E. Task 2 – Improving Beneficiary Safety and Health Through Information and Communications

1. Task 2a - Promoting the Use of Performance Data

Q301. Is it a correct reading of the SOW7 RFP that CMS has not assigned the QIOs to educate consumers or conduct outreach to the public or to beneficiaries specifically regarding nursing home and home health performance data.

A301. 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.

Q302. If this is incorrect, please supply references to the portion of the RFP that asks QIOs to undertake this activity.

A302. See #301.

Q303. The CMS Administrator and others have said that QIOs will be responsible for explaining the nursing home quality indicators, and possibly the home health indicators, to the public. However, the RFP suggests that QIOs may later be asked to conduct outreach to beneficiaries or the public generally in order to advance the goal of promoting the use of performance data. How will QIOs be funded for the cost and staffing for carrying out this function in the Seventh Scope of Work?

A303. See #301.

Q304. The OMB apportionment for the Seventh Contract does not fund two-thirds of the requested amount for public outreach and education to promote the use of performance data. Will CMS adjust the schedule for work on this task, or the amount of work to be done, given that most of the resources needed are not available?

A304. See #301.

Q305. If QIOs are directed by CMS to conduct further activities in the 7th SoW, will this be funded through a contract modification?

A305. See #301.

Q306. "Initially, implementation of this activity….QIOs' 6th Round Contract…CMS **may** direct all QIOs to conduct certain activities to further this goal" Please clarify whether QIOs have to do this or not.

A306. See #301.

Q307. The Statement of Work indicates that initially this work will be carried out through modifications to the QIOs 6th Round Contract. The evaluation attachment (J-7 indicates that more information will be provided in subsequent Statements of Work.

A307. See #301.

Q308. Will CMS provide the QIOs with recommendations on how to budget and plan resources for this section of the statement of work?

A308. See #301.

Q309. "However, during the period of the 7th Round Contract, CMS may direct all QIOs to conduct certain activities to further this goal". Since it is not possible to estimate costs on these unknown activities, does CMS intend to fund these activities separately under a contract amendment or special project?

A309. See #301.

Q310. Can CMS be more explicit as to how they want QIOs to promote this?

A310. See #301.

Q311. "Initially, implementation of this activity….QIOs' 6th Round Contract…CMS **may** direct all QIOs to conduct certain activities to further this goal" Please clarify whether QIOs have to do this or not. What is the guidance in the instance of a competitive contract?

A311. See #301

Q312. Will there be a modification to the existing contract?

A312. See #301

Q313. Should QIOs omit budgets and narratives addressing Task 2a-Promoting the Use of Performance Data until 6th SOW modifications are sent out? (QIOs are instructed not to include this activity in J-12 Sub-task Strategy

Matrix descriptions and the J-7 reference to 2a suggests evaluation will be specified at later date.)

A313. See #301.

Q314. How often will CMS generate reports of the aggregated data for State level reporting of quality of care measures?

A314. This has yet to be determined, but QIOs do not need this information to prepare business or technical proposals.

Q950. This attachment refers to a subsequent statement of work. When will this statement of work be issued?

A950. See #301.

Q1155. Please give examples of what types of activities CMS may direct QIOs to conduct.

A1155. See #301.

Q1190. When will we receive the detail necessary to budget staff and resources for this activity?

A1190. At this time staff and resources should be budgeted for only work required in the Statement of Work, including time to develop project proposals.

2. Task 2.b - Transitioning to Hospital-Generated Data

a. Background

Q315. In many states, the majority of hospitals do not seek accreditation by JCAHO. When these states also lack mandatory reporting laws, there is much less incentive for the hospital to invest the resources necessary to collect and report hospital level quality measures. QIO efforts on this sub-task would be greatly aided if CMS would make hospital reporting of quality measures part of the Medicare Conditions of Participation. Does CMS have any plans to do so? If so, when?

A315. CMS has no plans to make reporting of quality measures a part of the Medicare Conditions of Participation. CMS is, however, actually and visibly supporting development of a national reporting set and of State reporting pilots, which would be the foundation of a plan.

Q316. Is CMS aware of a hospital movement to change accreditation from JCAHO to American Osteopathic Association (AOA)?

A316. CMS is unaware of any movement to change accreditation from JCAHO to AOA.

Q317. Many of our hospitals were concerned about reporting data to the QIO during 6th SOW until we assured them that although we were analyzing their data, it was not being reported to CMS at that level, only statewide aggregate. Will there be any assurances QIOs can give providers that although their hospital-specific data is going into the CMS national repository-it will not be used against them in a punitive manner? We understand the plans for potential future public reporting but this will be a question we will be asked since their specific data will be reported.

A317. The same conditions that existed under the 6SOW will prevail under the 7SOW. In the absence of specific laws or regulations, data reported to CMS will be aggregated at the State level. The repository can be considered an extension of the QIO's authority.

Q318. Please confirm that the diagnoses hospitals will be expected to report only includes AMI, Heart Failure, Pneumonia (includes inpatient immunization), and Surgical Infection Prevention. We assume the outpatient topics such as diabetes, immunization & mammography are not included in this requirement even though they may be working on these topics in the outpatient areas - correct?

A318. Correct.

Q319. Attachment J-4 refers to four hospital quality indicators "see section __", but no section number is listed.

A319. This is an observation, not a question.

Q320. How available are the CDAC abstraction services?

A320. CMS will not be making any CDAC services available to the QIOs in the 7th SOW. If a QIO wishes to use CDAC services they must contract independently.

Q321. What would be the timeframe for completing reviews?

A321. Which reviews? Timeframes for QIO mandated reviews are in the manual.

Q322. What will be the deadline for securing CDAC abstraction services?

A322. See #223.

Q323. When will the QIOs receive the instrument to assess the current reporting capabilities of hospitals?

A323. We intend to have the instrument available at the beginning of the contract.

Q324. The first paragraph states, " In the future, it is expected that hospitals will report on a standard set of quality of care measures." To whom will the hospitals be reporting?

A324. This statement is made in reference to supposed future requirements that hospitals will be publicly reporting quality indicators.

Q325. Will CMS provide any incentives for hospitals to produce these reports?

A325. No, the only incentive currently being proposed is the ability to substitute electronic data for a copy of a medical record. But hospitals will be able to participate in QIO sponsored community based collaboratives in a way that would not be possible without the data.

Q326. The third paragraph states, "and have the largest number of hospitals possible collecting and reporting quality of cares measures." For the purposes of evaluation, how will the "largest number possible" be defined?

A326. The goal is a 50 percent increase.

Q327. Will the tools that are being developed allow facility-specific real-time analysis of the hospital data?

A327. The tools are being designed with this capability in mind.

