CMS-3142-NC-1

Submitter : **Dr. werqwer qwerer** **Date & Time:** **08/05/2004 05:08:01**

Organization : **werqwer**

Category : **Congressional**

Issue Areas/Comments

GENERAL

GENERAL

werqwer

Issues

Background

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CMS-3142-NC-1-Attach-1.doc

CMS-3142-NC-1-Attach-1.doc

CMS-3142-NC-2

Submitter : Mr. Luis Morales **Date & Time:** 08/13/2004 02:08:01

Organization : Virginia Health Quality Center

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

Thank you for the opportunity to provide input on the 7th SoW Evaluation Criteria. The Virginia Health Quality Center (VHQC) has comments on two subtasks, 1c and 2a, as detailed on the attachment.

CMS-3142-NC-2-Attach-1.doc

VIRGINIA HEALTH QUALITY CENTER

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Winner of Virginia's 2002 U.S. Senate Productivity & Quality Award Plaque for Progress in Performance Excellence

August 13, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3142-NC
PO Box 8016
Baltimore, MD 21244-8016
http://www.cms.hhs.gov/regulations/ecomments

Reference: CMS-3142-NC

Thank you for the opportunity to provide input on the 7th SoW Evaluation Criteria. The Virginia Health Quality Center (VHQC) has comments on two subtasks, 1c and 2a, as detailed below.

1. **Subtask #1c**
   a. **Issue:** Hospital satisfaction survey. Additional hospitals are appearing in PRS when they switch to acute care mpn (receiving a differing level of reimbursement). For example, in Virginia, 3 hospitals switched to acute care 8/1/2004. We have not had contact with them prior to this date, which could present a problem if they are sampled for the hospital satisfaction survey.
   b. **Example of the impact of the evaluation:** If a QIO's hospital customer satisfaction score is at 80%, these hospitals could pull the satisfaction rate below the minimum standard of 80%.
   c. **Possible solution**: Establish a cut off date for new entries as acute care hospital in regards to the satisfaction survey. For example, the hospital must be listed in PRS as an acute care hospital 60 (sixty) days prior to start of the initial sampling period allowing the QIO to establish a working relationship with the hospital.

2. **Subtask #2a**
   a. **Issue:** Based on the most recent version of Section F. of the QIO contract (version #011503-4A), Schedule F item #17, the first J-7 assessment criteria for 2a (i.e., "Timely completion and submission of a project work plan") currently only applies to the NHQI, with QIOs being notified as deemed necessary if additional work plans are required.
   b. **Example of the impact of the evaluation:** The possible lack of submission of a completed project work plan for HHQI or HQI.
   c. **Possible solution**: Incorporate language from Item #17 in Section F used to clarify and specifically define the J-7 criteria.

If you have any questions or comments about VHQC's response, please feel free to contact Mr. Luis G. Morales, Director of Performance Excellence, at (804) 289-5320 or lmorales@vaqio.sdps.org.

Submitter : **Date & Time:** 08/16/2004 05:08:10

Organization :

Category : Individual

Issue Areas/Comments

Issues

Standards for Minimum Performance

Task 1b Home Health Quality:
The complex evaluation includes the requirement that 30% of the states total HHA achieve statistically significant improvement (SSI) in one quality measure. In some of the states, this may not be feasible and may not reflect the real quality outcomes of the efforts of HHAs and the QIO.
Example:
To meet minimal expectations, 30% (n of 35) of the total HHAs (115) currently in our state must achieve statistically (SSI) in one quality measure. Of the 115 HHAs, 84 HHAs (73%) are eligible to be in the evaluation count because these HHAs supplied a formal plan of action to CMS by the deadline (Aug. 1, 2003). Of the total eligible, 50 (60%) are potentially classified as very small or small. The remaining 34 HHAs are potentially classified as medium or large. (Size key currently being developed by the Center for Health Services Research (CHSR) and is based on events/episodes of care). The CHSR is currently investigating the belief that large and medium size agencies have a greater chance of reaching SSI due to the number of episodes of care.
Participating HHAs are demonstrating an impressive relative improvement (March 2003-March 2004): 67% of participating HHAs choosing improvement/stabilization measures demonstrate a relative improvement of greater than 10%, and 46% of participating HHAs choosing emergent care/acute care demonstrate a relative decrease (improvement) of greater than 10%. If CMS were to change the evaluation to demonstrate overall statewide relative improvement, 43% of HHAs (n of 115) are currently demonstrating greater than 10 % improvement.

