

Male Speaker:

Our next speaker is Abby Block. Abby has been director since 2005 of the Center for Beneficiary Choices at CMS. In this position, she is responsible for operations and oversight of all Medicare Part C and Medicare Part D. Prior to her leadership of CBC, Abby was a senior advisor to CMS administrator Mark McClellan. Before moving to CMS, Abby was deputy associate director at the U.S. Office of Personnel Management where she led the Federal Employee Health Benefits Program. Please join me in welcoming to the podium someone for whom quality is surely job one, Abby Block.

[applause]

Abby Block:

Thank you, Chris. Let's see if I can -- ah, there we go. Okay, I'm going to talk a little bit today about the history of quality and performance measurement in Medicare Advantage. As you may or not know, staff from HCFA/CMS and HHS have long been involved in developing and refining health plan quality and performance metrics, even before they were used in the Medicare Plus Choice and Medicare Advantage Programs. For example, CMS staff served on the CPM for HEDIS measures for many years, and I know that because I served on the CPM for many years, almost from its inception when I was at OPM and got to know quite well some of the CMS or at that time, HCFA representatives. We all worked together for a long time through the development of HEDIS to what it is today.

In the early 1990s, some states required Medicaid programs to collect this data on Medicaid-managed care programs. And in the late 1990s, following the Balanced Budget Act, CMS began collecting HEDIS CAPS and later HOSS data from Medicare managed care plans. The decision to begin quality and performance data collection was motivated by several factors. First of all, of course, the need for accountability to oversee both plans and beneficiaries, the desire to make evaluation of managed care plans more objective; the desire to improve the value in government purchasing.

Reporting year 1997 was the first year of data collection. The data was used in various agency initiatives, including the Medicare compare Web site and a bar chart form in 1999. The Medicare and You handbook in 2000 reports to plans for use in quality improvement programs and in HHS Government Performance and Results Act goals. So at that time, you know, various uses for the data that was beginning to be collected.

By 2000-2001, CMS had enough data to create a plan rating system which eventually became the Performance Assessment System. It incorporated various data sources into a swing database in HPMS. It generated plans ranking based on performance relative to other plans, using individual and composite measures and allowed CMS to reward high performance plans. The reward that was used then and is still in place now was actually an exemption from certain features of the standard plan audits. That's not quite pay for performance, and so we're a long way from, you know, where eventually we hope to be going.

In terms of the current quality and performance metrics that are in place, we use HEDIS. We use HOSS, we use CAPS, we use independent review entity data. We use Part D performance measures. And I think you'll be hearing in more detail about all of those measurement systems today and tomorrow from CMS staff who are on the agenda to speak at this conference.

So current quality and performance measurement in Medicare Advantage. Where are we today? Over time, metrics and measurement systems have expanded and evolved. Goals remained largely the same -- accountability, value-based purchasing and objectivity in program evaluation -- to provide performance and quality-based information to beneficiaries to make enrollment decisions. For example, we have MA and prescription drug plan ratings. And two, to demonstrate the value of performance, for example, special needs plans quality measures. Previously, limited plan performance information was available on the Medicare Web site. But in 2007, CMS significantly revamped MA and Part D plan reporting on Medicare.gov. We organized the measures into domains and measure level ratings. We introduced a five-star rating system and made the information accessible and comprehensible to beneficiaries, which was the key.

So this is what the home page looks like. And this is how you would get to the plan ratings. And all this is really important, because for the first time in 2007, we actually linked these performance measures and plan ratings to the rest of the plan selection tool so that a beneficiary who was looking at information in order to help them select a plan would not only find all of the information about the plan's price, the premium, benefit structure, the providers and so on, but they would also find readily available in the same place on the same tool, the quality information, and that was really a first.

So here are some examples of the domains that we used. This is managing chronic conditions. And some of the measures that are included in that domain, as you can see, it's broad range of measures: osteoporosis measurement, diabetes care, several diabetes care measures, anti-depressant medication management, controlling blood pressure, rheumatoid arthritis management, testing to confirm chronic obstructive pulmonary diseases, continuous beta-blocker treatment. So a broad range of measures that measure managing chronic conditions.

So as I said, we had a five-star system, and the real innovation in 2007 was that we not only showed a comparison of plans, but we placed that comparison in a framework of comparisons to agreed upon standards. So this was unique for Medicare Advantage and prescription drug programs. The five-star system is not yet available for hospitals or nursing homes, but it's a direction in which CMS is actually starting to move.

So what's the significance of plan ratings? Plan ratings improve our ability to identify high performing plans and also to identify, you know, those plans that need improvement. They also substantially expand information available to beneficiaries for selecting high quality health and prescription drug plans.

