Empowering the Pharmacist: Understanding Pharmacy Benefit Designs to Improve Medication Access

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Disclosure to Learners

Lillian Torres, and Sara Ramos faculty for this CE activity, have no relevant financial relationship(s) with ineligible companies to disclose.
Eimeira Padilla is full-time employee of AbbVie

No clinical practice or care recommendations during this educational activity.
All of the relevant financial relationships listed for these individuals have been mitigated.

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Accreditation Council for Pharmacy Education as
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Provider Number: 0151

OBJECTIVES

Objective 1

Explain the core processes and regulatory frameworks of Commercial, Medicare, and Medicaid pharmacy benefit programs.

Objective 2

Identify segment-specific regulations and compliance requirements affecting pharmacy benefit administration.

Objective 3

Summarize best practices for navigating pharmacy benefit processes to support compliance and patient access.

PART 1

Managed Care Concepts

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Formulary Strategy and Specialty Drugs Director

MCS

Why Managed Care Knowledge Matters?

UNDERSTANDING HEALTHCARE SYSTEMS TO IMPROVE PATIENT OUTCOMES

Key Managed Care Models and Challenges for Pharmacy Personnel

DIFFERENT MANAGED CARE MODELS

MODEL	WHO IT SERVES	KEY FEATURES
MEDICARE	Individuals ≥65 years and certain disabled populations.	• Federal program administered by **CMS** • Parts A, B, C, D cover different services. • Options include Original Medicare and Medicare Advantage (Part C)
MEDICAID	Low-income individuals and families, pregnant women, children, elderly, and people with disabilities.	• Jointly funded by **federal** government and **states** • Eligibility and benefits vary by **state** • Managed care (MCOs) common in most states
COMMERCIAL	Individuals with employer-sponsored insurance or purchased private health insurance.	• **Private** insurance plans offered by employers or insurers • Wide variation in plan designs, networks, and **formularies** • May include HMO, PPO, EPO, POS, and HDHP plans

KEY CHALLENGES FACED BY PHARMACY PERSONNEL

01 REGULATORY COMPLEXITY
- Different regulatory requirements under each managed care model (Medicare, Medicaid, Commercial).

02 FORMULARY MANAGEMENT
- Handling formulary changes from multiple plans.
- Keeping up with updates to drug lists, tiers, and coverage criteria.

03 FORMULARY INTERPRETATION
- Misinterpreting formulary status, tiers, step therapy, or coverage rules can lead to claim denials and patient delays.

04 BENEFIT DETERMINATION
- Confusion between medical vs. pharmacy benefit billing pathways can result in processing errors and payment delays.

05 UTILIZATION MANAGEMENT (UM)
- Handling of prior authorizations (PA) requirements.
- Navigating step therapy, quantity limits, and other UM requirements.

IMPACT ON PATIENT OUTCOMES

IMPROVED ACCESS
Timely access to the right medications.

REDUCED DELAYS
Fewer treatment delays and disruptions.

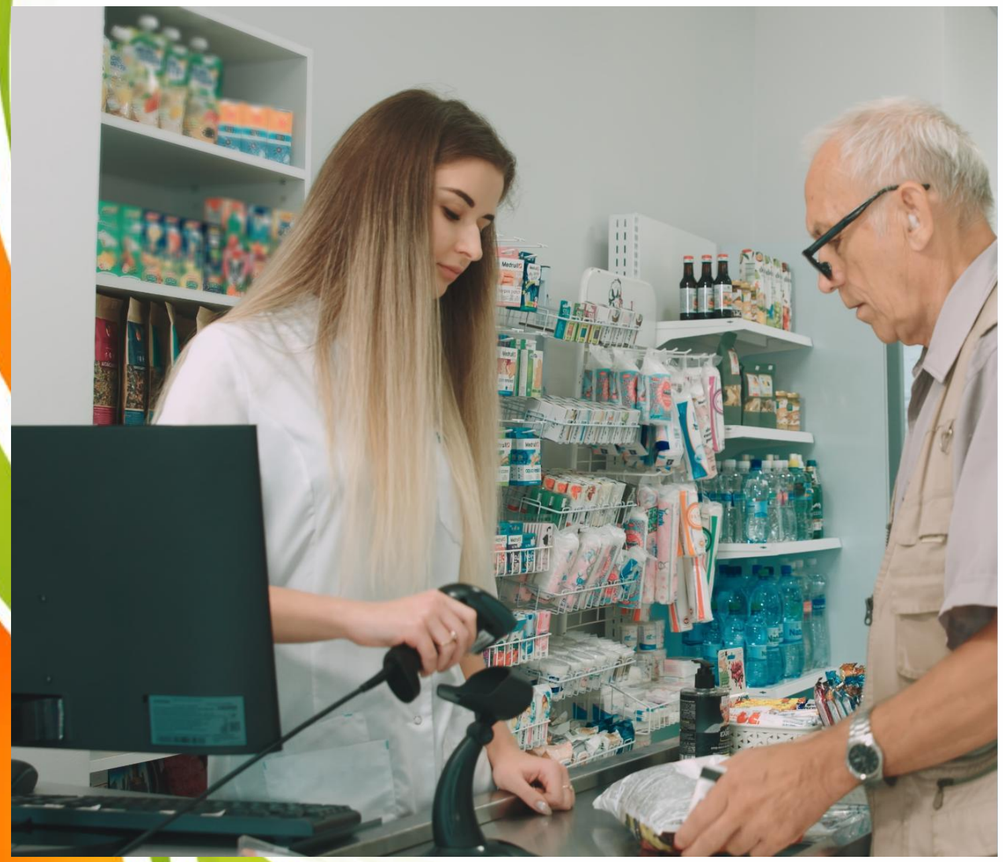
ENHANCED ACCURACY
Accurate benefit determination and coverage.

OPTIMIZED THERAPY
Better medication management and adherence.

BETTER OUTCOMES
Improved health outcomes and patient satisfaction.

A strong understanding of managed care models and proactive navigation of challenges help pharmacy teams deliver the right medication, to the right patient, at the right time.

Workflow Breakdowns Caused by Benefit Misunderstanding



Complex Benefit Structures

Pharmacy staff face challenges interpreting diverse and changing payer rules under time pressure at point of care.

Workflow Breakdown Impact

Misunderstandings lead to claim rejections, rework, delays, and disrupted patient therapy initiation.

Patient Care and Compliance Risks

Delays and errors reduce patient satisfaction and increase compliance risks from billing or authorization requirements.

Importance of Managed Care Knowledge

Strong managed care understanding enhances claims accuracy, timely therapy, and regulatory compliance.

FORMULARY MANAGEMENT VS. BENEFIT DESIGN

FORMULARY MANAGEMENT

A collaborative process that aligns **physicians, pharmacists,** and **healthcare teams** to ensure clinically appropriate and cost-effective therapy.

Drives optimal patient outcomes through evidence-based medication use.

Pharmacoequity is essential—ensuring all patients have fair access to appropriate medications.

Formularies play a critical role in determining medication access and affordability.

Interdisciplinary Pharmacy and Therapeutic Committees play a central role in formulary management.

WHAT IS BENEFIT DESIGN?

1. Defines what **services** are covered.
2. Determines **in-network providers.**
3. Establishes **patient cost-sharing:**
4. **Deductibles, Copayments, Coinsurance.**

BENEFIT DESIGN IS A KEY LEVER TO:

- Improve medication **access.**
- Reduce **out-of-pocket burden.**
- Support **equitable healthcare** delivery.

Together, effective formulary management and thoughtful benefit design drive better outcomes, lower costs, and healthier communities.

