



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

November 1, 2013

The Honorable Pat Steadman, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Steadman:

Please find the Department's response to the Joint Budget Committee on the Department of Health Care Policy and Financing's Medical Services Premiums; Legislative Request for Information #4.

Legislative Request for Information #4 states:

The Department is requested to report to the Joint Budget committee by November 1, 2013 on the costs and savings associated with providing comprehensive medication management services in conjunction with the Regional Care Collaborative Organizations to recipients in managed care or fee-for-service Medicaid who are taking at least five prescription drugs to treat two or more chronic medical conditions. The analysis should address both the costs and savings for the state as a whole and specifically for the Regional Care Collaborative Organizations. The report may include information concerning information technology infrastructure, connectivity, electronic records, and any other issues relating to implementation of comprehensive medication management services. In preparing the report the Department is requested to consult representatives from regional care collaboration organizations, chain pharmacies, independent pharmacies, physician organizations, and the schools of pharmacy of the University of Colorado and Regis University.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, MaryKathryn Hurd, at MK.Hurd@state.co.us or 303-547-8494.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Susan Birch', written over a light blue horizontal line.

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/ct

Enclosure(s)

CC: Representative Crisanta Duran, Vice-Chair, Joint Budget Committee
Representative Jenise May, Joint Budget Committee
Representative Cheri Gerou, Joint Budget Committee
Senator Mary Hodge, Joint Budget Committee
Senator Kent Lambert, Joint Budget Committee
John Ziegler, Staff Director, JBC
Kevin Neimond, JBC Staff
Eric Kurtz, JBC Analyst
Henry Sobanet, Director, Office of State Planning and Budgeting
Erick Scheminske, Deputy Director, Office of State Planning and Budgeting
Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting
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Tom Massey, Policy and Communications Office Director
MaryKathryn Hurd, Legislative Liaison
Rachel Reiter, Communications Director



**COLORADO DEPARTMENT OF HEALTH CARE
POLICY AND FINANCING**

LEGISLATIVE REQUEST FOR INFORMATION # 4

COMPREHENSIVE MEDICATION MANAGEMENT

NOVEMBER 1, 2013

Legislative Request for Information #4 states:

The Department is requested to report to the Joint Budget committee by November 1, 2013 on the costs and savings associated with providing comprehensive medication management services in conjunction with the Regional Care Collaborative Organizations to recipients in managed care or fee-for-service Medicaid who are taking at least five prescription drugs to treat two or more chronic medical conditions. The analysis should address both the costs and savings for the state as a whole and specifically for the Regional Care Collaborative Organizations. The report may include information concerning information technology infrastructure, connectivity, electronic records, and any other issues relating to implementation of comprehensive medication management services. In preparing the report the Department is requested to consult representatives from Regional Care Collaboration Organizations, chain pharmacies, independent pharmacies, physician organizations, and the schools of pharmacy of the University of Colorado and Regis University.

Executive Summary

The Department has conducted significant research and stakeholder engagement regarding comprehensive medication management (CMM) and medication therapy management (MTM). The Department has met with representatives from the Regional Care Collaborative Organizations (RCCOs), independent pharmacies, chain pharmacies, the Colorado Pharmacists Association, the University of Colorado's Skaggs School of Pharmacy and Pharmaceutical Sciences and Regis University's School of Pharmacy. Since the spring of 2013, the Department has hosted a series of ongoing stakeholder meetings which included all representatives of the pharmacy community mentioned above, the RCCO leadership and the Colorado Department of Public Health and Environment (CDPHE). All of these representatives were invited to participate to discuss CMM/MTM programs, current RCCO practices with respect to CMM/MTM services, options for pharmacists to work within or expand on current RCCO services, and the aspects of these programs that are unique to Medicaid.

As discussed in the Department's response to question 36 of the Joint Budget Committee's questions to the Department in December 2012 (JBC Response), regarding the literature on effective MTM programs, the Department found that the results on MTM/CMM programs are mixed. The return on investment varies from nothing to significant amounts. There is concern that the wide variation is due in large part to flaws in the cost avoidance methodologies. Sample selection details, attrition information, and selection bias are all potential factors that were seen in the reports reviewed by the Department.

