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CENTER FOR MEDICARE

DATE: December 20, 2011

TO: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

FROM: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: Request for comments regarding enhancements to the Part C and Part D Plan Ratings

In this document, we describe our proposed methodology for 2013 star ratings for Medicare Advantage (MA) and Prescription Drug Plans. We are sending this early alert to provide plans and advocates with advance notice of our planned methodology to enable stakeholders to comment in advance of our final 2013 Call Letter. The timing of the annual draft Call Letter, when combined with the statutory timing of the Advanced and Final Rate Notices, does not always allow CMS sufficient time to fully explore substantive suggestions made by commenters.

CMS has structured the current star ratings strategy to be consistent with its three-part aim: better care, healthier people and communities, and lower-cost care through improvement. Its measures span five broad categories, including:

- Outcome measures that focus on improvement to a beneficiary's health as a result of care that is provided;
- Intermediate outcome measures that concentrate on ways to help beneficiaries move closer to achieving a true outcome;
- Patient experience measures that represent beneficiaries' perspectives about the care they receive;
- Access measures that reflect processes or structures that may create barriers to receiving needed health care; and
- Process measures that capture a method by which health care is provided.

CMS uses the star ratings on the Medicare Plan Finder website to determine star ratings for Quality Bonus Payments (QBPs). Under the three-year QBP demonstration, which is being conducted from 2012-2014, MA plans that have a 3-star or higher rating are eligible for a gradually increasing QBP. And we have an on-going commitment to improve our star rating system.

For the upcoming year, CMS has three primary areas of focus for improvement. First, CMS wants to encourage continued high performance for our MA and Prescription Drug Plan sponsors. CMS expects that the Part C and D star rating system will drive plans to contract with physicians, hospitals, pharmacy benefit managers (PBMs), pharmacies and other providers that are committed to high quality care and services. For example, in our proposed methodology for 2013, we include a potential measure of the quality of hospital care that enrollees in a health plan receive. Second, CMS wants to encourage all enrollees to receive coordinated care across their health and drug benefits. To that end, we are adding a measure of care coordination for MA contracts and also adding a Part D measure focused on comprehensive medication reviews that are part of the Medication Therapy Management program. And third, CMS wants to incentivize plan improvement. We are proposing a measure that focuses on whether plans have consistently improved their performance over time.

CMS is committed to continuing to improve the Part C and Part D quality performance measurement system to increase focus on beneficiary outcomes, beneficiary satisfaction, population health, and health care efficiency. It is our hope that the star rating system will not only influence beneficiaries' plan choices but will also drive plans toward higher quality and more efficient care.

Your comments and suggestions will help CMS provide more specific guidance on the changes anticipated for the 2013 Plan Ratings in the final 2013 Call Letter, which we expect to provide to plans by April 2, 2012. The 2013 Call Letter will also describe potential enhancements for the 2014 ratings. Attachment A includes the enhancements that are being considered for the 2013 Plan Ratings. For reference, the list of measures and methodology included in the 2012 Plan Ratings is described in the technical notes: http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp.

We will consider all comments received by January 13, 2012 at 5pm EST as we finalize the methodology for 2013 Plan Ratings. Plans may also comment on this methodology as it is published in the draft Call Letter. Please submit only one set of responses per organization. Please submit all comments related to the Part C and D Plan Ratings to PartCRatings@cms.hhs.gov. Thank you for your participation.

Proposed Methodology for 2013 Plan Ratings

For the 2013 Plan Ratings, CMS is continuing to make enhancements to the current methodology to align it further with our policy goals. Below we describe the enhancements being considered for the 2013 Plan Ratings. Unless noted below, we do not anticipate the methodology changing from the 2012 Plan Ratings. The 2012 methodology can be found at https://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp under the 2012 Plan Ratings link. The star cut points for all measures and case-mix coefficients for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and Health Outcomes Survey (HOS) will be updated with the most current data available.

As announced in previous years, we will annually review the quality of the data across all measures, variation among plans, and the measures' accuracy and validity before making a final determination about inclusion of measures in the Plan Ratings.

New Measures

CMS is considering adding the following measures to the 2013 Plan Ratings:

- *Measures from the Hospital Inpatient Quality Reporting program (formerly known as Reporting Hospital Quality Data for Annual Payment Update) (Part C).* (See http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1138900298473 for a list of measures.) CMS is exploring whether the individual-level hospital data can be associated with individual Medicare Advantage (MA) contracts. CMS is examining the quality of Health Insurance Claim Numbers (HICNs) available on the hospital-level data to determine the feasibility of linking the hospital data to contract numbers. We will then analyze the data to determine if we can create an MA contract-level measure of the hospital care that enrollees in each contract receive.

