

# Pharmacist-Provided Medication Therapy Management in Medicaid



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## Disclaimer

This document is intended to inform state health agencies and Medicaid stakeholders about strategies to consider for implementing or expanding pharmacist-provided medication therapy management to improve care for Medicaid beneficiaries with chronic conditions. The findings and conclusions in this document are those of the authors, do not necessarily represent the official position of the Centers for Disease Control and Prevention (CDC), and are not intended to promote any particular state program or other action.

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# Introduction

Preventing and managing chronic diseases like heart disease, diabetes, and asthma pose major health care challenges. Six in 10 American adults have at least one chronic disease, and 4 in 10 adults have two or more.<sup>1</sup>

Medication therapy management (MTM) provides a unique and important opportunity to integrate pharmacists into patient care in the Medicaid program, particularly for patients with chronic disease. It is generally provided by pharmacists, either in the community setting or as part of an integrated health system. [Table 1](#) describes five core elements of the MTM service model.

While model MTM programs include all five core elements of MTM, payers, including Medicaid, may also offer variations of MTM that provide coverage and reimbursement for a subset of the core elements. Even a subset of MTM core elements may offer patients some benefit.

Pharmacist-provided MTM offers an effective mechanism to tailor, deliver, and monitor care for individuals,<sup>2</sup> especially those Medicaid beneficiaries burdened with costly conditions, in the United States.

This document provides an overview of state Medicaid coverage of MTM in fee-for-service (FFS) and managed care organization (MCO) programs as of March 2020. It includes

- A summary of evidence establishing the effectiveness of MTM.
- A description of the burden of chronic disease in the Medicaid population.
- A summary of state MTM laws related to Medicaid.
- Examples of coverage and reimbursement for MTM services in FFS and/or MCO programs.
- Considerations for implementing or expanding MTM services in Medicaid programs.

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**Table 1. Core elements of an MTM Service model\***

<b>Medication therapy review</b>	This is a systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them.
<b>Personal medication record</b>	This is a comprehensive record of the patient's medications (prescription and nonprescription medications, herbal products, and other dietary supplements).
<b>Medication-related action plan</b>	This patient-centric document contains a list of actions for the patient to use in tracking progress for self-management.
<b>Intervention and/or referral</b>	The pharmacist provides consultative services and intervenes to address medication-related problems; when necessary, the pharmacist refers the patient to a physician or another health care professional.
<b>Documentation and follow-up</b>	MTM services are documented in a consistent manner, and a follow-up MTM visit is scheduled based on the patient's medication-related needs, or the patient is transitioned from one care setting to another.

\*Adapted from [Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model](#) (Version 2.0).

# MTM Services Improve Clinical Outcomes and Contain Costs

Research demonstrates that MTM can improve clinical outcomes and provider prescribing habits while offering economic benefits.<sup>3</sup> Medicare has required Part D sponsors to cover at least a subset of MTM for eligible beneficiaries—specifically an annual medication review and targeted, quarterly medication reviews with follow-up interventions where necessary—since 2010.<sup>4</sup>

Various studies demonstrate that MTM can save thousands of dollars per individual in costs related to care each year,<sup>5,6</sup> including among Medicaid beneficiaries.<sup>7,8</sup> For example, between 2009 and 2010, the Connecticut Medicaid Program operated a pilot program to improve care for Medicaid beneficiaries with multiple chronic conditions; it included an MTM component. The state saved an estimated \$1,595 in annual total health care costs per beneficiary in the program.<sup>8</sup> Meanwhile, in Minnesota, one of the first states to offer MTM in Medicaid, the state's Department of Human Services saw annual cost savings of around \$800 per Medicaid beneficiary receiving MTM.<sup>8</sup>

Research conducted across a variety of payers and populations indicates that MTM can be effective in improving clinical outcomes as well. Individuals who received MTM services saw decreases in blood

pressure<sup>9</sup> and A1C levels,<sup>10,11</sup> increases in overall medication adherence,<sup>12</sup> and reductions in negative medication side effects.<sup>13</sup> A wide variety of patient populations, including individuals with commercial insurance,<sup>9</sup> Medicare beneficiaries,<sup>12</sup> and low-income groups,<sup>10,11</sup> saw clinical improvements with MTM. In practice, Ohio's Medicaid MTM program reduced emergency department and hospital admission rates among beneficiaries who participated in the program.<sup>8</sup> In general, evidence consistently demonstrates that MTM is a clinically and financially effective intervention for Medicaid enrollees and other insured individuals.



