the provision of assistance related to four strategies that if adopted by providers can lead to high performance: measurement and reporting of quality, adoption and use of health information technology, redesign of care processes, and change in organizational culture and management.

During the spring of 2005, the Program convened a series of four two-day meetings with providers, accreditors, provider organizations and medical specialty societies, and other government agencies. The meetings were organized by setting: nursing home, home health, hospital, and physician office. Participants made recommendations on setting-specific future quality measurement development, use of the four strategies in improving care, and how the QIO Program should operate to support quality improvement. Participants strongly endorsed the need for the Program to support quality measurement and to improve through the dissemination of information and provision of assistance directly to providers who need it for quality reporting and quality improvement.

Concurrently, CMS expanded its emphasis on demonstrable, systematic quality improvement. The Agency issued, in July 2005, a Quality Improvement Roadmap that included as its aim the provision of "the right care for every person every time." The Roadmap described five activities that CMS will use to achieve this aim:

- Work through partnerships, including within HHS, with other Federal and State agencies, and with nongovernmental partners including health professionals.
- Publish quality measurements and information, including measures directed toward both the beneficiary audience and the professional/provider/purchaser audience.
- Pay in a way that expresses our commitment to supporting providers and practitioners for doing the right thing – improving quality and avoiding unnecessary costs, and promoting competition to improve quality and lower costs – rather than directing more resources to less effective care.
- Assist practitioners and providers in taking the necessary steps to make care more effective and less costly, in particular greater use of effective electronic health systems.
- Become an active partner in driving the creation and use of evidence about the effectiveness of healthcare technologies, to bring effective innovations to patients more rapidly, and to help doctors and patients use the treatments we pay for more effectively.

The Roadmap ensures that the QIOs will play a crucial role in these activities.

The QIO 8th SOW was launched in August of 2005. The 8th SOW incorporated several features of Program improvement:

- National goals were set, with QIO contracts setting related targets at the state level, based on a focused set of largely publicly-reported measures, and aiming at high levels of performance (see Appendix 1 for 8th SOW contract measures)
- QIOs were assessed with respect to their ability to succeed on each contract task, primarily based on 7th SOW performance, and those determined to be at risk were required to implement acceptable capability improvement plans

- The award fee structure was enhanced such that most of the award is based on individual QIO performance and the achievement of national goals by the Program

- Program evaluation was strengthened by concentrating most QIO resources on working with identified subsets of providers in each state, with the collection of data on the type and intensity of QIO assistance, and survey information on whether the provider believes that improvement could have been achieved without the assistance

- National contracts for support of QIO work at the state level were restructured and made performance-based, with a new structure for coordination of management and activities

While measurable quality improvements have been occurring in Medicare, concerns have been raised about whether the QIOs are having the greatest impact possible on achieving these improvements. For example, a month prior to the 8th SOW launch, an article in the Journal of the American Medical Association raised questions about whether the improvement that had been observed in hospital quality measures in the 6th SOW was attributable to the Program. Members of Congress and others have also raised questions about Program management, impact, and the low volume of beneficiary complaint reviews and policies restricting the release of information on the review to the complainant.

Over the past six months, CMS undertook an intensive internal Agency review of the Program and its future. Through this ongoing review, the Agency took a fresh look at what needs to be done to improve the quality and efficiency of care for Medicare beneficiaries. We considered the role that the QIO Program should play in supporting Agency efforts as described in the Quality Improvement Roadmap, particularly related to the Agency's initiatives to modernize Medicare through pay-for-performance and competitive bidding programs. We assessed what changes need to be made to Program management. We have also considered how the Program can support the Presidential initiative to provide better information on quality and cost for health care consumers and providers. Recent efforts to improve quality reflect the idea that shared quality improvement goals and consistent quality measures for all patients will result in less

burden to providers, as well as the opportunity to identify and achieve meaningful performance improvements. Thus, to achieve demonstrable and significant improvement in care for Medicare beneficiaries, the Program is supporting partnerships that engage a broad group of stakeholders for the purpose of improving quality of care for all patients based on common goals and measures. This approach facilitates leveraging private sector resources and expertise at the local and national level, with a potentially more significant impact on the quality and efficiency of the health care system.

