

August 23, 2004

Administrator Mark B. McClellan  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

**File Code: CMS-3142-NC**

Dear Administrator McClellan:

The American Health Quality Association (AHQA) appreciates the opportunity to comment on the Evaluation Criteria and Standards for Quality Improvement Program Contracts. We acknowledge the difficulty faced by the Centers for Medicare & Medicaid Services (CMS) in devising an evaluation method and criteria that appropriately measures contractor performance, is fair and equitable to the Quality Improvement Organization (QIO) contractors, and does not result in any unintended negative consequences for Medicare beneficiaries, providers and practitioners or the Medicare program. We offer the following comments and suggestions for CMS consideration and request that the 7<sup>th</sup> Scope of Work (SoW) evaluation process and criteria be revised to provide a more appropriate assessment of QIO performance under the current contract.

Our comments and suggestions are grouped and labeled as requested in the Federal Register notice published on July 23, 2004.

**Background**

As stated in the Notice, Section 1153 (h)(2) of the Social Security Act requires the Secretary to publish the general criteria and standards that will be used to evaluate the “efficient and effective” performance of contract obligations by the QIOs. This is an extremely important specification as AHQA believes that some elements of the criteria contained in Version #011503-4A of the Attachment J-7 – General Evaluation Plan don’t adequately account for external influences, data limitations and other factors that can serve to mask “efficient and effective” QIO performance. We will discuss some of issues in the relevant sections of our comments.

**Measuring QIO Performance**

Untimely and Unstable Performance Evaluation Plan

The performance evaluation criteria are a major driver for how a QIO develops and implements its plan to perform the work required by its Medicare contract. Contractors should not be asked to bid on or sign a contract that is completely lacking or contains an incomplete evaluation plan. Unfortunately, that’s just what

happened in the 7<sup>th</sup> SoW when a “final” evaluation plan was not available until mid-January 2003. This meant that the Round 1 & 2 QIOs had little choice but to sign contracts and begin working without a complete evaluation plan or clear understanding of what would be required for successful performance.

Further, the evaluation plan has proved to be highly unstable. Because it was written without all of the necessary details for how the evaluation would actually be applied, the QIOs have been forced to respond to evaluation implementation documents that were not released until well into the contract performance period. Additionally, significant revisions have been made to the plan as a result of issues with the SoW and new policies and initiatives in Medicare and in health care generally. These changes have complicated QIO efforts to properly assign limited resources and to ensure that contract requirements are being met.

AHQA strongly recommends that CMS carefully consider the difficulties created by the lack of a timely and stable evaluation plan before it makes any determination not to renew a contract. We are very pleased that CMS is committed to avoiding a repeat of this situation in the 8<sup>th</sup> SoW. However, that should not prevent CMS from taking appropriate steps to address the issues in the current SoW.

#### Uniform QIO Contract Renewal Procedure

CMS should develop and use a uniform national procedure for determining whether a QIO will be eligible for non-competitive contract renewal or will be subject to a competitive contracting process. The process for the 6<sup>th</sup> SoW was ill defined and appeared to foster and result in significant variation with regard to how CMS arrived at contract renewal/competition decisions.

Attached is a proposed flow diagram developed with input from the AHQA Uniform Contract Renewal Procedures Workgroup. The diagram retains many of the elements that were used in the 6<sup>th</sup> SoW, but it provides a complete picture of the entire process that can be expected and planned for by CMS and the QIOs.

The primary goals in establishing a procedure should be to provide maximum transparency and to establish a minimum level of uniformity in the process and criteria used for making renewal/competition decisions. This will provide the contractors with clear expectations and a better understanding of the rationale used by CMS officials in making decisions. The process should prescribe certain elements of transparency, opportunities for QIO response/feedback and CMS decision criteria, but should not be expected to remove all flexibility or opportunity for subjective assessment in the process.

