AN OVERVIEW OF MEDICATION THERAPY MANAGEMENT (MTM) AND ITS IMPACT ON PHARMACY PRACTICE

NC Mutual Spring Conference
March. 2016
Ugo Nwachukwu, PharmD
I am employed by Mirixa corporation.
Learning Objectives

- Review component of MTM
- Review MTM qualification criteria
- Discuss trends and statistics in MTM service delivery
- Review reporting expectations for MTM programs
- Review CMR completion rate and health plans expectation
- Evaluate pharmacists’ role in driving quality improvements
- Explore MTM’s impact to pharmacy practice
What is Medication Therapy Management (MTM)?

• MTM is a patient-centric and comprehensive approach to improve medication use, reduce the risk of adverse events, and improve medication adherence.

• Designed to ensure covered Part D drugs are appropriately used to optimize therapeutic outcomes

• Programs include high-touch interventions to engage the beneficiary and their prescribers.

• Two main components of an MTM program are
  – Comprehensive Medication Review (CMR)
  – Targeted Medication Review (TMR)
Comprehensive Medication Review (CMR)

- A CMR is a **systematic process** of collecting patient specific information, **assessing medication therapies to identify medication related problems**, developing a prioritized list of medication related problems, and creating a plan to resolve them with the patient, caregiver and/or prescriber.

- A CMR is an **interactive** person–to–person or telehealth medication review and **consultation** conducted in real–time between the **patient** and/or other **authorized individual**, such as prescriber or caregiver, and the pharmacist or other qualified provider and is **designed to improve patients’ knowledge** of their prescriptions, over–the–counter (OTC) medications, herbal therapies and dietary supplements, identify and address problems or concerns that patients may have, and empower patients to self manage their medications and their health conditions.*

- Must provide patient with a written summary in CMS’ standardized format.

*National MTM Advisory Board
Targeted Medication Review (TMR)

- TMR is ongoing monitoring of all beneficiaries enrolled in the MTM program to determine if new drug therapy problems have arisen,
- Monitor whether any unresolved issues need attention,
- Assess if the beneficiary has experienced a transition in care
- Must occur at least quarterly upon enrollment in the MTM program
- Can be person-to-person or system generated
- Could lead to a follow-up intervention with the patient's prescribers either passively (fax, or mail) or interactively if deemed necessary
MTM Eligibility Criteria for Medicare Part D Beneficiaries

- Beneficiaries must meet a conditions threshold
  - Plans cannot require more than 3 chronic diseases as the minimum number
  - Plans may set this minimum at 2–3
- Beneficiaries must meet a number of medications threshold
  - Plans cannot require more than 8 Part D drugs as the minimum number of Part D drugs that a beneficiary must have filled to be eligible
- Beneficiaries must meet a cost threshold
  - In 2016, the annual cost threshold for covered Part D drugs is $3,507.00
  - Cost determination may be based on historical claims or projected cost from the program year
- CMS encourages health plans to expand the eligibility criteria as they deem necessary to meet the needs of their members
Trends in MTM Eligibility Criteria for Medicare Part D Beneficiaries

- Part D programs targeted beneficiaries with at least three chronic diseases.

2014

2015

*Source: CY2014 and 2015 MTM Fact sheet*
Trends in MTM Eligibility Criteria for Medicare Part D Beneficiaries

- Diabetes, Chronic Heart Failure (CHF), and Dyslipidemia and Hypertension are the top targeted diseases.

*Source: CY2014 and CY2015 MTM Fact sheet*
Trends in MTM Eligibility Criteria for Medicare Part D Beneficiaries

- More than half of programs target beneficiaries who have filled at least eight covered Part D drugs.

<table>
<thead>
<tr>
<th>Minimum Number of Covered Part D Drugs</th>
<th>% of all MTM Programs</th>
<th>% of MA-PD MTM Programs</th>
<th>% of PDP MTM Programs</th>
<th>% of MMP MTM Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3.2%</td>
<td>3.3%</td>
<td>2.6%</td>
<td>3.7%</td>
</tr>
<tr>
<td>3</td>
<td>1.3%</td>
<td>1.2%</td>
<td>1.3%</td>
<td>3.7%</td>
</tr>
<tr>
<td>4</td>
<td>1.5%</td>
<td>1.2%</td>
<td>3.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>5</td>
<td>5.2%</td>
<td>5.2%</td>
<td>7.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>6</td>
<td>15.5%</td>
<td>14.1%</td>
<td>19.5%</td>
<td>33.3%</td>
</tr>
<tr>
<td>7</td>
<td>21.6%</td>
<td>20.4%</td>
<td>32.5%</td>
<td>14.8%</td>
</tr>
<tr>
<td>8</td>
<td>51.7%</td>
<td>54.6%</td>
<td>32.5%</td>
<td>44.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minimum Number of Covered Part D Drugs</th>
<th>% of all MTM Programs</th>
<th>% of MA-PD MTM Programs</th>
<th>% of PDP MTM Programs</th>
<th>% of MMP MTM Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>1.6%</td>
<td>1.5%</td>
<td>1.4%</td>
<td>2.9%</td>
</tr>
<tr>
<td>3</td>
<td>0.7%</td>
<td>0.7%</td>
<td>1.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>4</td>
<td>2.1%</td>
<td>1.9%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>5</td>
<td>6.1%</td>
<td>5.9%</td>
<td>4.3%</td>
<td>8.7%</td>
</tr>
<tr>
<td>6</td>
<td>15.5%</td>
<td>15.4%</td>
<td>15.7%</td>
<td>26.1%</td>
</tr>
<tr>
<td>7</td>
<td>17.0%</td>
<td>15.6%</td>
<td>31.4%</td>
<td>13.0%</td>
</tr>
<tr>
<td>8</td>
<td>56.0%</td>
<td>58.9%</td>
<td>42.9%</td>
<td>46.4%</td>
</tr>
</tbody>
</table>

