United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

December 8, 2005

Martin Margolies
Chief Executive Officer
PRONJ
557 Cranberry Road, Suite 21
East Brunswick, NJ 08816-4026

Dear Mr. Margolies:

As you are aware, in July 2005, the *Washington Post* featured a series of articles on healthcare quality in the Medicare Program. More specifically, the July 26 article questioned whether or not Quality Improvement Organizations (QIOs) limit patient access to medical information and have a more than cozy relationship with physicians. The concerns raised in this article necessitated a further analysis and in-depth inquiry, especially since QIOs received $367 million in FY 2004 from the Centers for Medicare & Medicaid Services (CMS) and $1.1 billion for their current three-year contract. Of the $367 million allocated to QIOs in FY 2004, PRONJ received approximately $18 million to ensure medical care is: reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting.

As Chairman of the Senate Finance Committee (Committee), I sent a letter to CMS on August 11, 2005, which requested information (e.g., contracts, travel expenses, board compensation, and performance audits) from more than 15 QIOs to ensure beneficiaries are receiving quality care and pertinent information in a timely and appropriate fashion. Thank you for your prompt response to my letter; however, additional information is necessary to clarify a number of issues that surfaced during the Committee's review of PRONJ's documents.

Accordingly, please respond to the inquiries set forth below by no later than December 29, 2005.

I. BOARD MEMBER TRAVEL

PRONJ documents revealed that the entire board of directors traveled from New Jersey to the Cayman Islands and California for annual "retreats," with total costs exceeding $100,000 in FY 2003 and 2004. In both years, the retreats occurred during the first week of November. The Committee would appreciate receiving additional information regarding these retreats.

As a preliminary matter, it is difficult to understand why an entire board would need to travel from New Jersey to the Grand Cayman to discuss improving quality of care for beneficiaries, but I am eager to receive your detailed and documented explanations. In this regard, please:

a. Identify all attendees present for any portion of these two retreats, including name, title, affiliation with the QIO, if any, etc.;

b. Identify any speakers, presenters or the like, including but not limited to family members, CMS or Department of Health and Human Services (HHS) staff members, and/or other non-board members present;

c. Identify the source of the funds expended for each of these retreats, including amounts and specific allocations; and

d. Provide expense reimbursement and travel policies that the board has adopted.

II. BOARD MEMBER COMPENSATION

In FY 2003, PRONJ compensated its 21-member board a total of $526,976, averaging about $25,000 per board member. This seems like an alarming sum considering the majority of national not-for-profit corporations do not pay their board members. Based upon our preliminary review, one PRONJ board member received $18,485 from a single CMS contract. Accordingly, please respond to the following questions and requests for information and records:

a. Provide descriptions of all transactions with disqualified persons (as defined under Internal Revenue Code section 4958(f)). Provide copies of all legal opinions and minutes from board meetings discussing these transactions for the period of September 2000 through December 31, 2005[1];

b. Describe in detail and explain the process used by PRONJ for determining compensation levels for board members;

c. List the total compensation provided to each PRONJ board member for the period of September 2000 through December 31, 2005, including all funding sources;

d. Verify that the amounts reported on Form 990 represent the total economic benefits each board member and top five highest paid staff received from PRONJ for FY 2003 to the date of this letter. If not, please describe in detail what other benefits were received, including the fair market value of those benefits;

e. Did you establish the rebuttable presumption under section 53.4958-6 of the Foundation and Similar Excise Taxes Treasury Regulations as to the compensation and benefits reported for any of the board members? If yes, please

[1] As a 501(c)(3) organization, PRONJ reported on it's Form 990 that it spent over $1.2 million compensating its five highest paid employees.

provide copies of all supporting documentation. If no, provide the documentation supporting the reasonableness of the compensation and benefits reported;

f. Did PRONJ have an employment contract or any other compensatory agreement with any of the board members? If yes, please provide a copy of the contract or agreement;

g. Does the amount of compensation and benefits reported agree with the amount reported on each board member's Form W-2 or Form 1099? If not, please explain the difference;

h. Did any of the board members use any property that PRONJ owned or leased (such as an automobile, aircraft, real estate, credit card, etc.) from FY 2003 to the date of this letter? If yes, did PRONJ include the value of this usage in the amount of compensation and benefits reported? Was the value included on the individual's Form W-2 or Form 1099? Please explain if this value was not included; and

i. Provide the number of years each board member has served on the PRONJ board and any include any policies that reference term limits for board members, the Chief Executive Officer (CEO) and executive management.

