Questions about the 3rd Round QIO Request for Proposal

General Questions

1. Which version of "Solicitation 01" posted on the website on September 6, 2002 is correct? The first zip file contains four (4) files that are not included in the second zip file. **All necessary files for submitting a proposal will be provided through this amendment.**

2. The electronic release contains several different files, 3 of which we have identified as previously submitted 7th Scope RFP question sets and appropriate CMS answers. Please verify that these sets of questions comprise the total Q&A's that CMS feels are relevant to potential offerors. If the 3 files are not the inclusive questions and answers, request we furnished updated electronic copies or additional Q&As as soon as possible.

   For example, the set marked "Questions and Answers RFP No. CMS-02-001/ELH" begins with a question concerning Standard Form 33 and contains 5 pages of Q&A's for General Questions and Section B of the RFP. We have a copy of an earlier version of Q&A's which contains 20 pages and also includes Q&As for Sections G, H, K, L, and M. Should we consider the 20 page set to be directive in nature or can CMS provide further clarification? All questions and answers from Group I and Group II and Group III solicitations will be provided with this amendment.

3. Documents marked "DOCN.doc" and DOCO.doc" are the same, J4 Attachments list and draft PRO manual. Is this correct? Are we missing another RFP document that may have been intended in place of the duplicate? All correct versions of necessary attachments will be provided with this amendment.

4. The same is true for "DOCr.doc and DOCs.doc" concerning electronic funds transfer. Please clarify. See answer to number 3 above.

5. There remain several inconsistencies between this RFP and the answers provided by CMS for Round 1 & 2 QIOs. For example, the page limitation for Tabs 1 and 2 for Round 1 QIOs was increased to 44 pages, but this RFP still states the 40-page limitation. Which is correct? For all such cases of inconsistency, should precedence be given to this RFP or the previously issued Q&As? The page limitation for preparation of a proposal in response to this solicitation shall be as noted in the amended section L, attached.

6. Has a decision been made as to the role of the QIO in quality improvement initiatives for nursing homes in their state that are part of a national chain?

A. No.

7. What period will comprehend the remeasurement for the statewide improvement in Nursing Homes, SNF in the case of Puerto Rico

A. A work group is currently developing the specifications for this. Remeasurement will need to be completed before the 28th month of the contract.

C.3.D.1., page 22

8. Given the contract effective date of February 1, 2003, how will the due dates of December 15, 2002 and February 3, 2003 for reporting the selected NH measures and identified participant NHs, respectively, be modified to accommodate 3rd Round QIOs?

A. The dates of December 15, 2002, and February 3, 2003, are the same for all QIOs regardless of round. For Task 1.A., all QIOs are on the same schedule.

9. Will the 6th Scope remeasurement be used as the baseline for the 7th Scope?

A. Yes, whenever appropriate.

10. Will the 6th Scope remeasurement of mammography screening be used as the baseline for the 7th Scope?

A. YES

11. Will the 6th Scope remeasurement of Diabetes indicators be used as the baseline for the 7th Scope?

A. Yes

12. If a hospital does not want to use the CART tool for abstraction and uses the paper version of the tool, Will the QIO has to enter that information in the CART system or will the hospital submit the form to the CDAC?

A. It is our intention at this time, that the QIO will do the data entry from the paper form.

13. Will the CDAC do the data entry for the hospitals that use the paper version of the abstraction tool?

A. No.

14. Task 2b. Transitioning to hospital-generated data
C.3.E.2.b.(i). The RFP states that the QIO will do an assessment of hospitals' (and hospital contracted third party vendors') readiness to collect and disseminate quality of care measures. The assessment will include a CMS provided list of information to be collected about the hospitals' capacity to report. Will the results of this assessment be used to determine the baseline for the QIO's requirement, under Attachment J-7, for a 50% decrease in the rate of not reporting by the 28-month evaluation? If not, what method will be used to determine the baseline?

