ABSTRACT

BACKGROUND: A key to efforts in controlling Medicare Part D costs is helping beneficiaries use medications more effectively (i.e., improve patient adherence and reduce adverse drug events). As such, the Medicare Modernization Act (MMA) requires Part D prescription drug plans to establish medication therapy management (MTM) programs. These programs employ pharmacists or other qualified providers to provide counseling and other services to enrollees who have high drug costs due to multiple medications for treating multiple chronic conditions.

OBJECTIVE: To review current MTM programs in Part D plans and to provide an overview of the key role that pharmacists play in implementing these programs.

SUMMARY: MTM programs are an important part of the MMA’s strategy to manage increasing medication costs among Part D beneficiaries. There is a potential to identify additional beneficiaries who qualify for these programs, thus improving the quality of life, cost-effectiveness, and appropriate drug utilization for more enrollees. The approval of permanent Current Procedural Terminology (CPT) codes for MTM services will make it easier for pharmacists to bill for these benefits. A survey published by the Agency for Healthcare Research and Quality (AHRQ) has evaluated the MTM services currently being offered by Part D plans. The services that were most frequently offered included patient education (75% of programs), promoting adherence (70%), and medication review (60%). There is an obvious need for plans to measure therapeutic outcomes with their MTM programs to document the effectiveness of these programs. Although this measurement is not yet required by the Centers for Medicare & Medicaid Services (CMS), it is in the plans’ interest to benchmark their MTM programs and determine whether the expense of designing and implementing such programs is justified by improvements in outcomes among beneficiaries.

CONCLUSIONS: MTM programs are an increasingly important part of ensuring that Part D plans are providing optimal therapeutic benefit for beneficiaries while managing costs. As such, plans need to consider both how they identify eligible enrollees and how they can target those who are most likely to benefit from MTM. In addition, clear, measurable goals for MTM programs must be established to demonstrate their cost-effectiveness.

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Introduction

The Medicare Modernization Act (MMA) was initiated to help Medicare beneficiaries afford the increasing cost of prescription drugs by subsidizing drug costs through stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans. A key part of the MMA’s strategy for managing the increases in medication costs includes the use of medication therapy management (MTM) programs that employ the services of pharmacists and other health care professionals to help ensure appropriate and cost-effective drug use among beneficiaries. The MMA requires Part D prescription drug plans to operate cost-effective MTM programs that provide counseling and other assistance to enrollees who have multiple chronic diseases (e.g., diabetes, asthma, hyperlipidemia, and congestive heart failure), who use multiple medications, and who incur high drug costs. MTM programs, which are broadly defined by the Centers for Medicare & Medicaid Services (CMS), can include a variety of methods (e.g., mailed letters, telephone conversations, face-to-face interactions) that promote better understanding of appropriate medication use, improved adherence to therapy, and the reduction of adverse events, all with the goal to improve the overall quality of medication use. These programs are funded according to a negotiated contract between drug plans (MA-PDs or PDPs) and CMS.

Which Beneficiaries Qualify for MTM?

Beneficiaries that qualify for MTM services are individuals with multiple chronic diseases taking multiple medications, and who are consequently likely to incur annual Part D drug costs in excess of a standard amount specified by the Secretary of Health and Human Services. Data from the 2002-2003 Medical Expenditure Panel Survey (MEPS) indicate that beneficiaries aged 65 years and older who met the expenditure threshold (adjusted to $3,810 in 2003 dollars) report an average of 11 unique medications, 82 prescriptions, and 5 chronic conditions. Approximately 9.2% of adults aged 65 years or older met the expenditure threshold. Women made up a higher percentage of the group that met the threshold compared with those that did not. The factors that predicted meeting the expenditure threshold included age, requiring help with daily activities, having functional limitations, receiving military health care services, and being a Medicaid beneficiary. Additional factors that predicted meeting the threshold included having mental health disorders, ulcers, diabetes, dyslipidemia, cardiac disease, chronic obstructive pulmonary disease (COPD), and the number of chronic conditions. Among older adults meeting the expenditure threshold, more than 60% reported 5 or more chronic conditions, while those who reported between 1 and 3 chronic conditions did not meet the threshold. Investigators noted that 97% of the older adults who exceeded the expenditure threshold had 2 or more chronic diseases, while all had filled at least 3 unique prescriptions during the year.
Medication Therapy Management

