

**NASPA Fall Meeting  
November 18-19, 2007  
Longboat Key, Fla.**

Below is a summary of discussions that occurred at the NASPA Fall meeting provided to NASPA members for informational purposes.

**MTM Discussion** moderated by Marghie Giuliano, NASPA MTM Workgroup Chair.

Participants in the first panel were: Anne Burns, APhA; Steve Mullenix, Mallinckrodt (NCPDP MTM Focus Group moderator); Patty Kumbera, Outcomes; Rebekah Jackowski, Mirixa

**APhA/NACDS MTM Core Elements (slides attached)**

Anne Burns, APhA began the discussion with an overview of the MTM Core Elements. She highlighted the collaborative work by APhA and NACDS in creating and updating the Core Elements document. Version 2.0, currently still in draft form, has an increased emphasis on patient transitions of care, stresses the importance of team based approach and includes sample personal medication record and medication-related action plan in patient-friendly formats. In addition there is a stronger emphasis on patient empowerment to self manage medications and clarification of documentation components.

Continue to advocates for an annual comprehensive medication therapy review designed to improve patient's self-management of medications, (including non prescription, herbal, and other dietary supplements) and when patient experiences a transition of care

**NCPDP MTM Focus Group**

Steve Mullenix, of Mallinckrodt, Inc., has been serving as NCPDP MTM Focus Group moderator, provided a summary of their work. NCPDP serves as an ANSI-accredited SDO and provides an open forum for all stakeholders for development of standardization. A MTM Focus Group was convened initially in July. There were 32 participants from industry and virtually all professional organizations. (NASPA was represented by Mindy Rasmussen and Ernie Boyd). Initially, seven broad objectives were developed (attached) in draft form and presented to the Focus Group in October via Webinar. The final draft included six broad objectives that were presented and assigned to Work Group 10 – Professional Pharmacy Services at the NCPDP Work Group meeting held in early November. Work Group 10 agreed to create a special Task Group (named Standardization of Electronic Transactions for Pharmacist-Provided Clinical Services Task Group) dedicated to this effort. Steve summarized the NCPDP approach as: assessing, identifying, engaging, promoting, and continuing to reassess.

**Mirixa (M) and Outcomes (O)**

Patty and Rebekah had been given questions in advance. The questions guided their remarks.

*How can other "networks" interface with your existing platform if I am using a different documentation system? Would a state be allowed to sign up to use your documentation system, if they have an existing network or their own employer contract?*

M: Collaboration amongst pharmacies/networks is possible. The program would have to be run on the Mirixa "platform" – but can be customized to meet the network's specifications.

O: A critical component in the Outcomes system is standardization of deliverables/process – it has been proven to be effective and a key component to their program. Collaboration with other networks is already occurring with Outcomes. We have a large chain that is using the Outcomes platform as their own internal platform for programs they market themselves or provide for other MTM programs in the marketplace. Interfacing with other pharmacy management systems/documentation systems is currently taking place. For example, we are working with a

large chain to interface with their systems. In addition, we continue discussions with various pharmacy software systems regarding the possibility of integration.

When Outcomes holds the contract with the payer, pharmacists access our web-based platform at no charge for documentation and billing. Yes, we encourage states that have an existing network or employer contract to use the Outcomes platform. If an existing relationship exists between a state and an employer group, the state can obtain a "premium subscription" to use the Outcomes platform to document our standard covered services or document disease state management services that are being provided via protocol. Our system would support how you define covered services, payment, etc.

Another option is for the state to bring that business to Outcomes and receive Co-marketing revenue for doing such. We also have Territory Management agreements with states for their support of programs utilizing the Outcomes platform. By offering these two options, we are encouraging standardization of deliverables and standardization of the MTM documentation process.

*With the movement of several different MTM programs and employer contracts in each state, how do you see the future of MTM evolving? Are the proprietary MTM platforms a competitor in each state establishing a network or a resource for them? Is there opportunities to partner?*

M: Collaborative involvement- standardization with Mirixa is the platform, but programs can be crafted to meet each state's or employer's needs. We would like to engage the profession. Mirixa views itself as a resource if you have a network in your state.