The IOM recommendations for restructuring and improving the QIO Program are generally consistent with the improvements that have been undertaken in the QIO Program. In the next section, we describe the IOM recommendations on different aspects of the QIO Program, and indicate CMS' improvement efforts in these areas. Our ongoing review of the program is expected to produce results that CMS will use to consider possible further improvements to the Program.

Section Two: IOM Study and Recommendations

Section 109 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Institute of Medicine (IOM) of the National Academy of Sciences to conduct an evaluation of the program under Part B of Title XI of the SSA, and submit a report on the results of the study, including any recommendations for legislation. The IOM is directed to include in the study a review of the following:

- An overview of the program under such part.
- The duties of organizations with contracts with the Secretary of HHS under such part.
- The extent to which quality improvement organizations improve the quality of care for Medicare beneficiaries.
- The extent to which other entities could perform such quality improvement functions as well as, or better than, QIOs.
- The effectiveness of reviews and other actions conducted by such organizations in carrying out those duties.
- The source and amount of funding for such organizations.
- The conduct of oversight of such organizations.

Section 109 of the MMA also provides that if, based on the IOM study, the Secretary of HHS finds that other entities could improve quality in the Medicare program as well as, or better than, the current quality improvement organizations, the Secretary shall provide for increased competition through the addition of new types of entities which may perform quality improvement functions.

The IOM made recommendations in five areas: focus on quality improvement and performance management; data processing; program management; program evaluation; and, program funding. The recommendations follow:

1. Focus on Quality Improvement and Performance Measurement

Recommendation: 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 HHS, and the Centers for Medicare & 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 improve 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 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.
    - Improvement 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.

Recommendation: Quality Improvement Organizations (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.

Recommendation: 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. The 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.

Recommendation: 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 concerning coverage 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.

2. Data Processing

Recommendation: 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 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.

3. QIO Program Management

Recommendation: 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 core, support, and special study contracts within the program; 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' 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 contract 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 carrying out 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 should provide guidance for the continuous improvement of program management, coordination, and communications.

4. QIO Program Evaluations

Recommendation: 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 the 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 evaluation of the effectiveness of quality improvement interventions is 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' 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.

5. QIO Program Funding

Recommendation: 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.

Section Three: Response to IOM Recommendations

Following the release of the IOM study, CMS refined its approach to program improvement that resulted from the internal review that the Agency initiated last fall. CMS views the IOM recommendations as generally consistent with the conclusions that arose from this ongoing internal review of the Program. In some areas, there are differences. A summary of CMS' response to the IOM recommendations and a discussion of ongoing CMS activities in each of the five IOM recommendation areas are as follows:

1. Focus on Quality Improvement and Performance Measurement

- CMS agrees that the Program should support performance measurement and improvement. We see the Program as an essential component of Agency and Departmental initiatives in transparency and performance-based payment of providers.
- CMS agrees that all providers should be encouraged to measure and improve quality, and that QIOs should provide technical assistance to support such improvement.
- CMS views the change in the requirements for QIO contractors as requiring statutory change, and will explore the inclusion of that in a proposal for statutory change through the established mechanisms for such a proposal.
- CMS agrees that QIO governance requirements should be changed, and will modify current contracts to incorporate such changes.
- CMS views case review, particularly related to beneficiary complaints, as an important part of the Program, and believes that changes to the current structural and confidentiality requirements would necessitate statutory change. CMS will explore the inclusion of that in a proposal for statutory change through the established mechanisms for such a proposal, and will propose regulatory changes as appropriate.

Performance Measurement and Improvement

Over the past several years, improving quality of care for Medicare beneficiaries has become an increasingly important part of CMS' agenda. Since 2002, CMS has supported collaborative quality initiatives in nursing home, home health and hospital settings, with a focus on making publicly available measures of provider performance on quality measures on its Compare website. More recently, the Agency has begun to link these measures to provider reimbursement, with payment related to reporting of quality data by providers, and ultimately to performance on these measures. These efforts are consistent with provisions in section 501(b) of the MMA, and as revised under section 5001(a) of the Deficit Reduction Act of 2006 (DRA). The efforts are also providing further steps toward greater transparency of information on quality and cost for consumers of health care services. They reflect a growing understanding of the importance of quality measurement and improvement to the safety, effectiveness, and patient-centeredness of care for beneficiaries, and to the efficiency of resource use and its impact on the Medicare Trust Fund.

