

## Summary of Comments to the Star Ratings Request for Comments

On November 22, 2013 CMS sent out a Request for Comments for the 2015 Star Ratings and beyond to Part C and D sponsors, stakeholders and advocates that described CMS' proposed methodology for the 2015 Star Ratings for Medicare Advantage (MA) and Prescription Drug Plans (PDP). We received approximately 115 comments representing plans, pharmaceutical companies, consumer groups and measurement development organizations. This document provides a summary of the comments received and how we addressed these comments in the draft 2015 Call Letter.

- *Formal rulemaking:* Some commenters to our Request for Comments requested a more formal rulemaking process for proposed Star Ratings changes, instead of relying on our authority under § 1853(b), the relationship the quality Star Ratings have to payment rates, and the regulations at §§ 422.152(b) and 422.516(a) to use this Advance Notice/Call Letter process for these changes. We believe that our approach is better for administration of the Part C and D programs. We have initiated twice yearly comment periods on the Star Ratings in response to the need for transparency and advance notice. In the annual Request for Comments and the Call Letter we lay out the Star Ratings methodology for two or more years ahead. For example, the Request for Comments recently released in November 2013 announces potential changes for 2015, 2016, and beyond. When there are changes in clinical guidelines that impact the Star Ratings measures, we try to make these updates more quickly to align with the clinical standards. If we were to use a more formal rulemaking process for Star Ratings changes, we would not be able to quickly adjust the Star Ratings to reflect changes in the clinical guidelines nor encourage continuous quality improvement. We have included more detail in the draft Call Letter about moving measures to the display page when significant changes in measure specifications happen during the measurement year without advance notice. We additionally publish detailed technical specifications and provide contract specific technical guidance in understanding how a contract scored on a measure.

CMS' initial work last year to identify and understand some best practices of high-performing plans found that their models of care and continuous quality improvement were not focused on year to year changes, but rather they identified areas for long-term improvements in clinical outcomes, access of care and beneficiary satisfaction. High-performing plans did not wait until CMS' announcement of industry initiatives, rather their approaches to these areas were often ahead of CMS' technical changes. We therefore believe CMS' current processes of proposing and planning modifications to the Star Ratings are best continued as they are.

- *Modifications for some patient populations:* As part of our Request for Comments, we received several comments about Special Needs Plans (SNPs). Medicare Advantage

organizations are permitted to design SNPs that target individuals dually eligible for Medicare and Medicaid, beneficiaries that have certain chronic conditions, or those receiving care in institutions. These options let plans target these populations, develop and implement approaches that enhance access to and coordination of care, and improve quality of care. Over the past several years, organizations have argued that CMS should make special allowances in the Star Ratings program for SNPs and other plans that enroll hard-to-reach populations. These possible allowances have included bonus points for SNP-specific measures, requests for case-mix adjustment for member characteristics, comparisons only to similar SNP subtypes, stratification in displays, and a Star Ratings system distinctly and uniquely for SNP plans.

CMS maintains that organizations can develop and implement approaches that enhance access to and coordination of care and improve the quality of care, which would then be reflected in higher Star Ratings. We believe that our existing payment and Star Ratings methodologies adequately address differences between these populations and other MA enrollees. For example, an analysis of SNP performance in the 2011 Star Ratings found that increasing levels of SNP enrollment in contracts did not lead to low Star Ratings in either Part C or Part D. In fact, as we have stated previously, the number of contracts with less than a 3-star overall rating (below average performance) drops when SNP enrollment increases from 50 percent or more to 100 percent (77 FR. 22114, Apr. 12, 2012), which is comparable to contracts with fewer than 50 percent SNP enrollment. We believe that our current methodology supports a single standard of care for all Medicare beneficiaries, and analysis of Star Ratings results suggests Medicare Advantage organizations can focus on SNP population needs without compromising broader population health goals.

#### **A. New 2015 Measures Proposed in Request for Comments:**

##### *1. Pharmacotherapy Management of COPD Exacerbation (PCE) (Part C).*

#### **Summary of Comments:**

The majority of the commenters supported the importance of this measure but asked for clarifications on the specifications of this measure. A few commenters were against including this measure in the 2015 Star Ratings.

- Many commenters pointed out the following circumstances should be considered for exclusion:
  - patients on other drugs cannot be prescribed these medicines;
  - patients with certain conditions (such as diabetes) and upper age limit;
  - patients discharged to nursing home or hospice;

- patients went to urgent care
- patients hospitalized longer than 2 weeks
- Several commenters pointed out the following circumstances should be considered:
  - hospitalized patients can be treated with IV corticosteroids or given prescriptions and thus do not need a 2<sup>nd</sup> dose within 14 days of discharge;
  - patients may have these prescriptions before they were hospitalized;
  - patients often are given 90 day prescriptions; therefore the timeframe for dispensing a bronchodilator should be extended to 120 days;
  - treatment (e.g., discharged on nebulized bronchodilator) as Part B benefits should be included.
- Several commenters requested clarifications on data source (pharmacy claims vs. medical record documentation), and clarification on the method of averaging the two rates,
- A few commenters were against the use of averaging the two rates.

**Revised Proposed Change:**

CMS plans to revise the Request for Comments proposal and instead keep this measure on the display page for 2015. According to the National Committee for Quality Assurance’s (NCQA) guidelines, any patient with an active medication (systemic corticosteroids and bronchodilators) at the time of the episode is considered to be numerator complaint. The PCE measure is based on the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines which list both medication categories (bronchodilators and corticosteroids) as the gold standard for treatment of patients with obstructive lung disease. NCQA will be working with its advisory panels to investigate whether use of intravenous steroids and nebulizers can be added to the numerator of this measure. They anticipate any changes will be reflected in the October update to the Healthcare Effectiveness Data and Information Set (HEDIS) 2015 volume.

2. *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (Part C).*

**Summary of Comments:**

Most commenters were against the inclusion of this measure into the 2015 Star Ratings, citing several major concerns:

- Many commenters raised concerns that many members may choose to use alternative treatment such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and

Veteran's Administration that are not covered under Medicare, or Medicaid covered programs, and plans would not receive a claim for those services.

- Many commenters asked to expand the treatment options to include both telephone contacts and electronic visits by licensed providers.
- Many commenters requested to exclude patients with chronic diagnoses or on routine monitoring.
- Several commenters recommended emphasizing or including screening in the measure.
- A few commenters expressed concerns about coding and diagnosing as they can vary across providers, and can be inaccurate.
- Several commenters were concerned that plans with higher proportion of low SES or dual eligible, or younger members will be at a disadvantage, and asked for case-mix adjustment.
- Many commenters asked to extend the 14 days to 30 days so plans would have more time to receive the initial diagnosis and follow up.
- A few commenters also expressed concerns about confidentiality as the standards for mental health professionals are more rigorous than HIPAA.

