

# *Health Care Reform and its impact on MA Plans*

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# *National strategy to improve health care quality*

- Improvement of health outcomes, efficiency and patient centeredness of health care;
- Delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;
- Identification of gaps in quality, efficiency, comparative effectiveness information and health outcomes measures and data aggregation techniques;
- Improvement of federal payment policy to emphasize quality and efficiency;
- Enhancement to the use of health care data to improve quality, efficiency, transparency, outcomes and research;
- Address the health care provided to patients with high cost chronic diseases;
- Reduction of health disparities.

# Strengthening Health Care Quality Improvement (QI) Programs

- Improve health care quality, reduce medical errors and health disparities, and advance the delivery of patient-centered medical care to be measured and verified.
  - Effective care management
  - Care coordination
  - Chronic disease management
  - Medication and care compliance initiatives
  - Prevention of hospital readmissions;
  - Activities to improve patient safety and reduce medical errors by using best clinical practices;
  - Promotion of evidence-based medicine;
  - Wellness and health promotion.

# Strengthening Health Care Quality Improvement (QI) – Cont.

**Care Coordination** – direct interaction between the insurer, the member (e.g. face-to-face, telephonic or web-based interactions or other modalities) and providers to:

- coordinate a patient’s care between multiple providers making sure medical records are shared between all the patient’s physicians and activities to improve patient safety and reduce medical errors
- effective case management such as making/verifying appointments and medication and care compliance initiatives and arranging and managing transitions from one setting to another (such as hospital discharge to home or to rehabilitation center and prevention of hospital readmissions);
- care coordination activities to encourage evidence based medicine; and health information technology expenses to support these activities.

# Strengthening Health Care Quality Improvement (QI) – Cont.

**Chronic Disease Management** individually tailored *chronic disease management programs* that interact with the insured to provide medication and care compliance initiatives, such as

- (a) remind member of doctor appointment,
- (b) check that member is following a medically effective prescribed regimen for dealing with the specific disease/condition,
- (c) incorporating feedback from member in the management program,
- (d) provide coaching on dealing with the disease/condition;
- (e) chronic disease management activities to encourage evidence based medicine, and
- (f) health information technology expenses to support these activities.

# Strengthening Health Care Quality Improvement (QI) – Cont.

**Preventive Care and Wellness Programs:** Programs that interact with members.

- (a) Wellness assessment,
- wellness/lifestyle coaching programs,
- coaching programs designed to educate members on clinically effective methods for dealing with a specific chronic disease
- coaching or educational programs and health promotion activities designed to change member behavior (e.g., smoking, obesity;
- Establishment of preferred provider organizations
  - Quality providers with best health outcomes

# Strengthening Health Care Quality Improvement (QI) – Cont.

- Public access to information on providers through different media, including official information from local licensing bodies:
  - Final administrative or judicial determinations and settlements on licensure or malpractice
  - Boards
  - Years of experience
  - Ranking in terms of health outcomes
  - Other information

# 2011 Medicare Advantage Plans Star Rating System



# Why Stars?

- The Star Rating Program measures health plan's **quality** and **performance** that supports CMS's goal of ensuring that Medicare Advantage beneficiaries receive coordinated, efficient and high-quality care.
- CMS is going to reward plans for **high** and **stable** performance based on Star Ratings.
- This rating will impact the MA plans' market.



# CMS Purposes

1. Provide beneficiaries info on MA performance that they may consider (in addition to cost and benefit info) when choosing a plan.
2. Determine Quality Bonus Payment (QBP).
3. Assist CMS in identifying poor performing organizations for compliance actions.

