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CENTER FOR MEDICARE

DATE: April 20, 2017

TO: Part C and D Sponsors, excluding PACE organizations

FROM: Amy Larrick Chavez-Valdez, Director
Medicare Drug Benefit and C & D Data Group

SUBJECT: Sponsors' review of data used for Medicare Part C and D Star Ratings

It is important that Part C and D sponsors regularly review their underlying measure data that are the basis for the Part C and D Star Ratings. The purpose of this memo is to remind sponsors of the various datasets and reports available for ongoing monitoring purposes. CMS expects sponsors to routinely monitor these data and immediately alert CMS if errors or anomalies are identified. Sponsors who wait to raise issues with their data until CMS' Star Ratings plan preview periods may find there is inadequate time to investigate and resolve them within the production schedule for the fall release of the Star Ratings. For measures that are based on data reported directly from sponsors, any issues or problems should be raised well in advance of CMS' plan preview periods.

The pages that follow provide information about data available for ongoing review of many of the Star Ratings measures. Most of the data are posted in HPMS, under Quality and Performance, and Performance Metrics. We provide the paths to each dataset when available. Please note that these datasets often provide much more information than what is used for CMS' Star Ratings. Previous years Star Ratings Technical Notes found packaged with the data at http://go.cms.gov/partcanddstarratings also provide detailed information about each of the measure calculations.

CAHPS measures (Part C and D)

Official CAHPS preview reports will be emailed to the Medicare Compliance Officer in August. Official CAHPS plan reports will be mailed (on a CD) to the Medicare Compliance Officer in late September/early October.

If you have questions about MA and/or PDP CAHPS data please contact: MP-CAHPS@cms.hhs.gov

HOS measures (Part C)

HPMS HOS Star Ratings Validation page

- To access HOS Star Ratings Validation, from the top navigation bar select: "Quality and Performance," then "HOS," then "Star Ratings Validation." Select the appropriate cohort and contract number/name.

The Cohort 16 (2013-2015) data are currently posted. The Cohort 17 (2014-2016) data will be posted by early August.

If you have questions about HOS data please contact: HOS@cms.hhs.gov

Complaints about the Health/Drug Plan (Part C and D)

HPMS Performance pages

- To access the Complaint Rates Reports, from the top navigation bar select: "Quality and Performance," then "Performance Metrics," then from the left navigation bar select "Complaint Tracking," then "Complaint Rates." Select the appropriate report period.

The 2016 reports are currently posted. The 1st quarter 2017 report will be released by the end of April.

Any adjustments per CMS' CTM Standard Operating Procedures must be made by June 30 of the following year in order for the changes to be reflected in a contract's Star Ratings data (e.g., changes to 2016 complaint data must be made by June 30, 2017 for the 2018 Star Ratings). It is inappropriate for a plan to request retroactive reassignment during the plan preview periods of the Star Ratings data.

On February 24, 2017, CMS released an HPMS memo on the Updated Complaints Tracking Module (CTM) Standard Operating Procedures (SOP). The SOP included revisions to the complaint categories and subcategories, including labels to indicate that they are excluded from the Star Ratings complaints measures. The updated exclusions per the SOP will be applied to complaint data for 2017.

Technical data questions related to your plan's CTM performance should be sent to CTM@cms.hhs.gov, with a copy to your Account Manager.

Appeals Data (Part C) Independent Review Entity (IRE) data

Measures:

- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions

Information regarding the Part C reconsideration process is available to Medicare Advantage (MA) organizations on the www.medicareappeal.com website (see HPMS memo "Changes to the MAXIMUS Website" dated 09/27/2012).

The data available on this website are updated daily; therefore, MA organizations that notice discrepancies or have questions about the data should bring these issues to the attention of MAXIMUS as they arise. MA organizations are encouraged to submit any questions they may have about the data to the email box linked under the 'Contact Us' tab on the MAXIMUS Part C appeals website or on the Contact Information page in the Medicare Advantage Reconsideration Process Manual.

As stated in the 2018 Call Letter, any necessary changes to IRE data must be made by June 30 of the following year in order for the changes to be reflected in a contract's Star Ratings data (e.g., changes to 2016 IRE data must be made by June 30, 2017 for the 2018 Star Ratings).