O: Outcomes is already administering MTM programs in several states and many state associations have partnered with Outcomes to help coordinate the pharmacy network within those states. The future of MTM will evolve to a standard based upon what can be sold to payors. Our standardized program is based upon over 8 years of experience in administering MTM programs, and we feel we have created an MTM service delivery model that works for both payors and pharmacies.

In each state, it will vary on whether Outcomes may be viewed as a competitor or a resource. In those states where Outcomes is administering a program, we would likely be viewed as a resource. In those states where Outcomes is not administering a program, we could be viewed as a resource in terms of an opportunity to collaborate or as a competitor. Territory management and co-marketing represent two opportunities for states to partner with Outcomes to help promote and manage the delivery of face-to-face MTM services.

Effective 1/1/2008 Outcomes will have covered lives in every state. If a state develops their own programs and their own platform (this is where we'd be competitors), the pharmacies will still then be faced to deal with multiple systems. A standard will evolve over time – a standard of what data elements are critical and essential for billing MTM services – but it will take time and experience.

*How do you ensure education standards of care across your network? How can we all move toward standardization of these education criteria? Should it be based on level of service? Can the education criteria be linked with levels of services provided?*

M: Encourage education and training on how to use the platform. In addition, there are educational resources on the system linked with service provided. Currently, the programs administered by Mirixa do not require any specific training beyond familiarization with the programs being offered and use of the MirixaPro platform. Beginning next year the system will keep track of what training and resources are reviewed by the pharmacist. Some discussions with new contracts have contemplated a required training component depending on what services or disease states will be covered. In 2008 there will be a training site to play with "mock" patients.

O: All participating pharmacists must complete the Outcomes Personal Pharmacist™ Training Program. The training is a one-hour program demonstrating how to document and bill for face-to-face MTM services using the Outcomes platform (such as the covered services, how to document and bill, what is the quality assurance process, etc.). We feel a network trained in the delivery of MTM is a better prepared network, and therefore, training in the delivery of MTM should become a standard in the marketplace. In addition, to promote standards of care across our nationwide network of pharmacists Outcomes implements a quality assurance process to ensure all MTM claims are documented in accordance with policies and procedures.

Specific contracts may require pharmacists to obtain additional education in order to participate. For example, a diabetes disease state management program may require specialized training in diabetes, if that particular payer requires it and Outcomes is administering their policies and procedures on their behalf.

*Since your platforms pay the pharmacists for different levels of services, from a small intervention to case management, how do you see pharmacists using a CPT code reimbursement in the future?*

M: The system converts the billable service into a CPT code. The program sponsor or plan, specifies what services must be completed to in order to bill for the session. The plans usually specify an estimated length of time to complete the session, but the reimbursement is based on the service.

O: Outcomes has mapped all of our reason, action, and result codes to the appropriate CPT codes. However, our payment model is structured based on outcomes, not time. CPT codes do not tell the picture of what happened during an intervention, they only represent the amount of time it took a pharmacist to complete a service. Therefore, to demonstrate the value of medication therapy management services provided by a pharmacist, we believe pharmacists should be paid using a fee-for-service model based on the outcomes of the service provided, rather than paid for process.

Other general comments made:

M: Beginning 2008 for the CCRx cases, if a pharmacy does not complete their cases within the given timeframe, the cases will be reassigned to another pharmacy for completion. In addition, auditing has begun to assure that the patients pharmacists have billed for actually received services. Pharmacists should keep documentation that patients receive services just as they keep documentation that patients receive prescriptions.

O: Outcomes recently announced an alliance with ASCP to increase access to local MTM services for Outcomes-eligible patients nationwide. We recognize the value of expanding our network to utilize consultant pharmacists in providing MTM services to further increase the number of patients served. Our goal is to keep MTM local via face-to-face services. First, we try to get the dispensing pharmacy to provide MTM, if that fails, we try to get another pharmacist in the geographic area to provide services to the patient (another retail site, consultant pharmacists, physician office-based pharmacists, etc.). If that fails we will back it up with a phone-based MTM provider as a last resort. There is no deadline of time, but is rather based on the needs and patience of the covered member. Ultimately, we'll do what it takes to get the patient served.