Q329. third paragraph, last sentence – "During the transition to electronic self-reporting by hospitals…" Will this work be completed by the CDACs or the QIOs during the transition?

A329. The CDACs.

Q330. For how many of the inpatient topics must a hospital be self collecting data in order to be considered to be a hospital that is collecting data?

A330. It is felt that a hospital that is reporting on one indicator would choose to complete all indicators as a matter of efficient resource utilization.

However, for our purposes, if a hospital is reporting on at least one indicator, it will be considered to be a reporting hospital.

Q331. Do the hospitals have to collect on 100% of qualifying records, or may they collect on a sample?

A331. We are unsure of the meaning of "qualifying records", however, the records that a hospital is required to report, those requested by the CDAC for the quality indicator surveillance sample, constitute a sample in and of themselves. We expect to be able to adjust the CMS sample to use records abstracted by the hospital for other purposes, i.e. to report to a vendor, if the hospital has used a random sample.

Q332. Will CMS consider an augmentation to the Conditions of participation to require hospitals to collect data in the CMS formats and for the CMS topics?

A332. See #315

Q333. Since the CMS indicators and the Joint Commission indicators have been aligned, and data collection will be requested of the hospitals, is there not an impact on QIOs?

A333. In this case, one abstraction can meet both JCAHO requirements and CMS needs.

Q334. That is, QIOs' achievement of Task 2b will be directly related to the percent of hospitals in their state that are members of the Joint Commission. Does CMS have any plans to address this inequity that is beyond the QIO's control?

A334. We currently do not have such plans.

Q335. Would it be appropriate/acceptable for QIOs to advocate that hospitals in their state join the Joint Commission?

A335. I No, this should be a hospital's business decision.

Q336. Current TQIP data show that there is no correlation between hospital based data collection and relative inpatient improvement. With this knowledge, how do we as the QIO justify this collection of the hospital data?

A336. This answer is not needed to prepare business or technical proposals.

Q338. Does CMS intend to require hospitals to submit data as part of their participation agreements in order to make it possible for this program to succeed?

A338. See #315.

Q339. If not, what incentives will hospitals have for participating?

A339. See #315.

Q340. For budgeting purposes, what is the magnitude of the expectations in the SOW7 for "QIOs to conduct certain activities to further this goal"?

A340. QIOs should propose cost based on the stated requirement and applicable Manual sections.

Q341. For example, media campaigns?

A341. We do not release government cost estimates or their assumptions.

Q342. When will the CMS abstraction tools become available?

A342. The CMS approved abstraction tool is scheduled for production release on August 1, 2002.

Q343. When will the standard file definitions and abstraction protocols become available?

A343. The standard file definitions and abstraction protocols are scheduled for production release on August 1, 2002.

Q345. QIOs are advised to: "…have the largest number of hospitals possible collecting its own measures." How will it be determined that the "largest number possible" are collecting?

A345. The goal is a 50 percent increase.

Q346. QIO providing abstraction services for hospital-specific programs: to what extent does the QIO need to provide support, and does this abstraction have to be related to the CMS-approved quality indicators?

A346. We understand that QIOs have been providing abstraction services to hospitals as part of their quality improvement efforts. It is our intention that the QIOs will reduce this effort in favor of hospitals conducting their own abstractions. Given this, we believe it is inconsistent with our efforts for the QIOs to abstract records for hospitals outside of the contract requirements.

Q347. Example: can the hospital request that the QIO abstract medical records for trending of C-sections as it relates to the hospital's overall QI plan?

A347. See #346.

Q348. Can the QIO accept validation performed by other measurement systems?

A348. If by other measurement systems you are implying using a data abstraction tool other than the CMS supplied tools or tools with identical specifications, then the answer is no. Our intent is to have the data conform to the CMS approved tool requirements.

Q349. Example: accreditation vendor regularly performs data validation. Can the QIO accept these findings, or does QIO need to perform its own validation, thus requiring the hospital to undergo two separate validation efforts?

A349. We would want to know, initially, if the accreditation vendor data validation conforms to our validation results. For vendors abstracting data for some number of hospitals, the QIOSC will validate the vendor's data abstraction using the same process that a QIO would use in a hospital setting. This will suffice for data validation in all of the vendor's contracting hospitals. Should this prove the vendor's processes are producing valid data, we would consider accepting the vendor's process in future

Q350. "In the future, it is expected that hospitals will report on a standard set of quality of care measures". Have the hospitals been told this or will they be told of this expectation by CMS?

A350. This is not a legal expectation, but merely an attempt to forecast the future. We believe this is the direction that events are heading and that public reporting of hospital indicators of quality will revolve around a standard set of measures.

Q351. Has the confidentiality of the hospital-specific data been considered or is it assumed that since this will eventually be publicly reported data, there is not a confidentiality issue at this point?

A351. Unless regulations are changed, hospital-specific data remains confidential within the QIOs, as it is (under the current text & interpretation of 42 CFR 480), QIO (PRO) data.

Q352. Some hospitals have not been willing to provide the QIO their quality improvement data in the past because they were afraid that it would be

reported to CMS? Will this be an issue and if so, will CMS inform the hospitals that this is a requirement?

A352. The same conditions that existed under the 6SOW will prevail under the 7SOW. In the absence of specific laws or regulations, data reported to CMS will be aggregated at the State level. The repository can be considered an extension of the QIO's authority, and hospital specific data will not be reported to CMS.

Q353. This section contains significant fiscal and resource implications. Does CMS plan to provide QIOs with resources commensurate with the number of providers in the state to perform the data collection, validation, and reporting requirements?

A353. The purpose of this RFP is to describe the work and ask the QIOs to propose a budget to accomplish this work. Please let us know what you think it will take to accomplish this work.

Q354. This subtask states that "hospitals may ask the QIO to abstract additional data…" As this may prove highly resource intensive, could CMS clarify level of effort and activity expected on the part of the QIO?

A354. We expect the QIOs to provide some data abstraction to the hospitals, but we also expect this effort to decline as the contract progresses. We recognize that some smaller and rural hospitals may need more assistance and possibly will not be able to conduct their own data abstraction services. However, under the 6th SOW, the QIOs have experience with this aspect of dealing with their hospitals. The QIO is in the best position to understand the needs in their State. Any current level of effort might be seen as the starting point with the expectation to reduce this as the contract progresses and hospitals become more self sufficient; small and rural hospitals being a possible exception.

Q355. In many states, the majority of hospitals do not seek accreditation by JCAHO. When these states also lack mandatory reporting laws, there is much less incentive for the hospital to invest the resources necessary to collect and report hospital level quality measures. QIO efforts on this sub-task woul+d be greatly enhanced if CMS would make hospital reporting of quality measures part of the Medicare Conditions of Participation. Does CMS have any plans to do so?

A355. See question 315.

