

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

**MEETING SUMMARY**

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## RAND Technical Expert Panel Medicare Advantage (MA) and Part D Contract Star Ratings

April 30<sup>th</sup>, 2019

### MEETING ATTENDEES

#### Technical Expert Panel Members

NAME	POSITION
Arlene Ash, PhD	Professor and Division Chief for Biostatistics and Health Services Research in the Department of Quantitative Health Services, University of Massachusetts Medical School
Liza Assatourians, JD	Vice President of Federal Programs, America's Health Insurance Plans (AHIP)
Anne Burns, RPh	Vice President, Professional Affairs at the American Pharmacists Association (APhA)
Kim Caldwell, BS	Principal, Texas Star Healthcare Consulting
Lindsey Copeland, JD	Policy Director, the Medicare Rights Center
Jennifer Eames Huff, MPH	Independent consultant; Senior Advisor, Pacific Business Group on Health
Eve Kerr, MD, MPH	Louis Newburgh Research Professor of Internal Medicine, University of Michigan Medical School, Director of the Ann Arbor VA Center for Clinical Management Research, and Director of the Michigan Program on Value Enhancement
Elisa Munthali, MPH	Senior Vice President of Quality Measurement, National Quality Forum
Amy Nguyen Howell, MD, MBA	Chief Medical Officer, America's Physician Groups (APG)
Deborah Paone, DrPH, MHSA	Performance Evaluation Lead for Quality Measurement, Social Determinants of Health, and Care Innovation, Special Needs Plans (SNP) Alliance
Ninez Ponce, MMP, PhD	Professor, University of California Los Angeles Fielding School of Public Health's Department of Health Policy and Management, Director of the Center for Global and Immigrant Health
Patrick Romano, MD, MPH	Professor of Medicine and Pediatrics, University of California Davis School of Medicine
Allyson Schwartz, MSS	President and CEO, the Better Medicare Alliance
Nadine Shehab, PharmD, MPH	Senior Scientist, Medication Safety Program in the Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention
Dolores Yanagihara, MPH	Vice President of Analytics & Performance Information, Integrated Healthcare Association (IHA)



**RAND Staff**

Cheryl Damberg, PhD (Project Director)  
Maria DeYoreo, PhD (co-Project Director)  
Marc Elliott, PhD  
Justin Timbie, PhD  
Andy Bogart, MS  
Erin Taylor, PhD  
Bob Rudin, PhD  
Jessica Phillips, MS

## MEETING SUMMARY

### Welcome and Introductions

- The RAND meeting facilitator and project lead Statistician, Marc Elliott, began the meeting by welcoming attendees and introducing new Technical Expert Panel (TEP) member, Kim Caldwell.
- Marc Elliott reviewed the agenda and meeting goals. During this third meeting of the TEP, RAND indicated it would provide updates on analyses conducted since the last TEP meeting and solicit input on: 1) the utility and feasibility of constructing and reporting Star Ratings at smaller geographic units, 2) patient-reported outcome measures (PROs), 3) price transparency measures, and 4) interoperability measures.

### The Utility and Feasibility of Constructing and Reporting Star Ratings at Smaller Geographic Units

- Currently, CMS reports Star Ratings at the contract level. Because a single contract can cover multiple geographic areas and performance may vary across areas there is interest in exploring the reporting of performance at smaller geographic units.
- To assess the informativeness of constructing and reporting Star Ratings at smaller geographic reporting units (GRUs), RAND conducted exploratory simulations using 12 quality measures included in the MA Star Ratings. RAND applied four different definitions of GRUs for reporting geographically-stratified results: 1) census divisions, 2) Medicare Advantage (MA) regions, 3) states, and 4) hospital referral regions (HRRs).
- RAND team member, Justin Timbie, presented findings from analyses to assess the informativeness of geographically-stratified reporting. The analyses focused on 1) estimating models to explain contract variation in performance and generate informativeness metrics and 2) assessing the mean reliability of geographically-stratified scores. Additionally, RAND examined contract characteristics for GRUs that did not meet sample size/reliability criteria. *A copy of this presentation can be found in the corresponding slide deck.*
- Questions posed to the TEP were as follows:
  - ***Is there value in geographically-stratified reporting of Star Ratings?***
  - ***Are there any potential unintended consequences and methodological challenges of geographically-stratified reporting that should be considered?***
  - ***Are there specific analyses that might help identify the unintended consequences?***
    - One TEP member commented that geographically-stratified reporting could be helpful for beneficiaries and contracts by focusing attention and improvement efforts on smaller areas. The same Star Rating cut points would have to be set across all GRUs in order to make GRUs comparable. There was concern that some GRUs will be too small to meet sample size and reliability thresholds.

