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United States Government Accountability Office
Washington, DC 20548

December 6, 2010

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

Subject: *Medicare: CMS Needs to Collect Consistent Information from Quality Improvement Organizations to Strengthen Its Establishment of Budgets for Quality of Care Reviews*

Medicare funds health care services for more than 46 million beneficiaries.¹ The Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—contracts with private organizations known as Quality Improvement Organizations (QIO) to, among other core functions, improve the quality of care for Medicare beneficiaries. CMS contracts with one QIO for each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. One of the QIOs' many responsibilities is to review quality of care concerns, raised by Medicare beneficiaries or others, to determine whether Medicare-financed medical services meet professionally recognized standards of health care.² Quality of care reviews may address a range of issues, such as inappropriate treatment or hospital staff not administering medications on time; may involve a variety of health care services and settings; and may include a range of Medicare providers or practitioners.³

¹Medicare is the federal health insurance program for people over age 65, individuals under age 65 with certain disabilities, and individuals diagnosed with end-stage renal disease.

²QIOs are required to conduct an appropriate review of all written quality of care concerns from Medicare beneficiaries, or their representatives, alleging that the quality of services they received did not meet professionally recognized standards of health care. 42 U.S.C. § 1320c-3(a)(14); see also 42 C.F.R. § 476.71(a)(2) (2009). QIOs are also required by their contracts to review such concerns from CMS or CMS-designated entities, such as Medicare Administrative Contractors, the CMS contractors whose responsibilities include processing and paying Medicare claims. Professionally recognized standards of health care are defined as statewide or national standards of care, whether in writing or not, that professional peers, such as physicians, recognize as applying to their fellow peers practicing or providing care within a state. See 42 C.F.R. § 1001.2 (2009).

³For the purposes of quality of care reviews, a “provider” is defined as a hospital or other health care facility, agency, or organization and a “practitioner” is defined as a physician or other health care professional licensed under state law to practice his or her profession. See 42 C.F.R. § 1004.1 (2009).

CMS enters into 3-year contracts with QIOs for a range of activities and reviews, including quality of care reviews.⁴ For each QIO contract, CMS establishes a budget reflecting the estimated costs of these activities and reviews.⁵ For the most recent contracts, which cover August 1, 2008, through July 31, 2011, CMS's budgets for the QIOs totaled about \$1.1 billion, with approximately \$208 million for all types of reviews, including QIOs' quality of care reviews, as well as some other activities. Questions have been raised about CMS's ability to set budgets appropriately for QIOs' quality of care reviews. A 2006 report by the Institute of Medicine (IOM)⁶ and a 2008 internal report commissioned by CMS identified weaknesses in CMS's ability to accurately compare costs across QIOs. Based on reports of wide variation in the costs that QIOs report for conducting these reviews, you raised questions about how CMS establishes QIOs' budgets.

Ensuring that QIOs' budgets are based on accurate information is particularly important because CMS's contracts with the QIOs are funded from the Medicare Trust Funds, which are primarily used to support inpatient and outpatient health care services for Medicare beneficiaries.⁷ QIO contracts are funded from the Medicare Trust Funds in proportions from each that CMS determines to be fair and equitable,⁸ and the QIO program is not subject to the same kind of congressional oversight as other CMS programs, which are funded through the annual appropriations process. Policymakers are concerned about the long-term solvency of these Trust Funds and thus their ability to fund health care services for Medicare beneficiaries in the future.

You raised questions about the information QIOs report to CMS for budgeting purposes and how CMS uses this information. To assist congressional consideration of this matter, this report describes and assesses the information CMS uses to establish the portion of QIOs' budgets for quality of care reviews.

To conduct this work, we reviewed CMS's current 3-year contract with QIOs, and CMS policies, such as CMS's QIO policy manual⁹ and relevant CMS policy memos. We reviewed these materials and interviewed agency officials in order to identify the information that CMS used, including information obtained from the QIOs, to establish the QIOs' budgets for their quality of care reviews for the 9th Statement of Work. We also reviewed these materials, as well as relevant statutes and regulations, and interviewed agency officials in order to

⁴CMS's current contract, the 9th Statement of Work, began on August 1, 2008, and will end on July 31, 2011. QIOs are responsible for performing many other activities and reviews in addition to quality of care reviews. For example, under their current contracts, QIOs are also responsible for collecting and analyzing data about the rates of health care associated infections in health care facilities and reviewing beneficiary appeals of denial of Medicare coverage for certain services.

⁵The budgets are not maximum amounts that QIOs can receive from CMS. The amounts QIOs receive may be higher or lower than the budgeted amounts. Amounts for which QIOs are reimbursed are determined by a monthly review by CMS of vouchers of costs incurred by each QIO. CMS officials reported that if a QIO thinks it will overspend its budgeted amount, the QIO notifies CMS in writing to explain why it expects that its costs will exceed budgeted amounts in order for CMS to determine if it will provide the QIO additional funds.

⁶Institute of Medicine, *Medicare's Quality Improvement Organization Program: Maximizing Potential*, (Washington, D.C.: 2006).

⁷The Hospital Insurance Trust Fund primarily finances hospital, home health, skilled nursing facility, and hospice care for Medicare beneficiaries, while the Supplementary Medical Insurance Trust Fund primarily helps finance physician, outpatient hospital, home health, and other services for Medicare beneficiaries.

⁸See 42 U.S.C. § 1320c-8.

⁹CMS Publication #100-10, *Quality Improvement Organization Manual* (revised 2003, 2006).

understand the quality of care review process. We then administered a Web-based pre-interview questionnaire and conducted structured interviews with officials from a judgmental sample of seven QIOs, in order to obtain information about how the QIOs conduct their quality of care reviews, the variation in their implementation of these reviews, and the information they regularly report to CMS about these reviews. We selected these seven QIOs based on the number of individuals eligible for Medicare residing in each of the 48 contiguous states and the District of Columbia using CMS's 2009 Medicare enrollment data and taking into account QIO corporate affiliations and geographic distribution (see encl. I for more information about our scope and methodology). The information we obtained from our selected QIOs cannot be generalized to all QIOs.

