MANAGED CARE OUTLOOK

The Insider's Business Briefing on Managed Healthcare

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At Presstime

PCORI Issues New Calls for Research Proposals

The Patient-Centered Outcomes Research Institute (PCORI) has released a series of funding announcements offering up to $76 million in support for patient-centered comparative clinical effectiveness research (CER) projects under PCORI's five broad National Priorities for Research.

In releasing this latest round of PCORI Funding Announcements (PFAs), PCORI has further streamlined its application process based on applicant feedback, offering more guidance on research areas and topics of greatest interest. Furthermore, more support is available under two of the PFAs: a maximum of $5 million in direct costs through the Improving Healthcare Systems announcement and $1.5 million under the Improving Methods for Conducting Patient-Centered Outcomes Research PFA.

Beginning with this funding round, all Letters of Intent (LOIs) for proposals, due Friday, September 5, will be "competitive," meaning they will be screened for their responsiveness to the announcement and how well they fit program goals. PCORI staff will notify researchers whether they are invited to submit full applications by Friday, September 19.

More information is available at www.pcori.org. ■

Wolters Kluwer
Law & Business

The Value of Transparency in Health Care Quality Performance

Rand Hager

When health plans or managed care organizations submit quality measures to the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), a state, or other entity, there are complex processes, assumptions, decisions, and equations that go into producing each individual result. Transparency into these multifaceted calculations is becoming more important for quality managers in the managed care environment. Since 1999,[1] certified auditors have been drilling down on insurers' HEDIS® submissions to confirm their validity and accuracy. Now, other oversight organizations are increasingly requiring similar reviews and validations, and this is a beneficial trend.

(See The Value of Transparency… page 3)

Inefficient Communication Methods Cost the Average U.S. Hospital Nearly $2 Million Annually

Inefficient communication during critical clinical workflows costs the average U.S. hospital about $1.75 million annually, according to a new report from Imprivata® and the Ponemon Institute. Titled "The Imprivata Report on the Economic Impact of Inefficient Communications in Healthcare," the report finds that a significant amount of time is wasted during these workflows — primarily due to the inefficiency of pagers and the lack of adoption of secure text messaging. The report also finds that the use of secure text messaging could reclaim more than half of this wasted time and minimize the economic loss.

The "Imprivata Report on the Economic Impact of Inefficient Communications in Healthcare" surveyed more than 400 health care providers in the United States to identify areas of

(See Inefficient Communication… page 8)

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National Briefs

Report Shows Residents of Rural States Face More Challenges with Insurance: A report from the University of Pennsylvania and the Robert Wood Johnson Foundation shows that people living in mostly rural states have access to fewer insurance plans and face higher average monthly premium costs compared to the rest of the country. Even within many states, urban and rural premiums differ by a wide margin. The report finds that nationally, on average, the second-lowest Silver plan premium for a 50-year-old nonsmoker is $369 in the nation's urban counties and $387 in rural counties. Despite the merely slight difference in average premiums across the nation, there is a high level of variation from state to state. In states where 50 percent or more of those eligible to enroll in exchanges live in rural counties, the average premium cost of the second-lowest Silver plan for a 50-year-old nonsmoker is $452; it's just $402 in states where less than 5 percent of those eligible live in rural counties. The report also finds that, on average, people living in largely rural states have fewer plan options.

Study Shows Consumer Transparency on MRI Costs Saved $220 per Test in Overall Costs, Increased Competition: Consumers who chose less expensive MRIs after receiving price information helped save $220 per test in total health system costs, according to a recent study. The study also showed that this awareness was linked to a shift in consumer behavior, decreasing the use of high-cost hospital-based MRIs, and ultimately reducing price variation between hospital and non-hospital facilities for consumers. The $220 in savings represents a combination of consumer out-of-pocket expenses and health plan or employer medical costs. The study, commissioned by WellPoint subsidiary, AIM Specialty Health, and conducted by WellPoint health outcomes subsidiary, HealthCore Inc., reviewed data from about 100,000 members in WellPoint affiliated health plans in the Northeast, Midwest, and Southeast from 2010 to 2012. For more information, go to www.wellpoint.com.

