



The American Health  
Quality Association

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Stephen F. Jencks, M.D.  
Director, Quality Improvement Group  
Office of Clinical Standards and Quality  
Health Care Financing Administration  
7500 Security Boulevard  
Baltimore, Md. 21244-1850

Dear Dr. Jencks:

AHQA very much appreciates having this opportunity to recommend changes in the CMS evaluation strategy for the Seventh QIO contract cycle (SOW7). Speaking on behalf of the Association leadership, I would like to acknowledge at the outset that participants in this effort have, after numerous meetings and discussions, a new appreciation for the level of effort and degree of compromise required to come up with an evaluation scheme for the Seventh QIO contract. I would also like you and your colleagues to be aware that participants in the AHQA deliberations are unanimous in their desire to compliment CMS staff for the many improvements made since the sixth contract.

We are disappointed that we could not reach agreement on more of the pressing evaluation issues, despite having made a strenuous effort to respond within the short time allotted. In future contract cycles, I will propose to AHQA's leadership that the Association proactively undertake an exercise like this one, in which positive proposals are offered in addition to the many questions and critiques previously submitted in formal comments. For now, I am confident that our leaders have still have more to offer if CMS is willing to continue working with AHQA on SOW7 evaluation issues.

Turning to the substance of our comments, please note that in our remarks below, unless a specific change is recommended, we intend for the original language to remain as in the December 3, 2001 draft Seventh Statement of Work.

**C.2.0. Requirements. B. 4. Other Requirements – Partnering.**

Recommendation 1. We recommend the insertion of the following definitions.

- “Collaborator” means anyone identified by the QIO as committed to working on a sustained basis with the QIO to bring about quality improvement.
- “Collaborating Provider” means a nursing home, home health agency or other institutional provider of services identified by the QIO as working on a sustained basis with the QIO to bring about quality improvement.

- “Collaborating Practitioner” means a physician or other licensed health professional identified by the QIO as working on a sustained basis with the QIO to bring about quality improvement.
- “Stakeholder” means a party with a self-identified interest in the clinical topics or provider types affected by the QIO’s quality improvement efforts. A stakeholder may or may not be working with the QIO on quality improvement.

**C.3.0. B Tasks – General Evaluation Plan.**

Recommendation 2. Page 7. First paragraph under General Evaluation Plan. The current evaluation scheme places too much responsibility on QIOs to demonstrate success, as measured by insufficiently tested quality indicators, in new care settings. There are many variables not controlled by the QIO that could result in little change in the nursing home and home health indicators, and impede hospital self-reporting of quality indicators, during the short 13 months QIOs will have to encourage improvement. No QIO should be regarded as having failed its Seventh contract requirements because of unimpressive results in one of these developmental programs. We recommend revision of the first sentence to read:

“Under this contract, the QIO shall achieve an acceptable overall score for its work in tasks one through three in order to have its contract renewed non-competitively.”

Recommendation 3. Third paragraph under General Evaluation Plan. We recommend CMS insert after the first sentence the following:

“Members of the CMS-wide panel will be selected for their expert knowledge regarding the Medicare QIO program, including its evaluation, data sources, and marketplace and other factors that may influence a QIO’s apparent performance under each of the subtasks.”

Recommendation 4. Page 7. Second paragraph under “B. General Evaluation Plan.” We recommend CMS abandon the subtask-specific “expected performance levels.” We do not believe there is adequate data or experience to establish anything other than arbitrary expected performance levels. CMS should look for satisfactory overall performance on the contract requirements. A QIO should not be rejected for contract renewal based on failure to meet expected performance levels for a single subtask. We recommend that CMS revise this paragraph to read,

“If the QIO has achieved an acceptable overall score for its work in tasks one through three, its contract can be non-competitively renewed. If, however, the initial assessment of the QIO’s performance suggests that it has not achieved an acceptable overall score, it shall be referred to a CMS-wide panel for a second, more in-depth assessment of its contract performance.”

Recommendation 5. Page 8, following the fourth paragraph under “B. General Evaluation Plan.” We recommend that CMS insert the following new language as two new bulleted paragraphs following the sentence, “At a minimum the panel will consider the following criteria:”

“whether a QIO which has achieved a low relative improvement has actually achieved a significant absolute percentage point improvement, which is inadequately reflected in the QIO’s relative improvement percentage due to low baseline performance in the State;”

“whether CMS or one of its contractors has failed to provide deliverables or other information specifically promised under this contract which was needed by the QIO to fulfill its obligations under the contract;”.

