9th Scope of Work Renewal Questions & Answers

Question Number	RFP Section	Question	Revised Answers
AR133	C.6.1 (pages 30-31)	Beneficiary Protection/Task Description/Required Activities/a. Review Activities, on pages 30-31 of the RFP states the following: A. Task 1. Case Reviews: The QIO shall conduct case review activities, in accordance with CMS Internet-Only Manual instructions, TOPS and SDPS Memos, and other CMS policy directives for: 2. Utilization Reviews a. Sources i. Hospital-requested Higher-Weighted Diagnosis-Related Groups (DRGs) ii. Utilization reviews referred by CMS or CMS-designated entities (e.g., FI, SSA, OIG) b. Other Instructions Does number 2.a.ii above include FI referrals for coverage determinations which QIOs have been doing for many years?	QIOs will continue to receive referrals from the FIs, some of which may involve coverage determinations.
AR55	C.6.2 Patient Safety, Paragraph 2, (page 36)	It mentions that CMS will create a suitable representative sample for the measured population for pressure ulcer reduction in hospitals, when will this occur?	Identification of hospitals for this measure will be based on corresponding county of nursing homes that meet criteria for the PrU measure. If a QIO chooses a nursing home without a corresponding hospital available, it is expected that the QIO will utilize the “15%” leeway in order to recruit a suitable hospital. It is expected that a QIO may recruit one hospital for each Nursing Home they expect to work with under the PrU-NH component. CMS will establish a representative sample for the PrU-Hospitals component; this information will be available prior to start of contract. The measure used for hospital PrU has not yet been

			determined; it will likely incorporate existing work done in this area. It is expected that CMS will provide data abstraction related to this component; evaluation related to this component will be based on the remeasurement score relative to the baseline Achievable Benchmarks of Care with 70% as the minimum average passing score. Please see revised contract language.
CT77	C.6.2. Patient Safety, Page 42, Final Evaluation Measures	Page 42 references Pressure Ulcer 3 with the repository "TBD". Has CMS considered using MPSMS data to benchmark hospital pressure ulcer rates?	Please see revised contract language.
CT93	C.6.3 Prevention, Page 55, Task 1	Do we need to submit a provider list?	Please see revised Section L.
DE, PA, WV 102	C.6.3., Prevention, Task 9, Page 59	Has DOQ-IT University web site been tested and proven stable to support the amount of traffic for this task?	CMS will evaluate the site for stability.
DE, PA, WV 105	C.6.3., Prevention. Page 142	CMS to provide template for readiness assessment and consent form; when will they be available?	Any reference to readiness assessment has been deleted.
DE, PA, WV 294	C.6.3., Prevention. CRC Screening, page 60	How will CMS correct for variations in under reporting of colorectal cancer screening tests in claims data?	This task uses both claims and EHR reporting to maximize potential for more accurate data.
FL72	Section C, Theme 6.3, pg 54, Practice Site	Does CMS have the readiness assessment forms and signed consent forms available now?	Any reference to readiness assessment has been deleted.
FL73	Section C, Theme 6.3, pg 54, Practice Site	If the readiness forms are not available now, when will they become available?	Any reference to readiness assessment has been deleted.
FL74	Section C, Theme 6.3, pg 54, Practice Site	What are CMS requirements for the readiness assessment forms?	Any reference to readiness assessment has been deleted.
FL79	Section C, Theme 6.3, pg 56, Task 3	Clarify how DOQIT-U will be utilized for the purpose of education of PPs.	DOQIT U is one resource for QIOs to use in their education of the PPS on care management process and effective use of their EHRs.
IA34	C.6.3 Task 3 Promote Care Management Processes for Preventative Services using EHR Paragraph:	Will continuing education credit (CME/CEU) be applied or available for the education for Doctor's Office Quality Information Technology-University? This will affect our strategy and approach for this task.	CMS will take this under consideration.

	Second paragraph Subparagraph: n/a Page Number: 56		
NH23	C.6.3 pg. 55	The RFP states: "Further, after the Secretary has recognized additional interoperability standards, such as those presented by the Health Information Technology Standards Panel (HITSP), when a practice implements, acquires or upgrades its health IT systems, <u>it must utilize</u>, where available, health IT systems and products that meet the more recently recognized interoperability standards." 1. How is the QIO contractor to control selection and or upgrades of health IT systems? 2. If a provider chooses not to select systems that "meet the more recently recognized interoperability standards" what should be the QIOs course of action? It is critical that the contractor understands all the responsibilities associated with the contract in order to assess, plan for and mitigate risk.	This is clarified in the SoW.
OR43	C.6.3 Prevention, pg. 55	What are the specific required tasks for the NPs? Do the NPs have to complete the "Assessment of Care Processes" since they are required to complete the OSS?	The OSS in the 9th SoW was not the same as in the 8th SoW. CMS will rename this instrument and provide a template.
RI22	Section M. Theme 6.3, Number of PP, Pg 261	The contract states "In responding to this RFP for this component, each QIO must first prepare two documents…" which include a number corresponding to the total number of Physician Practices the QIO is agreeing to recruit – and the name / address of each organization, as well as the number off Medicare DM and underserved patients. This conflicts with the statement in question RI23. Does CMS expect the QIO to recruit and identify participating practices as part of this RFP?	CMS will revise the language to state that the QIO shall submit an excel worksheet to reflect the number of practices it believes it can recruit.
UT16	C.6.3. Prevention, Task 2: Identification of pool of non-participating practices (NPs), Refer to the table on top of the page. Page 56	1. Is ECI determined by current OSS definitions? 2. Does the QIO determine this? 3. What happens if clinic's OSS conflicts with QIO's determination (they often misinterpret OSS questions)? 4. What about non-8th SOW practices that do not have current OSS information?	1. & 2.This table will be clarified in the SOW. PPs' and NPs' practice characteristics will be determined by the QIO-administered assessment of care process. See also AZ88 3. A contractor will assign NP practices based on information reported by QIOs and practices. 4. The 8th SOW OSS results will not be used as a basis for assignment for

