MEDICARE PART D STAR RATINGS & PHARMACY PERFORMANCE
WHO IS GORMAN HEALTH GROUP?

Gorman Health Group is the leading solutions and consulting firm for government-sponsored health programs.

Government Programs
Leading enterprise of national consulting services and software solutions for payers and providers.

Our Mission
Our mission, as the industry’s most active professional services consultancy and provider of technology-based solutions, is to empower health plans and providers to deliver higher quality care to beneficiaries at lower costs, while serving as valued, trusted partners to government health agencies.

Washington, DC
Headquartered in Washington, DC with more than 200 staff and contractors nationwide with over 2,000 combined years of Government Programs experience.

Leadership
Deep payer and provider knowledge coupled with Centers for Medicare & Medicaid Services (CMS) regulatory expertise.

Privately Owned
Founded in 1996
Our clients have **one-stop access to expert advice, guidance, and support**, in every strategic and operational area for government-sponsored programs, across seven verticals.

**CLINICAL**
Changing how you approach Medical Management, Quality and Stars

**PHARMACY**
Leading experts in Part D, PBM, formulary and pharmacy programs

**HEALTHCARE ANALYTICS & RISK ADJUSTMENT SOLUTIONS**
Implementing cross-functional risk adjustment programs for medical trend management and quality improvement

**PROVIDER INNOVATIONS**
Supporting network design and medical cost control implementation

**COMPLIANCE**
Offering guidance and support in every strategic and operational area to ensure alignment with CMS

**OPERATIONS**
Bringing excellence to every aspect of your implementation from enrollment to claims payment

**STRATEGY & GROWTH**
Leading experts in Marketing, Sales and Strategy development that create short and long-term profitable growth
MEDICAID SERVICES

Dedicated to assisting Medicaid Managed Care Organizations achieve **strategic, operational, and quality** goals across five verticals.

**CLINICAL**
Blending medical and pharmacy to improve care coordination, outreach and utilization management to meet the complex needs of your membership.

**FINANCIAL ALIGNMENT**
Providing health economic solutions for the needs of the Medicaid population including long-term care, behavioral health, and chronic condition management.

**STRATEGIC POSITIONING**
Analyzing and evaluating organizational adaptability, and readiness for change in new policy and population management environments.

**QUALITY PROGRAM OVERSIGHT**
Guidance and support to achieve the results your members and regulators expect while attaining compliance with State and Federal rules.

**OPERATIONS**
Creative solutions to maximize cost effectiveness, and deliver lasting results from eligibility to provider contract management, and claims.
PRODUCT SERVICES

Software solutions to stay compliant, maximize revenues, and manage complex processes.

SALES SENTINEL™
Sales Sentinel™ is a module-based software solution designed to assist government managed care organizations onboard agents, provide training, manage ongoing oversight activities, and pay commissions effectively and compliantly.

VALENCIA™
Valencia™ provides rigorous, compliant, and transparent workflow controls that ensure your operational processes — and the resulting payment — are as accurate as possible.

OMT™
OMT™ is the complete compliance toolkit designed to perform ongoing monitoring and auditing, manage regulatory notices, document corrective actions, and streamline member material review.

CaseIQ™
CaseIQ™ not only captures all of the data points needed to categorize, work, and report MA and Part D appeals and grievances, it also guides case processors through each case to minimize the risk of non-compliance due to user error.

Gorman University™
Gorman University™ provides training sessions on a variety of industry topics, each designed to meet the unique needs of your organization.

The Point™
The Point™ provides a clean and concise view of constantly updated content, delivering all the industry information you want, when you need it.
TODAY’S AGENDA

• Key Elements of the Current Part D Star Ratings Landscape
• Fine-tuning the PBM Relationship
• Analytic Best Practices to Monitor and Optimize Medication-related Metrics
• Performance-based Pharmacy Networks
• Community Pharmacists – An Untapped Resource
Of the 9 triple-weighted ratings, 7 are directly or indirectly related to medication therapy.

Plan ratings can have an impact on enrollment.

Very small improvements in performance measures can have a large impact on Star Ratings.

Conversely, inattention to medication therapy can impact a plan’s entire Star Rating.

