PQA Summary of Points of Interest
February 18, 2020

CMS Advance Notice of Methodological Changes for Calendar Year 2021 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies – Part II

On February 5, 2020, the Centers for Medicare & Medicaid Services (CMS) released Part II of the Advance Notice of Methodological Changes for Calendar Year 2021 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies. Of note, CMS will not publish a Call Letter for 2021, as it has done in previous years. In addition to the Advance Notice, CMS will use rulemaking to enhance the Part C and D programs, codify several existing CMS policies, and implement additional technical changes (see Proposed Rule CMS-4190-P, which was published in the Federal Register February 18).

PQA drafted this high-level summary of points of interest for our multi-stakeholder membership. A condensed summary of PQA measure-specific information is provided at the top of page 2. Section 1 (pages 2-3) includes general information, Section 2 (pages 4-5) focuses on areas related to the use of PQA measures, and Section 3 (pages 6-7) focuses on other medication measure related content.

We applaud CMS’ comment periods on the Star Ratings in response to the need for transparency and advance notice. Historically, the Part C and D Star Ratings methodology was adopted and updated through the Part C and D Call Letter, with additional guidance issued in annual Technical Notes. Starting with the 2021 Star Ratings, any changes to the methodology for calculating the ratings, the addition of new measures, and substantive measure changes will be proposed and finalized through rulemaking.

Submitting Comments:
To submit comments or questions electronically:
   - Follow instructions for “submitting a comment”
Note: Comments must be received by 11:59 p.m. ET on Friday, March 6, 2020.

Key Dates
<table>
<thead>
<tr>
<th>March 6, 2020:</th>
<th>Comments on Advance Notice due by 11:59 PM Eastern Standard Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than April 6, 2020:</td>
<td>CMS will announce the MA capitation rates and final payment policies</td>
</tr>
</tbody>
</table>

PQA’s summary follows. For further details on any of the points summarized below, we have indicated page numbers and encourage you to refer to the full language from the document, which can be accessed here.
CONDENSED SUMMARY

1. As discussed in the 2020 Call Letter, the Concurrent Use of Opioids and Benzodiazepines (COB), Use of Opioids at High Dosage in Persons Without Cancer (OHD), Use of Opioids from Multiple Providers in Persons Without Cancer (OMP), and Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) measures will be added to the display page for 2021 (using 2019 data).

2. CMS previously described updated methodology for the Antipsychotic Use in Persons with Dementia Overall (APD), Antipsychotic Use in Persons with Dementia, for Community-only Residents (APD-COMM), and Antipsychotic Use in Persons with Dementia, for Long-term Nursing Home Residents (APD-LTNH) measures for the 2019 measurement year for the 2021 display page.

3. CMS will consider implementation of PQA’s sociodemographic status (SDS) risk adjustment recommendations in the future (i.e., for the 2022 measurement year or beyond) for PQA’s three adherence measures – Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) – used in the Part D Star Ratings.

4. CMS plans to begin reporting PQA’s Initial Opioid Prescribing for Long Duration (IOP-LD) measure in the Patient Safety reports for the 2020 measurement year; to add this measure to the display page for 2023 (2021 data) and 2024 (2022 data); and will consider adding it to the Star Ratings in the future pending rulemaking.

ATTACHMENT V. UPDATES FOR PART C AND D STAR RATINGS (begins on p. 58)

CMS codified the methodology for the Part C and D Star Ratings program in the CY 2019 Final Rule for performance periods beginning with 2019; that final rule lays out the methodology for the 2021 Star Ratings. This Attachment provides updates that are required by regulation to be made through the process described for changes in, and adoption of, payment and risk adjustment policies in section 1853(b) of the Act. CMS solicits input on future measures and concepts as they continue to enhance the Star Ratings over time.

Section 1. General

MEASURE UPDATES FOR 2021 STAR RATINGS (pp. 58-67)

Improvement Measures (Part C & D) (pp. 58-60)

The measures that will be used to calculate the 2021 improvement measures are listed in Table 1. PQA measures included in the calculation for the 2021 improvement measures are in the table, below, excerpted from Table 1: 2021 Star Ratings Improvement Measures.
<table>
<thead>
<tr>
<th>Part C or D</th>
<th>Measure</th>
<th>Measure Type</th>
<th>Weight</th>
<th>Improvement Measure</th>
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<tbody>
<tr>
<td>D</td>
<td>Medication Adherence for Hypertension (RAS antagonists)</td>
<td>Intermediate Outcome</td>
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<td>Yes</td>
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<tr>
<td>D</td>
<td>Medication Adherence for Cholesterol (Statins)</td>
<td>Intermediate Outcome</td>
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<td>D</td>
<td>Statin Use in Persons with Diabetes</td>
<td>Intermediate Outcome</td>
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<td>Yes</td>
</tr>
</tbody>
</table>

