Medicare Part D Update:  
Navigating the Potholes and  
Discovering New Opportunities

Medicare Parts C & D  
Quality Measurement and  
Plan Ratings

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Disclosure

Vikki Oates does not have any actual or potential conflicts of interest in relation to this program.

Session Overview

• Pharmacies are an integral part of the success of Part D
• Today’s discussion will focus on:
  • Prescriber Identifiers
  • Coverage Gap Discount program
  • Medication Therapy Management
  • Plan Ratings
Prescriber Identifiers

- Medicare Advantage/Part D CY 2012 Call Letter
  - Any of 4 prescriber identifiers acceptable for CY2012 PDE records (e.g., NPI, DEA number, UPIN or state license number)
- Requirements will be discussed related to:
  - Pharmacy Claims
  - Beneficiary “paper claims”
  - Claims for DEA Schedule II-IV drugs
Reason for Requirement Changes for Prescriber Identifiers

• OIG released a report in June 2010 on Invalid Prescriber Identifiers on Medicare Part D Drugs.
  • Found $1.2 billion in payments associated with over 18 million PDE records from 2007 that contained 527,749 invalid prescriber identifiers

Prescriber Identifier Requirements

New Requirements for CY2012:
• Sponsors must ensure that prescriber identifiers are active and valid on PDE records submitted to CMS.
• “Paper claims” submitted by beneficiaries must contain a valid prescriber ID before PDE record is submitted.
• Sponsors must confirm validity of DEA numbers on Schedule II-IV controlled substance drugs or map NPIs for these drugs to a prescriber’s DEA number.
  • Part D requirements do not alter existing DEA (or state) requirements for validation.
Coverage Gap Discount Program

What is the Coverage Gap?

• Until 2011 beneficiaries paid 100% of covered drug costs in between 2 phases of the drug benefit.

• The term “coverage gap” refers to the phase of the Part D benefit between the Initial Coverage Limit (ICL) and the Catastrophic Threshold.

• For example, in the 2011 standard benefit, the coverage gap begins after total spending reaches $2,840 and continues until the beneficiary’s out-of-pocket expenditures reach $4,550.
### Affordable Care Act Approach

<table>
<thead>
<tr>
<th>Year</th>
<th>Phase</th>
<th>Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Phase One</td>
<td>Beneficiary Rebates</td>
</tr>
<tr>
<td>2011</td>
<td>Phase Two</td>
<td>Point-of-sale Discounts</td>
</tr>
<tr>
<td>2012 to 2020</td>
<td>Phase Three</td>
<td>Movement towards 25% Cost Sharing</td>
</tr>
</tbody>
</table>

### Example, Standard Benefit 2010

![Diagram illustrating total covered drug spending with phases labeled as follows:
- Initial Coverage Limit
- Out-of-pocket Threshold
- Catastrophic Coverage
- 75th Plan Pays
- Coverage Gap
- 80th Reinsurance
- 25th Coinurance
- Medicare Pays Reinsurance
- Direct Subsidy Beneficiary Premium
- Beneficiary Liability](image)
Impact on Benefit 2010-2020
2011 Standard Benefit

2011 – Point Of Sale Discounts

Process designed to be seamless to beneficiaries
- CMS provides estimated prospective payments for coverage gap discounts to Part D sponsors
- Part D sponsors advance discounts at POS on coverage gap claims and submit discount information to CMS on PDEs
- Third party administrator (TPA) invoices manufacturers
- Manufacturers reimburse Part D sponsors directly
- CMS offsets amounts against future Part D sponsor payments
2011 Beneficiary POS Payments Include

- Approximately 50% - brand-name drugs from contracted manufacturers
- 93% of generic drug costs
- Dispensing Fee
- Taxes
- For "Straddle" claims
  - Proportion of drug costs that fall in the Coverage Gap
  - Dispensing fee