Since the writing of the JBC Response, the Department has continued to do research on MTM/CMM programs. The research has been based on reports provided by the stakeholders, reports found by Department staff, reports from vendors who provide MTM/CMM services and an in person presentation to the Department, RCCO leadership and pharmacy stakeholders from a national MTM/CMM vendor. After analyzing and comparing the variety information provided, the Department continues to have the same concerns about these reports and their results. When reviewing these reports, we also had to take into account the variance of Colorado Medicaid program in relation to other states programs. The Department believes that MTM/CMM services can be useful for Medicaid clients. However, the services must be

provided in a way that is effective in order for the services to be beneficial. Paying for MTM/CMM services that are provided in a vacuum or with incomplete information is not as effective as services provided where the pharmacist has access to the client's complete health care record and has an established relationship with the other members of the medical team treating the client. Any model the Department moves forward with must be adaptable to Colorado Medicaid environment and work on a regional level within each of the different RCCOs. While we have not found a program or product that fits easily into Colorado Medicaid model through this research, we have been working with pharmacy stakeholders and RCCOs to determine ways MTM and/or CMM could be integrated into local models through our Accountable Care Collaborative (ACC). Some RCCOs are already using pharmacists in care coordination teams and have integrated them into their client care model. Others are interested in working collaboratively with the pharmacists to determine how this integration can occur in their region. Further in the report we outline what each RCCO may or may not be doing currently in regards to pharmacy integration. This collaborative work is ongoing and we feel confident that what will be achieved is a regional solution that works for the pharmacists, for the RCCOs and most importantly for the clients we all serve.

Cost Analysis

While the Department recognizes the benefits of MTM and/or CMM services, it is difficult to quantify these benefits. After reviewing a variety of reports from multiple sources we found factors in the return on investment methodologies contained in these reports that have reaffirmed our concerns with the reporting results. As mentioned above, there is wide variation in impact and effectiveness due in large part to flaws in the cost avoidance methodologies. Sample selection details, attrition information, and selection bias are all potential factors that were seen in the reports reviewed by the Department.

The Department has care coordination teams in place in our RCCOs that are directly involved in decision making for client care. Based on the current care coordination it is difficult to quantify the impact of a change in prescription or dosing regimen and it is particularly difficult to discern which health care professional was responsible for which portion of the positive health care impact. It is clear that pharmacists provide a service by checking to ensure that a prescription is written appropriately and that there are no drug interactions or contraindications. Pharmacists have done this for decades and is part of the services included in our higher dispensing fee. However is much more difficult to determine if the change results in reduced health care costs now or in the future. There are measurements that have been used, but again, in many of these studies there are flaws in the analysis and the measurements typically assume that if a pharmacist was involved, all of the positive impact was due to the pharmacist's intervention. It does not adequately take into account that other health care professionals are also involved in the health care of the client and may also contribute to the positive health care outcomes. In Colorado specifically, it is particularly difficult because the Department already has care coordination efforts in place. It is impossible to determine when changes are due to care coordination efforts, physician visits with clients, nursing visits and consultations, physical/occupational therapy sessions, or a pharmacist's review of medications.

Integration of Information

There is agreement from all stakeholders that MTM/CMM services that are provided independent of care coordination and with incomplete client information will not be effective for improving client outcomes or an efficient investment for the State. A pharmacist in a retail setting has limited information with which to provide MTM and particularly CMM services. More information must be provided. Through the RX Review program, the Department provides additional prescription claims information that helps. But this is still an incomplete picture. Medical record information and/or integration with the medical team is necessary to have the full set of information with which to make a recommendation. Thus, a program through which pharmacists are a part of integrated clinical teams is the ideal. Retail pharmacists can provide support to the integrated clinical teams by doing MTM services that are coordinated with the clinical team's efforts.

During the stakeholder meetings, in order to increase the ability for retail pharmacies to do MTM/CMM services in a comprehensive manner, there was discussion on how to integrate medical records between Medicaid providers such as is done in closed systems such as the Veterans Administration and Kaiser Permanente. In those systems, pharmacists throughout the network have access to the patient's full medical record and can do comprehensive drug reviews. This is not possible in today's Medicaid world where there are numerous providers throughout the state who are not connected electronically. Because these providers are independent from each other, they do not have a system to automatically share electronic medical records. In addition, some providers still use paper records. Finally there are HIPAA concerns and other privacy and communication issues that need to be addressed when unrelated providers share health care information.

