

An Update on Medicare Part C & D 2012 Plan Ratings

July 27, 2011

Part C & D User Group Call

Session Overview

- National Quality Strategy and Plan Ratings
- Review of Methodology for the Plan Ratings
- Stakeholder Feedback
- Changes for 2012 Plan Ratings
- HPMS Plan Preview Periods



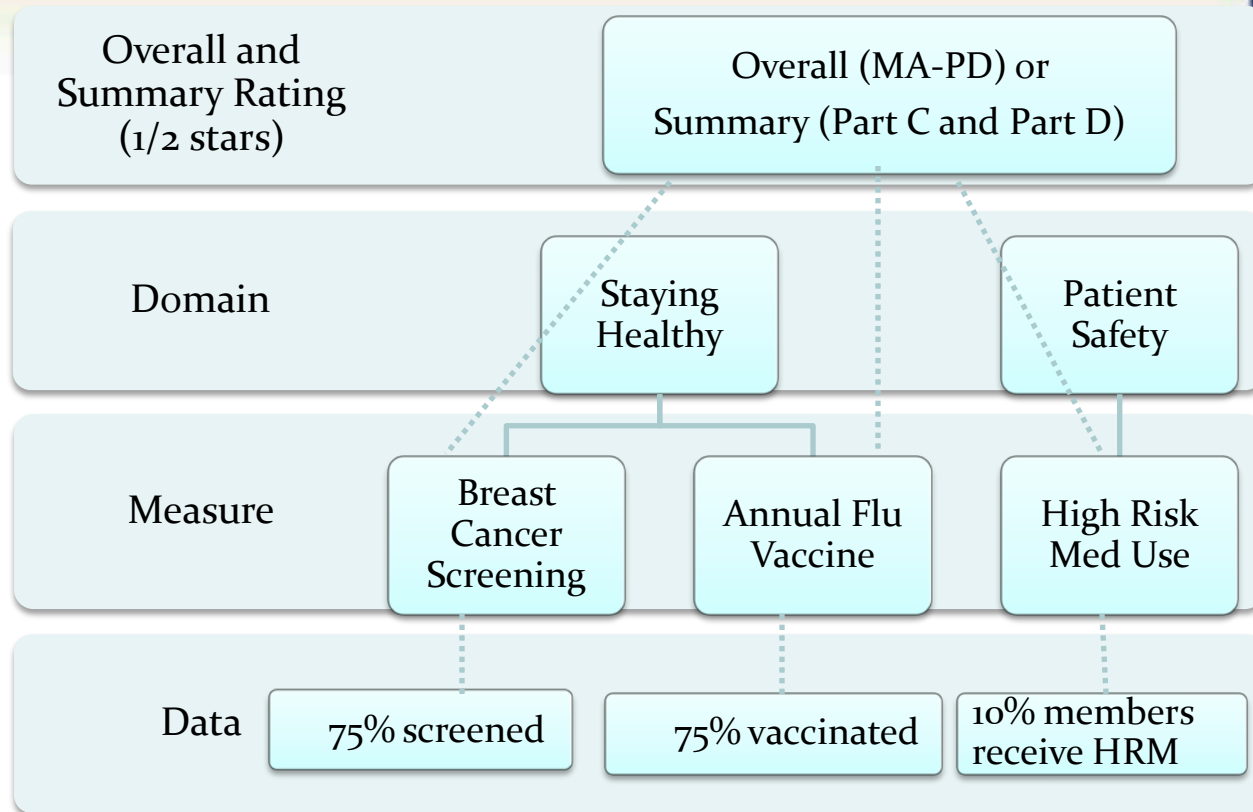
National Quality Strategy and Plan Ratings

Evolution of Plan Ratings

- As the Plan Ratings evolve, we are taking into consideration:
 - The six Institute of Medicine aims
 - Safe, effective, patient-centered, timely, efficient, and equitable
 - The Triple Aim
 - Improve the individual experience of care
 - Improve the health of populations
 - Reduce the per capita costs of care for population
 - Three National Aims (National Quality Strategy)
 - Better care
 - Healthy people/healthy communities
 - Affordable care

Review of Methodology for the Plan Ratings

Plan Ratings – 3 Levels of Stars



Stakeholder Feedback

Stakeholder Feedback Solicited Regarding Future Directions for Plan Ratings

- 2012 Proposed Part C & D Rule
- 2012 Call Letter
- CMS' Request for Comments

CMS' Request for Comments

- This Spring, we asked sponsors and stakeholders about three main areas:
 - Which measures should be used to gauge quality improvement?
 - Which measures should be retired?
 - How should we weight the quality and performance measures in the Plan Ratings?
- We continue to consider comments for 2012 and future Plan Ratings.

