J-2 Award Fee Plan

Q689. Government assessment at the 28th month of the contract is inconsistent with FAR 16.405-2(b)(3) that requires evaluation periodically throughout the contract to make the incentive of the award fee effective as an inducement for good performance.

A689. Thank you for your comment.

Q690. To comply with the FAR, CMS should evaluate the QIOs at 6-month intervals, or at minimum once in each of the three contract years (e.g., 9-month, 18-month and 27-month evaluations). If CMS considers this too labor intensive, the first two evaluations could be based on the Regional Office's evaluation of performance and the third assessment could be the comprehensive assessment the award fee plan contemplates. If CMS determines to maintain an award fee approach, QIOs recommend consideration of the process and methodology utilized by CMS' Program Safeguard Contractor program.

A690. Thank you for your comment.

Q691. The combined fee structure equals a maximum 5% fee in this RFP (fixed=3%, Base=0%, Award=2%). This is about half of the possible maximum fee that was available in the SOW6. The purpose of a performance-based contract is to provide sufficient potential reward to motivate superior performance. The fee structure in this RFP does not provide sufficient incentive. It is actually comes quite close to being only a cost-based contract.

A691. Thank you for comment.

Q693. The words "and no later than the 32nd month" should be added to the end of that paragraph.

A693. The CMS intends to have decisions made by or within the 32nd month. The final J-2 will convey that intent.

Q694. By what date will CMS finalize the scoring methodology and determine the maximum score for each subtask?

A694. The CMS will provide the maximums prior to contract award; this information is not needed for preparation of business or technical proposals.

J-3 Standards and Guidelines for Printed Materials

Q695. What is the FMIB?

A695. The CMS's Financial Management and Investment Board.

Q696. What is the OCOS?

A696. The CMS's Office of Comunications and Operations Support

Q697. Please clarify our responsibilities relative to this material.

A697. QIOs shall adhere to these standards and guidelines for printed materials, or will be out of compliance with the contract.

J-4 Selected QIO Manual Sections

Q12. Statement of Work/Contract Provisions in conflict with Attachments/Manuals- On numerous occasions, the manuals conflict with the statement of work and the contract provisions included in the RFP: Some examples include:

- Hospital Data-abstraction – the RFP states "have the largest number of hospitals possible collecting" and the J-7 sets the expectation at at least 50%.
- Board composition – encourage diversity at H-10 vs. mandate doing a change within three years per Manual Part 22.
- DRG validation and medical necessity definitions – in the current contract, a full-blown medical necessity review not required. The draft manual now stipulates QIOs are to perform a more comprehensive review. This will increase costs greatly in this area. The statement of work is silent on the specifics.
- Contract provisions delete compensation ceilings/caps included in previous contracts yet the Business Proposal Instructions at J-12 require rationale if exceeded.

A12. Thank you for your comments. The CMS will review the language and ensure that the final contract language and Manual do not conflict.

Q14. Program Manuals in Draft Form - Draft manuals create confusion and challenges for contractors to adequately comply with contract requirements. They can also lead to technical direction outside of the scope that can result in a change in work/cost. It is critical that these be finalized prior to contract execution.

A14. Yes, but the Clearance process for PRO Manual approval/distribution is significantly protracted. Providing draft manual sections within the RFP allows CMS expectations to be communicated in real time.

Q614. The case management concept approach to handling beneficiary complaints will be incorporated into Part 5 of the PRO/QIO Manual at a later date. This includes a proposed mediation process which is still being revised and refined. Should the costs of implementing mediation be included in the budget proposal at this time?

Q614. Yes. 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.

Q698. Not all sections referenced to be included in Attachment J-4 are present (e.g., some sections only contain table of contents with no corresponding sections). Are new draft versions available for review or should the Offeror utilize the existing PRO manual for these sections?

A698. CMS will amend the RFP to add missing pages. However, J-4 only includes sections referenced in the Statement of Work.

Q699. Page 4-53 of Attachment J-4 states, “you are to establish written criteria or obtain national criteria (e.g., InterQual) for non-physician review use when screening FFS and M+CO organization cases for referral for physician review.” Is the Contractor responsible for the purchase cost of InterQual®?

A699. The QIO should include costs for InterQual® in its business proposal if it plans to use InterQual®.

Q700. The success of the QIO will possibly be measured by realizing a "payment error rate that is no greater than 1.5 standard deviations above the baseline payment error rate". Will the multiple data points required when computing a standard deviation be the same QIO's rates over time or compared to other QIOs?

A700. A QIO is compared to itself.

Q701. The final version of J-4 had only 6 pages of PRO Manual Part 16, and was missing Part 22 and the unnumbered section "For Preparing Hospital for Date Reporting". The initial electronic version included these sections. Please clarify that the electronic version of these sections has not changed.

A701. A complete J4 attachment will be attached to this amendment.

Q702. Will CMS provide the mechanism for the QIO to sample the state's database to select the records or will the QIO be expected to create that query process?

A702. QIOs will not have access to any State’s database, also QIOs will not have access to any raw MDS or OASIS data.

Q703. The manual indicates that all short term, acute care hospitals are to be included in the survey. However, the manual indicates CAHs have a 1 in the 3rd and a 3 in the 4th positions. Please clarify if CAHs are to be included.

A703. Critical Access Hospitals will be included. The CMS will review the language and ensure that the final contract language and Manual do not conflict.

Q704. Provider certification - the manual indicates that 90% or better of the cases will agree with the QIO assessment of the quality measures. Please clarify if this is calculated for all elements abstracted or only those affecting the quality indicators, e.g. are demographics excluded in the calculations such as patient name, ID, admit date, etc.?

A704. Though CMS wonders whether one can determine if the quality measures agree or not if the demographics are not identifying the same patient, the answer to this question is a very fine technical point and unlikely to have material resource implications for QIOs. The QIOs therefore do not need this information to prepare business or technical proposals.

Q705. The manual indicates we do not need to stratify our sample for data validation by topic. We know from our experience that the same abstractors are not usually doing the abstraction across topics. If the random sample is not stratified by topic, we will not get a clear picture of accurate data for each topic. Will there be more CMS instructions on the data validation process or will the QIO determine the sampling and number of records to be included in the data validation process?

A705. Not all details have been determined, but it is highly likely that the CMS will provide guidance and instructions in due time. QIOs do not need this information to prepare business and technical proposals.

Q706. This section states to conduct beneficiary complaint review only. Does this mean that QIOs will no longer review HINNs/NODMARs in Critical Access Hospitals?

A706. The QIOs will continue the review of HINNS in critical access hospitals. We will correct the instruction before final release.

Q707. Section 4230.E, page 4-30. Please give an example of when the hospital would give a denial notice, which is not a HINN, where the QIO has the authority to grant “grace days.”

A707. Though this information is not needed to prepare QIO business or technical proposals, CMS has no desire to hoard information: the application of "grace days" is very limitied under the Medicare PPS. Under the limitation on liability provisions, the QIO could determine that the provider has no knowledge or could have not known that the care was not coverd and grant "grace days" in accordance with this provision.

