



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

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Updates on Plan Performance and QIP/CCIP Expectations

Liz Goldstein , CPC/MDBG/DCAPP

CAPT Marsha Davenport, MD, CPC/MCAG/DSP

Liz Goldstein

Good morning. Today I will be giving you an update on the planned readings, and as most of you know, each file in October, we put on our Medicare plan binder tool, plan ratings that give information to consumers about the quality and performance of their plans.

I think the wrong slides are up.

I will be talking about the methodology for the plan ratings, some of the changes that we're going to be making for the calendar year 2011 planned rating. I am talking about the plan preview that will be coming up in September.

These plan ratings will go up on the Medicare plan binder tool in October.

Excuse me, could you tell us the content of the first slide?

Says plan ratings update.

If you could hold one second.

Sure.

I am going to keep going, actually, as we're changing the slide.

I apologize, but I don't believe we have that slide deck.

By chance do you have them on a thumb drive?

No, they said they had it.

We will work behind the scenes.

We will just keep going. One thing about public health, you have to be flexible.

My slides can stay there for now, I will just catch up with it. I would like to give an overview of some of the things I would like to talk about this morning with you. A little bit of background on what we're doing, where we have come to this point with quality improvement, and quality improvement program, give you a little bit more information on the program itself. Currently, and ultimately, hopefully, as much as I can share with you today, where we're going with that, program.



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

Most of you are aware the quality improvement program is grounded in the code of federal regulation and we really do use that code to develop and design quality improvement program, quality improvement project and chronic care improvement program.

We also have had an update in April on the code of federal regulation and that's something I will talk a little about, how that impacts some of the changes we want to make in the quality improvement program. With the affordable care act we will have future directions we will have to address and we will get into some of those, but most of those activities are currently under development and are not available for us to share at this point.

Today I will focus on two purposes of this presentation, to describe the program and give you somewhat of an update on where we are going with our future program.

I would like to spend a few minutes talking about defining quality and how we look at quality for the Medicare Advantage program. Quality is a very complex concept. It can really have a different context, depending on the particular environment or how we're going to address it, what we want to accomplish. One thing we talk about a lot is the multiple dimensions of quality. I will share a few of those with you, but keep in mind there are more dimensions I won't show visually or have time to address, but it is a complex concept and also evolving, not a static concept. We are continually trying to identify where we can make changes and where we can improve our outcomes based on the definitions we are using.

I think it's key as part of this dialogue and as we move forward with future discussions to identify the attribute that's make quality unique for Medicare Advantage organization and also for the special needs plan. This is a diagram that I put here to help me more than you, hopefully will help you focus on where our process is with quality. Quality is all-encompassing, the system, the provider and patients. You have to bear with me, I am a clinician and I will use the term patient interchangeably for enrollees, beneficiaries, talking about the same group of people we are trying to serve.

I will spend a few minutes going into some of the examples going into quality for each of these levels or dimensions, so I can make sure as we move into the discussion we have the same framework.

From the systems perspective I am looking at benefits, how the benefits made available to the patient really have a quality outcome for them, their health status is improved or maintained and we have positive health outcomes. Some of these benefits could be as simple as making sure patients who have diabetes are getting their hemoglobin A 1 C tested annually, or immunizations are provided as we need on an annual basis or as appropriate.

Access to care is no stranger to all of us, that's clearly an attribute of quality we want to measure and to ensure our patients are beneficiaries, have access to the providers, services that they need to maintain and improve their health.

Provider network is key. Provider net work is unique for Medicare Advantage. We want to ensure we have well-trained providers. Primary care providers are at a premium right now. That's, when I was in medical school, the emphasis was focusing on what specialty are you going to train in? Primary care provider in general were not thought of as being something that was lucrative, attractive, where physicians wanted to spend their time. Unfortunately, I always conceived of myself being what I call the "old family doctor." With my horse and buggy going



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

around to see patients. I still believe in that concept, although I have a specialty it is standing up on primary care, taking care of patients from the beginning to the end of their life, where I focus on preventive medicine. Making sure we have the network of primary care provider system key and the foundation of what we are trying to do in developing a managed care system with the quality and services available to our patients.

