MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2394

2005 SENATE HUMAN SERVICES

SB 2394

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2394

Senate Human Services Committee

☐ Conference Committee

Hearing Date January 31, 2005

Tape Number	Side A	Side B	Meter #
3	x		130-1490
Committee Clerk Signature	Cathy Kinnard		

Minutes:

Chairman Lee opened the hearing on SB 2394. All members were present.

Senator Richard, introduced the bill and is the main sponsor of it.

Testimony in favor of SB 2394

Senator J. Lee, District 13, Fargo. Even though this bill is not in perfect form, I hope we can put work together so we can use medication therapy management as a tool. I see a bill role for pharmacists to help us disease management because dosage and utilization has a lot to do with disease management.

Patricia Hill, Executive Vice President for the North Dakota Pharmacists Association.

See written testimony (Attachment 1, 1A)

Arnold Thomas, Wanted to see how this bill linked to HB 1465 which is also being heard by joint committees today. Want to draw committees attention to SB 2284 and SB 2312. I don't see any permissive language in SB 2394 with respect to the Department's ability to contract for

program delivery. As I read SB 2394, it indicates that the Department has a responsibility to develop and implement a medication management program. It must provide medication management services, not restricted only to medical assistance. It must provide that the services be provided by pharmacists to collaborate with physicians. I was wondering if the bill might be strengthened by permitting the Department some flexibility in terms of contracting out the program implementation aspects of it with those who would be able to achieve the program objectives as envisioned by the sponsors of the bill. I'd be happy to help out with an amendment.

Neutral Testimony on SB 2394

David Zentner, Director of Medical Services for the Department of Human Services

See written testimony (Attachment 2)

There was no more testimony on SB 2394

Chairman Lee closed the public hearing on SB 2394.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2394

Senate Human Services Committee

❑ Conference Committee

Hearing Date February 2, 2005

Tape Number	Side A	Side B	Meter #
2	X		5000 - 5750
Committee Clerk Signature	Janet Jones		

Minutes:

Senator Judy Lee opened the committee work on SB 2394.

All members of the committee were present.

SB 2394 ties with HB 1465.

Discussion was held as to Mr. Zenter's testimony and knowing that the committee will be working harder on SB 1465 as it will be coming from the house in a draft sort of form. The committee does not want to rely on the house doing what the senate committee is wanting will SB 2394, the thought is to do a better job with one bill than work on two similar bills.

Senator Richard Brown made a motion for Do Not Pass of SB 2394.

Senator Stanley Lyson second the motion.

Roll call vote for Do Not Pass of SB 2394 was taken indicating 5 YEAS, 0 NAYS AND 0 ABSENT OR NOT VOTING.

Senator Brown will carry SB 2394.

FISCAL NOTE

Requested by Legislative Council
01/25/2005

Bill/Resolution No.: SB 2394

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2003-2005 Biennium		2005-2007 Biennium		2007-2009 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$200,000	$0	$206,040
Expenditures	$0	$0	$200,000	$200,000	$206,040	$206,040
Appropriations	$0	$0	$200,000	$200,000	$0	$0

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2003-2005 Biennium			2005-2007 Biennium			2007-2009 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
$0	$0	$0	$0	$0	$0	$0	$0	$0

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill would create and enact a new section to chapter 50-24.1 of the NDCC relating to creation of a medical assistance program for medication therapy management services in collaboration with pharmacists and physicians. The program would provide medication therapy management services to medical assistance recipients to ensure appropriate use of prescription drugs to improve therapeutic outcomes and to reduce adverse drug reactions.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The department would receive federal title XIX funds at the administrative 50% match rate totalling $200,000 for 2005-2007 and $206,040 for 2007-2009.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Operating expenditures for 2005-2007 would increase $400,000 of which $200,000 would be general funds; for 2007-2009 operating expenditures would increase $412,080 of which $206,040 would be general funds.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

Operating line appropriations expenditures for 2005-2007 would need to be increased by $400,000 of which $200,000 would be general funds.

Name:	Debra A. McDermott	**Agency:**	Human Services
Phone Number:	328-3695	**Date Prepared:**	01/31/2005

Date: 2-2-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2394

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DO NOT PASS

Motion Made By Sen. Brown Seconded By Sen Lyson

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment Sen. Brown

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2394: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO NOT PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2394 was placed on the Eleventh order on the calendar.

2005 TESTIMONY

SB 2394

Attachment 1

Testimony to Senate Human Services Committee
Senator Judy Lee, Chairwoman

RE: Support for SB 2394 – Medication Therapy Management Services (MTMS)

Senator Lee and members of the committee, my name is Patricia Hill and I serve as the Executive Vice President for the North Dakota Pharmacists Association. I am testifying today on behalf of our 650 members who can be found in various pharmacy practice settings all across the state. This extensive network of healthcare professionals is keenly interested in efforts to expand access to medication therapy management services (MTMS) for all North Dakota citizens.

Currently, through the Community Care Rx card – one of the Medicare approved discount drug cards – we are delivering these services to thousands of North Dakota Seniors (and millions across the nation). You may not know that CCRx is the ONLY discount card offering medication therapy management services and pharmacists are being reimbursed for providing their professional medication expertise. The pharmacists are reimbursed from a trust fund created from the $30 annual fee that was paid by the Medicare recipients and held in trust until the federal government approved this additional service through the CCRx card.

The same partners offering the CCRx formed an alliance with our state pharmacy association to offer MTMS and disease state management proposals to the ND Public Employees Retirement System last November. With the combined resources of our partners and the ND pharmacy network we offered PERS a medication therapy management program for all 52,000 members and their dependents as well as a disease state management pilot program for 200 asthma and diabetic members. The funding for this program is pending legislative approval and we are hopeful these proposals will be funded and selected for implementation by late summer 2005.