To assess the reliability of QIOs' responses to our Web-based pre-interview questionnaire, we manually checked the responses to identify illogical or inconsistent responses and other indications of possible errors. We also conducted follow-up interviews with the officials we interviewed from the selected QIOs in order to clarify their answers and to gain a contextual understanding of their responses to certain questions on our pre-interview questionnaire and to our interview questions. To assess the reliability of CMS's 2009 Medicare enrollment data, which we used to select the seven QIOs, we reviewed relevant documentation about the data. We determined that the enrollment data we used for our report were sufficiently reliable for our purposes.

We conducted this performance audit from October 2009 through December 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

To help establish QIOs' budgets for quality of care reviews for the current contract, the 9th Statement of Work, CMS used information that QIOs are required to provide to the agency about the volume of QIOs' quality of care reviews and the costs associated with conducting these reviews. CMS requires the QIOs to record information about the volume of their quality of care reviews in CMS's Case Review Information System (CRIS) and to record information about their labor costs in CMS's Financial Information and Vouchering System (FIVS). However, CMS has not established clear instructions for how QIOs should record volume and cost information in these systems. We found inconsistencies among some QIOs in the ways they record certain volume and cost information in CRIS and FIVS. As a result, the historical quality of care review volume and cost information CMS obtains is inconsistent across QIOs and CMS cannot be assured that the budgets it establishes for QIOs' quality of care reviews are appropriate.

We obtained written comments on a draft of this report from the Department of Health and Human Services (HHS). HHS agreed with our recommendation that the Administrator of CMS develop clear instructions for how QIOs are to record volume and cost information in CRIS and FIVS. We incorporated HHS's technical comments as appropriate.

Background

QIOs conduct quality of care reviews to determine if Medicare-financed health services meet professionally recognized standards of health care. Quality of care reviews are just one type of review QIOs are required to conduct. QIOs also conduct what are known as utilization reviews to determine whether Medicare services provided are medically necessary, reviews of beneficiary appeals for denials of Medicare coverage for certain health care services, and reviews of possible violations of the Emergency Medical Treatment and Active Labor Act.¹⁰ From August 1, 2008, through July 31, 2009—the first year of the current QIO contract—CMS’s data show that the QIOs completed about 2,800 quality of care reviews initiated by beneficiaries. The QIOs also completed about 16,000 quality of care reviews initiated by non-beneficiary sources.¹¹

QIOs are required to conduct quality of care reviews for concerns raised by Medicare beneficiaries.¹² Beneficiaries may raise their quality of care concerns¹³ by mailing a letter to a QIO or by calling a QIO’s helpline¹⁴ to register their concerns orally,¹⁵ but QIOs can proceed with further steps of the quality of care review only after beneficiaries submit written descriptions of their concerns. Therefore, QIOs may proceed with reviews for oral beneficiary concerns only if they obtain a written concern from the beneficiary.^{16,17} QIOs are

¹⁰The Emergency Medical Treatment and Active Labor Act requires Medicare participating hospitals with emergency departments to provide emergency screening examinations and stabilization treatments to individuals, including women in labor, regardless of individuals’ ability to pay for the services. 42 U.S.C. § 1395dd.

¹¹These sources can include CMS or CMS-designated entities, such as Medicare Administrative Contractors—CMS contractors whose responsibilities include processing and paying claims—or the QIOs themselves when they identify quality of care concerns during the course of other types of reviews.

¹²A beneficiary’s designated representative may also submit a concern on his or her behalf. In this report, we use the term “beneficiary” to refer to both beneficiaries and their representatives.

¹³If QIOs determine beneficiaries’ concerns are unrelated to the quality of Medicare services or other QIO responsibilities or activities, they may refer beneficiaries’ concerns to another entity for resolution. For example, QIOs may refer beneficiaries’ questions about billing to the appropriate CMS contractor for resolution.

¹⁴A beneficiary helpline is a QIO-staffed, toll-free telephone number that beneficiaries may call to voice quality of care concerns or to request other Medicare-related information or assistance from the QIO.

¹⁵Beneficiaries also may call 1-800-MEDICARE, a nationwide, toll-free number that is operated by a CMS contractor. Beneficiaries can call this number to inquire about any Medicare services or benefits. If a 1-800-MEDICARE representative determines that a beneficiary’s call is related to the quality of Medicare services, he or she will refer the beneficiary to the QIO in the beneficiary’s state.

¹⁶Section 1154(a)(14) of the Social Security Act requires that QIOs conduct an appropriate review of all written quality of care concerns from Medicare beneficiaries alleging that the quality of services they received did not meet professionally recognized standards of health care. See 42 U.S.C. § 1320c-3(a)(14). Based on this requirement, CMS does not permit QIOs to proceed with further steps of a quality of care review unless beneficiaries submit a written description of their concerns or if QIOs determine that the received oral concerns are of a serious or urgent nature. See CMS Publication #100-10, *Quality Improvement Organization Manual*, Chapter 5: Quality of Care Review, § 5010A (Baltimore, Md: revised Aug. 29, 2003). CMS instructs QIOs to assist beneficiaries who voice their concerns orally in preparing written descriptions of their quality of care concerns, in order to proceed with quality of care reviews.

¹⁷As of December 3, 2010, CMS did not permit QIOs to initiate quality of care reviews for concerns from beneficiaries transmitted by e-mail or facsimile. CMS officials told us that the agency plans to allow QIOs to accept quality of care concerns submitted by beneficiaries via e-mail and facsimile, although as of December 3, 2010, CMS had not established a date for when it would begin accepting these kinds of submissions.

also required by their contracts to conduct quality of care reviews for quality of care concerns identified through non-beneficiary sources. After receiving a written quality of care concern, QIOs review the beneficiary's medical records. Specifically, CMS requires QIOs to review the beneficiary's medical records held by the providers or practitioners that delivered the Medicare services about which there is a concern, in order to determine whether or not the Medicare services delivered to the beneficiary met professionally recognized standards of health care. QIOs are required to notify beneficiaries of the QIOs' final determinations at the conclusion of a quality of care review.¹⁸ (See encl. II for additional information about QIOs' processes for conducting quality of care reviews.)

CMS Uses Volume and Cost Information Provided by QIOs to Establish Quality of Care Review Budgets, but CMS Has Not Provided Clear Instructions for Recording This Information

In order to help establish QIOs' budgets for quality of care reviews for the current contract, the 9th Statement of Work, CMS used information that QIOs are required to provide the agency about the volume of QIOs' quality of care reviews and the costs associated with conducting these reviews.¹⁹ However, CMS has not established clear instructions for how QIOs should record volume and cost information in the electronic systems used to provide CMS with this information. We found inconsistencies among some QIOs in the ways they record certain volume and cost information in these systems.

