

Resource Guide

Health Care Quality Metrics and Measures

This updated guidance on health care quality and performance standards is intended to provide the aging and disability networks with trending information that can inform their health plan contracting strategies. A keener understanding of evolving health plan quality standards aids Area Agencies on Aging (AAAs) and other community-based organizations (CBOs) in identifying health plan contracting targets and aligning the services they market and sell to those potential health plans. Industry trends embracing the social determinants of health (SDOH) as leading factors in quality of health outcomes offers new opportunities for engagement between the health care and social care delivery systems.

Regulatory and Industry Drivers for Quality Standards

“Quality measures are tools that help us measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.”

Centers for Medicare & Medicaid Services (CMS)¹

Health care is one of the most heavily regulated industries in the country. Federal and state governments exercise considerable oversight over the establishment and monitoring of industry quality standards while national industry and accreditation standards are layered on top of regulatory requirements. Leading organizations such as the **National Association of Insurance Commissioners (NAIC)**,² the **Joint Commission**³

and the **National Committee for Quality Assurance (NCQA)**⁴ have established considerable quality and performance standards for their respective industries. **Endorsements**⁵ from accrediting bodies are often required for organizations seeking eligibility to receive Medicare and Medicaid contracts.

Accreditation ranking signifies a level of achievement in meeting regulatory and industry quality and performance standards. Documentation of industry quality and performance achievements is often condensed into **quality report cards**,⁶ which show scores in key domains as well as demonstrate how health care organizations rank both locally and nationally. These report cards assist consumers as they select health plans and providers. Organizations with higher quality rankings earn additional funding for achieving superior results; those with poorer rankings may face penalties such as limited enrollment or loss of contracts. Demonstrating quality achievement is essential to the growth and financial well-being of health care organizations. As CBOs develop business cases to market to the industry, it is critical to connect the impact of the services and supports provided by AAAs and other CBOs on the industry’s achievement of quality performance. This Resource Guide provides guidance to assist AAAs and other CBOs with enhancing engagement opportunities with health plans, often referred to as managed care organizations (MCOs). The information may apply to Medicaid MCOs, Medicare Advantage Plans, employer-based health plans or Exchange plans.

Outputs vs. Outcomes

Typical CBO quality standards are based on services and supports outputs reporting, which doesn’t align with health plan standards. Reporting required by traditional CBO funders is focused on how many units of service are provided, or how many consumers are served, not necessarily the impact of the services provided. This variance can make it challenging for CBOs to collect,

analyze and report on the efficacy of their programs and demonstrate value in a way that is meaningful to a health plans.

Health care quality standards are complex and primarily centered on the impact of the quality of care delivered and how this care influenced consumer health outcomes, cost effectiveness and the consumers' health care experience. **Healthcare Effectiveness Data Information Sets (HEDIS)**⁷ is a quality measurement tool commissioned by CMS and developed by NCQA that evaluates outcomes across a variety of clinical quality standards such as controlling blood pressure and managing diabetes. The federal government's **Consumer Assessment of Healthcare Providers and Systems (CAHPS)**⁸ assesses consumers' experience in the health care system on issues such as provider accessibility, wait times for appointments and satisfaction with provider interactions.

Quality standards evolve over time and are guided by many factors, including regulatory reform (coverage of the chicken pox vaccine); unforeseen circumstances, such as the COVID-19 pandemic (assessment of isolation/loneliness), or notable population health/industry trends (**NCQA's introduction of race/ethnicity stratifications and revisions to acknowledge and affirm member gender identity to advance health equity**).⁹

Additionally, measuring quality varies across the health care ecosystem. In-patient safety standards are critically important for hospitals but are not factors in health plan ratings. However, both industries are measured by avoidable admission/readmission standards. Moreover, to reflect consumers' unique experience in a variety of health care delivery settings, there are multiple versions of the **CAHPS surveys**¹⁰—hospital, health plan, hospice, home health and more.

The importance of measuring and reporting consumer satisfaction has increased significantly in recent years, especially in the wake of the **Affordable Care Act's adoption of the Triple Aim**.¹¹ The Triple Aim philosophy seeks to drive health care quality improvement by focusing on population health outcomes, curbing health care costs and measuring patient experience. For NCQA accreditation, CAHPS results are weighted at 50 percent of a health plan's overall score. This means that CBOs that show the impact of their services and

supports on consumer satisfaction can add value to their marketing strategy and increase the likelihood that a health plan will take notice. For instance, aggregation of participant surveys from evidence-based programs could bolster your value proposition by demonstrating impact on consumer experience. CBOs may also be interested in utilizing the **CAHPS Home and Community-Based Services survey**¹² to collect and analyze agency consumer satisfaction.