Recently, the Academy of Managed Care Pharmacy (AMCP) sponsored a study to assess and validate the Sound Medication Therapy Management Programs, version 1.0.² Field studies conducted by the National Committee for Quality Assurance (NCQA) reported for 13 PDP and 18 MA-PD MTM programs that beneficiaries selected for inclusion into the program had on average 2.6 chronic conditions, 5.6 medications, and annual drug expenditures ≥ $4,000.² Among the PDP and MA-PD plan members in this study, on average, only 11% (range 3%–27%) qualified for MTM programs according to CMS reportable criteria.² Thus, opportunities to better identify patients who may benefit from MTM programs represent a challenge to plan sponsors. More than 60% of Medicare beneficiaries are afflicted with 2 or more chronic conditions and may benefit from MTM initiatives (Figure).³

In the authors’ opinions, (a) expanding the population eligible for MTM programs at various levels of intensity could improve quality of life, cost-effectiveness, and appropriate utilization of medication therapies for these beneficiaries, which could have a positive effect on lowering overall medical utilization for plan sponsors, and (b) the CMS may place additional requirements on plan sponsors to extend MTM program eligibility as a mechanism to increase quality and encourage more appropriate cost-effective management initiatives to help mitigate rising health care costs in Medicare.

The Role of Pharmacists in MTM

The implications of MTM for pharmacists and pharmacy practice are significant, providing an opportunity for an increasing role for pharmacists in direct patient care. With their knowledge of pharmacotherapy, as well as a thorough understanding of insurance coverage and pharmacy benefit design, pharmacists are ideally suited to provide MTM services. The convenience and accessibility of being able to talk to a pharmacist about drug therapy are important benefits of pharmacist-provided MTM.⁶ In addition, there is increasing evidence that MTM services provided by pharmacists can improve medication adherence and clinical outcomes.⁴,⁵ For example, the Asheville Project demonstrated improvements in both clinical outcomes and patient-reported adherence to American Diabetes Association-recommended behaviors among patients with diabetes who received ongoing consultations with community-based pharmacists.⁵

One challenge that pharmacists have faced relative to this evolving role is how they are able to bill for the patient care services they provide. Toward that end, in 2005, 3 Current Procedural Terminology (CPT) codes for pharmacists were made available to bill third-party payers for face-to-face MTM services (Table).⁶,⁷ Initially introduced as temporary codes to allow the profession time to demonstrate their therapeutic value, new

<table>
<thead>
<tr>
<th>Temporary Code</th>
<th>Permanent Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0115T</td>
<td>99605</td>
<td>Initial 15 minutes of medication therapy management service(s), including assessment and intervention if appropriate; for a new patient</td>
</tr>
<tr>
<td>0116T</td>
<td>99606</td>
<td>Initial 15 minutes of medication therapy management service(s), including assessment and intervention if appropriate; for an established patient</td>
</tr>
<tr>
<td>0117T</td>
<td>99607</td>
<td>Each additional 15 minutes; used in addition to 99605 or 99606</td>
</tr>
</tbody>
</table>

MTM includes the following documented elements, as stated in guidelines established by the Pharmacist Services Technical Advisory Coalition (PSTAC), an organization that was founded to support billing for pharmacists’ professional services:

- Review of the pertinent patient history
- Medication profile (prescription and nonprescription)
- Recommendations for improving health outcomes and treatment compliance

Additional information is also available on the coalition’s website at: http://www.pstac.org/.

