What is Medication Therapy Management?

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Presenter

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Disclosures and Declarations

The speaker has no relevant financial relationships that would be considered a conflict of interest for purposes of this program

No Artificial Intelligence was used in the creation of this slide deck nor this program

The slide deck provided as a handout for this program was provided in Title II compliant format[1]

1. Title II is also called the Americans with Disabilities Act https://www.ada.gov/law-and-regs/regulations/title-ii-2010-regulations/

Relationships

The speaker declares that the following members of her family are now or have been licensed by the Nebraska Department of Health & Human Services

Husband	Hydrogeologist
Daughter	**Pharmacist**
Father	**Pharmacist**
Brother	Athletic Trainer
Uncle	**Pharmacist**
Daughter-in-Law	Nurse
Niece	Nurse

Active Learning Statement

This program will not require any physical exertion nor dexterity for successful completion.

Please let the program sponsors know if this program is causing any challenges that may be able to be corrected.

Learning Objectives

At the completion of this program the alert attendee should be able to:

1. Explain the origins of Medication Therapy Management (MTM),
2. Describe the pharmacotherapy issues identified by MTM, and
3. Devise a way to utilize data from medication therapy management services

Standards for Pharmacy continuing education are 3 to 5 learning objectives per 60 minutes; 2.25 to 3.75 per 45 minutes

Which drug is covered by Med B?

Which drug is billed to Medicare Part B?

A. Shingles vaccine
B. Oral cancer therapies
C. Erythropoiesis-stimulating drugs
D. Anti-rejection agents
E. Each of these

Quick history of Medicare

Signed into law by President Lyndon Johnson in 1964

- covered very few drugs
  - cancer chemotherapy side effect treatments
  - drugs for renal failure
  - inhaled drugs in solution for breathing disorders
    (inhalers - no, nebulizers - yes)

Realistic evaluation of drug therapy

A brief listing of drugs that didn't exist when Medicare was created

- propranolol
- clonazepam
- triamterene
- albuterol
- cimetidine (all H_2 blockers)
- cyclosporin
- mupirocin
- budesonide
- captopril (all ACE inhibitors and all ARBs)
- ondansetron – was covered by Medicare when it came on the market in 1988
- monoclonal antibody products

OBRA 1990

Federal Government requires pharmacists to conduct drug-use-review before filling any prescription for Medicaid beneficiaries

Requires an offer of counseling for Medicaid beneficiaries

Medicare part D

Medicare Part D signed into law by President George W Bush in 2003, with effective date 1 January 2006

covers many more drugs than Medicare Part B

Which drugs are NOT covered by Med D?

A. Monoclonal antibodies

B. PDE5 inhibitors

C. Multiple vitamins

D. Cough & Cold products

E. None of these are covered

Initial Purpose of MTM

to Calm Fear

the Federal Government was afraid of moral hazard with Medicare Part D

What is moral hazard

Generally, it’s risk-taking behavior

In healthcare and health insurance it’s a change in behaviors because someone else is paying for the therapy

When it’s your money you choose the generic

When it’s someone else’s money you insist on brand name

How to manage moral hazard

Set boundaries for payment – only pay for generics

Assure payments are for necessary services or diagnoses

Prevent the need for payment by preventing the problem

Medication Therapy Management

A service conducted by a pharmacist and paid for by Medicare Part D plans

Starts with Complete Medication Review (CMR)

- Create a list of drugs the patient is taking
  - includes vitamins, dietary supplements, other over-the-counter products, cannabis
- Create a list of diagnoses and medical procedures
- Create a list of vaccines

Potential savings from problems being identified

Drug-to-drug interactions

Missing drugs

Needed vaccines

Other drug issues

- duplicate therapy
- non-adherence
- side effects

Drug – to – drug interactions

An interaction causing decreased metabolism = toxicity
An interaction causing increased metabolism = under treatment

Sources of drug-to-drug interactions
- Multiple prescribers
- Multiple pharmacies
- Products not in the PDMP
  - supplements
  - cannabinoids & CBD

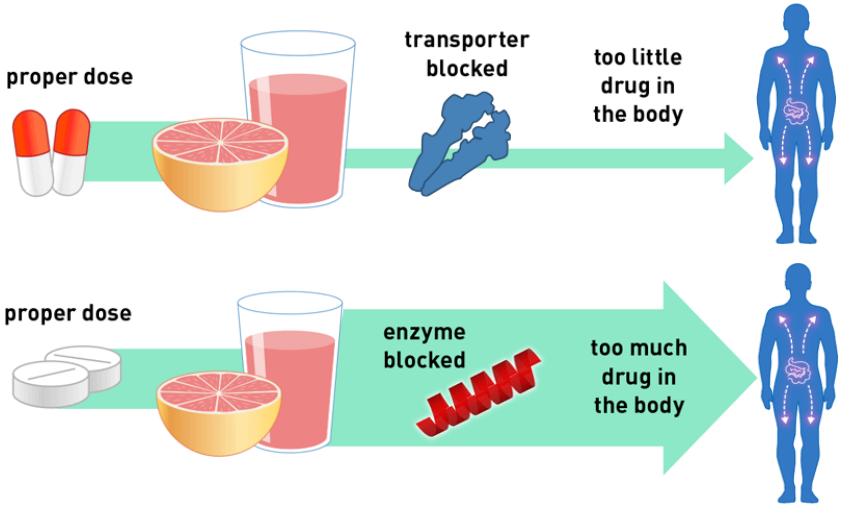
Grapefruit & CBD Interactions

Some statins

Some calcium channel blockers

Some anti-rejection drugs

Some anti-anxiety drugs



Graphics from the FDA
Available to all US citizens
See citation in references

Missing Drugs

Drugs recommended in chronic care guidelines,
that aren't in the regimen

Patient with diabetes
protective ARBs (or ACE-I)

Patients with atrial fibrillation
anti-coagulant therapy

Needed vaccines

COVID in 2020

- Death rate from COVID-19 among adults age 85 years and older (1,645 per 100,000)
- 2.8 times higher than the rate for 75 to 84 years (589.8 per 100,000)
- 7 times higher than 65-74 (234.2 per 100,000)

Tetanus

- Mortality in seniors is over 60% if over 79 years of age

Shingles

- Still patients with confusion over the change in zoster vaccines

Duplicate therapies

Polypharmacy

Multiple drugs with multiple mechanisms of action used to treat a chronic condition

ACE + calcium channel blocker + diuretic

Duplicate Therapy

Multiple drugs with the same mechanism of action

ACE + ARB

The prescriber intends to CHANGE drugs the rest of the health care team and the patient believe the prescriber is ADDING a drug

Non-adherence

Why are patients not following our recommendations?

- Expense
- Concern about diagnosis or purpose
  - including “I was cured”
- Poor instructions
- Side effects
- Social media
- **“My daughter-in-law’s best friend’s brother’s dog-walker says…”**

Side Effects

Afraid to tell providers unless asked directly

We say stupid stuff such as, “Chief Complaint” when the patient isn’t complaining at all, they are simply describing what’s happening or answering a question

Patients don’t realize that they are having side effects

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Important Dates

Handout due 7 August 2026

any research or changes from CMS after that date are NOT included in this program

Program Presentation 21 August 2026

Program expiration 21 August 2028

science and pharmaceutical care change so quickly that any reliance on this program after August 2028 is not appropriate

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