RAND Medicare Advantage (MA) and Part D Contract Star Ratings Technical Expert Panel April 30, 2019 Meeting

PRESENTATION

Cheryl L. Damberg and Maria DeYoreo

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Technical Expert Panelists

- Arlene Ash, PhD
- Liza Assatourians, JD
- Anne Burns, RPh
- Kim Caldwell, RPh
- Lindsey Copeland, JD
- Jennifer Eames Huff, MPH
- Eve Kerr, MD, MPH
- Elisa Munthali, MPH
- Amy Nguyen Howell, MD, MBA
- Deborah Paone, DrPH, MHSA
- Ninez Ponce, MMP, PhD
- Patrick Romano, MD, MPH
- Allyson Schwartz, MSS
- Nadine Shehab, PharmD, MPH
- Jane Sung, JD
- Dolores Yanagihara, MPH

New Panelist

Kim Caldwell has been practicing pharmacy for more than 40 years. Mr. Caldwell is Principal at Texas Star Healthcare Consulting. He led Pharmacy Professional Affairs and Comprehensive Health Insights teams at Humana and was Division Director at the Center for Medicare and Medicaid Services (CMS) for Clinical and Economic Performance in the Center for Beneficiary Choices. Mr. Caldwell's other professional service includes more than 12 years on the Texas State Board of Pharmacy and two terms on the Texas Statewide Health Coordinating Council.

RAND Attendees

- Cheryl Damberg, researcher and project Director
- Maria DeYoreo, statistician and project co-Director
- Marc Elliott, researcher and lead statistician
- Justin Timbie, researcher and task lead
- Andy Bogart, analyst
- Erin Taylor, researcher and task lead
- Bob Rudin, researcher
- Jessica Phillips, project manager

Meeting Agenda – April 30, 2019

11:00 am – 11:10 am ET (8:00 am – 8:10 am PT)	**Review of Today's Agenda and Meeting Goals**	Cheryl Damberg
11:10 am – 12:00 pm ET (8:10 am – 9:00 am PT)	**Update on Utility and Feasibility of Constructing and Reporting Star Ratings at Smaller Geographic Units**	Justin Timbie, Andy Bogart, and Marc Elliott
12:00 pm – 12:10 pm ET (9:00 am – 9:10 am PT)	**Update on Patient-Reported Outcome Measures**	Cheryl Damberg
12:10 pm – 12:30 pm ET (9:10 am – 9:30 am PT)	**Soliciting Input on Price Transparency**	Erin Taylor and Cheryl Damberg
12:30 pm – 12:50 pm ET (9:30 am – 9:50 am PT)	**Soliciting Input on Interoperability**	Bob Rudin and Cheryl Damberg
12:50 pm – 1:00 pm ET (9:50 am – 10:00 am PT)	**Closing Comments**	Cheryl Damberg

Update on Utility and Feasibility of Constructing and Reporting Star Ratings at Smaller Geographic Units

Justin Timbie, Andy Bogart, Susan Paddock, Cheryl Damberg, Maria DeYoreo, and Marc Elliott

Key Questions for the Geographic Simulations

- Does the performance of contracts relative to one another differ “meaningfully” across geographic areas?
- Would reporting contract performance using smaller, geographically-defined units produce different Star Ratings compared with contract-level reporting?

Our Methodology Identifies When Stratified Performance Reporting Might be Beneficial

- Stratified reporting is beneficial when the relative performance of healthcare entities differs across strata
  - CMS Office of Minority Health currently stratifies contract performance by beneficiary race/ethnicity
- "Informativeness" is a metric that quantifies how much information is gained by stratified reporting
  - Measures the % of contract variation within a geographic area that is explained by stratification
  - We estimate the average % across all geographic strata

"Informativeness" Quantifies the Variation in Contract Performance that is Explained by Stratification

- Informativeness is measured on a scale from 0 to 1
  - Informativeness =0 when contracts have the same relative performance across the geographic units examined
  - Informativeness =1 when variation in contract performance is explained entirely by the geographic units examined
- We use cutoffs to identify low, moderate, high informativeness
  - below 0.25 (Low): less than 25% of contract variation is explained by geographic strata
  - 0.50 or higher (High): 50% or more of contract variation is explained by geographic strata

We Estimated and Compared Informativeness For Four Types of Geographic Areas

- Census Divisions (n=9)
- MA Regions (n=26)
- States (n=51)
- Hospital Referral Regions (n=306)

Our Main Analysis Focused on 6 Measures

Performance Measures

1. HEDIS: Breast Cancer Screening
2. HEDIS: Osteoporosis Management in Women who had a Fracture
3. HEDIS: Diabetes Care - Blood Sugar Controlled
4. CAHPS: Getting Needed Care
5. CAHPS: Rating of Drug Plan
6. PDE: Diabetes Medication Adherence

We Then Examined 6 Additional CAHPS Measures in a Subsequent Analysis

Performance Measures

1. HEDIS: Breast Cancer Screening
2. HEDIS: Osteoporosis Management in Women who had a Fracture
3. HEDIS: Diabetes Care - Blood Sugar Controlled
4. CAHPS: Getting Needed Care
5. CAHPS: Rating of Drug Plan
6. PDE: Diabetes Medication Adherence

Additional Performance Measures (All CAHPS)

1. Getting Appointments and Care Quickly
2. Care Coordination
3. Customer Service
4. Rating of Health Care Quality
5. Rating of Health Plan
6. Getting Needed Prescription Drugs

We Used Data from 477 Contracts and Created Smaller "Geographic Reporting Units"

- 421 MA-PD and 56 PDP contracts that received Star Ratings in 2018
  - We present only MA-PD results
- Contracts were split into units defined by geography (e.g., states)
  - "Geographic Reporting Units"
- Analyses were limited to beneficiaries in GRUs that met sample size/reliability criteria (next slide)

We Used Minimum Sample Size/Reliability Criteria to Identify Eligible Geographic Reporting Units (GRUs)

Measure category	Sample Size	Reliability
HEDIS	≥ 500 enrollees & ≥ 30 patients in measure denominator	≥ 0.7 (only if geographic reporting unit has 500-999 enrollees)
CAHPS	--	≥ 0.7 & ≥ 30 patients in measure denominator
PDE	> 30 eligible member-years enrollment	--