**Revised Proposed Change:**

This measure encourages members who have a new episode of alcohol or other drug (AOD) dependence to initiate and engage in AOD treatment. However, CMS acknowledges the concerns the commenters raised, especially regarding the measure does not include self-help groups such as AA and NA. Therefore, CMS proposes to keep both the measure of Initiation of AOD Treatment and the measure of Engagement of AOD Treatment on the display page.

NCQA has provided detailed clarifications on this measure:

- There is currently a lack of clinical guidelines or strong evidence to support telephone contacts or electronic visits for substance abuse treatment.
- The intent of the measure is to focus on new treatment episodes. People with a treatment history 60 days before the earliest date of service during the measurement year are excluded from the measure.
- The USPSTF does not support routine substance use screening among adults.
- The measure is based on billing data and thus uses the CPT, POS, and UB92 codes for visits/services. By including CPT (used by providers), POS, and UB92 codes (used by

facilities), NCQA is able to address these differences in billing practices and include all relevant services. In ICD-10, there are additionally codes for AOD “use” that are not included in IDC-9. In early 2014 we will be meeting with our Behavioral Health Measurement Advisory Panel to determine if these codes should be included in the measure. These changes would be reflected in HEDIS 2015, published in May 2014.

- The measure has two age strata and a total rate. NCQA has guidance for plans to report measures for dual eligible members.
- NCQA followed the clinical guidelines that recommend the importance for patients to initiate treatment in the first two weeks.
- It is important to note that the measure is pure claims-based, and no chart abstraction is needed. Services billed to health plans are observable to plans in the claim data.

### 3. *Special Needs Plan (SNP) Care Management (Part C SNPs).*

#### **Summary of Comments:**

Some commenters disagreed with adding this measure to the 2015 Star Ratings. The concerns expressed include the following:

- Some think the measure does not account for members who refuse reassessment.
- Some want different types of SNPs to be measured differently.
- Some think the measure requirements need to be stable for a couple of years, and be posted another year on the display page before moving the measure to the Star Ratings.
- Some think there should be better definition and grace periods for timeliness. Some want better review of the submitted data, like HEDIS measure auditing.

#### **Revised Proposed Change:**

CMS plans to proceed with the proposal to add this measure to the 2015 Star Ratings. CMS does not agree that members who refuse assessment should be excluded; attempts to account or adjust for these types of cases may cause new issues with reliability and validity of the reported data. CMS will not modify the current definition of timeliness, which meets the goals of the Medicare program. CMS does not believe minor definition changes prohibit this measure from being added to the 2015 Star Ratings.

As commenters noted, HRA timeliness for members who change plans, especially those under the same sponsor, may be an area for clarification. However, CMS also points to the flexibility offered in how HRAs are conducted and formatted and suggests sponsors use the opportunity to better tailor care to the individual member enrolling in a new product.

Data from this reporting section undergo yearly validation and achieved mean data validation scores of 96.2 for calendar year 2012 reporting. CMS believes the current annual data validation procedures to be sufficient and successful.

It is unclear to CMS that there is sufficient justification to measure different SNP types differently or to adjust for member characteristics. Furthermore, health disparities and individual characteristics of members should not be used to lead to different standards of care for different populations. SNPs will be compared against all other such plans, as the standard of care is the same across type of plan and across states.

4. *Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (Part D).*

**Summary of Comments:**

The majority of commenters supported this display measure becoming a Star Rating; however, many concerns were raised that plans would begin to restrict their MTM program eligibility criteria in hopes of increasing their CMR completion rate or that variations in eligibility criteria create an uneven playing field. Many commenters opposed moving this measure from the display page, and requested CMS defer it another year (2016 Star Ratings, which would be based on 2014 plan-reported data), or maintain its weight as a process measure (1x).

Data validation concerns were reported by a few commenters; they asked how CMS would ensure these data are accurate representations of the MTM work being conducted. Others asked that CMS instead consider introducing outcome-based measures for evaluations of MTMPs.

Some sought proposed benchmarks for performance, and asked that we release initial thresholds/cut-points using the just-released 2014 display data.

Some commenters requested inappropriate adjustments such as maintaining the exclusion of LTC beneficiaries despite the change in 2013 MTM requirements per the Affordable Care Act, or that LTC MRRs should be counted as CMRs. Commenters asked that hospice patients are excluded.

A few commenters requested technical clarifications, such as the definition of a CMR, or questioned MTM requirements, such as use of CMS' standardized format, or the provision of a CMR within 60 days of eligibility.

**Revised Proposed Change:**

We will propose deferring the addition of this measure until the 2016 or 2017 Star Ratings. This proposal is based on a number of factors including: feedback received during the Request for Comments regarding differences in rates of MTM eligibility, changes to the MTM requirements beginning 2013 including the requirement to provide CMR to LTC beneficiaries, and proposed

revisions to Part D MTM requirements, with a proposed effective date of January 1, 2015 (CMS-4159-P, Medicare Program: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs). In addition, while variations between sponsors' MTM program eligibility criteria exists, it is unclear to CMS the best manner in which to equitably and appropriately adjust the CMR rates.

Once this measure is added as a Star Rating, CMS plans to weight the CMR measure as a process measure (1x). CMS will consider future outcomes-based MTM measures when developed and endorsed through a consensus process.

CMS is considering if hospice patients should be excluded from this measure. Using data from the Enrollment Database (EDB), CMS would exclude an enrollee reported to have entered hospice at any point during the measurement year, regardless of whether the contract reported him/her as receiving a CMR.

CMS clarifies that the denominator for this measure includes only those beneficiaries that meet the contracts' specified targeting criteria per CMS-Part D requirements; MTM enrollees based on other expanded or plan-specific targeting criteria are not included. Furthermore, the CMR measure includes those beneficiaries who were enrolled in the MTM program for at least 60 days during the reporting period. Beneficiaries who opt out of MTM after these 60 days are still included in the measure.

Comments regarding MTM requirements such as the inclusion of LTC beneficiaries or DRR are out of scope. Only CMRs which meet CMS requirements and definitions will be counted.

## **B. Changes to Measures for 2015**

### **CMS is modifying the methodology for the following measures:**

1. *Breast Cancer Screening (Part C)*.

### **Summary of Comments:**

About half of the commenters that expressed an opinion on this change supported moving this measure to the 2015 display page, while the other half disagreed with this change and advocated for keeping this measure in the 2015 Star Ratings.

- For those that supported moving this to the display page, they commented that this was a significant specification change. Some even commented that CMS should reassess inclusion as part of Star Ratings once the data are available.
- A couple of commenters thought it should be moved to the display page for multiple years.

- The commenters that disagreed with this change noted that they have already been following the new clinical guidelines, this change has long been expected, and they have known about this change since July 2013. Others noted the importance of cancer screening and believed that this change was not significant enough to warrant moving the measure to the display page.
- Most commenters thought it made sense to redo 4-star thresholds. Some commenters asked for CMS to publish targets for this measure.

