



ADVANCED STRATEGIES IN MEDICARE ADVANTAGE AND PART D STAR RATINGS

JOHN GORMAN

Executive Chairman
March 2, 2018

GORMAN
HEALTH GROUP



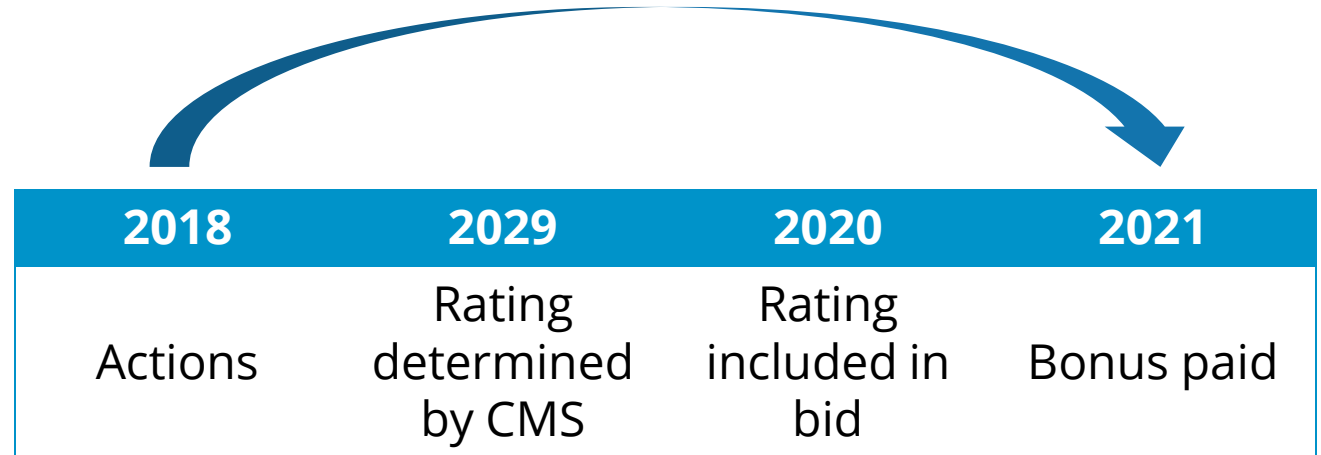
TODAY'S AGENDA

- ④ 2018 Star Ratings Debrief
- ④ Program Updates
- ④ Trends in the Evolving Landscape

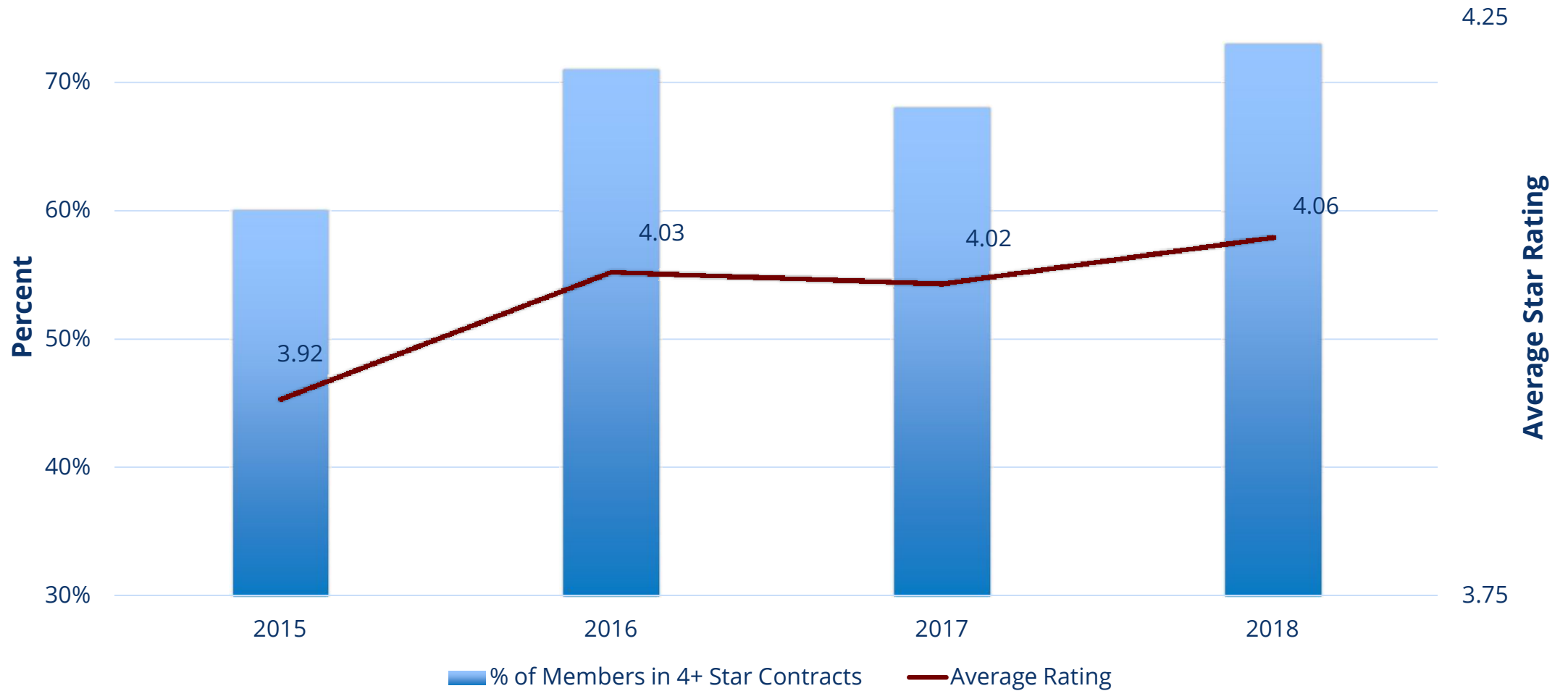
STARS, REBATES & BONUSES

Bonus & Rebate Amount by Quality Rating		
Quality Rating	Bonus %	Rebate %
New Plan	3.5%	65%
<3.5 stars	0.0%	50%
3.5 stars	0.0%	65%
4 stars	5.0%	65%
4.5 - 5 stars	5.0%	70%