Q356. The J-7 Attachment suggests that for Task 2b, QIOs will be accountable for "installing and supporting" the use of CMS approved abstraction tools. By what authority will QIOs go onsite to hospitals to perform software installations?

A356. The SOW clearly states that the QIOs will perform this function at the request of the hospital. The QIOs are to be available to perform this function as they are asked. There is no authority to require a hospital to use these tools.

Q357. Should hospitals' unwillingness to permit installations or report data be construed as a QIO performance issue?

A357. This is a performance-based contract, under which one of the Contractor's (QIO's) responsibilities is to convince hospitals to partner in health care quality improvement and in clinical quality data collection.

Q358. What constitutes a participating hospital in terms of self-abstraction – participation on one indicator, one project, all projects?

A358. For our purposes, if a hospital is reporting on at least one topic, it will be considered to be a reporting hospital.

Q359. The RFP states CMS will determine whether the QIOs have performed all expected data validations in the hospitals in their state within "prescribed timeframes". What are the prescribed timeframes?

A359. The RFP clearly states that validations are to be done twice a year in uncertified hospitals and once a year in certified hosptials.

Q360. It is suggested that Critical Access Hospitals (CAH) be excluded from the total hospital count because JCAHO has excluded them from ORYX requirements. Working with CMS will be over and above their ORYX requirements and create an extra burden on the CAHs. Does this task apply to Acute Care Hospitals only, or does it include Critical Access Hospitals?

A360. CAH will be excluded.

Q361. Is it the intention of CMS that the QIOSC for this task will collectively obtain and correlate all potential data collection tools from accreditation vendors, in relation to the CMS tool, or is this task to be performed by each individual QIO with every possible accreditation vendor in their state?

A361. No, we expect the QIOSC to do this work.

Q362. Will the SDPS vendor provide the database management system for use in collecting data generated under Task 1c and with the self-generated hospital data under Task 2b?

A362. Yes. The SDPS contractor will manage the QIO clinical warehouse and associated database management system.

Q1156. Is it expected that the QIO send staff on-site to each hospital in its state in order to "assess the current reporting capabilities". What is CMS's expectation here?

A1156. This has yet to be determined. We are considering several alternatives, including but not limited to, phone survey, mail in and a web based collection. Our preference will be a web based approach with the QIOs following up with providers not completing the survey.

Q1157. Is it expected that the QIO send staff on-site to each hospital in order "to provide technical assistance to hospitals as they take on this responsibility" of abstracting their own data?

A1157. Not necessarily. This will be the QIO's option.

Q1158. What is CMS's expectation here?

A1158. See #1157.

Q1159. Please expound on the expectation for the QIO to "lay the foundation for a data validation mechanism once a hospital engages in abstracting its own data". Specifically what is CMS's expectation here?

A1159. We believe the expectation is clear as laid out in the RFP; perform data validation on abstracted records twice a year for uncertified hospitals and once a year for certified hospitals.

Q1160. Please elaborate on the requirement to "use a database management system to confidentially collect the measures reported by the hospitals". Is the QIO required to develop this system?

A1160. We intend to collect the abstracted data in online data bases with full MIS query and report capabilities for the QIOs.

Q1161. Can the SDPS be used here?

A1161. Yes.

Q1162. Can the CMS data abstraction tool be used here?

A1162. Yes.

Q1191. This section describes a great deal of discretion/latitude in the services that the QIO must provide to the hospitals for data abstraction. This latitude will make it extremely difficult for QIOs to budget for this activity. Please provide more specific guidance as to the scope of abstraction services required under this contract.

A1191. We believe we have supplied sufficient information in the RFP. Please review the responses to the enclosed questions for further insights.

Q1192. If the technical assistance requested and required by hospitals exceeds available resources, what guidance will CMS provide to QIOs to respond to these requests?

A1192. If this happens we will work with the QIO.

Q1193. Are there standards for checking reliability?

A1193. The standards in the RFP refer to data validation for hospitals abstracting quality indicators. The requirement is 90 percent. Otherwise, we do not understand the reference.

Q1194. What are the expectations in terms of the QIO doing the data collection for the hospitals and/or supporting them?

A1194. Our expectation is clearly stated in the RFP; we expect the QIOs to reduce their data abstraction services and transition hospitals to collecting their own data.

Q1195. If the hospitals want to hire the QIO to do the data collection, please define when the QIO can charge.

A1195. That is a matter for legal counsel.

b. Task Description

Q1163. How many days after the contract effective date will CMS provide the list of information that it requires about the ability and capacity of each hospital to collect and report quality of care measure information?

A1163. We are developing the listing right now. We will make it available as soon as possible.

(i) Assessing Hospital Status

Q363. What will the list of information, provided by CMS, contain about a hospital's ability and capacity to collect and report quality of care measure information?

A363. This has yet to be determined.

Q364. How is this information obtained?

A364. We are considering several alternatives, including but not limited to, phone survey, mail in and a web based collection. Our preference will be a web based approach with the QIOs following up with providers not completing the survey.

Q365. When will this listing become available to the QIOs?

A365. We are developing the listing right now. We will make it available as soon as possible.

Q366. Will the QIO be able to rely on hospital provided information regarding the use of third party vendors or will QIOs be expected to talk directly with third party vendors a hospital may be using?

A366. Once the QIO has identified that the hospital is using a third party vendor, and who it is, the QIOSC will discuss the data issues directly with the vendor.

Q367. What is the expectation of the QIO to insure the information for each hospital is current for each quarter?

A367. We expect the QIO to review the data quarterly and validate on a sampling basis under their IQC plan.

Q368. Does this relate to only the hospital's ability to collect data or also that they are abstracting current discharges?

A368. Our intent was to determine a hospital's status with respect to collecting quality indicator data. We presume that hospitals will be collecting current data.

Q.369. Is there a minimum number of cases a provider will need to abstract?

A369. See Question 331.

Q370. Also is there a timeframe after discharge when the case should be abstracted?

A370. See #369.

Q371. Will the QIOs have to monitor Medicare discharge claims retrospectively to determine if an appropriate sample were sampled?

A371. No (if we correctly understand the question).

Q372. States, "Any information collection/survey activities conducted by the QIO must be done in accordance with Section C.2.B.7." Should this refer to C.2.B.9?

A372. Yes, A383(a), below.

Q373. Does this mean that each quarterly update of the hospital's information should be considered a survey, which must be individually approved by CMS.

A373. No, once the initial survey is completed, the QIOs will follow up as outlined in question 367.

Q374. The last sentence states that, "Any information collection/survey activities conducted by the QIO must be done in accordance with Section C.2.B.7." This section on page 14 is titled "Workplan". Do you actually mean Section C.2.B.9, which is on page 15 and is titled "Information Collection Activities"?

A374. Yes, see A383(a), below.