# 5-Star Rating System

Each year, CMS will rate each plan using a 5-star rating system. A plan can get ratings between one to five stars as follows:



POOR- Means poor performance



FAIR- Means below average performance



GOOD- Means average performance

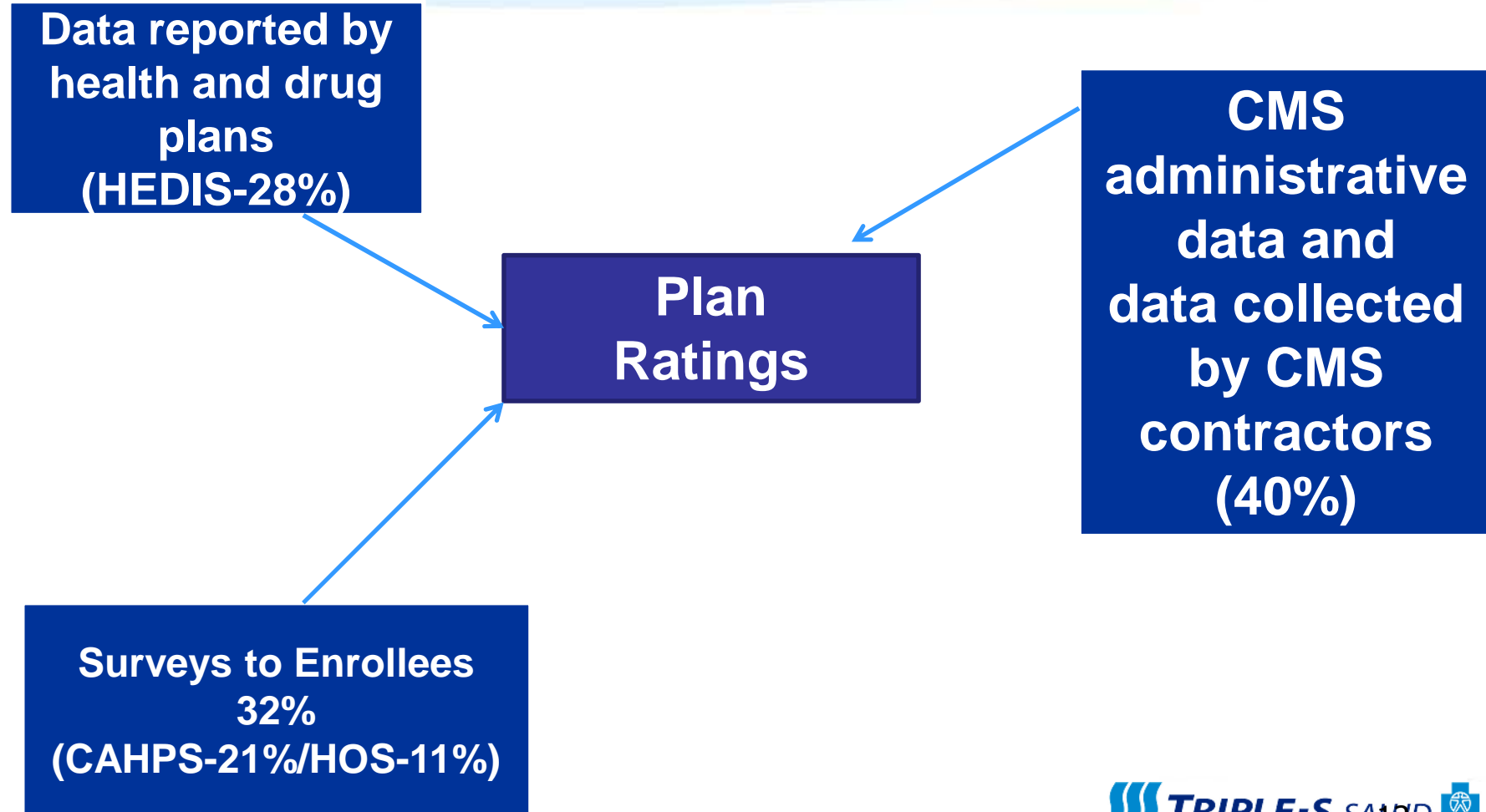


VERY GOOD- Means above average performance



EXCELLENT- Means excellent performance

# Data sources for plan ratings

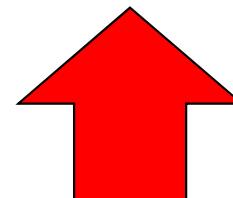


# Data time period for data sources

- Each data source has a different reporting timeframe:
  - HEDIS- June
  - PDE- Monthly, final due by June
  - PF- Biweekly
  - Appeals by IRE/CTM/Lis Match- Jan to June
  - Call Center/CAHPS- Feb to June
  - HOS- April to August

