

CMS- 3188-NC

Because the referenced comment number does not pertain to the subject matter for CMS- 3188-NC, it is not included in the electronic public comments for this regulatory document.

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CMS-3188-CN

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**CMS-3188-NC-7 Evaluation Criteria and Standards for Quality Improvement
Program Organization Contracts**

Submitter : Ms. Marvalene Blades

Date & Time: 09/01/2007

Organization : Individual Nurse Provider

Category : Nurse

Issue Areas/Comments

Background

Background

I am a new Nurse Provider since October 2005, and a LVN for 21 years ;the last 15 years in the Home Care Industry. I have heard the many frustrations vented by Nurses and Responsible Caretakers as it relates the the numerous Home Health Agencies. The Caretakers are made to sign an agreement before the agencies takes their cases to provide the Nurses,the agreement releases the agencies from liability if they don't provide a Nurse and the primary caregiver would have to take on the responsible for the care of their loved ones. Such an agreement is acceptable for perhaps once in a while the agency is unable to provide a nurse; but I have been to cases where I was the first nurse a family was seeing in 4-5 days. The system is set up where these agencies are being paid for a approved amount of hours whether the beneficiaries are receiving those hours of nursing care or family member care. This method is causing a lot of confusion and frustration with the beneficiaries's family.

GENERAL

GENERAL

I have a plan that will save the State Billions of dollars over time.
Will make sure that beneficiaries receives the care that the State pays for.
I would like to discuss this plan with the appropriate State Representative.
I can be contacted by e-mail Sealeysoasis@yahoo.com

Measuring QIO Performance

Measuring QIO Performance

The Individual Nurse Provider program is a great program as a solution to cut cost to the State and to give the HHA Industry some competition so that they may perhaps tighten up their act.
I experience the process when I provided care for 20 hours a day for 108 days to a ventilator dependent beneficiary. As a nurse I had no problem with putting out all these hours, my problem began when I started the billing process at the end of the 90 day approval period. I then learn of first having to bill the beneficiary secondary insurance and many other things that as a Nurse I never had to do. I have learned and would like to make this Service known to other LVN in the Homecare Industry.

**Standards for Minimum
Performance**

Standards for Minimum Performance

Since the agencies were the only means available for the Nurses to get Clients, the Nurses have become very dependent. Anything that requires having to do with paper work is a deterrent. Perhaps if the Department eliminate the need for a denial letter from secondary insurance and make the process as simple for Individual Nurse Providers, I truly believe that the State can save billions of dollars by using the Nurses directly instead of paying all that extra to the HHA.

**CMS-3188-NC-8 Evaluation Criteria and Standards for Quality Improvement
Program Organization Contracts**

Submitter : Janet Williams

Date & Time: 09/04/2007

Organization : Janet Williams

Category : Other Association

Issue Areas/Comments

Background

Background

QIOS are prohibited from working with home health providers to correct their OASIS coding, yet OASIS coding for Improvement in Dyspnea is extremely subjective. Conversely, QIOS were allowed to utilize OASIS instruction during the 7SOW, so that providers have been conditioned to seek OASIS advice from the QIO.

GENERAL

GENERAL

Due to the subjective nature of OASIS coding for the Dyspnea measure, accurate OASIS coding is a critical element that can significantly impact the agency's rate and is frequently an inaccurate tool for measuring quality performance in dyspnea. Removing this key element of coding instruction from the QIO's arsenal strips the QIO of one of the most important tools. Additionally, when providers specifically ask for instruction in this area (specific to MO questions for Dyspnea), QIOs are prohibited from teaching the correct coding standards. In Oklahoma, the state health department holds minimal training - of which the technical aspects of OASIS submission take up the most time. Due to budgetary problems with our state health department, OASIS training in our state is lagging behind what it needs to be given the frequency of turnover and staffing changes in our growing HHA population.

Measuring QIO Performance

Measuring QIO Performance

The requirement for a 17% relative improvement in Dyspnea appears to be unrealistic, given the subjective nature of that measure and the QIO's inability (due to CMS prohibition) to provide OASIS coding education.

Of the 9 QIOS that selected Dyspnea for their statewide measure, the average RFR is 12.72% (May '07 data) - far short of goal. Compare this to Oral Meds and Pain.

Of the 30 QIOs who selected Oral Meds, the average RFR is 7.69%, right on target for the 8% RFR goal.

