Medicare is the largest single purchaser of health care in the United States, and the quality of care its beneficiaries receive could set the standard for all patients. Quality improvement organizations (QIOs) are private, historically physician-directed groups that receive Medicare funds to foster quality health care services, including review of complaints and appeals. In the last contract period (2002-2005), 41 organizations held 53 QIO contracts covering the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands (38 of the 41 are not-for-profit organizations).

Quality of care for Medicare beneficiaries is improving, but the pace of change is slower than desired. The QIO program needs restructuring to focus on activities, especially technical support, that will strengthen health care provider performance and produce better health outcomes for beneficiaries.

Requested by Congress and sponsored by the Centers for Medicare and Medicaid Services (CMS), this report is the second in the Pathways series that focuses on accelerating the pace of quality improvement efforts. The first report discussed the importance of measuring and reporting health care providers’ performance, while a third report will examine payment incentives.

MAINTAIN THE QIO PROGRAM AS A KEY PLAYER IN QUALITY IMPROVEMENT

QIOs have evolved under different organizational names and performed many functions over the past 35 years. They have been charged with examining beneficiary complaints and appeals, promoting health care quality, ensuring that Medicare was billed appropriately, and reviewing claims to determine if care met local, peer-reviewed quality standards. While QIOs still perform these functions, their emphasis has shifted toward active promotion of quality that meets national, evidence-based guidelines. QIOs have expanded their original focus on hospitals to include nursing homes, physician practices, home health agencies and health plans.

The goal is for high quality care to be available throughout the nation. The umbrella of the QIO program can foster and coordinate change across the country. This provides an opportunity for greater con-
sistency and the national alignment of improvement efforts. The Institute of Medicine (IOM) concludes that the QIO program should continue since a federally sponsored role in quality improvement is so important to the health of the country.

**CHANGE THE FOCUS TO TECHNICAL ASSISTANCE**

The expansion of public reporting on the performance of health care organizations and practitioners, along with the growth of incentive programs designed to raise quality levels, will increase demand by health care providers for the type of expert assistance that QIOs offer. To meet this anticipated surge in demand, the IOM recommends that QIOs refocus all of their efforts toward quality improvement technical assistance. QIOs should concentrate on helping providers improve their delivery of care, their organizational cultures, and information systems instead of handling beneficiary complaints, appeals, and other case reviews. QIO technical assistance activities cover five dimensions:

- Improvement of care documented by statewide performance measures (e.g., rate of mammography screening for appropriate populations)
- Improvement in provider capability to gather data and report on performance measures
- Adoption and use of improved systems (e.g., electronic health record)
- Changing the way care is delivered or assessed (e.g., required assessments of immunization status of the elderly by home health agencies)
- Monitoring and changing organizational culture (e.g., turnover rate of staff, satisfaction of residents and staff of nursing homes).

**HELP PROVIDERS AT EVERY LEVEL OF PERFORMANCE**

Provider participation in QIO programs is and should remain voluntary. Regardless of their level of quality, some providers have been reluctant to work with QIOs because of the QIOs’ dual role with both quality improvement and regulatory responsibilities. Refocusing their role on technical assistance and removing the regulatory responsibilities should alleviate any fear of sanctions.

**REASSIGN REGULATORY FUNCTIONS**

Proper handling of Medicare beneficiary complaints, appeals and other case reviews is important. The IOM therefore recommends that CMS hold open competition to contract with selected qualified entities to perform these functions. This might encourage other organizations or a few QIOs to conduct these activities in a more effective manner at the regional or national level, and give beneficiary complaints the attention they deserve.

**OPEN COMPETITION FOR ALL QIO CONTRACTS**

Most organizations currently holding QIO contracts have functioned as QIOs for many years, with few contracts changing hands. Currently, contracts are ended only for non-performance. Just because a QIO performed well on the previous contract does not mean that it would be the best candidate for a new and different scope of work.

IOM recommends that all QIO contracts be lengthened to five years (from the current three) and that all be opened for competition at the end of each scope of work. The QIO program should continue to contract for a dedicated QIO in each state, although the number of organizations CMS chooses to contract with may decrease from the current 41.
EXPAND EXPERTISE OF QIO GOVERNANCE

QIO boards currently have a predominance of physician representation, nearly two-thirds of all board members. To achieve greater balance, boards should include more representatives of other health fields and consumers as well as members with expertise in arenas related to technical assistance, such as health information technology. Boards should also reflect the communities they serve and provide greater oversight and accountability.

IMPROVE DATA HANDLING AND REPORTING CAPABILITY

IOM calls on CMS to revise the QIO program’s data-handling practices. Current data feedback procedures are not timely enough. Ideally, electronic health records will help the performance measurement and reporting system of the future to produce useful data in real time to assist practitioners improve the quality of their care. Data would also reflect care that patients receive from multiple providers over time, regardless of payer.

ENSURE EFFECTIVENESS OF QUALITY IMPROVEMENT SYSTEM

CMS must establish clear goals and strategic priorities for the QIO program based on national goals, and improve the program’s management. To determine how future funding can be spent most effectively, more rigorous evaluations of the program and of specific technical assistance methods are needed.

