

**Report to Congress on the Evaluation of the Quality Improvement Organization
(QIO) Program for Medicare Beneficiaries for Fiscal Year 2006**

Michael O. Leavitt
Secretary of Health and Human Services
2009

EXECUTIVE SUMMARY

Section 1161 of the Social Security Act (the Act) requires the submission of an annual report on the administration, cost, and impact of the Quality Improvement Organization (QIO) Program during the preceding fiscal year. The statutory mission of the QIO Program, as set forth in section 1862(g) of the Social Security Act, is to promote the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. The quality strategies of the Medicare QIO Program are carried out by state and territory specific QIO contractors working with health care providers in their state, territory, and the District of Columbia.

The QIO Program is administered through 53 performance-based, cost-reimbursement contracts with 41 independent organizations. These contracts contain a multi-tiered award fee plan based upon individual and group performance. The QIOs' technical performance is evaluated at both the 18th month and at the 28th month of their 36-month contract. The QIOs submit vouchers on a monthly basis and are reimbursed for their costs. Their monthly invoices are thoroughly reviewed and certified by an assigned project officer and contract specialist. The 53 QIOs are staffed with physicians, nurses, technicians, and statisticians. Approximately 2,300 QIO employees nationwide conduct a wide variety of quality improvement activities to ensure the quality of care provided to Medicare beneficiaries. Approximately 54,000 providers and one million practitioners¹ nationwide potentially could be subject to review by the QIO in their state/jurisdiction and may receive QIO technical assistance (TA). In FY 2006, QIO Program expenditures totaled approximately \$400 million compared with \$398 million in FY 2005². QIO work has been carried out in 3-year contract cycles, known as Statements of Work (SOW). During FY 2006, the QIO Program was still in an early stage of the 8th SOW contract, which was phased in with staggered starting dates several months apart beginning in August 2005.

Background

The statutory authority for the QIO Program is found in Part B of Title XI of the Social Security Act, as amended by the Peer Review Improvement Act of 1982. The Social Security Act established the Utilization and Quality Control Peer Review Organization Program, now known as the QIO Program. The statutory mission of the QIO Program, as set forth in Title XVIII—Health Insurance for the Aged and Disabled, section 1862(g) of the Social Security Act—is to promote the effectiveness, efficiency, economy, and

¹ These data and categories are from CMS Office of Research, Development, and Information. "CMS Program Data" Sources "ORDI/OACT/OFM/CMM" Providers Plans as of 12/31/06; published June 2007.

² This information provided by the CMS Office of Financial Management.

quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. Based on statutory language and the experience of the Centers for Medicare & Medicaid Services (CMS) in administering the Program, CMS identified the following requirements for the QIO Program:

- Improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of health care;
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and items that are reasonable and medically necessary and that are provided in the most economical setting; and
- Protect beneficiaries by expeditiously addressing individual cases such as beneficiary quality of care complaints, contested Hospital Issued Notices of Noncoverage (HINNs), alleged violations of the Emergency Medical Treatment and Labor Act of 1986 (42 U.S.C. § 1395dd, EMTALA), and other beneficiary concerns as required by the statute.

Under Title XI—General Provisions, Peer Review, and Administrative Simplification, section 1161 of the Social Security Act—CMS is required to submit an annual report to Congress on the QIO Program. According to statute, this report is required to include information on the administration, cost, and impact of the Program during the preceding fiscal year.

I. PROGRAM ADMINISTRATION

Description of Quality Improvement Organization Contracts

In 2005, the QIO Program began its eighth 3-year contract cycle, the 8th SOW. During FY 2006, the QIO Program was still in the early stage of the contract which was phased in with three staggered starting dates several months' apart beginning in August 2005. The 8th SOW contract focuses on quality improvement for nursing homes, home health agencies, hospitals, and physician practices through organizational “transformations” intended to produce more rapid, measurable improvements in care. The QIOs 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 information and communication technologies. The 8th SOW contract also includes case review and other beneficiary protection activities as well as the Hospital Payment Monitoring Program (HPMP).