# Stars scorecard timing

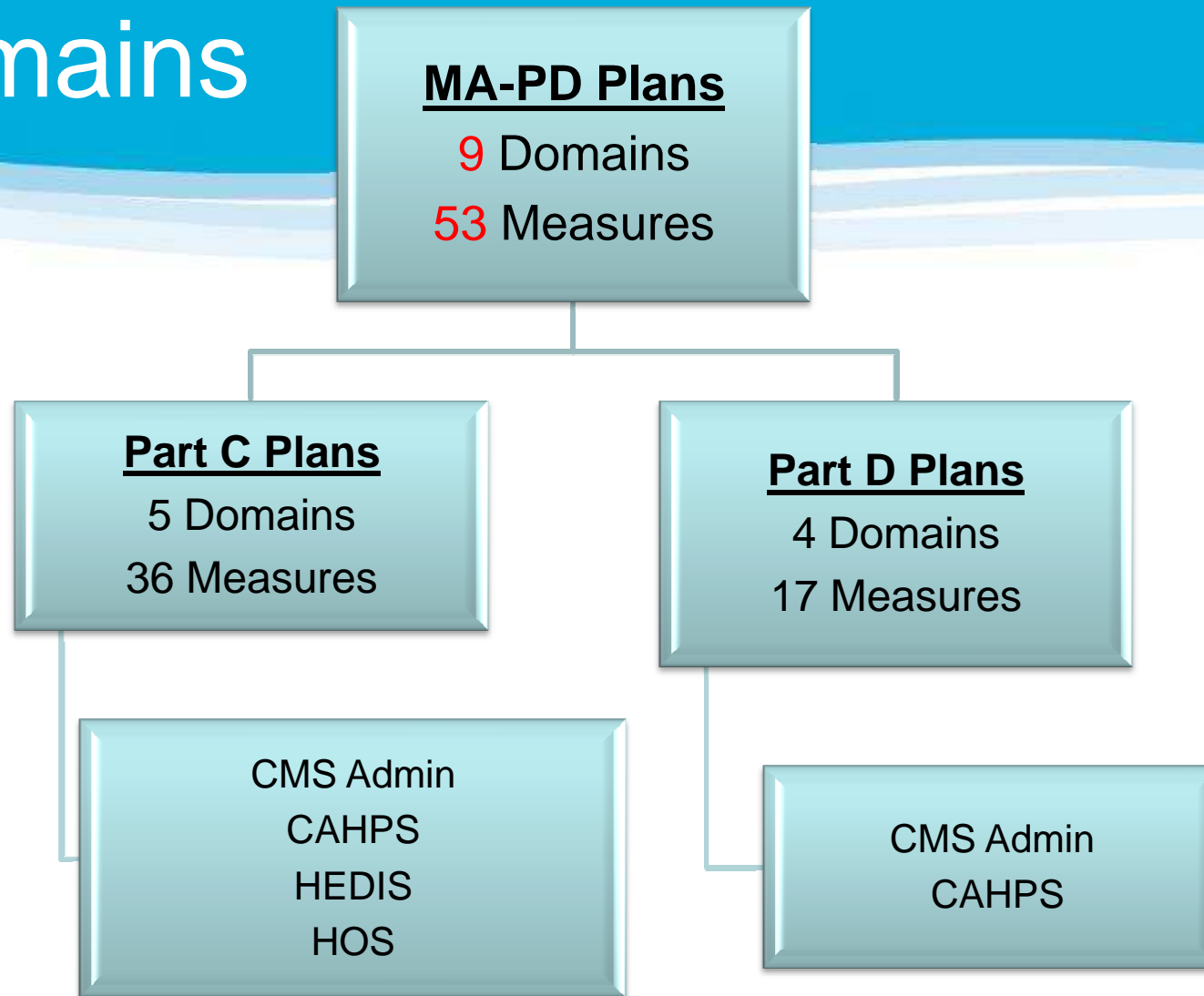
	<b>2012 Stars Scorecard</b>	<b>2013 Stars Scorecard</b>	<b>2014 Stars Scorecard</b>
Year measured (Data)	2010	2011	2012
Date Published	4Q 2011	4Q 2012	4Q 2013
Payment Year Impacted	2013	2014	2015



Here we are now!

