GOVERNMENT PROGRAMS COMPLIANCE OFFICER NEWSLETTER

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HEALTH CARE SERVICE CORPORATION

Message from Kim Green
HCSC Government Programs Compliance Officer

Welcome to the first quarter newsletter!

We live in a society where we classify and rank things to ensure we identify the best products or services. An assessment of the quality, standard or performance of an item being classified often utilizes stars as a symbol. In a similar manner, CMS (Centers for Medicare & Medicaid Services) has created "Star Ratings" to examine the Medicare Health Plan's Quality and Performance. The Five Star Quality Rating System created by CMS serves as both an educational tool for Medicare beneficiaries to identify "best plans" and serves as a metric that may have considerable impact on Medicare Advantage and Prescription Drug Plan Sponsor reimbursement. Star ratings metrics target areas that are important to Compliance performance. CMS uses star ratings to provide a snapshot of a plan's performance in meeting the requirements.

Inside this edition, we are going to examine the Five Star Quality Rating System in more detail. I hope that you find this information helpful. If you would like additional information about "Star Ratings", please refer to www.cms.gov.

As always, please remember that you are required to report any suspicious behavior or potential wrongdoing related to any government contract. All calls to our hotline can be made anonymously and without fear of intimidation or retaliation.

Our Medicare and Fraud hotline numbers and email address are also included in this newsletter so that you may contact us should you have any questions or concerns. I would also like to encourage you to visit our website and submit any general questions or news items that you would like to hear about in future newsletters. Our website is www.hisccompliance.com and our email address is HISCCOMPLIANCE@BCBSIL.COM.

I hope you enjoy this newsletter!

Kim Green

HCSC Government Programs Compliance Officer

In this issue

Medicare Star Quality Rating System Overview

The Medicare Star Quality Rating System was developed by the Centers for Medicare & Medicaid Services (CMS) in 2007. The five-star quality rating system provides quality and service related information to Medicare beneficiaries by measuring Medicare beneficiaries' experience with their health plan and the health care system. The star ratings allow beneficiaries and CMS to assess plan performance. It also provides beneficiaries with a simple objective way to determine the highest quality plans in their area by educating beneficiaries on quality and making quality data more transparent. The Star Rating System applies to all Medicare Advantage (MA) lines of business including Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee-For-Service (PFFS) and Prescription Drug Plans (PDP).

Each individual Medicare health plan is assigned an overall rating from 5 stars to 1 star, based on the plan's performance in more than 50 specific areas which are grouped into different categories. Each area is assessed individually and assigned a star quality rating to reflect that assessment.

The number of stars assigned to the Medicare health plan represent the following:

★★★★★5 stars for excellent performance

★★★★4 stars for above average performance

★★★3 stars for average performance

★★2 stars for below average performance

★1 star for poor performance.

The ratings are updated annually based on ongoing monitoring and analysis. Some Medicare health plans, however, may be too new or not have enough data to be rated. The ratings are posted on www.medicare.gov in the Medicare Plan Finder section for Medicare eligible enrollees. They are also posted on www. cms.gov at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.

Star Ratings and Marketing

Plan Sponsors must provide overall Star Ratings information to beneficiaries through the standardized Star Ratings information document. The Star Ratings information document must be distributed with any enrollment form and/or Summary of Benefits. This document must also be available on plan websites.

Star Ratings are generally issued in October of each year. Plan sponsors are required to use updated Star Ratings information within 15 days of the release of the updated information and may only reference the contract's individual measures in conjunction with its Overall Star Rating, or Part C/D Summary rating in marketing materials. Plan sponsors must ensure that all marketing of Star Ratings information is compliant with CMS' Medicare Marketing Guidelines.

For complete information about Medicare Marketing Guidelines, please refer to Chapter 3 of the Medicare Managed Care Manual or Chapter 2 of the Prescription Drug Benefit Manual at www.cms.gov.

Star Ratings and Quality Bonus Payments (QBPs)

In 2012, CMS began a three-year demonstration project for Medicare Advantage plans wherein CMS awarded "quality bonus payments" (QBPs) to plans based on the plan sponsor's star ratings. Under the demonstration, plans must receive at least 3 stars to be eligible for QBPs. The amount of QBP is determined by the star rating; the higher a contract's star rating, the greater the QBP percentage. For example, 3-star plans will receive a 3% QBP, 4-star plans receive a 4% QBP, and 5-star plans receive a 5% QBP.