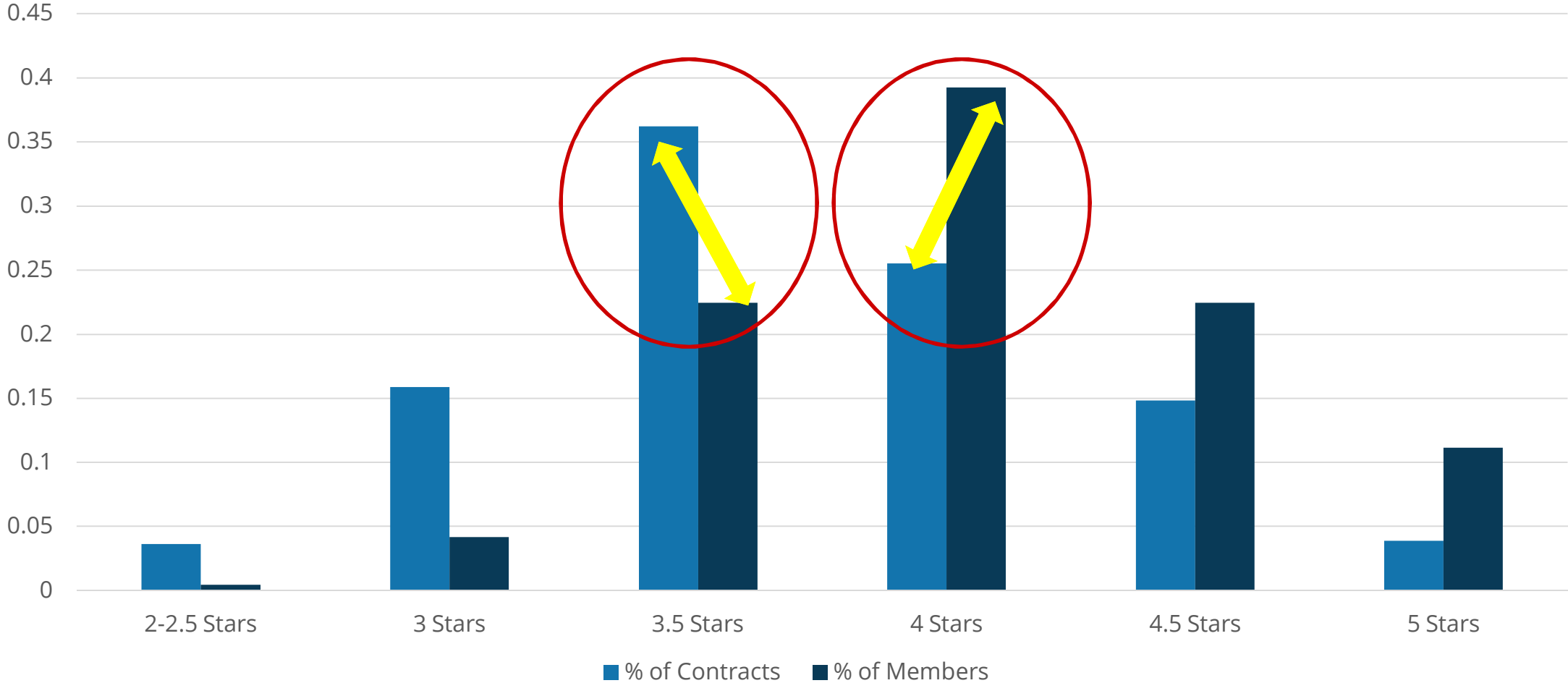
BONUS & REBATE LAG



2018 STAR RATINGS HIGHLIGHTS



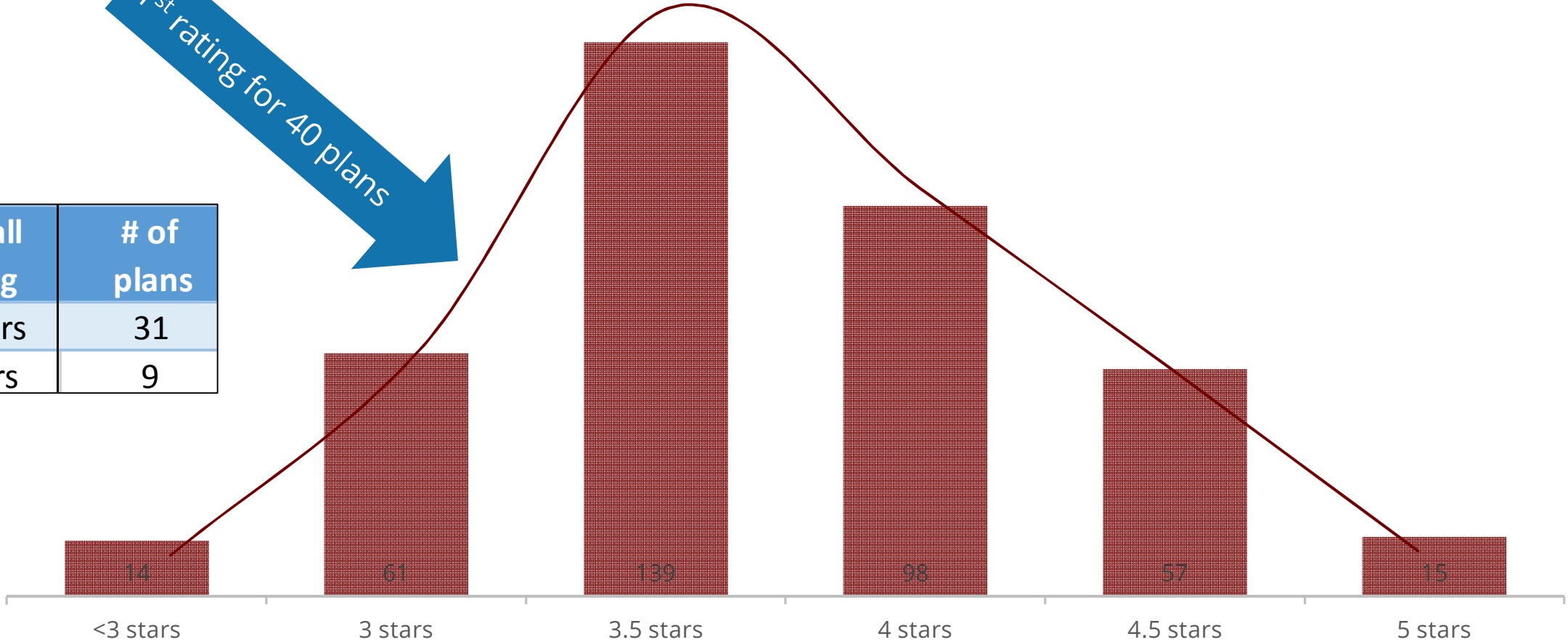
LEVERAGING 4+ STARS: QUALITY BONUSES, ENHANCED BENEFITS, CONTRACT SHIFTS



