

FALL 2012 CMS CONFERENCE



TRANSCRIPT

Day 1 06a: Star Ratings Update

Tudor, Oats, Goldstein

We're now here to talk about our Star Ratings. We think, generally, we need to move toward discussions of improving the quality overall of Medicare Advantage plans and Part D plans, as opposed to just talking about sort of what are the technical requirements and how do you do this measure and how do you do that measure. Our quality rating system has developed from its infancy in 2006, where we had only Part D ratings and only for some process measures, to a full-blown quality rating system for 2013 for both Medicare Advantage and Part D, with emphasis placed on outcome measures and incorporation of beneficiary perceptions, access measures, and important process measures.

Our plan finder incorporates not only the measures but clear messaging to beneficiaries on plans that are higher than average quality, and you saw some of those plans here today and a warning sign on plans that are persistent low performers. The Medicare Advantage Payment System further aligns pay for performance, with higher payments to plans that have higher quality ratings.

As this measurement system continues to develop, we've also standardized the change approach, and that's what I wanted to spend a few minutes on. First we've initiated our December letter, which highlights our approach for the Star Ratings for one year later. This approach outlines the measures, their changes, and identifies possible new measures for that time period. We started this last year and found it to be a good way to outline our approach for the industry. We plan to continue it for this December.

We next modify what we put out in December in our draft call letter, which we release in February, where we provide any changes and the reasons for those changes. Again, this release is the release for comment and is finalized in our final call letter. The blueprint serves as a basis for plan ratings that come out in the final version in October. The results of this process are that there are at least two different opportunities annually for input by plans into what is included in the Star Ratings. While we accept comments on our methodology for the measures for which we are responsible; for example, customer service wait time, we use our consensus building organizations to properly make changes to those measures for which they are responsible. This includes NCQA, NQF, and PQA.

Plans are encouraged to take their concerns on HEDIS measures; for example, adherence measures and other measures from these organizations back to them in order to provide additional input on specifications. CMS believes that the specifications around consensus-built measures should be the domain of the group that constructed that measure. In order to maintain the integrity of the consensus process, CMS believes that these groups should be the path for change and measures as well.

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We've also initiated two plan previews where we are open to plan comments. Not on the process or the technical specifications, because those comments are made at an earlier date, but on data issues, cut point issues, and discrepancies between what the plan believes is correct and what CMS believes to be correct. The second of these previews is set to begin Friday. We believe that plans need to spend more time with their previews to ensure that they understand the data that CMS used to determine their Star Ratings.

Finally, we've established both a dispute and an appeals process around the Medicare Advantage and Part D Star Rating program, primarily because of the implementation of quality bonus payments in the ACA. This program allows plans another opportunity to identify data issues with their ratings and to bring them to CMS's attention. These process improvements provide plans with multiple opportunities to give feedback to CMS.

As our focus shifts to improving the Star Rating system and updating it to incorporate the most important measures that CMS has, we urge plans to participate in this process in a meaningful way. So I'd like now to turn it over to Vikki Oates and Elizabeth Goldstein. They're two of my best people, and they're going to talk to you about new changes in the Star Rating system as we go forward.

So we're just going to quickly talk about accountability, quality, and responsibility of plans, level of measurement, maintaining the integrity of the plan ratings, and future directions, and we'll be asking you for some feedback on some of the issues and directions that we're thinking about for the upcoming months.

This is something we've been trying to stress to both plans and fee-for-service providers. We're trying to raise the quality bar for both the fee-for-service Medicare program, as well as for Part C and Part D. In the fee-for-service program you'll see quality reporting programs developing for all of our providers, so you see it historically for hospitals, home health, nursing homes, ESRD facilities. Now it's outpatient facilities, cancer facilities, hospice, so we're really covering the broad spectrum, so collecting both quality information and patient experience information across all these various settings. Similarly, as we're raising the bar for our fee-for-service program, we expect that Part C and D sponsors are accountable for the care provided by physicians, hospitals, and other providers that their enrollees use.

We sometimes get comments from some plans, "We're not responsible for the care that's provided to our enrollees in physicians offices or in hospitals." So, as a Medicare program is responsible for the care that our fee-for-service beneficiaries get in physician offices and hospitals, we see the Part C and D plans also accountable for the care that's provided to their enrollees in physicians offices, as well as hospitals and other provider types.

Another issue that comes up in discussions with plans, your quality improvement activities in some plans do this, a lot of plans do this already, should focus on improving the overall quality of care across the full spectrum of services. It should not be limited just to the plan ratings measures. Clearly, we're not measuring everything that should be measured or could be measured. You shouldn't just be focusing on one plan ratings measure. We once in a while get comments about "Well we improved on this one measure, and now you're transitioning it out of the plan rating system." You should be focusing on, you know, all the care that you're providing. And what we do

here is when plans do focus on, you know, all the care that's being provided to their members, they do very well on all the plan ratings measures.

