MEDPAC Medicare Payment Advisory Commission

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February 29, 2012

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8016
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Re: Request for comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2013 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2013 Call Letter

The Medicare Payment Advisory Commission (MedPAC) is pleased to provide comments on the Centers for Medicare and Medicaid Services' (CMS) February 17, 2012, Advance Notice of Methodological Changes for Calendar Year (CY) 2013 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2013 Call Letter Advance Notice. We appreciate your staff's work on the notice, particularly given the competing demands on the agency.

Our comments pertain to the proposed changes to, and certain aspects of, the star system used to rate plan quality and to determine bonus payments. As a general comment on the memorandum and the changes you have already made in the Medicare Advantage (MA) and Part D plan rating system, we commend your work in improving the system by adding more outcome measures and by giving greater weight to outcome and patient experience measures rather than process and contract performance measures. We support your intention to maintain that emphasis as you continue to refine the rating system, and as you add new measures such as those that you propose to consider adding, if feasible, from the Hospital Inpatient Quality Reporting system.

Our specific comments deal with several issues: a concern over the reporting unit for quality reporting and for determining plan bonuses; the question of how improvement can be recognized and rewarded in the ratings; and comments regarding measures that are to be publicly displayed, but which will not be a factor in the star ratings that are the basis of bonus payments.

The reporting unit for Medicare Advantage plans

The Commission has previously expressed concern about the reporting unit for data on quality, in particular for plans that serve very large, geographically dispersed areas—typically private fee-for-service plans and regional preferred provider organizations (RPPOs). Because Medicare Advantage quality data are reported at the contract level (the "H number" or, for regional plans,

the "R number"), results for a given contract may not give beneficiaries an entirely accurate picture of the quality of care they can obtain through a plan in their geographic area or how the plan compares to fee-for-service Medicare in the area. As we noted in our March 2010 Report to the Congress, breaking up plans into smaller reporting units is sometimes not feasible because a plan may have too few enrollees in an area for valid quality data to be generated, but there may be ways to address the issue of small numbers.[a]

In examining the most recent plan reporting on quality measures, we found that the problem of the reporting unit is not limited to PFFS or RPPO plans. Many "local" HMOs also have contract configurations that combine heterogeneous health care markets. Two examples of this are Humana's Florida-based HMO plan, contract H1036, which operates in several non-contiguous states, and United's Nevada plan, H2931. The Humana plan has expanded, under the Florida-based contract number, to include HMOs in Portland, Oregon, and in Mississippi and North Carolina. The H2931 contract in Nevada is the surviving contract number after the consolidation, under one H number, of two contracts, Health Plan of Nevada of Las Vegas and of Reno—plans in two very distinct health care markets that previously reported results independently. In both of these cases, we believe that CMS should maintain separate reporting units for the different geographic areas for quality reporting and for determining eligibility for quality bonus payments. If contract H1036 has too few enrollees in the Portland area at this time to report data, that should be the information conveyed to beneficiaries, and that should be the basis of the star rating (under the policy used to assign star ratings to new plans). Given that the two Nevada areas were able to report independently in the past, and there was not an issue with small numbers, the two geographic areas should resume separate reporting of quality measures.

We would suggest that CMS examine the current geographic configuration of contracts to determine the optimal reporting units for quality data and for the awarding of bonuses so that, to the extent feasible, distinct health care markets constitute the reporting units for plans operating across different geographic areas.

Incorporating a measure of improvement

We support the concept of enhancing the star rating system to incorporate a means of rewarding improvement in quality measures. The Commission believes that pay-for-performance systems should both recognize high quality and reward improvement. CMS proposes adding one measure to the set of what are now a maximum of 50 measures in the star system. The specific methodology that is proposed consists of examining the change in individual measures to determine whether there was a statistically significant decline or improvement in the measure from one year to the next. The net difference between the number of measures that improved (if any) and those that declined (if any) would yield a result that would determine a star rating based on the relative performance of the plans. For example, one plan might have improved on three measures and declined on two measures, for a net improvement (+1 net change). Such a plan will receive a higher star rating than a plan that improved on three measures but also declined on three measures, or no net improvement (0 net change).

