Meeting Summary

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RAND Medicare Advantage and Part D Contract Star Ratings Technical Expert Panel

Summary of October 2024 Meeting

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About This Document

This document provides a summary of an October 2024 meeting of the RAND Medicare Advantage and Part D Contract Star Ratings Technical Expert Panel. The goal of this meeting was to obtain input from the technical expert panelists on how the Centers for Medicare & Medicaid Services could streamline the Medicare Advantage and Part D Star Ratings measure set.

An annex to this report that provides slides that were presented during this meeting is available at www.rand.org/t/CFA3973-1.

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RAND Technical Expert Panel: Medicare Advantage and Part D Contract Star Ratings, October 30, 2024

Meeting Attendees

Technical Expert Panel Members

- Steven Asch, M.D., M.P.H., Stanford University
- Arlene Ash, Ph.D., University of Massachusetts
- Liza Assatourians, J.D., America's Health Insurance Plans
- Darrell J. Gaskin, Ph.D., Johns Hopkins University
- Emma Hoo, B.A., Purchaser Consultant
- Catherine MacLean, M.D., Ph.D., Hospital for Special Surgery
- Deborah Paone, Dr.PH., M.H.S.A., Special Needs Plan (SNP) Alliance
- Patrick Romano, M.D., M.P.H., University of California Davis
- Debra Saliba, M.D., M.P.H., A.G.S.F., University of California Los Angeles, RAND, Veterans Affairs Los Angeles HSR&D Center of Innovation
- Jane Sung, J.D., AARP
- Gina Upchurch, RPh., M.P.H., Senior PharmAssist

RAND Staff

- Cheryl L. Damberg, Project Director
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- Zach Dietrich, Research Programmer

Meeting Summary

Welcome and Introductions

- RAND started the meeting by providing an overview of the Medicare Advantage (MA) and Part D Star Ratings program.
- The goal of this Technical Expert Panel (TEP) meeting was to obtain input from the TEP on how the Centers for Medicare & Medicaid Services (CMS) could streamline the MA and Part D Star Ratings measure set. TEP members were asked the following questions:
  - Where should CMS prioritize the focus of Star Ratings to improve the quality of care for enrollees?
  - If CMS wanted to narrow the set of measures, what areas should it focus on for Star Ratings?
- RAND described several motivations for streamlining the MA and Part D Star Ratings measure set, including reducing complexity and burden; clarity of focus on clinical care, outcomes, and patient experience with care; and alignment with the CMS Universal Foundation measure initiative, which focuses on a core set of measures (at the time of this meeting, there were ten measures that focused on adult care). RAND noted that CMS has other performance monitoring mechanisms for measures that might be removed from the Star Ratings.

Initial Comments and Questions

- RAND asked TEP members the following questions:
  - Are there measures that are of lower importance that could be removed to better focus Star Ratings on clinical care, outcomes, and patient experience?
  - Which measures are most critical to retain to measure the quality of health and drug plans?
- A TEP member noted that the Star Ratings program is a high-stakes program with large amounts of funds on the line. The Star Ratings matter to the contracts and their investors. Although it is hard to argue with the CMS Universal Foundation measure set, the stakes are so high that it is worthwhile to include as many measures as possible so that the ratings are not sensitive to the oddities in a single measure.
- A TEP member noted that, for some Star Rating measures, the samples do not reflect the diversity of enrollees. In those cases, it might be worth considering whether the measure should be included in the Star Ratings.

- A TEP member commented that more measures are better as long as they are unique measures (i.e., they measure different dimensions of quality). They observed a hole in the MA measure set around hospital quality and access measures. For example, this TEP member indicated that it is very challenging to get procedures approved in MA given prior authorization policies, and they wondered whether there should be a measure that surveys hospitals about procedures authorized.
- A TEP member commented that sometimes the goal is to measure things beyond or correlated with the measure. This member sought clarification on what the benefit is to decreasing the measure set: Is it just to reduce burden for contracts?
- A TEP member shared a concern about contract responsiveness and the data-collection quality for a measure once it is removed from the Star Ratings program, even if the measure continues to be monitored by CMS.
- A TEP member commented that beneficiaries use Star Ratings to differentiate between plans and to select plans; keeping this in mind is important.
- A TEP member commented that some measures need to be focused on clinical outcomes. They specifically noted that adherence measures focus on the filling of prescribed medications, which is the process rather than the outcome—and additionally is potentially gameable with 90-day automatic mail-order refills. They also wondered whether there is a measure that captures medical loss ratios of the plans.

