Managing Diabetes Care: Health Plan/PBM Strategies to Improve Medication Compliance

Tuesday, December 17, 2013

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About the Speakers

JEAN BALTZ is a diabetes strategic consultant with Humana Inc. For more than 20 years Jean has practiced as a Certified Diabetes Educator and is a Board Certified Clinician in Advanced Diabetes Management. Jean is also a Registered Dietitian and a clinical social worker. Jean engages in provider oversight, program development and review and national lecturing. Patient care includes the spectrum of diabetes from prediabetes to insulin pump starts and management. Jean is active in leadership activities with the American Association of Diabetes Educators and the American Diabetes Association. She is interested in the support and strengthening the promotion of empowerment and efficacy of persons with diabetes. Jean holds a B.S. from Indiana University Bloomington in Exercise Science and Choreography and a Master of Medical Science in Clinical Nutrition and Research from Emory University School of Medicine. Contact Jean at jbaltz@humana.com.

JOSH FREDELL, Pharm.D., is a pharmacist and serves as director of product innovation and management at CVS Caremark. Josh and his team provide ownership for products and services focused both on promoting good trend and managing bad trend. This includes step therapy, drug utilization review, safety solutions, Pharmacy Advisor and other strategies to help manage trend appropriately. He joined CVS Caremark in 2003 and has held a variety of positions in the areas of pharmaceutical services, adherence, channel management, clinical programs and generics. Previous to CVS Caremark, Josh was a clinical pharmacist with UPMC Health Plan. Josh obtained his Pharm.D. from the University of Pittsburgh. Contact Josh at joshua.fredell@caremark.com.

Moderator: Lauren Flynn Kelly, editor of AIS’s Drug Benefit News.

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(1) Email your question(s) to moderator Lauren Flynn Kelly at lkelly@aishealth.com or

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WEBINAR PROGRAM
• Introductions/Administrative Reminders
• Speaker Presentations
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• Diabetes Best Practice
• Intervention Opportunities and Barriers to Adherence
• Combining Clinical Care and Diabetes Self-Management Education
• Cost-Benefit Analysis of Adherence Programs

Part 2: Josh Fredell, Pharm.D., CVS Caremark Corp.
• Overview: Chronic Conditions and Medication Adherence
• CVS Caremark and Member Engagement
• Pharmacy Advisor: Strategies and Results
• Improving Adherence Through Data Integration
• Looking Ahead to New Solutions

Part 3: Questions and Answers
Emerging Strategies to Improve Medication Adherence in Diabetes Care

Jean C. Baltz BC-ADM, CDE, MMSc, RD, MSW

December 17, 2013

An AIS Webinar
Drug Nonadherence Is Associated With Adverse Clinical Outcomes in Diabetes

• Nonadherence to medication may explain the suboptimal achievement of therapeutic targets.

• Approximately 1 in 5 (21.3%) of patients were nonadherent in that they failed to have at least 80% of days covered by filled prescriptions.

• Nonadherent patients had higher all-cause mortality (5.9% vs 4.0%, P<0.001) and higher all-cause hospitalization (23.2% vs 19.2%, P<0.001).

Source: Ho PM et al. Arch Intern Med. 2006;166:1836-1841
Before you tag a person or persons with diabetes as “noncompliant” make sure you have walked in their shoes for a day or two.

- “Noncompliant suggests a bunch of naughty, misbehaving patients who are simply too lazy or stubborn to follow orders.” - DiabetesMine AT

- Compliance is judgmental.

- Adherence reflects a collaborative effort, from education to literacy level, provider, family, social and the person with diabetes.

What is in a word?
“Adherence” is the new “Compliance”
Diabetes Best Practice

Medication Adherence Intervention Opportunities and Barriers to Adherence

Combining clinical care with individualized Diabetes Self-Management Education aids in medication adherence

Cost-Benefit Analysis of Adherence Programs

Review available adherence tools and the incorporation into diabetes management

Diabetes Best Practice
Diabetes Mellitus is a chronic illness that requires continuing medical care and ongoing patient self-management education and support to prevent acute complications and to reduce the risk of long-term complications.

Diabetes Care is complex and requires multifactorial risk reduction strategies beyond glycemic control.

A large body of evidence exists that supports a range of interventions to improve diabetes outcomes.

Components of the comprehensive diabetes evaluation; Current treatment of diabetes, including medications, medication adherence and barriers, thereto, meal plan, physical activity patterns, and readiness for behavior change.
Diabetes is a Progressive Disease
Sites of Action of Non-Insulin Medications

- **Insulin secretion**
  - Sulfonpyrethras
  - Meglitinides
  - Incretins

- **Glucagon secretion**
  - Incretins
  - Amylin

- **GI**
  - Incretins
  - α glucosidase inhibitors
  - Amylin
  - Bile acid sequestrant

- **Hepatic glucose output**
  - Metformin
  - Thiazolidinediones

- **Lipotoxicity**
  - Thiazolidinediones
  - Salicylates

- **Appetite control**
  - Incretins
  - Amylin

- **Glucose reabsorption**
  - SGLT2 inhibitors

- **Glucose uptake and utilization**
  - Thiazolidinediones
  - Metformin

- **Hyperglycemia**
Review of Tools

Medication Adherence Intervention Opportunities and Barriers to Adherence

Combining clinical care with individualized Diabetes Self-Management Education aids in medication adherence

Diabetes Best Practice

Review available adherence tools and the incorporation into diabetes management

Cost-Benefit Analysis of Adherence Programs
Medication Tools, Surveys and Support

- Electronic Tools to Measure and Enhance Medication Adherence; The American College of Preventive Medicine
- National Community Pharmacists Association Medication Adherence Educators Toolkit; American Association of Colleges of Pharmacy
- MAP NYC Medication Adherence Project; Improving Outcomes for Patients With Chronic Disease; A Toolkit and Training Guide (2010)
- Medication Education Delivers Success (MEDS); Student Pharmacists and 340B Pharmacy Study

- Merisky MMAS-4, MMAS-8
- ASK-20, ASK-12
- Adherence Estimator
The Morisky Scale MMAS-4, MMAS-8
Morisky DE, Green LW, Levine DW. Concurrent and predictive validity of a self-reported measure of medication adherence. Medical Care 1986;24;67-74

ASK-20, ASK-12
Consists of clinically actionable items representing multiple factors that affect medication adherence.

The ASK-20 survey demonstrated satisfactory validity and internal consistency and may be used to identify actionable barriers to adherence across a spectrum of chronic diseases.

ASK-12 was developed to increase effectiveness of the intervention by quickly identifying the most prevalent factors that influence medication adherence.
The Adherence Estimator asks questions about key areas known to impact medication adherence

- After the patient responds to 3 quick statements, the resource gauges the likelihood of adherence
- Provides personalized feedback that helps support conversations
- The Adherence Estimator is a patient-centered resource that can identify patients who may be at risk of medication nonadherence.

**3 quick statements**

- “I am convinced of the importance of my prescription medication.”
- “I worry my prescription medication will do more harm than good to me.”
- “I feel financially burdened by my out-of-pocket expenses for my prescription medication.”

**Response options include:** Agree completely, Agree mostly, Agree somewhat, Disagree somewhat, Disagree mostly, Disagree completely
Medication Adherence Intervention Opportunities
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Cost-Benefit Analysis of Adherence Programs
Medication Adherence Intervention Opportunities
Barriers to Adherence

- A wealth of smartphone apps, timers, pill cases, electronic pill medication reminder systems, memory aids and reminders
- Behavioral, motivational and educational interventions
- Dosing simplification and combination medication
- **The Patient-Physician relationship; Motivational Interviewing**
- Family and friends network of support
- Disease self-management education
- Socio-economic, and sustainable financing
- Shared decision-making
The Relationship

I WANT YOU To Take Your Medications
Patient and physician factors associated with adherence to diabetes medications

PURPOSE The purpose of this study was to examine the influence of patient and physician psychosocial, sociodemographic, and disease-related factors on diabetes medication adherence. These factors were also examined as effect modifiers of the association between quality of the patient-physician relationship and medication adherence.

METHODS Data were collected from 41 Geisinger Clinic primary care physicians and 608 of their patients with type 2 diabetes. Adherence to oral hypoglycemic medications was calculated using a medication possession ratio based on physician orders in electronic health records (MPR(EHR)). MPR(EHR) was defined as the proportion of total time in the 2 years prior to study enrollment that the patient was in possession of oral hypoglycemic medications. Linear regression was used to examine the influence of patient- and physician-level factors on adherence. Effect modification of the patient-physician relationship-adherence association was evaluated by adding the main effects of the individual-level factors and their cross-products to the models.

