APPENDIX. Compensation Models for MTM
2016 Update

Bonus Module. Compensation Models for Medication Therapy Management (MTM)

Goal Statement

To guide pharmacists providing MTM services in the reimbursement systems currently available for pharmacist MTM services and to outline future challenges and opportunities related to compensation for MTM.

Proposed Educational Objectives

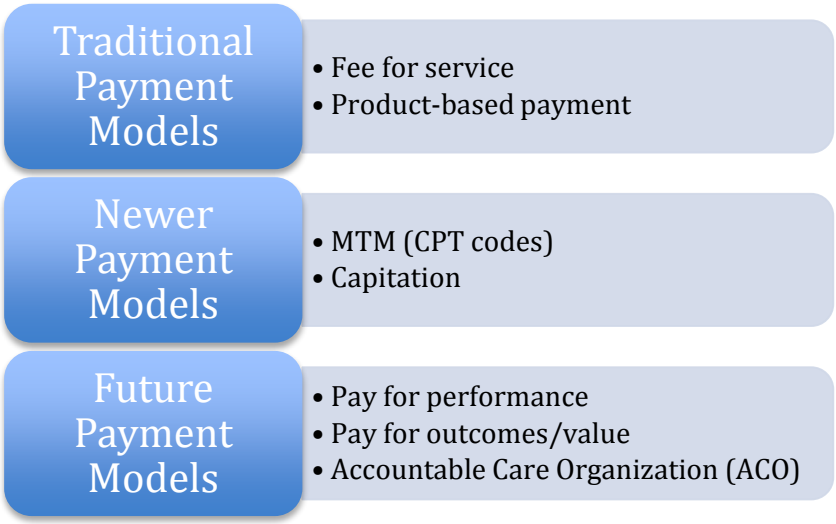
At the conclusion of the activity, the learner will be able to:

- Describe payment systems for pharmacists under Medicare Part D
- Implement billing and coding requirements under Medicare Part D
- Discuss non-Medicare models for compensation of MTM

Overview

Understanding the various compensation models currently in place—and the potential opportunities with future healthcare reform—is an important part of MTM. Studies have shown that pharmacists are willing and prepared to perform MTM services, and that growing numbers of healthcare providers, payers (managed care organizations and others), hospitals, and patients recognize the value in pharmacist-provided MTM.[1-4] The challenge for the pharmacy profession going forward is how to translate the real value of pharmacists' patient-care (or "cognitive") services into financial compensation. Doing so successfully will allow pharmacy organizations to grow and thrive in today's healthcare market, rather than trying to derive most of their compensation from traditional product-oriented systems (Figure 1).

Figure 1. Evolving Payment Models for Healthcare Delivery Services



CPT=current procedural terminology.

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Medicare Part D and Pharmacist Compensation

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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA 2003) set the initial stage for pharmacists to be compensated for providing medication therapy management (MTM) services to patients eligible for Medicare Part D benefits.[5]

MMA 2003 stated that:

- Payers providing prescription drug benefits under Medicare Part D must establish MTM services for certain beneficiaries with chronic health conditions;
- Providers can bill Medicare for performing MTM services;
- Pharmacists are among the qualified professionals eligible to provide MTM services.

How do pharmacists get paid for MTM under Medicare Part D?
The Center for Medicare & Medicaid Services (CMS) requires that pharmacists who wish to bill for MTM must obtain a National Provider Identifier (NPI) number. The National Plan & Provider Enumeration System of CMS operates an online application process on its website.[6] Pharmacies and organizations must maintain a separate NPI identifier from that of individual pharmacists.

Role of third-party MTM vendors
Unlike Medicare Parts A and B, Medicare Part D is privatized. This means that the government contracts with payers (e.g., insurers and managed care organizations) for Medicare Part D benefits and does not pay the providers directly. Subsequently, many national companies often subcontract with third-party MTM vendors such as Mirixa, Outcomes MTM, and others. These organizations then partner with pharmacists and other healthcare providers to target potential patients who may benefit from MTM services. Third-party MTM vendors serve as intermediaries between the health plan and the pharmacist or pharmacy.

