**Welcome to the Community Care Family Care Partnership Program**

**(HMO SNP)(Community Care) Medication Therapy Management**

**Web Page**

Some members who have several complex medical conditions may need to take many drugs at the same time or have very high drug costs. In addition, some members are considered at risk beneficiaries under a Drug Management Program. The Medication Therapy Management (MTM) program can help members in these situations. This is a free and voluntary service for eligible members and is not considered a benefit.

The goal of the Medication Therapy Management program is to be sure members are using the drugs that will treat their medical conditions best and are getting the desired results from their medications. The MTM program also tries to reduce medication problems that may occur as well as inform members about safe disposal of medications. Authorized drug take back sites for safe disposal of medications can be found at the following DEA websites:

* [*www.deatakeback.com*](http://www.deatakeback.com)
* [*https://apps2.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e2s1*](https://apps2.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e2s1)

Community Care is pleased to work with the Centers for Medicare & Medicaid Services (CMS) to provide this program to eligible members.

**Who is eligible for the Medication Therapy Management Program?**

Members of Community Care’s Family Care Partnership (HMO SNP) (Community Care) must meet all of the following criteria to be eligible for the program:

1)A)Take a minimum of six (6) prescription drugs covered by Medicare Part D.

 B)Have two (2) of the targeted diagnoses as documented in their electronic medical

 record on the Community Care system. The targeted diagnoses for 2024 are:

o Rheumatoid Arthritis

o Chronic Heart Failure (CHF)

o Dyslipidemia

o Asthma

o Bi-polar disorder.

C)Have Medicare Part D covered drug costs equal to or greater than $1332.50 per calendar quarter.

2)Are at-risk beneficiaries under a Drug Management Program

Members who meet the above criteria will automatically be enrolled in the 2024 MTM program. Members will be contacted by mail and/or telephone and informed of their enrollment in MTM. They will also be offered an opportunity to schedule an annual comprehensive medication review (CMR). This is a free and voluntary service for eligible members, so they may choose not to participate at that time.

**What services are provided by the MTM Program?**

• Each quarter a pharmacist or other health professional will review the member’s

medications.

• The review will consider the following criteria:

o Is the member taking appropriate medications for the targeted diagnoses?

o Has laboratory testing been done to monitor for those diagnoses?

o Is the member taking their prescribed drugs as assessed by how often they fill

their prescriptions?

o Are there possible significant drug to-drug interactions for the targeted

diagnoses?

o Are there are other drug concerns that should be looked at?

• An annual comprehensive medication review (CMR) will also be offered. The CMR is

conducted by a pharmacist or other health professional and may be done in person or

on the phone. It takes about 30 to 60 minutes to complete. A member may refuse this

review.

• If the member agrees to the CMR, it will include the member’s medications (prescription

and non-prescription), an evaluation for a high number of medications (more than three

(3) drugs used to treat the same condition and greater than or equal to fifteen (15)

Medicare Part D medications) and an assessment for high risk medications identified on

the Beer’s Criteria 2023.

• A written summary of the completed CMR will be mailed to the member, including a list

of current medications, issues discussed with the member and a plan for the member to

address these issues. The summary will be written in a standardized way provided by

Medicare.

• Therapy recommendations will be sent to the member’s primary care physician or nurse

practitioner for follow-up.

**A blank copy of the Personal Medication List is at the end of this document.**

**For more information or to request MTM service documents, please contact:**

• Megan Farley-Snieg, Pharm D at (414)902-2527

• Community Care Inc. Pharmacy; 1555 S Layton Blvd, Milwaukee, WI 53215

|  |
| --- |
| Community Care has a Medicare Advantage Special Needs Plan contract with the Centers for Medicare and Medicaid Services (CMS) and a contract with the Wisconsin Department of Health Services (DHS) for the Medicaid Program. Enrollment in Community Care depends on contact renewal. Enrollment is available to individuals who have both Medical Assistance from the State and Medicare, reside in the service area and are functionally eligible as determined by the Wisconsin Long-Term Care Functional Screen.  |

*< Insert letter date >*

< Additional space for optional plan/provider use, such as barcodes, document reference numbers, beneficiary identifiers, case numbers or title of document >

*< Insert member name >*

*< Insert member address 1 >*

*< Insert member address 2 >*

*< Insert member city, state, and zip code >*

Dear *< Insert member name >*,

Thank you for talking with me on *< Insert CMR date >*, about your health and medications. As a follow-up to our conversation, I have included two documents:

1. Your **Recommended To-Do List** has steps you should take to get the best results from your medications.
2. Your **Medication List** will help you keep track of your medications and how to take them.

If you want to talk about these documents, please call *< Insert MTM provider/department name >* at *< Insert contact information for MTM provider/plan, phone number, days/times, TTY, etc. >*.

I look forward to working with you and your doctors to make sure your medications work well for you.

Sincerely,

*< Insert MTM provider name >*

*< Insert MTM provider title>*, *< Insert Part D plan/pharmacy name/organization name >*

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1154. The time required to complete this information collection is estimated to average 40 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850

**Recommended To-Do List**

Prepared on:*< Insert CMR date >*

You can get the best results from your medications by completing the items on this **“To-Do List.”**

Bring your **To-Do List** when you go to your doctor. And, share it with your family or caregivers.

**My To-Do List**

|  |  |
| --- | --- |
| **What we talked about:***< Insert summary of discussion for topic 1 >* | **What I should do:*** *< Insert action item for topic 1 >*
* *< Insert action item for topic 1 >*
 |

|  |  |
| --- | --- |
| **What we talked about:***< Insert summary of discussion for topic 2 >* | **What I should do:*** *< Insert action item for topic 2 >*
* *< Insert action item for topic 2 >*
 |

|  |  |
| --- | --- |
| **What we talked about:***< Insert summary of discussion for topic 3 >* | **What I should do:*** *< Insert action item for topic 3 >*
* *< Insert action item for topic 3 >*
 |

|  |  |
| --- | --- |
| **What we talked about:***< Insert summary of discussion for topic 4 >* | **What I should do:*** *< Insert action item for topic 4 >*
* *< Insert action item for topic 4 >*
 |

**Medication List**

Prepared on:*< Insert CMR date >*

Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.

Note any changes to how you take your medications.
Cross out medications when you no longer use them.

| **Medication** | **How I take it** | **Why I use it** | **Prescriber** |
| --- | --- | --- | --- |
| **< *Insert generic name and brand name, strength, and dosage form for current/active medications* >** | < *Insert regimen, (e.g., 1 tablet by mouth daily), use of related devices, and supplemental instructions as appropriate* > | < *Insert indication or intended medical use* > | < *Insert prescriber name* > |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Add new medications, over-the-counter drugs, herbals, vitamins,
or minerals in the blank rows below.

| **Medication** | **How I take it** | **Why I use it** | **Prescriber** |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| Exclamation point icon**Allergies:** *< Insert allergy information >* |

|  |
| --- |
| Exclamation point icon**Side effects I have had:** *< Insert side effect information >* |

|  |
| --- |
| Exclamation point icon**Other information:** *< Optional >* |

|  |
| --- |
| **Pencil iconMy notes and questions:** |