In the Quality Roadmap the CMS issued in July 2005, the Agency committed itself to the vision of achieving "the right care for every person every time," where the right care corresponds to the six IOM aims of safety, effectiveness, efficiency, patient-centeredness, timeliness, and equity. The Roadmap identified five activities that it would use in pursuit of this vision:

- Partnerships with governmental agencies and with nongovernmental partners
- Collection and public reporting of quality measurements and information
- Payment policies for providers that are consistent with improving quality and avoiding unnecessary costs
- Assistance to practitioners in improving quality and efficiency, particularly through greater use of effective health information technology.
- Developing and using information about the effectiveness of health care technologies

As CMS pursues these strategies, the need for leadership and support for their implementation will increase. Performance measures, and a reporting infrastructure, will be as increasingly important as public reporting, pay-for-performance, competitive bidding for Medicare services, and other aspects of value-based purchasing expand. These strategies will increase the motivation of providers to improve quality, but help is needed in order for improvement to occur and to reach high levels of performance. This will stimulate need and demand by providers for technical assistance.

The QIO Program is a primary source of leadership and support for implementation of the Quality Improvement Roadmap as it evolves to meet future needs and developments, and particularly for Agency activities related to public reporting and pay-for-performance. The Program is doing this by providing CMS with an infrastructure and field support to lead its efforts to achieve high levels of quality and efficiency in its programs through private-public collaboration on performance measurement and improvement. The Program is accomplishing this through:

- Quality measure development
- An infrastructure that measures data collection, reporting, analysis, and validation
- The development and provision of information on how to improve performance, and the provision of direct technical assistance to providers that seek to improve performance
- The setting of national goals and leadership and support for partnerships and campaigns that seek to achieve them at the national and state levels
- Local and regional quality initiatives that seek to improve quality and efficiency in identified areas of high opportunity and impact
- The provision of information to beneficiaries and the public that supports person-centered care
- The review of beneficiary complaints with an emphasis on promoting transparency of response and improvement activities by providers
- Other case review activities

- Evaluation of its methods so as to promote learning about how to achieve excellence in care delivery
- Evaluation of its impact on quality and efficiency of care

Measure Development and Reporting Infrastructure

Many stakeholders have an interest in the development of quality measures and reporting of performance on them by providers. CMS is committed to working in partnership with provider organizations, consumer groups, accreditation organizations, payers, purchasers, other federal agencies, and other stakeholders to increase the availability of measures and performance reporting.

As part of the current quality measurement and reporting activities, the QIO Program is a key source of support for measure development activities. The Program will continue to identify areas in which measure development is needed in order to improve quality and efficiency, and through expert panels and field testing, it will support development and specification of measures in these areas. Other stakeholders are also contributing to such measure development, and the Program contributes to the measures consensus work of the National Quality Forum.

The Program is playing an expanded role in the collection of performance information on an increasing array of quality measures. A substantial part of the data reported in the National Healthcare Quality Report published by the Agency for Healthcare Research and Quality (AHRQ) is supported by Program activities. The Program currently provides the national infrastructure for hospital reporting on quality measures. This infrastructure includes a data collection tool, a channel for data submission, a data repository, data validation, and results reporting to providers and the public. Hospital reporting is linked to payment in the Medicare program, and will form the basis for performance-based payment under Medicare. The Program also supports maintenance of data collection tools, and data warehousing used in nursing home and home health agency public reporting.

On August 22, the President issued an Executive Order directing federal agencies that administer or support health insurance programs to take steps that will result in more complete and open information for consumers. The order requires agencies to take steps to share information about the quality of care delivered by doctors and hospitals, as well as the prices paid to these providers. The order also requires agencies and their health care contractors to promote the use of interoperable health information technology products, so that data can be easily shared. In addition, it requires agencies to offer insurance options that reward consumers who exercise choice among health providers based on value and quality of care.

The QIOs are supporting expanded efforts for quality data reporting, building on private-sector efforts, which are more effective in helping consumers make decisions about their care and in supporting provider efforts to improve care. These new activities include a Medicare pilot project, which will be conducted initially in six regions of the country that

will incorporate data from private insurers and Medicaid, as well as Medicare, in providing information on the quality of physician services in those areas to Medicare beneficiaries, and the public generally. Porviders, employers, unions, insurers, and consumer alliances have been cooperating in this Medicare project, which will evaluate effective approaches to measuring quality and costs of care, including innovative approaches to collecting data electronically. The project will also include development, implementation, and expansion of the use of measures that reflect Medicare and non-Medicare patient data, and that as a result are more precise and comprehensive, and less burdensome to providers. In collaboration with AHRQ, and in cooperation with the private sector, the Department expects to promote the expansion of this project to other areas of the country as rapidly as possible.

