Evaluation of the Part D Enhanced Medication Therapy Management (MTM) Model: Fifth Evaluation Report

Appendix A: Enhanced MTM Participating Sponsors

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APPENDIX A ENHANCED MTM PARTICIPATING SPONSORS

A.1 SilverScript/CVS Insurance Company

SilverScript/CVS Insurance Company's (SilverScript/CVS) Enhanced MTM implementation was structured into five distinct interventions. All interventions used Part D claims for targeting, while one also used Part B claims, and another also used Parts A and B claims. Beneficiaries could qualify for one or more interventions if they met intervention-specific targeting criteria. Information in this appendix reflects SilverScript/CVS's Enhanced MTM implementation as of the end of the Model.

A.1.1 Sponsor Overview

Region(s): 7 (VA); 11 (FL); 21 (LA); 25 (IA, MN, MT, ND, NE, SD, WY); 28 (AZ)
Plan Benefit Package(s): S5601-014, -022, -042, -050, -056
Number of Prescription Drug Plan (PDP) Enrollees:
Model Year 1: 794,115
Model Year 2: 1,002,808
Model Year 3: 986,725
Model Year 4: 852,738
Model Year 5: 731,414
Number of Enhanced MTM-Eligible Beneficiaries:
Model Year 1: 727,076 (91.6% of Model Year 1 enrollment)
Model Year 2: 869,207 (86.7% of Model Year 2 enrollment)
Model Year 3: 887,075 (89.9% of Model Year 3 enrollment)
Model Year 4: 815,163 (95.6% of Model Year 4 enrollment)
Model Year 5: 703,846 (96.2% of Model Year 5 enrollment)

Sources: Medicare Advantage Prescription Drug (MARx) and Common Medicare Environment (CME).
Notes: Prescription Drug Plan (PDP) enrollment only included Enhanced MTM-participating contract plans. Enhanced MTM eligibility was conditional on enrollment in the participating PDP in the CME.

A.1.2 Participating Organizations

SilverScript/CVS's Enhanced MTM interventions were overseen by its Pharmacy Benefit Manager (PBM), CVS Caremark, and its parent company, CVS Health (collectively referred to hereafter as "CVS"). Table A.1.1 summarizes the roles of these organizations in Enhanced MTM.

Table A.1.1: SilverScript/CVS Enhanced MTM Partnerships

Organization	Role in SilverScript/CVS's Enhanced MTM Implementation
SilverScript Insurance Company (SSI)	• Enhanced MTM sponsor organization.
CVS	• Oversaw the entire Enhanced MTM implementation. • For Pharmacy Advisor Counseling, Medication Therapy Counseling, and HealthTag interventions: ○ Conducted beneficiary targeting and outreach. ○ Delivered Enhanced MTM services. ○ Handled prescriber outreach. ○ Documented and reported Enhanced MTM services.
Accordant (CVS Subsidiary)	• For Specialty Pharmacy Care Management intervention: ○ Conducted beneficiary targeting and outreach. ○ Delivered Enhanced MTM services. ○ Handled prescriber outreach. ○ Documented and reported Enhanced MTM services.
OutcomesMTM[a] (External MTM vendor)	• Leveraged the extensive network of retail and community pharmacies to deliver Enhanced MTM services for the Medication Therapy Counseling and Long-Term Care interventions.
Omnicare[b] (CVS Subsidiary)	• Participated in the OutcomesMTM pharmacy network to provide Enhanced MTM services to long-term care beneficiaries.

[a] Added in August 2018 (Model Year 2) to provide additional support for Enhanced MTM service delivery.
[b] Added in January 2019 (Model Year 3).

A.1.3 Enhanced MTM Interventions

As shown in Table A.1.2, four SilverScript/CVS Enhanced MTM interventions began in Model Year 1 and continued through the end of the Model. These interventions focused on: (i) beneficiaries at risk for high health care costs (Medication Therapy Counseling intervention); (ii) beneficiaries with select rare diseases (Specialty Pharmacy Care Management intervention); (iii) beneficiaries with newly prescribed medications, adherence problems, or gaps in care (Pharmacy Advisor Counseling intervention); and (iv) beneficiaries due for a flu, pneumonia, or shingles vaccination (HealthTag intervention). SilverScript/CVS's only Enhanced MTM intervention addition occurred in the third quarter (Q3) of Model Year 2, when SilverScript/CVS began offering Enhanced MTM services to beneficiaries residing in long-term care facilities (Long-Term Care intervention).

Table A.1.2: SilverScript/CVS Enhanced MTM Intervention Implementation Milestones

	Model Year 1 (2017)				Model Year 2 (2018)				Model Year 3 (2019)				Model Year 4 (2020)				Model Year 5 (2021)			
Enhanced MTM Intervention	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Medication Therapy Counseling	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Specialty Pharmacy Care Management	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Pharmacy Advisor Counseling	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
HealthTag (Vaccine)	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Long-Term Care							■	■	■	■	■	■	■	■	■	■	■	■	■	■

■ Intervention active in quarter

Enhanced MTM Intervention Targeting

Table A.1.3 provides an overview of SilverScript/CVS's targeting processes for its five Enhanced MTM interventions.

Table A.1.3: SilverScript/CVS Enhanced MTM Intervention Targeting Overview

Enhanced MTM Intervention	Relevant Targeting Categories[a]	Targeting Process	Data Source
Medication Therapy Counseling (MTC)	• High Costs • Conditions	Included beneficiaries predicted to be at high risk for high health care costs based on a proprietary algorithm.	Part D
Specialty Pharmacy Care Management (SPCM)	• Conditions	Identified beneficiaries with rare conditions through (i) disease-specific algorithms that used medical and pharmacy claims or (ii) referrals from the beneficiary, health care providers, or CVS specialty pharmacy after verifying the beneficiary met intervention targeting criteria.	Parts A, B, and D
Pharmacy Advisor Counseling (PAC)	• Med Use ○ DTP ○ New Med	Identified beneficiaries for brief counseling services pertaining to new medications or medication refills using pharmacy claims.	Part D
HealthTag	• Vaccine	Identified beneficiaries to receive flu, pneumonia, or shingles vaccine reminders, or eligible for other SilverScript/CVS Enhanced MTM interventions.	Parts B and D
Long-Term Care[b]	• High Costs • Conditions	Included long-term care beneficiaries predicted to be at high risk for high health care costs based on a proprietary algorithm.	Part D

[a] High Costs: targeting based on high Medicare Parts A, B, and/or D costs; Conditions: targeting based on the presence of one or more chronic conditions; Med Use: targeting based on medication utilization; DTP (drug therapy problem): Med Use sub-category related to medication adherence issues, adverse drug reactions/interactions, gaps in care (e.g., needing additional drug therapy), dosage issues, and/or unnecessary or inappropriate drug therapy; New Med: Med Use sub-category related to newly prescribed medications; Vaccine: targeting beneficiaries based on the need for a vaccine.

[b] Implemented in Model Year 2 to address the needs of long-stay long-term care residents.

Enhanced MTM Services

Table A.1.4 provides an overview of SilverScript/CVS's Enhanced MTM services, which varied in their level of intensity, depending on the Enhanced MTM intervention. Three of these interventions provided both high- and low-intensity services, one provided high-intensity services only, and one provided low-intensity services only.

Table A.1.4: SilverScript/CVS Enhanced MTM Service Overview

Enhanced MTM Intervention	Significant Service Categories[a]	Level of Intensity[b]	Service Frequency	Enhanced MTM Services
Medication Therapy Counseling (MTC) and Long-Term Care (LTC)	• CMR	High	Recurrent	• **Comprehensive Medication Review (CMR):** ○ Conducted telephonically by a call center or in person by a community pharmacist.[c] ○ Focused on identifying medication-related problems broadly related to indication, safety, effectiveness, and adherence. • **Follow-up calls** for CMR recipients: ○ Focused on any changes to medications and the status of any previously identified medication-related problems, new medication-related problems, or disease states not covered during previous phone calls. ○ Frequency generally driven by the number of disease states and pharmacist discretion.
	• TMR (beneficiary)	High	One-time	• **Patient Consultation (Targeted Medication Review [TMR])[d]:** A beneficiary-facing TMR consultation (e.g., over-the-counter medication consultation, medication assessment for high-risk medications, medication education).
	• TMR (prescriber)	Low	One-time	• **Prescriber Consultation (TMR)[d]:** A consultation between a pharmacist and a beneficiary's prescriber to resolve or prevent DTPs for which a change in therapy required prescriber approval.
	• Medication adherence (pharmacist)	High	One-time	• **Patient Adherence Consultation[d]:** A consultation between a pharmacist and beneficiary to identify, resolve, and/or prevent medication adherence issues (e.g., medication overuse or underuse).
	• Case/disease management	High	One-time	• **Comprehensive Diabetes Care Education[d]:** A consultation between a pharmacist and beneficiary focused on holistic diabetes self-management education.
	• Immunization assessment, reminder, and administration	Low	One-time	• **Immunization Reminders[d]:** Pharmacists encouraged beneficiaries who had not received recommended vaccines to receive them. Pharmacists either administered the vaccine or referred beneficiaries to their prescriber's office for vaccine administration. In some cases, pharmacists also educated the beneficiaries' prescribers about the importance of immunizations.

Enhanced MTM Intervention	Significant Service Categories[a]	Level of Intensity[b]	Service Frequency	Enhanced MTM Services
Specialty Pharmacy Care Management (SPCM)	• Case/disease management • Medication reconciliation	High	Recurrent	• **Initial assessment call:** ○ Conducted telephonically by a primary nurse assigned to the beneficiary. ○ Focused on disease-specific beneficiary risk assessment completion. ○ Assigned the beneficiary a risk level that related to the level of care management received. ○ Produced a collaboratively developed care plan that directed the focus of future follow-up. • **Follow-up calls** were directed by risk level, and focused on care optimization, symptom management, self-care, co-morbidities, and medication optimization. • **Referrals** for additional services designed to help beneficiaries identify appropriate community resources (e.g., financial assistance, support with activities of daily living, long-term planning), support beneficiaries with acute needs (e.g., hospitalization/discharge, scheduled surgery), and promote beneficiary engagement in their own care. • **Educational resources** included targeted articles, access to online education, and a monthly newsletter.
Pharmacy Advisor Counseling (PAC)	• TMR (beneficiary) • Adherence (pharmacist)	High	One-time	• **Targeted pharmacist services** consisted of brief clinical conversations, delivered telephonically or in person to: ○ Explain the importance of a new medication and addressed cost barriers, as needed; ○ Reinforce the importance of continuing medication therapy, provide medication-specific information, and address any patient-specific issues; ○ Provide reminders about upcoming refills; ○ Provide information about a health condition associated with the medication; ○ Reinforce the importance of the medication to health outcomes, encourage refills, and address barriers; or ○ Discuss gaps in care with the beneficiary. • **Education materials** included condition-specific brochures and possible referrals to disease management programs and/or other health care providers.
	• TMR (prescriber)	Low	One-time	• **Targeted pharmacist services** consisted of informing prescribers about gaps in care.
HealthTag	• Immunization assessment, reminder, and administration	Low	One-time	• **Immunization reminders:** Flu, shingles, and pneumonia vaccination reminders provided to HealthTag-eligible beneficiaries.

[a] "Significant services" were services for a given sponsor intervention that were not initial outreach or non-tailored education. There were 12 significant service categories used across sponsors. See Table B.6.3 of Appendix B for a full list and definitions of these significant service categories.

