New Opportunities for Pharmacists to provide Medication Therapy Management (MTM) Services

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Presented by
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Objectives

1. Be able to describe the concept of using Pharmacists to provide MTM services in Medicare patients and CMS requirements for these services.
2. Be able to describe the new opportunities in the Affordable Care Act for Pharmacists to collaborate with other Healthcare Providers to provide MTM services.
3. Review “real life” case presentations in which Pharmacists can provide MTM in the community.

How did Medication Therapy Management get started?

• Medication Therapy Management or MTM was created from the concept of Pharmaceutical Care, which was developed in the 1990’s.
• Pharmaceutical Care is defined as:
  – A comprehensive process assessment of a patient’s medication and medical history
  – Identifying drug therapy problems
  – Developing a patient-centered care plan & follow up

Medicare’s Definition of Medication Therapy Management

• In 2003, the Medicare Modernization Act was established to require that MedicarePart D insurers provide Medication Therapy Management Services (MTMS) to selected beneficiaries, with the goals of providing education, improving patient adherence, and detecting adverse drug events and medication misuse.
• Controlling Cost, Quality Improvement

Medicare’s Definition of Medication Therapy Management (MTM)

• According to the Medicare Modernization Act:

MTM is the evaluation of medication therapy to improve continuity of care and health care outcomes.
CMS’ evolution of Medication Therapy Management (MTM) Services?

- 2006: Few Requirements, Flexibility
- 2010: Increased consistency, new criteria and service level requirements
- 2012-2013: Targeting beneficiaries who most need MTM, expand access, evaluate outcomes

Source: www.cms.gov

CMS’ Criteria for MTM services

A. Chronic Diseases
   - One to four Chronic Diseases
   - The Seven Core Chronic Diseases: Hypertension, Heart Failure, Diabetes, Dyslipidemia, Respiratory Diseases (COPD, Asthma), Bone Diseases (Osteoarthritis, Osteoporosis, Rheumatoid Arthritis), Mental Health (Depression, Schizophrenia, Bipolar Disorder, Alzheimer’s)
   - Each Medicare Part D sponsor will submit an application to denote which chronic diseases they will target.

B. Multiple Covered Part D Drugs
   - Minimum of two to eight prescriptions
   **Categories:** Chronic/Maintenance Drugs, Disease-Specific Drugs, or specific Part D Drug Classes.

C. Incur an expense of $3100.20 on Medicare Part D medications
   - Each plan has a formula of how they determine the prescription expenses for that plan (i.e. data from the previous 12 months, or previous quarter)
   **Starting in 2013, All Part D Plans are required to offer MTM Beneficiaries, including Long-Term Care Residents.**

Examples of Medicare Part D Plans Criteria

A. Humana
   - Pt must have multiple chronic diseases states (3 of the 4: diabetes, high blood pressure, high cholesterol, asthma/COPD)
   - 8 chronic meds
   - $3100 in drug costs

B. America’s 1st Choice
   - Pt must have at least 2 chronic diseases
   - At least 4 Medicare Part D meds
   - $786 in drug costs

C. Windsor
   - All Medicare Part D members

Medication Therapy Management Programs

1. Outcomes - www.Outcomesmtm.com
   - Humana, Windsor, America’s 1st Choice
   - Dispensing Pharmacies
   - Independent Consultant Pharmacists

   - Must be a dispensing pharmacy
   - CVS Caremark, Express Scripts

The Five Core Elements of MTM

- All MTM services should contain the following components:
  - Comprehensive Medication Review (CMR)
  - Personal Medication Record (PMR)
  - Medication-Related Action Plan (MAP) [Beneficiary Cover letter-2013]
  - Intervention and/or Referral
  - Documentation and follow-up
Questions???