Coordinated care. I am a strong proponent of coordinated care, especially what I term complex coordinated care. Very few of our Medicare beneficiaries are going to have one disease or condition that has to be addressed. They are going to have multiple comorbidities that may not even be directly related to any one disease, but impact and are linked to, maybe even the ideology is from a social network, some other aspect in their life. Coordinated care is complex and is really from our standpoint at CMS, complex coordinated care and requires strong integration, strong networks, strong communication and we're working towards that. We're hoping we work together with you to do that and have a program that our beneficiaries can benefit from.

The last example here is clear. The goal is to improve, maintain patient's health status and have a positive health outcome. Satisfaction builds on that. A patient with access to a strong network who can reach his or her primary care provider, get in to see the provider, communicate with the provider or the team, will end up being satisfied with the care that he or she has, and I think that if we focus on this care system, I think satisfaction will come.

This is just using the same model to look at the special needs plans. The C SNPs are the care, chronic care, and the D, and the Institutionalized SNPs. The unique aspect of SNPs, looking at quality, how to address quality, we need to think about developing chronic care improvement programs, quality improvement programs that, projects that reflect the unique aspect of the SNP plan. When it comes to the chronic care improvement program we should be addressing one or more of the 15 condition that's make a patient eligible to be in the C SNP. With the dual eligibility we need to think about integrating in the quality improvement project aspects of the Medicaid program as well as Medicare program. Following a similar model. We have to re-think how we develop the QIPs and CCIPs for the SNP programs.

Then, one key tool that the SNP program has available to the patients and for the network is the model of care. What can we do to strengthen that model of care that will be used by the interdisciplinary care team to direct and focus the patient's care.

I would like to talk about some of the quality improvement program specifics. It's important to understand the quality improvement program is an umbrella term and the most familiar pieces for all of us, the quality improvement project, QIPs and chronic care improvement program or CCIPs. But those two elements are just that, two elements under a larger umbrella, the quality improvement program. Having other aspects, performance measures, a health information system, and program review, both internal and external, as well as the remedial action. I would like us to think about the remedial actions as a last resort, focusing on some of the earlier parameters, elements of the quality improvement program, remedial actions, what usually comes out in the audits as corrective action plans really should be, putting on my preventive medicine hat, something preventive. One of the things we're trying to do at CMS with the quality improvement team is provide more support to M aparteners in that we want to make sure that we provide good guidance, training, technical assistance, so that the QIPs and CCIPs, when evaluated and scored, really do reflect your best efforts and that if we end up with a correction action plan it's something that really just -- could not be addressed even with the best



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

effort, but that's not where we want to go. We want to help plans, work with you to develop strong quality improvement programs across our MA system.

Then the special needs program,

From our quality improvement perspective, we have already started measuring structure and process, measures for quality, but we really need to focus on outcomes, one of the future directions that we are addressing. We are looking to develop outcome measures specifically for our Medicare population. At this point we are hoping to award a contract to work on that. It's something we are looking forward to and hope it will help us direct and improve our quality improvement PRAO*EUPL.

KWEUPL KWEUPL. we have to do a better job on our part to support you and we're trying to do that. That's one internal goal to work towards. In addition, we have two other things to work on, that's improving the website for information and the topic quality *FPLGZ so you have that as a resource.

Chapter 5 under managed care is [indiscernible] we worked hard over the past months to make revision and update that. We are very far along on a version we hope to be putting into clearance and out for review soon. We realize that information is not useful to you and we are trying our best to improve that so you have accurate information on which to refer to develop your quality improvement project and chronic care improvement programs.

In particular, the chronic care improvement program and the quality improvement program are not fully described in the current chapters on the website for chapter 5. I know it's difficult, even with the guidance we put out to be able to develop strong QIPs and CCIPs. That's part of the reason we wanted to have a focused audit this past summer, to be able to obtain QIPs, CCIPs from the plans, to equality without any type of punitive action, no KA*Pes KA*Pes will be designed or suggested. To have an audit to see where the gaps are, how to intervene with technical assistance and training to improve the QIPs and CCIPs. In April the regulation came out addressed CMS with the chance to determine if we wanted to have specific to these conditions topics available for plans to select on which to build the QIPs, CCIPs, to have an understanding of conditions, clinical, non-clinical QIPs were being developed and CCIPs. That was our primary area of focus for us for this specific audit this past July and August.

However, it will help us also to finalize some of the issues in chapter 5 related to QIPCCIPs to try to make that clearer in terms of how we operationalize it and the elements we described the elements needed to develop the QIPs or CCIPs.