NOTE- Plan's star rating for 2012(CY2011) will be published in fall 2011 (mid September).

# Domains



## NOTE

CMS is currently using only **51** measures since the two (2) Part D-CTM measures are equivalent to the Part C-CTM measure.

# Part C – Domain 1

## Staying Healthy (37%)

### Staying Healthy: screenings, tests and vaccines (13 measures)



- Breast Cancer Screening.
- Colorectal Cancer Screening in Older Adults.
- Cholesterol Screening for Patients with CV conditions.
- Cholesterol Screening for Patients with Diabetes.
- Glaucoma Screening in Older Adults.
- Annual Monitoring of Patients on Persistent Medications.
- Annual Flu Vaccine.
- Pneumonia Vaccine.
- Improving or Maintaining Physical Health.
- Improving or Maintaining Mental Health.
- Osteoporosis Testing in Older Women.
- Physical Activity in Older Adults (advising).
- Adults' Access to Preventive/Ambulatory Health Services.

# Part C – Domain 2

## Managing Chronic Conditions (21%)

### Managing Chronic (long-term) Conditions (10 measures)



- Osteoporosis Management in Woman who had a Fracture.
- Diabetes Care: Eye Exam Performed.
- Diabetes Care: Attention for Nephropathy.
- Diabetes Care: Blood Sugar Controlled (HbA1c Poor Control >9).
- Diabetes Care: Cholesterol Controlled (LDL-C<100mg/dl).
- Controlling Blood Pressure.
- Disease Modifying Anti-Rheumatic Drug Tx in Rheumatoid Arthritis.
- Use of Spirometry Testing in the Assess and Dx of COPD.
- Management Urinary Incontinence in Older Adults (receiving).
- Fall Risk Management (managing).

# Part C – Domain 3

## Health Plan's Responsiveness and Care (18%)

### Health Plan's Responsiveness and Care (6 measures)



- Getting Needed Care.
- Doctors who Communicate Well.
- Getting Appointments and Care Quickly.
- Customer Service.
- Overall Rating of Health Care Quality.
- Overall Rating of Health Plan.

# Part C – Domain 4 (15%)

## Health Plan Members Complaints and Appeals

### Health Plan Members' Complaints and Appeals (4 measures)



- Complaints about the Health Plan (for every 1,000 members).
- Health Plan Makes Timely Decisions about Appeals.
- Fairness of Health Plan's Denials to Member's Appeal, based on a Independent Reviewer.
- Corrective Action Plans for Problems Medicare Found During an Audit of the Health Plan (more stars are better because they mean fewer serious problems).

# Part C – Domain 5

## Health Plan's Telephone Customer Service (9%)

### Health Plan's Telephone Customer Service (3 measures)



- Time on Hold When Customer Calls the Health Plan.
- Accuracy of Information Members Get When They Call the Health Plan.
- Availability of TTY/TDD Services and of Foreign Language Interpretation When Members Call the Health Plan.

# Part D – Domain 1

## Drug Plan's Customer Service

### Drug Plan Customer Service (7 measures)



- Time on hold when customer calls drug plan.
- Time on hold when pharmacist calls drug plan.
- Accuracy of information provided by CSRs.
- Availability of foreign language interpreter and TTY/TDD.
- Drug plan's timeliness in giving a decision for members who make an appeal.
- Fairness of drug plan's denials to a member's appeal, based on an independent reviewer.
- Providing Pharmacists with Up-to-Date and Complete Enrollment Information.

# Part D – Domain 2

## Drug Plan's Member Complaints and Staying with Drug Plan

### Drug Plan Member Complaints and Staying with Drug Plan (3 measures)



- Complaints about Joining and Leaving the Drug Plan (per 1,000 members).
- All Other Complaints about the Drug Plan (per 1,000 members).
- Seriousness of Problems Found by Medicare During an Audit of the Contract.

