2010 Medicare Part D Medication Therapy Management (MTM) Programs

June 8, 2010

FACT SHEET

OVERVIEW

Medication Therapy Management (MTM) programs were significantly enhanced for the 2010 contract year, and expanded requirements were put into place in order to increase the number of beneficiaries eligible for MTM services and the intensity of interventions, and to provide for the collection of more robust plan-reported data for outcomes analysis. This Fact Sheet presents a summary of the 2010 MTM programs under Medicare Part D.

BACKGROUND

The Medicare Modernization Act of 2003 (MMA) under title 42 CFR Part 423, Subpart D, establishes the requirements that Part D sponsors must meet with regard to cost control and quality improvement including requirements for MTM programs. The initial CMS regulations for MTM established a general framework that allowed sponsors' flexibility to promote best practices.

After analyzing common practices, requirements for 2010 were revised for greater consistency among the Part D MTM programs and to raise the level of the MTM interventions offered to positively impact the medication use of Medicare Part D beneficiaries. The revised requirements are described in the 2010 Call Letter[1] and Chapter 7 of the Prescription Drug Benefit Manual[2]. The requirements will be summarized within this Fact Sheet when applicable.

REVIEW OF 2010 MEDICATION THERAPY MANAGEMENT PROGRAMS

Each Part D sponsor is required to incorporate a MTM program into their Plan's benefit structure. These requirements do not apply to MA Private Fee for Service (MA-PFFS) organizations, as described in 42 CFR §422.4 (a)(3). However, considering MA-PFFS organizations have an equal responsibility to provide a quality Part D product, CMS encourages MA-PFFS organizations to establish a MTMP for Medicare beneficiaries. Annually each spring, sponsors submit a MTM program description for CMS to review and approve for the next contract year, as this approval is required for all MTM programs.[3] Additionally, to promote evolving MTM best practices and to consider the best interests of the Medicare beneficiary, CMS allows certain mid-year positive changes to the Part D sponsors' approved MTMP. Part D sponsors may request changes for approval during specified update windows.[4]

Therefore, this universe of active Part D contracts with an approved MTM program in 2010 includes 678 contracts (585 Medicare Advantage prescription drug plans (MA-PDs) and 93 prescription drug plans (PDPs)). Throughout this fact Sheet, these will be referred to as MTMP contracts or MTM programs. Employer contract MTM programs have been included in the statistics for PDPs. This analysis includes characteristics of 2010 MTM program applications approved during the spring Annual Review and changes approved during the September and March update windows as of April 6, 2010.

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[1] 2010 Call Letter. Accessed June 8, 2010. http://www.cms.gov/PrescriptionDrugCovContra/Downloads/2010CallLetter.pdf

[2] Prescription Drug Benefit Manual. Chapter 7-Medication Therapy Management and Quality Improvement Program. Accessed June 8, 2010. http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter7.pdf

[3] Memo: Contract Year 2010 Medication Therapy Management Program (MTMP) Submission. Accessed June 8, 2010. http://www.cms.gov/PrescriptionDrugCovContra/082_MTM.asp#TopOfPage

[4] Memo: Process for Part D Sponsors to Request Changes to a Medication Therapy Management Program (MTM). Accessed June 8, 2010. http://www.cms.gov/PrescriptionDrugCovContra/082_MTM.asp#TopOfPage

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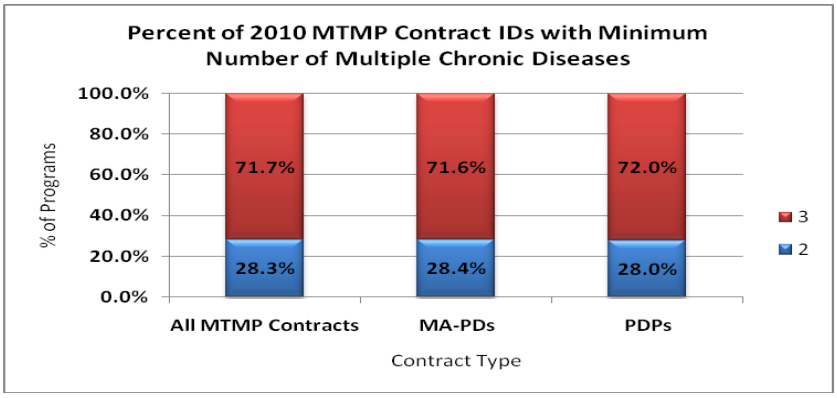
Eligibility Criteria