### **Revised Proposed Change:**

CMS continues to propose moving this measure to the display page for one year. In the draft Call Letter we added some additional language about when CMS will move a Star Ratings measure to the display page when there is a specification change. If the specification change has been announced prior to 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 population covered by the measure, we will move it to the display page. 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. Since the specification change for Breast Cancer Screening alters the denominator, CMS will move this measure to the display page for one year.

### *2. Annual Flu Vaccine (Part C).*

### **Summary of Comments:**

Most commenters supported the change in the wording of the CAHPS question to allow flu shots from July versus September of the particular year. Although there was support for this change, there were some comments related to this measure.

- Commenters wanted the survey data to be supplemented with plan-submitted data and/or immunization registries. Others wanted this measure to rely solely on claims data.
- Other comments focused on suggested changes to the wording of this question.

### **Revised Proposed Change:**

CMS plans to proceed with changing the language for the flu shot question and to include this measure in the 2015 Star Ratings. This change will potentially increase the number of sample members responding that they did get a flu shot. Since this change does not alter the denominator for this measure, we are proceeding with this change. A number of commenters were concerned about whether beneficiaries can respond to surveys and whether this is the appropriate method for gathering information about flu shots. Surveys are a valid way to gather

this type of information; the types of questions include in the CAHPS surveys are ones where the beneficiary is the best or only source for the information. The flu shot information is collected through a survey since there are a variety of places where people can get flu shots and the plan may not have a record of a flu shot in their administrative data depending on where the flu shot was received.

### 3. *High Risk Medication (Part D).*

#### **Summary of Comments:**

While commenters appeared to be familiar with CMS' plan to apply the updated HRM list for the 2015 Star Ratings, the majority requested for it to be applied with modifications. Modifications included: exclude barbiturates, and other Part D protected class drugs; exclude beneficiaries based on indications for use; and exclude non-benzodiazepine hypnotics (citing that PQA's exclusion of benzodiazepines will inappropriately increase the use of these drugs). A few note that the PQA is currently testing a measure concept that would potentially address this issue; the measure evaluates the percentage of individuals 65 years of age and older that received two or more prescription fills for any benzodiazepine sedative hypnotic for a cumulative period of more than 90 days. A few stated that since estrogen is an HRM but its use is encouraged by the Part C measure, Osteoporosis Management, it should also be excluded from the PQA list.

Others requested CMS defer these changes another year, to the 2016 Star Ratings. They stated that any changes made to Star Rating measures should be prospectively applied, after being formally announced by CMS. These commenters cite the 2015 Call Letter as CMS' formal announcement of these changes, and therefore they should first be applied to the 2014 PDE for 2016 Star Ratings.

Some commenters asked that patients enrolled in hospice or palliative care be excluded. Many stated CMS should allow for formulary changes to support the HRM measure. Some submitted technical proposals, such as evaluating quantity dispensed, not just number of fills. A few requested CMS adjust for LIS enrollment, or SNP plans.

#### **Revised Proposed Change:**

No changes will be made to this proposal. This is CMS' third formal announcement of this change. CMS first alerted plans about this change in the 2013 Call Letter and has been providing monthly HRM patient safety reports to sponsors using the updated list since 2012. CMS will not modify the PQA's HRM measure list, such as modifications that are specific for Part D coverage considerations. CMS does not feel that hospice stays impact this measure.

### 4. *Medication Adherence for Diabetes Medications (Part D).*

### **Summary of Comments:**

The majority of commenters supported the addition of two drug classes to this measure, in order to provide a more accurate representation of a beneficiaries' adherence to his/her DM regimen.

- The commenters that opposed this change appeared to be confused about the measure calculation and specifications, as they cited the two drug classes' side effects and higher cost as potential barriers to adherence. These commenters often requested that this change is delayed another year to the 2016 Star Ratings (and tested as a 2015 display measure). We will need to clarify the intention of this change is to account for these agents, whereas previously, beneficiaries may have changed to these two drug classes, and could have appeared to be non-adherent.
- We received a few requests to add a new class of hypoglycemic medications to this measure: Sodium glucose co-transporter 2 (SGLT2) inhibitor (brand name Invokana, generic name canagliflozin).

### **Revised Proposed Change:**

No changes will be made to this proposal. CMS' adoption of PQA's addition of two drug classes will result in a more complete measure of beneficiaries' adherence to diabetes therapy. Previously, beneficiaries changing to these medications could have been marked as non-adherent. This change will account for that utilization.

PQA updated their specifications for 2014 to include SGLT2 inhibitors. CMS will propose to add this new drug class for the 2016 Star Ratings using 2014 PDE.

### *5. Appeals Upheld (Part D).*

### **Summary of Comments:**

Comments for and against this proposal were pretty evenly split.

- Most of the commenters who agreed with the proposed change were concerned with the use of the first 6 months of 2013 data for both 2014 and 2015 ratings.
- Some commenters agreed that that data from a plan year may more accurately reflect performance and enable smoother tracking of data submitted.
- Many plan sponsors suggested that if CMS intended to increase the data timeframe to a year, they should also adjust the exclusion such that the minimum case threshold is ten.
- Some commenters suggested that if CMS planned on making the change is should first move the Appeals Upheld measure to the display page for the 2015 ratings period, and then return it to the Star Rating for 2016. Plans also proposed alternative ways to phase

this change into the 2015 and 2016 Star Ratings. Commenters noted this was the first notice of the extended time frame though the majority of the measurement period (2013) is over, which limits the ability of sponsors to undertake intervention focusing on improvements.

- Some commenters were in favor of CMS continuing to use the most recent plan data as a better reflection of the plan's current performance.

### **Revised Proposed Change:**

CMS continues to believe that expansion to a full 12 months of data used in the measure will provide a more comprehensive and objective evaluation of a plan's performance than the current six month period. CMS' review for data integrity issues is discussed in a latter section of this document. We understand Sponsors' requests to provide advance notice of this change. As a result of feedback received, CMS will propose deferring this change to the 2016 Star Ratings. We will re-evaluate and adjust as necessary the minimum number of cases. For the 2015 Appeals upheld measure, CMS will continue to use the first 6 months of 2014 IRE data.

### *6. MPF Accuracy (Part D).*

#### **Summary of Comments:**

Concerning the addition of 60 and 90 days supplies to the measure, commenters recommended to either take the dispensing fee out of the calculation – as different days supplies may have different dispensing fees and plans currently can only supply one dispensing fee – or allow plans to submit different dispensing fees with their Medicare Plan Finder (MPF) data and ensure these dispensing fees are used in the accuracy scoring calculation.

Concerning the addition of non-retail pharmacies to the scoring calculation (currently only retail pharmacy claims are used), some commenters are concerned that different types of pharmacies (LTC, HI, etc.) may have different pricing than retail claims. So when the pharmacy is retail *and* LTC, for example, the Pricing Guidance instructs the plan to submit a retail price. This may cause inaccurate scores. Furthermore, commenters stated the pharmacy type is often incorrectly coded by dispensing pharmacies, also contributing to inaccurate scores.

