NCPA Preview of 2014 CMS Final Call Letter
April 2, 2013

NCPA is pleased that the Centers for Medicare & Medicaid Services has recognized and addressed in the final version of its "call letter" many of the egregious PBM practices that NCPA has alerted the agency to over the last several years. Below is a preview of the final call letter, including notable wins for community pharmacy. NCPA is preparing a more in-depth summary that we will distribute soon.

CMS Cracks Down on Auto-Ship Refill Programs in Part D

- In response to automatic delivery programs which CMS believes is leading to significant waste and increased costs to the Part D program, **CMS is telling Part D sponsors they should require their network retail and mail pharmacies to obtain patient consent to deliver a prescription, new or refill, prior to each delivery.**
- Such confirmation is unnecessary if the beneficiary personally initiates the refill or new prescription request.
- This does not affect retail refill reminder programs that require the patient to pick-up the prescription and does not apply to long-term care pharmacy dispensing and deliveries.
- This policy is expected to be implemented no later than January 1, 2014.
- Regarding existing auto-ship policies, CMS believes that current practices should be improved, and **if the beneficiary is unable or unwilling to communicate consent to each delivery, then mail-order or pharmacy delivery services may not be appropriate.**
- Stating the rationale behind this new requirement, CMS referenced NCPA's comments and stated,

> "We received a number of comments that indicate beneficiaries return large quantities of unneeded medications to community pharmacies for take-back programs because they were unable to stop auto-ship refill programs."

CMS Concerned with Sponsors Incentivizing Mail Order

- CMS stated that they are concerned with plans offering powerful incentives such as $0 or very low cost sharing for 30-day supplies at mail-service, without offering the same at retail. **These practices are driving purchasing behavior for beneficiaries for whom mail-service may not be a good option.**
- Referencing comments NCPA submitted, CMS stated that they "have already seen high complaint rates and numerous access problems around this issue in 2013. Furthermore, CMS referenced community pharmacists who spend a lot of time helping their customers resolve problems with switching to mail-order service. **Consequently, CMS is reconsidering 30-day mail-service benefit designs.**
- **Part D sponsors should anticipate that CMS may not approve 2014 benefit designs with extremely attractive mail-service cost sharing incentives for 30-day supplies if such cost sharing is not also available throughout their retail network.**

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CMS Addresses Reimbursement Issues Surrounding Short-Cycle Dispensing

- Beginning January 1, 2014, Part D sponsors must establish and apply a daily cost-sharing rate to certain prescriptions that are dispensed by a network pharmacy for less than 30 days' supply.
- While the call letter section regarding short cycle was only a reminder to sponsors of the upcoming requirements, CMS took the opportunity to address comments, like those submitted by NCPA, that demonstrated strong opposition to prorated dispensing fees by stating, **"if the reports of prorating dispensing fees are accurate, we are disappointed that sponsors would reimburse dispensing fees in a way that incentivizes wasteful dispensing of maximum amounts and at the same time financially penalizes the most efficient dispensing methodologies to reduce unnecessary waste and cost in the Part D program."**

CMS Pulls Back on Requiring Prior Authorizations for Hospice and ESRD Drugs

- NCPA opposed requirements in the draft call letter that, starting in January 2014, sponsors must place beneficiary–level prior authorization requirements on categories of drugs that "may be" Hospice or ESRD-related.
- In the final call letter CMS states they will **neither require nor encourage** extraordinary utilization management of these drugs but permit sponsors to use other approaches, such as pay-and-chase, to resolve payment responsibility for these drugs.

CMS Will Not Require Prior Authorization for Extemporaneous Compounds

- The call letter states that 50% of Part D compounds were from either a LTC or home infusion pharmacy and that more than 80% of sterile compounds were from LTC and home infusion pharmacies.
- In order to ensure that Part D only covers medically necessary Part D compounds, CMS proposed that pharmacies would need to obtain justification via prior authorization from the prescriber as to why no FDA approved product is clinically suitable for the patient.
- The final call letter references opposition, such as NCPA's, to these additional requirements on compounded drugs and states that CMS agrees with commenters "to wait for the results of other pending Federal actions" and will contemplate additional, future guidance on this issue.

CMS Sets Record Straight with Plan Sponsors Concerning Egregious Audit Practices

- CMS is concerned that the growing practice of post-audit total claim recoupments from pharmacies is distorting Part D payment, as well as compromising Part D data integrity and impairing ability to oversee the program.
- CMS restated its proposal in the original call letter that Part D plans can only recoup the full amount of a prescription claim under certain circumstances. These include fraudulent claim, duplicate claim, excluded provider, or the lack of a valid prescription.
- Plans can adjust claims (but not fully recoup) for such administrative issues such as wrong NPI, pharmacy service type, prescription origin code, or directions that don't match with the original claim. This should reduce the incidence of full claim recoupments for pharmacies for other than truly fraudulent claims.
- CMS will not introduce consistent standards across Part D plans regarding all PBM audit practices as such action is beyond the scope of this call letter.
- Regarding NPI submissions, CMS clearly states that the duty to resolve a missing or apparently incorrect NPI error is on the sponsor, not the pharmacy.

CMS Questions Preferred/Non-Preferred Pharmacy Networks

- CMS reminds Part D sponsors that preferred pharmacy networks are not allowed to increase CMS payments to the plans.
- CMS' initial results from scrutinizing part D drug costs in preferred vs. non-preferred networks suggest that costs may be higher in preferred networks than in non-preferred networks in some plans.
- In the final call letter CMS acknowledges NCPA's own analysis of costs being higher in preferred networks: "And one pharmacy association referred us to the findings of a study it had conducted which appears to corroborate our concerns."
- **CMS strongly believes that Any Willing Pharmacy that can meet the terms and conditions of the preferred arrangements in the sponsor's preferred network is the best way to encourage price competition and lower costs in the Part D program. Doing so would likely mitigate beneficiary disruption and travel costs, especially in rural areas. However, CMS states that mandating this policy is beyond the scope of the call letter.**

CMS addresses preferred network marketing tactics

- Beneficiary communication concerning preferred networks must be clear and unambiguous and under no circumstances may sponsors inform LIS beneficiaries that they must fill prescriptions at preferred network pharmacies in order to get LIS copays.
- Both written and verbal communications must be differentiated by LIS status, whether through mailings or Customer Service Representative (CSR) scripts.
- The designation of preferred and non-preferred networks must be accurate **at the time of bid submission.**
- **If a plan sponsor does not have contracted preferred pharmacy arrangements at the time of bid submission, that sponsor may not indicate the offering of a preferred network.**
- If a sponsor does not differentiate cost sharing between preferred and non-preferred networks, it may not designate any pharmacies in its network as preferred.