AHA Launches New Social Platform to Connect Health Care Professionals: A new social platform created exclusively for the health care field debuted recently at the AHA-Health Forum Leadership Summit. Designed to connect health care professionals with each other and the vendors who serve them, AHA SmartMarket™ is an interactive marketplace where health care professionals can search products and services, rate and review product performance, and collaborate with a network of trusted peers and experts. Developed with input from health professional leaders and the vendor experts that serve the complex health care field, users of AHA SmartMarket can find solutions for challenges unique to the health care field; compare products side by side; rate and review products/services that have worked effectively for the user's organization and access ratings and reviews from trusted connections in the user's network; and join discussion groups to share successes achieved and efficiencies gained. ■

The Value of Transparency...

(from p. 1)

In one state-specific example, plans participating in the California Pay for Performance (P4P) program must document a substantial audit trail and process for each submitted measure by following a ROADMAP (Record of Administration, Data Management, and Processes), very similar to HEDIS. The black box calculations that were once a way of doing business in quality measure reporting are on their way out. As a result, our industry's improved precision is helping health plans and their provider networks achieve real progress on HEDIS measures, Medicare Star ratings, and other industry report cards.

Whether you work in a health plan or a provider setting, you have certainly contributed to measuring the quality of health care delivery. My introduction into health care quality began when I started a job as a software developer with an emerging health care analytics firm that was developing a HEDIS engine. Our firm's customers were health plans, and our solution supported quality managers during their annual NCQA HEDIS event by helping them collect hybrid data, calculate measures, and support the audit process. Seven months later when we finished the project, I was sleep-deprived, hated the IPU (Inpatient Utilization) measure, and felt anxiety about the idea of working with contracted HEDIS auditors. Nevertheless, I had also developed a budding appreciation for the complex nature of measuring health care quality. I saw how vital it was for managed care organizations, quality vendors, auditors, and NCQA to have good, reliable data. I concluded the pain was worth the gain.

Now, when we examine the current medical quality performance data landscape, we see NCQA, CMS, individual states, and employers holding health plans to ever-higher quality standards. In addition, insurers' revenues are increasingly tied to the outcomes of quality programs. Subsequently, measuring health care quality has become even more demanding and complex. Because of this growing intricacy and the underlying need to understand how delivery affects quality, transparency into these processes and calculations of quality programs is shifting. Some accreditation bodies, regulators, and purchasers say that documenting these measures is *important* while others have made transparency a *requirement.*

Transparency Relationship Triangle

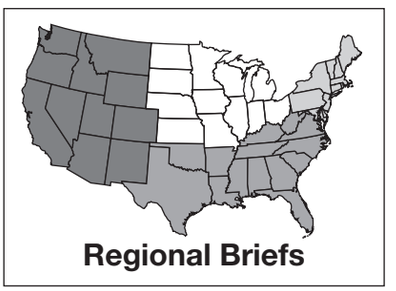
Usually, three principal parties are involved in submitting an insurer's data to NCQA:

- the health plan;
- a quality vendor that collects, organizes, and submits HEDIS data on the health plan's behalf; and
- the certified auditor that validates the calculated data.

Quality managers within health plans rely heavily on the expertise of their quality vendor to manage a valid data collection and results calculation process. Inherently, the vendors know the mechanisms of these processes better than the health plans, because it is their core competency. Nevertheless, quality managers should have transparent access to all of that detail. After all, the health plans, not the quality vendors, are accountable for the submitted results. Moreover, the health plan is also responsible to answer NCQA-certified auditors about the details of their calculations. This dependency on the quality vendor can result in long wait time between when the auditors request information and when the quality vendors can prioritize, process, and finally deliver the results. Even with the most responsive quality vendors, this process takes precious time.

