

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

*Medicare's Quality Improvement Organization Program:
Maximizing Potential*

Public Briefing - March 9, 2006

Key Messages: 1

1. The quality of care for Medicare beneficiaries is improving, but the pace of change is too slow and gaps in quality persist. The QIO program has potential to become an important national resource to accelerate the improvement of quality, but needs a major restructuring. Demand for QIO assistance will grow as pay for performance and external reporting requirements increase.

Key Messages: 2

2. QIOs should focus on technical assistance for performance measurement and improvement. CMS should contract separately with capable organizations for reviews of complaints, appeals and other cases.

Key Messages: 3

3. A strong, focused QIO network is essential to the effective implementation of performance measurement and reporting. The QIO program should assist providers to develop their own capacity to measure and improve their performance.

Key Message: 4

4. CMS should ensure rigorous evaluations at all levels of the QIO program because of limited evidence currently on the impact of the program. Findings of the evaluations should guide both program and management improvements.

Redesigning Health Insurance Project

- MMA (PL 108-173) mandated *two* studies
 - Sec 328 – study of performance measures and their use to align payment with performance
 - Sec 109 – study of Medicare's Quality Improvement Organization program
- The committee empaneled by the IOM will produce *three* reports:
 - Performance Measurement Report
 - Payment Incentives Report
 - Performance Improvement Report

Committee Members

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- Bobbie Berkowitz, University of Washington
- Donald M. Berwick, Institute for Healthcare Improvement
- Bruce E. Bradley, General Motors Corporation
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Why performance improvement?

- Gap remains wide between the bold vision laid out in the *Quality Chasm* report and the current state of the U.S. health care delivery system
- Quality of care for Medicare beneficiaries has been improving too slowly
- Expansion of public reporting of performance and payment incentives for quality will create demand among health care providers for technical assistance with quality improvement

Why an Institute of Medicine Study of QIOs?

- QIO responsibilities expanding to cover Part D, drug therapy quality
- Impact of QIOs and QIO program unclear
- Previously recommended program evaluation not conducted

MMA (PL 108-173) -section 109

- Institute of Medicine study of QIO program:
- Overview of program
- Extent to which QIOs improve quality of care in Medicare
- Extent to which other organizations could do these tasks as well as QIOs
- Effectiveness of QIO case reviews and other activities
- Funding amount and source for QIOs, and
- Oversight of QIOs

Committee's Approach to Research

- Recognize QIO program is ongoing, constantly changing
- QIOs vary considerably on many criteria; typical or average not always useful
- Start study during transition from 7th SOW to 8th SOW
- No comprehensive description of program available
- Original data collection and analysis needed
- Collect data from a variety of sources and by different methods
- Compare and integrate findings
- Brief program history; focus on 7th SOW

Research Challenges

- Data collection could not be built into 7th or 8th SOWs
- No systematic data collection from providers and beneficiaries because of OMB survey restrictions
- Confidentiality concessions required de-identification of QIO-specific data
- Report to serve multiple audiences:
 - Part 1 = policy focus and recommendations
 - Part 2 = descriptive details and analyses

Data Resources

- Focused literature review
- Web-based data collection from QIOs
- CMS QIONet data
- Telephone interviews with CEOs, random sample of 20 QIOs
- Visits to 10 QIOs
- CMS 3-day briefing
- Face-to-face interviews and focus groups
- Specific data requests to CMS staff

Findings and Conclusions

- Quality of care in Medicare has improved over time
- Not possible to determine QIO program's contribution to improvements; evidence limited
- QIO program has potentially valuable nationwide infrastructure devoted to promoting quality improvement
- Value of program could be enhanced:
 - Focus on technical assistance for quality improvement
 - Strengthen governance and structure of QIOs
 - Improve CMS' management
 - Conduct more rigorous evaluation of impact

Focus on Quality Improvement and Measurement Recommendation 1

The QIO program must become an integral part of strategies for future performance measurement and improvement. Congress, DHHS, and CMS should strengthen and reform key dimensions of the QIO program, emphasizing provision of technical assistance for performance measurement and quality improvement. These changes will enable the program to contribute to improved quality of care for Medicare beneficiaries as they move through multiple health care settings over time.

Recommendation 1, continued

- Quality improvement should aim for: safety, effectiveness, patient centeredness, timeliness, efficiency, and equity.
- QIO services should be available to all providers, Medicare Advantage organizations and prescription drug plans.
- QIO services should emphasize hands-on and other technical assistance aimed at building provider capacity.

Recommendation 2

QIOs should actively encourage all providers to pursue QI and should assist those providers requesting technical assistance; if demand exceeds resources, priority should be given to those providers who demonstrate the most need for improvement or who face significant challenges in their efforts to improve quality. CMS should encourage and expect all providers to continuously improve the quality of care for Medicare beneficiaries.

QIO Board and Organizational Structure Recommendation 3

Congress and CMS should strengthen the organizational structure and governance of QIOs to reflect the new, narrower focus on technical assistance for performance measurement and QI. Congress should eliminate the requirement that QIO governing boards be physician-access or physician-sponsored, while also enhancing the boards' ability to provide oversight and direction.

