

Pathways to Quality Health Care

MEDICARE'S QUALITY IMPROVEMENT ORGANIZATION PROGRAM

Maximizing Potential

Committee on Redesigning Health Insurance Performance Measures,
Payment, and Performance Improvement Programs

Board on Health Care Services

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Medicare's Quality Improvement Organization Program: Maximizing Potential (Series: Pathways to Quality Health Care)

Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs

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Medicare's Quality Improvement Organization Program is the second book in the new Pathways to Quality Health Care series. Focusing on performance improvement, it considers the history, role, and effectiveness of the Quality Improvement Organization (QIO) program and its potential to promote quality improvement within a changing health care delivery environment that includes standardized performance measures and new data collection and reporting requirements. This book carefully examines the QIOs that serve every state as well as the national program that guides and supports them. In addition, it highlights the important roles that a national program with private organizations in each state can play in promoting higher quality care. Medicare's Quality Improvement Organization Program looks closely at the technical assistance role of the QIO program and the need to encourage and support providers to improve their performance. By providing an in-depth assessment of the federal experience with quality improvement and recommendations for program improvement, this book helps point the way for those who strive to create higher quality and better value in health care. Intended for multiple audiences, Medicare's Quality Improvement Organization Program is essential reading for members of Congress, the federal executive branch, the QIOs, health care providers and clinicians, and stakeholder groups.

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Summary

In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, section 109), the U.S. Congress requested that the Institute of Medicine (IOM) conduct an evaluation of the Quality Improvement Organization (QIO) program administered by the Centers for Medicare and Medicaid Services (CMS). The QIO program consists of a set of federally administered contracts that support QIO services in each state, as well as special studies and program support services at the national level. This report responds to the congressional request by providing an overview of the QIO program and an assessment of its impact on the quality of health care for Medicare beneficiaries, funding levels and sources for QIO activities, CMS oversight of those activities, and the extent to which other organizations could perform similar functions. (The congressional request to the IOM did not include a fiscal integrity review.) This report builds on the IOM's *Quality Chasm* series, which outlines a vision for a better health care system meeting six key aims: health care should be safe, effective, patient-centered, timely, efficient, and equitable.

The IOM Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs conducted this assessment during a time of significant change in the health care environment in the United States, characterized by increased attention to safety, beneficiary protection, quality improvement, efficiency, and performance measurement. In preparing this report, the committee considered how the QIO program can best participate in this new health care environment and contribute to the achievement of higher quality in provider performance and in the health care received by Medicare beneficiaries.

BACKGROUND

The Medicare Context

Medicare is the single largest purchaser of health care in the United States; in 2004 the program paid more than \$295 billion in benefits to care for 41.7 million beneficiaries. CMS has an obligation to ensure that the care received by all Medicare beneficiaries meets the standards all Americans deserve. As the original *Quality Chasm* report makes abundantly clear, however, Medicare beneficiaries, like Americans generally, too often do not receive quality care that meets scientifically established guidelines and suffer worse health outcomes as a result. At the same time, per capita spending on health care in the United States is higher than that in any other developed country. Americans deserve greater value from their expensive investments in health care. To this end, it will be necessary to close the large gap remaining between the quality of care that is provided and the quality of care that all Americans should receive.

Among those over age 65, the primary Medicare population, 87 percent have at least one chronic condition, and more than 36 percent have three or more such conditions. Transitions in care from one provider setting to another, particularly important for individuals with chronic conditions, are not efficient and well coordinated in the current health care system. Adverse drug events in hospitals and ambulatory care settings are a serious problem and may be more likely to occur among chronically ill individuals and during transitions in care.

As administrator of Medicare, CMS has an opportunity to lead other federal and private insurers and purchasers in stimulating improvements in health care practices. In addition to the QIO program, CMS has certain mechanisms at its disposal that can promote the diffusion of best-care practices, including Conditions of Participation, Survey and Certification requirements, and other regulatory and research authorities. All these mechanisms should be focused on improving the quality of U.S. health care in the 21st century and implementing a national performance measurement and reporting system that can support quality improvement efforts.

