Pharmacy Newsletter
Q1 2024

Looking for Ways to Improve Star Ratings? Focus on Medication Management

The Centers for Disease Control and Prevention (CDC) estimates six out of 10 adults in the U.S. have a chronic disease.[1] Appropriate pharmacotherapy is a key component of managing chronic conditions, but prescribing the medication is only the first step – medications won't work if you don't take them.

The Centers for Medicare & Medicaid Services (CMS) Part D medication adherence Star Rating measures help increase the number of Medicare members taking their cholesterol (statin), diabetes and/or hypertension (RAS antagonist) medications as prescribed. CMS considers a member adherent with their medication if they have a proportion of days covered (PDC) of 80% or higher.[2] According to the Pharmacy Quality Alliance (PQA), the PDC is the percent of days in the measurement period covered by prescription claims for the same medication or another in its therapeutic category, and the PDC threshold is the level above which the medication has a reasonable likelihood of achieving the most clinical benefit.[3] These Star Ratings are given a triple weight by CMS, increasing the impact they have on overall ratings.

Many factors can affect a patient's adherence to their medications and impact their ability to control their condition as their provider prescribed. Cost can often have an impact on adherence to medication – for most of our plan members for 2024 all Part D covered formulary medications are available for a $0 co-pay, helping to remove some of the financial barrier to medication adherence and access. Adherence rates also depend on a patient's agreement and ability to adhere to prescriber recommendations. Higher patient satisfaction is 1.2 times more likely to lead to adherence.[4] The following tips and discussion can help address adherence and improve patient engagement with their medication therapy:

- **Health literacy.** Talk to patients about why they're on their medication, and the impact of not taking their medication as prescribed. For example, their statin medication is not just to lower their cholesterol numbers, but to prevent heart disease and stroke.
- **Discuss and address adherence barriers.** Make this a part of each visit when reviewing medications. Ask patients questions about concerns they have related to side effects, accessing their medications, or concerns about taking their medication. Consider asking patients to bring in their current medication bottles to help with the discussion. As an example, 2019 CMS data shows that only 50% of patients were reminded about prescription refills, and only 33% were reminded to take their medications.[5]
- **Set expectations for length of treatment:** If treating a condition requiring ongoing therapy, set expectations about getting timely refills to prevent large gaps between fills. This is especially important when discussing a new therapy or renewing refills.
- **Consider extended days' supply prescriptions:** When clinically appropriate, consider writing extended day supplies for prescriptions for chronic conditions - our plans cover 100-day supply prescriptions for patients. This helps with patient convenience and minimizes the need for additional trips to the pharmacy, especially if that is a barrier to getting their medications.

AmeriHealth Caritas
VIP Care

- **Do the directions on the label match the current dose?** If the dose or frequency is changed, inform the pharmacy to void the old prescription and send a new prescription with the current directions to the pharmacy. Verbally informing a patient to change their directions will not match the current pharmacy claim, potentially impacting their adherence calculation. Even if following how verbally instructed, this may cause them to appear non-adherent to their current medication.
- **Reminders:** There are many options available to help remind patients to take their medication. This includes pill boxes, refill reminder messaging from pharmacies, and programs like medication synchronization to "match up" fills of multiple medications on the same day, improving convenience for the patient.

How else can taking the right medications impact Star Ratings?

The CMS Star Ratings also include several other measures that are impacted by getting the appropriate medications prescribed and taken consistently. For chronic conditions such as hypertension and diabetes, appropriate pharmacotherapy is important to managing and controlling the condition. In addition, chronic conditions of diabetes and hypertension can also increase risk for cardiovascular disease and stroke and may be appropriate to consider for preventative statin therapy. The following Star Ratings reflect these outcomes:

- **Statin Use in Persons with Diabetes:** Percentage of Medicare members with diabetes ages 40 – 75 who receive at least one fill of a statin medication in the measurement year. Members with diabetes are defined as those who have at least two fills of diabetes medications during the measurement year.
- **Statin Therapy in Patients with Cardiovascular Disease:** Percentage of males ages 21 – 75 and females ages 40 – 75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and received moderate or high intensity statin therapy.
- **Controlling Blood Pressure (BP):** The percentage of members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled at <140/90 mmHg.
- **Glycemic Status Assessment for Patients with Diabetes (GSD):** The percentage of diabetic enrollees age 18-75 whose most recent glycemic status (hemoglobin A1c [HbA1c] showed their blood sugar is under control during the measurement year adequate control is < 8.0%, poor control is > 9.0%

