Medicare Advantage (MA) and Part D Contract Star Ratings

PRESENTATION

Cheryl L. Damberg and Maria DeYoreo
RAND Technical Expert Panel (TEP)

Medicare Advantage (MA) and Part D Contract Star Ratings

November 7, 2019
TEP members

- **Arlene Ash**, PhD University of Massachusetts
- **Liza Assatourians**, JD, America’s Health Insurance Plans
- **Anne Burns**, RPh, American Pharmacists Association
- **Kim Cadwell**, RPh, Texas Star Healthcare Consulting, LLC
- **Lindsey Copeland**, JD, Medicare Rights Center
- **Emma Hoo**, Pacific Business Group on Health
- **Eve Kerr**, MD, MPH, University of Michigan
- **Elisa Munthali**, MPH, National Quality Forum
- **Amy Nguyen Howell**, MD, MBA, America’s Physician Groups
- **Deborah Paone**, DrPH, MHSA, Special Needs Plan (SNP) Alliance
- **Ninez Ponce**, MMP, PhD, University of California Los Angeles School of Public Health
- **Patrick Romano**, MD, MPH, University of California Davis
- **Allyson Schwartz**, MSS, Better Medicare Alliance
- **Jane Sung**, JD, American Association of Retired Persons
- **Dolores Yanagihara**, MPH, Integrated Healthcare Association
Welcome to our newest TEP member

**Emma Hoo**—Director of the Pay for Value team at Pacific Business Group on Health

- Her work focuses on care redesign, measurement and payment reform initiatives, including assessment of Accountable Care Organizations, adoption of common Accountable Care Organization quality and efficiency measures, and expanding use of patient-reported outcomes measures.

- She has managed joint purchasing and performance measurement initiatives for health plan, pharmacy benefit, and disease management services on behalf of PBGH members.

- Hoo has published on provider network management and design, consumer-directed health plans, Accountable Care Organizations, and quality reporting requirements for health insurance exchanges.

- Previously, she was director of operations for a Northern California medical group, with responsibility for contracting, data analysis, and information systems.
RAND team members

- Cheryl Damber, Project Director
- Maria DeYoreo, Project co-Director
- Research team for today’s meeting topics:
  - Marc Elliott, Principal Senior Statistician
  - Justin Timbie (geographic analyses)
  - Andy Bogart (geographic analyses)
  - Melony Sorbero (ESRD)
  - Erin Taylor (Generic Rx)
- Chau Pham, Project Manager
<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>3:00 pm – 3:10 pm ET (12:00 pm – 12:10 pm PT)</td>
<td>Review agenda and meeting goals</td>
<td>Cheryl Damberg</td>
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<tr>
<td>3:10 pm – 3:35 pm ET (12:10 pm – 12:35 pm PT)</td>
<td>ESRD measures</td>
<td>Melony Sorbero</td>
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<tr>
<td>3:35 pm – 4:00 pm ET (12:35 pm – 1:00 pm PT)</td>
<td>Generic prescribing measures</td>
<td>Erin Taylor</td>
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<tr>
<td>4:00 pm – 4:30 pm ET (1:00 pm – 1:30 pm PT)</td>
<td>Reporting Star Ratings at the Parent Organization level for select measures</td>
<td>Maria DeYoreo and Cheryl Damberg</td>
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<td>4:30 pm – 4:50 pm ET (1:30 pm – 1:50 pm PT)</td>
<td>Update on geographic reporting analyses</td>
<td>Justin Timbie</td>
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<td>4:50 pm – 5:00 pm ET (1:50 pm – 2:00 pm PT)</td>
<td>Closing comments</td>
<td>Cheryl Damberg</td>
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ESRD Measures

Melony Sorbero
CMS is considering adding ESRD treatment measures to Part C and Part D Star Ratings in future

- Medicare is the primary payer for individuals with end-stage renal disease (ESRD)
- Historically few beneficiaries with ESRD were enrolled in Medicare Advantage
- Beneficiaries with ESRD could only enroll in Medicare Advantage if:
  - Enrolled in a chronic condition special needs plan that focuses on ESRD
  - Have job-based insurance through insurance company that offers a Medicare Advantage Plan
- The Twenty-First Century Cures Act (CURES; P.L. 114-255) allows beneficiaries with ESRD to enroll in any Medicare Advantage plan starting in 2021
ESRD is final stage of chronic kidney disease (CKD)

- CKD: kidneys are damaged and ability to filter blood is reduced
  - 5 stages based on glomerular filtration rate (GFR)
    - ESRD is GFR less than 15 mL/min and represents kidney failure
  - Estimated 30 million adults in America have some level of CKD
    - More than 726,000 have ESRD

