

# New Specs for Quality Improvement Organizations



Marc Bennett  
President & CEO  
*HealthInsight*  
March 25, 2014



# Who is HealthInsight?

*Our business is redesigning healthcare systems for the better*

- A private, non-profit, community based organization dedicated to improving health and health care, primarily serving the states of Nevada, New Mexico, and Utah.
- *HealthInsight is a recognized leader in*
  - Quality improvement;
  - Transparency and public reporting;
  - Health information technology initiatives;
  - Healthcare system redesign;
  - Payment reform efforts;
  - Human factors science research and application; and
  - Quality assurance (through Compliance Health).



# Presentation Summary

- QIO 101: QIO program background
- QIO 2.0: future direction in the QIO 11<sup>th</sup> Scope of Work
- Implications for Partnering between QIOs and other organizations



# Background on QIO Program

- Created in 1984 by Congress to replace the Medicare PSRO program
- 37 QIOs now hold contracts in 53 states and territories to provide QA and QI services worth ~\$210 million a year in the 10<sup>th</sup> SOW. Total three-year apportionment of \$1.5b
- Original focus on quality assurance and peer review has largely shifted in the past 2 decades to quality improvement and convening
- Trade Adjustment Assistance Act of 2011 congress changed QIO structure



# What Do QIOs Do Now?

Improve effectiveness, efficiency, economy, and quality for Medicare beneficiaries.

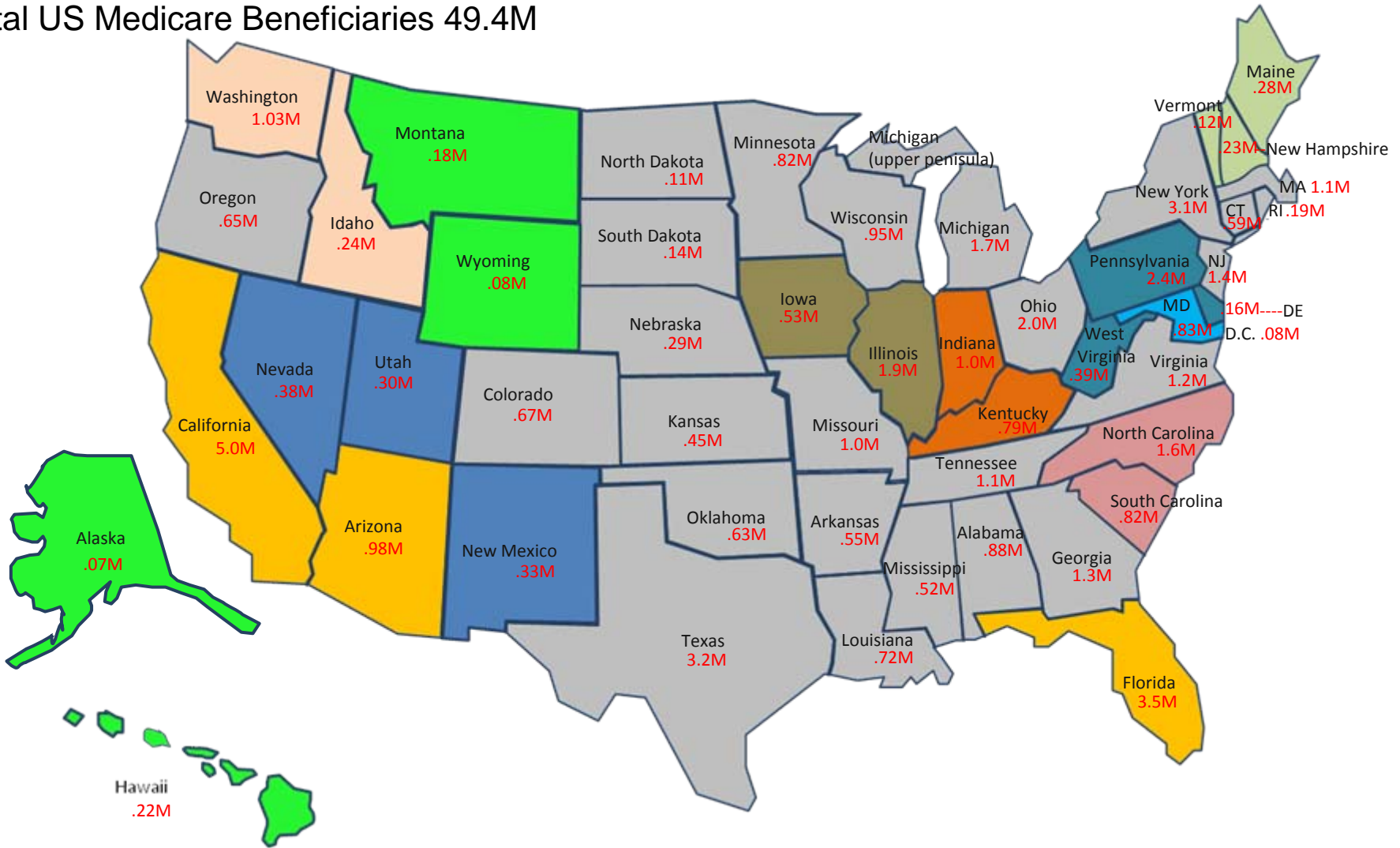
Through core functions of:

