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2 CENTERS FOR MEDICARE AND MEDICAID SERVICES

3 Quality Improvement Organization

4 9th Scope of Work

5 Pre-Proposal Conference

6

7 January 28, 2008

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9 Centers for Medicare and Medicaid Services

10 7500 Security Boulevard

11 Baltimore, Maryland

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1 P R O C E E D I N G S

2 (The conference was called to order at

3 9:03 a.m., Monday, January 28, 2008.)

4 DR. STRAUBE: Good morning to you all.

5 We're just dialing in so we have some folks who are

6 going to be on listen only mode coming in, so if we

7 can just wait another 30 seconds or so here, we can

8 get started. Okay.

9 Why don't we get started and anybody who

10 hasn't got a seat yet, feel free, there are plenty of

11 chairs over on this side also.

12 Good morning, and I want to welcome you

13 all to the QIO program 9th Scope of Work Pre-Proposal

14 Conference.

15 We have been working and when I say we,

16 not just myself and Terris King, but a host of people

17 here at CMS, in the Department, and with numerous

18 stakeholders, working very very hard over the past

19 year and a half to two to come to this point. I

20 wanted to remind everybody that I think there were

21 many driving forces in terms of our devising a 9th

22 Scope of Work. We had some intense internal review

23 starting about two years ago or a little bit more,

24 when I first came back here and knew there were some

25 issues with the program that certainly related to the

1 public.

2 We had some intense interactions soon

3 thereafter with the Senate Finance Committee and

4 Senator Grassley and others on the Hill. Soon after

5 that we had what I think has become the bible for

6 guiding how this program, at least recommendations,

7 broad recommendations dealing with careful thought

8 ought to go, and we will get back to that in a

9 second, the IOM report on Medicare's Quality

10 Improvement Organization program and most

11 importantly, the site proviso that comes after that

12 as to maximizing potential.

13 And then we had discussions with the QIOs,

14 with other stakeholders in the healthcare industry

15 and so forth, and all of this led to what has been

16 over the past year an effort by CMS working much more

17 closely across the Department.

18 For the first time ever we did two things.

19 One, we focused on what the Secretary of HHS,

20 Secretary Leavitt's priorities were for the

21 Department as a whole, and we also included all of

22 the components of the Department in the planning and

23 in the clearance process going forward.

24 So this, the documents that have been

25 recently released were the culmination of a year and

1 a half of work involving very wide input, and I think
2 we have in many respects answered many of the
3 challenges and recommendations of the Institute of
4 Medicine report going forward.
5 It has been to my dismay that things don't
6 change as rapidly sometimes as we would like them to
7 change, so we have a lot of work to do. And we're
8 already of course thinking about the 10th Scope of
9 Work, but I'm jumping way ahead of all of this, and
10 today we're going focus on this bidders conference to
11 go over the current RFP that's available, the details
12 of that and so forth.
13 I did want to, before I get into the
14 introduction here, wanted to mention, however, what
15 the major conclusions and recommendations, the big
16 overview recommendations that the IOM gave to us as a
17 QIO program.
18 First of all, they noted and observed that
19 the quality of healthcare for Medicare beneficiaries

20 over time, and they're going back over the last

21 decade, has improved steadily. But their second

22 conclusion and finding was that the existing evidence

23 that has been available in prior scopes of work was

24 inadequate to determine to what extent the QIO

25 program had really contributed to that quality

1 improvement. I think all of us in this room to some
2 extent, some more than others perhaps, believe very
3 strongly that the QIO program has been a major
4 contribution to healthcare improvement for Medicare
5 beneficiaries and in fact, for all citizens of the
6 United States.
7 But the challenge that we are clearly
8 faced with is measuring, quantifying and proving in a
9 more scientific evidence-based manner that that
10 indeed is the case, and one of the reasons for that
11 as we are all going to hear from the President in the
12 State of the Union this evening, as it becomes
13 apparent that the economy is challenged, that it's a
14 program that spends $1.2 billion historically every
15 three or four years, or $400 million a year, are we
16 getting the best value for that money, regardless of
17 what activities have occurred before.
18 So going forward we have to prove the
19 value of the program on an ongoing basis. We can't

20 wait until three years from now to look back and

21 possibly find that we didn't succeed. We have to

22 succeed during those three years, and we believe that

23 the proposed RFP goes a long way towards assuring

24 that.

25 One interesting number that I heard, that

1 1.2 billion, when you come to work for CMS, 1.2

2 billion doesn't sound like a whole lot of money after

3 a while, since we spend hundreds of about billions of

4 dollars of money every year. But I saw an

5 interesting thing over the weekend where they were

6 talking about consumer spending, and the number that

7 popped up in front of me was that the combined

8 consumer spending in China and India per year is $1.6

9 billion. So in other words, the 400 million we spend

10 on the QIO program is one quarter of the total

11 consumer spending in these two huge countries with

12 many, many people. So in the world economic

13 perspective it's a phenomenal amount of money, and

14 even in the United States budget, it's not

15 insignificant.

16 The third broad recommendation that the

17 IOM mentioned was that value could be enhanced for

18 the program and we could maximize potential savings

19 if we did a number of things. And those included,

20 number one, a focus on the QIOs providing technical

21 assistance to support quality improvement efforts, so

22 a focus more on providing technical assistance as

23 opposed to doing research studies or holding

24 conferences that might not provide as much technical

25 assistance as the IOM had hoped we all might.

1 The second was to broaden the governance
2 space and structure, so there have been some changes
3 over last year in terms of our guidance, but there
4 will be requirements in the RFP that pertain to a
5 governance structure, conflict of interest issues,
6 et cetera.
7 And then the third, and not the least, has
8 to do with improving CMS management, particularly
9 related to data systems that are essential to QIO
10 maximizing its potential, and also doing program
11 evaluations of the work that we are all doing, and
12 that includes CMS management team as well as the
13 QIO's performance under the contract.
14 So again, we think that this has all been
15 put into the existing RFP and we would like to talk
16 about that a little bit more today as we go and
17 answer some questions. Is the slide set working?
18 SPEAKER: Five minutes.
19 DR. STRAUBE: We will keep going. The

20 main objectives that we wanted to cover today was

21 first and foremost, to inform the potential QIO as

22 well as incumbent QIOs on opportunities in the 9Th

23 Scope of Work that the folks might want to consider

24 contracting for. We wanted to clarify what our goals

25 and themes were for the 9th Scope of Work that are

1 coming out of OCSQ and the Agency. We wanted to
2 stress something that I don't know that we've
3 facilitated as much in the past as we'd like to this
4 time insofar as we can, at least providing an
5 opportunity for partnership among any number of
6 people who are in this room and beyond that.
7 We have received over 3,000, I think it's
8 approaching 4,000 questions so far on the RFP, so
9 insofar as we can start to try to give people some
10 feedback on those questions, that's one of the main
11 purposes for today, although you can imagine that
12 4,000 questions takes quite a bit of time to be
13 responsive to in a detailed manner, so we will still
14 be working on that. And you'll hear a little bit
15 about the process for how ongoing questions, or for
16 how all of the questions that may not be answered
17 today will be answered going forward.
18 We want to talk about what's new in the
19 9th Scope of Work and what we're going to be looking

20 for in the oversight process. Contracting

21 opportunities, are there new contracting

22 opportunities that this presents? We believe it does

23 and we will try to talk about those today. We would

24 like to come out of today also, although it would be

25 hard for me to believe that with 4,000 questions

1 we've missed any question, it could well be that we
2 have, so if there are some that we haven't been made
3 aware of, this is another opportunity today.
4 And we would like in the partnering aspect
5 to, just the very fact that we have many, many people
6 from many, many organizations today under the
7 existing structure, we would like to have people
8 think outside the box and think, gee, are there ways
9 that people can partner that haven't before, in
10 fulfilling the 9th Scope of Work and doing an even
11 better job.
12 We have made some structural changes,
13 there need to be more in our regional offices, but we
14 want, we view -- although the QIOs have been our
15 contractors, they are also our customers too, and we
16 want especially from the regional office standpoint
17 to be sure that they are participating in our
18 oversight of the program and at the same time
19 enhancing communications, getting information to QIOs

20 in a more rapid customer friendly manner than they

21 perhaps have before.

22 You are going to hear right after I finish

23 speaking from Terris King about reducing disparities.

24 This is a personal topic for myself and for Terris

25 that we have been trying to push within the Agency

1 and I think so far we have been successful in that,

2 but we want to incorporate that into the entire 9th

3 Scope of Work, as you could guess.

4 And then we will have interactive sessions

5 at the end with questions.

6 Some of the other areas of discussion have

7 to do with information technology and security. This

8 is an area that the Agency has needed to focus on

9 before, and I think we've started to address this

10 massive challenge and we will talk about that.

11 There are several key contract provisions

12 that I think the questions have pointed out to us

13 that we need to be at least informing people of what

14 our intent was, and in some cases considering how we

15 might include those contract provisions by

16 modifications before we get too far into the process

17 here.

18 By the way, in passing I want to say that

19 I came into the Agency here at central office with

20 when the 8th Scope of Work contract had been

21 developed and was already partially out on the

22 street, and we ended up having to go through multiple

23 contract modifications because I don't think things

24 were thought out quite as thoroughly as they needed

25 to be. Our intent this time around is to get this as

1 close to right as we can, and we do not intend to
2 make multiple contract modifications throughout the
3 course of the Scope of Work unless that's absolutely
4 necessary and indicated. Okay.
5 There are three cross-cutting themes in
6 the 9th Scope of Work that we, although you will hear
7 about our four themes, I wanted to stress and
8 highlight that these three themes are exceedingly
9 important, and although there may not be
10 specifications in the contract, that you have to do
11 certain things to hit these three cross-cutting
12 priorities. We would like everybody to be thinking
13 about how in all of the work that they do relative to
14 the QIO program, we can always try to retain some
15 focus on these priorities.
16 I've already mentioned the one that we
17 think has been underemphasized by the healthcare
18 industry in general, and that's reducing healthcare
19 disparities. But not surprisingly, two of the other

20 major priorities, in fact I would say these are the

21 top two priorities of Secretary Leavitt are, first,

22 promoting the use of health information technology,

23 and second, focusing on so-called value driven health

24 care. So we will be talking about that today as we

25 go forward also.

1 We have a couple of slides that I don't
2 really want to go into, both on broad use of HIT, I
3 think we're all very clear that is essential to
4 driving quality improvement forward. In terms of
5 value driven health care on slide eight, we're
6 primarily focusing on the four cornerstones that we
7 use here in the Department and at CMS, which is first
8 and foremost promoting adopting interoperable health
9 information technology.
10 But it's increasingly measuring and
11 publishing quality information for use by consumers,
12 payers and other parties across the United States.
13 Measuring and publishing price and cost information,
14 something that I think is new to the QIO program but
15 is absolutely essential and I think QIOs will be, if
16 not best positioned, certainly one of the key drivers
17 of being able to push not only quality as it has in
18 the past, but price and cost information. And then
19 finally, linking the QIO program efforts to promoting

20 quality and efficiency of care through incentives,

21 perhaps pay for performance, perhaps other forms of

22 recognition and so forth.

23 So, we hope that today we will succeed in

24 better educating folk and answering some of the

25 questions they have about the Scope of Work. I'm

1 proud that we set up an aggressive time line that
2 many in the Department as well as the Office of
3 Management and Budget and elsewhere thought we could
4 not meet, but we in fact are on schedule with our
5 time line. It's still a tight time line but we
6 intend to have contracts awarded, the Scope of Work
7 starting on August 1st of this year and with the
8 necessary support structure in place to support that
9 on day one.
10 In terms of what we would like to stress
11 again today is that all of us, including not only
12 those of us at CMS, but all of us be very open minded
13 to the change that is occurring and has to occur. We
14 would like to, we hope, show that we are very
15 energized and enthusiastic about this change and
16 think it's going to in fact reduce the criticism of
17 the QIO program and have it in a much better place to
18 allow the 10th Scope of Work to do even greater
19 things. We hope people will be willing to see the

20 opportunities that this presents here, not only to

21 the QIO program as a whole, but I believe for

22 individual QIOs and other contractors. And we also

23 think that this is a good day to think about

24 partnering, not just with stakeholders in your

25 states, but with other Quality Improvement

1 Organizations and other contractors going forward.

2 So with that, that's just an overview of

3 what we hope to accomplish today. I would like to

4 turn things over now to Terris King, my deputy

5 director of OCSQ. And Terris, because we believe

6 that the health studies are so important, is going to

7 spend a little bit of time just reviewing how we

8 envision that that's going to be incorporated on the

9 Scope of Work.

10 Thank you all very much for coming and I

11 look forward to the dialog that goes on today. Thank

12 you.

13 MR. KING: Good morning. First of all, I

14 want to echo Barry's opening salvo to welcome you all

15 here this morning and I think this is a great

16 turnout. I think it's a testimony of what we're at

17 least attempting to do with this particular contract,

18 this Scope of Work, to really operate a bit

19 differently than we have in the past.

20 Some of the things that we've done in the

21 past would be to say okay, here's the contract,

22 basically you figure it out and whatever questions we

23 can answer, we'll answer those to the best of our

24 ability. What we're attempting to do today is really

25 to reach out and to say okay, if we accomplish no

1 more today than simply to reduce the number of

2 modifications that we have in this contract, I would

3 say that today has been a success. Because we'll

4 have a chance, over and above the three or 4,000

5 questions that Barry talked about, to hear from you

6 today some additional questions that will augment

7 what we have.

8 And the questions we have of course come

9 from the QIO community, but today we have represented

10 several other entities within this room. We have

11 those that are here to meet those current QIOs, to

12 learn a bit more about our program, to subcontract,

13 to work with you in some capacity, and during the

14 disparities part of our discussion we will have a

15 chance to go into that. And then we have those that

16 are just interested in QIO work in general. And so

17 with this exchange we believe it will be a process

18 that will allow us to really become far more solid,

19 and because as Dr. Straube mentioned, we're operating

20 earlier in the program in terms of our planning, it

21 will enable us to have a far more solid contract as

22 we move forward.

23 Now to do what we have planned here today

24 and with your participation, I guess one other thing

25 I want to say, not only speak to us, but I encourage

1 you to speak to each other, talk to each other.

2 There are individuals in this room that you cannot

3 know. There is no way, because we've invited here

4 today individuals, once again in helping us, it's not

5 about endorsing any company or endorsing any set of

6 skills, it's just about putting people in the room

7 that hopefully you will at least give some

8 consideration to linking your proposals and processes

9 up with them to really make whatever it is you plan

10 to do before.

11 Now to do this, as Barry mentioned, it

12 hasn't been two people or even three with Dr. McGann,

13 Barry and I in a leadership capacity, and certainly

14 Dr. Paul McGann in terms of the substance and content

15 of what we're doing. And before we get into the

16 disparities piece, Paul is going to come and talk to

17 you about the content.

18 But before we do that, we want to have a

19 chance to recognize and to thank in a very public way

20 following some welcoming comments our partners in the

21 Office of Contracting, the Office of Acquisitions and

22 Grant Management.

23 One of the things that we've heard from

24 the QIO community is how important it is to have a

25 content component, the subject matter component

1 linked tightly with the contract component of CMS so

2 that we speak with one voice, so that the contract

3 end and the substance end of what we plan to do, of

4 what our vision is for this program as we remind the

5 QIO community of what we've done, which is to build a

6 business model on clinical themes, a business model

7 on clinical themes. It is important for that

8 linkage, whether acquisition and grants component,

9 it's important with that linkage of those that will

10 really keep a finger on the pulse of where the

11 program is.

12 And we're happy to have Dr. Lisa McAdams

13 here with us representing our regional component, our

14 quality component in the region, because that is the

15 role of the region. So it is this three-way

16 partnership, if you will, that will enable us to move

17 out with a contract that will be beneficial and to

18 keep a close accountability and oversight in what

19 we're doing.

20 So with that said kind of an opening

21 salvo, I would like Rod and then I know one of his

22 key people, Naomi, who is really our detail in terms

23 of what we're doing, and we really thank Naomi and I

24 don't know if Brian is here anywhere today, because

25 they have really done a great job in keeping us

1 focused on the details of what we really need in

2 order to move that forward. So with that said, the

3 director of the Office of Acquisition.

4 MR. BENSON: Thank you, Terris. As Terris

5 said, I am the director of the Office of Acquisition

6 and Grants Management and it's my pleasure to welcome

7 everybody here today on behalf of CMS as well as the

8 Office of Acquisition and Grants Management. And

9 Terris recognized Naomi, who is well known to the

10 existing QIO people. This is Brian Habbel, the other

11 person he mentioned right here at the corner. Brian

12 is the director of our division of quality contracts

13 within OAGM.

14 It's our sincere hope that the conference

15 today will give you some of the information and

16 insights you need into the 9th Scope of Work and to

17 enable you to prepare a proposal that's competitive

18 and that meets our needs and the needs of the

19 program. Our office works in close concert with OCSG

20 with Barry and Terris. We're really responsible more

21 for, you know, making sure that the provisions and

22 requirements are legally implemented through the

23 contracting mechanisms we award. And just as

24 importantly for our purposes today, it's our

25 responsibility to make sure that the contracts are

1 awarded in accordance with the basic principles of

2 competition, so that's a big responsibility that

3 falls on our office.

4 I was thinking, I was asked to give a

5 little opening remark today and I was thinking about

6 it a little bit, and I know there's been a lot of

7 discussion about the 9th Scope of Work and the QIO

8 program and what's going on with that, but I just had

9 a couple different thoughts.

10 I've been working on Medicare contracts in

11 kind of one capacity or another for 31 years and I

12 have to tell you, the last few years, there have just

13 been so many changes, you know, it's not business as

14 usual here anymore at CMS. In my capacity I have

15 responsibility for basically all the contracts that

16 support the Medicare contracts and as many of you

17 know, for years we really carried out the

18 administration of the Medicare program through

19 contracts with Medicare engineers and carriers,

20 pretty much they did everything that was necessary,

21 the entire range of functions that were necessary to

22 administer the program were done through those

23 contracts.

24 Not long ago we started changing

25 significantly how we contract for the administration

1 of the Medicare fee for service program. We pulled
2 out standard systems maintenance and data centers and
3 program integrity activities from those Medicare
4 engineering and carrier contracts and we started
5 awarding separate contracts for those various needs
6 and administering those contracts in different ways.
7 The engineering and carrier contracts were all
8 awarded noncompetitively and had been reviewed
9 noncompetitively for some 30 years. And when they
10 were competing all of a sudden, those requirements
11 became much of more of a program integrator for how
12 it all fit together.
13 More recently now we're competing with the
14 Medicare administrative contracts and we've
15 introduced now a competition into how we handle the
16 fee for service program, you know, across the board
17 for virtually every aspect of it. And it kind of
18 struck me, like what's happening with the QIO
19 program, both in the changes -- from a programmatic

20 standpoint, you know, it's becoming, I guess my

21 word's a beneficiary incentive, you know, like value

22 driven healthcare and some of the other things, you

23 know, much more concern about the beneficiaries.

24 A big change that I've seen is there is

25 much more of a vision across the board about how

1 things are going to be done and how things fit
2 together. You know, Barry and Terris have done a
3 great job of sort of putting together, you know,
4 taking the IOM study and all the other things you
5 know, throughout the government, the Department, OMB
6 and others, and sort of bringing all those ideas to
7 fruition in a meaningful way, you know, in the
8 contracts and the statement of work that are
9 competing now.
10 So I think that everything that's going on
11 in sort of my mind, it all kind of fits together as a
12 broader scheme here I think throughout CMS, around
13 competition, around how we administer our contracts
14 and how we administer our programs. And I think
15 what's going on in this conference here today, what's
16 going on with the changes in the 9th Scope of Work
17 and the QIO program seems to me to be very specific
18 with the broad overall range of changes and the
19 different visions that are our Agency has in how we

20 administer the Medicare program.

21 And I think it's really important, you

22 know, for this conference, that you have a good

23 understanding of the 9th Scope of Work, that you're

24 able to go back and you have the information you need

25 to prepare a competitive proposal, that in putting

1 together your proposal you really understand what the

2 government requirements are, that you've addressed

3 those requirements, and that you give us a

4 competitive proposal introducing all the efficiencies

5 you can into how you put things together.

6 So with that, those are just opening

7 remarks, but we really are, you know, we really

8 appreciate you taking the time to be here today. And

9 I know my staff, Brian, Naomi and others have put a

10 tremendous amount of work into it, as have the OCSQ

11 staff and I really hope you benefit from it. I think

12 Naomi now has a couple of words to say also by way of

13 introduction. Thank you very much.

14 MS. HANEY-CERESA: Good morning. I would

15 like to welcome all of you here today, as everyone

16 else has before me, and to let you know that we

17 really do appreciate your participation in this

18 pre-proposal conference.

19 I am the contracting officer for the 9th

20 Statement of Work Quality Improvement Organization

21 contract, and to begin the pre-proposal conference

22 I'm going to start off with some housekeeping and

23 some process type discussion.

24 First of all, as you all are probably

25 aware, there are some cell phones in the audience

1 that we don't really want to listen to. So if you

2 didn't have an opportunity, please shut them off at

3 this time. And if you need to take a call or make a

4 call, please step outside so that you don't disturb

5 the others at the conference.

6 Going down the list of things, we just

7 want to let you know that we're going to have a lot

8 of discussion today and you will probably hear a lot

9 more detailed information or information that could

10 be used to supplement what we have out on the street.

11 We want to alert you that nothing that is said in

12 this room or conveyed to you in any way changes the

13 solicitation that's on the street. We will make

14 changes to that solicitation as necessary through the

15 formal modification process and that amendment will

16 be posted on FedBizOpps. So just to bear in mind

17 that the solicitation that is out there still is a

18 solicitation even though we're having the conference

19 today, and any further changes will be made through

20 that process for the entire public to see.

21 If you haven't registered for the

22 conference and you've come into the room and you

23 didn't pass by the registration desk on the outside,

24 please make sure that you register at a break time,

25 catch somebody and make sure that you get your

1 information listed as actually having attended the

2 conference.

3 We have one hard copy attachment to the

4 solicitation that's not available on FedBizOpps and

5 we do have hard copies of that attachment here. So

6 before you leave today, please see me at the

7 registration desk at a break time and I will make

8 sure that I get you a copy. And we're not going to

9 give out duplicate copies of that attachment, so as

10 we give you one, we're going to record that we gave

11 it to you and we would encourage you make sure that

12 you take that back to your proposal development team.

13 And if we receive other written requests for that

14 attachment but you've already received one, it might

15 be a challenge for us to get you a second one,

16 because we're trying to conserve on paper and FedEx

17 dollars.

18 I want to let you know that we are having

19 the pre-proposal conference transcribed or recorded,

20 and we will be having a transcription of that. We're

21 going to try to post it on FedBizOpps as much as

22 possible, we don't know the length of it at this

23 time, so we will try to get that information out to

24 you. So stay tuned on FedBizOpps for some

25 information relative to the transcription of the

1 conference.

2 We're going to ask that you not ask any

3 questions throughout the discussion of the

4 conference. We're going to keep things rolling

5 along, but we will have an opportunity for you to

6 write down your questions and to deposit them in

7 boxes, question boxes. Regan, do we know where the

8 boxes are going to be?

9 SPEAKER: They will be outside the door.

10 MS. HANEY-CERESA: Please hold your

11 questions and write them down.

12 We know that you're going to run into a

13 lot of CMS staff and run into the presenters at

14 breaks and at lunch time, and in order to protect the

15 integrity of the process for the competition, we're

16 asking you not to ask these individuals questions

17 related to the RFP. Obviously we want to give

18 everybody the same opportunity to see the information

19 and to get the same consistent information, so the

20 questions that we have deposited in the boxes, we

21 will try to answer as many of those later on in

22 another break session. If we don't get to answer

23 them all, we'll make them available in an amendment

24 to the RFP.

25 Going forward, I would like to mention to

1 you that we have some important dates in the

2 acquisition planning schedule.

3 Proposals are due from our renewal QIOs at

4 least at this point in time on February 14th. The

5 proposals for the competitive solicitation will be

6 due on March 11th. As you have already heard, the

7 9th Statement of Work is expected to start on August

8 1st, and that is a firm date, and special projects

9 will begin August 1st as well.

10 Just to let you know, we're anticipating

11 the award of a cost plus award fee type contract with

12 some cost plus fixed fee elements to that contract.

13 If you have any other questions today or

14 you need assistance, you can seek me out, you can

15 seek Brian Habbel out, and Brian, you may want to

16 stand up so they will know what you look like for

17 those in the audience that don't know you, and we

18 will be glad to help you in any way that we can. If

19 you want to contact me, my telephone number is

20 410-786-1607. My e-mail address is

21 naomi.haney-ceresa@cms.hhs.gov.

22 We're going to turn it over now, we have a

23 number of different presenters for you from the

24 technical side of the house. Dr. Paul McGann is

25 going to speak to you on the overview of content and

1 framework for accountability. Mr. Terris King will
2 be back to talk to you about reducing healthcare
3 disparities. Tom Kessler will be talking to you
4 about beneficiary protection. Elizabeth Donohoe will
5 be talking to you about patient safety. Linda Smith
6 will be discussing prevention themes. Doug Brown,
7 patient pathways and care transition. Dr. Lisa
8 McAdams, how CMS manages the QIO program. Cynthia
9 Wark will be talking to you about approaches to
10 information technology for the 9th Statement of Work.
11 Alfreda Staton will be discussing eligibility
12 requirements and governance. Brian Habbel will be
13 discussing conflicts of interest. And then we will
14 be back to Dr. Paul McGann again on valuable contacts
15 for contracting and subcontracting opportunities.
16 Thank you and enjoy the day.
17 DR. MCGANN: Thanks, Naomi. I would like
18 to add my welcome to everybody else this morning, we
19 really appreciate you being here. I spent most of my

20 weekend reading your 3,000 questions that have

21 already been submitted and I want to congratulate you

22 because it was one of the more value experiences I

23 have had over the last year. You're a very dedicated

24 and extremely intelligent group of people and your

25 questions have already helped us, we met earlier this

1 morning to talk about a lot of this. So thank you

2 very much and we hope that today will be another good

3 example of interaction.

4 So if we could go to my overview, I really

5 in the 20 minutes allotted to me want to do two

6 things this morning, and they are the first two

7 things on that slide. I want to talk to you about

8 what Barry was talking about, that there are some

9 things new in the QIO program from all previous

10 scopes of work. And that real fundamental new thing

11 is the framework for accountability. And because

12 that's so new and so important, I'm going to spend

13 the first ten minutes of my talk outlining what we

14 see now as our new framework for accountability.

