



**CMS 2011 MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN  
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Vikki Oates: Good morning, everyone, and thank you for being here today. Liz Goldstein and myself will be discussing the current and future state of the plan ratings. As you can see our overview, we will be talking about why quality measurement, as John mentioned this morning, is important to CMS, the methodology of the plan ratings that we're currently displaying on medicare.gov, the distribution of the contract year 2011 plan ratings, what do they look like now, how many plans have four or five stars, how many are load performers. We will also talk about the quality bonus payments and the impact or the ties of the plan ratings to those quality bonus payments, and then the future directions and what we're thinking about for contract 2012, plan ratings that will be displayed this fall. Only a few months away.

We'll start out talking about the quality measurement. Quality is complex and multidimensional, but as you can see here, the patient should be the central focus of our quality efforts. CMS's efforts, as John mentioned this morning, are focused on improving quality among the plans to help the beneficiaries have better health outcomes. When you think about measuring quality, we are looking at both structure, process, and outcomes measures, and CMS is focused this year on trying to improve and increase the number of outcomes measures.

As you can see from this slide, the plan ratings can be used for multiple purposes. Public reporting through the medicare.gov website, looking at it from compliance perspectives, technical assistance, policy implications. But ultimately now with the Affordable Care Act, we actually have the plan ratings being used for payment purposes.

Talking about the methodology of the current plan ratings. As many of you know, there are five different levels of data displayed on the plan ratings. The lowest level of data is the measured level. This actually provides the data value for each of our measures at that lowest level, if individuals are interested. Most beneficiaries may not care that it's a thirty second or forty-five-second hold time, but they can look at the star value for that individual measure as well.

Then each of the measures is grouped into domains. And those are related measures that are grouped together, and the average of the individual measures in each domain make up the domain star rating. Following the domain star rating level, you actually have a summary rating for both Part C and Part D measures. That's an adjusted average of all the individual measures across all domains, and we have an I – what we call an I-factor. It's a slight bump where contracts are rewarded for high and stable performance. And at the summary rating level we actually provide half stars.

And this year for contract 2011, contract year 2011, the MAPDs actually got a combined overall rating between Part C and Part D. This rating, again, was looking across all the individual measures and looking at an adjusted average across all of those. And again we provided the differentiation at a half star level. And for those of you interested in Appendix 1 at the end of your slides, we won't go through that today, but you can actually see all of the measures in each domain for both the Part C and Part D ratings.

Here if we look at – there are multiple data sources that feed the plan ratings. You can see here health and drug plan's data goes into the plan ratings. We have multiple contractors that help us monitor different efforts in the plans, and they provide the data to us, and that way we can assure consistency in the way the measures are calculated across all plans. We have enrollee surveys that are done, the CAHPS surveys. And then we have administrative data that are used as

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well. We have IRE data, we have PED data that are used. And if you look at Appendix 2 at the end of your presentation you will also see the list of the data sources, different types of data sources.

One of the things that we wanted to mention that we've heard internally within CMS is that we have other monitoring efforts going on. And often compliance officers within the plans are notified and communicated to regarding those monitoring efforts. And sometimes other staff among a plan who are working on the plan ratings don't necessarily communicate with those compliance officers. So one of the things we'd like to recommend is a little bit more communication among plan rating staff and the compliance officer staff to make sure that both sides of the house are helpful getting each other out, and that will prevent some of the uncertainty and questions that come to CMS.

For contract year 2011, this year, we started implementing a few new items. As I mentioned, the overall Part C and D plan ratings for the MAPDs, we make that measure available. We have a low performing icon, and then Liz will talk about what we're thinking about in the future for high-performing plans. But this year we have a low performing icon that was displayed if a contract had less than three stars is their summary rating for three years in a row, counting this year. We also implemented minimum four star thresholds across some of the measures where we had an updated history. And we will be looking to add new measures where we have now at least two years' worth of data, two or three years, and no changes in specifications. We'll be setting new four-star thresholds for some other measures. And if we have a CMS standard, if a plan reaches that standard, they will receive three, three or more stars for that.

