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Under this contract, to merit having its contract renewed non-competitively the QIO shall meet the performance criteria (including a score of 1.0 or greater for Tasks 1a through 1e and 2b) on 10 of the 12 subtasks (9 of 11 for states with no M + C plans) of Task 1 through Task 3 of this SOW, provided that for both the subtasks which do not meet the criteria the QIO has:

1) Achieved a score of 0.6 or better on all subtasks, only for those subtasks with quantitative measures (tasks 1a through 1e and 2b) and
2) For the remaining subtasks only, in the judgment of its Project Officer, the QIO expended a reasonable effort to address these subtasks, developed and implemented an appropriate initial work plan, assessed during the contract period whether it is achieving results which are likely to lead to success in meeting contractual performance expectations, and has made appropriate adjustments to its work plan based on these results.

To be considered successful (though not meriting a non-competitive renewal) the QIO shall meet the performance criteria (including a score of 1.0 or greater for tasks 1a through 1e and 2b) on 9 of the 12 subtasks (8 of 11 for states with no M+C plans) of task 1 through Task 3 of this SOW, provided that for the subtasks which do not meet the criteria the QIO has:

1) Achieved a score of 0.6 or better on all subtasks, only for those subtasks with quantitative measures (tasks 1a through 1e and 2b), and
2) For the remaining subtasks only, in the judgment of its Project officer, the QIO expended a reasonable effort to address these subtasks, developed and implemented an appropriate initial work plan, assessed during the contract period whether it is achieving results which are likely to lead to success in meeting contractual performance expectation, and had made appropriate adjustments to its work plan based on these results, and
3) Failed to meet the criteria in no more than two subtasks of any one Task.

Except as provided in Task 3b, any special study that the QIO might carry out as part of Task 4 of the SOW will be evaluated separately, and is not a part of this evaluation plan.

If the QIO has not met the criteria to merit a noncompetitive renewal, it shall be notified of CMS's intention not to renew its contract and will be informed of its right to request an opportunity to provide information pertinent to its performance under the contract to a CMS-wide panel.

The CMS-wide panel will be made up of representatives from each of the 4 QIO Regional Offices and the Central Office. The QIO's project officer will not be eligible to represent the Regional Office on the panel when it reviews the work of his/her QIO. However, the project officer will be available to answer any questions the panel may have. The QIO will also be given an opportunity to provide additional information. The panel will have the right to create its own procedures, but must apply them consistently to all QIOs it reviews.

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The panel will use the criteria listed below and in any subsequent Federal Register notice to decide whether any unforeseen or uncontrollable events or forces had negatively impacted the QIO's work, or if there is any other reason to believe that it would be in the government's best interest to noncompetitively renew the contract. At a minimum the panel will consider the following criteria:

- the degree of collaboration the QIO exhibited with the Quality Improvement Organization Support Centers (QIOSCs) and other QIOs, both by sharing the lessons and tools it developed and by adopting practices and tools developed by other QIOs;
- whether the QIO was a new contractor in the 7th SOW;
- whether specific identifiable circumstances uniquely interfered with the QIO's efforts;
- evidence suggesting that the QIO has done exceptional work in one or more of the other Task areas; and
- any other issues which the panel may deem relevant.

Upon completion of its review, the panel will make a recommendation for a final disposition to the OCSQ Director.

CMS will evaluate the QIO's performance on each sub-task by some combination of the following elements:

- statewide improvement on the quality measure(s);
- improvement on the quality of care measure(s) among a group of identified participants as defined within each subtask;
- satisfaction among providers regarding their interactions with the QIO.

  Satisfaction will be assessed using a survey, the purpose of which will be to:

  - Measure satisfaction as one component of the QIO's evaluation.
  - Identify opportunities where the QIO can improve satisfaction.

The satisfaction survey will provide a composite measure of each provider group's satisfaction with QIO activities such as technical assistance, data feedback, interventions, effecting system changes, and providing tools. In general, CMS expects at least 80% of the respondents will report achieving a targeted level of satisfaction according to a measure to be determined.

CMS will construct a sampling frame for these surveys using lists of contacts associated with providers supplied by the QIOs (see individual subtasks for further details). The satisfaction surveys will be conducted at a single point in time before the 28th month of the contract. The survey will measure the satisfaction of surveyed providers with their interactions with the QIOs during the seventh SOW.

