Medicare Is Finally Offering More Flexibility for MTM Programs

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The Medicare program is finally providing Part D outpatient drug plans with some flexibility for medication therapy management (MTM) programs. The Centers for Medicare and Medicaid Services (CMS) announced an MTM pilot program starting in 2017 that offers Part D prescription drug plans (PDPs) potential improvements and incentives to upgrade their MTM plans, which even the CMS admits have failed to live up to expectations.

If there is a key watchword in this pilot program, it is “pharmacist.” The CMS hopes that PDPs will make greater and better use of pharmacists and that physicians and pharmacists will form a more unified nexus in caring for Part D patients. However, the CMS will not change its policy prohibiting pharmacists from billing for MTM services. The hope is that the PDPs will use their incentive payments from Medicare to reimburse pharmacists, although the CMS has introduced what the American Pharmacists Association (APhA) views as an antipharmacist element in the pilot.

The Academy of Managed Care Pharmacy (AMCP) has been among the groups pushing for more MTM flexibility. Mary Jo Carden, AMCP Vice President of Government and Pharmacy Affairs, says PDPs will have just a short time to assess whether the “enhanced” MTM pilot program, which will be available only in certain geographic areas, suits them well enough to upgrade their MTM plans, which even the CMS admits have failed to live up to expectations.

The per member/per month incentive payment—which will differ from plan to plan, based on the scope and intensity of MTM services offered—is meant to provide the PDP with additional funds that it could use, for example, to pay inhouse or retail pharmacists for providing MTM services. However, the plans will be required to “earn back” those payments in the form of savings.

The performance payment will be based on the PDP meeting quality and cost targets, similar to the structure of the accountable care organization program. For the years 2017 and 2018, those payments will be based on a PDP reducing Medicare Part A and B costs for its members by 2%. That reduction will have to be for the entire PDP membership, not just the members enrolled in the enhanced MTM program. The performance bonus would be a $2 per-member increase in the government subsidy to the plan premium, leading to lower beneficiary premiums.

Starting in 2019, the CMS hopes to have specific quality standards in place.

One thing that seems a bit curious about the proposed program is the CMS’s intention to waive a provision in the current MTM legal grounding that says an “MTM may be furnished by a pharmacist,” when an intervention not typically provided by a pharmacist is necessary to “resolve all barriers to optimized drug therapy or for financial need.” That language imposes no requirement on anyone. So the APhA argues that removing the language appears to conflict with statements throughout the announcement that specifically mention pharmacists and emphasize the need to utilize pharmacists and strengthen the coordination between them and the entire health care team, including the patient.

The success of the pilot program will depend on the CMS resolving that question about pharmacist participation and other critical issues, such as reporting of data from the PDPs, the 2019-and-beyond quality standards, and the sufficiency of incentive payments. The plans will ultimately determine how much of those incentives get passed along to retail and managed care pharmacists, who will probably have to do yeoman’s work to make this MTM pilot program a success.

REFERENCE