Establishing a Web-based program for reimbursement for medication therapy management services

This installment of the Medicare Modernization Act (MMA) Q&A describes pharmacists’ use of a Web-based program to document and be reimbursed for medication therapy management (MTM) services provided to enrollees in a Medicare Part D prescription drug plan. The program is administered by Outcomes Pharmaceutical Health Care, which uses a nationwide network of pharmacists to provide face-to-face MTM services. Medi-CareFirst, a Part D prescription drug plan for patients in Maryland, Delaware, and the District of Columbia, is one of four Part D programs that have contracted with Outcomes to administer the plans’ MTM services in 2006. Under a pilot program, Jeffrey Brewer, Pharm.D., BCPS, clinical pharmacy specialist for primary care at The Johns Hopkins Hospital in Baltimore, has registered with Outcomes to provide MTM services to Medi-CareFirst patients.

Brewer and Patty Kumbera, R.Ph., chief operating officer for Outcomes, were interviewed separately in May about the Outcomes system and its use at Johns Hopkins.

Q: From your perspective, what is Outcomes and what does it do?
A: Brewer: Outcomes is a Web interface for MTM documentation that allows pharmacists to get involved in reimbursement and billing without knowing a lot about those processes. The information is entered by the clinical site that is providing the patient care and is then processed by Outcomes, which holds the contracts with the payers. Outcomes is basically the intermediary between the payers and the clinical pharmacist.

Kumbera: Outcomes is a national leader in the design, delivery, and administration of MTM programs. Even though the market is just waking up to MTM because of all the focus on Part D, we have been administering these types of programs with various payers since 1999. We work with employer groups, health plans, union funds, Medicaid, and, most recently, Medicare Part D programs. We have a national network of pharmacists who deliver MTM services face to face. Most of our pharmacists are in community pharmacies, but pharmacies associated with health systems in an outpatient setting are eligible to provide the services as well. That is how we are getting involved with Johns Hopkins, because it has outpatient pharmacies that serve the patients of Medi-CareFirst, which has outsourced its Part D MTM program to Outcomes.

Q: What specific MTM services can be reimbursed through Outcomes?
A: Kumbera: We reimburse for a comprehensive medication review—a scheduled, face-to-face visit where the pharmacist and patient discuss prescription drugs, nonprescription drugs, herbal supplements, samples from the doctor, everything. The goal is to inventory all those drugs
and look for cost-saving opportunities, drug therapy problems, drug–drug interactions, and other potential problems and resolve them by working with the patient and the prescriber.

**Brewer:** When we complete the review, we may find that patients are taking medications very differently than their provider thinks they are. They could be taking more or less than what was prescribed. Another common discrepancy is when the patient never filled a prescribed medication, or perhaps has not filled it for a year. The physician may be unaware that the patient may also be taking herbal products. These discrepancies are picked up very quickly by the pharmacist in this comprehensive medication review.

**Kumbera:** We also pay for physician consultations. These may involve a pharmacist identifying a drug therapy problem—a dose too high, a dose too low, a drug–drug interaction, adverse effects, or a medication not working appropriately—and working with the physician to make a change to help that patient. Another covered service is patient compliance consultations between the patient and the pharmacist that do not necessarily involve the physician. For example, the pharmacist may see that a patient is overusing or underusing a medication, or perhaps the patient uses an inhaler and is consuming inhalers fast and wasting a lot of medication because of poor technique. The pharmacist can work with the patient to resolve that type of compliance problem.

The last area is patient education and monitoring. For any new or changed prescription, or if the pharmacist recommends a nonprescription product, we will pay to educate and monitor the patient. Education takes place before patients walk out the door, so they know what they should expect and how to use their medication properly. Telephone follow-up can determine if the medication is working and if the patient is still taking the drug properly or is having any problems.

**Q:** How do pharmacists join the Outcomes network?

**A:** Kumbera: Pharmacists have to com-

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The Outcomes Personal Pharmacist Training Program, a two-hour, American Accreditation Council for Pharmacy Education-accredited course. The course is offered online, on a CD-ROM, or at one of our periodic live training sessions. The practice site also has to submit an Outcomes Participating Pharmacy Agreement, which can be done online.