15 And then because we're going to spend most

16 of the rest of the gay on the details of the content,

17 and I'm sure every single person in this room has

18 read every page of the RFP, I'm going to go lightning

19 speed through an overview of what the content is,

20 most of which isn't new, but I want to do that to put

21 it all in context, because you're going to hear a lot

22 of details from a lot of technical people the rest of

23 the day, and I know especially for the CEOs in the

24 room, it's often helpful to have a broad overview to

25 put every everything in perspective. Throughout all

1 these talks, both the first one and the second one,

2 we're going to emphasize those three points.

3 Both Barry and Terris talked about the

4 business model. This is not an academic model. I

5 came from academia and I describe the 7th and 8th

6 Scopes as academia. This is fundamentally a business

7 model in running the contract, I'm going to mention

8 that many times.

9 I want to recognize explicitly the

10 importance of competition and efficiency and I think

11 Rod alluded to that already. Competition and

12 efficiency we believe has really been built into this

13 RFP.

14 And then you can't really achieve any of

15 those business objectives without a good measurement

16 system, and we think we have a much better

17 measurement system than we've ever had before.

18 Why are we doing all this? Well, our

19 shared goals here in the end are to help providers

20 prevent illness, decrease harm to patients, and

21 reduce waste in health care. That's why I came to

22 CMS and that's why all of you are members of quality

23 improvement organizations. We want to help the

24 beneficiaries.

25 And my last slide is going to turn full

1 circle around and show you that with this new
2 emphasis we're actually able to calculate and tell
3 our Department and OMB in quantitative terms if we're
4 successful with this contract, how we're actually
5 going to help the beneficiary in the end.
6 The framework for accountability really
7 has three main parts to it. The first is that the
8 clinical themes based on the evidence were really put
9 not into an academic model but a business model. The
10 second is that for all the measurable outcomes that
11 we have, we have a very good measurable outcome
12 system, we're linking constantly the basic points of
13 the contract to evidence-based interventions. And
14 the third, which moves back to some things Barry was
15 talking about in terms of criticism of the program,
16 is that we spent a lot of time addressing the
17 attribution issue that he referred to. We haven't
18 solved the attribution issue but we've come a long
19 way from the last Scope of Work. Next slide.

20 So the business model for management,

21 what's that all about? Well, most of you in the room

22 know a lot more about business than I do, but in my

23 application and the technical team's application of

24 quality improvement measurement to the world of

25 business and the framework of accountability, we used

1 these three principles. First of all, we want to
2 focus resources; we don't want to rate a generic one
3 size fits all contract and just distribute it across
4 53 states and territories and try to cover statewide
5 everything for everybody that lives in the state.
6 We've taken a very different approach, we're focusing
7 our resources, and there's many, many examples of
8 that you're going to see today.
9 The second one is that we try to extend to
10 allocate the most resources to the most capable
11 organizations, and that's just another way of saying
12 the business principle of competition.
13 And finally, we've got a measurement
14 system that isn't this baseline remeasurement that
15 we've seen in previous scopes of work but it's a
16 measurement system that keeps on trucking, and keeps
17 on clicking every month, every quarter for 36 months,
18 and never ever lets up. Next slide.
19 This linking of interventions to outcomes

20 is a very, very important part that we haven't done

21 very well in the past. It starts with our

22 outstanding measurement system but it doesn't end

23 there.

24 The standardized set of interventions,

25 most of which is built on work that has been done in

1 the 7th and 8th Scope of Work and a lot of which is
2 currently done by MEDQIC, gives a standard set of
3 interventions that will apply to each of these
4 measures. Probably the best delineated in the
5 contract now in the RFP can be found in the care
6 coordination and care transition theme. I urge those
7 of you who are working on other themes to actually
8 read that measurement system because it really
9 analyzes what I'm talking about here.
10 The third point on that slide is that
11 QIOs, you the contractors need to work constantly in
12 every one of the 36 months of this contract to
13 constantly link the actions that you're doing, the
14 interventions, to the measurement system that we've
15 created.
16 And then finally, you're going to hear
17 from Dr. McAdams from our Dallas regional office
18 about the actual details of the continuous
19 monitoring, how does that work, what role do the

20 project officers and science officers play. Lisa is

21 going to cover all that. Next slide.

22 Very quickly, I just want to mention what

23 we have done for attribution, we're not claiming it's

24 the final solution, but I'd be remiss if I didn't at

25 least mention it. Attribution was a big, big subject

1 in the IOM review and instead of previous scopes of

2 work where it was really hard for us to say how QIOs

3 selected providers that the would work with, we've

4 taken an opposite approach here where CMS is choosing

5 the participants that QIOs can work with using

6 specified criteria ahead of time. A lot of this is

7 exemplified in the patient safety theme with the

8 so-called J-17 attachment and we're going to be

9 talking about that later today.

10 I've already mentioned the use of

11 standardized interventions disseminated with the help

12 of support contractors, we'll mention that later in

13 the day. Several themes, care transition, care

14 coordination and prevention among them, make the

15 first use to my aware of attempting to do what we say

16 on the academic side are matched control group. Now

17 the pure scientists among you recognize that these

18 truly aren't control groups in a scientific sense,

19 but whether you call them control groups or

20 comparison groups, we really tried very hard to put

21 that element into health attribution.

22 And then finally, careful management of

23 partnerships. There's a lot of use of campaigns in

24 big national organizations now and some of the theme

25 leads are going to talk to you about managing those

1 partnerships in a very careful way so that we get the

2 benefits of partnership but we don't give away

3 attribution. Next slide.

4 This is probably the most important slide

5 in the framework of accountability and it has to do

6 with contract monitoring. Instead of previous scopes

7 of work where we had a 28-month measure at the end of

8 the contract, we now have both 18-month, that is

9 midpoint of the contract, and 28-month milestones

10 specified quantitatively in advance. All the theme

11 leads are going to talk to you about what those mean

12 exactly in their theme. The 18-month milestone is

13 put there to gauge progress of the contract, and it's

14 also put there to make significant decisions should

15 the milestone not be met at the midpoint of the

16 contract. Next slide.

17 Those decisions are kind of summarized

18 here. Dr. McAdams is going to go into that in much

19 more detail than I am, but just look at that last

20 bullet point there. It is possible and the contract

21 language allows CMS, should the 18-month milestone

22 not be met, to redirect contract funding as a

23 consequence of failure to meet those expectations.

24 We're going to spend a lot of time talking about that

25 and since it's so new, I expect there will be a lot

1 of questions.

2 So, the next slide summarizes the

3 framework for accountability. We this time have

4 individualized contracts and proposal review so it's

5 a very tailor-made scope of work. We're focusing

6 assistance in those areas of the country and to those

7 providers who need it the most. We're introducing

8 competition to the extent allowed under current law,

9 even for the core work. We've introduced the concept

10 of subnational contracting, which we will get into

11 more detail later, and as Dr. McAdams will describe

12 to you, we're implementing very close, much closer

13 than ever before contract monitoring and management

14 of poor performance, including the 18-month

15 milestone.

16 So that's a whirlwind summary of the

17 framework of accountability. I want to switch now to

18 an even faster whirlwind summary of the content, and

19 you will hear about all this in detail over the next

20 few hours.

21 As you all already know, there are four

22 themes. Some people have expressed confusion at the

23 designation in the RFP document so I put the little

24 6.1, 6.2, 6.3 and seven series after the names as we

25 go through here. But just like we announced months

1 ago, there are four themes in this scope of work.

2 They were formatted with help from our friends OAGM,

3 to help us put the proposal out, the RFP out in such

4 a way that it could be reviewed in an efficient

5 manner. Next slide.

6 If you really want to understand this, say

7 you're a CEO in the crowd or you want to have sort of

8 the high level view, 50,000-foot view of what this

9 RFP is about, because it can be daunting and

10 complicated if you get into the weeds, what you do is

11 you start at the top of this slide, and I have three

12 or four slides like this with that green arrow which

13 shows the 50,000-foot view at the top and as the

14 arrow goes down, you get into more and more into

15 detail. I'm going to stop at the 59 total measures

16 but you can keep going, and that arrow goes all the

17 way down to the floor there and as you hear from the

18 theme leads, you will see more details.

19 But it's four themes, I actually think

20 there are five themes given the importance of

21 evaluation, and those themes can be divided into ten

22 groups or components. And then within each of the

23 components there are final outcome measures that will

24 enter our information system. There are 44 of those

25 final outcome measures and then if you add the

1 18-month first evaluation period measures, there's an

2 additional 15 measures, to bring it to a total of 59

3 measures in our management information system. As I

4 say, if you want to keep going in the weeds beyond

5 that, you need to talk to theme people, but they can

6 get into the scheduled deliverables, aggressive

7 monitoring, and the people that are running the

8 individual themes should in fact do that. Next

9 slide.

10 So let's get from the four themes to the

11 ten components, It's possible to list all ten

12 components on one slide and that's shown here. I'm

13 not going to enumerate them because you're going to

14 hear about them later, but there they are all on one

15 slide. So if you do need to talk about the 9th Scope

16 of Work components, they do fit on one slide.

17 If you want to go one further level down

18 from there into the measure slide, measure level, you

19 cannot fit it all on one slide. So I'm counting them

20 up here and I think there are four slides to

21 compactly do the measures, and I'm just going to rip

22 through them fast, you're going to hear about all

23 these measures in greater detail later today.

24 So the next slide are the four measures

25 for beneficiary protection, the slide after that are

1 the 14 measures in patient safety; for ease of

2 discussion and so they would fit on this slide, I

3 have grouped those 14 measures into eight categories.

4 Just as one example, look at category six, the SCIP

5 infection measures, there are six measures clustered

6 under that one line. That's why the numbers don't

7 add up to 14 there, because I clustered them for ease

8 of discussion.

9 If you want to understand prevention go to

10 the next slide, where you have the three components

11 of prevention, the core prevention, the focused

12 disparities work, and the CKD work. The last two,

13 they're subnational and the contracts have 7.X

14 designators next to them, or 6.X, and there are ten

15 individual measures across the prevention theme.

16 And the final slide of this series is the

17 care transition theme, and the care transition theme

18 deploys ten very deeply thought-out measures. I have

19 clustered those ten measures into five groups, they

20 will be reviewed with you later today by Doug Brown,

21 but you'll see at the top I posted the

22 rehospitalization rates, which is the raison d'etre

23 of this theme. So your rehospitalization rates are

24 what you're trying to reduce, the other measures

25 support that, and we have four different types of

1 rehospitalization measures in that theme.

2 So to summarize then, go to the next

3 slide. As I've told you, we have 44 final outcome

4 measures, 15 more 18-month measures, and all 59 of

5 those measures will be in our management information

6 system.

7 Now in the couple of minutes I've got

8 left, I'm going to go even faster and if you want to

9 ask questions about any of the subjects on this next

10 slide, there are six of them there, by all means

11 write down a question and put it in the box. So I

12 just have one or two slides of each of these and I'm

13 just going to show them to you because you have

14 copies of them right there.

15 The first topic is what is new in the 9th

16 Scope other than the framework of accountability?

17 That's what's new in beneficiary protection, and

18 really it all comes down to beneficiary protection.

19 We're doing a much better job than we've ever done

20 before of increasing a linkage between extensive case

21 review in either every state. Every state has

22 Medicare beneficiaries who have things to say about

23 our system, and as a program we need to get better at

24 hearing what our beneficiaries have to say, and then

25 we have to link what they say about our program, just

1 like we link your questions to the contract, we have

2 to link what the beneficiaries say about our program

3 back to our quality improvement work. We don't do

4 that very well right now and the aim of the 9th Scope

5 of Work is to do that better. Next slide.

6 The other themes have new work that's

7 listed there measure by measure. It's kind of a

8 fundamental change in philosophy that better

9 acknowledges new public health problems such as

10 antibiotic resistant infection, and I'll let you read

11 that at your leisure.

12 Going on to the next slide, matching the

13 scope to the resources that are available, that's a

14 problem that every government program has, and I dare

15 say every business has throughout the United States.

16 The way we've approached that in the 9th Scope of

17 Work that we haven't done well before, but we think

18 we've done very well in the 9th, is to declare

19 certain projects at national implementation levels;

20 beneficiary protection is a great example of that.

21 There are other parts of this contract

22 that are at what we call a subnational implementation

23 level. That allows us to increase competition so

24 that we deploy those resources which might be a

25 little more complicated themes only in those areas or

1 to those contractors who demonstrate in their
2 proposal a very high likelihood of success in
3 accomplishing the stated goal. CKD, focused
4 disparities and care transitions theme, the whole
5 theme, are examples of that.
6 And then finally as we prepare for the
7 10th Scope of Work, the most potent deployment of
8 these resources would be in the special projects
9 realm, and that is the subject of the next slide.
10 I'm not going to read it, but basically the focus of
11 special projects in any scope of work is actually
12 mostly to prepare for the next scope of work. So the
13 special projects that we're having in the 9th are
14 going to have very high levels, very high quality
15 evaluation criteria, they're going to try to start
16 them all, as Naomi said, on August 1st, and we're
17 going to try to have all the results available and
18 disseminated to the QIO community so that they can be
19 very useful as we develop the 10th Scope of Work.

20 The next slide summarizes the current

21 concept around support contractors and I'm sure we'll

22 have a lot of questions, I'm not going to dwell on

23 it. Suffice it to say that in preparation now we

24 have four contracts for competition corresponding to

25 each of the four basic themes. We also have four

1 contracts in preparation on the left-hand column for
2 the cross-cutting themes, and one for communication.
3 Next slide.
4 Unlike in the 8th Scope of Work, these QIO
5 contracts, that's one of the things that is taking us
6 a while, are going to have top level high quality top
7 notch evaluation systems, including the 18-month
8 midpoint evaluation. And we're insisting on that and
9 you'll see when the RFPs come out, they will be much
10 different than any of the support contracts in the
11 previous years.
12 Evaluation is really, really important to
13 us this time, which is the subject of the next slide.
14 The next two slides are on evaluation, there's two
15 types, contract evaluation as we've already covered,
16 and program evaluation. Next slide.
17 The program evaluation is going to be a
18 separate independent contractor. The IOM talked a
19 lot about this not just in their last report but in

20 their previous two reports. This time it's going to

21 happen and so the deliverable for all QIO national

22 program evaluations will be a report of how effective

23 we are at a national level in the year 2011 at the

24 end of the 9th Scope of Work based on all the

25 measures that I've described to you.

1 And so to conclude, my last slide is what
2 I promised you, and what Rod said too in his opening
3 remarks. It's really all about the beneficiaries.
4 And the reason we were successful as OCSQ and OAGM
5 under Barry and Terris's leadership as we approached
6 OMB and asked for funding at this level for the 9th
7 Scope of Work is because of our prespecified
8 measurement system. We were able to link it to the
9 beneficiaries by the numbers that you see on this
10 slide. This is what we're trying to accomplish in
11 the next three years. We have a shared goal that's
12 focused on the beneficiary and we hope as we work
13 through the contract details the rest of the day and
14 answer your questions and interact and learn from
15 each other, that many tens of hundreds of thousands
16 of beneficiaries will experience the benefit of all
17 of our hard work three.
18 Thanks very much for your attention and
19 we're going to turn it back over to the deputy OCSQ

20 director, Mr. Terris King.

21 MR. KING: I appreciate it. I'm going to

22 stand in the center, and this is both symbolic and

23 strategic. It's symbolic because with health

24 disparities, this is really what you have to do.

25 This is about being in the midst of the community,

1 this is not a top down process. This is about
2 working in the community to increase health literacy
3 of the underserved communities that exist so that
4 everything is tied to a business model, everything is
5 tied to a clinical outcome, so that we improve the
6 health of those who have diabetes. That's what it
7 is. I mean, it's really basic.
8 Now it's symbolic because I want to speak
9 what this is about. This is not about operating with
10 CEOs and clinicians at the top level. This is about
11 community organizations, the real challenge, getting
12 people to come out and be trained so that we train
13 them how to change their lifestyle, how to eat
14 differently, how to manage your meds differently so
15 you get better. So that we see in a claim that
16 hemoglobin A1c tests have been done, LDL has been
17 done to check your cholesterol, blood pressure has
18 been taken, eye examinations have been taken.
19 Because if that is done, then the likelihood is

20 there's an action plan in place for you to get

21 better. So I want you to see that.

22 It's strategic because I figured if I

23 stood in the middle I could see the slides a little

24 better.

25 (Laughter.)

1 And it's also strategic because I'm not
2 going to take a lot of time with the slides. What I
3 just told you is it. That's it, so we're going to
4 make up for lost time, it's just that simple.
5 Now we've already seen a top rate interest
6 in what we're doing before we start. A week or so
7 ago we were called to the Senate office building to
8 talk to a bipartisan committee, senators headed by
9 Senators Kennedy, Hawkins and Obama, the Health
10 Education and Labor Pension Committee, who is looking
11 at a bipartisan bill to impact this issue of health
12 disparities. Dr. McGann and I and Georgetta had a
13 chance to go and talk about what we are doing
14 already, what we've done in the 8th Scope of Work,
15 what you've done in terms of sensitizing providers,
16 what Dr. Malone and company are doing in Florida in
17 our special study that speaks to the issue of health
18 disparities, and I encourage you to talk to him, and
19 what we know can be done because we've seen this

20 already operate. So you cannot tell us it will not

21 work and it cannot work because it can.

22 We have folks here from the Agency on

23 Aging that I'd like to stand, just so they know who

24 you are, so they can see. These are the kinds of

25 folks that I would like you to talk to. Dr. McGann

1 and I traveled with them to Pennsylvania -- thank you
2 both, David -- and we saw in Germantown this kind of
3 process work, where they were working at a community
4 level to train people on how to get better in terms
5 of diabetes and they had a waiting list of people who
6 wanted the training. And it wasn't they were giving
7 them so much money and incentive, it's just that it
8 was at a ground level, people who quite honestly had
9 not heard of the QIO program were willing to work
10 with them, people, a line of people to get this done,
11 and they were giving us testimony on how well they
12 had improved, weight loss, cholesterol down,
13 everything better, people with canes and walkers.
14 DR. MCGANN: One lady lost 75 pounds.
15 MR. KING: This can be done, so there's no
16 doubt about that. So this isn't original, we're just
17 taking a model that we've seen in other places, put
18 it together and say QIOs, go at it. We have people
19 here who are accustomed to working in communities

20 like yourself, not to say you're not, but at a ground

21 level. There are contractors here who are

22 accustomed, trusted sources, accustomed to working in

23 the communities with Asians, Native Americans,

24 African Americans and Latinos. That's who this is

25 focused on.

1 We didn't pull this out of the sky when it
2 comes to diabetes. AHRQ has told us that this is one
3 of the greatest killers in terms of chronic diseases
4 in the African American community. So we have reason
5 to do this.
6 Now we can flip through the slides, just
7 take a look at them. This is not just an EDC person,
8 in every part of our process one of the big issues is
9 finding them. So where you see it in every diabetic,
10 that's one issue, but in the other themes it's about,
11 and that's what that bipartisan committee wanted to
12 talk about. Our data doesn't always speak to this
13 issue of where are those who suffer from disparities.
14 So this is about can we find them, and so that's what
15 that slide is basically about, finding them in
16 patient safety, finding them in care coordination,
17 finding them with pressure ulcers and restraints. We
18 have those individuals who suffer from disparities in
19 terms of how restraints are being used for the

20 underserved versus not. Finding that data. EDC is

21 about every diabetic counsel, so maybe you said not

22 only do we find them but here's an intervention in

23 place to make the clinical outcomes improve.

24 All the other slides, data, find them,

25 that's what's this is about.

1 Next slide, that's the summary. That's
2 it. That's it. That's it. Simple. Find those who
3 suffer from health disparities. Every diabetic
4 counsel is about putting together an intervention to
5 change, to transform, to get them better, using
6 community health workers, using certified diabetes
7 experts who are paid already as clinicians by CMS to
8 make them better. That's it. Very simple.
9 Look. One of the lessons we learned from
10 the current scope of work is don't try to get
11 complicated. Don't try to make it complicated. Make
12 this simple enough where we've got it, you know
13 exactly what we're looking for you to do.
14 The other issue, are there disparities in
15 beneficiary protection? Are there disparities in
16 complaints that are made? Are there instances of
17 people complaining about quality of care issues where
18 imbedded in those complaints are issues around
19 disparity, racial or ethnic issues? Or one of the

20 main disparities that we know in the other themes we

21 can attack is socioeconomic disparities. One of the

22 things that I've learned is one of the greatest

23 disparities exists in states like West Virginia,

24 socioeconomic. So in those areas we have to be able

25 to find and then build a model through EDC where we

1 attack this issue.

2 So Tom Kessler is going to come and talk a

3 bit about our beneficiary protection area and what

4 we're going to do in that particular area, not just

5 to grow in terms of what we're doing with

6 disparities, but broader than that, what that entire

7 theme is about. So he'll give you some perspective

8 of what we're doing in the beneficiary protection

9 area, but I hope I've given you a clear indication of

10 what we're looking for in terms of the cross-cutting

11 theme of health disparities in the 9th Scope of Work.

12 Thank you.

13 MR. KESSLER: Good morning. One of the

14 first things I want to do is introduce Donna

15 Williamson. Donna Williamson is a registered nurse

16 and she has 20 years of experience as a nurse. She's

17 also going to serve as the government task leader for

18 beneficiary protection. I of course am the theme

19 lead and I'm fairly new to the Office of Clinical

20 Standards and Quality. I actually came on board in

21 May and I have quickly learned that whatever the old

22 way was, we're certainly trying to make sure things

23 are innovative and done differently for the 9th Scope

24 of Work. One of the things I want to do in terms of

25 talking about the beneficiary protection theme is to

1 highlight some of the differences that we're going to

2 undertake so that we can really take this in a new

3 direction and make sure we're getting the most out of

4 beneficiary protection activities.

5 The first slide really goes over the basic

6 things that are in the statute, Section 1154 of the

7 Act actually talks about the fact that what we're

8 looking at here, whether or not items and services

9 are reasonable and necessary, whether the services

10 met acceptable standards of care, and then the last

11 would be whether the items and services proposed to

12 be provided in a hospital or other healthcare

13 facility on an inpatient basis, could these items and

14 services be effectively provided more economically on

15 an outpatient basis or an inpatient facility of

16 another type. So those are the three broad areas.

17 Now the next slide actually gets into what

18 we refer to as the mandatory, the statutorily

19 mandated activities. And these certainly,

20 utilization reviews and quality reviews are two

21 aspects of this, but really the ones that we're

22 focusing on are the appeals and those are what you

23 know as the Grijalva, BIPA and Weichardt appeals

24 processes where you go in and look at the

25 appropriateness of discharges from the various

1 settings, and that crosses over fee for service and

2 Medicare advantage. The Weichardt is the newest of

3 course, and that certainly has been a process that

4 seems to be working well so far based on what we're

5 observing. The goal there was to make sure the

6 beneficiaries were getting adequate notice and it

7 does appear that through the data we're seeing, that

8 beneficiaries are now getting those notices to tell

9 them about their appeal rights, et cetera, through

10 the Weichardt process, and that began July 1st of

11 2007.

12 The other is the quality of care reviews

13 and that is of course the QIO's obligation, to make

14 sure that beneficiaries are getting an appropriate

15 level of care and again, that crosses over between

16 fee for service and Medicare advantage. The quality

17 of care reviews is the main focus that we're going to

18 take in terms of trying to get better results out of

19 the information and the activities that we conduct

20 through beneficiary protection. The quality of care

21 issues come directly from the quality of care

22 reviews, but they also can come from other reviews

23 where we actually identify quality of care issues.

24 Now one last note. I actually don't list

25 sanction activities here, that of course is on the

1 next slide for whatever reason, but that actually is
2 a statutorily mandated activity, so just make note of
3 that. It's not as if we are, you know, we no longer
4 have the sanction activity as a mandatory
5 responsibility. Next slide.
6 The other case review activities that
7 we're undertaking are the ones listed here basically,
8 but just a couple of things to point out. Our focus
9 is going to be on the quality improvement activities
10 and in fact I'll get into even more detail about
11 those later on because that's going to be such a big
12 focus of the 9th Scope. And some of you I see in the
13 audience actually, I also saw you at QualityNet and
14 that's a topic that we went over at QualityNet, so
15 some of this may actually sound familiar to you when
16 we get into the specifics. But it's really,
17 basically we're trying to figure out a way to better
18 utilize the data that we get out of these quality
19 improvement activities.

20 In addition, we are going to increase the

21 emphasis on collaboration with CMS contractors

22 because we want to make sure that we have effectively

23 maintained levels of communication, and that we're

24 using that information to the best we can.

25 And then one other difference that I want

1 to note under the 9th scope, it's not a new activity

2 but it is new to beneficiary protection programs, two

3 items of support for the reporting hospital quality

4 data for annual update programs, and that will now

5 also be included under the beneficiary protection

6 program, so just make note of that. That is

7 something that is new. Next slide.

8 As Dr. McGann mentioned, one of the

9 biggest things that we're going to be looking at is

10 measurement, and we want to really try to make sure

11 that we have definitive measures. While there's not

12 going to be an 18-month hurdle associated with

13 beneficiary protection, really our goals are still

14 the same in terms of making sure that we can define a

15 process where we can actually evaluate the work, the

16 effectiveness of the work in an ongoing manner, and

17 so that we can actually identify areas that are

18 problematic. We're working hard to make sure that we

19 have that capability built into the 9th scope.

20 Of course the timeliness of reviews is

21 going to be a primary focus. Certainly there are

22 various time frames that we have to adhere to because

23 of the regulatory processes that are covered by the

24 beneficiary protection program, so that's a key. We

25 have to make sure that we adhere to those time limit

1 requirements, but certainly we're going to make sure

2 that we also look at whether or not beneficiaries are

3 satisfied with the complaint process, that is an area

4 that we definitely want to concentrate on and we will

5 do that through the 9th scope measurement. We also

6 want to make sure, because we're putting so much

7 emphasis on the quality improvement activities, that

8 we have definitive mechanisms in place to make sure

9 that these quality improvement activities are being

10 utilized to the best extent that we can. Next slide.

11 Oh, okay. What we've actually been

12 talking about and I believe Terris actually mentioned

13 it, is linking case review to quality improvement.

14 This is where the system-wide changes actually come

15 into play and that's something, again, that we first

16 started talking about at QualityNet and trying to

17 just make sure that we're talking these situations or

18 these systems changes that are out there and

19 utilizing them to the best extent that we can. And

20 really what we're focusing on is that the QIOs use

21 not only the advocacy data that's collected in terms

22 of doing quality of care reviews and you know,

23 complaints, appeals, et cetera, but that they are

24 also taking the results, the specific factual

25 circumstances of the individual quality of care

1 reviews and seeing how best to utilize that

2 information to make improvements in the quality of

3 healthcare.