As many of you are familiar with the website, this just shows you the Medicare.gov, how you get into the plan finder. But one of the nice things that we wanted to just remind folks is out there is we have a plan ratings filter this year. So that you can see on the screen, it may be a little difficult to see, but they're, for each of the filters within the plan rating is where a beneficiary or shift counselor or someone who's helping a beneficiary identify which plan might be the best for them, they can select multiple different options. They can filter by premium, they can filter by deductible. And they also now have the ability to filter by plan ratings. So if someone wants to look at only plans in their area that have three or more stars, they can use this filter to narrow that search down.

And this just shows you a sample of planned comparison where you can actually see three plans that you're interested in at each domain level, and then the individual measures within that domain, so you can look for the area that may be of most importance to you or to a beneficiary and help them to narrow their search down or find a plan that meets their needs.

And with that I'll turn it over to Liz Goldstein to talk about what are we seeing for the contract year 2011 ratings and then what are we looking to in the future for 2012. Thank you.

Liz Goldstein: Thanks, Vikki. I'm going to go through the slides on the distribution on the calendar year 2011 ratings fairly quickly and spend more of the time talking about future directions. This is the MAPD combined C and D score that Vikki mentioned that was new this year. And this shows you what the current distribution is. As you can see most contracts are three, three-and-half stars. There are a number of contracts as you can see from this display that do not have data for us to give it an overall score. On this sheet about sixty of the contracts are too new to be measured. The rest of the contracts are too small. CMS has been trying to give recommendations to NCQA because this is particularly a problem with HEDIS data collection, so we've been trying to give recommendations for them to start revisiting some of the technical specifications for measures, looking at who's included, excluded, as well as thinking about measurement and are there other measures that we would be able to use to measure care in these small contracts.

This is the summary score, the health plan summary score. As you can see, what this is looking at is changes from calendar year 2010 to calendar year 2011. In the majority of contracts, their score remained the same, and we had some increasing, a few decreasing. In general, for measurement you want the scores to be fairly stable year to year. If there's a huge amount of fluctuation from year to year, that suggests there is a problem with measurement. So, as you can see on the slide, the scores are fairly stable year to year.

This is for health plans. It's the drug summary score. And again, most of the contracts had similar scores to the previous year, so there's not a huge amount of variation.

This slide provides information about the scores for the PDPs, their summary score for calendar year 2010 and calendar year 2011.

And this final slide showing the distribution shows changes from calendar year 2010 to calendar year 2011 for the PDP score, and as you can see, most stayed the same, and you had some increases and decreases, but there's not a whole lot of variation.

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This is just to know we've done some analysis looking at where four and five-star contracts are located around the country. I want to note on this slide, this is for, what this is showing is these contracts had services areas covering these states, so they may not have actual enrollees, but they do exist, and it's an option for enrollees.

This slide notes our five star contracts for calendar year 2011, so we have three MAPDs and four PDP contracts, and we'd like to, you know, as we move forward and implement more quality improvement and more focus on the plan ratings, we'd love the number of contracts to increase with five stars over time.

This year, as Vikki mentioned and probably most of you are aware, we have the consistently low performer icon on the website, and twenty contracts on the Part C side had low performing scores. Four contracts on the Part D side. And this slide just notes some of the measures that they did poorly on. These were the ones that they did the worst on, but to get a low performing icon, as Vikki said, you had to get below three stars three years running. So overall, it's not just these measures, you had to have been doing poorly on the plan rating. So these are some areas for low performing contracts that they may want to focus on to bring up these really low scores.

The next slide again focuses on the low performers. And these are, we have on the Part C side five domains for public reporting we group the measures under. So the places where the low performers are having the most issues is with staying healthy, measures relating to staying healthy. Measures related to managing chronic conditions. Measures related to health plan responsiveness and care. That's the CAHPS measures. And they tend to do better on the customer service. And complaints and appeals on the Part C side.

This is for the Part D side. In the places where the low performers tend to do poorly is drug member complaints and audit findings. Also on member experience with drug plans, which are the CAHPS measures. And they also have some issues with drug pricing and patient safety. So these are some areas if you are a low performer that you really should be focusing your quality improvement activities. And this is some aggregate data, so clearly if you're a low performer, you need to look at your own data to identify opportunities for improvement.