2021 Star Ratings Program and the Categorical Adjustment Index (pp. 60-66)

- The methodology for the Categorical Adjustment Index (CAI) is described in the annual Medicare Part C & D Star Ratings Technical Notes available on the CMS webpage at [https://go.cms.gov/partcanddstarratings](https://go.cms.gov/partcanddstarratings).
- The candidate measure set for Part C and Part D, which will be included in the determination of the 2021 CAI values, includes (PQA measures are bolded): Adult BMI Assessment, Annual Flu Vaccine, Breast Cancer Screening, Colorectal Cancer Screening, Diabetes Care – Blood Sugar Controlled, Diabetes Care – Eye Exam, Diabetes Care – Kidney Disease Monitoring, Improving Bladder Control, Medication Reconciliation Post-Discharge, MTM Program Completion Rate for CMR, Monitoring Physical Activity, Osteoporosis Management in Women who had a Fracture, Reducing the Risk of Falling, Rheumatoid Arthritis Management, Medication Adherence for Diabetes Medications, Medication Adherence for Hypertension, Medication Adherence for Cholesterol, Statin Therapy for Patients with Cardiovascular Disease, and Statin Use in Persons with Diabetes.

Extreme and Uncontrollable Circumstances Policy (pp. 66-67)

- In the CY 2020 Final Call Letter and the CY 2020 Final Rule, CMS finalized a set of rules for adjusting the calculation of Star Ratings for the Parts C and D organizations that are impacted by extreme and uncontrollable circumstances.
- The same policy as used for adjustments to 2020 Star Ratings based on extreme and uncontrollable circumstances will be continued for CY 2021 Star Ratings.
  - To determine whether a contract was impacted (such that it would be an “affected contract” eligible for adjustments), CMS compares the number of enrollees in the Individual Assistance area at the time of the extreme and uncontrollable circumstance to the number of enrollees outside the Individual Assistance area.
  - In cases where contracts with at least 25% of enrollees residing in FEMA-designated Individual Assistance areas were affected by consecutive year disasters (2018-2019), for all measures except HOS (Health Outcome Survey), these doubly-affected contracts would receive the higher of the 2021 Star Rating or what the 2020 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2018 disaster for each measure (CMS will use the corresponding measure score for the Star Ratings year selected).
  - For HOS, these doubly-affected contracts would receive the higher of the 2021 Star Rating or what the 2020 Star Rating would have been in the absence of any adjustments that took into account the effects of the 2017 disaster for each measure (CMS will use the corresponding measure score for the Star Ratings year selected). This is due to the longitudinal nature of the HOS data collection.
CMS will continue to solicit feedback on new measure concepts as well as new and updated measures and will also continue to provide advance notice regarding measures considered for implementation as future Star Ratings measures. New measures and measures with substantive specification changes must remain on the display page for at least two years prior to becoming a Star Ratings measure.

1. **Concurrent Use of Opioids and Benzodiazepines (COB), Use of Opioids at High Dosage in Persons Without Cancer (OHD), Use of Opioids from Multiple Providers in Persons Without Cancer (OMP), and Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) (Part D) [PQA] (p. 71)**
   - As discussed in the 2020 Call Letter, the COB, OHD, OMP, and OHDMP measures will be added to the display page for 2021 (using 2019 data).
   - As communicated in the April 17, 2019 HPMS memo, UPDATES - 2019 Medicare Part D Patient Safety and Overutilization Monitoring System Reports, CMS clarified:
     - When calculating the denominator requirement of $\geq 15$ total days’ supply of opioid medication the following steps are applied: i) when dispensed on different days, the days’ supply is summed for the total days’ supply, and ii) in the case of multiple prescriptions dispensed on the same day, total days’ supply will only include the supply of the prescription with the longest days’ supply.
   - Starting with the 2020 year of service (YOS) data, per the updated PQA specifications, beneficiaries with a sickle cell diagnosis at any time during the measurement year will be excluded from these measures.