- A TEP member commented that Medicaid is a state driven program and therefore there could be a lot of value in state-level ratings; this TEP member is excited to see future results from the analyses.
- One TEP member commented that we need to determine the cut off for the informativeness metric that supports shifting to GRU reporting. Would geographically-stratified reporting be applied for some measures or all measures? The TEP member commented that they could imagine operational challenges would be higher if geographically-stratified reporting was used for some measures and not others.
  - RAND noted that stratified reporting within contracts has been done for HEDIS and CAHPS measures based on beneficiary race/ethnicity rather than geography. This information was developed outside the Star Ratings project and with the purpose of informing contracts about racial/ethnic disparities.
- A TEP member asked whether RAND has conducted any conceptual and empirical work to look at what might be driving geographic variation. The member stated there may be factors driving CAHPS scores that are beyond the control of contracts, for example, a shortage of primary care physicians in a market. The member said this would not necessarily be the contract's fault, but the providers are stretched too thin and therefore have lower CAHPS scores. The TEP member also said scores could be influenced by poor customer service in a certain area which could reflect labor market characteristics or poor training efforts by a contract (though the latter is within the contract's control).
  - RAND clarified that the methodology used to estimate informativeness controlled for main effects of geography through fixed geographic effects in a model that contains contract random effects, so we are already adjusting for the overall effect of geography, or the average within-contract effect associated with geography. Anything that's out of control of contracts is controlled for. In other words, Plan X may be above average compared to other plans overall, but it may perform poorly in a specific geographic area and great everywhere else, as compared to other plans. The cause of performance therefore has to do with what the plan is doing differently in that area and is not due to a general characteristic of the geographic area.
  - Results are different across CAHPS and HEDIS measures, which may speak to the fact that uniform strategies being applied by contracts across geographic areas work for HEDIS measures but CAHPS measures require more geographically-tailored attention.
- A TEP member noted that they like the idea of presenting ratings by state and contract because that provides more relevant information to beneficiaries. The member is curious if RAND has looked at coherence across measures in different GRUs for the same contract. Are there contracts that consistently perform well across GRUs?



- RAND hasn't examined geographic-deviations for a contract across different measure types. However, in another analysis focused on race/ethnicity, RAND found that contracts that delivered good quality of care to minorities for some measures tended to do so for other measures. RAND commented that this is a good suggestion for future analysis of the geographic-level reporting work.
- One TEP member commented that quality measure developers encounter challenges in demonstrating meaningful differences in measure event rates at the contract level; this then hinders what otherwise could be a sound measure from moving forward for consideration for incorporation into Star Ratings. The member stated that developing sound approaches for alternate ways to report Star Ratings could have a positive influence in the measure development space as well in that it can encourage more than one way of assessing whether a measure is meaningfully different across various strata. The member understood that the considerations/simulations RAND is making are for Star Ratings as a whole vs. specific measures, but thought any consideration given to alternate levels of reporting can potentially have a beneficial indirect impact on the measure development space as well, which may be another reason to pursue this approach.

### **Update on Patient-Reported Outcome Measures**

- RAND team member, Jessica Phillips, presented a summary of comments received by CMS on patient-reported outcome (PRO) measures, including feedback on the two existing Health Outcomes Survey (HOS) measures and incorporating additional patient-reported outcome measures into the Star Ratings program. *A copy of this presentation can be found in the corresponding slide deck.*

### **Soliciting Input on Price Transparency**

- RAND task lead, Erin Taylor, presented an overview on tools and information available to beneficiaries on prescription costs and considerations for introducing measures that support greater price transparency. *A copy of this presentation can be found in the corresponding slide deck.*
- Questions posed to the TEP were as follows:
  - ***Are there 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 a contract compares to other contracts on cost?***
  - ***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?***