[b] High-intensity services involved interactive discussions between a beneficiary and an Enhanced MTM provider (often a pharmacist). Low-intensity services did not involve the beneficiary directly (i.e., services that were directed to the prescriber only) or involved only one-way sharing of information with the beneficiary (e.g., vaccine reminders or interactive voice response [IVR]).

[c] Community pharmacy and additional call center capabilities were added in Model Year 2 when SilverScript/CVS added OutcomesMTM as a vendor.

[d] These services were delivered by OutcomesMTM and not CVS. (OutcomesMTM and CVS provided services for the MTC intervention.) Only OutcomesMTM and Omnicare provided services for the Long-Term Care intervention.

A.1.4 Outreach Strategy

Table A.1.5 describes SilverScript/CVS's beneficiary and prescriber outreach approach.

Table A.1.5: SilverScript/CVS Outreach Strategy Overview

Outreach Categories	SilverScript/CVS Approach
Beneficiary Outreach	• Beneficiary outreach varied for each of the five Enhanced MTM interventions. ○ For the MTC, PAC, and SPCM interventions, beneficiaries were mailed an introductory letter notifying them of their eligibility for Enhanced MTM services and describing the types of services and their benefits. This was followed by outreach telephonically, in person, or via interactive voice response (IVR)[a] for the MTC intervention, telephonically or in person for the PAC intervention, and telephonically or via text for the SPCM intervention.[b] • Beneficiary outreach for the LTC intervention occurred via the LTC facility, which contacted the beneficiary directly. • Beneficiary outreach (i.e., vaccination reminders) for HealthTag only occurred in community pharmacies when an eligible beneficiary visited the pharmacy to fill a prescription. • Following integration with the Epic Electronic Health Record (EHR), beneficiaries eligible for the SPCM intervention had the ability to submit secure messages to SPCM staff and schedule appointments for SPCM services through the Epic patient portal.[c]
Prescriber Outreach	• Prescriber outreach was limited to post-service, and the nature of communication varied across Enhanced MTM interventions: ○ Following all MTC and LTC services, prescribers received a list of medication-related problems and recommendations for addressing these problems for the MTC intervention. ○ For the SPCM intervention, prescriber communication was ongoing and may have included updates about a beneficiary's risk status, care coordination needs, vaccination status, etc. ○ Prescriber communication for the PAC intervention was primarily focused on gaps in care. ○ The HealthTag intervention did not involve any direct prescriber communication or outreach. • Outreach occurred telephonically, by fax, or by mail for the MTC, LTC, PAC, and SPCM interventions.

[a] IVR was added near the end of Model Year 2 (2018) as an additional strategy to inform beneficiaries about their eligibility to receive a CMR service.

[b] Text messaging capabilities were added to the SPCM intervention midway through Model Year 3 (June 2019) to supplement the existing telephone outreach to beneficiaries, depending on beneficiary preferences.

[c] The functionality to enable secure messaging through Epic was implemented early in Model Year 3 (2019).

A.2 Humana

Humana consistently offered two Enhanced MTM interventions—a risk-based intervention and a transitions-of-care intervention—throughout Model implementation. The risk-based intervention used Parts A, B, and D claims data to stratify beneficiaries into four risk groups based on their predicted cost risk to Humana. Beneficiaries received outreach for services based on their risk category, identified drug therapy problems (DTPs), or chronic conditions. All beneficiaries with a recent hospital discharge were eligible to receive transitions-of-care medication reconciliation services. In Model Year 2 (2018), one of Humana's Plan Benefit Packages (PBPs) lost its benchmark status. Consequently, low-income subsidy (LIS) beneficiaries previously enrolled in that PBP were automatically enrolled in other PBPs. Information in this appendix reflects Humana's Enhanced MTM implementation as of the end of the Model.

A.2.1 Sponsor Overview

Region(s): 7 (VA); 11 (FL); 21 (LA); 25 (IA, MN, MT, ND, NE, SD, WY); 28 (AZ)
Plan Benefit Package(s): S5884-105, -108, -132, -145, -146
Number of PDP Enrollees:
- Model Year 1: 457,388
- Model Year 2: 287,507
- Model Year 3: 255,580
- Model Year 4: 226,670
- Model Year 5: 194,300

Number of Enhanced MTM-Eligible Beneficiaries:
- Model Year 1: 221,631 (48.5% of Model Year 1 enrollment)
- Model Year 2: 180,145 (62.7% of Model Year 2 enrollment)
- Model Year 3: 169,906 (66.5% of Model Year 3 enrollment)
- Model Year 4: 156,891 (69.2% of Model Year 4 enrollment)
- Model Year 5: 128,112 (65.9% of Model Year 5 enrollment)

Sources: MARx and CME.
Notes: PDP enrollment only included Enhanced MTM-participating contract plans. Enhanced MTM eligibility was conditional on enrollment in the participating PDP in the CME.

A.2.2 Participating Organizations

Table A.2.1 presents Humana's partners and their roles in Enhanced MTM as of the end of the Model.

Table A.2.1: Humana Enhanced MTM Partnerships

Organization	Role in Humana's Enhanced MTM Implementation
Humana Insurance Company	• Enhanced MTM sponsor organization.
Humana Pharmacy Solutions	• Oversaw overall implementation of the Enhanced MTM Model for Humana Insurance Company. • Performed beneficiary targeting and outreach for Enhanced MTM. • Managed and handled payment for Enhanced MTM services.
OutcomesMTM [a]	• Administered Enhanced MTM interventions. • Provided the technology platform for documentation and billing of Enhanced MTM services. • Leveraged the extensive network of community pharmacies for Enhanced MTM service delivery.
Telephonic MTM Vendor [b]	• Provided telephonic Enhanced MTM services through a call center from Model Year 1 (2017) to Model Year 3 (2019).
Admission, Discharge, and Transfer (ADT) Data Vendor [c]	• Provided state health information exchange (HIE) data support to help identify beneficiaries with recent hospital discharges for the transitions-of-care medication reconciliation service from Model Year 2 (2018) to Model Year 4 (2020).

[a] Humana used the OutcomesMTM call center to provide telephonic Enhanced MTM services until Q3 of Model Year 4, after which it transitioned to delivering all services solely through community pharmacies.

[b] Added midway through Model Year 1 to provide additional support in the delivery of telephonic services, but discontinued in Q3 of Model Year 4 when Humana decided to stop using call centers to provide telephonic Enhanced MTM services.

[c] Added in Model Year 2 to overcome barriers to using claims data for identifying beneficiaries recently discharged from a hospital. In Q3 of Model Year 4, Humana discontinued its use of state HIE data for transitions-of-care medication reconciliation service targeting.

A.2.3 Enhanced MTM Interventions

As shown in Table A.2.2, Humana launched two Enhanced MTM interventions at the start of Model Year 1, and these interventions continued through the end of the Model. Humana did not add any new Enhanced MTM interventions.

Table A.2.2: Humana Enhanced MTM Intervention Implementation Milestones

	Model Year 1 (2017)				Model Year 2 (2018)				Model Year 3 (2019)				Model Year 4 (2020)				Model Year 5 (2021)			
Enhanced MTM Intervention	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Risk-Based																				
Transitions of Care Medication Reconciliation																				

Enhanced MTM Intervention Targeting

Humana re-stratified its entire beneficiary population at the beginning of Model Year 4 (2020) using a new targeting approach for its Risk-Based intervention. The new targeting approach used Parts A, B, and D data and involved predictive modeling that assigned risk scores based on predicted medical and pharmacy costs. In previous Model Years, Humana stratified beneficiaries using only Part D claims. Humana changed its targeting approach because it found the Part D claims-only approach generated risk scores that were more likely to fluctuate due to acute illness or injury. The predictive approach using Parts A, B, and D data produced risk scores that were comparatively more stable over time (i.e., beneficiaries assigned to the high-risk tier were more likely to continually meet criteria for "high risk" over time).[1]

Humana also changed the targeting approach for its Transitions of Care Medication Reconciliation intervention over time. In Model Year 1, Humana used Parts A and B data as well as pharmacists to identify beneficiaries with a recent hospital discharge, but then switched to using HIE data in Model Year 2 in an effort to increase completion of transitions-of-care services. In early Model Year 4, Humana discontinued the use of state HIE data after its internal analysis found that using HIE data to target beneficiaries for the transitions-of-care intervention was not cost effective. Humana continued to offer this intervention through the remainder of the Model but relied solely on pharmacists to identify hospital discharges.

Table A.2.3 provides an overview of Humana's targeting processes for its two Enhanced MTM interventions.

[1] Consistent with previous Model Years, beneficiaries remained in the highest risk tier for which they qualified.

Table A.2.3: Humana Enhanced MTM Intervention Targeting Overview

Enhanced MTM Intervention	Relevant Targeting Categories[a]	Targeting Process	Data Source
Risk-Based	• High Costs • Med Use ○ DTP • Conditions	Assigned beneficiaries into one of four risk groups (high-risk, medium-risk, low-risk, and monitoring) based on health care utilization, drug expenditures, and information about health status and chronic conditions.[b] Enhanced MTM service opportunities could also be identified by community pharmacists.	Parts A, B, and D
Transitions of Care Medication Reconciliation[c]	• Transitions	Identified eligible beneficiaries in all risk groups with a recent hospital discharge to receive the transitions-of-care medication reconciliation service. Beneficiaries were identified through patient consultations at community pharmacies.	Pharmacist identification

[a] Med Use: targeting based on medication utilization; DTP: targeting based on medication adherence issues, adverse drug reactions/interactions, gaps in care, dosage issues, and/or unnecessary or inappropriate drug therapy; Conditions: targeting based on the presence of one or more chronic conditions; High Costs: targeting based on high Medicare Parts A, B, and/or D costs; and Transitions: targeting beneficiaries who experienced a recent discharge from the hospital.

[b] Beneficiaries in the monitoring group were not targeted for Risk-Based intervention services.

[c] In Model Year 1, Humana used Parts A and B data as well as pharmacists to identify beneficiaries with a recent hospital discharge. Use of ADT data through state HIE began in Florida in Model Year 2 and was implemented in Louisiana and Virginia in Model Years 3 and 4, respectively. In Q3 of Model Year 4, Humana discontinued the use of ADT data through state HIEs in all three states and switched back to only having pharmacists identify eligible beneficiaries.

Enhanced MTM Services

Table A.2.4 provides an overview of Humana's Enhanced MTM services for both of its Enhanced MTM interventions. For Humana's Risk-Based intervention, services were tailored to beneficiaries' risk profiles, drug utilization problems, and specific chronic conditions. Although Humana did not change its overall interventions, it changed the services offered over the course of the Model to beneficiaries who were eligible for the interventions. In Model Year 2, Humana added a flu immunization reminder to its Risk-Based intervention. However, Humana discontinued the service midway through Model Year 3 after determining that it was ineffective in driving beneficiary behavior change and duplicative of other efforts to increase flu vaccinations. Similarly, at the beginning of Model Year 4, Humana eliminated the comprehensive medication review (CMR) service from its Risk-Based intervention after its internal analyses found the service did not result in medical cost savings.

At the beginning of Model Year 4, Humana built upon its comprehensive diabetes care education service[2] and launched a new chronic condition management service. The new service encompassed holistic disease management and education focusing on 10 different chronic conditions.[3] Humana launched the chronic condition management service after its internal analyses found that the comprehensive diabetes care education service was valuable in driving

[2] Implemented in Model Years 1-3.