			this task.
GA	C.6.3 Prevention	In the newly revised RFP, Section L.14a Volume 1-Tab 5 Additional Technical Considerations for Theme 6.3 Prevention, the Excel spreadsheet calls for in cell B3, the proposed cost for working with each practice. In Section L.13.c, the RFP states that "under no circumstances shall the offeror include costs in the Technical Proposal".	This requirement is deleted. Cost will be provided in the Business Proposal only.
TN114	C.7.1, RFP Section L. Disparities Technical Proposal Instructions (page 247)	How can the QIO provide a list of the provider practices if there is no data available to ensure that the providers meet the enrollment requirements specified in Section C.7.1?	The QIO should submit a list of potential practices it believes meets the criteria in Section C.7.1 based on current experience.
PP4 (AR10)	C.7.2. Task 4 Evaluation of Task Performance 3 Interim Measures, a.I-1 Description (page 87) PROPORTION OF TRANSITIONS	Will CMS provide a tracking tool (electronic) for transition attributions for very participating provider? If not, will development be funded under QIO 9th SoW contract?	CMS will have the proportion of transitions table (Section J, Attachment J-10 § 1) calculated from claims annually and that table will be used for all estimates of pervasiveness of the QI process (I-1, 2,3,4,6, and O-3 and O-6). In order to calculate those rates, the QIO will report their estimates of the relevant rates for each targeted provider, which will be multiplied by the rate in the proportion of transitions table. The QIO will justify their estimates in narrative format and will show how the QIO adjusted the estimate to account for overlap among interventions (in which one beneficiary could have had care improved by multiple interventions). For example, a QIO with two hospitals in which each has 10% of the transitions and one has fully implemented CARE and the other has implemented it in half of the discharges (and both are measuring the intervention), will have a reported rate of 100% of Hospital A and 50% of Hospital B for I-6, each of which is multiplied by 10% and summed, giving 15% of transitions affected. If the hospitals had also implemented

			medication reconciliation but in the reverse ratio, with Hospital A having achieved this only for about half of their discharges and Hospital B in all discharges, then each ends up with 100% of their transitions affected, and the sum is 20%. Of course, in these examples some downstream partners would have implemented the changes also, and their role would be estimated and added to the sum.
PP7 (AR19)	C.7.2. Task 1.A.3. (page 76) & Section M.3 (page 271-273) TARGET POPULATION	"The technical proposal must show the calculation which confirms that the population is large enough to detect the targeted reduction in rehospitalization (….), on page 76 this is listed as a part of the plan to be submitted within one month of award? Please clarify which is accurate. If latter, how is this submitter to obtain data to make such confirmation of stable population?	The technical proposal must show an initial estimate with whatever data can readily be brought to bear (such as the number of hospitalizations from the Dartmouth Atlas data and other demographic information). The support QIO will work with the selected sites to confirm the estimate using an ad hoc draw of claims data. The target will be to settle the populations before the contracts start, but the final deadline will be one month after contract initiation. A sample calculation is now given in Section J, Attachment J-10 § 2.
PP22 (AR35)	C.7.2. Task 2 Interventions 3. Intervention Plan: c (page 81) EVALUATION OF OUTCOME MEASURES	Analyses of what?	The QIOs will be able to analyze the databases provided from claims and any other data that is available locally or through national sources. Two examples of the kind of data that the QIO can provide were generated by the VALUE special project and are included in Section J, Attachment J-10 § 6. If a QIO cannot manage these databases or the analyses, the Support QIO can do so, and that need must be articulated clearly in the Theme QIO's proposal.
PP32 (AR98)	C.7.2. (page 104) EVALUATION OF OUTCOME MEASURES	On page 104, on Table 3, what are the baseline time frames and is it the same across all measure numbers?	The interim measures, O-3, and O-6 do not have a comparison with baseline. The planned comparison timeframes for all other measures are now given in a table in Section J, Attachment J-10 § 4.
PP40	Section C.7.2.,	How will CMS operationalize the term "transition"?	The method for operationalizing