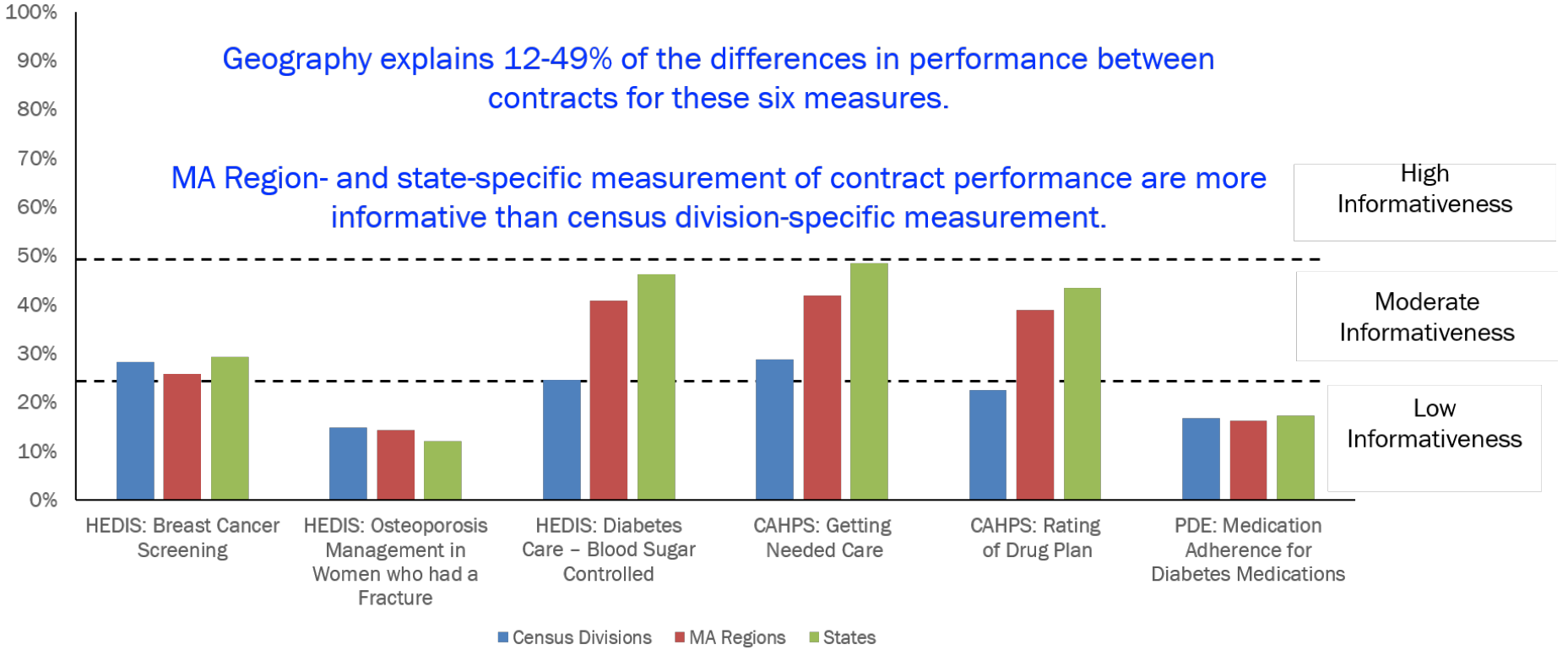
The Simulations Comprised Three Main Steps

1. Estimated models to explain contract variation in performance and generate "informativeness" metrics
   - 6 measures * 4 geographic areas = 24 models
2. Examined six additional CAHPS measures
3. Assessed mean reliability of stratified scores

We Had Difficulty Fitting Models for Certain Geographic Units and Measures

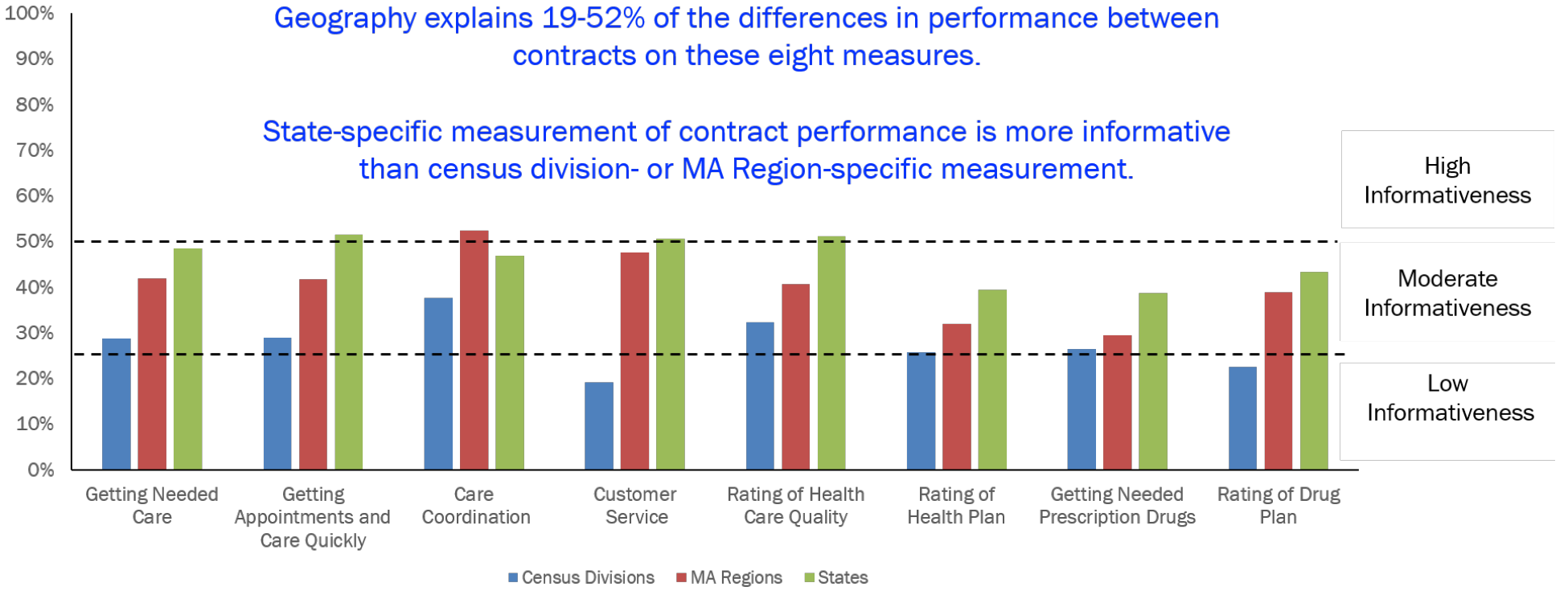
- For HRR simulations, we had insufficient power to estimate contract performance within HRRs
  - All six models failed to converge (HRR results are not shown)
  - Models failed to converge even after we restricted the sample to try to improve stability
- For all other simulations, we had difficulty fitting models for no more than 2 measures (see next two slides)