[3] Chronic conditions included hypertension, hyperlipidemia, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), cardiovascular disease, depression, asthma, rheumatoid arthritis, and osteoarthritis.

cost savings. However, after the first month of implementation, Humana reduced the number of chronic conditions targeted for this service to three conditions[4] and discontinued consultations for low-risk beneficiaries because service uptake in the first month far exceeded budget expectations. In Q2 of Model Year 4, Humana stopped identifying new beneficiaries for chronic condition management services to control the volume of services. Humana also discontinued the medication synchronization service in Q1 of Model Year 4 due to budgetary reasons. At the beginning of Model Year 5, Humana restarted the chronic condition management service as originally planned, focusing on all 10 selected chronic conditions, and restarted the medication synchronization service.

[4] Humana selected CHF, COPD, and cardiovascular disease because it anticipated the chronic conditions management service would have the largest impact on medical costs of beneficiaries with these three chronic conditions.

Table A.2.4: Humana Enhanced MTM Service Overview

Enhanced MTM Intervention	Significant Service Categories[a]	Level of Intensity[b]	Service Frequency	Service Description
Risk-Based[c]	• TMR (beneficiary)	High	One-time	• **Patient Consultation (Targeted Medication Review [TMR])[d]:** A beneficiary-facing TMR consultation (e.g., over-the-counter medication consultation, medication assessment for high-risk medications, medication education).
	• TMR (prescriber)	Low	One-time	• **Prescriber Consultation (TMR)[d]:** A consultation between a pharmacist and a beneficiary's prescriber to resolve or prevent DTPs for which a change in therapy requires prescriber approval.
	• Medication adherence (pharmacist)	High	One-time	• **Patient Adherence Consultation[d]:** A consultation between a pharmacist and beneficiary to identify, resolve, and/or prevent medication adherence issues (e.g., medication overuse or underuse). • **Medication Synchronization[d,e]:** Pharmacists synchronized beneficiaries' medication fill dates.
	• Medication adherence (pharmacist)	High	Recurrent	• **Adherence Monitoring[d,f]:** Pharmacies accepted accountability for beneficiaries' medication adherence for certain drug classes and received a bonus when targeted beneficiaries reached a specific adherence goal by the end of the year. Quarterly adherence monitoring checkpoints were conducted and barriers to adherence were identified and documented.
	• Case/disease management	High	Recurrent or one-time	• **Chronic Condition Management[g]:** A pharmacist consultation and follow-up services focusing on holistic chronic conditions self-management education. The number of follow-ups were determined by the beneficiaries' risk scores. High-risk beneficiaries received up to three follow-ups, medium-risk beneficiaries received up to two follow-ups, and low-risk beneficiaries did not receive any follow-ups. Pharmacies were eligible for bonus payments upon completing all follow-ups with targeted high- and medium-risk beneficiaries.
Transitions of Care Medication Reconciliation	• Transitions of Care (medication reconciliation)	High	One-time	• **Transitions-of-Care Medication Reconciliation:** A pharmacist compared pre-admission medications with post-discharge medications to identify potential DTPs. After the service, the beneficiary and the beneficiary's primary care provider received a reconciled medication list.[h]

[a] "Significant services" were services for a given sponsor intervention that were not initial outreach or non-tailored education. There were 12 significant service categories used across sponsors. See Table B.6.3 of Appendix B for a full list and definitions of these significant service categories.

[b] High-intensity services involved interactive discussions between a beneficiary and an Enhanced MTM provider (often a pharmacist). Low-intensity services did not involve the beneficiary directly (i.e., services that were directed to the prescriber only) or involved only one-way sharing of information with the beneficiary (e.g., vaccine reminders or IVR).

[c] Until the beginning of Model Year 4, Humana offered a CMR service to high-risk beneficiaries. Humana's CMR was a recurrent, high-intensity service that entailed a pharmacist reviewing all medications with the beneficiary, focusing on potential DTPs such as drug interactions or adherence issues. Humana discontinued the CMR service at the beginning of Model Year 4. Also, Humana offered flu immunization reminders for high- and medium-risk beneficiaries between late Model Year 2 and mid-Model Year 3 but

discontinued the this service after determining that it was not effective in driving beneficiary behavior change and was duplicative of other efforts to increase flu vaccinations, and therefore was not adding value to the Risk-Based intervention.

[d] High-, medium-, and low-risk beneficiaries could be targeted.

[e] The medication synchronization service was launched midway through Model Year 1 and discontinued in Q1 of Model Year 4. Humana reported eliminating the medication synchronization service because of budgetary concerns following the greater-than-anticipated uptake for its chronic condition management service in Model Year 4. The service was resumed in Q2 of Model Year 5.

[f] The adherence monitoring service was only provided to high- and medium-risk beneficiaries in Model Year 1, and expanded to low-risk beneficiaries in Model Year 2.

[g] Humana launched this new service, focusing on 10 chronic conditions, at the beginning of Model Year 4 in lieu of its comprehensive diabetes care education service. Shortly after launching this new service, Humana decided to pare down the number of chronic conditions and stop identifying new beneficiaries for service delivery because uptake far exceeded budget assumptions. At the beginning of Model Year 5, Humana resumed offering chronic condition management for all 10 original chronic conditions.

[h] From Model Year 2 though Model Year 4, beneficiaries in Florida who completed the transitions-of-care medication reconciliation service within 30 days of hospital discharge received a monetary incentive. Humana discontinued the incentive in Model Year 5 because it did not affect service completion rates.

A.2.4 Outreach Strategy

Table A.2.5 describes Humana's approach to beneficiary and prescriber outreach.

Table A.2.5: Humana Outreach Strategy Overview

Outreach Categories	Humana Approach
Beneficiary Outreach	• An initial invitation letter was mailed to all high-, medium-, and low-risk beneficiaries.[a] • In-person or telephonic outreach was made to high-risk beneficiaries and beneficiaries identified for transitions-of-care medication reconciliation services to engage them in the specific services for which they were eligible. • Additional Enhanced MTM outreach methods included emails and web alerts[b] to provide beneficiaries with general information about Enhanced MTM and encourage them to schedule appointments. • Patient resource letters were mailed to beneficiaries eligible for medication adherence monitoring.
Prescriber Outreach	• Fax communication to prescribers included patient summaries and recommendations for changes in therapy after the completion of CMRs, transitions-of-care medication reconciliations, and TMRs. • Telephonic outreach was used as needed to address urgent medication recommendations with prescribers. • A small number of physician clinics with embedded pharmacists were leveraged to deliver Enhanced MTM services in these clinics, helping engage prescribers in Enhanced MTM implementation.

[a] The letter invitation was launched at the beginning of Model Year 3. In Model Years 1 and 2, a postcard invitation was mailed to all high-, medium-, and low-risk beneficiaries.

[b] Web-based outreach methods were launched toward the end of Model Year 1 and the beginning of Model Year 2. An informational web page was launched at the beginning of Model Year 3.

A.3 Blue Cross Blue Shield Northern Plains Alliance

The Blue Cross Blue Shield Northern Plains Alliance (BCBS NPA) offered five Enhanced MTM interventions in Model Year 5. One of these interventions primarily targeted beneficiaries at high risk for adverse drug events (ADEs) based on multi-drug interactions. To determine beneficiaries' risk for ADEs, BCBS NPA risk-scored and stratified its entire plan enrollment via an algorithm that used Part D claims data and incorporated multi-drug interaction analyses. Call center pharmacists and community pharmacies provided services for high-risk beneficiaries. For other interventions, BCBS NPA used Parts A, B, and D claims data to identify beneficiaries eligible to receive TMR-like services, transitions-of-care services, and/or chronic care management services from community pharmacies through a secondary platform. Information in this appendix reflects BCBS NPA's Enhanced MTM interventions as of the end of the Model.

A.3.1 Sponsor Overview

Region(s): 25 (IA, MN, MT, ND, NE, SD, WY)
Plan Benefit Package(s): S5743-001
Number of PDP Enrollees:
Model Year 1: 241,495
Model Year 2: 239,959
Model Year 3: 219,296
Model Year 4: 199,220
Model Year 5: 151,097
Number of Enhanced MTM-Eligible Beneficiaries:
Model Year 1: 50,461 (20.9% of Model Year 1 enrollment)
Model Year 2: 49,105 (20.5% of Model Year 2 enrollment)
Model Year 3: 73,353 (33.4% of Model Year 3 enrollment)
Model Year 4: 86,196 (43.3% of Model Year 4 enrollment)
Model Year 5: 52,700 (34.9% of Model Year 5 enrollment)

Sources: Enhanced MTM Encounter Data Master File and CME.
Notes: PDP enrollment only included Enhanced MTM-participating PBPs. Enhanced MTM eligibility was conditional on enrollment in the participating PDP in the CME. Due to irregular patterns in BCBS NPA's MARx data, BCBS NPA advised the evaluation team to use Encounter Data to define its Enhanced MTM-eligible population.

A.3.2 Participating Organizations

Table A.3.1 presents BCBS NPA's partners as of Model Year 5 and their roles in Enhanced MTM.

Table A.3.1: BCBS NPA Enhanced MTM Partnerships

Organization	Role in BCBS NPA's Enhanced MTM Implementation
Blue Cross Blue Shield Northern Plains Alliance (BCBS NPA)	• Enhanced MTM sponsor organization.
ClearStone Solutions, Inc. (ClearStone)	• Blue Cross Blue Shield of Minnesota affiliate. • Administered BCBS NPA's Part D Plan Benefit Package (PBP). • Provided oversight and managed Enhanced MTM implementation.
Tabula Rasa HealthCare (TRHC)	• External MTM vendor that worked with ClearStone for BCBS NPA's Enhanced MTM implementation. • Performed beneficiary targeting, prioritization, outreach, Enhanced MTM service delivery, provider communication. • Provided the proprietary web platform for documentation of medication risk stratification, medication risk scores, and Enhanced MTM services. • Contracted with community pharmacies to provide Enhanced MTM services using TRHC's proprietary web platform and reimbursed these pharmacies for service completion.
DocStation[a]	• External vendor that provided a secondary proprietary web platform to community pharmacies, which was used for other services in addition to Enhanced MTM. • Leveraged the proprietary algorithm that identified care gaps based on disease state, medication, and other clinical factors to individualize beneficiary services. • Partnered with community pharmacies to provide services via a proprietary web platform. • Provided ongoing performance incentives to community pharmacies through value-based reimbursements.

[a] Added in Model Year 2.