*Source: CY2014 and 2015 MTM Fact sheet
Trends in MTM Eligibility Criteria for Medicare Part D Beneficiaries

- MTM programs used expanded eligibility requirements beyond CMS’ minimum requirements

<table>
<thead>
<tr>
<th>Eligibility Criteria</th>
<th># of Programs</th>
<th>% of Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only target enrollees who meet the specified targeting criteria per CMS requirements</td>
<td>556</td>
<td>81.0%</td>
</tr>
<tr>
<td>Use Expanded Criteria: Target both enrollees who meet the specified targeting criteria per CMS requirements and enrollees who meet other plan-specific targeting criteria</td>
<td>130</td>
<td>19.0%</td>
</tr>
<tr>
<td>Total</td>
<td>686</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Source: CY2014 and 2015 MTM Fact sheet*
MTM Reporting Elements

- Beneficiary identified as cognitively impaired at time of comprehensive medication review (CMR) offer or delivery of CMR.

- Received annual CMR with written summary in CMS standardized format.

- Date(s) of CMR(s) with written summary in CMS standardized format.

- Method of delivery for the annual CMR.
  - F2F; Telephone; Telehealth consultation; or Other.

- Qualified Provider who performed the initial CMR.
Reciprocal of CMR.
• Beneficiary, Beneficiary’s prescriber; Caregiver; or Other authorized individual.

Number of drug therapy problem recommendations made to beneficiary’s prescriber(s) as a result of MTM services.

Number of drug therapy problem resolutions resulting from recommendations made to beneficiary’s prescriber(s) as a result of MTM recommendations.
Why Should Pharmacists care?

- Consistent with pharmacists training
- Ensures medications are used to optimize therapeutic outcomes through improved medication use
- Reduces the risk of adverse events
- Improves adherence to medications
- Pharmacists are compensated

- CMR Completion rate to be part of a health plan’s Star Ratings in 2016
CMR COMPLETION RATE’S IMPACT ON STAR RATINGS

Important to note National Averages for CMR Completion Rates taken from Table C-2 in Medicare 2016 Star Rating Technical Notes

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Name</th>
<th>MAPD Numeric Average</th>
<th>MAPD Star Average</th>
<th>PDP Numeric Average</th>
<th>PDP Star Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>D11</td>
<td>High Risk Medication</td>
<td>7%</td>
<td>4.1</td>
<td>11%</td>
<td>3.1</td>
</tr>
<tr>
<td>D12</td>
<td>Med Adh – Diabetes</td>
<td>77%</td>
<td>3.9</td>
<td>80%</td>
<td>2.7</td>
</tr>
<tr>
<td>D13</td>
<td>Med Adh – Hypertension</td>
<td>79%</td>
<td>4.1</td>
<td>82%</td>
<td>3.6</td>
</tr>
<tr>
<td>D14</td>
<td>Med Adh - Cholesterol</td>
<td>75%</td>
<td>4.0</td>
<td>78%</td>
<td>3.5</td>
</tr>
<tr>
<td>D15</td>
<td>MTM CMR Completion Rate</td>
<td>30.9%</td>
<td>2.3</td>
<td>15.4%</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Cut Point for 3 Star Rating was set above the National Average for CMR Completion Rate and higher than expected signaling a strong message from CMS.
Completion Rate is Important and Quality Matters

- Document the actions you took to address the drug therapy problems presented

- Document and provide actionable recommendations to prescribers

- Counsel your patients and document what information you provided to them

- Provide the patient with a Medication Action Plan (MAP) with a Personal Medication List (PML) in CMS’ standardized format
MEDICATION THERAPY MANAGEMENT PROGRAM
STANDARDIZED FORMAT

- The Medicare Part D Medication Therapy Management (MTM) Program Standardized Format is a written summary of a comprehensive medication review (CMR).
- Developed to improve the quality of MTM programs and provide consistency in beneficiary communications.
- Format cannot be modified, but its content must be tailored and customized for the patient.
- Three main components of this document:
  - CMR Cover Letter (CL)
  - Medication Action Plan (MAP)
  - Personal Medication List (PML)
Section I: The Cover Letter

• Purpose of the cover letter (CL)
  – Remind the beneficiary of what occurred during the CMR,
  – Introduce the MAP and PML, and
  – Describe how the beneficiary can contact the MTM program.
Section II. The Medication Action Plan (MAP)

• The Medication Action Plan (MAP) describes
  – Specific action items resulting from the interactive CMR consultation,
  – Beneficiary’s responsibilities, and
  – healthcare provider activities that may affect the beneficiary’s tasks.
• A plan to assist the beneficiary with resolving issues of current drug therapy and to help achieve the goals of medication treatment
• May also include acknowledgement and reinforcement of favorable behaviors
• Focuses on the most important activities for the beneficiary
• Not intended for communication with other healthcare providers
Section II. The Medication Action Plan (MAP)