- Improving quality of care
- Protecting integrity of Trust Fund: reasonable and necessary, provide appropriate setting
- Protecting beneficiaries: beneficiary complaints; appeals; case review; violations of EMTALA



# Current QIO Infrastructure: 53 State-based Contracts with 37 Contractors

Total US Medicare Beneficiaries 49.4M



# Key Data Sources

- Trade Bill Language
- CMS RFI on possible redesign of QIO Program geographic boundaries
- CMS Proposed Rule implementing the Trade Bill provisions
- Slides from the CMS Proposal Conference Sessions on the QIO 11th Scope
- Some educated guessing



# CMS Quality Strategy





# CMS Quality Strategy

National Quality Strategy	CMS Quality Strategy
Making care safer by reducing harm caused in the delivery of care	Make care safer by reducing harm caused in the delivery of care
Ensuring that each person and family are engaged as partners in their care.	Strengthen person and family engagement as partners in their care
Promoting effective communication and coordination of care.	Promote effective communication and coordination of care
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.	Promote effective prevention and treatment of chronic disease
Working with communities to promote wide use of best practices to enable healthy living.	Work with communities to promote best practices of healthy living
Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.	Make care affordable



# CMS Quality Strategy -- Vision

The vision of the CMS Quality Strategy is to optimize health outcomes by improving clinical quality and transforming the health system.



# CMS Quality Strategy -- Mission

We, the CMS Quality components, serve CMS, HHS, state Medicaid and Children's Health Insurance Program (CHIP) agencies, and the public as a trusted partner with steadfast focus on improving outcomes, beneficiary experience of care, and population health, and reducing healthcare costs through improvement. To maintain this focus, we will:

- Lead quality measurement alignment, prioritization, and implementation and the development of new innovative measures
- Guide quality improvement across the nation and foster learning networks that generate results
- Reward value over volume of care
- Develop and implement innovative delivery system and payment models to improve care and lower costs
- Collaborate across CMS, HHS, and with external stakeholders
- Listen to the voices of beneficiaries and patients as well as those who provide healthcare
- Foster an environment that will create the capacity for providers to improve quality through use of locally generated data and local innovations in care delivery
- Be a model of effective business operations, customer support, and innovative information systems that excel in making meaningful information available
- Develop individuals, create high-functioning teams, foster pride and joy in work at all levels, continuously learn, and strive to improve



# CMS Quality Strategy -- Values

The CMS Quality Strategy aligns with the CMS Organizational Strategy's values, and we commit our work to the following:

- **Beneficiaries and Patients Come First** – We put first the best interest of the people we serve.
- **Public Service** – We take pride in our unique and privileged role in the healthcare of the nation.
- **Integrity** – We hold ourselves to the highest standards of honesty and ethical behavior.
- **Accountability** – We earn trust by being responsible for the outcomes of our actions.
- **Teamwork** – We foster unconditional teamwork and regard every employee in CMS as available and willing to help others.
- **External Collaboration** – We strive to work in full cooperation with the private sector.
- **Innovation** – We encourage finding and testing new ideas in all that CMS does.
- **Excellence** – We are committed to strengthening our organizational culture of striving for excellence in our products and services as well as in how we do business.
- **Respect** – We treat all our stakeholders and one another with the utmost respect and professionalism.