A.3.3 Enhanced MTM Interventions

As shown in Table A.3.2 below, BCBS NPA made changes to the Enhanced MTM interventions offered to eligible beneficiaries over the first four Model Years but did not make any changes in Model Year 5. At the start of the Model, BCBS NPA offered a single Enhanced MTM intervention via its primary platform, TRHC's risk mitigation platform, for beneficiaries at high risk for drug interactions. In Model Year 2, BCBS NPA launched a short-term, primarily education-focused opioid intervention for health care providers who either prescribed opioids with competing drugs or prescribed high volumes of opioids (Prescriber Opioid Education intervention), which concluded as planned later that year.[5] Also in Model Year 2, BCBS NPA recruited and developed an extensive network of community pharmacies, in addition to the TRHC call center. Pharmacists employed by these pharmacies were trained and certified to perform interventions using the primary platform. Through its primary platform, BCBS NPA launched and completed a Low-Risk/High-Cost intervention with two discrete cohorts of beneficiaries in Model Years 2 and 3. However, BCBS NPA discontinued the Low-Risk/High-Cost intervention after Model Year 3 because internal analyses indicated that it was not driving significant medical savings for the target population. In Q3 of Model Year 2, BCBS NPA added a second proprietary web platform in community pharmacies, DocStation's platform. Through this secondary platform, BCBS NPA launched new interventions targeting beneficiaries for brief services (e.g., new medication and adherence assessments, immunization compliance assessments, and medication reconciliation) in the community pharmacy setting (Community Pharmacy Smart Recommendations intervention).[6]

In Model Year 3, BCBS NPA added two new interventions through the secondary platform: a transitions-of-care intervention and a chronic care management intervention, which included both hemoglobin A1c and blood pressure monitoring for beneficiaries with diabetes. In Q3 of Model Year 4, BCBS NPA implemented a new process for identifying social and financial needs of patients receiving services through the secondary platform and providing them with information and referrals to local resources. In Q4 of Model Year 4, BCBS NPA added another intervention through its secondary platform—an opioid intervention (Safe Opioid Use Assessment). The Safe Opioid Use Assessment intervention included an initial opioid use disorder assessment for beneficiaries with new opioid prescriptions. After completing the assessment, pharmacists were presented with suggested services based on the beneficiary's needs.

[5] In previous evaluation reports, this intervention was referred to as the Opioid intervention.

[6] In the Evaluation of the Part D Enhanced Medication Therapy Management (MTM) Model: First Evaluation Report, this intervention was referred to as the Community Pharmacy Light Touch intervention.

Table A.3.2: BCBS NPA Enhanced MTM Intervention Implementation Milestones

	Model Year 1 (2017)				Model Year 2 (2018)				Model Year 3 (2019)				Model Year 4 (2020)				Model Year 5 (2021)			
Enhanced MTM Intervention	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
High-Risk	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Prescriber Opioid Education					■	■														
Low-Risk/High Cost							■	■			■	■								
Community Pharmacy Smart Recommendations							■	■	■	■	■	■	■	■	■	■	■	■	■	■
Transitions of Care										■	■	■	■	■	■	■	■	■	■	■
Chronic Care Management Initiative											■	■	■	■	■	■	■	■	■	■
Safe Opioid Use Assessment															■	■	■	■	■	■

■ Intervention active in quarter

Enhanced MTM Intervention Targeting

Table A.3.3 provides an overview of BCBS NPA's targeting process for each of its Enhanced MTM interventions.

Table A.3.3: BCBS NPA Enhanced MTM Intervention Targeting Overview

Enhanced MTM Intervention	Relevant Targeting Categories[a]	Targeting Process	Data Source
High-Risk	• Med Use ○ DTP	Prioritized outreach to beneficiaries with the highest risk scores for potential multi-drug interactions and side effects based on types of medications.[b]	Part D

Prescriber Opioid Education[c]	• Med Use
	  ○ DTP
	  ○ Opioid
		Identified high-volume opioid prescribers to educate about opioid prescribing, and select beneficiaries with opioid medication-related safety risks.	Part D

Low-Risk/ High-Cost[d]	• High Costs	Identified a subset of beneficiaries with low risk scores and high medical costs.	Parts A and D

Community Pharmacy Smart Recommendations[e]	• Med Use
	  ○ DTP
	  ○ New Med
	• Vaccine
		Identified beneficiaries who had begun new medications, had challenges with medication adherence, and/or needed an immunization assessment/medication reconciliation among beneficiaries who filled their medications at participating community pharmacies.	Part D

Transitions of Care[f]	• Transitions	Identified beneficiaries who were recently discharged from the hospital among those who filled their medications at participating community pharmacies.	Part D

Enhanced MTM Intervention	Relevant Targeting Categories[a]	Targeting Process	Data Source
Chronic Care Management	• Conditions • Med Use ○ Number of Meds	Identified beneficiaries with diabetes and at least 10 medications among those who filled their medications at participating community pharmacies.	Parts A, B, and D
Safe Opioid Use Assessment[g]	• Med Use ○ Opioid	Identified beneficiaries with new opioid prescriptions in the previous 180 days among those who filled their medications at participating community pharmacies that were trained to deliver the intervention.[h]	Part D

[a] Med Use: targeting based on medication utilization; DTP: targeting based on medication adherence issues, adverse drug reactions/interactions, gaps in care, dosage issues, and/or unnecessary or inappropriate drug therapy; New Med: targeting based on newly prescribed medications; Number of Meds: targeting based on a certain number of medications; Opioid: targeting based on opioid use or misuse; Conditions: targeting based on the presence of one or more chronic conditions; High Costs: targeting based on high Medicare Parts A, B, and/or D costs; Transitions: targeting beneficiaries who experienced a recent discharge from the hospital; and Vaccine: targeting beneficiaries based on the need for a vaccine.

[b] BCBS NPA modified its High-Risk intervention targeting approach in early Model Year 4 to prioritize outreach to beneficiaries with the highest risk scores at the time of outreach from a subset of beneficiaries who reached a predetermined risk score threshold over the last 12 months. Previously, beneficiaries reaching the risk score threshold at any point over the last 12 months were targeted, regardless of their risk level at the time of outreach.

[c] Short-term initiative that was implemented and completed in Model Year 2.

[d] Implemented during Model Years 2 and 3, and discontinued thereafter.

[e] Implemented in Model Year 2 in a phased approach after developing, testing, and refining targeting approaches.

[f] Implemented in Model Year 3 after BCBS NPA's vendor collaborated with pharmacists and health systems to develop the intervention and overcome barriers in using medical claims data to identify beneficiaries with recent discharges. Prior to this, community pharmacists identified beneficiaries with recent hospital discharges via discharge paperwork or other indicators during pharmacist-beneficiary interactions.

[g] Implemented in Model Year 4.

[h] In Model Year 5, BCBS NPA made two changes to the targeting for the Safe Opioid Use Assessment intervention: 1) the new opioid medication lookback window was extended to 180 days from 90 days to capture more prescription fills; and 2) the value set for targeting opioid medications was expanded to identify more opioid prescriptions.

Enhanced MTM Services

Table A.3.4 provides an overview of BCBS NPA's services for all of its Enhanced MTM interventions, many of which were delivered solely by community pharmacies. A CMR-type service known as the Medication Safety Review (MSR) was BCBS NPA's core Enhanced MTM service that was delivered in the High-Risk intervention by both a vendor call center and community pharmacies. Call center pharmacists could refer beneficiaries with financial or logistical needs for additional support.

In Model Year 2, BCBS NPA started offering beneficiary-facing services under its Community Pharmacy Smart Recommendations intervention (e.g., new medication assessment, medication adherence assessment, immunization compliance assessment, and medication reconciliation) either telephonically or in person in the community pharmacy setting via its secondary platform. In Model Year 3, BCBS NPA added two new interventions and corresponding services to be delivered through this platform. These included a medication reconciliation service for beneficiaries with a recent hospital discharge and various case/disease management services to achieve established clinical goals for beneficiaries targeted for the Chronic Care Management intervention. Beginning in Q3 of Model Year 4, community pharmacists referred patients receiving services through the platform to local resources if the pharmacist delivering the intervention identified needs that could be addressed through community resources. In Q4 of Model Year 4, BCBS NPA added the Safe Opioid Use Assessment intervention to determine a beneficiary's risk for opioid use disorder and provide relevant education depending on risk level. This intervention was based on the ONE Rx program, which provides education about opioid misuse and accidental overdose.[7]

[7] See https://onerxproject.org for more information.

Table A.3.4: BCBS NPA Enhanced MTM Service Overview

Enhanced MTM Intervention	Significant Service Categories[a]	Level of Intensity[b]	Service Frequency	Service Description
High-Risk	• CMR	High	Recurrent	• **Medication Safety Review (MSR):** Call center/community pharmacists worked with beneficiaries to update information about current medications and reconcile medications. Within 72 hours of the medication reconciliation, pharmacists conducted detailed reviews of beneficiaries' medications and addressed potential DTPs related to the medication safety risks identified. Pharmacists and beneficiaries developed collaborative action plans, which were mailed to the beneficiaries and sent to prescribers, along with any medication recommendations.
	• Medication reconciliation	High	One-time	• **Medication Safety Review Lite (MSR-Lite):** Call center/community pharmacists worked with beneficiaries to update information about current medications and reconcile medications, but were unable to connect with beneficiaries subsequently to complete an MSR. In lieu of conducting an MSR, call center pharmacists reviewed reconciled medications and followed up with the prescribers if DTPs were identified. Call center pharmacists provided prescribers with recommendations to remediate adverse drug event risks that they would have discussed with beneficiaries during an MSR.
	• TMR (prescriber)	Low	One-time	• **Medication Safety Alert (MSA):** For beneficiaries targeted for an MSR who did not complete a medication reconciliation or an MSR, call center pharmacists reviewed beneficiaries' medication claims information, sent a mailer to beneficiaries identifying potential risks, and followed up with prescribers if risks were identified.
	• Cost-sharing and social support	High	One-time	• **Forward Need:** Beneficiaries who received Enhanced MTM services via the primary platform and who were identified as having possible socioeconomic challenges could be contacted telephonically by a ClearStone Solutions social worker to assess the issue. If needed, the social worker informed beneficiaries about existing external programs that could be helpful.[c]
Prescriber Opioid Education[d]	• TMR (prescriber)	Low	One-time	• Short-term initiative designed to increase prescriber awareness about opioid medication risks and help mitigate risks for patients. Targeted prescribers received onsite (i.e., in-office) education about opioid prescribing, and call center pharmacists completed non-beneficiary-facing targeted medication safety reviews for a subset of beneficiaries with identified risks.
Low-Risk/High-Cost[e]	• CMR	High	One-time	• **Medication Safety Review (MSR):** Low-risk/high-cost beneficiaries received one MSR service (described above).
	• Cost-sharing and social support	High	One-time	• **Forward Need:** Beneficiaries identified as having possible socioeconomic challenges could be offered the Forward Need service (described above).

Enhanced MTM Intervention	Significant Service Categories[a]	Level of Intensity[b]	Service Frequency	Service Description
Community Pharmacy Smart Recommendations	• TMR (beneficiary)	High	One-time	• **New Medication Assessment:** Assessment and counseling following the start of a new medication.
	• Medication adherence (pharmacist)	High	One-time	• **Medication Adherence Assessment:** Refill reminders if a beneficiary was non-adherent to a certain set of medications.
	• Immunization assessment, reminder, and administration	Low	One-time	• **Immunization Compliance Assessment:** Assessment of immunization status and delivery of vaccination, as appropriate.
	• Medication reconciliation	High	Recurrent	• **Medication Reconciliation:** Conducted if a beneficiary had not received a medication reconciliation within the last 6 months.
	• Cost-sharing and social support	High	One-time	• **Whole Patient:** A community pharmacist provided local resource information to beneficiaries identified as having possible socioeconomic challenges during an Enhanced MTM service generated via the secondary platform. Community pharmacists received $10 for following up with beneficiaries four weeks after their initial Whole Patient consultation to assess what services or resources they used.[f]
Transitions of Care	• Transitions of care (medication reconciliation)	High	One-time	• **Transitions of Care Medication Reconciliation:** A community pharmacist conducted medication reconciliation and an adverse drug event assessment if the beneficiary was recently discharged from a hospital, aiming to complete these services within 7 days of discharge.
	• Transitions of care (CMR)	High	One-time	• **Transitions of Care Medication Review and Education:** A community pharmacist conducted a medication review if the beneficiary was recently discharged from a hospital. The pharmacist could also provide education to the beneficiary, aiming to complete these services within 7 days of discharge.
	• Cost-sharing and social support	High	One-time	• **Whole Patient:** Beneficiaries identified as having possible socioeconomic challenges could be offered the Whole Patient service (described above).
Chronic Care Management	• Case/disease management	High	Recurrent	• A community pharmacist documented the targeted beneficiary's blood pressure and hemoglobin A1c measurements, and selected services to achieve established clinical goals based on the beneficiary's unique needs and clinical profile. Pharmacies were eligible for a payment for keeping beneficiaries' blood pressure under control.
	• Cost-sharing and social support	High	One-time	• **Whole Patient:** Beneficiaries identified as having possible socioeconomic challenges could be offered the Whole Patient service (described above).