4 Now the system-wide change that I

5 mentioned, the way that we're defining it is it's a

6 change which normally has an impact beyond an

7 individual beneficiary or provider, results in a

8 tangible improvement to a system or process, and

9 improves the quality of healthcare for Medicare

10 beneficiaries. So we're really looking for those

11 changes that go beyond just that single beneficiary,

12 and want to make sure that we're taking those

13 circumstances and seeing if they could be applicable

14 to other providers, you know, maybe even other

15 settings, and you know, making changes that are

16 really going to have broad-based improvements in

17 health care.

18 One of the things that we're focusing on

19 is that the QIO must, you know, develop a proviso in

20 the implementation of these system-wide changes so

21 that the positive impact of these changes can

22 actually be measured over time. Certainly to make

23 the change is one thing, but is that change having an

24 impact such that three months down the road we're

25 seeing a better result? You know, if it's something

1 related to medication errors, there's been a decrease

2 in medication errors. So we're really looking for

3 those tangible changes that we can actually measure

4 over the course of time.

5 Now these system-wide changes, they're

6 going to be developed through the analysis of the

7 individual quality of care concerns. You can also do

8 them through the trending and the data analysis,

9 collaboration with the state survey agencies,

10 intensified review or in fact, it's one of those

11 things that you can actually, if you're reaching out

12 to providers, having discussions with them, if there

13 are things that are identified as a result of those

14 collaborations with providers, certainly that's

15 something that you would want to look into to see if

16 there are improvements that can be made.

17 And one last piece on this slide is that

18 the Quality Improvement Organization Support

19 Contractor, QIOSC will play a role in assuring that

20 we have the most effective outcomes with regard to

21 these system-wide changes. The QIOSC will actually

22 still serve some of the traditional roles of the

23 QIOSC in terms of coordinating responses to policy

24 questions, et cetera, and in training, but they are

25 also going to be involved in these quality

1 improvement activities, again, with the focus of

2 making sure that we're getting information out there

3 to be shared and utilized by the community.

4 Overall our goals as I've mentioned, the

5 focus goes back to these quality improvement

6 activities. And while we certainly know that we have

7 a ways to go, we want to get to a point where we are

8 seeing that quality improvement activities are being

9 generated for pretty much all confirmed quality of

10 care concerns. And in fact when we look at these

11 system-wide changes, we want to get to a point where

12 we're actually -- we can actually demonstrate through

13 the data that we're having one of these system-wide

14 changes for about every 50 quality of care concerns.

15 So this is something that we're really going to be

16 focusing on for the 9th scope.

17 And again tying back to QualityNet, one of

18 the things we taught there was, you know, in

19 discussing with different QIOs since I came on board

20 in May, a lot of the QIOs were doing some great

21 things in terms of making system changes. But when

22 we had discussions with them about what did you do

23 with that, did you tell any other providers, did you

24 tell anybody in your state at all, for the most part

25 the answer was no, that in fact the change was made

1 for that system and that individual hospital, and it

2 didn't go beyond that. And it just seems that we

3 could be doing quite a bit more there to make sure

4 that if we have this great system change that we've

5 identified, and again, we can put that phrase on the

6 front of it that says the QIO facilitated this system

7 change, then we could actually take those

8 circumstances and begin to expand and build on them

9 to show that we are having a positive impact on the

10 quality of health care.

11 And I believe next, is it Linda? Linda

12 Smith is actually going to come up and talk about the

13 prevention theme.

14 MS. SMITH: Good morning. My partner,

15 Dr. Eugene Freund was not able to be with us today,

16 he's in the Public Health Service and he was

17 deployed, so we will miss him but his spirit will be

18 here just the same. Next slide.

19 Through this presentation what I will do

20 is provide an overview of the prevention theme,

21 briefly explain the evaluation measures, and discuss

22 key aspects of the monitoring and accountability

23 framework. Next slide please.

24 The goal of the prevention theme is for

25 QIOs to work with physician practices using

1 evidence-based interventions to prevent disease and
2 to slow disease progression, using cost effective
3 approaches. There are three topics within the
4 prevention theme which, you've heard quite a bit
5 about some of them. The first topic is the core
6 measures, which include mammography and colorectal
7 cancer screening, and influenza and pneumococcal
8 vaccinations. Medicare provides coverage for
9 prevention services for these measures; however, the
10 data shows that these prevention services are
11 underused. The second topic within the prevention
12 theme is chronic kidney disease and the third is
13 disparities within the Medicare population with a
14 diagnosis of diabetes. Next slide please.
15 One of the interventions the QIOs should
16 be using to improve prevention is through the use of
17 electronic health records. Quality improvement
18 organizations in the 9th Scope of Work will work with
19 physician practices who have already implemented

20 electronic health records and who have already

21 implemented care management processes. In the 8th

22 Scope of Work we spent a lot of time with physician

23 practices looking to adopt electronic health records

24 and to use them within their practices.

25 Additional within the 9th Scope of Work,

1 as Dr. McGann alluded to earlier, there will be

2 comparison groups, the QIOs will recruit practices

3 who meet the CMS eligibility criteria and CMS will

4 match these two groups. The QIOs will provide

5 intense interventions in one group called the

6 participant and practice group, and the other is

7 considered a nonparticipating practice group, which

8 will be used for comparison. Next slide.

9 On this slide there are listed two

10 resources that will be very valuable to you to

11 provide background information on some encouraging

12 interventions. The Rand study simplifies the

13 evidence from the scientific literature related to

14 the four core prevention measures. This report

15 provides background information on the effectiveness

16 of certain interventions, identifying the most

17 effective to the least effective.

18 A second resource is the Doctor's Office

19 Quality Information Technology project referred to as

20 DOQ-IT. Under the 8th Scope of Work we tried to

21 focus on providing technical assistance for the

22 physician practices to adopt the EHR and use them for

23 implementing CMS policy. Electronic healthcare

24 records have been shown to improve communication

25 between patients and providers and also gives the

1 patient better access to timely information and
2 improved physician office education. DOQ-IT
3 University is a web-based tool to provide physician
4 practices support on assessment, planning and
5 implementation of the policy. DOQ-IT University is a
6 key resource for QIOs to provide education to their
7 participants.
8 In the 9th Scope of Work we will recruit
9 practices again who have already implemented
10 electronic healthcare records and who have already
11 implemented care management processes. That is quite
12 different from the 8th Scope. The recruited
13 practices in the 9th Scope will also agree to submit
14 and report data to CMS; that is one of the areas that
15 was problematic for the 8th Scope and it is critical
16 for the 9th Scope to be successful for this
17 particular theme.
18 A prevention theme support, contractors
19 will assist the federal community to help develop

20 additional treatments and interventions to improve

21 existing interventions. Research has shown that

22 multiple interventions are more effective in

23 improving the rates of screening and immunizations of

24 the Medicare population, including the underserved.

25 Next slide please.

1 Another resource is the MEDQIC web site,

2 which is the Medicare Quality Improvement Community

3 web site, and you can look under the tab entitled

4 physician services. You can find resources there

5 that include many prevention measures. To learn more

6 about CMS prevention services benefits, coverage,

7 billing, coding and reimbursement, the Medicare

8 network web site is the source of information. In

9 addition to the prevention services, educational

10 resources can be found on other CMS prevention sites.

11 Next slide.

12 So how will the QIOs evaluate their

13 ongoing measures? Recruitment of eligible practices

14 is crucial for success in this theme. QIOs will be

15 evaluated based on percentage of practices actually

16 recruited, percentage of practices that receive the

17 required post-recruitment training, and the

18 percentage of practices successfully reporting

19 quality data to CMS. Next slide.

20 Additionally, the QIOs will be evaluated

21 on the quality improvement rates for mammography and

22 colorectal screening, and influenza and pneumococcal

23 vaccination. Next slide.

24 A second topic which we have heard today

25 is disparities, and Mr. King has gone through this

1 topic very thoroughly. I just want to add a couple
2 more particularly as it relates to the prevention
3 theme. As Mr. King stated, the prudent intervention
4 for disparities in the population is the diabetes
5 self management education program. The QIOs must
6 work with community partners to facilitate
7 accessibility of that diabetes self management
8 education to beneficiaries, and the QIO is expected
9 to establish partnerships with primary care
10 physicians, certified diabetic educators and
11 community health workers. Next slide.
12 Again, the MEDQIC is a resource for
13 information and you can look under the tab entitled
14 underserved. And addition web site is the Health
15 Disparities Collaboratives web site. Again, as
16 Mr. King expressed, community and partnership are the
17 cornerstones to be successful with this particular
18 topic, so this web site will give you access to other
19 partners focused on community involvement. Next.

20 So for disparities the QIO will be

21 evaluated on four measures, the percentage of

22 practices recruited and the relative improvement

23 rates for hemoglobin testing, lipid testing and eye

24 exams. Next.

25 As Mr. King stated earlier, disparities is

1 a focused topic within the prevention theme. The
2 practices shall report to CMS data on the race,
3 ethnicity and ZIP code of its patient population.
4 The prevention theme support contractor will assist
5 with analysis of disparities for all the managers
6 under the prevention theme. Next.
7 A third topic under the prevention theme
8 is chronic kidney disease, also called CKD. As
9 stated by Dr. McGann, this is going to be an area of
10 focus studied throughout our program. CKD is an
11 optional competitive task. Any QIOs interested
12 should included their proposal at the time that they
13 submit their overall proposal for the 9th Scope of
14 Work. Next.
15 CKD is a worldwide public health problem
16 that is on the rise. Diabetes has become the most
17 common cost cause of blindness. Persons at the risk
18 of developing CKD are those with diabetes, high blood
19 pressure, cardiovascular disease, and a family

20 history of kidney disease. African Americans have

21 the highest overall risk for CKD, African Americans

22 develop end stage renal failure at an earlier age

23 than other ethnic groups, and the risk of these cases

24 are four times higher in African Americans and

25 American Indians or Alaskan natives as whites.

1 Therefore, the goal of the CKD task is to

2 take the incidents and decrease the progression of

3 CKD among the Medicare beneficiaries, specifically to

4 promote timely testing for nephropathy, to reduce

5 kidney disease due to diabetes, slowing the

6 progression of kidney disease in persons with

7 angiotensin converting enzyme inhibitors and

8 angiotensin receptor blocking agents, and to promote

9 early placement of arteriovenous fistulae in

10 individuals beginning hemodialysis.

11 So how would this be accomplished? The

12 QIOs will work again with community partners such as

13 the end-stage renal disease network, provider

14 associations, beneficiary representative groups,

15 community health centers, and other quality

16 improvement projects and practices to meet the goals.

17 They should focus on development and communication of

18 evidence-based clinical practices, provide

19 identification for beneficiaries, and work through a

20 collaborative model to effect system change. Next.

21 There are three evaluation measures for

22 CKD, relative improvement rates for the testing of

23 nephropathy, the use of ACE or ARB treatment in early

24 stage CKD, and the percentage of new dialysis who

25 begin dialysis with AVF access. Next.

1 You've heard senior management continue to

2 stress the need for QIOs to demonstrate attribution.

3 Throughout this scope of work we will require

4 quarterly reporting on the progress in these

5 activities to the theme management team, and you will

6 hear more about the regional office's part in

7 tracking this progress from Dr. McAdams. Next.

8 Monitoring. This slide just shows you

9 some examples of the ongoing monitoring requirements

10 that are expected in the 9th Scope of Work. The

11 successful QIO proposal will assure it meets the

12 contractual obligations, and examples of these types

13 of reporting requirements are shown here. The

14 purpose of this monitoring is to require these people

15 to stay on course. Next.

16 These are the required 18-month measures

17 relating to core measures. The QIO must have

18 recruited 80 percent of the participating practices,

19 90 percent of recruited practices must have received

20 initial post-recruitment education, and 70 percent of

21 recruited practices must be successfully reporting

22 data to CMS. Next.

23 For disparities, the QIO must have

24 recruited 80 percent of the participating practices

25 and 25 percent of the participating Medicare

1 population must be enrolled in the project. Next.

2 For chronic kidney disease the QIO must

3 demonstrate a four percent relative improvement rate

4 for the three measures. Next.

5 The 18-month evaluation criteria must have

6 been met in order for the QIO to continue their work.

7 If the QIO does not recruit sufficient participating

8 practices and beneficiaries early in the contract

9 cycle, there is the potential for failure to meet

10 data reporting requirements and to achieve success.

11 If the 18-month benchmarks are not met, the QIO

12 contract could be terminated or redirected. Next.

13 In summary, the prevention theme includes

14 core measures consisting of the mammography and

15 colorectal cancer screening, the influenza and

16 pneumococcal vaccination rates. This is a national

17 effort, as is disparities along with the directed

18 effort focusing on the diabetic as presented by

19 Mr. King, and also on CKD which is an optional

20 competitive effort. The successful recruitment of

21 practicees and of beneficiaries and effective

22 interventions are hallmarks of potential success for

23 the prevention theme.

24 The contact information for Dr. Freund and

25 myself are on the next slide and we look forward to

1 working with you. Thank you.

2 MR. KING: So here's what we will do next.

3 Within your package you have the information about

4 questions, there should be a sheet that looks like

5 this, a lined sheet within your package for

6 questions, okay, and there is a box outside the door

7 where we can place our questions. And then we will

8 come back later in the conference during lunch and

9 we'll answer the series of questions that you have

10 from today, from this morning. And then you will

11 have an opportunity again to fill this out for all

12 the issues that we cover after break towards the end

13 of the program and then you will have a chance to

14 turn those in, and there is another place later in

15 today's conference where we'll answer those

16 questions.

17 So you will have a couple of

18 opportunities, am I correct, Brian?

19 (Discussion off the record.)

20 MR. KING: There are four boxes out there,

21 the boxes are labeled by theme, so that will help us

22 in terms of being able to categorize and going

23 through the questions.

24 The other thing other than answering

25 questions is that while we're looking at questions

1 and answering those, that we would like you to do is
2 communicate with each other. We want to make sure
3 that some of you don't say, well -- we know this,
4 that there are people in the room as well as Agency
5 staff, and we're not endorsing, not endorsing any
6 company, but are there others here who are really
7 specialized and have experience in working at a
8 community level on the kinds of issues we're talking
9 about, particularly in the disparities arena. If you
10 are, stand. Great.
11 Because we know the QIO community has
12 experience with this, but there are others here that
13 are here for the purpose of getting to know you, so I
14 want you to go and at least see who they are by face.
15 So use your break time to turn in questions,
16 communicate with other entities. We're not endorsing
17 you. Communicate with other entities and that way, I
18 mean, this is one of the major purposes for doing
19 this, it's a couple-fold. Because everything we've

20 put forth in addition to what Dr. McGann said about

21 substantive questions, simplified process, minimizing

22 modifications, we want the processes to work. And so

23 whatever or whomever you can bring in the room that

24 can add to the experience that you already have, that

25 many of you already have, that can help us be

1 successful, and that's what we wanted to do today.

2 So with that said, is there something

3 else? Naomi?

4 MS. HANEY-CERESA: Don't forget,

5 attachment J-10-A is the only hard copy attachment to

6 the RFP that's not available electronically on

7 FedBizOpps, so to assist us in minimizing the cost of

8 getting you a copy of that attachment, I'm going to

9 go sit out at the registration desk, we have hard

10 copies. If you have an opportunity at this break,

11 stop by and pick up a copy; if you don't, we have

12 other breaks and we have lunch time, and so you will

13 have other opportunities. But we do want to get that

14 to you at this conference so we don't have to send it

15 out through Federal Express afterwards. Thank you.

16 MR. KING: All right. So with that said,

17 we know we do have, and Mary and Paul mentioned this,

18 the three or 4,000 questions that we got from the

19 renewals. We know the questions are due on February

20 5th, it's repetitive, but we have those questions.

21 We'll have some more questions today, we're not

22 fielding questions, put your questions in the box by

23 theme, or you can talk to us during breaks. You have

24 ten minutes for break, so thank you very much.

25 (Recess.)

1 DR. STRAUBE: We're going to go ahead and
2 ask people to take their seats immediately, or step
3 out in the hallway.
4 It's my pleasure, our next focus section
5 here is on the patient safety theme. This is
6 certainly a theme that's garnered a lot of attention,
7 there's a lot of work going on in the patient safety
8 arena ever since the IOM report on preventable errors
9 came out, and we've had, like the other teams, a lot
10 of positive response on this.
11 So I would like to, it's my pleasure to
12 introduce Dr. Elizabeth Donohoe, who was out in the
13 San Francisco regional office but has come back to
14 join us and is on a detail working on the patient
15 safety theme along with Jade Perdue, one of our staff
16 people here who recently joined us in person.
17 Without further ado, I'll turn it over to
18 Dr. Donohoe. Liz.
19 DR. DONOHOE: Thank you, Dr. Straube, for

20 that. I do want to thank you all for being here and

21 thank you for your patience. Sometimes just getting

22 through our security process can certainly be trying,

23 so I appreciate you all being here today.

24 As Dr. Straube said, I'm Liz Donohoe, I'm

25 an internist and geriatrician. I just came to OCSQ

1 last month and of course the learning curve has been

2 rather steep. Jade Perdue sitting right here, she's

3 the government task for patient safety and has

4 certainly been a full partner in this effort and I

5 would like to thank her for everything she has

6 contributed. We're all doing really important work

7 here and the common goal is to improve the health

8 care provided to our beneficiaries. We certainly

9 look forward to working together with you to achieve

10 this goal.

11 This slide provides a brief overview of

12 what I will cover in this talk, a discussion of

13 what's new in the 9th Scope of Work, including use of

14 established provider pools, and then I'll discuss

15 some measure specifics and QIO evaluation.

16 Just so we're all working from the same

17 blueprint, we're defining patient safety as freeing

18 patients from the risk of harm or loss resulting from

19 their interaction with the healthcare delivery

20 system, independent from their specific disease

21 process. As you can see, this definition potentially

22 covers a wide range of issues under patient safety.

23 For the 9th Scope of Work, I'm sure you're

24 all aware that we have chosen a theme-based approach

25 as opposed to setting, as with done previously.

1 These components were chosen based on prior
2 successes, pertinent public health needs, and areas
3 where large numbers of beneficiaries are likely to
4 benefit from quality improvement interventions. And
5 by reducing the incidence of these events, we create
6 an opportunity to simultaneously improve healthcare
7 and reduce costs.
8 We need to do this through reducing the
9 numbers of nursing home and hospital acquired
10 pressure ulcers, restraints used in nursing homes,
11 surgical site infections and complications,
12 infections related to MRSA, and we also include
13 interventions focused on drug interactions, retention
14 on inappropriate medications, as well as poor
15 performing nursing homes.
16 Now I will briefly review each of the
17 components in patient safety. Within patient safety
18 there are six components, four of which are being
19 carried over from the 8th Scope of Work. So this is

20 based upon work that you are already doing and many

21 of whom are doing this very well, restraints,

22 pressure ulcers, surgical care improvement and

23 personal infection prevention, and drug safety are

24 not new.

25 And although many of the measures carry

1 over from the 8th Scope of Work, we do have a number

2 of new measures that are not, including pressure

3 ulcers in hospitals, two new SCIP measures, measures

4 related to MRSA, and poorly performing nursing homes.

5 I will now go over each of these new components and

6 measures and provide some background as to why CMS

7 believes they are important to include.

8 Recently increased attention has been

9 placed on the incidence of hospital-acquired pressure

10 ulcers. About 20 percent of pressure ulcers

11 identified in nursing home residents originate

12 outside the nursing home, generally from an acute

13 hospital. Some cross-cutting measures are needed to

14 reduce incidence of pressure ulcers. In addition,

15 CMS has recently initiated requirements related to

16 hospital-acquired conditions, and pressure ulcers are

17 included in that requirement. One reason that this

18 is important is that patients who develop pressure

19 ulcers in the hospital have a mean length of stay of

20 13.14 days, compared to 4.83 days for patients

21 without pressure ulcers. So you can imagine the

22 improvement in quality of health care, quality of

23 life, and cost savings that could be associated with

24 reducing the incidence of hospital-acquired pressure

25 ulcers.

1 The two new SCIP measures include Card 2
2 and Infection 7. SCIP Card 2 is a guideline
3 published by the American College of Cardiology and
4 the American Heart Association. Because the
5 attributable mortality associated with perioperative
6 cardiac events is so high, and because the risk is
7 substantially increased in those patients with
8 chronic beta blocker therapy before and after
9 surgery, interventions to improve perioperative beta
10 blocker use in this patient operation are very
11 important.
12 For SCIP Infection 7, perioperative
13 normothermia has been shown to reduce the risk of
14 cardiac arrhythmia due to the perioperative bleeding
15 in transfusion requirements and enhance normal
16 medication metabolism, as well as reducing surgical
17 site infection in those patients undergoing
18 colorectal surgery. Next.
19 Now most of know about the increased

20 public health awareness due to the latest MRSA

21 infections. According to an article released in JAMA

22 last year, MRSA caused more than 94,000 life

23 threatening infections and roughly 19,000 deaths in

24 2005, the majority of them connected to a healthcare

25 setting. People who have MRSA infections are four

1 times likely to die as patients who have staph
2 infections that are susceptible to antibiotic
3 treatment. CMS is committed to working with Centers
4 for Disease Control and Prevention in putting
5 MRSA-related quality improvement efforts on the radar
6 screen of our hospital providers. Next.
7 CMS is also committed to reaching out to
8 those facilities, including nursing homes, who have
9 consistently not performed well in quality measures
10 and other areas. QIOs will be working with those
11 homes to improve quality of care provided to our
12 beneficiaries. Those nursing homes will be
13 identified based on evaluations in conjunction with
14 CMS's survey and certification and the nursing homes
15 will be assigned to QIOs. The QIOs will perform a
16 root cause analysis to identify factors leading to
17 poor performance and action plans will be implemented
18 involving QI efforts.
19 Okay, so those are the new components.

20 Next.

21 Another aspect of the 9th Scope of Work

22 that is unique is the guidance provided by CMS to

23 establish provider pools. In order to effectively

24 reach out to those providers that can benefit most

25 from quality improvement interventions, CMS has

1 formed provider pools from which the QIO can recruit
2 within certain components. These pools set a maximum
3 number of facilities by state which a QIO can work
4 with under a component. Those components that have
5 associated CMS provider risks include pressure
6 ulcers, restraints, and SCIP measurements. Provider
7 lists include solely those providers that fell below
8 certain criteria based on performance outcome
9 measures that are publicly reported. QIOs also have
10 the option to recruit additional facilities. Next.
11 Again, factors addressed to establish
12 provider pools include performance based on quality
13 outcome measures. The pressure ulcer measures
14 applied to nursing homes will be used to determine
15 that provider list. Hospitals in corresponding
16 counties of those nursing homes comprise an
17 additional list used for the pressure ulcer hospital
18 measure. The idea here is that based on referral
19 patterns, the QIO can identify hospitals that refer

20 to nursing homes who have high pressure ulcer rates.

21 Similarly, those nursing homes or providers who are

22 associated with physical restraint measures were

23 identified based on performance of long-stay

24 residents through a physical restraint measure. We

25 know that QI efforts aimed at improving these outcome

1 measures do work. Next.

2 Most hospitals who fell below criteria

3 related to performance on Infection 1 and Infection 3

4 both related to timing of antibiotics comprised the

5 providers pool for the SCIP measures. The provider

6 pool for hospitals that were reported on measures

7 related to MRSA will be drawn from the National

8 Health Safety Network System, which is overseen by

9 the CDC. QIOs may approve additional hospitals to

10 participate in the NHSN system. It's important to

11 note here that while the other provider pools were

12 established based on performance of quality outcome

13 measures, the pool related to MRSA measures does not

14 identify hospitals related to performance at all, it

15 merely provides the total number of hospitals

16 voluntarily reporting on the NHSN system currently.

17 The (inaudible) will define their universe of

18 facilities under those components. Next.

19 Now that we've gone over what's new in the

20 9th Scope, let me tell you about the specific outcome

21 measures that we will use for evaluation under the

22 patient safety theme. We are looking for QIOs to

23 make a demonstrative difference in performance of

24 outcome measures in those facilities in which they're

25 working. Pressure ulcer one is high risk long-stay

1 residents who have pressure sores. This is taken
2 from nursing home QM reporting data. Pressure ulcer
3 three are patients with hospital-acquired pressure
4 ulcers. Physical restraints are long-stay residents
5 who were physically restrained for seven consecutive
6 days, and that is taken from nursing home QM
7 reporting data. We want to reduce those numbers.
8 Next.
9 The SCIP component includes all the
10 measures you see on the screen. SCIP Infection 1,
11 antibiotic initiated within one prior to incision;
12 Infection 2, antibiotic consistent with guidelines;
13 Infection 3, antibiotic that's stopped with 24 hours
14 of surgery; 4, glucose control for cardiac surgery; 6
15 is proper hair removal; and Infection 7 we have a
16 typo, it should be the colorectal surgery. Card 2 is
17 the perioperative beta blocker. VTE 1 is when the
18 prophylaxis is ordered and VTE 2, the appropriate
19 timing of the VTE prophylaxis. We want compliance

20 with these measures to increase. Next.

21 For the MRSA measures, the first one is

22 MRSA infection rate and the second is the

23 transmission rate. We want these rates to decrease.

24 Again, these measures will be tracked in hospitals

25 voluntarily participating in NHSN. Next.

1 For the drug safety measures, we address
2 both drug-drug interaction and potentially
3 inappropriate medications, and we would like to see
4 these measures decrease. These are the same measures
5 that were included in the 8th Scope of Work. Next.
6 The poor performing nursing home component
7 includes outcome measures that address improvement in
8 quality measures as well as satisfaction surveys of
9 nursing homes on the technical assistance provided by
10 the QIOs.
11 So that's the overview of outcome measures
12 by component. Evaluation will involve measurements
13 of both process and outcome measures. We are looking
14 for a benchmark measure rate of improvement within a
15 component. Next.
16 Evaluation will be conducted at 18 months
17 and 28 months after the start of the contract. The
18 18-month hurdle generally includes process measures
19 which will serve as a building block to success in

20 the 28-month hurdle, which focuses on outcome

21 measures. The bottom line is to improve the quality

22 of care that beneficiaries receive and that is

23 reflected by moving the measures. Next.

24 So how do we move the measures and improve

25 the health care provided to Medicare beneficiaries?

