Impact of a Clinical Outreach Program on Diabetes Treatment CMS STAR Rating

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BACKGROUND

- Both angiotensin-converting enzyme inhibitors (ACE-I) and angiotensin receptor blockers (ARBs) have demonstrated kidney-protective effects in diabetes, and are also effective in treating hypertension (in patients with diabetes and hypertension, therapy should include an ACE-I/ARB, as long as one is tolerated).[1]
  - ACE-I (and in some cases, ARBs) have been shown to improve cardiovascular and renal outcomes via effects that are independent of blood-pressure reduction.
  - Blood pressure goal for patients with diabetes is <140/90.[2]
- The Centers for Medicare and Medicaid Services (CMS) have incorporated appropriate treatment of patients with diabetes and hypertension into their Medicare Part D Health and Drug Plan Quality and Performance Ratings (STAR ratings).[3]
- To assist payers in improving the quality of care delivered to their beneficiaries, Magellan Rx Management has developed and implemented a Diabetes Treatment Clinical Program designed to specifically address the quality standards incorporated into the CMS Star Rating Measure D10, Diabetes Treatment - Appropriate utilization of ACE-I, ARBs, or direct renin inhibitors (DRI) in patients with diabetes and hypertension.

OBJECTIVE

- To measure the impact of a clinical program on measure D10-the proportion of patients with diabetes and hypertension on ACE-I/ARB/DRI therapy within a regional Medicare health plan.

METHODS

- The Diabetes Treatment Measure population consists of all members who have filled a diabetes and hypertension medication between January and December 2014.
- Members are considered compliant when their hypertension agent is an ACE-I/ARB/DRI and non-compliant when not receiving an ACE-I/ARB/DRI.
  - The treatment rate is calculated by taking the numerator (compliant members) divided by the denominator (compliant + non-compliant members).
- A clinical program was implemented to increase the treatment rate, which was to be accomplished through telephonic outreach by clinical staff to providers, pharmacies, and patients.
- The focus of this outreach was recommending use of an ACE-I/ARB/DRI, when appropriate.

RESULTS

Table 1. Outreach Status of Non-Compliant Members

Status	Member Count	Member Count %
Treatment Measure Population	4,185	100%
Outreach Population	903	22%
Conversions to ACE-I/ARB/RI	391	43%
Clinical & Non-Clinical Rationale for Non-Compliance	257	29%

Figure 1. Treatment Rate vs. Projected Rate without Conversions

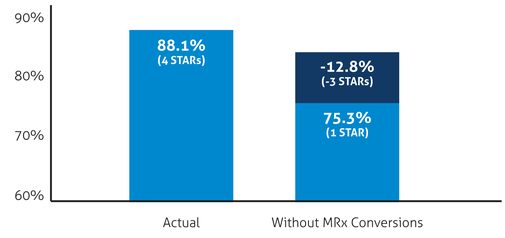


Figure 2. Unsuccessful Reason Types

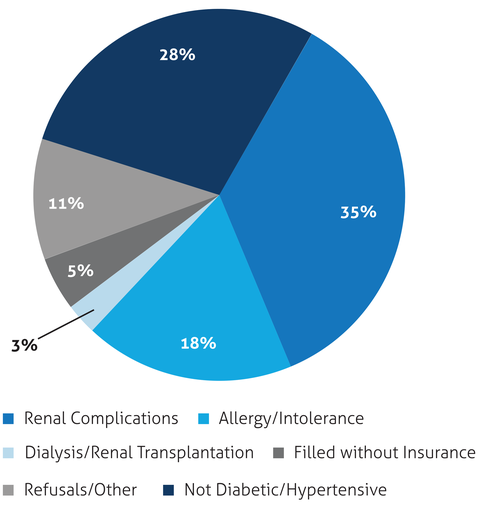
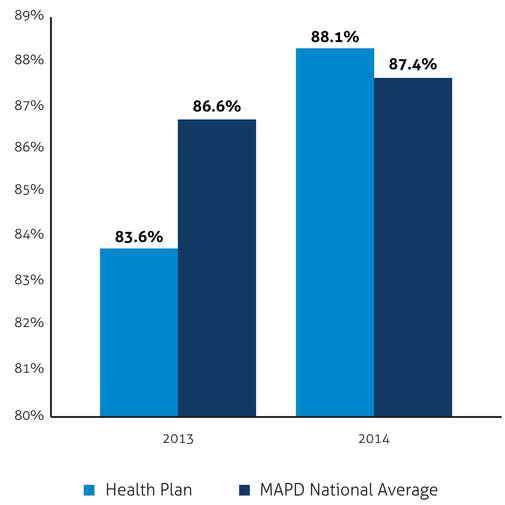


Figure 3. Treatment Rate Improvements vs. MAPD National Avg.



DISCUSSION

- Between January and December 2014, a Diabetes Treatment Clinical Program utilizing clinical outreach resulted in a treatment rate of 88.1% (4 stars) for a regional Medicare health plan, representing a 4.5% increase compared to the same time period in 2013.
  - 391 resulted in a claim for either an ACE-I/ARB/DRI.
  - 257 resulted in clinical and non-clinical rationale for non-compliance.
- Without successful conversions (members with an ACE-I/ARB/DRI claim after outreach), the treatment rate would have been as low as 75.3% (1 star).
- The most common reasons patients in the Diabetes Treatment population did not receive an ACE-I/ARB/DRI were renal complications (35%), patient was not diabetic or not hypertensive (28%), patient had an allergy/intolerance to the medication (18%), and patient refusal (11%).
- It has been estimated that a cumulative, overall 1-star improvement across all measurements (from 3 to 4) is worth $50 per member per month.

LIMITATIONS

- The true impact of the Diabetes Treatment Clinical Program may be affected by the following confounders:
  - Overlapping providers for other members resulting in patients entering the measure as compliant due to the outreach (who otherwise would have entered the measure as non-compliant).
  - Members who received a claim for an ACE/ARB/DRI post-outreach who may have received an ACE/ARB/DRI regardless.

CONCLUSION

- Clinical outreach to non-compliant members and their associated providers and pharmacies resulted in a 1-star improvement for the Diabetes Treatment Measure and prevented a 2-star decrease.
  - Treatment rate in a health plan utilizing a Diabetes Treatment Clinical Program increased by 4.5% from 2013 to 2014 compared to the national average of 0.8%.
- Many patients did not use ACE/ARB/DRI due to clinically valid reasons. These include renal complications, not having diabetes and/or hypertension, and allergies/intolerance. Clinical interventions focusing on improving this measure should take these situations into account to ensure patients are receiving appropriate medications.

REFERENCES

1. Ravid M, Savin H, Jutrin I, et al. Long-term stabilizing effect of angiotensin-converting enzyme inhibition on plasma creatinine and on proteinuria in normotensive type II diabetic patients. Ann Intern Med 1993; 118:577.
2. James PA, Oparil S, Carter BL, et al. 2014 evidence-based guideline for the management of high blood pressure in adults: report from the panel members appointed to the Eighth Joint National Committee (JNC 8). JAMA 2014; 311:507.
3. Medicare 2014 Part C & D Star Rating Technical Notes. Centers for Medicare & Medicaid Services. Updated September 2013.

DISCLOSURES

- This research was conducted by Magellan Rx Management, Newport, RI, without external funding.