



THE AMERICAN
HEALTH QUALITY

ASSOCIATION

Recommendations to Congress

for a

**Medicare
Quality
Accountability
Program**

March 2006

Legislative Proposal: Medicare Quality Accountability Program March 2006

Introduction

This proposal by the American Health Quality Association (AHQA) would establish the “Medicare Quality Accountability Program” to replace the current beneficiary complaint program. This is the second in a series of AHQA proposals to modernize the Medicare Quality Improvement Organization (QIO) program.

The policy elements set forth below would be written into the Social Security Act to replace the existing beneficiary complaint program paragraph at Section 1154(a)(14). Several related provisions of law would remain in place. For example, QIOs would continue to handle expedited beneficiary initiated appeals, QIOs would continue to review EMTALA cases (implementing reforms enacted in the MMA), QIOs would still be obliged to obtain the services of appropriate specialists to review cases alleging poor specialty care, the identities and deliberations of QIO peer reviewers would continue to be confidential, and QIOs would continue to be indemnified for good faith execution of duties.

AHQA will be releasing additional legislative proposals to improve the QIO program as these are approved by the Association’s board of directors.

Medicare Quality Accountability Program Specifications

(a) Purpose The purpose of the Medicare Quality Accountability Program is to:

- 1) Improve the awareness and responsiveness of health care plans, providers, and practitioners to consumer concerns about clinical quality and service;
- 2) Assist plans, providers, and practitioners in adopting effective techniques to identify and respond promptly and effectively to consumer concerns;
- 3) Distinguish and respond appropriately to quality problems arising from failure of clinical systems, and those arising from incompetent or reckless actions of individuals;
- 4) Discover suboptimal clinical and health care service processes that are likely to result in clinical and service quality problems, and assist plans, providers, and practitioners in taking effective action to eliminate the cause of such process failures;
- 5) Identify plans, providers, or practitioners that are unwilling or unable to take effective action to eliminate the cause of clinical process failures, and refer such entities and individuals for appropriate enforcement action by state and federal authorities.

(b) Outreach and Education Each QIO shall conduct extensive outreach to the public, plans, providers, and practitioners to –

- 1) Through publication of an annual quality report for each state, and by other means, promote awareness of standardized quality measures that may be used for evaluating care and for choosing plans, providers, and practitioners;
- 2) Offer to the public, plans, providers, and practitioners advice, tools, and techniques designed to encourage patients and family members to state their concerns about clinical quality and service quality directly to their caregivers and health care administrators, and to facilitate a timely and appropriate response to such concerns; and
- 3) Promote awareness of the services the QIO offers to complainants, and the limitations of those services, including disclosure that a QIO cannot award damages, and that a QIO report to a complainant is not admissible as evidence in any civil court action.

(c) Facilitation of Remedies Promptly upon receiving a written complaint from a beneficiary or representative of a beneficiary, subject to receiving the complainant's permission to disclose his/her identity, the QIO shall –

- 1) Determine whether the complaint allegations are confirmed, and, with respect to confirmed allegations, determine whether appropriate action has been taken to prevent a recurrence of the confirmed problem;
- 2) In cases where such concerns have not been sufficiently addressed, request additional action by any plan, provider, or practitioner substantially involved in the service that is the subject of the complaint, and, if appropriate, offer dispute resolution services; and

- 3) In cases involving confirmed clinical process problems which are likely to harm current or future patients, for a reasonable period provide technical assistance to the plan, provider, or practitioner and monitor results.

(d) Referral for Enforcement Action After a reasonable period of providing assistance to a plan, provider, or practitioner, a QIO shall determine whether clinical process problems identified as a result of a complaint remain likely to harm current or future patients. Except in circumstances described in paragraph (3), in determining the duration of the reasonable period for the purposes of this subsection, the QIO shall take into consideration the likelihood of harm and the seriousness of harm to current and future patients if the confirmed concerns were to continue, and the extent of improvement which has been achieved by the plan, provider, or practitioner.

- 1) If the determination is that harm is likely, the QIO shall offer an opportunity for explanation by the plan, provider, or practitioner, and, subsequent to the opportunity for explanation, the QIO shall make its final determination whether the plan, provider, or practitioner has failed to take appropriate and feasible action to improve the clinical process;
- 2) If the final determination under paragraph (1) is that the plan, provider, or practitioner has failed to take appropriate and feasible action to improve, the QIO shall refer the entity or individual to appropriate state authorities for enforcement action;
- 3) If the QIO determines that a provider or practitioner has grossly and flagrantly violated the obligations of section 1156 (a), the QIO shall immediately initiate procedures established under section 1156(b) for referral to the Secretary.

(e) Reporting of Findings and Actions After making the determinations in subsections (c) and (d), the QIO shall --

- 1) Report to the complainant whether their complaint allegations were confirmed and actions being undertaken by the plan, provider, or practitioner to address the confirmed allegations. Notwithstanding any other provision of law, such reports by the QIO to the complainant shall not be admissible in any civil litigation; and
- 2) No less than annually, compile and make available to the public in the report required by subsection (b)(1) the numbers, frequency, and types of complaints received, successful actions undertaken by plans, providers, and practitioners to prevent recurrence of problems identified by complainants, actions taken by the QIO to assist the public, plans, providers, and practitioners in identifying, reporting, and preventing recurrence of service and clinical quality process problems. Such reports shall not disclose the identities of the QIO reviewers, complainants, nor those who are the subject of complaints, except the names of entities and individuals referred pursuant to subsection (d) shall be disclosed with the reason for referral.

(f) Continuous Improvement in Complaint Handling Process Immediately upon enactment, the Secretary shall in consultation with the QIOs begin to redesign current procedures for receiving and responding to patient complaints. The aims of this initial redesign effort are to align these processes with the program purposes identified in subsection (a) and to make these processes as timely as possible in responding to the needs of complainants, consistent with the rights of plans, providers, and practitioners. The Secretary and each QIO shall continuously measure the satisfaction of complainants, plans, providers, practitioners, mediators, dispute resolution facilitators, and QIO staff who have been in-

involved in the follow up of complaints, with the aim of making further procedural changes to improve the timeliness and effectiveness of the complaint handling process in fulfilling the program's purposes.

(g) Funding The estimated incremental cost of executing the Medicare Quality Accountability Program shall be added to actual expenditures for the beneficiary protection function of the QIO program in fiscal year 2006.

(h) Evaluation The Secretary shall monitor and report to Congress regarding (1) the reliability of QIO complaint determinations, (2) the availability of the services of physician reviewers for both primary care and specialty cases handled by QIOs, (3) changes resulting from the continuous improvement process described in subsection (f), the actions of enforcement authorities in following up referrals made by QIOs, and (4) any discernible trends in civil litigation for monetary damages filed by individuals who have complained to QIOs.

The Secretary shall provide the first report due no later than three years following enactment of this section, and annually thereafter. No later than seven years after enactment of this section, the Secretary shall include in such report a recommendation as to continuation, modification, or repeal of the Medicare Quality Accountability Program.