1 By promoting increased use of proven interventions

2 and best practices and instituting change in

3 methodologies. CMS aims to do this by initiating the

4 CMS National Patient Safety Initiative. Next.

5 The CMS National Patient Safety Initiative

6 will partner with healthcare leaders across the

7 country to sustain and grow the national learning

8 community of QIOs, hospitals, nursing homes and all

9 Medicare providers, an action to positively impact

10 patient care, and in doing so provide a significant

11 cost savings in the following critical areas:

12 Healthcare-associated MRSA infection, recurrence of

13 pressure ulcers, use of physical restraints, surgical

14 site infections and complications, adverse drug

15 effects, specifically drug-drug interactions and

16 potentially inappropriate medications, and very poor

17 performing nursing homes. Next.

18 Supports and tools that will allow QIOs

19 and providers to accomplish this include the Agency

20 for Healthcare Research and Quality TeamSTEPPS pool,

21 the nursing home survey, the hospital leadership

22 quality assessment tool, training sessions that

23 target best practices, the development of national

24 quality improvement leaders, as well as QI change

25 packages, web sites, conference calls, best practice

1 films, and ongoing support from our QIO support

2 contractor. Next.

3 That concludes the patient safety section.

4 Again, we all look forward to working with you. We

5 thank you for your time and attention, and I will now

6 turn the podium over to my colleague Doug Brown, with

7 care transitions.

8 MR. BROWN: Good morning everyone. My

9 name is Doug Brown, I work with, within the division

10 of chronic and post-acute care under the Quality

11 Measurement and Health Assessment Group. This is

12 actually our first time interacting to this degree

13 with the QIO program and we are all very, very

14 excited to do so. First off, I am the government

15 task leader for this theme and unlike the other

16 themes, we do not have a particular individual

17 identified as the quote-unquote theme lead. Instead

18 we have elected to fill this role with a board-like

19 organism made up of several of the experts within our

20 division and group, namely Mary Pratt, the division

21 director; Judy Tobin, who you will hear from in just

22 a second regarding the continuity assessment record

23 evaluation instrument; Dr. Joanne Lynn, our

24 geriatrician and medical officer; as well as several

25 others from the regional offices; who also include

1 our group director and deputy director, Mike Rapp and

2 Debbie Hattery. So we are all very, very excited to

3 work with the program to this degree and we're

4 looking forward to getting started.

5 First off, the care transitions theme,

6 what will it do? We seek to improve the quality of

7 care for Medicare beneficiaries that transition

8 between healthcare providers, and in doing so we

9 expect and we hope to reduce rehospitalization rates

10 measurably, so a lofty goal, and I think that we can

11 achieve it.

12 Within this theme there are essentially

13 four separate tasks that we are asking from the QIOs,

14 two of which are the cornerstones of all the work

15 that we're asking to be done. First off, site

16 selection in the community, and secondly the

17 interventions. These interventions are those

18 designed to be implemented within those selected

19 communities that would then drive down the

20 hospitalization rates and improve quality of care.

21 The last two, monitoring and reports and evaluation

22 of task performance, those are simply how we will

23 monitor the program's progress through a mixture of

24 quantitative care and outcome measures, as well as

25 several narrative reports describing the progress

1 that's made along the way throughout the theme.

2 First off then, community and provider

3 recruitment and selection, this is where we're asking

4 that the QIOs select certain areas in which they want

5 to work, so first off we expect that one of the

6 initial questions is going to have to be, is there

7 the will within this community to work on this to

8 drive down rehospitalization rates and to take a

9 major step toward, you know, implementing several

10 interventions. Namely we will -- and this is why

11 Judy Tobin is here as well -- one of the major

12 requirements within this theme is to implement the

13 continuity assessment record and evaluation, which is

14 a new assessment instrument that we have been

15 developing and are very excited about, but you will

16 hear more details about that in a second.

17 Secondly, are modifiable drivers of

18 rehospitalization present? If the community has

19 already implemented several things to, sort of on

20 their own to drive down rehospitalizations, and all

21 that are left are those intangible, unbreakable

22 factors that we just have no control over, then

23 that's obviously not a place that we want to go with

24 this theme. Speaking of which, this is one of the

25 subnational tasks in the 9th Scope of Work, so this

1 is a competitive theme and we will not be going to

2 the 53 states with it.

3 Second, or lastly, is the population large

4 enough that the gains we expect for that, that it can

5 guarantee or help guarantee to achieve the gains that

6 we suspect or expect in this theme, namely the two

7 percent reduction in the rehospitalization.

8 Next, the interventions. We have

9 categorized the interventions into three areas.

10 First, we want the QIOs to implement interventions or

11 assist the communities that they have selected in

12 implementing the interventions on a hospital-wide or

13 system-wide basis, also implementing interventions

14 that target specific diagnoses such as AMI, heart

15 failure or pneumonia, and also interventions that

16 target specific reasons for readmission. So whatever

17 unique characteristics that that particular community

18 or site that you have selected, whatever those,

19 whatever is driving their rehospitalization

20 particularly, then that would be an area that we

21 would like you to focus on.

22 Lastly, or second to last, monitoring and

23 reports, there are essentially two narrative reports

24 that we're asking for. There is the initial report

25 characterizing the site that you have selected and by

1 this we mean tell us about the community that you

2 have chosen to go into, what are all the factors that

3 contribute to rehospitalization, what is the

4 political structure, what is, you know, the community

5 like. So we want to gather as much information as

6 possible. In some ways this is doing a root cause

7 analysis, although that has a particular meaning, but

8 it's identifying what is particular or what is unique

9 in this community that we have to deal with.

10 Then the narrative reports on progress,

11 this is essentially a periodic report that tells us

12 the progress that you've made since the last

13 reporting period.

14 Next I will get into the actual measures

15 that we've designed for this theme and there are two

16 categories of measure, first the midpoint measurement

17 and then, which is actually the 18-month period, and

18 then a 28-month measurement. So first, and just as

19 we're talking about the majority of these measures,

20 they will discuss what percentage of transitions the

21 measure is taking care of or representing.

22 And just to sort of quickly define that,

23 costs as you go into your community, you decide that

24 you would like to work with this particular hospital,

25 we want to know of all the transitions that are

1 occurring there, by you reviewing that particular

2 hospital, what proportion of all the transitions that

3 are occurring in that community does that hospital

4 represent. So we've established some baseline

5 thresholds that at the 18-month point so that if at

6 least we haven't achieved these, then the likelihood

7 of a successful project or theme is truly diminished,

8 and it's not necessarily due to the QIO, it's just

9 that maybe the community isn't as interested as we

10 originally thought. So it gives us an opportunity to

11 make some business decisions at that point as to do

12 we want to continue in this community or should we

13 start looking at redirecting our funds.

14 So first, agreeing to participate, this is

15 again, it's going back to the percentage of

16 transitions or the proportion of transitions. If you

17 get one provider that has signed up, how much of the

18 total transitions is that provider responsible for.

19 So each provider has their proportion that is

20 associated with them and you just tally up that

21 proportion.

22 Hospital or community system-wide

23 interventions that are implemented, and this is at

24 the 18-month mark, disease-specific interventions

25 that are implemented and reasons for readmission. So

1 back to those three categories of interventions that
2 we would like to focus on, what proportion of all the
3 transitions are being covered by them.
4 Next, and this is still on the 18-month
5 mark, of the interventions that you have implemented
6 in the community or have assisted the community in
7 implementing, what percentage of those interventions
8 actually have active measures associated with them.
9 So if you implement an intervention, how actively is
10 that intervention being measured for success or
11 improvement in quality.
12 And then transitions which are implemented
13 and measured interventions apply. So you have
14 implemented five things, or five interventions, four
15 of which are being actively measured and monitored
16 for quality improvement, so we want to know, of those
17 that you are actively measuring and monitoring for
18 quality improvement, what proportion of the total
19 transitions are being covered by that intervention.

20 So clear as a bell, I'm sure. Don't

21 worry. In our SOW and as we're continuing to address

22 questions and answers, we are seeing ways that more

23 specificity, we're able to give more specificity to

24 these measures, so we are working very hard to do so.

25 Okay. At the 28-month mark we have

1 several outcome measures. First off, two sort of

2 associated with the satisfaction survey, HCAHPS first

3 on medication management, secondly on discharge

4 planning, and we're looking to reduce the failure

5 rate, which is also defined, by eight percent.

6 Where the beneficiary is seen by a

7 physician in the 30 days before rehospitalization, so

8 they were discharged and then they were readmitted 30

9 days later, during that time was a physician seen or

10 some healthcare provider, and we would like to see

11 that failure rate reduced, and the failure is no,

12 they did not see anyone, we would like to see that

13 failure rate reduced by eight percent as well.

14 Interventions that showed improvement, so

15 back again to the ratio of interventions that you

16 have implemented and are actually monitoring. Now of

17 those that you are monitoring, what proportion of the

18 population or the population's transitions are

19 actually being improved by those interventions. So

20 this is the rate of improvement on those

21 interventions.

22 Then to, sort of the bulk of what we're

23 doing in this theme is the 30-day rehospitalization

24 rate, to reduce that by two percentage points. And

25 also within this we recognize that that might not be

1 as sensitive to change as we would like, so we have
2 also put in here rehospitalization for AMI,
3 rehospitalization for heart failure and
4 rehospitalization for pneumonia, reducing all of
5 those by two percent.
6 So next, I will turn it over to Judy Tobin
7 and she will walk us through the CARE instrument,
8 which I'm sure everyone is interested in.
9 MS. TOBIN: Thank you, Doug, good morning.
10 You folks are approaching and getting ready for
11 another break. I'm going to spend about five minutes
12 with you about before turning it over to our next
13 speaker, Lisa McAdams. I work at OIG with John Lynn
14 and a number of people, I'm the lead project officer
15 helping to develop the CARE instrument, which is an
16 Internet based instrument and it is one of the
17 proposed interventions for helping to support the
18 care transition teams as the Medicare beneficiaries
19 start transitioning amongst provider settings.

20 So what I would like to do is just take a

21 few minutes and recap what is CARE, continuity

22 assessment record and evaluation, this Internet-based

23 instrument, and how is it expected to support the

24 theme of care transitions and really how to

25 contribute to better coordinate care as our Medicare

1 beneficiaries do transition among settings.

2 So as many of you know and probably most

3 if not all of you know, the CARE instrument has been

4 developed really to meet the requirements of the

5 Deficit Reduction Act of 2005 and it is going to be

6 first used in the next couple of months, in March,

7 under a payment perform demonstration which the

8 Office of Research Development and Information is

9 leading, and they're really examining care and

10 patient characteristics across providers an over

11 time, and where the CARE instrument comes into play

12 is it has been developed as a uniform assessment

13 instrument to measure and compare Medicare

14 beneficiaries health and functional status across

15 providers and over time, that currently existing

16 instruments really cannot compare, whether it's

17 function or they're all measured in different ways,

18 or captured in different time frames. So what was

19 mandated under the Deficit Reduction Act was, again,

20 to come up with a standardized way to compare these

21 outcomes of beneficiaries as well as resource

22 utilization over settings over time.

23 And then additionally what we were charged

24 with by the administrator and our executive staff was

25 this is really the right time to make this an

1 Internet-based instrument and not make it a form.

2 Let's make this a dynamic instrument that can be

3 changed rapidly to accommodate both clinical changes,

4 how we treat people, as well as provider changes.

5 In terms of the content of CARE, the way

6 it is arranged, it does go across settings over time.

7 There is a core set of information which is measured

8 in every setting and then there are additional

9 supplementary items which may be more specific to a

10 particular condition or a particular setting. And

11 those core items really cover the major areas,

12 administrative, medical, cognitive, functional,

13 prognosis, as well as discharge status and continuity

14 of care, which is of particular interest to our

15 audience here today.

16 We do plan to take the demonstration

17 version of CARE and refine it for use in the 9th

18 Scope of Work. We would still certainly want some

19 standardization and continuity of data and how it's

20 collected, but we know there are some specific needs

21 in the 9th Scope of Work as well.

22 When it will be used and where it will be

23 used in the payment demonstration, we know this will

24 be a little bit different in the 9th Scope of Work,

25 but this is just to give you the as-is picture

1 starting in March, in a few weeks. They are actually
2 beginning user acceptance testing as we speak over at
3 the 7-11 in the Social Security building.
4 It will be administered at hospital
5 discharge and will be administered upon admission and
6 discharge from the post-acute care settings being
7 studied in the demonstration, which includes patient
8 rehabilitation facilities, skilled nursing
9 facilities, home health agencies, as well as
10 long-term care in hospitals.
11 And what I would like to say is I think
12 we're at a very interesting point. We're at a really
13 unique point. We have such an opportunity here with
14 our QIOs and our partners in the community, and at
15 CMS, to really be in a formative stage of care on
16 this IT platform. It's a unique opportunity to
17 participate in shaping this very important
18 instrument. And our aim under the 9th Scope of Work
19 is to really, again, to support safe transitions for

20 our Medicare beneficiaries, and there is good

21 evidence that using an electronic health record that

22 can be rapidly communicated amongst providers and

23 rapidly and accurately communicate critical

24 information, whether it's medication lists or the

25 type of care, can help to support better transition,

1 better planning, better care coordination for our
2 beneficiaries. The CARE instrument really does
3 support some of those opportunities in terms of being
4 uniform standardized data collection, Internet based,
5 interoperable, and enabling us to rapidly communicate
6 critical information.
7 So I hope you share our enthusiasm and
8 excitement. We're delighted to be part of the 9th
9 Scope of Work. And I would like to close and I shall
10 turn it over to Lisa McAdams.
11 DR. MCADAMS: Good morning. Well, it's my
12 honor and privilege to welcome all of you, you've had
13 a number of welcomes from a lot of the staff here at
14 CMS, and it's my honor on behalf of all the regional
15 office staffs, as well as my consortium and my boss,
16 Dr. Randy Ferris, who is a consortium administrator
17 for the consortium for quality improvement and survey
18 and certification operations, and I want to tell you
19 a little more about that later on. But welcome.

20 I'm going to talk a little bit about the

21 goals and objectives that we have for managing this

22 program. I'm going to talk about the organizational

23 structure that we have between central office and the

24 regional offices for managing the program. I'm going

25 to talk about the elements of our management program

1 and then get into some things that we need you as

2 contractors, potential contractors to do once we get

3 into the implementation phase of the contract. And

4 then finally, I'm going to give you a little bit of

5 information about how we will be evaluating and

6 measuring what we're doing in the area of program

7 management. So that's some exciting and interesting

8 things that I think those of you who have been

9 working the QIO program for a while will be

10 interested in hearing.

11 Objectives of the program. We need, and

12 you heard Paul, Dr. McGann allude to some of the

13 accountability issues and the things that we have

14 done to modify what we have done with this scope of

15 work, and that applies also to the management of the

16 program. We need to provide adequate oversight over

17 the QIO program. We need to be able to identify

18 problems that crop up, or areas where within various

19 of the themes we're not hitting targets that we've

20 assessed along the way before we get to a 28-month,

21 so that we can take action to address those

22 performance gaps, okay? We want this program to be

23 successful. We want for our beneficiaries to benefit

24 from the good work that you can do in the QIO program

25 and to do that we need for you to be successful, so

1 we need to be monitoring those numbers and make sure
2 that in our oversight that we address that. Another
3 element of that is protecting the trust fund.
4 So as we're looking at things, you've
5 heard a lot of about measurements and monitoring and
6 interim measures and monitoring measures and outcome
7 measures, and 18-month measures and 28-month
8 measures. But with all of that information, as well
9 as the information that you will be providing us, we
10 will have the opportunity to provide the necessary
11 information for making decisions related to the
12 program, and I'll talk a little bit more about some
13 of those things in a few minutes.
14 But then we also want to identify
15 opportunities for improvement not just based on the
16 performance gaps but also based on best practices
17 that there may be out there. So one of our goals
18 with program management is to not only look at where
19 we have issues and problems but where are we doing

20 things right and how can we share that information

21 both within CMS but amongst you as well, so that we

22 can achieve those goals of improving the care for the

23 beneficiaries.

24 So the organizational structure, Barry,

25 Dr. Straube talked about the partnership that we have

1 between the regional offices and central office,

2 between our counterparts in OCSQ, our counterparts in

3 OAGM, and then also the consortium for quality

4 improvement and survey and certification operations.

5 That's the consortium within the regions that handles

6 the business lines of quality improvement, the QIO

7 program, the end stage renal disease network program,

8 but also the decisions of survey and certification,

9 you know, our state survey agency, as well as the

10 chief medical officers in each of the regions within

11 CMS.

12 We went through a reorganization in the

13 regional offices about a year ago and though many of

14 you are familiar with the four regions that have been

15 involved in the quality improvement work, we have the

16 Boston regional office, the Dallas regional office,

17 the Kansas City regional office, and the Seattle

18 regional office. In the past the regional offices

19 had all functioned under a regional administrator.

20 With the reorganization we reorganized by business

21 lines, so as I mentioned, Dr. Ferris as the

22 consortium administrator for what we call CQISCO, and

23 I'll use that because it's a lot easier than saying

24 consortium for quality improvement and survey a

25 certification operations.

1 With CQISCO he is now the lead, the

2 consortium administrator for the four regional

3 offices that handle the quality improvement program,

4 okay? As well as the other two business lines of

5 survey and certification work and the chief medical

6 officer work that I alluded to, okay? So we now have

7 a structure where we can better than every before

8 reduce some of the variations that can occur because

9 we're in different regional offices, you know, and we

10 can also communicate better with our counterparts in

11 OCSQ and OAGM because we're speaking with one voice,

12 we're identifying the issues, we're working very well

13 together to make sure that this is a tight strong

14 management program so that we can achieve things in a

15 way that perhaps we haven't in the past. Next slide.

16 Oh, the cast. There are a lot of folks

17 that are involved in doing the work. It's a large

18 program and it takes a lot of staff in order for us

19 to adequately manage the program. I've listed a lot

20 of them there for you. Of course the leadership in

21 OCSQ, in OAGM, in CQISCO. The other managers, some

22 of whom you're familiar with as associate regional

23 administrators or ARAs. The contracting officer,

24 Naomi, who you met earlier. Naomi also has contract

25 specialists that work with her putting together

1 contract pieces and working with a project officer in
2 all of the things that have to happen in putting
3 those contracts together for you. The theme leads
4 and the government task leads, you have heard from
5 some of them this morning, and they have a content
6 expertise, they're the ones that really understand
7 and are responsible for what's in the statement of
8 work in their area, in their theme or subtheme, or
9 component. The financial management specialists are
10 some folks that are in our business operations
11 support group, and they have a better knowledge of
12 the financial issues. They work with our OCSQ
13 leadership as well as with the project officers
14 related to the financial vouchering and looking at
15 how all the dollars are being spent.
16 The project officers and the science
17 officers tend to be located in the regional offices,
18 although there are sometimes exceptions to that. As
19 well as the theme leads and GTLs, they're pretty much

20 in the central office, but sometimes there are

21 exceptions to that. But the general rule is that the

22 GTLs and theme leads are in the central office, the

23 project officers or science officers are in the

24 regional offices. The theme leads and the GTLs are

25 theme specific. Project officers on the other hand,

1 they're contractor specific, so they have assigned to
2 them by state usually one of the, you know, anywhere
3 from three to four contracts for the Quality
4 Improvement Organization, okay? So they will look
5 across all things, they have to be familiar with all
6 the scopes of work, but they're looking at things
7 from a contractual perspective, how are you doing as
8 far as meeting the contract expectations.
9 So elements of the monitoring program, if
10 you think about managing anything, you have to lay
11 out expectations, then you look at how folks are
12 delivering on those expectations. You have an
13 information system in which you capture information
14 related to that. And then you have processes that
15 you use for managing the program. I'm going to talk
16 just a little bit about some of those.
17 The elements are laying out expectations,
18 we've provided you with a scope of work and that's a
19 huge one. But in addition to that there's a manual,

20 the QIO Manual. There are sometimes transmittals by

21 standard data processing system and transmittal of

22 policy system memos that communicate important

23 information about our expectations. And then there

24 is the individual direction given to QIOs through the

25 project officer, through the contracting officer,

1 through the government task leaders.

2 And I do want to mention just briefly that

3 the project officer and the government task leader

4 are the only two in addition to the contracting

5 officer that can give you directions related to your

6 contract. The contracting officer has delegated

7 authority to the project officers and the government

8 task leaders to handle those pieces of the contract.

9 Related to the contract, Paul, Dr. McGann

10 alluded to the fact that we have in this contract

11 unlike ever before, we have not only the 18-month

12 evaluation, or hurdle as some folks are referring to

13 it, but we also have, if you've looked at the RFP, we

14 have laid out in there performance expectations all

15 along the way. So we're serious about really

16 monitoring performance within this Scope of Work and

17 making sure that we're hitting those performance

18 expectations. We're serious about taking action at

19 the 18th month where performance expectations are not

20 being met. And I excerpted for you there what it

21 says in the RFP relating to the 18th month,

22 consequences for not hitting those performance

23 expectations.

24 Moving on, you know, the way that you

25 communicate information to us, the deliverables that

1 we have, and those can be reports, plans,

2 assessments, activities data, other information that

3 you provide into the SDPS system. We do have the

4 SDPS system, which is one of our IT components for

5 monitoring the program. We also are building a

6 management information system which pulls from SDPS

7 and some of our other systems to provide us with

8 management reports and information that we need in

9 managing the program.

10 So the process is, then, that we will be

11 using within the 9th Scope of Work for monitoring the

12 program include things that those of you who have

13 been in the program are familiar with, but some of

14 those are going to be used to a degree that we

15 haven't used them in the past. We used calls, we

16 used financial voucher reviews, site visits and

17 performance improvement plans.

18 There are a host of different calls that

19 we have and I've listed a few of them there. We have

20 internal calls as well as calls with our contractors,

21 and internally a lot of communication goes on between

22 project officers and GTLs and themes, between

23 leadership in the program, so up and down and across

24 all different directions. But the project officers

25 will also be having a monthly call with each of their

1 QIOs to be talking about the performance of the QIO

2 in the Scope of Work. They will be talking to you

3 about the activities that you're using, the

4 strategies that you're using, your organization for

5 handling the different things, your IQC plan,

6 internal quality control plan. So they'll be looking

7 at all of those in these monthly calls. And then we

8 have national calls where the GTLs in association

9 with the QIOSCs will be sharing information as well

10 as practices and what have you about the specific

11 things. The next slide.

12 Financial voucher review is another

13 element that you may be familiar with. On a monthly

14 basis our project officers, and for special projects

15 as well, the government task leaders look at the

16 information that you submit related to your spending

17 in the various themes, and they have to make

18 recommendations to the contracting officer and the

19 contract specialist about any issues, whether the

20 vouchers should be certified or not.

21 Moving on to the site visits, there are

22 about three primary types of site visits. One is

23 titled routine site visits, and those are where the

24 project officer and perhaps another regional office

25 staff member actually comes on site, looks at some of

1 the administrative things that they need to be
2 looking at that are in the contract requirements as
3 well, looks at security issues, looks at case review,
4 how you're doing your case review, looks at some of
5 the theme specific activities, but they're getting a
6 good picture as those -- we used to call them annual
7 site visits but they're not exactly annual, so we're
8 going to call them routine site visits, and they will
9 be looking at a host of things while they're on site.
10 We also have management oversight reviews.
11 Now these include some of our counterparts from
12 central office, from the business operations support,
13 from OCSQ leadership and more the QIG leadership.
14 And they look in more detail at financial issues and
15 some of the program issues, try to identify best
16 practices, other things that we want to share across
17 the program where we're identifying both good and
18 bad. You know, when we identify something that's not
19 good we don't want everybody else doing that, the

20 same practice, so if we share that information with

21 you then we can head that off. And that's a subset

22 of contractors; not everybody will have management

23 oversight review, whereas everybody will have an

24 annual site visit or a routine site visit from their

25 project officer.

1 And then of course we have the Defense
2 Contract Audit Agency audits which are more in detail
3 looking at financial issues. The next slide.
4 Performance improvement plans. Now those
5 of you that have been in the program are familiar
6 with what a PIP is, but for the 9th Scope of Work we
7 really anticipate using a lot more PIPs than we have
8 ever before in the past. I mentioned that there are
9 performance expectations laid out throughout the
10 contract, and even before that 18-month evaluation or
11 18-month hurdle, if you're not hitting on the
12 performance expectations that are laid out in the
13 contract for any of those measures, whether it's an
14 interim measure, a monitoring measure, an 18-month
15 measure, one of those ones that we're tracking and
16 have laid out in the expectations, we may be putting
17 you on a performance improvement plan. The project
18 officer may be requesting a performance improvement
19 plan from you to address that performance gap. So we

20 anticipate using these actually fairly heavily if

21 performance expectations aren't being met.

22 Once you submit your performance

23 improvement plan the project officer assesses that

24 for adequacy, whether it's really addressing the

25 issue that has been identified, and they will approve

1 it or not approve it. Then of course you will

2 implement that performance improvement plan, the

3 project officer will monitor your implementation of

4 it. Now if you're not, if you don't submit a

5 performance improvement plan when the project officer

6 has requested one, or you're not implementing your

7 performance improvement plan as you have indicated in

8 your approved plan, there are contractual actions

9 that can be taken. So again, don't take a PIP

10 lightly. I mean, the worst action could be

11 termination of the contract, so there are serious

12 actions that we're taking to increase the

13 accountability within the program.

14 So how does it really all work together?

15 Well, the project officers are looking at data that's

16 in the information management system related to all

17 these measures, you know. And the theme leads and

18 the project officers are having discussions on a

19 quarterly basis, surveillance calls, looking at

20 performance issues and whenever there is a problem

21 identified with the performance, they're going to ask

22 for a PIP. You know, we're communicating that up to

23 our senior leadership so everybody is aware of what's

24 going on, and there are any number of actions that

25 are taken based on the results of those. So monthly

1 calls, site visits, any of those could be a time
2 where a project officer could identify that a
3 contract requirement isn't being met or performance
4 expectations aren't being met based on the data that
5 we have and the expectations that we have laid out.
6 So what do you need to do as contractors?
7 Well, help the project officers as they're setting up
8 a schedule of routine monthly calls with you. And
9 when you provide information, provide complete
10 concise accurate information. If you're
11 communicating to the government task lead or the
12 theme lead, copy the project officer. As I
13 mentioned, the project officer is the one that
14 manages the contract. The government task leader,
15 they handle the content, but the project officer
16 needs to know if you're having discussions with a
17 theme leader, so always keep them in the loop.
18 Submit your deliverables timely, and
19 really take seriously your internal quality control.

