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Inter Valley Health Plan
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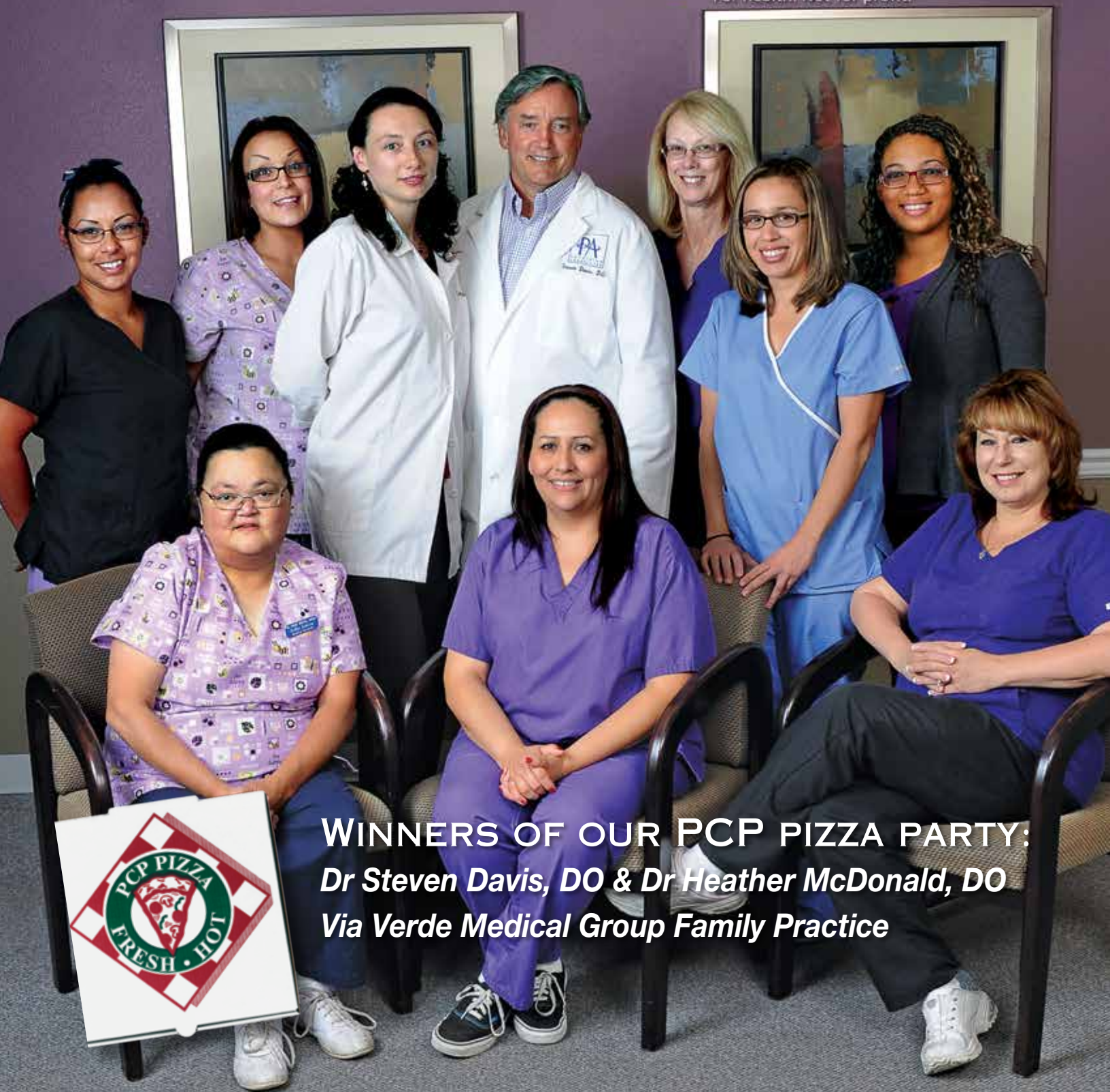


Winners of our PCP pizza party:

Dr Steven Davis, DO & Dr Heather McDonald, DO
Via Verde Medical Group Family Practice

REDUCING HOSPITAL READMISSIONS

Approximately 20 percent, or one in five, of recently hospitalized Medicare patients are readmitted to the hospital within 30 days of discharge, reports a study published in an April 2009 issue of the New England Journal of Medicine. One in three patients are back within 90 days, and as many as 50 percent of patients are readmitted within the year. The reasons are multi-faceted, but the study concludes "older patients often don't understand how to care for themselves after being released, and even if they do, many lack the family and even medical support to do so adequately."