Technical Assistance

Achievement of the vision of the right care for every person every time requires a high level of performance by providers. Public reporting and performance-based payment programs also drive and support high performance levels. However, the impact of programs to support and reward better performance is limited by the fact that many providers do not know how to effectively implement needed changes to achieve maximum performance improvement. Innovators and change agents in health care need access to the best ideas, the most useful measures, the most inspiring case studies, and the support of peers.

Over the past decade, the QIO Program has been an important national resource in identifying and spreading best practice information, and in developing the capacity of organizations and providers to use it in improving care. In 2005, the Program brought together providers, provider organizations, accreditors, and other stakeholders in a series of meetings to assess the type of assistance that the Program should provide in the nursing home, home health, hospital, and physician office settings. Two types of assistance were identified: information that providers and other organizations can access and use without QIO involvement, and technical assistance that QIOs offer directly to providers.

The QIO Program has already begun to offer these two types of assistance to providers seeking improvement. Through its website, www.medqic.org, the Program offers comprehensive information and tools related to best practices and ideas for change on a variety of topics in nursing home, home health hospital, and physician office settings. The Program is beginning to make some of this content available through online interactive support. This enables providers to directly access information that helps them improve care, and is also available to other organizations that work with providers on improvement, such as provider trade organizations, medical specialty societies, and private sources of assistance and consulting.

The bulk of Program resources in the 8th SOW are committed to offering providers direct assistance in the form of learning collaboratives and consultative assistance. QIOs in each state are helping providers make changes needed to achieve high levels of

performance in nursing homes, home health care, hospitals, and physician offices on measures of performance that are specified in the QIO contract (see Appendix 1).

In order for providers to achieve high levels of performance, fundamental changes in how they provide care are often needed. The QIO Program is using its resources to help providers implement four strategies that can yield high performance: measurement and reporting, adoption and use of health information technology, redesign of care processes, and changes to organizational culture and management. These transformational strategies differ from the incremental changes that QIOs promoted in the past, and are needed if providers are to achieve high performance.

In offering assistance, the QIO Program must make choices about where to commit resources. Support for the Quality Improvement Roadmap vision means helping providers offer care that is safe, effective, efficient, patient-centered, timely, and equitable. During its second phase, the Program focused largely on effectiveness of care, with a more recent emphasis on safety in hospitals. Increasingly, the Program will add support for patient-centeredness, equity, and efficiency.

With rising costs, efficiency of resource use is critical to the future of the Medicare program. Quality improvement has the potential for improving resource use by promoting evidence-based care and reducing overuse of services, preventing complications and adverse events, and improving the ability of patients to manage their conditions. This especially includes improvements in the coordination of care for patients with multiple illnesses or end-stage renal disease. The QIO Program has the potential to make a substantial contribution to efficiency of resource use in Medicare, and investments in the QIO Program will increasingly focus in areas where their costs can be substantially offset by quality improvements that increase efficiency.

The Program is currently in the process of contracting for special projects that will develop the evidence base for improving quality and efficiency for the Medicare population. Projects include:

- Preventing hospital admission for patients in nursing homes;
- Improving transitions of care for patients moving across settings;
- Measuring and improving palliative and hospice care; and
- Improving the quality and efficiency of care for patients with multiple chronic illnesses.

The Program must also make choices about which providers to assist. In the first phase of the Program, case review was used to identify providers with deficiencies, who were expected to undertake corrective action plans. In the second phase, QIOs made a decision about which providers to work with based on an assessment of those who could make the most improvement. The Program will continue to seek to support all providers who request help in measuring and improving performance, using either or both of the two types of assistance. In prioritizing resources, the Program will continue to use capability for improvement as a criterion for receipt of assistance, but this will be considered in the context of need for assistance (whether the provider could improve

using internal or other non-QIO resources), opportunity for improvement (gap between current and ideal performance), and design considerations related to Program evaluation.