Phase 3, 2011 to 2020 Movement to 25% Cost Sharing

- Beneficiaries to receive savings until the donut hole is "completely closed" in 2020.
- Medicare coverage increases.
  - For brand-name drugs to augment manufacturer-sponsored discounts.
  - For generic drugs coverage increases 7% per year.
- Ultimately beneficiaries will be responsible for only 25% coinsurance payments rather than paying 100% of the costs as they did prior to ACA.
Phase 3, 2011 to 2020
Movement to 25% Cost Sharing

<table>
<thead>
<tr>
<th>Year</th>
<th>Brand-name Drugs</th>
<th>Generic Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>50%</td>
<td>93%</td>
</tr>
<tr>
<td>2012</td>
<td>50%</td>
<td>86%</td>
</tr>
<tr>
<td>2013</td>
<td>47.5%</td>
<td>79%</td>
</tr>
<tr>
<td>2014</td>
<td>47.5%</td>
<td>72%</td>
</tr>
<tr>
<td>2015</td>
<td>45%</td>
<td>65%</td>
</tr>
<tr>
<td>2016</td>
<td>45%</td>
<td>58%</td>
</tr>
<tr>
<td>2017</td>
<td>40%</td>
<td>51%</td>
</tr>
<tr>
<td>2018</td>
<td>35%</td>
<td>44%</td>
</tr>
<tr>
<td>2019</td>
<td>30%</td>
<td>37%</td>
</tr>
<tr>
<td>2020</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Impact on Benefit 2010-2020
2020 Standard Benefit
Where We Are Today
Beneficiaries in the GAP

![Graph showing beneficiaries in the GAP over time.]

Where We Are Today
Total Discounts

![Graph showing total discounts over time.]

- Discount Amount (cumulative)
- Discount Amount (by month)
Medication Therapy Management (MTM) Update

MTM Programs

- All Part D sponsors must submit their MTM program descriptions to CMS annually for review and approval.
  - Requirements for the MTM programs have become more robust.
  - Reporting of data related to the implementation of the MTM programs has become more comprehensive.
- CMS is focused on identifying potential opportunities to increase awareness of MTM programs among beneficiaries.
MTM Program Criteria

- Plan Finder will provide Medicare beneficiaries 2012 MTM program eligibility information.
- The information will be displayed via a link on the “Your Plan Results” page for MA-PDs and PDPs.
  - Link: View Plan Medication Therapy Management (MTM) Program Eligibility Information.
  - Clicking the link opens an Excel spreadsheet and Glossary posted on the CMS website.
- The table will list information from sponsors’ CMS-approved 2012 MTM programs from the HPMS MTM Program Submission Module, including programs approved during the upcoming September update window.

Sample: Plan Results Page: PDPs
Sample: MTM Definition

Table Mock-up

<table>
<thead>
<tr>
<th>Two ways to find an MTM Program</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>REQUIREMENT 1: Your Health Conditions</td>
<td>REQUIREMENT 2: Drugs You Take</td>
<td>REQUIREMENT 3: Your Drug Spending</td>
<td></td>
</tr>
<tr>
<td>Sort by Plan Contract Number</td>
<td>Sort by Plan Name</td>
<td>Sort by Plan Type</td>
<td>You must have AT LEAST this many health conditions</td>
</tr>
</tbody>
</table>
| Note: You must meet all 3 requirements to qualify for the MTM program.
Affordable Care Act and MTM

- Section 10328 of the Affordable Care Act requires the development of a standard action plan and written summary that will be provided to beneficiaries following a comprehensive medication review.
- CMS has developed a standard format and written summary. It was published in the Federal Register for a 60-day comment period.
- During this 60-day period, an expert panel was conducted along with beneficiary, provider, and plan testing. The final 30-day comment period will begin in October.
- Part D plans must begin utilizing this form and summary starting January 1, 2013.