RIGHT MEDICATION → RIGHT PATIENT → RIGHT OUTCOME

Types of managed care: Commercial, Medicare, Medicaid

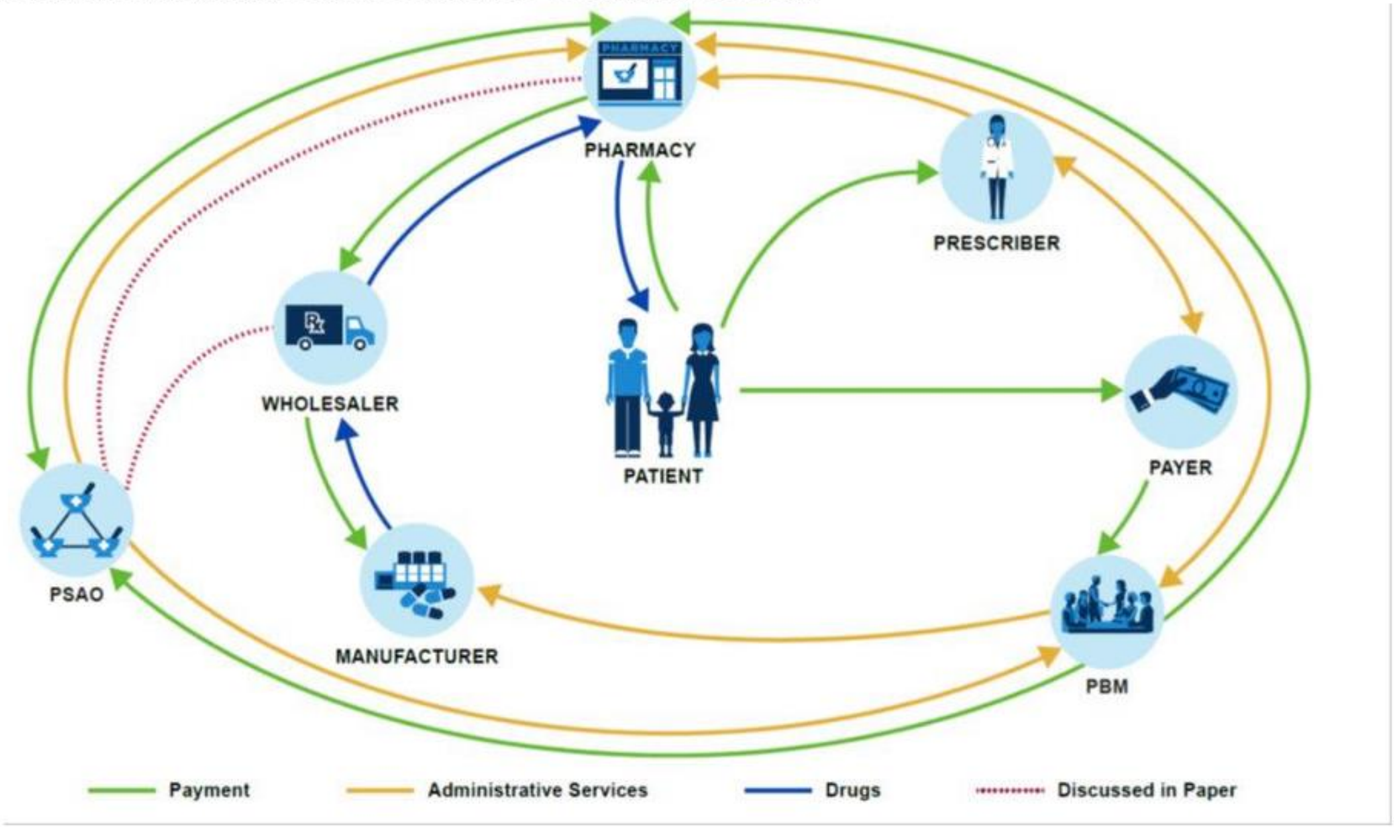
Category	Commercial	Medicare (Part D / MA-PD)	Medicaid (FFS & Managed Care)
Regulatory Landscape	State-regulated (OCS) + ERISA (self-funded plans)	Federally regulated (CMS) with strict compliance requirements	Joint federal–state oversight; state-specific variability
Formulary Design	Highly flexible; employer & PBM-driven	CMS-approved formularies with protected classes	State PDLs; preferred vs. non-preferred drugs
Utilization Management	Aggressive (PA, step therapy, quantity limits) varies by employer	Standardized but still extensive PA and step therapy rules	Strict controls; PDL-driven PA and step therapy common
Pricing & Rebates	Negotiated between PBM, and manufacturers	Regulated rebate structure and CMS oversight, MFP	Supplemental rebates negotiated by states
Patient Cost Sharing	Variable (copay, coinsurance, deductibles)	Defined benefit phases (deductible, initial, catastrophic)	Minimal cost-sharing; focus on access
PBM Flexibility	High flexibility in benefit design and contracting	Low flexibilty—must meet CMS rules and benefit structure	Low flexibility due to state mandates
Network Management	Narrow, preferred, or open networks	Pharmacy access standards required by CMS	Broad networks; access requirements vary by state
Key Operational Challenge	Complexity and variability across employers	Compliance and benefit phase navigation	State variation and administrative complexity

Administration of a Pharmacy Benefit

- Core functions:
  - Formulary management
  - Claims processing
  - Utilization management

H. INTERRELATION OF PARTIES IN THE CHAIN AND TRANSACTION COSTS

The diagram below provides a simplified illustration of the pharmaceutical distribution chain and the major entities involved that will be discussed in more detail in this section.[32]



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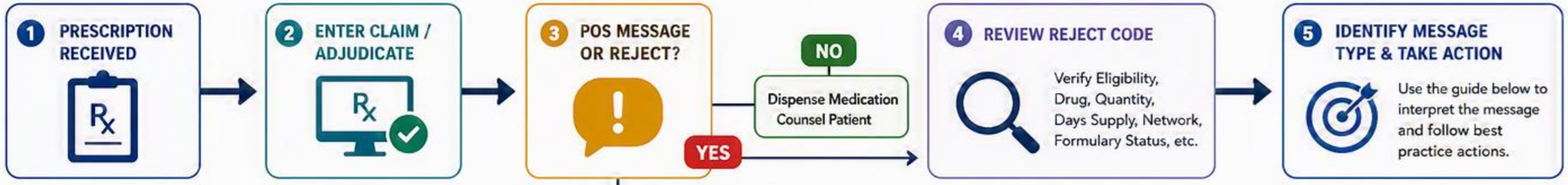
POINT OF SALE (POS) PHARMACY WORKFLOW

How to Interpret POS Messages & Take Best Practice Actions



POS MESSAGE SCENARIOS, MEANING & BEST PRACTICE ACTIONS

	1 PRESCRIPTION WORKFLOW & POS MESSAGE OVERVIEW	2 EXCLUSION: NOT A COVERED BENEFIT	3 NON-FORMULARY: MAY BE COVERED UNDER EXCEPTION PROCESS	4 OUT OF NETWORK PROVIDER	5 COST LIMIT EXCEEDS	6 DAYS SUPPLY EXCEEDS	7 PRIOR AUTHORIZATION REQUIRED	8 STEP THERAPY REQUIREMENTS	9 DOCUMENT & FOLLOW UP
MEANING	POS messages (rejects or alerts) provide real-time information about a claim.	Drug or service is excluded from coverage and will not be reviewed for medical necessity.	Drug is not on the formulary but may be covered with an exception and may be reviewed for medical necessity.	Provider/pharmacy is not contracted with the plan.	The submitted cost or maximum allowed amount has been exceeded.	Submitted days supply exceeds the plan's allowed limit.	Plan requires clinical review and approval before the medication can be covered.	Patient must try the plan's preferred medication(s) before the requested drug is covered.	All actions and communications should be documented and followed up.
BEST PRACTICE ACTIONS	• Always read the full message and code. • Verify patient eligibility, drug, quantity, days supply, and plan rules. • Determine next step based on message type.	• Inform prescriber and patient. • Discuss covered alternatives or cash options. • Document conversation and resolution.	• Contact prescriber to initiate formulary exception/PA. • Gather clinical justification. • Submit request to plan and follow up.	• Inform patient. • Redirect to in-network pharmacy/provider when possible. • Contact plan if clarification is needed.	• Review claim details (drug, strength, NDC, quantity, price). • Consider lower-cost alternative if clinically appropriate. • Request override/PA if needed.	• Adjust days supply to plan limit if appropriate. • If not appropriate, request coverage exception/override.	• Notify prescriber immediately. • Submit PA with required clinical information. • Follow up on status.	• Verify patient's claims history for required step therapy drugs. • If criteria not met, request step therapy exception with clinical rationale.	• Document all calls, messages, and actions taken. • Communicate updates to patient/prescriber. • Reprocess claim when resolved.
KEY POINTS	Accurate interpretation prevents delays, denials, and patient frustration.	Claims for excluded items are not eligible for medical necessity review.	Exception requests may require clinical documentation and review.	Using in-network providers maximizes benefits and reduces patient cost.	Plan limits are based on maximum allowable cost or reimbursement thresholds.	Use the minimum effective days supply based on patient needs and plan rules.	Timely PA submission helps avoid therapy delays.	Step therapy is a type of prior authorization focused on lower-cost alternatives first.	Good documentation supports continuity of care and audit compliance.

BEST PRACTICE FOLLOW-UP CHECKLIST

- Communicate clearly with patients and prescribers.
- Document all interactions and actions.
- Follow up on pending requests.
- Reprocess claim when issue is resolved.
- Ensure patient understands next steps.
- Protect patient safety, access, and plan compliance.

GOAL: Resolve issues efficiently, minimize delays, and ensure patients receive the right medication at the right time.

REFERENCES

- CMS – Drug Plan Rules (Prior Authorization, Step Therapy, Quantity Limits) https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
- CMS – Formulary and Tiering Exceptions https://www.cms.gov/medicare/appeals-grievances/prescription-drug/exceptions
- NCPDP Reject Codes (Industry Standard) https://ncpdp.org/ncpdp-reject-code-lists/
- Medi-Cal Rx – NCPDP Reject Codes https://medi-calrx.dhcs.ca.gov/

Note: Plan rules and messages may vary. Always refer to the specific health plan and PBM guidelines.

How administration of a pharmacy benefit differs by segment: Commercial, Medicare, Medicaid

COMMERCIAL

- Market-Driven (Employer & PBM-Driven)
- Highly Flexible Formularies
- Complex Benefit Structures
- Workflow Breakdown Impact (Claim Rejections, Delays)

MEDICARE

- CMS-Regulated (Part D)
- Structured Compliance requirements
- CMS-approved formularies with protected classes
- Key Challenge: Compliance and benefit phase navigation

MEDICAID

- Joint Federal-State Oversight
- Preferred Drug Lists (PDLs)
- Minimal Cost-Sharing (Focus on Access)
- State Variability and administrative complexity

Managed Care Intro Knowledge Check

Question 1

What is the primary reason pharmacy personnel need education on managed care across Commercial, Medicare, and Medicaid plans?

A. All managed care plans use identical pharmacy benefit rules.
B. Each plan has unique benefit designs, formularies, utilization management requirements, and regulatory requirements.
C. Managed care knowledge is only needed for specialty medications.
D. Managed care rules only affect insurance companies.

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D. Managed care rules only affect insurance companies.

Correct Answer: B

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Managed Care Intro Knowledge Check

Question 2

Which of the following outcomes is most likely when pharmacy personnel have knowledge gaps in managed care?

A. Improved patient access to medications.
B. Increased formulary adherence and regulatory compliance.
C. Claims errors, audit findings, and delays in patient access to therapy.
D. Reduced need for utilization management.

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Managed Care Intro Knowledge Check

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C. Claims errors, audit findings, and delays in patient access to therapy. ☑
D. Reduced need for utilization management.

Correct Answer: C

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Managed Care Intro Knowledge Check

Question 3

Which of the following is an expected outcome of effective managed care education for pharmacy personnel?