The QIO program encompasses 41 organizations that hold 53 contracts with CMS to provide services in all 50 states, Puerto Rico, the Virgin Islands, and the District of Columbia. The contracts require each QIO to offer technical assistance to nursing homes, home health agencies, hospitals, prescription drug plans, pharmacies, and physician practices to help them improve the quality of care they provide to Medicare beneficiaries. The QIOs also have the responsibility to protect beneficiaries and the Medicare Trust Funds by reviewing individual cases. In addition to the 53 QIOs, the QIO program funds several QIO Support Centers (QIOSCs), which

serve as national resources and provide assistance to the QIOs in carrying out these responsibilities. The QIO program also funds numerous special studies and contracts to support existing program functions and to conduct research and develop materials for quality-related activities.

Over time, the QIO program has evolved to address new requirements and expectations. It now constitutes a multifaceted enterprise that deserves a thorough analysis to:

- Highlight significant assets that can be used to shape the future of health care.
- Identify functions that might be discarded or reassigned to other appropriate agencies.
- Recommend actions to strengthen the program and CMS management practices.

The recommendations offered in this report for restructuring the QIO program are intended to spur more rapid improvement in health care quality. This restructuring of the QIO program, in coordination with the use of performance measurement, reporting, and payment incentives (addressed in the other reports in the IOM's *Pathways to Quality Health Care* series), should enable great strides in closing the quality gap.

History and Current Status of the QIO Program

Over the course of more than 35 years, federal priorities for the QIO program have changed from quality assurance and retrospective utilization review of individual case records to systemic collaboration with providers for the improvement of overall patterns and processes of care. Observations drawn from the history of the program offer several key insights:

- Many QIO staff, boards, and executives have a long history with the program and established relationships with health care providers on which they can draw for valuable resources and perspectives.
- Although the views of many providers have changed along with the program's evolution, some hospital executives and physicians still perceive the QIOs primarily as regulators.
- Frequent changes in the required activities of the QIOs demand that contractors demonstrate flexibility and adaptability. They also create significant challenges to any assessment of the program.

In this report, the IOM committee focused on activities performed during the 7th and 8th contract periods (2002–2005 and 2005–2008, respectively),

also referred to as scopes of work (SOWs).¹ Most of the data collected to assess the program relates to the 7th SOW.

KEY FINDINGS AND CONCLUSIONS

Extensive variations in the organizational structures and the specific services of the QIOs make generalizations difficult. Nonetheless, the committee's assessment led to the following conclusions:

- The quality of the health care received by Medicare beneficiaries has improved over time.
- The existing evidence is inadequate to determine the extent to which the QIO program has contributed directly to those improvements.
- The QIO program provides a potentially valuable nationwide infrastructure dedicated to promoting quality health care.
- The value of the program could be enhanced through the use of strategies designed to focus the QIOs' attention on the provision of technical assistance in support of quality improvement, to broaden their governance base and structure, and to improve CMS's management of related data systems and program evaluations.

Following is a discussion of the key findings that led to these conclusions. First, though, it is important to note that in the process of examining the QIO program, the committee considered a number of options for and alternatives to the program, including restructuring or reorganizing the federal program and contracting with other private organizations. The committee's recommendations concerning the future of the QIO program are based on an assessment of these options and alternatives.

Quality Improvement in Medicare

Published evidence indicates improvements in the quality of care received by Medicare beneficiaries between 1998 and 2004, although the numbers of quality measures studied are limited, and those examined focus

¹CMS contracts with private organizations for QIO services in each state for 3-year periods. CMS uses the acronym SOW for both "scope of work" and "statement of work." In this report, the committee uses SOW only for "scope of work" and adopts the general usage of SOW by the QIO community, in which the term denotes either tasks required in general or the time period of a contract. When discussing specific details of QIO work, the committee refers to the contract itself. For example, the 7th SOW was from 2002 to 2005. It required all QIOs to provide technical assistance to nursing homes, and the contract for this SOW stipulated that QIOs must recruit 30 percent of nursing homes to develop a plan of action.

primarily on the quality of care provided in hospitals. Improvements have occurred in areas targeted as national priorities (and for QIO attention), such as rates of mammography, care provided after a heart attack, and rates of screening and treatment for diabetes. Managed care organizations have also demonstrated improvements in the care provided to Medicare beneficiaries. As noted above, however, there is substantial room for further improvement. In addition to the deficiencies in care transitions and unacceptable rates of adverse events mentioned earlier, many people do not receive appropriate preventive care, and the quality of other services varies greatly among providers and by the geographic location, race, and income of the beneficiary.