Concerning the scoring of claims where the MPF display price is higher than the price at the POS (PDEs), commenters voiced concerns that there is more risk of bait and switch by displaying lower prices on MPF than are charged at POS, versus charging lower prices at the POS than displayed on MPF, therefore CMS and Part D sponsors should remain focused on the existing Star Rating measure.

Other general comments were:

- Any changes (adding different day supplies and pharmacy types) should make the measure a display measure.
- Because current Accuracy scores are so high and tightly clustered, the measure should be retired or converted to a display measure.
- Because 100% accuracy is impossible, the measure should be retired or converted to a display measure.
- Because POS pricing changes more frequently than MPF pricing, the measure should be retired or converted to a display measure.

**Revised Proposed Change:**

CMS will continue to use the Accuracy Measure (where the MPF displays a lower price than the actual price at the point of sale) as part of the Star Ratings. We will also keep the restriction limiting evaluation to claims for 30-day supplies, and will evaluate claims for 60, and 90-day supplies. CMS received concerns about this proposed change because MPF only accepts one brand and one generic dispensing fee per pharmacy, regardless of the days' supply dispensed. CMS seeks further clarification about the magnitude of differences in dispensing fees for 30, 60 and 90 days. CMS would view such issues as having a more significant and immediate issue with pricing displayed on Medicare Plan Finder, than a modification to a Star Rating measure. Making this change in the future would also necessitate a change in the pricing data submission requirements to account for all of the dispensing fees for the three different days of supply that are able to be displayed on the MPF. Regarding the addition of other than retail pharmacy types, CMS will not be making this proposed change. CMS will continue to evaluate PDE and other pricing/pharmacy data to determine if this will be a change made for the 2016 Accuracy Measure.

*7. Beneficiary Access and Performance Problems (Part C and D).*

**Summary of Comments:**

The majority of commenters disagreed with the changes in this measure. Although some commenters were neutral, there were no commenters that agreed with this change. The following summarizes the comments received for this measure.

- Many want this measure retired.
- Many want this measure to be weighted as 1.
- Many want the audit results to be not included in the measure, because it is not fair to those that are audited.

- Many did not understand what was being changed and wanted a clearer description.
- Some think consumers are misled because of the difference between audited and non-audited contract data.
- Some want data used in the measure to be accessible to the contracts on a quarterly basis.
- Some say this measure is duplicative of past performance and do not think it should be in the Star Ratings.

**Revised Proposed Change:**

Based on the comments received, CMS will propose moving the Beneficiary Access and Performance Problems to the display page since there were significant methodological changes during the measurement period.

8. *Medication Adherence Measures (Part D).*

**Summary of Comments:**

More than half of the commenters supported CMS' adjustment for hospice patients and for SNF stays (for PDPs).

- Many requested CMS delay the implementation of the hospice adjustment until the payment related issues regarding Part D and hospice have been resolved. A few requested additional background on CMS' goal and intention for this adjustment.
- Many SNPs requested that CMS work to obtain their SNF stay data in order to allow equitable adjustments for these stays.
- Commenters requested that CMS accept supplemental data to the PDE, adjust for LIS enrollment, and/or case-mix adjust all ADH measures.
- We received requests to enhance Acumen's monthly reports and provide additional technical support for plans calculating their own ADH reports.

**Revised Proposed Change:**

CMS plans to proceed with these proposed modifications for the 2015 Star Ratings. We do not feel that the recent clarifications to address Part D payment for drugs for beneficiaries enrolled in hospice or how the guidance is finalized would conflict with this proposal to account for hospice stays. On the contrary, adjusting for hospice stays, as we already do for inpatient stays, should more accurately reflect drugs covered under the hospice benefit or waived through the beneficiary's hospice election. This adjustment should benefit the sponsor regardless of which party pays for the drugs.

CMS will adjust MA-PDs' ADH rates for SNF stays when those data become available to CMS. We are unable to set-up processes for specific SNPs to provide their records of such data. We disagree that the application of SNF stays for PDPs is inequitable, as CMS' cut-points are determined for PDPs and MA-PDs separately.

CMS' patient safety reports provide information about adjustments for in-patient stays. If these changes are finalized for the 2015 Star Ratings, we will look to modify the 2013 reports to reflect these additional adjustments.

#### 9. *Obsolete NDCs.*

##### **Summary of Comments:**

Most commenters supported adoption of PQA's revised methodology to claims for NDCs with an obsolete date within the measurement year. Some requested that CMS further modify PQA's specifications to allow for 6 months, or up to 3 years after a NDC is obsolete.

A few commenters recommended we use GPIs or GCNs instead of NDCs.

##### **Revised Proposed Change:**

CMS had announced adoption of PQA's obsolete methodology in the 2014 Call Letter, and expects to proceed as planned for the 2015 Star Ratings. We will continue to evaluate obsolete NDCs, and do not feel GPIs or GCNs can be supported.

We will propose for the 2016 Star Ratings and display measures (using 2014 PDE data) to implement PQA's updated 2014 obsolete date methodology which captures NDCs from MediSpan, First Databank, and the FDA NSDE file and includes NDCs with an obsolete date within six months prior to the beginning of the measurement year.

#### **C. Retirement of Measures: *Glaucoma Testing (Part C)***

##### **Summary of Comments:**

The majority of commenters agreed that the measure should be retired. Some commenters were concerned that beneficiaries would no longer get tested for glaucoma. A few commenters wanted to keep the measure because they worked to improve it this past year.

##### **Revised Proposed Change:**

CMS is proposing to proceed to retire this measure. Starting with HEDIS 2015, this measure will no longer be collected by NCQA as part of HEDIS. Plans should follow the current clinical guidelines for glaucoma and for all health conditions whether there is or is not a measure in Star Ratings covering that condition.

## **D. Contracts with Low Enrollment**

### **Summary of Comments:**

Most commenters disagreed with adding low enrollment contracts (contracts with 500 to 999 enrollees) into the Star Ratings.

- Some commenters thought CMS should delay this change until 2016, while a couple of commenters suggested waiting until we have multiple years of experience.
- Others thought we should not add low enrollment contracts to the Star Ratings, but these contracts should submit data for monitoring purposes.
- Other commenters expressed concern about outliers and volatility of scores for low enrollment contracts and whether this would skew results for everyone.
- A few commenters suggested alternative cut-offs for low enrollment (i.e., 1,500 and 15,000).
- There was some concern from some commenters that it will be easier for low enrollment contracts to do well.
- A couple of the commenters wanted low enrollment SNP contracts to be able to decide voluntarily whether to participate in Star Ratings.

