The 2017 Medicare Star Ratings: How to Translate New CMS Data Into Future Successes

Wednesday, November 2, 2016

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About the Speakers

CHRISTIE TEIGLAND, Ph.D., is vice president of advanced analytics with Avalere Health (an Inovalon company). She is an expert in the design and implementation of statistical studies focused on comparative effectiveness, predictive analytics and performance measure development. Prior to joining Avalere, she served as Senior Director of Statistical Research at Inovalon, where she managed quality measure projects awarded by the National Committee on Quality Assurance (NCQA), URAC, the Pharmacy Quality Alliance (PQA), and other organizations. In 2014-15, she directed an impactful study investigating disparities in outcomes in dual eligible and socioeconomically disadvantaged Medicare beneficiaries. Dr. Teigland was invited to serve on the newly formed National Quality Forum Disparities Standing Committee in 2015, and serves as co-chair of the PQA Measures Update Panel. Dr. Teigland has served on CMS technical expert panels including Nursing Home Quality Measures, Five Star Quality Rating System, CAHPS, and national expert panels convened by Harvard, The RAND Corp. and the Agency for Healthcare Research and Quality. Dr. Teigland received her Ph.D. and M.S. in Econometrics from the University of New York at Albany, and has a B.A. in Management Science and Economics from Moorhead State University. Contact Dr. Teigland at cteigland@inovalon.com.

PATRICK DONNELLY is director of product execution for Inovalon’s Quality Spectrum solution. In this role, he is responsible for ensuring seamless product operations and quality intervention strategies for Medicare, Medicaid, Federal Employee Health Benefit, and commercial Affordable Care Act health plans. For the past decade, Mr. Donnelly has focused on international health care and quality initiatives at the state and federal level, which includes creating a patent-pending Medicare star rating quality and financial performance tool. He has a B.B.A in Finance and International Business, and a B.A. in History, and Russian Language and Literature from the University of Notre Dame. Contact Mr. Donnelly at pdonnelly2@inovalon.com.

Moderator: Lauren Flynn Kelly, managing editor of AIS’s Medicare Advantage News.

Three Ways to Submit Your Questions for the 30-Minute Q&A Session

Presentations should run approximately 60 minutes, with 30 minutes of questions and answers. Questions may be submitted in three different ways:

Prior to the Webinar

(1) Email your question(s) to moderator Lauren Flynn Kelly at lkelly@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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Patrick Donnelly, Director, Inovalon
Christie Teigland, Ph.D., Vice President, Avalere Health

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WEBINAR OUTLINE

Part 1: Patrick Donnelly and Christie Teigland, Ph.D.

- 2017 Star Ratings Highlights
- Measure-Level Star Rating Performance and Movement
- Impact of New Adjustments to Address SES in Star Ratings
- Future Changes to Star Ratings
- Quality Improvement Strategies for 2018 and Beyond

Part 2: Questions and Answers
The 2017 Medicare Star Ratings: How to Translate New CMS Data into Future Successes

Christie Teigland, Ph.D.
Vice President, Avalere Health

Patrick Donnelly
Director, Inovalon

An AIS Webinar
November 2, 2016
Discussion Objectives

- Review highlights of CMS 2017 Star Ratings for Medicare Advantage plans
- Offer insights on specific CMS quality measures that proved particularly challenging this year
- Assess how plans were impacted by new adjustments to account for the impact of socio-economic and disability status on ratings
- Address future changes to CMS Star Ratings for 2018 and 2019
- Discuss quality improvement strategies to focus on for 2018 and beyond
CMS 5-Star Quality Rating Introduction

Objectives of CMS’ 5-Star Quality Rating System

- Measure quality in Medicare Advantage (MA) and Prescription Drug Plans (PDPs)
- Assist Medicare Advantage beneficiaries in finding the best plan
- Improve level of accountability for the care provided by physicians, hospitals and other providers

<table>
<thead>
<tr>
<th>Star Rating</th>
<th>Plan Quality Performance</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>★★★★★</td>
<td>Excellent</td>
<td>5% bonus, 70% rebate, year-round enrollment</td>
</tr>
<tr>
<td>★★★★★</td>
<td>Above Average</td>
<td>5% bonus, 65% rebate</td>
</tr>
<tr>
<td>★★★★</td>
<td>Average</td>
<td>50% rebate</td>
</tr>
<tr>
<td>★★★</td>
<td>Below Average</td>
<td>Possible loss of CMS contract if 3-year trend (Part C / Part D Summary)</td>
</tr>
<tr>
<td>★★</td>
<td>Poor</td>
<td>Possible loss of CMS contract if 3-year trend (Part C / Part D Summary)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Star Ratings Measure Categories</th>
<th>Quality Improvement</th>
<th>Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Patient Experience</th>
<th>Access</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable Weight</td>
<td>5x</td>
<td>3x</td>
<td>3x</td>
<td>1.5x</td>
<td>1.5x</td>
<td>1x</td>
</tr>
<tr>
<td>Number of Measures</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>12</td>
<td>8</td>
<td>16</td>
</tr>
</tbody>
</table>
Focus on Star Ratings

The importance of Star Ratings has grown over time and continues to serve multiple purposes.

- Star ratings help seniors compare plan options
- Highly rated plans get bonus payment
- Contract termination for plans consistently below 3 Stars*
- Prohibition of enrollment via website for low-rated plans
- Website “warning” icon for low-rated plans and highlight for high-rated plans
- Special enrollment period for 5-Star plans
- Special enrollment period for members of < 3-Star plans

*In the CY 2016 final Call Letter, CMS announced that contracts that earned their third consecutive Part C or Part D rating of less than three stars with the release of the 2016 ratings in the fall of 2015 would receive non-renewal notices from CMS in February 2016 with an effective date of December 31, 2016.
Star Ratings Measure Sources

Star Ratings include measures from numerous sources, adding complexity to future planning.

Data Sources

- CMS Contractors
- Complaint Tracking Module (CTM)
- Medicare Part D Data Files
- Independent Review Entity
- HEDIS®
- CAHPS
- Health Outcomes Survey (HOS)

Plan’s Overall Star Rating

Star Rating Breakdown by Domain

**Part C Breakdown**
- Weight: 52 (63%) Avg Rating: 3.86
- Weight: 18 (35%)
- Weight: 9.5 (17%)
- Weight: 9 (17%)
- Weight: 11 (21%)

**Part D Breakdown**
- Weight: 31 (37%) Avg Rating: 4.10
- Weight: 14 (45%)
- Weight: 9 (31%)
- Weight: 4.5 (15%)
- Weight: 3 (10%)

**Overall Star Rating Breakdown**
- Weight: 52 (63%) Avg Rating: 3.86
- Weight: 31 (37%) Avg Rating: 4.10

**Overall Star Rating**
- 3.97

- Managing Chronic Conditions: Average Rating 3.71
- Staying Healthy: Average Rating 3.76
- Member Experience: Average Rating 3.65
- Member Complaints: Average Rating 4.27
- Customer Service: Average Rating 4.11

- Drug Safety & Pricing Accuracy: Average Rating 3.60
- Member Complaints: Average Star Rating 4.18
- Customer Service: Average Star Rating 3.58
- Member Experience: Average Star Rating 3.53

Averages are enrollment weighted with enrollment data from December of the measurement year (IE: Dec 2015 enrollment for 2017 Ratings).
Star Rating Trend: MA-PD and PDP

Medicare Advantage Prescription Drug (MA-PD) plans experienced a drop in their average Overall Star Rating from 3.99 Stars for 2016 to 3.97 Stars for 2017, Medicare Prescription Drug plans (PDP) had an increase in their average Part D Star Rating from 3.38 Stars for 2016 to 3.52 Stars for 2017. This is the first Star Rating year that MA-PD plans experienced a drop in scores.

Averages are enrollment weighted with enrollment data from December of the measurement year (IE: Dec 2015 enrollment for 2017 Ratings).
Star Rating Trends: Contracts

Contract consolidation continues as we see fewer rated contracts and higher performing contracts taking an increasing percentage of enrollees.

<table>
<thead>
<tr>
<th>Year</th>
<th>5 Stars</th>
<th>4.5 Stars</th>
<th>4 Stars</th>
<th>3.5 Stars</th>
<th>3 Stars</th>
<th>&lt; 3 Stars</th>
<th>Unrated</th>
<th>% of 4+ Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>9</td>
<td>46</td>
<td>51</td>
<td>119</td>
<td>144</td>
<td>71</td>
<td>129</td>
<td>24%</td>
</tr>
<tr>
<td>2013</td>
<td>11</td>
<td>54</td>
<td>62</td>
<td>131</td>
<td>126</td>
<td>63</td>
<td>129</td>
<td>28%</td>
</tr>
<tr>
<td>2014</td>
<td>11</td>
<td>65</td>
<td>87</td>
<td>141</td>
<td>109</td>
<td>18</td>
<td>246</td>
<td>38%</td>
</tr>
<tr>
<td>2015</td>
<td>11</td>
<td>60</td>
<td>86</td>
<td>138</td>
<td>73</td>
<td>26</td>
<td>222</td>
<td>40%</td>
</tr>
<tr>
<td>2016</td>
<td>12</td>
<td>65</td>
<td>102</td>
<td>112</td>
<td>66</td>
<td>12</td>
<td>201</td>
<td>49%</td>
</tr>
<tr>
<td>2017</td>
<td>14</td>
<td>67</td>
<td>97</td>
<td>107</td>
<td>67</td>
<td>12</td>
<td>179</td>
<td>49%</td>
</tr>
</tbody>
</table>

MA-PD contracts only.
Enrollment data from December of the measurement year (IE: December 2015 enrollment for 2017 Star Rating).
Measure-Level Star Rating Performance

2017 Part C and D measure performance demonstrates 30% of the measures with a national average in the 4-Star range. 2017 measures outperforming others have not consistently maintained a trend of improvement.

**Part C & D Highest Performing Measures**

<table>
<thead>
<tr>
<th>CMS ID</th>
<th>Measure Description</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>D10</td>
<td>MPF Price Accuracy</td>
<td>4.6</td>
<td>3.5</td>
<td>4.7</td>
</tr>
<tr>
<td>C26</td>
<td>Complaints about the Health Plan</td>
<td>4.2</td>
<td>3.9</td>
<td>4.6</td>
</tr>
<tr>
<td>D04</td>
<td>Complaints about the Drug Plan</td>
<td>4.2</td>
<td>3.9</td>
<td>4.6</td>
</tr>
<tr>
<td>C11</td>
<td>Care for Older Adults – Pain Assessment</td>
<td>4</td>
<td>4.1</td>
<td>4.5</td>
</tr>
<tr>
<td>C07</td>
<td>Adult BMI Assessment</td>
<td>3.8</td>
<td>4.1</td>
<td>4.4</td>
</tr>
<tr>
<td>C09</td>
<td>Care for Older Adults – Medication Review</td>
<td>3.9</td>
<td>4.3</td>
<td>4.4</td>
</tr>
</tbody>
</table>

**Part C & D Lowest Performing Measures**

<table>
<thead>
<tr>
<th>CMS ID</th>
<th>Measure Description</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>C18</td>
<td>Reducing the Risk of Falling</td>
<td>3.3</td>
<td>2.7</td>
<td>2.4</td>
</tr>
<tr>
<td>D15</td>
<td>MTM Program Completion Rate for CMR</td>
<td>n/a</td>
<td>2.3</td>
<td>2.4</td>
</tr>
<tr>
<td>C04</td>
<td>Improving or Maintaining Physical Health</td>
<td>4.6</td>
<td>3.3</td>
<td>2.6</td>
</tr>
<tr>
<td>C12</td>
<td>Osteoporosis Mgmt in Women with a Fracture</td>
<td>2.1</td>
<td>2.5</td>
<td>2.7</td>
</tr>
<tr>
<td>C06</td>
<td>Monitoring Physical Activity</td>
<td>2.2</td>
<td>2.9</td>
<td>2.9</td>
</tr>
<tr>
<td>D03</td>
<td>Appeals Upheld</td>
<td>3.7</td>
<td>3.3</td>
<td>2.9</td>
</tr>
</tbody>
</table>
Measure-Level Star Rating Movement

2017 Star Rating results show that key measures are outperforming others. These Part C and D measures demonstrate an improvement trend, although some 2017 average Star Rating results have slowed.

Average Star Rating Change
2017 vs. 2016

<table>
<thead>
<tr>
<th>CMS ID</th>
<th>Measure Description</th>
<th>2016 to 2017 Rating Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>D10</td>
<td>MPF Price Accuracy</td>
<td>1.2</td>
</tr>
<tr>
<td>C17</td>
<td>Rheumatoid Arthritis Management</td>
<td>0.7</td>
</tr>
<tr>
<td>C26</td>
<td>Complaints about the Health Plan</td>
<td>0.7</td>
</tr>
<tr>
<td>D04</td>
<td>Complaints about the Drug Plan</td>
<td>0.7</td>
</tr>
<tr>
<td>C16</td>
<td>Controlling Blood Pressure</td>
<td>0.6</td>
</tr>
<tr>
<td>C08</td>
<td>Special Needs Plan (SNP) Care Mgmt</td>
<td>0.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CMS ID</th>
<th>Measure Description</th>
<th>2016 to 2017 Rating Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>C04</td>
<td>Improving or Maintaining Physical Health</td>
<td>-0.7</td>
</tr>
<tr>
<td>D02</td>
<td>Appeals Auto–Forward</td>
<td>-0.6</td>
</tr>
<tr>
<td>D14</td>
<td>Medication Adherence for Cholesterol</td>
<td>-0.5</td>
</tr>
<tr>
<td>D03</td>
<td>Appeals Upheld</td>
<td>-0.4</td>
</tr>
<tr>
<td>D12</td>
<td>Medication Adherence for Diabetes</td>
<td>-0.4</td>
</tr>
<tr>
<td>D11</td>
<td>High Risk Medication</td>
<td>-0.4</td>
</tr>
</tbody>
</table>
Star Rating Regionality

Star Rating performance continues to be highly regional, with certain areas of the country consistently over or underperforming national trends. This is seen at the measure-level and the overall-level, as shown in the map below.