    A. No, the survey will not be used for that purpose. We will determine the number of reporting hospitals by the data submitted to the clinical warehouse.

15. J-11 table under Task 1 – deliverables, item 1
Are project plans required for all Task 1 subtasks 1a-f? It appears that 1a, 1b, and 1e are required based on the delivery requirements of J-11. Are plans required for tasks 1c, 1d, and 1f? Also, the SEFF modification dated August 21, 2002 only requires entry of a project plan for task 1e

    A. At this time, Tasks 1b and 1e require "Project Plans". (Task 1a requires a plan to partner with stakeholders.) The SEFF modification dealt with **only** the deliverables due within 90 days of effective date pending PARTner release. CMS is reviewing its requirements and due dates and may make changes as it moves forward.

16. Is it required to submit a project template and a recruitment plan for task 1f if there is no Medicare + Choice plan within the state at the start of the contract?

    A. No, however if a M+C plan is contracted in the State after the beginning of the contract, a recruitment plan should be completed within the first year of the MCO contract.

17. Is it necessary to submit an Attachment J-12 template for Task 2a as part of the technical proposal? There is a statement on J-12 template format table that a template is not required. Similarly, is there a requirement for submission of Task 2a costs given the J-12 (page 10, paragraph 11) given the statement that the QIO should not enter any costs unless directed. Has such a directive been given?

A. Technical and Business Proposals for Task 2a are required for **competitive procurements only**. Therefore, **for competitive procurements only,** the J-12 template for Task 2a is required.

Please propose cost and technical proposal for work to be performed beginning February 1, 2003 (See Section F).

18. The answer to question 68 of the Questions and Answers for Round 2 QIOs states that "(CMS) no longer anticipate(s) QIOs being involved in data validation efforts for 2b. This will become a CDAC function." Has this determination been made and the QIOs will not be responsible for the abstraction related to validation?

A. This is correct, the CDACs will abstract the charts to validate hospital submitted data. The QIOs will be responsible for monitoring each hospital's validation status.

19. Section C.3.D.2.b (page 24) – Previous versions of the 7th SOW have specified a minimum number of Home Health Agencies to be included in focused quality improvement projects (i.e. – 30% of all HHAs in the state). This language is not included in the RFP issued for Group III QIOs. Has CMS eliminated the requirement for collaboration with individual HHAs in focused QI projects?

A. The old version read "~~The target participation rate is at least 30% of the HHAs in the state~~". It has been removed from the new 7th SoW version. The new version C.3.D.2b(v) contains the phrase "offer education and training to all HHAs in the state on HH OQBI…" to inform QIOs that the ultimate goal under Task 1.b. is the participation of all HHAs in the state. The revised language contained in the J-7 provides additional clarification regarding HHA participation as it applies to the evaluation of QIOs under Task 1.b. Essentially, in order to achieve the basic requirement of the Task 1.b. evaluation, QIOs should seek to continuously recruit all HHAs in the State.

C.3.D.2.b (vii) - Home Health Quality Improvement (Page 25)

20. The specific agencies constituting the participating group may change throughout the contract cycleHowever, only those agencies listed as identified participants within 6 months of the contract effective date will be considered for evaluation purposes.

Does CMS expect the QIO to continue recruiting participants beyond the first 6 months?

A. Yes. Please disregard the "6 months" language. It should have been removed from the SoW. Recruitment should continue throughout the 7th SoW.

21. If so, would the participants recruited after the first 6 month be counted toward the 30% statistically significant improvement required in the evaluation?

A. Yes, as long as sufficient time since recruitment (specifications currently being developed) has passed to detect improvement on selected measures (per the OBQI report).

C.3.D.4.b (ii) - Task 1d Physician Office Quality Improvement (Page 28) and Attachment J-7 - Evaluation Plan (Page 14)

22. Will immunizations only be evaluated at a statewide level

A. Yes

23. Section C.3.D.4.b (page 28) – The text of the RFP indicates that QIOs must work with 5% of the primary care physicians in the state. However, the target number of physicians and the methodology used to calculate the target number specified in the RFP attachments describes a 10% target. Which is correct?