### **Revised Proposed Change:**

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. Low enrollment contracts, as defined in §422.252, are those where enrollment is such that HEDIS and HOS data collections cannot be used to reliably measure the performance of the health plan. In the past, we have believed that contracts with less than 1,000 enrollees would meet that definition but we have reevaluated whether that threshold is an appropriate implementation of the regulatory standard. Contracts with less than 1,000 enrollees first submitted HEDIS data to CMS in the summer of 2013. As a precursor to including low-enrollment contracts in the Star Ratings, CMS included HEDIS scores for low-enrollment contracts as part of the 2014 display measures. Based on the data we received, CMS has determined that there are 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.

CMS proposes to delay for one year including these contracts with enrollment from 500 to 999 enrollees into the Star Ratings on Medicare Plan Finder to gain an additional year of experience with collecting and analyzing these data and to evaluate the reliability of the data. 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 used for QBPs. Contracts with 500 or more enrollees in most cases will have sufficient data to produce both overall and Part C and D ratings. The HEDIS data for contracts with less than 500 enrollees will continue to be posted on the display page as these will continue to be considered low enrollment contracts.

The 2014 and 2015 display pages will include simulated Star Ratings for contracts with 500 to 999 enrollees, following a preview period. Using the most recent data for the 2014 Star Ratings, simulated overall ratings for 31 contracts with less than 1000 enrollees show 13% would have received 2.5 stars, 26% would have received 3 stars, 39% would have received 3.5 stars, 10% would have received 4 stars, and 13% would not have enough measures to be rated. Contracts with less than 1000 enrollees will not be included in the cut point calculations for the 2014 and 2015 Star Ratings, but contracts with 500 to 999 enrollees will be included in the cut point calculations for 2016 and going forward. It is important to note that only the measures where the contract meets the minimum denominator requirements are included in the Star Ratings. Thus, if a contract with 500 to 999 enrollees does not meet the minimum denominator requirements for a measure, the particular measure will not be included in their overall rating calculation.

## **E. Data Integrity**

### **Summary of Comments:**

About half of the commenters that expressed an opinion on this issue supported CMS' policy on data integrity. Most of the other commenters supported the concept of data integrity in general but thought that the reduction to one star was too severe a penalty.

- Some commenters who were either neutral or supported the policy wanted CMS to provide a formal appeals process for plans to dispute any findings related to data integrity. CMS should only consider issues that have been finally adjudicated, with all appeals exhausted, before this additional penalty is triggered. Some commenters recommend that CMS provide a clearer description of the standard used and processes followed by CMS to determine when to downgrade a Plan's measure Star Rating.
- Some commenters who supported CMS' approach to reduce the ratings if incorrect data were used recommended looking at an alternative approach to allow the potential for more than the automatic 1-star rating depending on the type or degree of the error. They recommend looking at a stepped penalty approach depending on the type and degree of error. Others proposed reducing measure stars by one star instead of dropping it to one star. Some commenters recommend that CMS revise the data integrity policy to include only cases where there has been egregious and systemic submission of biased or erroneous data and not include isolated and unintentional errors.
- A couple of commenters recommended that CMS provide information about the process the agency follows to ensure the integrity of data reported by third party contractors, such

as the IRE, that are utilized by CMS to evaluate organization/plan sponsor data integrity. Some of the commenters had widespread concerns regarding the lack of transparency in the data validation process and were requesting more clarification about the validation process.

- Some commenters noted that plans are already subject to penalties and sanctions through the audit and compliance processes questioned whether this additional penalty is necessary given their significant consequences.

### **Revised Proposed Change:**

Protecting data integrity is a high priority for CMS, especially for measures using non-validated data. CMS' current policy is to reduce a contract's measure rating to 1 star if it is identified that biased or erroneous data have been submitted. This policy ensures that CMS is measuring true performance. Contracts are able to review and discuss CMS' findings prior to the final release of Star Ratings. While CMS maintains that it is the responsibility of the contract to follow CMS' requirements, we understand plans' request for CMS to establish the scope of errors made.

We note that HEDIS data, plan-reported data, and survey data already undergo data validation processes. However, data used to monitor areas such as contracts' processing of coverage determinations/exceptions or organization determinations are not consistently audited. CMS has frequently found evidence that sponsors fail to follow requirements to forward Part C denials and to auto-forward untimely Part D initial coverage determination or redetermination requests to the IRE. Consequently, these contracts' data do not represent the contracts' actual processes. CMS cannot objectively measure those contracts, nor do we feel it appropriate to simply exclude them from these important beneficiary access measures. Without the ability to identify and reduce these contracts' ratings, there is risk that CMS will reward contracts with falsely high ratings in these measures, while penalizing those contracts that do follow the requirements. Ultimately, the measures would no longer yield fair evaluations of sponsors' performances.

CMS has restrictive timelines for production of the Star Ratings for each Fall AEP, review of QBP appeals, and final calculation of ratings for QBPs the following year. So, we are interested in suggestions that can balance CMS' high standards for compliance, our requirement to have accurate measure data that are unbiased from sponsors' errors or misprocessing, and the application of transparent and objective criteria for star reductions. One option could be for contracts to elect to have independent audits initiated to provide accurate evidence that would dispute CMS' reductions of their ratings. Audits would be conducted at the contract's expense, in an effort to quantify and qualify the degree of error existing in the entire dataset. Audits would be conducted following standards developed by CMS. Another option may be for CMS to apply incremental reductions to measures based on the number of errors found. Reductions could range from CMS subtracting a star from a contract's measure rating to CMS reducing the

rating down to one star. Depending on the viability of proposals, CMS may implement these changes for 2015 or 2016 Star Ratings.

## **F. Changes for Measures Posted on the CMS Display Page**

1. *CAHPS measures about contact from a doctor's office, health plan, pharmacy, or prescription drug plan (Part C).*

### **Summary of Comments:**

Most commenters disagreed or were neutral about adding these measures to the display page.

- Several suggested that plans do not have control over these types of measures.
- A few felt that CMS should use more objective data that do not rely on patient memory, for example claims or other administrative data about health plan contacts.
- Several expressed concern that the CAHPS survey was already too long.
- A few stated that these types of measures would be unfair to SNPs and that we should implement a SNP-specific survey or utilize different cut points.
- Several encouraged CMS to case-mix adjust these measures.

### **Revised Proposed Change:**

Parts C and D sponsors are accountable for the care provided by physicians, hospitals, and other providers to their enrollees. These measures have been included in the CAHPS survey since 2013. In response to requests for more SNP-specific data, CMS is soliciting suggestions for questions that could be added to the CAHPS survey that address SNP Care Teams.

2. *CAHPS – Complaint Resolution (Part C and D).*

### **Summary of Comments:**

Most commenters opposed the creation of this display measure. Commenters questioned CMS' methodology for fairly evaluating subjective responses to determine when contracts failed to meet requirements or maintain their responsibilities in resolving complaints versus when beneficiaries were not satisfied with the resolution of the complaint.

### **Revised Proposed Change:**

CMS will continue investigating creation of a Complaint Resolution CAHPS measure to potentially be used as a display measure in the future. However, based on the need for more testing and a request for more technical clarifications (e.g., exclusion of some complaints), this measure is no longer proposed as a 2015 display measure.

