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.

Attachment J-7, Task 1a and 1b, Nursing Home and Home Health

Q857. What are the relative rates of improvement necessary for statewide and participant improvement?

A857. See previous answers and revised J-7

Attachment J-7 DRAFT General Evaluation Plan
Task 1b: Home Health Care Quality Improvement

Q858. Due to the unique challenge of implementing quality improvement in the home health care environment a graded approach that recognizes success in the processes of implementation as well as the desired outcome – improvement in care, is recommended. The outcome based quality improvement program is a well developed and proven quality improvement tool. It does, however, require an intensive approach for Quality Improvement Organizations to implement with home health agencies unfamiliar with quality improvement theory and practice.

A858. See revised J-7

Recommendation: Therefore we recommend the following step wise evaluation approach.

Evaluative Goal 1.

Q859. The QIO will have trained 30% of the home health agencies in their state in the Outcome Based Quality Improvement program. The comprehensive

training will empower the participating organizations to fully implement the OBQI program.

A859. See Revised Attached J-7.

Q860. The QIO will provide a comprehensive training that will be evaluated as good or excellent (average across each Agency's evaluation) by 60% of those participating agencies.

A860. See Revised Attached J-7.

Evaluative Goal 2.

Q861. The QIO will work with the home health agency community in order to insure that 15% (i.e. 50% of those facilities trained) of all agencies will develop and submit an acceptable plan of action (PER obqi GUIDANCE) during the 7th scope of work (by the 28 th month of the contract).

A861. See Revised Attached J-7.

Q862. Home Health Agencies evaluation of the QIO technical assistance offered will be rated as good or excellent by 60% of the participating agencies.

A862. See Revised Attached J-7.

Evaluative Goal 3.

Q863. Of the Home Health Agencies that submit acceptable plans of action, 33% (or 5% of all the Home Health Agencies) will demonstrate statistically significant improvement in one of the targeted outcomes in the risk-adjusted outcome reports.

A863. See Revised Attached J-7.

Q864. Will the evaluation component for statewide improvement in HHAs be calculated across all publicly reported OASIS quality of care measures or only for a specified subset of the measures?

A864. See Revised Attached J-7. Statewide improvement is not in Task 1(b).

Q865. When will the final indicators for HHA be provided to QIOs?

A865. See Revised Attached J-7.

Q866. The formula for improvement uses a "*", which could be confusing. We are presuming that it means "multiply"; please clarify.

A866. See Revised Attached J-7.

Q867. For subtask (1.a) and (1.b) can CMS identify what is the minimum expected performance improvement?

A867. See Revised Attached J-7.

Q868. For statewide improvement – will all measures be used or only the measures selected by the QIO?

A868. See Revised Attached J-7. The Statewide improvement has been deleted from Task 1(b).

Q869. Similar to LTC, it appears that no "expected" statewide improvement percentage has been set. That percentage should be set less than the 8% set for both the hospital and office settings. The HHA indicators are new for almost all of the QIOs. Setting unreasonable improvement percentages will force QIOs to devote lopsided resource allocations to home health. In the absence of any information on the trends in HHA indicators or the success of pilot projects in changing them, the targets for these projects should be kept minimal.

A869. See #868

Q870. Improvement on selected CMS publicly reported OASIS quality of care measures…Which quality of care measures?

A870. see #177.

Q871. Who selects the measures?

A871. See Answer #177.

Q872. When will we find out what they are?

A872. See Anwer #172.

Q873. How long will it take to accurately test these indicators?

A873. The utility of OASIS data for monitoring patient outcomes of care and improving quality of care under Medicrae have been well demonstrated over a period of 12 years in multiple demonstration sites across the country. OASIS was developed primarily for purposes of measuring outcomes for adult home care patients.

Q874. What are the expected minimum performance levels for identified participants and statewide?

A874. See Revised Attached J-7.

Q875. A target rate of 30% of the HHAs is to be selected for improvement projects. In one state alone, this equates to approximately 286 HHAs. In addition, this will be the first relationship between the QIO and the HHAs. It will be difficult enough to establish effective working relationships with this volume of HHAs, much less achieve performance improvement of quality indicators.

A875. HH Pilot QIOs ave a recruitment rate of 50% to 80%. QIOs shuld consult with QIOSC on recruitment efforts. The contract allows for increase funding for larger states with more HHAs.

Q876. How is CMS going to determine who the contact at the HHA will be to survey for evaluative purposes? There may be multiple contacts with varying levels of involvement.

A876. See Revised Attached J-7.

Q877. Will the evaluation component for statewide improvement for HHAs be calculated across all publicly reported OASIS quality of care measures or only for a specified subset of the measures?

A877. See Revised Attached J-7.

Attachment J-7 DRAFT General Evaluation Plan
Task 1c: Hospital Quality Improvement

Q878. The SoW does not include an information about the relative weights assigned to the hospital quality indicators. When will this information become available?

A878. I understand that all measures will be weighted equally.

Q879. It has been decided by CMS that after a record request for the 125 records per topic per state has been identified, CMS will check for any of the requested records in the national clinical repository. Any of the records not in the repository will be requested and providers will have the option of sending them to the CDACs to be abstracted or to abstract themselves. Please provide more information about the validity of using both hospital-abstracted and CDAC-abstracted data in combination when computing QIO surveillance and remeasurement rates.

A879. Answers regarding validity are not necessary for you to successfully bid your contract.