A. 5 Percent is correct. The Statement of Work will be amended. The August 20, 2002 version of J-7 also reflects 5 percent.

24. Section C.3.D.5.b (page 29) – The RFP issued to Group I QIOs included a "Task 1e Spreadsheet – Disparities Project Recommendations" as an Attachment. This document specified whether the QIO was to continue it's underserved population project from the 6th SOW or to propose a new disparities project for the 7th SOW. This spreadsheet was not included in the RFP for Group III QIOs. Has CMS made a decision about the status of the 6th SOW underserved population projects for each of the Group III QIOs? If so, could this information be provided

A. QIO should contact their Project Officer concerning their Task 1e projects selections.

C.3.D.5., page 29

25. What was the 6th SoW disparities project topic/focus for Nebraska? Is the current disparities project to be continued from the 6th SoW or is a new disparities project to be initiated in the state of Nebraska?

A. The records at Central Office indicate that Nebraska did diabetes in African Americans. The competitive awardee QIO should contact their Project Officer regarding their Task 1e project selection.

C.3.E.2.b (iii) - Transitioning to Hospital-Generated Data (Page 34)

26. In the set of questions related to Cycle 2 which begins with "General Questions, General Questions on the Contract (Questions or questions that are about overall concerns and not related to a specific component of the RFP.)," the answer to question 68 states, "We no longer anticipate QIOs being involved in data validation efforts for 2b. This will become a CDAC function."

    The 3rd round RFP states "The QIO shall determine the accuracy of the reported hospital quality of care measures by reabstracting a sample of Medicare cases known to have been abstracted and submitted by the hospitals in their State." Please clarify.

    A. This is correct, the CDACs will abstract the charts to validate hospital submitted data. The QIOs will be responsible for monitoring each hospital's validation status.

27. Statement of Work paragraph C.3.D.2.b identifies "participant." Are only those home health agencies that submit a "plan of action" as defined by the HHA QIOSC considered participants? Is there a definition of "participant?"

    A. Yes. Participants are HHAs who have agreed to actively participate in the OBQI system and accept the assistance offered by the QIOs.

28. C.2.E.1 (page 32): Promoting the Use of Performance Data: The RFP indicates that initial implementation of this activity will be carried out through a 6SOW contract modification. Please clarify how CMS will determine funding and identify responsibilities for Task 2a of the contract in the case of a acceptable competitive bid where the 7 SOW contract is awarded to a different contractor than the 6 SOW contract holder.

    A. This issue is still being discussed within CMS. An official response will be disseminated as soon as a decision is reached on how to handle situations like this.

C.3.E.2.b.(iii), pages 34-35

29. This section of the RFP indicates the tasks associated with data validation are the responsibility of the QIO. The General Questions, Answer 68,

however, indicate that CMS no longer anticipates the QIOs being involved in data validation efforts for 2b, as this will become a CDAC function. Which is correct?

A. The QIOs will still be involved in the data validation efforts. The CDACs will abstract charts for data validation, but the QIOs will be responsible for monitoring the validation status of the hospitals.

30. C.2.E.3.ii.: Helpline: In the event of a QIO with a multistate contract, can helpline calls from State A be processed by staff located in State B (the corporate office of the multi-state contractor)?

A. The QIO does not need to change the way that it processes helpline calls as a result of CMS channeling calls through 1-800-MEDICARE. So long as the QIO provides to CMS (when requested) information on the phone number where 1-800-MEDICARE CSRs should transfer the calls (which may be the same number for two or three states), there should not be any problems.

C.3.E.3.b.(ii), page 37

31. What is the average number of beneficiary and provider calls to the help line in a 12-month period for the state of Nebraska based on 6th SoW volumes?