The activities of the QIO Program are carried out by a network of organizations staffed with physicians, nurses, technicians and statisticians—experts in health care quality—responsible for all 50 states, the territories, and the District of Columbia. Approximately 2,300 QIO employees nationwide conduct a wide variety of quality improvement activities to improve the quality of care furnished to Medicare beneficiaries. The Program is administered through 53 performance-based, cost-reimbursement contracts with 41 independent organizations. A single organization can have more than one QIO contract. These contracts contain a multi-tiered award fee plan based upon

individual and group performance. The QIOs' technical performance is evaluated at both the 18th month³ and at the 28th month of their 36-month contract. The QIOs submit vouchers on a monthly basis and are reimbursed for their costs. Their monthly invoices are thoroughly reviewed and certified by an assigned project officer and contract specialist. QIOs are evaluated according to how well they reach CMS specified performance goals. The goals pertain to performance in the following areas:

1. Conducting statutorily mandated case review and conducting mediation of beneficiary complaints about the quality of health care services,
2. Measuring, monitoring, and reducing the incidence of improper fee-for-service inpatient payments,
3. Improving clinical performance,
4. Increasing clinical performance reporting,
5. Increasing adaptation and use of interoperable health information technology,
6. Implementing key process changes, and
7. Improving organizational culture.

The last five goals listed above are specific to four settings: nursing homes, home health agencies, hospitals, and physicians' offices. For a complete explanation of QIO contract evaluation criteria, see the *Federal Register*, 72 *Fed. Reg.* 44,150 (August 7, 2007).

QIOs Interacting with Health Care Providers and Practitioners

QIOs work with and provide technical assistance to health care practitioners and providers such as physicians, hospitals, nursing homes, and home health agencies. In addition to working with practitioners and providers, QIOs work with beneficiaries, other partners, and stakeholders to transform care delivery systems, to safeguard the integrity of the Medicare Trust Fund, and to investigate beneficiary complaints about quality of care.

Any provider or practitioner who treats Medicare patients and is paid under Title XVIII of the Social Security Act may receive technical assistance from a QIO and may be potentially subject to review by the QIO. CMS estimates that approximately 54,000 providers and one million practitioners nationwide may interact with QIOs each year. Interaction can come in a variety of forms including direct intensive QIO assistance to providers and practitioners, occasional contact with the QIO at professional meetings, visits to the QIO website, and/or QIO patient care and record review on behalf of beneficiaries.

Protecting the Medicare Trust Fund

The QIO Hospital Payment Monitoring Program (HPMP) protects the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for inpatient acute care services that are reasonable and medically necessary, are provided in the most

³ This Report contains data from the 18th month which is January 2007, outside of the fiscal year. Data was collected during FY 2006. It takes several months for the data to be validated and aggregated.

appropriate setting, and are appropriately coded. The purpose of HPMP is to measure, monitor, and reduce the incidence of improper payments for short-term and long-term acute hospital care. Payment error estimates resulting from measuring and monitoring such payments are reported annually in the “Improper Medicare Fee-for-Service Payments” report and contribute to the overall error estimate that is included in the Agency’s financial statements. From approximately 41,000 sampled medical records (the sampling timeframe for the FY 2006 estimate was calendar year 2005 discharges) reviewed for the FY 2006 fee-for-service estimate, \$14.5 million in overpayments and \$2.0 million in underpayments were identified through QIO case review. The savings to the Trust Fund are accrued when the overpayments and underpayments are adjusted by the contractors. As of the date this report was written, Medicare’s administrative contractors have made adjustments for \$10.5 million in overpayments and \$1.6 million in underpayments.

CMS distinguishes between two major categories of payment errors—those related to coding and those related to admission necessity. Coding errors accounted for 29 percent of the gross payment errors identified (underpayments plus overpayments) in the FY 2006 estimate. The frequency of overpayments based on coding error exceeded the frequency of underpayments, with 60 percent of coding errors due to overpayment and 40 percent due to underpayment. Most (67 percent) of the gross payment errors identified by HPMP are related to admission of patients who do not meet medical necessity criteria. These errors arise from issues including improper billing for inpatient admission rather than observation status; improper acute care admissions billing for beneficiaries under the hospice benefit; and unnecessary inpatient admissions for purposes of qualifying for the skilled nursing facility benefit. The additional 4 percent consist of payment errors due to: lack of documentation, billing errors, and Maryland length of stay errors. Maryland is not paid under the Diagnostic Related Groups (DRG) system.

With the contract cycle beginning August 1, 2005 QIOs proposed projects to work with providers in their jurisdictions on issues related to improper payments. After a thorough review of each project proposal, CMS allocated \$9.8 million for the 53 projects approved. The projects covered HPMP issues such as: DRG coding, unnecessary admissions, billing error, and combinations of these issues.

Protecting Medicare Beneficiaries

This is described below under contract Task 3a.

Empowering Beneficiaries

The QIO Program supplies information about institutional providers on *Nursing Home Compare*, *Home Health Compare*, and *Hospital Compare*. These web sites provide information and help beneficiaries choose among Medicare certified providers. The publicly available Compare tools not only lend transparency to health care but are also likely to stimulate providers to improve their care.

