Quality Improvement Program

Quality improvement is an essential element in the delivery of care and services by Blue Cross Medicare Advantage (HMO/PPO). To define and assist in monitoring quality improvement, the Blue Cross Medicare Advantage (HMO/PPO) Quality Improvement Program focuses on measurement of clinical care and service delivered by physician, professional provider, facility or ancillary providers against established goals. Key components of the program described below include the Chronic Care Improvement Program (CCIP), Quality Improvement Projects (QIPs) and performance monitoring (HEDIS, CAHPS, HOS). Formal evaluation of the program occurs annually to assess the impact and effectiveness of the program.

Chronic Care Improvement Program (CCIP)

A set of interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions and include patient identification and monitoring.
Other programmatic elements may include the use of evidence- based practice guidelines, collaborative practice models involving physicians as well as support-services providers, and patient self-management techniques.

Quality Improvement Project (QIP)

An organization's initiative that focuses on specified clinical and non-clinical areas.
Healthcare Effectiveness Data and Information Set (HEDIS®)
A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

A patient's perspective of care survey, administered annually, in which a sample of members from provider organizations (e.g., MAOs, PDPs, PFFS) are asked for their perspectives of care that allow meaningful and objective comparisons between providers on domains that are important to consumers; create incentives for providers to improve their quality of care through public reporting of survey results; and enhance public accountability in health care by increasing the transparency of the quality of the care provided in return for the public investment status.

Health Outcomes Survey (HOS)

This survey is the first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the VR-12, to assess both physical and mental functioning. A sample of members from each Medicare Advantage organization health plan is surveyed. Two years later these same members are surveyed again to evaluate changes in health.

Quality of Care Issues

The Quality Improvement Program includes aggregation and analysis of trend for quality of care issues. A quality of care complaint may be filed through the Medicare health plan's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

The QIO is comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

CMS Star Ratings

The Centers for Medicare and Medicaid Services (CMS) posts quality ratings of Medicare Advantage plans to provide Medicare beneficiaries with additional information about the various Medicare Advantage plans offered in their area. CMS rates Medicare Advantage plans on a scale of one to five star and defines the star ratings in the following manner:

5 Stars	Excellent performance
4 Stars	Above average performance
3 Stars	Average performance
2 Stars	Below average performance
1 Star	Poor performance

The quality scores for Medicare Advantage plans are based on performance measures that are derived from four sources:

- Healthcare Effective Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey (HOS)
- CMS administrative data, including information about member satisfaction, plans' appeals processes, audit results, and customer service
- CMS groups the quality measures into five domains:
- Staying healthy: Screenings, Tests, and Vaccines
- Managing Chronic (long-term) Conditions
- Ratings of Health Plan Responsiveness and Care
- Member Complaints, Problems Getting Services, and Choosing to Leave the Plan
- Health Plan Customer Service

All rated plans receive both summary scores and overall scores. The summary score is used to provide quality-based payments and an overall measure of a plan's quality based on indicators specific to quality and access to care. The overall score differs from the summary score because it combines a plan's summary score with its Part D plan rating.

Cooperation

Participating physician, professional provider, facility or ancillary providers must comply and cooperate with all Blue Cross Medicare Advantage (HMO/PPO) Medical Management policies and procedures and in the Blue Cross Medicare Advantage (HMO/PPO) Quality Assurance and Performance Improvement Programs. In addition, participating physician, professional provider, facility or ancillary providers must cooperate with the independent quality review and improvement organization, [Quality Improvement Organization (QIO)], approved by CMS in its review of quality of care and investigation of quality complaints on behalf of the Medicare program. KEPRO is the QIO for Blue Cross Medicare Advantage (HMO/PPO).

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