Volume 23, Number 20 *October 19, 2017*

MEDICARE ADVANTAGE NEWS

News and Analysis of Medicare Advantage, Medicare Part D and Managed Medicaid

Contents

3 MA, Part D Sponsors Tout Extra Benefits, Provider Pacts for 2018

4 In Age of Uncertainty, Some States Seek Medicaid Work Requirements

4 Table: States With Notable 1115 Demo Waivers Recently Approved or Pending

5 Insurers, Provider Partners Seek Delay of Health Insurance Tax

7 Table: Overall Star Rating Distribution for MA-PD Contracts, 2015-2018

8 News Briefs

Managing Editor
Lauren Flynn Kelly
lkelly@aishealth.com

Executive Editor
Jill Brown

Plan Crosswalking, Moving Cut Points May Explain Stagnation in 2018 Star Ratings

The highly anticipated release of 2018 star quality ratings data for Medicare Advantage and Part D plan sponsors indicated relatively stable performance compared with prior years, as the average overall star rating for MA Prescription Drug plans (MA-PDs) inched up from 4.02 for the 2017 ratings to 4.06 for 2018 (see table, p. 7). And as the data showed a slight drop in the number of MA-PD contracts earning 4 stars or higher, they also revealed a greater percentage of beneficiaries enrolled in high-performing plans. But for most of the publicly traded managed care organizations, the ratings declined, meaning a decrease in bonus payments expected in 2019, observed securities analysts.

According to the data posted on Oct. 11 to the Part C and D Performance Data page at www.cms.gov, approximately 44% of MA-PDs (170 contracts) that will be offered in 2018 achieved overall ratings of 4 or above, down from 49% of plans (178 contracts) offered in 2017. Weighted by enrollment, nearly 73% of MA-PD enrollees are currently in contracts that will have 4 or more stars in 2018, compared with approximately 69% based on 2017 star ratings, CMS said.

Akhil Rao, specialist master with the health plan practice at Deloitte Consulting with a focus on government programs, remarks that these changes are evidence of sponsors that have been earning higher reimbursement bonuses investing that money back into their plans to enhance their benefits. "I think it's a [reflection] of members choosing those high-performing plans because the benefits are way better at that same level than those that are not able to offer those great benefits, so there's a drive during the [Annual Election Period and Special Election Period] to move toward these high-quality plans," he tells AIS Health.

continued on p. 6

Calif. Ruling, DOJ Dismissal Are Tentative Wins for UnitedHealth in False Claims Fight

A recent ruling in an ongoing False Claims Act lawsuit against UnitedHealth Group may be a minor victory for the health insurer as it battles federal allegations of inflating Medicare Advantage risk-adjusted payments and "looking the other way" when medical chart reviews turned up invalid diagnoses. The ruling prompted the Dept. of Justice (DOJ) to drop that suit, although the District Court for the Central District of California in its Oct. 5 order gave the federal government room to amend the complaint.

Insurers should not take comfort from these developments, advisers warn, as the DOJ has not abandoned a parallel whistleblower suit pending in the same district and the government's interest in MA plan practices is likely to continue.

The federal government on May 1 intervened in allegations against UnitedHealth contained in the Fourth Amended Complaint (FAC) filed by former SCAN Health Plan employee James Swoben *(MAN 5/11/17, p. 8)*. The whistleblower filed his initial suit against SCAN in 2009, adding UnitedHealth and others that same year and additional

insurers in future via amended complaints alleging that the carriers conducted retrospective reviews of patient records in order to identify only additional diagnosis codes that would drive higher MA risk scores leading to enhanced risk-adjusted payments. SCAN in 2012 settled with the United States and Swoben, but the plaintiff continued to pursue his case against the remaining defendants. The DOJ earlier this year intervened in the allegations against UnitedHealth and filed a separate complaint-in-intervention (*U.S. ex rel. Benjamin Poehling v. UnitedHealth Group, Inc.*, 16-08697).

Both complaints charged that the insurer for years conducted a chart review program designed to identify additional diagnoses not reported by treating clinicians that would boost payments and alleged that the insurer ignored certain information uncovered through the chart reviews to avoid repaying the government for funds it was not owed.