Targeted beneficiaries for the MTM program as described in § 423.153(d)(1) are enrollees in the sponsors' Part D plan who have multiple chronic diseases, are taking multiple Part D drugs, and are likely to incur annual costs for covered Part D drugs that exceed a predetermined level as specified by the Secretary. The cost threshold was lowered to $3,000 for 2010.

Multiple Chronic Diseases
Sponsors are required to target beneficiaries with multiple chronic diseases, and they define the minimum threshold for eligibility into their MTM program. For 2010, CMS established both a ceiling and a floor in the minimum number of chronic diseases that may be required. Therefore, a plan sponsor had the discretion to determine whether to target beneficiaries with at least two chronic diseases or at least three chronic diseases. The percent of MTM programs (MTMP) by the minimum number of multiple chronic diseases that they target is shown in the table below. Regardless of contract type, approximately 72% of 2010 MTM programs require a minimum of three chronic diseases.



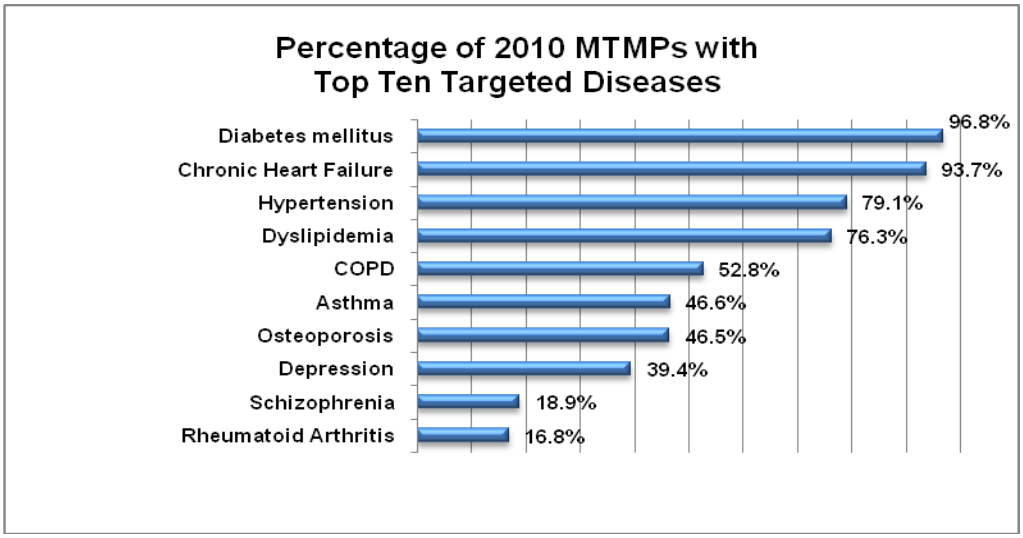
Sponsors may target beneficiaries with any chronic diseases or limit enrollment in their MTM program to beneficiaries having specific chronic diseases. In defining multiple chronic diseases for eligibility, 4.6% of 2010 MTM programs are targeting beneficiaries with any chronic disease, and 95.4% are targeting beneficiaries with specific chronic diseases.

At a minimum, in 2010, sponsors must target at least four of the following seven core chronic diseases: Hypertension, Heart Failure, Diabetes, Dyslipidemia, Respiratory Disease (such as Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung disorders), Bone Disease-Arthritis (such as Osteoporosis, Osteoarthritis, or Rheumatoid Arthritis), and Mental Health Diseases (such as Depression, Schizophrenia, Bipolar Disorder, or Chronic and disabling disorders).