Studies conducted to date cannot be used to determine the cause of the improvements that have occurred because of limitations in the study designs, the complexity of the programs being evaluated, and conflicting results. Yet the difficulty of attributing quality improvement to any specific intervention or program is not limited to the QIO program; rather, it is characteristic of quality improvement interventions in general and applies to improvement efforts of other organizations as well. The lack of evidence does not mean the interventions undertaken by the QIOs and other organizations have had no impact. The committee was unable to document conclusively whether individual QIOs or the program as a whole has had a positive impact, a negative impact, or no impact on the quality of care during the period of the 7th SOW. However, CMS's preliminary reports of performance on quality measures during the 7th SOW suggest that providers that worked intensely with a QIO on an intervention showed greater improvement than those that did not.

Are some QIOs more effective than others? There appears to be a common perception that some QIOs are outstanding, while others are mediocre. According to performance measures, some QIOs are better than others at improving quality on a particular care dimension or a specific task. Objective global measures of QIOs, however, do not exist, and CMS's contract performance scores for QIOs neither indicate which fall into each level of performance nor highlight significant differences in overall performance.

Despite these uncertainties, the committee concluded that the QIO program has the potential to help meet the crucial need of improving the quality of health care. As implementation of a broad national performance measurement system proceeds and payments increasingly reward quality improvement, the need for technical assistance for quality improvement efforts will increase. The QIO program's nationwide coverage, support resources, and partnering relationships with providers are distinct assets. A major restructuring of the program should enhance its ability both to meet this need for assistance and to document the resulting impact on quality of care. A sharper focus on technical assistance and more systematic and rig-

orous evaluations of the program's current and future efforts would provide a stronger evidence base that could be used to guide future decisions about the program. At the same time, the other organizations performing QIO-like functions in the private sector deserve further scrutiny, as CMS's implementation of the recommended structural reforms to increase open competition might allow such organizations to complement, augment, or in some cases replace current organizations holding QIO contracts.

Structural Issues

The presence of organizations with trained experts dedicated to providing quality improvement services in every state is a significant asset at both the local and national levels. The committee notes that the QIOs and CMS have established important relationships with providers, their professional associations, and various other stakeholder groups, thus promoting concerted, coordinated quality improvement efforts. Some providers, such as small physician practices, will have a particular need for assistance with reporting of performance measures and quality improvement in the future. In sum, the potential exists for a reconfigured QIO program to have a measurable positive impact on the quality of care for Medicare beneficiaries. To realize this potential, however, it will be necessary to address a number of structural issues.

QIO Board Composition, Functions, and Structure

The boards of organizations holding QIO contracts are heavily dominated by physicians. Most QIO boards have only one (mandated) consumer representative, which is insufficient to influence the attainment of more patient-centered care. The committee concluded that QIO governance generally lacks (1) sufficient representation of individuals with the required expertise other than physicians, and of individuals from outside the health care field; (2) tools for assessment of the performance of individual board members and the board as a whole; (3) important committees for finance, auditing, and strategic planning; and (4) adequate transparency.

Physician-Access or Physician-Sponsored Organizations

The legislative requirement that eligible organizations attain specific levels of local physician involvement is outmoded, and reflects the historical use of case review to identify local outliers instead of the goal of raising all care to the level of evidence-based national guidelines and standards. Elimination of this requirement could increase competition for QIO contracts.

Conflicts of Interest

A QIO is restricted from contracting with health care providers in its state for technical assistance or review services similar to those covered by its core Medicare contract. QIOs would be able to serve more providers and beneficiaries if they could contract for additional services and supplement their CMS funds with those from providers and other sources.

Confidentiality Restrictions

Confidentiality restrictions on the QIOs' treatment of clinical data reflect the protective attitudes of the predecessor programs and provider interests. Given the current interest in transparency, public reporting, and consumer access to information, those restrictions are largely inappropriate and constrain use of the data for intervention programs.

