CMS 2012 MEDICARE PRESCRIPTION DRUG BENEFIT SYMPOSIUM

MARCH 20-21, 2012
MARRIOTT HUNT VALLEY INN
HUNT VALLEY, MD

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

# Using Part D Data for Provider Feedback
## *Stephen Kogut, Ph.D.*
## *Lynn Pezzullo, PPh., CPEHR*

As the introduction mentioned, I am with the College of Pharmacy at the University of Rhode Island. Our pharmacy class sizes have been increasing year to year, but I'm getting used to presenting to larger audiences but it's a little bit bigger. I hope our pharmacy class sizes don't get this big. But, nevertheless, getting used to presenting to larger audiences and it's nice to see so – so much interest in this particular session.
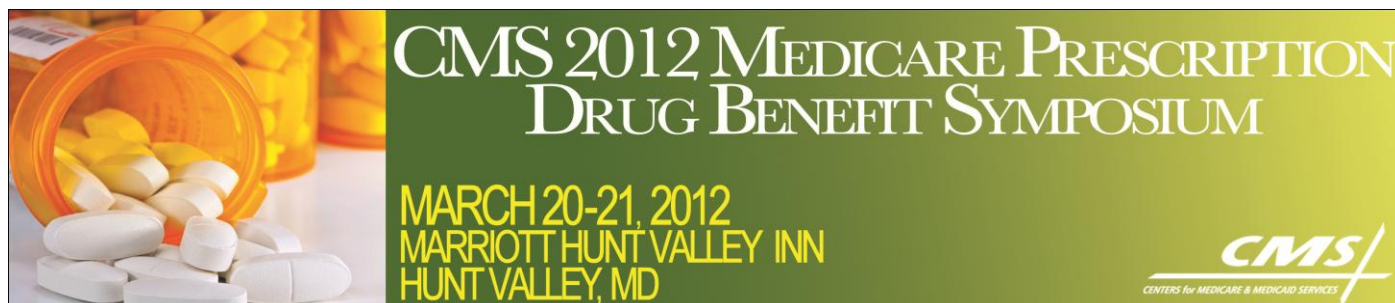
We're here to present with you some of the results from our experiences working within the Medicare QIO program to improve medication quality under Medicare Part D drug programs. And that work has really began in 2006. My experience with the QIO community stems all the way back to 1999 when I had collaborated with a Massachusetts peer review organization at the time to be – to do some work in measure development and improving quality of medication use under Medicare Part D. So I've for a number of years had the privilege to be involved in this work, and it's really terrific that we're able to represent this work. I looked across the program schedule, and it seems we may be the only group that's presenting some of the QIO experience, so I'm grateful to have that opportunity to present at least some of that background from Rhode Island.

I'm not an employee of the Rhode Island QIO. I should disclaim that and mention that. Our work, Lynn and I, has been collaborative and we're going to share this session. So I'm going to present some of the information about the first phase of this work, from 2006 through 2008. And Lynn will then describe the program that was sort of the next phase focusing on folks with chronic disease and medication used for those conditions. So terrific. All right.

So I think I can speak on behalf of Lynn and mention that I declare no conflicts of interest or financial interests in any product or service mentioned in this presentation including grants, employment gifts, stock holdings and honoraria. Just been really fortunate to have been involved in this work and have the support of the University in engaging in these efforts as well.

So this is what we intend to accomplish in presenting the results of this Medicare Part D QIO work. This is sort of understand how Part D. claims data or Part D data were used in those two projects and maybe along the way learned a little bit about some of the opportunities and limitations in using this data source in working with providers specifically to try and improve quality on medication management.

So as I mentioned, those are the two projects that we'll be talking about, and the current scope of work, this tenth scope of work, is focusing on placing more clinical pharmacy management within an interdisciplinary care team, and I think maybe there's many folks in this room that are involved in those efforts. The first phase of this, as I mentioned, was to improve medication management among beneficiaries enrolled in Medicare Part D plans. The QIOs at the time in 2006 were tasked with working with Medicare, PDPs, and Medicare Advantage plans to improve medication utilization. It was sort of open ended and flexible and just lots of room for innovation and creativity much like the MTM provision was when – at the time. So there was all sorts of decisions to be made with respect to therapeutic area, the scope of medication management to – to tackle, and as a result of that you have these varied and

CMS 2012 MEDICARE PRESCRIPTION DRUG BENEFIT SYMPOSIUM

MARCH 20-21, 2012
MARRIOTT HUNT VALLEY INN
HUNT VALLEY, MD
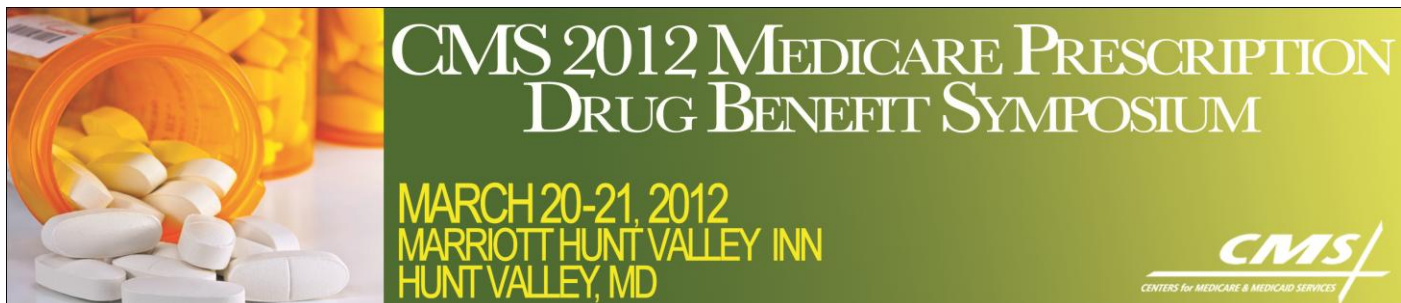
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

