



American Pharmacists Association[®]

Improving medication use. Advancing patient care.

July 11, 2006

Medicaid Commission Members
 U.S. Department of Health and Human Services
 Hubert H. Humphrey Building
 200 Independence Avenue, S.W.
 Suite 450G
 Washington, D.C. 20201

Dear Governor Sundquist, Governor King, and Members of the Commission:

As you continue to review potential areas for long-term savings in the Medicaid program, APhA urges you to consider pharmacist-provided Medication Therapy Management (MTM) services for Medicaid beneficiaries as a way to improve patient care and reduce health care costs. The American Pharmacists Association (APhA), founded in 1852 as the American Pharmaceutical Association, represents more than 57,000 practicing pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in advancing the profession. APhA, dedicated to helping all pharmacists improve medication use and advance patient care, is the first established and largest association of pharmacists in the United States.

MTM programs compensate pharmacists for providing a range of clinical services to patients. MTM services include thoroughly educating a patient about his/her medication and the conditions for which it is prescribed, reviewing a patient's medication regimen and developing a medication action plan to address identified issues, monitoring the patient's drug therapy over time, screening for potential adverse effects of medication, and monitoring a patient's ability to take his/her medication correctly.¹ By incentivizing pharmacists to spend this additional time with patients, Medicaid programs can optimize therapeutic outcomes, improve medication use, reduce the risks of adverse events and drug interactions, and increase patient adherence and compliance with prescribed regimens. For every dollar spent on pharmaceuticals, another dollar of spending results from "drug misadventures."² And others have calculated that drug-related morbidity and mortality in ambulatory patients alone cost an estimated \$177 billion annually.³ But, nearly 60% of such adverse medication-related outcomes could be eliminated by providing pharmaceutical care through MTM services.⁴

¹ The consensus definition of MTM is located at:

<http://www.aphanet.org/AM/Template.cfm?Section=Home&CONTENTID=4577&TEMPLATE=/CM/ContentDisplay.cfm>

² Brooks JM, McDonough RP, Doucette W. Pharmacist reimbursement for pharmaceutical care services: Why insurers may flinch. *Drug Benefit Trends*; June 2000; 45-62.

³ Ernst FR, Grizzle, AJ. Drug-Related Morbidity and Mortality: Updating the Cost-of-of Illness Model. *Journal of the American Pharmaceutical Association*; 2001 Mar-Apr; 41(2):192-199.

⁴ Johnson JA, Bootman JL. Drug related morbidity and mortality and the economic impact of pharmaceutical care. *American Journal of Health System Pharmacy*; 1997; 54:554-558.

An initial "Welcome to Medicaid" MTM session for Medicaid beneficiaries could dramatically improve the quality of care and patient outcomes.

- For example, community pharmacists providing medication therapy management services to asthma patients in an HMO reduced hospitalizations by 77% and decreased emergency room visits by 78%.⁵
- The medication therapy management services of pharmacists in 1000 hospitals saved nearly 400 lives and \$5.1 billion in health care costs.^{6,7}
- In another study, patient compliance with medication for high cholesterol improved from a national average of 40% to 90% with medication therapy management.⁸

Patient health clearly stands to benefit from MTM services.

An initial MTM session for Medicaid beneficiaries could also significantly reduce health care expenditures.

- For every dollar invested in pharmacists providing these patient-focused services, an estimated \$16.70 is saved in health care costs.⁹
- Pharmacists providing MTM services to patients in long-term care facilities increased the number of patients receiving optimal care by 45% - resulting in an estimated \$3.7 billion in cost avoidance.¹⁰
- In another study patients treated with blood thinners in a pharmacist-managed anticoagulation clinic had fewer emergency room visits, fewer hospitalizations, and showed a total cost savings of \$1,621 per patient.¹¹

While such comprehensive pharmaceutical services would be ideal, an initial MTM session is an excellent first step towards reducing unnecessary costs in Medicaid.

With such improved patient outcomes and reduced health care expenditures, there is little doubt that MTM services could contribute considerably to the efforts of the Commission to modernize care for Medicaid beneficiaries as MTM programs have done for many others. Medicare Part D now provides MTM services for targeted enrollees as does the Department of Veterans Affairs. Florida, Iowa, Minnesota, Mississippi, Missouri, Ohio, and Wisconsin also offer MTM services to its Medicaid beneficiaries.¹² The health services department for the Minnesota Medicaid program said that while it expects to spend an estimated \$11,410 on MTM services in the first three months of its program, it expects to save \$136,980 in fiscal year 2007 from improved patient outcomes.¹³

⁵ Rupp MT, McCallian DJ, Sheth KK. Developing and marketing a community pharmacy-based asthma management program. *Journal of the American Pharmaceutical Association*; 1997 Nov-Dec; 37(6):694-9.

