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CENTER FOR MEDICARE

DATE: November 22, 2013

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

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

SUBJECT: Request for Comments: Enhancements to the Star Ratings for 2015 and Beyond

This document describes the proposed methodology and changes for the 2015 Star Ratings for Medicare Advantage (MA) and Prescription Drug Plans. To provide advanced notice, potential changes for the 2016 Star Ratings and beyond are also included. MA Organizations, Prescription Drug Plan Sponsors, advocates, and other stakeholders have this opportunity to provide comments in advance of the draft 2015 Call Letter. The timing of the annual draft Call Letter, when combined with the statutory timing of the Advance and Final Rate Notices, decreases the time allowed to fully explore substantive changes suggested by commenters. This Request for Comments allows CMS to have additional time to review and evaluate comments prior to the Final Call Letter. If you plan to respond to this Request for Comments, please follow the instructions listed in Attachment A. In addition, please do not 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 six priorities in the National Quality Strategy. The six priorities include: making care safer by reducing harm caused by the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models. The 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.

The Star Ratings are used to inform beneficiaries about the performance of health and drug plans on the Medicare Plan Finder website, as well as for the basis of Quality Bonus Payments (QBPs) for MA organizations. Priorities include enhancing the measures and methodology to reflect the true performance of organizations and sponsors, maintaining stability because of the connection to payment, and providing advance notice of future changes.

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. The hope is that the Star Ratings system will not only influence beneficiaries' plan choices but also drive organizations and sponsors toward higher quality and more efficient care.

Your comments and suggestions will help CMS provide more specific guidance on the changes anticipated for the 2015 Star Ratings in the final 2015 Call Letter, which we expect to provide to plans by April 7, 2014. The 2015 Call Letter will also describe potential enhancements for the 2016 Star Ratings and beyond. Please note that this memo describes enhancements that are being considered for the 2015 Star Ratings and potential changes for future years beyond 2015. For reference, the list of measures and methodology included in the 2014 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 Thursday, December 19th at 5pm ET as we finalize the methodology and changes for the 2015 Star Ratings. Or plans may also comment on this methodology when it is published in the draft Call Letter.

Please submit all comments related to the Part C and D Star Ratings to PartCRatings@cms.hhs.gov; only one set of responses should be submitted per organization.

Thank you for your participation.

Proposed Enhancements to the 2015 Star Ratings and Beyond

One of CMS' most important strategic goals is to improve quality of care and general health status for Medicare beneficiaries. For the 2015 Star Ratings, CMS is continuing to make enhancements to the current methodology to further align it with 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 year, we try to expand measures to include those related to patient management.

In this document, we describe the enhancements being considered for the 2015 Star Ratings and beyond. Unless noted below, we do not anticipate the methodology changing from the 2014 Star Ratings. The 2014 methodology can be found at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html under the 2014 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 for 2015 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 organizations and sponsors, and the measures' accuracy and validity before making a final determination about inclusion of measures in the Star Ratings.

A. New 2015 Measures:

As stated in the 2014 Call Letter, CMS intends to add the following measures to the 2015 Star Ratings. Since these would be first year measures, the weight assigned to each would be "1".

1. *Pharmacotherapy Management of COPD Exacerbation (PCE) (Part C).* This measure is defined as 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 2014 Technical Specifications, Volume 2 for more information about data specifications.) Both rates from the HEDIS 2013 data are shown on the 2014 display page. For 2015, we are considering incorporating a combined PCE measure that averages these two rates.

2. *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (Part C)*. We are considering adding the percentage of adult members with a new episode of alcohol or other drug (AOD) dependence who received 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) to the 2015 Star Ratings. We will maintain the measure, the 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), on the display page. (See HEDIS 2014 Technical Specifications, Volume 2 for more information about data specifications.) The measure used would focus on the 18 and older. The 2013 HEDIS data for this measure are shown on the 2014 display page.

