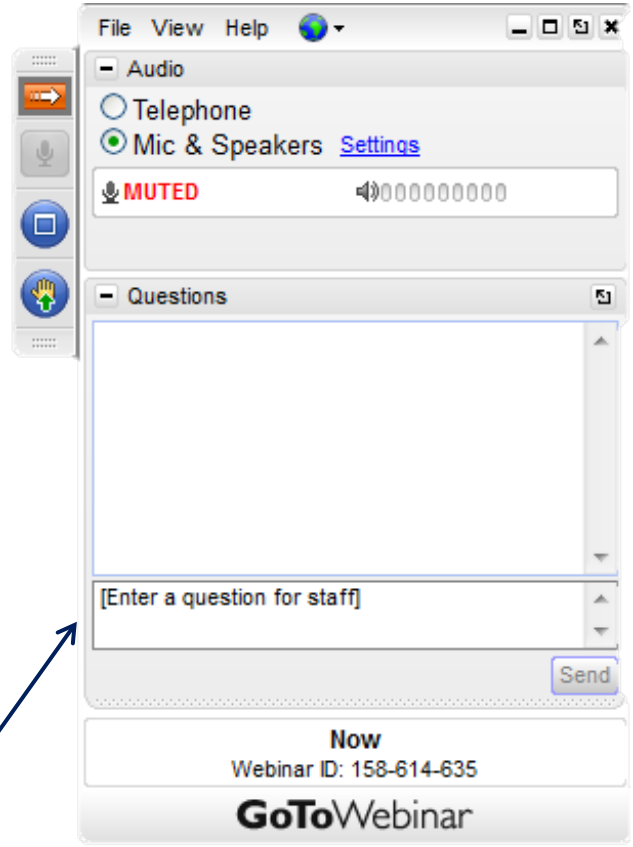
How to Ask a Question



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AMCP Summary of the Proposed Rule

Available at:

- **AMCP.org → Policy& Advocacy → 2020 Letters Statements & Analysis**

https://www.amcp.org/sites/default/files/2020-03/AMCP_Summary_2021_PartCandDProposedRule.pdf

Speakers

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AMCP

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Agenda

Topic	Speaker
Timeline	Carrie Monks
Key Policy Issues for AMCP	Ross Margulies
Question & Answer	Carrie Monks and Ross Margulies