CMS Uses Information QIOs Provide about the Volume and Cost of Their Quality of Care Reviews to Help Establish Budgets for These Reviews

For every 3-year contract, CMS establishes a budget for each QIO reflecting the estimated costs of the activities and reviews the QIO is responsible for performing, including quality of care reviews. CMS officials told us that, in order to establish the portion of a QIO's budget for quality of care reviews for the current contract, the 9th Statement of Work, the agency used information about the volume and cost of these reviews the QIO performed under the previous 3-year contract. Specifically, CMS used this historical information to estimate each QIO's budgetary needs for performing quality of care reviews from August 1, 2008, through July 31, 2011. CMS then added these quality of care review estimates to estimates for performing other contracted activities, in order to establish the current 3-year budget for each QIO.

CMS obtained information about the volume of QIOs' quality of care reviews from the Case Review Information System (CRIS), a CMS electronic information system used to record information about QIO activities and reviews, including quality of care reviews. CMS requires QIOs to use CRIS to record information about quality of care reviews and other types of reviews, such as utilization reviews, within 3 days of performing a task, such as responding to a beneficiary's oral concern. This information may include summaries of oral and written beneficiary concerns received, notes about the progress of medical record reviews, and information indicating whether the QIO determined that Medicare services met professionally recognized standards of health care. QIOs use two main categories—the beneficiary complaint and case review categories—to record information about their quality of care reviews in CRIS.

¹⁸See 42 U.S.C. § 1320c-3(a)(14).

¹⁹The volume of QIOs' quality of care reviews refers to the number of these reviews conducted by QIOs.

- **Beneficiary Complaint Category.** This category is used to record information about written quality of care concerns QIOs receive from beneficiaries. QIOs use this category to record information, such as the date on which the QIO received the written beneficiary concern and the date on which the QIO completed the medical record review. QIOs also use this category to record information about their final determinations about whether the Medicare services beneficiaries received met professionally recognized standards of health care.
- **Case Review Category.** This category is used to document the type of review the QIO is conducting—that is, whether the QIO is conducting a quality of care review or another type of review, such as a utilization review.

To calculate the volume of quality of care reviews that QIOs conducted under the previous contract, CMS used the number of records that QIOs created in the CRIS beneficiary complaint category and the number of records marked as quality of care reviews in the CRIS case review category.²⁰

To obtain information about the cost of QIOs' quality of care reviews, CMS officials used information from another CMS electronic information system, the Financial Information and Vouchering System (FIVS), which is used to record information about the labor costs associated with QIOs' various activities and reviews, including quality of care reviews. QIOs are required, on a monthly basis, to record cost information into FIVS, such as the number of hours QIO employees spend conducting reviews and QIO employees' hourly rates of pay. CMS established 18 cost codes for QIOs to use for recording their labor costs related to conducting reviews, including quality of care reviews, under the current contract.²¹ One of these codes—the quality of care review cost code—is the primary code used to record labor costs associated with quality of care reviews, such as costs associated with conducting medical record reviews or communicating with beneficiaries, providers, and practitioners about the quality of care review process.

To establish the portion of QIOs' budgets for quality of care reviews, CMS officials told us they use the volume and cost information QIOs are required to record in CRIS and FIVS. Specifically, to establish budgets for QIOs' quality of care reviews for the current 3-year contract, the 9th Statement of Work, CMS officials used this volume and cost information in a multistep process. First, using the volume and cost information the QIOs recorded in CRIS and FIVS during the previous 3-year contract period, CMS calculated a nationwide median number of labor hours per quality of care review.²² Next, CMS instructed the QIOs to use this nationwide median number of labor hours or the QIO's own average number of labor hours

²⁰In addition, QIOs also may record information about oral beneficiary concerns they receive using the helpline category in CRIS. In general, this category is used to record information such as beneficiaries' names, addresses, and telephone numbers when they call a QIO's helpline. QIOs also may use this category to record summary information about the concern, document whether the QIO mailed any written materials to the beneficiary, and track referrals to other entities, such as other Medicare contractors, if the QIO determines that the concern is not related to the quality of Medicare services or other QIO responsibilities or activities.

²¹These 18 cost codes include a utilization review cost code to record QIOs' costs when QIOs perform reviews to determine the necessity and reasonableness of Medicare services provided to a beneficiary, and a helpline cost code to record QIOs' costs for helping beneficiaries who call a QIO's helpline.

²²In order to develop the nationwide median number of labor hours for a review, CMS officials told us they determined the average number of labor hours per quality of care review for each QIO, using the volume of reviews QIOs recorded in the CRIS case review category and the total number of labor hours each QIO recorded for these reviews in FIVS. CMS then sorted the average numbers for the 53 QIOs from smallest to largest and determined the nationwide median number of labor hours per quality of care review. The nationwide median number of labor hours per quality of care review CMS used to estimate QIOs' budgets for the current contract was 41.2 hours.

per quality of care review—whichever was lower—to develop proposed budgets to conduct quality of care reviews under the 9th Statement of Work.²³ Further, the QIOs’ proposed budgets were to be based on the result of this labor hours calculation and the volume of quality of care reviews the QIOs expected they would perform over the course of the next 3 years.²⁴ CMS officials told us that the QIOs then added their estimates for quality of care reviews to their estimates for other activities and reviews, and submitted their proposed budgets to CMS about 4 months prior to the start of the current contract.

After receiving each QIO’s budget proposal, CMS officials reviewed the proposals by comparing them to CMS’s own estimates of funding each QIO would likely need to conduct its activities and reviews for the 9th Statement of Work, including quality of care reviews.²⁵ As part of this review, CMS determined whether each QIO’s proposed budget was higher or lower than CMS’s own estimates for these reviews. Officials then negotiated with each QIO to agree upon a total budget for the current 3-year contract, which included an amount for conducting quality of care and other reviews.