The most frequently targeted diseases in 2010 are closely aligned with the same top diseases as targeted for MTM in 2007 through 2009, with the exception of schizophrenia which has replaced osteoarthritis as a top ten targeted disease. Another mental health disease, bipolar disorder, was the eleventh most targeted disease in 2010. Diabetes, Heart Failure, Hypertension and Dyslipidemia are the top targeted diseases. It should also be noted that almost 60% of programs are broadly targeting beneficiaries with 'Cardiovascular' diseases. Overall, the top ten targeted diseases align with the top drugs and classes of drugs utilized by Medicare Part D beneficiaries which are Cardiovascular and Metabolic Syndrome agents and Psychotherapeutic agents[5]. The graph below provides the percentage of MTM programs for 2010 that target beneficiaries with

[5] Part D Data Symposium. October 30, 2008 and March 18, 2010. Presentations accessed June 8, 2010 at: http://www.cms.gov/PrescriptionDrugCovGenIn/09_ProgramReports.asp#TopOfPage

these top ten diseases. When submitting their MTM application, sponsors are allowed to make multiple selections to denote all of the specific chronic diseases which they are targeting. These are not mutually exclusive.



Multiple Covered Part D Drugs

The second MTM program targeting criterion requires a beneficiary to be taking multiple covered Part D drugs. Each program sets the minimum number of covered Part D drugs a beneficiary must have filled for MTM program eligibility. In previous years, the minimum thresholds specified by sponsors were between two and fifteen. For 2010, CMS also established both a ceiling and a floor in the minimum number of drugs that may be required (two to eight), considering in 2009, almost 90% of MTM programs were already targeting beneficiaries with a minimum threshold of 8 or fewer Part D drugs. Therefore, in 2010, sponsors may set this minimum threshold at any number equal to or between two and eight. For example, one sponsor may specify that a beneficiary must have filled a minimum of five covered Part D drugs to be targeted for MTM services (along with meeting the other two criteria), whereas another sponsor may specify that the beneficiary must have filled a minimum of two covered Part D drugs.

The percent of 2010 MTM programs that target beneficiaries with the respective minimum number of covered Part D drugs is provided in the table below in aggregate and broken out by MA-PDs and PDPs. Approximately two-thirds of MTM programs target beneficiaries who have filled at least eight covered Part D drugs. The largest differences in the minimum number of covered Part D drugs indicated by MA-PDs and PDPs are observed for criteria of 2 and 5.

Minimum Number of Covered Part D Drugs	% of All MTMP Contracts	% of MA-PD MTMPs	% of PDP MTMPs
2	5.5%	4.8%	9.7%
3	1.2%	1.2%	1.1%
4	1.5%	1.0%	4.3%
5	10.3%	11.1%	5.4%
6	6.0%	5.8%	7.5%
7	9.1%	9.2%	8.6%
8	66.4%	66.8%	63.4%

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Sponsors indicate in their MTM program application if any Part D drug applies, if chronic/ maintenance drugs apply, if disease-specific drugs apply related to the chronic diseases, or if specific Part D drug classes apply. Over one-third (38.2%) of all 2010 programs allow any Part D drug to qualify for this requirement, while the remaining require Part D drugs for chronic conditions (42.0%), disease specific drugs related to chronic diseases (9.3%) and specific Part D drug classes (10.5%). A higher share of PDP MTMPs target any Part D drug (52.7%) compared to MA-PD MTMPs (35.9%), whereas a higher share of MA-PD MTMPs target chronic Part D drugs (44.8%) compared to PDP MTMPs (24.7%).