What Are Medicare Health Plans Rated On?

The Star ratings strategy is consistent with CMS' Three Aims (better care, healthier people/healthier communities and lower costs through improvements) with measures spanning the following five broad categories:

1. Outcomes: Outcome measures focus on improvements to a beneficiary's health as a result of the care that is provided.
2. Intermediate outcomes: Intermediate outcome measures helps move the Plan closer to true outcome measures. Controlling Blood Pressure is an example of an intermediate outcome measure where the related outcome of interest would be better health status for beneficiaries with hypertension.
3. Patient experience: Patient experience measures represent beneficiaries' perspectives about the care they have received.
4. Access: Access measures reflect issues that may create barriers to receiving needed care. Plan makes timely decisions about appeals is an example of an access measure.
5. Process: Process measures capture the method by which health care is provided.

Star Ratings are based on the results of the categories also known as Domains. The domains for Medicare Advantage and the Prescription Drug Plans are as follows:

Medicare Advantage (Part C)

Domain: 1- Staying Healthy: Screenings, Tests, and Vaccines

Domain: 2- Managing Chronic (Long-Term) Conditions

Domain: 3- Member experience with the health plan

Domain: 4- Member Complaints, Problems Getting Services, and improvement in the health plan's performance

Domain: 5- Health Plan Customer Service

Prescription Drug Plan (Part D)

Domain: 1- Drug Plan Customer Service

Domain: 2- Member Complaints, Problems Getting Services, and improvement in the drug plan's performance

Domain: 3- Member Experience with Drug Plan

Domain: 4- Patient Safety and accuracy of Drug Pricing

Each domain represents a series of individual measures. The 2014 Medicare Star Ratings are comprised of a total of 51 measures. There are 36 separate measures across the five different domains for Medicare Advantage Plan (Part C) and 15 separate measures for Prescription Drug Plan (Part D).

The measures have different weight in calculating the Star Ratings. For the 2014 Star Ratings, CMS assigned the highest weight to outcomes and intermediate outcomes, followed by patient experience/complaints and access, and then process measures. Process measures were weighted the least. The overall rating for the Medicare Health Plan is calculated as weighted averages of the ratings of individual measures.

The measures selected are reported using a combination of different data sources.

The data sources used for start ratings include:

- **Healthcare Effectiveness Data and Information Set (HEDIS) data**: HEDIS is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS data are collected through surveys, medical charts and insurance claims for hospitalizations, medical office visits and procedures. Some of the quality measures in the Star Ratings are calculated based on the collection of HEDIS data. For example, the glaucoma testing measure is collected through a review of claims and encounter data.

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data**: The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services. The Centers for Medicare & Medicaid Services also administers a version of the CAHPS Health Plan Survey designed for Medicare beneficiaries. The CAHPS survey is conducted annually in the spring. Survey responses are collected from a sample of Medicare health plan members who receive the survey. The survey data are publicly reported by contract number. The results from the Medicare CAHPS surveys are published in the Medicare & You handbook and on the Medicare Options Compare Web site (www.medicare.gov). Some star rating measures based on CAHPS survey results include flu and pneumonia shot rates and rates of satisfaction.
- **Health Outcomes Survey (HOS) Data:** Medicare health outcomes survey (HOS) measures the physical and mental health of the Medicare members. The Health Outcomes Survey (HOS) is conducted annually and assesses the health plan's success in maintaining and improving the functional status of their beneficiaries over time. The survey is sent to the Medicare members at the beginning (baseline measure) and after two years (follow-up measure). Taking risk adjustment factors into account, two-year change scores are calculated and the physical and mental health status of beneficiaries are categorized as better, the same or worse than expected with a roll-up of that information to the contract level. Some star ratings are based on survey results, such as questions related to falls risk and physical activity.
- **Health Plan Operational Data**: Some of the star ratings are also based on data reported to the Centers for Medicare & Medicaid Services by health plans. Examples include complaints and appeals.

For detailed information about Star Rating Measures, please refer to the Medicare 2014 Part C & D Star Rating Technical Notes at www.cms.gov.

Visit our website:

www.hisccompliance.com

Fraud Hotline: Available 24/7

Report fraud issues anonymously

1-800-543-0867 – for Members

1-877-272-9741 – for Producers, Vendors & Providers

1-877-211-2290 – for Employees

If you have any news or questions that you would like included in the newsletter, please send an email to:

HISCCOMPLIANCE @ BCBSIL.COM