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Contracting for Quality: Medicare's Quality Improvement Organizations

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OVERVIEW — *This paper examines the role of quality improvement organizations (QIOs, formerly known as PROs, or peer review organizations) in improving the quality of medical care delivered to Medicare beneficiaries in both fee-for-service and managed care environments. It looks at the expansion of the QIOs' portfolio in their new contract cycle to include quality improvement activities in nursing homes, home health services, and physicians' offices as well as responsibilities for public education. The paper explores the evolution of QIOs, changes in their priorities over time, and the projects in which they are currently engaged. It also considers their role in the formulation and execution of a national quality agenda.*

Contracting for Quality: Medicare's Quality Improvement Organizations

Quality is a notoriously difficult matter to legislate, especially when it comes to health care. The market is complicated, financing is painfully channeled, and the science base is evolving more rapidly than medical practice can accommodate. Despite these difficulties, however, the quest continues, for—as the Institute of Medicine (IOM), RAND, and the Dartmouth Center for the Evaluative Clinical Sciences keep pointing out—clinical quality in the United States is not all that it could or should be. Many demonstration projects, one approach to improving quality, have been proposed and a number are already implemented. Some policymakers have called for another approach, the establishment of a new federal quality agency.

The federal budget already funds numerous quality activities across multiple agencies. The Department of Health and Human Services (DHHS) participates in public-private partnerships such as the National Quality Forum and FACCT (the Foundation for Accountability) and oversees a network of organizations to foster quality care in Medicare. For decades, the government has also funded endeavors to address quality issues at the local, practice level. Today, each state has a quality improvement organization (QIO) that contracts with Medicare to monitor and improve the care delivered to beneficiaries.

Each QIO operates under a contract known as a “statement of work,” governed by extensive portions of Titles 11 and 18 of the Social Security Act, Part B, as amended by the Peer Review Improvement Act of 1982. Specific QIO tasks fall under three areas of responsibility, as provided in the act and reiterated in the statement of work:

- 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 only pays for services and items that are reasonable and medically necessary and that are provided in the most appropriate (for example, economical) setting.
- Protect beneficiaries by expeditiously addressing individual cases, such as beneficiary complaints, provider-issued notices of noncoverage, EMTALA (Emergency Medical Treatment and Active Labor Act) violations (“dumping”), and other statutory responsibilities.

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Within this statutory framework, emphases can vary. In the Clinton administration, weight was placed on statewide hospital quality improvement projects, shifting somewhat toward payment integrity in the second term. Thus far, the Bush administration's emphasis appears to be on expanding QIO activities in care settings beyond hospitals and educating the public on the availability and value of quality information. Many find the addition of thousands of new providers and the need to track new sets of quality indicators difficult to reconcile with the funding cut incorporated in the president's budget.

BACKGROUND

Early Development

Since Medicare's enactment in 1965, Congress has made a series of efforts to establish organized quality assurance for Medicare beneficiaries. The first foray (which occurred between 1970 and 1975) was the establishment of experimental medical care review organizations (EMCROs), voluntary associations of physicians who reviewed inpatient and ambulatory care services provided by Medicare and Medicaid. Overseen and funded by the National Center for Health Services Research (a predecessor agency to today's Agency for Healthcare Quality and Research), the EMCROs' mission was to encourage physicians to work together and to develop better methods of assessing and assuring quality of care.¹

Meanwhile, rising program costs generated concerns that the federal government lacked an effective mechanism to identify and deter hospitals and physicians who were responsible for unnecessary or substandard care.² Legislation first introduced in 1970 became the basis for a 1972 amendment to the Social Security Act creating professional standards review organizations (PSROs). Proponents felt that utilization and quality determinations should be entrusted to physicians with expertise in local practice patterns, not to insurers such as Medicare's fiscal intermediaries (which had previously borne sole responsibility for deciding whether care should be paid for). PSROs were charged with determining for reimbursement purposes whether services were medically necessary, provided in accordance with federal standards, and rendered in the appropriate setting. Framers of the legislation saw their primary mission as reducing the use of unnecessary or inappropriate services that, under a cost-based reimbursement model, were presumed to be driving up costs.³

PSRO activities included hospital utilization review, development of hospital discharge data, the conduct of medical care evaluation and quality review studies, and the construction and analysis of hospital and physician practice profiles. The central mechanism was case review—for which panels of physicians were paid an hourly rate—and the basis for decisions regarding appropriateness and necessity was professional judgment.