One of the main reasons behind hospital readmissions is an overall lack of understanding of patient care instructions and how that care will be coordinated once the patient returns home.

The discharge process should not start at discharge it should start as soon as the patient is hospitalized. During admission is the time to start gathering the information necessary to make the transition to home or alternate level of care (i.e. nursing home or custodial facilities) as smooth as possible. The best place to start is by asking the right questions about the care the patient will need before he/she even leaves the hospital.

The most important questions to consider are those related to basic self care. Can the patient perform the functions of daily life activities, such as bathing independently, dressing, preparing meals and eating? Can he or she safely walk without assistance? Does the patient have transportation to get to doctor's appointments? Is memory and mental alertness sufficient to coordinate these tasks?

Prescriptions are another critical area of concern for older patients leaving the hospital. Ideally, patients need to know what medications they are supposed to take and when to take them. Patients also need to be able to reconcile the medications they were taking before they entered the hospital with any new ones they were prescribed. It is important to make sure the patient either has all of the medicines needed or has the ability to get them, and that there is a basic understanding of what each prescription is for and the potential side effects.

Another common problem that increases the risk of readmission is that patients don't always communicate the real story about their home environment and who will be able to care for them.

Whether the patient is still in the hospital or in the doctor's office, always make sure a family member or friend is with the patient when talking to any medical personnel. When a patient is not feeling well, it can be difficult to make sense of the information given, and another person may think of questions that don't immediately come to mind. A family member or friend can also help

with writing down the information in a notebook, along with contact names and phone numbers, so the patient can refer back to it.

One of the biggest roles that a primary care physician can play in reducing hospital readmissions is to accommodate patients with a follow-up office visit within the first to second week of discharge from the hospital. Promoting discussions related to Advance Care Planning/Advance Directives including End of Life discussions also facilitates patient engagement in the care planning process.

PHARMACY UPDATE FOR SERVICE TO SENIORS

Inter Valley Health Plan's Pharmacy and Therapeutics Committee continually reviews all drugs for formulary inclusion or exclusion. Physicians can stay informed through this publication, *Info-Link*.

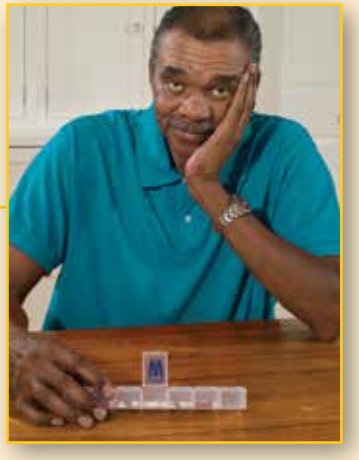
Covered Drug Name	Alternate Drug Name	Tier Description	Utilization Limits
POMALYST CAP 4mg	mannitol	specialty	PA
ENOXAPARIN INJ 300/3Ml	LOVENOX	non-preferred brand	PA,QL (84 per 30 days)
CYCLOSPORINE CAP 25mg MOD	NEORAL/GENGRAF	non-preferred generic	PA
CLINDAMYCIN CAP 75mg	CLEOCIN	non-preferred generic	
MONTELUKAST GRA 4mg	SINGULAIR	preferred generic	QL (30 per 30 days)
OXCARBAZEPIN SUS 300mg/5m	TRILEPTAL	non-preferred generic	
POMALYST CAP 1mg	mannitol	specialty	PA
BUPROPN HCL TAB 300mg XL	WELLBUTRIN XL	non-preferred generic	QL (30 per 30 days)
POMALYST CAP 3mg	mannitol	specialty	PA
XELJANZ TAB 5mg	tofacitinib	specialty	PA
BUPROPN HCL TAB 150mg XL	WELLBUTRIN XL	non-preferred generic	QL (30 per 30 days)
LINZESS CAP 145mcg	linaclotide	non-preferred brand	QL (60 per 30 days)
LINZESS CAP 290mcg	linaclotide	non-preferred brand	QL (30 per 30 days)
POMALYST CAP 2mg	mannitol	specialty	PA
KADCYLA INJ 100mg	ado-trastuzumab	specialty	PA
PREZISTA SUS 100mg/ml	darunavir	non-preferred brand	
ETODOLAC CAP 300mg	etodolac	non-preferred generic	

PA = Prior Authorization QL = Quantity Limits

For more information about the drugs covered by Inter Valley Health Plan, please visit our website at www.ivhp.com/site/PrescriptionDrugSearch.Aspx or call Pharmacy Services, 7:30 am to 8 pm, 7 days a week, at 800-523-3142. TTY/TDD users should call 800-505-7150.

