VALUE-BASED PAYMENTS, STAR RATINGS AND THE LESSONS OF MEDICARE ADVANTAGE

A Presentation to the 11th Annual Value-Based Payment and P4P Summit

JOHN GORMAN
EXECUTIVE CHAIRMAN

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CUT TO THE CHASE!

- Medicare: world's largest VBID/VBP laboratory
    - Medicaid, ObamaCare, large commercial purchasers follow 3-5 years later
- Next frontier: social determinants
- Star Ratings drive the market, and bar is rising
- "A Darwinian moment" for payers, providers and vendors, especially PBMs

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VBID LESSONS FROM MEDICARE ADVANTAGE/PART D

1. All healthcare is local. Start by tailoring best practices to a specific panel of members
2. Addressing social determinants must be first priority before quality measures can improve
3. Reduce cost sharing for specific drugs/classes, e.g., oral agents, insulins
4. Exempt specific drugs/classes from cost sharing in the “donut hole”: target those patients with high annual drug spending for greatest benefit
5. Reduce cost sharing for enrollees with chronic conditions
6. Incentivize members to participate in medication therapy management programs (MTM)
7. Create multi-tier cost sharing arrangements for high-value providers to encourage their use
8. Team-based proactivity is key – must be ahead of the curve on quality measures and hard-wired into workflow

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COST SHARING = BARRIER TO ACCESS

- Increases in member cost-sharing leads to a reduction in the use of essential services, worsening health disparities, exacerbating overall costs.
- Effects worse among low-income individuals and beneficiaries with chronic illness

The New York Times

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Business Day

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ECONOMIC VIEW

When a Co-Pay Gets in the Way of Health

By SENDHIL MULLAINATHAN
Published: August 10, 2013

ECONOMISTS specialize in pointing out unpleasant trade-offs — a skill that is on full display in the health care debate.

Enlarge This Image

Minh Uong/The New York Times

We want patients to receive the best care available. We also want consumers to pay less. And we don't want to bankrupt the government or private insurers. Something must give.

The debate centers on how to make these trade-offs, and who gets to make them. The stakes are high, and the choices are at times unseemly. No matter how necessary, putting human suffering into dollars and cents is not attractive work. It's no surprise, then, that the conversation is so heated.

What is a surprise is that amid these complex issues, one policy sidesteps these trade-offs.

FACEBOOK
TWITTER
GOOGLE+
SAVE
EMAIL
SHARE
PRINT
REPRINTS

THE GRAND BUDAPEST HOTEL

Source: Goldman D. JAMA. 2007;298(1):61–9. Trivedi A. NEJM. 2008;358:375-383. Trivedi A. NEJM. 2010;362(4):320-8.. Chernew M. J Gen Intern Med 23(8):1131–6.

IN MA, HIGHER OOP COSTS = WORSE HEALTH AND DISPARITIES, INCREASED COSTS

Out of Pocket Expenditures for MA Beneficiaries, 2011-2015

office visits

20 fewer outpatient visits*

2.2 additional hospital admissions*

(* Per 100 Enrollees)

Trivedi A. NEJM. 2010;362(4):320-8.

diagnostic tests

Mammography rates were 8.3 % lower in plans with cost-sharing compared to those with full coverage

Trivedi A. NEJM. 2008;358:375-383

Source: Univ. of MI Center for V-BID, 2016

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VBID CAN ADDRESS SYSTEMIC PROBLEMS

Members, Providers and Vendors Can All "Follow the Money"

Category	Sources	Estimate of Excess Costs	% of Waste	% of Total
Unnecessary Services	• Overuse beyond evidence-established levels • Discretionary use beyond benchmarks • Unnecessary choice of higher-cost services	$210 billion	27%	9.15%
Inefficiently Delivered Services	• Mistakes, errors, preventable complications • Care fragmentation • Unnecessary use of higher-cost providers • Operational inefficiencies at care delivery sites	$130 billion	17%	5.66%
Excess Admin Costs	• Insurance paperwork costs beyond benchmarks • Insurers' administrative inefficiencies • Inefficiencies due to care documentation requirements	$190 billion	25%	8.28%
Prices that are too high	• Service prices beyond competitive benchmarks • Product prices beyond competitive benchmarks	$105 billion	14%	4.58%
Missed Prevention Opportunities	• Primary prevention • Secondary prevention • Tertiary prevention	$55 billion	7%	2.40%
Fraud	• All sources – payers, clinicians, patients	$75 billion	10%	3.27%
	Total	**$765 billion**		**33.33%**