3. *Special Needs Plan (SNP) Care Management (Part C SNPs).* This measure captures the completion of initial and annual standardized health risk assessments among SNPs and is available now on the CMS display page. This measure is defined as the percent of eligible SNP enrollees who received a health risk assessment (HRA) during the measurement year. The denominator for this measure is the sum of the number of new SNP enrollees for the organization and the number of SNP enrollees eligible for an annual reassessment for the organization. The numerator for this measure is the sum of the number of initial assessments performed on new SNP enrollees during the measurement period and the number of annual reassessments performed on SNP enrollees eligible for a reassessment. An organization must have a minimum of 30 SNP enrollees eligible to have a SNP assessment for the rate to be calculated. Organizations that did not score at least 95% on data validation for their reporting of the SNP care management reporting section and organizations that were not compliant with data validation standards will be shown with, "CMS identified issues with this plan's data." (See http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html for more information about data specifications.)

4. *Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (Part D).* This measure is based on the PQA-endorsed measure, Completion Rate for Comprehensive Medication Review (CMR), which measures the percentage of beneficiaries who met eligibility criteria for the Medication Therapy Management (MTM) program and who received a CMR. CMS proposes adding this measure to the 2015 Star Ratings (using 2013 data). The denominator is the number of 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 included in the denominator who received a CMR during the reporting period. Only a CMR that meets CMS definitions and includes providing an individualized, written summary of the CMR in CMS' standardized format shall be reported and counted as a CMR. CMS will include LTC beneficiaries in the measure calculation, since Part D sponsors have been required since 2013 to offer CMRs to all beneficiaries enrolled in the MTM program at least annually regardless of setting. An organization/sponsor must have 31 or more 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 to have an MTM CMR rate calculated. Organization/sponsors that did not score at least 95% on data validation for their reporting of the MTM program section or did not meet CMS' additional audit/review criteria will be shown with, "CMS identified issues with this plan's data." Sponsors are reminded that they should not restrict their MTM eligibility criteria to limit the number and percent of beneficiaries who qualify for these programs and to whom they must offer a CMR.

B. Changes to Measures for 2015

Due to the release of the new American College of Cardiology (ACC)/American Heart Association (AHA) Guideline on the Treatment of Blood Cholesterol, NCQA will be convening its Cardiovascular Measurement Advisory panel in order to address the question of whether a change is needed in their HEDIS measures related to LDL-C control. CMS will be following these discussions for any impact in the Star Ratings.

CMS is modifying the methodology for the following measures:

1. *Breast Cancer Screening (Part C)*. The specification for the Breast Cancer Screening measure is being modified to reflect changes in HEDIS 2014. In HEDIS 2013 the measure was defined as the percentage of women 40 to 69 years of age who had a mammogram for breast cancer every two years. The specification for 2014 revises the age range from 40 to 69 years old to 50 to 74 years old and increases the numerator time frame for documentation of a mammogram from 24 months to 27 months. These changes were a result of NCQA's measure re-evaluation process that included: a scan of clinical guidelines and evidence; feedback from variety of stakeholders, including women's health experts, clinicians, consumer advocates, and health plans; and a public comment period. The revised age range aligns with current recommendations from the U.S. Preventive Services Task Force (Grade B recommendation), American Academy of Family Physicians, and others. The increased numerator time frame from 24 to 27 months provides a 3-month grace period to account for logistics of obtaining a mammogram and is in response to concerns that the lack of a grace period results in women being screened more often than every two years. This change in specifications aligns the measure with the clinical guidelines that were first available in 2009. Since the measure specification changed during the measurement year and includes additional members for the denominator of the measure, we propose to move this measure to the display page for one year (2015). We would include this measure in the 2016 Star Ratings.

2. *Annual Flu Vaccine (Part C)*. NCQA is changing the flu shot question used in CAHPS so survey respondents will be asked whether they received a flu shot since July of each year (instead of September) since the timeframe when people get flu shots has been getting earlier each year. This does not change the denominator for this measure, but members who get their flu shots earlier will be included. We will eliminate the pre-determined 4-star threshold for this measure for the 2015 Star Ratings due to the measure specification change.

3. *High Risk Medication (Part D).* As stated in the 2014 Call Letter, the updated PQA HRM list, based on the AGS recommendations to the Beer's List, will be applied to calculate the HRM measure for the 2015 Star Ratings using 2013 Prescription Drug Event (PDE) data. Part D coverage of barbiturates (used in the treatment of epilepsy, cancer, or a chronic mental health disorder) and benzodiazepines began in January 2013. The updated PQA HRM list includes barbiturates, not benzodiazepines. Therefore, the measure calculation will reflect Part D coverage changes, and Part D covered barbiturates will be included in the calculation for the 2015 Star Ratings (using the 2013 PDE data).