Plan Ratings Design and Enhancements
Plan Ratings
Why it is Important to Plans

• With the Affordable Care Act, Plan Ratings are now tied to Bonus Payments for Medicare Advantage plans.
• The Plan Ratings information is integrated into the Medicare Plan Finder (MPF) and is posted on the CMS website.
• Beneficiaries will have a special enrollment period to switch plans if they are in a low performing plan.
• Beneficiaries are relying on these ratings to incorporate into their enrollment decision making.

Quality Bonus Payments (QBPs)

• QBPs are part of the national strategy for implementing quality improvement in health care.
• Under the Affordable Care Act, starting in 2012 MA plans with a star rating of 4 or higher would qualify for a QBP.
• However, CMS implemented a three-year demonstration to test whether providing scaled bonuses leads to more rapid and larger quality improvements in MA program quality scores.

<table>
<thead>
<tr>
<th>Quality Bonus % (2012, 2013, 2014)</th>
<th>1 and 2 stars</th>
<th>3 stars</th>
<th>3.5 stars</th>
<th>4 stars</th>
<th>5 stars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Law</td>
<td>none</td>
<td>none</td>
<td>none</td>
<td>1.5%, 3%, 5%</td>
<td>1.5%, 3%, 5%</td>
</tr>
<tr>
<td>Demonstration</td>
<td>none</td>
<td>3%</td>
<td>3.5%</td>
<td>4%, 4%, 5%</td>
<td>5%</td>
</tr>
</tbody>
</table>
Plan Ratings – 3 Levels of Stars

Overall and Summary Rating (1/2 stars)

Domain

Staying Healthy

Patient Safety

Measure

Breast Cancer Screening

Annual Flu Vaccine

High Risk Med Use

Data

75% screened

75% vaccinated

10% members receive HRM

Plan Ratings Filter

There are a total of 51 plans available in your area.
You are now viewing 2011 plan data. View 2010 plan data.
Sample Plan Comparison

<table>
<thead>
<tr>
<th>Overall Plan Rating</th>
<th>Plan A (S****-***)</th>
<th>Plan B (S****-***)</th>
<th>Plan C (S****-***)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.5 out of 5 stars</td>
<td>3.5 out of 5 stars</td>
<td>4 out of 5 stars</td>
</tr>
</tbody>
</table>

**Prescription Drug Plan Ratings**

<table>
<thead>
<tr>
<th>Plan A (S****-***)</th>
<th>Plan B (S****-***)</th>
<th>Plan C (S****-***)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug Plan Customer Service</strong></td>
<td><strong>Drug Plan Customer Service</strong></td>
<td><strong>Drug Plan Customer Service</strong></td>
</tr>
<tr>
<td>3 out of 3 stars</td>
<td>3 out of 3 stars</td>
<td>3 out of 3 stars</td>
</tr>
<tr>
<td>Time on Hold When Customer Calls Drug Plan</td>
<td>Time on Hold When Customer Calls Drug Plan</td>
<td>Time on Hold When Customer Calls Drug Plan</td>
</tr>
<tr>
<td>****</td>
<td>****</td>
<td>****</td>
</tr>
<tr>
<td>Time on Hold When Pharmaceutical Calls Drug Plan</td>
<td>Time on Hold When Pharmaceutical Calls Drug Plan</td>
<td>Time on Hold When Pharmaceutical Calls Drug Plan</td>
</tr>
<tr>
<td>****</td>
<td>****</td>
<td>****</td>
</tr>
<tr>
<td>Availability of TTY/VOI Services and Foreign Language Interpretation When Members Call the Drug Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>****</td>
<td>****</td>
<td>****</td>
</tr>
</tbody>
</table>

Implemented for CY2011

- Overall combined Part C and D Rating for MA-PDs available.
- Low performing icon displayed on Medicare Plan Finder (PF) for contracts with less than 3 stars for the Part C and/or D summary rating for the prior 3 years.
- Used minimum thresholds for CMS’ assignment of 4 stars.
  - Other star assignments are based on the distribution of data.
- When a CMS standard is reached, a contract receives 3 or more stars (e.g., call center hold time).
Changes for 2012 Plan Ratings