# Future Quality Improvement Organization (QIO) Program

Pre-proposal Conference, December 16, 2013

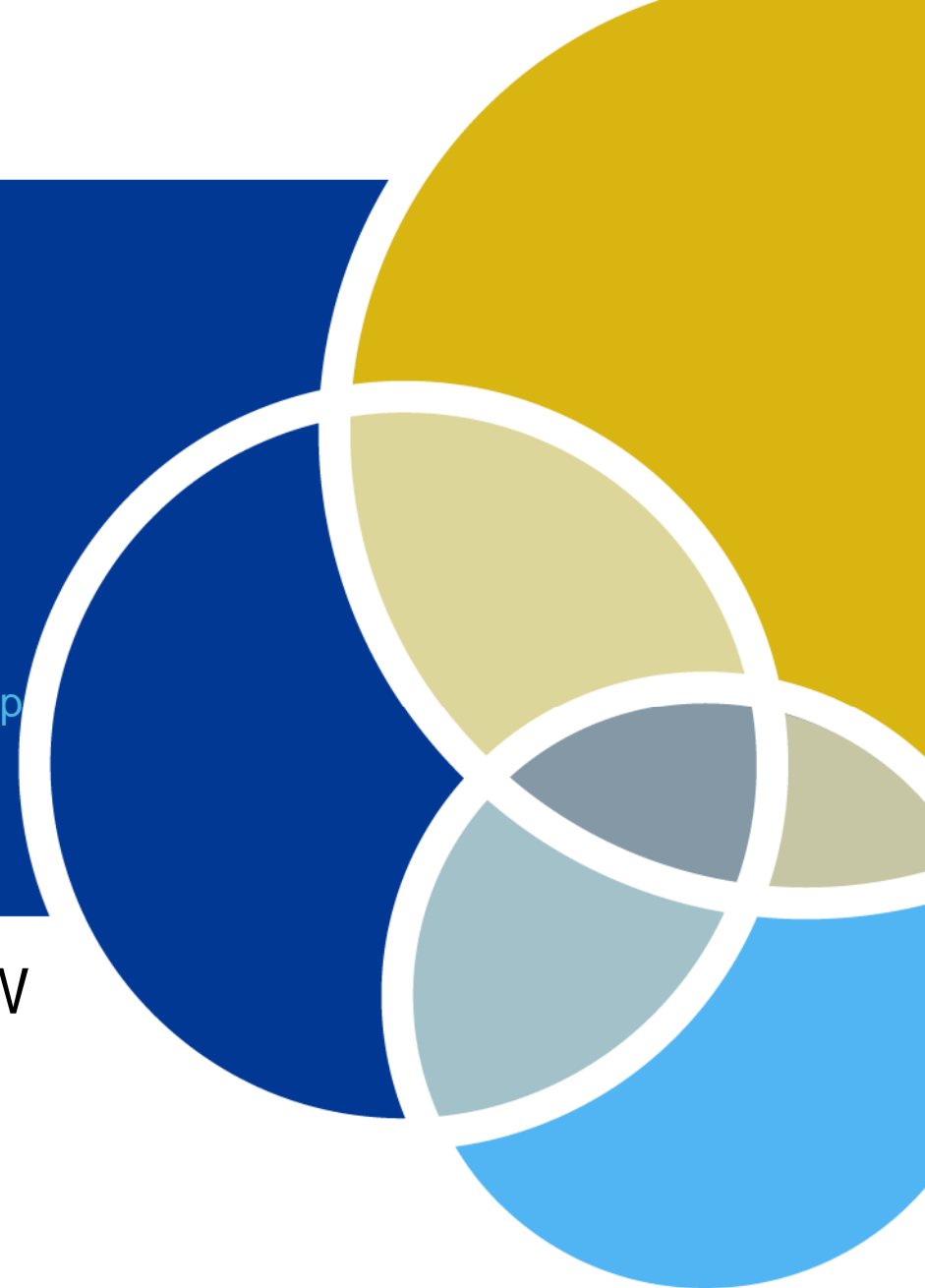
- Competitive contracts: Full & Open Competition
- Big impact to current contractors: 12-17 contracts
- A challenge to industry to implement: 3-6 States per award
- A challenge to CMS to implement: Major redesign in a few months
- 5-year contracts
- Separation of case review & quality improvement
- Unique solicitation provisions: IDIQ, multiple task awards
- Additional support contracts



# Program Overview & Vision for Our Future: Reflect, Reframe, Revise and Refocus

Jean Moody-Williams, RN | Director, Quality  
Improvement Group

Preparing for the QIO 11th SOW



# Reflect.....

## Think deeply or carefully about

- QIO program dates back to the 1970s with the creation of the Professional Standards Review Organization (PSRO) program.
- PSROs performed utilization reviews and special studies to improve the quality of care, primarily for Medicare and Medicaid.
- In 1982, as part of the Tax Equity and Fiscal Responsibility Act, Congress replaced the PSRO program with the Utilization and Quality Control PRO.

# Reflect...PROs

1. Assembled and analyzed data on services provided to Medicare beneficiaries, and
2. Intervened when services had been provided unnecessarily, inappropriately, or with inadequate quality.
3. Required to randomly sample a percentage of hospital records for case review, including:
  - inadequate discharge planning,
  - medical instability of the patient at discharge,
  - deaths,
  - nosocomial infection,
  - unscheduled return to surgery,
  - trauma suffered in the hospital, and
  - medication or treatment changes within 24 hours of discharge without adequate observation.



