Summary of Comments to the Request for Comments on 2016 Star Ratings and Beyond

February 24, 2015

On November 21, 2014, CMS released a memo, *Request for Comments: Enhancements to the Star Ratings for 2016 and Beyond,* to Part C and D sponsors, stakeholders and advocates. The memo described CMS' proposed methodology for the 2016 Star Ratings for Medicare Advantage (MA) and Prescription Drug Plans (PDP). We received approximately 103 comments representing plan sponsors, associations, consumer groups and measurement development organizations. This document provides a summary of the comments received and how we addressed these comments in the draft 2016 Call Letter.

A. Changes to the Calculation of the Overall Rating and the Part C and D Summary Ratings

Summary of Comments:

Almost half of the commenters supported eliminating pre-determined 4-star thresholds, while the remaining commenters were concerned about the change. More commenters were in support of eliminating the pre-determined thresholds all at once versus gradually phasing them out over time. Although there was some support for adding the annual improvement percentage increase (IPI) to the thresholds, the majority of commenters were not in favor of implementing the IPI.

- Commenters that agreed with eliminating the pre-determined thresholds expressed strong support in ensuring that there is an accurate view of plan performance.
- Commenters opposing elimination of the pre-determined thresholds said the predetermined thresholds help plans set goals internally and develop value-based purchasing contracts with providers. They compare them to knowing the passing grade in advance of a test. Additionally, some commenters stated that these thresholds provide transparency and stability to the program. Some commenters claimed that moving targets are not conducive to strategy development, while having no targets at all would make it more difficult. Some commenters who disagreed or were neutral about this change were of the opinion that the 4-star predetermined thresholds should be retained or alternatively updated based on earlier year's data so that they would be available to plans prior to the measurement period. A couple of commenters noted that CMS could set maximum thresholds that could be lowered or adjusted as needed. A few commenters were concerned that Dual SNPs are impacted more by the elimination of 4-star thresholds. A small number of commenters suggested that like plans should be compared (e.g., Dual SNPs with other Dual SNPs or non-LIS areas with plans within those non-LIS areas).

- Some commenters assumed that all thresholds would go up with the elimination of pre-determined 4-star thresholds.
- Although some supported the annual IPI saying that it would help set expectations and create stability for plans, others noted that improvement from year to year is not linear and there is some variability in scores from year to year. Some commenters noted that this change would set unrealistic expectations for improvement for some measures and would not decrease misclassification.

Response:

We will proceed as planned and announced in prior Call Letters with eliminating all pre-determined 4-star thresholds for the 2016 Star Ratings. We will not implement the annual IPI. Our primary goal in eliminating pre-determined thresholds is to improve the accuracy of the assignment of the overall and Part C and D summary Star Ratings and to make sure the system creates incentives for quality improvement.

Some commenters expressed concern that all thresholds would go up with this change, and we ran a simulation to examine these concerns. For the Part C measures with pre-determined 4-star thresholds in 2015, close to half of the 4-star cut points would remain the same or go down, while the remaining would go up. For MA-PDs in the Part D measures with pre-determined 4-star thresholds, 60% (3 measures) would remain the same or go down, and 40% (2 measures) would go up. For PDPs, 20% (1 measure) would have a lower 4-star cut point and 80% (4 measures) would go up. This simulation does not show significant increases in thresholds across all measures.

B. New 2016 Measure:

CMS intends to add the following measure to the 2016 Star Ratings.

Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (Part D).

Summary of Comments:

- Approximately half of commenters supported the inclusion of the MTM CMR Completion rate measure into the 2016 Part D Plan Ratings, while other commenters opposed adding the measure to the Star Ratings or provided additional recommendations regarding the measure specifications.

- Some organizations that opposed adding the measure to the Star Ratings noted that if the measure was added, that a weight of "1" would be appropriate. A few commenters that opposed adding the measure recommended that the measure remain a display measure, citing that this was not an appropriate performance metric for the Star Ratings or that outcomes-based MTM measures may be more appropriate for inclusion in the Star Ratings.
- Some commenters provided recommendations for CMS to consider before adding the measure including:
    - Additional exclusion factors (such as LTC beneficiaries, beneficiaries who opt-out of the MTM program, or beneficiaries who decline the CMR or do not respond to outreach attempts);
    - Adjustments to account for variation in eligibility criteria;
    - Factors to account for and incentivize more generous eligibility criteria.
- Other comments were out of scope and provided comments regarding changes to MTM eligibility requirements which would require rulemaking.

