NCPA Summary of CMS 2012 Part D Final Rule

PBM Transparency
- Health care reform legislation required CMS to impose new transparency requirements on PBMs in Part D and the new health care exchanges.
- NCPA urged CMS to provide guidance on how they will implement these new transparency requirements.
- In the Final Rule, CMS did not address NCPA’s request to implement the Part D health care reform legislation PBM transparency requirements as CMS has told NCPA that the health care reform transparency are already being imposed on Part D sponsors.

Cost Sharing
- Presently, original Medicare patients are not subject to cost sharing for preventive services.
- Under the Final Rule, CMS will prohibit Medicare Advantage from charging cost-sharing for in-network preventive services for which there is no cost sharing under Original Medicare.
- NCPA supported this change.

MTM
- CMS is implementing a standardized format for MTM comprehensive medication reviews (CMRs) and is allowing these CMRs to be completed via tele-health methods.
- NCPA urged CMS to allow NCPA to play a role in developing the CMR standardized format, to require that only pharmacists be allowed to complete CMRs and urged CMS to recognize that face-to-face CMRs are more effective than tele-health CMRs.
- In response CMS stated:
  - It will allow input by stakeholders for developing the standardized CMR forms, but there would be little variability in the standardized format for MTM forms. NCPA has shared our concerns with CMS that without sufficient flexibility, pharmacists may not always have access to the information needed to complete the CMR and may later be subject to recoupment for failure to include such information on the CMR;
  - It will allow telehealth MTM services; and
  - It will not require that CMRs only be done by pharmacists.

Coverage Gap
- CMS will provide additional educational materials to stakeholders regarding the process of closing the coverage gap.
- CMS anticipates permitting actuarially equivalent co-payments in the coverage gap for drugs that are not applicable (that is, generic drugs) starting in 2018 when beneficiary cost sharing for these drugs will be below 50 percent.

Pharmacist Definition
- Within the Part D program, CMS added a definition for the term “pharmacist,” where no definition existed before.
CMS defined pharmacists within the Part D program to include only those licensed by US authorities as pharmacists.

The purpose of this change was to prevent foreign licensed pharmacists from participating in the Part D program.

NCPA supported this change.

Data Transfers for Terminated Plans

During the termination of Fox Insurance last year, NCPA members faced difficulties in receiving timely reimbursements owed to them by Fox.

NCPA urged CMS to require terminated sponsors to expedite transfer of patient data, but CMS refused to impose a time period for transferring patient data when a sponsor is terminated.

NCPA also urged CMS to take action to ensure that pharmacists continue to be reimbursed when a sponsor is terminated. CMS will not take such action, stating that pharmacists can invoke the prompt pay regulation and seek CMS compliance under that provision.

Tiered Cost Sharing

With regard to MA organizations, CMS had proposed to prohibit MA organizations from varying the level of patient cost sharing for basic or supplemental benefits for any reason, including based on provider groups, hospital network or the beneficiary’s utilization of services.

NCPA sought to ensure that the prohibition extended to the drug benefit under Part C, as well as extending this prohibition to Part D.

CMS did not finalize the prohibition on tiered cost sharing by MA plans, but will provide future guidance on this issue.

Compound Drugs

CMS had proposed to allow sponsors to deny payment for non-Part D ingredients and prohibit pharmacies from balance billing for those ingredients.

NCPA urged CMS to require sponsors to adopt only one of the options above.

CMS responded by prohibiting balance billing for non-Part D ingredients of Part D compounds.

CMS stated that Part D sponsors can either directly pay for non-Part D ingredients on the pharmacy claim (without charging the beneficiary or reporting these costs on the PDE to CMS); or (2) Part D sponsors can reimburse pharmacies for these ingredients as part of the dispensing fee.

For compounded drugs, CMS will not require sponsors to base non-LIS beneficiary cost-sharing on the most expensive Part D drug ingredient.

Short Cycle Dispensing

CMS was persuaded by NCPA comments requesting a delay. Implementation of the short cycle regulation will now take effect on January 1, 2013.

CMS will require all pharmacies servicing LTC facilities, including not only closed-door LTC pharmacies, but also retail pharmacies and mail order pharmacies that dispense to LTC facilities, to dispense solid oral doses of brand-name medications to patients in 14-
day-or-less increments (this provision does not apply to settings such as group homes, assisted living facilities, ICF/MRs, IMDs, and I/T/U pharmacies).

- Two types of medications are excluded from the requirement to dispense solid oral doses of brand-name drugs in 14-day supplies: (a) antibiotics and (b) drugs that are dispensed in their original container as indicated in the Food and Drug Administration Prescribing Information or those that are customarily dispensed in their original packaging to assist patients with compliance (for example, oral contraceptives).

- The proposed rule has been modified to require only that your pharmacy report a calculated amount of medication that has gone unused. However, pharmacies that voluntarily adopt 7-day-or-less dispensing for both brand and generic drugs do not need to report unused drugs to Part D plans.