Managed Healthcare ExecutiveMedicare Part DLog in to save to my locker

CMS unveils enhanced MTM program

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By Mari Edlin

It has been a decade since the Medicare Modernization Act took effect, creating Medicare Part D and tacking on mandatory medication therapy management (MTM) services to encourage the appropriate use of drugs by older adults.

In 2010, the Centers for Medicare & Medicaid Services (CMS) significantly tweaked MTM, providing changes in targeting criteria and giving the program more consistency. Three years later, the comprehensive medication review (CMR) as part of MTM services became a mandate for every program.

This evolution will be capped by Part D Enhanced MTM slated for January 1, 2017. Introduced by CMS' Center for Medicare and Medicaid Innovation (CMMI) for Prescription Drug Plans (PDPs) only [Medicare Advantage-Prescription Drug plans (MA-PDs) and PDPs participate in the current MTM program], it should provide more flexibility along with prospective and performance incentives.

Enhanced MTM

CMMI's overall goals for Enhanced MTM are:

- Improving compliance with medication protocols through appropriate prescribing and proper use.

- Reducing medication problems.
- Increasing patient knowledge of the drugs they take.
- Improving communications among prescribers, pharmacists, caregivers and patients.

Kurt Proctor, senior vice president, strategic initiatives, National Community Pharmacists Association, applauds the enhanced model emphasizing its incentives for prescribing appropriate drugs and for reducing other healthcare costs, such as fewer hospitalizations and emergency department visits. However, he acknowledges that MTM results in higher drug utilization and costs because of increased adherence and pharmacist participation.

The Congressional Budget Office estimates that a 1% increase in the number of prescriptions filled would cause Medicare's spending on medical services to fall by roughly 0.2%.

Proctor also looks forward to more flexible eligibility criteria so that those who really need MTM services are targeted, not just because they meet requirements.

Agreeing with Proctor, Mary Jo Carden, vice president, government and pharmacy affairs for the Academy of Managed Care Pharmacy (AMCP), says, "MTM may not be the best way to go for some beneficiaries even if they meet criteria requirements, but those most in need should receive it."

Michael Johnsrud, senior vice president, health economics and outcomes research for Avalere, a healthcare consulting company, says enhanced MTM will give plans the ability to design creative MTM programs to solve over- and under-identification of eligible members, target them appropriately, leverage services and benefits and improve outcomes. "It should enable pharmacists to improve drug utilization, control side effects and increase adherence," he says.

Next: Standardization challenges

Standardization challenges

Carden is concerned that pharmacists currently are not receiving sufficient reimbursement for their services in MTM programs. She notes that MA-PDs and PDPs are not reimbursed based on the number of members, resulting in less payment for pharmacists.

She also points out that MTM lacks electronic standards across states for delivering MTM and recommends the adoption of special clinical codes to be used across all platforms. AMCP supports Systematized Nomenclature of Medicine Clinical Terms that provide core general terminology for electronic health records and include terms for pharmaceuticals, devices, diagnoses, clinical findings and symptoms.

Due to a lack of reimbursement and electronic standardization, Carden says some pharmacists are resistant to providing MTM.

On the other hand, she notes that emerging telehealth models for completing MTM requirements that utilize pharmacists more directly, and recognition of pharmacists as providers in some states, are helping to drive participation.

Proctor anticipates that Star Ratings related to drug adherence and utilization should drive MTM services, increasing completion of all MTM components while showing improvement.

Carden says the Star Ratings are not just process measures, but they also require outcomes, triggering pharmacist interventions to accomplish them.

The ratings measure the following percentages: adults older than age 65 who are taking high-risk medications; patients with diabetes/hypertension who receive an ACE inhibitor or an angiotensin receptor blocker; patients taking medications for diabetes, high cholesterol and hypertension who have adherence rates greater than 80%; and beneficiaries who received a CMR with a written summary in the CMS standardized format.

Carden outlines other challenges related to inconsistency facing AMCP: lack of clarity regarding quality and outcomes measurements that will be used, the process for creating and adopting measures and the frequency with which measures will be updated and communicated.

Johnsrud says there also should be more standardization of codes used to bill third-party payers for MTM services provided during a face-to-face engagement between a pharmacist and patient.

Typically, pharmacists are reimbursed on a fee-for-service basis, but Proctor says there is a trend toward reimbursement based on performance. The three “pharmacists-only” CPT professional services codes are based on time rather than on complexity.

In addition, Johnsrud sees a gap among payers, health systems and pharmacists in standards for MTM services offered and advocates for pharmacist access to patient clinical information to achieve effective MTM.

Next: Commercial plans on board

Commercial plans on board

While most of the MTM activity is taking place in Medicare, the private sector is adopting similar services for its members.

Priority Health, a Michigan-based health plan, initiated its MTM program in 2010 and a year later, partnered with Outcomes MTM, which designs, delivers and oversees the administration of MTM programs. Outcomes MTM created a national network of contracted pharmacists and developed an electronic platform for Priority Health, which enables pharmacists to see a queue of eligible patients for MTM identified through claims data, along with patient medication needs.

Through reporting from Outcomes MTM, Priority Health can document services, total cost of care, medical and pharmacy costs, HEDIS scores due to MTM and success of its MTM program. Pharmacists bill the plan to receive reimbursement; they receive a defined fee-for-service payment and incentives for identifying *and* resolving medication problems, the latter paid annually.

Erica Clark, director of clinical pharmacy programs, Priority Health, says that pharmacists are anxious to provide MTM services in the plan and as demand increases, they should find opportunities to expand their own services.

Based on its 2011 Part D MTM program, the plan launched an aggressive MTM program for its commercial members in 2015, becoming the only plan in Michigan using community pharmacists at retail pharmacies and those embedded in enhanced patient-centered medical homes. Priority Health also added pharmacists in primary care offices to the network.

In order to include every Medicare beneficiary—regardless if they meet MTM criteria—Priority Health established an opt-out, all-in strategy and provides an opportunity for pharmacists and physicians to refer patients. “Some members might think they don’t need MTM services, but we have seen them benefit,” Clark says.

She says the plan uses claims data to identify its targeted population but because data often lag, referrals enable immediate interventions by pharmacists. For example, a patient who might be on a new regimen because of a heart attack could receive MTM services when picking up their new medications.

To meet MTM requirements for Priority Health’s Medicare population, members need to be taking four or more medications, have three or more chronic conditions, and exceed CMS’ annual dollar threshold. Priority Health also is measuring the number and percent of members who receive a CMR.

Twenty-two percent of Priority Health’s members—based on 2014 data and reported in 2016—received CMRs. The national average for PDPs is 15.4% in 2016, according to CMS.

Patients often decline a CMR because they believe their doctor or nurse does this for them when reviewing their medications. Clark emphasizes that there is a difference between medication reconciliation at the doctor’s office and the more robust and complete review of all prescribed and over-the-counter medications through an MTM program.

For that reason, Priority Health is focusing on educating members and providers about the value of MTM and has stepped up its outreach strategies to schedule CMRs with members.

When Priority Health analyzed total cost of care, the plan found that while there was an investment in MTM services, the result was a decrease in both pharmacy and medical spend. Of the cost savings, 90% was attributed to medical cost savings, Clark says