MTMS and the Million Dollar Question: How Will ALF Residents Benefit?

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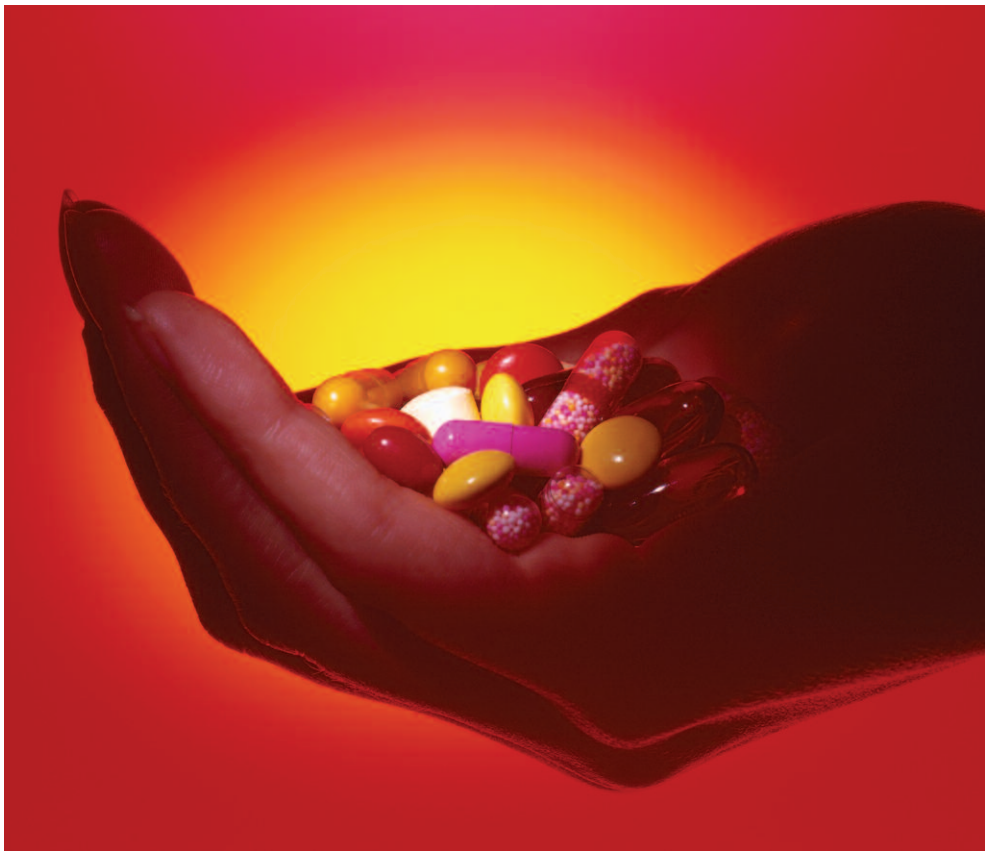
Many assisted living facilities (ALFs) manage medications in much the same way as is done in skilled nursing homes. Medications are delivered from institutional pharmacies that provide special packaging as well as medication administration records for documenting the dispensing of meds to residents. By and large, this system helps minimize medication errors and ensure that residents receive drugs appropriately. However, this could change shortly—simply because the government doesn't consider ALFs to be long term care facilities.

The new Medicare prescription drug benefit, which will go into effect this coming January, separates ALFs from skilled nursing facilities in the way medications are managed. This is because—according to the final rules regarding the drug benefit—ALFs do not fall under the definition of a long term care facility. As a result, ALF seniors will be excluded from three important benefits offered only to nursing home residents. These include special packaging, a special enrollment period, and elimination of any cost sharing for dually eligible residents, ie, those who receive Medicare and Medicaid benefits.



Introducing MTMS: Roles and Purpose

One aspect of the Medicare prescription drug benefit that could put some resident-specific services back in ALFs is a provision for Medication Therapy Management Services (MTMS). According to the Centers for Medicare and Medicaid Services (CMS), MTMS should include enhanced enrollee understanding through beneficiary education counseling and other means of promoting the appropriate use of medications and reducing the risk of potentially adverse events associated with medication use.

