

CHAPTER

# 4

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**Enhancing Medicare's  
technical assistance to  
and oversight of providers**

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# R E C O M M E N D A T I O N S

**4-1** The Congress should redesign the current Quality Improvement Organization program to allow the Secretary to provide funding for time-limited technical assistance directly to providers and communities. The Congress should require the Secretary to develop an accountability structure to ensure these funds are used appropriately.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

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**4-2** The Congress should authorize the Secretary to define criteria to qualify technical assistance agents so that a variety of entities can compete to assist providers and to provide community-level quality improvement. The Congress should remove requirements that the agents be physician sponsored, serve a specific state, and have regulatory responsibilities.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

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**4-3** The Secretary should make low-performing providers and community-level initiatives a high priority in allocating resources for technical assistance for quality improvement.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

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**4-4** The Secretary should regularly update the conditions of participation so that the requirements incorporate and emphasize evidence-based methods of improving quality of care.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

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**4-5** The Congress should require the Secretary to expand interventions that promote systemic remediation of quality problems for persistently low-performing providers.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

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**4-6** The Secretary should establish a public recognition program for high-performing providers that participate in collaboratives or learning networks, or otherwise act as mentors, to improve the quality of lower performing providers.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

# Enhancing Medicare's technical assistance to and oversight of providers

## Chapter summary

The Commission continues to be concerned about the slow pace of quality improvement and recognizes that Medicare has a responsibility to exercise its policy levers to accelerate improvement. The Commission has recommended numerous payment policy changes to encourage quality improvement. These changes include pay for performance, medical homes, penalties for high rates of hospital readmissions, and bundled payment. In this chapter, the Commission concludes that other policy levers—technical assistance and conditions of participation—can better complement the intent of recent changes in payment policy and contribute to quality improvement. Specifically, the Commission's recommendations aim to:

- fundamentally restructure the quality improvement organization program to give providers and communities the choice of who assists them and flexibility in how they use the resources.
- increase the number and variety of technical assistance entities that can assist providers and communities and introduce greater competition in the market.
- make technical assistance to low-performing providers and community initiatives a high priority as a strategy to complement payment policy and address persistent health care disparities.
- update the conditions of participation so that the requirements incorporate and emphasize evidence-based methods of improving quality of care.

## In this chapter

- Redesign Medicare's technical assistance program for quality improvement
- Stimulate the quality and value of technical assistance by increasing competition
- Target quality improvement funds
- Update conditions of participation to align them with current quality improvement efforts
- Improve provider accountability and oversight of COPs
- Publicly recognize high performers

- increase accountability of providers by expanding CMS’s use of interventions that promote system-wide remediation of quality problems among persistently low-performing providers.
- improve public recognition of high-performing providers that participate in learning networks to assist low-performing providers.

This package of recommendations seeks to address some of the problems that likely have constrained the effectiveness of Medicare’s technical assistance and oversight efforts in the past. While CMS’s management of the Quality Improvement Organization (QIO) program evolves to address past problems, the program has had difficulty in demonstrating its effectiveness; according to our recent interviews with various experts and stakeholders, the level of expertise of the current QIO contractors is perceived as uneven and, in some cases, unequal to the task. By reforming technical assistance while expanding the use of regulatory consequences for persistent low performance and creating a recognition program for high performers that help low performers, this package of changes could create a better balance in incentives and accountability for the whole spectrum of providers.

This package is also shaped by changes in the environment surrounding the QIO program. First, a growing number and type of organizations dedicated to supporting quality improvement have emerged and their expertise could benefit Medicare’s technical assistance program. In addition, payment policies (e.g., penalties for high readmission rates, hospital-acquired complications, value-based purchasing) have recently been enacted that are intended to create the incentive for providers, particularly hospitals, to improve their quality. A concern with these policies is that low performers subject to payment penalties—some of which are serving a poor or minority population facing public health challenges—will find it more difficult to improve because of the penalties. By directing technical assistance resources to these providers, Medicare could, at least in part, allay concerns about holding providers accountable when they serve a challenging or disadvantaged patient population. The goal of improved care should exist for all patients, regardless of health status, income, and race, but the Commission recognizes that those expectations are more likely to be met if they are combined with additional resources to accelerate the provider’s ability to address particularly challenging care delivery environments. Instead of lowering standards, the goal is to target assistance to those who need it most.

To be clear, this package of recommendations envisions fundamental changes to the current QIO program. No longer would there be a standing organization in every state financed by the federal government to ask providers to participate in

quality improvement activities as QIOs do today. Instead, funding would be made available directly to providers and communities—with a focus on those that are low performing or that face a challenging environment—for them to purchase technical assistance in the market.

These recommendations reflect the Commission’s judgment that it is time to try another approach to supporting quality improvement. There are reasons to believe the structure we outline will be effective, but success is not certain. For this reason, the grant program should be independently evaluated at a reasonable interval after inception to determine its efficacy. In addition, the Commission’s recommendations are intended to be directional and do not address all implementation issues likely to arise. We recognize that administrative challenges may require that these changes be implemented in stages and expect that administrative feasibility will be taken into consideration in shaping implementation.

We pursue these ideas while noting that CMS continues to work to improve the QIO program. CMS is in the process of finalizing the 10th statement of work, the three-year contract that governs the work of the QIOs, that begins in August 2011. Concurrently, the fiscal year 2012 President’s budget includes several legislative proposals to address problems the Commission and others have raised (Institute of Medicine 2006, Medicare Payment Advisory Commission 2010). They include changing the geographic scope of QIO contracts, eliminating the conflict of interest between beneficiary protection and quality improvement activities, and expanding the pool of contractors eligible for QIO work. However, the Commission’s package of recommendations goes further than these proposals and initiatives, particularly as it would redirect funding for technical assistance to providers and communities and emphasize a strategy for focusing on and engaging low performers, improving accountability for low performance, and recognizing the role of high performers in helping low performers. ■



The Commission's June 2010 report highlighted the evidence of the slow pace of quality improvement in Medicare (Medicare Payment Advisory Commission 2010). More recently the Commission's analysis of overall inpatient hospital quality found that, from 2006 through 2009, risk-adjusted in-hospital and 30-day mortality rates declined for 5 major clinical conditions, but patient safety indicators for 7 monitored conditions did not improve significantly, and readmission rates remained unchanged (Medicare Payment Advisory Commission 2011). This research suggests there is considerable room for quality improvement in reducing readmissions and hospital-acquired infections as well as in eliminating errors in the delivery of care that result in harm to patients.

