Life & Health

Health Care Communiqué

Q2 2014

STAR RATINGS 2015 AND BEYOND

Over the last few years, CMS has steadily increased the emphasis on STAR ratings. A low STAR rating has financial implications and places Sponsors at risk. CMS will assign the Low Performance Icon (LPI) to Sponsors who receive a STAR rating lower than a three, and will use this information as part of its selection process for Program Audits as well as possible contract termination.

There are four new STAR measures that were rolled out in the 2014 Call Letter, two which are measurable in 2015:

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (Part C)

- Percent of adult members with a new episode of alcohol or other drug (AOD) dependence who received initiation of AOD treatment.
- Would keep the engagement of AOD treatment on the display page.
- Both rates appear on the 2014 display page.

(continued...)

STAR RATINGS 2015 AND BEYOND *(Continued)*

Special Needs Plan (SNP) Care Management (Part C)

- Percent of eligible SNP enrollees who received a health risk assessment (HRA) during the measurement year.
- Only for Contracts with ≥ 30 SNP enrollees.

Each of these measures will have an assigned weight of "1." CMS has also added that contracts with more than 500 enrollees as of July 2013 will now be part of STAR ratings in 2015 with simulated scores. CMS retired the Glaucoma Testing measure for Part C this year.

CMS modified several STAR ratings for 2015. They are as follows:

- **Annual Flu Vaccine (Part C)** – will begin to include members that received a flu shot earlier in the year and will eliminate the pre-determined four-star threshold for this measure.
- **Medicare Adherence for Diabetes Medications (Part D)** – addition of two additional drug classes, added language that evaluated compliance with the therapy, not a drug class.
- **Weighting Changes Improvement** – CMS will increase the weight of the improvement measure to 5 times the process measure for those contracts rated 2.5 or more.

- **Appeals Upheld (Part D)** – for 2015 will be based on the first six months of data from 2015; in 2016 this will be based on the entire 2014 calendar year of data.
- **Complaints about the Plan (CTM)** – for 2015 will be based on the first six months of data from 2015, in 2016 this will be based on the entire 2014 calendar year of data.

In its 2015 Call Letter, CMS lists the new STAR measures for 2016:

- Pharmacotherapy Management of COPD Exacerbation (PCE) (Part C)
  - Percent of COPD exacerbations for memb ers 40 years of age and older who had an acute inpatient discharge or ED encounter.
  - Two rates for 2014 display page –
    - dispensed a systemic corticosteroid within 14 days of the event.
    - dispensed a bronchodilator within 30 days of the event.
  - Would incorporate a combined PCE measure that averages the two rates for 2015 Star Ratings.
- **Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (Part D)** –
  - Percent of beneficiaries who met eligibility criteria for the Medication Therapy Management (MTM) program and who received a CMR.
  - CMRs must meet the CMS definition to be reported and counted.
- **Changes in the Calculation of the Overall Rating and the Part C and D Summary Ratings** – changes will be implemented for 2016 ratings. Simulated ratings based on the new criteria will come out in Fall 2014.

CMS reminded MA organizations and PDP sponsors that under its regulatory authority it can terminate the contracts of organizations that fail for three consecutive years to achieve at least three stars on their Part C and/or D performance as of the end of 2014, based on three years of data, beginning with 2012. CMS plans to terminate, effective December 31, 2014, those contracts that have failed to achieve a three-star rating for Part C and/or D in three consecutive years 2013, 2014 and 2015.

CMS FIRST PUBLIC USE FILE (PUF) OF PLAN-REPORTED DATA

On April 28, 2014 CMS released a memo outlining the proposed release of plan-reported data in a Public Use File (PUF). The initial PUF is scheduled for a spring 2014 release, and will utilize data from CY 2012 Part C and Part D Reporting Requirements.

CMS has established mandatory reporting requirements for Part C and D plans. Since 2011, CMS has implemented Data Validation (DV) standards to ensure that plans reporting was accurate and consistent. CMS has been using this reporting data for internal monitoring purposes, and recently has been using the data to generate display measures that are reported publicly. CMS may add some of these measures to the Star Rating System in the future.