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In effect, the process was geared more to punishing “bad actors” than to encouraging systemic improvement.

The Health Care Financing Administration (HCFA) in DHHS also regarded PSROs as enforcers rather than ambassadors. In a program evaluation published in 1980, the agency described PSROs as “formalized externally authorized and mandated local physician organizations expected to function as a regulatory system exercising control via performance evaluations tied to financial and professional sanctions.”⁴ However, the PSROs were not permitted to impose sanctions directly, only to make recommendations to HCFA. Moreover, their localized character may have vitiated their enforcement zeal, in that reviewing physicians would in many cases have had relationships with those under review.

When Medicare adopted prospective payment for hospitals in 1983, PSROs were replaced by the clumsily named Medicare utilization and quality control peer review organizations—called peer review organizations (PROs) for short—which Congress envisioned as a leaner and more efficient review mechanism. Where there had been at one time as many as 300 PSROs, there would be 54 PROs, one for each state and territory. Contracts were to be awarded on the basis of competitive bidding rather than as grants, and the funding cycle lengthened from one year to two (later three). Program costs were to be paid from the Medicare trust fund rather than through the appropriations process. Where PSROs had to be physician-sponsored organizations, PROs had the option to be physician-access organizations, that is, organizations with a sufficient number of physicians available to them to ensure adequate review capability. Local physicians were no longer permitted to review their colleagues and competitors.⁵

The PRO mission was still to review the medical necessity, reasonableness, and quality of care and the appropriateness of care setting. The first contract cycle or “statement of work” (1984 to 1986) emphasized utilization review, focusing on hospital admissions, readmissions and transfers, accuracy of coding, and medical necessity. Under pressure from Congress, the second statement of work added more quality review responsibilities. Quality review and utilization review were both watchdog activities that could be (and frequently were) perceived by providers as adversarial and/or inappropriate (“cookbook medicine”).

Reviews of PRO effectiveness over time were mixed. In the Omnibus Budget Reconciliation Act of 1986, Congress required the PROs to dedicate substantial effort to quality monitoring and instructed the secretary of health and human services to contract for an IOM study of quality review in Medicare that would include an examination of current methods. The ensuing IOM report found PROs commendable in some respects, but seriously limited. It concluded by recommending that the program be revamped in such a way that its real—not just ostensible—focus would be quality assurance, with more emphasis on patient outcomes, provider communications, and episodes of care extending beyond the hospital.

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The IOM characterized PROs as “inclined toward reaction, external inspection, and regulation,” and called for a redesign that would “be more proactive in data collection and feedback and...actively foster professionalism and internal quality improvement.”⁶

The Health Care Quality Improvement Program (HCQIP)

The next stage in PRO evolution was hatched in HCFA. Agency official Stephen F. Jencks, M.D., and Administrator Gail Wilensky, Ph.D.,⁷ reported in the *Journal of the American Medical Association* in August 1992 that the agency was reshaping its approach to improving care for Medicare beneficiaries along the lines envisioned by the IOM, the goal being “to move from dealing with individual clinical errors to helping providers to improve the mainstream of care.”⁸ For PROs, the primary role was to be technical assistance.

Incorporated in the new initiative were new data systems, pilot projects for PROs in new collection and analysis techniques, and training in working with hospitals and physicians to develop local QI projects. As Jencks and Wilensky significantly noted, “The HCQI initiative can only reach its potential if HCFA, the PROs, and the hospital and medical communities work together, because fear and adversarial relations will cripple quality-improvement efforts.”