SOURCE: "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America." Institute of Medicine (2013)

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APPLYING V-BID TO SPECIALTY PHARMA

- Impose no more than modest cost-sharing on high-value services
- Reduce cost-sharing in accordance with patient- or disease-specific characteristics
- Relieve patients from high cost-sharing after failure on a different medication
- Use cost-sharing to encourage patients to select high-performing providers and settings

Health | Wed May 13, 2015 12:01am EDT

Number of Americans using $100,000 in medicines triples: Express Scripts

BY BILL BERKROT

More than a half-million U.S. patients had medication costs in excess of $50,000 in 2014, an increase of 63 percent from the prior year, as doctors prescribed more expensive specialty drugs for diseases such as cancer and hepatitis C, according to an Express Scripts report released on Wednesday.

Of the estimated 575,000 Americans who used at least $50,000 in prescription medicines last year, about 139,000 used at least $100,000 worth of medication, nearly triple the 47,000 who hit that mark in 2013, the report said.

The total cost to health plans for U.S. patients with prescription drug expenses in excess of $50,000 was $52 billion in 2014, Express Scripts said in its report: "Super Spending: Trends in High-Cost Medication Use."

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VBP LESSONS FROM MEDICARE ADVANTAGE/PART D

Value-Based Payment Models in Medicare:

	With MA populations	With commercial populations
PCMH	67%	72%
ACOs with shared savings	53%	62%
Global capitation	40%	45%
ACOs with shared risk	43%	45%
Bundled payments	33%	41%
None	7%	7%

0% 10% 20% 30% 40% 50% 60% 70% 80%

With MA populations
With commercial populations

Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

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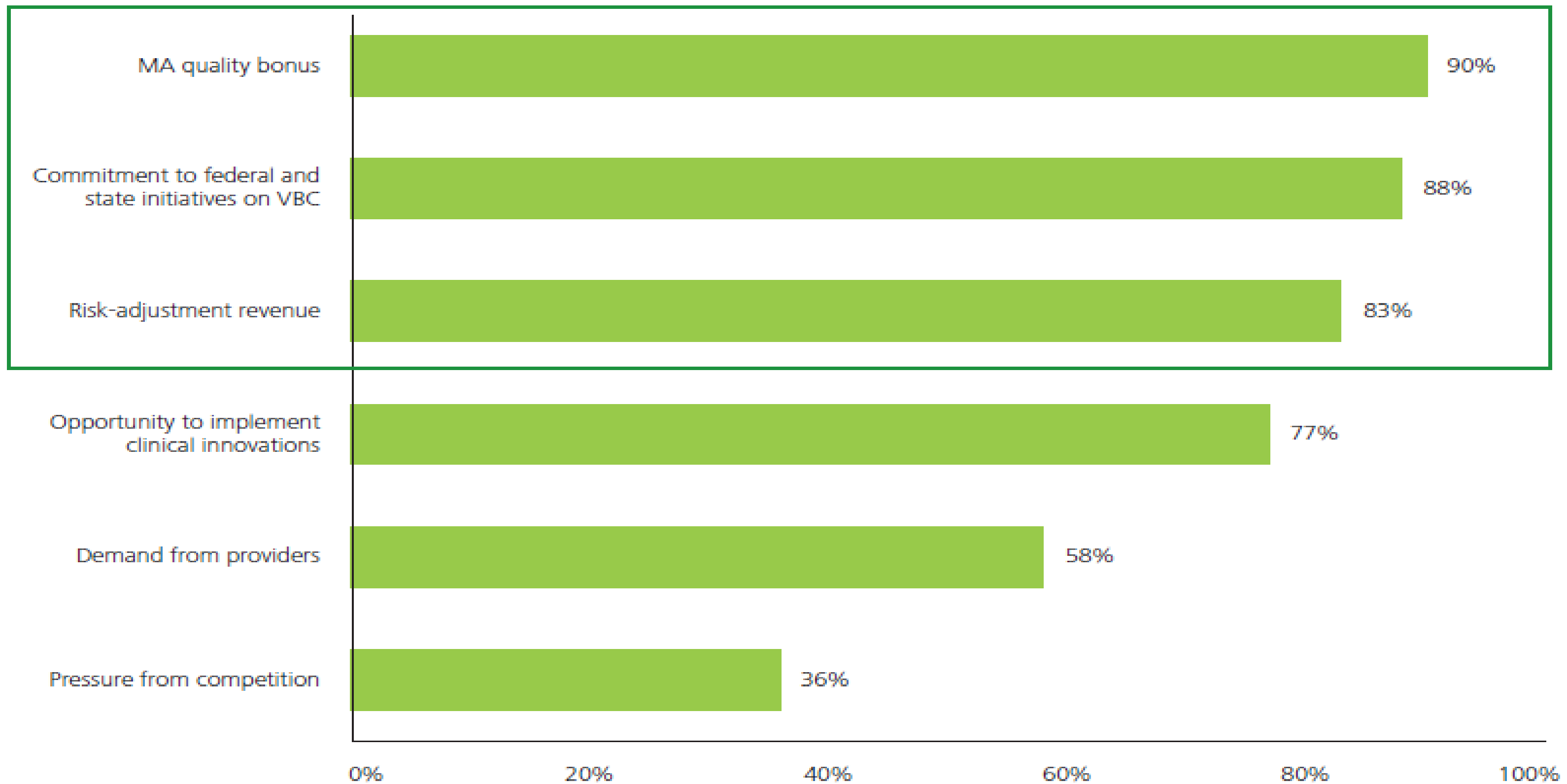
VBP LESSONS FROM MEDICARE ADVANTAGE/PART D

