PQS Summary of Quality-Related Updates:
CMS Advance Notice - CY2018 Draft Call Letter

PQS
PHARMACY QUALITY SOLUTIONS

PQS is providing the following summary of points of interest related to Quality measures. Information related specifically to pharmacy is presented first with Appendix A providing additional information related to medication use and management that is more plan-specific. The full Advance Notice of Methodological Changes for Calendar Year (CY) 2018 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter is Available **HERE**

General Highlights

2018 Call Letter focuses on improving MA, MAPD, and PDP programs through four key outcomes and is identical to the four key outcomes that were outlined in previous years.

1. Improve quality of care for individuals
2. Promotion of alternative payment models
3. Program integrity and beneficiary/tax-payer value
4. Improve beneficiary experience

CMS has structured the Call Letter in the same manner as they did for the 2016 calendar year and continues to articulate a focus on improving the bid review, decreasing costs, ***promoting creative designs***, and improving protections for beneficiaries in order to accomplish the outcomes listed above.

Key Next Date - Final Call Letter will be released on **April 3, 2017.**

Removal of Measures from the Star Ratings (p. 82)

- High Risk Medication Use (Part D)
  - The measure is transitioning to a display measure for 2018 – more details listed below in the Display Measures update.
  - Measure performance will still be tracked and made available through the Patient Safety Analysis website.
  - Decision is based upon statements from the American Geriatrics Society, which highlighted that the intent of the measure was not to be punitive as medications on the High Risk list are not contraindications and are only recommendations and considerations.

2018 CMS Display Measures

All previous 2017 Display Measures will continue as display measures for 2018. However, some of the measures contain specification changes.

- **High Risk Medication Use (Part D) – PQA**
  - HRM drug list was revised by PQA and the American Geriatrics Society. The new list removed 3 medications and added 14 additional medications. CMS re-calculated HRM rates using the new updated list and rates increased by 3.5% and 3.3% for MAPD and PDP respectively.
  - CMS stated that avoiding potentially inappropriate medications in the elderly remains important and the measure will be reconsidered for the Star Ratings again in the future once all analyses and specification changes are completed by PQA.

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PQS PHARMACY QUALITY SOLUTIONS

- **Statin Use in Persons with Diabetes (Part D) – PQA**
  - Measures the percentage of patients between 40 – 75 years old who received at least two diabetes medication fills and also received a statin medication during the measurement period.
  - Measure was updated to exclude members with ESRD – which will be implemented starting with the 2017 CY data.
  - Just as before, the measure also excludes members on Hospice according to CMS Enrollment Database information.
  - CMS stated that the measure is planned to become a Star Rating Measure for 2019.

- **Drug-Drug Interactions (Part D)**
  - PQA also updated the list of medication pairs associated with this measure.
  - CMS is planning to implement the revised measure drug list for the 2019 Display Measures using 2017 PDE data.

- **Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes (Part D)**
  - CMS is proposing to remove this measure from the 2018 Display Measures and is planning to replace this measure with the Antipsychotic Use in Persons with Dementia measure from PQA below.

- **Antipsychotic Use in Persons with Dementia (Part D)**
  - Measures the percentage of Medicare Part D beneficiaries 65 years or older with dementia who received prescription fills for antipsychotics without evidence of a psychotic disorder or related condition.
  - The PQA measure is reported overall and at three different levels associated with the care setting (community only, short-term nursing home, and long-term nursing home). CMS is proposing to only include the overall rate (i.e. across all care settings) for the 2018 Display Measure.
  - CMS will consider displaying the breakouts associated with different care settings possibly for the 2019 Display Measures and will then assess the potential to transition to a Star Rating for 2020.

- **Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D)**
  - PQA has made changes to the measure specifications which will impact the calculations associated with the 2017 Patient Safety reports.
  - CMS is planning to add these measures to the 2019 Display Measures but not to the Star Ratings at this time.
  - Changes the measure include:
    - The treatment period for Measures 1 and 3 (Opioids at High Doses (OHD) and Opioids at High Doses from Multiple Providers (OHDMP)) must be 90 days or more.
    - ICD-9 and ICD-10 codes will be changed to align with the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI) cancer value set.
    - All buprenorphine products indicated for medication-assisted treatment (MAT) will be excluded.

Changes to Existing Star Rating Measures (p. 80)

- **Special Needs Plan (SNP) Care Management (Part C) *and* Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D)**
  - Measure specifications will remain the same.
  - Only change is the performance scores associated with these two measures transitioning to a full rounded integer and not a rate reported to one decimal place.