UnitedHealth has said it rejects the claims in both suits and in July sought dismissal of *U.S. ex rel. Swoben v. Secure Horizons, et al.* (09-5013) for the government's failure to state a claim *(MAN 7/27/17, p. 8)*. In a motion filed July 14, UnitedHealth took issue with various aspects of the DOJ's adoption of the whistleblower's FAC, arguing that Swoben's claims were based on conduct that allegedly took place 10 years prior to the March 2017 filing of the FAC and are thus barred by the statute of repose.

Medicare Advantage News (ISSN: 1089-6589) is published 24 times a year by AISHealth, 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Managing Editor, Lauren Flynn Kelly; Executive Editor, Jill Brown; Marketing Director, Donna Lawton

Subscriptions to *MAN* include free electronic delivery in addition to the print copy, e-Alerts when timely news breaks, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of *MAN* content and archives of past issues.

To order an annual subscription to **Medicare Advantage News** ($636 bill me; $586 prepaid), call 800-521-4323 (major credit cards accepted) or order online at www.AISHealth.com.

UnitedHealth also pointed out that the Ninth Circuit Court of Appeals, which upheld an earlier court decision to dismiss the case, "expressly refused" to address Swoben's "reverse false claims theory" that he attempted to revive in the FAC.

The district court on Oct. 5 agreed with both points and granted the motion, but dismissed certain other arguments with leave to amend. For one, the district court found that the DOJ's complaint-in-intervention failed to identify the corporate officers who signed attestations to the allegedly fraudulent risk adjustment or that those individuals "knew or should have known that the attestations were false." The court also found that the complaint lacked the specificity to satisfy Rule 9(b), which requires that a "party must state with particularity the circumstances constituting fraud or mistake," according to the Oct. 5 order.

"This is certainly an important decision...and a big win for United to get a dismissal at this early stage in this kind of litigation. That said, DOJ will have an opportunity to refile," observes Bob Ramsey, a shareholder in Buchanan Ingersoll & Rooney's health care section, where he represents health care providers in a variety of regulatory, transactional and reimbursement matters. "The [DOJ has] invested a fair amount of time and effort and resource into this so far, so I would anticipate that it's not going to fold its tent and go away. And I wouldn't be surprised if the DOJ continues to press forward in the other cases, so I think while it's certainly a good win for United, it's a battle and the war has not been won yet."

The U.S. Attorney's Office in California on Oct. 12 filed a notice of voluntary dismissal without prejudice. A spokesperson with the department declined to comment for this story.

Court Ruled That Case Lacked Specificity

Additionally, the court cited a two-year-old Supreme Court ruling in *Universal Health Services v. U.S. ex rel. Escobar* to assert that the complaint failed to allege that the "challenged conduct" was material to the government's decision to pay UnitedHealth's risk-adjusted claims. "Escobar established a heightened materiality standard, sort of what you have to prove to say, 'But for your fraudulent behavior, the government would have paid the claim,'" explains Ramsey. "The Supreme Court kind of set that standard, but it takes a number of other cases to interpret that standard and really give the health care industry knowledge of what is that standard."

"The government's decision to drop the suit, despite being granted leave to amend, highlights the significant obstacles that will need to be overcome in pursuing [False Claims Act] cases involving managed care plans," weighs in Angela Bergman, an associate in the Nashville

office of Bass, Berry & Sims PLC. "While the U.S. Attorney's Office has indicated that it will turn its sights to a similar case in the same district, it must still address the substantial deficiencies noted in the dismissal."

According to a statement from UnitedHealth spokesperson Matt Burns, the insurer is "pleased with the government's decision to dismiss these meritless claims."

Contact Bergman at abergman@bassberry.com, Burns at matt_burns@uhc.com or Ramsey at robert.ramsey@bipc.com. ✧

MA, Part D Sponsors Tout Extra Benefits, Provider Pacts for 2018

Medicare Advantage and Part D sponsors appear to be sweetening the deal for potential and existing enrollees this Annual Election Period, as multiple companies are touting enhanced supplemental benefits beyond the usual fitness programs and dental coverage in addition to new provider partnerships and service areas, according to an AIS Health analysis of company press releases and marketing materials that have been released since Oct. 1. And despite the return of the health insurance tax (HIT) established by the Affordable Care Act (see story, p. 5), premium increases for 2018 appear to be more modest than anticipated, according to a preliminary analysis of the 2018 CMS landscape and benefit files conducted by actuarial consulting firm Oliver Wyman.

