Health Plan Strategies for Boosting Medicare Star Ratings

Thursday, February 23, 2012

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About the Speakers

STEPHEN WOOD is a senior vice president at OptumInsight, where he leads the Government Programs Management and Strategy practice. His work in senior markets dates to the mid-1980s when he worked with hospitals to implement DRG payments by Medicare. Since that time, he has worked with organizations to review and develop strategies, conduct new product feasibility assessments, improve performance and implement new programs. Mr. Wood has over 25 years of experience in managed care, governmental programs, senior markets and strategic consulting in the health insurance industry. A frequent speaker and author, he was selected as one of the Top 25 Consultants of 2009 by Consulting Magazine. Mr. Wood graduated from the University of Chicago and holds a master's degree from the Harris School of Public Policy at the University of Chicago. Contact Mr. Wood at stephen.wood@optum.com.

DANIEL WEINRIEB is manager of clinical relationships at HealthNow New York, Inc., doing business as BlueCross BlueShield of Western New York and BlueShield of Northeastern New York. He is currently responsible for leading the organization’s Medicare Advantage STAR Quality Improvement Project and manages the company’s efforts to encourage provider and member engagement to drive quality of care and service to all HealthNow beneficiaries. Mr. Weinrieb received his undergraduate degree from Clarkson University. He is studying for an MBA degree from Canisius College in Buffalo, New York. Mr. Weinrieb began his career in health care in 2005, when he started the Medical and Healthcare Division for StraussGroup, Inc., a division of Management Recruiters International, a global executive search firm. He spent the next three years developing business and recruiting C-level clinical and non-clinical executives for health care organizations and medical device companies around the world. Mr. Weinrieb then moved on to the health insurance industry where he has specialized in physician and member engagement since 2008 with a primary focus on the Medicare population and improving the quality of care and service to Medicare Advantage Beneficiaries across New York state. Contact Mr. Weinrieb at weinrieb.daniel@healthnow.org.

Moderator: Jill Brown, executive editor of AIS

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The speakers’ presentations will run approximately 60 minutes and be followed by 30 minutes of questions and answers. Questions may be submitted in three different ways:

Prior to the Webinar

(1) E-mail your question(s) to moderator Jill Brown at jbrown@aishealth.com or

During the Webinar

(2) To send a question from the Webinar page, go to the Chat Pod located in the lower left corner of your screen. Type your question into the dialog box at the bottom and then click on the blue send button or

(3) Dial *1 on your phone keypad and an operator will connect you to the moderator so that you can ask your question(s) "live" with the Webinar participants listening
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WEBINAR PROGRAM

• Introductions/Administrative Reminders
• Speaker Presentations
• 30-Minute Q&A Session

WEBINAR MATERIALS


Presentation by Stephen Wood

Health Plan Strategies for Boosting Medicare Star Ratings ...............................................................................................................................page 15

Presentation by Daniel Weinrieb


Presentation by Stephen Wood

Selected Medicare Advantage News Articles ........................................................................................................................................page 51

WEBINAR OUTLINE

Part 1: Stephen Wood, OptumInsight
  • Best practices

  • Corporate Goal and Enterprise-Wide Initiative
  • Overview of the Strategy
  • Generating Employee Buy-In
  • Member Interventions
  • Provider Interventions
  • Community Initiatives
  • Successes in 2011
  • Key Strategies for 2012

Part 3: Stephen Wood, OptumInsight
  • Your Stars Self-Test
  • Potential Changes to New Star Measures
  • Emerging Practices and Trends for 2012
  • 2013 Medicare Advantage Draft Call Letter: Star Rating System Impacts

Part 4: Questions and Answers

Stephen Wood, Senior Vice President

An AIS webinar

Feb. 23, 2012
Objectives and Agenda

• Agenda
  1. Best Practices
  2. Potential Changes to New Star Measures
  4. 2013 Medicare Advantage Draft Call Letter: Star Rating System Impacts
Background: Optum Stars Experience

- 10 of the top 25 MA Plans
- HMO, PPO, SNP, PFFS, PDP, PBM
- Overall Stars scores ranging from 2.5 Stars to 5 Stars
- Over 35 separate in-depth Stars engagements
- Millions of MA lives
- Focus group research nationwide to better understand CAHPS and HOS results
- Multiple long-term Stars improvement implementation engagements
- Products, tools and services support Stars improvement in place at dozens of organizations

The Time is NOW to address 2015 payment issues

- For example: 2013 payments are based on 2012 Star Ratings, which, in turn, are based on:
  - 2010 HEDIS Dates of Service and 2012 Submission
  - 2010 HOS survey data
  - 2011 CAHPS survey data, and
  - Combination of 2010 and 2011 CMS administrative data
  - Measures and calculation methodology announced in September 2011

HEDIS = Healthcare Effectiveness Data and Information Set
Best Practices
Industry Performance: 26% of Plans Improved Overall Score 2011-2012

1. The rate of improvement is accelerating on Part C
2. Part D slowed overall improvement
3. Very few plans improve 1 Star in one year

**Sources:**
CMS Stars scorecard data 2011-2012, OptumInsight analysis.
Projection: Can Plans Improve in Both 2013 and 2014?

1. 7% of plans improved an entire star over two years
2. 1% of plans improved 1.5 stars
3. Almost a third of plans showed net declines over that period

<table>
<thead>
<tr>
<th>Percent of Plans</th>
<th>2010-2011</th>
<th>2011-2012</th>
<th>2010-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Part C Scores</td>
<td>21%</td>
<td>34%</td>
<td>29%</td>
</tr>
<tr>
<td>Declining Part C Scores</td>
<td>42%</td>
<td>15%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Sources:
CMS Stars scorecard data 2011-2012, OptumInsight analysis.
Improvement Framework

Improvement Model

- Organization and Strategy
- Data & Reporting
- Provider Engagement
- Member Engagement
- Operations Improvement
An overarching strategy makes the necessary investments in growth, process management, people and technology.

Most plans are committing resources to achieve 5 Stars on the operational measures.

Provider and Member Engagement - Approach

Each time MA Plan interfaces with a Provider or a Member, there is an opportunity to impact the:

- Accuracy of each member’s disease burden
- Adherence to evidence-based medicine
- Access and utilization of healthcare services

DM = disease management. CM = case management. ACOs = accountable care organizations. PCMHs = patient-centered medical homes.
Health Plan Strategies for Boosting Medicare Star Ratings

Daniel Weinrieb
Manager, Clinical Relationships

AIS Webinar
Feb. 23, 2012
Create and execute cross departmental strategies designed to improve the quality of care and service to our Medicare Advantage beneficiaries and achieve 5-star status.
A Corporate-Wide Initiative

• Becoming a 5-star plan is a corporate goal
  – Delegated Entities have ownership too

• Create a Star Action Team consisting of cross-functional project leaders and change agents and make it have a purpose!

• Purpose
  – To have an action team comprised of all associated functional departments, dedicated solely to the measurement of the star ratings.

• The role of the team
  – Educate staff and generate buy-in
  – Analyze current process and identify opportunities
  – Prioritize initiatives
  – Create action plans with targeted interventions, actionable solutions and measurable outcomes
  – Provide monthly status reports
  – Manage interdepartmental accountability
  – Execute and monitor progress
The Strategy

- Generate corporate buy-in
- Identify the target audience, act thoughtfully and measure outcomes
  - Members
  - Providers
  - Community
  - Employees

- Prioritize
  - Short- and long-term plans
    - Quality and health outcome survey initiatives
    - Member Experience Initiatives

- Use what we already have and communicate
  - Data
  - Collateral
  - Existing team structure
The Team Approach Employee Buy-in

- Facilitate corporate-wide training
- Make star a part of monthly department meetings
- Ask for input
- Work smarter, not harder
- Celebrate successes
- Compliance is paramount
Member Interventions Outcomes and Experience

• **Stratify the population**
  - Wants and needs
  - Chronic conditions
  - Risk
  - Retention, acquisition, and age-ins

• **Streamline communications**
  - Value vs. volume
  - Integrated calendar
  - By measure
  - Consistent look and feel

• **Make star a driver in quality improvement**
  - Action plans became QIPs
  - Create a “Senior Solutions Team”

• **Compliance is paramount**

QIP = Quality Incentive Program
Provider Interventions Outcomes and Experience

- **Profile the network**
  - High performers vs. low performers
  - Volume of HEDIS measures

- **Reintroduce physician to their provider representative**

- **Revamp messaging**

- **Restructure P4P**
  - Align with star
  - Pay for outcomes, not process

- **Give them a star rating**
  - Compare to peers

- **Ask for their advice**
Community Initiatives

• Healthy Changes Everything
  – Segment the community and deploy programs

• Partner with local consortiums and community resources

• Promote wellness programs
  – FitBlue
  – Health coaching
  – Blue Life providers

• Good For You!
  – Do one thing!
Successes in 2011

- Star Action Team is leading the charge
- Every department was trained on star
- Provider network has been profiled
- Launched our “quick hit” solutions
  - Using 2011 HEDIS-approved data and provider support
  - Health management conversations
  - Customer service representative conversations
- Enhanced monitoring and created corrective action plans
  - Survey results
  - HRAs
  - HEDIS
  - G&A
  - Compliance plans
- Conducted internal Part C and D audits

HRAs = health risk assessments.
Key Initiatives in 2012

- Star Dashboard
- Provider engagement
- Facilitation of enhanced HRAs
  - Providers
  - Sales Staff
  - Health Coaches
- Implement prospective reviews and risk adjustment projects
- Layered approach to marketing and communications
- Enhanced partnership with delegated entities and audit performance
- Expand community presence

Stephen Wood, Senior Vice President

An AIS webinar

Feb. 23, 2012
Your Stars ‘Self Test’

• Categories are derived from our Stars assessments and implementation activities

• We have found that overall improvement is derived from the organization, not indiscriminately tackling particular measures.
  • And the measures change anyway!!