Recommendation 6. Page 10, B. General Evaluation Plan, “3. Changes in Quality of Care Measures.” Because the nursing home and home health quality indicators and improvement efforts are new and relatively untested, CMS should add the following language that commits the agency to reviewing its expectations after data becomes available on QIO efforts in these care settings. We suggest CMS add, at the end of this paragraph, the following new sentence:

“In addition, CMS commits to evaluating data from the nursing home and home health pilot projects and, to the extent feasible, data reflecting the results of national implementation of the nursing home and home health quality improvement projects, for the purpose of adjusting its expected performance level.”

Recommendation 7. Page 10-11. General Evaluation Plan, “4. General Evaluation Criteria for Subtasks 1a-1d and 1f.”

Implicit in the evaluation formula is the equal weighting of each subtask (the result of having each subtask contribute the same expected value to the total Task Performance Average (TPA)). However, the home health care projects will begin late in SOW7 and will be just getting underway when remeasurement for SOW7 is begun. This subtask should be weighted lower than the others, because it will reflect less work and is therefore structurally predisposed to have less impact during the contract period. Another way to address this issue would be to reduce the “expected performance level,” but as we can find no basis for recommending a particular level of expected performance, our comments address adjusting the weights.

### **Task 1a and 1b -- Nursing Homes and Home Health.**

For both the new nursing home and home health tasks, the challenge is to come up with a way of minimizing damage to the program and its contractors caused by reliance on prematurely selected “expected performance level” figures. No one knows what performance level is reasonable to expect in these new and untested programs. Contracts will be signed and performance expectations imposed before the results of pilot State projects are known. The performance indicators themselves (consistently mislabeled as “measures” in the draft) command none of the respect earned by CMS’ hospital performance indicators after years of refinement. Uncontrollable exogenous factors are very likely to overwhelm the influence of QIOs, yet are unlikely to be identified even retroactively and so are unlikely to be taken into consideration by the CMS-wide panel. In view of these realities, AHQA is opposed to the notion of an “expected performance level” that holds QIOs uniquely accountable for performance in what should be frankly acknowledged as an experimental program.

Recommendation 8. Before CMS imposes an “expected performance level” for the nursing home and home health subtasks, the threshold for minimum performance improvement in collaborators

and statewide should be evaluated after CMS sees several quarters of improvement data in at least the pilot States. However, because the experience in these carefully selected States will not be representative of the experience of most other QIOs, data from the rest of the nation should also be examined at this time. AHQA has proposed revised language to the contract to give force to this recommendation (see above, “General Evaluation Plan, 3. Changes in Quality Measures”).

### **Subtask 1a, 1b (e) Evaluation.**

Regarding numbered paragraph (2), nursing homes in particular are unlikely to attempt improvements on 10-15 quality indicators simultaneously. Each facility will probably select a small number of indicators, perhaps one or two, on which to focus its limited staff resources. The evaluation must not hold QIOs accountable for improvement on indicators for which facilities are not attempting to improve performance. In addition, the draft perhaps inadvertently proposes to evaluate QIOs for “technical assistance” provided by “state partners” (i.e., “participating nursing homes that received technical assistance provided by the QIO/state partners”). If state partners provide technical assistance, how can QIOs be accountable for the quality of that assistance? Finally, 10% of nursing homes in a State with a large population or geographic area will demand substantial resources in what we now know will be an under funded contract.

Recommendation 9. We recommend the language pertaining to the nursing home and home health subtasks be amended to provide greater flexibility. Please note that analogous language to that appearing below should also appear in subtask 1b, subsection (e)(2).

“(2) Improvement on each of a subset of 3-5 CMS nursing home quality indicators selected by the QIO for the seventh contract cycle, based on the performance of each nursing home that received direct technical assistance from the QIO on one or more of the QIO-selected indicators. A minimum of 10% of nursing homes or nursing homes accounting for 10% of beds in the State, or 10 nursing homes in States with fewer than 100 nursing homes, is expected to participate.”

Recommendation 10. Performance expectations for home health agencies should be carefully extrapolated from initial results in the pilot states. The experience in these States is unlikely to be representative because they were selected for the strength of the QIOs’ programs and the willingness of the industry to participate. We believe CMS should carefully monitor the observed improvement as interim data are obtained, and make necessary adjustments. AHQA urges the inclusion of the following language (previously included by CMS elsewhere in the draft SOW7 document) on page 15 at the end of subsection (e):

“CMS commits to evaluating data from the home health pilot projects and, to the extent feasible, data reflecting the results of national implementation of the home health quality improvement projects, for the purpose of adjusting its expected performance level.”