4. *Medication Adherence for Diabetes Medications (Part D)*. As stated in the 2014 Call Letter, CMS is adopting 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 to the numerator and denominator (meglitinides and incretin mimetic agents).

5. *Appeals Upheld (Part D)*. We propose to modify this measure from using the current 6-month snapshot to use the same 12-month measurement period as the Part D Appeals Auto-forward measure. For example, instead of using 6 months of 2014 data, the 2015 measure would use the full 12 months of 2013 data. This change will allow consistency between the two appeals measures as well as expand the measurement period. We will eliminate the pre-determined 4-star threshold for this measure due to this specification change.

6. *MPF Accuracy (Part D).* This measure incorporates data from Part D organization/sponsors' Medicare Plan Finder (MPF) files, specifically information about the types of claims dispensed by each pharmacy in an organization/sponsor's network. Currently, we exclude PDE claims from retail pharmacies that are also reported by sponsors as being long term care, mail order, or home infusion pharmacies. We propose to remove this restriction, and instead use PDE data to identify retail claims for evaluation in this measure. We will also remove the restriction to evaluate only claims for 30-day supplies, and will evaluate claims for 30, 60, and 90-day supplies.

7. *Beneficiary Access and Performance Problems (Part C and D)*. We are incorporating the changes in the audit scoring methodology announced in the March 17, 2013 "Final Program Audit Scoring Methodology" (see http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/HPMS-Memo-Final-Program-Audit-Scoring-Methodology.pdf for more information). This change introduced a scoring system that generates an audit score for every organization/sponsor audited based on the number and severity of deficiencies detected in an organization/sponsor's operations. In this new scoring system, a lower score represents better performance on the audit. As indicated in the HPMS memo, CMS will no longer use the number of samples passed or failed in determining audit scores for the Star Ratings.

   Starting with the data for the 2015 Star Ratings, an audit score will be calculated by utilizing the audit results for each of the following program areas: Part D Formulary and Benefit Administration; Part D Coverage Determinations, Appeals, and Grievances (CDAG); Part C Organizational Determinations, Appeals, and Grievances (ODAG); and Compliance Program Effectiveness. These four core program areas are used because they are consistently audited each year and have limited changes to the audit protocols from year to year.

   The final Star Rating audit score for an organization/sponsor would be calculated using the total number of audit points (determined based on both the number of unique deficiencies identified and the severity of those deficiencies) in these four areas, divided by the total number of audit elements tested. Cut points to determine the point reductions for the audit finding will be determined by an analysis of cumulative data, beginning with the 2012 audit data.

Depending on the final audit score, organizations/sponsors could be reduced by up to 50 points from the starting audit score of 100. There are no changes proposed in 2015 to the calculation and point deductions for sanctions, CMPs, and compliance letter (CAM Score) portions of the audit measure.

8. *Medication Adherence Measures (Part D).* Based on stakeholder feedback, we propose to adjust the three Medication Adherence measures to account for beneficiaries with hospice enrollment or Skilled Nursing Facility (SNF) stays, during which the Part D sponsor would not be responsible for providing prescription fills for relevant medications. These adjustments would be an extension of a similar adjustment currently applied to adherence measures to adjust for beneficiary stays in inpatient (IP) facilities. The basis for this change is as follows: Analysis of the 2013 data (with dates of service between January 1, 2013 and July 31, 2013, submitted by August 31, 2013), found a small proportion of beneficiaries included in the adherence measure that are enrolled in hospice. Adjustments to the measure for hospice enrollment have a negligible impact on overall adherence rates, increasing the rate on average by approximately 0.16 - 0.19 percentage points. After the SNF adjustment, overall adherence rates increase by approximately 0.37 - 0.45 percentage points. Although the impact of these two specification changes is small, they improve the validity of the measures.

   While hospice information from the Medicare Enrollment Database (EDB) and IP claims from the Common Working File (CWF) are available for both Fee-for-Service (FFS) and Part D beneficiaries, SNF claims are only available for beneficiaries in FFS, and thus those enrolled in a PDP sponsor. The SNF adjustment will only impact PDP sponsors; when such data are available for MA-PD organizations, this adjustment will be expanded to include those organizations as well. The SNF adjustment will only impact PDP sponsors.