20 That's something you should be doing routinely, but

21 as we're requesting performance improvement plans,

22 we're going to be expecting to see within those how

23 you have done, your cost analysis based on the

24 performance gap, and how you have developed

25 improvement actions and how you plan to implement

1 those within that PIP. So your internal quality

2 control plan can really be the basis for the

3 information you provide within the PIP. Next slide.

4 Oh yes. This is the fun stuff. I

5 mentioned at the beginning that this, there may be an

6 opportunity, I mean, this is some exotic stuff for me

7 because we have been working on this for a long time

8 and it's actually coming to fruition. So how are we

9 going to measure how we in CMS at OCSQ and four DQIs

10 are managing a program? Well, we've actually built

11 and begun to implement within the 8th Scope of Work

12 an internal quality improvement program of our own.

13 We have identified the important measures related to

14 our management of the program and we are collecting

15 data on a regular basis to monitor our own internal

16 performance.

17 And for the 9th Scope of Work, you know,

18 we will be modifying that a little bit, we have

19 already begun that work, and so we will continue to

20 monitor our own performance as to how we're

21 implementing these processes, and how we're measuring

22 our own performance, just as we expect you to do.

23 And so there's some examples mentioned on

24 the next slide for you, proportion of QIOs for which

25 monthly status calls were held, proportion of QIO

1 core contract vouchers certified timely, and I won't
2 go through the rest of those, but just to show you
3 how serious we really are about the accountability,
4 not only for the program as a whole but internally in
5 our management of it.
6 And so I think next is another opportunity
7 for you to talk about questions. Please, if you have
8 them, get them into the boxes out there, and they are
9 theme specific or topic specific, and so for the
10 questions for the last three speakers, the care
11 transitions and patient safety and myself, you know,
12 we will then be addressing those after lunch, as well
13 as the speakers from earlier this morning.
14 MS. HANEY-CERESA: Just one minute please.
15 I want to mention that we do have boxes out there,
16 four separate poxes for the theme questions, but a
17 few of you have what are considered more general
18 questions and you didn't know where to put those
19 general questions. If you have questions that are of

20 a general nature, you can hand them to any one of the

21 individuals sitting at the registration desk and just

22 indicate that it's a general question. We weren't

23 trying to eliminate general questions, but you know,

24 we were encouraging you to ask as many questions as

25 you feel necessary today and we will try to answer as

1 many of those as possible. But just indicate, if

2 it's other than a theme specific question, that you

3 put it down as general and we'll look at it as well.

4 MR. KING: And Naomi, why don't we mention

5 as well, in terms of some of the theme leads have

6 talked or mentioned about e-mailing a question to

7 them, but we want the questions after today, if there

8 are questions, send them to Naomi. We want them sent

9 to our contracting officer, that's the funnel for all

10 of the questions.

11 MS. HANEY-CERESA: Right. Section L-8 of

12 the RFP does have a central mailbox and if you have

13 any communications with us, I know you're seeing some

14 theme specific, theme leader and GTL information in

15 the slides, because we are in a competitive arena, we

16 can't have you contacting any of those individuals or

17 your contract specialists or current project

18 officers. If you have a contract with CMS, you

19 shouldn't be discussing the competitive RFP with

20 anybody other than the contracting officer. So if

21 you want to contact me directly, my name and e-mail

22 address are available to you on FedBizOpps and I gave

23 it to you earlier.

24 And please, you know, help us maintain the

25 integrity of the process and not compromise it for

1 any of you in the room, and so don't contact your

2 individual project officers, theme leads or others

3 concerning this RFP that's out on the street. Direct

4 your questions to me or if you are trying to address

5 questions specific to the RFP, follow the

6 instructions in section L-8 for submitting those

7 questions. Thank you, Terris.

8 MR. KING: Now in the same way, unless

9 Dr. Straube has anything he wants to say, in the same

10 way that we had individuals who are here at the

11 community level stand, some of those individuals who

12 work at community level of various organizations said

13 we don't know who the QIO is, and I couldn't imagine

14 anybody not knowing their QIO. So the QIOs who are

15 in the room, would you please stand? Thank you very

16 much.

17 So now we have an hour for lunch, be back

18 here at five after one, we will be back here and will

19 answer the questions. Thank you.

20 (Luncheon recess.)

21 MS. HANEY-CERESA: All right. Good

22 afternoon. I hope all of you enjoyed your lunchtime

23 and break, and are ready and geared up for the second

24 half of day. We're going to answer the questions.

25 We have compiled all the questions and tried to break

1 them down as much as we could be by theme and those
2 that are general in nature. I'm going to try to
3 answer as many of the general questions as I possible
4 can. If we don't get to everybody's questions, don't
5 bee afraid to resubmit that question using the
6 section L-8 process for questions on the competitive
7 RFP. And then following me we'll go down to each of
8 the themes.
9 So if you're ready, I'm going to read the
10 question and provide you with a brief answer, and
11 we'll try to get through as many as possible. Doug,
12 are you going to let me know when my time is up?
13 Okay.
14 First question: Given all the activities
15 that build on the 8th Statement of Work, is it
16 possible for a new organization to be become a QIO?
17 And the answer is yes. And what we tried to do is
18 give you as much information up front in the RFP of
19 how to become eligible to become a QIO and to give

20 you as much time as possible to fill out and become

21 eligible to respond to the RFP. So we truly believe

22 that you can become a QIO.

23 Question two: Please explain what

24 redirection of the contract means when a QIO fails to

25 meet the 18-month evaluation measures. I'm going to

1 refer to you page 27 of the RFP and I'm going to read

2 an excerpt from there, and it starts with criterias

3 not met. And CMS may, among other remedies, elect

4 not to continue the work or the funding for the theme

5 or component of the theme where appropriate for the

6 contract duration. In other words, we're going to

7 look at all of our remedies and one of them is that

8 we may not elect to continue the work or the funding

9 for that theme with you.

10 Question three --

11 DR. STRAUBE: Naomi, maybe you could for

12 question two, go into what other types of remedies

13 there might be, besides terminating the full

14 contract.

15 MR. KING: Well, we did talk about that a

16 bit just as you are suggesting, Barry. That's

17 exactly what Naomi wanted me to focus on. And we

18 wanted to be very careful because this is the way the

19 contract reads, and we also know that other remedies

20 could include redirecting to other entities through

21 the QIO, so there are other remedies. So among the

22 laundry list of remedies we have, including stopping

23 the work, a lot depends upon what the results are.

24 For example, you could have results that show many

25 across the board problems and there would be what Dr.

1 McGann frequently calls global failure, and there

2 would be one set of remedies for that kind of issue,

3 versus a different kind where it's a particular QIO,

4 and then there's another statement. So what this

5 statement in the contract gives us is the opportunity

6 and the flexibility to take the appropriate next

7 steps based on the data, based on what we see, and

8 then we can follow the menu of options that we would

9 have.

10 And I think that, which was Naomi's

11 suggestion, was really what the questioner was

12 asking, what else can you do, can you stop this work,

13 period, in the 9th Scope? Yes, because we understand

14 that this is something that we thought we could get

15 done with the following methods. But if globally

16 we're seeing it problematic, can we work through QIOs

17 for other entities to perform the work, yes, that is

18 another possible remedy. And so that's what really

19 falls to the exact point of the question that was

20 asked, okay?

21 DR. STRAUBE: That's good. I think just

22 for the audience, that's helpful to clarify, and also

23 to stress a few points. One, the termination of the

24 contract is not the preferred remedy, that's number

25 one, in case people think that's what is going to

1 happen all the time. Number two, it does depend on

2 the circumstances. And number three, this was a

3 very, very strong message that we got back from OMB

4 in particular, the Department, Senate Finance

5 Committee, and those three in particular felt why are

6 we spending dollars. When somebody is halfway into a

7 contract, and you have a contractor building a home

8 or doing other things, if it looks like it's not

9 going to get done at all or on time, why would you

10 want to continue, so why should we continue to spend

11 taxpayer dollars. So that's the reason behind this,

12 there is flexibility.

13 MS. HANEY-CERESA: Thank you.

14 Question three: The RFP for competitive

15 states was just released on FedBizOpps last week.

16 How did CMS get 3,000 questions on a just released

17 RFP? You're correct, the RFP was released last week.

18 However, the renewal QIOs received a renewal RFP back

19 in the end of December and the 3,000 questions are

20 from the renewal QIOs.

21 Did CMS release the noncompetitive RFP to

22 only existing QIOs or was this released on

23 FedBizOpps? The renewal QIOs received their

24 noncompetitive RFP through e-mail transmission.

25 FedBizOpps is being used for the competitive

1 solicitation process.

2 Does not early release of noncompetitive

3 RFP give QIOs a competitive advantage? And the

4 answer to that is no. We released the renewal RFP to

5 the QIOs who are renewal QIOs. There are competitive

6 states that are open for competition and those QIOs

7 in those states did not receive the renewal RFP.

8 DR. STRAUBE: And just for clarification,

9 this is the RFP for the core tasks within the Scope

10 of Work. There are other contractual issues that

11 will be forthcoming, so there might be people out

12 there perhaps not distinguishing between the two; is

13 that correct? For instance, a QIO that supports

14 contracts for other studies, so that's another piece

15 of competition.

16 MS. HANEY-CERESA: Right.

17 Question number six: If the proposal

18 response is submitted by U.S. Mail overnight express

19 and a duplicate copy is hand delivered, will the

20 first one logged in be considered the response and

21 what will happen to the second one? No, we're not

22 going to accept second ones. So I want to make sure

23 that you clearly look to the RFP because it provides

24 full and complete instructions for submission of your

25 proposal and if you don't provide a complete proposal

1 with all the copies prior to the date and closing

2 time, we're not going to accept here's a

3 hand-delivered copy and the rest are going to be

4 shipped. We're not going to do that. It clearly

5 states that you have to submit a complete RFP with

6 all the proposal volumes on time.

7 How CMS manages a QIO program, here's a

8 question. What authority specifically has the

9 contracting officer delegated to each project

10 officer? And a follow-up question is, what authority

11 specifically has the contracting officer delegated to

12 the government task leaders? What I'm going to do,

13 I'm not going to go into each and all of those

14 responsibilities, I'm going to refer you to two

15 critical sections of the RFP.

16 For project officers, they're delegated

17 the authority under Section G-8 of the RFP and it's

18 very clearly outlined, and for GTLs, they're

19 delegated authority under Section G-9. So I would

20 suggest that you read those two sections and they are

21 very clear on what authority has been delegated.

22 Next question: In the business proposal

23 you reference Schedules A, B, C, for indirect costs.

24 No such schedules were provided. Is it CMS's intent

25 that bidders create their own schedules based on

1 content mentioned in the instructions for Schedules

2 A, B and C? And what I would like to say instead of

3 just blatantly saying yes, do that, we want to go

4 back and actually take a look at that section, we

5 didn't have sufficient time to do that. So we'll

6 look at that section and any follow-up revisions or

7 amendments to the RFP will be made through the formal

8 process in the next couple of weeks.

9 Next question: For most of the technical

10 volumes, CMS clearly states the common information

11 desired in the resumes. However, Volume VII

12 instructions ask for curriculum vitae or resumes,

13 CVs. Would it be acceptable to provide all volumes'

14 resumes the with the same format and content? And

15 again, I think we'll go back and take a look at that

16 and talk to the GTL for that area and the theme lead.

17 I think they wanted a little bit more information, a

18 little more tailed information there, and that

19 probably was the reason why we didn't just put

20 resumes down again.

21 In the RFP CMS stipulates, A, to print on

22 recycled paper, B, to print on bright white paper

23 that can be recycled. Which do you prefer? Recycled

24 white paper. I think everybody here kind of gets the

25 idea. You know, we would prefer where possible that

1 you use recycled paper and as white a copy as you

2 can, because some of the recycled paper makes it

3 difficult to read if you don't use one that's a

4 little better grade.

5 Let's see. Next question: Given the

6 number of questions submitted to date, do you

7 anticipate an extension to the proposal submission

8 date? It is understood that 8/1/08 award date is

9 firm, but any update on submittal date would be

10 appreciated. And the answer to the question is that

11 questions are due on February 5th for the competitive

12 RFP. At that time CMS will give consideration based

13 upon the quantity and complexity of those questions

14 as to whether or not an extension will be granted.

15 Probably the last question: What is CMS

16 doing to measure from the 8th Statement of Work IPG

17 and general improvement design to show attribution?

18 What does analysis know or show? 85 percent of QIOs

19 paneled, let's use this data please. I don't think

20 that we fully understood this question. It seems

21 like it's more pertinent to the 8th Statement of Work

22 as opposed to this RFP process that we're in, so I'm

23 going to ask the author of this question to maybe

24 resubmit it in the formal question and answer session

25 that's going to be available under L-8 of the RFP.

1 We're not really sure that this is really relevant to

2 us today.

3 Okay, I guess it's time to turn it over to

4 Paul.

5 DR. MCGANN: Thank you, Naomi. Good

6 afternoon, everyone, I have been assigned six

7 questions. It really isn't six questions, though,

8 because in real life people break their questions

9 down into several, so several of these have several

10 parts, so why don't we get started.

11 The first question is what I call a

12 question to set the limits of discussion for today.

13 It's a good question but we do have to set limits.

14 So this is the question: How do organizations

15 propose special projects that may be more efficient

16 ways of addressing the themes or components? This is

17 our answer: We will not discuss this question, which

18 is a special studies policy question, at this time.

19 At this conference we are focusing on what you need

20 to know to submit your proposals for the 9th Scope of

21 Work program. It is a good question, but we're just

22 not going to go there today.

23 Question number two: When do you

24 anticipate issuing the special study RFP? The answer

25 is, in time for contract award before August 2008.

1 Part B of this question: Will there be an additional
2 question and answer period for the revised RFP? I'm
3 going to assume for purposes of discussing this
4 question that that's referring not to special studies
5 but to the to 9th Scope of Work core contract because
6 that's what we're discussing. So I need to say
7 again, will there be an additional question and
8 answer period for the revised 9th Scope of Work core
9 contract RFP? The answer is no, we do not foresee
10 that at this time.
11 Next question: This one is a little more
12 complicated. What specifically did Dr. McGann
13 mean -- I get that a lot -- when he indicated there
14 would be competition even for core work? So let me
15 say it again. What specifically did Dr. McGann mean
16 when he indicated there would be competition even for
17 core work? So you understand the question or
18 distinction here, there is clearly competition for
19 the subnational, and it's true I did say there's

20 competition in core work, so how does that work and

21 what does that mean, very, very good and important

22 question. So here we go.

23 What I'm about to say is not a perfectly

24 realistic scenario but if you think about the meaning

25 of the story I'm about to tell you, you will see how

1 competition was introduced to some core tasks in the
2 9th Scope of Work. Example: Patient safety is a
3 core task. CMS will give each of you a list of
4 targeted nursing homes to work with, for example, on
5 reducing the use of physical restraints in those
6 nursing homes. Let's say that two similar sized
7 states each have 100 nursing homes on their list of
8 targeted nursing homes, this is a hypothetical.
9 So if state A -- and each state is going
10 to submit a proposal. If state A says they can do,
11 in their proposal, 80 of the 100 nursing homes on
12 that list, then that's what they'll write in their
13 proposal, and say they will turn that in to CMS. And
14 state B, let's say similar sized, also has a hundred
15 on the list, state B submits their proposal and they
16 say they can do 20 of the hundred nursing homes on
17 their list. So that's the scenario.
18 Then look at it from CMS's point of view.
19 When we look at those two proposals, state A is

20 promising to do four times more work than state B and

21 that's good from our perspective because we want more

22 work done and more quality improvement to happen. So

23 that's one element of competition.

24 But there's another element of competition

25 that we've introduced for the very first time in the

1 QIO program in its 25-year history. As you know, you
2 also have to cost out your work. So it's reasonable
3 to propose that in this example I've given you, state
4 A who's proposing to work with 80 nursing homes will
5 cost it out at a higher rate than state B would in
6 only working the 20 nursing homes. But I'm sure you
7 can imagine a very talented contractor who has
8 figured out how to do this in an ultraefficient way
9 and maybe not this time, but maybe in the 10th Scope
10 of Work, there could be a contractor who could
11 achieve excellent results in 80 nursing homes for
12 about the same cost to the government as state B
13 would for 20 nursing homes. That's another level of
14 competition that we introduced. That's my answer to
15 that question.
16 Next question: This has two parts. First
17 part, slides indicate that many QIOSC contracts will
18 be started or effective in June or July of 2008.
19 When will the RFPs for these contracts be released?

20 The answer is, CMS hopes to release the RFPs for the

21 QIOSCs in the next one to two months and is

22 considering various acquisition strategies. Part two

23 of the question: Previously, specifically at QualNet

24 2007, there was a discussion of QIOSC-like entities.

25 What QIOSC and QIOSC-like entities will be maintained

1 and/or initiated, i.e., what topics, areas of

2 experience will these contracts cover? And our

3 answer to that question is in my presentation from

4 this morning on slide 37, so my answer is please see

5 slide 37 for the current QIOSC plans from my

6 presentation this morning.

7 Next question. When will QIOSC

8 contractors be available? So this is a variation to

9 the same theme except not RFP, so when will the QIOSC

10 contractors be available, and I think there's some

11 good statements that follow that, so I'm going to

12 read those as well. This is of issue not only to

13 potential bidders of the support work, but it is also

14 critical for the core contractors to understand what

15 support will be forthcoming to support them in their

16 core contract work. It will affect both price and

17 technical approach. For example, does the QIO need

18 to create tools or will they be provided? If so,

19 which ones? That's the question. It's an excellent

20 question.

21 And my answer comes in two parts: First

22 of all, I have had an opportunity to review the 3,000

23 questions that we already have and I can assure you

24 that there are, many, many, perhaps hundreds of

25 specific questions on this very topic in the

1 questions that have been submitted. So I refer all

2 of you who are interested particularly in specific

3 tools to see the answers that are in the written

4 responses that will be provided shortly to the

5 questions in the RFP that will address many, many of

6 those specific instances. Here for purposes of today

7 I will say in general CMS will attempt to make the

8 tools standardized and in general CMS will attempt to

9 distributes these tools through the support

10 contractors. But again, please look at the formal

11 response to the individual questions for individual

12 tools.

13 And then I have one last question. Do I

14 have time, Doug?

15 SPEAKER: Yes.

16 DR. MCGANN: This is a very important

17 issue so I'm going to read it carefully. 30 percent

18 of Medicare beneficiaries live in rural America and

19 the fraction is increasing. A large proportion are

20 poor. There does not appear to be any work in the

21 9th Scope of Work focused on this large group. Could

22 you address how the program plans to address this

23 area? That is a good question and I can tell by

24 Mr. King's reaction, he may want to amplify my

25 answer. But it is a serious issue and we have been

1 asked this question many times, so I think it does

2 deserve a pause and some serious consideration.

3 So here's my response. Attention to rural

4 healthcare issues are very important to CMS

5 leadership both within and outside of the QIO

6 program. CMS is sensitive to the fact that moving

7 away from a setting-based statement of work to a

8 theme-based setting of work risks creating the

9 impression of a lack of interest in one provider

10 setting or another. Among other constituencies,

11 rural healthcare providers and home health agencies

12 could fall into this category with the reorganization

13 of the QIO program from the 8th to the 9th Statement

14 of Work. Recall our design principle. We would like

15 to deploy scarce QIO resources where they are most

16 needed.

17 If resources are needed in rural areas as

18 indicated by performance measures, we will deploy

19 resources there. A good example of this is the

20 patient safety theme. If resources are needed in

21 home health agencies, resources will be deployed

22 there. A good example of this is the care

23 coordination, patient pathways or care transitions.

24 In every instance, even in hospital and physician

25 offices, the focus will be on improving measured

1 performance and not specifically on setting.

2 Do you have anything to add?

3 MR. KING: The only thing I wanted to add

4 on that goes back to a brief statement I made earlier

5 having to do with disparity, and what we've learned

6 in terms of the data around socioeconomic issues

7 having to do with disparities. And that speaks

8 specifically to this issue of rural, and imbedded in

9 that question was an issue around the poor.

10 So it's not just words about being

11 sensitive to that, it was an issue that I took

12 particular interest in ensuring that during this

13 Scope of Work, particularly when we think beyond the

14 prevention theme but also as part of it, were we in

15 patient safety, were we in care coordination, where

16 we find around socioeconomic issues. Part of the

17 issue goes back to you have to have data that says

18 this is where the disparity exists. So whether it's

19 through these special studies or the other parts of

20 the contract, once again, that I've just iterated,

21 where we find the disparity, then that's issue one,

22 finding, have data to support that there is a need.

23 Now while that's going on, we have a model

24 that through the 9th scope we are moving forward.

25 And we talked about that as it relates to diabetic

1 health. We could find ourselves quite easily with a

2 tool belt of different processes that we could bring

3 to bear in the next scope of work, not thinking too

4 far ahead of ourselves, but definitely as we look at

5 possibilities, already worked to, in terms of

6 culturally sensitive specialties to sensitize

7 providers. So we've already worked on that issue as

8 part of the 8th. So now we come up with a model that

9 that's about increasing health literacy for health

10 outcomes in the 9th.

11 So we could very well find ourselves in

12 socioeconomically impoverished areas in the 10th with

13 a variety of methods that we could employ, because

14 now we know whether it's race, ethnicity differences

15 around certain health issues, we know where it

16 exists. We'll know whether it's around socioeconomic

17 issues, we'll know where it exists. And then we'll

18 have a variety of tools that we could employ as

19 interventions as we move forward to address those

20 issues. And that is thinking both operationally in

21 terms of what we improve with the 9th Scope and

22 strategically in terms of what we can plan for the

23 next scope of work.

24 So that's how we're looking at this, and I

25 think that's really the way we're going. So we want

1 to be clear, not only haven't we ignored that issue,

2 that's part of what we really want to nail around the

3 socioeconomic issues in the 9th Scope.

4 DR. MCGANN: And Terris, I just want to

5 add one last thing. Read your contract carefully in

6 all the core themes. You will find deliverables that

7 require that you are to prepare reports that impact

8 exactly the issue that Mr. King described in the

9 question and answer. We haven't specified the format

10 of the report, but you need to analyze your state

11 from that perspective exactly from the way Terris was

12 describing it and give that report to us so that we

13 can create a database and the approach to this

14 problem, and we'll do an even better job in the 10th.

15 MR. KESSLER: All right. These are

16 questions related to beneficiary protection. Will

17 the RAC or MAC contractors that perform HTMB-like

18 work be looking for quality of care concerns? If the

19 RAC or MAC contractors find quality of care concerns

20 in their HTMB work, will they refer these cases for

21 follow-up by QIOs? How will QIOs be paid for any

22 follow-up of quality concerns identified by other

23 contractors? And the answer is: The RACs and MACs

24 should have a method in place to identify quality of

25 care concerns and refer these concerns to the QIOs.

1 The expectation is that these cases will be included
2 as referrals from other CMS-designated entities for
3 funding purposes.
4 And the next one: If increasing awareness
5 of a complaint process is key, why is there no real
6 delineation of this work in the RFP? There is no way
7 to include it under beneficiary protection that we
8 can see, as costs must be broken down by review and
9 we are only allowed a certain amount of FDEs per type
10 of review. The answer: We certainly understand that
11 there are funding limitations in terms of what has
12 been traditionally done as outreach, but there are
13 other contractual provisions within beneficiary
14 protection that must be utilized to increase
15 awareness, including collaboration with other CMS
16 contractors and designated entities such as state
17 survey agencies, reporting on system-wide changes
18 generated through quality improvement activities, and
19 information sharing through QIO web sites.

20 And that's it. Next we're going to turn

21 it over to Linda with prevention.

22 MS. SMITH: Thank you, Tom. Question one:

23 The inability of practices to report data to CMS

24 QCRIs was labeled a problem in the 8th Scope of Work.

25 What does CMS see as areas in this inability and how

1 does it address these areas in this scope of work?

2 Answer: Under the 8th Scope of Work problems were

3 related to physician practices and ability to submit

4 data from the electronic health record to the CMS

5 data warehouse. CMS staff led an advisory group of

6 QIOs and submitted a report identifying various

7 topics with recommendations. These recommendations

8 are under review.

9 Question, CKD: The presenter implies that

10 CMS believes that the largest opportunity in this

11 task is the African American Medicare beneficiary

12 population. In this selection criteria for this

13 subnational task, what weight is given to

14 demographics? Specifically, would a state with a

15 negligible African American population realistically

16 be considered for this task? Answer. The presenter

17 provided data on the impact of CKD to different

18 ethnic groups. As stated by Dr. Straube and

19 Mr. King, health disparities is a focus of the Agency

20 and a cross-cutting theme throughout the 9th Scope of

21 Work. In the CKD proposal the QIO should identify

22 opportunity for improvement and the population to be

23 targeted. The proposals will be evaluated on the

24 QIO's ability to meet statewide targets.

25 Question: The contract calls for QIOs to

1 recruit nonparticipating providers for the prevention
2 theme. The speaker describes these practices as the
3 control group. Why would any provider agree to be a
4 control and do work for the QIO with no return?
5 Answer: As stated by the senior leadership, health
6 information technology is an Agency priority and any
7 practices that participate in the QIO program will
8 leverage their opportunities to participate in other
9 CMS initiatives such as PQRI and pay for performance.
10 Question: CKD, if a noncompete QIO is
11 interested in CKD in their state and other
12 competitive states, should that QIO submit one CKD
13 proposal or multiple proposals for each state they
14 are interested in? Answer: QIOs can only perform
15 QIO subnational work in the states in which they are
16 awarded the core contract requirements. QIOs cannot
17 perform subnational work in other states.
18 Now I turn it over to Liz.
19 MS. HANEY-CERESA: Can I just elaborate on

20 that question? I just want to make sure everybody

21 understands. In the competitive environment if you

22 are submitting a proposal for one of the states or

23 multiple states, the RFP is very clear. What it says

24 is that you have to submit a full proposal for all

25 the work that you intend to perform in that state.

1 So if you're submitting a proposal for the
2 competitive core work in that state and you elect to
3 participate as part of the subnational themes that
4 are open for you to submit a proposal, you have to
5 submit separate and complete proposals clearly marked
6 for each state that you want to be considered. You
7 can't submit one proposal and say here's a proposal,
8 you know, evaluate it for multiple states. We're not
9 going to do it because of the way we have structured
10 our evaluation teams. So just make sure if you want
11 to bid on more than one contract for the various
12 states that are open, we need complete sets of
13 proposals for each state clearly marked, and that is
14 in the RFP.
15 DR. DONOHOE: Okay. These questions
16 address the patient safety theme and I just want to
17 thank you all for your questions, these as well as
18 the 3,000 or so other questions that we have received
19 have really helped us to really streamline and

20 hopefully tighten up this document, so thank you.

