F. Task 3 - Medicare Beneficiary Protection Program

1. Background

2. Requirements

a. Task 3a- Beneficiary Complaint Response Program

Q499. **Recommendation:** The AHQA Beneficiary Complaint Workgroup recommends the complaint task be implemented in a manner consistent with the following principles:

A. QIOs should continue to handle complaints concerning the clinical quality of care.
B. QIOs should continue to prepare confidential sanction recommendations for gross and flagrant violations of professionally recognized standards of care.
C. QIOs should not be directed to offer mediation to complainants in cases that do involve clinical quality of care problems.
D. QIOs should be directed to offer mediation to complainants in cases that do not involve clinical quality of care problems, if resources are augmented by Congress to take on this function.
E. CMS standards for case review reliability must be grounded in science and operational realities.
F. CMS should redefine the purpose of complaint investigations from determining whether professionally recognized standards of care were violated to determining whether the quality of the clinical aspects of care provided in the case should be improved. QIOs should work with providers on the development and monitoring of quality improvement plans.
G. QIOs should implement a case management structure that clearly and early communicates the process for possible disclosure of findings to the complainant.

A499. Thank you for your input. As this is not a question, it does not require an answer to enable QIOs to prepare business or technical proposals.

Q500. **Recommendation:** Remove language that requires mediation as a mechanism to resolve beneficiary complaints. There is no compelling cost/benefit argument, because some form of review is required for mediated cases in addition to the mediation function, and because mediation is inappropriate for cases in which quality complaints are validated. (This will require consistent changes to Attachment J-4 as well.)

A500. The CMS disagrees. The language will remain in the SOW. The CMS believes that, if the beneficiary and provider/practitioner agree to mediation, it is a viable mechanism to resolve many quality of care concerns.

Q501. An evaluation component of the beneficiary complaint process states the "proportion of complaint reviews for which quality improvement activities." Can this "proportion" be defined? Since the greatest percentage of current beneficiary complaints result in "no quality issue," this "proportion" would be low.

A501. The numerator for the proportion in question would be the complaints resulting in the activities, while the denominator would be the number of cases where opportunities for improvement are present.

Q502. Is the QIO responsible for initiating inter-QIO reliability work?

A502. Yes, the QIOs will implement these activities using the plan provided by CMS.

Q503. Is it the expectation of CMS that QIOs subcontract with professional mediators when the mediation process is used?

A503. Yes, each QIO is responsible for securing its own professional mediator services.

Q504. States, "When directed by CMS, the QIO shall offer mediation …" For the purposes of budgeting for this activity, what does "directed by CMS" mean and what are the projected levels of this activity?

A504. "Directed by CMS" means that CMS will tell the QIO when to start using the mediation process. CMS (likely through a QIOSC) will provide the integrated medical record review and mediation procedures, guidelines concerning qualifications of mediators and how to obtain these services, the necessary training and materials to QIOs before mediation is implemented.

Q505. Can CMS provide guidance for locating acceptable mediators and how to estimate the cost of their services?

A505. Since many states require that mediatiors be certified by the State's (Lawyers') Bar Association, said Bar Association can generally provide a listing of available, certified mediators. See response to Q. 508 and 1180 for the projected costs involving this activity.

Q506. Is mediation binding on the parties?

A506. Yes.

Q507. Is there another level of appeal?

A507. No, there is not another level of appeal.

Q508. "When directed by CMS, the QIO shall offer mediation if voluntarily accepted by the beneficiary and provider/practitioner.["] Since the timeframe for implementation is indefinite, on what basis should the QIOs budget for their proposals?

A508. QIOs should include costs for training to educate beneficiary, provider, practitioner communities about mediation. However, CMS or 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, that CMS has data for, the competitive contracts had the following volume of complaints: PA 191, AR 37, and IL 114.

Q509. Or will CMS fund this activity through a contract amendment?

A509. See response to Q. 508.

Q510. Will QIOs be expected to implement "mediation" as an alternative to beneficiary complaint resolution at the beginning of its contract cycle or will it be phased in sometime after the contract begins?

A510. The mediation implementation will be " phased in" during calendar year 2003. We project implementation will begin on or about June 2003.

Q511. Regarding the referral of complaints to other entities (also see reference to Attachment J-4, Draft Manual Information for Part 5, Chart 1), is it expected that a case manager would evaluate and make referrals to outside entities when appropriate?