I'm going to now focus a little bit on the quality bonus payments before I go into future directions. As all of you know, as part of the Affordable Care Act, it introduced quality bonus payments for the Medicare Advantage Program. And this is really part of a national strategy to improve the quality of care across the country. Under the Affordable Care Act, beginning in 2012, MA contracts with a star rating of four or higher would qualify for a quality bonus payment.

As I'm sure all of you in the room know, CMS introduced a quality bonus payment demonstration, and this is a three-year demonstration. And the goals of the demonstration was really to see if we'd change these percentages if we could drive more rapid and larger quality improvements. We really want to create incentives so contracts improve the care that they're providing to our beneficiaries. And so as finalized in the payment notice that was published last week, during the demonstration for 2012 and 2013, contracts that have three stars, the quality bonus payment percentage will be three percent; for three-and-a-half star plans it will be three-and-a-half percent; for four and four-and-a-half star plans it's going to be four percent; and for five-star plans it is five percent. For 2014 the only changes for four and four-and-a-half star plans it will be five percent, similar to five star contracts will get during the first two years of the demonstration.

The other issue I just wanted to note. Probably most of you are aware of the special election area. Information was made available last week in the final call letter, and the special election period will apply to both MA and PDP enrollees, so there'll be, plans with five stars will be able to market and get beneficiaries year round.

I'm going to spend the rest of the presentation focusing on future directions for the plan ratings. Right now we have fifty-three measures that make up the Part C and D plan ratings. Given the linkage to payment now you really want to spend time and we've started this activity to make sure it's a robust system for measuring quality. As we add measures and take away measures and make adjustments so a plan (inaudible) over time, we want to align with the IOM's Six Aims for Improving Healthcare Delivery. So this is measures related to safety. Timeliness of care. Effectiveness of care. Efficient, equitable and patient-centered.

As we add measures, we are really looking towards consensus building organizations such as NQF, NQA, PQA, all those organizations out there that do a great job developing measures and getting consensus among the stakeholders.

As we make improvements to the plan ratings, we're aligning with the goals of the agency, and so across the different provider types and plans we want to make sure there is a mix of different types of measures, process, outcomes, patient experience measures. Where possible we want to align public reporting and payment across the Medicare and Medicaid programs. We want to, as much as we can, to minimize the burden on providers and we want to, as I said before, use nationally-endorsed measures.

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As we look at modifying how we do calculations for the plan ratings, also again we're trying to align with all the different value-based purchasing programs across the agency. We want to score looking at overall achievement on how plans are doing relative to if there are national benchmarks or thresholds. We want the scoring methodologies weighted toward outcomes, patient experience and functional status, and this is, you know, kind of, it's an agency goal. We want to make sure that the scoring is reliable, easy to understand and stable over time. Right now we're scoring methodology as you could see by the distributions I presented, it's very stable from year to year. So we want to make sure that any changes we make to the methodology, that we still have stable scores over time. We don't want, for example, for our measure scores to be fluctuating a huge amount year to year because that suggests a problem with the measurement.

As we consider new measures, we'll clearly have to consider what data is available, will be collected in time for the plan reading. Clearly we need to look at reliability and validity issues of any additional measures. We also, as I said before, want to look at the value of any additional measures in supporting the IOM six aims.

For all measures each year we'll be looking at quality in the data. Looking at variation among plans as well as looking at accuracy, validity and stability. So every year CMS will spend some time revisiting the whole set of measures and makeup of plan ratings to see which measures should potentially be retired and which measures should be retained in the plan ratings.

For the enhancements, for the next few years we laid out in the 2012 call letter potential enhancements to the plan ratings. And I wanted to emphasize these are potential enhancements. We don't get all the data from the plan ratings until July, August of each year. So clearly once the data comes in, you need to look at the data and see if we're planning to add additional measures, look at the quality of the data. We also for existing measures, we want to look at them each year when the data comes in and make sure there's not an issue. And if we do see an issue in the July or August timeframes we may pull or make modifications very quickly before you see the data during one of our preview periods. In each call letter each year we'll be trying to lay out what the plan ratings we'll look at or potential changes for the following year. So it's an opportunity each year in the call letter for us to at least make you aware of potential enhancements. We'll continue to provide through HPMS memos and user group calls additional information to you about the star ratings. So you'll be sure purchasing the user group calls in spring and summer as we finalize different approaches for the fall.