- Other sub-task specific criteria

The term "Improvement" as used in this SOW shall be defined mathematically to mean the relative reduction in the failure rate. As an example, if a measured indicator at baseline had a 20% rate, then 80% of the eligible population failed to receive the indicated care. A 10% reduction in the failure rate would mean that 28% of the population (20% + (10% of 80%, or 8%) received the indicated care at re-measurement. As a second example, if the baseline rate were 70%, then the failure rate would be 30%. A 10% reduction in the failure rate in this second example would mean that 73% of the population (70% + (10% of 30%, or 3%) received the indicated care at re-measurement.

The final evaluation assessment of each subtask will be based on an average of the QIO's relative improvement on each evaluation criterion. The expected minimum improvement level will serve as the reference point for each calculated relative improvement. For instance, if a particular performance criterion had a minimum expected performance of 10% improvement and the QIO actually achieved a 12% improvement; that would be 120% of the expected improvement. Likewise, an 8% observed improvement would be considered to be 80% of the expected 10% improvement.

In a number of the Task 1 subtasks, statewide improvement will be averaged with the improvement among a set of identified participant providers. In these cases CMS has set a target percentage of identified participant providers, and the relative weights of the statewide improvement and of identified participants' improvement will combine to equal 80% and will be a function of the percentage of the target (up to 150%) that the QIO identifies as participants.

The weight for statewide improvement could range from approximately 80% (very few identified participants) to 14% (150% of the target number of identified participants), using the following formula:

$$\text{Weight}_{\text{statewide improvement}} = 80\% - (44\% \text{ X actual identified participants} \div \text{target participants})$$

The weight for improvement among identified participant providers could range from nearly 0 (very few identified participants) to 66% (150% of target identified participants), following the following formula:

Weight $_{\text{identified participant improvement}}$ = 44% X actual identified participants ÷ target participants)

(The 44% factor was chosen because the equation, using that factor, behaves identically to a much more complicated process which was proposed to balance the relative contributions of statewide vs. identified participant performance.)

CMS will make no efforts to further validate the identified participants or confirm QIO activity with these participants. In addition, CMS will not remove outpatient identified participants except in the case of exceptional circumstances such as the closing of a facility or death/retirement of an identified participant physician. If identified participants are removed, they will be removed from both baseline and re-measurement and their removal will affect the number of identified participants used in calculating the relative weights.

As an example of how the calculations of QIO performance would work, assume that CMS set expected minimum amount of improvement of 10% on the state wide indicator, 20% among the identified participants, and at least 80% of the survey respondents reporting being mostly or fully satisfied with their interactions with the QIO. Additionally, assume that the identified participants represent 25% of that eligible, while the CMS minimum was 20%. These criteria would be combined into a weighted average as depicted in the following table:

Criterion	*Obs Perform*	*Expected Perform*	*Obs % Collab*	*Min % Collab*	*Weight*
Statewide	*8%*	*10%*			*.25*
Identified participant	*22%*	*20%*	*25%*	*20%*	*.55*
Satisfaction	*82%*	*80%*			*.2*

If we assume that the QIO achieved the results shown in the table, the results would be combined into a weighted average, the task performance average (TPA), using the formula below:

TPA = (0.25 * (0.08/0.10)) + (0.55 * (0.22/0.20)) + (0.20 * 0.82/0.80) = 1.01 (being equal to or greater than one, this is a passing score.)

CMS reserves the right to adjust the expected minimum thresholds downward and/or remove criteria from a task evaluation based on experience with the amount of improvement achieved during the contract cycle or in pilot studies currently in progress, and/or any unforeseen circumstances.

Task 1a - Nursing Home Quality Improvement

The QIO will be held accountable for improvement in the quality of care measure rates for all nursing homes in the state and for identified participant NHs. QIOs will be evaluated on Task 1a based on the following components:

(1) Statewide improvement on the set of 3-5 publicly reported quality of care measures which the QIO has selected in consultation with stakeholders. CMS expects an 8% improvement, averaged over all the selected measures;

(2) Improvement for the selected CMS NH publicly reported quality of care measures for identified participants; with a target of 10% (10 for states with fewer than 100 nursing homes). Improvement is achieved for the measures selected for each nursing home and then averaged across all identified participants. If the QIO selects more than one measure for a nursing home, the lowest improvement score for that participant will be dropped prior to averaging across the improvement scores for this participant. CMS expects an 8% improvement for this element; and

(3) NH satisfaction. CMS will survey identified participating NHs using a composite measure of satisfaction that reflects the types of activities that QIOs are expected to have undertaken with these providers. CMS expects that at least 80% of the identified participant NHs will report that they have reached a targeted level of satisfaction according to a measure to be determined. To add performance expectations in exchange for the additional apportionment funds provided in late 2002, CMS will additionally work to assess statewide Nursing Home satisfaction for "non-participating" nursing homes: nursing homes that the QIO has not selected as identified participants.