Other recent studies add to the sense of stagnancy in quality improvement. A study looking at 10 hospitals in North Carolina over 6 years found a common rate of harm to patients that remained unchanged over the period, despite extensive national efforts to improve patient safety (Landrigan et al. 2010). The Department of Health and Human Services Office of Inspector General examined a small nationally representative random sample of Medicare beneficiaries discharged from inpatient hospitals during October 2008 and estimated that 13.5 percent of hospitalized Medicare beneficiaries experienced serious adverse events during their hospital stays. An additional 13.5 percent of beneficiaries experienced events during their hospital stays that resulted in temporary harm. Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable (Levinson 2010). Another study looking at three of the nation's large leading hospitals found similar rates of adverse events (Classen et al. 2011).

Medicare has a number of ways to encourage quality improvement. Among them are the technical assistance provided through the Quality Improvement Organization (QIO) program and Medicare's standards for providers' participation in the program, known as the conditions of participation (COPs). To understand these efforts in context, it is helpful to enumerate the other prominent levers Medicare has to influence quality:

- **Payment policy**—The way Medicare pays for covered benefits influences how and what care is delivered, particularly because Medicare is the single largest purchaser in the market. Over the next few years, Medicare will begin to adjust for most

health care services some portion of payment based on the quality of care. Hospital payment policies aimed at quality improvement include value-based purchasing, reduced payment for hospital-acquired conditions, and penalties for relatively high rates of readmissions. In addition, through its demonstration authority, Medicare is experimenting with payment policies aimed at quality (and efficiency) improvement, including additional payments for medical homes and shared savings programs such as disease management and the physician group practice demonstration. Recently, CMS announced a five-year demonstration project that will provide grants to hospitals working in tandem with community-based organizations or to community-based organizations directly to offset the costs associated with better managing care transitions.

- **Public reporting**—Medicare's share of the market and volume of claims allows it to measure the relative performance of providers on a variety of quality metrics. Increasingly, Medicare is publicly reporting the results by provider on its website (e.g., Hospital Compare, Home Health Compare, Medicare Advantage Compare), allowing providers to see how they compare with their peers and allowing beneficiaries to make more informed choices about their care. Providers, often citing professional pride, note that this public display has motivated improvement. There is less evidence that beneficiaries are widely using the data. Public reporting is evolving as consensus around new measures emerges and older measures that have exhausted their usefulness are retired.
- **Medical education**—Medicare has a large role in financing the nation's medical education system (spending \$9.5 billion in 2009); its policies can influence the number of physicians and nurses trained and the nature of their training. The Commission has noted that Medicare requires minimal accountability from the recipients of this funding and has recommended that a portion of the funding be allocated based on standards specifying ambitious goals for practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice (Medicare Payment Advisory Commission 2010).
- **Benefit design**—Several aspects of benefit design can be used to promote improved quality. For example,

under a value-based insurance design, Medicare has eliminated cost sharing for preventive services (e.g., bone mass measurement, flu vaccinations) to encourage beneficiaries to use these services. Another approach that private insurers have taken is to rank providers in tiers based on their performance on quality metrics and to charge beneficiaries lower cost-sharing rates for seeking care from providers in the higher tiers. Another way to potentially improve quality is through coverage decisions so that Medicare covers only care known to be medically necessary and effective.

The federal government has agencies and programs other than Medicare designed to influence the quality of care provided nationally. They include the Office of the National Coordinator for Health Information Technology, the Federal Coordinating Council for Comparative Effectiveness Research, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the National Institutes of Health, the Health Resources and Services Administration, and the Institute of Medicine. In addition, the Medicaid program and the Department of Veterans Affairs have their own policies, which can influence providers' quality improvement activities.

In this environment, we examine how Medicare can better use the resources and leverage of its QIO program and conditions of participation, and we make several recommendations for improvement. This package of recommendations seeks to address some of the problems that likely have constrained the effectiveness of Medicare's technical assistance and oversight efforts in the past. While management of the QIO program evolves to address past problems, the program has a history of not demonstrating its effectiveness and even now, according to our interviews with experts and stakeholders, the expertise of its contractors is perceived as uneven and, in some cases, unequal to the task.

While some QIOs have certainly provided outstanding service, the growth over the past decade in the type and number of entities devoted to quality improvement combined with the emergence of new payment incentives presents an opportunity to improve the effectiveness of these resources. By reforming technical assistance while expanding the use of regulatory consequences for persistent low performance as well as a recognition program for high performers, this package of changes could create a better balance in incentives and accountability for the whole spectrum of providers.

These recommendations reflect the Commission's judgment that it is time to try another approach to supporting quality improvement. There are reasons to believe the new structure we outline might be effective, but success is not certain. For this reason, the grant program should be independently evaluated at a reasonable interval after inception to determine its efficacy. In addition, the Commission's recommendations are intended to be directional and do not address all the implementation issues that are likely to be implicated. To the extent that these recommendations are pursued, the Commission will have additional opportunities to address those issues.

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### **Redesign Medicare's technical assistance program for quality improvement**

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In the current three-year contract for QIOs known as the ninth statement of work (SOW), Medicare is spending \$1.1 billion to support the QIO program. Most of that money goes to private QIOs, mostly not-for-profit organizations, to perform activities related to quality improvement in specific clinical areas (e.g., pressure ulcers, methicillin-resistant *Staphylococcus aureus* (an antibiotic-resistant bacterium), surgical infections, and care transitions) and beneficiary protection (e.g., handling beneficiary complaints and other review activities). Currently, 41 QIOs hold 53 contracts to provide services in every state as well as in Puerto Rico, the Virgin Islands, and the District of Columbia.

Technical assistance funds now go directly to the designated QIOs, and it is incumbent on them to reach out to providers and encourage improvement. However, if the funds instead went directly to the providers and communities, who in turn would use the grant money to purchase technical assistance from a qualified agent of their choice, providers and communities would be more constructively engaged in sustained quality improvement.