The RCCOs and primary care providers use our Statewide Data Analytics Contractor (SDAC) to access data for clients enrolled with the RCCOs. The RCCOs can see all the data for all Medicaid clients enrolled with their RCCO. The primary care providers can only see data for the Medicaid clients that are attributed to them as their medical home. The data can be viewed as a population or for individual members but it is static claim data that is refreshed each month and can be presented in reports or in detail. The SDAC is not an electronic health record and data cannot be added to the SDAC by providers or by the RCCO. The SDAC does not contain any other clinical data and is not expected to contain anything other than historical claim data in the foreseeable future.

The Department is currently pursuing a budget request to help address some of the interconnection between providers. The request would enhance the Department's and Medicaid providers' ability to exchange and aggregate Medicaid client data, resulting in improved care coordination and better-informed health care decisions. This request would leverage the transformative work already being done by the Quality Health Network (QHN) and the Colorado Regional Health Information Organization (COHRIO) on health information technology in Colorado. While we believe the funding of R-5 is a step in the right direction, this request is a multi-year project and there is no simple, near-future, comprehensive solution to these issues. Thus, in the current Medicaid world, it is important to work with systems that are already established to share data at least to some degree.

Existing RCCO and Pharmacy Integration

The Department believes that the RCCOs are in an ideal position to provide MTM/CMM services. While RCCOs have reported that their provider networks are not completely connected electronically, RCCOs are performing care coordination in a comprehensive manner. Much of the infrastructure needed for care coordination is already established in each RCCO. RCCOs had also reported that, to varying degrees, pharmacists are currently being used to assist in care coordination. Based on this, at one of the stakeholder meetings, the Department asked each RCCO to discuss in detail what MTM/CMM services are already being performed in that RCCO. The results from each RCCO are described below.

RCCO 1, which encompasses the Western Slope and Larimer County, reported that there are relationships with pharmacists throughout the region. Community care teams that have been established in a variety of ways based on the needs of each community. The clinical teams have clinical representation and social workers and some include pharmacists. They gave some examples such as in Steamboat, the team includes Yampa Valley Medical Center and a local pharmacist. In Durango, they use a local health department, which utilizes the services of a local pharmacist. In a Salud clinic, there is a protocol for physicians and nurses to refer patients to the clinical pharmacist for disease management.

RCCOs 2 (Northeast and Eastern Plains counties), 3 (East Metro counties - Adams, Arapahoe, Douglas), and 5 (Denver County) are all run by the same provider. These RCCOs reported that pharmacist services vary between their three regions. Approximately 40-50% of care coordination is delegated to the Federally Qualified Health Centers (FQHCs), and the pharmacists in those FQHCs assist with care coordination services. The amount varies based on the resources of the FQHCs. They also have in-house pharmacists who provide MTM services. These pharmacists meet with the care coordinators. These RCCOs also use the University of Arizona's MTM program. This RCCO MTM program is based on the Medicare MTM programs that this provider also runs. These RCCOs brought up the difficulty of sharing information between entities and providers and that there are Memoranda of Understanding regarding this issue for each area.

Region 4, consisting of the Southern/southeastern counties of Colorado, reported that their philosophy is that health care is local and the best outcomes occur with local teams are able to coordinate care. Region 4 has a focus group designed to look at opioid use but they are using the SDAC data, which is not "real-time". The pharmacists in the FQHCs have access to more real-time data.

Region 6, encompassing Boulder and the West Denver Metro counties, reported that they delegate about 40% of care coordination to the FQHCs. Much of the remainder of care coordination is performed by physicians who use claims data to put together a care plan. They also work with the Behavioral Health Organization. They are currently doing a study to determine who needs services and how to best provide those services. They are also working on the development of the care teams and this is an evolving process. They stated that there is no direct relationship with pharmacists and the care teams at this time.

Region 7, made up of the Southern Front Range counties of El Paso, Elbert, Teller, and Park, reported that they are in the beginning stages of looking at ways to integrate pharmacists. They noted that many of the practices in this region still use paper charts, which makes clinical coordination difficult. There are case managers who use data from the SDAC to help but the SDAC data is dated information.