Continuing with some of the future directions. We actually think we're probably going to look towards having an annual audit. This will be tied to the fact we want to intervene early and not get us along the continuum where we have the corrective action plans, but to provide technical assistance and training and interventions for programs before we get to that point.

We intend to improve methods for reporting. We will look at the present body of knowledge we developed from the summer, identify how we might change the tool that's used for QIPs, CCIPs, change based on that information. Again, the other two points I can't overemphasize, ongoing technical assistance and training are critical to this process.

I mentioned the website, we clearly need to do a lot of work to do, we are poised to do that, very



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

energetic, excited about doing that. I haven't talked much about the outreach material and that's something we will have for you, under development, have more conversations about how we can provide you with tools specifically that will help you in this process.

In closing, I want to make my point that it's very important. We are all on the same page here to have a very strong quality improvement program. It's not a waste of time and I think in the long run many of us will see the benefits of strong QI program with our patient outcomes. We hope to increase the opportunities for measuring health outcomes to some of the processes under development now at CMS, and we look forward to working with you on those. Finally, I just want to remind you that quality is multi-dimensional and as you look at your plan, how your plan is organized, keeping in mind that quality does, and addressing quality and quality improvement makes good business sense and we look forward to being here to support you, work with you and work together to try to improve quality across all the MA programs.

Thank you.

[Applause]

We will start again. As I said, this morning I will talk about the methodology for the plan rating, some of the changes for the calendar year 2011 and discussing the plan previews coming up shortly for all contracts.

In terms of the current methodology, we have different levels for the plan ratings. So the first level is actual data for each individual measure. On the part C side we have 37 individual measures. On the Part D side there are 18 individual measures. The data for each measure could be a percentage, numeric value, for the whole kind measures, a second of -- really depends on what the measure is, how that data is displayed. Each individual measure gets a star rating from one to five.

The next level is the domain level. These are really topic areas such as staying healthy. For part C there are five domains or topic areas. This is for making information easier for someone using the website, grouping similar measures in the topic together. With domain level there's a star assigned based off of how contract does for each individual measure.

There's the next level, an overall summary rating for part C and Part D. Plans that offer a prescription drug, summarizing the measures related to Part C services, then they get a summary rating for Part D that summarizes all of the individual measures focusing on their drug coverage. These summary readings are an average of the individual measure stars and we do reward or adjust the score for high and stable performance. We are looking for contracts that are overall doing well on the measures and there's little SRAEURPBS across the variance. For the individual measure levels, as well as domain, it's just full stars. One, two, three. We did this for the summary, providing differentiation, information for consumers when they are choosing a contract.

The next level, this is just for MA contracts that are offering drug coverage, an overall rating that summarizes the quality and performance for all Part C and D measures combined. This is new this year. It's really to help consumers when they are looking at that information, they will have one number if they don't want to get into the details to look at, that summarizes quality and performance across both Part C and D measures. Again, this is an average of all the individual measure of stars across Part C and D. Contracts are rewarded for high stable performance and providing differentiation.



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

I will spend a few minutes talking about the different data sources that go into the planned ratings, most of you are familiar with these data sources. We get one set of data from the health and drug plans, some in particular, the data that Linda was speaking about earlier, CMS contractors, we do a number of different surveys of enrollees of your plans, and some data comes from CMS administrative data.

I will review each of these data sources, give you a feel for the different sets of data that fall under these category and information about the time period that will go into the 2011 plan ratings, publish on the website in October. Information from health and drug plans. Some of the data is [indiscernible] data, has things such as breast cancer screening or osteoporosis testing. The data that will feed into the calendar year 2011 planned rating is a calendar year 2009 data submitted to MCQA in June 2010. Just to remind you, this data is [indiscernible] the -- tracked by auditors. If there's an issue with the data, there's an issue with a measure being biased, that data is not submitted to NCQA, codes coming to us to let us know the data was biased. That would not be included in the plan ratings, however, if there's biased information and we don't have data because of that, the plan for that measure will automatically get one star. I wanted to note that.

The next set of data is prescription drug data. This is used, for example to measure the use of high-risk medication, the data Sim RAR to [indiscernible] the calendar year 2009 data. And we go through a reconciliation process to ensure the data are accurate. The final set of data is the plan finder pricing files, used to measure things such as accurate price information for the plan finder tool. This is calendar year 2009 data and CMS does extensive quality assurance in these data to ensure they are accurate.

