FUTURE OF QUALITY MEASUREMENT:

THE STAR RATINGS SYSTEM IN MEDICARE ADVANTAGE

JULY 22, 2019

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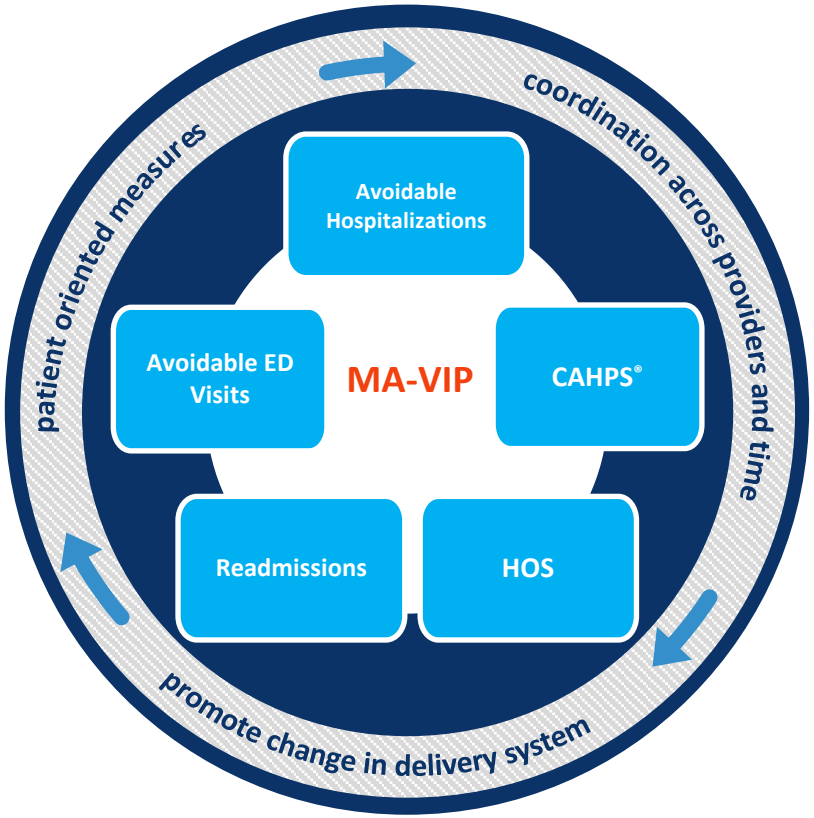
CURRENT MA QUALITY BONUS PROGRAM

- Instituted in 2012 by CMS in accordance with the Patient Protection and Affordable Care Act (PPACA).
- Uses a 5-star rating system to provide information to beneficiaries and determine eligibility for bonus payments.
- Leveraged pre-existing CMS 5-star rating system.
- Plans rated 4+ stars receive a 5% increase in their benchmarks (10% in some counties).
- Ratings of 1 to 5 stars are assigned based on a plan's relative performance on 46 measures which carry varying weights.
- Performance thresholds are determined using a "tournament model," with thresholds determined after the performance period.
- Current programs do not represent local performance and do not appear to effectively capture differences in social risk factors.
- Patient access and experience measures increasing in weight while HEDIS measures experience unprecedented change.

MEDPAC'S PROPOSED MA VALUE INCENTIVE PROGRAM

- Commission plans to design this program to replace the current QBP.
- Removes NCQA HEDIS® measures and PQA PDE measures.
- Administrative measures removed; plans to be held accountable for insurance functions through compliance standards rather than quality programs.
- Quality calculated for each Parent Organization within a local market.
- Scoring methodology uses prospective performance targets.
- Uses peer groups (i.e. fully dual-eligible beneficiaries versus non-fully dual-eligible beneficiaries) to convert quality measure performance to financial rewards and penalties.
- Applies budget neutrality to the MA quality payment program.
- Aligns a small group of measures with other programs to reduce burden on providers.
- Measurement should be largely calculated or administered by CMS, preferably with data already being reported, such as claims and encounter data.



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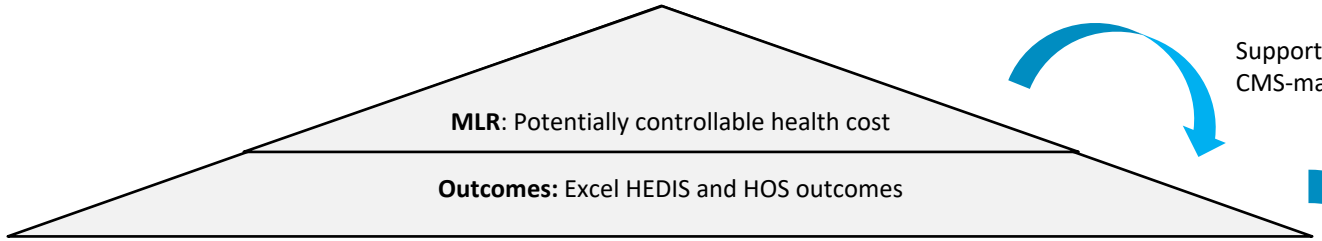
2020: A NEW ERA FOR STARS STRATEGY

Drive outcomes in areas of need

Data allows targeting specific members, measures and providers

Extreme focus on member experiences and access

Proactive adaptation to data interoperability, Part D rebate changes



Supports internal business strategy and CMS-mandated priorities

Focus on non-medical determinants of health issues and cost drivers

Identify and pursue high-priority issues and care gaps. Provide personalized support and care as needed to achieve outcome.

Supp. Benefits
- Compensates for or ameliorates impact of injuries/health conditions or reduces avoidable utilization
- Must produce non-zero direct medical cost
- OTC such as compression garments, cooking classes as part of nutrition/health education, fall prevention kits as part of home & bathroom safety devices, implantable hearing aids

SSBCI
- Allow tailored benefits, addresses gaps in care, improves health outcomes
- Member must have 1+ comorbid, complex condition
- Meals beyond limited basis, provision of food/produce, non-medical transportation, pest control, indoor air quality equipment/services, benefits to address social needs, structural improvements (ramps, widened hallways/ doorways)

Non-Uniform Benefits
- Vary, or target, SSBCI related to an enrollee's specific medical condition or needs
- HCBS partners can help determine whether individuals meet criteria for SSBCI
- HRA's (inc. via IHAs) with detailed documentation of decisions serve as eligibility documentation

Person-Centered Member Engagement:
The way members interact with the entire healthcare system defines their experience, drives positive outcomes and reduces costs.

Provider Partnerships:
Providers do what we incent them to do. The way we contract, incentivize, engage with and resource providers defines the scope of their interactions with our members.

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