"I think our expectation was that carriers were going to not put beneficiaries on a seesaw, so they weren't going to reduce premiums in 2017 only to grow them back in 2018," observes Josh Sober, a principal in the Milwaukee office of Oliver Wyman. "And the premium increases are there, but they're coming down from what we saw in 2017."

Restricting its analysis to products in metropolitan statistical areas that persisted from 2017 to 2018, Oliver Wyman observed an average premium change on an enrollment-weighted basis of 91 cents, or an increase of about 3.1% from $29.02 per member per month to $29.93 PMPM. This is compared with an increase observed in those same areas of about $2 from 2016 to 2017. Those changes do not apply to Special Needs Plans (SNPs) or Employer Group Waiver Plans.

"So not only had carriers apparently anticipated the reinstatement of the health insurance tax and not given too much back in 2017, but they're actually in a slightly more competitive or optimistic place this year than they were last year," Sober tells AIS Health. This is also supported by a higher number of net new contracts for 2018, which appear to be mostly from MA organizations that already have products in the market, he adds.

Wellness benefits and population health programs appear to be on the rise for 2018, observes Sober. "For the markets we've looked at, we're seeing increases in transportation benefits, which we think is related to getting some of the sicker enrollees to primary care a little bit more easily," Additionally, Sober says the firm is seeing a faster-than-expected reduction in expanded prescription drug gap coverage as the so-called donut hole closes.

Anthem, Centene Expand MA Offerings

Here are highlights from company press releases unveiling new offerings and product enhancements for 2018:

◆ ***AmeriHealth New Jersey*** added RWJBarnabas Health, one of the most comprehensive health systems in the state, to its first-tier provider network in the AmeriHealth Advantage plan, expanding the plan's reach to six additional counties in northern New Jersey. Members in that plan can obtain services from RWJBarnabas Health's Physician Enterprise and acute care hospitals at lower copayments and out-of-pocket costs.

◆ ***Anthem, Inc.***, in addition to service area expansions by many of its subsidiaries, unveiled a new collaboration with Cleveland Clinic to offer the new Anthem MediBlue Prime Select $0 premium HMO plan, through which members can receive physician and hospital services exclusively through the Cleveland Clinic. According to *Crain's Chicago Business*, the plan differs from Anthem's other MA offerings in the state in that it is the insurer's only exclusive network arrangement in Northeast Ohio. Meanwhile, Anthem Blue Cross is expanding its MA reach in California with plans in six additional counties. Three SNPs and the Anthem Value Plus HMO will feature access to the CareMore physician-led delivery system as well as the Nifty After Fifty clinically supervised full-body training program for mature adults.

◆ ***Anthem subsidiary Amerigroup*** boasted service area expansions in several states, as well as an array of supplemental benefits. Depending on the plan, these extras include: LiveHealth Online, which enables members to connect with board-certified doctors through two-way live video using a smart phone, tablet or computer with a webcam, at a $0 copay; access to a quarterly stipend to pay for certain over-the-counter health products; $0 copays for prescription drugs on multiple coverage tiers; 24 routine podiatry visits per year (with a $0 copay, depending on the plan); $3,000 annual hearing aid benefits; and an allowance of routine transportation services for pharmacy and medical visits within 60 miles.

◆ ***Centene Corp.*** introduced Allwell from Sunflower Health Plan in Kansas. Allwell will offer HMOs for the first time in Johnson and Wyandotte counties that feature a variety of benefits, such as $0 premiums, $0 primary

care provider copays and optional dental coverage, said Centene.

◆ ***Humana Inc.,*** in addition to a new co-branding partnership with Cleveland Clinic in Ohio, said it expanded its existing relationship with TruHearing to including hearing care and hearing aid benefits within MA plan offerings in 27 new states for a total of 34. Members will be able to obtain two hearing aids per year (one per ear) and three provider visits for fittings and evaluations with copays ranging from $399 to $999, depending on the choice of hearing aid and plan selection.