Q880. The sample size of 125 cases per topic per quarter is not sufficient to determine statewide improvement, especially after denominator exclusions are applied. With this methodology, a six-month time period comparable to the baseline will only contain 250 abstracted cases. To obtain the desired 750 cases for comparison, an 18-month time period is required. This would require the remeasurement period to begin between the third and sixth months of the contract. We still have a pre/post analysis scheme as it states that CMS will generate remeasurement rates based on the four "most recent" quarterly samples prior to the end of contract evaluation. Given the delay in obtaining and abstracting medical records, this places the beginning of the remeasurement time period at month 13 of the contract. What is the purpose of the surveillance-type methodology if the power of times series analysis will not be employed?

A880. It is the difference between evaluating the program and evaluating contract performance.

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Q881. In relation to the CTWA described in the evaluation plan, please clarify if CMS will consider “relative” improvement or “actual” improvement.

A881. The documents clearly state that relative improvement (reduction in failure rate) will be used for performance measures in the evaluation.

Q882. This QIO would like clarification on the sampling size to be used. The statement of work indicates that CMS expects to sample approximately 125 cases per clinical topic in each state each calendar quarter. Will a sample of only 500 cases/topic for remeasurement be statistically valid?

A882. CMS expects to sample approximately 125 cases per clinical topic in each state each calendar quarter.

Q883. The evaluation formula indicates that weights will be assigned for each inpatient project quality indicator. When will the weights be made available?

A883. We plan to use a simple average

Q884. For the satisfaction surveys – how will the results of responses for hospitals/ physician offices and M+COs be combined?

A884. They will not be, the surveys will be task-specific.

Q885. Recommendation: It is not feasible that the inpatient remeasurement period would be based on the quarter just preceding a QIO's 28th month (e.g. a Round 1 QIOs 28th month is in November; it's not feasible to request, abstract and include cases for the period ending in September). Optimally, the remeasurement period as proposed in the RFP would be the year ending two quarters prior to a QIOs remeasurement period (i.e. ending in with a QIOs 23rd month - June for a Round 1 QIO). This means the remeasurement period would begin with a QIOs 12th month - similar to the sixth contract cycle. As in the sixth contract cycle, 11 months is not a realistic amount of time for QIOs to work on interventions and partnering in a three contract before CMS begins evaluating QIOs starting with the 12th month- only one year into the contract. Please consider an alternate evaluation strategy such as using three quarters and increasing the sample size for those three quarters. Note also that the six-month inpatient remeasurement periods during the sixth contract cycle ended fully 11 months before a QIOs 28th month (i.e. from a QIOs 12th through 17th month). Given similar timing during the seventh contract cycle for the CDACs to complete remeasurement abstraction relative to a QIOs 28th month, that would translate to an early one year inpatient remeasurement period of the 6th through 17th month.

A885. Thank you for your comment.

Q886. Recommendation: MCO and Fee-for-service evaluations. CMS states that the improvement found in fee-for-service and MCO patients will be calculated separately and then combined according to the level of MCO penetration in the state. This will likely overweight MCO patients since MCO members (who include fewer of the oldest, sickest or nursing home residents) have much lower hospitalization rates than fee-for-service Medicare, particularly for some conditions. It would be better to combine fee-for-service and MCO inpatients in accordance with their actual proportion of the patients for each condition (AMI, HF, CAP and selected surgeries).

A886. Thank you for your comment.

Q887. The SoW does not include any information about the relative weights assigned to the hospital quality indicators. When will this information become available?

A887. The indicators will be weighted equally for each topic as per the revised attachment J7.

Q888. Since there will be two baseline rates provided at the start of the contract, one for FFS and MCOs, will there be two rates throughout the process?

A888. See revised J-7.
HEDIS data is collected every year for M+COs so that data will be available generally in July for the previous year.

Q889. How will this affect the proposed evaluation since it appears that there is a CTWA for only the four clinical topics and not for eight based on community of service?

A889. There are efforts underway to improve these measures

Q890. CMS proposes to use aggregate data for the four most recent quarterly samples (500) cases for evaluation purposes. Given the experience of having small denominators/numerators for several indicators with 750 case samples, will this provide a valid performance measure?

A890. CMS current plans to use 500 cases

Q891. Will the 500 case clinical topic evaluation sample include both FFS and MCO records

A891. Yes

Q892. Since data for remeasurement will be taken from quarterly samples, evaluation of QIO performance will be based on about a year of intervention activity in order to have the data ready for the 28th month evaluation. Wasn't this an issue raised during the Sixth Scope of Work that QIOs are evaluated on only a year's worth of work in a three-year contract?

A892. Yes it was. This is less of a problem for continuing topics (and continuing QIOs).

Q893. If there is a separate sampling of records to derive the MCO performance rate, what are those specifications?

A893. We will have to supplement the 6th Scope remeasurement for it to serve as a baseline for this aspect of the 7th

For task 1d, the specifications are the HEDIS measurements for Diabetes and Mammography, it will not be derived from a sampling of records. HEDIS data is stored on a public use file located at http://www.hcfa.gov/stats/hedisdwn.htm

Q894. Were M+CO beneficiaries sampled during the remeasurement period for the sixth scope of work, which is stated will serve as the baseline for the seventh scope of work?

A894. No.

Q895. The sampling strategy for cases for the inpatient topics has been modified to allow for a time series analysis to account for incremental improvements over the life of the contract period. Why does the analysis methodology not capitalize on the sampling strategy, but instead revert to the less desirable pre-test/post-test design?

A895. See 880

Q896. When will the weights for specific indicators in the formula for Topic Weighted Average be available?

A896. They will be weighted equally per the revised attachment J7

Q1216. Task 3.c: Other Beneficiary Protection Activities – Relability of Review: What criteria for reliability are we expected to follow?

A1216. We will provide guidance through the Task 3 support QIO with respect to the criteria that the QIOs need to follow.

