

## Where Do We Go From Here?

### Star Quality Ratings: Legal, Operational and Strategic Questions for MA Organizations and Part D Plan Sponsors

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Anne W. Hance  
McDermott Will & Emery  
Washington, DC

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## Agenda

- Why we're talking about star ratings
- Quality performance measures
- Legal issues, strategic and operational considerations
- Questions and comments

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## Why We're Talking About Star Ratings

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## Medicare Advantage Payments Under the Affordable Care Act (ACA)

- CY 2012 begins the transition to FFS-linked benchmarks
  - Counties assigned to a quartile, based on FFS spending in the county
  - Each county's benchmark equals a percentage of FFS spending, determined according to the quartile assignment
    - Highest FFS-spending quartile – benchmark is 95% FFS costs
    - Second highest FFS-spending quartile – benchmark is 100% FFS costs
    - Third highest FFS-spending quartile – benchmark is 107.5% FFS costs
    - Lowest FFS-spending quartile – benchmark is 115% FFS costs
    - County assignments change with CMS rebasing
- Transition to new payment methodology is incremental between 2012 and 2017, depending on the amount of the PMPM reduction

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## Medicare Advantage Payments Under the ACA (cont.)

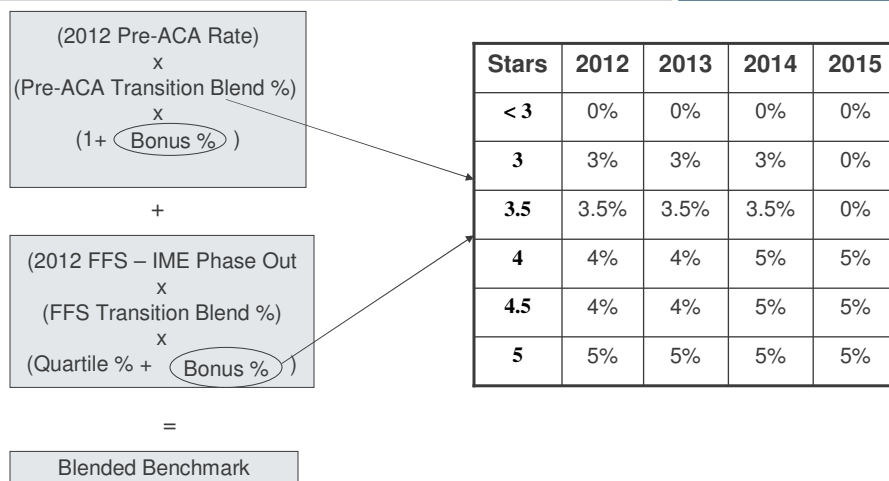
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- Quality bonuses for high-ranking MA Plans
  - Ranking based on CMS 5-star quality rating system
  - Phase-in 1.5 - 5% bonuses for 4- and 5-star Plans
  - Double bonuses (up to 10 %) for “qualifying plans in qualifying counties”
  - Bonuses available for new and low-enrollment MA Plans

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## Medicare Advantage Payments Under the ACA (cont.)

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Morgan Stanley Research, Managed Care: Expecting Improvement in Medicare Adv. Star Ratings – October 5, 2011 (slightly modified)

## Medicare Advantage Payments Under the ACA (cont.)

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- Reduction in MA “rebates”
  - CY 2012-2014 phase-down of MA rebates to 50%
  - High ranking quality MA Plans eligible for 65 - 70% rebate retention
  - Certain new and low-enrollment MA Plans may be eligible for 65 – 70% rebate retention

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## Medicare Advantage Payments Under the ACA (cont.)

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Stars	Pre-ACA Rebate %	ACA-Rebate %	CY 2012 Phase-in	CY 2013 Phase-in	CY 2014
<3	75%	50%	66.7%	58.3%	50%
3	75%	50%	66.7%	58.3%	50%
3.5	75%	65%	71.7%	68.3%	65%
4	75%	65%	71.7%	68.3%	65%
4.5	75%	70%	73.3%	71.7%	70%
5	75%	70%	73.3%	71.7%	70%

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Morgan Stanley Research, Managed Care: Expecting Improvement in Medicare Adv. Star Ratings – October 5, 2011

## Medicare Advantage Payments Under the ACA (cont.)

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Plan #1: 2 stars	Plan #2: 4 stars	Plan #3: 5 stars
Benchmark = \$800	Benchmark = \$832	Benchmark = \$840
-	-	-
Bid = \$750	Bid = \$750	Bid = \$750
=	=	=
\$50	\$82	\$90
x	X	x
50%	65%	70%
=	=	=
Rebate = \$25	Rebate = \$53	Rebate = \$63
Total Payment = \$775	Total Payment = \$803	Total Payment = \$813

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Morgan Stanley Research, Managed Care: Expecting Improvement in Medicare Adv. Star Ratings – October 5, 2011