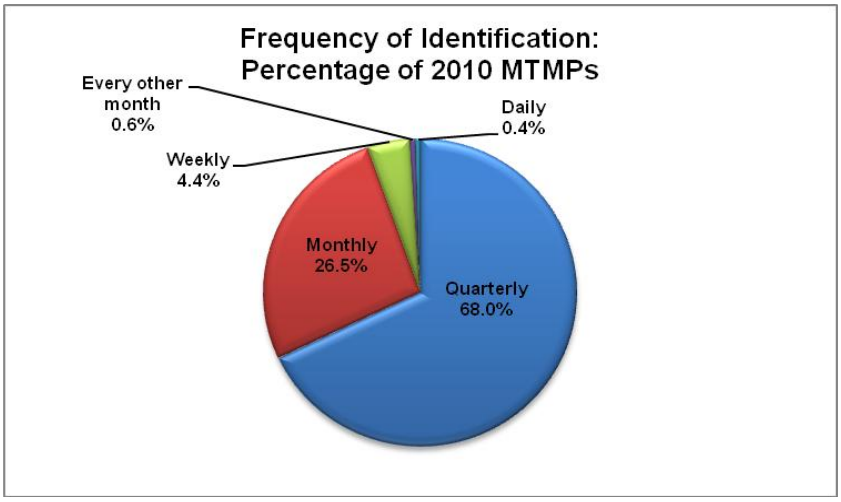
Likely to Incur $3,000

A beneficiary must also be likely to incur an annual cost of at least $3,000 for all covered Part D drugs. This cost threshold was lowered from $4,000 to $3,000 for 2010. The sponsor must provide a description of the analytical procedure used when determining if a beneficiary is likely to incur this annual cost threshold for 2010 such as the specific threshold(s), formula, or information on the model used. MTM programs in 2010 continue to apply varying costing methodologies, but the majority of analyses are based on specific threshold(s) of $750 in Part D covered drug costs for the previous quarter or $250 the previous month. A number of programs also use historical data from the past 12 months.

Method of Enrollment

CMS revised the MTM enrollment requirements for 2010. Sponsors must enroll targeted beneficiaries using an opt-out method of enrollment only. Therefore, in 2010, 100% of MTM programs are enrolling targeted beneficiaries using an opt-out enrollment.

Sponsors must target beneficiaries for enrollment in the MTMP at least quarterly during each plan year. Over two-thirds (68.0%) of 2010 MTM programs identify targeted beneficiaries quarterly and 26.5% of programs identify beneficiaries monthly. A smaller share of MTM programs identifies targeted beneficiaries more frequently than monthly.



All Part D sponsors use drug claims data to identify eligible beneficiaries for their MTM programs in 2010. In addition, 28.2% of the MTM programs use of medical claims data, but it is more likely for MA-PD MTM programs to use medical claims (30.3% of MA-PD MTM programs versus 15.1% of PDP MTM programs). Sponsors used other types of data to aid with identification such as 4.0% of MTM programs use information collected from the beneficiaries, and 2.2% use lab data. All of these are not mutually exclusive categories.

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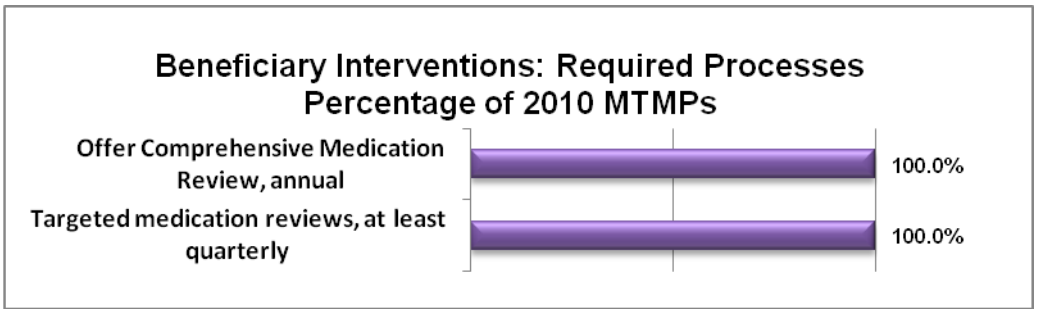
Interventions

Sponsors must offer a minimum level of medication therapy management services for each beneficiary enrolled in the MTM program that includes interventions for both beneficiaries and prescribers. They must also offer a comprehensive medication review (CMR) by a pharmacist or other qualified provider at least annually and perform quarterly medication reviews with follow-up interventions when necessary. Sponsors may offer additional value added services above the required services.