The pharmacy network in North Dakota is a huge asset in the delivery of medication therapy management services, because successful programs depend on patient access to the expertise and counsel of our highly trained pharmacists. SB 2394 is the perfect compliment to the Medicare program that begins one year from now, and includes medication therapy management services in the new drug coverage under Part D. One important element in MTMS is to ensure reimbursement to the pharmacist for their services. In other states, the results have been impressive.

One of our partners for the NDPERS projects is Outcomes Pharmaceutical Health Care. They provide MTMS for Florida Medicaid and the state has saved millions. Another example from Outcomes is a proposal in the state of Washington (included in your materials). The interesting aspect of Outcomes is that their experience has been so positive, they offer a performance guarantee to each state: each intervention by a pharmacist includes an estimate of the health care costs avoided as a result of that intervention. Audits are done by an outside quality assurance company on each claim to ensure validity. Outcomes guarantees annual cost avoidance at least equal to the program costs or they refund the difference back to the state! That is how certain they are of the successes to date from MTMS.

Interest by healthcare providers statewide is growing exponentially, especially with the recent data on cost savings from efforts focused on the chronically ill and addressing their needs in order to improve their health and lower overall costs (see "Health Disparities Collaboratives" website attached.)

I strongly encourage your support of SB ~~2283~~ 2394. Thank you for this opportunity to testify.

WASHINGTON MEDICAID
MEDICATION MANAGEMENT SERVICES
PILOT PROJECT

April 2003

Submitted by:
The Washington State Pharmacy Association
in conjunction with
Outcomes Pharmaceutical Health Care

WSPA
WASHINGTON STATE PHARMACY ASSOCIATION

OUTCOMES
Pharmaceutical Health Care™

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RESTRICTED USE

Patricia Hill

Introduction

The use of medication as a first line health care tool is a common practice. As new and innovative pharmaceuticals have been introduced to the market, more physicians are turning to medication as their primary treatment approach. A recent study in *Health Affairs* reported that physician prescribing has increased 59% over the past 15 years. The study also found that physicians are 43% more likely to prescribe multiple drugs today than they were in 1985. Despite this trend, physicians remain largely insulated from information on drug costs. According to a study published recently in the *Journal of General Internal Medicine*, 72% of physicians remained "unaware of drug costs", even after receiving an eight-page pocket guide that outlined prices for more than 100 commonly used drugs.

Medication Waste

As drug prescribing has increased, so have the costs associated with medication waste. Medication waste occurs whenever:

- A higher cost medication is used when a lower cost alternative was available to treat a given condition.
- A patient is non-compliant with their prescribed regimen.
- A patient experiences a side effect or reaction to a medication, requiring additional medical attention or treatment.
- A medication fails to achieve the desired therapeutic results.

The *Archives of Internal Medicine* published a study in 1995 estimating the cost of medication waste in the US at greater than $76 billion per year. By 2001, the *Journal of the American Pharmaceutical Association* reported that this problem had more than doubled, soaring to an estimated $177 billion per year. These studies also attributed 20 million lost workdays and over 200,000 deaths per year to the inappropriate use of prescription medication.

Like most payors, Washington Medicaid is experiencing escalating costs due to medication waste. By arming Washington pharmacists and Medicaid recipients with the Outcomes Encounter Program™, Washington Medicaid can reduce medication waste, improve health care quality, and lower costs. The Encounter Program is Outcomes' proprietary medication management system.

Proposal

This proposal outlines a program to identify the types of medication waste that exist within the Washington Medicaid covered recipient population and to measure and report the impact of participating Outcomes pharmacists on these issues through the Outcomes Encounter Program.

This proposal is grouped into 7 sections: (1) Pharmacy Provider Network; (2) Services to Covered Recipients; (3) Data Management; (4) Performance Guarantee; (5) Client Requirements; (6) Fee Schedule and Projections; and (7) Qualifying Statements.

1. Pharmacy Provider Network

Traditionally, pharmacists have been used to ensure the accurate dispensing of medications. The Encounter Program dictates an enhanced level of performance from participating pharmacy providers - requiring them to collaborate with patients and prescribers to identify, resolve, and prevent medication waste. To accomplish this, Outcomes proposes the following:

- Outcomes will review historical claims data from Washington Medicaid to identify those pharmacies that are most patronized by Washington Medicaid's covered recipients.
- Outcomes will then contact those pharmacies and enroll as many as possible into the Outcomes Encounter Program network.
- Enrolled pharmacists will receive additional training on the identification of Washington Medicaid covered recipients and the provision of Encounter Program covered services to these recipients.
- A sufficient number of pharmacies will be enrolled into the participating provider panel to meet or exceed performance guarantees (see page 4).

Because Encounter Program service delivery, documentation, and claims submission is a departure from traditional pharmacy practice, a strategy for network management will be implemented, inclusive of the following:

- Generation of quarterly pharmacy provider "report cards" to assess performance.
- Use of systems for maintaining and assessing site management information and tracking provider performance and communications.
- Provision of telephonic, electronic, and on-site assistance to pharmacy providers to improve and maintain provider performance.

2. Services to Covered Recipients

A primary feature of the Outcomes Encounter Program is that it facilitates activity on the part of the pharmacist, covered recipient, and physician to minimize medication waste and provides documentation of that activity. Covered services in the program include: (1) Comprehensive Medication Review; (2) Prescribing Assistance; (3) Drug & Dosage Verification; and (4) "OTC" Medication Consult.

<u>Comprehensive Medication Review</u>

- The improper use of multiple medications can lead to health complications and also become a major source of medication waste. Washington Medicaid recipients taking 4 or more medications may meet with a participating pharmacist for a review of their entire medication profile - inclusive of

prescription and non-prescription drugs, herbal products, nutritional supplements, etc. to detect any conflicts, duplications, or cost savings opportunities. If the pharmacist detects a complication, they will consult with the recipient and/or their doctor to address the issue.

