DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTER FOR MEDICARE

DATE: November 30, 2012

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 Star Ratings

In this document, we describe our proposed methodology for the 2014 Star Ratings for Medicare Advantage (MA) and Prescription Drug Plans, also referred to as Plan Ratings. We also include some potential changes for the 2015 Star Ratings and beyond to give plans advance notice. We are providing plans and advocates this opportunity to comment in advance of the draft 2014 Call Letter. The timing of the annual draft Call Letter, when combined with the statutory timing of the Advanced and Final Rate Notices, diminishes the time allowed to fully explore substantive changes suggested by commenters. This Request for Comments allows CMS to have sufficient time to review and evaluate comments prior to the Final Call Letter. If you respond to this Request for Comments, you do not have to re-submit the same comments at the time of the draft Call Letter.

CMS has structured the current Star Ratings strategy to be consistent with the Three-Part Aim: better care, healthier people and communities, and lower-cost care. Our 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 to inform beneficiaries about the performance of their available plans on the Medicare Plan Finder website, as well as for the basis of Quality Bonus Payments (QBPs) for MA organizations. We are committed to continually improve our Star Rating system. For the upcoming year, we have three major areas of focus – new measures, such as the comprehensive medication reviews that are part of the Medication Therapy Management program, changes to specifications of existing measures, and enhancements in terms of how the Low Performer Icon, the Part C and D summary ratings, and the overall rating are calculated.

CMS is committed to continuing to improve the Part C and Part D quality and performance measurement system to 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 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 2014 Star Ratings in the final 2014 Call Letter, which we expect to provide to plans by April 1, 2013. The 2014 Call Letter will also describe potential enhancements for the 2015 Star Ratings and beyond. Attachment A includes the enhancements that are being considered for the 2014 Star Ratings and potential changes for future years beyond 2014. For reference, the list of measures and methodology included in the 2013 Star Ratings is described in the technical notes: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

We will consider all comments received by January 3, 2013 at 5pm EST as we finalize the methodology for 2014 Star 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 Star Ratings to PartCRatings@cms.hhs.gov. Thank you for your participation.

Attachment A

Proposed Methodology for 2014 Star Ratings

For the 2014 Star Ratings, CMS is continuing to make enhancements to the current methodology to further align it with our policy goals. In this section, we describe the enhancements being considered for the 2014 Star Ratings and unless noted below, we do not anticipate the methodology changing from the 2013 Star Ratings. The 2013 methodology can be found at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html under the 2013 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 Star Ratings.

A. New Measures

CMS is considering adding the following measures to the 2014 Star Ratings:

- *Special Needs Plan (SNP) Care Management measure (Part C SNPs)*. This measure captures the completion of initial and annual standardized health risk assessments among SNPs. See http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/PartCTechSpecs_Oct11.pdf for more information about data specifications.

- *Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (Part D).* This measure is based on the Pharmacy Quality Alliance (PQA) endorsed measure, Completion Rate for Comprehensive Medication Review (CMR), which measures the percentage of MTM-eligible beneficiaries who received a CMR. It is defined as the percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR), based on validated 2012 beneficiary-level plan-reported MTM data (collected as part of the Part D reporting requirements). The denominator is the number of non-Long Term Care (non-LTC) beneficiaries who were at least 18 years or older as of the beginning of the reporting period and who were enrolled in the MTM program for at least 60 days during the reporting period. The numerator is the number of beneficiaries from the denominator who received a CMR during the reporting period. Currently, LTC beneficiaries are excluded from this measure calculation using the plan-reported LTC enrollment element, in which plans indicate for each beneficiary eligible for MTM if the beneficiary was a LTC resident for the entire time they were enrolled in MTM during the reporting period. CMS has conducted additional testing and has concerns about the potential for gaming, and accurate exclusion of MTM program enrollees based