(AZ)	Patient Pathways, General p. 74. MEASURE DEFINITION AND SPECIFICATION		"transition" for purposes of most measures is given in Section J, Attachment J-10 § 1. In summary, the proportion of transitions table treats all non-Medicare, non-institutional care as "home" and counts all transitions between institutions and between institutions and home. Thus, a person who goes from ordinary office-based care to home health care agency does not have a counted transition, nor does a person who transfers from home care agency to hospice. On the other hand, a person who goes from SNF to long-term care residence will be counted as a transition. In monitoring the progress of interventions, the QIOs and clinical partners can monitor transitions in other ways, so long as the definitions are explicit.
PP50 (AZ)	Section C.7.2., Task 2, p. 79 ALTERNATIVES TO USE OF CARE	Is implementation of the CARE tool required or optional?	Efforts to implement the CARE tool are required, but the QIO and its community can exercise substantial flexibility in how to implement the tool. See new Section J, Attachment J-10 § 9 - 11.
PP52 (AZ)	Section C.7.2., sec 2, p.80.	Is the expected number of interventions 3 based upon areas of activity or 9 based upon areas of activity x intervention categories (med management, POC, post discharge follow-up)?	The expected number of interventions is some much higher number, but they mostly should respond to the priorities of participants in the local project and the opportunities for improvement. All sites shall implement CARE; and, depending upon the exact strategy, that alone might attend to most categories. Since the evidence is best for medication reconciliation, plan of care, and post-discharge follow-up, all sites will try those out or explain why they do not fit well in their setting. Some intervention plan must address rehospitalization risks for each of the three diagnoses (AMI, CHF, and Pneumonia). Those deciding the intervention array should

			also bear in mind the evaluation measures, which will require that the interventions improve all-cause re-hospitalization, physician visit before all-cause re-hospitalization, patient satisfaction with information on medicines and with discharge information, and re-hospitalization after a hospitalization for at least one diagnosis group among CHF, AMI, or pneumonia.
PP57 (AZ)	Section C.7.2, Task 2. Areas of Activity, p.80 TARGET POPULATION: DISEASE SPECIFIC	Are QIOs limited to work on disease specific projects limited to CHF, AMI and PNE or are other disease conditions possible candidates for interventions based upon their cost/prevalence in the community?	The interventions must include improvements expected to affect persons with these three diagnoses but may also include other diagnoses.
PP61 (AZ)	Section C.7.2., Task 2. Interventions, 4. Data/Analysis Methods Supplied, a Databases, item i., p. 82	An annual release of data by pre-specified zip code will impair potential gains that could be made by promoting more flexible access to claims data. For example, after convening a community of stakeholders it may become very apparent that other stakeholders and other specified zip codes need to be present. Is there some consideration to allowing us to update our data request for zip codes of interest on a quarterly basis instead of annually, since we will be evaluated quarterly?	If a Theme QIO wants to include additional ZIP codes in their cohort, in general they are welcome to do so through ad-hoc requests of additional data. Once the lock-down of the population definition (for purposes of evaluation measures) is accomplished, however, modification to that definition will be quite unusual and will entail having the Support QIO investigate and recommend the course of action to the GTL. The data availability now proposes to include Part A quarterly – see Section J, Attachment J-10 § 7.
PP62 (AZ)	Section C.7.2., Task 2 Interventions, 4. Data/Analysis Methods Supplied, a Databases, items i. and ii., p. 82 DATABASE DELIVERY AND CONTENT	Are we correct in understanding that the dataset to be supplied semi-annually (4.a.ii) is to establish care patterns in the community to assist the community in designing interventions, and the database described in 4.a.i will be used for evaluation? And if this is not the case, could you further clarify the differences in the two datasets described in these sections?	See PP71 (CO) and Section J, Attachment J-10 § 5 .

PP71 (CO)	Page 82 Section C.7.2. Para 4 a.i and para 4.a.ii DATABASE DELIVERY AND CONTENT	Are we correct in understanding that the dataset to be supplied semi-annually (4.a.ii) is to establish care patterns in the community to assist the community in designing interventions, and the database described in 4.a.i will be used for evaluation? And if this is not the case, could you further clarify the differences in the two datasets described in these sections?	Both datasets can be used, as appropriate, to guide intervention. The dataset with a longer follow-up will also be used to compute a monitor of adverse effect: the 180-day re-hospitalization rate. See the more extensive descriptions now in Section J, Attachment J-10 § 5.
PP72 (CO)	Page 83 Section C.7.2. Para 1.a.iii CARE SYSTEM PARTNERS	With regard to the statement that the "plan must include a strategic list of these individuals" we are assuming that this means a list of organizations and contact information as opposed to a list of individual people's names. Is this correct?	The intention here was to encourage a *strategic* list – one that showed that the QIO had insight as to who is especially important to bring on board and why. There is no need to name names if characterization by role is more appropriate. The Theme QIO can chose to submit a full report for filing in PATRIOT and a redacted version with certain identifying information obscured for CMS personnel to read.
PP86 (CO)	Section C.7.2. Page 91 Para e EVALUATION OF OUTCOME MEASURES	Will QIOs be expected to calculate measure O-5a-c or will these measures come from another source? Will these measures reflect care given during the same timeframe as the timeframe from which the other measures are calculated?	These measures will be calculated by CMS – quarterly without risk-adjustment and annually with risk-adjustment. They will reflect the same time-frame. See also Section J, Attachment J-10 § 1.
PP90 (CT)	C.7.2. Patient Pathways, page 76, 1st paragraph under 3. Line 6. MEASURE DEFINITION AND SPECIFICATION	When calculating the power, should we use ALL re-admission or the power needs to satisfy each specific condition (AMI, HF, PNE)?	For purposes of the calculating the power, use all re-admissions of fee-for-service patients within 30 days. See example in Section J, Attachment J-10 § 2.
PP91 (CT)	C.7.2. Patient Pathways, page 86, Task 4.1. First Evaluation period, Table 18 MONTH EVALUATION	The table references minimum acceptable performance thresholds – How is baseline value determined? In other words, 30% transition from?	See PP 32 (AR 98) and Section J, Attachment J-10 § 4.
PP95 (DE, PA, WV 169)	C.7.2., Patient Pathways. Task 1, A.3, page 76	Please clarify the proposed reduction in the 30-day all-cause re-hospitalization after all-cause discharge measure. Is the proposed percentage reduction a	It is a simple reduction in percentage points, which is what this question terms "absolute improvement." Thus,

