DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE

DATE: November 10, 2016

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

FROM: Amy Larrick Chavez-Valdez, Director, Medicare Drug Benefit and C & D Data Group

SUBJECT: Request for Comments: Enhancements to the Star Ratings for 2018 and Beyond

Proposed options for adjusting Star Ratings for audits and enforcement actions starting with the 2018 Star Ratings for Medicare Advantage (MA) and Prescription Drug Plans (PDPs) are described in this document. MA Organizations, PDP Sponsors, advocates, and other stakeholders have this opportunity to provide comments in advance of the draft 2018 Call Letter. Because the timelines for the annual draft Call Letter, combined with the statutory deadlines for the Advance and Final Rate Notices, do not provide CMS sufficient time to fully explore substantive changes suggested by commenters, this Request for Comments (RFC) allows CMS additional time to review and evaluate comments prior to the Call Letter process.

Comment and questions related to this RFC may be sent to: PartCandDStarRatings@cms.hhs.gov. Please submit only one set of responses per organization.

Comments submitted by November 29th at 5pm ET will be considered as we finalize proposed changes for the 2018 Star Ratings for the draft 2018 Call Letter. Stakeholders will have another opportunity to comment on the 2018 Star Ratings methodology and proposed changes through the draft Call Letter process. The same comments should not be resubmitted to the draft Call Letter.

Thank you for your participation.

Request for Comments: 2018 Star Ratings

One of CMS' most important strategic goals is to improve the quality of care and health status of Medicare beneficiaries. For the 2018 Star Ratings, CMS continues to enhance the current methodology so it advances our policy goals. Our priorities include enhancing the measures and methodology to reflect the true performance of organizations and sponsors, maintaining stability due to the link to payment, and providing advance notice of future changes. This document presents several options for adjusting Star Ratings for audits and enforcement actions. For reference, the list of measures and methodology included in the 2017 Star Ratings is described in the Technical Notes available on the CMS webpage: http://go.cms.gov/partcanddstarratings. Comments or suggestions for other measures or aspects of the Star Ratings will be solicited as part of the 2018 draft Call Letter.

In recent years, audit findings could affect Star Ratings in three ways: 1) plans under sanction were subject to automatic reductions in their overall Star Ratings; 2) specific audit findings could lead to Civil Money Penalties (CMPs) or sanctions which lower performance on the beneficiary access and performance problems (BAPP) Star Rating measure; and 3) audits could also identify a sponsor's processing and operational issues which affect the completeness of data used for the Star Ratings. In this Request for Comments, we discuss options related to the first two items. CMS will separately discuss enhancements to the Star Ratings data integrity process in the draft 2018 Call Letter.

As announced in the March 8, 2016, HPMS memo, CMS suspended the reduction in the overall and summary Star Ratings of contracts that are under sanction while CMS re-evaluates the impact of sanctions, audits, and CMPs on the Star Ratings. In response to the draft 2017 Call Letter, we received multiple comments suggesting that CMS revise its policy of automatically reducing the Star Ratings of sanctioned contracts to 2.5 stars, or reducing by one star the ratings of those contracts already rated at 2.5 stars or lower. Commenters raised several concerns. For example, under this policy highly-rated contracts could be subject to a more severe penalty than lower-rated contracts as their rating could be reduced by multiple stars to reach 2.5 stars, while low-rated contracts faced a rating reduction of only one star. When CMS announced this policy

for the 2012 Star Ratings, relatively few contracts had achieved ratings of 4 stars or above, and fewer than 30 percent of Medicare Advantage (MA) enrollees were in plans offered under these highly rated contracts. In 2017, we estimate 49% of MA contracts that offer prescription drugs will achieve 4 or more stars, and 68% of MA enrollees will be in plans with 4 or more stars. Having considered these comments and the growth in the number of highly rated contracts, CMS agreed to reassess the impact of audits and enforcement actions on the calculation of Star Ratings and propose a revised approach in the draft 2018 Call Letter. Through this Request for Comments for 2018 Star Ratings, MA Organizations, Prescription Drug Plan (PDP) Sponsors, advocates, and other stakeholders have an opportunity to provide comments in advance of the draft 2018 Call Letter, allowing more time for CMS to fully explore substantive changes suggested by commenters prior to the Call Letter process.

