HEDIS, STAR Performance Metrics

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Goals

• Discuss what HEDIS and Star Metrics are

• Discuss their impact on Health Plans

• Discuss their impact on the Healthcare Market
What is HEDIS®?

**Healthcare Effectiveness Data & Information Set**

- A standard measurement tool created by the National Committee for Quality Assurance (NCQA)
- Used by 90% of American health plans to measure performance on important dimensions of care and service
- HEDIS reporting is required for NCQA accreditation, CMS Medicare Advantage Programs, used for Consumer Report health plan rankings

Allows for measurement, standardized reporting and accurate, objective side-by-side comparison
How HEDIS® measures are created

• NCQA’s Committee on Performance Measurement, a broad-based group representing employers, consumers, health plans and others, debates and decides collectively on the content of HEDIS®

• Performance measures are a set of technical specifications that define how to calculate a rate for important indicators of quality

• HEDIS measures must meet three key criteria: Relevance, Soundness, Feasibility
HEDIS Measures

• The 80 measures are divided across five different domains of care:
  – Effectiveness of Care
    • Includes PH and Chronic Care process and outcome measure
  – Access/Availability of Care
    • Member survey questions
  – Experience of Care
    • Member survey questions
  – Utilization and Relative Resource Use
    • Inpatient and outpatient utilization, utilization/cost
  – Health Plan Descriptive Information
Preventive Health

• Cancer screening:
  – Breast, Cervical, Colorectal

• Immunizations:
  – Childhood immunizations, Flu

• BMI Screening

• Appropriate testing for URI
HEDIS Effectiveness of Care Measures

Chronic Care

• Diabetes Screening:
  Eye exam, LDL-C, A1c, Nephropathy
• Controlling High BP
• COPD medication
• Asthma medication
• Antidepressant medication
Consumer Assessment of Healthcare Providers and Systems

CAHPS

• Over 500 health plans across the United States use CAHPS® to monitor how well consumers are satisfied with the care and service they receive.
CAHPS Questions

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Claims Processing
- Rating Personal Doctor
- Rating Specialist
- Rating Health Care
- Rating Health Plan
NCQA accreditation is based on 3 components: Annual results of HEDIS clinical measures, CAHPS member experience survey, Triennial results of the NCQA onsite survey.

Accreditation points

<table>
<thead>
<tr>
<th>Points</th>
<th>90 - 100</th>
<th>80 - 89.99</th>
<th>65 - 79.99</th>
<th>55 - 64.99</th>
<th>0 - 54.99</th>
<th>90 - 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation</td>
<td>Excellent</td>
<td>Commendable</td>
<td>Accredited</td>
<td>Provisional</td>
<td>Denied</td>
<td>Excellent</td>
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Medicare Star Program

Quality Bonus Payments (QBP) for plans with Medicare Star Rating $\geq 4$ stars

• The implementation of the Patient Protection and Affordable Care Act resulted in the development of an incentive program for Medicare Advantage plans.

• The program has the potential to provide millions of dollars in financial awards to Plans, based on the ratings of the overall care provided to members.

• QBP are contingent upon a 4 or 5 Star rating score from approximately two years prior; therefore, the amounts issued in the year 2014 will be based on the ratings plans receive in the year 2012.

• The ACA essentially tied a portion of a plan’s payment to its star rating score.
Current CMS Star Rating System Rates Medicare Plan Offerings Based on Variety of Measures

- Each year CMS releases quality ratings for all MA and Part D plans

- Ratings range from 1 star (poorest quality) to 5 stars (highest quality)

- Plans are rated at the contract level, not the individual plan or county level

- Current ratings based on measures ranging from clinical performance to customer service
### STAR RATING Measure Examples

<table>
<thead>
<tr>
<th>Part C Measures</th>
<th>Part C / Part D Measures</th>
<th>Part D Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal cancer screening</td>
<td>Complaints about the health plan/ drug plan</td>
<td>Accurate pricing information on plan website and Plan Finder tool</td>
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<tr>
<td>Plan all-cause readmissions</td>
<td>Beneficiary access and plan performance issues</td>
<td>Members taking high risk drugs when safer alternatives existed</td>
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<tr>
<td>Getting appointments and care quickly</td>
<td>Members choosing to leave the plan</td>
<td>Medication adherence for diabetes, hypertension, and cholesterol</td>
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<td>Rheumatoid arthritis management</td>
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<tr>
<td>Osteoporosis management</td>
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### Part C Score includes Measures in Five Different Domains

