Section I Respondent Information

Name:	Laura Moore, President and Chief Executive Officer
Mailing Address:	Masspro, 245 Winter St., Waltham, MA 02451
Phone Number:	781-419-2711
Fax Number:	781-487-0083
Email:	lmoore@masspro.org

Section II Organization Information

Name:	Massachusetts Peer Review Organization, Inc. (Masspro)
Mailing Address:	245 Winter St., Waltham, MA 02451
Phone Number:	781-890-0011
Fax Number:	781-487-0083
Email:	info@masspro.org

Section III Response to Questions

1. Which of the options outlined in Appendix A do you believe best positions the QIO Program collectively, as well as QIO entities individually, to deliver maximum program value to beneficiaries?

   The rationale behind our recommendations in response to this Request for Information (RFI) attempts to address the overlying objectives that are outlined in Appendix A of the RFI. As stated in Appendix A, the Centers for Medicare and Medicaid Services (CMS) wants "to ensure that Quality Improvement Organizations (QIOs) deliver maximum impact to care in the Medicare program and value to taxpayers."

   Given the criteria above, Masspro believes that either maintaining the current contract structure, in which one contractor represents a single state/territory, or moving towards an approach more consistent with Option 3, consolidating contracts for those QIOs delivering services in multiple states or allowing offerors to develop their own regional structures, would enable CMS to achieve the following:

   - leverage infrastructure that currently exists, minimizing transition and ramp up costs that occur when restructuring contract work and transferring responsibilities to new contractors;
   - maintain expertise and the local presence required to engage health care providers to actively and consistently participate in successful quality initiatives; and

- minimize disruption to patient care provision as we continue on our collective journey to implement the Affordable Care Act (ACA) and improve health care not only for Medicare beneficiaries but for all individuals accessing health care services.

Our primary concern with Options 1 and 2 is that these particular regional models could result in CMS identifying and using contractors who would not necessarily have deep or broad expertise in the cultural or clinical practice environment for which they are performing their work. In some cases the regions, as defined in Appendix A, are actually unaffiliated and disparate in terms of how patient care is delivered. For example, the Hospital Referral Regions approach does not actually capture the referral patterns where most patient care is being provided today to Medicare beneficiaries. The settings lost in this regional structure include nursing homes, home health, and primary and specialty care. The quality improvement work and the financial investment that CMS has sponsored in previous contracts on improving clinical outcomes in these settings, perhaps most notably in reducing hospital readmissions by focusing on patient centered care and care transitions, could become compromised. We mention hospital readmissions specifically because this work has been highlighted at a national level with the recent article in the *Journal of the American Medical Association* which noted that this work has saved the Medicare program millions of dollars each year.

In addition, moving to these options would not enable CMS to access or leverage the current infrastructure it has in place with the existing QIO program. For example, where there are QIOs administering services across multiple states under these models there are several cases where these do not "fit" neatly into the proposed new regional structures which could result in extensive and/or confusing and drawn out procurement processes that could strain CMS staff and financial resources.

Lastly, we would ask CMS to carefully consider making significant or wholesale changes to how the quality improvement work is delivered at the same time it is regionalizing beneficiary review services. Too much change across the QIO program could result in provider confusion, decreased participation in CMS quality improvement initiatives and ultimately a decrease in the quality of patient care delivered to Medicare beneficiaries.

We would advise CMS to ensure that the contracting approach it ultimately adopts does not jeopardize the substantial gains in quality improvement that have already been achieved and sustained through the QIO program. We understand that there is potential value in consolidation, and we would ask that CMS consider adopting regionalization as a pilot initiative before seeking a wholesale change to the program. We believe there are two models that CMS could pursue that would establish a more scaled approach that would allow it to demonstrate and track both the clinical and financial results associated with a

regional versus state-based system. One is to simply consolidate states under one contract for those QIOs that already serve multiple states. For example, our neighboring QIO, Northeast Health Care Quality Foundation, is currently responsible for New Hampshire, Vermont and Maine. The QIO has three separate contracts, one for each state, and three separate Contracting Officer Representatives (CORs) to monitor the QIO's efforts in each state. It seems logical to consolidate the three states under one contract with one COR monitoring the work of the QIO. This would definitely help to achieve the CMS objective of reducing operational costs and redundancies (from an internal CMS perspective). The second approach is to request bids on contracts from QIOs that would propose the composition of the "region." As in the RFI, CMS can require that regions must still encompass full states to ensure state-wide improvement efforts across the nation. This approach would also maintain local presence and expertise that has broad and deep knowledge of CMS quality improvement efforts past and present.

2. What advantages would the program expect to realize by adopting each of the two options you articulated in your response to Question 1?

