Chris Eisenberg

Chris Eisenberg:
Okay great. Thanks Chris. Again, Chris Eisenberg Director of Health Plan accountability at CMS, and while I'm going to be talking some about HEDIS and some other things today, I want to just take maybe ten minutes and tee it up for you and give you a sense of the quality related data that we get in under the Medicare Advantage Program and to emphasis a little bit more of how we use it, what we do with it, rather than the details around HEDIS reporting given some of the folks who have talked to you already. You've had the real experts address you already regarding HEDIS. That's not to say that if you have technical specifications, types of questions, that I won't try to answer them and to the extent that I don't know the answer, be glad to scribe your question and get back to you, but I want to spend a little bit more time talking about what we're doing with the data and how we use it from a plan over sight standpoint.

This slide just kind of walks you through some of the HEDIS history. Which I'm sure many of you know from my perspective it became a program requirement at the end of 1997 and we've been reporting, we've been taking the reported data since then and using it in a variety of ways.

Currently, there are about eight measurement domains and some sub-domains as well and that's what those look like. For our purposes we're using some measures from at least across all of those domains or sub-domains.

This is always a slide that folks from the health plan community like and say, "Can you send me that slide?" because there is always this question, "I am a cost planner, I am a this kind of planner, or I am that kind of planner, do I have to report HEDIS?" And I know people feel a little uncomfortable you know like asking the question, umm, maybe like a month before they find out the answer is yes.

[laughter]

Right? I think I'm right on that. So, umm, just putting this one up here to make sure that people do understand which plans do report HEDIS. Obviously local and regional Medicare Advantage organizations, Cost plans, 1876 Cost, 1833 if you're an HCPP out there, you do not report HEDIS, certain types of demonstrations, and there was quite a little list of does report/doesn't report, happy to report that it's in the Medicare Managed Care Manual, Chapter 5. If you want to know, okay, I am a demo, am I reporting or am I not reporting, but it would have been a slide in and of itself. So you can look that one up for yourself.

Let's talk about private fee-for-service. If you are a private fee-for-service organization and you meet either of those two criterion, we are strongly encouraging you to report HEDIS data to us. We know that there are issues with private fee-for-service plans not controlling the medical record and not having a network per se. So, while it is voluntary

we are encouraging PFFS plans to report HEDIS if you have a thousand or more enrollees and you've had a contract as of 7/1/2007.

In 2008 we will continue to require that PPOs or we will for the first time require that PPOs report HEDIS measures using the administrative collection method. Which plans don't report HEDIS? If you're a PACE, and if you're a PACE, you know you're not a plan, you're a provider. PACE providers if you're an MSA there is a short list of fee-for-service demonstrations and in CMS talk we refer to these demonstrations as more of a fee-for-service like demonstrations such as CCIP.

Lets talk a little bit about why we collect data. I mean the obvious answers are we have a requirement in your contract, and there is a regulation that say we collect HEDIS data along with CAPS and HOS other types of performance measures when the MMA is passed. There is a provision that says the quality data that CMS is gathering right now they'll continue to gather and if CMS wants to gather more of that data there has to be, and it may be rule making, it has to be some sort of a consultation to sort of go over and beyond where we are now. So there is the requirements that are in regulation and there are the requirements in your contract. I like to think of the answer to that question more in terms of if your going to gather something and your going to require someone to send it to you, in essence a reporting requirement, you really ought to have, from CMS's perspective, a good plan for how you're going to use it. And from my perspective I think we do have a good plan for how we use HEDIS and other types of data.

I would just sort of back up just for a moment and say if you were to think of sort of the organizational construct around the quality information that CMS gathers for purposes of contract administration and plan oversight, it sort of looks like this. It would be like an umbrella, and that umbrella would be named the quality improvement program and underneath that umbrella you'd have three prongs, and you'd have Quality Improvement Programs or projects that you have to submit every year, there would be Chronic Care Programs that has to be part of the overall gestalt of your quality program, and then you have to submit data. HEDIS is one example; CAPS is another type of example; HOSTAT is another example. We use HEDIS in other types of data for performance assessment across a variety of venues.