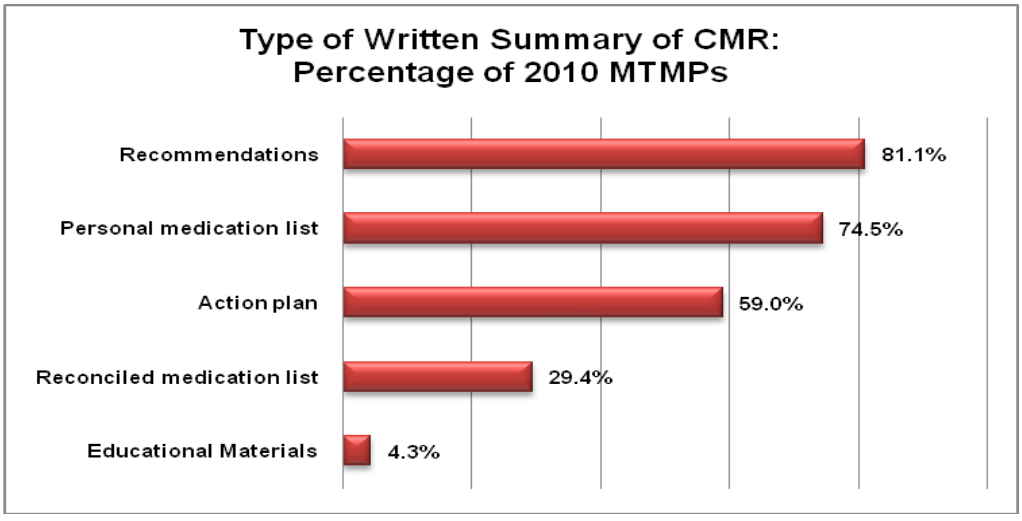
Beneficiary Interventions

In 2010, 100% of MTM programs offer CMRs at least annually and perform targeted medication reviews at least quarterly. These are required interventions.



A CMR is a review of a beneficiary's medications, including prescription and over-the-counter (OTC) medications, herbal therapies, and dietary supplements, that is intended to aid in assessing medication therapy and optimizing patient outcomes. The initial CMR must include an interactive person-to-person consultation. This real-time interaction may be face-to-face or through other interactive methods such as the telephone. Almost 100% (99.9%) of MTM programs perform the interactive, person-to-person CMR consultation via the phone. A quarter (25.8%) of programs also offers face-to-face consultations.

Furthermore, sponsors must implement a systematic process to summarize the interactive consultation and provide an individualized written or printed "take-away" to the beneficiary such as a personal medication record, reconciled medication list, action plan, recommendations for monitoring, education, or self-management. The graph below displays the top five types of written summaries provided to beneficiaries by the MTM programs. Multiple selections were allowed.



