2nd Update on Medicare Part C & D 2012 Plan Ratings

September 8, 2011

Part C & D User Group Call

Session Overview

- Call Letter 2012 Update
- HPMS Plan Preview #2
- Measure Updates
- Weighting of Measures
- Adjustment for Sanctioned Contracts
- Low Performing Contracts
- Future Directions
- MTM Update

Plan Ratings Strategy

- The current Plan Ratings strategy, laid out in the 2012 Call Letter is consistent with the Three Part Aim (better care, healthier people/healthier communities, and affordable care) with measures spanning five broad categories:
  - Outcomes
  - Intermediate outcomes
  - Patient experience
  - Access
  - Process

2012 Call Letter

Potential Enhancements	
Weighting of measures	Implemented for the 2012 Plan Ratings. See slide 18.
Reducing the ratings for serious compliance issues.	Implemented for the 2012 Plan Ratings. See slide 21.
Rewarding contracts for quality improvement	Delayed. See slide 24.
Controlling for concentration of providers in a geographic area	Delayed. See slide 25.

2012 Call Letter (cont.)

Potential New Measures	
All-cause Readmissions (Part C)	Implemented
Advising Smoker and Tobacco Users to Quit (Part C)	Not implemented (reliability issues)
Body Mass Index (Part C)	Implemented
SNP-specific Measures : 3 Rates (Part C)	Implemented
Measures from Hospital IQR (Part C)	Delayed
Voluntary Disenrollment (Part C and D)	Implemented
Transition Process (Part D)	Delayed
Medication Adherence : 3 Rates (Part D)	Implemented

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Average Stars for New Measures

Plan All-Cause readmissions	3.34
Care for Older Adults – Medication Review (SNP)	3.54
Care for Older Adults – Functional Status Assessment (SNP)	2.81
Care for Older Adults – Pain Screening (SNP)	2.72
Adult BMI Assessment	2.81
Members Choosing to Leave the Plan	3.22 (MA) ; 3.66 (PDP)
Medication Adherence – Cholesterol	3.03
Medication Adherence – Diabetes	3.05
Medication Adherence – Blood Pressure	3.05

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2012 Call Letter (cont.)

- Retirement of Measures
  - “CMS will be examining the quality of the data variation among plans and the measure’s accuracy and validity before making a final determination about inclusion.”

Measures Retired for 2012

Measures to be posted on CMS Display page http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp)
Appropriate Monitoring for Pts Taking Long Term Meds (Part C)
Osteoporosis Testing (Part C)
Doctors who Communicate Well (Part C)
Testing to Confirm Chronic Obstructive Pulmonary Disease (Part C)
Call Center – Customer/ Beneficiary Hold Time (Part C and D)
Call Center – Information Accuracy (Part C and D)
Drug Plan Provides Pharmacists with Up-to-Date and Complete Enrollment Information about Plan Members (Part D)
Completeness of the Drug Plan's Information on Members Who Need Extra Help (Part D)

2nd Plan Preview Period

- September 8th – September 16th
- Will include Part C & D measure data, star assignments for each measure, domain, summary and overall level (as applicable) by contract
- In addition to technical notes, cut points for the star values will be available

2nd Plan Preview Period (cont.)

- Please carefully review the Technical Notes, understand changes from 2011, and preview the data and star assignments in HPMS before contacting CMS with questions or data issues

Technical Notes

- Technical notes combine information for the Part C & D Plan Ratings
- Comments will be accepted through 5pm ET on September 16th
- Send questions to these CMS mailboxes:
  - Part C measures: PartCRatings@cms.hhs.gov
  - Part D measures: PartDMetrics@cms.hhs.gov

Take advantage of the 2nd preview period!

2012 Plan Ratings Go Live

October 12, 2011

Additional Opportunity to Learn

- CMS 2011 Medicare Advantage & Prescription Drug Plan Fall Enrollment, Marketing, and Compliance Conference
  - September 20, 2011 from 8:30-5:30 in Hunt Valley, MD
  - Star Ratings Overview: Ask the Experts

Quality Improvement Strategies

- Plans' quality improvement (QI) strategies should focus on improving overall care that Medicare enrollees are receiving across the full spectrum of services
- QI strategies should not be limited to only the Plan Ratings measures
- Retired measures are still displayed publicly on cms.gov and monitored by CMS
- Poor scores on display measures are subject to compliance actions by CMS