   Adjustments to the proportion of days covered calculation would be made using the following steps:

   I. Identify start and end dates of relevant types of stays for beneficiaries included in adherence measures.

      i. Use IP claims from the CWF to identify IP stays.
      ii. Use SNF claims with positive payment amounts from the CWF to identify SNF stays.[1]
      iii. Use hospice records from the EDB to identify Hospice stays.

   II. Remove days of relevant stays occurring during the measurement period from the numerator and denominator of the proportion-of-days covered calculation.

   III. Shift days supply from Part D prescription fills that overlap with the stay to uncovered days after the end of the relevant stay, if applicable. This assumes

[1] Although we do not generally observe SNF claims for Part C beneficiaries, due to enrollment changes and data anomalies we may observe a negligible number of claims for non-Fee-for-Service (non-FFS) beneficiaries.

the beneficiary receives the relevant medication from a different source during the stay and "stockpiles" the Part D prescription fills for later use.

9. *Obsolete NDCs.* As stated in the 2014 Call Letter, beginning with the 2015 Star Ratings and display measures (using 2013 PDE data), we will implement the PQA's specification change to account for obsolete NDCs. NDCs with obsolete dates will be included in the measure calculation if their obsolete dates are within the period of measurement (measurement year) as reported by PQA.

C. Retirement of Measures

We plan to remove the Glaucoma Testing (Part C) measure from the 2015 Star Ratings due to the U.S. Preventive Services Task Force's recent conclusion that the current evidence is insufficient to assess the balance of benefits and harms of screening for primary open-angle glaucoma in adults.

D. Contracts with Low Enrollment

As a precursor to including low-enrollment contracts in the 2015 Star Ratings, CMS has included HEDIS scores for low-enrollment contracts as part of the 2014 display measures. Contracts with less than 1,000 enrollees first submitted HEDIS data to CMS in the summer of 2013. These data were analyzed, and we see sufficient data to reliably measure and report on contracts with 500 or more enrollees in July of the HEDIS measurement year in the Star Ratings. That is, contracts with 500 or more enrollees as of July 2013 will be included in the 2015 Star Ratings. Contracts with 500 or more enrollees in most cases will have sufficient data to produce both overall and Part C and D ratings. The HEDIS data for contracts with less than 500 enrollees will continue to be posted on the display page.

E. Data Integrity

CMS wants to reiterate the importance of ensuring that the data used for CMS' Star Ratings are accurate and reliable. While protecting the accuracy and integrity of all data used for Star Ratings is critical, CMS is especially concerned about measures using organization/sponsor-reported or organization/sponsor-submitted data, for example, the Part C and D appeals measures use data that sponsors report to the IRE. CMS' audits and other investigations have consistently shown that sponsors fail to follow requirements for forwarding Part C denials and auto-forwarding untimely Part D initial coverage determination or redetermination requests to the IRE. Other areas of concern are the two new proposed measures that focus on SNP care management and MTM CMRs which are also based on organization/sponsor reported data. While all these data undergo separate data validation, CMS may perform additional audit/review to ensure the validity of data, such as MTM-related data, for specific contracts. Without independent validation of these data, there is risk that CMS will reward contracts with falsely high ratings in these areas.

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. This would include cases where CMS finds mishandling of data, inappropriate processing, or implementation of incorrect practices by the

organization/sponsor have resulted 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 or PDE data requirements; a contract's errors in processing coverage determinations/exceptions or organization determinations; compliance actions 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 Part C and D Reporting Requirements data validation related to organization/sponsor-reported data for specific measures. CMS has taken several steps in the past years to protect the integrity of the data; however, we continue to identify new vulnerabilities where inaccurate or biased data could exist.

F. Changes for Measures Posted on the CMS 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 tested before inclusion into the Star Ratings. Similar to the 2014 display page, organizations/sponsors 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. It is expected that all other 2014 display measures will continue to be shown on www.cms.gov.

We are considering introducing the following measures to the 2015 display page. Some of these measures may be included as 2016 Star Ratings measures:

1. *CAHPS measures about contact from a doctor's office, health plan, pharmacy, or prescription drug plan (Part C)*. For example, measures include questions that ask about reminders for appointments, 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; and reminders to fill or refill a prescription, and to ensure medications are taken as directed.