A. Elimination of all prior authorization requirements.
B. Improved regulatory compliance, claims accuracy, formulary adherence, and patient access.
C. Standardized formularies across all managed care plans.
D. Fewer medications covered under pharmacy benefits.

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Managed Care Intro Knowledge Check

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C. Standardized formularies across all managed care plans.
D. Fewer medications covered under pharmacy benefits.

Correct Answer: B

PART 2

Commercial Segment

Lillian Torres Rodriguez, RPh, BCGP

Pharmacy and Clinical Account Manager

Triple S

FINANCIAL TYPE

Fully Insured Clients Small & Large Groups

Pays a fixed monthly premium to an insurance carrier.

- **Fixed Premium Payments**
- **Health Plan Assumes Financial Risk**
- **Predictable Budgeting**
- **Limited Customization**
- **Administrative Simplicity**
- **State and Federal Regulations**

Self-Insured Clients

Pays employee healthcare claims instead of paying premiums to an insurer.

- **Large Employers**
- **Financial Responsibility**
- **Broad Customization**
- **Control Over Reserves**
- **Improve Cash Flow**
- **Federal Regulation not state law**
- **Use of Third-Party Administrators (TPAs)**
- **Stop-Loss Insurance**

Metallic

“Metallic” or metal tier plans refer to quality levels of health insurance coverage as defined by the Affordable Care Act (ACA).

- **Individual**
- **Coverage Levels – Fixed Cost**
- **Health Plan Assumes Financial Risk**
- **Predictable Budgeting**
- **Standardized Benefits**
- **Higher Deductibles and Copay**
- **State and Federal Regulations**

Key Comparative Considerations

FINANCIAL TYPE

Factor	Fully Insured	Self-Insured	Metallic
Risk	Insurer	Employer	Insurer
Cost Predictability	High	Low	High
Flexibility	Limited	High	Limited
Administrative Complexity	Low	High	Low
Size	50- (small group) & 50+ (large group)	Large (typically 500+)	Individual

REGULATORY CONSIDERATIONS

State

- Law 194 2011 “Código de Seguros de Salud de PR”/ “Cartas Normativas” / Amended – Law 23 - 2025
- Law 21 – 2008 “Tratamiento Tabaco”
- Law 140 – 2010 – Treatment of opioid addiction.
- Law 275 – 2012 “Carta de Derechos de los Pacientes y Sobrevientes de Cancer” / Amended – Ley 165 - 2024
- Law 107 – 2012 “Igualdad de Cobertura Cáncer”
- Law 79 - 2020: “Ley Especial para Asegurar el Acceso al Tratamiento y Diagnóstico de los Pacientes de Cáncer en PR.”
- Law 248 -2018 “Carta de Derechos de las Personas con Diagnóstico Positivo a VHI”
- Law 62 - 2024 Hereditary Angioedema
- Law 109 – 2022 “Ley Población con Albinismo y Síndrome de Hermansky-Pudlak”
- Law 109 – 2023 “Asistencia Copago / Aportación”
- Law 163 – 2024 “Protección, Integración, Bienestar Espectro Autista”
- Law 63 – 2025 “Protección y Bienestar menores de edad”

*Fully Insured Clients / Metallic

Federal

- ERISA*
- Patient Protection and Affordable Care Act (PPACA)
- Health Insurance Portability and Accountability Act (HIPAA)

* ASO & Large Groups (20 +)

CODIGO DE SEGUROS DE SALUD PR

Fully Insured Clients
Small & Large Groups

Metallic - Individual

Scope:

- To **regulate** the handling of **prescription medications** by health insurance organizations or insure
- To **standardize** in PR the guidelines for **audits** of health care claims.
- To **promote** the availability of **medical plans** for employers of small and medium-sized businesses in PR.
- To **prohibit** the use of **discretionary clauses** in medical plans and **income protection** coverage in case of disability.
- To **provide** the standards for establishing and maintaining the procedures that health insurance organizations or insurers must follow to ensure that covered persons or insured persons obtain a **timely and adequate** resolution of their **grievances.**
- To set **uniform** requirements for coverage for newborn children, newly adopted children, and children placed for adoption, in both group and individual medical plans; to establish standards for long-term care insurance; and for other related purposes.

CODIGO DE SEGUROS DE SALUD PR

(Chapter 4: Prescription Medications)

Applicability and Scope

- Health Insurance Organization
- Administer of Prescription Drug Benefit for outpatient

Formulary Management

- Pharmacy and Therapeutic Committee
  - Drug Evaluation – 90 days
  - Clinical Evaluation – Medical Based Evidence
  - Records and Reporting Requirements
  - Formulary Changes
    - Negative
    - Positive
- MOOP
- Normative Letters

Availability of Information

- Formularies
- Drug Management Information
- Exception Process Information

CODIGO DE SEGUROS DE SALUD PR

(Chapter 4: Prescription Medications)

Exceptions Requirements

- Apply to non-formulary, alternative for a discontinue drug, step therapy and quantity limited.
- Prescriber written justification evaluation
  - Solid clinical, medical and scientific evidence
  - Accepted practical guidelines
- Does not apply to coverage exclusions.
- Notification of denial
  - Appeal process

Records and Reporting Requirements

- Regulation Compliance
- Determination Documentations
  - Formularies
  - Prescription Management
  - Exceptions
- Period: 3 years
- Exception Process Information

Responsibility for Oversight and Contracting

- Insurers are responsible for compliance with this chapter.
- If a third party is hired, the insurance companies are also responsible.

Disclosure Requirements

- Policies, Certificates, Information Brochures and Coverage Summaries
- Compressive Description

Federal Laws

Self Insured Groups

“Código de Seguro de Salud”

Employee Retirement Income Security Act (ERISA)

To protect the interests of participants and beneficiaries in employee benefit plans.

- **Health Insurance**

Patient Protection and Affordable Care Act (PPACA)

A comprehensive U.S. healthcare reform law designed to expand access to affordable health insurance, improve care quality, and reduce healthcare costs.

- **Preventive Treatments**
  - To cover specific preventive services without any cost-sharing, such as copayments, deductibles, or co-insurance.

Health Insurance Portability and Accountability (HIPAA)

Established to safeguard patient privacy and secure health information. HIPAA sets strict standards for managing, transmitting, and storing protected health information.

PHARMACY BENEFIT DESIGN

Formulary
(Close Formulary)

A list of prescription drugs that pharmacy benefit plan covers.

- **Specific FDA-approved drugs**
- **More Exclusions**
- **Manage Drug Cost**
- **Tier based on cost and coverage levels**

Copayment Structure

- **Tier Levels**
- **Preferred and Non-preferred**
- **Copayment vs Coinsurance**
- **Initial Deductible**
- **First Level Coverage**
- **MOOP – maximum-out-of-pocket**

Open Benefit
(Open Formulary)

Covers a wide range of prescription drugs with few exclusions.

- **All FDA-approved drugs are generally covered**
- **Limited Exclusions**
- **Can potentially lead to higher costs for the insurance plan clients or self-insured.**
- **Less tier levels**

Exclusion

- **Standard exclusion in the Healthcare Industry.**
- **Exceptions to the application of the exclusion**
  - **Fully Insured – not flexible**
  - **Self Insured - flexible**

Pharmacy Network

- **Broad Access**
- **Limited Access**
- **Preferred Pharmacy**
- **Non-preferred Pharmacy**

CASE SCENARIO

Pharmacy Benefit Design

Fully Insured vs Self Insured vs Metallic

- How is the insurance plan financed?
- What are the laws and regulations that apply to the benefit?
- What are the options for medication coverage?
  - Drug List
  - Copayment Structure
- What are the options of Pharmacy Networks?
- Determine applicable coverage exclusions.

Commercial Benefit Knowledge Check

Question 1

Pays a fixed monthly premium to an insurance carrier.

A. Self-insured
B. Metallic
C. Fully Insured
D. Self-insured and Metallic
E. All

Commercial Benefit Knowledge Check

Question 1

Pays a fixed monthly premium to an insurance carrier.

A. Self-insured
B. Metallic
C. Fully Insured ☑
D. Self-insured and Metallic
C. All

Correct Answer: C

Commercial Benefit Knowledge Check

Question 2

True or False: The requirement for an exception process apply to coverage exclusions.

A. True
B. False

Commercial Benefit Knowledge Check

Question 2

True or False: The requirement for an exception process apply to coverage exclusions.

A. True
B. False ☑

Correct Answer: B

Commercial Benefit Knowledge Check

Question 3

Regulate the handling of prescription medications by health insurance organization.

A. Patient Protection and Affordable Care Act
B. ERISA
C. Código de Seguros de Salud de PR
D. ALL

Commercial Benefit Knowledge Check

Question 3

Regulate the handling of prescription medications by health insurance organization.

A. Patient Protection and Affordable Care Act
B. ERISA
C. Código de Seguros de Salud de PR ☑
D. ALL

Correct Answer: C

PART 1

Medicare Fundamentals

Sara Ramos González, PharmD

VP of Pharmacy Development and Network Integration

Triple-S

WHO QUALIFIES

Eligibility for Medicare

Age 65+

U.S. citizens or legal residents (5+ years) who qualify through age, regardless of health status.

Disability

Under 65 with a qualifying disability, generally after receiving Social Security Disability Insurance (SSDI) for 24 months.

ESRD or ALS

End-Stage Renal Disease or ALS (Lou Gehrig's disease) qualifies regardless of age, often with no waiting period for ALS.

STRUCTURE

The Four Parts of Medicare

Part A
Hospital Insurance

Inpatient hospital, skilled nursing, hospice, some home health.

Part B
Medical Insurance

Outpatient care, physician services, preventive care, durable equipment.

Part C
Medicare Advantage

Private-plan alternative bundling A + B (usually + D) with extra benefits.

Part D
Prescription Drug

Outpatient prescription drug coverage through private plans.