Sanction and Pre-sanction activities

QIOs are charged with referring practitioners and providers to the Office of the Inspector General (OIG) when they identify a case or cases meeting criteria for either grossly and flagrantly violating any obligation in section 1156(a) of the Act in one or more circumstances, or failing in a substantial number of cases substantially to comply with any obligation imposed in section 1156(a) of the Act. Section 1156(b) (1) of the Act requires that the QIO provide the practitioner or other person with an opportunity to enter into and complete a corrective action plan (CAP), if appropriate. In FY 2006, there were two (2) referrals to the OIG for sanction activity, eighteen (18) cases in which pre-sanction activity occurred, eight (8) corrective action plans and four (4) cases from prior fiscal years that were resolved as providers or practitioners successfully completed a CAP.

II. PROGRAM COST

Under Federal budget rules the QIO Program is defined as mandatory rather than discretionary because QIO costs are financed directly from the Medicare Trust Fund and are not subject to the annual appropriations process. In FY 2006, QIO Program expenditures totaled \$400 million. This spending represents approximately 9 dollars annually for each of the over 43 million Medicare beneficiaries to improve quality of care, and approximately one tenth of one percent (0.1 percent) of the \$375 billion Medicare expenditures during that year. Similarly in FY 2005 the QIO \$398 million represented 9 dollars annually for each of the over 42 million beneficiaries and one tenth of one percent of the \$333 billion Medicare expenditures.

III. PROGRAM IMPACT

The Department of Health and Human Services (HHS) 2006 Annual Report to the Congress on the state of health care quality for all Americans, *The National Healthcare Quality Report*, found that improvements in hospital care may have resulted from public reporting of health care quality measure data, focused quality improvement programs including the activities of the QIO Program, and policies that supported improvement initiatives.⁴ This current Report to Congress reflects interim data available after an 18-month period completed in December 2006 for QIO-provided assistance to nursing homes, home health agencies, hospitals, and physician practices. Some of the most significant contract tasks are reviewed in the following sections and are summarized in the table at the end of this section.

Contract Task 1: Assisting Providers in Developing the Capacity for and in Achieving Excellence

⁴ Agency for Healthcare Research and Quality, 2006 National Healthcare Quality Report. Rockville, MD: AHRQ; December 2006. Available at: <http://www.ahrq.gov/qual/nhqr06/nhqr06report.pdf>.

Under Task 1, the contract specifies two components: statewide work and work with an identified participant group (IPG). The IPG consists of providers who receive concentrated assistance from QIOs on at least one quality measure. Non-IPG providers receive no concentrated assistance. The 8th SOW emphasizes five dimensions: measuring results, reporting clinical performance, systems adoption and use (especially electronic health record systems), process changes, and transformation of organizational culture.

Contract Task 1a: Nursing Home

For identified participant nursing homes, the QIOs focus on helping providers decrease the rate of pressure ulcers and the rate of physical restraint use, which are the Government Performance and Results Act of 1993 (Public Law No. 103-62) (GPRA) goals for nursing home care. Another key area includes improving the management of pain in chronic (long stay) residents. Annually each QIO works with all nursing homes in the state to set quality improvement targets for pressure ulcers and physical restraints. To promote individualized care for nursing home residents, the QIO works with groups of identified participant homes to collect information on resident and staff experience/satisfaction with care and staff turnover. The QIO offers technical assistance to analyze this information and to use quality improvement science to suggest ways to improve both.

Using data collected in 2006 Quarter 3 (available January 2007), a notable improvement was observed in the physical restraints measure with an 18 percent improvement in all homes and 27 percent improvement in the Identified Participant Group (IPG) homes. Chronic care pain showed similar improvement. Nationally, nursing homes reached an 18 percent improvement in all homes and 25 percent improvement in the IPG homes with which the QIOs closely work on chronic care pain. Improvement in the high-risk pressure ulcer measure continued to show slower, steady improvement. At the contract midpoint in early 2007, 60 percent of the QIOs met the interim evaluation requirements. CMS worked individually with QIOS who were not meeting performance expectations through on-site visits and monitoring calls. CMS worked with these QIOs to assist them with identifying the cause of the performance problems. Corrective action plans were developed. These QIOs received follow-up visits and/or monitoring calls to monitor implementation of the corrective action plans and to track progress towards meeting performance expectations.

