QUALITY IMPROVEMENTS

Under the Medicare Modernization Act (MMA) and the proposed rule, Prescription Drug plans and Medicare Advantage plans will be required to have ongoing quality improvement programs.

Medication Therapy Management

Plans offering the new Medicare drug benefit will be required to have a medication therapy management program to ensure the appropriate use of prescription drugs to improve outcomes and reduce adverse drug interactions. CMS is proposing to allow plans flexibility in choosing how to target this service. In general, it will be directed at patients who:

- have multiple chronic conditions (such as asthma, diabetes, hypertension, high cholesterol and congestive heart failure);
- are taking multiple medications; and,
- are likely to have high drug expenses.

The therapy management program will also be coordinated with other chronic care management and disease management programs operating in other parts of Medicare, and will be developed in cooperation with pharmacists and physicians.

Therapy management sessions are sometimes referred to as “brown bag” consults because patients are asked to gather all their medicines in a bag and bring them in for the pharmacist to review. They serve several purposes:

- Letting the pharmacist see all the medications the patient is taking so they can spot dangerous combinations of drugs and look for changes that might improve the patient’s overall health.

- Giving the pharmacist an opportunity to explain to the patient the proper way to take their medications and suggest tools a patient might use to keep track of their drug regimen.

- Letting the beneficiary ask questions and receive feedback from the pharmacist.

Like the rest of the drug benefit, medication therapy management will be a new service for Medicare. Currently, a few state Medicaid programs reimburse pharmacists for providing these “cognitive services.”

Collection of Data

Prescription Drug plans will also be required to collect and submit their data claims to CMS, both for payment and risk adjustment purposes, and to monitor and improve quality.

Expanded Responsibilities of Quality Improvement Organizations (QIOs)

Currently, Medicare Quality Improvement Organizations (QIOs) are responsible for monitoring and evaluating the quality of activities of health care providers under Medicare Part A and Part B. Under the MMA, QIOs' responsibilities will also include providing quality improvement assistance for prescription drug therapy to Medicare Advantage plans and Prescription Drug plans.

Electronic Prescribing

Medication errors will be sharply reduced by the electronic prescribing provisions in the MMA. The Secretary of Health and Human Services is working with providers and the National Committee on Vital and Health Statistics to accelerate the adoption of initial electronic prescribing standards. Under the timeline established in the MMA, electronic prescribing based upon national standards is to be mandatory for participating drug plans by 2009, although CMS expects to mandate a starter set of well-established standards by January 2006. Electronic prescribing is entirely voluntary for doctors. The Act also authorizes the federal government to give grants to doctors to help them buy computers, software, and training to get ready for electronic prescribing.

Medicare Advantage Quality Improvement

By 2006, each Medicare Advantage plan will be required to have an ongoing chronic care improvement program and quality improvement program. The proposed rule excludes Medicare Advantage private-fee-for-service and MSA plans from quality improvement requirements because enrollees are not restricted to care from a network of providers.

Under the quality improvement program, Medicare Advantage plans are required to include quality improvement projects that could be expected to have a favorable effect on health outcomes and enrollee satisfaction. Medicare Advantage plans can select their own topic areas based on the needs of their enrolled population as long as it is relevant to the Medicare population. Requirements are broad in order for Medicare Advantage organizations to continue carrying out performance improvement projects that they have been doing for years. In addition, Medicare Advantage organizations must encourage providers to participate in CMS and HHS quality improvement initiatives.

Each Medicare Advantage plan must provide for the collection, analysis, and reporting of data that permits measurement of health outcomes and other indices of quality. PPOs will be required to collect, analyze, and report data that are furnished

by providers, and the Secretary will establish separate rules for Medicare Advantage regional plans.

Comments on the proposed regulations will be accepted until October 4, 2004. Comments should be submitted to the Centers for Medicare & Medicaid Services at www.cms.hhs.gov/regulations/ecomments