Informativeness of Geographic Variation in Relative Contract Performance: 6 Measures



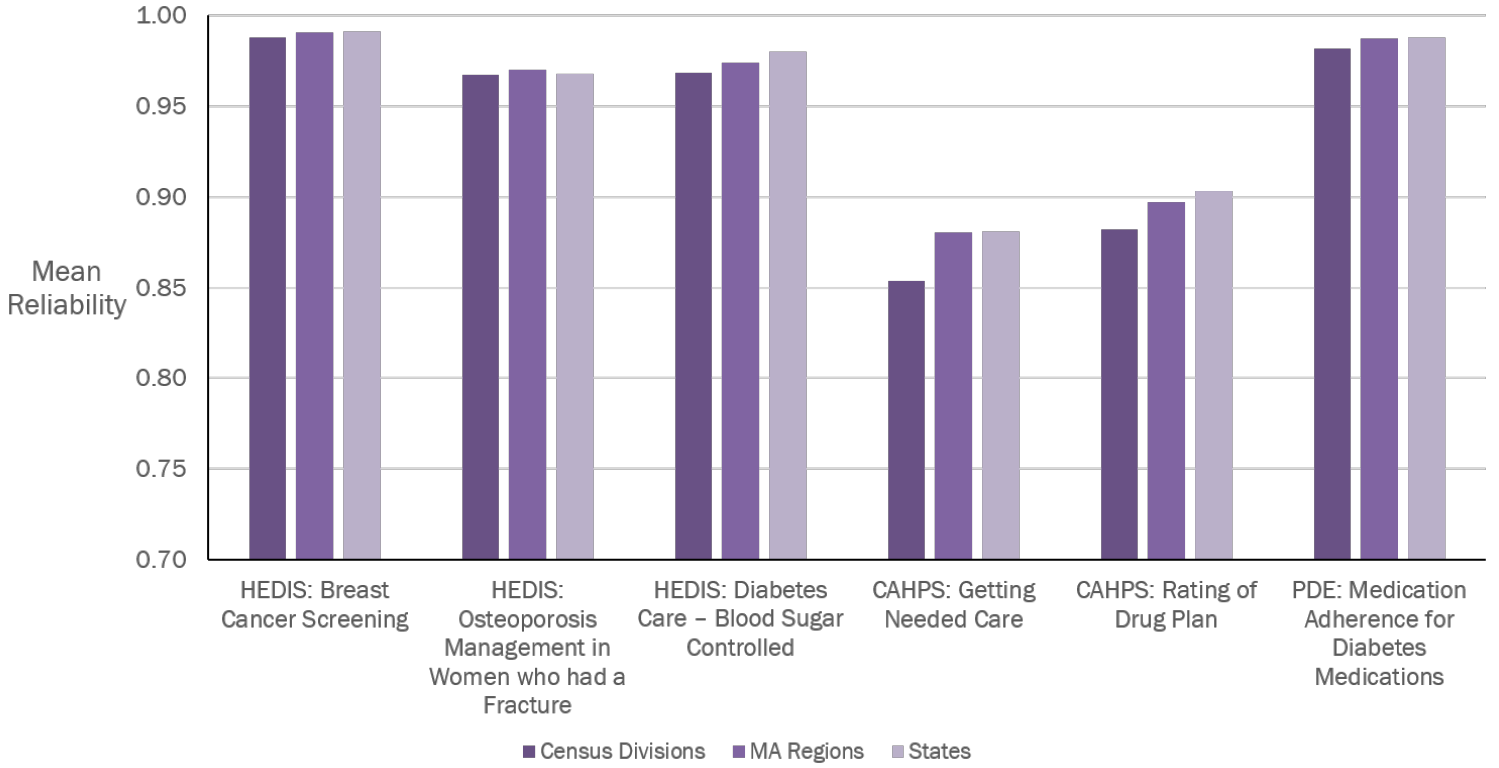
An informativeness value of 0% means that geography explains none of the differences in performance between contracts; 100% means that geography explains all of the differences in performance between contracts.

Informativeness of Geographic Variation in Relative Contract Performance: All CAHPS Measures



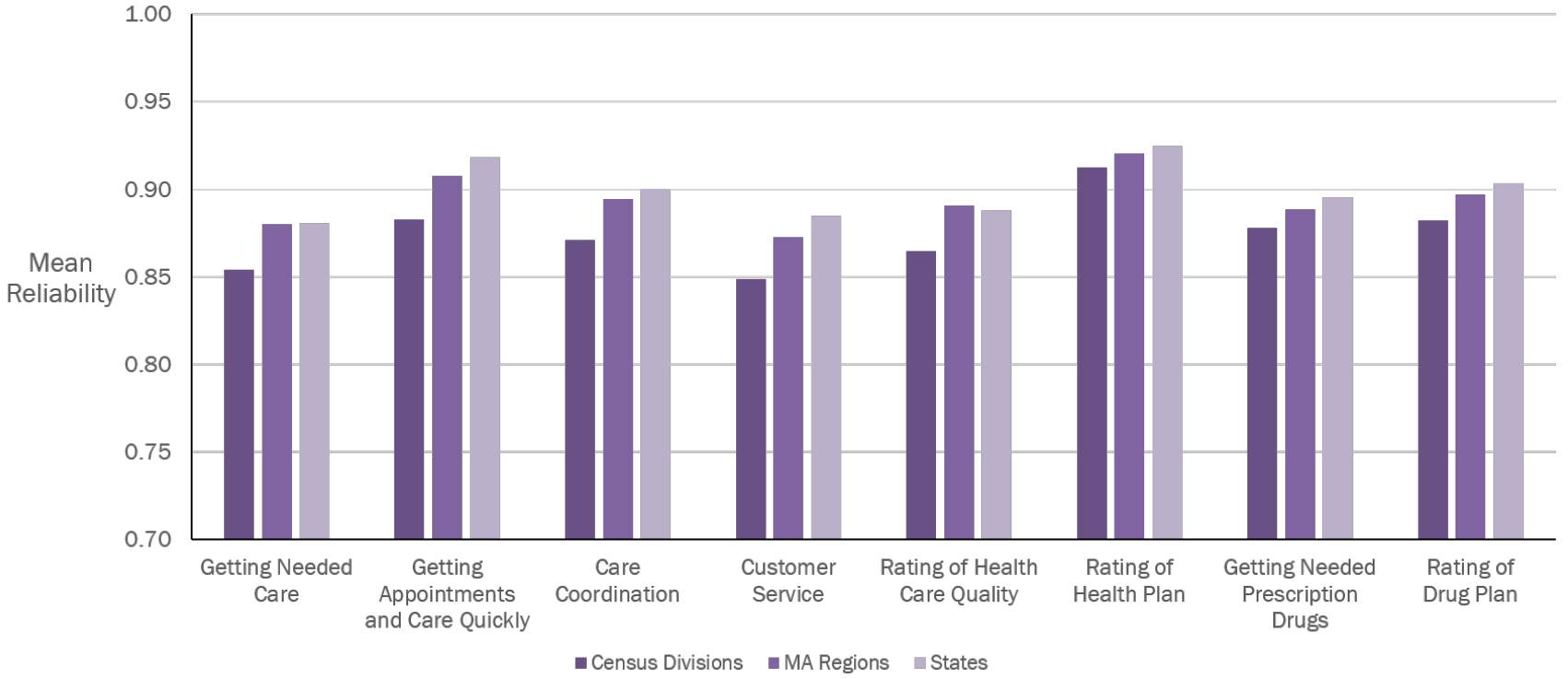
An informativeness value of 0% means that geography explains none of the differences in performance between contracts; 100% means that geography explains all of the differences in performance between contracts.