### **States- Discussion of different MTM programs**

States were given questions in advance. The following questions guided their remarks.

- 1) Do you have a formal network in your state? Does your network include *pharmacists* or *pharmacies*? Why?

- 2) Is there any standardization for criteria that pharmacists must meet in order to provide these services?
- 3) What is your business model? How is it sustainable?
- 4) Do you currently have any business? What steps did you take to get this business?
- 5) What billing model does the MTM program in your state use? Do you use G-codes integrated with the pharmacists CPT codes?
- 6) Are you actively seeking employer contracts in your state to expand MTMS to provide more opportunities for MTM to exist in your state?

**Arizona:** The network in Arizona has been established to initially to provide services for employer group participating in the APhA Foundation Health MapRx Program to provide diabetes services. The program is set up with pharmacists or pharmacies. Since this contract is designated for diabetes management, pharmacists must be a CDE or go through a diabetes training program. The network will be paid an annual fee per new patient and annual fee per renewal patient. This program is a pilot for 18 months; and then it is hoped that it will expand across the entire state. The billing will utilize CPT codes and services are built on different levels of time. Are considering build in the use of G codes. They are hopeful they will be able to use patient base for outcomes. They are actively seeking employer contracts.

**Michigan:** Michigan has just launched Well Street Care Management, a medication therapy service company through their for profit subsidiary. Well Street will serve as a contracting agent for its network. Both pharmacists and pharmacies will be included in the network. Their approach is that all licensed pharmacists can do basic MTM-want to be very inclusive; however they will hold participating pharmacists accountable to get the job done. They intend to be market responsive in their offerings. Currently they are looking at self-insured employers and insurance groups to offer MTM services to patients with chronic diseases as well as those at risk of developing a chronic disease.. Well Street plans on collecting outcomes information.

**Connecticut:** They are actively seeking one contract that will require the creation of a network of pharmacists. They plan on including anyone who wants to be involved. They are currently in discussion with a national insurer to provide services for diabetes. They will require diabetes certificate program or CDE. The network will operate on a per patient enrollment fee and administrative fee. The network will be responsible for billing for pharmacy services and paying pharmacists. Currently in discussions as to use of G codes and/or CPT codes.

**Wisconsin:** In 1995 amended state budget to create a pharmaceutical care payment system for their state Medicaid. They developed a program to bill for services through pharmacy prescription billing system. Every pharmacist was offered the ability to be included in the program. PSW did the training and had approximately 900 pharmacists participate. Program has been in effect for 12 years and only about 100 use and 25 actively use. PSW continues to advocate to 3<sup>rd</sup> party payers to provide payment for pharmacy services. There is a half dozen of programs that are rarely used. One thought as to why there is minimal participation by pharmacists is the variability of the programs with few patients qualifying. It was too difficult to transform practice and create a business model that makes sense for the pharmacist. Two years ago PSW facilitated discussions with a several insurers to develop a MTM model. They have agreed to go forward with a select group of 50 pharmacies. The association will provide significant training and support. All of the pharmacies will all use one IT system that is being created by McKesson. They will beta test the program in 5 pharmacies in December and all 50 in February. They will use CPT codes for billing. PSW will not be creating a network of pharmacies; they serve a role of advocacy and education.

**Florida:** They have been in the network management 30 years. They create standardized network contract agreement applicable to an entity so it includes pharmacist or pharmacy. Fees determined by plans. Have an overall agreement and plan design- which is handled as an addendum to their contract. Employers and pharmacists have been coming to them to get help in implementation of MTM programs. FPA has found setting up booth to promote MTM at league of

cities or counties. Invite HR association or Risk Management assessment to annual meeting to promote

**Iowa:** IPA has served in an advocacy and education role for decades. They do not have a pharmacy network. In Iowa there are several offerings through Outcomes. In addition, in 1999 their Medicaid program began Pharmaceutical Case Management (PCM). To participate in this program you have to be a PharmD or go through a specified training program. In 2005, Blue Cross Blue Shield began a MTM program for employees. A new program for state employees is currently being developed. The billing of services for the PCM program are on a HCFA 1500 form utilizing CPT codes.