Enhanced MTM Intervention	Significant Service Categories[a]	Level of Intensity[b]	Service Frequency	
	• TMR (beneficiary)	High	One-time	• A community pharmacist could educate the targeted beneficiary about their medication regimen and/or work with the beneficiary to develop a home medication compliance regimen.
Safe Opioid Use Assessment	• TMR (beneficiary)	High	One-time	• **Safe Opioid Use Assessment:** A community pharmacist conducted an assessment to determine the beneficiary's risk for opioid use disorder. Pharmacists were presented with suggested services based on the beneficiary's need.
	• Cost-sharing and social support	High	One-time	• **Whole Patient:** Beneficiaries identified as having possible socioeconomic challenges could be offered the Whole Patient service (described above).

[a] "Significant services" were services for a given sponsor-intervention that were not initial outreach or non-tailored education. There were 12 significant service categories used across sponsors. See Table B.6.3 of Appendix B for a full list and definitions of these significant service categories. CMR: Comprehensive Medication Review; TMR; Targeted Medication Review.

[b] High-intensity services involved interactive discussions between a beneficiary and an Enhanced MTM provider (often a pharmacist). Low-intensity services did not involve the beneficiary directly (i.e., services that were directed to the prescriber only) or involved only one-way sharing of information with the beneficiary (e.g., vaccine reminders or IVR).

[c] Beginning in Model Year 5, call center staff asked all beneficiaries eligible for the High-Risk intervention about socioeconomic challenges or needs, rather than listening during the service to see if beneficiaries' comments suggested there was an unaddressed need.

[d] Short-term initiative that was implemented and completed in Model Year 2.

[e] Implemented in Model Years 2 and 3 only.

[f] Implemented in Model Year 5.

A.3.4 Outreach Strategy

Table A.3.5 describes BCBS NPA's approach to beneficiary and prescriber outreach.

Table A.3.5: BCBS NPA Outreach Strategy Overview

Outreach Categories	BCBS NPA Approach
Beneficiary Outreach	• **High-Risk Intervention** ○ Targeted beneficiaries received a mailed brochure describing the Enhanced MTM intervention and its potential benefits and informing them of an upcoming call from either a partner call center or local pharmacy. Beneficiaries with the highest risk scores were prioritized for outreach.[a] ○ When possible, a local community pharmacy initiated contact with the beneficiary either via phone or at prescription pick-up. Depending upon state law, either a pharmacy technician or pharmacist performed initial contact and completed a medication reconciliation. A local community pharmacist then performed the MSR. ○ In cases where beneficiaries were unreachable or did not use a community pharmacy in the network, beneficiaries were contacted by the vendor call center. ○ Additional outreach strategies were used in cases where beneficiaries were unresponsive or unreceptive to outreach attempts, including mailing letters and SMS text messaging.[b] ○ Quarterly newsletters were sent to all beneficiaries targeted for the high-risk intervention, which contained general information about services in addition to relevant seasonal content. ○ Call center staff made follow-up calls to beneficiaries four weeks after MSR completion to inquire about expected behavioral outcomes (e.g., whether the member met with the prescriber after the MSR, whether the member implemented any of the recommended changes). Beneficiaries who received MSRs could also receive SMS text messages following the service.[c] ○ Call center pharmacists could refer beneficiaries with financial or logistical needs to a social worker who served as a resource navigator to connect members to financial/social services for additional support. ○ Targeted beneficiaries were encouraged to download a mobile application developed to help beneficiaries manage their medications.[d] • **Community Pharmacy Smart Recommendations, Transitions of Care, Chronic Care Management, and Safe Opioid Use Assessment Interventions** ○ Community pharmacists engaged beneficiaries via multiple touch points including inbound/outbound phone calls, appointment-based visits, and at prescription pick-up. ○ Outreach to beneficiaries eligible for the Chronic Care Management intervention was prioritized based on the number of medications.[e] ○ If a call center pharmacist identified beneficiary needs during delivery of an intervention, they could relay this information to a BCBS NPA social worker who would investigate local resources that could address the beneficiary's needs. The social worker sent identified resources to the community pharmacist, who then shared the resources with the beneficiary.

Outreach Categories	BCBS NPA Approach

Prescriber Outreach	• Prescribers received faxed, mailed, and electronic communications; and telephone outreach as needed to address medication recommendations.
	• Targeted high-volume opioid prescribers of beneficiaries with opioid medication-related risks received education about opioid prescribing through the short-term Prescriber Opioid Education intervention.[f]
	  o All targeted prescribers received mailed educational materials.
	  o A subset of targeted prescribers (~50) received onsite educational visits.
	• Prescribers received proactive fax outreach to inform them about beneficiary eligibility for the High-Risk intervention.
	• Prescribers of beneficiaries targeted for the High-Risk intervention could also access a prescriber web portal where they could review and respond to their patients' medication action plans.[g]
	• In some cases, prescribers who did not respond to or accept pharmacist recommendations received follow-up from call center staff.
	• In some cases, prescribers were contacted by pharmacists to obtain recent blood pressure and/or hemoglobin A1c measurements for beneficiaries targeted for the Chronic Care Management intervention.

[a] In Q2 of Model Year 4, beneficiaries with high risk scores who had never participated in the High-Risk intervention were prioritized for outreach over beneficiaries who had previously participated.

[b] The text messaging campaign was launched in Model Year 2 as an additional touch point opportunity for BCBS NPA.

[c] Implemented in Model Year 2 (for high-risk beneficiaries only) to gather data on beneficiary acceptance of Enhanced MTM recommendations.

[d] The mobile application, designed by one of BCBS NPA's vendors, was released for beneficiary use in Q2 of Model Year 3. Reported uptake of the mobile application was low, and BCBS NPA attributed this to the limited use of smartphones among the Enhanced MTM-eligible population.

[e] Began in Q1 of Model Year 4.

[f] Launched in Model Year 2.

[g] The prescriber web portal was launched at the end of Model Year 3, though BCBS NPA reported low prescriber uptake in subsequent Model Years.

A.4 UnitedHealth Group

UnitedHealth Group (UnitedHealth) categorized all participating plan beneficiaries as high- or low-risk based on a risk scoring algorithm that used beneficiary characteristics and drug therapy problems (DTPs) identified through Part D claims. Beneficiaries received a different suite and intensity of services based on their risk category. Beneficiaries may also have received additional services if they were recently discharged from the hospital or were late to refill their medications, as identified by Part D claims. Information in this appendix reflects UnitedHealth's Enhanced MTM interventions as of the end of the Model.

A.4.1 Sponsor Overview

Region(s): 7 (VA); 11 (FL); 21 (LA); 25 (IA, MN, MT, ND, NE, SD, WY); 28 (AZ)
Plan Benefit Package(s): S5921-352, -356, -366, -370, -380
Number of PDP Enrollees:
- Model Year 1: 175,927
- Model Year 2: 134,271
- Model Year 3: 206,147
- Model Year 4: 192,692
- Model Year 5: 180,201

Number of Enhanced MTM-Eligible Beneficiaries:
- Model Year 1: 95,552 (54.3% of Model Year 1 enrollment)
- Model Year 2: 73,411 (54.7% of Model Year 2 enrollment)
- Model Year 3: 109,368 (53.1% of Model Year 3 enrollment)
- Model Year 4: 106,534 (55.3% of Model Year 4 enrollment)
- Model Year 5: 113,186 (62.8% of Model Year 5 enrollment)

Sources: MARx and CME.
Notes: PDP enrollment only included Enhanced MTM-participating contract plans. Enhanced MTM eligibility was conditional on enrollment in the participating PDP in the CME.

A.4.2 Participating Organizations

Table A.4.1 presents UnitedHealth's partners and their roles in Enhanced MTM as of the end of the Model.

Table A.4.1: UnitedHealth Enhanced MTM Partnerships

Organization	Role in UnitedHealth's Enhanced MTM Implementation
UnitedHealth	• Enhanced MTM sponsor organization. • Oversaw Enhanced MTM Model implementation.
OptumRx	• Conducted Enhanced MTM intervention targeting. • Provided Enhanced MTM services and beneficiary outreach. • Leveraged retail pharmacy network for Enhanced MTM Model implementation. • Conducted prescriber outreach. • Generated and provided Enhanced MTM reporting (MARx TC-91, Encounter Data, Monitoring Measures).
Eliza Corporation[a]	• Provided interactive voice response (IVR) telephone support for the Adherence Monitoring intervention automated refill reminders.

[a] Added in Model Year 2 to support automated Adherence Monitoring intervention.

A.4.3 Enhanced MTM Interventions

As shown in Table A.4.2, UnitedHealth did not add or discontinue any Enhanced MTM interventions in Model Year 5. UnitedHealth launched two Enhanced MTM interventions at the start of Model Year 1, and a third intervention in Q2 of Model Year 2. All three interventions continued through the end of the Model. UnitedHealth's Enhanced MTM interventions focused on (i) select DTPs; (ii) transitions of care; and (iii) medication adherence.

Table A.4.2: UnitedHealth Enhanced MTM Intervention Implementation Milestones

	Model Year 1 (2017)				Model Year 2 (2018)				Model Year 3 (2019)				Model Year 4 (2020)				Model Year 5 (2021)			
Enhanced MTM Intervention	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Risk-Based	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Transitions of Care	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Adherence Monitoring						■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

Enhanced MTM Intervention Targeting

Table A.4.3 provides an overview of UnitedHealth's targeting process for its Enhanced MTM interventions.

Table A.4.3: UnitedHealth Enhanced MTM Intervention Targeting Overview

Enhanced MTM Intervention	Relevant Targeting Categories[a]	Targeting Process	Data Source
Risk-Based	• Med Use ○ DTP ○ Number of Meds • Conditions	Assigned a risk score based on beneficiaries' demographic and clinical characteristics and drug therapy problems (DTPs). The risk score was used to assign beneficiaries to high- or low-risk categories.[b]	Part D
Transitions of Care	• Transitions	Used predictive screening algorithm to identify beneficiaries (regardless of risk level) recently discharged from hospital. Discharge status was confirmed by a phone call to the beneficiary.	Part D
Adherence Monitoring[c]	• Med Use ○ DTP	Identified beneficiaries who had filled a medication within medication classes used for CMS Star Rating adherence measures (e.g., statins, diabetes medications, hypertension medications) and were overdue for a refill.	Part D

[a] Med Use: targeting based on medication utilization; DTP: targeting based on medication adherence issues, adverse drug reactions/interactions, gaps in care, dosage issues, and/or unnecessary or inappropriate drug therapy; Number of Meds: targeting based on a certain number of medications; Conditions: targeting based on the presence of one or more chronic conditions; and Transitions: targeting beneficiaries who experienced a recent discharge from the hospital.
[b] Risk scores were assessed annually for all beneficiaries (high- and low-risk) between Model Years 1 and 4. In Model Year 5, risk scores for low-risk beneficiaries were assessed quarterly to determine if they increased.
[c] Implemented in Model Year 2.

