D. Specific Tasks

1. Task 1a - Nursing Home Quality Improvement

a. Background

Q116. Please provide a definition of a "nursing facility".

A116: For the purposes of Task 1A of this contract, a "nursing facility" is a Medicare or Medicaid certified nursing home. Swing beds are not included, nor are intermediate care facilities for the mentally retarded/developmentally disabled. CMS prefers that QIOs place higher priority on Medicare and Dually (Medicare and Medicaid) certified facilities than on nursing homes certified only by Medicaid in assembling its cohort of "identified participant nursing homes.

Q117. Are the QIOs to work only with Medicare or Medicare/Medicaid nursing homes?

A117. See Q&A # 116, above. QIOs may work with Medicare, Medicaid, and Dually (Medicare & Medicaid) Certified facilities.

Q118. Does CMS intend to provide MDS resident level data to QIOs?

A 118: The definition of "resident level data" as CMS understands it is: "data file(s) containing the entire MDS for a given time period as transmitted by nursing homes in a specific state." Neither CMS nor its contractors (*e.g.* the NH QIOSC) will provide the entire or "raw" MDS to QIOs. A QIOSC will have access to the data as defined above for all states. Every QIO will receive for the NHs in its state quarterly standard analytic reports (SAR) created by a QIO expert in this data (under Task 4 contract with CMS or under subcontract to the QIOSC). The SAR for each QIO will contain information about the publicly reported QI rates in its state (and national comparisons), and information on individual facilties' QI rates – which may include resident-level information. (Resident-level information is distinct from resident-level raw data.) The format for the SARs is being developed and tested during the 6-state pilot. CMS expects the format to the SARs to evolve during the 7th SOW, as a result of feedback from QIOs using the SAR.

Q119. If so, at what intervals?

A119. CMS will arrange for QIOs to receive their state- and facility-specific information (<u>not</u> raw data) on a quarterly basis. (See Q&A #118, above).

Q120. What is the date range of the information that is publicly reported?

A120. Public reports are quarterly, each based on a calendar quarter of transmitted MDS data. There is a time lag of one calendar quarter between the reporting of the data by the nursing home and the public reporting of the QI rates calculated from that data. (Calendar quarters begin January 1, April 1, July 1, and October 1 of a calendar year.) For example, for the six state pilot, the measures publicly reported in April 2002 are based upon fourth quarter (October 1 through December 31) 2001 transmitted MDS data.

Q121. Will CMS establish a minimum expected threshold performance goal for this task both statewide and for identified participants?

A121. CMS expects each QIO to achieve at least some improvement in QI rates for the set of 3-5 publicly reported measures on which it elects to focus. "Some" is defined as "greater than 0%". (QIOs should note that the QI rates published are likely to be failure rates -- rates of things which are undesirable -- and therefore improving the rates would mean reducing the rates.) See Attachment J-7 for the target relative reduction in failure rates.

Q122. Are the 3-5 QIO selected indicators weighted equally?

A122. Yes.

Q123. Can a decrease in one indicator be compensated by an increase in another selected indicator?

A123. The evaluation will involve a simple average.

Q124. In calculating the improvement, is the sum of the average improvement (decrease in failure rate) divided by the number of selected indicators?

A124. The evaluation will involve a simple average.

Q125. Will the participating agencies results be simply added together and divided by the number of participating agencies or will weighting be used based on the number of patients in residence during the baseline and remeasurement period?

A125. The evaluation will involve a simple average.

Q126. How will the MDS and OASIS data sets be made available to QIOs – monthly, quarterly, by request, etc.?

A126. CMS will not provide raw MDS or OASIS data to QIOs. Please note that MDS is specific to the nursing-facility setting (Task 1a) and OASIS is specific to the Home Health Agency setting (Task 1b). OASIS information will therefore not feature in activities in the NH setting (Task 1a).

Q127: What constitutes and intervention in a nursing home?

A127: The definition of "intervention" in reference to QIO (formerly PRO) activities is located in Attachment J-1, glossary. "Quality Improvement Project" in the context of QIO contracts is defined in Part 16 of the PRO Manual.

Q140. Please define the term "nursing home." For example, does the definition include all Medicare/Medicaid certified nursing homes, or only those that are skilled nursing facilities?

A140. See Q&A 116 & 117.

Q1099. There currently are publicly reported, quality improvement measures for nursing homes posted out on the Internet. How will the 10 – 15 NH quality of care measures derived from the MDS differ?

A1099. The quality measures for the 7th SOW have not yet been selected. CMS cannot determine at this time how they differ from any that are posted on the Internet on March 11, 2002. See questions 131, 132, and 146.

Q1100. Does CMS plan to educate the public on how to interpret and use the information?

A1100. QIOs should not budget any costs in the 7th Scope of Work for this activity. CMS may issue a contract modification in the future requiring Task 2a implementation. If that occurs, CMS will ask QIOs to submit budgets in reponse to the modification.

Q1101. Is the QIO expected to educate the public on how to interpret the information?

A1101. QIOs should not budget any costs in the 7th Scope of Work for this activity. CMS may issue a contract modification in the future requiring Task 2a implementation. If that occurs, CMS will ask QIOs to submit budgets in reponse to the modification.

Q1102. What is the rationale for the care measures chosen by CMS to work on?

A1102. The measures have not yet been selected for 7th SOW. The National Quality Forum (NQF) will provide to CMS recommendations for measures, and rationale for their recommendations, in August 2002. See question 146.

Q1103. How accurate is the MDS data?

A1103. NHs transmitting MDS data have multiple incentives to provide accurate data. One important incentive for NHs to submit MDS as accurately as possible is that MDS is a part of reimbursement systems for Medicare and Medicaid. Another is that MDS submissions are a key feature of the survey & certification system. CMS recognizes that the data are not **perfectly** accurate, but believes them to be reasonably accurate. In addition to reimbursement and other CMS uses, MDS data have been used for data-based published papers in scientific journals; therefore a degree of accuracy is inferred by the larger scientific community. MDS is the best available source of data for the publicly reported measures.

Q1104. Will there be a risk adjustment for NHs with the oldest, sickest patients?

A1104. The quality measures for the 7th SOW have not yet been selected. CMS cannot describe or define risk adjustment to measures until the measures themselves are selected. See question 146.

Q1105. Does the MDS allow for risk adjustment?

A1105. Yes. (See also questions 146 and 1104.)

Q1106. When will QIOs know how media campaigns will be conducted for publicly reported MDS measures….and how this will be reflected in QIO budgets?

A1106: Such campaigns would be conducted under Task 2 of the contract. Refer to Task 2 of the Statement of Work, to relevant proposal instructions, and to Q&As for Task 2 for guidance and information on this matter.

Q1107. "Are the quality indicators the same as the 11 quality indicators in the NH Pilot Project?"

A1107. The quality measures for 7th SOW have not been selected. (See also questions 146 and 1099.)

b. Task Description

Q127. What constitutes an intervention in a nursing home?

A127. The definition of "intervention" in reference to QIO (formerly PRO) work is: "any activity taken by a QIO as part of a quality improvement project." Examples of interventions include: provision of technical assistance, clinical education, beneficiary education, media campaigns, and partnerships. "Quality Improvement Project" in the context of QIO contracts is defined in Part 16 of the PRO Manual.

Q1108."Who, where is NH support QIOSC?"

A1108. Rhode Island Quality Partners (RIQP) is currently leading the QIOs' efforts in the 6th SoW (including those conducting "alternate settings" projects in nursing facilities as well as those in the SNF-QMR pilot and the 6-state NH public reporting quality initiative pilot). RIQP is currently developing materials and training to support QIOs as we move forward with the national roll-out of public reporting.

Q1109."What kind of training?"

A1109. See questions 128 and 129 (below).

Q1110."When is the training scheduled?"

A1110. See Questions & Answers 128 and 129 (below).

Q128. When will the NH Support QIOSC training take place?

A128. Information and training on the NH setting is and is expected to remain an ongoing process. Monthly teleconference calls in which all QIOs are invited participate began in February, 2002, and are hosted by Rhode Island Quality Partners (RIQP), the QIO currently leading and supporting QIO projects in the NH setting. Also, the QIO Interventions Collaborative coordinated by PRO-West includes a NH Community of Practice, providing for NH-setting knowledge transfer between QIOs. Additional training, including but not limited to instructional materials, manuals, and formal seminars at national meetings (*e.g.* the CMS-sponsored QualNet Conference in September, 2002) is currently in development.

Q129. Will travel be required?

A 129. Formal seminars at national meetings will require travel. A great deal of information dissemination, training, and inter-QIO knowledge transfer will be conducted via means which do not require travel.

At this time, CMS anticipates that there will be one formal seminar in late summer, 2002, and that there is likely to be another formal seminar activity early in 2003, perhaps using the AHQA Technical Conference as a venue.

Q130. In preparation for release of Nursing Home data to the public and to facilitate partnership/collaboration with the Nursing Homes, will the QIO receive the data for review prior to its release?

A130. Neither CMS nor its contractors will provide raw MDS data to QIOs (see again Q&A #118, above). Nursing facilities do not need to preview the raw data, as they were the ones who submitted it. In answering this question, CMS therefore reads the question as "Nursing Home rate information" rather than "Nursing Home data".