Response:

We will proceed as proposed and announced in prior Call Letters to add the MTM CMR completion rate measure to the 2016 Star Ratings (based on 2014 plan-reported and validated data) using the specifications from the 2015 Display Measure. We continue to believe that this measure is an appropriate addition to the Star Ratings to increase the uptake of this valuable service. We currently include other process measures in the Star Ratings. We will also consider the addition of outcomes-based MTM measures when developed and endorsed through public consensus by measure development organizations.

CMS will share comments regarding specification change recommendations with the Pharmacy Quality Alliance (PQA). We do not propose to implement additional specification changes. Sponsors are reminded that LTC beneficiaries will not be excluded from this measure calculation; sponsors are statutorily required to offer a CMR to all beneficiaries enrolled in their MTM program at least annually, including beneficiaries in LTC settings. Also, while this is a voluntary service, sponsors may increase beneficiary engagement through more effective outreach strategies which increase MTM program and CMR participation.

C. Additional 2016 Star Ratings Measures:

CMS intends to return these measures to the 2016 Star Ratings.

Breast Cancer Screening (Part C).

Summary of Comments:

Two-thirds of commenters supported returning the Breast Cancer Screening measure to the Star Ratings. A few commenters recommended keeping the measure on the Display Page for an additional year, due to changes in methodology. A few commenters gave suggestions for changes to the specifications, such as excluding certain populations. Examples of suggested exclusions were beneficiaries older than 65 who are long-term residents of nursing homes, those with advanced dementia, in hospice care and with severe and persistent mental illness.

Response:

We will proceed as planned and include this measure in the 2016 Star Ratings.

Call Center – Foreign Language Interpreter and TTY Availability measures (Part C & D).

Summary of Comments:

Many commenters misinterpreted the Request for Comments proposal of a November to June timeframe to mean that CMS would monitor some sponsors during the annual enrollment period (AEP), while other sponsors would be monitored outside of AEP. There were also a significant number of commenters requesting information about the data issues found for 2015 Star Ratings, and how they would be resolved for the 2016 Ratings. A minority of commenters recommended the measure be moved to the Display page before returning to Star Ratings. Some commenters submitted technical questions about the Call Center monitoring project.

Response:

We have clarified in the draft 2016 Call Letter that all sponsors would be monitored during the same time period within the timeframe, and that the monitoring period would be similar to previous years. Additional information will be forthcoming about CMS' call center monitoring. The technical questions about the Call Center monitoring project are being reviewed by the appropriate CMS team.

Beneficiary Access and Performance Problems (Part C & D).

Summary of Comments:

Most comments submitted agreed with the return of the Beneficiary Access and Performance Problems measure as specified. Only a few disagreed with the change in the measure, citing either the measure was duplicative to the evaluation of Past Performance, or requesting that audit results continue to be included. A few commenters submitted technical suggestions for the HPMS Compliance Activity Monitoring module which are being reviewed by CMS.

Response:

We will proceed as planned and include this measure in the 2016 Star Ratings.

D. Changes to Measures for 2016

Controlling Blood Pressure (Part C).

Summary of Comments:

The majority of commenters supported the proposed change to the Controlling Blood Pressure measure. Slightly more than one-quarter of commenters gave suggestions for changes to the specifications, such as excluding "white coat hypertension" and utilization of a Holter Monitor at home. A few commenters asked if the proposed change will impact the numerator and denominator. The suggestions have been shared with the National Committee for Quality Assurance (NCQA) for their consideration.

Response:

We will proceed as planned and include this measure in the 2016 Star Ratings since enrollees that meet the old guidelines will automatically meet the new guidelines. This change only impacts the numerator of the measure, not the population included.

Plan Makes Timely Decisions about Appeals (Part C).

Summary of Comments:

Nearly two-thirds of commenters supported the proposed change to exclude dismissals. One-third of commenters stated that they recognized the reason for the change and are hopeful the change will strengthen the measure's accuracy.

Response:

We will proceed as planned and include this measure in the 2016 Star Ratings.

Plan All-Cause Readmissions (Part C).

Summary of Comments:

The majority of commenters supported the proposed change. The minority of commenters voiced concerns that the thresholds were not realistic or suggested transitioning this measure to the Display Page for one year due to the methodological changes. For the 2015 Star Ratings there were more significant changes to the cut points reflecting changes in the distribution of scores across plans.