Prescribing Assistance

- Formularies, Preferred Drug Lists, Prior Authorization rules, and other prescribing guidelines can be confusing – both to recipients and their doctors. Participating pharmacists will assist Washington Medicaid recipients to use the most cost-effective generic and brand name medications.

Drug & Dosage Verification

- When Washington Medicaid recipients have a prescription filled, participating pharmacists will perform a 10-point review of the drug and dosage for safety, effectiveness, and potential interactions with other medications. If the pharmacist detects a conflict, they will contact the recipient's doctor to resolve the problem.

"OTC" Medication Consult

- Non-prescription/over-the-counter or "OTC" medications can oftentimes resolve minor ailments inexpensively. However, selecting an appropriate OTC can be difficult, and the improper use of these drugs can further complicate a condition or delay necessary treatment. Participating pharmacists will provide consultations to Washington Medicaid recipients on appropriately utilizing OTC medications to treat allergy symptoms, cough and cold needs, acute pain relief, and other conditions.

3. Data Management

Outcomes will supply a secure, web-based system to capture claims data associated with pharmacist interventions to reduce medication waste. Features of the secure system include:

- Paperless claim adjudication.
- 24/7 pharmacy provider system access.
- Administration of recipient eligibility file, participating pharmacy file, participating pharmacist file, and covered service claims file.
- Quality assurance claims audit of submitted covered service claims.
- Payment processing to pharmacy providers for approved covered service claims.
- Data management and reporting on provider performance and the frequency, type, and outcome of covered service claims.

4. Performance Guarantee

Each pharmacist intervention will include an estimation of the health care costs avoided as a result of the intervention. An outside quality assurance company of national reputation will audit interventions to assure that each claim of avoided cost is both reasonable and foreseeable. Outcomes will guarantee annual estimated cost avoidance at least equal to program costs with any shortfalls refunded to Washington Medicaid.

5. Client Requirements

In order to assist Outcomes in the provision of covered services, the following cooperative activities would be required from Washington Medicaid:

- Remit recipient eligibility to Outcomes on a timely basis.
- Provide Outcomes with access to prescription claims data in a suitable electronic format for the purpose of identifying highly patronized pharmacies and generating pharmacy "report cards".

6. Fee Schedule and Projections

Based on information supplied to Outcomes, the following fee schedule and projections are proposed:

Assumptions

Average Number of Eligible Recipients	498,429
Annual Prescription Count	11,009,796

Fee Schedule

Pharmacist Payment Pool	$0.38 Per Eligible Per Month
Audit/Quality Assurance Fees	$0.03 Per Eligible Per Month
File Maintenance Fees	$0.01 Per Eligible Per Month
Administrative Fee	$0.06 Per Eligible Per Month
Total	$0.48 Per Eligible Per Month
Annual Program Cost	$2,870,950

Projected Intervention Volume

Physician Interventions	92,200
Patient Interventions	51,600
Total	143,800

Projected Savings

Estimated Cost Avoidance (Drug Product)	$6,257,400
Estimated Cost Avoidance (other Medical)	$8,316,800
Total Annual Estimated Cost Avoidance	$14,574,200
Annual Program Cost	$2,870,950
Net Savings	$11,703,250

7. Qualifying Statements

- Outcomes has generated projections for cost reductions documented through the company's Estimated Cost Avoidance model. This model does not measure "hard" costs, but estimates savings achieved through the reduction of avoidable health care utilization. This Estimated Cost Avoidance model has been validated by independent study. Outcomes supports the measurement of "hard" costs to evaluate the Program, however, the funding for such evaluation is not included in this proposal.

- Outcomes has used its Estimated Cost Avoidance savings model to document cost reductions for a number of private employer sponsored health plans. Data from these health plans were used to generate savings projections for this proposal. These populations may be markedly different from the Washington Medicaid population in terms of health care utilization, demographics, etc. – these differences may impact the accuracy of the projections.

- The projections listed in this proposal are based on historical performance of the Outcomes network. Historical performance should not be interpreted as a guarantee of future performance. However, Outcomes is prepared to guarantee that cost avoidance documented through the Estimated Cost Avoidance model will be at least equal to program costs or the difference will be refunded to the state at the conclusion of the Program.

- The projections listed in this proposal assume a pharmacist activity rate equal to 50% of that experienced in other markets. Higher performance rates would likely lead to a higher return on investment for Washington Medicaid.

Iowa Medicaid Pharmaceutical Case Management: A Basic Description for Pharmacists

Eligible physician/pharmacy teams can be reimbursed for providing Pharmaceutical Case Management services for eligible Medicaid recipients who are identified by Medicaid as at high risk for having trouble taking their medicines safely and effectively.

Pharmaceutical Case Management (PCM) services involve physicians and pharmacists working together to help patients use their medications safely and effectively. Physician team members prescribe and establish treatment goals for their patients enrolled in the PCM program. Pharmacist team members provide supplemental follow-up and feedback between physician visits about patient compliance, achievement of treatment goals, and occurrence of side effects. Pharmacists must partner with a physician to participate. Pharmacists and physicians must meet eligibility requirements to participate.

As instructed by the Iowa Legislature, the University of Iowa Colleges of Public Health, Pharmacy, and Medicine evaluated the PCM program. An advisory committee of physicians and pharmacists was assembled to provide input to the research team. The research team provided a final report to the legislature in December 2002. A significant improvement in safe use of medication was documented in patients receiving PCM services.

How is a physician-pharmacist team established?

Generally, physicians and pharmacists are already working together on an as-needed basis. The PCM program strives to strengthen these relationships, make them more intentional, with focus on patients with special medication needs. The real team building will happen over time as the team interacts around the care of the enrolled patients. Teams for some patients will include a single physician and a single pharmacist. For other patients, particularly in urban areas, several pharmacists from a single pharmacy and several physicians from a group practice will build a team.