• They are prioritized by ability to ‘move the needle’

• Grade yourself!

• A grade of B+ or better to suggests a high probability of improvement
# Organizational Alignment

<table>
<thead>
<tr>
<th>Best Practice</th>
<th>F</th>
<th>D</th>
<th>C</th>
<th>B</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated senior staff in place to manage stars</td>
<td>&lt;1.0 FTE</td>
<td>6/1/12</td>
<td>4/1/12</td>
<td>2/1/12</td>
<td>Pre 1/1/12</td>
</tr>
<tr>
<td>CXO oversight committee meetings</td>
<td>Delegated down</td>
<td>Ad hoc</td>
<td>Budget Cycle</td>
<td>Quarterly</td>
<td>Monthly</td>
</tr>
<tr>
<td>Ancillary vendor performance data monitored by stars team</td>
<td>Not monitored</td>
<td>Quality audits yearly</td>
<td>Ad hoc</td>
<td>Quarterly</td>
<td>Monthly</td>
</tr>
<tr>
<td>PBM contract includes performance guarantees aligned with stars</td>
<td>“Awaiting re-contracting”</td>
<td>Post Q3</td>
<td>7/1/12</td>
<td>Partial</td>
<td>Yes</td>
</tr>
<tr>
<td>PBM technical staff attend cross functional grievance, CTM meetings</td>
<td>“No, contract doesn’t require it”</td>
<td>Just Accn’t staff</td>
<td>Partial</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>PBM staff actively engaged in stars governance process</td>
<td>“No, contract doesn’t require it”</td>
<td>Just Accn’t staff</td>
<td>Partial</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

CXO = C-Suite officer.
# Member Engagement

<table>
<thead>
<tr>
<th>Best Practice</th>
<th>F</th>
<th>D</th>
<th>C</th>
<th>B</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiating calls to members with care opportunities</td>
<td>“Newsletter is sufficient”</td>
<td>Q4 ‘12</td>
<td>Q3 ‘12</td>
<td>Q2 ‘12</td>
<td>Q1 ‘12</td>
</tr>
<tr>
<td>Populations are stratified as are programs and approaches for eligible populations</td>
<td>“Sometimes”</td>
<td>Post Q2</td>
<td>5/1/12</td>
<td>3/1/12</td>
<td>1/1/12</td>
</tr>
<tr>
<td>Members served in model with care managers embedded with providers</td>
<td>Don’t know</td>
<td>1-4%</td>
<td>5-14%</td>
<td>15-19%</td>
<td>&gt;20%</td>
</tr>
</tbody>
</table>
## Provider Engagement

<table>
<thead>
<tr>
<th>Best Practice</th>
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<th>D</th>
<th>C</th>
<th>B</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers treating 75% of members trained on stars and interpretation of reports</td>
<td>“Universe too large”</td>
<td>Q4 ’12</td>
<td>Q3 ’12</td>
<td>Q2 ’12</td>
<td>Q1 ’12</td>
</tr>
<tr>
<td>Aligned payment incentives with providers treating 30% of members</td>
<td>“Modeling scenarios”</td>
<td>2013</td>
<td>Q4 ’12</td>
<td>Q3 ’12</td>
<td>Q2 ’12</td>
</tr>
<tr>
<td>Providers covering 25% of members reimbursed for quality</td>
<td>“Sometimes”</td>
<td>Post Q3</td>
<td>7/1/12</td>
<td>4/1/12</td>
<td>Pre-1/1/12</td>
</tr>
<tr>
<td>Provider covering 15% of members reimbursed to support workflow changes</td>
<td>“Sometimes”</td>
<td>Post Q3</td>
<td>7/1/12</td>
<td>4/1/12</td>
<td>Pre-1/1/12</td>
</tr>
</tbody>
</table>
# Operations

<table>
<thead>
<tr>
<th>Best Practice</th>
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<th>D</th>
<th>C</th>
<th>B</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 CTM, grievance and call center trending meetings</td>
<td>No mechanism exists</td>
<td>Ad Hoc</td>
<td>Quarterly</td>
<td>Monthly</td>
<td>Weekly</td>
</tr>
<tr>
<td>Percent of Parts C and D Operational metrics calibrated to 5 stars</td>
<td>“Still calculating budget impact”</td>
<td>35%</td>
<td>50%</td>
<td>75%</td>
<td>85%</td>
</tr>
</tbody>
</table>
## Data and Reporting

<table>
<thead>
<tr>
<th>Best Practice</th>
<th>F</th>
<th>D</th>
<th>C</th>
<th>B</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated management dashboard available</td>
<td>Multiple reports acceptable</td>
<td>6/1/12</td>
<td>4/1/12</td>
<td>2/1/12</td>
<td>Pre 1/1/12</td>
</tr>
<tr>
<td>HEDIS Opportunities (Gaps in care) reporting operational</td>
<td>“Sometimes”</td>
<td>Post Q3</td>
<td>7/1/12</td>
<td>4/1/12</td>
<td>Pre-1/1/12</td>
</tr>
<tr>
<td>Care opportunities reports delivered to providers treating 75% of members</td>
<td>“Universe too large”</td>
<td>Q4 ’12</td>
<td>Q3 ’12</td>
<td>Q2 ’12</td>
<td>Q1 ’12</td>
</tr>
</tbody>
</table>
## Clinical Programs

<table>
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<tr>
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<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of disease and case management programs aligned with stars</td>
<td>“CM doesn’t report to Medicare team”</td>
<td>Q3 ’12</td>
<td>Q2 ‘12</td>
<td>Q1 ‘12</td>
<td>Pre Q1 ‘12</td>
</tr>
<tr>
<td>Implement robust transitional care program</td>
<td>“Sometimes”</td>
<td>Post Q2</td>
<td>5/1/12</td>
<td>3/1/12</td>
<td>Pre-1/1/12</td>
</tr>
<tr>
<td>DM program incorporates all HEDIS and Rx measures as outcomes</td>
<td>“Sometimes”</td>
<td>Post Q2</td>
<td>5/1/12</td>
<td>3/1/12</td>
<td>Pre-1/1/12</td>
</tr>
<tr>
<td>100% Interventions on clinical programs structured to impact measures</td>
<td>“Sometimes”</td>
<td>Post Q2</td>
<td>5/1/12</td>
<td>3/1/12</td>
<td>1/1/12</td>
</tr>
</tbody>
</table>
# Clinical Programs

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<th>B</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTM program integrated with Disease and Care management and stars</td>
<td>No</td>
<td>2013</td>
<td>Data or Rounds</td>
<td>Data and rounds</td>
<td>Data and workflow</td>
</tr>
<tr>
<td>MTM program aligned with stars</td>
<td>“Newsletter is sufficient”</td>
<td>Q4 ’12</td>
<td>Q3 ‘12</td>
<td>Q2 ‘12</td>
<td>Q1 ‘12</td>
</tr>
<tr>
<td>Adherence program implemented</td>
<td>“Still calculating budget impact”</td>
<td>Q3 ’12</td>
<td>Q2 ‘12</td>
<td>Q1 ‘12</td>
<td>Pre Q1 ’12</td>
</tr>
<tr>
<td>Adherence program aligned with stars</td>
<td>No</td>
<td>2013</td>
<td>Data or Rounds</td>
<td>Data and rounds</td>
<td>Data and workflow</td>
</tr>
</tbody>
</table>

MTM = medication therapy management.
Potential Changes to the Stars System
Coming Changes

• December 20th memo serves as draft to which plans should respond
  – Final changes to be announced in 2013 call letter, due 4/2/2012

• 3 key enhancements proposed (weighted @ 1)
  – Hospital quality
  – Care coordination
    • Comprehensive medication reviews
    • CAHPS care coordination composite
  – Reward Consistent improvement over time

• Increased weighting of All-Cause Readmissions measure
Emerging Issues
Let Us Recall The Impact of Reweighting

**HEDIS, HOS, CAHPS**

- **2011**
  - Other: 40%
  - CAHPS: 21%
  - HEDIS: 28%
  - HOS: 11%

- **2012**
  - Other: 43%
  - CAHPS: 17%
  - HEDIS: 29%
  - HOS: 11%

**“Other***”

- **2011**
  - Drug Safety: 4%
  - Data Integrity and Exchange: 6%
  - CTM + Audits + Disenrollment: 8%
  - Appeals: 13%
  - Call Center: 6%

- **2012**
  - Drug Safety: 18%
  - Data Integrity and Exchange: 3%
  - CTM + Audits + Disenrollment: 9%
  - Appeals: 7%
  - Call Center: 6%

*Values are percent of total score

**Sources:**
CMS Stars technical notes, OptumInsight analysis.
Relationships of Measures

CAHPS (Ease of Getting Rx) \( \xrightarrow{R^2 25\%} \) Adherence (Oral Dbtes)

- Low adherence highly correlated with self reported access problems
- Plans should not assume generic tiering solves access problems
- Hypotheses:
  - Administrative claims rejections
  - Non-financial barriers (psychosocial)
2013 Medicare Advantage Draft Call Letter
Star Rating System Impacts
## Executive Summary