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## Impact of Chronic Disease in Medicaid

The positive results of MTM are especially relevant to the Medicaid population, given the disproportionate burden that chronic disease has on Medicaid beneficiaries. Medicaid beneficiaries experience higher rates of hypertension than people with commercial or private insurance plans.<sup>14</sup> Medicaid beneficiaries are also more likely than the general public to have at least one chronic condition, frequently having multiple diseases, such as hyperlipidemia, hypertension, and diabetes.<sup>14</sup> The health disparities that Medicaid beneficiaries

experience are due to a number of factors; they face higher levels of social barriers to health care than their privately insured peers, as well as higher rates of under- and unemployment, housing instability, substance use disorder, and mental illness.<sup>15,16</sup> However, multisite MTM programs like *Project IMPACT: Diabetes* demonstrate that MTM can improve clinical outcomes for underserved communities that are disproportionately affected by chronic disease.<sup>10</sup>

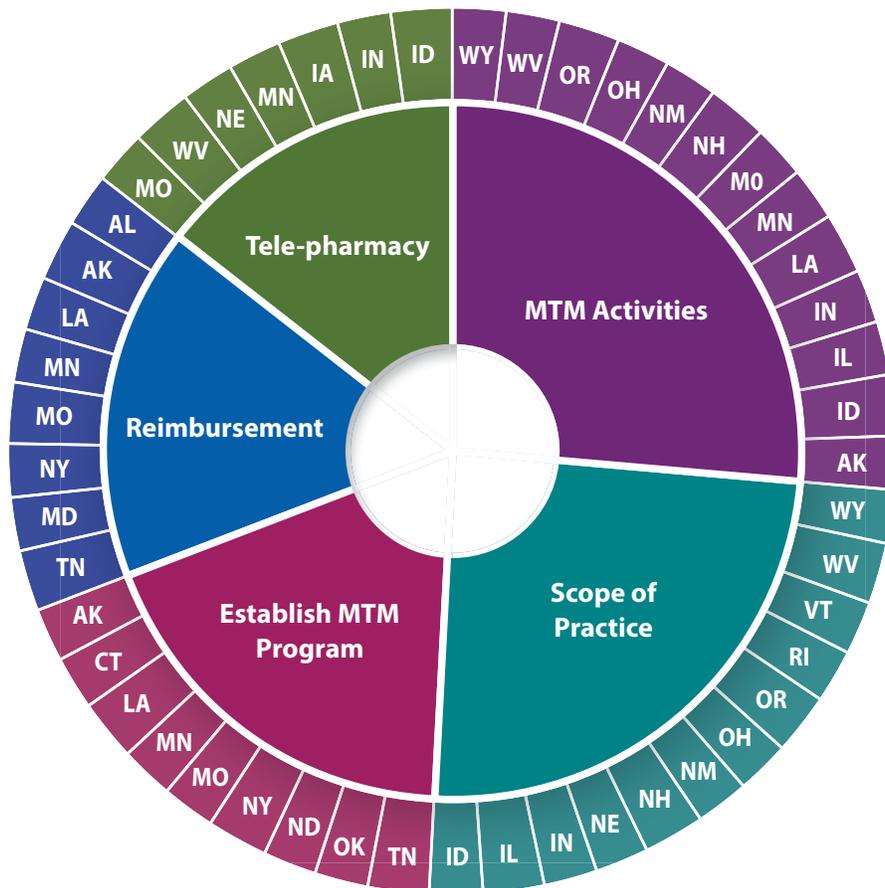
# State MTM Laws Relating to Medicaid

Some states address pharmacist-provided MTM through statutes, regulations, or other policies. As of November 30, 2019, 25 states had laws addressing pharmacist-provided MTM services, including some laws specific to the Medicaid program.<sup>†</sup> Of these, 12 states included provision of MTM services in pharmacists' scope of practice, 13 states' laws described activities that fit within the scope of MTM services, and eight states' laws permitted Medicaid reimbursement for MTM services provided by pharmacists (Figure 1). In nine states, the law directed a state agency to

establish an MTM program for Medicaid beneficiaries, and in seven states, telepharmacy was authorized as an approach for providing MTM services to patients outside of the pharmacy setting.