I mentioned earlier special needs plans quality measures. This is a whole new area for us. Since

5/22/2008

CMS – Abby Block

their inception, there's been the expectation that SNPs would provide more meaningful health services choices for beneficiaries than other MA plans. Yet, neither the statute nor our regulations provide specific guidance on how to specialize clinical programs. There was a total lack of quality and performance data that really hampered or ability to demonstrate how these so-called special needs plans are special.

The tremendous growth in SNPs and SNP enrollment, you know, further justified and in fact really further demanded the need for quality metrics. So CMS and the geriatric measurement panel or the GMAP of the NCQA worked collaboratively to develop initial recommendations for SNP quality measures. In November of 2007, the GMAP finalized their measure recommendations from existing measures. And this was step one, by the way. There really wasn't sufficient time to develop and put in place a new measurement set. So we, in agreement with NCQA and the GMAP decided that what we would do for year one was work with existing HEDIS measures and other measures. And so what NCQA put together were 13 HEDIS measures and a set of structure and process measures. Those measures were on display for public comment through January of 2008. The HEDIS measures remained the same but minor modifications were made to the structure and process measures based on the public comment that was received.

But the SNP measures will be collected for contract year 2009, and training for health plans on reporting requirements is currently underway. And where we go, of course, in the future with SNP measures is very significant. This is a process under development. In terms of measurement categories, we're looking at benefit design, risk assessment and care planning, coordination of services, caregiver engagement, which is really, you know, critical in this area, internal measurement of performance, and both beneficiary and caregiver experience.

So, where are we at the moment? Currently CMS only measures plans at the contract level, not at the plan benefit package level and only for contracts with 1,000 members. But for the SNP-specific measures, we will collect them from every SNP and will collect them at the plan benefit package level. So this is really new territory in terms of measurement collection at CMS. The HEDIS measures and structure and process measures to be used in 2008 are part of a three-year strategy proposed by NCQA. For 2009 and 2010, some of these measures will be further refined for SNP-specific use and additional measures will be developed and collected.

Let me just say a little bit more about the SNP process. As you probably know, there is a moratorium on SNP plans for contract year 2009, so we are not accepting applications for any new SNP products in 2009, but we already have over 700 SNP plans in the Medicare Advantage Program. And so there is quite a broad base there and a lot of congressional interest in terms of how to move forward with this program. And there are, you know, various alternatives. The program could just be sunsetted so that the SNP product would no longer exist as a discreet product within Medicare Advantage. Or it could be extended, but extended with, you know, specific conditions and provisions. And so the measurements that we are going to put out publicly will be very, very significant in terms of not only the CMS decision-making process, but the congressional decision-making process as well. There are many, many people out there are that are extremely interested in seeing some kind of demonstration of what the special value

5/22/2008

CMS – Abby Block

of these so-called special needs plans really is, and so this measurement and effort has very, very great significance. And we're looking forward to our continued work with NCQA, hopefully moving forward through this, you know, three year project to develop this new and special measurement set.

So what's the future of quality and performance measures in Medicare Advantage? We certainly need to improve, you know, our current quality measurement initiatives. While the current initiatives achieve some of CMS's quality and performance measurement objectives, they're constrained by the sources and types of data that's gathered, by plan monitoring and compliance infrastructure, and by limitations of consumer tools. There are several sources and types of data available, but you know we obviously have a wish list in terms of expanding, you know, the somewhat limited available data sets. We're looking ahead, as I said, to the next stages of SNP measurement. We're also just beginning really a Part C performance measurement initiative. And we're looking at MA utilization data. And this is another very new and critical initiative that we're just beginning to undertake.

We have had many questions, as you may know, from the Hill and from other sources about how the extra benefits that beneficiaries in Medicare Advantage plans receive -- how they're actually utilized by those beneficiaries. It's very clear, and you all, I'm sure, are well aware, that plans use their rebate money to provide extra benefits for the people who enroll in Medicare Advantage plans. So we know very clearly what's offered, but the question we keep getting from the Hill in particular is, "Well, you know what's offered, but you have no idea of what beneficiaries are actually using." So we're starting the process now and moving ahead into 2009 and forward to begin collecting MA utilization data so that we will actually have concrete information not only about the benefits, the extra benefits that Medicare Advantage plans can offer, but also about how beneficiaries are actually using those benefits. We're also looking ahead to improvements to HEDIS measures. And some of these efforts, as I said, are already underway.

The other big area for us is plan monitoring and compliance. We have an integrated plan for how to use plan-rating information for purposes of plan monitoring and compliance and plan improvement. And this is something that we really need to develop and get to a point where it becomes more useful, even more useful than what we have now.