### 3. CAHPS – Health Information Technology – EHR measures (Part C).

#### **Summary of Comments:**

Many commenters expressed concern that these measures would be added to the Star Ratings. Those that agreed or were neutral regarding these measures felt they were appropriate for the display page only.

- A few felt that health plans should not be accountable for whether providers utilize health IT and that these measures would not be useful or reliable as a metric of plan performance.
- Several expressed concern that these measures were subjective and that members may not be able to accurately report use of electronic devices. A few suggested that these measures may disadvantage SNPs.
- A few suggested that information could be gathered through provider surveys or other means. Several stated the CAHPS survey is already too long.

#### **Revised Proposed Change:**

As stated in the Request for Comments, these measures would be added to the display page for informational purposes only; we are not proposing to add them to the Star Ratings. CMS recognizes that this is an evolving area so initially these measures would be collected and fed back to plans as part of their annual CAHPS Plan Reports for quality improvement.

### 4. Transition monitoring (Part D).

#### **Summary of Comments:**

Transition Monitoring Program Analysis (TMPA) investigates whether Part D sponsors, in compliance with 42 CFR § 423.120 (b)(3), are administering formulary transition policies that provide enrollees with a one-time temporary supply of requested non-formulary drugs to allow time for the enrollees to switch to alternative therapies. CMS will publish results for those contracts that failed protected class and non-protected class thresholds. These data will be displayed prior to becoming part of the Star Ratings in 2015. The majority of commenters agreed or was neutral to CMS adding this new (display) measure.

- Several expressed concerns regarding the number and weighting of Part D measures may be disproportionate to those in Part C.
- Several expressed concerns regarding the ability to review the TMPA result feedback prior to data appearing on the display page.

- There were a few concerns that the transition requirements are outdated, and that a measure based on adherence to transition requirements should not be included on the display page or in the Star Ratings. Therefore, the measure does not provide meaningful information about plan performance.
- There were a few concerns that the TMPA process is still relatively new and evolving and that TMPA measures should not be implemented for display or use in the Star Ratings until they have undergone thorough testing.
- There were a few concerns that having two display measures (protected class and non-protected class) may be confusing.

**Revised Proposed Change:**

CMS plans to proceed with its current processes of requiring formulary transition policies that provide enrollees with a one-time temporary supply of requested non-formulary drugs to allow time for the enrollees to switch to alternative therapies. CMS acknowledges that some commenters feel that the transition policy is outdated. However, this regulatory requirement protects the beneficiary and this comment is beyond the scope of what was requested. CMS also understands that Part D sponsors would like to receive TMPA results prior to display measures being released. However, Part D sponsors are currently given the opportunity to provide feedback on rejected claims. Based on this feedback (and CMS review of responses), plan sponsors either pass or fail the analysis. CMS thus believes that plan sponsors already have the opportunity to provide feedback before measure data are released. Moreover, Part D sponsors should not wait to receive TMPA results to implement corrective measures. CMS identified these concerns during the potential inappropriate rejected claims sampling set that was provided to Part D sponsors. CMS acknowledges the TMPA process is still evolving but disagrees that this measure does not provide a meaningful measure of Plan performance.

5. *Combined MPF Price Accuracy (Part D).*

**Summary of Comments:**

Many commenters were concerned that because of the lag time between the MPF display updates (every two weeks) and that point of sale (POS) pricing updates more frequently, that either:

- To achieve accuracy between MPF and POS, plans would be discouraged from utilizing lower prices at POS as soon as drug prices decreased so that POS pricing would update only when MPF display updated. This would cause the beneficiaries to potentially pay high prices. Or,
- Plans would be penalized for charging the beneficiaries lower prices at POS in this same scenario.

Some commenters are concerned that pharmacies offer discount programs, U and C pricing, and the use of coupons, all of which are out of the control of the plan and harm the plan's score in this measure.

**Revised Proposed Change:**

CMS will move forward with the proposal to create a new Accuracy measure that evaluates claims where the MPF displays prices that are higher than prices charged at the POS. This will be a display measure. CMS will monitor the results of this measure to determine if and when this measure will be made a Star Ratings measure. CMS will also monitor the results and evaluate the feasibility of a combined Accuracy Measure for Star Ratings.

6. *Disenrollment Reasons (Part C and D).*

**Summary of Comments:**

About half of the commenters agreed with the addition of this measure to the display page but asked for clarifications; the remaining commenters did not want this measure on the display page or added to Star Ratings.

- Many commenters stated that many disenrollment reasons have no correlations with plan performances. In particular, many commenters pointed out that “financial reasons” can be members’ personal situation and choices, and thus plans should not be held responsible.
- Many commenters asked to exclude members switching plans under the same contract, and some asked to exclude members switching under the same parent organization.
- Several commenters expressed concerns about too many surveys and this survey being too long.
- A few commented that SNPs have a continuous special enrollment period, and therefore the result should be adjusted for this enrollment period.
- Several commenters requested clarifications on the methodology (e.g., which reasons will be on display; will different reasons be given same weight; will it replace the current “Members Choosing to Leave the Plan” measure)
- A couple of commenters were concerned that beneficiaries would misinterpret the results on the display page.
- A few commenters urged CMS to give more timely feedback to plans.

### **Revised Proposed Change:**

CMS plans to proceed with introducing composite measures of the primary reasons for voluntary disenrollment to the 2015 display page. We are considering in the future potentially including a drill-down on the MPF website for the primary reasons why beneficiaries left their plan. Prior to making a final decision about including this on MPF in the future, CMS will conduct testing with potential users of the site to ensure that they understand the information. Any further changes will be announced in a future Request for Comments.

### **We are considering the following changes to measure specifications on the 2015 display page:**

#### *7. Drug-Drug Interactions Measure (Part D).*

### **Summary of Comments:**

Less than half the commenters supported CMS' proposal to align with the PQA's updated Drug-Drug Interactions (DDI) list for the 2015 display measures. Many commenters opposed the change, or the measure concept itself, stating that these changes should not be made retrospectively but rather should be made for the 2016 display measure (based on 2014 PDE). Those that objected to the measure requested that thresholds be set based on DDI severity, or that CMS remove DDIs if the prescriber had been consulted. A few requested this measure be removed from the display measures entirely.

### **Revised Proposed Change:**

These changes were first outlined in the 2014 Call Letter. We will proceed with these updates as announced for the 2015 display measures.

Additionally, we note that PQA's 2014 specifications will delete the age criteria for this measure. Historically, we have not applied an age criteria for this measure, and will continue not to.

## **G. Forecasting to 2016 and Beyond**

### *1. 2016 Changes in the Calculation of the Overall Rating and the Part C and D Summary Ratings*

### **Summary of Comments:**

While a majority of commenters disagreed with this proposed change, there were a few who were in support. A large number of commenters were neutral and said they would be able to make a full evaluation for the proposal after CMS released contract specific information showing impact of removing the 4-star thresholds. A few commenters referenced the Inovalon study in support of their argument that rating system account for differences between dual and non-dual population.