Based on the wide variety of activities and stages of development between the RCCOs, the Department believes that a blanket, state-wide, one size fits all MTM/CMM model is not ideal. This coincides with the original purpose of developing seven RCCOs. The various RCCO regions were created so that different approaches to reach the same goal could be instituted in each region. The RCCOs devise the best plans and procedures for their regions. The Department believes that the same principal applies to MTM/CMM services. Thus, the Department asked the pharmacy stakeholders and each RCCO to meet to discuss in depth how each RCCO interacts with local pharmacists, what is already being done in that RCCO in regards to pharmacy integration and where there are opportunities for pharmacy contribution to client care in each RCCO. The initial meetings occurred in September and October 2013. The Department asked for status reports to ensure that progress was being made and determine how the Department can assist in the continued discussions. The Department expects these discussions to be ongoing as more information about current systems is learned by each party and innovative ideas and solutions are determined through these discussions. The status reports are shared below.

RCCO/Pharmacy Ongoing Discussions

RCCO 4 reported that they shared names and locations of the independent pharmacists in RCCO 4. They found that some pharmacists are currently working with the RCCO's care coordinators, as well as, in one case the pharmacist sits on a board of an organization and works closely with West Central Mental Health Center. The RCCO and the pharmacy stakeholders agreed to keep looking for additional opportunities to collaborate.

RCCOs 2, 3, and 5 reported that the group discussed their mutual goals as well as short term and long term opportunities to partner. The RCCOs expressed their appreciation of the value pharmacists can add in the ACC, especially on the patient engagement side. They explained the differences between their MTM program in Medicare and the RCCO program and why the Medicare model cannot be replicated in the RCCOs. This is due to the fact that RCCOs do not pay claims, RCCOs are not at risk for medical costs, and RCCOs do not have real-time pharmacy data. They discussed other opportunities that may work. This included capitalizing on existing relationships between RCCO members and pharmacies, having pharmacies assist in the process of getting clients into medical homes, and participating in the medical home model.

The pharmacy stakeholders provided an executive summary, recommendations and findings based on their meetings with the RCCOs and their research. They reported that they met with six of the RCCOs. They note that all of the RCCOs are performing some form of medication management but none have a formal CMM program. They also note that all of the RCCOs emphasized the need for physicians to know the pharmacists who are providing CMM services and the MTM/CMM services must be integrated into the RCCO care management programs. The RCCOs asked the pharmacy stakeholders to provide additional information about the

pharmacists located in each RCCO region. This information will assist in the ongoing conversations about potential integration opportunities in each region. The suggestions included medication reconciliation, medication compliance, chronic pain management/substance abuse reviews, expansion of medication review to non-prescription drugs, supplements and herbal products, and education and outreach. The Department expects that the ongoing conversations will center around some of these suggestions.

Application of Existing MTM Programs to Colorado

During the stakeholder process, there were suggestions for MTM/CMM services that would not work in Colorado. For example, the pharmacy stakeholders asked the Department to look at Minnesota's MTM program as a potential model for Colorado Medicaid. In Minnesota, a statute was passed in 2005 establishing coverage of MTM services through Minnesota Medicaid. An eleven-member committee was convened to advise on the implementation and administration of the MTM services. The resulting program is a fee-for-service program whereby pharmacists are paid for providing MTM services based on the complexity of the case. The pharmacist self-selects how complicated the case was and how much time was spent on the case and submits a procedure code to bill for the services. The pharmacists may contact providers about the findings but are not required to do so. Some clinics have taken upon themselves to integrate the MTM services within their clinics but nothing has been established by the Minnesota Medicaid program to do this. There was a preliminary report done but no comprehensive report analyzing the cost-effectiveness of the program has been completed. Minnesota Medicaid has hosted stakeholder meetings recently to look for any improvements that can be made to the program but nothing definitive has been proposed.

Minnesota's program is not ideal for Colorado because it is a fee-for-service model that is not integrated into other health initiatives. The Department is moving away from fee-for-service models. The Department also believes that a successful program is integrated with other care coordination programs. The Department has asked stakeholders to assist in finding a way to integrate pharmacist services into what health initiatives are already being done.

The pharmacy stakeholders also asked the Department to review a number of vendors that provide MTM services. For example, the Department hosted a two-hour presentation from a national vendor of MTM/CMM services with the RCCO leadership and pharmacy stakeholders. The national vendor had no experience in the Medicaid population and could not speak to how their successful commercial world tactics in MTM/CMM would equate to Medicaid clients, who differ greatly. For example, the vendor talked about incentivizing workers to join their program by offering reductions in co-pays or premiums. Because Medicaid has little to no co-pays for our clients and is not allowed to waive copays for some and not others, that successful method of enrollment in the commercial world would not work in Medicaid.

