PQA-Prepared Summary of Points of Interest Related to Performance Measurement, Star Ratings Performance and PQA Measures Used in the CMS Medicare Program

Announcement of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter

PQA has drafted this high-level summary of points of interest to our multi-stakeholder membership. We have focused primarily on summarizing those areas that impact the use of PQA measures. We applaud CMS’s twice yearly comment periods on the Star Ratings in response to the need for transparency and advance notice. We also appreciate their forward look at this program, and the manner in which they lay out their plans for Star Rating methodology—often projecting out their plans for two or more years ahead.

Finally, we also recognize that changes in clinical guidelines may impact the Star Ratings measures. CMS has laid out a clear pathway to consider changes to clinical guidelines and how they can respond to these changes in the Star Ratings and Display Measure programs most efficiently.

For further details on any of the points summarized below, we have indicated page numbers/sections and would encourage you to refer to the full language from the document (view PDF):

Contracting Organizations with Ratings of Less than Three Stars in the Three Consecutive Years: Effective Date of Termination Authority (Pages 56-57): CMS reminds MA organizations and PDP sponsors that they have the regulatory authority to terminate contracts that fail for three consecutive years to achieve at least 3 stars on their Part C or D performance. This will be based on three years of data, beginning with 2012. CMS “advises contracting organizations to examine their star rating performance history and assess their level of exposure to the risk of having CMS terminate their Medicare contract based on star ratings before the start of the 2015 contract year.” It may be in the best interests of organizations and sponsors with “at risk” contracts to consider electing to non-renew those contracts. Alternatively, organizations and sponsors could explore whether it is allowable to consolidate membership currently enrolled in plans offered under low-performing contracts into other plans that will be offered during 2015 in the same service area under a different contract rated at three stars or better.
Enhancements to the 2015 Star Ratings and Beyond (Pages 58 through 75)
PQA strongly encourages its members to review this section very carefully.

**Page 58:** CMS reiterates the three principles it takes into consideration when making enhancements to the Star Ratings program. These are cross-cutting principles that apply to all quality programs within CMS.

1. Plans should be scored on their overall achievement relative to national or other appropriate benchmarks. In addition, scoring methodologies should consider improvement as an independent goal.
2. Measures or measurement domains need not be given equal weight, but over time, scoring methodologies should be weighted towards outcome, patient experience and functional status measures.
3. Scoring methodologies should be reliable, as straightforward as possible and STABLE over time and enable consumers, providers and payers to make meaningful distinctions among plans’ performance.

One of the ways in which meaningful distinction among plans’ performance can be made is to incorporate improvement as an independent goal separate from achievement. Increasing the weight of improvement aligns with other CMS programs where improvement receives a significant weight in the total performance scores. Increasing the weight of improvement also rewards MA organizations and Part D Sponsors for making progress in raising their performance, while maintaining one standard of care for all patient populations.

**Page 60:** CMS references that organizations have suggested special allowances be made in the Star Ratings program for Special Needs Plans. Suggestions have included bonus points for SNP-specific measures, requests for case-mix adjustment for member characteristics, comparisons only to similar SNP subtypes, separate listings in plan finder and other displays, displaying SNPs separately, and a Star Ratings system distinctively and uniquely for SNPs. CMS states that some contracts with high dual or LIS populations are doing very well on Star Ratings. CMS is aware of studies cited by commenters, but many of the studies in this area have methodological shortcomings. “However, we are increasing the weight of the improvement measures to help contracts that are experiencing challenges increasing their Star Ratings due to their patient populations served. CMS is continuing to conduct additional analyses in this area.”

CMS notes, “we rely on consensus based organizations’ decisions about whether a measure should or should not be case-mix adjusted. If the decision is made to include case-mix adjustment in a measure, the case-mix adjustment model is part of the published measurement specifications, so no additional adjustment by CMS would be needed. Since the presence or absence of case-mix adjustment is part of the measure specifications, any change (or introduction) of the model needs to be vetted through the same consensus process.” CMS will annually review the quality of the data across all measures, variation among organizations and sponsors, and the accuracy and validity of measures before making a final determination about inclusion in the Star Ratings.

**Note from PQA:** PQA will be exploring this question of risk adjustment/case-mix adjustment with a group of technical experts as well as with the PQA Board of Directors. This issue should be considered not only for measures currently in use in the CMS Star Ratings program, but also for measures that are now under development, and measures that are proceeding to be tested by PQA and its partners this year.

**Changes to Measures. Page 61.** “If the specification change has been announced in advance of the measurement period, there is no need to move the Star Ratings measure to the display page. If the specification change is announced during the measurement period and impacts the denominator or population covered by the
measure, the measure will be moved to the display page for at least one year. If the change does not impact the denominator of the measure, CMS will continue to include it in the Star Ratings. For example, if during the measurement period, additional codes are added that would increase the number of numerator hits for the measure, CMS will continue to include the measure in the Star Ratings.”

**High Risk Medication (Part D) Page 62:** As stated in the 2014 call letter, the updated Pharmacy Quality Alliance HRM list, based on the American Geriatrics Society (AGS) recommendations to the Beer’s List, will be applied to calculate the HRM measure for the 2015 Star Ratings using 2013 Prescription Drug Event (PDE) data.

Sponsors were aware of the updated Beer’s Criteria to consider updates to their procedures ahead of the 2013 Contract Year. CMS will not modify or remove medications from the PQA-endorsed HRM list.

**Medication Adherence for Diabetes Medications (Part D) Page 63.** “We reiterate that this measure evaluates adherence to diabetes medications, and not adherence to a specific drug class used to treat diabetes. As stated in the 2014 Call Letter, CMS will adopt PQA’s changes to this measure’s specifications for the 2015 Star Ratings (using 2013 PDE data), specifically, the addition of two additional drug classes for meglitinides and incretin mimetic agents.” PQA updated its specifications for 2014 to include sodium-glucose co-transporter 2 inhibitors. CMS plans to add this new drug class to the measure calculation for the 2016 Star Ratings using 2014 PDE.