For 7th SOW, CMS will update posted QI measures for all states on its website(s) every calendar quarter (See Q&A 120, above). The QI measures will be calculated by a contractor and provided to CMS. CMS currently anticipates providing facilities a brief window of opportunity to review their rates prior to the public posting of each update, but the mechanism for this has not been finally determined. CMS has not determined whether QIOs will also have access to updates for preview prior to posting, as the answer of the feasibility of this depends on many factors including the mechanism chosen to allow the facilities' preview of the update rates. The facility-preview system is not, for practical reasons (*e.g.* timing, resource requirements) likely to build in the QIOs as an intermediary between CMS and the nursing facilities.

Q131. Will there be any variation in the CMS publicly reported data results from the data submitted by the Nursing Home?

A131. Nursing facilities submit the raw MDS. (For those not familiar with the MDS, it is a resident assessment instrument, and facilities are required to complete MDS assessments at certain intervals as part of the conditions of participation.) CMS will have a contractor calculate the publicly reported QI rate information at the facility level. The difference between the data submitted and the

information publicly reported is the difference between raw data and facility-level information derived from analyzing that data.

Q132. Is the publicly reported data aggregate?

A132. (See also Q&A # 131, above.) The publicly reported information (CMS will not be publishing raw data) will be in the form of facility-specific rates for the QI measures. The facility's rate is derived from an aggregate of that facility's resident-level data. The statewide & national rates are an average of facility rates. To reiterate, as the purpose of publicly reporting quality information is to allow informed consumer choice on the basis of differences in provider quality, the unit of analysis for CMS publicly reported QI measures will be the nursing facility.

Q133. How many NH QIOSC training sessions will be held and in what locations?

A133. See Q&As 128 & 129, above.

Q134. How many QIO employees should be budgeted to attend?

A134. At this time, CMS estimates that 2 QI staff members should attend the formal NH QI seminar in late summer, 2002. The preferred QI staff are project managers for the NH setting and perhaps HCQIP directors. (The training will be aimed at providing people who do the work ona daily basis tools, strategies, and skills for daily use.) It is too soon to determine which staff might comprise the target audience for any training which transpires after September, 2002.

Q135. Should the QIO budget for materials and reproduction costs associated with the NH QIOSC materials?

A135. Yes. In some instances, the materials will be ready to print, and in others the QIO will need to add its contact information to the stock design. Either way, we currently anticipate that each QIO will be expected to print and distribute QI materials to facilities in its State.

Q136. If so, what is the quantity of copies and copy type (color or black and white)?

A136. The content of the QI-systems improvement materials for NH use (QI systems in general and topic-specific materials) are not yet sufficiently developed for those developing them to provide a definitive answer to this question. Based on experience with 6th-

SOW experience with inpatient and outpatient "Project In A Box" interventions, CMS would suggest that each topic's materials package might run from $20 to $45 per recipient, including overhead, shipping & handling costs associated with printing and distributing it. How many units of each topic's materials any QIO will need is something the QIO must attempt to forecast based on its provider population, and its experience in its state. (The QIO is not expected to simply ship the full package of materials on every topic, unsolicited, to every NH in its state. Experience has shown this is not a highly effective method of recruiting/motivating hospitals or physicians, and CMS has no reason to believe NHs would respond more favorably to this approach than do those other types of provider.)

A QIO having limited experience in the NH setting might find other QIOs (more experienced in the setting) and its State's nursing home industry trade associations to be potential sources of helpful resource-planning and needs-assessment information.

As a point of information, CMS used an OSCAR report (generated on April 24, 2001) of the total certified (Medicare & Medicaid) facilities by state to determine the number of nursing facilities in each state for purposes of planning this solicitation. The total facilities per state from that report is listed in the table below:

Table of SNFs per QIO Contract, per OSCAR 04/24/2001

State	Facilities	State	Facilities	State	Facilities
AK	15	LA	237	OK	235
AL	221	MA	492	OR	121
AR	189	MD	239	PA	752
AZ	145	ME	126	PR	7
CA	1,262	MI	389	RI	97
CO	201	MN	409	SC	204
CT	250	MO	459	SD	89
DC	20	MS	138	TN	277
DE	37	MT	101	TX	1,012
FL	721	NC	412	UT	81
GA	324	ND	88	VA	230
HI	42	NE	171	VI	1
IA	305	NH	67	VT	42
ID	81	NJ	361	WA	260
IL	658	NM	69	WI	369
IN	498	NV	47	WV	113
KS	258	NY	664	WY	33
KY	305	OH	896		

National Total = 14,820

Q137. Please define "QIO/Provider Activity Reporting Tool." Is this TQIP or a substitute for TQIP?

A137. CMS will develop a tool for QIOs to report activity with providers, partners, or collaborators during this scope of work. This will replace TQIP and other current reporting tools.

The "QIO/Provider Activity Reporting Tool" designates the standard SDPS reporting mechanism which will replace TQIP for the 7th SoW.

Q138. This section states that not using the NH Support Training methods will decrease availability of NH QIOSC support. We presume that this is to allow the QIOSC to stay focused. This also implies that the QIO that chooses not to follow this route is venturing into uncharted waters. This is confusing in light of the fact that the pilot project has no outcome data and will not have any until after the start of the first round contracts?

A138. The scope of QIO intervention activities within the scope of the 6-state pilot is not expected to yield quantitative (remeasurement) data on quality improvement methods, as the sample size of facilities participating with QIOs in this endeavor is too small (5-7 NHs per QIO). The information the pilot will yield about the intervention methods tested by the pilot QIOs will be qualitative. RIQP, in consultation with the other 5 pilot-state QIOs, will select methods and materials on which to provide all QIOs training prior to national public-reporting roll-out based on the pilot QIOs' experience and professional expertise.

Q139. What if the remeasurement data in the pilot reveals no improvement or actual worsening of performance. (The same issues applies to HHA subtask).

A139. See again the answer to Q&A 138, above. CMS does not believe the same issue applies to the HHA subtask: preliminary data from the pilot/demonstration project for implementing OBQI in HHAs indicate that performance improves upon implementation of the HH OBQI system.

Q141. What is the Provider Activity Reporting Tool and when will it be developed?

A141. See Q&A # 137, above.

Q142. Selecting 3-5 publicly reported measures in consultation with stakeholders –The timeline for this activity seems ambitious. The data is due to be released in October, however, the release is dependent upon many external factors. In addition, QIOs and stakeholders will be coordinating a tremendous amount of work and will be doing this in potentially inclement weather and during the holidays. Would CMS consider extending the timeline for this activity?

A142. CMS has no plans to extend the timeline for this activity.

Q143. Must all QIOs select 3-5 measures by December 15, 2002, or is this date for first cycle QIOs only?

A143. The public reporting of quality of care in NHs will roll out nationally in October, 2002. All QIOs will be expected to have attended training and begun establishing relationships with stakeholders in the NH setting prior to October, 2002. All QIOs will be expected to conduct activities in support of the public reporting initiative and the providers it impacts at the time of the national roll-out. Those QIOs still operating under the 6th SoW QIO (formerly PRO) contract will receive a contract modification to incorporate the specific requirements prior to September 1, 2002.

Q144. Please define stakeholders.

A144. The term "stakeholders" as used in reference to entities with whom QIOs should partner in selecting their focal set of the publicly reported measures is intended to include groups that represent the nursing homes (also known as for-profit and not-for profit trade organizations) as well as groups who represent Medicare beneficiaries and nursing facility residents. Other stakeholders include State Survey and Certification Agencies, State Medicaid Agencies, Fiscal Intermediaries, clinical and professional groups, and local service organizations.

The term "stakeholders" as it is used in the QIO contract overall is defined in Attachment J-1, glossary, as follows: Any organization/group with an interest in improving health care in relation to the topic on which the QIO is working. Stakeholders include such organizations as State Health Agencies, State Medical Associations, Specialty societies, providers, advocacy groups, consumer groups, etc. (See Attachment J-1)

Q145. Does CMS mean trade groups or individual nursing homes that might participate in QI activities? (Pilot experience demonstrates a large disconnect between the two audiences.)

A145. See Q&A # 144, above.

Q140. Please define the term "nursing home." For example, does the definition include all Medicare/Medicaid certified nursing homes, or only those that are skilled nursing facilities?

A140. See Q&A 116 & 117.

Q146. When will QIOs receive the list of CMS nursing home quality indicators to choose from?

A146. In August 2002, CMS will announce its final selection of measures which will be publicly reported in October 2002. The QIOs will have access to this decision. During the 6 state pilot, the six QIOs and the support QIO are preparing materials for the pilot measures. It is quite possible that the topics of some of the pilot measures will be the same as the topics for the measures reported in October 2002.

Q147. What data source will be used to compile the list of potential participant nursing homes?

A147. The Online Survey Certification and Reporting (OSCAR) System provides the names, addresses, and certification information for nursing facilities nationwide. For QIOs seeking a list of potential participant nursing homes by name and address for their states, potential sources of the information available today include: requesting public use files from CMS; requesting OSCAR reports 5 and 6 from their respective States' Survey & Certification Agencies; and enlisting the partnership of nursing home industry associations in their States. An even more immediately accessible alphabetic listing of nursing homes in a QIO's state by name and address is "Nursing Home Compare" at www.Medicare.gov

Q148. If this information needs to be updated, what will be the process for updating the file?

A148. Facilities are entered and updated in OSCAR by State Survey & Certification Agencies. Further information about OSCAR is available in Chapter 4 of the *State Operations Manual*, accessible to QIOs and the public at www.hcfa.gov

Q149. This section specifies a 10% target participation rate for NHs in the state, with a minimum of 10 facilities in states with fewer than 100 NHs. The 10% target would result in a significant number of targeted facilities in large state with many NHs. Would CMS consider establishing a ceiling or maximum number of facilities for this sub-task?