Plan All-Cause Readmissions

- CMS will only use data for members 65+
- Final Rate = ((Observed/Expected)) NatAvgObs) 100, where:
  - Observed = Count of all 30-day Readmissions/Count of all Index Stays
  - Expected = (Count of Index Stays for one Age Group/ Count of Index Stays for all Age Groups) x Average Adjusted Probability for that Age Group, Summed across Age Groups
  - NatAvgObs = Count of all 30-day Readmissions/Count of all Index Stays, Averaged across Contracts

Care for Older Adults

- Only applies to contracts with SNP(s)
- Measures reported at Plan Benefit Package (PBP) level
- CMS combines reported rates for all SNP PBPs within a contract using NCQA-developed methodology for enrollment-weighting:
  - Final Rate = PBP Rate x (Total Eligible in that PBP/ Total Eligible in all SNP PBPs), Summed across SNP PBPs
- Relative distributions will be used (no predetermined thresholds), so distributions of summary and overall ratings do not change significantly and no adjustments are needed

Members Choosing to Leave the Plan

- Percent of members who chose to leave the plan (from Medicare's enrollment system)
- Calculated as the number of members who chose to leave the plan January 1, 2010 – December 31, 2010 divided by all members enrolled in the plan at any time during 2010
- The numerator includes beneficiaries with disenrollment codes 11, 13, 14 and 99 (documentation can be found in the Plan Communications Guide Appendices table H.6)
  - Most disenrollments are code 13 – disenrollment because of enrollment in a new plan

Members Choosing to Leave the Plan (cont.)

- Excludes members who left their plan due to circumstances beyond their control such as:
  - Members who moved out of the service area
  - Members affected by a service area reduction
  - PBP termination
  - LIS reassignments
  - Employer group members
  - Members in PBPs who were granted special enrollment exceptions

Weighting of Measures

- Previously all measures were weighted equally, suggesting equal importance
- We solicited feedback regarding weighting from stakeholders through a Request for Comments this spring
- Plan Preferences:

  Intermediate outcome > Outcome and Process > Patient Experience > Access
- Advocate Preferences:

  Intermediate outcome > Patient Experience > Outcomes and Process > Access

Methodology

- CMS created simulations based on stakeholder feedback; both plan and advocate recommendations tended to reduce rather than increase average star rates
- CMS also modeled various options that weight outcomes, intermediate outcomes, and/or patient experience more than other measures
- The 2012 Plan Ratings weights:

  Outcomes and Intermediate outcomes (3) >

  Patient Experience and Access (1.5) >

  Process (1)

2012 Plan Ratings Weights

- 2012 Plan Ratings will:
  - Weight outcomes and intermediate outcomes 3x as much as process measures
  - Weight patient experience and access measures 1.5x as much as process measures

Sanctions

- Contracts with serious compliance issues (i.e., CMS has issued enrollment sanctions), will have their 2012 Plan Ratings reduced:
  - Contracts under sanction with 3 or more stars will be automatically assigned 2.5 stars.
  - Contracts under sanction with less than 3 stars will receive a 1-star reduction.

Sanctions (cont.)

- CMS will evaluate and adjust Plan Ratings at two periods each year:
  - August 31: Plan Ratings will be adjusted for current sanction status on the Medicare Plan Finder (MPF), consistent with MPF schedule
  - March 31: Plan Ratings will be updated for contracts whose sanctions have ended and for contracts newly sanctioned, for quality bonus payment purposes and for updating the MPF

Low Performing Contracts

- Since 2011, CMS has marked plans rated less than 3 stars with a low performer icon.
- An additional cautionary message will appear on the MPF for beneficiaries selecting to enroll in these plans.
- 1-800 Medicare representatives will also reiterate the low performance of these plans to discourage enrollment.

Future Directions

- In support of the Three Part Aim, the emphasis on patient experience measures may increase in future years through CMS' weighting methodology.
- We are exploring options for rewarding contracts for improvement in future years.
  - Demonstration currently rewards MA contracts for improvement
  - Additional rewards for improvement may be delayed until end of demonstration to avoid duplication
- CMS will continue to provide details about these changes in the 2013 and future Call Letters.

Future Directions: Health Professional Shortage Areas (HPSAs)

- Our analyses found little association between percent of beneficiaries residing in areas with HPSAs and Plan Ratings
- Majority of U.S. is designated as a HPSA, so utility of control is unclear
- Concerns about the reliability/validity of HPSA designations have resulted in an Affordable Care Act requirement to re-visit the methodology
- Other measures of provider supply to be considered, but no adjustment for provider concentration will be made for 2012 Plan Ratings

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MTM Update

MTM Program Criteria

- Plan Finder will provide Medicare beneficiaries 2012 MTM program eligibility information.
- The information will be displayed via a link on the "Your Plan Results" page for MA-PDs and PDPs.
  - Link: *View Plan Medication Therapy Management (MTM) Program Eligibility Information.*
  - Clicking the link opens an Excel spreadsheet and Glossary posted on the CMS website.
- The table will list information from sponsors' CMS-approved 2012 MTM programs from the HPMS MTM Program Submission Module, including programs approved during the upcoming September update window.