Comments:

Measuring Quality Improvement

- More commenters support:
 - Rewarding contracts that improve in all measures.
 - Using objective measures.
- Some support for only including measures where performance is low or variation is high.
- Concerns:
 - Rewarding improvement at all.
 - Rewarding contracts with improved yet still low performance.
 - Some measures' data are too old for plans to intervene effectively based on the results.

Comments: Measures to be Retired

- Some commenters recommend retiring:
 - Using self-reported data.
 - Have small denominators or small number of beneficiaries impacted.
- Other suggestions:
 - Modify existing measures instead of retiring them.
 - Develop a methodology for retiring measures.
 - E.g., retire when plans reach a ceiling in overall performance, or measures with low accuracy and precision.

Comments: Weighting Plan Ratings

- Support for weighting objective/clinical measures more than subjective or administrative/process measures (e.g., HEDIS more than call center measures).
- Weight more: Measures that are more challenging to achieve, or measures that plans directly influence.
- Weight less: Measures that impact a small number of enrollees.
- Some support for weighting within existing domains.

Other Feedback

- Suggestions:
 - Have a trial period of new measures before including in Plan Ratings.
 - Give more lead time and specificity with proposed measures.
 - Include more measures in Medicare & You Handbook.

Other Feedback

- Criticism:
 - Ratings rely too heavily on selected health conditions.
 - Too many Part C measures compared to Part D.
 - Ratings are not applicable to/biased against SNPs, separate thresholds should be created for HMOs/PPOs, SNPs.

Changes for 2012 Plan Ratings

Changes for 2012 Plan Ratings

- High performing icon for 5-star contracts.
- Retirement of measures.
- Additional measures.
- Measure revisions.
- 4-star thresholds.
- To be discussed during August 24th call:
 - Adjustment for sanctioned contracts.
 - Incorporation of improvement and weighting.

High Performing Icon

- CMS will highlight contracts receiving an overall or summary rating of 5 stars with this icon:



This plan got
**Medicare's highest
rating** (5 stars)

- Information on medicare.gov will note that beneficiaries can enroll in 5-star plans at any time during the year.

Retirement of Measures

- We consider retiring measures where contracts have “topped out,” or additional improvements are not practical.
- Monitoring will continue in these areas; CMS may take compliance actions against contracts falling outside CMS’ standards.
- Measures will be added to display page at http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp

Part C Measures to be Retired for 2012 Plan Ratings

- Doctor Communication.
- Osteoporosis Testing.
- Appropriate Monitoring for Patients Taking Long Term Medications.
- COPD Testing.
- Call Center – Hold Time.
- Call Center – Information Accuracy.

Part D Measures to be Retired for 2012 Plan Ratings

- Low Income Subsidy (LIS) match rate.
- 4Rx timeliness.
- Call Center – Beneficiary Hold Time.
- Call Center – Information Accuracy.

Additional Potential Measures for the 2012 Plan Ratings: Part C

- Plan All-Cause Readmissions.
- Smoking Cessation.
- Adult BMI Assessment.
- Care for Older Adults (SNP Measure)
 - Medication Review.
 - Functional Status Assessment.
 - Pain Screening.

Additional Measures for the 2012 Plan Ratings: Part D

- Medication Adherence.
 - Diabetes.
 - Cholesterol.
 - High Blood Pressure.
- Enrollment Timeliness.

Medication Adherence

- Previously shown on the CMS display page as a composite measure of three disease states.
- The percentage of adult beneficiaries who met the Proportion of Days Covered (PDC) threshold of 80 percent or greater during the measurement year.
- The PDC is the percent of days in the measurement period “covered” by prescription claims for the same medication or another in the drug class.
- Rates are calculated for Statins, ACEIs/ARBs, and across classes of oral Diabetes medications.
- A higher rate signals better performance.