A149: CMS considered multiple options and their implications before setting the target at 10% of facilities or for states with fewer than 100 total facilities, 10 facilities. CMS believes the 10% target reasonable; the consequence of falling short of the target percentage of facilities participating is merely that greater weight will be placed on the statewide rates of the set of quality indicators on which the QIO chose to focus.

Q150. (Refer to section C.3.D.2.b. (viii) for a description of how a HHA evaluation is handled.) QIOs are directed to provide a list of participant nursing homes. Are only participants used in the evaluation similar to the HHA provision?

A150. That portion of the QIO's contract performance evaluation for Task 1a, NH quality improvement, specific to identified participant facilities will be based upon the identified participant nursing homes' baseline and remeasurement quality indicator improvement. The provider-satisfaction survey component of QIO contract performance evaluation has not yet been developed. If the survey encompasses both identified-participant nursing homes and nursing homes at large in a QIO's State, CMS will structure the survey and analysis so as to appropriately account for the differing perspectives on identified participants and facilities at large.

Q151. Can the list of participating NHs change during the SoW ?

A151. QIOs may provide intensive technical assistance to as many facilities as feasible in order to achieve optimal results on the statewide rates. Only those facilities identified as participants by the deadline date specified in the contract will constitute the identified participant cohort for the purposes of evaluating the QIO's contractual performance on Task 1a.

Q152. When will the QASIS QIs be determined including the total number that QIOs will be required to use?

A152. CMS presumes that "QASIS" is "OASIS" with a typographical error. OASIS is specific to the Home Health Setting. For answer to the question, see #177 & #1115, in the section of Q&As pertaining to Task 1b.

Q153. The RFP indicates the measures shall be selected by December 15, 2002 and the participants identified no later than February 3, 2003. Should not the dates be reversed and the participants encouraged to select measures of interest and relevance?

A153. The dates for selecting the QIO's set of the publicly reported measures and its cohort of identified participant nursing facilities are sequenced deliberately. The sequencing allows each QIO to select a set of measures important to the stakeholder groups in nursing home quality of care in its state and to then report as identified participants facilities committed to improving their performance on one or more of the measures comprising the QIO's focal set.

The deadline dates for selecting the QIO's focal set of the publicly reported measures and for finalizing the cohort of identified participant facilities are uniform across all three start-dates of QIO contracts.

Q154. Do these dates apply to all QIO groups or will the dates be adjusted per contract cycle?

A154. The deadline dates for selecting the QIO's focal set of the publicly reported measures and for finalizing the cohort of identified participant facilities are uniform across all three start-dates of QIO contracts.

Q155. The RFP states that QIOs must, no later than February 3, 2003, provide a list of identified participant nursing homes. How many more than the 10% should the quality improvement organization get to participate to allow for those that decide during the contract that they no longer want to or can participate (closures, lose key staff, etc).

A155. The 10% target is not a minimum requirement, it is a target (see answer to Question # 149, above). The % of total nursing homes participating with the QIO is determined by the number the QIO identifies (reports) to CMS by the deadline date. CMS will remove facilities from a QIO's cohort of identified participants only under exceptional circumstances: a facility is physically destroyed by a natural disaster (tornado, flood, fire, etc) or the facility is dropped from Medicare and/or Medicaid participation for egregious deficiencies in resident care or other serious violations of regulations/conditions of participation. Staff turnover is an inherent contextual challenge to quality improvement the NH setting and shall not

be considered sufficient reason to remove a facility from a QIO's cohort of identified participants. Unless otherwise specified in the contract language or J-7 (evaluation plan), for purposes of weighting the QIO's 1a performance evaluation, the % of total facilities identified as of the deadline date will be the % participating value entered in the weighting equation.

Q156. Does the 10% requirement mean that QIOs must end up with 10% at the end of the contract, or start with that proportion on the initial list?

A156. See Q&A 155, above.

Q157. Does the Nursing Home information clearinghouse exist?

A157. The nursing home information clearinghouse is in development. RIQP, in collaboration with the other pilot QIOs, is in the process of assembling content materials for the nursing home clearinghouse. Other workgroups are tasked with developing the clearinghouse infrastructure which the NH information will populate.

Q158. Do all clearinghouses still exist?

A158. The clearinghouses are currently under development (see Answer to Question # 157, above).

Q159. The RFP identifies that the quality of care report (public reporting) will be delivered by October 2002. In the same section, it identifies that prior to the start of the SOW7 contract period, CMS will finalize the publicly reported NH quality of care measures. Is there a set date in October? If QIOs receive the report Oct 31, 2002, there is no lead-time.

A159. QIOs will be held harmless if CMS does not provide QIOs the information and guidance necessary to meet a deadline for an activity which is dependent upon CMS providing such information and guidance to the QIOs.

Q160. The QIO shall participate in the NH Support QIOSC training. Who is conducting this training, where, and when? Especially important when this training forms the basis for the QIO approach to improve care and outcomes for the NH quality of care measures.

A160. See Q&As 128 and 129, above.

Q161. The RFP states that QIOs shall provide technical assistance. Is there a further description of technical assistance in regard to nursing homes?

A161. Technical assistance" is in the context of QIO work defined as "Interventions undertaken by a QIO with providers and practitioners as part of a QIP." Clearly, there are differing levels of intensity of technical assistance in any and all settings. There is not, however, a specialized definition of technical assistance peculiar to the nursing home setting.

Q162. If CMS is unable to publicly report on the quality of care provided to Medicare beneficiaries in NHs by the stated dates, will QIOs be held harmless from any negative impact caused by late reporting?

A162. QIOs will be held harmless from negative impact directly attributable to delays in CMS publicly reporting quality of care. For example, a delay of a month or two in CMS publicly reporting quality of care measures would likely result in CMS extending the deadlines for QIOs to select their focal set of measures and identify their participating nursing homes by a like time period. The same delay would not warrant an exemption from the required activities in Task 1a, nor excuse a QIO from demonstrating improvement on its selected set of the publicly reported measures.

Q163. Are the reporting dates different for round 1, 2 and 3 QIOs?

A163. See Q&A 154, above.

Q164. Is it necessary to report the number of nursing homes monthly in TQIP?

A164. The QIO must enter the names, addresses, and provider numbers of identified participant nursing homes into TQIP (or its equivalent, successor) system by the deadline specified in the contract and evaluation plan. QIOs may be asked to report monthly on the number of facilities (outside the participant group) who have requested and received informational materials on improving clinical care related to the publicly reported measures within that month.

Q165. A QIO is to work collaboratively with at least 10% of the Nursing Homes in the state, has CMS set a target goal for the % of beneficiaries affected?

A165. No.

Q166. What data source should QIOs use to define the number of nursing homes in their state?

A166. Data source to define number of nursing homes in the state is OSCAR. (See Q&A # 147). For definition of nursing home for Task 1a, see Q&As 116 & 117.

Q167. Please define if participant nursing homes are inclusive of both skilled nursing facilities (SNFs) and intermediate care facilities (ICFs).

A167. See Q&As # 116 & 117, above. QIOs should note that facilities comprising their cohort of identified participants must for practical reasons participate in Medicaid, at the least, since only providers participating in at least one program (Medicare &/or Medicaid) must transmit MDS. The publicly reported QI measures are expected to be MDS-derived, so we cannot determine baseline or remeasurement rates for facilities not participating at least in Medicaid. Priority in selecting the cohort is placed, in descending order: Medicare & Dually (Medicare & Medicaid) Certified Skilled facilities; facilities certified as skilled, but participating only in Medicaid and not Medicare; and, finally, Medicaid-participating ICFs.

c. Support

Q168. The introduction to this paragraph mentions the "Reference Document". When will be the entire reference document be available to QIOs?

A168. See #1.

Q1111. Is the technical information reported by CMS on NH indicators on this web: www.medicare.gov/nhcompare/search/ or is there another web site location, and what is that address?"

A1111. As of March 11, 2002, information about quality for nursing homes is on the web site as indicated in the question. As 7th SOW publicly reported measures have not yet been selected, technical information on them is not yet available. Places to seek more technical information than is posted on

the consumer-oriented Medicare.gov Web site include www.hcfa.gov and www.cms.gov (At this point, CMS.gov is online, but remains under development. Content is in process of being migrated from the old HCFA address, but complete population of the new and improved site is expected to take some time.)

Q1112. Section C.3, Page 22 NH QI - Can the list of participating NHs change during the SoW ?

A1112. See Questions & Answers 151 and 155.

Q1113. C.3.D.1.c, page 23 – What is the Reference Document to which this section refers and when will be available?

A1113. See Question & Answer # 168

Q1114. C.3.D.1.c(vii) – Will QIOs be expected to participate in the QIOSC structured communication?

A1114. The structured communication is provided to support QIOs. Individual QIOs' participation is voluntary.

Q169. For educational purposes, this QIO suggests finding an appropriate balance between regulatory compliance and clinical based evidence in regards to the train-the-trainer sessions.

A169. Thank you for your input.

Q170. What type of discrepancies are anticipated?

A170. The text of the Statement of Work as issued in the RFP indicated the following: "The QIOSC will provide ongoing technical support to QIOs to assist them in helping NHs to understand the discrepancies between the publicly reported data and other CMS NH quality reports."

The use of the term "discrepancies" was incorrect. The term which is correct is "differences".

