How Medicare Advantage, Medicaid Health Plans Can Improve Quality Reporting

Health Plan Quality Reporting_Jay Baker

By Jay Baker Apr 24, 2018

Integration of risk, quality, and care programs is among the steps that can help health plans in the government-sponsored healthcare space lower the burden of accurately documenting and reporting quality metrics.

In today's government-sponsored healthcare environment, a primary goal is to drive quality improvement through measurement and transparency. Medicare and Medicaid quality-rating systems use public displays of data to help consumers make more-informed decisions about their health care and to encourage hospitals and clinicians to improve the quality and cost of inpatient care.

The intent is to move away from strict fee-for-service compensation and tie the cost and quality of care to the payment model. This approach has created an additional burden on organizations to accurately document and report the results of quality measures.

About Government Quality-Rating Systems

The Centers for Medicare & Medicaid Services (CMS) uses a five-point Star Rating system that measures how well Medicare Advantage (MA) and prescription drug (Part D) plans perform.

The rating system provides a way to compare performance among several plans, learn more about differences among plans, and look at plan ratings in each category. Specifically, the star rating is comprised of several domains related to quality of care provided, patient experience, and plan administration. Based on their overall star rating, plans receive a bonus payment equal to a percentage increase of the plan-wide benchmark payment rate (plans that receive an overall score of 4 or better add 5 percent to the applicable percentage adjustment).

These additional payments, in turn, can be used by plans to provide additional benefits to beneficiaries or to reduce cost sharing—features that are likely to factor into beneficiaries' choice of MA plans. The Star Rating program is also meant to drive improvements in the quality of plans, and this secondary effort seems to have been successful based on industry improvements in reported measures over time, according to CMS. Star Ratings determine up to 5 percent of revenue projection.

Medicaid's Quality of Care Performance Measurement seeks to gauge the degree to which evidence-based treatment guidelines are followed, where indicated and reported, and to assess the results of care. The use of quality measurement helps strengthen accountability and support performance improvement initiatives.

These measures can be used to demonstrate a variety of activities and healthcare outcomes for particular populations. They are state-specific and can generate both rewards and penalties. Typically, states pick a core set of quality measures, which have technical specifications with audit review of measurements and which can be objectively compared between and across different health plans.

Key Strategies

The challenges in delivering quality care, documenting outcomes, and accurately reporting outcomes are systemic throughout health care. Successful quality programs share key factors:

- Integrating risk assessment, care management, and quality reporting into a holistic care program instead of managing them in silos or departments
- Aligning incentives and objectives between patients, providers, health plans, and the government
- Deploying a technology infrastructure that supports an integrated program from start to finish and year-round

Integrating risk, quality, and care programs. The primary focus of risk adjustment programs is to accurately access, document, and report the chronic and acute health conditions of each member in the population. Often, risk programs are organized within the financial department of a plan, while the quality programs report to the clinical side.
Risk and quality programs work best when integrated within the organization, however. The risk program identifies members who fall into high-risk groups and who require additional screening and care to ensure that their health conditions do not progress or worsen. The quality program ensures that timely and complete care is provided and documented.

The benefits of such an integrated program include:

- Reduction of program administration costs by reducing duplication
- Prioritization of interventions that impact both risk and quality results

What's more, population health moves from a single lens to a holistic approach, thereby improving care and lowering the cost of supporting a population.

Aligning incentives and objectives. Solving the most common issues that affect quality reporting requires cooperation and active involvement from all stakeholders who are involved in the delivery of care. Health plans must understand and implement quality programs that engage both providers and members while satisfying government requirements.
Specifically, providers need training and financial incentives to change their practices to deliver the desired quality outcomes, while members require information and relationships to ensure that they will actively participate in their care.

Many of the best quality programs utilize ongoing interventions that provide actionable information to providers and members when and where they need the information. These programs also promote relationships, communication, and involvement of the member's care team, expanding the definition of *care team* to include spouses, parents, and/or children. The result is a holistic care plan that has active involvement from all key stakeholders who are involved with the treatment of chronic conditions.
The main benefit of aligning incentives across stakeholders is that everyone is engaged and working toward the same outcomes. Generating awareness and obtaining buy-in are challenging but nevertheless essential for a successful quality program.

Deploying a holistic technology platform. Many organizations look at risk and quality as projects that are initiated and completed throughout the year. Technology and processes are implemented and operate on a project cadence. This approach, however, leads to missed opportunities because a patient population is always in flux. Once a member is identified for an intervention, there may be other factors that should have been reviewed or a test that should have been ordered. At the same time, a project-oriented approach limits the timeliness of data at the point of service and allows care and data to fall through the cracks.
The alternative approach allows a plan to partner with a provider network and move to a program-oriented approach. A program continuously takes in new data, requiring tighter data integration between the health plan's systems and the provider's electronic health record. Fresh data are used to stratify the population, identify gaps in risk, improve care quality, and provide actionable information to providers and members when they need it—at the point of care.
In this way, issues can be quickly identified and remedied before they cause significant consequences.

Optimizing HEDIS performance. As the industry standard in quality reporting, NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) quantifies performance measurement for health plans, risk-bearing entities, and providers. In reporting year 2018, NCQA has grouped the quality measures into the following categories: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Risk Adjusted Utilization, Relative Resource Use, and Health Plan Descriptive Information.
For health plans, HEDIS results are often tied to financial incentives—both directly, as a bonus or a reduction in a capitated premium; and indirectly, by steering passive member enrollment to plans with more favorable quality outcomes.

Certified HEDIS engines can provide prospective measurements of HEDIS measures while also:

- Identifying members who qualify for measures

- Running measures continuously for provider performance and feedback
- Providing a continuous year-round process for identifying members who need additional support, such as transportation, provider access, care management of debilitating illnesses, help to address previous noncompliance, and behavioral health

Making the Most of Quality Measurement

Risk adjustment and quality outcomes are vitally important for the financial health of health plans and the delivery of superior benefits. Reaching top performance, however, requires tremendous resources.

Integration of risk, quality, and care programs removes silos between risk and quality, promoting efficiency as well as an integrated view of the population and outcomes. Alignment of incentives and objectives with all stakeholders can ensure that everyone is working toward the same outcomes. Finally, deploying a holistic technology platform allows for continuous data exchange and the ability to deliver actionable information to the point of service.

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