Contract Task 1b: Home Health

For identified participant home health agencies, QIOs focus on reducing the rate of acute care hospitalizations by decreasing avoidable, unnecessary hospitalizations. The identified participants also work on improving the rate of one other agency-selected, publicly reported Outcome and Assessment Information Set (OASIS) measure.⁵ The most commonly selected OASIS measures are: improvement in pain interfering with activity, improvement in Dyspnea (difficulty breathing), or improvement in the management of oral medications. Identified participant home health agencies also work to evaluate and improve organizational culture and implement telehealth (telemonitoring and phone monitoring). Statewide, the QIOs work with

⁵ Information on OASIS can be found at: <http://www.cms.hhs.gov/OASIS/>.

home health agencies to: reduce the rate of acute care hospitalizations; improve the rate of one QIO-selected OASIS measure; and promote influenza and pneumococcal vaccinations of home health patients. In January 2007, interim data indicated that 46.3 percent of the QIOs either met or exceeded expectations in the Home Health tasks. As of the end of November 2006, the identified participant group has improved the acute care hospitalization rate over baseline by approximately 1.7 percent. This represents approximately 16,600 fewer hospitalizations. CMS worked individually with QIOs who were not meeting performance expectations through on-site visits and monitoring calls. CMS worked with these QIOs to assist them with identifying the cause of the performance problems. Corrective action plans were developed. These QIOs received follow-up visits and/or monitoring calls to monitor implementation of the corrective action plans and to track progress towards meeting performance expectations.

Contract Task 1c1: Hospital

QIOs work statewide encouraging hospitals to submit clinical performance data to the Hospital Quality Alliance (HQA). The HQA, Improving Care through Information, is a public/private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care. Quality performance information collected from the more than 4,000 participating hospitals is reported on *Hospital Compare*, a website tool developed by CMS.

To improve clinical performance, QIOs work with IPG hospitals on an Appropriate Care Measure (ACM).⁶ The ACM is composed of the process measures published in *Hospital Compare*. A case is counted in the ACM numerator only if the hospital provides all of the eligible processes of care. Standard processes of care are a key to hospital improvement, and QIOs work with IPG hospitals to adopt standard processes of care in five clinical areas: prevention of surgical site infections, cardiovascular complications, venous thromboembolism, ventilator-associated pneumonia, and promotion of the use of fistulas for hemodialysis. To encourage systems improvement and organizational culture change, QIOs work with IPG hospital leadership to facilitate the use of Computerized Physician Order Entry (CPOE) systems, bar coding, and telehealth systems. The Surgical Care Improvement Project (SCIP) IPG is part of a larger national effort that utilizes both process and outcome measures. Hospitals in the SCIP IPG collect data for the surgical site infections and venous thromboembolism measures (plus the Vascular Access and Global measures). The QIO assists hospitals in collecting data on as many of the SCIP process and outcome measures as possible since the national effort uses the entire measure set for its evaluation purposes.

In January 2007, interim data indicated that 90.6 percent of the QIOs either met or exceeded expectations in the ACM. CMS worked individually with QIOs who were not meeting performance expectations through on-site visits and monitoring calls. Data were not available for SCIP.

Contract Task 1c2: Critical Access Hospital/Rural PPS Hospital

⁶ The ACM is a composite measure of care at the patient level for three clinical topics-acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PNE).

QIOs help promote transformational change in Critical Access Hospitals (CAHs) and rural Prospective Payment System (PPS) hospitals by working to improve clinical performance measures and safety cultures in these hospitals. QIOs assist IPG CAHs and rural PPS hospitals using a safety culture survey provided in the Rural Organization Safety Culture Change toolkit. QIOs also assist these hospitals in selecting, testing, and implementing changes that demonstrate improvement in the organization's safety culture. The QIO uses AHRQ's Hospital Survey on Patient Safety Culture to assess the safety climate in each of the IPG hospitals. Training on the AHRQ tool was provided to the QIOs during the QualityNet Conference in September 2005. Based on the baseline survey results, the QIO works with each hospital to identify an area it intends to focus on to improve the patient safety climate. The QIO provides assistance in implementing processes to improve the safety climate based on the area(s) the hospital identifies in the survey. In January 2007, interim data indicated that 71.7 percent of the QIOs either met or exceeded expectations in the areas of CAH tasks. CMS worked individually with QIOs who were not meeting performance expectations through on-site visits and monitoring calls.

