Navigating the Shift to Quality-based Healthcare:
Three Strategies for Improving Health Plan Quality Ratings

Today’s healthcare climate requires health plans to offer high-quality care to their members and to be held publicly accountable for it. Two key measures assess health plan quality: CMS star ratings, which the Centers for Medicare and Medicaid Services (CMS) uses to rate Medicare Advantage plans, and the Healthcare Effectiveness Data and Information Set (HEDIS), a tool published by the National Committee for Quality Assurance (NCQA), which more than 90 percent of health plans use to measure performance.

These measures, and the financial incentives and penalties associated with them, are leading health plans to reexamine standard operating procedures to more effectively close care gaps and provide high-quality services – and for good reason. Health plans that focus on improving quality, and by extension HEDIS and CMS star ratings, stand to gain significant financial benefits.

HEDIS ratings, which consist of 81 measures across five domains of care, directly tie reimbursement for healthcare services to quality. A health plan’s CMS star rating, which is used to rate Medicare Advantage plans, is based on the percentage of HEDIS measures the health plan meets. Health plans serving Medicare populations must adhere to certain star quality measures to qualify for reimbursement.

Poor star ratings translate to both a loss of reimbursement and financial penalties assessed by CMS. Consistently poor performance can lead CMS to revoke a health plan’s privilege to offer Medicare programs. Because ratings are publicly available and commonly used by individuals who are shopping for a health plan, poor ratings also contribute to a negative public image that can affect revenues.

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On the other hand, plans exceeding average performance can qualify for quality bonus payments. Last year, plans that earned at least four stars received a five percent boost to their monthly per-member payments from Medicare, according to Modern Healthcare. Beginning in 2014, plans with scores of less than four stars no longer qualified for bonus payments.

La Chandra Plummer, a HEDIS Program Manager at a midsized health plan, outlined the financial impact of HEDIS quality ratings for an article published by CareNational Medical Management. “For a health plan with just 100,000 members being evaluated by HEDIS, each quality measure would mean around $17 million in reimbursements from federal or state agencies,” Plummer said. “When you consider that there are 20-25 measures directly tied to reimbursement (depending on the health plan and the population served) that is significant amounts of money!” USA Today reported that major insurers offering Medicare Advantage plans are set to be awarded as much as $1.5 billion in bonus payments in 2017.

The average Medicare Advantage star rating rose last year, from 3.92 in 2015 to 4.03 in 2016. Half of all plans received a four-star rating in 2016, compared with just 40 percent of plans in 2015, according to a Modern Healthcare analysis. When weighted by enrollment, CMS said three fourths of all Medicare beneficiaries are now enrolled in a plan with a four-star or higher rating. Despite the increase in the number of four-star ratings last year, nearly a third of plans experienced a rating decrease of at least 0.5 stars, data scientist Richard Lieberman told the publication. “[This finding] emphasizes the notion that continuous quality improvement means continuous, underlined and bolded,” Lieberman said. “You just can’t kind of push an organization to get to four stars and say, ‘Oh great, we made it, now we get our bonus.’ This says very clearly: Don’t sit on your laurels.”

To mitigate a loss of revenues from bonus payment, plans will need to maintain a laser-sharp focus on quality improvement initiatives that will position them for ratings of four stars or higher. Below are three strategies that can help health plans navigate the shift to a healthcare reimbursement model that is increasingly focused on quality.

1. Create an Organizational Culture of Quality

The U.S. spends more money per person on healthcare than any other nation in the world. Yet Americans often do not get the care they need, according to a report published by the Brookings Institute. Preventive care is underused, resulting in higher spending on complex, advanced – and often preventable – diseases such as hypertension, heart disease and diabetes. According to RAND research cited in the report, Americans receive just 55 percent of recommended treatments for preventive care, acute care and chronic care management. For example, just 24 percent of diabetes patients received all recommended HbA1c testing during the researched period.

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A quality-based model requires health plans to be accountable for the health of their member populations, and many HEDIS measures are designed to urge health plans to focus on prevention and early detection of chronic disease. But a preventive approach represents a significant paradigm shift from the traditional healthcare model, in which member interactions are typically based on specific health episodes. To improve quality, health plans must focus on maintaining the health of their populations, in addition to effectively treating those with acute or chronic conditions.

Two key initiatives can help health plans establish an organizational culture of quality. First, health plans should create a quality department and appoint quality officers who will be responsible for improving the health plan’s performance in both HEDIS and CMS star rating programs. These quality officers will measure and monitor the quality of service the plan’s members get and stay up to date on evolving requirements. Second, health plans should create programs, based on their quality department’s findings, to address areas of poor performance and close care gaps identified in HEDIS audits, leading to higher ratings the following year.