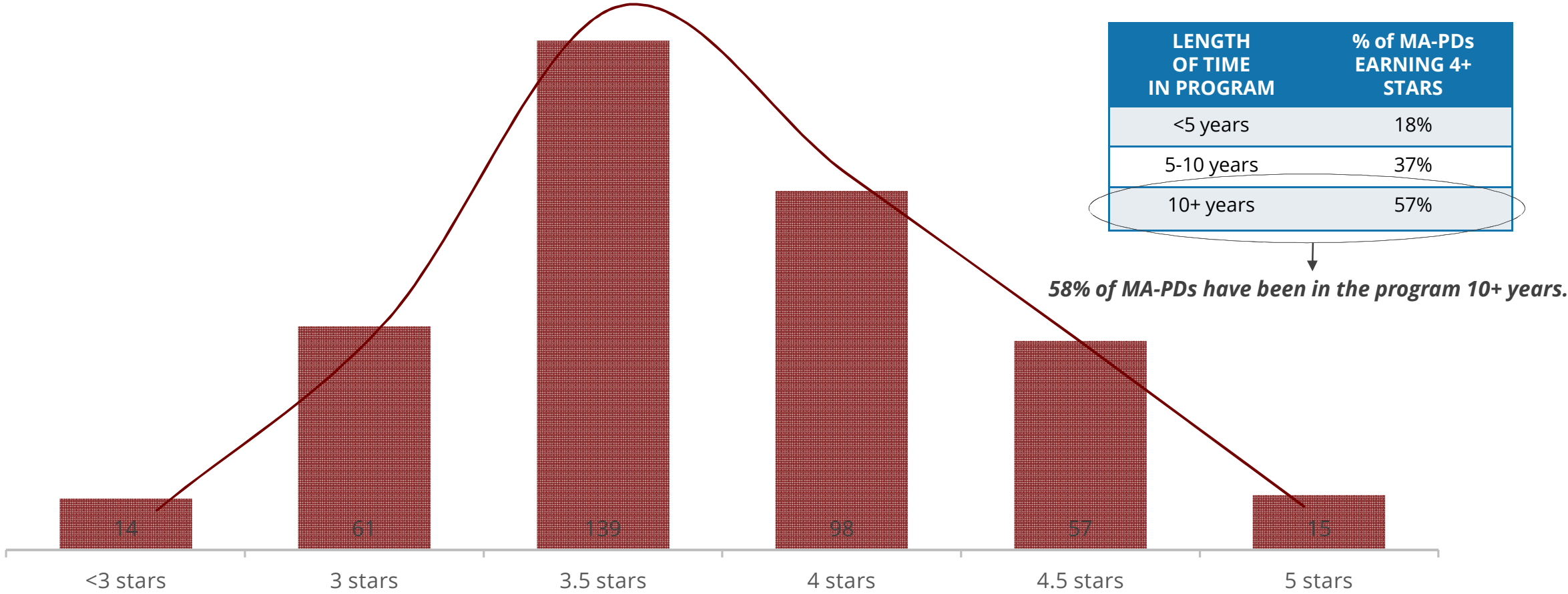
NEW ENTRANTS FACE HEADWINDS

1st rating for 40 plans

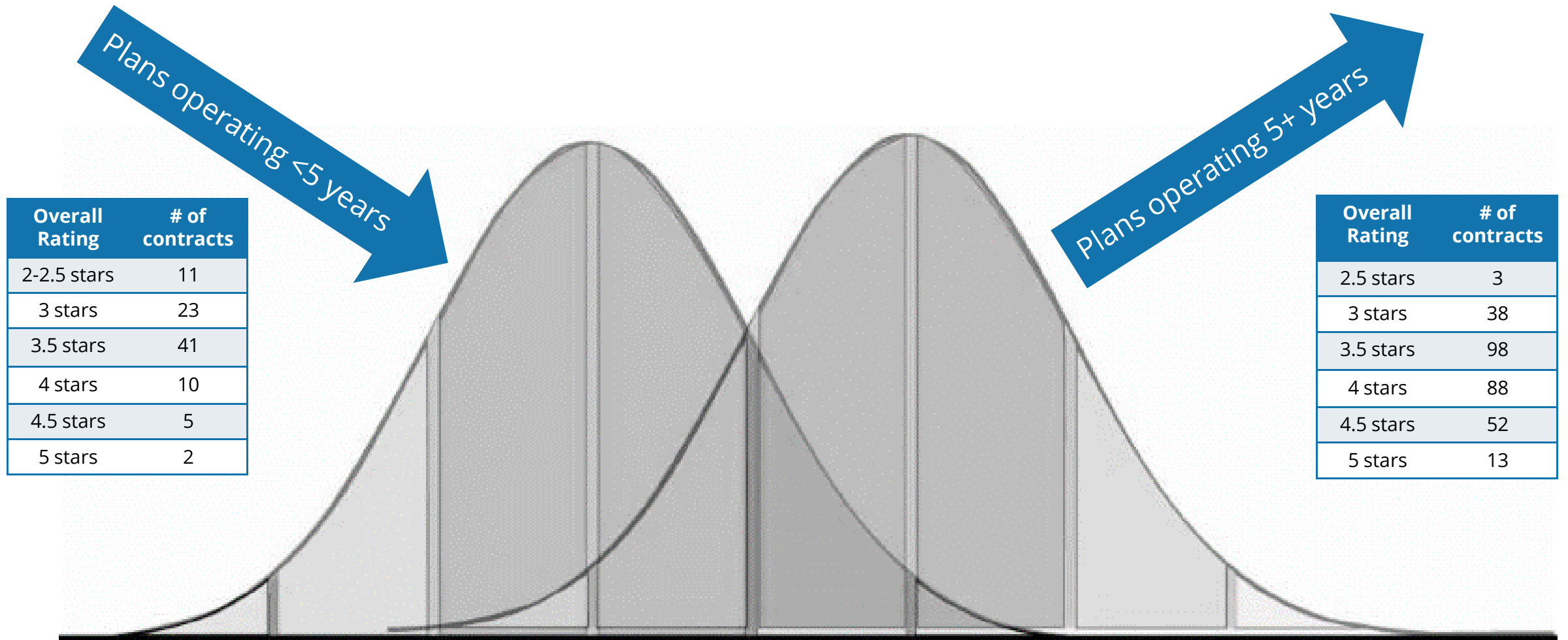
Overall Rating	# of plans
<4 stars	31
4 stars	9