Of the 10 QIOs who selected Pain, the average RFR is 14.3%, exceeding the 10% RFR goal.

Clearly, a 17% RFR in Dyspnea is unrealistic, given that QIOs cannot provide OASIS coding instruction for this extremely subjective measure, especially when HHAs are asking for instruction in this area. Removing that key element from a QIO's arsenal severely reduces the QIO's ability to reach a 17% RFR.

The RFR for Improvement in Dyspnea should be reduced to a more realistic (and reachable) figure - perhaps 13% or 14%.

**CMS-3188-NC-9 Evaluation Criteria and Standards for Quality Improvement
Program Organization Contracts**

Submitter : Ms. Teresa Mota

Date & Time: 09/04/2007

Organization : Ms. Teresa Mota

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

If QIOs are to truly be measured on their effectiveness, the measures should not be based on factors that the QIO cannot control. If a QIO provides appropriate clinical and quality improvement education and support for NHs to make changes, but the NH does not implement said changes, why should this reflect badly on the QIO? QIOs should be measured on the type and level of QIO intervention at the facility and state levels, involvement in state partnerships and initiatives, etc. Improvement in the measures reflects changes NHs make, based on MDS coding (which is not always valid), not necessarily the quality or level of QIO intervention. Although the measures do appear to improve with increased QIO intervention, they are not a direct measure of QIO intervention, nor should they be used as a primary vehicle to measure QIO performance.

**CMS-3188-NC-10 Evaluation Criteria and Standards for Quality Improvement
Program Organization Contracts**

Submitter : Ms. Linda Stratton

Date & Time: 09/06/2007

Organization : UnitedHealth Group - Ovations

Category : Health Plan or Association

Issue Areas/Comments

Background

Background

Comment #1: p44151, BACKGROUND

Summary of Requirement

Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and items that are reasonable and medically necessary and that are provided in the most economical setting.

Issue/Concern

In reviewing a small sample of appeals that were overturned by QIOs, plan Medical Directors identified several cases for which it is believed there was an inappropriate decision made by the QIO. These overturned appeals required maintenance of patients for a long length of stay at a higher level of care when the patient could have been safely transitioned to a lower level of appropriate care in accordance with Medicare coverage criteria.

We believe that in these cases the QIO decisions are operating contrary to their broader function which is to "Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for the services and items that are reasonable and medically necessary and that are provided in the most medically appropriate economical setting."

In addition, there is a concern about the possibility of inconsistent decision making from within a QIO as well as across QIOs. For example, situations have been identified where a QIO will uphold the plan decision and another QIO will overturn a decision for the same type of appeal. Inconsistent decisions have also been made from within a QIO for very similar types of cases. We believe consistent decision making is in the best interest of beneficiaries because it applies Medicare benefits consistently, fairly, appropriately utilizes their 100 day SNF benefit, and provides effective care management of patients with multiple chronic conditions.

Recommendation

We recommend CMS develop an oversight process to address concerns about a consistent and uniform application of the Medicare benefits within and across the QIOs. In addition, we would welcome the opportunity to work with CMS on developing such a process.

**Standards for Minimum
Performance**

Standards for Minimum Performance

Comment #2: p.44152-44155 STANDARDS FOR MINIMUM PERFORMANCE

Summary of Requirement

References to establishing statewide targets for identified quality improvement initiatives in each provider type.

Issue/Concern

Working with 50 different statewide quality improvement targets is not only difficult to manage and resource intensive, but may not be necessary because clinical evidence is available to establish a national quality improvement targets for quality initiatives.

Recommendation

When clinical evidence is available, CMS identify a national target for quality improvement initiatives.

**CMS-3188-NC-11 Evaluation Criteria and Standards for Quality Improvement
Program Organization Contracts**

Submitter : Ms. Lisa Williams

Date & Time: 09/06/2007

Organization : Kansas Foundation for Medical Care, Inc.

Category : Federal Government

Issue Areas/Comments

Measuring QIO Performance

Measuring QIO Performance

Last paragraph of section II. Measuring QIO Performance & Criteria for Non-Competitive Renewal of Contracts - "For the 9SOW, we are considering a requirement that QIOs achieve a "full pass" or an "excellent pass" on all tasks and sub-tasks for the non-competitive renewal of their contracts for the 10SOW - Will QIOs have an opportunity for input/feedback regarding the development of the 9SOW measures and their evaluation criteria? For instance, using a proportional credit method (instead of requiring a certain threshold before any points are received) would allow for higher sensitivity in assessing level of improvement.

