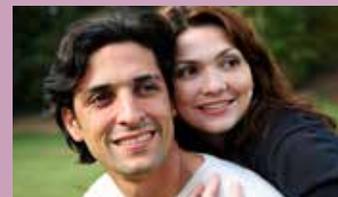AMERICAN PHARMACISTS ASSOCIATION

Medication Therapy Management Digest

The Pursuit of Provider Status to Support the Growth and Expansion of Pharmacists' Patient Care Services

March 2014

Dear Colleague

When the initial *Medication Therapy Management Digest* was published in 2008, it reported on the first national environmental scan of pharmacists' provision of medication therapy management (MTM). This edition reports on the sixth such environmental scan to be conducted by the American Pharmacists Association (APhA). The findings demonstrate that MTM continues to be on a growth curve and pharmacists' value is increasingly being recognized in a variety of settings.

In recent years, environmental scans suggest increasing roles for pharmacists resulting from innovative care models, spurred by the implementation of the Affordable Care Act of 2010. Today, pharmacists are care providers who offer a broad range of patient care services throughout the health care system— including MTM. The benefits of these services are clear. As data in this digest and elsewhere demonstrate, pharmacists have growing roles in improving patient outcomes and improving performance on quality measures.

As in previous years, pharmacists face financial and economic barriers to optimization of patient care services that improve patient outcomes. There is a need for more business models that value and cover services provided by pharmacists.

In 2013, this ongoing expansion of patient care services occurred alongside a concerted national and state-level push to gain recognition of pharmacists as health care providers. Achievement of provider status is crucial to ensure that patients have access and coverage in viable business models. As payers and other decision makers become increasingly aware of the problem of medication mismanagement and its financial consequences, education about the roles pharmacists can play in addressing these problems will be needed. Grassroots outreach by pharmacists to educate policy makers and other decision makers is necessary to stimulate provider status efforts and move the initiative forward. As the provider status movement continues to unfold, APhA is collaborating with pharmacy organizations and developing tools and resources to support state-level efforts. Pharmacists can learn more about these efforts at www.pharmacist.com/advocate.

I extend sincere thanks to the researchers who were involved both in the expert advisory panel for the environmental scan as well as in the development of this issue of the *MTM Digest* for their insight and guidance to advance pharmacists' patient care services and promote provider status.

Sincerely,

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Executive Vice President and Chief Executive Officer
American Pharmacists Association

MTM and Provider Status Activities in 2013

Pharmacists provide a broad range of patient care services in the U.S. health care system. The expertise that pharmacists bring to health care teams to optimize medication use and patient care can be utilized in a variety of practice settings ranging from community pharmacies to specialized health-system settings. Patient care services provided by pharmacists include MTM, disease state management, transitions of care services, health and wellness activities, and many others. These services improve patient care, reduce costs, and are seen by many as an opportunity to help address the primary care provider shortage. However, barriers to widespread implementation of financially viable business models have hampered efforts to expand services to meet the needs of the health care system.

To address these barriers and promote more system-wide implementation of pharmacists' patient care services, a concerted push to advance provider status for pharmacists began in 2013. (It is important to note that while the term "provider status" often refers to the inclusion of pharmacists in the list of providers who are paid for patient care services by third-party payers such as Medicare Part B, the term has alternate meanings in other situations and to various groups.) From APhA's perspective, the pursuit of provider status involves a multipronged strategy that targets many different entities and includes many approaches at both the state and federal levels. APhA also believes provider status advancement is critical to expanding the number of patients who can benefit from pharmacists' patient care services.

The 2013 push was fueled in part by the allocation of $1.5 million by the APhA Board of Trustees toward a multifaceted, long-term effort by APhA and others in the profession to gain provider status for pharmacists. The ultimate goal of this initiative is to employ a consensus-based approach for advocacy and legislative efforts to help improve patient access to the patient care services that pharmacists can provide. The initiative seeks to ensure:[1]

1. Payers and policy makers give patients access to pharmacists' patient care services and recognize pharmacists as health care providers who improve access, quality, and value of health care.

2. Patients have access to pharmacists' patient care services through the Centers for Medicare and Medicaid Services (CMS), other federal and state health benefit programs, integrated care delivery models (e.g., accountable care organizations [ACO], medical homes), and private payers (e.g., commercial insurers, self-insured, patient self-pay) by listing pharmacists as providers and/or properly valuing these services in payment models.

3. Every patient's health benefit plan package includes pharmacists' patient care services as a core component.

APhA is fostering and encouraging collaboration and a unified voice among pharmacy organizations to address Congress about the Medicare portion of provider status. In January 2013, a coalition of 14 organizations began working on provider status including the development of principles to guide pharmacy's quest for provider status. Pharmacy organizations are currently working together on identifying Medicare Part B legislative or regulatory changes to serve as the basis of a legislative request or bill that pharmacy organizations could support.

Although many barriers and challenges remain, integrated care models such as Medicare ACOs and patient-centered medical homes are creating opportunities for pharmacists to provide patient care services and be reimbursed for their services. Furthermore, innovative care models are not limited to government programs; opportunities also exist in commercial and self-insured employers' health plans.

State-Level Efforts

Each state provides its own legislative and regulatory opportunities for advancing the pharmacy profession. Potential strategies include seeking changes in Medicaid programs. Another strategy could include seeking the expansion of states' scope of practice and the services pharmacists can legally perform in each state. In 2013, California passed legislation (SB 493) that provides new practice authorities for pharmacists in the state. While the new law specifically designates pharmacists as health care providers, it does not address payment issues. Examples of the expanded authorities include: ordering and interpreting tests to monitor and manage the efficacy and toxicity of drug therapies, and initiating and administering routine vaccinations. The law also creates a new practitioner title for pharmacists—Advanced Practice Pharmacist (APP)—and provides additional authorities to pharmacists who receive the APP credential.[2,3] The California Pharmacists Association (CPhA) website provides a detailed summary of authorities granted to pharmacists under the new the law.[4]

As part of APhA's provider status initiative, an environmental scan of states' provider status activities and outcomes was conducted. The purpose of the environmental scan was to uncover and describe the characteristics of states that have made progress toward pharmacist provider status. The goal of the scan was to gather data to guide the design of further advocacy initiatives related to pharmacist provider status. Topics addressed in the scan included:[1]

**Themes Influencing Progress
Toward Provider Status**

Category	Theme
Functions	• Pharmacist capacity (skills and engagement) • Unified message to public, providers, payers, policy makers, and pharmacy itself • Evidence dissemination
Structures	• Recognition by health care system and legislation but insufficient reimbursement for sustainability • Payment and service models • Pharmacist recognition by public providers, payers, policy makers • Geographic effects • Information technology
Relationships	• Collaborations outside pharmacy • Collaborations inside pharmacy • Relationships with key decision makers

• Describing elements of success.
• Identifying barriers and ways to minimize those barriers.
• Determining messages and information that are most effective in convincing decision makers.
• Developing recommendations for how pharmacy organizations can contribute to success in this domain.
• Developing tools or information that can be used to support the case for pharmacist provider status.

Results from the environmental scan included 11 themes that can be grouped into categories of functions, structures, and relationships.

Based on the findings of the state-level environmental scan, it appears that readiness for achieving provider status within a state is dependent upon the state pharmacy profession's ability to: (1) reliably produce the service, then (2) promote pharmacy's capacity to others outside pharmacy, and (3) develop strategic decisions for how to position the "ask" for provider status.[1]

Ongoing Efforts in Support of MTM and Other Patient Care Services

Additional activities took place in 2013 that support pharmacists' provision of MTM and other patient care services on an ongoing basis. Implementation of integrated care models under the Affordable Care Act continued to expand practice opportunities for pharmacists. Through these opportunities, pharmacists are improving patient outcomes through MTM, medication reconciliation, patient education, and other medication management services. The value of such services has been recognized both by federal agencies and in reports from influential organizations.

Developments Within Medicare Part D

In 2013, CMS released a study that investigated how Part D MTM programs in operation in 2010 affected Medicare beneficiaries' adherence, quality of prescribing, resource utilization, and cost of hospital and emergency room (ER) care for patients with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes. The report, available at http://innovation.cms.gov/Files/reports/MTM_Final_Report.pdf, revealed that MTM programs

improved medication adherence and quality of prescribing for CHF, COPD and diabetes patients, particularly when CMRs were provided. In addition, MTM programs decreased hospital utilization and costs in diabetes and CHF patients receiving CMRs. The researchers concluded that, "MTM programs are an effective tool for improving the health of complex Medicare beneficiaries," and that "MTM programs also appear able to reduce health service costs."

Each year in the spring, CMS publishes a Call Letter for Medicare Part D plans, which contains annual adjustments and requirements that Prescription Drug Plans must implement for the following year. In April 2013, CMS issued the final 2014 Call Letter that continued to emphasize the important role of MTM services provided by pharmacists in the Medicare Part D program. (As reported in 2012, pharmacists are the leading provider of MTM services across all Part D MTM programs and are utilized by 99.5% of plans.[5])

CMS efforts to improve and expand the Part D MTM program and increase the number of patients receiving these services were major themes in the Call Letter.

CMS encouraged plans to:[6]

- Optimize their MTM programs for those who may achieve the greatest benefit.
- Offer MTM services to an expanded population of beneficiaries who do not meet eligibility criteria.
- Use MTM to promote coordination of care.
- Adopt standardized health information technology (IT) for documentation of MTM services.
- Promote beneficiary awareness about MTM.
- Continue use of the comprehensive medication review (CMR) completion rate as a Part D display measure.

The Call Letter confirms the continued use of quality measures developed by the Pharmacy Quality Alliance (PQA), including those related to MTM. These quality measures are part of the CMS star rating system for Part D plans.

Standardizing the Process of Care

As discussed in the last issue of the *MTM Digest,* the Joint Commission of Pharmacy Practitioners (members include APhA and other national pharmacy organizations) is leading an effort to articulate and promote a standardized pharmacists' patient care process and the use of standard terminology for pharmacists' patient care services. The care process, currently in draft form, addresses patient-centered care delivered in collaboration with other members of the health care team. It applies to pharmacists in any practice setting for the delivery of a wide array of patient care services.

Consistency in the process pharmacists use to deliver patient care services is necessary for those services to be understood, predictably delivered, measured, and ultimately valued in the marketplace. Patients, payers, and providers will have clearer expectations for pharmacists' services, which should in turn facilitate greater uptake and tracking of outcomes. The finalized pharmacists' patient care process is anticipated to be released in 2014.