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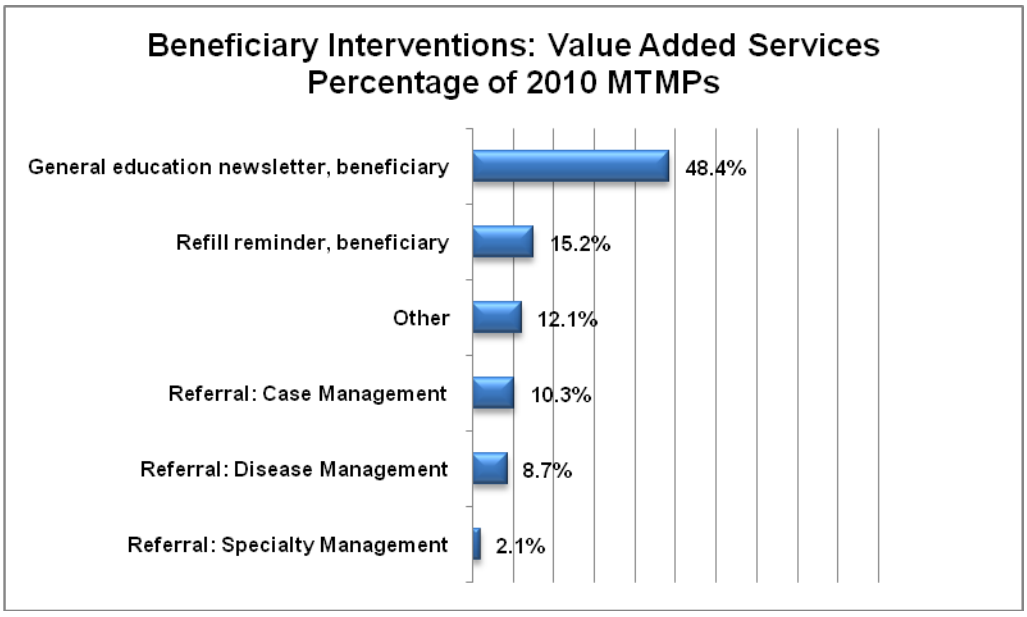
For targeted beneficiaries enrolled in the MTM program that are in a long term care (LTC) setting, sponsors are not required to offer the interactive CMR component. Sponsors must still perform quarterly medication reviews and offer interventions targeted to the beneficiaries' prescribers, as these are requirements for all beneficiaries enrolled in the MTM program regardless of setting and regardless of whether or not they decline the CMR offer. The targeted medication reviews assess medication use, monitor whether any unresolved issues need attention, new drug therapy problems have arisen, or if the beneficiary has experienced a transition in care. Part D sponsors provide follow-up interventions as necessary.

Above the required interventions, sponsors provide additional value added services as shown in the graph below. Multiple selections were allowed.



Prescriber Interventions
Sponsors are required to offer interventions to the beneficiaries' prescribers. In 2010, 100% of MTM programs offer interventions to prescribers to resolve medication-related problems or optimize therapy. Almost 15% of programs provide a patient medication list to the prescriber.

In their MTM program application, sponsors indicate the methods of delivering these interventions to the prescriber: 92.3% fax the consultations, 74.9% provide phone consultations, and 70.5% provide mailed consultations. Multiple selections were allowed.

Provider of MTM Services
MTMP is considered an administrative cost (component of the plan bid) by CMS. Part D Sponsors are required to explain how their fees account for the time and resources associated with their MTM program. They have the flexibility to determine the billing mechanisms and established fees for pharmacists and other qualified providers associated with providing MTM. These arrangements are between the Part D sponsors and the providers of MTM services.

Sponsors can utilize internal and/ or outside personnel to provide their MTM services. In 2010, 46.8% of programs utilize internal staff, and 80.0% of programs utilize outside personnel. No significant differences were observed between MA-PDs and PDPs in terms of the use of internal or outside personnel.

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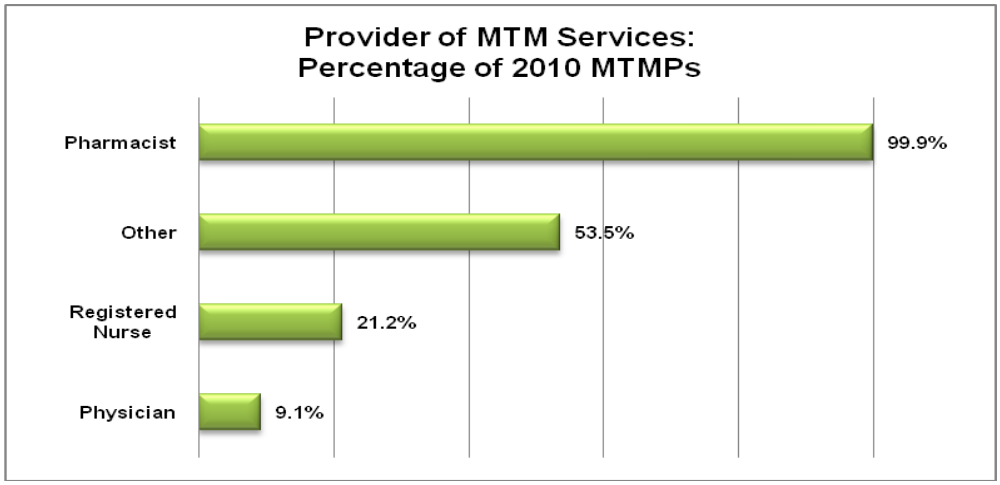
Per the MTM requirements, MTM services may be furnished by pharmacists or other qualified providers. Sponsors indicate that they will utilize pharmacists, physicians, registered nurses, and/ or others. These are not mutually exclusive, and sponsors may utilize any single type of qualified provider or any combination of providers.