Response:

We will proceed as planned and include this measure in the 2016 Star Ratings.

Osteoporosis Management in Women who had a Fracture (Part C).

Summary of Comments:

Nearly one-half of commenters gave suggestions for additional changes to the specifications, such as excluding dementia patients, long-term nursing home residents and hospice patients. The remainder of comments was divided as either supporting the proposed change, or disagreeing and advocating the measure is removed from the Star Ratings altogether. A few commenters suggested transition to the Display Page due to measure methodological change. Suggestions for changes to this measure have been shared with NCQA.

Response:

We will proceed as planned and include this measure in the 2016 Star Ratings.

Complaints about the Health/Drug Plan (CTM) (Part C & D).

Summary of Comments:

A majority of commenters supported expanding the measurement timeframe. The remaining comments were neutral and only a few disagreed with the proposal. Some were concerned that the proposal will result in double counting the first 6 months of CTM data for 2016 Star Ratings, and recommended CMS move the measure to the display page for one year. Others requested CMS distinguish Part C and Part D complaints in MA-PD plans to allow for more accurate comparisons between MA-PDs, MA-only plans, and PDPs, or additional CTM exclusions.

Response:

We will proceed as planned and include this measure in the 2016 Star Ratings. CMS' analyses to compare 6 month and 12 month CTM rates found that the majority of contracts' complaint rates were either similar or decreased when using the full year of data.

Improvement measures (Part C & D).

Summary of Comments:

Only a few comments were submitted to this area, and most requested clarification about the inclusion/exclusion of measures for the improvement measures. For example, it was noted that the CTM measure was included for the Part C improvement measure, but excluded for the Part D. Some questioned the exclusion of the Medication Adherence for Diabetes Medications measure from the Part D improvement measure. Some commenters proposed methodology changes for CMS' calculation of quality improvement.

Response:

For the draft 2016 Call Letter, we have clarified that the CTM measures will be excluded from both Part C and D improvement measures and the Diabetes Adherence measure will be included in the Part D improvement measure. We will review the suggested methodology changes for consideration for future Star Ratings. Any proposals for future changes will be included in CMS' Fall 2015 Request for Comments in order to solicit feedback from all stakeholders.

Appeals Measures (Part D).

Summary of Comments:

The majority of commenters supported CMS' proposals to extend the Auto-forward measure measurement period to a 12 month period, to modify the Upheld measure to include re-opened cases and re-evaluate the minimum threshold of 5 cases. Less than one-third of commenters disagreed with these proposals, while submitting additional methodology suggestions:

Auto-forward measure:

- Change the measurement period to July 1 – June 30 or to an 18-month period which would include the previous 12 months plus the first six months of the current year.

Upheld measure:

- Account for the volume of cases appealed to the Independent Review Entity (IRE) as well as the occurrence of members or physicians submitting different or additional information to the IRE that was not submitted to the plan.
- Extend the timeframe for re-openings from the first three months to the first six to eight months of the year.
- Move to the display page for 2016 and then return it to Star Ratings for 2017.

Response:

We will proceed with the proposed changes for the 2016 Star Ratings. Additionally, in the draft Call Letter we propose that cases remanded by the IRE are also excluded from the Auto-forward measure. Several suggestions submitted to CMS cannot be operationalized for the Star Ratings, for example use of an 18 month measurement period, or extending the timeframe for applicable re-openings. The changes proposed to the Upheld measure should only improve some sponsors' rates; therefore we believe it is unnecessary to move the measure out of the Star Ratings for one year.

Medication Adherence (for Diabetes Medications and Hypertension (RAS antagonists) and Diabetes Treatment) (Part D).

Summary of Comments:

Most commenters supported the proposal to use the beneficiary ESRD coverage start and termination dates reported in the Medicare Enrollment Database (EDB) rather than ICD-9

codes or RxHCCs to identify beneficiaries for exclusion for the 2016 Star Ratings. The most common suggestion was to exclude the ESRD beneficiaries for the entire year, not the period between the ESRD coverage start and termination dates. Other comments concerned potential data lag and underreporting of ESRD in the EDB, and that CMS should retire the Diabetes Treatment measure due to the Eighth Joint National Committee high blood pressure guidelines.