A511. The QIO is required to make appropriate referrals. If the QIO believes that its case managers are capable to perform this task, it may assign it to them.

Q512. If a QIO determines that the most efficient method for triaging these cases is by someone other than a case manager, would another staff member be allowed to handle these outside referrals?

A512. See response to Q. 512.

Q513. This section states: "Where the QIO makes a recommendation that a provider and/or practitioner develop and implement a plan for improvement, the QIO shall follow up to evaluate whether improvement has occurred." Is the follow-up of the quality improvement by the practitioner specifically for cases generated from beneficiary complaints, or is the follow-up to occur on all case review activities that identify quality concerns in which possible quality improvement by the provider/practitioner is appropriate?

A513. This requirement applies to both situations when improvement plans are to be followed by providers/practitioners. As in previous SOWs, the QIO should determine what documentation, based on the plan is needed to support its actions taken including frequency and duration of the monitoring (e.g., documentation of contacts and results).

Q514. What documentation will be required of the QIO to demonstrate to CMS that the follow-up did occur?

A514. See response to Q. 513.

Q515. What does CMS expect in regards to frequency and/or duration of the follow-up required?

A515. See response to Q. 514.

Q516. More clarification is needed on the expectation for the QIO to develop quality improvement plans for beneficiary complaint cases and monitoring those improvement plans. If QIOs are required to develop quality improvement plans for single cases, and if monitoring of those plans by the QIO involves profiling and additional case review, this will represent a significant increase in workload.

A516. The QIO development of improvement plans and monitoring of these plans under the case review activity when confirming quality concerns are not new requirements under the 7th SOW.

Q517. Further clarification is needed on the mediation process, to include examples of types of cases this could be used for, and clarifications on what type of staff can qualify as a true "mediator."

A517. See response to Q. 505. Through the Task 3 support QIO, CMS will provide this information at a later time. In the interim, we provided copies

of the CMS study on the use of mediation that contain pertinent information during the recent AHQA training.

Q518. Clarification is needed on how the QIOs will be evaluated on the new case management and mediation requirements to include what percentage of cases, if any, will the QIO be expected to conduct mediation on.

A518. The case management activity will be evaluated like any other case review activity. (The timeliness of review, the documentation of the necessary contacts, etc.) With regard to the percentage of mediation cases, we will provide more specific instructions at a later time. In the interim, the cases subject to mediation will be evaluated against the QIO efforts in educating the beneficiary/provider/practitioner communities at large and the individual efforts at the time of the complaint in an effort to secure voluntary participation.

Q519. On the attachment, Draft Manual information, A Case Management Approach to Handle Beneficiary Complaint Responses, it is stated under B. Process that the QIO should "Periodically update complainant on the status of the complaint response."

A519. Periodically means any amount of contact that is needed to keep the beneficiary/ provider/ practitioner informed. We provided information about these communications during the case review training at the recent AHQA training in Dallas, Texas. The management concept was presented by CMRI and materials were provided illustrating this approach.

Q520. Please define periodically.

A520. See response to Q. 519.

Q521. What is the minimum amount of contact expected and should it be documented in PROvantage?

A521. All contacts made should be documented. We expect that amount of beneficiary and provider/practitioner contacts would vary from case to case. Generally, initial, follow up/status and final contacts should be made.

The contact will be documented in the Case Review Information system (CRIS).

Q522. If this will be a requirement, will there be fields added in PROvantage to capture this information?

A522. The fields will be in the Case Review Information system (CRIS).

Q523. On the attachment, Draft Revised QIO Beneficiary Complaint Response Process, it is stated that when the physician reviewer determines that care could have been better, the determination should be made when:

- Care was grossly and flagrantly unacceptable
- Care failed to follow generally accepted guidelines or usual practice
- Care could have reasonably have been expected to be better.

A523. See #524.

Q524. Wouldn't this require new review outcome codes for PRAF, in that there is currently an "S" for gross and flagrant, a "C" for confirmed quality concern, but no outcome for "care could reasonably have been expected to be better?

A524. Yes. We will revise the PRAF to include new categories.

Q525. Will the PRAF categories be expanded to encompass concerns of this nature, as they might not fit into the current concern categories which primarily relate to care that failed to follow generally accepted guidelines or usual practice.

A525. We will provide scenarios and written letters applying the new categories. Also, see response to Q 524.

