Coverage for Comprehensive Medication Management Services for Medicare Patients:

"Getting the medications right" in a reformed and modernized program

The American College of Clinical Pharmacy (ACCP) urges Congress to enact legislation to provide Medicare patients with coverage for comprehensive medication management (CMM) within the Part B medical benefit. This direct patient care service, provided by qualified clinical pharmacists working as formal members of the patient's health care team, has been demonstrated to significantly improve clinical outcomes and enhance the safety of medication use by patients.

Effective CMM also saves overall health care costs by reducing unnecessary use of more costly health care services. By helping ensure that seniors' medication use is effectively coordinated, this service is a benefit that enhances seniors' health care outcomes and contributes directly to Medicare's goals for quality and affordability.

A needed benefit that contributes to more cost effective and patient-centered care

The importance of "getting the medications right" is widely recognized by health policy analysts and quality experts as a key to more efficient, cost-effective and patient-centered care.[1] [2] This is particularly critical for seniors because the central role that medications play in their care and treatment is undeniable:

- The typical Medicare beneficiary sees two primary care providers and five medical specialists in any given year. Four of every five medical encounters result in a prescription order (new or refill);[3]
- 66% of Medicare beneficiaries have two or more chronic diseases; 40% have four or more;[4]
- 60% of seniors are taking 3 or more discrete prescription or non-prescription medications at any point in time.[5]

Despite these facts, traditional practice models and payment policies result in disjointed prescribing and distribution of medications from unconnected professional "silos." No effective incentives currently exist in Medicare Part B to support a coordinated medication management service for beneficiaries delivered by an effective inter-professional health care team. When combined with the continuing growth in the number and categories of medications -- and greater understanding of the genetic and physiologic differences in how people respond to their medications -- the current system consistently fails to deliver the full promise medications can offer.

The too-common result -- particularly in Medicare seniors -- is a range of medication-related problems that frequently are either unrecognized or inadequately addressed:

- dosing "mistakes" that can result in either under treatment or preventable adverse events – or both;
- inappropriate, ineffective, or unnecessarily costly medication choices for the established goals of care;
- duplicative or interacting medications;
- avoidable side effects;
- inconsistent adherence or other patient challenges or issues that directly reduce treatment success.

In short, the current medication use "non-system" fails to get the medications right far too often.[6]

Comprehensive Medication Management "gets the medications right"

CMM is a service provided directly to patients by qualified clinical pharmacists who practice as members of functional inter-professional teams. This care occurs in some health care settings today, including integrated private sector delivery systems, the Veterans Administration, some community health centers and other settings. But it is only rarely available to most Medicare beneficiaries – the people most in need and most likely to benefit from the service.

In the emerging environment of patient-centered medical homes (PCMH), the practice of CMM is now recognized as a core strategy to achieve better clinical outcomes and quality. The Patient-Centered Primary Care Collaborative (PCPCC) supports the practice of team-based CMM and has published a resource guide to assist with the integration

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[1] Smith, MA et.al. Why pharmacists belong in the medical home. Health Affairs 2010;29(5):906-13. (May 2010)

[2] Isetts, BJ et.al. Managing drug-related morbidity and mortality in the patient-centered medical home. Med Care 2012;50:997-1001 (November 2012)

[3] Pham, HH et al. Care patterns in Medicare. NEnglJMed 207:356:1130-1139. (March 2007)

[4] CMS Chartbook 2012. Centers for Medicare and Medicaid Services.

[5] CDC/NCHS Statistical Data Brief. September 2010.

[6] Parekh, AK et.al. The challenge of multiple comorbidity for the US health care system. JAMA 2010;303(13):1303-1304 (April 7, 2010)

of this service into clinical practice in the PCMH.[7] Medicaid programs in North Carolina and Minnesota now support CMM within the practice and service components of their primary care delivery systems.[8]

What is comprehensive medication management and how does it work?

Working in formal collaboration with physicians and other members of the patient's health care team, qualified clinical pharmacists:

- identify and document medication-related problems of concern to the patient and all members of the care team, using a consistent care process that assures medication appropriateness, effectiveness and safety;
- initiate, modify, monitor, and discontinue drug therapy to resolve the identified problems and achieve medication-related outcomes that are aligned with the overall care plan and goals of therapy; and
- engage and educate patients and families in fully understanding their medication regimen, supporting active patient engagement in the successful use of their medicines to achieve desired health outcomes.

In "getting the medications right," CMM also contributes to enhanced productivity for the entire health care team, allowing other team members to be more efficient in their own patient care responsibilities. Team members are freed up to practice at the highest level of their own scopes of practice by fully utilizing the qualified clinical pharmacist's skills and training to coordinate the medication use process as a full team member.

Who is a "qualified clinical pharmacist?"

A qualified clinical pharmacist:

- has a doctor of pharmacy degree (Pharm.D.) or possesses equivalent clinical training/experience;
- has a formal collaborative drug therapy management (CDTM) agreement with a physician/medical group or has been granted clinical privileges to provide the service by the care setting in which (s)he practices;
- is certified or eligible for certification in a pharmacy practice specialty recognized by the Board of Pharmacy Specialties (BPS).

Why is this benefit important to add to Medicare Part B?

In addition to the data previously described, there are additional reasons why this service can be of particular value to Medicare Part B beneficiaries:

- Nearly half of all Medicare beneficiaries' medication use is "disconnected" from their medical benefits under Medicare Part B because they choose not to enroll in a Medicare Part D drug plan.
- While Part D plans offer a "medication therapy management" (MTM) program for limited numbers of beneficiaries, these programs are, by law, administrative in purpose and scope. Part D plan administrators – not patients or clinicians - determine who can access an MTM program.
- The benefit would be available for all Part B-enrolled beneficiaries regardless of how they access or pay for their prescription medications, including creditable coverage from private and/or supplemental plans.
- The benefit would provide improved outcomes and quality achievement in Medicare Part B, AND contribute directly to goals for cost savings within Medicare Part A, including reduction in avoidable hospitalizations, readmissions, and emergency department visits.

Action needed

"Getting the medications right" is an essential objective for a modernized, cost-effective and quality-focused Medicare program. Congress should enact legislation to reform Medicare Part B to cover comprehensive medication management services provided by qualified clinical pharmacists as members of the patient's health care team.

[7] Integrating comprehensive medication management to optimize patient outcomes. PCPCC Resource Guide, Second Edition June 2012. Available at www.pcpcc.net

[8] Minnesota statute 256B.0625 Subd. 13h, 2005. Available at www.revisor.mn.gov/statutes/?id=256B.0625