In terms of data from CMS contractors, two sets of data are data from the independent review entity, this focuses on appeals measures. The time frame covers January '09 through June 2010, and our contractor conducts extensive QA checks, as well as plans also through the plan preview process, reconcile any discrepancy, that's a critical piece to look at your data carefully. I am not going to spend much time talking about the call center data, since Linda was talking about that earlier. Just to note the time frame for the plan ratings is February through June 2010. The next source of data is survey enrollees. Two sources of information for this. One is the KA*PS survey, provider and system survey, a survey that is done annually to measure your enrollees' experiences with your plan. Just to note, hopefully, everyone in the room in the room is aware for next year the model data collection is changing for the KA*P survey, you as a contract need to pay for the data collection. From are extensive data checks done, there's oversight of the mail and telephone operation, silent monitoring of telephone calls, extensive data cleaning done to make sure there are no out of range values, none of the data looks odd or there are no issues. Once we move to the models where vendors are approved to conduct the survey we will be doing extensive oversight of these vendors to make sure they are following the data collection protocols.

The next survey is -- health outcomes survey, examples of measures, improving, maintaining physical health, as well as a handful of [indiscernible] measures collected. Here again, similar to where KA*PS is moving there are vendors that conduct the survey on behalf of you. The HOS team provides extensive oversight of these approved vendors to ensure they are following the data collection protocols. There's a lot of [indiscernible] related to -- showing a valid, reliable data set, provides a lot of actionable information for the plans.



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

The final set of data are administrative data. These includes enrollment files, dis-enrollment information this, as well as LIS matrix. The data for the 2011 plan rating will focus on calendar year 2009. The LIS matrix will focus on the first task of -- that may be a typo, focus on the first half of 2010. We do validation of CMS administrative records, clearly keep looking at the data, doing checks to ensure it's accurate. The next set of data is complaint tracking module. This is focusing on Part C and D plan rate. The data included is the first half of 2010. There are standard operating procedures that plans need to follow to check and correct information in this module. If you correct it we won't know it's wrong. I really encourage you for the CTM measures or HPMS, you follow the standard operating procedures to ensure your information is correct. The final set of data is audit records. This is a measure we had last year focusing on whether the contract had issues during the audit, in particular, issues related to beneficiary harm, access. The time period for the 2011 ratings is the calendar year 2009 audits. In terms of data checks, central and regional offices review this data ongoing, to ensure it's correct. The audit modules are accessible by the plans. If they see issues we encourage you when you see them do you contact us.

We will spend a little time talking about the changes for the 2011 plan rating. The first change I mentioned already, MA contracts offering drug benefits, a combined Part C and D this year, to be adding this to the website, we think this will be very useful for consumers. We have spoken to users of the website, really something they are interested in having, we are excited about being able to add it this year.

As most of you probably know from our HPMS memos, we will be adding an additional icon to the website this year, a load performing icon, displayed on the Medicare plan finder website when a contract has for summary rating Part C or Part D has received less than 3 stars for the prior three years. That would include, goes up on the website in October, the 2009 plan rating, 2010 plan rating and 2011 plan ratings. So we have our plan previews, note whether your contract will be receiving this icon as well as sending out communications to those contracts so they have a heads up they will be receiving this icon on the website.

A new enhancement this year for our calculations, we're setting minimum thresholds for the assignment of four stars. Once we shortly provide contracts the thresholds, trying to over time provide extracts more information about what we expect for performance to receive a four or more stars for the individual measures.

We are just setting four stars thresholds, the others to determine the other star assignments will be based on the distribution of the data each year. There's a case where we will not be setting four-star thresholds, rather three-star thresholds, whether there's a CMS standard. For the full time measures Linda Lindh was talking about earlier, when that standard is reached a contract will receive three or more stars, and over time if we add more measures that have CMS standards we will follow the same procedures. If you meet the standard you will get at least three stars for that particular measure.

This is another change that we are making this year for contracts that are not required to submit the full set of measures. We will be basing the summary off a smaller set of measures. This mainly for privacy service contracts, next year collecting the full set of measures, so it's a one-year issue.

In terms of corrective action plan measure or the audit measures I mentioned previously, we have revised this measure slightly to just to focus on audit issues with potential harm,



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

beneficiary -- you will see more information when you draw the plan preview, provide you with the detailed technical notes.