Contract Task 1d1: Physician Practice

In FY 2006, at the statewide level, QIOs promoted quality initiatives including the Physician's Quality Reporting Initiative (PQRI); supported collaborative quality improvement activities involving Medicare Advantage organizations; by request, worked with End Stage Renal Disease (ESRD) Networks to improve rates of fistula use and influenza and pneumococcal vaccinations; and in four states collaborated with eligible physician practices that had enrolled in a pilot program, the Medicare Care Management Performance Demonstration (MCMP) under section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). While serving in their usual role of assisting Medicare practitioners in improving the quality of their care, QIOs collaborated with the practices involved in the MCMP demonstration to assist them in effectively implementing and using interoperable electronic health records (EHRs) to improve the quality of patient care and to report quality measures on the patients included in the MCMP project. The QIOs worked with entities involved in the demonstration as collaborators and appropriate stakeholders with interests that parallel the QIOs Title XI activities.

QIOs worked with IPG practices towards transformational change in patient care through the use of eHealth technology, patient care process redesign, and performance measurement. QIOs' interaction with physician practices help guide the physician practices through the process of implementing an EHR. Subsequent to installation of an EHR system, QIOs assisted practices in managing patients by providing tools for preventive services and management of chronic diseases, e.g., diabetes and heart disease.

CMS closely monitored the QIO goals in task 1d1 based on monthly data results from QIO deliverables. As of January 2007, QIOs exceeded the goal to work with 5 percent of

the practices in their state (a national total of 3,695) and had recruited 3,932 physician practice sites. Furthermore, QIOs exceeded the rate of underserved practices targeted for recruitment (539) by recruiting 1,162. QIOs are continuing to work actively to further the adoption and effective utilization of this technology to improve patient care. To further this goal, CMS has implemented a Doctor's Office Quality Information Technology (DOQ-IT) University Web site that offers assistance to practices nationally with the goal of improving patient care. For the DOQ-IT, physician office task, QIOs submitted monthly progress reports. CMS monitored the progress each QIO was making and if it was determined that the QIO was behind in a specific segment of the task, CMS had a focused monitoring call with the QIO to determine what the issues and/or barriers were in that particular state.

Contract Task 1d2: Underserved Populations

As part of the work in the physician practice setting, QIOs work at the statewide level to improve clinical quality indicators for diabetes in underserved populations. For this specific task underserved populations include: African Americans, Hispanic/Latinos, Asian/Pacific Islanders and American Indian/Alaskan Natives. QIOs also work to promote systems improvement through Doctor's Office Quality (DOQ) activities with an underserved population under Task 1d1.

With a Task 1d2 specific IPG, QIOs work on practice and practitioner changes related to Culturally and Linguistically Appropriate Services (CLAS) standards and culturally competent care. The QIO utilizes either the online Office of Minority Health (OMH) cultural competency or the Manhattan Cross Cultural Group (MCCG) tool to conduct cultural competency improvement education. The OMH tool consists of three themes. Component one addresses culturally competent care, component two addresses language access services, and component three allows the clinical administrator or a practitioner to complete the OMH "A Family Physician's Practical Guide to Culturally Competent Care" tool. The MCCG tool consists of a non-clinical and a clinical component which addresses culturally competent care education. Practices/practitioners completing the cultural competency education programs should be able to communicate more effectively and efficiently with the underserved Medicare population, which in turn will improve the quality of healthcare received by the underserved population. In January 2007, interim data indicated that 46.3 percent of the QIOs either met or exceeded expectations in the underserved population tasks. The Project Officers conducted monthly QIO monitoring calls for all QIOs regardless of their interim performance. Quarterly monitoring calls were conducted by the GTLs to identify QIOs under-performing during the interim contract period. GTLs offered one-on-one assistance to low-performing QIOs via Focused Monitoring conference calls and a mentoring program was available for high-performing QIOs to share best practices with QIOs that are struggling.

Contract Task 1d3: Physician Practice/Pharmacy: Part D Benefit

As part of QIO efforts in the physician practice setting, QIOs focus on improving safety in the delivery of prescription drugs using evidence-based guidelines. As authorized by

section 109(b) of the MMA, QIOs offer quality improvement assistance pertaining to prescription drug therapy to Medicare providers and practitioners, to Medicare Advantage organizations offering Medicare Advantage plans, and prescription drug sponsors offering Medicare prescription drug plans (PDPs).

As part of QIO efforts in the physician practice setting in this SOW, the QIO focuses on improving safety in the delivery of prescription drugs. Widespread use of e-prescribing with comprehensive decision support tools is expected to improve the quality of prescription drug delivery. Until this broader use is in place, the QIO implements quality improvement projects focusing on improved prescribing, using evidence-based guidelines. CMS works with the QIO to develop and implement new methods to gather and disseminate better evidence for healthcare decision-making. This activity includes collection, linkage, and de-identification of Part D and other data; assisting in implementation of clinical registries and practical clinical trials; and other work necessary to support the development and use of better evidence for decisions.