The Department is concerned with the ability of any of these vendors to take their existing MTM/CMM programs that have been successful in the commercial world and apply them to the Medicaid world. For example, Medicaid tends to serve different populations than commercial insurance. Many Medicaid clients have disabilities that are not typically covered in commercial insurance. In addition, these programs often focus on diabetes, hypertension and dyslipidemia; while these are common conditions in the commercial insurance plan world and Medicare, these

are not as prevalent in the Medicaid world and conditions such as behavioral health are more prevalent. Another issue that Medicaid faces that is less in the commercial world is that many Medicaid clients are transient and difficult to track in a consistent manner. So-called “Medicaid churn” is another concern - many clients only stay on Medicaid for a short period of time before they transition off the program. This makes it particularly difficult for providers to consistently connect with these clients and provide CMM/MTM services effectively. This is different from the commercial insurance world where patients change insurance based on job changes and life changes but do not alternate from having insurance and not having insurance as often as it occurs in the Medicaid world.

Many of these programs cost hundreds of thousands of dollars in exchange for the vendor paying pharmacists to provide MTM services. The vendors themselves report significant savings as a result of their services but they generally assume that if a pharmacist provided any service, all savings associated with that patient is directly related to that pharmacist’s services. It does not take into account what other health professionals may already be doing with regard to that client. For example, if a pharmacist counsels a diabetic patient on proper testing techniques and the patient become more compliant, the assumption is that the pharmacist is responsible. However, there likely are physicians and nurses and other health professionals who are also working to encourage that same patient to be more compliant. Thus who is actually responsible for the increased compliance is not easily discernible. This is particularly important to determine if a program is going to pay a pharmacist for making that positive health outcome.

With all of these concerns, the Department asked the pharmacy community to assist with ideas on how these vendors could be successful in the Medicaid world. In the report from the pharmacy stakeholders, they mention reports that state that there are successful programs in other states but these reports have many of the flaws mentioned above when looking at their return on investment analysis. In addition, there are no details addressing the specific issues raised above of how to make a vendor-run MTM program successful and cost-effective in the Medicaid world. There is a need for continuing discussion on this.

Collaboration with Colorado Schools of Pharmacy

Both Colorado Schools of Pharmacy believe strongly in MTM/CMM services. Regis University is training students and preceptors to be certified to provide MTM services. The University of Colorado is also providing a national MTM certification course to their students. However, representatives from Regis and the University agree that paying providers to provide a service without any connection to any other clinical service and with incomplete information is not useful and is not cost-effective. Both schools have examples of successful MTM/CMM programs as well as disease management programs that are occurring in systems where pharmacists have access to the patient’s medical record. Both schools are working with CDPHE on expansion of their disease management programs through a CDPHE grant. Programs such as these present other potential avenues for pharmacy integration into the coordination of care.

Both schools also agree that MTM can occur in a retail setting is but by the nature of what information a retail pharmacy has access to is limited in its effectiveness. Comprehensive Medication Reviews (CMRs) that are done in the retail setting are not as comprehensive as those done in clinics and other settings where the pharmacist has access to the full medical record. In a

retail setting where the pharmacist has access to just the drug records, CMRs are going to be limited and may be more akin to a medication review. This is a useful review but does not accomplish the same goals as a full CMR done in a clinical setting. Both schools agree that simply expanding RX Review to provide additional MTM services in a fee-for-service model is not a viable or cost effective option.

Other authorities agree with this assessment. In the Resource Guide entitled “The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes” published in June 2012 , it is acknowledged that MTM “cannot be done effectively unless all of the patient’s providers are informed and care is coordinated with the team.” They also note that CMM is best accomplished when the program is flexible in design to allow for a team approach. While the Resource Guide acknowledged the variety of ways in which MTM services may be provided, including at the point-of-sale and over the telephone, the Resource Guide indicates that the most effective methods are when the pharmacist is a part of the medical team or is otherwise integrated into the medical team’s care of the patient.