Among the benefits of these services is the availability of efficient data capture of patient health measurements and goals, automated systems such as physician summary letters, and protocols for managing certain disease states. These organizations have access to patient-specific health information from the health plans which can be shared with the pharmacist prior to MTM, greatly simplifying the process of information-gathering

CPT codes for MTM
Third-party MTM vendors might not use Current Procedural Technology (CPT) codes as part of their billing structure, and instead set specific fees to pay for MTM services. If a pharmacy provides MTM services for a payer that <u>does</u> rely on CPT codes, the current codes for MTM are as follows:

- 99605 First 15-minute interview
- 99606 Follow-up visit, 15 minutes
- 99607 Each additional 15-minute increment

The pharmacy bills in 15-minute time increments, so a 45-minute initial MTM appointment with the patient is billed as:

- CPT 99605: first 15 minutes
- CPT 99607: Additional 15 minutes
- CPT 99607: Additional 15 minutes

Unfortunately, much of the time spent on Medicare Part D MTM is not billable, including preparation, record gathering, and documentation. Required documentation of the encounter involves:

- Provide a copy of the treatment plan to patient
- Document that the patient was able to repeat back recommendations to verify understanding
- Send copies of the treatment plan to other providers
- Keep copies for pharmacist records

CMS STAR Ratings Systems and MTM Funding

CMS STAR ratings are a way for healthcare payers to gain bonus funding from CMS based on quality measures. CMS's 5-Star Ratings are weighted averages, based on 53 criteria that derive from quality measures such as Healthcare Effectiveness Data and Information Set (HEDIS). In addition to allowing Medicare consumers to compare the quality of health plans, providers, and facilities (such as nursing homes), certain providers are eligible for bonus payments under Medicare if they receive a rating of 3 or more stars. Those with lower star ratings are flagged for potential termination of their CMS Medicare contract. The STAR ratings are:[7]

5 stars	Excellent
4 stars	Above average
3 stars	Average
2 stars	Below average
1 star	Poor

Health plan ratings are measured in 5 distinct categories:[7]

1. Members' compliance with preventive care and screening recommendations
2. Chronic condition management
3. Plan responsiveness, access to care, and overall quality
4. Customer service complaints and appeals
5. Clarity and accuracy of prescription drug information and pricing

MTM is expected to become an increasingly important part of STAR ratings in the coming years. Currently, only about 11% to 13% of patients who are eligible for MTM under Medicare Part D are receiving MTM services, while a more ambitious goal might be closer to 25% to 40%. Health plans' STAR ratings will be influenced by the number of completed CMRs (comprehensive medication reviews) among their members, as well as the other Pharmacy Quality Alliance (PQA) measures listed below. (All of the bulleted items below are triple-weighted for pharmacists, meaning that they have a substantial impact on STAR ratings.)

Domain 4. Drug Pricing and Patient Safety[8]

- D14 – High Risk Medication
- D15 – Diabetes Treatment
- D16 – Part D Medication Adherence for Oral Diabetes Medications
- D17 – Part D Medication Adherence for Hypertension Medications (renin angiotensin system antagonists)
- D18 – Part D Medication Adherence for Cholesterol Medications (statins)

Pharmacist Compensation for MTM: Looking Beyond Medicare Part D

Is Medicare Part D compensation sufficient?

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Many pharmacists and pharmacy organizations find that the compensation provided through Medicare Part D is not sufficient to allow them to focus their MTM services solely or primarily on this patient population. MTM services are often targeted toward the sickest patients, for whom the funding does not reflect the complexity of care needed.[9] In addition, a major limiting factor of current MTM programs is the lack of standardization for documentation and billing.[10]