21 Also just for clarification, the

22 attachment previously known as Attachment C is now

23 known as Attachment J-17, that will be available very

24 soon, I don't have a date for you, but it will be

25 available very soon. That is the attachment that

1 lists specific names and addresses of the facilities

2 under each applicable component by state and that

3 will be available soon. Okay.

4 Question one: Table B, which is the one

5 that delineates the maximum numbers of facilities by

6 component by state, Table B has changed from the

7 renewal RFP to the competitive RFP. Can you explain

8 changes to the criteria and numbers? The questioner

9 is correct to point out that this is very important

10 information needed to complete your proposals.

11 Table B is meant as a guide for maximum numbers of

12 providers by component. This was updated based on

13 some budget considerations from the initial RFP. The

14 one that went out for the competitive bids is the one

15 that we are currently using and it also will be used

16 for our baseline data. CMS plans to specify targeted

17 provider lists by issuing lists of targeted

18 providers, which will be in Attachment J-17.

19 Next question: Will CMS provide out of

20 state bidders the names of providers in Table B? The

21 names of providers will be provided in Attachment

22 J-17. Out of state QIO bidders will be provided the

23 appropriate Attachment J-17 for the state for which

24 they are submitting a proposal.

25 Next question: In areas where local data

1 justifies, may a bidder offer an additional solution
2 to Scope of Work requirements? A public reporting
3 state has a hundred percent of hospitals reporting
4 MRSA data whereas NHSN hospitals show zero. And
5 whoever submitted that question, thank you for
6 bringing that to our attention. It's a very good
7 point and certainly something that we will have to
8 take into consideration.
9 With respect to MRSA, NHSN is a voluntary
10 network of hospitals that report hospital infections
11 to the CDC. Our relationship with the CDC is what
12 will allow us to attribute progress in a decrease of
13 infection and transmission rates to the QIO program.
14 QIOs have an opportunity to recruit hospitals into
15 the NHSN system. Of consideration is that state
16 hospital systems may not be reporting the same
17 measures. This is something that will certainly need
18 to be looked at further and consistent measurement is
19 certainly of the utmost importance in the 9th Scope

20 of Work and again, we're going to consider that and

21 be able to get a better answer to you, hopefully

22 shortly.

23 Next question: What are the implications

24 of the statement, QIOs have the option to recruit

25 additional facilities? Now again, in Attachment

1 J-17, CMS is providing guidelines, names of specific
2 facilities by component by state, but CMS does
3 acknowledge that there could be limitations in our
4 methodologies and also that some QIOs may have some
5 creative approaches to addressing facilities that
6 aren't on that list. And to that end, we are
7 allowing states some wiggle room, a 15 percent wiggle
8 room.
9 The number of facilities for each
10 potential provider recruitment pool are delineated in
11 Attachment J-17. There is no required minimum number
12 of provider recruits under any patient safety
13 component in any state or jurisdiction. All
14 facilities that are recruited by a QIO must agree to
15 report on all measures of that component. QIOs
16 choosing to work in the pressure ulcer component must
17 work with nursing homes and hospitals. The QIO may
18 recruit up to 15 percent of the total number of
19 providers they will work with under a component from

20 among providers not included in Attachment J-17. The

21 QIO must submit the criteria used to select those

22 providers in the proposal to CMS.

23 In no case may the total number of

24 providers exceed the maximum number of providers as

25 specified in Table B, nor may the number of providers

1 not identified in J-17 exceed 15 percent of the total

2 number of the providers the QIO recruits to work

3 with. So the 15 percent, up to 15 percent of the

4 total number of those providers are up to the QIO's

5 discretion, and that must be clarified and defined

6 within the proposal.

7 Now my colleague Jade Perdue is going to

8 answer some additional questions.

9 MS. PERDUE: How are we on time, Doug?

10 Okay. Very quickly then.

11 Which surveys will be utilized for patient

12 safety during the 9th Scope of Work? And the answer

13 to that is, there are three of the AHRQ survey

14 instruments. It's specifically geared towards

15 obtaining an assessment of hospital cultures with

16 regard to patient safety and this tool should be

17 provided to all hospitals, specifically to the

18 corresponding floors that the QIO chooses to work

19 with in the 9th. As an example, it might be the

20 surgical unit if you choose to work within the SCIP

21 component.

22 If the tool has been given to the hospital

23 within one year of the 9th Scope beginning, with the

24 approximate start date being August 1st, the results

25 may be used for 9th Scope of Work purposes. Any

1 amount of time over one year and then the survey

2 should be readministered. Similarly, the AHRQ

3 nursing and culture survey instrument should be

4 utilized for assessing patient safety cultures in

5 nursing homes, and that will be available to you all

6 before the launch of the 9th Scope of Work.

7 And then finally, the hospital leadership

8 and quality assessment tool will be available also

9 during, for your use in the 9th, and that is

10 specifically geared towards hospital leadership such

11 as the CEO, CFO or executive medical director.

12 Let me see if I can get one more question

13 in. With regard to tools, and this is going back to

14 the similar questions that Dr. McGann had earlier,

15 tools with regard to patient safety, tool updating

16 and development will occur before the launch of the

17 9th Scope of Work. QIOs should plan to use the

18 available tools but as hospitals and nursing homes

19 begin to make large gains, new tools may need to be

20 developed and used. The expectation will be that

21 QIOs share successful tools and practices with one

22 another to foster a community of quality improvement

23 with regard to patient safety measures. Some

24 examples may include but are not limited to effective

25 PDSA, dashboards, clinical cue cards, et cetera.

1 Thank you. I hand it over to Doug Brown.

2 MR. BROWN: We received three questions on

3 care transitions. The first question is, is the CARE

4 assessment tool available? If so, how do we access

5 it. Well, we wanted to wait until August to show it

6 to you, but if you want to ruin the surprise -- no.

7 It's on the PRA web site on the care transitions

8 appendices, Appendix C, Section C.2 also gives a link

9 directly to the Paper Work Reduction Act web site

10 where the CARE instrument is located. The first two

11 appendices in that section are the instrument itself

12 in its paper form and also a matrix of all the data

13 items that are on the instrument. The online version

14 or the electronic version of the instrument is not

15 yet available. It is currently undergoing testing,

16 user acceptance testing is actually going on as we

17 speak, and we will make that available as soon as we

18 can.

19 Question two: The RFP and speaker refer

20 to populations that are large enough for the expected

21 gains, specifically a two percent absolute reduction

22 with .05 error and 80 percent power. Most

23 calculations of such numbers result in or around

24 3,000 or 4,000 discharges per quarter. This number

25 would eliminate all but the largest facilities,

1 effectively eliminating all rural communities. Is
2 this the intention of CMS or are we misinterpreting
3 the RFP? This actually is a misinterpretation. When
4 we are talking about the rates, we are talking about
5 for the community or the site that was selected and
6 chosen by the QIO, so this is the global reduction in
7 rehospitalization rates. So the actual number of
8 population for the community, we are expecting to be
9 around 200,000, and those three to 4,000 discharges
10 actually would apply to the entire community. So I
11 hope that helps.
12 SPEAKER: It would still eliminate
13 virtually, for example northern New England.
14 MR. BROWN: Well --
15 MS. HANEY-CERESA: Doug, we can take that
16 off line.
17 MR. BROWN: Right. But to go along with
18 the question that the bidder has asked, if you wanted
19 to go into smaller areas, then we would allow that.

20 We would just make sure that you understand that in

21 order to achieve the expected gains, your measure of

22 improvement would have to be so much larger.

23 Last question: Are QIOs eligible to

24 propose subnational projects that extend to other

25 states or should their proposals focus only on the

1 states in which they are performing with national
2 products? Because the beneficiary cohort is defined
3 by ZIP code of residence, the theme QIO can obtain
4 data concerning the beneficiaries overall claims
5 experience, including claims from other states.
6 However, to work with providers out of state, QIOs
7 should work out an agreement with the QIO for that
8 state so as to avoid inefficiencies or reduced
9 effectiveness.
10 For example, the QIO in Arkansas can know
11 that 100 patients were discharged from Memphis
12 General Hospital. The Arkansas QIO cannot obtain
13 data on all of the patients that MGH, the Memphis
14 General Hospital has discharged. In order to talk
15 with staff at MGH about standard discharge procures
16 in use of care, the Arkansas QIO should secure the
17 cooperation from the QIO in Tennessee. Thus,
18 projects that expect to cross state lines may need to
19 improve collaboration from another QIO from the

20 start, or they may find such a community to be less

21 desirable.

22 Those are all my questions. I believe

23 Lisa McAdams is next.

24 DR. MCADAMS: I think it's Georgetta.

25 MS. ROBINSON: Okay. For health

1 disparities we actually have three questions.

2 The first question: What is the role or

3 what are the potential opportunities in historically

4 black colleges and universities and Hispanic serving

5 institutions in the 9th Scope of Work? Answer: The

6 potential role for Hispanic serving institutions and

7 historically black colleges and universities in the

8 9th Scope of Work may be serving as subcontractors or

9 partners with quality improvement organizations who

10 will be working with underserved Medicare diabetes

11 populations. These subcontractors can aid with

12 recruitment of community health workers and

13 population specific beneficiaries. Historically

14 black colleges and universities and Hispanic serving

15 institutions both have knowledge and expertise in the

16 areas of outreach and intervention and are seen as

17 trusted sources within communities that could make

18 them a potential subcontractors for these important

19 activities.

20 Question number two: The Scope speaks to

21 diabetes self management education programs that must

22 be offered to patients. CMS themes are directing the

23 use of specific programs. Should the bidder include

24 staffing and training tools of additional programs?

25 Answer: In the Scope it states that the QIO will

1 facilitate training of appropriate personnel at the

2 organizational sites using evidence-based

3 CMS-approved diabetes self management and education

4 programs within the underserved population. The

5 definition of what constitutes a CMS-approved

6 diabetes self management education program can be

7 found on page 71 of Appendix A in the request for

8 proposal.

9 Question three: Community intervention

10 agency activity is directly correlated to

11 reimbursement recognition. Does the QIO have any

12 latitude in the CMS reimbursement levels, perhaps

13 even extracontractually? Answer: QIOs cannot

14 provide financial rewards for beneficiaries or

15 community health workers for participating in

16 subnational prevention disparities work.

17 Those are the questions for health

18 disparities.

19 DR. MCADAMS: I have just a couple of

20 questions here.

21 What system is being used or may we

22 propose one to assure our monitoring in the CMS

23 oversight is focused on special cause variation, not

24 common cause? One thing to let you know for the 9th

25 Scope of Work, one of the tools that we're building

1 is a monthly status report of each of the contractors

2 that we have, and those status reports will collect

3 information where there are issues and what actions

4 are being taken related to those issues, as well as

5 best practices that are being identified as the

6 project officers have their regular discussions with

7 the contractors.

8 So through that system, as well as the

9 data that we will be collecting within our dashboard

10 in the management information system, we're going to

11 be monitoring a lot of information and both special

12 cause and common cause variation are important for us

13 to monitor. For example, if we find that many QIOs

14 are failing to hit performance expectation, a common

15 cause may be related to the theme itself or the

16 expectations we have set. Our actions for addressing

17 that would be very different from our actions to

18 address a special cause related to QIO activities,

19 et cetera.

20 The second question: If the QIO is

21 implementing a CMS-prescribed action but not getting

22 the results, when can the QIO change processes to

23 create the change required? Timely flexibility is

24 critical here. And the answer: The performance

25 expectations in some basic types of activities are

1 specified within the Scope of Work. There is much

2 room for a QIO to choose and implement different

3 interventions to drive improvement. Where transfer

4 and intervention are heading the wrong way, even if

5 you haven't failed to meet a performance expectation,

6 the QIO can modify and/or change altogether their

7 intervention approach. They should keep both the

8 project officer and the theme lead GTL apprised of

9 their action, as well as the root cause results that

10 led to selection of the new intervention.

11 That's it for me, and I think now we're

12 ready to move on to our afternoon program and Cynthia

13 Wark.

14 MS. WARK: Thank you, Lisa, and good

15 afternoon, everyone. My name is Cynthia Wark, I'm

16 the director of the information systems group in the

17 Office of Clinical Standards and Quality, and in my

18 presentation I will be covering approaches to

19 information technology in the QIO 9th Scope of Work.

20 Goals for this session are twofold.

21 First, to inform organizations who are interested in

22 competing for QIO program work, participants will

23 understand how IT systems work in the QIO program,

24 and secondly, for organizations who are interested in

25 performing IT work, participants will understand what

1 sort of opportunities may exist in the future. And

2 so the reason for those two goals is you understand

3 how the QIO apportionment works and the funding

4 sources.

5 There are two specific line items where

6 resources are provided for information system work.

7 In the first line it is work that is performed by the

8 QIOs, staff in the QIO organization performs work

9 locally, and I will address that in the presentation.

10 And then the other funding source is for centralized

11 resources. We have a number of contracts that are

12 run by federal staff in my group in the information

13 system group here in Baltimore and that is the work

14 when I say for those of you interested in performing

15 IT work, that is the work that I'm referring to

16 there.

17 The Health Care Quality Improvement System

18 is known as HCQIS, and we generally refer to that as

19 QualityNet. It is considered a major application

20 environment, it uses application groups, shared

21 database servers and wide area network resources to

22 monitor and improve utilization and quality of care

23 for Medicare and Medicaid beneficiaries. Next slide.

24 QualityNet is composed of four application

25 groups. The first is the Consolidated Renal

1 Operations in a Web-Enabled Network, and we refer to

2 that as CROWNWeb. That is a collection of systems

3 that support our end stage renal disease network

4 program, so we have things like the standard

5 information management system that is used by our

6 ESRD network contractors, and that is the equivalent

7 of SDPS for our ESRD program.

8 Then we have the standardized data

9 processing system for QIOs and I'll elaborate more on

10 that.

11 We also have value based purchasing IT

12 programs and IT infrastructure. Those are things

13 like the hospital reporting programs to support the

14 annual payment update, it is the Physician Quality

15 Reporting Initiative IT systems and the hospital

16 outpatient reporting programs. Those are programs

17 that were mandated under the Tax Relief and

18 Healthcare Act of 2006 and that is now our third

19 major component under QualityNet.

20 And then the fourth area, the quality

21 improvement and evaluation system for states and for

22 CMS.

23 And so why am I telling you, why do we

24 have four major areas when you're really looking at

25 one, and the reason is that as these systems are

1 developed and we add on to them, it is important for
2 QIOs to understand where our systems come from, how
3 they're developed, how they integrate with other
4 systems that the Agency has, and then vice versa, how
5 does the work that the QIOs and the QIO program do
6 feed into that IT infrastructure. Next slide.
7 The QualityNet system consists of
8 complexes, we have three complexes. The first one is
9 located at the CMS central offices here in Baltimore
10 and that is largely where our data feeds come from,
11 the billing and claims system, and it's a direct feed
12 into our QualityNet systems. Complex 2 is located at
13 the Iowa Foundation for Medical Care in Des Moines,
14 Iowa. Complex 3 is located at the Buccaneer Computer
15 Systems and Services Organization in Warrenton,
16 Virginia. We also have a national work of actually
17 56 QIO physical sites. We have one clinical data
18 abstraction center that's in York, Pennsylvania, and
19 that's where our medical records are extracted for

20 the QIO program. And then we have 18 end stage renal

21 disease networks. Next slice.

22 SDPS is an application group whose purpose

23 is to provide hardware and software tools to enable

24 QIO personnel to fulfill the requirements of the

25 contract. So for those of you who have not been a

1 QIO before or held a QIO contract, you should note
2 that in the mid 1990s we centralized a major portion
3 of the hardware and software that supports all of the
4 QIOs. So a lot of the resources are provided
5 centrally, including the work stations that you need
6 and the desktop images, those are all handled
7 centrally, and we are planning on doing equipment
8 refreshes over the next few months and into the
9 latter part of this year, where the work stations
10 will be provided to all QIOs.
11 The SDPS applications will support the 9th
12 Scope of Work themes that you have heard about today
13 and the tasks associated with those themes. The SDPS
14 infrastructure is standard and supported by CMS,
15 including work stations, file and print servers, and
16 software. We have a fairly extensive effort underway
17 now to evaluate all of the tasks required in the 9th
18 Scope of Work, to evaluate all of our existing
19 applications, and to determine all of the

20 modifications that are needed to support the 9th

21 Scope of work. Referring back to the metrics that

22 you heard Dr. McGann talk about earlier this morning,

23 we are crosswalking each of those metrics, the

24 applications and the databases needed to support

25 those, with our infrastructure, and that is the work

1 that will happen prior to the 9th Scope of Work

2 beginning this fall.

3 To support improved accountability in the

4 9th Statement of Work, CMS will develop and implement

5 a management information system. You've heard about

6 that quite a bit today and in a couple of slides I

7 will show you a diagram of what we envision that

8 system to look like.

9 Examples of some of the SDPS software

10 applications are, we have data collection tools like

11 CART or the CMS abstraction and reporting tool. We

12 also have QualityNet Exchange, which enables the

13 secure transmission of data. We have the case review

14 information system which tracks medical records and

15 performs online case review activities. And PARTner,

16 the Program Activity Reporting Tool, allows QIOs to

17 collect the information requested by CMS, so a lot of

18 the deliverables are reported through PARTner and

19 many of the metrics that we will have in the 9th

20 Scope of Work will use the data that is submitted

21 through PARTner. Next slide.

22 I wanted to include a snapshot of the

23 qualitynet.org web site as a reference, again, for

24 those of you who are not as familiar with the QIO

25 programs. This is our portal web page for all of the

1 applications and web sites related to the QIO
2 program. And although you can't see it on the screen
3 here, down on the bottom on the right-hand side there
4 is a link to the 2007 QualityNet presentations, some
5 of those have been referenced today, and a great deal
6 of the information system presentations that were
7 provided at QualityNet can be found on this web site.
8 Also, the manuals for the IT work that is
9 performed in the core contract by the QIOs, we're
10 looking to have those posted shortly. There is a QIO
11 manual on the CMS web site and under Chapter 8 is the
12 area where the IT materials are available. However,
13 those are not included in what is publicly posted
14 today. We are working to get those cleared and
15 posted on the CMS web site. Because the environment
16 in the past didn't support the level of competition
17 that we're seeing now, those materials were only
18 available on our intranet site for QIOs. And so what
19 we're having to do is remove all of the information

20 like network diagrams and IT addresses. All of those

21 sort of things that we really don't want to make

22 public for security reasons, we're pulling that out,

23 and we will post the remainder of the materials, and

24 there's quite a bit there.

25 We'll have the QualityNet system security

1 policies, the incident response procedures, SDPS

2 database administrator guide, and infrastructure IT

3 administrator manuals. Now for those of you who

4 would like these materials prior to the clearance and

5 the posting of these on the CMS web site, please let

6 me so and we will make sure that you get a copy,

7 through Naomi, through the contracts office. We will

8 coordinate that.

9 I believe in the earlier proposal it said

10 that they would be made available upon request and so

11 rather than having to provide those materials to

12 every person requesting, we decided to post them

13 publicly, but we need to go through the clearance

14 process first. So in the meantime please contact

15 Naomi and we'll make sure that you get a copy. Next

16 slide.

17 The management information system will

18 provide reports to monitor and evaluate the QIO

19 program and progress of individual contractors. The

20 MIS will use data from multiple sources including the

21 financial vouchering system, surveys, deliverables,

22 clinical and administrative databases, and case

23 review data. And the MIS will contain summary

24 reports that show performance based on evaluation

25 metrics, cost associated with the metrics, and status

1 of deliverables.

2 The next page is a diagram of how we

3 envision MIS to be built. On the bottom right-hand

4 side are the clinical warehouses and then feeding

5 into the standardized data processing system

6 applications, you see a database there for FIVS,

7 which is our financial vouchering system. And then

8 off to the left-hand side there's a data entry box

9 and that is so that, for example, the project officer

10 monitoring requirements, they will be able to enter

11 their data directly into the MIS to have it reported.

12 Up on the top of the page, the boxes show contract

13 performance reports, deliverable status reports, new

14 dashboard reporting on the metrics, QIO status

15 reports, and site visit reports. Next slide.

16 QIOs and FISMA. Quality improvement

17 organizations historically have been exempt from

18 FISMA. Recent security incidents within the federal

19 sector have forced the legislative branch to

20 reevaluate security guidelines and requirements.

21 This reevaluation has led to new requirements for QIO

22 facilities to meet FISMA requirements. Next please.

23 In order to begin baseline assessments, we

24 will have security audit teams visit every QIO twice

25 over the upcoming three-year period to perform a

1 baseline and a follow-up analysis of the current
2 FISMA controls in place. QIOs, like fiscal
3 intermediaries and carriers, will enter baseline
4 assessment findings into a CMS tool and create their
5 corrective action plan to address the QIO FISMA
6 requirements. The plan includes performing site
7 visits and addressing the findings. QIO sites will
8 begin working to mitigate all of the identified risk
9 findings and weaknesses. Next slide.
10 Strategically, going back to my earlier
11 slide about the QualityNet enterprise and all of the
12 major application groups that are being built there,
13 consistent with that, CMS seeks to deliver quality
14 products on time by managing scope and employing an
15 effective systems development life cycle. The Agency
16 has a systems development life cycle that is applied
17 to the building of all IT tools and IT investments.
18 Therefore, we seek to achieve efficient
19 use of resources by aligning with enterprise efforts.

20 For example, we utilize agency service agreements

21 where available. AT&T and Cognos, today the SDPS

22 infrastructure funds a portion of those agency

23 agreements, and therefore for example with reporting,

24 Cognos is a technology that we look to move to. We

25 will adopt enterprise standards wherever possible.

1 We will adhere to security requirements. And we will

2 use the enterprise system development mechanism

3 wherever possible.

4 Potential contract opportunities.

5 Consistent with competition and our general

6 contracting strategy, we will evaluate all contracts

7 and select the best strategy in coordination with the

8 CMS Office of Acquisition and Grants and the Office

9 of Information Systems. And again as you heard from

10 others earlier, we would even encourage you to

11 consider partnering with organizations that have

12 experience. The QIOs have experience in the business

13 world of QIO work, and of course IT companies who

14 have been performing work in other areas for CMS have

15 experience with Agency standards, and so we would

16 encourage you to network and consider opportunities

17 as they become available.

18 That's the end of my presentation and I

19 think I turn it over to Alfreda Staton.

20 MS. STATON: Good afternoon. Over the

21 next few minutes I will discuss with you the

22 requirements that you must meet in order to become a

23 quality improvement organization. For those in the

24 audience who are interested in becoming

25 subcontractors, you will not need to meet those

1 requirements. Next slide please.

2 In order to become eligible as a quality

3 improvement organization you must either be physician

4 sponsored or physician access. And you must

5 demonstrate an ability to perform review as set forth

6 in 475.104 of the Code of Federal Regulations. You

7 may also refer to Section 1154 of the Social Security

8 Act for explicit details about the functions of a

9 QIO. Next slide please.

10 Physician-sponsored organizations must be

11 composed of at least 20 percent of the licensed

12 doctors of medicine and osteopathy practicing in the

13 review area, or demonstrate through letters of

14 support from physicians, physician organizations, or

15 through other means that it is representative of the

16 area physicians. And of course, not be a healthcare

17 facility, healthcare facility association, or

18 healthcare facility affiliate, as specified in

19 475.105 of the CFR.

20 If I could hold that slide there for one

21 moment, let's talk about the 20 percent figure. It's

22 a figure that was specified by Congress regarding

23 ownership interests, and of course that appears also

24 in Section 1153 of the Social Security Act, next

25 slide please.

1 A physician-access organization has
2 available to it a sufficient number of licensed
3 doctors of medicine or osteopathy practicing in the
4 area to assure adequate peer review of the services
5 provided, and of course that is referenced in
6 42 CFR 475.103. And of course it cannot be a
7 healthcare facility, healthcare facility association
8 or healthcare facility affiliate as specified in the
9 Code of Federal Regulations as well. Next slide
10 please.
11 A physician-access organizations also has
12 to have available to it at least one physician in
13 every generally recognized specialty, and this could
14 be any specialty, gynecology, nephrology, internal
15 medicine, dermatology, in no specific order. And
16 last, has an arrangement with physicians under which
17 the physicians would conduct review for the
18 organization. The physician-access option may be the
19 easier option for most of you interested parties in

20 the audience due to the time restrictions. Next

21 slide please.

22 Ability to perform review. A

23 physician-sponsored or physician-access organization

24 will be capable of conducting review if CMS

25 determines that the organization is able to meet

1 quantifiable performances objectives, and those
2 currently are timeliness and beneficiary
3 satisfaction. And of course it performs review and
4 quality review functions established again under
5 Section 1154 of the Social Security Act, in an
6 efficient and effective manner. Next slide.
7 CMS will determine that the organization
8 is capable of conducting review and quality review,
9 if one, the organization's proposed review system is
10 adequate and secure; two, the organization has
11 available sufficient resources, including access to
12 medical review skills, to implement that system; and
13 three, the organization's quantifiable objectives are
14 acceptable, and I mentioned those objectives on the
15 last slide.
16 Before I move on to the governance
17 requirement, in summary, in order to be eligible to
18 participate as a quality improvement organization,
19 you must be either physician sponsored or physician

20 access, and have an ability to perform reviews. Next

21 slide please.

22 Over the next few minutes I will briefly

23 discuss the governance requirements as they appear in

24 our 9th Statement of Work. When responding to the

25 CMS request for proposal the organization must

1 specify how the board will oversee the management of
2 the QIOs. The purpose of governance requirements are
3 for efficient and effective management, it sets the
4 overall policy and direction, and it maintains
5 oversight responsibilities. Next slide.
6 Prior to the 9th Scope of Work the
7 governance requirements were merely guidelines, QIOs
8 had full discretion in selecting the members of its
9 governing body, their length of service and their
10 responsibilities. With the 9th Scope of Work, these
11 guidelines are now requirements in the 9th Scope of
12 Work, and this is in response to the recommendations
13 of Congress, the Institute of Medicine, the General
14 Accountability Office, and the Office of Inspector
15 General. The recommendations suggested that the
16 guidelines now have a narrower focus on technical
17 assistance, on performance measurements and quality
18 improvement which will enhance the governing body's
19 ability to provide oversight or direction. Next

20 slide please.