When and where is the care delivered? How does it get started?

Under the direction of the Department of Human Services, patients can be identified by physicians and pharmacists as eligible to receive services if they meet certain criteria. Participating providers may also receive lists of eligible patients in their practice. The pharmacist will contact the patients identified to encourage them to participate. The pharmacist will also contact the patients' physicians to discuss pharmaceutical case management, discuss eligible patients whom they are collectively serving, and explore the particular roles of each team member. Once each member of the team and the patient have indicated a willingness to participate, the care team can choose communication methods and begin providing PCM services for the eligible patient.

Patricia Hill

The pharmacist will schedule an appointment with the patient to conduct an "initial assessment." During the initial assessment, the pharmacist will:

- Take a medication history;
- Determine the indication for each medication, and record progress toward achieving treatment goals;
- Assess patient compliance;
- Detect any side effects or side effect risks that can be reduced (e.g., by changing dose, choosing lower risk medications, or using particular monitoring procedures);
- Assess the need for regimen change, patient self-management education, and for administration and monitoring device training; and
- Make written recommendations to the physician about any actions the team should consider, and about desired follow-up methods and frequency.

Care team discussion regarding assessments can be conducted in person or by telephone, but a brief written version must also be created.

The physician will finalize the action plan by:

- Reviewing the pharmacist's report; and
- Approving or modifying (in writing to the pharmacist) the action plan proposed by the pharmacist.

The action plan may include a physician visit, but a visit is not required for physician reimbursement for PCM services.

After the team agrees upon an action plan, the pharmacist may directly initiate the plan, or may assist the patient in scheduling a physician visit if this is the next agreed-upon step. In either case, a "follow-up assessment" is scheduled with the pharmacist at the interval agreed upon by the team.

What is a problem follow-up assessment?

During the problem follow-up assessment, the pharmacist will:

- Assess progress toward achieving the objectives of the action plan;
- Update the action plan by recording the progress made and making a written recommendation about what, if any, further action is needed and when the pharmacist should see the patient for follow-up.

The physician will review the pharmacist's recommendations and, in writing, approve or modify them to finalize the current action plan.

What happens when the goals of the action plan have been achieved?

When the patient no longer requires follow-up for the medication action plan, the pharmacist and physician will continue to see the patient for their prescription and medical needs, respectively. During this usual care, new medications may be prescribed, other medications adjusted, and new medication use issues may arise. The "new problem assessment" is the mechanism by which the physician/pharmacist patient assessment cycle of the PCM program can be restarted if new medication use issues arise. This process allows for continual patient monitoring for problems due to medications.

During the new problem assessment, the pharmacist will:

- Briefly review the patient's medication history for changes;
- Identify any aspects of the new or adjusted medication that increases risk of medication side effects, compliance problems, or difficulty achieving treatment goals, and
- Make recommendations to the physician about any actions the team should consider and about desired follow-up methods and frequency.

If no new medication use problems arise by the time the goals of the action plan have been achieved, the pharmacist will schedule a six-month "preventive follow-up assessment" with the patient. During the preventive follow-up assessment, the pharmacist will:

- Update the medication history;
- Assess patient compliance;
- Assess progress toward achieving treatment goals;
- Reinforce desired self-management behaviors;
- Detect new risk factors;
- Assess the need for regimen change and new patient education; and
- Make written recommendations to the physician about any actions the team should consider about desired follow-up methods and frequency.

Which patients are eligible?

Eligible patients are those who take four or more regularly scheduled non-topical medications, are not nursing home residents, and who have at least one of twelve select disease states (congestive heart failure, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux disease, peptic ulcer disease, and chronic obstructive pulmonary disease.) Other disease states may be added as the program matures.

How are providers reimbursed?

Pharmacists may file a claim when they submit their written recommendations to the team physician. Physicians may file a claim when they return their written approval or modification to the pharmacist. If the provider care team members are not the primary care providers for the patient, the team members are also required to forward a copy of the action plan to the patient's primary care providers. Pharmacy and physician members will each be reimbursed according to the following schedule:

Service Type	Reimbursement Amount	Maximum Number of Payments
Initial Assessment	$75	One per patient
Problem Follow-up Assessment	$40	Four per patient per 12 months
New Problem Assessment	$40	Two per patient per 12 months
Preventive Follow-Up Assessment	$25	One per patient per 6 months