Functions and Impacts of the QIOs

The QIOs had three main functions under the 7th SOW:

- Offer providers technical assistance in improving the quality of care through collaboratives or other interventions by supporting process redesign, data collection and interpretation for internal quality improvement, and dissemination activities related to the use of publicly available comparative quality data.
- Provide education and communications for beneficiaries.
- Protect beneficiaries and the Medicare Trust Funds by reviewing complaints and appeals and performing other case reviews to estimate payment error rates and address other billing concerns.

The 8th SOW (2005–2008) retains the technical assistance and protection functions of the 7th SOW, but the education and communications function has been subsumed under the other two. Indeed, the QIOs contribute indirectly to beneficiary education—an integral part of quality health care—through the technical assistance they offer to providers. Moreover, many stakeholder groups in the community, as well as other CMS programs, work directly with beneficiaries, and QIOs often partner with them to reach beneficiaries through public information campaigns. The contract for the 8th SOW was designed to encourage quality improvement through organizational “transformations” intended to produce more rapid, measurable improvements in care. The QIOs must work intensively with subsets of individual providers to help them redesign care processes and make internal systemic changes, such as the adoption and implementation of health infor-

mation and communications technologies, so as to narrow the gap between current and ideal standards of care. The contract also includes new activities related to the Medicare Part D prescription drug benefit.

Strengthening beneficiary protection is critical, and some case review is needed, but CMS could manage those functions more appropriately through contracts with other organizations. The evidence indicates that QIOs have not publicized beneficiary rights effectively and have issued fewer provider sanctions in recent years. This may be the result of inherent conflicts of interest: QIOs consider providers, not beneficiaries, to be their primary clients, and a QIO may not want to antagonize the providers it needs to participate in its interventions and satisfaction surveys.

Beneficiaries have multiple avenues at the state level for pursuing complaints, such as state survey and certification agencies, ombudsman programs, state insurance oversight bodies, and state medical boards. Medicare needs to do a better job of educating beneficiaries about their rights under federal law and directing them to an agency that will handle their complaints expeditiously and fairly, with an emphasis on improving the quality of health care in the future and with a focus on the beneficiary as the primary client. For example, CMS could consolidate complaints, appeals, and case reviews into four regional centers, each having a larger staff with more expertise than would be possible for any single QIO currently. The competitors for these regional contracts might include some of the QIOs most capable of performing such reviews, as well as other organizations. The committee could not determine the cost-effectiveness of the various categories and types of case reviews from the available program data.

The current concentration in the QIOs of all three functions—technical assistance, beneficiary education and communications, and protection of beneficiaries and the trust funds—contributes to several shortcomings:

- Hostile attitudes among some providers and a reluctance to participate in QIO quality improvement activities.
- Possible conflicts of interest that could limit the QIOs' aggressive pursuit of complaints, appeals, and problematic cases.
- Inefficient operations concerning staffing, particularly with regard to on-call physicians who are needed 24 hours a day, 7 days a week to review urgent appeals for the coverage of services.

Given the growing demand for external reporting of quality and efficiency measures and the increasing number of programs offering financial rewards for quality improvements, providers are likely to increase their requests for technical assistance. QIOs would have greater value if they concentrated their limited resources on the provision of technical assistance to support performance measurement and quality improvement. Providers' needs for such assistance are substantial, and internal and commercial re-

sources to meet these needs are frequently unavailable or unaffordable. The committee therefore concluded that the regulatory functions of the various case reviews should not remain in the core SOW for every QIO and should devolve to other appropriate organizations.

Management of the QIO Program

CMS has the challenge of managing the QIO program in the field, as well as integrating it into the operational responsibilities of the Medicare program. The committee identified several areas in which management changes could improve the effectiveness of the QIOs.

Lack of Program Priorities

The contract for the 8th SOW does not set overall program or QIO priorities, although it specifies the individual tasks in great detail. The complex evaluation formulas provided are of little use to the QIOs for prioritizing their work and reflect the absence of overall strategic priorities, a comprehensive evaluation plan, and program guidance.

