Results from a High-Touch Clinical Program to Improve Star Ratings Measure: Statin Use in Persons with Diabetes

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Background
• The Centers for Medicare & Medicaid Services (CMS) implemented a 5-Star quality rating system for Medicare plans in order to drive quality improvement and reward clinical improvement in health plans.
• One of the newest quality measures added to the Star Ratings calculation is Statin Use in Persons with Diabetes (SUPD), which measures the percentage of beneficiaries aged 70–75 years who were dispensed at least two diabetes medications and received a statin medication prescription for the measure.

• The Star Blue Guide of Cardiology/Better Heart Health (fka UHCW guidelines) recommended treatment to reduce in-hospital coronary strategy to be primary prevention and cardiovascular disease (CVD) for persons aged 70–75 years with diabetes (class I recommendation).

• Most patients have a rate of at least 80% within the United States nearly 10% per year in need of costs and cost productivity. By 2030, most direct medical costs associated with heart disease and stroke could be more than $300 trillion, which would virtually wipe out Medicare's revenue.

• To assist a 9000-member life Medicare health plan in improving the quality of care delivered to their beneficiaries and maximizing Star performance, Magellan Rx Management (MRx) collaborated on the development and implementation of a pharmacist-led clinical program designed to specifically address the SUPD Star measure.

• The target population was prioritized for outreach based on several criteria including:
  1. Heart disease and stroke cost the United States nearly $1 billion per day in medical costs and lost productivity. By 2030, annual direct medical costs associated with CVD are projected to rise to more than $818 billion, while lost productivity costs could exceed $275 billion.

• For the 2017 measurement year, MRx achieved incremental treatment rate improvement from 80.4% to 83.6% – a 3.2% increase compared to 2016. The 3.2% increase was nearly double the MAPD national average rate of improvement during the same time period (which was only 1.7%).

• When assessing the impact of the program, successful conversions without a clinical contact were not included, which may underestimate the impact of the program.

Methods
• A clinical program was implemented to improve the SUPD treatment rate through various methods of identification, prioritization, and clinical engagement.
• MRx performed a monthly identification of the target population through prescription claims analyses. The target population consisted of non-compliant and predicted non-compliant members.

• Non-compliant members are defined as those who a diabetes medication is not on their formulary. This cohort represents the primary outreach group.

• Predicted non-compliant members are defined as those with 1 diabetes medication prescribed but not filled. This cohort of members constitutes the secondary outreach group, which represents a predictive strategy aimed at identifying members likely to enter the non-compliant status.

• The larger population was prioritized for outreach based on several criteria including:
  1. Number of diabetes medications (N = 1 vs. >1)
  2. Potentially high/low use of a statin medication
  3. Presence of cut-off criteria associated with medications and claims analyses
  4. Documented challenges with statin therapy (eg, myopathy)

• Various methods of clinical engagement were utilized including:
  1. Member-specific focusing to targeted prescribers, identify potential candidates for statin therapy
  2. Pharmacists attended outreach to providers, members, and/or pharmacies to facilitate facilitation of statin therapy, as appropriate

Purpose
• To measure the impact of a clinical program on performance for the CMS DI quality measure: States in Persons with Diabetes (SIPDI)

Results

<table>
<thead>
<tr>
<th>Year</th>
<th>Status of SUPD</th>
<th>Non-Compliant Members</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 (Baseline)</td>
<td>76.0%</td>
<td>114</td>
<td></td>
</tr>
<tr>
<td>2016 (1st Program Year)</td>
<td>77.2%</td>
<td>147</td>
<td></td>
</tr>
<tr>
<td>2017 (2nd Program Year)</td>
<td>78.5%</td>
<td>160</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Contact Summary, by Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-2017</td>
<td>Practitioner Refusal</td>
</tr>
<tr>
<td>2015-2017</td>
<td>12.7%</td>
</tr>
</tbody>
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Discussion

• For the 2016 measurement year, MRx achieved incremental treatment rate improvement from 80.4% to 83.6% – a 3.2% improvement compared to baseline. During the same timeframe, the MAPD national benchmark only improved by 1.2% from 76.0% to 77.2%.

• For both 2016 and 2017 measurement years, the treatment rate would have likely experienced a decrease without the clinical program when compared to the previous year.

• Several interventions and follow-up contacts were needed in order to achieve improvements in the treatment rate – on average, MRx made five to eight contacts per targeted member.

• This is a comprehensive and proactive identification strategy which includes targeting members who are likely to become non-compliant, MRx is able to intervene on members earlier. This allows for more clinical interventions and follow-up contacts in order to maximize impact.

• Leveraging historical information, such as prior statin use, can be helpful in identifying high-priority members for outreach since these cases may involve diagnostic determination that require treating non-compliance cases (even in the absence of an underlying chronic condition).

• Pharmacies documented various clinically justified barriers to statin therapy during interventions, including myalgia/myopathy, intolerance, and liver disease/dyslipidemia. Cases with non-clinical barriers such as potential provider refusal may benefit from additional follow-up and academic detailing in the future.

Conclusion
• Phacist identification, multifaceted prioritization, and active clinical engagement are all important factors in improving the treatment rate for the SUPD Star quality measure.

• Such results support the efficacy and validity of a focused clinical program, especially given that the SUPD measure may be weighted more heavily towards the overall Star rating calculation in the future.

• It has been estimated that a cumulative 1-Star improvement for the overall rating (eg, from 3 to 4 Stars) will result in $5 per member per month.

• Engaging members for the SUPD Star measure may also have a positive impact on other Part D measures such as diabetes and statin medication adherence.

Limitations
• By performing prior identification of non-compliant members for the SUPD star measure based on the presence of any one diabetes medication (eg, there is the potential to over-identify the larger population and conduct outreach to members who may not qualify the denominator in the measurement year. However, it is likely that the over-identified members will enter the denominator in the following measurement year.

References
3. Greenwald C. Heart Disease and Stroke Cost America Nearly $1 Billion a Day in Medical Costs, Lost Productivity. CDC Foundation. 2013.

Disclosures
• This research was conducted by Magellan Rx Management without external funding.