2. Focus on Disadvantaged Populations

Because health plans are rated on how often members with long-term conditions get certain tests and treatments that help manage those conditions, health plans serving populations with a high incidence of chronic disease may have a harder time maintaining high ratings. The chronic disease burden is concentrated among poor populations, as the World Health Organization notes on its chronic diseases and health promotion page, and chronic disease tends to go unmanaged in these patients.

CMS has proposed changes to the Medicare Advantage risk adjustment model that could take population characteristics, such as dual eligibility for Medicare and Medicaid, into account. Regardless of how the risk adjustment model changes, focusing quality improvement initiatives on lower-income segments can help health plans address significant gaps in care and improve star ratings.

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A study conducted by the Pittsburgh Post-Gazette and Milwaukee Journal Sentinel helps shed light on care gaps associated with lower-income populations. The study found a significant shortage in access to primary care in poor neighborhoods across major U.S. cities, demonstrating the increased difficulty these populations face in preventing and managing chronic diseases. “Fifty-eight percent of the nation’s 5,800 federally designated ‘primary care shortage areas’ fall in census tracts of highest poverty,” the Post-Gazette reported.

Many of BioIQ’s health plan clients report that the lack of an assigned primary care physician creates challenges in closing care gaps. Most of the time, lower-income populations that have limited access to care facilities account for the majority of members without a designated primary care provider. A shortage in primary care leads to overburdened physicians in these neighborhoods. Relying on these already overburdened physicians to help close care gaps is not scalable. As a result, health plans are employing alternative methods, such as at-home test kits, screening events and home health visits.

At-home test kits can be an effective and affordable solution for increasing screening rates of disadvantaged populations. A variety of simple biometric tests can be performed by health plan members at home and mailed to a lab for
processing. This method enables health plans to close care gaps without the logistical challenges associated with limited access to primary care physicians.

Other health plans are hosting screening events at local malls and other public spaces in areas with limited access to primary care providers. By hosting screening events in areas that are accessible to disadvantaged populations, health plans can quickly gather biometric data points that are indicators of chronic disease risk – such as BMI, blood pressure, glucose and cholesterol levels and more – and enroll at-risk members in condition management programs.

3. Focus on Improving Performance for Specific Measures

The changes that the Affordable Care Act has made to reimbursement models has encouraged health plans to be honest about their shortcomings and to work rapidly to address them. Plans that allocate resources to measures with the highest potential for improving overall quality ratings can see significant gains in a short amount of time.

By focusing on one key measure, Vantage Health Plan was able to raise its overall quality rating and qualify for more federal funding, according to a recent report in USA Today. Vantage executives told USA Today that they had particularly low rates for one key star rating measure: follow-up osteoporosis screening in elderly women who had a recent fracture. They purchased a mobile ultrasound unit to facilitate at-home screening, and in just one year, the proportion of their beneficiaries screened went from 13 percent to 71 percent. The increase translated to a .5-star rating boost and an extra $8 million in funding to reinvest in quality initiatives and improve the benefits offered to members.

Colorectal cancer screening represents another key improvement area for health plans. Screening rates for colorectal cancer lag behind other cancer screening rates. Fewer than half of men and women over age 50 are screened at the recommended intervals, according to data published by the Health Resources and Services Administration (HRSA), even though research shows that several screening methods can effectively detect early-stage cancer and polyps. When screening identifies a colorectal tumor in its early stages, the cost of treatment is often significantly less than if the tumor is detected later.

A study by the consulting group Oliver Wyman found that seven key metrics are most predictive of overall star ratings: breast cancer, colorectal cancer, glaucoma testing, annual flu vaccination, diabetes care – blood sugar control, controlling high blood pressure, and member complaints about the health plan.

Focusing on one or more of these areas, or areas that have been identified as gaps in a given member population, can help boost ratings quickly. Ratings are determined on a curve, so demonstrating significant improvement in areas that other health plans tend to lag behind, such as colorectal cancer screening, can boost overall rating scores even more significantly, while decreasing future spending and, in some cases, saving lives.
How BioIQ Can Help

The BioIQ platform can help health plans close care gaps, increase member engagement and improve quality ratings. BioIQ is a platform for population health measurement that provides health plans a simple way to configure screening programs for target segments of their member populations. Health plans can target specific care gaps by configuring screening programs for specific segments of their member populations and providing convenient screening options that ensure high participation rates, such as at-home test kits, screening events or home health visits. BioIQ offers tests that target several specific HEDIS and CMS star rating measures.

For each screening program, BioIQ provides detailed reporting and analytics demonstrating the operational and biometric outcomes of each screening program, as well as a participant portal that enables health plans to engage with members, coordinate follow-up care and more.

By launching a screening program with BioIQ, health plans can both close care gaps for key star ratings measures and gather data about the health of their member populations to help inform future initiatives.