Q526. "Care that could reasonable have been expected to be better" could include issues which go beyond the current PRAF categories. Does CMS plan to provide new outcome codes and PRAF categories for the QIOs to use for these issues?

A526. See responses to Q.524 and 525.

Q527. When confirming that "care could reasonably have been expected to be better,"(if this primarily involves non-PRAF categories of concern, or communications issues) will the QIO be expected to issue the standard inquiry notices, notifying the physician of the potential concern, or will a different approach/notice be necessary, and thus development of additional letters?

A527. The QIO will follow the current notification process.

Q528. Also, please clarify what types of cases would fall under the category "care could reasonably have been expected to be better,"

to include examples, and clarification on whether or not this would include documentation issues.

A528. Scenarios and written letters will be provided in the near future. In general, these new categories exclude documentation issues.

Q529. If CMS requires the QIO to request an improvement plan on a single case, is there an expectation that this request would be based on a single physician reviewer determination or by consensus of a physician committee? This clarification is needed in order to adequately budget staff/physician resources needed for this activity.

A529. Under the current SOW, the QIO uses the most appropriate physician reviewer and in some cases, may use more than one. We expect that this process will remain the same under the 7th SOW.

Q530. On Chart 1, Flowchart for complaint response and resolution, there is step entitled "Area needing improvement involves Health care exp." Please define what is meant by "Health Care Exp" and give examples of when this would be applicable.

A530. The gray areas of this chart are for future implementation. CMS will provide instructions and examples using this step at a later time during the 7th SOW.

Q531. On the Draft – Proposed Mediation Process under the Beneficiary Complaint Response Program, the definition of a Mediator is given under the Definitions section. It is stated that the mediator should "be affiliated with a mediation organization." Please clarify if the mediator can be an employee of the QIO, or must the mediator be someone not involved with the QIO?

A531. See responses to Q. 504, 505, and 508.

Q532. Also, under the section entitled "An Integrated Beneficiary Complaint Review Approach", d) states "At the end of the 15-day (or 5-day period). Shouldn't this read "At the end of the 30-day (or 5-day period)?

A532. Yes, the language in question will be corrected.

Q533. Under the "Mediation" section, e) indicates that at the conclusion of the mediation, the QIO will be responsible for monitoring the terms of the signed agreement. Please clarify what types of monitoring

should be utilized in monitoring the mediation agreement, i.e., periodic beneficiary satisfaction surveys, etc.

A533. This monitoring is a follow up to ensure that the provider/practitioner implements the terms/conditions agreed to by the parties. We expect the QIO will determine what is needed to appropriately meet this requirement. The QIO may work with the provider/practitioner in identifying how best to monitor the agreement. We will provide more direction in the near future.

Q534. Please clarify how the QIO is to weigh (and prove that we considered) the probable benefits of a quality improvement activity in follow up to a beneficiary complaint?

A534. See response to Q. 514 and 516.

Q535. Is a formal analysis expected as part of every case file?

A535. It is not clear what is meant by formal analysis. The QIO is responsible for evaluating the results of the quality implementation plan to ensure that the desired changes/compliance occurred and for the QIO to determine if the issues have been resolved or there is a need for further action(s).

Q536. Will something be recorded in the data system?

A536. Yes

Q537. Please clarify when the QIO should conduct review of a complaint over which we do not have statutory authority as is seemingly indicated in the last paragraph of this section.

A537. This is not a new requirement. The statement refers to the statutory authority under 1154(a)(14) of the Social Security Act and not to the broad statutory authority under 1154(a). Part 5 of the PRO Manual (see section 5010) guides the QIO on how to handle complaints that do not meet the conditions specified at 1154(a)(14).

Q538. How many mediation training sessions will be conducted, how many should attend, and where will they be located?

A538. At this point, we do not have the training plan. Most of the training sessions will be conducted by WEBEX access. The QIO may decide how many people should attend at this particular sessions. Howeve, active participation could be limited to allow adequate training and the like. It could also be conducted (if needed) at the regional level.

Q539. Will mediation training be offered prior to the beginning of the Scope of Work?

A539. No. See response to Q. 510.

Q540. To what extent are QIOs to inform the beneficiary or his/her representative of the final disposition of the review?

A540. The QIO will follow the Federal regulations at 42 CFR 480 and the PRO Manual instructions at Parts 5 and 10. Any identifiable practitioner information must be disclosed with the consent of that particular practitioner.