However, in the new cutting-edge, transparent environment, the quality vendors should preemptively provide health plans with tools to access not only the results but also information about the processes and calculations used to produce those results. Consequently, health plans with access to this transparent data can respond quickly to their auditors' queries. Instead, the auditors see the whole data

(See The Value of Transparency… page 5)



Northeast

Independence Blue Cross Partners with Philadelphia University on Certificate Program: When it launched its Center for Health Care Innovation in February, Independence Blue Cross said the Center would serve as a place where the company's associates and external partners could innovate, collaborate, learn, and implement path-finding new concepts in health care. As part of that broad initiative, Independence has now partnered with Philadelphia University on a pilot program called "A Primer on Innovation," a four-week customized leadership program designed to introduce Independence leaders to the principles and practices of innovation using Philadelphia University's signature methods of active, collaborative, and real-world learning. Upon finishing the program, Independence associates will receive a certificate in innovation. The coursework that's part of "A Primer on Innovation" can also be applied toward other design programs at Philadelphia University, including the Strategic Design MBA program.

New Study Reveals Health Crisis in Bronx Prison Re-Entry Populations: More than 58 percent of parolees and those released from prison who are sent to the Bronx from New York State prisons have major chronic conditions, including substance abuse and mental issues, AIDS, and hepatitis C, according to a new study by Health People: Community Preventive Health Institute. The study, "Health Gaps Survey of Bronx Re-Entry Populations," also found that, despite state policy that says prison releases should return to the area where they lived prior to prison, 38 percent of those surveyed who had been sent to the Bronx by the New York State Department of Corrections and Community Supervision said they had never lived in the Bronx. The study also documented major barriers to re-entry populations receiving appropriate care. For example, 58 percent said they did not have a Medicaid card on leaving prison, and almost two-thirds (64 percent) were not given a basic package of their medical records.

Midwest

UnityPoint Health Partners, UnitedHealthcare Collaborate in Iowa: UnityPoint Health Partners and UnitedHealthcare are collaborating to provide coordinated health care aimed at improving care quality and reducing costs for residents enrolled in UnitedHealthcare's employer-sponsored health plans in Cedar Rapids, Des Moines, Dubuque, Fort Dodge, Waterloo, and the Quad Cities. This new accountable care organization (ACO) between UnityPoint Health Partners and UnitedHealthcare seeks to help shift Iowa's health care system from one based on volume of care to one that rewards quality and value. UnityPoint Health Partners' network of physicians will manage all aspects of the patients' care.

South

BCBS of Louisiana Launches Quality Blue Value Partnerships to Engage More Providers: As the health insurance industry increasingly rewards providers for delivering higher value care, the industry is naturally shifting from the traditional fee-for-service model, which rewards volume and can be duplicative or medically unnecessary, toward care that adds value and is cost effective. That is the principle behind Blue Cross and Blue Shield of Louisiana's Quality Blue family of programs. In these programs, Blue Cross collaborates with providers in its networks to bring value by improving patients' health outcomes and keeping health care costs in line. Building on the success of existing Quality Blue programs, most notably Quality Blue Primary Care, Blue Cross is rolling out a new program to continue the transformation to value-based care. Quality Blue Value Partnerships launched in July, with five large provider systems currently enrolled: Baton Rouge Clinic, Baton Rouge General Physicians

Group, Gulf States Quality Network, Ochsner Health System, and West Calcasieu Virtual Medical Home. For more information about the Blue Cross Quality Blue programs, go to www.bcbsla.com/Providers/Pages/QualityBlue.aspx.

West

Blue Shield of California Provides 2% Pledge Funding to Support Statewide, Next Gen HIE: Blue Shield of California has provided $35.6 million in funding from its 2% Pledge program to create the California Integrated Data Exchange (Cal INDEX) and support it for its first three years of operation. Cal INDEX is an independent, not-for-profit organization that is developing a statewide, next-generation health information exchange (HIE). This comprehensive collection of electronic patient records will include clinical data from health care providers and health insurers. In addition to Blue Shield of California, Anthem Blue Cross is also providing funding for Cal INDEX's operating costs over the next three years. After three years, participating providers and insurers will provide revenue to Cal INDEX through subscription fees. ■

The Value of Transparency...

(from p. 3)

aggregation processes right then and there. This streamlined process saves tremendous time, which the quality manager can direct toward other challenges and responsibilities.