<table>
<thead>
<tr>
<th>Current Measures Being Retired From 2013 Stars</th>
<th>New Measures Being Added to 2013 Stars</th>
<th>Changes in Measure Weighting for 2013 Stars</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access to Primary Care Visit</td>
<td>1. Care Coordination (CAHPS)</td>
<td>No changes (original proposal to move 2 Drug Safety measures from 3x to 1x has been thrown out…all Part D Clinical measures weighted 3x for 2013 Stars)</td>
</tr>
<tr>
<td>2. Pneumonia Vaccine</td>
<td>2. Quality Improvement (Year-over-year statistical test)</td>
<td></td>
</tr>
</tbody>
</table>

**New Measures Being Added to 2014 Stars**

1. Hospital Inpatient Quality Reporting Program (Part C)
2. Use Of Highly Rated Hospitals By Plan Members (Part C)
3. Evaluation Of A Contract’s CCIP And QIP (Part C)
4. Medication Therapy Management Completion Rate For Comprehensive Medication Review
5. Grievance Rate Per 1,000 Enrollees (Part C And D)
6. Appropriate Implementation Of Part D Transition Processes (Part D)
7. Serious Reportable Adverse Events (Part C)
8. SNP Care Management (Part C)
Draft Call Letter – Enhancements To 2013 Plan Ratings

• Feedback On Proposed Rating Methodology For CY 2013
  – Two New Measures Be Included As Display Measures Only
    • Hospital Inpatient Quality Reporting
    • Medication Therapy Management Comprehensive Medication Review
  – Added Technical Comments To Clarify Proposals
  – CMS Three-Part Aim
    • Better Care
    • Healthier People/Healthier Communities
    • Lower Costs Through Improvements

• Measures Span Five Broad Categories
  – Outcomes
  – Intermediate Outcomes
  – Patient Experience
  – Access
  – Process
Draft Call Letter – Enhancements To 2013 Plan Ratings

• Adding Measures
  – Care Coordination
    • Based On 2012 CAHPS Survey
  – Quality Improvement
    • Based On Statistical Tests At The Individual Measure Level To Determine If Significant Improvement Or Decline

• Changes To Methodology Of Current Measures
  – Medicare Plan Finder Composite (Part D)
    • Limit Comparison Of PDE To Plan Finder For Q1-Q3 Only
    • Consider Changing To Price Accuracy On Plan Finder Only And Moving Price Stability Portion To CMS Display Page
  – High-Risk Medication (Part D)
    • Explore Changes To Account For Single Fills And Transition Fills
    • Consider Applying Specifications And Medication List Changes To 2014+
    • Evaluate Inclusion Of Benzodiazepines And Specified Barbiturates For 2014+
    • Due To Specification Changes, Previously Announced 4-Star Threshold Will Not Apply For 2013 – Instead Stars Will Be Based On Statistical Analysis And Relative Ranking Of Plans’ Scores
Draft Call Letter – Enhancements To 2013 Plan Ratings

• Changes To Methodology Of Current Measures
  – Adherence Measures (Part D)
    • Proportion Of Days Covered Based On PDE
    • Working On Methods To Account For Inpatient/SNF Stays Where Medication Fills Would Not Be In PDE
  – Plan Makes Timely Decisions About Appeals (Part C)
    • % Of Appeals Timely Processed Out Of All Contract Appeals Decided By IRE (Includes Upheld, Overturned, Partially Overturned, Dismissed Appeals)
    • Change Is The Inclusion Of Dismissed Appeals
  – Call Center – Foreign Language Interpreter And TTY/TDD Availability (Part C And D)
    • Will Begin Collecting Measures In 2012 From Contracts That Only Had SNPs
    • Number Of Successful Contacts/Number Of Attempted Contacts
    • Successful Means Establishing Contract With
      – Translator And Either Starting Or Completing Survey Questions OR
      – TTY/TDD Operator Who Can Answer Questions
    • Due To Change, Previously Established Four Star Threshold Will Not Apply For 2013
Draft Call Letter – Enhancements To 2013 Plan Ratings

- Changes To Methodology Of Current Measures
  - Enrollment Timeliness (Part C And D)
    * Considering Expanding To MA-Only Contracts
    * Based On Enrollment Transactions During 1/1/2012 Thru May Or June 2012, Depending On Availability Of June Data
  - Beneficiary Access And Performance Problems (Part C And D)
    * Effective Score For Contracts With Full Performance Audit Will Be Replaced By % Of Elements Passed Out Of All Elements Audited
    * Exploring setting A Minimum Threshold Of 5 Audited Elements
    * Adjust CAP Reporting Period From Current 14 Months To The 12 Months From 1/1 TO 12/31 Of A year
Draft Call Letter – Enhancements To 2013 Plan Ratings

• Four Star Thresholds
  – Will Apply Previously Established Thresholds For A 4-Star Rating Unless Changes Were Made To A Measure’s Technical Specifications
  – Reviewing Methodology To Determine Cut Points And Thresholds For Improving Or Maintaining Physical Health And Improving Or Maintaining Mental Health
  – Current Thresholds Can Be Found Under The 2012 Plan Ratings Link At https://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp

• Weighting Categories Of Measures
  – Propose To Keep Same Weightings As For 2012
  – Outcome And Intermediate Measures Given 3 Times The Weight Of Process Measures
  – New Plan Ratings Get Weight Of 1 For The First Year And Based On Category In Second Year
  – Continue To Weight HRM And Diabetes Treatment Measures As Intermediate Outcome Measures
    • Changing To Process Measures Would Contradict CMS Efforts To Recognize Quality Initiatives By Prescription Plans
Draft Call Letter – Enhancements To 2013 Plan Ratings

• Measures Being Removed From Plan Ratings And Moved To Display Page
  – Pneumonia Vaccine (Part C)
    • Due To Long Recall Period For This Measure
  – Access To Primary Care Doctor Visits (Part C)
    • Little Variation In Scores Across Contracts And Scores Skewed High

• New Measures For Display Page
  – Hospital Inpatient Quality Reporting Program (Part C)
  – Grievance Rate Per 1,000 Enrollees (Part C And D)
  – Appropriate Implementation Of Part D Transition Processes (Part D)
  – Serious Reportable Adverse Events (Part C)
  – SNP Care Management (Part C)
  – Calls Disconnected When Customer Calls Health Plan (Part C)
  – Medication Therapy Management Completion Rate For Comprehensive Medication Review (Part D)
  – Price Stability (Part D)
  – Appeals Upheld (Part C And D)
Draft Call Letter – 2014 Plan Ratings

• New Measures
  – Hospital Inpatient quality Reporting Program (Part C)
  – Use Of Highly Rated Hospitals By Plan Members (Part C)
  – Evaluation Of A Contract’s CCIP And QIP (Part C)
  – Medication Therapy Management Completion Rate For Comprehensive Medication Review
  – Grievance Rate Per 1,000 Enrollees (Part C And D)
  – Appropriate Implementation Of Part D Transition Processes (Part D)
  – Serious Reportable Adverse Events (Part C)
  – SNP Care Management (Part C)

• Methodology Changes
  – Explore Controlling For Concentration Of Providers In A Geographic Area Such As Through HPSAs
Draft Call Letter – HEDIS 2013 Requirements

• Proposal To Eliminate 1,000 Member Threshold For Reporting HEDIS
  – Effective 2012 Measurement Year (Due 6/15/2013)
  – Working On Strategy To Create Plan Scores For Low Enrollment Plans

• Plan Types Not Required To Report
  – CCRC Demonstration
  – PACE

• Closed Cost Contracts Are Required To Report

• Mergers Or Novations Must Report On All Members

• Conversions Must Report Based On Type In Measurement Year

• Organizations Reporting Summary Data Must Also Report Patient-Level Detail

• SNPs With 30+ Members In 2/2012 Must Report
Draft Call Letter – Plans With Less Than Three Stars

• CMS Will Issue Formal Compliance Notice Each Year To All Sponsors That Receive Low Ratings

• In 2013, CMS Will Issue Notices To Individuals In Low Rated Plans Alerting Them Of The Low Rating And Offering An Opportunity To Request A Special Enrollment Period (SEP) To Move To A Higher Quality Plan

• CMS Will Initiate Action To Terminate Contracts Following
  – Publication Of Annual Plan Ratings That Assigns Third Consecutive Summary Rating Of Less Than Three Stars
  – Confirmation Data Used To Calculate Stars Ratings Reflect Sponsors Substantial Non-Compliance With Part C Or Part D Requirements
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CMS Unveils Planned 2013 Star-Rating Changes, Including Improvement Measure


In an unprecedented memo sent to Medicare Advantage and stand-alone Prescription Drug Plan (PDP) sponsors on Dec. 20, CMS laid out its preliminary plans for star-rating changes for 2013 and asked for comments on them by Jan. 13. Both the early notice of the potential changes and many of the changes themselves drew praise from MA sponsors and consultants, although some raised concerns about particular items.

The nine pages of memo plus attachment are from Cynthia Tudor, Ph.D., director of the Medicare Drug Benefit and C & D Data Group at CMS. The changes she outlined include a proposed rating — and the methodology for it — based on how much MA and PDP plans have improved at the individual-measure and contract level over multiple years. Other contemplated new star-rating categories include “a Part D measure focused on comprehensive medication reviews that are part of the Medication Therapy Management [MTM] program,” MA measures based on the Hospital Inpatient Quality Reporting program, and MA “survey measures of care coordination from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that will be administered in 2012.”