A. For the 12 month period from September 24, 2001 thru September 24, 2002, the total number of calls was 661 or 12.7 per week.

32. C.2.F.2.: Beneficiary complaints: In the event of a QIO with a multistate contract, can beneficiary complaints from State A be processed by staff located in State B (the corporate office of the multi-state contractor)?

A. Cases should be processed in the state of origin.

33. C.2.F.2.a. The QIO is to review all written quality of care complaints from Medicare beneficiaries or their designated representative. What is the number of written complaints received by the Nebraska QIO for a recent 12-month period?

A. The numbers available were based on the first 18months. The total number of beneficiary complaint reviews for the first 18 months of the sixth SoW were as follows:

Nebraska: 18
Texas: 64

C.3.F.2.a., page 38

34. What is the average number of complaints received in a 12-month period for the state of Nebraska based on 6th SoW volumes?

A. The total number of beneficiary complaint reviews for the first 18 months of the sixth SoW were as follows:

Nebraska: 18
Texas: 64

35. C.2.F.2.c. Can the number of HINN/NODMAR reviews completed by the Nebraska QIO for a recent 12-month period by provider? What is the anticipated number of EMTALA reviews and "All Other Case Review Activities"?

A. We cannot provide number of reviews by provider. For the competitive contracts, the total number of reviews for 12 month period during the 6th round contract for specific categories of review were as follows:

Nebraska:
HINNS: 10
NODMARS: 1
EMTALA: 5

Texas:
HINNS: 66
NODMARS: 1
EMTALA: 7

C.3.F.2.c., pages 39-41

36. What is the average number of HINN/NODMAR reviews and EMTALA reviews for “All Other Case Review Activities” completed in a 12-month period for the state of Nebraska based on 6th SoW volumes?

A. We cannot, at this time, provide an average over the entire sixth contract cycle. For the competitive contracts, the total number of reviews for one 12 month period during the sixth scope for specific categories of review were as follows:

Nebraska:

HINNS: 10
NODMARS: 1
EMTALA: 5

Texas:
HINNS: 66
NODMARS: 1
EMTALA: 7

37. C.2.F.3.b.: HPMP: In the event of a QIO with a multistate contract, can cases referred by the CDAC concerning State A be processed by staff located in State B (the corporate office of the multi-state contractor)? Will the CDAC send records directly to staff at the corporate office?

A. The case should be processed in the state of origin.

38. Attachment J-7 Task 1b: Home Health Quality Improvement
There is a requirement for significant improvement in a targeted outcome. Please define "significant improvement" in this context. The OBQI reports identify several potential levels of improvement. These include 0.05 below average, 0.10 below average, within range and 0.10 above average. Is movement from 0.05 below to 0.10 below average considered a "significant improvement"? Similarly, an improvement from 0.10 above to 0.05 above is improvement, but can it be considered significant?

A. "Significant improvement" is defined in the OBQI report. In previous Q & As we (CMS) expressed our intention to use the 0.10 level.

39. Section J-7: Task 1d: At the September 2002 Quality Net Conference, Kathy Winchester announced that 7 SOW evaluation for influenza and pneumococcal (PPV) immunization rates may be based on a data from a source other than the periodic BRFSS (or a BRFSS-like) survey. Please clarify the method/database used for PPV and influenza immunization evaluation as well as the baseline and remeasurement timeframe

A. We are developing those specifications and are now planning to use the Consumer Assessment of Health Plans Survey (CAHPS), under which a Round 3 QIO's remeasurement would be based on the 2003-4 flu season. The J-7 attachment has been modified appropriately.

40. J-12, pg 2 METHOD OF SUBMISSION: The Excel spreadsheet file titled BP7SOW was not included in the Solicitation posting of September 6, 2002. Will this file be available in a later posting?