# Reflect....

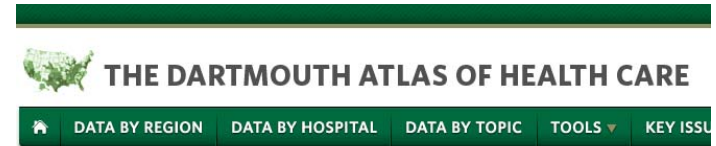
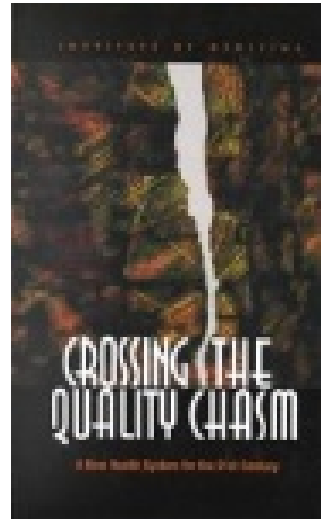
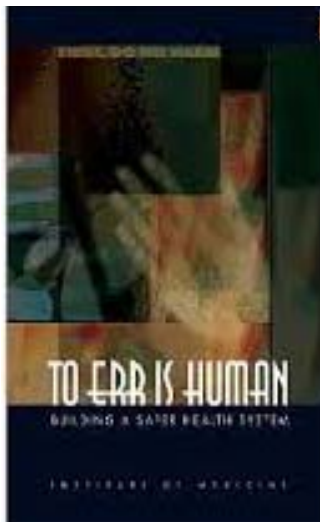
- If a hospital had too many deficiencies within sampled records, the PROs could do an intensified review (100%).
- Physicians with persistent quality problems faced harsh penalties, including payment denial and recommended exclusion from participation in the Medicare program.

# Reflect

- In 1992, role of PROs changed with implementation of Health Care Quality Improvement Initiative (HCQII).
  - HCQII shifted focus from individual case reviews to reporting patterns of care delivered to beneficiaries.
- PROs were to:
  - Examine practice patterns at the institutional, regional, and national level, rather than uncover individual physician lapses in quality for punitive purposes.
  - Evaluate quality of care using national, disease-specific guidelines, rather than local criteria.
  - Work collaboratively with hospitals as partners in the development and implementation of hospital quality improvement initiatives (instead of merely collecting data).
- Consistent with the new collaborative style and broadening scope of the PRO program, it was officially renamed the QIO Program in 2001.

# Reframe...

Frame or express a concept differently



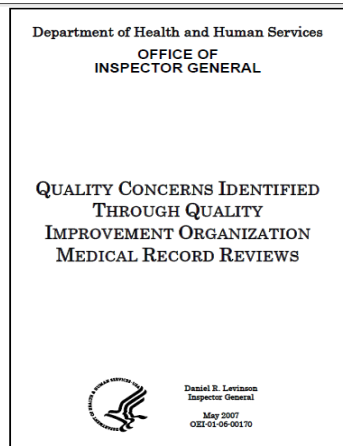
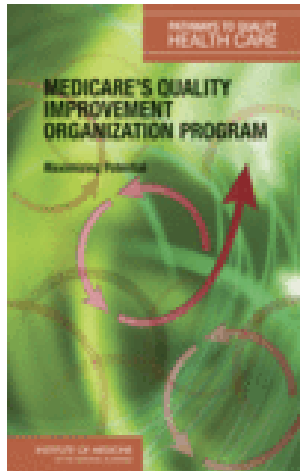
**Understanding of the Efficiency and Effectiveness of the Health Care System**

For more than 20 years, the Dartmouth Atlas Project has documented glaring variations in how medical care are distributed and used in the United States. The project uses Medicare data to provide information and about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research helped policymakers, the media, health care analysts and others improve their understanding of our health system and forms the foundation for many of the ongoing efforts to improve health and health systems in America. [LEARN MORE](#)



# Reframe...

Frame or express a concept differently



RESEARCH HIGHLIGHTS

## The First National Report Card on Quality of Health Care in America

How good is the quality of health care in America? To answer this question, Elizabeth McGlynn led a team of experts in the largest and most comprehensive examination ever conducted of health care quality in the United States. Called the Community Quality Index Study, it assessed

### Key findings:

- Overall, adults received about half of recommended care.
- Quality of care was similar in all of the metropolitan areas studied.

## Toward an Evaluation of the Quality Improvement Organization Program: Beyond the 8<sup>th</sup> Scope of Work

### Final Report

January 29, 2007

By:

Janet P. Sutton, PhD, Lauren Silver, BA, Lucia Hammer, MBA, and Alysia Infante, MPA  
NORC

Prepared for:

[Office of the Assistant Secretary for Planning and Evaluation \(ASPE\)](#)  
[U.S. Department of Health and Human Services \(HHS\)](#)

Submitted by:

NORC at the University of Chicago and Health Policy and Evaluation, Georgetown University

### For Immediate Release

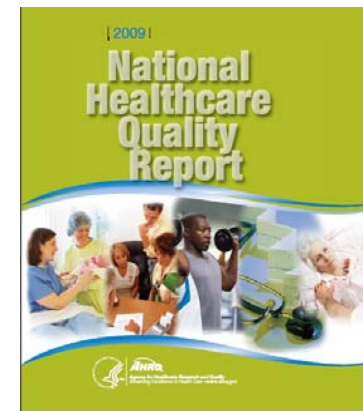
June 3, 2009

## Grassley works to improve Medicare quality with improved QIO system

WASHINGTON --- Senator Grassley is asking the Centers for Medicare and Medicaid Services (CMS) to explain how it justifies using a government auditing firm that the Government Accountability Office has found to be "non-compliant" for its audits of the Quality Improvement Program, which is responsible for improving Medicare quality.