Response:

We will proceed as planned to use ESRD data in the EDB to identify beneficiaries for exclusion for the 2016 Star Ratings. In the draft Call Letter, we clarify that beneficiaries identified with ESRD will be excluded from the measure for the entire year, and that EDB ESRD data issues should be adequately resolved by the time the final measure rates are calculated in July of the year following the measurement year. We also state in the draft Call Letter the recent decision by the PQA to retire the Diabetes Treatment measure, and CMS' subsequent steps for this measure for the 2017 Star Ratings.

Medication Adherence (Diabetes Medications, Hypertension (RAS antagonists), and for Cholesterol (Statins)) (Part D).

Summary of Comments:

The vast majority of commenters supported the proposal to use the exact death date when available in the Common Medicare Environment (CME) instead of the CME disenrollment date as the end of the beneficiary's measurement period when calculating the diabetes, hypertension and cholesterol adherence rates. Additional comments were about the potential inconsistency of death dates reported in the CME and a few other miscellaneous suggestions.

Response:

We will proceed as planned to use the actual death date as reported in the CME to identify the end of the beneficiary's enrollment period, and clarify that any death date data issues should be adequately resolved by the time the final measure rates are calculated in July of the year following the measurement year.

Obsolete NDCs (Part D).

Summary of Comments:

The majority of comments supported using the updated 2014 methodology for the 2016 Star Ratings, however, several suggested that the NDC lists be updated more frequently (i.e., monthly). Those who disagreed suggested using a longer period of 12 or 24 months for the obsolete NDCs inclusion period prior to the beginning of the measurement period.

Response:

We will proceed as planned. We will share technical comments with the PQA for their consideration for their processes to maintain the NDC lists.

CAHPS (Part C & D).

Summary of Comments:

Half of the comments on this section were neutral on the proposed modification to allow low reliability contracts to receive 1 or 5 stars, or requested clarification (e.g., whether scores will be used in calculation of thresholds). A few commenters expressed support for the proposed modification.

Response:

We will proceed as planned.

E. Retirement of Measures

Summary of Comments:

By a large majority, the commenters supported the retirement of the cholesterol measures. The primary concern was that the modifications to standards/guidelines for treatment will take time to implement, so retirement from Star Ratings is premature.

Response:

We will proceed as announced. NCQA has retired the measures of cholesterol screening for diabetes and cardiovascular care, and a measure of cholesterol control for diabetes care, so CMS will no longer included them in the Star Ratings. At the end of 2014, the PQA elected to retire the measure Appropriate Treatment of Hypertension in Diabetes. CMS

proposes to retain the Diabetes Treatment measure for the 2016 Star Ratings, which is based on 2014 data, and then remove it from the 2017 Star Ratings.

F. Temporary Removal of Measures from Star Ratings

Improving Bladder Control (Part C).

Summary of Comments:

Most commenters agreed with removing the Improved Bladder Control measure out of the Star Ratings temporarily, but many suggested this change should be permanent or that all Health Outcomes Survey (HOS) derived measures be removed permanently. A few commenters acknowledged that there were changes to specifications, but recommended not dropping the measure from the Star Ratings, even temporarily. A few comments requested more national benchmarking information to help plans trying to improve on this measure.

Response:

No changes will be made to CMS' proposal. Changes to the measure required revising the underlying survey questions in HOS. The revised questions will be first collected in 2015. As a result of these changes, there will be no data for this measure for the 2016 and 2017 Star Ratings.

G. Contracts with Low Enrollment

Summary of Comments:

The majority of commenters were either supportive or neutral in terms of the proposal to include contracts with 500-999 enrollees in the 2016 Star Ratings. Some commenters thought low enrollment contracts should be excluded from all cut point calculations beyond HEDIS. A few raised concerns about low enrollment contracts meeting the denominator requirements for the Star Ratings measures.

Response:

CMS will proceed as planned and re-define the definition of low enrollment so contracts with enrollment between 500-999 enrollees are included in the 2016 Star Ratings as long as they meet the minimum number of measures required for an overall rating. Contracts

with 500-999 enrollees have always received a Star Rating for all non-HEDIS measures as long as they met the denominator requirements. The addition of contracts with 500-999 enrollees should have no impact on the cut point calculations of non-HEDIS measures since they have been included from the very beginning of the Star Ratings program. The only change introduced starting with the 2013 HEDIS was the collection of HEDIS data for contracts with less than 1,000 enrollees so, consequently, the calculation of Star Ratings for HEDIS measures is the only new addition. For HEDIS measures we are recommending to exclude contracts from the cut point calculations if the contract-level reliability is less than 0.7. As for all contracts, if the contract does not meet the measure-level denominator requirement, the particular measure will not be included in the calculation of the overall rating.