The first major HCQIP project was the Cooperative Cardiovascular Project, designed to improve care for Medicare patients with acute myocardial infarction (AMI). A committee convened by HCFA and the American Medical Association designed quality indicators heavily based on clinical practice guidelines developed by the American College of Cardiology and the American Heart Association. PROs in four states refined the indicators, developed data collection instruments and computer algorithms, abstracted data from medical records, and evaluated the results for each quality indicator. The PROs then shared the results with providers in their states and encouraged the adoption of QI plans. Over the project period (1992 to 1996), performance on all quality indicators improved significantly in all four pilot states.⁹

In the fifth contract cycle (1996 to 1999), PROs implemented the Cooperative Cardiovascular Project and similar projects in hospitals across the country. In 1999 (the beginning of the sixth contract cycle), HCQIP projects became national, and every PRO was required to produce measurable statewide improvement in the clinical areas of breast cancer, diabetes, heart failure, pneumonia, and stroke as well as AMI. Each PRO was required to work on projects in all six areas. At the same time, PROs were responsible for developing and executing local QI projects and QI projects in conjunction with Medicare+Choice organizations (M+COs) in states where there are M+C options. (The division of QIO effort between the fee-for-service and M+C realms is prescribed in statute as equivalent on a per-enrollee basis.) Overarching objectives included the development

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and testing of QI projects in nonhospital settings and the reduction of the disparity of care provided to beneficiaries in disadvantaged population groups.

As of this writing, the Centers for Medicare and Medicaid Services, or CMS (formerly HCFA) had released performance results for 36 states on the 22 HCQIP indicators. All states are evaluated quantitatively on all measures, with success measured by assessing changes in statewide baselines (as calculated by CMS) over a period of time. Presented as percentage improvement in the failure rate, the figures vary from state to state and by condition, ranging from 100 percent improvement—that is, a failure rate of zero—on some conditions to declines of several percentage points on others.

Overall, improved quality was documented on 20 of the indicators (the exceptions being smoking cessation counseling while hospitalized for AMI and blood culture before administering antibiotics to pneumonia patients) and all states showed improvement on a majority of the indicators. The evaluation formula takes some account of the relative ease of improving against a poor initial baseline performance and the difficulty of improving when performance is already very good.

The waxing emphasis on quality improvement and collaboration as the heart of the PROs' mission was paralleled by an evolution in oversight and evaluation philosophy. As then-Deputy HCFA Administrator Michael Hash said in a speech about the sixth statement of work, "PROs are focused on achieving state-wide improvements in [the specified clinical areas]. In return, we have relaxed most of the procedural requirements of previous contracts. We are paying for results and leaving PROs to work with their local partners in the way that the partnerships determine will be the most effective."¹⁰

Participation in QIO-sponsored projects is entirely voluntary on the part of hospitals and other providers. What QIOs offer as incentives are reliable, real-time feedback on individual performance and comparison data on statewide performance benchmarks, along with educational materials, clinical and analytical tools, and information exchange opportunities. QIO leaders are united in a belief that most providers are eager to improve the care they deliver if they can do so without economic hardship or what they regard as unwarranted intrusion.

PROs into QIOs

As noted earlier, the PROs' statutory name is long and rarely used. "PRO" is in essence a nickname that could be changed. In announcing a new nursing home quality initiative, Secretary of Health and Human Services Tommy Thompson said, "We're going to put the information on-line at www.medicare.gov and will be promoting it locally through Quality Improvement Organizations, formerly known as Medicare Peer Review

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Organizations.” The QIO moniker, already employed by the American Health Quality Association (AHQA, the PRO/QIO trade group), was echoed in the president’s budget proposal and is slated to be made “official” in the *Federal Register* by June 1. Henceforth in this paper, “QIO” will be the term employed.

