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CLIENT ALERT

CMS Seeks Comments on Proposed Enhancements and Modifications to the Star Ratings for Medicare Advantage and Part D Prescription Drug Plans

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December 2014

On November 21, 2014, the Centers for Medicare & Medicaid Services ("CMS") released a Request for Comments on proposed enhancements and modifications to the 2016 Star Ratings for Medicare Advantage ("MA") and Part D Prescription Drug ("Part D") plans and on reforms designed for the 2017 Star Ratings and beyond. Comments submitted by 5 p.m. (ET) on December 17, 2014, will be considered by CMS as it finalizes the draft 2016 Call Letter in February 2015. Submitted comments will inform CMS's finalization of the methodology for the 2016 Star Ratings, which will be announced in the final 2016 Call Letter to be published in April 2015.

The proposed changes reflect CMS's ongoing campaign to improve the Medicare Star Ratings, which are designed to help MA and Part D beneficiaries compare health plans and providers based on quality and performance and to reward top-performing plans. The Request for Comments addresses changes to the methodology for calculating Star Ratings as well as the ratings' underlying quality measures.

This proposal is of particular interest given recent statements by CMS that it will delay acting on its authority to terminate contracts with consistently low Star Ratings as well as CMS's discussions regarding whether to adjust outcome measures for sociodemographic factors.

CMS Delays Acting to Terminate Plans with Low Star Ratings

CMS has calculated and published Star Ratings for certain Medicare managed care plans—since 2007 for Part D plans and 2008 for MA plans.[1] In April 2012, CMS finalized regulations authorizing CMS to terminate MA organizations and Part D sponsors that failed to achieve, over a period of three years, at least a three-star plan

[1] *See* Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013 and Other Changes; Final Rule, 77 FR 22072, 22108 (Apr. 12, 2012).

rating.[2] The regulations explicitly exclude from the calculation Star Ratings issued prior to September 2012.

CMS expressed its intent to use this termination authority earlier in 2014, stating that, with the issuance of the contract year 2015 Star Ratings in October 2014,[3] CMS would have the requisite three years of Star Ratings issued after 2012 on which CMS could act to terminate under this authority.[4] However, in September 2014, CMS issued a notice to select MA and Part D sponsors stating that CMS would not exercise this authority to terminate contracts for 2015. Nevertheless, CMS intends to use this authority at the end of 2015 to terminate low-performing contracts meeting the three-year criterion.[5]

CMS does not discuss the basis for its decision not to act on its termination authority. Insight may be gained, though, from the fact that, at approximately the same time as CMS stated it would defer acting to terminate low performers, CMS also released a Request for Information regarding the impact of dual-eligible enrollment on an MA or Part D plan's ability to achieve higher performance scores on quality measures.[6] Stating that plan sponsors had suggested that enrollment of disproportionate numbers of dual eligibles impacted their ability to achieve higher ratings under the Star Ratings System, CMS requested input in the form of research on "whether dual status causes lower MA and Part D measure scores," or "[a]lternatively, . . . research that demonstrates that high quality performance in MA or Part D plans can be achieved in plans serving dual eligible beneficiaries and how that performance level is obtained." CMS also references research completed by an Expert Panel under the National Quality Forum ("NQF"), which recommends that outcome measures be adjusted for sociodemographic factors under certain conditions.[7] Research specifically looking at MA and Part D has shown that "organizations focusing on low-income individuals encounter systematic challenges due to the characteristics of the populations they serve," and that "[t]hese challenges result in lower ratings in the Star System, even for

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[2] *Id.*

[3] *See* 2015 Part C & D Medicare Star Ratings Data (v10 23 2015), http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

[4] CMS, Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, pages 56-57, April 7, 2014, http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf.

[5] CMS, "Suspension of Termination of Low Performing Icon (LPI) Plans for 2015," September 8, 2014, http://op.bna.com/hl.nsf/id/myon-9ntnrm/$File/terminatema.pdf. It is interesting to note that this document does not appear to be posted on CMS's public website.

[6] CMS, Request for Information – Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees, September 8, 2014, http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Request-for-Information-About-the-Impact-of-Dual-Eligibles-on-Plan-Performance.pdf.

[7] National Quality Forum, Risk Adjustment Based on Socioeconomic Status or other Socioeconomic Factors, August 15, 2014, http://www.qualityforum.org/Publications/2014/08/RA_SES_Technical_Report.aspx.

MA plans that are effectively serving low-income beneficiaries, threatening the viability of these plans and endangering the health of the most vulnerable."[8]

Proposed Methodological Changes

Changes to the Calculation of MA and Part D Ratings

CMS has introduced changes designed to improve the method by which summary Star Ratings are assigned to lessen the risk of "misclassification"—where the generated ratings do not align with a contract's true performance. CMS noted that corrective measures are required as certain features that were previously implemented to enhance the simplicity and transparency of the quality rating system have increased the potential for measurement errors.