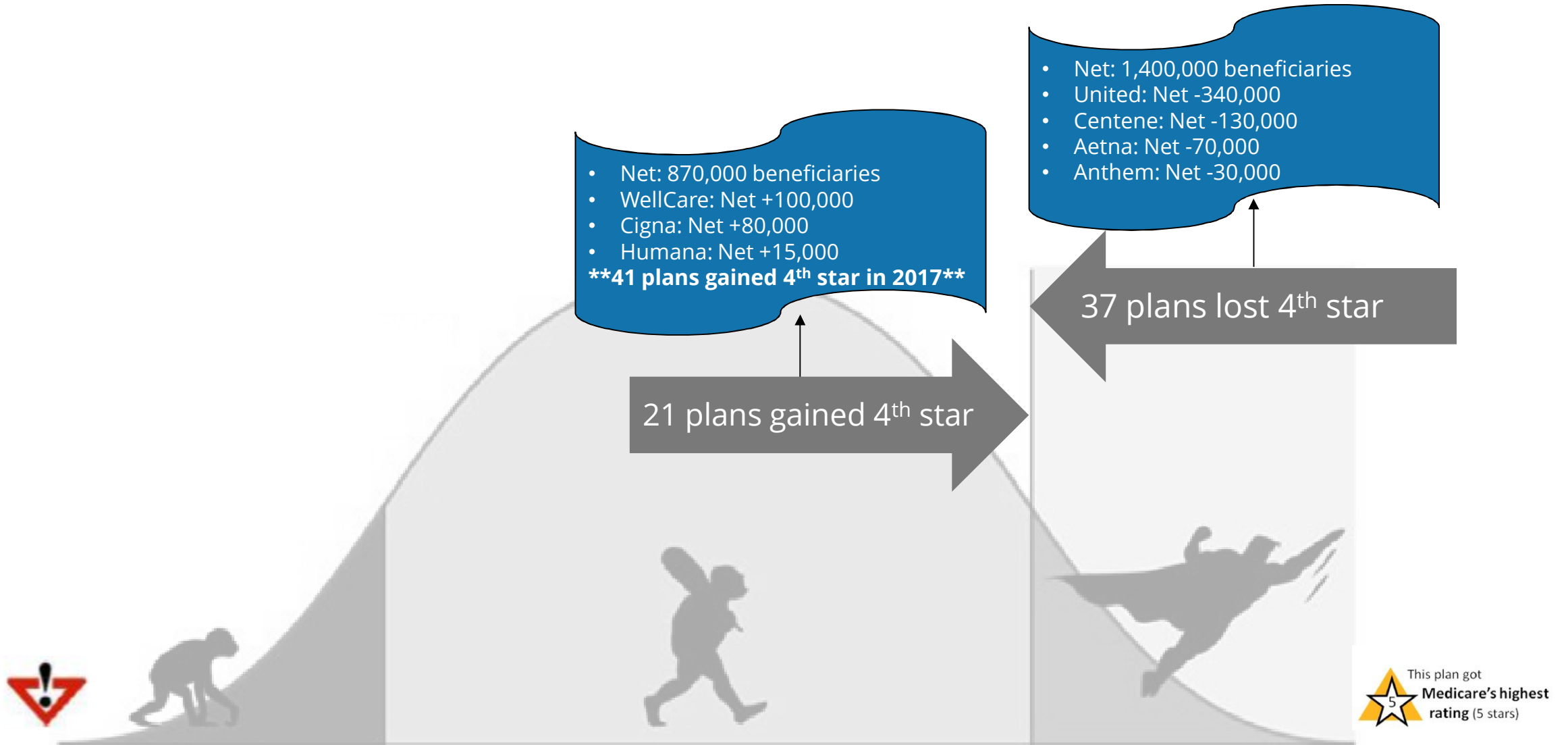
NEW ENTRANTS FACE HEADWINDS



A TALE OF TWO BELL CURVES

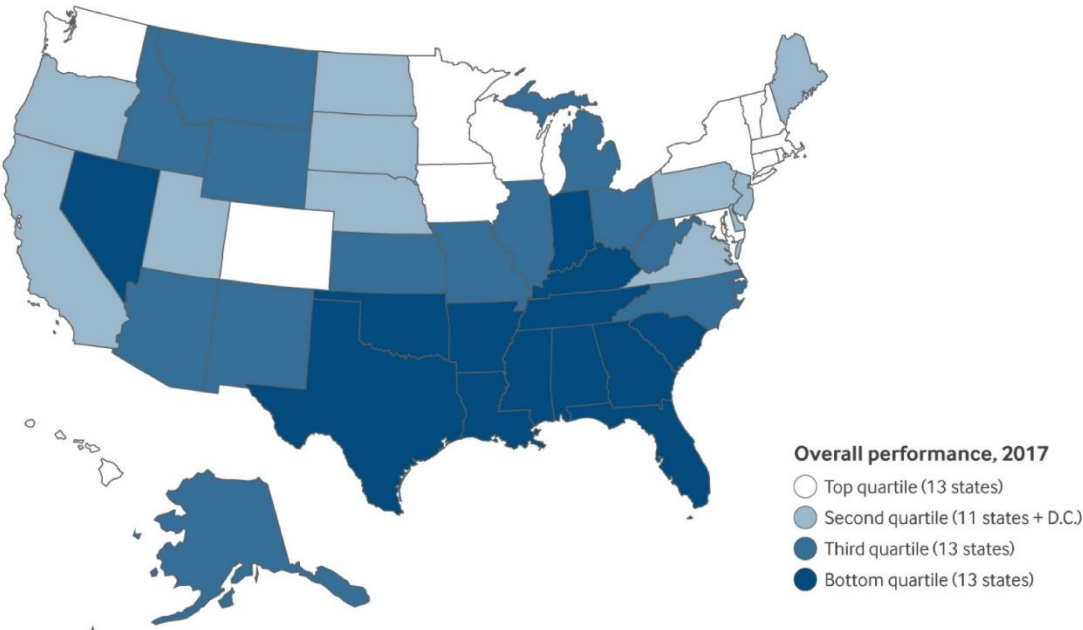


THE PURSUIT OF QUALITY BONUS PAYMENTS



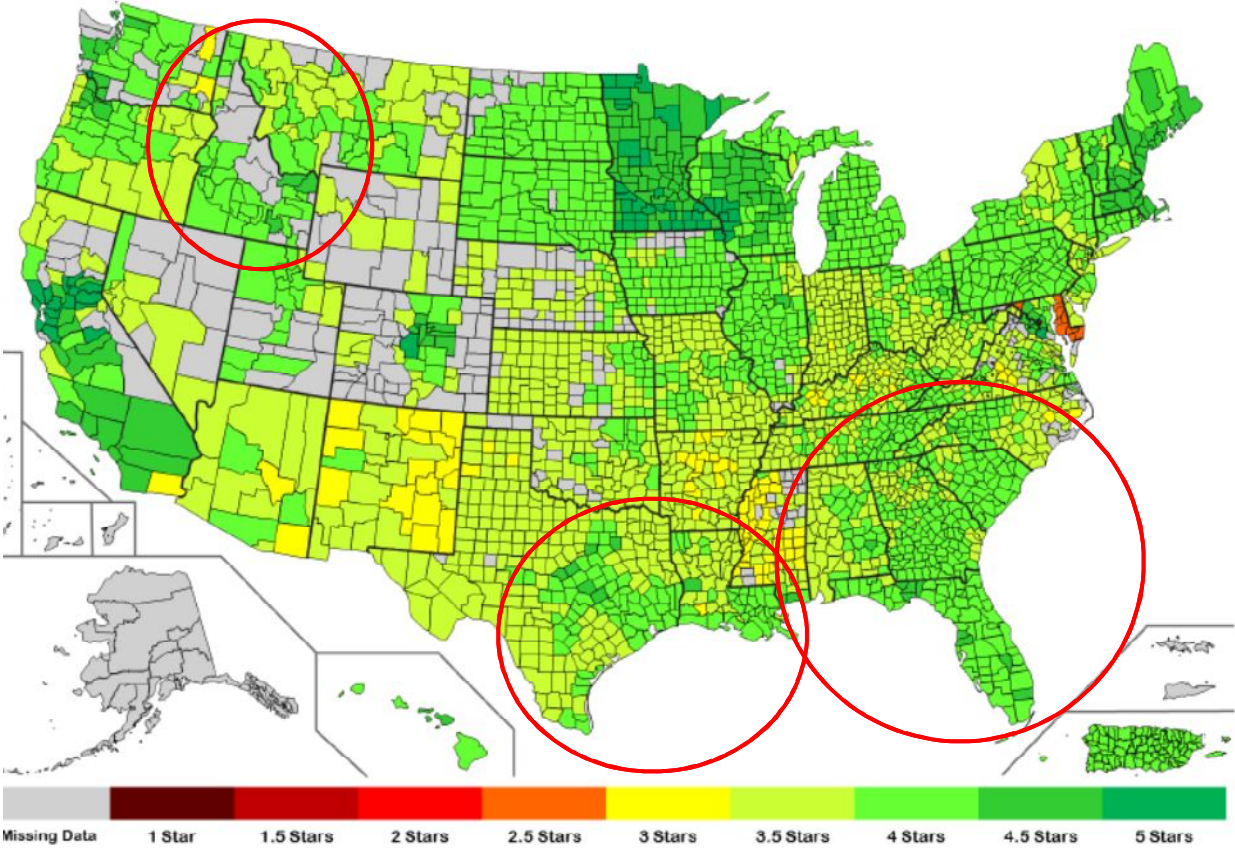
WHERE ARE STAR RATINGS INFLUENCING QUALITY?

Overall State Health System Performance: Scorecard Ranking, 2017



Source: D. C. Radley, D. McCarthy, and S. L. Hayes, *Aiming Higher: Results from the Commonwealth Fund Scorecard on State Health System Performance 2017 Edition*, The Commonwealth Fund, March 2017.

2018 Star Ratings - Enrollment Weighted Average MA-PD Overall Rating in Non-EGHP Counties



Source: Centers for Medicare and Medicaid Services. *2018 Star Ratings Fact Sheet*, October 2017. <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>

STAR RATINGS SUPPORT A CULTURE OF EXCELLENCE

Complaints per 1,000

Star Rating	2017	2018
★★ ½	0.55	.71
★★★	0.40	.32
★★★★ ½	0.22	.21
★★★★★	0.16	.10
★★★★★ ½	0.10	.09
★★★★★★	0.08	.12

% Disenrollment

Star Rating	2017	2018
★★ ½	20%	20%
★★★	17%	16%
★★★★ ½	11%	11%
★★★★★	10%	8%
★★★★★ ½	7%	6%
★★★★★★	4%	5%

ARE STAR RATINGS IMPROVING QUALITY?

IMPROVEMENT NEEDED

- ② Improving/Maintaining Physical Health
- ② Reducing the Risk of Falling
- ② Osteo. Mgmt in Women w/ Fracture
- ② Monitoring Physical Activity

PERFORMANCE PLATEAU

- ② Breast Cancer Screening
- ② Diabetes Care
 - A1c Control
 - Eye Exam
 - Medication adherence (oral medications)
- ② Annual Flu Vaccine
- ② Rheumatoid Arthritis Management
- ② Improving or Maintaining Physical Health
- ② Monitoring Physical Activity
- ② Plan All-Cause Readmissions
- ② Reviewing Appeals Decisions
- ② MPF Price Accuracy
- ② Part D Foreign Language/TTY Availability
- ② Members Choosing to Leave the Plan
- ② Getting Needed Care
- ② Getting Needed Drugs
- ② Getting Appts. & Care Quickly
- ② Care Coordination
- ② Customer Service
- ② Rating of Healthcare Quality
- ② Rating of the Health Plan
- ② Rating of the Drug Plan

4-STAR CUT POINTS: THE BELL CURVE AT WORK

Part C Measures

- ↑ 3% or more 8 measures
- ↑ 1-2% 8 measures
- ↔ No Change 5 measures
- ↓ 1-3% 5 measures
- ↓ 4-6% 5 measures
- Incomparable 3 measures