Q541. The QIO is to review all written quality of care complaints from Medicare beneficiaries or their designated representative. What is the number of written complaints received by the Illinois QIO for a recent 12-month period?

A541. For the most recent 18-month period for which we have data, 114 Cases

Q542. This section refers in two places to section 1154(a)(14). Should this be reference 1154(a)(13)?

A542. No, the citation is correct. Section 1154(a)(14) refers to the review of beneficiary complaints of quality care. Section 1154(a)(13) refers to the review of readmission within 31 days from a hospital discharge

b. Task 3b-Hospital Payment Monitoring Review Program

Q543. Under what name should the QIO develop/market this program? "Hospital Payment Monitoring Review Program" - as cited in the scope or "Hospital Payment Monitoring Program" - as cited in the PRO manual?

A543. Hospital Payment Monitoring System.

Q544. Is CMS considering stratifying the sample for the surveillance records? Under the current methodology, the case mix makes it difficult to determine true improvement.

A544. The current sample is designed to give a specified level of precision. This is a matter of sample size and not the size of the universe. There are no plans to make any changes.

Q545. How many surveillance records and how often can we anticipate receiving records from the CDAC?

A545. The surveillance sample size will be reduced in the 7th scope of work. We also hope, overtime, to reduce the number of false positives forwarded to the QIOs. For now, we expect the number of records forwarded to the QIOs to decrease relative to the reduction in the sample size. We expect the CDAC process for sending records to the QIO to be unchanged.

Q546. Will the QIO continue to receive a 10 percent sub-sample of records that were approved by the CDAC?

A546. Yes.

Q547. If so, will the QIO be provided with case specific data so these records can be identified by the QIO?

A547. No.

Q548. How often will CMS provide monitoring reports?

A548. Quarterly.

Q549. Are the "monitoring reports" cited in the SoW different than the "summary tables" cited in 11015 of the PRO Manual?

A549. No.

Q550. Will a new baseline be calculated for this program?

A550. 6th SOW surveillance data will be used to calculate the baseline for the 7th SOW. See Question 573.

Q551. If so, what are the discharge dates that represent the baseline?

A551. The baseline will come from the end of the 6th SOW contract. At this time, we propose using the last 12 months of the 6th SOW.

Q552. Will technical denials be counted as "errors" by CMS when establishing statewide error rates?

A552. Yes.

Q553. The scope indicates that the QIO has the option to conduct projects beyond the surveillance monitoring and hospital profiling. If the QIO submits plans for approval to CMS, and those plans are not approved, how is the QIO to make improvement in this program?

A553. CMS expects to approve projects aimed at significant problem areas. We expect to target limited resources more efficiently with this plan.

Q554. If the QIO submits plans that are not approved by CMS, is this taken into consideration at the time of evaluation?

A554. Yes, this may be taken into consideration at the time of evaluation.

Q555. QIOs are required to submit project proposals, to be funded under Task 4 for "potentially significant" inappropriate utilization and "aberrant" coding. In order define appropriateness to submit a project proposal and to budget for this work, could CMS better define it's expectations by defining "potentially significant" and "aberrant"?

A555. Not at this time. The QIO will need to evaluate their state specific data and determine what they believe to be potentially significant and aberrant. CMS does anticipate providing future guidance regarding project development.

Q556. How many cases will be part of the CDAC random sample?

A556. The surveillance sample size will be reduced in the 7th SoW. The exact number of cases to be in the sample has not been finalized.

Q557. Will there be an additional validation sample, and if so, how large will it be?

A557. No.

Q558. The last paragraph on this page states, “The QIO shall develop project proposals to address identified and potentially significant inappropriate utilization and aberrant coding patterns and submit them to its Project Officer for approval.” Attachment J-4, Draft Manual Part 11, Section 11010.A - Purposes, states, “ Conducting analysis that will form the basis for identifying potential problems problem areas in admission patterns and developing project plans…” Please clarify.

A558. We do not understand what clarification is needed.

Q559. Are QIOs to conduct analysis and develop projects only for admission concerns or for both admission and coding/DRG issues?

A559. QIOs may do both.

Q560. Will payment error evaluation address both unnecessary admissions and incorrect coding/DRG assignment?

A560. Yes.

Q561. Are all hospital payment monitoring projects to be developed under Task 4?

A561. All hospital payment monitoring projects CMS approves will be funded under Task 4.