Attachment J-7 DRAFT General Evaluation Plan
Task 1d: Physician Office Quality Improvement

Q897. The question of bias in favor of states with smaller Medicare populations is raised when considering that CMS expects the QIO to demonstrate at least 8% improvement in the combined topic weighted average at the 28th month of the contract for both statewide and identified participants.

A897. See #241.

Q898. How will CMS obtain the list of physicians?

A898. See Q242

Q899. Where will the data come from (UPIN problems with FI)?

A899 See #243.

Q900. With respect to the 10%, are there geographic/regional requirements? May QIO target MSAs?

A900. See #244 & #245.

Q901. What is participation?

A901. See #246

Q902. Are there levels of intensity---if so, what are their definitions?

A902. See #247

Q903. How will participation be validated?

A903. See #248.

Q904. The SoW does not include any information about the relative weights assigned to the physician office quality indicator. When will this information become available?

A904. No relative weights (other than 1) will be assigned. Diabetes, pneumonia and breast cancer topics will factor equally in the evaluation. Within each of those topics, individual indicators will factor equally. In the revised J7, each subtask will be considered separately and subtasks will not be combined or averaged.

Q905. Using BRFSS data for immunizations will not allow CMS to determine the improvement for the "participants".

A905. See #235 and #237. CMS is deleting the immunization component from the identified participants' improvement for evaluation.

Q906. Without a standard and valid method of assigning beneficiaries to physicians, the physician office measures become impossible to compute for the "participants". No such method currently exists or is proposed.

A906. See #237. CMS will develop a standard method.

Q907. This statement uses the term "identified participants". Is this referring to an 8% improvement in measures, CTWA or participants?

A907. We do not know to what statement this refers. As discussed in Attachment J-7, CMS expects the QIO to demonstrate at least 8% improvement in the statewide calculation and at least 8% improvement in the measures of the identified participants.

Q908. For the satisfaction surveys – how will the results of responses for hospitals/ physician offices and M+COs be combined?

A908. No, they will not be combined.

Q909. Are individual physicians/clinics allowed to focus on the clinical topics of their choice and priority, or are they (and, in turn, QIOs) measured on improvement in all three topics (diabetes, mammography, and immunization)?

A909. See Q235 and Q237. QIOs will be measured on improvement in the identified participant group in the areas of diabetes and cancer screening.

Q910. The SoW does not include any information about the relative weights assigned to the physician office quality indicators. When will this information become available?

A910. See Q904

Q911. Indicators for participating physicians (immunizations). How will CMS handle measurement of performance of the "participating" physicians for immunizations, or will these indicators only be measured (and evaluated) statewide?

A911. Statewide. See #235 and #237.

Q912. Statewide mammography rates for fee-for-service women. In the 6SOW these rates suffered from the problem that women who spend time in Medicare as Secondary Payor status were not excluded from the denominator. This may include a significant proportion of Medicare women age 52-69 and it falsely lowers coverage rates in ways that may vary between states and over time. This should be corrected in the SOW7 or an explanation given as to why it cannot be.

A912. Medicare as Secondary Payor status has not yet been determined to bias the rates. For Medicare beneficiaries with Medicare as Secondary Payor, private insurance would need to fully pay for the mammogram, and not submit a claim to Medicare. Of all mammography claims during a biennial period, fewer than ½ of 1% are for beneficiaries with unpaid claims.

Q913. How do you determine physicians who are responsible for the care of patients with breast cancer and immunizations?

A913. See #235 and #237.

Q914. Patients can self-refer or be referred by any physician that they see for these indicators. Does CMS have a process or know how to link patients to physicians with greater precision than that currently used by QIOs for each of the clinical topics to meet the 10% intensive improvement? s

A914. See #237. CMS will develop a standard method.

Q915. Statewide improvement – If HEDIS and BRFSS data are used for remeasurement, the data will come a full year before the end of the contract and again will not give the QIO much time to have an impact on the indicators.

A915. HEDIS data are reported annually and are available annualy on the public use file. We are currently working with CDC regarding the BRFSS data.

Q916. Are the improvement numbers for both statewide and intensified group intended to be the same at 8%?

A916. Yes. Within each of those topics, individual indicators will factor equally. In the revised J7, each subtask will be considered separately and subtasks will not be combined or averaged.

Q917. The evaluation process requires QIOs to target physicians identified as caring for 10% of the beneficiaries in the state. Does this mean physicians caring for 10% of the beneficiaries in the state for each of the clinical topics?

A917. See #235 and #237.

Q918. The CTWA for this task indicates a two step process will be used. Can CMS clarify how the weights for MCO membership will be included in this calculation?

A918. There is not a two step process, see answer to #904.

Q919. The question of bias in favor of states with smaller Medicare populations is raised when considering that CMS does not provide resources in proportion to state size yet expects the same degree of improvement regardless. Reconsideration is requested.

A919. The CMS plans under this contract to provide resources in proportion to number of providers in the state.

Q920. How will CMS obtain the list of physicians?

A920. From the QIOS, see response to Q. 237

Q921. Where will the data come from (UPIN problems with FI)?

A921. See #237.

Q922. With respect to the 10%, are there geographic/regional requirements?

A922. No.

Q923. May QIO target MSAs?

A923. See #237.

Q924. Improvement on the quality of care measures listed above for the identified participants. The target for the identified participant group is physicians identified as caring for 10% of the beneficiaries in the state. This task requires linking of the beneficiary population with physicians. How will patients be linked to physicians in fee for service settings?

A924. See #237.

Q925. As the percent cared for will fluctuate throughout the SoW, are there plans to adjust the participant group during the SoW?

A925. No. QIOs will submit a list of identified participants within 6 months of the contract effective date. CMS will not remove identified participants from the list except in the case of exceptional circumstances, as discussed in Attachment J-7.

Q926. CMS will need to supply the QIOs with Part B data throughout the SoW.

