U.S. SENATE COMMITTEE ON

Finance

SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN

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For Immediate Release
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Grassley Expresses Renewed Concern Over Medicare Quality Improvement Organizations

WASHINGTON – Sen. Chuck Grassley, chairman of the Senate Committee on Finance, is expressing renewed concern regarding the seeming lack of effectiveness and accountability by Medicare contractors known as Quality Improvement Organizations (QIOs). QIOs have a major responsibility to investigate individual Medicare beneficiary complaints and appeals about the quality of doctor and hospital care.

Grassley initiated his inquiry into the activities and operations of QIOs last summer. The preliminary findings of his inquiry indicate problems related to expenditures, board member and executive staff conflicts of interest, the beneficiary complaint process, and the effectiveness of QIO activities in improving the quality of health care. To ensure accountability, Grassley is asking CMS to consider changing the basis for funding QIOs to focus on results relative to improved quality of care and instituting competition in the QIO contracting process. Grassley further emphasizes the need for transparency in the Medicare beneficiary complaint process, a major function of the QIOs.

"Beneficiaries should never be left in the dark about the kind of care they or their loved ones receive," Grassley said. "The services of QIOs are intended for the protection of Medicare beneficiaries and the improvement of the quality of care. Unfortunately, there is a lack of information on the value of these services and whether or not QIOs are in fact meeting their mission. We need greater accountability and rigorous oversight of the QIOs and an evaluation of their effectiveness. Taxpayers and Medicare beneficiaries need to have faith that the dollars spent on their behalf by the QIOs aren't wasted and that they are deriving value from these expenditures."

The text of Grassley's March 3 letter to CMS Administrator Mark McClellan follows.

March 3, 2006

Via electronic transmission
The Honorable Mark McClellan
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator McClellan:

As Chairman of the Committee on Finance (Committee), I initiated a review of the Medicare Quality Improvement Organization (QIO) program in August 2005. Specifically, I asked my Committee staff to examine, among other things, the effectiveness of the program in improving quality of care, as well as to assure that taxpayer dollars are being spent appropriately. As we know, taxpayer funds make up more than 80 percent of the monies provided to the QIO community. Also, I want to take this opportunity to thank you for providing the Committee with the information I requested through correspondence dated August 11, 2005, and January 4, 2006.

My Committee staff have reviewed the documents provided by the Centers for Medicare and Medicaid Services (CMS) and interviewed some of your staff as well as a number of physicians and nurses and one hospital chief executive officer (CEO) with experience working with QIOs. This preliminary review raises a number of concerns regarding questionable expenditures, board member and executive staff conflicts of interest, and the quality and effectiveness of QIO services. I am writing today to provide you with some of my concerns regarding the initial findings of that review.

I. QUESTIONABLE EXPENDITURES

According to the documents provided to the Committee, it appears that most, if not all, of the QIOs provided some level of compensation to its board members. The total amount ranged from several thousand to several hundred thousand dollars, some portion of which comes from Medicare funds. For example, in FY 2003, one QIO compensated its board of directors a total of $526,976, averaging about $25,000 per board member. According to acquisition and grants management staff at CMS, most QIOs are 501(c)(3) not-for-profit organizations. The amounts paid to some of the board members seem exorbitant considering the majority of national not-for-profit corporations do not compensate their respective board members. (1)

The appropriateness of some travel expenses incurred by some of these non-profit QIOs is also questionable. Documents from a QIO show that board members traveled to Colorado Springs, CO, in FY 2005 for a leadership retreat, and to Brewster, MA, on Cape Cod in FY 2004 and Stowe, VT, in FY 2003 for CEO retreats.

In addition to questionable travel expenses, the Defense Contract Audit Agency's (DCAA) audits of the QIOs reveal that some QIOs incurred questionable or unallowable costs that DCAA concluded should not have been funded with taxpayer dollars. For example, one QIO spent $9,831 on unallowable entertainment costs in FY 2003 to finance parties held at its offices and $5,202 in FY 2002 for a summer Hawaiian party and an employee retirement luncheon. Another DCAA QIO audit reveals that a QIO incurred $33,292 in questionable and unallowable costs, such as $16,971 for promotional items and exhibit booths, $3,311 for a welcome reception, and $500 for a social membership to an airline club. It also appears a QIO paid $13,083 for promotional items to distribute at various meetings, all of which are unallowable advertising and public relations costs.

II. POTENTIAL CONFLICTS OF INTEREST

There is also concern as to whether or not QIOs have the necessary controls in place to prevent inappropriate business relationships. It is disconcerting that QIO board members may be overseeing contracts, reviewing beneficiary satisfaction surveys, and assessing physician performance for the

same organizations where their profits will rise or fall based upon the boards' decision. QIO boards should be diverse and transparent, allowing all members to make clear decisions unhampered by apparent or perceived conflicts of interest.

Based on my Committee staff's review of documents, it appears that some QIOs have financial arrangements or relationships that appear to pose conflicts of interest. For example, DCAA QIO audits in FY 2002 and 2003 show that one QIO compensated its board chair $3,100 monthly ($37,200 annually) as a "consultant." The DCAA concluded that this "compensation" arrangement could "cause a loss of objectivity or impartiality or otherwise interfere with free exercise of his or her judgment." A review of the FY 2004 IRS Form 990 reveals that this same QIO made a $160,000 loan to a for-profit corporation of which the QIO's CEO was also a board member.

III. QIO EFFECTIVENESS

There is sparse evidence to suggest that QIOs are effective. A recent *Journal of the American Medical Association* article, "Do Quality Improvement Organizations Improve Quality of Hospital Care for Medicare Beneficiary?" concluded that hospitals that participate with the QIO program are not more likely to demonstrate improvements in quality than hospitals that don't participate. [2] CMS and others have raised methodological concerns about this particular study; however, even a research study published two years prior did not find conclusive evidence about the degree to which improvements in quality can be attributed to QIO efforts.[3] These research findings raise questions about the effectiveness of QIOs.