RESULTS In adjusted analyses, satisfaction with the physician's patient education skills, patient beliefs about the need for their medications, and lower diabetes-related knowledge were associated with better adherence to oral hypoglycemic medications. Shorter duration of time with diabetes and taking only oral hypoglycemic medications were also associated with better adherence. Finally, the association between shared decision making and medication adherence was significantly modified by patients' level of social support.

CONCLUSIONS This study identified several patient-, physician-, and disease-related factors that should be targeted to maximize the potential for developing tailored adherence-enhancing interventions within the context of a collaborative patient-physician relationship.
• Identify specific barriers and set goals. Barriers that create poor adherence are progressive and ever changing and individualized.

• Diabetes is a progressive individualized disease that requires progressive medication changes.

• Use the motivational interviewing technique, monitor and follow-up for real behavior change.

• Good communication between patient and provider is essential and addressing medication use should be part of every patient visit.
Clinical Care and Diabetes Self-Management Education

Medication Adherence Intervention Opportunities and Barriers to Adherence

Combining clinical care with individualized Diabetes Self-Management Education aids in medication adherence

Diabetes Best Practice

Review available adherence tools and the incorporation into diabetes management

Cost-Benefit Analysis of Adherence Programs
Does combining clinical care with patient-specific diabetes education emphasizing medication and lifestyle modifications and patient empowerment aid in medication adherence?

- DSMT Interventions demonstrated improved adherence
- Educator and patient relationship and to work collaboratively with the provider in a shared decision-making approach
- Educational interventions must be continuous and tailored to an individual patient’s needs and situation
- Clinical inertia appears to be less with the person receiving Diabetes Self Management, critical to attaining metabolic control and preventing complications of diabetes.

Source: “Improving Medication Adherence in Chronic Disease Management” April 2011, Vol 60, No 4 Supplement to The Journal of Family Practice
The most effective strategies have involved trusted health professionals taking the time to engage with patients regarding their goals and preferences.

Educators counsel PWD on the purpose and goals of therapy, the administration and duration of therapy, what to expect from the treatment, and how to handle common barriers such as side effects or cost.
Cost-Benefit Analysis of Adherence Programs

Diabetes Best Practice

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Cost-Benefit Analysis of Adherence Programs
Show Me the Money

- Of all medication-related hospital admissions in the United States, 33% to 69% are due to poor medication adherence, estimated cost of approximately $100 billion a year.

- The total economic impact of medication non-adherence contributes to costly health complications, worsening of disease progression, and preventable utilization.

- Despite the growing recognition of the problem, little progress has been made to improve medication adherence at a population level.
Medication Adherence Leads To Lower Health Care Use and Costs Despite Increased Drug Spending

- Improved medication adherence by people with four chronic vascular diseases **increased pharmacy costs**
- It also produced **substantial medical savings** as a result of reductions in hospitalization and emergency department use
- Findings indicate that programs to improve medication adherence are **worth consideration** by insurers, government payers, and patients, as long as intervention costs do not exceed the estimated health care cost savings

*Source: Health Aff January 2011 30:191-99*
The Economic and Societal Trend Highlights the Importance of Diabetes Prevention and Intervention

- The total estimated cost of diagnosed diabetes in 2012 is $245 billion, $176 billion in direct medical costs and $69 billion in reduced productivity.
- Annual medical expenditures are $7,900, 2.3 times higher than they would be in the absence of diabetes.
- Nearly 26 million people in the United States have diabetes, 7 million of whom may be undiagnosed.
Emerging Strategies to Improving Medication Adherence in Diabetes Care

Josh Fredell
Director, Strategic Product Management

1 in 2 Americans Has a Chronic Condition

Chronic conditions drive 75% of health care spend.

$1 of every $5 in U.S. health care is spent on patients with diabetes.

Prevalence of chronic conditions continues to rise.

Diabetes prevalence has tripled in 15 years.


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Medication Effectively Manages Most Chronic Conditions When Taken as Prescribed

BUT

\[ \frac{1}{2} \text{ of patients do not adhere to their medication therapies} \]

LEADING TO

Higher risk for adverse events, resulting in

\$290B in health care costs

IN RESPONSE

The industry increasingly recognizes the role of medication adherence in the quality of overall care; CMS is increasing weight in the Five-Star Quality Rating System metrics


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Changing Plan Members’ Adherence Behaviors Can Be Challenging

- Members’ barriers to adherence range from simple to complex
  - Forgetfulness
  - Communication barriers
  - Complex drug regimens or adverse effects

- Improving adherence requires plans to address members’ varied needs
  - Members with complex barriers to adherence may require in-depth interventions
  - Each member has unique personal preferences and demographics that determine which interventions will motivate them to act
CVS Caremark is Evolving to More Effectively Improve Member Health

WHERE WE WERE: TRADITIONAL PBM
Supporting appropriate utilization with mail and clinical solutions
- Refill reminders
- Off-therapy letters
- 90-day fills
- Plan designs

WHERE WE ARE: INTEGRATED PHARMACY SERVICES PROVIDER
Improving member health through unmatched access
- Face-to-face counseling at CVS/pharmacy
- One-on-one counseling for members in all channels
- Mail pricing on 90-day fills at CVS/pharmacy

WHERE WE’RE GOING: PHARMACY INNOVATION COMPANY
National leader in improving member health
- Publishing adherence and behavioral research
- Testing new technologies
- Delivering value to clients and members with innovative solutions
Pharmacy Advisor®: Addressing Chronic Conditions with Better Medication Management

- **Pharmacy Care**
  - Targeted interventions: first fill, non-adherence, gaps in therapy
  - Support integrated health management activities through member referrals and member-level reporting

- **Member Access**
  - Face-to-face counseling at 7,500+ CVS/pharmacy locations
  - Proactive outbound calls from a dedicated team of pharmacists for targeted members who use mail or other retail pharmacies

- **Pharmacists’ Expertise**
  - Pharmacists receive ongoing training on targeted conditions and motivational interviewing techniques
  - Insights gathered from 3M+ member interactions provide a uniquely effective member experience
We Engage Members in Every Channel: CVS/pharmacy, Mail Service, Other Retailers

FACE TO FACE at CVS/pharmacy

- Members build relationships with pharmacists at one of 7,500+ local stores
- Pharmacists initiate conversations when members are already focused on their therapy
- Conversations are typically brief and easily fit into members’ pharmacy visits

BY PHONE for mail and other retailers

- Counseling by a dedicated team of experts
- Based on our experience and research, we initiate counseling when members are most likely to need our support
- Member preferences for time and day are tracked and used to time outreach
- Results are tracked and used to identify best practices
2012 Results: Pharmacist Counseling Helps Improve Adherence

- We have engaged **642K** members with diabetes and high-risk cardiovascular conditions
- Provided **3.8M** live interventions, including **3.4M** at CVS/pharmacy

### Percent of Non-Adherent Members with Diabetes Who Moved to Optimal Adherence *(2012)*

<table>
<thead>
<tr>
<th></th>
<th>PHARMACY ADVISOR®</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORAL ANTIDIABETICS</td>
<td>48.7%</td>
<td>38.8%</td>
</tr>
<tr>
<td>ACE INHIBITORS</td>
<td>55.9%</td>
<td>46.5%</td>
</tr>
<tr>
<td>ARBS</td>
<td>56.9%</td>
<td>46.7%</td>
</tr>
<tr>
<td>LIPID-LOWERING MEDICATIONS</td>
<td>52.7%</td>
<td>43.5%</td>
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*Pharmacy Advisor and control group populations are matched and include other adherence programs implemented by clients.*

*Statistically significant. P-value <.0001.
1. CVS Caremark Enterprise Analytics; Evaluating the Impact of Pharmacy Advisor on Adherence and Gaps in Care, 2013.
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Case Study: Optimal Adherence and Ongoing Interventions

Members (%) With Optimal MPR: Diabetes

- 45%
- 50%
- 55%
- 60%
- 65%

Members (%) With Optimal MPR: Diabetes

Source: 2012 CVS Caremark Enterprise Analytics.
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Coordinating and Delivering Health Opportunities to Improve Quality of Care

Physicians
Providing real-time data to create a more complete view of their patients

CVS/pharmacy
Face-to-face relationship improves effectiveness of message

+ minute clinic
Supports low-cost screening, monitoring and acute care

Real-time Rx data and clinical targeting to identify opportunities to improve care
Third-Party Messaging: Improving Adherence Through Data Integration