During the MA & PDP Fall Conference and Webcast on September 8, 2016[1], CMS outlined three potential options to address sanctions, audits, and CMPs for the Part C and D Star Ratings Program, presented new features on Medicare Plan Finder (MPF) related to sanctioned contracts effective October 1, 2016, and requested feedback from stakeholders on potential options or any other additional suggestions to address this issue. The new policy we establish to address the impact of enforcement actions and audits on Star Ratings should align with CMS' policy goals of adjustments that reflect the magnitude of the issue at hand and transparency in both the development and application of any adjustment. The integrity of the Star Ratings, their value in incentivizing contracts to provide the best quality of care to beneficiaries, and the ability of the ratings to aid in the selection of a plan, must not be compromised.

One option we presented for addressing audit findings and enforcement actions in the Star Ratings is to reinstate the reductions that existed previously to sanctioned contracts' overall rating. As done in the past, contracts under an enrollment sanction would automatically be assigned 2.5 stars for their highest-level Star Rating (which we call overall rating for MA-PDs, Part C rating for MA-only contracts and Part D rating for PDPs). If a contract under sanction already has 2.5 stars or below for its highest-level rating, it would receive a 1-star reduction.

[1] https://www.cms.gov/outreach-and-education/training/cteo/event_archives.html

Alternatively, a contract under sanction could be reduced by a half or whole star. A second option would be to develop and introduce an audit measure for Star Ratings. The measure would rely on data from audits conducted over the past several years. A third option would be to revise the current beneficiary access and performance problems (BAPP) measure. The BAPP measure in Star Ratings includes sanction status, CMPs, and data from the compliance activity module (CAM). In this option the measure would be revised to reflect the magnitude of the CMPs, and sanction status would continue to reduce this measure to one star.

We appreciate the careful consideration of the options and feedback provided in response to the Fall Conference Listening Session. The vast majority of commenters did not support reducing a contract's overall Star Rating due to a CMS sanction. There was concern that an automatic deduction to the overall Star Rating would not take into account the level or severity of the issue associated with the sanction, would affect high performing contracts disproportionally more, and would not necessarily be related to the quality measures included in the Star Rating program. In general, commenters did not favor the option of developing an audit measure using previous audit results, since not all contracts are audited each year and audit findings may not be directly tied to the Star Ratings measures. Commenters suggested that the impact on the Star Ratings should be commensurate with the severity of the audit findings or enforcement actions and should reflect recent performance issues. Other commenters suggested that the impact of enforcement actions should be reflected through one measure in the Star Ratings and not multiple ones. Although there was not universal agreement among commenters about whether enforcement actions should be reflected in the Star Ratings, many respondents supported a revision to the BAPP measure, such as increasing the weight of the measure or adjusting the CMP deduction based on its severity. Based on the comments received, we are proposing to move forward with a revision to the BAPP measure with changes made to respond to the comments we received. The Star Ratings would then continue to consider enrollment sanctions and other audit actions through the BAPP measure, but sanctioned contracts would not receive an automatic reduction in their overall Star Rating.

As detailed in the Medicare 2017 Part C & D Star Rating Technical Notes, the current BAPP measure is based on CMS' sanctions, CMPs, and Compliance Activity Module (CAM) data.

Currently, the BAPP measure receives a weight of 1.5 and is classified as an access measure. The data timeframe for the measure spans from January 1st to December 31st of the measurement period for the Star Ratings year. (For example, for the 2017 Star Ratings, the timeframe used for the BAPP measure was January 1, 2015 through December 31, 2015.) Every contract begins with a BAPP measure score of 100. A contract's score is then reduced contingent on their sanction status, CAM score, and each CMP related to beneficiary access. Contracts under sanction have their score reduced to 0 and receive one star for this measure. The CAM portion of the BAPP score combines information on the notices of non-compliance, warning letters (with or without business plan), and ad-hoc CAPs and their severity. The CAM score per contract is calculated and then converted to deductions ranging from 0 to 80 in increments of 20, using a scale (see the Technical Notes for details). The CMP-portion of the BAPP measure currently carries a 40 point deduction per CMP.