Subsection (e)(3). The proposed surveying to determine satisfaction among various stakeholders is an innovative component of the evaluation. It should be strengthened. CMS should acknowledge that “collaborators” and “partners” may include providers, State survey and certification officials, Medicaid officials, trade and professional associations (e.g, organizations representing nursing homes, medical directors, consultant pharmacists), State Long Term Care Ombudsman program

officials, and local patient advocacy group(s). The surveys of such persons and entities will necessarily be different from one another, unless questions are very superficial.

Recommendation 11. We recommend the following approach be used in surveys evaluating QIOs in both subtasks 1a and 1b:

- Separately designed surveys of state officials, association representatives, and providers.
- Satisfaction survey design should be developed by CMS in conjunction with AHQA with sufficient lead-time to permit consulting with some providers about its design without unduly rushing their consideration of the design.
- Instead of a pre-post pair of satisfaction surveys, there should be at least three surveys of nursing home and home health providers to measure their satisfaction with the QIO's support for them – to ensure the QIO gets at least one interim report on its performance (as viewed by its collaborators) during the course of the contract.
- The first survey should not be conducted until about 9 months in to the SOW7 contract period, to permit QIOs time to identify collaborating providers (a task to be accomplished 6 months into the contract), plus a few additional months for the QIO and providers to understand what each has to offer.
- The satisfaction surveys should attempt to ascertain more than simply satisfaction, but should also attempt to gauge whether the nursing home and home health agency has made any changes to its processes of care. The Standing Orders Project provider survey includes some useful examples of this type (please see attached survey instrument).

#### **Subtasks 1a, 1b, (f). Weighting of each component.**

Recommendation 12. In addition, as it has become clear that QIOs will experience significant real reductions in resources to undertake a substantially expanded scope of work, AHQA has reluctantly come to believe that statewide improvement is an unrealistic expectation in the 13 months QIOs will have to complete the new nursing home and home health subtasks. The weighting for statewide improvement should not be increased beyond 20%.

**Task 1c: Hospital Quality Improvement – (d) Evaluation.** Statewide Improvement on quality of care measures.

Recommendation 13. Provider and M+CO collaborators will frequently want to see interim aggregate data on quality performance. QIOs should be in a position to reliably promise this information to their provider collaborators on a known schedule. To meet this level of expectation will put demands on CMS and its support QIO(s), and expose QIOs to some risk of disappointing collaborators. We recommend that on page 17 the following new wording be added after the second paragraph:

“The QIO shall be held harmless from performance problems, including a failure to respond either to provider performance or QIO performance problems it could not reasonably be

expected to know of, as a result of the failure of CMS to provide timely baseline rates and/or periodic interim updates pertaining to FFS or M+CO beneficiaries.”

Recommendation 14. In the last paragraph of page 17, subsection (d) states that CMS will “create an overall state estimate rate of improvement by merging the pre- and post-improvement rates from the FFS and M+CO data. CMS will do this by creating an average of the two improvement rates, weighted by the average state M+CO penetration rate across the three years of the 7<sup>th</sup> SOW. This will likely give too much weight to the M+CO enrollees’ experience since M+CO members include fewer of the oldest and sickest Medicare beneficiaries who account disproportionately for Medicare hospitalizations. If hospital claims data are available for the M+CO enrollees, it would be more accurate to combine fee-for-service and M+CO inpatients in accordance with their actual proportion in the group of patients with each condition (AMI, heart failure, community acquired pneumonia, and selected surgeries).

Recommendation 15. On page 18, under “(2) Hospital and M+CO Satisfaction,” CMS indicates its intention to survey the level of satisfaction of hospital and health plan personnel. If a QIO is aggressive in seeking to persuade a provider to abstract its own data under the related Task 2b, the provider may register its unhappiness with CMS’ demands by reporting a low level of satisfaction with CMS’ contractor, the QIO. The survey methodology should attempt to ascertain whether rejection or discomfort with CMS policies is responsible for low satisfaction levels reported by hospital providers.