- Puerto Rico score adjustments enable new 4-Star plans.
- "Northern Nice" - High CAHPS scores buoy plan performance in the north.
- Critical adjustments in Cut Points impact performance in multiple regions.

MA-PD contracts only.
Medication Adherence Cut Points rebounded in 2017 Star Ratings, leading to lower Part D and Overall performance.

### Medication Adherence Cut Points

#### Medication Adherence for Diabetes Medications

<table>
<thead>
<tr>
<th>Year</th>
<th>5 Stars</th>
<th>4 Stars</th>
<th>3 Stars</th>
<th>2 Stars</th>
<th>1 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>108 (25%)</td>
<td>135 (31%)</td>
<td>91 (21%)</td>
<td>62 (14%)</td>
<td>37 (9%)</td>
</tr>
<tr>
<td>2016</td>
<td>101 (25%)</td>
<td>199 (49%)</td>
<td>79 (19%)</td>
<td>28 (7%)</td>
<td>1 (&lt;1%)</td>
</tr>
<tr>
<td>2017</td>
<td>88 (22%)</td>
<td>121 (31%)</td>
<td>84 (21%)</td>
<td>89 (23%)</td>
<td>13 (3%)</td>
</tr>
</tbody>
</table>

#### Medication Adherence for Hypertension

<table>
<thead>
<tr>
<th>Year</th>
<th>5 Stars</th>
<th>4 Stars</th>
<th>3 Stars</th>
<th>2 Stars</th>
<th>1 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>52 (12%)</td>
<td>125 (28%)</td>
<td>139 (31%)</td>
<td>75 (17%)</td>
<td>56 (12%)</td>
</tr>
<tr>
<td>2016</td>
<td>200 (47%)</td>
<td>109 (26%)</td>
<td>65 (15%)</td>
<td>50 (12%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>2017</td>
<td>164 (40%)</td>
<td>122 (30%)</td>
<td>71 (17%)</td>
<td>39 (10%)</td>
<td>11 (3%)</td>
</tr>
</tbody>
</table>

#### Medication Adherence for Cholesterol

<table>
<thead>
<tr>
<th>Year</th>
<th>5 Stars</th>
<th>4 Stars</th>
<th>3 Stars</th>
<th>2 Stars</th>
<th>1 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>32 (7%)</td>
<td>172 (39%)</td>
<td>174 (39%)</td>
<td>54 (12%)</td>
<td>14 (3%)</td>
</tr>
<tr>
<td>2016</td>
<td>148 (35%)</td>
<td>153 (36%)</td>
<td>111 (26%)</td>
<td>12 (3%)</td>
<td>2 (&lt;1%)</td>
</tr>
<tr>
<td>2017</td>
<td>89 (22%)</td>
<td>154 (38%)</td>
<td>75 (18%)</td>
<td>74 (18%)</td>
<td>17 (4%)</td>
</tr>
</tbody>
</table>
Dual Eligible Beneficiaries Have Significantly Different Profiles

Sample MA Member Characteristics*

*MORE Registry MA beneficiaries, 2014.
Assigning Weights to Determinants of Health

Health Outcomes

Length of life 50%
Quality of life 50%

Health Behaviors (30%)
- Tobacco Use
- Diet & Exercise
- Alcohol & Drug Use
- Sexual Activity

Clinical Care (20%)
- Access to Care
- Quality of Care

Social and Economic Factors (40%)
- Education
- Employment
- Income
- Family & Social Support
- Community Safety

Physical Environment (10%)
- Air & Water Quality
- Housing & Transit

Health Factors

Policies and Programs
Types of Disparity

When examining differences in the outcomes between the dual eligible, low income subsidy or disabled groups, the disparities can be decomposed into two components:

**Between-Contract Disparities:**

These differences represent *true differences in quality* between plans and *are not* appropriate for adjustment.

**Within-Contract Disparities:**

These are differences between subgroups within a particular contract that *may be* appropriate for adjustment.
CMS RAND Study: Findings

CMS reported significant negative effect of dual/LIS and disability status for the majority of measures

- **75%** of measures showed significantly lower performance among duals/LIS
- **73%** showed worse performance among those with disability

Effect of patient characteristics and socio-economic status

- CMS reported that dual status effect was *not sensitive to*:
  - Inclusion of patient characteristics such as age, gender, HCC, end-stage renal disease
  - Inclusion of socio-economic factors measured at the Census ACS Block level after adjusting for within plan effect for 7 of 9 Star measures evaluated
CMS Findings: Differences in Average Score for 12 of 16 Measures Reviewed

Average Within Contract Disparity Across All Contracts By Measure For LIS/DE Status

- Reducing Risk of Falling: 12%
- Adult BMI Assessment
- Medication Adherence Cholesterol
- Controlling High Blood Pressure
- Medication Adherence Diabetes
- Monitoring Physical Activity
- Diabetes Care: Kidney Disease
- Plan All Cause Readmission
- Medication Adherence Hypertension
- Rheumatoid Arthritis Management
- Annual Flu Vaccine
- Diabetes Care: Eye Exam
- Osteoporosis Management
- Colorectal Cancer Screening
- Breast Cancer Screening
- Diabetes Care: Blood Sugar Controlled

CMS: Centers for Medicare & Medicaid; LIS: Low-Income Subsidy; DE: Dual Eligible.
Interim Adjustment to Address SES in MA Star Ratings

Categorical Adjustment Index (CAI)

- 7 of 44 Star measures were selected for adjustment
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Diabetes Care – Blood Sugar Controlled
  - Osteoporosis Management in Women w/ Fracture
  - Rheumatoid Arthritis Management
  - Reducing Risk of Falling (Note: positive dual status effect!)
  - Medication Adherence for Hypertension

- The 6 measures with a negative impact comprised 13.6% of the 44 Star measures for 2015.
- Factoring in the contribution of each of the measures to the overall rating, the maximum contribution of the adjusted measures is 19.4%.
- Any upward adjustment for high dual plans may be reduced by the Risk of Falling measure, which had a positive impact on Star Ratings for high dual plans because they tend to perform better on this measure.

Interim Adjustment to Address SES in MA
Star Ratings: Adjustment at the Measure Level

Example: Breast Cancer Screening (BCS) had the largest adjustment factor of 0.085 (8.5%) for 100% dual eligible plans

<table>
<thead>
<tr>
<th>Contract H999 (100% Dual/LIS members)</th>
<th>Measure Score</th>
<th>Star Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Rate</td>
<td>63.0%</td>
<td>3 Stars</td>
</tr>
<tr>
<td>Adjusted Rate</td>
<td>71.5%</td>
<td>3 Stars*</td>
</tr>
</tbody>
</table>

*Top of BCS rating threshold for 3 Stars is 74%

- Contract H999 would have no adjustment to their overall Star Rating from the BCS measure.
- Contracts would generally need to be close to the top of the threshold for a measure to have a change in Star Rating for the measure.
- Contracts would need to have a change in Star Rating for all 6 measures to have any change in their Overall Star Rating.
### Example: Contract H999
*(Category 7: Between 73.9% and <99.0% dual/LIS and >26.5% disabled)*

<table>
<thead>
<tr>
<th>Contract H999</th>
<th>Star Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Rate</td>
<td>3 Stars</td>
</tr>
<tr>
<td>Adjusted Rate (+0.055)</td>
<td>3.0 + 0.055 = 3 Stars*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIS/DE Decile</th>
<th>CAI Adjustment Applied to Overall Star Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-0.016</td>
</tr>
<tr>
<td>2</td>
<td>-0.006</td>
</tr>
<tr>
<td>3</td>
<td>0.002</td>
</tr>
<tr>
<td>4</td>
<td>0.014</td>
</tr>
<tr>
<td>5</td>
<td>0.025</td>
</tr>
<tr>
<td>6</td>
<td>0.029</td>
</tr>
<tr>
<td>7</td>
<td><strong>0.055</strong></td>
</tr>
<tr>
<td>8</td>
<td>0.081</td>
</tr>
</tbody>
</table>

CAI: Categorical Adjustment Index; DE: Dual Eligible; LIS: Low-Income Subsidy; MA: Medicare Advantage; SES: Socio-economic Status.
The Inovalon analysis of CAI demonstrates that the factor had minimal impact on Star Ratings and is only providing a boost for plans on the edge of achieving a higher Star Rating. This is due to the maximum CAI factor of 0.08. Only 15 (4%) of 364 MA plans had their Star Rating increased due to CAI. No plans dropped a Star Rating due to the CAI.

CAI: Categorical Adjustment Index; SES: Socio-economic Status.

<table>
<thead>
<tr>
<th>Summary of CAI Adjustment on Contracts Overall Star Rating</th>
<th>2016</th>
<th>2017*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracts with .5 Star Increase</td>
<td>11 (2.6%)**</td>
<td>15 (4.0%)***</td>
</tr>
<tr>
<td>Contracts with .5 Star Decrease</td>
<td>1 (0.24%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Contracts With No Change in Star Rating</td>
<td>409 (97.1%)</td>
<td>349 (96.0%)</td>
</tr>
</tbody>
</table>

**1 contract to 3.0; 5 contracts to 3.5; 3 contracts to 4.0; 2 contracts to 4.5
***1 contract to 2.5; 1 contract to 3.0; 8 contracts to 3.5; 5 contracts to 4.0

*The Inovalon analysis of CAI demonstrates that the factor had minimal impact on Star Ratings and is only providing a boost for plans on the edge of achieving a higher Star Rating. This is due to the maximum CAI factor of 0.08. Only 15 (4%) of 364 MA plans had their Star Rating increased due to CAI. No plans dropped a Star Rating due to the CAI. CAI: Categorical Adjustment Index; SES: Socio-economic Status.
Inovalon Duals Study\(^1\): Member-Level Analyses

### Main Data Source

- **Inovalon’s MORE\(^2\) Registry\(^\circledast\):** Statistically de-identified administrative claims database with data for >137 million unique individuals, including demographics, dual eligible status, low-income subsidy status, and medical and pharmacy utilization.

### Supplemental Data Sources

- **Inovalon’s HEDIS Quality Measure Scores:** Five-Star Quality Measures at the member-level.
- **Acxiom Market Indices Data:** Detailed source of near neighborhood socio-economic characteristics including income, education, household size and other key social determinants of health factors.
- **AHRQ Area Health Resource File:** County-level data on physician and mental health professional shortage areas.

Inovalon Duals Study

- Inovalon found **significant effect of socio-economic factors** using more precise assignment of characteristics to members, **after adjusting for dual status**.

- Inovalon found **significant effect of chronic conditions, age, gender and other community resource characteristics**, after adjusting for dual status.
### Summary of Characteristics Contributing to the Observed Disparities in Star Outcomes

<table>
<thead>
<tr>
<th>MA Member Characteristic</th>
<th>Rheumatoid Arthritis Mgmt.</th>
<th>Breast Cancer Screening</th>
<th>High Risk Meds</th>
<th>Medication Adherence</th>
<th>All Cause Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/Drug/Substance Abuse</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Lower Home Ownership Area</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Disability as Original Reason for Entitlement</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Living in Primary Care Shortage Area</td>
<td>+</td>
<td>-</td>
<td></td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Living in High Poverty Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Male Gender</td>
<td>-</td>
<td></td>
<td>+</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Age</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Percent of Population Never Married</td>
<td></td>
<td></td>
<td></td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

**+** Increases disparity in rates  
**-** Reduces disparity in rates
Outstanding Questions Related to CMS CAI Approach

1. Were the SES data from U.S. Census ACS used by CMS/RAND sensitive enough to capture the association of social risk factors on Star outcomes?

2. Did the approach to adjust only for within plan differences between duals and non-duals fully capture the impact of greater burden of disease and social status on outcomes for disadvantaged members?

3. Do duals in plans with a relatively low percentage of duals have the same clinical, demographic and socio-economic profile as those in plans with a relatively high percentage of duals?
The Inovalon Duals Study used near neighborhood level data to assign socio-economic characteristics to members.

Research has demonstrated the close association of a person’s characteristics and health behaviors to near neighborhood characteristics.

The Acxiom Market Indices data is an aggregation of data from multiple databases (e.g., government information, buying activity, financial behavior).

Provides about 30 million discrete data points based on Zip+4 areas (average of 8 households per neighborhood).

Previous studies examining socio-economic characteristics (including the CMS RAND study) have generally utilized U.S. Census data available at the 5-digit ZIP code level (about 40,000 areas) or American Community Survey (ACS) area block group data (about 250,000 areas).

These sources provide information averaged across multiple disparate neighborhoods, resulting in a relatively imprecise assignment of characteristics to individuals.
In 2015, the ACS sampled approximately 3.5 million housing unit addresses.

This represents about 2.5% of households, but the final sampling ratio is much lower.

Final interviews (which include occupied and vacant housing units), correspond to about 1.6% of housing units.

At the state level, the final interviews range from a low of 1.2% (Florida) to a high of 2.7% (North Dakota) of total housing units.