A926. CMS will contract with a QIOSC to provide Part B datasets throughout the SoW.

Q927. Task 1(d)(2) states that QIOs must work with that number of physicians who treat 10% of the beneficiaries. How are we to know who these doctors are?

A927. See #237.

Q928. Will we get a list from CMS with the names of each doctor and how many Medicare benes he filed a claim for in the previous year or something like that?

A928. See #237.

Q929. Lacking this, how are we to proceed? For example, our State has 730,000 beneficiaries so 10% is 73,000. One metropolitan area alone has nearly 3 million people and roughly 450,000 beneficiaries, way more than 10%. 73,000 is 16% of 450,000.

A929. See #237.

Q930. Can we take the total number of primary care docs (maybe + endocrinologists) in that metro area and identify 16% of them to work with?

A930. See #26.

Q931. This assumes that care of benes is equally divided among the PCPs. If we do not do it this way, how, in the absence of the list mentioned above, are we to identify who the doctors are that we must work with?

A931. See #237.

Q932. When will the weights for specific indicators in the formula for Topic Weighted Average be available?

A932. See #904.

Q1221. J-7, Task 1.d(2), page 10 – Practicing physicians tell us that they can't identify their fee-for-service patients because FFS patients are free to leave a practice without notifying anyone, to visit multiple care providers contemporaneously, and it isn't even certain that the physician will be notified when the patient expires. Are the QIOs free to work with participating providers to set their own definition of their patient population?

A1221. Yes, though CMS will determine, for purposes of contract evaluation, the method for linking individual beneficiaries to practices.

Attachment J-7 DRAFT General Evaluation Plan
Task 1e: Underserved and Rural Beneficiaries Quality Improvement

Q933. How will the "collaborator and /or provider survey" be handled if interventions have been directed at beneficiaries (i.e. no provider intervention)?

A933. If the interventions have been directed only at beneficiaries, then the beneficiaries will be surveyed.

Q934. For projects continued, will CMS apply the 6th evaluation criteria or the 7th?

A934. No, the evaluation criteria for the 6th SoW will not be used for the 7th SoW. The evaluation criteria for Task 1e in the 7th SoW can be found in the J-7 attachment.

Q942. I heard at the AHQA meeting that the QIO had to work with at least 10% of a selected rural or underserved population and that there must be at least a 7% disparity between the underserved and the served to work with a particular underserved group. The question is how do we select out the Hispanics, for example, from everyone else when doctors usually take all comers regardless of "served" status. Could we use county data perhaps?

A942. See #943.

Q943. Is there some other way of distinguishing between patients short of the imprecise method of going with all the docs who have a Hispanic name?

A943. While we would like to, we cannot answer questions about what you heard at the AHQA conference. Please search for your answer in the responses to questions directed at aspects of the RFP.

Attachment J-7 DRAFT General Evaluation Plan
Task 1f: Medicare+Choice Organizations Quality Improvement

Q935. How is expected improvement defined?

A935. See revised J-7.

Q936. Is the goal for the MCO an expected improvement number from CMS?

A936. There is not a specific/specified improvement number for M+COs, they need to show improvement.

Q937. The evaluation indicates under the weighting component that the QIO will have 75% of the evaluation based on the QAPI improvement of the M+CO. Why is the QIO being held responsible and evaluated on the success of the M+CO QAPI?

A937. The QIO performance is based on 50% not 75%. While it is true that the M+COs are under no obligation to collaborate with the QIO, this is also true for hospitals, physicians, nursing homes and HHAs. Also, the M+CO is not held to a numeric improvement rate in its QAPI, it is evaluated on showing an improvement.

Q938. How is CMS going to determine who the contact at the M+CO will be to survey for evaluative purposes?

A938. We are considering contacting the QIO to determine the M+CO contact. We will also contact the M+CO CEO as well as the Quality Director.

Q939. Will the evaluation exclude M+COs and their QAPI projects that do not request technical assistance from QIO?

A939. No.

Q940. CMS needs to specify the formula translating QAPI improvement results into a number or fraction that is used to modify/multiply the 75% weighting.

A940. The QIO performance is based on 50% not 75%. While it is true that the M+COs are under no obligation to collaborate with the QIO, this is also true for hospitals, physicians, nursing homes and HHAs. The M+CO is not held to a numeric improvement rate in its QAPI, it is evaluated on showing an improvement.

Q941. Which QAPI projects will be evaluated? Those that are scheduled for completion in 2003 and/or 2004, etc.?

A941. Yes, we will look at the QAPI projects for 2000 (Community Acquired Pneumonia) and for 2001 (Congestive Heart Failure). For the CHF project, we will review only the quality improvement project and not the activities related to CHF extra payment.

Q944. The majority of QIO performance for this sub-task (75%) is based upon the improvement achieved by Medicare + Choice organizations on their QAPI projects. QIO experience with M+C organizations during the 6th SoW has not been very encouraging, with most M+C health plans declining QIO offers of technical assistance. Although QIOs will approach M+C plans differently under the 7th SoW, the health plans are still under no obligation to collaborate with the QIO. M+C plan performance on QAPI projects may not improve in spite of the best efforts of the QIO. It does not seem appropriate to hold the QIO accountable for a performance measure over which it has no control.

A944. The QIO performance is based on 50% not 75%. While it is true that the M+COs are under no obligation to collaborate with the QIO, this is also true for hospitals, physicians, nursing homes and HHAs. Also, the M+CO is not held to a numeric improvement rate in its QAPI, it is evaluated on showing an improvement.

Q945. How will CMS identify M+CO beneficiaries, penetration rates and where will the abstracted data for these beneficiaries be obtained?