H. Data Integrity

Summary of Comments:

Many commenters requested clarification about use of Data Validation findings and cautioned CMS to ensure various technical concerns such as inter-rater reliability are resolved before implementation for star reductions. Others misunderstood the Request for Comments proposal to mean that this would replace other validation activities. Some commenters submitted technical questions about the Data Validation requirements. A few commenters advocated CMS should begin to apply incremental reductions (e.g., subtract 1 star from a contract, versus reduce its rating to 1 star) based on data issues found.

Response:

We clarified in the draft 2016 Call Letter that additional development will be necessary before incorporating these findings for the Star Ratings. CMS had previously solicited feedback for incremental reductions in the draft 2015 Call Letter, and stakeholders had strongly opposed such actions, citing that this could increase subjectivity.

I. Dual/LIS Status

Summary of Comments:

Several commenters expressed support and appreciation for CMS' thoughtful, cautious approach to examining and learning whether some plans are truly disadvantaged due to their disproportionate share of dual-eligible (Dual) or low income subsidy (LIS) beneficiaries. Commenters noted the focus of the examination of the LIS/Dual issue should

be on improving the quality and accuracy of the Stars Ratings for the benefit of the beneficiary selecting a plan. Two responders highlighted the need for the ratings to accurately reflect the consumer experience. Several commenters discussed CMS' goal to better understand if a causal relation exists between ratings and LIS/Dual status. A couple of responders disagreed with the current approach and contend that evidence of causality is not needed before implementing changes to the Star Ratings. Two of the responders encouraged additional research to identify the appropriate means for adjustment (if warranted).

Many of the respondents referenced their previous submission in the fall of 2014 related to the Request for Information (RFI) that demonstrated that dual status causes lower MA and Part D quality measure scores or research that demonstrated that high quality performance in MA or Part D plans can be achieved in plans serving dual-eligible beneficiaries.

The majority of the comments focused on risk adjustment and stratification. Many respondents favored risk adjustment to account for SES (socio-economic status) factors to level the playing field and allow for like comparisons (apple to apples). Several responses supported the National Quality Forum's (NQF) approach for adjusting measures for sociodemographic factors. There were some respondents that were opposed to risk adjustment and feared that it would mask disparities in care and disincentive plans to improve care. Several comments suggested a separate rating and/or stratification for LIS/Duals that may include different measures and/or cut points for plans that have a high proportion of LIS/Duals to make like (or fair) comparisons.

Several respondents discussed short and long-term responses to the LIS/Dual issue. Many of these respondents favored a transitional policy with a short term plan implemented in 2016 for plans that serve a high proportion of LIS/Dual enrollees. There were several comments that discussed working with measure developers. There was concern about the timeliness of a CMS response if the measure was to be reviewed by its measure developer. Other suggestions to account for a LIS/Dual impact included adjusting the star measures by 0.5 star; while another commenter suggested a 0.5 star adjustment for SNP plans only. Two respondents discussed the need for public comment, plan preview for any proposed changes, and/or transparency.

Response:

The research conducted by CMS and submitted in response to the RFI has revealed some differences in Star Ratings measure-level performance for LIS/Dual beneficiaries, although for the majority of measures the differences are small. Even for measures with larger observed differences, evidence of an association between higher Dual enrollment (and higher LIS beneficiary enrollment) and lower Star Ratings, however, does not prove causality. For some measures, scores were higher for plans with higher Dual enrollment. Additionally, in some cases, the association between LIS/Dual dissipated or reversed once the models included additional individual characteristics. For some Part D measures, the differential between LIS and non-LIS results was specific to whether the plan was an MA-PD or PDP. Further, findings suggest that certain beneficiary characteristics—namely, educational attainment, dual eligibility, self-rated general health status, and age—are strongly associated with better rates for several HEDIS measures within contracts. In addition, the preliminary analysis revealed that in general, contracts that have a high percentage of LIS enrollees have LIS group means on par with the non-LIS enrollees in the contract.