Quality and Value-Based Payment Models

Value-based payment models have been deployed across the country as a means to incentivize the health care ecosystem to meet quality and performance standards. These models pay health plans and health care providers based on measures related to quality, efficiency, cost and patient experience. They are an alternative to **fee-for-service payment**¹³ models which encourage billing based on the *quantity* of services delivered rather than the *quality* of services outcomes. Results from a 2014 **Availity study**¹⁴ reported that nearly 75 percent of U.S. physicians were involved in at least one value-based payment model.

To improve quality most Medicaid and Medicare contracts feature some form of incentive payment to encourage quality improvement among health plans. The Medicare Star Ratings also feature such incentives. Under this rating program, CMS annually evaluates the quality of Medicare Advantage (MA) and Part D Prescription (PDP) plans based on their performance against a set of standards that reflect clinical and consumer satisfaction domains and include results from HEDIS, CAHPS and the **Health Outcomes Surveys (HOS)**.¹⁵ Plans are ranked according to their performance, and scores are based a scale of one to five. Plans with a Star rating of four or five can receive additional money from CMS that can be used to fund supplemental benefits like dental services or home modifications. Star Ratings have a substantial financial impact on plans with a Guidehouse **study**¹⁶ showing that a single one-Star ratings improvement could result in an eight to 12 percent annual increase in MA member enrollment.

Beyond Clinical Quality Measurement

Despite these organized systems for measuring and improving quality, achieving the goal of quality improvement remains elusive. The failure to consider non-clinical influences on health outcomes has proven to be a major barrier to improving quality. Traditionally, leading health plan quality and performance indicators have been exclusively focused on measuring clinical outcomes. The influence of the social determinants of health on clinical outcomes has largely not been addressed in health care policy. Whether it's access to transportation for medical visits and congregate meals, assistance with paying for utility services or support with hospital-to-home transitions, leveraging resources to address consumers' health and social care needs has been an increasingly crucial factor in the industry's quality and performance measurement standards. In an [August 2018 Modern Health Care article](#),¹⁷ Dr. Richard Seidman from LA Care Health Plan, a California-based Medicaid managed care plan, opined:

"If what we are paid is based on the outcomes we are able to produce, it begins to shift the focus and realization that ... we need to begin to make investments in those issues that while not traditionally health care-related, have such a huge impact on health."

Legislation that predated the COVID-19 pandemic, like the [CHRONIC CARE Act](#),¹⁸ called for more MA plan attention to SDOH services and relaxed the definition of primarily health related benefits and allowed plans to offer social care services for high need and chronically ill beneficiaries. NCQA introduced new quality measures for 2023 health plan HEDIS reporting like [Social Need Screening and Intervention \(SNS-E\)](#),¹⁹ which is intended to encourage health plans to assess and address members' food, housing and transportation needs. Additionally, plans are to identify specific needs and connect members with resources necessary to address unmet social needs. This measure looks at members who were screened at least once during the measurement period for unmet food, housing and transportation needs, and who received an appropriate intervention for positive screening results.

Health Equity is a Quality Marker

The impact of the COVID-19 pandemic has placed new attention on health care disparities—and the crushing need for social care services to support high-need consumers. As reported in a 2022 [SameSky](#)²⁰ report, health disparities in the U.S. are responsible for about \$93 billion in excess medical costs per year and significant human losses from premature deaths. The report further cites that people of color have a disproportionately higher incidence of chronic disease, which often requires costly treatments. More than 20 percent of Hispanic people ages 20 and older have diabetes, compared with 13 percent of White people.

Confronting health care disparities is a high priority and the industry is adopting aggressive measures to mitigate the barriers that contribute to these disparities. One example is [the President's Executive Order on Advancing Racial Equity](#),²¹ which calls for collective efforts across governmental agencies to pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized and adversely affected by persistent poverty and inequality. CMS has also published its [Six Pillar Strategic Framework](#),²² which emphasizes advancing health equity by addressing the health disparities that underlie the health care system. CMS also plans to introduce health equity quality measures into future Star Ratings measures.

CBO Opportunities for Integrated Care Engagement

Contracting with health plans is a strategic opportunity for AAAs and CBOs interested in building their client base, increasing earned revenue and developing sustainable business models. The expansion of quality markers that emphasize social care services and health equity should foster more integrated care engagement across the health care and social services ecosystems. AAAs and other CBOs are *the* subject matter experts on social care services and should leverage their experience to seek paid contracting relationships with health care organizations. To be clear, CBO services

are not a magic bullet for the industry; however, when combined with strong clinical and systematic quality improvement strategies, they can contribute to broader framework that encourages the successful achievement of quality performance goals. The ability of CBOs to assess primary health plan needs and align

social care services with these needs strengthens the foundation of person-centered care.