# Part D – Domain 3

## Member's Experience with Drug Plan

### Member's Experience with Drug Plan (3 measures)



- Getting Info from Plan about Prescription Drug Coverage and Cost.
- Members' Overall Rating of Drug Plan.
- Getting Needed Prescription Drugs.

# Part D – Domain 4

## Drug Pricing and Patient Safety

### Drug Pricing and Patient Safety (4 measures)



- Completeness of the Drug Plan's Information on Members Who Need Extra Help.
- Drug Plan Provides Accurate Price Information for Medicare Plan Finder Web Site and Keeps Drug Prices Stable.
- Members' utilization of drugs with a high risk of side effects (HRM).
- Diabetic members use recommended hypertension drugs.

# CAHPS Survey

- Consumer Assessment of Healthcare Providers and Systems
- Developed by Agency for Healthcare Research and Quality (AHRQ)
- Conducted annually by CMS to assess the experiences of beneficiaries in MA plans
- Sample selected by CMS' Office of Information Services (OIS) from CMS administrative data in January
- Data acquisition during the first half of the year (from Feb to June) and measures member's experience over the previous 6 months
- MA-PD questionnaire of 97 questions group under several composites conducted by mail or phone

# CAHPS data for Part C Star Ratings

## Measure- Annual Flu Vaccine

- Have you had a flu shot since September?

## Measure-Pneumonia Vaccine

- Have you ever had a pneumonia shot? This shot is usually given only once or twice a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine.

# CAHPS data for Part C Star Ratings

## Measure- Getting Needed Care

- In the last 6 months, how often was it easy to get appointments with specialists?
- In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?

# CAHPS data for Part C Star Ratings

## Measure- Doctors who communicate well

- In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last 6 months, how often did your personal doctor listen carefully to you?
- In the last 6 months, how often did your personal doctor show respect for what you had to say?
- In the last 6 months, how often did your personal doctor spend enough time with you?

# CAHPS data for Part C Star Ratings

## Measure Getting appointments/care quickly

- In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last 6 months, not counting the times when you needed health care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?

# CAHPS data for Part C Star Ratings

## Measure- Customer Service

- In the last 6 months, how often did your health plan's Customer Service give you the information or help you needed?
- In the last 6 months, how often did your health plan's Customer treat you with courtesy and respect?
- In the last 6 months, how often were the forms for your health plan easy to fill out?

# CAHPS data for Part C Star Ratings

## Measure- Overall Rating of Health Care Quality

- Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

## Measure- Overall Rating of Plan

- Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate all your health plan?

# CAHPS data for Part D Star Ratings

## Measure- Getting needed prescription drugs

- In the last 6 months, how often was it easy to use your plan to get the medicines your doctor prescribed?
- In the last 6 months, how often was it easy to use your plan to fill a prescription at a local pharmacy?
- In the last 6 months, how often was it easy to use your plan to fill prescription by mail?

# CAHPS data for Part D Star Ratings

## Measure-Getting info from the Plan about prescription Drug Coverage and Cost

- In the last 6 months, how often did your plan's Customer Service give you the information or help you needed about prescription drugs?
- In the last 6 months, how often did your plan's Customer Service staff treat you with courtesy and respect when you tried to get info or help about prescription drugs?
- In the last 6 months, how often did your plan give you all the info you needed about which prescription medicines were covered?
- In the last 6 months, how often did your plan give you all the info you needed about how much you would have to pay for your prescription medicine?

# CAHPS data for Part D Star Ratings

## Measure- Overall Rating of Drug Coverage

- Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate all your health plan for coverage of prescription drugs?

# HEDIS

- Healthcare Effectiveness Data and Information Set.
- Developed by NCQA, contains non-survey (HEDIS) and survey (HOS) measures.
- One of the most widely used set of health care performance measures in the US.
- Reflects data from January 1<sup>st</sup> to December 31, while data collected from March to May and submitted on June of next year.
- HEDIS 2010(MY 2009) means that the data was reported on June 2010 but reflects services provided from January 1<sup>st</sup> to December 31, 2009.