According to the Institutes of Medicine, when pursuing quality improvement in health care often it is not known "which factors will best yield widespread implementation: the success of particular knowledge, practice, or technology is context specific and depends on local conditions and human factors (Davidoff, 2009) (see Chapter 9 for discussion of the spread of ideas within an organization)" (p.164). To ensure that CMS has a substantial and meaningful positive impact on the quality of patient care delivered to Medicare beneficiaries and potentially all US citizens, it will be imperative for it to ensure that its contractors combine best practices with a local knowledge of community barriers and competing priorities. As stated above we believe this is best achieved through either Option 3 or 4. The advantages of either option include:

- Programs are administered and maintained by local contractors who are able to ensure the appropriate assignment of resources provided by CMS. Due to their familiarity with the challenges in patient demographics, disparities and distribution to services across care settings, as well as other available state resources, such as other quality improvement initiatives or expertise, help to ensure CMS is successful in its work.
- Continuing to use existing QIO personnel to deliver services maintains and leverages the established relationships with organizational leaders within trade organizations and providers. QIO staff has a local, in-depth understanding of the clinical environment that currently exists and the cultural dynamics within the settings where quality improvement must take place which is imperative to effect cultural change to ensure successful patient care delivery improvements that are sustainable.

In our own work as the QIO for Massachusetts we can point to quantifiable results that demonstrate how critical the above two points are in successfully implementing meaningful improvement in health care delivery systems that impact Medicare beneficiaries. In the current 10th Scope of Work, under Task C.8. Integrate Care for Populations and Communities our relative improvement rate (RIR) for 30-Day Readmission per 1,000 beneficiaries is trending at 20% both at the individual community and statewide levels. At the community level we attribute this to the ongoing and consistent on-site technical assistance our staff provides to the health care providers involved in this work. At the state-wide level, we have taken on a leadership role in facilitating a state-wide coalition with all the key trade organizations (such as the Massachusetts Hospital Association, the Coalition for the Prevention of Medical Errors, Massachusetts Senior Care Association, just to name a few) that enables us to identify and spread best practices across the entire health care delivery system.

- Under the current QIO program, we have seen that organizations outside of the state are capable of bidding on work in other states. Continuing to let this evolve through combining contracts for those QIOs that work in more than one state and allowing QIOs to propose combinations of states would avoid the loss of local support and collaboration opportunities that could occur in a "forced" regionalization model. As CMS is already aware, without provider buy-in and active participation it is ultimately the patient that suffers the consequences.
- Testing the regionalization model as described in the preceding bullet point should provide CMS with both cost and performance measurement data that it could then compare to its state-based contracting model to identify any additional value achieved.

We have reviewed the QIO contracting landscape that exists today. Adopting a model where CMS would simply award one contract to those QIOs who hold multiple states, versus multiple contracts representing each state, we calculated a 30% reduction in the number of contracts to administer. This is a significant reduction that could help CMS achieve its goal to reduce operational costs and administrative redundancy and may under-represent what could be achieved given that this simple analysis assumes no other consolidation between QIOs as we move toward the 11th Scope of Work.

3. How could CMS improve each of the two options selected from Appendix A to be sure that it delivers the most impact to patients' safety and well-being?

One of the strengths of the current CMS QIO program is that QIOs are required to have in place certain qualifications to establish them as a trusted resource for improving patient care for Medicare beneficiaries. We would suggest that CMS maintain some of the most critical elements of these requirements and that contractors should have the following in place:

- A governance structure that consists of a body of representatives that is diverse in their background and expertise including beneficiary, provider, practitioner and other stakeholders in their community.
- Ability to demonstrate and maintain competency and expertise in medicine, nursing, health information technology, health information management, statistics, health education, quality improvement, as well as other disciplines.
- Experience in systematically applying strict security and privacy standards in their handling of sensitive data and information;
- A proven history and ability to fulfill high standards and requirements in accounting and financial practices, ensuring integrity related to expenditures of Medicare Trust Fund dollars.

As indicated earlier in this response, to ensure that there are no unintended consequences or negative effects on Medicare beneficiaries, CMS should test change to the QIO contracting structure through pilots with local QIO contractor collaboration and consolidate existing state contracting where QIOs are delivering services in multiple states to effectively assess regionalization. Much of quality improvement work is based on implementing small scale tests of change to provide the ability to mitigate any negative effects proactively and more adeptly foster success.

4. What are some important factors for CMS to consider if the Agency were to adopt each of the chosen approaches in organizing QIO Program work this way? What else should CMS think about as it makes its QIO Program framework decision?

When reviewing the proposed regionalization approaches identified by CMS in this RFI, we could not find any evidence or research findings that support regionalization of QIO functions in order to achieve clinical improvements or improved health care outcomes as compared to the current state-based model. We again recommend that pursuing a pilot test model of regionalization would be a better approach to provide CMS with information as to whether or not consolidation does have an impact on cost, quality of care, efficiency in service delivery or contract administration efforts, as well as instill confidence in the ongoing contract model it determines to pursue to ensure effective quality improvement efforts that are also more efficient in terms of operational costs.

As a QIO we are partial to encouraging our clients to embrace the quality improvement principles that we are asking providers to put in place when working on CMS improvement efforts. Conducting small-scale tests of change are more in line with continuous quality improvement principles that we, Masspro and CMS, have been promoting and using very successfully for the past three scopes of work. We would encourage CMS to pursue this approach once again as it reviews it QIO contract administration practices and appreciate the opportunity to provide our input in this response.