LEVERAGE CVS CAREMARK’S CLINICAL TARGETING

**YOUR PLAN**
Identifies opportunities using:
- Medical claim information
- Data from case managers, physicians and DM programs

**HEALTH PLAN**
Delivers member health opportunities through:
- Physicians using EMR tools
- Case managers
- Disease management (DM) programs
- Call centers and websites

LEVERAGE CVS CAREMARK’S UNIQUE CHANNELS

**YOUR PLAN**
Identifies opportunities using:
- Real-time pharmacy claims
- High-impact clinical targeting

**HEALTH PLAN**
Delivers member health opportunities through:
- CVS/pharmacy
- MinuteClinic®
- Call center
Supporting Your Health Management Goals with Real-Time Data and Clinical Targeting

IDENTIFIES OPPORTUNITIES TO:
- Improve adherence
- Close pharmacy gaps
- Promote Rx savings opportunities

YOUR PLAN INTEGRATES DATA AND FACILITATES OUTREACH

- Physician sees alert in EMR and addresses during member visit
- Case Management addresses during scheduled conversation
- Outbound call to member from your call center

HELP IMPROVE
- Adherence
- Gap closures
- Cost reduction
Promoting Positive Behavior Change with Unparalleled Access to Members

HEALTH PLAN

IDENTIFIES OPPORTUNITIES TO CLOSE MEDICAL AND PHARMACY GAPS

CVS CAREMARK DELIVERS

- Monitor chronic condition
- Administer lab tests to close medical gaps

- Face-to-face counseling to close pharmacy gaps
- Rx label messages reinforce opportunities

- Live targeted outbound calls
- Inbound phone access to live representatives

PROMOTES

- Resolution of opportunities at point of care
- Member engagement with trusted local pharmacists and nurse practitioners
- Low-cost, convenient member care

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Leveraging What We Do Today to Develop New Innovations and Enhance Existing Solutions

- Our extensive research with leading medical and academic partners creates unique insights
- We test these insights in pilot programs
- Pilot results help us identify the most effective solutions
- We introduce proven, innovative solutions
- We enhance existing solutions to be more effective
Ongoing Investment: New Ways to Drive Adherence

**WHO**
is at risk for non-adherence?

- Intelligent targeting and decision science to focus outreach
- Member segmentation
- Diagnostic tools to understand adherence barriers

**WHAT**
strategies will be most effective?

- Refill synchronization
- Spectrum of reminder devices to support varied regimens
- Digital tools and mobile apps
- Personalized medication reviews at CVS/pharmacy
- Patient-centric packaging

**HOW**
best to communicate?

- Unmatched member outreach channels
- Connectivity and messages through prescribers and EMRs
- Interventions at network pharmacies
A Personalized Approach to Improving Adherence

**Philip, age 65**
Multiple conditions and medications, most likely to respond to adherence outreach

**Tom, age 42**
Rarely follows therapy, adherence intervention less likely to have an impact

**Maria, age 28**
Newly insured, just diagnosed with asthma, digitally savvy, potential cost barrier, no primary care provider

### Personalized Solutions

- Synchronize refills to reduce complexity
- Evaluate use of home device suited to multiple medications
- Send electronic alert into prescriber workflow for prescriber messaging to patient
- Outreach through lower-cost channels
- Attempt to motivate through incentives and social support strategies delivered through digital tools
- Pharmacist counsels Maria at CVS/pharmacy and suggests a generic and 90-day supply
- Enrolled in SMS refill and order-ready reminders
- Provides referral to MinuteClinic®
• Engage and motivate members on the importance of staying on medications
• Leverage investments in innovative technologies to make adherence simple
• Provide consistent access to coordinated pharmacy care services
• Focus on member education to overcome possible barriers
• Reduce health care costs by keeping patients adherent
Experience from 3.8M+ Consultations Informs a More Effective Approach to Behavior Change

Patterns of member challenges emerge as we counsel members across unique populations and record our results.

Patterns help us identify areas of special need for specific populations:
- Regimen complexity
- Limited understanding of plan benefits
- Access to transportation or limited mobility

Our pharmacists apply successful tactics based on our experience, according to members’ unique needs.
Diabetes Study Links Mail Order to Outcomes, With a Few Caveats


While prior research has demonstrated the potential for mail order pharmacy use to improve medication adherence and control of cardiovascular disease risk factors, a new report published in the November issue of the American Journal of Managed Care looks into the “unintended consequences” of mail order by examining its potential impact on patient safety and utilization for diabetes patients. The results are good news for mail order stakeholders: Researchers concluded that mail order pharmacy use is not associated with adverse events in most diabetes patients and may be linked with improved health outcomes.

Authors of the study report, titled “Safety and Effectiveness of Mail Order Pharmacy Use in Diabetes,” claimed to be the first to examine the potential impact of mail order on patient safety and utilization outcomes. Researchers pointed out that diabetes patients, who often take multiple medications and are thus at greater risk of being exposed to contraindicated medications, could miss critical face-to-face pharmacist or physician consultations aimed at preventing such contraindications if they regularly order their medications through the mail. Moreover, mail order use may result in inadvertent reductions in preventive care services and/or laboratory monitoring, they suggested.

To see if these theories had any meat, researchers selected subjects from the Kaiser Permanente Northern California Diabetes Registry who were prescribed a new antiglycemic, antihypertensive or lipid-lowering medication from Jan. 1 through May 1, 2006. A total of 17,217 diabetes patients met study eligibility criteria; 5,890 (34.2%) used the mail order pharmacy at least once to refill their new cardiometabolic medication during the study period. Several key findings emerged:

◆ **Diabetes patients under 65 years old were less likely to have an all-cause emergency department visit** (33.8% vs. 40.2%); less likely to have a preventable ED visit (7.7% vs. 9.6%) and less likely to receive a recommended serum creatinine lab test within 30 days if their index medication was an ACE, ARB or diuretic (41.2% vs. 47.2%).

While there was no statistically significant difference in potassium lab testing in this group, or for any lab testing in patients 65 and older, researchers recommended in-person pharmacy refills to increase opportunities for monitoring of persistent medications in settings where laboratories and pharmacies are in the same location.

◆ **Diabetes patients aged 65 or older had fewer preventable ED visits** (13.4% vs. 16.3%), but slightly more overlapping days of supply of contraindicated medications (1.1% vs. 0.7%).

While the rates of overlap were “extremely low” for both mail order and retail pharmacy users, researchers added that this data point supports previous evidence suggesting that older patients who are on multiple medications may require additional monitoring for adverse events. In conclusion, “Interventions to increase mail order pharmacy use may improve outcomes, but should employ patient-centered approaches sensitive to care access,” the authors wrote.
Results Support Mail Order for Adherence

“Overall, this study illustrates a foundational belief that the type of pharmacy access and the days supply provided to the patient can impact patient outcomes for patients with diabetes,” observes Joshua Fredell, Pharm.D., director of product management at CVS Caremark Corp., where he is closely involved with the company’s Pharmacy Advisor program. “Recent studies conducted by CVS Caremark have also confirmed the importance of 90 [plus] days supply of chronic medications to improve adherence as well as the impact of appropriate counseling and support in person and over the phone. This new research adds to the growing body of adherence and outcomes research and points to the ongoing need to identify those approaches that will help each individual be more adherent to their necessary medications.”

Catamaran Corp. Senior Vice President and Chief Medical Officer Sumit Dutta, M.D., echoes the need for individualized approaches to addressing adherence. “There is no channel that will have all members,” he tells DBN. “If someone chooses to use mail and it works for them, that’s great, but there’s still going to be a portion of members who choose a different channel across all drugs. And they will require help. Regardless of whether someone chooses to use mail — and adherence may or may not be higher in mail — they still need the services that [PBMs] provide to promote adherence.”

View the study at http://ht.ly/r5rIK#.

Contact Fredell via Christine Cramer at christine.cramer@cvscaremark.com and Dutta via Emily Hendricks at emily.hendricks@zenogroup.com. ♦

Aetna, CVS Caremark Embark on Six-Month Post-Discharge Rx Pilot


In collaboration with its PBM partner, CVS Caremark Corp., and Dovetail Health, Aetna Inc. is looking to head off medication-related hospital readmissions with a six-month pilot program in which members can enroll and receive in-home or telephonic pharmacist consultations. Effective June 24, the Aetna Rx Home Success Program targets Aetna members who are on multiple medications and offers “personal support” from a pharmacist, with a focus on members who have recently been released from a hospital, nursing home or rehabilitation facility.