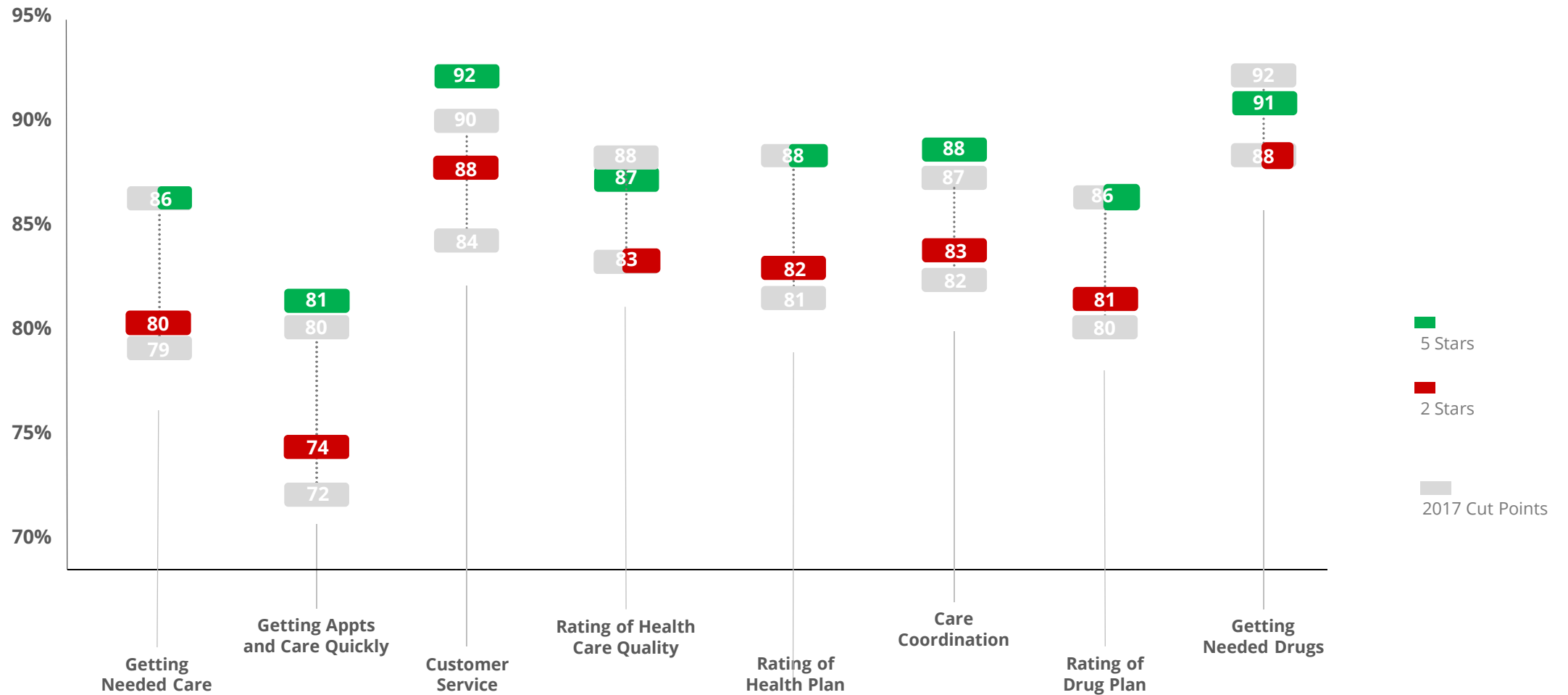
Part D Measures

- ↑ 3% or more 2 measures
- ↑ 1-2% 4 measures
- ↔ No Change 1 measure
- ↓ 1-3% 1 measure
- ↓ 4-6% 3 measures
- Incomparable 3 measures

Other Significant Cutpoint Changes:

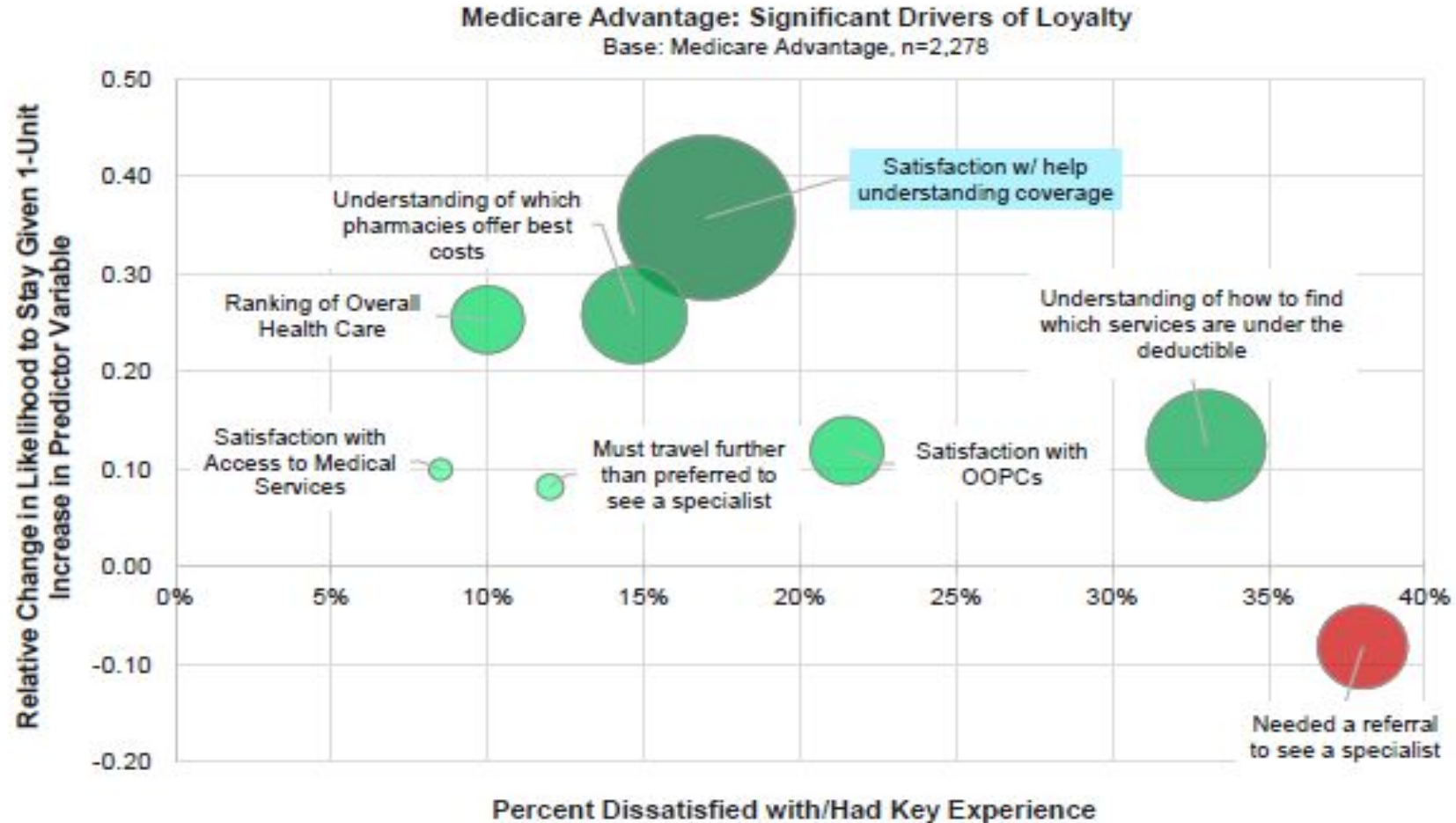
Controlling Blood Pressure, Diabetes Care – A1c Controlled, Breast Cancer Screening, Adult BMI Assessment, Care for Older Adults measures, OMW, Medication Adherence measures

CAHPS® AND THE MEMBER EXPERIENCE: EVERY MEMBER MATTERS



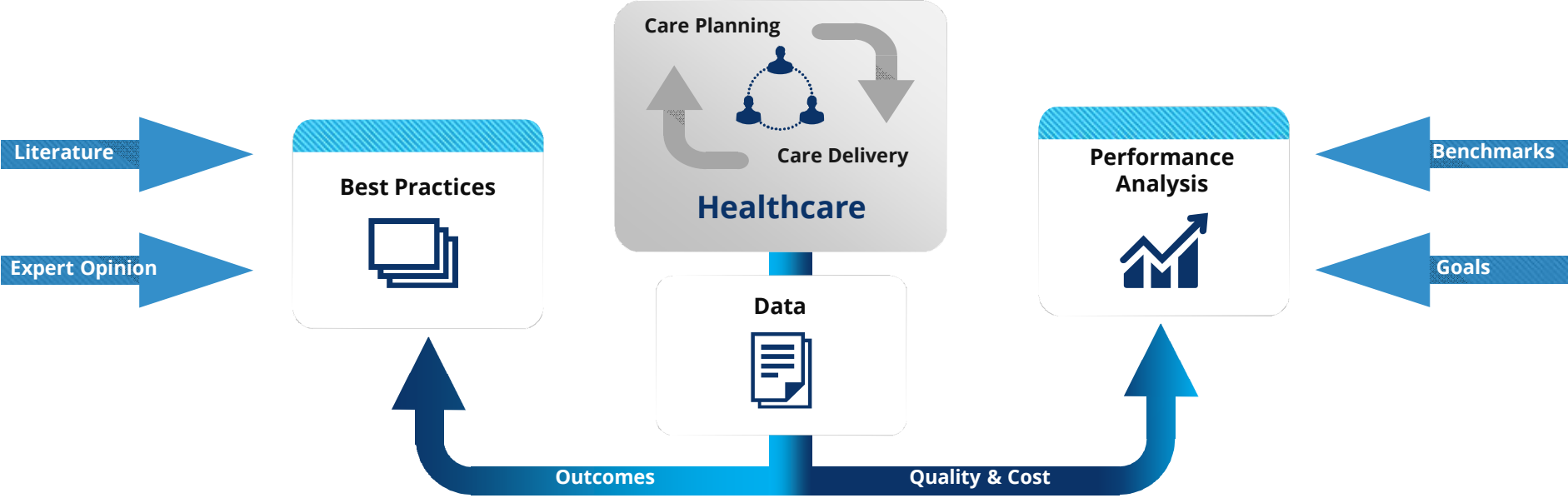
LEVERS OF LOYALTY

Varying Factors Impact the Member Experience



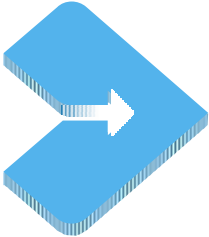
Source: Deft Research, 2016 Medicare Member Experience Study

