Response of PCMA President and CEO Mark Merritt
Questions for the Record
"Examining the Medicare Part D Medication Therapy Management Program"
October 21, 2015
Committee on Energy and Commerce
Subcommittee on Health

Q: It is clear that utilization of the Part D Medication Therapy Management program has been quite low since its inception. There may be a number of reasons contributing to this, but it seems that Part D plans have high eligibility criteria for their covered beneficiaries resulting in low participation. Why is it that most plans require three or more chronic conditions and eight or more prescription drugs?

Part D plan sponsors design their MTM programs around very specific statutorily outlined criteria that are reviewed and updated regularly by CMS. The Part D program regulations at 42 CFR §423.153 establish as benefit parameters for targeted beneficiaries no more than three chronic diseases and up to eight Part D drugs (See Attachment A). The CMS Part D benefit group updates these parameters on an annual basis through the Call Letter process. On April 7 of this year, this final guidance was published for the 2016 benefit year (See Attachment B). According to CMS's guidance, "*[s]ponsors must enroll targeted beneficiaries using an opt-out method of enrollment only."* In other words, the beneficiaries who are automatically enrolled in the program are those who meet the stated regulatory criteria.

Generally speaking, plans in the marketplace follow the program parameters. Unfortunately, this one-size-fits-all approach has not been effective in identifying appropriate beneficiaries, or in getting beneficiaries once identified to engage in the program. In addition, with the uncertainty of how MTM costs that are incurred with respect to activities that exceed the regulatory parameters are treated under the Part D medical loss ratio rules, plans are reluctant to undertake the risks involved in diverging from the regulatory standards.

As discussed in my written testimony,

> *We hear reports from our own companies mirroring CMS' findings that current rules governing MTM result in misaligned incentives that are most prominent in stand-alone Part D plans. Unlike Medicare Advantage plans that manage the entire range of Medicare benefits (MA-PDs), stand-alone drug plans manage only the prescription drug benefit for enrollees. As a result, the incentive to design and deploy innovative and creative measures to improve medication management runs up against the reality that savings generated in Parts A and B of Medicare as a result of better adherence will not accrue to the Part D plan, which undertakes such an effort. In addition, increased spending for MTM benefits in a stand-alone drug plan puts upward pressure on beneficiary premiums for that plan while the savings in the traditional Medicare program benefits are not going to reduce plan premiums as they would in an MA-PD plan.*
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> *Misallocation of resources is also a result of requirements determining which beneficiaries receive MTM. Under current requirements, beneficiaries meeting targeting criteria for MTM are supposed to receive certain services and interventions, such as the annual comprehensive medication review (CMR). Beneficiaries are targeted for MTM according to the condition and number of drugs prescribed, and annual drug spending. However, if an enrollee declines the annual CMR—indicating the enrollee believes he or she is well controlled on medications or possibly is indifferent or even hostile to receiving an intervention—the plan sponsor is still required to perform other MTM services at least quarterly on an on-going basis for that*

individual. This can result in a waste of significant resources that could be used to prioritize MTM services for beneficiaries who want, need, and would benefit from them. Indeed, a CMS-sponsored report by Acumen recently found that for the three disease conditions studied (i.e., diabetes, CHF and COPD), MTM programs, on average, increased Part D costs annually by $75 to $181 per patient, with no clear proof that the current MTM programs as currently implemented have created robust or persistent improvements.

While our companies fully embrace the need to help improve medication use and to reduce the risk of adverse events, they agree with these findings and believe the current enrollee targeting criteria and extensive process requirements prevent the Part D MTM program from accomplishing its intended goals.

…Congress should assure that all Part D plans <u>not</u> participating in the Model may include any costs incurred to create and implement innovative MTM programs as a quality improving activity for purposes of Medical Loss Ratio (MLR), whether inside or outside the Model test. Doing so will encourage those plans outside the geographic footprint of the Model test to also innovate in what most agree is a flawed MTM system.

In the 2015 Medicare Part D proposed rule, CMS sought to lower the thresholds for the current MTM eligibility criteria so that more beneficiaries would qualify. PCMA submitted extensive comments on the proposal (See Attachment C), where we detailed the many shortcomings of this approach.

Q: It seems like a way to significantly limit people's eligibility for the program. Can you comment on this?

As noted above, there is significant consensus that the existing CMS eligibility requirements for the MTM program are poorly targeted and ineffective. Indeed, after receiving extensive comments on the proposed 2015 Medicare Part D rule, which would have significantly expanded the criteria, CMS was convinced that the existing construct does not work and thus backed away from its expanded benchmarked auto-enrollment criteria.

We are pleased with the new CMS Model Test for MTM, as it is not simply expanding eligibility for a dysfunctional program but instead providing for the possibility of new parameters that will target appropriate beneficiaries and provide incentives to help assure that increased numbers of patients will participate.