CDC Releases Tools to Support Collaborative Practice Agreements

In December 2013, the Centers for Disease Control and Prevention (CDC) released tools designed to improve patient care services through collaborative practice agreements (CPAs). Developed in partnership with the APhA Foundation, the CDC tools customize a core set of seven recommendations for use in CPAs; these recommendations emerged from a January 2012 consortium meeting convened by the APhA Foundation and funded by CDC, and a resulting article.[8] The tools are customized for four audiences, including pharmacists, other health care providers, payers, and decision makers.[9,10]

The seven recommendations for advancing pharmacists' patient care services through CPAs are:[10]

1. Create and expand an infrastructure that embeds pharmacists' patient care services and CPAs into care, while creating ease of access for patients.
2. Use simple, understandable, and empowering language when referring to pharmacists' patient care services.
3. Allow the health care providers who enter into the CPA to define the details of each agreement.
4. Examine and redesign health professional scope of practice laws, education curricula, and operational policies to create synergy, promote collaboration, and make the best use of support staff.
5. Properly align incentives based on meaningful process and outcome measures for patients, payers, providers, and the health care system.
6. Provide incentives and support for the adoption of electronic health records and the use of technology in pharmacists' patient care services.
7. Maintain strong, trusting, and mutually beneficial relationships with patients, physicians, and other providers and encourage those individuals to promote pharmacists' patient care services.

The tools published by CDC combine details for how to implement these recommendations along with case studies describing the successful implementation of CPAs and pharmacists' patient care services.

The publication of these tools represents just one aspect of CDC's interest in pharmacy in recent years. In another example in 2013, CDC announced a 5-year project involving funding for state governments to promote health and to prevent and control chronic diseases and their risk factors. These grants include opportunities for pharmacists in conjunction with other members of the health care team.[9]

Support for Pharmacists' Services From IMS Health

In June 2013, IMS Health (an organization that describes itself as a "provider of information, technology, and services dedicated to making healthcare perform better") released a report titled *Avoidable Costs in U.S. Healthcare: The $200 Billion Opportunity From Using Medicines More Responsibly.* This report concluded that the U.S. health care system incurs costs of more than $200 billion due to inappropriate use of medications. These costs account for an estimated 10 million avoidable hospital admissions, 78 million outpatient treatments, 246 million prescriptions, and 4 million emergency department visits, and constitute 8% of total annual health care expenditures.[11]

Profile on California: Championing State Provider Status Efforts

Jon Roth, MS, CAE

Throughout the country, there are states and pharmacists making advancements continually for the benefit of patients, the health care system, and the profession. California's provider status effort is one example of the accomplishments that occurred in 2013. CPhA Chief Executive Officer Jon Roth played a key role in the California provider status success story, and he has shared his insights with APhA.

As Roth explained, the focus on asking for state-level provider status in California started in September 2012 based on discussions among the CPhA Board of Trustees following a provider status summit hosted at APhA headquarters. "We felt that provider status for pharmacists could be politically viable given the need for more primary care providers as millions of people become newly insured under the Affordable Care Act," he said. "Recognizing that pharmacists' skills are underutilized, particularly at the community level, we saw an opportunity."

Jon Roth, MS, CAE

Once the strategic decision to pursue provider status was made, CPhA established a joint task force that included representation from a wide array of pharmacy practice settings. The goal of the joint task force was to establish consensus and craft desired legislative language that identified the most important pharmacy requests, but remained realistic given the political landscape. Based on these discussions, the decision was made to establish an initial goal applicable for any pharmacist and then establish additional duties that only certain pharmacists could perform. The decision to require some additional training to earn an "Advance Practice Pharmacist" title was based on developing a bill that appeared reasonable and acceptable to many stakeholders. Roth noted, "Adding the requirements provided an additional level of comfort for stakeholders who want to ensure that pharmacists are qualified to provide the advanced services in the bill."

Likewise, the decision was made to ask only for recognition through provider status rather than to request payment for specific services. California has had years of substantial budget constraints, which makes it much more difficult to pass any bill that has a financial impact on the state. "Asking simply for recognition also promotes the appearance of pharmacists as a reasonable and respectable organization, whereas a more aggressive proposed bill that included everything pharmacists could want might have damaged the perceived integrity and credibility of the organization," noted Roth. Therefore, "it was a clear-cut decision to try to move the needle rather than to shoot for the moon," he continued. The goal was to obtain recognition first, and then address payment as a later step in the process.

CPhA began the process to promote a provider status bill by having conversations both with individuals in the legislature and with other stakeholders, including medical societies, before the bill was introduced or promoted to the public or discussed in the media. "This friendly heads-up was designed to open up dialogue with groups who might oppose the bill and create an opportunity to address any concerns in a collegial manner, rather than a confrontational one," Roth explained.

After these discussions, CPhA engaged a media communications

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firm to write editorial pieces promoting pharmacy provider status as an opportunity to address the primary care shortage expected to accompany expanded coverage through Affordable Care Act. The communications plan focused on the benefits of the change for patients, including improved access to care, as well as the fact that pharmacists' skills are often underutilized. Roth stated, "Interestingly, it was not necessary to stress the value of the pharmacist, because patients and decision makers were already familiar with pharmacists' abilities."

This process had a very beneficial effect as some groups supported the bill and the medical association was neutral on the bill. The California Association of Physicians Groups, which represents groups such as ACOs and other large integrated and comprehensive health care groups, supported the bill and actively lobbied on its behalf. The Medical Board of California, which is the state licensing agency for physicians, also supported the bill. This situation created a dynamic in which it was much more feasible to have the legislature pass the bill.

CPhA reached out to a state senator who is an actively practicing optometrist and well-versed in health care issues. This relationship and additional discussions led to the development of a package of three bills that expanded access for pharmacists, optometrists, and nurse practitioners. Having multiple practitioners involved with these bills allowed the associations to work together synergistically, unify their messages, and address opposition. Unfortunately, the nurse practitioner and optometrist bills were held in the legislature due to opposition by the medical association and other groups. However, the pharmacist bill made its way through the California legislature in August and was signed by the governor on October 1, 2013.

The law granting California pharmacists provider status and expanded authorities took effect on January 1, 2014. Over the

coming months, the Board of Pharmacy will promulgate regulations regarding the credentialing of Advanced Practice Pharmacists and addressing technical issues for the two protocols called for in the bill. To remove administrative barriers, protocols will be developed

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on a state-wide level, rather than requiring individual pharmacists to establish signed protocols with individual physicians.

"Pharmacists in California are clearly thrilled by the developments," reports Roth. "It's the most engaged I've seen our members around any single issue. They are really excited and many are inquiring how to achieve the Advanced Practice Pharmacist title."

Additionally, although the law does not require Medicaid to pay pharmacists for patient care services, some third-party payers, including managed care plans, have expressed interest in paying pharmacists for these activities. CPhA plans to work with these organizations to develop scalable models that can be adopted by others and has initiated dialogue with the state Medicaid office to explore future options for payment.

Roth believes that there are many opportunities for pharmacists in other states to pursue a similar path. He stated, "With the issues surrounding access to primary care and the underutilization of pharmacists, we believe there is a strong and persuasive rationale for states to expand roles for pharmacists, particularly when you look at the data supporting the cost, quality, and efficacy of pharmacy services."

The report identifies the following factors as contributors to inappropriate medication use:

- Medication nonadherence (which was noted to be the largest avoidable cost).
- Delayed evidence-based treatment.
- Misuse of antibiotics.
- Medication errors.
- Suboptimal use of generics.
- Mismanaged polypharmacy in older adults.

The report also identified several opportunities for improvement, and specifically identified pharmacists as providers who are able to improve medication use.[11] These findings provide further evidence and support for expanding the patient care service roles of pharmacists in order to improve patient outcomes while controlling total health care spending.

American College of Physicians Position Paper on Clinical Care Teams

In November 2013, the American College of Physicians (ACP) released a position paper intended to offer principles, definitions, and examples of dynamic clinical care teams, and recognized clinical pharmacists throughout its framework.[12] "Clinical pharmacists" were included in ACP's definition of a clinical care team. Furthermore, ACP notes that cooperative approaches among team members will be needed to address physician shortages. Collaboration with a pharmacist is also provided as one of the examples of how clinical care teams function. The example says:[12]

An internist using a formal collaborative drug therapy management agreement with a clinical pharmacist refers a patient for ongoing medication management or decisions that meet

jointly developed clinical goals of the care plan developed from the physician's or team's diagnostic workup and assessments. Achievement of medication-related goals is sustained or documented or revisions to the patient's care plan or medication management are accomplished either through referral back to the physician or through collaboratively developed care plan adjustments.

Strong Support in Health Affairs Special Issue on the Workforce

The November 2013 issue of *Health Affairs,* "Redesigning the Health Care Workforce," featured several articles addressing expanded roles for pharmacists in new care models that are emerging through the Affordable Care Act to address patient care needs. These articles noted that pharmacists are well-positioned to fill gaps in primary care. For example, one article stated, "primary care capacity can be greatly increased without many more clinicians: by empowering licensed personnel, including registered nurses and pharmacists, to provide more care."[13]

A second article emphasized the importance of clinical care models in the evolving delivery of health care and highlighted the integral role of pharmacists participating on such teams, including patient-centered medical homes, community-based care teams, and ACOs.[14] The article identified medication management for high-risk patients as one of the crucial roles that pharmacists can serve on these teams. However, the lack of direct compensation to pharmacists for the provision of such services was cited as a barrier to fully utilizing pharmacists' expertise. This finding was underscored in a third article, which noted that the benefits provided by pharmacists as well as pharmacy technicians will be enhanced once issues such as provider status and reimbursement are addressed.[15]

The Sixth APhA MTM Environmental Scan

In 2007, APhA began conducting periodic environmental scans of providers and payers regarding their involvement with MTM services and reporting results in a digest. Data from these surveys allow researchers to track progress and developments in the provision of MTM services and related programs over time. In the surveys conducted from 2007 through 2010, questions focused on provision of MTM services. Starting in 2012, the survey was expanded to include questions related to provision of MTM within integrated care models. Looking forward, APhA intends to expand the future surveys and resulting issues of this digest to address pharmacist-provided patient care services more broadly.

