2023 HOUSE HUMAN SERVICES

HB 1095

2023 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1095
1/17/2023

Relating to the inclusion of comprehensive medication management services in health benefit plans.

Vice Chairman Ruby called the meeting to order at 9:45 AM.

Chairman Robin Weisz, Vice Chairman Matthew Ruby, Reps. Karen A. Anderson, Mike Beltz, Clayton Fegley, Kathy Frelich, Dawson Holle, Dwight Kiefert, Carrie McLeod, Todd Porter, Brandon Prichard, Karen M. Rohr, Jayme Davis, and Gretchen Dobervich. All present.

Discussion Topics:

- Reduce health care cost
- Better health care for patients
- Health care cost study
- Comprehensive medication management
- Telehealth
- Pharmaceutical directory
- Form advisory committee
- Credentialing providers
- Increase in potential pharmacy providers
- Comprehension Med Management services (CMM)
- Prevent overmedicating

Representative Weisz introduced HB 1095.

Jon Godfread, North Dakota Insurance Commissioner, testified in favor of HB 1095, #13536.

Chrystal Bartuska, Division Director, Life/Health/Medicare ND Insurance Department, testified in favor of HB 1095, #13533.

Mark Hardy, Executive Director of the ND State Board of Pharmacy, testified in favor of HB 1095, # 13660.

Maari Loy, Pharmacy Operations Manager, Essentia Health, testified in favor of HB 1095, #13745, #12848

Mike Schwab, Executive Vice President of the ND Pharmacists Association, testified in favor of HB 1095, #13826.

Tom Kraus, Vice President for the American Society of Health System Pharmacists, testified in favor of HB 1095, #13246, # 13247.

Dylan Wheeler, Head of Government Affairs, Sanford Health, testified in opposition to HB 1095.

Jack McDonald, America's Health Insurance Plans, testified in opposition to HB 1095, #13744.

Megan Houn, Blue Cross Blue Shield of ND, testified in opposition to HB 1095.

Additional Written Testimony:

Douglas Gugel-Bryant, PharmD BCPS, Fargo ND, # 12936

Brody Maack, past President of the ND Society of Health-System Pharmacists, #13531.

Elizabeth Monson, North Dakota Society of Health System Pharmacists, #13779.

Katherine Capps, member of the Get the Medications Right Institute, #13242, #13241, #13240.

Jesse Rue, Pharmacist, Rugby, ND, #13376.

Amanda Brummel, Vice President of Clinical Pharmacy Service for M Health Fairview, #13232.

Amy Werremeyer, Vice President of the ND Pharmacists Association, #13346.

Scott Miller, Executive Director of the ND Public Employees Retirement System, #13251.

Allison Hursman, Pharmacist, Fargo, ND, #13296.

Vice Chairman Ruby adjourned the meeting at 10:28 AM.

Phillip Jacobs, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1095
2/14/2023

Relating to the inclusion of comprehensive medication management services in health benefit plans.

Chairman Weisz called the meeting to order at 10:27 AM.

Chairman Robin Weisz, Vice Chairman Matthew Ruby, Reps. Karen A. Anderson, Mike Beltz, Clayton Fegley, Kathy Frelich, Dawson Holle, Dwight Kiefert, Carrie McLeod, Todd Porter, Brandon Prichard, Karen M. Rohr, Jayme Davis, and Gretchen Dobervich. All present.

Discussion Topics:

- Committee action
- Amendments (23.8073.01001)

Representative Porter moved to amend HB 1095 (replace medical with pharmacy). #26137

Representative Dobervich seconded.

John Arnold, Deputy Insurance Commissioner, answered committee questions.

Voice vote: Motion carried.

Representative Rohr moved an amendment. (Pg. 6 Expiration date August 1st 2025, add the APRN's for the list of stakeholders for the committee.) #26136

Representative Frelich seconded.

John Arnold, Deputy Insurance Commissioner, answered committee questions.

Representative Rohr withdrew her amendment.

Representative Porter moved an amendment. (Upon completion of the rule making process the committee will be dissolved)

Representative Anderson seconded.

Voice vote: Motion carries.

Representative Rohr moved to amend HB 1095 (Pg, 6 lines 1-3 adds the APRN's to the list of stakeholders to the advisory committee and moves it all down.)

Representative McLeod seconded.

Voice vote: Motion carries.

Chairman Weisz presented emailed amendments from Jack McDonald, Retained Counsel for AHIP. #26142 and #26143

John Arnold, Duty Insurance Commissioner, answered committee questions.

Representative Ruby moved a DO PASS as amended with (23.8073.01001)

Representative Porter seconded.

Roll call vote:

Representatives	Vote
Representative Robin Weisz	Y
Representative Matthew Ruby	Y
Representative Karen A. Anderson	Y
Representative Mike Beltz	Y
Representative Jayme Davis	Y
Representative Gretchen Dobervich	Y
Representative Clayton Fegley	Y
Representative Kathy Frelich	Y
Representative Dawson Holle	Y
Representative Dwight Kiefert	Y
Representative Carrie McLeod	Y
Representative Todd Porter	Y
Representative Brandon Prichard	Y
Representative Karen M. Rohr	Y

Motion carries: 14-0-0.

Bill carrier: Representative Frelich

Vice Chairman Ruby adjourned the meeting at 10:56 AM.

Phillip Jacobs, Committee Clerk By: Leah Kuball

23.8073.01001
Title.02000

Adopted by the House Human Services Committee

February 14, 2023

2-14-23

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1095

Page 2, remove lines 23 through 29

Page 3, line 25, replace "medical" with "pharmacy"

Page 3, line 26, after "of" insert "pharmacists and"

Page 3, line 28, replace "medical" with "pharmacy"

Page 3, line 29, replace "2023" with "2024"

Page 4, remove lines 4 through 17

Page 4, remove line 25

Page 4, line 26, replace "c." with "b."

Page 4, line 29, replace "d." with "c."

Page 4, line 29, replace "the" with "that"

Page 5, line 1, replace "e." with "d."

Page 5, line 3, replace "f." with "e."

Page 5, line 12, replace "2023" with "2024"

Page 5, line 19, after "training" insert "and credentialing"

Page 6, line 1, after the underscored semicolon, insert:

"k. An advanced practice registered nurse;"

Page 6, line 2, replace "k." with "l."

Page 6, line 3, replace "December 1, 2023" with "June 30, 2024"

Page 6, line 8, after the underscored period insert "Upon completion of the rulemaking process, the committee is dissolved."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1095: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1095 was placed on the Sixth order on the calendar.

Page 2, remove lines 23 through 29

Page 3, line 25, replace "medical" with "pharmacy"

Page 3, line 26, after "of" insert "pharmacists and"

Page 3, line 28, replace "medical" with "pharmacy"

Page 3, line 29, replace "2023" with "2024"

Page 4, remove lines 4 through 17

Page 4, remove line 25

Page 4, line 26, replace "c." with "b."

Page 4, line 29, replace "d." with "c."

Page 4, line 29, replace "the" with "that"

Page 5, line 1, replace "e." with "d."

Page 5, line 3, replace "f." with "e."

Page 5, line 12, replace "2023" with "2024"

Page 5, line 19, after "training" insert "and credentialing"

Page 6, line 1, after the underscored semicolon, insert:

"k. An advanced practice registered nurse;"

Page 6, line 2, replace "k." with "l."

Page 6, line 3, replace "December 1, 2023" with "June 30, 2024"

Page 6, line 8, after the underscored period insert "Upon completion of the rulemaking process, the committee is dissolved."

Renumber accordingly

2023 SENATE HUMAN SERVICES

HB 1095

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1095
3/7/2023

Relating to the inclusion of comprehensive medication management services in health benefit plans.

9:00 AM **Madam Chair Lee** called the hearing to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** were present.

Discussion Topics:

- Pharmacist roles
- Pharmacy roles
- Prescription drugs
- Task force
- Continuum health care
- Medication management

9:01 AM **Representative Weisz** introduced HB1095 testified in favor verbally.

9:09 AM **John Arnold, Deputy Commission, ND Insurance Department,** testified in favor verbally, includes amendment. #22704

9:20 AM **Mark Hardy, PharmD, Executive Director ND Board of Pharmacy,** testified in favor. #22327

9:29 AM **Michael Schwab, Executive Vice President, ND Pharmacists Association,** testified in favor. #22551

9:41 AM **Dylan Wheeler, Head of Government Affairs Sanford Health Plan,** testified in opposition. #22517

10:00 AM **Megan Houn, Public Affairs, ND Blue Cross Blue Shield,** testified in opposition. #22708

10:11 AM **Karlee Tebbutt, America's Health Insurance Plans**, testified online in opposition. #22534

10:13 AM **Scott Miller, Executive Director, ND Public Employees Retirement System,** testified neutrally. #22191

10:18 AM **Madam Chair Lee** adjourned the hearing.

Additional Testimony:
Chrystal Bartuska, Life Health Director, North Dakota Insurance Department in favor #22411, 22412.
Tim Blasl, President, North Dakota Hospital Association in favor 22418
Allison Hursman, Pharmacist in favor #22444
Maari Loy, Pharmacy Operations Senior Manager, Essentia Health in favor #22491
Michael Murphy, Acting Head of Government Affairs, American Pharmacists Association in favor #22503
Brody Maack, PharmD, BCACP, CTTS, Past President of the North Dakota Society of HealthSystem Pharmacists and Chair-Elect of the American Society of Health System Pharmacists in favor #22504
Rebecca Aubart, Pharmacy Student in favor #22526

10:18 AM **Madam Chair Lee** closed the hearing.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1095
3/27/2023

Relating to the inclusion of comprehensive medication management services in health benefit plans.

10:14 AM **Madam Chair Lee** called the meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion Topics:

- Technical changes
- Task force
- Patient outcomes
- Medication management
- Advisory committee

Senator Lee calls for discussion.

10:16 AM **Mark Hardy**, **Executive Director, North Dakota Board of Pharmacy,** provided information verbally.

10:17 AM **Mike Schwab**, **Executive Vice President, North Dakota Pharmacist Association,** provided information #26689.

10:19 AM **Megan Houn**, **Vice President of Public Policy and Government Affairs, North Dakota Blue Cross and Blue Shield,** provided information verbally.

10:19 AM **Chelsey Matter, Executive Director, Government Programs, North Dakota Blue Cross and Blue Shield,** provided information verbally.

10:27 AM **Mike Schwab,** provided additional information verbally.

10:34 AM **Megan Houn**, provided additional information verbally.

10:38 AM **Mike Schwab**, provided additional information verbally.

10:44 AM **Dylan Wheeler, Head of Government Affairs, Sanford Health Plan,** provided information verbally.

10:48 AM **Chrystal Bartuska**, **Life Health and Medicare Division Director, North Dakota Insurance Department,** provided information verbally.

11:05 AM **Madam Chair Lee** adjourned the meeting.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1095
3/27/2023

Relating to the inclusion of comprehensive medication management services in health benefit plans.

3:21 PM **Madam Chair Lee** called the meeting to order. **Senators Lee, Clemens, K. Roers, Weston, Hogan** were present. **Senator Cleary** was absent.

Discussion Topics:

- Pharmacists
- Medications
- Best practices

3:24 PM **Jon Godfread, Insurance Commissioner, North Dakota Insurance Department,** proposed amendment on behalf of John Arnold #26764, #26763.

3:30 PM **Dylan Wheeler, Head of Government Affairs, Sanford Health Plan,** provides information verbally.

3:34 PM **Mike Schwab, Executive Director, North Dakota Pharmacist Association,** provides information verbally.

3:40 PM **Megan Houn, Vice President Public Affairs, North Dakota Blue Cross Blue Shield,** provided information verbally.

3:48 PM **Chrystal Bartuska, Life Health and Medicare Division Director, ND Insurance Department,** provides information verbally.

3:49 PM **Senator K. Roers** moved to **adopt amendment** #26764, strike line 2 and 12 on page 3, line 28, change medical to pharmacy, change page 6 on line 10 to an organization representing advance practice registered nurse.
Senator Weston seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	AB
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion passed 5-0-1.

Senator Hogan moved **DO PASS** as **AMENDED**.
Senator Weston seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	AB
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion passed 4-1-1.

Senator Lee will carry HB 1095.

3:57 PM **Madam Chair Lee** adjourned the meeting.

NOTE: Bill was reconsidered on 3/29/2023.

Patricia Lahr, Committee Clerk

23.8073.02001
Title.03000

Adopted by the Senate Human Services Committee

March 27, 2023

AC 3-27-23 (1 of 1)

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1095

Page 2, line 26, after the first "to" insert "eligible"

Page 2, line 26, after "enrollees" insert "who elect to participate in a comprehensive medication management program"

Page 2, line 30, after "provider" insert ", if applicable, and"

Page 3, line 2, remove "The enrollee had three or more hospital admissions in the preceding year;"

Page 3, line 3, remove "c."

Page 3, line 4, replace "Congestive heart" with "Heart"

Page 3, line 9, replace "d." with "c."

Page 3, line 11, remove "; and"

Page 3, line 12, remove "e. Additional criteria identified by the commissioner and adopted by rule"

Page 3, line 17, after "carrier" insert "network's or health carrier's affiliate'"

Page 3, line 21, replace "December 31, 2024" with "January 1, 2025"

Page 3, line 28, replace "medical" with "pharmacy"

Page 4, line 3, remove "The health carrier shall audit quarterly at least twenty-five percent of provider"

Page 4, remove lines 4 and 5

Page 4, line 6, remove "c."

Page 4, line 9, replace "d." with "c."

Page 4, line 11, replace "e." with "d."

Page 4, line 14, remove "Gender;"

Page 4, line 15, remove "(3)"

Page 4, line 16, replace "(4)" with "(3)"

Page 4, line 17, replace "(5)" with "(4)"

Page 4, line 18, replace "(6)" with "(5)"

Page 4, line 20, replace "December 31, 2024" with "January 1, 2025"

Page 4, line 24, after "recommendations" insert "for the implementation of comprehensive medication management and"

Page 4, line 28, after the first underscored comma insert "provider directories,"

Page 4, line 28, remove "and"

Page 4, line 28, after "requirements" insert ", billing standards, and potential cost-savings and cost increases to consumers"

Page 5, line 10, after "An" insert "organization representing"

Page 5, line 10, replace "nurse" with "nurses"

Renumber accordingly

Att
3-27-23
(1-2)

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1095
3/29/2023

Relating to the inclusion of comprehensive medication management services in health benefit plans.

9:04 AM **Madam Chair Lee** called the meeting to order. **Senators Clemens, K. Roers, Weston, Hogan** were present. **Senator Lee** was absent.

Discussion Topics:

- Pharmacists
- Medications
- Best practices

Senator Cleary calls for discussion.

Senator K. Roers moved to reconsider previous action.
Senator Hogan seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	AB
Senator Sean Cleary	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion passed 5-0-1.

Senator K. Roers moved to **adopt amendment,** page 3, keep the date as of December 31, 2024. LC 23.8073.02002
Senator Hogan seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	AB
Senator Sean Cleary	Y
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion passed 4-1-1.

Senator Hogan moved **DO PASS** as **AMEDNED.**
Senator Weston seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	AB
Senator Sean Cleary	Y
Senator David A. Clemens	N
Senator Kathy Hogan	Y
Senator Kristin Roers	N
Senator Kent Weston	Y

Motion passed 3-2-1.

Senator Lee will carry HB 1095.

9:14 AM **Madam Chair Lee** adjourned the meeting.

Patricia Lahr, Committee Clerk

23.8073.02002
Title.04000

Adopted by the Senate Human Services Committee

March 29, 2023

AGT 3-29-23 (1-2)

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1095

Page 2, line 26, after "to" insert "eligible"

Page 2, line 26, after "enrollees" insert "who elect to participate in a comprehensive medication management program"

Page 2, line 30, after "provider" insert ", if applicable, and"

Page 3, line 2, remove "The enrollee had three or more hospital admissions in the preceding year;"

Page 3, line 3, remove "c."

Page 3, line 4, replace "Congestive heart" with "Heart"

Page 3, line 9, replace "d." with "c."

Page 3, line 11, remove "; and"

Page 3, line 12, remove "e. Additional criteria identified by the commissioner and adopted by rule"

Page 3, line 17, after "carrier" insert "network's or health carrier's affiliate"'

Page 3, line 28, replace "medical" with "pharmacy"

Page 4, line 3, remove "The health carrier shall audit quarterly at least twenty-five percent of provider"

Page 4, remove lines 4 and 5

Page 4, line 6, remove "c."

Page 4, line 9, replace "d." with "c."

Page 4, line 11, replace "e." with "d."

Page 4, line 14, remove "Gender;"

Page 4, line 15, remove "(3)"

Page 4, line 16, replace "(4)" with "(3)"

Page 4, line 17, replace "(5)" with "(4)"

Page 4, line 18, replace "(6)" with "(5)"

Page 4, line 24, after "recommendations" insert "for the implementation of comprehensive medication management and"

Page 4, line 28, after the first underscored comma insert "provider directories,"

Page 4, line 28, remove "and"

Page 4, line 28, after "requirements" insert ", billing standards, and potential cost-savings and cost increases to consumers"

Page 5, line 10, after "An" insert "organization representing"

Page 5, line 10, replace "nurse" with "nurses"

Renumber accordingly

AG
3-29-23
(1-2)

REPORT OF STANDING COMMITTEE

HB 1095, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (3 YEAS, 2 NAYS, 1 ABSENT AND NOT VOTING). Engrossed HB 1095 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

Page 2, line 26, after "to" insert "eligible"

Page 2, line 26, after "enrollees" insert "who elect to participate in a comprehensive medication management program"

Page 2, line 30, after "provider" insert ", if applicable, and"

Page 3, line 2, remove "The enrollee had three or more hospital admissions in the preceding year;"

Page 3, line 3, remove "c."

Page 3, line 4, replace "Congestive heart" with "Heart"

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Page 3, line 11, remove "; and"

Page 3, line 12, remove "e. Additional criteria identified by the commissioner and adopted by rule"

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Page 4, line 6, remove "c."

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Page 4, line 28, remove "and"

Page 4, line 28, after "requirements" insert ", billing standards, and potential cost-savings and cost increases to consumers"

Page 5, line 10, after "An" insert "organization representing"

Page 5, line 10, replace "nurse" with "nurses"

Renumber accordingly

TESTIMONY

HB 1095

Essentia Health Fargo
Pharmacy Services
3000 32nd Ave S
Fargo, ND 58103
(701)-364-8143
Maari.loy@essentiahealth.org

Memo: Support HB1095

Dear Industry, Business, and Labor Committee:

I am writing in support of HB 1095; relating to the inclusion of comprehensive medication management services for the patients of the State of North Dakota.

The patients of North Dakota do not have access to the pharmacy services our pharmacists are eager to provide. This lack of access has a negative impact on the health outcomes our patients could achieve.

In the rural and urban areas across the state of North Dakota, Essentia Health achieves a high quality of care as the only Accountable Care Organization (ACO) across the state. Putting a pharmacist into the care mix is critical to our care model across our organization, and is currently being done. HB1095 for North Dakota will provide the access to the comprehensive medication management services our patients need in North Dakota.

Please let me know if you have additional questions. Thank you for your service to NoDak!

Respectfully,

Dr. Maari Loy, PharmD, BCPS, MBA
Pharmacy Operations Senior Manager
Essentia Health Fargo

Home Address: 1052 Morningside Ct; Casselton, ND 58012

4567 Main Street
City, State 98052
(718) 555–0100
yuuritanaka@example.com
linkedin.com/in/yuuritanaka

Yuuri Tanaka

Adrian King
Hiring Manager
VanArsdel, Ltd.
123 Elm Avenue
City, State 98052

Dear Adrian King,

Start with a statement about why you are excited about the job you are seeking. Enthusiasm is key, and your personal connection to the role is much more important than flashy words and exclamation marks. Keep it brief and easy to read quickly.

If you feel a second paragraph is needed, touch on areas of the role that interest you. State your desire to learn more, suggest a follow up call or email. Be clear about your respect for busy schedules.

(Here's a tip: be sure to try Word Editor for suggestions on how to make this cover letter the best it can be.)

Sincerely,

Yuuri Tanaka

4567 Main Street
City, State 98052
(718) 555–0100
yuuritanaka@example.com
linkedin.com/in/yuuritanaka

Yuuri Tanaka

Adrian King
Hiring Manager
VanArsdel, Ltd.
123 Elm Avenue
City, State 98052

Dear Adrian King,

Start with a statement about why you are excited about the job you are seeking. Enthusiasm is key, and your personal connection to the role is much more important than flashy words and exclamation marks. Keep it brief and easy to read quickly.

If you feel a second paragraph is needed, touch on areas of the role that interest you. State your desire to learn more, suggest a follow up call or email. Be clear about your respect for busy schedules.

(Here's a tip: be sure to try Word Editor for suggestions on how to make this cover letter the best it can be.)

Sincerely,

Yuuri Tanaka

Mr. Chairman and Committee Members,

My name is Dr. Douglas Gugel-Bryant and I am an ambulatory care clinical pharmacist working in Fargo, North Dakota. This descriptor for a pharmacist may sound foreign as many do not associate pharmacists in a specialty setting outside of the pharmacy. There are many different types of pharmacists with different trainings which delineate our expectations of practice. In my role, I do not dispense any medications like you might assume would be the role of a pharmacist.

I currently work in an outpatient primary care clinic managing patients with select disease states. I will order medications under a collaborative practice agreement with the physicians and advanced practice providers at my clinic and other primary care clinics within my healthsystem. The goal of my role is improving patient care, patient access, and outcomes. My daily activities include contacting patients over telemedicine and in office visits to help adjust medications (either increase or decrease a medication dose, start or stop a new medication, etc) to help a patient reach their health goals. As an example, in diabetes management, I will contact patients to make medication adjustments to get patient's blood sugars at goal in a timely but safe manner. This is just a brief summary of one of my duties. I am also meant to be a medication expert and resource to the staff at the clinics and for our patients answering whatever questions I can. Other aspects of my daily duties include helping patients afford and acquire their medications as well. I can confidently state that I have saved patients thousands of dollars on their medications and have been able to get patients medications which they normally would not be able to afford. This statement, in general, increases patient outcomes because they were able to take their medications they needed.

One unfortunate element is the fact that I have barriers to being able to help as many patients as possible. The greatest barriers are with delineation of what services I can provide, which patients I can help manage, and the ability for insurance coverage of my services. The current HB 1095 is a bill which would help limit those barriers I listed previously. This would allow for increased access to pharmacist services helping manage patients and improving their health outcomes and goals. This would not be limited to a certain patient in a specific location, these barriers exist for all pharmacists similar to me practicing all over the state helping any person. I am speaking on behalf of the ambulatory care pharmacists I know all over the state when I say this is an exciting bill to allow us to help as many people of North Dakota.

During pharmacy school, I was reinforced by my mentors that "the patient is why I am here". I am here to serve. I am optimistic about this bill as it will allow myself and other pharmacists like me to practice at the top of my license and serve North Dakota residents as best as possible. Thank you for your time and consideration in HB 1095.

Dr. Douglas Gugel-Bryant, PharmD, BCPS

TESTIMONY OF M HEALTH FAIRVIEW SYSTEM

January 11, 2023

Mr. Chairman and Members of the Committee:

I am Amanda Brummel, Vice President of Clinical Pharmacy Services for M Health Fairview. M Health Fairview is an integrated health system which includes 12 hospitals and 56 primary care clinics with over 100 specialties in collaboration with the University of Minnesota Physicians. In addition, we have had a comprehensive medication management (CMM) program since 1998. The CMM program has grown to include 45 pharmacists in 53 clinic locations. In 2022, the CMM team saw over 14,000 unique patients with over 33,000 visits.

We are also a member of Health-Systems Alliance for Integrated Medication Management (HAIMM). HAIMM is comprised of CMM leaders from each of the state's health systems offering CMM services. In 2021, these health systems employed 158 pharmacists and 14 PGY1 pharmacy residents in ambulatory care-focused experiences. These practitioners provided services in 251 clinic locations, generating over 111,000 encounters to over 48,000 unique patients.

Comprehensive Medication Management is the practice model that we provide in our system and in our Minnesota health system. We have demonstrated that when you ensure that each medication is indicated (appropriate for the patient's health condition), effective (it is helping the patient to meet their clinical goals), safe and that they can be adherent to the medication (no education or financial barriers), that CMM can improve clinical outcomes, decrease total cost of care, improve patient engagement and satisfaction and improve provider/care team satisfaction.

House Bill 1095 ensures that patients will have access to level of care.

H.B. 1095 Implements a Key Recommendation of the ND Health Care Cost Study

North Dakota's Health Care Cost Study, commissioned by the Insurance Department, specifically identified the need for medication optimization as a tool to control healthcare costs

for North Dakotans. The Cost Study identified that improved medication management represents "***a major opportunity for cost savings and health improvement***." As we have demonstrated in our health system and state, that is the result when comprehensive medication management has been implemented.

Comprehensive Medication Management Yields Positive ROI and Improved Outcomes

Studies of comprehensive medication management services have consistently shown that when these services are integrated in team-based care, therapeutic goals are achieved more consistently, costs decrease, and the patient and provider experience improves.

Comprehensive Medication Management Outcomes from M Health Fairview

Reduced Costs[1]

- Total health expenditures decreased from $11,965 to $8,197 per patient.
- 12:1 ROI when comparing the overall health care costs of patients receiving team-based medication management to patients who did not receive those services.

Decreased hospital readmission rates[2]

- Patients who received a medication management services after hospital discharge had a 33% lower rate of 30-day readmissions rates than patient who did not.

Improved Patient Care[3][4]

- 85% of patients had at least one medication therapy problem identified.

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[1] Brummel A, Westrich K, Evans MA, Plank GS, Penso J, Dubois RW. Best Practices: Improving Patient Outcomes and Costs in an ACO Through Comprehensive Medication Therapy Management. Journal of Managed Care and Specialty Pharmacy. 2014(20):12.

[2] Budlong H, Brummel A, Rhodes A, Nici H. Impact of Comprehensive Medication Management on Readmissions Rates. Population Health Management 2018; 21(5):395-400.

[3] Ramalho de Oliveria D, Brummel AR, Miller DB. Medication therapy management: 10 years of experience in a large integrated health care system. Journal of Managed Care Pharmacy 2010; 16(3):185-95.

[4] Brummel AR, Soliman AM, Carlson AM, Ramalho de Oliveira D. Optimal Diabetes Care Outcomes Following Face-to-Face Medication Therapy Management Services. Population Health Management. 2013;16(1):28-34. doi.org/10.1089/pop.2012.0023

- Of those, 29% had 5 or more problems identified.
- Improvement of optimal care in complex patients with diabetes, demonstrating that the percentage of patients optimally managed was significantly higher for the CMM program patients (21.49% vs. 45.45%, $P < 0.01$)

Improved patient experience

- 95.3% of patients agreed or strongly agreed that their overall health and well-being had improved as a result of team-base medication management services.
- 95% of patients rated their pharmacist as a 9 or 10 top box

Improved provider experience[5]

- Physicians reported increased satisfaction that their patients were receiving better care and highlighted increased achievement of quality measures.
    - 87% of medical providers strongly agreed that they feel confident in the medication recommendations given by M Health Fairview's CMM pharmacists
- Primary care providers reported improved workload and less mental exhaustion.

Unfortunately, existing programs implemented by most insurers to manage medication use do not always achieve these goals. H.B. 1095 improves on existing offerings to ensure patients consistently receive medication management services that are appropriately designed to achieve the cost savings and quality improvements envisioned in the Cost Study. In Minnesota we have been able to partner with our insurance providers, to ensure CMM was implemented as outlined in proposed language.

Credentialing and Inclusion of Pharmacists in Provider Networks Is Not a Barrier to Implementation

[5] Funk K, Pestka D, McClurg M, Carroll J, Sorensen T. Primary Care Providers Believe That Comprehensive Medication Management Improves Their Work-Life. Journal of the American Board of Family Medicine. 2019; 32(4):462-473.

For pharmacists working in facilities like hospitals, rural health clinics, and health centers, the bill specifically recommends that insurers rely on the credentialing that is already being done by the facility, and insurers already have contract relationships with facilities to reimburse them for services provided by members of their care teams. Since 2006 we have been credentialed by insurance providers in our state. We follow the same process that our medical providers do which would be consistent with what has been outlined. In Minnesota, we bill under the pharmacist. Medication management is a medical service, and in order to provide that services, there must be a mechanism for insurers to reimburse the care team for services provided by the pharmacists.

Insurers Should Ensure Adequate Inclusion of Pharmacists in Networks

Delivering comprehensive medication management services requires direct engagement from a pharmacist with the patient and their care team. This is a different service that dispensing medications. Simply having an existing network of pharmacies to dispense medications does not ensure that patients will have access to the clinical services of pharmacists that are essential to the implementation of medication management. Network adequacy requirement help to support this but must be realized that this may take time to fully develop. Adequate support and funding of CMM services will support the growth of the network. Also, the telemedicine support will also provide support in areas that may not have this service established yet, while growth occurs.

Comprehensive Medication Management has been a key service that we provide to our patients to ensure they are able to manage their medications, improve their health and clinical outcomes, and to reduce total costs of care. M Health Fairview supports House Bill 1095 but realizes network adequacy may take time to develop and the timeline for this may need to be phased.

HOUSE BILL NO. 1095

Presented by: Katherine H. Capps, Executive Director, Board Member, GTMRx Institute (www.gtmr.org)

Before: Human Services Committee

Date: January 17, 2023

Mr. Chairman and Members of the Committee:

I am Katherine Capps, co-founder, executive director, and board member of the Get the Medications Right Institute (GTMRx) and I am here in support of HB 1095. GTMRx is a multistakeholder coalition of over 1,700 individuals from 1,100 organizations throughout the country bringing critical stakeholders together, bound by the urgent need *to get the medications right*. We are physicians, pharmacists, health IT innovators, drug and diagnostics companies, consumer groups, employers, payers and health systems. We have come together to save lives and save money through comprehensive medication management. Our work is built on the shoulders of the Primary Care Collaborative and a 2012 resource guide designed for primary care physicians to encourage appropriate use of medications to control illness and promote health entitled *Integrating Comprehensive Medication Management to Optimize Patient Outcomes.*[1]

It is the job of the physician to make sure that patients understand how *and* when to take their medications— and when to stop their medications. But they cannot do this alone. It takes a team. Improving patient awareness of the harms and benefits associated with certain medications or combinations of medications may be the difference between life and death. We all have a personal story or a family member who has experienced some type of medication disaster. This should come as no surprise to any of us here today, the primary way we treat and prevent illness is through medications.

More than 20,000 prescription medication are on the market today.[2] Nearly 80% of patients visiting their primary care provider leave with a prescription.[3] Nearly 30% of adults take five or more medications, and that percentage is higher among those over 65. [4] Pharmaceuticals are the most common medical intervention and treatment, but their potential for both *help* and *harm* is enormous.

[1] Patient-Centered Primary Care Collaborative. The patient-centered medical home: integrating comprehensive medication management to optimize patient outcomes. 2012. www.pcpcc.org/sites/default/files/media/medmanagement.pdf
[2] Fact Sheet: FDA at a Glance
[3] Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug-Related Morbidity and Mortality. Ann Pharmacother. 2018 Sep;52(9):829-837. doi: 10.1177/1060028018765159.
[4] Medication Errors. June 2017, http://psnet.ahrq.gov/primers/primer/23/medication-errors

The question is not "are patients taking their medicine." Rather, the question is this: "Are they taking the right medications?" Merely being on the medication and staying on the medication (adherence) is not a sufficient outcome or measure for health plans and PBMs.

Medication therapy problems occur every day and carry with them a huge economic burden. Programs that support the primary care physician and the patient to ensure safe, effective and appropriate use of medications must be put in place. Only then can we effectively and comprehensively manage and address the enormous number of drug therapy problems and protect patients.

The Cost of Not Getting it Right

What happens if you take no action to advance solutions offered in House Bill 1095? Waste, more waste, and unnecessary death.

More than 15 years ago, The Institute of Medicine reported that over 1.5 million preventable adverse drug events occur annually in the United States.[5] It's only grown worse.

The human and financial toll associated of poorly optimized medications — medications that are wrong, skipped or not used as intended — is tremendous. More than 275,000 people die and $528 billion is wasted every year due to our trial-and-error approach to medication use.[6]

Misuse, underuse or overuse of medications can lead to treatment failure, adverse effects and toxicity causing significant morbidity or mortality. With over 80% of Americans now taking one or more medications per week, and rates of hospital admissions resulting from medication-related problems continuing to rise, a strategy must be implemented to ensure that we "get the medications right" for all patients.[7]

House Bill 1095 ensures that patients will have access to **comprehensive medication management** (CMM). CMM is a patient-centered approach to optimizing medication use and improving patient health outcomes. It is delivered by a clinical pharmacist working in collaborative practice with the patient and her physician. The CMM patient care process ensures each patient's medications (whether prescription,

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[5] Institute of Medicine. In: Aspden P, Wolcott J, Bootman JL, Cronenwett LR, editors. *Preventing Medication Errors*. Washington, DC: The National Academies Press; 2007. https://doi.org/10.17226/11623

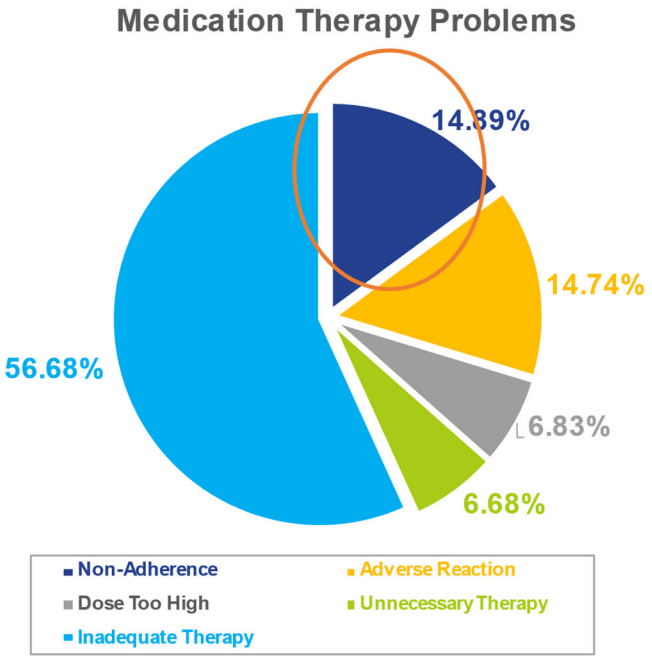
[6]Watanabe JH, McInnis T, Hirsch JD. op cit

[7] The Outcomes of Implementing and Integrating Comprehensive Medication Management in Team-Based Care: A Review of the Evidence on Quality, Access and Costs, December 2022 https://gtmr.wpenginepowered.com/wp-content/uploads/2022/12/Telehealth-Evidence-Document.v4-1.pdf

nonprescription, alternative, traditional, vitamins or nutritional supplements) are individually assessed to determine that each medication has an appropriate indication, is effective for the medical condition and is achieving defined patient and clinical goals, is safe given the comorbidities and other medications being taken, and that the patient is able to take the medication as intended and adhere to the prescribed regimen.

The evidence shows that CMM improves quality of care and has an average return-on-investment (ROI) of 3:1 to 12:1 when applied to patients with chronic conditions.[8,9,10]

CMM goes beyond medication adherence by establishing an optimal patient-centered regimen in additional to optimal use. It is critically important to consider each patient's specific personal issues – especially those with multiple chronic conditions. Our current approach to medication therapy fails to do that, and as a result, people are dying, and costs are rising.

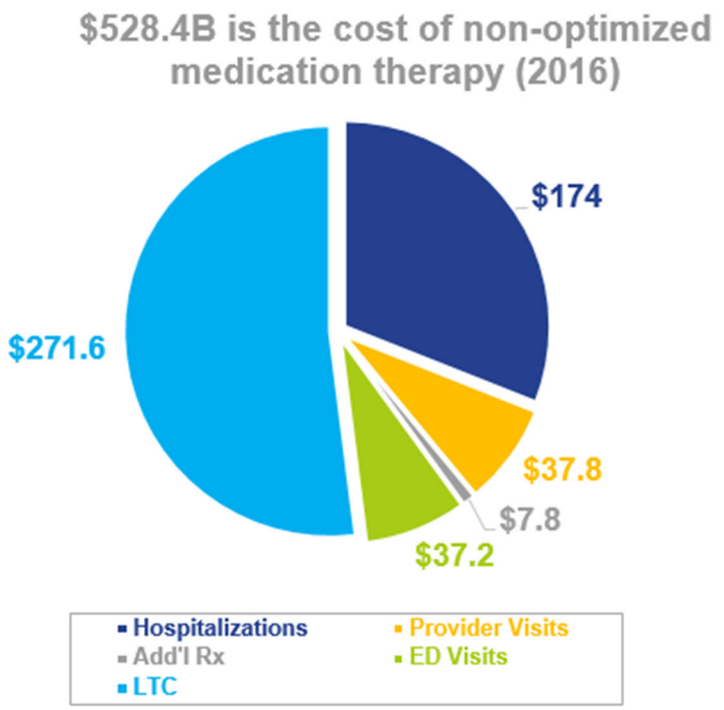


American College of Clinical Pharmacy (ACCP). Comprehensive Medication Management in Team-Based Care. https://www.accp.com/docs/positions/misc/CMM%20Brief.pdf

Beyond adherence: Addressing all medication therapy problems

As I mentioned earlier, the financial and human toll of getting the medications wrong is enormous. To solve this, we need a comprehensive way to address all medication therapy problems, not simply adherence. Working with the patient across multiple visits, the clinical pharmacist, in collaborative practice with the physician, can minimize or even eliminate medication therapy problems. It takes time: These problems run much deeper than a lack of adherence or

[8] Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug-Related Morbidity and Mortality. Ann Pharmacother. 2018 Sep;52(9):829-837.
[9] Cobb CD. Optimizing medication use with a pharmacist-provided comprehensive medication management service for patients with psychiatric disorders. Pharmacotherapy. 2014 Dec;34(12):1336-40.
[10] Cipolle RJ, Strand L, and Morley P. Pharmaceutical Care Practice: The Patient Centered Approach to Medication Management. Third Edition. New York, NY: McGraw-Hill Medical; 2012.



