

September 20, 2004

William Rollow, MD  
Acting Director  
Office of Clinical Standards and Quality  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21207

**RE: Medicare Quality Improvement Program  
Proposed Summary of Draft 8<sup>th</sup> Statement of Work**

Dear Dr. Rollow:

The American College of Physicians (ACP), representing over 116,000 doctors of internal medicine and medical students, is pleased to submit comments on your proposed summary of the draft 8<sup>th</sup> Statement of Work (SOW) for the Medicare Quality Improvement Program. ACP lauds the continuing cooperative collaboration between the Centers for Medicare and Medicaid Services (CMS), Quality Improvement Organizations (QIOs), the College, and the American Academy of Family Physicians (AAFP) in seeking new ways to improve quality of care by bringing the benefits of health information technology (HIT) to the physician office.

ACP strongly supports a model that gives QIOs the principal responsibility for developing and implementing programs to encourage physicians to acquire HIT to support quality improvement. We believe the best way to achieve this goal is with the support from professional societies and outside experts as needed to supplement the QIOs long-standing experience and credibility with physicians on quality improvement.

In ACP's experience, QIOs have had a very strong working relationship with the physician community, as evidenced by letters of support that several of our chapters have submitted on behalf of their own QIOs, endorsement of the Doctors Office Quality—Information Technology (DOQ-IT) program discussed below, and the fact that ACP has not heard any complaints from ACP's 116,000 members about their QIOs in the last five years. Thus, ACP feels strongly that turning over any HIT responsibilities to outside entities who lack a positive track record with physician would, in our estimation, undermine CMS's physician HIT adoption goals.

While ACP strongly supports giving QIOs a key role in promoting the adoption HIT to improve quality, we also believe it is important that the QIOs' performance in this regard be continually evaluated by CMS. As part of this evaluation, CMS should develop mechanisms to solicit the views of practicing physicians and to provide such physicians with objective criteria for grading the QIO's performance.

ACP's commitment to making HIT work to the advantage of both patients and physicians is already being demonstrated in our direct participation in CMS's DOQ-IT demonstration program. We have actively encouraged our California membership to participate with the California QIO, Lumetra, and will soon take the same action for our chapters in the other three DOQ-IT states, Utah, Massachusetts, and Arkansas. In addition, as you are aware, we are very close to executing a sub-contract with the Arkansas QIO to provide technical assistance to interested Arkansas physicians on HIT adoption and practice redesign. We hope that the model we develop in Arkansas can be adapted to other QIOs.

ACP has also demonstrated its commitment through our continued discussion about a potential National Quality Partnership with your office and AAFP, which we feel will provide a strong underpinning to the coming 8<sup>th</sup> SOW. We are also in the process of reviewing a proposal from the Arizona QIO for a Primary Care Partnership between the Arizona QIO, ACP, and AAFP which was recently submitted to your office.

ACP has learned through years of providing technical practice management support to our physician members, and more recently through research on policy papers examining issues and obstacles to HIT adoption, that physicians need:

- (1) A trusted source of guidance in HIT adoption, meaning organizations that are experienced in working with physicians in a practice setting, such as a QIO or national or local medical association chapter;
- (2) Financial incentives to encourage HIT adoption and limit physician exposure to the risk of such new investment. The absence of such incentives would greatly limit physician willingness to take on this new technology and surely undermine the potential success of CMS's HIT adoption efforts;
- (3) Help in selecting hardware/software vendors, since most physicians do not have the technical expertise to distinguish amongst the confounding number of choices available on the HIT market.

ACP's comments on the 8<sup>th</sup> SOW focus on the two CMS proposed options for accomplishing all 8<sup>th</sup> SOW tasks, both of which mandate use of outside contractors under specified circumstances for QIO quality improvement activities, and for new tasks related to helping physicians adopt HIT and perform practice redesign.

**ACP Comments on: Proof of Capability and Competitive Contracting (pp.2-3)**

CMS is proposing two options for performance of QIO responsibilities, both of which would require use of a CMS approved sub-contractor. Option 1 makes this a requirement only when a QIO cannot demonstrate "capability of excellent performance" for a particular 8<sup>th</sup> SOW task; while Option 2 makes use of an outside contractor mandatory for specific physician office related tasks, regardless of QIO capabilities.

ACP firmly believes that, because of their intimate familiarity with their local health care environments and their years of direct experience working with physicians in a variety of quality improvement activities, QIOs should be given maximum flexibility in performing, or sub-contracting out, 8<sup>th</sup> SOW duties. QIOs are best suited to assess their own performance capabilities, and to either directly perform 8<sup>th</sup> SOW tasks, or to sub-contract out selected task(s) to organization(s) which are both technically competent and also thoroughly familiar with the local health care environment's organization, public health issues and needs, and which already have credibility and acceptance in the medical community.

ACP is concerned about CMS's Proof of Capability requirement, specifically that every QIO must, for all tasks except those relating to physician offices, demonstrate it is "capable of excellent performance" under the 8<sup>th</sup> SOW. What standards and criteria will CMS apply to determine what constitutes "excellent performance" capability? We are also concerned that, should a QIO not meet this high bar for performing a particular task, that the QIO will be restricted to sub-contracting out this work to an organization on a list approved by CMS. Though such organizations may have acceptable technical skills, will they have the awareness of the local health care environment, as well as acceptance in the local medical community, to perform the tasks optimally?