The MTMS also may be used to increase enrollee adherence to prescription drug regimens through medication refill reminders, special packaging, compliance programs, and other means. Further, to ensure that the appropriate medications are prescribed, these services could include detection of adverse drug events and patterns of overuse and underuse of prescription drugs.

CMS also has envisioned several minor roles for the MTMS program:

- Performing patient health status assessments
- Formulating prescription drug treatment plans
- Managing high cost specialty medications
- Evaluating and monitoring patient response to drug therapy
- Providing education and training
- Coordinating medication therapy with other care management services
- Participating in state-permitted collaborative drug therapy management

Through the MTMS, CMS hopes to ensure that prescribed Medicare Part D medications are used appropriately to optimize therapeutic outcomes. This program also is designed to reduce the risk of adverse events, including adverse drug interactions, in targeted beneficiaries. These medication-related problems include:

- Indication
  - Additional drug therapy needed
  - Unnecessary drug therapy being used
- Effectiveness
  - Ineffective drug therapy
  - Dosage too low
- Safety
  - Adverse drug reaction
  - Dosage too high
- Convenience
  - Adherence to therapy

Uncertainties Remain... Answers Forthcoming

While the concept of MTMS seems to present an opportunity to ensure effective medication management for seniors, there remain several questions about how the program will work and who will benefit. This is primarily due to the fact that CMS is leaving many of the details regarding the MTMS to the discretion of the private prescription drug plans to decide. These important decisions include exactly who is eligible for these services, who can provide the services, and what the payment system will be.

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CMS has emphasized that the MTMS is a voluntary benefit for targeted beneficiaries. As to whom these beneficiaries are, the agency simply has stated that they must meet three criteria:

- Have multiple chronic diseases
- Take multiple Part D drugs
- Are likely to incur annual costs for covered Part D drugs that exceed a predetermined level as specified by the Secretary of Health and Human Services (ie, $4,000 per year).

While the third criterion is quite specific, the other two are vague and wide open to interpretation by the prescription drug plans. These organizations could choose to define "multiple" diseases or drugs or as two, 10, or 20. Clearly, however the drug plans interpret and define these criteria, in turn, will determine what beneficiaries will be eligible to receive the MTMS.

Another question about the MTMS that remains is who will administer the services. CMS has left this, too, up to the individual plans. Various disciplines have suggested that they are the most appropriate practitioners to serve as qualified providers of these services. Nonetheless, a plan could justify the designation of whatever group—nurses, pharmacists, physicians, or nurse practitioners—they choose as being most appropriate.

At the same time, plans also must decide what these services will involve. For some plans, services may be limited to a telephone evaluation program led by trained nurses. For others, it may be much more intensive or extensive and involve face-to-face medication reviews and coordination with residents' physicians to assure optimization of medications.

Slowly, however, answers are forthcoming; and the specifics of MTMS are coming into focus. For example, Community Care Rx is the first plan to state publicly that—through Outcomes Pharmaceutical Health Care—it will pay consultant pharmacists to provide the following services:

- Comprehensive medication review ($30 fee)
- Prescriber consultation to alter therapy ($20 fee)
- Patient consult that does not require prescriber intervention ($15 fee)

Will ALF Residents Benefit?

Obviously, many ALF residents will qualify for the MTMS; but because these services will vary from plan to plan, it is difficult at this time to predict what ALF residents will benefit and how.

Nonetheless, ALFs don't have to sit back helplessly and hope for the best. They can take a proactive stance. For example, they can begin now to work with their pharmacy providers to identify which plans offer the best package of medication access and medication-related services for their residents. Toward this end, ALFs will need to make sure that their pharmacy providers are networked with many plans and that they are contracted to provide appropriate MTMS. For those residents who need the MTMS but who do not meet the qualifications—such as a resident with Alzheimer's disease with less than $4,000 per year in medication expenditures, ALFs will need to charge these residents for MTMS and pay the pharmacist or other practitioner to provide these services.