- *Survey measures of care coordination from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that will be administered in 2012 (Part C).* This includes questions related to the following areas:
  - Whether doctor had medical records and other information about the enrollee's care,
  - Whether there was follow up with the patient to provide test results,
  - How quickly the enrollee got the test results,
  - Whether the doctor spoke to the enrollee about prescription medicines,
  - Whether the enrollee received help managing care, and
  - Whether the personal doctor is informed and up-to-date about specialist care.

  These are new questions for 2012. Once the data are available after survey administration, CMS will construct a care coordination composite using factor analysis

to determine its reliability prior to making a final decision about inclusion. We want to ensure that we are capturing true differences in performance across contracts.

- *Medication Therapy Management (MTM) program measures related to Comprehensive Medication Reviews (Part D).* These measures may include the Pharmacy Quality Alliance (PQA) approved measure, Completion Rate for Comprehensive Medication Review (CMR), which measures the percentage of MTM-eligible beneficiaries who received a CMR. The PQA measure sets the denominator as the number of MTM eligible beneficiaries, and the numerator as the number of beneficiaries in the denominator who received a CMR. CMS anticipates calculating the 2013 MTM CMR measure using 2011 beneficiary level plan-reported MTM data (collected as part of the Part D reporting requirements). CMS is currently reviewing the PQA specifications to determine if any modifications are needed. In line with the current PQA specifications, CMS anticipates defining the eligible population as Part D enrollees 18 and older who met the MTM eligibility criteria and were enrolled in the MTM program as of October 31 in the measurement year. CMS is testing modifying the eligible population definition for continuous MTM enrollment as beneficiaries enrolled in the MTM program for at least 60 days and excluding MTM-eligible beneficiaries that were also long-term care residents. A minimum number of MTM-eligible beneficiaries will be required in order to calculate a contract's percentage for this measure.

- *A measure of quality improvement (Part C and D).* The proposed methodology for the improvement measure is to calculate improvement at the individual measure level and use statistical tests to determine whether there has been significant improvement or decline at the measure level prior to creating a measure of net improvement at the contract level. The steps are:
  1) For each measure that has been collected for two years, calculate a contract-level improvement score. This will be a simple change from year one to year two.
  2) Perform a t-test for the year-to-year change at the measure level. Score the change into significant decline, no change, or significant improvement.
  3) Net the improvements (e.g., number of significant improvements minus number of significant declines at the contract level).
  4) Score the net improvement count into a 5-star classification by examining the distribution and setting cut points.

This methodology would provide all contracts with at least two years worth of data with an improvement score. We are considering how to account for contracts already achieving high scores across most measures.

Since all of the measures in this section would be first year measures, the weight assigned would be "1".

Changes to the Methodology of Current Measures

CMS is considering modifying the methodology for the following measures:

- *Medicare Plan Finder (MPF) composite (Part D).* We plan to limit the comparison between Prescription Drug Event (PDE) and Plan Finder prices to only 1st, 2nd and 3rd quarter PDEs, as Plan Finder prices are locked on Medicare.gov at the end of September. Note, however that previous evaluations did not find that the inclusion of 4th quarter PDEs significantly changed plans' scores in this measure.

- *High-Risk Medication (HRM) measure (Part D).* CMS recognizes the efforts of the American Geriatrics Society to provide a comprehensive 2011 update of the Beers Criteria. Once this update is completed, CMS will work with other quality measure development organizations, including the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA), to revise the current measure's technical specifications as appropriate. CMS will also work with these partners to explore changes to the technical specifications such as accounting for transition fills or single fills. CMS' previously selected 4-star threshold for the HRM measure will not be applicable due to these technical specification changes.

- *Adherence (ADH) measures (Part D).* CMS is working with our quality measure development partners to examine appropriate methods of adjusting the Proportion of Days Covered (PDC) measure calculation to account for beneficiaries' inpatient stays (such as inpatient hospitals or skilled nursing facilities) in which their medication fills would not be included in PDE data.

- *Plan Makes Timely Decisions about Appeals (Part C).* The calendar year 2011 data will include dismissed appeals.