on plan-reported LTC status. CMS' initial attempts to validate the plan-reported LTC status of MTM program enrollees against data on nursing home stays from the Minimum Data Set (MDS) found that approximately 25% of MTM program enrollees reported by plans as LTC beneficiaries for the entire time they were enrolled in MTM were reported in MDS as never being a LTC resident (conversely, 75% of MTM program enrollees reported as LTC beneficiaries were reported in MDS as being a LTC resident). In contrast, CMS found plans' reporting of beneficiaries as not being enrolled in LTC, or with unknown LTC status matched MDS records. As a result of these findings, CMS is concerned that there is a risk of plans incorrectly reporting a beneficiary as being a LTC resident in order to exclude them from the CMR completion rate calculation when a CMR was not delivered in order to improve their rates. This would prevent accurate comparisons of plans' MTM programs by CMS. CMS already provides plans with a long-term care institutional indicator to assist in identifying beneficiaries with SNF or other LTC status and believes that this data source is preferable to plan-reported data. However, CMS seeks feedback regarding the methods used by plans to determine the LTC status of each MTM program enrollee (including their status for the entire period or at any time in the period), and suggestions for improving this measure calculation. CMS is also considering continued use of plan-reported LTC status, but to only exclude those MTM enrollees from the denominator for the 2014 Plan Rating reported as LTC residents if LTC status is verified in MDS. We would welcome comments to this potential inclusion and suggestions for other methods to ensure accuracy of LTC status.

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

B. Changes to the Methodology of Current Measures

CMS is considering modifying the methodology for the following measures:

- *Call Center – Foreign Language Interpreter and TTY/TDD Availability (Part C and D). Affects Puerto Rico Plans only.* Recognizing that Spanish is the predominant language in Puerto Rico, beginning in 2013 CMS is proposing to measure English as a foreign language for contracts for which Puerto Rico is the exclusive service area. We are proposing to replace "non-English language" with "foreign language" in the metric to reflect this change.

- *Quality Improvement (Part C and D).* CMS' methodology currently includes a hold harmless provision for contracts with overall ratings of 4 or more stars that would have their overall rating decreased with the addition of the improvement measure(s). CMS is proposing to modify the methodology so contracts are also held harmless if their individual measure stars are 5 stars in the two years being evaluated for improvement. That is, if a contract receives 5 stars in an individual measure for the two years being measured, we may consider they maintained/improved performance for purposes of the improvement measure(s), regardless of whether their measure data have declined in the 2nd year.

- *High-Risk Medication Use (Part D).* This measure is based on the PQA-endorsed High Risk Medication (HRM) measure. The HRM measure is defined as the percentage of Medicare Part D enrollees 65 years or older who received two or more fills of at least one HRM (i.e., the same HRM drug) during the measurement year. The PQA updated the HRM measure specifications and NDC list as a result of the American Geriatrics Society (AGS) recommendations to the Beers List. CMS evaluated the new HRM list, and there is approximately 50% overlap in drugs that are included on both the prior HRM drug list and the updated list. CMS began using the updated PQA HRM medication list to calculate the 2012 HRM rates provided to contracts via the Patient Safety Analysis Website since August 2012. This was also announced in the 2013 Call Letter. CMS is proposing that the updated PQA HRM list be applied to calculate the HRM measure for the 2014 Star Ratings using 2012 Prescription Drug Event (PDE) data. Also, based on requests for clarification, CMS is proposing that the following clarification be made to the measure technical notes: *This measure calculates the percentage of Medicare Part D beneficiaries 65 years or older who received two or more prescription fills for <u>the same HRM drug</u> with a high risk of serious side effects in the elderly*. CMS' methodology already takes into account 2 or more fills for the same HRM (active ingredient); please refer to the Report User Guide on the Patient Safety Analysis Website for more information. As Part D coverage of barbiturates (used in the treatment of epilepsy, cancer, or a chronic mental health disorder) and benzodiazepines will begin January 2013, we anticipate these changes, if made, would be incorporated in the calculation for the 2015 Star Ratings. We expect that a pre-determined 4-star threshold cannot be set for this measure for several years, and that this measure will continue to be excluded from the Improvement measure, given the continued specification changes. CMS will continue to base star thresholds on statistical analyses and relative ranking of plans' scores.