Weighting of each component

(1) Statewide improvement on the set of CMS publicly reported NH quality of care measures =80% – (44% X actual identified participants ÷ target participants)

(2) Improvement in the selected performance measures for the identified participant NHs that received technical assistance from the QIO= 44% X actual identified participants ÷ target participants

(3) Provider satisfaction 20% (15% identified participants, 5% "non-participating" nursing homes, this weight may be adjusted on a case-by-case basis to ensure that no surveyed "non-participating" nursing home contributes to the evaluation in excess of the contribution of a surveyed identified participant.)

Task 1b: Home Health Quality Improvement

The QIO will be held accountable for improvement in the OBQI quality of care measure rates for a set of identified participant HHAs. QIOs will be evaluated on Task 1b based on the following components:

(1) The extent to which the number of participating HHAs, with significant improvement in a targeted outcome, equals or exceeds 30% of the total number of HHAs in the state. For example, if in a state with 100 HHAs, 30 or more participating HHAs are determined to have achieved a statistically significant improvement in at least one of their selected indicators, the QIO will have met the CMS performance expectation - a score of 30/30 or 1. Additional HHAs with improvement would incrementally add to the QIOs score). NOTE: HHAs must have at least one selected OBQI quality of care measure which they are targeting in order to be considered for the numerator for this component. All HHAs in the state will be in the denominator regardless of whether they have chosen a measure to target**;** and

(2) Identified participant satisfaction. CMS will survey identified participant HHAs using a composite measure of satisfaction that reflects the types of activities that QIOs are expected to have undertaken with these providers. CMS expects that at least 80% of the HHA respondents report that they have reached a targeted level of satisfaction according to a measure to be determined. To add performance expectations in exchange for the additional apportionment funds provided in late 2002, CMS will additionally work to assess statewide Home Health Agency satisfaction for those agencies not specifically participating with the QIO ("non-participating" Home Health Agencies).

Weighting of each component

(1) Percent of HHAs that demonstrates a statistically significant improvement in at least one of their selected OASIS quality of care measures (CMS expects 30% of HHAs in the state to have a statistically significant improvement in at least one of their selected OASIS quality of care measures) = 80%

(2) HHA satisfaction/evaluation of QIO= 20% (15% identified participants, 5% "non-participating" HHA's, this weight may be adjusted on a case-by-case basis to ensure that no surveyed "non-participating" HHA contributes to the evaluation in excess of the contribution of a surveyed identified participant.)

Task 1c - Hospital Quality Improvement

QIOs will be evaluated on sub-Task 1c based on the following criteria:

(1) Statewide improvement on the quality of care measures listed in the SOW, and

(2) Hospital satisfaction – CMS will elicit feedback from the hospitals in the State. CMS expects that at least 80% of the respondents will report that they have reached a targeted level of satisfaction according to a measure to be determined.

(1) Statewide improvement on quality of care measures

CMS will abstract data from samples of medical records to obtain statewide estimates of each quality of care measure. CMS expects to sample approximately 125 cases per clinical topic in each state each calendar quarter, or a total of 1500 cases over the 3-year life of the contract.

CMS will create and provide to the QIO at the start of the 7th Contract Cycle baseline rates for each state. These baseline rates will reflect the care delivered in the state during the period covered by the 6th SOW re-measurement, for those measures that are in the 7th SOW. Because some 6th SOW measures have been revised for the 7th SOW, the initial baseline rates available to the QIOs will represent estimates of the 7th SOW rates derived from 6th SOW data; more precise 7th SOW baseline rates will be provided to the QIO in as timely a manner as possible. CMS will provide one set of rates for each performance measure. CMS will provide the QIO with periodic interim estimates of the performance measure rates throughout the contract period. CMS will aggregate the four most recent quarterly samples prior to the end-of-contract evaluation and will generate re-measurement rates based on these four combined quarterly samples.