A945. There will not be abstracted data for these beneficiaries, the penetration rates will be obtained from the latest numbers reported to CMS by the M+COs. The HPMS, the Health Plan Management System, is housed on QualityNet and contains summary data for HEDIS. It will be determined, if in fact, patient-level HEDIS data is needed for the QIOs.

Q946. Will there be a separate sample of these beneficiaries or are they included in the random selection of 125 per quarter?

A946. For the M+CO rate, we will use HEDIS data as submitted.

Q947. How will CMS identify M+CO beneficiaries, penetration rates and where will the claims data for these beneficiaries be obtained?

A947. See #945.

Q948. How can QIOs be held responsible for QAPI improvement? The QIO can offer assistance to the M+CO; however, the M+CO is not required to respond to our offers.

A948. See #944.

Q949. The J-7 states that, for the inpatient provider evaluation, M+CO's will be included but in Section C.3.D.6.a: it states that "in almost all cases, any project authorized under this sub-task will not involve inpatient care." This specifically refers to QAPI project topics. Why then are M+CO's included on the inpatient provider satisfaction evaluation.

A949. This is incorrect and will be deleted.

Attachment J-7 DRAFT General Evaluation Plan
Task 2b: Transitioning to Hospital Generated Data

Q951. For a hospital to be "counted" as reporting performance data to the QIO, must the hospital be reporting on all quality indicators?

A951. It is felt that a hospital that is reporting on one indicator would choose to complete all indicators as a matter of efficient resource utilization. However, for our purposes, if a hospital is reporting on at least one indicator, it will be considered to be a reporting hospital.

Q952. If all indicators are not required, is there a minimum number which must be reported before the hospital can be said to be submitting performance data?

A952. See #951.

Q953. Is the Customer Satisfaction Survey related to the providers' use of CMS approved abstraction tools described for this sub-task a different survey than the one described for sub-task 1-c?

A953. The details of the survey plans and designs are not yet final. The CMS team developing the surveys is certainly aware of the need to differentiate between satisfaction with the tools, the QIOs' support for the providers' use of the tools, and the QIOs' other activities to support QI.

Q954. Will these surveys be combined into a single survey instrument?

A954. See question 953.

Q955. Please provide more details concerning the expectation of this task.

A955. This is all we have at this time.

Q956. How will CMS determine if the QIO has performed all expected data validations?

A956. We will include a record of each validation effort in the hospital survey.

Q957. Bullet 1 – What is meant by "reporting hospitals"?

A957. A hospital abstracting it's own quality indicator data.

Q958. Bullet 2 – Is the decrease referred to in this bullet referring to "relative" or "actual" decrease in hospital reporting?

A958. We intend to measure a relative decrease.

Q959. Bullet 4 – Where can the QIOs find additional information on the timeframe that will be "prescribed"?

A959. The RFP clearly states that validation are to be done twice a year in uncertified hospitals and once a year in certified hosptials.

Q960. The J-7 does not refer to how QIOs might document their inability to attain 50% of hospitals collecting their own data. Should this be included in the RFP?

A960. 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.

Q961. What is the operational definition of "hospitals not reporting abstracted data to the QIO"?

A961. We do not understand the question.

Q962. Is a hospital counted as reporting abstracted data to the QIO if it reports any abstracted data?

A962. It is felt that a hospital that is reporting on one indicator would choose to complete all indicators as a matter of efficient resource utilization. However, for our purposes, if a hospital is reporting on at least one indicator, it will be considered to be a reporting hospital.

Q963. Does the reporting need to achieve minimal parameters of scope of periodicity to qualify?

A963. See #962.

Q964. Is the 80 percent or more completeness number defined as having all fields completed or does this have something to do with the validity of the data?

A964. All fields completed.

Q965. If validity is considered, is this from individual records or the overall validity identified by comparing their tool with the CMS definitions and specifications?

A965. The outcomes of individual records abstracted by both systems must agree.

Q966. (second bullet) How is the original number of hospitals reporting to the QIO determined – TQIP, QIO reported or other methodology?

A966. Hospitals will be surveyed by the QIOs at the beginning of the contract. The number of hospitals reporting abstracted data will be measured via QualityNet exchange.

Q967. It is stated that "CMS expects a 50 percent or more decrease in the percentage of hospitals not reporting abstracted data to the QIO by the end of the 28th month of the contract." This is an unrealistic expectation for states with a large percentage of small, rural hospitals that are not JCAHO-accredited. We recommend limiting the hospitals eligible for this task to those that are accredited by JCAHO.

A967. This is a statement.

Q968. Would it be better for the target for hospital abstracted data to be based on the % of hospitals (the current criteria) or the % of claims the hospitals generate?

A968. The hospital is the focus of this activity, therefore it must be the percent of hospitals

Q969. CMS needs to define "completeness" in the phrase completeness of the assessment survey information.

A969. We believe we have, 80 pecent of items completed on all surveys.

Attachment J-7, Task 2b,Transitioning to Hospital Data.

Q970. What is the source of the information that CMS will use to measure the proportion of hospitals that have implemented a data abstraction system?

A970. Hospitals will be surveyed by the QIOs at the beginning of the contract. The number of hospitals reporting abstracted data will be measured via QualityNet exchange.

Attachment J-7, Task 2b, Transitioning to Hospital Data

Q971. How will each of the four (4) components listed be weighted?

A971. If you are referring to items i throught iv under Task Description for Task 2b, we anticipate that each element of the task will be weighted equally.

Task 2c: Other Mandated Communications Activities

Q972. The term "success" is subjective. Would CMS further define the term?

A972. The evaluation criteria for this item should determined in collaboration with the Project Officer.

Q973. The attachment states that the "task will be assessed by the Project Officer." Will there be uniform criteria to avoid variation and subjectivity?

A973. There is no plan for this at this time. See #972.