2. *CAHPS – Complaint Resolution (Part C and D)*. CMS is interested in using beneficiaries' responses regarding their satisfaction with the resolution of their complaints as a new display measure for informational purposes. This information would complement the information currently available on complaint rates.

3. *CAHPS – Health Information Technology – EHR measures (Part C)*. There are many local, regional, and national initiatives to accelerate the adoption of electronic health records that 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 added a small set of questions to the 2014 CAHPS survey to obtain information on the use of electronic health records from the patient perspective. For example, measures include questions that ask about whether a computer or handheld device was used during office visits; whether the patient found the provider's use of a computer or handheld device helpful; and whether the patient found it harder or

easier to talk to provider when the provider used a computer or handheld device. This display measure is for informational purposes only.

4. *Transition monitoring (Part D).* We anticipate developing two display measures using CY 2013 results of the Transition Monitoring Program Analysis (TMPA): 1) Protected Class Failure Rates, and 2) Non-Protected Class Failure Rates. The TPMA investigates whether Part D sponsors, in accordance with 42 CFR § 423.120 (b)(3), are adequately administering formulary transition policies that provide enrollees with a one-time temporary supply of requested non-formulary drugs to allow time for the enrollees to switch to alternative therapies consistent with Part D regulations and requirements. In the CY 2012 pilot of TMPA, CMS conducted two analyses on rejected claims data provided by a sample of selected sponsors: 1) to identify continuing beneficiaries who had a rejected point-of-sale (POS) claim in CY 2012 for a drug that qualified for a transition fill, and 2) to identify rejected POS claims for Part D drugs for new members from January 1, 2012 to January 21, 2012. Sponsors responded to each claim in question, providing explanations for whether the claim was rejected correctly or incorrectly. After analyzing the results of all of the contracts included in the sample, approximately 27% of contracts exceeded the protected class and/or non-protected class drug failure threshold. Based on the failure rate in the CY 2012 transition monitoring analysis, Part D audit findings, and self-disclosed transition errors CMS continues to be concerned that sponsors are not appropriately adjudicating transition supplies. The transition monitoring program was expanded in CY 2013 to include all contracts that utilize a formulary for Part D, with the exception of National PACE, Medicare-Medicaid Plans, and Employer-Direct 800 series employer group waiver plans. CMS expects to publish results for all contracts in Fall 2014.

5. *Combined MPF Price Accuracy (Part D).* In Fall 2013, CMS introduced a new display measure, "Plan Submitted Higher Prices for Display on MPF", which evaluates when an organization/sponsor's posted price for a Part D drug is higher than the actual price charged at the POS. It is, essentially, the counterpart of the MPF Price Accuracy Star Rating measure, which measures the opposite scenario – that is, when an organization/sponsor's posted price for a Part D drug is lower than the actual price charged at the POS. CMS is interested in industry feedback about the new display measure, and the feasibility of combining the two accuracy indices into one measure in the future. CMS would develop specifications for the combined measure at the earliest for a 2015 display measure before considering it as a Star Rating measure for a later year. If this measure was added to Star Ratings, it would replace the current price accuracy measure.

6. *Disenrollment Reasons (Part C and D)*. CMS has implemented the PDP and MA Plan Disenrollment Reasons survey in 2013. A random sample of voluntary disenrollees at each contract is 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. This is similar to the disenrollment reasons information that CMS formerly made public for health plans prior to 2006 when the reasons for disenrollment were linked to the disenrollment rates information. CMS will be

providing individual reports back to contracts with results for their enrollees with comparisons to state, regional, and national estimates in August 2014. The primary purpose of the reports is to assist MA and PDP contracts with quality improvement efforts, and to that end, we will provide both composite measures of the primary reasons for disenrollment and drill-down item information. Composite measures of the primary reasons for disenrollment will be introduced to the 2015 display page.

We are considering the following changes to measure specifications on the 2015 display page:

7. *Drug-Drug Interactions Measure (Part D)*. This measure is adapted from the PQA Drug-Drug Interactions (DDI) measure. It is defined as the percent of Medicare Part D beneficiaries who received a prescription for a target medication during the measurement period and who were dispensed a prescription for a contraindicated medication with or subsequent to the initial prescription. The PQA reviewed and updated the list of drug-drug interactions. We propose to implement the updated PQA DDI measure list for the 2015 display measure (using 2013 PDE data). The changes made to the DDI list include:

    I. Delete the DDIs - carbamazepine and propoxyphene; tamoxifen and bupropion, duloxetine, fluoxetine, and paroxetine; warfarin and cimetidine; warfarin and fibrates (fenofibrate, fenofibric acid, gemfibrozil).