Some potential additional measures for the 2012 plan ratings, and again I want to emphasize potential. All cause readmission rates is a new measure being collected through HEDIS. So we're excited that we're finally collecting this information, but we'll have to look at the quality of the data before we make a decision whether to include it in the plan ratings. Some additional measures that we're looking at are listed on the slide, so it has things such as advising smokers and tobacco users to quit, body mass index, potentially some special needs plan specific measures, measures from the hospital and patient quality reporting program and some potential Part D measures such as medication adherence.

Other enhancements for the 2012 plan ratings. We'd really like to, by the fall, to be weighting measures. Clearly we'd like to give more weight to outcome and clinical measures versus more administrative data. So that's something we're working hard so we'll be there by the fall. Another area, based on feedback we've received from state (inaudible), we want to look at whether we could control for the concentration of providers in geographic areas. So through, as an example, identification of health professional shortage areas. So this is something we're just starting to look at, so it's a potential enhancement for 2012 or 2013.

We want to begin rewarding contracts for quality improvement. We really want to create incentives for contracts to improve the care they're providing to our beneficiaries. This year, as announced through the call letter, we're planning to reduce the overall and/or summary plan ratings for serious compliance issues. A serious compliance issue is when CMS curtails marketing and enrollment in that contract. So it's not just a minor issue, it's something that's major. We will also, we're working to add an additional icon to the Plan Finder tool in the fall for high performing contracts. So our five-star contracts would get this high performing icon, and we think this will be a nice addition to the website to really highlight the high performing contracts.

Here's a list of some additional measures, and this is for the 2013 plan ratings. And we listed these also in the call letter. So again this group listed on this side are potential additional measures for 2013. Clearly for a lot of these we're still looking at the feasibility. But this is to give you a little bit more longer-term look at where we're going with the plan ratings.

I want to also note before we open it up to questions is that as we're making these enhancements to the plan ratings, we really value stakeholder input. So you will be seeing in the upcoming weeks a request for comments about some of the changes that we're planning to make to the plan ratings. And we appreciate any input that you're able to give us.

With that said, I'm going to open up to questions.

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Jill: All right. We're going to do it the same way. Just raise your hand if you have a question and some of our folks with the handy-dandy flashlights will be around. Here we go. We have a question already? Hands up. And once again, please just tell us your name and where you're from.

Audience Question: Thank you. My name's [Audience Member's Name Withheld]. I'm with [Organization Name Withheld]. And I have a question about the payments and the marketing enrollment advantages that are given to health plans with five star ratings. Has there ever been contemplation within CMS of opening up year round marketing and enrollment to plans that have four or four-and-a-half stars? These students are usually thought to do pretty well in life, and it seems to me that a competitive advantage is being handed on a silver platter to those plans who have done really well and that they're in the best position to stay very well with the encouragement of CMS, and that those who are on the lower end of the scale get squeezed out. It seems like your numbers really focus on how stable the ratings are over periods of two to three years indicating that it's very, very difficult to improve. And I know that improvement is what we want. But it seems to me that CMS ought not to be in the business of narrowing the market and enabling the better-performing health plans to stay at the very top and disadvantaging the others.

CMS Panelist: A couple of pieces to that question. I think Tony is going to address part of it, but in terms of quality improvement, I think until this year we hadn't created incentives for quality improvement and I think with adding the payment incentives, I know just in terms of the questions we get day to day from clients and stakeholders. I know clients are paying a lot more attention to their ratings and to implementing quality improvement activities. So I think you are going to see changes in scores. I think before if a plan was a one star, got one star on HEDIS measures, they never really paid attention to that. They figured that's okay, it doesn't make much of a difference, you know, maybe beneficiaries are looking at this information, but they really didn't have incentives to improve the care. So I think over time our hope is that through these payment incentives you will see more quality improvement. And I think just from all the feedback we're getting, I think that's happening today. I think plans are focusing on what can they do to improve their score. So I think you will see more five star contracts over time. But I'm going to let Tony address the rest of it.