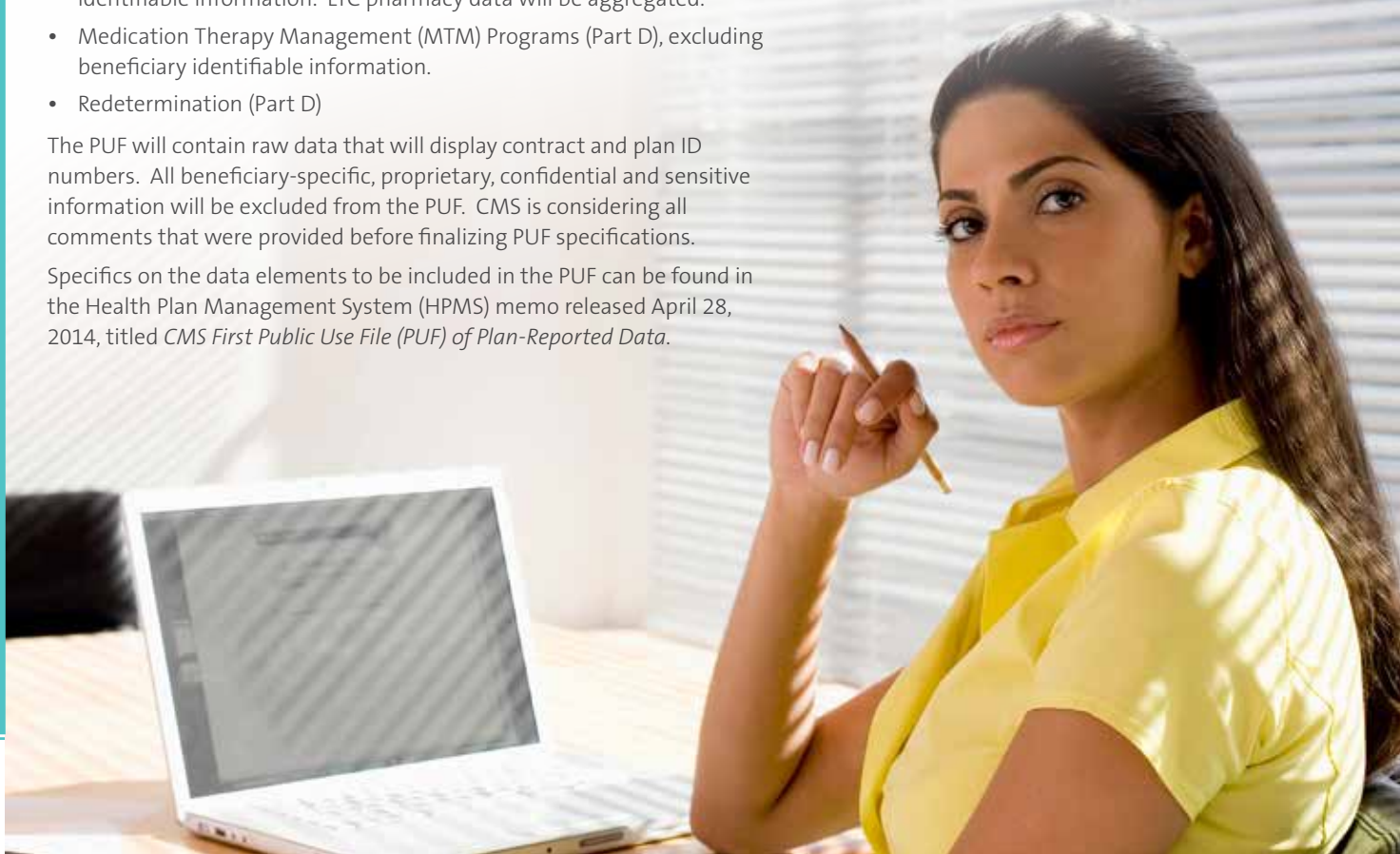
The Office of the Inspector General (OIG) has recommended expanding the release of PUFs containing plan-reported data, which CMS collects through the Part C and D Reporting Requirements. CMS has also received requests for plan-reported data based on the Freedom of Information Act (FOIA). Based on these requests and in an effort to promote transparency and increase accountability within the Medicare Program, CMS believes that making this data available to the general public, researchers and academic institutions, health care organizations and government agencies will ultimately increase the quality of care and services that Medicare beneficiaries receive.

The following reporting sections from CY 2012 Part C and D data will be released in the PUF:

- Enrollment and Disenrollment (Part C and D)
- Grievances (Part C and D)
- Special Needs Plans (SNPs) Care Management (Part C)
- Coverage Determinations and Exceptions (Part D)
- Organization Determination/Reconsiderations (Part C)
- Long-Term Care (LTC) Utilization (Part D), excluding pharmacy identifiable information. LTC pharmacy data will be aggregated.
- Medication Therapy Management (MTM) Programs (Part D), excluding beneficiary identifiable information.
- Redetermination (Part D)

The PUF will contain raw data that will display contract and plan ID numbers. All beneficiary-specific, proprietary, confidential and sensitive information will be excluded from the PUF. CMS is considering all comments that were provided before finalizing PUF specifications.

