

Quality Improvement Programs of HHS

HHS requires that each Medicare Advantage plan (MA) develop and maintain a quality improvement program (PIP) for the purpose of improving the quality of care provided to enrollees in each MA plan offered.<sup>1</sup> The overall purpose of the Health Care Quality Demonstration Program<sup>2</sup> and the Quality Assessment and Performance Program<sup>3</sup> is to provide for consistent evaluation and improvement of the MA plans and to provide measurable benchmarks by which the beneficiaries can compare programs. The ability to compare programs is at the core of HHS' rationalization for the format of the MA plans. In order to make an informed decision, beneficiaries must have a basis of comparison and the PIP's provide the data for that comparison. By identifying plans with good performance and quality ratings it provides beneficiaries with the opportunity to enroll in a program that has proven itself, provides an incentive for plans to continuously improve, and a disincentive for plans to maintain static programs (by virtue of the fact that CMS can decline to renew contracts if performance levels are not met). Some of the other methods utilized include, determining best practice guidelines including increasing benchmark levels, gathering input from beneficiaries regarding efficacy and utilization, and providing care in a culturally and ethnically sensitive manner.

Healthcare Quality Demonstration Project

The Healthcare Quality Demonstration Program (HQDP) was initiated in an effort to measure the performance and improvements necessary for participating plans.<sup>4</sup> In essence it acts as a sort of "Report Card" for the plans. In order to provide beneficiaries with an opportunity to compare Medicare Advantage plans (MA) (formerly Medicare + Choice, or M+C) those plans must implement and maintain a program meeting minimum stipulated requirements.<sup>5</sup>

The directives establishing the HQDP state that its purpose is to encourage the delivery of improved quality in patient care.<sup>6</sup> It is to achieve that goal in part by:

- 1) providing incentives to improve the safety of care provided and achieving efficient allocation of resources;

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<sup>1</sup> 42 U.S.C. § 1395w-22(e)

<sup>2</sup> 42 U.S.C. § 1395cc-(3)(b)

<sup>3</sup> 42 C.F.R. § 422.152 (a)

<sup>4</sup> 42 U.S.C. § 1395cc-(3)(b)

<sup>5</sup> 42 C.F.R. § 422.152 (a)

<sup>6</sup> 42 U.S.C. § 1395cc-(3)(b)

- a. the incentives seem to be the thought that if a plan is well ranked it will draw consumers to it and away from other plans.
- 2) implementing and using “best practice” guidelines by providers;
  - a. CMS will look at historical data and trends derived from like-programs and set performance levels “best practice” guidelines, during contract negotiations for plan renewal
- 3) reducing scientific uncertainty in the delivery and care provided;
  - a. by reviewing data on under- and over-utilization of services care trends will produce equilibrium, allowing maximum efficiency of resources
- 4) encouraging shared decision making between providers and beneficiaries;
  - a. the exchange inherent in a competitive delivery system is assumed to equate to shared decision making
- 5) ethnically and culturally sensitive delivery of health care.
  - a. participation in the program is a key to realizing efficiencies in a market driven system. Thus, since non-whites are an increasing portion of the population it is imperative that their issues be addressed.

The program review is to include both clinical and non-clinical services and is to measure performance, develop practice guidelines, require regular evaluation and adjustment, and follow-up on the effectiveness of the adjustments using predetermined methodologies. The results must be provided to CMS at their request and a mechanism must be in place to provide providers and enrollees with the results of the evaluation. Plans must show significant improvement over their prior performance levels and sustain those improvements over time.<sup>7</sup> If CMS determines that the plan has not met the requirements they have the option of non-renewal upon the contract’s expiration.

The framework for the MA plans requires that they do the following in order to participate.<sup>8</sup>

1) *Measuring and Reporting*

Utilizing measurements in a standard format required by CMS the plan will measure and report data relating to –

- a. Clinical areas including the enrollee’s use of the services, perception of the care received, and the effectiveness of the care; that is, how well is the plan actually delivering the care; and
- b. Non-clinical areas such as access to and availability of the services, the grievance and appeals process in place, and the organizational characteristics;

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<sup>7</sup>Id. § (d)(9)

<sup>8</sup> For contracted plans on or after January 1, 2006 changes have been made to the collection, analysis, and reporting of data. The purpose of the program is stated as “improving the quality of care provided to enrollees...” Requirements are now in place for the establishment of quality improvement reporting programs for MA regional plans with the same requirements as the local plans. Restrictions have been placed on the Secretary restricting him/her from collecting any data not collectable as of November 1, 2003 unless the Secretary presents to Congress a report, prepared in consultation with the MA organizations and private accrediting bodies. Additionally, contracted plans post-January 1, 2006 must include a discrete quality improvement plan for chronic care improvement containing methods for monitoring and identifying enrollees eligible for participation in the program based on plan established criteria. 42 U.S.C. 1395w-22(e)

how is the organization structured and what is the protocol in place for addressing beneficiary concerns.