# HEDIS data for Star Rating

- **Breast Cancer Screening (BCS)**- percentage of female plan members aged 40 to 69 who had a mammogram during the past 2 years.
- **Colorectal Screening in Adults (COL)**- percentage of plan members aged 50 to 75 who had appropriate screening for colon cancer.
- **Cholesterol Management for Patients with Cardiovascular conditions (CMC)**- percentage of plan members with heart disease who have had a test for LDL cholesterol within the past year.

# HEDIS data for Star Rating (cont)

- **Comprehensive Diabetes Care (CDC)-**  
percentage of plan members with diabetes who have had:
  - A test for LDL cholesterol within the past year and that showed an acceptable level, 100mg/dl.
  - An eye exam to check for damage from diabetes during the year.
  - A kidney function test during the year.
  - An A-1-c lab test during the year that showed their average blood sugar is under control (<9%).

# HEDIS data for Star Rating (cont)

- **Glaucoma Screening in Older Adults (GSO)**- percent of plan members aged 65 or older who got a glaucoma eye exam for early detection.
- **Annual Monitoring for Pts with Persistent Medications (MPM)**- percent of plan members who got a 6 month (or longer) prescription for a drug known to have possibly harmful side effects among seniors if used long-term, and who had at least one appropriate F/U visit during the year to monitor these medications:
  - Angiotensin Converting Enzyme (ACE) inhibitors
  - Angiotensin Receptor Blockers (ARB)
  - Digoxin
  - Diuretics
  - Anticonvulsants

# HEDIS data for Star Rating (cont)

- **Adult's Access to Preventive/Ambulatory Health Services (AAP)**- percent of plan members age 20 and older who saw their PCP during the year .
- **Osteoporosis Management in woman who had a fracture (OMW)**- percent of plan members aged 67 and older who broke a bone and got screening or tx for osteoporosis within 6 months.
- **Controlling Hypertension (CBP)**- percent of plan members 18 to 85 years of age with HBP who got tx and were able to maintain a healthy pressure (BP140/80 mmHg).

# HEDIS data for Star Rating (cont)

- Disease Modifying Anti-Rheumatic drug Tx in Rheumatoid Arthritis (ART)- percent of plan members with RA who got 1 or more prescription(s) for an anti-rheumatic drug (DMRADs).
- Use of Spirometry Testing in the Assess and Diagnosis of COPD (SPR)- percent of plan members 40 or older with active COPD who got appropriate spirometry testing to confirm the dx .

# Medicare HOS

- Health Outcome Survey and contains the survey HEDIS measures.
- Assess MA's ability over time to maintain or improve the physical and mental health of its Medicare members over time.
- Data collected at the beginning and end of 2-year (cohort) interval:
  - Baseline Report can be used to identify potential interventions for maintaining or improving health status.
  - Performance Measures or Follow-Up Report describes the change in the beneficiaries' health status over time.
- HOS 2009 Cohort 12 Baseline Reports- means that data collection for the baseline was done at the beginning of 2009 and the F/U will be done at the end of 2011. While the baseline report will be available at the beginning of 2010 and the F/U will be available at the end of 2012.

# HOS data for Star Rating

- **Improving or Maintaining Physical Health (PCS)**- percentage of all plan members whose physical health was the same or better than expected after two years.
- **Improving or Maintaining Mental Health (MCS)**- percentage of all plan members whose mental health was the same or better than expected after two years.
- **Osteoporosis Testing in Older Women (OTO)**- percent of female members age 65 or older who had a bone density test to check for osteoporosis .

# HOS data for Star Rating (cont)

- **Physical Activity in Older Adults (PAO-advising)**- percent of plan members aged 65 or older who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.
- **Management Urinary Incontinence in Older Adults ((MUI-receiving)**- percent of plan members aged 65 or older with a urine leakage problem who discussed the problem with their doctor and got tx for it within 6 months.
- **Fall Risk Management (FRM- managing)**- percent of members aged 65 or older with a problem falling, walking or balancing who discussed it with their doctor and got tx for it during the year .