PATIENT SAFETY MEASURES

Performance and quality measures are used by the Centers for Medicare and Medicaid Services (CMS) so that Medicare beneficiaries have the information necessary to make informed enrollment decisions by comparing available health and prescription drug plans. They also provide measures of quality across Part D Plans. As part of this effort, CMS currently calculates and publicizes eight patient safety measures for five therapeutic areas:



High Risk Medication (HRM)
Diabetes Treatment (DT)
Drug-Drug Interaction (DDI)
Diabetes Medication Dosage (DMD)
Adherence (ADH).

The HRM, DT, and three ADH measures, which are adapted from the measures developed and endorsed by the Pharmacy Quality Alliance (PQA), contribute to a plan's Part D Star Rating and are available on the Medicare Plan Finder at www.medicare.gov. The DDI and DMD measures, also PQA measures, are part of the Part D Display Measures available on the CMS website at www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp.

According to the CMS, the use of high risk medications should be avoided or used with caution in the senior population. These drugs are considered by medical experts to have a high risk of side effects when used by seniors and, therefore, may pose a safety concern. Some of these drugs simply are not effective enough to be routinely used or are no longer recommended because newer, safer alternatives are now available. Alternative therapies may include non-drug treatment. Inappropriate use of these high risk medications can lead to increased morbidity and mortality as well as increased and avoidable health care costs. Some of the drugs considered as HRM are Glyburide, Digoxin and Ambien to name a few. It is the primary care physician who has the ability to advise their elderly patients about the drugs that may impact their health and the cost of health services.

Inter Valley Health Plan continues to make an intense effort to remind clinicians of which drugs pose the greatest degree of threat for elderly members. In the columns at right you will find a list of drugs to avoid in the senior population.

HIGH RISK MEDICATIONS

ANTICHOLINERGICS

(excludes TCAs) first-generation antihistamines (as single agent or as part of combination products) – excludes OTC products

- Brompheniramine
- Carbinoxamine
- Chlorpheniramine
- Clemastine
- Cyproheptadine
- Dexbrompheniramine
- Dexchlorpheniramine
- Diphenhydramine *(oral)*
- Doxylamine
- Hydroxyzine
- Promethazine
- Triprolidine

ANTIPARKINSON AGENTS

- Benztropine *(oral)*
- Trihexyphenidyl

ANTITHROMBOTICS

- Ticlopidine*
- Dipyridamole, *oral short-acting** *(does not apply to extended-release combination with aspirin)*

ANTI-INFECTIVE

- Nitrofurantoin *(include when cumulative day supply is >90 days) (A)*

CARDIOVASCULAR

- Disopyramide*
- Digoxin *(>0.125 mg/day) (C)*
- Nifedipine, *immediate release**

Alpha blockers, central

- Guanabenz*
- Guanfacine*
- Methyldopa*
- Reserpine *(>0.1 mg/day)* (B)*

HIGH RISK MEDICATIONS *continued*

ENDOCRINE

- Estrogens** *with or without progesterone (oral and topical patch products only)*
- Desiccated thyroid
- Megestrol

Sulfonylureas, long-duration

- Chlorpropamide
- Glyburide

GASTROINTESTINAL

- Trimethobenzamide

CENTRAL NERVOUS SYSTEM

- Chloral hydrate*
- Meprobamate

Antipsychotics

first generation (conventional)

- Thioridazine
- Mesoridazine

Barbiturates

- Amobarbital*
- Butabarbital*
- Butalbital
- Mephobarbital*
- Pantobarbital*
- Phenobarbital
- Secobarbital*

Nonbenzodiazepine hypnotics

(include when cumulative day supply is >90 days) (E)

- Eszopiclone
- Zolpidem
- Zaleplon

Tertiary TCAs *(as a single agent or as part of a combination product)*

- Amitriptyline
- Clomipramine
- Doxepin *(>6 mg/day) (D)*
- Imipramine
- Trimipramine

Vasodilators for dementia

- Ergoloid mesylates*
- Isoxsuprine

PAIN MEDICATIONS

- Meperidine
- Pentazocine*

Non-COX-selective NSAIDS***

- Indomethacine
- Ketorolac

SKELETAL MUSCLE RELAXANTS

(as a single agent or as part of a combination product)

- Carisoprodol
- Metaxalone

*Infrequently used drugs.