really interesting projects that were taking shape throughout the United States, and I would suspect many of you in this room were involved in those projects from the perspective of one stakeholder group or another. And that work has been catalogued in a supplement that I'll show you in a slide or two.

CMS provided some examples of performance measures that might be relevant to these areas of study, but they didn't proscribe any, so there was lots of room to try and create or borrow or implement measures from other contexts that might be useful within this setting. And what made it really interesting is that the QIOs were responsible for establishing relationships with the PDPs and the MAPD plans directly. So there was lots of outreach. Many of the plans, as you know, don't have a local presence in the markets that they serve. They're at least, you know, a forum for face-to-face meeting with administrators, etc., so it really made it in some ways a challenge to try and formalize these partnerships and – and – and – and – and come to some common ground with respect to the aims of these projects.

So this was the – the supplement that I mentioned. In 2007 the *Journal of Managed Care Pharmacy* published this what I think is a really terrific catalog of all of the Medicare QIO projects in this area during this particular – this – this period. Now the results of these projects aren't presented here, but there's really a nice description of the aims of the projects, what populations are being addressed and outcome measures were being, you know, examined. So there's just a myriad of projects from, you know, polytherapy with atypical antipsychotics to therapeutic monitoring to the use of cholinergic drugs in patients with dementia or elderly patients. Certainly inappropriate medication use among seniors. Potentially inappropriate medication use. Many domains and many areas that I'm sure you're very familiar with.

I bring this to your attention because it may be worthwhile to sort of thumb through this supplement and there may be some projects that align with some of the work that you're doing currently. And I would urge you to reach out to the QIO that conducted this work. As I mentioned, the results haven't been – were not included in this – in the supplement, but certainly the projects have completed at this point and there's a – there's a final report and there's lots of lessons learned and good experience in conducting these projects, so, you know, I'd encourage you to reach out to the QIO program directors and – and, you know, find out what lessons might be applicable to the work that you're currently engaging in so that this work can be sort of a stepping stone to – to your work in these areas. So that's the supplement. Just wanted to provide, you know, some attention to that.

So within Rhode Island we had this – this opportunity to tackle really medication management in any condition or in any realm that we thought might best fit our needs for our state. And we focused our project in this scope of work on improving medication management in diabetes, which is probably an area that's familiar to many of you in terms of medication management initiatives. We knew that there were drug therapies that improved health outcomes. There was certainly opportunity for improvement from what we were reading in the literature about the underuse of clinically important medications and patient adherence being suboptimal. We also sort of knew that we could identify patients that had diabetes from pharmacy claims data with maybe an acceptable level of specificity. Now maybe pharmacy claims data weren't so sensitive, in other words there could be lots of folks we envision that we wouldn't identify as being diabetic from the pharmacy claims data. They may be managing their – their condition through lifestyle interventions or that sort of thing, but we had a, you know, the notion, certainly, that if a patient, certainly a Medicare beneficiary, was using a medication, an antiglycemic, that this person had diabetes. We knew the prevalence of the disease was significant, and we thought we'd have, you know, sort of a good base of – a good population in which to work with.