Data collected for the first environmental scan in 2007 showed that providers varied widely on how they implemented MTM service offerings and typically did not use specific measures to quantify the costs and benefits of MTM. Although MTM providers did not use systematic methods for assessing value from providing MTM services to their patients, they did associate value with provision of MTM services as being part of their professional role in the health care system and society. The results of the 2007 environmental scan also showed that payers for MTM services varied widely on how they implemented and monitored their organizations' MTM programs. They associated value of these programs with cost avoidance/minimization, improved member satisfaction, improved member medication

compliance/adherence, and quality indicators (e.g., Healthcare Effectiveness Data and Information Set [HEDIS], National Committee for Quality Assurance).[16-19]

Results from the second environmental scan conducted in 2008 were generally similar to the 2007 data. Notable differences included greater definition of MTM programs and services by greater numbers of respondents, revealing maturation among service providers and payers. However, the results from 2008 were similar to 2007 findings regarding: (1) MTM service structure; (2) value assessment of MTM services; (3) financial aspects (e.g., costs, billing, payment); and (4) barriers to provision of MTM.[20]

The third environmental scan conducted in 2009 revealed that the progression and maturation of MTM service provision leveled off.[21] Although the reasons for valuing MTM services as well as the challenges and barriers remained the same, many payers reported a reluctance to dedicate resources to MTM services. It is unknown whether the finding was a result of a challenging economy, variations in survey respondents from year to year, or a true shift in MTM development. Anecdotal evidence suggested that providers and payers who were not already invested in MTM services may have sought a more conservative strategy in 2009, electing not to pursue new, innovative services in a time of economic uncertainty. Conversely, in pockets of the country where MTM services were established, pharmacist-provided MTM services may have been embraced as a cost-saving strategy for overall health care systems through improved patient outcomes and efficient use of health care dollars.[21]

Results from the fourth environmental scan conducted in 2010 found that MTM continued to grow and mature. In addition, consistent findings from year to year showed that some aspects of MTM had become established within the organizations that were providing and paying for these services. In 2010, there was an emergent "channel of distribution" for MTM service provision through which information, services, and payment were created and exchanged. In this new channel of distribution for MTM, organizational relationships and cost efficiencies were proposed to be important considerations in the near term.[22]

In 2011, APhA, under the direction of the MTM Survey Advisory Board, conducted a study to summarize findings from the environmental scans conducted from 2007 through 2010. These findings were interpreted along with insights gained from the Future of Medication Therapy Management Roundtable convened in October 2010. Researchers also proposed ideas for future positioning and integration of MTM programs.[19,23] Research on effective marketing strategies was used to interpret these findings.

The MTM Survey Advisory Board concluded that there is a need for strategic planning related to understanding the size, structure, and behaviors of the target markets for MTM services. This strategy should focus on different relationships simultaneously to position and integrate MTM into the U.S. health care system. Other research that summarizes MTM survey articles published from 2004 through 2009 reached conclusions that are very similar to those of past APhA MTM environmental scans.[24]

The fifth environmental scan, conducted in 2012, found: (1) MTM was continuing on a growth curve; (2) pharmacist capacity for patient care was being recognized in integrated care models; (3) MTM providers and payers were trying to become more efficient in MTM service delivery through work system design and standardization of care processes; and (4) patient relationships were highlighted as being important for achieving MTM service expansion and growth.[25]

The 2013 study described in this edition of the digest is the sixth environmental scan conducted by APhA under the direction of the advisory board to collect data from providers and payers of MTM service delivery. Of 7,925 providers who were sent an e-mail invitation to participate in the survey, 2,536 viewed the message and 516 returned a survey containing usable data. Of 705 payers who were sent an e-mail invitation to participate in the survey, 92 viewed the message and 37 returned a survey containing usable data. Both the payer and provider surveys used the pharmacy profession's consensus definition of MTM, agreed to by 11 national pharmacy organizations.[26] (Contact APhA at mtm@aphanet.org for more information about survey methods.)

The objective of the surveys of payers and providers was to gather information to answer the following questions:

1. What is the value associated with pharmacist-provided MTM services from the provider and payer perspectives?
2. What specific measures, if any, are providers and payers using to quantify MTM costs and benefits?
3. What are barriers to providing MTM services to individuals reported by providers and payers?
4. What methods/strategies are providers and payers using to incorporate pharmacists providing MTM services into new or emerging interdisciplinary team-based models of care (e.g., ACOs, medical home models)?
5. What strategies are providers and payers using to compensate pharmacists and pharmacies for services provided in new or emerging interdisciplinary team-based models of care?
6. What practice/organizational changes have providers and payers made from 2012 to 2013?

Results from these surveys were compared with those conducted in previous years to assess changes taking place in the market.

Providers Responding to Our Survey

Provider Characteristics

- Characteristics of providers responding to the survey have been generally similar from 2007 through 2013, which allows for comparison among findings and monitoring of trends.
  - The most common practice settings over the past several years of the survey have included chain pharmacy, independent pharmacy, and hospital pharmacy.
- The most common job titles were staff pharmacist, clinical pharmacist, pharmacy manager, and pharmacy owner.
  - Fewer respondents described themselves as clinical pharmacists than in 2012. Nevertheless, this job title has been the first or second most common title since 2009.
- 43% of providers held a doctor of pharmacy degree and 16% had completed a residency.
  - The percentages of providers who have these credentials are higher in this survey than national averages. For example, in the 2009 National Pharmacist Workforce Survey, 24% held a doctor of pharmacy degree and 9% had completed a residency.[27]
- A significant number of respondents also held certificate and specialist training.
  - 31% had participated in the MTM Certificate Training Program developed by APhA.
  - 4% were Certified Diabetes Educators.
  - 3% were Board Certified Pharmacotherapy Specialists.
  - 3% were Board Certified Ambulatory Care Pharmacists.
  - 3% were Certified Geriatric Pharmacists.
  - 3% held other Board of Pharmacy Specialties credentials.

Provision of MTM Services

- Overall, 71% of respondents reported providing MTM services as defined in the consensus definition.
  - Of those providing services, 13% had done so for less than 1 year, 17% provided services for 1 to 2 years, 30% provided services for 3 to 5 years, and 26% provided services for more than 5 years; 15% reported that they did not know.
- 39% of those not offering services at the time of the survey (n=143) reported that they were very likely or somewhat likely to begin providing services in the next 12 months. This percentage was similar to responses in previous years (42% in 2012 and 32% in 2010).

Patient Care Settings Represented in the Provider Survey

Chain pharmacy: 21 (2013), 26 (2012), 22 (2010)
Independent pharmacy: 21 (2013), 14 (2012), 21 (2010)
Hospital pharmacy: 17 (2013), 18 (2012), 12 (2010)
Supermarket pharmacy: 6 (2013), 7 (2012), 8 (2010)
Mass merchandiser pharmacy: 1 (2013), 1 (2012), 2 (2010)
Other patient care practice: 20 (2013), 22 (2012), 21 (2010)
Other organization: 14 (2013), 12 (2012), 14 (2010)

- 2013 (n=515)
- 2012 (n=427)
- 2010 (n=755)

Percent of Respondents
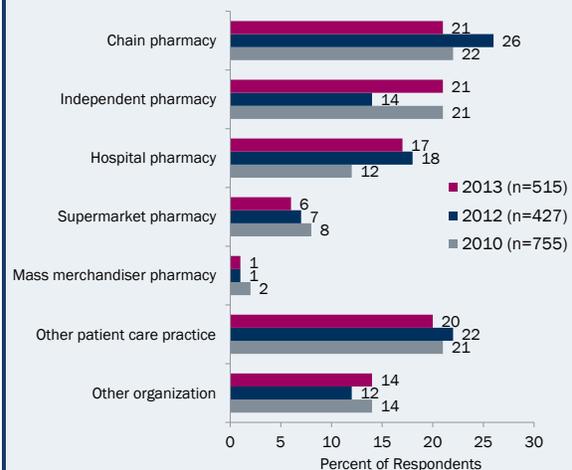
Other patient care practice included: ambulatory care clinic, community health center, federal pharmacy, long-term care, assisted living, home health care, home infusion, specialty pharmacy, hospice, mail service pharmacy, nuclear, or other patient care practice setting.

Other organization included: independent consultant, managed care, pharmacy benefits management, academia, association, non-patient care government agency, non-patient care corporation, research, or other non-patient care organization.

Capacity to Provide MTM Services

- Providers were asked to estimate the number of patients who receive MTM services from their practice each week.
  - The mean number of patients was 47 (range 0 to 1,600), with a median of 6. This was increased somewhat from 2012, when providers reported delivering MTM services to a mean of 39 patients per week, with a median of 6.
  - The mean number of patients for whom providers *could* provide services was 95 (range 0 to 1,600), with a median of 20. This was increased somewhat from 2012, when the mean number of patients was 72, with a median of 20.

Payers Responding to Our Survey

Payer Characteristics

- 2013 represented the first year in which health maintenance organization (HMO)/managed care organization was not the most common type of organization represented in the survey.
- 2013 survey respondents included more diverse organizational representation than in previous years.
  - In 2008 through 2012, more than 50% of respondents were from HMO/managed care organizations, while in 2013, no more than 30% of respondents were from one type of organization.

The most common job titles among payer respondents were director (40%) and manager (30%).

  - Organizational characteristics and job titles for payers fluctuated from one survey year to the next. These fluctuations and the relatively small sample sizes for payers should be considered when interpreting the findings from year to year.

Payer Provision of MTM Services

- 81% of payer respondents reported offering MTM services as defined in the consensus definition.
  - This percentage increased somewhat from the 77% reported in 2012, but was somewhat lower from the 86% in 2010. Percentages have remained elevated from the 62% reported in 2007.
  - These findings were generated from a sample of organizations likely to be paying for MTM services and, thus, are not representative of all health care payer organizations in the United States. Rather, they provide insight from payers who are engaged in MTM service provision or are considering it for their organization.

Organizations Represented in the Payer Survey
Multiple Responses Allowed

Legend:
- 2013 (n=20)
- 2012 (n=37)
- 2010 (n=33)

State Medicaid program: 30, 27, 15
HMO/managed care organization: 20, 51, 55
Insurer: 10, 16, 12
MTM program administrator: 10, 8, 9
Pharmacy benefit management company: 10, 3, 12
MTM contract vendor company: 10, 3, 9
Accountable care organization: 5, 3, 3
Self-insured employer: 5, 0, 6
Medical home: 0, 5, 3
Claims administrator: 0, 3, 3
Insurance co-op: 0, 0, 0
Benefits coalition: 0, 0, 0
Other: 5, 14, 0

Percent of Respondents

Other included: Children's Health Insurance Program; chain pharmacy, college of pharmacy, integrated care organization, Medicare Advantage plan, and PACE.
HMO = health maintenance organization; Program of All-Inclusive Care for the Elderly.