Plan Ratings Strategy

- The current Plan Ratings strategy, laid out in the 2012 Call Letter is consistent with the Three Part Aim (better care, healthier people/healthier communities, and affordable care) with measures spanning five broad categories:
  - Outcomes
  - Intermediate outcomes
  - Patient experience
  - Access
  - Process
CMS’ Request for Comments

- Sponsors and stakeholders were solicited for comments in three main areas:
  - Which measures should be included when calculating quality improvement in the Medicare Advantage and Part D Plan Ratings?
  - Which measures should CMS potentially retire from the Plan Ratings?
  - How should CMS weight the quality and performance measures that are part of the Plan Ratings?

2012 Changes for Plan Ratings

- Call Letter 2012 Update
- Measure Updates
  - New measures
  - Retirement of measures
- Weighting of Measures
- High Performing Contracts
- Special Enrollment Period
- Low Performing Contracts
- Adjustment for Sanctioned Contracts
- Future Directions
# 2012 Call Letter

## Potential Enhancements

<table>
<thead>
<tr>
<th>Measure</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighting of measures</td>
<td>Implemented for the 2012 Plan Ratings</td>
</tr>
<tr>
<td>Reducing the ratings for serious compliance issues</td>
<td>Implemented for the 2012 Plan Ratings</td>
</tr>
<tr>
<td>Rewarding contracts for quality improvement</td>
<td>Delayed</td>
</tr>
<tr>
<td>Controlling for concentration of providers in a geographic area</td>
<td>Delayed</td>
</tr>
</tbody>
</table>

## Potential New Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-cause Readmissions (Part C)</td>
<td>Implemented</td>
</tr>
<tr>
<td>Advising Smoker and Tobacco Users to Quit (Part C)</td>
<td>Not implemented (reliability issues)</td>
</tr>
<tr>
<td>Body Mass Index (Part C)</td>
<td>Implemented</td>
</tr>
<tr>
<td>SNP-specific Measures: 3 Rates (Part C)</td>
<td>Implemented</td>
</tr>
<tr>
<td>Measures from Hospital IQR (Part C)</td>
<td>Delayed</td>
</tr>
<tr>
<td>Voluntary Disenrollment (Part C and D)</td>
<td>Implemented</td>
</tr>
<tr>
<td>Transition Process (Part D)</td>
<td>Delayed</td>
</tr>
<tr>
<td>Medication Adherence: 3 Rates (Part D)</td>
<td>Implemented</td>
</tr>
</tbody>
</table>
## Average Stars for New Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Stars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan All-Cause readmissions</td>
<td>3.34</td>
</tr>
<tr>
<td>Care for Older Adults – Medication Review (SNP)</td>
<td>3.54</td>
</tr>
<tr>
<td>Care for Older Adults – Functional Status Assessment (SNP)</td>
<td>2.81</td>
</tr>
<tr>
<td>Care for Older Adults – Pain Screening (SNP)</td>
<td>2.72</td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>2.81</td>
</tr>
<tr>
<td>Members Choosing to Leave the Plan</td>
<td>3.22 (MA) ; 3.66 (PDP)</td>
</tr>
<tr>
<td>Medication Adherence – Cholesterol</td>
<td>3.03</td>
</tr>
<tr>
<td>Medication Adherence – Diabetes</td>
<td>3.05</td>
</tr>
<tr>
<td>Medication Adherence – Blood Pressure</td>
<td>3.05</td>
</tr>
</tbody>
</table>

## Patient Safety Reports and Website
Patient Safety Analysis Website

- Allows Part D sponsors to compare their performance to overall averages and monitor their progress in improving the Part D patient safety measures.
- Access to actionable monthly reports:
  - Performance graph and high-level rate summaries.
  - Contract-level patient safety reports for expanded analyses and information.
  - Detailed beneficiary-claim level and outlier reports.