Q974. Will QIOs be provided the criteria at the outset of the contract?

A974. See #973.

Q975. What are the objective criteria for success for each of the activities (i.e., "use" of a Consumer Advisory Council, "broadening" consumer board representation, "implementation" of outreach plan)?

A975. See #972.

Attachment J-7 DRAFT General Evaluation Plan
Task 3a: Beneficiary Complaint Response Program

Q976. CMS expects that 80% of respondents to the satisfaction survey related to the beneficiary complaint process will report they were mostly or completely satisfied with the QIO review process. We think it is unlikely that the beneficiaries will make a distinction between the review process and the review outcome - giving the QIO low ratings if the review did not produce the result they expected. We also have concerns that the limits on disclosure which QIOs must face will result in unsatisfied beneficiaries who do not understand why the QIO can not be more comprehensive in discussing the complaint investigation. This beneficiary perspective could also lead to low satisfaction scores for the QIO, based not on QIO performance but rather on the requirements of the law. We suggest beneficiary feedback about the complaint process be used to improve the process by both CMS and the QIO, but not be used to evaluate QIO performance.

A976. A response to this is not likely to be helpful in preparing contract proposals, however CMS has no desire to hoard information: We believe that beneficiaries will be able to distinguish between the review process and the review activity with effective beneficiary educational outreach efforts. The QIO needs to educate the beneficiary population at large on the review process and expectations. By doing so, At the time of a beneficiary complaint, it would facilitate the case manager's responsibility in explaining and discussing the process and expectations to the individual beneficiary. Additionally, the information collected from the beneficiary satisfaction evaluation will identify the part(s) of the process that the beneficiary is satisfied or dissatisfied with.

Q977. Bullet 4 – How does CMS plan to complete the IRR given that QIOs have the option to use different review criteria?

A977. Under Task 3a, the IRR refers to the intra-QIO inter-rater reliability activities. This activity uses the QIO's own process and criteria.

Q978. Proportion of complaint reviews for which quality improvement activities have been recommended to providers/practitioners. Should this be the percentage of cases with quality issues rather than those with a complaint? Not all complaints result in quality issues being identified.

A978. This will be the percentage of cases with confirmed quality issues.

Q979. What is the rationale for setting an 80% threshold? CMS expects that 80% of respondents to the satisfaction survey related to the beneficiary complaint process will report they were mostly or completely satisfied with the QIO review process. We think it is unlikely that beneficiaries will make a distinction between the review process and the review outcome - giving the QIO low ratings if the review did not produce the result they expected. We also have concerns that the limits on disclosure faced by QIOs will result in unsatisfied beneficiaries who do not understand why the QIO cannot be more comprehensive in discussing the complaint investigation. This beneficiary perspective could also lead to low satisfaction scores for the QIO, not because of QIO performance, but rather due to limitations in the law. We suggest beneficiary feedback about the complaint process be used to improve the process by both CMS and the QIO, but not be used to evaluate QIO performance. If CMS does not delete the 80% evaluation criteria, then a minimal response rate should be defined in order for the survey data to be valid.

A979. This purpose of this activity is to solicit input about satisfaction with the review process and not with the outcome of the review. See response to Q. 976.

Q980. The evaluation criteria "Proportion of complaint reviews for which quality improvement activities have been recommended to providers/practitioners" is too general. What proportion is expected?

A980. See responses to Q. 978, Q. 514, and Q. 516.

Q981. Also, please define quality improvement activities.

A981. See response to Q. 978.

Q982. Does this mean proportion of complaint reviews in which a quality improvement plan is requested from providers/practitioners?

A982. See A978.

Q983. Will CMS define the methodology to be utilized to ensure reviewer reliability within and between QIOs?

A983. The scope of this activity for Task 3a is for “within reliability.” CMS will provide the intra-QIO inter-rater reliability methodology through the Task 3 QIOSC.

Q984. In regards to timeliness of completed reviews, how will timeliness of reviews be measured?

A984. It will be measured against the established review time frames and the individual QIO’s actual completion timeframes. Generally, this measure will apply to the overall timing of review of cases completed. Where discrepancy are noted, most likely, the individual timeframes would need to be examined (including justifications and documentation).

Q985. Does "at least 80% of the time" apply to the overall timing of review or individual timeframes for each step of the beneficiary complaint review process?

A985. See response to Q. 979.

Task 3a Beneficiary Complaint Response Program

Q986. QIO success on this task will be assessed by the proportion of complaint reviews for which quality improvement activities have been recommended to providers/practitioners. If a state has a low number of beneficiary complaints or they are all from different providers it would be difficult to establish a pattern of poor quality of care.
Does this imply that quality improvement will have to be undertaken for single isolated errors? Please expand on the intent of this.

A986. The QIO must implement improvement plans based on individual cases. The purpose of this activity is to resolve a situation before it becomes a pattern (or a more severe concern). If a pattern is detected, the QIO should establish an improvement plan.

Task 3b: Hospital Payment Monitoring Review Program

Q987. Is CMS considering stratifying the sample for the surveillance records? Under the current methodology, the case mix makes it difficult to determine true improvement.

A987. 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.

Q988. 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?

A988. The QIO will be compared to itself.

Q989. The second possible method of evaluating the QIO involves "improving provider performance in relation to any and all projects… "There is no explanation of how the QIO will be measured if the QIO is working on multiple projects.

A989. This is a statement.

Q990. When will the QIO receive their baseline error rate from CMS?

A990. This is yet to be determined. It is expected to be early in the 7th SOW.

Q991. What are the discharge dates for the remeasurement?

A991. This will vary by round.

Q992. The QIO will be successful if it makes "substantial" and "effective" effort and makes "acceptable" progress. How will "substantial" and "acceptable" be measured?