21 The governing body requirements are, the

22 QIO governing body shall develop and implement a

23 compliance program. They shall make publicly

24 available by posting on the web site information

25 pertaining to the governing body, the number of

1 members, names, length of appointment, cap on
2 service, when appointments are made, affiliations and
3 compensation. The QIO shall also specify that the
4 number of members should not exceed 20 voting
5 members. The governing board members shall include
6 representatives of a variety of healthcare setting
7 and disciplines, and non-healthcare backgrounds.
8 The governing body shall have at least one
9 beneficiary/consumer representative. With boards
10 with more than ten members, we recommend that you
11 choose at least two. The QIO shall adopt a policy
12 that two-thirds of the members should be independent,
13 and there shall be a six-year cap on member service
14 time. The QIO shall adopt a policy or it shall have
15 a quorum rule that no business will be conducted
16 unless a majority of the members present are
17 independent. The duties of members must be specified
18 in bylaws and attendance and participation of at
19 least 50 percent of all members at board meetings.

20 The QIO shall develop and implement an annual

21 performance evaluation, annual governing body self

22 assessment, and a performance improvement plan.

23 And of course you will have the

24 opportunity to submit questions on this portion of

25 the presentation during the question and answer

1 period.

2 I think the next speaker is Naomi, oh,

3 okay, Brian Habbel, who will address conflicts of

4 interest. Thank you.

5 MR. HABBEL: No applause necessary here.

6 Good afternoon, everybody. I'm Brian Habbel, I'm the

7 division director in the Office of Acquisition and

8 Grants Management, and my voice will wake everybody

9 up just in case you're not stirring around too well.

10 Before I do get started talking about conflict of

11 interest I do want to talk about the reference to

12 these 3,000 questions or so that we've received that

13 have been mentioned quite a few times on quite a few

14 occasions today.

15 The 3,000 questions that we received were

16 strictly from the renewal QIOs. The only people who

17 had the opportunity to submit those questions were

18 the renewal QIOs. You know, your questions are due

19 on February 5th, but I do have to say, I think it

20 would probably make prudent sense that Naomi and

21 myself are going to look through those questions, and

22 questions that pertain to like the Statement of Work,

23 Section B, there's some things that we think might

24 have some overflow to help you better prepare for

25 your proposal for these competitive RFPs, we will

1 release them. You know, we want to provide
2 contractors as much opportunity as you can to submit
3 a competitive proposal and we think that will help
4 out. We at CMS are still in the process of answering
5 those questions and we in the contracts office
6 haven't seen even seen them yet, so they are quite a
7 few days from even going out, so I just want
8 everybody to know that those questions we've received
9 from the renewals, we haven't responded to them, and
10 we will consider releasing them for the competitive
11 RFP process just to help everybody prepare their
12 proposals. Naomi, anything you want to add to that?
13 MS. HANEY-CERESA: Thank you. Brian and I
14 always share our time. Today I had a little bit more
15 than he did. Just, not going directly to those
16 questions, but we've had a number of individuals
17 concerned that the questions that were submitted in
18 the drop box earlier that we haven't fully answered
19 every question. And what I want to let you know is

20 that we're answering the questions, as many of them

21 as we possibly can. Some of your questions require

22 us to go back and actually spend more time looking at

23 the RFP and also discussing those questions

24 internally.

25 So please don't feel that we're picking

1 and choosing questions to answer, we are to some

2 degree, those that we feel we can answer in this

3 particular session. Questions that we don't answer,

4 I would highly recommend that you submit those

5 questions under the competitive question process.

6 Again, look to section L-8 of your RFP. Not that we

7 will ignore what you did here today, but as we leave

8 this forum, we've got so much going on and we have so

9 many other questions that we're trying hurriedly to

10 address, we don't want to ignore that you might have

11 submitted a question in this forum that we didn't get

12 to answer. So please, if you didn't get your

13 question answered in any of the discussion earlier

14 and then we're going to have another session a little

15 later on, resubmit the question. Do not count on us

16 to go back and put that into the process for having

17 it addressed at the next question and answer issuance

18 for the competitive RFP. Thank you.

19 MR. HABBEL: Thanks. I'm here to talk

20 about contract section H.11, conflict of interest.

21 And I can tell you from just looking at it from the

22 8the Scope of Work standpoint, we spent a lot of time

23 over the 8th Scope of Work addressing conflict of

24 interest issues and the intent of this clause is to

25 help kind of streamline some of those issues.

1 Whether you're an existing QIO or you plan on bidding
2 on this competitive carrot, before you bid, you do
3 need to read this clause pretty carefully just to
4 insure that you don't have any conflicts of interest
5 with any business relationships outside the state in
6 which you're planning to bid.
7 The QIO Scope of Work includes the
8 beneficiary protection theme. The work in this theme
9 area includes case review functions, utilization
10 review functions, appeal cases, anti-dunking cases,
11 quality improvement activities, alternate dispute
12 resolution, sanction activities, physician monitoring
13 and other oversight activities. As a result of these
14 activities, in general an actual or apparent or
15 potential conflict may take place when you engage in
16 business relationships with providers, payor
17 organizations or health plans in that particular
18 state. Next slide.
19 So from our perspective, conflicts of

20 interest need to be resolved and you need to take

21 them pretty seriously. In this case we can't aware

22 contracts if there's going to be a serious conflict

23 within the state in which you're submitting the

24 proposal. Next slide.

25 And I'm just kind of going to go through

1 in what I'm going to say here, and again, you do need

2 to go back and read that clause very specifically,

3 but I'm just going to summarize what it says, because

4 if you haven't had the opportunity. It is a conflict

5 or potential conflict if you have a direct or

6 indirect financial relationship with, number one, a

7 provider of services located in the area for which

8 the QIO is required to perform services under the

9 terms of the contract. Number two, payor

10 organizations inside the area where the QIO is to

11 perform. Or number three, health plans in the area

12 where the QIO is to perform. This relationship can

13 exist through the QIO's parent companies or

14 subsidiaries as a result of relationships executives

15 may have with outside entities. And when I say that,

16 this relationship, I mean a conflict may exist based

17 on that.

18 It isn't a conflict of interest if you

19 have a relationship with organizations located

20 outside your QIO area. It isn't a conflict if you

21 have an individual arrangement that does not exceed

22 five percent of the core contract with an entity, or

23 20 percent of the core contract for all arrangements

24 with an entity in your state, or that may be viewed

25 as a conflict. It isn't a contract of interest if

1 you have a financial relationship with the state,

2 local or federal agency. It isn't a conflict if you

3 enter into a financial relationship that has been

4 approved by Naomi. And also, it isn't a conflict of

5 interest if you serve on the board of directors

6 within your state in an ex officio nonvoting

7 capacity.

8 A QIO, a conflict of interest exists if

9 you enter into a relationship with an organization in

10 your area whose function directly relates to Medicare

11 reimbursement. It's also a conflict of interest if a

12 QIO is related to a provider of services, payor

13 organization or health plan.

14 And in addition to that, the contracting

15 officer can still determine if a conflict of interest

16 exists even though you have not notified us, if for

17 some reason you find out there's a problem. Next

18 slide.

19 It's also the QIO's responsibility to

20 ensure that subcontractors do not have relationships

21 that create conflicts of interest. We have numerous

22 reporting requirements in the contract. And one is,

23 you know, per the instructions in the RFP you're

24 required to notify us if you have any conflicts. And

25 actually deliverables in the contract note that

1 you're to notify us of any conflicts or the
2 arrangements you have on February 28th of each year
3 and 45 days prior to actually having a change in any
4 arrangements, existing arrangements or new
5 arrangements that you have. Next slide.
6 In that provision there are resolution
7 procedures in the event that a conflict of interest
8 can't be resolved. That's pretty much it, but I
9 would encourage you to read that clause. Thank you.
10 DR. STRAUBE: We're running ahead of
11 schedule, which is probably a good thing. I think
12 that the next step is that we should probably go
13 ahead and take our break, mainly because we want to
14 allow another question and answer period. So the
15 format will be similar to what we did this morning.
16 You should have forms for any questions. I believe
17 the staff is working on questions already, but
18 clearly we want questions for the afternoon session
19 first and foremost being focused on the IT,

20 eligibility and the conflict and governance issues

21 that you just heard about.

22 We may not have enough time to carefully

23 give an accurate answer on those that go back to the

24 morning session, but I would I suggest since we're

25 all gathered here and this is important to everybody,

1 there may be some unanswered questions or some

2 follow-ups that you would have normally wanted to

3 pick up a microphone this morning, so why don't we

4 continue to take those other questions also, but I

5 can't promise you whether we can answer them in quite

6 the detail that we did this morning. We'll try our

7 best.

8 So let's see, it's 2:35. Why don't we

9 regather here at 2:50, ten of three, and we have a

10 couple other presentation issues and we will spend

11 the time there with questions and answers. Thanks

12 again. Ten of three.

13 (Recess.)

14 SPEAKER: Good afternoon. I have three

15 brief announcements. Number one, someone has lost a

16 stylus to one of their PDAs. I don't know which

17 brand it belongs to but if you're missing it, we will

18 have it on the table outside.

19 Also, we have two corrections on our list

20 of attendees today and we have to apologize for the

21 errors. On page eight, you see a contact name of

22 Patricia Howell, number 92. The correct company name

23 is Managed Healthcare Unlimited. Again, that's

24 Managed Healthcare Unlimited, number 92.

25 The second correction on page one, where

1 you see the contact is Valerie Biggs, and that's
2 number nine, the correct company name is Healthcare
3 Resolution Services, Incorporated. Again, number
4 nine on page one, the correct company name is
5 Healthcare Resolution Services, Incorporated. Thank
6 you. We will now turn it over to Dr. Paul McGann.
7 DR. MCGANN: Welcome back, everyone,
8 coming into the home stretch here.
9 Several of you have remarked to me that
10 some of our messages today have been perceived to be
11 harsh, and those of you who know me that I'm never
12 harsh, but the purpose of my talk this afternoon is
13 in all seriousness to try to convey some of the sense
14 of excitement that we have in a totally new approach
15 to a Statement of Work. And I'm hoping at the end
16 you'll agree with me that this is very exciting and
17 that the opportunities I'm about to describe to you,
18 whether you're a new company, a small business, a
19 subcontractor or QIO, in some ways of thinking it

20 could be seen as being drastic, but really if you

21 stop and think of what we're trying to accomplish, or

22 what I'm going to tell you in the next 15 minutes or

23 so is actually very exciting and opens up all kinds

24 of new possibilities. So this isn't going to be

25 theoretical at all, it's going to be really concrete

1 and practical. So if we could have the first slide.

2 What we're going to talk about for 15

3 minutes is how can we get the communities and the

4 smart people that want to improve health care in this

5 country together so that everybody takes advantage of

6 everybody's intelligence, experience and skills, and

7 that we really achieve way beyond the minimum

8 requirements as spelled out in the RFP. And that's

9 really what we're after, we're after going way beyond

10 minimum requirements. So we believe that there are,

11 here at CMS we believe there are phenomenal

12 opportunities both now and in the future and I've

13 chosen to break down these opportunities by time

14 periods, and on this slide you see the five time

15 periods that I think the opportunities fall into.

16 So the first four are kind of concrete

17 opportunities over the next year or two and then the

18 last one, which is kind of the theoretical one,

19 remember, things are changing rapidly in the 10th

20 Scope of Work, which if we're successful in the 9th

21 Scope of Work will be even bigger and better,

22 provides the most opportunity at all, but I'm going

23 to focus on one through four. So, next slide.

24 What's available now? Right now at the

25 QIO level, in other words the desire to be or act as

1 a QIO, you've already heard about this in detail, so
2 if you want to be a QIO in any particular state
3 whether you're an existing QIO in a renewal state or
4 whether you're a brand new organization who has
5 always aspired to be a QIO and you meet the
6 requirements, there are 13 contracts within our
7 national program of 53 contracts that are potentially
8 available for competition now. And if you need to
9 knew the details of that, go to FedBizOpps and it
10 will all be spilled out in greater detail. So that's
11 the QIO level, if you are a QIO and want to work in
12 another state, or if you want to become a brand new
13 QIO, those are your current opportunities right now,
14 because the RFP is active as of last week.
15 At the subcontractor level for a QIO, and
16 current or new QIO might possibly need your services
17 for the 9th Scope, especially for some tasks. We
18 keep bringing up healthcare disparities because
19 that's one of our big priorities as are the other

20 cross-cutting themes. But a current existing renewal

21 QIO or even one of the 13 QIOs that are up for

22 competition now may in fact, if you're a small

23 business or company that know how to work, for

24 example in communities of underserved populations,

25 may really need your services, and we think it would

1 be really nice if you offered your services to join

2 those who think they might benefit.

3 There are many examples of this in the

4 contract and we don't have time to go over them all,

5 but one particular one that we know for sure is in

6 the health disparities task within the prevention

7 theme. That health disparities task has really

8 important recruitment challenges that have to be

9 overcome and we know from our pilot work that that's

10 a difficult thing to do. So we believe there are

11 many small businesses, and when Terris King was

12 talking he asked people to stand up. There are

13 people here now who know how to do that and not every

14 QIO knows how to do that. I even see people raising

15 their hands now. So I'm going to refer many times

16 during this talk to the list of attendees, and we

17 really strongly advise those of you who aren't a

18 hundred positive that you can recruit for one

19 population or another, to take advantage of that.

20 What about at the support contract level?

21 That is not the purpose of this meeting. We believe

22 that some of the support contractors will be at

23 QIOSC, some of them will be QIOs doing their own

24 scope of work, but we think some of them will be

25 non-QIOs, and we're hoping to get those procurements

1 underway in the next few weeks. But those support
2 contractors also will need probably assistance
3 through subcontracting, so that's yet another
4 opportunity that's going to become available in the
5 next few weeks.
6 And then finally for individual special
7 projects, these again will be announced maybe in the
8 next one or two months, probably not all at once
9 although I have to consult with OAGM about that.
10 Special studies are being done and often require
11 subcontractors, so that's yet another opportunity to
12 look for. Next slide.
13 So these are the dates to keep in mind, I
14 think mostly if you are one of those small businesses
15 I'm talking about. The proposals are due for the
16 majority of the QIOs in the QIO program, so this for
17 the renewal QIOs whose procurement started actually
18 in December, the proposals, their final proposals for
19 their renewal contracts are due at CMS on February

20 14, 2008. So in those renewal states, it's very

21 important if you're going to work with them that you

22 get in touch with them before they finish their

23 proposal.

24 Now for the 13 states that are competitive

25 RFPs, and you can find out who they are by consulting

1 FedBizOpps because that procurement's underway, their

2 proposals are due on March 11, so you have a little

3 bit more time to get together with them to be part of

4 their proposal. And then of course the 9th Scope of

5 Work, as you've heard, will start exactly on August

6 1st, 2008. Many of the QIO support contracts as

7 we've talked about in the question and answer

8 session, are going to start in June and July, so just

9 keep watching FedBizOpps for that. And we're aiming

10 to get our special projects for this project going on

11 August 1st, 2008, so watch FedBizOpps for that as

12 well. Next slide.

13 I talked about this this morning so we

14 won't spend any time on it, but the list of eight

15 bullets lists the eight support contracts we're

16 intending to get out in the next few weeks. Next

17 slide.

18 Now the subcontracting opportunities are

19 everywhere you have expertise in the Scope of Work.

20 I gave you a broad overview early this morning and

21 then throughout the day you heard detailed

22 presentations of every theme and every component in a

23 theme, but remember everything I've said, just to

24 emphasize it. It's not just subcontracting to an

25 individual state QIO. It's also subcontracting to

1 the support centers or QIOSCs. It's also potential
2 subcontracting to QIO special projects. And
3 especially review and listen carefully to what
4 Cynthia Wark, the director of our information systems
5 group told you earlier about health information
6 technology; that's a major thrust of ours and I think
7 there's going to be opportunities not just now, but
8 as the 9th Scope of Work goes on.
9 Now it is the 21st century and this little
10 list is just a little behind the 20th century in my
11 book, so I want to let you know that CMS is exploring
12 many ways of getting potential contractors and
13 subcontractors together. We don't have that ready
14 for you just now but as you can imagine, there may be
15 electronic ways to get these to communities so that
16 you can in an interactive way find each other very
17 rapidly. Right now for subcontractors it's very easy
18 to find the name of the QIO in all 53 states by going
19 to our web site, MEDQIC, www.medqic.org, and you will

20 find the name and contact information for every

21 current QIO. But we're trying to work at an even

22 more advanced level to try to get that going in the

23 next week or so. Next slide.

24 So what are the dates then? August 1st,

25 2008 the contract begins and begins in all 53 states

1 and territories at the same time. Most themes

2 require recruitment of participants to be successful

3 and in some themes, recruitment may be a challenge in

4 some areas. I've already talked about that in health

5 disparities but it also complies to other components.

6 And it's possible that some QIOs may require

7 assistance to be successful with recruitment. So

8 that's one outstanding area that we keep mentioning

9 as a good place for subcontracting.

10 But further on in the contract, if you

11 think about our evaluation structure, month 12 to 18,

12 there is this 18-month first evaluation period and

13 all 53 QIOs must clear the evaluation criteria for

14 that or there will be enforced changes in the way

15 their contract is run. So this is going to be a

16 critical time period for all QIOs and at that point

17 even a QIO who now and on August 1st doesn't believe

18 they need assistance, their performance numbers that

19 they're looking at might actually show that it might

20 have been a good idea to take up those offers with

21 data assistance at the beginning. That would be a

22 great time for potential subcontracts to look at

23 whatever communication web site we develop to see

24 what the opportunities would be at the midpoint of

25 the 9th Scope of Work.

1 And then finally, if you fast forward to
2 the last year, these are all three-year contracts, so
3 if you think of the last year for the 9th Scope of
4 Work, if you think for a minute, that's exactly where
5 we are right now in the 8th Scope of Work, this is
6 the last year of the 8th Scope of Work. And so
7 during the last year of the 9th Scope of Work, we
8 will be having conferences like this again for the
9 10th Scope of Work and if you have not been able to
10 plug in up to that time, we believe there will be a
11 lot more opportunities as we finish the 9th and go
12 into the 10th for everybody to play and everybody to
13 get involved, even earlier than you could at this
14 time. So I think that's a really good thing to plan
15 on if you can't get things together in the other
16 short time frames that I talked about.
17 So I'm just going to finish up by
18 mentioning some things about the long-term future
19 here, and of course nobody knows exactly the

20 long-term future, but next slide outlines the four or

21 five points I've put down for the 10th Scope of Work.

22 So that will be 2011 and the world could be a very,

23 very different place than it is now in 2011. So for

24 those of you who are CEOs and like strategic

25 thinking, like to thing big about the future, I

1 happen to like to think big about the future, go to

2 that Institute of Medicine report on the QIO program.

3 I've seen several people carrying it around, it's got

4 a big green cover, it's like five or 600 pages,

5 published in 2006. I'd encourage you to go read

6 that, because that gives you like a little road map

7 of where things might be headed.

8 Pay attention to current legislative

9 proposals actually on the books now. There's several

10 pieces of legislation related to the QIO program.

11 One is called Grassley-Baucus, but there are others.

12 If you're interested in the strategic planning theme

13 and what the opportunities are going to be over the

14 next few years, go and read those pieces of

15 legislation. Not saying any will be passed or not,

16 but it will give you ideas of where this is all

17 headed.

18 I'd also you to remember, out third

19 cross-cutting theme is value driven health care, and

20 I encourage you to read more on that, because now I

21 think if you have been paying attention today, you're

22 seeing how the QIO program is actually starting to

23 plug in to the payment delivery systems from CMS.

24 And that's really what's generating this energy, and

25 I really encourage you to go to our CMS web site. We

1 just published the Medicare value-based purchasing

2 plan for hospitals. That document is a really

3 critical document, I would encourage those of you

4 doing strategic planning to look at it. So now is a

5 very good time to revisit the strategic plan and we

6 believe as exciting as we are today, that the 10th

7 Scope of Work is going to be a veritable cornucopia

8 of excitement and enthusiasm.

9 So to finish up here, on the last slide

10 there, use your list of attendees here today. If you

11 don't have it, it looks like this, it's old fashioned

12 technology on paper, pick it up at the registration

13 desk. That will be your first contacts, plus all the

14 business cards you've collected. Remember what I

15 said, we're working on a more efficient 21st century

16 way to do that same thing soon here.

17 If you're a QIO, seek out the companies

18 with expertise in theme and priority areas that are

19 here; many of them are here. Raise your hands if

20 you're companies like that. They're here, we invited

21 them specifically for this purpose, so don't leave

22 the room without finding these people that are

23 raising their hands.

24 If you're a company, talk to existing QIOs

25 and likely offerors for QIO contracts. If you talk

1 to the QIOs, to all the other people who aren't
2 raising their hands here, who are probably with QIOs,
3 go out, you know, the early bird gets the worm, so go
4 out and seek some business.
5 CMS does encourage the widespread
6 dissemination of the information on the 9th Scope of
7 Work and the QIO program. We want it to be well
8 known and well recognized; that's why we're having
9 these open door quorums and conferences like this.
10 And we especially for the sake of our beneficiaries
11 want this program to be successful, and far more
12 successful than it has ever been before. And we
13 truly believe that forums like this and working
14 together can help us do that. So our shared goal is
15 to help providers prevent illness, decrease harm to
16 patients and reduce waste in health care, and we
17 thank you for your desire to help us improve
18 Medicare's quality improvement program. So, I hope
19 that was very positive.

20 And Barry, I'm not sure, are we ready to

21 go with questions? Doug, where are we at?

22 SPEAKER: We're ready.

23 MS. WARK: The first question I have in

24 the IT area is: When will CRIS, the case review

25 information system, be updated to a newer more

1 intuitive and friendly system? The answer is: Our

2 intent is to modify the existing case review

3 information system known as CRIS to meet the

4 reporting needs of the 9th Scope of Work. Our plan

5 is to release a new version of CRIS in time for the

6 contract starting on August 1st, 2008.

7 Additionally, an independent review of

8 case review activities is currently underway. We are

9 anticipating some recommendations from that effort in

10 the area of IT systems. We will evaluate the

11 recommendations and plan for additional updates to

12 CRIS or other necessary applications over time.

13 The second question I have is: Will there

14 be an RFP for management information systems? If so,

15 when will it be released? The answer is: Yes, there

16 will be an RFP to build a management information

17 system. We are currently reviewing the best

18 acquisition strategy to proceed with this effort.

19 Number three: On slide 157, IT Potential

20 Opportunities, what are the examples of the

21 opportunities and when would these be announced? The

22 answer is: The current system has a number of

23 contracts that support our IT work. For example, we

24 have contract with a clinical data abstraction

25 center, we have a contract for infrastructure

1 support, and contracts for application development.

2 Two of these contracts were awarded during the 8th

3 Scope of Work through a competitive process. When

4 the existing contracts are nearing the end of the

5 period of performance, we will evaluate the best

6 acquisition strategy and compete as appropriate.

7 The fourth question is: Are FISMA

8 security control requirements applicable to all QIO

9 employees or a subset? The answer is: All work

10 funded with federal dollars and the employees

11 performing the work on those contracts are applicable

12 to federal security control requirements. So all of

13 the QIO employees working on the QIO contract would

14 be covered under the FISMA requirements.

15 Those were my questions.

16 MR. KING: Cynthia, back to just that

17 third question, just to see if we have a sense of

18 timing in respect to when the existing contracts were

19 near the end, do we have any date, months, in terms

20 of time?

21 MS. WARK: We certainly know with the

22 existing contracts that we have, and I gave some

23 examples in the area of the key data and

24 infrastructure support. We have several application

25 development contracts and I don't have the exact

1 dates. We certainly can provide additional

2 information about how we would make those

3 opportunities known and as I said, in general we

4 evaluate each of our contracting opportunities as we

5 near the end of a current period of performance, and

6 I think the IT area for SDPS is a good example where

7 in the 8th Scope of Work we did go through a

8 competitive process and as Brian and Naomi have noted

9 on several occasions, of course we looked to small

10 business firms first as the preferred mechanism and

11 then we would go on to other avenues.

12 MR. KING: Because for that particular

13 one, it's not so much what method we would employ but

14 at least giving some idea in terms of time as to when

15 existing contracts will come to some end, and so

16 maybe that's something in terms of future questions

17 to be answered. If questions come in, we can give

18 some indication of that as we move forward, because I

19 know there has to be some entities here that are very

20 interested in what dates certain work could become

21 available. Okay.

22 DR. STRAUBE: I would just like to add for

23 focus too that the answer to this question that

24 Cynthia just gave is certainly focused on the short

25 to intermediate term plans. I wanted to maybe entice

1 ou folks to know that there's a tremendous amount of

2 interest on how all of the CMS efforts, whether it's

3 quality improvement, value-based purchasing, and

4 other contractual issues kind of merge together and

5 overlap. And I think particularly with the quality

6 improvement and value-based purchasing efforts, OCSQ

7 is going to be, it appears, taking over more and more

8 of the value-based purchasing system, and the systems

9 and the issues that we're dealing with for collection

10 of data for improvements is going to have to overlap

11 with the process, they're going to have to come

12 together, so this area in the short to intermediate

13 term is complicated enough, but I think it's going to

14 just explode, not in a bad way we hope, but explode

15 in terms of being even more important going forward.

16 I think that's good for the QIO program and certainly

17 good for people who want to play an IT role in this.

18 MS. HANEY-CERESA: Okay. I'm going to

19 give the general questions and the responses to the

20 general questions and then I'm going to turn it over

21 to Brian for the conflict of interest portion.

22 So the first general question that we

23 received is: Are people responding to the RFP

24 encouraged to seek partnership with the minority

25 organizations? If so, how are they given credit?

1 And at this point in time, yes, we are encouraging
2 the QIOs to seek partnerships and subcontracting
3 opportunities with minority organizations and other
4 small businesses as a part of meeting and achieving
5 the subcontracting goal requirements, because
6 everybody will be responsible for sending in a
7 subcontracting plan and there are definite goals for
8 meeting those subcontracting requirements. So we are
9 encouraging that you QIOs take into consideration
10 working with small businesses and small minority
11 businesses and organizations in achieving those
12 goals.
13 Second question is: Will names and titles
14 and e-mails be provided of the attendees today? And
15 I think Paul already give you that answer. There is
16 a complete list of the attendees on the registration
17 desk, so be sure you pick that up before you leave
18 today.
19 Next question: Will the answers to

20 questions from the renewal RFP be made available for

21 the competitive RFP bidders? Yes, we are going to

22 make those questions and answers available to you.