Advocacy Now, Access Later

While CMS believes that MTMS will evolve to become the cornerstone of the Medicare prescription drug benefit, this can only happen if providers push for appropriate services for seniors and access to these services by all residents who need them. They also need to develop strategies for handling instances where residents need the MTMS but do not meet the criteria to receive these services. By taking the role of advocate seriously now, ALFs can help ensure safe, effective, and affordable medication management for their residents once the Medicare prescription drug benefit goes into effect next year. ALC

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Assisted Living Challenge: Heightening Awareness of Venous Thromboembolism

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that staff can understand and apply in practice. While the Seventh American College of Physicians Conference on Antithrombotic and Thrombolytic Therapy's recommendations[10] are clearly too complex for most staff members, emphasizing key points is simple. Table 2 lists some basic facts that staff should know.

In the case of anticoagulants, one study has documented that clinicians may be reluctant to use newer (and preferred) LMWHs because of their acquisition cost (which is different than the overall cost of treatment) or prescribers' habits or lack of familiarity with these drugs.[17] Similar barriers exist among residents and their families; they may consider the cost at the pharmacy dispensing window or shy away from subcutaneous injections, but not understand the limitations of oral warfarin. Staff also may have their own preferences or misconceptions. Education designed to present facts in a way that is easy to understand and apply will enable choices that can maximize outcomes, minimize risks, and are acceptable for residents, staff, and families alike.

In the end, practitioners and staff who assist residents and their families with decisions about administration route, logistics, and true cost of various anticoagulants will earn their confidence and respect.

ALFs should approach VTE awareness and monitoring in the same manner as other silent killers and use all available techniques to spread the word. ALC

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References

1. Heit JA, Silverstein MD, Mohr DN, Petterson TM, O'Fallon WM, Melton LJ 3rd. Risk factors for deep vein thrombosis and pulmonary embolism: a population-based case-control study. *Arch Intern Med.* 2000;160:809-15.

2. Agency for Healthcare Research and Quality. Diabetes Disparities Among Racial and Ethnic Minorities. Available at http://www.ahrq.gov/research/diabdisp.htm.

3. Alikhan R, Cohen AT, Combe S, et al; MEDENOX Study. Risk factors for venous thromboembolism in hospitalized patients with acute medical illness: analysis of the MEDENOX Study. *Arch Intern Med.* 2004 May 10;164(9):963-8.

4. Ferrari E, Chevallier T, Chapelier A, Baudouy M. Travel as a risk factor for venous thromboembolic disease: a case-control study. *Chest* 1999;115:440-4.

5. Scurr JH, Machin SJ, Bailey-King S, Mackie IJ, McDonald S, Smith PD. Frequency and prevention of symptomless deep-vein thrombosis in long-haul flights: a randomized trial. *Lancet* 2001; 357: 1485-9.

6. Goffard C. Maids' concern save couple. St. Petersburg Times February 18, 2000: page 1.

7. Sloane PD, Gruber-Baldini AL, Zimmerman S, et al. Medication undertreatment in assisted living settings. *Arch Intern Med.* 2004;164:2031-7.

8. Tooher R, Middleton P, Pham C,et al. A systematic review of strategies to improve prophylaxis for venous thromboembolism in hospitals. *Ann Surg.* 2005;241:397-415.

9. Stinnett JM, Pendleton R, Skordos L, Wheeler M, Rodgers GM. Venous thromboembolism prophylaxis in medically ill patients and the development of strategies to improve prophylaxis rates. *Am J Hematol.* 2005;78:167-72.

10. Geerts WH, Pineo GF, Heit JA, et al. Prevention of venous thromboembolism: the Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. *Chest.* 2004 Sep;126(3 Suppl):338S-400S.

11. Kearon C. Epidemiology of venous thromboembolism. *Semin Vasc Med* 2001;1:7-26.

12. Facts and Comparisons. Anticoagulants. IN:*Drug Facts and Comparisons*, 59th edition. Philadelphia, PA: Lippincott Williams & Wilkins; 2005.

13. Schull PD, ed. *Nursing Spectrum Drug Handbook.* Hoffamn Estates, IL:Nursing Spectrum; 2005.

14. Perry DP, Webster TR. Medication-related problems in aging: Implications for professionals and policy makers. *Generations.* 2000;24:28-40.

15. Thompson Micromedex

16. Lawrence DM. My mother and the medical care ad-hoc-racy. *Health Affairs.* 2003;22:238-40.

17. Bhatt NV, Vogenberg RH, Engaging physicians in cost savings initiatives: eliminating medication cost bias in the selection of inpatient medications. *Physician Executive* 2005;31:12-18.