Available Patient Safety Reports

- Adherence (ADH) Measure Report**
- High Risk Medication (HRM) Measure Report*
- Diabetes Treatment (DT) Measure Report*
- Drug-Drug Interaction (DDI) Measure Report**
- Diabetes Medication Dosing (DMD) Measure Report**

* Part D Plan Rating on Medicare.gov Plan Finder
** Part D Display Measure on CMS.gov
Website Enhancements from Plan Feedback

- Development of beneficiary-level, prescriber-level, service-provider, and claim-level files to Patient Safety reports.
- Additional flags on claim-level file, which allows plans to identify new Patient Safety occurrences within a report.

Retirement of Measures

- We consider retiring measures where contracts have “topped out,” or additional improvements are not practical.
- Monitoring will continue in these areas; CMS may take compliance actions against contracts falling outside CMS’ standards.
- Measures will be added to display page at http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp
Measures Retired for 2012

Measures to be posted on CMS Display page
http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp

- Appropriate Monitoring for Pts Taking Long Term Meds (Part C)
- Osteoporosis Testing (Part C)
- Doctors who Communicate Well (Part C)
- Testing to Confirm Chronic Obstructive Pulmonary Disease (Part C)
- Call Center – Customer/Beneficiary Hold Time (Part C and D)
- Call Center – Information Accuracy (Part C and D)
- Drug Plan Provides Pharmacists with Up-to-Date and Complete Enrollment Information about Plan Members (Part D)
- Completeness of the Drug Plan’s Information on Members Who Need Extra Help (Part D)

Weighting of Measures

- Previously all measures were weighted equally, suggesting equal importance
- Feedback received from stakeholders showed:
  - Plan Preferences:
    Intermediate Outcome > Outcome and Process > Patient Experience > Access
  - Advocate Preferences:
    Intermediate Outcome > Patient Experience > Outcomes and Process > Access
Methodology to Determine Weighting

- CMS created simulations based on stakeholder feedback; both plan and advocate recommendations tended to reduce rather than increase average star rates
- CMS also modeled various options that weight outcomes, intermediate outcomes, and/or patient experience more than other measures
- The 2012 Plan Ratings weights:
  Outcomes and Intermediate Outcomes (3) >
  Patient Experience and Access (1.5) >
  Process (1)

2012 Plan Ratings Weights

- 2012 Plan Ratings will:
  - Weight outcomes and intermediate outcomes 3x as much as process measures
  - Weight patient experience and access measures 1.5x as much as process measures
High Performing Icon

• CMS will highlight contracts receiving an overall or summary rating of 5 stars with this icon:

  ![This plan got Medicare's highest rating (5 stars)](image)

• Information on medicare.gov will note that beneficiaries can enroll in 5-star plans at any time during the year.

Special Enrollment Period

• CMS will establish a Special Enrollment Period (SEP) beginning in 2012 to allow MA and PDP beneficiaries to enroll in 5-star plans.

• Beneficiaries can use this special enrollment period once per year.

• Plans will be able to market year round.

• More detailed information on the SEP was provided in a memo and the 2012 Call Letter.
Low Performing Contracts

- Since 2011, CMS has marked plans rated less than 3 stars with a low performer icon.
- An additional cautionary message will appear on the MPF for beneficiaries selecting to enroll in these plans.
- 1-800 Medicare representatives will also reiterate the low performance of these plans to discourage enrollment.

Sanctions

- Contracts with serious compliance issues (i.e., CMS has issued enrollment sanctions), will have their 2012 Plan Ratings reduced:
  - Contracts under sanction with 3 or more stars will be automatically assigned 2.5 stars.
  - Contracts under sanction with less than 3 stars will receive a 1-star reduction.
Sanctions (cont.)