Q562. In J-7 Draft Evaluation Plan, it appears that these projects are discussed as part of Task 3. Evaluation of Task 4 Projects is not addressed. Please clarify.

A562. The projects approved will be funded under Task 4, but evaluated under Task 3.

Q563. Should adequate staffing to conduct all CMS required and approved projects be included in this proposal under Task 3b?

A563. No. Projects approved by CMS will be funded separately.

Q564. If QIOs identify an area of potential concern , can it be addressed through case review rather than as a project?

A564. Yes.

Q565. How will the monitoring profiling mentioned in this section be assessed?

A565. These are internal QIO activities that may not be directly assessed. Project Officers, however, may request information on this activity as a part of their monitoring of the QIO.

Q566. What mechanism will be used in the assessment?

A566. See #565.

Q567. To aggressively pursue the desired outcomes of the Hospital Payment Monitoring Program, Are QIO's allowed to conduct ongoing educational programs and technical assistance to hospitals independent of specific projects?

A567. Yes, but for funding implications, please see question 575.

Q568. Does CMS expect profiling beyond profiling of case review results?

A568. No.

Q569. Will CMS provide an estimated sample size for the "random sample" to be used for measuring national and statewide error rates?

A569. The surveillance sample size will be reduced in the 7th SoW. The exact number of cases to be in the sample has not been finalized.

Q570. How soon and how often will QIOs receive the periodic monitoring reports for their state?

A570. Quarterly.

Q571. Will CMS be providing any further guidance, criteria, etc to be used by QIOs in deciding when "inappropriate utilization and aberrant coding patterns" justify the development of project proposals?

A571. Yes. The QIO will need to evaluate their state specific data and determine what they believe to be potentially significant and aberrant. CMS does anticipate providing future guidance regarding project development.

Q572. Is it expected that QIOs would use improvement methodology, similar to methods employed in quality improvement projects, in projects developed with a utilization/coding focus?

A572. QIOs should use their own judgement and knowledge of their state to determine the appropriate methodology to address these issues, but the concept of the quality improvement is one available model.

Q573. What period will make up the baseline error rate for HPMP in the seventh contract cycle?

A573. The baseline error rate will be established by the most recent available 12-month period from the 6th SOW surveillance data.

Q574. What period will make up the re-measurement period for evaluation purposes?

A574. As in the 6th SOW, the remeasurement period will be a rolling 12 months.

Q575. Please clarify whether all payment monitoring projects will be funded under Task 4 or only those projects directed by CMS?

A575. Projects directed by CMS or proposed by the QIO and approved by CMS will be funded under Task 4. QIOs may choose to conduct other projects or activities without additional funding.

Q576. Is the title of the program replacing PEPP "Hospital Payment Monitoring Review Program" or "Hospital Payment Monitoring Program"?

A576. Hospital Payment Monitoring Program.

Q577. How often will QIOs receive periodic monitoring reports from the support QIO?

A577. Quarterly.

Q578. Will the QIO be able to receive these reports in both paper and electronic format?

A578. No, reports will be in an electronic format.

Q579. Will CMS strive to supply QIOs with timely data to be used in analyses for payment error projects? Use of current data when requesting hospital participation in projects is important to the provider community.

A579. Yes.

Q580. Clarification is needed as to the level of effort expected from QIOs related to general interventions for reducing payment errors that are not directly related to a CMS directed or QIO approved project.

A580. The QIOs will be supplied quarterly monitoring data generated under contract by CMS; the QIOs will also have a body of information based upon the case reviews conducted for the surveillance sample and other cases brought to the QIOs attention through other activities, i.e. beneficiary complaints. We expect the QIO to be in a position to review and understand the implications of this data and either propose projects for

separate funding; conduct short, limited reviews to confirm or deny suspicions, or continue monitoring if the decision is made that no problems are apparent. The quarterly reports are going to present hospital specific data. We expect that much of the intervention work will be directed at specific facilities exhibiting behavior outside of normal patterns. This will lead to very directed, very specific projects. It is in this spirit that we expect the QIOs to respond to patterns revealed in the quarterly data.

Q581. Please define what will be considered general interventions versus project interventions requiring CMS approval. For example, if a QIO disseminates data to all hospitals that includes the hospital's proportion, percentile, and statewide comparative data, is this considered an intervention or a project?

A581. General interventions are directed at the provider community at large, whereas, project interventions are associated with a specific project. Data dissemination could be either of these.