III. BOARD MEMBER DIVERSITY

Only one member of PRONJ's 21-member board is not a physician. Although current guidelines only require one consumer member, many QIOs have taken dramatic steps to diversify board membership. For example, one QIO has a mix of certified public accountants, physician assistants, registered nurses, and multiple consumer representatives. This example completely contrasts the PRONJ physician-monopolized board.

The CMS Organizational Manual requires that QIO boards be composed of "a diverse group of members so as to reflect in terms of gender, race, ethnicity, rural/urban, and socio-economic status, the Medicare Population of the State." Furthermore, section 9353(b) of the Omnibus Budget Reconciliation Act of 1986 requires that QIOs have at least one consumer representative who must be a Medicare beneficiary. After reviewing PRONJ's Board of Trustee's curriculum vitae, bylaws, and responsibilities, it appears the board lacks diversity and the necessary procedures to prevent inappropriate business relationships. Furthermore, it is disconcerting that PRONJ board members are overseeing contracts, reviewing beneficiary satisfaction surveys, and assessing physician performance for the same organizations where they stand to benefit or lose profits based upon the board's decision. QIO boards should be diverse and transparent, allowing all members to make clear decisions unhampered by apparent conflicts of interest. Accordingly, please:

a. Clarify PRONJ's rationale for maintaining a physician-monopolized board; and

b. Provide a copy of PRONJ's bylaws and other policies designed to prevent board members from possible conflicts of interest and inappropriate business relationships. If bylaws have changed over the past five years, please provide all versions.

IV. BENEFICIARY COMPLAINTS

Beneficiaries must be knowledgeable of and have access to the QIO complaint process for QIOs to fully address quality concerns and detect errors and fraud. In addition, QIOs should respond to all beneficiary complaints in a timely and responsive manner. However, from August 2004 to July 2005, PRONJ reviewed 106 beneficiary complaints. Although this is an increase of 80 percent over the 59 complaints reviewed in 2000, this number still appears drastically low given the more than 1.2 million Medicare beneficiaries residing in New Jersey. Accordingly, please:

a. Explain why, in the PRONJ's opinion, there are so few reported complaints.

In light of the fact that there are so few beneficiary complaints in New Jersey, another question logically arises. Are Medicare beneficiaries in New Jersey aware of and knowledgeable about the complaint process? In particular, the PRONJ website does not clearly identify a link for beneficiaries to file a compliant. When the term "beneficiary complaint" is entered into the search button, only two documents are identified and neither the1-800-MEDICARE nor the PRONJ number for reporting a complaint is listed. Moreover, the only "educational document" on the PRONJ website was found under the Medicare Beneficiary Protection Program site and then under "Intervention Materials." In light of the limited information on the website, please:

a. State whether or not PRONJ educates Medicare beneficiaries on the complaint process and describe in detail all efforts to do so; and

b. Provide the results of PRONJ's beneficiary satisfaction survey on the complaint process for each of the last five years.

The CMS Manual requires that QIOs complete reviews of beneficiary complaints with no quality concerns within 85 calendar days and within 120 calendar days for complaints with quality concerns. Of the 106 complaints reviewed from August 2004 to July 2005, 23 percent contained a valid quality concern. However, from the information provided it appears that 43 cases are still under review and do not have a completion date. This conflicts with the required timeframe for reviewing beneficiary complaints. Furthermore, information provided by CMS shows that PRONJ had only completed 61 percent of cases referred to mediation in a timely fashion. It is alarming that beneficiaries are not receiving information about quality of care in a more expeditious manner. In light of these facts, please:

a. Explain what actions PRONJ has taken to address the 24 cases that had a quality concern and what actions PRONJ has taken to correct similar deficiencies that may have gone unreported;

b. Provide documented reports to CMS on PRONJ's timeliness and responsiveness for all reported claims over the past five years; and

c. Describe PRONJ's coordination with hospitals and State Survey Agencies to maximize the number of beneficiary complaints received and reviewed.[2]