PART B

Medical Insurance

- Covers outpatient physician visits, preventive services, durable medical equipment, labs, and some drugs administered in a clinical setting (e.g., infusions, injectables) — this is where “Part B drugs” and buy-and-bill live.
- Requires a monthly premium and an annual deductible; beneficiaries generally pay 20% coinsurance after the deductible.
- Enrollment is optional but penalized if delayed without other creditable coverage — a permanent premium surcharge applies.
- Part B vs. Part D drug classification is a recurring pharmacy strategy question (site of administration, self-administered vs. provider-administered).

TIMING MATTERS

Medicare Enrollment Periods

IEP	Initial Enrollment Period: 7-month window around a beneficiary's 65th birthday.
GEP	General Enrollment Period: Jan 1–Mar 31 for those who missed their IEP; coverage starts the following month.
AEP	Annual Enrollment Period: Oct 15–Dec 7 — switch between Original Medicare, MA, and Part D plans.
MA OEP	MA Open Enrollment: Jan 1–Mar 31 — one plan switch allowed for those already in an MA plan.
SEP	Special Enrollment Periods: triggered by qualifying life events (e.g., moving, losing employer coverage).

TWO PATHS

Original Medicare vs. Medicare Advantage

Original Medicare (A + B)

- Fee-for-service, administered directly by CMS
- Any provider that accepts Medicare, nationwide
- No annual out-of-pocket maximum
- Needs separate Part D plan for drug coverage
- Medigap available to fill cost-sharing gaps

Medicare Advantage (Part C)

- Private plans approved and paid by CMS
- Network-based (HMO/PPO) with defined service areas
- Annual out-of-pocket maximum required
- Usually bundles Part D and extra benefits (dental, vision, OTC)
- Often lower premiums; requires prior authorization/referrals more often

PART 2

Medicare Advantage (Part C)

How private plans deliver Medicare benefits — and why pharmacy strategy centers here.

PART C

What Is Medicare Advantage?

- An alternative way to receive Medicare benefits through CMS-approved private insurers, rather than directly through the federal government.
- Many plans add extra benefits: dental, vision, hearing, over-the-counter allowances, transportation, and meals
- Enrollment has grown steadily for over a decade, and MA now covers more than half of all Medicare beneficiaries nationally.
- Plans operate within defined networks and service areas, and can require referrals, prior authorization, and step therapy.

PLAN DESIGNS

Medicare Advantage Plan Types

HMO

Health Maintenance Organization — in-network care, usually requires a PCP referral to see specialists.

PPO

Preferred Provider Organization — more flexibility to see out-of-network providers, typically at higher cost.

PFFS

Private Fee-for-Service — plan determines payment terms; provider participation decided visit-by-visit.

SNP

Special Needs Plan — tailored for chronic conditions (C-SNP), dual-eligible (D-SNP), or institutionalized (I-SNP) members.

QUALITY BONUS PROGRAM

CMS Star Ratings Overview

- CMS rates MA and Part D plans annually on a 1–5 star scale across dozens of quality and performance measures.
- Categories include staying healthy (screenings/vaccines), managing chronic conditions, member experience, complaints, and drug safety/pricing.
- A single low-performing measure can pull down a plan's overall rating

5-Star Special Enrollment

Members may switch into a 5-star plan any time of year, outside standard enrollment periods.

WHERE PHARMACY DRIVES QUALITY

Star Ratings: Key Pharmacy Measures

PDC (Proportion of Days Covered)

Adherence measure for statins, RAS antagonists, and diabetes medications — among the most heavily weighted Part D measures.

MTM Completion Rate

Comprehensive Medication Review completion for members enrolled in Medication Therapy Management programs.

Statin Use in Diabetes (SUPD)

Percentage of diabetic members appropriately prescribed a statin for cardiovascular risk reduction.

COB (Concurrent Opioid & Benzodiazepine)

Patient safety measure tracking members with overlapping opioid and benzodiazepine fills.

HISTORY & STRUCTURE

Part D: Prescription Drug Coverage

- Created by the Medicare Modernization Act (MMA) of 2003; coverage began January 1, 2006.
- Delivered exclusively through private plans — standalone Prescription Drug Plans (PDPs) or bundled within Medicare Advantage (MA-PDs).
- Each plan maintains its own formulary, pharmacy network, and cost-sharing structure, subject to CMS approval and minimum coverage requirements.
- Pharmacy Benefit Managers (PBMs) administer claims adjudication, formulary management, and rebate negotiation on behalf of plans.

2026 BENEFIT DESIGN

Part D Benefit Phases (Post-IRA Redesign)

1

Deductible

Standard deductible applies before coverage begins (plans may waive it).

2

Initial Coverage

Member pays coinsurance/copays; plan and manufacturer discount share costs.

3

Catastrophic Coverage

Triggered once the member reaches the annual out-of-pocket cap ($2,100 in 2026) — $0 cost-sharing for the rest of the year.

Since the Inflation Reduction Act redesign, the separate “coverage gap” (donut hole) phase has been eliminated — the benefit now moves directly from initial coverage into catastrophic coverage once the annual cap is met.

Statutory Exclusions (§20.1)

Excluded under Social Security Act §1927(d)(2)

Excluded — No Exceptions

- Anorexia, weight loss, or weight gain agents
- Fertility agents
- Cosmetic purposes or hair growth agents
- Symptomatic cough & cold relief

Excluded — Common Missteps

- Prescription vitamins/minerals (except prenatal & fluoride)
- Nonprescription (OTC) drugs
- Drugs tied to mandatory manufacturer testing/monitoring purchases
- Erectile/sexual dysfunction agents (unless approved for another indication)

Also excluded from basic Part D: Benzodiazepines and Barbiturates were excluded historically, but both have been covered for ALL medically-accepted indications since 2013 (benzodiazepines) and 2014 (barbiturates).

Bridge Program - Background & Purpose

Why does the Bridge exist?

The Medicare GLP-1 Bridge is a short-term CMS demonstration that provides eligible Medicare Part D beneficiaries early access to certain GLP-1 drugs for weight management

Legal Authority

Section 402(a)(1)(A) of the Social Security Amendments of 1967, applied to Part D by section 1860D-42(b) of the Social Security Act.

Narrow Design

By design, the Bridge includes only beneficiaries who would not otherwise have access to a GLP-1 through Part D.

Outside Part D

The Bridge operates completely outside the Part D coverage and payment flow, using a single CMS central processor.

Program at a Glance

Key facts every pharmacy team member should know

$50

Flat monthly patient copay

$245

Net price per monthly supply

3

Eligible drugs: Wegovy® Foundayo® & Zepbound®

2027

Program runs through Dec. 31, 2027

BIN / PCN for claims	028918 / MEDDGLP1BR
Reimbursement floor	No lower than WAC, less copay, plus dispensing fee and applicable sales tax
Counts toward TrOOP / GCPDC / M3P?	No — the Bridge is entirely outside the Part D payment flow
CMS contact	GLP1Demo@cms.hhs.gov

Part D Plan Sponsor Obligations

The Bridge does not waive existing Part D requirements

- Sponsors are not participants in the Bridge and bear no financial or administrative role in furnishing these drugs.
- Sponsors must continue to cover GLP-1s for Part D-coverable indications, consistent with their CY2026 bids, regardless of formulary placement.
- Sponsors must not deny or limit access in a way that improperly encourages use of the Bridge instead of Part D coverage.
- CMS is conducting rigorous monitoring of Part D and Bridge data to detect inappropriate shifting of beneficiaries and may act under 42 CFR 423.752.
- The Bridge does not modify beneficiary appeal rights or coverage determination requirements under 42 CFR Part 423, Subpart M.

The P&T Committee (§30.1)

Every formulary must be built and reviewed by a compliant committee

Membership

Multiple clinical specialties; majority must be practicing physicians and/or pharmacists

Elderly/disabled expertise

At least one practicing pharmacist AND one physician expert in caring for elderly or disabled populations

Independence

At least one pharmacist and one physician free of conflict with the sponsor and manufacturers

Meeting cadence

Must meet at least quarterly; decisions documented in writing

New drug review

Reasonable effort to review within 90 days of market release; decision required within 180 days

Binding authority

P&T formulary-inclusion recommendations are binding; UM recommendations are advisory only

Building an Adequate Formulary (§30.2.1–30.2.3)

CMS checks breadth, depth, and access

Categories & Classes

- Minimum 2 chemically distinct drugs per category/class (unless only 1–2 exist and one is clinically superior)
- Two dosage forms/strengths of the same drug do NOT satisfy the 2-drug rule
- CMS may require more than 2 drugs where absence would substantially discourage enrollment
- USP or AHFS classification systems are pre-approved; alternate systems are compared for similarity

DRUG COVERAGE STRUCTURE

Formularies & Drug Tiers

1	**Preferred Generic**	*Lowest copay*
2	**Generic**	*Low copay*
3	**Preferred Brand**	*Moderate copay*
4	**Non-Preferred Drug**	*Higher cost-share*
5	**Specialty**	*Coinsurance, often highest*

The Pharmacy & Therapeutics (P&T) Committee determines which drugs are covered and at which tier — balancing clinical evidence, safety, and net cost.

The Six Protected Classes (§30.2.5)

"All or substantially all" drugs must be on formulary

Immunosuppressants	Antidepressants	Antipsychotics	Anticonvulsants	Antiretrovirals	Antineoplastics

Why: prevents discouraging enrollment by beneficiaries dependent on these drugs and protects against therapy interruption for vulnerable populations.