	MEASURE DEFINITION AND SPECIFICATION	relative improvement (i.e., (baseline-remeasurement)/baseline), absolute improvement (i.e., baseline – remeasurement), or reduction in failure rate (i.e., (baseline – remeasurement)/baseline – best attainable rate))?	if a community has a 30% re-hospitalization rate at 30 days and has a target of 5%, the rate at the end of the project has to be less than 25%. See also Task 4 Minimal Acceptable Performance Thresholds, as well as Section J, Attachment J-10 § 1.
PP104 (DE, PA, WV 178)	C.7.2. Patient Pathways. Task 2, 4.a.i.2, page 82 DATABASE DELIVERY AND CONTENT	Please clarify the date range given for the data in the annual databases to be provided by CMS. More specifically, does the phrase "one year prior and six months after the third quarter of the prior year (initially 2007)" refer to the time periods from 7/1/2006 – 3/31/2008, 7/1/2007 – 3/31/2009, etc.?	Yes, the questioner is correct. See also Section J, Attachment J-10 § 3 and 7.
PP109 (DE, PA, WV 183)	C.7.2., Patient Pathways. Task 2, 4.a.iv, page 82	Please clarify who will be responsible for analyzing the databases provided by CMS. The contract states the databases may be analyzed by the "QIO or the theme support QIO". Will the QIO be required to depend on the theme support QIO for timely and accurate analysis of the databases?	In the pilot work for this Theme, the teams found it to be an advantage to do some of their own analyses and to rely upon the coordinating QIO for some analyses. CMS expects that this larger project will follow that pattern, but the final division of labor will depend somewhat on the skills and resources of the best proposals. The analyses that all of the QIOs use to guide interventions and to evaluate progress (e.g., the identified measures and the provider specific data examples from the VALUE special project, See Section J, Attachment J-10 § 6) will probably be best to analyze centrally for efficiency and comparability. However, QIOs that have the capability to run ad hoc analyses in their own data may find that useful in informing their community partners quickly and testing hunches in existing data. Furthermore, some QIOs that otherwise have strong opportunities and resources in this theme may not have computer or statistician capacity to manage analyses, and they would have to rely upon the support QIO more extensively. Thus, proposals on this Theme should be frank and

			honest about the capacity and interest of the proposer to do analyses on-site and the degree to which a support QIO is seen as helpful or unnecessary. This will affect allocation of the tasks, but not the performance of those tasks.
PP115 (DE, PA, WV 189)	C.7.2., Patient Pathways, Task 4, 4.f, page 92 IMPLEMENTATION OF CARE TOOL	Please provide evidence that the implementation of the CARE instrument will support patient transitions. This tool is currently still in the demonstration phase, with Phase II scheduled to begin in January 2008, and the final report on the results of the demonstration to be submitted to Congress in 2011. Are QIOs intended to be a part of this demonstration project?	QIO use of the CARE instrument in the 9th SOW is not part of the payment demonstration. CARE was designed to support clinical excellence and its use in this project is not contingent upon its use in the payment demonstration. CARE can be used more flexibly and improvements will be made in the instrument and its performance during the 9th SOW, in response to the experience of the clinicians and the QIOs. If a proposal uses a community that is a participant in the Post-Acute Care Payment Demonstration, then the CARE instrument and its platform cannot be modified until that project is done (no more than 9 months, starting in summer 2008). See the list of potential communities in Section J, Attachment J-10 § 11.
PP117 (DE, PA, WV 191)	C.7.2., Patient Pathways. Table 3, page 104 MEASURE DEFINITIONS AND SPECIFICATIONS	Under Measures O-1a, O-1b, and O-2 the goal is defined as "8% reduction in the failure rate". Please define the calculation for this reduction in failure rate. If it is similar to the 8th SoW calculations ((baseline – remeasurement)/ (baseline – best attainable rate)), then what is the "best attainable rate"?	The measure will be a reduction of the failure rate by at least 8% of the baseline. Further specifications are now given in Section J, Attachment J-10 § 1. In addition, the Support QIO will calculate a test of trend for these measures.
PP134 (GA)	Part I – Section C.7.2., Task 1.A.2., page 76 OUTCOME MEASURE EVALUATION	When will rehospitalization rates be available and where will they be posted?	CMS will calculate 30-day re-hospitalization rates every quarter and post them to PATRIOT.
PP135 (GA)	Part I – Section C.7.2., Task	Provide the timeframe for the hospital discharges for baseline and remeasurement calculations.	See table of Timeframe for Evaluation of Measures in Section J, Attachment