CMS has proposed to remove the predetermined four-star measure thresholds for the 2016 Star Ratings. These thresholds have been used as a tool to distinguish between high-performing contracts that receive four or five stars and low-performing contracts that receive one, two, or three stars. Although some plan sponsors have embraced these thresholds as providing useful targets for quality improvement, CMS maintains that the thresholds increase the risk of misclassification. Also, data suggests that plan sponsors tend to achieve more significant improvement in MA and Part D measures that are not subject to the predetermined thresholds.

As an alternative to eliminating the four-star thresholds, CMS suggested that the thresholds could be modified by annual improvement percentage increases ("IPI") that reflect national trends in star improvements. Under this scenario, if the national average score for a measure increased over an annual period, the applicable four-star threshold would similarly be increased through the IPI.

CMS also stated that it will maintain the use of "reward factors" for contracts that exhibit consistently high performance. These reward factors add set levels of value to contracts at the high end of the rating scale that have low variation and high mean performance in their individual measure scores.

Contracts with Low Enrollment

Beginning with the 2016 Star Ratings, contracts with more than 500 enrollees will be admitted in the ratings system and eligible for 2017 quality bonus payments ("QBPs"). This represents a significant expansion, as contracts with less than 1,000 enrollees had previously been excluded from the Star Ratings process. CMS has determined that contracts with 500 or more enrollees produce enough data to be reliably measured and that their inclusion will improve transparency and provide more information to beneficiaries.

[8] Howard Weiss and Sara Pescatello, Medicare Advantage: Star Systems Disproportionate Impact on MA Plans Focusing on Low-Income Populations, September 22, 2014, http://healthaffairs.org/blog/2014/09/22/medicare-advantage-stars-systems-disproportionate-impact-on-ma-plans-focusing-on-low-income-populations/.

Data Integrity

CMS is taking steps to enhance the quality measures and controls designed to ensure the accuracy and reliability of data used for Star Ratings. Contracts that are found to have submitted biased or incorrect data are vulnerable to having their measure rating reduced to one star. To decrease the risk of rewarding contracts with falsely high ratings, CMS is developing more comprehensive reviews of measures using organization or plan sponsor-reported data. Among other things, CMS plans to increasingly use MA and Part D data validation results as part of a comprehensive review of plan sponsors' operational systems and to verify submitted data.

Proposed Changes to Quality Measures in 2016

New Part D Measure for Medication Therapy Management: A new measure, titled "Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (Part D)," has been introduced, which would measure the percentage of beneficiaries who qualify for the Medication Therapy Management ("MTM") program and who received a comprehensive medication review ("CMR") with a written summary. Part D sponsors are forbidden from restricting their MTM eligibility criteria in an effort to restrict the number of MTM-qualifying beneficiaries and reduce the plan sponsors' obligation to provide CMRs.

Reintroduced Measures: CMS intends to reincorporate the following three measures in the 2016 Star Ratings: Breast Cancer Screening (Part C); Call Center – Foreign Language Interpreter and TTY Availability Measures (Part C & D); and Beneficiary Access and Performance Problems (Part C & D).

Retired Measures: Based on recently released guidance on the treatment of blood cholesterol published by the American College of Cardiology ("ACC")/American Heart Association ("AHA"), the following measures will be removed from the Star Ratings: Cardiovascular Care: Cholesterol Screening; Diabetes Care: Cholesterol Screening; and Diabetes Care: Cholesterol Controlled.

Temporary Removal of Measure: The Improving Bladder Control (Part C) measure will be temporarily removed from the Star Ratings while the National Committee for Quality Assurance ("NCQA") implements changes to the measure and the underlying survey questions in the Health Outcome Survey.

Methodological Changes for Star Ratings: CMS is considering a host of methodological modifications that impact the following measures:

- Controlling Blood Pressure (Part C)
- Plan Makes Timely Decisions About Appeals (Part C)
- Plan All-Cause Readmissions (Part C)
- Osteoporosis Management Women Who Had a Fracture (Part C)

- Complaints About the Health/Drug Plan (CTM) (Part C & D)
- Improvement Measures (Part C & D)
- Appeals Upheld (Part D)
- Medication Adherence (for Diabetes Medications and Hypertension (RAS Antagonists)) and Diabetes Treatment (Part D)
- Medication Adherence (Diabetes Medications, Hypertension (RAS Antagonists), and for Cholesterol (Statins)) (Part D)
- Obsolete NDCs (Part D)
- Consumer Assessment of Healthcare Providers and Systems ("CAHPS") Survey (Part C & D).