Jill: Anyone else have a question? I'm sorry, I'm sorry.

Audience Question: Just with respect to the enrollment part of the question. I'm [Audience Member's Name Withheld] from the [Organization Name Withheld]. Just a couple of points. It was pointed out it's an evolving situation in terms of the use of star ratings for enrollment incentives, but the authority on which this approach is based has to do with exceptional circumstances and so I think that's why we're starting with only the five star because as you can see from the ratings that it's quite exceptional for a plan to even have five stars. So you have to look at the statute and the basis for the enrollment exception.

Jill: Other questions? [Audience Member's Name Withheld], you have one?

Audience Question: Hi. [Audience Member's Name Withheld] from [Organization Name Withheld]. I've got a question about some of the aging of the quality scores. Because of the nature of them, some of the results are delayed, you know, eighteen months or so. Is there any thought about how to make the ratings more time-sensitive so if you're performing well now it would somehow be reflected in the scores?

CMS Panelist: We realize that there are time lags in the collection and reporting of information, and that's something that we continue to look at at CMS. Part of the issue is, for example, for clinical measures you need to really capture it over a year period. And because of enrollments and dis-enrollments, it's difficult to do it from a July to July period or some other period of time to make it more recent. So it's something we're continuing to look at. At this point I think we're trying to produce them as fast as we can, and given the amount of time it takes the plans, for example the HEDIS measures, to collect it and report it to us, we haven't found a solution yet. But something we're continuing, you know, to look at, and if you have suggestions of ways to make it faster, we'd be happy to listen to them.

Jill: Go ahead, Mike.

Audience Question: In the Medicare and You booklet that gets mailed out, is there any thought to there being a five star plan rating in there as well as the medicare.gov site?

CMS Panelist: Yes, what's in the Medicare and You handbook at this point is one CAHPS measure for PDPs and one for MA contracts. The reason we don't at this point put the overall star rating in the handbook is the timing issue. Those handbooks have to be produced, production starts in September given the millions that have to be printed and sent out. We are looking at ways, later on in the year if we could update the handbook potentially, or what's on the web, or maybe for new enrollees. So it's something we're continuing to look at if there are ways during the year at least to maybe update it with that information.

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Jill: Good. We have a question right here.

Audience Question: [Organization Name Withheld]. Question for Dr. Goldstein. Is there any consideration being given to adjusting for regional differences in medical practice? Here we're not talking about the number of providers, but what I hear from another of plans is depending on where you are in the country, the equality of care will differ, and it's not really reflected in the star ratings.

Liz: Right. We do not adjust the plan ratings for geographic differences. It's similar to actually all our rating systems for all provider types in Medicare, they're not geographic adjustments. We know quality of care does differ across the country, but we don't want to adjust these differences. For example, we are looking at healthcare professional shortage areas because that potentially would be a reasonable thing to adjust for. But just because the care differs across the country doesn't imply, we don't want to adjust that way. We've gotten comments before, shouldn't every state have five star contracts and to give accurate information, reliable information to beneficiaries we want them to know the actual quality of care provided by their plan.

Jill: Thank you. We have a question over here.

Audience Question: Hi. [Audience Member's Name Withheld] with [Organization Name Withheld]. My question is beneficiary-related. If a beneficiary ages into Medicare and they're on an HMO plan, and that HMO plan doesn't have a five-star rating and it's not the annual election period, are they limited just to the five star plans?

CMS Panelist: They have for new beneficiaries, they have an initial enrollment selection period, so they are not limited.

Audience Question: So any of the plans they could choose from?

CMS Panelist: Um hmm.

[Audience Member's Name Withheld]: Thank you for clarifying.

Jill: Great. We have a question right here.