Revenue Optimization Efforts Are Core Drivers Of MA VBP Activity



Source: Deloitte Center for Health Solutions, 2015 Study of Medicare Advantage Health Plans and Providers

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STAR RATINGS DRIVE THE MARKET

Star Rating	Complaints/ 1,000	% Disenroll Annually
★★	0.91	21.5%
★★ ½	0.55	17.48%
★★★	0.42	14.79%
★★★ ½	0.33	9.27%
★★★★	0.22	6.92%
★★★★ ½	0.15	4.89%
★★★★★	0.16	1.91%

- Medicaid, ObamaCare already following MA approach
- Medicare Advantage plans beat commercial in HEDIS
- <4-Star plans “circling the toilet bowl”
- ≤3-Star plans “dead men walking”
- .5 Star = ~ $15-$50 PMPM

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ACHIEVING THE GOAL

2014

AVG STAR RATING
3.84

Final Year of Star Ratings Demo

2015

AVG STAR RATING
3.92

40% of MA-PDs earned ≥4 Stars

60% of MA-PD enrollees are in contracts with ≥4 Stars

2016

AVG STAR RATING
4.03

49% of MA-PDs (179 contracts) earned ≥4 Stars

71% of MA-PD enrollees are in contracts with ≥4 Stars

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71% of MA-PD enrollees are in contracts with ≥4 Stars

BUT…..
- 369 plans were rated in 2016. 188 more are on the chase.