CMS said in the memo it also is considering assigning all new plan-rating measures the lowest possible weight of 1 in the first year, with the weight in the second year depending on which weighting category the measure is in (e.g., outcomes get the highest weight). But the agency again does not plan to adjust star scores for provider-shortage geographical areas as measured in the government’s Health Professional Shortage Areas (HPSAs). And CMS is proposing to retire an MA measure on “access to primary care doctor visits” on which it acknowledges plans generally are scoring “very high.”

There are “no bombshells” in the memo, says Nathan Goldstein, newly named CEO of consulting firm Gorman Health Group, LLC. CMS instead is “saying what it values,” and continuing themes such as holding plans responsible for the performance of their provider networks, Goldstein tells MAN.

The agency is continuing its move toward specific outcome measures, notes consultant Stephen Wood, senior vice president at OptumInsight. He had said before the memo was released that it was unlikely CMS would start an adjustment for geographical areas this year, since that would open up a “Pandora’s box” of difficult issues.

“It is a positive development that plans are getting more information sooner about what the agency is thinking,” says Jennifer Kowalski, a director at consulting firm Avalere Health LLC. She adds that the proposed changes are in line with previous statements CMS has made.

Not only are plans getting more information, but they also are getting specific details about methodology. On the quality-improvement measure, for instance, CMS outlined four steps that it may use to calculate individual-measure and contract-level improvement scores for all contracts “with at least two years worth of data.” The agency added, “We are considering how to account for contracts already achieving high scores across most measures.”
The measure to reward improvement drew praise from an industry source, who calls it a “perfectly reasonable starting point.” The source, who asked not to be identified, sees the effort as vindication for a viewpoint often expressed by MA sponsors that “it’s easier to be a high-star-rated plan in some parts of the country” than others.

The industry source terms as “good” the CMS concept of starting with statistical methodology for this improvement determination. The agency, however, he adds, still will need to decide if improvement in more than half of measures constitutes improvement for star-rating purposes or whether it will look for a higher bar, such as improvement in all measures. It appears as though CMS will give itself some flexibility, he asserts.

**CMS Says It Will ‘Monitor’ HPSA Changes**

However, the memo’s detail about the methodology does not contain references to geographical variation. Indeed, the agency’s comments about one perhaps-feasible way to adjust for geography — HPSAs — indicate they won’t be used unless HPSA methodology is altered. HPSAs aim to measure where providers are in short supply in relation to needs, but their accuracy has been criticized and is under government review (*MAN* 9/15/11, p. 3). “We are continuing to monitor the changes in the methodology for determining HPSAs,” the memo said. “If the revised HPSAs are available over the next couple months, we will reevaluate and announce in the 2013 Call Letter [in April] whether any adjustments will be included in Plan Ratings.”

On the potential new hospital measures, which would be in addition to the all-cause hospital readmissions measure adopted for 2012, CMS said it is “exploring whether the individual-level hospital data [derived from the Hospital Inpatient Quality Reporting program] can be associated with individual Medicare Advantage contracts.” If the data can be linked, explained CMS, “we will then analyze the data to determine if we can create an MA contract-level measure of the hospital care that enrollees in each contract receive.”

“This is complicated,” responds the industry source. He points out that hospitals operating in disadvantaged areas generally aren’t scoring well on the fee-for-service side (FFS) of Medicare, and CMS would run into the same thing on the MA side if it uses the same approach. It might be better, the source suggests, if CMS instead compares MA inpatient hospital care quality to that of FFS in the same geographical area.

**Some Measures Focus on Care Communication**

The agency also outlined details it may use in new measures for 2013 based on the CAHPS survey administered in 2012. The questions asked on the survey that CMS expressed interest in included whether the doctor had medical records about the enrollee’s care and whether there was follow-up with the patient to provide test results, as well as how quickly the enrollees got the test results. CMS also cited questions about whether the enrollee “received help managing care” and “whether the personal doctor is informed and up-to-date about specialist care.”

There are concerns in the industry about CAHPS, the source notes, partly because CAHPS does not give greater weight to care for the sickest and frailest plan enrollees, even though that’s where plans focus much attention.

But the source has nothing but praise for the CMS plan to give all new measures a weight of 1 in the first year. For 2012, he recalls, some new measures were given higher weights (e.g,
hospital all-cause readmissions got the top weight of 3), so “this [change] seems reasonable and appropriate.”

The contemplated MTM measure related to comprehensive medication reviews may include a Pharmacy Quality Alliance-approved measure that calculates the number of beneficiaries receiving a CMR as a fraction of the number of MTM-eligible beneficiaries, CMS said. The agency said it may modify the MTM-eligible population definition to clarify that it is measuring beneficiaries enrolled in MTM for at least 60 days and excluding beneficiaries residing in long-term care.

This would be a continuation of the big role CMS is assigning to Part D measures based on their importance in measuring “patient experience” even though the dollars available to plans for “adjudicating” the drug benefit pale next to those for the medical benefit, notes Goldstein. He points to the average Part D measure weight of 1.88 in the star ratings now, compared with 1.44 for MA measures.

CMS also said in the memo that it is considering releasing on the 2013 “display page” measures in development, including the grievance rate per 1,000 enrollees, implementation of Part D transition processes to ensure continuity of care, “serious reportable adverse events,” a specific care management measure for MA Special Needs Plans, and an MA measure for calls disconnected when the customer phones the health plan.

And the agency said it is considering retiring two MA measures: pneumonia vaccine, because of “the long recall period for this measure,” and access to primary care doctor visits, “since there is little variation in the scores across contracts with the scores being skewed very high.”

The industry source says “plans need to be concerned if the measures retired are ones the industry performs well on consistently.” Dropping those measures, he says, will make plans’ performance look worse than it actually is.

Retiring the primary care access measure “makes the test harder,” agrees Goldstein. But this is not the first time CMS has retired high-score measures, and “they’re going to keep doing it, so the program will get a little harder each year,” he asserts.

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Drug Measures Hurt Star Ratings for MA Plans, Require Closer Ties


Perhaps somewhat lost in the focus on how much Medicare Advantage plans improved overall in the CMS star ratings unveiled Oct. 12 (MAN 10/13/11, p. 1) is how many problems they experienced on the prescription-drug portions of the ratings. CMS confirmed to MAN that problems reflected in plans’ scores on drug-related measures, which got more weight in 2012 than in previous years, constituted a major reason there were substantially more MA plans with ratings below three stars for 2012 than for 2011. But consultants commenting on the woes with the overall drug scores in general and the especially troublesome medication-adherence measure in particular did not envision any easy solutions.
The problems on the drug measures weren’t limited to MA plans. In fact, unlike for MA plans, overall ratings for stand-alone Prescription Drug Plans (PDPs) fell for 2012, with the average rating weighted for enrollment standing at 2.96, down from 3.49 in 2011, according to an analysis by consulting firm Avalere Health LLC. Moreover, Avalere said, of the 245 PDPs that bid low enough for 2012 to qualify for auto-assigned low-income subsidy (LIS) members, 67% had a decrease in their star ratings. Next year, the firm added, 52% of LIS-eligible plans are rated at only two stars, compared with just 3% of LIS-eligible plans this year. Put another way, of the 47 PDPs that had ratings of four or more stars in 2011, 11 were not eligible in 2012, and all of the remainder had a decrease in their 2012 ratings, Avalere noted.

The firm attributed this “precipitous decline” largely to changes in the star ratings for 2012. CMS overall, Avalere pointed out, put a greater emphasis for the 2012 ratings on clinical outcome measures such as medication adherence (MAN 8/18/11, p. 1). And PDPs, unlike MA plans, don’t participate in CMS’s large-scale demonstration program that awards quality bonus payments for plans that achieve ratings as low as three stars.

Part D Woes May Relate to Use of Vendors

Medicare Part D measures are a problem for MA plans themselves for a variety of reasons, said consultant Nathan Goldstein, executive vice president of Gorman Health Group, LLC, in an Oct. 20 AIS webinar on new star-rating requirements and shifting strategies for meeting them. Goldstein explained that many of the Part D measures are “controlled by delegated entities,” so they often are kept at an “arm’s length relationship” by MA plans. This makes it tougher to influence those vendors for purposes of improving star ratings, he suggested.

Jane Scott, vice president, clinical services at Gorman Health Group and the second speaker in the webinar, said one way of dealing with this is to develop outreach efforts aimed directly at the members. That’s harder to do in PDPs than in MA, Goldstein noted, because PDPs tend to be “diffuse” in their coverage areas.

“Part D really matters,” he maintained, citing, among other things, the greater disparity between high and low scorers among MA plans in the new star ratings than in the 2011 results. He pointed out that about 15% of MA contracts now are on CMS’s “watch lists” because of overall scores below three stars.

Asked when CMS might exercise its newly asserted power to remove MA plans that have had ratings below three stars three years in a row (MAN 10/13/11, p. 1), he said it could be as early as next year, but CMS should give another year after this to allow time for low-scoring sponsors’ corrective action plans to have an effect. He added that “CMS likes to keep bullets in the chamber.”

Not just in Part D but also overall, Goldstein said, MA plans no longer can afford, for star-rating purposes, to have “arm’s length” relationships. He said that includes the need to have closer relationships with providers, especially since HEDIS ratings, which include many provider-related aspects, still account for 35% of star-rating measures. Goldstein also pointed out that controlling blood pressure, clearly an area requiring active provider involvement, was one of the measures assigned the highest weight in the new star ratings.