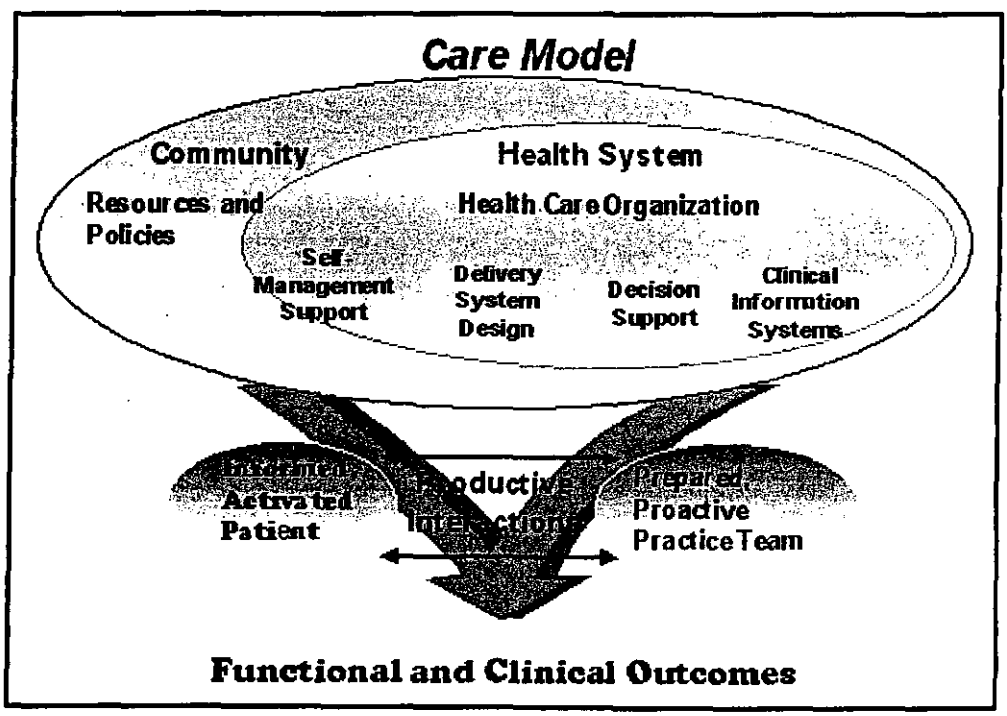
2000 Legislation: Human Services Appropriations Bill: $414,000 PHARMACEUTICAL CASE MANAGEMENT STUDY. There is appropriated from the general fund of the state to the department of human services for the fiscal year beginning July 1, 2000, and ending June 30, 2001, the following amount or so much thereof as is necessary, to be used for implementation of a disease-specific pharmaceutical case management study to measure the effects of case management for medical assistance recipients identified by the department as high risk for medication-related problems. The funds shall be used to equally reimburse physician-pharmacist teams who participate in the study. An advisory committee whose membership consists of representatives of the Iowa medical society, the Iowa pharmacy association, and the department of human services shall establish and implement the pharmaceutical case management study. The university of Iowa college of public health, in conjunction with the colleges of medicine and pharmacy, shall perform an evaluation of the study at no cost to the state and shall submit a final report of the findings of the evaluation and any recommendations to the general assembly by December 15, 2002. The department shall submit a progress report by December 15, 2001, and a final report by December 15, 2002, to the general assembly. The department shall adopt rules to implement this section which comply with the notice of intended action requirements of section 17A.4, subsection 1, and which may be adopted as emergency rules pursuant to section 17A.5, subsection 2, after notice is provided. The rules shall be reevaluated by the department of human services with input from the Iowa medical society and the Iowa pharmacy association, upon submission of the final report or by December 15, 2002, whichever occurs first:

Chronic Care Model

- Background
- Participating in a Collaborative
- Activities
- Achievements
- Models for Changing Practice
- Organizational Structure
- Collaboratives Brochure

The Chronic Care Model is a population-based model that relies on knowing which patients have the illness, assuring that they receive evidence-based care, and actively aiding them to participate in their own care. It is recommended that a sub-group of the entire population be the focus of change in practice for the duration of the Collaborative. The Model as shown below has six components:

1. The health care organization
2. Community resources and policies
3. Self-management support
4. Decision support
5. Delivery system design
6. Clinical information systems



Chronic Care Model Change Concepts

Health Care Organization

- Goals to improve chronic care are part of the organization's business plan.
- Senior leaders visibly support improvement in chronic illness care.

- Benefit packages designed by the health care organization promote good chronic illness care.
- Provider incentives encourage better chronic illness care.
- Improvement strategies that are known to be effective are used to achieve comprehensive system change.

Community Resources and Policies

- Effective programs are identified and patients are encouraged to participate.
- Partnerships with community organizations are formed to develop evidence-based programs and health policies that support chronic care.
- Health care organizations coordinate chronic illness guidelines, measures an care resources throughout the community.

Self-management Support

- Providers emphasize the patient's active and central role in managing their illness.
- Standardized patient assessments include self-management knowledge, skills, confidence, supports, and barriers.
- Effective behavior change interventions and ongoing support with peers or professionals are provided.
- The care team assures care planning and assistance with problem solving.

Decision Support

- Evidence based guidelines are embedded into daily clinical practice.
- Specialist expertise is integrated into primary care.
- Provider education modalities proven to change practice behavior are utilized.
- Patients are informed of guidelines pertinent to their care.

Delivery System Design

- Team roles are defined and tasks delegated.
- Planned visits are used to provide care.
- The primary care team assures continuity.
- Regular follow-up is assured.