- Not all CMRs services delivered will result in specific issues identified or actionable recommendations for patients
- Pharmacists will be able to document in the MAP such non-actionable recommendations as
  - Reinforced compliance
  - Acknowledgement of beneficiary success with medication therapy
  - Maintenance of current effort towards medication and health management
Sample MAP

Medication Action Plan (MAP)

What we talked about:

- Insert description of topic

What I need to do:

- Insert recommendations for beneficiary's activities

What I did and when I did it:

- Leave blank for beneficiary's notes

My follow-up plan (add notes about next steps):

- Leave blank for beneficiary's notes

Questions I want to ask (include topics about medications or therapy):

- Leave blank for beneficiary's notes

If you have any questions about your action plan, call <insert MTM provider contact information, phone number, days/times, etc.>

Date Prepared: Insert date

What we talked about:

- Insert description of topic

What I need to do:

- Insert recommendations for beneficiary's activities

What I did and when I did it:

- Leave blank for beneficiary's notes

My follow-up plan (add notes about next steps):

- Leave blank for beneficiary's notes

Questions I want to ask (include topics about medications or therapy):

- Leave blank for beneficiary's notes

If you have any questions about your action plan, call <insert MTM provider contact information, phone number, days/times, etc.>
Section MAP-6

- In the “what we talked about” field, pharmacist documents what was discussed with the patient,

<table>
<thead>
<tr>
<th>What we talked about:</th>
<th>What I need to do:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Insert description of topic&gt;</em></td>
<td><em>Insert recommendations for beneficiary activities&gt;</em></td>
</tr>
<tr>
<td><em>Leave blank for beneficiary’s notes&gt;</em></td>
<td></td>
</tr>
</tbody>
</table>

- This could be
  - Medication dose is too high or too low
  - Goals of therapy
  - How to reduce the risk of medication adverse event
  - Optimal time to take a medication, ex. Statins
  - Education provided related to patient’s disease state

- This information is reportable to CMS at the end of each calendar year
Section MAP-6

- In the “what I need to do” field, the pharmacist documents what the patient needs to do to address what the pharmacist documented in “what we talked about” field.

<table>
<thead>
<tr>
<th>What we talked about:</th>
<th>What I need to do:</th>
<th>What I did and when I did it:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; Insert description of topic &gt;</td>
<td>&lt; Insert recommendations for beneficiary activities &gt;</td>
<td>&lt; Leave blank for beneficiary’s notes &gt;</td>
</tr>
</tbody>
</table>

- This could be
  - Follow up with prescribers to discuss increase or decrease of your dose (the pharmacist should also forward a recommendation to the prescriber)
  - Monitor blood pressure regularly at home and share info with doctors
  - Take this medication with food, or two hours after food
  - Take this medication in the evening for better result

- This information is NOT reportable to CMS at the end of each calendar year
Section MAP-6

- In the “what I did and when I did it” field, this field is left blank **for the patient to use** after the GMP is complete.

<table>
<thead>
<tr>
<th>What we talked about:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; Insert description of topic &gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What I need to do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; Insert recommendations for beneficiary activities &gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What I did and when I did it:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; Leave blank for beneficiary’s notes &gt;</td>
</tr>
</tbody>
</table>

- Educate the patient that he/she will be able to manually enter when he/she took action regarding the recommendation you provided in the “what I need to do” field.

- This information is NOT reportable to CMS at the end of each calendar year.
Section MAP-7 and 8

- These are left blank for the **patient to complete** after the CMR.

- The pharmacist may provide the patient with the information to include here:

  - **My follow-up plan** (add notes about next steps):
    <Leave blank for beneficiary’s notes>

  - **Questions I want to ask** (include topics about medications or therapy):
    <Leave blank for beneficiary’s notes>

- This information is NOT reportable to CMS at the end of each calendar year.
Good Sample MAP

Here are 3 examples of a well documented MAPs completed by pharmacists during HIV Care and ART management:

<table>
<thead>
<tr>
<th>What we talked about:</th>
<th>What patient needs to do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C Goal</td>
<td>You said that your Hemoglobin A1C was down to 6% after you had been removed from insulin therapy. That is great! Keep eating a healthy diet and regulating your blood sugar.</td>
</tr>
<tr>
<td>Medication Adherence</td>
<td>You are doing very well at keeping up with and taking your medicine regularly. Continue to do so and contact us here at the pharmacy if you run into any problems.</td>
</tr>
<tr>
<td>Wants to &quot;get off&quot; Zolpidem</td>
<td>Speak to MD about decreasing and eventually titrating down Zolpidem. Consider melatonin to help sleep.</td>
</tr>
</tbody>
</table>
Not so good Sample MAP

Here are two examples of poorly documented MAPs completed by pharmacists during different MTM sessions:

<table>
<thead>
<tr>
<th>What we talked about:</th>
<th>What patient needs to do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>discussed all mentioned above</td>
<td>we mentioned what was mentioned above</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What we talked about:</th>
<th>What patient needs to do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>side effects, problems with regimen</td>
<td>nothing</td>
</tr>
</tbody>
</table>
Personal Medication List (PML)