Q708. Section 4255, page 4-33. Does this section mean when a patient is readmitted to a different hospital for care that could have been provided in the first admission?

A708. Though this information is not needed to prepare QIO business or technical proposals, CMS has no desire to hoard information: Section 4255, page 4-33applies to a readmission to the same or another hospital.

Q709. Section 4410, page 4-47. The review settings listed below don't match with the review settings listed under Part 5, Beneficiary Complaints. The following settings are listed as being under the QIO's scope in that section: Ambulatory surgical centers (ASCs); Comprehensive outpatient rehabilitation facilities (CORFs); Emergency rooms (ERs); Home health agencies (HHAs); Hospices; Hospital outpatients areas (HOPAs); Inpatient hospitals/units; Outpatient physical therapy and speech/language pathology services; Critical Access Hospitals (CAHs); Skilled nursing facilities (SNFs); SNF. swing beds within inpatient hospitals/CAHs; Specialty hospitals (e.g., psychiatric and rehabilitation); Physicians' offices; and Community mental health facilities (CMHFs). This could lead to confusion regarding the setting under the scope of beneficiary complaint review.

A709. We agree that the settings at Part 4 does not include all the ones mentioned in Part 5. We will add physician offices and community mental health facilities to Part 4 and will standardize the language on both Parts 4 and 5.

Q710. Section 4540, page 4-60. QIOs will be evaluated on review timeliness. Review timeliness can be impacted by the volume of cases received on any given day. Currently, work flows from CMS sub-contractors (primarily the CDACs and FIs) is not regulated. In other words, QIOs may receive a bolus of cases for review on one day of the month, making all cases due for completion on the same day. Additionally, multiple boluses are often received in one month. Does CMS have a plan to modify sub-contractor referrals to avoid "surges" in work

A710. The evaluation of review timeliness may take into consideration external circumstances that may justify sporadic and unusual delays. However, to the extent possible, the QIO is responsible for having available an adequate number of reviewers and a contingency plan to meet

unpredictable review demands. Although the cases may have been received the same day, the actual completion time frame could be different. For example, during the screening period, an extra 15 days may be given because some cases may need additional documentation to be submitted. For other cases, providers/practitioners may respond to the opportunity of discussion at different interval during the 20 day-period

Q711. ("Draft Manual Information for Part 5: Draft Revised QIO Beneficiary Complaint Response Process"). Under the "Process" section, the "Communicate to meet beneficiary concerns" subsection states at the third bullet: "Structure final communication (to beneficiary) around successful development of improvement activities." Does the QIO need to update the beneficiary regarding the outcomes of the quality improvement implemented by a provider?

A711. We have not made a final decision on this requirement. Most likely this information will not be known at the time of the final notification. However, to the extent possible, if it is known, the QIO should include this information if it is known at the time of the final notification.

Q712. How will the QIO know at the time of a "final communication" that there has been "…successful development of improvement activities?"

A712. See response to Q. 711

Q713. ("Draft Manual Information for Part 5: Draft Revised QIO Beneficiary Complaint Response Process"). Under the "Physician Reviewer" section, the first bullet under the "Actions" subsection states: "Initiation of sanction process and /or immediate referral to the licensing authority." In addition, under all 3 bullets in this subsection, the RFP states: "Immediate reporting to the licensing authority and initiation of sanction activity should occur for all cases in which care is grossly and flagrantly unacceptable and where there is immediate danger to the health and safety of other beneficiaries." These statements do not appear to be supported by the "Chart 2: Draft Sanction Protocol Flow Chart," which indicates the "…case would go to physician committee or as determined by the PRO procedure." Who actually initiates the sanction process?

A713. The QIO determines the structure and procedures to initiate the sanction process consistent with the Federal regulations at 42CFR 1004 and the draft PRO Manual sanction instructions included with SOW.

Q714. Who is to decide if the licensing authority is notified, is it the physician reviewer who reviewed the case, or after the "committee" has reviewed the case (the scenario supported by Chart 2)?

A714. See response to Q. 713.

Q715. Please clarify the actions that the individual physician reviewer is to take in regards to the sanction process.

A715. See response to Q. 713

Q716. ("Draft Manual Information for Part 5: Draft Revised QIO Beneficiary Complaint Response Process"). Under the "An Integrated Beneficiary Complaint Review Approach, Receipt of Complaint" section, the fourth bullet states: "Request medical record and confirm the provider or practitioner to submit the medical record within 30 calendar days. For expedited beneficiary complaint reviews, inform the provider or practitioner to submit the medical record within the first work day." Please define the term "expedited beneficiary complaint review."

A716. "Expedited beneficiary complaint review" refers to situations where the beneficiary is still an inpatient or receiving health services.

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Q717. Who determines if a complaint is to be expedited, the QIO or the beneficiary?

A717. See responses to Q. 715 and 716.

Q718. What criteria are used to determine an expedited complaint?

A718. See response to Q. 716

Q719. The same questions regarding expedited reviews apply to items c), d), and e) under the following subsection ("Medical Record Review").

A719. See responses to Q. 715 and 716.

Q720. Section 7000, page 7-5. Does this mean that QIOs do not have the authority to review HINNs given in a SNF swing bed situation?

A720. We will correct the instruction. The QIOs will continue the review of HHINS in a SNF swing bed situation.

Q721. If the QIO does not review, to whom would the beneficiary appeal to?

In addition, this is in conflict with section 357.B of the *SNF Manual* (Citation: PRO is source of notice—where a beneficiary is in a swing bed, the PRO notifies the beneficiary or the person acting on his behalf in writing that the care is not covered or is no longer covered).

A721. See response to Q 719

Q722. Part 11, general reference. There does not seem to be clear delineation of what is required activity under the HPMP if the QIO is not engaged in HPMP projects. For example, the QIO draft manual contains sections on interventions and collaboration efforts. Would a QIO that is not engaged in approved projects be engaged in these activities?

A722. Yes. 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.

Q723. Part 11, general reference. In the absence of the term "PEPP," is it appropriate for QIOs to use the term "mandatory for hospitals" when referring to future HPMP work?

A723. Yes, a hospital's responsibilities under HPMP are the same as under PEPP.

Q724. Part 11, page 11-8. Assuming these monitoring reports are different from the data tables referred to in the draft QIO manual, how soon will QIOs start to receive these data reports and how often will they be received?

A724. The monitoring reports will be delivered at the start of the 7th SOW and will be delivered quarterly thereafter.

Q725. Language regarding the composition of the Board of Directors and/or the Consumer Council is supposed to be contained in J-4. There appears to be missing pages in J-4. When will the missing pages be provided?

A725. The Q and A RFP amendment will include the missing pages.

Q726. On numerous occasions, the manuals conflict with the statement of work and the contract provisions included in the RFP (i.e. board composition – encourage diversity vs. mandate doing a change within three years; DRG

validation and medical necessity definitions etc). Which applies critical for budgeting and overall contract compliance?