Timeline

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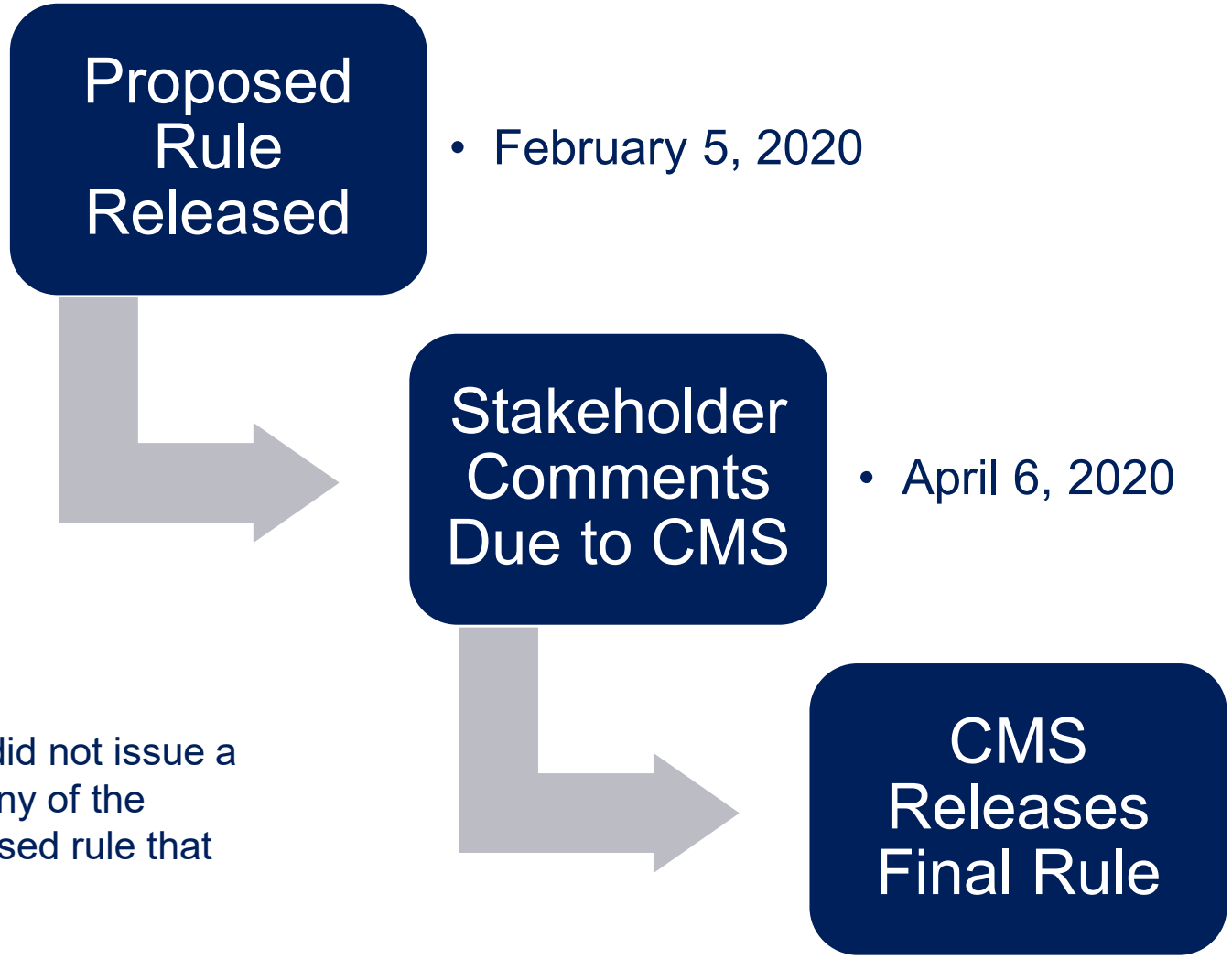


In a break from historic precedent, CMS did not issue a Call Letter this year, instead including many of the program and policy changes in this proposed rule that had typically been in the Call Letter.

Key Policy Issues for AMCP

Establishing Pharmacy Performance Standards

- CMS proposes to establish new reporting requirements to require Part D plan sponsors to disclose the pharmacy performance measures they use to evaluate pharmacy performance in their network pharmacy agreements.
  - CMS plans to report this information publicly in order to increase transparency around pharmacy performance measurement.
- CMS also seeks comments from stakeholders on Part D pharmacy performance measures more broadly, including recommendations for potential Part D Star Ratings measures to incentivize use of a standard set of pharmacy performance measures.
  - The proposed rule encourages the industry to continue working to establish a consensus set of performance measures.

Second Preferred Specialty Tier

- CMS proposes to allow Part D plans to establish up to two specialty tiers.
  - Plans will have the flexibility to determine which drugs are placed on each specialty tier.
    - Under the proposal, if a plan has two specialty tiers, one must be a preferred tier with lower cost sharing.
    - CMS declined to limit the lower cost specialty tier to generic drugs and biosimilar products.
    - Plans may design exceptions processes so that Part D drugs on specialty tiers are not eligible for a tiering exception to non-specialty tiers, but must allow exceptions to the lower cost specialty tier.

Beneficiary Real Time Benefit Tool (RTBT)

- CMS proposes add a requirement that Part D plan sponsors implement a beneficiary RTBT to allow enrollees to view timely, clinically appropriate, patient-specific formulary and benefit information.
    - Effective January 1, 2022.
        - CMS had previously required that plan sponsors support a *prescriber* RTBT as of January 1, 2021.
    - The beneficiary RTBT will be required to include real-time information on the enrollee's cost sharing as well as clinically appropriate formulary alternatives (including the formulary status and utilization management requirements of the alternatives).