A couple other changes for this year. The Part D CTM or complaints measure has been revised for map Ds so the denominator is based off of total contract enrollment. Last year it was based on Part D, this year total contract enrollment.

In terms of dis-enrollment measure this year, all contracts are included, including SNP and it will be based off the Medicare beneficiary database looking at enrollment transaction codes. Just to note a few more changes for the coming year. Last year we created composites for some of the measures focusing on cholesterol screen and diabetes care. This year we're breaking them back out to the individual measures. In particular, since we're setting those thresholds this year we want to make it very transparent to the contracts what they need to do to achieve more and more stars. It's a little harder, in particular for the diabetes care measure, which included for individual measures.

The next change, the rate of case auto forward to the IRE. We are doing additional QA on this measure this year. We were finding instances where cases were auto forwarded during the measurement period and right after the measurement period ended there was a bunch auto forwarded. We are looking at a lot, doing QA, extending the time frame for this measure to ensure contracts aren't holding back cases until the measurement period ends, and then pushing them through. The final change I will speak about, regarding [indiscernible] plan finding or pricing. We created a composite of two measures, combines the plan finder price stability measure from last year, as well as the similarity of the plan finder and PDE prices.

I will briefly talk about the methodology for calculating the star measure ratings. We have a lot of detail in our technical notes, I will put everyone to sleep if I go into too much detail. The basic methodology, and I will talk a little about this in the upcoming slides, is relative distribution and clustering and significance testing. To quickly go through these in terms of relative distribution and clustering, this is applied to the majority of the measures. Basically the principle behind this is we want to ensure that for our star ratings we consider the buckets for one, two, three four five as clusters or groups. We want to ensure we're in a group or cluster, the distance between scores, difference between scores within that group is fairly small. At the same time, to our statistical techniques, we're trying to ensure there's differentiation across these clusters or groupings. If someone gets one star versus three stars, there really is a difference between those or a one and two, there's a difference between those.

The techniques we use, the premise behind it is to ensure contracts that dial into the same star rating have similar score and if they fall into different star ratings there is some difference between them.

This is just to note for the KA*PS measures it's somewhat similar methodology, but also given survey data, focus on the reliability of the measurement and reliability is impacted by your sample size, response rate, we add significance testing to our calculations to ensure that a one star contract is different from a three-star contract. It's really trying to ensure because of potential reliability issues for the data that the star assignments were assigned, really valid reliable.

I will quickly go through how we calculate the various scores. For the domain score, it's an average of the individual measure stars within the domain, pretty simple.



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

In terms of the Part C and D summary ratings, as well as The overall combined summary score for MAPDs, the individual measure star ratings are average and we reward contract that's do well over all and do consistently well. To note here again, we have the half stars assign said. I mentioned before and I will repeat on this slide we are setting this year the four-star thresholds, they are pre-determined based off of historical data. For places where we have a CMS standard we are saying three-star thresholds. Some measures where there are no predetermined four-star thresholds, for new measures or measures where there's been a specification change. We need history before we set the four-star thresholds.

I will quickly show you one example, for breast cancer screening. The red line is the four-star threshold in this example. You can see on this slide the bottom, X axis is star value, the Y is the score, contract got. This is trying to show how contracts map across the star values. The blue shading, most of the contracts, star value are grouped within that box. You see for example one you have some outliers falling below the other contracts.

I will tell you a little about the plan preview. It begins mid-September and we will send a memo soon to alert you to when it begins. It's a high priority for to you closely review your data, identify any issues, if you have questions, concerns, please let us know. We're asking to expedite review of your request, make it flow much easier so we don't have to be going back and forth prior to beginning to answer your questions, to provide information to us to identify your contract, as well as detailed information regarding your question or issue.

The next slide, I include the detailed information we want from you in regard to identifying your contract. So please include this in all requests to us. including the contract IDs. That's really important to us when we are trying -- we have lots of questions in our mailbox and you don't give us contract numbers, we need to go back and forth with you to be able to answer the questions.

We want detailed information regarding the question or issue, the measure mean and as much information you can give us about your question or concern or issue, we would appreciate it, that would expedite our review if we fully understand what your concern is.