A726. The Statement of Work is the controlling document for budgeting purposes. CMS will review the language and ensure that the final contract language and Manual do not conflict. However, if the language does not conflict and is referenced by citation in the SoW, the QIO should proposed cost based on what is contained in the Manual.

Q727. The draft manuals provide detailed information as to how the QIO will conduct the work activities in the SOW7. Should the QIOs response to the RFP be based upon the level of resources necessary to perform work activities as detailed in this manuals or as outlined in the statement of work?

A727. See response to Q726.

Q728. The electronic version of the RFP and attachments seems to include sections not available in the hard copy official RFP (Draft manual sections for preparing hospitals for data reporting and Draft Manual Sections for Part 22 – Board requirements, for example). Please clarify.

A728. CMS will amend the RFP to ensure that all referenced Manual Sections are included.

Q729. Section 4020, (p. 4-7) Assistant at Cataract Reviews - Will QIOs have access to Outpatient records to facilitate selection of cases for validation review?

A729. Yes. This is not a new review requirement. This review activity is within the statutory authority of 1154(a).

Q730. Section 4020, assistants at cataract Surgery, B. states that the QIO should notify ophthalmologists in their state that they must obtain approval for assistant before surgery. Please clarify how often this notification is required, i.e., annually, etc.

A730. This is not a new requirement. The annual notification will suffice if the QIO determines this frequency is adequate. The QIO needs to determine how often this notification is needed based on the QIO experience with this review. The QIO should make sure that the provider outreach educational effort includes this requirement (as needed). It may coordinate its effort with the intermediary and carrier. Additionally, the QIO must ascertain that the intermediary and carrier are referring any case without prior-QIO approval.

Q731. Section 4050, Hospital Requested Higher Weighted DRG Assignments, Review Process, page 4-8: definition of performing a medical necessity review needs to be clarified.

A731. A medical necessity review is performed to adequately address the hospital's request for higher weighted DRG unless prior to this request, the case was reviewed for medical necessity. The QIO must determine whether the admission is medically necessary before approval of this request

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Q732. Section 4105, Reviews, (pages 4-13 …4-26) What are the required reviews for each select reason, i.e., when is invasive procedure review required?

A732. See response to Q.602.

Q733. When is admission review required?

A733. See response to Q.602. Admission review is to determine the medical necessity of the inpatient stay

Q734. Cost outlier review? Etc.

A734. See response to Q.602.

Q735. Section 4105, C. Strategies to Employ, it is stated that the QIO should develop/update quality screening criteria. Please clarify if QIOs must develop their own quality screens, or if it is acceptable to use the generic quality screens developed by CMS several years ago?

A735. See section 4510 of the PRO Manual. The QIO may use any criteria accepted by the practitioner/provider community and must update it as needed (including the criteria referenced above).

Q736. Section 4130, DRG Validation Review, page 4-47: "If the physician query form is leading in nature, or if it introduces new information, the non physician reviewer must refer the case to the physician reviewer" Does this mean the majority of cases with physician query forms will be referred to the physician reviewer?

A736. While CMS understands the relevance and potential resource implications of this issue, CMS does not have definitive information on which to provide an estimate. The QIO should use its best judgement based on its experience in case review.

Q737. Section 4130, (p. 4-8) Higher Weighted DRGs - Please clarify the required reviews for this select reason.

A737. See response to Q 731.

Q738. What is meant by a “medical necessity review”?

A738. See section 4410 of the PRO manual for definition.

Q739. Are other reviews required in addition to the coding/DRG validation? This represents a significant change from current practice.

A739. A determination whether the admission is medically necessary must be performed by the QIO. If quality concerns are raised, a quality review also must be performed.

Q740. Section 4210, Outlier/LOS: Need clarification when a LOS review/day-outlier review is indicated. The QIO manual seems to be vague. While this does not appear to be anything new in the manual from the 6SOW, it still seems left to interpretation. Would the QIO review all day-outliers identified during the course of regular review?

A740. Yes, if this review applies. See response to Q 602.

Q741. Section 4230, C., Determining the Provider/Practitioner’s Liability, it is stated that the QIO should “Determine the practitioner’s liability only in those cases involving payment denials of surgical and cost outliers with physician component, and inpatient/ambulatory/outpatient surgical denials based on lack of medical necessity." In these situations the carrier automatically adjusts its records (under the A/B link process) upon receipt of the QIOs written or electronically submitted denial and liability determinations.

A741. The QIO notifies the carrier by providing a copy of its written notice to the beneficiary. With regard to the electronic reporting to the carrier, we will clarify this activity in the final Part 7 manual instructions.

Q742. Please clarify when this process is in effect – does it include adjustment of practitioner’s payment on an outpatient procedure determined by the QIO to be not medically necessary?

A742. Correct.

Q743. Does this mean that it is not necessary to notify the FI, only the carrier on these types of cases?

A743. The FI will need to be notified if it processed the provider's Part B claim.

Q744. It is also stated under this section, "If a provider or practitioner is in doubt as to whether a service/item is covered, it may contact you for advice." Please clarify what type of service/items would be expected to fall under this.

A744. Any Part A or B health care service/item. It is up to the QIO to determine (on a case-by-case basis) whether it can provide this advice.

Q745. Obviously some items provided on an outpatient basis would not normally be reviewed by the QIO. Wouldn't it be advisable for the QIO to instruct the practitioner to contact the FI or carrier, in order to ensure accurate coverage/billing information?

A745. Correct. See response to Q.743.

Q746. Section 4255, circumvention of PPS, indicates that one case alone would not constitute circumvention of PPS and that the QIO is to monitor for a pattern. In the event that the QIO discovers one isolated case, how should this be handled?

A746. Like in any other case needs to determine the degree of the concern and take any necessary action. For example if the case involves gross and flagrant issues, it must take action to initiate sanction process accordingly.

Q747. The QIO manual is vague on this. Is it appropriate to use the potential/final letters that discuss circumvention of PPS? It appears that one might only use these letters if a pattern was identified and, then and only then, could the second admission is denied.

A747. No. The payment denial of the second admission applies to the individual case. Further action applies to the pattern of cases.

Q748. Section 4400, Inpatient Hospital Units, page 4-48: This DRAFT section instructs QIOs to conduct beneficiary complaint review. The present QIO Manual specifies to conduct review of both utilization and quality of care complaints. Does this still apply?

A748. Yes, the utilization review applies if the QIO detects such issues that must be addressed.

Q749. Section 4410, Review Settings, there is no mention of physician office setting as being one in which the QIO has review authority. Shouldn't this

setting be added, as QIOs are expected to review beneficiary complaints that involve a physician office setting?

A749. See response to Q 709.

Q750. Section 4520, Requesting Medical Record/Reviewing Documentation, page 4-54: This section instructs QIOs to send a reminder (spelled remainder) notice. Is this a requirement before technically denying a medical record?