Watanabe, JH, McInnis, T, & Hirsch, JD. "Cost of Prescription Drug–Related Morbidity and Mortality." Annals of Pharmacotherapy, 2018; 52(9), 829–837.

medications). Medication therapy problems include dosage issues (dose too high or too low), unnecessary therapy, inappropriate medications, inadequate therapy, adverse reactions, and medications that simply don't work and need to be stopped.

It Takes a Team: Physician, Patient, Clinical Pharmacist

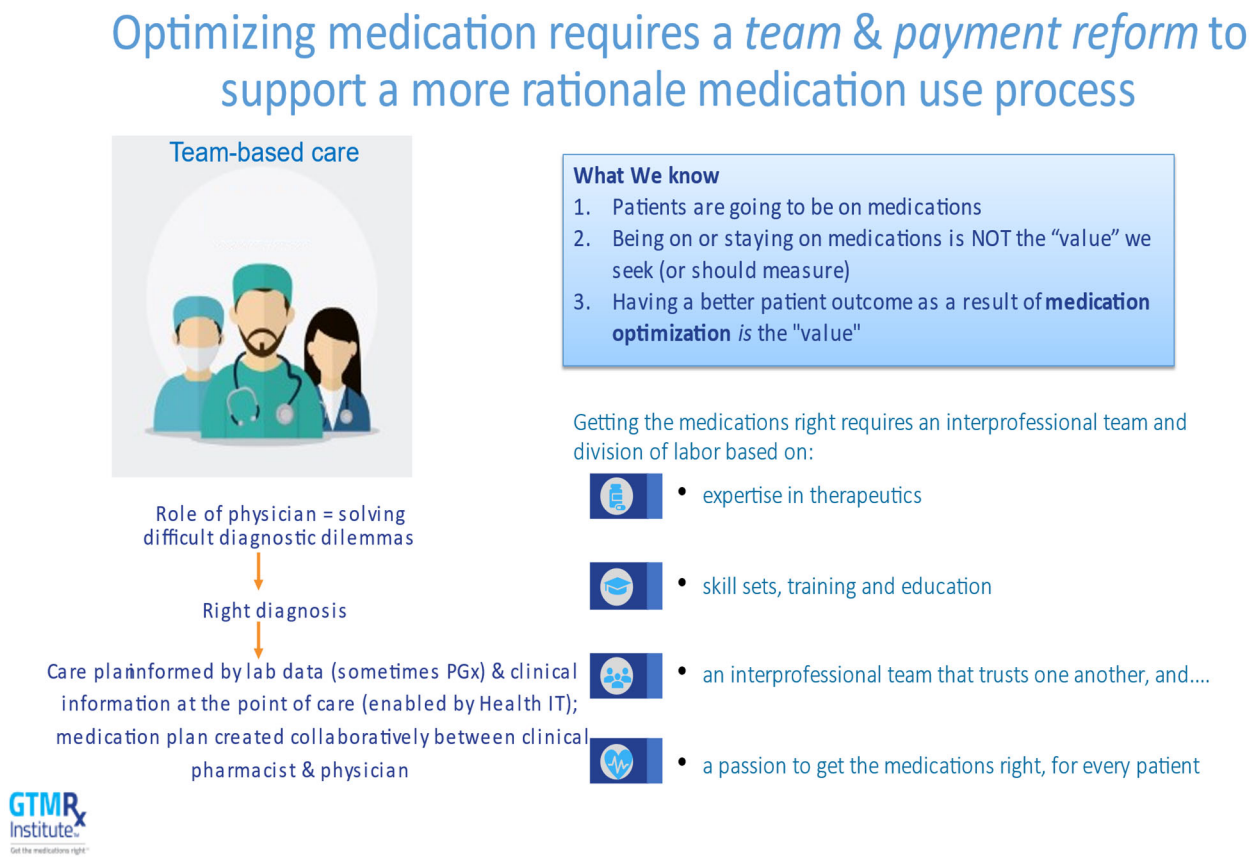
Paul Grundy, MD, president of the GTMRx Institute, former founding president of the Primary Care Collaborative in Washington, and former Chief Transformation Officer at IBM has, for decades, advocated for person-centered, team-based care. He makes the case that the physician has two primary tasks that only they can do: difficult diagnostic dilemmas and creating relationships of trust with their patients. Beyond that, they must surround themselves with other professionals with complementary skills, such as behavioral health specialists, social workers and, to our point today, clinical pharmacists. The clinical pharmacist is a medication specialist and as Grundy points out, does a much better job of managing medication and supporting patient needs around medication.

I agree with Paul that fully embracing a team-based approach cannot happen soon enough: Just as clinicians cannot hold all medical data and research in their heads, neither can they carry the total burden of patient care on their shoulders.

When team-based care is supported through professional training, collaboration, infrastructure and reimbursement models, people receive better, individualized care. This more personal, collaborative approach facilitates collection and use of appropriate information related to social risks, social needs,

barriers to care, etc. which can lead to higher quality, more equitable care, especially for people with chronic conditions.[11]

The current piecemeal approach to health care involves each provider working in a silo. That's the opposite of coordinated care. A team-based approach to medication use helps ensure that care is coordinated and medications are managed appropriately. With CMM, the clinical pharmacist is no longer siloed. They are integrated into the care team as part of a patient care process, partnering with the patient and physician for better care. In the CMM process, a clinical pharmacist works in collaborative practice with the patient, the patient's physician and other care team members to develop



an individualized medication plan that achieves the intended goals of therapy *and* includes appropriate follow-up to determine actual patient outcomes. This team-based approach ensures the patient has access to the appropriate expertise, be it the clinical pharmacist, the social worker, the nutritionist, or the behavioral health specialist.

[11] Rahayu SA, Widianto S, Defi IR, Abdulah R. Role of Pharmacists in the Interprofessional Care Team for Patients with Chronic Diseases. J Multidiscip Healthc. 2021 Jul 5;14:1701-1710

Through **House Bill 1095** you have an opportunity to make sure that patients will have access to this level of coordinated, comprehensive primary care.

Who Benefits from a More Comprehensive Way to Manage Medications?

Patients benefit; as I've already shown. In particular, CMM helps patients who

- Have multiple conditions and are being treated by multiple providers, on multiple medications.
- Are transitioning from one setting of care to another, such as a recent discharge from the hospital to home or a nursing home.
- Are being treated for complex diseases, that require multiple medications and may require balancing clinical goals with patient costs and quality of life.

Health plans benefit from improved HEDIS measures, impact on total cost of care for beneficiaries, impact on drug safety, effectiveness and appropriate use. (See table below.)

Employers benefit from a lower total cost of care, less absenteeism and fewer emergency department visits, hospitalizations and readmissions. [12,13,14,15,16]

North Dakota taxpayers benefit from the impact on reductions in total cost of care (which drive insurance premiums).

[12] Brummel, A., Lustig, A., Westrich, K., Evans, MA., Plank GS., Penso J., and Dubois RW. Best Practices: Improving Patient Outcomes and Costs in an ACO Through Comprehensive Medication Therapy Management. J of Managed Care and Specialty Pharmacy. 2014. (20): 12.
[13] The Outcomes of Implementing and Integrating Comprehensive Medication Management in Team-Based Care: *A Review of the Evidence on Quality, Access and Costs*, GTMRx, October 2020
[14] Brummel, A, Carlson, A. "Comprehensive Medication Management and Medication Adherence for Chronic Conditions." *Journal of Managed Care Pharmacy* 2016; 22 (1); 56-62.
[15] Budlong, H, Brummel, A, Rhodes, A, Nici, H. "Impact of Comprehensive Medication Management on Hospital Readmission Rates." *Population Health Management* 2018.

Physicians benefit from having a medication specialist on the team. As Paul Grundy noted, physicians need the support of the team. Peter Teichman, MD, MPA, a GTMRx Physician Advisor, made a similar case in the *AAFP Practice Journal.* "With high ratios of education and training to sphere of practice, clinical pharmacists are capable of stepping into the challenges of daily clinical care, making substantial contributions to care teams, and building robust population health program." [17]

CMM Could Improve Performance On Several HEDIS® Measures

PCE: Mgt of COPD	CDC: Comprehensive DM Care	POD: Pharmacotherapy for Opioid Use disorder	DRR: Depression Remission or Response	IET: Initiation and Engagement of Alcohol & Other Drug Abuse or Dependence Treatment	
AMR: Asthma Medication Ratio	OMW: Osteoporosis Testing & Mgt.	DDE/DAE: Medication Mgt. in Older Adults	HDO: Use of Opioids at High Dosage	UOP: Use of Opioids from Multiple Providers	COU: Risk of Continued Opioid Use
CBP/HBD: Controlling Blood Pressure	AMM: Antidepressant Medication Mgt.	PBH: Persistence of Beta Blocker (MI)	ADD: Follow-up Care for Children with ADHD	SPC/SPD: Statin Therapy (CVD & DM)	SAA: Adherence to Antipsychotic Rx (Schizophrenia)
PCR: Plan All-Cause Readmissions		EDU: Emergency Dept. Utilization		HPC: Hospitalization for Potentially Preventable Complications	
TRC: Transitions in Care		FMC: Follow-Up After ED Visit for People with Mult. High-Risk Chronic Conditions		CAHPS Health Plan Survey: Multiple Measures	

GTMRx Institute

Source: Barr, M. ACCP International Conference 10.22

Why in North Dakota? Why Now?

This isn't a political issue. Neither is it an academic issue. It is an issue of life and death. It is also an opportunity for total cost of care savings, improved health outcomes and movement toward a healthier North Dakota .

As you know, **H.B. 1095** implements a key recommendation of the North Dakota's Health Care Cost Study, ensuring that that patients will have access to optimized medications. That study, commissioned by the Insurance Department, specifically identified the need for medication optimization as a tool to control health care costs. It called improved medication management "***a major opportunity for cost savings and health improvement***." Indeed, it is. Also from the study: "If addressed appropriately, the

[17] Teichman P, Wan S. How to Integrate Clinical Pharmacists into Primary Care. *Family Practice Management*. 2021;28(3):12-17. https://www.aafp.org/pubs/fpm/issues/2021/0500/p12.html

state can reasonably expect to see lower hospital-related utilization and substantial cost savings." That has been the result where comprehensive medication management has been implemented.[18]

The point of this legislation is to ensure that all drug treatments lead to better health outcomes. You should expect nothing less from the medications that your tax dollars, your citizens and your employers pay for. Why should you pay for medications that may harm, hurt or drive people into the nursing home, back to the hospital, to the emergency room or the morgue?

As lawmakers, you have an opportunity to help your mother, your grandfather, your friends and neighbors. People are dying. Health care costs are soaring. Patients are taking medications that are making them less healthy. We can change this by getting the medications right. You have the power to change this with approval of **House Bill 1095.**

Thank you, I am happy to answer any questions you may have. The Institute stands ready to share research, evidence, use cases and financial ROI to this committee.

[18] The Outcomes of Implementing and Integrating Comprehensive Medication Management in Team-Based Care: A Review of the Evidence on Quality, Access and Costs, December 2022 https://gtmr.wpenginepowered.com/wp-content/uploads/2022/12/Telehealth-Evidence-Document.v4-1.pdf

GTMRx Buy Right Strategy

Comprehensive Medication Management in Benefits Design: *A Toolkit for Employers*

Concerned about medication misuse, underuse or overuse in your pharmacy and medical program?

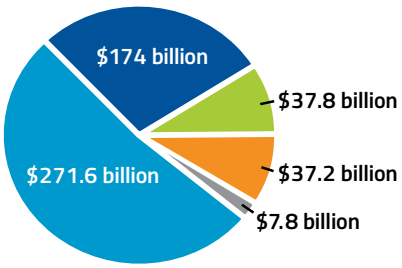
Everyone is different, not every medication is right for every person. Comprehensive medication management (CMM) is a well-established process of care that ensures that every medication an individual takes is appropriate and effective for them.

CMM is *different* from medication therapy management (MTM), a broad term that has, over the years, come to include all sorts of activities related to pharmacy benefit management (PBM). MTM activities are not clearly defined or implemented in a standard way by PBMs and health plans. Employers should be wary of programs that offer only single service activities (ex. adherence, medication reconciliation, comprehensive medication review) such as those found in Medicare Part D prescription drug plans; this is not CMM. CMM is a well-defined process to optimize medication use that has delivered consistent results. This 10-step process of care is delivered in collaborative practice with a physician by a qualified member of the health care team (usually a clinical pharmacist) and designed specifically to ensure that all medications are optimized for that patient. It may also include tools such as pharmacogenomic (PGx) testing to target correct therapies. CMM is a patient-focused process versus a medication-focused activity.

This toolkit explores the benefits of CMM for individuals and for the employers who pay for benefits. Research published in March 2018 reveals the waste to the system when the wrong drugs are prescribed, drugs are skipped or make people sicker, cause an estimated 275,689 deaths per year.[1] In financial terms, there's also a $528 billion price tag attributed to non-optimized medication use.

Non-optimized medication use costs $528.4 billion in waste attributed to:

- Long-Term Care Admissions
- Hospitalizations
- Emergency Department Visits
- Provider Visits
- Additional Prescriptions



Decreasing waste, improving quality and ensuring appropriate use of medications through health benefit design is a high priority for employers. As you plan your health benefit strategy (for pharmacy and medical), and as you seek to contract for programs that optimize medication use and manage medication therapy problems, use this toolkit to work with your:

About the GTMRx Institute

The **Get the Medications Right Institute** brings critical stakeholders together, bound by the urgent need to optimize outcomes and reduce costs by getting the medications right. We are physicians, pharmacists, nurses, patients, health IT innovators, drug and diagnostics companies, consumer groups, employers, payers—aligned to save lives and save money through comprehensive medication management. Our goal is to ensure appropriate and personalized use of medication and gene therapies by advancing a scientific, evidence-based and cost-effective decision-making process and a team-based, systematic approach to medication use. We believe this will offer consumers a personalized approach to medication use. For those who pay for care, it will create a reduction in total cost of care—saving lives and saving money.

Questions? See our *GTMRx Belief Statements*

1 Watanabe J, et al. Cost of Prescription Drug–Related Morbidity and Mortality. Annals of Pharmacotherapy, March 26, 2018. Accessed 3 April 2018. http://journals.sagepub.com/eprint/ic2iH2maTdI5zfN5iUay/full.

- Pharmacy Benefit Managers (PBMs)
- Medical carriers
- Benefit consultants
- Solution providers (PGx, others)
- Employees

Use this infographic to guide discussions with others: *Drug Spend: Decrease Waste, Improve Quality, and Ensure Appropriate Medication Use.*

> ***"CMM starts with the patient, not the pills."***
>
> — **Katherine H. Capps, Executive Director, Get the Medications Right Institute**

What is CMM? The standard of care that ensures each patient's medications (whether they are prescription, nonprescription, alternative, traditional, vitamins or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken and able to be taken by the patient as intended.[2]

Return on Investment for CMM

The return on investment (ROI) of CMM has been well documented, as articulated by Cipolle, et al., "to average around 3:1 to 5:1 and can be as high as 12:1, resulting in a reduction in the direct mean medical cost of between $1200 and $1872 per patient per year for each of the first 5 years for those patients with chronic diseases such as diabetes, cardiovascular health issues, asthma and depression."[3] The evidence of its effectiveness continues to grow. It has been shown to:

- improve the health of populations
- enhance the experience of care for individuals
- reduce per capita cost of health care
- improve access to care and improve physician satisfaction and work/life balance

How CMM Works

CMM is a patient-centered care process designed to optimize medication use and improve patient health outcomes. Usually a clinical pharmacist, in collaborative practice with a physician, provides the service, working in partnership with the patient, nurses and others on the health care team.

CMM begins with a recommendation from a physician to consult with a clinical pharmacist on the care team and includes *all* the steps of the CMM process (Figure 1). Just as the services of physical therapists, behavioral health workers, dieticians and others are necessary to provide the patient with coordinated, comprehensive care, CMM strengthens the ability of the team and makes everyone more effective. When delivered in the manner described, CMM contributes unique data, quality decisions and new solutions for patients and important new knowledge about the effectiveness and safety of medications across the continuum of care.[4]

It starts with an assessment to determine:

- ✔ **Is this medication needed?**
- ✔ **Is this medication appropriate?**
- ✔ **Is this medication effective?**
- ✔ **Is this medication safe if taken with other medications?**
- ✔ **Is the patient able to take the medication as intended?**

Once a determination is made that the medication is safe, effective and appropriate (sometimes with use of diagnostics tools such as pharmacogenomics [PGx]), the patient's ***ability to adhere*** to the prescribed regimen is considered.

Identifying medication therapy problems

Medication problems generally fall into three "buckets": ***overuse*** of medications that don't improve health and may cause harm; ***underuse*** of critical drugs needed for acute or chronic health problems; and ***misuse*** of medications such as opioids. All three can contribute to higher costs and impact health, particularly for patients:

- with one or more chronic condition
- who take a number of medications
- who see multiple physicians (prescribers).

2 McInnis, Terry, et al., editors. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes.* 2nd ed., Patient-Centered Primary Care Collaborative. PCPCC Medication Management Task Force collaborative document.

3 Cipolle RJ, Strand L, and Morley P. Pharmaceutical Care Practice: The Patient Centered Approach to Medication Management. Third Edition. New York, NY: McGraw-Hill Medical; 2012.

4 *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes.* 2nd ed., Patient-Centered Primary Care Collaborative. PCPCC Medication Management Task Force collaborative document.

Figure 1. 10 Steps to Achieve CMM

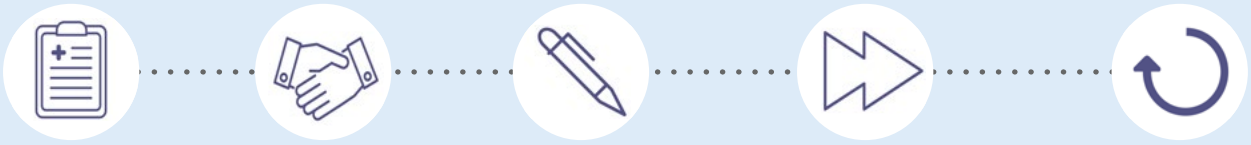
1. Identify patients that have not achieved clinical goals of therapy.

2. Understand the patient's personal medication experience, history, preferences & beliefs.

3. Identify actual use patterns of all medications including OTCs, bioactive supplements & prescribed medications.

4. Assess each medication for appropriateness, effectiveness, safety (including drug interactions) & adherence, focusing on achievement of the clinical goals for each therapy.

5. Identify all drug therapy problems.



6. Develop a care plan addressing recommended steps including therapeutic changes needed to achieve optimal outcomes.

7. Ensure patient agrees with & understands care plan which is communicated to the prescriber or provider for content & support.

8. Document all steps & current clinical status vs. goals of therapy.

9. Follow-up evaluations are critical to determine effects of changes, reassess actual outcomes & recommend further therapeutic changes to achieve desired clinical goals & outcomes.

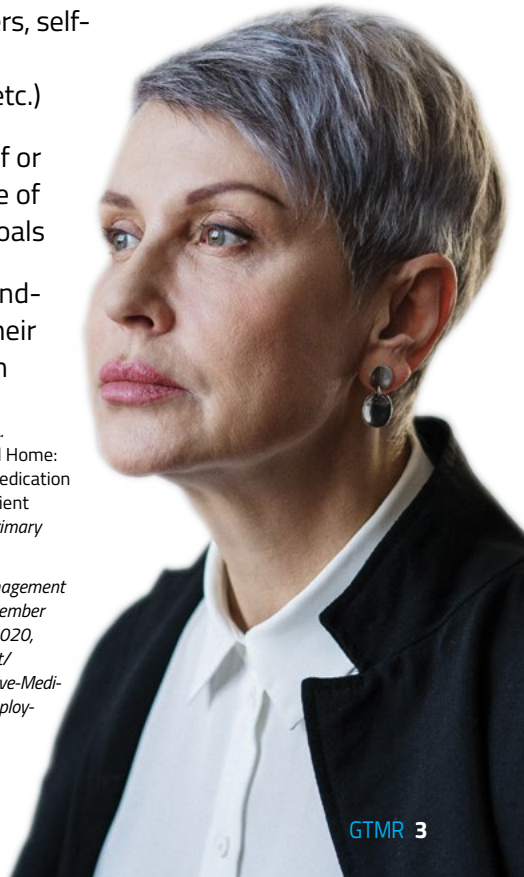
10. CMM is a reiterative process! Care is coordinated with other team members & personalized goals of therapy are understood by all team members.

McInnis, Terry, et al., editors. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes.* 2nd ed., Patient-Centered Primary Care Collaborative, The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes. PCPCC Medication Management Task Force collaborative document.

Patients Who Benefit Most from CMM

Significant evidence is accumulating to establish the positive impact that CMM has on patient outcomes.[5] Patients who benefit most include those:

- With one or more chronic conditions treated by multiple providers/multiple patients taking multiple medications
- With high ER/urgent care/hospital utilization
- With one or more complex medications requiring specialized administration and frequent outcomes assessments
- Transitioning between specialists and primary care providers visits, ER/Urgent Care visits, or discharge from a hospital/long-term care facility
- At risk for sub-optimal clinical outcomes due to medication therapy problems such as errors in self-administration, doses too high or low, adverse drug reactions, etc.
- Taking new medications requiring personalized education and on-going assessment of outcomes (inhalers, self-injectables, narrow therapeutic index, etc.)
- Showing absence of or erratic maintenance of intended therapy goals
- Problems understanding and following their medication regimen



McInnis T, Webb E, and Strand L. The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, *Patient Centered Primary Care Collaborative, June 2012*

Comprehensive Medication Management FAQ for Employers. (GTMRx November 2020). Retrieved December 1, 2020, from https://gtmr.org/wp-content/uploads/2020/11/Comprehensive-Medication-Management-FAQ-for-Employers-11252020.pdf

5 https://www.amjmed.com/article/S0002-9343(20)31173-6/abstract

CMM and Value-Based Payment

Because CMM decreases waste in the system and delivers on the promise of the Quadruple Aim[6] (improve the health of populations, enhance the experience of care for individuals, reduce the per capita cost of health care and improve provider satisfaction), it provides measurable value that can serve as the basis for payment.

Employers can pay for CMM services provided as part of contracted services from health plans, medical carriers and PBMs through:

- agreements with carved-out CMM service providers;
- agreements with accountable care organizations (ACOs) or colleges of pharmacy; or
- by linking providers to existing value-based structures such as MACRA (Medicare Access and CHIP Reauthorization Act of 2015), that provide incentives to providers to adopt CMM.

See CMM use cases and learn more from the experience of commercial health plans, retirement systems, government payers and employers.

> ***"The problem is not solely the inability to keep people on medications. It's also a failure to optimize medication use. This requires going upstream in the medication use process and first ensuring every medication is appropriate, effective, safe and that the patient is willing and able to take it as prescribed."***
>
> — **Sandra Morris, Senior Advisor, GTMRx Institute, Former Senior Benefits Manager, Procter & Gamble**

CMM and PGx Testing

Pharmacogenomics (PGx) is the study of how a patient's genetic profile determines their body's metabolic responses to specific medications. The role of PGx testing has a significant place in determining which drugs match best to which patients in the right amounts at the right time. With CMM, physicians working in collaborative practice with a pharmacist, can leverage PGx testing and interpretation to guide use of the right medications. When used as a diagnostic tool as part the CMM process, PGx testing allows for precisely fitted and delivered medical care based on the unique characteristics of an individual patient's genetic profile, their lifestyle and environment. The outcomes of PGx testing combined with CMM include:

- Reduced cost
- Better patient outcomes
- Improved provider satisfaction
- Improved access to care

Employer Resources from GTMRx: GENERAL

To learn more about the value of CMM for payers, consumers and society, CMM Value Framework: **7-MINUTE READ**

Employer Resources from GTMRx: EVIDENCE

The Outcomes of Implementing CMM in Team-Based Care: **17-MINUTE READ**

Outcomes of Implementing and Integrating PGx within CMM in Team-Based Care: **18-MINUTE READ**

Teacher's Retirement System of Kentucky: Pharmacogenomics: Improving outcomes, lowering costs by making precision medicine personal: **10-MINUTE READ**

Employer Resources from GTMRx: FAQS & TOOLS

GTMRx FAQs for Employers: **10-MINUTE READ**

Contracting for CMM Services: **7-MINUTE READ**

Employer Resources from GMTRx: RATIONALE

The Problem: Starting or continuing medications without a comprehensive evaluation of the patient's health issues and medications: **4-MINUTE READ**

Employers as Changemakers: Why Employers Should Care About CMM: **4-MINUTE READ**

Moving from Precise to Personalized Medication Management with PGx and CMM: **7-MINUTE READ**

Employer Resources from GTMRx: USE CASES

Use Cases of CMM in Practice: **5-MINUTE READ**

"Mike's Journey: A Patient and His Physician Talk about Getting His Medications Right with CMM + PGx": **LISTEN TO PODCAST**

6 Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med 2014;12(6):573-6. https://doi.org/10.1370/afm.1713.

CALL TO ACTION

Employers have intrinsic interest in workforce well-being to ensure employees remain productive. They also hold the power of the purse to shape benefit plans. Outlined are seven steps employers as health plan sponsors can take to decrease waste and ensure value from dollars spent on the drug benefit by making CMM an integral part of the employee health benefit strategy:

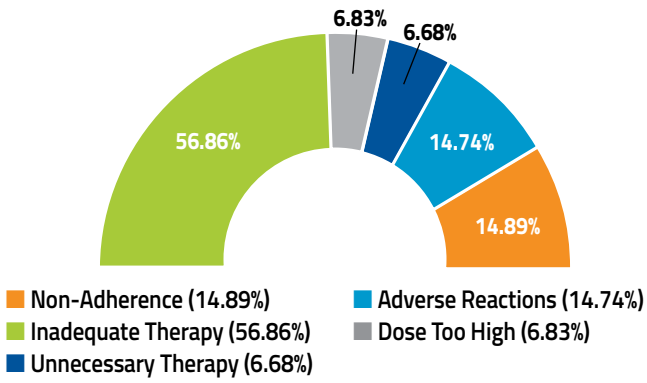
1 **Learn more about CMM** to inform discussions with your current vendors. Medical carriers, PBMs, TPAs and ACOs may provide MTM services, but they are limited in scope and effectiveness in dealing with medication therapy problems beyond adherence (Figure 2). Tools that will help:

- Read an overview of the patient care process for delivering CMM and how CMM programs are being used today.
- Share with your benefit consultants and vendors the 10 Steps to Achieve Comprehensive Medication Management and the review of the evidence for implementing and integrating CMM in team-based care.
- Explore use cases demonstrating how organizations across the country are optimizing medication use through CMM and talk to your existing vendors about piloting similar programs for your members.

2 **Talk to your medical carriers, health plans and PBMs** asking them to share their strategies and new product and service solutions designed to optimize medication use (beyond adherence programs). Be open to their offer to pilot projects designed to meet your goals. Points to guide your discussion:

- Let them know that the current trial-and-error approach to medication use must change.
- Ask your medical carrier how they currently identify individuals who haven't met clinical goals of therapy and how they evaluate and mitigate issues such as wrong dose, adverse events, inadequate therapy, failed therapy, non-adherence and deprescribing.

Figure 2. Types of Medication Therapy Problems[7]
It's not all about adherence!



- Ask your medical carrier or PBM about their quality improvement process for addressing medication therapy problems beyond adherence alone.
- Ask your PBM's clinical pharmacists how they plan to integrate PGx testing effectively within your plan.
- Ask your medical carrier and PBM what measurement practices are in place to catalyze appropriate, safe, effective medication use.
- Ask your medical carrier and PBM how they reward network providers who consistently deliver care that is free from medication misadventures (overuse, underuse and misuse of medications).
- Ask your medical carrier and PBM if their network providers can access an integrated medication record ***and*** the patient's clinical data at the point-of-care to ensure the right information is available to evaluate, manage and change medications as appropriate.

> *"We're trying to change the status quo and transform pharmacy benefits."*
>
> — **Cheryl Larson, CEO, Midwest Business Group on Health (MBGH)**

7 Comprehensive Medication Management in Team-Based Care. American College of Clinical Pharmacy. www.accp.com/docs/positions/misc/CMM%20Brief.pdf

3 **Collect the right data.** Ask your medical carrier, TPA, and PBM to work with you to create trend reports that identify those members in greatest need for CMM services.

- Work with your local business coalition to define common terms, specific data queries and simple claims analysis methods to paint a top-line picture of benefits (cost, quality and utilization impact) gained by implementing CMM programs for your population.

4 **Gain leadership support.** After identifying current gaps and gathering data from your vendors, use it to gain leadership support to ensure that investments are used to optimize medication use and that CMM is covered as a health benefit.

5 **Engage brokers and consultants.** Ask them to identify new products and services designed to optimize medication use through the delivery of CMM. Keep in mind, traditional MTM programs do not focus on all activities needed to manage and mitigate medication therapy problems (Figure 2).

6 **Use your contract authority.**

- Align and integrate optimized medication use as an overall patient care and health benefit strategy.
- Use benefit plan design to shape vendor response and encourage innovative product solutions.
- Design and encourage health plan payment models that sufficiently support CMM services and recognize opportunities for virtual access to these services (telehealth as a modality to deliver CMM.)
- For PBMs, require use of available, clinically-proven pharmacogenomic testing to guide decision making in prior authorization for medication use.
- Waive step-therapy requirements and financial penalties related to formulary use if, through CMM and/or pharmacogenomic means, a specific medication is determined to be most appropriate for the patient.

7 **Build primary care and other stakeholder alliances.** Ally with your employer health care coalition and work with primary care in your community to identify how you can support value-added primary care services designed to optimize medication use through your medical plan design.

About this Tookit

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The Outcomes of Implementing and Integrating Comprehensive Medication Management in Team-Based Care: *A Review of the Evidence on Quality, Access and Costs, December 2022*

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Each year in the United States, over $528 billion is wasted and 275,000 lives are lost due to non-optimized medication use.[1] Misuse, underuse or overuse of medications can lead to treatment failure, adverse effects and toxicity causing significant morbidity or mortality. With over 80% of Americans now taking one or more medications per week, and rates of hospital admissions resulting from medication-related problems continuing to rise, a strategy must be implemented to ensure that we "get the medications right" for all patients.[2,3] Comprehensive medication management (CMM) is a patient-centered approach to optimizing medication use and improving patient health outcomes. It is delivered by a clinical pharmacist working in collaboration with the patient and other health care providers. The CMM patient care process ensures each patient's medications (whether prescription, nonprescription, alternative, traditional, vitamins or nutritional supplements) are individually assessed to determine that each medication has an appropriate indication, is effective for the medical condition and achieving defined patient and clinical goals, is safe given the comorbidities and other medications being taken, and that the patient is able to take the medication as intended and adhere to the prescribed regimen.[4]

Integration of CMM into existing patient care processes ensures a "whole health" focused approach. The value of CMM lies in the ability of medication optimization to facilitate achievement of the goals defined as the quadruple aim of health care: improving the quality of care, reducing health care costs, improving both patient and health care provider experience.[5]

This document summarizes key findings from published studies evaluating the value of CMM in supporting the quadruple aim. The studies selected have integrated CMM into team-based care in a myriad of different health care systems spanning the spectrum from individual provider offices with privately insured patients to non-profit value-based payment health care systems and government run health care systems. Regardless of the location, findings are consistent that when CMM is integrated into team-based care, therapeutic goals are achieved, costs decrease and the patient and provider experience improves. Importantly, as we strive to achieve health equity, the fifth element of the new quintuple aim of health care, new research has demonstrated the ability of CMM to help in reaching that goal.[6] Clinical pharmacists have already demonstrated the value of CMM in increasing patient access to health care, and work is underway to develop processes for identifying and addressing social determinants of health that may adversely impact the ability to achieve medication optimization. The document will continue to evolve as the integration of CMM into health care expands and the data on its value continues to grow.

Produced by Health2 Resources GTMRx Institute 2022© | 12.2022

I. Summary of Data on Improved Quality of Care and Reduced Costs after Implementing CMM

CMM results in over $1 million savings in Texas primary care clinics during incentive payment program

- A one-year observational study of 3,280 adult patients participating in a Texas delivery system incentive-based payment reform program revealed significant cost savings in those receiving CMM. Patients were eligible for the CMM program if they were receiving more than four medications and had been diagnosed with at least one chronic disease (diabetes, hypertension, heart failure, COPD or asthma). A clinical pharmacist reviewed the patients' records and created action plans for 290 patients with a total of 311 medication-therapy problems (MTPs). Two physicians conducted independent reviews of the pharmacist's recommendations to establish inter-rater reliability of the MTPs, with agreement on a final count of 301 MTPs in 280 patients.
    - **Better care:** Of the identified problems, recommendations for 150 (49.8%) were fully implemented by the primary care team, with the other 129 (42.8%) partially implemented. The majority were categorized as related to medication safety/adverse drug reactions (56.8%), with the second most common category being medication indication (34.9%).
    - **Reduced costs:** Resolution of MTPs resulted in an estimated cost savings of $1,143,015 in 2016 US dollars. The largest portion of this cost avoidance was achieved through the prevention of 62 hospital admissions.

Chung TH, Hernandez RJ, Libaud-Moal A, et al. The evaluation of comprehensive medication management for chronic diseases in primary care clinics, a Texas delivery system reform incentive payment program. BMC Health Services Research. 2020; 20:671. doi: 10.1186/s12913-020-05537-3.

Retrospective analysis of economic and utilization outcomes of CMM in a large Medicaid plan using a novel artificial intelligence platform

- In this observational study, the authors used mixed-effects regression models to assess savings and associated economic impact of a modified CMM program. This program incorporated the principles of CMM, including its holistic approach, but it did not involve embedment in a clinic with the team and patient. Instead, the pharmacists interacted with patients by phone; assisted with their care by an advanced artificial intelligence platform that created a patient profile; and provided clinical decision support. Pharmacists provided recommendations via fax or by phone to providers for a total of 2,150 Medicaid members ages 40-64 years with an average of 10 medications for chronic conditions. Cost and utilization data were compared from 2017 and 2019 to capture the impact of the addition of CMM in 2018.
    - **Better care:** A total of 7,485 interventions were made with 46,090 recommended actions. The majority of recommended actions (84.6%) were to stop the medication because it was either not needed or duplicate therapy. The next most common action (32.3%) was to change a medication dose to optimize therapy.
    - **Reduced costs:** The authors found a statistically significant decrease in the total cost of care of 19.3% ($p < 0.001$) or $554 per patient per month. Medication costs alone decreased by 17.3% ($p < 0.001$) or $192 per patient per month.

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- There was a 15.1% decrease in emergency department visits, a 9.4% decrease in hospitalizations and a 10.2% decrease in days of hospital admission (all results statistically significant).
- Assessing the savings in light of the cost of program implementation and maintenance, the authors reported a 12.4:1 return on investment.

Kessler S, Desai M, McConnell W, et al. Economic and utilization outcomes of medication management at a large Medicaid plan with disease management pharmacists using a novel artificial intelligence platform from 2018 to 2019: a retrospective observational study using regression methods. Journal of Managed Care and Specialty Pharmacy. 2021; Sep;27(9):1186-1196. doi: 10.18553/jmcp.2021.21036.

Real-world impact of a pharmacogenomics-enriched CMM program

- A novel program incorporating pharmacogenomics (PGx) into CMM services has recently shown to be valuable in moving patients closer to their treatment goals when compared to standard care. Patients in the Kentucky's Teachers' Retirement System were offered the opportunity to enroll in the PGx-CMM program, with the results from the 5,288 who enrolled compared to a group of 22,387 patients who chose to continue standard care over the initial 32-months of the program. The characteristics of the two groups were similar at baseline, however the patients who chose to enroll in the PGx-CMM program were on more medications.
  - **Better care:** A total of 4,716 medication therapy problems were identified in the PGx-CMM group resolved through 3,228 medication action plans made by the pharmacist.
  - **Reduced costs:** When compared to the patients receiving standard care, participants in the PGx-CMM group experienced an average reduction of $7000 in direct medical charges. The authors also noted a positive shift in healthcare utilization away from acute care (emergency department use or hospitalization) and towards greater use of primary care options.

Jarvis JP, Peter AP, Keogh M, et al. Real-world impact of a pharmacogenomic-enriched comprehensive medication management program. Journal of Personalized Medicine. 2022;12(3):421. doi: 10.3390/jpm12030421.

Positive impact of CMM on diabetes outcomes in Federally-Qualified Health Centers (FQHCs)

- This retrospective study highlights the results from 8 FQHCs participating in the *BD Helping Build Healthy Communities* program that used the funding to support integration of CMM services. These centers provided care for diverse patients populations in sites throughout the US: Arizona, California (San Marcos and Los Angeles), Florida, Indiana, Mississippi, New Jersey and Puerto Rico. Within the CMM services provided, patient education and instructions for self-monitoring were emphasized.
  - **Better care:** A total of 2,502 patients were included in the study, with a primary outcome of change in hemoglobin A1c (A1c) at 6 months and a secondary outcome of change in systolic blood pressure (SBP).
    - A statistically significant reduction in A1c was documented between baseline and the 6-month follow-up (9.4 vs 8.2, $p < 0.01$), as well as a statistically significant reduction in SBP (140.8 vs 130.2 mm Hg, $p < 0.05$).
    - Patients demonstrated sustained reductions in both A1c and SBP beyond 6 months, with a reduction in A1c still present at the 24-month evaluation.