According to Aetna spokesperson Katelyn Morgan, the insurer was approached by CVS Caremark about implementing such a program and recognized the need to address hospital readmissions among its members. “Our review showed that better discharge planning and medical reconciliation and optimization of pre- and post-hospital medications could improve the overall continuum of member care and prevent a return trip to the hospital,” she tells DBN.

CVS Caremark and Dovetail Health were already working together when CVS Caremark approached Aetna about the benefits of a readmission prevention program, reveals Morgan. “Aetna agreed with the concept, which led us to piloting the program as a ‘proof
of concept,” she tells DBN. Dovetail Health provides the home-visit element, while CVS Caremark handles the telephonic outreach.

Once a member has been identified as at-risk for readmission through an Aetna proprietary algorithm, an Aetna case manager confirms that the member meets the criteria for the program and is the first person to contact the patient. When a member wants to enroll, there is a “seamless referral” to Dovetail Health and CVS Caremark, which then have an enrollment specialist contact the member, she explains.

For those members who decide to enroll in the program, a pharmacist will reach out to them to schedule either an in-home visit or detailed phone conversation. The pharmacist will review any new and/or pre-existing medications, help create a care plan between patient and physician, address potential medication-related issues, identify gaps in care and educate members about their medicines, according to an Aug. 20 press release from Aetna. The pharmacist will also consider other risk factors, such as chronic conditions and home safety, and aid in arranging follow-up visits with the patient’s physician.

Qualifying members are divided into two groups: high risk and moderate risk. Enrollees who are identified as high risk for hospital readmission will be contacted within two days of discharge in order to schedule an in-home medication review conducted by a Dovetail pharmacist. Moderate-risk members, meanwhile, qualify for medication reviews over the phone from CVS Caremark pharmacists. All members will receive ongoing support in the form of follow-up phone calls over the course of 30 days. At the same time, Aetna case management nurses for continuing care coordination will mentor members, adds the insurer. At the end of the 30-day period, the member will then be discharged from the program and moved back to Aetna Case Management for continued follow-up and care.

The six-month pilot program will be offered in the District of Columbia, Maryland and northern Virginia. Aetna will measure readmission rates and member satisfaction at the end of the pilot.

**Hospital Discharge Is Hotbed of Concern**

UnitedHealth Group had success with a similar pilot conducted through its PBM, OptumRx, in June 2012 when it focused on commercially insured members who were new to a disease management program and qualified for comprehensive medication reviews (CMRs). Patients were identified as high risk if they’d recently been discharged from the hospital and were taking multiple medications or had been released and were on a high-risk drug that could have contributed to a readmission. OptumRx pharmacists conducted the CMRs via an extended phone call to identify what issues those at-risk patients were experiencing that could impact either cost or quality of care, and members were then referred back to their nurse case manager for any necessary follow-ups.

“Members like to be contacted and know that somebody’s looking after them, and of course [pharmacist interventions have the potential to] reduce total health care costs,” contended OptumRx Chief Medical Officer Brian Solow, M.D., during a June 26 AIS webinar, “Post-Discharge Medication Reconciliation Strategies for Health Plans and PBMs.”

Whether it’s leaving the hospital or moving to a rehabilitation facility, a care transition is where patients tend to have medication-related issues and that’s when it’s most important to perform medication reconciliation, compiling an accurate list of all the medications a patient
is taking, including over-the-counter meds, added Jan Berger, M.D., chief medical officer at Silverlink Communications, during the webinar.

“The whole area around post-hospital discharge has become very focused and very charged because of the financial and quality implications that CMS has placed around this with [Medicare] star quality ratings for health plans and to the hospitals [with the introduction of the Medicare Hospital Readmission Reduction Program], so incentives are finally aligned,” Berger observed. “What’s often happening today, though, is it can be an issue that’s hard to scale.” While health plans and PBMs often use predictive modeling to target an at-risk population such as those who’ve just left the hospital, there are often psychosocial reasons not easily identified in medical claims, she pointed out.

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Mobile Prescription Therapy Offers Novel Approach to Diabetes Treatment

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People with diabetes now have another arrow in their treatment quiver. But it’s not a drug, although it does require a prescription. WellDoc, Inc. is rolling out its mobile prescription therapy BlueStar, which will be adjudicated through the pharmacy benefit the same as other prescription drugs. Companies such as Ford Motor Co. and Rite Aid Corp. have said that they will cover the product for employees and covered dependents.

BlueStar received FDA clearance as a therapy for diabetes type 2, which is notoriously hard to manage. Almost 26 million people in the U.S. have diabetes, which represents 8.3% of the population, says the American Diabetes Association. About 95% of that total is diagnosed with type 2 diabetes. According to the CDC, about 1.9 million diabetes diagnoses were made in 2010 among the population of people at least 20 years old. And more than 1 million of those cases were in the 45-to-64 age group.

The total cost of diagnosed diabetes in the U.S. last year was $245 billion, up from $174 billion in 2007 — a 41% increase over five years, notes the association. The largest components of that total are costs for hospital outpatient care, drugs to treat complications of diabetes, diabetic medications and supplies, physician office visits and stays in nursing/residential facilities. Additional drivers include indirect costs such as absenteeism and reduced productivity. Government insurers provide 62.4% of the care, with commercial insurers responsible for 34.4%.

While many people with the condition take insulin and/or an oral medication, “Self-management education or training is a key step in improving health outcomes and quality of life. It focuses on self-care behaviors, such as healthy eating, being active, and monitoring blood sugar. It is a collaborative process in which diabetes educators help people with or at risk for diabetes gain the knowledge and problem-solving and coping skills needed to successfully self-manage the disease and its related conditions,” says the CDC.

BlueStar is aimed at helping people with their self-management, as well as health care providers.
WellDoc offers face-to-face training for physicians and their staff. After a physician has prescribed the product, “the pharmacy adjudicates the claim, and we simultaneously enter a registration profile that allows the pharmacy to dispense a BlueStar customized to each patient’s medication regimen, medical history and physician orders,” explains Chris Bergstrom, chief strategy and commercial officer at WellDoc. This is followed by face-to-face training for the patient by a WellDoc Certified Diabetes Educator. The patient sets up a user account, and BlueStar’s software is downloaded onto all of his electronic devices, such as computers, mobile phones and tablets. Providers can access it by fax and soon by electronic medical records as well.

Diabetes-related data about the patient are entered into the account so each patient’s care can be personalized. In addition to medications, the patient tracks information about his blood glucose readings, diet and exercise. BlueStar captures and stores those data and then provides motivational, behavioral and educational coaching based on the information.

And when the patient goes in for a doctor’s visit, the physician will have a clinical decision support report that is “based on the patient’s life and provides actual evidence-based recommendations,” explains Bergstrom. WellDoc’s customer care is available to any patient using BlueStar or any physician prescribing it.

“The product learns and adapts to a physician’s orders and to a patient’s evolving needs as they progress through the terrible and complex disease of diabetes,” says Bergstrom.

WellDoc has had experience with a somewhat similar product known as DiabetesManager. However, the two products are not the same, maintains Bergstrom. “The DiabetesManager was a call center-based product sold in the B2B market to disease management companies, and one of its primary features was enterprise tools that made nurse case managers more efficient. BlueStar is significantly different in that it is designed for the much larger provider market. It requires a prescription, has clinical decision support for HCPs [i.e., health care professionals], enhanced algorithms, increased levels of personalization, and incorporates standards of care and co-morbidities,” he says.

In addition, he clarifies, although an app is included in this product, BlueStar is a mobile integrated therapy, which is not the same thing as an app. “The mobile revolution has been a blessing and a curse. A blessing in that everyone understands how connectivity can unlock value in any industry — even health care. A curse in that everything is thought of as just an app, which generally implies a thin piece of software that performs a specific function,” says Bergstrom. “We designed BlueStar before there was an iPhone or an app store. The essence of the product is built using artificial intelligence called an expert system that is a powerful clinical and behavioral algorithmic self-management platform. An app happens to then be one element of the product, but the full product is an end-to-end solution that can scale a physician’s care to his or her diabetes population in real-time, 24/7.”

He tells DBN that BlueStar “is not tied to a device”; a person’s account is in the cloud, and each device has a native copy. “By residing natively on each device, the full performance of BlueStar can be realized even when there is sporadic connectivity (e.g., in an airplane, basement or rural area). Then, when the device returns to coverage, BlueStar reconnects with the cloud for seamless updates and syncing,” explains Bergstrom. “Further, BlueStar maintains military grade security and encryption, is HIPAA compliant and has safety measures
allowing for lost devices.” WellDoc also has “controls in place to mitigate fraud, waste, and abuse of our product.”