Standards for Minimum Performance

Standards for Minimum Performance

Task 1a - The Federal Register notice includes 'improving management of depressive symptoms'. The contract modification that the QIOs received in March removed all expectations regarding depression. The only place it is evident is in the evaluation section of the contract modification, where CMS removed the expectation for 'improvement' and said that .08 points would be given to all QIOs for 'working' on this measure.

Task 1a - The Federal Register does not document the opportunity for the QIO to obtain extra credit for work related to NHFT; as is documented in the most recent contract.

Task 1b - (3rd bullet point in the 1b section) - 'The QIO will have extra credit added to its total Task 1b evaluation score for improving results on both the OASIS acute care hospitalization measure and the selected publicly reported OASIS outcome measure'. We interpret this to pertain to the substitute/extra insurance HHAs, but the wording is not clear.

Task 1d2 (page 44154) - The Federal Register refers to the QIO working at a statewide level to improve clinical performance measures results in the areas of diabetes, mammography and adult immunization. In the March, 2007 QIO contract modification, the adult immunization clinical performance measure was deleted as a requirement.

**CMS-3188-NC-12 Evaluation Criteria and Standards for Quality Improvement
Program Organization Contracts**

Submitter : David Schulke

Date & Time: 09/06/2007

Organization : American Health Quality Association

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

Comment Regarding the Effect of Deobligation on Measuring QIO Performance:

" Most of the changes to task 1d3 evaluation criteria noted in the Federal Register were already specified in the previous contract modification dated March 27, 2007.

" However, a significant change has not been reported in the Federal Register notice. Prior to publication of the Federal Register notice on August 7, 2007, CMS decided to deobligate funding for this task, instructing QIO contractors to cease work in this area, so that CMS may use the funds for another initiative. This change was ordered prior to publication in the Federal Register on August 7, 2007, but it is not mentioned in the Federal Register notice, even though it constitutes a very significant change in the QIO contract. We object to this deobligation of funding for Task 1d3 on the grounds that --

1) It is questionable whether CMS may cut off funding for work specifically required by federal law to be in the QIO Scope of Work following enactment by Congress of Section 109 of the Medicare Modernization Act. If this task is not included in the 9th SoW, it would be inconsistent with the direction of Congress.

2) The deobligation will assure poor performance as assessed by CMS's evaluation based on process and customer satisfaction because it will mean projects are not completed, affecting CMS process evaluation, and customers and partners of the QIOs will be alienated by cessation of agreed upon projects, harming their satisfaction with the work done by the QIO.

3) It constitutes a significant change in the contract affecting Measurement of QIO Performance but has not been publicly noticed or published in the Federal Register.

Comment regarding consistency of measures:

We have looked into the criteria and calculation methods for clinical measures across different sub tasks in 8th sow. They are not consistent. Some of them give proportional credits such as task 1d2 and task 1c2, others don't give any if certain thresholds are not met such as task 1a, task 1b and task 1c1.

To improve clinical measures usually involves multiple faceted effort, which may include QIO QI effort, providers' care, patient's health conditions, family members' cooperation and more. With the influence of the multi-factors, a positive RFR, even a small positive number is not easy to be reached. Therefore, the evaluation method needs to be very sensitive to assess the achievement in those measures.

With the threshold method, however, the score may not reflect the progress at all in some cases. For example, a QIO reached 12% RFR in the IPG ACH measure for task 1b, the QIO will be given 0 score because they did not meet 25% RFR--a threshold to get credit (0.23 credit points).

Proportional credits seem sensitive in reflecting QI effort in clinical measures. As the method used in Task 1d2 and task 1c2, proportional credits can be given with the following formula: $\text{item credit points}^* (\text{Actual RFR} / \text{expected RFR})$. With proportional credit method, the QIO will obtain $0.23 * 12\% / 25\% = 0.11$ points.

In summary:

- 1) the method of the evaluation in clinical measures should be consistent across all sub-tasks;
- 2) Because the proportional credit method has higher sensitivity in assessing the achievement in clinical measures than the threshold method, it is suggested to be used in all sub-tasks if applicable.

GENERAL

GENERAL

See attachment

Measuring QIO Performance

Measuring QIO Performance

Task 1d1

Comment:

Measuring QIO Performance -- Office Systems Survey (OSS). A significant OSS problem is likely to artificially reduce success rates, making the program and its contractors appear less successful than they have actually been.