The Statement of Work will be amended to read: "The QIOSC will provide ongoing technical support to QIOs to assist them in helping NHs to understand the differences between the publicly reported data and other CMS NH quality reports."
Some areas where there can be differences include: source(s) of data; definition of numerator; definition of denominator; whether risk adjustment is employed; and if so the type of risk adjustment employed.

Q171. How will the number of beneficiaries served by participating nursing homes relate to the evaluation process?

A171. The unit of analysis for public reporting is the facility level. CMS has no plans to attempt to weight the analyses according to facility size, facility census counts/rates, or the demographics of facilities' surrounding geographic area.

Q1118. What is the precise definition of a nursing home A118: See question 116.

A1118. See question 116.

Q1119. For instance, if a chain of homes is identified, does each location count as a separate home?

A1119. Each facility is identified by a certification number. A chain of nursing homes is not considered one nursing home; each facility within the chain has its own certification number. A QIO working with a chain must report to CMS (via the appropriate SDPS standard reporting tool) identification information for each individual facility within the chain which is participating in the QIP on which the chain is working in partnership with the QIO. Identifying information needed for CMS to identify the facilities for purposes of evaluating identified-participant improvement includes: the certification number, name (*e.g.* "Hypothetical Healthcare at Atlantis" as distinct from "Hypothetical Healthcare at Nirvana"), and address (physical location) of each of the individual facilities

d. Changes in Quality of Care Measures

e. Evaluation

f. Deliverables

2. Task 1b: Home Health Quality Improvement

a. Background

Q172. What is the timeline for completion of the CMS public reporting of HHA quality measures?

A172 The publicly reported measures will be available after they are selected, tested and timed for public release by the CMS Administrator.

Q173. This section specifies that QIO improvement efforts should focus on the 10-15 quality of care measures from OASIS that will be publicly reported. Will QIOs be expected to address all publicly reported measures or to concentrate on a subset of 3-5 measures as in the NH setting?

A173. The QIO will be held accountable for improvement on the set of CMS publicly reported OASIS outcome measures and for improvement on HHA targeted OASIS measures for the participating HHAs. After OBQI training, HHAs will identify outcome measures to target. The QIO will assist HHAs in this process. When the home health publicly reported measures are selected by the CMS Administrator, QIOs will likely be asked to provide additional focus and support to HHAs which need to target these outcomes.

Q174. What is the timeframe for CMS to publicly report on the quality of care provided by home health agencies?

A174. See answer to question #172

Q175. What is the date range of the information that is publicly reported?

A175. The reports are based on one year of data and are updated monthly. Publicly reported information could be updated monthly. However, this has not been decided by CMS.

Q176. The contract discusses narrowing of the number of measures for nursing homes. There is no discussion of narrowing of the 10-15 measures for Home Health Agencies as in previous drafts. Is this correct?

A176. The number of publicly reported measures has not yet been determined by CMS Administrator.

Q177. The SOW7 states that there will be 10-15 publicly reported OASIS quality of care measures and that CMS will instruct QIOs to focus their quality improvement efforts (and measure statewide improvement) on care in those areas. This, however, is contrary to the premise of the OBQI process which most, if not all, QIOs are likely to use for the home health initiative. OBQI allows home health agencies to choose two of the 41 OASIS indicators, based on what is most necessary according to the their own profile of care, as the focus of their improvement efforts. It is quite possible that HHAs will choose two measures that are not included in CMS's 10-15 publicly reported measures. Additionally, the proposed Medicare conditions of participation follow the OBQI method by allowing HHAs to select any two OASIS measures for improvement.

A177. The publicly reported measures will specify outcome measures to be focused on at the national level. QIOs should help HHAs with understanding of CMS' mission related to those publicly reported measures. For HHAs participating in the OBQI model, the HHA's targeted outcome measures are guided by a set of criteria. This criteria is designed

to help HHAs understand the outcomes that need to be targeted for improvement. The publicly reported measures may not fall within the targeted outcomes for some HHAs. That is, HHAs doing well on the publicly reported measures will not have to work as diligently on them. QIOs should assist HHAs in identifying the measures to be targeted. The targeted measures will continuously evolve over time as HHAs go through their OBQI cycles.

Q178. This section specifies that QIO improvement efforts should focus on the 10-15 quality of care measures from OASIS that will be publicly reported. Will QIOs be expected to address all publicly reported measures or to concentrate on a subset of the measures as in the nursing home setting?

A178. Please see answer for Question #177 QIOs and HHAs should conduct careful review of the publicly reported measures and their own OASIS/OBQI reports to proceed with need assessment.

Q179. If CMS is unable to publicly report on the quality of care provided to Medicare beneficiaries in HHAs by the stated dates, will QIOs be held harmless from any negative impact caused by late reporting?

A179. Please see attached Revised J-7.

Q180. Are the reporting dates different for round 1, 2 and 3 QIOs?

A180. Public reporting dates will be determined by the CMS Administrator. Timing will not be adjusted to the QIO contract rounds. All QIOs are expected to begin participation in the OBQI project at the start of the 7th SOW regardless of Round or the dates of the publicaly reported measures.

Q181. In preparation for release of Home Health data to the public and to facilitate partnership/collaboration with the Home Health Agencies, will the QIO receive the data for review prior to its release?

A181. No.

Q182. Will there be any variation in the CMS publicly reported data results from the data submitted by the Home Health Agency?

A182. No, the publicly reported measures will be derived from the OASIS data submitted by HHAs.

Q183. Is the publicly reported data aggregate?

A183. Yes, the publicly reported data are aggregated. The reports are based on one year of data and are updated monthly. They are also risk-adjusted.

Q184. Will CMS establish a minimum expected threshold performance goal for this task both statewide and for identified participants?

A184. This will be outlined in attachment J7.

Q185. When will the indicators be specified?

A185. The indicators will consist of the 41 OASIS outcome measures.

Q186. There are currently 41 measures. In section C.3.D.2.a, "it is expected, but not yet decided, that there will be approximately 10-15 publicly reported OASIS quality of care measures." Will QIOs be expected to see improvement in all the measures or will CMS select specific measures for improvement?

A186. When selected by CMS, there may be emphasis on the set of CMS publicly reported OASIS measures. Participant improvement will be based on the set of OASIS quality of care measures targeted by participating HHAs. (See Attachment J for more clarification; the Statewide component has been removed.)

Q187. Since the Outcome Based Quality Improvement Program (OBQI) recommends that home health agencies work to improve a limited number of measures, will the results be measured on measures each individual participating home health agency chooses to improve or will the agencies be measured on all the CMS determined measures?

A187. See answer to Question #186

Q188. Will the participating agencies results be simply added together and divided by the number of participating agencies or will weighting be used based on the number of patients seen by each agency? This applies to both baseline and remeasurement periods.

A188. Clarification is provided in Attachment J.

Q189. Will we be working with all ten to fifteen OASIS measures or will we be selecting a specified number as with nursing homes?

A189. See answers to #176 &178

Q190. It appears that the selection of measures and participating HHAs will occur before the measures themselves are available. This timetable is more restrictive than that set out for the nursing home projects. This could put the 1st round QIOs at a disadvantage in recruiting facilities when the work content is undefined. When will these measures be available?

A190. Statewide improvement has been deleted from Task 1(b) Evaluation. See attached revised J-7.

Participant improvement will be on the set of OASIS quality of care measures targeted by participating HHAs.
QIOs should not wait for the publicly reported measures to recruit HHAs. They should start recruiting as soon as they have signed on to the 7thSOW.

Q1115. Section C.3., Page 24 – When will the OASIS Qis be determined including the total number that QIOs will be required to use?

A1115. The publicly reported measures will be available after they are selected, tested and timed for public release by the CMS administrator. Each participating HHA will make independent determination of outcome measures they will work with. QIOs will provide assistance in the process.

Q1120. What is the official CMS definition of a HHA (ex: Medicare certified, skilled services…)?

A1120. In general, any Medicare certified HHA licensed by the State Licensing and Certification Agencies with recommendations from Regional Home Health Intermediaries.

Q1121. Will the QIO receive the date for review prior to its release

A1121. No. HHAs are mandated to report OASIS. The reports will be released by a CMS data contractor to be downloaded by HHAs, State agencies and components within CMS. QIOs will have access to these reports and will be taught how to analyze them in assisting the HHAs in their QI efforts.

Q1122. By what medium will the information be publicly reported (Internet, newsletters, media…)?

A1122. This process is being finalized. Possibly all the above, probably a CMS web-site.

Q1123. Will QIOs have access to the patient level data that produce OASIS reports?

A1123. Not as a rule. QIOs will not need patient level data to perform their duties under Task 1b.

b. Task Description

Q1098. C.3.D.1.b. Task Description – See above comments about sharing costs and the directive from CMS to other CMS contractors (C.2.B.4). Given our current work with other QIOs, we understand the level of technical assistance designed for the nursing home; however, we have received questions from other QIOs about the level and intensity of technical assistance. Can guidance be given to the QIOs as to the level and intensity of technical assistance that is expected for this setting, as well as all other settings that mention technical assistance?

A1098.No.

Subsections (vii) and (viii) indicate that target participation rate is at least 30% of HHAs in the state and the participating group may change throughout the contract cycle with QIOs reporting participating HHAs monthly in TQIP; However, only those agencies listed as identified patipants within 6 months of the contract effective date will be considered for evaluation purposes.

Q1116. If a HHA drops out can the QIO recruit others to meet this requirement or should we over recruit in anticipation of dropouts?

A1116. QIOs should attempt to recruit all HHAs in their state. QIOs should consult with other HH OBQI QIOs in the 6th SOW pilot.