Administrative Measures

- RAND asked the following questions:
  - Should the administrative measures (specifically complaints about the health/drug plan, plan makes timely decisions about appeals, reviewing appeals decisions, and Part C and D call center foreign language interpreter and teletypewriter availability) remain part of the Star Ratings?
  - Should the administrative measures be moved to the CMS display page for monitoring only?
- A TEP member commented that these measures are critical. They also noted that there are reports every day in the news about algorithms being used by the plans to deny care and contracts making financial decisions to say no on the first request because enrollees and their providers give up trying to fight for approvals.
- A TEP member stated that these measures are conceptually important; however, they were not sure what the best approach would be to address the small numbers in the current measure denominators.
- Another TEP member recommended that the denominators should be all enrollees, not just those enrollees who filed an appeal. The measure should focus on how often care was denied, because many issues do not make it all the way to the appeals process.

- Multiple TEP members agreed that administrative measures are important and that the measures speak to the trust enrollees have in the plan.
- A TEP member commented that the Universal Measure Set, with Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures that are comparable across CMS quality programs, is important for comparing performance across different programs or different patient populations.
- A TEP member asked whether the current Star Ratings administrative measures represent the best way to measure the desired concept. The TEP member expressed concern that challenges that enrollees face in obtaining care also happen earlier in the process, with utilization management, and that the current appeals measures might underrepresent the full set of challenges that beneficiaries experience. The existing appeals measures,[1] which capture the downstream end of the process, might not adequately capture the desired concept.
- A TEP member highlighted the improvement measure and wondered whether the focus should be on how a contract is currently performing and not on past performance. The member suggested that CMS should consider removing the improvement measure. Additionally, they commented that there might be more changing of contracts among who are dual-eligible or low-income subsidy (LIS) enrollees and wondered whether the measure "members choosing to leave the plan" (i.e., contract voluntary disenrollment rate) is adjusted for differences in the mix of enrollees in a contract.
  - RAND responded that dual-eligible and LIS enrollees can switch plans monthly starting in 2025 under a special election period, which is not permitted for the non–dual-eligible/non-LIS population. The measure "members choosing to leave the plan" is not adjusted for the mix of enrollees in the contract.
  - RAND commented that the improvement measure is designed to encourage improvement year over year regardless of high or low performance and is weighted highly (a weight of 5). With the hold harmless provisions in the Star Ratings scoring algorithm, if a high performing contract does worse with the improvement measure included, the improvement measure is not included in the contract's Star Rating calculation.
    - In response, a TEP member commented that the improvement measure sounds like a most improved award and asked whether contracts really need more incentives to improve.
- A TEP member noted that, by the time a grievance or appeal gets to a plan or CMS level, there have been several layers of approvals or denials that happen at the level of

[1] The Part C Appeals measures address the Independent Review Entity process. If an MA plan makes an adverse reconsideration decision (i.e., upholds its initial adverse organization determination), in whole or in part, the plan must automatically submit the case file and its decision for review by the Part C Independent Review Entity.

the provider organization. These denials might not be reported formally to CMS; as a result, the number of appeals at the plan level often is much smaller than the total volume that is occurring in terms of the member experience. Additionally, the plan level appeal/denial numbers might roll up the variation among a large number of provider organizations with which a given plan contracts; thus, even though there is little variation overall, there could be significant differences across provider organizations. Although the plan is still responsible for which provider organizations it contracts with, some provider organizations (which are delegated financial risk) are more restrictive with authorizations than other organizations.

- A TEP member sought to confirm that the complaints measure reflects complaints made to CMS, not to State Health Insurance Assistance Program counselors. RAND confirmed it is complaints made to CMS, not to State Health Insurance Assistance Programs. The TEP member commented that it can be intimidating for the beneficiary to report to CMS. Additionally, it was noted that a beneficiary with low literacy would be less likely to navigate an appeals process.
- There was agreement among TEP members that appeals and complaints measures are downstream in the process of enrollees experiencing problems with accessing needed care and that it would be helpful to measure denials of care that are happening upstream.