Q582. If a QIO disseminates data to all hospitals and requests outlier hospitals to review a sample of records for outlier DRGs, is this considered an intervention or a project?

A582. See question 581.

Q583. Can CMS provide guidance as to level of core staff (versus additional staff for special projects when funded) needed to perform the tasks outlined for the Hospital Payment Monitoring Program?

A583. No, this must determined by the individual QIO.

Q584. How will projects transition into the new SOW. Will QIOs continue their 6th SOW projects that are still in the re-measurement phase?

A584. This issue has been addressed in a recent 6th SOW contract modification. For questions, please contact your contracting officer.

Q585. Will general compliance activities continue if they are not associated with a specific project?

A585. This would be at the QIO's discretion. See question 575 for funding implications.

Q586. The DRAFT QIO Manual provides some description of what the CMS monitoring reports will contain. Will this represent data that QIOs can share with providers directly?

A586. Yes.

Q587. Will the existing baseline error rate remain as the reference point for ongoing surveillance?

A587. No. The baseline error rate will be established by the most recent available 12-month period from the 6th SOW surveillance data.

Q588. How can a QIO expect to impact its surveillance rate if requests to conduct local projects are not approved?

A588. Appropriate, well-designed projects should be approved. If a QIO does not received approval for any submitted projects, this will be considered in the evaluation.

Q589. If QIOs have well established methods for estimating local payment error rates, may QIOs use the available date it analyzes to directly engage providers in education activities related to payment errors or must a QIO develop formal projects proposals before intervening with providers.

A589. Nothing prohibits the QIO from engaging in these types of activities. However, in order for activities to be funded under Task 4, formal project approval is required. See question 575.

Q590. Projects proposed by QIOs must include detailed budget projections. What are the implications here for collaborative projects involving other contractors?

A590. None, do not propose costs for these projects.

Q591. Are all provider-specific interventions based on a surveillance system considered "special studies'?

A591. To the extent that they are part of an approved project, yes.

Q592. Will these need project proposals developed and approved?

A592. Yes.

Q593. Periodic monitoring reports – Will these be quarterly or yearly?

A593. Quarterly.

Q594. If projects/interventions arise from routine medical review activity, are these also considered "special studies" that require project proposals and approval?

A594. They could be. If it is a project for the Hospital Payment Monitoring Program, in order to be funded under Task 4, it requires a project proposal and CMS approval.

Q595. How can the error rate be reduced if a project has not been approved?

A595. Appropriate, well-designed projects should be approved. If a QIO does not received approval for any submitted projects, this will be considered in the evaluation.

Q596. Can there be activities initiated that are not part of a project example: data feedback reports on patterns identified in the provider profiling activities

A596. Yes.
General interventions are directed at the provider community at large, whereas, project interventions are associated with a specific project. Data dissemination could be either of these.

Nothing prohibits the QIO from engaging in these types of activities. However, in order for activities to be funded under Task 4, formal project approval is required.

Q597. Can the QIO assume that the number of CDAC referrals for Payment Monitoring will be unchanged from the 6SOW?

A597. No. The surveillance sample size will be reduced in the 7th SoW. The number of associated CDAC referrals should decrease accordingly. See #545.

Q598. How many projects does CMS envision a QIO will conduct under this topic area?

A598. This will vary by QIO, but we cannot say at this time.

Q599. The QIO shall review all cases referred by the CDAC's as part of a random sample to produce national and statewide error rates for coding and medical necessity for estimating the payment error rate for inpatient PPS services. What is the anticipated volume of coding and medical necessity cases to be selected for review?

A599. We expect some reduction in the number of CDAC referrals compared to that experienced during the 6th SoW. See #597.

Q1181. What is the volume of the CDAC random sample to produce national and statewide error rates for coding and medical necessity?

A1181. The size of the surveillance sample will be reduced in the 7th SoW. See #545 and #556.

p. **39, Task 3b, -Hospital Payment Monitoring Review Program, states "The QIO shall monitor the hospital admission and coding patterns… ; …determine the potential for errors and inappropriate utilization by providers.[and] …develop project proposals to address identified and potentially significant inappropriate utilization and aberrant coding patterns and submit them to its Project Officer for approval."**

Q1182. If the QIO develops project proposals to address significant potential for errors or inappropriate utilization by providers, please clarify whether or not this work falls under Task 4, Special Projects.