---

**Example: Washington, DC**

- District of Columbia has **287** 5-digit ZIP codes
- In 2015, ACS final sample of housing units = **4,696**
- **= 16 households** per 5-digit ZIP code
- There are **714 ZIP-4 areas** per 5-digit ZIP on average!
Inovalon Example: PQA Drug Measure Risk Adjustment

As a first step, we analyzed the impact of simply stratifying MA-H measure rates by LIS status.

- There was some movement of plans in the middle quartiles, but changes in rank were small, similar to the CMS CAI Adjustment results.

*Note: Lower rank = higher adherence rate; contracts below diagonal line have better rank after stratification and contracts above line have worse rank after stratification.

CAI: Categorical Adjustment Index; LIS: Low Income Subsidy; PQA: Pharmacy Quality Alliance.
Inovalon Example: PQA Drug Measure Risk Adjustment

Medication adherence for hypertensive drugs (MA-H) quality measure showed significant negative association with outcomes for the following characteristics:

1. **Disability + age** (must use interaction term — *disabled less likely but older people more likely* to be adherent — odds ratio for disabled aged 18-54 is 0.54; odds ratio for disabled aged 70+ is 0.87)

2. **Gender** (*males less likely* to be adherent)

3. **Race/ethnicity**

4. **Dual status** (*non-duals less likely to be adherent* after adjusting for socio-economic status!)

5. **# of unique medications** (*more meds, more likely* to be adherent, consistent with literature)

6. **% of households that own home** (*higher home ownership in neighborhood, more likely* to be adherent)

7. **% of neighborhood population below POVERTY level** (*higher percent of poverty, less likely* to be adherent)

8. **Education** (*higher education, more likely* to be adherent)

*Note that LIS is not significant in the model when dual status is included; but both dual status and socio-economic factors are significant.*
Impact of Applying More Comprehensive Risk Adjustment: Medication Adherence

- Many plans changed rank
- Plans above the line ranked lower after adjustment
  - This indicates that these plans performed worse based on performance of other plans serving a similar population.
- Plans below the line ranked higher after adjustment
  - This indicates these plans performed better relative to other plans serving a similar population.
  - Plans below the line appeared to have a lower quality of care than they were actually providing before adjusting for all population risk factors.

Results were consistent for all 3 medication adherence measures
Outstanding Questions Related to CMS CAI Approach

1. Were the SES data from U.S. Census ACS used by CMS/RAND sensitive enough to capture the association of social risk factors on Star outcomes?

2. Did the approach to adjust only for within plan differences between duals and non-duals fully capture the impact of greater burden of disease and social status on outcomes for disadvantaged members?

3. Do duals in plans with a relatively low percentage of duals have the same clinical, demographic and socio-economic profile as those in plans with a relatively high percentage of duals?
## Distribution of MA Part C and Part D Contracts by Percent Dual Eligible Enrollment

### Contracts by Percent LIS/Dual* Enrollment: Distribution, Size, and Average Risk Scores (2016)

<table>
<thead>
<tr>
<th>Contract Percent Dual</th>
<th>0-19%</th>
<th>20-49%</th>
<th>50-79%</th>
<th>80-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Contracts (374)</td>
<td>208 (55.6%)</td>
<td>76 (20.3%)</td>
<td>36 (9.6%)</td>
<td>54 (14.4%)</td>
</tr>
<tr>
<td>Average Enrollment</td>
<td>46,021</td>
<td>38,099</td>
<td>27,786</td>
<td>7,409</td>
</tr>
<tr>
<td>Median Enrollment</td>
<td>20,291</td>
<td>17,745</td>
<td>17,244</td>
<td>4,239</td>
</tr>
<tr>
<td>Average Risk Score</td>
<td>0.94</td>
<td>1.03</td>
<td>1.15</td>
<td>1.41</td>
</tr>
</tbody>
</table>

- **Dual enrollment in contracts is highly skewed**
  - Over half (56%) of all contracts have <20% duals and are much larger on average (46,000 members on average).
  - 14% of contracts have >80% duals and are much smaller on average (7,400 members on average) duals.
  - Thus, 70% of contracts will likely show statistically insignificant “within plan” differences due to unbalanced split of duals vs. non-duals.
  - Contract mean risk scores are directly associated with percent dual (higher percent dual = higher risk scores or members).

---

*Only Low Income Subsidy (LIS) status is publicly available and the CMS/RAND study used LIS/Dual interchangeably. About 93% of LIS are dual eligible; about 7% are LIS only, but considered similar to duals.*
Based on the distribution of contracts

- The “within contract” disparity effects were largely captured by only 30% of all contracts with between 20-80% duals.
- Contracts with a higher proportion of non-duals are much larger and have significantly lower risk scores on average.
- Risk scores are directly correlated with contract percent dual, and are 50% higher among members of contracts with >20% duals compared to those with <20% duals (mean risk score 1.41 vs. 0.94).

MA: Medicare Advantage
Do All “Between Plan” Differences Represent “True Differences” in Quality?

- Let’s assume contracts with <20% duals are all in the group with <7% of members living below the poverty level, and contracts with >80% duals are all in the group with 24%-100% of members living below the poverty level.

- Is it accurate to assume that the observed “between contract” differences in adherence rates represent true differences in quality between the two groups of MA contracts?

Example: Medication Adherence Rates by Percent of Members Living Below Poverty Level

- **Statins**
  - 0%-7%: 70.9%
  - 8%-13%: 69.0%
  - 14%-23%: 67.0%
  - 24%-100%: 63.9%

- **Antidiabetics**
  - 0%-7%: 74.9%
  - 8%-13%: 74.4%
  - 14%-23%: 73.0%
  - 24%-100%: 70.5%

- **Antihypertensives**
  - 0%-7%: 76.1%
  - 8%-13%: 74.6%
  - 14%-23%: 73.2%
  - 24%-100%: 70.4%

MA: Medicare Advantage.
Percent of Contracts with Overall Rating of 4 Stars or Higher

- Contracts with <20% dual/LIS enrollees consistently perform best every year while contracts with >20% dual enrollment consistently perform worst every year.

- Given the <50% SNP contracts have significantly lower risk scores and higher SES profiles compared to >50% SNP contracts, are we certain the higher Star Ratings “between” these groups of contracts are due to higher quality performance?

LIS: Low Income Subsidy; SES: Socio-economic Status; SNP: Special Needs Plan.
1. Were the SES data from U.S. Census ACS used by CMS/RAND sensitive enough to capture the association of social risk factors on Star outcomes?

2. Did the approach to adjust only for within plan differences between duals and non-duals fully capture the impact of greater burden of disease and social status on outcomes for disadvantaged members?

3. Do duals in plans with a relatively low percentage of duals have the same clinical, demographic and socio-economic profile as those in plans with a relatively high percentage of duals?
Are All Duals the Same?

Do the “duals” in the low dual plans look like duals in high dual plans?

Dual eligible beneficiaries can have widely different characteristics and are subject to State Medicaid rules and expansion (e.g., many non-duals may be poor, so we may be comparing duals to “near or sometimes” poor non-duals and thus find no differences in outcomes).

Do the “non-duals” in high dual plans look like non-duals in low dual plans?

- Do the non-duals in high dual contracts have a higher number of comorbidities and mental health conditions or higher historical burden of disease?
- Do they have lower incomes or education on average?
- Are they near the threshold of dual eligible?

Higher dual contracts have higher risk scores and lower Star Ratings on average.
Outstanding Questions

Questions remain related to risk adjusting star measures for social determinants of health, including:

1. Was the SES data utilized sensitive enough to capture the impact of SES at the individual plan member level?

2. Did the decision to adjust only for “within plan” differences capture all true disparities in outcomes for the disadvantaged population given the highly skewed distribution of contracts and significantly different risk profiles?

3. Should additional measures be adjusted for clinical risk factors that are more prevalent in duals and low income, disadvantaged members, such as disability, depression, dementia, mental health and behavioral issues, and other diseases/conditions?

4. Is there a better approach to adjust for social and clinical risk factors that impact quality outcomes for all MA members with these characteristics?

The commonly accepted approach to risk adjustment is to adjust across an entire population so that all patient risk factors are taken into account at the member level.

MA: Medicare Advantage; SES: Socio-economic Status.
Future Changes to Star Ratings

Changes to Star Ratings measures require plans to consistently review and adjust quality initiatives.

2018 Star Ratings Changes

- Improving Bladder Control (Part C) Temporarily removed from 2017 Star Ratings
  - Expect the measure to return as a Star Rating measure with the 2018 Star Ratings
- Medication Reconciliation Post Discharge (Part C) NCQA Update
  - Includes all MA Plans and age range expanded to 18 and older
- Hospitalizations for Potentially Preventable Complications (Part C) NCQA New Measure
  - Assess the rate of hospitalization for complications of chronic and acute ambulatory care sensitive conditions

2019 Star Ratings Changes

- Statin Therapy for Patients with Cardiovascular Disease (Part C) NCQA New Measure
  - Measures the percentage of males (21-75) and females (40-70) identified as having cardiovascular disease and dispensed at least one high-intensity statin medication
- Statin Use in Persons with Diabetes (Part D) PQA New Measure
  - Percentage of patients (40-75) who received at least two diabetes medication fills and received a statin medication
- Asthma Measures (Part C) NCQA New Measures
  - (I) Medication Management for People with Asthma*; (II) Asthma Medication Ratio**

*Percentage of members with asthma and dispensed medications; **Percentage of members with asthma and had a ratio of controller medication of .50 or greater.
The Time to Act is Now

Quality Star Ratings rely on measure sets from two years prior, so planning must start now.

- CMS uses the most recently available data from the various measure sets to determine the Star Ratings for plans.

April

- 2019 Star Ratings methodology finalized; bids submitted

September

- CMS announces Cut Points for 2019 Star Ratings

October

- 2019 Star Ratings Performance Released

January 1

- 2019 Plan Year Begins

2017

- 2017 data collected and applied to later years

2018

- Plans learn how they will be evaluated in 2019, after four months of the reporting year have already passed
- Plans learn how performance will translate into Star Ratings just one month before 2019 ratings are released

2019

- Plans learn their 2019 Star Ratings; beneficiaries view Star Ratings to make 2019 enrollment decisions; enrollees informed if they are in a consistently low performing plan

2020

- 2020 plan payments are made based on 2019 Star Ratings based on 2018 performance

Quality as a Culture

Addressing the challenges of quality improvement requires a complete solution.
Questions?

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‘Stars’ Align for Anthem, BCBS of Mass., But MA Enrollment Remains a Blip for Blues

Reprinted from the November 2016 issue of AIS’s monthly newsletter The AIS Report on Blue Cross and Blue Shield Plans (not affiliated with or sponsored, endorsed or approved by the Blue Cross Blue Shield Association or any of the independent Blue Cross and Blue Shield companies). Visit the Marketplace at http://AISHealth.com for more information.

Although many Blue Cross and Blue Shield plans are small players in the Medicare space compared with national insurance carriers such as Humana Inc. and Aetna Inc., several of them scored top quality marks when CMS released its 2017 star quality ratings for Medicare Advantage (MA) products and stand-alone Prescription Drug Plans (PDPs) Oct. 12. Higher star ratings are tied to higher Medicare reimbursement for MA plans. Carriers that achieve at least a 4-star rating (out of a possible 5) receive a 5% bonus payment from CMS under the star-rating program.

Blues plans traditionally have been focused on commercial group and individual markets, and that experience helped them become central players in the public insurance exchanges and the Medicare supplemental market. But MA remains a relatively new market for many Blues plans.

Some Blues plans are new to the market. Blue Cross and Blue Shield of Nebraska on Oct. 17 announced it was entering the MA market — with two plans in six counties aimed at the state’s growing senior population. The Nebraska Blues plan has 60,000 people enrolled in Medicare supplemental products, but it is new to MA.

**Blues Are Expanding Medicare Footprint**

Other Blues plans are expanding their MA presence. BlueCross BlueShield of Tennessee says it has 100,000 MA members — up 223% since 2008, The Chattanooga reported Oct. 6. And some, like Highmark Inc., are enhancing their MA services. In an Oct. 1 statement, the Pittsburgh-based Blues plan said its MA members in western Pennsylvania will, for the first time, be able to obtain their prescriptions at reduced copayments and/or coinsurance through a preferred network of pharmacies participating in the Community Blue Medicare HMO Signature and Security Blue HMO ValueRx plans.

“Blues plans have historically been grounded in commercial insurance. They are finally recognizing the importance of this market — which is clearly a growth area in the overall health care space — and acknowledging that they need to be competitive in it,” says Joseph Marinucci, an analyst at the ratings firm Standard & Poor’s. For Blues plans, star ratings

### Top 12 Largest Publicly Traded MA Carriers by Enrollment, October 2016

<table>
<thead>
<tr>
<th>Insurance Carrier</th>
<th>Enrollment</th>
<th>Market Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealth Group</td>
<td>3,932,807</td>
<td>21%</td>
</tr>
<tr>
<td>Humana Inc.</td>
<td>3,207,647</td>
<td>17%</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>1,404,280</td>
<td>8%</td>
</tr>
<tr>
<td>Aetna Inc.</td>
<td>1,394,362</td>
<td>8%</td>
</tr>
<tr>
<td>Anthem, Inc.</td>
<td>624,305</td>
<td>3%</td>
</tr>
<tr>
<td>Cigna Corp.</td>
<td>522,320</td>
<td>3%</td>
</tr>
<tr>
<td>WellCare Health Plans, Inc.</td>
<td>338,439</td>
<td>2%</td>
</tr>
<tr>
<td>Centene Corp.</td>
<td>301,013</td>
<td>2%</td>
</tr>
<tr>
<td>Triple-S Management Corp.</td>
<td>113,980</td>
<td>1%</td>
</tr>
<tr>
<td>Universal American</td>
<td>114,580</td>
<td>1%</td>
</tr>
<tr>
<td>Molina Healthcare, Inc.</td>
<td>96,419</td>
<td>1%</td>
</tr>
<tr>
<td>Magellan Health</td>
<td>966</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>6,507,880</td>
<td>35%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>18,558,998</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**NOTE:** Shaded rows are Blue Cross Blue Shield licensees.
**SOURCE:** CMS and Credit Suisse Research, October 2016
can be a significant differentiator. “In many ways, it’s the difference between surviving and thriving,” he adds.