The patient eligibility criteria for Medicaid MTM services were typically limited to those individuals taking one or more medications to treat or prevent one or more chronic conditions. The conditions that were covered included hypertension, diabetes, hyperlipidemia, and asthma.

**Figure 1.** States with MTM laws in effect, November 30, 2019



<sup>†</sup>To identify these laws, legal researchers at CDC used the legal search engine Westlaw to collect relevant statutes and regulations related to MTM services available to Medicaid beneficiaries in the 50 states and D.C. In addition, Medicaid state plan amendments, waivers, and publicly available MTM program manuals were reviewed to determine MTM services available to Medicaid beneficiaries and program requirements.

## MTM Services Available in Some Medicaid Programs

Several state Medicaid programs provide coverage for MTM services in their FFS and/or MCO programs for eligible beneficiaries. However, MTM coverage and reimbursement is not universal.

As of March 2020, 11 states had Medicaid programs covering pharmacist-provided MTM services to some extent:\* **Delaware, Indiana, Kansas, Michigan, Minnesota, Missouri, North Dakota, Ohio, Tennessee, Virginia, and Wisconsin.**

- Four states required MTM in their Medicaid FFS programs: **Michigan, Missouri, North Dakota, and Wisconsin.**
- Six required MTM in Medicaid MCO programs: **Delaware, Indiana, Kansas, Ohio, Tennessee, and Virginia.**

- One required MTM in both Medicaid FFS and MCO programs: **Minnesota.**
- Because a lack of law surrounding MTM does not preclude a state from offering or reimbursing for MTM, several states offering MTM services in their Medicaid programs have done so without corresponding legislation: **Delaware, Kansas, Michigan, Virginia, and Wisconsin.**

Nine states provided one or more components of MTM: Colorado, Iowa, Mississippi, Montana, North Carolina, New Hampshire, Oklahoma, Oregon, and Washington. Services in these states frequently offered some core elements of MTM, such as medication therapy review and medication-related action plans, but were often limited to a one-time intervention or restricted in terms of providers allowed to participate.

## Considerations for Implementing or Expanding MTM in Medicaid Programs

MTM activities included under the five core elements are generally activities that pharmacists in all states are permitted to do, regardless of the expansiveness of a state's pharmacist scope-of-practice laws.<sup>17</sup>

This section compiles information about six current MTM practices and relevant examples that state health agencies and Medicaid stakeholders may consider when implementing or expanding pharmacist-provided MTM programs. Additionally, state Medicaid agencies have several possible avenues for creating and implementing MTM programs or building on existing MTM programs.

### Key Consideration 1

#### Assess current MTM activities

State Medicaid programs may already be reimbursing pharmacists for some or all core elements of MTM. States could assess what their FFS programs are

currently covering, as well as any steps their managed care plans are taking to reimburse pharmacists for MTM. The results of this assessment could be used to identify gaps and inform how best to expand pharmacist-provided MTM services for that state.

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\*Researchers at George Washington University reviewed publicly available Medicaid MCO contract template and provider manuals outlining reimbursable services and requirements for Medicaid FFS and MCO in the 50 states and D.C. Results were cross-walked against information from the Centers for Medicare and Medicaid Services' 2018 Drug Utilization Review survey of Medicaid FFS and MCO.