QIOs TODAY

At the beginning of the seventh contract cycle, there are 37 QIOs in operation, some with multistate contracts. They are private, independent organizations, of which 33 are nonprofit and 4 are investor-owned. QIOs employ professionals who have expertise in health care quality that encompasses both clinical and analytical perspectives.

CMS divides the states into three groups for QIO contracting purposes. Requests for proposals for the seventh statement of work have been issued to the first group of 19 states. New contract dates for the three groups are staggered from August 1 to February 1. While a proposal must be submitted for each state, contract renewal is not necessarily competitive. If a QIO met the performance standards in each of the five task areas in the sixth statement of work (national QI projects, local QI projects, QI projects with M+C organizations, payment error reduction, and other mandatory activities), it will be granted a non-competitive contract renewal. If not, as is the case with 3 of 19 in the first group, the existing QIO will have to compete for the contract. Likely competitors are multistate QIOs. The only time high-performing QIOs will have to compete for renewal is if a qualified organization within a state decides to become a contender for a contract currently held by a QIO outside the state.

In addition to their contracts with CMS, QIOs may undertake quality review, data analysis, and other tasks under contracts with other federal agencies, local and state governments, and private corporations. For example, the West Virginia Medical Institute (QIO for West Virginia and Delaware) has data management contracts with the Departments of Defense and Veterans Affairs. KePRO (Pennsylvania and Ohio) also contracts with the Department of Defense, in this case providing oversight for the TriCare program. IPRO (New York) was awarded a contract to audit Medicare HEDIS (Health Plan Employer Data and Information Set)¹¹ data and convene a Geriatrics Measurement Advisory Panel for the National Committee for Quality Assurance.

QIOs are also active in the Medicaid program. States are required to contract with external quality review organizations (EQROs) to evaluate the care provided to enrollees in Medicaid managed-care programs. Forty states have such programs, and all but four of them contract with a QIO for EQRO services (mainly medical record review).¹² The reason is not simply that QIOs are conveniently located in most states. Before enactment of the Balanced Budget Act (BBA) of 1997, the federal match on

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activities conducted by PROs was 75 percent, while the same activities carried out by another entity were matched at only 50 percent. The BBA expanded the 75 percent category to other types of contractors, but this does not appear to have altered the behavior of states (perhaps because regulations implementing the change were long in coming).

QIOs may also have contracts to provide other services, such as preauthorization, to Medicaid programs. For example, KePRO conducts hospital and home health precertification for Florida's Medicaid program, while the Oklahoma Foundation for Medical Quality performs its own state's psychiatric precertification. Several states contract with QIOs to work with beneficiaries and providers to improve outpatient drug utilization in the Medicaid population.

The Seventh Contract Cycle

As in the sixth cycle, QI projects are the heart of QIO activities. All seventh-cycle projects are on national topics, though individual project design is local. A change has occurred in clinical priorities; the areas of concentration for national projects for hospitals under this contract will be AMI, heart failure, pneumonia, and the prevention of infection following surgery. (See Figure 1, page 9, for a listing of the associated measures.)