Plans may treat PDP and MA-PD Star Ratings efforts very differently for obvious reasons – how does this differentiation occur?
### RATINGS CHANGE YEAR OVER YEAR

#### 2016 vs. 2015 Part D Ratings

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Improvement Measure</th>
<th>Weight</th>
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</thead>
<tbody>
<tr>
<td>Call Center – Foreign Language Interpreter and TTY Availability</td>
<td>Call Center</td>
<td>No</td>
<td>1.5</td>
</tr>
<tr>
<td>Appeals Auto-Forward</td>
<td>IRE</td>
<td>Yes</td>
<td>1.5</td>
</tr>
<tr>
<td>Appeals Upheld</td>
<td>IRE</td>
<td>No</td>
<td>1.5</td>
</tr>
<tr>
<td>Complaints about the Drug Plan</td>
<td>CTM</td>
<td>No</td>
<td>1.5</td>
</tr>
<tr>
<td>Members Choosing to Leave the Plan</td>
<td>Medicare Beneficiary Database Suite of Systems</td>
<td>Yes</td>
<td>1.5</td>
</tr>
<tr>
<td>Beneficiary Access and Performance Problems</td>
<td>CMS Administrative Data</td>
<td>No</td>
<td>1</td>
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<tr>
<td>Drug Plan Quality Improvement</td>
<td>Star Ratings</td>
<td>No</td>
<td>5</td>
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<tr>
<td>Rating of Drug Plan</td>
<td>CAHPS</td>
<td>Yes</td>
<td>1.5</td>
</tr>
<tr>
<td>Getting Needed Prescription Drugs</td>
<td>CAHPS</td>
<td>Yes</td>
<td>1.5</td>
</tr>
<tr>
<td>MPF Price Accuracy</td>
<td>PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medi-span</td>
<td>No</td>
<td>1</td>
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<tr>
<td>High Risk Medication</td>
<td>Prescription Drug Event (PDE) data</td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>Medication Adherence for Diabetes Medications</td>
<td>Prescription Drug Event (PDE) data; Medicare Enrollment Database (EDB) File; Common Working File (CWF)</td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>Medication Adherence for Hypertension (RAS antagonists)</td>
<td>Prescription Drug Event (PDE) data; Medicare Enrollment Database (EDB) File; Common Working File (CWF)</td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>Medication Adherence for Cholesterol (Statins)</td>
<td>Prescription Drug Event (PDE) data; Medicare Enrollment Database (EDB) File; Common Working File (CWF)</td>
<td>Yes</td>
<td>3</td>
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<tr>
<td>Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews</td>
<td>Part D Plan Reporting</td>
<td>No</td>
<td>1</td>
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</tbody>
</table>
THE NOVELTY HAS WORN OFF

Create and Refine Your Stars Game Plan

- Revisit analytics and reporting
- Catalog and evaluate your current Part D tactics
- Decide how your PBM can help you or hurt you and act accordingly
- Take a fresh look at partnering with providers, especially retail pharmacists
REFINE YOUR STARS GAME PLAN

• Revisit your vision for Part D Stars leadership and accountability within your organization:
  o Are the right team(s) designing and leading Part D Stars initiatives?
  o What staff is conducting Part D Stars initiatives? What part is your PBM playing as part of your leadership team (more on this later)?
  o Who is responsible for data/analytics for Part D Stars initiatives?
  o Do you have the right outcomes methodology monitoring so you know what is working (near and long term)?
  o Do you have adequate funding for Part D Stars activities?
  o How are Part D Stars activities coordinated with providers (including pharmacies, medical providers) and PBMs?

• Implement frequent, productive communication and monitoring.