Enhanced MTM Services

Table A.4.4 provides an overview of UnitedHealth's tailored, beneficiary-specific Enhanced MTM services for each of its Enhanced MTM interventions. UnitedHealth varied the combination and content of services depending on intervention eligibility and beneficiary needs. In addition to the services described in Table A.4.4, UnitedHealth also provided beneficiaries with educational materials, including condition-specific information.

Table A.4.4: UnitedHealth Enhanced MTM Service Overview

Enhanced MTM Intervention	Significant Service Categories[a]	Level of Intensity[b]	Service Frequency	Service Description
Risk-Based	• CMR	High	One-time	• **"Lean" Comprehensive Medication Review (CMR)**: Medication review focused on drug therapy problems (DTPs), which resulted in a portable medication list and educational materials about DTPs discussed during the CMR and/or related conditions (e.g., diabetes, chronic pain) sent to beneficiaries via mail. This service was conducted telephonically or by a community pharmacist if beneficiaries were hard to reach by telephone.[c] In the Risk-Based intervention, this service was delivered to high-risk beneficiaries only. High-risk beneficiaries could receive a TMR (described below) if new DTPs were identified by the next 90-day follow-up. • **Pharmacists Referrals to Other Services:** Beneficiaries were directed to existing services based on pharmacists' clinical judgment and beneficiary needs identified during the Lean CMR. This service was delivered to high-risk beneficiaries only.
	• TMR (beneficiary)	High	Recurrent	• **Targeted Medication Review (TMR):** If new DTPs were identified by the next 90-day follow-up, a pharmacist reviewed the DTPs to determine whether beneficiaries would receive a TMR (beneficiary) or an additional Lean CMR. This service was delivered to high-risk beneficiaries only.
	• TMR (prescriber)	Low	Recurrent	• **TMR:** If DTPs were identified during an automated TMR, the prescriber was contacted. There was no beneficiary-facing outreach. This service was delivered to high- and low-risk beneficiaries.
Transitions of Care	• Transitions of care (CMR)	High	Recurrent	• **Lean CMR:** Similar to Lean CMR provided to high-risk beneficiaries but focused on newly prescribed medications, review of discharge notes (if available), and how to avoid future hospital admissions. This resulted in similar post-Lean CMR materials as for the high-risk group, plus a medication action plan. • **Follow-up Consultations:** Occurred 10 days after the initial Lean CMR. Beneficiaries also continued to receive services associated with their risk group.
Adherence Monitoring[d]	• Medication adherence (automated)	Low	One-time	• **Automated Refill Reminder:** If a medication adherence problem was identified during an automated review, beneficiaries received an interactive voice response (IVR) telephone call, which provided the option to transfer to a dispensing pharmacy to refill medications.

[a] "Significant services" were services for a given sponsor-intervention that were not initial outreach or non-tailored education. There were 12 significant service categories used across sponsors. See Table B.6.3 of Appendix B for a full list and definitions of these significant service categories.

[b] High-intensity services involved interactive discussions between a beneficiary and an Enhanced MTM provider (often a pharmacist). Low-intensity services did not involve the beneficiary directly (i.e., services that were directed to the prescriber only) or involved only one-way sharing of information with the beneficiary (e.g., vaccine reminders or IVR).

[c] The community pharmacist component was piloted in Model Year 1 and fully implemented in Model Year 2 to support CMR provision for hard-to-reach beneficiaries. Beneficiaries were considered hard to reach if the telephone number on file was invalid or if they could not be reached after three outreach attempts.

[d] Implemented in Model Year 2. In Model Years 2 through 4, adherence monitoring services were considered completed if UnitedHealth connected live with a beneficiary. In Model Year 5, services were considered completed if UnitedHealth left a voicemail or connected live with a beneficiary.

A.4.4 Outreach Strategy

Table A.4.5 describes UnitedHealth's approach to beneficiary and prescriber outreach.

Table A.4.5: UnitedHealth Outreach Strategy Overview

Outreach Categories	UnitedHealth Approach
Beneficiary Outreach	• High-risk beneficiaries were mailed an initial informational welcome packet with intervention-specific information and a call-in number. • High-risk and transitions-of-care beneficiaries received outbound telephonic outreach. If beneficiaries were amenable to completing Enhanced MTM services, they were connected to a pharmacist for an immediate CMR, or if it was not a convenient time, they were scheduled for a CMR at a later date. After three unsuccessful attempts to reach high-risk beneficiaries by telephone, the case was transferred to a retail pharmacy. • In Model Year 4, high-risk beneficiaries began receiving IVR calls as an additional form of outreach to schedule a CMR or receive a direct transfer to a pharmacist to deliver a CMR immediately. • Beneficiaries who were late to refill their medication received an IVR refill reminder call. Beneficiaries were offered a direct transfer to their preferred pharmacy to refill their medications.
Prescriber Outreach	• Prescriber communication occurred primarily through fax. Pharmacists completing Enhanced MTM services contacted prescribers by telephone only if severe drug therapy problems (DTPs) were detected after a Lean CMR with a high-risk or transitions-of-care beneficiary. • When a DTP was identified during an automated TMR, prescribers received Enhanced MTM recommendations by fax or mail.

A.5 WellCare

By the end of the Model, WellCare offered four Enhanced MTM interventions, each with a distinct focus. Targeting for all interventions, except the Hospital Discharge intervention, relied on Part D claims. The Hospital Discharge intervention used ADT (Admission, Discharge, and Transfer) data feeds through Florida and Arizona's health information exchanges (HIEs). Two other interventions also used Parts A and B claims for chronic condition and/or risk identification. All interventions, except the Hospital Discharge intervention, involved a first phase of targeting to determine beneficiary eligibility and a second phase to determine which beneficiaries were offered services. Beneficiaries could qualify for one or more interventions. Although the core components of the Enhanced MTM services were similar across interventions, the combination and content of these services varied. Information in this appendix reflects WellCare's Enhanced MTM implementation as of the end of the Model.

A.5.1 Sponsor Overview

Region(s): 7 (VA); 11 (FL); 21 (LA); 25 (IA, MN, MT, ND, NE, SD, WY); 28 (AZ)
Plan Benefit Package(s): S4802-012, -069, -083, -089, -092
Number of PDP Enrollees:
Model Year 1: 155,072
Model Year 2: 150,175
Model Year 3: 132,517
Model Year 4: 148,074
Model Year 5: 149,703
Number of Enhanced MTM-Eligible Beneficiaries:
Model Year 1: 110,456 (71.2% of Model Year 1 enrollment)
Model Year 2: 105,953 (70.6% of Model Year 2 enrollment)
Model Year 3: 97,876 (73.9% of Model Year 3 enrollment)
Model Year 4: 99,751 (67.4% of Model Year 4 enrollment)
Model Year 5: 100,711 (67.3% of Model Year 5 enrollment)

Sources: MARx and CME.
Notes: PDP enrollment only included Enhanced MTM-participating contract plans. Enhanced MTM eligibility was conditional on enrollment in the participating PDP in the CME.

A.5.2 Participating Organizations

Table A.5.1 presents WellCare's partners and their roles in Enhanced MTM.

Table A.5.1: WellCare Enhanced MTM Partnerships

Organization	Role in WellCare's Enhanced MTM Implementation
WellCare	• Enhanced MTM sponsor organization. • Oversaw Enhanced MTM implementation. • Provided outreach, Enhanced MTM service delivery, provider communication. • Documented and reported Enhanced MTM services.
RxAnte	• Conducted beneficiary targeting. • Assigned targeted beneficiaries to MTM vendors. • Provided operational and outcomes reporting support for the ongoing management of Enhanced MTM implementation.
University of Florida Center for Quality Medication Management	• Notified beneficiaries eligible for Enhanced MTM about the Enhanced MTM Model. • Provided outreach, Enhanced MTM service delivery, provider communication. • Documented and reported Enhanced MTM services.
Mirixa Corporation[a]	• Provided outreach, Enhanced MTM service delivery, provider communication. • Documented and reported Enhanced MTM services.
OutcomesMTM[b]	• Provided outreach, Enhanced MTM service delivery, provider communication. • Documented and reported Enhanced MTM services.
Eliza Corporation	• Used interactive voice response (IVR), email, and text to send medication adherence reminders to beneficiaries.
RR Donnelly	• Developed and distributed a quarterly education newsletter to Enhanced MTM–eligible beneficiaries.
Healthwise	• Provided clinical content for WellCare website.
Medkeeper	• Maintained MTMExchange, a documentation system used for Enhanced MTM services by WellCare and University of Florida.
Audacious Inquiry	• Florida Health Information Exchange (HIE) vendor. • Provided daily data feeds for the Hospital Discharge intervention.

[a] Served as one of WellCare's Enhanced MTM partners between Model Years 1 and 3. Mirixa Corporation was acquired by Cardinal Health in 2019 and integrated into OutcomesMTM.
[b] Added at the beginning of Model Year 4 following the acquisition of Mirixa Corporation.

A.5.3 Enhanced MTM Interventions

As shown in Table A.5.2, WellCare launched four Enhanced MTM interventions in Q1 of Model Year 1: (i) medication adherence; (ii) opioid utilization; (iii) high drug utilization, and (iv) select DTPs. In Q3 of Model Year 3 (July 2019), WellCare discontinued the select DTPs intervention, after internal analyses revealed that Enhanced MTM services for the individual DTPs addressed by the intervention either produced no medical savings or the cost to provide services did not offset any savings. WellCare's other three Enhanced MTM interventions that were implemented at the start of the Model continued through the end of the Model. In Q1 of Model Year 3, WellCare added a transitions-of-care intervention (Hospital Discharge) for beneficiaries residing in Florida who were discharged after an inpatient hospital admission. In Q1 of Model Year 4, WellCare expanded this intervention to include beneficiaries residing in Arizona.

Table A.5.2: WellCare Enhanced MTM Intervention Implementation Milestones

	Model Year 1 (2017)				Model Year 2 (2018)				Model Year 3 (2019)				Model Year 4 (2020)				Model Year 5 (2021)			
Enhanced MTM Intervention	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Medication Adherence	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Opioid Utilization	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
High Utilizer	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Select Drug Therapy Problems	■	■	■	■	■	■	■	■	■	■										
Hospital Discharge									■	■	■	■	■	■	■	■	■	■	■	■

■ Intervention active in quarter

Enhanced MTM Intervention Targeting

Table A.5.3 provides an overview of WellCare's targeting processes for its Enhanced MTM interventions.

