

NCPA Summary: Medicare Part D Proposed Rule Contract Year 2021 and 2022

NCPA is carefully analyzing the proposal¹ and will be seeking member input prior to commenting by the April 6th deadline. NCPA is pleased that CMS is recognizing the need for greater transparency and standardization of pharmacy performance in the Part D program, an issue NCPA has advocated for many years.

Pharmacy Performance:²

CMS proposes to require Part D sponsors to disclose to CMS the pharmacy performance measures they use to evaluate pharmacy performance to:

- Determine the extent to which the measures are appropriately applied across all pharmacy types;
- Explain if there is a pharmacy performance problem, “as pharmacy price concessions after the point-of-sale have continued to grow annually;”
- Enable predictable reimbursement for pharmacies and cost sharing for beneficiaries, “given the growing use of pharmacy performance measures in determining the final cost of a drug under Part D and the impact of these recoupment practices on the amount a beneficiary pays for a Part D drug at the POS.”

CMS encourages the industry to work together to develop a set of pharmacy performance measures and Part D sponsors to adopt such measures to ensure standardization, transparency, and fairness.

- CMS encourages Part D sponsors to use a third party, independent organization that is free of conflict of interest to assess pharmacy performance on such measures.
- CMS is encouraged by the efforts of the Pharmacy Quality Alliance (PQA) and stakeholders to create a standard that could be used in Part D.

CMS is also seeking comment on:

- Principles that Part D pharmacy performance measures should adhere to, including potential burden or hardship of performance measures on independent or rural pharmacies;
- Recommendations for potential Part D Star Ratings metrics related to these measures; and
- Data elements, timeline, and method of submission for the reporting of pharmacy performance measures.

Specialty Pharmacy:

CMS proposes to allow Part D plans to have up to two specialty tiers by permitting a new preferred specialty tier with lower cost sharing, beginning Jan. 1, 2021. CMS proposes to:

- Codify the maximum cost sharing for the higher specialty tier;
- Codify the methodology that determines and increases the specialty tier cost threshold;
- Require sponsors to permit tiering exceptions between the two specialty tiers; and
- Permit sponsors to determine which drugs go on either tier subject to the proposed cost threshold.³

¹ *Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly*, CMS-4190-P; RIN 0938-AT97 (Feb. 18, 2020).

² *Id.* at p. 220-223.

³ *Id.* at p. 177-178.

Real Time Benefit Tool:

CMS proposes to require each Part D plan to implement a beneficiary Real Time Benefit Tool (RTBT) by Jan. 1, 2022 that will allow enrollees to view patient-specific, real-time formulary and benefit information. Plans would be able to use existing secure patient portals, develop a new portal, or use a computer application to fulfill this requirement.⁴

Opioid Policies:

CMS implements the following SUPPORT Act provisions:⁵

- **Mandatory implementation of drug management programs (DMPs)** for at-risk beneficiaries by Part D sponsors beginning Jan. 1, 2022.⁶ Implementation has been optional since 2019, when Part D sponsors could first adopt them.
- **Modifies definition of “potential at-risk beneficiary”** to include an individual who has history of opioid-related overdose and requires inclusion of these beneficiaries in sponsors’ DMPs beginning Jan. 1, 2021.⁷
- **Suspension of pharmacy payments pending investigations credible allegations of fraud.**⁸ Starting Jan. 1, 2020, the SUPPORT Act allows Part D prescription drug plan sponsors and Medicare Advantage prescription drug plans to suspend payments to a pharmacy pending investigation of credible allegations of fraud. The plan sponsor shall notify CMS if the plan sponsor has suspended any payment to a pharmacy. A fraud hotline tip without further evidence must not be treated as sufficient evidence for a credible allegation of fraud. The Secretary must consult with the Inspector General of HHS in determining whether there is a credible allegation of fraud.
- **Expanding eligibility for medication therapy management programs in Part D.**⁹ Starting Jan. 1, 2021, at-risk beneficiaries for drug abuse in the Part D program shall be included in the list of targeted beneficiaries eligible for MTM services. Targeted beneficiaries will include beneficiaries who are determined to be ARBs under DMPs (defined above under DMP section).

⁴ *Id.* at p. 205. Note, this is different from the mandated prescriber RTBT that integrates prescribers’ e-prescribing and electronic medical records, which must be implemented by Jan. 1, 2021.

⁵ *Id.* at p. 78.

⁶ *Id.* at p. 78; required under section 2004 of the SUPPORT Act.

⁷ *Id.* at p. 81; required under section 2006 of the SUPPORT Act. CMS proposes to define “history of opioid-related overdose” to mean that for the Part D beneficiary, a recent claim has been submitted that contains a principal diagnosis code reflecting an opioid overdose, regardless of the type of opioid and at least one recent PDE for an opioid dispensed to such beneficiary has been submitted.

⁸ Section 2008 of the SUPPORT Act.

⁹ *Id.* at p. 94; required under section 6064 of the SUPPORT Act.