Q: What other Part D plans are using Outcomes to provide MTM services?
A: Kumbera: Medi-CareFirst is the only standalone Part D prescription drug plan that contracted with us for 2006. But three Medicare Advantage managed care plans are also using Outcomes for 2006—AvMed Health Plans in southern Florida, the Health Plan of San Mateo in the San Francisco area, and John Deere Health Care, in which most patients are in Tennessee and Virginia. Several plans have asked us to help them for 2007.

Q: How many patients in these plans are eligible for MTM services?
A: Kumbera: For two of our four Part D clients, every patient is eligible, so there are about 35,000 Medi-CareFirst patients and about 20,000 with AvMed. The other plans are offering MTM services to select patients, on the basis of Centers for Medicare and Medicaid Services general criteria. For the Health Plan of San Mateo, approximately 1200 participants are eligible for MTM services, and John Deere Health Care is offering MTM services to about 500 patients.

Q: Is the Outcomes network open only to dispensing pharmacists?
A: Kumbera: No. Although many of the MTM services are most easily identified in conjunction with the dispensing function of an outpatient pharmacy, we do not limit the program to those settings. For example, we have independent consulting pharmacists who provide the services at the patient’s home or in an assisted-living facility. We also work with outpatient pharmacies like Johns Hopkins that are tied to a health system.

Brewer: If you have an outpatient pharmacy associated with your hospital and a passion for patient-focused care, it is a relatively easy transition to become an MTM provider. If you do not have an outpatient pharmacy, then this would be a consultative-type service, which would be a bit more difficult to initiate. However, hospital pharmacists certainly have many of the necessary skills to provide the services.

Q: Why did Johns Hopkins decide to become part of the Outcomes network?
A: Brewer: Outcomes is an early leader—it is one of the first systems to link direct patient care with specific reimbursement for pharmacists’ clinical services. But other systems for pharmacist-provided MTM services are coming into the marketplace now. We are in the process of contracting with MemberHealth’s Community Care Rx medication review program, and we are also looking into Humana’s new MTM program.

Personally, I believe that reimbursement models like these incentivize pharmacists to take more responsibility for the safety and the care of their patients. Even though pharmacists have been trained to provide patient-focused care, we do not routinely have time to spend 5 or 10 minutes with the patient talking about the control of diabetes, for example. By moving to one or more of these MTM systems, pharmacists can provide such care as part of the job. And that is important for the profession. I think this is the future of pharmacy.

At a more basic level, deciding to incorporate MTM services into pharmacy practice requires a needs assessment and an evaluation of the pharmacy and its workflow. Can the pharmacy staff continue to dispense products safely if the MTM program is added as a frontline function? Do the staff currently have the practical skills needed to perform MTM services? How many medication errors are occurring in the handoff between the hospital and the community pharmacies that could potentially be decreased through an outpatient MTM program?

Q: How does Johns Hopkins identify patients who are eligible for MTM services?
A: Brewer: We initiated this as a six-month pilot project starting in the Johns Hopkins outpatient pharmacies. We firmly believe that the majority of MTM services can be provided by any pharmacist.

My background as a primary care-trained pharmacist gave me a high level of comfort in dealing with the clinical situations that arise. Our biggest struggle is in bringing clinical services to a traditional community pharmacy model.

I am providing the initial clinical and administrative support for the MTM project. Our ultimate goal is to integrate financial and performance incentives to reward pharmacists for quality patient care. In April of this year, I started seeing Medi-CareFirst patients and submitting MTM encounters to Outcomes.

So far, one other staff pharmacist at Johns Hopkins has become approved by Outcomes. Our plan is to expand this pilot to one or two pharmacists in each outpatient pharmacy. We are keeping it in a controlled environment so we can determine all the variables, identify implementation barriers, and make adjustments until the program is fully functional.

We are also evaluating how this program would work for frontline pharmacists—could they take a half day of each week for MTM, or would this just be worked into the day as needed? We are far from figuring out the optimal workflow for our site.

Throughout the pilot project, we are logging the number of hours we spend on MTM services and the number of patients we interview. We want to see how much reimbursement and time are needed per patient. We will also evaluate the type and importance of the interventions. Then we will decide whether we want to roll out the program to all of our patients or just focus on certain patient groups. So we are building the infrastructure for a full clinical pharmacist career track in outpatient health-system pharmacy.

Q: How is Johns Hopkins implementing the MTM program?
A: Brewer: We have asked them to help us for 2007.