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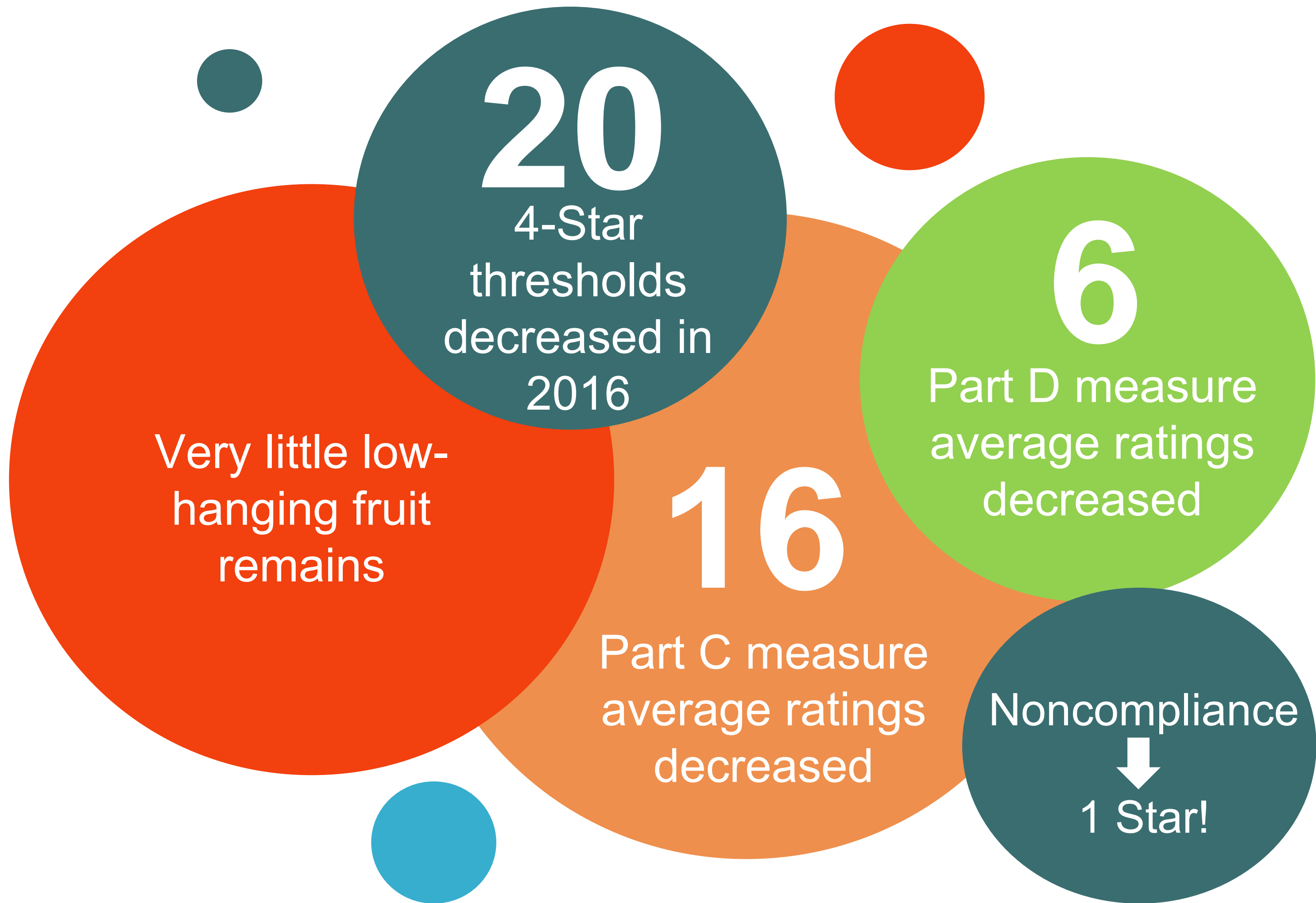
THE GAME GETS TOUGHER



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STAR RATINGS IN 2016

- The "Divine Dozen"
  - New/returning: CIGNA, Sierra, Tufts, Group Health (MN), Essence
  - Repeat rock stars: Kaiser, Martin's Point (ME/NH), Gunderson
- Six "Walking Dead," 3 eligible for termination end of 2016
- SNPs improved = HMOs/PPOs
- No rest for the weary: 4-Star plans in 2016 won't be in 2017