Medicare Part D MTM Report

A recent report on the Center for Medicare and Medicaid Services’ (CMS) MTM programs also supports the Department’s suggestion of having pharmacists who are integrated in the team performing CMM services and retail pharmacists supporting the clinical team’s efforts in ways that increase positive health outcomes. In August 2013, Accumen, Inc. did a report for CMS on the effectiveness of the Medicare Part D MTM programs (Medication Therapy Management in Chronically Ill Populations: Final Report). Medicare has required MTM programs since 2006. This study investigated how Part D MTM programs in operation in 2010 affected Medicare beneficiaries’ adherence, quality of prescribing, resource utilization, and cost of hospital and emergency room (ER) care. Furthermore, this quantitative analysis was coupled with a qualitative investigation aimed at identifying important intervention components for achieving Part D MTM program success. This study specifically focused on beneficiaries with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes because these individuals are at high-risk for poor health outcomes and thus could benefit greatly from improved medication management. While the Medicare population has differing health issues from the Medicaid population and the program design for Part D plans is significantly different than Medicaid, the study is an interesting addition to the MTM discussion.

The study found that MTM programs improved medication adherence and quality of prescribing for CHF, COPD and diabetes patients, particularly when CMM-like services (CMRs) were provided. MTM enrollees who received CMRs were more likely to experience increases in medication adherence and improvements in quality of prescribing, suggesting that the annual CMR may be one of the more important components of the MTM program. In order to do an effective CMR, the pharmacist should have access to the patient’s complete health care record and medication information. Simply using the medication information is not an adequate CMR and become more of just a medication review. This supports the Department’s position that CMRs must be completed by pharmacists who are integrated into the care coordination team.

According to the report, MTM programs initially improved the safety of drugs prescribed in new enrollees (during the first six months) but these positive effects had diminished or reversed by

one year after enrollment. For example, the enrollees had their high-risk medications discontinued and had less drug-drug interactions than non-enrollees at the six-month mark. However, this difference disappeared by the one-year mark and the two groups had similar amounts of drug-drug interactions and high-risk medications.

The report also found that MTM programs decreased hospital utilization and costs in the diabetes and CHF patients who received CMRs. Patients with COPD did not experience significant cost savings with or without CMRs even though MTM programs did increase adherence to long-acting maintenance drug therapies for COPD. MTM programs were also often associated with decreased emergency room utilization and costs but there was a relatively small per patient cost savings when looking at overall hospital costs.

Thus again this reports supports the Department's belief that MTM services can be beneficial but need to be done in a comprehensive manner in order to reap real benefit. It also suggests there may be differences in effectiveness depending on disease states. The report's conclusions are mixed and the effectiveness is based on the services performed and the patient's disease type. Some of the reports final recommendations on an effective MTM program included targeting and aggressively recruiting patients to complete a CMR based on information on medical events such as recent a hospital discharge in addition to scanning for the usual MTM eligibility criteria and coordinating care between health care providers and incorporating MTM services into that coordination of care.

These recommendations correspond with the Department's ideas on integrated pharmacists providing CMM services with retail pharmacists providing supporting MTM services. Specifically having a combination of some pharmacists directly involved in care coordination teams who do CMRs and consultations on difficult cases and retail pharmacists who provide MTM services when warranted.

Conclusion

Over the last six months the Department has held a multitude of stakeholder meetings, conference calls and discussions around the issue of CMM/MTM. The Department researched other states, commercial programs and varying research studies on the topic in an effort to explore the feasibility of these programs into Colorado Medicaid. As documented throughout this report, the Department strongly believes that it is important to correlate MTM/CMM efforts with other coordinated care efforts spearheaded by the Department. Many of the programs or options for CMM/MTM that have been presented to the Department simply pay pharmacists on a fee-for-service basis when the pharmacists provide medication management services. There is no coordinating these services with what other providers are doing or confirming that it was the pharmacist's actions that directly resulted in the improved client health outcome. While there can be benefits to the review, this is not a cost-effective method by which to improve health outcomes. Care coordination is the care delivery model moving forward for our Medicaid clients in Colorado. The ACC and the RCCOs are a testament to the success of this model and our November 1, 2013 ACC report shows the continued success of this program for our clients and for the state.¹ As highlighted in this report, there are some promising options for pharmacy

¹ This report is the Department's response to the FY 2013-14 Legislative Request for Information #2.

integration into the work of the ACC and RCCOs. We are hopeful that the recent discussions started between the individual RCCOs and the pharmacists will provide the Department with some innovative proposals for integration of pharmacists that will work within the current Colorado Medicaid model.