Clinical, Outcome and Patient Experience Measures

- RAND asked TEP members the following question:
  - Are there any currently included clinical or experience measures that are less important and should be removed?
- A TEP member that stated all of the clinical and patient experience measures are important. They expressed that more work is needed to improve survey responsiveness to ensure broad representation of all enrollees.
- A TEP member commented that there are many measures focused on diabetes, whereas there are no measures for other conditions that are important for the senior population, such as Alzheimer's or behavioral health.
- A TEP member recommended additional clinical measures that are focused on prevention of chronic conditions and pointed to the Centers for Disease Control and Prevention, which has developed preventive measures for chronic conditions.
- A TEP member expressed concern about the measure weight applied to the plan all-cause readmissions measure and wondered whether this measure should be retained. They stated that readmissions to a hospital are not necessarily bad, are sometimes needed to ensure safe care, and have been shown to be sensitive to social factors. The TEP member noted that contracts are already incentivized to reduce hospitalizations because they are financially at risk and have to pay for hospital care when it occurs,

which is expensive. They commented that, given these issues, the weight of 3 on this measure is too high.

- A TEP member recommended measures focused on hospital care and that it might be helpful to know the quality of care among hospitals in an MA plan's network. The TEP member noted that what plans can actually do and be accountable for is determined by the hospitals with which the plan contracts (i.e., high- or low-quality hospitals).
- Another TEP member expressed caution about CMS focusing on measures related to network management, because CMS would not want to indirectly make access more difficult for some populations if providers that disproportionately serve safety-net communities and tend to perform more poorly on some measures are excluded from plan networks.
- A TEP member commented that it is important to understand what is under the control of the contract. Their network of hospitals is under the control of the contract. This TEP member also noted that experience with a health/drug plan is very important. They commented that the current drug safety measures (i.e., adherence measures) have been shown to be gameable. They noted that the increases in medication adherence as currently measured are not tied to quality of care. They noted the need to think about gameability of some measures. For example, health plans can use 90-day mail refills to check a box that they have met the measure without determining whether the patient in question is actually taking the medication, and therefore the measure is not accurately measuring adherence. They also commented that the practice of over-supplying medications via mail order was quite unsafe.
- Another TEP member reiterated that current medication adherence measures are not measuring the right thing: They measure the filling of medications, not the outcome. Additionally, they expressed concern with existing Comprehensive Medication Reviews that are conducted virtually and do not foster a relationship with a provider to navigate the appropriate and safe use of medications. The TEP member suggested editing the Comprehensive Medication Review measure to reward in-person engagement with local community pharmacists, which will build valuable relationships. They contended that virtual interactions are less effective for pharmacy education and building patient relationships.
- A TEP member noted that the Part C statin therapy measure does not have a lot of variation in performance across contracts and suggested that could be a candidate measure to remove.
- A TEP member expressed endorsement of functional status measures because they reflect/capture a lot of information.

Special Needs Plan–Specific Measures

- RAND asked TEP members:

  - Should the Star Ratings Special Needs Plan (SNP)–specific measures be retained?
  - Or should the SNP-specific measures be excluded to simplify and hold all plans accountable to the same measure set?

- A TEP member commented that the SNP measures are hard measures to achieve high performance on but are otherwise good measures. They noted that these measures (e.g., percentage of members whose plan did an assessment of their health needs and risks in the past year) are important concepts for all older adults and wondered why CMS would not apply these measures to all MA enrollees and not just those enrolled in SNPs.
- A TEP member noted that the devil is in the details in terms of which components of medication review are happening. Electronic health records now prepopulate this with a check mark, and the review is not individualized. They noted that these prepopulated automated medication reconciliations might not assess important concepts, such as whether patients truly understand the instructions on how to safely take medications and whether the enrollee can read the labels. They noted that medication reconciliation is a time-consuming, complex process, but is very important—and that the median performance on this measure suggests that many people are simply checking the boxes set up within the electronic health record system.
- A TEP member commented that they have heard SNPs reporting that medication reconciliation is a heavy lift to complete.

