SECTION B - SUPPLIES OR SERVICES AND PRICES/COSTS

B.1. DESCRIPTION OF SERVICES

This is a contract with a Utilization and Quality Control Peer Review Organization (hereinafter referred to as a Quality Improvement Organization, QIO) in accordance with Section 1154 of the Social Security Act. The purpose of this contract is to assist providers (see Section J, Attachment J-1, Glossary, for definition of "provider") (nursing homes, home health agencies, hospitals, and physician practice sites) in measuring and reporting quality, producing and using electronic clinical information, redesigning care processes, and transforming organizational cultures so as to accelerate the rate of quality improvement and broaden its impact thereby increasing the value offered to beneficiaries through traditional Medicare, Medicare Advantage, and Part D benefits. Performance of the requirements of the Statement of Work focuses on two (2) domains of activity:

- assisting providers in developing the capacity for and achieving excellence in care; and

- protecting beneficiaries and the Medicare Program.

B.2. TYPE OF CONTRACT

This contract type is a combination of cost-plus-fixed-fee (CPFF) and cost-plus-award-fee (CPAF). Payment of fee will be made based upon the requirements of Section B, Section C subtask evaluation criteria and Section J, Attachment J-2 Award Fee Plan. Fees available under this contract are as follows:

Base Fee = 1% of contract costs (excluding pass-through and special projects costs), to be paid monthly to the QIOs.

Full Pass Performance Award Fee = 1% of contract costs (per subtask) if QIO meets full pass performance criteria (excluding pass-through and special projects costs).

Excellent Pass Performance Award Fee = 1% of contract costs (per subtask) if QIO meets excellent pass performance criteria (excluding pass-through and special projects costs).

Group Award Fee = 2% of contract costs per subtask for each QIO. The following two (2) criteria must be met in order for the QIOs meeting the full pass performance criteria to receive the group award fee:

- The QIO meets the full pass performance criteria; and

- No more than five (5) QIOs have failed to meet at least the conditional pass performance criteria for that subtask.

In addition, the composite performance scores of all QIOs must meet or exceed the specified criteria shown below in the Award Fee Methodology section – Group Award Fee. Only those QIOs meeting the full pass performance criteria for that subtask will be eligible to receive the Group Award Fee.

Fixed Fee = 4% fixed fee for Information Systems (IS), Contractual Requirements (CR) and Special Projects (SP) contract costs.

B.3. CONSIDERATION AND PAYMENT

A. Total Contract Amount

The total estimated cost-plus-fees (TEC+Award, Base and Fixed Fee) is $_____ (see notes below).

NOTES: The Total Contract Amount provided above includes all tasks based upon the following:

Pass-Thru Costs

1. Pass-Thru Costs are included in the amount provided above for Total Estimated Costs (TEC).
2. Base Fee is not paid on Pass-Thru Costs (Information Systems (IS) and Contract Requirements (CR)).
3. Pass-Thru Costs are not used in the calculation of the award fees.

Task 3a Beneficiary Protection

The Total Contract Amount provided above includes the three (3)-year estimated cost and associated fees for Task 3a Beneficiary Protection.

Task 4 Special Projects

Task 4 Special Projects (SP) will be incorporated into the contract by issuance and execution of a formal contract modification (see Section B.4). Upon issuance of an SP contract modification, Section B.3.A, entitled, "Total Contract Amount," and Section B.3.B, entitled, "Table of Total Estimated Cost and Associated Fees," will be modified accordingly.