Support for National Goals and Partnerships

The Quality Improvement Roadmap highlights partnerships between CMS and other stakeholders as a critical component of Agency efforts to improve quality and efficiency. CMS works closely with provider organizations, medical societies, accreditors, purchasers, payers, business coalitions, consumer groups, and other federal agencies in developing its quality initiatives. The QIO Program has played a significant role in such partnerships. The Program has led and supported nursing home, home health, hospital, and ambulatory care initiatives at the national and state level, and will continue to do so.

Since 1999, CMS has set goals for quality of care for Medicare beneficiaries in compliance with the Government Performance Results Act (GPRA). Current goals relate to such measures as nursing home pressure ulcers, nursing home restraints, influenza immunization, mammography, diabetic care, surgical infection prevention, and use of fistulas for dialysis access.

CMS is committed to expanding its role in setting of goals for the Medicare Program in conjunction with other federal agencies and stakeholders. Such goals are a critical component of the Agency's efforts to move from volume- and intensity-based payments to financial support that is based on patient need and quality of care. Some goals will be embedded in national campaigns that set specific targets for achieving measurable results within defined periods of a year or two. CMS is planning a Nursing Home Campaign the goal of which is to monitor key indicators of nursing home care quality, promote excellence in care giving for nursing home residents, and acknowledge the critical role of nursing home staff in providing that care. Specifically, the Nursing Home Campaign will assess progress toward achieving the following measurable goals:

1. Reducing high risk pressure ulcers;
2. Reducing the use of daily physical restraints;
3. Improving pain management for longer term nursing home residents;
4. Improving pain management for short stay, post-acute nursing home residents;
5. Establishing individual targets for improving quality;
6. Assessing resident and family satisfaction with the quality of care;
7. Increasing staff retention; and
8. Improving consistent assignment of nursing home staff, so that residents regularly receive care from the same caregivers.

Most health care providers deliver care to Medicare beneficiaries as well as patients insured by commercial insurers. Recent efforts to improve quality reflect the idea that shared quality improvement goals and consistent quality measures for all patients will result in less burden on providers, as well as the opportunity to identify and achieve meaningful performance improvements. Thus, to achieve demonstrable and significant improvement in care for Medicare beneficiaries, the Program is supporting partnerships that engage a broad group of stakeholders for the purpose of improving quality of care for

all patients based on common goals and measures. This approach facilitates leveraging private sector resources and expertise at the local and national level, with a potentially more significant impact on the quality and efficiency of the health care system. The QIO Program sets targets for improvement at the state level for each QIO during each contract period. In the 8th SOW, these goals were formulated so as to achieve Program-level performance targets. In some cases, these goals were also formulated on the basis of recommendations from technical expert panels convened under special QIO contract.

Future QIO Program goals will be based on the Agency's expanded goal-setting process, on expert input. Some QIO Program goals will also be derived from national campaigns. The QIO will be responsible for developing state-specific plans for achieving targets, and for tracking provider-specific performance and progress in implementing changes that are needed to achieve high levels of performance, as well as for providing technical assistance to providers. Program goals at the state level will be specified in QIO contracts.

Support for Local/Regional Initiatives

Over the past several scopes of work, QIOs have had the ability to propose projects that they believe address local opportunities in specified areas, such as nursing home and home care in the 6th SOW, healthcare disparities focused on underserved populations in the 6th and 7th SOWs, hospital payment error in the 7th and 8th SOWs, and Part D services in the 8th SOW. Additionally, there has been opportunity for QIOs to propose projects for special funding outside of the "core" QIO contract. Most of the resources in the Program, however, have been devoted to funding the work of the core contract, and the tasks in the contract have generally been required in all states. This has the advantage of creating consistency across states in the content of QIO work. It has the disadvantage, however, of reducing the opportunity for applying funds to areas of specific opportunity for impact.

The QIO program is expanding its role in producing comprehensive quality measures. CMS will identify topics and measures on which improvement is a priority, to achieve national goals, to reduce regional variation, or to impact efficiency of resource use. The Program will invite contractors to submit proposals for projects to achieve improvement in these areas, and will award these contracts based on projected impact and contractor ability. CMS will assure those who submit proposals will be evaluated in a systematic manner, consistent with other proposals submitted to the Department, and submitters will be notified in a timely manner of the results of the review or the status of the project. Additionally, QIOs and other entities may submit proposals for local/regional projects that impact quality and efficiency of care for Medicare beneficiaries. The local/regional initiatives will be expected to promote person-centered care.

