Every year, the Centers for Medicare & Medicaid Services (CMS) make changes to its Five-Star Quality Rating System, better known as Star Ratings.

Star Ratings help consumers compare Medicare Advantage (MA) and Medicare Advantage Prescription Drug Plans (MAPD) based on quality, cost and coverage. Star Ratings are also used as a financial incentive for plans to ensure high quality.

CMS included a summary of Star Ratings for the 2017 calendar year in its final Rate Announcement and Call Letter. The summary identified which quality measures were added, which measures were removed and which measures stayed the same.

Even though CMS doesn't assign Star Ratings to independent community pharmacies, the services you provide to patients can affect the results of health plans' Star Ratings. And, health plans can issue their own ratings to pharmacies and measure a pharmacy's performance by reviewing claims.

So, you'll want to pay attention to what criteria the Star Ratings measure. Here's a breakdown of updates to the 2017 Star Ratings.

**Changes to Star Ratings Measures for 2017**

**High Risk Medication Use (Part D)**
- Will not move to the display measures for 2017, but will move to the display measures in 2018.
- Any patient with a hospice indicator at any point in the measurement period will be removed from the measure calculation.
- There will be revised criteria to calculate the average doses for doxepin, reserpine and digoxin.
Medication Adherence for Hypertension (RASA)

- Patients who have one or more claims for sacubitril/valsartan (Entresto™) will be removed from the denominator.

Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR Measure (Part D))

- CMS will implement data integrity checks to ensure the appropriateness of data used to support the measure.

Improvement Measures (Parts C & D)

- The process has been updated to account for measures with at least two years of data.
- If a contract has a score with very low reliability for enrollees with less than six months of enrollment, CMS can use the previous year’s score.

Appeals Timeliness/Reviewing Appeals Decisions Measures (Part C) and Appeals Upheld Measure (Part D)

- The deadline for allowing the appeals decisions to impact the measure will be extended to May 1. This is in order to account for appeals filed in the end of the benefit year, which may extend well into the next benefit year.

Transition from ICD-9 to ICD-10 (Part C & D)

- Both ICD-9 and ICD-10 will be used in 2017 due to the implementation within the 2015 benefit year.

Measures Removed from Star Ratings for 2017

Improving Bladder Control (Part C)

- The measure will not be used for reporting in 2017, but will continue to be a display measure for the 2018 calendar year.

CMS Display Measures for 2017

Statin Use in Persons with Diabetes (SUPD) (Part D)

- Will begin as a display measure, and CMS recommends it remain a display measure for two years.

Medication Reconciliation Post Discharge (Part C)

- Measures the percentage of discharges from acute or non-acute inpatient facilities of patients who were 66 years of age or older and who had their medications reconciled within 30 days of discharge.

Impact of Socio-Economic and Disability Status on Star Ratings

- CMS is going to proceed with the Categorical Adjustment Index (CAI) as the method to account for statistical differences. It will forego any use of the Indirect Standardization method.
Additional Updates

Access to Preferred Cost-Sharing Pharmacies
• There will be no changes in preferred cost-sharing pharmacy guidance for 2017 due to improved access.

Annual MTM Eligibility Cost Threshold
• The threshold for the 2017 MTM program is $3,919 in expected annual Part D drug costs.

Contracts with Consecutive Poor Performance
• Plans that have not achieved at least a three star overall rating for the past three years will receive a non-renewal notice with the last effective date of Dec. 31. Star Ratings will not be calculated for contracts that will not be renewing in 2017.

New Measures for 2018 and Beyond

Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer (Part D)
• Represents three total measures: opioid high dosage, multiple prescribers and multiple pharmacies and the combination measure, and multiple providers with high dosage.

Antipsychotic Use in Persons with Dementia (APD) (Part D)
• Will replace the current display measure of “Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes”.

For more information on Star Ratings, visit EQuIPP at equipp.org.

The full Medicare Part D 2017 educational series is available online on the TriNet section of pbahealth.com