Q375. Last paragraph -- "The QIO shall be the point of contact for each hospital and shall serve as the technical support for importing hospital collected measurement data into CMS SDPS data collection system." In light of proposed budget reductions and CMS' expressed intent to look for efficiencies, this seems to be an inefficient duplication of services and resources, as it requires each QIO to develop, staff, and maintain a technical support function for its state's hospitals. QIOs will have little direct control over the integrity and operation of the data system. This proposed arrangement creates an unnecessary barrier between the providers inputting data into the system and the organization responsible for the design and operation of the data collection system. If the data collection system is centralized and uniform, does it not make sense to

develop a centralized technical support function that can at least handle initial technical support requests?

A375. By point of contact we imply that the QIO is the local, familiar contact for the hospital. The specific technical expertise may reside with the SDPS or QIOSC staff and the QIO will use that staff to resolve technical issues, but the QIO is intended to be the locus for questions within the State. The QIO will be responsible for supporting providers with the use of the CMS abstraction tool if the hospital elects to use this tool. The QIOSC will be available to assist the QIO. The SDPS contractor will provide technical support for the abstraction tool

Q376. The last sentence under b.i. states "Any information collection/survey activities conducted by the QIO must be done in accordance with Section C.2.B.7". Should this be C.2.B.9, as 7 relates to the Workplan requirement and 9 relates to Information Collection Activities?

A376. Yes, see A383(a), below.

Q377. In addition, assessing hospital status appears to be a survey activity – what will be put in place to facilitate the timely approval of this survey activity?

A377. This has yet to be determined.

Q378. Is the hospital-generated data expectation for PPS hospitals only, or also for Critical Access Hospitals?

A378. For PPS hospitals only.

Q379. What will the list of information, provided by CMS, contain about a hospital's ability and capacity to collect and report quality of care measure information?

A379. This has yet to be determined. We are considering several alternatives.

Q380. How is this information obtained?

A380. See #379.

Q381. When will this listing become available to the QIOs?

A381. We are developing the listing right now. We will make it available as soon as possible.

Q382. Does CMS really intend quarterly?

A382. We expect the QIO to review the data quarterly and validate on a sampling basis under their quality assurance plan for EACH hospital.

Q383(a). "The QIO will maintain the information in the SDPS system… Any information collection/survey activities conducted by the QIO must be done in accordance with Section C.2.B.7." Section C.2.B.7. of what?

A383(a). This was an incorrect citation. The correct citation should be Section C.2.B.9 of the contract. (Further instructions and details will be found in the relevant part of the PRO Manual).

Q383(b). It is stated that the "QIO will maintain the information (on hospital readiness to collect and report quality of care measure information) in the SDPS system." Will CMS provide the capability to store this information in a standard database to all QIOs?

A383(b). The SDPS contractor will support this function.

Q384. What is an "Information Intermediary"?

A384. We believe this question is a technical term related to communications activities, but cannot be certain of that interpretation. As QIOs do not need this information to complete their business or technical proposals, we recommend the inquirer pose this question to CMS staff expert in communications activities in a more interactive (real-time) dialogue separate from the procurement process.

Q385. In reference to the RFP section to be utilized in conducting information collection/survey activities, should this be section C.2.B.9 rather than C.2.B.7?

A385. Yes.

Q386. The RFP states "…the QIO shall assure that the hospital uses standard file definitions and abstraction protocols equivalent to CMS data abstraction tool." There is no reference in the RFP to hospitals using electronic medical records (EMRs). We have found in our special study that electronic abstraction cannot be the same as manual abstraction from a paper record, especially with regard to exclusion criteria. Definitions within EMR abstraction cannot be the same as manual ones. The EMR may be a better tool. There is, particularly, a problem when the QIO uses manual abstraction to validate electronic abstraction. Is CMS discouraging hospitals that use EMRs for quality measurement?

A386. No we are not, but they must conform to the CMS specificiations in order to be used. In addition, see #361.

Q387. When will CMS provide the list of information it requires about the ability and capacity of each hospital to collect and report quality of care measure information?

A387. We are developing the listing right now. We will make it available as soon as possible.

Q388. When CMS creates reports based upon this information in the SDPS system, what are the standards for "complete" information? (see J-7)

A388. All elements of the hospital survey are completed appropriately.

Q389. Can the QIO begin to assess hospital status information relevant to Task 2.b. now in lieu of the CMS list of required information?

A389. Sure, but keep in mind that the QIO may have to go back to the hospitals to collect requested information they may miss in the first pass.

Q390. C.3.E.2.b. (i), page 34 This section states that any information collection/survey activities conducted by the QIO must be done in accordance with Section C.2.B.7. Should this reference be C.2.B.8 or C.2.B.9?

A390. Yes, this reference should be C.2.B.9

Q1164. It would seem that in order for the QIO to properly "determine the extent to which individual hospitals are prepared to collect and disseminate quality of care measures information" on-site visits to each hospital and access to hospital data collection systems will be required. The same would be true for third party vendors. Is this assumption correct?

A1164. This assumption is not correct. We are considering several alternatives, including but not limited to, phone survey, mail in and a web based collection. Our preference will be a web based approach with the QIOs following up with providers not completing the survey.

Q1165.If so, how is the QIO to gain access to these systems?

A1165.N/A

Q1166.Does the QIO have this authority?

A1166.N/A

(ii) Provide Technical Assistance on Data Abstraction Tools

Q391. What constitutes an approved-CMS data abstraction tool?

A391. One supplied by CMS.

Q392. Will CMS consider a data collection tool developed by a nationally recognized organization or study, such as NRMI or American Heart Association's "Get With The Guidelines" program, as an approved-CMS abstraction tool?

A392. No.

Q393. In the event a hospital chooses another data abstraction tool, what is the expectation for the QIO to assure it meets CMS definitions and abstraction protocols?

A393. By conducting the required data validations using the CMS tool, we will know whether the third party tool is acceptable. The RFP clearly states that validations are to be done twice a year in uncertified hospitals and once a year in certified hospitals.

Q394. Is it sufficient to review their hard copy or does the QIO also perform data validation as will be completed on the CMS tool?

A394. See #393.

Q395. Technical assistance could potentially mean a wide array of activities. What is the CMS vision for how this work is carried out, up to and including providing equipment to hospitals that need it?

A395. Our vision includes telephone support, on site help for installation, providing documentation. We will not authorize equipment.

Q396. This section states that CMS will provide a list of information about the ability and capacity of each hospital to collect and report quality of care measure information. What will happen if CMS is unable to provide this information or is unable to provide it in an timely manner?

A396. CMS will provide of list of items of information that we wish to collect about each hospitals ability and capacity to abstract data. It is the QIO's responsibility to see that each hospital has completed the necessary items.

