PHARMACY QUALITY SOLUTIONS

PQS Summary of Quality-Related Updates in the CY2018 Final Call Letter

Final Call Letter Available **HERE**

How to use this PQS Summary of the Final Call Letter

- **In February, PQS summarized the quality-related updates to the CY 2018 Draft Call Letter. To quickly understand how the proposed changes may have been finalized, confirmed, or changed, PQS has outlined in BLUE the confirmed details or comments as it related to the proposed update or change.**

2018 Call Letter had focused 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 had structured the Call Letter in the same manner as they did for the 2017 calendar year and continued 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 Dates

Deadline for submission of CY 2018 MTM Programs – May 1, 2017 (excludes those plans participating in the Enhanced MTM model test)

CY 2018 Bid submission deadline: June 5, 2017

Enhancements to the 2018 Star Ratings and Beyond (p. 79)

New and Returning Measures for 2018

- Medication Reconciliation Post Discharge (Part C) – 2018 Star Rating (New) ***[Confirmed]***
  - 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).* ***[Confirmed in Final Call Letter]***
      - *Will start with 1x weighting as a process measure* ***[Confirmed in Final Call Letter]***
      - *Shift to a 3x weighting for 2019* ***[This comment was left out of the Final Call Letter]***

- Improving Bladder Control (Part C) – 2018 Star Rating (Returning) ***[Confirmed]***
  - 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. ***[Confirmed in Final Call Letter]***
  - Changed the treatment indicator to assess whether treatment was discussed, as opposed to it being received (focus on shared decision making). ***[Confirmed in Final Call Letter]***
  - Added an outcome indicator to assess the degree to which urinary incontinence impacts beneficiaries' quality of life. ***[Confirmed in Final Call Letter]***
- ***Future Notes:***
  - Will return as a Star Measure for 2018 with a 1x weighting. ***[Confirmed in Final Call Letter]***

Changes to Existing Star Rating Measures (p. 82)

- Improvement measures (Part C & D) ***[Confirmed]***
  - 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)

- SNP Care Management (Part C) ***and*** Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D) ***[Confirmed]***
  - 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. ***[Confirmed in Final Call Letter]***
    - ***CMS testing of this update revealed that contracts' Star Ratings either remained the same or increased when the rates were changed from a percentage with one decimal point to an integer.***

- MPF Price Accuracy (Part D) ***[Confirmed]***
  - Will use 2016 Medicare Plan Finder pricing data and PDE claims
  - Calculation methodology has changed slightly and involves: ***[Confirmed in Final Call Letter]***
    - 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.

        - ***Sponsor Comments: CMS stated that they received many plan sponsor comments on this change where sponsors stated, "in order to perform well in this measure, they cannot offer lower prices at point of sale in real time than the prices that are displayed on MPF."***
            - *CMS responded with the bullet above that these instances will not negatively impact a plan's performance score for this measure.*

Removal of Measures from the Star Ratings (p. 84)

- High Risk Medication Use (Part D) ***[Confirmed]***
    - The measure is transitioning to a display measures 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. ***[Confirmed in Final Call Letter]***
    - 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 Star Rating Program and the Categorical Adjustment Index *[Confirmed]*

- 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. ***[Confirmed in Final Call Letter]***
- 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. ***[Confirmed in Final Call Letter]***
    - ***Final tables and categorizations for LIS/DE and disability groups are displayed starting on page 90.***
    - ***Puerto Rico will continue to have an additional adjustment for contracts that serve Puerto Rico alone.***
- More information can be found at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

2018 Display Measures (pg. 97)

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) ***[Confirmed]***
    - 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.

- ***In the interim, until the full measure specifications are assessed based upon alternative data sources, NCQA recommended to change the wording on the CAHPS measure to: "Have you ever had one or more pneumonia shots? Two shots are usually given in a person's lifetime and these are different from a flu shot. It is also called the pneumococcal vaccine."***

- Hospitalizations for Potentially Preventable Complications (Part C) ***[Confirmed]***
  - 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 ***[Confirmed in Final Call Letter]***

- Statin Therapy for Patients with Cardiovascular Disease (Part C) – NCQA ***[Confirmed]***
  - 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. ***[Confirmed in Final Call Letter]***

- High Risk Medication Use (Part D) – PQA ***[Confirmed]***
  - 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. ***[Confirmed in Final Call Letter]***

- Drug-Drug Interactions (Part D) ***[Confirmed]***
  - 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) ***[Confirmed]***
  - 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) ***[Confirmed]***
  - 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, long-term nursing home). CMS is proposing to only include the overall rate (i.e. across all care settings) for the 2018 Display Measure. ***[Confirmed in Final Call Letter]***
  - 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. **[Did not mention a year for transitioning to Star Rating in Final Call Letter]**

- Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D) ***[Confirmed with small change on OHDMP for 2019 Display]***
    - PQA has made changes to the measure specifications which will impact the calculations associated with the 2017 Patient Safety reports.
        - ***Term "morphine equivalent dose" will be changed to "morphine milligram equivalents"***
        - ***All three measures will continue to be displayed in the Patient Safety Reports***
    - CMS is planning to add these measures to the 2019 Display Measures but not to the Star Ratings at this time. ***[Confirmed in Final Call Letter]***
    - Changes the measure include: ***[Confirmed in Final Call Letter]***
        - 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.
    - ***CMS received several comments from sponsors on the similarity of the Opioids at High Doses from Multiple Providers (OHDMP) measure to the opioid overutilization criteria that CMS currently uses in the Overutilization Monitoring System.***
        - ***Only the OHDMP measure will be added to the 2019 Display Measures***

- Statin Use in Persons with Diabetes (Part D) – PQA ***[Confirmed]***
    - 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. ***[Confirmed in Final Call Letter]***
    - 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. ***[Confirmed in Final Call Letter]***

Looking at 2019 and Beyond

Patient Safety Reports ***[Change]***

- 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.
    - ***CMS: "…sponsors expressed how valuable the reports are for their performance improvement and monitoring activates. Therefore, CMS will continue to provide the reports on a monthly basis and send outlier notices on a quarterly basis."***

Care Coordination Measures (Part C) ***[Change]***

- 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: "Based on feedback received from the draft Call Letter, we are not moving forward with a change in weights to the care coordination measures at this time."***

Transitions of Care (Part C) ***[No Updates]***

- 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.
    - ***Received comments and passed along to NCQA for consideration.***

Opioid Overuse (Part C) ***[No Updates]***

- 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.
    - ***Received comments and passed along to NCQA for consideration.***

New PQA Measures in Development ***[No Updates]***

- 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.

General Items

Coverage Gap ***[Confirmed in Final Call Letter]***

- 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: ***[Confirmed in Final Call Letter]***

- 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 ***[Confirmed in Final Call Letter]***

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 has been set to $3,967, a 1.22% increase from 2017.***

Access to Preferred Cost Sharing Pharmacies (PCSP) – Preferred Pharmacies ***[No Updates]***

- 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