The following sections describe some of the measures that are most commonly used to evaluate health care entities.

CAHPS Measures

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of health care providers and ease of access to health care services.

CAHPS® measures cover a variety of focus areas, including health plans, health care facilities, home health care, hospice, etc. Understanding a potential partner's CAHPS® results may give CBOs an idea of which services a potential partner may find especially valuable. Some of the CAHPS® measures are used in the development of Star Ratings.

Additionally, if a CBO is interested in measuring the experience of its own clients and their overall consumer satisfaction with the services it provides—especially under Medicaid long-term services and supports (LTSS) programs—the Agency for Healthcare Research and Quality (AHRQ) has a CAHPS® survey for home and community-based services (HCBS) that can provide insight into these metrics.ⁱ

Health Outcomes Survey

The Health Outcomes Survey (HOS) is a mandatory patient reporting tool used to evaluate Medicare Advantage plan performance through consumer surveys each year. HOS is supported by NCQA under a contract with CMS and represents a foundational component of the Medicare Advantage Star Ratings

system that appears on the Medicare Plan Finderⁱⁱ tool and is used by consumers to compare Medicare plans.

According to the Medicare Health Outcomes Surveyⁱⁱⁱ website, uses for HOS include “targeting quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping beneficiaries make informed health care choices; and advancing the science of functional health outcomes measurement.” Current HOS survey instruments may be downloaded at www.hosonline.org/en/survey-instrument.²³

HEDIS Measures

The Healthcare Effectiveness Data and Information Set (HEDIS)ⁱⁱⁱ is managed by NCQA and is widely used to measure the performance and quality of health care organizations and systems. It is an important component of the Medicare Star Ratings and includes more than 90 measures across six domains:

- Effectiveness of Care (including Care for Older Adults measures)
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems

i Information about this survey is available at <https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/cahps-home-and-community-based-services-survey/index.html>

ii Information on the Medicare Plan Finder tool is available at <https://www.medicare.gov/plan-compare/#/?year=2023&lang=en>

iii <https://www.ncqa.org/hedis/>

Medicare Advantage and Medicare Prescription Drug Plan Star Ratings

Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) plans receive Star Ratings every year.^{iv} These publicly available, annual performance ratings are used to help consumers compare plans. CMS compiles information from HEDIS, CAHPS, HOS and various other sources, including Medicare beneficiary surveys, provider surveys, CMS plan monitoring activities and plan-submitted data.

Medicare Advantage plans are rated on their performance in five areas:

- **Staying healthy:** Are the plan's members receiving recommended screenings, tests and vaccines following guidelines on best practices for members to stay healthy?
- **Managing chronic (long-term) conditions:** How well do plan members manage their known conditions (by receiving recommended tests, screenings and treatments)?

- **Member Experience:** Is the plan responsive to the needs and care of its members (based on member ratings of their plan)?
- **Problem Indicators:** How often do members complain, do members have problems getting necessary services, did CMS identify problems with the plan, is the plan's performance improving or deteriorating, and what portion of the plan's members leave the plan in a given time period?
- **Customer Service:** How well do health plans take care of their members from a customer service perspective, and how do they handle member appeals?

Drug plans are rated on the drug safety and accuracy of drug pricing, as well as member experience, customer services and problem indicators.

In addition to providing information to assist consumers select plans, Star Ratings also have other implications. Plans with four or more Stars receive bonus payments from CMS, while plans receiving a Star Rating of fewer than three stars for three consecutive years may be terminated by CMS. In addition, plans with five Stars are eligible for year-round open enrollment.

^{iv} See Star Measures for plans in your state at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/>



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National Association of Insurance Commissioners (content.naic.org/)

Medicaid and CHIP Scorecard (www.medicaid.gov/state-overviews/scorecard/downloads/2021-scorecard-fact-sheet.pdf)

The Joint Commission (www.jointcommission.org/)

National Committee for Quality Assurance (www.ncqa.org/about-ncqa/)

CAHPS Home and Community-Based Services (HCBS) Survey Database (www.ahrq.gov/cahps/cahps-database/hcbs-database/index.html)

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CAHPS Measures of Patient Experience (www.ahrq.gov/cahps/consumer-reporting/measures/index.html)

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P4P

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In Depth: Hospitals tackling social determinants are setting the course for the industry (www.modernhealthcare.com/article/20180825/NEWS/180809949/in-depth-hospitals-tackling-social-determinants-are-setting-the-course-for-the-industry)

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