CMS will provide the QIO a state-specific baseline combined topic average near the start of the 7th SOW. CMS will provide the QIO a second state-specific combined average, based on re-measurement data, in time for an end-of-contract evaluation.

The combined topic average will be calculated from the following core measures:

<u>For AMI:</u>

AMI-1 Aspirin at Arrival
AMI-2 Aspirin Prescribed at Discharge
AMI-3 ACEI for LVSD
AMI-4 Adult Smoking Cessation Advice/Counseling
AMI-5 Beta Blocker Prescribed at Discharge
AMI-6 Beta Blocker at Arrival
AMI-7a Thrombolytic Agent Received Within 30 Minutes of Hospital Arrival
AMI-8a PTCA Received within 90 Minutes of Hospital Arrival

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(N.B.: AMI-7 Median Time to Thrombolysis and AMI-8 Median Time to PTCA will be reported but, since they are so closely related to AMI-7a and AMI-8a, will not be included for purposes of QIO evaluation).

For HF:
HF-1 Discharge Instructions
HF-2 LVF Assessment
HF-3 ACEI for LVSD
HF-4 Adult Smoking Cessation Advice/Counseling

For PNE:

PNE-1: Initial Antibiotic Received Within 4 Hours of Hospital Arrival
PNE-2: Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients
PNE-3a: Blood Cultures Performed Within 24 Hours Prior to or After Hospital Arrival
PNE-3b: Blood Culture Performed Before First Antibiotic Received in Hospital
PNE-4: Influenza Immunization
PNE-5: Pneumococcal Immunization
PNE-7: Oxygenation Assessment

(N.B.: PNE-3 [blood cultures] is a two-part measure. Each part will account for 1/2 the weight of the entire measure. Because of the lack of a suitable baseline, PNE-6 Smoking cessation advice will be calculated, tracked and reported, but not included in the performance-based evaluation until the next (8th SoW) contract cycle).

For SIP:

SIP-1: Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision
SIP-2: Prophylactic Antibiotic Selection for Surgical Patients
SIP-3: Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time

The combined topic average will be calculated in two steps. First, an average will be calculated for each of the four sets of indicators, one for each clinical topic, based on the following formula:

The Topic Average (TA) will be calculated as:

$$\text{Topic Average (TA)} = (\underline{w1}\text{Indic}_1 + \underline{w2}\text{Indic}_2 + \ldots\underline{wn}\text{Indic}_n) / \underline{\text{sum of w1=>wn}}$$

where: Indic = Indicator Performance (from 0% - 100%)

n = Number of indicators in the clinical topic set
w = weighting factor

w = 1 for all measures with the following exceptions:
For AMI-4 and HF-4 (Adult Smoking Cessation Advice/Counseling) and HF-1 (Discharge instructions), w = 0.5
For AMI-7a (Thrombolytic Agent Received…) and AMI-8a (PTCA Received…), w = 0.1
In addition, for AMI-7a and/or AMI-8a, if any QIO has a re-measurement denominator for the measure that is less than ten (10), that measure will be dropped from evaluation for that QIO (i.e., w = 0).

As a second step, the four clinical topic averages will be combined, based on the following formula:

Combined Topic Average (CTA) = $\sum$(TAs) / 4

where: TA= Topic Average

CMS expects the QIO to demonstrate at least 8% improvement in the Combined Topic Average (CTA) by the 28th month of the contract.

(2) Hospital satisfaction. CMS will survey hospitals using a composite measure of satisfaction that reflects the types of activities that QIOs are expected to have undertaken with these providers. CMS expects that at least 80% of the hospital respondents will report that they have reached a targeted level of satisfaction according to a measure to be determined.

Weighting of each component

(1) Statewide improvement – 75%

(2) Hospital satisfaction - 25%

Task 1d - Physician Office Quality Improvement

QIOs will be evaluated on Task 1(d) based on the following three general criteria:

(1) statewide improvement on quality of care measures;

(2) improvement on (FFS - based) diabetes and cancer screening quality of care measures for identified participant physicians (target: 5% of the active primary care physicians in the state as approximated by CMS); and

(3) physician satisfaction - CMS will elicit feedback from the physician designees in the state who participated with the QIO. CMS expects that at least 80% of the respondents will

report that they have reached a targeted level of satisfaction according to a measure to be determined.

