Six Part D drug plans sail into uncharted waters on January 1 when they embark on experiments with medication therapy management (MTM) programs in the new Medicare demonstration program. At a time of seemingly rapid prescription-drug cost increases, the five-year demonstration program will test the proposition that Part D plans can target MTM programs the way they want—not the way Medicare regulations insist they do. Those flexible member-targeting and intervention policies, the latter expected to include more physicians and pharmacies, will hopefully lead to lower Medicare Part A and B costs for the federal government.

The six plans participating in the demonstration are: Blue Cross and Blue Shield Northern Plains Alliance, Blue Cross and Blue Shield of Florida, CVS Health, Humana, UnitedHealthcare, and WellCare Prescription Insurance. They will test their particular targeting and intervention strategies in selected regions: Region 7 (Virginia), Region 11 (Florida), Region 21 (Louisiana), Region 25 (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming), and Region 28 (Arizona).

“Through this model, we are hopeful that Part D plans will invest in medication therapy management and identify new, effective strategies to optimize medication use and improve care coordination in Medicare,” said Patrick Conway, MD, Acting Principal Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS).

The six plans had to lay out their strategies for the demonstration and were chosen based on those. The idea is that the CMS will pay separately, beyond its normal payment, for each MTM demonstration, with those funds allowing each plan to go beyond in spending what they typically spend for MTM plans. They will be allowed to target members for MTM services in ways they have not been able to do in the past, either because of the presumed cost of expanding services or the restrictions on targeting them.

There are nearly 40 million Medicare beneficiaries enrolled in a Medicare-sponsored plan that provides prescription drug coverage, with approximately 24 million Medicare beneficiaries accessing their prescription drugs from a stand-alone prescription drug plan (PDP) operating within the Part D outpatient benefit. Those PDPs, operating in every state, must offer MTM services to plan members who meet three criteria: having more than one chronic condition, taking multiple drugs (between two and eight), and incurring annual costs for covered Part D drugs above a cost threshold ($3,138 in 2015). Those criteria fit about 25% of Part D recipients, but only 11% receive MTM services.

The “out-of-bid” annual upfront payment is expected to allow plans to enrich their MTM offerings. The 2% per member back-end “performance” payment is an incentive for them to reduce Part A/B costs. The CMS is setting a minimum savings rate of 2% in order to qualify for the performance payment. But in figuring the savings, the agency will subtract the upfront payments it made to plans. That will make it harder for the plans to reach the 2% target. The CMS explains:

Note that this approach of offsetting Parts A and B cost savings by the aggregate amount of prospective payments for the same period offers plans a strong encouragement to be judicious when determining the upfront cost of their intervention, since this amount will count against them when calculating savings for purposes of determining eligibility for performance payments.

The CMS expects the six PDPs to upgrade their connections, electronic and otherwise, with both physician offices and pharmacies. According to the agency, “sponsors may lack information to help assess medication-related risks, such as claims or other descriptors of ongoing medical care or alignment of beneficiaries with an ACO [accountable care organization].”

Again, it is unclear whether the six plans will aggressively upgrade their MTM programs given the CMS’s “strong encouragement to be judicious” with their spending. It seems almost contradictory to tell PDPs to spend funds to expand their efforts, with Medicare footing the bill, but on the other hand, give them “strong encouragement to be judicious” in those expenditures if they want a back-end incentive payment.

The use of the word “judicious,” argues Larry Kocot, a former top CMS pharmacy official now working with the Healthcare and Life Sciences Group at KPMG LLP, “seems to be a reasonable cautionary reminder.” So maybe “contradictory” is too strong a word. But no one would read the CMS “cautionary reminder” as a clarion call to action either.

REFERENCES