Table A.5.3: WellCare Enhanced MTM Intervention Targeting Overview

Enhanced MTM Intervention	Relevant Targeting Categories[a]	Targeting Process	Data Source
Medication Adherence	• Med Use ○ DTP • Conditions	Identified beneficiaries who were or who were likely to become non-adherent to medication classes used for CMS Star measures (statins, renin-angiotensin system antagonists, and oral anti-diabetics), anti-retroviral medications,[b] calcium channel blockers, and beta blockers.[c]	Parts A, B, and D
Opioid Utilization	• Med Use ○ Opioid	Identified beneficiaries who were or were potentially at risk for opioid abuse and/or overdose.	Part D
Select Drug Therapy Problems[d]	• Med Use ○ DTP	Identified beneficiaries who had one or more select drug therapy problems.	Part D
High Utilizer	• Conditions • Med Use ○ Number of Meds	Identified beneficiaries who were taking multiple medications and who had certain chronic conditions.	Parts A, B, and D
Hospital Discharge	• Transitions	Identified beneficiaries residing in Florida and Arizona[e] who were recently discharged from an inpatient hospital admission.	HIE

[a] Med Use: targeting based on medication utilization; DTP (drug therapy problem): Med Use sub-category related to medication adherence issues, adverse drug reactions/interactions, gaps in care (i.e., needing additional drug therapy), dosage issues, and/or unnecessary or inappropriate drug therapy; Conditions: targeting based on the presence of one or more chronic conditions; Opioid: Med Use sub-category related to opioid use or misuse; Number of Meds: Med Use sub-category related to beneficiaries who were prescribed a certain number of medications.

[b] WellCare discontinued targeting for anti-retroviral medications midway through Model Year 3 (July 2019) because internal data showed targeting beneficiaries based on this drug class did not produce medical savings.

[c] WellCare began targeting beneficiaries taking calcium channel blockers and beta blockers for its Medication Adherence intervention at the beginning of Model Year 3 (2019) after internal analyses showed improving adherence to these medications represented an opportunity for increasing medical savings.

[d] WellCare discontinued this intervention halfway through Model Year 3 (2019).

[e] WellCare began targeting beneficiaries residing in Florida at the beginning of Model Year 3 (2019) and beneficiaries residing in Arizona at the beginning of Model Year 4 (2020).

Enhanced MTM Services

Table A.5.4 provides an overview of WellCare's tailored, beneficiary-specific Enhanced MTM services for each of its Enhanced MTM interventions. The combination and content of WellCare's services varied by intervention and beneficiary needs. In addition to the services described in Table A.5.4, WellCare also provided beneficiaries with educational materials, including a quarterly newsletter and online resources, and offered a "HealthLine Hotline," which was promoted in beneficiary outreach and education materials and allowed beneficiaries to initiate contact regarding medication questions or concerns.

Table A.5.4: WellCare Enhanced MTM Service Overview

Enhanced MTM Intervention	Significant Service Categories[a]	Level of Intensity[b]	Service Frequency	Service Description
Medication Adherence[c]	• CMR	High	Recurrent	• **Comprehensive Medication Review (CMR):** Collected beneficiary-specific health and medication information, including lifestyle/behavioral factors; assessed medication therapies to identify medication-related problems (MRPs); and developed a prioritized list of MRPs to resolve with the beneficiary, caregiver, and/or prescriber. • **Quarterly Reviews:** Follow-up medication reviews for beneficiaries who received a CMR.
	• Medication adherence (pharmacist)	High	One-time	• **Targeted System-Generated Review:** Involved a phone conversation with the beneficiary to discuss reasons for adherence or potential non-adherence.
	• Medication adherence (automated)	Low	One-time	• **Interactive Voice Response (IVR):** Used automated calls, text, or email to provide refill reminders or other medication adherence services.
Opioid Utilization	• TMR (prescriber)	Low	Recurrent	• **Targeted System-Generated Review:** Involved prescriber communication to address opioid medication-related issues.
Select Drug Therapy Problems[d]	• TMR (prescriber)	Low	Recurrent	• **Targeted System-Generated Review:** Involved prescriber communication to address specific, pre-identified medication-related issues. The beneficiary was not typically involved in this service.
High Utilizer	• CMR	High	Recurrent	• **CMR:** Entailed comprehensive review of health and medications (described above). • **Quarterly Reviews:** Follow-up reviews (described above).
Hospital Discharge	• Transitions of Care (CMR)	High	Recurrent	• **CMR:** Entailed comprehensive review of health and medications (described above). • **Quarterly Reviews:** Follow-up reviews (described above).

[a] "Significant services" were services for a given sponsor intervention that were not initial outreach or non-tailored education. There were 12 significant service categories used across sponsors. See Table B.6.3 of Appendix B for a full list and definitions of these significant service categories.

[b] High-intensity services involved interactive discussions between a beneficiary and an Enhanced MTM provider (often a pharmacist). Low-intensity services did not involve the beneficiary directly (i.e., services that were directed to the prescriber only) or involved only one-way sharing of information with the beneficiary (e.g., vaccine reminders or IVR).

[c] Beneficiaries targeted for the Medication Adherence intervention who were considered high priority may have received any of the three service categories listed above, beneficiaries who were considered moderate priority may have received the Medication adherence (pharmacist) or Medication adherence (automated) service categories, and beneficiaries who were considered low priority may have received the Medication adherence (automated) service category only.

[d] No beneficiaries who were newly eligible for the Select Drug Therapy Problems intervention were recommended to receive a service after the intervention was discontinued in July 2019. Beneficiaries who qualified for the intervention prior to July 2019 may have received the service subsequent to the intervention's discontinuation.

A.5.4 Outreach Strategy

Table A.5.5 describes WellCare's approach to beneficiary and prescriber outreach.

Table A.5.5: WellCare Outreach Strategy Overview

Outreach Categories	WellCare Approach

Beneficiary Outreach	• WellCare used a combination of call center and community pharmacies to conduct beneficiary outreach.
	• All eligible beneficiaries received enrollment outreach by telephone to notify them that they may be contacted to receive Enhanced MTM services, followed by a mailed welcome letter to explain the Enhanced MTM Model and introduce the vendors that may be contacting them.
	  o Eligible beneficiaries who were targeted to receive Enhanced MTM services may have received additional outreach by phone, in person, or via interactive voice response (IVR), depending on the intervention and services for which they were targeted.
	  o Beneficiaries targeted for the Hospital Discharge intervention, who were not already eligible for other WellCare Enhanced MTM interventions, may have received outreach to complete the Transitions of Care (CMR) service before receiving enrollment outreach.
	• Outreach was coordinated for beneficiaries who were targeted for multiple interventions to not overburden beneficiaries with multiple, overlapping contact attempts.
	• Quarterly educational newsletters containing general medication, health, and lifestyle information were sent to all Enhanced MTM-eligible beneficiaries.

Prescriber Outreach	• Prescriber outreach occurred after an Enhanced MTM service. • After a CMR, prescribers received a copy of the beneficiary's personalized medication list by fax to ensure prescribers were aware of beneficiaries' current medication regimens. • Recommendations to the prescriber for medication changes were prioritized based on the severity of the issue the recommendation addressed. • Pharmacists also considered the severity of the drug therapy problem (DTP) when deciding how to contact the prescriber to address the DTP (i.e., by fax, mail, or phone).

A.6 Blue Cross Blue Shield of Florida

By the end of the Model, Blue Cross Blue Shield of Florida (BCBS FL) offered 10 Enhanced MTM interventions. The Enhanced MTM interventions used a combination of data from Medicare Parts A, B, and D claims and data from Florida's health information exchange (HIE) to target beneficiaries for services. While the types of services offered in the various interventions were similar, the focus areas of the services varied. Information in this appendix reflects BCBS FL's Enhanced MTM interventions as of the end of the Model.

A.6.1 Sponsor Overview

Region(s): 11 (FL)
Plan Benefit Package(s): S5904-001
Number of PDP Enrollees:
- Model Year 1: 64,630
- Model Year 2: 60,857
- Model Year 3: 55,976
- Model Year 4: 55,885
- Model Year 5: 52,446

Number of Enhanced MTM-Eligible Beneficiaries:
- Model Year 1: 35,021 (54.2% of Model Year 1 enrollment)
- Model Year 2: 22,733 (37.4% of Model Year 2 enrollment)
- Model Year 3: 29,221 (52.2% of Model Year 3 enrollment)
- Model Year 4: 28,582 (51.1% of Model Year 4 enrollment)
- Model Year 5: 29,685 (56.6% of Model Year 5 enrollment)

Sources: MARx and CME.
Notes: PDP enrollment only included Enhanced MTM-participating contract plans. Enhanced MTM eligibility was conditional on enrollment in the participating PDP in the CME.

A.6.2 Participating Organizations

Table A.6.1 lists BCBS FL's partners and their roles in Enhanced MTM implementation.

Table A.6.1: BCBS FL Enhanced MTM Partnerships

Organization	Role in BCBS FL's Enhanced MTM Implementation
BCBS FL	• Enhanced MTM sponsor organization, oversaw Enhanced MTM implementation.
Genoa Medication Management Systems (GMMS)	• Conducted Enhanced MTM intervention targeting and provided Enhanced MTM clinical services and outreach.
OutcomesMTM[a]	• Provided Enhanced MTM clinical services and outreach.
OneCall[a]	• Provided transportation services to qualifying beneficiaries in need of support to pick up prescriptions from the pharmacy.
GuideWell Connect[b]	• Conducted prescriber outreach. • Subsidiary of GuideWell Mutual Holding Corporation, which also owns BCBS FL.
Availity	• A real-time information network connected to the state health information exchange (HIE), used by BCBS FL and GMMS to support targeting efforts and services, and facilitate provider referrals for Enhanced MTM services.
Prime Therapeutics	• Served as BCBS FL's pharmacy benefits manager (PBM), managed the co-pay waivers.
RxAnte	• Provided predictive analytics for medication adherence targeting from late Model Year 1 (2017) to mid-Model Year 2 (2018).
CSS Health[c]	• Provided services for the End-Stage Renal Disease (ESRD) Prevention intervention to help members resolve issues related to provider appointments, nutrition, medications, and other chronic kidney disease (CKD)-related care.

[a] Added in Model Year 4 (2020).
[b] Added in Model Year 3 (2019).
[c] Added in Model Year 5 (2021).

A.6.3 Enhanced MTM Interventions

As shown in Table A.6.2, BCBS FL increased the number of its Enhanced MTM interventions over the course of the Model. In Model Year 1, BCBS FL launched six Enhanced MTM interventions, five of which continued throughout the entire Model. In Model Year 2, BCBS FL added two new Enhanced MTM interventions and two transitions-of-care sub-interventions (the Transitions of Care Expansion intervention and Community-Based Hospital Readmission intervention).[8] In Model Year 3, BCBS FL added one new intervention focused on behavioral health.

In Model Year 4, BCBS FL discontinued the Specialty Drug Program intervention, noting that it did not significantly alter beneficiaries' medications, health, and cost of care. In Model Year 5, BCBS FL launched two new interventions focused on chronic conditions. The ESRD Prevention intervention focused on medication management and care coordination for patients with CKD Stages 1-3. The Congestive Heart Failure (CHF) Exacerbation intervention monitored beneficiaries with CHF for weight gain and coordinated with a provider if a diuretic medication was needed.

Table A.6.2: BCBS FL Enhanced MTM Intervention Implementation Milestones

	Model Year 1 (2017)				Model Year 2 (2018)				Model Year 3 (2019)				Model Year 4 (2020)				Model Year 5 (2021)			
Enhanced MTM Intervention	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Hospital Prevention	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Diabetes Plus 3	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Anticoagulant	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Transitions of Care	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Medication Adherence	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Specialty Drug	■	■	■	■	■	■	■	■	■	■	■	■								
Continuity of Care					■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Statin Use in Persons with Diabetes							■	■	■	■	■	■	■	■	■	■	■	■	■	■
Behavioral Health										■	■	■	■	■	■	■	■	■	■	■
End-Stage Renal Disease																		■	■	■
Congestive Heart Failure																		■	■	■

■ Intervention active in quarter

[8] The transitions-of-care intervention encompassed three smaller sub-interventions: (i) the Transitions of Care intervention, which included beneficiaries contacted within 7 days of discharge; (ii) the Transitions of Care Expansion intervention, which included beneficiaries contacted between 8 and 30 days of discharge; and (iii) the Community-Based Hospital Readmission intervention, which provided in-home services to beneficiaries residing in specific Florida counties. The first intervention was launched in Model Year 1, and the latter two in Model Year 2. In Model Year 4, BCBS FL suspended the Community-Based Hospital Readmission sub-intervention due to the COVID-19 public health emergency (PHE).