Compared to previous program years, pharmacists continue to be the leading provider of MTM services. Overall, regardless of whether the sponsor was utilizing in-house and/ or outside personnel, 99.9% of MTM programs in 2010 utilize pharmacists to provide their MTM services. Fewer programs in 2010 utilize physicians and registered nurses, while a larger share of programs are using 'other' providers.



As mentioned above, 80.0% of programs utilize outside personnel. Outside personnel may include a PBM, MTM vendor, disease management vendor, community pharmacists, long term care (LTC) pharmacists or others. Of the programs that utilize outside personnel, 72.3% utilize a PBM (48.8% of all 2010 MTM programs), 0.2% utilize a disease management vendor (0.1% of all programs), 31.9% utilize a MTM vendor (21.5% of all programs), 29.7% utilize community pharmacists (20.1% of all programs), 10.9% utilize LTC pharmacists (7.4% of all programs), and 5.9% utilize other outside personnel (4.0% of all programs). In 2010, there was an increase in the share of MTM programs that utilize a PBM or a MTM vendor. Furthermore, it is possible that the share of programs that utilize community pharmacists is under reported because a number of MTM vendors utilize a network of community pharmacists to provide the MTM services.

SUMMARY

More robust Medicare Part D MTM programs are in place for 2010. All targeted beneficiaries who are eligible will be automatically enrolled into these programs. One-hundred percent of the programs will offer a CMR, at least annually, and sponsors will perform on-going monitoring of the beneficiaries' medication use to identify medication-related issues through targeted medication reviews at least quarterly. Pharmacists remain the leading provider of MTM services across all MTM programs. Sponsors continue to refine their targeting criteria to not only meet the CMS requirements, but to optimize beneficiary identification. CMS will monitor sponsors' movement to more restrictive criteria. It is expected that more Part D beneficiaries will be eligible for MTM in 2010 and beyond, and it is estimated that approximately 25 percent of the Part D eligible population will meet the three criteria and be targeted for MTM services, compared to 10% to 12% in previous program years. These estimates are based on analyses of Prescription Drug Event (PDE) data and will be confirmed using the 2010 Part D reporting requirements data.

2010 Medicare Part D Medication Therapy Management (MTM) Programs

CMS has expanded the data elements that sponsors are required to submit to CMS regarding their MTM programs as part of the 2010 Part D Reporting Requirements. Sponsors already report the number of beneficiaries eligible for MTM and the number of beneficiaries who opted out of the MTM program. For 2010, at the beneficiary level, Part D sponsors must measure and report to CMS through these reporting requirements the receipt of the CMR, the number of targeted medication reviews, number of prescriber interventions, and the change(s) in therapy directly resulting from the MTM interventions. These data are due to CMS in February 2011 and will enable CMS to perform more robust analysis of the MTM programs and interventions, evaluate the revised 2010 MTM requirements, and identify additional best practices. Furthermore, CMS is exploring meaningful performance measures that could be used to evaluate the effectiveness and quality of the Part D MTM programs through its MTMP Monitoring Support contract and through collaborations with external stakeholders.

Questions regarding this Fact Sheet may be sent to: partd_mtm@cms.hhs.gov.