◆ ***Sunrise Advantage Plan*** is one of at least three new institutional SNPs offered by nursing home chains. The plan will offer comprehensive care coordination with participating Sunrise Senior Living communities in Illinois, New York, Pennsylvania and Virginia.

Contact Sober at josh.sober@oliverwyman.com. ✧

In Age of Uncertainty, Some States Seek Medicaid Work Requirements

Last year's election of Donald Trump (R) sent shock waves through much of the country, and for public health stakeholders, one question immediately took the forefront: What does this mean for Medicaid?

Under the Affordable Care Act (ACA), over 14 million people became eligible for and enrolled in Medicaid, many of them nondisabled childless adults, a population that was typically excluded from the program. Republican leaders have long opposed enrolling this population, believing that public funds should be reserved for critical populations, such as the elderly, children and disabled individuals. Now that the ACA appears to be here to stay, however, this population must be managed, and the door is open for change. Bolstered by Trump's win, several states hope to make their expansion population less costly, and ultimately reduce it, by implementing conservative reforms such as limited eligibility, benefit designs that mirror employer-sponsored coverage and work requirements.

To date, work requirements are not a condition of any state Medicaid program, although they have been implemented in several states for other public assistance programs, such as Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Many experts in the field view these reforms as unlikely to hold up against much scrutiny — as many in the Medicaid population are seniors, children, disabled individuals or primary caregivers in the home, and would not be in the workforce regardless. And those who can work already do. Among the nondisabled Medicaid expansion population, only 13% are not working or in school, according to data from the 2015 National Health Interview Survey. But with Republicans at the helm, the environment has become much more favorable to sweeping reforms.

Former HHS Secretary Tom Price, M.D., and CMS Administrator Seema Verma in March sent a letter to states, affirming their commitment to helping states

States With Notable 1115 Demo Waivers Recently Approved or Pending

State	Program Name	1115 Waiver Status	Latest Statewide Managed Medicaid Enrollment	Latest Statewide FFS Enrollment
Alabama	Alabama Medicaid Transformation	Approved Feb. 9, 2016	0	879,493
Arkansas	Arkansas Works	Approved Dec. 8, 2016, amendments pending since June 30, 2017	0	921,075
Illinois	Illinois Behavioral Health Transformation	Pending since Oct. 20, 2016	1,882,742	1,428,239*
Indiana	Healthy Indiana Plan 2.0 (Amendment)	Pending since July 20, 2017	1,211,791	284,934
Kentucky	Kentucky HEALTH	Pending since Sept. 8, 2016, modifications proposed July 3, 2017	1,579,849	228,082
Maine	MaineCare (Amendment)	Pending since Aug. 2, 2017	0	266,297
Massachusetts	MassHealth (Amendment)	Pending since Sept. 8, 2017	804,552	571,307
New Jersey	New Jersey FamilyCare (Amendment)	Approved July 27, 2017	1,522,245	82,329
North Carolina	North Carolina's Medicaid Reform Demonstration	Pending since June 1, 2016	0	2,101,038**
Wisconsin	Wisconsin Badger Care Reform	Pending since June 15, 2017	750,329	293,749

*includes 321,139 enrollees in Illinois Health Connect's Primary Care Case Management Program.
**includes approximately 1.6 million enrollees in Community Care of North Carolina, a public-private partnership with regional provider and hospital networks
SOURCE: MMM, AIS's Medicare and Medicaid Market Data. Visit the MarketPlace at www.AISHealth.com for a free interactive demo.

implement alternative models of Medicaid delivery and encouraging them to seek waiver authority *(MAN 3/30/17, p. 1)*. They cited several areas where states could innovate and request waivers, many of which overlap measures already in place in Indiana's Medicaid expansion program, which Verma designed. The potential reforms include:

◆ Beneficiary contributions, such as small monthly premiums and copayments for some services;

◆ Efforts that support employment among Medicaid eligibles;

◆ New benefit designs for Medicaid members that include features that mirror private insurance, such as Health Savings Accounts;

◆ Discouraging the use of emergency services for non-emergency care;

◆ Ways to make it easier for Medicaid eligibles to enroll in employer-sponsored health insurance;

Insurers, Provider Partners Seek Delay of Health Insurance Tax

Many Medicare Advantage plans will be offering $0 monthly premium plans and a wide array of supplemental benefits in 2018, but the Better Medicare Alliance (BMA) and other industry trade groups worry that benefit offerings won't continue to be so rich as the health insurance tax (HIT) established by the Affordable Care Act returns and continues to increase. As a one-year moratorium on the tax lapses in 2018, the HIT will be reinstated at a higher annual level of $14.3 billion (compared with $13.9 billion that would have been collected in 2017), of which more than 20% falls on MA and Part D plans, according to BMA.