Forecasting to 2019 and Beyond

New PQA Measures in Development

- Concurrent Use of Opioids and Benzodiazepines
  - The percentage of individuals 18 years and older with concurrent use of opioids and benzodiazepines.
- Adherence to Non-infused Disease Modifying Agents Used to Treat Multiple Sclerosis
  - The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement period for disease-modifying agents treating multiple sclerosis

Appendix A

Health Plan related information

General Highlights

Coverage Gap

- In a continued effort to reduce the coverage gap or "donut hole" associated with the Part D benefit, the co-insurance for 2018 is reduced. The cost sharing details for applicable and non-applicable medications is listed below:

Applicable Medications *(brand)*			
Year	**Beneficiary Coinsurance**	**Plan Liability**	**Manufacturer Discount**
2018	35%	15%	50%

Non-Applicable Medications *(generic)*		
Year	**Beneficiary Coinsurance**	**Plan Liability**
2018	44%	56%

Immunizations:

- Beneficiaries will be responsible for the costs associated with vaccinations at the co-insurance rate specified with Medicare Advantage. For 2018, the beneficiary will pay 35% and the plans will pay 65% of dispensing fees and administration fees while in the coverage gap.

2018 CY Proposed Out-of-pocket threshold: $8,417.60

Annual MTM Eligibility Cost Threshold

- CMS defines the general criteria for MTM eligibility where one of the criterion is the expected annual Part D drug costs for beneficiaries. For the 2017 MTM program, CMS has increased this threshold to $3,919 which is up $412 from the previous year. The threshold for the 2018 program will be adjusted and finalized in the 2018 Final Call Letter.

Access to Preferred Cost Sharing Pharmacies (PCSP) – Preferred Pharmacies

- CMS has continued to be pleased with the level of access plan sponsors have provided to beneficiaries. Plans must have the following minimum access standards. Plans that do not meet the access standards will be identified as outlies and will be required to disclose marketing materials indicating that the plan offers low access to preferred pharmacies.
    - Urban: pharmacy access within 2 miles of less than 40% of beneficiaries' residences
    - Suburban: pharmacy access within 5 miles of less than 87% of beneficiaries' residences

  - Rural: pharmacy access within 15 miles of less than 70% of beneficiaries' residences

2018 Star Rating Program and the Categorical Adjustment Index

- CMS will continue to use the Categorical Adjustment Index (CAI) as an interim analytical adjustment to account for disparities that exist in performance between contracts having beneficiaries with Low Income Subsidy and/or dual eligible (LIS/DE) and disability status.
- Results/understanding of the CAI on the 2017 Star Ratings
  - Overall
    - 19 contracts had an **increase** in their overall Star Rating by **½ Star**
      - 9 contracts went from 3.5 to 4 Stars
  - MA Only / MAPD
    - 7 contracts increased by ½ Star for Part C Summary Rating
    - 16 MAPD contracts had a Part D (PDP) Summary Star increase by **½ Star**
  - PDP
    - 9 decreased by ½ Star
    - 3 increased by ½ Star

CAI methodology will continue unchanged for 2018. More information can be found at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

New and Returning Measures for 2018

- **Medication Reconciliation Post Discharge (Part C) – 2018 Star Rating (New)**
  - Measures the percentage of discharges from acute or non-acute inpatient facilities who were 66 years of age and older who had their medications reconciled within 30 days of discharge (NCQA).
    - Typically this measure has been for Special Needs Plans, but is now expanding to include all Medicare Advantage plans and now includes members who are 18 and older.
    - ***Future Notes:***
      - *CMS is considering to add this measure to a broader set of future measures related to care transitions along with other measures or indicators (See Care Coordination and Transitions of Care Below).*
      - *Will start with 1x weighting*
      - *Shift to a 3x weighting for 2019*
- **Improving Bladder Control (Part C) – 2018 Star Rating (Returning)**
  - Measures the percentage of beneficiaries with urine leakage who discussed their problem with their provider and received treatment for the issue (NCQA).
    - Changes from NCQA include:

- Denominator now includes all adults with urinary incontinence, not just those who consider urinary incontinence to be a problem.
- Changed the treatment indicator to assess whether treatment was discussed, as opposed to it being received (focus on shared decision making).
- Added an outcome indicator to assess the degree to which urinary incontinence impacts beneficiaries' quality of life.

- ***Future Notes:***
  - Will return as a Star Measure for 2018 with a 1x weighting.

2018 Display Measures

All previous 2017 Display Measures will continue as display measures for 2018. However, some of the measures contain specification changes.

- **Pneumococcal Vaccination Status for Older Adults (Part C)**
  - Currently collected through CAHPS surveys – CMS has received feedback on finding better ways to assess immunization status other than survey data. CMS is exploring potential options and is open to hearing from plan sponsors. Much of the interest is stemming from the pneumococcal vaccination status needing to take into account both series of the vaccine per recommended guidelines.