TARGET TO GOAL: FOCUS ON ABCS

Inter Valley Health Plan's Chronic Care Improvement Program (CCIP) is designed to help health care professionals and their patients better combat the multiple risk factors associated with cardiovascular disease (CVD) and diabetes, by focusing on the ABC's.

Heart disease and stroke, the first and third leading causes of death for men and women, are among the most widespread and costly health problems facing our nation today, yet they also are among the most preventable. Cardiovascular diseases, including heart disease and stroke, account for more than one-third (33.6%) of all U.S. deaths.

Death rates alone cannot describe the burden of heart disease and stroke. In 2010, the total costs of cardiovascular diseases in the United States were estimated to be $444 billion according to the American Heart Association. Treatment of these diseases accounts for about $1 of every $6 spent on health care in this country. As the U.S. population ages, the economic impact of cardiovascular diseases on our nation's health care system will become even greater.

Empowering patients to lead a healthy lifestyle—not using tobacco, being physically active, maintaining a healthy weight, and making healthy food choices—greatly reduces a person's risk of developing heart disease or stroke. Preventing and controlling high blood pressure, high cholesterol and maintaining A1C level at 7% or below also play a significant role in cardiovascular health. For example, a 12–13 point reduction in average systolic blood pressure over 4 years can reduce heart disease risk by 21%, stroke risk by 37%, and risk of total cardiovascular death by 25%. Improved control of cholesterol or blood lipids (i.e. LDL, triglycerides) can reduce CVD complications by 20-50%. And in general, every percentage point drop in A1C blood test result (e.g. from 8% to 7%) reduces the risk of diabetes, kidney, eye and nerve disease by 40% per the United Kingdom Prospective Diabetes Study.

A CHANGE IS GONNA COME: THE ICD-10

The International Classification of Diseases. 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code set will be replaced by the International Classification on Diseases, 10th Edition, Procedure Coding System /Clinical Modification (ICD-10-PCS/CM) in 2014. This will affect diagnosis reporting with dates of service or discharge for inpatients that happen on and after October, 2014.

ICD – 10 Assessments: Clinical Documentation Evaluation

Documentation is critical

After thousands of ICD – 10 assessments, it has been noted that only 65% of today's documentation is ready for the ICD-10 transition. This confirms that one of the largest problems following the October 1, 2014 implementation date will be insufficient documentation to support the specificity required for the new ICD-10 code sets. The concern that this has been forgotten among the other education, training, and implementation objectives. If the office is fully prepared for the ICD-10, but clinical documentation has not improved, accurate coding and proper payment will not be possible. It is believed a behavioral change in documentation habits for most providers will be necessary — and now is the time to start preparing.

Just as an increase in the number of words in a dictionary doesn't make it more difficult, the greater number of codes in ICD-10-CM/PCS doesn't necessarily make it more complex. In fact, the greater number of codes in ICD-10-CM/PCS make it easier to find the right code. In addition, just as it isn't necessary to search the entire list of ICD-9-CM codes for the proper code, it is also not necessary to conduct searches of the entire list of ICD-10-CM/PCS codes. The Alphabetic Index and electronic coding tools will continue to facilitate proper code selection. It is anticipated that the improved structure and specificity of ICD-10-CM/PCS will facilitate the development of increasingly sophisticated electronic coding tools that will assist in faster code selection. Because ICD-10-CM/PCS is much more specific, is more clinically accurate, and uses a more logical structure, it is much easier to use than ICD-9-CM. Finally most physician practices use a relatively small number of diagnosis codes that are generally related to a specific type of specialty, so the learning curve may not be that challenging.

Non-pressure Chronic Ulcers with Necrosis of Muscle

ICD-9-CM	Angioplasty 1 code (39.50)
ICD-10-PCS	Angioplasty codes 854 codes – specifying body part, approach, & device, including:
047K04Z	Dilation of right femoral artery with drug-eluting intraluminal device, open approach
047K0DZ	Dilation of right femoral artery with intraluminal device, open approach
047K0ZZ	Dilation of right femoral artery, open approach
047K34Z	Dilation of right femoral artery with drug-eluting intraluminal device, percutaneous approach
047K3DZ	Dilation of right femoral artery with intraluminal device, percutaneous approach

BRIDGING THE GAP IN DRUG COSTS

Prescription drugs can be life-saving. But Medicare Part D drug coverage can be confusing. Especially when patients reach the "donut hole" — that gap where there is a temporary limit on what the drug plan will cover for prescriptions.