- CMS will evaluate and adjust Plan Ratings at two periods each year:
  - August 31: Plan Ratings will be adjusted for current sanction status on the Medicare Plan Finder (MPF), consistent with MPF schedule
  - March 31: Plan Ratings will be updated for contracts whose sanctions have ended and for contracts newly sanctioned, for quality bonus payment purposes and for updating the MPF

Technical Notes

- Technical notes combine information for the Part C & D Plan Ratings
  - [http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp#TopOfPage](http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp#TopOfPage)

- *Plan Ratings Go Live October 12, 2011*
Future Directions for CY2013 and Beyond

Future Directions

- In support of the Three Part Aim, the emphasis on patient experience measures may increase in future years through CMS’ weighting methodology.
- We are exploring options for rewarding contracts for improvement in future years.
- CMS will continue to provide details about these changes in the 2013 and future Call Letters.
### Potential Additional Measures for CY2013 Plan Ratings

- Survey measures of care coordination
- Case-mix adjusted mortality rates
- Preventable hospitalizations
- Serious Reportable Adverse Events
- Grievances
- Use of highly rated hospitals by plan members
- Evaluation of a contract’s Chronic Care Improvement Program (CCIP) and Quality Improvement Project (QIP)
- Medication therapy management (MTM) measures

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### Resources

- Part C measures: PartCRatings@cms.hhs.gov
- Part D measures: PartDMetrics@cms.hhs.gov
- MTM: PartD_MTM@cms.hhs.gov
Medicare Part C/D Performance Measures

Implications and Opportunities for Community Pharmacy

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Senior Director, Pharmacy Quality Alliance

Disclosure

David Nau does not have any actual or potential conflicts of interest in relation to this program.
Implications for Community Pharmacy

- All Medicare plans have incentives to improve quality (e.g., marketing, enrollment advantages)
- Medicare Advantage plans will have even greater financial risks for quality in 2012 (QBPs)
- The plans’ incentives/risks will cascade to the pharmacy network contracts
  - Preferred networks for high-performing pharmacies
  - Public reports on pharmacy quality
  - Pay-for-performance incentives

How Should Pharmacies Prepare?

- Learn about Medicare plan (star) ratings
- Know the “stars” for your key plans
- Self-assess your store on adherence & safety
- Identify services that can improve star ratings
  - Medication adherence & safety interventions
  - Medication therapy management
- Be willing to partner with other pharmacies to implement common services to drive stars (more stores = more leverage)
Key Points on Medicare Plan Ratings

- Part C (Medicare Advantage) = 36 measures
- Part D (MA-PD and PDP) = 17 measures
- PQA developed/maintains 5 of the current Part D measures (adherence and safety measures)
- The PQA measures address “intermediate outcomes” and thus are weighted more heavily than the other Part D measures that address process (e.g., wait time on phone).

Pharmacy Quality Alliance (PQA)

- Started in 2006 (NCPA was a founding member)
- Non-profit, multi-stakeholder, membership organization (70 member organizations today)
  - Pharmacy associations and pharmacies
  - Health plans and PBMs
  - Pharmaceutical research/manufacturers
  - Government agencies (CMS, FDA)
  - Others (e.g., AARP, Surescripts, Mirixa)
Pharmacy Quality Alliance (PQA)

- Develops & tests “quality measures” related to medications that could be used for evaluation of drug plans and pharmacies
- Uses consensus-driven process through workgroups, expert panels and member voting
- Workgroups and expert panels comprised of pharmacists, physicians & other clinicians
- Promotes harmonization of quality measures with other quality-measurement groups

PQA Measures (Examples)

- Medication adherence:
  - Proportion of Days Covered (PDC)
    - Oral diabetes medications
    - ACEI/ARB medications
    - Cholesterol (statin) medications

- Medication safety/appropriateness:
  - High-risk medications in the elderly
  - Use of ACEI/ARBs in patients with diabetes and HT
  - Drug-drug interactions
### Medicare Part D – 2012 Benchmarks