CMS’s Instructions to QIOs for Recording Volume and Cost Information for Quality of Care Reviews Lack Clarity

Although CMS requires QIOs to record volume and cost information about their quality of care reviews in CRIS and FIVS, the agency has not provided clear instructions for how QIOs should record this information in these systems. CMS has established basic requirements for the quality of care review information QIOs must provide to the agency; however, these requirements do not include specific instructions about how QIOs should record volume and cost information in CRIS and FIVS. CMS’s requirements are outlined in CMS’s current QIO contract, a 2003 QIO policy manual, and a 2008 policy memo. According to CMS’s contract, QIOs must record all information about their quality of care reviews in CRIS within 3 days. However, the contract and policy manual do not specify which CRIS categories QIOs should use to record certain types of information related to the volume of quality of care reviews. In addition, CMS’s 2008 policy memo identifies the different cost codes QIOs should use to record their labor costs in FIVS under the current contract.²⁶ However, CMS’s memo does not specify exactly which quality of care review tasks should be recorded with each cost code.

²³CMS officials told us that the agency instructed QIOs to use the lesser of the nationwide median or the QIOs’ own average number of labor hours per review in their budget proposals for quality of care reviews as a means of limiting increases in spending on these reviews between the previous contract and the current contract.

²⁴To calculate their estimated labor costs for quality of care reviews, QIOs multiplied either CMS’s nationwide median number of labor hours per quality of care review or their own average number of labor hours per quality of care review—whichever was lower—by their average hourly wage rates. QIOs’ expected volume of quality of care reviews was based on their historical volume of these reviews.

²⁵CMS officials told us that their budget estimates for each QIO’s quality of care reviews were based on CMS’s estimates for the volume of quality of care reviews each QIO was expected to conduct. The estimates were based on the QIO’s historical volume of these reviews—that is, the volume of these reviews the QIO recorded in the CRIS beneficiary complaint category during the previous 3-year contract period. CMS’s budget estimates also included the nationwide median number of labor hours per quality of care review and the QIO’s inflation-adjusted average hourly wage rates.

²⁶CMS Standard Data Processing System Memo #08-191-F1, *Financial Information and Vouchering System (FIVS) 9th Statement of Work 719A Cost Elements* (issued July 10, 2008).

We found inconsistencies among some QIOs in the ways they record volume and cost information in CRIS and FIVS, respectively. (See encl. III for examples of variation in the seven QIOs' implementation of other quality of care review tasks, such as how QIOs review medical records.) Among the seven QIOs we interviewed, we found that all seven create a record in the CRIS beneficiary complaint category when they receive a written beneficiary concern that relates to the quality of Medicare services; however, some QIOs also create a record in this category under other circumstances. Specifically, we found:

- Three of the seven QIOs also create records in the beneficiary complaint category when they receive oral beneficiary concerns that they expect will eventually result in a written beneficiary concern. However, in some cases beneficiaries ultimately do not submit written concerns to the QIO, which means that the QIO cannot initiate a quality of care review.²⁷ Therefore, these three QIOs could report a higher volume of beneficiary complaint records in CRIS, relative to the four QIOs that do not create records in the CRIS beneficiary complaint category for oral beneficiary concerns.
- Two of the seven QIOs also create records in the beneficiary complaint category for written beneficiary concerns that may not relate to the quality of care for Medicare services received by the beneficiaries. The remaining five QIOs record this information in another CRIS category. Therefore, the two QIOs could report a higher volume of records in the beneficiary complaint category than the remaining five QIOs report.

In addition, when conducting quality of care reviews initiated by another type of review, such as a utilization review, QIOs vary as to whether they create a record for a quality of care review in the CRIS case review category. Specifically, we found:

- Three QIOs create records in the case review category for quality of care reviews they perform, but only when they determine that Medicare services did not meet professionally recognized standards of health care.
- In contrast, the remaining four QIOs create records in the case review category for quality of care reviews regardless of the QIOs' final determinations about whether Medicare services met professionally recognized standards of health care.

Similarly, while all seven QIOs in our review use FIVS to report cost information to CMS, in some cases the QIOs vary in which of the FIVS cost codes they use to classify labor costs associated with conducting the quality of care review process. We found:

- QIOs do not always use the quality of care cost code to record their labor costs when they identify a quality of care concern while conducting other types of reviews, such as a utilization review. While staff from two QIOs reported using the quality of care cost code, staff from the remaining five QIOs reported using other cost codes. As a result, these five QIOs could be reporting lower labor costs for quality of care reviews relative to the remaining two QIOs.

²⁷In these cases, the three QIOs label these records as abandoned in the CRIS beneficiary complaint category and do not perform a medical record review. QIOs may proceed with a medical record review if they determine that received oral concerns are of a serious or urgent nature.

- Four of seven QIOs record their labor costs under the quality of care review cost code for activities associated with the helpline, such as when following up with beneficiaries who express their concerns orally through the QIO's helpline. As a result, labor costs recorded under the quality of care review cost code for these four could be higher when compared to the other three QIOs that record their labor costs for activities associated with the helpline under the helpline cost code.

Conclusions

To set the QIOs' budgets for quality of care reviews, CMS depends on historical volume and cost information the agency obtains from the QIOs. However, because CMS does not provide clear instructions for how the QIOs should record their volume and cost information in CMS's information systems, CMS does not obtain consistent information across the QIOs it oversees. Without consistent information on the volume and costs for quality of care reviews, CMS cannot ensure that the budget for these reviews that it establishes for each QIO is appropriate. By providing clear, specific instructions for how the QIOs should record information in CRIS and FIVS, CMS could improve the information it obtains from the QIOs to establish budgets for quality of care reviews.

Recommendation for Executive Action

To ensure that QIOs consistently record volume and cost information for their quality of care reviews and to help ensure that the budgets CMS establishes for these reviews are appropriate, the Administrator of CMS should develop clear instructions specifying how QIOs should record information about the volume and costs of their quality of care reviews in CRIS and FIVS.

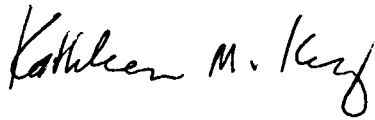
Agency and QIO Comments

The Department of Health and Human Services provided us with written comments on a draft of this report. The department's comments are reprinted in enclosure IV. HHS agreed with our recommendation and offered additional comments from CMS. In its comments, CMS indicated that the agency is taking steps to improve the collection of volume and cost information from QIOs. CMS said it would provide explicit and clear guidance to QIOs about how to record this information prior to the start of the 10th Statement of Work. HHS also provided technical comments that we incorporated as appropriate.

We also provided the seven QIOs we interviewed the opportunity to verify statements they made that were used to support our findings and incorporated their comments as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are listed in enclosure V.