Pastakia SD, Clark A, Lewis K, et al. The impact of clinical pharmacist led comprehensive medication management on diabetes care at Federally Qualified Health Centers within the BD Helping Build Healthy Communities program. Journal of the American College Clinical Pharmacy. 2022;5:273-282. doi.org/10.1002/jac5.1679.

Healthcare utilization and outcomes in cardiovascular patients receiving CMM services

- This quasi-experimental three-year non-randomized clinical study evaluated the impact of CMM services in older patients (ages 65-80 years) with established cardiovascular disease. Patients could self-refer to a pharmacist providing CMM serves or could be referred by their physician or other health-care providers. Patients receiving usual care (not referred or electing to have CMM) served as the control group. Parameters compared included blood pressure, A1c, LDL, TC and healthcare utilization.
  - **Better care:** Patients in the CMM group achieved statistically lower systolic and diastolic blood pressures (mean change -9.02 mm Hg and -4.99 mm Hg, respectively, both $p < 0.001$). Total cholesterol and LDL were also significantly lower in the CMM group compared to controls. While the mean A1c declined to a greater extent in the CMM patients, the difference compared to controls was not statistically significant.
  - **Reduced costs:** The number of hospital admissions was 3.35 higher in the control group (95% CI 1.16-10.00). Unplanned primary care visits were 2.34 times more frequent in the controls (95% CI 1.52-3.57).

Brajkovic A, Bosnar L, Gonzaga do Nascimento MM, et al. Healthcare utilization and clinical outcomes in older cardiovascular patients receiving comprehensive medication management services: A nonrandomized clinical study. International Journal of Environmental Research and Public Health. 2022;19:2781. doi: 10.3390/ijerph19052781.

Best practices: improving patient outcomes and costs in an ACO through comprehensive medication therapy management

- Since 1998, pharmacists at the Fairview Health System have cared for more than 20,000 patients and resolved more than 107,000 medication-related problems which, if left unresolved, could have led to hospital readmissions and emergency department visits. Fairview Pharmacy Services utilized 23 CMM pharmacists (approximately 18 full-time equivalents) working in 30 locations, who conduct pharmacotherapy workups as part of the medication optimization services.
  - **Better care:**
    - Approximately 27% of patients needed additional drug therapy and medication dosages increased.
    - Thirteen percent of the drug therapy problems were the result of unnecessary drug therapy and inappropriately high dosages.
  - **Reduced costs:** Fairview MTM showed a 12:1 ROI when comparing the overall health care costs of patients receiving services to patients who did not receive those services.
    - Total health expenditures decreased from $11,965 to $8,197 per person ($n = 186$, $p < 0.0001$).
    - Pharmacist-estimated cost savings to the health system over the 10-year period were $2,913,850 ($86 per encounter), and the total cost of CMM was $2,258,302 ($67 per encounter), for an estimated ROI of $1.29 for every dollar spent.

Brummel A, Lustig A, Westrich K, Evans MA, Plank GS, Penso J, Dubois RW. Best Practices: Improving Patient Outcomes and Costs in an ACO Through Comprehensive Medication Therapy Management. J of Managed Care and Specialty Pharmacy. 2014. (20): 12.

Budget impact analysis of a pharmacist-provided transition of care program

- Synergy Pharmacy Solutions (SPS) initiated a pharmacist-provided transition of care program for adult members of Kern Health Systems (KHS) managed Medicaid health plan who were classified as high risk using the Johns Hopkins Adjusted Clinical Groups (ACG) predictive model. High-risk patients admitted to participating hospitals were referred to the SPS TOC program and contacted via telephone within two to four days after discharge. Once a referred patient agreed to participate, the SPS team provided CMM.
  - **Reduced costs:** A budget impact analysis was conducted using a decision-tree model developed and built from the payer perspective. This tool was used to evaluate the impact of the program expansion to additional participating hospitals on total health care costs, including inpatient, outpatient, medication and emergency department costs, in six-month increments up to two years.
    - The budget impact model showed that in the first six months, the CMM program resulted in cost avoidance of over $4.3 million in total health care costs to the plan, which corresponded to $3 per member per month.
    - By the end of year two, the savings reached over $4 per member per month, for a total of $25.6 million.

Ni W, Colayco D, Hashimoto J, Komoto K, Gowda C, Wearda B, McCombs J. Budget Impact Analysis of a Pharmacist-Provided Transition of Care Program. Journal of Managed Care & Specialty Pharmacy. Feb 2018.

Comprehensive medication management results in improved care and cost savings in mental health system

- Psychiatric patients have multiple risk factors for chronic medical conditions and their need for multiple medications increases the risk of adverse events, drug interactions and poor adherence. This retrospective study of CMM assessed the quality of the service provided and patient outcomes within a mental health system through initial and follow-up visits focused on chronic medical conditions and psychiatric therapy.
  - **Better care:** Complex patients were referred to the CMM clinic with a mean of 13.7 medications and 10.1 medical conditions per patient. Providers found an average of 5.6 medication-related problems per patient, the most common being adverse drug reactions, unnecessary medications, inappropriate doses and poor adherence. Overall, clinical status improved in 52% of patients.
  - **Reduced costs:** The service projected a net cost avoidance of $90,484 over 2.25 years, or $586.55 per patient from avoidance of hospitalization or emergency department visits (33.7%) and savings in medication costs (66.3%). This resulted in an ROI of $2.80 per dollar spent.
  - **Improved patient experience:** A patient satisfaction survey indicated that 93% of patients felt the service was "extremely" or "very helpful", noting the positive changes made to their medication regimens. The majority of patients (89%) would refer friends or family for a medication review.

Cobb CD. Optimizing medication use with a pharmacist-provided comprehensive medication management service for patients with psychiatric disorders. Pharmacotherapy. 2014;34:1336-1340. doi.org/10.1002/phar.1503.

Medication therapy management: 10 years of experience in a large integrated health care system

- Assessment of the clinical, economic and humanistic outcomes of 10 years of experience with medication optimization within Minnesota's Fairview Health Services utilizing medication therapy management (a precursor to CMM). Data from 33,706 patient encounters were included in the evaluation.

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- **Better care:** 85% of patients had at least one medication therapy problem identified. Of those, 29% had 5 or more problems identified. The most frequent issues were the need for an additional medication (28.1%) and adjustment of a subtherapeutic dose (26.1%). Fifty-five percent of patients not at goal at the time of enrollment in the program improved after their medication regimens were optimized.
- **Reduced costs:** The program produced an average cost savings per encounter of $86. Average cost to provide the service was $67 per encounter, producing an estimated return on investment of $1.29 per $1 spent in administrative cases.
- **Improved patient experience:** 95.3% of patients surveyed gave a rating of agree or strongly agree to the statement that their overall health and well-being had improved as a result of the service.

Ramalho de Oliveira D, Brummel AR, Miller DB. Medication therapy management: 10 years of experience in a large integrated health care system. Journal of Managed Care Pharmacy 2010;16(3):185-95. doi: 10.18553/jmcp.2010.16.3.185.

The effect of clinical pharmacist-led comprehensive medication management on chronic disease state goal attainment in a patient-centered medical home

- A retrospective comparison study of the effect of pharmacist-led CMM on achievement of chronic diabetes treatment goals. This study took place in 11 clinics within a primary care network designated as a patient-centered medical home and affiliated with a large academic medical center. Achievement was defined as reaching a combined goal of a hemoglobin A1c < 8%, blood pressure < 140/90, and placement on statin therapy for dyslipidemia.
  - **Better care:** 40% of patients receiving CMM reached the combined treatment goal versus only 12% of patients in the control group ($p < 0.001$) over the 13-month study. Patients receiving CMM also had significantly greater improvement in individual assessments of A1c, blood pressure and use of a statin from their baseline to the completion of the study.

Prudencio J, Cutler T, Roberts S, Marin S, Wilson M. The Effect of Clinical Pharmacist-Led Comprehensive Medication Management on Chronic Disease State Goal Attainment in a Patient-Centered Medical Home. Journal of Managed Care & Specialty Pharmacy, 24 (5): 423-429. 2018. doi: 10.18553/jmcp.2018.24.5.423.

Comprehensive medication management leads to improvements in diabetes, hypertension and dyslipidemia

- In 2008, Brazil's Ministry of Health established the Nucleo de Apoio a Saude da Familia (Family Support Teams), multidisciplinary teams consisting of pharmacists, nutritionists, physical therapists and social workers, to support the primary care physician and nurse. After implementation of CMM services, treatment goals were assessed using a quasi-experimental study design in 1,057 patients covered by five clinical pharmacists over a 2-year period.
  - **Better care:** The mean difference from initial to final values showed statistically significant improvement for A1c (-0.8 +/- 0.4), systolic and diastolic blood pressure (-3.3 +/- 1.5 and -1.4 +/- 1.0), low-density lipoprotein cholesterol (-19.5 +/- 6.0) and total cholesterol (-21.0 +/- 7.3).

Santos BD, Nascimento MMGD, de Oliveira GC, et al. Clinical impact of a comprehensive medication management service in primary health care. Journal of Pharmacy Practice 2019;0897190019866309. doi:10.1177/0897190019866309.

Comprehensive medication management prevents drug interactions in older adults

- The frequency of clinically significant drug interactions was assessed in patients over 60 receiving CMM services. Beers criteria (reflecting potentially serious interactions) and the Dumbreck systematic review of United Kingdom's national drug interaction guidelines were used to define drug interactions in patients. The majority of patients had three or more health problems, 94% were taking more than two medications and 55% were taking more than five medications.
  - **Better care:** Clinicians providing CMM identified and prevented or resolved 22 drug interactions in 20 patients using the Beers criteria (4.9%) and 210 interactions in 111 patients using the UK national guidelines (27%). Disease states most strongly associated with a drug interaction were diabetes, heart failure and central nervous system diseases.

Santos TOD, Nascimento MMGD, Nascimento YA, et al. Drug interactions among older adults followed up in a comprehensive medication management service at primary care. Einstein (Sao Paulo). 2019 Aug 22;17(4):eAO4725. doi: 10.31744/einstein_journal/2019AO4725.

Assessment of the clinical utility of pharmacogenetic guidance in a comprehensive medication management service

- The evaluation of a collaborative pilot program aimed to demonstrate the benefit of incorporating pharmacogenetic information into CMM services. The pre- and post-interventional study evaluated 24 Hispanic patients who had a traditional CMM visit with a pharmacist prior to having pharmacogenetic testing. Genotyping was then performed to evaluate genetic variance in drug metabolizing enzymes. The pharmacist then incorporated the new pharmacogenetic information into the patient's management.
  - **Better care:** 129 medication-related problems were identified on the first visit, with a median of five conditions per patient and three recommendations made for changes in the medication regimen per patient. Genotyping revealed variants with the potential to affect the safety and/or effectiveness of one or more current medications in 96% of patients, with a median of three variants per patient.
  - **Better care:** Over 20% of the medications used in this patient cohort were affected by one or more of the variants. Using this information, the pharmacist was able to identify 22 additional medication-related problems, increasing the median number to six, and revised the medication action plans for all of the patients to incorporate the pharmacogenetic information.

Rodríguez-Escudero I, Cedeño JA, Rodríguez-Nazario I, et al. Assessment of the clinical utility of pharmacogenetic guidance in a comprehensive medication management service. Journal of the American College of Clinical Pharmacy. 2020;3:1028–1037. https://doi.org/10.1002/jac5.1250

II. Summary of Data on Improved Quality of Care, Patient and Provider Experience, and Patient Access to Care after Implementing CMM

Veterans give their experience with clinical pharmacists providing CMM high marks

- Evaluation of patient experience is an important component of assessing health care quality. Clinical pharmacists in Veterans Health Administration (VHA) facilities operate as advanced practice providers, seeing patients independently for CMM services under their scope of practice.

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- **Improved patient experience:** In a 9-month assessment conducted in 2021, patient experience surveys were sent to randomly selected veterans via email to evaluate a recent outpatient health care encounter a VA clinical pharmacist. A total of 743 Veteran surveys were completed with a response rate of 20%.
  - For individual domains of patient experience, the percentage of respondents selecting scores of 4 or 5 on a 5-point Likert scale were 94.4% for ease and simplicity of getting to the appointment, 91.9% for quality, 94.9% for employee helpfulness (provider willingness to listen and provide explanations), 95% for patient satisfaction and 91.9% for confidence and trust in the facility.
  - Results demonstrate that veterans' experiences with clinical pharmacists providing CMM were highly positive in every patient experience domain.

McFarland MS, Tran M, Ourth HL, Morreale AP. Evaluation of patient experience with Veterans Affairs clinical pharmacist practitioners providing comprehensive medication management. Journal of Pharmacy Practice. 2022 Aug 4;8971900221117892. doi:10.1177/08971900221117892.

Effect of an integrated clinical pharmacist on the drivers of primary care provider burnout

- Family medicine and internal medicine providers at Mayo clinic facilities in Minnesota and Wisconsin participated in a cross-sectional quality improvement survey to assess the perceived efficacy of the integration of clinical pharmacists into the clinic team. A total of 119 providers (physicians, nurse practitioners and physician assistants) responded to the survey. The majority had worked with an integrated clinical pharmacist for 2 to 5 years.

  - **Better care:** 91% of providers were extremely satisfied with the clinical pharmacy services in their clinic, with 90% agreeing that clinical pharmacists help patients make progress towards their health care goal, improve quality measures and assist with effective management of the patient panel. The most commonly reported collaborative activities were curbside consults, chronic disease management and CMM.

  - **Improved provider experience:** More than 95% of providers indicated that pharmacists were critical members of the health care team. They also strongly agreed that working with clinical pharmacists decreased their workload and allowed them to find greater meaning in their work. Providers believed the integration of clinical pharmacists into their clinics gave them more time to focus on the aspects of their work that were more professionally fulfilling.

Haag JD, Yost KJ, Kosloski KA, et al. Effect of an integrated clinical pharmacist on the drivers of provider burnout in the primary care setting. Journal of the American Board of Family Medicine. 2021;34:553-560. doi: 10.3122/jabfm.2021.03.200597.

Assessing the impact of integration of clinical pharmacists into teams on access to care for rural veterans

- This observational study evaluated team perceptions on the success of a program to integrate the VA clinical pharmacy specialists (CPS) providing CMM. Using a mixed methods evaluation, the CPS and their clinical team members were surveyed using the medication use process matrix (MUPM) as well as semi-structured interviews. The study reflected team interactions during 496,323 patient encounters from October 2017 to March 2020. A total of 124 CPS and 1,177 other clinical team members responded to the self-administered web-based questionnaire. An additional 22 interviews were completed with CPS and other clinicians.

  - **Improved provider experience:** The evaluation indicated good integration of the CPS in the primary care teams, as perceived by the other team members.

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- Both primary care team members and the CPS agreed on the high level of contributions provided in all 5 domains of the MUPM, with mean scores of 2.3 to 2.9 on a scale of 0 to 3.
- Findings from the interviews supported the perception that the majority of providers believed the CPS are making substantial contributions to patient care. Provider interviews highlighted the important role the CPS plays by providing CMM to relieve provider burden of care.
- The study also found that CPS reported higher job satisfaction when compared to previous data, citing less burn out and better role fit.

McCullough MB, Zogas A, Gillespie C, Kleinberg F, Reisman JI, Ndiwane N, Tran MH, Ourth HL, Morreale AP, Miller DR. Introducing clinical pharmacy specialists into interprofessional primary care teams: Assessing pharmacists' team integration and access to care for rural patients. Medicine (Baltimore). 2021 Sep 24;100(38):e26689. doi: 10.1097/MD.0000000000026689. PMID: 34559093; PMCID: PMC8462613.

Perceptions of integration of the clinical pharmacist into the PCMH model by the PCMH team

- Integration of CMM by a clinical pharmacist in a Department of Veterans Affairs facility was rated by the primary care team (physicians, nurses and staff) for seven domains.
  - **Better care:** 80% of responses rated the ability of the pharmacist to evaluate medication therapy and monitor the effectiveness and safety of medication therapy as a highly positive benefit.
  - **Improved access to care:** 87% of physicians and nurse practitioners responded that CMM integration by a clinical pharmacist increased access to their clinic by decreasing the time patients had to wait for primary care services.
  - **Improved provider experience:** 93% of physicians and nurse practitioners responded that CMM integration by a clinical pharmacist improved their job satisfaction.

McFarland S, Lamb K, Hughes J, Thomas A, Gatwood J, Hathaway J. Perceptions of Integration of the Clinical Pharmacist into the PCMH Model by the PCMH Team. Journal for Healthcare Quality. 2017. doi:10.1097/JHQ.0000000000000114.

Primary care providers believe that comprehensive medication management improves their work-life

- Part of a larger study of CMM implementation in Minnesota and North Carolina, this series of structured interviews was conducted with 16 primary care providers (PCPs) to identify the impact of CMM on their work life. Responses were then categorized to develop common themes.
  - **Better care:** Participants reported increased satisfaction that their patients were receiving better care and highlighted increased achievement of quality measures.
  - **Improved provider experience:** In addition to citing a decreased workload, PCPs reported a decrease in mental exhaustion related to the reassurance of having a clinical pharmacy colleague and enhanced opportunities for professional learning. This beneficial impact of team-based clinical pharmacist-provided CMM aligns with previously identified methods for decreasing burnout and engagement among primary care providers.

Funk K, Pestka D, McClurg M, Carroll J, Sorensen T. Primary Care Providers Believe That Comprehensive Medication Management Improves Their Work-Life. Journal of American Board of Family Medicine. 2019; 32(4): 462-473. doi: 10.3122/jabfm.2019.04.180376.

Pharmacists providing CMM gain increased efficiency in patient access through use of telemedicine

- This retrospective review evaluated the efficiency of the Tennessee Valley patient-aligned care team (PACT) clinical pharmacy specialists (CPS) providing CMM using patient encounter data, and it reviewed objective patient metrics to evaluate if the quality of care had been compromised during the COVID-19 pandemic. Data collection focused on the number of clinic encounters (in person, by phone or via telehealth), patient accountability to appointments, the number of disease states managed, insulin use, A1c and blood pressure in patients from 2019 and 2020.

  - **Improved access to care:** The total number of PACT CPS encounters increased 32% in 2020, and the number of unique patients increased by 12%.
    - There was a statistically significant increase in telephone visits from 5,230 to 18,715 (accounting for 32% of visits to 87%) while in-person visits decreased from 9,099 to 1,093 (accounting for 56% of all visits to only 5%). Video visits increased but remained a relatively uncommon method of patient encounter.
    - Rates of cancelled appointments and patients not showing up for their appointments also significantly decreased between 2019 and 2020.

  - **Sustained outcomes:** The goal of the study was to identify any negative impact on the quality of care caused by the transition to virtual patient visits.
    - There was no difference in the average change in A1c, with an average reduction of 0.57% in the 2019 cohort and 0.58% in the 2020 cohort ($p = 0.94$).
    - Average reductions in systolic (SBP) and diastolic blood pressures (DBP) also showed no significant change with average reductions in SBP being 3.1 mmHg and 3.2 mmHg ($p = 0.968$) in 2019 and 2020, respectively, and a mean reduction in DBP of 1.1 mmHg in 2019 and 2 mmHg in 2020 ($p = 0.3$). Markers for both diabetes and hypertension showed no negative impact on the conversion to phone and video visits during the pandemic.

Thomas AM, Baker JW, Hoffman TJ, Lamb K. Clinical pharmacy specialists providing consistent comprehensive medication management with increased efficiency through telemedicine during the COVID19 pandemic. Journal of the American College of Clinical Pharmacy. 2021;4: 934-938. doi: 10.1002/jac5.1494.

Optimizing the primary care clinical pharmacy specialist: increasing patient access and quality of care within the Veterans Health Administration

- The Department of Veterans Affairs has integrated the PCMH model as the delivery method of primary care since 2010. The VA Clinical Pharmacy Specialists (CPS) Provider practicing CMM in primary care is a large component of the ability for the VA to increase access and the quality of care for veterans. Currently, there are more than 1,850 CPS practicing CMM in primary care. In fiscal year 2019, patient aligned care team CPS documented 2,561,124 CMM interventions during 1,248,635 patient care encounters.

  - **Improved access to care:** VA Primary Care CPS demonstrated that 27% of primary care return appointments could be averted to a CPS.

  - **Better care:** Multiple studies performed within the VA have shown improvement in specific quality indicators:
    - Significant reduction in median A1c values to 7.7% (interquartile range [IQR] (0.5); $p < 0.001$) from a baseline A1c of 10.0% (IQR + 0.7).

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- Significant reductions in median systolic blood pressure (SBP) and diastolic blood pressure (DBP) from a baseline of 142/83 (IQR + 10 for SBP and 8 for DBP) to 134/79 (IQR + 7 for SBP and 7 for DBP; $P < 0.001$).
- CPS coordinated follow-up post-COPD discharge from a hospital or an emergency department (ED) within 30 days. Patients had a 0% composite readmission rate to the ED or hospital for a COPD exacerbation within 30 days of discharge.

McFarland MS, Nelson J, Ourth H, Groppi J, Morreale A. Optimizing the primary care clinical pharmacy specialist: Increasing patient access and quality of care within the Veterans Health Administration. J Am Coll Clin Pharm. 2020;3:494-500.

Impact of comprehensive medication management on hospital readmission rates

- The Fairview Health System implemented a formal care transitions process that included referrals to outpatient services provided by CMM pharmacists to determine whether or not a CMM visit with a CMM pharmacist within 30 days of hospital discharge decreased readmissions at 30 days post discharge when compared with patients who did not receive a CMM visit. In total, 1,291 hospitalizations had a CMM visit within 30 days of discharge.
  - **Better care:** At 30 days post discharge, patients who received a CMM visit had a significantly lower rate of readmissions compared to the comparator cohort (4.2% lower, $p < 0.001$).
  - **Improved access to care:** 60% of patients received their CMM visit within seven days of hospital discharge.

Budlong H, Brummel A, Rhodes A, Nici H. Impact of Comprehensive Medication Management on Hospital Readmission Rates. Population Health Management 2018. 21(5): 395-400.

Endnotes

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2. Slone Epidemiology Center at Boston University. Patterns of Medication Use in the United States 2006: A Report from the SloneSuSurvey. http://www.bu.edu/slone/files/2012/11/SloneSurveyReport2006.pdf. Accessed June 2020.
3. Morabet N, Uitvlugt E, van den Bemt B, et al. Prevalence and Preventability of Drug-Related Hospital Readmissions: A Systematic Review. J Am Geriatr Soc. 2018 Mar;66(3):602-608. doi: 10.1111/jgs.15244. Epub 2018 Feb 22.
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6. Nundy S, Cooper LA, Mate KS. The quintuple aim for health care improvement: a new imperative to advance health equity. *JAMA.* 2022;327(6):521-522.

Medication Optimization Use Case

MINNESOTA HEALTH FAIRVIEW ▪ Minneapolis-St. Paul, Minnesota	
Focus Area	Chronic disease model that incorporates the clinician providing CMM services into a primary care patient population. The chronic disease therapy model focuses on outcomes seen when the clinician provides CMM care for common primary care conditions such as cardiovascular disease, diabetes, etc.
At-a-Glance	■ **Organization Type:** Integrated Health System ■ **Launch Date:** 1997 ■ **Payment and Funding Sources:** ▪ CMM is a covered service for all Medicaid patients, Fairview employees, PreferredOne/ ClearScript members. ▪ Contracts with other commercial, managed Medicaid and Medicare payors.
Organization Details	Fairview is an integrated health system with 360,000 health plan members, more than 34,000 employees and more than 5,000 system providers. It consists of the following: ▪ 12 hospitals and medical centers ▪ 3,519 licensed beds ▪ 2,071 staffed beds ▪ 56 primary care clinics ▪ 100+ specialties ▪ 90+ senior housing locations ▪ 36 retail pharmacies
Brief History of CMM Program, Scope of Services	Started in 1997 as a partnership with the University of Minnesota and Fairview. The program matured in 2006 when Medicare Part D and Minnesota Medicaid required plans to offer medication therapy management (MTM) benefits to members. Positive return on investment, provider and patient satisfaction scores and improvement in quality outcomes led to expansion of the program. CMM has become a required element in care delivery re-design in primary care clinics and is now being included as part of Fairview's ACO and risk-managed payor contracts.

Results & Achievements

Focus on the Quadruple Aim

- *Better Outcomes*
- *Cost Savings*
- *Patient Satisfaction & Engagement*
- *Clinician Satisfaction*

Better Outcomes

- The percentage of diabetes patients optimally managed was significantly higher for CMM patients compared to the year prior (21.49% vs.45.45%, P < 0.01). The HbA1c showed a mean reduction of 0.54%. Patients who opted in for CMM had higher Charlson scores, more complex medication regimens and a higher percentage of diabetes with complications.
- Exposure to face-to-face CMM services resulted in improvement of medication adherence with statins, ACEI/ARBs and B-Blockers.
- State of MN diabetes pilot increased from 16% to 42% meeting all goals in a 12-month period.
- 59.7% asthma patients cared for by CMM clinicians achieved the MN community measure for optimal asthma care vs. the state average of 16% in 2011.
- Using a risk-adjusted rate the CMM group has experienced approximately 20% fewer readmissions than might be expected, given their increased level of risk.

Cost Savings

- An average 12:1 ROI in terms of reduced overall health care costs. Overall health care cost reduction of 31.5% after one year of medication therapy management.
- An employer analysis showed that each $1 of medication therapy management billed costs would approximate an average $8.98 savings for total health care costs on all enrolled members.

Patient Satisfaction & Engagement

- 95% of patients agreed or strongly agreed that their overall health and well-being had improved because of CMM.
- Research has shown that patients feel that the CMM clinician is a resource for care/education, that they are more accessible and that they help to coordinate care.

Clinician Satisfaction

- 95% of providers surveyed were confident in the recommendations of the Fairview CMM clinician.
- 92% of providers agreed or strongly agreed that having an CMM clinician at their clinic has helped their patients improve their health and make progress towards their clinical goals.

Patient Success Story	Anita was used to being active. She worked locally for 35 years until back surgery and a hip replacement caused her to retire. A diagnosis of diabetes during a hospital stay last December sent her health into a downward spiral. The problem began when she tried to renew the diabetes medication after a post-hospital rehabilitation stay. Because of mobility limitations, Anita was not able to see her physician and went without her medication for several months. *"Talking to Brittany and getting my medications straightened out has been important," says Anita. "I don't think it would have been possible without her help."* "Brittany has been a lifesaver in many ways," says Anita, 67-year-old Fairview patient. Anita's multiple chronic diseases and related complications had created barriers to care and landed her in the hospital. She needed specialized help to get her health back on track. That's where Dr. Brittany Symonds, medication therapy management clinical pharmacist, stepped in. She serves as part of a network team that came together to help Anita. *"My blood sugar went sky high," says Anita. "I ended up back in the hospital."* For Anita, multiple factors conspired to create what Dr. Symonds called "a perfect storm." Barriers to care included medication cost and mobility issues preventing Anita from visiting her doctor. Dr. Brittany Symonds worked with Anita by phone, reducing the number of clinic visits needed, and helped her find less expensive medications through a mail-order source. Anita calls medication therapy management "one of the best things Fairview instituted. If I hadn't had Brittany, I don't think I'd have my diabetes under control and feel as well as I do today." Additional stories at: https://www.fairview.org/services/medication-therapy-management/patient-stories
Team-Based Care Strategy	■ **Interprofessional Team Roles:** ▪ Triage nurses, care coordinators (social work and RN case managers), inpatient nursing staff trained on CMM and when to refer patients ■ **Role of the Clinician:** ▪ Scope of Advanced Practice: Collaborative practice agreement covering 20+ chronic disease states ■ **Care Delivery Modality:** ▪ In-person, phone and video visits. Extensive communication via MyChart (EHR communication) when needed ▪ 60-minute initial (new) patient visits/30-minute return visits ▪ Patients average two visits/year with pharmacist
Patient Referral Criteria	■ **Eligible Patients:** All patients are eligible for CMM services. ■ **Populations of Focus:** Diabetes, hypertension, hyperlipidemia, smoking cessation, COPD, heart failure, asthma, transplant, HIV and CF patients in specialty locations (among other specialties). Transitions of care, special focus on mental health discharges.

Size of CMM Program	**Number of:** ■ **Pharmacists:** 45 ▪ Pharmacist FTE: 30.2 in direct pt care ■ **Practice Sites:** 55 ■ **Resident Pharmacists:** 5 PGY-1 ■ **Student Pharmacists/Interns:** 2 ■ **Support Staff:** ▪ 3 coordinators: scheduling, coding, billing, recruitment calls ▪ 1 business supervisor ▪ 3 CMM supervisors ▪ 1 CMM Operations Lead ■ **Unique patients served (2019):** ▪ 12,798 patients ▪ 26,460 visits
Program Success Factors	■ **Expanded Roles and Responsibilities of the Pharmacist** ▪ Broad collaborative practice agreements ▪ Consistent care process and follow-up ■ **Convenient Patient Access and Simple Program Entry** ▪ Multiple care delivery modalities (e.g., in-person, telemedicine) ■ **Demonstrate Efficiency & Effectiveness of Cross-Setting Team-Based Care** ▪ CMM eases primary care workload ■ **Demonstrate & Articulate CMM's Value** ▪ Consistently high patient and provider satisfaction scores ▪ Continued ROI studies with positive results ▪ Meaningful, experiential learning opportunities for advanced pharmacy practice experience students
Next Steps, Future Goals	■ Resourcing clinics without a CMM clinician on-site ■ Payment structures to support CMM services

References	Brummel, A. "Optimal Diabetes Care Outcomes Following Face-to-Face Medication Therapy Management Services" *Population Health Management:* 2012. Brummel, A, Carlson, A. Comprehensive Medication Management and Medication Adherence for Chronic Conditions. *Journal of Managed Care Pharmacy* 2016; 22 (1); 56-62. Schultz, H., Patient-perceived value of Medication Therapy Management (MTM) services: a series of focus groups. *Innovations in Pharmacy:3*(4)96. McInnis, T. Capps, K. Get the medications right: a nationwide snapshot of expert practices—Comprehensive medication management in ambulatory/community pharmacy. *Health2 Resources,* May 2016. Sorensen, TD, Sorge LA, Millonig, M et al. Integrating medication management: lessons learned from six Minnesota health systems. September 2014. Additional articles: https://www.fairview.org/services/medication-therapy-management/news
Program Contact Information	**Allyson Schlichte, Pharm.D., MBA, BCACP** Medication Therapy Management Operations Lead Aschlic1@fairview.org 612-510-0767
Developed by the Best Practices and Innovative Solutions Subgroup of the GTMRx Practice and Care Delivery Transformation Workgroup	

Clearly Defined Roles and Responsibilities Help CMM Program to Deliver Services Efficiently

AT A GLANCE

RiverStone Health Clinic
Billings, MT

Person in charge: Amy Moser, Pharm.D., BCACP, CPP

Organization type: FQHC, Level 3 patient-centered medical home

Year CMM Launched: 2010

Payment sources: Medicaid, some private insurers

Funding sources: Primarily through the FQHC contract with some support from the HRSA 340B medication discount program.

Number of pharmacists: 3 (1.5 FTEs)

Number of CMM sites: 1

Unique CMM patients served in 2019: 317

Can patients self-refer? Yes

Collaborative Practice Agreements: For diabetes, hypertension, dyslipidemia, ASCVD risk reduction, COPD, asthma, smoking cessation, thyroid disorders and GERD. They also provide services for high-risk for readmission hospital discharges and integrated behavioral health team.

Fully integrated into a medical home practice, the CMM pharmacists at RiverStone Health Clinic are part of a clinical team that identifies and resolves patients' unmet needs.

Bringing clinical pharmacy skills to that team—and being fully integrated into the medical home—leads to better outcomes and higher satisfaction for its underserved community.

Patients may be referred to the clinical pharmacists by any member of the patient care team in the clinic for CMM. Referrals are based on an assessment of needs, not a particular diagnosis. Clinical pharmacists are part of the team that identifies patients for CMM. Patients can self-refer (usually for follow-up) if they have a primary care provider at the clinic, but they are almost always initially referred by a staff member. Regardless of how a patient is referred, each receives comprehensive medication management.

Staffing and training

Three pharmacists, accounting for 1.5 FTE, are supported by one or two students (generally accounting for 1.5 FTEs). As part of a medical home team, the clinical pharmacists have access to staff who help with scheduling, pre-visit planning and other issues. The team of pharmacists hope to be able to add a pharmacy tech position to the CMM program.

Access innovation on the horizon

RiverStone consists of a centrally located clinic and several satellite sites. Any patient is eligible for CMM services, and these visits are conducted via telemedicine for patients of the satellite sites.

"It is critical for patients to understand and agree with their treatment in order to achieve good outcomes."

Measuring impact

The CMM program at RSH Clinic tracks identified drug therapy problems. Having collaborative practice agreements in place for several common disease states allows for over 90% of drug therapy problems to be resolved by the pharmacists at the CMM visit.

Success factors

RSH has identified four factors crucial to the success of their program:

1. **The ability to identify and meet a patient's needs:** This is fundamental to the program's success.
2. **The pharmacists' skill set:** Pharmacists offer a unique skill set that complements the rest of the clinical team.
3. **Clearly defined roles and responsibilities:** The pharmacy team understands the role and function of each team member.
4. **Appropriate funding:** CMM is supported as part of the PCMH and funded through various channels. The clinic has a contract with University of Montana School of Pharmacy to support student advanced pharmacy practice experience. It receives Medicaid and private insurance payments for the visits conducted by the clinical pharmacists, and our physicians and administrators value the contribution of pharmacists on the team. Positions are supported through the clinic's federal grant funding for FQHCs.

Lessons learned

1. **They need us.** Clinical pharmacists are an important part of the care team. We are able to spend more time with the patient to ensure they really understand how to use their medication correctly to get the best outcomes.
2. **Clinical pharmacists make a unique contribution to the team.** Since clinical pharmacists are trained to be medication experts, they are uniquely qualified to identify and resolve drug therapy problems, such as drug interactions or adverse reactions.
3. **Patients must be part of the decision-making process.** It is critical for patients to understand and agree with their treatment in order to achieve good outcomes. We feel it is most helpful to meet the patient where they are at and then help them move forward toward their goals.

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TESTIMONY OF THE AMERICAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS

January 17, 2023

Mr. Chairman and Members of the Committee:

I am Tom Kraus, Vice President of the American Society of Health-System Pharmacists (ASHP). ASHP is the collective voice of pharmacists who serve as patient care providers in hospitals, health systems, ambulatory clinics, and other healthcare settings spanning the full spectrum of medication use. The organization's more than 60,000 members include pharmacists, student pharmacists, and pharmacy technicians. For more than 80 years, ASHP has been at the forefront of efforts to improve medication use and enhance patient safety.

Why Is Comprehensive Medication Management Needed?

The risk of medication problems is greatest when patients are:

1) Suffering from **multiple diseases,** being treated by **multiple physicians**
2) **Transitioning from one setting of care to another**, such as a recent discharge from the hospital
3) Being treated for **complex diseases** that require multiple medications and may require balancing clinical goals with patient costs and quality of life

ASHP Fellow, Rita Shane has identified that "each of these situations can contribute to **overuse** of medications that don't improve health and may cause harm, **underuse** of critical drugs needed for acute or chronic health problems; or **misuse** of medications such as opioids."[1] Any one of these challenges can lead to higher cost and worse outcomes.

To optimize a patient's medication use, each medication should be individually assessed to determine that it is appropriate for the patient, effective to treat the medical condition, and safe given the patient's comorbidities and other medications being taken. This is a multi-step, team-based process that requires collaboration between a clinical pharmacist, the treating

[1] Shane R. The Problem: Starting or Continuing Medications Without a Comprehensive Evaluation of the Patient's Health Issues and Medications. (https://gtmr.org/blog-the-problem)

physicians, and the patient. Once a care plan is developed to address the recommended changes, the team provides follow-up evaluations to monitor clinical goals and outcomes while reassessing personalized goals of therapy.

House Bill 1095 ensures that patients will have access to exactly that type of care.

H.B. 1095 Implements a Key Recommendation of the ND Health Care Cost Study

North Dakota's Health Care Cost Study, commissioned by the Insurance Department, specifically identified the need for medication optimization as a tool to control healthcare costs for North Dakotans. The Cost Study identified that improved medication management represents "***a major opportunity for cost savings and health improvement***." The Cost Study goes on to indicate that, "If addressed appropriately, the state can reasonably expect to see lower hospital-related utilization and substantial cost savings." That has been the result where comprehensive medication management has been implemented.

Comprehensive Medication Management Yields Positive ROI and Improved Outcomes

The Cost Study highlighted research demonstrating that "[the] data from the delivery of this service are positive, with a demonstrated return on investment (ROI) as high as 12:1 with an average of 3:1-5:1. ROI reflects an ability to decrease hospital admissions, physician visits, and emergency department admissions and reduce the use of unnecessary and inappropriate medications."[2]

Studies of comprehensive medication management services have consistently shown that when these services are integrated in team-based care, therapeutic goals are achieved more consistently, costs decrease, and the patient and provider experience improves.

Case Study: Minnesota's Experience with Team-based Medication Therapy Management

Reduced Costs[3]

- Total health expenditures decreased from $11,965 to $8,197 per patient.

[2] https://www.accp.com/docs/positions/misc/CMM%20Brief.pdf

[3] Brummel A, Westrich K, Evans MA, Plank GS, Penso J, Dubois RW. Best Practices: Improving Patient Outcomes and Costs in an ACO Through Comprehensive Medication Therapy Management. Journal of Managed Care and Specialty Pharmacy. 2014(20):12.

- 12:1 ROI when comparing the overall health care costs of patients receiving team-based medication management to patients who did not receive those services.

Decreased hospital readmission rates[4]

- Patients who received comprehensive medication management after hospital discharge had significantly lower readmissions rates.