2. **Antipsychotic Use in Persons with Dementia Overall (APD), Antipsychotic Use in Persons with Dementia, for Community-only Residents (APD-COMM), and Antipsychotic Use in Persons with Dementia, for Long-term Nursing Home Residents (APD-LTNH) (Part D) [PQA] (pp. 71-72)**
   - As communicated in the April 17, 2019 HPMS memo, UPDATES - 2019 Medicare Part D Patient Safety and Overutilization Monitoring System Reports, CMS described the updated methodology for the APD, APD-COMM, and APD-LTNH measures for the 2019 measurement year for the 2021 display page.
     - The denominator requirement of $\geq 2$ prescription claims must have different dates of service. The PQA clarified that $>60$ days’ supply is cumulative for any cholinesterase inhibitor or NMDA receptor antagonist. The days’ supply of eligible antipsychotic drugs in the numerator is cumulative.
     - Also, when calculating the numerator and denominator total days’ supply requirements, the following steps are applied: i) when dispensed on different days, the days’ supply is summed for the total days’ supply, and ii) in the case of multiple prescriptions dispensed on the same day, total days’ supply will only include the supply of the prescription with the longest days’ supply.

3. **Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D) [PQA] (p. 72)**
   - As discussed in past Call Letters, PQA tested its medication adherence measures, which are used for the Star Ratings, for potential risk adjustment of the measures (i.e., adjustment for
socioeconomic status (SES) or sociodemographic status (SDS)), and included draft recommendations in its Measure Manual.

- The risk-adjusted adherence measures were endorsed by the National Quality Forum (NQF) in the 2019 Spring cycle (NQF endorsed #0541).
- CMS will consider implementation of the PQA recommendations in the future for these Star Ratings measures (i.e., for the 2022 measurement year or beyond).
- Substantive measure changes must be proposed and finalized through rulemaking.
- **PQA Note:**
  - PQA has finalized our recommendations for SDS risk adjustment for the three PQA health plan adherence measures – PDC-Diabetes All Class, PDC-Renin Angiotensin System Antagonists, and PDC-Statins – in Medicare Part D, as follows:
    - The measure rates should be risk adjusted for SDS characteristics to adequately reflect differences in patient populations.
    - The measure rates should be adjusted for the following beneficiary-level SDS characteristics: age, gender, dual eligibility/Low-Income Subsidy (LIS) status, and disability status.
    - The measure rates should be stratified by the beneficiary-level SDS characteristics listed above to allow health plans to identify disparities and understand how their patient population mix is affecting their measure rates.

**POTENTIAL NEW MEASURES (pp. 73-79)**

1. **Initial Opioid Prescribing (IOP) Measures (Part D) [PQA] (pp. 76-78)**
   - PQA developed and endorsed three initial opioid prescribing (IOP) measures aligned with the CDC Guideline for Prescribing Opioids for Chronic Pain.
     1. **Initial Opioid Prescribing at High Dosage (IOP-HD):** This measure assesses the percentage of individuals 18 years and older with one or more initial opioid prescriptions with an average daily morphine milligram equivalent (MME) of 50 or greater.
     2. **Initial Opioid Prescribing for Long Duration (IOP-LD):** This measure assesses the percentage of individuals 18 years and older with one or more initial opioid prescriptions for more than 7 cumulative days’ supply.
     3. **Initial Opioid Prescribing for Long-Acting or Extended Release Opioids (IOP-LA):** This measure assesses the percentage of individuals 18 years and older with one or more initial opioid prescriptions for long-acting or extended-release opioids.

Beneficiaries enrolled in hospice, with a cancer diagnosis, or with a sickle cell disease diagnosis during the measurement year or the 90 days prior to the earliest date of service for an opioid medication during the measurement year are excluded from all three IOP measures.

The measures will provide additional tools for Part D sponsors to monitor initial opioid prescriptions that increase risk for chronic opioid use and opioid use disorder.

- **CMS plans to begin reporting only the IOP-LD measure in the Patient Safety reports for the 2020 measurement year; to add this measure to the display page for 2023 (2021 data) and 2024 (2022 data); and will consider adding it to the Star Ratings in the future pending rulemaking.**
- **CMS will perform additional analyses of the IOP-HD and IOP-LA measures internally and monitor any notable utilization trends in the future.**
- **CMS is interested in stakeholder feedback on these new IOP measures.**
Changes to Existing Star Ratings and Display Measures (pp. 67-72)

1. Controlling High Blood Pressure (Part C) [NCQA] – Display measure (p. 68)
   - This measure is on the display page for the 2020 and 2021 Star Ratings and CMS finalized returning it to the 2022 Star Ratings in the final rule published April 16, 2019.
   - The current denominator specification for this measure looks for two outpatient visits with a diagnosis of hypertension in the measurement year or the year prior.
     o For measurement year 2020, NCQA is exploring modifying the timing of the denominator to look for two outpatient visits with a diagnosis of hypertension in the first six months of the measurement year or the year prior.
   - The numerator would still assess the most recent blood pressure reading on or after the date of the second qualifying denominator event.
   - This change to the denominator provides a minimum six-month window for interventions that might assist in bringing members’ blood pressure under control.
   - CMS welcomes feedback on this potential update (non-substantive change).