After careful consideration of the comments, CMS is exploring options for revising the BAPP measure. The following changes are being considered for the 2018 Star Ratings BAPP measure: (a) increasing the weight of the measure to 3; (b) changing the data timeframe to allow use of more recent data; (c) revising the CMP deduction methodology; and (d) modifying the BAPP cut points. Below are additional details to the proposed changes. We encourage suggestions for other possible revisions to the BAPP measure.

To appropriately reflect the importance of the factors that determine the measure and multidimensionality of the BAPP measure, CMS is proposing to change the weight of the measure to 3. Because this would be designated as a specification change, it would initially be weighted 1, and then weighted 3 the following year and going forward. The proposed change in the weight to 3 signals that the measure is the sole measure of a critical area of performance, access, and represents a plan's cumulative performance in this area, including sanction status which represents conduct that poses a serious threat to the health and safety of Medicare beneficiaries.

We also welcome input regarding when this measure would be implemented in Star Ratings. One approach would be to implement the revised BAPP measure with the 2018 Star Ratings with

a weight of 1 and then a weight of 3 for the 2019 Star Ratings. An alternative would be to keep the BAPP measure as is for 2018 Star Ratings; the revised BAPP measure would be on the display page for one year prior to including it in the 2019 Star Ratings with a weight on 1 and then a weight of 3 would be assigned in the 2020 Star Ratings.

We also propose to change the data timeframe to the time period from July of the measurement year to June of the following year. The change in the timeframe would allow the use of more recent data, as suggested by many commenters. However, as the revised measure is introduced into Star Ratings, we propose including an 18-month period. For example, for the 2018 Star Ratings that are released in the fall of 2017, the BAPP measure would be calculated based on data from January 1, 2016 to June 30, 2017 (an 18-month period) instead of January 1, 2016 to December 31, 2016 (a 12-month, calendar year period). For the 2019 Star Ratings that are released in the fall of 2018, the measurement period would be July 1, 2017 to June 30, 2018 (a 12-month, non-calendar year period).

CMS seeks further comment on the possible revisions to the BAPP methodology for determining the deduction for CMPs. We propose that the deduction for CMPs be capped at 40 points total, instead of 40 points per CMP. We also propose three alternate methods to accurately reflect the relative severity of the CMP across the cited contracts of the parent organization or the cited contracts themselves. We propose doing this in part by using the size of the unadjusted CMP[2] which takes into account the deficiency, any aggravating or mitigating factors, and whether the penalty is calculated on a per enrollee basis or per determination basis. The size of the unadjusted CMP would be used in conjunction with the total enrollment of the cited contracts of the parent organization, the enrollment of each cited contract of the parent organization, or the total number of violations cited in the CMP:

1) **Deduct the same amount for each contract in a parent organization**. CMS could apply the same scaled CMP deduction to all contracts cited in the CMP notice, based

[2] CMS applies caps to CMPs when certain thresholds are reached in order to prevent excessive penalties. For purposes of the Star Ratings, CMS would apply the unadjusted CMP amounts instead of the capped amounts.

on a ratio of the unadjusted CMP amount to enrollment at the time of the enforcement action. For example, if a parent organization with two contracts cited in the CMP notice (one contract with 15,000 enrollees and the other with 35,000 enrollees at the time of the enforcement action for a total of 50,000 enrollees) received a total unadjusted CMP value of $100,000 during the measurement period, the ratio would be $100,000/50,000 or 2. The ratio takes into account the total number of beneficiaries in the cited contracts and the severity of the issue indicated by the unadjusted CMP amount. The ratio rescales the CMP for the parent organization to a per-beneficiary value by taking the unadjusted CMP amount divided by the total enrollment in the contracts included in the CMP notice. To determine the CMP deduction for each contract cited in the CMP notice, the ratio would be converted to a deduction using the proposed values below:

Ratio	BAPP Deduction for CMPs
Under 5	10 points
5 up to 10	20 points
10 up to 15	30 points
15+	40 points

In the example above, if the parent organization received a ratio of 2, both contracts would receive a 10 point deduction for CMPs in the BAPP measure.