# The Demonstration Project

- 3 year period. Will be in effect from 2012 to 2014
- Partial payments will be available to plans with ratings of 3 to 3.5 stars. Scaled approach- the higher a plan's star ratings, the greater the bonus payment.
- Will test whether providing scaled bonuses will lead to more rapid and larger year-to-year quality improvements in MA program compared to the current law bonus structure.
- MAOs may seek review of their star rating while quality bonus payment are made under the demonstration.

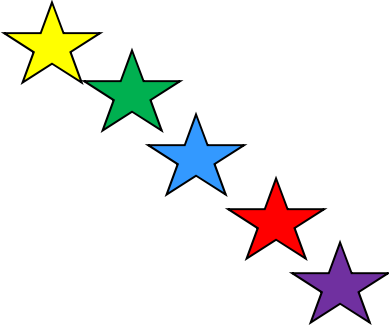
# Public Information

- Plan Star Ratings are displayed in the Medicare Plan Finder tool on [www.medicare.gov](http://www.medicare.gov) to help beneficiaries compare Medicare health plans and choose a plan that meets their specific needs in their area.
- *Low Performing Contract Indicator*- For contract 2011 year, if a plan has a Part C summary rating of 3 or lower for three consecutive years (current year and the past two years), the plan will have a low performance icon affixed to the plan name in the Medicare Plan Finder tool on [www.medicare.gov](http://www.medicare.gov) to alert beneficiaries about the quality information for the plan they are considering. These plans: will be monitored, required to participate in QI projects that CMS chooses, ask for CAPs and sanctions.



**Caution:** For three years in a row, the Medicare program has given this plan a low *overall* rating. If you are considering enrolling in this plan, look closely at the detailed rating for this plan.

# High performers are rewarded

- *Special Election Period (SEP)*- Beginning 2012, CMS will allow beneficiaries eligible for MA to enroll in 5 stars-MA plans any time during the year.
  - An additional 5% QBP payments
  - Accelerated payments
  - 70% rebate levels
- 
- Poor performers may suffer the termination/denial of their application or expanded service area request.
  - *Coming soon*- Star Ratings will be assign for SNP products.

# What health care providers can do to improve the stars?

- Establish and communicate your organization goals
- Adopt the EHR and claim the federal incentives.
  - Develop and maintain a timely reporting structure
  - Adequate documentation of health conditions, co-morbidities and treatments
- Develop a Quality Improvement Work Plan for your organization that incorporate all star-related activities with realistic timeliness.
  - Monitor the progress of the plan periodically
  - Set patient's goals
  - Tailor individualized physical activity regimes
  - Contact patients for follow up
  - Refer patients to community resources

# Organizational QI Work Plan

- **Initiation phase:**
  - Analyze your current data/scores
  - Review current applicable initiatives in place
- **Planning phase**
  - Develop specific organizational objectives
  - Appoint a Chief to lead your Quality Team
- **Executive phase**
  - Implement plan
  - Monitor progress
- **Evaluation phase**
  - Measure progress
  - Re-evaluate interventions and make changes if necessary

# Distribution of Overall Plan Ratings for MA-PD Contracts 2011

Overall Score	Contract Counts	%
5 stars	3	05
4 stars	74	13.2
3 stars	271	48.4
2 stars	48	8.6
Not enough data to calculate overall rating	104	18.6
Plan too new to be measured	60	10.7
Total	560	100

# Distribution of Overall Plan Ratings for PDP Contracts 2011

Part D Score	PDP Count s	%
5 stars	4	6.1
4 stars	12	18.2
3 stars	39	59.1
2 stars	5	7.6
Not enough data to calculate overall rating	4	6.1
Plan too new to be measured	2	3.0
Total	66	100

# References

- Medicare Fact Sheet, CMS Office of Public Affairs  
202-690-6145
- Medicare Health Plan Quality and Performance  
Ratings, 2011 Part C Technical Notes
- 2011 Part D Technical Notes, CY2011 Medicare Part  
D Plan Ratings Technical Notes: 2<sup>nd</sup> Plan Preview  
September 2010



Get focus in **Quality**  
and  
become a **Quality Focused Organization**

Questions?