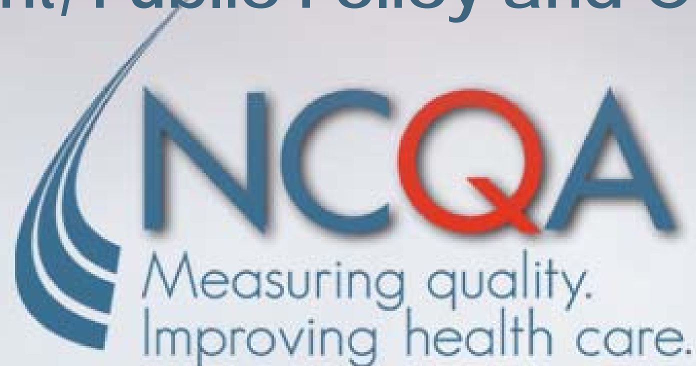
Medicare Advantage Star Ratings

Sarah Thomas
Vice President, Public Policy and Communications



Overview

- The current star rating system
- CMS's plans so far
- Making the system better
- Getting an even bigger payoff

THE CURRENT STAR RATING SYSTEM

Measures included in the system

Topic	# of Measures	Data source
Staying Healthy: Screenings, Tests & Vaccines	12	HEDIS, HOS, CAHPS
Managing Chronic conditions	7	HEDIS & HOS
Ratings of Health Plan Responsiveness and Care	6	CAHPS
Health Plan Members' Complaints Appeals and Choosing to Leave the Health Plan	5	CTM, CAHPS & CMS Audits
Health Plan's Telephone Customer Service	3	CMS Phone Monitoring

Strengths of the Star Ratings

- Incorporation into Medicare Compare
- (Almost) equal treatment of HMOs and PPOs
- Transparency – significant detail available on individual plan performance
- Summary information into stars
- New flag showing low performing contracts

NCQA
Measuring quality.
Improving health care.

Issues and areas for improvement

- Lack of measures of cost
- Many administrative measures
- No weight on measures where greatest payoff or opportunity
- Missing data

Distribution of Star ratings for 2011

- Most enrollment (60 percent) in 3 and 3.5-star plans; 24 percent in 4+ star plans
- Almost one quarter (24 percent) of plans (9 percent of enrollees) not rated
- Only three plans have 5 stars
- Including Part D ratings shifts the distribution

Source: Kaiser Family Foundation, 2011

CMS'S PLANS SO FAR

Provisions from PPACA

- Overall changes to payment rates by setting new and lower benchmarks
- Quality bonus for 4+ star plans of up to 5 percent
- Plans with higher quality scores can offer better benefits to enrollees

