Quality Measures Overview

Health care quality, Stars and Member Engagement Initiatives
Section 1

Introduction
Introduction

Stars – Quality Measures Overview

UnitedHealthcare is focused on helping members live healthier lives and ensuring that they have access to affordable, high-quality care.

In this presentation you will learn what UnitedHealthcare is doing to ensure that your patients who we insure are accessing quality health care.
Introduction

This presentation will help you better understand the programs and services available to help you continue to help improve patient care.

*Working together, we can help your patients get the most from their benefits.*
A Changing Health Care Landscape

• New regulations, economic pressures and patient expectations are changing health care in America

• Health plans and physicians are being called on to close gaps in care and improve overall quality

• The Centers for Medicare & Medicaid Services (CMS) is directly connecting reimbursement for Medicare services to patient outcomes

• Together, we can help Medicare beneficiaries get the most from their benefits – meaning, better use of limited resources to drive quality outcomes for you and your practice
High Performing Health Plan Characteristics

Members:
• Visit primary care physician at least once a year and receive an Annual Wellness Visit
• Receive necessary screenings, tests and preventive care
• Can easily access specialists and other health services
• Experience excellent, timely customer service

Physicians:
• Apply best practices and adhere to evidence-based medicine management
• Incorporate team-based coordination models
• Leverage data and technology to close gaps in care and strengthen the patient relationship
• Are incentivized for meeting and exceeding quality standards
Many Views of Health Care Quality

- National measurement programs reflect different dimensions of plan performance and health outcomes
- Measurements emphasize physician collaboration and patient engagement
- Industry quality programs include:
  - HEDIS (Healthcare Effectiveness Data and Information Set)
  - CAHPS (Consumer Assessment of Healthcare Providers and Systems)
  - HOS (Health Outcomes Survey)
  - National Committee for Quality Assurance (NCQA) Accreditation
  - Medicare Star Ratings
Section 2

Quality Measures and Centers for Medicare & Medicaid (CMS) Star Ratings
CMS Star Ratings: Key Points

• CMS reports scores and compares plans based on performance
• CMS also uses Star Ratings to determine reimbursement
• The ratings are used to compare Medicare Advantage and Prescription Drug Plans
• Ratings emphasize patient care and satisfaction, using national clinical and service-quality measures, health outcomes and patient feedback
  • Health outcomes are weighted three times more than health plan operations (HEDIS-driven)
  • Patient satisfaction is weighted 1.5 times more than health plan operations (CAHPS-driven)
• CMS Star Ratings measures can change annually
# CMS Star Ratings: Key Points

Four categories CMS uses to measure quality:

<table>
<thead>
<tr>
<th>Operational Excellence Measures</th>
<th>Part D Measures</th>
<th>HEDIS and Clinical Quality Measures</th>
<th>Operational Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewing Appeals and Call Center Performance</td>
<td>Access to PCP and Part D Medication Adherence</td>
<td>Health Screenings, Testing, Vaccines and Diabetes Care</td>
<td>Customer Service and Health Plan Performance</td>
</tr>
</tbody>
</table>
CMS Star Ratings: Key Points

There are 17 HEDIS/pharmacy measures currently used to accumulate data for provider reports.

<table>
<thead>
<tr>
<th>HEDIS/Pharmacy Measures</th>
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</tr>
</thead>
<tbody>
<tr>
<td>C01-Breast Cancer Screening – Mammogram (ages 50 to 74)</td>
<td>C20-Rheumatoid Arthritis – DMARD (ages 18 and older)</td>
</tr>
<tr>
<td>C02-Colorectal Cancer Screening (ages 50 to 75)</td>
<td>D11-High Risk Medication – Members 65 and older who received prescriptions for certain drugs with a high risk of side effects when there may be safer drug choices.</td>
</tr>
<tr>
<td>C03-Cholesterol Management for Patients With Cardiovascular Conditions (ages 18-75)</td>
<td>D12-Diabetes Treatment – Evaluates number of members being treated for both diabetes and hypertension that are currently taking a renin angiotensin system (RAS) antagonist.</td>
</tr>
<tr>
<td>C04-Diabetic Care – Cholesterol Controlled – LDL-C Screening, Less Than 100mg/dL (ages 18 to 75 years)</td>
<td>D13-Medication Adherence for Diabetes Medications – Evaluates the percentage of Medicare plan enrollees that adhere to their prescribed diabetes medication based upon the member's prescription fill history.</td>
</tr>
<tr>
<td>C05-Glaucoma Screening (ages 67 and older)</td>
<td>D14-Part D Medication Adherence for Hypertension (ACEI or ARB) – Evaluates the percentage of Medicare plan enrollees that adhere to their prescribed RAS antagonist hypertension medication (ACE inhibitor, ARB or aliskiren) based upon their prescription fill history.</td>
</tr>
<tr>
<td>C10-Adult Body Mass Index (BMI) Assessment</td>
<td>D15-Part D Medication Adherence for Cholesterol (Statins) – Evaluates the percentage of Medicare plan enrollees that adhere to their prescribed &quot;statin&quot; cholesterol medication based upon their prescription fill history.</td>
</tr>
<tr>
<td>C14-Osteoporosis Management in Women who had a Fracture (women ages 67 and older)</td>
<td>C17-Diabetic Care – Blood Sugar Controlled – HbA1c (ages 18 to 75) Actual lab test results</td>
</tr>
<tr>
<td>C15-Diabetic Care – Eye Exams (ages 18 to 75)</td>
<td>C18-Diabetic Care – LDL-C Screening (ages 18 to 75)</td>
</tr>
</tbody>
</table>
# CMS Star Ratings: Key Points