Improved Patient Care[5]

- 85% of patients had at least one medication therapy problem identified.
- Of those, 29% had 5 or more problems identified.

Improved patient experience[5]

- 95.3% of patients agreed or strongly agreed that their overall health and well-being had improved because of team-base medication management services.

Improved provider experience[6]

- Physicians reported increased satisfaction that their patients were receiving better care and highlighted increased achievement of quality measures.
- Primary care providers reported improved workload and less mental exhaustion.

The extensive evidence of improved patient outcomes, cost savings, and patient and physician satisfaction from comprehensive medication management is too long to be included in this testimony. To support the Committee's understanding of the impact of these services, I have attached a more extensive summary of research, gathered by the Get the Medications Right Institute.

Comprehensive Medication Management Builds on Programs to Improve Medication Use

The Cost Study recommends that a medication optimization program should "allow consumers to have a comprehensive review of all their prescription drugs to assure that the consumer is on the correct dosages of the correct medications, and to review any unfavorable drug interactions….Hospital systems, physicians, and pharmacists should routinely discuss

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[4] Budlong H, Brummel A, Rhodes A, Nici H. Impact of Comprehensive Medication Management on Readmissions Rates. Population Health Management 2018; 21(5):395-400.

[5] Ramalho de Oliveria D, Brummel AR, Miller DB. Medication therapy management: 10 years of experience in a large intergerated health care system. Journal of Managed Care Pharmacy 2010; 16(3):185-95.

[6] Funk K, Pestka D, McClurg M, Carroll J, Sorensen T. Primary Care Providers Believe That Comprehensive Medication Management Improves Their Work-Life. Journal of the American Board of Family Medicine. 2019; 32(4):462-473.

medication optimization with their patients. Patients with multiple conditions should regularly have their medications reviewed in order to ensure patient compliance, drug interactions, and changing medical history." ASHP agrees with these statements. Unfortunately, existing programs implemented by most insurers do not achieve these goals. While payer-led population-level tools are helpful, individualized medication management cannot be effectively delivered solely by reviewing claims, or from a call center, or by an IT tool. Medication management requires direct engagement with the pharmacist, the treating physicians, and the patient. H.B. 1095 improves on existing offerings to ensure patients consistently receive comprehensive medication management services that are appropriately designed to achieve the cost savings and quality improvements envisioned in the Cost Study.

Comprehensive Medication Management is Truly Team Based

The role of the pharmacist in comprehensive medication management is to identify medication problems and therapeutic goals, work with the physician team and the patient to resolve problems, and execute the medication changes agreed to by the team. It is not intended to allow the pharmacist to independently treat patients. H.B. 1095 makes clear that the legislation does not modify pharmacists' scope of practice.

Credentialing and Inclusion of Pharmacists in Provider Networks Is Not a Barrier to Implementation

Medication management is a medical service, not a drug benefit. In order to provide that service, there must be a mechanism for insurers to reimburse the care team for clinical services provided by pharmacists.

For pharmacists working in facilities like hospitals and rural health clinics, B.H. 1095 specifically recommends that insurers rely on the credentialing that is already being done by the facility. Insurers already have contract relationships with facilities to reimburse them for services provided by members of their care teams. Insurers may also be able to simplify billing by allowing physicians to submit bills for medication management services provided by pharmacists on their care team.

Outside of facilities, insurers already have relationships with independent community pharmacists and rely on them to deliver essential pharmacy services to North Dakotans. It is appropriate to pay these pharmacists directly for clinical services they provide.

Insurers Should Ensure Adequate Inclusion of Pharmacists in Networks

Delivering comprehensive medication management services requires direct engagement from a pharmacist with the patient and their care team. This is a different service than dispensing medications. Simply having an existing network of pharmacies to dispense medications does not ensure that patients will have access to the clinical services of pharmacists that are essential to the implementation of medication management. Network adequacy requirements help to ensure that plan beneficiaries will have sufficient access to pharmacists contracted to support this type of care.

As the North Dakota Health Care Cost Study indicated, “There is no reason insurers shouldn’t be deploying these resources to the comorbid populations.”

The American Society of Health-System Pharmacists strongly supports House Bill 1095.

The Outcomes of Implementing and Integrating Comprehensive Medication Management in Team-Based Care: *A Review of the Evidence on Quality, Access and Costs, December 2022*

Developed by the Evidence Based-Resources Subgroup of the GTMRx Practice and Care Delivery Transformation Workgroup:

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Each year in the United States, over $528 billion is wasted and 275,000 lives are lost due to non-optimized medication use.[1] Misuse, underuse or overuse of medications can lead to treatment failure, adverse effects and toxicity causing significant morbidity or mortality. With over 80% of Americans now taking one or more medications per week, and rates of hospital admissions resulting from medication-related problems continuing to rise, a strategy must be implemented to ensure that we "get the medications right" for all patients.[2,3] Comprehensive medication management (CMM) is a patient-centered approach to optimizing medication use and improving patient health outcomes. It is delivered by a clinical pharmacist working in collaboration with the patient and other health care providers. The CMM patient care process ensures each patient's medications (whether prescription, nonprescription, alternative, traditional, vitamins or nutritional supplements) are individually assessed to determine that each medication has an appropriate indication, is effective for the medical condition and achieving defined patient and clinical goals, is safe given the comorbidities and other medications being taken, and that the patient is able to take the medication as intended and adhere to the prescribed regimen.[4]

Integration of CMM into existing patient care processes ensures a "whole health" focused approach. The value of CMM lies in the ability of medication optimization to facilitate achievement of the goals defined as the quadruple aim of health care: improving the quality of care, reducing health care costs, improving both patient and health care provider experience.[5]

This document summarizes key findings from published studies evaluating the value of CMM in supporting the quadruple aim. The studies selected have integrated CMM into team-based care in a myriad of different health care systems spanning the spectrum from individual provider offices with privately insured patients to non-profit value-based payment health care systems and government run health care systems. Regardless of the location, findings are consistent that when CMM is integrated into team-based care, therapeutic goals are achieved, costs decrease and the patient and provider experience improves. Importantly, as we strive to achieve health equity, the fifth element of the new quintuple aim of health care, new research has demonstrated the ability of CMM to help in reaching that goal.[6] Clinical pharmacists have already demonstrated the value of CMM in increasing patient access to health care, and work is underway to develop processes for identifying and addressing social determinants of health that may adversely impact the ability to achieve medication optimization. The document will continue to evolve as the integration of CMM into health care expands and the data on its value continues to grow.

Produced by Health2 Resources GTMRx Institute 2022© | 12.2022

I. Summary of Data on Improved Quality of Care and Reduced Costs after Implementing CMM

CMM results in over $1 million savings in Texas primary care clinics during incentive payment program

- A one-year observational study of 3,280 adult patients participating in a Texas delivery system incentive-based payment reform program revealed significant cost savings in those receiving CMM. Patients were eligible for the CMM program if they were receiving more than four medications and had been diagnosed with at least one chronic disease (diabetes, hypertension, heart failure, COPD or asthma). A clinical pharmacist reviewed the patients' records and created action plans for 290 patients with a total of 311 medication-therapy problems (MTPs). Two physicians conducted independent reviews of the pharmacist's recommendations to establish inter-rater reliability of the MTPs, with agreement on a final count of 301 MTPs in 280 patients.
    - **Better care:** Of the identified problems, recommendations for 150 (49.8%) were fully implemented by the primary care team, with the other 129 (42.8%) partially implemented. The majority were categorized as related to medication safety/adverse drug reactions (56.8%), with the second most common category being medication indication (34.9%).
    - **Reduced costs:** Resolution of MTPs resulted in an estimated cost savings of $1,143,015 in 2016 US dollars. The largest portion of this cost avoidance was achieved through the prevention of 62 hospital admissions.

Chung TH, Hernandez RJ, Libaud-Moal A, et al. The evaluation of comprehensive medication management for chronic diseases in primary care clinics, a Texas delivery system reform incentive payment program. BMC Health Services Research. 2020; 20:671. doi: 10.1186/s12913-020-05537-3.

Retrospective analysis of economic and utilization outcomes of CMM in a large Medicaid plan using a novel artificial intelligence platform

- In this observational study, the authors used mixed-effects regression models to assess savings and associated economic impact of a modified CMM program. This program incorporated the principles of CMM, including its holistic approach, but it did not involve embedment in a clinic with the team and patient. Instead, the pharmacists interacted with patients by phone; assisted with their care by an advanced artificial intelligence platform that created a patient profile; and provided clinical decision support. Pharmacists provided recommendations via fax or by phone to providers for a total of 2,150 Medicaid members ages 40-64 years with an average of 10 medications for chronic conditions. Cost and utilization data were compared from 2017 and 2019 to capture the impact of the addition of CMM in 2018.
    - **Better care:** A total of 7,485 interventions were made with 46,090 recommended actions. The majority of recommended actions (84.6%) were to stop the medication because it was either not needed or duplicate therapy. The next most common action (32.3%) was to change a medication dose to optimize therapy.
    - **Reduced costs:** The authors found a statistically significant decrease in the total cost of care of 19.3% ($p < 0.001$) or $554 per patient per month. Medication costs alone decreased by 17.3% ($p < 0.001$) or $192 per patient per month.

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- There was a 15.1% decrease in emergency department visits, a 9.4% decrease in hospitalizations and a 10.2% decrease in days of hospital admission (all results statistically significant).
- Assessing the savings in light of the cost of program implementation and maintenance, the authors reported a 12.4:1 return on investment.

Kessler S, Desai M, McConnell W, et al. Economic and utilization outcomes of medication management at a large Medicaid plan with disease management pharmacists using a novel artificial intelligence platform from 2018 to 2019: a retrospective observational study using regression methods. Journal of Managed Care and Specialty Pharmacy. 2021; Sep;27(9):1186-1196. doi: 10.18553/jmcp.2021.21036.

Real-world impact of a pharmacogenomics-enriched CMM program

- A novel program incorporating pharmacogenomics (PGx) into CMM services has recently shown to be valuable in moving patients closer to their treatment goals when compared to standard care. Patients in the Kentucky's Teachers' Retirement System were offered the opportunity to enroll in the PGx-CMM program, with the results from the 5,288 who enrolled compared to a group of 22,387 patients who chose to continue standard care over the initial 32-months of the program. The characteristics of the two groups were similar at baseline, however the patients who chose to enroll in the PGx-CMM program were on more medications.
  - **Better care:** A total of 4,716 medication therapy problems were identified in the PGx-CMM group resolved through 3,228 medication action plans made by the pharmacist.
  - **Reduced costs:** When compared to the patients receiving standard care, participants in the PGx-CMM group experienced an average reduction of $7000 in direct medical charges. The authors also noted a positive shift in healthcare utilization away from acute care (emergency department use or hospitalization) and towards greater use of primary care options.

Jarvis JP, Peter AP, Keogh M, et al. Real-world impact of a pharmacogenomic-enriched comprehensive medication management program. Journal of Personalized Medicine. 2022;12(3):421. doi: 10.3390/jpm12030421.

Positive impact of CMM on diabetes outcomes in Federally-Qualified Health Centers (FQHCs)

- This retrospective study highlights the results from 8 FQHCs participating in the *BD Helping Build Healthy Communities* program that used the funding to support integration of CMM services. These centers provided care for diverse patients populations in sites throughout the US: Arizona, California (San Marcos and Los Angeles), Florida, Indiana, Mississippi, New Jersey and Puerto Rico. Within the CMM services provided, patient education and instructions for self-monitoring were emphasized.
  - **Better care:** A total of 2,502 patients were included in the study, with a primary outcome of change in hemoglobin A1c (A1c) at 6 months and a secondary outcome of change in systolic blood pressure (SBP).
    - A statistically significant reduction in A1c was documented between baseline and the 6-month follow-up (9.4 vs 8.2, $p < 0.01$), as well as a statistically significant reduction in SBP (140.8 vs 130.2 mm Hg, $p < 0.05$).
    - Patients demonstrated sustained reductions in both A1c and SBP beyond 6 months, with a reduction in A1c still present at the 24-month evaluation.

Pastakia SD, Clark A, Lewis K, et al. The impact of clinical pharmacist led comprehensive medication management on diabetes care at Federally Qualified Health Centers within the BD Helping Build Healthy Communities program. Journal of the American College Clinical Pharmacy. 2022;5:273-282. doi.org/10.1002/jac5.1679.

Healthcare utilization and outcomes in cardiovascular patients receiving CMM services

- This quasi-experimental three-year non-randomized clinical study evaluated the impact of CMM services in older patients (ages 65-80 years) with established cardiovascular disease. Patients could self-refer to a pharmacist providing CMM serves or could be referred by their physician or other health-care providers. Patients receiving usual care (not referred or electing to have CMM) served as the control group. Parameters compared included blood pressure, A1c, LDL, TC and healthcare utilization.
  - **Better care:** Patients in the CMM group achieved statistically lower systolic and diastolic blood pressures (mean change -9.02 mm Hg and -4.99 mm Hg, respectively, both $p < 0.001$). Total cholesterol and LDL were also significantly lower in the CMM group compared to controls. While the mean A1c declined to a greater extent in the CMM patients, the difference compared to controls was not statistically significant.
  - **Reduced costs:** The number of hospital admissions was 3.35 higher in the control group (95% CI 1.16-10.00). Unplanned primary care visits were 2.34 times more frequent in the controls (95% CI 1.52-3.57).

Brajkovic A, Bosnar L, Gonzaga do Nascimento MM, et al. Healthcare utilization and clinical outcomes in older cardiovascular patients receiving comprehensive medication management services: A nonrandomized clinical study. International Journal of Environmental Research and Public Health. 2022;19:2781. doi: 10.3390/ijerph19052781.

Best practices: improving patient outcomes and costs in an ACO through comprehensive medication therapy management

- Since 1998, pharmacists at the Fairview Health System have cared for more than 20,000 patients and resolved more than 107,000 medication-related problems which, if left unresolved, could have led to hospital readmissions and emergency department visits. Fairview Pharmacy Services utilized 23 CMM pharmacists (approximately 18 full-time equivalents) working in 30 locations, who conduct pharmacotherapy workups as part of the medication optimization services.
  - **Better care:**
    - Approximately 27% of patients needed additional drug therapy and medication dosages increased.
    - Thirteen percent of the drug therapy problems were the result of unnecessary drug therapy and inappropriately high dosages.
  - **Reduced costs:** Fairview MTM showed a 12:1 ROI when comparing the overall health care costs of patients receiving services to patients who did not receive those services.
    - Total health expenditures decreased from $11,965 to $8,197 per person ($n = 186$, $p < 0.0001$).
    - Pharmacist-estimated cost savings to the health system over the 10-year period were $2,913,850 ($86 per encounter), and the total cost of CMM was $2,258,302 ($67 per encounter), for an estimated ROI of $1.29 for every dollar spent.

Brummel A, Lustig A, Westrich K, Evans MA, Plank GS, Penso J, Dubois RW. Best Practices: Improving Patient Outcomes and Costs in an ACO Through Comprehensive Medication Therapy Management. J of Managed Care and Specialty Pharmacy. 2014. (20): 12.

Budget impact analysis of a pharmacist-provided transition of care program

- Synergy Pharmacy Solutions (SPS) initiated a pharmacist-provided transition of care program for adult members of Kern Health Systems (KHS) managed Medicaid health plan who were classified as high risk using the Johns Hopkins Adjusted Clinical Groups (ACG) predictive model. High-risk patients admitted to participating hospitals were referred to the SPS TOC program and contacted via telephone within two to four days after discharge. Once a referred patient agreed to participate, the SPS team provided CMM.
  - **Reduced costs:** A budget impact analysis was conducted using a decision-tree model developed and built from the payer perspective. This tool was used to evaluate the impact of the program expansion to additional participating hospitals on total health care costs, including inpatient, outpatient, medication and emergency department costs, in six-month increments up to two years.
    - The budget impact model showed that in the first six months, the CMM program resulted in cost avoidance of over $4.3 million in total health care costs to the plan, which corresponded to $3 per member per month.
    - By the end of year two, the savings reached over $4 per member per month, for a total of $25.6 million.

Ni W, Colayco D, Hashimoto J, Komoto K, Gowda C, Wearda B, McCombs J. Budget Impact Analysis of a Pharmacist-Provided Transition of Care Program. Journal of Managed Care & Specialty Pharmacy. Feb 2018.

Comprehensive medication management results in improved care and cost savings in mental health system

- Psychiatric patients have multiple risk factors for chronic medical conditions and their need for multiple medications increases the risk of adverse events, drug interactions and poor adherence. This retrospective study of CMM assessed the quality of the service provided and patient outcomes within a mental health system through initial and follow-up visits focused on chronic medical conditions and psychiatric therapy.
  - **Better care:** Complex patients were referred to the CMM clinic with a mean of 13.7 medications and 10.1 medical conditions per patient. Providers found an average of 5.6 medication-related problems per patient, the most common being adverse drug reactions, unnecessary medications, inappropriate doses and poor adherence. Overall, clinical status improved in 52% of patients.
  - **Reduced costs:** The service projected a net cost avoidance of $90,484 over 2.25 years, or $586.55 per patient from avoidance of hospitalization or emergency department visits (33.7%) and savings in medication costs (66.3%). This resulted in an ROI of $2.80 per dollar spent.
  - **Improved patient experience:** A patient satisfaction survey indicated that 93% of patients felt the service was "extremely" or "very helpful", noting the positive changes made to their medication regimens. The majority of patients (89%) would refer friends or family for a medication review.

Cobb CD. Optimizing medication use with a pharmacist-provided comprehensive medication management service for patients with psychiatric disorders. Pharmacotherapy. 2014;34:1336-1340. doi.org/10.1002/phar.1503.

Medication therapy management: 10 years of experience in a large integrated health care system

- Assessment of the clinical, economic and humanistic outcomes of 10 years of experience with medication optimization within Minnesota's Fairview Health Services utilizing medication therapy management (a precursor to CMM). Data from 33,706 patient encounters were included in the evaluation.

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- **Better care:** 85% of patients had at least one medication therapy problem identified. Of those, 29% had 5 or more problems identified. The most frequent issues were the need for an additional medication (28.1%) and adjustment of a subtherapeutic dose (26.1%). Fifty-five percent of patients not at goal at the time of enrollment in the program improved after their medication regimens were optimized.
- **Reduced costs:** The program produced an average cost savings per encounter of $86. Average cost to provide the service was $67 per encounter, producing an estimated return on investment of $1.29 per $1 spent in administrative cases.
- **Improved patient experience:** 95.3% of patients surveyed gave a rating of agree or strongly agree to the statement that their overall health and well-being had improved as a result of the service.

Ramalho de Oliveira D, Brummel AR, Miller DB. Medication therapy management: 10 years of experience in a large integrated health care system. Journal of Managed Care Pharmacy 2010;16(3):185-95. doi: 10.18553/jmcp.2010.16.3.185.

The effect of clinical pharmacist-led comprehensive medication management on chronic disease state goal attainment in a patient-centered medical home

- A retrospective comparison study of the effect of pharmacist-led CMM on achievement of chronic diabetes treatment goals. This study took place in 11 clinics within a primary care network designated as a patient-centered medical home and affiliated with a large academic medical center. Achievement was defined as reaching a combined goal of a hemoglobin A1c < 8%, blood pressure < 140/90, and placement on statin therapy for dyslipidemia.
  - **Better care:** 40% of patients receiving CMM reached the combined treatment goal versus only 12% of patients in the control group ($p < 0.001$) over the 13-month study. Patients receiving CMM also had significantly greater improvement in individual assessments of A1c, blood pressure and use of a statin from their baseline to the completion of the study.

Prudencio J, Cutler T, Roberts S, Marin S, Wilson M. The Effect of Clinical Pharmacist-Led Comprehensive Medication Management on Chronic Disease State Goal Attainment in a Patient-Centered Medical Home. Journal of Managed Care & Specialty Pharmacy, 24 (5): 423-429. 2018. doi: 10.18553/jmcp.2018.24.5.423.

Comprehensive medication management leads to improvements in diabetes, hypertension and dyslipidemia

- In 2008, Brazil's Ministry of Health established the Nucleo de Apoio a Saude da Familia (Family Support Teams), multidisciplinary teams consisting of pharmacists, nutritionists, physical therapists and social workers, to support the primary care physician and nurse. After implementation of CMM services, treatment goals were assessed using a quasi-experimental study design in 1,057 patients covered by five clinical pharmacists over a 2-year period.
  - **Better care:** The mean difference from initial to final values showed statistically significant improvement for A1c (-0.8 +/- 0.4), systolic and diastolic blood pressure (-3.3 +/- 1.5 and -1.4 +/- 1.0), low-density lipoprotein cholesterol (-19.5 +/- 6.0) and total cholesterol (-21.0 +/- 7.3).

Santos BD, Nascimento MMGD, de Oliveira GC, et al. Clinical impact of a comprehensive medication management service in primary health care. Journal of Pharmacy Practice 2019;0897190019866309. doi:10.1177/0897190019866309.

Comprehensive medication management prevents drug interactions in older adults

- The frequency of clinically significant drug interactions was assessed in patients over 60 receiving CMM services. Beers criteria (reflecting potentially serious interactions) and the Dumbreck systematic review of United Kingdom's national drug interaction guidelines were used to define drug interactions in patients. The majority of patients had three or more health problems, 94% were taking more than two medications and 55% were taking more than five medications.
  - **Better care:** Clinicians providing CMM identified and prevented or resolved 22 drug interactions in 20 patients using the Beers criteria (4.9%) and 210 interactions in 111 patients using the UK national guidelines (27%). Disease states most strongly associated with a drug interaction were diabetes, heart failure and central nervous system diseases.

Santos TOD, Nascimento MMGD, Nascimento YA, et al. Drug interactions among older adults followed up in a comprehensive medication management service at primary care. Einstein (Sao Paulo). 2019 Aug 22;17(4):eAO4725. doi: 10.31744/einstein_journal/2019AO4725.

Assessment of the clinical utility of pharmacogenetic guidance in a comprehensive medication management service

- The evaluation of a collaborative pilot program aimed to demonstrate the benefit of incorporating pharmacogenetic information into CMM services. The pre- and post-interventional study evaluated 24 Hispanic patients who had a traditional CMM visit with a pharmacist prior to having pharmacogenetic testing. Genotyping was then performed to evaluate genetic variance in drug metabolizing enzymes. The pharmacist then incorporated the new pharmacogenetic information into the patient's management.
  - **Better care:** 129 medication-related problems were identified on the first visit, with a median of five conditions per patient and three recommendations made for changes in the medication regimen per patient. Genotyping revealed variants with the potential to affect the safety and/or effectiveness of one or more current medications in 96% of patients, with a median of three variants per patient.
  - **Better care:** Over 20% of the medications used in this patient cohort were affected by one or more of the variants. Using this information, the pharmacist was able to identify 22 additional medication-related problems, increasing the median number to six, and revised the medication action plans for all of the patients to incorporate the pharmacogenetic information.

Rodríguez-Escudero I, Cedeño JA, Rodríguez-Nazario I, et al. Assessment of the clinical utility of pharmacogenetic guidance in a comprehensive medication management service. Journal of the American College of Clinical Pharmacy. 2020;3:1028–1037. https://doi.org/10.1002/jac5.1250

II. Summary of Data on Improved Quality of Care, Patient and Provider Experience, and Patient Access to Care after Implementing CMM

Veterans give their experience with clinical pharmacists providing CMM high marks

- Evaluation of patient experience is an important component of assessing health care quality. Clinical pharmacists in Veterans Health Administration (VHA) facilities operate as advanced practice providers, seeing patients independently for CMM services under their scope of practice.

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- **Improved patient experience:** In a 9-month assessment conducted in 2021, patient experience surveys were sent to randomly selected veterans via email to evaluate a recent outpatient health care encounter a VA clinical pharmacist. A total of 743 Veteran surveys were completed with a response rate of 20%.
  - For individual domains of patient experience, the percentage of respondents selecting scores of 4 or 5 on a 5-point Likert scale were 94.4% for ease and simplicity of getting to the appointment, 91.9% for quality, 94.9% for employee helpfulness (provider willingness to listen and provide explanations), 95% for patient satisfaction and 91.9% for confidence and trust in the facility.
  - Results demonstrate that veterans' experiences with clinical pharmacists providing CMM were highly positive in every patient experience domain.

McFarland MS, Tran M, Ourth HL, Morreale AP. Evaluation of patient experience with Veterans Affairs clinical pharmacist practitioners providing comprehensive medication management. Journal of Pharmacy Practice. 2022 Aug 4;8971900221117892. doi:10.1177/08971900221117892.

Effect of an integrated clinical pharmacist on the drivers of primary care provider burnout

- Family medicine and internal medicine providers at Mayo clinic facilities in Minnesota and Wisconsin participated in a cross-sectional quality improvement survey to assess the perceived efficacy of the integration of clinical pharmacists into the clinic team. A total of 119 providers (physicians, nurse practitioners and physician assistants) responded to the survey. The majority had worked with an integrated clinical pharmacist for 2 to 5 years.

  - **Better care:** 91% of providers were extremely satisfied with the clinical pharmacy services in their clinic, with 90% agreeing that clinical pharmacists help patients make progress towards their health care goal, improve quality measures and assist with effective management of the patient panel. The most commonly reported collaborative activities were curbside consults, chronic disease management and CMM.

  - **Improved provider experience:** More than 95% of providers indicated that pharmacists were critical members of the health care team. They also strongly agreed that working with clinical pharmacists decreased their workload and allowed them to find greater meaning in their work. Providers believed the integration of clinical pharmacists into their clinics gave them more time to focus on the aspects of their work that were more professionally fulfilling.

Haag JD, Yost KJ, Kosloski KA, et al. Effect of an integrated clinical pharmacist on the drivers of provider burnout in the primary care setting. Journal of the American Board of Family Medicine. 2021;34:553-560. doi: 10.3122/jabfm.2021.03.200597.

Assessing the impact of integration of clinical pharmacists into teams on access to care for rural veterans

- This observational study evaluated team perceptions on the success of a program to integrate the VA clinical pharmacy specialists (CPS) providing CMM. Using a mixed methods evaluation, the CPS and their clinical team members were surveyed using the medication use process matrix (MUPM) as well as semi-structured interviews. The study reflected team interactions during 496,323 patient encounters from October 2017 to March 2020. A total of 124 CPS and 1,177 other clinical team members responded to the self-administered web-based questionnaire. An additional 22 interviews were completed with CPS and other clinicians.

  - **Improved provider experience:** The evaluation indicated good integration of the CPS in the primary care teams, as perceived by the other team members.

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- Both primary care team members and the CPS agreed on the high level of contributions provided in all 5 domains of the MUPM, with mean scores of 2.3 to 2.9 on a scale of 0 to 3.
- Findings from the interviews supported the perception that the majority of providers believed the CPS are making substantial contributions to patient care. Provider interviews highlighted the important role the CPS plays by providing CMM to relieve provider burden of care.
- The study also found that CPS reported higher job satisfaction when compared to previous data, citing less burn out and better role fit.

McCullough MB, Zogas A, Gillespie C, Kleinberg F, Reisman JI, Ndiwane N, Tran MH, Ourth HL, Morreale AP, Miller DR. Introducing clinical pharmacy specialists into interprofessional primary care teams: Assessing pharmacists' team integration and access to care for rural patients. Medicine (Baltimore). 2021 Sep 24;100(38):e26689. doi: 10.1097/MD.0000000000026689. PMID: 34559093; PMCID: PMC8462613.

Perceptions of integration of the clinical pharmacist into the PCMH model by the PCMH team

- Integration of CMM by a clinical pharmacist in a Department of Veterans Affairs facility was rated by the primary care team (physicians, nurses and staff) for seven domains.
  - **Better care:** 80% of responses rated the ability of the pharmacist to evaluate medication therapy and monitor the effectiveness and safety of medication therapy as a highly positive benefit.
  - **Improved access to care:** 87% of physicians and nurse practitioners responded that CMM integration by a clinical pharmacist increased access to their clinic by decreasing the time patients had to wait for primary care services.
  - **Improved provider experience:** 93% of physicians and nurse practitioners responded that CMM integration by a clinical pharmacist improved their job satisfaction.

McFarland S, Lamb K, Hughes J, Thomas A, Gatwood J, Hathaway J. Perceptions of Integration of the Clinical Pharmacist into the PCMH Model by the PCMH Team. Journal for Healthcare Quality. 2017. doi:10.1097/JHQ.0000000000000114.

Primary care providers believe that comprehensive medication management improves their work-life

- Part of a larger study of CMM implementation in Minnesota and North Carolina, this series of structured interviews was conducted with 16 primary care providers (PCPs) to identify the impact of CMM on their work life. Responses were then categorized to develop common themes.
  - **Better care:** Participants reported increased satisfaction that their patients were receiving better care and highlighted increased achievement of quality measures.
  - **Improved provider experience:** In addition to citing a decreased workload, PCPs reported a decrease in mental exhaustion related to the reassurance of having a clinical pharmacy colleague and enhanced opportunities for professional learning. This beneficial impact of team-based clinical pharmacist-provided CMM aligns with previously identified methods for decreasing burnout and engagement among primary care providers.

Funk K, Pestka D, McClurg M, Carroll J, Sorensen T. Primary Care Providers Believe That Comprehensive Medication Management Improves Their Work-Life. Journal of American Board of Family Medicine. 2019; 32(4): 462-473. doi: 10.3122/jabfm.2019.04.180376.

Pharmacists providing CMM gain increased efficiency in patient access through use of telemedicine

- This retrospective review evaluated the efficiency of the Tennessee Valley patient-aligned care team (PACT) clinical pharmacy specialists (CPS) providing CMM using patient encounter data, and it reviewed objective patient metrics to evaluate if the quality of care had been compromised during the COVID-19 pandemic. Data collection focused on the number of clinic encounters (in person, by phone or via telehealth), patient accountability to appointments, the number of disease states managed, insulin use, A1c and blood pressure in patients from 2019 and 2020.

  - **Improved access to care:** The total number of PACT CPS encounters increased 32% in 2020, and the number of unique patients increased by 12%.
    - There was a statistically significant increase in telephone visits from 5,230 to 18,715 (accounting for 32% of visits to 87%) while in-person visits decreased from 9,099 to 1,093 (accounting for 56% of all visits to only 5%). Video visits increased but remained a relatively uncommon method of patient encounter.
    - Rates of cancelled appointments and patients not showing up for their appointments also significantly decreased between 2019 and 2020.

  - **Sustained outcomes:** The goal of the study was to identify any negative impact on the quality of care caused by the transition to virtual patient visits.
    - There was no difference in the average change in A1c, with an average reduction of 0.57% in the 2019 cohort and 0.58% in the 2020 cohort ($p = 0.94$).
    - Average reductions in systolic (SBP) and diastolic blood pressures (DBP) also showed no significant change with average reductions in SBP being 3.1 mmHg and 3.2 mmHg ($p = 0.968$) in 2019 and 2020, respectively, and a mean reduction in DBP of 1.1 mmHg in 2019 and 2 mmHg in 2020 ($p = 0.3$). Markers for both diabetes and hypertension showed no negative impact on the conversion to phone and video visits during the pandemic.

Thomas AM, Baker JW, Hoffman TJ, Lamb K. Clinical pharmacy specialists providing consistent comprehensive medication management with increased efficiency through telemedicine during the COVID19 pandemic. Journal of the American College of Clinical Pharmacy. 2021;4: 934-938. doi: 10.1002/jac5.1494.

Optimizing the primary care clinical pharmacy specialist: increasing patient access and quality of care within the Veterans Health Administration

- The Department of Veterans Affairs has integrated the PCMH model as the delivery method of primary care since 2010. The VA Clinical Pharmacy Specialists (CPS) Provider practicing CMM in primary care is a large component of the ability for the VA to increase access and the quality of care for veterans. Currently, there are more than 1,850 CPS practicing CMM in primary care. In fiscal year 2019, patient aligned care team CPS documented 2,561,124 CMM interventions during 1,248,635 patient care encounters.

  - **Improved access to care:** VA Primary Care CPS demonstrated that 27% of primary care return appointments could be averted to a CPS.

  - **Better care:** Multiple studies performed within the VA have shown improvement in specific quality indicators:
    - Significant reduction in median A1c values to 7.7% (interquartile range [IQR] (0.5); $p < 0.001$) from a baseline A1c of 10.0% (IQR + 0.7).

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- Significant reductions in median systolic blood pressure (SBP) and diastolic blood pressure (DBP) from a baseline of 142/83 (IQR + 10 for SBP and 8 for DBP) to 134/79 (IQR + 7 for SBP and 7 for DBP; $P < 0.001$).
- CPS coordinated follow-up post-COPD discharge from a hospital or an emergency department (ED) within 30 days. Patients had a 0% composite readmission rate to the ED or hospital for a COPD exacerbation within 30 days of discharge.

McFarland MS, Nelson J, Ourth H, Groppi J, Morreale A. Optimizing the primary care clinical pharmacy specialist: Increasing patient access and quality of care within the Veterans Health Administration. J Am Coll Clin Pharm. 2020;3:494-500.

Impact of comprehensive medication management on hospital readmission rates

- The Fairview Health System implemented a formal care transitions process that included referrals to outpatient services provided by CMM pharmacists to determine whether or not a CMM visit with a CMM pharmacist within 30 days of hospital discharge decreased readmissions at 30 days post discharge when compared with patients who did not receive a CMM visit. In total, 1,291 hospitalizations had a CMM visit within 30 days of discharge.
  - **Better care:** At 30 days post discharge, patients who received a CMM visit had a significantly lower rate of readmissions compared to the comparator cohort (4.2% lower, $p < 0.001$).
  - **Improved access to care:** 60% of patients received their CMM visit within seven days of hospital discharge.

Budlong H, Brummel A, Rhodes A, Nici H. Impact of Comprehensive Medication Management on Hospital Readmission Rates. Population Health Management 2018. 21(5): 395-400.

Endnotes

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Medication Optimization Use Case

MINNESOTA HEALTH FAIRVIEW ▪ Minneapolis-St. Paul, Minnesota	
Focus Area	Chronic disease model that incorporates the clinician providing CMM services into a primary care patient population. The chronic disease therapy model focuses on outcomes seen when the clinician provides CMM care for common primary care conditions such as cardiovascular disease, diabetes, etc.
At-a-Glance	■ **Organization Type:** Integrated Health System ■ **Launch Date:** 1997 ■ **Payment and Funding Sources:** ▪ CMM is a covered service for all Medicaid patients, Fairview employees, PreferredOne/ ClearScript members. ▪ Contracts with other commercial, managed Medicaid and Medicare payors.
Organization Details	Fairview is an integrated health system with 360,000 health plan members, more than 34,000 employees and more than 5,000 system providers. It consists of the following: ▪ 12 hospitals and medical centers ▪ 3,519 licensed beds ▪ 2,071 staffed beds ▪ 56 primary care clinics ▪ 100+ specialties ▪ 90+ senior housing locations ▪ 36 retail pharmacies
Brief History of CMM Program, Scope of Services	Started in 1997 as a partnership with the University of Minnesota and Fairview. The program matured in 2006 when Medicare Part D and Minnesota Medicaid required plans to offer medication therapy management (MTM) benefits to members. Positive return on investment, provider and patient satisfaction scores and improvement in quality outcomes led to expansion of the program. CMM has become a required element in care delivery re-design in primary care clinics and is now being included as part of Fairview's ACO and risk-managed payor contracts.

Results & Achievements

Focus on the Quadruple Aim

- *Better Outcomes*
- *Cost Savings*
- *Patient Satisfaction & Engagement*
- *Clinician Satisfaction*

Better Outcomes

- The percentage of diabetes patients optimally managed was significantly higher for CMM patients compared to the year prior (21.49% vs.45.45%, P < 0.01). The HbA1c showed a mean reduction of 0.54%. Patients who opted in for CMM had higher Charlson scores, more complex medication regimens and a higher percentage of diabetes with complications.
- Exposure to face-to-face CMM services resulted in improvement of medication adherence with statins, ACEI/ARBs and B-Blockers.
- State of MN diabetes pilot increased from 16% to 42% meeting all goals in a 12-month period.
- 59.7% asthma patients cared for by CMM clinicians achieved the MN community measure for optimal asthma care vs. the state average of 16% in 2011.
- Using a risk-adjusted rate the CMM group has experienced approximately 20% fewer readmissions than might be expected, given their increased level of risk.

Cost Savings

- An average 12:1 ROI in terms of reduced overall health care costs. Overall health care cost reduction of 31.5% after one year of medication therapy management.
- An employer analysis showed that each $1 of medication therapy management billed costs would approximate an average $8.98 savings for total health care costs on all enrolled members.

Patient Satisfaction & Engagement

- 95% of patients agreed or strongly agreed that their overall health and well-being had improved because of CMM.
- Research has shown that patients feel that the CMM clinician is a resource for care/education, that they are more accessible and that they help to coordinate care.

Clinician Satisfaction

- 95% of providers surveyed were confident in the recommendations of the Fairview CMM clinician.
- 92% of providers agreed or strongly agreed that having an CMM clinician at their clinic has helped their patients improve their health and make progress towards their clinical goals.