Sample: Plan Results page: PDPs

Prescription Drug Plans

Prescription Drug Plans offer only drug coverage (Part D)

There are 31 plans in **21244** that match your preferences. View 10 View 20 View 50

View plan quality and performance ratings for all Prescription Drug Plans

View Plan Medication Therapy Management (MTM) program eligibility information [?]

Compare Plans

Sort Results By Lowest Estimated Annual Retail Drug Cost Sort

	Estimated Annual Drug Costs:[?]	Monthly Premium: [?]	Deductibles:[?] and Drug Copay[?] / Coinsurance:[?]	Drug Coverage: [?] and Drug Restrictions: [?]	Overall Plan Rating:[?]	
	Retail Pharmacy Status: Preferred-Network Annual: $0 Rest of 2012: $0 **Mail Order** Annual: $0 Rest of 2012: $0	$0.00 Drug: $0.00 Health:N/A	Annual Drug Deductible: $0 Health Plan Deductible: N/A Drug Copay/ Coinsurance: $2 - $90, 33%	All Your Drugs on Formulary: Yes Drug Restrictions: Yes Many Generics Lower Your Drug Costs	★★★½ 3.5 out of 5 stars	Enrollment begins November 15, 2010

Sample: Plan Results page: MA-PDs

Medicare Health Plans with Drug Coverage

Medicare Advantage Plans with Drug Coverage offer both health and drug coverage

There are 9 plans in **21244** that match your preferences. View 10 View 20 View 50

View plan quality and performance ratings for all Medicare Health Plans with Drug Coverage

View Plan Medication Therapy Management (MTM) program eligibility information [?]

Compare Plans

Sort Results by Lowest Estimated Annual Health and Drug Cost Sort

	Estimated Annual Drug Costs:[?]	Monthly Premium: [?]	Deductibles [?] and Drug Copay[?] / Coinsurance:[?]	Health Benefits: [?]	Drug Coverage: [?] and Drug Restrictions: [?]	Estimated Annual Health and Drug Costs:[?]	Overall Plan Rating:[?]	
	Retail Pharmacy Status: Network Annual: $660 Rest of 2012: $249 **Mail Order** Annual: $621 Rest of 2012: $223	$0.00 Drug: $0.00 Health: $0.00	Annual Drug Deductible: $0 Health Plan Deductible: $0 Drug Copay/ Coinsurance: $8 - $80, 33%	Doctor Choice: Plan Doctors Only Out of Pocket Spending Limit: $6,700 In-Network D V H	All Your Drugs on Formulary: Yes Drug Restrictions: Yes No Gap Coverage Lower Your Drug Costs	$3,650	**Caution** - This plan got **low ratings** from Medicare 3 years in a row	Enrollment begins November 15, 2010

Sample: MTM Definition

Medicare.gov

The Official U.S. Government Site for Medicare

Close Window

Plan Finder Home | Print

- Supporting Information
- Learn More About Plans
- How Plans Work
- Help
- Glossary

Glossary

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z ALL

TERM	DEFINITION
Medication Therapy Management (MTM) Program	A program offered by Medicare Drug Plans for members with complex health needs to help members and their doctors make sure that their medications are working. MTM programs include a free discussion and review of a member's medications by a pharmacist or other health professional to help them use them safely. Each member gets a summary of their discussion to have available when he/she talks with their doctors or other health care providers. Members who take medications for more than one chronic health condition may contact their drug plan to see if they're eligible.

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Table Mock-up

Two ways to find an MTM Program

1. Sort by Plan. Use the grey filter button to show			2. Match Your Health Condition and Drugs. Use the grey filter buttons to only show MTM programs that match				
			Note: You must meet all 3 requirements to qualify for the MTM program.				
			REQUIREMENT 1: Your Health Conditions		REQUIREMENT 2: Drugs You Take		REQUIREMENT 3: Your Drug Spending
Sort by Plan Contract Number	Sort by Plan Name	Sort by Plan Type	You must have AT LEAST this many health conditions	You must have some of THESE SPECIFIC health conditions	You must be taking AT LEAST this many Part D drugs	You must be taking some of THESE SPECIFIC types of drugs	You must spend AT LEAST this much in total drug spending each year