- Risk factors include diabetes, high blood pressure, heart disease, and family history of kidney failure
Part C & Part D Star Ratings include very few kidney disease specific measures

- Currently includes *Diabetes Care – Kidney Disease Monitoring*
  - Percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had medical attention for nephropathy during the measurement year (numerator)

- However, ESRD patients are included in most other measures in Star Ratings
  - Excluded from measures on:
    - Statin use among people with cardiovascular disease and diabetes
    - Medication adherence for diabetes, hypertension, and cholesterol
  - ESRD meets advanced illness portion of advanced illness and frailty exclusion* for:
    - Breast cancer screening
    - Colorectal cancer screening
    - Diabetes care – eye exam, kidney disease monitoring, and blood sugar controlled
    - Rheumatoid arthritis management

* Beneficiaries 66 years or older who meet criteria for both advanced illness and frailty are excluded from selected measures.
Executive order on Advancing American Kidney Health identified policy goals, which can inform ESRD measure development and selection

- Prevent kidney failure through better diagnosis, treatment, and incentives for preventive care
- Increase patient education and choice of ESRD treatments, and encourage development of artificial kidneys
- Increase access to kidney transplants by modernizing regulation and systems
- Adopt payment models to incentivize earlier identification and treatment of advanced kidney disease and increase home dialysis and kidney transplants
Identified existing measures for ESRD and CKD more broadly

- Focused on ESRD Quality Incentive Program (QIP), the Center for Medicare and Medicaid Innovation (CMMI) Comprehensive ESRD Care Model (CEC), Merit-based Incentive Payment System (MIPS), and other NQF measures

- Identified 75 CKD or ESRD measures
  - More than half are specific to care delivered in facilities
  - 6 include health plan as level of analysis
    - Chronic Kidney Disease: Monitoring Parathyroid Hormone (PTH)
    - Chronic Kidney Disease - Lipid Profile Monitoring
    - Chronic Kidney Disease with LDL Greater than or equal to 130 – Use of Lipid Lowering Agent
    - Influenza Immunization specific to those with CKD/ESRD
    - Chronic Kidney Disease: Monitoring Calcium
    - Chronic Kidney Disease: Monitoring Phosphorus
  - 6 measures focus on pediatric population
Clinical process of care measures are most common

• Types of measures identified for beneficiaries with ESRD:
  – 49 process of care measures
  – 21 outcome/intermediate outcome measures
  – 3 structural
  – 1 patient experience
  – 1 cost/resource use

• Some measure care already assessed in Star Ratings, but limit population to those with ESRD or CKD. For example:
  – Influenza immunization for those with ESRD
  – Medication reconciliation for those with ESRD
Examples of ESRD-related measures that could potentially be modified for inclusion in Star Ratings

• Standardized Hospitalization Ratio for Dialysis Facilities (not in a program; outcome; NQF #1463)

• Infection Monitoring: National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Patients Clinical Measure (ESRD QIP; outcome; based on NQF #1460)

• Vascular Access Type (VAT) Measure Topic – Catheter greater than 90 Days Clinical Measure (ESRD QIP; similar MIPS measure; outcome; NQF # 0256)

• Clinical Depression Screening and Follow-up Reporting Measure (ESRD QIP; CEC; process; based on NQF# 0418)
Key questions for TEP

- Should CMS consider adding CKD or ESRD measures to the Star Ratings in the future?

- Are there certain CKD or ESRD quality of care measures that should be higher priority for potential inclusion in the Star Ratings?

- Are there issues CMS should consider in adding CKD or ESRD measures given the uncertainty about how many beneficiaries with ESRD will select Medicare Advantage?

- Will any of these plan-level measures work (given small denominators)?
Generic Prescribing Measures

Erin Taylor
Background

• CMS is considering additional measures designed to encourage cost reductions and increased efficiency

• Dispensing low-cost generic alternatives instead of more-costly branded medications is one approach to reduce prescription drug costs

• For purposes of these analyses, CMS relies on the definitions of brands and generics as outlined in 42 CFR § 423.4
## Generic dispensing rates

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Category of Prescription Drugs</th>
<th>Included/ Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic Dispensing Rate (GDR)</strong></td>
<td>Generic and Brand</td>
<td>Included</td>
</tr>
<tr>
<td></td>
<td>Generic Only</td>
<td>Included</td>
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<tr>
<td></td>
<td>Brand Only</td>
<td>Included</td>
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<tr>
<td><strong>Generic Substitution Rate (GSR)</strong></td>
<td>Generic and Brand</td>
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<td></td>
<td>Generic Only</td>
<td>Excluded</td>
</tr>
<tr>
<td></td>
<td>Brand Only</td>
<td>Excluded</td>
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</table>
Generic prescribing rates have historically been very high in Part D