Patient Success Story	Anita was used to being active. She worked locally for 35 years until back surgery and a hip replacement caused her to retire. A diagnosis of diabetes during a hospital stay last December sent her health into a downward spiral. The problem began when she tried to renew the diabetes medication after a post-hospital rehabilitation stay. Because of mobility limitations, Anita was not able to see her physician and went without her medication for several months. *"Talking to Brittany and getting my medications straightened out has been important," says Anita. "I don't think it would have been possible without her help."* "Brittany has been a lifesaver in many ways," says Anita, 67-year-old Fairview patient. Anita's multiple chronic diseases and related complications had created barriers to care and landed her in the hospital. She needed specialized help to get her health back on track. That's where Dr. Brittany Symonds, medication therapy management clinical pharmacist, stepped in. She serves as part of a network team that came together to help Anita. *"My blood sugar went sky high," says Anita. "I ended up back in the hospital."* For Anita, multiple factors conspired to create what Dr. Symonds called "a perfect storm." Barriers to care included medication cost and mobility issues preventing Anita from visiting her doctor. Dr. Brittany Symonds worked with Anita by phone, reducing the number of clinic visits needed, and helped her find less expensive medications through a mail-order source. Anita calls medication therapy management "one of the best things Fairview instituted. If I hadn't had Brittany, I don't think I'd have my diabetes under control and feel as well as I do today." Additional stories at: https://www.fairview.org/services/medication-therapy-management/patient-stories
Team-Based Care Strategy	■ **Interprofessional Team Roles:** ▪ Triage nurses, care coordinators (social work and RN case managers), inpatient nursing staff trained on CMM and when to refer patients ■ **Role of the Clinician:** ▪ Scope of Advanced Practice: Collaborative practice agreement covering 20+ chronic disease states ■ **Care Delivery Modality:** ▪ In-person, phone and video visits. Extensive communication via MyChart (EHR communication) when needed ▪ 60-minute initial (new) patient visits/30-minute return visits ▪ Patients average two visits/year with pharmacist
Patient Referral Criteria	■ **Eligible Patients:** All patients are eligible for CMM services. ■ **Populations of Focus:** Diabetes, hypertension, hyperlipidemia, smoking cessation, COPD, heart failure, asthma, transplant, HIV and CF patients in specialty locations (among other specialties). Transitions of care, special focus on mental health discharges.

Size of CMM Program	**Number of:** ■ **Pharmacists:** 45 ▪ Pharmacist FTE: 30.2 in direct pt care ■ **Practice Sites:** 55 ■ **Resident Pharmacists:** 5 PGY-1 ■ **Student Pharmacists/Interns:** 2 ■ **Support Staff:** ▪ 3 coordinators: scheduling, coding, billing, recruitment calls ▪ 1 business supervisor ▪ 3 CMM supervisors ▪ 1 CMM Operations Lead ■ **Unique patients served (2019):** ▪ 12,798 patients ▪ 26,460 visits
Program Success Factors	■ **Expanded Roles and Responsibilities of the Pharmacist** ▪ Broad collaborative practice agreements ▪ Consistent care process and follow-up ■ **Convenient Patient Access and Simple Program Entry** ▪ Multiple care delivery modalities (e.g., in-person, telemedicine) ■ **Demonstrate Efficiency & Effectiveness of Cross-Setting Team-Based Care** ▪ CMM eases primary care workload ■ **Demonstrate & Articulate CMM's Value** ▪ Consistently high patient and provider satisfaction scores ▪ Continued ROI studies with positive results ▪ Meaningful, experiential learning opportunities for advanced pharmacy practice experience students
Next Steps, Future Goals	■ Resourcing clinics without a CMM clinician on-site ■ Payment structures to support CMM services

References	Brummel, A. "Optimal Diabetes Care Outcomes Following Face-to-Face Medication Therapy Management Services" *Population Health Management:* 2012. Brummel, A, Carlson, A. Comprehensive Medication Management and Medication Adherence for Chronic Conditions. *Journal of Managed Care Pharmacy* 2016; 22 (1); 56-62. Schultz, H., Patient-perceived value of Medication Therapy Management (MTM) services: a series of focus groups. *Innovations in Pharmacy:3*(4)96. McInnis, T. Capps, K. Get the medications right: a nationwide snapshot of expert practices—Comprehensive medication management in ambulatory/community pharmacy. *Health2 Resources,* May 2016. Sorensen, TD, Sorge LA, Millonig, M et al. Integrating medication management: lessons learned from six Minnesota health systems. September 2014. Additional articles: https://www.fairview.org/services/medication-therapy-management/news
Program Contact Information	**Allyson Schlichte, Pharm.D., MBA, BCACP** Medication Therapy Management Operations Lead Aschlic1@fairview.org 612-510-0767
Developed by the Best Practices and Innovative Solutions Subgroup of the GTMRx Practice and Care Delivery Transformation Workgroup	

Clearly Defined Roles and Responsibilities Help CMM Program to Deliver Services Efficiently

AT A GLANCE

RiverStone Health Clinic
Billings, MT

Person in charge: Amy Moser, Pharm.D., BCACP, CPP

Organization type: FQHC, Level 3 patient-centered medical home

Year CMM Launched: 2010

Payment sources: Medicaid, some private insurers

Funding sources: Primarily through the FQHC contract with some support from the HRSA 340B medication discount program.

Number of pharmacists: 3 (1.5 FTEs)

Number of CMM sites: 1

Unique CMM patients served in 2019: 317

Can patients self-refer? Yes

Collaborative Practice Agreements: For diabetes, hypertension, dyslipidemia, ASCVD risk reduction, COPD, asthma, smoking cessation, thyroid disorders and GERD. They also provide services for high-risk for readmission hospital discharges and integrated behavioral health team.

Fully integrated into a medical home practice, the CMM pharmacists at RiverStone Health Clinic are part of a clinical team that identifies and resolves patients' unmet needs.

Bringing clinical pharmacy skills to that team—and being fully integrated into the medical home—leads to better outcomes and higher satisfaction for its underserved community.

Patients may be referred to the clinical pharmacists by any member of the patient care team in the clinic for CMM. Referrals are based on an assessment of needs, not a particular diagnosis. Clinical pharmacists are part of the team that identifies patients for CMM. Patients can self-refer (usually for follow-up) if they have a primary care provider at the clinic, but they are almost always initially referred by a staff member. Regardless of how a patient is referred, each receives comprehensive medication management.

Staffing and training

Three pharmacists, accounting for 1.5 FTE, are supported by one or two students (generally accounting for 1.5 FTEs). As part of a medical home team, the clinical pharmacists have access to staff who help with scheduling, pre-visit planning and other issues. The team of pharmacists hope to be able to add a pharmacy tech position to the CMM program.

Access innovation on the horizon

RiverStone consists of a centrally located clinic and several satellite sites. Any patient is eligible for CMM services, and these visits are conducted via telemedicine for patients of the satellite sites.

"It is critical for patients to understand and agree with their treatment in order to achieve good outcomes."

Measuring impact

The CMM program at RSH Clinic tracks identified drug therapy problems. Having collaborative practice agreements in place for several common disease states allows for over 90% of drug therapy problems to be resolved by the pharmacists at the CMM visit.

Success factors

RSH has identified four factors crucial to the success of their program:

1. **The ability to identify and meet a patient's needs:** This is fundamental to the program's success.
2. **The pharmacists' skill set:** Pharmacists offer a unique skill set that complements the rest of the clinical team.
3. **Clearly defined roles and responsibilities:** The pharmacy team understands the role and function of each team member.
4. **Appropriate funding:** CMM is supported as part of the PCMH and funded through various channels. The clinic has a contract with University of Montana School of Pharmacy to support student advanced pharmacy practice experience. It receives Medicaid and private insurance payments for the visits conducted by the clinical pharmacists, and our physicians and administrators value the contribution of pharmacists on the team. Positions are supported through the clinic's federal grant funding for FQHCs.

Lessons learned

1. **They need us.** Clinical pharmacists are an important part of the care team. We are able to spend more time with the patient to ensure they really understand how to use their medication correctly to get the best outcomes.
2. **Clinical pharmacists make a unique contribution to the team.** Since clinical pharmacists are trained to be medication experts, they are uniquely qualified to identify and resolve drug therapy problems, such as drug interactions or adverse reactions.
3. **Patients must be part of the decision-making process.** It is critical for patients to understand and agree with their treatment in order to achieve good outcomes. We feel it is most helpful to meet the patient where they are at and then help them move forward toward their goals.

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Get the medications right

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TESTIMONY OF SCOTT MILLER

House Bill 1095 – Comprehensive Medication Management Services Mandate

Good Afternoon, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in a neutral position regarding House Bill 1095.

This bill creates a mandate regarding health insurance plan coverage of comprehensive medication management services. Assuming this is a health insurance plan coverage or payment mandate, this bill does not appear to comply with the statutory requirement in NDCC section 54-03-28(3) that health insurance plan mandates first apply to NDPERS. Further, I am unaware that a cost-benefit analysis has been provided. NDCC 54-03-28 requires both of those problems to be corrected before this Committee can act on SB 2140.

Deloitte, the health plan consultant for NDPERS, was still reviewing this bill when I submitted this testimony. I will advise the Committee if we have their comments by the hearing.

House Human Services Public Hearing

January 17th, 2023

Chairman – Rep. Robin Weisz

Mr. Chairman and member of the Human Services Committee, my name is Allison Hursman and I live in Fargo, ND. I am a pharmacist who has had the privilege of working in the "ambulatory care setting" for the past four years. What this means is that I don't work in a traditional pharmacy setting. I am not surrounded by shelves of drugs on a daily basis. Instead, I work in the clinic and see patients, who schedule appointments to see me, just like a medical provider would. Generally, I see patients for chronic medication management, which includes visits focused on polypharmacy, chronic disease state management, opioid tapers and more. I am a credentialed and privileged provider, which means that I can prescribe mediations, order labs, change doses of medications, etc. just like a medical provider.

Patients are asked to bring all of their medications with them their appointment with me and often will show up with a grocery bag full of prescription medications, over the counter products, herbal supplements and topical preparations. They are almost always embarrassed by the number of medications that they are taking, whether they are on 5 medications or 40+.

I say that it's a privilege to work in ambulatory care because there are a relatively small number of pharmacists who work in this setting. Right now, in North Dakota, there are less than 30 pharmacists who identify as working as an ambulatory care pharmacist (<2% of pharmacists in the state). The majority of all ambulatory care pharmacist positions are located in the larger metropolitan areas or at Indian Health Services (IHS). Leaving most of the state unserved by an ambulatory care pharmacist.

I help to serve the healthcare team by assisting in managing chronic disease states such as hypertension, dyslipidemia, and diabetes. I generally have a lot more access in my schedule than a medical provider. This access also allows me to follow-up with patients sooner and on a more regular interval than they would with their provider. This becomes important in ensuring that patients are tolerating their mediations, were able to pick them up from the pharmacy and afford the medications, are using them correctly, etc. As a pharmacist, I'm often able to intercept issues prior to the patient seeing their provider again, correcting issues within weeks as opposed to three to six months. I work to ensure that patients are able to afford their medications, finding alternative options when necessary. In my role, I also assist in helping to ensure that patients are meeting their health goals. In doing chronic disease management, I can adjust a patients medications every time that I see them, sometimes on a

weekly basis, to ensure that their blood pressure or glucose levels are at goal when they see their provider again.

One of my favorite services that I have provided in my ambulatory care practice is opioid tapers. I am referred patients who are currently taking opioid medications and would like to get off of them or decrease their usage to a less dangerous level. This work is very rewarding in seeing patients quality of life improve by decreasing the amount of opioid that they are taking and finding alternative medications or modalities to manage their pain. I will always remember the patient who told me that I "saved his life" by managing his opioid taper at a rate that he was able to tolerate and minimize any potential withdrawal effects.

Unfortunately, insurance companies are not mandated to pay for the services provided by pharmacists at this time. This limits the number of health systems or community pharmacies that are able to justify the value of having a pharmacist on their team who is providing comprehensive medication management. This is especially difficult for the health systems and pharmacies located in rural areas. This mandate would assist pharmacists in getting reimbursed for the services that we are providing and the work that we are doing to improve patient outcomes and the health of the residents across North Dakota.

I ask for your support of HB 1095 and improving the care for patients of the state of ND. Thank you for your time and consideration.

Respectfully,

Allison Hursman, PharmD, BCGP

Fargo, ND

House Industry, Business and Labor Public Hearing
January 15th, 2023
Chairperson –

Submitted by:
Amy Werremeyer, PharmD, BCPP
2169 Victoria Rose Dr. S
Fargo, ND 58104

Dear Chairperson and members of the House Human Services Committee,

My name is Amy Werremeyer and I live in Fargo, ND. I am Vice President of the North Dakota Pharmacists Association Pharmacists, and the current President-elect of the American Association of Psychiatric Pharmacists. I am also a pharmacist who doesn't work in a pharmacy. I am a Board Certified Psychiatric Pharmacist (BCPP). I don't dispense, sell or make drugs, but I do practice pharmacy and positively impact patient health. In general, this is a concept that can be difficult for people to understand. I don't think that my family or those closest to me even have a good idea as to what I really do at work. Rightfully so, as I don't work as a stereotypical pharmacist does. So, the million dollar question becomes, what do I really do? Understanding this will help put into perspective the positive impact that House Bill 1095 will have on optimizing mediation use in North Dakotans.

I currently work in a clinic setting and previously worked in a hospital setting for over 14 years. I consider myself a medical provider who specializes in medication optimization, especially for patients who are taking psychiatric medications, but I work with all types of medicines too. I meet with patients in an exam room or in their hospital room, just like how you would meet with your other medical provider (doctor, nurse practitioner, physician associate, etc). I generally spend 30-45 minutes talking with a patient about their medications. This includes prescription medications, over the counter medications, herbal products and supplements.

Throughout our visit, I will analyze their entire medication regimen for opportunities for improvement. Are they taking two medications that are duplicative or working against each other? I ask the patient about side effects – specific side effects that are commonly associated with the medications that they are taking. Best case scenario, they aren't having any adverse effects from their medications. However, all too often, I do see patients who are struggling with potentially avoidable side effects from their medications. I also very commonly see patients that are prescribed medications but don't know what to expect from them, and therefore prematurely stop taking them. This is a common issue with mental health (aka psychiatric) medications—it's very difficult for patients to know what to expect from them or how to know if they're working, thus they often aren't taken long enough to be helpful.

I also will sometimes see the prescribing cascade that can follow. For example, a patient is started on a medication to lower their depression. This medication can cause them to gain weight. So they are started on another medication to reduce their appetite. This medication makes them have an increase in anxiety, so they are started on a 3rd medication to decrease anxiety. And this all continues, stemming from one medication-related side effect.

As we work through each of the patient's medications and discuss why they are taking it, if it is working for them and whether they are experiencing any side effects, I am evaluating the continued need for this medication. When meeting with patients, I often tell them that I prefer to take away

medications as opposed to add them. Most patients that I meet with think that they are taking too many medications, whether they are on 4 or 40. This is not an exaggeration. Providers at my hospital would refer patients to me strictly for "polypharmacy". The provider feels that the patient may be taking too many medications and would like an expert to look at their regimen and see if there is anything that can be eliminated or may be dangerous for the patient. I also provide much-needed education to patients, helping to equip them to benefit from their medications rather than abandoning them or taking them in dangerous ways. I have personally seen the very high impact that my pharmacy services bring to patients and other members of the healthcare team. My research in this area has shown that being a part of my educational intervention has kept patients out of the ER—a very important health outcome for patient health as well as healthcare dollars saved!

Patients are also referred to me for helping them optimize their medications for controlling various conditions, such as anxiety, opioid use disorder, alcohol use disorder and many other mental health conditions. I am a credentialled and privileged provider and have worked under a collaborative practice agreement with my provider colleagues. This has allowed me to utilize my expertise and pharmacist training to prescribe new medications, adjust doses of medications, order lab tests, and discontinue medications to aid in optimizing patients' care, just as their other medical provider would. The patients continue to see their regular medical provider as they normally would, however because they need extra attention and care, I am able to manage their conditions in between their regular provider visits in order to help free up time for providers to see their other patients in their very busy schedules.

Enhancing patients' health by improving their medication experience and increasing access to pharmacists' care is my passion. I have given multiple continuing education presentations to other healthcare providers including nurses, doctors, advanced practice clinicians and pharmacists on this topic. These presentations highlight the importance and positive impact that the pharmacist can have on a patient's health when working as an integral member of the health care team. It is my hope that through these educational endeavors and clinical experiences, I can inspire others to continue the work of medication optimization and deprescribing as it is not a task that can be accomplished by one singular individual. Further, if this type of pharmacy practice were to become more common across pharmacy settings (such as in community pharmacies), then patients will have a more healthy and enjoyable medication experience across all transitions of care.

I urge this committee to support robust comprehensive medication management in ND by supporting House Bill 1095, which will lead to better health outcomes, reduce hospital readmissions, and promote optimization of patients' medication experience. As you can see, much of the work pharmacists do closely mirrors the care patients receive at chronic disease follow up visits with their medical provider, and this work helps to improve patient health while freeing up the time of our overworked medical provider team members. Additionally, pharmacists are recognized as a "health care practitioner" in North Dakota Century Code. Unfortunately, not all North Dakota citizens have access to this high-level pharmacist care due to lack of insurance companies including these types of pharmacist services into their overall health benefit design. If pharmacists were able to provide various medication optimization services and be reimbursed just as any other healthcare provider who can provide these services, the patient is ultimately the one who benefits the most. I encourage this committee to support medication optimization services that allow pharmacists take a more active role in providing care for the patients of North Dakota.

Thank you for your consideration,

Dr. Amy Werremeyer, PharmD, BCPP

House Human Services Committee

HB 1095

January 17, 2023

Chairman Weisz and members of the House Human Services Committee, for the record, my name is Jesse Rue, and I am a pharmacist who works at both a hospital and drugstore in Rugby, ND. I am submitting my testimony in support of HB 1095, which would include comprehensive medication optimization services into health benefit plan designs.

This committee may hear testimony to the effect that the provisions in this bill are not necessary, or perhaps the tasks described are already being undertaken across North Dakota. Experience has taught me the opposite, and that implementing such a program would benefit citizens in Rugby and across the state.

In my experience, this bill describes work that has great value, addresses critical health needs for the state, and—critically—this bill describes work which is not being done at grand scale across North Dakota.

I wish to highlight three key benefits of this bill:

- **Optimized Care:** creates framework to deploy a high quality, high value care model throughout the state.
- **Coordinated Care**: activates pharmacists into coordinated care teams regardless of practice site.
- **Efficient and Scalable**: harnesses processes already in place such as medical billing and provider credentialing, which enable reliable and scalable deployments so that all can enjoy the benefits across the state.

DISTINCT INNOVATIONS IN THIS BILL

This bill describes a model that is distinct from current standard pharmacy dispensing practices. It describes an intensive, coordinated model to improve care for chronic diseases, improve quality of care, and reduce costs.

I was pleased to see language about developing standards of care guidance as a central tenet of this bill. While each patient is unique, chronic conditions often have treatment guidelines which improve the care quality and health of the great majority of people. To take a broad, statewide approach to this in partnership with insurance plans is quite innovative.

Built correctly, we believe these standards will improve care quality while ensuring that providers retain the ability to personalize care to the needs of each patient.

Good care coordination means cost avoidance. Care coordination is a critical tool to impact Emergency Room (ER) visits as well as hospital admissions. Ongoing monitoring and optimization of therapy at the community level is essential for any comprehensive efforts at reducing ER and hospital utilization. Care Management activities are the best tool we have to improve quality and reduce avoidable expenses, thereby increasing value for patients, plans, and sponsors. **It is my belief that good care coordination for chronic disease cannot be done without pharmacy medication expertise being deployed to the problem.**

It may well be true that all politics is local—the same can be said for healthcare. One key to success with this bill is that it must activate the patient's community providers (such as community pharmacists) into the patient care team.

This care cannot be delivered by a computer algorithm, and it cannot be outsourced to a faceless call center in Arizona. It is care which must be delivered in the patient's own community by the patient's own provider team, and I hope that this bill will reflect that should it gain your support.

Individually, many pieces of this bill have successful precedent in other states. Putting the pieces together as described in HB 1095? **That would be truly innovative.**

CARE IS SHIFTING INTO THE COMMUNITY

Care increasingly is shifting to outpatient and community settings. As such, a robust strategy to engage community-based caregivers like pharmacists is essential to realize benefits.

Coordinating care in the community, monitoring medication therapy for populations, and utilizing health information in modern ways can all be understood as key aspects of true medication optimization work. With proper information, pharmacists are able to provide this today, particularly in rural areas where access challenges are most acute.

COMMUNITY BASED PROVIDERS AND COORDINATING CARE

Care Coordination is a concept that is foundational to this bill, and it is vital to creating the healthcare infrastructure that will serve us into the future.

It is unlikely that value-based care can be successful at scale without recognizing the need for ongoing, community-based care in these populations. In this sense, the accessibility, ease of access, and frequency of engagement with pharmacists is a resource that this bill can tap. Activating caregivers in the community, clinic, and hospital settings is essential.

This is work that is not being done at scale across North Dakota and which this bill can help remedy.

LACK OF CAPACITY

In this bill's text, I appreciate the annual notice to notify the patient and primary care provider of eligibility. **I respectfully offer the suggestion that language be inserted to also notify the patient's primary community pharmacy.** If we are to innovate care in North Dakota, we must begin with the proper notifications to the key players or else we will fail at creating coordinated models. This attribution process of patients to specific providers, clinics, and pharmacies is a procedure well known to payers today.

There are care coordination programs in place nationally which do have many things in common with the provisions of this bill. The best example may be Chronic Care Management, known as CCM. Similar to this bill, CCM strives to provide intensive care to patients with chronic diseases through care coordination efforts. Medicare has a great affinity for CCM because their studies have repeatedly demonstrated CCM to be effective in improving care as well as saving money.

The biggest problem that Medicare experiences with CCM? Lack of uptake by providers.

> "Almost 9 in 10 PCPs (86%) say they have felt unable to address the needs of their chronic care patients adequately—with 28% saying this happens frequently. For most physicians—85%, lack of time was cited as the key culprit."
>
> The Whole Patient and Nothing but the Patient (ajmc.com)

> Since inception in 2016, less than 10% of the over 30 million Medicare beneficiaries with multiple chronic conditions are receiving CCM service. This concerns CMS considerably, given their belief that the program's effectiveness is legitimate, proven, and quantifiable.
>
> Chronic Care Management Services Improve Health Outcomes and Reduce Costs for America's Seniors | Bipartisan Policy Center

It is remarkable that Medicare has created a framework program that improves health and reduces expenses but they do not have adequate caregiver uptake in delivering the program. And so, Medicare cannot reap the benefits.

Neither can the patients across the country. I am very confident that CCM-style services are underutilized in North Dakota the same as they are across the country.

This presents a clear opportunity for patients, caregivers, payers and sponsors across North Dakota—through this bill, there is a mechanism to install similar themes to the CCM program and tap into underutilized pharmacist providers to scale this rapidly.

Increasing the availability of qualified healthcare providers to deliver these services is a rational step forward and directly addresses roadblocks that medical practices have in delivering that care. (In fact, there may be areas to improve the current bill's plan design by incorporating some of the eligibility criteria and frequency of care visits from CCM).

CHRONIC CARE DELIVERY IS BECOMING CONTINUOUS

Nationwide, we have been witnessing a clear shift in care from an episodic model (where less follow-up occurs between clinic visits) to a model which monitors one's health for the entire time between clinic visits. This ongoing approach is a true innovation and allows care teams to intervene before patients deteriorate to the point of requiring a visit to the ER or hospital. The optimization foundation of this bill helps to harmonize North Dakota with that future.

Patients with chronic diseases represent the highest expenditures in our health system today and will continue to do so for the foreseeable future. **For most chronic diseases, medication therapy remains a foundational part of their therapy, so it is rational to include medication specialists such as part of the core benefit design.**

This is another key benefit of this bill.

CONCLUSION

The future of high quality, affordable care depends heavily upon improving health outside clinic and hospital locations. Community providers will increase in importance.

Rural health is community-focused and deeply tied to relationships. This is a reality which community caregivers (such as pharmacies) understand intuitively and operate in daily.

This bill creates a roadmap to activate these caregivers into the larger care team, as it is only by thoughtful collaboration that we can meet the needs of the people we serve. **This is a bill that I believe has several real and long-term benefits for my rural community as well as other communities across the state, whether they be rural, suburban, or urban.**

I ask for your support of HB 1095. Thank you for your time and consideration.

Respectfully Submitted,

Jesse Rue, PharmD, BCPS

Rugby, ND

House Human Services Committee
January 17th, 2023
Chairman – Rep. Robin Weisz

Submitted by:
Brody Maack, PharmD, BCACP, CTTS
523 Piper St
Kindred, ND 58051

Mr. Chairman and members of the Human Services Committee, my name is Brody Maack and I live in Kindred, ND. I am past President of the North Dakota Society of Health-System Pharmacists, and the current Chair-elect of the American Society of Health-System Pharmacists Section of Ambulatory Care Practitioners. I am also a pharmacist who doesn't work in a pharmacy. I don't dispense, sell or make drugs, but I do practice pharmacy and positively impact patient health. In general, this is a concept that can be difficult for people to understand. I don't think that my family or those closest to me even have a good idea as to what I really do at work. Rightfully so, as I don't work as a stereotypical pharmacist does. So, the million dollar question becomes, what do I really do? Understanding this will help put into perspective the positive impact that House Bill 1095 will have on optimizing mediation use in North Dakotans.

I work in a clinic setting, and I consider myself a medical provider who specializes in medication optimization. I meet with patients in an exam room, just like how you would meet with your other medical provider (doctor, nurse practitioner, physician associate, etc). I generally spend 30-45 minutes talking with a patient about their medications. Patients are asked to bring in all of their medications to our meetings. This includes prescription medications, over the counter medications, herbal products and supplements. They often present with a grocery bag full of things.

Throughout our visit, I will analyze their entire medication regimen for opportunities for improvement. Are they taking two medications that are duplicative or working against each other? I ask the patient about side effects – specific side effects that are commonly associated with the medications that they are taking. Best case scenario, they aren't having any adverse effects from their medications. However, all too often, I do see patients who are struggling with potentially avoidable side effects from their medications.

I also will sometimes see the prescribing cascade that can follow. For example, a patient is started on a medication to lower their blood pressure. This medication can cause them to retain more fluid. The patient has swelling in their ankles, so they are started on another medication to reduce the swelling. This medication makes them have to go to the bathroom more often, so they are started on a 3rd medication to decrease urinary frequency. And this all continues, stemming from one medication-related side effect.

As we work through each of the patient's medications and discuss why they are taking it, if it is working for them and whether they are experiencing any side effects, I am evaluating the continued need for this medication. When meeting with patients, I often tell them that I prefer to take away medications as opposed to add them. Every patient that I meet with thinks that they are taking too many medications, whether they are on 4 or 40. This is not an exaggeration. Providers at my clinic will refer patients to me strictly for "polypharmacy". The provider feels that the patient may be taking too many medications and would like an expert to look at their regimen and see if there is anything that can be eliminated or may be dangerous for the patient.

Patients are also referred to me for helping them optimize their medications for controlling various conditions, such as high blood pressure, diabetes, anticoagulation and tobacco cessation. I am a credentialled and privileged provider and work under a collaborative practice agreement with my provider colleagues. This allows me to utilize my expertise and pharmacist training to prescribe new medications, adjust doses of medications, order lab tests, and discontinue medications to aid in optimizing patients' care, just as their other medical provider would. The patients continue to see their regular medical provider as they normally would, however because they need extra attention and care, I am able to manage their conditions in between their regular provider visits in order to help free up time for providers to see their other patients in their very busy schedules.

Enhancing patients' health by increasing access to pharmacists' care is my passion. I have given multiple continuing education presentations to other healthcare providers including nurses, doctors, advanced practice clinicians and pharmacists on this topic. These presentations highlight the importance and positive impact that the pharmacist can have on a patient's health when working as an integral member of the health care team. It is my hope that through these educational endeavors and clinical experiences, I can inspire others to continue the work of medication optimization and deprescribing as it is not a task that can be accomplished by one singular individual. Further, if this type of pharmacy practice were to become more common across pharmacy settings (such as in community pharmacies), then patients will have a more healthy and enjoyable medication experience across all transitions of care.

I urge this committee to support robust comprehensive medication management in ND by supporting House Bill 1095, which will lead to better health outcomes, reduce hospital readmissions, and promote optimization of patients' medication experience. As you can see, much of the work pharmacists do closely mirrors the care patients receive at chronic disease follow up visits with their medical provider, and this work helps to improve patient health while freeing up the time of our overworked medical provider team members. Additionally, pharmacists are recognized as a "health care practitioner" in North Dakota Century Code. Unfortunately, not all North Dakota citizens have access to this high-level pharmacist care due to lack of insurance companies including these types of pharmacist services into their overall health benefit design. If pharmacists were able to provide various medication optimization services and be reimbursed just as any other healthcare provider who can provide these services, the patient is ultimately the one who benefits the most. I encourage this committee to support medication optimization services that allow pharmacists take a more active role in providing care for the patients of North Dakota.

Thank you for your consideration,

Dr. Brody Maack, PharmD, BCACP, CTTS

HOUSE BILL NO. 1095

Presented by: **Chrystal Bartuska, Division Director, Life/Health/Medicare**
North Dakota Insurance Department

Before: **House Human Services Committee**
Representative Weisz, Chairman

Date: **January 17, 2023**

Good morning, Chairman Weisz and members of the committee. My name is Chrystal Bartuska, and I am the director for the life, health, and Medicare division of the Insurance Department. I am here today in support of House Bill 1095 and will explain the comprehensive medication management services to be offered in health benefit plans. As HB 1095 consists of a single section, I will go through the sections of section of 26.1-36.11, the chapter that would be created by this bill.

To start, section one creates the definitions used in the chapter. Key among these is the definition of "comprehensive medication management," which can be found on page one, line nine through page two, line 18. This defines the services to be included, such as formulating a medication treatment plan, monitoring the enrollee's response to therapy, and performing a comprehensive medication review. Again, the full definition can be found on pages one and two of the bill.

Section two details the requirements placed on health carriers while providing comprehensive medication management. This includes:

- Regular notification of enrollees and the enrollee's primary care provider of the program if the enrollee meets certain health requirements. Those requirements can be found on page three, lines ten trough twenty-one.
- Making comprehensive medication management services available via telehealth.
- A requirement that an adequate number of participating pharmacists in the carriers' network, including population-based metrics found on page four, lines six through seventeen.

- A requirement that a pharmacist directory indicate which pharmacists are participating providers under the comprehensive medication management program.
- An effective date requiring these services be provided beginning in the 2024 plan year.

Section three requires the Commissioner to establish and facilitate an advisory committee to implement the requirements of chapter 26.1-36.11. The advisory committee is to develop best practice recommendations on standards to ensure pharmacists are adequately included and appropriately utilized in comprehensive medication management programs. The advisory committee's initial recommendations would be due no later than December 1, 2023. Membership of the advisory committee consists of:

- The state health officer, or designee;
- An organization representing pharmacists;
- An organization representing physicians;
- An organization representing hospitals;
- A community pharmacy with pharmacists providing medical services;
- The two largest health carriers in the state based on enrollment;
- The NDSU school of pharmacy;
- An employer as a health benefit plan sponsor;
- An enrollee;
- Other representatives appointed by the Insurance Commissioner.

Lastly, section four grants the Insurance Commissioner the authority to go through the Administrative Rules process and then present rules to the Administrative Rules Committee for adoption.

These services are an expansion of what all the carriers do now within their companies, and you will hear other testimony that this is getting to be a popular service in other states. The department does not recognize this as a new mandate of benefits, and we

did confirm that with legislative council. This bill creates criteria around the program and streamlines the contracting and credentialling with the providers and pharmacists.

As Commissioner Godfread mentioned, we believe that many of the concerns that health carriers have risen could be addressed by the advisory committee and administrative rules process. Additionally, we are happy to work with stakeholders to draft any amendments that the committee feels are better addressed in the Century Code than in Administrative Rules to strengthen this HB 1095 as it would be a valuable service to our constituents.

Thank you, I am happy to answer any questions that you may have.

HOUSE BILL NO. 1095

Presented by: **Jon Godfread, Insurance Commissioner**
North Dakota Insurance Department

Before: **House Human Services Committee**
Representative Weisz, Chairman

Date: **January 17, 2023**

Good morning, Chairman Weisz and members of the committee. My name is Jon Godfread, and I am the North Dakota Insurance Commissioner. I am here today in support of House Bill 1095.

The 67th Legislative Assembly passed HB 1010, part of which requested legislative council to conduct a study on medication optimization. The Insurance Department assisted with the study and worked with various actuarial consultants and found that a program of this nature would benefit the consumers of North Dakota. These findings were consistent with the recommendations from the Interim Health Care study that 66th Legislative Assembly tasked my office with conducting.

The consultants from the current study collaborated with the insurance carriers in the state and asked questions surrounding these types of programs. As a result of the study, we found that all the carriers already offer some of these services in some of the programs they already have in place. House Bill 1095 would just put parameters around the requirements to ensure there is consistency for the consumers, pharmacists, providers, and the insurers.

House Bill 1095 requires the insurers to ensure that if a pharmacist or provider is conducting comprehensive medication management programs that they are credentialed and have the correct criteria to advise patients on the best medication regiments and to achieve good outcomes as a result of the program. We recognize that this may be a different process for insurers in their provider contracting, but these programs are designed to be help medication management.

One issue that was brought to our attention is that there are some sections of the bill that may create additional administration and challenges for the insurer's and that was not our intent when drafting this legislation. We want the patients of North Dakota to have more options available to them to ensure healthy outcomes. Also, we need to keep in mind that programs like this have resulted in lower overall costs in utilization. A little investment in during implementation pays dividends once these programs are up and running.

We also want to point out that some of the logistical criteria and overall program will be vetted out through the advisory committee and even potential administrative rules process.

We know there may be opposition to this bill, but we are committed to working through any issues to ensure we get consumers what they need in our state. We have offered to work with the insurers and are open to suggestions but have not seen any recommendations to date.

Ultimately, this program was the result of our Health Care Cost study, as such, it is believed to be a program that will ultimately bring costs down in our state. To accomplish this necessary goal, things may have to change, programs may have to evolve, comprehensive medication management is a proven tool to improve patient outcomes, satisfaction, and adherence to medication, and in doing so improve the health of the consumer, thus lowering the overall medical spend. I would argue this bill is 5 years in the making, it was studied during our health care cost study and was determined to be a good idea then.

It was again study during this interim and was determined to be a good idea at that point, so much so it was recommended for inclusion in our Essential Health Benefits.

Ultimately, what you have before you is an idea that should not only improve the patient experience, improve their overall health and outcome, but over the long run attempt to bring down the cost of health care.

I would now like to turn it over to Chrystal Bartuska, who is the Life and Health Division Director at the North Dakota Insurance Department, to walk through the bill.

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Mark J. Hardy, PharmD
Executive Director

Bill No 1095 – Comprehensive Medication Management
House Human Services Committee
9:30 PM - Tuesday – January 17th, 2023

Chairman Weisz and Members of the House Human Services committee, for the record I am Mark Hardy Executive Director of the North Dakota State Board of Pharmacy.

The Board of Pharmacy is supportive of the parameters of HB1095.

In the Board of Pharmacy's role in regulating the professional of pharmacy we see the tremendous impact that the profession makes in the care of patients every day in the State of North Dakota. The citizens of our great state rely upon and need our pharmacists practicing at the top of their scope in an increasingly complex world of medications. You all, the legislature, have been supportive of expanding the practice of pharmacists in the state and pharmacists are utilizing these important tools in their practices everyday.

We commend the Insurance Commissioner's Office on their work to request that comprehensive medication management services be included within health benefit plans. This will serve to enhance the impact that our pharmacists are making on the public at large.

Please feel free to reach out to me anytime if I can be of any assistance to you as you work through this important legislation.

Respectfully submitted by
Mark J. Hardy, PharmD

January 17, 2023

HOUSE HUMAN SERVICES COMMITTEE
HB 1095

CHAIRMAN WEISZ AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing on behalf of America's Health Insurance Plans or, as it is commonly known, AHIP.

AHIP and AHIP members support the concept to ensure that North Dakotans have access to comprehensive medication management – that is a core function of a health insurance providers' role because we have the full picture of a patient's medications from various doctors/prescribers and are able to flag potential adverse reactions.

However, as drafted AHIP has strong concerns with the bill as proposed. Overall, this legislation is a benefit mandate and will increase health insurance costs for North Dakotans and will lead to consumer confusion.

There are number of problematic provisions in the bill and a number of issues that, at the very least, need refinements. These include –

- The list of services included in the definition of "comprehensive medication management" is vague.
    - Health plans need more specific guidance information regarding what is meant by each of these. In order to reimburse for each of these services, we need to ensure there is a coordinating CPT code, which is set by an independent body – if there is no CPT code for a given service, then billing and paying for that service becomes highly complicated.
- Concerned about requiring health plans to contract/credential pharmacists as providers. Currently insurers contract with pharmacies, not pharmacists, and is part of how health plans meet their national accreditation standards as required by North Dakota.
    - This bill would require a complicated provider contracting process to take place with a universe of providers who often have little history of contracting with health plans, submitting medical claims for reimbursement, etc. because these interactions have historically taken place between the health plan and the facility (pharmacy).
    - This will require that insurers have to separately contract with every pharmacist, which is going to take a lot of time and money.

- Network adequacy requirements based on time and/or distance should not be placed specifically in law as percentages may always change as city populations ebb and flow, size, but can be discussed with our regulators. We appreciate the bill allows these services to be provided by telehealth.
    - We generally oppose strict time or distance standards because they are difficult to meet and don't take into consideration things like geography and differing populations and telehealth, which this bill explicitly allows for.
- Similar to network adequacy, specific to plan directory requirements change over time.
    - There's no guarantee that every pharmacy in the existing network would want to provide services as described; and no guarantee that every pharmacist in all pharmacies would want to provide them.
    - It would be very difficult to explain who enrollees can go to for what services if all pharmacists don't contract to provide these services. This could be even more confusing in a directory – what if a pharmacist isn't taking new patients for these services but the pharmacy that they work for is accepting new patients for their usual medication dispensing services?
    - The effective date of the bill does not provide sufficient time for implementation. Health plans would have less than a year to create all of new contracts and provide these services.