Appeals measures (Part D) Independent Review Entity (IRE) data

Measures:

- Appeals auto-forward
- Appeals upheld

Part D plan sponsors should use the www.medicarepartdappeals.com website to monitor their appeal timeliness and effectuation compliance data to ensure accuracy (see HPMS memo "Changes to the MAXIMUS Website" dated 09/27/2012).

The data available on this website are updated daily; therefore, plan sponsors that notice discrepancies or have questions about the data should bring these issues to the attention of MAXIMUS as they arise. Plan sponsors are encouraged to submit any questions about the data to the email box linked under the 'Contact Us' tab on the Part D website.

HPMS Performance pages

- To access the Part D Appeals Reports, from the top navigation bar select: "Quality and Performance," then "Performance Metrics," then from the left navigation bar select "Appeals (Part D)," and then select the appropriate report period.
- The 2016 reports are currently posted. The 1st quarter 2017 report will be released mid-May.

As stated in the 2018 Call Letter, any necessary changes to IRE data must be made by June 30 of the following year in order for the changes to be reflected in a contract's Star Ratings data (e.g., changes to 2016 IRE data must be made by June 30, 2017 for the 2018 Star Ratings).

Beneficiary Access and Performance Problems (Part C and D)

As of February 2016, CMS provides access to Notices of Noncompliance, Warning Letters, and Ad-Hoc Corrective Action Plans (CAPs) to all plan sponsors. (See HPMS memo "Access to the HPMS Compliance Activity Module letters" dated 02/19/2016)

- To access the Compliance Activity module, from the top navigation bar select: "Monitoring" then "Compliance Activity." Users may only access information connected with the contracts associated with their User IDs.

Compliance Activity data used in the Star Ratings is pulled by the "Report Issued" date. The CY 2016 data are available for review. If you do not see this module in HPMS, contact CMSHPMS_Access@cms.hhs.gov

For questions or problems with compliance actions posted to HPMS please contact:

- Part C: PartCCompliance@cms.hhs.gov
- Part D: PartD_Monitoring@cms.hhs.gov

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

HPMS Performance pages

- To access the Part C or D Call Center Reports, from the top navigation bar select: "Quality and Performance," then "Performance Metrics," then select from the left navigation bar "Call Center Monitoring" and then Part C prospective beneficiary customer service and/or Part D prospective beneficiary customer service."

The next set of FL/TTY reports will be released in July 2017. In addition, plans/sponsors may download and review their raw call data directly from HPMS to validate the results. We encourage plans/sponsors to contact CMS via CallCenterMonitoring@cms.hhs.gov if they believe an error occurred.

Part C and D Reporting Requirements

Measures:

- SNP Care Management (Part C)
- MTM program completion rate for CMR (Part D)

HPMS Plan Reporting Data Validation page

- To access this page, from the top menu select "Monitoring," then "Plan Reporting Data Validation." Select the appropriate contract year. Select the PRDVM Reports. Select "Score Detail Report." Select the applicable reporting section (e.g. Medication Therapy Management Program).

If you do not see this module in HPMS, contact CMSHPMS_Access@cms.hhs.gov

If you have questions about the Part C Plan Reporting data please contact:

- Part C: Partcplanreporting@cms.hhs.gov
- Part D: Partd-planreporting@cms.hhs.gov

Patient Safety measures (Part D)

Monthly reports available for Part D sponsors through the Patient Safety Analysis Website - https://PartD.ProgramInfo.US/PatientSafety. Access to this website is granted via each contract's Medicare Compliance Officer.

Includes Star Rating, Display Page, and other patient safety measure reports:

- High Risk Medication (HRM)
- Medication Adherence (ADH) for Cholesterol (Statins)
- Medication Adherence (ADH) for Hypertension (RAS Antagonists)
- Medication Adherence (ADH) for Diabetes Medications
- Medication Adherence for HIV/AIDS (Antiretrovirals)
- Drug-Drug Interaction (DDI)
- Diabetes Medication Dosage (DMD)
- Statin Use in Persons with Diabetes (SUPD)
- Use of Opioids at High Dosage in Persons without Cancer (OHD)
- Use of Opioids from Multiple Providers in Persons without Cancer (OMP)
- Use of Opioids at High Dosage and from Multiple Providers in Persons without Cancer (OHDMP)
- Antipsychotic Use in Persons with Dementia (APD)
- High Acetaminophen Daily Dose (APAP-HD)

For technical questions related to the user authorization process or access to the website or reports, please contact CMS contractor, Acumen, at PatientSafety@AcumenLLC.com.