(1) Statewide Improvement

CMS will use administrative claims data to measure diabetes and mammography quality of care measure rates for FFS beneficiaries. The second set of indicators will reflect the care received by M+CO members (if any) in the state. The M+CO Breast Cancer and Diabetes indicators will be derived from a weighted average of the most recently available annual HEDIS data prior to the start of the Seventh Scope contract, reported by the M+CO plans in the state. The weights will reflect the proportion of the total M+CO membership in the state. Statewide flu and pneumococcal (PPV) immunization rates will be based on periodic Consumer Assessment of Health Plans Study (CAHPS) survey results which currently combine FFS and M+CO beneficiaries.

CMS will provide the QIO a state-specific baseline combined topic-weighted average near the start of the 7th SOW. CMS will provide the QIO a second state-specific combined topic-weighted average, based on re-measurement data, in time for an end-of-contract evaluation.

The Combined topic average (TA) will be calculated as follows:

Combined Topic Average (CTA) = ($\underline{w1}Indic_1 + \underline{w2}Indic_2 + ...\underline{wn}Indic_n$) / $\underline{\text{sum of } w1 => wn}$

where: Indic = Indicator Performance (from 0% - 100%)

n = Number of indicators in the clinical topic set
w = weighting factor

w, the weighting factor will be as follows:

- .75 for statewide Pneumococcal (PPV) Immunization
- .25 for Influenza immunization
- .33 x (1 – M+C penetration) for each of the three FFS diabetes indicators
- .33 x (M+C penetration) for each of the three M + C HEDIS diabetes indicators
- (1 – M+C penetration) for the FFS mammography indicator
- (M+C penetration) for the M + C mammography indicator

(M+C penetration is defined as the fraction of Medicare beneficiaries in the state enrolled in M + C plans at the FFS baseline and re-measurement points. The source for this will be existing CMS M + C enrollment data.)

CMS expects the QIO to demonstrate at least 8% improvement in the Combined Topic Average (CTA) by the 28th month of the contract.

(2) Improvement on the diabetes and cancer screening quality of care measures for the identified participants

The target for the identified participant group is 5% of the active primary care physicians in the state (as approximated by CMS). CMS expects the QIO to demonstrate at least 8% improvement in the measures for those beneficiaries for which they are linked. This improvement will be based on FFS claims data only.

(3) Physician Satisfaction

CMS will survey identified participant physicians using a composite measure of satisfaction that reflects the types of activities that QIOs are expected to have undertaken with these providers CMS expects that at least 80% of the respondents will report that they have reached a targeted level of satisfaction according to a measure to be determined. Physicians will be permitted to assign proxy respondents, (i.e., office staff) and one respondent (or proxy) may represent an entire group practice.

Weighting of each component

(1) Statewide improvement = 80% – (44% x actual identified participants ÷ target participants)

(2) Improvement of identified participants = 44% x actual identified participants ÷ target participants

(3) Identified participant satisfaction = 20%

For purposes of the above weighting scheme, the maximum ratio of actual to target identified participants is 1.5, and CMS has supplied each QIO with a target number of identified participants which should approximate 5% of the primary care physicians in the state.

Task 1e – Underserved and Rural Beneficiaries Quality Improvement

The QIOs work on this task will be primarily evaluated on the success of the QIO's efforts to reduce disparity between the targeted underserved group and their geographically relevant non-underserved reference group, from baseline to re-measurement. To be judged to have performed minimally successful on this task, the QIO must demonstrate disparity reduction. In other words, the absolute difference in baseline disparity must be reduced at re-measurement. Secondarily, QIOs will also be evaluated on three factors which collectively demonstrate knowledge generated by the QIO about the underserved target group, the interventions planned upon the

basis of that knowledge and the use of literature on effective interventions, and by demonstrating the effectiveness of their intervention through analyses comparing the intervention group and a well-argued contrast group that does not receive the target intervention. Success on the primary evaluation criteria of reducing disparity will result in a "pass" evaluation judgment and a numeric score on this sub-task of "**1**".

(Primary evaluation score worth 1 point = PASS).

- The reduction in disparity is based on a change in percentage points in disparity from baseline to re-measurement. Standard mathematical rounding will be used, with all percentages using no more than 1 decimal place.

- To be judged to have performed minimally successful on this task, the QIO must demonstrate disparity reduction. In other words, the absolute difference in baseline disparity must be reduced at re-measurement.

