Scott County (Group #2604) MTM Program Protocol
Package codes: SI826 and SI28

BACKGROUND

HealthPartners is offering our MTM program to help members better manage their medications high risk by meeting with a clinical pharmacist for FREE.

PATIENT IDENTIFICATION

- HealthPartners uses clinical and demographic data to identify and target members who would be great candidates for MTM.
- A member can self-refer to the program.
- A member can be referred to the program from any healthcare provider.

PATIENT RECRUITMENT

- If HealthPartners targets the member for the program (as listed above), an email or a letter containing the invitation message will be sent along with information about how to make an appointment with a HealthPartners Network MTM provider.
- There are no copays for MTM visits (even for members with high deductible type plans).
- Face to face appointments are preferred. Telephone visits are allowed.
- The frequency of MTM visits will be determined by the MTM pharmacist and the member's other providers, with the intent that MTM services will occur frequently enough to help achieve the member's health goals.

PARTICIPATION INCENTIVES

Members who agree to participate in the MTM program will sign a one-time participation agreement form at their first visit with the pharmacist. Members will receive the following incentives for the duration of their participation in the program.

- Waiver of co-payments for medications on the MTM drug lists for:
  - Antipsychotic drugs
  - Asthma drugs
  - CAD drugs (high cholesterol and hypertension drugs)
  - Depression drugs
  - Diabetic drugs

Program participation requirements are detailed in the participation agreement form. If participation requirements are not met, member will be dis-enrolled from the program and will not be eligible for re-enrollment.

IF A MEMBER WAS INVITED TO THE PROGRAM AND WOULD LIKE TO USE A DIFFERENT MTM PROVIDER THAN THEY WERE ASSIGNED TO:

- Let the member know they can see all of their in-network MTM options by searching Find Care on their authenticated HealthPartners portal login website page and provide them the general link if needed. https://www.healthpartners.com/public/login/
- Also, direct member to call member services (number on back of insurance card) if they need additional assistance in finding a MTM provider

HealthPartners Medication Therapy Management (MTM) Program

Scott County Participation Agreement Form

This program is a partnership between you and your clinical pharmacist. In order to participate and stay in this program, you must agree to the following terms and conditions:

- Remain covered under HealthPartners health plan
- Meet with your clinical pharmacist at a recommended interval which will be determined at your first MTM visit, with a minimum of one visit every 6 months.
- Follow through any recommended lab tests and test your blood glucose and blood pressure at home (if applicable).
- Keep all appointments with your other healthcare providers and follow through on all referrals (doctors, nurse educators, dietitians, etc.) that your clinical pharmacist recommends
- Give authorization to primary care physician's office to share medical information (separate Patient Authorization for Release of Protected Information).

If you have three missed appointments in a calendar year which include no shows, fail to schedule follow-up appointments or cancellation, you will be withdrawn from the program. You do have the ability to re-enter after another MTM visit and a new Participation form is signed.

If you follow these terms, you will qualify for the following:

- Waiver of co-payments for medications on the MTM drug lists for:
  - Antipsychotic drugs
  - Asthma drugs
  - CAD drugs (high cholesterol and hypertension drugs)
  - Depression drugs
  - Diabetic drugs

Please read the statement below. If you agree, please sign and date this form and provide it to your clinical pharmacist.

I, (print name here) _____, have read and agree to the terms above. By signing below, I promise to comply with these terms. I understand that I must follow these terms to keep this agreement in effect. I give my authorization for HealthPartners clinics and HealthPartners staff to share medical information, medical advice and consultation reports with my physician.

Signature: _____ Date: _____
Member ID Number (required): _____
If participant is a minor, requires signature from a parent or guardian.
Pharmacist Name:_____Date: _____
Pharmacist Signature:_____
Pharmacist Email:_____

Please return a copy of the signed participation form to HealthPartners to activate the prescription incentive by:*
1) Fax at (952)853-8829
2) Email to mtmcoordinators@healthpartners.com
3) Mail to HealthPartners Attn: MTM Coordinator Mail Stop 21111B 8170 33rd Avenue South Bloomington, MN 55425
**Please allow 5-7 business days for processing.*