Q1117. If only the HHAs on the list will count for evaluation process, how will this affect the QIOs evaluation?

A1117. QIOs are being evaluated for HHA participant improvement of the outcome measures. Another evaluation component is participant satisfaction of training provided by QIOs.

Q191. Reference is made to "improving quality of care measures Statewide." No provision is made for improving performance for the group of participants, which seems at odds with the evaluation methodology.

A191. See Attachment J7. Also see Answer to #190.

Q192. Will there be only one (1) HH OBQI training session made available to QIOs?

A192. The QIOSC will offer a formal 2 ½ day intensive OBQI training to each QIO. There will be ongoing support provided by the QIOSC and CMS subsequent to training.

Q193. Where will the HH OBQI training session(s) be held and how many QIO employees should be budgeted to attend?

A193. Training location has not yet been determined. It will be 2 ½ days in train the trainer format. It would include overview of HH industry, OASIS, HHPPS, OBQI content with interactive exercises. QIOs need to send a minimum of two staff members (staff could be project manager, medical director, project co-ordinator). The goal is to develop a training program that can be replicated. However, all the required materials are already available in Power Point format. QIOs need to plan for mailroom staff and other support staff to compile manuals, notebooks, etc.

Q194. When will the HH OBQI training take place and will travel be required?

A194. See answer to question #193.
It will be offered within 3 months of contract effective date.

Q195. Note: this section has two iii's indicated. This question relates to "within 6 months of the contract effective date…" How does CMS define the participant list for physician office quality improvement?

A195. See duplicate Question 252.

Q196. Are QIOs to offer education to all HHAs in the state or only to agencies which are identified participants?

A196. QIOs are directed to offer education and support to all HHAs in their state. Those elected to take the offer will become participants.

Q197. Are QIOs expected to offer all HHA in the state education and training on all OASIS quality of care measures or just those publicly reported measures?

A197. See answer #177.

Q198. This section specifies a 30% target participation rate for HHAs in the state. This is an aggressive target and would result in the identification of a large number of targeted HHAs in states with many organizations. Would CMS consider establishing a ceiling or maximum number of HHAs for this sub-task?

A198. The five HHOBQI Pilot QIOs have a participation rate of 50% to 80%. The contract allows for increased funding for larger states with more HHAs.

Q199. What data source will be used to compile the list of potential participant home health agencies?

A199. All Medicare HHAs from OSCAR and state home health associations

Q200. If this information needs to be updated, what will be the process for updating the file?

A200. Update own files within QIO with copy to GTL and PO

Q201. Is there missing information? “The target participation rate is at least 30% of the HHAs in the State …

A201. No

Q202. (See Glossary at J-1 for …)” Does the … represent missing information?

A202. No, the dots are only dots, typographical errors and not an ellipsis. These dots will be deleted.

Q203. This section specifies a 30% target participation rate for HHAs in the state. This is an aggressive target and would result in the identification of a large number of targeted HHAs in states with many organizations. Would CMS consider establishing a ceiling or maximum number of HHAs for this sub-task?

A203. The five HH OBQI pilot QIOs have a participation rate of 50%-80%. The contract allows for increase funding for larger states with more HHAs.

Q204. A QIO is to work collaboratively with 30% of the Home Health Agencies in the state, has CMS set a target goal for the % of beneficiaries affected?

A204. No

Q205. No later than six months from the contract effective date, provide a list of identified participant HHAs. How many more than the 30% should the quality improvement organization get to participate to

allow for those that decide during the contract that they no longer want to or can participate (closures, lose key staff, etc).

A205. QIOs should try to recruit as many participants as they can. See answer to #202

Q206. Must we end up with 30% at the end of the contract?

A206. 30% is the target rate. QIOs should try to recruit as many participants as they can

Q207. Pilot experience indicates that the OSCAR list is not accurate. We are concerned about how the denominator will be calculated based on an outdated list. Please reconsider/comment.

A207. The denominator will be submitted by the QIO. The pilot QIOs get their updated lists from State Home Health Associations.

Q208. This indicates that the QIO will provide training to the Home Health Agencies. Is this considered duplicative since the State is also providing training to the Home Health Agencies?

A208. Training provided by the state is limited to help with understanding of the OASIS and OBQI reports. QIOs will be offering 1 ½ day of training to HHAs to learn OBQI system and effect change.

Q209. Is it necessary for the QIO to participate in the training to be given "credit" for this task?

A209. QIOs are encouraged to collaborate with State OASIS co-ordinators and the Survey and Certification staff.

Q210. What data source should QIOs use to define the number of home health agencies in their state?

A210. Start with OSCAR and contact state HH Association to get updated list.

Q1125. How will the target participation rate of 30% be calculated since the current OSCAR data system doesn't contain an accurate listing of Medicare certified Home Health Agencies

A1125. CMS would have to depend on QIOs' report of baseline at beginning of the contract cycle. QIOs should consult with QIOSC on this matter. In

general, an accurate list can be obtained by contacting the state HH Associations and other sources. QIOs will have an opportunity to submit information about this issue.

Q1126. In RI, all Home Health agencies are required to be Medicare certified as a condition of Medicaid participation. Will these agencies be included in the 30% calculation, even though many of them do not see or bill for Medicare beneficiaries?

A1126. Presently, all Medicare Certified agencies have to participate in OASIS reporting. Agencies that are certified but choose not to bill Medicare will still be in the denominator and numerator of statewide reporting. It would be prudent for them to participate in the OBQI model offered by the QIOs.

Q1127. Will CMS provide the QIO with a state-specific list of HHAs?

A1127. No. The list can be obtained via OSCAR and may be available through the local state HH Associations.

Q1128.If so, when?

A1128. CMS reads #1128 as contingent upon the answer to # 1127 being affirmative. The answer to #1127 is negative, therefore Q 1128 is not applicable.

Q1129. If not, what will be done to assure accuracy between QIO and CMS information?

A1129. I assume this question follows Q1127
For evaluation purposes, the initial baseline will be determined by QIOs' report at beginning of the project but may be updated with confirmed information.

Q211. How does CMS plan to evaluate the QIO based on potential participating HHAs changing during the contract cycle?

A211. Please see Revised Attached J-7.

Q212. Some agencies, operating under one provider number, have multiple sites of operation. Should the QIO plan to work with the staff at each site of operation?

A212. It depends on administrative structure of the agency. Train the trainer model might be applicable in some and not the others.

Q213. States, “The specific agencies constituting the participating group may change throughout the contract cycle. The QIO will report the number of participating HHAs monthly in TQIP; However, only those agencies listed as identified participants within 6 months of the contract effective date will be considered f or evaluation purposes? Please clarify.

A213. Please see Revised Attached J-7.

Q214. What is meant by the sentence, “The specific agencies constituting the participating group throughout the contract cycle”?

A214. Please see Revised Attached J-7.

Q215. Which OASIS reports does CMS intend providing to the QIOs?

A215. QIOs can download OASIS/OBQI reports that the state and HHAs have access to. They are based on one year of data and updated monthly.

Q216. At what time intervals?

A216. They are based on one year of data and updated monthly. They are also risk adjusted.

c. Support

Q1130. How often will QIOs receive this information, and how will it be communicated?

A1130. As for update of HHA listing, QIOs should work with the QIOSC and the state HH associations.

Q1131. When will this clearinghouse be available?

A1131. It is available now. The address is www.obqi.org
QIOs can sign in as guest. Any QIO wishing to have more access than as a “guest” can call Delmarva foundation at 1-800-869-6600. Ask for Barbara Vencill who will assign a QIO user ID and password.

Q1132. Would CMS consider adding a FAQ section to the clearinghouse website?

A1132. A FAQ section is in the Clearinghouse Web site plus many other features.

Q1124. Will QIOs be expected to participate in the QIOSC structured communications?

A1124. Yes

Q1133. In section C.3.D.2.b.viii, QIOs are required to report participating HHAs every month via TQIP, but this section (C.3.D.1.b.vii) does not contain a similar requirement. Will the QIO be required to report participating nursing homes monthly in TQIP?

A1133. See Question & Answer 164.

d. Changes in Quality Measures

e. Evaluation

Q217. How will the number of beneficiaries served by participating home health agencies relate to the evaluation process?

A217. They will be considered in the aggregate report of the outcome measures.

3. Task 1c - Hospital Quality Improvement

a. Background

Q218. CMS has previously indicated that future plans would allow QIOs to stop work on a specific quality indictor once a high level of performance had been achieved. These "completed" indicators would be dropped entirely or go into a surveillance mode to insure performance did not deteriorate over time. The "completed" indicators would then be replaced with new quality measures selected by CMS and negotiated with the QIO. The 7th SoW does not include any of these provisions. Will QIOs be allowed to address new quality indicators as replacements for existing indicators with high performance levels?

A218. We have not made that determination. Our goal would be to do so in a way that did not increase the QIO resources directed to the topic.

Q219. If so, how will that process work?

A219. See #218.

Q220. Please indicate if the disparities projects are the only projects requiring a project plan. It is not mentioned in the other sections.

A220. Requirements for each component of the Scope are listed individually.

Q1134. Please clarify how the baseline for CAHs will be calculated, since they weren't included in 6th SOW data collection. What about a hospital that transitions to a CAH during the contract?

A1134. We will need to resample to do this. It is unlikely that this will be a large sample

Q1135. On IP indicators where the QIO is above 90% what is the mechanism for us to obtain a waiver?