A1182. The projects are funded under Task 4 but evaluated under Task 3b.

Q1183. How many cases can QIOs expect to be referred from the CDACs as part of the random sample?

A1183. The surveillance sample size will be reduced in the 7th SoW. The number of associated CDAC referrals should decrease accordingly.

Q1184. In reading the evaluation portion (attachment J-7) there is new information about how task 3 will be evaluated. For task 3b, the Hospital Payment Monitoring Review Program (formerly PEPP) the QIO is being evaluated on completion of review in a timely manner (which we expected) but also included it says:
"Additionally the QIO must be successful in relation to one of two of the following criteria:

- **With respect to the absolute payment error rate as measured by the surveillance sample, the QIO will be judged successful if the follow up payment error rate is no greater than 1.5 standard deviations above the baseline error rate.**

- **The QIO will be judged successful if it makes substantial and effective effort and progress in improving provider performance in relation to any and all special projects approved or directed by CMS."**

QIOs understood PEPP in 7SoW to be a monitoring task not one to show improvement. Since a QIO may or may not have a special project in the next SOW, how does CMS envision a QIO's ability affect the payment error rate between baseline and surveillance if we are not working with the hospitals to improve?

A1184. Whether or not a QIO has undertaken a special project will be taken into account at the time of a QIO's evaluation.

Q1185. In addition, another evaluation component for task 3 is regarding reliability of review. The RFP clearly states the QIO will be evaluated on internal IRR as well as IRR among other QIOs. Mark Krushat and Amelia Jackson were asked specifically at AHQA how CMS could expect IRR among QIOs when there is no mandated standard review criteria? The answer was that CMS would only hold QIOs accountable for internal IRR and there was no plan for a mandated standard criteria to be used by all QIOs. We learned from the Coral IRR special study that QIOs using different criteria leads to variation at the most basic level of review, not to mention the variation at physician level review. Why is CMS changing their position on only evaluating internal QIO IRR and including IRR among QIOs?

A1185. CMS has not changed its position. QIOs are evaluated on internal IRR **.**

Q1186. Is it appropriate to submit proposed Special Projects for the Hospital Payment Monitoring Program with the RFP?

A1186. No.

Q1187. What is proposed time frame for implementation of mediation in the Beneficiary Complaint Response program?

A1187. We project implementation on or about June 2003.

Q1188. When will the case management concept be incorporated into the QIO Manual?

A1188. The use of case management is effective with the implementation of the 7th SoW.

Q1189. How is "consistently" defined?

A1189. The same action produces the same result.

c. Task 3c - Other Beneficiary Protection Activities

HINN/NODMAR Review

Q600. There is no mention in the SOW7 RFP of the phase-in of new QIO reviews of notices of discharge/termination of services in non-hospital settings as per Section 521 of the Benefits Improvement and Protection Act of 2000 (BIPA). This law becomes effective on October 1, 2002 and the assignment of the responsibility for the initial review of these notices is at the discretion of the Secretary

Recommendation: To speed up the implementation of the current law, include the expectation that all QIOs will be responsible for the initial determination (and possibly the reconsideration) of these notices as well as the current HINN and NODMAR reviews, pending issuance of regulations.

A600. The review of HINNs/NODMARs remains the same until further notice from CMS.

Q601. Other than those referring entities described in the QIO Manual at Section 4070 Referrals, are there additional potential referring entities?

A601. The answer to this question is not needed to complete the business or technical proposal. If, in the course of the contract, a QIO receives an apparent referral from an entity it does not believe is described in the QIO Manual, it should request from its Project Officer technical guidance on how it should respond to the apparent referral.

Q602. To what extent are QIOs to pursue those review activities not listed in the SOW but listed in the PRO Manual?

A602. The QIO should pursue any review activity listed in the PRO Manual if it is relevant to the case under review. (For example, the QIO should address issues related to circumvention of PPS, readmission within 31 days, cost outlier issues, etc.)

Q603. Can the number of HINN/NODMAR reviews completed by the Illinois QIO for a recent 12-month period by provider? What is the anticipated number of EMTALA reviews and "All Other Case Review Activities"?

A603. Illinois had: 29 requests for EMTALA review and 66 requests for HINN/NODMAR. For the most recent 18 month period on which CMS has data, the competitive contracts had the following volume of complaints:

- IL 114
- PA 191

Q604. The first sentence contains the word physician in parentheses. Why are parentheses used?