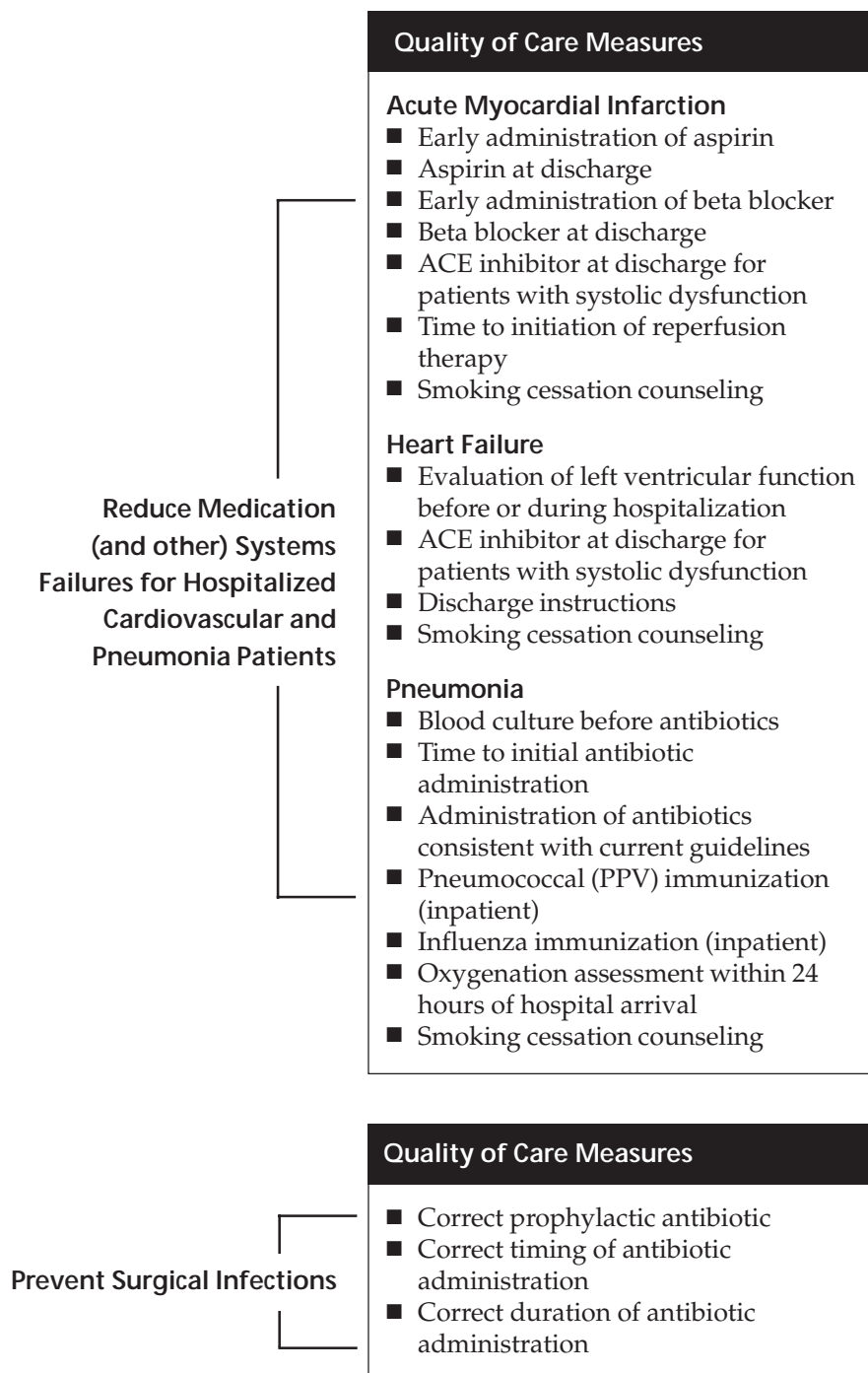
Total direct funding to QIOs over the three years of the seventh cycle is approximately \$735 million. The proportion of funding expected to be associated with various tasks is broken out in Figure 2 (page 10). Quality improvement project activities account for 45 percent of the total, down from about 55 percent in the sixth contract cycle. However, CMS characterizes the approximately \$90 million newly allocated to public education and reporting as an integral component of its clinical performance improvement strategy.

Collaboration with providers is a theme sounded repeatedly in contract language. A requirement that overarches all tasks is this:

The QIO shall coordinate its activities with other stakeholders in the state working on comparable improvement efforts or interested in teaming with the QIO. This coordination may include creating, joining, and/or supporting partnerships with organizations with similar goals and objectives, or facilitating ongoing discussion among the various stakeholders....The goal of such coordination is to utilize resources efficiently and avoid duplication of effort and inconsistencies, which are burdensome to providers and practitioners.