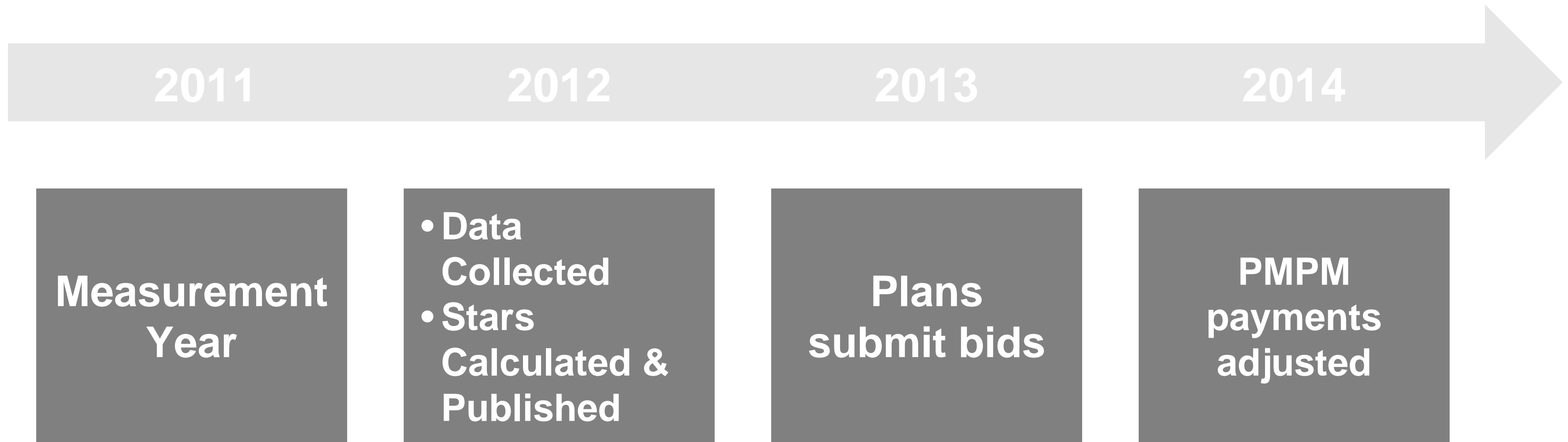
Potential payment increase

100,000 member MA plan:	Before Health Reform	Payments with 3.5 Stars	Payments with 4 Stars
MA County Benchmark	$800 PMPM	$720 PMPM (FFS level)	$720 PMPM (FFS level)
Plan Bid	$600 PMPM	$600 PMPM	$600 PMPM
Quality Bonus	N/A	$0	$36 (5% bonus)
Rebate	$150 (75% of difference between bid and benchmark)	$60 (50% of benchmark – bid)	$84 (70% of benchmark – bid)
Total PMPM	$750 PMPM	$660 PMPM	$720 PMPM
Total Annual Payment	$900 million	$792 million	$864 million

$72 Million Increase

Adapted from Health Dialog, shows full phase in

Three year lag between measurement and payment



Adapted from Health Dialog.

Demonstration

- Intended to strengthen incentives for improvement
  - Ratings based on overall scores (including Part D scores)
  - Bonus payments to contracts rated as average performers (3 or 3.5) as well as to those that receive 4 or more stars
  - Contracts with 5 stars receive higher bonus payments than under law and than 4- and 4.5- star contracts
- Costs $1.3 billion from 2012 to 2014

MAKING THE SYSTEM BETTER

Goals for Pay for Performance

- Improve and reward performance
- Include measures that:
  - have broad consensus
  - sufficient sample size
  - reflect real opportunities for improvement
- Score performance in a way that is transparent and defensible to plans and the public
- Includes a process to add and retire measures, change scoring to reflect changes over time

Design Choices

- Attainment vs. improvement (rewarding best plans vs. those that are working to get better)
- Addressing regional variation in performance (politics)
- Weighting some measures more than others

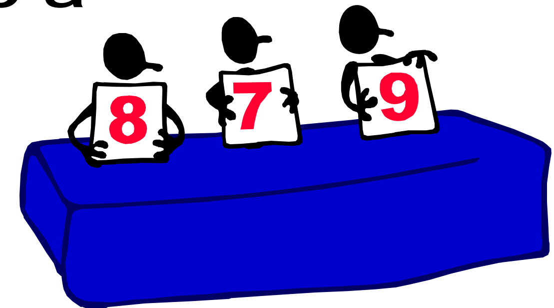
NCQA
Measuring quality.
Improving health care.

Measures to Include

- Ranking and report cards
  - Focus on consumers and media
  - Support decision making among health plans
  - Consumer experience an important factor
- Pay for performance
  - Intersection of evidence based medicine, measurement, payment policy and population health
  - More focus on identifying and rewarding the most effective interventions/practices that affect the most people
  - Opportunity to give stronger incentives to do work on which plans might otherwise not focus

Scoring Issues

- Plans with small enrollment
- Plans for which a given measure is not applicable
- Relative difficulty of different measures; consider normalization
- Scoring on missing data can bias scores (e.g. the missing rate corresponds to a measure for which performance is typically poor)
- Imputation one option - based on national/regional means, information from a plans non-missing measures, measure type (admin vs. hybrid)