Under this approach, providers and communities would be empowered to select the technical assistance agent best suited to their needs. Accordingly, technical assistance agents working with their clients would conduct a needs assessment to determine their process and organizational defects and have the flexibility to determine how technical assistance would be best provided. The focus of the assistance could vary by provider and community. For some, quality problems stem from the challenges of

meeting the needs of a poor population, a geographically isolated population, or a culturally diverse population. For example, providers may lack the cultural competency to communicate with patients in ways that overcome language barriers and take into consideration key factors, such as patients' perspectives, lifestyle, and preferences, all of which can influence outcomes. For other providers, problems stem from not understanding how to collect and manage their data to identify quality problems, from operating in a culture that does not promote safety, from having limited physician cooperation, or from experiencing high staff turnover so that the benefits of training efforts are quickly lost. Under the approach envisioned here, technical assistance would be tailored to the provider as it strives to meet the needs of the community.

In addition, because objectively measuring the effectiveness of quality improvement interventions is so challenging, introducing competition and provider choice could be an important force in promoting effective assistance. Providers and communities would be able to vote with their feet, ideally basing their choice on expertise and the experience of fellow consumers (i.e., other providers and communities).

To be clear, under this approach, there would no longer be a single organization designated to serve a state. Providers and communities receiving a grant could choose to work with organizations that previously served as QIOs and met CMS criteria for technical assistance agents, but, presumably, there would be other organizations to choose from as well. The beneficiary protection functions, such as receiving and investigating complaints, would be moved to another entity, which would avert the current conflict of interest concerns and ideally yield some efficiency gains.

There are numerous considerations in how the technical assistance grants would be allocated to providers and communities, a few of which we address here. First, some low performers might not know how poorly they are doing or might not be equipped to make an informed choice. They might need guidance, which could come in the form of oversight of compliance with the COPs, as discussed later in this chapter (see p. 109). Surveyors and accreditors could be responsible for helping providers assess their needs and for informing them of their choices. Alternatively, CMS, either directly or through a contracting entity, could be responsible for providing that direction, particularly if the provider is at risk of failing to meet the COPs. Poorly performing communities may be similarly unaware of their relative performance.

Therefore, CMS may also have a role in identifying these communities and suggesting that they avail themselves of technical assistance resources.

Second, CMS would need to establish criteria for how grant money will be allocated and how it can be used. One possibility is that the magnitude of the grant could vary depending on the relative needs of the grantee. For example, some could receive larger grants to be used for one-on-one assistance, while others could receive smaller amounts sufficient to offset the costs of participating in a learning collaborative being offered in the private sector. Helping to support provider participation in private learning collaboratives could be a cost-effective way to increase the number of providers who gain from this funding. Additional considerations in prioritizing who receives grants would be the provider's performance on quality measures (addressed later in this chapter, p. 106), the likelihood that significant improvement will result, and the financial resources of the provider. In addition, whether the grant money can be used for costs associated with quality improvement (such as health information technology or staff), rather than solely for technical assistance, will need to be determined. If flexibility is allowed, sustainability of those improvement activities when the technical assistance grant has ended should be planned for.

Third, the grant program would need to hold providers and communities accountable for use of the funds. The burden of accountability would be largely on the provider or community that receives the funds. Low performers must improve performance; if not, they will face payment penalties through new payment policies such as value-based purchasing, readmission penalties, and reduced payment for hospital-acquired conditions. Further accountability could be imposed through oversight of compliance with the conditions of participation (see discussion, p.109). For example, very-low-performing providers who do not improve within a reasonable interval after having received assistance could be terminated from Medicare. The need for accountability also suggests that communities should be defined as provider-led coalitions or entities, as providers can ultimately be held accountable for poor performance. In addition, spending of this federal grant money (i.e., the current QIO funds) should be transparent and subject to audit.

For technical assistance agents, the quality of the assistance will, at least in part, be evident by their ability to improve the performance of their clients on the mix

of measures discussed above. This assessment could be complemented by clients’ qualitative reviews, so that even if the improvements in performance were not yet evident in the data, improvements in culture or processes (e.g., new procedures, management changes) that should soon lead to measurable improvements could be noted. Similarly, providers who thought their performance improved despite the role of the technical assistance agent could report that to CMS. The record of improvement as well as these reports could be made available to the marketplace, much as is done by Consumer Reports, Angie’s List, and other websites that provide feedback from former customers to prospective customers.

Fourth, to create an effective market of technical assistance agents, CMS would need a structure conducive to producing good “consumer” information; relying on market forces can work well only if adequate information is available to consumers (i.e., providers and communities). For example, the agency could create an online marketplace, where providers would see their choices of technical assistance agents (those who have met the standards and agreed to the transparency requirements associated with the program that serve their geographic area). Each agent’s record of improving performance would be posted along with qualitative reviews by previous clients. In addition, technical assistance agents would include marketing material that indicates their area of expertise. Being able to access this information in one place should facilitate the best match between providers and assistance agents.

In considering these changes, we are mindful of the budgetary impacts. This recommendation is designed to redirect current resources and not increase spending. The Commission recognizes that quality improvement is important and some may believe it deserves significantly more federal resources than are currently available. However, quality improvement should be central to every provider’s mission and should not be considered an extra function that needs separate funding on a routine basis. At the same time, some providers simply may not have the knowledge to undertake the breadth of initiatives required, or they may face a particularly challenging environment. Because the consequences of these challenges adversely affect the quality of care for beneficiaries, Medicare has a role in supporting providers’ quality improvement efforts to the extent that its support is effective.

We recognize that changing the program as outlined here entails new administrative tasks for CMS to perform or oversee—for example, grant making, setting up a web-

based marketplace, and approving assistance agents—but the current program requires substantial resources and staff to manage, and they can be redirected.

#### RECOMMENDATION 4 - 1

**The Congress should redesign the current Quality Improvement Organization program to allow the Secretary to provide funding for time-limited technical assistance directly to providers and communities. The Congress should require the Secretary to develop an accountability structure to ensure these funds are used appropriately.**

#### RATIONALE 4 - 1

Directing financial assistance to providers who in turn seek out technical assistance creates a more competitive marketplace, which could improve the quality of technical assistance offered. In addition, it could increase the likelihood that the provider and community receive assistance relevant to their quality improvement needs.