    II. Add the DDIs - carbamazepine and clarithromycin, erythromycin and telithromycin.

G. Forecasting to 2016 and Beyond

1. *2016 Changes in the Calculation of the Overall Rating and the Part C and D Summary Ratings*

a. Background

CMS is interested in improving the accuracy of the assignment of overall and Part C and D summary ratings that are used for public reporting to Medicare beneficiaries and as the basis for Quality Bonus Payments (QBPs) for MA organizations. In constructing Star Ratings, a key concern is the potential for generating Star Ratings that do not reflect a contract's "true" performance, otherwise referred to as the risk of "misclassifying" a contract's performance (e.g., scoring a "true" 4-star contract as a 3-star contract, or vice versa). Misclassification occurs in any measurement system because all performance measurement is a mixture of *signal* (true performance) and *noise* (random measurement error due to rounding, variation due to who is sampled, and similar factors). Over the years several features have been implemented in the quality rating system to simplify the information for consumers, as well as to make the information more transparent for organization/sponsors. For example, we group the measure scores into star categories and round the data to make it easier for consumers to understand what a particular score means. We have also implemented some pre-determined 4-star thresholds since the 2011 Star Ratings to increase transparency for organizations/sponsors and set a priori

expectations for high performance. However, all of these features create more "noise" or measurement error in the system.

b. Current Scoring Method

The 2014 overall Star Rating is a composite measure that is constructed from 36 measures for Part C and from 15 measures for Part D. The measures are numeric scores such as counts and percentages of screening and testing, chronic care, patient experience, customer service, and patient safety measures. Currently, each measure is assigned a rating from 1-5 stars. The principle for assigning a Star Rating for a measure is based on evaluating the maximum score possible and testing initial percentile star thresholds with the actual score. Scores are grouped using statistical techniques to minimize the distance between scores within a grouping (or "cluster") and to maximize the distance between scores in different groupings.

There are two methods for calculating the measure stars:

- Clustering. Clusters are defined as contracts with similar distances between their data values and the center data value. The measure scores are inputs for a clustering algorithm, which determines break points in the distribution and groups the scores into star categories.
- Significance testing. The measure scores are assigned stars with a combination of percentile-based categories and whether the score is significantly different from the mean of all contracts.

For the 2014 Star Ratings, 25 Part C and 5 Part D measures have pre-determined 4-star thresholds (68% of Part C measures, and 33% of Part D measures) that are not set by the clustering algorithm. For the 2015 Star Ratings, we will not introduce any new 4-star thresholds. We will also eliminate two previously set 4-star thresholds for measures due to specification changes: Annual Flu Vaccine (Part C) and Appeals Upheld (Part D).

For those measures with pre-determined 4-star thresholds, any contract with a measure score above the threshold receives 4 or 5 stars, and any contract with a score below the threshold receives 1, 2, or 3 stars. This pre-determined 4-star threshold is applied before the clustering or significance testing. For example, for clustered measures, first the contracts that score above the pre-determined threshold are selected, and then this subset is clustered into two categories to determine which contracts receive 4 stars and which receive 5 stars.

Performance consistency across measures is considered an important indicator for the reliability of quality measurement. The individual measures selected by CMS for Star Ratings are proxies for the underlying central concept of high quality care. As such, consistently high performance across our measures is an indication that we can be more confident that an organization/sponsor's underlying operations and clinical services reflect the high quality of care they provide. In contrast, an organization/sponsor that demonstrates more erratic behavior in measures may not offer the same consistent quality, due to non-aligned operations or clinical services. An organization/sponsor's

inconsistent performance—high on some measures, low on others—could also mean mismanagement of some areas by internal staff or subcontractors.