[a] Medicare Payment Advisory Commission. 2010. *Report the Congress: Medicare payment policy*.

We would suggest that in computing the measure of improvement CMS should use the weighting system the agency uses in assigning star ratings, whereby outcome measures are given greater weight than process measures. If, for example, there were only four measures used to judge improvement, one of which was an outcome or intermediate outcome measure with a weight of three, and there were three process measures each weighed at one, then a plan that improved on the outcome measure (+3) but declined on two of the process measures (-2) and was unchanged on the remaining process measure would have a net improvement.

As stated in the notice, plans that have attained high levels of quality may not benefit from the proposed improvement measure in that no further improvement may be possible among high-performing plans for certain measures. While it is important to add measures of improvement, we believe, as CMS states in the notice, that attainment should be the primary basis for rewarding good performance on quality measures. The proposed methodology continues to emphasize attainment because the improvement measure will be only one of a large number of measures. As CMS adds more measures of improvement, attainment should continue to be the primary basis for rewarding high quality.

Cut points and levels of improvement

One way to potentially recognize and reward improvement within the MA sector as a whole is to use a different approach to the setting of cut-off points for different star ratings from one year to the next. For the past two years, and for the coming year, the threshold performance level for achieving a 4-star rating has not changed for most measures. However, the minimum rating for achieving a 5-star rating has declined for some measures because of the distribution of results across plans during the rating year. For example, the 4-star threshold for breast cancer screening is at 74 percent, but the level of 5-star performance declined from 82 percent to 80 percent between 2010 and 2011. We would suggest that once it has been established that the best plans can perform at the 82 percent level in one year, for future years the expectation, for example, should be that the best plans should be able to perform at least at the 82 percent level, if not higher. From one year to the next, the 5-star threshold should either remain at the same level as the preceding year, or it should be raised because of the new distribution of results.

New measures for the display page

Display measures are measures with published results but which are not part of the star rating system (with current display measures published at http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp#TopOfPage). Display measures can include new measures as well as measures that had been elements of the plan rating system but are withdrawn from the star system. A measure withdrawn from the star rating system can be a measure that plans continue to report or which continues to be collected through beneficiary surveys. For example, for 2013, the pneumonia vaccine measure, a star rating measure in 2011 and 2012, will be moved to display status because of the long recall time involved in determining a plan's rate on this measure (in that the rate is the percent of beneficiaries surveyed

who reported ever having received a pneumonia vaccination). The measure of access to primary care (at least one primary care visit in the year) is moving to display status "since there is little variation in the scores across contracts with the scores being skewed very high," as stated in the proposal.

The proposal lists several new measures that CMS may include in the display measures on the 2013 display page. The Commission supports addition of these measures for display on CMS's website. In particular, two measures being considered, grievance rate per 1,000 enrollees and appropriate implementation of Part D transition processes, would provide meaningful information about the quality of services provided by Part D plan sponsors and would provide incentives to plan sponsors that are consistent with the goal of improving the quality of pharmacy services provided under Part D.

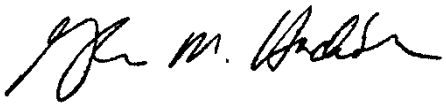
Regarding the general issue of maintaining display measures, we are aware that the National Committee for Quality Assurance withdraws measures from continued use once a certain level of performance has been achieved and no further improvement can be reasonably expected. Rather than simply move such measures from the star ratings to the display page, CMS should evaluate whether they have sufficient utility in assessing quality to justify the burden of continued reporting, and if not, discontinue such measures instead.

Conclusion

MedPAC appreciates the opportunity to comment on important policy proposals from CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/cz/wc