The intent is to collect data regarding actual and perceived elements of concern to beneficiaries using the plan.

CMS will establish, at the time of contract negotiations, minimum performance levels at the local, regional and national levels based on historical data and trends and the plan must meet those levels by the end of the contract year. If the minimum levels are not met CMS may decline to renew the plan contract.<sup>9</sup>

2) *Performance Improvement Projects*

Performance improvement projects (PIP) are organizational initiatives that focus on goals of quality improvement by measuring current performance which is then used as a baseline and by then developing interventions specifically addressed to increase those outcomes. The plans must establish PIP's that are representative of the full population they serve in all areas of clinical and non-clinical service they provide. CMS specifically requires that they address:

A) Clinical Areas

- i) prevention and care of acute and chronic conditions
- ii) high-volume and high-risk services
- iii) continuity and continuation of services

B) Non-clinical Areas

- i) Appeals, grievances, and other complaints
- ii) Access to, and availability of services

In addition to PIP's initiated by the plans CMS may require the organization implement organization-specific PIP's and participate in national or statewide PIP's.<sup>10</sup>

The plans are required to conduct ongoing assessments their performance using quality indicators that are objective, clearly and unambiguously defined, and based on current knowledge or research. Additionally, they must actually be able to measure the outcomes of the PIP's in question, that is, the satisfaction of the enrollees, the health and functional status or measures that can adequately act as proxy for those measurements.<sup>11</sup>

The plan is responsible for developing and maintaining a database to collect, analyze and integrate information pertaining to the PIP. The plan must also assure the reliability and completeness of the data, and to make it available to CMS. The PIP itself must also be evaluated by the plan on at least an annual basis to assure the effectiveness of the PIP and must correct any problems brought to its attention. Finally, the plan must include a separate focus on racial and ethnic minorities.<sup>12</sup> Since non-whites are an increasing portion of the population effort must be made to address particular issues in those groups in order to maximize the effectiveness of these plans.

*What This Means for Beneficiaries and Advocates*

The establishment of the Healthcare Quality Demonstration Project provides an opportunity, in theory, for specified MA plans to establish continual improvement

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<sup>9</sup> 42 C.F.R. § 422.152(c)

<sup>10</sup> Id. §§ (d)(1-6)

<sup>11</sup> Id. §§ (d)(7-9)

<sup>12</sup> Id. § (f)

protocols with the aim to improve services to beneficiaries and allow the beneficiaries to have a basis for comparing plans. Optimally, the comparison would be no more complicated than a check-list. Things are rarely that simple, especially when it comes to health care providers.

The rationale behind the way in which MA plans have been developed is that of the efficiencies of the "free market", that is, when organizations are allowed to compete they will develop programs that benefit the consumer. However, free market endeavors require access to complete and valid information for informed consumer decisions. It is not enough that PIP's provide CMS with data. Oversight must assure that the data provided is valid, thus the methodologies used in data collection must be valid. Beneficiaries or their advocates must be vigilant regarding the manner in which the data is collected by the plans, the manner in which it is organized by CMS and presented to the consumer. Although the regulations require that the data be accessible to the beneficiaries the ease of access and the form of that information will be telling. Although it is certainly convenient to be able to look at a brochure provided by a plan administrator it behooves one to dig a little deeper into the information provided to make a truly informed decision. Knowledgeable advocates should be better able to look at the data provided to CMS, whether in raw or compiled form, and advise their clients

There is also a potential benefit to the plans. By developing efficiencies and best practice guidelines for their own businesses the plans can improve their business practices by comparing themselves to others. In this regard competition can be good. Since CMS is supposed to monitor the progress of the assessments and use the benchmarks in renegotiating provider contracts the theory is that the base-line standards should continue to rise and there will be a check on unscrupulous business practices.