Person-Centered Care

Person-centered care is one of the six IOM aims. It can also be seen as a defining aspect of the vision in the Quality Improvement Roadmap—the right care for every person every time calls for care that reliably meets the patient's needs. To achieve this vision, care must be organized around the person's, not the provider's, needs. Person-centered care can also result in better self-care, which is particularly important in chronic conditions, which are a substantial part of the burden of illness, and cost, in the Medicare population. As such, person-centered care is an important element in the improvement of quality and efficiency.

The IOM Quality Chasm report articulated the goal of person-centered care in this way: "to customize care to the specific needs and circumstances of each individual, that is, to modify the care to respond to the person, not the person to the care." Person-centered care changes the person's role to becoming an active consumer and participant in care. It enables patients and families to make choices based on good information about diagnostic/treatment decisions and selection of providers, to be full partners in care planning and management, to have service delivery design match their likely priorities, and to receive responsive review of and information about complaints and appeals about the shortcomings of their care.

Achieving person-centered care requires fundamental changes in the way care is delivered: information that supports patient and family choice and self-care, care process design and customization to the patient's preferences and values, continuity/reliability/advance planning, assessment of patient experience, responsive complaints and appeals processes.

In the 8th SOW, the QIO Program has provided leadership and support for initiatives to move health care toward patient-centered practices. QIOs are assisting nursing homes in measuring and improving resident experience, in managing pain, in reducing pressure sores, and in reducing use of restraints. QIOs have taken the lead in helping physicians' offices to adopt electronic health records systems and in putting into place care management processes that enable patients and families to manage their chronic conditions and that help to ensure continuity and reliability across time. The QIO Program supports the availability of information about the comparative performance of provider organizations through the Compare websites. The QIOs also address beneficiary complaints, with use of mediation among the parties in appropriate situations.

The QIO Program is expanding its support for person/patient-centered care through these mechanisms. Additionally, the Program continues to:

- Support development and reporting of patient-centered measures, including measures of patient experience;
- Promote public understanding of provider/local/regional performance results on quality and efficiency, and the use of this information to improve care and self-care;

- Promote public sector and market-based availability of information and tools, including Personal Health Record Systems, that patients can use in selecting providers, in making informed diagnostic and treatment decisions, and in self-care, by supporting reporting of provider performance data and information on the functionality and usability of personal health systems and tools;
- Offer assistance to providers in redesign of care processes so that they improve patient experience and better meet the needs and preferences of patients and care-givers, through development of information regarding best practices, help in implementing them, and participation of patients and families in quality improvement teams;
- Responsively address beneficiary complaints and appeals;
- Promote the expansion of the Medicare pilot project under which Medicare data will be combined with data of other insurers and Medicaid in order to provide comprehensive measures of the quality of services;
- Support improvements in the coordination and management of care across settings and transitions from one setting to another (e.g., the hospital to nursing home or home care); and
- Lead and support national and local collaborations between patient, care-giver, and consumer groups, provider groups and other federal agencies to promote person-centered healthcare.

Beneficiary Complaints

The QIO program is required by law to provide an appropriate review of all written beneficiary complaints about the quality of healthcare services they receive. The process established to provide that review was the subject of two critical reviews by the Office of the Inspector General in 1994 and 2000. As a consequence, for the QIO 7th SOW, significant changes were made to the process. The QIO contract was revised to create accountability for performance on several key metrics: timeliness of response, beneficiary satisfaction, and the initiation of quality improvement activities where appropriate to an identified quality concern. Additionally, mediation was offered to beneficiaries and providers to facilitate resolution of issues. As a result, 93% of complainants are now satisfied with the review process, and one quarter of cases with identified quality concerns result in systematic quality improvement plans implemented by providers.

Despite these gains, CMS believes that there is opportunity for substantial further improvements in the handling of beneficiary complaints, some of which can be accomplished by regulation. Most complainants want a process that helps them understand what happened, and if there is something that should not have occurred, they want to know that action has been taken to prevent future occurrences. In addition to the current beneficiary complaint work, CMS is determining how it can permit the disclosure of information from complaint review to beneficiaries and restrict redisclosure of this information and its use in liability actions.