Intended to help patients

• Understand their medications and their treatment plans
• Stay engaged in the management of their drug therapy
• Improve both communication about medications and tracking of all medications
• Assists with managing their medications
  – Add new medications and their start dates
  – Redact discontinued product
  – Indicate the stop dates and reasons for stopping
Personal Medication List (PML)

- Reconciled list of all active medications at the time of the CMR
- Updated list with over-the-counter medications and herbal supplements
- Must be completed and updated during the CMR
- Must contain the purpose and directions for medications use
### Personal Medication List (PML)

Compare these two PML documents from real cases:

<table>
<thead>
<tr>
<th>Medication: MetFORMIN HCl Oral Tablet 500 MG</th>
</tr>
</thead>
<tbody>
<tr>
<td>How I use it: <strong>qd</strong></td>
</tr>
<tr>
<td>Why I use it: Diabetes</td>
</tr>
<tr>
<td>Date I started using it:</td>
</tr>
<tr>
<td>Why I stopped using it:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication: Omeprazole Oral Capsule Delayed Release 20 MG</th>
</tr>
</thead>
<tbody>
<tr>
<td>How I use it: <strong>qd</strong></td>
</tr>
<tr>
<td>Why I use it: Acid Reflux</td>
</tr>
<tr>
<td>Date I started using it:</td>
</tr>
<tr>
<td>Why I stopped using it:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication: Solifenacin Succinate (VESIcare) Oral Tablet 5 MG</th>
</tr>
</thead>
<tbody>
<tr>
<td>How I use it: <strong>qd</strong></td>
</tr>
<tr>
<td>Why I use it: <strong>UNKNOWN</strong></td>
</tr>
<tr>
<td>Date I started using it:</td>
</tr>
<tr>
<td>Why I stopped using it:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication: Lisinopril Oral Tablet 40 MG</th>
</tr>
</thead>
<tbody>
<tr>
<td>How I use it: Take 1 tablet by mouth every day.</td>
</tr>
<tr>
<td>Why I use it: High Blood Pressure</td>
</tr>
<tr>
<td>Date I started using it:</td>
</tr>
<tr>
<td>Why I stopped using it:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication: Omeprazole Oral Capsule Delayed Release 20 MG</th>
</tr>
</thead>
<tbody>
<tr>
<td>How I use it: Take 1 capsule by mouth every day.</td>
</tr>
<tr>
<td>Why I use it: Acid Reflux</td>
</tr>
<tr>
<td>Date I started using it:</td>
</tr>
<tr>
<td>Why I stopped using it:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication: Pravastatin Sodium Oral Tablet 80 MG</th>
</tr>
</thead>
<tbody>
<tr>
<td>How I use it: Take 1 tablet by mouth every day at bedtime.</td>
</tr>
<tr>
<td>Why I use it: High Cholesterol</td>
</tr>
<tr>
<td>Date I started using it:</td>
</tr>
<tr>
<td>Why I stopped using it:</td>
</tr>
</tbody>
</table>
Current business models

- In-House MTM provider for the PBM

- Outsourced MTM service through MTM Vendor
  - Mirixa Corporation
  - OutcomesMTM (A Cardinal Company)
  - Pharm MD
  - SinfoniaRx
  - Assurance System (Medication Management System)
  - Some University Systems

- Call-Center practice

- Independent practitioners
Payment

• MTM CPT Codes
  – 99605
  – 99606
  – 99607
• Flat fee for a CMR
  – $45 to $75
• Flat fee for a TMR
  – $15 to $40
  – Additional revenue based on findings
• Payment to pharmacies rather than pharmacists (unless you’re an owner)
• Could potentially increase due to CMR completion rate’s impact on Star Rating
Looking Forward

- Use your technicians
- Schools of pharmacy can be a good resource for talent
- Explore creative contracting opportunities
- Remember, patients won’t buy-in if you don’t offer it
Break
AN OVERVIEW OF CMS MEDICARE PART C AND D PERFORMANCE MEASURES- STAR RATINGS, AND THEIR IMPACT ON PHARMACY PRACTICE

NC Mutual Spring Conference
March. 2016
Ugo Nwachukwu, PharmD
OBJECTIVES

- Review the purpose of CMS Performance measures
- Review the metrics that make up CMS performance measures
- Discuss how Star Ratings impact pharmacy practice
- Discuss pharmacist role in improving these performance measures
- Discuss current trends and potential changes to CMS performance measures
**Star Rating - What is It?**

- Drive organizations and sponsors toward higher quality and more efficient care
- Serve as the basis of Quality Bonus Payments (QBPs) for MA organizations
- Inform beneficiaries about the performance of health and drug plans
- Plans are rated from one Star to Five Stars
Star Ratings are aligned with National Quality Strategy

- Make care safer by reducing harm
- Engage patients and family as partners in care
- Use effective communication and coordination of care
- Promote prevention and treatment practices for leading causes of mortality
- Use of best practices to enable healthy living
- Make quality care more affordable for all
## Comprehensive Overview of CMS Quality Programs