	1.A.3., page 76		J-10 § 4.
PP139 (IA)	Solicitation Section, paragraph and subparagraph (if applicable): C.7.2. Patient Pathways, Task 2: Interventions	Will CMS be distributing any tools or providing any other resources and/or data to support this project?	CMS intends to supply data and analysis code as identified in Section J, Attachment J-10 § 3 and 6, the CARE instrument (Section J, Attachment J- 10 § 9-11 and its internet platform and a Support QIO.
PP156 (MD54)	Section C H-CAHPS	Subsection C.7.2. – Patient Pathways Theme: page 104, Table 3 Outcome Measure O-1a: There is no question on the Jan. 2770 HCAHPS that discusses mediation management AT or AFTER discharge. Is the "written instructions' #20 to stand as proxy?	Questions 16 and 17 measure medication management during the hospital stay, (did the patient receive information on what the medication was for and possible side effects). Question 20 is more generally referring to appropriate discharge planning. The HCAHPS questions are now included in Section J, Attachment J-10 § 1.
PP158 (MD56)	Section C TARGET POPULATION: DISEASE SPECIFIC	Subsection C.7.2. – Patient Pathways Theme: page 105, Table 3 Outcome Measure O-5 a-c: Can the QIO choose ONE of these three diagnoses to track outcome measure data, or must all 3 be tracked? Table 2 or page 102 Interim measure I-3 states "Percentage of patient care transitions…that addresses AMI, CHF OR pneumonia." This is confusing.	The measure will be tracked by CMS for all three diagnoses. The evaluation allows for successful completion of this Theme with interventions affecting all three diagnoses and improvement (in 30-day rehospitalization) in at least one. See also DE, PA, WV 173 and 191
PP181 (NH31)	C.7.2. Task Description/Required Activities Task 1: Community/Provider Recruitment/Selection: pg. 76 DATABASE DELIVERY AND CONTENT	The analysis for this work to define the populations will need to include data from the Part A data, Part B data, home health, nursing home as well as potential other sources. Currently QIOs only have access to less than 42 months of a limited Part A data set. CMS states in the RFP they will provide data for the population on or before November 1, 2008 (RFP pg 82). Item #3 under Task 1 requires the QIO to produce a report that includes a defined population by month one of the contract. 1. If CMS feels the data provided on November 1, 2008 is important to the work and will assist in the analysis of utilization of services, should not the report be due after the data is provided or the data be provided prior to the report due date?	The utilization data will now be available earlier – see Section J, Attachment J-10 § 7.
PP188 (NJ93)	Section C.7.2. DATABASE	What is the plan for getting ongoing, timely access to claims data for this task? Is there a chance that we will be able to have access to claims data more	See PP61 and Section J, Attachment J-10 § 3.

	DELIVERY AND CONTENT	frequently than semi-annually? It is difficult to predict in advance what providers will determine they need, both in terms of patient populations, and in terms of adding other providers to the work. We are concerned that having to adhere to pre-specified ZIP code and provider claims data may not allow optimal flexibility to serve the community's evolving data needs.	
PP212 (NJ131)	Section C.7.2. Page 91 Para 4.d.iii DATABASE DELIVERY AND CONTENT	If the QIO is responsible for a quarterly report that includes an updated proportion of transitions table where will this quarterly data be obtained if QIOs will only be receiving claims data annually or semi-annually?	The Proportion of Transitions Table will be calculated annually. The databases now proposed are listed in the SOW and in Section J, Attachment J-1.
PP216 (NJ135)	Section C.7.2. Page 91 Para e DATABASE DELIVERY AND CONTENT	Will these measures reflect care given during the same timeframe as the timeframe that all of the other measures are calculated?	Yes – see the diagram of time of generating data and reporting data in Section J, Attachment J-10 § 7.
PP218 (NJ137)	Theme 7.2. Patient Pathways (Care Transition) (Optional) (Page 86) EVALUATION OF INTERIM MEASURES	Interim Measures – Since the measure will include Medicare FFS Part A and Part B data, what will be considered a reasonable time lag for calculation of the measures, that will demonstrate impact given the six month or great data lag that is common in Part B claims data and three or more months for Part A? This task will have an evaluation at 18 months, meaning little data will be available to assess performance.	The main measures of performance at 18 months are process measures showing that the QIO and its partners are engaging in substantial, measured, and pervasive interventions. The historical claims records will establish the Proportion of Transitions Table, so the measures evaluated at 18 months do not rely upon current data or trends in that data. The availability of data and the lags involved throughout the project are portrayed in Section J, Attachment J-10 § 7.
PP232 OH84	C.7.2., Patient Pathways, Outcome Measures, O-3 Description, page 91	What is meant by "Percentage of patient care transitions…for which implemented and measured interventions show improvement"?	See the Proportion of Transitions Table in Section J, Attachment J-10 § 1 for the percentage of care transitions and PP 119 for the rest of the question.
PP238 TN62	Theme C.7.2., Section 3 (page 76)	What is baseline for all of the interim and outcome measures?	See Table in Section J, Attachment J-10 § 4.
PP251	C.7.2., Patient	How is a "transition" defined?	See the discussion in the Proportion