Better ‘Attribution’ to Providers Can Help

A way of achieving closer coordination for MA plans with providers is better “attribution” of plan members to their primary care providers, says Kristian Marquez, senior
director, clinical and quality outcomes for star-ratings data vendor MedAssurant, Inc. His firm, Marquez explains in an interview with MAN, uses “attribution logic” to determine the plan member’s primary care physician. He adds that such determinations require “capture” of data not usually obtained, such as the member’s results before joining the plan.

Additional uses of data that can help in boosting star ratings, Marquez says, include examining the member’s behavioral and other characteristics to clarify all the services that member needs. This could include overcoming such barriers to care as transportation, and that also requires working closely with providers, he says.

“All the low-hanging fruit is gone,” Marquez asserts. “Gone are the days” when a plan could just do campaigns directed at all members, he adds, and the focus now needs to be looking at individual members. In the past, explains Dan Rizzo, chief innovation officer at MedAssurant, not all members got plan attention, but this no longer is feasible, especially since the average MA member is assessed in about seven CMS star-rating measures.

Marquez says an aspect of star ratings that will become more important as CMS continues to boost its focus on outcomes is the frequency of delivering an outcome, such as a certain hemoglobin A1c level or an LDL (i.e., “bad”) cholesterol measure. This in turn, he explains, means ensuring members understand the tools the MA plans have in place, such as phone access to clinicians, to help members adhere to the correct care protocols.

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To purchase a recording and accompanying materials from the Oct. 20 AIS star-ratings webinar, please call (800) 521-4323 or visit the MarketPlace at www.AISHealth.com.

Stars Winners Include Humana, United; Universal American Loses


There were plenty of winners and also a significant number of losers in the 2012 Medicare Advantage star ratings released by CMS Oct. 12 (MAN 10/13/11, p. 1). Among publicly owned MA plan sponsors, companies strongly boosting their average star scores included Humana Inc. — which stands to get an additional $200 million in quality bonus payments in 2013 according to one estimate as a result of its improvement — as well as Aetna Inc., Coventry Health Care, Inc., UnitedHealth Group and WellPoint, Inc. The only substantial loser among major MA plans was Universal American Corp., which securities analyst Carl McDonald of Citigroup Global Markets estimates will surrender more than $55 million of bonus payments as a result of falling ratings.

On the private, not-for-profit plan side, Gundersen Lutheran Health Plan in Wisconsin and Martin’s Point Generations Advantage in Maine were among the six MA prescription drug (MA-PD) plans moving up from 2011 rankings to reach the five-star level in 2012. Both organizations cite their local roots, as well as specific strengths, for helping them reach the pinnacle level. Of the 12.21 million total MA members, about 1.08 million or 8.9% are in plans that earned five stars for 2012, according to an analysis provided to MAN by strategist
Alan Roberts of OptumInsight. There were more than 560 MA plans evaluated by CMS, but more than 20% of them were deemed to not have enough data or be too new to be star-rated.

The average score for an MA plan for 2012 was 3.44 stars, according to CMS, up from 3.18 stars for 2011. Securities analyst Tom Carroll of Stifel Nicolaus estimated in an Oct. 17 research note that plans with 87% of existing MA enrollment will receive bonus payments in 2013 based on their new 2012 star scores, up from about 80% eligible in 2012 based on 2011 scores. But Universal American, which had its average score drop from 3.2 to 2.8, will be eligible only for sharply reduced bonuses, and Puerto Rico operator Triple-S Management Corp., which saw its score dip from 2.5 to 2.4, will not be eligible for any star bonus. Both plan sponsors are handicapped by operating in geographical areas not known for high average quality of care, since the star ratings do not adjust for location.

They were clearly the exceptions among the publicly traded plans, however. The biggest winner probably was not the highest-rated plan but instead Humana Inc., which moved from a non-bonus-eligible average score in 2011 to a bonus-eligible 3.1 in 2012, said McDonald in an Oct. 17 research note. The change, he calculated, is worth more than $200 million in additional star-payment revenue, for a new total of almost $684 million, even though only 4,208 of Humana’s 1.93 million MA enrollees are in plans with a four-star rating (and none above).

Humana would have been eligible for some bonuses based on the 2011 scores, since some of its ratings were three stars and above, but the new level places it, at $794 million, second only to UnitedHealth Group in amount of 2013 bonuses based on McDonald’s figures. Moreover, United’s Erickson Advantage plan notched 4.5 stars, the highest rating for a unit of a publicly traded company, and only 6% of its 2.30 million MA members are in plans with ratings below three stars, McDonald’s data showed.

For all the companies, the size of the bonuses does not mean their profits will grow directly by anything near those amounts. CMS rules require that star bonus payments be used either to increase benefits or reduce out-of-pocket costs that the plans’ members otherwise would incur. This, of course, improves their competitive position in marketing against plans that don’t get bonuses.

MA plans that score five stars get a 5% bonus from CMS, aside from being able to retain a bigger percentage of the difference between their bids and the CMS-determined benchmark rate for a county than do lower-rated plans. Four- and 4.5-star plans get a 4% bonus, while 3.5-star plans get 3.5% and three-star plans get 3%. Overall, according to McDonald, star ratings will add an average of 3.0% to the payment rates of publicly traded plans in 2013, up from 2.7% in 2012.

McDonald’s figures show that WellPoint, with all its plans clustered between three and four stars, stands to get $181.2 million in star bonus payments in 2013, while Aetna, with a healthy average star rating of 3.5, is in line to receive $153.9 million. HealthSpring, Inc. had a small dip in its average star score, but still stands to get $114.3 million. Similarly, Health Net, Inc. dropped slightly from a high base, but is in line to get $82.5 million, he estimated, and Coventry, with a small gain in its average score, stands to receive $81.1 million.
WellCare Health Plans, Inc. had a small reduction in its average but still is in line to receive $39 million in 2013 star-rating bonuses since more than 90% of its membership is in plans rated three stars (none above that), according to McDonald.

**Gundersen, Martin’s Point Climb Last Rung**

Among five-star plans this time, the big winner, of course, was Kaiser Foundation Health Plan, which McDonald determined has more than 950,000 members enrolled in five-star MA-PD plans, not counting members of Group Health Cooperative (GHC), a Washington state plan that is affiliated with Kaiser but operates independently.

But among smaller plans getting five stars, one of the most compelling stories is that of Gundersen, which is expanding to Iowa in 2012. The 13,000-member plan earned 4.5 stars in 2011, but "assigned a project lead and mobilized staff in a concerted effort to focus on securing a five-star status," Patti Craig, the project lead for the effort, tells MAN. Craig, a quality accreditation and audit specialist at the health plan, explains, “We identified measures that were lower scoring and implemented improvement processes. At the same time, we continued to work on keeping our higher-scoring measures intact. It was a health plan-wide effort to increase our star rating.”

In a similar category is 12,500-member Martin’s Point, which also had a 4.5-star rating a year ago. The Portland-based plan is a unit of Martin’s Point Health Care, which owns primary care practices in three Maine cities. Larry Henry, vice president for Medicare at the organization, stresses its home roots, as well as gains in preventive-services ratings, as helping it earn top ratings on member satisfaction. “I think that really matters,” he told the Bangor Daily News. “For our member services representatives, this is their home. They’re going to take care of their neighbors, and that really comes through.”

Another “winner” was the 22-member Alliance of Community Health Plans (ACHP), which boasted that seven of its members (representing a total of four organizations) received five stars in the MA-PD rankings. Aside from Kaiser, GHC and Martin’s Point, Marshfield Clinic’s member Security Health Plan repeated as a five-star plan.

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**CMS Proposes ‘Benign’ MA/Part D Rule, Letting It Cut Plans, Delve Into Contracts**


Industry insiders tell MAN they expect some pushback from Medicare managed care plans worried about whether CMS, in its proposed Medicare Advantage and Part D rule issued Oct. 3, is moving too fast with respect to its still-evolving performance ratings. CMS’s proposed rule for the first time would give the agency explicit authority to drop plans from the MA and Part D programs that fail to earn at least three stars under a five-star quality rating system over three years.

Plans also likely will take exception to CMS’s proposal to apply fee-for-service (FFS) Medicare standards to MA organizations’ contracting with hospitals with respect to
hospital-acquired conditions, thus moving the agency into the details of Medicare plans’ provider agreements.

Still, several industry insiders echo Tom Hutchinson, a former top CMS official who is now a managing director with law firm SNR Denton US LLP, when he says “in general it’s a pretty benign reg.” While plans are concerned in general with how the star-ratings system is working, the biggest part of CMS’s nearly 300-page notice of proposed rulemaking (NPRM) seeks to codify requirements under the health reform law, including the 50% discount on brand-name drugs in the Part D coverage gap, he says.

CMS’s NPRM for the 2013 MA/Part D contract year also would give more benefit flexibility to fully integrated dual eligible (FIDE) MA Special Needs Plans.

In past years, much of this content would have been contained in CMS’s annual MA/Part D call letter, industry sources tell MAN. This is CMS’s second year of using regulations as the principal vehicle for communicating program changes, perhaps to create a stronger legal footing if any challenges ensue, they assert. “If you tried to exclude someone without three stars for three years without a regulation,” explains Hutchinson, “they would sue and you’d probably lose. It would be awfully tough to kick a plan out based on a call letter.”

As it did a year ago, CMS is issuing the NPRM in the fall, with the idea of issuing a final rule next spring — right before it notifies Medicare plans of the next year’s finalized payment rates.