The Transparency Story

Transparency, in its most basic and useful form, is direct access to the list of the services used to calculate a quality metric. The data subsets should include administrative claims, pharmacy data, lab results, vision exam findings, information gathered from the chart review process, electronic medical record (EMR) data, and any other data sources allowed by the quality program. Having access to just these subsets can be very helpful in many ways, including:

- building the picture of why a member was included in a measurement;
- creating an opportunity to validate the calculations, which in turn builds trust in the vendor; and
- providing readily available information for an audit.

Having transparency into these data sets available not only builds trust between the auditor and the vendor, but it also allows the auditor to validate on his or her schedule instead of waiting on the results of a request for more information from the vendor. When the auditor is happy, everyone is happy.

Transparency, in its greatest form, tells a data story-of-care. There are two parts to this story. First, encounter-related data describes care that members receive. It portrays why some members are compliant for a particular measure and why others are not. It provides an indication of where more information can be found and the timeframe for when members might need additional services to be compliant in the future. The second part of the story, the explanatory data, focuses on cataloging and describing the data itself. In the explanatory data, we can see clues as to the relevance and quality of each data source and how it impacts a member's rate.

For quality managers to gain that necessary level of transparency to tell the story-of-care, there are several elements they should require of the quality vendor to certify the validity of the data and make it easy to satisfy auditors. They are:

- the member's demographics, such as age, gender, applicable health plan;
- an indication of the member's eligibility as it relates to each metric;
- the provider that delivered and/or managed the member's care;
- the basic list of services used in the quality calculation, as described earlier;

- details about each service: what the service was, who performed it, when it was performed, any measurement or result of the service, and how it applies to the metric;
- an indication of which service or services are representative of the actual compliance; using the most recent service is what helps determine when the next service might need to occur;
- a description of where the service information originated, such as the name of the lab vendor or details about the medical record abstraction; and
- a description of the type of service information, such as claim, lab, pharmacy, etc.

Insight from Measuring Impact

Explanatory data is not only an essential part of transparency; some of it is now a requirement. This past measurement year, 2013, NCQA implemented a new Supplemental Data Impact Reporting requirement for its HEDIS program and a Measure Impact Reporting requirement for its California P4P program. These requirements oblige health plans and their quality vendors to provide analytics describing how various data sources impact each rate.

Many managed care organizations, however, found it difficult to comply. "There are health plans and vendors out there who weren't able to deliver on impact reporting for HEDIS this year, because they weren't ready," explained David Oliver, an ADVantis Solutions Engineer at ADVantis, a subsidiary of the Indianapolis-based health plan Advantage Health Solutions. "But, next year, they're going to have to deliver. Additionally, I suspect CMS will be requiring impact reporting from health plans for Shared Savings ACO programs."

But, for these descriptions and impact statements to be truly effective, health plans should capture and measure the impact of various data sources at every level of quality reporting. When we aggregate the details up to the measure, and even up to the quality program, the story of our data really takes shape — a powerful tool for a health plan. "I'm all in for transparency in quality reporting," Oliver said. "Today, as ADVantis works with Altegra Health to extract data from EHR systems for quality measure and gap in care reporting, we are adding data source and provider information at the record level in anticipation of these new impact reporting requirements."

Data Source Rollups

When we begin examining our data story-of-care, we develop more insight into the quality and functionality of our data. For example, a lab vendor's results may produce little impact because they report on panels that are too general to help health plans meet HEDIS measurement requirements. Perhaps, when you drill down on the true problem, you find that a particular physician group is ordering tests incorrectly, or the doctors prefer tests that happen to not help with HEDIS measures. You also could learn that the quality vendor is not interpreting the results correctly. When quality managers notice these anomalies, they discover an opportunity for easy validation that something is amiss and narrow the discrepancy down to a source.

Perhaps one of the more important benefits is the precise understanding of how each data source impacts each measure and the entire quality program. This knowledge even lends insight into the impact on quality initiatives. Knowing the value of each data source, especially each third-party vendor, can direct coding practices, drive more effective quality initiatives, and may even help in the evaluation of EMR systems and third-party vendors. The potential is limited only by the delivery of transparency and the understanding of its relevance.

