

An Overview of the QIO Beneficiary Complaint Process

Center for Medicare Advocacy, Inc.

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

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History and Current QIO Description

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1982 Legislation

“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).”

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

The Statute Further Provides

“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.”

Statutory Functions

- QIOs were assigned a number of functions in addition to reviewing complaints about the quality of services:
 - Monitoring overutilization of services and providers
 - Peer review to assure care meets professional standards
- Handling beneficiary complaints was never a central role
- Quality measurement and improvement have become the focus of the QIOs

QIO Contracts

- In 2005, 41 QIOs were under contract to perform functions in each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands
- Organized as a 3-year Scope of Work (SOW)
- For 2005-2008 (8th SOW), QIO contracts total \$1.265 billion
- Perform non-government functions as well

Makeup of QIOs

- Generally non-profit with physicians making up 20% of the ownership, membership, and representation
- 85% of boards have at least one member affiliated with a hospital
- Required to have a consumer board member
- Prohibited from direct conflicts of interest

Critiquing the QIOs

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Major Critiques of the QIOs

- 1990 IoM Report – *Medicare: A Strategy for Quality Assurance*
- 1995 DHHS OIG Report – *The Beneficiary Complaint Process of the Medicare PROs*
- 2001 DHHS OIG Report – *The Medicare Beneficiary Complaint Process: A Rusty Safety Valve*
- 2006 IoM Report – *Medicare's Quality Improvement Organization Program: Maximizing Potential*

They said...

- Beneficiaries are generally unaware of the QIO complaint process
- In 2004, QIOs received 1 complaint for every 14,000 beneficiaries
- QIOs do not provide meaningful and substantive responses to complainants
- The process is extremely lengthy, taking 220-250 days on average

They also said...

- QIOs resolve very few complaints in favor of the beneficiary
- Recommended sanctions against physicians fell from 31 to 1 per year from 1985-2005
- For substantiated complaints, QIOs recommended:
 - From 1986-1994: 278 sanctions
 - From 1995-2003: 12 sanctions

They agree that...

- QIOs are more oriented toward the provider community than to the beneficiary community and are not comfortable being both technical advisor and regulator.

2006 IoM Report

- Recommended a new system to receive and resolve Medicare beneficiary complaints about quality of care
- These entities should “treat the beneficiary as their primary client.”

CMS Response to 2006 IoM Report

*Report to Congress: Improving the Medicare Quality
Improvement Organization Program –
Response to the Institute of Medicine Study*

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CMS Recommends QIOs Continue to Review Beneficiary Complaints

- CMS devoted little space to the IoM recommendations concerning the beneficiary complaint investigation function of QIOs
- CMS believes that legislative changes will be needed to make the process transparent
- CMS would like to permit disclosure of information with certain limitations

AHQA Response to 2006 IoM Report

*Recommendations to Congress
for a Medicare Quality Accountability Program*

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AHQA Response to IoM Report

- The American Health Quality Association represents the QIOs
- Recommended that Congress enact a new Medicare Quality Accountability Program
- Under the proposal, QIOs would continue to receive and resolve complaints
- QIOs would inform complainants whether the allegations were confirmed and, if so, the actions taken by the provider

AHQA Response

- QIO reports would not be admissible as evidence in any civil case
- QIOs would refer cases for enforcement of providers with persistent problems after receiving technical assistance from QIOs or if the provider grossly or flagrantly violated the law
- Identity of reviewers, complainants, and providers would not be disclosed

Conclusion

- Important questions about how the complaint investigation process for Medicare beneficiaries can best be performed have been raised.
- This conference and the papers prepared for it will endeavor to provide answers to these questions.

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