#### IMPLICATIONS 4 - 1

##### Spending

- Spending would be constrained to no more than the QIO program funding levels.

##### Beneficiary and provider

- To the extent that providers are responsive to the intent of technical assistance funding, beneficiaries should receive improved care. Providers would receive the technical assistance funds directly.

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### Stimulate the quality and value of technical assistance by increasing competition

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In the last decade, an increasing number of organizations have gotten involved in spreading quality improvement, including national quality organizations, professional associations, providers (e.g., Geisinger Consulting Group was formed by the Geisinger Health System to advise other providers about innovative strategies to improve quality and transform the delivery system), consulting firms, and regional health improvement collaboratives. For example, more than 40 regional health improvement collaboratives around the country—many of which have recently formed—help improve quality by measuring performance, providing training and assistance to providers, and coordinating the health

improvement activities in the community (Network for Regional Healthcare Improvement 2011). Ideally, Medicare-sponsored technical assistance would draw on the expertise of this diverse and growing set of organizations. Under the current QIO program, it does not. A variety of requirements serve as barriers to entry for other organizations. In the ninth SOW, CMS awarded a new QIO contract to only one new contractor (another QIO). Competition for new QIO contracts is usually from organizations serving as QIOs in other states.

One barrier is that QIOs must serve an entire state. Some entities may not be prepared to serve a whole state but might be particularly good at helping specific types of providers, such as those in a given region of the state or rural providers. The current requirement that each state have a QIO can result in money being directed to states where providers are generally good, leaving a smaller portion of funding for states with greater need.

Another well-noted barrier is that QIOs be either a “physician-sponsored” or a “physician-access” organization. These designations require specific thresholds for the number of physicians in the organization’s ownership or membership and serve to limit competition for designation as QIOs.

A third barrier is the requirement that QIOs perform regulatory oversight as well as receive and investigate beneficiary complaints. Currently, QIOs have responsibility for addressing beneficiary complaints about quality-of-care concerns and conducting other reviews of the adequacy of care and billing, such as reviewing medical records to determine whether a hospital emergency department failed to provide federally mandated emergency medical care or whether a hospital request for a higher paying diagnosis related group is appropriate.

Aside from creating other problems, these requirements may preclude some good technical assistance agents from competing to participate as QIOs. First, organizations that specialize in technical assistance may not want to develop the expertise and infrastructure to perform the oversight functions. Second, a QIO’s regulatory responsibilities can restrict its technical assistance activities because of concern about potential conflicts of interest. In general, QIOs are not permitted to accept payment from the same entities over which they have regulatory authority. This restriction can limit the ability of the technical assistance experts to develop and maintain other lines of business outside the QIO contract.

These restrictions must be lifted to expand the pool of expertise and the competitiveness of the program. Some requirements would be necessary to ensure that only legitimate organizations with experience are eligible to participate and that conflicts of interest are avoided; the Secretary would need to develop those criteria. Given those assurances, however, a diversity of technical assistance agents could be encouraged. In this way, organizations participating in the private sector on quality improvement could be available to work with the providers and communities in greatest need. In the absence of the restrictive provisions, technical assistance agents could be available, for example, to address rural problems or to focus on data management, inner city challenges, or management issues. Expanding the pool would not mean that organizations that currently function as QIOs would be excluded; given their experience with Medicare providers, they would be expected to meet the criteria for participation and compete successfully for business.

#### RECOMMENDATION 4-2

**The Congress should authorize the Secretary to define criteria to qualify technical assistance agents so that a variety of entities can compete to assist providers and to provide community-level quality improvement. The Congress should remove requirements that the agents be physician sponsored, serve a specific state, and have regulatory responsibilities.**

#### RATIONALE 4-2

Currently, multiple barriers exist to prevent a broader array of technical assistance agents from competing for Medicare funding to assist providers and communities in quality improvement. Increased competition should result in more effective technical assistance being available to providers and communities. An entity not engaged in technical assistance could assume the beneficiary protection and other regulatory responsibilities currently provided by QIOs.

#### IMPLICATIONS 4-2

##### Spending

- There are no direct spending implications.

##### Beneficiary and provider

- To the extent that providers are responsive to the intent of the incentive, beneficiaries should receive improved care. Some providers would receive technical assistance directly.

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## Target quality improvement funds

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The Commission is supportive of collaboratives and learning networks, where providers share their experiences, benchmark their performance to others', and learn from their peers' successes and failures. Many in the field find that significant benefits can come from allowing peer-to-peer learning and mentoring relationships to develop. However, the Commission believes it is important to underscore the value of assisting low-performing providers. In addition, the Commission recognizes the value that can be gained from supporting community-wide quality improvement initiatives.

### Low-performing providers

There are at least two advantages of targeting quality improvement funds to low performers. First, this approach can help providers respond to new payment policies that hold them accountable for poor quality of care. These policies include payment penalties for high readmission rates, hospital-acquired infections, and poor performance on quality measures as part of the value-based purchasing program for hospitals. A concern with these policies is that low performers subject to payment penalties—some of which are serving a poor population facing public health challenges—will find it more difficult to improve because of the penalties. By directing technical assistance resources to these providers, Medicare could, at least in part, allay concerns about holding providers accountable when they serve a challenging or disadvantaged patient population. The goal of improved care should exist for all patients, regardless of health status, income, and race, but the Commission recognizes that those expectations are more likely to be met if they are combined with additional resources to accelerate the provider's ability to address particularly challenging care delivery environments. Instead of lowering standards, the goal is to target assistance to those who need it most.