- *Call Center – Foreign Language Interpreter and TTY/TDD Availability (Part C and D).* In 2011, this measure was not collected from contracts that only had Special Needs Plans (SNPs). In 2012, CMS will resume collecting this measure from all SNPs. There will also be a modification in 2012 regarding how successful contacts are defined for this measure. The calculation of this measure is the number of successful contacts with the interpreter or TTY/TDD divided by the number of attempted contacts. Successful contact with an interpreter will be defined as establishing contact with a translator and either starting or completing survey questions. Successful contact with a TTY/TDD service will be defined as establishing contact with a TTY/TDD operator who can answer questions about the plan's Medicare Part C or Part D benefit. The prospective enrollee phone number will be used for this measure.

- *Enrollment Timeliness (Part C and D).* CMS is considering expanding this measure from PDPs and MA-PDs to include MA-only contracts. The data timeframe for this measure will be January 1, 2012 through May or June 2012, depending on availability of June data in time for the 2013 Plan Ratings.

- *Beneficiary Access and Performance Problems (Part C and D).* The methodology is being modified so the effectiveness score for contracts that received a full performance audit will be replaced with the percentage of elements passed out of all elements audited. There are no other changes to methodology.

Four Star Thresholds

Similar to 2012, CMS will continue to apply previously established 4-star thresholds, unless changes have been made to a measure's technical specifications. This may impact the HRM and Call Center – Foreign Language Interpreter and TTY/TDD Availability 4-star thresholds if changes are made to those measures. CMS is also reviewing the methodology to determine cut points and thresholds for Improving or Maintaining Physical Health and Improving or Maintaining Mental Health. The current thresholds for all other measures can be found in the Technical Notes available at https://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp under the 2012 Plan Ratings link.

Weighting Categories of Measures

We are considering keeping the same weighting categories used for the 2012 Plan Ratings, in which outcome and intermediate outcome measures were given 3 times the weight of process measures, while patient experience and access measures were given 1.5 times the weight of process measures. We may revise the weighting categories for the HRM and Diabetes Treatment measures. We are also considering assigning new Plan Ratings measures a weight of "1" the first year, and then the weight in the second year would depend on the weighting category. The following table lists the proposed 2013 Plan Ratings measures and their weighting categories.

Measure Name	2013 Proposed Weighting Category	2013 Proposed Weight
Breast Cancer Screening	Process Measure	1
Colorectal Cancer Screening	Process Measure	1
Cardiovascular Care – Cholesterol Screening	Process Measure	1
Diabetes Care – Cholesterol Screening	Process Measure	1
Glaucoma Testing	Process Measure	1
Annual Flu Vaccine	Process Measure	1
Improving or Maintaining Physical Health	Outcome Measure	3
Improving or Maintaining Mental Health	Outcome Measure	3
Monitoring Physical Activity	Process Measure	1
Adult BMI Assessment	Process Measure	1
Care for Older Adults – Medication Review	Process Measure	1
Care for Older Adults – Functional Status Assessment	Process Measure	1
Care for Older Adults – Pain Screening	Process Measure	1
Osteoporosis Management in Women who had a Fracture	Process Measure	1
Diabetes Care – Eye Exam	Process Measure	1
Diabetes Care – Kidney Disease Monitoring	Process Measure	1
Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measures	3
Diabetes Care – Cholesterol Controlled	Intermediate Outcome Measures	3
Controlling Blood Pressure	Intermediate Outcome Measures	3
Rheumatoid Arthritis Management	Process Measure	1
Improving Bladder Control	Process Measure	1
Reducing the Risk of Falling	Process Measure	1
Plan All-Cause Readmissions	Outcome Measure	3
Getting Needed Care	Patients' Experience and Complaints Measure	1.5
Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	1.5
Customer Service	Patients' Experience and Complaints Measure	1.5
Overall Rating of Health Care Quality	Patients' Experience and Complaints Measure	1.5
Overall Rating of Plan	Patients' Experience and Complaints Measure	1.5
Complaints about the Health Plan	Patients' Experience and Complaints Measure	1.5
Beneficiary Access and Performance Problems	Measures Capturing Access	1.5
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	1.5
Plan Makes Timely Decisions about Appeals	Measures Capturing Access	1.5
Reviewing Appeals Decisions	Measures Capturing Access	1.5
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Measures Capturing Access	1.5
Call Center – Pharmacy Hold Time	Measures Capturing Access	1.5