To support its concerns, BMA commissioned Morning Consult to conduct a national poll of more than 2,000 Medicare-eligible seniors on their awareness of the HIT. According to the Oct. 5 report from BMA, 84% of respondents said they were not aware or familiar with the tax and 83% said they would be negatively impacted if their health insurance premiums were to rise by $245, which is what actuarial and consulting firm Oliver Wyman in August had projected as the per-enrollee increase for MA members if the HIT were to return in 2018. Those estimates were based on certain assumptions, such as plan performance and bids holding steady in other areas (e.g., administration, care management, provider contracting) or premium revisions to keep pace with a more competitive market.

"The reason this is so important is that 37% of beneficiaries live on annual incomes of less than $20,000. They're fixed incomes, very price sensitive, [and] 26% of beneficiaries on MA are dually eligible for Medicare and Medicaid, so we are really talking about those who do not have the $245 extra a year and rely on the additional benefits and reduced cost sharing," asserted BMA President and CEO and former House Rep. Allyson Schwartz (D-Pa.) during an Oct. 5 media call to discuss the status of the HIT.

As a result, BMA in late August sent a letter to Congress calling for the delay of the HIT that was followed by an ally letter signed by various business groups, providers and provider-led insurers, nursing associations, senior advocates and other organizations with a stake in senior care. Schwartz said BMA has received some "good policy response," including legislation introduced on Sept. 26 by Sen. Cory Gardner (R-Colo.) and 10 other senators that would extend the moratorium on the tax through 2018. "We've been getting some very positive reactions when we talk to members on the Hill about their interest in doing this," she added. "With so many things to do and so many things on their mind, we want to keep this in their mind and hopefully part of that to-do list before the end of the year."

Since the HIT is already incorporated into 2018 products, CMS could with some regulatory authority under the direction of Congress make an adjustment allowing for "those dollars to go back into the pockets of seniors" in the form of rebates, for example, suggested Schwartz.

Any additional delay of the HIT "is not going to have any influence on the products that the beneficiary sees [in 2018], but it would give plans additional security as they go into 2019 product development... to ensure that they can continue to offer competitive rates and potentially enhance some of the dynamics that [are taking place as plans position for 2018] such as increased number of contracts and modest premium increases," weighs in Josh Sober, a principal in the Milwaukee office of Oliver Wyman, who did not author the August paper.

Contact Schwartz via BMA spokeswoman Adjoa Adofo Kyerematen at aadofo@bettermedicarealliance.org or Sober at josh.sober@oliverwyman.com.

◆ Waivers that support families enrolling in the same plan; and

◆ New eligibility procedures that do not guarantee continuous coverage.

In response to the letter, several states submitted new or amended Section 1115 Demonstration Waiver requests with these changes in mind (see table, p. 5). Among states that are not requesting work requirement programs or benefit design changes (e.g., Illinois, New Jersey), integration of primary care, behavioral health services and long-term care to improve member outcomes (and therefore cut costs) is the primary focus.

While it's clear the administration wants to champion these Medicaid overhauls, it's uncertain when these requests will be approved. With Secretary Price's exit from HHS in September, the agency's next steps seem to be up in the air. And at least eight states are awaiting approval of new or modified demonstration waivers. ✧

From the editors of AIS's Medicare and Medicaid Market Data

For Some, Stars Remain Stable

continued from p. 1

At the same time, MA organizations are migrating members from lower performing plans to higher performing ones. "And while it sounds as if it's inorganic and fake, I would take the view that now you're not chastising plans for being low performing, you're migrating them to higher plans so you're able to get the 4-star or higher [per-member per-month] dollar values from CMS and are able to provide the necessary benefit to improve the lives of members in those plans," observes Rao. "So I think you're seeing a combination of the effects of these two factors that are causing a lesser number of plans to actually be 4-star or higher, but the net sum is that the membership in 4-star or higher is still greater than what it was in prior years."