Who Is Receiving MTM Services?

Eligibility by Insurance Coverage—Providers

- Providers reported providing MTM services to patients with diverse types of insurance.
- The types of insurance providers have remained relatively consistent. In 2008, 2009, 2010, 2012, and 2013, the four most common insurance types that patients had were:
  - Medicare Advantage plans.
  - Medicare supplemental plans.
  - Commercial health insurance (health and/or prescription coverage).
  - Stand-alone prescription drug plans.

Sources of Patient Referrals to MTM Services/Programs

Referral Source	2013 (n=242)	2012 (n=198)
Referred by an MTM vendor (e.g., Outcomes MTM, Mirixa)	42	43
Referred through collaboration with another practitioner (e.g., physician, nurse practitioner, pharmacist)	25	28
Referred by a health plan (e.g., private payer, ACO, medical home)	13	12
Self-referred	12	10
Other	8	7

Percent of Respondents (0–50)

Similar data are not available for 2010
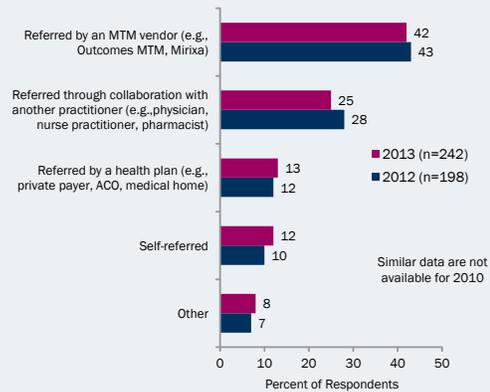
Other included: clinical research, hospital discharges, internal identification criteria, identification by pharmacist, acute care role, computer algorithm, company call center, protocols, word-of-mouth referral.

ACO=Accountable care organization.

Insurance Types of Patient Populations Receiving MTM Services From Providers
Multiple Responses Allowed

Insurance Type	2013 (n=242)	2012 (n=198)	2010 (n=466)
Medicare Advantage plans	47	43	44
Medicare supplemental plans	43	41	40
Commercial health insurance	39	39	40
Stand-alone prescription drug plans	36	32	36
Self-paying (fee-for-service)	30	28	32
HMO/managed care plans	28	26	35
Hospital discharge	26	23	27
State Medicaid program	26	7	34
PPO plans	21	21	25
Acute care	21	18	25
Self-insured health/prescription benefit coverage	20	23	21
Specific employer benefit group	17	19	24
Long-term care/assisted living	17	14	18
Medicare SNPs	16	19	14
Patients as part of medical home	14	13	15
Health savings accounts	13	15	16
Traditional health indemnity plans	13	13	16
Home care	13	13	15
Medical home	11	10	0
Patients as part of accountable care organizations	11	5	3
Federal sector (DoD, PHS, VA)	10	10	14
Accountable care organizations	10	8	0
Other	8	8	11

Percent of Respondents (0–50)

Other included: targeted patient populations, free clinic, uninsured, indigent.
DoD = Department of Defense; HMO = health maintenance organization; PHS = Public Health Service; PPO = preferred provider organization; SNP = special needs plans; VA = Veterans Administration

Reflections From an MTM Provider

"[MTM has] improved outcomes such as HEDIS scores, hospitalization rates, safety (drugs to be avoided in the elderly, ACEI/ARB use in patients with hypertension and diabetes, etc.), and clinical outcomes (LDL control, A1C control, medication adherence, etc.)."

Strategies for Identifying Patients—Providers

- In both 2008 and 2009, the top three ways that providers identified potential candidates for MTM services were:
  - Patients having specific disease states (e.g., asthma, diabetes).
  - Patients with a specific health plan.
  - Patients taking a specific number of medications.
- In light of these findings, the question was changed in 2010 to evaluate how patients were referred for MTM services.
  - The most common method was for patients to be referred by an MTM vendor (53%), followed by health plan or pharmacy benefit management (PBM) referral (41%), prescriber or physician referral (37%), or through self-referral (35%).
- In 2012, the question was changed again to focus on the *proportion* of patients entering the MTM service from various referral sources.
  - The greatest proportion of patients were referred by an MTM vendor (e.g., OutcomesMTM, Mirixa), followed by referral through collaboration with another practitioner.
- Providers were questioned in 2012 and 2013 about which marketing strategies had been most successful.
  - In both years, 75% reported that direct contact with patients was the most successful marketing strategy. Collaboration with other health care providers and word-of-mouth promotion were the second and third most successful strategies, respectively.

Integrated Care Models

- In 2012 and 2013, providers were asked about the provision of MTM services within integrated care models.
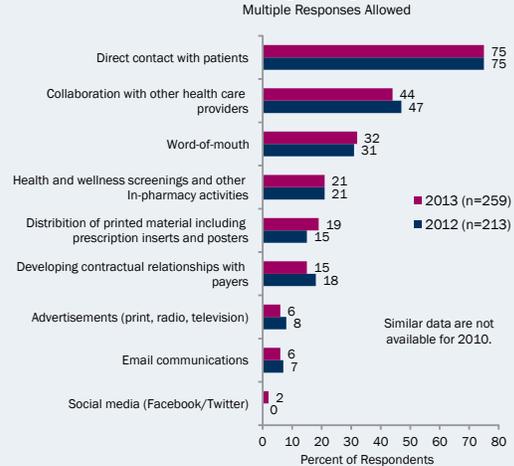 - In 2013, 32% of those who responded to this question (n=259) reported that they provided services in an integrated care model. (This was similar to the 31% reported in 2012.)
  - The most common models in 2013 were a medical home model (15% of all respondents), followed by a transitions of care model (9%), ACOs (9%), and other (9%).
  - Medication management services were provided most often, followed by patient education, drug information, medication reconciliation, chronic disease management, and medication adherence.
  - Of the 86 providers in integrated care models, 58% were paid a salary, 20% received fee-for-service payments, 12% contracted for services, 6% received pay for performance, and 5% received capitated payments.

Successful Marketing Strategies for MTM Providers
Multiple Responses Allowed

Strategy	2013 (n=259)	2012 (n=213)
Direct contact with patients	75	75
Collaboration with other health care providers	44	47
Word-of-mouth	32	31
Health and wellness screenings and other In-pharmacy activities	21	21
Distribution of printed material including prescription inserts and posters	19	15
Developing contractual relationships with payers	15	18
Advertisements (print, radio, television)	6	8
Email communications	6	7
Social media (Facebook/Twitter)	2	0

Percent of Respondents

Similar data are not available for 2010.

Reflections From an MTM Provider

"I have heard from physicians that they feel patients receive more comprehensive care when the pharmacist is part of the team."

Provision of Services in Integrated Care Models
Multiple Responses Allowed

Service	2013 (n=86)	2012 (n=67)
Medication management services	77	79
Patient education	74	77
Drug information	69	65
Medication reconciliation	64	60
Chronic disease management	57	55
Medication adherence services	53	58
Prevention and wellness services	36	36

Percent of Respondents

Similar data are not available for 2010.
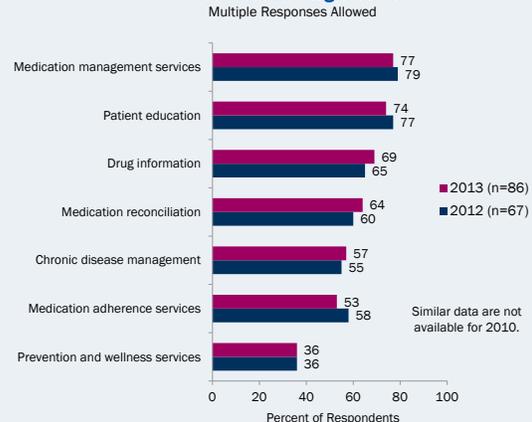
Eligibility by Insurance Type—Payers

- As seen in 2008, 2009, 2010, and 2012, Medicare Advantage plans were the most frequently reported coverage type conferring eligibility for MTM services in 2013.
- State Medicaid programs were the second most common coverage type in 2013 (56%; up from 17% in 2010), followed by members of a specific employer benefit group, and Medicare stand-alone prescription drug plans.
- 31% of payers offered services as part of a medical home (up from 10% in 2012), and 31% offered services as part of an ACO (up from 7% in 2012).

Eligibility by Patient Characteristics—Payers

- Payers were most likely to report patient eligibility based on a specific number of medications (88% of payers).
- As in 2008, 2009, 2010, and 2012, other common strategies for determining patient eligibility in 2013 were specific disease states, a specific number of disease states, and specific drug spends.

Insurance Types of Patient Populations Eligible for MTM Services From Payers
Multiple Responses Allowed

Insurance Type	2013 (n=16)	2012 (n=29)	2010 (n=30)
Medicare Advantage plans	88	52	77
State Medicaid program	56	38	17
Specific employer benefit group	50	17	23
Medicare stand-alone prescription drug plans	50	17	47
HMO/managed care plans	38	45	30
PPO plans	38	24	17
Medicare supplemental plans	38	17	20
Medical home	31	10	13
Members as part of ACOs	31	7	0
Self-insured health/prescription plan coverage	25	17	17
Commerical insurance	25	14	20
Traditional health indemnity plans	25	10	13
Health savings accounts	25	7	3

Percent of Respondents

ACO=Accountable care organization; HMO = health maintenance organization; PPO = preferred provider organization

Characteristics of Patients Eligible for Coverage of MTM Services From Payers
Multiple Responses Allowed

Characteristic	2013 (n=16)	2012 (n=29)	2010 (n=30)
Specific number of medications	88	79	83
Specific number of disease states	81	72	70
Specific disease states	75	76	60
Specific drug spend	75	66	70
Specific medications	25	17	30
Specific health plan	25	17	20
History of noncompliance/nonadherence	19	10	10
All members are eligible	13	17	20
Documented/suspected medication-related problem	13	10	17
Documented or suspected adverse drug reaction	13	10	13
History of emergency deptartment or hospital discharges	13	7	7

Percent of Respondents

Determining Patient Eligibility—Payers

- Payers reported several strategies for identifying patients eligible for services: 63% reported that the health plan identified patients, while 25% reported that pharmacists identified patients (down from 52% in 2012); this was the lowest percentage reported since the question was first asked in 2008.
- Physicians identified patients for 6% of payers.
- Patients were identified by "other" 50% of the time. Written responses for this category included: all are eligible, IT department, disease manager, PBM, vendor, MTM company, automated program, and sponsor contract.