Q397. This states that the QIO will assure that the hospital uses standard file definitions" How is the QIO supposed to assure that this takes place?

A397. The QIO will be provided the standard file definitions and the appropriate documentation. They will be expected to make this information available to the hospitals. CMS, through the SDPS contractor will determine which hospitals have failed to conform to the specifications and notify the QIO. The QIO will be responsible for notifying the hospitals and offer assistance to straighten out their problems.

Q398. Third paragraph - under what authority will the QIO "assure that the hospital uses standard file definitions and abstraction protocols equivalent to the CMS data abstraction tool"?

A398. If we do not accept the hospital's submission because of failure to conform, then the hospital will be required to send paper copies of the requested records to the CDAC.

Q399. What constitutes an approved-CMS data abstraction tool?

A399. The one CMS supplies.

Q400. Could a data collection tool developed by a nationally recognized organization or study, such as NRMI or American Heart Association's "Get With the Guidelines Program" be considered as an approved-CMS abstraction tool?

A400. No, but the tools may meet CMS standards as determined by the data validation process.

Q401. What are the system requirements that are classified as "minimum?"

A401. We do not understand the reference for this question.

Q402. What is the system programmed in and what is the expected timeframe and mode for delivery?

A402. The tool will be developed under approved SDPS standards and is scheduled for production release on August 1, 2002.

Q403. How does CMS expect the QIO to enforce the requirement that hospitals use standard file definitions and abstraction protocols equivalent to the CMS data abstraction tool?

A403. We expect the QIOs to persuade and not enforce. However, if the hospital fails to conform, then the hospital will have to send paper copies of the requested records to the CDAC.

Q404. This section seems to indicate that QIOs will almost necessarily need to create a help desk strategy to assist hospitals in communication, IT and understanding of clinical definition behind abstract requirement. Creating capacity to provide this service for each hospital in a state is highly resource intensive. Is CMS aware of the budget requirements in this task?

A404. Yes we are aware of both the CMS and QIOs responsibility to support hospital/provider communication.

We are asking, through the RFP, for an assessment from the QIO of what those requiements might be. The information will be supplied to the QIO and the QIO will serve as a local point of contact for the hospital.

Q405. Does CMS plan on adapting its own tool to reflect any changes in JCAHO measure specifications as they may occur? Otherwise, if CMS maintains the same measures throughout scope of contract, and JCAHO has made updates in the same time frame, the QIO will be experiencing unusual burden to identify data mismatches between tools, and establishing mechanisms to deal with these differences.

A405. We are coordinating with the JCAHO in the development of the standard tools and definitions. We intend to remain in concert with JCAHO through out the contract.

Q406. Is the QIO expected to assess data validation using only the CMS-approved tool, even if the hospital abstracts records with a tool supplied by their accreditation vendor?

A406. Yes.

Q407. Is CMS only concerned with reliability, or is accuracy of the answers a concern, as well? Reliability conveys consistency of response across abstractor pool, even if the response is not correct.

A407. The intent is that the third party product gives the same answer as the CMS tool. We presume the tool to be correct.

Q408. Please specify the criteria for reliability currently being used by the CDACs.

A408. Reliability is determined by having two different abstractors abstract the same case blindly. The results are compared and reliability is calculated as the number of answers agreed as a percentage of total answers.

The CDACs are currently running at 97 percent reliability.

Q409. When will the CMS tool be made available to the QIO?

A409. We are developing the tool right now. We will make it available as soon as possible.

Q410. Will the CMS data abstraction tool be developed in MedQuest?

A410. The tool will be developed under approved SDPS standards.

Q411. Will CMS or the QIOSCs provide training for the QIOs on the new CMS data abstraction tool?

A411. Absolutely.

Q412. If yes, when and where?

A412. Yet to be determined, but the Webex technology is promising.

Q413. When will CMS provide details about this application and requirements for running it on a hospital system?

A413. Details regarding the tool and requirements for the tool will begin to be disseminated during April 2002.

Q414. Will the tool incorporate all of Task 1.c. clinical conditions and quality indicators?

A414. This is the intention

Q415. Can a hospital elect to abstract only one (1) quality indicator or must all quality indicators be abstracted?

A415. A hospital may elect to abstract only one topic, but all indicators in the topic.

Q462. Is the CMS approved tool one tool which covers all four inpatient project topics or four separate tools?

A462. It is one tool that covers all inpatient topics.

Q463. What sampling methodology should the hospitals use for abstraction of the inpatient projects?

A463. If the hospital chooses to use a sampling methodology, then the JCAHO sampling requirements will suffice.

Q464. Is this sampling methodology the same as the JCAHO sampling requirements?

A464. See #463.

Q465. On the second page of this section, the third paragraph states, " All short term, acute hospitals are to be included in the survey. This includes Critical Assess Hospitals (CAH) as well as specialty hospitals." What type of specialty hospitals are to be included?

A465. CMS does not have an answer readily available, however the relatively small number of such specialty hospitals suggests that QIOs do not need a definitive answer to this question in order to prepare business or technical proposals.

Q466. Please further describe the data flow for the CMS data collection tool and the JCAHO ORYX vendor abstractions.

A466. JCAHO ORYX vendors may use the CMS abstraction tool to submit data to the clinical warehouse on behalf of their provider.

Q467. Specifically, will the JCAHO data and the CMS data be stored in the same database?

A467. Provider, CDAC, QIO, and vendor data will be stored in the clinical warehouse.

Q468. Where will this database be located and what mechanisms are available to the QIOs, hospitals and ORYX vendors to update this database?

A468. The database is located at the SDPS contractor complex and is available via QualityNet eXchange for update access.

We intend that the data will reside in SDPS with full MIS query and report capabilities

Q1167. Can the QIO require that hospital staff be trained at the QIO's location in order to fulfill the requirements in this section or must the QIO provide assistance on-site at each hospital?

A1167. This is at the discretion of the QIO.

Q1168. Does the QIO have the authority to disapprove the use of data abstraction tools should the QIO determine that such tools are sub-standard?

A1168. By conducting the required data validation using the CMS tool, we will know whether the third party tool is acceptable.

Q1169. Can the QIO require that all hospitals use the CMS data abstraction tool?

A1169. No.

Q1170. When may we expect the list of information required for the QIOs to assess the ability and capacity of each Hosp. to collect and report quality of care measure information?

A1170. We are developing the listing right now. We will make it available as soon as possible

Q416. The QIO will participate in inter-QIO data reliability projects. Is there an estimate of the number of cases we will be required to reabstract each year so that we can project adequate resources?

A416. We have not yet determined this number. But it will be less than 400 cases a year.

Q417. What will be the scope of the inter-QIO data reliability projects? Are these to be considered special projects?