B. Table of TEC and Associated Fees

Task Number	Estimated Cost	Base Fee (1%)	Full Pass Performance Award Fee (1%)	Excellent Pass Performance Award Fee (1%)	Group Award Fee (2%)	Fixed Fee IS, CR, and SP (4%)

Task 1 Assisting Providers in Developing the Capacity for and Achieving Excellence (TOTAL)						
1a: Nursing Home						
1b Home Health						
1c1 Hospital						
1c2 Critical Access Hospital/Rural PPS Hospital						
1d1 Physician Practice IPG						
1d2 Physician Practice/ Underserved Populations						
1d3 Physician Practice/ Pharmacy: Part D Benefit						
Task 2 (Reserved)						
Task 3 Protecting Beneficiaries and the Medicare Program (TOTAL)						
3a Beneficiary Protection (excluding Fast Track Appeals and Expedited Appeals)						
3a Beneficiary Protection Fast Track Appeals and Expedited Appeals Months 1 thru 12						
3a Beneficiary Protection Fast Track Appeals Only and Expedited Appeals Months 13 thru 24						
3a Beneficiary Protection Fast Track Appeals and Expedited Appeals Months 25 thru 36						
3b Hospital Payment						

Monitoring Program						
Task 4 Special Projects (SP)						
IS						
Task 1 Contract Requirements (CR)						
Task 3 Contract Requirements (CR)						
Task 1 Pass-Thru						
Task 3 Pass-Thru						
Totals						

C. Schedule for Payment of Base Fee and Fixed Fee

Payment of the fixed base fee and other fixed fees (IS, CR, and SP) will be made in accordance with the schedule provided below. As authorized under FAR 52.216-8, after payment of 85% of these fixed fees, CMS may elect to withhold 15% or $100,000 (whichever is less).

The QIO will be paid fixed fees as identified above in accordance with the following fee schedule:

MONTH	PAYMENT/MONTH	TOTAL
1-35	$_____	$_____
36	$_____	$_____
TOTAL		$_____

Note: Regardless of the period of performance for an SP, the associated fixed fee shall be allocated across the remaining months of the contract period (not period of performance for the SP). Therefore, as SP are incorporated into the contract, the Section B.3.C. will be modified accordingly.

D. Reallocation of Costs for Tasks 1 through 3, IS, and CR

Costs provided in Table B.3.B are estimates only. During contract performance, the QIO may move funding at any time to ensure successful performance as follows:

1. Task 1 funds may be moved within the Task 1 subtasks and other costs (CR and Pass-Thru).
2. Task 3 funds may be moved within the Task 3 subtasks and other costs (CR and Pass-Thru) with the exception of funding for Task 3a Beneficiary Protection Fast Track Appeals and Expedited Appeals **cannot** be utilized for performance of any other Task.

3. Funding for IS **cannot** be utilized for performance of any other Task.

B.4. TASK 4 SPECIAL PROJECTS

A. Special Projects

As provided under Section C.6.Task 4 and in accordance with the procedures contained in Section G.18. and Section J, Attachment J-15, CMS reserves the right to direct the QIO to initiate a Special Project (SP) not currently defined under the Statement of Work (SOW) or to approve an application from a QIO to conduct an SP. SPs will be awarded on a CPFF basis. The table provided below will be completed (through execution of contract modification) as SPs are incorporated into this contract.

SP Number	FIVS Number	Can Number	SP Title	Period Of Performance	Funded Amount

B. Reallocation of Funds for Task 4

Funds associated with Task 4 **cannot** be redirected for performance of Tasks 1 through 3. Additionally, Task 4 funding **cannot** be reallocated from one SP to another without prior consent from the Contracting Officer.

The QIO is advised that the following scenarios are applicable to funding for Task 4 SPs funding only:

If the QIO completes a SP and has remaining funds
or

If the QIO is under spending (based upon the funded amount for the SP)
or

If the QIO reaches 75% of the total estimated cost for a particular SP and does not have sufficient funding to complete the SP,
then

The QIO must simultaneously notify the Contracting Officer, Project Officer (PO) and the appropriate Special Project Government Task Leader (SPGTL) in order to obtain a contractual remedy. QIOs are advised that the notification shall be in accordance with the Limitation of Cost clause, FAR 52.232-20, as incorporated in Section I of this contract.

B.5. CEILINGS

A. General

The cost limitations addressed in this Section apply only to the QIO contract. As a business entity, a QIO may exceed the cost limitations provided below as long as amounts in excess of the noted ceilings are not charged (either directly or indirectly) to this particular contract.

The QIO is advised that all costs associated with this contract, either directly or indirectly, are subject to audit.