DiabetesManager has three FDA clearances, and WellDoc has gotten clearance for BlueStar as well. The company worked with the National Council for Prescription Drug Programs (NCPDP), which creates consensus-based standards on various issues impacting the pharmacy industry, to demonstrate that BlueStar should be viewed the same way as a prescription drug, including indications for use specified on its clearance.

According to Bergstrom, “The FDA does not require clinical outcomes for 510k clearance, only human factors and safety testing. However, WellDoc chose to conduct multiple randomized controlled trials to demonstrate to the market effectiveness to ensure meaningful value can be realized by patients and providers.” He notes that the company was founded by physicians, so “demonstrating this evidence was part of WellDoc’s DNA. From the trials we know that the two main features of BlueStar each show unique value in driving outcomes, specifically (1) the contextually relevant, automated, real-time and longitudinal patient coaching drove about a 1.4 point A1C reduction and (2) the automated patient level clinical decision support added another 0.5 point A1C improvement. These features changed patient and provider behavior respectively while working in constant synergy.”

**Initial Focus Is on Private Insurers**

WellDoc has focused on getting reimbursement from private payers first and then likely will target government insurers. Asked why that is, Bergstrom says that although he’s taken this approach, as well as the reverse sequence, in past experiences, “Generally, there isn’t a right or wrong approach as they feed off each other, so once you start one, the other gets pulled in anyhow.”

Still, he says, various factors led to the company’s approach with BlueStar:

- **There was “strong demand from the commercial market** as payers knew they would soon need products that went beyond the pill to address quality, engagement, care coordination, [and] satisfaction, as well as cost and outcomes.”

- **“A significant portion of Medicare lives are managed by the private payers** anyhow via Medicare Advantage.”

- **“The product works well with seniors but is not ideal** for the elderly generation,” described as older than 80.

- **“Over the past few years public policy has been dynamic** — the general trend was clear, but the details not well known,” Bergstrom says. “Separately, several states are now approaching us for their Medicaid lives as we have successfully shown significant improvement in hospital and ER visits in Medicaid demonstrations, and they value the fact that BlueStar is the great social equalizer...allowing rich and poor to get the exact same quality coaching and support for the same standards of care.”

He tells DBN that private payers have had a “positive” response to BlueStar and that many are asking WellDoc for follow-up visits so they can really understand the therapy and how it works. “They recognize BlueStar fills a void in diabetes self-care and strengthens the patient-physician relationship in a way that other prescription products can’t,” says Bergstrom. “They also value how BlueStar can fit into their normal business model since it is
FDA cleared, has an FDA granted unique NDC [i.e., National Drug Code] product code and can be recognized by pharmacies; thus, it is treated just like all other prescription products.” The company, he says, spent seven years “and $10s of millions of dollars” on getting the product to where it is now.

**Price Is Negotiated With PBMs, Payers**

Asked about the cost for a prescription, Bergstrom says that BlueStar’s Wholesale Acquisition Cost “is listed in the compendia and approved by NCPDP, but pricing is negotiated uniquely with individual PBMs and payers. In certain situations rebates and modest discounts apply. However, we have publicly stated that even though BlueStar is a first-in-class, best-in-class product, our pricing is significantly less than most branded diabetes prescription products.” In other publications, the company has cited $300 per month as the price tag for those therapies.

Bergstrom adds that “similar to all prescription products, a patient’s doctor must continue to refill the product based on their assessment of the patient’s medical necessity for BlueStar and their state laws governing how often they can prescribe.”

OptumRx has one external commercial client that had a July 1 implementation date, spokesperson David Himmel tells DBN. The PBM, he says, “feel[s] it’s premature to compare/contrast or discuss challenges with such limited data.”

And according to David Lassen, chief clinical officer for Prime Therapeutics LLC, the PBM has a few plans assessing the technology, but it has no true experience to speak of at this time.

BlueStar “officially launches in a few months in a yet-to-be announced regional roll-out followed by a national deployment in 2014,” says Bergstrom.

He adds that “we don’t expect to be an overnight success” because in the health care industry, “anything new...goes through a journey before it is widely covered and adopted. Fortunately, our trail was blazed by prior diabetes self-management products, such as blood glucose meters, insulin pens and insulin pumps, which were all new-to-the-world categories at one time, yet they became part of the standard of care for managing diabetes.”

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**CVS Caremark Sees Potential For Major Savings From Adherence**

*Reprinted from the July 12, 2013, issue of AIS’s biweekly newsletter Drug Benefit News. Call (800) 521-4323 for more information.*

While a recent flurry of industry reports and surveys focus on various aspects of medication adherence, their consensus is clear: The U.S. health care system could avoid millions of dollars in medical costs — and improve patient outcomes — if medication adherence rates were to improve. CVS Caremark Corp.’s latest analysis, in addition to projecting potential state-by-state cost savings through improved adherence, for the first time focuses on how differences in adherence affect health plans, employer-sponsored plans and Medicare Part D Prescription Drug Plans (PDPs), the three market segments served by its PBM business.
CVS Caremark’s “2013 State of the States: Adherence Report,” released June 27, projects potential cost savings ranging from $13 million (Alaska’s maximum potential medical savings by achieving optimal medication possession ratio, or MPR) to $1.2 billion (California’s maximum potential savings by converting all brand prescriptions to generics when available).

The report draws on data from CVS Caremark’s 2012 PBM book of business, and makes its state-by-state projections by examining medication adherence rates and the use of generic drugs across four common health conditions: diabetes, hypertension, high cholesterol (dyslipidemia) and depression, the company says.

Maryland Has Highest Overall MPR

CVS Caremark’s report also lists states with the highest overall adherence measures within each market segment.

In the health plan segment, Maryland had the highest overall MPR by state at 81.9%; Minnesota had the highest overall generic dispensing rate (GDR) at 93.4%; Pennsylvania had the highest overall first fill persistency rate (FFPR) at 79.8%; and Maine had the highest overall 90-day dispensing rate at 74.7%.

In the employer-sponsored plan segment, the report lists Vermont as having the highest overall MPR and FFPR at 84.7% and 81.1%, respectively; Minnesota again had the highest GDR at 92.4%; and Connecticut had the highest 90-day dispensing rate at 55.5%. For Medicare enrollees, Maine had the highest overall MPR at 86.3%; Massachusetts, the highest GDR at 92.0%; New Jersey, the highest FFPR at 94.2%; and Alaska, the highest 90-day dispensing rate at 54.1%.

More broadly, CVS Caremark’s report found that across the three market segments, patients with depression generally had the lowest adherence rates; those with high blood pressure were most compliant. Medicare beneficiaries had the highest adherence rates across the three member groups, the report notes, and 90-day dispensing rates were generally highest among members of employer-sponsored plans. It also found regional variations across groups: The lowest adherence rates for health plan members with diabetes and depression were in the Midwest, for example, while the South had the lowest rates for patients with any condition in employer-sponsored plans and PDPs.

Among other recent studies examining adherence:

◆ A first-of-its-kind patient survey on medication adherence in the U.S., released June 25 by the National Community Pharmacists Association (NCPA), gives chronically ill Americans aged 40 and older a C+ on average. NCPA fails one in seven members of this group, the equivalent of 10 million-plus adults. The report card calculated grades based on patients’ self-reported answers about whether in the past 12 months they had failed to fill a prescription, neglected to have a prescription refilled, missed a dose, took a lower or higher dose than prescribed, stopped a prescription early, took an old medication for a new problem without consulting a doctor, took someone else’s medicine or forgot whether they had taken a medication. NCPA says the survey was conducted among a national sample of 1,020 adults age 40 and older who had gotten a prescription for a chronic condition.

◆ An OptumRx study released June 27 concludes that patients using specialty-pharmacy adherence programs had consistently lower costs and higher therapy compliance than did those using conventional retail pharmacies. The study, published in the Journal of Managed
Care Pharmacy, followed for a year two groups of employer-sponsored health plan enrollees who had gotten kidney transplants. One group of 519 plan enrollees filled at least 80% of renal transplant immunosuppressants at specialty pharmacies; the other group of 519 filled at least 80% of medications at retail pharmacies. Researchers found a 30% reduction in transplant-related medical costs and a 13% reduction in overall health care costs for the former group.