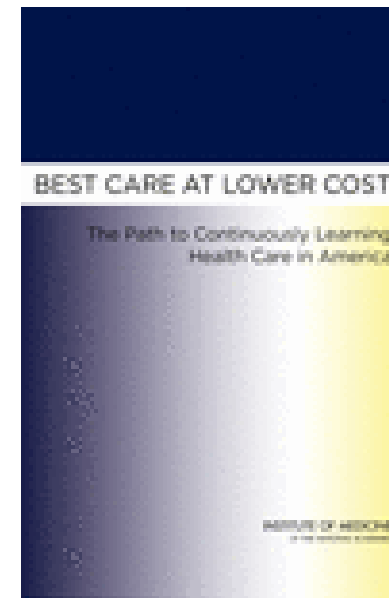
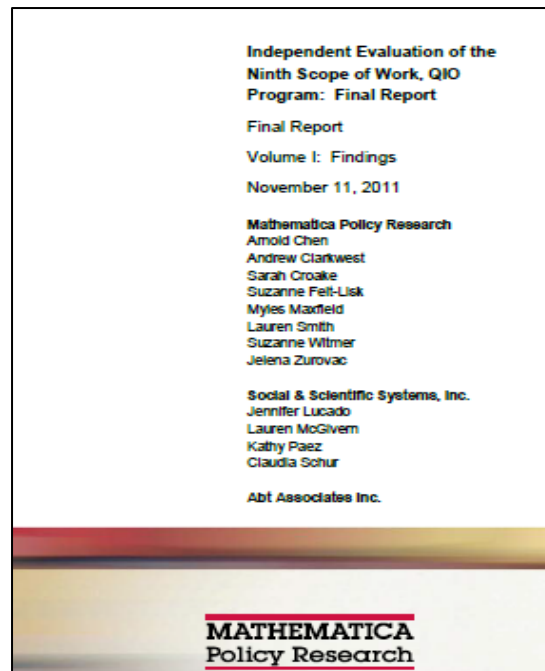
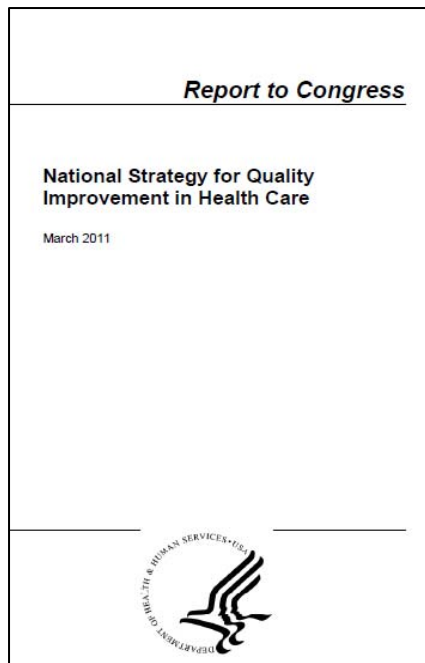
A report last summer of the Government Accountability Office (GAO), GAO-08-857, found that the contracted agency responsible for auditing the Quality Improvement Programs failed to be in compliance with acceptable government standards during its auditing of various Department of Defense contractors.

"There are documented problems with the QIO program and legislative reforms are needed to focus the program in an effective way. Until that gets done, CMS needs to do everything in its power to keep the QIO program on track," Grassley said. "The fact that CMS is relying on a substandard auditor to review the QIO program is discouraging and calls into question the agency's commitment to using the resources it has to improve Medicare quality."



# Revise.

Reconsider or alter in the light of further evidence and new developments



## TITLE II—TRADE ADJUSTMENT ASSISTANCE

SEC. 200. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the “Trade Adjustment Assistance Extension Act of 2011”.

(b) TABLE OF CONTENTS.—The table of contents for this title is as follows:

# Revise...

Reconsider or alter in the light of further evidence

## Section 261 -

Amends the SSA to:

- (1) rename a utilization and quality control peer review organization a quality improvement organization (QIO), and
- (2) revise requirements for contracts with Medicare QIOs with respect to the quality of care furnished to beneficiaries under SSA title XVIII (Medicare).
  - Requires the Secretary to establish throughout the United States local, state, regional, national, or other geographic areas with respect to QIO contracts.
  - Extends the term of QIO contracts from three years to five years.
  - Authorizes the Secretary to consider a variety of factors in selecting QIO contractors that would provide for the most efficient and effective administration, such as geographic location, size, and prior experience in health care quality improvement.