MANAGING YOUR MEMBER EXPERIENCE JOURNEY



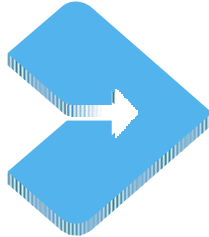
JOURNEY MAP

- What are members experiencing today?
- What calls, letters, and home visits are they receiving?
- Which outreaches are required, and which are optional?



STRATEGY ASSESSMENT

- Who do we want to interact with members and why?
- When and where do we want to interact with members?
- Will we use model or non-model documents?

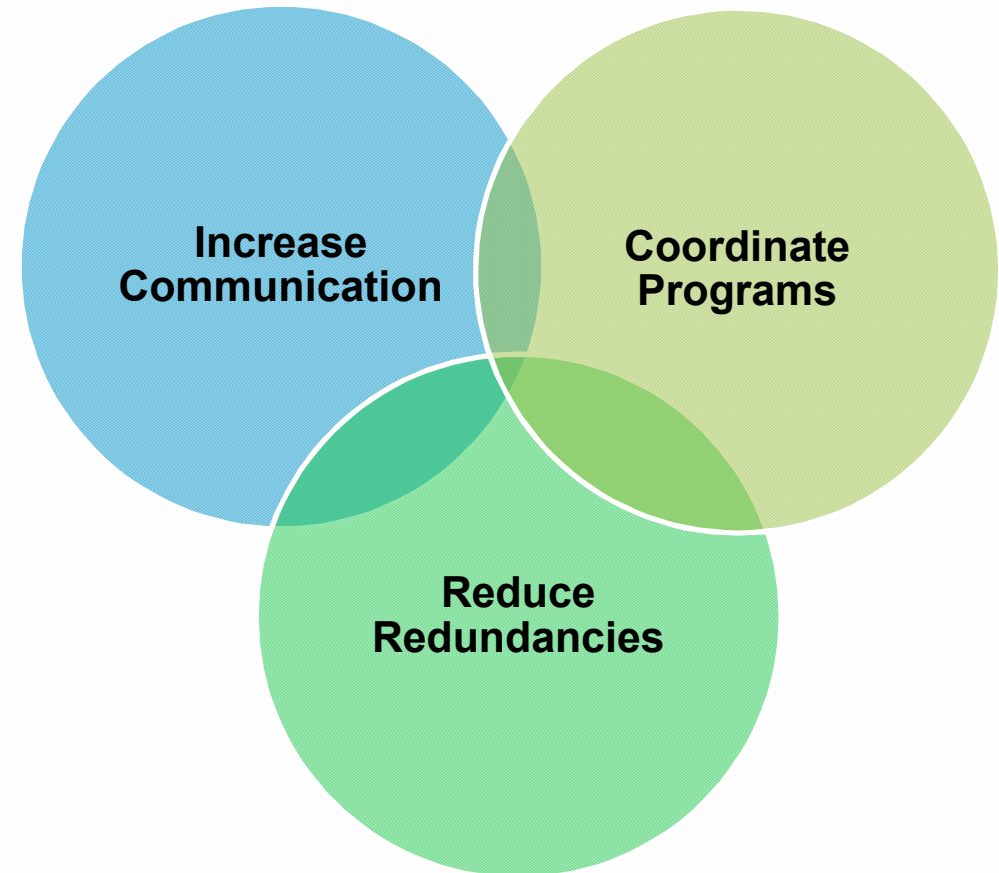


MEMBER EXPERIENCE ALIGNMENT

- How effective are our interactions?
- How aligned is messaging across departments?
- Are all outreaches aligned with our goals?
- Are we achieving highest possible ROI from each outreach?

CROSS-FUNCTIONAL MEMBER EXPERIENCE TEAM

- ④ Reduced Disenrollment Rates
- ④ Increased Member Loyalty and Referrals
- ④ Return on Investment via:
 - Risk Adjustment
 - Medical Management
 - Quality Bonus Programs



FINANCIAL IMPACT

New vs. Renewal Members PMPM

- ② Hypothetical new member vs. a retained member
- ② Considers impacts on revenue as well as cost differences
- ② Illustrative with all other factors being equal to provide a view of differentials between new and retained members

\$ Per Member Per Month (PMPM)	New Member	Retained Member	Impact of Retention
Revenue	\$850	\$893	Risk adjustment success is realized on retained members in the year following actions
Medical Expense	(\$757)	(\$741)	Population management returns show up in subsequent years
Administrative Cost	(\$68)	(\$65)	Misc. incremental costs of new members – welcome packet, initial assessment, etc.
Acquisition/Renewal	(\$36)	(\$18)	Commission or cost of sales
PMPM EBIT	(\$10)	\$69	Earnings Before Interest & Taxes

This analysis provides a hypothetical view of the financial differences between new and renewing members in each revenue/cost category.

WHAT'S WORKING?

A GROWING FOCUS ON SUBSTANCE, NOT FORM

REDUCING THE RISK OF FALLS

~35% of Medicare beneficiaries are hospitalized each year. Falls account for ~15% of all readmissions within 30 days.

Falls were reduced by 61% for patients who had comprehensive risk assessment after a fall.

Implementation of a fall-risk screening instrument without associated policy and procedure changes has only a limited effect on falls.

Screening to identify individuals at high risk of falls is an important component of a successful fall prevention program.

ADULT BMI ASSESSMENT

BMI <20 is associated with increased chronic diseases and mortality in seniors.

Weight loss in seniors can decrease function and quality of life and increase risk of in-hospital complications.

Obese seniors experience and self-report worse health status and experience higher utilization than other enrollees – even overweight beneficiaries.

BMI >30 increases risk for hypertension, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, osteoarthritis, sleep apnea, and some cancers.

BLADDER CONTROL

Patients with UI had significantly worse HOS scores on other HOS measures than those not experiencing UI.

The economic cost of UI continues to rise as up to 20% of seniors have enough UI to limit some aspect of their lives.

UI can limit confidence/social activity, cause/increase depression, cause member not to take important medications, and increase cost for incontinence products.

In most cases, UI can be treated in whole or in part with improvements in hygiene, health, and confidence.