CMS 2012 MEDICARE PRESCRIPTION DRUG BENEFIT SYMPOSIUM

MARCH 20-21, 2012
MARRIOTT HUNT VALLEY INN
HUNT VALLEY, MD

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The aims of the project were to improve rates of clinically important medication use, so not only maybe anti-diabetic medications, but certainly medicines for lipids and intertensin active medications as well. We also sought to promote better patient adherence with these therapies. The – the strategy here is to work directly with providers rather than with patients directly. There were maybe sort of limited resources available to – to deploy, and we thought maybe we'd get the best bang for our buck in working directly with providers and share some tools and strategies and tactics, etc. And not only promoting the use of effective therapies, we thought, you know, certainly if there are medicines that prevented – present harm in the patient with diabetes we want to educate and reduce the use of those therapies and certainly promote the use of generic medications where at all possible.
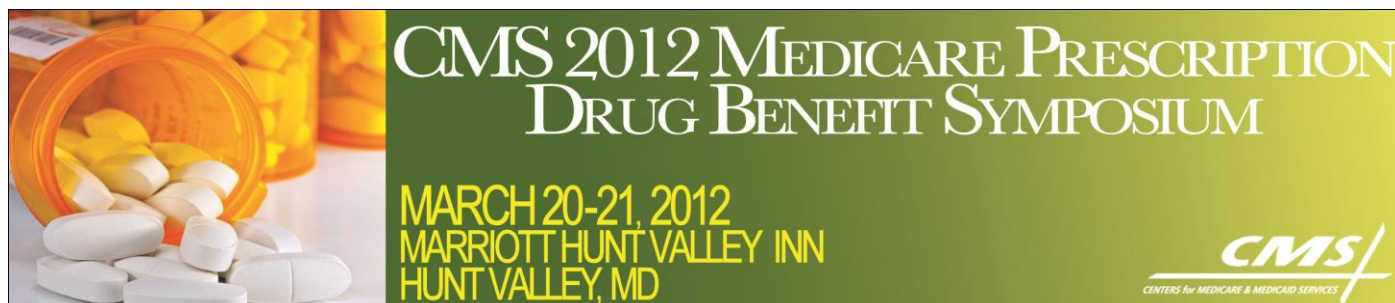
So, you know, we knew we'd be working with pharmacy claims data. You're familiar with many of the strengths and weaknesses of this data source, but we did think that the strengths of the data source could be leveraged to execute this project. And, you know, I think – I think it worked successfully. Certainly we knew that if we had evidence that a medication was dispensed, you know, that's probably solid evidence that the prescribing of an ACE inhibitor or a statin medication actually did occur.

And then the longitudinal nature of the database gave us an opportunity to measure medication adherence in a way that maybe, you know, a problem as to a medication list from another source may not have enabled. Certainly before Medicare Part D pharmacy claims data or, you know, had been utilized, you know, in a myriad of ways for – for – for a long duration of time. So it's a familiar data source, and we thought that it would be suitable for the project providing, you know, we kept our measurements at larger units of analysis. What we meant by that was, you know, maybe in working with larger physician groups, with larger PDPs, with maybe higher levels of analysis anyway that comparability across those measures might be meaningful. If we started drilling down to individual practitioners and really low patient sample sizes, you know, we didn't necessarily know how robust that measurement might be and how suitable it might be for quality improvement, so we'll – we'll look at that as we move forward.

I think you're probably very familiar with some of the weaknesses of pharmacy claims data. Certainly there are some conditions like diabetes or dyslipidemia where the dispensing of a medication is a pretty good indication that there is a diagnosis of diabetes or dyslipidemia. Other conditions it's not so straightforward, of course, so, you know, the dispensing of a – of an atypical antipsychotic medication or an antidepressant, right, doesn't necessarily mean a patient has schizophrenia or depression. There could be a number of different indications. So that was a limitation that we had to be careful about.

Certainly we weren't – there's going to be some incompleteness of the data with respect to cash prescriptions, maybe drug sampling. The data timeliness was an issue for us, and working with the Medicare Part D drug plans we were able to exchange data fairly quickly, you know, within 30-day periods. But even with that, looking back over a six-month period, for example, may not be sufficient to address a drug contraindication or – or something that required some timely action. But certainly for changing processes of care, the measurement could be timely enough to reveal some trends and comparisons that might enable providers to do that.

So some strengths and weaknesses presented here. This was our framework for thinking about what our measurements were going to be. We sort of used the FDA framework, I guess, of safety and effectiveness and including cost as well. And we started to think and brainstorm, well, within the condition of diabetes, what medications are evidence based or – or effective and we should be ensuring that patients are receiving them and benefitting from the therapy through optimal adherence. Within diabetes

CMS 2012 MEDICARE PRESCRIPTION DRUG BENEFIT SYMPOSIUM

MARCH 20-21, 2012
MARRIOTT HUNT VALLEY INN
HUNT VALLEY, MD

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

maybe there are medications that cause disglycemia or may be problematic with respect to increased risk or hypoglycemia in and of themselves. So we – we looked at that as well.

And certainly this was an area – this was a time before let alone generic Lipitor, this was before even Simvastatin was available generically, so the utilization of generic statin medications was on our radar screen as well.
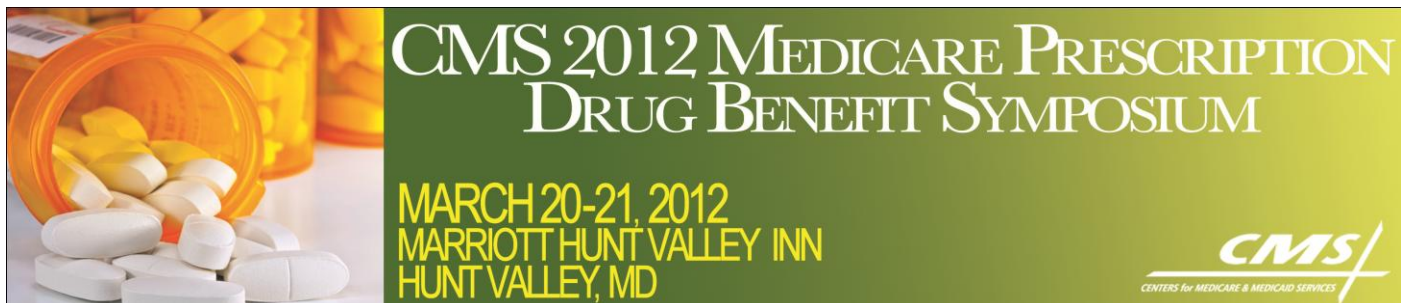
And here were the measurements within these domains that we ended up with. So we looked at the prescribing of angiotensin active drugs. We looked at patient adherence to those therapies. We looked at the prescribing drugs of dislipidemia. We examined patient adherence to statin drugs particularly. Within the realm of safety we did identify some medications that we thought would increase the risk of hyper or hypoglycemia. And the cost measures involved not only generic medication use but – well, actually just that, generic medication use for ACEs and for statins. We also looked at generic use of oral hypoglycemics. This was a measure that we later abandoned because it became a little complex to try and assimilate from the pharmacy claims data. But the theory there – or the thought there was if we could look at just among users of metformin and sulfanurias, what percentage of those users were using generic products.