Specifics on the data elements to be included in the PUF can be found in the Health Plan Management System (HPMS) memo released April 28, 2014, titled *CMS First Public Use File (PUF) of Plan-Reported Data*.



MEDICARE PART D HOSPICE CLAIMS

Updated 2014 Requirements for Prospective Review

The Centers for Medicare and Medicaid Services (CMS) requires that Part D sponsors ensure that drugs and/or biologics that may be covered under the Medicare Part A hospice program benefit, do not pay on Part D. Drugs that are used for the palliation and management of a terminal illness and related conditions need to be billed to Part A for members that have elected their Hospice benefits.

Plans have typically used retrospective review and "pay and chase" processes to identify and redirect the billing of applicable hospice drug claims. For CY 2014, CMS strongly encourages plan sponsors to implement a prospective review of potential hospice drug claims by placing a beneficiary-level prior authorization on prescription drugs for patients enrolled in hospice.

Hospice Information Reported – Daily Transaction Reply Report (DTRR)

Hospice election information is sent to Plans on the DTRR which is used to update of the Plan's eligibility files. The DTRR includes a hospice indicator, a hospice start date and a hospice termination date. Hospice data are reported on the DTRR at the time of the beneficiary's enrollment in a Part D plan, or hospice election if that election is made later. Updated data are reported when the hospice start dates change to reflect a new benefit period or a termination date is added due to death, discharge or revocation of the election by the member.

Point of Service Edits and Messaging

The member's eligibility information and hospice indicator should trigger a prior authorization review by the Plan for appropriate billing. Plans are to apply National Council for Prescription Drug Programs (NCPDP) edits for prior authorization and messaging:

Code	Description
A3	This Product May Be Covered Under Hospice – Medicare A
75	Prior Authorization Required.
569	Provide Notice: Medicare Prescription Drug Coverage and Your POS messaging should also include information such as "Hospice Provider-Request PA" and reference to a 24-hour pharmacy help desk phone number to call or contact with questions.

MEDICARE PART D HOSPICE CLAIMS *(Continued)*

Coverag e Review and Determinations

Coverage of the drug claim is deemed payable under the Part D benefit if the Hospice provider and/or physician indicates that the drug is unrelated to the beneficiary's terminal diagnosis or related conditions. For documentation of review and coverage determinations, a best practice is to assure inclusion of the following:

- Patient current enrollment in Hospice
- Hospice name and contact information
- Confirm medication is or is not related to the terminal illness or related conditions and covered under the hospice benefit.

If medication is NOT related to the patient's terminal illness or related conditions, assure documentation of the hospice provider's explanation of why the condition being treated is unrelated and not covered under hospice (and likewise eligible for coverage under Medicare Part D).

In cases when the prescriber is unaffiliated with hospice and/or unwilling to coordinate with the member's hospice services to provide an explanation for the Prior Authorization (PA), Plans may contact the hospice agency directly for this information.

Coverage determination and adjudication timeframes that apply are 24 hours (expedited) or 72 hours (standard) starting from when the Plan receives the coverage determination request.

Retrospective Determinations of Payment Responsibility

Although prospective review will greatly improve directing of hospice drug claims to be billed appropriately, retrospective review is still necessary. If the Part D plan has paid for drug claims prior to receiving notification of the beneficiary's hospice election, the sponsor must perform a subsequent review of claims paid within the hospice election period and should conduct outreach to the hospice provider or prescriber to make retrospective determinations of payment responsibility for the drugs. In order to determine whether the drug is for treatment of a condition unrelated to the terminal illness or related conditions, CMS expects the prescriber or hospice provider to coordinate with the Plan regarding these claims and, as requested by the Plan, provide the necessary written information explaining that this is:

1. a drug unrelated to the terminal illness or related conditions; or
2. a beneficiary liability. For drugs that are to be covered through the hospice benefit and are, therefore, not covered under Part D, Plans must delete the PDE for the claim and remove the costs from the member's accumulators (e.g., TrOOP and gross covered drug costs.). Since the sponsor is recovering the Plan's paid amount from the member, the sponsor should not require the pharmacy to reverse the claim.

Many plans are assuring that operational policies and procedures are in place for the addition of prospective review of hospice claims for appropriate billing. This includes implementation and appropriate administration of system edits for prior authorization and POS messaging for timely coverage determination. For more specific details about CY 2014 Hospice Prescription Claims processing requirements, please see the available references below.