A750. No. This reminder requirement applies to all request for medical records made by the QIOs. For the CDAC sample under the Hospital Payment Monitoring Program, the CDACs send the reminder letter notification

Q751. Section 4520, Requesting Medical Record/Reviewing Documentation, page 4-54: indicates that the CDAC will mark a record canceled 31 days from the date of the request. The present QIO Manual indicates 45 days. Please clarify.

A751. Records for non PEPP records are cancelled after 120 days. The 312-day record cancellation is related to the PEPP and Mark Krushat is the PEPP Government Task Leader.

This is a revised policy. The CDAC will cancel the case on day 31 if the record is not received by day 30. The QIO will deny the case on day 46 if the record is not received by day 45.

Q752. Section 4560, Maintaining Memoranda of Agreements (MOAs), page 4-61 – Please clarify as to whether QIOs are to obtain and maintain MOAs. This requirement is not included in the statement of work, is highly resource intensive.

A752. See response to Question # 41.

Q753. Section 4580 Monitoring Hospital's Physician Acknowledgement Statements QIO Manual suggests that the list of new physicians include UPIN, date admitting privileges granted, date acknowledgement was signed, and the date of physician's first claim. Typically, such information is necessary only in those instances where a provider is noncompliant. Would it be reasonable not to require this information from all providers?

A753. The instructions as drafted are to meet individual QIOs' needs. The QIO may use the necessary information it may need to meet this monitoring requirement. As a result of working with other QIOs through the Task 5

workgroup, we learned that other QIOs use this information and will like to continue doing so.

Q754. Section 4580, (p. 4 –62) Annual Acknowledgement Monitoring – Please clarify the specific QIO tasks required under this activity. For example, the PRO Manual does not specify what is to be done with the list of physicians once the hospital submits it to the QIO.

A754. The CMS is unable to answer this question at this time.

Q755. Draft Manual Information for Part Draft Proposed Mediation. It is unclear whether or not all parties must agree to mediation in order for the process to take place.

A755. Yes, all parties must agree to mediation.

Q756. Draft Manual Information for Part 5, An Integrated Beneficiary Complaint Review Approach, -Receipt of Complaint: please confirm the timeframe required for acknowledgment of receipt. (within the first full workday, as opposed to 5 calendar days)

A756. The CMS will clarify the language describing timeframe in the Draft Manual Information prior to final issuance.

Q757. Draft Manual Information for Part 5, An Integrated Beneficiary Complaint Review Approach, -Medical Record Review, paragraph (a): "Conduct a nonphysician screening followed by a physician review", does this mean that every concern requires a physician review?

A757. Yes. Every case with identified (utilization/quality) concern(s).

Q758. Draft Manual Information for Part 5, An Integrated Beneficiary Complaint Review Approach, -Medical Record Review, paragraph (e): Does this mean QIOs will not incorporate the confidentiality regulation that allows practitioners to prohibit disclosure.

A758. No. If a complete medical record review is conducted, the final notification to the beneficiary follows the current Federal regulations limitations stated above.

Q759. Section 7005C, discusses Combines Notices in Swing Bed situations, request clarification regarding liability; rather it is how Medicare reimburses the provider. Therefore, the issue of 2 discharge planning days appears confusing. Also, because of the statement regarding the 2 discharge planning days, it is unclear as to where a continued stay HINN is issued to a beneficiary from a provider who has swing beds. Would

they be liable the day after the notice, even though they are not going into the swing bed?

A759. The instruction at section 7005 C clearly states that the beneficiary will be liable the day following receipt of notice. A change from acute care to skilled care or less than skilled or vice-versa is not a physical change from one bed to another bed (the patient remains on the same bed.)

Q760. Section 7015, Beneficiary Request for QIO Hospital Issued NNC Review, A#1, Immediate, Review, page 7-7: There is no provision for the medical record. Review the case within 2 working days following the beneficiary's request *and receipt of the medical record,* should be added.

A760. We will revise the instruction as needed

Q761. Section 7015, Beneficiary Request For QIO Hospital Issued NNC Review, A# 2, Review After Discharge, page 7-7: There is no provision for the medical record. Review the case within 30 calendar days of receipt of the request *and receipt of the medical record,* should be added

A761. The current instruction reflects the language of the 1154(e) statute.

Q762. Section 7015, Beneficiary Request for QIO Hospital Issued NNC Review, B#1, page 7-7: The hospital should provide the medical record after the date that the beneficiary requests review, instead of *receives the notice.*

A762. We will revise final instruction as needed.

Q763. Section 7015, Beneficiary Request For QIO Hospital Issued NNC Review, B#1, (b) page 7-8: The QIO should complete the review within 2 working days following the beneficiary request *and receipt of the medical records.*

A763. See Q&A 761, above.

Q764. Section 7025. Monitoring of HINNs Section A, p.7-9 Are the HINNs going to be monitored against the chart for every HINN or is the monitoring just of the HINN letter?

A764. A review of the HINN content can lead into a review of the medical record if a concern(s)is raised during this activity.

Q765. Clarification is required for section 7025 A and B 3. One indicates review all HINNs no less than every 6 months and the other indicates review all HINNs.

A765. Under 7025A, we will clarify in the final instruction that the QIO should monitor the HINNs no less than every 6 months (i.e., twice a year).

However, the QIO has the flexibility to conduct this monitoring on an ongoing basis (or more frequently) if it finds that it more efficient relative to its own organization. For section 7025B3., we will specify under the first bullet that all notices are reviewed to determine whether the content of the HINN is appropriate.

Q767. Section 7025, HINNS/NODMAR. The following question refers to Attachment J-4 of the SOW, page 7-10, first bullet under 3. Review Process, which states that QIOs are to review "all HINNs" (i.e., the care was not covered from the point identified by the hospital…) Please clarify that review is required for 100% of all HINNs and not just cases with beneficiary liability (second bullet).

A767. See response to Q. 765

Q768. Draft Manual Sections (unnumbered) for Preparing Hospitals for Data Reporting.
Please define the "active role' the QIO should play in getting hospitals to collect or abstract quality indicators. If hospitals do not have the resources or refuse to engage in this activity, how should the QIO document its efforts to be compliant with this requirement?

A768. We will be conducting a survey of a hospital's readiness to participate. We propose to use this form to document this type of information on a hospital.

Q769. Assessing Hospital Information Technology (IT) Structure The PRO Manual states that all facilities with a zero in the third position should be included in the IT survey. Should this statement be expanded to include critical access and specialty hospitals which do not have a zero in the third position of their provider number (third digit of 1, 2, 3, or 4)?

A769. Assessing Hospital Information Technology (IT) Structure should include CAH and Non-PPS facilities.

Q770. Where in SDPS can QIOs find guidance on the identification of these facilities (i.e., PRS)?

A770. PRS and the QIONet are good resources.

Q771. Providing Technical Support. Supporting a Data Abstraction Tool.
Does CMS have any guidance as to the amount of onsite assistance that will be required of the QIO for supporting the data abstraction tool? (i.e., #s 1, 2, 4 in this section)

A771. No. However, 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.