- *Medication Adherence for Oral Diabetes Medications (Part D).* CMS is proposing to adopt PQA's changes to this measure's specifications for the 2015 Star Ratings (using 2013 PDE data), specifically the addition of two additional drug classes, meglitinides and incretin mimetic agents; both are indicated for monotherapy. If a beneficiary switches from any of the other medications to one of these agents, they will be considered adherent to their diabetes therapy. CMS will determine if these changes are significant, and if so, this would necessitate the suspension of a pre-established 4-star threshold (if established for 2014 Star Ratings).

- *MPF Price Accuracy (Part D).* When comparing the Prescription Drug Event (PDE) total cost to the Plan Finder total cost, CMS has not penalized contracts when the point of sale (POS) costs are lower than the advertised costs. Contracts are penalized if the POS costs are higher than the advertised costs. CMS is considering changing the methodology to account for any cases where the POS cases are substantially different from the advertised costs, in order to discourage the inaccurate display of high prices for select drugs or drug classes in attempt to reduce enrollment by some beneficiaries.

- *Rounding of measure data.* CMS proposes to round all measure data and cut points used for CMS' Star Ratings, including Part D Patient Safety measures, to whole numbers, in order to avoid small differences in decimal values that result in differences in performance ratings.

Other Changes

As usual, CMS expects to update existing measures with current specifications or underlying data. For example, CMS will refresh analyses to include updated NDC lists provided by the PQA for the respective patient safety measures. These changes are typically reflected in ongoing information shared with Plans, e.g., Patient Safety Website reports, prior to the release of Star Ratings. Other updates to CMS' monitoring and audit protocols may be reflected as well.

C. Four Star Thresholds

Similar to 2013, CMS will continue to apply previously established 4-star thresholds, unless significant changes have been made to a measure's technical specifications. There are no measures for 2014 Star Ratings that have significant technical changes that would necessitate a change from the current 4-star thresholds. The current cut-points for all other measures can be found in the Technical Notes available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html under the 2013 Plan Ratings link.

CMS proposes to set 4-star thresholds for all measures that have been part of the Star Ratings for at least two years based on the historical data. The table below lists the 2014 proposed new 4-star thresholds for Part C and D measures:

Measure	MA-only	MA-PDs	PDPs
Adult BMI assessment	≥61%	≥61%	-
COA – medication review	≥81%	≥81%	-
COA – functional status assessment	≥75%	≥75%	-
COA – pain screening	≥56%	≥56%	-
Plan all-cause readmissions	≤11%	≤11%	-
Complaints	≤0.19	≤0.19	≤0.19
Audit	>60	>60	>60
Voluntary disenrollment	≤10%	≤10%	≤10%
Medication Adherence for Oral Diabetes Medications	-	≥ 76%	≥ 77%
Medication Adherence for Hypertension (RAS antagonists)	-	≥ 77%	≥ 79%
Medication Adherence for Cholesterol (Statins)	-	≥ 72%	≥ 74%

CMS has emphasized the importance of supporting the Million Hearts Campaign. A number of measures in the Star Ratings are consistent with this aim, as they monitor cardiovascular care,

blood pressure, and medication adherence. High quality in these measures is expected to reduce risks for heart disease, hypertension, and stroke in Medicare beneficiaries. For 2015 Star Ratings, we are proposing to raise the 4-star thresholds for the following measures that are relevant to the Million Hearts Campaign to encourage quality improvement by plans on these six measures:

1. Cardiovascular Care – Cholesterol Screening (Part C)
2. Controlling Blood Pressure (Part C)
3. Diabetes Treatment (Part D)
4. Medication Adherence for Oral Diabetes Medications (Part D)
5. Medication Adherence for Hypertension (RAS antagonists) (Part D)
6. Medication Adherence for Cholesterol (Statins) (Part D)