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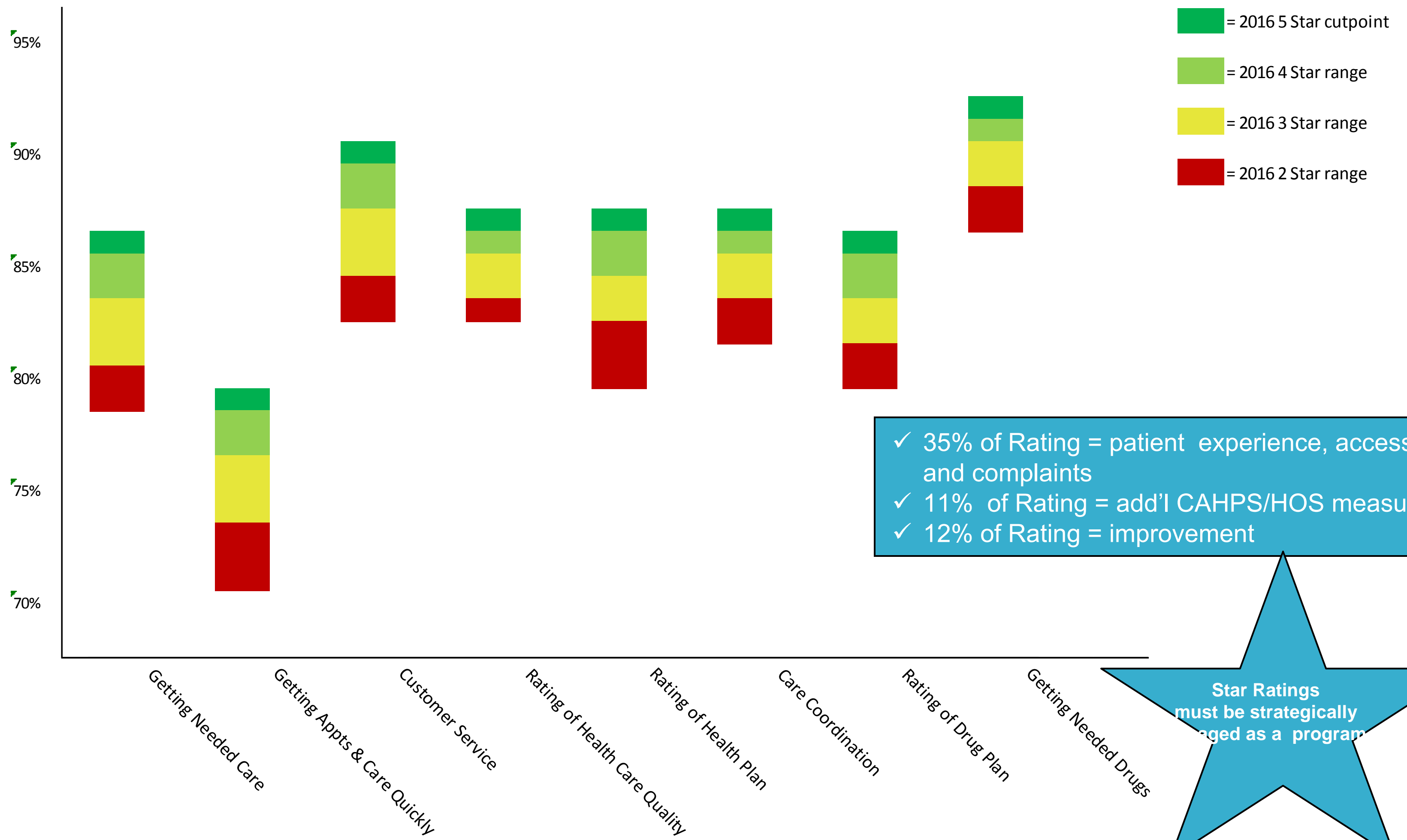
MEASURING NUANCES: CAHPS



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2016 PART C STAR RATINGS MEASURES

2016 ID	2015 ID	Measure	Data Source	Improvement Measure	Weight
C01	DMC22	Breast Cancer Screening	HEDIS	No	1
C02	C01	Colorectal Cancer Screening	HEDIS	Yes	1
C03	C04	Annual Flu Vaccine	CAHPS	Yes	1
C04	C05	Improving or Maintaining Physical Health	HOS	No	3
C05	C06	Improving or Maintaining Mental Health	HOS	No	3
C06	C07	Monitoring Physical Activity	HEDIS / HOS	Yes	1
C07	C08	Adult BMI Assessment	HEDIS	Yes	1
C08	C09	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	Yes	1
C09	C10	Care for Older Adults – Medication Review	HEDIS	Yes	1
C10	C11	Care for Older Adults – Functional Status Assessment	HEDIS	Yes	1
C11	C12	Care for Older Adults – Pain Assessment	HEDIS	Yes	1
C12	C13	Osteoporosis Management in Women who had a Fracture	HEDIS	Yes	1
C13	C14	Diabetes Care – Eye Exam	HEDIS	Yes	1
C14	C15	Diabetes Care – Kidney Disease Monitoring	HEDIS	Yes	1
C15	C16	Diabetes Care – Blood Sugar Controlled	HEDIS	Yes	3
C16	C18	Controlling Blood Pressure	HEDIS	Yes	3
C17	C19	Rheumatoid Arthritis Management	HEDIS	Yes	1
C18	C21	Reducing the Risk of Falling	HEDIS / HOS	Yes	1
C19	C22	Plan All-Cause Readmissions	HEDIS	Yes	3

Table title: 2016 Part C & D Star Ratings Measures

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2016 PART C STAR RATINGS MEASURES