P4P Results 2004 – 2008
Lessons Learned

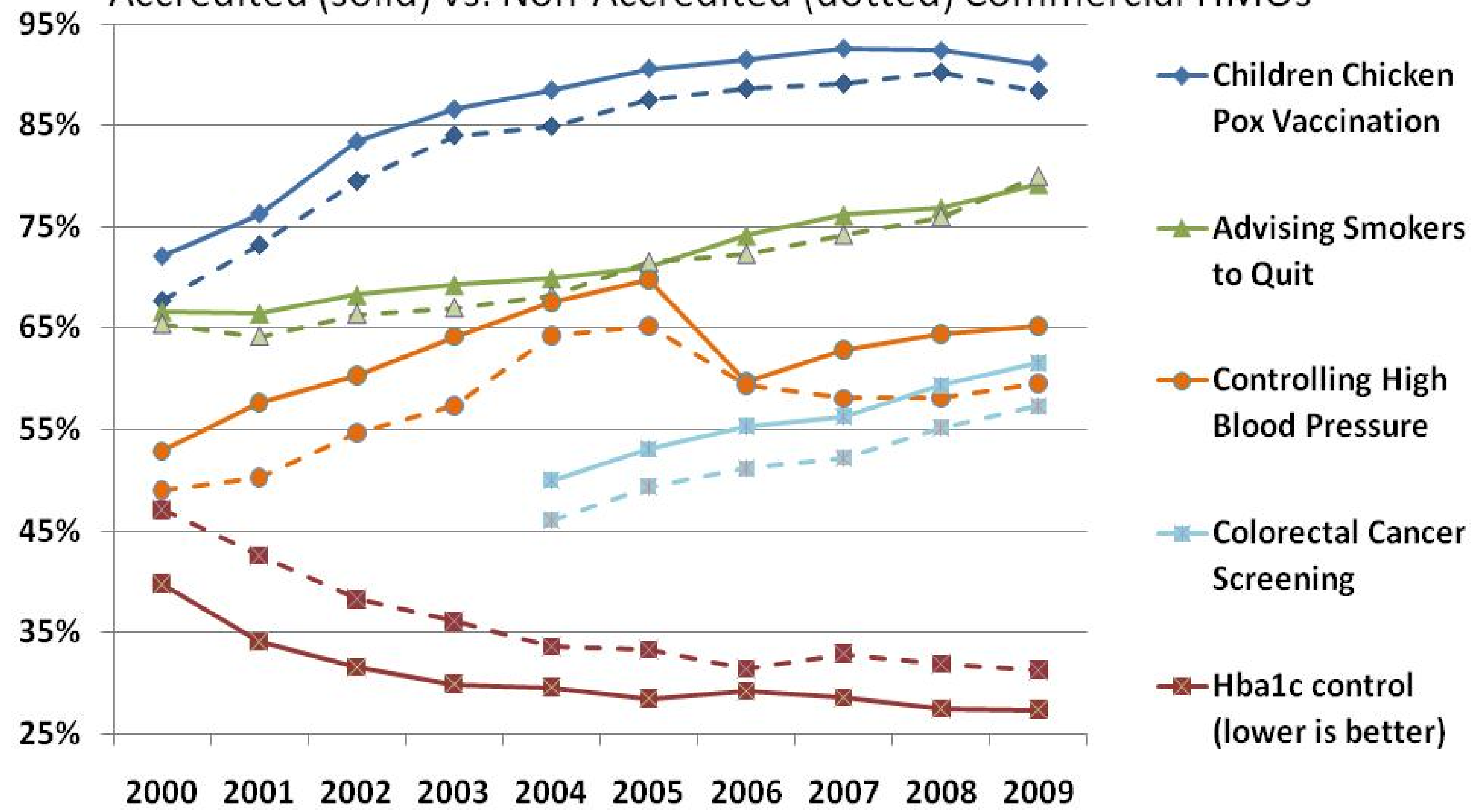
- Physician organizations respond favorably to health plan collaboration
- Physician group engagement has strengthened
- Health plan engagement has weakened
- Attention to pay and metrics needs to be balanced
- Measuring appropriate use, overuse and cost efficiency is essential but difficult

P4P Results 2004 – 2008
Lessons Learned

- Geographic variation may be symptomatic of underlying provider disparity
- Clinical and administrative data streams must be merged
- Reward improvement as well as performance, particularly to address disparities
- System-wide performance breakthrough remains elusive

GETTING AN EVEN BIGGER PAYOFF

Steady improvement on some measures, room for improvement remains



Medicaid Pay-for-Performance

- Pay for performance for health plans very common in state Medicaid programs; used for bonus payments and for autoassignment
- Each state has its own system – many include HEDIS (or variant)
- As of 2005, few used measures of efficiency, patient experience, structural measures (e.g. HIT adoption, accreditation)
- Little evaluation or recent synthesis of findings across states

Source: Commonwealth Fund 2007

Quality Improvement Programs in Health Care Reform

- Starting in 2012, Secretary (in consultation with stakeholders) to develop reporting requirements for all group health plans
- Secretary to develop a quality rating system for Exchanges
- Health plans in Exchanges must reward quality through market-based incentives

PPACA Definition of Quality Improvement

PPACA	How NCQA Lines Up
Improve health outcomes •Case management •Care coordination •Medical homes •Quality reporting and documentation of care •Disparities	• Many measures of process (case management, continuity and coordination of care) • Intermediate outcomes measures (HbA1C, blood pressure) • HOS and CAHPS measures • Patient-centered medical home • HEDIS used to measure disparities; Multicultural Health Care Distinction
Reduce readmissions	• New measure for use in Medicare to be collected in 2011
Improve patient safety	• Ambulatory measures such as: — Antibiotic overuse — Medications to be avoided; monitoring — Falls prevention
Wellness and health promotion	• Measures of process around identifying needs, engagement in activities • Immunization rates • Tobacco cessation • BMI measurement

Clinician and health plan P4P

- Many quality measures in use in clinician pay for performance, including Medicare Quality Reporting System
- CMS using resource use as well as quality measures in feedback reports, eventually in payment modifier
- Could be great opportunity to align and focus together with health plan P4P

Summary

- Medicare Advantage star rating system a great opportunity to improve quality
- System needs to evolve to address missing data, add measures to capture triple aim
- Potential to get an even bigger effect if linked to other initiatives

QUESTIONS?