Q772. Data Validation. Provider Certification.
Are de-certified providers defined as those with an agreement rate equal to or less than 80%?

A772. Agreement rates are less than 90 pecent.

Q.773. Data Validation. Inter-QIO Validation. What level of effort can the QIO expect to expend on conducting inter-QIO validation?

A773. At the non-physician and physician reviewer levels.

Q774. Draft Manual Sections (S) for Part 22, QIO Board - Guidance in this section conflicts with Section H-10 Diversity of QIOs requirements in the contract provisions of the RFP and represents inappropriate intrusion into organizational governance issues. CMS should understand that many QIOs supply services to more than just the Medicare population. While diversity is laudable and indeed all contractors should and do comply with Title VII requirements, mandates are unwarranted and without authority.

A774. CMS will revise the Statement of Work and the Manual to reflect the H-10 contract language.

Q1206. J-4 DRAFT Manual, Part 5, page 75 – "Review the medical record along with the allegations of the complaint to determine is there are quality of care concerns." Is this non-physician or physician review?

A1206. Generally, a non-physician reviewer will screen the case and a physician reviewer will review when the non-physician reviewer raises concerns (i.e., quality of care concerns).

Q1207. If no quality of care concerns are identified as a result of this review, would mediation still be entertained?

A1207. Yes, the case would be considered for mediation.
Beneficiary complaint review revolves around the issues raised by the complainant. Therefore, mediation does not solely rely specifically on the identification of quality of care concerns (identified problems with care), but resolution of the issues of the complaint (which may not be problems associated with the care).

Q1208. J-4, PRO Manual Section 11010, page 123 – "Meeting your statutory requirements to review specific categories of services, such as unnecessary admissions and up coded DRG assignments…" Does HPMP still involve undercoding as well?

A1208. The HPMP is concerned with correct coding. Through the program, all errors are to be sent to the FI for correction. If the error results in an underpayment to the hospitals, then we would expect the correction to still be made and the hospital reimbursed appropriately.

Q1209. J-4, PRO Manual Section11015 B.1, page 125 – "CMS will supply to the QIO, through the support QIO, summary tables of utilization statistics for facilities in our State." When can QIOs expect the initial receipt of this information in the 7th SOW and with what frequency will QIOs receive this data thereafter?

A1209. Quarterly.

Q1210. J-4, PRO Manual Section 11030(b), page 133 – CMS explains how we are to work with the QIO to get clearance before beginning any activity in a hospital is there an expected turn around time from the QIG when this information is be requested.

A1210. If by QIG you mean the OIG, then, yes, the expected turn around time is two weeks. If you mean QIG, then we do not understand the question.

J-5 Data Supplied by CMS

Q15. Dates and CMS accountability on Data - The RFP does not delineate the time frames for delivery of data form CMS. The majority of the contract deliverables are dependent upon timely and accurate data from CMS. Expectations and accountability must be clear at the outset of the contract to ensure fairness and optimum success. Please provide explicit data delivery time frames within the J-5 and J-7 attachments.

A15. Section A, Attachment J-5 outlines the data in the CMS warehouse that are updated on a monthly basis. These data will be in the warehouse, and hence not delivered. QIOs will access the warehouse to analyze these data and perhaps move a small subset of these data to their local server for further analysis.

Section B, Attachment J-5 states that the ARF will be placed on individual QIO database servers on an annual basis.

Section C, Attachment J-5, regarding ad hoc requests for data: It is not possible to provide dates for these requests at this time. QIOs will make these requests, and once approved by CMS, the Data Support QIO, the QIOSC for data, will provide the data to the QIO.

Section D, Attachment J-5, regarding various files. It is not possible to provide exact dates for the delivery of these data. The Data Support QIOSC will be providing these datasets, and this contract has not yet been awarded. **In any event, knowledge of specific delivery dates for these data is not a requirement for proposal preparation and submission purposes**. QIOs will be notified of actual delivery dates once they are known.

Q775. Will CMS commit to a date this data becomes available?

A775. Part B only – An estimated date is not available at this time. However, a QIO may continue to receive ad hoc data until the analytical files are available. See also Answer 15, above.

Q776. If not, will QIOs be held harmless if the data is furnished late?

A776. CMS will not commit in advance to hold a QIO harmless for any particular circumstance. We will condsider modifications in the evaluation to respond to identified problems and/or other circumstances.

Q778. What is the “Physician missed opportunity file”?

A778. This is an outpatient analytical file that identifies physicians that missed the opportunity to provide a beneficiary a diabetic service or mammogram during an office visit and calculates a rate for that missed opportunity.

Q779. Enrollment data is listed under item A. as being available through the QualityNet Warehouse, but under item C. it states that the EDB must be requested Ad-hoc. Is there a difference in these files?

A779. The EDB data is available in the QualityNet warehouse. There is no need to do an ad hoc request.

Q780. If not, which section is correct?

A780. The EDB data is available in the QualityNet warehouse. There is no need to do an ad hoc request.

Q1211. What would be the purpose of the QIO accessing the HH data out of the Part A files?

A1211. None: we do not use Part A files for HH data.

Q1212. Can you give us an overview of what the flat file dump of HMO tables (Attachment J-5) will look like?

A1212. The answer to this question is not needed to complete the business or technical proposal.

Q1213. What input do QIOs have in creating QIOC's level measurement and analytical data sets?

A1213. The answer to this question is not needed to complete the business or technical proposal.

Q1214. What is the process/requirements for accessing additional data through Government Task Leaders?

A1214: The details of this process are not yet finalized. The answer to this question is not needed to complete the business or technical proposal.

Q1215. What are the timelines for data presentation to QIOs?

A1215. Section A, Attachment J-5 outlines the data in the CMS warehouse that are updated on a monthly basis. These data will be in the warehouse, and hence not delivered. QIOs will access the warehouse to analyze these data

and perhaps move a small subset of these data to their local server for further analysis.

Section B, Attachment J-5 states that the ARF will be placed on individual QIO database servers on an annual basis.

Section C, Attachment J-5, regarding ad hoc requests for data: It is not possible to provide dates for these requests at this time. QIOs will make these requests, and once approved by CMS, the Data Support QIO, the QIOSC for data, will provide the data to the QIO.

Section D, Attachment J-5, regarding various files. It is not possible to provide exact dates for the delivery of these data. The Data Support QIOSC will be providing these datasets, and this contract has not yet been awarded. **In any event, knowledge of specific delivery dates for these data is not a requirement for proposal preparation and submission purposes**. QIOs will be notified of actual delivery dates once they are known.

J-7 Evaluation Plan

Recommendation: There are two evaluation criteria mentioned in the RFP: one statewide change in the indicator and one in a survey. Recommend CMS add a third evaluation component related to actual hospital participants in particular QI topics.

Q8. Lack of finalization of weights and measures – The measures and their relative weights, particularly for the new settings, are not yet finalized. These must be finalized as soon as possible but no later than the time of contract execution. Contractors cannot be held accountable and liable for the achievement of improvement where tools and resources are not provided by CMS at the start of the contract.