References:
1) Social Security Act. Hospice Care; Hospice Program, Section 1861(dd)
2) Federal Register, Hospice Care, Title 42, Part 418
3) Part D Payment for Drugs for Beneficiaries Enrolled in Hospice—Final 2014 Guidance, March 10, 2014
4) Part D Payment for Drugs for Beneficiaries Enrolled in Hospice, Q & A, updated April 18, 2014

Prepared by: Lynn Nishida, R.Ph. – AVP, Solid Benefit Guidance May 16, 2014

CY 2015 MEDICATION THERAPY MANAGEMENT PROGRAM

CMS recently released the guidance to Part D sponsors regarding contract year (CY) 2015 Medication Therapy Management (MTM) programs. The submission deadline is June 2, 2014; the module for submission was released on May 19, 2014.

A CMS-approved MTM program is a required element in a Part D sponsor's bid and must be submitted annually. (MTM program services are considered an administrative cost and must be included in the Plan bid.) This requirement does not apply to MA Private Fee-for-Service organizations or PACE organizations. However, CMS encourages these organizations to establish an MTM program to improve quality for Medicare beneficiaries. CMS will communicate with each sponsor regarding the status of the review of their MTM program, including if resubmission is required to correct deficiencies or if the program meets all of the minimum requirements for approval. Once MTM is approved, all changes to a Part D sponsor's approved MTM program for a given contract year must be submitted to CMS for review and approval prior to the implementation of the changes.

Requests for changes to an approved MTM Program are permitted for the following reasons:

1. Part D sponsors may make positive changes to the targeting criteria to make the eligibility more inclusive or to increase the number of beneficiaries eligible to receive Part D MTM services, including:
   - Decreasing the minimum number of multiple chronic diseases;
   - Expanding the list of specific chronic diseases that apply;
   - Decreasing the minimum number of multiple covered Part D drugs;
   - Expanding the list of specific covered Part D drugs, or types of drugs, that apply.
2. Part D sponsors may make program enhancements or maintenance changes, including changes to:
   - Frequency of identification to increase or promote ease of beneficiary participation;
   - Expand the levels of intervention or services provided to targeted beneficiaries;
   - Methods of documenting and measuring outcomes;
   - The qualified provider of MTM services.
   - Any fee schedules established for pharmacists and other MTM providers if using outside personnel. CMS will request that Part D sponsors disclose the newly established fees for outside personnel.
3. Part D sponsors may not make any negative changes to their MTM program, including changes that:
   - Promote discriminatory or exclusionary practices,
   - Decrease the number of enrollees eligible for MTM services,
   - Lower quality or robustness of MTM services.

CY 2015 MEDICATION THERAPY MANAGEMENT PROGRAM *(Continued)*

MTM Program

MTM is a patient-centric and comprehensive approach to improve medication use, reduce the risk of adverse events and improve medication adherence. At a minimum, Plan sponsors must offer each enrolled beneficiary ALL of the following:

1. Interventions for both beneficiaries and prescribers.
2. An annual comprehensive medication review (CMR) with written summaries in CMS' standardized format.
   - The beneficiary's CMR must include an interactive, person-to-person or telehealth consultation performed by a pharmacist or other qualified provider, and may result in a recommended medication action plan.
   - If a beneficiary is offered the annual CMR and is unable to accept the offer to participate, the pharmacist or other qualified provider may perform the CMR with the beneficiary's prescriber, caregiver or other authorized individual.
   - In the event the beneficiary is cognitively impaired or otherwise unable to participate, we recommend that the pharmacist or qualified provider reach out to the beneficiary's prescriber, caregiver or other authorized individual, such as the resident's health care proxy or legal guardian, to take part in the beneficiary's CMR.
   - An individualized, written summary in the CMS' standardized format must be provided following each CMR.
3. Quarterly targeted medication reviews (TMRs) with follow-up interventions when necessary. Part D sponsors must assess the findings of these reviews to determine if a follow-up intervention is necessary for the beneficiary and/or their prescriber. TMRs must be implemented once a beneficiary has enrolled, and if applicable prior to the completion of a CMR.

Beneficiaries enrolled in the MTM program may refuse or decline individual services without having to disenroll from the program. Sponsors may request changes to their CMS-approved program during any of the following Update Cycle windows:

- September 1 – September 10, prior to the contract year;
- March 1 – March 10, within the contract year;
- June 1 – June 10, within the contract year;
- September 1 – September 10, within the contract year.

Targeting Beneficiaries

Targeting beneficiaries for the MTM program must meet ALL of the following criteria.