STAR RATINGS IS A DATA GAME

STARS PERFORMANCE AND PROJECTIONS															GORMAN HEALTH GROUP						
CONTRACT ID	PART C	2018 PROJECTIONS										2019 PROJECTIONS									
		ELIGIBLE	COMPLIANT	RATE	RATING	DOWN	UP	DISTANCE TO NEXT STAR	2018 PROJECTION	ELIGIBLE	COMPLIANT	RATE	RATING	DOWN	UP	DISTANCE TO NEXT STAR	2019 PROJECTION				
Personal Choice 65 PPO																					
H3909																					
	Proposed: Improving Bladder Control																3				
	Proposed: Medication Reconciliation																3				
	Proposed: Statin Therapy for Patients with Cardiovascular Disease																4				
	Proposed: Hospitalizations for Potentially Preventable Conditions																5				
C01	Breast Cancer Screening	15,269	8,000	52%	2	(1,434)	1,619	2		15,269	8,000	52%	2	(1,434)	1,619	2					
C02	Colorectal Cancer Screening	32,586	20,355	62%	3	(152)	2,781	3		32,586	20,355	62%	3	(152)	2,781	3					
C03	Annual Flu Vaccine	NA	NA	75	4	-1%	3%	4		NA	NA	75	4	-1%	3%	4					
C04	Improving or Maintaining Physical Health	NA	NA	70%	3	-3%	2%	3		NA	NA	70%	3	-3%	2%	3					
C05	Improving or Maintaining Mental Health	NA	NA	90%	5	-3%	0%	5		NA	NA	90%	5	-3%	0%	5					
C06	Monitoring Physical Activity	NA	NA	50%	3	-1%	4%	3		NA	NA	50%	3	-1%	4%	3					
C07	Adult BMI Assessment	30,000	17,495	58%	2	(3,995)	1,405	2		30,000	17,495	58%	2	(3,995)	1,405	2					
C08	Special Needs Plan (SNP) Care Management	25,000	17,495	70%	3	(3,970)	1,055	3		25,000	17,495	70%	3	(3,970)	1,055	3					
C09	Care for Older Adults - Medication Review	28,000	17,495	62%	3	(1,535)	3,505	3		28,000	17,495	62%	3	(1,535)	3,505	3					
C10	Care for Older Adults - Functional Status Assessment	30,000	17,495	58%	3	(895)	4,705	3		30,000	17,495	58%	3	(895)	4,705	3					
C11	Care for Older Adults - Pain Assessment	31,000	17,495	56%	2	(6,025)	795	2		31,000	17,495	56%	2	(6,025)	795	2					
C12	Obstetrics Management in Women who had a Cesarean Section	29,000	17,495	60%	4	(2,705)	2,805	4		29,000	17,495	60%	4	(2,705)	2,805	4					
C13	Diabetes Care - Eye Exam	9,547	4,567	48%	2	(1,75)	1,257	2		9,547	4,567	48%	2	(1,75)	1,257	2					
C14	Diabetes Care - Kidney Disease Monitoring	9,547	9,200	96%	4	(5)	154	4		9,547	9,200	96%	4	(5)	154	4					
C15	Diabetes Care - Blood Sugar Control	9,547	5,000	52%	2	(322)	919	2		9,547	5,000	52%	2	(322)	919	2					
C16	Controlling Blood Pressure	100	87	87%	5	(12)	-	5		100	87	87%	5	(12)	-	5					
C17	Rheumatoid Arthritis Management	930	626	67%	2	(31)	72	2		930	626	67%	2	(31)	72	2					
C18	Reducing the Risk of Falling	NA	NA	66%	4	-3%	7%	4		NA	NA	66%	4	-3%	7%	4					
C19	Plan All-Cause Readmissions	11,684	1,100	9%	4	-3%	6%	4		11,684	1,100	9%	4	-3%	6%	4					
C20	Getting Needed Care	NA	NA	82	3	-1%	2%	3		NA	NA	82	3	-1%	2%	3					
C21	Getting Appointments and Care Quickly	NA	NA	76	3	-3%	1%	3		NA	NA	76	3	-3%	1%	3					
C22	Customer Service	NA	NA	87	3	-1%	2%	3		NA	NA	87	3	-1%	2%	3					
C23	Falling of Health Care Quality	NA	NA	84	2	-1%	1%	2		NA	NA	84	2	-1%	1%	2					
C24	Rating of Health Plan	NA	NA	82	2	-1%	1%	2		NA	NA	82	2	-1%	1%	2					
C25	Care Coordination	NA	NA	83	2	-1%	2%	2		NA	NA	83	2	-1%	2%	2					
C26	Complaints about the Health Plan	NA	NA	0.3%	1	NA	NA	1		NA	NA	0.3%	1	NA	NA	1					
C27	Members Choosing to Leave the Plan	NA	NA	2.7%	4	NA	NA	4		NA	NA	2.7%	4	NA	NA	4					
C28	Beneficiary Access and Performance Problems	NA	NA	80	5	NA	NA	5		NA	NA	80	5	NA	NA	5					
C29	Health Plan Quality Improvement	NA	NA	-	3	NA	NA	3		NA	NA	-	3	NA	NA	3					
C30	Plan Makes Timely Decisions about Appeals	NA	NA	98%	5	NA	NA	5		NA	NA	98%	5	NA	NA	5					
C31	Reviewing Appeals Decisions	NA	NA	75%	2	NA	NA	2		NA	NA	75%	2	NA	NA	2					
C32	Call Center - Foreign Language Interpreter and TTY Availability	NA	NA	94%	4	NA	NA	4		NA	NA	94%	4	NA	NA	4					
Current Part D																					
Proposed: Statin Use in Persons with Diabetes																					
D01	Call Center - Foreign Language Interpreter and TTY Availability	NA	NA	93%	4	NA	NA	4		NA	NA	93%	4	NA	NA	4					
D02	Appeals Auto-Forward	NA	NA	21.2	1	NA	NA	1		NA	NA	21.2	1	NA	NA	1					
D03	Appeals Upheld	NA	NA	0.69	3	NA	NA	3		NA	NA	0.69	3	NA	NA	3					
D04	Complaints about the Drug Plan	NA	NA	0.45	4	NA	NA	4		NA	NA	0.45	4	NA	NA	4					
D05	Members Choosing to Leave the Plan	NA	NA	0.3%	2	NA	NA	2		NA	NA	0.3%	2	NA	NA	2					
D06	Beneficiary Access and Performance Problems	NA	NA	60	4	NA	NA	4		NA	NA	60	4	NA	NA	4					
D07	Drug Plan Quality Improvement	NA	NA	0.60	4	NA	NA	4		NA	NA	0.60	4	NA	NA	4					
D08	Rating of Drug Plan	NA	NA	85	4	-1%	1%	4		NA	NA	85	4	-1%	1%	4					
D09	Getting Needed Prescription Drugs	NA	NA	92	5	0%	0%	5		NA	NA	92	5	0%	0%	5					
D10	MFF Price Accuracy	NA	NA	85	1	NA	NA	1		NA	NA	85	1	NA	NA	1					
D11	High Risk Medication	2,000	120	6%	3	(20)	3		2,000	120	6%	3	(20)	3							
D12	Medication Adherence for Diabetes Medications	7,000	5,601	80%	4	(71)	209	4		7,000	5,601	80%	4	(71)	209	4					
D13	Medication Adherence for Hypertension (RAS antagonists)	2,500	1,911	77%	3	(56)	44	3		2,500	1,911	77%	3	(56)	44	3					
D14	Medication Adherence for Cholesterol (Statins)	3,500	2,000	57%	1	-	310	1		3,500	2,000	57%	1	-	310	1					
D15	MTM Program Completion Rate for CMR	5,963	3,385	57%	3	(535)	80	3		5,963	3,385	57%	3	(535)	80	3					

Monitor multiple Star Ratings cycles

Model impact of potential new measures

Predictively model impact of operational decisions

Account for CMS variables

HUGE IMPACT OF SOCIAL DETERMINANTS

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Some studies attribute as much as 50% of healthcare outcomes to social determinants of health.



PRODUCT DESIGN

Strategically Diversify Product Portfolios

➤ To create a benefit package that will be sustainable while engaging new enrollment and retaining membership, health plans will need to analyze:

- Market penetration
- Product trends
- Plan comparison
- Wellness programs and ancillary benefits
- Value-based insurance design
- Preferred provider networks
- Medical, pharmacy, and social needs of the community



PRODUCT DESIGN: THE FOUNDATION FOR EXCELLENCE



- ④ Copays, cost-sharing, formulary design
- ④ Care management, disease management, and other supportive programs
- ④ Palliative care and wellness programs
- ④ Referral requirements
- ④ Ancillary benefits (vision, dental, hearing, nutrition, transportation)
- ④ Provider and pharmacy networks
- ④ Programs and resources to support social determinants of health

SUPPLEMENTAL BENEFITS FLEXIBILITY: *IN CALL LETTER, CODIFIED IN BUDGET RESOLUTION*

- ② CMS seeks to allow for benefits which “compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization.”
- ② Opportunity for plans to offer more meaningful benefits that address social determinants of health:
 - CMS is broadening its definition and will permit MA plans to offer additional benefits as “healthcare benefits” – that is, to include it in the bid.
 - For a service or item to be “primarily health related,” it must “diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization.”

