DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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DATE: November 18, 2013

TO: All Part D Sponsors

FROM: Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: Request for Comments – Standardized Format for the Part D Medication Therapy Management Program Comprehensive Medication Review Summary

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Since January 1, 2013, Part D sponsors have been required to provide an individualized, written summary in CMS' standardized format to beneficiaries after a comprehensive medication review (CMR) as part of the Medication Therapy Management (MTM) program. In this document, we describe proposed changes to the standardized format. We are providing plan sponsors, advocates, and other stakeholders the opportunity to comment ahead of the Paperwork Reduction Act (PRA) process.

CMS initially developed the standardized format through extensive engagement with stakeholders, including testing with Part D plans, MTM providers, and beneficiaries, and review of comments submitted during the PRA process. The standardized format contains templates for a Cover Letter, Medication Action Plan, and Personal Medication List. A copy of the standardized format can be found on the CMS.gov MTM webpage at: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html

These proposed revisions are based upon feedback from beneficiaries and stakeholders about their experience with the standardized format since implementation. A Technical Expert Panel of long-term care (LTC) stakeholders was also convened to gather suggestions on how to optimize the integration and effectiveness of the standardized format in LTC settings. We are soliciting your comments for improvements in advance of submitting proposed changes via the PRA. In addition, we are interested in understanding your estimates of the time and costs associated with implementing the proposed revisions to the standardized format. We do not intend to make significant changes, but rather consider minor changes to improve its efficacy.

Attachment A lists the proposed changes. Attachment B provides a mock-up of the proposed revisions.

Please submit your comments to **partd_mtm@cms.hhs.gov** with "CMR Summary Comments" in the email subject line. We will consider all comments received **by December 20, 2013**. Only one set of comments should be submitted per organization.

All interested parties will have an opportunity to provide additional comments pursuant to the PRA process in the coming months.

Thank you for your participation.

Attachment A: Proposed Changes to Medication Therapy Management Program Standardized Format

Note: Each change should be considered discretely (i.e., independent of all other changes listed here).

A. Cover Letter

A.1. In the Cover Letter, change the 2nd sentence in the 1st paragraph:

From: "Medicare's MTM (Medication Therapy Management) program helps you to make sure that your medications are working."

To: "Medicare's MTM (Medication Therapy Management) program helps you understand your medications and use them safely."

A.2. In the Cover Letter, change the 1st sentence of the 2nd paragraph:

From: "Along with this letter are an action plan (Medication Action Plan) and a medication list (Personal Medication List)."

To: "This letter includes an action plan (Medication Action Plan) and medication list (Personal Medication List)."

A.3. In the Cover Letter, change the 1st bullet below the 2nd paragraph to make reference to a care team, such as in a LTC facility:

From: "Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other health care providers."

To: "Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team."

B. Medication Action Plan

B.1. In the Medication Action Plan, change the 1st sentence in the paragraph below the instruction bullets to make reference to a care team, such as in a LTC facility:

From: "Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers."

To: "Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team."

C. Personal Medication List

C.1. In the Personal Medication List, suggest that Part D sponsors add a statement in the Other Information field or CMS insert new text above the PRA statement describing that changes to the beneficiary's medication regimen could have occurred since the clinical encounter, such as, "Remember to update this list if there are changes since your medication review."

Attachment B: Mock-up with Proposed Revisions

Medication Therapy Management Program
Standardized Format – English

< MTM PROVIDER HEADER > *< PLAN LOGO >*

< Insert date >

< Insert inside address >

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

< Insert salutation >:

Thank you for talking with me on *< insert date of service >* about your health and medications. Medicare's MTM (Medication Therapy Management) program helps you understand your medications and use them safely.

This letter includes an action plan (Medication Action Plan) and a medication list (Personal Medication List). **The action plan has steps you should take to help you get the best results from your medications. The medication list will help you keep track of your medications and how to use them the right way.**

- Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team.
- Ask your doctors, pharmacists, and other healthcare providers to update them at every visit.
- Take your medication list with you if you go to the hospital or emergency room.
- Give a copy of the action plan and medication list to your family or caregivers.