Second, focusing technical assistance on low performers could help address disparities in care. Where beneficiaries receive their care matters. Different facilities have dramatically different levels of success, and this difference matters especially for minorities because they tend to receive most of their care from physicians and hospitals that tend to have lower quality (Bach et al. 2004, Jha et al. 2007). For example, among African American beneficiaries in a market with high racial segregation, the risk of admission to a high-mortality hospital was 35 percent higher than for whites in the same market

(Sarrazin et al. 2009). Another study found that risk-adjusted mortality after acute myocardial infarction was significantly higher in hospitals that disproportionately served African Americans (Skinner et al. 2005). Another study, which uses volume as a proxy for quality of care by looking at services where a volume–outcome relationship has been established, found that African American patients of all ages and insurance types in the New York metropolitan area from 2001 to 2002 were significantly less likely than white patients to use a high-volume hospital for all but one of the services examined; Hispanic patients were less likely than whites to use high-volume hospitals for 15 of the 17 services (Gray et al. 2009). The observed differences in the use of high-volume hospitals did not seem to be accounted for by proximity (minorities tended to live closer to the high-volume hospitals) or insurance status (differences persisted among patients with the same insurance coverage). Similarly, African American patients have been found to enter the worst-quality nursing homes (Angelelli et al. 2006).

The success of technical assistance targeted to low performers will depend on the metrics used to rate performance. Evaluation of a provider's performance should be based on outcome measures, which include measures of “systemness,” select process measures, patient experience measures, functional status, and findings from survey and certification agencies. The mix and weighting of these components would evolve to allow for changes that reflect the latest findings in reliability and value in quality measurement. The process for their development should be evidence based and transparent.

A concern with focusing on low performers is that some are unlikely to improve even with assistance. When certain ingredients are absent—effective leadership, for example—culture change and quality improvement may be elusive, even with sound technical assistance (Curry et al. 2011). This possibility may be minimized by empowering the targeted providers with choice and flexibility about the type of technical assistance needed to help their institution. For providers resistant to improving quality, this package of recommendations seeks to expand oversight interventions that can further improve care. An example is system improvement agreements in which a provider makes a substantial investment in quality improvement as an alternative to termination from participation in Medicare (see p. 111). Combining assistance to low performers with the structure and accountability of these agreements may be critical to increasing the likelihood of improved quality. In

addition, current law allows for termination without these agreements, and that may well be appropriate for providers who have poor quality and are functioning in a community where other providers can meet patients' needs.

While the reasons for focusing on low performers are compelling, the success of collaboratives that bring a variety of providers together warrants flexibility in allocation of technical assistance resources. Lessons can be learned and shared from helping midrange performers who face challenging environments. In addition, high performers can function as models and mentors and can help motivate struggling providers. For these reasons, some share of quality improvement resources could remain available for technical assistance to midrange and high performers.

### Communities

Another consideration in targeting technical assistance resources is the need to address the fragmentation—or lack of “systemness”—in health care delivery, which can be particularly problematic for Medicare beneficiaries who are often dealing with multiple chronic conditions and declining functional status. Bringing all the resources together in a community—physicians, community health centers, and hospitals as well as local government agencies, nonprofit social services, and patient advocates—could be especially productive in developing more comprehensive care and strategies that can prevent readmissions, initial admissions, and emergency department visits. Therefore, assistance should also be available to communities so that a combination of providers and stakeholders can work together to address problems. Assistance could be restricted to those communities that face challenges as measured by Medicare data on cost and quality, or eligibility could be open to any community that demonstrates initiative and commitment to use the funds to improve the health of the community regardless of the challenges present. QIOs, working on the Care Transitions project, under the ninth SOW, have worked with communities to reduce readmission rates and report success (Brock and Goroski 2010).

Communities could also be defined as a group of providers seeking to work together to address a common problem—one that they share but that is not necessarily related to local coordination of care. Accordingly, an additional approach may be to allow groups of a given provider type (e.g., hospitals, nursing homes), including those that are geographically disparate, to apply to use the funds

to collectively improve a quality problem like hospital-acquired conditions or culture change.

### RECOMMENDATION 4-3

**The Secretary should make low-performing providers and community-level initiatives a high priority in allocating resources for technical assistance for quality improvement.**

### RATIONALE 4-3

Targeting Medicare's limited technical assistance resources to low performers would help to balance the intent of payment policies that financially penalize low performers, may reduce racial disparities in quality of care, and will minimize displacement of private resources. However, the Commission recognizes the value of engaging a spectrum of expertise in addressing quality problems and believes flexibility is warranted. Community-level initiatives should be a high priority because they can effectively address issues such as care transition and chronic disease management as well as issues that groups of providers collectively identify and commit to addressing.

### IMPLICATIONS 4-3

#### Spending

- There are no direct spending implications.

#### Beneficiary and provider

- To the extent that providers are responsive to the intent of the incentive, beneficiaries should receive improved care. Minority beneficiaries in particular should benefit from improved quality of care.

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### Update conditions of participation to align them with current quality improvement efforts

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Another way Medicare can stimulate quality improvement is by reforming its COPs—the minimum standards that certain provider types are required to meet to participate in Medicare—and their enforcement. Providers, state governments, and the federal government collectively spend millions of dollars annually preparing for and conducting surveys to ensure compliance with these standards, yet it is unclear if and to what extent these efforts have accelerated the pace of change.

COPs are heavily structural requirements and have not been broadly updated, particularly for hospitals, in a

long time. While the COPs require that facilities conduct “quality improvement activities” and processes like reporting drug administration errors, they do not broadly require that providers adopt processes that are known to improve quality. They also do not require that providers demonstrate improvement or efforts to improve their performance on publicly reported quality measures. Yet, anecdotal evidence suggests that better performing facilities are adopting process improvements (e.g., checklists to prevent central line infections, medication reconciliation, adhering to hand-washing protocols) and are focused on measuring and improving their performance on widely accepted quality measures.

The COPs could be updated to build in and reinforce the importance of making the process changes that improve outcomes. At the same time, COPs could be changed to better reflect organizational structures that have evolved (e.g., vertically integrated entities that have streamlined management responsibilities) and reduce the perception that being surveyed for compliance with the COPs is like “death by a thousand duck bites” (as observed by Robert Wachter, a noted expert on patient safety and health care quality). CMS recognizes the need for revisions and has begun drafting a proposed rule updating the hospital COPs.