A variety of methods are available to accomplish these activities. CMS supports engaging physicians because improving prescribing begins with modifying physicians' behavior. This can be accomplished by providing data and information in ways that support behavior change. CMS supports working with network pharmacies because they detect errors and problems with the medications they dispense, and they interact with beneficiaries. Pharmacy policies, procedures, and quality checks need to be implemented to be consistent with quality, safety, and cost-effectiveness goals.

For Task 1d3, QIOs had the readily met expectation to design, obtain approval for and conduct a project. All QIOs met this expectation. Project officers, at their own discretion, had conversations with QIOs if they had concerns about meeting the relevant deliverables. In FY (or CY) 2006, there were no project officer concerns that rose to the level where further action was necessary, nor did any concerns require formal tracking. As of the time of this report, reliable performance data on the impact of this new initiative during FY 2006 is not yet available.

Contract Task 2 (Reserved)

There is no Task 2.

Contract Task 3a: Beneficiary Protection

This task involves all case review activities necessary to conduct statutorily mandated review of beneficiary complaints about the quality of health care services. It also involves all activities associated with other required case reviews, including EMTALA reviews, beneficiary appeals of discharge, and fiscal intermediary referrals. In January 2007, interim data indicated that 98.1 percent of the QIOs either met or exceeded expectations in the areas of beneficiary protection.

QIOs respond to beneficiary quality of care complaints. Any beneficiary who receives services from a Medicare provider may request review of those services for quality of care concerns. In the 7th QIO contract cycle, as a result of two HHS Office of Inspector General (OIG) reports and other concerns identified by the Program, CMS made significant changes to beneficiary complaints review. For the first time, the QIO contract included performance expectations related to timeliness, complainant satisfaction, and the implementation of quality improvement plans by providers. QIOs changed their process of complaints review to make it more responsive to beneficiaries. A case management approach to complaints was implemented, and a mediation option for resolution of appropriate complaints was introduced. These changes were included in the 8th SOW contract.

In FY 2006, QIOs reviewed 90,646 medical records and 3,717 beneficiary complaints. In addition, the QIOs reviewed 22,464 records related to beneficiary appeals of terminations of services provided in the hospital, skilled nursing facility (SNF), comprehensive outpatient rehab facility (CORF), home health agency (HHA), and hospice settings. QIOs also reviewed 28,074 records as a result of hospital-requested higher-weighted Diagnosis Related Group (DRG) review, and 877 cases as a result of EMTALA referrals. Other reviews resulted from referrals from CMS central or regional offices, Fiscal Intermediaries, Program Safeguard Contractors, and reviews associated with HPMP projects.

Contract Task 3b: Hospital Payment Monitoring Program

In the 8th SOW contract, CMS directed the QIOs to continue the HPMP. The purpose of HPMP is to measure, monitor, and reduce the incidence of improper fee-for-service inpatient payments, including those resulting from errors in: DRG coding; provision of medically necessary services; and appropriateness of setting, billing, and prepayment denial. Per the Improper Payments Information Act (IPIA) of 2002 (Public Law No: 107-300), an improper payment is defined, in part, as “any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements; . . .” Incorrect amounts are overpayments and underpayments (including inappropriate denials of payment or service). A prepayment denial is a denial of payment prior to payment versus denial or taking back of payment after payment has been made. Inappropriate prepayment denials are underpayments. Prepayment denials of acute care inpatient claims at the Fiscal Intermediaries or Medicare Administrative Contractors (FI/MAC) add to Medicare improper inpatient payment amount as the error rate is calculated using the sum of overpayments and underpayments as required by the IPIA.

The authority for QIOs to conduct the HPMP appears in the QIO statute. Section 1154(a) of the Social Security Act requires that a QIO review some or all of the professional activities in its geographic area of Medicare providers and practitioners for the purpose of determining, among other things, whether Medicare covered services are or were reasonable and medically necessary and provided in the appropriate setting. For fee-for-service inpatient hospital claims (paid and denied), HPMP fulfills the CMS requirement

to comply with the IPIA. In January 2007, all QIOs under the program were on track to meet or exceed requirements on payment error rates, timing of review, monitoring activity reporting, and project completion to pass this contract task. QIOs continue to work on the problem of inpatient stays of short duration where services should have been rendered at a lower level of care, often outpatient. Such inappropriate admissions account for an estimated one billion dollars annually and are the single largest factor contributing to payment error for acute inpatient claims.