<table>
<thead>
<tr>
<th>Domain Category</th>
<th>Examples of Performance Measures</th>
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</thead>
<tbody>
<tr>
<td><strong>Staying Healthy:</strong></td>
<td>▪ Screening for breast cancer, colorectal cancer, cholesterol, and glaucoma</td>
</tr>
<tr>
<td><strong>Screening, Tests, Vaccines</strong></td>
<td>▪ Annual flu vaccine</td>
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<td></td>
<td>▪ Adult BMI assessment</td>
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<tr>
<td><strong>Managing Chronic Conditions</strong></td>
<td>▪ Reducing the Risk of Falling</td>
</tr>
<tr>
<td></td>
<td>▪ Ensuring proper and appropriate diabetes care</td>
</tr>
<tr>
<td><strong>Member Experience with Health Plan</strong></td>
<td>▪ Ease of getting needed care and seeing specialists</td>
</tr>
<tr>
<td></td>
<td>▪ Getting appointments and care quickly</td>
</tr>
<tr>
<td></td>
<td>▪ Overall rating of health plan quality</td>
</tr>
<tr>
<td><strong>Health Plan Member Complaints and Appeals</strong></td>
<td>▪ Complaints about the health plan</td>
</tr>
<tr>
<td></td>
<td>▪ Beneficiary access and performance problems</td>
</tr>
<tr>
<td></td>
<td>▪ Members choosing to leave the plan</td>
</tr>
<tr>
<td><strong>Health Plan’s Customer Service</strong></td>
<td>▪ Reviewing appeals decisions</td>
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<td></td>
<td>▪ Plan making timely decisions about appeals</td>
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Source: Medicare Health Plan Quality and Performance Ratings 2013 Part C and D Technical Notes. Released October 2012. Note: Please see appendix for a full list of domains and star rating measures.
Star Ratings Include Measures from Various Sets of Performance Measures

- **Healthcare Effectiveness Data and Information Set (HEDIS®)**
  - Set of standardized performance measures of effectiveness of care, access to services, claims processing, customer service, etc.

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**
  - Standardized survey measuring patient care in the different settings of care.

- **Health Outcomes Survey (HOS)**
  - Survey of Medicare beneficiaries on patient reported outcomes

- **Complaint Tracking Module (CTM)**
  - Standardized system of tracking complaints for MA-PD plans and Part D plans

- **Independent Review Entity (IRE)**
  - Independent entity that determines elevated appeals and grievances for MA and Part D plans

- **Prescription Drug Event Data**
  - Tracks adherence to select medications within certain therapeutic areas.
CMS Places Greater Importance on Outcomes Measures Compared to Process Measures in Calculating Overall Scores

- **Process Measures**: Measure-level star rating multiplied by weight of 1.0*
- **Patient Experience and Access Measures**: Measure-level star rating multiplied by weight of 1.5
- **Intermediate Outcomes Measures**: Measure-level star rating multiplied by weight of 3.0
- **Outcomes Measures**: Measure-level star rating multiplied by weight of 3.0


* Process measures technically have no weighting factor and are only counted once in the calculation of the overall star rating for a plan.
A current plan’s star rating is based primarily upon data from two years prior to the current benefit year.

- For example, CMS will rely on a mix of 2013 and 2014 data in order to calculate the 2015 star ratings.
- Most of the 2015 star rating data is from 2013.

The ACA will essentially tie a portion of a plan’s payment to its star rating score**.

- The current star ratings for an MA plan will dictate plan payment for the upcoming benefit year.
  - For example, the 2015 star ratings will dictate any potential quality bonus payments for 2016.

Example: Data Lag for 2015 Ratings Star

<table>
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<tr>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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Achieving a high star rating score will derive incremental revenue from three levers

1. Plans must achieve a Medicare Star rating in 2014 of ≥ 4 stars (2012 data) to be eligible for a QBP
   - 4.0 – 4.5 stars: Quality bonus payment at 5%
   - 5 stars: Quality bonus payment at 5%

2. Rebates are linked to plan quality ratings
   - 5 stars: 70% of difference between bid and benchmark
   - 4.5 stars: 70% of difference between bid and benchmark
   - 4 stars: 65% of difference between bid and benchmark

3. Increased enrollees driven by transparency scores will indirectly increase revenue
   - ≥4 stars: Consumer transparency data will allow consumers to compare plans based on quality
Impact of HEDIS /STAR for Plans

• Measures used for NCQA accreditation

• Plan Comparison for Consumer Reports, State report cards, Employer RFI, Employer PG

• STAR Used by CMS for Transparency, Plan comparison and Quality Bonus

• HEDIS Quality metrics for Exchange QHP
Impact of HEDIS/Star on HC market

• Used for Performance metrics for NCQA certification of PCMH, ACO, Provider groups

• Used by plans for Value Based contracting with network providers, ACO, PCMH, Medical groups and individual providers