So what we did was we sought to partner with those Medicare Part D plans operating within our state, and we were able to engage several of them that were willing to participate in our collaborative. We actually ended up gaining the participation of enough plans which represented about 40% of all the enrollees within Rhode Island. For the data provided by those plans, we composed or calculated the measures on the previous slide, and using those data and those results, we – we prepared provider-specific letters. And those provider-specific letters presented that individual practitioner's rates on these measures compared with their peers or – or the average or for all providers with the data that we had available.

We – that was one tactic to our intervention. We had another arm where we had a clinical pharmacy service that was doing academic detailing and providing presentations at some of the larger provider groups to inform the group – the providers about what we were up to and to provide tools and support and resources and guideline-based sort of flow charts and algorithms that I think were pretty well received but certainly were – took some toil to develop.

So this is an example – this is the sample letter that we sent out to our physicians. I know it's hard to read from your handout. I do have some copies if you want to catch me later or you can send me an email and I'd be glad to email it your way. But, you know, the – the letter essentially explains to the prescriber, you know, what we were up to, what the quality improvement initiative entailed, and it presented their rates for utilization of ACEs or **\INAUDIBLE\** or their rate of prescribing for cholesterol-lowering medications. It showed the percentage of their patients that had optimal adherence defined as medication possession ratio greater than 80%. Again, as compared to the overall provider base within the data that we had access to. And then also the percent utilization of generic medications.

So we tried to, you know, getting back to the sample size issue and units of analysis when they get really small, we tried – what we did was we sent letters to all prescribers that had at least 30 patients in their patient panel that were identified from our data. So that was sort of our cut off. But, you know, was that too low, was that not low enough, that's what we went with. And it ended up being over a hundred letters that were sent out every two quarters.

4

CMS 2012 MEDICARE PRESCRIPTION
DRUG BENEFIT SYMPOSIUM

MARCH 20-21, 2012
MARRIOTT HUNT VALLEY INN
HUNT VALLEY, MD

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The bottom paragraph had contact information for our resources and for – and noted that there were resources available and we'd love to follow up, explain more about how the rates were calculated and to share some information about maybe some helpful patient handouts or other information that might be useful in – in sort of an academic detailing way.
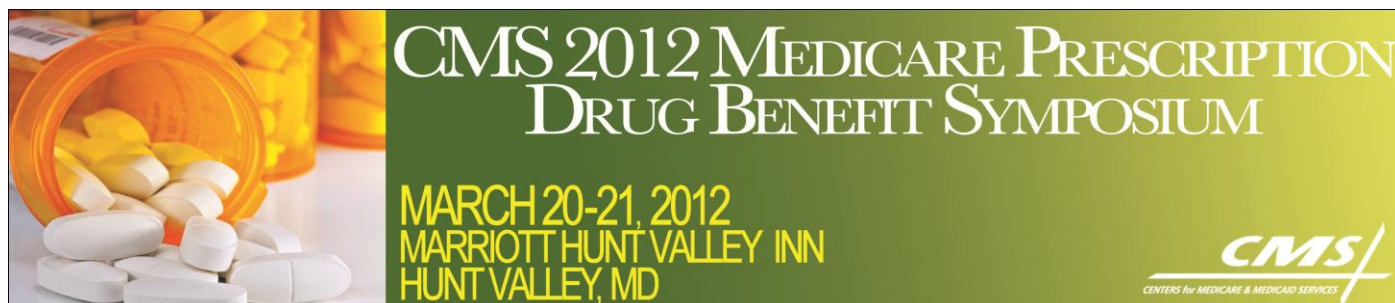
And these are some of our baseline results.  Or at least these are the characteristics of the patients that were identified through the initiative.  So there was – there was an age breakout where, you know, maybe about 12% of patients in either 2006 or 2007 were less than 65 years of age, but for the most part, about 80% - or 80-plus-percent were patients who were 65 or older.  Now some of the other variables listed down below were some interesting co-variants that we thought might be useful to include in the analysis.  So, for example, we looked at patients that also received the dispensing for a nitrate medication indicating coronary artery disease.  That's sort of a – a known groups validity.  In other words, if we thought the data were actually, you know, reliable and valid, what we should expect to see here is that if there are folks with, you know, clinically symptomatic artery disease, we'd expect a higher percentage of those folks using lipid-lowering medications, right, and – and that's what we saw as we'll see in the slide or two.