23 We anticipate posting them on the FedBizOpps site, so

24 we'll definitely put those up and annotate them as

25 being the questions and the answers from the renewal

1 RFP so that everybody has an opportunity to see those

2 answers and questions as well, and we expect that

3 that will happen within the next couple of weeks. So

4 just stay tuned. We can't give you an exact date

5 because we're in the process of finishing that

6 amendment up, but just stay tuned and monitor

7 FedBizOpps.

8 Who will be reviewing the RFP, how is the

9 decision going to be made and who will be making the

10 decision on the RFP? And what I'm assuming this is,

11 is who will be reviewing our proposals that come in

12 to the competitive solicitation we have out there and

13 who will be making the decision on who those awards

14 will go to, and how will the decision be made? And

15 what I would refer you back to is to the RFP that's

16 out on the street. Section M of that RFP will give

17 you the evaluation and the award process.

18 We do have separate technical and business

19 evaluation panels that will be reviewing the

20 proposals. From those reviews we will have

21 recommendations that will be made to the contracting

22 officer as to who the award will be. Once we get

23 down to that stage, the contracting officer will be

24 the source selection official, but that's opportunity

25 solely at the contracting officer level, we do have

1 recommendations coming down with the evaluation

2 reports, both from a technical and business

3 perspective.

4 And we will be making a best value award,

5 and that process for the best value continuum is

6 carefully explained in Section M of the RFP, so

7 please read that.

8 When will awards for the competitive

9 proposals be announced? If everything goes well and

10 we're able to stay on track with the acquisition

11 cycle that we have planned, we're anticipating that

12 those awards might carry over into June or possibly

13 July. We're actually hoping we have it on a faster

14 track than that, but at this point in time with the

15 volume of questions that have come in on the

16 renewals, we're giving that date as an anticipated

17 date, sometime in June and if need be in July. But

18 definitely these contracts will be awarded in

19 sufficient time for contract performance to begin on

20 August 1st.

21 How can national minority organizations

22 and community-based organizations participate in this

23 process? And I think that throughout the day you've

24 heard some discussion as, you know, these

25 organizations being your partners, possibly through

1 the subcontracting process, and I think that we've

2 given information throughout the day that those are

3 opportunities. Barry, do you want to add to that?

4 DR. STRAUBE: No, that's fine.

5 MS. HANEY-CERESA: Based on the proposed

6 time line for support RFPs, and in parentheses they

7 have QIOSCs, which are quality improvement

8 organization support contracts, will the competitive

9 states have an opportunity to submit a support

10 proposal? And I think at this point in time to

11 address each and every opportunity for these support

12 contracts is a little preliminary for us. It will

13 depend on the acquisition strategy that is actually

14 selected for each and every support contract. Any

15 other additional information, Barry?

16 DR. STRAUBE: No. I guess to again try to

17 get a little more information, and the team should

18 correct me if I'm overstating this, but it sounds

19 like somebody is concerned that the competitive QIOs

20 might not be able to play a role and compete for

21 this, and I don't know, we certainly haven't made any

22 decision about that and I suppose we could take that

23 into consideration, but that has not been part of our

24 thinking so far.

25 MS. HANEY-CERESA: Thank you.

1 The RFP indicates a QIO must obtain prior
2 approval from CMS prior to utilizing a consultant to
3 support 9th Statement of Work activities. If a QIO
4 charges a consultant to interact, is the QIO still
5 responsible for obtaining prior approval? I would
6 just like to refer you back to the definition of what
7 a direct cost and an indirect cost is in the OMB
8 A-122 circular for nonprofit organizations, and the
9 federal acquisition regulations for for-profit
10 organizations, and to caution you from moving and
11 mixing your directs and your indirects. Truly if
12 you're hiring a consultant to perform direct work and
13 that is work that is identified in Section C of the
14 contract, if that's the purpose of that consultant's
15 work, then that does have to be a direct charge to
16 your contract. But if you want further
17 clarification, go back and read what a direct charge
18 is in the OMB circular and what an indirect charge is
19 in the circular as well as in the FAR.

20 If we decide not to be a QIO, can we still

21 bid on QIOSC contracts or special projects? And

22 again, I think that at this point in time it depends

23 on how we award those QIOSCs, you know, support

24 contracts down the road. If we are going to announce

25 QIOSC contracts or what would be special projects as

1 other than special projects to be awarded under the

2 QIO contracts, those will be announced, possibly

3 announced on FedBizOpps or possibly through another

4 vehicle or another means, maybe the, you know, small

5 business program or whatever. But for us to be able

6 to answer that today, I think we're a little, we're

7 not really sure of where we're going with that

8 acquisition strategy at this point in time.

9 DR. STRAUBE: When I was sitting on the

10 other side of the table here, my brain would have

11 been running into, that's a yes or no question, why

12 can't you answer it yes or no. I've learned by

13 sitting on this side that it's much more complicated.

14 The reason we can't is there is a lot of people we

15 have to check in with, get clearance from, get

16 assurance that whatever we choose to do is legal and

17 in compliance with the statutes, is in compliance

18 with OMB, et cetera. Trying to put those all in line

19 takes some time and rather than just going down the

20 old route without trying to see if we can achieve

21 other options is why it's taking so long. We're

22 frustrated we can't give you an answer yes or no, but

23 hopefully soon.

24 MR. KING: I guess the one piece I will

25 add to that is if we base this on our current

1 experience, take everything that Barry said under

2 consideration, part of what we were able to do, not

3 saying this is a model or a model that we even

4 prefer, is that we were able to have entities perform

5 as subs working with QIOSCs to perform certain

6 functions for our program. So that is a model that

7 we could employ. The other model, as Barry is

8 describing with an entity not being a QIO, clearly

9 that's a model that would require all the approvals

10 that he talked about, the clearances to make sure

11 that it's appropriate.

12 So if I'm interested and sitting in this

13 room, and I want to bring the skills of my

14 organization to bear on this contract, opportunities

15 in all likelihood would be available, but the vehicle

16 that we use to get it done, that is where the

17 decision has to come, along with what specific work

18 we would look for, what do we need from the QIOSC.

19 And once again as Barry mentioned earlier, you

20 mentioned earlier as well, those decisions are still

21 in the decision making process. Okay?

22 DR. STRAUBE: One last addition to this

23 too, and that is that we are determined as we said

24 starting about two years ago, to having this Scope of

25 Work start on time. So at some point we hit a

1 fail-safe point at which we have to make a decision

2 about one of these two main methods that Terris has

3 described. So that will happen and we will get this

4 started on time.

5 MS. HANEY-CERESA: Thank you. Next

6 question, it's kind of along these lines, again. The

7 question is: How do specialty organizations such as

8 patient advocacy groups and minority focused schools

9 effectively market themselves as potential

10 subcontractors for QIOs and other contractors? And

11 one of the ways that we hope to help you do that is

12 by actually having the conference today and making

13 the list of attendees available to you. So please

14 make sure that you pick that up as you're leaving

15 here, and you'll have the names of the organizations

16 to contact and market and build your team with.

17 DR. STRAUBE: I would, on this one and

18 other related issues, also encourage QIOs or people

19 who become QIOs, to be thinking just the way we had

20 to think being responsive to OBM, Senate Finance

21 Committee, et cetera. So that is, it's great to go

22 out and look for partners and contractors, et cetera,

23 but I think you have to be asking the same questions,

24 that is, gee, sounds like good efforts you've done,

25 but can we really be sure that what you were doing

1 led to improvements? There's got to be some drill

2 down, I think, into what people are saying they can

3 do. I don't mean to be disparaging to anyone or any

4 organization, but you could end up contracting with

5 people who are used to the old model which is not

6 evidence-based interventions, and that could be a

7 mistake too.

8 MS. HANEY-CERESA: I have basically one or

9 two more that I'm going to be able to answer. The

10 next question is, would CMS provide the name, brief

11 description of individual's job, and a brief

12 description of the individuals assigned to the 9th

13 Statement of Work themes and components? For

14 example, provide the names of the GTLs, the theme

15 leaders, the project officers and the contracting

16 specialist. I just want to let you know that you did

17 get some of that information in the presentation

18 today. We're not able to give you all of that

19 information at this point in time. Obviously at the

20 time of contract award, those individuals will be

21 identified for you. So I just want to let you know,

22 some of it was made available through the

23 presentations today and as we get close to contract

24 award, you will be given some other information

25 relative to maybe firming up the contract specialist

1 and you know, project officers, et cetera.

2 Next question: Will CMS allow access to

3 existing QIO contracts other than through the FOIA

4 process? And if CMS will not allow access to the

5 existing QIO contracts other than through the FOIA

6 process, could you explain why CMS will not allow

7 such access? Obviously we cannot circumvent the

8 rules that pertain to the Freedom of Information Act

9 and how information is transmitted to the public

10 through the FOIA process, we have to follow that

11 process. So if you are interested in receiving a

12 copy of a QIO contract that is currently in place

13 then you have to adhere to the rules and the

14 submission process through the Freedom of Information

15 Act. We don't have any authority to circumvent that.

16 So, Brian.

17 DR. STRAUBE: Brian, before you go, I'm

18 going to jump in here. I have to run upstairs to

19 brief the deputy administrator, but I wanted to thank

20 everybody for their attendance today. I thank the

21 QIOs for their hard work and efforts over the various

22 scopes of work before and hope that we have a very

23 broad group of folks that are going to be with us and

24 helping as we go forward. Certainly the feedback

25 we've gotten has been very good, people are

1 enthusiastically taking on the challenges.

2 This is going to be a very different scope

3 of work and is going to be a very hard scope of work

4 for whoever ends up being the representatives in the

5 various states. And we appreciate that, but I think

6 it does answer many of the questions and the concerns

7 that a whole variety of critics and scrutinizers have

8 had of this program. We have regular sessions with

9 the Senate Finance Committee staff, sometimes with

10 principals on the Senate Finance Committee, and I was

11 telling David Schulte earlier that the last session I

12 went up to on the Hill a week and a half or two weeks

13 ago, the feedback I got was that they are starting to

14 believe that everybody gets it in terms of where the

15 QIO program needs to go, and even hints that they

16 might be focusing on different kettles of fish going

17 forward. Don't hold your breath on that one, I'm

18 not, but that's what I heard.

19 There still is some concern about

20 conflicts of interest and governance structure,

21 particularly with individual QIOs, they have some

22 perceptions but we're working on it. But I think

23 overall, all of us working together and sticking

24 together will help the program immensely. I think

25 that to me, you heard about three, what I call the

1 bread and butter, prevention, patient safety and

2 beneficiary protection. Those just seem to be right

3 on with traditional work that QIOs have done, with

4 new updated infection control and things like that.

5 But the care coordination, care transitions, patient

6 pathways theme, I think that's where the cutting edge

7 is.

8 You all know that there is a tremendous

9 focus by everybody. I, again, have been to two

10 international conferences over the last six months on

11 this and there have been many more. We know that IHI

12 is thinking of getting involved, the Commonwealth

13 Fund may be funding something they will be involved

14 with in a couple of states, the National Quality

15 Forum is holding a conference focused on this, and

16 there are a number of other efforts, including

17 medical home care and so forth. This will be the

18 lead in that particular area. So all of the efforts

19 of those folks I mentioned, you know, quality, high

20 visible organizations, are minuscule compared to what

21 I think we have planned here.

22 So I think in addition to good solid bread

23 and butter issues that will benefit the American

24 public and benefit the beneficiaries in particular,

25 we've got a new theme that is just very innovative

1 and will set the tone of where care goes over the

2 next decade.

3 In closing for me, in addition to thanking

4 everybody for coming and for your comments, questions

5 and continuing support as we go forward together, I

6 did want to make sure we recognized the staff here.

7 You've already heard, again, from Naomi, from Brian,

8 from Rod Benson on the OAGM side, from myself,

9 Terris, from Paul McGann, from the presenters of the

10 theme leads, Tom Kessler, Linda Smith, Liz Donohoe,

11 and also Lisa McAdams and Doug Brown, Cynthia Wark

12 this afternoon. But there are several folks who I

13 think are here that I would like from the CMS side to

14 stand up and be recognized also.

15 First of all, way in the back over there I

16 think is Regan Crump; Regan, why don't you stand up.

17 Regan, this went very smoothly today, it exceeded my

18 expectations which were pretty high. Regan is on

19 detail with us, he's a senior executive series

20 candidate and it was on a senior executive series

21 training kind of rotation. Regan led the team that

22 put this on. I know I'm going to miss folks, but

23 we've got Cheryl Boddin, I don't know if Cheryl is

24 here, we've got John Thomas, we've got Rick Methaney,

25 we've got Rachel Weinstein, we've got Jackie Whitley,

1 I'm not sure if Jackie's here. We've got Clarissa

2 Watley, who played an important role too. And Jackie

3 Harley, I said Clarissa, excuse me, so Jackie Harley

4 is sitting right back here also. So all of these

5 folks made a tremendous effort and I want to thank

6 them personally. I think this was a meaningful

7 conference.

8 With that, back to even more important

9 discussions of questions. I apologize that I have to

10 leave, but Brian will take over and answer some more

11 questions. Thank you.

12 MR. HABBEL: Thank you. Just to talk

13 about conflict of interest and one thing we've

14 learned over the past couple of years on conflicts of

15 interest is there is no easy answer to each

16 situation. Each situation really presents its own

17 unique set of opportunities and so some of these

18 questions that we've had just asked in a sentence or

19 two, we're not necessarily going to be able to give

20 you a cut and dry answer to some of those questions.

21 But the first question is: Will CMS

22 respond to questions about the specific conflict of

23 interest concerns on an individual basis, and in

24 parentheses, so that companies can address COI in

25 their proposals without releasing potential

1 competitive information through public Q&As. You
2 know what, we're going to have to think about that
3 one. It's a good question and I've addressed that
4 one time in my career but it was a little bit
5 different of a situation, so we'll think about that.
6 But just to say, if you do submit a proposal and you
7 do have a conflict of interest when your proposal is
8 submitted, we will take it into consideration and
9 evaluate whether you have any mitigation or ways to
10 resolve the conflict in a short or long term. So it
11 will be part of a risk assessment if you do have one
12 when we evaluate your proposal.
13 Another one here, if a physician is
14 employed by the QIO and is also employed as a medical
15 director for a nursing home or practice at a clinic,
16 is this a conflict of interest? I think it all
17 depends. Initially we answered that as yes, but you
18 know, you QIOs do have physician reviewers on staff,
19 so I guess it depends on what the roles of the

20 individuals are, so I think we would need a little

21 more information on that. Anything you want to add

22 to that, Naomi?

23 MS. HANEY-CERESA: No.

24 MR. HABBEL: Somebody had a concern about

25 slide 171 and 174. I didn't exactly understand what

1 the specific concern was, but to make a long story

2 short, the question is, is this clause unique for CMS

3 contracts? The answer is yes, it is unique to CMS

4 contracts, including the dollar amount in the

5 conflict of interest clause, which we kind of tied

6 back to the statute in terms of where there's a 20

7 percent figure in there for I believe the board

8 membership. And you will have to go back into the

9 statute and read it and then go back to the clause

10 and read it again, but it is a unique clause to the

11 CMS contract.

12 Another one, another question: Will

13 setting up a separate commercial QIO-like subsidiary

14 mitigate conflicts of interest that the parent

15 company or other subsidiaries may have? And I think

16 the answer here is I think we've got to review it on

17 a case-by-case basis, I don't think this is really

18 specific enough. We've seen in the past it's a

19 case-by-case basis.

20 If a prime QIO subcontracts with another

21 entity to perform QIO work, will the subcontractor be

22 subject to the same or similar conflict of interest

23 restrictions? And the answer there is yes, the

24 conflict of interest requirements are a flow down and

25 we will review on a case-by-case basis issues you may

1 have with your organizations and/or subcontractors.

2 And I did have one other question that

3 we're going to have to put it in writing to the

4 responses, it was a little bit hard to read and I

5 wasn't able to summarize it here, but it had to do

6 with the board of directors and the 20 percent

7 figure. The only thing I can tell you there is go

8 back and read the statute, read the clause. We will

9 provide an answer to that question once Q&As are

10 submitted to you.

11 MS. STATON: Okay. I have questions on

12 governance and eligibility requirements. The first

13 question, what does CMS consider the start date time

14 frame for board members, is it based on the beginning

15 of the 7th Scope of Work per SDCS memo 07-381? If

16 so, can we assume that the years of membership prior

17 to this are not counted? The start date for counting

18 board members is the date of the first round of the

19 7th Scope of Work contracts according to, yes, SDCS

20 memo 07-381. Prior years of membership will not be

21 counted.

22 Question two: Does the governance

23 requirement have to be in place by the start date of

24 the contract or at the time of proposal submission?

25 Yes, by the start of the contract.

1 Under what conditions would CMS grant a
2 waiver to board member term limits? Example: If
3 following term limits for all members resulted in
4 vetting the board of all key positions, example,
5 president, vice president, would this constitute good
6 cause to grant a waiver? CMS will determine on a
7 case-by-case basis whether or not a waiver would be
8 granted.
9 Will proposals that describe a compliance
10 program that is not yet fully in place but will be
11 fully in place by August 1 be scored lower than
12 proposals claiming that all requirements of the
13 compliance program are already in place? And the
14 answer is, CMS will perform a risk assessment of the
15 proposal to ascertain the degree of risk.
16 And the next question, when and how would
17 an organization obtain review by CMS for a waiver to
18 have a 21-member board of directors as referenced in
19 the RFP? And the next question is the estimated

20 determination response time. And the answer is, in

21 accordance with Section H-9 of the contract, CMS on a

22 case-by-case basis will determine whether or not a

23 waiver is acceptable, and waivers will be discussed

24 during the negotiation phase of the contract.

25 And the last question: Do any of the

1 governance requirements apply to QIO subcontractors?

2 If so, how do they apply? The answer to that is no.

3 MS. HANEY-CERESA: Excuse me, and thank

4 you. I just want to mention that when we put the RFP

5 together, there is in the governance piece, if you go

6 online and look at the competitive requirements, I

7 think we had a little bit longer time frame and I

8 think we did a little better job in putting in that

9 competitive RFP what the governance expectations are.

10 And while there is an opportunity for CMS on a

11 case-by-case basis to take a look at waivers and with

12 proper justification, we may be inclined to grant

13 approval of a particular waiver in a certain

14 situation, the preference is that you meet those

15 governance requirements by the start date of the

16 contract, which is August 1st. So while we do have a

17 little leeway in there, I just want to caution you

18 from believing that waivers are going to be

19 forthcoming very easily and very readily. We are

20 striving for meeting those requirements.

21 MS. ROBINSON: Okay, we had two disparity

22 questions. The first one is, if there are new

23 diabetes self management programs approved in the

24 attachment within a given state, should a QIO build a

25 new training program or continue with an identical

1 approach? The answer is, we prefer to see the

2 documents required in the disparities task of the

3 national theme.

4 The second question: Is there a database,

5 public database that can be accessed which lists the

6 certified diabetes educators that are on CMS's

7 payroll within our state? The answer is no.

8 However, there is a listing on the American Diabetes

9 Educators web site that recognizes the diabetes

10 educators in a variety of states.

11 DR. MCGANN: I had a content question that

12 slipped through, Terris.

13 MR. KING: Go ahead Paul.

14 DR. MCGANN: We know we're doing well,

15 because this is a question on a question. So here's

16 the question, it's an important point. Clarification

17 requested: Based on Dr. McGann's response to a

18 previous question, is it accurate to assume a QIO

19 could work with home health agencies on the pressure

20 ulcer prevention topic in patient safety if such work

21 drives improvement in the measure? Would it be

22 correct to assume that such interaction will not

23 technically be reimbursed by CMS, given the

24 assumption that CMS is funding QIOs based on number

25 of providers stipulated in the 9th Scope of Work? So

1 this is a very good question and I think the most

2 important line that indicates that it's a

3 sophisticated questioner, you remember it said, is it

4 accurate to assume a QIO could work with home health

5 agencies on the pressure ulcer prevention topic in

6 patient safety if such work drives improvement in the

7 measure?

8 So if such work drives improvement in the

9 measure is a really important phrase there, and in

10 this case it would be reducing the incidence of

11 pressure ulcer in hospitals, I'm assuming, and I

12 think it's really important to think about that

13 question. So I have three comments on the question.

14 The first I have already made, which is if the work

15 is driving improvement in measure, then that's

16 absolutely crucial.

17 And I would just caution you because I've

18 done a lot of work in trying to reduce pressure

19 ulcers in my career, it's very easy to convince

20 yourself that this will happen, and I've been burned

21 myself many times if you say in claim work it's going

22 to drive the pressure ulcer measure down and it turns

23 out that it doesn't. And in particular in this case,

24 the measure we're using in hospitals is the incidence

25 of pressure ulcers in hospitals presumably happens

1 because the hospital staff aren't turning patients or

2 doing appropriate preventive measures, it's hard for

3 me to make the link to a home health intervention

4 that's going to prevent that, but you might know

5 something different that I don't, so that's one

6 comment.

7 The second comment is if the question had

8 been in care coordination or care transitions the

9 question would have been very easy, and yes, in the

10 questions list that I reviewed for care coordination

11 and care transitions, it's explicit that there is a

12 reference in one of those answers to the inclusion of

13 home health agencies in the communities whose effort

14 is to reduce the rehospitalization rate. There I

15 think we can understand is a more direct connection

16 to home health agencies, so in that theme this

17 question would apply.

18 And then the third thing I'll say is that

19 this is a complex question, I've done the best I

20 could right here, but just like Brian said, we're

21 going to put together the list of questions that we

22 couldn't nail to the wall this afternoon, and will go

23 back to the technical staff and get an answer to this

24 specific question for you and post it, put it in

25 writing so you have access after all of the fine

1 minds here have a chance to chime in also, but that's
2 the best I could do extemporaneously. That's all I
3 have.
4 MR. KING: Thanks, Paul. So really quick,
5 because I think we've covered what we came to cover
6 and we may do something unusual, get out early, that
7 will be good.
8 I have three quick points, we don't have
9 to dim any lights, you can see what's there, and we
10 will go through these relatively quickly, kind of a
11 summary. You've gotten the point, I think very
12 clearly, at least for the QIOs because we've said
13 this again and again, Scope of Work is new, from our
14 perspective improved, from the perspective of those
15 that approve our apportionment, our money, have
16 approved the process, it's improved. The fact that
17 we're sitting where we are here signifies the fact
18 that it is improved. And the backdrop to this
19 process was not one that was predicted, that we find

20 ourself in this spot this early, so that's clear.

21 We have sent the clear message that the

22 part of what is business as usual is that we have

23 qualified and capable entities that have done great

24 work in the past. We haven't necessarily formulated

25 scopes of work in way that what, the kind of clarity

1 that we're hopeful we've improved on those scopes of

2 work for this one, and that to answer questions about

3 business as usual, at least in terms of business

4 models on clinical themes, this is different in terms

5 of not only those issues, but oversight as well as

6 some clear accountability and to the best of our

7 ability speaking to the issue of attribution.

8 We encourage, and hopefully the setting

9 today encourages the issues of partnership and

10 communication in order to move forward with this

11 process by bringing entities in the room that have

12 special skills in a variety of areas to hopefully

13 augment what you already bring to the table, because

14 what we're clearly attempting to avoid is the kind of

15 global failure that Dr. McGann and I talked about

16 earlier. We want this program to succeed and so that

17 was the real impetus behind having today's session,

18 because we're doing everything we can, not only

19 sessions like this, but I'm getting an awful lot of

20 frequent flier miles flying the country trying to

21 help set up the kind of infrastructure through other

22 entities to inform them of the kind of things that

23 we're looking to do in this particular contract.

24 There's a tremendous amount of interest in

25 what we're doing and all who have seen or spoken to

1 what we're trying to do are saying we're right
2 between the eyes in terms of the type of things that
3 we're focused on, in terms of our goals, in terms of
4 our themes, and we hope to emphasize the issues of
5 dates, where to look, contact lists, all those are
6 very important. So take with you that attendees
7 list.
8 I think next we have one slide here that
9 talks about time line. And that's the issue of when
10 the RFP will be publicly released, when the questions
11 are due, as far as competitives, is February 5th.
12 When will we issue answers to our questions, on the
13 19th of February, and today's session will add to
14 some of those questions. And I have to say, I mean
15 it's not tongue in cheek that those questions as if
16 they've been helpful.
17 They have been helpful because they're
18 adding greater clarity, and this is what we were
19 hopeful that QIOs and other interested entities would

20 do, would allow us the opportunity to add greater

21 clarity on our end as to what our intent is. But we

22 knew all the time that you would be in the best

23 position to tell us operationally what would be

24 feasible, what would be problematic and where it

25 would be any way what we put in an RFP. And we

1 wanted to avoid having anything that isn't right in
2 terms of this is our intent and with this operation
3 we can pull it off. We knew you would be in the best
4 position to critique that and give us the kind of
5 questions back that would enable us to strengthen our
6 process. So we appreciate that.
7 Proposals due, once again, March 11th.
8 And then as we move forward with the
9 contract award on July 29th, we're really looking
10 forward, but we need between now and that August 1st
11 start date, we have some tremendous challenges ahead
12 on our end, a number of things we have to approve and
13 get in place, and we know all about them, we heard
14 you. We need the tools, we need information, we need
15 to know what it is you expect us to do, we need a
16 contract that makes every attempt to minimize the
17 number of modifications. So we're doing our level
18 best to focus on all those pieces and parts before we
19 get to that start date.

20 Now this is not an attempt to lower

21 expectations, but realistically, any national

22 contract of this size and complexity, we're realistic

23 that there may have to be in all likelihood some

24 changes as we move forward in this process. So we're

25 not trying to sell it and say that there will be no

1 modifications at all after this thing is said and
2 done. That would be a lofty goal, but we know this
3 is far too complex and far too broad, and it's
4 fantasy for that to be a realistic goal. But still,
5 we want to start with a contract that is solid on
6 August 1st of '08.
7 And then we talk here as well, which is
8 also on our radar screen, a post-award conference,
9 QualityNet. We think our last conference was very
10 successful in terms of at least setting the framework
11 for what we're looking to do, and we just think the
12 timing would be appropriate for August after the
13 contract is accorded for us to come together again,
14 not kind of falling over ourselves trying to figure
15 out what it is we want to do, we're already being
16 clear on what it is we expect, but having those tools
17 out and the explanations operationally of what we
18 expect to have done, and that's more of a real
19 kickoff of this process for us in August. So that's

20 what we're looking for forward to then.

21 So you see there will be a couple places

22 where we'll have the chance to communicate some final

23 answers and then we will move forward from there.

24 Lastly I just want to say two words, thank

25 you to all of you who have not only participated but

1 who have remained to the bitter end. We thank you

2 for being a part of this process today and we

3 appreciate it. Thank you very much.

4 (Whereupon, the conference adjourned at

5 4:07 p.m.)

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