1. https://www.cdc.gov/chronicdisease/index.htm Accessed 03/06/2024
2. https://www.cms.gov/files/document/2024-star-ratings-technical-notes.pdf Accessed 03/06/2024
3. https://www.pqaalliance.org/adherence-measures Accessed 10/04/2023
4. 2. Nasir NM, Ariffin F, and Yasin SM. Physician-patient interaction satisfaction and its influence on medication adherence and type-2 diabetic control in a primary care setting. Med J Malaysia. 2018;73(3):163-169.
5. Centers for Medicare & Medicaid Services, Medicare 2020 Part C & D Display Measure Technical Notes, December 9, 2019. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/ PrescriptionDrugCovGenIn/Downloads/2019-Technical-Notes.pdf

Tips and Tricks to Manage Coverage Determination and Appeals Requests: How to Manage Your Patient's Drug Formulary Restrictions

Formulary restrictions due to changes in current formulary, or a patient switching to a new plan with different coverage options for their medications can bring new challenges for managing your patient's medications. We want to help avoid this transition period becoming a headache for you – and ease the potential burden of coverage determinations and appeals.

What are coverage determination requests and what are the types of requests?

A coverage determination (also called prior authorization) is defined as the receipt of, or payment for, a prescription drug that a beneficiary/patient believes may be covered under his/her Medicare Part D drug plan. There are many different types of coverage determinations that a beneficiary/provider/or beneficiary's appointed representative can request, which are as follows:

- **Formulary Exception** - a request that applies to medications which are not on the plan's formulary
- **Tiering Exception** - a request to have a medication pay at a lower cost share
- **Quantity Limit Exception** - a request that asks for a larger quantity of medication than the limits set forth by the health plan.
- **Step Therapy** - a request to forgo trying a first line or preferred agent in lieu of another agent
- **Drug with Prior Authorization Criteria**

Coverage determination request time frames

The time frames required for review are defined under Medicare Part D. Coverage determinations need to be reviewed within a specific time frame to provide patients with the best possible care so that there is no interruption in therapy. For **urgent** coverage determination requests, the managed care organization must issue a decision, whether it's an approval or denial, within **24 hours** of the time that the request was received. For **standard** coverage determination requests, the managed care organization must issue a decision, whether it's an approval or denial, within **72 hours** of the time that the request was received.

How do I find out what supportive information I need to provide to my patient's Medicare Part D plan for a medication coverage determination request?

All Medicare Part D plans have online formularies that inform the patient and the provider about what criteria must be met to satisfy prior authorization requirements for a medication. However, some medications are non-formulary, and in this case the patient must try all formulary alternatives before receiving the non-formulary medication, **OR** you must submit a supporting statement that includes information as to why the formulary alternatives would not be appropriate for the patient. You can check your patient's Medicare Part D plan website to obtain this information. Our plan includes a searchable option which easily informs you of the coverage status and provides alternatives if the medication is not formulary. Your patient also has access to these options on our website.

What if I do not submit adequate medical information or supportive evidence that meets the criteria for the drug that is being requested for review within the allotted CMS timeframes for coverage determinations?

When the Medicare Part D health plan reviews the request, if there is not enough supportive medical information to either approve or deny a coverage determination request for a medication, the health plan will fax a Request for Information (RFI) form to you, the provider. The RFI provides specific details about the missing information that is needed to appropriately review the requested medication to either approve or deny the request. **It is important for you to respond to RFIs in a timely manner; otherwise, a denial may be issued, which may delay patient therapy. To be timely with an RFI response, you would have to provide any supportive information to the health plan within 24 or 72 hours of the date of you receive the RFI depending on whether the request is urgent or standard, respectively.**

What if I provide the information needed for an approval of the Coverage Determination request to the health plan after the allotted time frame?

If the health plan denied the coverage determination because the supporting information was not received in a timely manner, the beneficiary/provider/beneficiary's appointed representative may file an appeal with the patient's Medicare Part D plan. An appeal must be filed within 60 days of the coverage determination denial date. If more than 60 days has passed since the denial decision date, the beneficiary/provider/beneficiary's appointed representative will need to resubmit the request as a new coverage determination request.

Turnaround times for Part D appeals are different than coverage determination time frames. An **urgent** appeal must be reviewed within 72 hours, and a **standard** appeal must be reviewed within seven days. Please note that RFIs will also be sent to you for appeals if there is not enough supporting information to make a decision for the appeal request.

We are here to help

Ensuring access to needed medications for your patient is our mutual goal – and we want to help make the process as smooth as possible for you as you help your patient's navigate the coverage determination process. Please use our plan website resources to access forms and fax information, submit online, or call us directly to assist you.

www.amerihealthcaritasvipcare.com/fl

AmeriHealth Caritas VIP Care®