One of the things that we're going to be exploring over the coming months, and this is something we are asking for your feedback today about, as well as we go out later this fall with our request for comment, so we're really interested in your feedback about this. It's what is the appropriate unit of analysis or appropriate, in some cases, units of data collection?" Now, at this point, most of our measurement occurs at the contract level except for a few SNIP-specific measures that are collected at the plan level and rolled up to the contract level.

One of the things we could see potentially moving towards in the future is some of the customer service or call center measures may be more appropriate, in some cases, to measure the parent organization. If there's a central (800) number across all your contracts, maybe that's the appropriate unit of analysis. Maybe for some of the clinical measures -- and this is something we're just starting to explore, so we'd like your feedback, maybe some of them would differ by your plan benefit packages. Maybe it wouldn't. But something -- we'll be exploring more, looking at the data that we have, where we can look at the benefit plan package or roll it up to the parent organization level, and it's something we'd appreciate your feedback about, whether it makes sense for some of these measures to move to a different unit of analysis. So this is something, you know, we're clearly going to be looking at internally at CMS but something we would really value your input today, as well as going forward as we do request for comments and consider changes, you know, for the future. I'm going to now turn it over to Vikki.

Hi, everyone, and thanks, Liz. Well we are looking for your feedback and ideas on the plan ratings. We just want to emphasize that we do take the plan ratings seriously. We want to ensure the continued integrity of the plan ratings, and we've put a lot of effort into making things as transparent as possible. We've significantly enhanced and lengthened, as you will see, our technical specifications document, which, hopefully, everyone reads. You don't have to read cover to cover, but it really has a lot of information in there, and we've taken a lot of time to really go into as much detail and be as transparent as possible with the technical specifications, so hopefully any question that arises from the plan ratings, you can find the answers in that document.

In terms of maintaining the integrity of the plan rating, I'd like to really discuss a couple points here. First, that NCQA is actually adopting a new process for the medical record review validation to ensure that the data that are abstracted through the medical record reviews meet the audit standards for sound processes and to make sure that the data abstracted are accurate. We also look at some of our measures for gaining potential.

So, for example, one of the measures that some plans have already had to deal with this year are around the drug plan makes timely decisions, basically our auto-forward rate, and we utilize data from various sources from our CTM, from the IRE, from audits, and even modeling that we do where we look at expected auto-forward rates versus actual auto-forward rates, and we look for outliers in those areas. If we identify some outliers or plans that we need to investigate further, we'll request information to support that the decisions that you've made have been done timely. So we'll request case file information or request a letter or denial notice, et cetera, to make sure that everything -- your decisions have been timely. And timeliness not only includes making the actual

decision for the auto -- for the exceptions or appeals, but also sending written notification to the beneficiary.

So in cases where we actually find data that are, in this case for this particular measure, data that are untimely and the case was not actually auto-forwarded to the IRE, those plans, some have already been notified and some will be notified shortly that they will actually be reduced to one star in that particular measure. Again, we want to ensure the integrity of the measure and that data are accurate. Going along with that same theme, we just wanted to reiterate from our May 5th memo that plans are prohibited from submitting PDE data that's based on data collected through other means than claimed by the network pharmacies or requests for reimbursement from beneficiaries.

So some of the future directions, and as Liz said today, we're looking for your ideas, thoughts, comments, but we want to continue to raise the bar to demand a strong level of quality and performance and look to not only focus on some of the other measures that we've done but really emphasize the focus on outcomes and beneficiary experience. We're looking, as Cynthia mentioned, to some of the consensus building organizations to help us develop new measures and make our plan ratings more robust, and we're even looking for alternative methods to evaluate improvement. So this year will be the first year that we actually have our improvement measure.

Hopefully, most folks have listened on the user group calls and have looked at the documentation we've put out already on how the measurement for improvement will be calculated this year, so we actually included as an individual measure. But there are all possible alternatives to that. Do we make it as some type of overall adjustment to the summary or the overall rating where you can get bumped up a star, or do we look at not only improvement but achieving a certain level of measurement, et cetera. So these are the types of things that we wanted to just kind of throw out to you today to let you know that we're thinking about these types of ideas. We want to hear your feedback and comments. And as Liz mentioned, we'll be putting out a request for comments again later this year like we did last year about any potential changes or things that we're thinking about for the 2014 plan ratings, although I know right now most folks are really interested in how their star ratings are going to be finalized for 2013.

We will have the data go live October 11th of this year, 10-11-12, as Liz reminded me. Easy to remember, and then the second plan preview, as Cynthia mentioned, will be this Friday. So please make sure that you take the time to look at your data. Hopefully, if there were really any data discrepancies, you would have identified that during the first plan preview. But, again, please take a look at your data, as we'll be finalizing these for the go-live date on the Medicare Plan Finder.