A8. This is a fair concern, and CMS staff and others are working to finalize these issues as soon as possible. Not having a specific CMS evaluation measure should not preclude a QIO from beginning work that will improve care for appropriate conditions and in relevant settings. In the event that CMS finds a given planned measurement impractical to implement, we will make appropriate modifications to the evaluation plan.

Q9. Lack of finalization of evaluation plan - The current draft leaves far too many items unspecified to provide a definitive critique. As we understand the current document is undergoing revision, we would request a final draft document for industry critique as soon as possible, particularly for the Group one procurement process. Finalization of this document is needed for bidder resource and program planning. CMS has stated that the scope of responsibilities of QIOs will be much greater without substantial increases in resources. Without the details, QIOs will not be able to wisely prioritize scarce resources and will waste precious time in building appropriate teams and coalitions to accomplish the work in a timely manner

A9. We are aware that manual portions are in draft form and will be working to rectify that. Please be guided as much as possible by the Scope of Work and the Q & A's

Q781. The current draft leaves far too many items unspecified to provide a definitive critique. As we understand the current document is undergoing revision, we would request a final draft document for industry critique as soon as possible, particularly for the Group one procurement process. Finalization of this document is needed for bidder resource and program planning. CMS has stated that the scope of responsibilities of QIOs will be much greater without substantial increases in resources. Without the details, QIOs will not be able to wisely prioritize scarce resources and will waste precious time in building appropriate teams and coalitions to accomplish the work in a timely manner.

A781. The RFP is a request for contract proposals, not critiques of program design or policy. The finalized J-7 is attached to this amendment.

Q782. The draft does not delineate any timeframes for delivery of data from CMS. Expectations and accountability must be clear at the outset of the contract to ensure optimum success and fairness in contract execution. Please provide explicit data delivery timeframes within the J-7 attachment.

A782. We will work to provide data in as timely a manner as possible. Data, expectations, and accountability are related but not equivalent. Please do not let missing data unduly interfere with your undertaking efforts to improve care in your state.

Q783. QIOs feel strongly that they should not be evaluated on the achievement of statewide improvement, particularly in the new untested arenas where CMS is contracting for less than 100% of facilities in these settings (SNF, HHA). Reconsideration is requested.

A783. Thank you for your comment.

Q784. Please clarify that the CMS-wide panel must perform an independent assessment of performance (a *de novo* review) and not merely review or "rubber stamp" the earlier decision of the technical evaluation team

A784. There will be one panel which will function as described in attachment J7, and not a separate set of teams.

Q785. Why doesn't the QIO's project officer, who presumably has the most detailed knowledge of the QIO's performance, have more of a role in the evaluation?

A785. Not necessary to submit a bid for this contract.

Q786. Why wouldn't the project officer present his/her evaluation of the QIO to the CMS-wide panel, even if he/she were not a voting member?

A786. See #785.

Q787. Please clarify the effect of the existence of the criteria listed as mitigating factors (or other reasons why it is in the Government's best interests to judge the work to be successful): that these mitigating factors or other reasons may outweigh or overcome the determination that the QIO has not met or exceeded the evaluation criteria for the task in question.

A787. This information is not needed to prepare business or technical proposals.

Q788. For Task 1, will the expected minimum improvement level be established for each State or will all States be subject to the same expected improvement?

A788. See the finalized J-7, attached to this amendment.

Q789. Bullet three enable the panel to take into account "whether the QIO was a new contractor in the seventh scope of work". It is recommended that all QIOs be treated equally and that the panel takes into account whether the work/performance in question was related to a new arena (like PEPP in the sixth scope of work).

A789. The list is not exclusive. Bullet three does explicitly recognize that a new QIO may have had less time than others to accomplish its goals. The panel also could determine that the disadvantage owing to a PRO's being new is not sufficient to explain its poor performance. These bullets list areas for the panel to consider and not criteria for making a recommendation.

Q790. What is the set target percentage of identified participant providers?

A790. See #237.

Q791. Among the identified number of participants, how will the combining of Medicare Providers be handled?

A791. Clearly, if a participating provider assimilates another provider (if, in Provider Reimbursement Manual terms, the participant provider is the one whose PIN survives the merger and is used for the merged entity), its participant status need not change. We presume this question refers to those cases where the participant is the provider who is assimilated, or where the providers merge in such a way that a new PIN is issued for the combination (neither PIN survives). CMS has not made a final decision on how we will handle these situations, as there are multiple options.

Q792. Will these providers be removed from both the baseline and re-measurement?

A792. The minute details have not yet been finalized.

Q793. How will data be collected for identified participant?

A793. See #237.

Q794. Will CMS collect it based on the list of participants submitted?

A794. Yes

Q795. Will the QIO collect it?

A795. No. See #237.

Q796. Will the identified participants collect it?

A796. See individual tasks. Nursing Homes, for example, are based on the MDS. Outpatient measures will be based on claims.

Q797. Will CMS provide the QIOs a listing of the possible questions that will be used to conduct the provider satisfaction survey?

A797. A CMS team has accepted the task of developing these instruments. QIOs do not need this information to prepare contract proposals.

Q798. We have several general questions about the "provider evaluation" component of the evaluation plan. This component appears in several places throughout the plan: Will the QIO have any input on the questions to be included in the provider satisfaction survey?

A798. See #797

Q799. Will CMS distribute the survey to all participating providers in each care setting or only to a sample of providers?

A799. Yes. Either option may be appropriate depending upon the number of providers identified. (The CMS reads the question as “all identified participant providers” rather than “all providers who participate in the Medicare program”, which would, clearly, represent in many cases a population so large fiscal prudence would mandate sampling.)

Q800. If a sample is used, how will it be selected?

A800. This has yet to be determined; please bid your contract on the assumption that it is a good thing for those with whom you collaborate to find the interaction satisfying

Q801. The evaluation plan makes no mention of response rates for the satisfaction survey. Inadequate response rates could skew the findings and render the results meaningless.

A801. Please bid your contract on the assumption that it is a good thing for those with whom you collaborate to find the interaction satisfying

Q802. Will CMS include this evaluation component only if an acceptable response rate is achieved?

A802. This has yet to be determined; please bid your contract on the assumption that it is a good thing for those with whom you collaborate to find the interaction satisfying

Q803. If so, what does CMS consider as acceptable?

A803. This has yet to be determined; please bid your contract on the assumption that it is a good thing for those with whom you collaborate to find the interaction satisfying

Q804. For all provider satisfaction surveys, CMS expects 80% of providers to report "mostly or fully" satisfied with QIO support. This is an extremely aggressive target. On what basis was the 80% standard selected?

A804. See #801.

Q805. Does CMS have any data which suggests this is a reasonable, achievable target?

A805. See #801.

Q806. Please provide details about the composition of the surveys and how they will be implemented.

A806. See #800.