2016 Part C & D Star Ratings Measures					
2016 ID	2015 ID	Measure	Data Source	Improvement Measure	Weight
C20	C23	Getting Needed Care	CAHPS	Yes	1.5
C21	C24	Getting Appointments and Care Quickly	CAHPS	Yes	1.5
C22	C25	Customer Service	CAHPS	Yes	1.5
C23	C26	Rating of Health Care Quality	CAHPS	Yes	1.5
C24	C27	Rating of Health Plan	CAHPS	Yes	1.5
C25	C28	Care Coordination	CAHPS	Yes	1.5
C26	C29	Complaints about the Health Plan	CTM	No	1.5
C27	C30	Members Choosing to Leave the Plan	Medicare Beneficiary Database Suite of Systems	Yes	1.5
C28	DME08	Beneficiary Access and Performance Problems	CMS Administrative Data	No	1
C29	C31	Health Plan Quality Improvement	Star Ratings	No	5
C30	C32	Plan Makes Timely Decisions about Appeals	IRE	No	1.5
C31	C33	Reviewing Appeals Decisions	IRE	Yes	1.5
C32		Call Center – Foreign Language Interpreter and TTY Availability	Call Center	No	1.5

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2016 PART D STAR RATINGS MEASURES

2016 ID	2015 ID	Measure	Data Source	Improvement Measure	Weight
D01		Call Center – Foreign Language Interpreter and TTY Availability	Call Center	No	1.5
D02	D01	Appeals Auto–Forward	IRE	Yes	1.5
D03	D02	Appeals Upheld	IRE	No	1.5
D04	D03	Complaints about the Drug Plan	CTM	No	1.5
D05	D04	Members Choosing to Leave the Plan	Medicare Beneficiary Database Suite of Systems	Yes	1.5
D06	DME08	Beneficiary Access and Performance Problems	CMS Administrative Data	No	1
D07	D05	Drug Plan Quality Improvement	Star Ratings	No	5
D08	D06	Rating of Drug Plan	CAHPS	Yes	1.5
D09	D07	Getting Needed Prescription Drugs	CAHPS	Yes	1.5
D10	D08	MPF Price Accuracy	PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medi-span	No	1
D11	D09	High Risk Medication	Prescription Drug Event (PDE) data	Yes	3
D12	D11	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data; Medicare Enrollment Database (EDB) File; Common Working File (CWF)	Yes	3
D13	D12	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data; Medicare Enrollment Database (EDB) File; Common Working File (CWF)	Yes	3
D14	D13	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data; Medicare Enrollment Database (EDB) File; Common Working File (CWF)	Yes	3
D15	DMD07	Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews	Part D Plan Reporting	No	1

Table title: 2016 Part C & D Star Ratings Measures

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WEAKNESS IN THE 2016 NUMBERS

2016 ID	Measure Description	2016 Avg Stars
D15	MTM Program Completion Rate for CMR	2.3
C12	Osteoporosis Management in Women With Fx	2.5
C08	Special Needs Plans (SNP) Care Management	2.5
C18	Reducing the Risk of Falling	2.7
C06	Monitoring Physical Activity	2.9
C13	Diabetes Care - Eye Exam	3.1
D03	Appeals Upheld	3.3
D08	Rating of Drug Plan	3.3
D09	Getting Needed Prescription Drugs	3.4