# Revise...

## Section 261 -

- Implements FAR requirements for QIOs and repeals requirement that Secretary provide a QIO with opportunity to provide performance information before terminating contract.
- Requires QIO contracting with Secretary to perform all specified activities, except:
  - to the extent otherwise negotiated with Secretary pursuant to contract, or
  - for a function Secretary determines is not appropriate for QIO to perform, such as a function that could cause a conflict of interest with another function.
- Requires QIO to perform quality improvement activities Secretary determines necessary for improving quality of care furnished Medicare beneficiaries.

# Refocus...

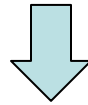
Focus attention or resources in something new or different



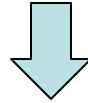


# Continued Evolution

Review for Premature Discharges (70s and 80s)



Public Reporting of Readmission Rates (90s)



Community Care Transitions (early 2000s)



Value Based Purchasing and Care Integration (early 2000s)



Population Care Management and  
Health Care Transformation

# Formula for the 11<sup>th</sup> SOW Development

Keeping the Patient at the Center + CMS and HHS Priorities + Statutory Requirements + Evidence and Input from National and Local Leaders in the Field + Experience and Data from 10<sup>th</sup> SOW and Previous Contracts = QIO 11<sup>th</sup> Statement of Work

**Example of Inputs Considered:** Secretary's Priorities (e.g. National Quality Strategy, Million Hearts, Partnership for Patients, HAI High Priority Goal)-National Action Plan to Prevent Health-care Associated Infections-National Prevention Strategy -HHS Action Plan to Reduce Racial and Ethnic Health Disparities-Federal Health IT Strategic Plan-AHRQ Comprehensive Unit Based Safety Program-HRSA Consultation in Rural Health and Adverse Drug Events-IOM Reports: Medicare QIO Program and Better Care at Lower Costs – GAO and OIG Reports –Focused Groups with Patients, Families and Providers of Care

# What Is Our End Goal....

Support a continuously evolving network of dedicated and committed experts in quality improvement, working together in partnership with multiple entities, patients and families to improve health care, support the creation of healthy people in healthy communities and lowering costs through improvement.

“To change a nation.....”

# Expansion of QIO Eligibility Requirements

- Requirements Finalized via OPPTS  
November 25, 2013; 42 CFR 475.

- QIO Area

Geographic area such as the state(s), region(s) or community(ies) in which the CMS contract directs the QIO to perform.

Must have the ability to perform QIO functions with objectivity and impartiality in a fair and neutral manner.

Not required to be physician-sponsored or physician-access organizations.



# Program Contract Structure

as of 8/1/2014

## Program Collaboration Center

*Independent Evaluation Center*

*QIN NCC*

### *Value Incentives and Quality Reporting Centers*

*O&E Hospital  
Inpatient-Psych-Cancer*

*O&E ASC and  
Outpatient*

*M&E /Analytics*

*Validation Support*

*Appeals*

**QIN - QIOs**

***QIO AREAS TBD***  
**# and distribution of  
 awards based on results of  
 full-and-open competition**

***BFCC Oversight &  
Review Center***

***BFCC NCC***

### **BFCC – QIOs**

***BFCC-QIO  
Area 1***

***BFCC-QIO  
Area 2***

***BFCC-QIO  
Area 3***

***BFCC-QIO  
Area 4***

***BFCC-QIO  
Area 5***

**BFCC** = Beneficiary and Family Centered Care  
**M&E** = Monitoring and Evaluation  
**NCC** = National Coordinating Center  
**O&E** = Outreach and Education  
**QIN** = Quality Innovation Network

# 11<sup>th</sup> Scope Apportionment

Total: \$3,995.6 M over 5 years

- Clinical Quality Improvement \$839.9 M
  - Healthy People Healthy Communities (\$159.3 M)
  - Better Healthcare: Patient-centered, Reliable, Accessible, & Safe Care (\$325.4 M)
  - Better Care at Lower Costs (\$88.8 M)
  - Technical Assistance (\$266.4 M)
- Value-based Purchasing Support Contracts and Quality Measures \$1,129.4 M
- Infrastructure, Coordinating Centers, and Special Initiatives \$562.0 M
- Beneficiary and Family-centered Care \$402.5 M
- Other Support Contracts and Staff \$1,061.8 M



# QIN-QIO Structure Overview

- **Objective:** Establish regions rather than individual states to perform SOW
- **Proposal:** Minimum three (3) states, maximum of six (6) states proposal
  - If fewer than 3 states proposed, proposal **will not** be evaluated and not considered for award.
  - States without a proposal will result in amendment of solicitation to provide an opportunity for offerors that did not submit the maximum number of proposals to include the state as part of their proposal.
- **Award:** Intent to award no fewer than three states per contract
  - CMS reserves the right to award fewer than 3 states to one contractor and reserves the right to make a single-state award.
  - Each IDIQ contract award may not cover more than 25% of Medicare Beneficiary population. Government intends to award no more than 25% of total Medicare beneficiary population to one offeror.