BEST PRACTICES & STRATEGIES FOR SUCCESS

- ④ Organization-wide commitment to:
 - Continuous improvement
 - Providing quality care to all members
 - Coordinated, clinically-contextual, care coordination
 - The MOC
- ④ Investment of resources where dual eligible populations reside and obtain care:
 - Case managers, physician extenders, health coaches, consultative pharmacists, social workers
 - Collaborations with high-volume dual eligible providers
 - Multi-modal CM, DM, and health coaching for convenience and comfort of dual eligibles
- ④ Knowledgeable and skilled staff

DATA COLLECTION, TRACKING & REPORTING: BEST PRACTICES

Creativity and innovation

- Meet with members where they live to allow first-hand assessment and optimal member comfort
- Store data electronically in a location where it can be queried and integrated with medical and medication data
- Hardwire processes that integrate non-clinical data into care planning, quality strategies, etc.

Review stakeholders and formal process

- Internal: business partners, units, committees, alliances
- External: vendors (e.g., data, survey, auditors), providers, community partners, social impact partners

Converting barriers and challenges into opportunities

- Timely and accurate
- Integration with flexibility
 - Sustainability
 - Scalability
- Usefulness

EXECUTION, EXECUTION, EXECUTION!



- ① Understand and effectively segment membership
- ① Support the physician/patient relationship
- ① Match interventions to members' needs
- ① Eliminate single-purpose outreaches and interventions
- ① Prioritize and integrate medical, clinical, behavioral, and pharmacy issues in member interventions
- ① Support and coordinate care for members across settings, particularly during transitions of care and upon new diagnoses
- ① Meet members where they are with empathy
- ① Empower staff to "go the extra mile"

2019 STAR RATINGS PROPOSALS

New Measures (Based on 2017 data)

- Statin Use in Persons with Diabetes (Part D)
- Statin Therapy for Patients with Cardiovascular Disease (Part C)

Measures for Removal

- Beneficiary Access and Performance Problems (BAPP)
- Reducing the Risk of Falling

New methodology for reductions to the 4 appeal measures that rely on data submitted to the Independent Review Entity (IRE)

- Scaled reduction policy using statistical criteria to reduce a contract's Star Rating for data that is incomplete or lack integrity

Part C and Part D Star Ratings Methodology

- Codifying principles for adding, updating, retiring measures and methodology for calculating and weighting measures for the 2019 performance period and first payment year of 2022

2019 STAR RATINGS AND DISASTER IMPLICATIONS

- ④ When circumstances meet the proposed criteria:
 - Contracts operating solely in Puerto Rico
 - 2018 CAHPS® and HOS surveys optional
 - Excluded from 2019 cut point calculations
 - Contracts with 60% or more enrollees in affected areas excluded from the clustering algorithms for non-CAHPS® measures
 - Other Affected Contracts
 - Must administer survey unless CMS-approved exception
 - If >25% of beneficiaries reside in affected disaster areas:
 - Higher of the 2018 or the adjusted 2019 Star Ratings
 - Higher of the current/previous Star Rating for each measure in the 2020 Star Ratings

STAR RATINGS 2020 AND BEYOND

New hypertension treatment guidelines are being evaluated by NCQA; Controlling Blood Pressure may be temporarily retired to the display page for the 2020 Ratings.

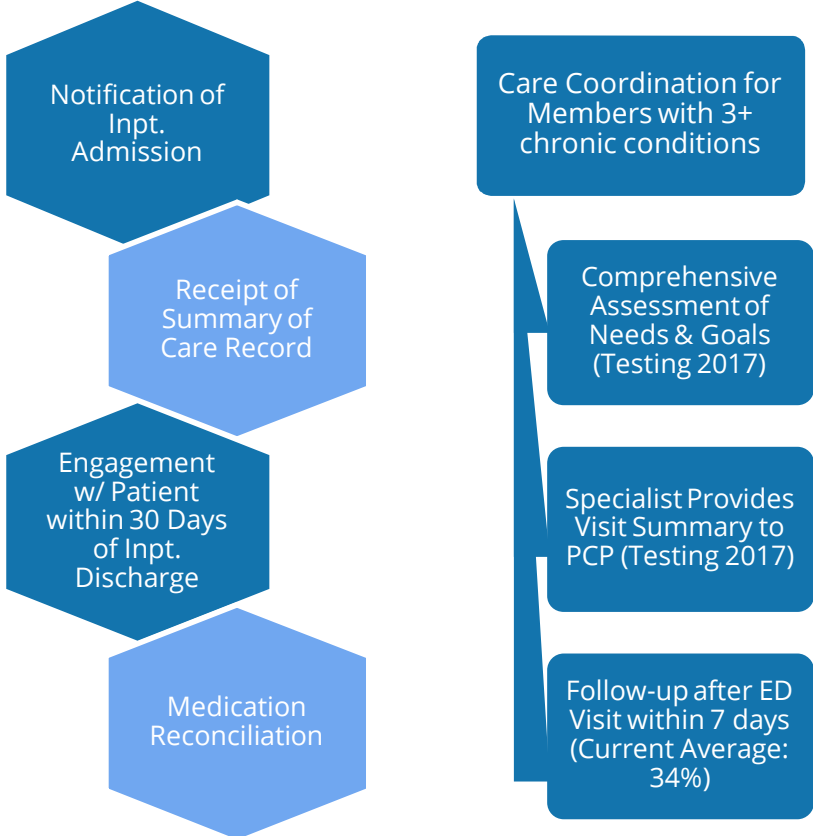
HEDIS® measures may not be clinically appropriate for all members, which could be incorporated into HEDIS® 2019.

Medication Adherence measures may be risk adjusted for various socio-demographic characteristics beginning with the 2018 calculations; once complete (expected in early 2019), CMS will determine how to implement within the Star Ratings program.

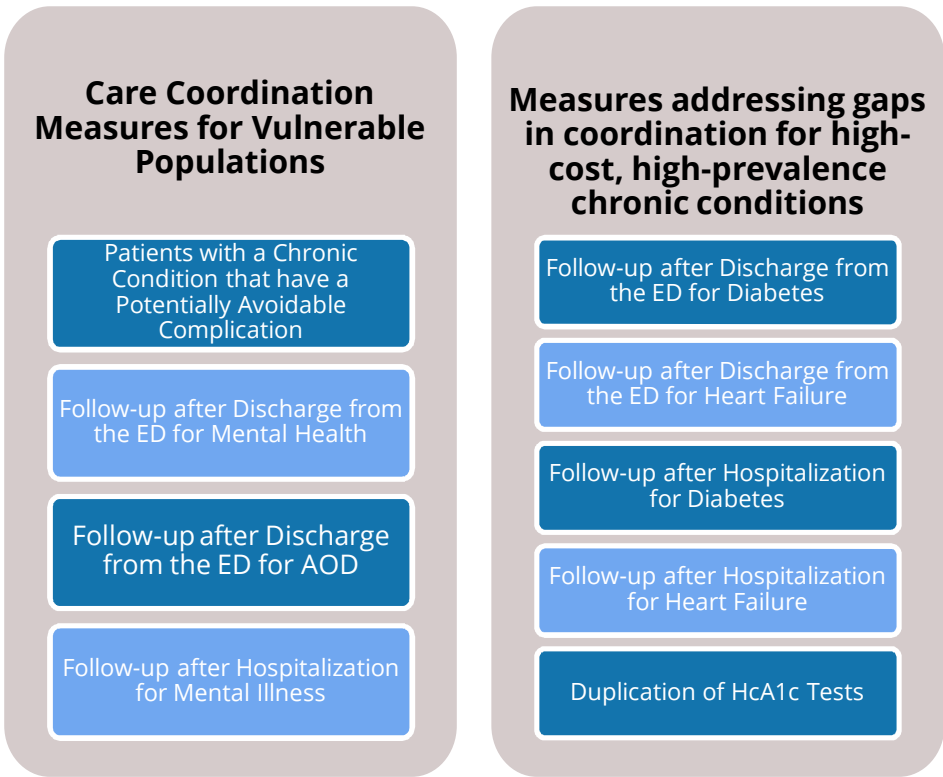
MPF Price Accuracy measure will be implemented through the display page for the 2020 and 2021 ratings; CMS seeks feedback on leaving the current MPF Price Accuracy measure “as is” until the new modified measure takes effect in the 2022 ratings.

LOOKING EVEN FURTHER AHEAD: EVIDENCE-BASED COORDINATED CARE

NCQA



IMPAQ



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