The Performance Assessment System, using that really as a noun, we've been using this sort of gathering of the various types of quality data since around 2000. I think Abby in her slides this morning touched on that, talked a bit about the history of that. We are able to array the data in such a way that we know which organizations at the state level, at the regional level, and at the national level perform higher or lower relative to their peers. And that information is very important to us especially when we pack it, package it with other like types of measures. For instance, access to care related measure out of HEDIS when combined with responses from the CAP survey where Medicare beneficiaries are giving us some sense of what their experience in a health plan is like. It's pretty powerful information especially when you package it together, and that's what we do under the Performance Assessment System.

Audit Risk Assessment Tool. Now that may be a term that's new to some of you. You know since we moved into the MMA environment where we have a lot more plans and the level of sophistication with the plans has grown likewise, there used to be a day in time where we liked to say we would audit every plan, across every program attribute, every two years. Well, we're not in that time anymore. We now use a risk assessment methodology to determine which organizations from an audit standpoint are we going to select for audit in any given year and it's HEDIS and other types, and I want to limit the comment just to HEDIS, but HEDIS and other types of data in part give us the kind of pointers, or indicators, that tell us we should be looking at this organization in this area and maybe this organization higher scores for instance, we're not going to be auditing or looking at.

And then the MAPD Performance ratings which I know Abby did talk about in her remarks earlier this morning. Really for the first time a much more powerful public display of these important measures across the four broad composites: access to healthcare, effective treatments for chronic conditions, preventing illness and complications and customer service.

Take a couple of minutes and just talk about a couple of things new for 2008. As we had mentioned before we are strongly encouraging PFFS organizations to participate in HEDIS and HOS if they meet the minimum reporting requirements, a thousand enrollees. For 2008 Medicare managed care contractor meeting the minimum reporting requirements must submit the summary level and they must also submit the patient level data.

How CMS is using and what we are doing with the patient level data may be a little bit different than what we had been doing in the past. For instance, the reporting requirement around that is now that organizations submit it directly to CMS via Gentran or Connect Direct and the summary level data continues to go to NCQA, and they package it for us, send it to us in September.

Wanted to go back to one -- I wanted to talk just about -- I thought I had a slide in here -- One of the things that we put in the call letter this year, and it looks like the slide dropped off, is that we are giving consideration to lowering the minimum enrollment requirement. Right now it's at a thousand. We know that there are other purchasers who in conjunction with their reporting requirements for HEDIS to NCQA have a lower minimum enrollment requirement, and that is one thing that we are looking at in terms of a possible change.

I don't have slides on the following two things I want to talk about just briefly as I'm running out of time. CCIP and QIP. You earlier will recall my illustration of an umbrella under which we have quality improvement projects, we have Chronic Care Improvement Program, and we have the submission of data.

Fortunately today at 3 o'clock there will be some folks from, two folks from two of our three Medicare Advantage Quality Review Organizations. We call them MACROS who

are going to talk to you in detail about QIP and CCIP. But with QIP I think you all know that it is a project, an annual project that you work on, the results of which may be audited by CMS if your organization is selected for audit, and for 2007 and 2008 we are auditing the quality chapter of the audit protocol, and we will be looking at CCIP and we will be looking at QIP. I think in the call letter and the manual it states that CMS reserves the right to announce national projects that would have to comprise your QIP. I don't speak for the policy folks at CMS, although I did check with them before I came over here today, and said let me just be sure, I don't recall hearing that CMS announced a national quality project for QIP, and they confirmed that's correct not this year although I guess it could happen in future years.

And then CCIP, Chronic Care Improvement Program, I used to get all balled up on this. People would ask me to come and talk about oversight health plans, and I would say you have to have a Chronic Care Improvement Project, and you need a Quality Improvement Program. And somebody in the back would be going you got them mixed up. This is a program not a project. So we're really looking for the Chronic Care Improvement Program to be something that weaves itself through the fabric of your overall quality efforts and initiatives. And again the MACROS folk are going to come and talk to you and give you some more of the details about some of the finding and how we use those data.

So with that I'll conclude my remarks. And I think we are taking questions at the very end after everybody talks and I think at this point I'm going to turn it over to Liz Goldstein who is going to talk about CAHPs.

[applause]

[end of transcript]