Plan Provides Accurate Drug Pricing Information for This Website

CMS will be providing contracts with preliminary as well as final Medicare Plan Finder (MPF) Price Accuracy reports. These reports will contain claim level information used for calculating their preliminary MPF Price Accuracy score. The preliminary reports will be available to all contracts for download in the Download Files section of the MPF Communications Web Portal beginning on April 24, 2017.

The final reports will available beginning in July 2017. All contracts receiving an MPF Price Accuracy score will have preliminary reports created and do not need to contact CMS to request a report. The methodology for calculating the scores for this 2018 Star Rating measure can be found in the Attachment to this memorandum. Only users with Summary & Confidential Beneficiary Report access permissions will be allowed to download reports. To update or confirm your level of access or to add users to a contract, please contact your Medicare Compliance Officer. For all technical questions related to downloading the files, please contact PlanFinder@AcumenLLC.com. For all questions related to the Accuracy Measure detail data, contact PartCandDStarRatings@cms.hhs.gov.

Members Choosing to Leave the Plan

This year CMS will be able to provide contracts with the source beneficiary-level disenrollment detail files used for the measure numerator prior to the first plan preview. The specific date when these files will be available for transfer will be announced in a future HPMS email.

Prior to requesting the disenrollment detail data files, we request that you identify the person in your organization with access to the mainframe file transfer (MFT) link your organization has with CMS. The MFT link goes by a few different names, such as GENTRAN, Connect:Direct and TIBCO. This MFT link is the method used to transfer enrollment/disenrollment data between your organization and CMS. Your knowledge of who can retrieve the data is necessary because the files auto-expire after a set period of time and are deleted.

When you are ready to receive the disenrollment detail files, please send an email to PartCandDStarRatings@cms.hhs.gov requesting the files. Your email should indicate that you know who can retrieve the data and list the specific contract numbers for which data are needed.

The Star Ratings mailbox will create and ship the files through MFT. Once the files are shipped, we will reply with the MFT file naming convention, a file layout document, and the summary level numerator and denominator data for the requested contracts.

Results from CMS' reviews for data integrity will be provided to sponsors prior to CMS' first plan preview this summer. Sponsors should send questions about these reviews to the CMS PARTCDQA@cms.hhs.gov mailbox.

Please submit general questions about Part C and D Star Ratings measures or methodology to PartCandDStarRatings@cms.hhs.gov. Please do not submit secure emails requiring CMS to login to access the questions as multiple staff triage your emails, and it is difficult to create and share login information. If you need to share personally identifying information (PII) with us, please contact us with an unsecure email to discuss a safe way to transfer the secure data. You should add the ratings mailbox to your safe sender list so our messages are not flagged as spam.

Thank you for your continued support of CMS' Part C and D Star Ratings.

Attachment: Methodology for 2018 Star Rating Medicare Plan Finder Price Accuracy Measure

CMS' drug pricing performance measure evaluates the accuracy of prices displayed on Medicare Plan Finder (PF) for beneficiaries' comparison of plan options. The accuracy score is calculated by comparing the PF price to the Prescription Drug Event (PDE) price and determining the magnitude and frequency of differences found when the latter exceeds the former. This document summarizes the methods currently used to construct each contract's accuracy index.

Contract Selection

The Part D Star Ratings rely in part on the submission of pricing data to PF. Therefore, only contracts with at least one plan meeting all of the following criteria are included in the analysis:

- Not a PACE plan
- Not an employer plan
- Part D plan
- Plan not terminated during the contract year

Only contracts with at least 30 PDE claims throughout the year are included in the accuracy measure. This ensures that the sample size of claims is large enough to produce a reliable accuracy score.

