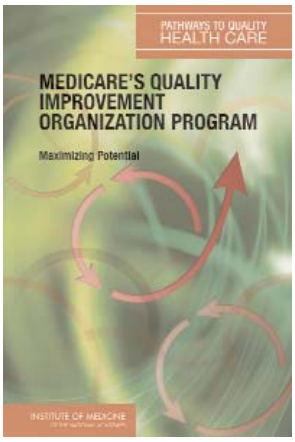
Medicare's Quality Improvement Organization Program: Maximizing Potential



Medicare is the largest single purchaser of health care in the United States, and the quality of care its beneficiaries receive could set the standard for all patients. Quality improvement organizations (QIOs) are private, historically physician-directed groups that receive Medicare funds to foster quality health care services, including review of complaints and appeals. In the last contract period (2002-2005), 41 organizations held 53 QIO contracts covering the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands (38 of the 41 are not-for-profit organizations).

Quality of care for Medicare beneficiaries is improving, but the pace of change is slower than desired. The QIO program needs restructuring to focus on activities, especially technical support, that will strengthen health care provider performance and produce better health outcomes for beneficiaries.

Medicare provided more than $340 billion in benefits to care for 42.3 million beneficiaries in 2005.

Requested by Congress and sponsored by the Centers for Medicare and Medicaid Services (CMS), this report is the second in the *Pathways* series that focuses on accelerating the pace of quality improvement efforts. The first report discussed the importance of measuring and reporting health care providers' performance, while a third report will examine payment incentives.

MAINTAIN THE QIO PROGRAM AS A KEY PLAYER IN QUALITY IMPROVEMENT

A federal role in quality improvement is important. QIOs are a unique national resource integral to quality improvement strategies.

QIOs have evolved under different organizational names and performed many functions over the past 35 years. They have been charged with examining beneficiary complaints and appeals, promoting health care quality, ensuring that Medicare was billed appropriately, and reviewing claims to determine if care met local, peer-reviewed quality standards. While QIOs still perform these functions, their emphasis has shifted toward active promotion of quality that meets national, evidence-based guidelines. QIOs have expanded their original focus on hospitals to include nursing homes, physician practices, home health agencies and health plans.

The goal is for high quality care to be available throughout the nation. The umbrella of the QIO program can foster and coordinate change across the country. This provides an opportunity for greater con-

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sistency and the national alignment of improvement efforts. The Institute of Medicine (IOM) concludes that the QIO program should continue since a federally sponsored role in quality improvement is so important to the health of the country.

CHANGE THE FOCUS TO TECHNICAL ASSISTANCE

The expansion of public reporting on the performance of health care organizations and practitioners, along with the growth of incentive programs designed to raise quality levels, will increase demand by health care providers for the type of expert assistance that QIOs offer. To meet this anticipated surge in demand, the IOM recommends that QIOs refocus all of their efforts toward quality improvement technical assistance. QIOs should concentrate on helping providers improve their delivery of care, their organizational cultures, and information systems instead of handling beneficiary complaints, appeals, and other case reviews. QIO technical assistance activities cover five dimensions:

- Improvement of care documented by statewide performance measures (e.g., rate of mammography screening for appropriate populations)
- Improvement in provider capability to gather data and report on performance measures
- Adoption and use of improved systems (e.g., electronic health record)
- Changing the way care is delivered or assessed (e.g., required assessments of immunization status of the elderly by home health agencies)
- Monitoring and changing organizational culture (e.g., turnover rate of staff, satisfaction of residents and staff of nursing homes).

The role of QIOs should be to educate and assist providers to improve health care practice rather than to supervise or regulate it.

HELP PROVIDERS AT EVERY LEVEL OF PERFORMANCE

Provider participation in QIO programs is and should remain voluntary. Regardless of their level of quality, some providers have been reluctant to work with QIOs because of the QIOs' dual role with both quality improvement and regulatory responsibilities. Refocusing their role on technical assistance and removing the regulatory responsibilities should alleviate any fear of sanctions.