Among Blues plan operators, Puerto Rico-based Triple-S Management Corp. had the highest percentage of enrollees in MA plans with 4 or more stars at 85.8%, according to CMS. Overall, the company’s HMO achieved a rating of 4 stars — up from 3 a year ago. About 85% of its MA membership is in an HMO. The carrier’s PPO maintained its 3.5-star rating overall and achieved 4.5 stars for PDPs. Among all carriers, Aetna had the highest percentage of members in a plan with 4+ stars with 90.8%, up slightly from 90% a year ago. Other Blues plans that earned five stars for their 2017 PDP plans include Excellus Health Plan, Inc. and Blue Cross Blue Shield of Michigan Mutual Insurance Company. Blue Medicare Rx — a joint venture among Blues plans in Connecticut, Massachusetts, Rhode Island and Vermont — also achieved a 5-star rating for 2017.

High ‘5s’ for Massachusetts Blue

Blue Cross Blue Shield of Massachusetts’ MA HMO plan was one of 14 plans nationally to receive a top rating of 5 stars this year, marking the first time the company was awarded the score. And the Blues plan’s MA prescription drug plan HMO was among just six MA-PDs nationally, and the only one in New England available direct to consumers, to receive 5 stars.

“Five stars is the Holy Grail in terms of our plans being recognized for quality. The only thing that’s harder than attaining a 5-star rating is keeping it,” says Ken Arruda, executive director of Medicare markets for the Massachusetts Blues plan. Even maintaining 4.5 stars requires a great deal of effort, he adds, noting that CMS considers 50 clinical measures and perceptual assessments when rating MA and PDP plans.

### Top 10 BCBS Entities by Medicare Advantage Enrollment, March 2016

<table>
<thead>
<tr>
<th>BCBS Entity</th>
<th>State(s)</th>
<th>Medicare Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem, Inc.</td>
<td>AL, AZ, CA, CO, CT, FL, GA, IA, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, NC, NH, NJ, NM, NV, NY, OH, OR, PA, SC, TN, TX, VA, WA, WI and WV</td>
<td>483,373</td>
</tr>
<tr>
<td>Blue Cross Blue Shield of Michigan</td>
<td>AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, ID, IL, IN, KS, KY, MA, MD, MI, MN, MO, MS, MT, NC, NJ, NM, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, WI and WV</td>
<td>414,321</td>
</tr>
<tr>
<td>Highmark Blue Cross Blue Shield</td>
<td>PA</td>
<td>294,261</td>
</tr>
<tr>
<td>Blue Cross and Blue Shield of Minnesota</td>
<td>AZ, FL, MN, TX, WI</td>
<td>190,745</td>
</tr>
<tr>
<td>Blue Cross and Blue Shield of Florida, Inc.</td>
<td>FL</td>
<td>120,529</td>
</tr>
<tr>
<td>Blue Cross and Blue Shield of North Carolina</td>
<td>NC</td>
<td>107,216</td>
</tr>
<tr>
<td>Excellus BlueCross BlueShield</td>
<td>FL, NC, NY, PA, SC</td>
<td>102,708</td>
</tr>
<tr>
<td>Blue Shield of California</td>
<td>CA</td>
<td>101,984</td>
</tr>
<tr>
<td>Independence Blue Cross (IBC)</td>
<td>AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, PR, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WW and WV</td>
<td>99,932</td>
</tr>
<tr>
<td>BlueCross BlueShield of Tennessee</td>
<td>AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, PR, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WW and WV</td>
<td>94,714</td>
</tr>
</tbody>
</table>

NOTE: Total Medicare Advantage enrollment for all BCBS entities nationwide = 2,745,096, as of March 2016.
Along with a health plan’s ability to manage chronic conditions and ensure positive member experiences, the agency also evaluates member satisfaction and customer service experiences. On the Part D side, plans also are rated on member experience with drug plans and drug safety.

“You can’t take your eye off any of those measures. It’s basic blocking and tackling to track year-round performance for all of those measures,” Arruda tells The AIS Report. “And you have to immediately create action plans if you see any sort of deterioration in any one of those measures.”

The Massachusetts Blues plan experienced an uptick in MA enrollment over the past four years, from 28,000 members in 2012 to nearly 45,000 members this year, which Arruda attributes to baby boomers aging into Medicare. He notes that a growing number of retirees are doing their MA shopping via computer, and says seniors also are looking beyond the overall star ratings and drilling down into scores in specific areas such as customer service.

Since the open enrollment period began Oct. 15, Arruda says there has been a spike in enrollment at informational seminars throughout the state. While 50 signed up for one such program, 450 showed up. He notes that it’s difficult to know if the increased shopping activity will translate into enrollment.

In September, the Massachusetts Blues was the top-rated Blues plan for performance and quality and one of just 13 health insurers in the nation to earn a top score of 5 out of 5 from the National Committee for Quality Assurance (The AIS Report 10/16, p. 5). “We do have a corporate focus on quality for all of our programs, both commercial and Medicare,” Arruda says.

**Anthem Doubles 4-Star Enrollment**

For the 2017 plan year, about half (51%) of Anthem’s MA members will be enrolled in a plan with a star rating of 4 or higher — up from 22% for 2016 and just 9% in 2015. For Anthem, the improvement could translate to a 1% bump in earnings per share, Citi Group Securities analyst Ralph Giacobbe suggested in an Oct. 13 note to investors. By contrast, 19% of Cigna Corp.’s MA contracts are in plans rated 4 stars or higher — down from 75% last year. Anthem operates Blues plans in 14 states and is the nation’s largest commercial health insurer with a total medical enrollment of about 38 million. Despite being one of the nation’s largest insurance carriers, Anthem has just 3% of the MA market (see table, p. 44).

Marc Russo, president of Medicare at Anthem, says while he’s happy with the results, he’s not surprised given the increased focus the company has placed on improving the program. Three years ago, the company established a goal of having up to half of its members in MA plans with 4 stars or more. “It was sheer hard work,” he tells The AIS Report. “While we are happy at 50%, we’re not content and intend to achieve higher percentages” in the coming years. Three years ago, just 5% of Anthem’s MA members were in plans with 4 or more stars. Since then, the company has invested “considerable resources” in the Medicare program. “We are very confident we are on solid ground and have a sustainable platform to facilitate growth.” He anticipates enrollment in Anthem’s MA plans will grow by more than the national average of 5% a year.

Like Arruda, Russo acknowledges that maintaining its star ratings will be challenging. Anthem, he says, has “put a lot more people on the ground” to work with providers and members and encourage preventive care, and will continue to do so.
In 2011, Anthem paid $800 million to acquire California-based CareMore Health Group and its 54,000 Medicare Advantage members, giving the insurer 26 care center clinics staffed by a variety of providers (The AIS Report 11/11, p. 7). A year later, it paid $4.9 billion for Medicaid managed care provider Amerigroup Corp., which had 2.3 million members in 13 states (The AIS Report 11/12, p. 1). Marinucci says Anthem might have been able to assimilate Amerigroup’s expertise more quickly, but now appears to be improving its Medicare profile with the help of CareMore’s skill set.

Russo acknowledges that CareMore has been a valuable asset and says Anthem has been able to take advantage of its knowledge. But CareMore’s clinic-based model is difficult to replicate and remains a distinct operating unit due to its unique care model. As such, Russo notes that Anthem’s Medicare improvement was not the result of leveraging any aspect of CareMore. All four of CareMore’s MA plans earned scores of 4 stars or more from CMS.

To boost enrollment in high-performing MA plans, Russo says some carriers consolidate lower-performing plans into higher ones. While that can be an easier route to improved scores, such a move can be risky if the level of performance can’t be maintained. “We felt like we had to get here the hard way.”

18.5 Million Now Enrolled In MA Plans

Nationally, about 18.5 million people were enrolled in an MA plan as of October — up nearly 5% from the same month last year, according to CMS. The average 2017 premium will drop by about 4% and the number of products offered nationwide will remain largely unchanged. Similarly, PDP enrollment increased about 3.2% from a year ago to 24.9 million.

During the Annual Election Period (AEP), which began Oct. 15 and runs through Dec. 7, many carriers, including Blues plans, are touting $0 and low-premium plans, service area expansions and product enhancements such as supplemental benefits and preferred pharmacy networks.

For the results of CMS’s 2017 Star Ratings, visit http://tinyurl.com/j4n7o59.

Contact Cathy Taylor for Russo at cathy.taylor@anthem.com, Rachel Coppola for Arruda at rachel.coppola@bcbsma.com and Marinucci at joseph.marinucci@spglobal.com.

Disease, Care Management Focus Leads to Improvement in 2017 PDP Star Ratings


Stand-alone Medicare Prescription Drug Plans showed impressive gains in their overall star ratings, in part because of a strong quality push following poor performance and a drop in star ratings last year for PDPs, according to 2017 star quality ratings data released by CMS on Oct. 12.

Overall, average PDP star ratings increased from 3.40 in 2016 to 3.55 for 2017. However, that’s still lower than the average 3.75 rating PDP plans earned in 2015. At the same time, results for Medicare Advantage prescription drug (MA-PD) plans stayed stable for last year.
Lynn Nishida, R.Ph., area vice president for pharmacy at Gallagher Benefit Services, Inc., says the 2017 star ratings reflect a push by plan sponsors to improve care and disease management.

“This includes working to improve health outcomes at the provider level, incentivizing quality of care and providing tools to help close care gaps in patient populations, and demonstrating the ability to drive improvements in four key areas: quality improvement, utilization management, member services and credentialing,” she tells DBN.

The results also indicate the more assertive approach plan sponsors are taking with vendors who provide clinical and outreach programs, Nishida says.

“In outsourcing these programs, there was little to no risk or incentives on the vendor’s part to improve or keep up with star metric cut points or thresholds established by CMS,” she says. “Plans that outsource these programs are now negotiating, if not demanding, performance guarantees, as well as overseeing these programs more intensely with month-to-month dashboards during the year to ensure improvements and proactive course correction that will keep them on track for 4- to 5-star ratings for key, individual metrics.”

PDPs now are making more careful strategic decisions about how to invest their efforts to improve star ratings, Nishida says. “Overall, plans are taking a more proactive approach in monitoring star cut points and forecasting where they will end up by the end of the year.”

Caroline Pearson, senior vice president for policy and strategy at Avalere Health, tells DBN that PDPs were able to maintain and increase their star ratings “particularly by focusing on those measures associated with high-risk medications. Plans have also benefited from investment in quality-improvement activities.”

Generally, plans have shown improvements in several clinical measures, including medication therapy management and medication adherence for diabetes, Pearson says. “In addition, plan performance has improved with fewer beneficiary complaints.” The most notable decrease, in terms of the average star ratings by measure, was in PDP performance on the appeals measures, she says.

### 2014–2017 Part D Rating Distribution for PDPs

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<th>Overall Rating</th>
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* The average Star Rating is weighted by enrollment. PDP = Prescription Drug Plan.

According to CMS, 49% of the 55 total PDP contracts that will be active and rated in 2017 received 4 or more stars. Close to 41% of PDP enrollees are in contracts with 4 or more stars, nearly a 9-percentage-point increase compared with 2016. “One company in particular — Health Care Service Corporation — had an increase from 3 to 4 stars in their PDP star rating, which drove some of the increase,” Pearson notes.

Only two PDPs received a Low Performing Icon for 2017, compared with six in 2016.

For 2017, six PDPs earned 5 stars, up from two plans for 2016 (see table, p. 48). Eight PDPs earned 4.5 stars, and 13 earned 4 stars. Four of the six 5-star plans have been in the program for 10 years or more, and only one has been in the program for fewer than five years, indicating that experience helps plans improve their ratings. Half of the 4.5-star plans and most of the 4-star plans also have been in the program for 10 years or more.

Still, Nishida notes that only one of the six PDPs that earned 5 stars this year — Tufts Insurance Co. — was a 5-star plan last year, “indicating that it is getting harder for PDPs to maintain their 5-star status.”

The other five PDPs earning five stars for 2017 are Excellus Health Plan, Inc.; Blue Cross Blue Shield of Michigan Mutual Insurance Company; Anthem Insurance Co. and the Blue Cross and Blue Shield plans of Massachusetts, Rhode Island and Vermont; the Blue Cross and Blue Shield Northern Plains Alliance; and Dean Health Insurance, Inc.

The ratings come as the data show more beneficiaries are enrolling in plans with 4 or more stars, Nishida says. “This lends additional support to perhaps beneficiaries beginning to weigh more of the pros and cons in selecting 4- and 5-star plans in shopping for a Medicare Part D plan — marketing efforts by the health plan as a 4-5 star plan may be paying off.”

Obviously, star ratings for health plans and PDPs are one of several considerations beneficiaries use in choosing a plan. Since some websites allow beneficiaries to shop and compare plans based on star ratings, those plans with less than a 4-star rating may not even be considered, even though Nishida says price — and the member’s estimated out-of-pocket costs — will continue to be the primary factor in plan choice.

“All things being equal — by way of premiums, deductibles and plan benefits — the star ratings could serve as the tipping point that the beneficiary uses in their final decision-making process,” she says.