B. Medical Records Photocopying/Pass-Thru Costs

The QIO will be paid for a properly certified invoice/voucher for medical records photocopying costs at a rate of $.12 per page for reproduction of PPS provider records and $.15 per page for reproduction of non-PPS institutions and practitioner records, plus first class postage. Specifically, hospitals and other providers (such as critical access hospitals) under a Medicare cost reimbursement system, receive no photocopying reimbursement from the QIOs. Capitation providers such as HMOs and dialysis facilities receive $.12 per page.

All other photocopying costs are to be directly charged to the task to which they apply and shall be reimbursed on the basis of the costs that are allowable. In order for a cost to be determined allowable, the cost must be allocable and reasonable.

C. Overnight Mail

Contract deliverables **shall not** be submitted utilizing overnight mail. All other overnight mailings (e.g., HINNS, NODMARS…etc) shall be at the discretion of the QIO and are subject to the Contracting Officer's determination of reasonableness.

D. Indirect Cost Rates

The indirect cost rate ceiling(s) for this contract is/are:

Overhead:	TBD*
Fringe Benefits:	TBD*
Other:	TBD*

(*To Be Determined)

B.6. SPECIAL FUNDING REQUIREMENTS

A. Task 1d1

(RESERVED)

B. Task 3a (See Table of TEC and Associated Fees)

C. Overall

(RESERVED)

B.7. TRANSITION SERVICES

In the event that CMS requires transition services from an incumbent QIO to a successor QIO, CMS will request a separate technical and business proposal for these services (see Section H.21.). These services will be incorporated into the contract if applicable.

SECTION C – STATEMENT OF WORK

TABLE OF CONTENTS

SECTION C. STATEMENT OF WORK

C.1. BACKGROUND & OVERVIEW

The statutory authority for this Statement of Work (SOW) is found in Part B of Title XI of the Social Security Act (hereinafter referred to as the Act), as amended by the Peer Review Improvement Act of 1982. The Act established the Utilization and Quality Control Peer Review Organization Program, now known as the Quality Improvement Organization (QIO) Program.

The statutory mission of the Program, as set forth in Section 1862(g) of the Act, is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

Based on legislative language and the experience of the Centers for Medicare & Medicaid Services (CMS) in administering the Program, CMS has identified the following requirements for the QIO Program:

- Improve quality of care for beneficiaries;

- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and medically necessary and that are provided in the most appropriate setting; and

- Protect beneficiaries by expeditiously addressing individual complaints, notices, and appeals, such as beneficiary complaints; provider-issued notices of non-coverage (Hospital-Issued Notice of Non-Coverage [HINN], Notice of Discharge and Medicare Appeal Rights [NODMAR], and Medicare Advantage appeal); Emergency Medical Treatment and Labor Act (EMTALA) violations; and other related statutory QIO responsibilities.

C.2. CONTRACT PURPOSE

The goal of this SOW is to assist providers (see Section J, Attachment J-1, Glossary, for definition of “provider”) (nursing homes, home health agencies, hospitals, and physician practice sites) in measuring and reporting quality, producing and using electronic clinical information, redesigning care processes, and transforming organizational cultures so as to accelerate the rate of quality improvement and broaden its impact. This SOW is designed to increase the value offered to beneficiaries through traditional Medicare, Medicare Advantage, and Part D benefits.

This SOW focuses on two (2) domains of activity:

- assisting providers in developing the capacity for and achieving excellence in care; and
- protecting beneficiaries and the Medicare Program.

C.3. TECHNICAL CONSIDERATIONS

The contractor (hereinafter referred to as "QIO") undertaking this SOW shall comply with all technical requirements outlined in this contract.

The QIO may meet the experience and expertise requirements for this SOW by documenting access to persons with relevant knowledge, skills, and abilities either within its own staff or by formal agreement with expert consultant(s) or other formal, documented partnership agreement(s). This documentation shall be made available to CMS upon request.

C.4. REQUIREMENTS

A. Contractual Requirements

The QIO, acting independently and not as an agent of the federal government, shall furnish the necessary personnel, materials, services, facilities, and supplies (except as may be otherwise specified in the contract) and otherwise do all things necessary for, or incident to, the performance of the work as set forth in this SOW.