A417. No, they will not be considered special projects. The inter-QIO data reliability is part of the overall CMS quality assurance plan for QIOs.

Q418. Last paragraph of that section refers to inter-QIO data reliability projects. Would CMS provide some guidance on how do plan for resources and budget without specific information on the IRR?

A418. We have not yet determined this number. But it will be less than 400 cases a year.

Q419. Does CMS have specific plans in mind that can be shared with QIOs to help determine the level of resources that will be needed for this activity?

A419. We have not yet determined this number. But it will be less than 400 cases a year.

Q420. Does CMS have a standard protocol that will be used for determining reliability?

A420. Abstraction by the QIO using the CMS tool must agree with the hospitals submitted data in 90 percent or more of the cases reviewed.

Q421. If so, can QIOs have additional information on that protocol?

A421. See #420.

Q422. The statement of work refers to 90% reliability for the data validation. Is this across all indicators captured by the hospital or is it for each indicator in the statement of work?

A422. Across all indicators. The element of selection is the abstracted record.

Q423. This section refers to a 90% reliability. Is this for each element, each indicator or each topic?

A423. See #422.

Q424. The SOW7 states, "Hospitals that consistently perform below 90% reliability….will be required to submit hard copy versions of charts (to the QIO)." In that situation does CMS intend that the QIOs will perform the abstractions of the hard copy charts, and should budget accordingly to include reviewer time and associated chart mailing and other costs?

A424. No, the CDACs will be performing the abstraction of these records. Remember, the records being requested (those for which we are allowing the hospital to submit an electronic abstraction) constitute the surveillance sample for the State level indicators used to evaluate the QIOs success under Task 1c.

Q425. Second paragraph - How is 90% reliability defined? How is "consistently perform" defined?

A425. Abstraction by the QIO using the CMS tool must agree with the hospitals submitted data in 90 percent or more of the cases reviewed. Consistently performed means that each validation sample meets the reliability requirements.

Q426. How often will QIOs be required to re-abstract data samples?

A426. The RFP clearly states that validations are to be done twice a year in uncertified hospitals and once a year in certified hospitals.

Q427. What will be the required sample size?

A427. The sample size, at each validation for each hospital, is a minimum of 30 abstracted charts, or whatever is available up to that number.

Q428. How will participation in inter-QIO data reliability projects be determined?

A428. All QIOs are subject to participation in the inter-QIO reliability studies and will participate in at least one activity per year.

Q429. How many cases will be typically involved in the inter-QIO data reliability projects?

A429. We have not yet determined this number. But it will be less than 400 cases a year.

Q430. Will CMS specify sampling parameters and frequency for hospitals who are collecting their own data?

A430. The RFP clearly states that validations are to be done twice a year in uncertified hospitals and once a year in certified hospitals.

The sample size, at each validation for each hospital, is a minimum of 30 abstracted charts, or whatever is available up to that number.

Q431. Will CMS specify sampling parameters and frequency for re-abstraction samples to be used for data validation?

A431. See #430.

Q432. Define “consistently performs at <90%”.

A432. Abstraction by the QIO using the CMS tool must agree with the hospitals submitted data in 90 percent or more of the cases reviewed. Consistently performed means that each validation sample meets the reliability requirements.

Q433. Does a single submission below 90% constitute the need to submit additional records?

A433. Two in a row. The hospital gets a pass on the first sample below 90 percent, but the frequency goes up to twice a year (if less). At the second sample below 90 percent, the hospitals must submit copies of the records.

Q434. What is meant by electronic submission for hospitals >90%?

A434. They can submit the abstraction data for the requested records, electronically.

Q435. Would this include self-abstraction for areas other than QI?

A435. No.

Q436. Will hospitals performing below 90% be subject to a larger volume of re-abstraction?

A436. No.

Q437. Should the QIO plan to abstract its data on an ongoing basis?

A437. Yes. Staggering the hospital data validation process is probably prudent.

Q438. What is the planned number of records to be abstracted for each topic during the inter-QIO IRRs?

A438. We have not yet determined this number. But it will be less than 400 cases a year. There is no topic specific number.

Q439. How many inter-QIO data reliability studies will be conducted?

A439. We have not yet determined this number. But it will be less than 400 cases a year.

Q440. What can we anticipate the volume of review required for these studies to be?

A440. That number is undetermined at this time. The sample size, at each validation for each hospital, is a ~~minimum~~ maximum of 30 abstracted charts, or whatever is available up to that number.

Q441. The QIO is to determine the accuracy of reported hospital quality of care measures by re-abstracting a sample of Medicare cases known to have been abstracted and submitted by the hospitals in their state. What is the number of cases that will be selected for re-abstraction by the Illinois QIO?

A441. The same size, at each validation for each hospital, is a ~~minimum~~ maximum of 30 abstracted charts, or whatever is available up to that number.

Q1171. QIOs have been encouraged QIOs to use the group, collaboration intervention models as much as possible due to the restricted resources. Based on the DRAFT PRO manual and RFP, it appears QIO will be required to use the individual intervention model of

moderate to high intensity to accomplish validation of all hospital received data. Does CMS agree?

A1171. CMS does not agree. The data validation exercise is only to assure that we are receiving accurate data with which to calculate the State wide quality indicators.

Q1172. Define current reporting capabilities of hospitals in each state.

A1172. This will be done at the beginning of the contract when the QIOs receive the survey instrument.

Q1173. Several of our hospitals, with our assistance have improved 6th SOW performance indicators to 100%. They are not interested in an ongoing program of collecting data on indicators where no opportunity for improvement exists. Will hospitals be expected to generate their own data on all 7th SOW indicators or only those indicators where an opportunity for improvement exists?

A1173. We will expect hospitals to generate their own data for all indicators.

(iv) Assistance on Collecting and Reporting Hospital Data

Q442. For the purpose of the QIO providing direct data abstraction services, CMS needs to better define "small hospitals and those lacking adequate internal resources to abstract data."

A442. CMS is of the opinion that the QIOs are in the best position to understand the nature of the population of hospitals in their State. With this understanding, the QIO should be able to judge the capabilities of the resident hospitals and determine to what extent small or rural (or some other designation) hospitals can independently fulfill data abstraction and data reporting requirements. We are giving the QIOs the ability to determine, within the context of their own State, the number of facilities that may need assistance in this respect. Therefore, we feel a standard definition would place an unreasonable burden on a QIO's ability to estimate resource requirements.

Q443. What is the standard process, if any, that the QIO must undertake to assure that the reported data conforms to standard file definitions and abstraction protocols as defined by CMS?

A443. This process will occur via QualityNet eXchange. The process will be automated to validate data input and return records failing edits.

Q444. In the SOW, it is expected that "as many hospitals as possible should be abstracting and reporting their own data", while the J-7 attachment says that QIOs are expected to decrease the number of hospitals not reporting abstracted data to the QIO by 50%. Which is correct?