Clinical Information Systems

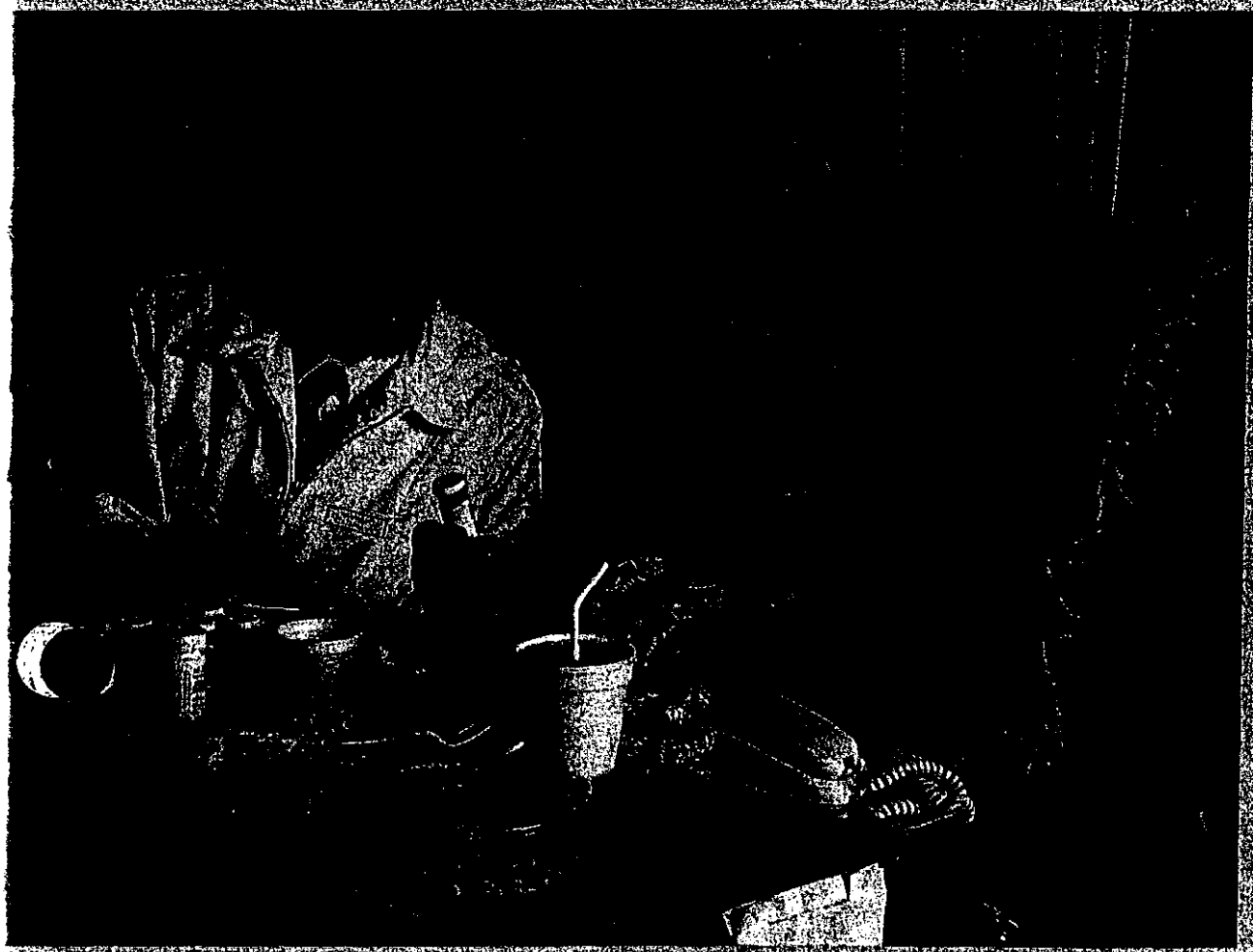
- There is a registry with clinically useful and timely information.

- Care reminders and feedback for providers and patients are built into the information system.
- Relevant patient subgroups can be identified for proactive care.
- Individual patient care planning is facilitated by the information system

Acknowledgements:
Improving Chronic Illness Care, a national program of the Robert Wood Johnson Foundation, MacColl Institute, Seattle, WA"

Attachment 1A

Medication Therapy Management Services



At Garrison Memorial Hospital, Pharmacist Kim Essler visits with Lillian Thompson, currently a Swing-Bed Patient.

An Ounce of Prevention is Worth a Pound of Cure

By Bethany Nesheim, Clearwater Communications

"This is the opportunity for pharmacists to step forward as not only dispensers but as educators," says Rick Detwiller, RPh and Director of Outpatient pharmacy at St. Alexius hospital in Bismarck.

Detwiller speaks of the new role pharmacists have taken on by becoming vital consultants for their patients. These consulting services are labeled MTMS, Medication Therapy Management Services, and have become a key point of interest, both nationally and locally, in working on the problem of rising healthcare costs.

Patricia Hill, executive vice president of the North Dakota Pharmacists Association says the old system of healthcare is expensive. "It waits until health issues reach acute stages before giving treatment, such as when a heart attack victim is rushed to the ER, or to the hospital, then requires surgery and is held for an extended stay." The new concept of intervention and prevention, she says, focuses on avoiding those more costly stages of treatment. "MTMS is central to that plan."

MTMS programs targets patients with chronic condi-

tions, such as diabetes and asthma, because they're the heaviest users of health care services. According to research through John Hopkins University, more than three-fifths of health care spending is on behalf of people with multiple chronic conditions. Currently, 133 million people, almost half of all Americans, live with a chronic condition. By 2020, as the population ages, that number will reach 157 million. Therefore, the cost crisis of America's healthcare system is expected to continue to rise unless a new solution is developed.

Recognition of MTMS programs as part of that solution has been building ever since the 'Asheville Project.' Beginning in 1997 in Asheville, North Carolina, the project arranged for pharmacists to be paid for counseling patients. Acting as a bridge to physicians during monthly sessions, pharmacists helped patients stay on track by offering advice on diet, exercise, stress reduction and medications. By 2002, the risk manager who approved the program said that he was receiving "a 4-to-1 return" on his financial investment. Health care costs and sick days from work were cut in half for the original 42 city workers involved.

"The Asheville Project is an example of where the numbers came together, and it worked. It worked so well that it's been a trigger for many of the things going on now," says Dave Olig, RPh, owner of Southpointe Pharmacy in Fargo.