Closing the Gaps

Now that we have aggregated the data sources, let's break them down again to expose even more value by stratifying according to the members' primary care providers. Patterns in the data sources utilized by primary care providers across one or more similar measures can be informational, at the least. If we limit the member population to only those with gaps in care and look for breaks in the patterns, we suddenly have actionable intelligence that

Key Takeaways

- Health plans and managed care organizations must have transparency into the data and methods that comprise their HEDIS and other reported quality measures.
- Health plans often rely on their quality vendors to calculate quality measures, and the vendors' methodologies must be transparent.
- While the encounter-related data is crucial, the explanatory data that explains the encounter-related data is also important to health plans and auditors.
- Explanatory data is not only an essential component of transparency, it is now a requirement for some organizations.
- Health plans must now report the impact of data sources to NCQA.
- Quality vendors must be on the forefront of the emerging transparency trend and provide preemptive insight into the quality of the data and the impact of the various sources.

identifies PCPs for more focused data collection efforts. For any quality manager ever forced to make an educated guess on where to direct resources to address gaps, this can be fundamental. Knowing where to dedicate time and energy to gain that extra CMS Star or capture key data to appropriately bolster a HEDIS measure is money in the bank.

Is Enough Data the Right Data?

All of this data gathering and information management comes at a significant cost to health plans, employers, states, and members. At some point, does the breadth of our data set begin to exceed its usefulness? After all, claims, pharmacy, lab, hybrid, and other data sources already portray a good story-of-care — especially when they are complete.

Perhaps the better question is, can the data be more accurate? This may be more important than adding additional data sources, which may not have a significant impact on rates. Catalyzing the quality of data from your existing sources might be more valuable, and easier to accomplish, than tapping into yet another repository of results you had not previously considered. Transparency provides the insight necessary to find the gaps in the data and clues about how to fill them.

Without All This Transparency …

As managed care journalist Matt Bloch recently pointed out, " … data can be incomplete or duplicated and skew the intelligence that results from the analysis."[2] Transparency exposes these issues and describes where they originated, providing opportunity to address them. The ability to address these kinds of data gaps not only helps the health plan submit accurate rates, it leads to accurate grading for providers.

Transparency is not an elusive concept, and generally some form of it is available from all quality vendors. The difference is how a vendor provides transparency. If it is not built into the delivery of the quality program, the quality vendor must produce a manual report for each request for transparency. Those responses take time, and the results might be old news after just a day or two. Transparency can be a simple list of the services used in the calculation of a quality metric, which is a good start. Nevertheless, the data story-of-care is missing. If you are convinced of the value of the transparency story, then you certainly can recognize the missed opportunities.

Transparency also is not the be-all, end-all solution for fixing all HEDIS woes, but it might be one of the more important tools in the toolbox. A quality program without transparency is like spreading butter with just your finger. The job will get done, but it will be messy, probably wasteful, and leave you with a desire to wash your hands of the process when it is over. If you work in health care, and you have been

affected by, or contributed to, the measurement of the quality of health care delivery, you can probably relate.

How Much Transparency Do You Want?

With the newly proposed Quality Rating System poised to go into effect in the commercial marketplace in 2015,[3] the requirement to measure quality will be even more prevalent. For health plans and provider organizations of all types, the results of that measurement will have an increasing impact on their bottom line. With so much at stake, it isn't enough for your quality analytics vendors to deliver the minimum necessary. Your vendor needs to be on the forefront of the emerging transparency trend and provide more insight into not only the quality of the data but also the impact of its various sources. Transparency is a critical necessity and is key to not only understanding impact but also in confidently reporting your health plan's most accurate quality rates. If your vendor does not provide the level of transparency you have decided you need, it should.

Rand Hager is the product manager for all Altegra Health Quality Performance products, is responsible for the design and future vision of each product's user experience (UX), and holds a Creator's Roundtable where he and his peers explore the vast possibilities within health care data. Originally a software engineer, Rand designed and developed quality performance engines for the CMS ACO Pioneer and Shared Savings models, NCQA-certified HEDIS®, and several state P4P programs. Rand graduated from Colorado Mesa University with a B.A. in Computer Science. ■

Footnotes:

1. Dalzell, Michael, "NCQA's New Rating Scheme To Allow Easier Comparison." *Managed Care Magazine*, September 1998: www.managedcaremag.com/archives/9809/9809.ncqa_report.html. (Accessed June 26, 2014).
2. Bloch, Matt, "With big data too much is never enough." Managed Healthcare Executive, August 1, 2013: managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/big-data-too-much-never-enough? (Accessed June 26, 2014).
3. Centers for Medicare & Medicaid Services. "Health Insurance Marketplace Quality Initiatives." - Centers for Medicare & Medicaid Services. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html (Accessed June 22, 2014).