If you want to talk about this letter or any of the papers with it, please call *<insert contact information for MTM provider, phone number, days/times, TTY, etc. >*. *< I/We >* look forward to working with you and your doctors to help you stay healthy through the *< insert name of Part D Plan >* MTM program.

< Insert closing, MTM provider signature, name, title, enclosure notations, etc. >

< *MTM PROVIDER HEADER* > < *PLAN LOGO* >

MEDICATION ACTION PLAN FOR < *Insert Member's name,* DOB: *mm/dd/yyyy* >

This action plan will help you get the best results from your medications if you:

1. Read "What we talked about."
2. Take the steps listed in the "What I need to do" boxes.
3. Fill in "What I did and when I did it."
4. Fill in "My follow-up plan" and "Questions I want to ask."

Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team. Share this with your family or caregivers too.

DATE PREPARED: < *INSERT DATE* >

What we talked about: < *Insert description of topic* >	
What I need to do: < *Insert recommendations for beneficiary activities* >	**What I did and when I did it:** < *Leave blank for beneficiary's notes* >

What we talked about:	
What I need to do:	**What I did and when I did it:**

What we talked about:	
What I need to do:	**What I did and when I did it:**

What we talked about:	
What I need to do:	**What I did and when I did it:**

What we talked about:	
What I need to do:	**What I did and when I did it:**

My follow-up plan (add notes about next steps)**:**
< Leave blank for beneficiary's notes >

Questions I want to ask (include topics about medications or therapy)**:**
< Leave blank for beneficiary's notes >

If you have any questions about your action plan, call *< insert MTM provider contact information, phone number, days/times, etc. >*.

< MTM PROVIDER HEADER > *< PLAN LOGO >*

PERSONAL MEDICATION LIST FOR *< Insert Member's name,* DOB: *mm/dd/yyyy >*

This medication list was made for you after we talked. We also used information from *< insert sources of information >*.

- Use blank rows to add new medications. Then fill in the dates you started using them.
- Cross out medications when you no longer use them. Then write the date and why you stopped using them.
- Ask your doctors, pharmacists, and other healthcare providers to update this list at every visit.

Keep this list up-to-date with:
- ☐ prescription medications
- ☐ over the counter drugs
- ☐ herbals
- ☐ vitamins
- ☐ minerals

If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

DATE PREPARED: *< INSERT DATE >*

Allergies or side effects: *< Insert beneficiary's allergies and adverse drug reactions including the medications and their effects >*

Medication: *< Insert generic name and brand name, strength, and dosage form for current/active medications. >*	
How I use it: *< Insert regimen, including strength, dose and frequency (e.g., 1 tablet (20 mg) by mouth daily), use of related devices and supplemental instructions as appropriate >*	
Why I use it: *< Insert indication or intended medical use >*	**Prescriber:** *< Insert prescriber's name >*
< Insert other title(s) or delete this field >: *< Use for optional product-related information, such as additional instructions, product image/identifiers, goals of therapy, pharmacy, etc., and change field title accordingly. This field may be expanded or divided. Delete this field if not used. >*	
Date I started using it: *< May be estimated by Plan or entered based upon beneficiary-reported data, or leave blank for beneficiary to enter start date >*	**Date I stopped using it:** *< Leave blank for beneficiary to enter stop date >*
Why I stopped using it: *< Leave blank for beneficiary's notes >*	

PERSONAL MEDICATION LIST FOR < *Insert Member's name*, DOB: *mm/dd/yyyy* >

(Continued)

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< *Insert other title(s) or delete this field* >:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

PERSONAL MEDICATION LIST FOR < *Insert Member’s name*, DOB: *mm/dd/yyyy* >

(Continued)

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< ***Insert other title(s) or delete this field*** **>:**	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< ***Insert other title(s) or delete this field*** **>:**	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
< ***Insert other title(s) or delete this field*** **>:**	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Other Information:

Remember to update this list if there are changes since your medication review.

If you have any questions about your medication list, call < *insert MTM provider contact information, phone numbers, days/times, etc.* >.