Example of "PASS"

- Disparity = Reference Group Performance Rate (54.1%) – Intervention Group Performance Rate (44.1%) = 10%; if at re-measurement the Disparity is <10%, Task 1e is a SUCCESS, i.e., Reference (55.2%) – Intervention Group (48.2%) disparity = 7%. This example shows a change of 3 percentage points.

Example of "FAIL"

Disparity = Reference Group Performance Rate (54.1%) – Intervention Group Performance Rate (44.1%) = 10%; if at re-measurement the Disparity is ≥ 10%, Task 1e FAILS, i.e., Reference (55.2%) – Intervention Group (42.2%) disparity = 13%; or no change.

Success on any of the secondary factors below will result in additional evaluation points in the following amount:

(1) **.2** points for success in fully describing the targeted intervention undeserved group to include demographics (age distributions, gender sub-groups, racial subgroups, economic indicators of subgroups living in near poverty levels, urban/rural groupings and geographic location), other pertinent cultural or ecological information to include barriers and causes for disparity, and contrasting these characteristics to those of the reference group:

(2) **.2** points for successfully documenting the direct relationship between the target population disparity and the intervention implemented for the project, with a focus on the disparity barriers addressed and rationale for the intervention chosen. Please include barriers, successes and lessons learned of the experience of this project.

(3) **.2** points for documenting quantitative intervention effectiveness (intervention vs. contrast group) using one of three options for contrast groups (which must be approved by the RO):

- In-state contrast group
- Other state/location contrast group
- National Comparison Groups (NCG)

PASS example – Intervention Group shows improvement (50% pre to 54% post) and Contrast Group shows no change (50% pre to 50% post). Passage is based on the equivalent rules for assessing disparity.

Success on both the primary and secondary components enables a total score of 1.6. In the event of not passing by not reducing disparity, a QIO could still receive an evaluation score of up to .6 if they are successful in all three secondary components.

Task 1f - Medicare+Choice Organizations (M+COs) Quality Improvement

QIOs will be expected to have demonstrated appropriate activity to include M+COs in Tasks 1a to 1e as determined by the project officer.
CMS will survey M+COs that have worked with the QIO using composite measure of satisfaction that reflects the types of activities that QIOs are expected to have undertaken with these organizations. CMS expects that at least 80% of the respondents will report that they have reached a targeted level of satisfaction according to a measure to be determined.

QAPI Improvement – CMS will use the results of the Medicare+Choice Quality Review Organizations (M+CQRO) or accreditation organization evaluation of the QAPI projects to determine if expected improvement was demonstrated.

The project officer will weigh each of the following measures equally:

(1) QAPI Improvement /Technical Assistance Given to M+COs

(2) Satisfaction Survey

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

Task 2a - Promoting the Use of Performance Data

QIO success on this task will be assessed by its Project Officer, Regional Office Communications Specialist, and the GTL for this task based on the following elements:

(1) Timely completion and submission of a project work plan;

(2) Timely completion and submission of all required reports and deliverables; and

(3) The extent to which the QIO used information provided by CMS (e.g., reports on number of website hits, telephone inquiries received, etc.) as well as any other feedback the QIO received (e.g., from internal evaluations, provided by partners, etc.) to refine its project activities to achieve the desired outcomes.

Task 2b - Transitioning to Hospital-Generated Data

(1) CMS will determine the completeness of the assessment survey information for each hospital. CMS expects the data to be complete for 80 percent or more of acute care and critical access hospitals in the state. Weight: 30%

(2) CMS will use hospital data submitted to the national repository via QualityNet Exchange to determine the proportion of hospitals within the State that have implemented a data abstraction system to abstract quality of care measures. For hospitals eligible for the 501(b) update (RHQDAPU), CMS expects thorough documentation of QIO efforts (through phone logs, email exchanges, meeting/contact reports, Web-X, and the like) to encourage participation by all eligible facilities, particularly detailing why a given hospital did not submit data for 501(b) public reporting.