"Substantially all" exceptions	Multi-source brands of identical structure, ER products when IR is included, same active moiety, and non-unique routes of administration may be excluded
Expedited P&T review	New drugs/uses in these classes get a 90-day review clock (vs. the normal 180 days) and must be added by the end of that period
No steering allowed	PA/ST cannot be used to steer current takers to preferred alternatives — applies to existing AND new enrollees already on therapy
HIV/AIDS practice	UM tools like PA/ST are generally not used in best-practice formularies for these drugs

Who Qualifies — and For How Long? (§30.4.1–30.4.4)

A transition fill bridges the gap while an exception is resolved

Eligible scenarios:

- New enrollees post-AEP
- Newly eligible Medicare beneficiaries
- Plan-to-plan switchers mid-year
- Enrollees hit by negative formulary changes
- LTC facility residents

Setting	Minimum Supply	Window
Retail	≥ 30 days (multiple fills allowed)	First 90 days of enrollment

108-day look-back: if a sponsor can't distinguish a new script from an ongoing therapy at POS, it must be treated as a transition fill.

Transition Notices & Special Populations (§30.4.8–30.4.10)

Communication requirements and edits that still apply

Required Notice

- U.S. First Class mail within 3 business days of the transition fill
- Only required with the FIRST fill if multiple fills complete the supply
- Must explain: supply is temporary, how to pursue an exception, appeal rights
- Reasonable effort required to notify the prescriber too (e.g., "Prescriber Copy")

Edits That Still Apply in Transition

- Part A/B vs. D determination edits
- Edits preventing non-Part D / excluded drug coverage
- Safety edits — e.g., beneficiary-level opioid limits, cumulative APAP quantity limits, early-refill logic
- If a safety edit shortens the fill, the beneficiary is still owed the remaining days to reach the full transition supply

COST & SAFETY CONTROLS

Utilization Management Tools

Prior Authorization (PA)

Requires clinical justification before certain drugs are approved for coverage — common for specialty and high-cost therapies.

Step Therapy (ST)

Requires trying a preferred, often lower-cost therapy first before a plan will cover a step-up alternative.

Quantity Limits (QL)

Caps the amount of a drug covered per fill or time period, aligned to clinical guidelines and safety thresholds.

Pharmacy Network Design

Preferred pharmacy networks and mail-order incentives steer utilization toward lower-cost, higher-quality dispensing channels.

Coverage & Organization Determinations

The first substantive decision in the process — everyone must be adjudicated by a physician or other appropriate health professional with sufficient clinical expertise when denying based on medical necessity.

PART C

Organization Determinations

- Covers benefits, services, and payment disputes under the MA plan
- Includes at-risk determinations under Drug Management Programs
- Any enrollee, provider (with a waiver of liability), or representative may request
- Plans must accept requests 24/7, including holidays

PART D

Coverage Determinations

- Whether a drug is covered and what the enrollee must pay
- Includes exceptions: tiering exceptions & formulary exceptions
- Requires prescriber supporting statement for exception requests
- At-risk determinations for Part D drug management

Tiering & Formulary Exceptions

An exception request is a special category of coverage determination that requires a supporting statement from the prescriber before the adjudication clock fully starts.

Tiering Exception

Requests a non-preferred drug be covered at a lower cost-sharing tier. Not available if the drug is on the plan's specialty tier.

Formulary Exception

Requests coverage of a non-formulary drug, or a UM requirement (e.g., step therapy, quantity limit) be waived.

SUPPORTING STATEMENT TIMING

- The plan may allow up to **14 calendar days** for the prescriber to submit the supporting statement
- Decision is due **72 hours (24 hours if expedited)** after the statement is received, or 14 calendar days after the request if no statement arrives
- A favorable exception decision remains valid for the **remainder of the plan year**

Initial Determination Clocks

PART C

Type	Standard	With Extension
Item or service	14 calendar days	28 days
Part B drug	72 hours	N/A
Expedited	72 hours	17 days
Expedited Part B drug	24 hours	N/A

PART D

Type	Timeframe
Standard	72 hours*
Expedited	24 hours*
Payment	14 calendar days

**Or 24/72 hrs after receiving the prescriber's supporting statement for exception requests. Part D timeframes and Part B drug/payment timeframes may never be extended.*

Missed timeframe = adverse decision. Part C: enrollee gains a level 1 appeal right. Part D: the plan sponsor must forward the full case file to the IRE within 24 hours of the missed deadline and notify the enrollee — it may not simply issue a late denial.

POLICY UPDATE

2026 IRA Changes at a Glance

Annual Out-of-Pocket Cap

First-ever hard cap on member cost-sharing for covered Part D drugs: $2,000 in 2025, $2,100 in 2026 (indexed annually).

Manufacturer Discount Program

Replaces the old Coverage Gap Discount Program; manufacturers contribute across both the initial and catastrophic phases.

Medicare Prescription Payment Plan

Members can elect to “smooth” out-of-pocket drug costs into monthly payments across the plan year.

Plan Liability Shifts

Plans now bear a larger share of catastrophic-phase costs, increasing incentives for tighter utilization management.

Phase 1: Enactment & Early Wins

2022 – 2023

Aug 16, 2022

IRA Signed Into Law

Sections 11001–11202 establish the Negotiation Program, inflation rebates, and Part D benefit redesign.

Jan 1, 2023

Insulin Cap & Free Vaccines

$35/month cap on covered insulin products; ACIP-recommended adult vaccines covered at $0; deductible waived for both.

Aug–Sep 2023

First 10 Drugs Selected

CMS publishes the first 10 Part D drugs selected for negotiation (initial price applicability year 2026), covering ~20% of Part D gross drug spend.

Oct 2023

Manufacturers Agree to Negotiate

All manufacturers of the 10 selected drugs agree to participate; formal negotiation period begins.

Phase 2: Negotiated Prices Set & Redesign Goes Live

2024 – 2025

Aug 14, 2024

First Maximum Fair Prices Published

Negotiated prices for the first 10 drugs are announced — 38%–79% below 2023 list prices; effective Jan 1, 2026.

Jan 1, 2025

Full Benefit Redesign Effective

$2,000 annual OOP cap; coverage gap and initial coverage limit eliminated; new 3-phase structure (deductible, initial, catastrophic).

Jan 1, 2025

Manufacturer Discount Program Launches

MDP replaces the Coverage Gap Discount Program; manufacturers discount applicable drugs in the initial and catastrophic phases.

Jan 17, 2025

Second Round: 15 Drugs Selected

CMS names 15 additional Part D drugs (incl. major diabetes/weight-loss agents) for negotiation; prices effective 2027.

Phase 3: Savings Take Effect & Rulemaking Catches Up

2026

Jan 1, 2026

Negotiated Prices Take Effect

The first 10 negotiated prices go live — the first year beneficiaries feel direct negotiation impact. Est. $1.5B in beneficiary savings; $6B to Medicare, in year one.

CY 2026

OOP Cap Indexed to $2,100

The annual out-of-pocket threshold, indexed to inflation, rises from $2,000 (2025) to $2,100 for 2026, per the CY 2026 Rate Announcement.

Nov 26, 2025

CY 2027 Proposed Rule Published

CMS proposes to codify the IRA redesign into permanent regulation — deductible, ICL/gap elimination, OOP threshold, MDP, specialty tiers, TrOOP.

Apr 2, 2026

CY 2027 Final Rule Released

CMS finalizes codification. Effective June 1, 2026; applicable to coverage beginning January 1, 2027.

Looking Ahead: The Negotiation Pipeline

2027 – 2029 and beyond

Jan 1, 2027

Round 2 Prices Take Effect

Negotiated prices for the 15 drugs selected in Jan. 2025 take effect for Part D.

Feb 2027

Round 3 Drugs Announced

CMS names the next round of drugs — up to 15 more, first year Part B drugs are eligible alongside Part D.

2028

Part B Drugs Enter Negotiation

Program formally expands to Medicare Part B (physician-administered drugs) for the first time.

2029+

Rounds Scale to 20 Drugs/Year

Beginning 2029, CMS selects 20 additional drugs annually from the costliest Part B and Part D products; each round is cumulative.

Note: The 2025 budget reconciliation act (H.R. 1) narrowed the pool of drugs eligible for future negotiation rounds; KFF estimates this increases Medicare spending by at least $5B.

IPAY 2027 Maximum Fair Prices — Part 1 of 2 (Drugs 1–8 by Part D Spend)

Drug Name	Manufacturer	Primary Indication(s)	MFP (30-day)	2024 List Price	Discount	Part D Spend (2024)
Ozempic / Rybelsus / Wegovy	Novo Nordisk	T2 Diabetes; CV Disease; Obesity	$274	$959	**71%**	$15.2B
Trelegy Ellipta	GlaxoSmithKline	Asthma; COPD	$175	$654	**73%**	$5.3B
Xtandi	Astellas Pharma	Prostate Cancer	$7,004	$13,480	**48%**	$3.4B
Pomalyst	Bristol-Myers Squibb	Multiple Myeloma; Kaposi Sarcoma	$8,650	$21,744	**60%**	$2.2B
Ofev	Boehringer Ingelheim	Idiopathic Pulmonary Fibrosis	$6,350	$12,622	**50%**	$2.1B
Ibrance	Pfizer	Breast Cancer	$7,871	$15,741	**50%**	$2.0B
Linzess	AbbVie	CIC; IBS-C	$136	$539	**75%**	$2.0B
Calquence	AstraZeneca	CLL/SLL; Mantle Cell Lymphoma	$8,600	$14,228	**40%**	$1.7B

Source: CMS Fact Sheet — Negotiated Prices for IPAY 2027 (November 2025)

IPAY 2027 Maximum Fair Prices — Part 2 of 2 (Drugs 9–15 by Part D Spend)

Drug Name	Manufacturer	Primary Indication(s)	MFP (30-day)	2024 List Price	Discount	Part D Spend (2024)
Austedo / Austedo XR	Teva	Huntington's Chorea; Tardive Dyskinesia	$4,093	$6,623	**38%**	$1.7B
Breo Ellipta	GlaxoSmithKline	Asthma; COPD	$67	$397	**83%**	$1.4B
Xifaxan	Salix Pharmaceuticals	Hepatic Encephalopathy; IBS-D	$1,000	$2,696	**63%**	$1.2B
Vraylar	AbbVie	Bipolar I; MDD; Schizophrenia	$770	$1,376	**44%**	$1.1B
Tradjenta	Boehringer Ingelheim	Type 2 Diabetes	$78	$488	**84%**	$1.1B
Janumet / Janumet XR	Merck Sharp & Dohme	Type 2 Diabetes	$80	$526	**85%**	$1.1B
Otezla / Otezla XR	Amgen	Plaque Psoriasis; Psoriatic Arthritis; Behçet's	$1,650	$4,722	**65%**	$1.0B

ⓘ Note: Entresto, Stelara, and Xarelto (IPAY 2026 drugs) will be removed from the Selected Drug List starting January 1, 2027, as generic/biosimilar versions are now being marketed.