PF Composite Price Accuracy Score

To calculate the PF Composite Price Accuracy Score, the point of sale cost (ingredient costs plus dispensing fee) reported on each PDE claim is compared to the cost resulting from using the unit price reported on Plan Finder.[1] This comparison includes only PDEs for which a PF cost can be assigned. In particular, a PDE must meet seven conditions to be included in the analysis:

1. The National Provider Identifier (NPI) number for the pharmacy on the PDE claim must appear in the pharmacy cost file as either a retail only pharmacy or a retail and limited access only pharmacy, regardless of pharmacy service type reported on PDE. Claims for pharmacies that are listed as retail in the pharmacy cost file and also have a pharmacy service type on the PDE of either Community/Retail or Managed Care Organization (MCO) are included as well. National Council for Prescription Drug Programs (NCPDP) numbers are mapped to their corresponding NPI numbers.
2. The corresponding reference National Drug Code (NDC) must appear under the relevant price ID for the pharmacy in the pricing file.[2]
3. The reference NDC must be on the plan's formulary.

[1] Plan Finder unit costs are reported by plan, drug, days of supply, and pharmacy. The plan, drug, days of supply, and pharmacy from the PDE are used to assign the corresponding Plan Finder unit cost posted on medicare.gov on the date of the PDE.

[2] Plan Finder prices are reported at the reference NDC level. A reference NDC is a representative NDC of drugs with the same brand name, generic name, strength, and dosage form. To map NDCs on PDEs to a reference NDC, we use First Data Bank (FDB) and Medi-Span to create an expanded list of NDCs for each reference NDC, consisting of NDCs with the same brand name, generic name, strength, and dosage form as the reference NDC. This expanded NDC list allows us to map PDE NDCs to PF reference NDCs.

4. Because the retail unit cost reported on the PF is intended to apply to a 1, 2, or 3-month supply of a drug, only claims with a days supply of 28-34, 60-62, or 90-93 are included. Claims reporting a different day supply value are excluded.
5. PDEs for dates of service during which the plan was suppressed from the PF or where the relevant pharmacy or drug was not reported in PF are not included since no PF cost can be assigned.[3]
6. PDEs for compound drugs or non-covered drugs are not included.
7. The PDE must occur in Quarter 1 through 3 of the year. Quarter 4 PDEs are not included because PF prices are not updated during this last quarter.

The PF Composite Price Accuracy Measure factors in both how much and how often PDE prices exceeded the prices reflected on the PF. The contract's PF Composite Price Accuracy score is the average of the Price Accuracy Score, which measures the difference between PDE total cost and PF total cost, and the Claim Percentage Score, which measures the share of claims where PDE prices are less than or equal to PF prices.

Once PF unit ingredient costs are assigned, the PF ingredient cost is calculated by multiplying the unit costs reported on PF by the quantity listed on the PDE. The PDE total cost (TC) is the sum of the PDE ingredient cost paid and the PDE dispensing fee. Likewise, the PF TC is the sum of the PF ingredient cost and the PF dispensing fee that corresponds to the same pharmacy, plan, and days of supply as that observed in the PDE. Each claim is then given a score based on the difference between the PDE TC and the PF TC. If the PDE TC is lower than the PF TC, the claim receives a score equal to zero. In other words, contracts are not penalized when point of sale costs are lower than the advertised costs. However, if the PDE TC is higher than the PF TC, then the claim receives a score equal to the difference between the PDE TC and the PF TC.[4,5] The contract level PF Price Accuracy Index is the sum of the claim level scores and PDE TC across all PDEs that meet the inclusion criteria, divided by the PDE TC for those same claims.

The PF Claim Percentage Index is the percent of all PDEs that meet the inclusion criteria with a PDE TC higher than the PF TC. Note that the best possible PF Price Accuracy Index is 1, and the best possible PF Claim Percentage Index is 0. This occurs when the PF TC is never lower than the PDE TC. The formulas below illustrates the calculation of the contract level PF Price Accuracy Index and PF Claim Percentage Index:

[3] Because sanctioned plans typically aren't suppressed on PF and display data to the plan's current enrollees only, non-suppressed sanctioned plans will have their data during the sanction counted towards the measure.

[4] To account for potential rounding errors, this analysis requires that the PDE cost exceed the PF cost by at least half a cent ($0.005) in order to be counted towards the accuracy score. For example, if the PDE cost is $10.25 and the PF cost is $10.242, the .008 cent difference would be counted towards plan's accuracy score. However, if the PF cost is higher than $10.245, the difference would not be considered problematic, and it would not count towards the plan's accuracy score.