Identifier of Patient Eligibility for MTM Services as Reported by MTM Payers
Multiple Responses Allowed

Category	2013 (n=16)	2012 (n=29)	2010 (n=30)
Health plan	63	45	70
Pharmacist	25	52	40
Physician	6	10	20
Other	50	31	31

Percent of Respondents
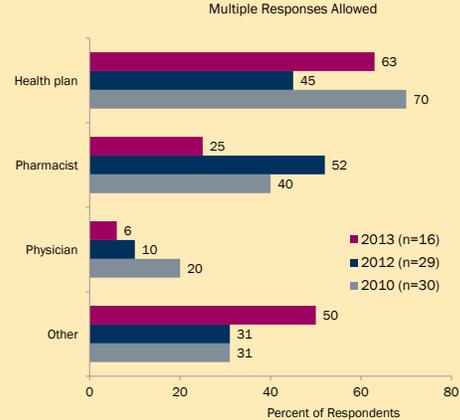
Other included: all are eligible, IT department, disease manager, PBM, vendor, MTM company, automated program, sponsor contract.
IT=Information technology; PBM=pharmacy benefit management.

Successful Marketing Strategies for MTM Payers' Organizations
Multiple Responses Allowed

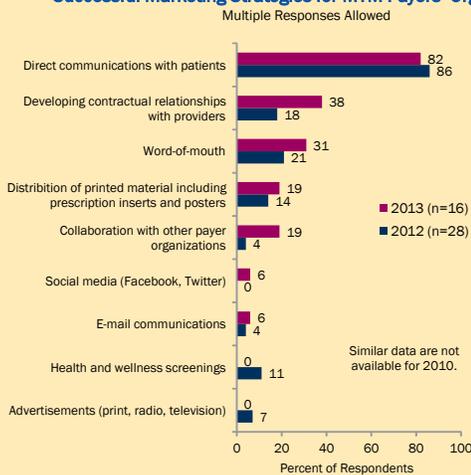| Strategy	2013 (n=16)	2012 (n=28)
Direct communications with patients	82	86
Developing contractual relationships with providers	38	18
Word-of-mouth	31	21
Distribution of printed material including prescription inserts and posters	19	14
Collaboration with other payer organizations	19	4
Social media (Facebook, Twitter)	6	0
E-mail communications	6	4
Health and wellness screenings	0	11
Advertisements (print, radio, television)	0	7

Percent of Respondents

Similar data are not available for 2010.

Reflections From an MTM Payer

"MTM helps my organization reach positive [CMS] star measures improving therapeutic outcomes, reducing medical costs, and increasing patients' satisfaction."

Marketing Strategies--Payers

- Payers also were questioned regarding the most successful strategies for publicizing MTM services.
  - Direct communication with patients was clearly the most successful marketing strategy, reported by 82% of payers.
  - Developing contractual relationships with providers, which was reported by 38% of payers as a successful marketing strategy, was the second most common strategy (up from 18% in 2012).
  - Word-of-mouth promotion was reported as a successful marketing strategy by 31% of payers.
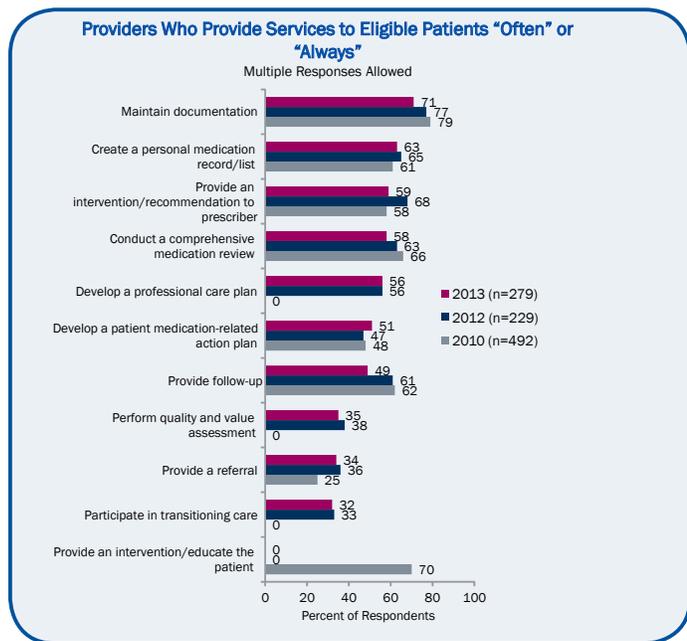
How Are MTM Services Provided?

Use of the Core Elements Model—Providers

- In 2008, 2009, 2010, 2012, and 2013, the majority of providers included components of the core elements of MTM services in the activities/services they "often" or "always" provided.
- The most common activities/services in 2013 were:
  - Maintain documentation (71%).
  - Create a personal medication record/list (63%).
  - Provide an intervention/recommendation to prescriber (59%).
  - Conduct a CMR (58%).

Providers Who Provide Services to Eligible Patients "Often" or "Always"
Multiple Responses Allowed

Activity	2013 (n=279)	2012 (n=229)	2010 (n=492)
Maintain documentation	71	77	79
Create a personal medication record/list	63	65	61
Provide an intervention/recommendation to prescriber	59	68	58
Conduct a comprehensive medication review	58	63	66
Develop a professional care plan	56	56	0
Develop a patient medication-related action plan	51	47	48
Provide follow-up	49	61	62
Perform quality and value assessment	35	38	0
Provide a referral	34	36	25
Participate in transitioning care	32	33	
Provide an intervention/educate the patient	0	0	70

Percent of Respondents (0–100)

- Providers also were asked to further describe their provision of services. When providing MTM services to an individual patient, providers (n=279) routinely include:
  - Collection of data/information from patient (90%).
  - Assessment (85%).
  - Development of goals/plan of care (80%).
  - Implementation of the plan of care (62%).
  - Monitoring of the plan or transition (53%).
  - Evaluation of the plan of care (54%).
- When asked about activities provided as part of MTM services, providers (n=279) reported:
  - Disease state management (67%).
  - Medication adherence services (61%).
  - Immunizations (60%).
  - Medication reconciliation (53%).
  - Health and wellness screenings (41%).
  - Smoking cessation (36%).
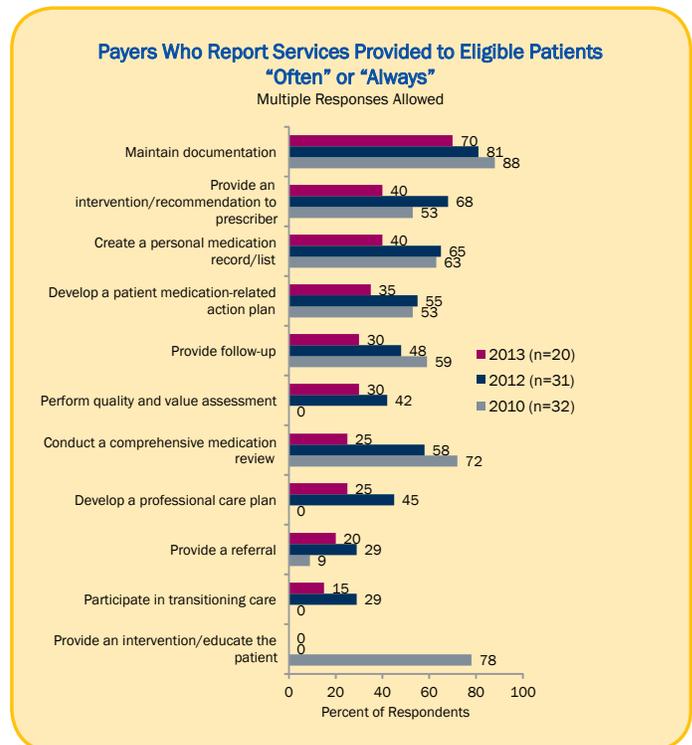 - Transition of care services (26%).

  - Educational mailings (22%).
  - Nutrition and weight loss (21%).

Based on written responses by MTM providers, processes they implemented in the past 3 years to improve the quality of MTM services delivered included:

- Electronic systems for standardizing documentation and billing.
- Electronic systems for work system design and workflow management.
- Investment in training.
- Standardization of care processes to improve efficiencies.
- Collaboration with other health care providers.
- Concerted efforts to use personal contacts with eligible patients.
- Use of home visits.
- Ongoing evaluation of programs.
- Integrating MTM services with other opportunities in other health care settings such as long-term care, hospitals, transitional care units, clinics, and community locations.
- Standardization, integration, and collaboration are consistent themes.

Payers Who Report Services Provided to Eligible Patients "Often" or "Always"
Multiple Responses Allowed

Activity	2013 (n=20)	2012 (n=31)	2010 (n=32)
Maintain documentation	70	81	88
Provide an intervention/recommendation to prescriber	40	68	53
Create a personal medication record/list	40	65	63
Develop a patient medication-related action plan	35	55	53
Provide follow-up	30	48	59
Perform quality and value assessment	30	42	0
Conduct a comprehensive medication review	25	58	72
Develop a professional care plan	25	45	0
Provide a referral	20	29	9
Participate in transitioning care	15	29	0
Provide an intervention/educate the patient	0	0	78

Percent of Respondents (0–100)

Use of the Core Elements Model—Payers

- As in previous years, the majority of payers reported that many MTM services were provided "often" or "always."
- Other activities that payers reported offering as part of MTM services included:
  - Medication adherence services (80%).
  - Educational mailings (75%).
  - Medication reconciliation (70%).
  - Disease state education (70%).
  - Disease state management (40%).
  - Transition of care services (30%).
  - Immunizations (25%).
  - Smoking cessation (20%).
  - Nutrition and weight loss (10%).
  - Health and wellness screenings (10%).

Disease State Management—Providers and Payers

The disease states managed by providers and the disease state management services reported by payers were similar. The most common disease states are those largely managed by the use of medications, indicating a growing recognition of the role of pharmacists in contributing to the care of patients with these conditions. These data are similar to those reported in 2012.

Delivering MTM Services—Payers

- As in 2008 through 2012, "pharmacists in-house" and "contracted pharmacists" were the two most commonly used providers for the delivery of MTM services; both were used by 56% of payers in 2013. As in previous years, contracted MTM provider organizations were the third most common provider (used by 44% of payers).
- Utilization of in-house nurses declined from 29% in 2008, to 17% in 2012, and 6% in 2013. However, the small sample sizes must be considered when interpreting these findings.
- Payers' written responses to "other" providers utilized included the terms "certified pharmacist" and "health educators."
- 81% of payers reported that services were delivered using telecommunications (including telephone and videoconference), and 56% reported that services were delivered (face-to-face) in person.
  - These data are similar to those reported in 2008, 2009, 2010, and 2012.
- In 2013, no organizations reported using a tiered approach to service provision in which some members received a phone intervention, followed by a face-to-face intervention for a subset of patients. However, 10% of respondents reported using this approach in 2012, down from 31% in 2008.
- As in previous years, the majority of payers reported that only a subset of patients who are eligible for services actually participate in the services.