A handwritten signature in black ink that reads "Kathleen M. King". The signature is written in a cursive style with a large initial 'K' and a long, sweeping tail on the 'g'.

Kathleen M. King
Director, Health Care

Enclosures – 5

Scope and Methodology

This report describes and assesses the information CMS uses to establish the portion of QIOs' budgets for quality of care reviews. To conduct this work, we reviewed the Centers for Medicare and Medicaid Services' (CMS) current 3-year contract with Quality Improvement Organizations (QIO)—the 9th Statement of Work¹—and CMS policies, such as CMS's Quality Improvement Organization (QIO) manual² and relevant CMS policy memos. We reviewed these materials and interviewed agency officials in order to identify the information CMS used, including information CMS obtained from the QIOs, to establish the QIOs' budgets for their quality of care reviews for the 9th Statement of Work. We also reviewed these materials, as well as relevant statutes and regulations, and interviewed agency officials in order to understand the quality of care review process. We then administered a Web-based pre-interview questionnaire and conducted structured interviews with officials from a judgmental sample of seven QIOs that currently hold contracts with CMS, in order to obtain information about how they conduct their quality of care reviews, the variation in their implementation of these reviews, and the information they regularly report to CMS about these reviews.

To identify the entities that hold QIO contracts for each state under CMS's current contract, we accessed a comprehensive list of QIOs from the QIO Directory on the QualityNet Web site (www.qualitynet.org), a Web site established by CMS for QIOs. The QIO Directory lists the name of each QIO, along with its telephone number and Web site address. We used individual QIOs' Web sites to gather contact information and information about whether the QIO is part of a multistate QIO corporate affiliation.³ We confirmed the QIO entities we identified as holding contracts in each state, as well as which of those QIOs have multistate corporate affiliations, with a QIO association.

To select our judgmental sample of seven QIOs, we ranked the 48 contiguous states and the District of Columbia⁴ by the number of eligible Medicare beneficiaries⁵ residing in each state, according to CMS's 2009 Medicare enrollment data. We then selected three states with a high number of eligible Medicare beneficiaries, two states with a medium number of eligible Medicare beneficiaries, and two states with a low number of eligible Medicare beneficiaries, in order to create our judgmental sample of seven states. Our selection also took into account corporate affiliations among QIOs as well as geographic distribution of the selected states. We included more states with a high number of eligible Medicare beneficiaries when selecting our judgmental sample of QIOs in order to develop a sample that represented a greater proportion of the total population of eligible Medicare beneficiaries nationwide. In all,

¹CMS's current contract, the 9th Statement of Work, began on August 1, 2008, and will end on July 31, 2011.

²Centers for Medicare & Medicaid Services Publication #100-10, *Quality Improvement Organization Manual* (revised 2003, 2006).

³For the purposes of this report, we define QIOs that have been awarded contracts from CMS for more than one state as having multistate corporate affiliations.

⁴For the purposes of QIO sample selection, we treated the District of Columbia as a state.

⁵Individuals who are eligible for Medicare include those who are age 65 or older, people under age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). Not all individuals who are eligible for Medicare are enrolled in this program. We ranked states based on the number of Medicare-eligible individuals residing in each state, not the number of individuals who are actually enrolled in the program.

Enclosure I

about 21 percent of the 2009 population of eligible Medicare beneficiaries in the United States resided in the seven states included in our sample. The information we obtained from our selected QIOs cannot be generalized to all QIOs.

To assess the reliability of QIOs' responses to our Web-based pre-interview questionnaire, we manually checked the responses to identify illogical or inconsistent responses and other indications of possible errors. We also conducted follow-up interviews with the officials we interviewed from the selected QIOs in order to clarify their answers and to gain a contextual understanding of their responses to certain questions on our pre-interview questionnaire and to our interview questions. To assess the reliability of CMS's 2009 Medicare enrollment data, which we used to select the seven QIOs, we reviewed relevant documentation about the data. We determined that the enrollment data we used for our report were sufficiently reliable for our purposes.

We conducted this performance audit from October 2009 through December 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Quality Improvement Organizations' (QIO) Processes for Conducting Quality of Care Reviews

There are four steps that QIOs should follow to conduct quality of care reviews.¹ Quality of care reviews are reviews of concerns raised by Medicare beneficiaries and others² to determine whether the quality of medical services financed by Medicare and delivered to beneficiaries met professionally recognized standards of health care.³ The first key step in the quality of care review process is for QIOs to receive quality of care concerns.⁴ Beneficiaries may initiate their quality of care concerns by mailing a letter to a QIO⁵ or by calling a QIO's helpline⁶ to register their concerns orally.⁷ QIOs may staff their helplines with clinicians, such as nurses, or with non-clinical staff. However, QIOs can proceed with further steps of the quality of care review only after the beneficiary submits a written description of the concern. Therefore, QIOs can proceed with reviews for oral beneficiary concerns only if they obtain a written concern from the beneficiary.⁸ CMS instructs QIOs to advise beneficiaries who registered their quality of care concerns orally to submit their concerns in writing and to assist beneficiaries in preparing written concerns when needed—for example, by sending beneficiaries a form to complete—in order to proceed with a quality of care review. QIOs

¹As of December 3, 2010, the Centers for Medicare & Medicaid Services' (CMS) QIO policy manual listed nine steps for the quality of care review process, which we simplified to four steps for this report.

²QIOs review quality of care concerns from Medicare beneficiaries, their representatives, and from CMS or CMS-designated entities, such as Medicare Administrative Contractors—the CMS contractors whose responsibilities include processing and paying Medicare claims. This enclosure focuses on QIOs' processes for conducting quality of care reviews that were initiated by beneficiaries and their representatives, and we use the term “beneficiaries” to refer to both beneficiaries and their representatives.

³Professionally recognized standards of health care are defined as statewide or national standards of care, whether in writing or not, that professional peers, such as physicians, recognize as applying to their fellow peers practicing or providing care within a state. See 42 C.F.R. § 1001.2 (2009).

⁴If QIOs determine beneficiaries' concerns are unrelated to the quality of Medicare services or their other responsibilities or activities, they may refer beneficiaries to another entity for resolution. For example, QIOs may refer beneficiaries' questions about billing to the appropriate CMS contractor for resolution.