A604. The word physician in parentheses is to make clear that the medical assessment is to be performed by a physician reviewer.

Q605. Is a physician review required, or only recommended?

A605. A physician review is required for all EMTALA cases.

Q606. The AHQA EMTALA Task Force has recommended that CMS require a 5-day QIO review of all EMTALA cases suspected to involve a medical, or clinical deficiency. Following a 5-day review, if the QIO determines that there is no medical, or clinical deficiency then the CMS RO should not be allowed to find a compliance deficiency on medical, or clinical grounds.

A606. We cannot accept this recommendation at this time.

All Other Case Review Activities

Post Review Activities

Q497. Will QIOs conduct any reconsideration of admission denials or any other utilization denials?

A497. Yes, unless directed by CMS to stop this activity.

Q498. Under what circumstances would cases be reopened and reviewed as required in 42 CFR 476?

A498. The circumstances to reopen cases are found at 42 CFR 476.96 and PRO manual instructions at section 7102.

3. Support

Q607. What are CMS plans to create a Medicare Beneficiary Protection QIOSC? Will there be a competitive solicitation available to all QIOs?

A607. We are projecting establishment of the Task 3 support QIO on or about May 1, 2002. We have not make a final decision on whether we will award the Task 4 project for QIOSC services competitively.

Q608. Is the reference to the QIO/Provider activity reporting system in Section F the next version of TQIP?

A608. The QIO/Provider activity reporting system will replace TQIP.

SECTION F - DELIVERIES OR PERFORMANCE

F.1. PERIOD OF PERFORMANCE

F.2. ITEMS TO BE FURNISHED AND DELIVERY SCHEDULE

Q609. There are a number of examples in this contract (listed below) that require the QIO to perform a deliverable that is dependent on another CMS contractor (e.g. QIOSC) of CMS itself. What provisions are or will be in place to address delays in delivery of these critical items?

- Work plan template – Source: CMS
- Nursing Home and Home health quality indicators- Source: CMS
- Selection guidelines – NH and HHA – Source: QIOSC
- Finalized publicly reported quality of care measures in Nursing Homes and Home Health Agencies – Source: CMS
- Indicators selection – NH and HHA – Source: CMS/QIOSC
- Training – NH and HHA – Source: QIOSC
- Hospital data collection requirements – Source: CMS/QIOSC
- Hospital File Definitions- Source CMS
- Reference document that contains a list of the types of materials that may be supplied by the various QIOSC and the currently estimated date of their availability—Source CMS

A609. The Reference Document will be an attachment to this amendment.

Q610. [This item] states that updates should be submitted monthly. Please describe what type of updates will be expected.

A610. Detailed reporting requirements and reporting systems are currently under development.

Q611. Please note the errors in this section. For example, items number 13, 14, 15 and 16 should be referenced to C.3.0.E, rather than to C.3.0.D. Later items referenced to C.3.0.D. should be referenced as C.3.0.F. The point is the numbering in the Schedule of Deliverables doesn't coincide with the text numbering.

A611. Thank you. We will ensure that the numbering is correct in the final version that the contractors receive for signature.

Q612. [This item] states, "Internet accessible, if available in HTML format…" Does this mean that the QIO cannot publish the Annual Report in PDF (Portable Document Format) to be accessed using Adobe Acrobat Reader?

A612. The "HTML format" reference is incorrectly phrased. The item will be corrected to read "format, such as HTML or PDF, which can be readily viewed or downloaded". PDF is an acceptable format.

Q613. In the "Description" column, are the SOW section numbers listed in items 13 through 18 correct?

A613. No, they are not. CMS will correct all Statement of Work citations in the Schedule of Deliverables prior to issuing final contracts.

Q1196. F.2 and J-11, page 47 – For many of the deliverables liste in section F.2, the only recipient designated is C, the SDPS contractor. The list in section F.2 does not agree with the recipient list in Attachment J-11. For example using the Work Plan that must be developed within 60 days of the contract start date, for Section F.2 the recipient is defined as C, the SDPS subcontractor, while in Attachment J-11 the recipients are listed as the Project Officer and Task Leaders. Would CMS please clarify the differences between these two lists?

A1196 The conflicts between contract sections will be corrected. The Workplan must be sent to the Project Officer. The Workplan may be integrated into the reporting mechanism (see response 80 above) and thus reported via the SDPS.