To support needed changes in the QIO's very important complaint review activities, CMS will engage QIOs to expand outreach to beneficiaries through media, print publications, direct communications, and work with the CMS Ombudsman on developing a link on the CMS web page.

Other Case Review

The QIO program has an existing statutory requirement to review some or all of the professional services in the QIO review area. Sections 1154(a)(1) and 1869 provide for state-based physician peer review of such services. Currently, in addition to review of beneficiary complaints as required by sections 1154(a)(1) and (a)(14), the QIO program satisfies this requirement by conducting the Hospital Payment Monitoring Program (HPMP), reviewing certain referrals, and reviewing all hospital requests for higher-weighted diagnosis related group payments (HWDRG). Additionally, such requirements are met through QIO review of certain beneficiary appeals resulting from the issuance of a notice of non-coverage, and reviews of alleged dumping cases they receive from the CMS regional offices in order to assist the regional office or the Office of the Inspector General. QIOs are also currently required by statute to review requests for assistants at cataract surgery and they monitor hospital compliance with obtaining physician acknowledgements.

These reviews are important to the Medicare program and its beneficiaries, and support for them by the QIO Program is appropriate. CMS is evaluating the need for developing other mechanisms to fulfill these review obligations as efficiently and effectively as possible. Some of the changes can be accomplished by regulation.

2. Data Processing

- CMS agrees that the provision of timely and accurate data to QIOs and providers is important, and will seek to further improve the timeliness of such data.
- CMS agrees that the Program can be an important source of data for other quality improvement, public reporting, performance-based payment, and other programs and will continue to engage in policy discussions concerning the infrastructure to provide such data.
- CMS believes that changes to requirements that govern QIO sharing of data would necessitate regulatory change, and will propose such change.

Data Management

CMS is committed to promoting the dialogue that is currently occurring regarding the appropriate structure for oversight and operation of quality data reporting, the roles for the public and private sectors, and the policies and procedure that should govern these activities. Through such dialogue, the most effective role of the QIO Program in this regard can be explored. As this occurs, the Program will examine and work to improve the current performance of the data infrastructure that it operates with respect to the timeliness of data availability, the ease of data submission and validation processes for providers, and the quality of the data itself.

These quality data are available through QIOs for their work with providers on improving quality. The timeliness of data is largely constrained by lag time in its submission, but the Program will assess and seek to improve timeliness. To achieve a substantial improvement in the breadth, timeliness and cost of producing performance data, it must be produced by electronic systems at the point of care. CMS is committed to promoting the use of health information technology by providers and the specification of quality measures such that they can be reported from electronic systems, and to harmonizing such activities with the developing National Health Information Network. In the QIO 8th SOW, the Program is supporting one of the largest national efforts to provide help to physician offices in adoption of health information technology, and its use in improving care and reporting clinical quality measures. The Agency is also encouraging hospitals and other providers to adopt health information technology that will allow for reporting of clinical quality data.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) embodies policy objectives that include protecting the privacy and security of certain individually identifiable health information, while ensuring under specified conditions that patients have access to their own protected health information. The Program currently has confidentiality rules that make it difficult for the reporting infrastructure to share information with a provider that is based on the care given by another provider. CMS promulgated these rules in order to prevent disclosure of the data the QIOs obtain during the course of case review, but they preceded more recent laws and regulations that provide updated protection for health information.

3. QIO Program Management

- CMS agrees that the QIO Program should set clear goals that are consistent with Agency and national goals.
- CMS agrees that the content of QIO contracts should be developed with input from stakeholder organizations, national and local.
- CMS agrees that the QIO contract should be clearly written, issued in a timely fashion, with support infrastructure developed so that it is available at the beginning of the contract period.
- Current statute requires a three-year contracting period.
- CMS agrees that there should be greater competition for QIO contracts and greater rewards and penalties built into the contract structure.
- CMS agrees that continued efforts to improve communication with and oversight of contractors should occur and such efforts are underway.

Performance-Focused Contract Structure

The current contract structure for the QIO Program as specified in section 1153(c)(3) of the statute states that CMS must contract with state-based organizations to do the work of improving quality and efficiency of care for Medicare beneficiaries. The majority of Program resources are devoted to funding this "core" contract. For each state, under the statute there can be only one QIO contractor, which is required to do all of the work required by the contract in that state, and the core contract is required to be three years in