When the task 1d1 physician office system survey first opened (in mid-July), QIOs nationwide were told there would be the possibility of physician offices re-opening surveys, after physicians completed them, to change incorrect answers. At the same time, the survey was re-designed to try to eliminate errors before they occurred (e.g., EHR contract dates were pre-populated). The inaccuracies we are seeing are common and are more likely to minimize the progress made by the physician office. But CMS has since decided that it may cause problems for the program if physician offices can reopen and correct inaccurate data in the OSS.

Comment Regarding Measuring QIO Performance of Task 1d3:

" Most of the changes noted in the Federal Register were already specified in the previous contract mod. (3/27/07)
 " However, a significant change has not been reported in the Federal Register notice. Prior to publication of the Federal Register notice on August 7, 2007, CMS decided to deobligate funding for this task, instructing QIO contractors to cease work in this area, so that CMS may use the funds for another initiative. This change was ordered prior to publication in the Federal Register on August 7, 2007, but it is not mentioned in the Federal Register notice, even though it constitutes a very significant change in the QIO contract. We object to this deobligation of funding for Task 1d3 on the grounds that --

1) It is questionable whether CMS may cut off funding for work specifically required by federal law to be in the QIO Scope of Work following enactment by Congress of Section 109 of the Medicare Modernization Act. If this task is not included in the 9th SoW, it would be inconsistent with the direction of Congress.

2) The deobligation will assure poor performance as assessed by CMS's evaluation based on process and customer satisfaction because it will

mean projects are not completed, affecting CMS process evaluation, and customers and partners of the QIOs will be

alienated by cessation of agreed upon projects, harming their satisfaction with the work done by the QIO.

3) It constitutes a significant change in the contract affecting Measurement of QIO Performance but has not been publicly noticed or published in the Federal Register.

CMS-3188-NC-12-Attach-1.DOC

CMS-3188-NC-12-Attach-1.DOC

CMS-3188-NC-12-Attach-1.DOC



AMERICAN
HEALTH QUALITY
ASSOCIATION

1155 21st Street, NW
Suite 207
Washington, DC 20036
(202) 715-5740 • F: (202) 331-9374
www.aqpa.org

**Comments on Evaluation Criteria and Standards
Published in Federal Register August 7, 2007
CMS-3188-NC**

BACKGROUND

Comment Regarding the Effect of Deobligation on Measuring QIO Performance:

- Most of the changes to task 1d3 evaluation criteria noted in the Federal Register were already specified in the previous contract modification dated March 27, 2007.
- However, a significant change has not been reported in the Federal Register notice. Prior to publication of the Federal Register notice on August 7, 2007, CMS decided to “deobligate” funding for this task, instructing QIO contractors to cease work in this area, so that CMS may use the funds for another initiative. This change was ordered prior to publication in the Federal Register on August 7, 2007, but it is not mentioned in the Federal Register notice, even though it constitutes a very significant change in the QIO contract. We object to this deobligation of funding for Task 1d3 on the grounds that --

- 1) It is questionable whether CMS may cut off funding for work specifically required by federal law to be in the QIO Scope of Work following enactment by Congress of Section 109 of the Medicare Modernization Act. If this task is not included in the 9th SoW, it would be inconsistent with the direction of Congress.
- 2) The “deobligation” will assure poor performance as assessed by CMS’s evaluation based on “process and customer satisfaction” because it will mean projects are not completed, affecting CMS process evaluation, and customers and partners of the QIOs will be alienated by cessation of agreed upon projects, harming their satisfaction with the work done by the QIO.
- 3) It constitutes a significant change in the contract affecting Measurement of QIO Performance but has not been publicly noticed or published in the Federal Register.

Comment:

We have looked into the criteria and calculation methods for clinical measures across different sub tasks in 8th sow. They are not consistent. Some of them give proportional credits such as task 1d2 and task 1c2, others don't give any if certain thresholds are not met such as task 1a, task 1b and task 1c1.

To improve clinical measures usually involves multiple faceted effort, which may include QIO QI effort, providers' care, patient's health conditions, family members' cooperation and more. With the influence of the multi-factors, a positive RFR, even a small positive number is not easy to be reached. Therefore, the evaluation method needs to be very sensitive to assess the achievement in those measures.