Audience Question: Hi. [Audience Member's Name Withheld]. Thank you for including the industry more upfront in terms of what's being measured. I noticed in the call letter that most of the ratings that are proposed are related to the MA side, and there wasn't a lot of discussion about the Part D side, and for the past few years we've been struggling with the patient safety ratings, and we wanted to get CMS's take on the methodology and if they would be willing to reconsider it, because right now the methodology is cumulative, so if a person was ever over sixty-five and on a drug that's considered "unsafe," then that counts against the plan for the entire year. And not only that but the patient safety rating doesn't actually take into account whether or not the drug was medically necessary, if it was provided under an exception, and if the plan did anything to remove the member from that drug, and so the national average I believe is two and three stars, respectively, for MAPD and PDP plans. And is there anything being considered to improve the patient safety measure, and is this really actually measuring patient safety across the industry?

CMS Panelist: Thanks –

Jill: Sure, go ahead.

[Audience Member's Name Withheld]: Thanks for that comment. We are constantly looking at all of our measures on the patient safety side. But what we see with that measure, but then you have to take into consideration is all plans are being measured the same so we're also looking to those consensus-driven organizations. And that is a measure that actually has been endorsed is, customized in terms of the actual drugs that are Part D covered drugs. So we are not, we are trying not to be in the business of changing specifications for endorsed measures. So it's something we're continuing to look at through our patient safety website that the plans have access to that I would encourage plans if they're not utilizing that fully to make sure that they go in there. We provide very detailed reports even at a beneficiary level to help plans make improvements and to get beneficiaries who don't need those drugs off of those drugs. so you are correct that if they're on it at any point in the year that the plan that beneficiary is going to count against that plan but for future measurements, that person would, if you can get them off of that drug, would not be counted the next time. We are constantly looking to organizations, especially pharmacy – the Pharmacy Quality Alliance for any other measures that we can pull in from a patient safety perspective, and as Liz mentioned, we are looking at making the medication adherence measures part of this year's plan ratings. We had those on our "display page" this past year, and again we provide detailed level reports for our patient safety site to help plans target those beneficiaries that need the most help in improving their adherence. And then for 2013 we're looking at possibly enhancing or including measures around

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medication therapy management programs. But again, we aren't trying to develop all of those measures ourselves. We're looking to the Pharmacy Quality Alliance and other NQF-endorsed measures that we can implement.

Jill: Good, we have time for two questions, and one is over here.

Audience Question: Hi. I'm [Audience Member's Name Withheld] from [Organization Name Withheld]. I have a follow-up question to [Audience Member's Name Withheld]'s question earlier. Instead of phrasing it in terms of geographic adjustment, I'd be curious about your thoughts phrasing it in terms of comparison to local fee-for-service standards because you talked about helping beneficiaries make good decisions and it would seem to me that you want to give a beneficiary decision based on their alternative choices, and also it's not, when you do comparison to fee-for-service, then it's not that you're saying all areas deserve five star plans, it's that in any area, if you perform well compared to the alternative, you should have the ability to achieve five stars. So I'd be curious about your comments on phrasing it that way. Thank you.

CMS Panelist: We are looking at comparison to fee-for-service. It's not something we can do today. One of the issues we're grappling with is a lot of the measures. For example, on the MA side, there are not fee-for-service equivalents that are regularly calculated. So that's something we're continuing to explore, because once we have that data we could start exploring is it feasible to do, you know, fee-for-service comparison. So that's something we've been talking about, and it's something we will continue to explore as well as when we start getting new encounter data from MA contracts that may help simplify some of these issues.

Jill: Our last question right down the middle.

Audience Question: Hi. I'm [Audience Member's Name Withheld] from [Organization Name Withheld]. With the problem that we struggle with is the ACE and ARPS inhibitors in a diabetic population. We find that through chart reviews or home risk assessment, that providers actually prescribe this medication, and for some reason the beneficiary gets it filled through another mechanism which actually doesn't use our health plan. So I guess the question really is, is there another way for us to submit that information rather than just through a PDE, because it seems like we're reaching out to the providers, the providers are doing what our expectations are, but yet we don't have another mechanism to actually submit that data to CMS.

CMS Panelist: That's an interesting point, and I'll take that back for our discussion as we start to go through each of the measures this year.