Mean Reliability of Stratified Scores: 6 Core Measures



Notes. The sample includes all MA Geographic Reporting Units that met measure-specific sample size/reliability criteria.

Mean Reliability of Stratified Scores:
All CAHPS Measures



Notes. The sample includes all MA Geographic Reporting Units that met measure-specific sample size/reliability criteria.

Our Geographic Analyses Covered Over 74% of Enrollees in our Sample of Contracts

	Percent of reporting units that meet sample size and reliability criteria				Percent of MA beneficiaries who live in reporting units that meet sample size/reliability criteria			
Measure	Contracts	Contract-Census Division Units	Contract-MA Region Units	Contract-State Units	Contracts	Contract-Census Division Units	Contract-MA Region Units	Contract-State Units
HEDIS: Breast Cancer Screening	91%	55%	39%	**34%**	99%	99%	99%	**99%**
HEDIS: Osteoporosis Management	62%	35%	23%	**18%**	97%	95%	93%	**92%**
HEDIS: Diabetes Care - A1c Control	97%	51%	31%	**23%**	99%	96%	93%	**89%**
CAHPS: Getting Needed Care	60%	36%	23%	**18%**	86%	82%	79%	**78%**
CAHPS: Rating of Drug Plan	77%	39%	24%	**18%**	89%	77%	74%	**78%**
PDE: Diabetes Medication Adherence	100%	67%	51%	**46%**	100%	99%	99%	**99%**

Most state-specific reporting units that do not meet measure-specific sample size and reliability criteria are sparsely-populated geographic areas.

State-Specific Reporting Is Easier for D-SNPs and Harder for PPO Contracts

Contract Characteristic	Number of Contracts	Total Number of State-Specific Reporting Units	% of State-Specific Reporting Units That are Ineligible for at least half of Measures (≥3 of 6)	% of MA Beneficiaries Enrolled in these Contracts that Live in These Ineligible State-Specific Reporting Units
Contract Type				
1876 Cost	10	17	17.6%	8.0%
HMO	310	633	52.6%	2.6%
Local PPO	85	1158	90.6%	29.6%
Regional PPO	9	336	95.8%	33.7%
D-SNP Enrollment				
<50% enrolled in D-SNPs	346	2105	81.7%	12.5%
≥50% enrolled in D-SNPs	75	99	37.4%	2.9%

Nearly 30% of Local PPO enrollees and 34% of Regional PPO enrollees live in states where contract performance cannot be reliably measured for their state for at least half of the six measures analyzed.

Possible Next Steps for Geographic Simulations

- Continue sensitivity analyses
- Expand informativeness analyses to include all beneficiary-level quality measures
- Derive star thresholds for Geographic Reporting Units and simulate overall Star Ratings
  - Incorporate all other measures (complaints, appeals, call center, etc.)
- Depending on these results, explore ways to provide stratified reports to beneficiaries

Patient-Reported Outcome Measures

Cheryl Damberg

April 30, 2019

Background

- CMS is considering using new and more targeted patient-reported outcome (PRO) measures to hold Medicare Advantage and Part D contracts accountable for the outcomes of care for their members
- Feedback and suggestions on adding PRO measures to the Star Ratings program were solicited through:
  - CMS Call Letter request for comments
  - RAND TEP

Existing PROs in Star Ratings

- Two Health Outcomes Survey (HOS) measures are included in the Star Ratings system:
  - **Measure C04: Maintaining or Improving Physical Health**
    - Percent of plan members whose physical health was the same or better than expected after two years
    - Case-mix adjusted
  - **Measure C05: Maintaining or Improving Mental Health**
    - Percent of plan members whose mental health was the same or better than expected after two years
    - Case-mix adjusted

Commenters

- CMS received comments on PRO measures from the following types of stakeholders:
  - Health Plans
  - Measure Developers
  - Advocacy Organizations
  - Health Care Consultants
  - Consumers
  - Pharmaceutical Companies
  - Professional Associations
  - RAND TEP Members

Comments on Current HOS Measures

- HOS measures are general measures of health-related quality of life, with the advantage of being broadly inclusive. Beneficiaries are eligible to respond to the questions regardless of any specific diagnosis or experience of specific symptoms ***(Health Plan)***
- Current HOS measures are a good start; however, more timely, real-time, patient-reported outcome measures are needed ***(RAND TEP)***
- Concern that low response rates bias results ***(Health Plan and RAND TEP)***
- Concern HOS measures conflate health and function and do not control for the natural aging process or patients' goals of care (e.g., a person with functional limitations can have good quality of life) ***(Health Plan and RAND TEP)***

Commenters Identified Benefits of PRO Measures

- Patients are the ideal source of information on how care affects their symptoms, functioning and overall quality of life *(Measure Developer)*
- Clinical measures provide information about clinical outcomes but PRO measures can capture different information on complexity or burden of treatment for the patient *(RAND TEP)*

