



# SYNOPSIS OF HEALTH CARE QUALITY MANAGEMENT SYSTEMS

**Administration for Community Living CBO Learning Collaborative Webinar**

**Presenter: Sharon R. Williams, Health Care Consultant**

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# QUALITY ASSURANCE: CONCEPTUALLY\*

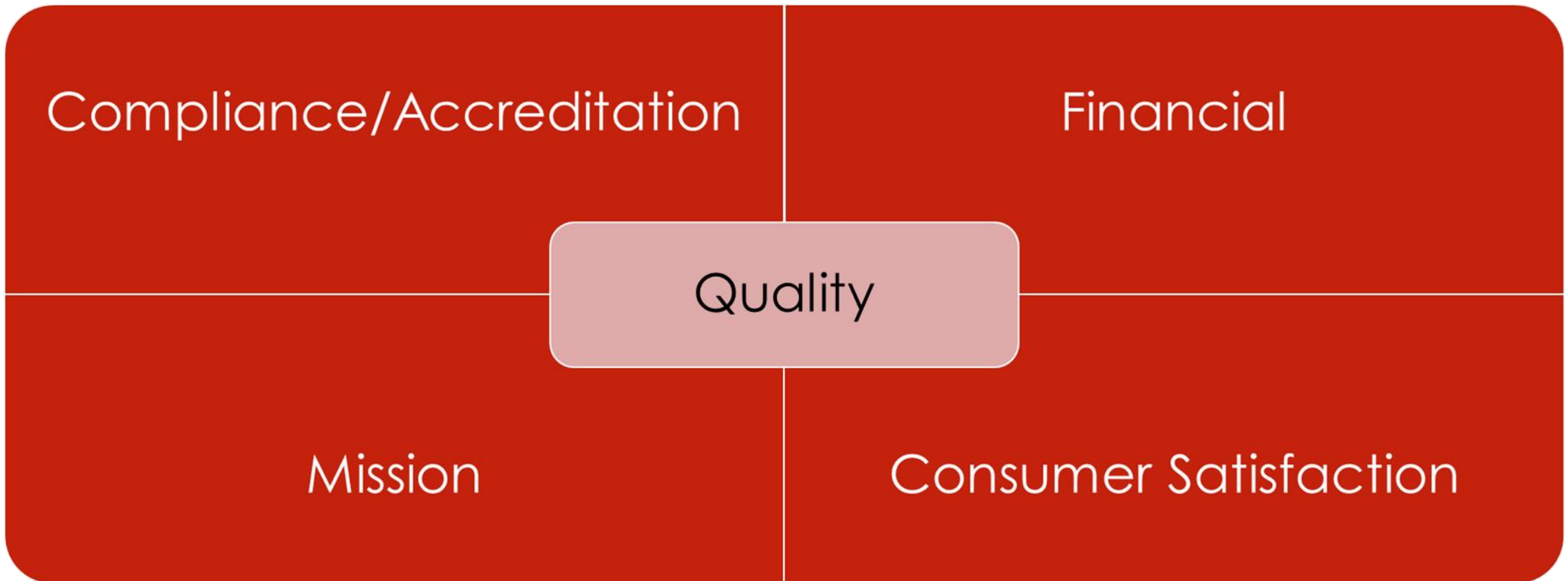
- **Quality Management goals should include:**
  - **Excellent care, strong coordination, high consumer satisfaction and good consumer health outcomes**
- **\*Quality Assurance**
  - **The Institute of Medicine (IOM) defines quality as —the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.**
- **\*Quality Improvement**
  - **The Agency for Healthcare Research and Quality (AHRQ) defines quality improvement as —doing the right thing at the right time for the right individual to get the best possible results.**

\*Medicare Part C Manual

# COMPONENTS OF QUALITY MANAGEMENT

- Adoption of medical quality management standards of care/QIP
- Establishment of Quality Improvement Committee
- Utilization Review
- Quality Management Studies
- Network Credentialing/Oversight
- Grievance and Appeals Review
- Member Satisfaction
- Program Evaluation/Reporting/Process Improvement