REASSIGN REGULATORY FUNCTIONS

Proper handling of Medicare beneficiary complaints, appeals and other case reviews is important. The IOM therefore recommends that CMS hold open competition to contract with selected qualified entities to perform these functions. This might encourage other organizations or a few QIOs to conduct these activities in a more effective manner at the regional or national level, and give beneficiary complaints the attention they deserve.

OPEN COMPETITION FOR ALL QIO CONTRACTS

Most organizations currently holding QIO contracts have functioned as QIOs for many years, with few contracts changing hands. Currently, contracts are ended only for non-performance. Just because a QIO performed well on the previous contract does not mean that it would be the best candidate for a new and different scope of work.

IOM recommends that all QIO contracts be lengthened to five years (from the current three) and that all be opened for competition at the end of each scope of work. The QIO program should continue to contract for a dedicated QIO in each state, although the number of organizations CMS chooses to contract with may decrease from the current 41.

EXPAND EXPERTISE OF QIO GOVERNANCE

QIO boards currently have a predominance of physician representation, nearly two-thirds of all board members. To achieve greater balance, boards should include more representatives of other health fields and consumers as well as members with expertise in arenas related to technical assistance, such as health information technology. Boards should also reflect the communities they serve and provide greater oversight and accountability.

IMPROVE DATA HANDLING AND REPORTING CAPABILITY

IOM calls on CMS to revise the QIO program's data-handling practices. Current data feedback procedures are not timely enough. Ideally, electronic health records will help the performance measurement and reporting system of the future to produce useful data in real time to assist practitioners improve the quality of their care. Data would also reflect care that patients receive from multiple providers over time, regardless of payer.

ENSURE EFFECTIVENESS OF QUALITY IMPROVEMENT SYSTEM

CMS must establish clear goals and strategic priorities for the QIO program based on national goals, and improve the program's management. To determine how future funding can be spent most effectively, more rigorous evaluations of the program and of specific technical assistance methods are needed.

FUND QUALITY IMPROVEMENT INFRASTRUCTURE ADEQUATELY

The QIO program budget is $1.265 billion for its current three-year contract; this amounts to less than 0.1 percent of Medicare's total budget. The distribution of QIO funds during its last contract period is shown in Figure 1.

Funds sufficient to support case reviews, appeals, and beneficiary complaints should be transferred from future QIO core contracts to the organizations that take over these duties. A concentrated effort will allow these concerns to be addressed more efficiently than distributing this function across all of the QIOs. However, funding for the quality improvement portion of the core contract will need to be increased to reflect inflation, the increased numbers of providers expected to be served, the labor-intensive nature of technical assistance, and recommended program evaluations.

CMS should make quality improvement an explicit expectation of all Medicare providers. Ideally, QIOs should have enough resources to help all providers who request assistance. If demand becomes overwhelming, QIOs should concentrate on the most underperforming providers, if they are willing to work at improving their quality.

QIOs should serve all health care providers who request assistance in each of the care settings QIOs currently cover.

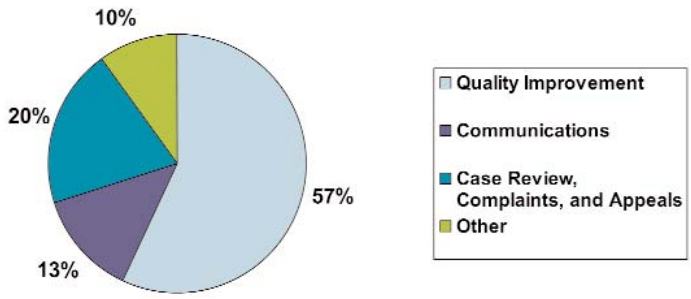

FIGURE 1. Distribution of QIO Spending on 7th SOW Core Contract
NOTE: As of December 2004.

FOR MORE INFORMATION...

Copies of *Medicare's Quality Improvement Organization Program: Maximizing Potential* are available from the National Academies Press, 500 Fifth Street, N.W., Lockbox 285, Washington, DC 20055; (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area); Internet, http://www.nap.edu. The full text of this report is available at http://www.nap.edu.

This study was supported by funds from the Centers for Medicare and Medicaid Services. Any opinions, findings, conclusions, or recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the organizations or agencies that provided support for the project.

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