Inefficient Communication...

(from p. 1)

communication inefficiency in three specific clinical workflows: patient admissions, coordinating emergency response teams, and patient transfers. Respondents agree that a significant amount of time is wasted during each workflow due to ineffective communications, primarily due to the inefficiency of pagers (as cited by 52 percent of survey respondents) followed by the inability to use text messaging (39 percent). Respondents also think that the use of secure text messaging could increase productivity, estimating that it could help reclaim about half of the wasted time.

"Our company has physicians working in facilities across the state, and this gives us a unique perspective. We are able to see a common pattern to the collaboration problems permeating all health care systems. In addition to seeing patients, physicians are tasked with two other very time-consuming tasks: documentation and collaborating/communicating with other health care professionals within a patient's ecosystem," explains Sawad Thotathil, MD, vice president of performance improvement at New England Inpatient Specialists. "These physicians are highly trained on the clinical decision-making side of care and yet routinely spend a great deal of their time on non-clinical tasks. The more time they spend on documentation and communication, both of which account for as much as 30 percent of the daily workflow, the less time they spend actually taking care of patients. At a time when we are facing a national — and local — shortage

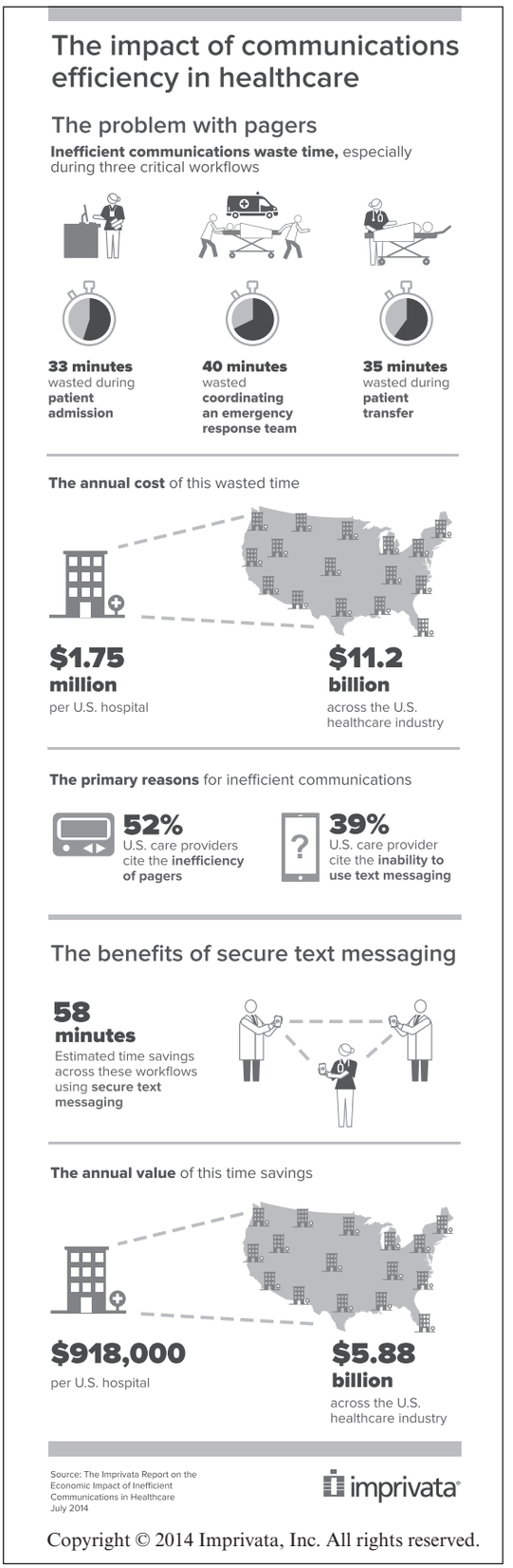
of physicians and nurse practitioners, it is critical that we find a way to devote a larger percentage of our time to bedside care. This report sheds light on one key area where we can begin to affect change: by reducing inefficient communications in health care."