A1135. We have yet to develop a mechanism. Your Project Officer is the source for technical direction.

b. Task Description

(i)

(ii)

Q221. How available are the CDAC abstraction services?

A221. It depends on the final budget allocation.

Q222. What would be the timeframe for completing reviews?

A222. It depends on the number of records, variables and complexity. Average time to abstract is about 50 minutes and project life cycle is about 9 months with module development.

Q223. What will be the deadline for securing CDAC abstraction services?

A223. Priority is given to national projects. CDACs operate based on first-in/first-out principal. Samples are located at the 25th of the month and 45 days is given to receipt about 90-95 percent of the records from the providers. And, then the abstraction is started.

Q.224. The inpatient topics are confusing in that all are evidenced based with a significant amount of literature to support them as improving care except the presence of indicator #6 for Pneumonia, "Oxygenation assessment with in 24 hours of hospital arrival". This indicator actually has evidence that supports a negative correlation to outcome. How can we, as the deliverer's of the message support this situation, particularly in the face of the support for the other clinical indicators.

A224. This was added to be more consistent with JCAHO's measures.

Q225. When will the data collection tool for surgical site infections be available?

A225. The CMS approved tool is scheduled for production release on August 1, 2002.

Q226. The table of quality of care measures, pneumonia. Are the vaccine indicators "screened/given" or "given." There is no detail if it was changed from the sixth contract cycle.

A226. A case "passes" these measures if vaccine status is documented and the patient either a) is not vaccinated because of contraindications (has had vaccine already, has allergy/sensitivity to vaccine, or refuses) or b) receives indicated vaccine.

Q227. Will QIOs be allowed to stop work on specific quality indicators once a high statewide level of performance has been achieved?

A227. This is yet to be determined

Q228. If so, will the "completed" indicators be replaced with other measures?

A228. See 227

Q229. How will this be factored into the evaluation process?

A229. CMS would have to make an adjustment, considering such factors as whether a baseline is available and whether or not there is sufficient time to deploy interventions.

Q230. For the blood culture quality indicator – Does this measure only when blood cultures are performed or does it measure that blood cultures are to be performed before antibiotics are administered in all instances?

A230. At present it measures both.

Q231. When seeking collaboration in the acute care setting, does medication (and other) system failures relate only to the quality of care measures listed by clinical topic?

A231. Yes

Q232. Which measures are identical to JCAHO and where do measures differ?

A232. All CMS measures apply solely to Medicare beneficiaries, an important difference from the JCAHO ORYX measures, where eligibility is not dependent on payment source.

Except as noted above, differences in the measures are outlined below. Detailed measure specifications for the CMS measures will be made available to all QIOs by the end of April 2002.

Heart failure: Measures are identical.

AMI: Measures identical except for the following:

- JCAHO has an inpatient mortality measure; CMS does not.
- The JCAHO time-to-treatment measures (i.e., time to thrombolysis and time to PTCA) calculate median times. CMS will calculate these measures as well as categorical time-to-treatment measures (i.e., proportion of PTCAs within 90 minutes, proportion of thrombolyses within 30 minutes); QIO evaluation will be based on the categorical time-to-treatment measures. JCAHO is planning to add these categorical time-to-treatment measures when the ORYX measures are revised.

The JCAHO will not have an influenza vaccine measure and does not currently have an antibiotic selection measure. We expect that any antibiotic selection measure that it develops will be very similar to that of CMS. Both organizations' antibiotic timing measures require the same data elements, but the JCAHO currently reports only a median time, while CMS uses a categorical time period for evaluation and reports median time as well. CMS currently plans to use a two-part blood culture measure (performance plus collection prior to antibiotics), while JCAHO will measure only collection prior to antibiotics. Both organizations' pneumococcal vaccine, oxygenation assessment, and smoking cessation measures are essentially identical.

Q233. Are any of the measures likely to change – which ones?

A233. QIOs should expect that the CMS antibiotic administration timing measure will target the first dose within 4 hours of arrival at the hospital. Very minor changes in the antibiotic selection measure are possible.

At present, CMS anticipates no changes in the cardiovascular quality measures over the 7th SOW. However, changes in guidelines over the next three years may necessitate currently unforeseeable modifications in the quality measures.

Q1136. Is there a minimum number of acute-care hospitals that the QIOs are expected to work with in the state?

A1136. No.

Q1137. Will there be exceptions / modifications provided to rural and CAH hospitals who are unable to provide the left ventricular ejection fraction test?

A1137. No.

Q1138. Can a test such as b-type Natiuretic Peptide (BNP) be substituted?

A1138. We will be using national indicators.

Q1139. How does CMS define "physician", and does that include optometrists?

A1139. This is discussed in the revised J7

Q1153. When will QIOs receive baseline data on the Surgical Site Infection Prevention project?

A1153. Round 1 rates will be available in June 2002, round 2 rates in September 2002, and round 3 rates in December 2002.

Q1154. Under Task 1c, the "Background" (Section C.3.D.3.a. of the RFP) states that the acute care hospitals now include Critical Access Hospitals in the 7SOW. Since 6SOW re-measurements will serve as 7SOW baseline measurements, and 6SOW did *not* include Critical Access Hospitals, how will this difference be accounted for in the 7SOW evaluation process?

A1154. We will have to collect and measure a supplementary sample.

c. Changes in Quality of Care Measures

4. Task 1d Physician Office Quality Improvement

a. Background

Q1140. How does CMS count services provided by VAs, Community Health Centers, IHS, private health insurance policyholders, etc. to Medicare beneficiaries?

A1140. We are currently relying on claims data.

Q1141. How does CMS define "primary care physician"?

A1141. See the revised J7

Q1142. Will CMS provide the QIO the state-specific universe of providers who treat Medicare beneficiaries for each topic condition, and the percentages of Medicare beneficiaries they treat within the state for those topic conditions?

A1142. Yes.

b. Task Description

Q234. What is the meaning of the parenthetical phrase "full state Medicare population?"

A234. This refers to the measurement strategy for immunizations. Similar to the 6th Scope, the survey will reach those age 65 and over who are Medicare fee-for-service and Medicare managed care.

Q1143. Please clarify the definition of "identified participant." Specifically, how will beneficiaries in FFS Medicare be assigned to physicians for purposes of calculating "identified participants" who treat at least 10% of the beneficiaries in the State for each topic area?

A1143. This has been addressed in the revised J7, attached to this amendment.

Q1144. What is the definition of "treat" in this case?

A1144. See Q&A # 237, below.

Q1145. Please elaborate on what is meant by using "specific interventions."

A1145. CMS is not mandating that a QIO use a "specific" intervention. Currently, in the Community of Practice effort, some interesting interventions are being used in the physician office setting including preventive health software, patient registry, etc. If a specific intervention was used in the physician office setting, the QIO could evaluate its effectiveness.

Q1146. Will the exact interventions be specified from CMS/QIOSC to the QIO?

A1146. This is a performance based contract. CMS will endeavor to provide QIOs with useful options.

Q235. 1) Are the referenced topic areas Diabetes, Cancer Screening, and Adult Immunizations?

A235. See Q237. Diabetes and Cancer Screening are the referenced topic areas. Adult immunization is being dropped from this subtask.

Q236. 2) Please give a precise definition of the denominator for each of these, and indicate how these data will be available to contractors.

A236. See Q. 237

Q237. QIOs are asked, within 6 months of the contract effective date, to provide a list of identified participant physicians. The list is to include participants who treat at least 10% of the beneficiaries in the State for each topic area. Does this mean that the QIOs will need to calculate the percentage of Diabetics each participant physician treats?

A237. The following is in response to all the questions regarding "targeting identified participants who treat at least 10% of the beneficiaries in the State for each topic area"

- CMS will create a number to approximate 10% of the active primary care physicians in the state, based on the number of combined Internal Medicine and Family Practice (also known as "General Practice") physicians, including subspecialties of the above for each QIO. The number will be the target number of identified participants for the diabetes and breast cancer (adult immunization is dropped from this subtask) components of task 1d b. (iii).

- The QIO will within 6 months of the start of its contract, provide to CMS a list of its identified participants, as well as physician identifiers (PINs and UPINs) necessary to identify patients for whom these physicians have submitted claims. The QIOs are free to include in the list of identified participants, any licensed practitioners that submits Medicare claims, regardless of other practice characteristics (specialty, group or other practice).

CMS will then identify two sets of beneficiaries:

1. All beneficiaries included in the data set that was used to calculate the state-specific diabetes baseline (and subsequently, remeasurement) and associated (by claims) with any practitioners in the set of identified participants which the QIO provided.

2. All beneficiaries both meeting the inclusion criteria for the mammography indicator and associated (by claims) with any practitioner in the set of identified participants that the QIO provided.

The beneficiary sets will be used to produce the baseline and remeasurement rates for diabetes and mammography indicators for the identified participants. CMS expects the QIO to demonstrate at least 8% decrease in failure rate in the measures for those beneficiary sets.

CMS is currently developing the methodology to link patients to practitioners for the purposes of evaluation. In the event it proves impractical to measure the identified participant-specific rates, the QIO will not be evaluated on this subtask, but on the statewide rates and participant satisfaction.

Q238. Is this even possible?

A238. See #237

Q239. Clarity may be necessary regarding the intention of sub-paragraph D.4.b.iii.

A239. This is not a question, it is a comment.