Concerns About PRO Measures

- Many factors outside the influence of plans (e.g., caregiving needs, social isolation/living situation, income support) impact patients' responses ***(Health Plan)***
- Plans with high number of members impacted by social determinants of health will be disproportionately impacted by such measures ***(Health Plan)***
- Implementation and reporting burden on plans and patients ***(Health Plan)***
  - Staff training and enhanced EHRs are needed to collect PRO measures
  - Time is required from patients to respond to questions

Comments Received - Recommendations

- Reduce weights assigned to existing HOS measures *(Health Plans)*
- Introduce PRO measures for specific clinical conditions such as asthma, heart failure, hip and knee replacement, and other high cost conditions compared to more general measures of health-related quality of life *(Advocacy Organization, Health Care Consultant, RAND TEP)*
- Test PRO measures among older adults with multiple chronic conditions *(Health Plan)*
- Focus on PRO measures that are actionable – measures that provide timely feedback; performance can be influenced by clinical improvement strategies *(Health Plans)*

Other Considerations Related to Selecting PROs

- Some plans already use PRO measures to assess clinical progress for individual patients; however, these may not be good candidates to assess PRO measures for populations because of small samples
- PRO measures that assess functioning or symptoms that cut across diagnoses and affect large populations may be good candidates
- How should CMS consider the applicability and actionability of a PRO measure for a contract?

Any additional comments for CMS?

Price Transparency in Medicare Part D

Erin Taylor and Cheryl Damberg

April 30, 2019

Background

- The Medicare Prescription Drug Benefit Program (Part D) provides coverage for pharmaceuticals to Medicare beneficiaries
- Beneficiaries are able to select a plan from among a variety of options available in their area, from two types of plans:
  - Medicare Advantage Prescription Drug Plans (MA-PD)
  - Stand-alone Prescription Drug Plans (PDPs), which operate alongside Original Medicare (fee-for-service, FFS)
- When beneficiaries consider their plan options, it may benefit them to consider the out-of-pocket costs they may incur, including:
  - Premium
  - Deductible
  - Cost sharing for specific drugs the beneficiary takes

Background, continued

- Information on the costs beneficiaries may incur is available via a variety of sources, including the Medicare Plan Finder

- Beneficiary costs can vary across a number of dimensions
  - How the plan structures its benefits
    - Whether there is a deductible, and whether some drugs are exempt from the deductible
    - How the plan designs cost sharing – standard benefit design (25%) versus tiered cost sharing
  - Pharmacies (some pharmacies may be preferred by the plan chosen)
  - Drugs the beneficiary currently takes
    - Brand versus generic options
    - Whether the drug is on the plan's formulary
  - Drugs the beneficiary may start to take during the plan year
    - Similar considerations as above, but difficult to predict what drugs may be prescribed

- *All of these dimensions can make it very difficult to identify and compare costs!!*

Price Transparency may be a way to Keep Drug Costs Down

- Medicare Plan Finder currently provides lots of information about beneficiary costs
- CMS goals related to increasing price transparency include:
  - Reduce the growth of beneficiary out-of-pocket spending by increasing awareness of total out-of-pocket costs
  - Increase beneficiary awareness of options for lowering total costs, including the availability of pharmacies with lower prices for their specific drugs
  - Increase plan competition for enrollees by encouraging beneficiaries to change to plans with lower prices, without reducing plan quality

Possible Mechanisms for Improving Price Transparency

- To affect enrollment (which lasts an entire year):
  - Modify the Star Ratings to add a new measure(s) about price transparency
  - Improve presentation of beneficiary cost information to facilitate beneficiary understanding of their potential costs
- Once enrolled, to encourage selection of lower-priced medications:
  - Develop tools to help their enrollees understand their costs and sort among pharmacies

After we show the current Medicare Plan Finder site, we will ask you for feedback on these and other options

Medicare Plan Finder Helps Beneficiaries Sort Through Their MA and Part D Options

- Beneficiaries can go to www.medicare.gov/find-a-plan/questions/home.aspx and enter the following types of information to see options:
  - ZIP code
  - Current plan enrollment (from a list of options in area)
  - Drugs the beneficiary is currently taking (incl. strength and dosage frequency)
  - Select up to two preferred pharmacies
  - Decide whether to see Original Medicare (FFS) and stand-alone Part D, MA-PD, MA-Only, or all options
- Beneficiaries must click through 6 different pages to see initial results
- Beneficiaries can also elect to enter their personal information from their Medicare ID card to see personalized results

An Example of Plan Finder Results…

- Entered information for an example ZIP code and two example drugs
  - ZIP code: 20814 (Maryland)
  - Current plan: WellCare Classic (PDP) with Original Medicare
  - Drug: atorvastatin (generic Lipitor) and Humira
    - Note: I entered Lipitor and was given the option to use the generic drug
  - Preferred pharmacy: selected two for comparison purposes
    - CVS
    - Harris Teeter
  - Decided to see results for both MA-PD and Original Medicare + PDP plans

Plan Finder Results Present Substantial Amounts of Information: the Landing Page

Your Current Plan(s)

WellCare Classic (PDP) (S4802-079-0)