What constitutes "enough" compensation to allow pharmacists to dedicate time to providing MTM? Wang and colleagues from the University of Tennessee College of Pharmacy surveyed community pharmacists to determine what these professionals would regard as a "willing to accept" (WTA) compensation figure for a typical 30-minute MTM session. Among the 348 pharmacists responding, the mean WTA figure was $63.31. (Thirty percent were willing to accept $30 while 85% thought $60 or more was fair for the 30-minute session). The survey results revealed that pharmacists' "WTA" figure is higher than the current MTM compensation levels (which range from $15 to $50 for 30 minutes). These authors recommended pharmacists "advocate for higher MTM compensation levels by third-party payers" and that they consider charging patients to reach sufficient compensation levels for MTM.[11,12]

Having provider status would allow pharmacists to bill directly for MTM and other healthcare services, rather than billing through a third party. A promising piece of Federal legislation, the Pharmacy and Medically Underserved Areas Enhancement Act (HR-295 in the House and S-314 in the Senate) was pending as of early 2016 and would expand the rights and responsibilities of pharmacists in providing patient care.

What Are Some Non-Medicare Compensation Models?
Health economists have noted that the current model, in which pharmacists are paid based on profits from drug and product sales, is "unsustainable," in that it does not compensate pharmacists for patient care and adding value to healthcare management.[13] In addition, pharmacy organizations often fail to collect data to demonstrate how these services have led to reduced healthcare costs.[13] Within the current avenues of healthcare reform, there are 3 potential ways to structure pharmacist payments (Table 2).

Table 2. Pharmacist Payment Models

Payment source	Programs
Traditional fee for service	Medicare Part D (CPT 99605–99607) Employer-based MTM plans (negotiated) "Incident to Physician" services, only available in hospital- or physician-based pharmacy clinics: • Transitional care management codes: 99495, 99496*[14] • Other, new incidence to physician services to be defined by CMS • Older CPT codes: 99211–99215 • Annual wellness visits (G0438, G0439)

	Diabetes self-management (CPT G00108 for individual or G00109 for group)
Outcomes (cost-savings/cost avoidance)	Helping healthcare organizations to prevent/ avoid penalties for hospital readmissions • CMS Readmission Reduction Program • Collaborative drug therapy management (CDTM)
Pay for value/pay for performance (P4P)	Revenues gained for achieving specific quality measures. • Accountable Care Organizations (ACO) • Patient-Centered Medical Home (PCMH) • 5-Star Ratings

*These are newer codes which are better funded than the older CPT codes.

Contracting With Employer-Based Health Plans

Providing MTM services for local organizations, such as employer-based health services, can be a good way for pharmacists to expand MTM opportunities beyond the Medicare Part D population. Many employer-based systems, especially large corporations, have an incentive to minimize healthcare costs and absenteeism rates and have adopted a more wellness-oriented focus compatible with MTM.[15] In these arrangements, pharmacists contract with the corporation to provide MTM (often in-house) for employees who are either targeted by the benefits department or who sign up voluntarily for the service. Such programs have been shown to result in significant per-employee cost savings and significant savings to the organization.[15-19]

Readmission Reduction Program

CMS penalties for hospitals under the Readmission Reduction Program constitute real dollars lost by the institution that does not achieve CMS performance standards. Penalties for hospital readmission within 30 days are in effect for patients with heart failure, pneumonia, acute myocardial infarction, chronic obstructive pulmonary disease (COPD), or total knee/hip arthroscopy. [18] In order to team up with payers and hospitals to control these penalties, pharmacists need to establish metrics that show a difference in readmission rates before and after MTM services, or with and without a pharmacist-provided MTM service.