A992. The definition of these terms will depend upon the projects. We intend to develop acceptable measures up front for each project.

Q993. Bullets 2 and 3 – How do will CMS or the QIO choose between the two criteria outlined?

A993. The requirement is to pass either of the criteria (i.e. one of the two). It is not necessary to choose between them.

Q994. Will CMS apply both criteria and determine success or are the criteria pre-determined?

A994. CMS will apply both criteria.

Q995. The J-7 evaluation of the PEPP section refers to a baseline payment error rate no greater than 1.5 standard deviations above the baseline payment error rate. What baseline rate is referred to here, the state? the national?

A995. The QIO will be compared to itself.

Q996. First bullet – "The QIO must complete the expected reviews……." What are the expectations for these requirements?

A996. We do not understand this question.

Q997. Please clarify what will constitute the CMS baseline rate for the 7th SOW.

A997. The baseline error rate will be established by the most recent available 12 month period from the 6th SOW surveillance data.

Q998. The QIOs will be judged successful if the follow-up payment error sample is no greater than 1.5 standard deviations above the baseline payment error rate. What is the timeframe for the baseline measurement rate for the SOW7?

A998. 12 months. They will vary by round.

Q999. The baseline and surveillance sample per state was inadequate for larger QIOs. Is CMS considering revisions to the sampling methodology to include a sample based on the number of state discharges?

A999. Sample sizes have been calculated to ensure adequate statistical precision at the state level. This is a matter of the size of the sample and not the universe from which the sample is drawn. There are no plans to change this approach.

Q1000. Will CMS allow adequate time to determine the effectiveness of hospital/QIO interventions? In the 6SOW, QIOs were evaluated on timeframes that gave minimal time for the QIO projects to demonstrate results. It takes hospitals time to put new systems in place and to educate hospital staff/physicians.

A1000. Yes, to the extent possible under a three-year contract.

Q1001. The number of projects individual QIOs will be involved with either as directed by CMS or QIO initiated with CMS approval will vary. Therefore, some QIOs may have multiple projects versus other QIOs may have no or few projects. The evaluation criteria that the QIO must make acceptable progress in improving provider performance in relation to any and all projects approved or directed by CMS may not be realistic for a QIO with multiple projects. Will

consideration be given to workload of the QIO and barriers the QIO may encounter for a specific project?

A1001. If necessary, QIOs will have the opportunity to present information of this nature.

Q1002. How can rates be improved it a QIO *does not* pursue a project(s)?

A1002. Appropriate, well-designed projects are likely to be approved. If a QIO does not received approval for any submitted projects, this will be considered in the evaluation.

Attachment J-7, Task 3b, Hospital Payment Monitoring Review Program.

Q1003. Can CMS provide an example of how the standard deviation will be derived?

A1003. See Cochran, "Sampling Techniques", 1977, p. 23, for the formula and additional information.

Q1004. Criterion two reads: "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 payment error rate." Is the ABSOLUTE PAYMENT ERROR RATE defined as the monetary value of all errors (over and underpayments)? (Attachment J-7, second to last page, criterion two)

A1004. No, the absolute payment error rate for a state is the sum of the dollar amount of the overpayments and the dollar amount of the underpayments divided by the dollar amount of the total reimbursement for that state.

Q1005.For round one QIOs, what is the payment error baseline period?

A1005. The baseline error rate will be established by the most recent available 12 month period from the 6th SOW surveillance data.

Q1006. When will a round one QIO receive the baseline payment error rate?

A1006.This is yet to be determined. It is expected to be early in the 7th SOW.

Q1007. How often will the performance of round one QIOs be evaluated by a follow up payment error rate?

A1007. Evaluation occurs at the end of the contract period.

Q1008. Task 3b – Hospital payment monitoring Review Plans states "the QIO must be successful in relation to one of the two following criteria:" Please explain how CMS will decide which of the two criteria will be used for evaluation.

A1008. The requirement is to pass either of the criteria (i.e. one of the two). It is not necessary to choose between them.

Task 3c: Other Beneficiary Protection Activities

Q1009. CMS expects reviews to be completed within timeframes at least 80% of the time for all other mandatory reviews. Clarification is needed regarding the statement "applies to total reviews and reviews done at any one time."

A1009. This is not a question, QIOs do not need answer to prepare contract proposals.

Q1010. Please define "reviews done at any one time."

A1010. This is not a question, QIOs do not need answer to prepare contract proposals.

Q1011. Is the 80% timing of review applicable by review type or overall for all mandatory reviews?

A1011. QIOs do not need answer to prepare contract proposals.

Q1012. QIOs may not be able to meet the 80% timing of review requirement for large review selections as a result of a CMS/OIG referral. Will consideration be given for unexpected fluctuations in review selections?

A1012. Normal standards of fairness in Federal contracting will apply.

Q1013. Will CMS define the methodology to be utilized to ensure reviewer reliability within and between QIOs?

A1013. Yes, but QIOs do not need to have it in order to prepare contract proposals.

J-11 SDPS Core Reporting Requirements

Section J-11

Q1014. What is the J-XX Sub-task Strategy Matrix?

A1014. This document is now included as part of J-12.

Q1015. Is this the required formatting template for submission of non-competitive written technical proposals?

A1015. Yes, the “J-XX Sub-task Strategy Matrix” is the required template for submission of the written technical proposals and is now contained in J-12.

J-12 Business Propsal Instructions and Forms and Technical Proposal Template

Q13. Which applies is critical for budgeting purposes and for overall contract compliance. (Ref. 52.215-8 Order of Precedence stipulates RFP over attachments). QIOs request QIOs request clarification.

A13. The Business Proposal Instructions do not provide a ceiling, but are meant to provide guidance to the QIOs on the affordability of their budget proposals.