We also had – now Rhode Island is dominated by sort of two large physician group practices, and we kind of pit them against each other.  And we said we could identify practitioners in your group and we could compare your group's performance on these measures with group B.  And – and we did that.  And it was, again, another example of larger units of analysis being a basis for comparison and – and really helped to gain the interest of – of these particular physician groups.  Now we – for reporting the data, we just sort of put them in the same pot so as not to – if anybody knew who was participating, we didn't want to sort of undermine their anonymity in any way or – or – or shed any light over who might have been doing better or worse, but you can also see if you consider the – the construct of maybe belonging to a group practice and receiving integrated care and – and maybe more advanced information technology systems.  Remember this was 2007 or so.  That was – part of these groups, you know, was care any better, or at least according to these measures, was – were medications used in a more effective way.

And then we also wanted to look at did it matter if, for example, if a patient was under the care of a specialist versus not receiving a prescription from –a prescriber identified as an endocrinologist.  Now these – all of these elements were identified through pharmacy claims data.  And so we had a provider DEA number, and from those DEA numbers we were able to cross match that with a list that was provided by the state and from listings of providers we were able to sort of assemble these co-variables.

So this looks at the rates for these measures over all.  And for two time periods, the first six months of 2006 and then for the first six months of 2007, and you can see that there is a – maybe a small marginal improvement across the two years.  But I think maybe more importantly is just to highlight the opportunity for improvement.  So there was, you know, a significant number of patients that were not receiving the medications.  There was certainly sub-optimal medication adherence that was identified.  And you can see the rate of use of generic products within medication for dislipidemia really corresponded with the entry of generic simvastatin to the market, so we sort of got an artificial bump for our project there that, you know, certainly we couldn't take credit for.  But you can also see that nearly 10% of patients did utilize a medication that, you know, might cause a risk for upsetting glycemic control, a corticosteroid, for example, maybe a quinolone antibiotic, that sort of thing.

So some **\INAUDIBLE\** things sort of come to light when we look across these co-variants with the prescribing of or dispensing of ACE inhibitors and lipid-lowering therapies.  We could see, for example, that younger patients tended to receive these medications less frequently.  Females tended to be

CMS 2012 MEDICARE PRESCRIPTION DRUG BENEFIT SYMPOSIUM

MARCH 20-21, 2012
MARRIOTT HUNT VALLEY INN
HUNT VALLEY, MD

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

receiving these medications more frequently. And as we mentioned, folks with symptomatic artery disease as measured using – or measured looking at nitrate medications were more frequently using lipid-lowering medications, so, again, sort of a – sort of an assessment here that correlates with what we might expect from some of these known groups.

There's also evidence that if you were a patient receiving care from one of the two larger group practices in the state, that you were more likely to receive a prescription for ACE inhibitors or lipid-lowering therapy. And these were statistically significant differences. So, you know, some evidence that there was some better quality medication use or medication management according to affiliation with one of these group practices.
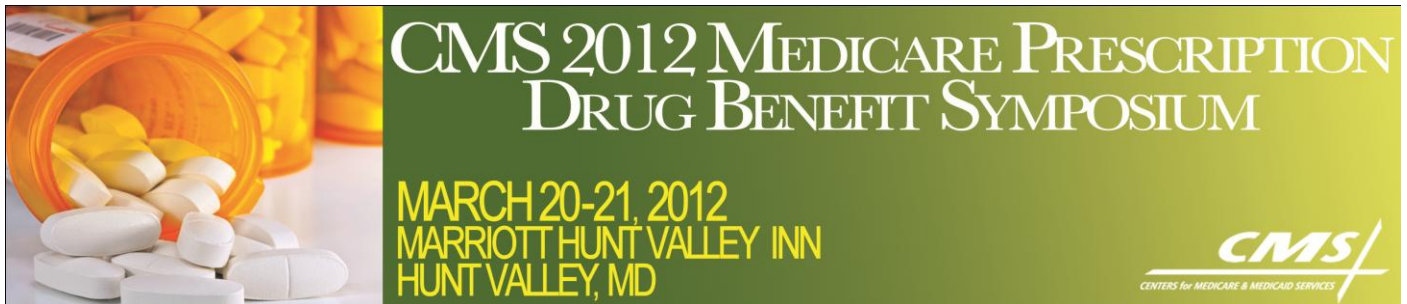
So that's – that's that. I'm going to move a little more quickly now just so we can have some time for Lynn, I apologize, but I just want to – I'm noticing that the time is – is running out before my eyes. So.

This is just a visual representation of our measures. Again, you can see that there is across a number of these different measures lots of opportunity for improvement. And then in the – in the far left corner, I apologize the – the figures don't really match the title here, but this just tells us that among all of the patients identified by the pharmacy claims data, almost 20% of them had a dispensing for a medicine indicating diabetes.

One of the collaborators in our projects had some interest in our adherence measure and wanted to know if it made any difference if we looked at adherence measuring it according to medication possession ratio or according to gaps in therapy. I know this is an issue or something that's been discussed quite a bit in the literature recently. So there was some work that we did with this plan to – to drill into that. I'm going to go through these slides, though, but if – I'm going to pass over them, I should say, in the interests of time, but if you're interested in this analysis, I'd refer you to the abstract here and essentially what we did was replicate these measures looking at diabetes medications, or antiglycemics specifically, according to adherence measured either by MPR or gaps in therapy.