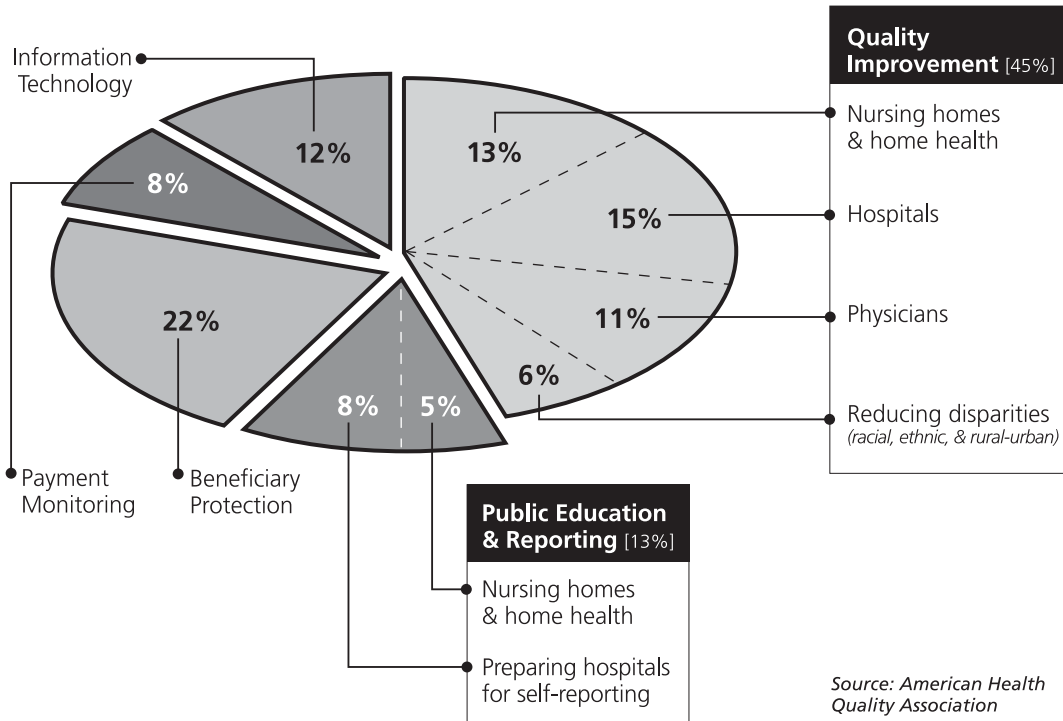
Beneficiary outreach will receive additional emphasis. In addition to public education campaigns, consumer representatives are directed to be added to QIO advisory panels to advise on beneficiary needs. QIO hotlines will answer questions on beneficiary rights, quality of care issues, and preventive health measures. Many QIOs already are engaged with senior groups in their states and localities and are regular sponsors of public service announcements and other outreach activities.

FIGURE 1
Measures Associated with National Quality Improvement
Projects under the Seventh QIO Contract Cycle



Source: Centers for Medicare and Medicaid Services.

FIGURE 2
Proportion of Direct QIO Funding Associated with Various Tasks during the Seventh QIO Contract Cycle



Source: American Health Quality Association

A commitment to standardization is also evident in the new statement of work. CMS has worked for several years with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to make quality of care measures consistent, such that a hospital can collect and report the same data to the agency and the accreditor. CMS also has included in the statement of work a notice of intent to change its measures if necessary “to ensure consistency with measures promulgated by the National Quality Forum (NQF).”¹³ In fact, the CMS/JCAHO measures have already been submitted to the NQF for its consideration, and are included in the draft measure set being circulated to NQF members.¹⁴

With standardized data elements, CMS believes that hospitals should begin, with QIO assistance, the transition to generating their own care quality data. Up to now, QIOs have done much of the necessary abstraction and collection themselves. Although public reporting of hospital-generated data is not required at this time, CMS plans to have the QIOs conduct pilot studies around data collection and public reporting to inform a national strategy for public reporting by hospitals.