Final Thoughts About Current Measures

- A TEP member commented that, in principle, there could be no limit to measures derived from administrative data because this is not burdensome to providers or plans; however, for other types of measures it is important to think about the burden. Having a small number of measures in Star Ratings for the sake of having a small set is not valuable. They summarized that the TEP discussion highlights how few measures capture what we care about—outcomes and patient experience with accessing and receiving needed care.
- A TEP member commented that most measures are under the control of medical groups and CMS should rethink what is under the control of the health plan and health system to promote what we want—better health outcomes. They wondered whether CMS should think about measuring care at the provider group level.
- A TEP member cautioned against using the word "streamlining," suggesting instead that the focus should be on how to better steer enrollees to contracts that have better outcomes. They also noted that CMS should prioritize measures that have been vetted through a peer review process that evaluates the measure's reliability and validity. They noted concerns about the reliability of some of the administrative measures.

- A TEP member emphasized that the goal of the Star Ratings should be helping beneficiaries select a contract that fits their needs (such as having many medications or having diabetes and which contracts perform well for those specific needs). This TEP member expressed less concern about reducing provider or contract burden and commented that the focus should be on usefulness of the quality ratings to beneficiaries.

Potential New Measures

- RAND asked TEP members the following questions:
  - Are there any unmeasured areas of clinical care, patient outcomes, or patient experience that have a high potential impact on quality and should be considered for new measures?
  - Are there emerging areas of clinical care not currently reflected in the Star Ratings that should be included?
- TEP members offered the following suggested areas for new measures:
  - measures of behavioral health (e.g., depression screening) and social determinants of health screening
  - measures that assess care for chronic conditions that are common among older adults that are not currently being measured (e.g., chronic lung disease, heart failure)
  - procedure-related measures (e.g., cataract procedures, coronary artery bypass graft surgery, joint replacement)
  - metrics reflecting how long it takes to reach a real person with a question or concern
  - additional vaccination measures
  - a telehealth-related measure
  - chronic disease self-management, falls prevention, and depression
  - measures related to functional status, pain management, and musculoskeletal conditions.
- One TEP member highlighted the need to monitor the Medicare Prescription Payment Plan and the implications of plans gathering funds beyond the premium.[2]
- A TEP member noted the recent increase in Ozempic-type drugs (glucagon-like peptite-1 [GLP-1] inhibitors) and the appropriate use of these drugs for weight loss to

[2] The Medicare Prescription Payment Plan is a new payment option in the prescription drug law that works with a beneficiary's current drug coverage to help them manage their out-of-pocket costs for drugs covered by the plan by spreading the costs of drugs across a calendar year (January to December). This program is voluntary for beneficiaries; instead of paying the pharmacy for drugs, the beneficiary will receive a bill from their health or drug plan to pay for their prescription drugs.

address diabetes and heart disease; therefore, they noted that a measure on use of GLP-1 inhibitors for weight control would be useful.

Other Comments

- A TEP member requested clarification on the rationale for using clustering over using benchmarks such as percentiles to assign Star Ratings.
  - RAND and a CMS representative responded that percentiles force a certain percentage of contracts to be 1, 2, 3, etc., stars. For some measures, most contracts are getting 4- and 5-star scores, and fewer contracts are receiving lower star scores. CMS indicated that the purpose was to allow industry performance to drive what scores look like for each measure. CMS previously used set thresholds and found that contracts knew what to do to just meet the threshold and stopped improving once they reached that threshold.
- A TEP member requested clarification on whether scores are at the contract level versus parent organization level, specifically when contracts have similar names.
  - RAND responded that the MA and Part D Star Ratings are at the contract level. Contracts under the same parent organization can have similar names, but the parent organization is one level up from the contract; a parent organization can have multiple contracts.
- A couple of TEP members wondered what the appropriate level should be for measuring performance. Should care delivered be assessed at provider level, facility or health system level, or at the contract level? They noted that MA contracts contract with providers but do not actually deliver care, so they were not sure that accountability rested with contracts.