The Concept of using Pharmacists to provide MTM Services

- Per CMS’ requirements, the MTM service can be provided by:
  - Pharmacists
  - Registered Nurses
  - Case Manager
  - Physician
  - Other (i.e. Pharmacy Techs, Pharmacy Students, MTM assistants)

Pharmacists as MTM Providers

- Pharmacists are the “Medication Experts” and therefore can resolve medication related problems, by:
  - Enhancing the patient’s understanding of medication therapy
  - Increase Adherence to medication therapy
  - Improve detection & prevention of Adverse Drug Events (d/c inappropriate med use, decrease ED visits, & decrease hospitalizations)

Pharmacists as “MTM Providers”

- Systematic Approaches that Pharmacists use to reduce/prevent Adverse Drug Events:
  - Partnerships for Patients (public-private partnership that improves quality, safety, and affordability of healthcare for all patients) & Patient Safety Clinical Pharmacy Collaborative
  - American Society of Health System Pharmacists (ASHP) — works with institutions to improve medication effectiveness and safety.
  - Websites: Healthcare Research & Quality (AHRQ), FDA.gov (Safe Use Initiative & ADE Reporting), Institute of Safe Medication Practices (ISMP.org), Institute for Health Care Improvement (IHI.org)
Pharmacist as “MTM Providers”

- More Systematic Approaches involving Pharmacists:
  - Medication Reconciliation - the process of creating and maintaining the most accurate list possible of all medications a patient is taking and using that list to guide the assessment of therapy.
  - Benefits: reduces hospital utilization, prevents readmissions, correct meds at all transition points

Patient Counseling vs. MTM

<table>
<thead>
<tr>
<th>Aspects of Service</th>
<th>Patient Counseling</th>
<th>MTM Services</th>
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<tr>
<td>Focus</td>
<td>Drug Product</td>
<td>Patient drug therapy regimen</td>
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<td>Practitioner-patient</td>
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<td>communication</td>
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<td>Documentation in patient care record required</td>
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<td>Documentation</td>
<td>“Offer to Counsel”</td>
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<tr>
<td>Practitioner follow-up</td>
<td>Not required</td>
<td>Required</td>
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<tr>
<td>Measures of success</td>
<td>Volume (# of prescriptions)</td>
<td>Improved patient outcomes</td>
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The Pharmacy Technician’s role in MTM

1. Educate patient’s about MTM services (brochures) and identifying eligible patients.
2. Scheduling appointments and making reminder phone calls.
4. Compiling and organizing patient records to assist the pharmacist with the medication therapy review (refill hx, disease states, labs)

The Pharmacy Technician’s role in MTM

5. Once appointment is over, the technician can enter the pharmacist’s notes into the MTM documentation system and ensuring that notes are signed by the pharmacist.
6. The technician can fax MTM documentation to the patient’s physician or to other healthcare providers.
7. The technician can assist with billing for MTM services and tracking payments received.

Why are “Pharmacists” as “MTM Providers” important in reducing Adverse Drug Events in the Medicare population?

- More Systematic Approaches involving Pharmacists:
  - Pharmacist Collaboration with other health professionals
  - AHRQ funded RED project – goal to improve the discharge process
  - Clinical Pharmacists, Nurse Advocates, PCP’s
  - 24% decrease in hospitalizations
  - Pharmacists involved on Interdisciplinary Rounds in ICU decreased ADE’s relating to prescribing errors - Lucian Leape, Researcher
Pharmacists’ Opportunities in the Affordable Care Act

• CMS Innovation Center
• Accountable Care Organizations
• Essential Health Benefits
• Medical Loss Ratio
• Integrated Care Models
• Transitional Care Models
• Improvements to Medicare Part D MTM, and
• Litigation to Determine the Constitutionality of the New Law

Care Transitions

Background: On Sept. 14, 2012, the title XVIII of the Social Security Act was re-introduced by the 112th Congress (HR Bill 6413). Now sited as the Medicare Transitional Care Act of 2012. Effective January 1, 2013.

Findings:
• More than 20 percent of older Americans suffer from 5 or more chronic conditions and these older adults typically require health care services from numerous providers across several care settings each year.
• Insufficient communication among older adults, family caregivers, and health care providers during transitions from one care setting to another contributes to poor continuity of care, inadequate management of complex health care needs, medication errors, and preventable hospital readmissions

Care Transitions

Additional Findings: Re-hospitalization is prevalent, extremely common among the chronically ill and elderly populations, and expensive to the health care system. Studies have estimated readmission rates to be in excess of 25% with the majority of re-hospitalizations occurring in the first three months.