## CMS Quality Bonus Payment Demonstration Project

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- Introduced in November 2010 for CY 2012-2014
  - Enhanced quality bonuses
    - 5-star MA Plans eligible for 5% bonus for CY 2012-2014
    - 4-star and 4.5-star MA Plans eligible for 4% bonus for CY 2012-2013 and 5% bonus in CY 2014
    - 3.5-star MA Plans eligible for 3.5% bonus in CY 2012-2014
    - 3-star MA Plans eligible for 3% bonus in CY 2012-2014
  - Bonuses applied to both parts of the blended benchmark
  - CMS will not apply the cap on the blended benchmark for 3- to 5-star MA Plans

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- Special election period for 5-star Plans
  - Initially established for MA Plans, extended to Part D Plans as well
  - Does not affect enrollment periods for other coverage
- Medicare.Gov displays symbols of high- and low-performing Plans
  - “Caution” rating for Plans with overall rating below 3-stars for 3 consecutive years
  - 5-star Plans receive high-quality designation

- Poor performers already subject to Corrective Action Plan letters
- CMS proposes to require maintenance of minimum 3-star rating for the MA and/or Part D Program(s) as a Program participation requirement
- CMS also proposes to permit CMS to terminate an MA Organization’s or Part D Plan Sponsor’s contract for failure to maintain a minimum 3-star rating for 3 consecutive years

## Quality Measures

## Star Quality Rating System

- Quality measures
  - 36 measures for MA Plans
  - 17 measures for Part D Plans
- Grouped into
  - 5 categories or “domains” for MA Plans
  - 4 categories or “domains” for Part D Plans
- All Plans under a contract get the same score
  - Part C score
  - Part D score
  - Beginning with the 2011 ratings (announced in Fall 2010), MA-PD Plans get “overall score” as well

## Data Sources

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- CMS administrative data
  - Various measures collected throughout the benefit year
  - *E.g.*, IRE appeals, call center performance
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Survey of beneficiaries regarding their health care
    - *E.g.*, flu and pneumonia vaccines, ease of getting to physicians
  - Survey conducted in spring of each year

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## Data Sources (cont.)

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- Healthcare Effectiveness Data and Information Set (HEDIS)
  - Data collection in June for prior benefit years
  - *E.g.*, screenings for breast, colorectal cancers and metrics for diabetic members
- Health Outcomes Survey (HOS)
  - Survey of beneficiaries as to their longitudinal health/health care under the Plan and changes in past two years
  - *E.g.*, status of physical, mental health, monitoring of physical activity
  - Members surveyed twice, two years apart

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### ▪ Individual measures

- Each contract receives a number of stars for each individual quality measure
- CMS designates performance standards for certain metrics
  - Meeting/exceeding a specific performance threshold automatically results in a pre-determined number of stars (e.g., 4 stars)
  - Compliance with an absolute regulatory standard typically results in automatic 3 stars
- Other metrics may be evaluated on a relative scale and may be adjusted for certain patient characteristics, such as age, physical/mental health status, Medicaid eligibility

### ▪ Domain measures

- Individual measure scores are grouped with similar measures
- A domain score is assigned a star rating, based on the weighted average of the measures

### ▪ Program and Overall Scores

- All of a Program's domains are combined to determine the Program score
- MA-PD Plans receive an overall score summarizing Part C and D Program scores

- CY 2012 Performance Ratings
  - Five new measures, four retired, and a few adjusted
  - Introduction of weighted scores
    - Patient outcome measures receive greatest weight
    - Then patient experience/complaints and access measures
    - “Process” measures weighted the least
  - Increased emphasis on measures for higher-risk beneficiaries
- Retired measures
  - Still displayed publicly on CMS website and CMS still monitors
  - Poor scores are subject to CMS compliance action

**Domain: 1 - Staying Healthy:  
Screenings, Tests and Vaccines**

- Measure: C01 - Breast Cancer Screening
- Measure: C02 - Colorectal Cancer Screening
- Measure: C03 - Cardiovascular Care – Cholesterol Screening
- Measure: C04 - Diabetes Care – Cholesterol Screening
- Measure: C05 - Glaucoma Testing
- Measure: C06 - Annual Flu Vaccine
- Measure: C07 - Pneumonia Vaccine
- Measure: C08 - Improving or Maintaining Physical Health
- Measure: C09 - Improving or Maintaining Mental Health
- Measure: C10 - Monitoring Physical Activity
- Measure: C11 - Access to Primary Care Doctor Visits
- Measure: C12 - Adult BMI Assessment

**Domain: 2 - Managing Chronic  
(Long Term) Conditions**

- Measure: C13 - Care for Older Adults – Medication Review
- Measure: C14 - Care for Older Adults – Functional Status Assessment
- Measure: C15 - Care for Older Adults – Pain Screening
- Measure: C16 - Osteoporosis Management in Women who had a Fracture
- Measure: C17 - Diabetes Care – Eye Exam
- Measure: C18 - Diabetes Care – Kidney Disease Monitoring
- Measure: C19 - Diabetes Care – Blood Sugar Controlled
- Measure: C20 - Diabetes Care – Cholesterol Controlled
- Measure: C21 - Controlling Blood Pressure
- Measure: C22 - Rheumatoid Arthritis Management
- Measure: C23 - Improving Bladder Control
- Measure: C24 - Reducing the Risk of Falling
- Measure: C25 - Plan All-Cause Readmissions