TX105	Pathways General Page 74		of Transitions Table in Section J, Attachment J-10 § 1.
PP256 TX110	C.7.2., Patient Pathways Task 2. Interventions 4. Data Page 82	The dates under C.7.2. Care Transitions, Page 82 i.2. and ii.2., the comparison of time that CMS will supply a data base to the QIO. Are the dates the third quarter of 2006-2007 plus 2008-March 2008 on i.2. and then ii.1. and 2.? This section is confusing; can you please further clarify the time periods?	See new table of dates in Section J, Attachment J-10 § 4 and 7.
PP258 TX112	C.7.2., Patient Pathways Task 4 Evaluation Page 85	We would not find a reference to the baseline data from which improvement in the outcome measures is calculated. What is the source and timeframe of the baseline data?	See new table of baselines in Section J, Attachment J-10 § 4.
PP268 WA66	C.7.2 p. 87	p. 87. 'Number of patient care transitions' are to be reported by the QIO. How does the QIO figure out the number of patient care transitions (using the methodology described in J-10? Will we have access to timely claims data, in which case there would still be a lag or will we be asking hospitals and other providers to submit this information to the QIO?	CMS will calculate the "Proportion of Transitions Table (see method is Section J, Attachment J-10 § 1. Data availability is outlined in Section J, Attachment J-10 § 3.
PP270 WI28	C.7.2., Task 4, 4.e. p.91	Will topic-specific 30-day all-cause readmission rates be used, or will the three topics (AMI, HF and PNE) be combined?	The 30-day re-hospitalization rates for each diagnosis will be calculated, and the evaluation threshold must be met with at least one.
PP271 AL 20	Attachment J-10A	This attachment wasn't provided to the QIO.	If a proposer still does not have access to the references, please let us know by contacting the Contracting Officer.
PP291 MA77	Section C.7.2. Patient Pathways (Care Transitions)	What is the plan for getting timely access to claims data for this task? Is there a chance that we will be able to have access to claims data more frequently than semi-annually? It is not always possible to predict in advance what providers will determine they need, both in terms of patient populations, and in terms of adding other providers to the mix as communities are constituted for this project. We are concerned that having to adhere to pre-specified zip code and provider claims data may not allow optimal flexibility to serve the community's evolving data needs.	The project now is considering providing Part A data quarterly. See Section J, Attachment J10 § 3. The Support QIO will manage the data draws and can improve the data elements as needed to serve multiple sites. In addition, a customized ad hoc data draw is possible.
PP 297 MA83	Page 81 Section C.7.2. Patient Pathways (Care Transitions) Para d	Since there is no standard agreed upon definition of appropriate versus inappropriate hospitalizations, especially at or near the end-of-life, can you suggest a method for ways to monitor for an unintended consequence, such as barrier to timely appropriate	The project has imposed four monitors: 180 day rehospitalization and 30-day mortality after AMI, CHF, or pneumonia. In addition, sites will be attentive to complaints and will

		hospitalizations?	impose their own monitors.
PP 304 MA90	Page 82 Section C.7.2. Patient Pathways (Care Transitions) Paragraph 4.a.i and paragraph 4.a.ii	It appears that the dataset to be supplied semi-annually (4.a.ii) is to establish care patterns in the community to assist the community in designing interventions, and the database described n 4.a.i will be used for evaluation. And if this is not the case, could you further clarify the differences in the two datasets described in these sections?	See the table describing the timing and use of the databases in Section J, Attachment J-10 § 3.
PP 311 MA98	Section C.7.2. Patient Pathways (Care Transitions) Page 87 Para c I-3	Are we to assume that interventions a community could pursue should be limited to only one of the 3 (HF, PNE or AMI)?	No. A community should do all that it can to improve after-hospital care, including transition of information (e.g., medication and treatments), creation of workable and transferred plans of care, and follow-up. The interventions should sometimes alter systems, sometimes address specific illnesses, and sometimes work to improve follow-up. The requirements are clarified in PP 52.
PP 314 MA101	Section C.7.2. Patient Pathways (Care Transitions) Page 91 Paragraph 4.d.iii	If the QIO is responsible for a quarterly report that includes an updated proportion of transitions table, where will this quarterly data be obtained if QIOs will only be receiving claims data annually or semi-annually?	The proportion of transitions table will be calculated annually by CMS. See Section J, Attachment J-10 § 7 and the revised SOW for the timing and content of other databases.
PP 316 PR50	C.7.2. Care Transitions, pages 87-89	Where is the database we need?	See Section J, Attachment J-10 § 3 and 7 to track all the provisional databases.
IA	C.7.2. Care Transitions	The new RFP for the 9th SoW refers to Appendices B & C several times in Theme 7.2, but we cannot find them in the materials posted on the CMS website. As you know, the appendices have critical information.	See Attachment J-10.
WV	C.7.2. Care Transitions	WVMI is preparing a response to Theme 7.2 (Patient Pathways). In the answers to the questions related to this theme, CMS refers numerous times to Appendix B. The only Appendix B we can find in the materials we received was in Attachment J10a and consists of the SQUIRE Guidelines. However, responses to PP7, PP139, PP32, PP50, PP61, PP71, PP90, PP115, PP117 and PP156 reference statistical tables and methods that have no relationships to the SQUIRE Guidelines. This information purportedly in Appendix B is critical to determining whether the project is adequately sized, is also critical to our understanding of the core quality measure (measure O-4) that is to be improved through this work. We could locate no other Appendix B with the materials posted on	The information will be included in the revised SoW dated 2/29/08.