- A few commenters supported the proposed change to remove the predetermined thresholds in order to reduce misclassification. Some supported renaming the i-Factor the Reward factor.
- Commenters that disagreed said that knowing the preset thresholds in advance helps plans set goals internally, track progress and change interventions as needed. These thresholds provide transparency and stability to the program. Moving targets are not conducive to strategy development, while having no targets at all would make it more difficult. Some commenters who disagreed or were neutral were of the opinion that the 4-star preset thresholds should be retained and based on the previous year's data so that they would be available to plans earlier.
- Some commenters recommended keeping the 4-star threshold but updating it every 3 years.
- Plans commented that the proposed change to the Overall Ratings and Summary Ratings calculation created significant impact to plan payment and Low Performer Icon considerations. They recommend that CMS institute a Formal Notice and Comment Rulemaking Process to Announce and Implement Changes to the Star Ratings, including publication in the Federal Register.
- Some commenters were concerned by disparities faced by plans that have a dual population. They reference the Inovalon study which “found that a significant association exists between dual eligible status and lower performance on specific Part C and D measure Star Ratings.” Commenters recommend risk adjustment of measures/ratings and comparison of D-SNPS with other D-SNPS. They also recommend selecting measures appropriate to SNPs.
- Some commenters who were against or neutral to the change said that if the change was to be implemented, they would prefer a phased in approach.
- Many commenters said they would comment further after seeing contract-specific information on the impact of removing the pre-set/pre-determined 4-star thresholds.

**Revised Proposed Change:**

We will be proceeding as planned. Plans will get their contract-specific data through HPMS following the release of the draft Call Letter. Our analyses suggest that measures without predetermined 4-star thresholds have more improvements compared to measures with predetermined thresholds. In the table below we show that on average 31.7% of contracts improved across the 23 Part C measures with 4-star thresholds, compared to 52.3% of contracts that improved across the eight Part C measures without 4-star thresholds. For Part D, on average 21.0% of contracts showed improvement across the five measures with 4-star thresholds, while

56.0% of contracts showed improvement across the five Part D measures without 4-star thresholds.

<b>Part C</b>		<b>Average %</b>
Measures with 4-star threshold (n= 23)		
	improvement	31.7%
Measures without 4-star threshold (n=8)		
	improvement	52.3%
<b>Part D</b>		<b>Average %</b>
Measures with 4-star threshold (n=5)		
	improvement	21.0%
Measures without 4-star threshold (n=5)		
	improvement	56.0%

### **Expected Changes to Measure Specifications or Calculations**

For HEDIS 2015, NCQA is considering revisions to the following measures included in the Part C Star Ratings. We appreciate the comments we received and are sharing them with NCQA.

#### *2. Osteoporosis Management in Women who had a Fracture (Part C).*

##### **Summary of Comments:**

Most commenters agreed with the changes, especially with exclusions for estrogen, dementia, and setting an upper age limit (though different ages were recommended by multiple commenters—ranging from 65 to 78, to age 90). A few comments also suggested that the way we currently capture “recent” fractures is flawed and needs to change. Some additional suggestions included limiting the fractures to only vertebral ones; adding other medication exclusions; and excluding plan members in hospice, nursing home or other long term care, rheumatoid arthritis, cancer, and those who are bedridden.

#### *3. Monitoring Physical Activity (Part C).*

##### **Summary of Comments:**

Most commenters did not think this measure was appropriate, fair, or accurate. Some said it cannot be attributed to plans; others said it could not be measured through a survey. Most suggested it should be moved to the display page. Some requested that members in an institution, home bound or chair bound, who have severe disabilities or multiple chronic conditions, or who are enrolled in hospice should be excluded. Some thought increasing physical activity should not be a universal goal or that plans cannot be held responsible for it; others wanted to make sure plans’ efforts to increase physical activity (above and beyond what physicians did in their practices) be captured and credited to the plans.

#### 4. *Plan All-Cause Readmissions (Part C).*

##### **Summary of Comments:**

Most commenters agreed that planned readmissions should be excluded, but they also wondered if and how that could be done without excess burden (going through medical records). Some commenters thought that plans with hospitalists or with tightly integrated delivery system might do better on the measure and that that was somehow unfair. Some recommended putting the measure on the display page. Some wondered how the index admission and 30-day readmission pieces were determined.

#### 5. *Improving Bladder Control (Part C).*

##### **Summary of Comments:**

Most commenters requested that bladder control exercise be considered a legitimate recommended intervention or treatment or asked for clarifications on this point. Some wanted the measure moved to the display page because the specifications are being changed.

#### 6. *Plan Makes Timely Decisions about Appeals (Part C).*

##### **Summary of Comments:**

Most plans had no comment. Some agreed that plans should be able to review and dismiss some cases from the calculation. Some recommended moving the measure to the display page.

##### **Revised Proposed Change:**

CMS is proceeding with the proposed change. CMS will not be moving this measure to the display page since this change was announced in advance of the measurement period.

## **H. Measurement Concepts**

CMS is committed to continuing to improve the Star Ratings by identifying new measures and methodological enhancements. We appreciate the comments received and will consider them as we continue to look at these measurement concepts. We welcome additional feedback and suggestions for new measures.

### 1. Alternatives to the individual measures' current level of evaluation.

##### **Summary of Comments:**

A few of the commenters that expressed an opinion on this topic supported evaluation of contracts at a PBP level. Similarly, a few were against PBP-level measurement and wanted to continue the current contract-level measurement. Most commenters were neutral and offered different levels of evaluation for consideration; for example, rating at a Parent Organization level

or separate ratings for SNP and non-SNP plans. Commenters were concerned that the rating at a PBP level would not be valid because of small member populations.

2. Additional measures of care coordination focusing on how well providers and organizations coordinate services.

**Summary of Comments:**

Commenters both supported and rejected the addition of new health care coordination measures. They requested additional clarity on any new proposed measures as well as an objective methodology. Several stated a bias exists towards integrated health care models and a few requested SNP-specific measures.

3. Measures of care transitions from one healthcare setting to another, for example, care transitions following hospital discharge.

**Summary of Comments:**

Most commenters noted that either transitions are already measured (for SNP plans) or are difficult to measure (for PDPs). Some additional comments suggested that CMS should move toward outcome measures, instead of process or paper-based record review measures.

4. Measures of patient-reported outcomes/intermediate outcomes collected through enrollee surveys, including additional ways to measure changes in health and mental health status.

**Summary of Comments:**

A few commenters supported the development of patient-reported outcome measures and even offered their own measures, but most requested that survey-based measures be limited to CAHPS and HOS or eliminated altogether because they are subjective, “imprecise,” unreliable, and/or invalid. Some specifically mentioned that ESRD or SNP populations are difficult to measure or should be excluded; most objected to the use of member surveys altogether.