#### **Task 1f. Medicare+Choice Organizations Quality Improvement.**

Recommendation 16. The language in the first sentence of the subsection (c), Evaluation, is guaranteed to produce wide variation in interpretations by Project Officers as to what is meant by “demonstrated appropriate activity.” A great deal of effort could be invested by many QIOs in satisfying some Project Officers, while other QIOs may satisfy their POs with brief summary reports. We recommend that CMS provide specific guidance, and that this guidance be worded to ensure parsimonious reporting is CMS’ expectation regarding these activities:

“The term ‘demonstrate appropriate activity’ means the QIO has documented its attempts to recruit the M+CO(s) in the State, and has provided a brief summary of any participation in QIO quality improvement projects by the M+CO(s) in the State.”

Recommendation 17. In the Evaluation subsection on page 22, the second paragraph refers to CMS eliciting feedback from “providers.” We recommend that feedback be elicited from the medical director or manager at the M+CO plan who has the most direct experience of working with the QIO.

Recommendation 18. In addition, this paragraph implies an unclear distinction between participation in a quality improvement project and receiving technical assistance from a QIO. Inasmuch as “technical assistance” and “participation in a quality improvement project” could mean many things, we recommend the following:

“‘Technical assistance’ means the provision of any data, analytic services, or quality improvement consultation services by a QIO to one or more M+CO plan employees or contractors.”

“‘Participation in a quality improvement project’ means that one or more employees or contractors of the M+C Organization is, with authorization from the M+CO, actively engaged in the implementation of an aspect of a quality improvement plan developed in consultation with the QIO.”

Recommendation 19. If CMS concurs that there should be a distinction between technical assistance and participation in a quality improvement project, we believe that health plans should be queried who have participated in a quality improvement project, because these collaborations will be of greater duration and ensure surveys are completed by those with the greatest insight into the capacity of the QIO to assist the M+CO.

#### **Task 2a. Promoting the Use of Performance Data.**

In subsection (e), Evaluation, CMS plans to “conduct a survey of beneficiaries and providers/practitioners to assess the change in their awareness of and understanding of, and involvement with the QIOs as a result of this task.” There is very little chance that 80% of beneficiaries will have an opinion about, let alone “be mostly or fully satisfied with the assistance given ... by the QIO.” We know from repeated surveys that achieving the core objective relating to performance data will be very challenging for QIOs to convey to beneficiaries.

Recommendation 20. We recommend this paragraph be rephrased as follows:

“CMS will also conduct multiple surveys of beneficiaries and providers/practitioners to assess the change in their awareness and understanding of performance data to make health care decisions. The results of these surveys will be transmitted promptly to the QIOs in each jurisdiction to assist in their ongoing attempts to improve their functioning under this task.”

#### **Task 2b. Transitioning to Hospital-Generated Data.**

Some portions of Task 2b suggest that CMS is attempting to accomplish a regulatory agenda using the voluntary quality improvement process. Some of CMS’ expectations would be more appropriate in the context of a hard requirement that hospitals self-report quality data, such as the statement appearing in the last paragraph of subsection (b)(2) that:

“Should a hospital choose to use a data abstraction tool other than that approved by CMS, the QIO shall assure that the hospital uses standard file definitions and abstraction protocols equivalent to the CMS data abstraction tool.”

The QIO will be in no position to provide such an assurance, and it is unclear that CMS has published rules that would allow the government to make such demands, even on its own behalf.

The basic notion underlying Task 2b, that is, that QIOs can facilitate systematic data-gathering by hospitals, is sound if not stretched too far. Several QIOs have been very successful in their efforts

to assist hospitals to self-abstract data. However, those organizations made a strategic decision years ago to prepare themselves and their hospital collaborators to achieve the current high level of self-abstractation, and their success will not be replicated in 28 months.

Variation in hospital self-abstractation can also occur for reasons outside of the QIOs. In many States, the transition to self-abstractation has been and will continue to be aided by the presence of a high proportion of hospitals that are “deemed” to meet Medicare conditions of participation by virtue of being JCAHO accredited. During the seventh QIO contract period, the JCAHO will insist that accredited institutions report a subset of the quality indicators the QIOs are required to address. In other States, however, a nationally uniform CMS self-abstractation target will strike financially pressed administrators and physicians as unreasonable, and will almost certainly reinforce notions of an insensitive and distant big government that the current Administrator is working hard to dispel.