A study in the July issue of Health Affairs finds that poor medication adherence, associated with additional medical and hospital visits, costs an extra $49 to $840 per Medicare beneficiary per month. Data were analyzed for beneficiaries with diabetes, heart failure or chronic obstructive pulmonary disease who were enrolled in Part D. Researchers, led by a professor at the University of Maryland School of Pharmacy, also said they produced a new metric, “potentially preventable future costs,” that can be used to target medication therapy management interventions to at-risk beneficiaries.

CVS Caremark says it developed an interactive online hub for use with its report, allowing users to filter data by market segment, health condition and adherence measure within a specific state or to draw comparisons across states, the company noted.

CVS Caremark spokesperson Christine Cramer tells DBN that the report is based on her firm’s expansive PBM book of business with claims for 60 million-plus members. “This large sample allows us to see a comprehensive picture of what medication adherence patterns look like across the country,” she says. She explains that CVS Caremark calculated potential cost savings on a state-by-state basis using a proprietary statistical model; it looks at estimated cost savings for aspects of care, such as differences in costs for health care services (e.g., hospitalizations or emergency department visits) between adherent and non-adherent patients and differences in costs between patients with gaps in care (i.e., diabetics without statins) and patients without gaps.

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Nonadherence Was Main Reason for $213B in Avoidable Health Care Costs


Last year, the U.S. health care system racked up $213 billion in avoidable costs due to the incorrect use of medications, according to a study from the IMS Institute for Healthcare Informatics released June 19. The report, titled Avoidable Costs in U.S. Healthcare: The $200 Billion Opportunity from Using Medicines More Responsibly, points out that this amount equates to 8% of the country’s total spending on health care in 2012.

The report studies six areas contributing to these costs: nonadherence, delays in evidence-based treatment, antibiotic overuse/misuse, medication errors, less-than-optimal use of generics and mismanagement of polypharmacy in older adults. Nonadherence to medications was the main driver, representing almost half of the avoidable costs — or $105.4 billion — last year (see chart, left). Those costs spanned various care settings (see chart, right).
However, at a June 14 conference call to discuss the findings, Murray Aitken, executive director of the IMS Institute, said that the company also sees “signs of improvement in some areas.” For example, patient adherence to drugs for hypertension, hyperlipidemia and diabetes—all conditions with large patient populations—has improved between three and four percentage points since 2009. And inappropriate use of antibiotics for people with the common cold or flu has declined from 20% in 2007 to 6% last year.

“Access to medications is important,” Aitken maintained. “But the responsible use of those medications is equally important.”

View the report at http://tinyurl.com/ldtesad.

### Avoidable Costs Due to Nonadherence

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Prime, Florida Blue Employ Integrated Strategy to Boost Adherence, Star Ratings

Reprinted from the April 12, 2013, issue of AIS’s biweekly newsletter Drug Benefit News. Call (800) 521-4323 for more information.

As CMS continues to place emphasis on medication adherence in its star quality ratings for Medicare Part D plan sponsors, plans that employ an integrated strategy with their PBMs are at an advantage when it comes to boosting adherence, suggested executives from Florida Blue and Blues plan-owned PBM Prime Therapeutics LLC during a recent AIS webinar. Drawing on lessons learned from their own combined experience, speakers advised using targeted and well-timed outreach and communication methods while watching out for barriers to adherence such as cost and patient misconceptions about their medications.

Medicare Part D plans are rated in four domains, which include drug pricing and patient safety. There are four measures related to medication adherence for hypertension, diabetes, high cholesterol and, as of 2013, HIV. Starting in 2012, adherence measures were weighted three times as much as star measures in the other domains, comprising almost half of the aggregate score in general. “So you can see there’s a tremendous amount of focus on adherence measures because of that weighting and the impact to plan sponsors,” explained David Lassen, Pharm.D., chief clinical officer at Prime, speaking at the March 28 AIS webinar, “Medicare Star Ratings: An Integrated Approach to Improving Medication Adherence Measures.”

Based on their experience working together to improve adherence measures, Florida Blue and Prime recommended incorporating the following four elements into an integrated strategy:

1. Utilize a “joint dashboard” or similarly shared tool to continuously evaluate the measurements and assess the impact of various interventions.

2. Review on an ongoing basis the communications between all parties involved in supporting the star rating measures.

3. Conduct pilots and proof of concepts to test and measure more targeted interventions, moving away from a “one-size-fits-all approach,” and determine if there’s something worth rolling out on a broader basis.

4. Constantly refine engagement activities, comparing and benchmarking various activities (e.g., mail campaigns, automated refill reminder programs) across the board.

When it comes to outreach methods, Cynthia Griffin, Pharm.D., senior director of pharmacy government programs at Florida Blue, advised that both timing and coordination are critical to impacting overall adherence. “I think we’ve learned in health plans over time, the best approach appears to be a holistic one in which the outreach efforts are focused on addressing multiple care gaps with fewer communications,” she observed. “[Members] don’t want to be bombarded with mass communications from their health plans or various vendors representing their health plans.”

In a telephone-based refill reminder pilot conducted in conjunction with Prime, Florida Blue targeted 17,000 members during a 30-day period to ask patients why they are likely to skip a drug. For those who were taking a single drug, 30% responded that they felt they didn’t need the drug. But for patients taking multiple medications, cost replaced “don’t need”
as the No. 1 answer (33% versus 25%). The next phase of Prime and Florida Blue’s collabor-
ration will include tailoring interventions based on patient preference and performing a
“deeper drill-down” into that “don’t need” category, said Griffin.

Experts Warn Against Free Generic Programs

When discussing the impact of pharmacy benefit design on medication adherence,
Lassen pointed out that members utilizing free or $4 generic drug discount programs of-
fered by retailers have the potential to skew data when it comes to tracking adherence. A
Prime study released last year was the first to quantify the impact of such programs on a
PBM’s ability to conduct and monitor clinical programs.

“We know that member cost-share does have a significant impact on adherence…and the
impact of managing generics in this space is also very significant,” he observed. But “ensur-
ing the generic copay for drugs in the star rating adherence measures are at or below com-
mon $4 generic cut-points helps otherwise the shifting in members to free generics, which
can cause potentially the member to not use their insurance card for processing the prescrip-
tion and impact the overall star rating measures negatively.” For plans that are considering
offering free generic programs of their own, Lassen recommended they “use a targeted ap-
proach targeting those [drugs] with star rating measures.”

“Within a given population or region there can be considerable utilization of these pro-
grams, and I think the challenge for us as plans is when members vary utilization from
month to month,” added Griffin. In other words, a patient may utilize his or her prescription
drug benefit one month, and then use one of the free drug programs the next month, lead-
ing the plan to view the member as nonadherent. Therefore, it may be necessary to engage
case managers and plan pharmacists to work through the process of determining a patient’s
overall adherence pattern, she suggested. “And I think it’s really key to engage the member
through your overall educational process so that they will understand the impact of various
practices.”

Suspecting that such programs were impacting the insurer’s ability to track and manage
adherence, Blue Cross & Blue Shield of Rhode Island conducted an internal analysis to deter-
mine that fewer claims were being lost than expected. “It was a little less, but not dramati-
cally less,” says Tara Higgins, R.Ph., clinical pharmacist, who did not speak at the webinar.
She explains to DBN that the majority of the Rhode Island Blues plan’s pharmacy contracts
employ a “lower of” logic, so if a patient goes into a Walmart and shows his or her insur-
ance card, the member will walk out paying the lower of either the copay amount or the
pharmacy’s amount, which is typically $4 for popular generic drugs sold at big-box retailer-
ers. Because of the way those contracts are written, the claim would still be captured by the
health plan as long as the member presented his or her insurance card.

“I’ve talked to friends that work in the retail setting and I’ve asked them if they ask for
the insurance card and they said yes,” reveals Higgins. “The thing that happens is patients
believe that they’re not eligible for the program if they present their card. So we have an op-
portunity to educate members and explain that they’re still eligible for these programs and
it’s important for the capturing of the information from a safety perspective [to present the
card].” ◊
2014 Star-Rating Changes Include Use of Individual-Measure Scores


In the draft 2014 “Call Letter” CMS issued Feb. 15, the agency backed away from several significant Medicare Advantage and Part D star-ratings changes it had been considering for 2014. But it is going ahead with two potentially very significant ones that would use actual individual-measure scores rather than star ratings for those measures in computing the key summary and overall star scores, and would boost the four-star cutoff points for measures related to the Million Hearts cardiovascular health initiative.