The proposed 4-star thresholds are as follows beginning with the 2015 Star Ratings:

Measure	**Revised 4-star Threshold**
Cardiovascular Care- Cholesterol Screening	≥ 87%
Controlling Blood Pressure	≥65%
Diabetes Treatment	MA-PDs ≥ 87.0%; PDPs ≥ 84.0%
Medication Adherence for Oral Diabetes Medications	MA-PDs ≥ 78%; PDPs ≥ 79%*
Medication Adherence for Hypertension (RAS antagonists)	MA-PDs ≥ 79%; PDPs ≥ 81%*
Medication Adherence for Cholesterol (Statins)	MA-PDs ≥ 74%; PDPs ≥ 76%*

D. Changes in the Calculation of the Overall Rating and the Part C and D Summary Ratings

In constructing Star Ratings for public reporting and the QBP program, a key concern is the possibility of generating Star Ratings that do not reflect a contract's "true" performance. This possibility is called the risk of "misclassifying" a contract (e.g., scoring a "true" 4-star contract as a 3-star contract).

To address this issue, CMS has been evaluating several analytic strategies in order to determine an approach to mitigate the risk of misclassification. After evaluating these strategies, CMS is considering changing the way MA, MA-PD, and PDP ratings are calculated. Instead of basing the overall star calculation on an average of star ratings for each individual measure (e.g., 1-5 stars), CMS proposes beginning with the 2014 Star Ratings to calculate star ratings by using the individual measure scores themselves (e.g., percent, rate, or score), which reflect more specific performance data than the measures' star ratings, and result in lower misclassification rates of overall contract performance. For example, Contract A scored 47% and Contract B scored 63% on C01 (Breast Cancer Screening) in 2013. Both of these contracts would have received 2 stars for the measure although they had a 16 percentage point difference in performance. By directly using the individual measure scores (instead of the 2-star rating), information about the relative differences in contacts' performances on each measure is accounted for in the overall and summary star calculations.

Beginning with the 2015 Star Ratings, CMS is proposing to include low-enrollment contracts in the Star Rating program. The change proposed above will become more critical in 2015 since there is concern that including low-enrollment contracts with fewer than 1,000 enrollees would increase the risk of performance misclassification for all contracts. Larger, as well as smaller, contracts' risk of misclassification may be affected, because each contract's star rating on each performance measure depends on the distribution of scores of all other contracts.

E. Low Performer Icon

CMS currently assigns the Low Performer Icon (LPI) to contracts receiving less than 3 stars for their Part C or Part D summary ratings for the last 3 consecutive years. Concerns have been raised by stakeholders over this definition, that is, an MA-PD contract under the current definition may switch back and forth from poor performance in Part C to poor performance in Part D from year to year and these contracts will not receive the LPI for poor performance. For example, under the current methodology, a contract can avoid being assigned the LPI if they previously had three years of low performance (less than 3 stars) on Part C but raised it to 3 stars in the current year, although they may have one or more years of low performance on Part D. In order to avoid providing potentially misleading information to beneficiaries, as well as creating inequality in CMS' monitoring and outreach activities for LPI contracts, CMS proposes assigning the LPI to any MA-PD contract receiving 2.5 stars or lower for any combination of their Part C or their Part D summary ratings for three consecutive years. This change will encourage consistent improvement in the quality of care across all of the C and D measures for MA-PD contracts.

F. Weighting Categories of Measures

We are planning to keep the same weighting categories used for the 2013 Star Ratings, in which outcome and intermediate outcome measures are 3 times the weight of process measures, while patient experience and access measures are 1.5 times the weight of process measures. We plan to assign new Star 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 tables list the proposed 2014 Star Ratings measures and their weighting categories.