Strategic Planning

The QIO program has begun a promising long-range strategic planning process that includes stakeholders and staff and involves meeting separately with representatives of each provider setting. This separate engagement with specific provider settings, however, is inconsistent with the IOM vision of integrated care. As noted earlier, Medicare patients, particularly those with chronic conditions, need care that is coordinated across provider settings. Thus quality and efficiency measure sets should include measures for multiple provider settings and reward all providers accordingly. The QIO program's strategic planning process should contribute to the alignment of the QIOs' technical assistance efforts with performance measurement, payment, and pay for performance. The new Part D prescription drug benefit represents another opportunity for QIOs to focus on the coordination of care across provider settings, because maintaining appropriate drug therapies is critical as a patient receives health care in multiple settings.

Lack of an Overall Program Evaluation

Previous IOM reports on the CMS programs that preceded today's QIO program called for overall program evaluations, as well as formative studies to guide tasks in progress. To date, CMS has not conducted a comprehensive program evaluation, and only a few published evaluations of specific QIO quality interventions exist, although some evaluations are

being planned for the 8th SOW. This lack of evaluations limited the information available for the present study and constrains the program's internal planning.

Overly Complex Contract Performance Evaluations

Assessments of a QIO's contract performance are based on complex formulas and separate calculations for each task. The increased complexity of tasks in the 8th SOW is reflected in a set of formulas and incentive awards more complicated than those used for the 7th SOW. These formulas indicate an excessive level of process management of the QIOs on the part of CMS and the need for greater strategic guidance.

Lack of Evaluation of QIOSC and Other Contracts

Nearly one-third of the total QIO program funding is allocated to contracts for QIOSCs, special studies, and support services. In contrast to the detailed formulas used to evaluate the QIOs' performance on the core contract, there are no clear criteria for the evaluation of contractor performance under these other contracts, and little formal evaluation of these contractors has taken place. At present, coordination among these contracts is lacking, and no management system for dissemination of the results of special studies and other research contracts is available.

Slow Data Processing

The Standard Data Processing System supports a range of communications tools, as well as the flow, processing, and storage of data from medical records. This system is essential to the QIO program and could become a critical component of a national system for performance measurement and reporting. A major concern of the QIOs and providers is that the data used to monitor provider progress often are not reported in a timely manner. As CMS increases the number of measures required for public reporting, the volume of data will grow, generating an increased need for timely and useful reports.

Late Issuance of the 8th SOW

The 8th SOW was released without sufficient time for the QIOs or other potential applicants to prepare properly for the new contract. Changes in the contract and uncertainties about future changes have persisted, with a major revision being issued more than 3 months after the contract's start date.

Three-Year Contract Length

The current 3-year contract length is problematic given the startup efforts required in response to the changes in each new contract; time lags in the availability of provider performance data; the time needed by CMS, the Department of Health and Human Services, and the Office of Management and Budget to develop the next contract; and the time required to conduct more rigorous evaluations of program interventions. Longer contract periods with increased interim monitoring would be more suitable for the management of the QIO program. In addition, extending the contract period beyond 3 years would allow the QIOs to focus on a consistent set of priorities for achieving basic transformation of the systems within provider settings.

RECOMMENDATIONS

Focus on Quality Improvement and Performance Measurement

Recommendation 1: The Quality Improvement Organization (QIO) program must become an integral part of strategies for future performance measurement and improvement in the health care system. The U.S. Congress, the secretary of the U.S. Department of Health and Human Services (DHHS), and the Centers for Medicare and Medicaid Services (CMS) should strengthen and reform key dimensions of the QIO program, emphasizing the 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.

- Quality improvement should embrace all six aims for health care established by the Institute of Medicine (IOM) (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 as needed by each provider setting, such as:
 - Instruction in how to collect, aggregate, and interpret data on the measures to be used for internal quality improvement, public reporting, and payment.
 - Instruction in how to conduct root-cause analyses and deep case studies of sentinel events or other problems.

- Advice and guidance on how to bring about, sustain, and diffuse internal system redesign and process changes, particularly those related to the use of information technology for quality improvement and those that promote care coordination and efficiency through an episode of care.
- Enhancement of and technical support for the direct role of providers in beneficiary education as an integral component of improved care, better patient experiences, and patient self-management.
- Assistance with convening and brokering cooperation among various stakeholders.