## Key Consideration 2

### Assess state pharmacist scope-of-practice laws

As noted above, the five core elements of MTM are activities that pharmacists in all states are authorized to perform. In states with more permissive scope-of-practice laws, pharmacists may be able to offer supplementary services, such as providing certain medical tests. State Medicaid stakeholders could review what activities pharmacists in their state are authorized to perform, in order to optimize how the Medicaid program can leverage their skills and services.<sup>17</sup>

## Key Consideration 3

### Consider including pharmacist-provided MTM as a benefit in state plans

Federal law requires state Medicaid programs to cover a list of mandatory benefits, but state Medicaid agencies have the discretion to cover services from a list of optional benefits as well.<sup>19</sup> State plans that include coverage of MTM, an optional benefit, have been shown to improve medication adherence and improved management of chronic conditions.<sup>8,20</sup> States can consider existing MTM evidence when exploring ways to reduce the burden of chronic disease.

### State Example

## Idaho



Idaho's pharmacist scope-of-practice laws are some of the broadest in the nation, offering pharmacists prescribing authority not permitted in other states. Since 2019, pharmacists in Idaho may prescribe drugs as long as one of the following four criteria are met: The conditions (1) do not require a new diagnosis, (2) are "minor and generally self-limiting," (3) have a test to guide clinical decision making that is waived under the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), or (4) in an emergency, during which drugs are immediately necessary to protect the health and safety of a patient.<sup>18</sup> This expanded authority could allow Idaho pharmacists who identify drug therapy issues to use their broad prescribing authority to adjust patients' medication regimens.

### State Example

## Michigan



In 2017, the Centers for Medicare & Medicaid Services approved Michigan's State Plan Amendment (SPA) to, among other changes, provide MTM services without cost sharing to their Medicaid beneficiaries.<sup>21,22</sup> The state submitted its SPA in response to the 2016 Federal Rule on Covered Outpatient Drugs (CMS-2345-FC), which directed states to adopt new regulatory definitions for pharmacy reimbursement, among other things.<sup>23</sup> The state used its pharmacy claims reimbursement processes to establish an MTM program for state Medicaid beneficiaries.

#### Key Consideration 4

#### Include pharmacist-provided MTM activities within standard contract template language for Medicaid managed care plans

As described in the examples below, states have used their contracts with MCOs to define which benefits the

plans must cover. These benefits include the services identified in federal Medicaid regulations and can include additional services as well.<sup>23</sup> Several states already include a provision in their contract template language that requires MCOs in the state to provide MTM services for the Medicaid beneficiaries for whom they are responsible.<sup>24</sup>

#### State Example

### Ohio, Iowa, and Kansas

In Ohio, contract template language for Medicaid MCOs states that potential contractors “shall develop” an MTM program that utilizes community pharmacists and other qualified providers to deliver MTM services.<sup>25</sup> Meanwhile, in Iowa, the state’s Medicaid MCO contract template language suggests contractors “may implement” an MTM program.<sup>25</sup> Among the states that do mention MTM in Medicaid MCO contract template language, the majority require that contractors establish an MTM program (i.e., “shall” rather than “may”).

Some state MCO contract templates also define the parameters of the state’s Medicaid MTM programming. In Kansas, the contract template



language is very specific and establishes MTM patient and provider eligibility, activities, appropriate locations for provision of services, and even reimbursement.<sup>25</sup> However, not all state contract templates that mention MTM are so specific. Iowa’s contract template language gives potential contractors more discretion when developing their MTM programming, stating only that MTM programs “shall be developed to identify and target members who would most benefit from these interactions. They shall include coordination between the Contractor, the member, the pharmacist, and the prescriber using various means of communication and education.”<sup>25</sup>

## Key Consideration 5

### Use evidence about pharmacist-provided MTM to inform decisions about other Medicaid benefits or initiatives

MTM may be viewed as a value-added service that can be employed as part of a broader benefit. Some states have integrated MTM into broader Medicaid

initiatives, such as a value-based purchasing program or a state waiver that tests a set of delivery or payment redesigns, with evidence reflecting improved health outcomes.<sup>26,27,28,29</sup> Stakeholders can use these experiences to inform their decision making when addressing issues faced by communities experiencing particularly high prevalence of chronic conditions.