Task 1d Physician Office Quality:
The rate of statewide and identified participants' improvement in quality care measures is determined though Medicare physician billing. These data have not been proven reliable in accurately capturing information used to estimate quality improvement measures.

Examples:
Within our state's identified participant group there is 1 Indian Health Service (IHS)/Tribal clinic that submits Part B claims to TrailBlazer Health. IHS clinics bill Trailblazers, who has the national contract for IHS. These clinics bill as a bundled visit and receive a standard payment regardless of services performed. Labs are not listed out separately, and thus there would be no way to determine what labs were performed. After comparing this clinic's actual rates obtained from their disease registry, (HbA1c: 73%, lipids: 61%) with Medicare claims rates, (HbA1c: 19%, lipids: 13%) we realized that there is a large discrepancy.

In our identified participant group there are 4 clinics that are considered Rural Health Clinics (RHC). Freestanding RHCs in our state bill the carrier (Noridian); labs billed separately and therefore should be in our billing data. Provider-based RHCs bill through the hospital's FI. Our state has two FIs, Trailblazers and Mutual of Omaha. RHCs may bill as a bundled hospital service; therefore labs may not appear in the Medicare billing data.

One identified participant clinic has indicated that they have a high proportion of their Medicare patients covered through military retiree benefits, and claims for these patients may not be submitted to CMS.

In a CMS-approved beneficiary mammography survey currently being conducted, 15 of 205 respondents noted they had bilateral mastectomies and would not be eligible for mammography. The respondents are included in the Medicare database and are expected to have breast cancer screening done.

Potential solutions:
1. Validation of claims data through medical record abstraction until more efficient systems are established.
2. Exclusion of beneficiaries having documented bilateral mastectomy.
3. The development of State (or MD office) registry for diabetes (and possibly mammograms).
4. Electronic medical records.

Submitter : **Date & Time:** 08/20/2004 08:08:32

Organization : PRONJ, The Healthcare Quality Improvement Org

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attached Microsoft Word document

Issues

Background

See attached Microsoft Word document

Measuring QIO Performance

See attached Microsoft Word document

Standards for Minimum Performance

See attached Microsoft Word document

CMS-3142-NC-4-Attach-1.doc

CMS-3142-NC-4-Attach-1.doc

CMS-3142-NC-4-Attach-1.doc

CMS-3142-NC-4-Attach-1.doc

PRONJ
THE HEALTHCARE QUALITY IMPROVEMENT ORGANIZATION OF NEW JERSEY, INC.
557 Cranbury Road, Suite 21, East Brunswick, NJ 08816-4026
Telephone: 732.238.5570 • Fax: 732.238.7766
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August 20, 2004

Centers for Medicare & Medicaid Services
Attention: CMS-3142-NC
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Sir or Madam:

PRONJ, The Healthcare Quality Improvement Organization of New Jersey, Inc., is submitting the following in response to your call for comments on the 7th Scope of Work Evaluation Criteria (**Federal Register**/Vol. 69, No. 141/Friday, July 23, 2004). All of our comments regard the Standards for Minimum Performance section.

STANDARDS FOR MINIMUM PERFORMANCE

General Criteria
"Satisfaction will be assessed using a survey, the purpose of which will be to:

- *Identify opportunities where the QIO can improve satisfaction."*

Comment
Is the identification of opportunities for improvement part of the SOW? What is CMS's plan for QIOs that do not have sufficient sample size to assess provider satisfaction?

General Criteria
"Satisfaction will be assessed using a survey, the purpose of which will be to:

- *Identify opportunities where the QIO can improve satisfaction.…Tasks 1f, 2a, 2c and all of Task 3 will be evaluated by the Project Officer using qualitative measures based on information provided in reports developed from data provided by the QIOs on the QIO's status to date."*

Comment
This is no longer true. Based on the document, *Guidance for Evaluation of 7SOW Non-Performance-Based Tasks*, and the Excel tool that will be used to evaluate QIOs' performance in the above six subtask areas, QIOs will be evaluated quantitatively**,** instead of qualitatively. The scoring system implemented in the Excel tool does not allow Project Officer to consider or give merit to extra work/activities conducted by a QIO during the SOW. In addition, the *Guidance* document should have been provided earlier in the SOW when a QIO signed its contract with CMS, not near the end when CMS is evaluating a QIO's work on these task areas.