Quality improvement in extra-hospital care settings is a significant consideration of the new contract. Most noticeably, QIOs have been assigned an important role in the nursing home quality improvement initiative that has become a priority for the CMS administrator. The initiative will provide comparative data on nine quality measures drawn from nursing homes' Minimum Data Set reports to CMS. DHHS released the first round of quality measurement data on facilities in six pilot states in late April. The program is slated to be active in all states as of October 2002. QIOs will provide "community-based assistance," including technical assistance to nursing homes and program promotion. Specifically, they will do the following:

- Develop and implement a plan to partner with relevant nursing home stakeholders, such as a state's survey and certification agency, Medicaid authority, trade and professional groups, and patient advocates.
- Offer information to all nursing homes in the state about systems-based approaches to improve care and outcomes.
- In consultation with stakeholders, select three to five of the publicly reported measures on which to focus efforts to improve quality of nursing home care in the state.
- Work closely with a target group of about 10 percent of nursing homes in the state.

QIOs in 27 states have a head start on dealing with nursing home quality issues. Organizations in Arkansas, New Jersey, Puerto Rico, Texas, and Virginia have undertaken projects to reduce the incidence of pressure ulcers (one of the measures now to be reported publicly). QIOs in Alabama and Missouri have worked on reducing falls. Rhode Island has addressed pain management. QIOs in 14 states have teamed with skilled nursing facilities to increase the number of Medicare beneficiaries receiving influenza and pneumococcal vaccinations.

Enthusiasm for proceeding to more broadly based assistance is not lacking. Resources may be, QIO officials from the pilot states have cautioned. Because the industry is far behind hospitals in developing quality protocols and data management infrastructure, interest in technical assistance is likely to be quite high. Becoming expert on nine quality measures at once is a tall order. Some QIO leaders are concerned that the extensive pilot-testing that hospital measures went through has been unduly condensed. One of the criteria for admission as a hospital-based measure in the sixth statement of work was evidence that both the practitioner and the QIO could have an impact on performance; such evidence, so far at least, is missing from the nursing home initiative. The plan for full roll-out in six months would not seem to allow for a great deal of reflection and fine-tuning based on the pilot.

The statement of work makes provision for outreach efforts in other sectors as well. It is anticipated that certain measures of quality will be selected for public reporting purposes from the OASIS (Outcome and

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Assessment Information Set) data set that home health agencies are required to use for reporting to CMS. In anticipation of this, QIOs are to begin forging relationships with stakeholders, arranging training for home health agency staff in quality improvement methodology and techniques and identifying agencies as participants (here the target is 30 percent participation).

Quality improvement projects in physician office settings target a group of physicians who collectively care for at least 10 percent of each state's Medicare beneficiaries. Quality measures on which improvement will be assessed are diabetic care (annual retinal exams, annual HbA1c testing, and biennial lipid profiling), mammography screening, and influenza and pneumococcal immunizations.

QIOs will still offer support to M+COs in carrying out the quality assessment and performance improvement projects required of them by CMS and will work to ensure consistent approaches in QI activities by all M+COs in a state. However, QIOs are expected to focus less on direct technical assistance than on involving M+COs in QI projects focused on physician-office and other outpatient care.

Beyond quality improvement, the QIOs are tasked with oversight, program integrity, and beneficiary protection duties. Many of these focus on case review, including investigation of both hospital-issued notices of noncoverage and notices of discharge and Medicare appeal rights as well as investigation of beneficiary complaints.

The Payment Error Protection Program (PEPP), a feature of the sixth statement of work that required QIOs to review cases for appropriateness of coding as well as provision of appropriate services, is all but missing from the seventh, though routine payment monitoring is provided for. CMS officials report that analysis of PEPP data indicated that the available case review methodology was really inadequate to generate meaningful error reduction. Pilot-testing of improved methodology is planned.