Beneficiary Real Time Benefit Tool (RTBT)

- CMS proposes to allow plan P&T committees to evaluate whether some drugs should be excluded from the beneficiary RTBT.
- CMS encourages, but does not propose to require, plan sponsors to include each drug's negotiated price.
- The proposal would allow plans to offer rewards and incentives to enrollees who use the tool.

SUPPORT ACT Implementation

- Per the SUPPORT Act statute, CMS proposes to require Part D plan sponsors to implement Drug Management Programs (DMPs) for beneficiaries at-risk for abuse or misuse of frequently abused drugs.
  - Beginning on January 1, 2022.
  - DMPs have historically been voluntary for plan sponsors.
  - The programs allow plans to limit a potentially at-risk beneficiary's access to opioid covers and/or benzodiazepines to a single prescriber, a limited network of pharmacies, or through specific point-of-sale edits.

SUPPORT ACT Implementation

- CMS proposes to modify the definition of a potentially at-risk beneficiary to include a Part D eligible individual who is identified as having a history of opioid-related overdose.
  - This history is proposed to be defined as a beneficiary for whom a recent claim has been submitted containing a principal diagnosis reflecting an opioid overdose, regardless of the type of opioid, and at least one PDE for an opioid dispensed to the beneficiary has been submitted.
    - Modified definition is mandated by the SUPPORT Act.

SUPPORT ACT Implementation

- The SUPPORT Act requires automatic forwarding of an enrollee's appeal of an at-risk determination to the Independent Review Entity (IRE). CMS proposes to implement this provision.
  - If a plan sponsors affirms its denial of the enrollee's internal appeal, the case will automatically be sent to the IRE.
  - Previously, an enrollee appealing an at-risk determination would have his case forwarded to the IRE when requested by the enrollee or if the plan failed to make a timely adjudication.
- The Act also requires implementation of a provision requiring Part D plans to implement payment suspensions for credible allegations of fraud.
  - Similar to CMS suspensions of payment for credible fraud allegations in traditional Medicare.

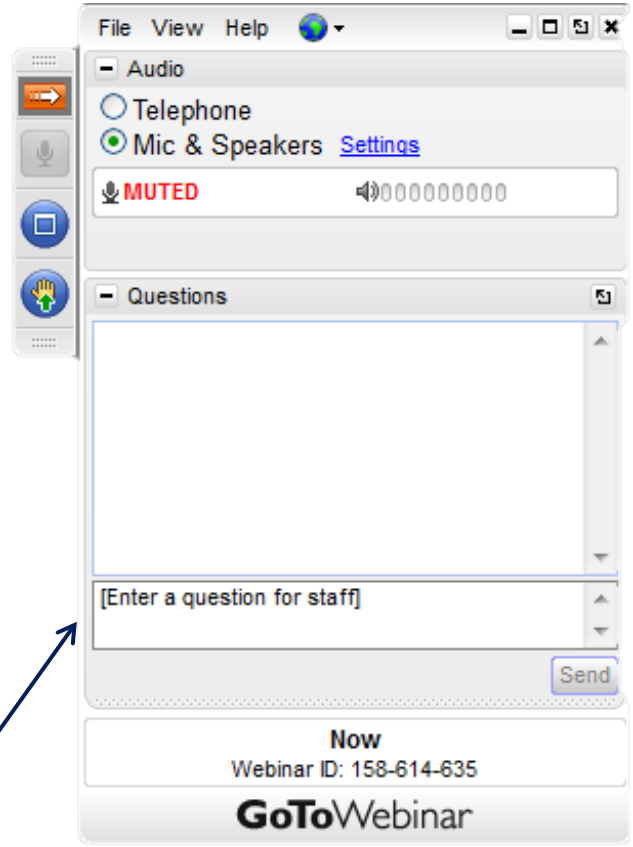
Star Ratings Patient Experience Measures

- CMS proposes to increase the weight of the patient experience complaints and access measures in the MA and Part D quality rating system.

- Proposal would increase the weight from the current weighting of 2 to a weight of 4.

Questions?

How to Ask a Question



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