The 2018 star quality ratings provide an indication of which plans will receive a 5% bonus for achieving overall ratings of 4 or higher. Comparing the new data to the 2018 "crosswalk file" — which CMS posted earlier this month — shows a slightly different picture because of improvements resulting from consolidating lower-rated plans into higher-rated ones.

According to an Oct. 11 research note from Evercore ISI, securities analyst Michael Newshel estimated that the percentage of beneficiaries in high-rated contracts actually dropped 340 basis points from an adjusted 75.7% of enrollees in bonus-qualifying 4-star or higher plans for 2018.

Company-level observations using the crosswalk data include that the percentage of members enrolled in 4-star or higher plans significantly declined for publicly traded insurers Centene Corp. and Cigna Corp., each because of a single large contract dropping from 4 stars to 3.5, observed analysts. UnitedHealth Group, Aetna Inc., Molina Healthcare, Inc. and Anthem, Inc. had smaller declines, while Humana Inc.'s ratings remained flat. But compared with 2018 payment year estimates based on the 2017 star ratings, Anthem's percentage of enrollees in 4-star or higher plans actually went up from 51% to a company record of more than 60%, according to an Anthem press release. Centene, however, is projected to have 18% of lives in 4-star or higher plans in 2018, down from 67% in 2017.

In an Oct. 11 note from Cowen & Co., securities analyst Christine Arnold pointed out that Cigna won its appeal for 2018 stars, which offers hope that Centene — which is planning to appeal an audit penalty in a California Health Net contract — will ultimately see an improvement in its ratings. Meanwhile, WellCare Health Plans, Inc. was the only publicly traded MCO to lift its star rating. The company's largest contract improved from 3 stars in 2017 to 4 stars in 2018, which helped raise its overall percentage of members in 4-star or higher plans to 39%, compared with roughly 18% in 2017. The acquisition of Universal American Corp., which was completed in April, added about 90,000 lives in 4-star or higher plans.

Meanwhile, the percentage of Prescription Drug Plans (PDPs) receiving an overall star rating of 4 or higher rose from 49% (27 contracts) last year to 52% (28 contracts) for their 2018 Part D rating. And the average star rating for PDPs rose from 3.55 last year to 3.62 for 2018. Weighted by enrollment, nearly 47% of PDP enrollees are in contracts with 4 or more stars, up from 41% in the 2017 star ratings.

More Than Half of 5-Star Plans Are MA-PDs

Similar to last year, a total of 23 contracts are highlighted on the Medicare Plan Finder with a high-performing (gold star) icon for achieving 5 stars; 15 of these are MA-PDs, seven are PDPs and one is an MA-only contract. Moreover, nine contracts will receive the gold star icon that did not receive it in 2017, CMS noted. These include six MA-PDs: Anthem Health Plans of New Hampshire, Inc., Blue Cross and Blue Shield of Minnesota, Dean Health Plan, Inc., Healthsun Health Plans, Inc., Kaiser Foundation Health Plan in Hawaii and Providence Health Assurance. No plans received the low-performing icon for 2018.

On a measure level, MA-PDs fared worse on average for 12 out of 34 Part C measures and had no change in performance for eight clinical measures, while the average star rating for seven out of 14 Part D measures de-

creased for MA-PDs. Rao points out for some measures, the cut points — which are determined using a clustering algorithm that identifies natural gaps that exist within the distribution of scores and creates groups — rose drastically as compared with prior years. For example, the average star rating among MA-PDs for D13 – Medication Adherence for Cholesterol (Statins) was 3.3, down from 3.5 in 2017 and 4.0 in 2016. But the 5-star cut point for that measure was 85%, which is a large jump from 82% in 2017. It's hard to determine at this point, however, what the driving factors are behind the higher threshold, as it could be due to plan migration, plan closures or an overall improvement among plans, he adds.