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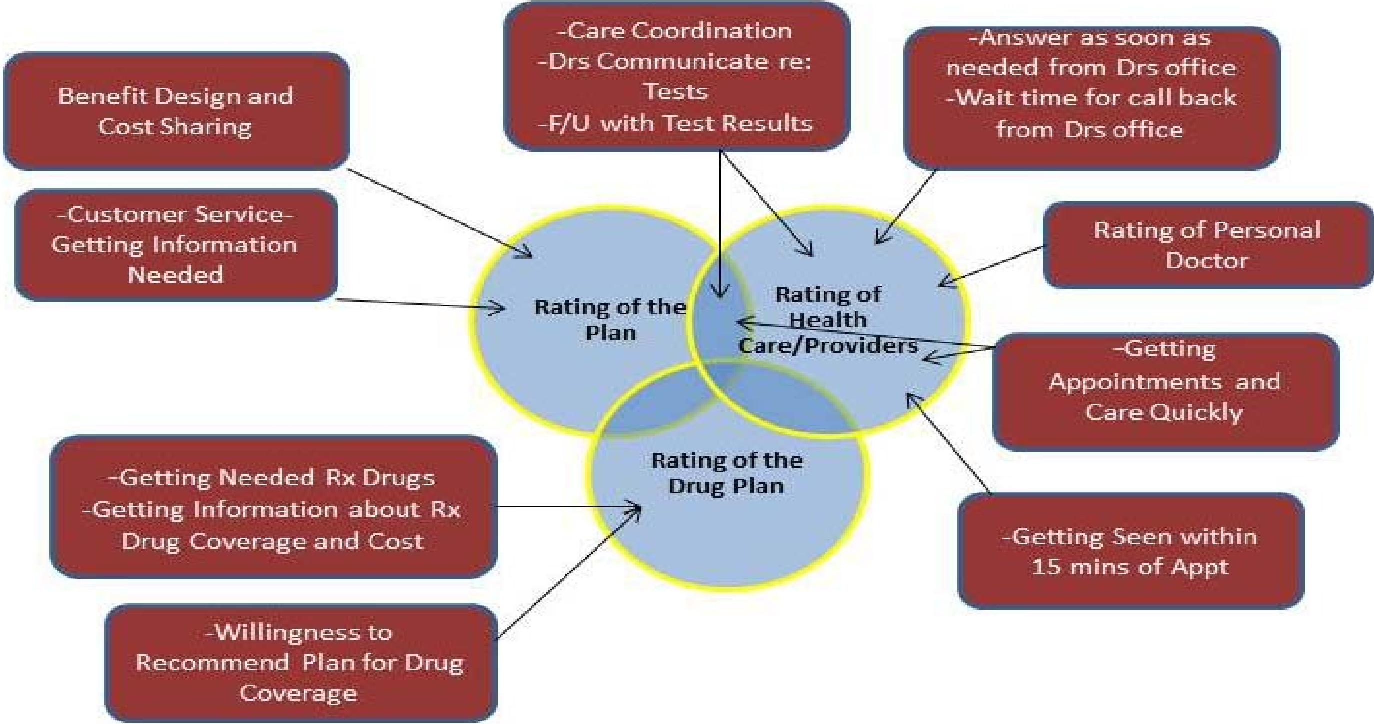
THE MEMBER EXPERIENCE: NOW HALF OF STARS



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OPPORTUNITIES FOR NEW RETAIL PHARMACY COLLABORATION

- ★ Medication Adherence
- ★ High Risk Medications
- ★ Annual influenza vaccine
- ★ Care for older adults – medication review, pain screening
- ★ Disease Management – A1c control, controlling BP
- ★ RA, Osteoporosis management
- ★ Reducing fall risk

Evaluate opportunities for retail pharmacists to expand services to high-risk members through MTM-like programs and expanded services.

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NEXT BIG THING IN MA AND PART D: VALUE-BASED INSURANCE DESIGN

MA/Part D VBID/MTM Demos

Rethinking formulary and benefit design

MTM gets real

Medicare Policy Changes

Aligning payment with medication optimization for the chronically ill

NEW NORMAL

Larger role for pharmacists as providers

Value-based approaches

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MEDICARE ADVANTAGE VALUE-BASED INSURANCE DESIGN (MA-VBID)

The VBID model will test structuring benefits for individuals with certain conditions in ways expected to have the greatest potential to positively impact enrollee health relative to cost.

The model is scheduled to begin on January 1, 2017, and will have a 5-year test period.

All or a portion of that plan's service area is located within a test state.