In summary, HB 1095:

1. Requires health plans to implement new contracting and new credentialing standards that do not exist today – Significant costs and oversight would be needed to implement.
2. Network adequacy requirements: The bill creates two pharmacy networks for carriers (essentially creates a whole new pharmacy network) – The bill prohibits carriers from using their existing pharmacy network to meet the network standard.
3. Provider Directory: Health plans already have competing priorities from the federal government to implement new federal requirements for provider directories. The new requirements in the bill are a significant lift and would be very expensive.

Therefore, AHIP respectfully requests a DO NOT PASS on this bill as it is now written. However, AHIP and our member plans would appreciate continued conversations with the bill sponsors for possible revisions.

Thank you for your time and consideration. I'd be glad to answer any questions I can.

Essentia Health

January 16, 2023

Dear House Human Services Committee:

I am writing in support of HB 1095; relating to the inclusion of comprehensive medication management services for the patients of the State of North Dakota.

The patients of North Dakota do not have access to the pharmacy services our pharmacists are eager to provide. This lack of access has a negative impact on the health outcomes our patients could achieve.

In the rural and urban areas across the state of North Dakota, Essentia Health achieves a high quality of care as the only Accountable Care Organization (ACO) across the state. Putting a pharmacist into the care mix is critical to our care model across our organization, and is currently being done. HB1095 for North Dakota will provide the access to the comprehensive medication management services our patients need in North Dakota.

Please let me know if you have additional questions. Thank you for your service to NoDak!

Respectfully,

Maari Loy, PharmD, BCPS, MBA
Pharmacy Operations Senior Manager
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House Human Services Committee
January 17th, 2023
Chairman – Rep. Robin Weisz

Submitted by:
Elizabeth Monson, PharmD, BCPS
4727 6th St. West
West Fargo, ND 58078

Mr. Chairman and members of the Human Services Committee, my name is Elizabeth Monson and I am a native of North Dakota, born and raised in Bismarck, ND, currently living in West Fargo. I am a pharmacist who works in a hospital pharmacy and I am the current president of the North Dakota Society of Health System Pharmacists (NDSHP). NDSHP currently includes 192 members, consisting of pharmacists, student pharmacists and pharmacy technicians who work in healthcare settings other than community pharmacies, such as hospitals and ambulatory care clinics.

As a pharmacist in the hospital setting I work alongside physicians, nurses and other healthcare providers to provide optimal medication management for patients. This includes talking to patients when they are admitted to the hospital to obtain an accurate home medication list and assess what should be continued or stopped on admission to the hospital. Along with continuing to assess every single medication that a provider orders in the hospital, at discharge I also review the medications the patient will take when they are discharged to their homes to make sure that everything is ordered appropriately during this transition of care. During these transitions of care, I often make recommendations to fix medication-specific problems. Examples include, medications being ordered that a patient no longer needs, medications being ordered that a patient already has, or interacts with a medication the patient is already taking, or medications being ordered with the wrong dose or duration.

Other members of NDSHP work in a clinic setting. They see patients one-on-one in a clinic exam room (just like you would see your primary care provider) and evaluate every single medication the patient is on. These pharmacists can make changes to medications through collaborative practice agreements (CPAs). This means that these pharmacists have prescriptive authority to prescribe medications to optimize a person's care. Pharmacists can also use these CPA's to help manage disease states such as diabetes or hypertension. This helps to decrease the workload for providers and increase access for patients.

Unfortunately, not all hospitals and clinics have the ability to provide these high-level pharmacist services due to the lack of insurance companies recognizing and paying for this benefit. In fact, most of these services in North Dakota are only offered in the metro areas or through the Indian Health Services which means that the majority of our patients in the rural communities of North Dakota do not have access to them. I encourage this committee to support medication optimization services that allow pharmacists to provide the best patient care for the patients of North Dakota.

NDSHP strongly supports House Bill 1095 and urges you to do the same.

Dr. Elizabeth Monson, PharmD, BCPS

NDPhA
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House Human Services Committee
Chairman, Representative Robin Weisz
01-17-2023
HB 1095 – 9:30

Chairman Weisz and members of the House Human Services Committee, for the record, my name is Mike Schwab, the Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of HB 1095.

Over the past decade, comprehensive medication management (CMM) services provided by pharmacists has gained widespread attention for achieving improved health outcomes in patients with chronic health conditions, while also reducing health care costs. CMM is a patient-centered approach to optimizing medication use and improving patient health outcomes that is delivered by a pharmacist working in collaboration with the patient and other healthcare providers. CMM is a comprehensive patient care process, with a definition and a set of essential functions and operational definitions that outline the steps required to deliver the intervention in a consistent standardized manner.

Many states already allow for a variety of CMM types of services to be provided by pharmacists (Wisconsin, Ohio, Washington State, Tennessee, Minnesota, and Idaho come to mind). In the past, the U.S. Surgeon General and the National Governors Association have both called for states to fully integrate pharmacists into healthcare teams and allow pharmacists to practice at the top of their scope of practice as the medication experts.

HB 1095 does not expand the scope of practice for a pharmacist. This bill also does not give pharmacists the ability to diagnosis, nor does this bill provide additional prescriptive authority for pharmacists.

This bill looks to leverage a pharmacist's expertise, increase patient health outcomes and reduce healthcare costs. There is an ever-growing set of data and literature that shows the value of CMM services being provided by pharmacists.

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Pharmacists have deep experience readily translatable to value and risk-based models of care. Their skillset makes them adaptable to the broad array of care delivery models which can benefit members, plans and sponsors. Rather than competing with medical staff providers, pharmacists look to collaborate and extend the critical work being done at clinics and hospitals.

> "Health plans may benefit from higher plan quality ratings, lower premiums and plan bids, increased shared savings, and quality bonus payments…Pharmacists can work alongside physicians in advanced care models and play a vital role in shaping the primary care practice transition to value-based care."
>
> Making the economic value proposition for pharmacist comprehensive medication management (CMM) in primary care: A conceptual framework. Research in Social and Administrative Pharmacy

This bill also establishes an advisory committee which allows all the players to voice their recommendations, to develop best practices, develop a standardization of care, focus on program quality measures, address care coordination and will establish health plan data reporting requirements. These are all key elements in developing successful CMM services.

Efforts, such as HB 1095, have been proven to be of value in many other states and in many areas of healthcare. CMM services also have a great track record of increasing patient health outcomes and providing a return on investment. If done right, these types of efforts benefit all players in healthcare, including the health insurance carriers. Thank you for your time and attention. I am happy to try and answer any questions.

Respectfully Submitted,

Mike

Mike Schwab
NDPhA EVP

TESTIMONY OF SCOTT MILLER

House Bill 1095 – Comprehensive Medication Management Services Mandate

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in a neutral position regarding House Bill 1095.

This bill creates a mandate regarding health insurance plan coverage of comprehensive medication management services. Assuming this is a health insurance plan coverage or payment mandate, this bill does not appear to comply with the statutory requirement in NDCC section 54-03-28(3) that health insurance plan mandates first apply to NDPERS. Further, I am unaware that a cost-benefit analysis has been provided. NDCC 54-03-28 requires both of those problems to be corrected before this Committee can act on SB 2140.

Deloitte, the health plan consultant for NDPERS, has reviewed the bill and provided the following comments:

The financial impact of comprehensive medication management services cannot be estimated without additional clarification of the details of the bill and potential costs from service providers. Deloitte Consulting recommends further study to estimate potential costs. Preliminary areas of consideration include:

1. The bill does not limit the comprehensive medication management services to the enrollees in the NDPERS uniform group insurance program. The financial impact on the uniform group insurance program will be influenced by how much of the cost of the services is born by the uniform group insurance program, the health plan/insurer, or other parties.
2. Sanford Health Plan, the current insurer, does not have comprehensive medication management as described in the bill. Sanford Health Plan will require additional staff and enhancement of pharmacist administered services to meet the requirements. The costs of these program enhancements will be dependent on additional information.
3. Sanford Health Plan provides drug utilization review services under the existing uniform group insurance program to monitor drug safety and gaps in care. Sanford Health Plan includes the cost of this program in the insured rate, it is not charged extra, and costs $0.16 per member per month. These drug utilization review services may be duplicative with the comprehensive medication management program or could potentially be used as a tool for providers as a component of the program.

4. Under the modified fully-insured arrangement, Sanford Health Plan will determine the adjustment to the insured rates due to the requirements of the program. The insured rates determined by Sanford Health Plan may not be equal to the administrative and claims costs estimated prior to the establishment of the services depending on Sanford's business strategy and underwriting and risk requirements.
5. Costs are dependent on the volume of services provided as part of comprehensive medication management. The volume of services will be variable based on the number of eligible members, the engagement rate of members, the members access to participating providers, and the frequency of services provided. NDPERS may have access to health care data through Sanford Health Plan to be able to estimate eligible members as part of further study on potential cost.
6. The bill requires an adequate number of pharmacists to deliver comprehensive medication management and specifically provides that "the participation of pharmacies in the health carriers network's drug benefit does not satisfy the requirement" (page 3, lines 24-25). Sanford Health Plan does not currently credential pharmacists as providers. If pharmacist credentialing is required by the health insurance provider, Sanford Health Plan would need to implement the processes and requirements to do so.
7. Provider reimbursement rates will be a key component of cost (along with volume of services, as discussed in (5) above. Reimbursement rates may depend on varying qualifying criteria including member need, setting of the visit (pharmacy, clinic, hospital, in-person, telehealth), encounter type (first encounter, follow up), etc.
8. The legislation allows for telehealth (page 3, lines 20-21). The proportion of care delivered via telehealth compared to in-person could impact cost to the extent that telehealth services are billed at a different rate than in-person services.
9. Comprehensive medication management may result in a change in clinical outcomes that will have an effect on cost. For example, medication management services may result in more frequent low-cost encounters that increases cost while avoiding adverse clinical outcomes that result in decreased cost.
10. The legislation establishes regulation for the directory of pharmacists participating and eligible to provide services. The provider directory must be publicly accessible without an account (or being enrolled in the insurance plan), the directory must be audited regularly such that at least 25% of provider entries are audited quarterly and 100% are audited annually, and the directory must have search functionality on fields including name, gender, location, facility affiliation, language spoken, and availability to accept new enrollees (page 4, line 17-30 and page 5, lines 1-10). Health carriers may not have provider directories that meet the requirements of these provisions today, which would necessitate time and investment to establish compliant directories.

11. The legislation establishes an advisory committee to implement the medication management services and assist in rulemaking and other topics. The advisory committee is responsible for delivering, by June 20, 2024, best-practice recommendations to the insurance commissioner and the department of health and human services (page 5, lines 14-31 and page 6, lines 1-8). There may be costs associated with developing initial best-practices report to the extent outside experts are required to conduct research in collaboration with, or on behalf of, the advisory committee and the scope of work required.

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Mark J. Hardy, PharmD
Executive Director

Bill No 1095 – Comprehensive Medication Management
Senate Human Services Committee
9:00 AM - Tuesday – March 7th, 2023

Madam Chair Lee and Members of the Senate Human Services committee, for the record I am Mark Hardy Executive Director of the North Dakota State Board of Pharmacy.

The Board of Pharmacy is supportive of the parameters of HB1095.

In the Board of Pharmacy's role in regulating the professional of pharmacy we see the tremendous impact that the profession makes in the care of patients every day in the State of North Dakota. The citizens of our great state rely upon and need our pharmacists practicing at the top of their scope in an increasingly complex world of medications. You all, the legislature, have been supportive of expanding the practice of pharmacists in the state and pharmacists are utilizing these important tools in their practices everyday.

We commend the Insurance Commissioner's Office on their work to request that comprehensive medication management services be included within health benefit plans. This will serve to enhance the impact that our pharmacists are making on the public at large.

Please feel free to reach out to me anytime if I can be of any assistance to you as you work through this important legislation.

HOUSE BILL NO. 1095

Presented by: **John Arnold, Deputy Commissioner**
North Dakota Insurance Department

Before: **Senate Human Services Committee**
Senator Lee, Chairwoman

Date: **March 7, 2023**

Good morning, Chairwoman Lee and members of the Senate Human Service Committee. My name is John Arnold and I am the Deputy Commissioner for the Insurance Department. I am here today in support of House Bill 1095 and will explain the comprehensive medication management services to be offered in health benefit plans.

First some background on this bill. The 67th Legislative Assembly passed HB 1010, part of which requested Legislative Council to conduct a study on medication optimization. The Insurance Department assisted with the study and worked with various actuarial consultants and found that a program of this nature would benefit the consumers of North Dakota. These findings were consistent with the recommendations from the Interim Health Care study that 66th Legislative Assembly tasked the Insurance Department with conducting.

The consultants from the current study collaborated with the insurance carriers in the state and asked questions surrounding these types of programs. As a result of the study, we found that all the carriers already offer some of these services in some of the programs they already have in place. House Bill 1095 would just put parameters around the requirements to ensure there is consistency for the consumers, pharmacists, providers, and the insurers.

House Bill 1095 requires the insurers to ensure that if a pharmacist or provider is conducting comprehensive medication management programs that they are credentialed and have the correct criteria to advise patients on the best medication

regiments and to achieve good outcomes as a result of the program. We recognize that this may be a different process for insurers in their pharmacy contracting, but these programs are designed to be help medication management.

One issue that was brought to our attention is that there are some sections of the bill that may create additional administration and challenges for the insurer's and that was not our intent when drafting this legislation. Our goal is to provide patients in North Dakota with more options to ensure healthy outcomes. Also, we need to keep in mind that programs like this have resulted in lower overall costs in utilization. A little investment during implementation pays dividends once these programs are up and running.

We know there may be opposition to this bill and that some see this as a new mandate under PERS. We have confirmed with our federal partners, legislative council, various consulting firms and even most of the carriers in the state, and it is not seen as a mandate by those parties. We understand that PERs may see it as a mandate under their process, but the reason for this is due to the fact that our current insurer for PERs does this in house and does not contract with any outside pharmacist or entity for the medication management programs. This should not be seen as a determent to the program and bill as a whole given if our PERs plan was with another carrier this would not be an expansion of the services already offered.

Some additional points to it not being a mandate is that this is an overall value-added service that is not filed in the plan documents as a benefit, nor do the services affect claims or direct premiums. These services would be calculated into the insurer's administrative costs and would be seamless to the consumer.

This program was the result of our Health Care Cost study, as such, it is believed to be a program that will ultimately bring costs down in our state. To accomplish this necessary goal, things may have to change, programs may have to evolve. Comprehensive medication management is a proven tool to improve patient outcomes,

satisfaction, and adherence to medication, and in doing so improve the health of the consumer, thus lowering the overall medical spend. I would argue this bill is five years in the making, it was studied during our health care cost study and was determined to be a good idea then.

It was studied again during this interim and was determined to be a good idea at that point, so much so it was recommended for inclusion in our Essential Health Benefits. Ultimately, what you have before you is an idea that should not only improve the patient experience and improve their overall health and outcome, but over the long run attempt to bring down the cost of health care.

As HB 1095 consists of a single section, I will go through the sections of section of 26.1-36.11, the chapter that would be created by this bill.

To start, section one creates the definitions used in the chapter. Among these is the definition of "comprehensive medication management," which can be found on page one, line nine through page two, line 18. This defines the services to be included, such as formulating a medication treatment plan, monitoring the enrollee's response to therapy, and performing a comprehensive medication review. Again, the full definition can be found on pages one and two of the bill.

Section two details the requirements placed on health carriers while providing comprehensive medication management. This includes:

- Regular notification of enrollees and the enrollee's primary care provider of the program if the enrollee meets certain health requirements. Those requirements can be found on page two, line twenty-seven trough page three, line twelve.
- Making comprehensive medication management services available via telehealth.
- A requirement that an adequate number of participating pharmacists in the carriers' network.

- A requirement that a pharmacist directory indicate which pharmacists are participating providers under the comprehensive medication management program.
- An effective date requiring these services be provided beginning in the 2025 plan year.

Section three requires the Commissioner to establish and facilitate an advisory committee to implement the requirements of chapter 26.1-36.11. The advisory committee is to develop best practice recommendations on standards to ensure pharmacists are adequately included and appropriately utilized in comprehensive medication management programs. The advisory committee's initial recommendations would be due no later than June 30, 2024. Membership of the advisory committee consists of:

- The state health officer, or designee;
- An organization representing pharmacists;
- An organization representing physicians;
- An organization representing hospitals;
- A community pharmacy with pharmacists providing medical services;
- The two largest health carriers in the state based on enrollment;
- The NDSU school of pharmacy;
- An employer as a health benefit plan sponsor;
- An enrollee;
- An advanced practice registered nurse; and
- Other representatives appointed by the Insurance Commissioner.

Lastly, section four grants the Insurance Commissioner the authority to go through the Administrative Rules process and then present rules to the Administrative Rules Committee for adoption.

So, in conclusion, these services are an expansion of what all the carriers do now within their companies, and it is getting to be a popular service in other states. This bill

creates criteria around the program and streamlines the contracting and credentialling with the providers and pharmacists. At the end of the day, we feel that HB 1095 will be a valuable service to our constituents.

Thank you, Chairwoman Lee and members of the committee. I am happy to answer any questions that you may have.

Prepared by the
North Dakota Insurance Department
March 7, 2023

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1095

Page 3 line 28, replace “medical” with “pharmacy”

Renumber accordingly

2023 House Bill 1095
Senate Human Services Committee
Senator Judy Lee, Chairman
March 7, 2023

Chairman Lee and members of the Senate Human Services Committee, I am Tim Blasl, President of the North Dakota Hospital Association (NDHA). I testify in support of House Bill 1095 and ask that you give the bill a **Do Pass** recommendation.

Hospitals support this bill because comprehensive medication management (CMM) helps ensure that each patient's medications are individually assessed to determine each is appropriate for that patient, effective for the medical condition, safe given other medications the patient may be taking, and able to be taken by the patient as intended.

CMM is designed to be a collaboration among health care providers to optimize patient outcomes. CMM provides better health care in multiple ways. Patients benefit from improved medication-related clinical outcomes and they benefit from the increased individualized attention to medications and impact on their daily lives. Physicians and other care team members benefit when clinical pharmacists apply their pharmacotherapeutic expertise in a collaborative way to help manage complex drug therapies. Physicians can dedicate more time to the diagnostic and treatment selection process, enabling them to be more efficient and spend more time providing medical care. Health plans and other payers benefit when they pay only for medications that are safe, appropriate, and effective. Keeping patients out of the hospital is one of the most important—and most cost-effective—goals of patient-centered care. Providing CMM to complex patients is one way to help accomplish this goal.

For these reasons, we ask that you give the bill a **Do Pass** recommendation. Thank you.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

Senate Human Services Committee

March 7th, 2023

Chairman – Rep. Robin Weisz

Madam Chair Lee and Members of the Senate Human Services Committee, my name is Allison Hursman and I live in Fargo, ND. I am a pharmacist who has had the privilege of working in the "ambulatory care setting" for the past four years. What this means is that I don't work in a traditional pharmacy setting. I am not surrounded by shelves of drugs on a daily basis. Instead, I work in the clinic and see patients, who schedule appointments to see me, just like a medical provider would. Generally, I see patients for chronic medication management, which includes visits focused on polypharmacy, chronic disease state management, opioid tapers and more. I am a credentialed and privileged provider, which means that I can prescribe mediations, order labs, change doses of medications, etc. just like a medical provider.

Patients are asked to bring all of their medications with them their appointment with me and often will show up with a grocery bag full of prescription medications, over the counter products, herbal supplements and topical preparations. They are almost always embarrassed by the number of medications that they are taking, whether they are on 5 medications or 40+.

I say that it's a privilege to work in ambulatory care because there are a relatively small number of pharmacists who work in this setting. Right now, in North Dakota, there are less than 30 pharmacists who identify as working as an ambulatory care pharmacist (<2% of pharmacists in the state). The majority of all ambulatory care pharmacist positions are located in the larger metropolitan areas or at Indian Health Services (IHS). Leaving most of the state unserved by an ambulatory care pharmacist.

I help to serve the healthcare team by assisting in managing chronic disease states such as hypertension, dyslipidemia, and diabetes. I generally have a lot more access in my schedule than a medical provider. This access also allows me to follow-up with patients sooner and on a more regular interval than they would with their provider. This becomes important in ensuring that patients are tolerating their mediations, were able to pick them up from the pharmacy and afford the medications, are using them correctly, etc. As a pharmacist, I'm often able to intercept issues prior to the patient seeing their provider again, correcting issues within weeks as opposed to three to six months. I work to ensure that patients are able to afford their medications, finding alternative options when necessary. In my role, I also assist in helping to ensure that patients are meeting their health goals. In doing chronic disease management, I can adjust a patient's medications every time that I see them, sometimes on a

weekly basis, to ensure that their blood pressure or glucose levels are at goal when they see their provider again.

One of my favorite services that I have provided in my ambulatory care practice is opioid tapers. I am referred patients who are currently taking opioid medications and would like to get off of them or decrease their usage to a less dangerous level. This work is very rewarding in seeing patients' quality of life improve by decreasing the amount of opioid that they are taking and finding alternative medications or modalities to manage their pain. I will always remember the patient who told me that I "saved his life" by managing his opioid taper at a rate that he was able to tolerate and minimize any potential withdrawal effects.

Unfortunately, insurance companies are not mandated to pay for the services provided by pharmacists at this time. This limits the number of health systems or community pharmacies that are able to justify the value of having a pharmacist on their team who is providing comprehensive medication management. This is especially difficult for the health systems and pharmacies located in rural areas. This mandate would assist pharmacists in getting reimbursed for the services that we are providing and the work that we are doing to improve patient outcomes and the health of the residents across North Dakota.

I ask for your support of HB 1095 and improving the care for patients of the state of ND. Thank you for your time and consideration.

Respectfully,

Allison Hursman, PharmD, BCGP

Fargo, ND

March 6, 2023

Dear Chair Lee and Senate Human Services Committee:

I am writing in support of HB 1095; relating to the inclusion of comprehensive medication management services for the patients of the State of North Dakota.

The patients of North Dakota do not have access to the pharmacy services our pharmacists are eager to provide. This lack of access has a negative impact on the health outcomes our patients could achieve.

In the rural and urban areas across the state of North Dakota, Essentia Health achieves a high quality of care as the only Accountable Care Organization (ACO) across the state. Putting a pharmacist into the care mix is critical to our care model across our organization, and is currently being done. HB1095 for North Dakota will provide the access to the comprehensive medication management services our patients need in North Dakota.

Please let me know if you have additional questions. Thank you for your service to NoDak!

Respectfully,

Maari Loy, PharmD, BCPS, MBA
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APhA
American Pharmacists Association

March 7, 2023

[submitted electronically via: ndlegis.gov]

The Honorable Senator Judy Lee
Chair, Human Services Committee
1822 Brentwood Court
West Fargo, ND 58078-4204

RE: HB 1095 (Weisz) – Relating to the inclusion of comprehensive medication management services in health benefit plans – SUPPORT

Dear Chair Lee, Vice Chair Cleary, and members of the Human Services Committee:

The American Pharmacists Association (APhA) appreciates the opportunity to submit proponent testimony on House Bill (HB) 1095 (Representative Weisz). HB 1095 will allow for the reimbursement of comprehensive medication management provided by pharmacists practicing within their scope of practice by health plans in the State. Realigning financial incentives in our health care system to allow for health plan reimbursement under the medical benefit of services provided by pharmacists ensures patients have more time with their most accessible health care professional, their pharmacist. It also properly aligns the current role of the pharmacist, with their extensive education and training, to practice at the top of their license.

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care and enhance public health. In North Dakota, with 1,100 licensed pharmacists and 790 pharmacy technicians, APhA represents the pharmacists, student pharmacists, and pharmacy technicians that practice in numerous settings and provide care to many of your constituents. As the voice of pharmacy, APhA leads the profession and equips members for their role as the medication expert in team-based, patient-centered care. APhA inspires, innovates, and creates opportunities for members and pharmacists worldwide to optimize medication use and health for all.

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We also support the submitted testimony from the North Dakota Pharmacists Association.

Substantial published literature clearly documents the proven and significant improvement to patient outcomes[1] and reduction in health care expenditures[2] when pharmacists are optimally leveraged as the medication experts on patient-care teams. The expansion of programs that increase patient access to health care services provided by their pharmacist in North Dakota is aligned with the growing trend of similar programs in other states, such as: California, Colorado, Idaho, Kentucky, Minnesota, Missouri, Nevada, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin, Wyoming, and others. In states where such programs have already been implemented, we are observing health plans recognizing the value of the pharmacist and investing in the services they provide in order to capitalize on the positive therapeutic and economic outcomes associated with pharmacist-provided care.[3]

As the most accessible healthcare professionals, pharmacists are a vital provider of care, especially for those living in underserved and remote communities. Patient access to pharmacist-provided care can address health inequities while reducing hospital admissions, increasing medication adherence, and decreasing overall healthcare expenditures by recognizing and covering the valuable health care services pharmacists provide, similar to North Dakota's recognition of many other health care providers.

The creation of programs that allow for the direct reimbursement of services provided by pharmacists through health plans opens additional revenue opportunities for these pharmacists to maintain their practice and provide valuable health care services that are necessary for many North Dakota communities. It is also important to note these programs are not expected to raise costs for health plans, as published literature has shown pharmacist-provided care results in cost savings and healthier patients.[4,5] This strong return on investment supports why many other states that have established comparable programs. For example, Oregon, identified in their fiscal

[1] Giberson S, Yoder S, Lee MP. Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011. Available at: https://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf

[2] Murphy EM, Rodis, JR, Mann HJ. Three ways to advocate for the economic value of the pharmacist in health care. Journal of the American Pharmacists Association. August 2020. Available at: https://www.sciencedirect.com/science/article/abs/pii/S1544319120303927

[3] CareSource Launches Pharmacist Provider Status Pilot. Published August 4, 2020. Available at https://www.caresource.com/newsroom/press-releases/caresource-launches-pharmacist-provider-status-pilot/

[4] Giberson S, Yoder S, Lee MP. Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011. Available at: https://www.accp.com/docs/positions/misc/improving_patient_and_health_system_outcomes.pdf

[5] Murphy EM, Rodis, JR, Mann HJ. Three ways to advocate for the economic value of the pharmacist in health care. Journal of the American Pharmacists Association. August 2020. Available at: https://www.sciencedirect.com/science/article/abs/pii/S1544319120303927

legislative analysis that the creation of a similar program would have "minimal expenditure impact on state or local government."[6]

For these reasons, APhA strongly supports HB 1095 and respectfully requests your "AYE" vote. If you have any questions or require additional information, please do not hesitate to contact E. Michael Murphy, PharmD, MBA, APhA Advisor for State Government Affairs by email at mmurphy@aphanet.org.

Sincerely,

Michael Baxter
Acting Head of Government Affairs
American Pharmacists Association

cc: Senator Sean Cleary, Vice Chairman
Senator David A. Clemens
Senator Kathy Hogan
Senator Kristin Roers
Senator Kent Weston

[6] FISCAL IMPACT OF PROPOSED LEGISLATION Measure: HB 2028 A. Seventy-Eighth Oregon Legislative Assembly – 2015 Regular Session. Available at https://olis.oregonlegislature.gov/liz/2015R1/Downloads/MeasureAnalysisDocument/28866.

Senate Human Services Committee
March 7th, 2023
Chairman – Senator Judy Lee

Submitted by:
Brody Maack, PharmD, BCACP, CTTS
523 Piper St
Kindred, ND 58051

Madam Chair Lee and members of the Senate Human Services Committee, my name is Brody Maack and I live in Kindred, ND. I am past President of the North Dakota Society of Health-System Pharmacists, and the current Chair-elect of the American Society of Health-System Pharmacists Section of Ambulatory Care Practitioners. I am also a pharmacist who doesn't work in a pharmacy. I don't dispense, sell or make drugs, but I do practice pharmacy and positively impact patient health. In general, this is a concept that can be difficult for people to understand. I don't think that my family or those closest to me even have a good idea as to what I really do at work. Rightfully so, as I don't work as a stereotypical pharmacist does. So, the million dollar question becomes, what do I really do? Understanding this will help put into perspective the positive impact that House Bill 1095 will have on optimizing mediation use in North Dakotans.

I work in a clinic setting, and I consider myself a medical provider who specializes in medication optimization. I meet with patients in an exam room, just like how you would meet with your other medical provider (doctor, nurse practitioner, physician associate, etc). I generally spend 30-45 minutes talking with a patient about their medications. Patients are asked to bring in all of their medications to our meetings. This includes prescription medications, over the counter medications, herbal products and supplements. They often present with a grocery bag full of things.

Throughout our visit, I will analyze their entire medication regimen for opportunities for improvement. Are they taking two medications that are duplicative or working against each other? I ask the patient about side effects – specific side effects that are commonly associated with the medications that they are taking. Best case scenario, they aren't having any adverse effects from their medications. However, all too often, I do see patients who are struggling with potentially avoidable side effects from their medications.

I also will sometimes see the prescribing cascade that can follow. For example, a patient is started on a medication to lower their blood pressure. This medication can cause them to retain more fluid. The patient has swelling in their ankles, so they are started on another medication to reduce the swelling. This medication makes them have to go to the bathroom more often, so they are started on a 3rd medication to decrease urinary frequency. And this all continues, stemming from one medication-related side effect.

As we work through each of the patient's medications and discuss why they are taking it, if it is working for them and whether they are experiencing any side effects, I am evaluating the continued need for this medication. When meeting with patients, I often tell them that I prefer to take away medications as opposed to add them. Every patient that I meet with thinks that they are taking too many medications, whether they are on 4 or 40. This is not an exaggeration. Providers at my clinic will refer patients to me strictly for "polypharmacy". The provider feels that the patient may be taking too many medications and would like an expert to look at their regimen and see if there is anything that can be eliminated or may be dangerous for the patient.

Patients are also referred to me for helping them optimize their medications for controlling various conditions, such as high blood pressure, diabetes, anticoagulation and tobacco cessation. I am a credentialled and privileged provider and work under a collaborative practice agreement with my provider colleagues. This allows me to utilize my expertise and pharmacist training to prescribe new medications, adjust doses of medications, order lab tests, and discontinue medications to aid in optimizing patients' care, just as their other medical provider would. The patients continue to see their regular medical provider as they normally would, however because they need extra attention and care, I am able to manage their conditions in between their regular provider visits in order to help free up time for providers to see their other patients in their very busy schedules.

Enhancing patients' health by increasing access to pharmacists' care is my passion. I have given multiple continuing education presentations to other healthcare providers including nurses, doctors, advanced practice clinicians and pharmacists on this topic. These presentations highlight the importance and positive impact that the pharmacist can have on a patient's health when working as an integral member of the health care team. It is my hope that through these educational endeavors and clinical experiences, I can inspire others to continue the work of medication optimization and deprescribing as it is not a task that can be accomplished by one singular individual. Further, if this type of pharmacy practice were to become more common across pharmacy settings (such as in community pharmacies), then patients will have a more healthy and enjoyable medication experience across all transitions of care.

I urge this committee to support robust comprehensive medication management in ND by supporting House Bill 1095, which will lead to better health outcomes, reduce hospital readmissions, and promote optimization of patients' medication experience. As you can see, much of the work pharmacists do closely mirrors the care patients receive at chronic disease follow up visits with their medical provider, and this work helps to improve patient health while freeing up the time of our overworked medical provider team members. Additionally, pharmacists are recognized as a "health care practitioner" in North Dakota Century Code. Unfortunately, not all North Dakota citizens have access to this high-level pharmacist care due to lack of insurance companies including these types of pharmacist services into their overall health benefit design. If pharmacists were able to provide various medication optimization services and be reimbursed just as any other healthcare provider who can provide these services, the patient is ultimately the one who benefits the most. I encourage this committee to support medication optimization services that allow pharmacists take a more active role in providing care for the patients of North Dakota.

Thank you for your consideration,

Dr. Brody Maack, PharmD, BCACP, CTTS

SANFORD HEALTH PLAN

Madam Chair and Members of the Senate Human Services Committee –

My name is Dylan Wheeler, Head of Government Affairs for Sanford health Plan, submitting comments today **in opposition** to HB1095, for a number of reasons. While we appreciate the diligent work by the Insurance Department on this issue, HB1095 is not clear on its impact or scope and has unresolved issues at this time. We do not challenge the importance and role of pharmacists as a valued partner in health care delivery and service to patients and members.

At its core, however, HB1095 is a coverage mandate, which would compel health carriers in North Dakota to provide coverage for Comprehensive Medication Management services, as defined in the bill. In fact, on page 2, lines 25 and 26 – the bill states "a health carrier **shall provide coverage** for licensed pharmacists to provider comprehensive medication management to enrollees." Sanford Health Plan generally opposes mandates, and this also true to HB1095. In addition to the coverage mandate, the current form of the bill appears to not comply with the necessary NDPERS 2 year pilot period.

In addition, we have concerns with the broad scope of the bill, premium implications, initial/continued investment to comply, and questions related to certain aspects of the proposal. To begin, HB1095 would authorize pharmacists to bill for and receive reimbursement for certain services as defined in the bill; however, what is not clear is how/what form those claims would be submitted under; i.e. what CPT codes, claim volume, etc. I want to make clear that we are not questioning the role of a pharmacist in care delivery, but in scoping, planning, and implementing the bill – we would like to be informed of the impact. In addition, our team has not been able to adequately price the premium impact of HB1095 as written, and that is due to a number of reasons; a primary one of which is that an advisory committee would continue to implement the bill post-passage – hence, further adjustments and critiques could occur in the future.

Next, the initial and continued investment to implement/oversee HB1095 is not clear. For example, HB1095 would require SHP to create new contracts for pharmacists, as health plans traditionally contract with pharmacies, not pharmacists. Moreover, HB1095 would require health plans to create a new stand-alone network and comply with additional network adequacy standards. Finally, we have additional questions about how this program will interplay with other payers in the state including government programs (Medicaid, Medicaid Expansion, Medicare, self-pay, dual-eligibles, etc.). As we know, some enrollees may receive their services from different providers, different payers, and perhaps different pharmacists. We want to ensure we can adequately capture utilization with the multiple touchpoints our members come into contact with.

To conclude, HB1095 is well-intended and recognizes a key piece in health care delivery; however, due to the unresolved issues, impact to premium, and HB1095 being a mandate – we respectfully oppose at this time.

Dylan Wheeler

Head of Government Affairs – Sanford Health Plan

Senate Human Services Committee
March 7th, 2023
Chairperson – Sen. Judy Lee

Dear Chairperson Lee and members of the Senate Human Services Committee,

My name is Rebecca Aubart and I am a pharmacy student from Colgate, ND. I am submitting my testimony for support of HB 1095 relating to the inclusion of comprehensive medication management services in health benefit plans.

I will be completing my nine year pharmacy education in May 2023 and will become a licensed pharmacist in North Dakota. I have been trained extensively on medication management which includes medication appropriateness, effectiveness, safety, interactions, and side effects. As medication experts, pharmacists are fully equipped and well within their scope of practice to provide these clinical services. Along with the clinical aspect, medication management includes proper patient education, training, counseling, adherence, and integration within the healthcare team as a whole. These pillars of comprehensive medication management are throughly trained and integrated throughout the Doctor of Pharmacy curriculum.

As I have completed clinical rotations at various sites across North Dakota, I have participated in comprehensive medication management services and have had pharmacist mentors who are experts in this area. These services have a large affect on our patients and I have seen my direct interventions impact patient health. One of my proudest moments as a student healthcare professional came while I was in an ambulatory care setting with a patient struggling with diabetes. I helped create a medication treatment plan and used collaborative practice agreements to cater a regimen that worked for the patient. We worked together weekly to reach their goals through in person visits, phone call check ins, different medication combinations, lifestyle coaching, and more. In five weeks the patient was able to reach their goals and targets because of the interventions I made. These services and interactions are why I am excited to practice pharmacy in North Dakota.

Pharmacist are fully qualified and currently completing comprehensive medication management. However, there are incentive limitations for providing these services that HB 1095 will improve upon. My future career goals include being involved in rural health and enhancing pharmacy based services in our rural communities. In many rural areas, the pharmacist may be the most accessible healthcare professional. Ensuring comprehensive medication management is available through all insurance plans and in these areas is important for improving patient and population health in North Dakota.

As a future healthcare professional in North Dakota, I support HB 1095 and I urge you to do the same. Thank you for your time.

Respectfully,

Rebecca Aubart, PharmD Candidate 2023

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March 7, 2023

Senator Judy Lee, Chairman
Senate Human Services Committee
North Dakota State Capitol
600 East Boulevard Avenue
Bismarck, North Dakota 58505

Re: AHIP Comments on House Bill 1095, *Health Benefit Plan Coverage of Comprehensive Medication Management*

Dear Chairman Lee and Committee Members,

AHIP and our local health insurance provider members support the intent of HB 1095 to ensure that North Dakotans can access comprehensive medication management care services when appropriate. In fact, we believe that every American deserves access to affordable, comprehensive, high-quality coverage and care.

AHIP appreciates the sponsors' willingness to work with AHIP and our member plans to our address our concerns and we appreciate the amendments that were adopted in the House. However, AHIP continues to have strong concerns with the bill as proposed. Overall, HB 1095 is a benefit mandate that will increase health insurance costs for North Dakotans and will lead to consumer confusion. For the reasons discussed below, AHIP and our members would appreciate additional time to work with the sponsors to address our concerns.

Medication therapy management programs increase costs for consumers without producing clinical benefits.

HB 1095 proposes to create a mandatory comprehensive medication management program for privately-sponsored plans, similar to the "Medication Therapy Management Program" (MTM Program) that currently exists in the Medicare program. Historically, the MTM Program is a complex, high-touch (and expensive) initiative that has not shown improved clinical outcomes or reduced health care spending. The Centers for Medicare and Medicaid Services has tried tweaking the MTM Program over the years, including starting a pilot version of an "enhanced" program, but this has not shown measurable improvements to overall spending or clinical outcomes for participating beneficiaries.[1] For these reasons, employers have not shown strong interest in MTM programs and health insurance providers have not been routinely including them in their plan offerings.

