DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE

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TO: Medicare Advantage Compliance Officers, Part C & D Sponsors

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

SUBJECT: 2012 Quality Bonus Payment Determinations and Administrative Review Process for Quality Bonus Payments and Rebate Retention Allowances

Background

The Affordable Care Act of 2010 mandates that CMS make quality bonus payments (QBPs) to Medicare Advantage (MA) organizations that achieve at least four stars in a five-star quality rating system. The Affordable Care Act also changes the share of savings that MA organizations must provide to enrollees as the beneficiary rebate, mandating that the level of rebate is tied to the level of an MA organization's QBP star rating. The law mandates two exceptions for determining the level of rebate for 2012: a low enrollment plan will be treated as having a rating of 4.5 stars and a new plan under a new parent organization will be treated as having a rating of 3.5 stars. Beginning in 2012, QBP star ratings will directly affect the monthly payment amount MA organizations receive from CMS.

Using our authority under the Social Security Act[1], CMS is conducting a nationwide three-year demonstration that will be in effect from 2012 to 2014 to test an alternative method for computing QBPs. The demonstration will test whether providing scaled bonuses to MA organizations with three or more stars will lead to more rapid and larger year-to-year quality improvements in their quality scores, compared to the current law bonus structure. For contracts at or above three stars, QBPs will be computed along a scale; the higher a contract's star rating, the greater the QBP percentage.

While the statute does not specify a process for requesting an administrative review of the star ratings, historically, CMS has made an administrative review process available to MA organizations for certain payment determinations. Accordingly, CMS is introducing a process through which MA organizations may request an administrative review of their star rating for QBP determinations and rebate retention allowances. The following explains the star ratings and the process for requesting a review of these ratings while QBPs are made under the payment demonstration.

[1] Section 402(a)(1)(A) of the 1967 Social Security Amendments, as amended

Star Ratings to be Used for QBP Determinations

The star ratings for the 2012 QBP determinations are the star ratings released November 10, 2010 as part of the Plan Ratings on the Medicare Plan Finder tool at www.medicare.gov for those contracts that had enough data to calculate an overall rating. Contracts that did not have an overall plan rating for 2011 fall into two categories, new MA contracts or low enrollment contracts. A new MA contract offered by a parent organization that has not had any MA contract(s) with CMS in the previous three years is treated as a qualifying contract, per statute, and assigned three stars for QBP purposes during the demonstration until the contract has enough data to calculate a star rating. For an organization that has had MA contract(s) with CMS in the previous three years, any new MA contract receives an average of the star ratings earned by the organization's existing MA contracts, which is weighted by the December 2010 enrollment. A low enrollment contract is a contract that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because of a lack of a sufficient number of enrollees to reliably measure the performance of the health plan. For 2012, low enrollment contracts receive three stars for QBP purposes. All MA contracts may view their star ratings for QBP purposes in HPMS by selecting Quality and Performance in the left navigation bar then select Part C Performance Metrics and then Quality Bonus Payment Rating.

In September 2010 during the Plan Star Rating preview, CMS provided information to MA organizations on the methodology for determining the star ratings. This information was posted at www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp prior to the posting of the plan ratings on the Medicare Plan Finder tool. During the preview period, MA organizations had the opportunity to raise questions about the calculation of the plan ratings and the underlying data. Based on questions raised during the preview period, CMS re-calculated one of the Part C measures, "Plan makes timely Decisions about Appeals," to exclude dismissals, and one of the Part D measures, "Drug Plan Provides Accurate Price Information for Medicare's Plan Finder Website and Keeps Drug Prices Stable," to exclude compounds, non-covered drugs, and to modify the exclusion criteria from an annual minimum to a quarterly minimum. CMS anticipates changes made during the preview period will reduce the number of MA organizations requesting an administrative review.

Administrative Review Process for QBP Determinations

The administrative review process is a two-step process that includes a request for reconsideration and a request for an informal hearing on the record after CMS has sent the MA organization the reconsideration decision. Both steps are conducted at the contract level. The first step allows the MA organization to request a reconsideration of how its star rating for the given measure in question was calculated and/or what data was included in the measure. If the MA organization is dissatisfied with the CMS' reconsideration decision, the contract may request an informal hearing to be conducted by a hearing officer designated by CMS.

Criteria for Requesting an Administrative Review

Requests for reconsideration and informal hearings may be filed for QBP purposes only under a limited set of circumstances. Both types of reviews may be filed on the basis of a calculation error (miscalculation) or a data inaccuracy (incorrect data). A calculation error could impact the

individual measure's value or the overall star rating. If an MA organization believes the wrong set of data was used in a measure (i.e., wrong timeframe for the data or wrong measure selected), this is considered a calculation error. A request for review based on data inaccuracy may only be filed for a subset of measures. The attachment to this memo includes information about whether a contract may request a review based on data inaccuracy (incorrect data) for each of the measures included in the star ratings. The contract may not request a review based on data accuracy for the following data sources:

- HEDIS measures since they were audited prior to submission to CMS;
- Measures based on beneficiary feedback, including data collected through CAHPS, HOS and CTM Complaints;
- Plan reported data, including Prescription Drug Event data, Plan Finder pricing and pharmacy data, plan responses to CMS-generated enrollment transactions, and plan-reported records including Low Income Subsidy status;
- Measures where there is a data issue because the contract did not follow standard operating procedures (e.g., CTM data); and
- Contract enrollment data from HPMS or MARx since the CMS information is the system of record for enrollment.