- Most inclusive measure (GDR) was 83.5% for MA-PDs and 81.9% for PDPs in 2017 (across all drugs dispensed under each program)

- GSR, which captures potential for substitution away from higher-cost branded drugs, was 91.6% for MA-PDs and 90.7% for PDPs in 2017
Generic prescribing can also focus on specific therapeutic classes

• While overall rates of generic prescribing are very high, rates within certain therapeutic classes may present room for improvement
Questions for the TEP

• What are some pros and cons of incorporating generic prescribing measures into the Star Ratings?

• Should CMS consider any additional generic prescribing measures, such as measures focused on specific therapeutic classes?
  – What classes might be worth exploring?

• How could biosimilars best be incorporated into the measures?
Reporting Star Ratings at the Parent Organization Level

Cheryl Damberg and Maria DeYoreo
How do plans and contracts relate to Parent Organizations?

PBP denotes “Plan Benefit Package”
DSNP, which refers to a Dual Eligible Special Needs Plan, is a type of PBP
How many contracts fall under a single Parent Organization?

- Of **306 Parent Organizations** in 2019, the majority have only a single contract (i.e., contract and Parent Organization are one and the same).

- 95% of Parent Organizations have 5 or fewer contracts.

- But there are a small number of very large Parent Organizations that have more than 5 contracts:
  - 3% have between 6 and 10
  - 1% have between 11 and 30
  - 2% have more than 30

<table>
<thead>
<tr>
<th>Number of Contracts</th>
<th>Percentage of Parent Organizations</th>
<th>Number of Parent Organizations</th>
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<tbody>
<tr>
<td>1</td>
<td>63%</td>
<td>192</td>
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<tr>
<td>2</td>
<td>17%</td>
<td>51</td>
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<tr>
<td>3</td>
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<tr>
<td>69</td>
<td>&lt;1%</td>
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Potential levels for measuring and reporting Star Ratings

- **Contract level**
  - Current approach used for most individual measures and overall Star Rating
  - A few measures (for contracts offering SNPs) are rolled up to contract level from PBP level

- **Parent Organization level**
  - Two possible approaches:
    - Contracts within the same Parent Organization would have scores aggregated to the Parent Organization level. All contracts within the Parent Organization receive the same score and Star Rating.
    - May report measure data only at the Parent Organization level

- **Below the contract level (previously explored)**
  - Measure performance for plan benefit packages (PBPs) or geographic units within contracts
Broad categories of measures

- HEDIS measures (breast cancer screening, diabetes care, all-cause readmissions)
- CAHPS measures (annual flu vaccine, ease of getting care, rating of health plan)
- Health Outcome Survey (HOS) measures (improving or maintaining health)
- Administrative measures (appeals, complaints, disenrollment measure)
Reporting clinical quality measures at Parent Organization level

Example: Breast cancer screening measure

- Percentage of female members age 52-74 who had a mammogram during the past two years (HEDIS measure)
- Currently measured at the contract level
- Percentage could also be calculated at the Parent Organization level
Calculating Parent Organization scores
Example: Breast cancer screening measure

- Parent Org A: Parent Organization score is equal to contract score (75%)
- Parent Org B: Parent Organization score is a (weighted) average of contract scores
  - Method 1: Weight by enrollment or number of eligible members: 
    \[ \frac{.6 \times 500 + .5 \times 1000 + .8 \times 8000}{9500} = .76 \] (76%)
  - Method 2: Equally weight contracts: 
    \[ \frac{.6 + .5 + .8}{3} = .63 \] (63%)
- All contracts in Parent Org B receive the same score
Reporting patient experience measures at Parent Organization level

Example: % of members disenrolling from contract

- How to calculate disenrollment rate at Parent Organization level?
  - The measure specification could be changed to reflect “members choosing to leave Parent Organization”
    - Members who switch contracts within a Parent Organization would not be counted as disenrolling

- How would measure specification change affect scores?
  - Contracts in single-contract Parent Organizations would see no change in disenrollment rates
  - Multi-contract Parent Organizations may see reduced disenrollment rates if members move between contracts under the same Parent Organization
Calculating % of members disenrolling from contract at Parent Organization level

- Disenrollment rates computed at contract level:
  - Disenrollment rate of contract 1 is 5%
  - Disenrollment rates of contracts B1, B2, and B3 are 10%, 0%, and 15%