Below are several recommendations that CMS should consider in developing and implementing a uniform procedure:

- Establish a set of criteria for panelists that will help ensure an objective, well-informed and equitable basis for Panel decisions regarding

renewal/competition of contractors. The following elements should be among those that should be included in the criteria:

1. In order to minimize variation in decisions, every Panel should be composed, to the maximum extent possible (e.g. at least two-thirds), of the same individuals.
  2. The number of individuals necessary to comprise the panel should be specified, as well as any specific staff positions that will be required to participate.
  3. Panelists should be neutral – they should not be personally invested in supporting a previous decision. Individuals involved in the decision to invite a QIO to the Panel should not be selected as panelists for that particular QIO. Their participation should be limited to making a presentation and/or submitting a report.
  4. Panelists should be required to have in-depth knowledge and regular interaction with the QIO program activities.
- A uniform process and agenda should be used for QIO presentations to the Panel. It should include specifics such as the expected total duration of the meeting, time available for the QIO presentation, required QIO staff participation, etc.
  - The Panel should have a consistent set of criteria to consider in making its recommendation. These criteria should be more detailed than the set specified in the J-7 General Evaluation Plan. For example, it should be expanded to include consideration of the long-term performance of the contractor over the course of multiple contracts.
  - A template should be developed for routinely providing a minimum level of feedback, in writing, to the contractor at the points specified in the process flow chart. Its purpose is to ensure that the QIO has access to the rationale for the decisions and, when a set of criteria are to be considered, how each appropriate criterion was considered and addressed.
  - Recognizing the need for management discretion, which may involve a degree of subjectivity, a minimum set of criteria should be established for decisions at the QESC and OCSQ Director levels. Among these criteria should be the following:
    1. Review should ensure that all of the appropriate steps and procedures were followed in the process to that point.
    2. Decisions should fully consider, using the information developed during the process plus any additional input requested from the QIO, the real costs and/or benefits to CMS that would result from competing the existing contractor.



## Panel Consideration of Past Performance of Established QIOs

As noted above, CMS should expand the minimum criteria for consideration by the Panel to include the contractor's prior performance. The long-term performance of an established QIO contractor should receive at least as much weight as new contractor status in the Panel criteria. AHQA contends that CMS should carefully consider the impact of replacing an existing contractor as it determines whether non-renewal is in the best interest of beneficiaries, providers and practitioners, Medicare and taxpayers. CMS should give every possible consideration to a contractor with well established provider and practitioner relationships, standing in their community and history of good performance.

We know that there are numerous external factors that can impact the ability of a contractor to meet the evaluation criteria. If a new contractor's lack of experience must be considered in determining whether it should be given dispensation for not performing well, then the past good performance of an established QIO contractor should weigh as heavily on the determination.

## Reasons for not Renewing a Contract

The Notice states that "meeting the minimum performance standards does not guarantee a noncompetitive renewal of its contract." Besides the out-of-state contractor example provided in the notice, it's unclear for what other reasons CMS could decide not to renew a performing contractor. CMS should provide a specific list of instances and explanations for when it can decline to non-competitively renew a QIO that meets the contract performance evaluation requirements and should be eligible for renewal.

## **Standards for Minimum Performance**

### Task 1b -- Home Health Quality Improvement

A significant number of QIOs could fail to meet the evaluation criteria for Task 1b because they have a significant number of small home health agencies (HHAs) in their states. The criteria for Task 1b should be revised to account for the difficulty that HHAs with small numbers of episodes (between 10 and 30) will have in achieving statistical significance on their selected OBQI measures. We know that in calendar year 2001, 13.7% of HHAs had either less than 10 or between 10 and 30 episodes, and 13 states had 20% or more of their HHAs in that category. It is more difficult for an HHA with 10-30 episodes in a targeted outcome to achieve statistically significant improvement and it's nearly or statistically impossible for those that start with high baseline rates.