A444. “As many as possible” is the goal; 50 percent is the benchmark.

Q445. To be counted as "collecting data", should a hospital be collecting data: 1) continuously?, 2) for a number of months over a year?, or 3) on all indicators and all topics? - or is there a minimum number of each?

A445. We would prefer both 1) continuously and 3) on all indicators and all topics, in that order. We recognize that hospitals will probably be doing less than this. This may be the only way, however, that a hospital will be in a position to provide abstracted data when the request comes in from a CDAC for a chart.

Q446. This section refers to the QIO assuring that non-CMS software used by hospitals will conform to CMS file formats and definitions. How will this be possible if the data is:

A446: Please refer to #447 and #448.

Q447. Collected in a proprietary format?

A447. The hospital should export the file to standard file formats or use the CMS approved tool.

The QIOSC will provide the standard file definitions and the appropriate documentation. The QIO will be expected to make this information available to the hospitals. The QIOSC will determine which hospitals have failed to conform to the specifications and notify the QIO. The QIO will be responsible for notifying the hospitals and offer assistance to straighten out their problems.

Q448. Collected using different case definitions?

A448. The hospital should not submit data that does not conform to the approved CMS definitions.

If we do not accept the hospital's submission because of failure to conform, then the hospital will be required to send paper copies of the requested records to the CDAC.

Q449. Available in a format that is not able to be converted via the provided SDPS software?

A449. SDPS software will not be provided to allow providers to convert to standard formats. The hospital or contractor should export the file to standard file formats using its own tools or use the CMS approved tool.

Q450. What if the hospital collects the data but refuses to submit the data to us?

A450. If they do not share their data with us, they will be required to submit to the CDACs the paper copies of records selected/required for surveillance samples.

Q451. What is their requirement/incentive to do so?

Q451. See questions #398 and #313.

Q452. What level of data collection is required for a hospital to be coutned as collecting data?

A452. At least a random sample of its discharges for all indicators for one topic.

Q453. That is, do they need to submit all data, for all indicators, on each topic in the inpatient setting to be counted?

A453. See #452.

Q454. Second paragraph – Is the "CMS SDPS data collection system" now operational and if not, when will it be operational?

A454. The CMS SDPS data collection system is scheduled for production release on August 1, 2002.

Q455. When will training regarding technical specifications be available?

A455. Training will begin on data elements beginning in April 2002. It will continue for various portions through September 2002.

Q456. What is the standard process, if any, that the QIO must undertake to assure that the reported data conforms to standard file definitions and abstraction protocols as defined by CMS?

A456. This process will occur via QualityNet eXchange. The process will be automated to validate data input and return records failing edits.

Q457. The QIO shall be responsible for the data sets provided by each hospital … What does responsible mean? To keep it, report it, assure accuracy of – or what?

A457. The QIO is responsible for submitting abstracted data into the clinical warehouse when a provider is unable to do so and for maintaining awareness of whether the hospital or contractor actually submits data.

Q458. How does CMS expect the QIO to enforce the requirement that hospitals use standard file definitions and abstraction protocols equivalent to the CMS data abstraction tool?

A458. This process will occur via QualityNet eXchange. The process will be automated to validate data input and return records failing edits.

Q459. Providing services through CDAC for hospital-specific abstraction: how will CDAC services be allotted?

A459. There will be no services provided through the CDACs. The hospitals may independently contract with the CDACs, but CMS will not be providing CDAC services directly to a QIO.

CDACs operate on the first-in/first-out principal, unless otherwise instructed.

Q460. First come, first served, or will each QIO be guaranteed a minimum.

A460. See #459.

c. Support

Q461. What level of support will the QIOSC provide as it relates to the CMS data abstraction tool?

A461. The QIO will be responsible for supporting providers with the use of the CMS abstraction tool. The QIOSC will be available to assist the

QIO. The SDPS contractor will provide technical support for the abstraction tool.

The QIOSC will provide all software, documentation, training materials for the QIO and training to the QIOs.

Q1174. When will the QIOSC for this task be identified?

A1174. As soon as the competition is complete.

Q1175. When will the QIOSC be releasing standard file definitions and standard abstraction protocols?

A1175. As soon as the competition is complete and the standards have been established.

3. Task 2c – Other Mandated Communications Activities

a. Background

Q472. Will there be a Communications QIOSC?

A472. Yes, currently that is the plan.

b. Task Description

(i) <u>Consumer Representation</u>

Q469. Is this statement to be taken literally, i.e., that the consumer membership of each Board of Directors, regardless of its present composition, shall be increased?

A469. The language for consumer membership on Boards of Directors will be revised to reflect the language in H.10 of the contract.

Q470. If so, by how much?

A470. See #469.

Q471. Will CMS give contractors any numeric guidelines?

A471. See #469.

Q473. The term CAC is confusing, as we already have CACs (Carrier Advisory Committees).

A473. No response is needed.

Q474. RFP references that QIO shall expand consumer membership on its Board of Directors and then references PRO Manual Section 2200-2230, attached at J-4 for information. There is no such information at J-4. Where is it and when will we get it?

A474. See #469.

Q475. How is “organizations whose primary responsibility is protecting the interest of Medicare beneficiaries” actualized?

A475. It is not clear what is meant by this question.

Q476. (Is “seniors” or “disabled” a substitute for Medicare beneficiaries?)
A476. Not necessarily, although in some instances it may be. The context of this question is not clear.

Q477. Consumer Representation states that CAC membership must include representatives from community and business organizations. Such organizations might include advocacy groups, provider associations, health care purchasers, information intermediaries, community-based organizations, media/public relations experts, and academicians with expertise in quality improvement or consumer information. Is it not the original intent of the CAC to be a mechanism to gain more diverse opinions/perspectives of underserved and rural beneficiaries?

A477. Not necessarily only from underserved and rural beneficiaries, but from a better representation of the beneficiaries in the QIO’s state.

Q478. Is it reasonable to assume that a QIO whose Board already has representation from provider associations, purchasers, intermediaries, community-based organizations and academicians could have a CAC composed of primarily advocacy groups?

A478. CAC membership and the rationale for that membership should be proposed to and approved by the Project Officer. The composition of the Board should not preclude this overall CAC composition.

Q479. Can CMS provide a discussion of aim and/or workplan for the CAC?

A479. The RFP states the purpose of the CAC. The QIO is responsible for determining how to achieve that purpose.

Q480. Is CMS willing to cover time and expenses for the high level representatives desired on the CAC?

A480. The QIO should raise that issue when it proposes its membership to the Project Officer. We do not anticipate substantial expenses for the CAC members.

Q481. Is 30 days sufficient time to submit a plan about size and structure of CAC? Recommend 60 days.