- Disenrollment rates computed at Parent Organization level:
  - Parent Org A has 5% disenrollment regardless of disenrollment measure specification
  - Under current measure specification, Parent Org B has \((50+50+100+50)/3000=8.3\)% disenrollment
  - Under measure specification change, Parent Org B has only \((50+50)/3000=3.3\)% disenrollment
Consequences of Parent Organization level reporting on example measures

- **Breast Cancer Screening**
  - Aggregating contracts within the same Parent Organization masks variation
  - Don’t want to do so if there is real variation in quality among contracts within the same Parent Organization
  - If no real variation, perhaps better to roll up to improve precision

- **Disenrollment**
  - Consumer may use as proxy for frequency of difficulties with contract
  - If people switch contracts because they are unhappy with their contract, present (contract-level) metric is appropriate
  - Parent Organizations that have many contracts may see lower disenrollment rates under the new (Parent Organization-level) disenrollment definition because beneficiaries may switch between contracts under the same Parent Organization
Do specific types of measures warrant Parent Organization level measurement?

• Are there measures that correspond to centrally run processes that would result in a common experience across contracts within a Parent Organization?

• Is there one centralized function within a Parent Organization that deals with appeals and complaints, for example?

• Are there certain types of measures that are definitely best calculated at the current contract level?
Key Questions for TEP

• Should we assess variation in scores across contracts within the same Parent Organization for a subset of measures?

• What are the pros and cons of calculating scores at the Parent Organization level and what should we consider?

• Which measures, if any, warrant Parent Organization level reporting?

• Are there particular analyses RAND should consider doing to inform CMS’ decisions?
Measuring Contract Performance Within Smaller Geographic Units: Describing Contract-Level Variation Across Areas and Measures

Justin Timbie, Maria DeYoreo, Andy Bogart, Cheryl Damberg, and Marc Elliott
Contract service areas vary in size

- Beneficiaries might find it hard to compare contracts using contract-level measures of performance.

- “Local” measurement of contract performance could help beneficiaries compare among plans in their local areas.
Would beneficiaries change plans under state-specific measurement?

- Previously, we showed that geography explained 12-49% of the differences in performance between contracts.
- These analyses did not examine differences in performance across geographic areas for individual contracts.
- State-specific measurement would only be expected to affect beneficiary plan selection if it identifies a different set of high-performing contracts in different states.
We assessed contract performance in each state

• For each contract we examined performance within each state relative to all other contracts in the state

• We used within-state **percentile scores** to determine whether a contract’s state-specific unit was high or low performing

• We examined consistency in performance for each contract
We assessed contract performance in each state

- For each contract we examined performance within each state relative to all other contracts in the state.

- We used within-state **percentile scores** to determine whether a contract’s state-specific unit was high or low performing.

- We examined consistency in performance for each contract.

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**Star Ratings involve national comparisons of contract performance. Our use of within-state comparisons is designed simply to illustrate how contracts perform differently in different states.**
We display a contract’s state-specific units with the highest and lowest relative performance

Each blue bar depicts the range of relative performance for a contract’s state-specific units.

- **Green triangle**: Geographic unit of contract 1001 with the highest relative performance: 90th percentile across all contracts operating in New Jersey.
- **Red triangle**: Geographic unit of contract 1001 with the lowest relative performance: 47th percentile across all contracts operating in Pennsylvania.
Within contracts the relative performance of state-specific units can vary

CAHPS: Getting Needed Care

Relative performance of a contract’s state-specific units (in percentiles)

Contract score on measure (in percentiles)

Each blue bar depicts the range of relative performance for a contract’s state-specific units

Only geographic units located in states with greater than or equal to 10 contracts meeting sample size and/or reliability criteria for the measure are depicted
High-performing contracts are not necessarily high performing across all states in which they operate.

Only geographic units located in states with greater than or equal to 10 contracts meeting sample size and/or reliability criteria for the measure are depicted.
We then examined consistency in performance across multiple measures.
Geographic differences in a contract’s relative performance are smaller when averaging across three measures.

*Highest* performing geographic unit (state) across three measures

*Lowest* performing geographic unit (state) across three measures

*The three measures need not be the same*
Summary of findings

- Within a contract, the relative performance of individual geographic units (measured in percentile scores) can vary.
- The differences in a contract’s relative performance are smaller when averaging across multiple measures.
- Since a contract’s relative performance varies across geographic units, we would expect some beneficiaries to switch to higher performing plans under state-specific measurement.
Geography-specific measurement raises several operational and policy challenges

- Many contracts have geographic units for which performance cannot be measured reliably
- Many measures are contract-level measures without a natural link to geography (e.g., complaints, appeals, call center)
- Uncertain whether plans might exit geographic areas in which they are underperforming