With the threshold method, however, the score may not reflect the progress at all in some cases. For example, a QIO reached 12% RFR in the IPG ACH measure for task1b, the QIO will be given 0 score because they did not meet 25% RFR--a threshold to get credit (0.23 credit points).

Proportional credits seem sensitive in reflecting QI effort in clinical measures. As the method used in Task 1d2 and task 1c2, proportional credits can be given with the following formula: item credit points* (Actual RFR /expected RFR). With proportional credit method, the QIO will obtain $0.23 * 12\% / 25\% = 0.11$ points.

In summary:

- 1) the method of the evaluation in clinical measures should be consistent across all sub-tasks;
- 2) Because the proportional credit method has higher sensitivity in assessing the achievement in clinical measures than the threshold method, it is suggested to be used in all sub-tasks if applicable.

MEASURING QIO PERFORMANCE

Comment:

NEW CONTRACT LANGUAGE: "That is, a QIO that receives an "Excellent Pass" on one or more subtasks and receives a "Conditional Pass" on no more than three subtasks and does not receive a "Not Pass" on any subtasks MAY BE eligible to have its contract renewed non-competitively."

CURRENT CONTRACT: "That is, a QIO that receives an Excellent Pass on one or more subtasks and receives a Conditional Pass on no more than three subtasks and does not receive a Not Pass on any subtasks WILL BE eligible to have its contract renewed non-competitively."

NEW CONTRACT LANGUAGE: "The QIO must promote statewide quality improvement by working with public health, provider groups, and other broad-based agencies to support the use of appropriate preventive and disease-based care processes."

CURRENT CONTRACT: "The QIO shall promote statewide quality improvement (e.g., diabetes, mammography, and immunizations) by working with public health, provider groups, and other broad-based agencies to support the use of appropriate preventive and disease-based care processes, INCLUDING THE "WELCOME TO MEDICARE VISIT [promotion of this Medicare benefit deleted]."

Comment:

II. Measuring QIO Performance & Criteria for Non-Competitive Renewal of Contracts

1) Page 44152, first column, middle of the page:

NEW CONTRACT LANGUAGE: "That is, a QIO that receives an "Excellent Pass" on one or more subtasks and receives a "Conditional Pass" on no more than three subtasks and does not receive a "Not Pass" on any subtasks MAY BE eligible to have its contract renewed non-competitively."

CURRENT CONTRACT: "That is, a QIO that receives an Excellent Pass on one or more subtasks and receives a Conditional Pass on no more than three subtasks and does not receive a Not Pass on any subtasks WILL BE eligible to have its contract renewed non-competitively."

2) Page 44152, second column, second paragraph:

NEW CONTRACT LANGUAGE: "For the 9th SOW, we intend to revise the criteria required for non-competitive renewal of contracts. For the 9th SOW, we are considering a requirement that QIOs achieve a "full pass" or an "excellent pass" on all tasks and subtasks for the non-competitive renewal of their contracts for the 10th SOW. We are also reviewing the process by which a QIO contract can be terminated, during the course of a SOW, on performance grounds."

CURRENT CONTRACT: No mention of any of this.

Satisfaction

Comment:

III. Standards for Minimum Performance (task 1)

Page 44152, second column, last paragraph before task 1a:

NEW CONTRACT LANGUAGE: "Each subtask of Task 1 will include a requirement to meet Satisfaction and Knowledge/Perception performance criteria for Provider identified participants (IPG) and non-identified participants (Non-IPG)." Satisfaction and knowledge/perception surveys and stakeholder knowledge/perception surveys will be used to measure performance. **

** Please note that this paragraph continues where it mentions about stakeholder knowledge/ perception surveys.

Comment:

- Language was added clarifying points for < 80% satisfaction survey results: 0 for 1a, 1b, 1c1, 1c2, 1d1, 1d2; a conditional pass for 1d3.
- Little or no effect; it only restates that satisfaction is all or nothing. If < 80% overall, all the subtasks (except 1d3) get zero points. If >= 80%, all the subtasks get 0.10 points.

Task 1a

Comment:

Page 44152, third column, task 1a, second paragraph:

NEW CONTRACT LANGUAGE: "The QIO will focus on decreasing the rate of pressure ulcers among high risk individuals, decreasing the use of physical restraints, IMPROVING THE MANAGEMENT OF DEPRESSIVE SYMPTOMS, and improving the management of pain in chronic (long stay) residents among a select group of identified participant nursing homes (IPG1) as well as other nursing homes requesting assistance from the QIO."