Virtually all of the individual measures for PDPs improved for 2017, with the exception of the Call Center measure, which looks at foreign language interpreter services and TTY availability. The average 2017 PDP star rating specifically for this measure dropped from 4.0 to 3.6.

Nishida says other “areas of challenges for PDPs” include:

◆ Drug plan quality improvement.
◆ Beneficiary access to needed prescriptions.
◆ Rating of drug plans.

“For these measures, PDPs have not yet been able to bounce back as fast on improving the average star metric to as high as they were in 2014 or 2015,” she says.

For MA-PD plans, meanwhile, CMS’s star ratings indicate stable results compared with last year: Out of 364 total contracts, 14 plans achieved a 5-star rating, 67 achieved a 4.5-star rating.
rating, and 97 achieved a 4-star rating. The average MA-PD star rating for 2017 is 4.00, close to even with a 4.03 average rating for 2016 and up slightly from a 3.92 average rating in 2015.

According to CMS, approximately 49% of MA-PDs that will be active and rated in 2017 earned 4 stars or higher for their 2017 overall rating, and close to 68% of MA-PD enrollees are in contracts with 4 or more stars. More than 90% of MA-PD enrollees are in contracts with 3 or more stars.

Contact Nishida at lynn_nishida@ajg.com and Pearson via spokesperson Frank Walsh at fwalsh@messagepartnerspr.com.

**PDPs Made Big Gains in 2017 Star Ratings, But Results Were Mixed for Large MA Firms**


2017 star quality ratings data for Medicare Advantage and Part D plan sponsors posted by CMS on Oct. 12 showed great gains by Prescription Drug Plans (PDPs), which had fallen in their average overall star rating last year. And while the new ratings indicate stable performance among MA Prescription Drug (MA-PD) plans, the results were mixed for some large MA insurers who were banking on payment incentives and high stars to tout during the Annual Election Period that begins on Oct. 15.

“Overall, what you see in the numbers is a surprising amount of stability in the measures, some stagnation in performance, and then real volatility at the measure level in how the plans are doing,” observes John Gorman, founder and executive chairman of Gorman Health Group, LLC (GHG). For instance, there was no change in 13 measures over a three-year period, “so we still have a lot of work to do and the progress is slowing,” he tells MAN.

While there was a large jump in the portion of MA-PDs earning a star rating of 4 or higher last year — 49% vs. 40% of contracts in 2015 — that percentage was unchanged for 2017, with 178 active MA-PD contracts rated 4 or higher, according to the new data. Weighted by enrollment, nearly 68% of MA-PD enrollees are in contracts with 4 or more stars, down slightly from 71% for 2016. The average overall star rating for MA-PDs in 2017 is 4.0, compared with 4.03 in 2016.

The total number of MA-PD contracts earning a 5-star rating rose from 12 in 2016 to 14 and included six new sponsors. Two of them, Physicians Health Choice and Optimum Healthcare, have Special Needs Plans (SNPs). This is the first year the ratings included an adjustment to account for the socioeconomic status of enrollees, although industry observers say it’s too soon to determine whether the concerns of plans serving highly disadvantaged populations were alleviated by the interim adjustment.

**Sizable Portion of Seniors Enroll in Top Plans**

Cara Kelly, vice president in the policy practice at Avalere Health LLC, says the ratings demonstrate that “there continues to be a large proportion of Medicare beneficiaries both in MA and to a lesser extent in PDPs enrolled in the higher-rated plans,” and that the slight decrease in the overall average rating for MA-PDs “doesn’t seem particularly notable” given how close the rates are to last year.
“That really in our view reflects the importance of the star ratings, particularly for the MA plans, since there are some pretty substantial payment incentives tied to high performance,” Kelly tells MAN. “And so I think the growth and enrollment in the top rated plans was probably due in some part to beneficiaries choosing those plans and in large part to plan attention and focus on this given these very important payment incentives that allow them to offer benefits that are richer or allow them to reduce cost sharing, which really attracts beneficiaries.”

Gorman points out that some plans were seriously impacted by 124 plans being rated for the first time, and most of them came in at 2.5 to 3 stars. “Whenever you have a significant increase in the denominator of a program that’s scored on a curve, it basically drives all of the scores to the left,” he tells MAN. “So plans that were 4 stars comfortably last year did relatively the same performance-wise and lost that fourth star. And for them, that’s a calamity, like Humana [Inc.].” Moreover, 34 plans that were above four stars dropped below 4 for 2017, and “these are the folks that got hurt the worst because they already booked the revenue,” he asserts. “It’s different if you’re 3.5 trying to get over 4 to get the bonus than having it and losing it.”

One “big winner” in the recent ratings was UnitedHealth Group, which achieved its goal of having at least 80% of members in plans rated 4 stars or higher by 2018. The percentage of United members enrolled in 4-star or higher plans went from 21% in 2016, to 63% in 2017 and to 84% in 2018, based on membership as of September 2016, observed Cowen & Co. securities analyst Christine Arnold in an Oct. 12 research note. “Improved star ratings should help to sustain momentum in [United’s] Medicare Advantage book,” she wrote.

Anthem, Inc. also showed significant improvements and expects to have 51% of members in 4-star or higher plans in 2018, up from 23% in 2017 and 9% in 2016, noted Arnold. The insurer’s overall average rating for 2017 is 3.67, up from 3.6 in 2016. And at 91%, Aetna Inc. continues to have the highest percentage of members enrolled in 4-star or higher plans, up from 90% in 2016, according to Arnold.

Cigna Corp. and Humana, meanwhile, both demonstrated significant reductions in their respective percentages of members enrolled in four-star or higher plans, which the

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<th>% Weighted By Enrollment</th>
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Average Star Rating: 3.86
| 2014  | 3.92 |
| 2015  | 4.03 |
| 2016  | 4.00 |

*The average Star Rating is weighted by enrollment. MA-PD = Medicare Advantage Prescription Drug plans.

companies partly attributed to comprehensive program audits. Approximately 20% of Cigna’s MA customers are expected to be in a plan with a star rating of 4 or higher in 2018, the insurer noted in an Oct. 12 filing with the Securities and Exchange Commission. “We do not believe that these Stars ratings reflect the quality offerings Cigna HealthSpring provides to beneficiaries. We will work fully with CMS through their process to ensure that they have the information and analysis needed to calculate final Stars ratings that more accurately reflect our performance,” stated Cigna. “We remain committed to our partnership with CMS and to delivering quality products and services to seniors, while working to mitigate the impact these Stars ratings could have on our offerings in 2018.”

And Humana for the second year saw its enrollment-weighted average drop. Based on membership as of July 31, 2016, the percentage of enrollees in 4-star plans or higher declined to approximately 37%, or 1.17 million members, from 78%, or 2.15 million members, in the prior year, according to an Oct. 12 press release from the insurer. The company said that decline “does not take into account certain operational actions the company intends to take over the coming quarters to mitigate any potential negative impact of these published ratings on Star bonus revenues for 2018” and the ratings “do not fully reflect the company’s focus on quality care for its members.”

**PDPs Made Significant Improvements**

PDPs made greater strides, earning an average overall star rating of 3.55 for 2017, up from 3.4 in 2016 but down from 3.75 in 2015. Approximately 49% of PDPs (27 contracts) that will be active in 2017 earned 4 or more stars, compared with 40% of PDPs (24 contracts) in 2016. Weighted by enrollment, nearly 41% of enrollees are in contracts with 4 or more stars, up from 32% the prior year, despite a continual drop in the number of PDP contracts since 2013, noted CMS. Six PDPs earned a 5-star rating, up from two the year before, but only one — Tufts Insurance Co. — held on to that status from 2016. And the number of PDPs receiving a Low Performing Icon dropped from 6 last year to just 2 for 2017.

PDPs demonstrated improvements on all four intermediate outcome measures as well as the process measure, Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews, which was new for 2016 and jumped from an average rating of 2.3 to 2.8 for 2017.

View the star ratings fact sheet and complete data at [http://tinyurl.com/zhcqjq5](http://tinyurl.com/zhcqjq5).

Contact Arnold at Christine.arnold@cowen.com, Gorman via Kristina D’Ambrosio at kdambrosio@gormanhealthgroup.com or Kelly via Frank Walsh at fwalsh@messagepartnerspr.com.

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**CMS Revisits Lowering of Star Ratings, Alters Plan Finder to Reflect Sanctions**


After a surprising policy suspension that gave sanctioned plans like Cigna Corp. a break on their star quality ratings, CMS now is considering several adjustments to the star ratings program to account for sanctions and other actions, and floated three potential changes by...
attendees at its Medicare Advantage and Part D fall conference on Sept. 8. At the same time, the agency has made a series of tweaks to the Medicare Plan Finder (MPF) tool, highlighting which plans are under an enrollment sanction and adding more information about the sanction itself. Officials explained that this is all part of the agency’s overall goal of improving transparency for enrollees and ensuring that star ratings accurately reflect both the plan sponsor’s performance and the enrollee experience.

CMS earlier this year stunned many industry observers when it issued an unusual memo temporarily halting its policy of lowering the highest star rating to 2.5 stars for contracts under an enrollment sanction (MAN 3/24/16, p. 1). The decision came via a March 8 memo, not publicized by CMS, less than two months after high-star-rated Cigna was notified of its indefinite suspension on marketing and enrollment for new members in both its MA and Prescription Drug Plan products.

During a listening session at the Sept. 8 conference, Sarah Gaillot, an analyst with the Medicare Drug Benefit and C&D Data Group, explained that CMS is taking a step back and weighing the impact of sanctions, audits and civil money penalties (CMPs) on star ratings and is now considering the following options for adjusting the ratings:

1. **Reinstating the reduction of sanctioned contracts’ overall star rating.** For example, CMS could deduct a value from the overall rating vs. an automatic downgrade.
2. **Developing a star ratings audit measure** that could be based on audits conducted in the past few years; and
3. **Revising the current Beneficiary Access and Performance Problems (BAPP) measure,** which is based on sanctions, CMPs and Compliance Activity Module (CAM) data, to reflect the varying sizes of the CMPs. This option would reflect the issues identified as well as contract enrollment, explained Gaillot.

CMS is encouraging feedback on the proposed changes in advance of its annual fall release of the request for comments on proposed star ratings enhancements and the draft call letter due out in February 2017. One commenter pointed out during the session that while the BAPP measure currently includes the audit performance and enforcement action, there are still other measures that could be impacted, and recommended that CMS find a way to “consolidate everything into one measure because the plans are being disproportionately affected.”

“CMS deserves credit for wanting feedback on the linkages between star ratings and a sanction,” Michael Adelberg, a former top CMS MA official who is now senior director at FaegreBD Consulting, suggests to MAN. “Last spring’s memo caught some people by surprise. This is a good opportunity to clarify.”

**CMS Aims for More Transparency on MPF**

Meanwhile, in an effort to ensure that seniors are able to make informed choices about their MA and Part D coverage options this fall, CMS has made a series of tweaks to the MPF to provide more clarity around sanctions. Currently, plans that are under sanction are removed from the MPF completely except for beneficiaries who are currently enrolled in that contract. Members are still able to view the information; however, the plan finder does not provide beneficiaries with much information about the sanction itself.

Alice Lee-Martin, another analyst with the Medicare Drug Benefit and C&D Data Group, explained that partly in response to feedback from beneficiary advocacy groups suggesting
that the MPF promote more transparency around enforcement actions, CMS has made several changes to the tool. Effective Oct. 1, these modifications include:

- **Users not currently enrolled in a sanctioned plan will be able to view sanctioned plans on the MPF.**
- **The MPF will feature a red Sanctioned Plan button, which users can click to see more information about the specific sanction.** A pop-up window will open displaying text that will explain the plan is under sanction for violating Medicare rules and cannot accept enrollments at this time, and will provide a link to the CMS sanction notice that was sent to the sponsor, explained Lee-Martin.
- **CMS will continue to suppress data such as cost information, premiums, deductibles and overall star ratings for sanctioned plans** to beneficiaries who are not enrolled in a sanctioned plan. However, CMS will display the pricing-related information for current enrollees of a sanctioned plan.
- **CMS has updated the star ratings tab to include the red Sanctioned Plan button and will not display a sanctioned plan’s overall star rating,** but will still allow enrollees to view the summary domain and measure-level stars.

CMS is requesting that comments on the star ratings adjustments be sent by Sept. 23 to PartCDQA@cms.hhs.gov. View a replay of the Sept. 8 conference at www.cms.gov/live.

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**CMS Suspension of Automatic Star-Rating Cuts for Sanctioned Plans Stuns Observers**


An unusual March 8 memo from CMS is causing both astonishment and thankfulness in portions of the Medicare Advantage industry because of its potential impact on the star quality rating system and its effect on plan revenues and member benefits. Other industry segments, along with a few securities analysts and consumer advocates, wondered why CMS was taking an action that so directly helped one large insurer, Cigna Corp., which otherwise would have had its high star ratings — and the upcoming bonuses tied to them — sharply cut back as of March 31.

The March 8 memo, not publicized by CMS, suspended the automatic and major reductions in star ratings that Cigna and another much smaller MA plan would incur if they are still under the agency’s so-called “intermediate sanctions” as of the end of this month.

“The suspension is a significant positive for Cigna,” wrote Barclays securities analyst Joshua Raskin in a March 8 research note. “Candidly, this is the first time that we can remember CMS making such a significant policy change for a specific carrier” without doing it via a proposed or final rule.