PRONJ
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Task Specific Standards
Task 2b—Transitioning to Hospital-Generated Data

Comment #1
Specific criteria on "Weighting of Each Component" outlined in J-7 version #011503-4A uses 30% for completeness of the assessment survey information. The HGD survey seems redundant for a state, such as New Jersey, which has 100% of its hospitals reporting.

Comment #2
A great deal of time and effort was invested in the NVHRI preview and the validation processes, neither of which were included in the evaluation criteria.

Task Specific Standards
Task 3b—Hospital Payment Monitoring Review Program

Comment
The specific criteria outlined in J-7 version #011503-4A states that the "QIO will be evaluated based on timeliness of reviews (and) reliability of its review." In the *Guidance* document mentioned above, the scoring of Task 3B includes both reliability and validity of review. Should the *Guidance* document be consistent with the J-7 evaluation criteria, which uses reliability, but not validity?

Task Specific Standards
Task 3—Improving Beneficiary Safety and Health Through Medicare Beneficiary Protection Activities

Comment
What is the rationale for selecting whether reliability or validity of review should be part of the J-7 evaluation criteria for each subtask area? For example, Task 3c does not require validity or reliability for evaluation, and Tasks 3a and 3b require reliability.

Thank you for your consideration in reviewing our comments on these evaluation criteria issues.

Sincerely,

Martin P. Margolies

Martin P. Margolies
Chief Executive Officer

Submitter : Ms. Sally Hart **Date & Time:** 08/20/2004 11:08:52

Organization : Center For Medicare Advocacy, Inc.

Category : Consumer Group

Issue Areas/Comments

GENERAL

GENERAL

Center For Medicare Advocacy, Inc.
100 North Stone Avenue, Suite 305
Tucson, Arizona 85701
(520) 327-9547

August 20, 2004

Center For Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attn: CMS-3142-NC

Re: Medicare: Evaluation Criteria and Standards for
Quality Improvement Program Contracts

Dear Sir or Madam:

The Center for Medicare Advocacy, Inc., founded in 1986, is a national non-partisan education and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare and quality health care. The Center represents thousands of individuals in appeals of Medicare denials at all levels of the administrative process. In addition to our own cases, we provide advice to attorneys and other advocates in their representation of Medicare beneficiaries through the Medicare appeals process.

The Evaluation Criteria and Standards for Quality Improvement Program Contracts, published in the Federal Register on July 23, 2004, raise several concerns to the Center. Our concerns are set forth as follows:

I. BACKGROUND

The description of QIO functions places protection of beneficiaries through review of individual cases last of the ?three broad functions? summarized in the evaluation criteria. Individual case reviews by QIOs, whether pertaining to quality of care or to termination of services, should be given a higher priority by CMS in its contracts and evaluations. Other organizations such as state licencing agencies and accreditation groups are available to perform the functions related to improving quality of health care generally.

II. MEASURING QIO PERFORMANCE

Again, Task 3 in the itemization of 4 QIO tasks is the only one that focuses on beneficiary protection activities. The Center believes that this task should be given far higher priority in the work of QIOs than the ?soft? work of carrying out provider and community education campaigns and data gathering activities outlined in the other 3 tasks.

III. STANDARDS FOR MINIMUM PERFORMANCE

Relevant to the Center?s concern about the lack of focus on individual cases is the absence of satisfaction among beneficiaries among the General Criteria listed in the Standards section, although satisfaction of providers and practitioners is included. Surely Congress intended for QIOs to serve primarily the interests of beneficiaries rather than providers and practitioners. Therefore, beneficiary satisfaction should be a major criterion rather than a minor factor in evaluating the work of QIOs.

We hope that you will revise the Evaluation Criteria and Standards for Quality Improvement Contractors, as well as the next Scope of Work for QIOs, to take these concerns into account

Yours very truly,

Sally Hart
Consulting Attorney,
Center For Medicare Advocacy, Inc.