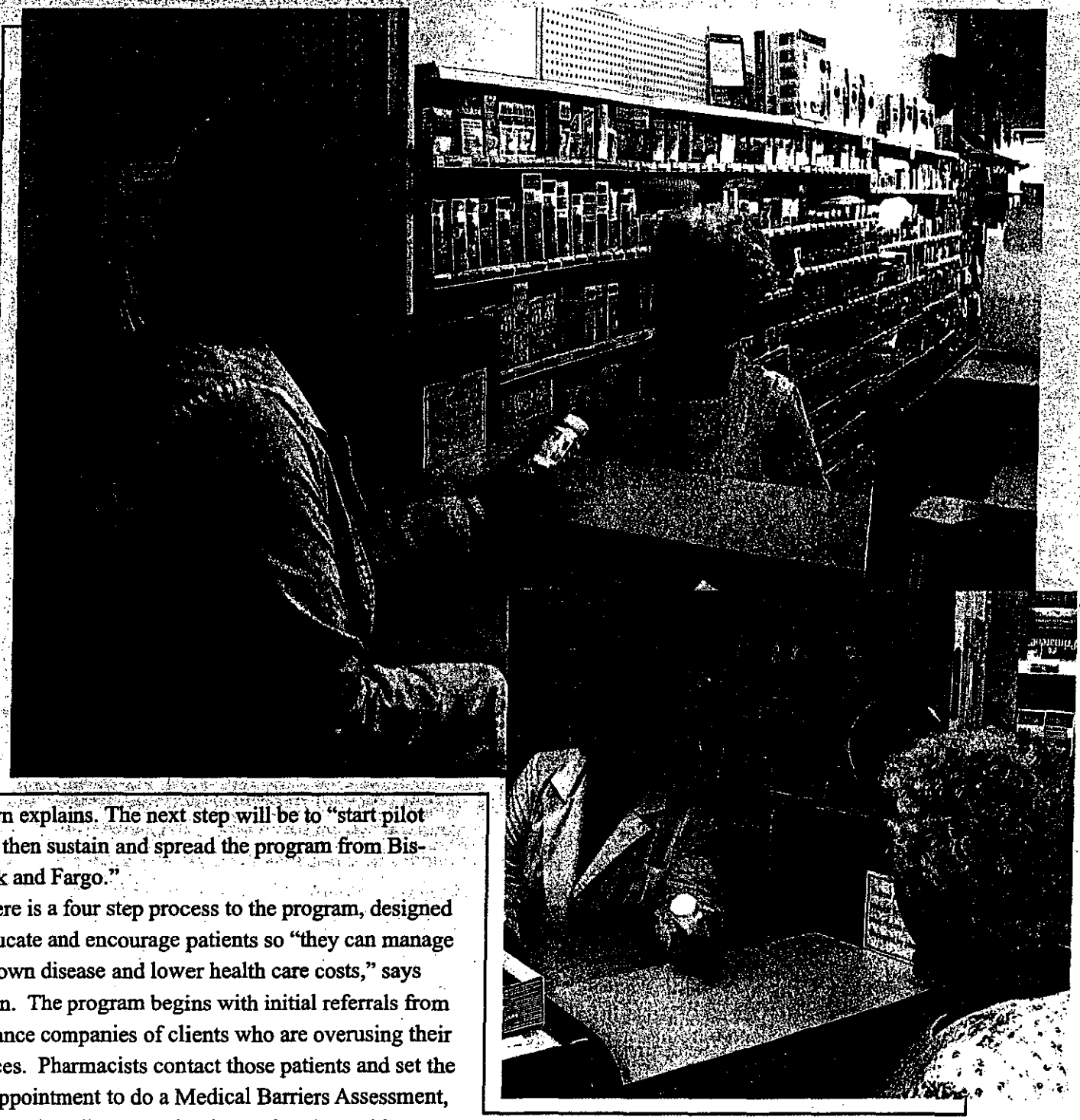
The results of the Asheville Project have stimulated the beginning of similar projects in other areas, and the concept is also being adopted into the new Medicare bill for 2006. Legislative guidelines are currently being written so that pharmacists will be paid for MTMS nationwide. "MTMS has the great potential to change our healthcare system," says Gary Pulvermacher, RPh, Region 8 CMS in Denver, is involved in research and planning of the new legislation. "This new system creates an enhanced role for pharmacists to work directly with patients at a local level," adds Hill.

Yet North Dakota is a step ahead in this movement, already having active MTMS payments through the CCRx Medicare-approved discount drug card, as well as disease management programs developed and waiting. (See NDPhA President, Curt McGarvey's message in this issue for more about the CCRx cards.)

At North Dakota State University in Fargo, Wendy Brown, PharmD, is part of the task force with Olig that developed a disease management program for asthma in 2001. ND Medicaid currently has the program on hold, but the North Dakota Public Employee Retirement System is considering approval of a program in early 2005. "This current pitch to ND PERS is very, very exciting - a world class proposal in my opinion, and unlike anything being done in the country right now," says Olig.

"We get so much disease management in school, now the steps to use it afterward are being put in place,"

Curtis Rudolph picks up a prescription from pharmacist Carla Aipperspach in Wishek.



Charlotte Young, owner and pharmacist at Napoleon Drug, meets with patient Margaret Fettig.

Brown explains. The next step will be to "start pilot sites, then sustain and spread the program from Bismarck and Fargo."

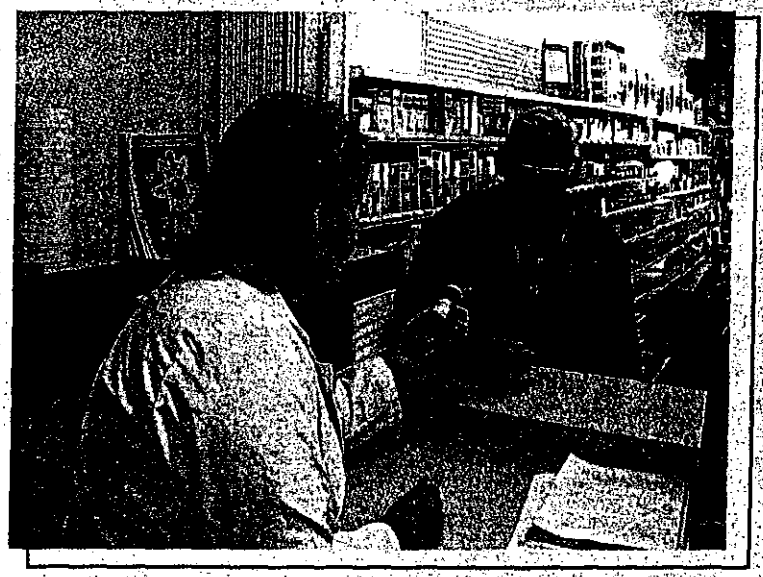
There is a four step process to the program, designed to educate and encourage patients so "they can manage their own disease and lower health care costs," says Brown. The program begins with initial referrals from insurance companies of clients who are overusing their services. Pharmacists contact those patients and set the first appointment to do a Medical Barriers Assessment, in which they discover what is causing the problem - it could be a medication compliance issue or missed information. Or, sometimes patients might simply be unable to read directions on the bottle, or they don't take it because they don't believe it's effective.

