2012 Revisions to Medicare Part D
December 14, 2011

Background

On April 4, 2011, the Centers for Medicare and Medicaid Services (CMS) released its Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter that includes additional updates and directions to Medicare Part D and Part C programs that contains additional information important to pharmacy. APhA submitted comments when it was originally proposed.

On April 15, 2011, CMS issued a final rule, Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Changes (76 Federal Register (FR) 21432), containing extensive technical and policy changes to the Code of Federal Regulations at Title 42 (Public Health) Parts 422 (Medicare Advantage Program) and 423 (Voluntary Medicare Prescription Drug Benefit) affecting:

- Medicare Advantage organizations (MA)
- Medicare Part D prescription drug programs (PDPs)
- MA prescription drug plans (MA-PDs)
- Pharmacists
- Pharmacies
- Medicare Patients
- Prescribers

The provisions of the final rule became effective on June 6, 2011, but because these programs operate under calendar year contracts, most provisions take effect January 1, 2012 and others will not begin until 2013. This document summarizes several of the more notable changes to existing law through the final rule and Call Letter pharmacists should be aware of in the coming year(s).

Summary of Key Changes for 2012

- **Prescriber Identifiers on Part D Claims** (Call Letter)
  - For 2012 Part D sponsors may continue to report on the prescription drug event (PDE) records one of the permissible, active and valid types of prescriber identifiers (i.e. national provider identifier (NPI), DEA number, unique physician identification number (UPIN) or state license number).
  - Part D sponsors will be required to confirm the validity of DEA numbers on Schedule II-V drug claims or map NPIs on these claims to the prescriber's DEA numbers. Moreover, plan sponsors will be required to confirm that the controlled substance is within the prescriber's scope of practice to prescribe.

- **Anticipated Co-Pay Requirements Using a Tiered Formulary** (Call Letter)
  - CMS will examine co-pay structures submitted by PDPs and anticipates that plans with co-payments above specified levels might be considered discriminatory.
• **Pharmacy and Medication Therapy Management Measures (MTM) for Inclusion in Plan Ratings and Performance (Call Letter)**
  o For 2012 and 2013, CMS will implement the following measures of interest to pharmacy for use in plan ratings:
    ➢ Medication adherence as a measurement of proportion of days covered according to the measure adopted by PQA.
    ➢ Advising Smoker and Tobacco Users to Quit.
    ➢ Requirement that special needs plans (SNPs) through MAs include medication reviews by prescribing practitioner or a clinical pharmacist, the presence of a medication list in the medical chart, and pain screening or pain management.

• **Simplification of Beneficiary Election Periods**
  o Beginning with plan year 2012, the annual coordinated election period will occur October 15 to December 7.

• **Approval of Special Needs Plans by the National Committee for Quality Assurance**
  o Effective January 1, 2012 all special needs plans (SNPs; Medicare plans with membership limited to those with specified diseases or conditions), existing, new, and those wishing to expand their service areas, must be approved by the National Committee for Quality Assurance (NCQA).
  o All SNPs must submit their model of care to CMS for NCQA evaluation and approval in accordance with CMS guidance.

• **Uniform Exceptions and Appeals Process for Prescription Drug Plans and MA–PD Plans**
  o Effective January 1, 2012, each PDP sponsor must use a single, uniform exceptions and appeals process.

• **Required Use of Electronic Transaction Standards for Multi-Ingredient Drug Compounds; Payment for Multi-Ingredient Drug Compounds**
  o NCPDP Telecommunications Standard Version D.0, which was adopted as the HIPAA standard that must be used by HIPAA covered entities for retail pharmacy drug claims on and after January 1, 2012, standardizes claims processing for compounded drugs.
  o Unlike the current version, in 2012 the pharmacy claim will reflect all ingredients of the compounded drug.

• **Part D Transition Requirements**
  o Effective January 1, 2012 the temporary supply of nonformulary drugs (including Part D drugs that are on a sponsor’s formulary but require prior authorization or step therapy under a sponsor’s utilization management rules) must be for up to at least 91 days, and up to 98 days, consistent with the dispensing increment, for beneficiaries residing in a LTC setting.

• **Medicare Advantage Benchmark, Quality Bonus Payments, and Rebate and Application of Coding Adjustment**
  o Beginning in 2012, benchmarks will be increased for plans that receive a 4-star or higher rating on a 5-star quality rating system.
  o The bonuses to plans will be 1.5 percent in 2012, 3.0 percent in 2013, and 5.0 percent in 2014.
  o Beginning with 2012, a qualifying plan means a plan that had a quality rating of 4 stars or higher based on the most recent data available for such year.
Summary of Key Changes for 2013

- **Improvements to MTM Programs**
  - Effective January 1, 2013 Part D sponsors must contract with LTC facilities to provide appropriate MTM services to residents in coordination with the monthly medication reviews and assessments performed by the LTC consultant pharmacist.
  - The final rule requires Part D sponsors to use a standardized format for the action plan and summary resulting from the annual comprehensive medication review, which includes a personal medication list, and permit the use of telehealth technology in the conduct of the CMR. CMS is finalizing these standard documents based on feedback received from stakeholders including APhA.
  - APhA will provide additional information as it becomes available.

- **CMS to Consider Use of MTM Measures and Other Measures in 2013** (Call Letter)
  CMS will consider incorporating MTM measures for comprehensive medication reviews. Other relevant measures under consideration for 2013 include: surveys of care coordination and preventable hospitalizations.

- **Appropriate dispensing of prescription drugs in long-term care facilities under PDPs and MA–PD plans**
  - Effective January 1, 2013, Part D sponsors must, when dispensing covered Part D drugs to enrollees in long-term care facilities, dispense solid oral doses of brand-name drugs in no greater than 14-day increments at a time. The law is further modified to collect and report the dispensing methodology used for each of these dispensing events and on the nature and quantity of unused brand and generic drugs.
  - Reporting on unused drugs is waived for Part D sponsors for drugs dispensed by pharmacies that dispense both brand and generic drugs in no greater than 7-day increments. Both solid oral doses of antibiotics and solid oral doses that are dispensed in their original container are also exempt from this requirement.
  - APhA will provide additional information as it becomes available.

**Conclusion**
This document summarizes some of the upcoming changes to the Medicare Advantage and the Medicare prescription drug benefit programs. For additional information, pharmacists should review the final rule and the Call Letter in their entirety to ensure awareness of and compliance with upcoming modifications to the law and related pharmacy practice.

**Resources**
- CMS Medicare Part D Resources
  [http://www.cms.gov/PrescriptionDrugCovGenIn/01_Overview.asp#TopOfPage](http://www.cms.gov/PrescriptionDrugCovGenIn/01_Overview.asp#TopOfPage)

- CMS Medication Therapy Management Resources
  [https://www.cms.gov/PrescriptionDrugCovContra/082_MTM.asp](https://www.cms.gov/PrescriptionDrugCovContra/082_MTM.asp)

- APhA Pharmacist.com Article