⁶ Bond CA, Raehl CL, Pitterle ME, Franke T. Health care professional staffing, hospital characteristics, and hospital mortality rates. *Pharmacotherapy* 1999; 19(2):130-8.

⁷ Bond CA, Raehl CL, Franke T. Clinical pharmacy services, pharmacy staffing, and the total cost of care in U.S. hospitals. *Pharmacotherapy* 2000 June; 20(6):609-21.

⁸ Bluml BM, McKenney JM, Cziraky MJ. Pharmaceutical care services and results in Project ImPACT: Hyperlipidemia. *Journal of the American Pharmaceutical Association* 2000; 40(2):157-165.

⁹ Schumock GT, Meek PD, Ploetz PA, Vermeulen LC. Economic evaluations of clinical pharmacy service - 1988-1995. *Pharmacotherapy* 1996; 16:1188-208.

¹⁰ The Fleetwood Project, American Society of Consultant Pharmacists.

¹¹ Chiquette E, Amato MG, Bussey HI. Comparison of an anticoagulation clinic with usual medical care. Anticoagulation control, patient outcome, and health care costs. *Archives of Internal Medicine* 1998; 158: 1541-7.

¹² Understanding Medicare Reform: What Pharmacists Need to Know.

http://www.aphanet.org/AM/Template.cfm?Section=APhA_Resources_Medicare&Template=/CM/ContentDisplay.cfm&ContentID=1709

¹³ Thompson C. Minnesota Pharmacists use CPT Codes. *AJHP News* July 1, 2006.

Implementing comprehensive MTM programs under the Commission's recommendation could help states tackle the costly chronically ill population. The APhA Foundation's Patient Self-Management Program (PSMP) uses the accessibility and skills of community pharmacists to benefit employers and their employees with chronic disease. The success of this model has been replicated in communities large and small throughout the country, and it could be easily applied to a State's Medicaid program.

In this model, an employer (or a coalition of employers within a community) works with the APhA Foundation to provide this voluntary benefit to its employees. Participating employees are then matched with a pharmacist from a network of providers. The pharmacist provider conducts one-on-one meetings with the employee and follows a process of care established by the APhA Foundation specifically for this program. The pharmacist serves as a "coach" and provides counseling and education with regards to one's disease, medication therapy, and lifestyle choices. This relatively simple intervention has led to remarkable results including savings of approximately \$918 per employee in total health care costs for the initial year, with an even greater savings in subsequent years.¹⁴

Building upon their early successes of the PSMP, the APhA Foundation recently kicked off the Diabetes Ten City Challenge, an innovative program that employers and communities can use to fight diabetes and reduce health care costs. Employer groups in ten communities were invited to establish a voluntary health benefit for employees and dependents. Using incentives, employers encourage people to manage their diabetes with the help of pharmacist coaches, physicians, and community health resources. Current participants include the following employers:

- Pittsburgh Business Group on Health
- Northwest Georgia Healthcare Partnership
- Hawaii Business Health Council, Honolulu
- City of Milwaukee
- The Charleston South Carolina Area
- University of Southern California
- Manatee County Government
- Pinellas County Sheriff's Office

In addition to improving the Medicaid program through the inclusion of MTM services, it is essential to fairly reimburse pharmacists for the drug product and compensate them for their dispensing-related services. Pharmacists have partnered with State Medicaid programs for years, helping to serve the needs of patients while also efficiently managing the limited resources of the program, such as working to increase appropriate use of generic medications. Such efforts have resulted in increased savings to the States. Unfortunately, these efforts have been ignored and states are now implementing recent federal revisions to the reimbursement formula for generic drug products in the name of greater transparency. If we are to truly move to a system that is more transparent, revisions to product cost calculation must also address payments to providers such as pharmacist dispensing fees. We are concerned that some State Medicaid Directors are unwilling to increase dispensing fees despite these looming product reimbursement cuts. As the attached slide indicates, dispensing fees are not the cause

¹⁴ Garrett DG, Bluml BM. Patient Self-Management Program for Diabetes: First-Year Clinical, Humanistic and Economic Outcomes. *Journal of the American Pharmacists Association*; 2005 March/April; 45(2): 130-137.

of increased costs of Medicaid drug benefits. It is unfair to continue to underpay and therefore undervalue the services of pharmacists across the country.

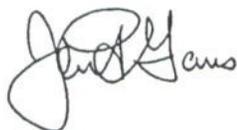
While your report to Congress on short-term savings in the Medicaid program did not speak directly to dispensing fees, your report did adopt many of the suggestions from the National Governors Association (NGA). The NGA's short-term savings proposals addressed dispensing fees and the need to make sure they were appropriate and not linked from the costs of drug products:

Dispensing Fees. "With the introduction of a new price methodology (AMP), states should have flexibility to determine appropriate dispensing fees for drugs. Dispensing fees should not be linked to the price of drugs, as was proposed by the President, nor should they be capped. Flexibility to determine dispensing fees is important to ensure that pharmacies are appropriately compensated and that pharmacists are encouraged to dispense the most cost-effective drugs for beneficiaries."¹⁵

The benefits of MTM are clear both financially and with improved patient outcomes. As a result, APhA strongly encourages the Commission to recommend in its report that an initial Medication Therapy Management (MTM) session be provided to Medicaid beneficiaries. We would appreciate the opportunity to present to the Commission about the value of investing in pharmacist-provided face-to-face medication therapy management services. Additionally, we strongly encourage the Commission to consider the impact continually underpaying pharmacists for their services will have on their ability to continue to provide services to Medicaid beneficiaries.