The 60-day public comment period on CMS’s newly proposed rule ends Dec. 12. It is expected to be finalized in April 2012, giving final rules as well as payment rates to plans in time for them to bid in June on the 2013 MA/Part D contract year.

“Basically, most of the provisions are very similar to what we saw the last time around [in terms of codifying previous guidance and clarifying program requirements],” says consultant Jean LeMasurier, Gorman Health Group, LLC’s senior vice president, public policy. But she, Hutchinson and others highlight several CMS proposals as interesting:

◆ **Giving more benefit flexibility to FIDE SNPs.** CMS is proposing to allow these plans to use additional dollars (left over after covering services specified in their bids) to provide benefits for personal care, delivery of meals and other nonmedical services. While such plans already are supposed to have Medicaid contracts, she says, CMS’s proposal would allow them to offer more services that Medicare doesn’t typically cover. “It offers [FIDE SNPs] the opportunity to provide a more tailored benefit package to the population that really needs it,” she says, and this, in turn, is likely to produce better health outcomes.

An industry source, who asks not to be identified, says CMS is setting high criteria for plans interested in benefit expansion. Thus, he says, “it’s a good thing for the relatively small number who will get this FIDE designation. It’s hard for me to see a downside, although it will create ‘haves’ and ‘have-nots’ in the industry.”

◆ **Excluding poorly performing MA and Part D plans.** While CMS addressed ratings in the call letter last year, the proposed rule for the first time gives specific authority to the agency, allowing CMS to remove a plan from the programs if it doesn’t at a minimum meet a three-star quality rating (on a five-star scale) for three consecutive years. LeMasurier says she thinks plans “are going to push back and say it’s too soon,” since rating measures continue to evolve and become more stringent. “At least it’s prospective, starting in 2012,” she says.
Figuring Out Where to Improve Isn't Easy

While maintaining three stars for three years seems reasonable on its face, Hutchinson says the rating system's construction makes it difficult for plans to figure out how to improve. “Right now we’re in data collection year 2011, so data collection this year will go into 2012 open-season star ratings and the 2014 payments, and no one knows which measures are going to be included or how they’re going to be weighted,” he says. “So if you get three stars, you don’t know what to do...because you don’t know what measures, what weight they’ll use next August [i.e., 2012]. CMS would say you can take proactive steps [and] improve everything. But with 50-some measures, it’s hard to improve everything all at once.”

The industry source cites an additional concern. While this isn’t the first time CMS has put numbers on the concept of what constitutes minimal acceptable performance for plans, “This is the first time they say you could in effect be thrown out for failure to achieve three stars in either your Part C or Part D ratings,” the source explains. “So if a plan gets 4.5 stars on the MA side and 2.5 stars on the Part D side, at the end of three years you could get ‘turned off’...So you could get thrown out for a subset of your performance measures.”

CMS also proposes giving the agency the authority to deny applications submitted by MA organizations and Part D sponsors that have performed poorly in the past. LeMasurier describes this as a good step, noting: “It’s not mandatory that they terminate a plan....They can always look at extenuating circumstances....It just puts more teeth into the meaning of the ‘stars’...and gives incentive for low performers to do better.”

But Hutchinson isn’t as certain. “If there were four plans that for three years in a row only got three stars and CMS only kicked out three of them, I think there would be an uproar,” he says, “so it’s unclear what the discretion would mean.”

Change May Be Designed to Close Loophole

The industry source says CMS is simply closing a loophole. “In the past, people have left MA and returned a year later with a new company, and the new company didn’t get stuck with a bad performance rating,” he says.

◆ Trying to bring FFS requirements on hospital-acquired conditions into the MA program. CMS says it wants to require by regulation that MA organizations put in their contracts with hospitals that they will reduce payments for Part A inpatient hospital services for serious events that could be prevented through the proper application of evidence-based guidelines. But, Hutchinson says, MA plans don’t pay exactly like FFS, using the same DRG construct and bundling of services, “so you’re creating this blanket rule that I’m not sure will work for everybody.”

“I’m not sure CMS wants to get into this [degree of detail] and mandate how plans will pay under contracts,” says Hutchinson.

To strengthen beneficiary protection, CMS also is considering changes to Medicare conditions of participation for long-term-care (LTC) facilities’ pharmacy services. CMS says it may require LTC consultant pharmacists to be independent of the LTC facility, pharmaceutical manufacturers and distributors, or any affiliate of these entities. “Although we have no evidence directly linking these arrangements to adverse outcomes,” CMS states, “we believe a requirement under consideration that LTC consulting pharmacists be independent would be appropriate and prudent because it would ensure that financial arrangements did not influence the consultant pharmacist’s clinical decision making.”
While CMS thinks this approach would be more patient-centered, LeMasurier says, “This could turn the industry upside down. I’d expect a big pushback from the nursing-home industry and pharmacies because it would change the business model and be more expensive.”


**Far More MA Plans Get Top Star Ratings for 2012; Six Kaiser Units Get Five Stars**


Medicare Advantage plans gained substantially in the number of both five- and 4.5-star plans in the 2012 CMS quality star ratings released Oct. 12. The agency listed nine MA prescription drug (MA-PD) and three MA-only plans as getting the top five-star rating for next year out of 446 MA plans evaluated, compared with just three MA plans of any sort getting that rating for 2011. But there also was a substantial rise in the number of MA-PD contracts CMS identified as low performers, apparently largely because of low scores on drug-related measures.

Five Kaiser Foundation Health Plan units in California, Colorado, Hawaii and Washington state got the five-star rating, as did Kaiser-affiliated Group Health Cooperative in Washington state. Three of those units are MA Special Needs Plans (SNPs), the first time SNPs have gotten five stars, CMS tells MAN. Looking at both the five-star and 4.5-star ratings, MA plans in Massachusetts, Wisconsin, Minnesota and upstate New York did especially well, and provider-affiliated plans continued their dominance in the CMS rankings.

While CMS did not provide complete summary data by MAN press time, its spreadsheets and tables of five-star MA-PD plans indicate the non-Kaiser entities gaining the top rating were Marshfield Clinic’s Security Health Plan in Wisconsin, Gunderson Lutheran Health Plan in Wisconsin, Martin’s Point Generations Advantage in Maine and Baystate Health’s Health New England in Massachusetts. CMS also lists three MA-only plans getting five stars: Medical Associates Health Plan in Illinois and Iowa, Dean Health Plan in Wisconsin, and Kaiser Foundation Health Plan in California.

A quick tabulation by MAN of 4.5-star-rated MA-PD plans for 2012 found 46, far eclipsing the 22 total MA plans getting that rating for 2011. This next-to-top rating was especially prevalent in Massachusetts, Minnesota and upstate New York, although it was present in many other areas as well. Essence Healthcare, for instance, improved from four to 4.5 stars in the St. Louis area and kept 4.5 in Washington state. Among publicly traded firms, UnitedHealth Group’s Erickson Advantage and Cigna Corp.’s CIGNA HealthCare of Arizona earned that ranking.

On the reverse side, CMS said that 135 MA-PD contracts were identified as “low performers” (i.e., less than three stars) in the new rankings, up from 63 a year ago.

Much of the increase in low performers stems from performance on Part D measures, consultant Stephen Wood, senior vice president of OptumInsight, tells MAN. Wood notes that Part D-related measures generally got higher weighting in the 2012 star ratings than in...
the 2011 edition, and there were more measures. Many plans did poorly on those measures, and the problems the Part D scores represent, especially difficulties in getting prescription drugs, he says, also were reflected in member satisfaction measures, which got more weight in the new ratings (MAN 9/15/11, p. 3).

A CMS spokesperson, who asks not to be identified, generally agrees with that assessment. The increased weighting of drug measures, the spokesperson says, did hit low-scoring plans harder than high-scoring plans, especially in the areas of medication adherence. This also showed up in rankings of stand-alone Prescription Drug Plans, she says, but she adds that there weren’t a lot more Part D measures this time since the agency also “retired” some of the previous ones.

A CMS official had told MAN in the weeks leading up to Oct. 12 that MA Special Needs Plans had an improvement in their average score from the prior year, but no summary data on that was immediately available.

The star ratings are especially important to MA plans beginning in 2012 because they are being used for the first-time to determine whether and how much MA plans get in much-coveted quality bonuses available to plans with ratings of three or more stars (MAN 11/25/10, p. 1). Five-star plans not only get the biggest bonuses, but they also get to market year-round, a huge advantage in competing for enrollees.

**Plans’ Increased Stars Focus Bears Fruit**

The new rankings represent the first ones for which there was a full year following the enactment of star-related quality payments in the health reform law when observers could tell whether there was a real difference stemming from MA plans’ new focus on improving star scores. “And the answer is yes,” consultant Nathan Goldstein, executive vice president of Gorman Health Group, LLC, tells MAN. He terms the results “a great thing for beneficiaries and the industry.” Pointing to provider-affiliated plans’ continued dominance in the star ratings, he adds that this model “will score best” in CMS’s system of measuring quality, although that doesn’t necessarily mean it is the best model of quality.

The CMS spokesperson says provider-affiliated plans do concentrate on coordination of care, and that rightfully is an important aspect of the star ratings. Overall, she and another CMS spokesperson tell MAN, there was a significant increase in the average MA plan score on most star-rating measures this time, as plans responded to the provisions of the reform law and put into place programs to improve their performance on the measures.

