Pharmacist Provider Coalition

July 22, 2003

Dear Conferee:

The professional pharmacy associations of the Pharmacist Provider Coalition (PPC) submit for conferee consideration the attached recommendations to blend and clarify the "Medication Therapy Management" portions of the Medicare reform bills (S. 1 and H.R. 1).

The Coalition applauds the work that went into developing this section. We have commented extensively over the past few years on this important benefit and are enthusiastic about how the concept has evolved. In blending the House and Senate language, the Coalition suggests a few important clarifications consistent with the intent of this section.

The incorporation of these suggestions into the final version of the conference bill will provide (1) a more accurate description of medication therapy management programs and (2) clearer direction for the provision of such services. Our suggested modifications are consistent with the current framework and should not result in additional cost to the program.

Attached please find an "overlay" of the suggested language changes on top of the current S.1 and H.R.1 language (Attachment A), as well as a "clean" version without editorial markings (Attachment B).

The modifications to Title 1, section 101 (1860D) are explained below in order of importance to the Coalition.

- Clarifying the Elements of the Medication Therapy Management Program (amending sec. (c)(2)(B) of S. 1 and (d)(2)(B) of H.R. 1): It is essential to clarify the elements of a medication therapy management program, including the core elements of case management and disease state management for high risk patients. While both the House and Senate language recognize the need for medication therapy management services, only the House language specifically includes these two elements. Including these two elements with beneficiary education, counseling, medication refill reminders, special packaging, and other compliance programs will help high risk beneficiaries improve their medication use, and protect Medicare's investment in the drug benefit. The language suggested by the Coalition elaborates on the Senate language used to define what "shall" and "may" be included in the quality assurance measures and systems to reduce medical errors.

The Coalition suggests incorporating all of these elements into the final bill, with case management and disease state management as core elements of any medication therapy management program. These elements are crucial components for improving chronic care and controlling Medicare costs and should be required as part of the medication therapy management program.

- Regulatory Oversight for MTMS Providers (amending sec. (c/d)(2)(A)): The House language notes that medication therapy management services “may be furnished by a pharmacy provider.” We urge the conferees to include this language in the final bill, as it is pharmacists who are the medication experts on the health care team and Medicare currently limits the services for which pharmacists can bill.

  To ensure appropriate regulatory oversight, it would also be beneficial to note that the pharmacy provider should be “licensed.”

- Administrator Discretion in Identifying High-Risk Patients (amending sec. (c/d)(2)(A)): Both the House and Senate language note that medication therapy management programs should target high risk patients, specifically patients with designated chronic conditions or taking multiple medications. We recommend providing the Administrator discretion to add other disease states when he or she determines that it is appropriate to do so.

- Appropriate Distinctions Among Covered Services (amending sec. (c/d)(2)(A)): The House language includes a provision that would allow a plan to distinguish between services “provided in ambulatory and institutional settings.” We agree that plans need sufficient flexibility to distinguish among different types of services. However, we recommend that this distinction be made based on the “duration and intensity of the service” rather than the setting where the service is provided. The complexity depends on the patient, their health condition, support services, and medication regimen.

- Fee Development (amending sec. (c/d)(2)(D)): The House and Senate language both recognize that in developing fees, plans should take into account the resources and time used in implementing the program. We concur, and recommend that plans be instructed to also take into account the direct and indirect costs of furnishing such services. In addition, the House bill includes a provision that requires plans to disclose such fees upon request from the Administrator.

- Treatment of Accreditation (amending sec. (c/d)(4): The House language includes the medication therapy management program as an element of the accreditation process. We support this language, as it helps to ensure that a strong medication therapy management program is implemented to improve patient care and control health care spending.

- In General (amending sec. (c/d)(1): The Coalition suggests two minor clarifications to this section. The House language notes that cost utilization, quality assurance, and
- medication therapy management programs can be provided directly or contracted out through appropriate arrangements. The Senate is silent on how the programs will be operated. It is beneficial to note that in many instances the plan may choose to contract with pharmacists or others to provide these services rather than providing them on their own.

  Both the House and Senate language also note that plans can utilize cost management tools (including differential payments). We believe it is misleading to highlight just one option for reducing costs and therefore suggest removing the reference to differential payments.

Medication Therapy Management Services Assessment

The Senate bill provides for an assessment of medication therapy management services (Title 1, section 110A). PPC strongly supports inclusion of this language in the final bill. We also recommend one change to the definition of "eligible beneficiary." Individuals receiving multiple medications should be included here, just as they are in Title 1, Section 101.

As MedPAC recognized in its June 2002 report, pharmacists' medication therapy management services offer substantial value in improving safety, enhancing outcomes, and managing the cost of drug therapy. While these programs have continued to grow and mature over the past decade, their evolution is far from complete.

A broad range of medication therapy management programs are currently provided in community, long-term care, clinic, managed care, private practice and other settings. Any, and perhaps all, of these models could prove to be an appropriate structure for serving Medicare beneficiaries, depending on their location, disease profile, and other factors. It is imperative for policymakers and program administrators to have experience in working with various models of both care delivery and payment in order to maximize the value from the medication therapy management benefit. The assessment project contained in the language of S.1 will prove invaluable in examining these issues prior to the implementation of the medication therapy management program required under the drug benefit. For this reason, we advocate as early a start date for this 1-year assessment as possible.

PPC looks forward to working with the conferees in fashioning a final bill that will offer beneficiaries improved access to medications and the medication therapy management services of pharmacists that help assure that those medications yield better clinical outcomes and improved health.

Sincerely,

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