To incorporate this consistency indicator into the rating process, CMS has applied an i-Factor, renamed as the "Reward Factor", to the mean overall and Part C and D summary ratings since 2009 in order to reward contracts if they have both consistently high and stable relative performance. Specifically, the i-Factor calculation adds a value of 0, 0.1, 0.2, 0.3, or 0.4 to each contract's overall and summary ratings according to the variability and mean performance of its measure stars, and in doing so it increases the number of contracts at the high end of the rating scale for contracts that have low variation and high mean performance in their individual measure scores. The 2014 Part C & D Star Rating Technical Notes provides more information about the calculations.

c. Concerns with Current Scoring Method

Using the whole-star individual measures, as well as pre-determined 4 star thresholds, results in a loss of information when aggregating up to the overall and summary ratings. Whole stars contain less information than the corresponding measure data because there is information loss associated with converting a numeric scale to a 1- to 5-star rating. That is, the range of values between whole numbers is not differentiated (e.g., a "high 3" looks like a "low 3"). While we understand sponsors' perceptions that pre-determined 4-star thresholds provide stability in setting performance expectations, in reality the use of pre-determined thresholds violates our principle of assigning stars that maximize the difference between star categories. Pre-determined 4-star thresholds can thus cause contracts to receive different ratings when there is no significant difference in their scores (e.g., if a 4-star threshold is 80%, a contract that scores 79% would receive 3.5 stars while a contract that scores 81% would receive 4 stars when there may be no meaningful difference between a score of 79 and a score of 81). This is counter to the industry feedback given to CMS that these thresholds assist organization/sponsors in targeting their improvement efforts. The use of pre-determined 4-star thresholds is also problematic when there is general improvement in measure performance over time or when there are changes to a measure's specifications. In this case, there may not be any contracts with 4 or 5 stars, or any contracts with 1, 2, or 3 stars, for a particular measure. These examples illustrate how pre-determined thresholds increase noise in the Star Ratings.

d. Proposed Changes to Thresholds for 2016

Based on extensive analyses of several options, we recommend moving from the current scoring methodology to a new method for the 2016 Star Ratings which removes the pre-determined measure thresholds. We would continue to use the "Reward Factor" for contracts with consistently high performance and continue our evaluations if changes are needed.

We will provide contract-specific information on the impact of removing pre-determined 4-star thresholds prior to the comment period for the 2015 draft Call Letter. This spring, we will release results of our analyses of performance trends in Star Rating measures, and as applicable, pre-determined 4-star thresholds. We welcome input as to whether these

changes should be introduced in 2016 or phased in to eliminate the pre-determined 4-star thresholds for process measures first in 2016 and the remainder in 2017.

Expected Changes to Measure Specifications or Calculations

For HEDIS 2015, NCQA is considering revisions to the following measures included in the Part C Star Ratings:

2. *Osteoporosis Management in Women who had a Fracture (Part C)*. This measure assesses the percentage of women who had a fracture and received either screening or treatment for osteoporosis. One of the treatments for osteoporosis listed in the measure is a prescription for estrogen. However, estrogen is included in the American Geriatrics Society's recently published list of potentially harmful medications in the elderly (i.e., Beers criteria). NCQA is reviewing the most recent evidence for osteoporosis treatment with experts in the field to determine if treatment with estrogen should be removed from this measure. Other revisions under consideration include adding an upper age limit to the measure and adding an exclusion for dementia.

3. *Monitoring Physical Activity (Part C)*. This measure, collected through HOS, assesses the percentage of beneficiaries who discussed their level of physical activity with their health care provider and were advised to start, increase, or maintain their level of physical activity. NCQA is currently exploring the possibility of revising the underlying survey questions used in this measure. These revisions would facilitate the possible addition of an outcome indicator that assesses whether patients increased their level of physical activity.

4. *Plan All-Cause Readmissions (Part C)*. This is a measure of the percentage of hospital discharges that result in a readmission for any cause within 30 days of discharge. This measure is reported as a ratio of a health plan's observed rate of readmission compared to an expected rate of readmission based on a risk-adjusted model. NCQA is considering two potential changes to this measure: 1) excluding planned readmissions from the measure and 2) removing the current exclusion from the denominator for hospitalizations with a discharge date in the 30 days prior to the Index Admission Date. NCQA and its Measurement Advisory Panels believe these changes will improve the validity of the measure.