AHQA suggests that CMS revise the 7<sup>th</sup> SoW evaluation to include a criterion for small agencies with between 10 and 30 episodes in their targeted outcome(s) to be evaluated on absolute or relative improvement as opposed to significant

improvement. Small agencies can achieve equal or far better absolute improvement than larger HHAs and still not be able to achieve statistical significance. Making this change would provide a much better indication of QIO performance and give proper credit to the improvements made by these small HHAs.

#### Task 1d -- Physician Office Quality Improvement

A number of issues have created significant problems for QIO efforts to show improvement on the outpatient quality measures for diabetes and mammography, particularly in the Identified Participant group. CMS should make appropriate revisions to account for these issues in the evaluation.

First, a major barrier to the QIO work in Task 1d has been the extremely late release of data for the statewide and Identified Participant groups. We understand that the process of obtaining the data, linking it to specific physicians for the Identified Participant group and releasing the data to the QIOs has been far more complicated and difficult than envisioned. This has resulted in the QIOs working with data that is more than a year old and made it extremely difficult or impossible to use the data to target their efforts or to make informed adjustments in their tactics. CMS needs to acknowledge this situation and revise the QIO evaluation for Task 1d.

AHQA recommends that CMS lower the improvement targets for Task 1d across the board in recognition of the significant data issues that have severely hampered QIO efforts. This problem is not one over which the QIOs have any control and, therefore, they should be held harmless to the greatest extent possible from the effects of the data problems.

Second, two studies released near the beginning of the 7<sup>th</sup> SoW coincided with a dip and then flat national mammography rates. The most recent data through June 2003 actually shows that the national rate has declined from baseline. The studies were released after the baseline period and put the QIOs in the situation of needing to dig out of a hole before they could start to reduce the failure rate.

Further complicating the situation is that the mammography measure is largely dependent on the beneficiaries taking the necessary steps to receive the test. This limits the ability of the QIO to impact the rate by working directly with physicians and often requires a significant amount of beneficiary communication. While the QIOs do undertake efforts to communicate with beneficiaries, CMS would need to instruct and fund the QIOs to increase that work in order to achieve the desired outcome.

AHQA recommends that CMS significantly reduce or eliminate (possibly require stabilization and maintenance instead) the required improvement for the mammography measure. CMS should also consider reducing the weight of the mammography measure in the Identified Participant group to make it equivalent to

each of the three diabetes measures (i.e. 25% for each of the four measures – three diabetes and mammography).

Third, an issue in a number of states is facilities (e.g. Federally Qualified Health Centers, Indian Health Service, military) that, for one reason or another, don't bill separately for diabetes tests (i.e. HbA1c and lipids) and therefore don't generate the Medicare claims necessary to count in the evaluation. This problem is particularly evident when the facility is included in the Identified Participant group for a QIO. The problem is partly attributable to confusion on the part of the providers and their carriers about whether the providers can bill Medicare separately for the services outside of the bundled payment they receive for diabetes care. While it's clear that the providers can bill in this way, there are some that still do not bill separately for the services.

In one state, a clinic diabetes registry shows HbA1c at 73% and lipids at 61%, while the claims rates show 19% and 13% respectively. This illustrates another issue that CMS needs to address with regard to obtaining data from legitimate sources other than claims. There are clinics and other providers that are providing good care, but the statewide or Identified Participant groups don't account for that good care.

AHQA recommends that CMS allow QIOs to drop these providers from their Identified Participant groups if they can show that the provider is not billing for the diabetes services. If the QIO can show that the provider has an alternate way of demonstrating that the care is being provided (e.g. disease registry), then CMS should develop a way to capture this data for the purposes of the QIO evaluation.

#### Task 1e – Underserved and Rural Beneficiaries Quality Improvement

AHQA is concerned about the evaluation of QIO disparity reduction projects under Task 1e. In particular, there are significant issues related to the methodology CMS used for calculating and establishing baseline measurement rates for the 16 states that selected inpatient projects for their work under Task 1e.