• Include clinical and operational experts on the Stars team.
MEASURE THEN MANAGE

Establish Analytic Ground Rules

- Drive medication measurement methodology consistency across the organization – is it PDC? MPR?
- Establish uniform look-back periods for targeting poor-performing members – “distinct plan year” vs. “year over year.”
- Update methodology as PQA specifications change and sync them correctly, i.e., HRM lists, added or deleted medications.
KEY PBM ATTRIBUTES TO ENSURE A SUCCESSFUL STARS PARTNERSHIP

It’s Not Only the Medication Metrics

• Knowledgeable Med D operations team – in addition to the medication metrics, understand where else your PBM can cause member dissatisfaction and CMS compliance problems
  o Coverage determination timeliness
  o Benefit set-up/reject code verbiage
  o Transition functionality
  o Medicare Plan Finder file accuracy
  o Acumen outlier support

• Knowledgeable Med D clinical program/Stars team
  o Tailorable programs and solutions that are driven from real-time claims
  o Collaborative relationship built on mutual goals and expectations
  o Star “friendly” formularies
LOOK TO YOUR PBM FOR ANALYTICS: “REAL TIME” AND ACTIONABLE

Targeting Your Efforts Means Investing in Analytics

• PDCs reported on a monthly basis beginning with Q2
• CMS consistent methodology verified
• Stars Report Cards reflective of:
  o Members
  o Pharmacies
  o Physicians
• Activity drill-down reports – available as frequently as “actionability” will allow
Exhibit 3.8

Number of Medicare Part D Stand-Alone PDPs using Preferred Pharmacy Networks, 2011-2014

<table>
<thead>
<tr>
<th>Year</th>
<th>PDPs using preferred networks</th>
<th>Other PDPs</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>2011</td>
<td>1,026</td>
<td>83</td>
<td>1,109</td>
</tr>
<tr>
<td>2012</td>
<td>892</td>
<td>149</td>
<td>1,041</td>
</tr>
<tr>
<td>2013</td>
<td>520</td>
<td>511</td>
<td>1,031</td>
</tr>
<tr>
<td>2014</td>
<td>328</td>
<td>841</td>
<td>1,169</td>
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</tbody>
</table>

2015 = 87%

NOTE: PDP is prescription drug plan. Excludes plans in the territories.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.
THE PBM MANAGES THE PHARMACY NETWORK RELATIONSHIP

The Game Is Changing

- “CVS Health (CVS) confirmed its Caremark pharmacy benefit management subsidiary would sell a smoke-free drugstore network to employers and health plans that would provide subscriber discounts for using “tobacco-free” pharmacies.”

- Isn’t this the definition of a preferred network based on quality vs. simply relying on reimbursement as the sole preferred network status criteria?

- What other attributes will follow for preferred network status in the future?
The motivation of health plans and PBMs in forming preferred pharmacy networks is clear: to control costs and increase profitability.

To participate in a preferred network, pharmacies must typically be willing to accept reduced reimbursement, thereby helping health plans, PBMs, and employers control costs.
Increasing Member Enrollment

Highly rated plans get certain marketing and enrollment advantages, which also boosts plans’ revenue. Members in a low-rated plan can switch to a 5-star rated plan at any time throughout the year, not just during open enrollment.

Increasing Revenue

Medicare Advantage plans and Medicare drug plans are being rated annually on their performance, on a scale of 1 to 5 stars (“Star Ratings”). MA-PD plans achieving Star Ratings of 4 (“above average”) or 5 (“excellent”) receive quality bonus payments, which can potentially represent millions of dollars in revenue.
THE CARROT
Extending P4P to the Retail Pharmacy Setting

• Health plans are rewarding top-performing physicians through Pay-for-Performance (P4P) models.
• A few health plans have started to venture into P4P for pharmacies, such as HealthPartners, Humana and Inland Empire Health Plan (IEHP).
• IEHP, a non-profit managed Medicaid health plan covering 720,000 lives in southern California, has started one of the first large P4P programs for community pharmacies in the country. Special needs health plan’s network encompasses nearly 720 pharmacies, split between chains and independents.
VALIDATING THE ROLE OF THE COMMUNITY PHARMACIST

Promoting Quality

• Under IEHP’s Pharmacy P4P Program, launched in October 2013, pharmacies will be eligible for a bonus payment every six months based on the quality of medication-related care they provide to IEHP members.
• Participating pharmacies are evaluated on how they perform on Medicare Part D Star Ratings measures (e.g., medication adherence and safety) plus asthma and generic dispensing rate compared to pre-determined standards.
• Each pharmacy in the IEHP network is able to track its performance via personalized dashboards within PQS’ EQuIPP platform.
• IEHP has publicly recognized pharmacies that achieved high-quality scores.