Moreover, while there are no new stars measures for 2014 as of now (that could change in the final call letter to be released April 1), CMS again is “considering” the retirement to the “display page” of several measures on which plans generally have done well. The net effect of these and other star-rating changes contemplated in the Call Letter furnishes another sign that CMS intends to keep “raising the bar” for MA and Part D plans, says Lucia Giudice, a senior manager at Deloitte Consulting LLP.

The most important change in the Call Letter, according to Kristian Marquez, vice president, clinical and quality outcomes for stars data analytics specialist Inovalon, Inc., is altering the methodology for calculating the summary and overall star ratings. The change CMS is proposing would start in 2014 and aims, the agency says, to get “more precise reflections of the performance data” than are supplied from the current method of using just the star ratings that MA and Part D plans get on individual measures. The agency cites an example of two MA contracts, one of which scores 47% and the other 63% on the breast cancer screening measure. Under the current method, both plans would get two stars on the measure, even though their scores differ by 16 percentage points, CMS notes. Marquez discussed that and the other proposed star-rating changes in a Feb. 20 AIS webinar.

“This is a really big deal,” Marquez tells MAN of the proposed change to instead use the actual individual-measure scores. While it won’t affect how plans seek to improve quality, he explains, it does boost the stakes for doing so. It is especially vital for plans “a couple of ticks close to the next highest star rating,” since “every percentage point now makes a difference,” Marquez asserts.

Four-Star Thresholds May Keep Rising

The other change he cites as particularly significant derives its importance not only from what it does but also from the rationale CMS is using. For the 2015 star ratings, the agency said in the Call Letter, it proposes raising the threshold levels plans must attain to earn four stars on four measures associated with the Million Hearts care improvement initiative by two percentage points each. The measures involved include two for MA (cardiovascular care-cholesterol screening and controlling blood pressure) and four for Part D (diabetes treatment, plus medication adherence related to diabetes drugs, hypertension and cholesterol).

CMS, according to Marquez, is articulating a thought process that Inovalon and some other stars specialists had expected: that the four-star cutoff points the agency furnishes each year are not designed to be “fixed forever” but instead would be raised over time. He
contends that part of the reason for this is financial. “There’s a finite amount of funding” available for stars bonuses, and this amount would get exhausted quickly if the levels of performance needed to earn the bonuses that four-star plans would continue to get in 2015 and beyond are not raised periodically, he asserts. CMS has set cut points only for four-star plans, leaving the performance levels for other scores dependent on the precise results of the rated plans.

Along somewhat similar lines, CMS moved in the Call Letter to end a loophole in its rating rules that now applies its Low Performer Icon (LPI) only to contracts receiving less than three stars for either their MA or Part D summary ratings for the last three years. This has led “stakeholders,” according to the Call Letter, to raise concerns that sponsors can switch their focus from year to year and alternate having poor stars performance in MA and Part D without being assigned the LPI. To avoid that, CMS is proposing to assign the LPI to any MA prescription drug (MA-PD) contract getting 2.5 or fewer stars in any combination of MA and Part D summary ratings. Marquez terms this proposal “not surprising.”

A CMS proposal that on the surface may be more unexpected is to delay for one year two new star measures that it had mentioned last Nov. 30 as possibly starting for 2014. They are the medication therapy management (MTM) program completion rate for comprehensive medication reviews (CMRs) and the MA Special Needs Plan (SNP) care management measure. Both will be kept on the display page, where they will be scored but the scores won’t be taken into account for 2014 star ratings.

Marquez says the delay on the MTM measure is logical in light of the lack of consensus on how to adjust for the “variance” that exists “across plans” in the use of MTM and CMRs. In addition, there is an issue, cited by CMS itself, of how plans have reported beneficiaries as long-term care (LTC) residents who could be excluded from CMR completion-rate calculations. CMS in the call letter proposes including LTC residents in the measure calculation — but the measure wouldn’t start till 2015 and would use data from 2013, when LTC beneficiaries no longer are exempt from the CMR requirement.

The care management measure delay, according to Marquez, is “something of a non-event.” He suggests that CMS apparently just wants more time to evaluate a situation that is complicated by socioeconomic issues surrounding SNP members.

Most of the other proposed star changes for 2014 and 2015 are the same as the agency had disclosed Nov. 30. Among those changes are inclusion of low-enrollment contracts in the ratings starting in 2015 and retirement to the display page for 2014 of measures for enrollment timeliness, getting information from drug plans and call center-pharmacy hold time.

These changes mark a continuation of CMS actions to remove from the star ratings administrative measures on which plans have done well, says Giudice.

But Marquez notes that some of the star measures CMS says it intends to add to the display page for 2014 and potentially use in 2015 ratings are ones on which MA-PD plans have some control and could fare well. These include pharmacotherapy management of COPD exacerbation, initiation of alcohol and other drug dependence treatment, and variation of Medicare Plan Finder price accuracy for Part D plans. Somewhat similarly, he says, plans could benefit from CMS’s intended addition of two more drug classes in the Part D measure for medication adherence on diabetes since members on these additional drugs could be considered adherent.
CVS Caremark, Express Scripts Approach 2014 Selling Season With Data-Driven Tools


As both stand-alone and insurer-owned PBMs gear up for the 2014 selling season, the big two PBMs tell DBN that they’re expanding their research into consumer behavior to offer data-driven products to existing and potential clients that will ultimately improve adherence and patient outcomes. Express Scripts Holding Co. has built a platform based on engendering healthy decisions, while CVS Caremark Corp. says it is placing “lots of focus within the organization around adherence.”

Building on the behavioral science and “consumerology” approach that was such a big part of the Express Scripts business model prior to the company’s 2012 acquisition of Medco Health Solutions, Inc., the former has adopted a new philosophy it calls Health Decision Science. “I think about it as a lens that allows us to focus on what’s causing our clients to have issues around the affordability of their benefits, as well as health and safety issues of the people that our clients are responsible for,” explains Glen Stettin, M.D., senior vice president of clinical research and new solutions.

“The fact of the matter is that there are lots of opportunities to make a decision, and bad decisions or poor decisions or uninformed decisions can really cause a problem in terms of both health and financial outcomes,” continues Stettin. Thanks to the combination of the two PBMs, Stettin says Express Scripts is able to draw on “rich, actionable data” and is applying data science to that information to explain why people are making these decisions and what to do about it. “You’ll see that come through in our portfolio of solutions, whether they’re around trying to influence people’s drug choices or around the pharmacy network and home delivery.”

Here’s how some existing products have been enhanced for 2013 based on the merger and this new Health Decision Science approach:

♦ ScreenRx. Built by Express Scripts on the notion that a letter to a physician or a phone call to a patient isn’t going to work for everybody, ScreenRx uses predictive modeling to identify patients who are at the highest risk of falling off their medication regimen and tailors interventions based on certain factors. “We recognize that what drives nonadherence in diabetes is different than what drives nonadherence in HIV, so there are some things that are similar, but there are different nuances about what’s the right thing to do based on the particular disease,” explains Stettin. In addition to gaining pharmacy data from Medco, Express Scripts has absorbed medical data for 25 million lives from Medco’s RationalMed program (see below), which Stettin says helps inform and make the predictive models even better and more precise. Another gain from the Medco acquisition is the use of its Thera-
peutic Resource Centers, organized by chronic condition and staffed with pharmacists who specialize and deal only with patients who have that condition.

- **RationalMed.** Health plans, employers and other clients who choose this safety and health product supply Express Scripts with medical data that the company integrates with pharmacy data. The goal is to “build a longitudinal record that allows us to look for safety issues and prevent errors that were otherwise undetectable when you don’t look at the data together,” says Stettin. One goal is to have as many legacy Express Scripts clients as possible participate in RationalMed so that the PBM can expand its data set, he adds.

- **Express Alliance.** This also was an Express Scripts offering prior to the merger that utilizes actionable data to improve coordination of care, but now “has some pretty interesting capabilities that were from the Medco organization,” says Stettin. For instance, the additional medical data contributes to predictive models that identify patients with gaps in care and aid in the creation of a “health action plan” through which patients are assigned a nurse case manager or care manager. In addition, the company has established a hotline that hooks up the care coordinators with its specialist pharmacists.

Stettin adds that Express Scripts continues to see client interest in narrower networks and narrower drug lists in both the traditional and specialty pharmacy spaces.