Table 1: Part C Measure Weights

Measure Name	Weighting Category	Part C Summary	MA-PD Overall
Breast Cancer Screening	Process Measure	1	1
Colorectal Cancer Screening	Process Measure	1	1
Cardiovascular Care – Cholesterol Screening	Process Measure	1	1
Diabetes Care – Cholesterol Screening	Process Measure	1	1
Glaucoma Testing	Process Measure	1	1

Measure Name	Weighting Category	Part C Summary	MA-PD Overall
Annual Flu Vaccine	Process Measure	1	1
Improving or Maintaining Physical Health	Outcome Measure	3	3
Improving or Maintaining Mental Health	Outcome Measure	3	3
Monitoring Physical Activity	Process Measure	1	1
Adult BMI Assessment	Process Measure	1	1
Care for Older Adults – Medication Review	Process Measure	1	1
Care for Older Adults – Functional Status Assessment	Process Measure	1	1
Care for Older Adults – Pain Screening	Process Measure	1	1
Osteoporosis Management in Women who had a Fracture	Process Measure	1	1
Diabetes Care – Eye Exam	Process Measure	1	1
Diabetes Care – Kidney Disease Monitoring	Process Measure	1	1
Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3	3
Diabetes Care – Cholesterol Controlled	Intermediate Outcome Measure	3	3
Controlling Blood Pressure	Intermediate Outcome Measure	3	3
Rheumatoid Arthritis Management	Process Measure	1	1
Improving Bladder Control	Process Measure	1	1
Reducing the Risk of Falling	Process Measure	1	1
Plan All-Cause Readmissions	Outcome Measure	3	3
Getting Needed Care	Patients' Experience and Complaints Measure	1.5	1.5
Getting Appointments and Care Quickly	Patients' Experience and Complaints Measure	1.5	1.5
Customer Service	Patients' Experience and Complaints Measure	1.5	1.5
Overall Rating of Health Care Quality	Patients' Experience and Complaints Measure	1.5	1.5
Overall Rating of Plan	Patients' Experience and Complaints Measure	1.5	1.5
Care Coordination	Patients' Experience and Complaints Measure	1.5	1.5
Complaints about the Health Plan	Patients' Experience and	1.5	1.5

Measure Name	Weighting Category	Part C Summary	MA-PD Overall
	Complaints Measure		
Beneficiary Access and Performance Problems	Measures Capturing Access	1.5	1.5
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	1.5	1.5
Health Plan Quality Improvement	Outcome Measure	3	3
Plan Makes Timely Decisions about Appeals	Measures Capturing Access	1.5	1.5
Reviewing Appeals Decisions	Measures Capturing Access	1.5	1.5
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Measures Capturing Access	1.5	1.5
Special Needs Plans (SNP) Care Management measure	Process Measure	1	1

Table 2: Part D Measure Weights

Measure Name	Weighting Category	Part D Summary	MA-PD Overall
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Measures Capturing Access	1.5	1.5
Appeals Auto–Forward	Measures Capturing Access	1.5	1.5
Appeals Upheld	Measures Capturing Access	1.5	1.5
Complaints about the Drug Plan	Patients' Experience and Complaints Measure	1.5	1.5
Beneficiary Access and Performance Problems	Measures Capturing Access	1.5	1.5
Members Choosing to Leave the Plan	Patients' Experience and Complaints Measure	1.5	1.5
Drug Plan Quality Improvement	Outcome Measure	3	3
Rating of Drug Plan	Patients' Experience and Complaints Measure	1.5	1.5
Getting Needed Prescription Drugs	Patients' Experience and Complaints Measure	1.5	1.5
MPF Price Accuracy	Process Measure	1	1
High Risk Medication	Intermediate Outcome	3	3

Measure Name	Weighting Category	Part D Summary	MA-PD Overall
	Measure		
Diabetes Treatment	Intermediate Outcome Measure	3	3
Medication Adherence for Oral Diabetes Medications	Intermediate Outcome Measure	3	3
Medication Adherence for Hypertension (RAS antagonists)	Intermediate Outcome Measure	3	3
Medication Adherence for Cholesterol (Statins)	Intermediate Outcome Measure	3	3
Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews	Process Measure	1	1