<table>
<thead>
<tr>
<th>Hospital Quality</th>
<th>Physician Quality</th>
<th>PAC Quality</th>
<th>Payment Models</th>
<th>Population Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful use EHR incentive</td>
<td>Meaningful use EHR incentive</td>
<td>Inpatient rehabilitation facility</td>
<td>Medicare Shared Savings Program (ACOs)</td>
<td>Medicare Part C</td>
</tr>
<tr>
<td>Inpatient quality reporting</td>
<td>Physician Quality Reporting System (PQRS)</td>
<td>Nursing Home Compare measures</td>
<td>Hospital value-based purchasing</td>
<td>Medicare Part D</td>
</tr>
<tr>
<td>Outpatient quality reporting</td>
<td>Value-based Payment Modifier (VM)</td>
<td>LTCH quality reporting</td>
<td>Physician Feedback</td>
<td>Medicaid Adult Core Measures</td>
</tr>
<tr>
<td>Ambulatory surgical centers</td>
<td>Maintenance of certification</td>
<td>Hospice quality reporting</td>
<td>ESRD QIP</td>
<td>Medicaid Child Core Measures</td>
</tr>
<tr>
<td>Readmission reduction program</td>
<td></td>
<td>Home health quality reporting</td>
<td>Innovations Pilots</td>
<td>Health Insurance Exchange Quality Reporting System (QRS)</td>
</tr>
<tr>
<td>HAC payment reduction program</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPS-exempt cancer hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient psychiatric facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
STAR RATINGS TOPIC AREA (DOMAINS)

- Medicare Advantage-MA (Part C) only plans - 5 domains
  - Thirty two (32) measures

- Prescription Drug Plans-PDPs (Part D) are measured on 4 domains
  - Up to 15 measures.

- Medicare Advantage with Prescription Drug-MA-PD (Part C+D) benefit contracts are measured on all 9 domains
  - Up to 44 unique measures.
# Medicare Part C Quality Measures

## Staying Healthy: Screenings, Tests and Vaccines
- Breast Cancer Screening
- Colorectal Cancer Screening
- Annual Flu Vaccine
- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health
- Monitoring Physical Activity
- Adult BMI Assessment

## Managing Chronic (Long Term) Conditions
- SNP Care Management
- Care for Older Adults – Medication Review
- Care for Older Adults – Functional Status Assessment
- Care for Older Adults – Pain Screening
- Osteoporosis Management in Women who had a Fracture
- Diabetes Care – Eye Exam
- Diabetes Care – Kidney Disease Monitoring
- Diabetes Care – Blood Sugar Controlled
- Controlling Blood Pressure
- Rheumatoid Arthritis Management
- Reducing the Risk of Falling
- Plan All-Cause Readmissions

## Member Experience with Health Plan
- Getting Needed Care
- Getting Appointments and Care Quickly
- Customer Service
- Rating of Health Care Quality
- Rating of Health Plan
- Care Coordination

## Member complaints and Changes in the Health Plan’s Performance
- Complaints about the Health Plan
- Members Choosing to Leave the Plan
- Beneficiary Access and Performance Problems
- Health Plan Quality Improvement

## Health Plan’s Customer Service
- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions
- Call Center – Foreign Language Interpreter and TTY Availability
# Part D Domains and Measures

<table>
<thead>
<tr>
<th>Drug Plan Customer Service</th>
<th>Member Complaints and Changes in the Drug Plans Performance</th>
<th>Member Experience with Drug Plan</th>
<th>Drug Safety and Accuracy of Drug Pricing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Call Center – Foreign Language Interpreter and TTY Availability.</td>
<td>• Complaints about the Drug Plan.</td>
<td>• Rating of Drug Plan.</td>
<td>• MPF Price Accuracy</td>
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<tr>
<td>• Appeals Auto-Forward.</td>
<td>• Members Choosing to Leave the Plan.</td>
<td></td>
<td>• High Risk Medication</td>
</tr>
<tr>
<td>• Appeals Upheld</td>
<td>• Beneficiary Access and Performance Problems.</td>
<td>• Getting Needed Prescription Drugs</td>
<td>• Medication Adherence for Diabetes Medications.</td>
</tr>
<tr>
<td></td>
<td>• Drug Plan Quality Improvement.</td>
<td></td>
<td>• Medication Adherence for Hypertension (RAS Antagonists)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Medication Adherence for Cholesterol (Statins).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• MTM Program Completion Rate for CMR</td>
</tr>
</tbody>
</table>
ALL MEASURES ARE NOT CREATED EQUAL

- **Outcome measure**
  - Improvement to a beneficiary’s health as a result of care
  - Triple weighted vs Process Measure

- **Intermediate outcome measure**
  - Mechanisms to help beneficiaries move closer to achieving true outcomes
  - Triple weighted vs Process Measure

- **Patient experience measures**
  - Represent beneficiaries’ perspectives about the care they receive
  - 50% higher weight than Process measure

- **Access measures**
  - Reflect processes or structures that may create barriers to receiving needed health care
  - The same or 50% higher weight than Process measure

- **Process-of-care measures**
  - Focuses on methods by which health care is provided.
  - Weighted 1
HIGH RISK MEDICATIONS (HRM)

- Intermediate Outcome Measure; Triple weighted
- Applies to Medicare beneficiaries 65 years and older
- Filled two prescriptions for the same HRM during the measurement period
- Negatively impacts health plans after the second prescription is filled
- Pharmacy’s performance is important to health plans
High Risk Medications

- Measures the percent of plan beneficiaries who filled prescriptions for certain medications with a high risk of serious side effects, when there may be safer medication choices.
- 2016 Star Ratings will be based on Prescription Drug Event (PDE) data from 1/1/2014 to 12/31/2014