A. Yes

41. Reference: J-12 Sub-Task Strategy Matrix (Example) and Section L.9. A, page 118 General Guidelines

"The template should not exceed 4 pages per subtask. (Times New Roman 12 pt)" The example provided does not comply with the overall guidance in L.9. A. for one inch margins. When the one-inch margins and 12-point font are applied, the 4 page limitation will become an issue. Request the guidance be amended to read Times New Roman 10 pt and that the one inch margin requirement be applied to the subtask matrices.

A. The L.9.A formatting requirements do not apply to the J-12 Matrix.

42. L.7.A.1. - We currently have a QIO contract, but not for the state for which we are submitting a proposal. Do we need to provide this information?

A. No.

L.9.B., page 116-117

43. This section instructs that Tab 1g should include Task 2(a); however, the instructions for the written narrative indicate that Tasks 2a and 4 should be excluded. Which is correct?

A. 2A should be proposed for a 9 month period effective the date of award (2/1) and nothing should be proposed for Task 4 unless the QIO has been given written authority to carry over a 6th round special study into the 7th round.

44. Reference: L.9.B, Page 118 - 40 page limitations are listed for both Tab 1 and Tab 2. In the first round, it is our understanding that 11 sub tasks were responded to and the page limitation for both tabs was 44. In the third round, we are responding to 12 sub tasks. Given the historical precedence of 4 maximum pages per sub task and per sub-task matrix, is it permissible to use a maximum length of 48 pages for both Tabs 1 and 2?

A. Revised Response: For renewal contracts, the matrix is not required for Task 2a; therefore, the 44 page limitation stands. For competitive proposals only, Tab 1 and Tab 2 are 48 pages each.

45. L.10.A. - The delivery address specifies "RFP No. CMS-02-002/ELH", should this be "CMS-02-003/EH" as specified on the SF33 included with the RFP?

A. CMS-02-003

46. What data source will be used for the statewide measure of flu and pneumococcal immunizations for 7th SoW evaluation? Will CMS be doing another BRFSS-like survey?

A46. See the October 4, SDPS Memorandum 02-305-PN, informing QIOs that CMS plans to use CAHPS, not BRFSS, as a data source for flu and pneumococcal immunizations for 7th SoW evaluation.

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

A235. See Q237. Diabetes and Cancer Screening are the referenced topic areas, adult immunizations is dropped from this subtask.

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

A237. The following is in response to all the questions regarding "targeting identified participants who treat at least **5%** of the beneficiaries in the State for each topic area"

- CMS will create a number to approximate **5%** of the active primary care physicians in the state, based on the number of combined Internal Medicine and Family Practice (also known as "General Practice") physicians, including subspecialties of the above for each QIO. The number will be the target number of identified participants for the diabetes and breast cancer (adult immunization is dropped from this subtask) components of task 1d b. (iii).

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

CMS will then identify two sets of beneficiaries:

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

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

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

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

Q238. Is this even possible?

A238. See #237

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

A254. See #235.

Q263. Defining the denominator of beneficiaries - in order to identify the participating physicians that treat 10% of the target beneficiaries in each topic area, the QIO must first identify the beneficiaries in the "universe" for that topic. For diabetes, this is a fairly straightforward proposition. However, for immunization and mammography, it is much more difficult. It appears the "universe" of beneficiaries for the immunization topic area would be all beneficiaries in the state and for breast cancer, it would be all female beneficiaries in the state. If so, targeting enough physicians to ensure that 10% of the appropriate beneficiaries are covered would involve the identification of very large numbers of physicians. There are other methodological problems as well. (E.g. for immunization, the BRFSS measurement strategy does not allow for the measurement of improvement at the individual physician level since the sample is statewide, and for breast cancer, the clinical service (mammography) is most often provided at a separate facility and billed by the radiologist, not the primary care physician.) Reaching 10% of the beneficiaries for the immunization and breast cancer topic areas would be extremely difficult because of the large numbers involved and the methodological difficulties. Would CMS consider revising the evaluation process for the physician office quality indicators to address these issues?

A263. See #237.

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

A902. See #247

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.

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

A247. See #237