<table>
<thead>
<tr>
<th></th>
<th>MA-PD</th>
<th>PDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDC – Diabetes</td>
<td>73.0%</td>
<td>74.4%</td>
</tr>
<tr>
<td>PDC – ACEI/ARB</td>
<td>72.2%</td>
<td>74.3%</td>
</tr>
<tr>
<td>PDC – Statins</td>
<td>68.0%</td>
<td>69.1%</td>
</tr>
<tr>
<td>Diabetes – ACEI/ARB  Use</td>
<td>84.1%</td>
<td>82.2%</td>
</tr>
<tr>
<td>High-Risk Medications</td>
<td>20.0%</td>
<td>22.2%</td>
</tr>
</tbody>
</table>

### Medicare Part D – 2012 Star Thresholds

<table>
<thead>
<tr>
<th></th>
<th>3-star</th>
<th>4-star</th>
<th>5-star</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MA-PD</td>
<td>PDP</td>
<td></td>
</tr>
<tr>
<td>PDC – Diabetes</td>
<td>70.7%</td>
<td>74.9%</td>
<td>78.8%</td>
</tr>
<tr>
<td>PDC – ACEI/ARB</td>
<td>70.1%</td>
<td>74.8%</td>
<td>77.9%</td>
</tr>
<tr>
<td>PDC – Statins</td>
<td>67.4%</td>
<td>70.8%</td>
<td>75.2%</td>
</tr>
<tr>
<td>Diabetes – ACEI/ARB  Use</td>
<td>83.2%</td>
<td>86.0%</td>
<td>87.3%</td>
</tr>
<tr>
<td>High-Risk Medications</td>
<td>≤22.2%</td>
<td>≤14.0%</td>
<td>≤9.3%</td>
</tr>
</tbody>
</table>
Part C Measures – 2012 Star Thresholds

Measures that can be impacted by pharmacists

<table>
<thead>
<tr>
<th>Measure</th>
<th>3-star</th>
<th>4-star</th>
<th>5-star</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes – Glycemic Control</td>
<td>60%</td>
<td>80%</td>
<td>88%</td>
</tr>
<tr>
<td>Diabetes – Cholesterol Control</td>
<td>43%</td>
<td>53%</td>
<td>66%</td>
</tr>
<tr>
<td>Blood Pressure Control</td>
<td>49%</td>
<td>63%</td>
<td>71%</td>
</tr>
<tr>
<td>SNP Plans – Medication Review</td>
<td>45%</td>
<td>67%</td>
<td>82%</td>
</tr>
<tr>
<td>Annual Flu Vaccine</td>
<td>65%</td>
<td>71%</td>
<td>76%</td>
</tr>
</tbody>
</table>

Quality Based Payments – Big Deal?

- The 2012 Medicare Advantage (MA) Rates were released in April 2011, and show how the star ratings will affect the CMS payments to MA plans.

- The difference in payment between 3-star and 5-star plans averages $16 per member per month but varies by the county of residence for the Medicare beneficiary.

- If a plan with 1 million MAPD members could increase its stars from 3 to 5, the plan’s revenue could increase by nearly $200 million per year.
Key Services to Consider: Adherence

- Reminders & auto-fill
- Refill synchronization
- Medication therapy management
- Point-of-dispensing screening of risk for non-adherence (diabetes and CVD medications)
- The last two strategies are being tested in PQA demonstration projects
- NCPA has many resources for adherence

E-QuIPP Initiative

- The E-QuIPP Initiative is being launched this Fall by PQA (2-3 states in 2011-12)
- Through E-QuIPP, community pharmacies can obtain their scores on PQA quality measures based on data from health plans or PBMs
- Pharmacies can also obtain access to quality improvement tools and other resources through E-QuIPP web-based platform
- Coming soon to your state
Refill Synchronization

Getting in Sync with Adherence Ratings

Kacee Blackwell, PharmD
Disclosure

Kacee Blackwell does not have any actual or potential conflicts of interest in relation to this program.