Cut points for Star Assignment in 2016

<table>
<thead>
<tr>
<th>TYPE</th>
<th>1 Star</th>
<th>2 Star</th>
<th>3 Star</th>
<th>4 Star</th>
<th>5 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA–PD</td>
<td>&gt;20%</td>
<td>&gt;12% to ≤20%</td>
<td>&gt;8% to ≤12%</td>
<td>&gt;6% to ≤8%</td>
<td>≤6%</td>
</tr>
<tr>
<td>PDP</td>
<td>&gt;14%</td>
<td>&gt;12% to ≤14%</td>
<td>&gt;10% to ≤12%</td>
<td>&gt;6% to ≤10%</td>
<td>≤6%</td>
</tr>
</tbody>
</table>

National Average PDP: 11% = 3.1 Stars

- Patients are usually identified after a prescription for a HRM is filled

Source: Medicare 2015 Part C & D Star Ratings Technical Notes
Adherence Measure – Diabetes Medications

- Intermediate Outcome Measure; Triple weighted
- Applies to Medicare beneficiaries 18 years and older
- Dispensed medication(s) across different classes of diabetes medications:
  - Biguanides,
  - Sulfonylureas,
  - Thiazolidinediones,
  - DiPeptidyl Peptidase (DPP)-IV Inhibitors,
  - Incretin mimetics, and
  - Meglitinides
  - SGLT 2 Inhibitor.
HOW IS NON–ADHERENCE IDENTIFIED?

- Calculated PDC based on claims data,

- PDC is the percent of time during which a patient received a medication or another in the same class,

- Non–adherence defined as a Proportion of Days Covered (PDC) typically < 80%

- PDC alone is not a sufficient indicator of adherence
  - Can account for gaps in refilling medication
  - Can be misleading
  - Often a good start
ADHERENCE MEASURES – DIABETES MEDICATIONS

- Measures the percent of Medicare Part D beneficiaries 18 years or older who adhere to their prescribed drug therapy across six classes of diabetes medications

- 2016 Star Ratings will be based on Prescription Drug Event (PDE) data from 1/1/2014 to 12/31/2014

**2016 Cut points**

<table>
<thead>
<tr>
<th>Type</th>
<th>1 Star</th>
<th>2 Star</th>
<th>3 Star</th>
<th>4 Star</th>
<th>5 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA–PD</td>
<td>&lt; 60%</td>
<td>≥60% to &lt;69%</td>
<td>≥69% to &lt;75%</td>
<td>≥75% to &lt;82%</td>
<td>≥82%</td>
</tr>
<tr>
<td>PDP</td>
<td>&lt; 75%</td>
<td>≥75% to &lt;80%</td>
<td>≥80% to &lt;83%</td>
<td>≥83% to &lt;95%</td>
<td>≥95%</td>
</tr>
</tbody>
</table>

- National Average MAPD: 77% = 4 Stars
- National Average PDP: 80% = 2 Stars
- Adherence = PDC equal to or higher than 80%

Source: Medicare 2016 Part C & D Star Ratings Technical Notes
ADHERENCE MEASURE – HYPERTENSION MEDICATIONS

- Intermediate Outcome Measure; Triple weighted

- Applies to Medicare beneficiaries 18 years and older

- Dispensed any of the following medication for hypertension:
  - Angiotensin Converting Enzyme (ACE) inhibitor,
  - Angiotensin II Receptor Blocker (ARB),
  - Direct Renin Inhibitor (DRI)

- Adherence calculation is based on Proportion of Days Covered (PDC)
ADHERENCE MEASURE — HYPERTENSION MEDICATIONS

- Medicare Part D beneficiaries 18 years or older who adhere to their prescribed drug therapy for renin angiotensin system (RAS) antagonists (Exclude patient’s with ESRD)
  - ACE-I,
  - ARB,
  - DRI
- Based on Prescription Drug Event (PDE) data from 1/1/2014 to 12/31/2014

2016 Cut points

<table>
<thead>
<tr>
<th>Type</th>
<th>1 Star</th>
<th>2 Star</th>
<th>3 Star</th>
<th>4 Star</th>
<th>5 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA–PD</td>
<td>&lt; 58%</td>
<td>≥58% to &lt;73%</td>
<td>≥73% to &lt;77%</td>
<td>≥77% to &lt;81%</td>
<td>≥81%</td>
</tr>
<tr>
<td>PDP</td>
<td>&lt; 76%</td>
<td>≥76% to &lt;78%</td>
<td>≥78% to &lt;82%</td>
<td>≥82% to &lt;85%</td>
<td>≥85%</td>
</tr>
</tbody>
</table>

Source: Medicare 2015 Part C & D Star Ratings Technical Notes
ADHERENCE MEASURE – CHOLESTEROL MEDICATIONS

- Intermediate Outcome Measure; Triple weighted

- Applies to Medicare beneficiaries 18 years and older

- Dispensed a statin and taking it as directed

- Adherence calculation is based on Proportion of Days Covered (PDC)
ADHERENCE MEASURES – CHOLESTEROL MEDICATIONS

- Medicare Part D beneficiaries 18 years or older who adhere to their prescribed drug therapy for cholesterol–Statins.