Organization: WellCare

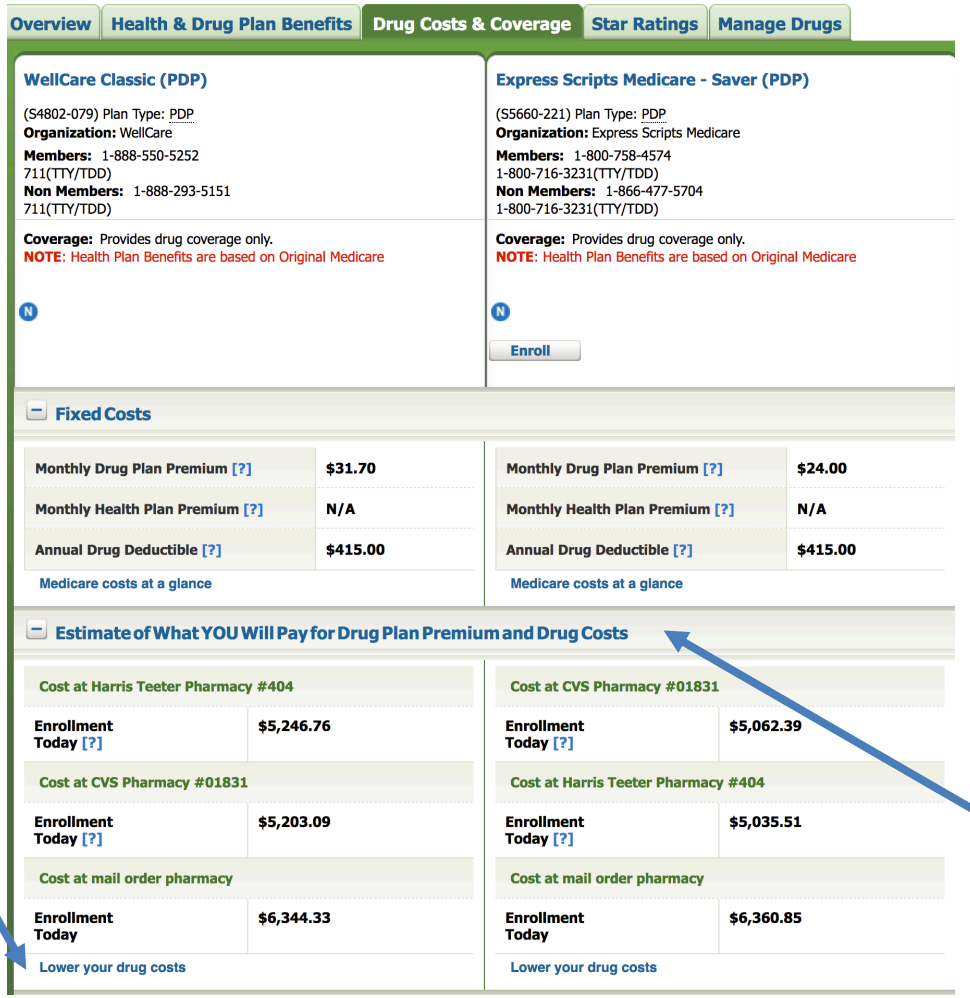
Estimated Annual Drug Costs: [?]	Monthly Premium: [?]	Deductibles: [?] and Drug Copay [?] / Coinsurance: [?]	Drug Coverage [?] , Drug Restrictions [?] and Other Programs:	Overall Star Rating: [?]
Retail Pharmacy Status: Preferred Cost-Sharing Cost as of Today: $5,203 **Mail Order** Cost as of Today: $6,344	$31.70	Annual Drug Deductible: $415 Health Plan Deductible: N/A Drug Copay/ Coinsurance: $0 - $41, 25% - 47%	All Your Drugs on Formulary: :**Yes** Drug Restrictions: **Yes** **Lower Your Drug Costs** **MTM Program : Yes** N	★★★ 3 out of 5 stars

Original Medicare (H0001-001-0)

Includes Part A (Hospital Insurance) and/or Part B (Medical Insurance) - Excludes Part D Drug Coverage

Estimated Annual Drug Costs: [?]	Monthly Premium: [?]	Deductibles: [?] and Drug Copay [?] / Coinsurance: [?]	Health Benefits: [?]	Drug Coverage [?] , Drug Restrictions [?]	Estimated Annual Health and Drug Costs: [?]	Overall Star Rating: [?]
Retail Cost as of Today: $56,855	Standard Part B: $135.50	Part B Deductible: $183	Doctor Choice: Any Willing Doctor Out of Pocket Spending Limit: Not Applicable N	N/A	$79,730 Includes $75,807 for drug costs	Not Available

You can Compare Multiple Plans and Pharmacies at Once



If you click this link you can find other ways to lower your costs (next page)

You can compare your total costs across pharmacies

Additional Information on how to Further Lower Drug Cost Sharing

Ways to Further Lower My Drug Cost Share

The drugs you entered are listed below, with available lower cost options for WellCare Classic (PDP) (S4802-079). You may be able to further lower your estimated costs by looking for generic alternative drugs, similar lower cost drugs, and/or mail order pharmacies. The savings options listed below are for your information only. You should talk with your doctor before making any changes to your prescription drugs.

Pharmaceutical Assistance Programs

Some pharmaceutical companies offer assistance programs for the drugs they make. Check the Pharmaceutical Assistance Programs column in the table below, and click 'yes' for more details about any programs.

Help you get from a Pharmaceutical Assistance Program won't count towards your out-of-pocket spending limits for Medicare Part D.

State Pharmaceutical Assistance Programs

Many states and the Virgin Islands offer help paying Part D plan premiums and/or drug costs. Find out if your state has a program by visiting our **State Pharmaceutical Assistance Program** site.

Retail Prices (30-day supply) | **Mail Order Prices (90-day supply)**

To view savings available from lower cost drugs select "click here to calculate savings".

– Save by comparison your drug choices

SELECTED DRUGS	SAVINGS AVAILABLE FROM LOWER COST DRUGS	PHARMACEUTICAL ASSISTANCE PROGRAMS
Atorvastatin Calcium TAB 10MG	N/A	No
Humira INJ 10/0.1ML	N/A	**Yes**

There is additional assistance available for Humira cost sharing

A Drop-down Option Lets You See How Much Medicare Pays for your Drugs

Estimated Full Cost the Plan Charges Medicare for Your Drugs

Cost at Harris Teeter Pharmacy #404	
Enrollment Today [?]	$47,097.00
Cost at CVS Pharmacy #01831	
Enrollment Today [?]	$46,564.38
Cost at mail order pharmacy	
Enrollment Today	$43,050.63

Cost at CVS Pharmacy #01831	
Enrollment Today [?]	$45,674.82
Cost at Harris Teeter Pharmacy #404	
Enrollment Today [?]	$45,312.48
Cost at mail order pharmacy	
Enrollment Today	$44,721.27

Below the Medicare Costs Option, You Can See How Much You Will Pay During Different Benefit Phases

CVS Pharmacy #01831 | Harris Teeter Pharmacy #404 | Mail Order Pharmacy

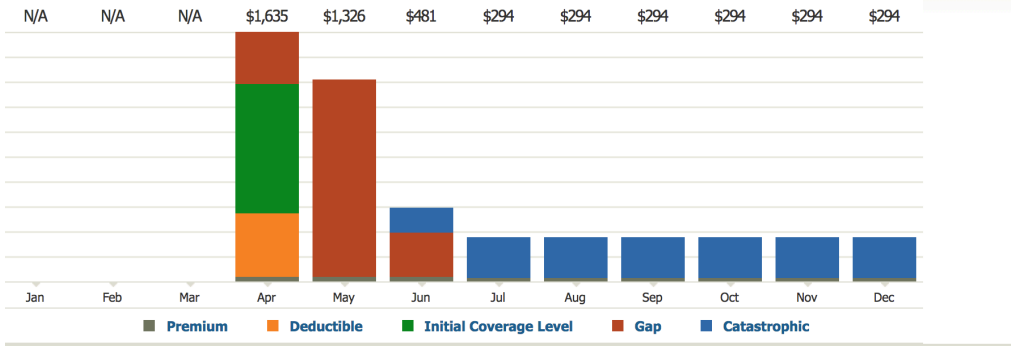
CVS Pharmacy #01831 - Preferred Retail Cost Sharing