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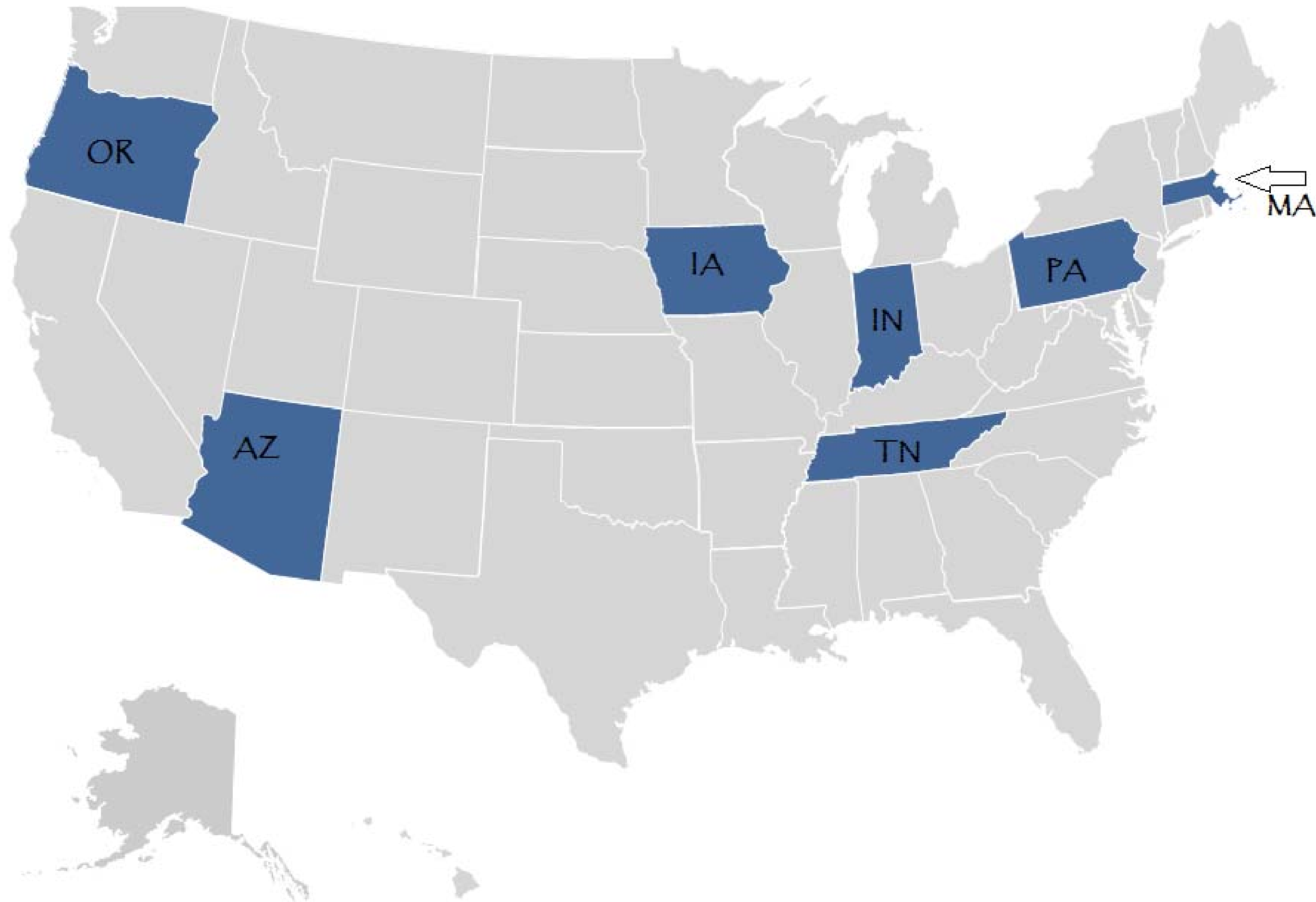
MA-VBID STATES



Source: Centers for Medicare & Medicaid Services

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MEMBER & PROVIDER ENGAGEMENT IMPROVE OUTCOMES

Medical Expense

Costs	Utilization
Customize network (ACOs, PCMH, narrow network)	Engage members for wellness visits
PCP attribution	Reduce cost sharing
Support services: transportation, DME, lab, home, counseling	Customize disease management programs
Pay for Performance	Maximize use of lower levels of care when appropriate

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MEMBER & PROVIDER ENGAGEMENT IMPROVE OUTCOMES

Pharmacy Expense

Costs	Utilization
Adjust formulary	Reduce cost-sharing
Encourage mail order at preferred pharmacies	Customize disease management programs
	Include medication management programs

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CONCLUSIONS

1. Tailor best practices to a member panel
2. Address social determinants first
3. Reduce cost sharing for specific drugs/classes
4. Exempt specific drugs/classes from cost sharing in coverage gaps
5. Reduce cost sharing for enrollees with chronic conditions
6. Incentivize members to participate in MTM
7. Create multi-tier cost sharing arrangements for high-value providers
8. Team-based proactivity is key
9. No innovation without collaboration
10. EVOLVE OR DIE.

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JOHN GORMAN

Executive Chairman

T 202.255.6924

E jgorman@gormanhealthgroup.com

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