The codes are not to be used to describe the provision of product-specific information at the point of dispensing or any other routine dispensing-related activities.


FIGURE Percent of Medicare Beneficiaries With Varying Numbers of Chronic Conditions, 1999

CPT = Current Procedural Terminology, MTM = medication therapy management

TABLE CPT Codes for MTM Payments

Adapted from Thompson CA. Am J Health-Syst Pharm. 2007; 64:2410-12 and the Pharmacist Services Technical Advisory Coalition. Available at: www.pstac.org/services/mtms-codes.html.⁶,⁷
permanent codes were introduced in late 2007 for use starting on January 1, 2008. The codes were upgraded to permanent status based largely on the recognition that many pharmacists are providing MTM services. However, pharmacists can only use these CPT codes to bill payers according to criteria established by the health plan, and these criteria can vary considerably among individual plans. The next step in the process will be to establish payment rates for these services.

**MTM Programs in Medicare Part D: A Survey**

A useful picture of the breadth of MTM programs recently being offered by Part D prescription drug plans is available from a survey of MTM programs published by the Agency for Healthcare Research and Quality (AHRQ) in early 2007. Data were obtained for 70 health insurance plans, representing 50 different PDPs and 221 MA-PDs that cover at least 12.1 million Medicare enrollees.8

**MTM Enrollment Criteria**

With 1 exception, nearly all of the 20 MTM programs included in the survey imposed restrictions on beneficiary eligibility. These 19 programs represent 90.5% of the MTM programs surveyed and account for roughly 11.2 million enrollees.8 Among the 19 MTM programs with eligibility restrictions, all restrict enrollment to individuals with a predefined number of diseases, with a median number (range) of disease states of 3 (2 to 5).8 In addition, many MTM programs limit enrollment to patients with specific chronic diseases. Twelve MTM programs in the survey (57.1%, representing 4.0 million enrollees) restrict services on this basis, while 8 of the programs specify only that the conditions be chronic.8 The diseases most commonly included in the restrictions were diabetes mellitus (12 programs), congestive heart failure (10 programs), asthma (8 programs), hypertension (8 programs), and hyperlipidemia (8 programs).8

According to the MMA, MTM services should be offered to Medicare beneficiaries whose annual Part D drug expense exceeds a dollar amount specified by the Secretary of Health and Human Services, which in 2006 was $4,000.8 Nearly all the programs surveyed (95.2%) required beneficiaries to meet a spending threshold before being offered enrollment in an MTM. They also required that a patient fill a certain number of prescriptions for chronic medications (median number of medications=6) in order to qualify for enrollment.8 A challenge these programs face is getting support from chain pharmacies, some of which may consider MTM a challenge to implement given resource demands associated with achieving maximum efficiency in prescription dispensing.

**MTM Benefi t Design**

In addition to differences in enrollment criteria among the MTM programs, there were also notable differences in the services offered to beneficiaries, both between and within individual MTM programs. Six MTM programs (28.6%) offered a tiered MTM service benefit, while 15 programs (71.4%) provided the same services to all eligible enrollees.8 The services that were offered most frequently included patient education (75% of programs), patient adherence (70%), and medication review (60%). In programs with tiered benefits, some services may be offered only to a subgroup of eligible enrollees, although it was not disclosed in the survey results how these tier assignments were determined.8

An important aspect of MTM programs involves how such services are provided to patients. Typically, services can be provided by mail, telephone, or face-to-face interactions with a clinician. As expected, each option provides specific benefits, with mailings being the least expensive option and direct clinician contact likely to be the most effective.8

In 75% of the plans surveyed, some or all MTM services were provided by mail. Among the most popular methods for providing services, in-house telephone call centers were used by 90.4% of programs.8 In contrast, relatively few programs reported the use of in-house case managers or the use of contracted pharmacies. Nineteen percent of programs provided face-to-face services via contract with pharmacies.8