2) **Deduct contract-specific amounts based on a contract's share of the unadjusted CMP**. CMS could scale the deduction using the unadjusted CMP amount, the number of enrollees per contract cited in the CMP notice, and the total enrollment for the parent organization's contracts cited in the notice at the time of the enforcement action. This alternate methodology takes into account the severity of the issue by using the unadjusted CMP amount and rescales the CMP deduction on a per cited contract basis, instead of a per beneficiary basis. The unadjusted CMP amount would be divided proportionally among the contracts cited in the notice by its share of the total enrollment at the time of the enforcement action. The maximum deduction for each contract cited in the parent organization's CMP would be 40 points. To determine the CMP score per contract, the total unadjusted CMP value would be

multiplied by the ratio of enrollees in a cited contract to total enrollment at the time of the enforcement action. This method allows for the differentiation of the CMP score by contract for parent organizations with more than one cited contract. Each contract cited in the CMP notice for a parent organization could potentially have a different value for the CMP score, assuming each contract has different enrollment. For example, if a parent organization with two contracts cited in the CMP notice (one contract with 30% of the total enrollment of all the contract cited in the CMP under the parent organization and the other with 70%) received a total unadjusted CMP value of $100,000 during the measurement period, $30,000 of the total CMP would be attributed to the smaller contract and $70,000 would be attributed to the larger contract. Next, all CMP scores across all contracts receiving a CMP in the measurement period would be used to determine the cut off scores that correspond to the following percentiles: 25th, 50th, and 85th. These are example percentiles and other possibilities can be proposed as part of this Request for Comments. In the example provided, two of the values that would be used to determine the scores that correspond to percentiles would be 30,000 and 70,000 along with all other CMP scores for the applicable measurement period. The scores that correspond to the percentiles would be used to form the four ranges for the deductions of 10, 20, 30 and 40 points. For example, if a contract's CMP score is at or above the value that corresponds to the 85th percentile, the contract would receive a 40 point deduction. The higher the CMP score percentile, the greater the deduction. Likewise, a contract with a CMP score below the score that corresponds to the 25th percentile would receive a deduction of 10 points. The values that correspond to the CMP score percentile cut offs would be determined each year based on the data for the applicable measurement period.

3) **Deduct the same amount for each contract cited in the CMP notice based on a ratio of the unadjusted CMP amount to the number of violations cited in the CMP.** Under this approach, if a parent organization received a total unadjusted CMP value of $1,000,000 during the measurement period and had five violations cited in the CMP, the ratio would be $1,000,000/5 or $200,000. The ratio takes into account

the total number of violations cited and the severity of the issue indicated by the unadjusted CMP amount. In another example if a parent organization received a total unadjusted CMP value of $400,000 during the measurement period and only had one violation cited, the ratio would be $400,000/1 which is $400,000. Next, all these values across all parent organizations receiving a CMP in the measurement period would be used to determine the cut off scores that correspond to the following percentiles: 25th, 50th, and 85th. The scores that correspond to the percentiles would be used to form the four ranges for the deductions of 10, 20, 30 and 40 points. For example, if a parent organization's BAPP score is at or above the value that corresponds to the 85th percentile, all contracts cited under that parent organization would receive a 40 point deduction. Likewise, all contracts cited under a parent organization with a CMP score below the score that corresponds to the 25th percentile would receive a deduction of 10 points. The values that correspond to the CMP score percentile cut offs would be determined each year based on the data for the applicable measurement period.

We propose retaining the BAPP measure score reduction for contracts under sanction; they would continue to be reduced to 0 and receive one star for this measure. The current CAM deductions would also continue to apply. The current cut points for the BAPP measure would need to be modified as a result of modifying the deduction for CMPs. We propose modifying the cut points as follows:

1 Star	2 Stars	3 Stars	4 Stars	5 Stars
0, 10 or 20	30 or 40	50 or 60	70 or 80	90 or 100

We welcome feedback on the proposed modifications to the BAPP measure, including how to account for the size of the CMP. We also welcome feedback on alternative ways to account for enforcement actions in the Star Ratings program.