Key Findings:

Analysis of California Senate Bill 1322 Comprehensive Medication Management

Summary to the 2017–2018 California State Legislature, April 19, 2018

AT A GLANCE

The version of California Senate Bill (SB) 1322 analyzed by CHBRP would require coverage of comprehensive medication management (CMM) for Medi-Cal beneficiaries.

1. CHBRP estimates that in 2019, 10.6 million Medi-Cal beneficiaries enrolled in DMHC-regulated managed care, as well as 3.8 million enrolled in County Operated Health System (COHS) managed care or associated with Medi-Cal fee-for-service (FFS) will have health insurance subject to SB 1322.
2. **Benefit coverage.** Among Medi-Cal beneficiaries enrolled in DMHC-regulated managed care, coverage for CMM would rise from 21% to 100%.
3. **Utilization.** Among Medi-Cal beneficiaries enrolled in DMHC-regulated managed care, utilization of CMM would rise from 0.38% to 1.82%.
4. **Expenditures.** For Medi-Cal beneficiaries enrolled in DMHC-regulated managed care, expenditures, adjusted by offsets, would increase by $2.9 million. Assuming a similar impact for Medi-Cal beneficiaries enrolled in COHS, an increase of $0.67 million would be expected. A similar per enrollee increase could occur for Medi-Cal beneficiaries associated with FFS, but the impact is unknown as the group may be dissimilar in terms of the presence of chronic conditions.
5. **Medical effectiveness.** There is limited evidence indicating that CMM is associated with better adherence, improved health outcomes, or decreases in emergency department or visits. There is limited evidence that CMM is associated with reduced hospital admissions.
6. **Public health.** In 2019, 109,000 Medi-Cal beneficiaries newly using CMM, would see improvements in medication adherence and disease-specific outcomes.

CONTEXT

Comprehensive medication management (CMM) is a healthcare practice that assesses all of a patient's medications individually for appropriateness, effectiveness for the medical condition, safety, and ability to be taken as intended by the patient.[1] CMM, which generally focuses on persons with one or more chronic conditions for which multiple medications may be prescribed, is delivered by qualified clinical pharmacists in a collaborative manner with treating physicians or other qualified medical providers.

BILL SUMMARY

SB 1322 would require Medi-Cal to cover CMM for beneficiaries identified as high risk for medication-related problems or as having one or more chronic diseases.

SB 1322 would also define CMM as a service that includes:

- Assessment of health status, personal preferences, use patterns (for prescription drugs/biologics, over-the-counter medications, and nutritional supplements);
- Documentation of current clinical status and the clinical goals for each chronic condition for which medication therapy is indicated;
- Assessment of each medication and identification of all medication therapy problems;
- Development and implementation of a written medication treatment plan with follow-up evaluation and needed alteration; and
- Verbal training, information, and support services for the beneficiary to enhance adherence/use.

SB 1322 specifies that CMM is a service delivered by a pharmacist that involves:

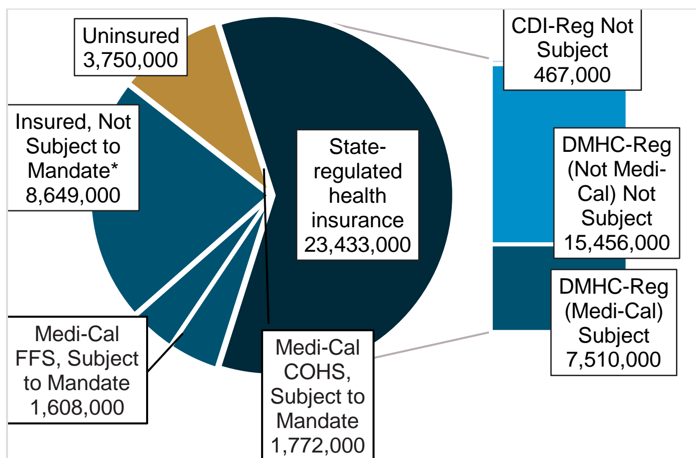
- Continual monitoring of medication therapy progress and problems; and
- An average of eight visits per year per enrollee engaged in CMM.