All eligible hospitals are to be contacted and given assistance as necessary to facilitate reporting data that is timely, accurate, and complete. If a hospital does not receive the full update and complains that it did not receive QIO support, the QIO must be able to document its efforts. Weight: 50%

(3) Hospital satisfaction with QIO data abstraction support. CMS will conduct a survey of appropriate personnel in a sample of those facilities in which the QIO has installed the CMS-approved abstraction tool and/or supports the ongoing collection of hospital data and submission to the national repository. This survey will be used to assess the hospitals' satisfaction with QIO support of their internal data abstraction efforts. CMS expects that at least 80% of the respondents will report that they have reached a targeted level of satisfaction according to a measure to be determined. Weight: 20%

A "reporting" hospital for the QIO evaluation is defined as:

- a hospital that collects <u>all</u> measures for at least one 7th SOW topic: Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PNE) or Surgical Infection Prevention (SIP) and submits the data to the QIO Clinical Warehouse via QualityNet Exchange;
- hospitals accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO) that collect all JCAHO measures on at least one of the AMI, HF or PNE (referred to as CAP by the JCAHO) topics (e.g., if the hospital collects the JCAHO measures for pneumonia, the hospital would meet the CMS definition of a "reporting"

hospital for purposes of the 7th SOW evaluation even though the CMS influenza and antibiotic selection measures are not currently required for the JCAHO) and submit the data to the QIO Clinical Warehouse via QualityNet Exchange;
- a non-JCAHO accredited hospital that submits to the QIO Clinical Warehouse via QualityNet Exchange the "starter set" of ten measures in accordance with "The National Voluntary Hospital Reporting Initiative."

For non-JCAHO accredited hospitals, a "reporting" hospital must submit a simple random sample of cases. Select all cases with a terminal digit of 0, 5, and 6 in the HICN (ignoring the BIC). This sample will correspond to the following scheme:

Total cases in topic	Sample (based on Medicare discharges)
<7	select all
7-34	select 7
35-350	select 20%
>350	select 70

For the SIP topic, it is expected that a hospital will sample cases for all procedures meeting the eligibility criteria for that topic.

For a given State, Critical Access Hospitals (CAHs) may be included in the number of "reporting" hospitals for the QIO evaluation under Task 2b at the QIOs' discretion. However, if a QIO chooses to include CAHs in the equation, then ALL the CAHs in the State must be included.

Task 2c - Other Mandated Communications Activities

QIO success on this task will be assessed by its Project Officer, based on the following elements:

(1) The establishment and use of a Consumer Advisory Council to advise and provide guidance regarding consumer related activities

(2) The QIO's success at broadening consumer representation on the QIO Board of Directors;

(3) The successful operation of a Beneficiary help line, as reflected in such measures as documented responses to inquiries within established reasonable time frames and efforts to ensure that responses are clear and substantive.

(4) The publication and distribution of an Annual Report.

Task 3 - Medicare Beneficiary Protection Program

Task 3a - Beneficiary Complaint Response Program

QIO success on this task will be assessed by based on the following elements:

(1) Timeliness of completed reviews. CMS expects reviews to be completed within the prescribed timeframes at least 90% of the time.

(2) Quality improvement activities. CMS expects QIOs to assess the proportion of complaint reviews for which quality improvement activities have been recommended to providers/practitioners.

(3) Reliability of review. CMS expects QIOs to assess reliability of its review of cases and undertake appropriate activities to improve its reliability of review.

(4) Beneficiary satisfaction with the complaint process. The QIO will conduct surveys of beneficiary complainants, once their complaint process has been completed. QIOs will be expected to assess complainant satisfaction and demonstrate that they have improved it, or undertaken appropriate improvement activities.

Task 3b - Hospital Payment Monitoring Review Program

To be fully successful in this task the QIO must:

- Complete reviews within the prescribed timeframes at least 90% of the time, assess reliability of its review of cases, identify opportunities for improvement, and communicate and report on its process and findings in accordance with CMS requirements.

In addition, the QIO must meet one of the following criteria:

(1) 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 errors above the baseline payment error rate.

(2) The QIO will be judged successful if it makes substantial and effective effort and makes acceptable progress in improving provider performance in relation to any and all projects approved or directed by CMS. The QIO must meet all reporting requirements in relation to such work. (If a QIO fails on the payment error criterion and has not been approved to conduct an HPMP project, then CMS will take into account other factors including, but not limited to, the number and quality of project requests submitted).

Task 3c - Other Beneficiary Protection Activities

QIO will conduct HINN/NODMAR review, EMTALA review, Other Case Review Activities and Post Review Activities. QIO success on this task will be assessed in relation to the following elements:

- Timeliness of completed reviews. CMS expects reviews to be completed within the allotted timeframes at least 90% of the time.