- A TEP member commented that increasing price transparency is important and it would be important to see on Plan Finder both the price to the beneficiary and the overall price across different pharmacies to provide a more complete picture of pricing options. This TEP member also noted that pharmaceutical manufacturers can change prices throughout the year and prices displayed online may be out of date.
- Another TEP member noted that price transparency is also a focus of Congress, including looking at the impact of rebates. The member stated that it is important not to lose sight of the impact of cost practices that take place after the point of sale, which impacts beneficiaries' access to pharmacies that are struggling to stay in business. The member said pharmacies provide a lot of services on low margins; also, formulary changes, including to generic medications, can occur throughout the year and can impact pricing.
- A TEP member commented that navigating Plan Finder is complex. When selecting a contract, beneficiaries are managing a lot of decisions at the same time and there is an overwhelming amount of information to consider. The member stated that beneficiaries don't return to Plan Finder as regularly as we would like them to, and if we want to encourage price transparency, we need to provide beneficiaries with tools and support over the long-term, not just initially.

### **Soliciting Input on Interoperability**

- RAND researcher, Bob Rudin, presented on types of clinical data exchange enabled by interoperability, recent proposed rules on interoperability, and a summary of comments received by CMS on exploring opportunities to incorporate interoperability measures into the Star Ratings program. *A copy of this presentation can be found in the corresponding slide deck.*
- Questions posed to the TEP were as follows:
  - ***What types of interoperability measures should CMS consider for Star Ratings?***
  - ***MA contracts:***
    - ***Sharing data with patients/members?***
    - ***Exchanging data with their contracted providers?***
    - ***Exchanging data with other contracts/payers?***
  - ***MA contracts' 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, vendor exchange networks, or networks that will be part of Trusted Exchanges (TEFCA)?***
  - A TEP member stated that dually-eligible beneficiaries receive multiple types of services (e.g., home and community-based services (HCBS), transportation, behavioral health services) and have high

social risk factors. The member said that it is important to share information across all service providers to achieve good care coordination, including information on behavioral/mental health; however, each state has different regulations regarding sharing behavioral/mental information. Additionally, the member stated that HCBS providers play an important role and without information from those providers half the picture is missing. The member said that data exchange capabilities and access to training vary widely; interoperability is a wonderful goal, but capability building is needed. The member stated that individual and family caregivers are quite good at keeping paper records and tend to be more attuned to the full continuum of care being received compared to an individual provider.

- A TEP member supported greater data sharing, including with mental health providers, which is not yet approved by Congress. The member noted that they have seen an increase in information sharing across contracts, providers, and community partners but more work is needed to build system-wide capacity. The member also noted that more incentives would be helpful.
- One member agreed with the previous two commenters. The member said that from the pharmacy perspective, individual practices have infrastructure in place, but the next hurdle is to establish meaningful exchange of information. The member said that it is unclear who should have access to the information and how to regulate the quality of the data being exchanged; introducing a measure now is premature unless it is a display measure focused on ability to exchange accurate data. A lot of historical data are starting to be exchanged. The member encouraged CMS to provide guidance to establish a foundation for meaningful metrics.
- Multiple TEP members expressed concern that it is too early to introduce interoperability measures in the Star Ratings program; it is going to take more work before interoperability can be operationalized.
- One TEP member shared that Medicare providers they know do not use electronic records and if forced to use them will stop working. Additionally, the member said that it is premature to know how to safeguard information moving across systems.
- One member stated that they would love if plans could share data. The member said they have experienced being a patient trying to transport medical records across providers – very annoying. The member said it falls on the regulatory environment to make this happen and they are unsure it makes sense to make contracts accountable. The member agreed we need to move in the direction of greater interoperability but didn't see that it is contracts holding progress back.
- A member said it is premature to focus on contracts; interoperability standards need to be adopted before moving forward.

- A TEP member stated that plans should have to provide data to patients when they ask for it and make it easier than providing stacks of poorly copied paper records. The member said an important dimension of information exchange is respecting active opt out, for example thinking of patients who received upsetting diagnoses.
- A member expressed frustration with difficulty of sharing information with family caregivers; this is something to consider when developing a measure. The member stated that data will be shared much more quickly across different applications and there is potential for data to be shared across platforms that are no longer HIPAA protected. Looking towards the future, how well will patient data be protected, and will patients understand where their data are being transferred to?
- A TEP member shared that they believe there is a lot of interest in sharing data with beneficiaries since beneficiaries want clinical data from providers. How can we compel plans to compel providers to share data?
- A member stated that CMS could possibly start with a structure measure; they don't think the marketplace is ready for a process measure.
- A member suggested that CMS could consider a measure focused on the extent that information exchange is occurring in the marketplace.