In a recent analysis of the 616,000 Medicare beneficiaries discharged from U.S. hospitals in 2005 with a diagnosis of heart failure, 27% were readmitted within 30 days, 39% within 60 days and almost 50% within 90 days.
Care Transitions

- According to Medicare claims data from 2003-2004, almost one fifth (19.6 percent) of the 11,855,702 Medicare beneficiaries who had been discharged from a hospital were rehospitalized within 30 days, and 34.0 percent were rehospitalized within 90 days.
- The Medicare Payment Advisory Commission estimates that hospital readmissions cost Medicare approximately $15 billion per year, $12 billion of which is for cases considered preventable.
- The MetLife Caregiving Cost Study demonstrates that American businesses lose an estimated $34 billion each year due to employees’ need to care for loved ones.

Care Transitions Models

- The National Transitions of Care Coalition has developed the Transition of Care Compendium, providing a centralized resource for providers to access all currently available evidence-based interventions and tools. www.ntocc.org
- The Care Transitions Intervention, developed by Eric Coleman, is primarily a transitions self-management model that provides coaching, skills, and tools to help patients and caregivers assert a more active role during transitions. This intervention has demonstrated lower rehospitalization rates and lower hospital costs per patient. Arch Intern Med. 2006;166:1822-1828.

Transitional Care Services

- A comprehensive assessment of the individual prior to the individual’s transition from one care facility to another care facility or home, including an assessment of the individual’s physical and mental condition, cognitive and functional capacities, medication regimen and adherence, social and environmental needs, and primary caregiver needs and resources. Development of a comprehensive medications management plan that ensures the safe use of medications and is based on the individual’s plan of care.
- Development of a comprehensive, evidenced-based plan of care for the individual developed with the individual and the individual’s primary caregiver and other health team members, identifying potential health risks, treatment goals, current therapies, and future services for both the individual and any primary caregiver.
- Implementation of a plan to facilitate the safe transition of the individual from one level of care, care setting, or provider to another.

Who Can Provide Transitional Care Services?

- According to the Medicare Transitional Care Act of 2012: The term ‘transitional care clinician’ means, with respect to a qualified individual, a nurse, case manager, social worker, physician, physician assistant, pharmacist, or other licensed health professional who—
  - (i) has received specialized training in the clinical care of people with multiple chronic conditions (including medication management) and communication and coordination with multiple providers of services, suppliers, patients, and their primary caregivers.
  - (ii) is supported by an interdisciplinary team in a manner that assures continuity of care throughout a transitional care period and across care settings (including the residences of qualified individuals);
  - (iii) is employed by (or has a contract with) a qualified transitional care entity for the furnishing of transitional care services.

Patient Case

- Mr.LJ is a 73 y.o. AA male who comes into your pharmacy complaining that he is concerned about being on so many medications and feels that he is being “over-medicated”. He asks you, the pharmacist, if you have time to sit down with him to go over his medications?
- PMHx: CHF, Type 2 DM, gout, hyperlipidemia, HTN
- Meds: Coreg 25mg, Cozaar 50mg, Lasix 40mg, Lipitor 80mg, Allopurinol 300mg, Norvasc 10mg, Glipizide XL 5mg, Januvia 100mg
- Estimated Monthly Cost - $1183
Patient Case

1. Based upon the CMS criteria for MTM, would this patient qualify for an MTM service? Why or Why Not?

2. Based upon the Medicare Part D plans mentioned, which plan would be the best for this patient? Why?

Patient Case

Ms. HS is an 83y.o. woman who is a regular patient in your pharmacy. She is usually very compliant with getting her refills every month. However, over the past month, you've noticed she has not refilled any medications. You call Ms. HS at home and her daughter answers the phone and begins to tell you that her mother has been very depressed over the loss of her sister, and therefore, has not been taking her medications. The daughter is also concerned about her mother being very “forgetful” over the past few months and wants to know if she & Ms. HS can meet with you one-on-one to go over her meds.

Patient Case

PMHx: Asthma, Depression, HTN, Hyperlipidemia, OA, Arrhythmia

Meds: Celexa 40mg, Singulair 10mg, Ventolin HFA 90mcg, Pravachol 80mg, Norvasc 10mg, Amiodarone 200mg

As an MTM Provider, how would you respond to the daughter? Would she qualify for a CMR if she had Humana?

Questions

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References