Further, mandating these kinds of programs on all plans will put significant strain on health insurance providers to find qualified staff to run them. In Medicare, for instance, plans already report shortages of qualified pharmacists/clinicians available to provide such services to enrollees, and that is only for about 1.4 million Part D participating enrollees nationwide (out of 18 million total, or about 8%). Because the population of North Dakota is so spread out, it is unlikely that there is a sufficient supply of qualified pharmacists available to meet the requirements of this legislation.

[1] Acumen LLC. Evaluation of the Part D Enhanced Medication Therapy Management (MTM) Model: Fourth Evaluation Report. April 2022. https://innovation.cms.gov/data-and-reports/2022/mtm-fourth-evalrept

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Health insurance providers are investing in innovative ways to serve patients – HB 1095 will impede market innovation.

MTM Programs are not the only way to help patients with complex medical conditions that require multiple medications to manage, and health insurance providers use both passive and active interventions to do so. These can include health plan outreach via wellness checks, calls, written/e-communications to promote patient adherence and mitigate side effects, etc., or using claims adjudication at the retail counter to prevent filing contra-indicated medications, and other claim-specific safety edits. Targeted interventions such as these are effective and far less resource intensive than mandating MTM style programs on entire plan enrollee populations. In addition, these interventions can be done without imposing a significant burden on patients.

MTM Programs work well for some patients, but not all of them, and member concerns with MTM Programs are common. Patients tend not to like overbearing interventions forced on them, and this results in many patients opting out of these programs altogether. It is better to allow health insurance providers to work with their members to determine if these kinds of "high-touch" engagements will work best for enrollees, versus having a broad-mandate which forces all patients and plans into them.

HB 1095 creates significant operational concerns, will increase health insurance costs for North Dakotans, and will lead to consumer confusion.

Beyond our overarching concerns with mandating an expensive and low-value MTM Program, AHIP also has the following concerns with HB 1095:

- HB 1095 requires health insurance providers to directly contract with pharmacists, essentially creating an entirely new provider network which does not currently exist in any state. This is a complicated operational process that requires each pharmacist to become credentialed and be able to submit medical claims for reimbursements. This raises multiple questions on how to handle pharmacies that are in-network versus, out-of-network. Not all pharmacists who practice there are credentialed and vice versa--i.e. how to handle pharmacists that want to contract, but who practice in an out-of-network pharmacy. Is there a limitation on how many patients a pharmacist may see? Will patients need to set up appointments to receive these services? Further, there is no guarantee that every pharmacy in an existing network would want to provide these services as described, and no guarantee that every pharmacist in all pharmacies would want to provide them. Will patients be required to make appointments with their in-network pharmacist if other pharmacists do not want to be credentialed?

- HB 1095 would require health insurance providers to treat pharmacists as "providers" equal to physicians for reimbursement purposes. For decades the U.S. Congress has debated granting pharmacists such "provider status" in Medicare. Despite widespread support, legislation has stalled because the U.S. Congressional Budget Office has scored it as significantly increasing federal spending, which would require significant spending cuts or new taxes under current budgetary "paygo" rules to implement. This would be no less true in North Dakota, with costs ultimately borne by employers and patients.

- Implementation of a MTM Program could create a significant issue for North Dakotan consumers within the Marketplace. This type of program could increase costs to such a degree that it could impact plan design and the ability of health insurance providers to meet the required actuarial value, (the percentage of total average costs for covered benefits that a plan will cover), particularly for bronze plans.

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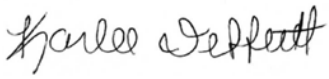
- The definition of "comprehensive medication management" in HB 1095 includes an exhaustive list of services for health plans to reimburse a pharmacist. In order to reimburse for each of these services, health insurance providers would need to ensure that there is a coordinating CPT code, which are established by an independent international body. Additionally, what occurs if a pharmacist is not willing to provide the additional services as listed?

Overall, we think many of the issues raised within HB 1095 are directly related to the scope of practice for pharmacists. As medication management is within the pharmacy scope of practice, nothing prevents pharmacists from providing these services now. Pharmacists should already be providing medical management services to plan enrollees as part of what they are paid for under plan pharmacy network participation contracts (i.e. dispensing fees, etc.). AHIP has strong concerns that this legislation will increase pharmacy profits at the expense of North Dakota consumers through increases in health insurance premiums.

We appreciate the opportunity to share our concerns and your consideration of our comments. Please do not hesitate to contact me at ktebbutt@ahip.org or 720-556-8908 if you have any questions.

Sincerely,



Karlee Tebbutt
Regional Director, State Affairs
AHIP – Guiding Great Health

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

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NORTH DAKOTA PHARMACISTS ASSOCIATION

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Senate Human Services Committee
Madam Chair, Senator Judy Lee
03-07-2023
HB 1095 – 9:00am

Madam Chair and members of the Senate Human Services Committee, for the record, my name is Mike Schwab, the Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of HB 1095.

Over the past decade, comprehensive medication management (CMM) services provided by pharmacists has gained widespread attention for achieving improved health outcomes in patients with chronic health conditions, while also reducing health care costs. CMM is a patient-centered approach to optimizing medication use and improving patient health outcomes that is delivered by a pharmacist working in collaboration with the patient and other healthcare providers. CMM is a comprehensive patient care process, with a definition and a set of essential functions and operational definitions that outline the steps required to deliver the intervention in a consistent standardized manner.

Many states already allow for a variety of CMM types of services to be provided by pharmacists (Wisconsin, Ohio, Washington State, Tennessee, Minnesota, Kentucky, Texas and Idaho come to mind). In the past, the U.S. Surgeon General and the National Governors Association have both called for states to fully integrate pharmacists into healthcare teams and allow pharmacists to practice at the top of their scope of practice as the medication experts.

HB 1095 does not expand the scope of practice for pharmacists. This bill also does not give pharmacists the ability to diagnosis, nor does this bill provide additional prescriptive authority for pharmacists.

This bill looks to leverage a pharmacist's expertise, increase patient health outcomes and reduce healthcare costs. There is an ever-growing set of data and literature that shows the value of CMM services being provided by pharmacists.

NDPhA
NORTH DAKOTA PHARMACISTS ASSOCIATION

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Pharmacists have deep experience readily translatable to value and risk-based models of care. Their skillset makes them adaptable to the broad array of care delivery models which can benefit members, plans and sponsors. Rather than competing with medical staff providers, pharmacists look to collaborate and extend the critical work being done at clinics and hospitals.

> "Health plans may benefit from higher plan quality ratings, lower premiums and plan bids, increased shared savings, and quality bonus payments…Pharmacists can work alongside physicians in advanced care models and play a vital role in shaping the primary care practice transition to value-based care."
>
> Making the economic value proposition for pharmacist comprehensive medication management (CMM) in primary care: A conceptual framework. Research in Social and Administrative Pharmacy

This bill also establishes an advisory committee which allows all the players to voice their recommendations, to develop best practices, develop a standardization of care, focus on program quality measures, address care coordination and will establish health plan data reporting requirements. These are all key elements in developing successful CMM services.

Efforts, such as HB 1095, have been proven to be of value in many other states and in many areas of healthcare. CMM services also have a great track record of increasing patient health outcomes and providing a return on investment. If done right, these types of efforts benefit all players in healthcare, including the health insurance carriers. Thank you for your time and attention. I am happy to try and answer any questions.

Respectfully Submitted,

Mike

Mike Schwab
NDPhA EVP

2.

Prepared by the
North Dakota Insurance Department
March 7, 2023

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1095

Page 3 line 28, replace "medical" with "pharmacy"

Renumber accordingly

Wolf, Sheldon

From: Megan Houn <Megan.Houn@bcbsnd.com>
Sent: Tuesday, March 7, 2023 9:50 AM
To: NDLA, S HMS
Subject: 1095 Testimony

Would you mind posting or emailing to committee members please?

1095 Testimony

Chairman Lee and Members of the Senate Human Services Committee,

Blue Cross Blue Shield of North Dakota (BCBSND) respectfully requests a Do Not Pass for House Bill 1095 in its current form. We view this as an insurance mandate which would require all carriers to create a new program to match the proposed legislation and respectfully ask that you add the PERS trial to identify utilization and administrative costs. However, we have been in communication with the DOI and if they accept our current program as fulfilling the requirements of this proposed legislation, then we will be in support.

BCBSND already has a medication optimization program in place at no cost to our members, which includes around 175 local pharmacists across the spectrum of pharmacies in the state (hospital, long-term care, stand-alone, chain, etc).

Our program uses an algorithm that identifies eligible members and then pushes those members out to the local pharmacists for contact. This algorithm is more comprehensive than the criteria outlined in HB 1095 and allows our program to account for network adequacy by utilizing tele-pharmacy. For example, suppose there is not an enrolled provider doing these services in Glen Ullen. In that case, we will have a pharmacist from another region reach out to the area without a provider.

As this program functions similar to that of one laid out in 1095, and would likely meet the intent behind the legislation, our concerns are limited to how 1095 wishes these programs would be implemented.

Firstly, in relation to member capture. Specifically, we are concerned about how we can capture all of the fully insured members who meet the criteria laid out in the bill. For example, we would not have insight into medications for which a member is paying cash, using GoodRx or manufacturer coupons, or for medications, they pick up over the counter. Another potential gap is that we do not have access to the Prescription Drug Monitoring Program (PDMP). As such, we can not have insight into all controlled substances a member is using if that member chooses to pay cash. Also, how do medications filled through Indian Health Services work? What about patients that switch insurance? If passed into law, we would not have knowledge into the previous medication lists for those members and we then would have difficulty complying with this regulation.

Secondly, we have concerns surrounding the provider directory. Since the passage of the federal No Surprises Act, we have been required to supply and maintain a provider directory. Despite multiple efforts (and modalities) to encourage providers to update their information, over 90% still have not responded. Our suggestion would be to require the pharmacists to be responsible for updating their own directory entries or have joint responsibility. Additionally, the directory calls for components we do not typically collect, one being gender which we think would fit better as an optional data field.

Thirdly, under 43.15-31.2,

> "Pharmacists are required with each prescription dispensed to explain to the patient or the patient's agent the directions for use and a warning of the potentially harmful effect of combining any form of alcoholic beverage with the medication and any additional information, in writing if necessary, to assure the proper utilization of the medication or device prescribed."

Because of this, we have concerns relating to the vagueness in the wording found on Page 3, section 4b.

> "Health carriers shall reimburse facilities for covered services provided by network pharmacists within the pharmacists' scope of practice per negotiations with the facility."

This vagueness could result in carriers reimbursing pharmacists for services that are part of their required scope of service under 43.15-31.2 instead of for the benefits intended by this program. When we look at Hawaii, where the coding NDPhA wants is used, data shows it will double the cost of our current program.

Additionally, we request that line 9 on Page 3 be removed. Patients with hospital admissions should already receive discharge counseling on their medications upon their discharge. Further, members that were admitted to the hospital who would benefit from this service will likely already qualify under sections A, C, or D regardless of the number of hospitalizations. However, members that don't meet criteria A, C, or D would not benefit from this service but would qualify solely for hospital admissions. An example would be a young person who has been admitted for three "bad luck" incidents, perhaps a broken leg, appendicitis, and concussion, who will qualify for this program but, due to the nature of their hospitalizations, will not benefit. So section B is unnecessary as those who would benefit from the program will already meet the criteria elsewhere and those who remain would not benefit.

Lastly, we request two cleanup amendments. The first is on Page 3, line 28 the word medical should be removed as our understanding is that it was inadvertently missed in the House amendment. Secondly, we request that line 12 on Page 3 be stricken. These programs come at a cost; not everything can be changed and updated quickly. There is a cost to BCBSND and our members every time something is added or changed, and for each patient encounter, it isn't administratively feasible to leave it open-ended.

It is for the above-mentioned reasons that BCBSND respectfully requests a Do Not Pass for House Bill 1095 in its current form.

Thank you.

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Proposed Amendment to HB 1095

Representative Rohr

Page 5, Line 20: Add an expiration date of August 1, 2025, to the advisory committee.

Page 6, line 1: remove "and"

Page 6, line 2: replace "Other representatives appointed by the insurance commissioner." With "an advanced practice registered nurse; and"

Page 6, line 3: insert "l. Other representatives appointed by the insurance commissioner."

** Adding APRN to list of stakeholders for advisory committee

Prepared by the
North Dakota Insurance Department
January 31, 2023

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1095

Page 2, remove lines 23 through 29

Page 3, line 25, replace “medical” with “pharmacy”

Page 3, line 26, after “of” insert “pharmacists and”

Page 3 line 28, replace “medical” with “pharmacy”

Page 3, line 29, replace "2023” with “2024”

Page 4, remove lines 4 through 17

Page 4, remove line 25

Page 4, line 26, replace “c” with “b”

Page 4, line 29, replace “d” with “c”

Page 4, line 29, replace the second “the” with “that”

Page 5, line 1, replace “e” with “d”

Page 5, line 3, replace "f” with “e”

Page 5, line 12, replace “2023” with “2024”

Page 5, line 19, after “training” insert “and credentialing”

Page 6, line 3, replace “December 1, 2023” with “June 30, 2024”

Renumber accordingly

February 14, 2023

HOUSE HUMAN SERVICES COMMITTEE
HB 1095

CHAIRMAN WEISZ AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing on behalf of America's Health Insurance Plans or, as it is commonly known, AHIP.

AHIP is opposed to HB 1095 in its current form, but has suggested amendments that have been submitted as testimony.

I urge you to consider these proposals. AHIP is fully prepared to work with the committee to see how these suggestions can be implemented.

Therefore, AHIP respectfully requests a DO NOT PASS on this bill as written but supports our proposed amendments. Thank you for your time and consideration. I'd be glad to answer any questions I can.

23.8073.01000

Sixty-eighth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1095

Introduced by

Representative Weisz

A BILL for an Act to create and enact chapter 26.1-36.11 of the North Dakota Century Code, relating to the inclusion of comprehensive medication management services in health benefit plans.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-36.11 of the North Dakota Century Code is created and enacted as follows:

26.1 - 36.11 - 01. Definitions .

For the purposes of this chapter, unless the context otherwise requires:

1. a. "Comprehensive medication management" means the thorough evaluation of all medications prescribed to an eligible enrollee to optimize therapeutic outcomes ~~medication management pursuant to a standard of care that enablesures each eligible enrollee's medications, both prescription and nonprescription, are individually comprehensively assessed to determine each medication is appropriate for the enrollee, effective for the medical condition, and safe, given the comorbidities and other medications being taken and able to be taken by the enrollee as intended. :Services provided in comprehensive medication management are, as follows:~~ Comprehensive medication programs established by plans to provide these services to eligible enrollees may include the following ~~services:~~

(1) Performing or obtaining necessary assessments of the enrollee's health status;

(2) Formulating a medication treatment plan;

(3) Monitoring and evaluating the enrollee's response to therapy, including safety and effectiveness;

(4) Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

Commented [TK1]: This language mirror's Medicare's description on the MTM program.

AHIP recommends regulatory language in 42 CFR § 423.153, describing the Medicare Part D MTM program requirements to promote consistency with federal standards. The CMS webpage providing additional background around the program can be found here

Commented [TK2]: Health plans cannot "ensure" that a standard is met since it is always change and it is not set by any kind of central authority. Health plans determine what is covered but not what is prescribed.

Commented [TK3]: Health plans do not have insight into a patient's use of over the counter medications unless the patient provides that information during a consultation. Over the counter medications are not typically covered by either the pharmacy or medical benefits. It is an unworkable requirement for the health plans to be made responsible for managing medications that are not covered by the plan.

(5) Providing verbal or written, or both, counseling, education, and training designed to enhance enrollee understanding and appropriate use of the enrollee's medications;

(6) Providing information, support services, and resources designed to enhance enrollee adherence with the enrollee's therapeutic regimens;

(7) Coordinating and integrating medication therapy management services within the broader health care management services being provided to the enrollee;

(8) Initiating or modifying drug therapy under a collaborative agreement with a practitioner in accordance with section 43 - 15 - 31.4 ;

(9) Prescribing medications pursuant to protocols approved by the state board of pharmacy in accordance with subsection 24 of section 43 - 15 - 10 ;

(10) Administering medications in accordance with requirements in section 43 - 15 - 31.5; and

(11) Ordering, performing, and interpreting laboratory tests authorized by section 43 - 15 - 25.3 and North Dakota administrative code section 61 - 04 - 10 - 06 .

b. This subsection may not be construed to expand or modify pharmacist scope of practice.

2. "Enrollee" means an individual covered under a health benefit plan.

3. "Health benefit plan" has the same meaning as provided in section 26.1 - 36.3 - 01, whether offered on a group or individual basis.

4. "Health carrier" or "carrier" has the same meaning as provided in section 26.1 - 36.3 - 01 .

~~5. "Rural service area" means a five-digit zip code in which the population density is less than four hundred individuals per square mile [2.59 square kilometers].~~

~~6. "Suburban service area" means a five-digit zip code in which the population density is between four hundred and one thousand individuals per square mile [2.59 square kilometers].~~

~~7. "Urban service area" means a five-digit zip code in which the population density is greater than one thousand individuals per square mile [2.59 square kilometers].~~

26.1 - 36.11 - 02. Required coverage for comprehensive medication management services.

1. A health carrier shall provide coverage for ~~licensed pharmacists to provide~~ comprehensive medication management to eligible enrollees who elect to participate in such programs.

2. At least annually, and upon the request of the enrollee, the health carrier shall provide, in print, or electronically under the provisions of section 26.1 — 02 — 32, notice of an enrollee"s eligibility to receive comprehensive medication management services ~~from a pharmacist,~~ delivered to the eligible enrollee and the enrollee"s designated primary care provider if applicable, if at least one of the following criteria are met:

a. The enrollee is taking five or more chronic medications;

b. The enrollee had three or more hospital admissions in the preceding year;

c. The enrollee was admitted to a hospital with one of the following diagnoses:

(1) Congestive heart failure;

(2) Pneumonia;

(3) Myocardial infarction;

(4) Mood disorder; or

(5) Chronic obstructive pulmonary disorder;

d. The enrollee has active diagnosis of comorbid diabetes and:

(1) Hypertension; or

(2) Hyperlipemia; and

e. Additional criteria identified by the commissioner and adopted by rule.

3. Comprehensive medication management services may be provided via telehealth as defined in section 26.1 — 36 — 09.15 and may be delivered into an enrollee"s residence .

4. The health carrier ~~shall include an adequate number of~~may contract with eligible pharmacists, pharmacies, or qualified clinicians ~~pharmacists~~ in the carrier"s network of participating ~~medical~~pharmacy or medical providers.

~~a. The participation of pharmacists and pharmacies in the health carrier network's drug benefit does not satisfy the requirement that health benefit plans include pharmacists in the health benefit plan's networks of participating medicalpharmacy providers;~~

b. For health benefit plans issued or renewed ~~after~~ on ~~or~~ after January 1, 2025~~December 31, 20232024~~, health

Commented [TK4]: Eligible enrollees should affirmatively agree to this, it should not be forced on them. Nationally, plans have encountered significant enrollee abrasion to auto-enrollment in such programs. Participation is strictly voluntary in Medicare.

Commented [TK5]: Request aligning this with the Plan Year

carriers that delegate credentialing agreements to contracted health care facilities shall accept credentialing for pharmacies ~~pharmacists~~ employed or contracted by those

facilities. Health carriers shall reimburse facilities for covered services provided by eligible network ~~pharmacists~~ pharmacies within the pharmacists'' scope of practice per negotiations with the facility;

~~c. The health carrier shall comply with the following comprehensive medication management network access standards:~~

~~(1) At least ninety percent of enrollee''s residing in each urban service area live within ten miles [16.09 kilometers] of a pharmacy or clinic affiliated with a pharmacist that is a participating provider in the health benefit plan''s medical provider network;~~

~~(2) At least ninety percent of enrollee''s residing in each suburban service area live within twenty miles [32.19 kilometers] of a pharmacy or clinic affiliated with a pharmacist that is a participating provider in the health benefit plan''s medical provider network; and~~

~~(3) At least seventy percent of enrollee''s residing in each rural service area live within thirty miles [48.28 kilometers] of a pharmacy or clinic affiliated with a pharmacist that is a participating provider in the health benefit plan''s medical provider network.~~

~~5. The health carrier shall post electronically a current and accurate directory of pharmacists who are participating medical providers and eligible to provide comprehensive medication management.~~

~~a. In making the directory available electronically, the health carrier shall ensure the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract;~~

~~b. The health carrier shall update the provider directory at least monthly;~~

~~cb. The health carrier shall audit quarterly at least twenty-five percent of provider directory entries for accuracy and retain documentation of the audit to be made available to the commissioner upon request;~~

~~dc. The health carrier shall ensure the one hundred percent of provider directory entries are audited annually for accuracy and retain documentation of the audit to be made available to the commissioner upon request;~~

~~Sixty-eighth~~

~~Legislative Assembly~~

~~ed. The health carrier shall provide a print copy of current electronic directory information upon request of an enrollee or a prospective enrollee;~~

~~fe. The electronically posted directory must include search functionality that enables electronic searches by each of the following:~~

~~(1) Name;~~

~~(2) Gender;~~

~~(3) Participating location;~~

~~(4) Participating facility affiliations, if applicable;~~

~~(5) Languages spoken other than English, if applicable; and~~

~~(6) Whether accepting new enrollees.~~

~~6. The requirements of this section apply to all health benefit plans issued or renewed after December 31, 20232024.~~

NEW SECTION: Pharmacy Participation and Certification

~~1.~~ A pharmacy participating in delivering comprehensive medication management services shall have a valid and up to date pharmacy license in this state and shall be certified in medication therapy management by a nationally-recognized credentialling organizations.

26.1 — 36.11 — 03. Comprehensive medication management advisory committee .

1. The commissioner shall establish and facilitate an advisory committee to implement the provisions of this chapter. The advisory committee shall develop best practice recommendations on standards to ensure pharmacies or appropriate clinicians ~~pharmacists~~ are adequately included and appropriately utilized in participating provider networks of health benefit plans without raising costs to consumers. In developing these standards, the committee also shall discuss topics as they relate to implementation, including program quality measures, pharmacist training and credentialing, provider directories, care coordination, ~~and~~ health benefit plan data reporting requirements, and potential cost savings and cost increases to consumers.

2. The commissioner or the commissioner's designee shall create an advisory committee including representatives of the following stakeholders:

a. The commissioner or designee;

b. The state health officer or designee;

c. An organization representing pharmacists;

d. An organization representing physicians;

Commented [TK6]: AHIP supports identifying clinicians/pharmacies that provide medication optimization in a carrier's provider directory so members can access this information. We suggest this requirement be accomplished through rulemaking or recommendations from the advisory council rather than in statute. Rulemaking would provide flexibility for carriers to implement new federal requirements on directories, as well as provide the DOI with flexibility to update requirements in the future.

Health plans would appreciate having the flexibility to tailor their directories to their enrollees.

e. An organization representing hospitals;

~~f.~~ A community pharmacy with pharmacists providing medical services;

g. The two largest health carriers in the state based upon enrollment;

h. The North Dakota state university school of pharmacy;

i. An employer as a health benefit plan sponsor;

j. An enrollee; and

k. Other representatives appointed by the insurance commissioner.

3. No later than ~~December 1, 2023~~June 30, 2024, the advisory committee shall present initial best practice recommendations to the Legislature. ~~insurance commissioner and the department of health and human services. The commissioner or department of health and human services may adopt rules to implement the standards developed by the advisory committee. The advisory committee shall remain intact to assist the insurance commissioner or department of health and human services in rulemaking.~~

Commented [TK7]: Recommendation should be subjective to legislative review. If recommendations are to remain subject to rulemaking, we recommend additional guardrails to ensure recommendations do not exceed the scope of the legislation or increase costs.

26.1 - 36.11 - 04. Rulemaking authority .

The commissioner may adopt reasonable rules for the implementation and administration of the provisions of this chapter.

23.8073.01000

Sixty-eighth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1095

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d. The enrollee has active diagnosis of comorbid diabetes and:

(1) Hypertension; or

(2) Hyperlipemia; and

e. Additional criteria identified by the commissioner and adopted by rule.

3. Comprehensive medication management services may be provided via telehealth as defined in section 26.1 – 36 – 09.15 and may be delivered into an enrollee's residence .

4. The health carrier may contract with eligible pharmacists, pharmacies, or qualified clinicians in the carrier's network of participating ~~medical~~pharmacy or medical providers.

;

b. For health benefit plans issued or renewed on or after January 1, 2025, health carriers that delegate credentialing agreements to contracted health care facilities shall accept credentialing for pharmacies employed or contracted by those

facilities. Health carriers shall reimburse facilities for covered services provided by eligible network pharmacieswithin the pharmacists' scope of practice per negotiations with the facility;

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2. The commissioner or the commissioner's designee shall create an advisory committee including representatives of the following stakeholders:

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3. No later than ~~December 1, 2023~~June 30, 2024, the advisory committee shall present initial best practice recommendations to the Legislature.

26.1 - 36.11 - 04. Rulemaking authority .

The commissioner may adopt reasonable rules for the implementation and administration of the provisions of this chapter.

The Outcomes of Implementing and Integrating Comprehensive Medication Management in Team-Based Care: *A Review of the Evidence on Quality, Access and Costs, December 2022*

Developed by the Evidence Based-Resources Subgroup of the GTMRx Practice and Care Delivery Transformation Workgroup:

M. Shawn McFarland, Pharm.D., FCCP, BCPS, BCACP, *National Clinical Pharmacy Practice Program Manager, Clinical Practice Integration and Model Advancement, Clinical Pharmacy Practice Office, Pharmacy Benefits Management Services, Veterans Health Administration*

Marcia Buck, Pharm.D., FCCP, FPPAG, BCPPS, *Director, Clinical Practice Advancement, American College of Clinical Pharmacy*

Shannon W. Finks, Pharm.D., FCCP, FACC, BCPS, BCCP, AHSCP-CHC, *Professor of Clinical Pharmacy, University of Tennessee College of Pharmacy*

Judith Jacobi, Pharm.D., FCCP, MCCM, BCCCP, *Senior Consultant, Visante Inc.*

Mary Ann Kliethermes, Pharm.D., FAPhA, FCIOM, *Director, Medication Safety and Quality, Office of Practice Advancement, American Society of Health-System Pharmacists*

Each year in the United States, over $528 billion is wasted and 275,000 lives are lost due to non-optimized medication use.[1] Misuse, underuse or overuse of medications can lead to treatment failure, adverse effects and toxicity causing significant morbidity or mortality. With over 80% of Americans now taking one or more medications per week, and rates of hospital admissions resulting from medication-related problems continuing to rise, a strategy must be implemented to ensure that we "get the medications right" for all patients.[2,3] Comprehensive medication management (CMM) is a patient-centered approach to optimizing medication use and improving patient health outcomes. It is delivered by a clinical pharmacist working in collaboration with the patient and other health care providers. The CMM patient care process ensures each patient's medications (whether prescription, nonprescription, alternative, traditional, vitamins or nutritional supplements) are individually assessed to determine that each medication has an appropriate indication, is effective for the medical condition and achieving defined patient and clinical goals, is safe given the comorbidities and other medications being taken, and that the patient is able to take the medication as intended and adhere to the prescribed regimen.[4]

Integration of CMM into existing patient care processes ensures a "whole health" focused approach. The value of CMM lies in the ability of medication optimization to facilitate achievement of the goals defined as the quadruple aim of health care: improving the quality of care, reducing health care costs, improving both patient and health care provider experience.[5]

This document summarizes key findings from published studies evaluating the value of CMM in supporting the quadruple aim. The studies selected have integrated CMM into team-based care in a myriad of different health care systems spanning the spectrum from individual provider offices with privately insured patients to non-profit value-based payment health care systems and government run health care systems. Regardless of the location, findings are consistent that when CMM is integrated into team-based care, therapeutic goals are achieved, costs decrease and the patient and provider experience improves. Importantly, as we strive to achieve health equity, the fifth element of the new quintuple aim of health care, new research has demonstrated the ability of CMM to help in reaching that goal.[6] Clinical pharmacists have already demonstrated the value of CMM in increasing patient access to health care, and work is underway to develop processes for identifying and addressing social determinants of health that may adversely impact the ability to achieve medication optimization. The document will continue to evolve as the integration of CMM into health care expands and the data on its value continues to grow.

I. Summary of Data on Improved Quality of Care and Reduced Costs after Implementing CMM

CMM results in over $1 million savings in Texas primary care clinics during incentive payment program

- A one-year observational study of 3,280 adult patients participating in a Texas delivery system incentive-based payment reform program revealed significant cost savings in those receiving CMM. Patients were eligible for the CMM program if they were receiving more than four medications and had been diagnosed with at least one chronic disease (diabetes, hypertension, heart failure, COPD or asthma). A clinical pharmacist reviewed the patients' records and created action plans for 290 patients with a total of 311 medication-therapy problems (MTPs). Two physicians conducted independent reviews of the pharmacist's recommendations to establish inter-rater reliability of the MTPs, with agreement on a final count of 301 MTPs in 280 patients.
  - **Better care:** Of the identified problems, recommendations for 150 (49.8%) were fully implemented by the primary care team, with the other 129 (42.8%) partially implemented. The majority were categorized as related to medication safety/adverse drug reactions (56.8%), with the second most common category being medication indication (34.9%).
  - **Reduced costs:** Resolution of MTPs resulted in an estimated cost savings of $1,143,015 in 2016 US dollars. The largest portion of this cost avoidance was achieved through the prevention of 62 hospital admissions.

Chung TH, Hernandez RJ, Libaud-Moal A, et al. The evaluation of comprehensive medication management for chronic diseases in primary care clinics, a Texas delivery system reform incentive payment program. BMC Health Services Research. 2020; 20:671. doi: 10.1186/s12913-020-05537-3.

Retrospective analysis of economic and utilization outcomes of CMM in a large Medicaid plan using a novel artificial intelligence platform

- In this observational study, the authors used mixed-effects regression models to assess savings and associated economic impact of a modified CMM program. This program incorporated the principles of CMM, including its holistic approach, but it did not involve embedment in a clinic with the team and patient. Instead, the pharmacists interacted with patients by phone; assisted with their care by an advanced artificial intelligence platform that created a patient profile; and provided clinical decision support. Pharmacists provided recommendations via fax or by phone to providers for a total of 2,150 Medicaid members ages 40-64 years with an average of 10 medications for chronic conditions. Cost and utilization data were compared from 2017 and 2019 to capture the impact of the addition of CMM in 2018.
  - **Better care:** A total of 7,485 interventions were made with 46,090 recommended actions. The majority of recommended actions (84.6%) were to stop the medication because it was either not needed or duplicate therapy. The next most common action (32.3%) was to change a medication dose to optimize therapy.
  - **Reduced costs:** The authors found a statistically significant decrease in the total cost of care of 19.3% ($p < 0.001$) or $554 per patient per month. Medication costs alone decreased by 17.3% ($p < 0.001$) or $192 per patient per month.

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- There was a 15.1% decrease in emergency department visits, a 9.4% decrease in hospitalizations and a 10.2% decrease in days of hospital admission (all results statistically significant).
- Assessing the savings in light of the cost of program implementation and maintenance, the authors reported a 12.4:1 return on investment.

Kessler S, Desai M, McConnell W, et al. Economic and utilization outcomes of medication management at a large Medicaid plan with disease management pharmacists using a novel artificial intelligence platform from 2018 to 2019: a retrospective observational study using regression methods. Journal of Managed Care and Specialty Pharmacy. 2021; Sep;27(9):1186-1196. doi: 10.18553/jmcp.2021.21036.

Real-world impact of a pharmacogenomics-enriched CMM program

A novel program incorporating pharmacogenomics (PGx) into CMM services has recently shown to be valuable in moving patients closer to their treatment goals when compared to standard care. Patients in the Kentucky's Teachers' Retirement System were offered the opportunity to enroll in the PGx-CMM program, with the results from the 5,288 who enrolled compared to a group of 22,387 patients who chose to continue standard care over the initial 32-months of the program. The characteristics of the two groups were similar at baseline, however the patients who chose to enroll in the PGx-CMM program were on more medications.

- **Better care:** A total of 4,716 medication therapy problems were identified in the PGx-CMM group resolved through 3,228 medication action plans made by the pharmacist.
- **Reduced costs:** When compared to the patients receiving standard care, participants in the PGx-CMM group experienced an average reduction of $7000 in direct medical charges. The authors also noted a positive shift in healthcare utilization away from acute care (emergency department use or hospitalization) and towards greater use of primary care options.

Jarvis JP, Peter AP, Keogh M, et al. Real-world impact of a pharmacogenomic-enriched comprehensive medication management program. Journal of Personalized Medicine. 2022;12(3):421. doi: 10.3390/jpm12030421.

Positive impact of CMM on diabetes outcomes in Federally-Qualified Health Centers (FQHCs)

This retrospective study highlights the results from 8 FQHCs participating in the *BD Helping Build Healthy Communities* program that used the funding to support integration of CMM services. These centers provided care for diverse patients populations in sites throughout the US: Arizona, California (San Marcos and Los Angeles), Florida, Indiana, Mississippi, New Jersey and Puerto Rico. Within the CMM services provided, patient education and instructions for self-monitoring were emphasized.

- **Better care:** A total of 2,502 patients were included in the study, with a primary outcome of change in hemoglobin A1c (A1c) at 6 months and a secondary outcome of change in systolic blood pressure (SBP).
  - A statistically significant reduction in A1c was documented between baseline and the 6-month follow-up (9.4 vs 8.2, $p < 0.01$), as well as a statistically significant reduction in SBP (140.8 vs 130.2 mm Hg, $p < 0.05$).
  - Patients demonstrated sustained reductions in both A1c and SBP beyond 6 months, with a reduction in A1c still present at the 24-month evaluation.

Pastakia SD, Clark A, Lewis K, et al. The impact of clinical pharmacist led comprehensive medication management on diabetes care at Federally Qualified Health Centers within the BD Helping Build Healthy Communities program. Journal of the American College Clinical Pharmacy. 2022;5:273-282. doi.org/10.1002/jac5.1679.

Healthcare utilization and outcomes in cardiovascular patients receiving CMM services

- This quasi-experimental three-year non-randomized clinical study evaluated the impact of CMM services in older patients (ages 65-80 years) with established cardiovascular disease. Patients could self-refer to a pharmacist providing CMM serves or could be referred by their physician or other health-care providers. Patients receiving usual care (not referred or electing to have CMM) served as the control group. Parameters compared included blood pressure, A1c, LDL, TC and healthcare utilization.
  - **Better care:** Patients in the CMM group achieved statistically lower systolic and diastolic blood pressures (mean change -9.02 mm Hg and -4.99 mm Hg, respectively, both $p < 0.001$). Total cholesterol and LDL were also significantly lower in the CMM group compared to controls. While the mean A1c declined to a greater extent in the CMM patients, the difference compared to controls was not statistically significant.
  - **Reduced costs:** The number of hospital admissions was 3.35 higher in the control group (95% CI 1.16-10.00). Unplanned primary care visits were 2.34 times more frequent in the controls (95% CI 1.52-3.57).

Brajkovic A, Bosnar L, Gonzaga do Nascimento MM, et al. Healthcare utilization and clinical outcomes in older cardiovascular patients receiving comprehensive medication management services: A nonrandomized clinical study. International Journal of Environmental Research and Public Health. 2022;19:2781. doi: 10.3390/ijerph19052781.

Best practices: improving patient outcomes and costs in an ACO through comprehensive medication therapy management

- Since 1998, pharmacists at the Fairview Health System have cared for more than 20,000 patients and resolved more than 107,000 medication-related problems which, if left unresolved, could have led to hospital readmissions and emergency department visits. Fairview Pharmacy Services utilized 23 CMM pharmacists (approximately 18 full-time equivalents) working in 30 locations, who conduct pharmaco-therapy workups as part of the medication optimization services.
  - **Better care:**
    - Approximately 27% of patients needed additional drug therapy and medication dosages increased.
    - Thirteen percent of the drug therapy problems were the result of unnecessary drug therapy and inappropriately high dosages.
  - **Reduced costs:** Fairview MTM showed a 12:1 ROI when comparing the overall health care costs of patients receiving services to patients who did not receive those services.
    - Total health expenditures decreased from $11,965 to $8,197 per person ($n = 186$, $p < 0.0001$).
    - Pharmacist-estimated cost savings to the health system over the 10-year period were $2,913,850 ($86 per encounter), and the total cost of CMM was $2,258,302 ($67 per encounter), for an estimated ROI of $1.29 for every dollar spent.

Brummel A, Lustig A, Westrich K, Evans MA, Plank GS, Penso J, Dubois RW. Best Practices: Improving Patient Outcomes and Costs in an ACO Through Comprehensive Medication Therapy Management. J of Managed Care and Specialty Pharmacy. 2014. (20): 12.

Budget impact analysis of a pharmacist-provided transition of care program

- Synergy Pharmacy Solutions (SPS) initiated a pharmacist-provided transition of care program for adult members of Kern Health Systems (KHS) managed Medicaid health plan who were classified as high risk using the Johns Hopkins Adjusted Clinical Groups (ACG) predictive model. High-risk patients admitted to participating hospitals were referred to the SPS TOC program and contacted via telephone within two to four days after discharge. Once a referred patient agreed to participate, the SPS team provided CMM.
  - **Reduced costs:** A budget impact analysis was conducted using a decision-tree model developed and built from the payer perspective. This tool was used to evaluate the impact of the program expansion to additional participating hospitals on total health care costs, including inpatient, outpatient, medication and emergency department costs, in six-month increments up to two years.
    - The budget impact model showed that in the first six months, the CMM program resulted in cost avoidance of over $4.3 million in total health care costs to the plan, which corresponded to $3 per member per month.
    - By the end of year two, the savings reached over $4 per member per month, for a total of $25.6 million.