A481. Yes, 30 days seems to be sufficient.

Q482. The second paragraph can be read to suggest that more than half the members of the Consumer Advisory Council must be from Medicare advocacy organizations. Suggest eliminating the sentence in favor of a more general requirement assuring representation by other organizations that serve beneficiaries.

A482. The RFP reads that more than half of the members must be from organizations whose primary responsibility is protecting the interests of Medicare beneficiaries. This seems to be in line with what is being suggested here.

Q483. The statement is made in the third paragraph of section C.3.D.3.b.(i) that: “The QIO *shall* expand consumer membership on its Board of Directors. See PRO Manual Section 2200-2230.” The PRO Manual at draft section Part 22 (last paragraph) states: “In addition, the board *must* be composed of a diverse group of members so as to reflect, in terms of gender, race, ethnicity, rural-urban, and socio-economic status, the Medicare population of the state. If the current governing board does not meet this criteria, then the QIO must develop a written plan to reconstitute the board

within three years, to meet the requirements set forth in the previous sentence." However, clause H-10 DIVERSITY FOR QIOs, states, "QIOs are *encouraged* to accept and implement the following [diversity] guidelines. . . this standard emphasizes commitment and a good-faith effort rather than specific outcomes." Is diversity a mandatory requirement (C.3.E.3.b.(i)/PRO Manual Part 22) or is it merely being encouraged as a good-faith effort (H-10)?

A483. See #469.

Q484. If diversity is mandatory (*per* C.3.E.3.b.(i)/PRO Manual at Part 22), what is CMS' justification and basis for imposing these requirements in excess of the following federal laws: Executive Order ("E.O.") 11246, that prohibits government contractors and subcontractors from discriminating in employment practices, and requires these contractors to take affirmative action to ensure that employees and applicants are treated without regard to race, color, religion, sex, or national origin; FAR 52.222-26, *Equal Opportunity* that implements E.O. 11246, and requires contractors to prepare an Affirmative Action Plan; and FAR 52.219-8/9 that require small business subcontracting plans?

A484. See #469.

Q485. The QIO is to maintain and staff a Medicare helpline to facilitate communications pursuant to all Tasks within the scope of work. What was the number of calls received in a recent 12-month period for Illinois and the average length of time for a call?

A485. CMS does not have that information.

Q486. Since all entities should be able to access the annual report through the corporation's or CMS' website, is our understanding correct that a limited number of hardcopies of the annual report should be produced for distribution only upon request?

A486. Yes.

Q1176. Could you define "expand consumer membership on its Board of Directors"?

A1176. See #469.

Q1177. If a QIO currently exceeds the requirements for consumer representation and cannot expand to more, how will this affect the evaluation for this task?

A1177. The QIO should raise that issue when it proposes its membership to the Project Officer.

Q1178. Task 2.C.b (i), page 36 - Consumer Representation states that CAC membership must include representatives from community and business organizations. Such organizations might include advocacy groups, provider associations, health care purchasers, information intermediaries, community-based organizations, media/public relations experts, and academicians with expertise in quality improvement or consumer information. Is it not the original intent of the CAC to be a mechanism to gain more diverse opinions/perspectives of underserved and rural beneficiaries?

A1178. Not necessarily only from underserved and rural beneficiaries, but from a better representation of the beneficiaries in the QIO's state.

Q1179. Is it reasonable to assume that a QIO whose Board already has representation from provider associations, purchasers, intermediaries, community-based organizations and academicians could have a CAC composed of primarily advocacy groups?

A1179. CAC membership and the rationale for that membership should be proposed to and approved by the Project Officer.

Q1180. (Medicare Beneficiary Protection Program) Under Task 3a of the 7th SOW, QIOs are responsible for conducting mediation when directed by CMS. How should the QIO project the costs for the mediation activity?

A1180. QIOs should include costs for training to educate beneficiary, provider, practitioner communities about mediation; however, CMS (likely through a QIOSC) will provide a training strategy and (to the extent possible) camera-ready materials. CMS anticipates that mediation costs (if agreed to by the parties) will be similar to the cost for full beneficiary complaint reviews. QIOs should use beneficiary complaint review information to project for mediation costs, taking into account the number of beneficiary complaints the QIOs encountered in the past. For the most recent 18 month period on which CMS has data, the contracts starting August 1 which are being competively procured had the following volume of complaints: PA 191, AR 37, and IL 114.

Q1242. Under Task 3a of the 7th SoW, QIOs are responsible for conducting mediation when directed by CMS. How should the QIO project the costs for the mediation activity?

A1242. QIOs should include costs for training to educate beneficiary, provider, practitioner communities about mediation, however, the CMS support contractor will provide a training strategy and camera ready materials. CMS anticipates that mediation costs (if agreed to by the parties) will be similar to the cost for full beneficiary complaint reviews. QIOs should use beneficiary complaint review information to project for medication costs, taking into account the number of beneficiary complaints the QIOs encountered in the past. For the most recent 18 month period, that CMS has data for, the competitive contracts had the following volume of complaints: PA 191, AR 37, and IL 114.

(ii) <u>Helpline</u>

Q489. Evaluation is based on documented responses to inquiries within "established, reasonable" timeframes. What is "reasonable?"

A489. The evaluation criteria for this item should be determined in collaboration with the Project Officer

Q490. How will our responses be documented so as to be measured as clear and substantive?

A490. As reported in SDPS.

Q491. When will the instrument to enter and track information be provided?

A491. See #495.

Q492. In the Statement of Work, the wording of this section refers to "the QIO shall maintain and staff a Medicare helpline to facilitate communications pursuant to all Tasks within this SoW". This statement infers that this is for providers and Medicare consumers. In the evaluation criteria (J-7), the criteria refers specifically to the "successful operation of a Beneficiary helpline". Please clarify if the Medicare help line is for providers and beneficiary's relating to all tasks, or only for beneficiaries.

A492. As it has been in the past, the QIO helpline is for Medicare beneficiaries, but issues that are raised by beneficiaries can apply to any task of the Scope of Work.

Q493. Will QIOs be funded to advertise their own helpline in addition the 1-800-Medicare helpline?

A493. There should not be additional expense for the QIOs to promote both helplines.

Q494. Will the QIO be required to maintain and staff a helpline to facilitate all tasks with this new scope?

A494. See #492.

Q495. Will PROVANTAGE be adjusted to capture information on "all tasks", as it currently does not capture HCQIP type information?

A495. All SDPS applications are under redesign for this scope of work.

(iv) <u>Implementation of Practitioner, Provider, and Beneficiary Outreach Activities</u>

Q496. What is the timeframe for submission of the provider and beneficiary outreach plans?

A496. There is no requirement for provider and beneficiary outreach plans in the RFP.