Medicare Backs Off on MTM Changes

Congressional and Patient-Group Opposition to Other, More Controversial Part D Reforms Sank the Plan

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Medicare has decided to ditch a pharmacist-favored expansion of the Part D medication therapy management (MTM) program.

The Centers for Medicare and Medicaid Services (CMS) requires Part D plans to identify patients with particular chronic illnesses taking multiple drugs and then provide them with MTM services aimed at keeping them out of the hospital and lowering plan and Medicare drug costs. But Part D plans have been providing MTM services to less than 10% of potential enrollees, which has concerned the agency. Those deprived of services appear to be disproportionately in minority populations. So a whiff of discrimination—the CMS has alluded to "racial disparities"— has attached itself to plan shortcomings.

But in a May 7, 2014 memorandum to Part D sponsors,[1] Jennifer Shapiro, MPH, Acting Deputy Director of the Medicare Drug Benefit and C & D Data Group, appears to ignore all of the MTM changes the CMS proposed on January 10, 2014. Those changes were part of a broader proposed rule including a number of revisions in the Part D and Part C (Medicare Advantage) programs for calendar 2015.[2] A coalition of groups including the American Society of Health-System Pharmacists, American Association of Colleges of Pharmacy, American Pharmacists Association, and American Society of Consultant Pharmacists supported the MTM changes.[3]

Many of those proposed Part D changes were much more controversial than the MTM plan. The most controversial was a proposal to reduce from six to three the "protected" drug categories in which plans must provide "all or substantially all" of the drugs in that category. There would have been new mandates on preferred pharmacy discounts. The number of Part D plans would have been limited. Those proposals—having nothing to do with MTM requirements—created a political tsunami. More than 400 patient groups, advocates, and trade associations descended on Congress in outrage. That opposition induced Democratic and Republican legislators alike to flood the CMS with disapproving letters.

That congressional pressure undoubtedly influenced Shapiro's memorandum. It simply reiterates the current requirements for "targeting" of potential patients, and the MTM services Part D plans are supposed to provide to them.

Sean Cavanaugh, CMS Deputy Administrator and Director of the Center for Medicare, states:

> CMS is committed to keeping the Medicare Part D prescription drug benefit successful, with broad beneficiary appeal and costs as low as possible. While we are currently reviewing comments on the proposed expansion of the medication therapy management (MTM) provisions in the proposed rule, we wanted to give the Part D sponsors needed guidance in their submission of their 2015 MTM programs.

The Academy of Managed Care Pharmacy was one of the few pharmacy groups to oppose the MTM changes, which it said would result in higher premiums for seniors because of "a costly and unnecessary program expansion targeted at beneficiaries who may not need or want the interventions." But in proposing the changes in January, the CMS was much more concerned that about 8% of those eligible for MTM are receiving services, way below the 25% level the CMS had projected when the Part D benefit was established in 2006.

It was against that backdrop that the CMS proposed to reduce Part D plan flexibility in targeting potential enrollees. Currently, a plan has to "auto-enroll" any member who meets all three targeting criteria.[4] One of those criteria is related to the number of chronic diseases a person suffers. Another concerns the number of drugs the person is taking. The third requires the member to incur annual drug costs over a certain level. Members who meet all three criteria receive an annual comprehensive medical review and then quarterly targeted medical reviews. Part D sponsors must assess the findings of these reviews to determine if a follow-up intervention is necessary for the beneficiary, the prescriber, or both. These assessments could be person to person or system generated. The follow-up interventions with the beneficiaries should be person to person, if possible, but may be delivered via the mail or other means.

Pharmacists have been trying for years to get the CMS to mandate that these assessments be done by pharmacists. That is not a requirement. In fact, the assessments are frequently done over the phone by nurses.

The targeting criteria allow a Part D plan to set a minimum number of drugs as high as eight, meaning someone would have to be taking eight drugs to qualify. Plans can set that bar much lower if they want. And spending has to exceed $3,138 annually. A member with three or fewer chronic diseases, out of a list of nine, is eligible. In other words, a plan cannot require members to have four or more chronic diseases.

All that was going to change in 2015. Plans were going to have to target all members taking as few as two drugs, with annual costs more than $620.

Those changes are out the window for 2015. But the Department of Health and Human Services has a new secretary, Sylvia Matthews Burwell. She may be able to withstand some of the congressional and interest-group pressure that got

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to Kathleen Sebelius, who was weakened by the uproar over the shaky Obamacare rollout.

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