The QIOs’ role in improving self-abstractation rates is already spelled out in the draft contract. There are several ways in which CMS itself can advance the agenda of hospitals strengthening their self-measurement and evaluation, while taking appropriate cognizance of the diverse situations facing the QIOs.

Recommendation 21. We recommend that CMS drop altogether its stated expectation that 50% or more of hospitals in every State will be reporting self-abstracted data by the end of the 28<sup>th</sup> month of the SOW7 contract. Some QIOs have already exceeded this threshold with the active cooperation of their hospital collaborators, while it is predictable that others (particularly in rural States with relatively few JCAHO accredited institutions) will fail to meet this target. Instead, CMS should negotiate a State-specific target for self-abstractation with every QIO. This target can be sensitive to the number of data elements that are necessary to satisfy CMS expectations, based on such clearly relevant factors as the scale of the JCAHO’s presence in the State. Under this approach, some QIOs may be free to use these resources for other tasks, while others may legitimately be permitted to stretch for a lower but more locally appropriate threshold.

Recommendation 22. CMS can seek to reach an agreement with JCAHO to the effect that all Oryx data gathered by hospitals will be shared confidentially with the QIO, which will help eliminate rework and make the QIO’s requests for additional abstraction less onerous.

### **Task 3. Medicare Beneficiary Protection Program.**

The new Statement of Work makes important strides in improving the responsiveness of the beneficiary complaint program. Case management is a proven strategy for improving service to complainants, quality improvement and better follow up of recommended actions are sound strategies. These are high priority reforms that will improve the responsiveness and effectiveness of the QIO program in investigating and acting on beneficiary complaints.

In addition to these reforms, before the SOW7 apportionment decisions were announced, both AHQA and CMS were pursuing a policy direction that would commit the QIOs to conducting mediation in beneficiary complaint cases. We know from talking with QIOs involved in CMS-funded pilot projects that mediation works, that it takes a great deal of effort to persuade practitioners to participate, that it is most appropriate for cases in which clinical quality is not a significant problem, and we know that QIOs have found that most complaint cases do not involve

preventable clinical quality problems, but rather originate in poor communications and misunderstandings.

Now that it is apparent that QIOs are to be assigned an ambitious set of new tasks, but with fewer dollars with which to accomplish them (and fewer still real dollars), our previous policy direction must be reconsidered. QIOs' scarce resources should be allocated to the highest priority tasks, and those should be clinical quality issues where Medicare beneficiaries' health and safety is be compromised if there is not improvement. Resources that can bring about clinical quality improvement and patient protection should not be expended on mediating cases in which communications problems between practitioners and patients are the principal issue.

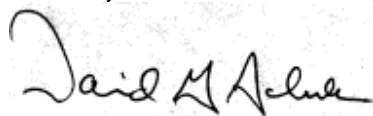
Recommendation 23. We recommend CMS eliminate the second bullet under Task 3(b)(1), Task Description, Beneficiary Complaint Review. This is a valid agenda for legislation that aims to reduce the volume of possibly unneeded litigation, provided that the Congress includes resources for QIOs to conduct large numbers of mediations between beneficiaries and practitioners or providers.

Reliability of Review. With Congress and the States poised to enact new appeal rights and other forms of case review, it appears that case review is not only an historically important core activity in this program --present since the creation of the QIOs and their predecessor PROs and PSROs-- but is also a public service that is here to stay. Nonetheless, CMS is right to seek improvements in the state of the art of case review. However, published studies on the reliability of case review strongly suggest that CMS will be disappointed in its expectation of QIOs that "blinded re-review of cases will result in identical findings at least 80% of the time."

Recommendation 23. CMS should ask for an improvement plan from each QIO that plots a course to steadily more reliable case review determinations. Given that reliability above 60% is essentially uncharted territory, CMS should focus on spurring innovation and speeding its diffusion amongst the QIOs. AHQA is willing to offer its forums and resources to assist CMS staff in bringing about improvement in case review reliability.

Steve, thank you for considering AHQA's suggestions. Should you wish to discuss any of these recommendations, or the analysis underlying them, I can be reached at (202) 261-7568 (direct) or at [dschulke@ahqa.org](mailto:dschulke@ahqa.org). Meanwhile, please be assured that I as well as AHQA's leaders remain strongly committed to working with you and your colleagues at CMS to build a faster, more economical and effective Medicare Quality Improvement Organization program.

Sincerely,



David G. Schulke  
Executive Vice President

Attachment: Nursing Home Standing Orders Project Survey