Additionally during this period Medicare provided us with some benchmarking data, so these are just a sense of something neat that occurred with the Medicare Part D data that I thought was worth sharing as well, and that is at the level of analysis that was the state, for each state, we received rates of medication use and these different indicators comparing to national benchmarks. And I think this is something that is really useful that can be done with Medicare Part D data and – and – and should be part of a national healthcare quality report from year to year. I know we are certainly using data in that way.

A point to make on this slide was just with respect to using prescription drug data, you know I hear from – from folks, maybe this could be something during the Q&A session that we might want to address as well, that all of the limitations of pharmacy claims data are sort of a consideration for today but we're migrating over to electronic health records and maybe we won't have these problems any more. And I would just argue that the electronic health record environment has some certain advantages to measuring quality of medication use, but, you know, I don't necessarily believe that, certainly, that the EHR would be a gold standard. So the idea here is to think across electronic medical records, prescription drug event data, and even electronic personal health records and thinking about what they each can bring to bear and how to reconcile across these three settings. If anybody has the ability to access these three data sources and can do a reliability assessment of medication lists across these three, I think that would be a tremendous contribution to the literature.

**CMS 2012 MEDICARE PRESCRIPTION DRUG BENEFIT SYMPOSIUM**

MARCH 20-21, 2012
MARRIOTT HUNT VALLEY INN
HUNT VALLEY, MD

**CMS**
CENTERS for MEDICARE & MEDICAID SERVICES

If you're wondering if medication possession ratio and adherence measures are validated according to maybe some harder outcomes like hospitalization or – or cost, here's just a starting point to point you in that direction.

And I'm going to skip our lessons learned so I can move over and give my colleague Lynn, who allowed me to share this with her but I don't think she expected that I'd be stealing her time. So, thanks.
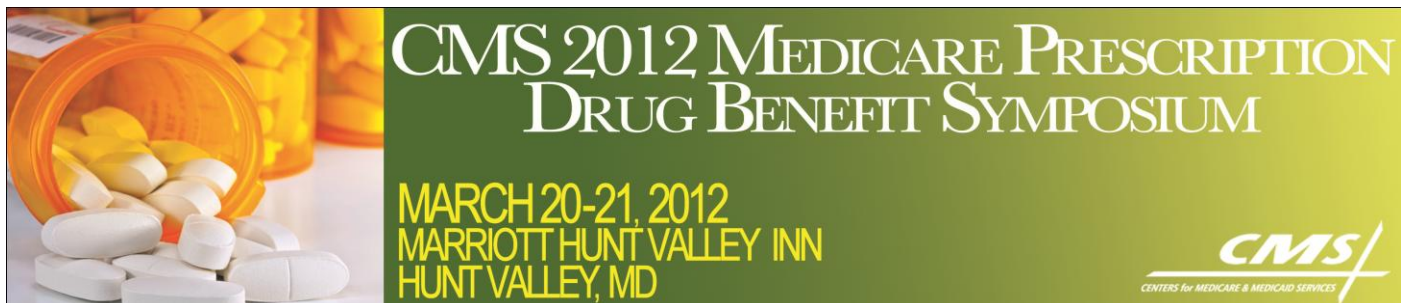
Thanks, Steve. So the good thing is I am a native Rhode Islander, so I can speak pretty quickly, so I will do that.

So as Steve had mentioned, the project that Steve was referring to just now was from our CMS quality improvement organization eighth scope of work. Moving into the ninth scope of work, which ended July of 2011, we had the opportunity not only for the quality improvement work for our core QIO contract, but there were other opportunities for QIOs to submit proposals to do some additional work and Healthcentric Advisors, the organization I work at, the QIO for the state of Rhode Island, we were awarded a three-year contract. We were one of 11 QIOs in the country that was focusing on improving care for patients with diabetes and kidney disease. So the three measures that we were looking at kind of covered the progression of disease. So first, the first point being earlier detection of kidney failure in patients with diabetes. The second being appropriate medication therapy, so prescribing of ACE inhibitors or ARB agents to slow progression of kidney disease in patients who have diabetes and hypertension and also chronic kidney disease. Then towards the end of the progression of disease, for those patients who do get to end-stage renal disease, insuring that they have an AV fistula in place and matured if hemodialysis is the course of therapy that they elect for their treatment for kidney failure.

So the measure definition, just to quickly review this. We were looking at Medicare fee-for-service beneficiaries between the ages of 18 and 75 who had a diagnosis of diabetes, hypertension, NCKD. And then to hit the numerator, it was those patients in the denominator who also had at least one Medicare Part D claim for an ACE inhibitor or an ARB agent within the one-year reporting period that we were looking at.