After a brief medical questionnaire, the patient is set with a disease educator who has been trained on a specific disease. In the case of asthmatics, the patients would then learn about the factors that trigger their asthma, how to recognize symptoms and correctly take their medications. For people with moderate to severe cases of asthma, knowing this information can keep them from ending up in intensive care, therefore saving in overall medical costs, says Brown.

In Dickinson, Dawn Pruitt, PharmD is certified in diabetes and has a similar disease management program developed, hoping to see it implemented for diabetic

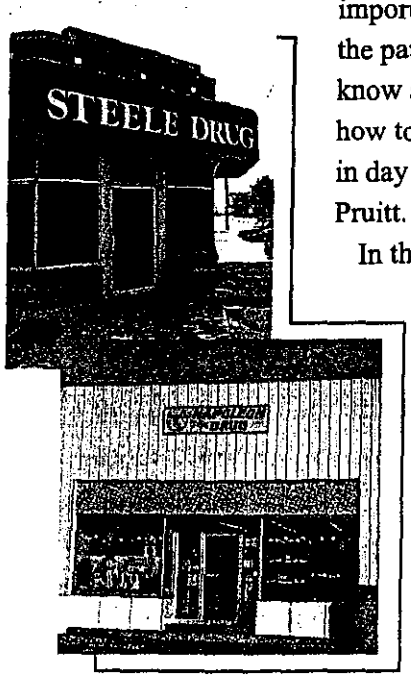
patients. Also arranged in four steps, the first meeting with the patient would include review of complete patient history, followed by creating a pharmaceutical care plan. Pruitt says it would last about an hour and include information on the importance of testing and monitoring. The second meeting would focus more on what the disease is, how it affects the patient, the lifestyle management that should correspond and medication use, ending with review and update of the overall care plan. "Ideally, another member of their health care team would be a dietician, certified in disease management, who would aid in dietary issues and recommended exercise," she says.

During the third visit, pharmacists would go into more detail about hypo- and hyperglycemia, the difference between them and how to manage each. Medication side effects, other drugs and over-the-counter products to avoid would be explained, as well as information about glucose level checks, how they work and why they're important. "At this point, the patients should really know about their disease and how to apply that knowledge in day to day living," says Pruitt.



Young also meets with Joe Fettig in Napoleon.

In the fourth and final meeting, pharmacists would share long-term complications that can happen if they don't take care of themselves, she says. Other tips, such as dental, eye, and foot checks would also be covered, as well as travel guidelines and explanation of what to do on sick days verses regular days. Ending with review and update of the care plan, this final visit should leave the patient "pretty well versed in being able to keep their disease under control, and knowing where to go with questions," explains Pruitt.



Store fronts of two pharmacies in North Dakota serving rural access areas.

This program is in place and ready to go, but patients who are interested and willing to do it are needed. Issues that have stopped potential clients have primarily dealt with rural access. Patients on Medicaid often have limited income for travel, which is a significant issue in patient consultation throughout the Midwest.

Yet "to really be able to do a good job, we have to have a sit down meeting," says Pruitt, who also explains that her patients "know me now as an information source, so they come to me with questions. It's nice to know that trust is there. We're always looking for avenues to improve healthcare."

Pruitt's statements correspond with results of the Asheville Project, from which the APhA Foundation received comments such as: "My pharmacist really cares about me. I could call her any time day or night," and "My pharmacist will set reasonable goals for me. It's not more pressure, but more how he can help me succeed."

Up until a couple years ago some doctors were reluctant to expand the role of the pharmacist, but today, the NDPhA says that evidence is clearly in favor of the new role and delivery to reduce overall costs. "I think physicians do an excellent job, but there's so much information it's almost impossible to cover everything from diagnosis, to therapy to medications," says Detwiller, who speaks from viewpoint of outpatient pharmacy and as a member of the North Dakota State Board of Pharmacy. "Patients can be exhausted, physically and emotionally, by the time a prescription is written. Pharmacists take the opportunity to meet with them one on one – MTMS is the future of pharmacy."

Attachment 2

TESTIMONY BEFORE THE SENATE HUMAN SERVICES COMMITTEE

REGARDING SENATE BILL 2394

JANUARY 31, 2005

Chairman Lee, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to provide information regarding this proposed legislation.

This bill would require the Department to establish a medication therapy management program. This approach is one method used to improve the delivery of quality services through disease management. The Department is currently examining several options available to us for implementing disease management. One of those options was presented this morning by Donald Muse, who suggested we concentrate our efforts on those recipients who incur high costs.

The Department has looked at the potential of using pharmacists to assist in the disease management process, and believe it can be a viable method of ensuring that Medicaid recipients receive quality care in a cost effective manner. We are somewhat concerned that this bill would mandate that we implement this approach, when other methods may also be effective in improving quality and controlling costs.

The Department has included $200,000 of which $100,000 is general funds, to begin a disease management program in our appropriation request for the next biennium.

Paragraph 3 indicates that the Department may apply to receive dollars from other sources to implement this program. It may be difficult to convince grantees

to provide funding because disease management can be provided as a service or administrative cost through the Medicaid program.

I would be happy to respond to any questions you may have.