

# Clinician Quarterly

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## Comments or Suggestions?

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[nhp.org](http://nhp.org)

## NHP Awarded Special Kids Special Care Contract

*From Paul Mendis, MD, Chief Medical Officer of Neighborhood Health Plan*



**S**pecial Kids Special Care (SKSC) is a medical program created and co-sponsored by Massachusetts Medicaid, the Department of Children and Families (DCF), and NHP. Following a competitive procurement process, NHP is proud to announce its selection as the only health plan through which this unique program is offered statewide, as of January 1, 2011.

SKSC was developed as a pilot in 1999 for children in foster care who have complex medical needs (e.g., multiple disabling congenital anomalies, shaken baby syndrome, progressive degenerative neuromuscular conditions) and focuses on the whole child by addressing medical, behavioral health, and developmental needs. The sponsoring agencies recognized that these children and their foster families could benefit from managed care because of their vulnerability to poorly coordinated treatment or services.

NHP's wholly owned clinical affiliate, the Community Medical Alliance (CMA), had developed a community-based specialized care management model for adults the state believed could be effective for children with complex medical needs. The ensuing pilot, operative in portions of eastern and central Massachusetts, enrolled up to 130 children at a time to receive individualized home-based services coordinated by CMA's pediatric nurse practitioners.

Typically these children have multiple specialists as well as a primary care physician involved in their care. The nurse practitioner plays an important role in facilitating communication and coordination among the other involved medical, behavioral health professionals, DCF case workers, school staff, and families. They provide ongoing home education and support for the foster parents, obtain needed durable medical equipment and, because they are available for consultation at all times, they can prevent unnecessary emergency room visits or hospitalizations.

Compelling evidence of improved quality, cost-effectiveness, family satisfaction, and testimonials from physicians led the sponsoring agencies to end the lengthy pilot and to expand the program.

Your patients potentially eligible for SKSC should be referred for screening via their local DCF office. [CC](#)

## Statistics Released from American Lung Association

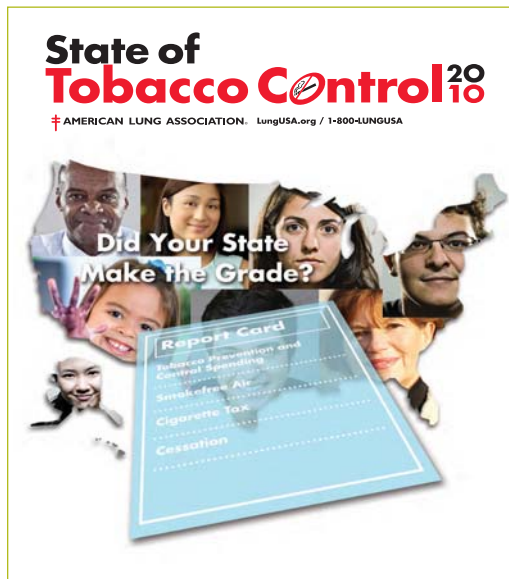
Slight Progress Made Despite Cuts and Setbacks

The American Lung Association (ALA) has released its State of Tobacco Control report<sup>1</sup>, which tracks progress on key tobacco control policies at state and federal levels. It assigns grades to tobacco control laws and regulations in effect as of January 1, 2011: An “A” is given for excellent tobacco control policies while an “F” indicates inadequate policies. The ratings pertain to the following four categories: smoke free air; cigarette tax; tobacco prevention; and control spending and cessation.

As explained on the ALA website: “Each state’s grades reflect how well its state tobacco control laws measure up to the best in the nation or to goals set by federal agencies such as the Centers for Disease Control and Prevention (CDC). Many states have hard-working tobacco control coalitions that encounter stiff resistance from state legislators and powerful tobacco interests. The grades in this report in no way reflect the level of effort invested by the public health community. Instead, it is the responsibility of elected officials to muster the political will

The ALA report shows that Massachusetts received an “A” rating under “smoke free air,” signifying strong smoking restrictions in workplaces, schools, and bars. In 2002, Massachusetts had the highest cigarette tobacco taxes in the nation; today it ranks 8th at \$2.51 per pack, enough to render a “B” rating for the second variable measured pertaining to “cigarette tax.” Although Massachusetts received “F” rating for “tobacco prevention and control spending” and “cessation,” some context on overall state patterns may help to shed light on this rating. For example, in 2007, no state was funding smoking cessation programs at 100 percent of the Center for Disease Control (CDC) levels.

The CDC Best Practices for Comprehensive Tobacco Control Programs provides standards for smoking cessation spending based on the tobacco tax revenues and tobacco industry settlements payments. The CDC recommendation for cessation spending in Massachusetts is \$90,000,000—



The American Lung Association’s comprehensive State of Tobacco Control 2010 report offers an up-to-date guide to policies and programs that have been proven effective in confronting the nation’s tobacco epidemic.

yet the 2011 Massachusetts funding for tobacco control programs is a little over \$10,000,000. State ranges varied widely, with the highest funding coming from Maine (using 85% of recommended funding), and the lowest state being Tennessee (using only 1.1% of the CDC recommendation). Overall, limitations in providing smoking cessation programs can be understood by examining the lack of funding or the reduction in legislative financial supports.