Enhanced MTM Intervention Targeting

Table A.6.3 provides an overview of BCBS FL's targeting processes for its Enhanced MTM interventions.

Table A.6.3: BCBS FL Enhanced MTM Intervention Targeting Overview

Enhanced MTM Intervention	Relevant Targeting Categories[a]	Targeting Process	Data Source
Hospital Prevention	• High Costs • Conditions	Included beneficiaries with a serious chronic condition, high expenditures, and a high risk score.[b]	Parts A, B, and D
Diabetes Plus 3	• Conditions	Included beneficiaries with diabetes and at least three other chronic conditions, and a high risk score.[b]	Parts A, B, and D
Anticoagulant	• Med Use ○ New Med	Included beneficiaries with a new anticoagulant prescription and a high risk score.[b]	Part D
Specialty Drug	• Med Use ○ New Med • Conditions	Included beneficiaries who had specialty drug prescriptions for select chronic conditions.[c]	Part D
Transitions of Care	• Transitions	Included any beneficiaries contacted within 30 days of a recent inpatient stay or emergency department (ED) visit for a chronic condition or recent inpatient hospitalization.[d]	HIE
Medication Adherence	• Med Use ○ DTP	Identified beneficiaries who were likely to become non-adherent to drugs included in Medicare Star Ratings adherence measures.[e]	Part D
Continuity of Care	• Med Use ○ DTP ○ New Med • Conditions • High Costs	Included beneficiaries with a high risk score who were targeted to receive an Annual Medical Review (AMR) in the previous Model Year, but who no longer qualified in the current Model Year.[f]	Parts A, B, and D
Statin Use in Persons with Diabetes	• Med Use ○ DTP ○ Number of Meds • Conditions	Included beneficiaries who qualified for the CMS Star Ratings Statin Use in Persons with Diabetes measure.	Part D
Behavioral Health	• Med Use ○ Number of Meds • Conditions	Included beneficiaries with certain behavioral health conditions who took multiple medications and had a high risk score.[f]	Parts A, B, and D
ESRD Prevention	• Conditions	Included beneficiaries with CKD Stages 1, 2, and 4.	Parts A and B
CHF Exacerbation	• Conditions	Included beneficiaries with CHF.	Parts A, B, and D

[a] High Costs: targeting based on high Medicare Parts A, B, and/or D costs; Conditions: targeting based on the presence of one or more chronic conditions; Med Use: targeting based on medication utilization; New Med: targeting based on newly prescribed medications; Transitions: targeting beneficiaries who experienced a recent discharge from the hospital; DTP: targeting based on medication adherence issues, adverse drug reactions/interactions, gaps in care, dosage issues, and/or unnecessary or inappropriate drug therapy; Number of Meds: targeting based on a certain number of medications.

[b] Risk score added to targeting criteria in Model Year 3.

[c] In Model Year 1, the Specialty Drug intervention targeted beneficiaries who had any new specialty drug prescriptions. In Model Year 2, BCBS FL limited the targeting criteria to beneficiaries who took specialty drugs for certain chronic conditions. In Model Year 4, BCBS FL discontinued the Specialty Drug intervention.
[d] In Model Year 1, the Transitions of Care intervention targeted beneficiaries with a recent inpatient hospitalization. In Model Year 2, BCBS FL also included beneficiaries who had a recent ED visit.
[e] For all Model Years, BCBS FL used a retrospective targeting approach for its Medication Adherence intervention. In the first half of Model Year 2, BCBS FL also used predictive targeting for this intervention.
[f] Risk score added to targeting criteria in Model Year 4.

Enhanced MTM Services

Table A.6.4 provides an overview of BCBS FL's tailored, beneficiary-specific Enhanced MTM services for each of its interventions. Depending on intervention eligibility and beneficiary needs, BCBS FL varied the combination and content of services provided. The number and length of the services varied by intervention and were based on pharmacists' clinical discretion. In addition to the services described in Table A.6.4, BCBS FL operated a call-in line ("Ask the Pharmacist") for beneficiaries to contact with medication-related questions or concerns. If a potential medication issue was identified when a beneficiary called in, the beneficiary was eligible to receive a TMR ("Medication Review on Demand").

Table A.6.4: BCBS FL Enhanced MTM Service Overview

Enhanced MTM Intervention	Significant Service Categories[a]	Level of Intensity[b]	Service Frequency	Service Description
Hospital Prevention, Diabetes Plus 3, Anticoagulant, Behavioral Health, and Specialty Drug[c]	• CMR • Cost/social support	High	Recurrent	• **Annual Medication Review (AMR):** BCBS FL's CMR that included a pharmacist review of each medication to determine that it was appropriate for the beneficiary, effective for the medical condition, safe given co-morbidities and other medications being taken, and could be taken as intended. • **Follow-up medication reviews (FMRs):** Brief follow-up evaluations with a pharmacist. • **Adherence barrier assessment:** Investigated and addressed the reasons a beneficiary was non-adherent to medication classes used for CMS Star measures. • **Transportation:** BCBS FL arranged no-cost transportation (via taxi or a similar service) for beneficiaries who required transportation assistance to pick up their prescription medications.[d] • **Co-pay waivers:** ○ **Beneficiary Incentives:** Co-pay discounts for eligible beneficiaries who initially declined to participate in Enhanced MTM services and/or were difficult to reach. ○ **Cost-share reductions:** No co-pay for certain generic medications for beneficiaries who stated that cost was a barrier to medication adherence during a pharmacist encounter.
Transitions of Care	• Transitions of care (CMR) • Cost/social support	High	Recurrent	• **In-home visit:** An in-home AMR, completed by a pharmacist for beneficiaries with high costs or recent emergency department (ED) visits residing in specific Florida counties.[e] • **AMR:** A telephonic AMR for beneficiaries who were either ineligible or who opted out of receiving an in-home visit. • **FMRs:** Follow-up reviews (described above). • **Transportation:** Transportation assistance (described above). • **Co-pay waivers:** Discounted or eliminated co-pays (described above).
	• Transitions of care (prescriber)	Low	One-time	• **TMR:** Involved a prescriber-facing TMR for beneficiaries eligible for the Transitions of Care intervention but unresponsive to outreach attempts or unreachable.

Enhanced MTM Intervention	Significant Service Categories[a]	Level of Intensity[b]	Service Frequency	Service Description
Medication Adherence	• Medication adherence (pharmacist) • Cost/social support	High	One-time	• **Adherence barrier assessment and prevention:** Consisted of a consultation between a pharmacist and beneficiary, the focus of which varied depending on the targeting approach described below. ○ Predictive – focused on patient education and self-efficacy for medication adherence. ○ Retrospective – investigated and addressed why patients became non-adherent. • **Co-pay waivers:** Discounted or eliminated co-pays (described above).
Continuity of Care	• CMR • Cost/social support	High	One-time	• **FMRs:** Follow-up reviews (described above). • **Co-pay waivers:** Discounted or eliminated co-pays (described above).
Statin Use in Persons with Diabetes	• TMR (beneficiary)	High	One-time	• **TMR:** Involved calling or sending a letter to a beneficiary if their provider was unresponsive to outreach attempts recommending a statin be prescribed.
	• TMR (prescriber)	Low	One-time	• **TMR:** Involved a pharmacist sending a letter to a beneficiary's provider to recommend prescribing a statin if one was not already prescribed.
ESRD Prevention[f]	• CMR • Case/disease management	High	Recurrent	• **AMR:** A telephonic AMR focused on management of diabetes and hypertension medications, medications that may negatively affect kidney function, and nutrition education. • **FMRs:** Follow-up reviews (described above). • **Case management:** Provided additional support for issues related to provider appointments, nutrition, medications, and other CKD-related care.
CHF Exacerbation[f]	• Case/disease management	High	Recurrent	• **Weight monitoring:** Beneficiaries monitored their weight using a Bluetooth-enabled scale that fed to a vendor for monitoring. If the beneficiary's weight was out of range, a non-clinical representative contacted the beneficiary to validate the weight reading. If the weight was valid, the representative would coordinate next steps with the beneficiary's physician, including prescribing diuretics as necessary.

[a] "Significant services" were services for a given sponsor intervention that were not initial outreach or non-tailored education. There were 12 significant service categories used across sponsors. See Table B.6.3 of Appendix B for a full list and definitions of these significant service categories. CMR: Comprehensive Medication Review; TMR: Targeted Medication Review.

[b] High-intensity services involved interactive discussions between a beneficiary and an Enhanced MTM provider (often a pharmacist). Low-intensity services did not involve the beneficiary directly (i.e., services that were directed to the prescriber only) or involved only one-way sharing of information with the beneficiary (e.g., vaccine reminders or IVR).

[c] The Specialty Drug intervention was discontinued in Model Year 4.

[d] Added in Model Year 4.

[e] In-home transitions-of-care services were suspended in Model Year 4 due to the COVID-19 PHE.

[f] Added in Model Year 5.

A.6.4 Outreach Strategy

Table A.6.5 describes BCBS FL's approach to beneficiary and prescriber outreach.

Table A.6.5: BCBS FL Outreach Strategy Overview

Outreach Categories	BCBS FL Approach
Beneficiary Outreach	• All beneficiaries were mailed a welcome packet with information about Enhanced MTM and a call-in number. • Beneficiaries who qualified for one or more of BCBS FL's beneficiary-facing interventions received telephonic outreach, unless otherwise noted.[a] Beneficiaries who qualified for the Statin Use in Persons with Diabetes intervention may also have received targeted mailings. Beneficiaries in the Transitions of Care Community-Based Hospital Readmission intervention received an in-home service if they resided in Florida and agreed to participate.[b] After an Annual Medication Review (a CMR service), patients were mailed a Medication Action Plan that included pharmacist recommendations and a Personal Medication List.
Prescriber Outreach	• Prescriber communication occurred primarily through a provider portal and by fax. Pharmacists called prescribers, if necessary, during Enhanced MTM service delivery. • When pharmacists recommended medication changes as a result of very-high-risk or high-risk beneficiaries' Enhanced MTM service, their prescribers received Provider Medication Action Plans (PMAPs), which listed the recommended medication changes. Prescribers also received instructions for responding to the PMAP. • If a moderate-risk beneficiary declined an Enhanced MTM service, the prescriber was sent proof of medication non-adherence. • As part of the Statin Use in Persons with Diabetes intervention, prescribers were sent a letter with pharmacist recommendations if a patient had diabetes but was not prescribed a statin medication. • BCBS FL encouraged prescribers to participate in the Enhanced MTM Model and provided instructions for beneficiary referral through presentations at Florida health care organizations and relevant conferences.

[a] BCBS FL planned to offer in-person community pharmacy services in Model Year 4; however, these services were not implemented due to the COVID-19 PHE. Community pharmacists instead delivered services telephonically in Model Year 4.
[b] In-home transitions-of-care services were suspended in Model Year 4 due to the COVID-19 PHE.