CMS-3142-NC-6

Submitter : Dr. Michael Tooke **Date & Time:** 08/23/2004 02:08:14

Organization : Delmarva Foundation

Category : Other

Issue Areas/Comments

Issues

Standards for Minimum Performance

Comments on 7th SOW Evaluation Criteria
File Code: CMS-3142-NC
Submitted by Delmarva Foundation for Medical Care (QIO for MD and DC)
Contact: Michael C. Tooke, MD, Chief Medical Officer (mtooke@dfmc.org)

III. Standards for Minimum Performance

1. With respect to subtask 1.B, we are concerned that HHAs with a small, but reportable, number of cases may be difficult to evaluate for significance of improvement. For example, an agency with 15 cases would need to have an improvement of 25% to reach statistical significance, whereas an agency with 1000 cases might need only a 4% improvement to be significant. In the District of Columbia, we deal with several small agencies, in a jurisdiction that does not have a large total number of agencies. In fact, all but one of our target agencies in the District of Columbia will have <30 episodes for their target outcomes. An unintended consequence of this measurement is excess burden to more poorly resourced small providers and the appearance of less substantial improvements in this sector than may be the case. We suggest that small HHAs be held to some other reasonable standard such as a favorable percentage change. When setting performance goals for outcomes and process measures, CMS should set confidence intervals around the targets in order to reduce the bias introduced by small samples. We have discussed our concerns about small agencies with the HH QIOSC. We understand that the QIOSC has submitted analyses on this issue to CMS that could be used to inform decisions for modifications of the QIO evaluation on 1.B.
2. With respect to subtask 1.D, the lateness of data has made it practically impossible to assess the effectiveness of our interventions, or to identify areas that need more intense intervention. Also, we are very concerned that the data available at the 28th month will not fully reflect the time period when our interventions were in place and most effective. Thus, the evaluation method may miss important improvements, and overlook effective interventions. We suggest that evaluation be based on data that represents a time period consistent with the actual intervention period.
3. With respect to subtask 1.E, it is our recent understanding that target group measurement will only go down to the county level. Our project, approved by our Project Officer and Science Officer, uses a set of 10 urban hospitals as the target population; there are other hospitals in the county that we did not include in the target group. Including them in the evaluation would make assessment of disparity reduction meaningless, if not impossible. We believe that this method would overlook the reduction in disparity in a significant urban inpatient population. We suggest that the evaluation use the same measurement criteria as approved for our project at the beginning of subtask 1.E.

Submitter : Ms. Meghan Harris **Date & Time:** 08/23/2004 05:08:34

Organization : Ohio KePRO

Category : Health Care Provider/Association

Issue Areas/Comments

Issues

Standards for Minimum Performance

General

For each task a threshold is set. While there is historical data to demonstrate that this is achievable in the Hospital and Physician Office setting, there has been no evidence presented indicating that the thresholds in the Nursing Home and Home Health agency settings are achievable. The pilot projects assessing the QIOs work in these settings did not show evidence that these thresholds were realistic.

The tasks that will be evaluated subjectively by the project officers would be less ambiguous if guidelines were set and the QIOs knew the components of the guidelines ahead at the start of the Scope of Work.

Task 1B

How can statistical significance be calculated for agencies with a small number of episodes of care?

How will the denominator for the 30% be determined? Agencies open and close all of the time. There are also the cases of merges and buy-outs, where the agencies still now bill under one Medicare number.

Task 1C

Many of these indicators will still have a small number in the denominator. There are provisions for the two AMI measures but even these provisions will not allow for an accurate and precise score to be calculated for each state. Also by collecting the same number of cases for a small state as collected for a larger state the precision and confidence interval is much smaller for that large state therefore, making the evaluation of the QIO less accurate.

Task 1D

There are many billing issues that can affect the evaluation. Services received are often times not billed to Medicare. Some of these cases are due to regulations like in the cases of the Indian Health Services and Rural Health Clinics. Another case is that of the beneficiary receives their mammogram at a free mobile unit that chooses not to bill Medicare because of the grants and monies they function under. This is also the case of those beneficiaries that are participating in trial programs for Diabetes. This can affect the Statewide score for each state but could have a more disastrous effect on a states Identified participant group score. The number of linked beneficiaries can be small and in the case of choosing a Federally Qualified Health Clinic in the ID group that does not bill for one of he above reasons, the rate will be small and will not accurately reflect the actual care given or improvements in care actually achieved.

Task 2B

This task is included in the list of quantitative tasks, however, the largest weighted criteria for this task is related to RHQDAPU. This criterion is worth 50% of the total score and does not have any quantitative measurement. There is no set proportion of hospitals that should be submitting data to the National repository. There is also, no method provided to measure the number of complaints due to RHQDAPU, and therefore the documentation of the QIOs efforts.

CMS-3142-NC-7-Attach-1.doc

Comments for CMS-3142-NC

STANDARDS FOR MINIMUM PERFROMANCE

General

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