# IMPLICATIONS FOR QUALITY MANAGEMENT SYSTEMS



# GENESES OF QUALITY MANAGEMENT

Federal/State  
Regulations

Contractual

Accreditation

Health  
Organization

# FEDERAL/STATE QUALITY DRIVERS

- Medicare/Medicaid Standards
  - *Dual demos*
  - *Medicaid Waivers*
  - *Model of Care*
  - *ACO*
- ACA
- Federal HMO Act
- State health insurance regulations and legislative edicts
- *Dual Demos' Memoranda of Understanding*
- Agency for Healthcare Research and Quality/Consumer Assessment of Healthcare Providers/Systems (CAHPS)

# STATE REGULATORY AUTHORITY

- Michigan INSURANCE CODE OF 1956 (EXCERPT) Act 218 of 1956
- 500.3508 Quality assessment program; quality improvement program.
- Sec. 3508.
- (1) A health maintenance organization shall develop and maintain a quality assessment program to assess the quality of health care provided to enrollees that includes, at a minimum, systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory requirements. A health maintenance organization shall make available its quality assessment program as prescribed by the commissioner.
- (2) A health maintenance organization shall establish and maintain a quality improvement program to design, measure, assess, and improve the processes and outcomes of health care as identified in the program. A health maintenance organization shall make available its quality improvement program as prescribed by the commissioner. The quality improvement program shall be under the direction of the health maintenance organization's medical director and shall include:
  - (a) A written statement of the program's objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, and performance improvement activities.
  - (b) An annual effectiveness review of the program.
  - (c) A written quality improvement plan that, at a minimum, describes how the health maintenance organization analyzes both the processes and outcomes of care, identifies the targeted diagnoses and treatments to be reviewed each year, uses a range of appropriate methods to analyze quality, compares program findings with past performance and internal goals and external standards, measures the performance of affiliated providers, and conducts peer review activities.

# CONTRACTUAL QUALITY DRIVERS

- Medicare Part C regulations
- *Model of Care (MOC)*
- State Medicaid Contracts
- ACO contracts
- Employer Contracts
- Quality Report Cards
- **Contractual incentives/penalties for rate setting, enrollment priorities and bonuses tied to quality performance**



# ACCREDITATION

- ***‘Accreditation is an evaluative, rigorous, transparent, and comprehensive process in which a health care organization undergoes an examination of its systems, processes, and performance by an impartial external organization (accrediting body) to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards.’\****
- Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
- URAC
- National Committee for Quality Assurance (NCQA)

\*As defined by URAC

# HEALTH ORGANIZATION MISSION DRIVEN QUALITY

Beyond external drivers, many health plans are organized for the delivery of quality health care as defined in their mission/vision statements.

- *'Our mission is to help people live healthier lives by ensuring access to health care coverage for the underserved. We accomplish that mission through innovative strategies like our Winning Priorities approach, and through innovative programs such as the Personal Care Model, Healthy First Steps, and disease management.'* **United Health Care Community Plan**
- *'AmeriHealth Caritas is a different kind of mission-driven health care organization. We've been dedicated to helping the underserved for 30 years. Wherever our members live, we reach them in ways they understand - with outcomes-driven care that enhances their quality of life...'* **Amerihealth Caritas Plan**

# COMMON CLINICAL AND NON CLINICAL PERFORMANCE INDICATORS

Clinical	Non Clinical
Preventative Health	Provider Network Adequacy
Chronic Disease Management	Physician/Hospital Credentialing
Post Hospitalization Care	Data Reporting
Child Adolescent Well Care	Consumer Satisfaction
Adult Measures	Timely Claims Payment
Older Adult	Grievance/Appeals