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Recommendation 2: QIOs should actively encourage all providers to pursue quality improvement 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.

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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 quality improvement. 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.

- Congress and CMS should improve QIO governance by requiring (1) broader representation of all stakeholders on QIO boards, including more beneficiaries and consumers with the requisite training and executive-level representatives of providers; (2) expansion of the areas of expertise represented on QIO boards through the inclusion of individuals from various health professional disciplines, group purchasers, and professionals in information management; and (3) greater diversity of quality improvement professionals on QIO boards through the inclusion of experts from outside the health care field and beyond the local community.

- QIO boards should strengthen their committee structures and consider development plans for individual members, implementation of annual performance evaluations, and annual assessments of the board as a whole as well as plans for its improvement.
- Organizations holding QIO contracts should include on their websites a listing of members of their boards of directors, along with information on the compensation provided to those members and the chief executive officer.

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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.

- Reviews of beneficiary complaints regarding the quality of care received are critical and should be a top priority for contractors that treat the beneficiary as their primary client. CMS should consolidate the review functions into a few regional or national competitive contracts or determine the most appropriate agencies with which to contract for the purpose in each state.
- To handle beneficiaries' appeals and other case reviews more efficiently, CMS could contract at the national or regional level with a limited number of appropriate organizations, such as fiscal intermediaries or individual QIOs. This devolution of responsibilities would allow QIOs to concentrate their resources on quality improvement efforts with providers.

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Data Processing

Recommendation 5: The secretary of 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 comprehensive review of its data-sharing systems, processes, and regulations to identify and correct practices and procedures, including abstraction of medical chart data,

that restrict the sharing of data by the QIOs for quality improvement purposes or that inhibit prompt feedback to the QIOs and providers on provider performance.

- The QIO program should support the processes of national reporting of performance measures, data aggregation, data analysis, and feedback.
- The secretary of DHHS should allow and encourage the sharing of medical claims data when the sharing of such data is not precluded by the privacy protections of the Health Insurance Portability and Accountability Act, as well as the sharing of more detailed complaint-resolution data with complainants.
- CMS should work toward the ultimate goal of 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 the data submitted by providers that participate in the Medicare program. Providers should be accountable for the validity and accuracy of the quality measurement data they submit. The QIOs should supply providers with technical assistance to improve the validity and accuracy of the data collected.

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QIO Program Management

Recommendation 6: CMS should establish clear goals and strategic priorities for the QIO program. Congress, the secretary of 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 the program's core, support, and special study contracts; and improving coordination and communication within the program.

- CMS should provide the QIOs with a coherent and feasible scope of work that sets forth clear priorities for quality improvement and performance measurement.
 - CMS's priorities and planning efforts should focus on integrating QIO collaboration with various types of providers to improve the coordination of patient care across multiple settings.

- To prepare for the 9th scope of work, CMS should consider conducting a national survey of the main provider settings (nursing homes, home health agencies, hospitals, outpatient physician practices, end-stage renal disease facilities, prescription drug plans, and pharmacies) to determine specific unmet needs for technical assistance. Such information might be complemented by information from focus groups conducted with a mix of representatives from the various settings.
- The QIO core contracts and the QIOSC contracts should include incentives aimed at promoting a broader transfer of knowledge concerning successful quality improvement interventions and more rapid improvement.
- The QIOs should have the resources they need to conduct at least one locally initiated quality improvement project on the basis of demonstrated need and the design and evaluation criteria established by CMS.
- Congress and CMS should change the contract structure for core QIO services for the 9th scope of work:
 - Strong incentives and penalties that reward high performance and penalize poor performance should be included. CMS should encourage sufficient competition for the core contracts to permit the selection of a QIO contractor on the basis of contractor-proposed interim and final performance measures and goals. During the contract period, there should be less process management of internal QIO operations by CMS.
 - Congress should permit extension of the core contract from 3 to 5 years to allow for the measurement, refinement, and evaluation of technical assistance efforts and the achievement of transformational goals.
 - There should be greater competition for each new contract. CMS should consider previous experience and performance as a QIO among the selection criteria; demonstrated capacity to support quality improvement on the part of any eligible organization should predominate.
 - Performance periods should be consistent. All QIOs should begin and end the contract cycle on the same date so the planning, implementation, and evaluation of each scope of work can be applied nationally.
 - A timetable should be established for goal setting, program planning, and funding processes for the core QIO contracts. The schedule should ensure that new scopes of work are issued in a timely fashion, and that contracts and funding levels are developed and finalized so as to allow sufficient time

for QIOs and competing organizations to prepare in advance for the new contract without major program and staff disruptions.