New requirements that could be included in the COPs to accelerate improvement in outcomes are discussed below:

- ***Improved performance on publicly reported measures***—For hospitals, the publicly reported measures could be those used for Hospital Compare. An advantage of this measure set is that they are widely accepted as valid indicators of quality and that specifics about reporting performance are well known. A disadvantage of focusing quality improvement efforts around these measures is that they focus on three conditions: acute myocardial infarction, pneumonia, and congestive heart failure. Facilities can respond by hiring nurses to work on quality for those conditions and make no other system-wide changes that improve quality. The Joint Commission is considering whether to require demonstrated improvement as part of its accreditation process and is seeking comment on the idea.
- ***Compliance with hand-washing protocols and discharge instructions***—At the November 2010 Commission meeting, Robert Wachter suggested using two measures that would reflect a greater commitment to quality improvement facility wide: compliance

with hand-washing protocols and with getting discharge instructions to the appropriate community provider within 48 hours of discharge. Hand-washing has been shown to be a highly effective strategy in reducing hospital-acquired infections, while poor communication between the hospital and community physicians is associated with higher readmission rates. How compliance is defined, measured, and audited are significant issues to be addressed in pursuing this approach since a national consensus on these measures has not been achieved.

- ***Compliance with the Joint Commission’s National Patient Safety Goals***—Currently, the Joint Commission has requirements called National Patient Safety Goals that are surveyed as part of its accreditation process. These requirements go beyond the COPs and include processes known to reduce central line infections, harm associated with anticoagulant therapy, and wrong-site surgery, for example.
- ***Participation by and accountability for physicians with respect to patient safety activities***—Physician leaders have called for more accountability and consequences for physicians, saying that “as long as transgressions carry no risk of penalty, some providers ignore the rules, believing that they are not at risk for the mistake the practices are designed to prevent, that they are too busy to bother, or that the practice is ineffective” (Wachter and Pronovost 2009). To encourage hospitals to monitor physician actions in the hospital for appropriateness, the COPs could require hospitals to demonstrate that physicians individually and as medical staff share accountability for patient safety.

This type of requirement can vary in its stringency. At the least, the COPs could require that the hospital demonstrate that physicians participate in activities such as using checklists or team-based training (Livingston 2010). Increasing in rigor, the COPs could require that hospitals develop their own penalties for clinicians’ failure to adhere to safe practices, such as failure to practice hand hygiene, mark the surgical site to prevent wrong-site surgery, or use a checklist when inserting central venous catheters (Wachter and Pronovost 2009).

Any changes to the COPs must be written in a way that allows for innovation and evolution that can lead to

higher quality health care as well as new models of health care delivery.

Our recommendation focuses on the COPs specifically, but multiple levels of regulation govern how they are implemented, and the way that each is developed and pursued affects the ability of these standards to drive productive change. The COPs state requirements at the broadest level.<sup>1</sup> Interpretive guidance exists as well as state manuals. Currently, changes to the interpretive guidelines are made without formal public comment. While this process improves the speed with which they are updated, the lack of formal input can potentially lead to counterproductive requirements. Updating the COPs more regularly should help address tensions that have recently arisen in the context of revisions to interpretive guidance.

#### RECOMMENDATION 4-4

**The Secretary should regularly update the conditions of participation so that the requirements incorporate and emphasize evidence-based methods of improving quality of care.**

#### RATIONALE 4-4

CMS has not regularly updated the COPs to include evidence-based processes that lead to high-quality care. By incorporating such processes, oversight of health care providers' compliance with the COPs could be more productive in driving quality improvement.

#### IMPLICATIONS 4-4

##### Spending

- There are no direct spending implications.

##### Beneficiary and provider

- To the extent that providers are responsive to the intent of the incentive, beneficiaries should receive improved care. Providers may find the survey process more constructive.

##### Improve provider accountability and oversight of COPs

Oversight of COPs is achieved through surveys by state agencies or by CMS-approved accrediting bodies. Some providers do not have a choice—for example, only state agencies survey nursing homes and dialysis facilities. In contrast, hospitals are given the option and about 80 percent of short-term, acute care hospitals are surveyed

by CMS-approved accrediting bodies; however, state surveyors survey some accredited hospitals in response to complaints or as part of a “look behind” effort to verify the work of accreditors. If a state survey agency finds that a provider fails to meet the conditions, that provider can be terminated from the Medicare program. While potentially a very powerful tool given the large adverse financial effect it would have for the vast majority of providers, it is rarely used.

A problem with oversight of the current survey and accreditation process is the limited range and use of intermediate consequences for significant violations of the criteria, particularly for hospitals. The concern is that this limitation results in poorly performing providers continuing to provide care without taking steps to change the institution's culture and its commitment to quality care. The discussion below explores existing tools and, in some cases, the possibility of expanding their use to a broader set of providers. Ultimately, the Commission finds the greatest promise in requiring system-wide remediation.

##### Levels of accreditation

In general, the accreditation process includes reviewing compliance with and encouraging improvement on the COPs. For example, the Joint Commission, the largest accrediting body, has different levels of accreditation that indicate the extent to which providers meet the COPs. In 2008, there were three levels: full, conditional, and preliminary denial of accreditation. In that year, 94.7 percent of hospitals that applied for accreditation received full accreditation and 4.6 percent received conditional accreditation (Tucker 2010). Under conditional accreditation, a facility is subject to more frequent surveys to check that problems have been addressed. Virtually no hospital is denied accreditation once an application is initiated, partly because providers who face the prospect of denial often withdraw from the process. In the past year, the Joint Commission revamped its levels of accreditation so that the designations are now: full accreditation, accreditation with follow-up survey, contingent accreditation, and preliminary denial of accreditation. At the moment, the Joint Commission staff is unsure whether all these various distinctions will be publicly available (Kurtz 2011).

Accreditors do not have enforcement authority. Even if they find a substantial violation of a condition or a situation that may pose immediate danger, they do not report it to the state agency. Instead, they issue requirements for improvement and conduct more frequent

inspections; in very rare circumstances, they deny accreditation. In addition, accreditors have recently begun submitting their survey results to CMS on a regular basis.

## **Financial penalties**

When state surveyors find problems, depending on the type of facility, intermediate sanctions exist that impose financial penalties. For example, nursing homes and laboratories in violation of COPs can be subject to civil monetary penalties (CMPs). Nursing homes can be denied payment for new admissions. Hospitals are not subject to these types of penalties.

