New Medicare Part D Program Targets Top Prescription Fillers

BY MITCHEL L. ZOLER
Philadelphia Bureau

PHILADELPHIA — Starting next year, Medicare Part D will feature a new wrinkle in the drug insurance program: medication therapy management.

A medication therapy management (MTM) program was mandated for 2007 by the Centers for Medicare and Medicaid Services (CMS) for selected Medicare beneficiaries who are participating in Part D coverage. MTM programs are targeted to beneficiaries who have multiple chronic diseases, use multiple medications in Part D, and have anticipated Part D costs for 2007 of more than $4,000, Mary Dorholt said at a conference sponsored by the American Society on Aging. The program, as it's currently structured, will apply to about 3% of Medicare beneficiaries who enroll in Part D, said Ms. Dorholt, vice president for Medicare client support at Medco Health Solutions Inc. in Maple Grove, Minn., a Part D sponsor.

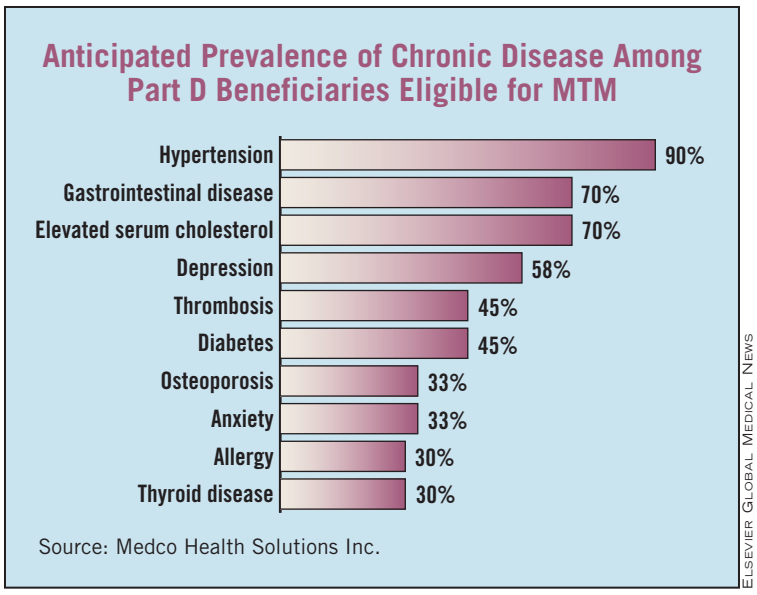
The minimum criteria for beneficiaries to qualify for a MTM program include having at least five chronic conditions, with at least two from this list: hypertension, elevated serum cholesterol, heart failure, diabetes, and chronic obstructive pulmonary disease. Beneficiaries also need a history of claims for at least six different medications that are covered under Part D. But the CMS policy also states that Part D sponsors can lower their eligibility standards so that more beneficiaries qualify for their MTM program.

Medco has developed a profile of the anticipated profile of chronic diseases that will occur in beneficiaries who qualify for their MTM program. The most common illness is hypertension, which is anticipated to affect about 90% of qualifying beneficiaries, Ms. Dorholt said.

Although the CMS requires Part D sponsors to offer a MTM program next year "to ensure that covered Part D drugs are appropriately used to optimize therapeutic outcomes" and to reduce the risk of adverse drug effects, the specifics of each program have been left to each Part D sponsor. The program Medco created is designed to educate beneficiaries on the importance of compliance, to identify and help eliminate barriers and risks from drug therapy, to review important health and safety issues, and to find opportunities for lower costs by more use of generic drugs and providing medications through the mail.

The essence of the program is to "talk to patients and help them understand why they are taking their drugs and how to take them correctly," said Ms. Dorholt.

Although individual beneficiaries will not pay for the MTM programs, they are required to enroll. A challenge for Medco and other part D sponsors will be to educate beneficiaries that the service is free and to encourage their enrollment, Ms. Dorholt said. ■



Generic Prescriptions Key to Avoid Part D Doughnut Hole

BY TIMOTHY F. KIRN
Sacramento Bureau

SEATTLE — With generic prescribing, a little can go a long way. In fact, by using generics 10% of the time, the Medicare Part D program could reduce drug spending by as much as $2 billion, according to an analysis presented at the annual research meeting of Academy Health.

That could be important because the analysis also showed that about 22% of Medicare beneficiaries who used to receive a $600 subsidy for prescription drugs under the previous Medicare program will no longer qualify for a subsidy, and 16%-23% will probably end up in what is called the doughnut hole of Medicare Part D, where they will have no drug coverage, said M. Christopher Roebuck, an economist with CareMark, Hunt Valley, Md., a pharmacy-benefits management company.