**What Caused Star-Sanction Change?**

“We are discouraged by CMS’ announcement, which diminishes accountability and transparency related to plan sanctions,” Stacy Sanders, federal policy director at the Medicare Rights Center, told *Kaiser Health News.* If CMS was concerned that the requirement mandating a reduction to 2.5 stars for a plan undergoing the agency’s intermediate sanctions...
was too severe for a high-star-rated MA organization (MAO), she said, it could have elected to drop star ratings by just one star as it does for low-rated plans rather than suspend star reduction for such sanctioned plans entirely.

CMS in a Jan. 21 letter from its Medicare Parts C and D Oversight and Enforcement Group imposed an indefinite suspension on Cigna’s marketing and enrollment for new members in both its MA and stand-alone Prescription Drug Plan (PDP) products (MAN 1/28/16, p. 8). The agency cited a host of severe deficiencies — including in coverage determinations and handling of appeals and grievances — and said that Cigna has a “longstanding history of noncompliance.”

CMS May Have Feared Market Destabilization

Observers queried by MAN did not attribute the policy change to an agency desire to show largesse to Cigna, which stands to gain between $213 million and $350 million from the shift based on estimates by securities firms. But some of the observers do suggest that the size of Cigna, which had more than 550,000 MA enrollees as of CMS’s February monthly data, might have led the agency to fear that slashing the insurer’s ratings and thus indirectly its benefits for 2017 might have destabilized substantial portions of the MA market during the Annual Election Period (AEP) this fall.

Specifically, Cigna/HealthSpring had more than 350,000 members as of the February data in five MA plans rated four stars and above for 2016, including 52,485 in a five-star plan in Arizona that was one of only 12 nationwide to earn this top honor plus nearly 150,000 in 4.5-star plans. And Cigna’s situation takes on greater significance because it has agreed to be acquired by Anthem, Inc. in a still-pending deal (MAN 7/30/15, p. 5).

CMS for its part did not cite the potential impact on the AEP as a reason for the policy change. The four-paragraph memo from Jennifer Shapiro, acting director of the Medicare Drug Benefit and C & D Data Group, sent out only via the electronic Health Plan Management System (HPMS) and not publicized, instead emphasized the changing star-ranking achievement background. “When CMS announced this policy for the 2012 Star Ratings,” Shapiro wrote, “relatively few contracts achieved ratings of 4 stars or above and fewer than 30% of Medicare Advantage plan enrollees were in plans offered under these highly rated contracts. Today, 49% of MA contracts, representing 71% of MA plan enrollees, have achieved ratings of 4 stars or above, compared to an estimated 17% in 2009.”

In response to the draft 2017 Call Letter issued Feb. 19, the memo said, CMS received “multiple comments” suggesting that it revise the mandatory-stars-reduction policy for “sanctioned contracts.” Shapiro added that “commenters raised several concerns, including one noting that high-rated contracts can be subjected to a more severe penalty than low-rated contracts” since the higher ones could lose multiple stars while low-rated contracts could lose only one star.

MAOs have made this argument before, but their pleas have become more urgent in recent years. Among the commenters seeking a change was not only the America’s Health Insurance Plans trade group but also CAPG, which represents the risk-bearing provider groups that have become big players in MA.

After having considered the comments “and the growth in the number of highly rated contracts, CMS agrees that we should reassess the impact of intermediate sanctions on the calculation of star ratings,” the memo said. So “effective immediately and on a prospective basis, CMS is suspending the automatic sanctions-based reduction in Star Ratings,”
according to Shapiro. She wrote that CMS will propose a revised approach in the draft 2018 Call Letter, which comes out in February 2017.

Action Was Needed Before March 31

The reason for announcing the change through an HPMS memo, Shapiro continued, was so that the policy change could be applied prior to the March 31 deadline for making adjustments to a contract’s star ratings based on its sanction status. March 31 is the date CMS’s Medicare Plan Finder and Quality Bonus Payment (QBP) determinations are adjusted for such changes, so the memo before that date allows CMS to give this information to MA sponsors before those data updates without changing its “established timelines,” Shapiro wrote.

This means that CMS will use the original 2016 star ratings, unless changed via CMS’s appeals process, to determine QBP eligibility for 2017. The whole timetable is very significant since there appears to be next to no chance that Cigna would be able to convince CMS by March 31 to lift the intermediate sanctions. Aetna Inc., which was hit with those MA and PDP sanctions in April 2010, did not have them lifted until June 2011, and intermediate sanctions for Health Net, Inc. lasted from November 2010 to August 2011.

Consultants, including two former CMS MA officials, had mixed reactions to the CMS memo. Avalere Health Vice President Tom Kornfield, who joined the company from CMS in 2015, says the impact of the major lowering of Cigna’s high star ratings that would have occurred were it not for the memo could have had a significant impact on beneficiaries, including loss of benefits and even possible loss of some of its MA plans.

But Kornfield also tells MAN “I’m not certain I understand why CMS didn’t propose or mention this” issue in the draft Call Letter. “That would have been an appropriate vehicle” for such a policy change, while doing it via an HPMS memo seems “out of left field,” he asserts.

Asked if there might have been political factors involved in the decision since nearly half of the next AEP falls during the final weeks of campaigning in a big election year when an adverse impact on MA premiums and benefits could be an issue, Kornfield replies that he doesn’t know. He points out it’s possible Cigna has been making rapid progress on remediating the deficiencies and that the policy change could be one way of recognizing that. The only other MA plan that appears now to be in MA intermediate sanctions is Ultimate Health Plans, Inc. in Florida (MAN 3/10/16, p. 8), but Cigna is far larger.

The issue CMS is addressing in the memo seems to be a legitimate one, suggests Michael Adelberg, a former top CMS MA official who now is senior director at FaegreBD Consulting. “As more beneficiaries come into 4- and 5-star-rated contracts,” he tells MAN, “the impact of dropping those contracts to 2.5 grows. This is not just an issue for the MAO, but also for the beneficiaries when the MAO submits bids based on the payment reductions. Large numbers of beneficiaries with reduced benefits creates difficulties for everyone.”

Asked about making the change via an HPMS memo, Adelberg replies, “This was not a ho-hum HPMS memo. Most HPMS memos offer new technical or administrative guidance. This one was about policy.”

Is there the danger of a mixed message on the importance of CMS sanctions when the agency does something like this? “With or without a star-ratings reduction,” responds
Adelberg, “the potential of missing an open-enrollment season forces appropriate attention from the sanctioned MAO.”

View the CMS March 8 memo by visiting the March 15 From the Editor entry at MAN’s subscriber-only Web page: www.aishealth.com/newsletters/medicareadvantage. Contact Kornfield at tkornfield@avalere.com and Adelberg at michael.adelberg@faegrebd.com.

‘45-Day Notice’ Proposes Small Pay Hike, CAI for MA Duals Plans, 50% EDS Phase-in


The best news for Medicare Advantage plans in the Advance Notice of 2017 payment rates and policies released late Feb. 19 was that, unlike in the same document the prior two years, CMS is proposing a pay increase — averaging 1.35% — based on cost trends. New data show Medicare medical costs will rise about 3% in 2017, close to the same figure CMS actuaries projected last December (MAN 12/17/15, p. 4). And there was other good news in the 225-page document, which includes the preliminary 2017 MA and Part D Call Letter, in the form of no proposed new restrictions on use of home health risk assessments (HRAs) or preferred cost sharing pharmacies.

There also was mixed news in the so-called “45-day notice” in the proposed adoption — with no phase-in — of a new payment system for risk adjustment. That would help plans with lots of full Medicare-Medicaid dual eligibles and hurt plans with primarily partial duals and those with few duals. Several industry actuaries and consultants tell MAN that the overall 2017 revenue impact of those risk-adjustment changes for MA plans will be worse than the 0.6% drop CMS estimated.

They perhaps were equally concerned by how much CMS is proposing to accelerate the phase-in of the MA encounter data system (EDS) for use in risk adjustment. MA plans have submitted the data since 2012, but CMS didn’t begin using them for risk adjustment until a 10% phase-in this year. The agency proposes to boost that to 50% in 2017, with the remaining 50% coming then from the longstanding risk adjustment payment system (RAPS), which accounts for 90% of MA risk adjustment in 2016. Consultants say numerous MA plans still have far to go until they have good encounter data, so the accelerated phase-in could be troublesome for them.

Such issues notwithstanding, “it could have been a lot worse,” says Bill MacBain, senior vice president, strategy at Gorman Health Group, LLC, speaking of the overall 45-day notice. The stock market seemed to agree, as there were sizable after-trading-hours gains Feb. 19 for publicly held insurers, especially duals-plan sponsors.

The reaction was somewhat more qualified when it comes to plans serving primarily low-socioeconomic-status (SES) beneficiaries. CMS proposed adopting the Categorical Adjustment Index (CAI) option from the two alternatives it had considered for offering short-term relief on star quality ratings to low-SES plans (MAN 12/3/15, p. 1). Pat Dunks, a principal and consulting actuary at Milliman, says it appears that “only a handful” of MA plans would get a “substantial improvement” (e.g., one percentage point) in pay from CAI,
while a few plans would have pay cuts and the remaining 97.5% of plans would have essentially unchanged pay.

But looking at CMS’s related proposed change in the overall MA risk-adjustment system — including the establishment of six pay classifications depending on the preponderance of full and partial duals and/or disabled persons among a plan’s enrollees (MAN 11/12/15, p. 1) — there would be a much bigger impact, the actuaries find.

**Pay for Full Duals Could Rise 8%**

For MA Special Needs Plans for duals (D-SNPs), for example, “it’s a windfall,” Tim Courtney, senior consulting actuary at Wakely Consulting Group, tells MAN. And Dunks calculates the pay hike for plans with only full duals as an “8% to 9% bump.” On the other hand, he notes, MA plans without many duals could get a 1% to 2% pay cut, and Courtney says that for the average MA plan (with 7% or 8% duals) his firm sees, the pay reduction would be about 1%.

Asked whether the new system, if adopted in the final 2017 pay notice CMS will issue April 4, is likely to spur many more D-SNP entries, Dunks tells MAN it is a “potential game changer” for D-SNPs but probably not till 2018 since the 2017 application deadline has passed.

Dunks, like several other consultants queried, expresses “mild surprise” that CMS proposed to implement the entire new system in 2017. Brian Collender, specialist leader in the health actuarial practice at Deloitte, who also was surprised, calculates a 9% to 10% pay hike for plans with just full duals and perhaps a 1.5% cut for other MA insurers. He tells MAN CMS might be thinking that the one-year moratorium in the Affordable Care Act’s health insurer fee that is paid by most MA plans could offset part of the negative impact on the non-duals MA insurers.

The way CMS is treating this one-year moratorium, enacted late last year, concerns some of the actuaries. As Dunks notes, CMS in the 45-day notice and conference call about it Feb. 19 made the “strong suggestion” that plans use the additional revenue they will have as a result of the moratorium to improve benefits for their MA members. The potential problem with this, as Courtney explains, is that the fee moratorium may be for just one year. So if MA plans improve benefits for 2017, they might be precluded from cutting benefits when the tax goes back on by CMS’s limit on the allowable Total Beneficiary Cost (TBC) increase, which remains at $32 for 2017, he explains.

MacBain points out that CMS did not discuss the TBC impact in relation to the insurer-fee moratorium in the 45-day notice. “This needs to be fixed in the final notice,” he asserts.

**Proposed EGWP Changes Will Draw Complaints**

Another aspect of the 45-day notice that may need to be changed, according to MacBain, relates to payments for Employer Group Waiver Plans (EGWPs) in MA. CMS in effect is proposing that EGWPs, which tend to have higher bids as a percentage of benchmarks than do non-EGWPs and thus cost the government more per enrollee, not be allowed to bid in the same way they have. The agency instead basically wants to pay them the lesser of the individual MA bid or the benchmark for the service area involved, MacBain says.

“There will be a lot of complaining about that,” he predicts. EGWPs, which have gained enrollment in recent years (to about 3 million now) as employers found them to be an attractive alternative to other forms of retiree coverage, serve a different population than do...
non-employer MA plans, contends MacBain. The EGWP enrollees may be high utilizers, he says, since they are accustomed to having good employee benefits, so there could be good reasons that their bids are higher.

Collender says the potential change could deter those insurers that haven't yet offered EGWPs and could create more incentives for the development of private exchanges instead.

The proposed shift in the calculation of MA risk adjustment in 2017 to being based 50% on EDS could have a big impact. Risk scores could be substantially lower, several consultants agree, because MA plans are still learning all the complexities and edits involved with the approximately 200 MA EDS data fields.

While three actuaries tell MAN they were surprised that CMS is proposing to go from 10% to 50% EDS in one year, and Courtney expects “pushback” from MA sponsors that fear a big adverse impact, two of the actuaries predict CMS won't back off. One reason for this, they say, is that the greatly expanded use of MA EDS is tied in with other changes CMS hopes to make in the future, including discontinuing use of coding-intensity adjusters. The 50% EDS phase-in also may be related to the absence of an HRA-restriction proposal for 2017, they say, because CMS can use encounter data to determine the validity of diagnosis codes obtained via HRAs.

But the same EDS requirement also leads some consultants to question CMS’s assumption in the 45-day notice that MA plans will be able to add 2.2% to their pay in 2017 via upward coding creep. Coupled with the complex ICD-10 coding system requirement that took effect last October, says one consultant, MA plans are unlikely to get as much improvement from better diagnosis coding next year as they have in recent years.