Expanding the use of financial penalties to other providers is an option but raises some issues. First, given recently enacted payment system penalties for poor quality (i.e., hospital value-based purchasing and high rates of readmissions), imposing additional penalties outside the payment system may penalize a provider twice for the same problem. To avert “double jeopardy” but still allow additional enforcement tools for failure to adequately meet the COPs, individual providers could be exempted from additional penalties, like CMPs, if they already incurred penalties under the payment system.

Second, financial penalties may undercut the ability of providers to improve quality since the penalty would drain needed resources. Third, to the extent that some providers view CMPs for quality problems as the “cost of doing business” and still not make needed improvements, their effectiveness is limited.

In this context it is worth noting an innovation the Congress recently adopted. With regard to nursing home CMPs, the Patient Protection and Affordable Care Act of 2010 provided CMS with the ability to reinvest Medicare CMP funds back into quality improvement activities for nursing homes. A subsequent CMS administrative rule provides that 90 percent of such funds will be reinvested. Funds may be reinvested in different nursing homes or in the same nursing home for which the CMP was applied, thereby allowing a facility’s lack of resources to be less of a factor when quality improvements are to be made.

## **Public disclosure**

Low-performing providers can be identified publicly, either solely through their performance on process or outcome measures or in tandem with survey results. Under Medicare’s Special Focus Facility (SFF) program, nursing homes designated as deficient are identified publicly (on Nursing Home Compare) and the board of each facility

is informed of the designation. No such program applies to hospitals. While online sites such as Hospital Compare identify poor performance on specific measures, they do not inform consumers that a facility has systemic quality problems that were detected by surveys.

The SFF program was created in 1987 to decrease the number of persistently low-performing nursing homes by focusing attention on them, and it has been strengthened over time. CMS has historically created a list of the 15 worst performing nursing homes in each state based on the number and severity of deficiencies cited on standard surveys, and states have discretion about which of them to choose for the program. States are then instructed to increase scrutiny of SFFs with more frequent surveys and to impose sanctions (e.g., CMPs) that increase in severity when the SFF does not improve.

The Government Accountability Office (GAO) finds the SFF program to be “essential” to protecting highly vulnerable beneficiaries and identifies the recent requirements for public disclosure and communication with boards as positive additions to the program. Interestingly, GAO found that some SFF facilities improved even though they may not have been surveyed as frequently as required or subjected to more robust enforcement, as the program requires (Government Accountability Office 2010). In addition, while most SFFs improved their performance, some failed to sustain their improved performance after graduation. Some states have added more aggressive policies around the SFF program. For example, Michigan sends a notification letter to all SFF candidates explaining that they are at risk of being selected as an SFF if they fail to address performance problems (Government Accountability Office 2010). The GAO recommended this practice to CMS, and CMS has implemented it nationwide.

Another approach to publicly identifying both low and high performers is exemplified in Nursing Home Compare’s five-star system. This system reflects overall nursing home performance across three domains: quality measures, staffing ratios, and survey findings.

## **Demonstrated remediation of violations**

Another type of consequence for poor performance imposed by CMS (in coordination with state survey agencies and regional offices) requires remediation of the identified violations. Among the less stringent measures are corrective actions required to address specific deficiencies within 2 (for immediate jeopardy) to 90 days, depending on the scope and severity of the problems,

to avoid termination from Medicare. This approach tends to result in quick fixes that are stopgap rather than transformative. Surveyors and facilities alike generally agree that they are not often triggering the kind of change needed, and one study found that enforcement of corrective action plans in nursing homes could be minimal (Louwe et al. 2007).

A more stringent measure before termination involves the temporary takeover of a facility's management. When a nursing home is cited with one or more deficiencies that constitute immediate jeopardy to resident health or safety, the law allows for federal temporary management. The temporary management appointed by CMS has full authority to hire, terminate, and reassign staff; spend nursing home funds; alter nursing home procedures; and otherwise manage a home to achieve its objectives. In reviewing the program, GAO found that most homes under temporary management (15 between 2003 and 2008) corrected deficiencies in the short term, although some continued to have compliance issues in the longer term. One limitation of this program is the lack of a cadre of temporary managers ready to step in. GAO has recommended that such a resource be developed to gain more from this authority. In addition, it recommends that CMS develop best practices for states and regional offices in implementing federal temporary management (Government Accountability Office 2009).

An approach that falls in the middle of the spectrum is to directly engage persistently poorly performing providers in system-wide, meaningful improvement. To demonstrate improvement, providers would need to perform a root cause analysis of their problems and demonstrate their efforts to ameliorate the situation. This effort could include being required to contract with a technical assistance agent or join a learning collaborative in clinical areas such as care transitions and reducing infections.

Another option would be to require low-performing providers to collect data on system-wide performance regularly and have a process for acting on it. In a recent study that looked at high- and low-performing hospitals on mortality rates from acute myocardial infarction, researchers found that high-performing hospitals viewed adverse events as opportunities to analyze root causes, learn from experience, and improve care. They reported incorporating data feedback into the organizational culture with a focus on learning rather than blaming. In contrast, low-performing hospitals reported variable

interest in data and minimal use of root-cause analysis (Curry et al. 2011).

Medicare has recently begun pursuing this type of approach with what it calls "system improvement agreements"(SIAs). Such agreements typically require an interrelated package of key actions within a defined period of time, such as:

- a root cause analysis of systemic issues through onsite peer review by individuals or by an entity that CMS selects or the facility selects subject to CMS approval,
- an action plan in consultation with a peer-review entity,
- funds placed in escrow to finance quality improvement,
- an independent quality monitor who can verify implementation of the plan,
- regular reports on improvements made, and
- waiver of appeal rights contesting termination.

CMS has used this tool with a select number of nursing homes and with seven transplant centers. These agreements accompany termination notices with delayed effective dates and are negotiated between CMS and the provider.