CURRENT CONTRACT: "In the area of clinical improvement, the QIO will focus on decreasing the rate of pressure ulcers among high-risk individuals, decreasing the use of physical restraints, and improving the management of pain in chronic stay residents among a select group of identified participant nursing homes (IPG1) as well as other nursing homes requesting assistance from the QIO."

Comment:

- Majority of changes were already specified in the previous contract mod. (3/27/07)
- Language was added clarifying how points will be calculated for staff and resident satisfaction surveys and nursing assistant turnover; this does not affect us as we already have or will meet the criteria for all these points
- Sentence that states, "A QIO with a zero score in any one of these core activities [IPG Clinical Quality, Target Setting, Experience of Care, Statewide Clinical Quality, Satisfaction and Knowledge/Perception] will be considered as Not Pass regardless of its final evaluation score" remains intact

Task 1b

Comment:

III. Standards for Minimum Performance (task 1)

Page 44152, third column, task 1b, first paragraph:

NEW CONTRACT LANGUAGE: "QIO work in the home health setting will focus at the statewide level on meeting or exceeding the statewide targets on the Outcome and Assessment Information Set (OASIS)."

CURRENT CONTRACT: "QIO work in the home health setting will focus at the statewide level on meeting or exceeding the statewide target reduction in failure rates (RFRs) on the Outcome and Assessment Information Set (OASIS) measure for acute care hospitalization and one additional QIO-selected publicly reported OASIS measure."

Comment:

- Language was added clarifying requirements for interim progress measures we have already been submitting per SDPS memo

Task 1c1

Comment:

- Changes were already specified in the previous contract mod. (3/27/07)

Task 1c2

Comment:

- This is a significant change—it will be more difficult to achieve an Excellent pass than before because there are fewer points available.
- Potential extra credit for CAHs to report data on new AMI transfer measures was deleted, as expected (had been potentially 0.20 point)
- Extra credit for at least one non-reporting CAH to work on CPOE, barcoding or telehealth was deleted (had been potentially 0.05 point)
- Total points available changed from 1.35 to 1.10

- Other changes were already specified in the previous contract mod. (3/27/07)

Task 1d1

Comment:

Measuring QIO Performance -- Office Systems Survey (OSS). A significant OSS problem is likely to artificially reduce success rates, making the program and its contractors appear less successful than they have actually been.

When the task 1d1 physician office system survey first opened (in mid-July), QIOs nationwide were told there would be the possibility of physician offices re-opening surveys, after physicians completed them, to change incorrect answers. At the same time, the survey was re-designed to try to eliminate errors before they occurred (e.g., EHR contract dates were pre-populated). The inaccuracies we are seeing are common and are more likely to minimize the progress made by the physician office. But CMS has since decided that it may cause problems for the program if physician offices can reopen and correct inaccurate data in the OSS.

Comment:

III. Standards for Minimum Performance (task 1d1)

1) Page 44153, third column, 2nd to last paragraph before 'Medicare Advantage':

NEW CONTRACT LANGUAGE: "The QIO must support quality initiatives including the Physician Voluntary Reporting Program (PVRP) by activities that include providing information to physicians on participation in the initiative and on physician performance and improvement for those that report."

CURRENT CONTRACT: "The QIO shall support quality initiatives including PVRP by activities that include providing information to physicians on participation in the initiative and on physician performance and improvement for those that report. THE QIO SHALL SUPPORT QUALITY INITIATIVES INCLUDING PQRI AS DESCRIBED IN THE TASK DESCRIPTION."

2) Page 44153, third column, last paragraph before 'Medicare Advantage':

NEW CONTRACT LANGUAGE: "The QIO must promote statewide quality improvement by working with public health, provider groups, and other broad-based agencies to support the use of appropriate preventive and disease-based care processes."

CURRENT CONTRACT: "The QIO shall promote statewide quality improvement (e.g., diabetes, mammography, and immunizations) by working with public health, provider groups, and other broad-based agencies to support the use of appropriate preventive and disease-based care processes, INCLUDING THE "WELCOME TO MEDICARE VISIT.""

Page 44153, third column, task 1d1, Medicare Advantage :

NEW CONTRACT LANGUAGE: "The Medicare Advantage part of Task 1d1 will be waived for States/jurisdictions that had low MA enrollment among the eligible Medicare beneficiaries during calendar year 2004."