Disease State Management— Specific Conditions Covered in 2013

Disease State	Providers (n=168)	Payers (n=19)
Diabetes	92%	88%
Hypertension	79%	63%
Dyslipidemia	61%	75%
Respiratory disease (e.g., asthma, chronic obstructive pulmonary disease)	53%	63%
Heart failure	49%	50%
Anticoagulation therapy	49%	25%
Pain management	37%	25%
Bone or joint disease (e.g., arthritis, osteoporosis)	31%	50%
Mental health	27%	38%
HIV/AIDS	20%	25%

Proportion of Eligible Patients Who Participate in MTM Services as Reported by MTM Payers
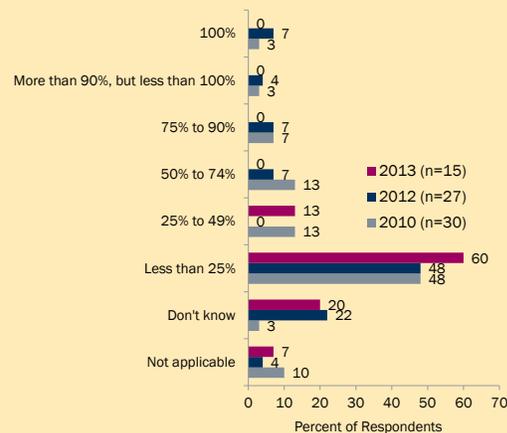
Value Associated With MTM Services

Perceptions of Value—Providers

- As seen in previous years, the greatest value of providing MTM services was increased professional satisfaction, followed by increased patient satisfaction, and increased quality of care/outcomes based on performance measures.
- Revenue generation and other financial factors were not rated as highly. It is noteworthy that providers are monitoring value of using professional/patient care outcomes to a greater extent than they are using business/economic outcomes.

Written comments revealed that MTM service development during 2013 was helping pharmacists become more integrated with their patients and the overall health care team by:
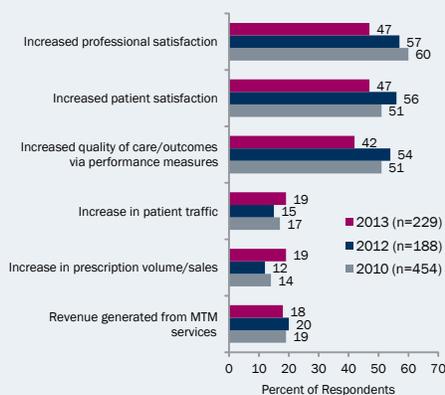
- Building connections with patients.
- Building professionalism.
- Creating collaboration.
- Enhancing the pharmacist's image with the public and colleagues.
- Obtaining a new level of respect from patients.
- Increasing patient–provider–pharmacist interaction.
- Establishing trust with patients.
- Achieving more personal interaction with patients.
- Feeling more a part of the health care team.
- Increasing patient loyalty.

Written comments indicated that value from MTM service provision has been achieved in the patient safety domain, especially in the area of decreased readmissions to hospitals through better patient adherence and better transitions of care. Comments also reflected that some providers are only recently getting started in this area and they are still learning about how to develop and provide MTM services.

Value From MTM Services—Payers

- As in previous years, all factors associated with value were rated as "very significant" or "significant" by payers.
- Increased quality of care/outcomes via performance measures was the primary factor for payers, followed by reduced total health care costs and increased professional satisfaction.
- Written comments indicated that payers felt MTM provides value for achieving CMS star ratings goals and CMR completion rates. They also reported overall health care cost savings and improved patient satisfaction. Some comments described how MTM is being used to "reduce gaps in health care delivery" and to have a "synergistic effect in servicing some of their more chronically ill members."
  - While MTM is being used for achieving targeted goals, there are also new relationships and opportunities being created that are taking pharmacists "beyond MTM."

Value to Provider Organizations Resulting From MTM Services
Percent Reporting "Very Significant"

Category	2013 (n=229)	2012 (n=188)	2010 (n=454)
Increased professional satisfaction	47	57	60
Increased patient satisfaction	47	56	51
Increased quality of care/outcomes via performance measures	42	54	51
Increase in patient traffic	19	15	17
Increase in prescription volume/sales	19	12	14
Revenue generated from MTM services	18	20	19

Percent of Respondents

Reflections From an MTM Provider

"By providing MTM to our employees, their health care costs have decreased. Their wellness has increased. By providing MTM to our cardiac rehabilitation patients, we have increased adherence and caught errors that have decreased overall health care dollars."

Monitoring the Outcomes—Payers

- Member satisfaction, the number of high-risk medications, and medication over/underutilization were the outcomes most commonly *measured* by payers.
  - Overall, payer measurement of outcomes was increased compared with previous years. However, these findings must be interpreted with caution due to the small sample size.
- Several outcomes were shown to be *improved* by MTM services, including:
  - CMR completion rates.
  - Inappropriate medications in elderly patients (Beers criteria).
  - CMS star ratings.
  - Patient quality of life.
  - HEDIS.
  - PQA measures.
  - Hospital readmission rates.

- Being able to segment and target patients who can benefit the most.
- Building confidence and retention.
- Being able to identify and resolve problems before they occur.
- Using MTM services as a way to differentiate oneself from competition.
- Creating new partnerships with other organizations and opening new opportunities.
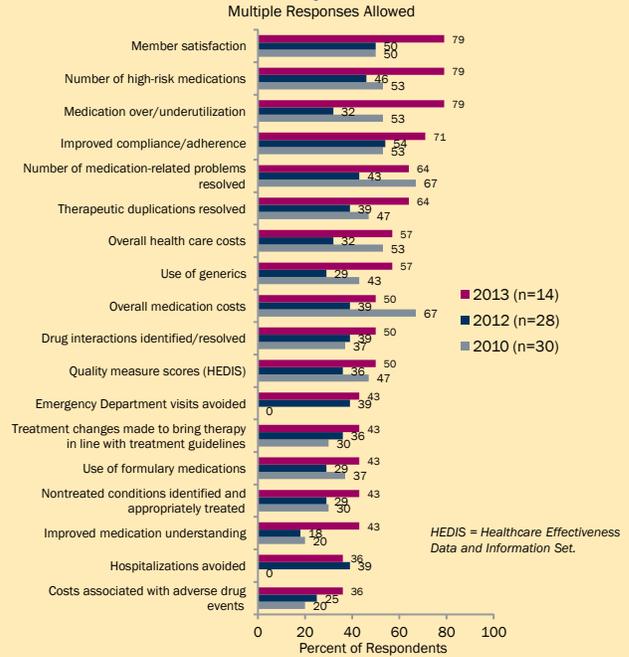
- Medication reconciliation measures.
- ACO quality measures.
- CMR completion rates are being used by CMS as a factor in determining a Part D plan's star rating.
  - CMS has stated, "Plan sponsors are expected to actively engage beneficiaries to increase the number of CMRs delivered to MTM enrollees, not just 'offer' CMRs."[5]
  - The findings suggest that in 2013, payers' strategies for implementation and evaluation of MTM were becoming more sophisticated in that they were able to focus on their organizations' goals and on the goals of meeting external quality metrics (e.g., CMR rates, Beers criteria, CMS star rating system).

Based on written responses by MTM payers, processes they implemented in the past 3 years to improve the quality of MTM services delivered included:
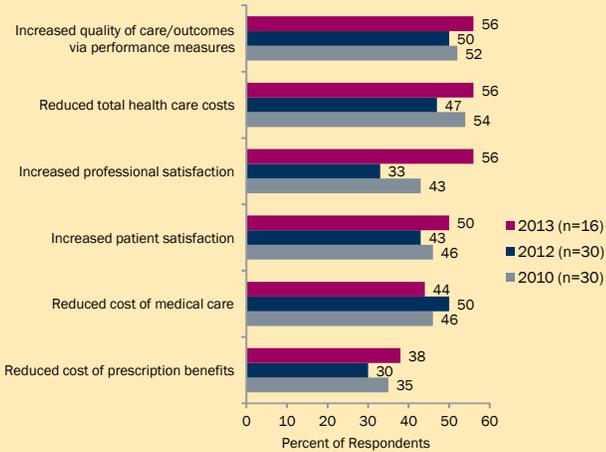
- Electronic systems for managing data.
- Collaboration with other organizations for member identification and member screenings.
- Integration of MTM programs with other areas.

Measurement of MTM's Impact — Outcomes Measured by Payers
Multiple Responses Allowed

Outcome	2013 (n=14)	2012 (n=28)	2010 (n=30)
Member satisfaction	79	50	50
Number of high-risk medications	79	46	53
Medication over/underutilization	79	32	53
Improved compliance/adherence	71	54	53
Number of medication-related problems resolved	64	43	67
Therapeutic duplications resolved	64	39	47
Overall health care costs	57	32	53
Use of generics	57	29	43
Overall medication costs	50	39	67
Drug interactions identified/resolved	50	39	37
Quality measure scores (HEDIS)	50	36	47
Emergency Department visits avoided	43	39	0
Treatment changes made to bring therapy in line with treatment guidelines	43	36	30
Use of formulary medications	43	29	37
Nontreated conditions identified and appropriately treated	43	29	30
Improved medication understanding	43	18	20
Hospitalizations avoided	36	39	0
Costs associated with adverse drug events	36	25	20

Percent of Respondents

HEDIS = Healthcare Effectiveness Data and Information Set.