⁵As of December 3, 2010, CMS did not permit QIOs to initiate quality of care reviews for concerns from beneficiaries transmitted by e-mail or facsimile. CMS officials told us that the agency plans to allow QIOs to accept quality of care concerns submitted by beneficiaries via e-mail and facsimile, although as of December 3, 2010, CMS had not established a date for when it would begin accepting these kinds of submissions.

⁶A beneficiary helpline is a QIO-staffed, toll-free telephone number that beneficiaries may call to voice quality of care concerns or to request other Medicare-related information or assistance from the QIO.

⁷Beneficiaries also may call 1-800-MEDICARE, a nationwide, toll-free number that is operated by a CMS contractor. Beneficiaries can call this number to inquire about any Medicare services or benefits. If a 1-800-MEDICARE representative determines that a beneficiary's call is related to the quality of Medicare services, he or she will refer the beneficiary to the QIO in the beneficiary's state.

⁸Section 1154(a)(14) of the Social Security Act requires that QIOs conduct an appropriate review of all written quality of care concerns from Medicare beneficiaries alleging that the quality of services they received did not meet professionally recognized standards of health care. See 42 U.S.C. § 1320c-3(a)(14). Based on this requirement, CMS does not permit QIOs to proceed with further steps of a quality of care review unless beneficiaries submit a written description of their concerns or QIOs determine that the received oral concerns are of a serious or urgent nature. See CMS Publication #100-10, *Quality Improvement Organization Manual*, Chapter 5: Quality of Care Review, § 5010A (Baltimore, Md.: revised Aug. 29, 2003).

Enclosure II

may also follow-up with beneficiaries who called the QIO but have not yet submitted written concerns.⁹

The second key step in the quality of care review process is for the QIO, after receiving a quality of care concern, to request, receive, and review the beneficiary's medical records.¹⁰ Specifically, CMS requires the QIO to request the medical records held by the providers or practitioners¹¹ who delivered the Medicare services about which there is a concern within 5 calendar days of receipt of the concern and to allow 30 calendar days to receive them.¹² To conduct medical record reviews, QIOs use physician reviewers¹³ to review the evidence documented in the beneficiary's medical records and to determine whether or not the Medicare services delivered to the beneficiary met professionally recognized standards of health care.¹⁴ QIOs and their physician reviewers may review medical records up to three times in order to reach a final determination regarding whether Medicare services met professionally recognized standards of health care.¹⁵ QIOs may offer beneficiaries an opportunity to pursue an alternative dispute resolution when they determine that Medicare services met professionally recognized standards of health care.¹⁶

In the third key step of the quality of care review process, CMS requires the QIO to notify involved providers or practitioners—through written notices—of the QIO's final determination. In instances where the QIO found that the care provided did not meet professionally recognized standards of health care, the QIO may use this written notice to inform the relevant providers or practitioners that they must take steps to improve the quality

⁹CMS, in the August 29, 2003, version of chapter 5 of the QIO policy manual, does not specify the time frame in which QIOs should follow up with beneficiaries who expressed their quality of care concerns orally but who subsequently do not submit written records of their quality of care concerns.

¹⁰QIOs may not request, receive, or review beneficiaries' medical records when they determine that the beneficiaries' concerns are unrelated to the quality of Medicare services.

¹¹For the purposes of quality of care reviews, a "provider" is defined as a hospital or other health care facility, agency, or organization and a "practitioner" is defined as a physician or other health care professional licensed under state law to practice his or her profession. See 42 C.F.R. § 1004.1 (2009).

¹²These time frames apply to retrospective quality of care reviews.

¹³Physician reviewers are practitioners who generally match the variables of licensure, specialty, and practice setting of a practitioner under review and maintain at least 20 hours a week of active practice. Physician reviewers are generally specialists in the same field as a physician under review. See CMS Publication 100-10, *Quality Improvement Organization Manual*, Chapter 4: Case Review, § 4620 (Baltimore, Md.: revised July 11, 2003).

¹⁴Some QIOs also have medical directors on staff, whose responsibilities may include evaluating physician reviewers' decisions about whether Medicare services met professionally recognized standards of health care.

¹⁵If QIOs' physician reviewers initially determine that the Medicare services provided did not meet professionally recognized standards of health care, the QIOs are required to afford the involved providers or practitioners an opportunity to provide additional information for the QIO to review. See 42 U.S.C. § 1320c-3(a)(14). If, after reviewing the medical record again with the additional information, the QIOs' physician reviewers still determine that the Medicare services did not meet professionally recognized standards of health care, the involved providers or practitioners may request that QIOs conduct one additional medical record review.

¹⁶An example of an alternative dispute resolution is a facilitated conversation where QIO staff talk separately with the beneficiary and the provider and/or practitioner with the intent of obtaining resolution to a beneficiary's quality of care concerns.

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of the Medicare services they provide, referred to by CMS as a quality improvement activity.¹⁷ In addition, for quality of care concerns initiated by beneficiaries and involving practitioners, the QIO also must seek the practitioners' consent to disclose details about the QIO's findings to beneficiaries.¹⁸

For the fourth and final key step of the quality of care review process, the QIO is required to provide the beneficiary with a written notification of its final determination about whether the Medicare services delivered by the provider or practitioner met professionally recognized standards of health care.¹⁹ CMS requires that these written beneficiary notices include a brief explanation of QIOs' quality of care review duties and functions, a brief summary of the beneficiary's quality of care concern, a statement about whether the Medicare services met professionally recognized standards of health care, and contact information for a QIO staff person.²⁰ In instances involving providers and where involved practitioners provide consent, CMS requires QIOs to provide additional details of their findings to beneficiaries beyond the statement of whether the Medicare services met professionally recognized standards of health care.²¹

¹⁷In its contract with QIOs, CMS defines a quality improvement activity as an activity initiated by a QIO that requires the provider or practitioner to articulate a plan or activity to improve an identified quality of care concern and for the QIO to follow up to ensure a plan is complete or an activity is undertaken. Examples of quality improvement activities initiated by QIOs include requiring the provider or practitioner to conduct staff training and requiring the provider or practitioner to review a process and reduce unnecessary steps.

¹⁸See 42 C.F.R. § 480.133(a)(2)(iii) (2009). QIOs are not required to obtain such consent from involved providers that were found to deliver Medicare services that did or did not meet professionally recognized standards of health care since provider-specific information is not included in the definition of confidential information. In contrast, practitioner-specific information is confidential. See 42 C.F.R. § 480.101(b) (2009).