Ni W, Colayco D, Hashimoto J, Komoto K, Gowda C, Wearda B, McCombs J. Budget Impact Analysis of a Pharmacist-Provided Transition of Care Program. Journal of Managed Care & Specialty Pharmacy. Feb 2018.

Comprehensive medication management results in improved care and cost savings in mental health system

- Psychiatric patients have multiple risk factors for chronic medical conditions and their need for multiple medications increases the risk of adverse events, drug interactions and poor adherence. This retrospective study of CMM assessed the quality of the service provided and patient outcomes within a mental health system through initial and follow-up visits focused on chronic medical conditions and psychiatric therapy.
  - **Better care:** Complex patients were referred to the CMM clinic with a mean of 13.7 medications and 10.1 medical conditions per patient. Providers found an average of 5.6 medication-related problems per patient, the most common being adverse drug reactions, unnecessary medications, inappropriate doses and poor adherence. Overall, clinical status improved in 52% of patients.
  - **Reduced costs:** The service projected a net cost avoidance of $90,484 over 2.25 years, or $586.55 per patient from avoidance of hospitalization or emergency department visits (33.7%) and savings in medication costs (66.3%). This resulted in an ROI of $2.80 per dollar spent.
  - **Improved patient experience:** A patient satisfaction survey indicated that 93% of patients felt the service was "extremely" or "very helpful", noting the positive changes made to their medication regimens. The majority of patients (89%) would refer friends or family for a medication review.

Cobb CD. Optimizing medication use with a pharmacist-provided comprehensive medication management service for patients with psychiatric disorders. Pharmacotherapy. 2014;34:1336-1340. doi.org/10.1002/phar.1503.

Medication therapy management: 10 years of experience in a large integrated health care system

- Assessment of the clinical, economic and humanistic outcomes of 10 years of experience with medication optimization within Minnesota's Fairview Health Services utilizing medication therapy management (a precursor to CMM). Data from 33,706 patient encounters were included in the evaluation.

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- **Better care:** 85% of patients had at least one medication therapy problem identified. Of those, 29% had 5 or more problems identified. The most frequent issues were the need for an additional medication (28.1%) and adjustment of a subtherapeutic dose (26.1%). Fifty-five percent of patients not at goal at the time of enrollment in the program improved after their medication regimens were optimized.
- **Reduced costs:** The program produced an average cost savings per encounter of $86. Average cost to provide the service was $67 per encounter, producing an estimated return on investment of $1.29 per $1 spent in administrative cases.
- **Improved patient experience:** 95.3% of patients surveyed gave a rating of agree or strongly agree to the statement that their overall health and well-being had improved as a result of the service.

Ramalho de Oliveira D, Brummel AR, Miller DB. Medication therapy management: 10 years of experience in a large integrated health care system. Journal of Managed Care Pharmacy 2010;16(3):185-95. doi: 10.18553/jmcp.2010.16.3.185.

The effect of clinical pharmacist-led comprehensive medication management on chronic disease state goal attainment in a patient-centered medical home

- A retrospective comparison study of the effect of pharmacist-led CMM on achievement of chronic diabetes treatment goals. This study took place in 11 clinics within a primary care network designated as a patient-centered medical home and affiliated with a large academic medical center. Achievement was defined as reaching a combined goal of a hemoglobin A1c < 8%, blood pressure < 140/90, and placement on statin therapy for dyslipidemia.
  - **Better care:** 40% of patients receiving CMM reached the combined treatment goal versus only 12% of patients in the control group ($p < 0.001$) over the 13-month study. Patients receiving CMM also had significantly greater improvement in individual assessments of A1c, blood pressure and use of a statin from their baseline to the completion of the study.

Prudencio J, Cutler T, Roberts S, Marin S, Wilson M. The Effect of Clinical Pharmacist-Led Comprehensive Medication Management on Chronic Disease State Goal Attainment in a Patient-Centered Medical Home. Journal of Managed Care & Specialty Pharmacy, 24 (5): 423-429. 2018. doi: 10.18553/jmcp.2018.24.5.423.

Comprehensive medication management leads to improvements in diabetes, hypertension and dyslipidemia

- In 2008, Brazil's Ministry of Health established the Nucleo de Apoio a Saude da Familia (Family Support Teams), multidisciplinary teams consisting of pharmacists, nutritionists, physical therapists and social workers, to support the primary care physician and nurse. After implementation of CMM services, treatment goals were assessed using a quasi-experimental study design in 1,057 patients covered by five clinical pharmacists over a 2-year period.
  - **Better care:** The mean difference from initial to final values showed statistically significant improvement for A1c (-0.8 +/- 0.4), systolic and diastolic blood pressure (-3.3 +/- 1.5 and -1.4 +/- 1.0), low-density lipoprotein cholesterol (-19.5 +/- 6.0) and total cholesterol (-21.0 +/- 7.3).

Santos BD, Nascimento MMGD, de Oliveira GC, et al. Clinical impact of a comprehensive medication management service in primary health care. Journal of Pharmacy Practice 2019;0897190019866309. doi:10.1177/0897190019866309.

Comprehensive medication management prevents drug interactions in older adults

- The frequency of clinically significant drug interactions was assessed in patients over 60 receiving CMM services. Beers criteria (reflecting potentially serious interactions) and the Dumbreck systematic review of United Kingdom's national drug interaction guidelines were used to define drug interactions in patients. The majority of patients had three or more health problems, 94% were taking more than two medications and 55% were taking more than five medications.
  - **Better care:** Clinicians providing CMM identified and prevented or resolved 22 drug interactions in 20 patients using the Beers criteria (4.9%) and 210 interactions in 111 patients using the UK national guidelines (27%). Disease states most strongly associated with a drug interaction were diabetes, heart failure and central nervous system diseases.

Santos TOD, Nascimento MMGD, Nascimento YA, et al. Drug interactions among older adults followed up in a comprehensive medication management service at primary care. Einstein (Sao Paulo). 2019 Aug 22;17(4):eAO4725. doi: 10.31744/einstein_journal/2019AO4725.

Assessment of the clinical utility of pharmacogenetic guidance in a comprehensive medication management service

- The evaluation of a collaborative pilot program aimed to demonstrate the benefit of incorporating pharmacogenetic information into CMM services. The pre- and post-interventional study evaluated 24 Hispanic patients who had a traditional CMM visit with a pharmacist prior to having pharmacogenetic testing. Genotyping was then performed to evaluate genetic variance in drug metabolizing enzymes. The pharmacist then incorporated the new pharmacogenetic information into the patient's management.
  - **Better care:** 129 medication-related problems were identified on the first visit, with a median of five conditions per patient and three recommendations made for changes in the medication regimen per patient. Genotyping revealed variants with the potential to affect the safety and/or effectiveness of one or more current medications in 96% of patients, with a median of three variants per patient.
  - **Better care:** Over 20% of the medications used in this patient cohort were affected by one or more of the variants. Using this information, the pharmacist was able to identify 22 additional medication-related problems, increasing the median number to six, and revised the medication action plans for all of the patients to incorporate the pharmacogenetic information.

Rodríguez-Escudero I, Cedeño JA, Rodríguez-Nazario I, et al. Assessment of the clinical utility of pharmacogenetic guidance in a comprehensive medication management service. Journal of the American College of Clinical Pharmacy. 2020;3:1028–1037. https://doi.org/10.1002/jac5.1250

II. Summary of Data on Improved Quality of Care, Patient and Provider Experience, and Patient Access to Care after Implementing CMM

Veterans give their experience with clinical pharmacists providing CMM high marks

- Evaluation of patient experience is an important component of assessing health care quality. Clinical pharmacists in Veterans Health Administration (VHA) facilities operate as advanced practice providers, seeing patients independently for CMM services under their scope of practice.

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- **Improved patient experience:** In a 9-month assessment conducted in 2021, patient experience surveys were sent to randomly selected veterans via email to evaluate a recent outpatient health care encounter a VA clinical pharmacist. A total of 743 Veteran surveys were completed with a response rate of 20%.
  - For individual domains of patient experience, the percentage of respondents selecting scores of 4 or 5 on a 5-point Likert scale were 94.4% for ease and simplicity of getting to the appointment, 91.9% for quality, 94.9% for employee helpfulness (provider willingness to listen and provide explanations), 95% for patient satisfaction and 91.9% for confidence and trust in the facility.
  - Results demonstrate that veterans' experiences with clinical pharmacists providing CMM were highly positive in every patient experience domain.

McFarland MS, Tran M, Ourth HL, Morreale AP. Evaluation of patient experience with Veterans Affairs clinical pharmacist practitioners providing comprehensive medication management. Journal of Pharmacy Practice. 2022 Aug 4;8971900221117892. doi:10.1177/08971900221117892.

Effect of an integrated clinical pharmacist on the drivers of primary care provider burnout

Family medicine and internal medicine providers at Mayo clinic facilities in Minnesota and Wisconsin participated in a cross-sectional quality improvement survey to assess the perceived efficacy of the integration of clinical pharmacists into the clinic team. A total of 119 providers (physicians, nurse practitioners and physician assistants) responded to the survey. The majority had worked with an integrated clinical pharmacist for 2 to 5 years.

- **Better care:** 91% of providers were extremely satisfied with the clinical pharmacy services in their clinic, with 90% agreeing that clinical pharmacists help patients make progress towards their health care goal, improve quality measures and assist with effective management of the patient panel. The most commonly reported collaborative activities were curbside consults, chronic disease management and CMM.
- **Improved provider experience:** More than 95% of providers indicated that pharmacists were critical members of the health care team. They also strongly agreed that working with clinical pharmacists decreased their workload and allowed them to find greater meaning in their work. Providers believed the integration of clinical pharmacists into their clinics gave them more time to focus on the aspects of their work that were more professionally fulfilling.

Haag JD, Yost KJ, Kosloski KA, et al. Effect of an integrated clinical pharmacist on the drivers of provider burnout in the primary care setting. Journal of the American Board of Family Medicine. 2021;34:553-560. doi: 10.3122/jabfm.2021.03.200597.

Assessing the impact of integration of clinical pharmacists into teams on access to care for rural veterans

This observational study evaluated team perceptions on the success of a program to integrate the VA clinical pharmacy specialists (CPS) providing CMM. Using a mixed methods evaluation, the CPS and their clinical team members were surveyed using the medication use process matrix (MUPM) as well as semi-structured interviews. The study reflected team interactions during 496,323 patient encounters from October 2017 to March 2020. A total of 124 CPS and 1,177 other clinical team members responded to the self-administered web-based questionnaire. An additional 22 interviews were completed with CPS and other clinicians.

- **Improved provider experience:** The evaluation indicated good integration of the CPS in the primary care teams, as perceived by the other team members.

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- Both primary care team members and the CPS agreed on the high level of contributions provided in all 5 domains of the MUPM, with mean scores of 2.3 to 2.9 on a scale of 0 to 3.
- Findings from the interviews supported the perception that the majority of providers believed the CPS are making substantial contributions to patient care. Provider interviews highlighted the important role the CPS plays by providing CMM to relieve provider burden of care.
- The study also found that CPS reported higher job satisfaction when compared to previous data, citing less burn out and better role fit.

McCullough MB, Zogas A, Gillespie C, Kleinberg F, Reisman JI, Ndiwane N, Tran MH, Ourth HL, Morreale AP, Miller DR. Introducing clinical pharmacy specialists into interprofessional primary care teams: Assessing pharmacists' team integration and access to care for rural patients. Medicine (Baltimore). 2021 Sep 24;100(38):e26689. doi: 10.1097/MD.0000000000026689. PMID: 34559093; PMCID: PMC8462613.

Perceptions of integration of the clinical pharmacist into the PCMH model by the PCMH team

- Integration of CMM by a clinical pharmacist in a Department of Veterans Affairs facility was rated by the primary care team (physicians, nurses and staff) for seven domains.
  - **Better care:** 80% of responses rated the ability of the pharmacist to evaluate medication therapy and monitor the effectiveness and safety of medication therapy as a highly positive benefit.
  - **Improved access to care:** 87% of physicians and nurse practitioners responded that CMM integration by a clinical pharmacist increased access to their clinic by decreasing the time patients had to wait for primary care services.
  - **Improved provider experience:** 93% of physicians and nurse practitioners responded that CMM integration by a clinical pharmacist improved their job satisfaction.

McFarland S, Lamb K, Hughes J, Thomas A, Gatwood J, Hathaway J. Perceptions of Integration of the Clinical Pharmacist into the PCMH Model by the PCMH Team. Journal for Healthcare Quality. 2017. doi:10.1097/JHQ.0000000000000114.

Primary care providers believe that comprehensive medication management improves their work-life

- Part of a larger study of CMM implementation in Minnesota and North Carolina, this series of structured interviews was conducted with 16 primary care providers (PCPs) to identify the impact of CMM on their work life. Responses were then categorized to develop common themes.
  - **Better care:** Participants reported increased satisfaction that their patients were receiving better care and highlighted increased achievement of quality measures.
  - **Improved provider experience:** In addition to citing a decreased workload, PCPs reported a decrease in mental exhaustion related to the reassurance of having a clinical pharmacy colleague and enhanced opportunities for professional learning. This beneficial impact of team-based clinical pharmacist-provided CMM aligns with previously identified methods for decreasing burnout and engagement among primary care providers.

Funk K, Pestka D, McClurg M, Carroll J, Sorensen T. Primary Care Providers Believe That Comprehensive Medication Management Improves Their Work-Life. Journal of American Board of Family Medicine. 2019; 32(4): 462-473. doi: 10.3122/jabfm.2019.04.180376.

Pharmacists providing CMM gain increased efficiency in patient access through use of telemedicine

- This retrospective review evaluated the efficiency of the Tennessee Valley patient-aligned care team (PACT) clinical pharmacy specialists (CPS) providing CMM using patient encounter data, and it reviewed objective patient metrics to evaluate if the quality of care had been compromised during the COVID-19 pandemic. Data collection focused on the number of clinic encounters (in person, by phone or via telehealth), patient accountability to appointments, the number of disease states managed, insulin use, A1c and blood pressure in patients from 2019 and 2020.
  - **Improved access to care:** The total number of PACT CPS encounters increased 32% in 2020, and the number of unique patients increased by 12%.
    - There was a statistically significant increase in telephone visits from 5,230 to 18,715 (accounting for 32% of visits to 87%) while in-person visits decreased from 9,099 to 1,093 (accounting for 56% of all visits to only 5%). Video visits increased but remained a relatively uncommon method of patient encounter.
    - Rates of cancelled appointments and patients not showing up for their appointments also significantly decreased between 2019 and 2020.
  - **Sustained outcomes:** The goal of the study was to identify any negative impact on the quality of care caused by the transition to virtual patient visits.
    - There was no difference in the average change in A1c, with an average reduction of 0.57% in the 2019 cohort and 0.58% in the 2020 cohort ($p = 0.94$).
    - Average reductions in systolic (SBP) and diastolic blood pressures (DBP) also showed no significant change with average reductions in SBP being 3.1 mmHg and 3.2 mmHg ($p = 0.968$) in 2019 and 2020, respectively, and a mean reduction in DBP of 1.1 mmHg in 2019 and 2 mmHg in 2020 ($p = 0.3$). Markers for both diabetes and hypertension showed no negative impact on the conversion to phone and video visits during the pandemic.

Thomas AM, Baker JW, Hoffman TJ, Lamb K. Clinical pharmacy specialists providing consistent comprehensive medication management with increased efficiency through telemedicine during the COVID19 pandemic. Journal of the American College of Clinical Pharmacy. 2021;4: 934-938. doi: 10.1002/jac5.1494.

Optimizing the primary care clinical pharmacy specialist: increasing patient access and quality of care within the Veterans Health Administration

- The Department of Veterans Affairs has integrated the PCMH model as the delivery method of primary care since 2010. The VA Clinical Pharmacy Specialists (CPS) Provider practicing CMM in primary care is a large component of the ability for the VA to increase access and the quality of care for veterans. Currently, there are more than 1,850 CPS practicing CMM in primary care. In fiscal year 2019, patient aligned care team CPS documented 2,561,124 CMM interventions during 1,248,635 patient care encounters.
  - **Improved access to care:** VA Primary Care CPS demonstrated that 27% of primary care return appointments could be averted to a CPS.
  - **Better care:** Multiple studies performed within the VA have shown improvement in specific quality indicators:
    - Significant reduction in median A1c values to 7.7% (interquartile range [IQR] (0.5); $p < 0.001$) from a baseline A1c of 10.0% (IQR + 0.7).

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- Significant reductions in median systolic blood pressure (SBP) and diastolic blood pressure (DBP) from a baseline of 142/83 (IQR + 10 for SBP and 8 for DBP) to 134/79 (IQR + 7 for SBP and 7 for DBP; $P < 0.001$).
- CPS coordinated follow-up post-COPD discharge from a hospital or an emergency department (ED) within 30 days. Patients had a 0% composite readmission rate to the ED or hospital for a COPD exacerbation within 30 days of discharge.

McFarland MS, Nelson J, Ourth H, Groppi J, Morreale A. Optimizing the primary care clinical pharmacy specialist: Increasing patient access and quality of care within the Veterans Health Administration. J Am Coll Clin Pharm. 2020;3:494-500.

Impact of comprehensive medication management on hospital readmission rates

- The Fairview Health System implemented a formal care transitions process that included referrals to outpatient services provided by CMM pharmacists to determine whether or not a CMM visit with a CMM pharmacist within 30 days of hospital discharge decreased readmissions at 30 days post discharge when compared with patients who did not receive a CMM visit. In total, 1,291 hospitalizations had a CMM visit within 30 days of discharge.
  - **Better care:** At 30 days post discharge, patients who received a CMM visit had a significantly lower rate of readmissions compared to the comparator cohort (4.2% lower, $p < 0.001$).
  - **Improved access to care:** 60% of patients received their CMM visit within seven days of hospital discharge.

Budlong H, Brummel A, Rhodes A, Nici H. Impact of Comprehensive Medication Management on Hospital Readmission Rates. Population Health Management 2018. 21(5): 395-400.

Endnotes

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Medication Optimization Use Case

MINNESOTA HEALTH FAIRVIEW · Minneapolis-St. Paul, Minnesota	
Focus Area	Chronic disease model that incorporates the clinician providing CMM services into a primary care patient population. The chronic disease therapy model focuses on outcomes seen when the clinician provides CMM care for common primary care conditions such as cardiovascular disease, diabetes, etc.
At-a-Glance	■ **Organization Type:** Integrated Health System ■ **Launch Date:** 1997 ■ **Payment and Funding Sources:** ▪ CMM is a covered service for all Medicaid patients, Fairview employees, PreferredOne/ ClearScript members. ▪ Contracts with other commercial, managed Medicaid and Medicare payors.
Organization Details	Fairview is an integrated health system with 360,000 health plan members, more than 34,000 employees and more than 5,000 system providers. It consists of the following: ▪ 12 hospitals and medical centers ▪ 3,519 licensed beds ▪ 2,071 staffed beds ▪ 56 primary care clinics ▪ 100+ specialties ▪ 90+ senior housing locations ▪ 36 retail pharmacies
Brief History of CMM Program, Scope of Services	Started in 1997 as a partnership with the University of Minnesota and Fairview. The program matured in 2006 when Medicare Part D and Minnesota Medicaid required plans to offer medication therapy management (MTM) benefits to members. Positive return on investment, provider and patient satisfaction scores and improvement in quality outcomes led to expansion of the program. CMM has become a required element in care delivery re-design in primary care clinics and is now being included as part of Fairview's ACO and risk-managed payor contracts.

Results & Achievements

Focus on the Quadruple Aim

- *Better Outcomes*
- *Cost Savings*
- *Patient Satisfaction & Engagement*
- *Clinician Satisfaction*

Better Outcomes

- The percentage of diabetes patients optimally managed was significantly higher for CMM patients compared to the year prior (21.49% vs.45.45%, P < 0.01). The HbA1c showed a mean reduction of 0.54%. Patients who opted in for CMM had higher Charlson scores, more complex medication regimens and a higher percentage of diabetes with complications.
- Exposure to face-to-face CMM services resulted in improvement of medication adherence with statins, ACEI/ARBs and B-Blockers.
- State of MN diabetes pilot increased from 16% to 42% meeting all goals in a 12-month period.
- 59.7% asthma patients cared for by CMM clinicians achieved the MN community measure for optimal asthma care vs. the state average of 16% in 2011.
- Using a risk-adjusted rate the CMM group has experienced approximately 20% fewer readmissions than might be expected, given their increased level of risk.

Cost Savings

- An average 12:1 ROI in terms of reduced overall health care costs. Overall health care cost reduction of 31.5% after one year of medication therapy management.
- An employer analysis showed that each $1 of medication therapy management billed costs would approximate an average $8.98 savings for total health care costs on all enrolled members.

Patient Satisfaction & Engagement

- 95% of patients agreed or strongly agreed that their overall health and well-being had improved because of CMM.
- Research has shown that patients feel that the CMM clinician is a resource for care/ education, that they are more accessible and that they help to coordinate care.

Clinician Satisfaction

- 95% of providers surveyed were confident in the recommendations of the Fairview CMM clinician.
- 92% of providers agreed or strongly agreed that having an CMM clinician at their clinic has helped their patients improve their health and make progress towards their clinical goals.

Patient Success Story	Anita was used to being active. She worked locally for 35 years until back surgery and a hip replacement caused her to retire. A diagnosis of diabetes during a hospital stay last December sent her health into a downward spiral. The problem began when she tried to renew the diabetes medication after a post-hospital rehabilitation stay. Because of mobility limitations, Anita was not able to see her physician and went without her medication for several months. *"Talking to Brittany and getting my medications straightened out has been important," says Anita. "I don't think it would have been possible without her help."* "Brittany has been a lifesaver in many ways," says Anita, 67-year-old Fairview patient. Anita's multiple chronic diseases and related complications had created barriers to care and landed her in the hospital. She needed specialized help to get her health back on track. That's where Dr. Brittany Symonds, medication therapy management clinical pharmacist, stepped in. She serves as part of a network team that came together to help Anita. *"My blood sugar went sky high," says Anita. "I ended up back in the hospital."* For Anita, multiple factors conspired to create what Dr. Symonds called "a perfect storm." Barriers to care included medication cost and mobility issues preventing Anita from visiting her doctor. Dr. Brittany Symonds worked with Anita by phone, reducing the number of clinic visits needed, and helped her find less expensive medications through a mail-order source. Anita calls medication therapy management "one of the best things Fairview instituted. If I hadn't had Brittany, I don't think I'd have my diabetes under control and feel as well as I do today." Additional stories at: https://www.fairview.org/services/medication-therapy-management/patient-stories
Team-Based Care Strategy	■ **Interprofessional Team Roles:** ▪ Triage nurses, care coordinators (social work and RN case managers), inpatient nursing staff trained on CMM and when to refer patients ■ **Role of the Clinician:** ▪ Scope of Advanced Practice: Collaborative practice agreement covering 20+ chronic disease states ■ **Care Delivery Modality:** ▪ In-person, phone and video visits. Extensive communication via MyChart (EHR communication) when needed ▪ 60-minute initial (new) patient visits/30-minute return visits ▪ Patients average two visits/year with pharmacist
Patient Referral Criteria	■ **Eligible Patients:** All patients are eligible for CMM services. ■ **Populations of Focus:** Diabetes, hypertension, hyperlipidemia, smoking cessation, COPD, heart failure, asthma, transplant, HIV and CF patients in specialty locations (among other specialties). Transitions of care, special focus on mental health discharges.

Size of CMM Program	**Number of:** ■ **Pharmacists:** 45 ▪ Pharmacist FTE: 30.2 in direct pt care ■ **Practice Sites:** 55 ■ **Resident Pharmacists:** 5 PGY-1 ■ **Student Pharmacists/Interns:** 2 ■ **Support Staff:** ▪ 3 coordinators: scheduling, coding, billing, recruitment calls ▪ 1 business supervisor ▪ 3 CMM supervisors ▪ 1 CMM Operations Lead ■ **Unique patients served (2019):** ▪ 12,798 patients ▪ 26,460 visits
Program Success Factors	■ **Expanded Roles and Responsibilities of the Pharmacist** ▪ Broad collaborative practice agreements ▪ Consistent care process and follow-up ■ **Convenient Patient Access and Simple Program Entry** ▪ Multiple care delivery modalities (e.g., in-person, telemedicine) ■ **Demonstrate Efficiency & Effectiveness of Cross-Setting Team-Based Care** ▪ CMM eases primary care workload ■ **Demonstrate & Articulate CMM's Value** ▪ Consistently high patient and provider satisfaction scores ▪ Continued ROI studies with positive results ▪ Meaningful, experiential learning opportunities for advanced pharmacy practice experience students
Next Steps, Future Goals	■ Resourcing clinics without a CMM clinician on-site ■ Payment structures to support CMM services

References	Brummel, A. "Optimal Diabetes Care Outcomes Following Face-to-Face Medication Therapy Management Services" *Population Health Management:* 2012. Brummel, A, Carlson, A. Comprehensive Medication Management and Medication Adherence for Chronic Conditions. *Journal of Managed Care Pharmacy* 2016; 22 (1); 56-62. Schultz, H., Patient-perceived value of Medication Therapy Management (MTM) services: a series of focus groups. *Innovations in Pharmacy:3*(4)96. McInnis, T. Capps, K. Get the medications right: a nationwide snapshot of expert practices—Comprehensive medication management in ambulatory/community pharmacy. *Health2 Resources,* May 2016. Sorensen, TD, Sorge LA, Millonig, M et al. Integrating medication management: lessons learned from six Minnesota health systems. September 2014. Additional articles: https://www.fairview.org/services/medication-therapy-management/news
Program Contact Information	**Allyson Schlichte, Pharm.D., MBA, BCACP** Medication Therapy Management Operations Lead Aschlic1@fairview.org 612-510-0767
Developed by the Best Practices and Innovative Solutions Subgroup of the GTMRx Practice and Care Delivery Transformation Workgroup	

Clearly Defined Roles and Responsibilities Help CMM Program to Deliver Services Efficiently

AT A GLANCE

RiverStone Health Clinic
Billings, MT

Person in charge: Amy Moser, Pharm.D., BCACP, CPP

Organization type: FQHC, Level 3 patient-centered medical home

Year CMM Launched: 2010

Payment sources: Medicaid, some private insurers

Funding sources: Primarily through the FQHC contract with some support from the HRSA 340B medication discount program.

Number of pharmacists: 3 (1.5 FTEs)

Number of CMM sites: 1

Unique CMM patients served in 2019: 317

Can patients self-refer? Yes

Collaborative Practice Agreements: For diabetes, hypertension, dyslipidemia, ASCVD risk reduction, COPD, asthma, smoking cessation, thyroid disorders and GERD. They also provide services for high-risk for readmission hospital discharges and integrated behavioral health team.

Fully integrated into a medical home practice, the CMM pharmacists at RiverStone Health Clinic are part of a clinical team that identifies and resolves patients' unmet needs.

Bringing clinical pharmacy skills to that team—and being fully integrated into the medical home—leads to better outcomes and higher satisfaction for its underserved community.

Patients may be referred to the clinical pharmacists by any member of the patient care team in the clinic for CMM. Referrals are based on an assessment of needs, not a particular diagnosis. Clinical pharmacists are part of the team that identifies patients for CMM. Patients can self-refer (usually for follow-up) if they have a primary care provider at the clinic, but they are almost always initially referred by a staff member. Regardless of how a patient is referred, each receives comprehensive medication management.

Staffing and training

Three pharmacists, accounting for 1.5 FTE, are supported by one or two students (generally accounting for 1.5 FTEs). As part of a medical home team, the clinical pharmacists have access to staff who help with scheduling, pre-visit planning and other issues. The team of pharmacists hope to be able to add a pharmacy tech position to the CMM program.

Access innovation on the horizon

RiverStone consists of a centrally located clinic and several satellite sites. Any patient is eligible for CMM services, and these visits are conducted via telemedicine for patients of the satellite sites.

"It is critical for patients to understand and agree with their treatment in order to achieve good outcomes."

Measuring impact

The CMM program at RSH Clinic tracks identified drug therapy problems. Having collaborative practice agreements in place for several common disease states allows for over 90% of drug therapy problems to be resolved by the pharmacists at the CMM visit.

Success factors

RSH has identified four factors crucial to the success of their program:

1. **The ability to identify and meet a patient's needs:** This is fundamental to the program's success.
2. **The pharmacists' skill set:** Pharmacists offer a unique skill set that complements the rest of the clinical team.
3. **Clearly defined roles and responsibilities:** The pharmacy team understands the role and function of each team member.
4. **Appropriate funding:** CMM is supported as part of the PCMH and funded through various channels. The clinic has a contract with University of Montana School of Pharmacy to support student advanced pharmacy practice experience. It receives Medicaid and private insurance payments for the visits conducted by the clinical pharmacists, and our physicians and administrators value the contribution of pharmacists on the team. Positions are supported through the clinic's federal grant funding for FQHCs.

Lessons learned

1. **They need us.** Clinical pharmacists are an important part of the care team. We are able to spend more time with the patient to ensure they really understand how to use their medication correctly to get the best outcomes.
2. **Clinical pharmacists make a unique contribution to the team.** Since clinical pharmacists are trained to be medication experts, they are uniquely qualified to identify and resolve drug therapy problems, such as drug interactions or adverse reactions.
3. **Patients must be part of the decision-making process.** It is critical for patients to understand and agree with their treatment in order to achieve good outcomes. We feel it is most helpful to meet the patient where they are at and then help them move forward toward their goals.

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Wolf, Sheldon

From: Arnold, John R. <jrarnold@nd.gov>
Sent: Monday, March 27, 2023 3:07 PM
To: Lee, Judy E.
Cc: Wolf, Sheldon; NDLA, Intern 02 - Pouliot, Lindsey; Godfread, Jon; Bartuska, Chrystal A.
Subject: FW: 1095 email to committee
Attachments: 23-8073-02000- 1095-amendments- DOI.docx

Good Afternoon,

Our apologies for coming into the committee work on this a bit late but thank you for the opportunity to continue to work on it. We have attached a copy of redline edits that we feel get closer to where the committee wants to get and some suggestions from other interested parties.

26.1-36.11-02- page 2 lines 26 & 27- We added eligible enrollees who elect to participate.
Page 3 line 4- removed congestive as requested
Page 3 lines15-26- The intent behind this section is to allow any and all pharmacists to participate in this program. We realize that SHP has an in-house program, but we feel that other pharmacist within their network should be able to participate. SHP is not the only company that may use 3rd parties or their affiliates to do this and so this section is to allow for local pharmacists to assist in the smaller communities. There has been debate on interpretation of this section stating that the carrier will need to "set up a whole new network of pharmacists". That is not our us as the regulator read that. There is nothing prohibiting the insurer's from utilizing their current contracted pharmacists, but they cannot use only their in house or direct affiliated or owned PBM's. UHC and Healthpartners use various 3rd parties or even specialty pharmacists and so we want to ensure that this is applied evenly amongst our carriers. This is not against SHP. Based on this we added "or their affiliates"
Page 4 line 3-5- we removed the quarterly review to alleviate some of the burden on the directory.
Page 4 line 14- removed gender as requested.

26.1-36.1-03- Advisory Committee- we added a line that references that we (as the advisory committee) will utilize numbers 1-11 in that section to come up with best practices for the consumer. The thought process that it is too vague or too prescriptive depends on which side of this bill you are on and what your current program looks like.

The bottom line and intent behind this bill is to allow for consumers to access a program that will help them manage their health and medications. We do not wish to add additional burden on the insurance companies, but there also needs to be some accountability and consistency for these programs to allow for easy process and ease to the consumer. There are documented studies that show these programs have a good return on investment with the consumers.

John Arnold
Deputy Commissioner

North Dakota Insurance Department
Safeguarding Promises. Fostering Fairness.
Jon Godfread, Commissioner

23.8073.02000

Sixty-eighth
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1095

Introduced by

Representative Weisz

A BILL for an Act to create and enact chapter 26.1-36.11 of the North Dakota Century Code, relating to the inclusion of comprehensive medication management services in health benefit plans.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-36.11 of the North Dakota Century Code is created and enacted as follows:

26.1-36.11-01. Definitions.

For the purposes of this chapter, unless the context otherwise requires:

1. a. "Comprehensive medication management" means medication management pursuant to a standard of care that ensures each enrollee's medications, both prescription and nonprescription, are individually assessed to determine each medication is appropriate for the enrollee, effective for the medical condition, and safe, given the comorbidities and other medications being taken and able to be taken by the enrollee as intended. Services provided in comprehensive medication management are, as follows:
   (1) Performing or obtaining necessary assessments of the enrollee's health status;
   (2) Formulating a medication treatment plan;
   (3) Monitoring and evaluating the enrollee's response to therapy, including safety and effectiveness;
   (4) Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) Providing verbal or written, or both, counseling, education, and training designed to enhance enrollee understanding and appropriate use of the enrollee's medications;

(6) Providing information, support services, and resources designed to enhance enrollee adherence with the enrollee's therapeutic regimens;

(7) Coordinating and integrating medication therapy management services within the broader health care management services being provided to the enrollee;

(8) Initiating or modifying drug therapy under a collaborative agreement with a practitioner in accordance with section 43-15-31.4;

(9) Prescribing medications pursuant to protocols approved by the state board of pharmacy in accordance with subsection 24 of section 43-15-10;

(10) Administering medications in accordance with requirements in section 43-15-31.5; and

(11) Ordering, performing, and interpreting laboratory tests authorized by section 43-15-25.3 and North Dakota administrative code section 61-04-10-06.

b. This subsection may not be construed to expand or modify pharmacist scope of practice.

2. "Enrollee" means an individual covered under a health benefit plan.

3. "Health benefit plan" has the same meaning as provided in section 26.1-36.3-01, whether offered on a group or individual basis.

4. "Health carrier" or "carrier" has the same meaning as provided in section 26.1-36.3-01.

26.1-36.11-02. Required coverage for comprehensive medication management services.

1. A health carrier shall provide coverage for licensed pharmacists to provide comprehensive medication management to eligible enrollees who elect to participate in such programs.

2 At least annually, the health carrier shall provide, in print, or electronically under the provisions of section 26.1-02-32, notice of an enrollee's eligibility to receive comprehensive medication management services from a pharmacist, delivered to the eligible enrollee and the enrollee's designated primary care provider if applicable, if at least one of the following criteria are met:

a. The enrollee is taking five or more chronic medications;

b. The enrollee had three or more hospital admissions in the preceding year;

c. The enrollee was admitted to a hospital with one of the following diagnoses:

(1) Heart failure;

(2) Pneumonia;

(3) Myocardial infarction;

(4) Mood disorder; or

(5) Chronic obstructive pulmonary disorder;

d. The enrollee has active diagnosis of comorbid diabetes and:

(1) Hypertension; or

(2) Hyperlipemia; and

e. Additional criteria identified by the commissioner and adopted by rule.

3. Comprehensive medication management services may be provided via telehealth as defined in section 26.1-36-09.15 and may be delivered into an enrollee's residence.

4. The health carrier shall include an adequate number of pharmacists in the carrier's network of participating pharmacy providers.

a. The participation of pharmacists and pharmacies in the health carrier or their affiliates network's drug benefit does not satisfy the requirement that health benefit plans include pharmacists in the health benefit plan's networks of participating pharmacy providers;

b. For health benefit plans issued or renewed after January 1, 2025 , health carriers that delegate credentialing agreements to contracted health care facilities shall accept credentialing for pharmacists employed or contracted by those facilities. Health carriers shall reimburse facilities for covered services provided by network pharmacists within the pharmacists' scope of practice per negotiations with the facility;

5. The health carrier shall post electronically a current and accurate directory of pharmacists who are participating medical providers and eligible to provide comprehensive medication management.

a. In making the directory available electronically, the health carrier shall ensure the general public is able to view all of the current providers for a plan through a

clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract;

b. c. The health carrier shall ensure that one hundred percent of provider directory entries are audited annually for accuracy and retain documentation of the audit to be made available to the commissioner upon request;

d. The health carrier shall provide a print copy of current electronic directory information upon request of an enrollee or a prospective enrollee;

e. The electronically posted directory must include search functionality that enables electronic searches by each of the following:

(1) Name;

(2)

(3) Participating location;

(4) Participating facility affiliations, if applicable;

(5) Languages spoken other than English, if applicable; and

(6) Whether accepting new enrollees.

6. The requirements of this section apply to all health benefit plans issued or renewed after January 1, 2025

26.1-36.11-03. Comprehensive medication management advisory committee.

1. The commissioner shall establish and facilitate an advisory committee to implement the provisions of this chapter. The advisory committee shall develop best practice recommendations for the implementation of comprehensive medication management, and on standards to ensure pharmacists are adequately included and appropriately utilized in participating provider networks of health benefit plans. In developing these standards, the committee also shall discuss topics as they relate to implementation, including program quality measures, pharmacist training and credentialing, provider directories, care coordination, health benefit plan data reporting requirements, billing standards and potential cost savings and cost increase to consumers.

2. The commissioner or the commissioner's designee shall create an advisory committee including representatives of the following stakeholders:

a. The commissioner or designee;

b. The state health officer or designee;

c. An organization representing pharmacists;

d. An organization representing physicians;

e. An organization representing hospitals;

f. A community pharmacy with pharmacists providing medical services;

g. The two largest health carriers in the state based upon enrollment;

h. The North Dakota state university school of pharmacy;

i. An employer as a health benefit plan sponsor;

j. An enrollee;

k. An advanced practice registered nurse; and

l. Other representatives appointed by the insurance commissioner.

3. No later than June 30, 2024, the advisory committee shall present initial best practice recommendations to the insurance commissioner and the department of health and human services. The commissioner or department of health and human services may adopt rules to implement the standards developed by the advisory committee. The advisory committee shall remain intact to assist the insurance commissioner or department of health and human services in rulemaking. Upon completion of the rulemaking process, the committee is dissolved.

26.1-36.11-04. Rulemaking authority.

The commissioner may adopt reasonable rules for the implementation and administration of the provisions of this chapter.