Value to Payer Organizations From Offering MTM Services
Percent Reporting "Very Significant"

	2013 (n=16)	2012 (n=30)	2010 (n=30)
Increased quality of care/outcomes via performance measures	56	50	52
Reduced total health care costs	56	47	54
Increased professional satisfaction	56	33	43
Increased patient satisfaction	50	43	46
Reduced cost of medical care	44	50	46
Reduced cost of prescription benefits	38	30	35

Percent of Respondents

Measurement of MTM's Impact — Reported Improvements in Quality Measures
Multiple Responses Allowed

	2013 (n=14)	2012 (n=28)	2010 (n=30)
Comprehensive medication review	71	57	0
Inappropriate medications in elderly patients	57	43	37
CMS star rating system	43	29	0
Patient quality of life/satisfaction surveys	36	7	1
Pharmacy quality alliance measures	29	29	30
HEDIS	21	21	33
Medication reconciliation measures	7	25	0
Hospital readmission rates	7	11	0
ACO quality measures	7	0	0
Other	0	4	7
None	0	4	7
Not applicable	7	0	1
Don't know	21	21	27

Percent of Respondents

ACO=Accountable care organization; CMS=Centers for Medicare and Medicaid Services; HEDIS = Healthcare Effectiveness Data and Information Set
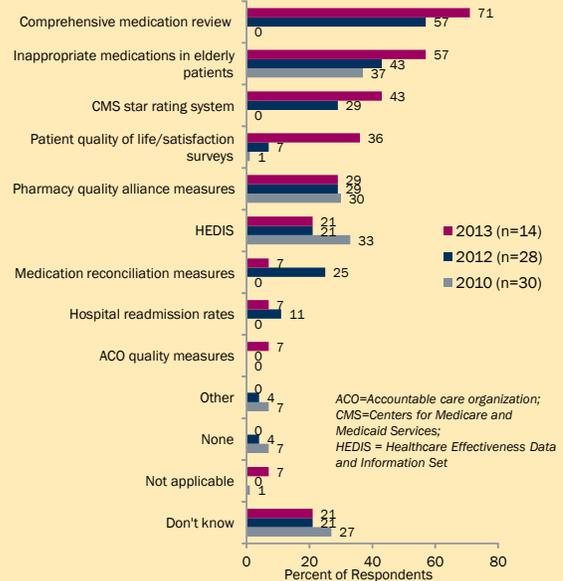
Reflections From an MTM Payer

"Outcomes provided have shown overall health cost savings, patient satisfaction, and support CMS star ratings for plans."

Looking at Challenges and Barriers for MTM Services

Challenges and Barriers for Providers

As in 2010 and 2012, the greatest challenges/barriers for providers were a lack of insurance companies paying for MTM services and "pharmacists have inadequate time."

The next most prominent barrier was "payment for MTM services is too low."

"Billing is difficult" and "inadequate support staff" were also cited as significant barriers.

Providers who were not providing services cited similar barriers.

Challenges/Barriers When Providing MTM Services Among Providers (mean rankings)	
Very significant	(No items ranked in this category)
Significant	Pharmacists have inadequate time (3.8) Lack of insurance companies paying for these services (3.7) Payment for MTM services is too low (3.5) Billing is difficult (3.5) Inadequate support staff (3.5)
Neither significant nor insignificant	Patients are not interested or decline to participate (3.4) Lack of collaborative relationships with prescribers (3.3) Trouble communicating/marketing to patients (3.3) Patients do not keep appointments (3.2) Documentation for services is difficult (3.2) Technology barriers (3.0) Unable to collect or access needed patient information (2.9) Inadequate space is available (2.9) Too few MTM patients to justify the cost (2.8) Inadequate training/experience (2.8) Too difficult to determine patient eligibility (2.8)
Insignificant	Management does not support provision of MTM services (2.3)
Very insignificant	(No items ranked in this category)

Based on a 5-point scale where 1=very insignificant and 5=very significant, n=259

Reflections From an MTM Provider

"MTM puts our pharmacy in a positive light to most physicians when they see the benefit of our services to their patients. [However,] the time it takes to prepare for the MTM consultation, the time spent with the patient and for follow up, and billing [are] not being considered in the payment for these services."

Looking at Challenges and Barriers for MTM Services

Challenges and Barriers for Payers

- The three most important challenges reported by payers in 2013 were:
  - Patients are not interested or decline to participate; this was the only challenge ranked as significant.
  - Resistance or lack of acceptance by physicians or other health care providers; this item was new in 2012.
  - Skeptical that these types of services would produce tangible outcomes.
- Written comments from 2013 indicate that payers have challenges related to:
  - CMR offer acceptance.
  - Coordinating with prescribers.
  - Creating a solid data-driven return on investment (ROI) model.
  - Contacting patients.
  - Tracking outcomes.
- Payers who were not offering MTM services (n=7) indicated that they are reluctant to pay for MTM services because of difficulties in communicating with eligible patients, securing physician support, and finding sufficient MTM providers to meet their needs.

Barriers to Providing MTM Services Reported by MTM Payers (mean rankings)	
Very significant	(No items ranked in this category)
Significant	Patients are not interested or decline to participate (4.0)
Neither significant nor insignificant	Resistance or lack of acceptance by physicians or other health care providers (3.4) Skeptical that these types of services would produce tangible outcomes (3.4) Eligible patients do not really need it (3.1) Providers do not have the training/experience (2.9) Insufficient MTM providers in the market area to meet needs (2.8) Too few MTM patients to justify the cost (2.7)
Insignificant	Too difficult to determine patient eligibility (1.7)
Very insignificant	(No items ranked in this category)

Based on a 5-point scale where 1=very insignificant and 5=very significant, n=18

Reflections From an MTM Payer

"[MTM services provide value by] addressing adherence, and high-risk medication and diabetes treatment star measures. [There is a] documented reduction in overall medical costs for patients that receive the service."

Financial Aspects of MTM Services

Costs to Implement MTM

- In 2012, the question related to provider costs for MTM services was changed from previous years to assess costs incurred in the past 12 months. (Previously, the question focused on costs to initiate the service.)
- In 2013, as in 2012, the greatest cost associated with running the MTM service was pharmacists' time, followed by pharmacists' training.
- 79% of providers reported that the investment in MTM was worth it from the organization's perspective.

Return on Investment for Providers

- In 2013, as in 2012, pharmacists were asked to compare the revenue generated by the provision of MTM services with the amount invested to provide MTM services to determine the ROI.
- The majority (80%) reported that they did not know their ROI.
- Of the 39 providers who had ROI information, 51% reported an ROI <1, 15% reported an ROI of 1, and 33% reported an ROI >1.
  - These results are consistent with comments made by some provider respondents. However, they are in contrast to the result that most respondents felt that the investment in MTM was worth it. This apparent discrepancy may exist because many of the current benefits of MTM services to providers are non-financial. However, the profitability of providing MTM services needs further attention.
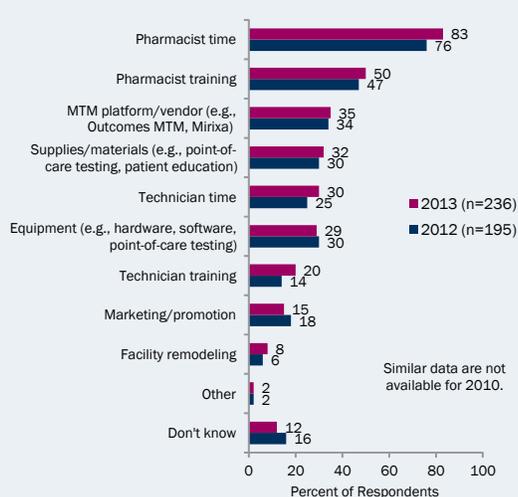
Pharmacist Compensation

- Payment for providing services as part of the standard pharmacist salary continued to be the method of compensation for the overwhelming majority of providers.
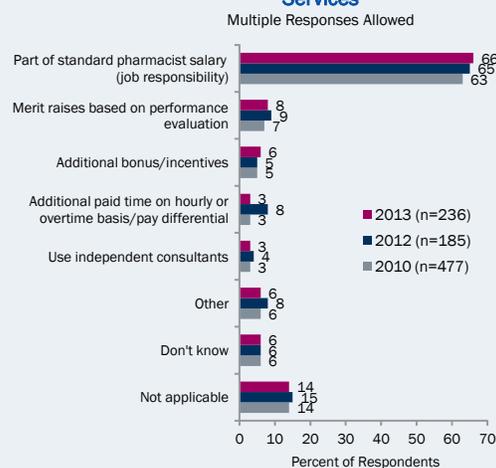
Payment for MTM Services

- 70% of providers reported billing for MTM services, which was similar to the percentage reported in previous years (63% to 70% in years 2008 through 2012).
  - Of those billing for services in 2013, 49% use *Current Procedural Terminology (CPT)* codes for claims processing. Among payers, 19% reported using *CPT* codes for MTM claims processing.
  - Among providers who reported billing, 35% reported that 100% of visits were being paid for by patients or plans; another 28% reported that payment was received for 76% to 99% of visits.
- Of those who were not billing for MTM services, written responses revealed some insight regarding why they were not billing. These responses showed that they: (1) had not yet set up billing capacity; (2) were funded through mechanisms for which there was no need to bill (e.g., grants, federal funding, part of bundled services); or (3) were not involved with billing aspects at their organization. These responses were similar to those provided in 2012.
- As in previous years, providers reported a variety of fee structures for MTM services, including:
  - 52% use a flat rate per service.
  - 50% use a fee-for-service basis.
  - 10% use a capitated rate.

Investment in MTM Services Reported by MTM Providers
Multiple Responses Allowed

2013 (n=236)
2012 (n=195)

Similar data are not available for 2010.

Pharmacist time: 83 / 76
Pharmacist training: 50 / 47
MTM platform/vendor (e.g., Outcomes MTM, Mirixa): 35 / 34
Supplies/materials (e.g., point-of-care testing, patient education): 32 / 30
Technician time: 30 / 25
Equipment (e.g., hardware, software, point-of-care testing): 29 / 30
Technician training: 20 / 14
Marketing/promotion: 15 / 18
Facility remodeling: 8 / 6
Other: 2 / 2
Don't know: 12 / 16

Percent of Respondents

Other included: administrative assistants for clinical pharmacists, program director, patient engagement, and pharmacy resident costs.

Methods of Pharmacist Compensation for Provision of MTM Services
Multiple Responses Allowed

2013 (n=236)
2012 (n=185)
2010 (n=477)

Part of standard pharmacist salary (job responsibility): 66 / 65 / 63
Merit raises based on performance evaluation: 8 / 9 / 7
Additional bonus/incentives: 6 / 5 / 5
Additional paid time on hourly or overtime basis/pay differential: 3 / 3 / 8
Use independent consultants: 3 / 4 / 3
Other: 6 / 8 / 6
Don't know: 6 / 6 / 6
Not applicable: 14 / 15 / 14

Percent of Respondents

Other included: academic affiliate, no compensation, clinical contracts, fee per patient, profit sharing, some pharmacist hours are voluntary.