2. Transitions of Care (Part C) [NCQA] – Display measure (p. 69)
   - For measurement year 2020, NCQA is exploring four updates to the Transitions of Care (TRC) measure. NCQA proposes to:
     o Revise the requirement of using one medical record from a specific provider to, instead, allow numerator information to be captured from “the outpatient medical record as well as other information accessible to the primary care provider (PCP) or ongoing care provider” – thereby helping the specification capture additional communication forms that occur regularly in the field and meet the intent of the measure. This change would also ensure that scores for the TRC measure and the standalone Medication Reconciliation Post-Discharge (MRP) measure would match. As such, the additional stand-alone MRP measure would no longer need to be separately reported.
     o Revise the timeframe for the Notification of Inpatient Admission and Receipt of Discharge Information indicators to “the day of admission or discharge, respectively, or within the following two calendar days.”
     o More broadly allow “instructions for patient care post-discharge” to count in the numerator of the Receipt of Discharge Information indicator rather than limiting it to only instructions given specifically to the PCP; thus, allowing additional data sources.
   - If approved, measure updates would be implemented in measurement year 2020.
   - CMS welcomes feedback on these potential updates (non-substantive changes).

Potential New Measure Concepts (pp. 73-79)

1. Prior Authorizations (Part C) (p. 73)
   - CMS is beginning work to develop a measure for the display page related to prior authorizations and is considering proposing it in the future as a Star Ratings measure to support beneficiary access to necessary and reasonable care.
• CMS is interested in feedback from stakeholders on any potential quality measures that could assess the performance of plans related to how well they administer and automate electronic prior authorizations.

2. Diabetes Overtreatment (Part C) [NCQA] (pp. 74-75)
   • NCQA is exploring new measure concepts that will assess overtreatment in patients with type 2 diabetes:
     o A measure that assesses whether clinically complex members with type 2 diabetes are being overtreated (as defined by HbA1c level and medications).
     o A potential outcome measure that focuses on the identification of hospitalizations, emergency department visits, and observation stays among diabetic adults due to hypoglycemia.
   • If developed and approved, the new measure would potentially be included in HEDIS for measurement year 2021.
   • CMS welcomes feedback on the feasibility and utility of this type of measure.

3. Generic Utilization (Part D) (pp. 75-76)
   • CMS plans to develop measures to assess generic and biosimilar utilization in the Medicare Part D program.
   • CMS is interested in comments on the following measure concepts:
     1. **Generic Substitution Rate** (higher is better): Total number of generic fills divided by the sum of brand and generic fills for drugs that had approved therapeutically equivalent generic products that were available on the market at the time of the fill.
     2. **Generic Therapeutic-Alternative Opportunity Rate** (lower is better): Total number of brand fills divided by the sum of brand and generic fills within select drug classes or Brand and generic drugs, subclasses where both brands and generics are available. Classes consisting of only brand National Drug Codes (NDCs) or only generic NDCs will be excluded from the measure.
     3. **Biosimilar Utilization Rate** (higher is better): Total number of biosimilar fills divided by the sum of reference biologics and biosimilar fills for biologics that had approved biosimilars available on the market at the time of the fill.
   • CMS seeks input to help shape more detailed measure specifications, such as:
     o What classification system should be used for the Generic Therapeutic-Alternative Opportunity Rate?
     o What specific classes or subclasses (where both brands and generics are available) should be excluded, due to significant variability in the safety or effectiveness of the available generic(s) compared to the brand(s)?
     o What are the current barriers to generic uptake?
   • CMS will continue to perform data analysis of current generic coverage, formulary placement, and generic utilization rates in Part D as well as consider the feedback on this measure concept.
   • CMS will also work with measure developers to explore potential measure concepts.
   • CMS’ goal is to propose to adopt measures that reward sponsors for high rates of generic utilization.