Summary of QIO Activities during FY 2006

The dollar amounts noted in this table refer to the 8th SOW tasks in FY 2006. Their total (\$250 million rounded) does not include support contracts, special projects, SDPS costs, or other prior year adjustments resulting from contract close-out activities. None of the QIO funds are used to fund either federal Full Time Equivalents (FTE) salaries or associated federal FTE travel, training, and supplies.

QIO 8 th SOW Task	Dollar Amount Spent on Task in thousands 10/01/05 to 09/30/06	<i>An example of the most significant activities and goals</i>	<i>An example of results from this Report where data is available for the time period of the Report</i>	<i>Percent of QIOs meeting or exceeding expectations and other benchmarks FY 2006</i>
1a. Nursing Home	\$36,069	<i>Worked with 2,487 IPG nursing homes for decreased use of physical restraints; improvement in management of chronic pain, improvement in high risk pressure ulcer; and worked in advancing excellence in care.</i>	<i>25% IPG improvement on chronic care pain and 27% IPG improvement on physical restraints</i>	60
1b. Home Health	\$26,829	<i>Worked with 1,420 IPG agencies for decreased avoidable hospitalizations; improvement in management of pain; improvement in Dyspnea; and improvement in oral medications.</i>	<i>1.7% IPG improvement in avoidable hospitalizations</i>	46
1c1. Hospital	\$37,592	<i>Worked with 1,658 IPG facilities for decreased surgical site infections, cardiovascular complications, venous</i>	<i>4,000 participating hospitals on Hospital Compare</i>	91

		<i>thromboembolism, ventilator-associated pneumonia, and promote the use of fistulas for hemodialysis. Statewide hospitals report on Hospital Compare.</i>		
1c2. Critical Access Hospital/Rural PPS Hospital	\$10,218	<i>Worked with 415 IPG facilities to increase CAH and PPS hospital safety culture.</i>	<i>100% of IPG hospitals administered baseline safety climate survey to staff.</i>	72
1d1. Physician Practice	\$41,660	<i>Worked with 3,710 IPG practices for increased use of interoperable health information technology to improve patient care.</i>	<i>QIOs exceeded the goal to work with 5% of the practices in their state</i>	100
1d2. Underserved Populations	\$13,132	<i>Worked with 7,891 IPG practices to increase physician practices' culturally competent care.</i>	<i>Recruitment for physician practices to participate in Task 1D2 began in August 2005 and continued through February 28th, 2007 so therefore results would not have been available in 2006.</i>	46
1d3. Part D Benefit	\$7,474	<i>CMS worked with each QIO to begin one project. To increase safety in the delivery of prescription drugs.</i>	<i>53 QIOs designed a project</i>	100
3a. Beneficiary Protection	\$62,152	<i>Statutorily mandated review of beneficiary complaints about the quality of health care services and all activities associated with other required case reviews.</i>	<i>Reviewed 90,646 medical records and 3,717 beneficiary complaints</i>	98
3b. Hospital Payment Monitoring Program	\$14,839	<i>Measure, monitor, and reduce the incidence of improper fee-for-service inpatient payments.</i>	<i>Reviewed 41,000 medical records</i>	<i>Found \$14.5 million in overpayments and \$2.0 in underpayments</i>

IV. PROGRAM AND ADMINISTRATIVE CHANGES IN FY 2006

Central and Regional Office Redesign and Integration

In FY 2006, the Office of Clinical Standards and Quality (OCSQ) reorganized the responsibility for the QIO Program. Under the redesign, OCSQ assumed overall responsibility for oversight, coordination, and administration of the Program. Furthermore, the four Associate Regional Administrators (ARAs) in regional offices with Divisions of Quality Improvement (DQIs) now share leadership responsibilities in supporting the Program under OCSQ. These responsibilities include development of the strategic plan, management and oversight of the core contract, stakeholder relationships, and the management of human and financial resources. In addition, the four regional office DQIs have responsibility and first-line authority for oversight of the individual QIOs. The DQIs have the responsibility to support and promote quality of care via cross-component and cross-regional work. With new QIO Program leadership in place in OCSQ and the regional offices, CMS assessed and began implementing the necessary changes required to improve the Program.