Return on Investment for Payers
- 21% of payers were able to report an ROI for services.
  - This was an increase from only 9% in 2009.
- Those who were able to report an ROI provided answers including 4:1, 5:1, and "13:1 for a single condition."

- These data demonstrate that some payers are seeing a positive ROI in MTM services and underscore the need for the development of payment models that support financial viability of MTM services for providers.

2013 MTM Changes Experienced by Providers and Payers

Changes Experienced in 2013—Providers
- 61% of providers reported an increase in the number of patients receiving MTM services in the past year.
  - This is similar to the 70% of providers who saw an increase in 2012, and 57% who saw an increase in 2010, indicating continued expansion and growth over the past several years.
  - 12% saw a significant increase in 2013 (compared with 27% in 2012).
  - 8% reported a decrease in the number of patients receiving MTM.
- Several providers made changes in their practice to accommodate increased MTM service demands.
  - 23% adjusted pharmacists' schedules to facilitate service delivery.
  - 15% added full-time pharmacists.
  - 8% remodeled facilities.
  - 7% added full-time pharmacy technicians.
- Contract opportunities generally increased from 2010 to 2012, and from 2012 to 2013.

Provider respondents were asked, "What is your organization's most important goal for 2014 relating to MTM services?" The goals listed were consistent with findings presented in other sections of this report.

Based on their written responses, several themes emerged:

- Complete all available MTM opportunities.
- Continue service expansion and growth.
- Expand number and types of services.
- Improve outcomes from services provided.
- Increase collaborations.
- Increase contracting.
- Increase patient awareness and patient engagement in MTM services.
- Increase revenues.
- Increase number of patients served.
- Increase completion rate.
- More referrals.
- More revenue.
- More participation.
- Track outcomes and demonstrate value.

Change in the Number of MTM Patients — Providers

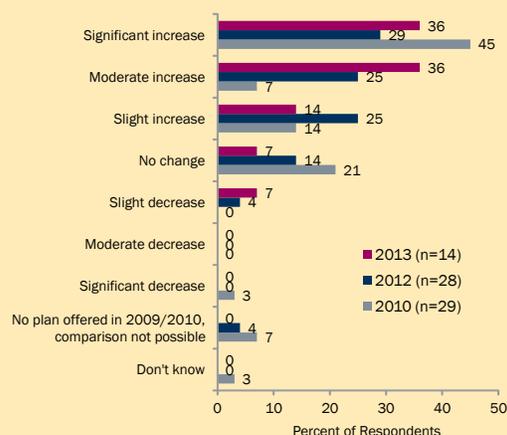| Category	2013 (n=227)	2012 (n=185)	2010 (n=442)
Significant increase	12	27	17
Moderate increase	25	22	18
Slight increase	24	21	22
Remained the same	16	7	17
Slight decrease	3	0	5
Moderate decrease	1	0	3
Significant decrease	4	2	1
Don't know	16	21	17

Percent of Respondents
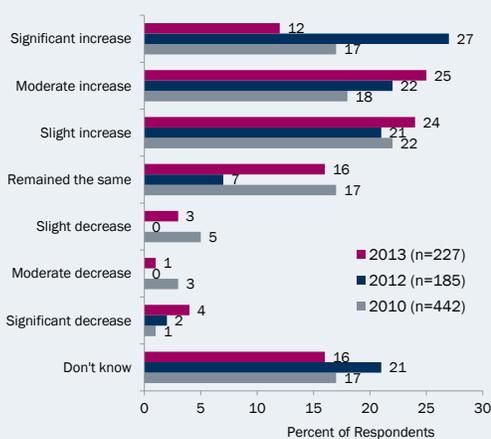
Reflections From an MTM Provider
"Patients appreciate that we are engaged in their health care and are willing to help them better their health outcomes."

Changes Experienced in 2013—Payers

- Many payers (72%) reported a moderate or significant increase in the number of patients receiving MTM services.
  - As with providers, these findings were similar to increases seen in previous years, indicating continued expansion and growth over the past several years.
- Many payers' organizations made modifications from 2012 to 2013. These included:
  - Enhanced MTM program offerings to beneficiaries for 2013 (64%).
    - 0% reported reducing their MTM program offerings.
  - Increased in-house provider staff (21%).
    - 0% reduced in-house provider staff.
  - Contracted with MTM network service provider to administer program for 2012 (7%).
  - Increased contracted provider staff (14%).
- Payers were asked to indicate what percentage of their beneficiaries receiving MTM services they expect will receive MTM services from contracted community pharmacists in the next year.
  - 64% responded "none" and another 14% indicated less than 25%.
  - 14% reported more than 75%.
- These findings suggest that some providers do continue to contract with pharmacies to provide services, while many others are expanding program offerings by increasing in-house capacity to deliver services.

Change in the Number of MTM Patients — Payers

Category	2013 (n=14)	2012 (n=28)	2010 (n=29)
Significant increase	36	29	45
Moderate increase	36	25	7
Slight increase	14	25	14
No change	7	14	21
Slight decrease	7	4	0
Moderate decrease	0	0	0
Significant decrease	0	0	3
No plan offered in 2009/2010, comparison not possible	0	4	7
Don't know	0	0	3

Percent of Respondents

Work systems and processes that payers have implemented to improve the quality of MTM services delivered included:

- Automated phone calls.
- Mailings and phone calls.
- Enhancements that include daily interventions.
- More robust quality review of CMR phone calls.
- Standardization, use of algorithms, segmentation, and targeting of care.
- Increased follow-up phone calls.

Discussion

When comparing the findings of the 2013 *MTM Digest* survey with those from previous years, it appears that pharmacist provision of MTM and other patient care services continues to grow and offer increasing value for the health care system. Data clearly show that pharmacists' patient care services have resulted in improved quality performance for health care plans and improved health care outcomes for patients.

The survey findings reveal an increasingly clinical focus for pharmacists' activities. In recent surveys, many MTM provider respondents described themselves as "clinical pharmacists" making this category one of the two most common job titles from 2009 through 2013. The emphasis on clinical roles is not surprising given that all graduates of pharmacy schools now are required to earn doctor of pharmacy degrees and are trained in the provision of patient care services. In addition, approximately two-thirds of the provider respondents in the 2013 survey had completed postgraduate training or held certification in a specialty area.

Comments from 2013 revealed increasing integration of pharmacists within heath care teams. The majority of pharmacists who work in integrated care models are compensated through salaried positions. It appears that while many pharmacists continue with the traditional MTM model, in which a CMR is completed by a pharmacist working in a community pharmacy and billing fee-for-service, others are increasingly delivering services in a setting where medication management is targeted to a specific organizational goal, completed by a pharmacist working in a non–community pharmacy setting, and for which no fee-for-service billing is generated.

Written comments about how pharmacists work with other members of the health care team in the integrated care models revealed several insights:

- Pharmacists work side by side with other health care team members.
- Collaboration and respect are evident for the contributions each team member provides to patient care.
- "Primary care clinical pharmacist" may be an emerging role for pharmacists.

- Coordinated communication is vital for success in the integrated care model.
- Protocols are used for care coordination among team members.
- Team members include nurses, social workers, physicians, and extenders. Patients are triaged and collaborations among team members are emphasized.
- Pharmacists are being integrated in ways that extend beyond MTM (e.g., managing certain disease areas and certain patient populations, filling in where gaps exist) as their skills become known in the integrated team model.

As seen in previous years, the value of MTM services to pharmacists is primarily derived from increased professional satisfaction, increased patient satisfaction, and increased quality of care. Written comments also revealed that value from MTM service provision has been achieved in the patient safety domain, especially in the areas of decreased hospital readmissions, improved patient adherence, and improved transitions of care. Financial incentives for the provision of MTM services are not as clear for providers, and this aspect is reported to be a barrier to further expansion of services. Broad recognition of pharmacists as providers is expected to help address this barrier and increase patient access to high-quality services provided by pharmacists.

Payers derived value from MTM services in several domains including increased quality of care and improved outcomes on performance measures. Payers also reported that MTM provides value for achieving

CMS star ratings goals and CMR completion rates. Additionally, they reported overall health care cost savings and improved patient satisfaction. Some comments described how MTM is being used to "reduce gaps in health care delivery" and to have a "synergistic effect in servicing some of their more chronically ill members." Furthermore, while MTM is being used for achieving targeted goals, there are new relationships and opportunities being created that are taking pharmacists beyond MTM. These developments are supported by widespread evidence in a variety of practice areas and clinical settings demonstrating that pharmacists' patient care services improve outcomes while reducing costs.[28]

It should be noted that organizational characteristics and job titles for payers fluctuated from one survey year to the next. These fluctuations and the relatively small sample sizes for payers should be considered when interpreting the findings from year to year and do not necessarily reflect national changes in how MTM programs are managed.

Additional findings from the survey indicate that MTM work systems and MTM processes are being aligned with desired outcomes of care. Providers are developing systems that support standardization, integration, and collaboration for the delivery of MTM services. When asked about the future, both providers and payers reported that they foresee ongoing expansion and growth for MTM services, including increased interprofessional collaborations, patient engagement, revenues, and demonstration of value by tracking outcomes.

In summary, there is a sense of movement toward new levels of MTM provision through the alignment of work systems, processes, and outcomes for MTM. Some of these changes are beyond traditional MTM approaches and may be aligning with the new health care environment that is emerging due to both health care reform legislation and market forces. However, lack of consistent reimbursement for pharmacists in some patient care settings continues as an important barrier that will need to be addressed for the value of pharmacists' patient care services to be optimized.

Looking forward, APhA will continue to monitor the development of patient care services provided by pharmacists beyond MTM. Assessments will include pharmacists' delivery of all patient care services permissible under state practice acts. Progress toward pharmacist provider status will be tracked on local, state, and national levels. APhA is profoundly committed to seeking increased access to pharmacists' patient care services and the companion goal of having pharmacists recognized for their critical role in providing patient care in collaboration with physicians and other providers on the health care team. Those interested in learning more and becoming involved are invited to visit www.pharmacist.com/providerstatusrecognition.

MTM Resources

Agency for Healthcare Research and Quality Effective Health Care Program
www.effectivehealthcare.ahrq.gov

American Pharmacists Association MTM Central
www.pharmacist.com/mtm

American Pharmacists Association and Academy of Managed Care Pharmacy MTM Connections
www.mtmconnections.org/final/2215100.asp

Centers for Medicare and Medicaid Services
Center for Medicare and Medicaid Innovation
www.innovations.cms.gov

Centers for Medicare and Medicaid Services
Part D Medication Therapy Management Program
www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html

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