In response to calls and questions from members, TPA staff requested and participated in a conference call with representatives from Magellan to discuss the recent letter that was sent to pharmacists and to gain guidance regarding further actions pharmacists need to take to resolve this issue.

The primary focus of this Magellan claims audit is to determine whether or not the pharmacist verified that the patient had no other primary insurance coverage prior to processing the claim using the Other Coverage Code of 1 (OCC-1).

TPA has sent an email to members with instructions from Magellan to assist pharmacists in preparing a response to Magellan regarding the list of claims in question. TPA members can also view the full news broadcast on the TPA website by going to bit.ly/tpa-news-9-18-2015 and entering their member login information.

Thank you to the TPA members who provided the technical, historical, and anecdotal information that facilitated our discussions with Magellan.

APhA ADDRESSES CHANGES TO MEDICARE PART D FOR 2016

Open enrollment for Medicare Part D begins on October 15, 2015, and ends on December 7, 2015. The following changes to Medicare in 2016, are excerpted from an APhA article dated September 15, 2015.

For the complete article, detailing important information regarding these changes, please visit:

www.pharmacist.com/key-changes-part-d-2016

CMS has released revisions to Part D that will take effect in 2016. Changes include added emphasis on medication therapy management (MTM) and postdischarge medication reconciliation, steps to improve access to services and information, and increased discounts on generic drugs.

Medication Therapy Management: Medicare will include completion rates for comprehensive medication reviews (CMRs) in star ratings in 2016. CMR Completion Rate will carry a weight of one in star ratings.

Postdischarge Medication Reconciliation: While CMS has not expanded eligibility for MTM, it has done so for postdischarge medication reconciliation. The benefit is now available to all Medicare Advantage beneficiaries aged 18 years and older.

Improving access and transparency: In 2016, beneficiaries’ access to covered services will figure into star ratings, with the reintroduction of the “Beneficiary Access and Performance Problems” measure.

In addition to the star ratings measure that touches on access, CMS has committed to better disseminating information to beneficiaries regarding preferred cost-sharing pharmacies in their plan’s network.

CMS has not specified how it will provide information on cost-sharing pharmacies to beneficiaries.

What pharmacies should tell their patients:

Medicare prescription drug plan premiums will remain stable at about $32.50 per month, up from $32 in 2015. But premiums for specific plans and regions vary from year to year.

In 2016, beneficiaries will continue to get a 55% discount on brand-name drugs during the coverage gap. The discount on generic drugs will increase from 35% to 42%.

Pharmacists should advise patients, however, that covered drugs and related restrictions can change from year to year.

Beneficiaries should review their annual notice of change (ANOC) and the summary of the new formulary in particular to make sure their prescriptions are still on the list. People who want to change plans should make sure the plans they are considering cover their prescriptions. If the summary of the new formulary does not include a beneficiary’s prescriptions, patients may find the full formulary online or call the plan to request it.

Pharmacists can direct patients who are shopping for a new plan to Medicare’s online plan finder tool (www.medicare.gov/find-a-plan). After patients gather all the information they need about a plan, pharmacists should advise patients to call the plan to confirm the information they found online.

Finally, according to Mitchell Clark, a spokesperson for the Medicare Rights Center who was featured in the article, pharmacists should discourage patients from making decisions based on price alone. “They should check to see if the plan they are considering covers all their medications, and whether any special permissions, such as prior authorization, step therapy or quantity limits, are required,” he said.