B. Specific Requirements

The QIO shall adhere to the following requirements as they apply to the specific Tasks and subtasks described in Section C.6.

1. Infrastructure Operations Support and Data Management

   The QIO shall adhere to the most current version of the policies and procedures outlined in the *QIO Infrastructure Operations and Support Manual* at http://qionet.sdps.org/secured_admin/qio_admin.shtml, the *QIO Information Technology (IT) Administration Manual*, the *QIO Database Systems Administrators Guide*, and the *QualityNet System Security Policies Handbook*. These policies and procedures are issued by CMS and shall be adhered to at all times during the contract, unless directed otherwise by CMS. These manuals delineate the roles and responsibilities for QIO computer users, QIO systems administrators, CMS personnel, and QualityNet Support Contractor personnel.

The QIO shall maintain all necessary documentation that meets or exceeds the performance standards and deliverables specified in Chapter 8, Infrastructure Operations Support and Data Management, of the *QIO Manual* (http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019035) and Section F – QIO Schedule of Deliverables.

2. Hardware/Software

The QualityNet Support Contractor(s) will provide each QIO with a file/print server and a workstation for each 0.5 or greater full-time equivalent (FTE) employee. The file/print server and each workstation will be equipped with a standard operating system and a software suite approved by CMS. If a QIO requires additional equipment and software, the QIO must receive approval from the Engineering Review Board (ERB) (see Section 2 of the *QIO Infrastructure Operations and Support Manual* at http://qionet.sdps.org/secured_admin/qio_admin.shtml; Section J, Attachment J-6, Engineering Review Board [ERB] User's Guide; and G.17. Engineering Review Board [ERB] Process for Obtaining Additional Hardware/Software) and must pay for the additional equipment and software out of QIO contract funds.

3. Reporting Requirements

The QIO shall report to CMS as directed in Section F – QIO Schedule of Deliverables and the Sections of the *QIO Manua*l referenced in this SOW. The QIO shall use all components and adhere to all procedures of the Standard Data Processing System (SDPS) data collection and reporting systems (including those outlined in the *SDPS User's Guide* and Section F – QIO Schedule of Deliverables) to manage and report work performed under this SOW.

4. Confidentiality

The QIO shall adhere to the confidentiality and disclosure requirements set forth in Section 1160 of the Act, 42 CFR Part 480; Section H of this contract, which limits uses and disclosures when QIOs are acting as business associates of CMS; the *QIO Manual*; and other applicable federal laws, regulations, and administrative directives.

The business associate agreement, as required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, applies with respect to any activities assigned to the QIO whereby the QIO is using or receiving protected health information or electronic protected health information on behalf of CMS's covered functions, such as payment or healthcare operations activities. Compliance with the business associate agreement provisions in

Section H is not required for uses or disclosures of protected health information or electronic protected health information by the QIO that are for CMS's health oversight activities.

5. Government Data

A listing of data to be supplied by CMS and the schedule by which they will be provided appears in Section J, Attachment J-5 Data Supplied by CMS. In general, Part A reported data will be available from the CMS Data Warehouse (see Section J, Attachment J-1, Glossary, for definition of "Data Warehouse"). The Quality Improvement Organization Support Centers (QIOSCs) and the SDPS contractor will create and deliver to CMS state/jurisdiction-level measurement and analytic datasets for distribution to QIOs. QIO requests for additional data or analytic datasets will be reviewed and approved by the Government Task Leader (GTL) for the Task or subtask (see Section J, Attachment J-1, Glossary, for the definition of "Government Task Leader").

6. Clinical Data Abstraction Center (CDAC) Subcontract

The QIO shall sign a subcontract with the CDAC and shall work directly with the CDAC on records management activities. The CDAC will (1) request medical records on behalf of the QIO; (2) work with the QIO to track which medical records have been received; and (3) track and report to the QIO on all photocopying and mailing costs incurred by providers or practitioners (see Section J, Attachment J-1, Glossary, for definition of "practitioner"). The CDAC may pay the pass-through costs if the QIO chooses to include this as a provision of its subcontract with the CDAC.