During **CVS Caremark’s** Dec. 13 Analyst Day, President and CEO Larry Merlo alluded to “next-generation” PBM programs that infuse “behavioral economics and predictive analytics.” Anita Allemand, Pharm.D., vice president of product innovation and management, explains that the company is building on the success of its Pharmacy Advisor program to augment pharmacy data with “rich data sources.” The pilot program is aimed at identifying what separates one patient from another when it comes to adherence. While Allemand says she can’t share the details of those alternative data sources just yet, the goal is to have a “360-degree view of that patient who has an adherence issue.”

“There’s data that shows that [for some patients,] no matter what you do, you will not be adherent, and there’s some data that says for some people you don’t need to have intense outreach because they are the types of people that will always be adherent,” explains Allemand. “Those two ends of the spectrum are fairly easy to identify, but what is in the middle is what I think is pretty groundbreaking: the people that we don’t know about, and what’s the right outreach for them.” Allemand adds that tailoring outreach methods to different patients may be more effective than frequency of the intervention. “We’re learning that if you reach out to someone three times, they’re frankly frustrated and they don’t want to hear from you again,” she says. As a result, the company is focusing more on how to design the content and the message that goes out to them.

### Integrated Data Has Predictive Power

She adds that using pharmacy data alone has “great predictive power because it’s very rich and it’s real time,” but it can achieve adherence rates in the 60% range, while combining that data with other sources “can really get to that predictive power in the 80s, which is fairly transformative.” Through Pharmacy Advisor, which targets specific disease states through either face-to-face or telephonic interventions, CVS Caremark knows a patient’s age, gender, plan design information, condition severity, etc. But what it would like to do, with patients’ consent, is track what kinds of questions the patients asked when they called a call center, what lifestyle challenges they may have that prevent them from picking up prescriptions,
or even their purchasing patterns such as what over-the-counter products they like to buy. “Ultimately that will all be embedded in our data warehouse by member and it will add to the pharmacy data so we can then very accurately predict past behavior, which relates to how someone will behave in the future,” asserts Allemand.

Meanwhile, other solutions that have already been piloted or offered in a limited capacity are now being rolled out more broadly. They include:

◆ **The use of electronic prior authorization (EPA) and smart prior authorization, or smart edits.** “Today lots of products have prior authorization. A member might go into the pharmacy and get a hard stop and be told that that product may not be covered, so these are two things that we’re rolling out to decrease disruption,” explains Allemand. Through EPA, physicians have the ability at the point of prescribing to understand the benefit design and go through prior authorization criteria immediately so that the prescription is processed seamlessly. Meanwhile, health plan clients enrolled in smart prior authorization supply medical data so that the patient’s diagnosis is already on file to ensure an automatic approval.

◆ **Value Formulary.** This two-tier formulary approach places generics on the first tier, and selected traditional brand products on the second tier in classes where multiple generics are not available. Specialty products would also fall on the second tier. CVS Caremark estimates that plan sponsors can save almost 12% by selecting this more aggressive formulary option, and accelerate generic dispensing rates that you would typically expect to achieve in 2015 as soon as this year.

◆ **Limited networks.** CVS Caremark now has four “off-the-shelf” network offerings, ranging from a full open network to a tiered approach. The most aggressive option is the Exclusive Choice Network, which is comprised of CVS/pharmacy and Wal-Mart Stores, Inc. locations. All of these options existed before, but the Exclusive Choice Network was enhanced for 2013, to ensure adequate coverage in areas where clients such as Blues plans have a more regional presence.

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**CVS Caremark Uses ‘High-Touch’ Method To Reach Noncompliant Cardio Patients**


After the successful launch of its Pharmacy Advisor program for diabetes, CVS Caremark Corp. now is directing its adherence efforts toward patients managing chronic cardiovascular illnesses. The program will focus on boosting medication compliance for four conditions: high blood pressure, high cholesterol, coronary artery disease and congestive heart failure (CHF).

Such strategies are becoming more important for plan sponsors, particularly those that offer Medicare Advantage or Part D products, as CMS has more heavily weighted drug adherence measures in its quality ratings and bonus programs.
“Cardiovascular as a whole is a pretty large part of any client’s spend,” explains Bill Grambley, director of health services at CVS Caremark. “There are a lot of generics there, and cardiovascular is a condition set that is expanding. It is one where there are very real outcomes that we can impact with adherence interventions, and it’s one where there’s a very real connection to medical claims so that employers and health plans can avoid higher expense issues.” Grambley declines to disclose specific outcomes results, however, as the PBM will unveil those Dec. 20 at its annual investor day.

Through the initiative, CVS Caremark reaches out to members at risk of falling off their drug regimen via strategically timed face-to-face and phone interventions, depending on how they typically obtain their prescribed therapies (i.e., via a retail store or mail-order facility). This is not unlike the Pharmacy Advisor program targeted to diabetes, which CVS Caremark launched in January 2011 after a six-month pilot in 2009 with the 80,000-employee firm ArcelorMittal. The difference here is that the PBM is reviewing pharmacy claims only to boost adherence, not to close gaps in care and improve compliance as was done for the diabetes program.

“With diabetes, the linkage between a specific group of therapies is very indicative of the condition. In essence, there are medicines to control blood sugar and with very few exceptions, people who use those are diabetic. With the cardiovascular conditions,” clarifies Grambley, “the linkage is not quite as specific for us to confidently identify a gap in care and allow us to discuss that gap with the member. A whole bunch of people could be on a statin but not qualify for a gap in care that would be indicated if we had medical data. There could be somebody who has the profile of a coronary artery disease patient but actually doesn’t have coronary artery disease; it just looks like it from our medications.”

As a result, the PBM looks at the medicines that are already on file for cardiovascular patients and identifies those who have a need for personal counseling. Triggers could be a person who is several weeks late in refilling a targeted therapy or a patient with one of the four conditions who is beginning a new targeted therapy.

**Retail-Based Method Wins**

In lieu of specific outcomes figures, Grambley offers the following general findings from both Pharmacy Advisor programs:

◆ **Store-based interventions outperformed those conducted by the call center.** There are a number of interventions that take place on the retail side, not all of them confined to the store. For instance, gaps-in-care interventions and first-fill counseling would occur at the store, but the retail pharmacist may make an outreach call for someone late in refilling a targeted script. “The fact that the person calling you is just three miles down the road helps with the conversation,” observes Grambley. “It’s not just a nameless, faceless person 1,000 miles away. It’s somebody that you would see if you walked into the store and could have that conversation with.”

Meanwhile, the call center has similar goals of improving adherence and gaps in care, but all of the interventions are done by phone. CVS Caremark has not directly measured the performance of a store-based call versus a call-center based call. Pilot data released by the company earlier this year showed that gaps in care were closed at rates bettering a control group by 59% for phone counseling and 91% for a face-to-face intervention.
◆ People tend to go back to their original behavior without interventions. Because there was a period of roughly seven months between the end of the ArcelorMittal pilot and the full launch of the program for diabetes, CVS Caremark was able to observe what happens over time when those “high-touch” interventions go away.

“For example, when somebody noticed they were two or three weeks late in refilling, they let it go for another two or three weeks until they remembered or happened to go to their doctor or some other trigger occurred, so it was pretty interesting to see that we had an impact. But if we stopped doing these things, over a period of time — it wasn’t immediate — the population tended to return to what it would have been doing without these interventions,” Grambley says.

Cardio Adherence Has High Savings Potential

CVS Caremark claims to have performed 1.7 million successful member interventions since last January and estimated earlier this year that it could save employers approximately $600 per year for each member with diabetes. The company would not disclose a similar savings estimate for the cardio program, citing plans to publish that data in the near future.

But a study conducted earlier this year by Aetna Inc., Harvard University and Brigham and Women’s Hospital found that patients with hypertension who followed their prescribed medication regimen saved nearly $4,000 per year, those with high cholesterol saved up to $1,200 per year, and CHF patients saved nearly $8,000 annually.

PBM Will Add More Conditions

Grambley explains that the cardiovascular initiative is a very natural extension of the diabetes program. “There are a lot of comorbidities between these [two conditions]; there’s obviously history that we can get from leveraging or reaching out on those cardiovascular therapies within the diabetes set. Within diabetes, there are specific therapies that are also used to treat cardiovascular conditions — ACE inhibitors, ARBs [angiotensin II receptor blockers], lipid control drugs — so we performed adherence interventions across those classes since we launched diabetes, and that gave us a good foundation on the cardiovascular side of what we would expect with those types of therapies.”

CVS Caremark now is enrolling clients, and would start serving cardiovascular patients in the spring. About nine to 12 months after that, predicts Grambley, the company plans to roll out Pharmacy Advisor for additional conditions.

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