- 2016 Star Ratings will be based on Prescription Drug Event (PDE) data from 1/1/2014 to 12/31/2014

2015 Cut points

<table>
<thead>
<tr>
<th>Type</th>
<th>1 Star</th>
<th>2 Star</th>
<th>3 Star</th>
<th>4 Star</th>
<th>5 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA–PD</td>
<td>&lt; 50%</td>
<td>≥50% to &lt;61%</td>
<td>≥61% to &lt;73%</td>
<td>≥73% to &lt;79%</td>
<td>≥79%</td>
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<tr>
<td>PDP</td>
<td>&lt; 68%</td>
<td>≥68% to &lt;73%</td>
<td>≥73% to &lt;78%</td>
<td>≥78% to &lt;83%</td>
<td>≥83%</td>
</tr>
</tbody>
</table>

- National Average MAPD: 75% = 4 Stars

- National Average PDP: 78% = 4 Stars

Source: Medicare 2016 Part C & D Star Ratings Technical Notes
MTM Program Completion Rate for CMR

- Medicare Part D beneficiaries 18 years or older who met the contracts’ (health plan’s) specified targeting criteria per CMS guideline and received a CMR during the reporting period

- 2016 Star Ratings will be based on Part D Plan Reporting, Medicare Enrollment Database from 1/1/2014 to 12/31/2014

2016 Cut points

<table>
<thead>
<tr>
<th>Type</th>
<th>1 Star</th>
<th>2 Star</th>
<th>3 Star</th>
<th>4 Star</th>
<th>5 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA–PD</td>
<td>&lt; 13.6%</td>
<td>≥13.6% to &lt;36.2%</td>
<td>≥36.2% to &lt;48.6%</td>
<td>≥48.6% to &lt;76.0%</td>
<td>≥76%</td>
</tr>
<tr>
<td>PDP</td>
<td>&lt; 8.5%</td>
<td>≥8.5% to &lt;16.6%</td>
<td>≥16.6% to &lt;27.2%</td>
<td>≥27.2% to &lt;36.7%</td>
<td>≥36.7%</td>
</tr>
</tbody>
</table>

- National average CMR Completion rate for MAPD is 30.9%

- National average CMR Completion rate for PDP is 15.4%

Source: Medicare 2016 Part C & D Star Ratings Technical Notes
IMPACT TO HEALTH PLANS

- Marketing advantage
- All year enrollment for high performing (5 Stars) plans
- Quality Bonus Payment (QBP) for MA and MA–PD Plans with Summary Ratings greater than 4 Stars
- Potentially decreased enrollment for low performing plans
MEDICARE PLAN FINDER

Select All

Available Plans Based On Your Filters

- Prescription Drug Plans (with Original Medicare)[?]
  - 27 plan(s) available

- Medicare Health Plans with drug coverage[?]
  - 7 plan(s) available

Select Star Ratings

Overall Star Rating - Show me plans with at least:

0 Stars to 5 Stars

Select Coverage Options

Select Special Needs Plans

Compare Plans

Sort Results by Overall Star Rating

KelseyCare Advantage Essential (HMO) (H0332-001-0)

- Organization: KelseyCare Advantage
- Estimated Annual Health and Drug Costs: $5,610
- Includes $3,144 for drug costs
- Overall Star Rating: 4.5 out of 5 stars

Retail
- Annual: $3,144
- Monthly Premium: $0.00
- Health Plan Deductible: $0
- Doctor Choice: Plan Doctors for Most Services
- Out of Pocket Spending Limit: $3,400 In-network

KelseyCare Advantage Essential+Choice (HMO-POS) (H0332-003-0)

- Organization: KelseyCare Advantage
- Estimated Annual Health and Drug Costs: $5,730
- Includes $3,144 for drug costs
- Overall Star Rating: 4.5 out of 5 stars

Retail
- Annual: $3,144
- Monthly Premium: $0.00
- Health Plan Deductible: $0
- Doctor Choice: Plan Doctors Only (some exceptions)
- Out of Pocket Spending Limit: $3,400 In-network
  - $10,000 Out-of-network
LEADING PERFORMERS

- Based on 5 Star Summary Rating
  - MA-only contract for achieving a 5-star Part C summary rating
  - a PDP contract for a 5-star Part D summary ratings
  - MA-PD contract for a 5-star overall rating (C and D)

- Designated high performing Icon

This plan got Medicare’s highest rating (5 stars)
HEALTH PLANS WITH HIGH PERFORMING ICON IN 2015

- PDP plans with 5 Star Summary Ratings

<table>
<thead>
<tr>
<th>Contract Number</th>
<th>Contract Name</th>
<th>Reason for LPI</th>
<th>Parent Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1822</td>
<td>HEALTHPARTNERS, INC.</td>
<td>Part D</td>
<td></td>
</tr>
<tr>
<td>S5743</td>
<td>WELLMARK IA &amp; SD, &amp; BCBS MN, MT, NE, ND, &amp; WY</td>
<td>Part D</td>
<td></td>
</tr>
<tr>
<td>S5753</td>
<td>WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION</td>
<td>Part D</td>
<td></td>
</tr>
</tbody>
</table>

- Health Partners and Wisconsin Physicians plans had not previously received 5-Stars