The reality is that physicians cannot get away from the fact that some things just need to be communicated, stresses Thotathil. Providers need to communicate with other providers and specialists; health plans need to communicate with providers; physicians need to be able to access lab reports; etc. There is no escaping these needs; the solution is to find easier and more effective ways to do it. Just as the health care environment has evolved over the years, so too must the communication tools and protocols evolve. And while there may be some "catching up" to do, help is within reach, he adds.

As was mentioned earlier, the report looks specifically at the impact of inefficient communication in the areas of patient admissions, coordinating emergency response teams, and patient transfers. But the problem is much bigger than just these three areas, says Thotathil. There are communication inefficiencies across the board.

"It is all about the routines that people are comfortable with," notes Thotathil. "At some point, we all have to make that leap outside of our comfort zone and identify what processes work best rather than simply what processes we have always been following. The system will force change, regardless of whether physicians and other health care professionals are ready; it is a matter of 'when,' not 'if.' So we must break out of our routines and our business-as-usual attitudes and look for the tools and resources that will help us take the next step."

A decade ago, it was okay for a nurse at a hospital to pick up the phone and call a patient's primary care physician and have a nice chat about the patient's care; it was okay to fax the patient's information and then wait for a response from his or her physician. But that



was a different time and a different environment, says Thotathil.

"We are talking about a lot of money — somewhere in the neighborhood of $11 billion as an industry — all attributed to slow or ineffiecient communications," notes Thotathil. "That is a staggering number, and it doesn't need to be when we have options available to us that provide greater flexibility and less disruption to our daily schedule. This will impact not only the financial bottom line but also the quality of care we provide to our patients. The less time we spend in communication, the more we can use our existing resources to overcome the physician shortage."

One of the simplest ways to do so is through secure texting, says Thotathil. "Gone are the days where we rely on slow, inefficient pagers and unsecure texting. Gone are the days where one physician waits to hear back from a specialist before administering care to a patient. Gone are the days where providers play phone tag. New technology allows us to communicate securely without delays — and in a more collaborative environment than ever before. But that will only happen if health care professionals embrace change and break away from what's 'comfortable.' Everyone benefits," he adds. "Physicians, hospitals, patients, health plans — from a financial perspective as well as a quality of care perspective. We made a decision to change, to embrace tools like Imprivata Cortext, and adoption has been high because benefits immediately become apparent to the individual physician."

Imprivata provides authentication, access management, and secure communications solutions for the health care industry. For additional information about Imprivata, go to www.imprivata.com. To access the full report, go to www.imprivata.com/imprivata-report-economic-impact-inefficient-communications-healthcare ■

Recent Analysis Shows Few Medicare Beneficiaries Receive Comprehensive Medication Management Services

An analysis from Avalere Health finds that less than half of all Medicare prescription drug (Part D) enrollees eligible for medication therapy management (MTM) programs receive these services. Under Medicare rules, the Centers for Medicare & Medicaid Services (CMS) requires all Part D plans to provide MTM services to beneficiaries who meet certain criteria and have high drug utilization. MTM services involve providing high-utilizing beneficiaries with a complete review of their medication regimens by a clinical pharmacist in order to provide education, improve adherence, and detect adverse drug events or inappropriate medication use. Specifically, CMS estimates that 25 percent of beneficiaries are eligible for MTM,[1] yet only 11 percent of all Part D enrollees were part of an MTM program in 2012.

"With only half of enrollees eligible for MTM programs receiving benefits, the Avalere analysis shows that these valuable services are under-used in Medicare," says Dan Mendelson, chief executive officer (CEO) of Avalere Health. "As regulators consider reforms, they will need to balance access to services with the operational realities faced by health plans."