- CMS should award QIOSC contracts several months in advance of a new QIO contract cycle to allow for the preparation of tools and materials for QIO use, definition of the required tasks and deliverables that will serve the QIOs and the Government Task Leaders, and inclusion of explicit methods for assessment of the contractor's performance. Congress and CMS should allow entities other than QIOs with expertise in quality improvement to bid on QIOSC contracts; familiarity with QIO work, the capability to carry out the work, and experience in performing the required functions should be appropriately weighted when the bids are assessed.
- The QIO core contract and contracts for special studies, support services, and QIOSCs should all reflect the explicit goals and priorities of the program.
- CMS and the Agency for Healthcare Research and Quality should establish ongoing mechanisms for sharing quality improvement knowledge and research results, especially through QIOSCs.
- CMS should take steps to improve coordination and communications within the QIO program and with QIOs. In particular, the roles and responsibilities of and communications among Project Officers, Contract Officers, Government Task Leaders, Scientific Officers, and QIO executives and their staff should be clarified.
 - CMS should build self-assessment, transparency, clearer communications, and continuous quality improvement into the daily workings of the team overseeing the QIO program, just as the QIOs expect providers to do.
 - The contracting function should be subordinate to and support the program management and business functions.
 - Ongoing program evaluations (see Recommendation 7) should provide guidance for the continuous improvement of program management, coordination, and communications.

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QIO Program Evaluations

Recommendation 7: CMS should develop four types of evaluation to assess the QIO program. CMS should conduct three of these

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

- The QIOs should be learning organizations, continually improving the assistance they offer to health care providers. CMS should develop explicit benchmarks for use in ongoing measurement of progress on the effectiveness and costs of the program.
- CMS should form a technical expert panel to offer ongoing guidance on the design of the three types of internal CMS evaluations, including options for identifying optimally performing QIOs, as well as methodologies for attributing quality improvements to the QIO program's interventions.
- CMS should ensure that evaluations of the effectiveness of quality improvement interventions are conducted. The committee suggests that CMS should use the most rigorous evaluation designs practicable, including randomized controlled trials. This approach should also contribute to CMS's overall program evaluation.
 - Evaluations should include concurrent, qualitative descriptions and assessments of the nuanced nature of the QIOs' role in quality improvement interventions and the roles of other players.
 - As appropriate, evaluations should be stratified among provider settings and across states and regions.
 - CMS should assess the cost-effectiveness of each type of intervention to assist with the allocation of resources.
- The secretary of DHHS should allocate adequate funds from the QIO apportionment to carry out, on an ongoing basis, both internal and external evaluations.

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QIO Program Funding

Recommendation 8: Congress and the secretary of DHHS should focus all QIO resources on supporting health care providers' performance measurement and quality improvement efforts. The secretary should remove from QIO core contracts funds sufficient to

support case reviews, appeals, and beneficiary complaints when those functions are devolved to other organizations. The secretary should increase the remaining funds to allow for inflation, the incorporation of evaluations into all QIO work, the increased numbers of providers and beneficiaries being served, and the labor-intensive nature of technical assistance and quality improvement activities.

- The multiple evaluations undertaken during the 8th and 9th SOWs should guide future funding decisions, with budget increases or decreases being provided according to the evaluation findings. If the evaluations demonstrate that no positive impact is attributable to the QIO program's efforts, CMS will need to rethink its quality improvement 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 the funding levels and policy direction of the QIO program, recognizing that adequate funding is necessary to reach the goals set for the QIO program.
- The secretary of DHHS should ease the conflict-of-interest restriction with regard to supplementing the QIO quality improvement budgets with external funds. Given the limits of federal funding, the QIOs should be allowed to seek funds for quality improvement activities from providers and other organizations as appropriate.