Learning Objectives

1. List three operational and/or beneficiary changes to the Medicare Part D program for 2012 and what pharmacies can do to prepare.
2. Describe two quality measures that are currently being measured in the Medicare Part D program.
3. Discuss the significance of the Medicare Part D plan ratings program and its potential future impact on community pharmacies.
Introduction

- Improve adherence through refill synchronization
- Pharmacy background
- Sync program basics
- Patient Centric Model data
- Patient benefits
- Pharmacy benefits

Yale Drug

- Rural, independent community pharmacy
- North central Oklahoma ~ 45 miles W of Tulsa
- Yale population ~ 1500 people
- Nearest prescriber is 10 miles away
- Nearest pharmacy is 9 miles away
- Primarily Medicare and/or Medicaid patients
- Many uninsured patients
Pharmaceutical Services

- Basic compounding
- Immunizations
  - Influenza
  - Zoster
  - Tdap
  - Pneumococcal
- Medication Therapy Management
- Delivery
- Long-Term Care

Synchronized Refills

- Initiated May 2009
- National Alliance of State Pharmacy Associations (NASPA)
  - Patient-Centric System (PCS) or Model (PCM)
  - Appointment-Based Model (ABM)
- Workflow Organization for “Frequent Fliers”
The Basics

- Review medication list and refill history
- Assign refill date
  - Highest copay
  - Number of Rx’s due near same date
  - Package restriction (30-day inhaler)
  - Patient preference (payday)
- Dispense “partial” fill to sync next fill date
  - Example:
    - 3 of 4 Rx’s due to fill on 21st
    - Other Rx is due on 8th
    - Fill 13 days supply of this Rx so that it will also be due on 21st
    - Then refill all four Rx’s on 21st for a 30 day supply

Getting Started

- “Frequent fliers”
  - Highest Rx counts - 18+!
  - “Traffic jam” waiters
  - Complainers
- Deliveries
- Adult caregivers
- Word of mouth
- Slow, steady growth
Improving Adherence

- Patient Centric Model
  - Pilot Data Analysis Report (Holdford & Inocencio)
  - Persistent patient – refill 80% of Rx’s within 15 days of due date
  - 56.8% of non-persistent patients became persistent after PCM intervention
  - ACEi/ARB - highest Rx volume
    - 33% non-persistent pre-intervention
    - 25% for 6 months post-intervention

Patient Benefits

- Create convenience
  - Fewer trips to pharmacy
  - Saves time/gas
- Avoid administrative gaps
  - Waiting for refill authorization from prescriber
  - Waiting for third party prior authorization
  - Out-of-stock medication
- Accountability
  - Personal communication with pharmacist/staff
Clinical Relevance

• Patients’ entire medication regimen filled together
• Time to make interventions
  • Uninterrupted counseling
• Changes in therapy identified
• Optimization opportunities more apparent

Change in Therapy Case

• Dr. verbally instructs pt to down from BID to daily w/o new Rx given.
• Rx will continue to show #60 for 30 days but refilled every 60 days (non-adherent).
• Pharmacy records will continue to show sig of BID (sharing with other providers).
• Pharmacist can more easily identify to request new Rx.
Optimization Opportunity

- Bupropion SR 150 mg being taken daily instead of BID (as written)
- Request Rx change to bupropion XL for once daily dosing

Yale Drug Sync Stats

- Pharmacy fills 250-300 Rx’s per weekday
  - Includes LTC
- Started synchronized refill program May 2009
- Currently 115+ patients enrolled
  - Approximately 825 Rx’s filled each month by sync
  - About 18% of our total “outpatient” Rx’s
  - At least 50% of patients with average 6+ Rx’s
  - Highest Rx count: 18
  - Lowest Rx count: 1
Enhanced Efficiency

• Decrease pharmacy phone calls
• Prevent dispensing “traffic jam”
• Reduce delivery frequency
• Eliminate IOU’s

Promote Loyalty

• Mail-order refusal
• Move out of town
• Independent advantage
Conclusion

- Improving adherence
  - Your role
  - Your responsibility
- Synchronized refills
  - Win/win for patients & pharmacy

Questions & Answers