Data compiled for MAN by OptumInsight Oct. 12 support those conclusions. Based on the plan scores, the consulting firm says, quality bonus payments will be made to MA contracts covering 87% of MA beneficiaries. Specifically, OptumInsight adds, 28.5% of MA membership is enrolled in plans with ratings of four or more stars, with 8.9% enrolled in five-star plans and 10.3% in 4.5-star plans. The national enrollment-weighted average score for 2012 is 3.56 stars, according to the firm.

The direct impact of the new star ratings on consumers is in doubt, however, because only a relatively small percentage of seniors is familiar with the rating system. A phone study of 483 Medicare-eligible seniors conducted Sept. 21 by Harris Interactive on behalf of Kaiser Permanente found that only 18% said they are familiar with the star-rating system. Moreover, of those who are familiar, less than one-third have used the system to select their health plan, according to Kaiser Permanente.
Updated CMS Star-Rating Changes Delay Some Shifts, but Not Most


There were few surprises when CMS on Sept. 8 unveiled its final plans for Medicare Advantage and Part D star-rating changes for 2012. The agency, as expected (MAN 8/18/11, p. 1), is moving to weighting of measures used in determining the ratings and is giving much higher weights to clinical-outcomes indicators and slightly higher ones to “patient experience and access” measures than to process measures. But it also delayed action on some other enhancements it had considered, including controlling for the concentration of providers in a geographic area and rewarding MA contracts for improved performance even if the overall ratings still aren’t high.

Most of the details about the final changes came from Liz Goldstein, Ph.D., director of CMS’s Division of Consumer Assessment & Plan Performance, in a Part C and D User Group conference call Sept. 8. Industry sources queried by MAN expressed only minor concerns with the changes and indeed were more concerned with the compressed Sept. 8-16 period that plans have to preview their 2012 star ratings before the ratings get finalized.

CMS is going ahead with implementation of two of the possible star-rating “enhancements” it said were under consideration in the 2012 MA and Part D call letter in April (MAN 4/21/11, p. 1), Goldstein noted. Aside from the weighting of measures, CMS will reduce the ratings of plans deemed to have “serious compliance issues.” Goldstein in the Sept. 8 call outlined the structure for that. It includes “automatically” assigning a rating of 2.5 stars — too few to qualify for any quality bonuses — to any contracts under CMS sanction that otherwise would have a rating of three or more stars. MA and Part D plans under sanction that have a rating of less than three stars would incur a full one-star reduction on their ratings.

The agency, according to Goldstein, will evaluate and adjust plan ratings for sanction status two times a year. One will occur Aug. 31 and will be based on the current sanction status listed on CMS’s Medicare Plan Finder. The other will be March 31, when ratings will be updated for contracts on which sanctions have ended and for those newly sanctioned, and the updated ratings will be used for quality-bonus payment purposes under both the health reform law and the agency’s huge three-year demonstration program (MAN 4/7/11, p. 1).

One of the other potential enhancements — rewarding contracts for quality improvement — is being delayed, Goldstein said, because the three-year quality bonus demonstration project already rewards plans for some improvements. She added that the agency delayed a potential enhancement to control for the concentration of providers in a geographic area — a frequent request of MA plans — partly because it found little association between the percentage of beneficiaries residing in so-called Health Professional Shortage Areas (HPSAs) and plan ratings. Moreover, the majority of the U.S. is designated as an HPSA, so the “utility” of it as a control is “unclear,” she asserted. There also are concerns
about the reliability and validity of HPSA designations, Goldstein noted, and those concerns led the health reform law to require revisiting the methodology for those designations.

Similarly, according to Goldstein, CMS is not implementing a new MA rating measure it had considered on advising smokers and other tobacco users to quit because of “reliability issues” surrounding the measure.

The agency is going ahead with “retiring” a host of measures that will not be used for star-rating purposes (but still will be monitored by CMS and displayed on its website) starting in 2012. Those MA measures are appropriate monitoring of patients taking long-term medications, osteoporosis testing, physician communications, testing to confirm chronic obstructive pulmonary disease, and call-center hold time and information accuracy.

Data Reliability Spurs Questions

Among the new star-rating measures outlined by Goldstein, who also described the methodology for calculating them, the ones spurring the most interest among MA plans seemed to be all-cause hospital readmissions and members choosing to leave the plan. Industry sources queried by MAN seemed to accept the desirability of using such measures but expressed concern about the reliability of the data. And one source wondered what will happen after the three-year CMS quality-bonus demonstration project ends and MA plans presumably cut benefits to reflect their reduced income, thereby spurring some membership losses as a result.

Goldstein’s details about the 2012 weights for star-rating measures did not draw objections from those queried by MAN, but it did elicit some caveats. The CMS plan calls for giving “outcomes and intermediate outcomes” weights of three times those of “process” measures and giving “patient experience and access” measures weights of 1.5 times those of process measures.

The concerns expressed to MAN centered on the patient-experience measures, which are partly based on the federally funded and administered Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS). One source says numerous people in the MA industry believe that CAHPS patient-experience measures “can be gamed.” The survey is administered in the spring, the source notes, so MA plans might “front-load” their “touches” to members for shortly before then, presumably boosting member satisfaction in ways that will come out in CAHPS results. The source adds, however, that other patient-satisfaction measures stem from HEDIS, which does not have that problem and has been used for evaluating MA plans for years.

McClellan Seeks Patient-Experience Measures

Former CMS Administrator Mark McClellan, M.D., also expressed concerns about the patient-satisfaction measures. Speaking at America’s Health Insurance Plans’ annual Medicare conference in Washington, D.C., Sept. 13, McClellan, who is now at the Brookings Institution, said CMS would use better patient-experience measures if it had them. He predicted that the weight of these measures in computing the star ratings will go up in subsequent years as better measures are developed.

The decision to delay any star-measures adjustment based on supply of providers in certain areas is “disappointing,” another industry source says, albeit understandable. There are indeed problems with the HPSA measures, the source concedes, but CMS could find ways to deal with them by focusing, for instance, on shortages of only certain kinds of providers. He
adds that the health reform law directs HHS (and thus CMS) to “rejigger” HPSA measurement, so at some point the agency will have to deal with this issue.

Similarly, according to the source, CMS eventually will have to set up a permanent mechanism for rewarding quality improvement by MA plans, another measure Goldstein said is being delayed for now. The quality-bonus demonstration program, in effect, rewards through 2014 such gains for plans rated at least three stars, but there is nothing on the books now to continue that after the demonstration period is over. A possible way of doing this, the source suggests, is developing a process under which any MA plan that gains a full star in its overall rating from one year to the next could be considered a four-star plan for rewards purposes.

CMS Unveils Specific Star-Rating Measures to Add, ‘Retire’; Changes May Cut Scores


Following up on indications it had given earlier, CMS late last month unveiled plans to “retire” some star-rating quality measures and institute others for 2012 Medicare Advantage plan ratings. While no plan executives or consultants queried by MAN questioned the agency’s intent in the changes, some pointed out that the measures slated for retirement are ones in which MA plans usually are doing well or in which ratings among the plans tend to be very similar.

Conversely, the new measures are likely to yield lower ratings, which could lead to overall lower scores — and thus to lower quality bonus payments under the new CMS demonstration program (MAN 2/24/11, p. 1) and the health reform law.

Despite that, two executives and two consultants tell MAN they generally welcome the changes, which move away from “process measures” of quality and toward actual outcomes measures. MA Special Need Plans, which long have pushed for SNP-specific measures, were especially pleased that CMS is proposing three of them that one plan calls “appropriate,” although it would like to see additional measures that also reflect the different characteristics of SNP members. The new and retired measures aren’t final yet but are likely to be soon unless there is adamant opposition from stakeholders.

The new details on potential star-rating changes came from Liz Goldstein, Ph.D., director of CMS’s Division of Consumer Assessment & Plan Performance, in the Part C & D User Group Call July 27. The proposed standards, she said, take into account the responses it received from MA plan sponsors on the agency’s request for comments in both the 2012 call letter (MAN 4/7/11, p. 1) and CMS’s spring conference (MAN 4/21/11, p. 1) on which measures should be used to gauge quality improvement, how measures should be weighted (MAN 5/19/11, p. 1) and which measures should be retired. Another call on related subjects is scheduled for Aug. 24.

The plan comments, according to Goldstein, showed substantial support for using objective measures of quality improvement and “some support” for including just measures in which “performance is low or variation is high.” She said that some commenters had recommended retiring use of self-reported data. Moreover, there was support in the comments for
“weighting objective/clinical measures more than subjective or administrative/process measures” and for giving more weight to measures that plans directly influence, she added.

As a result of the comments and the agency’s own goals, Goldstein said, CMS intends to retire for the 2012 rankings measures related to doctor communication, monitoring of patients taking long-term medications, testing for osteoporosis and chronic obstructive pulmonary disease (COPD), call-center hold time and information accuracy, and timeliness in submitting 4Rx change transactions for CMS-generated enrollment.

**Proposed New Measures Stress Clinical Issues**

She then outlined “additional potential measures” for the 2012 ratings for both MA and Part D. On the MA side, noted Goldstein, those include “all-cause” hospital readmissions; smoking-cessation counseling; adult body mass index (BMI) measurement; medication adherence — based on proportion of days covered — for diabetes, cholesterol and high blood pressure; “enrollment timeliness” — based on the percentage of time drug plans transmitted enrollment information to CMS within seven days — and three SNP-specific measures involving care for older adults. The SNP measures are medication review, functional-status assessment and pain screening. For all MA and Part D plans, CMS also intends to measure the percentage of plan members who chose to leave the plan in 2010, other than members who left due to factors beyond the plans’ control, Goldstein said.