POLICY ISSUES

The tension evident throughout the design and structure of the QIO program reflects the irresolution at the heart of quality efforts generally. Is the proper role of a quality-monitoring body to be a partner or an enforcer? Can providers be cajoled into and rewarded for improving quality, or must they be prodded and punished? A case can certainly be made for a combination of the two approaches. But having the same organization be both pal and cop presents difficulties. CMS is explicit that enforcement is a function encompassed in survey and certification, while collaborative quality improvement is the province of the QIOs. The QIOs clearly share this view, but the old dichotomy lingers in some perceptions.

Relationships with providers are key to the success of quality improvement projects. Not only is participation voluntary but also a QIO is only

one of many organizations extolling quality and seeking a piece of the provider's labors. There are both direct and opportunity costs associated with taking on QI projects. Activities and documentation called for by accreditors or health plans may seem to have more priority than QIO requests—another reason that standardization is eagerly sought.

In addition to competing demands, providers quite often face conflicting incentives. On the one hand, improvements in care outcome are a good thing, and providers may be eligible for some reward for improved performance. On the other, if (as proponents keep promising) good quality care really leads to cost savings, does it not follow that part of the savings come from the provider's own pocket? It is payers who bank the savings, not providers.

However, on a more immediate level, many providers have come to regard their QIO as a resource with assistance to offer in the here-and-now. One executive with a hospital group notes that, in addition to sharing QI ideas and tools, his QIO can offer insights into what CMS is thinking about.¹⁵

Another issue related to competing demands is the volume and detail of data to be collected—and the use(s) to which it will be put. QIO representatives express comfort with data that are used internally to make a provider aware of his performance and to identify areas for improvement. As an example, demonstrating to hospital staff that the 12 AMI patients out of 20 that are discharged without beta blockers is higher than the state average is fairly straightforward. Telling the local paper that 60 percent of Hospital X's heart patients are receiving substandard care is not. Collecting data clean and complete enough to defend public performance ratings tends to be complicated, expensive, and controversial.

Beneficiary protection activities have not been without controversy. A report in August 2001 by the DHHS Office of the Inspector General took CMS to task for a beneficiary complaint process it described as "an ineffective safety valve for Medicare beneficiaries" that rarely triggered intervention with providers.¹⁶ The report acknowledged that CMS contracts in fact treat complaints as "a distinctly minor activity." QIO officials report that by far the bulk of the complaints they receive have to do with billing, not quality of care; one chief executive officer recalled that, of some 400 calls to his organization's beneficiary hotline last year, three actually had to do with quality.

The uses to which data are put are an issue in beneficiary protection as well as in QI. While always something of a tug-of-war between consumer and provider interests, results of investigations into beneficiary complaints historically have been kept confidential unless the provider involved authorized their release. A lawsuit filed by Public Citizen on behalf of a Kentucky complainant may change that pattern. It led almost immediately to a summary judgment, issued in July 2001 by U.S. District Judge Ellen Huvelle in Washington, D.C., directing CMS to force the QIOs to

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comply with beneficiary requests for investigation results, even though that information could become the basis for malpractice suits. Oral argument in CMS's appeal of the ruling is scheduled to be heard in October.

CONCLUSION

QIO executives generally feel that their organizations are plugged in to efforts to develop national quality policy. AHQA's immediate past president serves on the board of directors of the National Quality Forum. Some QIOs have participated in projects with the Institute for Healthcare Improvement. The nursing home initiative will likely bring QIOs more into the public eye. Yet, to date, they do not seem to have achieved the status of a quality improvement "given" in the minds of policymakers beyond DHHS.

QIOs can muster talent, experience, and provider relationships in every state, though geographic variation certainly exists. They seem well-placed to help foster the culture change that analysts agree is necessary to wholesale quality improvement in American health care. Whether their partnership efforts are sufficient to drive such change is a question. Whether Medicare (or Congress) can muster the corresponding commitment is another.

ENDNOTES

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