Q240. The requirement of "identified participants" who treat at least 10% of the beneficiaries in the State for each topic area involves a much greater number of physicians in a large state QIO as compared with a state with a smaller Medicare population. Because changing the behavior of large numbers of physicians is much more difficult than changing the behavior of a few, it would seem that this requirement is biased in favor of states with smaller Medicare populations.

A240. CMS provides QIOs with resources in proportion to the number of providers or (as appropriate) practitioners in their states.

Q241. The question of bias in favor of states with smaller Medicare populations is raised when considering that CMS expects the QIO to demonstrate at least 8% improvement in the combined topic weighted average at the 28th month of the contract for both statewide and identified participants.

A241. CMS budget assumptions do account for differences in state provider/practitioner populations

Q242. How will CMS obtain the list of physicians?

A242. See #237.

Q243. Where will the data come from (UPIN problems with FI)?

A243. See #237.

Q244. With respect to the 10%, are there geographic/regional requirements?

A244. No.

Q245. May QIO target MSAs?

A245. Yes.

Q246. What is participation?

A246. See #237.

Q247. Are there levels of intensity---if so, what are their definitions?

A247. See #237

Q248. How will participation be validated?

A248. See Attachment J-7, "General Evaluation criteria for Task 1." CMS will make no further efforts to validate the identified participants or confirm QIO activity with these participants.

Q249. The idea of enough physicians to cover 10% of the beneficiaries may be unworkable. How are we to know when we have the magic number of physicians?

A249. See #237

Q250. This section specifies a target participation rate as physicians "who treat at least 10% of the beneficiaries in the state for each topic area." Linking beneficiaries to individual physicians is a problem. Beneficiaries frequently are seen by multiple providers and "assigning" the beneficiary to a single provider is difficult. QIOs consistently report significant error rates in linking patients to physicians regardless of the linking methodology used. Does CMS have a standard method that all QIOs should use when linking beneficiaries to individual physicians"?

A250. Linking each beneficiary to a single physician is not necessary.

Q251. To identify the participating physicians that treat 10% of the beneficiaries in each topic area, the QIO must first identify the beneficiaries in the "universe" for that topic. For diabetes, this is a fairly straight-forward proposition. However, for immunization and mammography, it is much more difficult. It appears the "universe" of beneficiaries for the

immunization topic would be all beneficiaries in the state and for breast cancer it would be all female beneficiaries in the state. If so, targeting enough physicians to ensure that 10% of the appropriate beneficiaries are covered would involve the identification of a very large numbers of physicians. There are other methodological problems as well... for immunization, the BRFSS measurement strategy does not allow for the measurement of improvement at the individual physician level since the sample is statewide, and for breast cancer, the clinical service (mammography) is most often provided at a separate facility and billed by the radiologist, not the primary care physician. Reaching 10% of the beneficiaries for the immunization and breast cancer topic areas would be extremely difficult because of the large numbers involved and the methodological difficulties. Would CMS consider revising the evaluation process for the physician quality indicators to address these issues?

A251. See #237.

Q252. Note: this section has two iii's indicated. This question relates to "within 6 months of the contract effective date…" How does CMS define the participant list for physician office quality improvement?

A252. The numbering of this section will be corrected. Identified participants are defined as those providers/practitioners identified by the QIO as participating in a quality improvement project.

Q253. The target is to include 10 percent of the beneficiaries in the state for each topic area. How will CMS link patients to "identified participant" physicians to determine physicians (a) who treat beneficiaries for each topic or (2) to measure improvement in the participant group?

A253. See #237, above.

Q254. With BRFS as the data source for the statewide flu and pneumococcal measures, how will CMS link patients to physicians?

A254. See #237.

Q255. This section refers to "the target is to include identified participants who treat at least 10% of the beneficiaries in the state for each topic area." Is this to imply that the QIO must provide a list of providers for <u>each</u> of the three topics to encompass 10% of the beneficiaries for <u>each</u> of the three topics? (This question is very specific and will make an extremely large impact on resource use. If we are to reach 10% of beneficiaries <u>across all three</u> conditions vs. <u>in each</u> may translate into 3-5x difference in resource allocation.)

A255. No, See response to Q. 237

Q256. What method will be available for QIOs to assign patients to providers?

A256. See #237.

Q257. Are there standard definitions that will be used nationally for this purpose?

A257. See #237. CMS will develop a standard method.

Q258. How will we provide information on providers that may change due to the disease state vs. the contract cycle (e.g. Influenza)?

A258. See #237.

Q259. Since Subtask 1d. is entitled "Physician Office Quality Improvement", shouldn't the office staff in addition to the physician be addressed in the satisfaction survey?

A259. The survey could be completed by the physician as well as the physician office staff.

Q260. What is the definition of "identified participant" physician?

A260. See #252.

Q261. The reference to "…general Task requirements listed in A…" is not clear. Is this reference to C.3.A?

A261. The general requirements are listed in C.3.C.1. General Requirements

Q262. This section specifies a target participation rate as physicians who treat at least 10% of the beneficiaries in the state for each topic area. As beneficiaries are often times seen by multiple providers, linking them to an individual physician is problematic. Does CMS have a standard method that all QIOs should use when linking beneficiaries to individual physicians?

A262. See #237 and #250. CMS will develop a standard method.

Q263. Defining the denominator of beneficiaries - in order to identify the participating physicians that treat 10% of the target beneficiaries in each topic area, the QIO must first identify the beneficiaries in the "universe" for that topic. For diabetes, this is a fairly straightforward proposition. However, for immunization and mammography, it is

much more difficult. It appears the "universe" of beneficiaries for the immunization topic area would be all beneficiaries in the state and for breast cancer, it would be all female beneficiaries in the state. If so, targeting enough physicians to ensure that 10% of the appropriate beneficiaries are covered would involve the identification of very large numbers of physicians. There are other methodological problems as well. (E.g. for immunization, the BRFSS measurement strategy does not allow for the measurement of improvement at the individual physician level since the sample is statewide, and for breast cancer, the clinical service (mammography) is most often provided at a separate facility and billed by the radiologist, not the primary care physician.) Reaching 10% of the beneficiaries for the immunization and breast cancer topic areas would be extremely difficult because of the large numbers involved and the methodological difficulties. Would CMS consider revising the evaluation process for the physician office quality indicators to address these issues?

A263. See #237.

Q264. The requirement of “identified participants” who treat at least 10% of the beneficiaries in the State for each topic area involves a much greater number of physicians in a large state QIO as compared with a state with a smaller Medicare population. Because changing the behavior of large numbers of physicians is much more difficult than changing the behavior of a few, it would seem that this requirement is biased in favor of states with smaller Medicare populations.

A264. See #240.

Q265. Working with physician specialty information from CMS during the sixth scope of work revealed that it led to inaccurate results in a great percentage of cases. CMS needs to provide a more accurate source of information on the specialty in which a physician routinely practices in order to carry out the objectives of this task.

A265. See #237.

Q266. Statewide improvement is defined as improvement on quality of care measures by identified participant physicians. Can the participant groups be concentrated in areas of high population?

A266. QIOs are free to identify participants in any location of their states.

Q267. What are the guidelines for identifying the target physician groups that care for 10% of the beneficiaries in the state?

A267. See # 237

Q268. States statewide flu and pneumococcal (PPV) immunization rates will be based on “periodic” BRFSS survey results. Define “periodic”.

A268. CMS is dependent on the Centers for Disease Control & Prevention for the BRFSS. The flu and pneumococcal immunization questions are scheduled to be asked during odd-number years.

Q269. Another concern is that problems with billing issues haven’t yet been addressed. Are these being fixed?

A269. It is not clear what billing issues the question is referencing.

Q270. Need clarification regarding the Medicare claims data CMS will provide for the physician office. Will the QIOs receive data during the SOW7 or just at baseline and remeasurement?

A270. CMS is in the process of contracting with a Data QIOSC to provide data to QIOs during the SOW .

Q271. How does CMS define physician?

A271. CMS will create a number to approximate 10% of the active primary care physicians in the state, based on the number of combined Internists, General Practitioners, Family Physicians and Ob/Gyn’s, including subspecialties of the above for each QIO. The number will be the target number of identified participants for the diabetes and breast cancer (adult immunization is dropped from this subtask) components of task 1d b. (iii).

The QIO will within 6 months of the start of its contract, provide to CMS a list of its identified participants, as well as physician identifiers (PINs and UPINs) necessary to identify patients for whom these physicians have submitted claims. The QIOs are free to include in the list of identified participants, any licensed practitioners that submits Medicare claims, regardless of other practice characteristics (specialty, group or other practice).

Q272. How does CMS define "primary care physician"?

A272. See #271.

Q273. Does the term “for each topic area” imply that the physician targets are different for each clinical topic area? Please provide an example of how this number is calculated.

A273. No. See #237.

Q274. Task 1 (d) requires the QIO to target "identified participant" physicians who treat at least ten percent (10%) of the beneficiaries in the state for each topic area. Can estimated volumes of the number of physicians this data represents for Illinois be provided to allow for determination of resources needed for pricing?

A274. Based on the estimated total number of Internist and family practice physicians practicing in the State, Illinois has 10,679 therefore 10% is 1,068.

5. Task 1e - Underserved and Rural Beneficiaries Quality Improvement

a. Background

b. Task Description

Q6. Has the requirement requiring a minimum number of rural health care providers been dropped? It is not mentioned in the RFP. Please comment.

A6. There is no requirement requiring a minimum number of rural health care providers for Task 1e.

Q275. The RFP states, "A copy of the approved project plan shall be submitted to the CMS Project Officer within 10 days of the 7th SoW contract effective date." Does this mean resubmitting the originally approved plan?