¹⁹See 42 U.S.C. § 1320c-3(a)(14).

²⁰CMS provides model language that QIOs may use in their final beneficiary notification letters—the letters with QIOs' final determinations regarding whether the Medicare services about which there is a concern met professionally recognized standards of health care. See CMS Publication #100-10, Quality Improvement Organization Manual, Chapter 5: Quality of Care Review, § 5030, (Baltimore, Md.: revised Aug. 29, 2003).

²¹The Department of Health and Human Services Office of Inspector General reported in October 2010 that QIOs obtained consent for disclosure from practitioners in 52 percent of the 2,768 requests for practitioner consent for disclosure made between August 1, 2008, and December 31, 2009. See Department of Health and Human Services Office of Inspector General, Memorandum Report: *Quality Improvement Organizations' Final Responses to Beneficiary Complaints*, OEI-01-09-00620, (Washington, D.C.: October 2010).

Selected Points of Variation among Quality Improvement Organizations (QIO) in Their Implementation of the Quality of Care Review Process for Quality of Care Concerns from Medicare Beneficiaries

This enclosure provides selected points of variation among the seven QIOs we interviewed in their implementation of the four steps of the quality of care review process.¹ We interviewed the seven QIOs about their quality of care review processes for quality of care concerns received from Medicare beneficiaries.

Key step of quality of care review process	Selected elements of the quality of care review process that vary among QIOs	Description of QIOs' variation
Step 1: Receive quality of care concern	Professional background of staff who instruct beneficiaries who register their concerns orally to submit written quality of care concerns. ^a	<ul style="list-style-type: none"> • Three QIOs use non-clinical staff to instruct beneficiaries who register their concerns orally to submit their quality of care concerns in writing. • Four QIOs use clinical staff, such as nurses, to instruct beneficiaries who register their concerns orally to submit their quality of care concerns in writing.
	Routinely assisting beneficiaries who register their concerns orally in preparing written quality of care concerns.	<ul style="list-style-type: none"> • Three QIOs routinely assist beneficiaries who register their concerns orally by preparing written quality of care concerns—such as by composing a written summary on the beneficiary's behalf and forwarding it to the beneficiary for signature. • Three QIOs routinely assist beneficiaries who register their concerns orally by completing the beneficiaries' demographic information but do not routinely assist beneficiaries by preparing written quality of care concerns on their behalf. • One QIO does not routinely assist beneficiaries who register their concerns orally either by completing the beneficiaries' demographic information or by preparing written concerns on their behalf.
	Following up with beneficiaries who register their quality of care concerns orally and do not submit written quality of care concerns. ^b	<ul style="list-style-type: none"> • Four QIOs contact beneficiaries who register their quality of care concerns orally only once within 30 days to follow up when written concerns are not received. • Three QIOs contact beneficiaries who register their quality of care concerns orally twice within 30 days to follow up when written concerns are not received.

¹As of December 3, 2010, CMS's QIO policy manual listed nine steps for the quality of care review process, which we simplified to four steps for this report.

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Key step of quality of care review process	Selected elements of the quality of care review process that vary among QIOs	Description of QIOs' variation
Step 2: Review medical record	Time given to relevant providers or practitioners to supply medical records. ^c	<ul style="list-style-type: none"> Two QIOs initially request that relevant providers or practitioners provide medical records to the QIO in fewer than 30 days. Five QIOs initially give relevant providers or practitioners a full 30 days to provide medical records to the QIO.
	Using specialists, such as orthopedists, as physician reviewers when specialists are involved in the quality of care concerns under review. ^d	<ul style="list-style-type: none"> Six QIOs almost always use specialists as physician reviewers when specialists are involved in the quality of care concerns under review. One QIO uses generalists and specialists as physician reviewers when specialists are involved in the quality of care concerns under review.
	Identifying and providing relevant professionally recognized standards of health care ^e for physician reviewers to consider when reviewing medical records.	<ul style="list-style-type: none"> Five of the seven QIOs identify and provide relevant professionally recognized standards of health care for the physician reviewers to consider when reviewing medical records. Two QIOs do not identify and provide relevant standards of health care for the physician reviewers.
	Medical Directors' involvement in accepting physician reviewer decisions.	<ul style="list-style-type: none"> Three QIOs told us that they generally accept their physician reviewers' decisions as final. Three QIOs told us that on occasion, their Medical Directors may change their physician reviewers' decisions. One QIO told us that its Medical Director may request another physician reviewer's opinion in lieu of accepting a reviewer's decision as final.
	Providing an opportunity for beneficiaries to participate in alternative dispute resolution. ^f	<ul style="list-style-type: none"> Seven QIOs offer beneficiaries the opportunity to participate in alternative dispute resolution.
Step 3: Notify provider or practitioner of final determination	Following up with practitioners concerning consent to disclose the details of QIOs' final determinations to beneficiaries. ^g	<ul style="list-style-type: none"> Five QIOs follow up with practitioners by calling, mailing, or faxing them reminders to return their consents for disclosure. Two QIOs do not follow up with practitioners from whom they have not received responses to requests for consent for disclosure.
	Action taken to convince practitioners to disclose the details of the QIOs' final determinations to beneficiaries.	<ul style="list-style-type: none"> One QIO takes action to convince practitioners to disclose the details of quality of care review findings to beneficiaries. Six QIOs do not take any action to convince practitioners to disclose the details of quality of care review findings to beneficiaries.

Enclosure III

Key step of quality of care review process	Selected elements of the quality of care review process that vary among QIOs	Description of QIOs' variation
	Who determines the appropriate quality improvement activity to initiate when Medicare services did not meet professionally recognized standards of health care. ^h	<ul style="list-style-type: none"> • Three QIOs rely on physician reviewers' recommendations about the appropriate quality improvement activity to initiate. • Two QIOs convene a committee of QIO staff to determine the appropriate quality improvement activity to initiate. • One QIO convenes a committee of physician reviewers to determine the appropriate quality improvement activity to initiate. • One QIO relies on its Medical Director to determine the appropriate quality improvement activity to initiate.
Step 4: Notify beneficiary of final determination	Information provided to beneficiaries about QIOs' review findings. ⁱ	<ul style="list-style-type: none"> • Three of the seven QIOs generally adhere to CMS's model language for the introduction, body, and closing paragraphs of their beneficiary notification letters. • Four of the seven QIOs include additional language in the introduction, body or closing paragraphs of their beneficiary notification letters, such as language to assure beneficiaries that the submission of their quality of care concerns will help improve the quality of health care for other Medicare beneficiaries—even in cases where the QIO's medical record review found that delivered Medicare services met professionally recognized standards of health care.