GAO finds that these agreements have the potential to improve the performance of nursing homes, even if the results to date are mixed. Four homes met the terms of their SIAs and graduated from the SFF program. As of August 2009, one of these homes was above average according to CMS's five-star system, and three were below or much below average. Two homes were terminated, and four others were continuing to struggle to improve. GAO notes that the program has had a slow rollout. As of March 2010, two years after the program started, CMS had not disseminated information to the regional offices describing elements that should be part of SIAs and had not catalogued lessons learned from their use. In addition, GAO found that as of May 2009, the central office was unaware of all the SIAs regional offices had in place and that one regional office had not heard of SIAs. GAO recommends that CMS provide its regional offices with a description of the elements that should be part of SIAs and catalogue any lessons learned (Government Accountability Office 2010).

CMS staff report a fair amount of success with SIAs with hospital transplant centers. Of the seven transplant centers targeted because they failed to meet minimum mortality rate standards, three improved performance to be within legal standards. Two others appear to be making progress. One or two others appear unable to improve their performance. In addition to care process reforms, often the problems center around changing leadership or key personnel in the program, adding specialized expertise, and improving internal quality improvement systems. The SIA process spotlights the problems and creates the imperative to make management changes that were previously allowed to continue (Hamilton 2011).

The Department of Health and Human Services Office of Inspector General has taken a similar approach to quality problems in nursing homes through its quality-of-care Corporate Integrity Agreements (CIAs). While similar to SFFs in the types of requirements, CIAs tend to focus more on the conduct of chain nursing homes than the SFF, have been in use longer (since 2000), and are generally in effect for longer periods. As of June 2008, 35 nursing home corporations had entered into these agreements. Under CIAs, nursing homes are required to seek outside technical assistance to identify changes that will help address quality problems. They may also require the establishment of corporate-level compliance officers, quality assurance monitoring committees, and the hiring of an independent monitor to see that the appropriate systems are in place. GAO notes there is little coordination between the SIA and CIA program, even though some facilities are in both programs (Government Accountability Office 2010).

These approaches offer a constructive way to improve care that facilities provide to beneficiaries and could be pursued more broadly if it were a formal program with adequate administrative resources. While the program is relatively labor intensive, efficiencies may be gained by establishing clear criteria for application as well as by standardizing terms.

In addition, there can be an important interplay between SIAs and the availability of technical assistance grants. The structure and oversight involved in executing an SIA could increase the likelihood that the grant would result in quality improvement. Having grant money available may also allow SIAs to be expanded to a larger number and more types of poorly performing providers. We see potential in this collaboration between the two programs despite the mixed experience CMS has had with the Nursing Home in Need (NHIN) program, which is part of

the QIOs' ninth SOW. While the results of the program have not been released, we understand that it did not appear to be effective and was costly to implement.

A number of design flaws appear to have undermined the intent of the NHIN program. First, there was a mismatch between the QIO measures used to monitor the effect of QIO assistance and the measures CMS uses to evaluate the performance of nursing homes. Second, because each QIO worked with just one nursing home in each state, efficiencies may have been lost; some QIOs had minimal expertise in working with nursing homes and required more resources as part of the learning process, and they were not able to defray those costs over multiple facilities.

#### RECOMMENDATION 4-5

**The Congress should require the Secretary to expand interventions that promote systemic remediation of quality problems for persistently low-performing providers.**

#### RATIONALE 4-5

While CMS has experimented with strategies to engage failing providers in system-wide improvement, it has not pursued them broadly. A mandate from the Congress would create a better platform to require low performers to make a system-wide investment in quality improvement or face being terminated from the program. Persistently poor performance comes at too great a cost to beneficiaries and should not go unaddressed.

#### IMPLICATIONS 4-5

##### Spending

- There are no direct spending implications.

##### Beneficiary and provider

- To the extent that providers are responsive to the intent of the interventions, beneficiaries should receive improved care. Certain providers will need to increase their investment in quality improvement.

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##### Publicly recognize high performers

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Although a focus on poor performers is essential to improving quality in Medicare, public recognition of high-performing providers, as measured across a broad range of metrics, is also important. These providers can shape expectations and standards for excellence in health care delivery, and they can help others achieve the same level of excellence.

Medicare Compare websites publicly report relative performance for several provider types. Some of Medicare's payment policies also give financial recognition based on performance. In addition, there are national quality award programs. For example, the National Quality Forum presents the National Quality Healthcare Award annually to an outstanding, quality-driven health care organization based on effective prioritization of performance improvement goals, a well-designed and deployed "dashboard" to measure and manage whole system performance, a commitment to transparency, data-driven improvement with an emphasis on care coordination and reducing disparities, and demonstrated results on publicly reported performance measures. The National Quality Forum, in partnership with the Joint Commission, also presents The John M. Eisenberg Patient Safety and Quality Awards annually, which recognize individuals and health care organizations that have made significant contributions to improving patient safety. In addition, the National Institute of Standards and Technology operates the Baldrige Award program, which makes awards for excellence in a number of areas, including health care. The award focuses on performance in six areas: product and service outcomes, customer-focused outcomes, financial and market outcomes, workforce-focused outcomes, process effectiveness outcomes, and leadership outcomes. In addition, private-sector organizations such as HealthGrades use hospitals' performance on the Agency for Healthcare Research and Quality Patient Safety Indicators for Medicare patients to distinguish high-performing facilities around the country.

These efforts could be complemented by a new recognition program that calls attention to high-performing providers that work to help their peers improve quality by participating in collaboratives or in direct mentor arrangements. Encouraging providers to assume these roles would likely accelerate improvements system wide. Recognition for taking on this role could be awarded by type of provider (e.g., hospital, nursing home, home health agency). In addition, there could be a further distinction so that, for example, high performance for hospitals could be recognized for rural hospitals, community hospitals, and academic medical centers separately.

#### RECOMMENDATION 4-6

**The Secretary should establish a public recognition program for high-performing providers that participate in collaboratives or learning networks, or otherwise act as mentors, to improve the quality of lower performing providers.**

#### RATIONALE 4-6

Public recognition of exceptional performance inspires other providers to improve their performance and continually redefine excellence. It helps avoid complacency among providers and beneficiaries alike.

#### IMPLICATIONS 4-6

##### Spending

- There are no direct spending implications.

##### Beneficiary and provider

- To the extent that providers are responsive to the intent of the incentive, beneficiaries should receive improved care. ■

## Endnotes

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- 1 Some aspects of the COPs are specified in statute and changes in them would require legislation.

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