**Minnesota:** The MN Medicaid program was legislatively mandated to implement a MTM program. MPhA has chosen an advocacy, not network management role. However, they have found that facilitating an informal networking of pharmacist who participate in program very beneficial for sharing lessons learned and motivating pharmacists. Pharmacists are qualified to participate if they graduated after 1996 or have completed one of two training programs (one offered by the Univ. of Minnesota or the APhA training program). They use CPT codes for billing. The interested twist to the mandate is that the Medicaid managed care plans were also required to offer MTM for their Medicaid recipients. At least one Medicaid MCO that also has Medicare Part D covered lives has implemented the Medicaid MTM program for their Medicare patients.

**Missouri:** Has facilitated the advocacy role, currently do not have a formal network. They have created a task force that works towards getting pharmacists to participate in all opportunities. In addition to the Medicare Part D programs, they work with their state Medicaid program and are currently seeking opportunities to discuss with employer groups.

*Marghie concluded this session asking the group what should the NASPA MTM workgroup focus on to assist the states with their MTM efforts? This is an area that we are actively seeking input and hope that members will continue to share their thoughts and ideas on where we need to focus our efforts.*

### **Discussion of Action Plan for Implementation of the JCPP Future Vision of Pharmacy Practice**

Mitch Rothholz, APhA provided a presentation that summarized the development of an action plan for the implementation of the JCPP Future Vision of Pharmacy Practice.

The Future Vision for Pharmacy Practice in 2015 was adopted by JCPP in November 2004.

*Pharmacy will be the healthcare professionals responsible for providing patient care that ensures optimal medication therapy outcomes.*

In late 2006, JCPP organizations selected Bob Elenblas to facilitate a workgroup to turn the vision into action. JCPP member organizations appointed volunteers to draft an action plan for the implementation of this vision in three core areas; practice model, payment policy, and communications.

Key questions that are critical today are to what extent is this vision shared by pharmacy as a whole? To what extent is this vision reflected in the practices of pharmacy today.

The process that the workgroups utilized was to start with the desired future state (vision) – and then identify strategy directions, critical success factors, objectives and action plans. This could serve as a process model for states to use in their own organizations.

The action plan is currently under review by the JCPP member organizations. It will be a standing agenda item for JCPP. Each organization, including the states, will need to develop

member communications to build awareness, understanding, support commitment and action. To be effective, this action plan will need to be part of each organization 's strategic planning.

After Mitch provided the overview, the following state executives joined the discussion to add a few remarks from their perspective and answer questions.

Larry Wagenknecht, Practice Model workgroup participant

Tom Temple, Payment Policy workgroup participant

Chris Decker, Communications workgroup participant

### **NCAP/Washington Clerkship Update (handout attached)**

Fred Eckel provided a summary of a new clerkship that NCAP is offering as a partnership with the Association of Community Pharmacists (ACP). ACP was founded by Mutual Drug in an attempt to increase the legislative voice of pharmacy. This clerkship enables NC students to select a Congressional rotation serving in the office of a North Carolina Senator or Member of the House. The student is assigned to the Health Care Policy advisor for that Member and the length of the rotation is at least two months. Fred serves as the preceptor for the clerkship. Housing for the students is paid for through NCAP's partnership with ACP. ACP has extended an offer to assist the Virginia Pharmacists Association and the South Carolina Pharmacy Association set up similar offerings. They have also indicated they would consider assisting additional states if there is an interest.

### **NACDS Update with Steve Anderson**

NASPA was honored to have Steve Anderson, NACDS CEO join us to provide an update and a few thoughts about future focus and opportunities with NACDS. His comments were welcoming and motivating. He stressed the important role that associations play in society. Associations facilitate individuals with common interests working together and getting things accomplished. He asserted that currently that strength is not being capitalized to its fullest potential for pharmacy. In addition, he expressed an interest in continuing the dialogue with state pharmacy associations to try to maximize our collective strength.