SELECTED DRUGS	FULL COST OF DRUG	Refill Frequency	Drug Costs During Coverage Levels: Deductible[?]	Initial Coverage Level[?]	Coverage Gap[?]	Catastrophic Coverage[?]
Atorvastatin Calcium TAB 10MG	$4.50	Every 1 Month	$0.00	$0.00	$1.66	$3.40
Humira INJ 10/0.1ML	$5,169.32	Every 1 Month	$5,169.32	$1,292.33	$1,292.33	$258.47
MONTHLY TOTALS:	$5,173.82		$5,169.32	$1,292.33	$1,293.99	$261.87

Estimated Monthly Drug Costs

CVS Pharmacy #01831 | Harris Teeter Pharmacy #404 | Mail Order Pharmacy

Monthly Costs for the Rest of the Year (based on enrollment today)



Graph depicts an estimate of your monthly prescription drug costs, including any applicable premium for this plan. Actual costs may vary.

View a more detailed explanation of these costs.

This is an example of what is shown when only one plan is selected.

Note some specific information provided:

- The full costs of the drugs are shown ($4.50 and $5,169.32 per month supply)
- The first drug is exempt from the deductible charged by the plan

If You Choose to Compare Two Plans, You See This Monthly Cost Breakdown (Instead of the Figure)

Estimated Monthly Drug Costs

Monthly Drug Costs at Retail Pharmacies

View Drug Cost Summary

MILESTONES	MONTH	YOUR COST
Deductible met	1st	$1,635.28
Donut Hole reached		
	2nd	$1,325.69
Catastrophic met	3rd	$480.70
	4th	$293.57
	5th	$293.57
	6th	$293.57
	7th	$293.57
	8th	$293.57
	9th	$293.57
	10th	$293.57
	11th	$293.57
	12th	$293.57

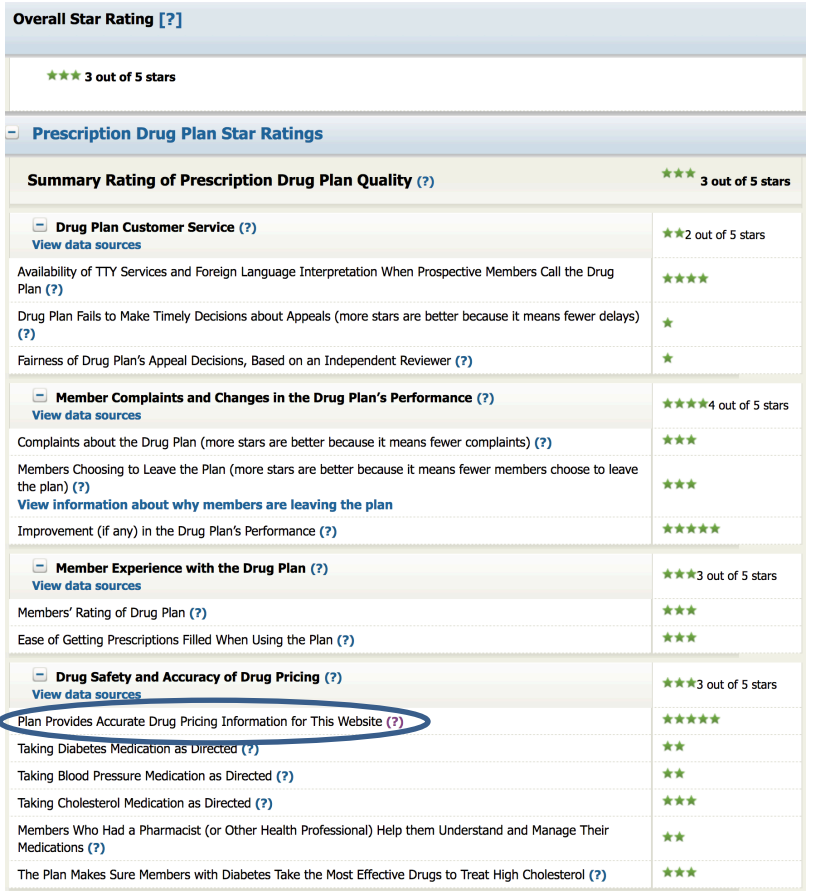
Monthly Drug Costs at Retail Pharmacies

View Drug Cost Summary

MILESTONES	MONTH	YOUR COST
Deductible met	1st	$1,594.39
Donut Hole reached		
	2nd	$1,282.94
Catastrophic met	3rd	$491.50
	4th	$277.78
	5th	$277.78
	6th	$277.78
	7th	$277.78
	8th	$277.78
	9th	$277.78
	10th	$277.78
	11th	$277.78
	12th	$277.78

The Star Ratings Tab Takes You to This Page (One Plan Shown)

Definition for this measure: A score comparing the prices members actually pay for their drugs to the drug prices the plan provided for this website (Medicare's Plan Finder website). Higher scores are better because they mean the plan provided more accurate prices



Overall Star Rating [?]