V. ERROR RATE - FRAUD, WASTE, AND ABUSE

The CMS requires that QIOs refer payment errors or fraud for investigation to the Office of the Inspector General at the Department of Health and Human Services. This is essential to identify, prevent, and deter fraud, waste, and abuse and to recoup improper payments in the Medicare Program. The error rate is also an important measure to evaluate government accomplishments and to identify improvement opportunities. The CMS Error Report (Report) released last week showed that although CMS was successful in cutting the Comprehensive Error Rate, there is still a lot of work that must be done to reduce the QIO error rate. The Report found the QIO error rate increased by 8.3 percent over last year. More specifically, the Report projected that PRONJ has the fifth highest improper payment amount across the QIOs, a total of $156,585, for long-term PPS acute care. From the increase in the QIO error rate it appears QIOs are not accomplishing their mission. Accordingly, please:

a. Provide information on the extent of PRONJ's efforts to comply with CMS's requirement to report fraud and errors to the OIG; and

b. Describe PRONJ's efforts to reduce its QIO specific error rate and to work with CMS in reducing the overall QIO error rate.[3]

VI. COLLABORATIONS WITH OTHER QUALITY INITIATIVES

As you are aware, there are numerous stakeholders involved with the national initiative to improve health care quality. The QIOs are one of these important players tasked to promote quality health services for Medicare beneficiaries and to determine appropriate utilization of services rendered. The Committee seeks to better understand whether or not the mission of the QIOs is unique from other quality initiatives and organizations. For example, the New Jersey 2005 Hospital Performance Report addressed hospital performance measures and acknowledged not the QIOs but the New Jersey's Quality Improvement Advisory Committee, the Department of Health and Senior Services, and the Joint Commission on Accreditation of Healthcare Organizations as the major contributors. Accordingly, please:

a. Describe PRONJ's coordination with the Joint Commission on Accreditation of Healthcare Organizations, the National Quality Forum, the New Jersey Department of Health and Senior Services, the Quality Improvement Advisory Committee, and the New Jersey State Board of Medicare Examiners. What is PRONJ's unique role in each of these partnerships?

[2] According to the August 18, 2005 memo from CMS to State Survey Agencies, "The hospital must inform the patient that he/she may lodge a grievance with the State agency directly, regardless of whether he/she has first used the hospital's grievance process."
[3] CMS allows QIOs that have well established methods for estimating local payment error rates to use the available data it analyzes to directly engage providers in education activities related to payment errors.

b. Describe in detail the relationship between PRONJ, Area VII – Physicians Review Organization, Inc., and Physicians Alliance of New Jersey, Inc. (PSRO)[4].

VII. MISCELLANEOUS

In addition to the concerns raised in this letter, please provide the following information:

a. The notes section from PRONJ's FY 2004 audit[5];

b. Copies of all internal control memos (to any board member and/or Chair) from FY 2000 through the present, including a summary and status update on all contracts subject to the penalty clause from FY 2002 to the present[6]; and

c. Costs and rationale associated with the change in PRONJ's name to Healthcare Quality Strategies, Inc. (HQSI).

Thank you in advance for your assistance on this matter. I would appreciate a response to the enumerated requests and concerns raised in this letter no later than December 29, 2005[7].

Sincerely,

Charles E. Grassley
Chairman

cc: HHS Secretary Michael Leavitt and CMS Administrator Mark McClellan

[4] Please include appropriate contact information for each organization for question VI-a and VI-b.
[5] The notes section was not included in the FY 2004 audit report provided by CMS.
[6] The internal memos are a vital component in reviewing the financial position of PRONJ.
[7] In complying with this document request, respond to each enumerated request by repeating the enumerated request and identifying the responsive document(s). In the event that a document is withheld on the basis of privilege, provide the following information concerning any such document: (a) the privilege asserted; (b) the type of document; (c) the general subject matter; (d) the date, author and addressee; and (e) the relationship of the author and addressee to each other. Each document produced shall be produced in a form that renders the document susceptible of copying. If the information requested is not available in the format requested, please notify the Committee, and we will be happy to accommodate other formatting options.