Industry executives and consultants generally gave positive reviews to the proposed changes. “CMS is demonstrating the star ratings will be dynamic and evolving,” says consultant Maureen Miller, vice president, Medicare services, at Visante Inc. Miller emphasizes that the items getting retired are mainly process measures and that even they stand to go on a “watch list” rather than necessarily disappear forever.

“I think it’s very smart on CMS’s part to be changing these,” she tells MAN, adding that “it’s a message to the industry to not get comfortable.”

But one industry executive, who asks not to be identified and also compliments the CMS approach, says there are complications for MA plans in some of the measures being retired.

The new measures, the executive tells MAN, almost by definition will be in areas where plans don’t do as well as in the retired measures and therefore could lead to lower scores and quality bonuses. There is no “ill intent,” however, in CMS’s changes, he stresses. The measures to be introduced, according to the executive, generally make sense, although they raise specific concerns. MA plans should want to get measured on all-cause readmissions, for instance, he contends, but there could be “misinterpretation” in how the data are reported. Similarly, medication-adherence measures are significant, and CMS is using the only measures it has available, but they show just prescriptions that are refilled, he says. They don’t reflect whether patients actually use the refilled prescriptions, nor do they take into account reselling of prescriptions — a particularly big problem in Medicaid, the executive adds.

Enrollment timeliness, he says, is another justifiable measure, but there are times when lack of timeliness is not an MA plan’s fault. If the largest plan in an area doesn’t renew its MA contract, for example, or if there are extreme weather conditions in an MA plan area, there may be delays in enrollment, and CMS should take such circumstances into account, the executive asserts.
Measuring members choosing to leave a plan also poses concerns, he tells MAN. He con- 
gratulates CMS for making specific exceptions for certain things, such as out-of-area moves 
and employer-group decisions. However, this still leaves the issue of markets in which peo-
ple tend to move a lot for other reasons and therefore where MA plans lose a lot of members, 
the executive says, and he recommends that CMS confirm this will not be held against plans, 
nor will any kind of service-area reduction.

**CMS Seeks to Gauge ‘Beneficiary Experience’**

CMS in this measure is basically just looking to gauge the “beneficiary experience” in 
the MA plan, Corey Ford, a manager in the health reform practice of consulting firm Avalere 
Health LLC, tells MAN. While a figure for voluntary departures by members is just a process 
measure, it’s an important one for assessing member satisfaction, he maintains.

Overall, says Ford, the star-rating changes were pretty much expected based on the 2012 
call letter. However, he agrees that the measures to be retired are ones that plans have done 
well on. Ford also concurs that there’s no reason to believe CMS selected the new measures 
for any reason other than feeling significant improvements in quality can be made through 
them.

All-cause readmissions fit with CMS’s goals for outcomes-based measures, and adult 
BMI measurement, while it’s a process measure, does fit with CMS’s expanded clinical focus 
and is an area that can stand improvement since the average plan performance on it is about 
36%, according to Ford. Medication adherence also isn’t necessarily outcomes based, he 
notes, but it too is a clinical indicator.

Perhaps the organizations most satisfied with the planned changes are SNPs, which long 
have pushed for measures that recognize the special needs of their populations. XLHealth 
Corp., one major SNP operator, is “really encouraged” that CMS has responded to those 
requests, says Laurie Russell, vice president of quality strategy and outcomes. Russell tells 
MAN the proposed SNP standards are “a good first step,” although she adds that they don’t 
“go far enough.” That’s because, she explains, there are only three measures, and there are 
other significant ones available. She notes that SNP models of care, along with structure and 
process (e.g., complex case management), are measured by outside organizations and there-
fore could be used in star ratings.

Omissions notwithstanding, Russell lauds the measures CMS chose for SNPs. 
Medication review is “appropriate,” she says, especially since medication problems are a 
big reason for hospital admissions and readmissions for SNP members. While there is diffi-
culty for SNPs in getting providers to document that they’ve done these medication reviews, 
XLHealth uses house calls and clinical pharmacist reviews and expects to do well on this 
measure, Russell says.

Functional-status assessment also is “very appropriate” for SNPs, and can be done via 
use of SF-36 or other comprehensive standardized forms, she says. Similarly, pain screening 
is a suitable measure but often doesn’t appear in administrative data, and XLHealth has been 
 focusing on it for a long time, according to Russell.

However, she adds that some SNPs will have difficulties with all three collecting and 
reporting requirements.

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CMS Escalates Its Use of Letters Seeking CAPs From MA Plans With Low Star Ratings


CMS this summer has boosted substantially its sending of letters directing Medicare Advantage plans with low star ratings to develop corrective action plans (CAPs) aimed at achieving a “good” rating in the future, MAN has learned. While in 2010 such letters were sent only to plans that scored less than three stars in multiple years, in 2011 these letters also went to plans with those below-average ratings in just the most recent year, two CMS officials tell MAN.

They defend the increased usage — which the officials, who ask not to be identified, say resulted in 116 letters being sent out in 2012 — as consistent with CMS policies, dating back even before the health reform law, to use star ratings for compliance purposes. While they say that plan actions in response to the letters won’t affect CMS decisions on whether to accept now-pending 2012 MA bids, they note that failure to take corrective actions on deficiencies can be grounds for subsequent contract terminations.

“What we’re trying to do is make sure plans are paying attention to this,” one CMS official says.

But some plans receiving the letters regard them as seeking to expand the role of the star ratings from the reform-law-mandated use in paying higher-quality MA plans more money to a new use as an enforcement mechanism. Moreover, “CMS is basically saying that everybody has to be above average,” which not only violates the laws of math but also is in contrast to the traditional “bell curve” pattern of MA star ratings, one plan tells MAN.

The plan, which also asks not to be identified, says CMS in the letters is attempting to use the star ratings as evidence that the recipients have insufficient administrative and management capabilities to meet their obligations as MA sponsors, even if there is no history of enforcement actions. The letters, according to the plan, are not specific in such areas as defining what is meant by a “good” rating or furnishing a date by which a CAP should be prepared.

They apparently are being sent on a contract-by-contract basis, so that a large MA sponsor with an overall star rating of 3 and above still might receive letters for its plans that have below this rating. The letters are signed by Cynthia Tudor, Ph.D., director of CMS’s Medicare drug benefit and C and D data group.

CMS apparently has sufficient authority in previously issued regulations and notices for sending the letters. A notice in the Federal Register, for instance, said that MA plans with less than a good star rating will be subject to intense monitoring. And the 2012 MA call letter released in April (MAN 4/7/11, p. 1) notes CMS will consider terminating contracts of plans that have not had adequate performance in three consecutive years.

Consultants see the letters as significant. They show there is a shift in utilization of star ratings from a performance measure for use in bonus payments to additional use as minimum levels of achievement needed to keep MA contracts, says, for instance, Nathan Goldstein, executive vice president of Gorman Health Group, LLC. The evolution, he says, is from a kind of “quality Darwinism” or value-based purchasing under which higher-scoring
plans would get “bragging rights” and better pay while lower-scoring (and thus lower-paid) plans eventually would die, to use as “a minimum requirement for meeting obligations as a Medicare plan sponsor.”

“CMS is delivering on statements made in the call letter that said explicitly they would subject [plans with] less than three stars to unique scrutiny and possible termination of their contracts,” he asserts. Goldstein contends that asking an MA plan to submit and execute on a CAP “is a classic escalation of enforcement.” The agency, in effect, is telling the plans receiving the letters that the plans know they have deficiencies (and in case they don’t, the letters spell out the deficiencies), and they need to remedy them, he says.

**Letters Lead to More Focus on Ratings**

_and regardless of their intent, adds Goldstein, the letters are bringing about what CMS wants to see, which is renewed intensity by plans, especially those “on the bubble,” in efforts to raise their star ratings._

Corey Ford, a manager in the health reform practice of MA and Part D consultant Avalere Health LLC, makes similar points. CMS has hinted previously that it would consider substandard star ratings a form of noncompliance, Ford tells _MAN_, and has become increasingly strict in review of MA plans in recent years. Ever since the reform law linked plan pay to the star ratings, MA plans have been “really focusing” on the ratings, starting with fixing “the low-hanging fruit,” he says.

The CMS officials themselves suggest that any changes the agency has made regarding the star ratings have been gradual and needed. One of the officials tells _MAN_ there are some MA plans that have had ratings below three stars since the beginning of Part D in 2006, so “we needed to take more action.”

While the letters requesting CAPs don’t say what constitutes the “good” ratings being sought, “good” means three stars, the official says. And the other official says that the CAPs don’t need to be submitted to CMS; they simply need to be carried out, since failure to do so could lead to termination of MA contracts. There is no due date on these CAPs, he says, because plans can prove they are taking corrective actions by improving the star ratings themselves.

The officials point out that there is no language in the letters indicating the star ratings will be used as a basis for denying 2012 bids. If plans receiving the letters have actual enforcement actions pending against them, though, they add, that could be the basis for denials.

They reject plan assertions that CMS is trying to make all MA plans “above average,” even though the agency’s own figures show that 271 of 560 contracts, representing 60.4% of MA prescription drug (MA-PD) plan enrollment, got three stars in the most recent rankings.

If all plans were performing at good levels, says one of the officials, they “wouldn’t be graded on a curve.” The official says the CMS expectation is that MA plans perform at good levels, and that this is what the letters are intended to help assure.

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