1. Have multiple chronic diseases, with three chronic diseases being the maximum number a Part D plan sponsor may require for targeted enrollment. MTM program must contain at least five of the CMS-recommend nine core chronic conditions.
2. Are taking multiple Part D drugs, with eight Part D drugs being the maximum number of drugs a Part D plan sponsor may require for targeted enrollment.
3. Are likely to incur annual costs for covered Part D drugs greater than or equal to the specified MTM cost threshold. The 2015 MTM program annual cost threshold is $3,138.

The above criteria are the minimum threshold. Sponsors may also offer MTM services to expanded populations of beneficiaries who do not meet the criteria. Sponsors are also encouraged, but not required, to offer MTM services or other interventions to beneficiaries who fill at least one prescription for an anti-hypertensive medication to support the Millions Hearts Initiatives to control high blood pressure and improve access and adherence to these medications. Overutilization of opioids is another area CMS identified, whereby beneficiaries may benefit from MTM services. Beneficiaries which meet criteria are automatically enrolled in the program; however they do have the option to disenroll.

CY 2015 MEDICATION THERAPY MANAGEMENT PROGRAM *(Continued)*

Website and Outcomes

Sponsors are expected to include on their websites a separate section about MTM programs, written in plain language to describe the programs and services offered. They are also expected to have a process in place to measure, analyze and report the outcomes of their MTM programs. Reporting should capture drug therapy recommendations and resolutions made as the result of the MTM recommendations as well as beneficiary satisfaction with MTM services, providers and outcomes.

Star Measure

Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews will remain a display measure for 2015 ratings, using 2013 data. This measure is defined as the percentage of beneficiaries who met eligibility criteria for the Medication Therapy Management (MTM) program and who received a CMR. When added as a Star Rating in 2016, CMS plans to weigh the CMR measure as a process measure (1x). CMS reiterates that only those beneficiaries that meet the CMS specified targeting criteria are included in this measure. Additionally, CMS proposes to exclude hospice patients from this measure because sponsors may not be fully responsible for the management of the beneficiary's medication use during the time a beneficiary is under hospice care

MTM Audits

CMS may pilot MTM program audits as early as the 2014 or 2015 audit season. The results of any new, piloted audit protocol, including the proposed MTM audits, will not count towards the sponsor's program audit score or Part D Star Ratings for at least the first year that the protocol is piloted. Sponsors that participate in the pilot will be contacted directly by CMS after the pilot audit is completed and given the opportunity to provide feedback on their experience with the pilot audit process and the protocols.

TIMELINE
UPCOMING PART D

June 2, 2014	Deadline submission for the following; • CY 2015 bids for all MA plans, MA-PD plans, PDP, cost-based plans offering a Part D benefit, Medicare-Medicaid Plans (MMPs), "800 series" EGWP and direct contract EGWP applicants and renewing organizations • CY 2015 Formularies, Transition Attestations, Prior Authorization/Step Therapy (PA/ST) Attestations and P&T Attestations due from all sponsors offering Part D including Medicare-Medicaid Plans • CY 2015 MTM Programs from all sponsors offering Part D including Medicare-Medicaid Plans • CY 2015 contract non-renewal, service area reduction notice to CMS from MA plans, MA-PD plans, PDPs and Medicare cost-based contractors and cost-based sponsors
June 6, 2014	Deadline for submission of CY 2015 Supplemental Formulary files, Free First Fill file, Partial Gap file, Excluded Drug file, Over the Counter (OTC) drug file, and Home Infusion file through HPMS Deadline for submission of Additional Demonstration Drug (ADD) file (Medicare-Medicaid Plans Only
June 30, 2014	Final date to submit CY 2014 marketing materials to ensure timely CMS review and approval. NOTE: Plans/Part D Sponsors may continue to submit CY 2015 file and use materials as these may be filed in HPMS five calendar days prior to their use.
Early July, 2014:	2015 Plan Finder pricing test submissions begin
Mid-Late July 2014	CY 2015 Limited Formulary Update Window
August 22-26, 2014	CY 2015 preview of the 2015 Medicare & You plan data in HPMS prior to printing of the CMS publication (not applicable to EGWPs)
August 28-30, 2014	First CY 2015 Medicare Plan Finder (MPF) Preview and Out-of-Pocket Cost (OOPC) Preview in HPMS
Late August/ Early September 2014	Plan preview periods of Star Ratings in HPMS
September 1, 2014	Final date for Part D sponsors to execute and submit a revised Business Associate Agreement (BAA) with the Part D Transaction Facilitation Contractor, NDCHealth dba RelayHealth.
September 10-13, 2014	Second CY 2015 Medicare Plan Finder (MPF) Preview and Out-of-Pocket Cost (OOPC) Preview in HPMS

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