If you have any questions or would like additional information please contact Hrant Jamgochian, APhA's Director of State Relations and Political Action, at (202-429-7575) or HJamgochian@APhAnet.org.

Sincerely,

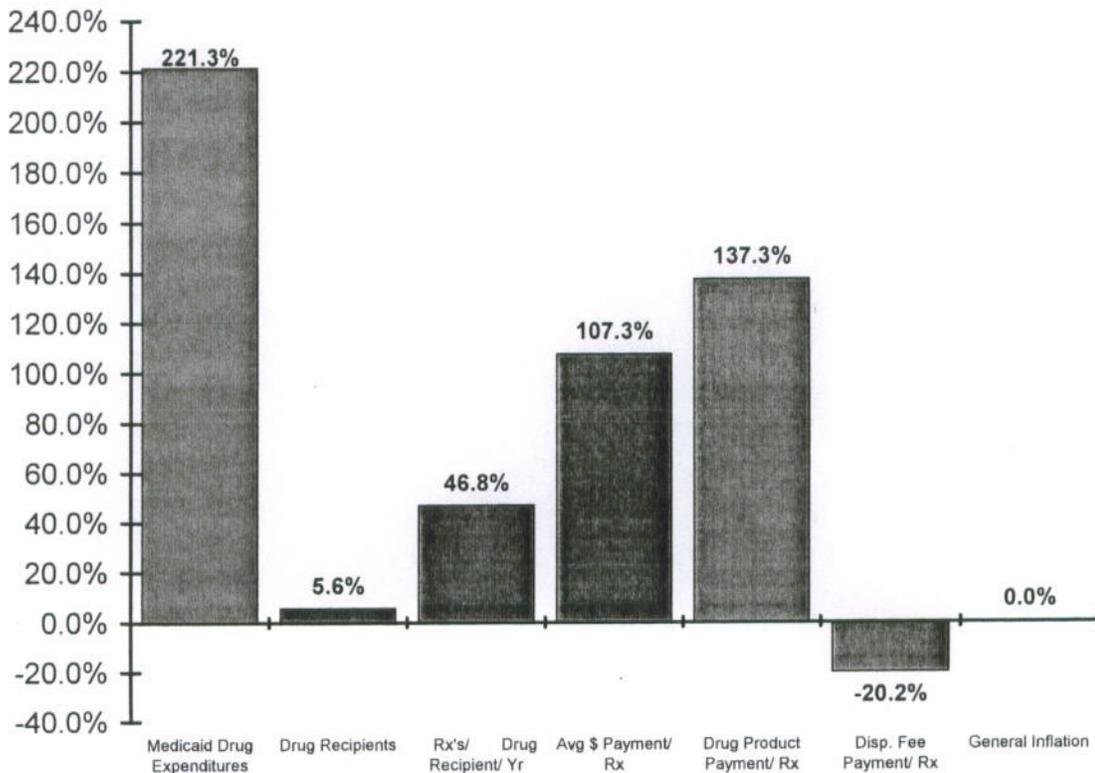


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Foundation
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¹⁵ <http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF>

Exhibit 2: U.S. Medicaid Drug Expenditures Percent Change in Major Components: 1992 to 2002 in Inflation Adjusted \$



SOURCE: Compiled by Stephen W. Schonheim, PRIME Institute, University of Minnesota from data found in CMS/HCFA-2082 Reports (adjudicated & paid claims), CMS/HCFA-64 Reports (budgeted and expended funds), CMS/HCFA Medicaid Drug Utilization public use files, and the annual volumes of Pharmaceutical Benefits Under State Medical Assistance Programs (Reston, VA: National Pharmaceutical Council, 1990 to 2002).

There are two lessons here. First, drug product prices at the manufacturer level are the major source of increase in Medicaid drug program expenditures. Thus, it is important to focus on this component of the payment policy. Second, these data suggest that pharmacy dispensing fees have not been a source of growth in drug program expenditures and that reductions to pharmacy dispensing fees have not been an effective way to reduce prices at the manufacturer level. Medicaid programs do not purchase drug products directly from manufacturers, but rather prescriptions are purchased through local pharmacies. If management of growth in drug product costs is the desired outcome, the efforts to manage this cost must be focused primarily at the manufacturer level.