Source: CMS Fact Sheet — Negotiated Prices for IPAY 2027 (November 2025)

Medicare Advantage Is the Backbone of PR's Health System

~650K

beneficiaries enrolled in Medicare Advantage in Puerto Rico

94%

MA penetration rate among eligible beneficiaries

>80%

of PR Medicare enrollees choose MA, vs. ~30% on the mainland

1%

of eligible beneficiaries remain on Traditional Medicare (~40,000 people)

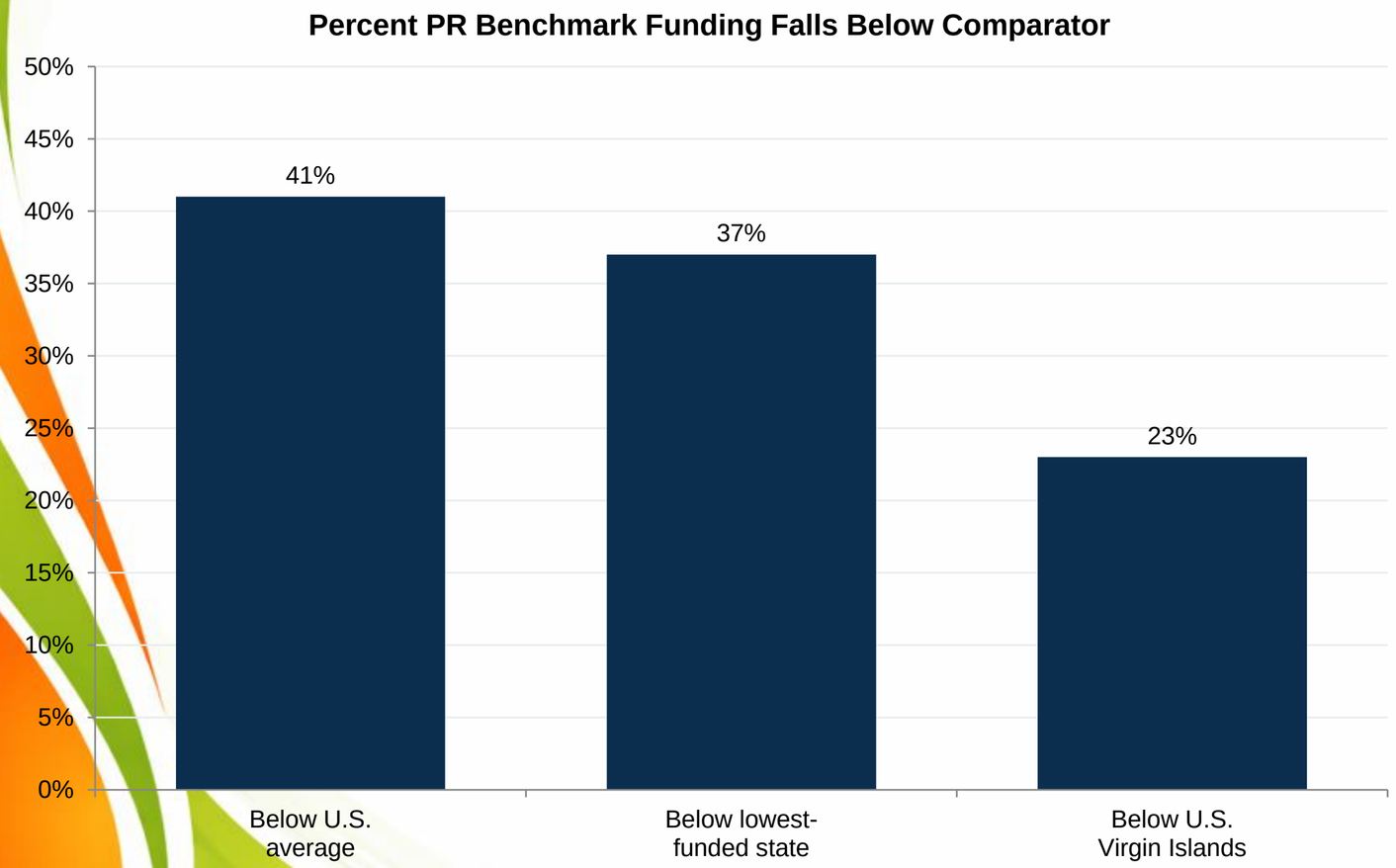
Why this matters

Puerto Rico residents pay the same Medicare payroll tax as mainland citizens, but the island receives the lowest level of federal Medicare spending in the country. Because such a large share of the population depends on MA for essentially all of their health coverage, underfunding at the benchmark level has an outsized impact on provider networks, access to specialists, and the sustainability of the local health care system.

Source: MMAPA – Medicaid and Medicare Advantage Association of Puerto Rico

MA Federal Benchmark Funding: How Far Behind Is PR?

Puerto Rico's Medicare Advantage benchmark funding trails every other comparison point in the country.

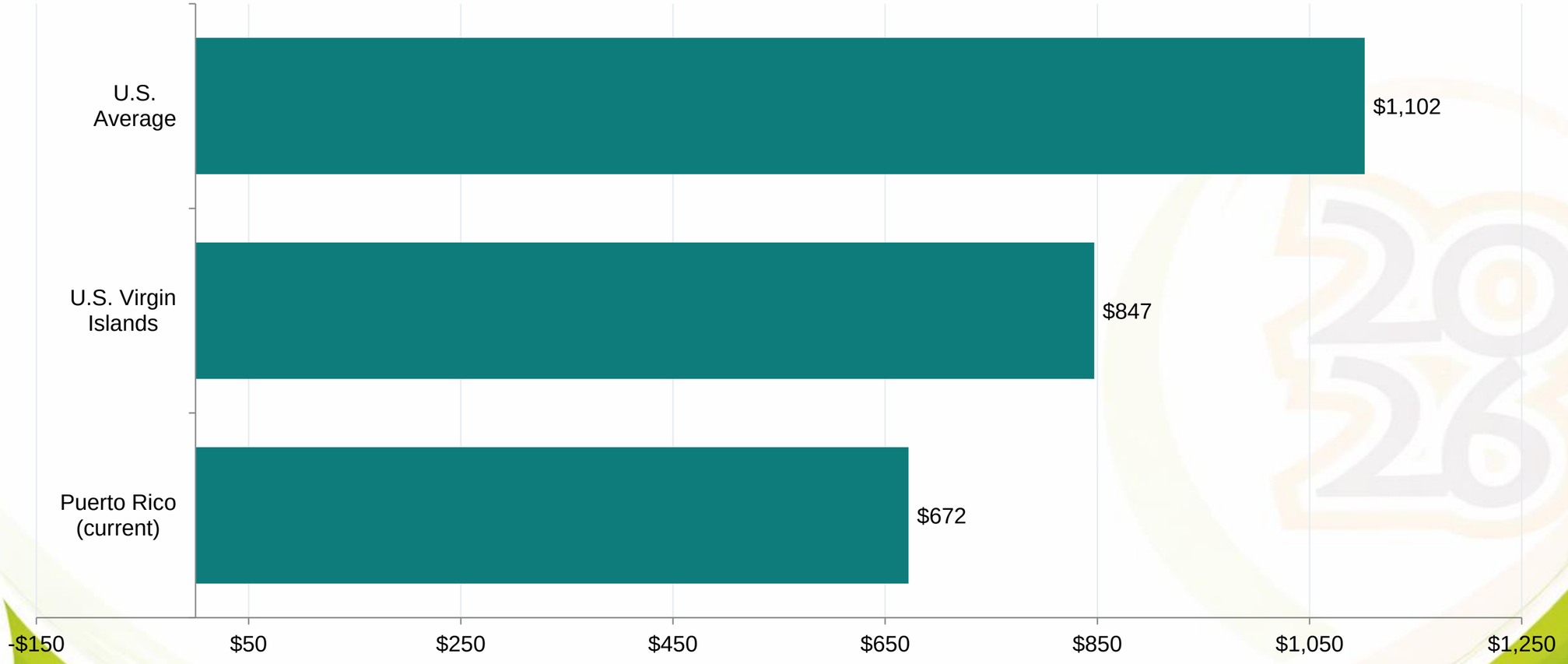


1. **41% below the U.S. average**
   in federal benchmark funding
2. **37% below the lowest state**
   even the least-funded U.S. state outpaces PR
3. **23% below the U.S. Virgin Islands**
   a neighboring territory with similar socio-economics

Source: MMAPA – Medicaid and Medicare Advantage Association of Puerto Rico

Base Premium: Puerto Rico vs. USVI vs. U.S. Average

Monthly MA base premium (PMPM benchmark) by jurisdiction, in U.S. dollars.



Gap: PR's premium is $175/month below USVI and $430/month below the U.S. average — a difference that compounds across hundreds of thousands of members.

Source: MMAPA – Medicaid and Medicare Advantage Association of Puerto Rico

Medicare Benefit Knowledge Check

Question 1

Under Medicare Advantage (Part C), which of the following are considered as part of the supplementary benefits from CMS?