### **Project Destiny Discussion**

Edith Rosato, NACDS

Ross Martin, Bearing Point

Jim Caro, sanofi-aventis

Mitch Rothholz, APhA

Doug Hoey, NCPA

Edith Rosato provided an overview of Project Destiny – a collaborative effort by NACDS, APhA and NCPA designed to deliver a strategic business, practice and financial plans that will establish community pharmacy's role as a valued, necessary health care provider and key component of the nation's health care system. Project Destiny is a coordinated effort between national pharmacy organizations with broad support by industry. The project uses as its framework the JCPP Future Vision for Pharmacy Practice in 2015. In addition, a mission was articulated for the project: *To validate community pharmacy's role in the delivery of health care as a valuable and integral component, accepted and recognized by patients, payer, and policymakers for the patient care services that they deliver.* BearingPoint, a global management and technology consulting company, was awarded the contract. The project focuses on four areas: Interoperability, practice model, and business model and communication strategy and is divided up in five phases. It is currently entering into the last phase. It is anticipated the project to be finalized by year end.

Ross Martin, from BearingPoint highlighted the health information exchange landscape providing a robust amount of information for further consideration and discussion. He challenged the

group with the following assertion: The healthcare information technology environment is exceedingly fragmented and impacted by regulatory issues. The marketplace is crowded with competition with few dominant market leaders in the clinical space. Community pharmacy has an opportunity to present itself with a singular voice and point of connection on the front end of care.

Jim Caro, sanofi-aventis shared a few remarks from industry's perspective regarding the project. Mitch Rothholz, APhA and Doug Hoey, NCPA added their perspectives of the significance of a multi-organizational effort to move community practice forward.

Key findings and recommendations should be finalized by the end of the year. It will take a tremendous investment by all state and national organizations to be successful.

### **How to Enhance the Effectiveness of State Pharmacy Associations**

The last session of the meeting was moderated by Steve Mullinex, Mallinckrodt and NASPA Associate Member Advisory committee chair.

*Staff note: The planning committee's intent on this block of time was to focus discussion on how state pharmacy associations could take all of the information presented in previous sessions on MTM, JCPP Vision, Enhancing Legislative Advocacy, Project Destiny and create actionable items that would enhance state pharmacy organizations. This was developed to try to move us from information to action.*

*However, when this session began, we quickly realized that a more basic discussion was expected due to the title of the session and agreed that the basic discussion needed to occur. We took the time available to brainstorm on the strengths/weaknesses of state pharmacy associations and global action items that are necessary for state pharmacy association's survival. In no means was this a strategic planning session but will serve NASPA to focus areas of future action and workgroups.*

### **Strengths of State Pharmacy Associations**

- Long standing legislative relationships
- Professional Credibility
- Honorable Purpose
- Non-competitive spirit that promotes sharing among state pharmacy associations
- Collective creativity
- Close to the grassroots

### **Challenges of State Pharmacy Associations**

- Inconsistency among the state associations
- Lack of resources
- Duplications of efforts/lack of efficiency
- Membership challenges particularly by employee pharmacists
- Aging of active members
- Too many stakeholders – with limited resources

### **Key Discussion Areas for future action**

#### **Organizational structure**

There was a strong feeling that the current organizational structure for pharmacy is not working and is unsustainable. An investment must be made by national and state organizations to seek a new model for American pharmacy. Everything should be on the table for consideration. State pharmacy associations should advocate for the this to continue to be a priority at a national level.

Need to commit resources to develop a model template of what is necessary for state pharmacy associations. This could be utilized to facilitate discussions on what resources can be shared,

what it takes to have an operational state pharmacy association in every state and what we are currently spending time/resources on that are duplicative or can be regionalized

***Value***

There was a strong feeling that the states had tremendous untapped knowledge database that could reside at the NASPA portal with users able to access and contribute documents for sharing. If all states contributed to a common repository we could create a tremendous value to each other.

A concise compilation of a case statement on poor medication usage and the value of pharmacists' services would assist in our efforts to promote pharmacists services.

***Membership***

Development of materials that would seek to present value statement to pharmacists (key area to concentrate is diversity) and pharmacy employers. Further discussions with large employers of pharmacists a key area of discussion.

***Resources***

Focused activity on organizational structure, value and membership should provide an opportunity to leverage and utilized resources in a more effective way.