MTM services are most easily identified in conjunction with the dispensing function. The pharmacy staff continues to dispense products safely if the MTM program is added as a frontline function. Do the staff currently have the practical skills needed to perform MTM services? How many medication errors are occurring in the handoff between the hospital and the community pharmacies that could potentially be decreased through an outpatient MTM program?
report from our computer to identify patients enrolled in Medi-CareFirst. This Part D plan allows all of their enrollees to receive MTM services. We telephone all of the Medi-CareFirst patients who have picked up a prescription at our pharmacy and offer our comprehensive medication review.

Q: Is Outcomes’ documentation process similar to what you use in your current practice setting?
A: Brewer: The documentation is similar to what I am used to in the primary care world, where we submit patient encounters for billing purposes. Most pharmacists in our outpatient pharmacies are not familiar with that process. Outcomes has identified this area as a new issue for most pharmacists, so that is where most of their training is focused. So, it is not an issue once training is completed.

Q: What lessons have you learned from your experience with this MTM program?
A: Brewer: You have to establish your credibility with patients very quickly. These patients may or may not know us and likely have never received full clinical services from their pharmacy when we first contact them. During the call, we only have 5–10 seconds to establish who we are and that we are from their local pharmacy. Next, we establish our competence and our empathy and describe the benefits we can offer that patient to enable the person to feel comfortable saying yes, I will sit down with you.

Once they see you in person, most patients are a little more comfortable discussing their medications. That is a big lesson that we struggled with early on: You have to get the person in the chair.

There needs to be some sort of training to help pharmacists build the confidence that they can conduct sustained, 10–30-minute clinical interviews with patients. And that is what we are working on—building that confidence and expertise in our pharmacists so they can sit down and have these extended discussions and feel confident with their clinical skills.

It is also critical that there is a patient counseling area that is relatively secluded and relatively quiet, for confidentiality and to keep patients relaxed. You want them to be comfortable during the interview. At Johns Hopkins, we are using quiet conference rooms away from the pharmacy for the interviews. We meet patients in front of the pharmacy and walk them to the conference room.

Q: What part of the process has been unusually challenging for you?
A: Brewer: MTM services are what I do in my private physician practice all day long, but my perspective is from that of the provider and prescriber. Trying to make MTM work from the pharmacy and dispensing viewpoint has actually been very challenging, because I do not have all of the information that I am used to having.

When I am in the clinic, I have laboratory and radiology results, acute care nurses, and the patient’s physician right there in the same suite with me. I have all of the patient’s medical history—the patient’s chart is right in front of me.

But in the pharmacy with a Medi-CareFirst patient, I do not have all that information. So I cannot make as robust a recommendation about MTM services as I can at my other site. And, when I contact patients’ physicians, they do not have the same relationship with me calling from the pharmacy that they would if I was working alongside them in their practice. These are all things that have to be taken into account as we are building our MTM program. One of the biggest positives about this system is the profession itself. We identify patients with drug-related problems, what we are trained to do, and communicate back to the health care team. The stronger our relationship with the provider, the more effective we will be. However, no permission is needed to provide our service.

Q: How many patients had you contacted and counseled for the MTM program as of early May?
A: Brewer: I have called 17 patients. Four have denied interest, I have seen 6 one time each, and 7 still need to be contacted again. Patients are trickling in, which has given us time to build our infrastructure.

We would not be able to handle a lot of patients for the pilot project. This volume is about what I would expect for anybody looking to get into MTM in this region, because Medi-CareFirst is just one Part D plan out of about 70 in Maryland. So the number of those patients who are actually coming to Hopkins to fill prescriptions should be small.

Q: What advice do you have for hospitals getting involved in MTM for Part D enrollees?
A: Brewer: Systems like Outcomes incentivize pharmacists to do high-level clinical interventions. That is the future of pharmacy. Now, each hospital is going to have to sit down and look at its resources and look at its vision and mission and see if MTM aligns with them. The hospitals may or may not be ready for this, they may or may not be interested in this. But this, I believe, is where the profession is going. It is time to stop asking permission and time to step up and take care of our patients in the context of the entire health system.

Kumbera: Pharmacists are the most logical providers of MTM services. If the profession does not step up to the plate and take advantage by strongly participating in the opportunities now available to pharmacists, others will do it, and we will lose that opportunity. If you like what you see at Outcomes, get your pharmacists trained, sign a Participating Agreement, and get paid for providing MTM services.

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