Q807. Please provide further clarification of how "the degree of collaboration the QIO exhibited with the QIOSCs and other QIOs... will be measured.

A807. This will be a judgement that CMS will have to make. When and if CMS determines that the degree of collaboration the QIO exhibited with the QIOSCs and other QIO is measurable we will work to include such a measurement in the performance based contracting scheme.

Q808. Although it states that CMS will make no further efforts to validate theidentified participants or confirm QIO activity with these participants, will TQIP (or its replacement) be used to track activities with these providers?

A808. For the purposes of evaluation, no, other than to identify them (if appropriate). None of this precludes a project officer from using such information to properly carry out their responsibilities.

Q809. It appears that there will be minimum expected improvement rates. What are these expected values for each sub-task?

A809. These are delineated in the revised J7.

Q810. The formula for TPA is sensitive to small changes. In the example, the QIO achieved the goal of scoring a total greater than or equal to 1. If the statewide observed performance was changed to 7% rather than 8%, the total score becomes 0.981 rather than 1.007. On a scale as small as this, this is a significant change for a non-significant change in rate.

A810. We have endeavored to set a threshold to respond to concerns about pitting QIOs against each other. Setting a higher threshold would solve the problem you've posed, though not without consequences.

Q811. The expected amount of improvement is not listed in bullet (2). Please provide the value of this expectation.

A811. See the revised J7 document.

Q812. The evaluation plan states that QIOs will need to demonstrate 8% improvement in the participants group and an 8% improvement in the CTWA, of which the participants group is a part. If the intent of CMS is to dually measure QIOs on this sub-task, please provide rationale as to why there appears to be dual measures for this sub-task.

A812. This is not a correct reading of the document which we have revised in opes of adding clarity.

Q813. The J-7 document does not address the relative indicator weights for the inpatient and outpatient subtasks. When will this be available?

A813. See the revised J-7.

Q814. The J-7 document makes no mention of relative weighting for the Nursing Home and Home Health Agency indicators for the CTWA for these subtasks. Are we to assume that they will be equally weighted?

A814. See the revised J-7

Q815. The J-7 document does not specify the performance standard for the Nursing Home and Home Health Tasks. When will this be available?

A815. See the revised J-7.

Q816. There appears to be an inconsistency in the J-7 document in the use of terms for the provider satisfaction evaluation. Should "mostly and fully" be changed to "somewhat and very" or vice versa? (This should be addressed throughout the document.)

A816. S see the revised J-7

Q817. When will the baseline Nursing home and Home Health agency data be available?

A817. CMS expects that the baseline rates for the publicly reported Nursing Home quality measures will be available in October 2002. Home Health is a more complex question, as a firm target date for selecting publicly reported quality measures has not yet been set. Please refer to the revised J-7, and answers relevant to its subtask, for more information on HH evaluation.

Q818. The J-7 makes no reference to the outpatient, home health or nursing home remeasurement timeframes. When will these be made available?

A818. See relevant answers for these subtasks.

Q819. CMS reserves the right to adjust the expected minimum thresholds based on experience with the amount of improvement achieved during the contract cycle and any unforeseen circumstances.

A819. This is correct.

Q820. This places the QIO at a significant disadvantage as it appears that the minimum threshold may become a "moving target". The PRO has no assurance of renewal despite their performance. How does the "hold harmless clause" relate to the above CMS statement in the evaluation section?

A820. CMS plans no "hold-harmless clauses" under this (7th Statement of Work) contract.

Q821. We are concerned about the validity of each of the satisfaction surveys CMS will conduct. What steps will CMS take to ensure and to demonstrate the validity of the results?

A821. See #803.

Q822. How will CMS measure the degree of collaboration with QIOSCs or other QIOs?

A822. The CMS will make these determinations on a case-by-case basis.

Q823. The QIOs should not be measured on statewide rates for the new work, due to the developmental nature of these areas. The pilots QIOs have an unfair competitive advantage in that CMS funded them three years in advance of the 7th scope to begin the development phase. The current evaluation section sets up the QIOs (and CMS) for failure. This SoW should be used as a period for the QIOs to learn about these areas. There should be evaluation, but it should be excluded from the QIO performance measure.

A823. See #807

Q824. States with large numbers of facilities will find it difficult to work with more than the expected numbers of skilled nursing facilities, home health agencies, and physicians without more resources than for the expected number. As nursing facilities and physicians require significant "onsite support" to improve, the budget will need to provide for enough staff to at least address the minimum requirements (since there is no cap on the number of nursing facilities and home health agencies). Since the formula for evaluation includes the numbers of facilities work with as collaborators (percent of expected with a possibility of 150%), this seems to bias against states with large number of facilities in Tasks 1a, 1b, and 1d.

A824. Budget estimates for each state were made to consider the level of work required

Q825. States with complex geographic territories are disadvantaged due to the travel complexity (i.e. increased travel time/cost) that they face in providing onsite support. Will compensation be provided to QIOs to allow adequate resources for this required travel?

A825. See #824

Q826. We have several questions about the "provider evaluation" component of the evaluation plan. This component appears in several places throughout the plan.
It is stated that "the weight for statewide improvement could range from 80%, for no identified participants, to 14%, for 150% of target identified participants." It is also stated that a satisfaction survey will be conducted among identified participants and/or stakeholders. If a QIO chooses not to identify participants for a subtask, will the satisfaction survey be dropped?

A826. This is not likely to be a productive approach.

Q827. Will the QIO have any input into the questions that will be included in the provider satisfaction survey?

A827. The details of the survey methodology have not yet been determined. Please submit your bids under the assumption that satisfaction on the part of those with whom you interact is a desirable outcome.

Q828. Will CMS distribute the survey to all participating providers in each care setting or only to a sample of providers?

A828. See #827

Q829. If a sample is used, how will it be selected?

A829. See #827

Q830. The evaluation plan makes no mention of response rates for the satisfaction survey. Inadequate response rates could skew the findings and render the results meaningless. Will CMS include this evaluation component only if an acceptable response rate is achieved?

A830. See #827

Q831. If so, what does CMS consider as acceptable?

A831. See #827

Q832. For all provider satisfaction surveys, CMS expects 80% of providers to report "mostly or fully satisfied" with the QIO. This is an aggressive target. On what basis was the 80% standard selected?

A832. See #827

Q833. Does CMS have any data that suggests this is a reasonable, achievable target?

A833. See #827

Q834. How and when will the baseline be calculated?

A834. see answers for specific tasks

Q835. Is 6SOW final measurement data going to be used or will there be a recalculation?

A835. It will be used, though with some supplementation and adjustment

Q836. It would be unfair for CMS to adjust *upward* the expected minimum thresholds at some future date in the 7th SOW. Please clarify intent.

A836. We are aware of this perception and, while rebuttable, we hope any errors are on the high side.

Q837. The table gives the weight for "Collaborator" as .54. If the formula (Obs % Collab)/(Min % Collab)*.44 is used, this number should be (25/20) (.44) = .55. How was the value .54 derived?