[5] The PF data includes floor pricing. For plan-pharmacy drugs with a floor price, if the PF price is lower than the floor price, the PDE price will be compared against the floor price.

$$\text{Price Accuracy Index} = \left(\frac{\sum_i \max(TC_{iPDE} - TC_{iPF}, 0) + \sum_i TC_{iPDE}}{\sum_i TC_{iPDE}}\right)$$

where

TC_{iPDE} is the ingredient cost plus dispensing fee reported in PDE_i, and
TC_{iPF} is the ingredient cost plus dispensing fee calculated from PF data, based on the PDE_i reported NDC, days of supply, and pharmacy.

$$\text{Claim Percentage Index} = \left(\frac{\sum_i Claims_{iPDE>PF}}{\sum_i Claims_{iTotal}}\right)$$

where

$Claims_{iPDE>PF}$ is the total number of claims where the PDE price is greater than the PF price

$Claims_{iTotal}$ is the total number of claims

We use the following formulas to convert the Claim Percentage Index and Price Accuracy Index into the PF Composite Price Accuracy score:

$$\text{Claim Percentage Score} = (1 - \text{Claim Percentage Index}) \times 100$$

$$\text{Price Accuracy Score} = 100 - [(\text{Price Accuracy Index} - 1) \times 100]$$

$$\text{PF Composite Price Accuracy Score} = (0.5 \times \text{Claim Percentage Score}) + (0.5 \times \text{Price Accuracy Score})$$

The score is rounded to the nearest whole number.

Example of PF Composite Price Accuracy Score *Calculation*

Table 1 shows an example of the PF Composite Price Accuracy Score calculation. This contract has 4 claims, for 4 different NDCs and 4 different pharmacies. This is an abbreviated example for illustrative purposes only; in the actual accuracy index, a contract must have 30 claims to be evaluated.

From each of the 4 claims, the PDE ingredient cost, dispensing fee, and quantity dispensed are obtained. Additionally, the plan ID, days of supply, date of service, and pharmacy number are collected from each PDE to identify the PF data that had been submitted by the contract and posted on the PF on the PDE dates of service. The NDC on the claim is first assigned the appropriate reference NDC, based on the brand name, generic name, strength and dosage form. Using the reference NDC, the following PF data are obtained: brand/generic dispensing fee (as assigned by the pharmacy cost file) and unit cost (as assigned by the Price File corresponding to that pharmacy and days of supply on the date of service). The PDE cost is the sum of the PDE ingredient cost and dispensing fee. The PF cost is computed as the quantity dispensed from PDE multiplied by the PF unit cost plus the PF brand/generic dispensing fee (brand or generic status is assigned based on the NDC).

The last column shows the amount by which the PDE cost is higher than the PF cost. When PDE cost is less than PF cost, this value is zero. The Price Accuracy Index is the sum of the last column plus the sum of PDE costs divided by the sum of PDE cost. The Claim Percentage Index is the number of rows where the last column is greater than zero divided by the total number of rows.

Table 1: Example of PF Composite Price Accuracy Score Calculation

NDC	Pharmacy Number	PDE Data					Plan Finder Data				Calculated Values			
		DOS	Ingredient Cost	Dispensing Fee	Quantity Dispensed	Days' Supply	Biweekly Posting Period	Unit Cost	Dispensing Fee		Brand or Generic Status	Total Cost		Amount that PDE > PF
									Brand	Generic		PDE	PF	
A	111	01/08/2016	3.82	2	60	60	01/04/2016-01/17/2016	0.014	2.25	2.75	B	5.82	3.09	2.73
B	222	01/24/2016	0.98	2	30	60	01/18/2016-01/31/2016	0.83	1.75	2.5	G	2.98	27.4	0
C	333	02/11/2016	10.48	1.5	24	28	02/01/2016-02/14/2016	0.483	2.5	2.5	B	11.98	14.09	0
D	444	02/21/2016	47	1.5	90	30	02/15/2016-02/28/2016	0.48	1.5	2.25	G	48.5	45.45	3.05
											Totals	69.28		5.78
											Price Accuracy Index			1.08343
											Claim Percentage Index			0.5
											PF Price Accuracy Score			71