We took a – kind of a multifaceted approach to quality improvement efforts. One segment focused more on more intensive support for a smaller subset of practices within the state, so we worked with 13 primary care practices. The other kind of parallel path that we took was more of a state-wide, higher-level systems change approach, and we developed and convened a state-wide coalition of key stakeholders to address that work. Just a couple examples of the work that we did more intensively with the 13 practices that we worked with. We provided on-site technical assistance, we had a vendor who went out and actually modified some of the coding in the EMRs so that they could develop and generate reports specific to this project. And, again, just to emphasize, I'll be focusing mainly on the ACE inhibitor and ARB prescribing for the patients for this – this example. So they were able to generate reports from the EMR and also exception reporting so that they could really drill down on those patients who needed the most attention and their support.

From a state-wide coalition perspective, we engaged partners such as the state pharmacists' association, the College of Pharmacy, we had the regional offices of the National Kidney Foundation, American Diabetes Association, so we were all working together collaboratively to achieve common aims and really leveraging the most efficient use of resources.

CMS 2012 MEDICARE PRESCRIPTION DRUG BENEFIT SYMPOSIUM

MARCH 20-21, 2012
MARRIOTT HUNT VALLEY INN
HUNT VALLEY, MD
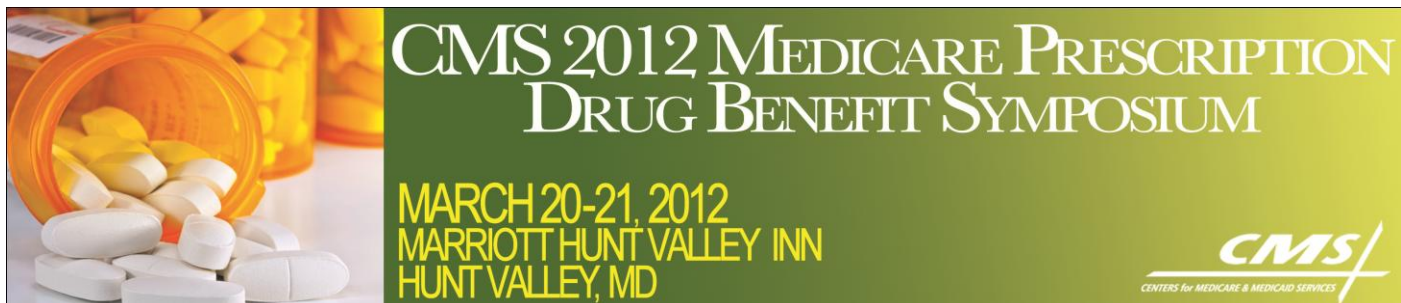
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Similar to what Steve had highlighted, this is a sample letter that we had sent out to physicians. We learned from the effectiveness from our eighth scope of work and also additional lessons learned so we kind of modified it a little bit. The message was similar. We provided physicians with their rates of prescribing ACE inhibitors and ARB agents in their – in this particular population, and also provided the state – the state rate and also the target rate that we were hoping that we could work with them to achieve. In addition to the letter, we also provided some resources, so, for example, we had some patient education materials that we included in the – in the mailing and encouraged them to use those materials with their patients and also to reach out to members of our team for additional resources. We also provided them with treatment algorithms around diagnosing the stages of kidney disease and the treatment the evidence-based guidelines aligned with that therapy.

Unfortunately, with all of the efforts we did not see the rate of improvement that we were hoping for. So we received quarterly data from CMS for these beneficiaries. We saw a little bit of progression, a little bit of improvement, but certainly not at the rate that we had anticipated we would see. So what we did as a next step, as you can see here, there's, you know, a little bit of progressing – progression, but certainly not – that blue line there that you see is our goal, so we – we weren't quite getting there.

So what we did was we drilled down on some of the information and we – we figured out, you know, we had some ideas of where these individuals could be, so there could be a situation where the – the medication was prescribed and actually dispensed but may not have been captured in the Part D claims data. It could be a situation where the physician prescribed it but the patient, for one reason or another, did not fill it. And then a situation where either the physician did not prescribe it or discontinued it for a particular reason.

And then what we did was we looked at the data. We identified, you know, where could we focus our resources to be most effective and most efficient, and we prioritized the list of physicians that we reached out to. So our first kind of approach was going – meeting up with large group practices, some of the endocrinologist practices in the state that – that were providing primary care for the majority of the beneficiaries that we were looking at. And we went out and supported their practices in completing chart reviews. So we did chart abstractions with the practices. We also had pharmacy students that participated in the project. And then what we did was with the findings from the chart abstractions, we put together reports that we sent back out to the physicians and we also requested an on-site meeting. So we were able to meet in person with a few of the practices, which was really a great benefit. It was an opportunity to have additional discussions on opportunities for additional interventions that they could put in place and provide a higher level of care to their patients. And had some really great discussions around the data and also encouraging them to leverage their EMRs to generate more frequent reporting so that they can maintain a higher level of focus on particular populations that need that additional care.

And just I will quickly go through the findings. So we completed 172 chart abstractions, and the way that that broke down, out of those 172, 26 of the beneficiaries were actually receiving an ACE inhibitor or an ARB agent but it was not in the numerator. And I'll talk about that in just another minute. Next bucket of – that it fell into, there were 19 patients where the – an ACE or an ARB was not prescribed or it was started but then discontinued, but there was documentation in the patient chart as to a specific contraindication as to why the physician was not prescribing that medication. And then another 42 where it was not prescribed or discontinued but there was a documented reason other than a contraindication. And there was a, you know, 19 of the patients that we were looking into had actually been deceased but time – sufficient time had not elapsed for them to come out of the denominator when we were looking at the claims data.