The frequency of MTM service provision also varied among the programs. Fourteen percent of programs provided services monthly and another 14% provided them annually. Nearly 25% of the programs did not specify a frequency for providing MTM services, but described their frequency as individualized according to patient need.8

Given that the MMA stipulates that MTM may be provided by a pharmacist and developed in cooperation with practicing pharmacists and physicians, it is not surprising that most of the programs (95.2%) employed pharmacists to provide MTM to their beneficiaries. Nearly half the programs (47.6%) also employed nurses, with physicians used by 14.3% of programs.8

**Documenting Outcomes of MTM Programs**

Since MTM programs are aimed at improving therapeutic outcomes for patients, there is an obvious need for plans to measure those outcomes and document the effectiveness of the MTM programs they provide; however, many plans are not yet doing this, or at least have not reported results of their evaluations. According to a survey by the American Pharmacists Association (APhA), numerous plans initially began MTM programs without plans to evaluate their effectiveness.9 The APhA also convened a task force to look at outcome measures that might be used by plans (as well as CMS) to evaluate MTM programs.9 The task force made a number of recommendations regarding the development of outcomes research for MTM services. It was recommended that outcomes analyses should include both short-term and long-term measures, as well as metrics to assess the economic impact of MTM services. In addition, there ought to be measures of adherence to established treatment standards and guidelines, monitoring of therapeutic outcomes, and monitoring to determine appro-
Among their findings was the recommendation that comparisons of different programs based on quality or performance to date is not yet sufficient across programs to enable an appropriate analysis requirement is intensive.

Some programs perform quality measurements across their entire populations, while half of the programs reported using Healthcare Effectiveness Data and Information Set (HEDIS) measures. However, the AMCP report notes that quality measurement to date is not yet sufficient across programs to enable comparisons of different programs based on quality or performance. Among their findings was the recommendation that MTM programs measure performance not only among those beneficiaries who are eligible for MTM services, but across the entire populations of their plans. This will make it possible for plans to identify benchmarks among programs and contribute to the establishment of best practices in the field.

Conclusions

MTM programs, which employ pharmacists and other health care professionals, represent a growing strategy to ensure appropriate and cost-effective drug use to ensure optimal outcomes. Under the MMA, Part D prescription drug plans are required to provide counseling and other assistance to enrollees who have multiple chronic diseases, require multiple medications, and incur high drug costs.

Identifying patients who may best benefit from participation in MTM programs is a challenge for plan sponsors. However, these programs offer beneficiaries an opportunity to improve the quality of life, cost-effectiveness, and appropriate drug utilization, thus reducing their health care utilization and costs to the MA-PD plan sponsors.

The growth of MTM programs also enables pharmacists and pharmacy practices to play a greater role in providing direct patient care. Their knowledge of pharmacotherapy, insurance coverage, and pharmacy benefit design, makes them an ideal choice as MTM service providers.

The eligibility criteria and services offered for MTM programs vary significantly. Eligibility can be based on a predetermined number of chronic diseases or limited to those with specific chronic diseases. Many MTM programs provide the same services to all eligible enrollees, but others offer a tiered benefit to MTM-eligible enrollees. Additionally, some plans offer MTM services monthly, while others are available only annually.

It is important that plans assess and document the therapeutic outcomes achieved through their MTM programs. Unfortunately, many plans are either not performing this evaluation or not reporting their results, despite an APhA task force’s recommendation that plans analyze the economic impact of MTM programs via short-term and long-term outcomes. The task force also recommended measurement of adherence to established treatment standards and guidelines and the monitoring of therapeutic outcomes and adverse drug events.

The establishment of measurable goals will enable both payers and CMS to assess the value of expanding MTM programs across populations. Although they are not yet required to document MTM outcomes, PDPs and MA-PDPs would find these data beneficial in determining whether the return on investment from their MTM programs justifies program design and implementation costs.

REFERENCES