		2/21/2007.	
CT116	C.7.3- CKD Optional, page 111, Task 2: HIT	Please clarify 'the QIO should follow, to the degree possible, the requirements as defined in the Prevention Theme". Is this meant for EHR requirements or PP requirements? If for an EHR, does it mean that CCHIT certification is not required?	See revisions to Section C.7.3. If the QIO opts to utilize HIT activities as a means to meet the clinical CKD targets, then CCHIT is required.
DE, PA, WV 223	C.7.3., CKD. Optional Task 1: Support for Companion CMS Quality Initiative, pp. 110-111	For extra credit, the SOW states the QIO can consider a component that would increase the number of providers reporting the companion measures to the clinical focus area of this CKD Task under PQRI reporting set. It further states the QIO would have to set a target for the number of Medicare providers. Does CMS have a minimum or maximum number of providers that the QIO must work with to receive extra credit?	See revised Sections C.7.3, L, and M.
DE, PA, WV 224	C.7.3., CKD. Optional Task 1: Support for Companion CMS Quality Initiative, pp. 110- 111	For the defined practice is there a minimum number of beneficiaries with CKD?	See revised Section C.7.3. CMS is not prescribing participating practice characteristics. Interventions should be utilized and sufficient numbers of providers targeted that will ensure that the Theme 7.3 goals are met. See answer to question KY30.
DE, PA, WV 225	C.7.3., CKD. Optional Task 1: Support for Companion CMS Quality Initiative, pp. 110- 111	What is the scope for the targeted Medicare provider—geographic or statewide?	See revised Section C.7.3.
DE, PA, WV 233	C.7.3., CKD. Deliverable # 63, number of providers recruited for each subtask 1.a., 1.b., and 1c., page 154	Contract requirement states "40% of practices recruited for each subtask." Can the same providers be recruited for subtasks 1.a., 1.b., and 1.c?	Yes, the QIO may choose

			targeted providers to be recruited at specific milestones within the contract. The QIO will determine the number (or percent) of providers to be targeted for participation in the CKD task statewide. See revised deliverable 63 in Section F.
DE, PA, WV 237	C.7.3., CKD. Deliverable # 63, page 154	Due date for this deliverable is quarterly and week 4. What does week 4 mean?	The due date for deliverable 63 has been changed in section F to one month. The contract starts on August 1, 2008 and the due date would be 30 days later (August 31, 2008).
MI154	C.7.3., Pg. 110, Last paragraph	RE: "…*the QIO shall consider as an optional component the Task of providing technical assistance to providers in Medicare quality incentive programs* …" What providers? All who ask for help or some targeted IPG type group?	See revised Section C.7.3. Also see answer provided for KY30.
MI155	C.7.3., Pg. 110, Optional Tasks	Is work on the Optional Task Description an "all or none" or can the QIO elect to work on only one or two of the Optional tasks? On page 159 states that the deliverable for the optional tasks will be tailored to the specific sub task that the QIO elects.	See revised Section C.7.3.
MI156	C.7.3., Pg. 111, Paragraph 3 (under CKD Optional Task 2: HIT)	RE: "…*compare the results of this approach (HIT adoption/use) to other activities undertaken, and where no activity is undertaken by the QIO*…" What results are compared - results for measures 1a-1c?	See revised Section C.7.3.
MI164	C.7.3., Pg. 115, last paragraph	RE: "…*by the end of quarter 2, 50% of practitioners/providers recruited…*" 50% of which practitioners? Is there some targeted group we are supposed to lay out at baseline?	See answers to questions GA11 and MO-54. Provider recruitment deliverables, as described in section F, require the QIO to submit to CMS the percentage of providers in the state targeted at the beginning of the contract, based on letter of

			commitment, and recruited at specific milestones within the contract (include in initial work plan, deliverables 62 and 63).
MO-54	C.7.3. General Question	May there be separate physician groups for each indicator or will all practices be included in the remeasurement for all 3 indicators?	The QIO may choose to target the same providers for all subtasks. CMS is not prescribing to the QIO what providers to target. Rather, the QIO should be looking at their statewide physicians and identifying those the QIO believes will help them achieve statewide clinical outcomes for each of the three indicators, as described in Theme C.7.3. The QIO will be required to identify targeted providers in their QI plan. Provider recruitment deliverables, as described in section F, require the QIO to submit to CMS the percentage of targeted providers recruited at specific milestones within the contract.
NH36	THEME C.7.3 CKD Optional Task 1: Support for Companion CMS Quality Initiatives pg. 110	The RFP refers to "providing technical assistance to providers in Medicare quality incentive programs that are directly aligned and support achievement of the CKD clinical focus areas defined in this SOW." 1. As these programs are Medicare programs, would CMS please provide a list of the names of "Medicare quality incentive programs that are directly aligned and support achievement of the CKD clinical focus areas defined in this SOW" that CMS has in mind? Having an exact understanding of the task being requested and its requirements will make for a more focused and accurate plan.	See revised Section C.7.3. PQRI is the primary quality incentive program. Fistula First and Healthy People 2010 are also important initiatives to improve healthcare that could be supported by the QIOs.
RI20	Section C, Theme C.7.3, Impact on Disparities, pg 107	The contract states – "…the QIO shall demonstrate anticipate and monitor the impact the quality interventions have on disparities in care…". Because RI does not qualify for disparities work (Theme 7.1) do we need to incorporate this component into our CKD plan?	Yes, you do. A disparity might be present or arise within the CKD population. See revised Section C.7.3. See answer to question CO7.
NJ	C.7.3 Chronic Kidney Disease	The proposal instructions for CKD in the summary of changes conflict with the proposal instruction in Section L. What is unclear is whether the information	Section L stands as issued and there is no supplemental information that will be allowed.