G. Integrity of Star Ratings

The data used for CMS' Star Ratings must be accurate and reliable. CMS has taken several steps in the past years to protect the integrity of the data; however we continue to identify new possibilities of inaccurate or biased data to be included. CMS' policy is to reduce a contract's measure rating to 1 star if it is identified that biased or erroneous data have been submitted by the plan or identified by CMS. This would include cases where CMS finds plans' mishandling or inappropriate processing or implementation of practices have result in biased or erroneous data. Examples would include, but are not limited to: a contract's failure to adhere to HEDIS, HOS or CAHPS reporting requirements; a contract's failure to adhere to Plan Finder data requirements; a contract's errors in processing of coverage determinations and exceptions; compliance actions taken against the contract due to errors in operational areas that would directly impact the data reported or processed for specific measures; and a contract's failure to pass data validation directly related to data reported for specific measures. This policy was applied 44 times for Part D (for approximately 0.4 percent of the Part D measures) and 47 times for Part C measures (for approximately 0.2 percent of the Part C measures) in the 2013 Star Ratings.

H. Disaster Planning

The effects of Superstorm Sandy were significant for Medicare beneficiaries in a number of areas, as well as the Parts C and D organizations that provide important medical care and prescription drug coverage for them. Plans have raised concerns that their Star Ratings could be adversely affected by the disruption in medical and drug services. As referenced in the November 7th HPMS memo on "Reminder of Pharmacy and Provider Access during a Federal Disaster or Other Public Health Emergency Declaration," areas potentially impacted would be those found at the Disaster

Federal Register Notice section on Federal Emergency Management Agency's (FEMA's) web site (http://www.fema.gov/news/disasters.fema).

Plans need to contact CMS through the Part C and D Plan Ratings mailboxes if they believe their operations and/or clinical care have had major issues as a result of the storm that would impact the Star Ratings measures. As each plan's situation is unique, we will ask for a description and justification for why each plan believes their Star Ratings may have been adversely affected and for which measures they are claiming an impact and for how long. Plans should not categorically consider one data source as invalid. For example, based on Prescription Drug Event (PDE) data, CMS may find beneficiaries' adherence to prescribed medications declined as a result of the storm. However, a plan cannot claim that High Risk Medications (HRM) rates increased from the storm.

For the HEDIS measures, plans should contact NCQA as well as their NCQA HEDIS auditor to request any modifications for the HEDIS reporting year 2013.

We welcome feedback about practical considerations to consider in addressing this issue.

I. Measures Being Removed from Star Ratings and New Measures for the Display Page

Display measures on www.cms.gov are not part of the Star Ratings. These may be measures that have been transitioned from the Star Ratings or they could be new measures that are being tested before inclusion into the Star Ratings. Similar to the 2013 display page, plans have the opportunity to preview their data on 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 Enrollment Timeliness, Getting Information from Drug Plan, and Call Center—Pharmacy Hold Time measures to the 2014 display page. The Enrollment Timeliness measure is being moved to the display page due to the lack of variation in the scores across contracts with the scores being skewed very high. Getting Information from Drug Plan is being moved to the display page since there is little variation in the scores across contracts with the scores being skewed very high. The Call Center—Pharmacy Hold Time is being moved to the display page since hold times have held consistently for several years.

We are also considering introducing the following measures to the 2014 display page in preparation for them potentially being included as 2015 Star Rating measures:

- *CAHPS measures about contact from a doctor's office, health plan, pharmacy, or prescription drug plan*. For example, measures include questions that ask about reminders for appointments for tests or treatment, to get a flu shot or other immunization, or screening tests such as breast cancer or colorectal cancer screening; follow up after a hospital stay; reminders to fill or refill a prescription, and to ensure medications are taken as directed.

- *Use of Highly Rated Hospitals.* Using the Hospital Value-based Purchasing scores, develop an enrollment weighted measure of hospital utilization.