Recommendation 3, continued

- Congress and CMS should improve QIO governance by requiring broader representation of all stakeholders on boards, expansion of expertise represented, and greater diversity.
- QIO boards should strengthen their committee structures and consider implementing annual performance self-assessments.
- Organizations holding QIO contracts should include on their websites a listing of board members and information on the compensation of members and the CEO.

Responsibility for Complaints, Appeals and Case Reviews Recommendation 4

Congress and CMS should develop mechanisms other than those already in place to better manage complaints and appeals of Medicare beneficiaries, as well as other case reviews. The QIO in each state should no longer have responsibility for handling beneficiary complaints, appeals, and other case reviews for payment or other purposes.

Recommendation 4, continued

- Review of beneficiary complaints should be a top priority and the function consolidated regionally or nationally or conducted by an appropriate state agency.
- CMS should contract with appropriate organizations regionally or nationally to handle beneficiary appeals and other case reviews.
- This devolution of responsibilities would allow QIOs to concentrate on quality improvement efforts with providers.

Data Processing Recommendation 5

DHHS and CMS should revise the QIO program's data-handling practices so that data will be available to providers and the QIOs in a timely manner for use in improving services and measuring performance.

- CMS should initiate a review of data-sharing systems, processes, and regulations to correct elements that inhibit prompt feedback on provider performance.

Recommendation 5, continued

- The QIO program should support the processes of national reporting of performance measures, data aggregation, data analysis and feedback.
- DHHS should allow and encourage sharing of medical claims data when it is not precluded by HIPAA privacy protections and sharing of complaint-resolution data with complainants.

Recommendation 5, continued

- CMS should work toward integrating more care data from all providers and public and private payers to create both records of patient care over time and population-level data.
- Independently of the core QIO contract, CMS should be responsible for ensuring and auditing the accuracy of data submitted by providers in Medicare. Providers should be accountable for the validity and accuracy of the quality measurement data they submit. QIOs should supply providers with technical assistance to improve the data collected.

QIO Program Management Recommendation 6

CMS should establish clear goals and strategic priorities for the QIO program. Congress, DHHS, and CMS should improve their management of the QIO program as necessary to support those goals, especially by enhancing contracting processes for the QIO core contract and QIO Support Center (QIOSC) contracts; integrating core, support, and special study contracts within the program; and improving coordination and communication within the program.

Recommendation 6, continued

- CMS should provide QIOs with a coherent and feasible scope of work that sets forth clear priorities for quality improvement and performance measurement.
- Congress and CMS should change the contract structure for core QIO services for the 9th SOW: including strong performance incentives, encouragement of competition for the contracts, extension of the contract from 3 to 5 years, and timely issuance of the new SOW.

Recommendation 6, continued

- CMS should award QIOSC contracts several months before a new QIO contract cycle to allow for preparation of tools and materials for QIO use and should allow other entities to compete with QIOs for the contracts.
- The QIO core contract and contracts for special studies, support services, and QIOSCs should all reflect program goals and priorities.

Recommendation 6, continued

- CMS and AHRQ should establish ongoing mechanisms for sharing QI knowledge and research results.
- CMS should improve coordination and communications within the QIO program and with QIOs.

QIO Program Evaluations Recommendation 7

CMS should develop 4 types of evaluation to assess the QIO program. CMS should conduct 3 of these 4 types of evaluation internally to assess QIO performance against predetermined goals and priorities at the following levels: 1) program as a whole, 2) individual QIOs with respect to the core contract, 3) selected quality improvement interventions implemented by QIOs. DHHS should periodically commission the 4th type of evaluation—*independent, external evaluations of the QIO program's overall contributions.*

Recommendation 7, continued

- QIOs should be learning organizations, continually improving.
- CMS should form a technical expert panel for guidance on evaluations.
- CMS should ensure that evaluations of the effectiveness of QI interventions are conducted.
- CMS should use the most rigorous evaluation designs practicable, including randomized controlled trials.
- DHHS should allocate adequate funds from the QIO apportionment to carry out the evaluations.

QIO Program Funding Recommendation 8

Congress and DHHS should focus all QIO resources on supporting providers' performance measurement and QI efforts. DHHS should remove from QIO core contracts funds sufficient to support case reviews, appeals, and beneficiary complaints when those functions are devolved to other organizations. DHHS should increase the remaining funds for inflation, evaluations, the increased numbers of providers and beneficiaries served, and the labor-intensive nature of technical assistance for QI activities.

Recommendation 8, continued

- Evaluations undertaken during the 8th and 9th SOWs should guide future funding decisions. If evaluations demonstrate no positive impact of the QIO program, CMS will need to rethink its QI approach and the possible benefit of transitioning funds to an alternative structure and strategy for Medicare.
- Once a national performance measurement and reporting system has been established, its priorities should help guide funding levels and policy direction of the QIO program.
- DHHS should ease conflict-of-interest restrictions on QIOs supplementing their QI budgets with external funds.

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www.nap.edu