In addition, SB 1322 would require the California Department of Health Care Services (DHCS) to evaluate the effectiveness of CMM.

[1] Refer to CHBRP's full report for full citations and references.

Figure 1 notes how many Californians have health insurance that would be subject to SB 1322.

Figure 1. Health Insurance in CA and SB 1322



Source: CHBRP 2018.
Notes: *Medicare beneficiaries, enrollees in self-insured products, etc.

IMPACTS

Medical Effectiveness

CHBRP found *limited* evidence that CMM improves health outcomes and reduces hospitalization relative to usual care. CHBRP found *limited* evidence that receipt of CMM improves medication adherence. There is *limited* evidence that CMM reduces hemoglobin A1c and a *preponderance* of evidence that it reduces blood pressure. There is *insufficient* evidence to assess the impact of CMM on mortality and on outpatient visits. Evidence regarding effects on emergency department visit rates is *inconclusive*. There is *limited* evidence that CMM reduces hospital admissions and *inconclusive* evidence regarding the effects of CMM on readmissions.

Benefit Coverage, Utilization, and Cost

Immediately below is a description of the impact SB 1322 would have on Medi-Cal beneficiaries enrolled in DMHC-regulated managed care. A further discussion of the bill's impacts on Medi-Cal beneficiaries enrolled in County Operated Health System (COHS) managed care or associated with the fee-for-service (FFS) program follows.

Benefit Coverage

SB 1322 would raise from 21% to 100% the portion of Medi-Cal beneficiaries enrolled in DMHC-regulated managed care with coverage for CMM.

Utilization

SB 1322 would raise from 0.38% to 1.82% the portion of Medi-Cal beneficiaries enrolled in DMHC-regulated managed care engaged in CMM.

Expenditures

Factoring in expected cost offsets, SB 1322 would increase annual expenditures for enrollment of Medi-Cal beneficiaries in DMHC-regulated managed care by $2,856,000 (0.00098%).

COHS Managed Care

CHBRP believes Medi-Cal beneficiaries enrolled in COHS managed care do not currently have coverage for an SB 1322–compliant CMM program. CHBRP assumes that the cost of providing CMM would be similar on a per enrollee basis to that of Medi-Cal beneficiaries in DMHC-regulated plans, as would related offsets. Consequently, annual expenditures for enrolling Medi-Cal beneficiaries in COHS managed care is expected to increase by $674,000.

Medi-Cal FFS

The per beneficiary impact noted above is based on CHBRP's analysis of impacts on Medi-Cal beneficiaries enrolled in DMHC-regulated plans. The similarity of the FFS population to this group is unknown, in particular the relative presence of one or multiple chronic conditions, which could alter use of CMM. For this reason, CHBRP can suggest that compliance for FFS beneficiaries would involve additional expenditure, and could result in similar offsets, but cannot offer an estimate.

Number of Uninsured in California

No measureable impact on the number of uninsured is projected.

Public Health

In the first year postmandate, of the 109,000 Medi-Cal beneficiaries newly using CMM (those with greatest disease burden), CHBRP estimates, based on limited evidence, that those engaged with CMM would see improvements in medication adherence, reductions in hemoglobin A1c levels among diabetics, reductions in mortality, and reductions in hospital admissions. In addition, based on a preponderance of evidence, CHBRP estimates that there would be a reduction in blood pressure among people with uncontrolled hypertension.

Long-Term Impacts

Limited evidence exists on the long-term outcomes of CMM on one or more chronic conditions. To the extent that CMM leads to optimized adherence and treatment regimens, there may be some continued improvement in health outcomes and some further decline in use of acute care services. Additionally, there may be postponement of long-term chronic disease outcomes such as heart attacks or kidney failure.

Essential Health Benefits and the Affordable Care Act

As SB 1322 is relevant only to the benefit coverage of Medi-Cal beneficiaries, it seems unlikely that SB 1322, which would require coordination through a CMM program of services already covered for most enrollees, would exceed the definition of essential health benefits (EHBs) in California.