# CONVENTIONAL HEALTH CARE QUALITY INDICES

## Accreditation

- Program/Structure
- HEDIS
- CAHPS

## Medicare

- MOC
- STAR Ratings
- ACO

## MOU

- Medicare/Medicaid
- State
- LTC

# HEDIS

- **Preventative/Well Care**
- Flu Shots for Adults
- Smoking Cessation
- **Older Adult Measures**
- Fall Risk Management
- Osteoporosis Testing in Women
- **Chronic Disease Management**
- Comprehensive Diabetes Care
- Appropriate Medications for Asthmatics

# HEDIS

- **The Healthcare Effectiveness Data and Information Set**
- *NCQA owned reporting tool*
- *Used by more 90 percent of America's health plans-allows cross plan comparisons*
- *Measures performance on important dimensions of care and service.*
- *75 measures across 8 domains of care.*
- Required reporting for Medicare Part C plans, most state Medicaid programs and Dual Demonstrations
- Based on health plan encounter/claims, medical record data, etc.

# MODEL OF CARE

- Required for Medicare Part C Special Needs Plans (SNPs) and participating Dual Demonstration health plans
- Health plan roadmap providing high quality care to the target population
- MOC reviewed by NCQA on behalf of CMS
- 11 elements, including:
  - Target Population definition/needs
  - Case Management protocol
  - Interdisciplinary Care Team
  - Overview of Quality Improvement Program, including ID of Quality Improvement Projects/Chronic Care Improvement Programs (CCIP)

# MOU

- Precursor to 3 way contract between feds, state, health plans for dual demonstrations—contract blue print
- Details the principles under which CMS/state and contracted plans will implement and operate the dual demonstration
- \*Contains plan specific expectations, including quality performance indicators, such as:
  - Customer Satisfaction (CAHPS)
  - % of enrollees with initial assessments completed w/in 90 days of enrollment
  - Follow up after hospitalization for mental illness
  - Readmission rates (30 days)
  - Reducing the risk of falling
  - Nursing facility diversion

\*OH MOU



# STAR RATING

- Medicare specific rating system for contracted plans
- Score--1-5, '5' is highest. High scoring plans get 'bonus' which can be applied to plan premiums/co pays to reduce member costs—enrollment incentive. Plans rated 2 or below may be subject to termination/enrollment restrictions
- Uses HEDIS, CAHPS and other data sources for evaluation
  - 9 domains/53 measures including:
    - Staying healthy-screenings/testing
    - Managing chronic conditions
    - Health plan responsiveness
    - Member complaints/appeals

# ALIGNMENT OF QUALITY MANAGEMENT BETWEEN CBOS/HEALTH PLANS

- Utilization Review
- Healthier Outcomes
- Consumer Satisfaction
- Population Based Quality Improvement (MOC)
- Data analyses/evaluation/process improvement
- Financial incentives

# CRITICAL RESOURCES FOR CBOS

- MOU/Dual Demonstration 3 Way Contract
- Medicare Manual—Quality Management Chapter/MOC
- NCQA/HEDIS and other accreditation entity standards
- CAHPS
- ACO contract
- Medicaid Contract
- Standard Health Organization Provider Agreement
- Health Organization Quality Improvement Plan
- Health Plan Report Cards

# REFERENCES

- <https://cahps.ahrq.gov/> -- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2014/Mar/1724\\_Zainulbhai\\_care\\_integration\\_dual\\_eligibles\\_ib.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2014/Mar/1724_Zainulbhai_care_integration_dual_eligibles_ib.pdf) -- *Assessing Care Integration for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative* (Issue Brief from The Commonwealth Fund)
- <http://www.ncqa.org/HEDISQualityMeasurement.aspx> -- Healthcare Effectiveness Data and Information Set (HEDIS)
- <http://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2013-5-Star-Enrollment-Period-Job-Aid.pdf> -- Medicare health plan star ratings
- [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality\\_Measures\\_Standards.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html) -- Medicare Shared Savings Program (Accountable Care Organization) Quality Measures and Performance Standards

THANK YOU!!!!!!

MORE ?????

sharonr.williams@comcast.net