Source: GAO analysis of interviews with seven QIOs.

^eEach QIO staffs a beneficiary helpline, a toll-free telephone number that beneficiaries may call to voice their quality of care concerns or to request other Medicare-related information or assistance from the QIO. QIOs may staff their helplines with clinicians, such as nurses, or with non-clinical staff.

^fCMS, in the August 29, 2003, version of Chapter 5 of the QIO policy manual, does not specify the time frame QIOs should follow up with beneficiaries who express their quality of care concerns orally but who subsequently do not submit a written record of their quality of care concerns.

^gFor the purposes of quality of care reviews, a "provider" is defined as a hospital or other health care facility, agency, or organization and a "practitioner" is defined as a physician or other health care professional licensed under state law to practice his or her profession. See 42 C.F.R. § 1004.1 (2009). CMS requires the QIO to request the medical records held by the providers or practitioners who delivered the Medicare services about which there is a concern within 5 calendar days of receipt of the concern and to allow 30 calendar days to receive them for a retrospective quality of care review. See 42 C.F.R. § 476.78(b)(2) (2009).

^hPhysician reviewers are practitioners who match, as closely as possible, the variables of licensure, specialty, and practice setting of a practitioner under review and maintain at least 20 hours a week of active practice. Physician reviewers are generally specialists in the same field as the physician under review. See CMS Publication 100-10, *Quality Improvement Organization Manual*, Chapter 4: Case Review, § 4620 (Baltimore, Md. revised July 11, 2003).

ⁱProfessionally recognized standards of health care are defined as statewide or national standards of care, whether in writing or not, that professional peers, such as physicians, recognize as applying to their fellow peers practicing or providing care within a state. See 42 C.F.R. § 1001.2 (2009).

^jQIOs may offer beneficiaries an opportunity to pursue an alternative dispute resolution when they determine that Medicare services met professionally recognized standards of health care. An example of an alternative dispute resolution is a facilitated conversation where QIO staff talk separately with the beneficiary and the provider and/or practitioner with the intent of obtaining resolution of a beneficiary's quality of care concerns.

Enclosure III

⁹For quality of care concerns initiated by beneficiaries and involving practitioners, the QIO must seek the practitioners' consent to disclose details about the QIO's findings to beneficiaries. See 42 C.F.R. § 480.133(a)(2)(iii) (2009). QIOs are not required to obtain such consent from providers that were found to deliver Medicare services that did or did not meet professionally recognized standards of health care because provider-specific information is not included in the definition of confidential information. See 42 C.F.R. § 480.101(b) (2009). The QIOs' findings about Medicare services delivered by providers are disclosed to beneficiaries.

¹⁰In its contract with QIOs, CMS defines a quality improvement activity as an activity initiated by a QIO that requires the provider or practitioner to articulate a plan or activity to improve an identified quality of care concern. Examples of quality improvement activities initiated by QIOs include requiring the provider or practitioner to conduct staff training and requiring the provider or practitioner to review a process and reduce unnecessary steps.

¹¹CMS provides model language that QIOs may use in their final beneficiary notification letters—the letters with QIOs' final determinations regarding whether the Medicare services about which there is a concern met professionally recognized standards of health care. See CMS Publication #100-10, *Quality Improvement Organization Manual*, Chapter 5: Quality of Care Review, § 5030, (Baltimore, Md.: revised Aug. 29, 2003).

Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

NOV 15 2010

Kathleen King
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) correspondence entitled: "Medicare: CMS Needs to Collect Consistent Information from Quality Improvement Organizations to Strengthen Its Establishment of Budgets for Quality of Care Reviews" (GAO 11-116R).

The Department appreciates the opportunity to review this correspondence before its publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT CORRESPONDENCE ENTITLED, "MEDICARE: CMS NEEDS TO COLLECT CONSISTENT INFORMATION FROM QUALITY IMPROVEMENT ORGANIZATIONS TO STRENGTHEN ITS ESTABLISHMENT OF BUDGETS FOR QUALITY OF CARE REVIEWS" (GAO-11-116R)

The Department appreciates the opportunity to review and comment on this draft report. This report describes and assesses the information that the Centers for Medicare and Medicaid Services (CMS) uses to establish the portion of QIOs' budgets for quality of care reviews.

GAO Recommendation

To ensure that QIOs consistently record volume and cost information for their quality of care reviews and to help ensure that the budgets CMS establishes for these reviews are appropriate, the Administrator of CMS should develop clear instructions specifying how QIOs should record information about the volume and costs of their quality of care reviews in Case Review Information Systems (CRIS) and Financial Information and Vouchering Systems (FIVS).

CMS Response

We concur with the recommendation made in the report, that CMS should develop clear instructions specifying how QIOs should record information about the volume and costs of their quality of care reviews in CRIS and FIVS.

The CMS acknowledges that there are differences in review processes and practices across the QIOs. In April 2009, CMS began redesigning the Beneficiary Protection Program case review processes and the design and development of a new CRIS. The redesigned processes and system will ensure standardization in the collection, analysis, and reporting of information related to quality of care and other review types, under the QIOs authority, to support budget decisions. In preparation for the 10th Statement of Work (SOW), CMS has conducted a review of case review operations identifying opportunities to improve the consistency of case review volume and cost. Prior to the start of the QIO 10th SOW, CMS will provide explicit and clear guidance to QIOs on the recording and reporting of case review volume and cost information.

We believe our actions to date demonstrate our success in addressing the need to improve the collection of information from QIOs to better establish the budgets for all case review functions. We look forward to working with the GAO to further address this issue for the well-being of all Medicare beneficiaries, and thank GAO for doing this work.

Enclosure V

GAO Contact and Staff Acknowledgments

GAO Contact

Kathleen M. King, (202) 512-7114 or kingk@gao.gov

Acknowledgments

In addition to the contact named above, Mary Ann Curran, Assistant Director; Julianne Flowers; Krister Friday; Regina Lohr; Alexis MacDonald; Lisa Motley; and Lisa Rogers were major contributors to this report.

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