There was a lot of discussion but no actual proposal in the 45-day notice to cope with the big MA financial problems in Puerto Rico (MAN 4/23/15, p. 6). As consultant Stephen Wood, a principal in Clear View Solutions, explains to MAN, “basically CMS rejected the Puerto Rico argument that the fee-for-service-based benchmarks [used in determining MA payment rates] do not accurately reflect the true costs” there. And even if it could find evidence of FFS underreporting, “CMS maintains that it doesn’t have the regulatory authority to make the changes that are requested” by Puerto Rico MA participants, he notes. However, he adds that the agency “did leave a small door open” as a result of finding that there is a far higher percentage of beneficiaries with zero FFS claims in Puerto Rico than on the mainland U.S.

In other parts of the 45-day notice, CMS proposed:

◆ A 2017 FFS normalization multiplier that would lower MA pay by 0.1%.
◆ Keeping the increase in the coding intensity adjustment at just the required 0.25% annual minimum.
◆ Applying TBC restrictions to each plan in cases when benefit plans are being consolidated, a potential negative for MA sponsors.
◆ No changes in Part D risk corridors.

View the 45-day notice and Call Letter at http://tinyurl.com/jxojarz. Contact MacBain at wmacbain@gormanhealthgroup.com, Courtney at timc@wakely.com, Dunks at pat.dunks@milliman.com, Collender at bcollender@deloitte.com and Wood at stephen.wood@clrviewsolutions.com. ◇
Trade Groups Cite Doubts About CMS’s Two Options for Adjusting Stars for SES


Trade associations representing Medicare Advantage plans serving disadvantaged populations expressed numerous reservations about the two options CMS last month requested comments on for offering interim relief on star quality ratings for such plans (*MAN 12/3/15, p. 1*). In their comment letters filed by the Dec. 10 CMS deadline, the associations all thanked CMS for seeking ways to help these financially ailing plan sponsors in the short run, but said they had numerous questions remaining even after a Dec. 3 one-hour CMS conference call on the two options. And they generally voiced doubts about how effective either option would be in granting meaningful relief.

At least one association alluded to another potentially troublesome issue that came up in the agency’s responses on the conference call. Regardless of which option CMS chooses, affected plans may not be able to preview their star ratings for the next year until significantly later in the year than they do now. And if CMS adopts the Indirect Standardization (IS) option, it needs to be based on the current year’s data, adding more uncertainties to the process for insurers.

The reservations expressed in the comment letters could lead CMS not to adopt either option. That would parallel action it took this year when it dropped a proposal to reduce the weighting of certain stars measures that plans serving populations with low socioeconomic status (SES) do poorly on after the vast majority of the comments it received were critical of that approach (*MAN 4/9/15, p. 1*).

In their comments, stakeholders praised aspects of both the IS option and the Categorical Adjustment Index (CAI) alternative, which was favored by the Medicare Payment Advisory Commission (MedPAC), among others. CAI uses a factor added to or subtracted from a contract’s overall and/or summary star rating to adjust within-contract disparities based on an MA contract’s percentages of low-income subsidy (LIS)/Medicare-Medicaid dual eligible (DE) and/or disabled beneficiaries. IS instead would adjust a subset of individual star ratings scores to account for within-contract LIS/DE and/or disability status differences not related to plan quality and would use an “expected measure score” as its key standard.

MedPAC, in its Dec. 2 letter from Chairman Francis (Jay) Crosson, M.D.,

| CAI and Indirect Standardization Differ In Approach Across Key Parameters |
|-----------------------------------------------------------|---------------------------------------------------------------|
| **Method 1: Categorical Adjustment Index (CAI)** | **Method 2: Indirect Standardization** |
| Star Measures Adjusted | Subset of 16 HEDIS/HOS/PDE measures | Subset of 16 HEDIS/HOS/PDE measures |
| Data Measurement Year | Current year or prior year | Current year |
| Adjustment Level | Adjusts based on mean difference in Star Rating (adjusted rating vs. observed rating) for groups of contracts | Adjusts measure scores at contract level |
| Method | Linear regression to calculate impact of dual eligible/disabled on measure score | Logistic regression to calculate impact of dual eligible/disabled on measure score |
| Adjustment | Groups of contracts with similar levels of duals/disabled | Contract |

said it has “two concerns” regarding the IS approach. One of them, according to the letter, is that several of the measures for which CMS and MedPAC “found population-based differences are measures that are reported based on medical record sampling (generally 411 records)” or on which some contracts report based on sampling while others report based on “the universe of enrollees to whom the measure applies.” The question MedPAC has, explained Crosson, is whether such a sample “yields a sufficient number of records for a subpopulation within a contract to be able to determine a valid measure result for the subpopulation.”

He said the second concern is that “if all enrollees within a subpopulation are used to determine an all-contract expected rate, then undue weight would be given to contracts that report based on the universe of enrollees to whom the measure applied.” An MA contract with far more diabetic enrollees than another plan has would yield a disproportionate impact on the key calculation of the expected rate, Crosson observed.

By contrast, he asserted, the CAI “is administratively less complicated but still addresses the concerns plans have raised.” So “we would thus urge CMS to implement this approach as an interim measure” given CMS’s desire to offer interim relief, he added.

**ACAP Seeks Examples on Duals Plans**

The Association for Community Affiliated Plans, on the other hand, did not take a position on the two options, contending that more information from CMS is needed before ACAP can determine how well the two approaches “adjust for SES.” Specifically, wrote ACAP CEO Meg Murray in the comments letter, it would like more detail and numeric examples to show this, “particularly for contracts with majority or 100% dual [i.e., Medicare-Medicaid dual eligibles] enrollment.”

Murray said ACAP also would like estimates of how star ratings would change for contracts under each approach and the “strengths and weaknesses” of each. And the letter asked for clarification on whether plans would need a minimum number of LIS/dual or disabled enrollees in order to receive an adjustment via either approach. Of ACAP’s 61 “safety net” plan members, 15 are in the ongoing CMS-backed demonstration for duals.

On the CAI, Murray wrote, ACAP asks to clarify whether institutionalized beneficiaries would be included in the adjustment. And on the IS option CMS should “clarify to what extent, if at all, the subset of adjusted measures would change year-to-year” and whether insurers “should expect both upside and downside adjustment” since in a few stars measures plans with high proportions of disabled duals outperform other plans, she said.

Consulting firm Avalere Health LLC prepared an analysis of the two options (see table, p. 60) as part of a stars-changes webinar Dec. 8. In this webinar, Christie Teigland, Ph.D., an Avalere vice president, said that more information is needed even after CMS’s Dec. 3 call on the options, especially on how the average national rates the agency would use in the options are calculated. But she added that for many of the stars measures, any adjustments would be “pretty small” under either option. This is especially true since the 16 star measures that could be adjusted account for only 27% of potential stars scores, according to Teigland.

All of those points figured prominently in the comments about the proposals submitted by two other associations, America’s Health Insurance Plans (AHIP) and the SNP Alliance, which represents MA Special Needs Plans.
The lengthy SNP Alliance comments centered on “four principal concerns” it had about the proposed options. The first one, the alliance wrote, is that “both options may only minimally account for underlying disparities in star performance for plans specializing in care of poor Medicare beneficiaries.” It based that conclusion on research showing that adjusting for just dual and/or LIS status “does not capture the full amount of within-contract differences in stars performance.”

Moreover, according to the alliance, “The number of measures targeted for inclusion in both models represents a subset of measures that research suggests are impacted by SES. We strongly urge CMS to apply the interim adjustment to all measures in the star rating system related to patient care” while excluding measures such as customer service and appeals rates “directly related to plan activity.”

Alliance Fears Interim Policy Could Stay

The alliance also asserted that “neither option incorporates many of the factors shown in the research to be of greatest importance in accounting for social determinants of health” such as income, education, occupation and social supports. The third concern was that CMS has not furnished sufficient information for plans to understand and fully evaluate the feasibility and impact of the options despite the details given in the agency’s Request for Comments (RFC) and call. Finally, and perhaps underlying its other three reservations, the alliance said it “is concerned that the interim proposal could easily become long-term policy without a more aggressive approach to address social determinants of health.”

Its recommendations, based on these reservations, included that “CMS should risk adjust quality measures in the star rating system for beneficiaries’ socio-demographic characteristics beginning in 2018.” For interim relief, it suggested that CMS maximize the number of measures selected for adjustment, with “at a minimum” using all 12 measures showing “a negative performance gap for dual eligible members, as well as consideration of neighborhood poverty and physician shortage factors.”

AHIP’s comments, sent by Mark Hamelburg, senior vice president, federal programs, begin by calling the proposals “an important step forward.” But AHIP too says it is being hampered in commenting by the lack of “detailed analyses of the potential impact of each approach.” While CMS has said it would be furnishing more details on both approaches when it releases the draft 2017 MA pay notice and Call Letter in February, Hamelburg noted, “we strongly urge the agency to release this information as far in advance of that time as possible,” along with estimates of the “total impact of each approach on the program as a whole.”

The comments go on to raise concerns about the time factors, pointing out CMS said in the Dec. 3 call that the options would require additional data-processing steps, resulting in a “compressed timeframe” for MA and Part D plans’ preview of their star ratings.

But AHIP’s strongest comments related to the potential impact on “high performing plans.” Citing comments in both the RFC and Dec. 3 call that the proposed adjustments could reduce star ratings for some plans, Hamelburg wrote that “we strongly disagree with this approach. No contract should be penalized if the adjusted Part C or D Summary Rating or Overall Rating calculated under the adopted approach would be lower than the unadjusted rating.” The Social Security Act “does not require changes to the star ratings system to be budget neutral,” he added.
Those comments may have stemmed from responses made in the CMS call by Elizabeth Goldstein, Ph.D., director of consumer assessment and plan performance in the agency’s Medicare Drug Benefit and C&D Data Group. She said that the adjustments could be either positive or negative and that CMS in any interim relief would be able to make adjustments only for those factors it has sufficient data on.

This raises a question articulated by Avalere Vice President and former CMS official Tom Kornfield during that firm’s webinar. “The question is whether it’s better to do nothing than to do this,” he asserted, and to wait for the permanent relief CMS may be able to offer in 2018 after it gets more data. Avalere’s sense of the options outlined in the RFC, he added, is “this doesn’t really solve the problem.”

View the CMS Dec. 3 presentation on the stars adjustment options by visiting the Dec. 17 From the Editor entry at MAN’s subscriber-only Web page: www.aishealth.com/newsletters/medicareadvantagenews.

Stars Memo Offers Two Complex Options to Aid Plans Serving Low-SES Members


There seems to be no question about what CMS regarded as the most important issue it needed to deal with in its annual star ratings enhancements memo, which the agency disseminated Nov. 12. CMS spent more than seven pages outlining two complex approaches it is considering for adjusting 2017 star ratings to take into account the impact of socioeconomic status (SES) and disability.

While industry executives and consultants tell MAN they appreciate the hard work and desire to help that CMS is exhibiting in the proposals, they have doubts about how effective either option would be. “I’m afraid there’s no silver bullet here,” says, for instance, Christie Teigland, Ph.D., senior director of statistical research at health data analytics firm Inovalon, Inc., which did a major study of the issue using data and other input from six MA sponsors and two trade groups last year (MAN 11/6/14, p. 1).

There were some other major subjects in the new stars memo, which came from Amy Larrick, acting director of CMS’s Medicare Drug Benefit and C & D Data Group, and for which comments are due by Dec. 10. Those subjects included a warning that the agency would be scrutinizing plans’ medication therapy management (MTM) programs for possible evidence of biased data. And CMS said it would remove two measures from use in scoring star ratings for 2017 and is making methodology changes on six other measures. But the agency is not adding any star scoring measures for 2017, and even a new adjustment it reports considering for Puerto Rico contracts in some ways involves the same kind of SES-related issues at the apparent forefront of its stars agenda for 2017 and beyond.

In general, Melissa Smith, senior consultant at Gorman Health Group, LLC, tells MAN, she is “not terribly surprised” by anything in the stars memo. She calls the absence of new stars measures for 2017 “welcome news” for health plans. They also will be heartened by CMS’s temporary removal, outlined in the memo, of the measure on improving bladder control, which MA sponsors generally have not done well on, she says.
Stars Options Raise Many Questions

The other temporarily withdrawn measure, on high risk medication (HRM), is in a different situation since 330 plans were rated at four stars or above on it, Smith notes. And one of the reasons CMS gave for this planned withdrawal is that “there is a significant association between dual eligible/low income status and HRM use...We recommend that the measure developers further review this measure to better understand the associations.” In the meantime, CMS apparently wants to finalize its own interim approach to the SES/disability issue in stars.

Its major new step toward that end, outlined after the agency cautioned that “CMS’ work is not complete,” is presenting two alternative approaches to adjusting for such disadvantaged status.

The first one, which CMS called the Categorical Adjustment Index, is a factor added to or subtracted from a contract’s overall and/or summary (i.e., MA or Part D) star rating to adjust “for the average within-contract disparity” based on the contract’s percentages of low-income subsidy (LIS)/dual eligible (DE) and/or disabled beneficiaries. “This approach is equivalent to case-mix adjustment or patient-mix adjustment,” CMS explained before detailing the specific ways it could be derived.

The second option, which CMS called Indirect Standardization, “would be applied to a subset of the individual star ratings measure scores.” The adjustment would focus, according to the memo, on the “within-contract LIS/DE and/or disability status difference while allowing for the existence of true differences in quality by contract.” The method would calculate an “expected measure score” using the percentages of these disadvantaged groups per measure “multiplied by the adjusted mean national performance for each subgroup.” Then, CMS added, “each contract would be judged against its expected performance,” and this observed-to-expected ratio would be multiplied by the adjusted national mean performance for all Medicare beneficiaries to get an “adjusted measure score.”