In the long-term, we believe that it may be appropriate to adjust the Star Ratings in cases where there is scientific evidence that performance on certain measures is impacted by patient factors such as comorbidities, disability, or LIS/Dual status. Additionally, we believe that such adjustments are warranted when these unadjusted patient factors may influence patient ability to meet recommended clinical guidelines. These factors could include, for example, health literacy issues, transportation issues, comorbidities, and disabilities.

We propose based on the comments received and the preliminary research conducted, to take the interim step of reducing the weights on this subset of Part C measures for MA and 1876 contracts and one Part D measure for PDP contracts for the 2016 Star Ratings. The subset of measures was selected on the basis of both statistical and practical significance and includes the following six Part C measures: Breast Cancer Screening, Colorectal Cancer Screening, Diabetes Care – Blood Sugar Controlled, Osteoporosis Management in Women who had a Fracture, Rheumatoid Arthritis Management, and Reducing the Risk of Falling. The weight of one measure for PDPs, Medication Adherence for Hypertension (RAS antagonists), would also be modified under this proposal for the 2016 Star Ratings Program. The weight of this measure would remain unchanged for MA-PDs. CMS would reduce the weights of the aforementioned subset of measures by half – thus, these Part C measures listed above except Diabetes Care – Blood Sugar Controlled, would have a modified weight of 0.5 for the Star Ratings for 2016 (instead of 1) for MA and 1876 contracts, and the Part C measure Diabetes Care – Blood Sugar Controlled for MA and 1876 contracts and the Part D measure listed for PDPs would have a modified weight of 1.5 (instead of 3) for PDPs. This adjustment is proposed regardless of a contract's percentage

of dual-eligible and/or LIS enrollees. The modified weights would just be applied to the individual measure stars for the subset of measures and would not be incorporated into the measure weights used for the improvement measures. CMS wants to continue to incentivize and reward improvements to these measures. Poor performing contracts overall can show significant improvement on individual measures.

The reduced weights will target immediate relief to plans with significant duals enrollment while maintaining incentives for all plans to improve on these important measures. Given the uncertainty about what is driving the association, we believe long-term adjustments must be based on further in-depth examination of the issue by CMS and its HHS partners in quality measurement, as well as external measure developers, to determine the driving factors for the difference that has been observed in the preliminary research and the RFI submissions. The research will extend beyond the subset of measures for which the weights would be modified in 2016. The additional research and examination of the issue will be used as the basis for any long term revisions to the methodology. CMS continues to encourage true quality improvement by all plans and cannot risk masking disparities in care or the integrity of the Star Ratings Program by implementing long term changes that are not grounded in scientific evidence.

J. Measures Posted on the CMS Display Page

Summary of Comments:

Of the few comments submitted, most were related about CMS' recent efforts to identify and notify contracts who are outliers in selected display measures. Some commenters opposed CMS' monitoring of these measures, or publicly posting of the measures.

Response:

Additional information is provided in the draft Call Letter about CMS' monitoring of various operational areas. We are not making other changes to the Display measures.

K. Forecasting to 2017 and Beyond

Potential changes to existing measures:

Medication Reconciliation Post Discharge:

Summary of Comments:

Most comments were supportive of this measure being developed, but many want more lead time with specifications; some are concerned the data will not be timely. Another comment was to divide the data into at least two age strata (over 65 and under). The negative comments were concerned that this measure is burdensome and not helpful to patients or providers. A few comments suggested that the measure depends on hospitals sharing data and there may be variations in how data are collected that should be standardized before the measure is implemented. Current HEDIS specifications refer to reconciliation being conducted by pharmacists, physicians, and nurses. There were comments praising the value of clinical pharmacists in this role, and others suggesting that additional provider types, such as discharge workers or social workers, be allowed to do the reconciliation.

Response:

Comments will be shared with NCQA.

CAHPS measures:

Summary of Comments:

Most commenters on this section were neutral on the proposed modification, or requested advance notice of any changes made due to the CAHPS 5.0 experiment. A few expressed concern about the CAHPS survey length in general. Several expressed support for the experiment.

Response:

We will proceed as planned with CAHPS 5.0 experiment and provide details on results as soon as they are available.

