July 11, 2013

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Kathleen.Sebelius@hhs.gov

The Honorable Marilyn Tavenner,
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Marilyn.Tavenner@cms.hhs.gov

Dear Secretary Sebelius and Administrator Tavenner:

The American Medical Association and the undersigned state medical societies are writing in response to the Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on options to change the Quality Improvement Organizations (QIOs) contracting process.

Our organizations represent the vast majority of practicing physicians, most of who have spent years or even decades building relationships with their QIOs and will, along with their patients, be disproportionately impacted by any changes to the current contracting process. Given the broad reach of any changes to the QIO contracting process, the Agency's decision to post this RFI on the Federal Business Opportunities Website (www.FedBizOpps.gov) was ill-considered and served to limit public review and comment. On this important issue, we believe CMS should have published the RFI in the Federal Register with a standard 60-day comment period, even though it may not be specifically required by statute. Thus, we request consideration of the following comments and urge the Agency to reassess how it solicits feedback in the future as a means to foster true transparency.

The RFI specifically requested comment on the "two most preferred" options or "exactly the one most preferred option below and an alternate framework." It goes on to say "the Agency cannot guarantee that a submission deviating from this approach would be considered." Given that three of the four options detail a variation on regionalizing the work done by QIOs (the final option chose to maintain the current, state-based structure), these very prescriptive instructions seem designed to produce a particular result by strongly implying that respondents who only support one option will be disenfranchised. Considering the potential impact of this RFI and to avoid perceptions of an unfair process, we strongly urge the Agency to give all responses appropriate consideration.

First, there is no statutory language that mandates changes to the QIO contracting process. Section 261 of the Trade Adjustment Assistance Extension Act of 2011 merely gives the Secretary the flexibility to do so. This is in contrast to the Value-Based Payment modifier, ICD-10 implementation, and meaningful use, to name a few current and near-term mandates facing the practice of medicine. All of these legislative mandates require learning curves that involve

changes to practice infrastructure, staffing, workflow, and other costly burdens. Moreover, one measurable impact of the healthcare exchanges will be the influx of millions of new patients into the healthcare system. Physicians are likely to lean on their QIOs for help to ensure that these new patients, many of whom will have newly diagnosed and/or untreated conditions, receive high quality and cost effective care. It is unwise to pursue a consolidation of the local QIOs, which are community resources that are trusted by patients and providers alike, just as the demand for services is likely to increase.

Another reason to maintain the status quo is that state-based QIOs can more easily customize their quality improvement activities to conform to state regulations and foster partnerships with local medical societies or professional boards in support of high value delivery innovations. As an example, QIOs in every state and territory are bringing together local stakeholders to develop community-specific approaches to reduce rehospitalizations; these efforts, which were reported in a January 2013 issue of the *Journal of the American Medical Association*, have informed the work of both the Partnership for Patients and the Community-Based Care Transitions Program. A regional QIO may not have the perspective to develop meaningful community-level guidance or the resources and credibility to engage local healthcare providers and their patients. At a time when the Agency is trying to increase patient satisfaction, improve population health, and reduce health care costs, regionalizing the QIOs would send the wrong message and have the opposite effect.

Finally, the Agency would be wise to remember the difficulties involved with consolidating the Medicare Administrative Contractors or overhauling the provider enrollment process. Even during periods of relative stability, these transitions took longer than expected, caused significant practice disruptions, and resulted in widespread confusion among physicians. Thus, our organizations' urge the Agency to preserve its flexibility by postponing consideration of QIO changes until the pace of healthcare reform is less frenetic, physician practices are more stable, and we all have a clearer sense of how each of the four options outlined in the RFI would impact quality and cost.

Sincerely,

American Medical Association
Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society

Medical Society of Delaware
Medical Society of the District of Columbia
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society