CMS 2012 MEDICARE PRESCRIPTION DRUG BENEFIT SYMPOSIUM

MARCH 20-21, 2012
MARRIOTT HUNT VALLEY INN
HUNT VALLEY, MD

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

So this is just an additional breakdown of those patients who were receiving an ACE inhibitor or an ARB agent but were not reflected in the claims data. Some of the physicians were providing samples so brand name ARBS, costly for the patient, so the main goal is to get this medication into the patient's hands and have them take it as prescribed, so some of the nephrologists and endocrinologists were actually providing some samples, so we found that 11 of the patients in the group that fit into that category. Prescriptions filled at a VA medical center. Those prescriptions are not reflected in the Part D data either. And then also we're all familiar with the discount generic programs, so, you know, those do not generate a prescript – a Part D claim. So overall, out of the 172 chart abstractions, we found that 26 patients, or 15%, were actually receiving the medication that they were intended to receive so the benefit is they are receiving the therapy that's needed. When you're looking at the data it's – it doesn't – it's not complete and doesn't accurately reflect that number.

This is just a breakdown of some of the contraindications that we saw. Allergies, cough with an ACE, hypercalcemia or some other type of contraindication that was indicated in the chart.

We also – some of the physicians and endocrinologists actually – they challenged some of the evidence-based guidelines if the patient did not have proteinuria, if they were currently normotensive, or if they were taking, you know, if their blood pressure was controlled on another anti-hypertensive class they weren't so willing to change that medication therapy for the patient.

So just to wrap up here. Lessons learned. As Steve was mentioning, you know, larger units of analyses. We can certainly leverage this data. We did find that it was a great opportunity to reach out to some of the larger physician groups, and when I talk about Rhode Island, a large physician group is seven, eight docs in one practice. A couple that Steve was mentioning, you know, they're larger groups with multiple sites, so that really was helpful. But one of the real key takeaways is leveraging the Part D data, at least as an initial approach to providers to generate – initiate some of those discussions, drill down in the details at their practice level – at the physician level to really help them, work with them and understand what their patient population looks like and what opportunities exist to improve the medication therapies for their patients.
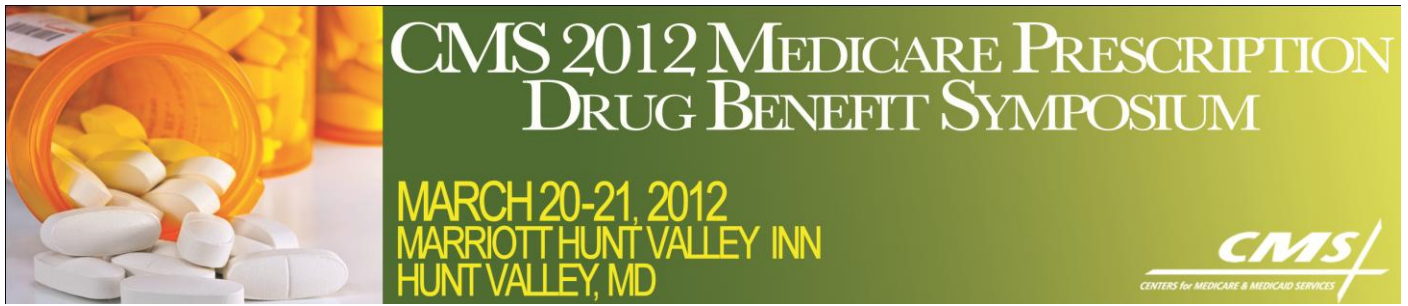
So with that I will turn it back over to Steve to go through the assessment questions, and then we will open it up for Q&A. Thank you.

Thanks, Lynn.

So it's time to conduct the assessment. Please get out your ARS response cards. We would encourage all of you to participate. As a reminder, if you are seeking CPE credit, you must respond to all assessment and evaluation questions. After the questions and responses are read, you will have ten seconds to respond. Maybe five. You will see the timer on the screen.

Potentially problematic features of Medicare Part D data as used for quality improvement purposes include timeliness of data, data completeness, difficulty determining diagnoses, all of the above. Please vote now. You have ten seconds.

The poll is now closed. Let's look at the results. Yes, so all of the above are potentially problematic features of Medicare Part D data. The three percent that answered "C", we did mention timeliness of data and data completeness as being issues that we could work with, but I think we probably could still categorize them as potentially problematic.

9

CMS 2012 MEDICARE PRESCRIPTION
DRUG BENEFIT SYMPOSIUM

MARCH 20-21, 2012
MARRIOTT HUNT VALLEY INN
HUNT VALLEY, MD

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Which of the following is not an appropriate application of Part D data for quality measurement? Determining generic utilization rates, calculating patient adherence to therapy, creating prescriber-specific reports, monitoring over-the-counter drug use?

Please vote now.  You have ten seconds.

The poll is now closed.  Let's look at the results.  And yes, the correct answer is "D", monitoring over-the-counter drug use.  And number – yes, number one I think was a transposition where genetic should have been generic.  Sorry about that.