- Average Star Rating by enrollment per PDP is 3.75

- Fifty three (53%) of PDP enrollees are in contracts with 4 or more Stars

Source: Fact Sheet-2015 Star Ratings
HEALTH PLANS WITH HIGH PERFORMING ICON IN 2015

- **MA–PD plans with 5–star Summary Ratings**

<table>
<thead>
<tr>
<th>Contract Number</th>
<th>Contract Name</th>
<th>Reason for LPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0524</td>
<td>KAISER FOUNDATION HP, INC.</td>
<td>Part C and D</td>
</tr>
<tr>
<td>H0630</td>
<td>KAISER FOUNDATION HP OF CO</td>
<td>Part C and D</td>
</tr>
<tr>
<td>H1019</td>
<td>CAREPLUS HEALTH PLANS, INC.</td>
<td>Part C and D</td>
</tr>
<tr>
<td>H1230</td>
<td>KAISER FOUNDATION HP, INC.</td>
<td>Part C and D</td>
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<tr>
<td>H2150</td>
<td>KAISER FNDN HP OF THE MID- ATLANTIC STS</td>
<td>Part C and D</td>
</tr>
<tr>
<td>H5050</td>
<td>GROUP HEALTH COOPERATIVE</td>
<td>Part C and D</td>
</tr>
<tr>
<td>H5262</td>
<td>GUNDERSEN HEALTH PLAN</td>
<td>Part C and D</td>
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<tr>
<td>H5591</td>
<td>MARTIN'S POINT GENERATIONS, LLC</td>
<td>Part C and D</td>
</tr>
<tr>
<td>H6360</td>
<td>HEALTHSPAN INTEGRATED CARE</td>
<td>Part C and D</td>
</tr>
<tr>
<td>H9003</td>
<td>KAISER FOUNDATION HP OF THE N W</td>
<td>Part C and D</td>
</tr>
<tr>
<td>H9047</td>
<td>PROVIDENCE HEALTH PLAN</td>
<td>Part C and D</td>
</tr>
</tbody>
</table>

- **Will receive Quality Bonus Payments (QBP) and are eligible for year–round enrollment**

Source: Fact Sheet-2015 Star Ratings
QUALITY BONUS PAYMENTS (QBP)

- Percentage increase to MA and MA–PD organizations that meets CMS quality standards

- Historically, MA and MA–PD plans received QBP at a lower Star Ratings.

- From CY2015 moving forward, only Plans with 4 Stars or higher will get QBP
How QBP Is Calculated?

- Health plans submit their bid to CMS (the plan’s cost for providing Medicare part A & B benefits)

- Most plans submit bids that are lower than the county benchmark (max amount CMS will pay the plan to provide Part A & B benefits)
  - Benchmark vary by county

- If the bid is below the county benchmark, the plan will receive a percentage of the difference between bid & the benchmark (rebate)

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>2016</th>
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</thead>
<tbody>
<tr>
<td>4.5+ Stars</td>
<td>70%</td>
</tr>
<tr>
<td>3.5 to &lt; 4.5 stars</td>
<td>65%</td>
</tr>
<tr>
<td>&lt; 3.5 stars</td>
<td>50%</td>
</tr>
</tbody>
</table>
How QBP is Calculated? (Cont.)

- ≥4 star plans will have 5% added to their benchmark

- Plans then receive the rebate percentage of the difference between the plan bid & the newly bonus adjusted Benchmark

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>2016 QBP Percentage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 stars</td>
<td>0%</td>
</tr>
<tr>
<td>3 stars</td>
<td>0%</td>
</tr>
<tr>
<td>3.5 stars</td>
<td>0%</td>
</tr>
<tr>
<td>4 stars</td>
<td>5%</td>
</tr>
<tr>
<td>4.5 stars</td>
<td>5%</td>
</tr>
<tr>
<td>5 stars</td>
<td>5%</td>
</tr>
</tbody>
</table>
LAGGING PERFORMERS

- Based on average of 2.5 Star Summary Rating
  - MA-only contract for achieving a 2.5-star on Part C summary rating x 3 consecutive years
  - PDP contract for achieving an average 2.5-star Part D summary rating x 3 consecutive years
  - MA-PD contract for achieving a 2.5-star overall rating (C and D) x 3 consecutive years

- Designated low performing Icon
IMPACT TO PHARMACIES

- Improve health outcome for your patients
- Coordinate care with local practitioner and enhance relationship with payers
- Opportunity to strengthen patient/pharmacist relationship
- Generate revenue for your pharmacy

MTM and Star Rating Programs Provide
ROLE OF TECHNOLOGY

- Provide a standardized mechanism for documenting clinical services delivered
- Identify some key issues present within a patient profile
- Simplify work flow
- Facilitate claims adjudication
- Support reporting to ensure compliance with CMS regulations
MTM AND RELATED TECHNOLOGIES

- MTM Provider Technology
  - Mirixa Corporation
  - PharmMD
  - SinfoniaRX
  - OutcomesMTM (recently acquired by Caremark)
  - Assurance System

- Star Rating Related Analytics
  - EQuIPP platform
  - RxAnte
WHERE CAN WE GO FROM HERE

- New Federal Legislations to expand pharmacists’ role
  - HR 592 (Pharmacy and Medically Underserved Areas Enhancement Act)
  - S 314
- States using pharmacy services to improve patient care
- Provider Status?
QUESTIONS?

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UNwachukwu@mirixa.com