Moreover, there was a notable decrease in the average star rating on C16 – Controlling Blood Pressure, which dropped from 4.0 on average in 2017 to 3.2 in 2018. Rao says the 5-star cut point for that measure moved by two percentage points, which is relatively high given the historically challenging nature of this measure and recent HEDIS changes associated with the measure that went into effect two years ago.

Other conclusions that can be drawn from the 2018 star ratings data include:

◆ ***Many high-performing plans did well on measures that are based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)***, such as C23 – Getting Appointments and Care Quickly or C25 – Rating of Health Care Quality, points out Rao. Kaiser Permanente, which has five 5-star contracts for 2018, has consistently high CAHPS scores, which Rao suggests is a result of successful member engagement and provider alignment to "bring about a seismic change in their patients' culture."

◆ ***Only 17% of plans that have less than five years' MA experience earned 4 or more stars,*** according to Gorman Health Group (GHG). "Most new entrants count on earning quality bonuses without investing the precise, nuanced rigor needed to earn 4 or more stars," wrote GHG's Melissa Smith, vice president of stars and quality innovations, in an Oct. 12 blog post. "For plans new to MA, these headwinds are significant and require commitment to overcome."

◆ ***Of the six plans that earned 5 stars for the first time in 2017, only three maintained their 5-star rating in 2018,*** observed GHG. "Achieving 5 stars requires a long-term, consistent corporate commitment to excellence — clinically, operationally, and culturally. For plans new to this elite achievement, it sometimes also requires a bit of luck while this trifecta of excellence is perfected," Smith advised.

CMS noted in a Oct. 11 press release accompanying the publication of the data that Medicare-eligible individuals will have more than 3,100 MA plans to choose from in 2018, compared with approximately 2,700 in 2017. And more than three-fourths of MA enrollees remaining in their current plan will have the same or lower monthly premium, CMS observed.

View CMS's star ratings fact sheet and data at http://tinyurl.com/ydxtqxjo. Contact Arnold at christine.arnold@cowen.com, Newshel at michael.newshel@evercoreisi.com, Rao at akhrao@deloitte.com or Smith at msmith@gormanhealthgroup.com. ✧

Overall Star Rating Distribution for MA-PD Contracts, 2015-2018

Overall Rating	2015 Number of Contracts	2015 %	2015 Weighted By Enrollment	2016 Number of Contracts	2016 %	2016 Weighted By Enrollment	2017 Number of Contracts	2017 %	2017 Weighted By Enrollment	2018 Number of Contracts	2018 %	2018 Weighted By Enrollment
5 stars	11	2.78	9.88	12	3.25	10.23	14	3.86	9.81	15	3.91	11.17
4.5 stars	61	15.44	19.59	65	17.62	25.02	70	19.28	24.45	57	14.84	22.47
4 stars	86	21.77	30.32	102	27.64	35.71	96	26.45	34.90	98	25.52	39.24
3.5 stars	136	34.43	26.78	113	30.62	19.60	109	30.03	22.06	139	36.2	22.45
3 stars	73	18.48	10.98	66	17.89	8.60	65	17.91	8.17	61	15.89	4.20
2.5 stars	26	6.58	2.37	11	2.98	0.84	9	2.48	0.62	12	3.13	0.46
2 stars	2	0.51	0.08	0	0.00	0.00	0	0.00	0.00	2	0.52	0.02
Total Number of Rated Contracts	395			369			363			384		
Average Star Rating*	**3.92**			**4.03**			**4.02**			**4.06**		

*The average Star Rating is weighted by enrollment.
SOURCE: CMS, Fact Sheet – 2018 Part C and D Star Ratings, Oct. 11, 2017. For more information, go to http://tinyurl.com/ydxtqxjo.

NEWS BRIEFS

◆ **Convey Health Solutions, a Florida-based specialized health care technology and services company, acquired Washington, D.C.-based consulting and software solutions firm Gorman Health Group (GHG).** According to an Oct. 16 press release, the combination of GHG's extensive market presence and "real-time insight" with Convey's technology expertise will enable Convey to more quickly expand its solutions in the Medicare Advantage and Part D markets. "We recognized that to unlock the full potential of the government-sponsored healthcare market we needed best-in-class services and technology," stated John Gorman, executive chairman and founder of GHG, in the release. "Together with Convey Health we have the ability to deliver both. We are energized by the incredible opportunity we can now provide to our clients and to the healthcare market." Visit www.conveyhealthsolutions.com.