Measure Name	2013 Proposed Weighting Category	2013 Proposed Weight
Appeals Auto–Forward	Measures Capturing Access	1.5
Appeals Upheld	Measures Capturing Access	1.5
Enrollment Timeliness	Process Measure	1
Complaints about the Drug Plan	Patients' Experience and Complaints Measure	1.5
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	1.5
Getting Information From Drug Plan	Patients' Experience and Complaints Measure	1.5
Rating of Drug Plan	Patients' Experience and Complaints Measure	1.5
Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	1.5
MPF Composite	Process Measure	1
High Risk Medication	Process Measure**	1
Diabetes Treatment	Process Measure**	1
Part D Medication Adherence for Oral Diabetes Medications	Intermediate Outcome Measures	3
Part D Medication Adherence for Hypertension (ACEI or ARB)	Intermediate Outcome Measures	3
Part D Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measures	3
Measures from the Hospital Inpatient Quality Reporting program (formerly known as Reporting Hospital Quality Data for Annual Payment Update)*	Process Measure	1
Survey measures of care coordination from the Consumer Assessment of Healthcare Providers and Systems (CAHPS)*	Patients' Experience and Complaints Measure	1
Medication therapy management (MTM) program measures related to Comprehensive Medication Reviews*	Process Measure	1
Improvement*	Outcome Measure	1

*If included in the 2013 Plan Ratings, these would be weighted as "1" because they would be first year measures. After that, they would be weighted according to their weighting category.
**These weighting categories reflect changes from 2012 Plan Ratings.

Measures Being Removed from Plan Ratings and New Measures for the Display Page

Display measures on cms.gov are not part of the Plan Ratings. These may be measures that have been transitioned from the Plan Ratings, or they could be new measures that are being tested before inclusion into the Plan Ratings. Similar to the 2012 display page, plans will have the opportunity to preview their data in the display measures prior to release on CMS' website. Data on measures moved to the display page will continue to be collected and monitored, and poor scores on display measures are subject to compliance actions by CMS.

CMS is considering transitioning the Pneumonia Vaccine (Part C) and Access to Primary Care Doctor Visits (Part C) measures to the 2013 display page. The Pneumonia Vaccine measure is being moved to the display page due to the long recall period for this measure. Access to Primary Care Doctor Visits is being moved to the display page since there is little variation in the scores across contracts with the scores being skewed very high.

We are also considering releasing the following measures that are in development to the 2013 display page:

- Grievance rate per 1,000 enrollees (Part C and D) (minimum enrollment will be required to calculate a rate; similar exclusion criteria as the complaint rate measures).

- Appropriate implementation of Part D transition processes by plans to ensure continuity of care for beneficiaries (Part D).

- Serious reportable adverse events (includes SRAEs and Hospital Acquired Conditions (HACs)) (Part C). See https://www.cms.gov/HealthPlansGenInfo/Downloads/PartCTechSpecs_Oct11.pdf for more information about data specifications. Adding this measure to the display page will depend on validation results.

- Special Needs Plans (SNP) Care Management measure (Part C SNPs). See https://www.cms.gov/HealthPlansGenInfo/Downloads/PartCTechSpecs_Oct11.pdf for more information about data specifications. Adding this measure to the display page will depend on validation results.

- Calls Disconnected when Customer Calls Health Plan (Part C). This information has been collected for Part C contracts and will now be displayed similar to data for Part D contracts.

It is expected that all other 2012 display measures will continue to be shown on cms.gov.

Summary of Changes to the Methodology for 2013 Plan Ratings

As described above, CMS is considering adding a small set of new measures to the 2013 Plan Ratings, including a measure of quality improvement. There are some potential modifications to the MPF composite, HRM, Adherence, Plan Makes Timeline Decisions About Appeals (Part C), Call Center – Foreign Language Interpreter and TTY/TDD Availability, Enrollment Timeliness, and Beneficiary Access and Performance Problems measures. Two Part C measures (Pneumonia Vaccination and Access to Primary Care Doctor Visits) will be moved to the display page. We are considering maintaining the weights (3 for outcomes and intermediate outcomes, 1.5 for patient experience and access measures and 1 for process measures) assigned to each of the categories of measures that were used in the 2012 Plan Ratings. At this point we do not have additional information about adjusting for Health Professional Shortage Areas (HPSAs). We are continuing to monitor the changes being made in the methodology for determining HPSAs. If the revised HPSAs are available over the next couple months, we will reevaluate and announce in the 2013 Call Letter whether any adjustments will be included in Plan Ratings.