The final slide is where you can send questions to us regarding the plan preview, as well as the [indiscernible] e-mail boxes already, we regularly get questions. The Part C plan ratings at CMS.HHS.gov. The Part D it's Part D metrics at --.gov. Please, When the preview starts, e-mail these box and we will answer your question. Sometimes people try send e-mails to individuals, please do not do that, please send to these mailboxes, that will expedite our review, ensure we have documentation of your questions and we can provide consistent information to all contracts.

I think that's the end of my presentation. We were going to open up for a short amount of questions.

[Applause]

If you have a question, come on down to one of the floor mics. If you are in the middle of a row, raise your hand, we have wireless mics, we will pass them to you. State your name, who you work for. Speak clearly. If your question is to be posed to Liz or Marcia.

I am Michele Johan son, I am here from [indiscernible], question for Dr. Golds STAOEPB



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

specific to the plan ratings regarding patient safety. We struggled with this the past two years, wonder about fairness, applicability. The reason why, they only identify when a beneficiary is taking an unsafe drug, whether it's on the formulary or medically necessary as result of coverage determination. We are not sure what the plan would be expected to do to influence those ratings if the doctor makes the ultimate decision and we have done everything we are required to do according to the Part D rules, willing to look at other type measures of patient safety, motivation behind the particular measures.

I can try to answer, work more on Part C measures, the Part D team is looking at various different measures. We will offer feedback to them. Something to take into consideration, how you can influence medication, we encourage you to provide information about which are safe, what you can do, we will in the future, I know expanding the Part D measures.

[indiscernible] performance measure tag on the plan preview, I am a little unclear as to how that will be removed, the timing that issue will be removed. You said when we meet the star rating that it would -- call center measures when we increase rating for customer service calls it would be updated, but it seems the update wouldn't happen until the next plan review because until by the time the measures are calculated, all year long, data from 2009, three years ago, that we are still going to be tagged, not updated timely.

The icon is related to the plan ratings, updated annually. So if you do receive it in October, it will not go away until the following year F your scores have increased. Something that will remain with you for the year, given the data sources are annual data sources, we can't update more frequently.

We have a question here.

I am [indiscernible] Freedom Health. Question to Liz. Whether When we get our plan preview e-mail will we get a statement for every measure like you had up on one of the screening measures showing where we stand relative to other plans, the break-up you gave up there with those each star having its mean, the distribution --

In terms of the plan preview, what you see is your individual measure scores and you will see what star rating you got. As part of our technical note, we will give you thresholds. If you got three stars, just throwing out numbers, 60% for that measure, you would know for three stars threshold was between 55 and 65. You get that information, but additional information about other contracts as part of the plan preview.

Next?

I am Kim Bradford from [indiscernible] health plan, question for Liz. I have two questions. One regarding the dis-enrollment, the measures appear to be taking into consideration employer group as well as individual dis-enrollment. If you move a large employer group reflecting a negative impact, has CMS considered what they might do to remove that negative impact from plans simply because an employer group moved from their plan to another plan?

At this point it would include both individual, dis-enrollment, as well as employer group dis-enrollments. What we are taking out of the measure are things such as service area reductions, reassignments, would include other types of dis-enrollment, something we can take into discussions about, but for this year it will be included.

My other question is regarding the pricing stability category, because apparently that measure is



CMS 2010 MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLAN FALL CONFERENCE

taking into consideration positive changes as well as negative changes. So if a plan is trying to capture a better price for a beneficiary, therefore changes their pricing to accommodate that, that's being reflected as well as negative change to beneficiary. Has CMS considered how they might not penalize plans for trying to capture better beneficiary pricing?

This is a measure I am not as familiar with, but something I can pass along to the Part D team for feedback.

However, all right. We have time for one last question.

I am Cathy Freedman with independent pharmaceutical consultants. I wondered if there are plans in the future to develop standards or star-rating information based on specific to employer group plans out there. Employers have access to the information to choose a plan. In terms of our star rating information, that's available to anyone publicly on our website. Clearly something they could start using or, especially as we start setting more of these four-star thresholds for measures. It clearly is something they could start looking at.

Then one last quick question, with regards to the data validation required for 2011, how does that tie into this or does it tie into this?

In terms of the data validation for –

That will come into play next year.

Oh, Part C and D reporting requirements, that will come into play as we add additional measures to the planned ratings. Some measures could come from the Part C and D reporting requirements. That validation will be critical to ensure information we are putting up on the website and using is part of the same range, accurate, reliable. That will play into this. Thank you.