CURRENT CONTRACT: "The Medicare Advantage part of Task 1d1 will be waived for states/jurisdictions that had <20% Medicare Advantage enrollment among eligible Medicare beneficiaries during calendar year 2004."

Comment:

NEW CONTRACT LANGUAGE: There is no mention of QIO work with ESRD networks for 1d1 in the new document. This is how its stated in the contract:

CURRENT CONTRACT: "At the request of an ESRD Network, the QIO shall work collaboratively with the ESRD Network on mutually agreed upon activities to engage physician practice sites to improve rates of native fistula use and influenza and pneumococcal immunizations."

Task 1d2

Comment:

Page 44154, first column, first paragraph under Task 1d2.

NEW CONTRACT LANGUAGE: "As part of QIO efforts in the physician practice setting, the QIO must, at the statewide level, work to improve clinical performance measure results for clinical quality indicators in the areas of diabetes, mammography, AND ADULT IMMUNIZATIONS for underserved racial/ethnic populations."

CURRENT CONTRACT: "As part of QIO efforts in the physician practice setting, the QIO shall, at the statewide level, work to improve clinical performance measure results for the four clinical quality indicators in the areas of diabetes and mammography for underserved racial/ethnic populations."

Quality of care measure for screening mammography was changed from annual to biennial, as expected.

Task 1d3

Comment Regarding Measuring QIO Performance of Task 1d3:

- Most of the changes noted in the Federal Register were already specified in the previous contract mod. (3/27/07)
- However, a significant change has not been reported in the Federal Register notice. Prior to publication of the Federal Register notice on August 7, 2007, CMS decided to "deobligate" funding for this task, instructing QIO contractors to cease work in this area, so that CMS may use the funds for another initiative. This change was ordered prior to publication in the Federal Register on August 7, 2007, but it is not mentioned in the Federal Register notice, even though it constitutes a very significant change in the QIO contract. We object to this deobligation of funding for Task 1d3 on the grounds that --

1) It is questionable whether CMS may cut off funding for work specifically required by federal law to be in the QIO Scope of Work following enactment by Congress of Section 109 of the Medicare Modernization Act. If this task is not included in the 9th SoW, it would be inconsistent with the direction of Congress.

2) The “deobligation” will assure poor performance as assessed by CMS’s evaluation based on “process and customer satisfaction” because it will mean projects are not completed, affecting CMS process evaluation, and customers and partners of the QIOs will be alienated by cessation of agreed upon projects, harming their satisfaction with the work done by the QIO.

3) It constitutes a significant change in the contract affecting Measurement of QIO Performance but has not been publicly noticed or published in the Federal Register.

Task 3a

Comment:

"Section C.6.B.3a.1. TASK 3a: BENEFICIARY PROTECTION

Replace:

CURRENT CONTRACT: Additional required activities under this Task are physician acknowledgment monitoring; inter-rater reliability (IRR) assessment; beneficiary satisfaction assessment; procedures based on the result of a review or analysis of review data; development of an Annual Report; and maintenance of a Medicare Helpline.

With:

NEW CONTRACT LANGUAGE: Additional required activities under this Task are physician acknowledgment monitoring; **beneficiary satisfaction assessment**; procedures based on the result of a review or analysis of review data; development of an Annual Report; and maintenance of a Medicare Helpline."

Comment:

- Quality improvement activities resulting from case reviews were designated as extra credit.
- Majority of changes were already specified in the previous contract mod. (3/27/07)

Task 3b

Comment:

- Changes were already specified in the previous contract mod. (3/27/07)

Deliverables

Comment:

- Some due dates, of which we were already aware, were corrected

- Language was clarified regarding Task 1a deliverable requirements for staff and resident satisfaction surveys and nursing assistant turnover; this does not affect us as we already have or will meet the criteria
- Majority of changes were already specified in the previous contract mod. (3/27/07)

Attachment J-2 Award Fee Plan

Comment:

- This language from the contract mod dated 2/1/07 regarding Task 1d1 was deleted: “..or implement a CCHIT certified Ambulatory EHR;” the replacement language is therefore different than that in the previous contract mod. (3/27/07)

Attachment J-10 Provider Satisfaction and Knowledge Survey Subcontract

Comment:

- Changes were already specified in the previous contract mod. (3/27/07)