5. *Improving Bladder Control (Part C)*. This measure, collected through HOS, assesses the percentage of beneficiaries with a urine leakage problem who discussed their problem with their provider and received treatment for the problem. NCQA made three changes to this measure. First, NCQA changed the denominator of both indicators to include all adults with urinary incontinence, as opposed to limiting the denominator to those who consider urinary incontinence to be an issue. This will remove a potential bias toward only sampling patients who were treated unsuccessfully. Second, NCQA changed the treatment indicator to assess whether treatment was discussed, as opposed to received. This will change the measure focus from receiving potentially inappropriate treatments, which often have adverse side effects, to shared decision making between the patient and provider about the appropriateness of treatment. Third, NCQA added an outcome indicator to assess how much urinary incontinence impacts quality of life for beneficiaries. This outcome indicator

will not be part of the Star Rating system until additional analyses have been done. These changes required revising the underlying survey questions in HOS. The revised questions will be first collected in 2015. As a result of these changes, there will be no data for this measure for the 2016 and 2017 Star Ratings.

CMS will also monitor any additional measures developed by NCQA for incorporation into the Star Ratings. For example, NCQA is currently testing a measure of potentially avoidable hospitalizations based on the AHRQ Prevention Quality Indicators (PQI). The proposed measure has two composites that assess the rate of hospitalization for acute and chronic ambulatory care-sensitive conditions. Depending on the outcome of testing and the development of appropriate risk-adjustment models, these would be potential measures for inclusion in the future. Additionally, NCQA is currently developing potential new health plan quality measures that address the continuum of depression care from screening to outcomes. Specifically, they are exploring quality measures of depression screening with a standardized tool, developing a follow-up plan, monitoring of depressive symptoms with a standardized tool, and remission of depressive symptoms. Where possible they are planning to align these measures with existing quality measures that are included in Meaningful Use, such as measures developed by CMS for clinician quality evaluation and measures developed by Minnesota Community Measurement. Again, CMS will continue to monitor these efforts.

6. *Plan Makes Timely Decisions about Appeals (Part C)*. CMS is revising the procedures relative to appeal dismissals beginning in January 2014. Beginning in 2014 organizations will be responsible for reviewing dismissal requests and making the decision, rather than forwarding requests to the Independent Review Entity (IRE) for the dismissal decision. Therefore, the IRE will not be capturing data around the timeliness of dismissal cases, and consequently, dismissals will be excluded from this measure for the 2016 Star Ratings.

H. Measurement Concepts

CMS is committed to continuing to improve the Part C and D Star Ratings by identifying new measures and methodological enhancements. Feedback or recommendations can help CMS' continuing analyses, as well as our collaboration with measurement development entities such as NCQA and PQA. Below are some areas where we welcome comments and input.

1. Alternatives to the individual measures' current level of evaluation. For example instead of measures being rated for each contract, should some be evaluated at the plan (PBP) level, or at the parent organization level? Are there other associations of contracts within business entities that could also be a measurement level?

2. Additional measures of care coordination focusing on how well providers and organizations coordinate services.

3. Measures of care transitions from one healthcare setting to another, for example, care transitions following hospital discharge.

4. Measures of patient-reported outcomes/intermediate outcomes collected through enrollee surveys, including additional ways to measure changes in health and mental health status.

5. Measures that are condition-specific (e.g., mental health such as depression screening, HIV/AIDs, COPD, cancer, etc.). This may include one or more measures for a particular condition.

6. Combined member dissatisfaction measure – CMS is considering methodologies to combine available data sources of complaints and grievances. As an interim step, CMS may modify the CTM measurement period from 6 months of the current contract year to 12 months of the prior contract year.

7. SNP-specific measures that would focus on any unique aspects of care provided by SNPs.

8. Alternative weighting of measures, specifically: 1) the improvement measure(s) in order to further recognize organizations/sponsors' efforts in improving quality. For example, increasing the improvement measure's weighting as an outcomes measure (3x) to 4 or 5 times the weight of a process measure in order to reward lower-performing contracts' strides to raise their performance; 2) the policy reasons for modifying the weight (3x) of the three Part D Medication Adherence measures.

9. Alternative methods for measuring improvement that ensure that the efforts of lower-performing contracts to improve are recognized in the Star Rating system.

10. Feasibility of replicating current HEDIS measures by using FFS administrative data – CMS is interested in evaluating stand-alone PDPs' performances in areas that traditionally are based on medical record reviews.