Another key ACP concern is the fact that local QIOs may lose direct control over quality improvement activities, which is the very core of what QIOs have been doing over the last 25 plus years. CMS should be circumspect about taking this work away from local QIOs, and be absolutely certain that any deficiencies in quality improvement are not due to local health or patient behavioral factors outside the QIO's control. As part of this evaluation, CMS should develop mechanisms to solicit the views of practicing physicians and to provide such physicians with objective criteria for grading the QIO's performance.

For all tasks relating to physicians' offices, including 1c1, 1d1, 1d2, and 1d3, CMS is proposing for comment both Option 1, described above, and Option 2. Option 2 would mandate all QIOs contract all physician office related tasks, including HIT adoption, to an outside contractor. ACP believes this latter option would likely have a negative outcome, essentially letting physicians fend for themselves in selecting from a potentially large list of vendors, without any technical support or guidance in making such a critical decision. Physicians may feel intimidated by being forced to make such a practice revolutionizing decision without trusted technical guidance, and drive them away from CMS's goal of expanding HIT adoption. Further, approved vendors may not have the sensitivity to local physicians that is critical to winning their confidence and commitment to participate and see HIT adoption through to a successful conclusion.

Clearly, vendors do have an important role to play once physicians have been given the guidance and support in taking the first few important steps to moving from a paper-based to paperless office operation. The role of educating physicians on what they need to know about HIT adoption, the obstacles, costs, and short and long term benefits, should be left to the QIOs or professional associations physicians know and trust.

ACP believes one vital component of winning physician support for HIT adoption, not addressed in the 8<sup>th</sup> SOW, is using a peer to peer physician “champion” network of early HIT adopters. In essence, a local QIO or its sub-contractor would identify a network of volunteer physicians who would be willing to share their experience and knowledge in selecting and implementing HIT systems. Nothing has quite the impact on winning physicians over as seeing a live peer demonstration of an electronic health record/practice management system in action. Knowing that a physician, much like themselves, has successfully worked through the obstacles of installing HIT and making it a powerful practice tool, is the best advertisement for bringing new physicians over to the HIT camp.

Ultimately, once a sufficient number of physician “champion” early adopters are identified, QIOs would be able to formalize HIT related education, by using a “train the trainers” model, with CMS offering QIOs appropriate funding to support these peer to peer activities.

### **ACP Recommendations on CMS’s Proposed Draft 8<sup>th</sup> SOW**

- 1. ACP believes QIOs should be given first priority to perform all quality improvement tasks and optimal flexibility to delegate these tasks to an organization with a proven track record in quality improvement activities and demonstrated familiarity with local health quality patterns.**
- 2. ACP believes that QIOs should be able to select sub-contractors who are thoroughly familiar with local health care markets and have credibility and support in the local physician community. Restricting QIOs to select sub-contractors from a CMS approved nationally certified list may not provide choices that have this local expertise.**
- 3. For all tasks relating to HIT adoption in physicians’ offices, CMS should assure that QIOs, or their sub-contractors, provide the initial stages of physician education and technical support, supplemented by a network of local physician HIT adoption “champions.” The goal should be to build physician confidence encouraging the move to HIT adoption, and guidance in making the right choices for hardware and software vendors.**
- 4. CMS should eliminate Option 2, which mandates all physician HIT adoption duties be delegated to outside contractors. This would force local physicians to choose vendors from a CMS approved list, without any local QIO or peer organization guidance and support, likely driving physicians away rather than toward HIT adoption.**
- 5. It is critical that CMS offer physicians financial incentives to encourage HIT adoption and lower physician exposure to financial risk. In this vein, we urge CMS to move promptly on authorizing such incentives under DOQ-IT as mandated under Section 649 of the Medicare Modernization Act. Providing similar incentives under**

**the 8<sup>th</sup> SOW is equally essential, and CMS should recognize that, without them, CMS should have a more realistic set of expectations of what QIOs can accomplish.**

Conclusion

ACP believes the proposed draft CMS 8<sup>th</sup> SOW holds much promise for bringing the benefits of HIT to the physician office, for the benefit of both patients and physicians alike. Our research on barriers to HIT adoption shows that physicians learn best from peers, and that physicians are most likely to take on this major investment once they have seen HIT being actively used by another physician. Getting the courage and guidance to take the first steps toward adopting HIT will come from organizations that know the needs and sensitivities of physicians best, such as their local QIO, and state and national medical organizations.

As such, ACP greatly encourages CMS to give local QIOs maximum flexibility to either directly perform or select sub-contractors to perform quality improvement and HIT adoption activities who are sensitive to their local physician communities. The goal is to provide the technical peer-to-peer confidence, underpinned by strong CMS financial backing, needed to allow physicians to take the plunge into HIT, and build a momentum that will ultimately make HIT-based offices commonplace.

As always, ACP welcomes the opportunity to work closely with CMS and other medical organizations to ensure the QIO program has the greatest positive impact for patients and physicians alike. Please direct any questions regarding this correspondence to Mark Gorden, at (202) 261-4544.

Sincerely,

Joseph W. Stubbs, MD, FACP  
Chair  
Medical Service Committee