## Quality Metrics (cont.)

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### Domain 3 - Ratings of Plan Responsiveness and Care

Measure: C26 - Getting Needed Care  
Measure: C27 - Getting Appointments and  
Care Quickly  
Measure: C28 - Customer Service  
Measure: C29 - Overall Rating of Health  
Care Quality  
Measure: C30 - Overall Rating of Plan

### Domain 4 - Member Complaints, Problems Getting Services, and Choosing to Leave the Plan

Measure: C31 - Complaints about the  
Health Plan  
Measure: C32 - Beneficiary Access and  
Performance Problems  
Measure: C33 - Members Choosing to Leave the  
Plan

### Domain 5 - Health Plan Customer Service

Measure: C34 - Plan Makes Timely Decisions about  
Appeals  
Measure: C35 - Reviewing Appeals Decisions  
Measure: C36 - Call Center – Foreign Language  
Interpreter and TTY/TDD Availability

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## Quality Metrics (cont.)

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### Domain 1 - Drug Plan Customer Service

Measure: D01 - Call Center – Pharmacy Hold Time  
Measure: D02 - Call Center – Foreign Language  
Interpreter and TTY/TDD Availability  
Measure: D03 - Appeals Auto-Forward  
Measure: D04 - Appeals Upheld  
Measure: D05 - Enrollment Timeliness

### Domain 2 - Member Complaints, Problems Getting Services, and Choosing to Leave the Plan

Measure: D06 - Complaints about the Drug Plan  
Measure: D07 - Beneficiary Access and  
Performance Problems  
Measure: D08 - Members Choosing to  
Leave the Plan

### Domain 3 - Member Experience with Drug Plan

Measure: D09 - Getting Information From Drug Plan  
Measure: D10 - Rating of Drug Plan  
Measure: D11 - Getting Needed Prescription Drugs

### Domain 4 - Drug Pricing and Patient Safety

Measure: D12 - MPF Composite  
Measure: D13 - High Risk Medication  
Measure: D14 - Diabetes Treatment  
Measure: D15 - Part D Medication Adherence for  
Oral Diabetes Medications  
Measure: D16 - Part D Medication Adherence for  
Hypertension (ACEI or ARB)  
Measure: D17 - Part D Medication Adherence for  
Cholesterol (Statins)

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## Challenges With the Current System

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- Quality rating system as a payment mechanism?
- Payments based on quality data from 1-3 years earlier
- Potential appeal opportunity at beginning of calendar year, prior to rate announcement (and benchmark determinations and bid submissions)
  - *E.g.*, Quality scores for CY 2013 payment subject to appeal in early 2012, prior to April 2012 announcement of CY 2013 rates

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## Timing of Data Collection and Ratings

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Payment Year	Data Year	Post-Performance Ratings for Open Enrollment	Post Performance Ratings for Payment Purposes	Timeframe for Appealing Quality Scores	Rate Notice Publication
2012	2009	October 2010	January 2011	Oct. 2010- Feb. 2011	Feb/April 2011
2013	2010	October 2011	January 2012	Oct. 2011- Feb. 2012	Feb/April 2012
2014	2011	October 2012	January 2013	Oct. 2012- Feb. 2013	Feb/April 2013
2015	2012	October 2013	January 2014	Oct. 2013- Feb. 2014	Feb/April 2014

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- Reliability of metrics
- Evolving metrics
  - In support of CMS’s “triple aim,” patient experience has and will continue to be emphasized
  - Will the Medicare Shared Savings Program quality metrics influence MA Plan quality measures?

## Legal, Strategic and Operational Considerations

## Select Legal Considerations

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- Beneficiary inducement prohibition
  - What is the inducement?
  - Is there a “particular provider” involved?
  - Is there an established exception?
- Anti-kickback statute
  - What is the referral?
  - What is the remuneration?
  - Is there a safe harbor available?
- False Claims Act
  - What are the payment implications?
  - What about certifications of data accuracy?

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## Select Legal Considerations (cont.)

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- Mid-year benefit enhancement
- Value-added items and services
- Uniform benefit and uniform premium requirements
- Physician incentive payment requirements
- PCP panel requirements

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## Some Strategic and Operational Considerations

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- Short-term initiatives to improve quality scores
  - Internal changes
  - Affecting change at the member and provider levels
    - Incentives vs. rewards
    - Creating “buy in”
    - Do you have the appropriate tools in place?

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## Some Strategic and Operational Considerations (cont.)

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- Long-term strategic initiatives
  - How do you engage the member in the long-term?
  - What initiatives can influence provider behavior?
  - Can you capitalize on other health care reform developments?

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Anne W. Hance  
202.756.8270  
ahance@mwe.com