A837. Good call; you are correct and the error has been corrected

Q1220. J-7, General Evaluation Criteria, page 4 – Paragraph 2, CMS states that they will not remove identified participants, except in the case of exceptional circumstances, such as the closing of a facility or death/retirement of an identified participant physician. Will CMS consider the closing of a physician practice, regardless of the reasons, to be an exceptional set of circumstances?

A1220. That depends on the circumstances.

Attachment J-7 DRAFT General Evaluation Plan
Task 1a: Nursing Home Quality Improvement

Q838. Item (2) The measurement is based on 10% of nursing home facilities. Currently there are 700 plus facilities with a average bed size (residents) of 100- We could be looking to affect the care of 7000 nursing home participants. Large states will suffer-any thoughts on what to use so that everyone is looking at the same sample size. Example- Rhode Island has 100 homes- their 10% is 10 - if they choose small facilities they will end up with a much smaller sample size.

A838. The nursing home is the unit used for publicly reporting measures. The CMS decided to use nursing home for the unit of analysis.

Q839. If we chose % of licensed beds- would it not be a more uniform sample size throughout the nation?

A839. See Q&A # 838, above.

Q840. Will evaluation components for statewide improvement in NHs be calculated across all publicly reported quality measures or only across the 3-5 measures selected by the QIO for focused efforts?

A840. The evaluation of the QIO's performance on statewide quality improvement will hold the QIO accountable for only the set of 3-5 of CMS's publicly reported quality indicator measures which the QIO will have selected in consultation with relevant stakeholders in its State.

Q841. Does CMS intend to develop a threshold for the term "some" improvement for the quality of care in these areas?

A841. "Some" improvement on NH quality indicator rates, which are most likely to be failure rates, can be defined as "greater than 0% reduction in the failure rate." See also Attachment J-7 to the RFP, as attached to this amendment.

Q842. Each of the tasks' evaluation components mentions the use of the Likert scale, which uses the terms "somewhat" or "mostly satisfied". For a satisfactory evaluation, the statement of work indicates that participants will be "mostly or " fully" satisfied with the assistance given it by the QIO. How will the terms be reconciled by CMS?

A842. Prior to contract award, CMS will ensure that the Statement of Work and Evaluation language on this topic are compatible.

Q843. The formula for improvement uses a "*", which could be confusing. We are presuming that it means "multiply"; please clarify.

A843. You are correct. We have modified the formatting to clarify.

Q844. For subtask (1.a) and (1.b) can CMS identify what is the minimum expected performance improvement?

A844. See Questions & Answers 841, 173, 184, and 843.

Q845. There is an inconsistency or mismatch in the language related to the Provider Satisfaction Survey. CMS expects 80% to be "mostly or fully satisfied." The footnote describing the five-point Likert scale to be used gives the two highest ratings as "4= somewhat satisfied and 5=very satisfied." It is not clear how the 80% "mostly or fully satisfied" criteria matches up with the Likert scale descriptions.

A845. See Q&A # 842.

Q846. Item (2) The measurement is based on 10% of nursing home facilities. For states with a large number of facilities, we anticipate the need for a tremendous amount of resources and a much larger sample size than a state with a lesser number of facilities. Would CMS consider a % of licensed beds instead of a percentage of facilities - would it not be a more uniform sample size throughout the nation?

A846. See Q&A # 838.

Q847. Will the evaluation component for statewide improvement for NHs be calculated across all publicly reported quality measures or only across the 3-5 measures selected by the QIO for focused efforts?

A847. The evaluation of the QIO's performance on statewide quality improvement will hold the QIO accountable for only the set of 3-5 of CMS's publicly reported quality indicator measures which the QIO will have selected in consultation with relevant stakeholders in its State.

Q848. Provider evaluation – CMS… will be mostly or fully satisfied with the assistance given it by the QIO. The footnote defining the scale does not include the "mostly" or "fully satisfied" categories. Does "somewhat satisfied" correspond to "mostly satisfied" and "fully satisfied" correspond to "very satisfied"?

A848. See the reviesed J-7 attachment.

Q849. What are the expected minimum performance levels for identified participants and statewide?

A849. The minimum is "greater than 0% reduction in the failure rates" and the target is 8% reduction in the failure rate. (See also revised J-7, attached to this amendment, and Q&A # 841.)

Q850. Who is responsible for determining which of the 3-5 indicators are to be selected for improvement projects within the state?

A850. As indicated in the Statement of Work, the QIO shall be responsible for selecting, in consultation with relevant stakeholders in NH care in its State, the set of 3-5 of CMS's publicly reported quality indicator measures.

Q851. In addition, when will the indicators be chosen?

A851. In August 2002, CMS will announce its final selection of measures which will be publicly reported in October 2002. The QIOs will have access to this decision. During the 6 state pilot, the six QIOs and the support QIO

are preparing materials for the pilot measures. It is quite possible that the topics of some of the pilot measures will be the same as the topics for the measures reported in October 2002.

Q852. At present, the indicators are being developed and there is the possibility that these indicators may be changed again in August. How are the QIOs supposed to be prepared for rollout in October if indicator information may or may not be finalized until August?

A852. The CMS would suggest QIOs spend their time between now and the announcement of the national NH quality indicator measures in developing understanding of and partnerships in the NH setting. CMS will also provide training on the indicators as soon as possible after CMS selects said indicators (see also Q&As # 128, 129, & 146).

Q853. How is CMS going to determine who the contact at the SNF will be to survey for evaluative purposes? Current project performance indicates that the QIO is more successful when they have multiple contacts (for accountability and in case someone resigns).

A853. Some details of the survey design have not yet been finalized. Fortunately, QIOs do not require this information in order to prepare and submit their contract proposals.

Q854. It appears that no "expected" statewide improvement % has been set. That percentage should be set less than the 8% figure for both the hospital and office settings. The LTC indicators are new for almost all of the QIOs. Setting unreasonable improvement percentages will force QIOs to devote lopsided resource allocations to LTC. In the absence of any information on the trends in NH indicators or the success of pilot projects in changing them, the targets for these projects should be kept minimal.

A854. See the revised J-7 attached to this amendment. See also Q&As 841, 173, 184, and 843.

Q855. Is there any incentive for the NH to work with us other than these public reports?

A855. CMS believes that the public reporting does provide a significant incentive for NHs to seek every available resource to assist them in improving their quality of care. This issue is not unique to the NH setting: see Q&A #110.

Q856. Where is the incentive to work with the QIO?

A856. See Q&As #110 & #855.

Q1217. Task 3.a: Timelines of Completed Reviews: What are the prescribed time frames?

A1217. The review timeframes are specified at section 4540 of the PRO Manual. We are planning to summarize these timeframes by adding an exhibit to the final instructions of Part 4.

Q1218. All Tasks with satisfaction measure: How will satisfaction be measured?

A1218. See #827

Q1219. Will we have input into satisfaction measures?

A1219. Those methodological details have not yet been worked out.