- *Pharmacotherapy Management of COPD Exacerbation (PCE).* The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department encounter on or between January 1– November 30 of the measurement year and who were dispensed appropriate medications. This measure includes two rates: 1) Dispensed a systemic corticosteroid within 14 days of the event; and, 2) Dispensed a bronchodilator within 30 days of the event. See HEDIS 2012 Technical Specifications, Volume 2 for more information about data specifications.

- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)*. We are considering adding the percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received: 1) Initiation of AOD Treatment—the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis; 2) Engagement of AOD Treatment—the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. See HEDIS 2012 Technical Specifications, Volume 2 for more information about data specifications.

- *HEDIS Scores for Low Enrollment Contracts*. As a precursor to including low enrollment contracts in the 2015 Star Ratings, CMS will publish HEDIS scores for low enrollment contracts as part of the 2014 display page. Contracts with less than 1,000 enrollees are first submitting HEDIS data to CMS in the summer of 2013. These data will be analyzed and presented on the display page prior to these data becoming part of the Star Ratings in 2015.

It is expected that all other 2013 display measures will continue to be shown on www.cms.gov.

J. Forecasting to 2015 and Beyond

Potential New Measures

- *Disenrollment Reasons*. CMS will be implementing an MA & PDP disenrollment survey in 2013. A random sample of voluntary disenrollees at each contract will be surveyed as close as possible to the actual disenrollment. In the previous pilot testing of this survey, beneficiaries frequently cited the following reasons for disenrollment: financial reasons, prescription drug benefits and coverage, patient experience with regard to prescription drugs, patient experience with regard to health plan, and coverage of doctors and hospitals. The primary reasons for disenrollment may be considered for new measure(s) to be included in Star Ratings in the future.

- *CAHPS – Health Information Technology – EHR measures*. There are many local, regional, and national initiatives to accelerate the adoption of electronic health records which will result in changes in terms of how care is delivered. Given this significant change in the healthcare delivery system, it is important to assess the use of electronic health records from the perspective of patients. CMS is considering adding a small set of questions to the CAHPS survey to obtain information on the use of electronic health records from the patient perspective. CMS is currently exploring modifying for the health plan setting a subset of questions that have previously been developed for the Clinician & Group CAHPS Survey that focus on:
    - Use of a computer or handheld device during office visits
    - Use of a computer or handheld device to look up test results or other information about patient during office visits
    - Use of a computer or handheld device to show patient information
    - Use of a computer or handheld device to order prescription medicines
    - Whether patient found provider's use of a computer or handheld device helpful
    - Whether patient found it harder or easier to talk to provider when provider used computer or handheld device

  If CMS goes forward with these items, they would be implemented in the 2014 CAHPS survey.

- *CAHPS – Complaint Resolution*. CMS is interested in using beneficiaries' responses regarding their satisfaction with the resolution of their complaints as a new display measure.

Changes to Measure Specifications or Calculations

- *Breast Cancer Screening for HEDIS 2014*. The National Committee for Quality Assurance is considering making the following modifications to this measure:
    - Raising the denominator upper age to 74 years;
    - Stratifying the measure into two age-group-based rates: 40-49 years and 50-74 years; and
    - Changing the numerator time frame from 24 months to 30 months.

  NCQA encourages health plans to provide feedback on the proposed changes through the NCQA public comment website available in February of 2013.

- *HOS Calculations.* The Star Ratings incorporate health outcome measures from the Health Outcomes Survey (HOS). CMS is exploring alternative scoring approaches such as a model that combines multiple health dimensions into a score from 0 to 1 where 0 represents death and 1 represents optimum functioning. Work is underway to assess reliability and validity of the model. CMS will provide plans with additional details on this model as they become available in the fall of 2013. If the additional work proves successful, CMS would

consider adding the measure derived from this model to the 2015 display page and potentially to Star Ratings in subsequent years.