- **Hospitalizations for Potentially Preventable Complications (Part C)**
  - Risk-adjusted measure that assesses the rate of hospitalization for complications of chronic and acute ambulatory care-sensitive conditions.
  - Measure was originally planned to be part of the 2018 Star Ratings as another measures associated with Care Coordination. However, NCQA has expressed some concerns with the measure and has asked for additional time to refine before moving the measure to a Star Rating.
  - Plan to move this measure to the 2019 Star Ratings

- **Statin Therapy for Patients with Cardiovascular Disease (Part C) - NCQA**
  - Measures the percentage of males 21 to 75 years of age and females 40 to 75 years of age who were identified as having clinical atherosclerotic cardiovascular disease and were dispensed at least one high or moderate-intensity statin medication during the measurement year.
  - CMS is proposing to keep this measure as a display for an additional year and move into a Star Rating for 2019.

Changes to Existing Star Rating Measures (p. 80)

- **Improvement measures (Part C & D)**
  - CMS will continue basing the Improvement Measure on metrics that have at least 2 years of data. If a contract has a score with very low reliability for enrollees with less than 6 months of enrollment, CMS can use the previous year's score.
  - As a reminder, all Part C and D measures are used to calculate the overall improvement measures except for those listed below:
    - Improving or Maintaining Physical Health (Part C)

        - Improving or Maintaining Mental Health (Part C)
        - Improving Bladder Control (Part C)
        - Medication Reconciliation Post-Discharge (Part C)
        - Beneficiary Access and Performance Problems (Part C)
        - Health Plan Quality Improvement (Part C)
        - Beneficiary Access and Performance Problems (Part D)
        - Drug Plan Quality Improvement (Part D)
        - MPF Price Accuracy (Part D)

- **MPF Price Accuracy (Part D)**
    - Will use 2016 Medicare Plan Finder pricing data and PDE claims
    - Calculation methodology has changed slightly and involves:
        - Modified list of PDEs that are used for the measure
        - Creating a new process to account for frequency and magnitude of differences between PDE and MPF price differences when a contract's PDE prices are higher than the MPF price changes.
        - CMS is aware of that point of sale pricing can change up to daily and MPF pricing is updated every two weeks. The new changes are designed to help account for the differences associated with the timing discrepancy.
    - CMS also informed plans that instances of PDE claims being less than the MPF prices do not negatively impact a plan's performance score for this measure.

Forecasting to 2019 and Beyond

Patient Safety Reports

- Historically, CMS has provided performance information for patient safety measures on a monthly basis. However, CMS has heard from plan sponsors who have concerns about the lag of time associated with the PDE data using NDC lists updated on a semi-annual basis. In order to minimize the monthly fluctuation in performance associated with time delay, CMS is proposing to release performance scores associated with the patient safety reports on a quarterly basis.

Care Coordination Measures (Part C)

- CMS believes one of the most important aspects for MA organizations is to help better manage care transitions and coordinate care. As a result, CMS is planning to categorize all care coordination measures as intermediate outcomes measures with a triple weighting starting with the 2019 Star Ratings. The triple weighting would be applied to the CAHPS Care Coordination measure and Medication Reconciliation measure and potentially others as additional care coordination measures are added in future years.
- CMS has recently partnered with two external contractors to help identify new care coordination measures.

Transitions of Care (Part C)

- CMS is currently collecting comments on the newly endorsed Transitions of Care measure that has 4 different indicators associated with it:
  - Notification of Inpatient Admission
    - Documentation of primary care practitioner notification of inpatient admission on the day of admission or the following day.
  - Receipt of Discharge Information
    - Documentation of primary care practitioner receipt of specific discharge information on the day of discharge or the following day.
  - Patient Engagement After Inpatient Discharge
    - Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided by primary care practitioner within 30 days after discharge.
  - Medication Reconciliation Post-Discharge (current HEDIS measure)
    - Documentation of medication reconciliation within 30 days of discharge.
- CMS is thinking of collecting the data in 2018 for an initial implementation for the 2020 Display Measures.

Opioid Overuse (Part C)

- NCQA also approved the three opioid measures developed and endorsed by PQA. However, NCQA and PQA are working on two additional measures which split out each component of the PQA Opioids from Multiple Providers measure. Instead of the PQA measure assessing the percentage of members receiving opioids from multiple providers including 4 or more prescribers and 4 or more pharmacies, the new measures would report a rate for the percentage of members receiving prescriptions for opioids from 4 or more prescribers and then a separate rate for the percentage of members receiving prescriptions for opioids from 4 or more pharmacies.
- Once testing is complete, CMS is looking to include for the 2020 Display Measures based upon 2018 data.

Comments and/or suggestions for future summaries are greatly appreciated.
Please let us know your thoughts.

PQS Staff
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