We believe that the calculated baseline rates for these inpatient projects do not accurately represent the true baseline levels for targeted underserved intervention groups. Because the sampling and estimated rates were constructed for statewide assessment and not underserved populations, it casts significant doubt upon the baseline data for these disparity reduction projects, and therefore, it is highly unlikely that a QIOs' performance on these projects can be accurately assessed. During its evaluation of QIOs for Task 1e, CMS should take into account the fallibility of the CMS-provided inpatient data by making accommodations for QIOs affected by these problems.

#### Task 2b – Transitioning to Hospital Generated Data

Task 2b has changed dramatically since the beginning of the 7<sup>th</sup> SoW as a result of the National Voluntary Hospital Reporting Initiative and the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU). CMS decided to require significant changes in the responsibilities of the QIOs under this subtask and has created confusion about how their performance will be judged.

While we understand the need for flexibility, the complaint driven process for assessing QIO efforts to help hospitals report data and receive the full payment update is not well defined. We would like to have a better understanding of how CMS will determine legitimate hospital complaints and what level of evidence a QIO will need to produce to show that they performed the task successfully as instructed.

Also, the evaluation of this subtask seems to contain irrelevant remnants from earlier versions of the work. For instance, the definition of a reporting hospital no longer seems to work with the RHQDAPU requirements regarding the 10 measures. As well, the initial decision by a QIO to include CAHs in Task 2b no longer seems relevant as they are exempt from RHQDAPU.

AHQA recommends that CMS review the evaluation criteria for Task 2b and make necessary adjustments to ensure it is relevant to the current requirements of the work.

#### Project Officer Guidance for Non-Performance Base Subtasks

AHQA is concerned about the recent effort led by the Dallas Regional office to develop guidance for Project Officers to use in assessing QIO performance on qualitative (non-performance based) subtasks in the 7<sup>th</sup> SoW. While we support the concept behind the effort to ensure that there is consistency in how the QIOs are evaluated by the Regional Offices, we are concerned that the guidance is converting the qualitative elements of the evaluation into quantitative elements.

For instance, the guidance assigns weights to certain QIO activities regarding communication with Medicare Advantage (MA) plans. QIOs can be awarded 1 point if they sent multiple letters to recruit plans in their quality improvement activities. However, the QIO is only able to get .5 point for sending emails to the MA plan. Not knowing this, the QIO may have disadvantaged itself in the evaluation by responding to the preference of an MA Plan representative to communicate via email.

Another example is the requirement that the QIO have at least 2 consumers on their board of directors. The evaluation of Task 2c calls for the QIO to “broaden consumer representation on the QIO Board of Directors” -- it doesn’t say anything about requiring more than the one consumer required by regulation. As well, it doesn’t recognize that a QIO may have enhanced consumer representation on its Board without increasing its size or number of consumer representatives. For instance, one QIO has a consumer Board member that serves on its CAC as well, and that individual provides a direct report to the Board every quarter. While this

element is only worth .05 point, it is just one demonstration of a qualitative element that has become quantitative.

The QIOs should have been provided with this guidance at the beginning of the contract as it would have made the evaluation of these subtasks clear and allowed the contractors to do what's necessary to meet the requirements. At this very late stage, developing specific definitions for these tasks and assigning weights for their successful completion makes it difficult or impossible for the QIOs to respond in time and puts them at a significant disadvantage going into the evaluation.

AHQA recommends that CMS give the Project Officers flexibility to depart from this guidance if, in consultation with the QIO, they find that the QIO understanding of the requirements or how they addressed them can not be fairly or adequately evaluated within the structure defined in the guidance documents.

As the QIOs transition to the 8<sup>th</sup> SoW, the evaluation of their performance in the 7<sup>th</sup> SoW will be critically important. AHQA urges CMS to consider our comments and recommendations and make reasonable adjustments to the evaluation to ensure that it is fair and equitable while providing the necessary assessment of contractor performance.

Please don't hesitate to contact me should you have any questions regarding AHQA's comments.

Sincerely,

Todd D. Ketch  
Vice President, Government Affairs