The report goes on to note that although the Massachusetts Tobacco Cessation and Prevention Program lost over 65 percent of its funding last year, the program’s infrastructure does remain intact—calling it “a victory in this poor economic climate, which will allow the program to maintain its infrastructure to build on in future years.” Furthermore,

another report from the Public Library of Science does say that for Massachusetts Medicaid members, the “use of a comprehensive tobacco cessation pharmacotherapy benefit was associated with a significant decrease in claims for hospitalizations for acute myocardial infarction and acute coronary heart disease. . . .”<sup>2</sup>

This groundbreaking finding, which is gaining national attention, suggests that, indeed, evidence-based smoking cessation supports are being offered in Massachusetts. Moreover, the ALA report demonstrates that NHP is the only Massachusetts plan covering all FDA-approved cessation medications without restrictions.

Another positive trend for Massachusetts is the lower levels of smoking prevalence compared to that of the country as a whole: 16.1 versus 18.4, respectively. There is still much more to do. But Massachusetts undoubtedly is on track, and is making progress responding to one of the country’s most devastating health and economic burdens. [CO](#)

1 American Lung Association, State of Tobacco Control, <http://www.stateoftobaccocontrol.org/ala-sotc2010.pdf>

2 Public Library of Science, A Longitudinal Study of Medicaid Coverage for Tobacco Dependence Treatments in Massachusetts and Associated Decreases in Hospitalizations for Cardiovascular Disease, [www.plosmedicine.org](http://www.plosmedicine.org)

## Pharmacy & Therapeutics Update

The NHP Pharmacy and Therapeutics Committee has reviewed the following medications.

Tier 1 (New Generics)	Tier 2	Tier 3
Accolate (zafirlukast) Ambien CR (zolpidem) Aricept (Donepezil) Monistat 1 Kit (miconazole suppository and cream) Opana (oxymorphone) Ponstel (Mefenaminc Acid) Prevacid Solu-tabs (lansoprazole) Sanctura (trospium chloride) Xyzal (Levocetirizine) Yasmin (drospirenone-ethinyl estradiol)	—	Actemra Livalo (pitavastatin) Lysteda

The Pharmacy and Therapeutics Committee has voted to implement a **quantity limit<sup>i</sup>** on:

- Livalo 30 tablets/30days
- Lysteda 30 tablets/28 days

The Pharmacy and Therapeutics Committee has voted to eliminate the step therapy<sup>ii</sup> program for **H2 Receptor Antagonist Step Therapy Program**.

The Pharmacy and Therapeutics Committee has voted **not to cover<sup>iii</sup>** the following medications:

- Zantac Efferdose
- Cambia Powder

The Pharmacy and Therapeutics Committee has voted to implement the step therapy<sup>iv</sup> program for **Selective Alpha Blockers for BPH Step Therapy Program** effective January 2011.

First Line Medications	Second Line Medications
Tamsulosin (Flomax)	Rapaflo (silodosin) Uroxatral (alfuzosin)

The Pharmacy and Therapeutics Committee has voted to change the step therapy<sup>v</sup> program for **HMG Co-A Reductase Inhibitors Step Therapy**:

First Line Medications	Second Line Medications	Third Line Medications
lovastatin pravastatin simvastatin	Altoprev Crestor Lescol/XL	Lipitor Vytorin

The Pharmacy and Therapeutics Committee has voted to place a **Prior Authorization<sup>vi</sup>** on the following medications:

- Actemra
- Lysteda

Check [www.nhp.org](http://www.nhp.org) (provider page) for the most up-to-date information about the NHP pharmacy program and the current medical necessity criteria. [CO](#)

i. Quantity limits promote cost effective prescribing by limiting the number of units of medication that can be dispensed over a given time. These are established based on strengths available and the recommended doses.  
 ii. Step Therapy is an automated case review based on P&T established guidelines and the individual member's NHP pharmacy profile. This process occurs with a pharmacy claims submission and does not require provider intervention if prior NHP pharmacy claims indicate use of the first line and/or second line medications.  
 iii. Requests for non-covered medications will be reviewed on a case by case basis.

iv. Step Therapy is an automated case review based on P&T established guidelines and the individual member's NHP pharmacy profile. This process occurs with a pharmacy claims submission and does not require provider intervention if prior NHP pharmacy claims indicate use of the first line and/or second line medications.  
 v. Step Therapy is an automated case review based on P&T established guidelines and the individual member's NHP pharmacy profile. This process occurs with a pharmacy claims submission and does not require provider intervention if prior NHP pharmacy claims indicate use of the first line and/or second line medications.  
 vi. Prior Authorization is an individual case review compared to P&T established guidelines before a prescription for the specific medication will be covered.



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## Availability of the Appropriate Practitioner to Discuss UM Decisions

In all instances of medical necessity denials, it is NHP's policy to provide the treating/referring practitioner with an opportunity to discuss a potential denial decision with the appropriate practitioner. NHP is accessible to practitioners seeking information about the utilization management process and authorization requests and decisions from 8:30 a.m. to 5:30 p.m. Monday through Friday.

Please call 800-462-5449 or 617-772-5565. The fax number is 617-772-5512 or 617-478-7175. For after-hours requests and utilization management issues, you may leave a message or fax. These lines are available 24/7. All requests and messages will be retrieved on the next business day. [CO](#)

## Utilization Management Decisions

NHP recognizes that underutilization of medically appropriate services has the potential to adversely affect our members' health and wellness. For this reason, NHP promotes appropriate utilization of services.

NHP's utilization management (UM) decisions are based only on appropriateness of care and service and existence of coverage. NHP does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does NHP provide financial incentives to UM decision-makers to encourage decisions that result in underutilization. [CO](#)