An administrative review cannot be requested for the following: the methodology for calculating the star ratings (including the calculation of the overall star ratings); cut-off points for determining measure thresholds; the set of measures included in the star rating system; and the methodology for determining QBP determinations for low enrollment and new plans.

Note: Before an MA organization requests an administrative review, it is important to consider that a change in data values for a measure may not necessarily change the star rating for that measure or the overall star rating for the contract. Since measure star ratings are based on cut off thresholds, a significant change in the data is usually required in order for a contract to move from a lower star rating to a higher one. Even if there is a change in the star rating for one or more measures, the contract's overall star rating may not change because the change is not significant enough to move it to the threshold for the next higher overall star rating. Please review the threshold cut points for Part C and D measures posted in HPMS. This information will help an MA organization determine whether requesting an administrative review will be beneficial to its organization.

Request for Reconsideration

As stated above, the administrative review process is a two-step process that begins with a request for reconsideration. This review is not meant to be a repeat of the preview period giving contracts another opportunity to raise general questions about how CMS calculates the plan ratings, nor is it intended to review how every measure was calculated. Instead, this review will afford an MA organization the opportunity to request review of specific measure values that may affect the calculation of the contract's QBP. The request for reconsideration must specify the miscalculation and/or incorrect data for the measure(s) in question. The request must include the specific findings or issues with which the contract disagrees and the reason for the disagreement, and should also include specific examples of the miscalculation and/or data inaccuracy. The request for reconsideration may include additional documentary evidence that the MA organization would like CMS to consider. In conducting the reconsideration, the reconsideration official will review the QBP determination, the evidence and findings upon which it was based, and any other written evidence submitted by the organization or by CMS before the reconsideration determination is

made. CMS will inform the MA organization of the reconsideration official's decision through electronic mail. The reconsideration official's decision is final and binding unless a request for an informal hearing is filed in accordance with the instructions provided with the reconsideration official's decision.

Request for a QBP reconsideration is made by completing Attachment A, "Request for Reconsideration" available in HPMS by selecting Quality and Performance in the left navigation bar then select Part C Performance Metrics and then Quality Bonus Payment Rating. To complete the form, macros must be enabled in Excel. The contract must email the completed form to QBPAPPEALS@cms.hhs.gov by **5:00 p.m. EST on January 7, 2011**. The file should include the contract number as part of the file name. A request for reconsideration must be submitted by the date and time above in order to reserve the right to later request an informal hearing.

Informal Hearing

Instructions for requesting an informal hearing will be provided with the reconsideration decision. An informal hearing request may not be made unless reconsideration was first requested and the decision sent to the MA organization. The informal hearing request must pertain only to the measure(s) and value(s) in question that precipitated the request for reconsideration. Such request must include a statement that describes the error(s) that the MA organization asserts CMS made in its QBP determination and how correction of those errors could result in the organization's qualification for a QBP or a higher QBP. The informal hearing review must provide clear and convincing evidence that CMS' calculation of the measure was incorrect. The burden is on the MA organization to prove an error was made in the calculation of the QBP.

CMS will attempt to complete all informal hearings by early April; however, decisions could be issued as late as May 15 of the year preceding the year in which the QBP is to be applied, especially in cases where the results of informal hearing require a recalculation of star values for many contracts. CMS is aware a May 15 deadline is necessary to afford MA organizations time to incorporate their QBP status into their plan bids, due by the first Monday in June. The hearing officer's decision is final and binding on both the MA organization and CMS.

In the event that the reconsideration official or hearing officer finds that the MA organization's QBP determination was incorrect, CMS is obligated to recalculate the organization's QBP status based on that finding. The recalculation could cause the requesting MA organization's QBP to go higher or lower. In some instances, the recalculation may not cause the star rating to rise above the cut-off for the higher QBP star rating. When the reconsideration official or hearing officer's decision requires that a measure be systematically recalculated for all contracts, all other affected contracts will receive the recalculation if it results in a higher star rating and any resulting change will be made to the plan ratings and QBPs for all affected contracts. Contracts' 2011 star ratings, which are used for 2012 QBPs, will not be decreased by CMS as a result of a systematic re-calculation; however, the issue will be addressed in next year's star ratings.

Any questions regarding this memo may be submitted to QBPAPPEALS@cms.hhs.gov.

Attachment: Request for Reconsideration