FUND QUALITY IMPROVEMENT INFRASTRUCTURE ADEQUATELY

The QIO program budget is $1.265 billion for its current three-year contract; this amounts to less than 0.1 percent of Medicare’s total budget. The distribution of QIO funds during its last contract period is shown in Figure 1.

Funds sufficient to support case reviews, appeals, and beneficiary complaints should be transferred from future QIO core contracts to the organizations that take over these duties. A concentrated effort will allow these concerns to be addressed more efficiently than distributing this function across all of the QIOs. However, funding for the quality improvement portion of the core contract will need to be increased to reflect inflation, the increased numbers of providers expected to be served, the labor-intensive nature of technical assistance, and recommended program evaluations.

CMS should make quality improvement an explicit expectation of all Medicare providers. Ideally, QIOs should have enough resources to help all providers who request assistance. If demand becomes overwhelming, QIOs should concentrate on the most underperforming providers, if they are willing to work at improving their quality.

---

FIGURE 1. Distribution of QIO Spending on 7th SOW Core Contract

NOTE: As of December 2004.
FOR MORE INFORMATION...

This study was supported by funds from the Centers for Medicare and Medicaid Services. Any opinions, findings, conclusions, or recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the organizations or agencies that provided support for the project.

The Institute of Medicine serves as adviser to the nation to improve health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public. For more information about the Institute of Medicine, visit the IOM home page at www.iom.edu.

Copyright ©2006 by the National Academy of Sciences. All rights reserved. Permission is granted to reproduce this document in its entirety, with no additions or alterations.

COMMITTEE ON REDESIGNING HEALTH INSURANCE PERFORMANCE MEASURES, PAYMENT, AND PERFORMANCE IMPROVEMENT PROGRAMS

STEVEN A. SCHROEDER (Chair), Distinguished Professor of Health and Health Care, University of California, San Francisco; BOBBIE BERKOWITZ, Alumni Endowed Professor of Nursing, Psychosocial and Community Health, University of Washington, Seattle; DONALD M. BERWICK, President and Chief Executive Officer, Institute for Healthcare Improvement, Cambridge, MA; BRUCE E. BRADLEY, Director Health Care Strategy and Public Policy, Health Care Initiatives, General Motors Corporation, Pontiac, MI; JANET M. CORRIGAN, President and Chief Executive Officer, National Committee for Quality Health Care, Washington, DC; KAREN DAVIS, President, The Commonwealth Fund, New York, NY; NANCY-ANN MIN DEPARLE, Senior Advisor, JPMorgan Partners, LLC, Washington, DC; ELLIOTT S. FISHER, Professor of Medicine and Community Family Medicine, Dartmouth Medical School, Hanover, NH; RICHARD G. FRANK, Margaret T. Morris Professor of Health Economics, Harvard Medical School, Boston, MA; ROBERT S. GALVIN, Director, Global Health Care, General Electric Company, Fairfield, CT; DAVID H. GUSTAFSON, Research Professor of Industrial Engineering, University of Wisconsin, Madison; MARY ANNE KODA-KIMBLE, Professor and Dean, School of Pharmacy, University of California, San Francisco; ALAN R. NELSON, Special Advisor to the Executive Vice President, American College of Physicians, Fairfax, VA; NORMAN C. PAYSON, President, NCP, Inc., Concord, NH; WILLIAM A. PECK, Director, Center for Health Policy, Washington University School of Medicine, St. Louis, MO; NEIL R. POWE, Professor of Medicine, Epidemiology and Health Policy, The Johns Hopkins University School of Medicine and Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; CHRISTOPHER QUERAM, President and Chief Executive Officer, Wisconsin Collaborative for Healthcare Quality, Madison; ROBERT D. REISCHAUER, President, The Urban Institute, Washington, DC; WILLIAM C. RICHARDSON, President Emeritus, The Johns Hopkins University and W.K. Kellogg Foundation, Hickory Corners, MI; CHERYL M. SCOTT, President Emerita, Group Health Cooperative, Seattle, WA; STEPHEN M. SHORTELL, Blue Cross of California Distinguished Professor of Health Policy and Management and Dean, School of Public Health, University of California-Berkeley; SAMUEL O. THIER, Professor of Medicine and Professor of Health Care Policy, Harvard Medical School, Massachusetts General Hospital, Boston, MA; GAIL R. WILENSKY, Senior Fellow, Project HOPE, Bethesda, MD

IOM STAFF

JANET CORRIGAN, Project Director; ROSEMARY A. CHALK, Project Director; KAREN ADAMS, Senior Program Officer, Lead Staff for the Subcommittee on Performance Measurement Evaluation; DIANNE MILLER WOLMAN, Senior Program Officer, Lead Staff on Quality Improvement Organization Program Evaluation; CONTESSA FINCHER, Program Officer; TRACY HARRIS, Program Officer; SAMANTHA CHAO, Senior Health Policy Associate; DANITZA VALDIVIA, Program Associate; MICHELLE BAZEMORE, Senior Project Assistant

1 Appointed to the committee beginning June 1, 2005. 2 Served through May 2005. 3 Served beginning May 2005. 4 Served through February 2006. 5 Served through July 2005.