In 2012, Part D beneficiaries who had at least two chronic conditions, take at least three medications, and have annual drug spending of more than $3,100 were eligible for MTM services. MTM programs are intended to optimize therapeutic outcomes through improved medication adherence and reduced risk of adverse events such as drug-drug interactions or clinically inappropriate therapies. In addition to offering eligible beneficiaries MTM services, Part D plans are required to offer all MTM enrollees a comprehensive medication review (CMR).

Part D Sponsor MTM Enrollment and CMR among Top 10 Part D Carriers by Enrollment, 2012		
	Percent of Part D Enrollees in MTM	**Percent of MTM Enrollees Receiving CMR**
Low	4.6%	2.4%
High	17.5%	73.8%
Overall	11.0%	9.6%

Avalere found significant variation, however, in participation in MTM programs and implementation of CMRs across carriers. Specifically, among the top 10 carriers participating in Medicare Part D, MTM enrollment rates ranged from a low of 4.6 percent to a high of 17.5 percent, with between 2 and 74 percent of MTM enrollees receiving a CMR. Overall, only approximately 1 percent of all Medicare Part D enrollees received a CMR.

While overall participation in MTM programs is low, enrollees in Medicare Advantage prescription drug plans (MA-PDs) were almost three times as likely as those in standalone prescription drug plans (PDPs) to receive a CMR. In addition, MA-PD enrollees were nearly four times as likely to receive an intervention — such as outreach to a prescriber or a change in therapy as a result of the CMR. ■

Endnote:

1. 2010 Medicare Part D Medication Therapy Management (MTM) Programs." Fact Sheet, CMS, June 2010, www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html.

Recent Study Shows Many Cancer Survivors Smoke Years after Diagnosis

Nearly one in 10 cancer survivors reports smoking many years after a diagnosis, according to a new study by American Cancer Society researchers. Further, among 10 cancer sites included in the analysis, the highest rates of smoking were in bladder and lung cancers, two sites strongly associated with smoking.

Cigarette smoking decreases the effectiveness of cancer treatments, increases the probability of recurrence, and reduces survival time. Nonetheless, some studies show a significant proportion of cancer survivors continue to smoke after being diagnosed. Most of those studies cover a relatively short time period. There remains a lack of information on smoking prevalence for survivors many years after diagnosis.

To help close that gap, researchers led by Lee Westmaas, PhD, looked at survey responses from nearly three thousand cancer survivors in the American Cancer Society's Study of Cancer Survivors–I (SCS-I), a longitudinal nationwide study of adult cancer survivors. The study was limited to those with one of the 10 most highly incident cancers at the time of enrollment (breast, prostate, bladder, uterine, melanoma, colorectal, kidney, Non-Hodgkin Lymphoma, ovarian, and lung).

Interviewed about nine years after diagnosis, 9.3 percent of the survivors reported being current smokers, 41.2 percent were former smokers, and 49.6 percent were never smokers. Among current smokers, 83.1 percent smoked every day. Nearly half (46.6 percent) indicated they planned to quit while 10.1 percent did not and 43.3 percent were not sure. Of the 1,209 former smokers, 88.6 percent had quit before their diagnosis.

Several socio-demographic variables were associated with current smoking status. Survivors who were younger, female, had lower education, and lower income were most likely

to remain smokers. The study also found that married smokers had lower intentions of quitting, an unexpected finding that the researchers say has not been previously reported.

"Effective cessation treatment for cancer survivors exists," write the authors, "but future population-based studies examining the importance of psychosocial variables, and their relationships to other health-related variables in predicting current smoking or motivation to quit, will further contribute to enhancing cessation strategies for all survivors who smoke."

The authors conclude that "[t]hose who smoke heavily long after their diagnosis may require more intense treatment addressing specific psychosocial characteristics such as perceptions of risk, beliefs of fatalism, etc. that may influence motivation to quit."

Article: Prevalence and Correlates of Smoking and Cessation-Related Behavior among Survivors of Ten Cancers: Findings from a Nation-Wide Survey Nine Years after Diagnosis, Cancer Epidemiol Biomarkers Prev, Published online Aug 6, 2014 doi: 10.1158/1055-9965.EPI-14-0046 ■