#### State Example

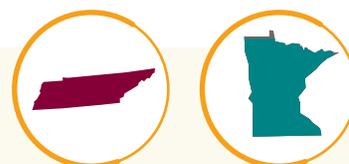
### Tennessee and Minnesota

The Tennessee MTM pilot program, which began in 2018, offers MTM as a benefit to Medicaid managed care beneficiaries participating in the state's Patient-Centered Medical Home (PCMH) or Health Link (HL) programs.<sup>30</sup> PCMH and HL programs are care delivery models developed to coordinate health care services for Medicaid beneficiaries. Approximately 37% of Tennessee Medicaid beneficiaries are enrolled in a PCMH organization.<sup>31</sup> For the MTM program, pharmacists provide services to beneficiaries who meet certain clinical risk criteria, through a collaborative practice agreement with PCMH and HL organizations.<sup>30</sup>

In Minnesota, HealthPartners, an integrated health system, provides MTM services for the Medicare and Medicaid beneficiaries for which it is responsible, through a value-based payment system called the Partners in Excellence (PIE) program.<sup>32</sup> PIE is a value-based payment system that rewards pharmacists for both positive clinical outcomes

and patient participation in MTM. In the PIE program, pharmacists receive a base-level payment for providing MTM services to patients. The pharmacists are also eligible for additional performance-based measurements, based on clinical outcomes such as blood pressure control and diabetes control.<sup>32</sup> Finally, pharmacists whose patients are achieving clinical outcome benchmarks can receive a second set of performance payments, based on patients' active participation in MTM activities.<sup>32</sup>

Pharmacists who are embedded in health systems and medical clinics are well represented in the PIE program. Despite outreach efforts, however, rates of participation among community pharmacists are much lower. HealthPartners acknowledges that community pharmacists have many competing priorities in their pharmacy practices and additional barriers to participation in MTM programs that pharmacists in integrated systems may not experience.<sup>32</sup>



## Key Consideration 6

### Consider increasing awareness and promoting utilization of MTM

State Medicaid agencies could increase awareness of MTM by informing providers about how to direct their patients to pharmacist-provided MTM services. State primary care associations may also assist in disseminating information about MTM to their Federally Qualified Health Center (FQHC) providers, and these

providers may provide information to their patients who are Medicaid beneficiaries.

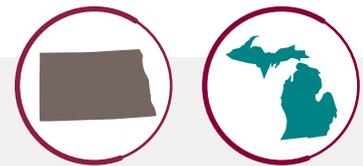
In addition to educating Medicaid beneficiaries, pharmacists could benefit from receiving clear, state-specific information about MTM requirements and training, including billing and coding practices. Medicaid agencies and MCOs could work with professional pharmacy societies and other stakeholders to ensure broad dissemination of this information.

#### State Example

### North Dakota and Michigan

In North Dakota, patients eligible to receive MTM services are either identified by the Department of Human Services (Department) or referred by prescribers, filling pharmacies, or MTM providers.<sup>33</sup> To refer a patient for MTM services, the prescriber, filling pharmacy, or MTM provider sends an MTM Service Authorization Request to the Department for approval.<sup>33</sup> Once the MTM service authorization has been approved, the Department refers the patient to an MTM provider for services.

Michigan requires that pharmacists complete the American Pharmacists Association's "Delivering Medication Therapy Management Services" certificate training program or another accredited MTM program before providing MTM services.<sup>34</sup> In addition to completing the training program, pharmacists must enroll in the state's claim processing system, the Community Health Automated Medicaid Processing System, and affiliate themselves with a pharmacy, FQHC, Tribal Health Center, or Rural Health Clinic in order to receive payment for MTM services.<sup>34</sup>



## Conclusion

Evidence suggests pharmacist-provided MTM can reduce overall health care costs and improve clinical outcomes. Several state Medicaid agencies have already implemented MTM services in their Medicaid programs. However, the majority of states have not implemented MTM programs for their Medicaid

beneficiaries.<sup>35</sup> Given the burden of chronic disease in the United States and within the Medicaid program in particular, state Medicaid agencies could consider the benefits of implementing or expanding their support of pharmacist-provided MTM.

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