The difficulty in isolating the effectiveness of the QIOs is not surprising given the number of public and private entities, in addition to the QIOs, who share the same mission and similar activities to improve the quality of health care. For example, the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Agency for Healthcare Research and Quality (AHRQ), and state survey agencies all participate in similar activities.

Interviews with a number of physicians and nurses and a hospital CEO indicate a lack of measurable objectives to determine the outcomes of QIO and provider efforts. This leads to lack of accountability by the QIOs for the quality of the services they provide to, among others, hospitals and nursing homes. This also makes it difficult to measure the success of the QIO program overall. Some individuals interviewed by my Committee staff also complained that the data analyses the QIOs conduct for the hospitals are of little value to them.

Discussions with the acquisition and grants management staff at CMS indicate that the contracting process does not reward QIOs for performance. In the last contracting cycle, only 6 of the 53 QIO contracts were subjected to a competitive bid process. Of these 6, only 1 QIO contract was not renewed. While continuity arguably has the benefit of helping to establish long-term working relationships, "presumptive renewal" of contracts also has disadvantages. One disadvantage is the potential for "cozy" relationships leading to lax accountability. One physician interviewed by my staff used that very word to describe the relationship that developed between QIOs and state hospital associations, or with particular hospitals or providers. A hospital CEO said that the relationship between the QIOs and the state medical association is a "good ol' boys network." He went on to say that the QIO was a "pawn" of the hospital association. Others interviewed felt pressured to "play" along with the QIOs or risk retaliation from the hospital association. To avoid these seemingly cozy relationships and to ensure a culture of accountability, perhaps CMS should consider subjecting all

QIO contract renewals to competition in the future.

CMS's payment/reimbursement system for QIOs is based primarily on QIO costs and deliverables, not on outcomes relative to quality improvement. QIOs simply submit vouchers to CMS on a monthly basis and CMS, by statute, is required to make payment within 15 days. Only 4 percent of CMS payments to QIOs are based on individual QIO or overall QIO performance. Even these payments are based on performance for meeting the contract terms, not necessarily for meeting benchmarks of quality.

The effectiveness of QIOs in one major area of responsibility, beneficiary complaints, is also questionable. The Committee's preliminary conclusions, based on information from a number of sources, including CMS, the Office of Inspector General, Department of Health and Human Services (OIG), several physicians and nurses, and a hospital executive, indicate that the QIO beneficiary complaint process is broken. One nurse interviewed by my Committee staff believes the complaint review process is simply a "bureaucratic exercise" ending with an unsatisfactory resolution for the patient/beneficiary and is of no benefit to improving the overall quality of healthcare. By law, QIOs are prohibited from disclosing the information used as the basis for their determinations. Additionally, this information, under most circumstances, is not subject to discovery in a criminal, civil, or administrative proceeding. A review of the complaint case statistics CMS provided to the Committee seems to indicate a small number of cases relative to the number of Medicare beneficiaries overall. From August 1, 2004 to August 30, 2005, the 53 QIOs reviewed 2,891 beneficiary complaint cases. When you consider that there are over 43 million Medicare beneficiaries, the number of complaint cases appears disproportionately low. Finally, a report issued by the OIG in August of 2001, concluded that accessibility to the QIO complaint process is questionable, it rarely triggers any intervention beyond a letter for substantiated complaints, and it fails to provide a meaningful response to complainants.[4] Given these findings, CMS should consider changes that would ensure greater transparency and increased responsiveness to beneficiaries in the complaint process.

In closing, I recognize that there is potential value in the existing QIO infrastructure that has been built over the last 20 years. Some critics of the QIOs who were interviewed by my Committee staff support the concept of the QIO program as well. However, they also believe that resolving the issues raised in this letter, among others, is necessary to increase the effectiveness of the QIOs and improve the quality of health care. In light of the aforementioned problems and concerns, perhaps it is time for CMS to consider redesigning the QIO program to maximize QIO effectiveness. Has CMS determined or identified problems similar to the ones outlined in this letter? If so, please describe in detail the extent of these problems and the actions that CMS has taken or plans to take to address them. Has CMS considered re-competing all QIO contracts in the future or providing funding based on outcomes?

As you are aware, I asked the OIG and the Government Accountability Office to evaluate the fiscal integrity, beneficiary complaint process, and the effectiveness of the services provided to the nursing home community by the QIOs. Next week, the Institute of Medicine is expected to release a report on its study of the QIO program as mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. My Committee staff will continue their review and be in contact with your office as additional questions and concerns arise.

Thank you for your attention to this important matter. I look forward to hearing from you regarding the issues, concerns, and questions raised in this letter by March 24, 2006.

Sincerely,

Charles E. Grassley
Chairman

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[1] See BoardSource web site at http://www.boardsource.org/QnA.asp?Category=21 (accessed March 2, 2006).
[2]Clare Snyder, G Anderson (2005). Do quality improvement organizations improve the quality of hospital care for Medicare beneficiaries? *Journal of the American Medical Association*, June 15, 2005, Vol. 293, No. 23.
[3]Stephen F. Jencks, E. D. Huff, T. Cuerdon (2003). Change in the quality of care delivered to Medicare beneficiaries, 1998-1999 to 2000-2001. *Journal of the American Medical Association*, January 15, 2003, Vol. 289, No. 3.
[4]Department of Health and Human Services, Office of Inspector General (August 2001). The Medicare Beneficiary Complaint Process: A Rusty Safety Valve. Washington, D.C.