# QIN Task Order Framework

## QIN Essential Functions

1. Results-Oriented Quality Improvement Activities
2. Community Learning and Action Networks
3. Technical Assistance (i.e., Quality Improvement Experts)
4. Integrated Communications

A

Excellence in Operations

B

Better Health

- B1. Improving cardiac health & reducing cardiac disparities
- B2. Reducing disparities in diabetes care
- B3. Coordinating care through Immunization Information Systems
- B4. Coordinating prevention through Health Information Technology

C

Better Care

- C1. Reducing care-associated infections
- C2. Reducing care-acquired conditions
- C3. Coordinating care to reduce readmits & adverse drug events

D

Lower Costs

- D1. Quality Improvement through Physician Value Modifier
- D2. Local QIO Projects

E

Technical Assistance

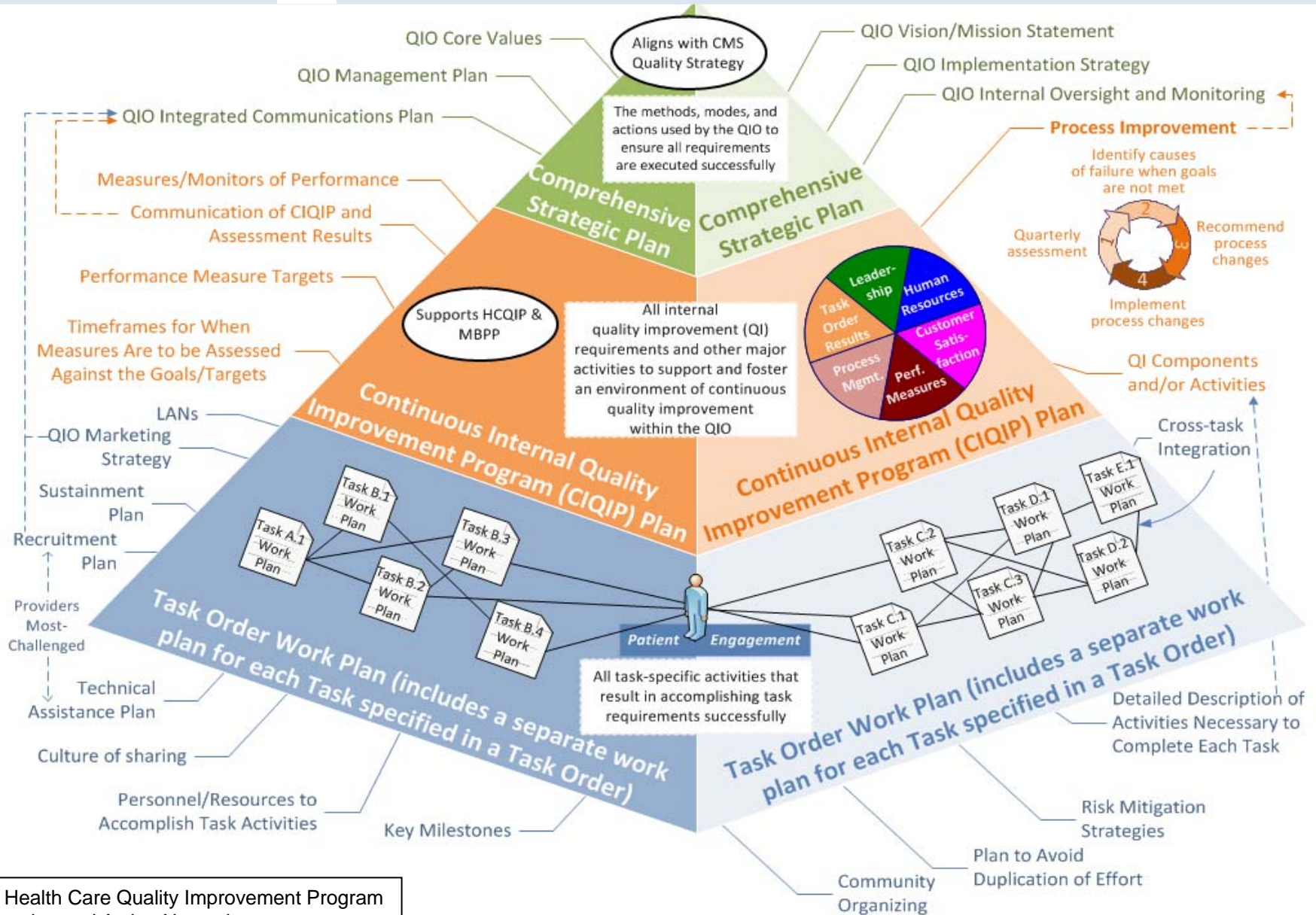
- BFCC-QIO, et al – Quality Improvement Initiatives
- Value-Based Purchasing



# Quality Innovation Network QIO Plans



Better Health, Better Care, Lower Cost



HCQIP – Health Care Quality Improvement Program  
 LAN – Learning and Action Network  
 MBPP – Medicare Beneficiary Protection Program  
 QIO – Quality Improvement Organization

This is for visualization purposes only.