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 contrct execution.

A14. The Clearance process for PRO Manual approval/distrbution is significantly protracted. Providing draft manual sections within the RFP allows CMS requirements to be communicated in real time.

This work statement is primarily of the performance type, which means relatively few activities are contingent upon obtaining Project Officer approval. This sentence states that, regardless of whether or not a **project** has been approved by a Project Officer, the information collection activity requires a separate aproval.

Q1016. If the QIO has a DCAA approved provisional rate for leave, can this rate be used?

A1016. See the Q&As pertinent to contract clauses pertaining to contract administration, invoicing, etc.

Personnel Loading Chart

Q1017. Should staff who have no direct labor hours (100% indirect staff) be reported on the Personnel Loading Chart?

A1017. Yes.

FTEs and Salaries

Q1018. One of the justifications provided for the reduced fee is the removal of compensation ceilings. However, the *Business Proposal Format for QIOs*, Forms and Instructions at Page Four requires explanations for salary increases greater than 5 percent to an individual's current salary and justify the salary proposed for all new employees. Further, QIOs shall

also explain organizational salary increases greater than 3 percent per year. How can you reconcile these two?

A1018. The Business Proposal Instructions do not provide a ceiling, but are meant to provide guidance to the QIOs on the affordability of their budget proposals.

Recommendation: We recommend removal of above mentioned requirements in the Forms and Instructions Attachment to the RFP. FAR requirements per reasonableness (31.201-3) ADEQUATELY cover this subject matter.

Q1019. This section spells out two specific possible limitations on salaries: 1) annual salary increases over 5% for an individual employee or any new hire, 2) annual salary increases of greater than 3% for an overall organization. Increases greater than these must be justified. This means that awarding both a merit increase and a COLA would almost always total an amount that has to be justified.

A1019.Not necessarily, inflation (COLA) is running at historical lows.

Recommendation: If CMS is removing the compensation ceilings, these two requirements cannot coexist. The percentages should be stricken from the proposal and CMS should rely on QIO justifications. CMS should also provide guidance to the QIOs as to what kind of data is considered "persuasive" in their justifications.

Comment: Individual QIOs should decide on the type of justification required to support increases.

Q1020. Section J-12. Page 9. IV. B. CMS Form 719 BP.- Quality Improvement Organization 7th SOW Business Proposal – "TOTAL COSTS" line. – **Cells in Column B through Column AG, Row 35 are formulas not data fields. Should the cells be shaded?**

A1020. It is true that the cells in Colume B through Colume AG, Row 35 are formula driven (not data input fields) and therefore should be shaded.

Q1021. Section J-12. Page 9. IV. B. CMS Form 719 BP.- Quality Improvement Organization 7th SOW Business Proposal – "TOTAL COSTS" column. – **Cells in Column AG, Rows 11 – 38 are formulas not data fields. Should the cells be shaded?**

A1021. Most of these cells are already shaded and it is true that all of them should be because they are formula driven.

Q1022. Section J-12. Page 17. IV. D. CMS Form 721 BP.- Indirect and Other Direct Cost- Column 8. Line a. & b. – **Cells in Column 8, Line a. & b. are formulas not data fields. Should the cells be shaded?**

A1022. Correct these cells should be shaded as they are not data input fields.

Q1023. Section J-12. Page 21. IV. E. CMS Form SUM – Staffing Proposal Summary. Column 1-7. Row 13 – **The formula in Columns 1 – 7, Row 13 includes a divisor of 4 to calculate a check sum average that should tie to row 10. However, the value in row 10 is the weighted average carried forward from the QIO staffing page, column 5, Grand Total Row. Out test of the forms indicates that the two amounts do not tie because one figure represents a weighted average and the other is a simple average of the weighted averages. This observation applies to Columns 1 thru 7, Row 13.**

A1023. The QIOs should ignore the totals in Row 13.

Q1024**.** Section J-12. Page 34. IV. G. CMS Form SC 1 – Subcontracts Proposal – Physician Reviewers. Column 54. – **Should cell C:89 be an data input field (not gray) instead of formula?**

A1024. Correct, cell C:89 should be a data input field and should not be shaded and should not have the formulae that is in it.

Q1025. Section J-12. Page 34. IV. G. CMS Form SC 1 – Subcontracts Proposal – Physician Reviewers. Column 55. – **Should cell D:89 include a formula multiplying Column 53 X Column 54?**

A1025. Cell D:89 should have the formulae B89*C89.

Q1026. Section J-12. Page 37. IV. H. CMS Form SC 2 – Subcontracts Proposal – Other – Column 10 Subtotal – Other Subcontractors – **Cell K:32 is blank. Is formula omitted?**

A1026. Cell K:32 should have the formulae =SUM(K21:K31).

Q1027. Section J-12. Page 37. IV. H. CMS Form SC 2 – Subcontracts Proposal – Other – Column 12 Subtotal – Other Subcontractors – **Cell M:32 is blank. Is formula omitted?**

A1027. Cell M:32 should have the following formula: **=SUM(M21:M31)**

J-16 SDPS Site Plan and Inventory

Security

Q1028. If the present site does not agree with the specifications stated, will CMS fund site alterations – such as fire rated walls, ceiling and doors?

A1028. QIOs shall include all costs for necessary site alterations in the business proposal.

SDPS Training Requirements.

Q1029. Will CMS fund all training listed?

A1029. No. SDPS training was provided when SDPS was implemented. It is each QIO's responsibility to hire and maintain qualified/trained staff. If a QIO chooses to hire someone without the requisite skills, it is the QIO's, not the Government's, obligation to provide the training.

Q1030. Will CMS fund training on COTS products required by SDPS?

A1030. No. See #1029