**Medication Adherence Measures, Part D. Page 64.** “Based on stakeholder feedback, beginning with the 2015 Star Ratings using 2013 PDE, we will adjust the three Medication Adherence measures to account for beneficiaries with hospice enrollment or Skilled Nursing Facility (SNF) stays, during which the Part D sponsor would not be responsible for providing prescription fills for relevant medications.” On page 65, CMS notes the steps used to made adjustments to the proportion of days covered (PDC) calculation.

**Supplemental Pharmacy Data. Page 65.** Please note the paragraph that states, “We continued to receive a number of comments regarding supplemental pharmacy data. CMS uses PDE data to calculate some of the measures for the Part D Star Ratings, including the Adherence measures. The PDE record contains prescription drug cost and payment data that enables CMS to make payments to plans and otherwise administer the Part D benefit. We do not accept any other supplemental pharmacy data to calculate these measures.”

**Note from PQA:** *PQA recognizes that some of its members have an interest in providing supplemental data for CMS to consider when calculating certain PQA measures.*

**Obsolete NDCs. Page 66.** Beginning with the 2015 Star Ratings and display measures (using 2013 PDE data), CMS will implement the PQA’s 2013 specification change to account for obsolete NDCs. NDCs with obsolete dates will be included in the measure calculation if their obsolete dates are within the period of measurement (measurement year) as reported by PQA.

For the 2016 Star Ratings and display measures (using 2014 PDE data), CMS will implement PQA’s 2014 obsolete date methodology. The methodology is explained on pages 66 and 67.

**Contracts with Low Enrollment. Page 67.** To help beneficiaries make more informed choices and to be as fully transparent as possible about the performance of all plans, CMS is moving toward including low enrollment contracts in the Star Ratings. In the past, CMS believed that contracts with less than 1,000 enrollees would meet that definition but they have re-evaluated the threshold. Based on the data CMS has received, going
forward, CMS has determined that there is sufficient data to reliably measure and report on contracts in the Star Ratings with 500 or more enrollees in July of the HEDIS measurement year. Beginning with the 2016 Star Ratings, contracts with 500 or more enrollees as of July 2014 will be included in the 2016 Star Ratings on the Medicare Plan Finder, and these ratings will be used for Quality Bonus Payments.

Changes for Measures Posted on the CMS Display Page. Page 69. “Display measures on [www.cms.gov](http://www.cms.gov) are not part of the Star Ratings. These include measures that have been transitioned from the Star Ratings, new measures being tested before inclusion into the Star Ratings, or other measures used for informational and monitoring purposes.”

The Medication Therapy Management Program Completion Rate for Comprehensive Medication Review (CMR) Pages 69-71. This measure is based on the Pharmacy Quality Alliance’s endorsed measure, “Completion Rate for Comprehensive Medication Review (CMR),” which measures the percentage of beneficiaries who met eligibility criteria for the MTM program and who received a CMR. CMS will defer adding this measure until the 2016 Star Ratings and maintain this as a display measure for 2015 using 2013 data. For the 2015 display measures, CMS will post sponsors’ MTM eligibility rates along their CMR rates. Once this measure is added as a Star Rating, the CMR will be weighted as a process measure (1x). CMS believes this measure represents an initial step in measuring MTM performance and CMS will consider other outcomes-based MTM measures when developed and endorsed through a consensus-process. LTC beneficiaries will be included in the measure; hospice patients will be excluded from the measure.

Note from PQA: PQA continues to work on the development of measures that assess drug therapy problems resolved as a result of a patient receiving a CMR.

The following changes will be made to measure specifications on the 2015 display page:

Drug-Drug Interactions Measure, Part D. Pages 72-73. This measure uses the PQA Drug-Drug Interactions (DDI) measure specifications. PQA reviewed and updated the list of drug-drug interactions and CMS will implement the updated PQA DDI measure list for the 2015 display measure.

Weighting Changes. Pages 73-74. CMS solicited feedback on alternative weighting of measures, specifically with regard to modifying the current weight of the improvement measure(s), which is at a 3, and also modifying the weight of the three Part D Medication Adherence Measures, which are also at a 3 at this time. CMS has determined that they will increase the weight of the improvement measure from a weight of 3 to a weight of 5. This change will be made for the 2015 Star Ratings. Additionally, CMS had proposed to decrease the weighting of the adherence measures from a 3 to a 1.5. While the current PQA-developed measures are claims-based, there is evidence that higher medication rates are linked with improvements in clinical outcomes. MA plans and PDP sponsors expressed concern that this type of change would be contrary to efforts to encourage coordination of care, as well as decrease performance in other quality measures. Due to these, and other considerations, outlined on page 74, CMS will maintain the weight of 3 for the adherence measures for the 2015 Star Ratings.

Antipsychotic Drug Use Data. Page 128. CMS is particularly concerned with unnecessary use of antipsychotic drugs in nursing homes, and as a result, continues to pursue strategies to increase awareness of antipsychotic use in long term care (LTC). CMS began to calculate a general atypical antipsychotic rate for the 2013 Part D Display measures using 2011 data. Although CMS has seen a small decline in the utilization rate of this class of
drugs as a result of MTM services, the average has remained relatively constant. CMS is working with LTC and mental health stakeholders to further raise awareness of the lack of improvement in the rate.

*Note from PQA:* *PQA has endorsed a measure specifically for use in the nursing home to address this. It was endorsed in 2013, and PQA will continue to encourage its potential use by CMS and other organizations.*