MPF Price Accuracy:

Summary of Comments:

About half of the commenters were either supportive or neutral to the proposed changes. One of the major proposed changes to the methodology is to take into account the PDEs that are priced accurately (e.g., within one half of one cent of the MPF posted price). Currently, contracts' scores are only based on their PDEs priced higher than MPF and the

magnitude of those differences. Some commenters felt one potential negative could be that a contract's magnitude of difference between PDE and MPF prices could be masked if it has a large volume of PDEs that match or less than PDEs. However, this methodology change would reward plans who have larger volumes of accurate PDEs. Commenters continue to cite as a general limitation that prices at the POS change very frequently, while there could be 4 weeks from the time a contract prepares MPF files for CMS to when the next dataset are reposted on the Plan Finder. Commenters allege that prices for more commonly used drugs (generics) update more frequently and thus that this proposal further penalizes plans.

The other significant proposed change to the measure relates to how CMS identifies pharmacy types, which affects which PDEs are included in the measure. For this step, we proposed to expand the data used to include PDE data in addition to MPF data. The main concern raised by the commenters was that the plans cannot control the data entered by pharmacists at the POS regarding the pharmacy type.

Response:

We will proceed with these changes as planned. CMS' analyses did not find inclusion of the number of accurate claims disproportionately affected certain contracts' scores. We also did not find contracts' scores were sensitive to high or low claim volume or the types of drugs such as generics or commonly used drugs. CMS' simulations found that the accuracy scores using the new methodology were generally similar to scores calculated using the current methodology.

CMS believes the PDE field "pharmacy type" is appropriate for use in this measure beginning with the 2015 PDE. As noted in the PDE requirements, CMS expected "sponsors and their network pharmacies to develop and implement controls to improve the accuracy of this information during 2013".

Potential new measures:

Care Coordination Measures:

Summary of Comments:

Commenters agreed about the importance of care coordination, and most were supportive of developing these measures further. However, some expressed caution about measurement. Many indicate support for moving beyond patient surveys to capture other

facets of the concept, but many are also worried that high levels of activity by non-physician healthcare workers will not be captured or credited. A number expressed concern that care coordination can mean many things (even brief phone calls that may not be documented or paid for) and that CMS has not indicated clearly which facets it is most concerned with measuring. Some also expressed concern that measuring one facet somehow may undermine other facets of care coordination. Some comments requested CMS consider who best to incentivize to achieve better coordination (plan, provider, ACO, medical group, etc.). Some suggested coordinating care for Duals may be intrinsically more difficult.

Response:

Comments and suggestions received to the Request for Comments have been shared with measure developers for their consideration.

Asthma Measure Suite:

Summary of Comments:

By a large margin, most commenters were not supportive of expanding these measures as planned. Supportive comments stressed that expanding the age range of these measures fills a measurement gap. Many comments were primarily concerned that the same medications can be used for asthma as for COPD, which is much more common in the older population. Some suggestions include insuring that asthma diagnoses be derived from the medical record and ICD codes rather than from prescription drug claims.

Response:

Comments and suggestions received to the Request for Comments have been shared with measure developers for their consideration. NCQA tested three asthma measures in the fall of 2014 to evaluate the effects of expanding the measure to include older adults. Testing results will be reviewed with NCQA's measurement advisory panels, including the Geriatric Measurement Advisory Panel. These panels will help NCQA determine whether expanding the age range of these measures to include the 65+ population is appropriate. The proposed changes, if approved, would be published in HEDIS 2016.

Depression:

Summary of Comments:

Most commenters were not supportive of the plan to develop measures related to the care of depression. A few supportive comments suggested younger Dual-SNP members need to be included and that CMS needs to be aware data collection will be challenging. For example, differentiating anxiety from depression when doing routine depression screening may be a challenge. Commenters that were not supportive of the development of these measures stated the measures will be impacted by SES, that they may not capture all treatments or that they may misdiagnose and mistreat patients with other co-morbid conditions, such as HIV. Commenters were concerned that state privacy laws may make data collection difficult and that the clinical goals, especially in the measured time frames, were unrealistic.

Neutral comments suggested allowing a broader range of screening instruments (such as is allowed in some MMP demonstration programs), paying more attention to how often at risk subgroups be screened for depression and how often those in treatment should be monitored. Some concern also was expressed that much treatment of depression does not involve medication or even providers paid through health insurance (e.g., pastoral counseling) and so will not be measured well.

Response:

NCQA is developing a new set of HEDIS measures that would assess depression care along the continuum of care. Comments and suggestions received to the Request for Comments have been shared with measure developers for their consideration.