CMS Commitment to Program Improvement

To more effectively lead the Program in a new direction, CMS publicly announced its commitment to strengthen the Program through improved evaluation design, enhanced financial oversight, increased competition for QIO contracts, and other QIO initiatives on August 31, 2006⁷

Management Oversight Review

To begin the process of improving program management, CMS staff and leadership visited several QIOs. The site reviews provided CMS with the opportunity to meet personally with QIO management and staff and to engage in detailed discussion about changes in policies necessary for improvement in governance, oversight, and review of Program expenditures. QIOs participating in reviews were selected based on contract size, volume of financial transactions, beneficiary populations, geographic area, and the CEO's commitment to share best practices.

During the 2006 site visits, CMS identified QIO best practices and issues that were not addressed through the contract, such as atypical charges. As a result, several actions were taken to ensure more scrutiny to QIO invoices, improve audits and QIO management reviews, and provide guidance.

⁷ The Department officially made this announcement through a Report to Congress on August 31, 2006. The Report to Congress is online at <http://www.cms.hhs.gov/QualityImprovementOrgs/>.

Steps were also taken to ensure that there would be more effective QIO governance and oversight of the Program. In addition to holding periodic meetings with QIO CEOs about the redesign of Program oversight and expectations of QIOs, CMS held a national videoconference with CEOs in August 2006 to address significant governance changes expected of QIOs.

Defense Contract Audit Agency (DCAA) Audits

To improve the oversight of the Program, CMS pays the Defense Contract Audit Agency (DCAA) to perform audit reviews of all contractor expenses. In calendar year 2006, incurred cost audits were performed for 24 QIOs. Additionally, CMS provided DCAA with additional funding to increase audit support. The increased auditing included other types of reviews above and beyond the indirect rate review activities that DCAA performed in the past. This allows DCAA to provide onsite checks at QIOs to validate work, perform accounting system reviews, and to undertake reviews of QIO purchase systems.

Business Operations Staff (BOS)

To serve as the focal point for all crosscutting business operations that affect the management of the QIO Program, the leadership of OCSQ created a Business Operations Staff (BOS). BOS's responsibilities include development of crosscutting business operations standards, procedures and policies, budget formulation, procurement planning, human resources management, staff development and training, and communications management.

National Partnering

In supporting the QIO Program, OCSQ took a leadership role in integrating the QIOs' role with the activities of national partners in various health settings, such as in ESRD services through the Fistula First outreach campaign, in the hospital setting through the SCIP for improving patient safety during surgery, in nursing homes through the Advancing Excellence in America's Nursing Homes campaign, and in the home health care setting through efforts to reduce avoidable hospitalizations. Not only the nursing home and home health but also the hospital and ESRD initiatives are aligned to support the core contract work of the QIOs. In 2006, BOS was in the strategic planning stages to identify further opportunities to promote awareness of the activities and success of the QIO Program.

V. CONCLUSION

American seniors deserve to have confidence in their health care and to age with dignity. A system that delivers the right care to every person every time is one way to help achieve that. The QIO Program—with a national network of independent organizations that perform under contracts with Medicare to share best practices, process improvement plans and tools, and practice innovations in nursing homes, hospitals, home health

agencies, physician practices, and in providing care to underserved populations—is a contributing factor to improvements in American health care.

Notwithstanding these improvements, substantially higher levels of performance are possible. With the 7th SOW lessons learned, the 8th SOW was developed and launched in August 2005. The 8th SOW seeks to promote even greater levels of health care quality improvement while also working to protect Medicare beneficiaries and maintain the integrity of the Medicare Trust Fund.

Next steps include continuing work with DCAA to refine audit protocols; planning QIO management reviews for FY 2007; providing additional training to QIOs on co-sponsorship, subcontracting, Financial Information and Vouchering System (FIVS), and property/security; and reviewing the QIOs' governance compliance programs.⁸ The Program will use quarterly contract and progress measure data to monitor QIO performance during the contract period, and will improve its structure and process for communicating with contractors.

APPENDIX 1— QIO CONTACT INFORMATION AND RESOURCES

More information on HHS Quality Initiatives and the QIOs can be found at <http://www.cms.hhs.gov/center/quality.asp>

MedQIC,

<http://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQPage/Homepage> is an online resource both for QIOs and for providers working with Medicare beneficiaries across the country. MedQIC is designed to foster quality improvement in health care by sharing best practices and process improvement strategies. For a listing of QIOs, go to MedQIC and click on “QIO Listings” on the home page.

⁸ Compliance programs deal with standards of conduct, preventing fraud and abuse, whistleblower protection, and auditing and monitoring such conduct in the contractor organization. CMS provides compliance guidance documents for contractor employees. Such employees need to be trained in compliance.