To conduct the analysis, Mr. Roebuck and colleagues used data from 37,425 individuals enrolled in Medicare drug discount card programs for at least 6 months, and who had filled at least one prescription. The researchers then assumed those same usage patterns, with some increase in usage when out-of-pocket costs go down, and applied a 3.5% annual rate for inflation.

The enrollees filled a mean of 19 prescriptions per year, 10 for generic drugs and 9 for brand name, for a mean total cost of $849, of which $538 was paid out of pocket.

Depending on the assumption used to estimate how the new coverage might increase use, the analysis suggests that out-of-pocket costs could increase for these beneficiaries by $38 to $187 annually. On the other hand, if the generic prescription rate were increased by 10%, it would save the beneficiaries a mean amount in the range of $41 to $55 in out-of-pocket costs and would decrease the amount spent by Medicare on each beneficiary by $62 to $71.

Extrapolating that to 33 million beneficiaries, Medicare could reduce its spending by about $2 billion annually, Mr. Roebuck said. ■

Medicare Adds Measures to Voluntary Reporting Program

BY MARY ELLEN SCHNEIDER
New York Bureau

Medicare officials plan to expand their voluntary quality reporting program to include more subspecialty measures next year.

The Physician Voluntary Reporting Program was launched last January with a set of 16 core measures, representing 19 of the 39 Medicare physician specialty designations. For 2007, Medicare officials have developed a draft list that includes quality measures that cover 32 of the 39 medical specialties.

Officials at the Centers for Medicare and Medicaid Services recently released a list of 86 unique quality measures from which they plan to select a subset for use in the program. The final list is expected to be posted by Jan. 1, 2007, but the list may be updated throughout the coming year. At press time, the list included 21 measures for internal medicine and family medicine, 11 for geriatrics, 8 for cardiology, 9 for neurology, 1 for psychiatry, 3 for rheumatology, and 4 specific to endocrinology.

Under the program, physicians can use either G-codes or CPT Category II codes, when available, to report on the measures. Physicians who participated in 2006 can expect to receive confidential feedback reports from the CMS sometime this winter.

In assembling the draft list of measures for 2007, CMS officials gave preference to measures that had been adopted or endorsed by the AQA (formerly called the Ambulatory Care Quality Alliance) and the National Quality Forum (NQF). They also tried to first include measures for which electronic data collection could be used, instead of reporting on claims.

But some physician groups have cited concerns about the additional measures being considered by the CMS. Dr. Lynne M. Kirk, president of the American College of Physicians, said that some of the 86 measures listed by the CMS have not been fully vetted by either the AQA or the NQF.

But Dr. Kirk is hopeful that the CMS will listen to the group's concerns. Last year, CMS officials had proposed beginning the program with 36 measures, but after hearing feedback from medical specialty societies, pared that list to a starter set of 16 measures.

While the intent of the program is good and the measures have been well chosen, the program creates too large a burden on physicians, said Dr. Richard Hellman, president-elect of the American Association of Clinical Endocrinologists.The use of G-codes to report data means that physicians have to train their staff to use the codes, he said. And even physicians who have already adopted electronic health records don't have a clear path to submit data electronically. While the CMS allows the use of CPT-II codes, which can be transmitted electronically and more easily by paper, these codes are not available for all measures. The CMS should only use measures that have CPT-II codes available, Dr. Hellman said.

The other major issue is that physicians are not getting any additional money for participating in the program, Dr. Hellman said. Physicians take on additional costs to report the data and they should be given an incentive, he said.The American College of Cardiology does not have a formal position on the Physician Voluntary Reporting Program. ACC officials were involved in the development of the eight cardiology-specific measures that are being considered for inclusion by CMS and ACC supports their inclusion in the program. But more details are needed on what data collection methods physicians can use. "We feel that payment for quality or performance is a complex issue and more testing and evaluation of the measures and prospective data collection tools" are needed, according to an ACC statement.

Of the eight measures for cardiology, five were for treatment for coronary artery disease. They included the percentage of CAD patients with diabetes and/or left ventricular systolic dysfunction (LVSD) who were prescribed ACE inhibitor or angiotensin receptor blocker (ARB) therapy, and the percentage of CAD patients who received antiplatelet therapy, at least one lipid profile or all component tests, and β-blocker therapy for prior MI.

The other three cardiology measures were for heart failure, and included the percentage of heart failure patients with left ventricular systolic dysfunction prescribed ACE inhibitors, ARB therapy, and β-blocker therapy; and the percentage of heart failure patients with paroxysmal or chronic atrial fibrillation prescribed warfarin therapy. ■

Information on the Physician Voluntary Reporting Program and the draft list of quality measures is available online at www.cms.hhs.gov/pvrp/01_overview.asp.