Hospitalizations for Potentially Preventable Complications:

Summary of Comments:

Most commenters were not supportive of measuring hospitalizations for potentially preventable complications. Some commenters wanted more information about how the measure would be calculated and/or lead time to see how the specifications work before CMS moves to adding the measures to Star Ratings. Some comments suggested that plans with high numbers of dual-eligible members will be disadvantaged. Most commenters with this concern requested risk adjustment, but using a different benchmark for plans with high enrollment of duals was also suggested.

Response:

NCQA is finalizing testing of a risk-adjusted measure of hospitalization for ambulatory care sensitive conditions based on the NQF endorsed Prevention Quality Indicators (PQI), developed by AHRQ. The new measure, if approved, would be published in HEDIS 2016. Comments and suggestions received to the Request for Comments have been shared with measure developers for their consideration.

Statin Therapy:

Summary of Comments:

Commenters supported the development of such measures, and a few submitted technical questions or recommendations for the measure developers.

Response:

No change to the proposal at this time.

High Risk Medication (HRM):

Summary of Comments:

About half of the comments did not support the proposed change to align with AGS' updates, and/or the measure itself. Almost all commenters requested the opportunity to provide additional feedback prior to implementing these changes. Technical specification suggestions included delay implementation of the new list until 2019 Star Ratings (based on 2017 PDE); exclude hospice patients; allow formulary changes and/or utilization management tools for HRM drugs; identify and adjust for any beneficiary-specific factors associated with HRM use; and exclude specific drugs on AGS' drug list.

Response:

No change to the proposal at this time. Comments and suggestions received to the Request for Comments have been shared with measure developers for their consideration.

Opioid Overutilization:

Summary of Comments:

Most commenters did not support the proposal to use the PQA's three pending opioid measures as performance measures. The most common comments were concerns about lack of clinical guidelines, standard exceptions, and resulting impact on medically necessary access and D-SNPs; requests for lock-in authority; high morphine equivalent dose (MED) that may be clinically appropriate; false positives when counting prescribers/pharmacies; and the need for more time. Others suggested continuing to use these measures in the Overutilization Monitoring System (OMS) and offered miscellaneous suggestions.

Response:

If the PQA endorses the three opioid measures, CMS may report them as Display Measures or in the OMS. The PQA measures would not be included in Star Ratings measures until further development of consensus clinical guidelines for the appropriate use of opioids to treat chronic pain.

L. Measurement Concepts

Summary of Comments:

Numerous respondents commented on a variety of topics including: the unit of reporting for Star Ratings, cut points, changes (inclusions and exclusions) for measures for the Star Ratings program, recommendations for areas for new measure development, and general concerns or suggestions related to the Star Ratings.

There was a lack of consensus regarding the unit of reporting that should be employed for the Star Ratings program and the manner in which cut points are delineated. Some commenters agreed with contract level reporting while others were in favor of reporting at the plan benefit package (PBP). Several respondents agreed with the current approach of setting cut points separately for MA-PDs and PDPs. A larger number of commenters supported ratings (and cut points) for SNPs and non-SNPs or Duals and non-Duals.

Responses related to changes in the current star measure set included the exclusion of the two osteoporosis-related measures for ESRD patients and the substitution of HEDIS measures for eye and foot exams. Two commenters suggested the display measure Pharmacotherapy Management for COPD Exacerbation (PCE) move from the display page to a star measure for 2016. There were a number of commenters who recommended avoiding the use of self-reported measures in favor of claims-based measures or due to specific concerns related to the accuracy of the information.

Comments were received on topics/areas for additional measures such as expanding adherence measures to include non-warfarin oral anti-coagulants or anti-retroviral therapy, and development of new measures for assessing in-network physicians, chronic heart failure, Alzheimer's, in specialty areas such as oncology, medication therapy management (MTM), and quality measures for all Advisory Committee for Immunization Practice ACIP recommended adult immunizations. Two commenters encouraged the continued collaboration with NQF to develop and refine measures for Star Ratings.

Other topics received included concerns related to the lack of alignment for D-SNPs between Model of Care and QIPP requirements and the Star Ratings, and the lack of information on cost and quality metrics related to cancer care.

Response:

CMS appreciates the feedback provided to this section, and will consider the ideas shared for Star Ratings proposals for CY 2017 and beyond. At this time, there are no changes proposed in direct response to the comments received in Measurement Concepts.