CMS Pre-proposal Conference

# Requirements for QI QIOs

- Capabilities to perform QI initiatives at the community and state levels
- Access to expertise in areas of health care related to QI initiatives
- Staff with knowledge of QI methodologies and information technology
- May consider prior experience



<b>NQS Six Priorities</b>	<b>Measures Focus Specifically On:</b>
<b>Making Care Safer</b>	Hospital-Acquired Conditions Hospital Readmissions
<b>Person- and Family-Centered Care</b>	Timely Care Decisionmaking
<b>Effective Communication and Care Coordination</b>	Patient-Centered Medical Home 3-item Care Transition Measure
<b>Prevention and Treatment of Leading Causes of Mortality</b>	Aspirin Use Blood Pressure Control Cholesterol Management Smoking Cessation
<b>Health and Well-Being of Communities</b>	Depression Obesity
<b>Making Quality Care More Affordable</b>	Out-of-Pocket Expenses Health Spending per Capita

# CMS Quality Strategy: Potential Focus Areas

- Three key strategic opportunities:
  - strategy for data collection, measurement, and reporting
  - infrastructure at community level for improvement efforts, and resources to identify, share, and evaluate progress
  - payment and delivery system reforms



# What does it take to be a QIN-QIO?

Skills in:

- Quality Improvement
- Process Redesign
- Lean and other improvement science
- Collaboration
- 1-on-1 and Group Learning
- Change Management



# What does it take to be a QIO?

- Connections:
  - Connection to providers of health care
    - All settings plus emerging ones (care managers, hospice)
    - Know how to help them change in a way that sticks
  - Connections to communities
    - Know how to help us collectively engage in change
  - Connections to other initiatives
    - Know how to link for synergy and to reduce provider burden across multiple initiatives



# QIO as Local Nexus

- We **connect people** together in the community
- We **build will** for change in our community
- We **bring programs together** to minimize confusion, accelerate pace, and maximize impact
- We **identify gaps**, and design strategies to fill those gaps



*'Networks offer many benefits for tackling wicked problems, in contrast to traditional hierarchal organizational approaches. Perhaps foremost, they can be formed as a "co-owned" space by stakeholders in the system... By being "co-owned," there is an important shift in power relationships and mutual accountability that creates an innovative environment. This environment can act as a "skunk works," in change agent parlance: a space where the normal rules that support and limit action can be suspended and new ones developed, based on the specific needs of addressing the wicked problem. After all, wicked problems are often the result of entanglements of structures, rules, and power relationships. Rather than participants simply being accountable to their organizations, these networks create a space for making the organizations accountable for the system's health—and that involves addressing wicked problems.'*

-Learning and Transformative Networks to Address Wicked Problems: A Golden Invitation, NonProfit Quarterly, December 2013



# What does it take to be a QIO?

- Experience with government contracting:
  - Able to deal with all the government financial, accounting, HR, security..... requirements
  - Scale to afford above and keep indirect rate reasonable
    - Many more funders setting caps lower than QIOs traditional rates

Do not underestimate the effort this takes

- Multiply your assumptions by 5x or 10x



# Estimated Time Line

- Final rule November 2013
- RFP for 11<sup>th</sup> SOW Released December 2013
- Responses for BFCC due January 2014
- Responses due February 2014 for QIN-QIO
- Negotiations in April, May, June, July
- BFCC Awarded by May 2014
- QIN Awarded by July 31, 2014



# What Do We Think We Know?

- CMS still values local presence for QI work, at least in some format
- Deep engagement and trust at the community level is critical to drive sustained and meaningful system redesign
- The new goals are exponentially harder than the last ones; we'll need all the help we can get
- The QIO program is a stable, growing source of ongoing support for improvement



# Implications for Payment Reform

- QIO Program aims will increasingly align with payment reform, public reporting, and clinical care redesign efforts within CMS and within the Department
- The QIO Program will increasingly align (and/or compete) with the work of RECs, HENs, Regional Collaboratives, Business Coalitions, SIM Plans, etc. in content and aim at least
- Most of these state and locally driven initiatives are not well-suited to work in a multi-state region; but CMS has created space at the table for through subcontracting
- CVEs have something to offer to the QIO program
- Partnership with a QIO bidder, formally or informally, may be attractive to accelerate progress

