POLICY AND PROCEDURE	
Title: Medication Therapy Management (MTM)	
Primary policy owner: Pharmacy	**Policy #:** PH42
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☐Behavioral Health & Social Services (BH/SS) 3) ☒ Benefits Administration (BA) 4) ☐ Case Management (CM) 5) ☐ Claims (CLMS) 6) ☒ Community Marketplace & Member Engagement (MAR) 7) ☒ Compliance (CMP/HPA) 8) ☐ Configuration (CFG) 9) ☐ Provider Contracting (CONT) 10) ☒ Cultural & Linguistics (CL) 11) ☐ Customer Service (CS)	12) ☐ Facilities (FAC) 13) ☐ Finance (FIN) 14) ☐ Human Resources (HR) 15) ☒ Information Technology / Core Systems (IT) 16) ☒ Pharmacy (PH) 17) ☐ Provider Networks (PRO) 18) ☐ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☐ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☐ Medical Management (MM)
Product Type: ☐Medi-Cal ☒D-SNP	**Supersedes Policy Number:**

I. PURPOSE

Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") is in compliance with all contractual requirements, applicable federal and state laws, and regulations for responding, preventing, reviewing, and investigating all reported and identified non-compliance.

To establish and administer a Medication Therapy Management (MTM) program in compliance with federal and state regulations and other program requirements.

II. POLICY

A. Health Plan must have a Medication Therapy Management (MTM) program that ensures optimum therapeutic outcomes for targeted beneficiaries through improved medication use and reduced risk of adverse events.

B. The MTM program must be offered, free of charge, to beneficiaries meeting certain criteria established by Centers for Medicare and Medicaid Services (CMS).

C. Health Plan must submit, annually, its MTM program description to CMS, for review and approval through Health Plan's Management System (HPMS) and receive approval, before implementing the program.

D. The Targeted Beneficiaries must meet the following criteria:
   1. Have at least three (3) of the following 10 core chronic diseases established by CMS: Alzheimer's disease, Bone disease – arthritis, Chronic Congestive Failure (CHF), Diabetes, Dyslipidemia, End Stage Renal disease (ESRD), Human immunodeficiency virus /acquired immunodeficiency syndrome (HIV/AIDS), Hypertension, Mental health (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions), and respiratory disease (including asthma, chronic obstructive pulmonary disease (COPD), and other chronic lung disorders).
   2. Take at least eight (8) chronic/maintenance medications, all of which must be Part D drugs.
   3. Incur a Total Drug spend (TDS) that is defined by CMS annually.
   4. Be identified as being At Risk Beneficiaries (ARBs) as defined in 42 CFR § 423.100.

E. Health Plan must enroll targeted beneficiaries in its MTM program using an opt-out method of enrollment, at least, quarterly during each year.

F. Health Plan must offer all the following services to each beneficiary enrolled in the MTM program:
   1. An annual Comprehensive Medication Review (CMR) with written summaries in CMS' Standardized Format.

a. The beneficiary's CMR must include an interactive consultation, performed by a pharmacist or other qualified provider.
b. For beneficiaries with cognitive impairment, the CMR may be performed with the beneficiary's prescriber, caregiver, or other authorized individual.

2. Quarterly Targeted Medication Reviews (TMRs) with follow-up interventions when necessary.
3. Information about safe disposal of prescription drugs that are controlled substances. This information must meet the criteria established in 42 CFR § 422.111(j).

G. Health Plan must include, on its website, a separate section about the MTM program including an explanation of the MTM program, a summary of services, and that they are free.
H. Health Plan must have a process in place to measure, analyze, and report the outcomes of the MTM program.
I. Annually, Health Plan must submit its MTM report to CMS for the full benefit year, on the last Monday of February of the following year. The report must have several elements that must capture all the MTM activities during the benefit year.