<table>
<thead>
<tr>
<th>Source Data</th>
<th>Score Weight¹,²</th>
<th>Strategies</th>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHPS / HOS</td>
<td>29%</td>
<td>Member Engagement, Physician Engagement, Operations Improvement</td>
<td>Member Engagement UnitedHealth Networks</td>
</tr>
<tr>
<td>HEDIS</td>
<td>33%</td>
<td>Member Engagement, Physician Engagement, Operations Improvements, Local Efforts</td>
<td>Quality Management and Performance, UnitedHealth Networks, Benefit Operations, Health Plans</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>14%</td>
<td>Member Engagement, Provider Engagement</td>
<td>Medicare Part D</td>
</tr>
<tr>
<td>Operations</td>
<td>24%</td>
<td>Operations Improvement</td>
<td>Benefit Operations, Optum Rx</td>
</tr>
</tbody>
</table>

¹² Source Data Weightings

<table>
<thead>
<tr>
<th>2013 Performance</th>
<th>2014 Data Collection</th>
<th>2015 Star Ratings</th>
<th>2016 Payments</th>
</tr>
</thead>
</table>

Key Ratings:
- **Excellent** (5 stars)
- **Very Good** (4 stars)
- **Good** (3 stars)
- **Fair** (2 stars)
- **Poor** (1 star)
CMS Star Ratings: Key Points

- Published annually by CMS at H-contract
- Health Care Reform is driving increased attention
- Star Ratings made up of health and drug measures
- The number of Stars earned by a health plan directly relates to the percentage of HEDIS measures met
- Penalty assessment for plans performing poorly 3+ years: www.medicare.gov, administrative holds, shut down
Section 3
Member Engagement Initiatives
2014 Incentives and Outreach to Empower Medicare Members

Annual Care Visit
• Members targeted through inbound and outbound phone outreach.
• Encourages members to schedule an Annual Wellness Visit from a physician and earn their member reward.
• Members receive a $15 gift card for completing the Annual Wellness Visit.

Optum Health Outreach
• Live nurse call to members with no wellness visit, or a gap in care to facilitate scheduling an appointment and provide member education.

iFOBT IVR and kit deployment
• Members will receive an IVR assessing their intent to receive a colorectal cancer screening, and if the member opts in, will be mailed an iFOBT kit that they mail to LabCorp for processing.
• Providers will be informed if their member is to receive an IVR call.
• Members and providers will receive the outcome reports.

MedXM In Home Osteoporosis Screening
• Members meeting the osteoporosis screening gap in care may receive a phone call assessing their desire for an in home screening via MedXM Mobile Dexascan.
• The member and their provider will receive test outcome reporting.
2014 Incentives and Outreach to Empower Medicare Members

**Diabetes Prevention and Control Alliance (DPCA)**
- Member outreach will be conducted via telephone calls to the targeted diabetic members in the identified markets and will include initial direct appointment scheduling.
- Members have the option of attending up to 4 visits with the pharmacist to review their medications and assess adherence, to complete targeted lab draws (A1C, LDL) with each visit as medically necessary and to obtain education on diet and exercise (BMI is recorded).
- The labs and other medical information is coordinated with the members primary treating provider.

**House Calls**
- Offered to all eligible UnitedHealthcare plan members
- Provides members with an in-home clinical visit from a nurse practitioner to discuss health care concerns
- The goal is to increase primary care physician (PCP) appointment rate and help coordinate care

**Pharmacy Refill Reminders**
- Recorded telephonic messages
- Promotes medication adherence by calling members before and after refill due dates

**New Member Orientation**
- Outbound calls to assist members with selection of primary care physician and offer information on value-add benefits, such as Nurse line, Social Service Coordinators (SSC) and hearing aide benefits
Physician Collaboration: Patient Care Opportunity Report (PCOR)

- PCOR is a monthly scorecard of various clinical measures at both the individual physician and group level.

- Report gives physicians timely, member-level clinical information that promotes the physician/patient relationship.

- Open care opportunities are highlighted, helping ensure members are up-to-date on all recommended preventive services, such as an annual wellness visit, vaccines and health screenings.

- Report compiles data from multiple systems and promotes collaboration, displaying information at the physician, member and medical group level.

- Algorithms predict a member’s future adherence with medication.

- Comprehensive picture of each individual member that includes not just due or overdue care opportunities, but also completed care and historical care adherence.
The report provided detailed member information and summarizes care opportunity data for each HEDIS measure.

Report details include:
• A stoplight color-coding system that scores each of our members’ progress and helps you identify and prioritize care.
• Member-level performance for each HEDIS and Part D measure
• Date of the last physical for each of our members to target those in need of an annual wellness visit.
This report summarizes data and highlights key metrics that indicate care opportunities for your practice’s UnitedHealthcare Medicare Advantage member population. Reports can also be viewed at the physician level, enabling you to assess your overall and individual performance. In addition, current and prior year reporting period compliance for each of the HEDIS/Pharmacy categories is provided, along with current Star Ratings.
PCOR Call to Action

**Summary:**

- Use and sort by the **Care Score** to identify the members with the most care opportunities
- Focus on “X’s” and yellow areas in the report
  - X = potential care needs
  - Yellow blocks = those who are partially adherent with the medication measure
- Osteoporosis – focus on date of fracture
- Use the group and physician-level summary reports to help identify any practice wide care opportunities

*If you have questions about PCOR, please contact your Network Management Representative.*
Thank You