		included in the revised summary of changes supersedes the language in the revised Section L.	
TN72	C.7.3 Prevention of Chronic Kidney Disease (page 110)	In the "Optional Task Description" section it states, "If the requirements outlined below are met, a QIO will be eligible to receive additional points during the selection process to ensure the most qualified QIOs are chosen." Does this statement imply that failure to include the optional tasks in a proposal reduces the chances of the offeror being awarded the CKD Task?	See revised Sections C.7.3, L, and M.
TN73	C.7.3 Prevention of Chronic Kidney Disease (page 110)	In the "Optional Task Description" section, Task 1 – Support for Companion CMS Quality Initiatives, it gives the example of increasing providers' participation in reporting the pertinent PQRI measures. Will the QIO be given direct access to the PQRI data, or otherwise be provided with this information on an ongoing basis for progress tracking purposes?	See revised Section C.7.3. See answer to question DE, PA, WV 207
UT32	C.7.3. Prevention: Chronic Kidney Disease (Optional), Optional Task Description, Task 2: HIT. Page 111	Can these practice sites overlap with the PP's and NP's in the core prevention task?	See revised Section C.7.3. See answer to question DE, PA, WV 206.
VA74	C.7.3, page 111	The RFP notes that the QIO can consider including components that would assist providers who are, or will be reporting and improving their clinical outcomes rates in the CKD focus areas. The QIO would have to set a target for assistance and the level of improvement, designate a timeframe for achievement of target, and clearly report and link QIO activities that led to improvement (e.g., rate of increase higher with providers that the QIO worked with in contrast to like providers in which the QIO did not provide assistance). If the QIO chooses this option, will they be expected to identify a matching group of PPs and NPs to demonstrate linkage of QIO assistance to PPs improved clinical outcomes?	See revised Section C.7.3.
TN93	F.2. Deliverable #79 (page 160)	There is no reference to monthly notice request for provisional rates from DCAA in G.3.D. Please clarify?	Provisional Rate reviews and changes should be made annually or when there is a significant change in the QIOs provisional indirect rate such that a significant under billing or over billing would occur. A temporary change in the QIO book of business

			does not warrant a provisional rate review to change the provisional rate as the temporary nature of more than likely will not cause a under billing or over billing situation. QIOs should note that CMS will establish the provisional billing rates for QIOs for the start of the 9th SOW QIO contract. After contract award, QIOs will continue to utilize DCAA for the provisional rate reviews and establishment of provisional rates when they change.
NE26	F. Deliverable #79, (page 160)	Notice request for provisional rates form DCAA (G.3.D) is due monthly. Should this not be within 90 days of contract award date, as stated in G.3.D?	See answer to TN93.
NE3	General	Will CMS issue a revised SF33, with corrected dates in Box 9, Solicitation?	No. The SF as originally issued should be used by QIOs when acknowledging the amendments that are issued to the RFP. Amendments have the effect of making changes to the dates on the SF.
RI30	Section G, G.3, page 169	If a QIO wanted to change their indirect methodology, would we need to seek prior approval form contracts before the RFP submission of February 14?	The cost impact does not apply to the 9th SOW submission since the rates will be developed in the new format and applied to the new 9th SOW. However, it may be required for the 8th SOW where costs have been incurred under previous methodology and now must be impacted for the new methodology. These cost impact statements can be submitted at a later date.
DE, PA, WV 245	F.2 – Schedule of Deliverables # 82, page 160	Would CMS change this deliverable to mirror instructions at H.11.C.2? (c)(2) – page 203 – where there is no prior approval under a threshold with an approved plan?	Deliverable #82 is being revised to specify an annual submission that lists all contractees and dollar amounts and other information for contracts falling under the 5% and the 20% thresholds. It will be due on February 28 each year and may be included with the deliverable #88, listing ownership interests. It will be for notification purposes only.
DE, PA, WV 247	F.2—Schedule of Deliverables # 87 Page 161	Please clarify this requirement as we can find no reference to “proposed subsidiary start-up” in Section H.11.	Section H.11.C.2. (b) includes subsidiaries under relationships that may be a conflict of interest. Section

			H.11.G has been added to specifically address subsidiary start-up.
DE, PA, WV 248	F.2—Schedule of Deliverables # 88 Page 161	Please clarify this requirement since Section H.11.G is not included in the RFP.	This deliverable should refer to H.11. D.1. (g)
TX133	F.2. Deliverables 82 Page 160	The requirement of notification to CMS 30 days prior to the start date of the proposed agreement is in conflict with H.11.C.2.(c).(2), which states that no prior approval shall be required for contracts that do not exceed the thresholds of this subpart. Please clarify this contradiction.	Deliverable #82 is being revised to specify an annual submission that lists all contractees, dollar amounts and other information for contracts falling under the 5% and the 20% thresholds. It will be due on February 28 each year and may be included with the deliverable #88, listing ownership interests. It will be for notification purposes only.
TX134	F.2 Deliverables 88. Page 161	What is included in the section since there isn't a section H.11.G in the RFP per this deliverable?	This deliverable should refer to H.11. D.1. (g)
CMS	J8a attachments	Question: The formula in the CMS spreadsheet divides the fee amount by the number of providers and calls that the cost per practice. Should this formula be corrected to divide the total cost (before fee) by the total proposed providers?	Answer: Yes. Please update the following Attachment J -8 formulas, as listed in the BP9SOW.xls - QIO F719 document: Cell I42: I35/I41 Cell K42: K35/K41 Cell M42: M35/M41 Cell O42: O35/O41 Cell Q42: Q35/Q41 Cell U42: U35/U41 Cell W42: W35/W41