5. Measures that are condition-specific (e.g., mental health such as depression screening, HIV/AIDs, COPD, cancer). These may include one or more measures for a particular condition.

**Summary of Comments:**

A large portion of commenters supported inclusion of mental health measures. Comments also related to concerns with small denominator sizes and costs. Additional concerns included separating SNPs.

6. Combined member dissatisfaction measure – CMS is considering methodologies to combine available data sources of complaints and grievances. As an interim step, CMS may modify the CTM measurement period from 6 months of the current contract year to 12 months of the prior contract year.

**Summary of Comments:**

- A little more than half the commenters supported CMS evaluating different ways to evaluate dissatisfaction.
- Many however did not support CMS' modification of the CTM measurement period from 6 months to 12 months. They stated this would result in using older data, and when the change is initially made, re-use of the same data for two releases of Star Ratings.
- Some appeared to be unfamiliar with the Grievance display measure, as they asked how grievances would be reported to CMS.
- Others reiterated that CMS should test any new measures on the display measure.

**Revised Proposed Change:**

We will clarify the proposal in the draft Call Letter and will propose to defer the change for the CTM measure to 2016. For 2016 Star Ratings, CMS will modify the CTM measurement period from 6 months of the current contract year to 12 months of the prior contract year. We believe 6 month expansion of the data used for this measure will provide a more comprehensive evaluation of the plan. Currently, complaints filed in the 2nd half of a year are not accounted for in a contract's performance rating when only the 6-month period is used. CMS will continue to use complaint data from January-June 2014 for the 2015 Star Ratings. CMS will continue to explore methodologies for combining complaints and grievance data. We will introduce any composite measure to the CMS display page for stakeholder feedback.

7. SNP-specific measures that would focus on any unique aspects of care provided by SNPs.

**Summary of Comments:**

Most commenters agreed that SNPs are unique and warrant measures to capture the value SNPs offer and the challenges SNPs face with the populations they serve. Most additionally suggest that SNPs of different types need to be compared to SNPs of the same type (e.g., dual eligible SNPs should only be compared to other dual eligible SNPs). Few specific measures were suggested, but many commenters thought the current quality improvement activities undertaken by SNPs warrant additional star points (0.5 stars). Admission/readmission to emergency departments, hospitals and nursing homes as well as outcomes more generally were suggested as potential measure types to use with SNPs.

## 8. Alternative weighting of measures.

### **Summary of Comments:**

#### *Alternate Weighting of the Improvement Measure*

A majority of commenters supported the importance of the improvement measure, and thus supported considering alternate weighting of it in order to encourage further improvement efforts; in particular, they supported increasing from the current weight of 3 to weight in the range between 5 and 13. Additionally, most of these commenters demanded that high performers at a minimum be held harmless by this change, or even be given extra reward for consistently exceptional performance.

Several commenters were against increasing the weight of the improvement measure. They either asked to keep the current weight of 3 for consistency or asked that the weight be reduced to 1, as they believe it is a process measure in nature and that higher weight could lead to misclassification of performance.

A few commenters proposed the following alternate ways of measuring improvement:

- Moving towards a system like the Hospital Value-based purchasing program, where hospitals can earn points either based on quality performance or on improvement, whichever is higher.
- Considering denominators: A plan that maintains a performance rate in spite of significant increases in the size of their denominator on a metric or metrics has made significant strides in performance given the increased workload.
- The application of the improvement measure should NOT be only limited to those plans with Star Ratings greater than 2.5 stars (or other minimum threshold).
- Applying an “improvement reward factor” relying on percentiles, similar to how the Reward Factor (i-Factor) is currently calculated.
- Instituting partial bonuses to plans that achieve 4+ stars in key measures or domains

#### *The policy reasons for modifying the weight (3x) of the three Part D Medication Adherence measures.*

A few commenters supported keeping the current weight at 3, but more commenters supported reducing the weights to 1 or 1.5, or combining the measures into a single measure, citing the following reasons:

- High correlations between these three measures. Members that are non-adherent to one medication are also likely to be non-adherent to other medications, so a plan may be

penalized on all three measures for a single member having difficulty with medication adherence.

- The nature of these measures is much closer to a process measure than an outcome measure.
- A plan's medication adherence rates are highly dependent on the demographic and socioeconomic mix of plan members. However, the lack of case-mix adjustment makes it inappropriate to consider these as true outcomes measures.
- The current weighting of these measures means that performance on medication adherence accounts for over 11% of a MA-PD's overall Star Rating (or almost half of a PDP's overall rating), which is disproportionate to any other measure or set of similar measures in the current Ratings system.

*Comments regarding weights of other measures*

- Several commenters requested to reduce weight on HOS measures.

**Revised Proposed Change:**

**Improvement:** CMS received mixed reactions to changing the weighting of the improvement measure. Some wanted the weight reduced to 1, some liked the current weight of 3, and others supported increasing the weight from anywhere from 5x to 13x a process measure. Given the importance of improvement, CMS is proposing to increase the weight to 5x a process measure for the 2015 Star Ratings. This change would further align the Part C and D Star Ratings with value-based purchasing in Medicare fee-for-service.

**Adherence:** CMS received both support to maintain the current weight of the three Part D Adherence measures, as well as requests to decrease their weight. We understand the current PQA-developed measures are claims-based, and therefore cannot measure true clinical outcomes of non-adherence. We disagree with the suggestion to combine these three measures into one composite measure which would contradict industry consensus and beneficiary testing. We welcome additional feedback during the Call Letter process, but would specifically solicit feedback on the option of CMS reducing the weight of these measures for the 2015 Star Ratings to a weight of 1.5, as access measures, versus maintaining their weight of 3 as outcomes measures. We will continue to consider future alternative measures of clinically significant non-adherence, which would be weighted as outcomes measures (3x).

9. Alternative methods for measuring improvement that ensure that the efforts of lower-performing contracts to improve are recognized in the Star Rating system.

**Summary of Comments:**

Some commenters supported CMS considering alternative methodologies for measuring improvement, while a few suggested that the current system provides sufficient incentive for improvement and advocated for keeping the current method. Suggested alternative methodologies include creating population-based measures, a matched cohort in fee for service, and utilizing a benchmark process similar to All-Cause Readmission measure.

**Revised Proposed Change:**

CMS will continue to consider the alternative methods and seek feedback. At this point, CMS will not change the current method.

10. Feasibility of replicating current HEDIS measures by using FFS administrative data – CMS is interested in evaluating stand-alone PDPs’ performances in areas that traditionally are based on medical record reviews.

**Summary of Comments:**

A minority of commenters supported using FFS data to replicate HEDIS measures for standalone PDPs. Most of commenters were either neutral or against the proposal. Many commenters stated that PDPs have limited or no influence over physicians operating in FFS and recommended against a measure that would attempt to replicate current HEDIS measures by using FFS administrative data.

**Revised Proposed Change:**

CMS continues to explore if this is feasible and welcomes additional feedback or ideas from sponsors.