CVS Health

Assessing the impact of beneficiaries' dual, LIS and non-LIS status on Part D plans' Star Ratings

EXECUTIVE SUMMARY

Background

The Center for Medicare & Medicaid Services' (CMS') Star Rating system is used to assess care the quality of care provided to beneficiaries enrolled in Part C and Part D plans. Part D plan sponsors have expressed concerns that plans that enroll larger proportions LIS beneficiaries may have more difficulty achieving higher quality care. CMS is interested in evaluating whether LIS versus non-LIS beneficiaries *within a given plan* have meaningfully different Star Ratings outcomes. Among dual-eligible, LIS, and non-LIS beneficiaries enrolled in 100 SilverScript Part D plans, CVS Health compared potential differences in 5 Star outcomes related to medication use: 1) high risk medications; 2) diabetes treatment; 3) medication adherence for diabetes medications; 4) medication adherence for hypertension (RAS antagonists); 5) medication adherence for cholesterol (statins).

Methods

Using a cross-sectional study design, 2013 SilverScript plan eligibility, demographic, and prescription drug claims data were used to assess outcomes among beneficiaries who met Stars inclusion criteria. Beneficiaries were assigned to 1 of 5 exposure groups based on their dual and LIS status during each month of 2013: Dual, full LIS; non-dual, full LIS; partial LIS; non-LIS; and mixed exposure (beneficiaries who changed exposure groups at least once during the 12 month study period). Each Star outcome was assessed at the beneficiary level, producing a dichotomous outcome, according to Star Ratings methodology. Conditional logistic regression was used to make beneficiary comparisons within each unique plan. LIS beneficiaries' odds of an outcome were compared with non-LIS beneficiaries' odds of an outcome, producing odds ratios. Unadjusted models reflecting the current CMS method for Star outcome calculation explored the relationship between LIS exposure group and outcome only, while adjusted models included covariates that might bias this relationship: age, gender, measures of clinical complexity (e.g., number of unique medications used), and SES measures. If odds ratios comparing LIS to non-LIS beneficiaries were equal to 1, then the LIS and non-LIS beneficiaries were comparable and the unadjusted models, CMS' current approach, is sufficient to eliminate differences in drug use. If odds ratios comparing LIS to non-LIS beneficiaries were not equal to 1, then the LIS and non-LIS beneficiaries were not comparable, and additional risk adjustment is needed to eliminate differences in drug use.

Results

During 2013, mixed beneficiaries had consistently more complex healthcare utilization and higher psychotropic drug use than beneficiaries in any of the other 4 exposure groups. In unadjusted models, LIS beneficiaries had significantly different odds of each Star outcome as compared to non-LIS beneficiaries. LIS financial support alone was <u>not</u> sufficient to eliminate differences in medication use for any of the 5 outcomes. In contrast, in adjusted models controlling for additional covariates, the odds ratios often moved closer to 1 and the 95% confidence intervals often included 1, mitigating differences in drug use between LIS and non-LIS beneficiaries.

Conclusions

LIS financial support does <u>not</u> eliminate differences in medication use among beneficiaries with varying abilities to afford medications. As a result, the current Star Ratings methodology penalizes plans that care for more LIS beneficiaries, and creates a disincentive to plans for caring for these vulnerable patients. Controlling for additional covariates that impact drug use reduces these differences.

Additional risk adjustment is needed to make fair comparisons across LIS groups. Further analyses are warranted to identify the most appropriate methodologies to improve beneficiaries' clinical outcomes.