A275. This means submitting the most current, complete and accurate project plan, approved by your CMS Project Officer, under which you intend to perform your 7th SoW Task 1e project.

Q276. The reader is told when project idea documents are due for options "i" and "ii" but not for "iii". Is this intentional?

A276. Current version project plans are required for continuing 6th SoW disparities projects (option "i"). New project idea documents and project plans are required for new projects (option "ii"). Since rural projects would be considered new projects (option "iii"), new project idea documents and project plans are required.

Q277. A note makes reference to a data source specified in Task 1d. Where is this data source specified?

A277. See Task 1d

Q278. Is it the same data source for immunization used in the sixth scope of work?

A278. BRFSS will be used for immunization

Q279. This seems to imply, in contrast to the previous drafts, that the QIO will have no say in the continuation of the current disparities project vs. a new project. Is that true?

A279. Each QIO's Project Officer was asked to inform Central Office about whether or not the QIO would be continuing its 6th SOW 'disadvantaged population' project into the 7th SOW as its underserved/rural (Task 1e) project. CO assumes that the RO recommendations were arrived at as part of each QIO's 28th month evaluation. Consequently, at this time, the decisions regarding which projects (new, continuing, etc.) the Round 1 QIOs will do in the 7th SOW have already been made and are reflected in the "Task 1e Spreadsheet – Disparities Project Recommendations" (See J Attachment List).

Q280. What selection criteria will be used by the Central and Regional office staff in this process?

A280. See Q&A # 279.

Q281. Will the QIO be able to provide information to assist in this process?

A281. See Q&A # 279.

Q282. Is 10 days adequate time to submit an approved project plan if we are continuing our same project?

A282. QIOs are responsible for keeping their project plans current throughout the project performance period. Working with the CMS Project Officer, any modifications/revisions/improvements, projected future developments and interventions, extension of projects statewide, expansion of partnerships, etc., as a result of learning/problem-solving, are to be kept current via the TQIP reporting system. Consequently, the Task 1e project plan to be submitted for the 7th SoW is to be the most current, complete and accurate project plan, approved by your CMS Project Officer, under which you intend to perform your 7th SoW Task 1e project.

Q283. What information will be used to determine if a QIO should continue their current disparity project or begin a new one?

A283. See Q&A # 279.

Q284. If we continue the same project does that mean the same project in the same area or does it allow for some modification or expansion of the current project?

A284. Any modifications/revisions/improvements, projected future developments and interventions, extension of projects statewide, expansion of partnerships, etc., as a result of learning/problem-solving, are to be approved by the CMS Project Officer. The Task 1e project plan to be submitted for the 7th SoW is to be the most current, complete and accurate project plan, approved by your CMS Project Officer, under which you intend to perform your 7th SoW Task 1e project.

The only time a new project plan is required is if the QIO proposes to change either the population or the indicator. Then the project becomes a new project (rather than a continuing project), and the entire new project process (i.e., PID/project plan approval) must be followed.

Q285. Is this an expectation for those QIOs continuing the same disparity project?

A285. Yes.

Q286. What is the deadline for the Project Officer's decision as to which approach we should include in our proposal?

A286. See Q&A # 279.

Q1149. C.3.D.5.b(ii) Underserved population is not defined in glossary J1. Please provide the definition and criteria for selecting an underserved population if different from the 6 SOW.

A1149. The definition for "underserved population" is the same for the 7th SoW as it was for the 6th SoW, with the addition of "rural". All Task 1e related definitions can be found in Attachment J-1e, a supplement to the Attachment J-1 "Glossary of Terms".

Q287. What degree of disparity needs to be demonstrated to initiate a rural project?

A287. In the *Terms and Definitions* for Task 1e, included in the RFP, the section “Evidence of Disparity” defines the degree of disparity.

Q288. If the QIO elects to select a second, rural topic area, should the budget under this tasking reflect maximum effort for both tasks, or is the overall percentage of the budget for this task set?

A288. Budget estimates and funding are based on one project.

d. Coordination

Q289. The reference to “See C.3. Above” is not clear. Please clarify the coordination aspects of this project involving rural and underserved beneficiaries.

A289. The reference is to “Support” on Page 22 of the Statement of Work.

6. Task 1f - Medicare+Choice Organizations (M+COs) Quality Improvement

a. Background

Q290. "In almost all cases…will not involve inpatient care" while under b. Task Description i. M+COs are to join projects under Task 1a to 1e---which includes inpatient care. Please clarify.

A290. You are correct, Task 1f does involve inpatient care as referenced in b.(1). The language “ In almost all cases, any project authorized under this sub-Task will not involve inpatient care.” Is in error and will be deleted.

Q291. At this subtask in the RFP it states that "In almost all cases…will not involve inpatient care" while under b. Task Description i. M+COs are to join projects under Task 1a to 1e---which includes inpatient care. Please clarify.

A291. See the response to #290.

Q292. For the 25% survey portion of the QIO evaluation: Whom is the survey sent to?

A292. See answer to #293 (below).

Q293. The physicians or the contact person at the M+CO that the QIO identifies?

A293. The precise details have not been finalized. Either or both may be included. QIOs will be notified once the determination is made, but do not need it to prepare business or technical proposals.

Q294. The background paragraph states, "In almost all cases, any project authorized under this subtask will not involve inpatient care." In Task Description paragraph b., however, it states, "…invite all M+COs in the state to join quality improvement projects on Tasks 1a to 1e." Since Task 1c is entirely inpatient care, is this setting excluded from the requirement to invite M+COs to participate?

A294. See response to # 290.

Q295. Similarly, would Task 1a (nursing homes) be excluded?

A295. No, work in nursing homes would not be excluded, see response to #290.

b. Task Description

Q296. QIOs are directed to "invite all M+COs in the state to join quality improvement projects." Does this refer to M+COs headquartered in the state?

A296. No, QIOs should contact each M+CO with a contract in the state regarding QI. There should not be a duplication of effort since M+COs in the state report on QAPI by a unique H #, therefore, QIOs are working with individual M+COs in the state, even when they are a part of the same corporation, e.g., PacificCare. Further, QIOs are encouraged to work on coordinating collaborative projects with all M+COs in the state.

Q297 If not, how do we prevent duplication for plans serving multiple states?

A297. See answer to #296

Q1147. C.3.D.6.b, page 31 – A state will be doing a new project for task 1e. Must the topic be decided now for us to write our technical proposal for this task?

A1147. The topic must be decided in time enough to meet the 7th SoW deliverable requirement under C.3.D.5.b that states: A QIO starting a new project under C.3.D.5.b shall submit a project idea document to its CMS Project Officer within 90 days of contract effective date for noncompetitive procurements and within 120 days of contract effective date for competitive procurements.

Q1148. If so, will we be able to access disparity data to make that decision during the RFP process?

A1148. Disparity data is available/accessible with assistance from the DASQIOSC (formerly "DASPRO").

Q298. There is a deliverable stated " Within 60 days of the contract effective date, the QIO shall submit a plan describing the methods it will use to accomplish this requirement". This deliverable is not included in the Delivery Schedule in Section F and therefore it is not clear as to who are the recipients of the plan.

A298. Yes, it was left off the deliverable list. Will add to the Deliverable List- Plan describing the methods QIOs will use to solicit M+CO participation in QIP for tasks 1a to 1e. Recipients – A and GTL.

Q299. There is a discussion of providing technical assistance on data abstraction. During the sixth contract cycle, QIOs have not been informed of changes to data element definitions. How will this problem be overcome during the seventh contract cycle?

A299. QIOs will be informed of changes to data element definitions.
QIOs are informed of any policy or operational changes effecting M+COs, through the SDPS M+CO Point of Contact.

Q300. There is a discussion of data validation. Will there be standards for validation (e.g., sample size) or will QIOs be free to construct data validation systems?

A300. b.(iii) Cannot locate the reference to data validation, it is not at Task 1f

Q1150. Who determines the availability of resources to decide whether we need to offer technical assistance under the 7th Scope contract, or charge for services?

A1150. The availability of resources will be determined at contract negotiations. However, the demand for this type of TA is expected to be very limited.

Q1151. Does "technical assistance" as used here include chart abstraction and data analysis for the M+COs?

A1151. Yes, though it is incumbent upon the QIOs to make wise choices about the efforts they support.

Q1152. Can we charge the M+Cos for chart abstraction services that relate to the required clinical topics in the 7SOW (diabetes, mammography, immunizations) or QAPI-required clinical topics?

A1152. Please refer to the conflict of interest langauge contained in the contract.

Q1241. In trying to do estimates for our organization for M+CO FTE's for the 7th SOW, a question has arisen regarding the sustained improvement year for the QAPI projects. Was it CMS's intent for sustained improvement, which falls in the fourth year after the 3 year cycle, to have the QIO's support the interventions as in the previous years. We have 2 different interpretations of the support level for sustained improvement. I could see this varying by topic and the intervention utilized.
As an example, for our flu or pneumonia support, if we stop the intervention, which we provide, it could directly impact the sustained improvement score. For projects which have systemic changes, the intervention support may not be needed.
So the question is, does CMS intend that we can budget for the fourth, sustained improvement year or was the intent for only the 3 year cycle?

A1241. The intent for providing technical assistance to M+COs was <u>not</u> based on the length of time it takes the M+CO to perform a National project, through sustained improvement The QIO is responsible on an ongoing basis to provide TA when requested by the M+CO, as it relates to a QAPI, and as a QIO's resources permit.