A. The annual out-of-pocket maximum
B. Extra benefits such as dental, vision, hearing, OTC allowances, transportation, and meals
C. The Part B monthly premium
D. The 20% coinsurance after the deductible

Medicare Benefit Knowledge Check

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Under Medicare Advantage (Part C), which of the following are considered as part of the supplementary benefits from CMS?

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B. Extra benefits such as dental, vision, hearing, OTC allowances, transportation, and meals ☑
C. The Part B monthly premium
D. The 20% coinsurance after the deductible

Correct answer: B

Medicare Benefit Knowledge Check

Question 2

Which pharmacy Star Ratings measure tracks members with overlapping opioid and benzodiazepine fills?

A. PDC (Proportion of Days Covered)
B. MTM Completion Rate
C. Statin Use in Diabetes (SUPD)
D. COB (Concurrent Opioid & Benzodiazepine)

Medicare Benefit Knowledge Check

Question 2

Which pharmacy Star Ratings measure tracks members with overlapping opioid and benzodiazepine fills?

A. PDC (Proportion of Days Covered)
B. MTM Completion Rate
C. Statin Use in Diabetes (SUPD)
D. COB (Concurrent Opioid & Benzodiazepine) ☑

Correct answer: D

PART 4

Medicaid & Its Governance in Puerto Rico

THE BASICS

What Is Medicaid?

- A joint federal-state (and federal-territorial) program that finances health coverage for eligible low-income individuals — established alongside Medicare under the 1965 Social Security Act Amendments (Title XIX).
- Unlike Medicare, Medicaid is means-tested: eligibility is based on income and household criteria, not age or work history.
- States and territories administer their own programs within federal rules, covering mandatory benefits (e.g., inpatient/outpatient care, physician services) plus optional benefits they choose to include, such as prescription drugs.
- In the 50 states and D.C., federal funding is open-ended and matched via the Federal Medical Assistance Percentage (FMAP) — Puerto Rico's model works differently

FUNDING STRUCTURE

How Puerto Rico's Medicaid Financing Differs

- States receive open-ended federal matching funds with no ceiling. Puerto Rico and the other territories instead receive an annual capped federal allotment under Section 1108 of the Social Security Act — once exhausted, the territory must cover any additional cost with local funds.
- Puerto Rico's FMAP is set by statute rather than calculated from per-capita income like the states. Temporary federal relief (Consolidated Appropriations Act, 2023) raised it to 76% through FY2027.
- This funding cliff risk is real: absent further Congressional action, both the enhanced FMAP and capped allotment amounts are scheduled to drop sharply after FY2027, which local health officials have flagged as a major fiscal risk to Plan Vital.

Annual Federal Cap

FY2025	**$3.475B**
FY2026	**$3.645B**
FY2027	**$3.825B**

FMAP: 76% through FY2027 (statutory), vs. open-ended matching for states.

WHO RUNS IT

Medicaid Governance in Puerto Rico

PR Department of Health

The federally designated “Single State Agency” for Medicaid — legally responsible for eligibility policy and the Medicaid State Plan.

ASES (PRHIA)

Administración de Seguros de Salud — a public corporation created by Act No. 72 of 1993, operating under delegated authority to administer day-to-day program operations.

Contracted MCOs

ASES contracts with Managed Care Organizations — currently four island-wide — that deliver covered services to enrollees.

Oversight & Quality

ASES monitors and evaluates MCO performance through its Quality Management Strategy, consistent with 42 CFR Part 438 federal managed care rules.

THE PROGRAM ON THE GROUND

Plan Vital: Puerto Rico's Medicaid Managed Care Program

- Puerto Rico's Medicaid program is delivered entirely through managed care — there is no fee-for-service “original Medicaid” option, unlike most states.
- The program has been rebranded over time: Reforma → Mi Salud (2010) → Government Health Plan → Plan Vital (since November 2018).
- Enrollees choose freely among the ASES-contracted MCOs serving their region, covering acute, primary, specialty, and behavioral health benefits.
- Scale: Plan Vital and its related categories cover roughly 1.5 million beneficiaries — with about 1.4 million (over 40% of the island's population) exclusively enrolled in Plan Vital alone.

WHERE MEDICARE & MEDICAID MEET

Medicare Platino & Dual-Eligible Members

- “Dual eligibles” are members enrolled in both Medicare and Medicaid — a large and clinically complex population in Puerto Rico, reflected in the high share of D-SNP (Dual Special Needs Plan) enrollment noted earlier.
- Medicare Platino is ASES's supplemental wraparound coverage, layered onto a contracted Medicare Advantage plan to cover cost-sharing and benefits Medicare alone doesn't fully address for dual-eligible members.
- Platino is offered through several contracted plans, coordinating Medicare's acute/primary coverage with Medicaid wraparound services — together approximating Plan Vital-equivalent coverage for duals.
- This dual-coverage layering makes coordination of benefits (COB), formulary alignment, and utilization management especially important for this population.

CONNECTING TO OUR WORK

Why Medicaid Governance Matters for Pharmacy

Preferred Drug List (PDL)

ASES governs the Plan Vital formulary; MCOs administer it within ASES-set parameters.

Cartas Normativas

ASES policy letters set binding rules — including biosimilar substitution and NDC grace periods.

Biosimilar Policy

PR-specific substitution rules shape conversion strategy differently than commercial or MA markets.

Funding Pressure

The FY2027 funding cliff makes cost-effective formulary and UM design a near-term strategic priority.

Salud Física PDL: governance and design

Governance

ASES designs and maintains the PDL through its PBM (Abarca), based on recommendations from the Pharmacy and Therapeutics Committee (CFT) - primary care physicians, specialists, and pharmacists active in clinical practice.

Mandatory use

The PDL is the official formulary of the Plan de Salud Vital.

Generic first

Using the bio-equivalent generic (FDA "AB" rated) as the first option is mandatory whenever one exists, unless ASES determines to also or only cover the brand.

A living document

The PDL is reviewed periodically, and changes are communicated through *Cartas Normativas* (policy letters) - the current version is the March 2026 revision.

Which formulary applies to which provider?

Formulary	Who uses it
Salud Fisica PDL	PCPs, specialists, and subspecialists; also reverse-placement physicians in mental health facilities if the beneficiary has a registered SMI condition.
Salud Fisica Subformulary	Physicians in the Mental Health Network.
Salud Mental PDL	Contracted psychiatrists and physicians in mental health treatment facilities.
Salud Mental Subformulary	Primary care physicians participating in the Primary Medical Groups.
Special subformularies	Dental, Nephrology, OB-GYN, Oncology, Emergency Room, HIV/AIDS - each with specific rules within the integrated care model.

PDL medications are evaluated for safety, demonstrated clinical efficacy, the existence of bioequivalents, and treatment cost-effectiveness.

Operating rules

Days supply

Acute: max. 15 days (extendable via exception). Maintenance: 30 days x 5 refills, or 90 days x 1 refill. (narcotics: single dispense only, no refills).

Prior Authorization (PA)

Every PA request must be resolved within 24 hours or less, provided the information is complete. Maximum validity of 12 months or per clinical protocol.

Emergency Rule (FEI)

Medications on the Integrated Emergency Formulary, analgesics, narcotics, and NSAIDs are dispensed for 5 business days following an Emergency Room visit; treatment continuity is managed by the PCP.

When and how to request a non-PDL medication

A medication outside the PDL is only approved by exception, and must meet at least one of these 4 clinical criteria:

1
Contraindication to the PDL medication(s)

2
History of a clinically significant adverse reaction to PDL alternatives

3
Evidence of therapeutic failure on all available PDL alternatives

4
No therapeutic alternative exists within the PDL

How the request is processed

- Requires clinical justification documented by the prescribing physician, explaining the reasons for the request.
- Coverage determination cases must resolve the request within 24 hours or less, if the information is complete.
- Availability of the bioequivalent generic version is always evaluated first, before approving the brand.

Medicaid Benefit Knowledge Check

Question 1

What is Medicare Platino?

A. A standalone Part D plan for dual-eligible members
B. ASES' supplemental wraparound coverage layered onto a contracted Medicare Advantage plan for dual-eligible members
C. A separate Medicaid program independent of Plan Vital
D. A pharmacy network exclusive to behavioral health providers

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Correct answer: B

Medicaid Benefit Knowledge Check

Question 2

Under the Plan Vital Emergency Rule (FEI), medications on the Integrated Emergency Formulary are dispensed for how long following an Emergency Room visit?