The problem on both approaches, according to Teigland, is that there is “lots of missing information we’d need to evaluate.” Among details she says are needed to assess the options are how many and which star measures the methods would be applied to. Teigland calls the first option a “much more blunt approach” than the second, which she reports “leaning toward” preferring. But if the first option used a broader set of risk-adjustment measures — such as adjustments for age, gender, income and prevalence of chronic conditions — that “would help,” Teigland says.

Whichever option CMS selects (and it raised the third possibility of a hybrid of the two), “my gut is it will not have much impact” on plans serving highly disadvantaged populations, Teigland tells MAN. She fears this could be a step back toward the only-small-changes-needed position CMS took Sept. 10 in unveiling its new research on the impact of duals/LIS status on stars performance (MAN 9/17/15, p. 1), before both the agency’s acting administrator and Center for Medicare director indicated about a month later that meaningful aid is on the way (MAN 10/29/15, p. 1). But Teigland also is quick to acknowledge that CMS seems to be really trying to give short-term relief to plans that need it.

Inovalon is formulating questions to ask Larrick about the approaches, Teigland says, and she praises the responsiveness of Larrick’s group in the past. However, regardless of how quick it is in answering, Inovalon will not be able to do all the needed modeling before...
the Dec. 10 comment deadline, Teigland says. So she’s hoping indications that CMS is willing to keep making changes until the advance 2017 MA payment notice and Call Letter is released in mid-February are correct.

John Baackes, CEO of L.A. Care Health Plan, which serves many duals and other disadvantaged populations, looks at the big picture on the proposed adjustments and calls it “good news.” While there weren’t sufficient useful data before for CMS to make pay adjustments for these populations, this is changing, he suggests. And he tells MAN that the kinds of options CMS is considering in the memo could have a “material” beneficial impact on L.A. Care’s finances.

In looking at other portions of the stars memo, Smith sees as significant the degree to which CMS intends in the coming years to introduce more measures related to medication. Among the new measures the memo lists as under consideration for 2018 and beyond, for example, are ones related to “medication reconciliation post discharge,” statin therapy for patients with cardiovascular disease and statin use in persons with diabetes. CMS said all of those will be added to the display page (i.e., not used for actual stars calculations) for 2017 and that it intends to use them for computing star ratings in 2018.

Moreover, the agency said it will add three measures related to use of opioids from multiple providers or at high dosage in persons with cancer to the display page in 2018, although it does not yet recommend adding them for actual star ratings because of several methodology concerns. It has plans for a new measure on antipsychotic use in persons with dementia for similar reasons.

The agency also is concerned about how plans are acting on existing medication measures related to MTM. “We intend to review and apply any relevant MTM program audit findings that could demonstrate sponsors’ MTM data were biased, outside of the Data Validation results,” the memo said. CMS explained that it suspects such sponsor activities as “attempts to restrict eligibility from their approved MTM programs, encouraging beneficiary opt-out of MTM programs within the first 60 days, or CMRs [i.e., Comprehensive Medication Reviews] that do not meet CMS’ definition per guidance. CMS may perform additional audits or reviews to ensure the validity of data for specific contracts. Without rigorous validation of star ratings data, there is risk that CMS would reward contracts with falsely high ratings.”

Smith says what her consulting firm is hearing is that some plans are “working aggressively to manage the denominator” in MTM calculations such as by removing member opt-outs from it to get higher fractions for purposes of boosting star-measure scores. She advises plans to review their “work flows and decision trees” on MTM, especially regarding opt-out criteria, to ensure they are meeting beneficiary needs and the goals of CMS.

The agency took a full page in the 27-page memo to discuss an “additional adjustment for contracts in Puerto Rico,” which does not have an LIS, to identify beneficiaries there whose incomes would qualify for an LIS designation in the mainland. This would be used in conjunction with whichever option CMS selects on the SES/disabled issue to try to help beneficiaries and plans there. The memo also points to “unique challenges that Puerto Rican contracts face in improving medication adherence” because beneficiaries there have high out-of-pocket costs. CMS considered reducing weights of the three Part D medication adherence measures in Puerto Rico but rejected that when its modeling indicated the highest ratings would be unchanged, and asked for other proposals “to account for the barriers” there.
CMS Study Findings Could Lead to Modest Stars Relief for MA Plans Serving Duals


The results of a new study commissioned by CMS and unveiled at its fall Medicare Advantage and Part D conference Sept. 10 could open the way to some modest star-ratings relief for MA plans serving Medicare-Medicaid dual eligibles and stand-alone Prescription Drug Plans (PDPs) serving Low Income Subsidy (LIS) beneficiaries. But there is no certainty about when or even if such aid, likely in the form of case-mix adjustment, will be coming.

And if it does come, the comments of the study author and the CMS official overseeing the research suggest it figures to be smaller-scale than these plans have hoped and that the author of Inovalon, Inc.’s big multi-payer study on the same subject last year (MAN 11/6/14, p. 1) contends is warranted.

Such qualifiers notwithstanding, the new research conducted by RAND Corp. for CMS does move further toward supporting contentions of plans serving primarily persons with low socioeconomic status (SES) that the CMS star quality ratings affect them negatively on some star measures. The differences RAND found, though, generally were not large, and there was one measure on which the duals/LIS beneficiaries actually fared better than non-duals/non-LIS in the same contract.

CMS: SES Has ‘Small’ Stars Impact

Elizabeth Goldstein, Ph.D., director of the Division of Consumer Assessment and Plan Performance in CMS’s Center for Medicare and the co-presenter with RAND researcher Cheryl Damberg, Ph.D., at the conference in Baltimore, did not make any commitments during the presentation. “The impact is small for most measures, so overall the number of measures that might need change is small,” she said in response to a question. Goldstein added that in CMS’s annual late-fall memo requesting comments about contemplated star-rating changes, the agency will include “any proposals we have for moving forward in the interim.” Changes on some “consensus measures” developed by other organizations and used by CMS in the star ratings, she noted, “could take [more] time.”

Among the things CMS will be “trying to determine,” she added in response to another question, is “whether [some star] measures need case-mix adjustment” to reflect the different pattern of star scores for duals/LIS and for disabled MA and PDP beneficiaries versus other beneficiaries.

Findings Won’t Delay MA Contract Terminations

“Stay tuned,” Goldstein said, for further developments on this. However, she also said that the new research findings would not prevent CMS from starting to terminate contracts
of consistently low-star plans in 2016, as it has been intending. The differences observed among beneficiary populations in the new research, she explained, were not large enough to explain the poor results of the MA plans CMS intends to terminate with overall star scores of three or below for three consecutive years.

The idea for the new research, she said in her presentation, came after CMS reported “mixed” initial findings about whether the current star-ratings structure discriminates against plans serving duals and LIS beneficiaries, as industry groups have contended (MAN 9/11/14, p. 7). Goldstein asserted that there was a need to identify what factors drove different stars performance since the agency doesn’t want to “mask” variation that is due to real differences in quality.

So CMS hired RAND to conduct a study looking in depth not just at how LIS/duals beneficiaries in plans fared on star ratings but also at how the disabled population in those plans fared, especially since a Medicare Payment Advisory Commission analysis this year suggested disability might be the bigger driver of star-rating differences, Damberg noted. Of the MA population, she said, 5.8% is both LIS/duals and disabled, 11.3% is LIS/duals only and 9.1% is disabled only. She added that MA contracts tend to have either a very high or very low percentage of LIS/duals beneficiaries, while most of the contracts have less than 25% of enrollees classified as disabled.

The RAND research distinguished “between-contract” from “within-contract” disparities in stars scores. This was based on what Damberg contended is the likelihood that between-contract differences “represent true differences in quality between plans and are not appropriate for adjustment,” while within-contract differences are between subgroups for a particular contract and “may be appropriate for adjustment.” Said Damberg: “We don’t want to be adjusting away true disparities in contracts.”

One way to address within-contract disparities, she continued, is via case-mix adjustment so that CMS can compare contracts as if they are serving the same mix of beneficiaries. In this way, according to Damberg, there is no incentive for providers not to treat “low-performing members.”

**Measures Studied Were Mainly HEDIS**

To look in depth at the need for such changes, RAND examined stars measures that weren’t already case-mix adjusted and that were basically beneficiary-level rather than plan-level focused. The organization came up with 16 such clinical indicators, the bulk of them HEDIS measures, although there also were three from the Pharmacy Quality Alliance regarding medication adherence. RAND used 2014 star-ratings data based on 2012 measurement year patient-level data for its study.

The research, Damberg explained, first looked at the likelihood of receiving the recommended care or outcomes, as measured by an “odds ratio.” It found that on 11 HEDIS measures, LIS/duals had a negative odds ratio compared with non-LIS/duals in 10 of the measures, although some of the differences were small, and for adult body mass index assessment the odds ratio was positive. For disabled beneficiaries, the pattern was similar, but there were two positive measures among the 11 plus one measure not assessed because it already, in effect, takes disabled status into account.

On the five other measures, four had negative odds ratios for LIS/duals (versus three for disabled), although the differences tended to be smaller, and the ratio on risk of falling was
strongly positive. Looking at all 16 measures, Damberg said, “there were more measures that demonstrated a positive association with disability” than had a positive association with LIS/duals status.

RAND went on to find that for the LIS/duals category, the negative odds-ratio effect was not a result of other patient characteristics such as age, gender or diagnosed condition as reflected in the Hierarchical Condition Category (HCC) coding used in MA.

So then the focus moved to within-contract disparities, and RAND found most of those differences were “relatively small,” albeit mainly negative for the LIS/duals as opposed to “a bit more mixed” for the disabled. LIS/duals performed poorer versus non-LIS/duals to a greater extent than disabled beneficiaries performed poorer versus nondisabled, Damberg noted.

While overall “it’s rather a mixed story,” she asserted, in eight of the 16 measures LIS/duals performed poorer than non-LIS/duals by more than two percentage points on the median (see table). This compared with only one measure on which the LIS/duals portion fared better by more than two percentage points and seven in which it performed very close to the non-LIS/duals contingent, as shown by a median percentage difference of between minus two and plus two points.

Summarizing the results, Damberg said “the research to date has provided scientific evidence that there exists an LIS/dual/disability effect for a small subset of the star ratings measures. The size of the effect is small in most cases and not consistently negative.”

The question now becomes what CMS will do with the findings. Since the impact found is small for most measures, said Goldstein in response to a question, the number of measures that might need change is small.

Even a small change, though, can be big for some plans, especially ones “on the cusp” of a three-star versus four-star rating since four stars means they’ll get star-rating bonuses, says Richard Bringewatt, chair of the SNP Alliance trade group, many of whose member plans serve duals and the chronically ill. He praises CMS for doing the study but tells MAN he is “perplexed” by the characterization of the differences found as “small.” The findings are “potentially huge” and add to the evidence that SES affects plan quality performance as measured in stars, he maintains.

There now is a “clear basis,” Bringewatt says, for using risk adjustment or stratification for plans serving these disadvantaged populations to “control for complexity of care circumstances.” He says CMS is likely to propose some new action regarding this in the fall, but won’t predict what kind and says “we’re open to all kinds of approaches.”

“CMS’ research shows a clear disparity in quality scores for people with low incomes or disabilities. This is consistent with our plans’ experience,” Meg Murray, CEO of the Association

### Summary of Within-Contract Differences in Star Scores for LIS/DE and Disabled Medicare Advantage Plan Members

<table>
<thead>
<tr>
<th>Median Percentage Point Difference Between Groups</th>
<th>Number of Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIS/DE – non-LIS/DE</td>
<td>Disabled – non-Disabled</td>
</tr>
<tr>
<td>Less than (-2)</td>
<td>8</td>
</tr>
<tr>
<td>Greater than 2</td>
<td>1</td>
</tr>
<tr>
<td>Between (-2) and 2 (inclusive)</td>
<td>7</td>
</tr>
<tr>
<td>Total Measure Count</td>
<td>16</td>
</tr>
</tbody>
</table>

Note: LIS/DE=Low Income Subsidy recipients/Medicare-Medicaid dual eligibles. Overlap of measures means found in both LIS/DE vs. non-LIS/DE and disabled vs. non-disabled.

* The readmissions measure is excluded as it is already adjusted for several factors that could determine disability status. SOURCE: Presentation by Elizabeth Goldstein, Ph.D., of CMS and Cheryl Damberg, Ph.D., of RAND Corp. at CMS MA/Part D fall conference, Sept. 10, 2015.
for Community Affiliated Plans (ACAP), tells MAN. “Although CMS described the within-contract effect as small,” Murray adds, “the research shows that the effect is there.”

Christie Teigland, Ph.D., senior director, statistical research at Inovalon and author of its big report last year on this subject, also takes issue with CMS’s depiction of the within-contract differences as “small.” The duals/LIS plans had lower performance in 12 of the 16 measures studied, she notes, and in some of these odds calculations the differences are “big.” She cites as an example breast-cancer screening, which the new RAND study found duals/LIS plan members 31% less likely to get.

Her major criticism of the CMS-RAND research is that it doesn’t go “far enough,” including fully covering the health consequences of living in poverty as the Inovalon study did. Teigland also tells MAN that the CMS study’s conclusion that the HCC diagnosis code is not related to stars performance is “not what we found at all,” citing renal disease as an example.

The case-mix adjustment CMS may be leaning toward might account for only 30% to 80% of plan stars-performance differences, according to Teigland, since there would be no real adjustment for poverty itself. But she does acknowledge it could help “plans in the middle” on star ratings.

View the CMS-RAND presentation on the new study by visiting the Sept. 17 From the Editor entry at MAN’s subscriber-only Web page: www.aishealth.com/newsletters/medicareadvantagenews. Contact Murray at mmurray@communityplans.net, Bringewatt at rich@nhpg.org and Teigland at cteigland@inovalon.com. ♦