Thankfully, under the Affordable Care Act, the gap is shrinking, and will be closed by 2020. Here's how Part D prescription drug benefits work today, and how they're changing.

HOW IT WORKS TODAY

Patients reach the gap when prescription drug costs paid by members and Inter Valley Health Plan reach the initial coverage limit.

For brand-name drugs, patients pay less than half of the drug's full price — 47.5% — plus a dispensing fee.

Meanwhile, the full price is counted toward a patient's out-of-pocket costs. That helps get them out of the gap faster.

For generic drugs, patients pay 79% of the full price, plus a dispensing fee (a 21% discount). But only what they pay counts toward their out-of-pocket costs.

Once patients pay $4,750 in out-of-pocket costs, they're out of the gap. After that, it's considered "catastrophic coverage," and they pay a much smaller coinsurance or copayment cost for drugs.

HOW IT WORKS IN 2020

The coverage gap as we know it today will be closed. Patients will pay 25% for both generic and brand-name drugs until they reach the yearly out-of-pocket spending limit.

In fact, the percentage they will pay for both generic and brand-name drugs has been shrinking steadily and will continue until it reaches the 25% mark in 2020.

Patients are eligible for coverage savings while they're in the gap if:

- The patient is currently in a program that offers Medicare Part D coverage.
- They do not receive Extra Help *(government assistance for people with limited income and resources).*
- They've reached the coverage gap. (*Note: The coverage gap varies by plan. Details are in the Evidence of Coverage book mailed to IVHP members each September.*)

Brand-Name Drugs Get "With the Program"

Just as in fashion and food, brand names can get pricey when it comes to prescription drugs. Happily, over 99% of all drug manufacturers have agreements with Medicare to participate in the Medicare

Coverage Gap Discount Program

The discount is based on the price Inter Valley Health Plan has set with the pharmacy.

Coverage Examples: Brand Vs. Generic

Already over $2970 in drug costs this year, Judy Jones hits the coverage gap. She goes to her pharmacy with a prescription for a brand-name drug. The total price is $82 ($80 for the drug plus a $2 dispensing fee).

But since the manufacturer covers 52.5%, Judy pays only 47.5%. So $80 x 0.475 = $38. Judy pays $38 plus the $2 dispensing fee (added after discount) = $40. The entire $82 counts as out-of-pocket spending.

Meanwhile, Judy's husband Jack is also in the gap. He gets a generic drug that costs $20 plus the $2 dispensing fee (added here before the discount) = $22.

Jack pays 79% of cost. $22 x .79 = $17.38. That $17.38 counts toward his out-of-pocket spending.

INTER VALLEY HEALTH PLAN
300 South Park Avenue
PO Box 6002
Pomona CA 91769-6002

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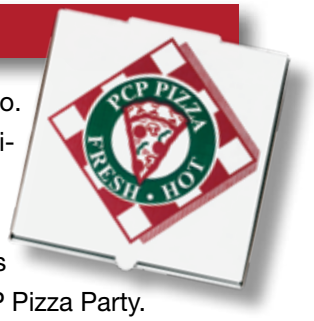
EDITOR'S NOTE:
We value your opinion. If you have any comments on this issue or have a topic suggestion for future issues, please contact Cyndie O'Brien at 909-623-6333 or cobrien@ivhp.com.

WIN A PIZZA PARTY ON US!



Inter Valley is proud of its providers and all the great work you do. As a token of our appreciation we are rewarding one lucky physician and their entire staff with a pizza party, delivered directly to their office. Dr Steven Davis, DO and Dr Heather McDonald, DO from the Via Verde Medical Group, Family Practice in San Dimas and their excellent team are the most recent winners of our PCP Pizza Party.

Your staff provide exceptional care to patients, and essential support to you every day. Show them how much you appreciate all they do by entering them for a chance to win. Fill in the information below and mail to Inter Valley Health Plan, Att. Pharmacy Dept, 300 South Park Ave, PO Box 6002, Pomona CA 91769-6002, or fax to 909-620-8092. Entries must be post-marked by July 15, 2013.

1. According to the CMS, the use of _____ _____ medications should be _____ or used with _____ in the _____ population.

2. _____ use of these high risk medications can lead to _____ _____ and _____ as well as increased and avoidable _____ _____ _____.

3. It is the _____ _____ _____ who has the ability to advise their _____ _____ about the drugs that may _____ their _____ and the _____ of health services.

Physician: _____

Office Address _____