HEALTH PLAN / COMMUNITY PHARMACY COLLABORATION

Rate the Star Performance of the Pharmacies in Your Network

• **Network Pharmacy Report Cards**
  - Allow for an overlay of the plan member with the pharmacy they frequent in conjunction with the Star performance of the pharmacy
  - Enable the plan to act in real time as data becomes available throughout the plan year
  - Provide the opportunity to target specific members at the pharmacy to close Star gaps!
ONCE THE PRIORITIES HAVE BEEN IDENTIFIED...

Health Plans Can’t Simply Direct the Pharmacy to “Just Do It”

- Dialogue should be ongoing throughout the plan year
- Health plan and pharmacy chain should share best practices
- Health plan should understand what retail pharmacy might already be doing to drive Star Ratings with their members
- Health plan needs to think of the pharmacist as a “provider of service”
COMMUNITY PHARMACY

Looking Beyond the Medication Measures

- Annual influenza vaccine
- CV care – cholesterol screening
- Care for older adults – medication review
- Care for older adults – pain screening

- Colorectal cancer screening
- Diabetes care – cholesterol
- Diabetes care – eye exam
- Osteoporosis management
- Reducing the risk of falling

MTM can drive many of these measures but not for enough members. Are there modified MTM processes that can address the non-qualifiers?
LEVERAGE YOUR PHARMACY EFFORTS TO PROMOTE MEMBER ENGAGEMENT

• Support and promote the pharmacist as a way to move the Stars needle with your members
• Leverage pharmacy interventions with case managers, etc., to address medication topics
• Use inbound calls as referral opportunities to drive CMR rates, adherence counseling, etc.
• Coordinate or conduct brown-bag sessions and focus groups
#### DISPLAY MEASURES ARE IMPORTANT AND MAY COUNT SOME DAY

<table>
<thead>
<tr>
<th>2015 Part D Display Measures</th>
<th>Part C Medication-related Display Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>- MTM Completion Rate</td>
<td>- Antidepressant Medication Management</td>
</tr>
<tr>
<td>- Transition Monitoring (2 new measures)</td>
<td>- Beta-Blocker Treatment after a Heart Attack</td>
</tr>
<tr>
<td>- Grievance Rate per 1,000 Enrollees</td>
<td>- Pharmacotherapy Management of COPD Exacerbation</td>
</tr>
<tr>
<td>- Combined MPF Price Accuracy</td>
<td>- CAHPS Measures about Contact from a Doctor’s Office, Health Plan, Pharmacy, or PDP</td>
</tr>
<tr>
<td>- Disenrollment Reasons</td>
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<tr>
<td>- Beneficiary Access and Performance Problems</td>
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<tr>
<td>- Drug-Drug Interactions</td>
<td></td>
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<tr>
<td>- Diabetes Medication Dosing</td>
<td></td>
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</tbody>
</table>

**2016 D Ratings**
AN EXPANDED DEFINITION OF QUALITY

National Quality Strategy – “Triple Aim”

- Better care for patients
- Healthier people and healthier communities
- Lower costs through improvements in the health care system

- Expanded thinking around programs that fall into these broad categories improves Star Ratings and also positions for the future
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Gorman Health Group, LLC (GHG) is a leading consulting and software solutions firm specializing in government health programs, including Medicare managed care, Medicaid and Health Insurance Exchange opportunities. For nearly 20 years, our unparalleled teams of subject-matter experts, former health plan executives and seasoned health care regulators have been providing strategic, operational, financial, and clinical services to the industry, across a full spectrum of business needs. Further, our software solutions have continued to place efficient and compliant operations within our client’s reach.

GHG offers software to solve problems not addressed by enterprise systems. Our Valencia™ software reconciles the capitation payment of more than six million Medicare beneficiaries and continues to support customers participating in the Health Insurance Exchanges. Nearly 3,000 compliance professionals use the Online Monitoring Tool™ (OMT), our complete Medicare Advantage and Part D compliance toolkit, while more than 45,000 brokers and sales agents are certified and credentialed using Sales Sentinel™. In addition, hundreds of health care professionals are trained each year using Gorman University™ training courses.

We are your partner in government-sponsored health programs