Accountable Care Organizations

Another approach is based on revenues gained for achieving certain quality standards such as those listed in Table 2. The Patient Protection and Affordable Care Act (ACA) resulted in the development of the Accountable Care Organizations (ACOs), which involve networks of clinicians and hospitals that share responsibility for a certain population of patients and are paid on a per-head or “capitation” basis.[20] Under these models, the organization theoretically has a strong financial incentive to provide quality care while keeping costs down. Thus, services provided by pharmacists that help prevent medication misuse or duplicate prescriptions, nonadherence, drug adverse events, and avoidable patient outcomes (such as uncontrolled diabetes) are going to be a significant value to these organizations.[21] As some authors have noted, “Pharmacists are in an ideal position to manage drug therapy and reduce health care expenditures; as such, they may be valuable assets to the ACO team.”[21]

Patient-Centered Medical Homes

The Patient-Centered Medical Home (PCMH) is another such format that has been encouraged by payers and public policy.[22,23] The PCMH is a care delivery model whereby patient treatment is coordinated in a centralized setting with an emphasis on partnerships and collaboration, information technology exchange, and greater patient accessibility to services.[24] The philosophy of these settings is consistent with the principles of MTM, and these delivery models have benefitted from inclusion of pharmacists on the team.[25,26]

State-Based Programs

There are several programs at the state level that provide payment for MTM services for patients receiving Medicaid benefits and certain other services (e.g., state and public employees, institutionalized patients). According to the National Conference of State Legislatures, these states include:

Colorado	Mississippi	North Carolina	Virginia
Florida	Missouri	Ohio	Washington
Georgia	Montana	Oregon	Wisconsin
Iowa	New Mexico	Utah	Wyoming
Minnesota	New York	Vermont	

In addition, other states have passed legislation that broadens the provider status of pharmacists. These legislative measures are a step toward better recognition of and compensation for pharmacists a Federal level with CMS.[27] Washington and Oregon are among the recent states adding legislation that names pharmacists as healthcare providers.

While the specific provisions for reimbursement vary in each state, most allow for pharmacists to receive compensation for providing MTM. In addition, some states have novel programs that offer greater compensation for MTM and have demonstrated significant cost savings in healthcare expenditures. Some the landmark studies that demonstrated cost savings of MTM are summarized below.

- An MTM program was initiated in Minnesota in 2005 for low-income patients with complex medical and drug-related needs.[28] Pharmacists received an average of $92.50 per patient visit, based on the complexity of care required. Pharmacists resolved an average of 3.1 drug therapy problems per patient, most of which were related to inadequate therapy. MTM services resulted in a 31% reduction in total health expenditures per patient, from $11,965 to $8,197, and a 14% increase in meeting patient's goals. (These savings exceeded the cost of MTM services by more than 12 to 1.)[28]

- In a 2011 Connecticut-based study of MTM performed through a Medicaid demonstration project at federally qualified health centers, pharmacists identified 917 drug therapy problems (10.4 per patient) which, when addressed, resulted in estimated annual savings of $1,595 per patient.[29] This included $1,123 per patient in medication claims and $472 per patient in medical, hospital, and emergency department costs. The study authors recommended that CMS "support the evaluation of pharmacist-provided medication management services in primary care medical homes, accountable care organizations, and community health care transition teams, as well as research to explore how to enhance team-based care."[29]

- In a study based on a large integrated healthcare system (Fairview Health Services in

Minnesota), data from 9,068 patient records over a 10-year period were analyzed to determine the impact of MTM services during that time. In this setting, patients either paid for MTM services out of pocket or met their payers' criteria for MTM reimbursement by Medicaid, Medicare, or private insurers.[2]

Future Challenges and Goals Related to Compensation for MTM

While many possible models for compensation are discussed here, they are not all in place to provide immediate compensation for a pharmacist starting an MTM practice. More systems for pharmacist compensation are needed in organizations at many levels. Specifically:

- There is a need to "marry" or integrate the current product-based payment models with the proposed service-based models
- Payment systems and data exchange should be standardized and uniform
- Pharmacist billing terminology needs to be consistent with existing provider models (such as CPT codes and ICD-9 electronic encounter forms)

Pharmacy professional organizations are focusing on compensation models, and much change can be anticipated. More pharmacists are adding MTM skills and certification to their repertoire, and more organizations are demanding the types of outcomes that MTM can provide. Still, it has been reported that fewer than 40% of pharmacists are paid for MTM services provided.[11] We need better compensation models for pharmacist cog and patient care services within healthcare organizations and in the setting of community pharmacy.[10,11]

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