Another key area that I've mentioned several times is consumer information. Of course, you know, we need to research and monitor to determine if and how consumers are using quality and performance data through Medicare.gov and other portals. So we have some consumer testing underway of Medicare options compare and the prescription drug plan finder. And I can say as an aside, having spent many, many years working in the area of quality measurement, that the whole area of making this information useful and meaningful to consumers and encouraging and educating consumers to use this information is one of the key, really key objectives of all the work we do. Because we can develop all the measures in the world, but if nobody uses the information, if it isn't being used by consumers, as well as by, you know, CMS and others, we have not really achieved our goal. So consumer information is a two-pronged effort. Number one there is the effort to develop the information, but the second, and I think at least equally

5/22/2008

CMS – Abby Block

important prong is getting people to use the information once we provide it.

Some other things looking forward, there is an organization fairly recently developed organization called the PQA, or the Pharmacy Quality Alliance. It was launched through a CMS open door forum, and CMS is a member of the PQA Steering Committee and an active member on PQA work groups. CMS supports the promotion of high value pharmacy services, including measurement approaches through a stakeholder-led pharmacy quality alliance. The measures being developed by PQA and its stakeholder for pharmacy quality and patient satisfaction will be considered for use by CMS in the Part D plan ratings. So we're very much looking forward to that. Once we have the measures that are being developed through the PQA, the Part D plan ratings will be far, far more robust than they are now. We have good measures out now, but they are primarily plan performance measures, and so we're really looking forward to being able to integrate the PQA measures into that measurement set. And with that, if we have time, questions?

Male Speaker:

Again, this conference is being recorded, so if you have questions for Abby, please come up to any of the four microphones located across the hall.

Peter Fitzgerald:

Hi, I'm Peter Fitzgerald with the National PACE Association, and one of the things we're looking at within our model is increased emphasis on consumer directed care. And I wonder if at CMS you have any thoughts on how we'll measure the quality impact of consumer directed care where as a comprehensive plan, we're still responsible for that care, but much of the delivery is now in the hands of consumers?

Abby Block:

Well that's a really good question and that's a real challenge. I think, you know, there are some things in place that help us do that. Certainly, some of the survey instruments are useful in that regard. And we're very interested, you know, in using and do use the information, you know, that we get from the CAP survey, for example, from HOSS and other, you know, instruments such as that.

We also, you know, do focus groups with beneficiaries, but I think, and particularly in the PACE Program, it would be very important to enhance the effort to get feedback from caregivers. The PACE population is a particularly vulnerable population, and while certainly we would want to get, you know, responses from the participants themselves, it would be very useful, you know, for PACE participants and others to really talk more to caregivers and get some of their input in terms of how they see things working.

Female Speaker:

At P&G, a lot of people know of us for consumer marketing expertise. We have worked with NCQA and our health care consumer institute. One of the challenges for a program like Medicare is you have a responsibility to communicate with everyone. But part of what we learn is that people respond to different forms of communication, so we often segment. And so I'm

5/22/2008

CMS – Abby Block

wondering, is if you might talk about CMS's perspective on segmentation, an idea that communicating in different ways to different segments of the Medicare population will resonate better, motivate people better, and you know, how might one achieve that in such a large encompassing program.

Abby Block:

Well I can only say that it's certainly a worthwhile goal. And it's something that we try to do and do in a limited way. We do have special publications for specific target audiences and so on. But, no doubt, you know, a lot more work could be done in that direction, and it's just really an issue of resources, you know, both staff and money, to be able to develop the broad variety of products that you're talking about. I can't see how anyone would disagree with the goal, so it's certainly something to work toward in the future.

Renee Underwood:

Hello, I'm Renee Underwood, Senior Vice President of Health Services for Health Spring, Inc. We're in five states, and we have MA plans as well as SNPS. And one of the things that's been very interesting to me is my background as a nurse is particularly with the SNPS in hypertension. As you study compliance, because compliance is the piece that I always look to, are the members taking their medications? And one of the things I've found is they are taking their medications, but there really needs to be another step in that because the physicians have patients on medication, but they're poorly controlled in terms of their hypertension. So I guess my question for you from the CMS perspective, because we work so closely with our providers, is what steps would you take within the CMS to get the physicians more engaged in the AMA, more engaged, and following JNC7 guidelines and those types of things to make sure patients are on the right meds for the right diagnosis? Loaded question, isn't it?

Abby Block:

Well I would turn that around and say that's one of the things we expect you all to do.

Renee Underwood:

And that's what my company does.

Abby Block:

That's the job of a SNP. That's why you're a special needs plan, and one of the things, as I know you well know, that we've started to ask the special needs plans to give us -- last year on the application process and this year -- will be, you know, doing it with the existing plans since we have a breathing spell with the moratorium. We're looking for models of care. We're looking for you to tell us exactly how you're going to work with your participating physicians and so on to address exactly those issues. So I think that that's something that special needs plans are uniquely able to do and hopefully are doing.

Renee Underwood:

Absolutely. Thank you.

Male Speaker:

5/22/2008

CMS – Abby Block

Any additional questions for Abby? Thank you again, Abby, for your great presentation, and for being here with us today.

Abby Block:

Well, thank you.

[applause]