★★★ 3 out of 5 stars

Prescription Drug Plan Star Ratings

Summary Rating of Prescription Drug Plan Quality (?)	★★★ 3 out of 5 stars
Drug Plan Customer Service (?) View data sources	★★ 2 out of 5 stars
Availability of TTY Services and Foreign Language Interpretation When Prospective Members Call the Drug Plan (?)	★★★★
Drug Plan Fails to Make Timely Decisions about Appeals (more stars are better because it means fewer delays) (?)	★
Fairness of Drug Plan's Appeal Decisions, Based on an Independent Reviewer (?)	★
Member Complaints and Changes in the Drug Plan's Performance (?) View data sources	★★★★ 4 out of 5 stars
Complaints about the Drug Plan (more stars are better because it means fewer complaints) (?)	★★★
Members Choosing to Leave the Plan (more stars are better because it means fewer members choose to leave the plan) (?) View information about why members are leaving the plan	★★★
Improvement (if any) in the Drug Plan's Performance (?)	★★★★★
Member Experience with the Drug Plan (?) View data sources	★★★ 3 out of 5 stars
Members' Rating of Drug Plan (?)	★★★
Ease of Getting Prescriptions Filled When Using the Plan (?)	★★★
Drug Safety and Accuracy of Drug Pricing (?) View data sources	★★★ 3 out of 5 stars
Plan Provides Accurate Drug Pricing Information for This Website (?)	★★★★★
Taking Diabetes Medication as Directed (?)	★★
Taking Blood Pressure Medication as Directed (?)	★★
Taking Cholesterol Medication as Directed (?)	★★★
Members Who Had a Pharmacist (or Other Health Professional) Help them Understand and Manage Their Medications (?)	★★
The Plan Makes Sure Members with Diabetes Take the Most Effective Drugs to Treat High Cholesterol (?)	★★★

MPF Price Accuracy Measure is Designed to Compare Prices Posted on Plan Finder with Those at Pharmacies

- Current measure is an index of price differences comparing prices submitted by plans for the Plan Finder and those observed in the Part D Prescription Drug Event (PDE) data
- Call Letter released on April 1, 2019 implements enhancements that will be used as a display measure in 2020 and 2021, including:
  - Construct an index measuring by how much and how often actual prices exceeded those posted on MPF
  - Expand the types of prescription drug events eligible for inclusion in the measure
    - Increase the days supply allowed from 30 to 100
    - Include both retail/community pharmacy and managed care organization prescriptions
  - Round the decimal for pricing to 2 digits and only count differences greater than $0.01

Questions for the TEP

- What tools might help increase price transparency in Part D and facilitate the following:
  - Beneficiary engagement in selecting lower-cost plans?
  - Selection of pharmacies offering lower costs to the beneficiary for his/her drugs?
- Are there any other measures CMS might consider adding to the Star Ratings to assess price transparency?
- Are there any measures CMS might consider for the Star Ratings that could help beneficiaries understand how the plan compares to other plans on cost?

Interoperability

Bob Rudin and Cheryl Damberg

April 30, 2019

Definitions of Interoperability

- **MACRA definition**: "the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes."

- **Twenty-First Century Cures definition**: "health information technology that enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and does not constitute information blocking."

CMS: Promoting Interoperability Program
(formerly Meaningful Use)

- Current requirements:
  - Use of certified electronic health record technology
  - Attestation to measures such as requesting/accepting summary of care document during transitions, and secure messaging with patient

Example "Use Cases" for Interoperability between Stakeholders

Use Case	Data	Value
Payer (or payer/provider) -> payer	Claims/encounter (+ clinical)	Facilitates pre-authorization, requirements for letters
Payer (or payer/provider) -> provider (contracted, inside plan, or external)	Claims/encounter (+ clinical)	Care coordination, informed/timely decision making
Payer (or payer/provider) -> patient	Claims/encounter (+ clinical)	Patient engagement/activation, transparency for decision-making, lets patient share with other payers or providers in theory

Examples of Types of Clinical Data Exchange Enabled by Interoperability

- **Queries:** When a patient shows up for care, provider sends out electronic request to other health systems and receives back standardized clinical data which is then incorporated into the patient's record
- **Push:** A provider sends a DIRECT message (similar to secure email) to another provider about a patient, instead of using fax
- **Consumer-mediated:** A patient downloads their record from one provider into a personal health record and makes it available to another provider of their choosing

Recent Proposed Rules on Interoperability

- Promotes patient access to data (clinical and administrative) through data standards and application programming interfaces (APIs)
- Promotes data exchange across payers and between patients and providers
- Promotes access to a provider directory and digital contact information for providers
- Requires Medicare Advantage (MA) organizations and other government programs to support interoperability as a condition of participation
- (Upcoming) Trust exchange framework – will provide structures and rules governing data exchange networks

CMS is Exploring Opportunities to Incorporate Interoperability Measures into Star Ratings

Summary of Call Letter Comments

- Many commenters supported the goal of more real-time information exchange across all levels (plans, health systems, providers, and patients)
  - CMS should implement a new Condition of Participation (CoP) for MA plans to require plans (and contract providers) to provide beneficiaries with the ability to access their health information, free of charge, in real-time, in a machine-readable format on their mobile device ***(patient group)***
  - Security and data privacy—need to ensure consumers have appropriate control over use and disclosure of their health data ***(patient group)***

Summary of Call Letter Comments

- Interoperability measures for MA plans should be clinically relevant, use-case driven, and aligned with existing or proposed measures in Medicare FFS ***(health care vendor)***
- Use of "interoperability-sensitive" measures (e.g., ensuring medication reconciliation) rather than measure technology adoption ***(informatics vendor)***
- Prior authorization optimization would be important use ***(plan)***

Summary of Call Letter Comments

- CMS should consider measures that assess ***(informatics vendor)***:
  - Referral loops and provider-to-patient exchange Use of Automated Admission, Discharge and Transfer (ADT) alerts to advance population health management and care coordination
  - Participation in the Trusted Exchange Framework and Common Agreement (TEFCA)—will decrease mechanical and procedural barriers to interoperability
  - Focus on the potential for telehealth within MA plans to serve as a measure of interoperability

Barriers to Interoperability

- Creating metrics at this time would disproportionately favor Integrated Delivery Networks due to fragmentation of existing HIEs and EHR systems ***(provider)***
- Infrastructure dependent on the resources available in each state, as well as the capacity of the health care community in each region. Need to build nationwide capacity first ***(plan)***
- Smaller providers in low-income, resource-scarce areas are particularly challenged ***(plan)***
- Need to reduce limitations for sharing information between providers, payers, and technology intermediaries ***(plan)***
- Standards for many technical and legal aspects of interoperability are still in development, and answers to some practical challenges (e.g., unique patient identifiers across datasets) remain elusive ***(health system)***

What Types of Interoperability Measures Should CMS Consider for Star Ratings?

- MA contract:
  - Sharing data with patients/members?
  - Exchanging data with their contracted providers?
  - Exchanging data with other contracts/payers?
- MA contract's providers:
  - Sharing data with patients/members?
  - Exchanging data with other providers/health systems within the contract?
  - Exchanging data with other providers through:
    - Data exchange networks, such as HIEs?
    - Vendor exchange networks (e.g., CommonWell, CareQuality)?
    - Networks that will be part of Trusted Exchanges (TEFCA)?