Proposed Changes to Quality Measures in 2017 and Beyond

Measures on the CMS Display Page: Organizations and plan sponsors may continue to preview their data through the display measures presented on the CMS website. While the display measures are not part of the Star Ratings, data on measures transitioned to the display page will continue to be monitored and poor scores on these measures are subject to CMS compliance actions. CMS will continue to provide advance notice of any measures that may be used as future Star Ratings.

Proposed Changes to Existing Measures:

- *Medication Reconciliation Post-Discharge Measure*: The NCQA is proposing to expand the coverage on this measure from solely Medicare Special Needs Plans to all of MA and to expand the target age range from adults over 65 years of age to adults over 18 years of age. These changes are intended to improve the measurement of post-discharge care coordination and patient safety for MA beneficiaries.
- *CAHPS Measures*: CMS will be conducting an experiment to assess whether to update the core CAHPS 4.0 Health Plan Survey to reflect the CAHPS 5.0 Health Plan Survey.
- *MPF Price Accuracy*: The Medicare Plan Finder ("MPF") Price Accuracy measure is slated to be updated by expanding the scope of prescription drug event ("PDE") claims subject to review and by including PDE-reported Pharmacy Service Type codes along with the MPF Pharmacy Cost data to identify retail claims. These modifications will increase the number of PDEs eligible for inclusion in the Price Accuracy Scores while continuing to identify only retail claims. The proposed changes may also be applied to mail-order claims. CMS also is considering changes to the methodology governing the calculation of price accuracy to better reflect the frequency of accurate price reporting.

Potential New Measures: The Request for Comments provides advance notice of the following series of measures that may be incorporated into the Star Rating process:

- *Care Coordination Measures*: Information on plans' care coordination efforts have previously been gathered from CAHPS surveys. CMS is considering new approaches to measuring plans' coordination approaches and the agency is requesting comments on how MA encounter data may be used to develop these measures.
- *Asthma Measure Suite*: NCQA will be conducting tests on the following three asthma measures: Use of Appropriate Medications for People with Asthma; Medication Management for People with Asthma; and Asthma Medication Ratio. CMS will be evaluating the effects of expanding these measures to include adults over the age of 65.
- *Depression*: NCQA is currently testing the following three HEDIS measures that assess depression along the continuum of care: Depression Screening and Follow-Up; Utilization of the PHQ9 for Monitoring of Depressive Symptoms; and Depression Remission, Response or Treatment Adjustment at 6 Months.
- *Hospitalizations for Potentially Preventable Complications*: NCQA is testing a risk-adjusted measure to assess the rate of hospitalization for complications of chronic and acute ambulatory care sensitive conditions.
- *Statin Therapy*: Two statin therapy measures are being developed to focus on patients with clinical atherosclerotic cardiovascular disease and patients with diabetes.
- *High Risk Medication* ("HRM"): CMS is monitoring the American Geriatric Society's review of revisions to the Beer's criteria, which may necessitate future changes to the Pharmacy Quality Alliance ("PQA") measure specifications and medication list.
- *Opioid Overutilization*: The PQA is considering the following three measures that examine multi-provider, high-dosage opioid use among cancer-free individuals over 18 years of age: Opioid High Dosage; Multiple Prescribers and Multiple Pharmacies; and Multi-Provider, High Dosage.

Measurement Concepts: CMS is welcoming feedback on new measures and methodological improvements to improve the Star Ratings. Specifically, CMS has invited comments on:

- Alternative levels of evaluation (e.g., plan benefit package ("PBP") or parent organization) to understand how provider networks may differ in terms of configuration and quality across PBPs.
- Potential new measures.

- Whether to expand the measurement period for the complaints about the Health Plan/Drug Plan measures and Appeals Upheld (Part D) measure to 12 months to increase the number of measured enrollees. This is in response to complaints from plan sponsors with low enrollment who are concerned that certain measures may be sensitive to small measure denominator size.
- Whether organization-specific cut points are appropriate for certain Part D measures.

CMS will consider comments submitted by 5 p.m. (ET) December 17, 2014, in drafting its proposals for the 2016 Star Ratings to be included in the draft 2016 Call Letter. The draft 2016 Call Letter is expected to be issued in February 2015, and stakeholders will then have a second opportunity to comment on the proposed 2016 Star Ratings methodology through the draft Call Letter public comment process. Epstein Becker Green is available to assist with drafting and submitting comments to the proposed changes to the Star Ratings methodology both now and/or through the Call Letter comment process.

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This Client Alert was authored by **Helaine I. Fingold** *and* **John S. Linehan***. For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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