◆ **Two entities were recently barred from enrolling new Medicare beneficiaries because of program violations.** USAble Mutual Insurance Co., doing business as Arkansas Blue Cross and Blue Shield, was informed in a Sept. 26 letter from CMS of its enrollment suspension for failing to maintain the required 85% minimum medical loss ratio (MLR) for the third consecutive year. According to the letter from the Medicare Parts C and D Oversight and Enforcement Group, the insurer reported the following MLRs for its Prescription Drug Plan (PDP) contract: 79.8% for calendar year 2014, 81.3% for CY 2015 and 84.0% for CY 2016. As a result, USAble will be removed from the list of PDPs from which beneficiaries may make a selection during the Annual Election Period that began on Oct. 15 and runs through Dec. 7. The Arkansas Blues insurer sought a reversal of the agency's decision, and petitioned the U.S. District Court for the Eastern District of Arkansas, arguing that the MLR requirement established in an amendment to the Affordable Care Act was misinterpreted by CMS and was not intended to apply to stand-alone prescription drug plans, reports the *Northwest Arkansas Democrat-Gazette*. The judge declined the insurer's request to lift the sanction, according to the newspaper. The company appears to be the first and only insurer in the country to face a suspension in its drug plan enrollment over the MLR requirement that became effective in 2014, adds the report. Meanwhile, PACE contractor Via Christi Healthcare Outreach for Elders, Inc. (VCH) on Oct. 3 was informed of an immediate enrollment suspension for an alleged failure to substantially provide its participants with medically necessary items and services that are covered PACE services. The decision resulted from "severe clinical and operational deficiencies" uncovered during an August 2017 unscheduled audit. View the letters at the Part C and D Enforcement Actions page at www.cms.gov.

◆ **CMS last month notified the second Part D plan sponsor this year of its intent to impose a civil monetary penalty (CMP) for excessively high rates of "auto-forwarding" to the Independent Review Entity (IRE).** According to a Sept. 18 letter from the Medicare Parts C and D Oversight and Enforcement Group, CMS intends to impose a $36,000 CMP on Premier Health Insuring Corp. for its MA Prescription Drug contract's inordinately high rate of coverage determinations and redeterminations auto-forwarded to the IRE for the second quarter of 2017. The letter specifies that Premier's "adjusted" auto-forward rate was 19.14 per 10,000 enrollees and is thus considered an outlier relative to other sponsors. Such a violation may result in an inappropriate delay in access to medications and/or pose financial hardship to enrollees, noted CMS. The agency earlier this year said it would begin issuing fines on a quarterly basis for high rates of IRE auto-forwarding and in July notified Merit Health Insurance Co. of its intent to impose a CMP in the amount of $59,600 for its outlier status *(MAN 9/7/17, p. 3)*. Visit www.cms.gov.

◆ **PEOPLE ON THE MOVE:** Industry veteran **Joseph Zubretsky** was named president and CEO of Molina Healthcare, Inc., effective Nov. 6. Zubretsky replaces CEO **J. Mario Molina, M.D.,** who was fired in May after the company delivered poor financial results *(MAN 5/11/17, p. 1)*, and will succeed **Joseph White**, who has been serving as interim CEO and will remain in his role as chief financial officer. Zubretsky has more than 35 years of experience in the insurance and financial services industries and recently served as president and CEO of The Hanover Insurance Group after a nine-year stint at Aetna Inc....Minnesota Medicare and Medicaid insurer UCare appointed **Mark Traynor** president and CEO. Traynor has been serving as interim president and CEO since April, and prior to that was senior vice president of provider relations and chief legal officer with the not-for-profit health plan.

If You Don't Already Subscribe to the Newsletter, Here Are Three Easy Ways to Sign Up:

1. Return to any Web page that linked you to this issue

2. Go to the MarketPlace at **www.AISHealth.com** and click on "Newsletters."

3. Call Customer Service at 800-521-4323

If you are a subscriber and want to provide regular access to the newsletter — and other subscriber-only resources at AISHealth.com — to others in your organization:

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)