III. PROCEDURE

A. The MTM program is delegated to the Pharmacy Benefits Manager (PBM) and its MTM vendor.
B. The PBM implements Health Plan's MTM program approved by CMS, including but not limited to:
    1. Identifying and enrolling eligible beneficiaries based on the eligibility criteria and targeting frequency specified in Health Plan's MTM program.
    2. Once enrolled, PBM and its vendor do not disenroll a beneficiary from the MTM program if they no longer meet eligibility criteria unless the beneficiary opts out of the program altogether. They are enrolled in the program for the remainder of the calendar year.
C. Upon enrollment into the MTM program, an Intro Letter is mailed to eligible beneficiaries.

1. The letter offers the beneficiary a one-on-one telephonic CMR with a qualified provider as specified in Health Plan's MTM program.
2. In addition to the Intro Letter, PBM's MTM vendor attempts to contact all MTM beneficiaries via phone to offer a CMR within 60 days of qualification.

D. Beneficiaries refusing a CMR stay in the MTM program and receive all of the other services including TMRs.
E. PBM's MTM vendor runs TMRs to identify specific intervention opportunities derived from daily data feeds.
    1. TMR categories include, but are not limited to, cost savings, safety concerns, medication adherence, and adherence to national treatment guidelines.
    2. MTMP participants may be contacted, by phone, for a person-to-person consultation about their TMRs and their prescribers may be outreached to via fax.
F. PBM ensures that all the elements required by CMS are captured including:
    1. Whether the member is cognitively impaired.
    2. Opt-out date and reason.
    3. Dates of CMR/TMR.
    4. All the requirements on CMS' annual "*MEDICARE PART D REPORTING REQUIREMENTS*" document.
G. PBM provides Health Plan detailed reports documenting MTM activities and measuring interventions:
    1. Beneficiary-level MTM program data.
    2. Activity reports including summary of MTM activities and outcome reports.
    3. Annual CMS MTM report with all the elements required by CMS.
H. Health Plan submits the MTM Program Description and Signed attestation to CMS via HPMS based on submission dates specified by CMS for the benefit year (generally early June prior to the benefit year).
I. When the program is approved, Health Plan forwards the Program Description to PBM for implementation.
J. Health Plan ensures that the MTM program description is on its website, according to CMS regulations.

K. Health Plan reviews, and approves, all the MTM member facing letters, annually, to ensure compliance with CMS requirements.
L. Health Plan informs PBM of foreign language requirements via the eligibility files.
M. Health Plan works with PBM to prioritize specific MTM enrollees based on needs such as low medication adherence.
N. Health Plan reviews all the reports provided by PBM to ensure that beneficiaries are being outreached and resolve incorrect/missing contact information issues.
O. Health Plan reviews and validates the annual MTM Report submission document prior to uploading it timely to CMS.

IV. ATTACHMENT(S)

A. Glossary of Terms Link

V. REFERENCES

A. Code of Federal Regulations 42 CFR § 422.111(j), Title I, Part 423, Subpart D, § 423.153.
B. Memo Contract Year 2025 Medication Therapy Management Program Submission: https://www.cms.gov/files/document/memo-contract-year-2025-medication-therapy-management-mtm-program-submission-v050624.pdf
C. Medicare Part D Reporting Requirements https://www.cms.gov/files/document/cy2025-part-d-reporting-requirements-08152024.pdf
D. Prescription Drug Benefit Manual, Chapter 7:MTM and Quality Improvement Program
E. Medication Therapy Management CMS Page: https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/medication-therapy-management
F. State Medicaid Agency Contract (SMAC)
G. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)

VI. REVISION HISTORY

Version*	Revision Summary	Date
001		
002		
003		
004		
Initial Effective Date: 09/24/2025		
Published Date:09/29/2025		

VII. Committee Review and Approval To Be Completed by Compliance

Committee Name	Version	Date
Compliance Committee	001	09/24/2025
• Privacy & Security Oversight Committee		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review Committee		
Quality Improvement Health Equity Committee (QIHEC)		
• Quality Operations Committee		
• Grievance Committee		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare Services (DHCS)			

Department of Managed Care (DMHC)			

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy