



BEYOND QIO:
**MODELING A MEDICARE BENEFICIARY COMPLAINT
PROCESS FOR QUALITY OF CARE**

**A Brief Overview of the Current
Medicare Beneficiary Complaint Process**

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History and Current QIO Complaint Process

In 1982 Congress created the Medicare Quality Improvement Organization (QIO) program.¹ Among other functions assigned to QIOs, the Medicare statute states:

The [Peer Review] organization shall conduct an appropriate review of all written complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual's behalf). The organization shall inform the individual (or representative) of the organization's final disposition of the complaint. Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.²

Under this part of their statutory duties, QIOs are required to review and investigate written complaints received from Medicare beneficiaries about the quality of Medicare-covered services received in Medicare-certified facilities.³ This is, however, a relatively small part of the current Scope of Work (SOW) for QIOs. The primary function of the QIOs for some years was to “accomplish [their] mission through peer review of cases to identify instances in which professional standards were not met for purposes of initiating corrective actions.”⁴ Starting in the early 1990s, “quality measurement and improvement became the predominant mode of [p]rogram operation.”⁵ The beneficiary complaint investigation function has never been a central part of the role of QIOs.

In 2005, 41 QIOs were under contract with the Centers for Medicare & Medicaid Services (CMS) to perform many functions, including complaint investigation, in each of the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.⁶ The work of the QIOs is governed by three-year contracts drafted to conform to a “Scope of Work

¹ The 1982 Tax Equity and Fiscal Responsibility Act (TEFRA, Pub. L. 97-248 § 143, Stat. 324, 382) abolished the old Professional Standards Review Organizations and created the Peer Review Organization program, which was intended to be a leaner and more effective program than its predecessor. The PROs were renamed Quality Improvement Organizations (QIOs) in 2003.

² 42 U.S.C. §1320c-3(a)(14), S.S.A. § 1154(a)(14).

³ 14 U.S.C. §1154(a)(14).

⁴ “Report to Congress: Improving the Medicare Quality Improvement Organization Program – Response to the Institute of Medicine Study.” Michael O. Leavitt, Secretary of Health and Human Services (2006) (hereinafter “2006 Leavitt Report”),

http://www.cms.hhs.gov/QualityImprovementOrgs/Downloads/QIO_improvement_RTC_fnl.pdf at 2.

⁵ *Id.*

⁶ “Medicare’s Quality Improvement Organization Program: Maximizing Potential,” Institute of Medicine, The National Academies Press, Washington, D.C. (2006) (hereinafter “2006 IoM Report”) at 162.

(SOW).”⁷ In the 7th Scope of Work (2002-2005), the overall cost to CMS of the QIO contracts was \$1,154.3 million dollars; that amount increased to \$1,265 million in the (current) eighth Scope of Work (2005-2008).⁸

In structure, QIOs are generally non-profit organizations, and most were established by 1975 for the purpose of conducting peer review under government contracts to control overutilization of services.⁹ They remain physician-oriented, with 20% physician ownership, membership, or representation.¹⁰ Eighty-five percent of the boards also have at least one member affiliated with a hospital.¹¹ Each QIO is required to have a consumer board member, although these members often appear to have other primary affiliations.¹² QIOs are prohibited from having direct conflicts of interest, e.g., they cannot be health care facilities,¹³ but they can and do perform other data collection, management, and analysis work for both CMS and non-CMS clients.¹⁴

Institute of Medicine Report (2006) and Predecessors

In March 2006, the Institute of Medicine (IoM) issued a comprehensive report on Medicare’s QIO program. It recommended, among other things, establishing a new system to receive and resolve Medicare beneficiary complaints about quality of care.¹⁵ The findings and recommendations on this point were not new.

Criticisms of QIOs’ complaint processes had been made as early as 1990, by an earlier IoM report, *Medicare: A Strategy for Quality Assurance* (1990), as well as by the Office of the Inspector General (OIG) in the Department of Health and Human Services in two reports, *The Beneficiary Complaint Process of the Medicare PROs*¹⁶ (1995) and *The Medicare Beneficiary Complaint Process: A Rusty Safety Valve*¹⁷ (2001). These reports were largely consistent in their criticisms of QIOs’ performance in handling beneficiaries’ complaints about quality of care. They reported that

- QIOs receive very few complaints; beneficiaries are generally unaware of the QIO complaint process.

⁷ 2006 IoM Report at 36 (Footnote 2).

⁸ *Id.* at 179-180.

⁹ *Id.* at 40, 162.

¹⁰ *Id.* at 161.

¹¹ *Id.* at 168.

¹² *Id.* at 165.

¹³ *Id.* at 171.

¹⁴ *Id.* at 185-186.

¹⁵ *Id.* at 112.

¹⁶ “The Beneficiary Complaint Process of the Medicare Peer Review Organizations,” OIG OEI-01-93-00250 (November 1995) (hereinafter “1995 OIG Report”), <http://oig.hhs.gov/oei/reports/oei-01-93-00250.pdf>.

¹⁷ “The Medicare Beneficiary Complaint Process: A Rusty Safety Valve,” OIG OEI-01-00-00060 (August 2001) (hereinafter “2001 OIG Report”), <http://oig.hhs.gov/oei/reports/oei-01-00-00060.pdf>.

- In 2004, there was one complaint for every 14,000 beneficiaries.¹⁸
- QIOs do not provide complainants with meaningful, substantive responses to their complaints.
- The complaint process is extremely lengthy
 - Process takes 220-250 days.¹⁹ While “CMS shortened the target time frames” for complaint resolution to 150 days, 43 of 55 complaints reviewed by the OIG in 2001 exceeded the new time frames.²⁰
- QIOs resolve very few complaints for beneficiaries
 - “The number of QIO recommendations for sanctions against physicians and hospitals stemming from beneficiary complaints has dropped from an annual average of 31 to an annual average of 1 over the last 20 years (Gaul, 2005).”²¹
- QIOs take limited action in response to substantiated complaints
 - 1986-1994, QIOs recommended 278 sanctions; 1995-2003, 12 sanctions.²²
- QIOs are more oriented toward the provider community than to the beneficiary community²³

In 2001, OIG found that there had been little improvement in QIOs’ complaint review process since its 1995 report. It identified two obstacles to a more effective beneficiary complaint process:

- Resolving beneficiary complaints is a minor part of QIOs’ activities; and
- “The PROs tend to be more oriented toward the medical community than to the beneficiary community.”²⁴

¹⁸ 2006 IoM Report at 113 (citing G. Gaul, “Once health regulators, now partners,” Washington Post (July 26, 2005), and W.C. Rollow, “The Medicare Quality Improvement (QIO) Program 7th SOW and Results (PowerPoint Presentation to the Committee on Redesigning Health Insurance, June 13, 2005)).

¹⁹ 1995 OIG Report at 8.

²⁰ 2001 OIG Report at 13.

²¹ 2006 IoM Report at 113.

²² The Office of Inspector General reported in April 1993 that the number of sanction referrals to OIG by Peer Review Organizations (PROs), a predecessor to QIOs, declined from a high of 72 in fiscal year 1986 to a low of 12 in FY 1991 and 14 in FY 1992. OIG, *The Sanction Referral Authority of Peer Review Organizations*, OEI-01-92-00250 at i (Apr. 1993), <http://oig.hhs.gov/oei/reports/oei-01-92-00250.pdf>. OIG identified three policy options: (1) repealing or substantially modifying the requirement that a sanction referral be made only if the provider is unwilling or unable to comply with requirements for care; (2) increasing the monetary penalty substantially; and (3) requiring referrals to state medical boards when PROs confirm serious quality of care problems. A concern about the third option, raised by the OIG, is that state medical boards would be required to review quality of care problems in individual cases, and that many boards do not have such investigatory and monitoring capacity in their current practice. *Id.* at 8-9.

²³ 2001 OIG Report at 15; 2006 IoM Report at 113.

The IoM reiterated these points in 2006. It found that “QIOs are not comfortable with the combined roles of technical assistant and regulator”²⁵ and that beneficiary complaints should be handled by entities “that treat the beneficiary as their primary client.”²⁶ QIOs’ primary function is providing technical assistance to providers; they see providers as their primary client.

CMS Response to IoM Report

The CMS description of the 2006 IoM recommendations devotes little space to the IoM recommendations concerning the beneficiary complaint investigation function of QIOs.²⁷ CMS notes that the IoM recommendation was to spin off this function in the hands of “a few regional or national contract[or]s or to determine the most appropriate agencies with which to contract for the purpose in each state.”²⁸

However, CMS differs from the IoM in preferring to retain the complaint review function of QIOs.²⁹ CMS thinks legislative change will be needed to make the complaint process transparent. The CMS response states that the agency would like to “permit the disclosure of information [about what happened and what action has been taken to prevent future recurrences] from complaint review to beneficiaries, but restrict the redisclosure of this information and its use in liability actions.”³⁰

American Health Quality Association response to IoM Report

The QIOs, through the American Health Quality Association, recommend that Congress enact a new Medicare Quality Accountability Program to replace the current beneficiary complaint process.³¹ Under this proposal, which would require legislative change, all QIOs would continue to receive and resolve complaints that were submitted in writing. QIOs would inform complainants whether their allegations were confirmed and actions taken by the health care provider to address confirmed allegations, but QIO reports to beneficiaries would not be admissible as evidence in any civil case. QIOs would provide technical assistance to providers for a “reasonable period” and would refer cases for enforcement if providers continued to have problems after receiving technical assistance or if providers grossly or flagrantly violated the law. Each QIO would also issue an annual report describing complaints and their resolution. The identity of reviewers, complainants, or providers would not be disclosed.

²⁴ 2001 OIG Report at 15.

²⁵ 2006 IoM Report at 112.

²⁶ *Id.*

²⁷ 2006 Leavitt Report at 7, 17-18.

²⁸ *Id.* at 7.

²⁹ *Id.* at 11.

³⁰ *Id.* at 18.

³¹ “Recommendations to Congress for a Medicare Quality Accountability Program.” American Health Quality Association, (March 2006), http://www.ahqa.org/pub/uploads/bene_comp_rcmds060306.pdf.

Conclusion

Important questions about how the complaint investigation process for Medicare beneficiaries can best be performed are raised in the 2006 IoM report. This conference and the papers prepared for it will endeavor to provide answers to these questions.