Enrollment Timeliness

- Previously a measure shown on the CMS display page.
- The percentage of time the drug plans (MA-PD and PDPs) transmitted the enrollment information to CMS within 7 days.
- This measure will enable beneficiaries to gauge how efficiently a plan is able to process enrollment applications in a timely manner.
- A higher rate signals better performance.

Additional Potential Measure for the 2012 Plan Ratings: Part C & D

- Members Choosing to Leave the Plan.
 - The percent of plan members who chose to leave the plan in 2010.
 - Exclusions: Members who left their plan due to circumstances beyond their control (such as members who moved out of the service area, affected by a service area reduction or LIS reassignments) are excluded from the numerator. Employer Group members are excluded from both the numerator and denominator.
 - Contracts with less than 1,000 enrollees will not be rated.

Measure Revisions

- Audit measure
 - Will incorporate CMS' risk-based audit strategy, and compliance notices.
- Better alignment between Part C & D appeals measures.
 - The Part D Appeals Upheld measure will be based on the date the IRE received the case, similar to Part C's Reviewing Appeals Decisions measure.

Revisions to Complaint Tracking Module (CTM) Measures

- Two Part D CTM measures to be combined.
- Newest CTM exclusions effective September 2010:

Cat ID	Category Description	Subcat ID	Subcategory Description
11	Enrollment/Disenrollment	16	Facilitated/Auto Enrollment issues
		18	Enrollment Exceptions (EE)
13	Pricing/Co-Insurance	06	Bene Lost or Denied LIS
		16	Part D IRMAA
30	Bene needs assistance acquiring Medicaid	01	Bene Needs Assistance Acquiring Medicaid
		90	Other Bene Needs Assistance Acquiring Medicaid
38	Contractor/Partner Performance	90	Other Contractor/Partner Performance

Note: Program Integrity complaints, which are in the CTM but not viewable by plans, are excluded as well.

CMS Designated 4-Star Thresholds

- Introduced last year, these may be set by CMS when appropriate.
- Measures must have at least two years of data, without significant technical specification changes.
- Nearly all of the 4-star thresholds applied for the 2011 Plan Ratings will remain for 2012 Plan Ratings.
- CMS will adjust the 4-star threshold for the Part D High Risk Medication measure to reflect propoxyphene's removal from the market.
 - 2% increase for 2012, and in 2013.

Additional 4-Star Thresholds

Part C	MA-PD/ MA only	
Call Center – Foreign Language Interpreter and TTY/TDD Availability.	≥ 71	
Part D	MA-PD	PDP
Call Center – Foreign Language Interpreter and TTY/TDD Availability.	≥ 80	≥ 82
Diabetes Treatment	≥ 86	≥ 83

HPMS Plan Preview Periods

1st Plan Preview Period

- Beginning of August.
- Comments will be accepted for one week.
- Will include both Part C & D measures.
- Will include data for each measure.
 - No CAHPS data.
- No stars are assigned for this preview.
- Technical notes, including draft website language, will be available.
- Opportunity for contracts to preview their data in HPMS, and alert CMS of any questions or data errors.

2nd Plan Preview Period

- End of August.
- Comments will be accepted for two weeks.
- Will include Part C & D measure data, star assignments for each measure, domain, summary and overall level (as applicable) by contract.
- In addition to technical notes, cut points for stars will be available.
- Opportunity for plans to preview their data and star assignments in HPMS, and alert CMS of any questions or data issues.

Technical Notes

- Technical notes will combine information for the Part C & D Plan Ratings.
- Send questions to these CMS mailboxes:
 - Part C Measures: PartCRatings@cms.hhs.gov
 - Part D Measures: PartDMetrics@cms.hhs.gov

Take advantage of both preview periods!

2012 Plan Ratings Go Live

October 6, 2011

Other Enhancements Coming this Fall

- A new link on medicare.gov will provide each contract's Medication Therapy Management (MTM) program eligibility information.
- This information may be useful for beneficiaries, caregivers, and State Health Insurance Assistance Program (SHIP) counselors to see which MTM programs are available.
- More robust information about MTM programs will be added to medicare.gov in the future.

Next User Group Call

- August 24th, 2011
- Topics will include:
 - Adjustment for sanctioned contracts.
 - Measuring quality improvement.
 - Weighting of Plan Ratings.
 - Questions from today's call.