A. 24 hours
B. 5 business days
C. 15 days
D. 30 days

Medicaid Benefit Knowledge Check

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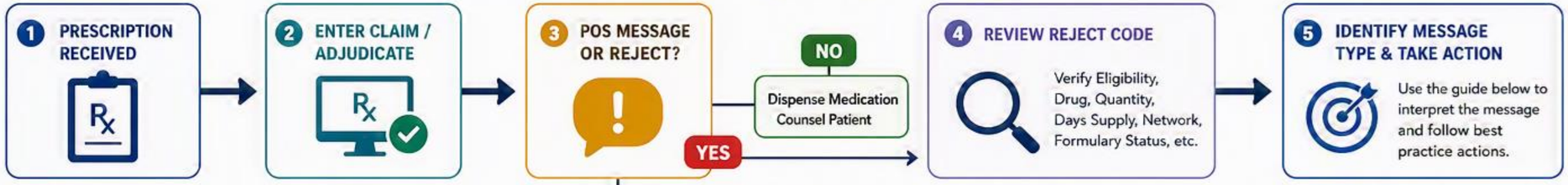
B. 5 business days ☑
C. 15 days
D. 30 days

Correct answer: B

POINT OF SALE (POS) PHARMACY WORKFLOW

How to Interpret POS Messages & Take Best Practice Actions



POS MESSAGE SCENARIOS, MEANING & BEST PRACTICE ACTIONS

	1 PRESCRIPTION WORKFLOW & POS MESSAGE OVERVIEW	2 EXCLUSION: NOT A COVERED BENEFIT	3 NON-FORMULARY: MAY BE COVERED UNDER EXCEPTION PROCESS	4 OUT OF NETWORK PROVIDER	5 COST LIMIT EXCEEDS	6 DAYS SUPPLY EXCEEDS	7 PRIOR AUTHORIZATION REQUIRED	8 STEP THERAPY REQUIREMENTS	9 DOCUMENT & FOLLOW UP
MEANING	POS messages (rejects or alerts) provide real-time information about a claim.	Drug or service is excluded from coverage and will not be reviewed for medical necessity.	Drug is not on the formulary but may be covered with an exception and may be reviewed for medical necessity.	Provider/pharmacy is not contracted with the plan.	The submitted cost or maximum allowed amount has been exceeded.	Submitted days supply exceeds the plan's allowed limit.	Plan requires clinical review and approval before the medication can be covered.	Patient must try the plan's preferred medication(s) before the requested drug is covered.	All actions and communications should be documented and followed up.
BEST PRACTICE ACTIONS	• Always read the full message and code. • Verify patient eligibility, drug, quantity, days supply, and plan rules. • Determine next step based on message type.	• Inform prescriber and patient. • Discuss covered alternatives or cash options. • Document conversation and resolution.	• Contact prescriber to initiate formulary exception/PA. • Gather clinical justification. • Submit request to plan and follow up.	• Inform patient. • Redirect to in-network pharmacy/provider when possible. • Contact plan if clarification is needed.	• Review claim details (drug, strength, NDC, quantity, price). • Consider lower-cost alternative if clinically appropriate. • Request override/PA if needed.	• Adjust days supply to plan limit if appropriate. • If not appropriate, request coverage exception/override.	• Notify prescriber immediately. • Submit PA with required clinical information. • Follow up on status.	• Verify patient's claims history for required step therapy drugs. • If criteria not met, request step therapy exception with clinical rationale.	• Document all calls, messages, and actions taken. • Communicate updates to patient/prescriber. • Reprocess claim when resolved.
KEY POINTS	Accurate interpretation prevents delays, denials, and patient frustration.	Claims for excluded items are not eligible for medical necessity review.	Exception requests may require clinical documentation and review.	Using in-network providers maximizes benefits and reduces patient cost.	Plan limits are based on maximum allowable cost or reimbursement thresholds.	Use the minimum effective days supply based on patient needs and plan rules.	Timely PA submission helps avoid therapy delays.	Step therapy is a type of prior authorization focused on lower-cost alternatives first.	Good documentation supports continuity of care and audit compliance.

BEST PRACTICE FOLLOW-UP CHECKLIST

- Communicate clearly with patients and prescribers.
- Document all interactions and actions.
- Follow up on pending requests.
- Reprocess claim when issue is resolved.
- Ensure patient understands next steps.
- Protect patient safety, access, and plan compliance.

GOAL: Resolve issues efficiently, minimize delays, and ensure patients receive the right medication at the right time.

REFERENCES

- CMS – Drug Plan Rules (Prior Authorization, Step Therapy, Quantity Limits) https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules
- CMS – Formulary and Tiering Exceptions https://www.cms.gov/medicare/appeals-grievances/prescription-drug/exceptions
- NCPDP Reject Codes (Industry Standard) https://ncpdp.org/ncpdp-reject-code-lists/
- Medi-Cal Rx – NCPDP Reject Codes https://medi-calrx.dhcs.ca.gov/

Note: Plan rules and messages may vary. Always refer to the specific health plan and PBM guidelines.

Final Summary

- **Complex pharmacy benefit landscape** across Commercial, Medicare, and Medicaid requires understanding of distinct regulations, formularies, and Pharmacy Benefit Design.

- **Knowledge gaps** among pharmacy personnel can contribute to claim denials, therapy delays, compliance risks, and inconsistent patient care.

- **Pharmacists and pharmacy technicians** play a critical role in accurately interpreting and applying pharmacy benefits at the point of care.

- **Structured, evidence-based education** strengthens understanding of regulatory requirements and segment-specific pharmacy benefit processes.

- **Improved competency** supports accurate claims processing, effective formulary management, consistent utilization review, and regulatory compliance.

- **Enhanced pharmacy practice** leads to fewer operational errors, reduced administrative burden, improved patient access, and higher-quality managed care outcomes.

Thank you

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POST TEST

Question 1 (Multiple Choice)
Which statement best describes a key regulatory distinction between Commercial and Medicare Part D pharmacy benefits?

A. Commercial plans and Medicare Part D are regulated solely at the state level

B. Medicare Part D plans must comply with CMS standards, while Commercial plans may be governed by ERISA and State Insurance Laws

C. Commercial plans require CMS approval for formularies

D. Medicare Part D plans do not use utilization management tools

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C. Commercial plans require CMS approval for formularies

D. Medicare Part D plans do not use utilization management tools

☑ Correct Answer: B
Justification:
Medicare Part D is federally regulated by CMS and must comply with detailed requirements in 42 CFR Part 423, including formulary standards and beneficiary protections. In contrast, Commercial Pharmacy Benefits may be regulated under ERISA for employer-sponsored plans and by state insurance laws, depending on plan structure.

POST TEST

Question 2 (True or False)

Medicaid pharmacy benefits may be administered under managed care arrangements that are subject to state-specific regulations within federal guidelines.

POST TEST

Question 2 (True or False)

Medicaid pharmacy benefits may be administered under managed care arrangements that are subject to state-specific regulations within federal guidelines.

☑ Correct Answer: True

Justification:

Medicaid operates as a federal–state partnership, allowing states to administer pharmacy benefits through fee-for-service or managed care models. While federal regulations establish minimum requirements, states maintain authority to implement additional rules affecting coverage, authorization, and reimbursement.

POST TEST

Question 3 (Multiple Choice)

Which regulation most directly governs formulary development and Pharmacy & Therapeutics (P&T) Committee requirements for Medicare Part D plans?

A. Title 26 of the Puerto Rico Insurance Code
B. ERISA Section 408(b)(2)
C. 42 CFR §423.120
D. Medicare Prescription Drug Benefit Manual, Chapter 6

POST TEST

Question 3 (Multiple Choice)
Which regulation most directly governs formulary development and Pharmacy & Therapeutics (P&T) Committee requirements for Medicare Part D plans?

A. Title 26 of the Puerto Rico Insurance Code
B. ERISA Section 408(b)(2)
C. 42 CFR §423.120
D. Medicare Prescription Drug Benefit Manual, Chapter 6

☑ Correct Answer: D
Justification:
Chapter 6 of the Medicare Prescription Drug Benefit Manual provides detailed CMS guidance on formulary design, P&T Committee standards, protected drug classes, and utilization management. While 42 CFR sets the legal framework, the manual explains how those requirements must be operationalized.

POST TEST

Question 4 (True or False)

Accurate identification of whether a patient is covered under Commercial, Medicare, or Medicaid plans can help reduce claim denials and improve patient access to medications.

POST TEST

Question 4 (True or False)

Accurate identification of whether a patient is covered under Commercial, Medicare, or Medicaid plans can help reduce claim denials and improve patient access to medications.

☑ Correct Answer: True
Justification:
Each coverage segment has distinct rules for formularies, prior authorization, and reimbursement. Correctly identifying the coverage type allows pharmacy personnel to apply the appropriate processes, reducing administrative errors and delays in therapy.

POST TEST

Question 5 (Multiple Choice)

Which practice best supports regulatory compliance across Commercial, Medicare, and Medicaid Pharmacy Benefit Programs?

A. Applying the same claims and authorization process regardless of coverage type
B. Relying solely on prescriber direction for benefit interpretation
C. Using standardized workflows that incorporate segment-specific rules and documentation
D. Prioritizing cost savings over regulatory requirements

POST TEST

Question 5 (Multiple Choice)
Which practice best supports regulatory compliance across Commercial, Medicare, and Medicaid pharmacy benefit programs?

A. Applying the same claims and authorization process regardless of coverage type
B. Relying solely on prescriber direction for benefit interpretation
C. Using standardized workflows that incorporate segment-specific rules and documentation
D. Prioritizing cost savings over regulatory requirements

☑ Correct Answer: C
Justification:
Standardized workflows that are adapted to each segment's regulatory and operational requirements promote consistent application of benefits while maintaining compliance. This approach helps pharmacy personnel navigate complexity while supporting accurate claims processing and appropriate patient access.

Key Definitions

Stakeholder	Role / Definition
Insurers	Contract with PBMs to manage the pharmacy benefit portion of health plans for members.
Employers	Design health benefits (often self-insured), may outsource administration to insurers or PBMs, and can carve out pharmacy benefits to specialized vendors.
Government Entities	Contract with insurers or PBMs to manage benefits for public employees; Medicaid programs often rely on managed care organizations, with variation by state.
Pharmaceutical Manufacturers	Research, develop, produce, and market prescription drugs for patient treatment.
Pharmacy Benefit Managers (PBMs)	Manage pharmacy networks, set reimbursement, design formularies, negotiate rebates, and coordinate financial and operational interactions across the drug supply chain.
Chain Pharmacies	Retail entities that own or operate multiple pharmacy locations where patients can fill prescriptions.
Independent Pharmacies	Privately owned pharmacies operated by pharmacists, focused on providing direct patient care services.
Pharmacy Services Administrative Organizations (PSAOs)	Organizations that support independent pharmacies with administrative functions, including contracting with PBMs and wholesalers.
Wholesalers	Purchase drugs from manufacturers, store inventory, and distribute medications to pharmacies, hospitals, and provider offices.
Medicare Part D	Federal program providing optional prescription drug coverage for individuals aged 65 and older.
Medicaid	Joint federal-state program that provides healthcare coverage, including prescription drugs, to low-income populations.

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