The QIO may choose to subcontract additional functions to the CDAC. However, these subcontracting arrangements shall be handled separately from the data abstraction agreement and shall be individually negotiated between the QIO and the CDAC subject to approval by the CMS CDAC Project Officer.

7. Coordination with Stakeholders

The QIO shall coordinate its activities with those of stakeholder organizations in its state/jurisdiction working on comparable improvement efforts or interested in teaming with the QIO. Stakeholders are organizations that have common goals with those of the QIO and may include provider membership associations; health care alliances; professional associations; clinical specialty organizations; state licensing, certification, and survey agencies; state and local health departments; accreditation organizations; payers; beneficiary advocacy groups; Medicare suppliers; state Medicaid agencies; and End-Stage Renal Disease (ESRD) Networks. Coordination with stakeholders may involve creating, joining, and

supporting partnerships with organizations with similar goals and objectives, or facilitating ongoing discussion among the various stakeholders. Specific guidance for the coordination of activities is provided in the Task- and subtask-specific Task Descriptions in Section C.6. Coordination between the QIO and stakeholders facilitates the efficient use of resources, avoids duplication of effort, minimizes inconsistencies, and reduces burden on providers and practitioners.

8. Communications

For communications activities in this SOW, CMS encourages the QIO to use Attachment J-3 QIO Communications Handbook (http://qionet.sdps.org/7thSOW/commclhouse/qiocommunichandbook.pdf) as a resource.

To accomplish the goals of the QIO program, CMS requires the QIO to manage its resources as efficiently and effectively as possible. In this regard, CMS recognizes three major sources from which the QIO can obtain marketing materials and resources: (1) other CMS contractors, including QIOSCs; (2) the ESRD Networks and the ESRD Network Coordinating Center for renal-related material; and (3) other external sources that provide non-copyrighted materials and resources. In addition, the QIO can develop its own materials, as outlined in C.4.B.8.e-j. below.

Based on these considerations, the QIO shall:

a. Develop and submit in accordance with Section F - QIO Schedule of Deliverables a partnership and communications plan describing the approach the QIO will take to engage stakeholders and how it will leverage and communicate the priorities of the QIO Program at the local level. Consumer Advisory Councils (CACs) already in existence may continue under this SOW and be included in the plan.

   CMS, working through its Communications QIOSC, will provide the QIO with a template for this plan as well as an overview of the activities, strategies, goals, and objectives of the QIO Program. The QIO shall populate these templates with its strategies for creating partnerships and/or coalitions for quality improvement at the local level. In addition, the QIO shall include all communication and promotional strategies for leveraging quality through outreach, education, and motivation. The QIO shall include strategies to address hard-to-reach target audiences and populations. The QIO submission using the CMS-provided template shall not exceed three (3) pages. CMS will review and may suggest modifications to the QIO's partnership and communications plan based on QIO Program priorities.

b. Provide assistance to the ESRD Network(s) in order to promote utilization of CMS-approved vascular access quality improvement programs, tools, and activities (including the National Fistula First Project). Resources permitting, in cooperation with the ESRD Network(s) and/or the ESRD Network Coordinating Center, the QIO shall provide appropriate educational, promotional, and/or other communication resources determined needed, and not already available through the ESRD Network Coordinating Center and/or the ESRD Networks. All QIO activities must have the documented approval of and/or collaboration with the ESRD Network(s) in the area of the planned activity or the ESRD Network Coordinating Center.

c. Offer, in accordance with Section 1154(a)(6)(B)(i) of the Act, to send a physician representing the QIO to meet with medical and administrative staff of each hospital the services of which it reviews (see Chapter 12, Section 12200, of the *QIO Manual*).

d. Consult the relevant information clearinghouse among those maintained by the Communications QIOSC, the MedQIC QIOSC, other QIOSCs, and (for renal-related material) the ESRD Networks and ESRD Network Coordinating Center and CMS prior to developing new communication strategies, activities, and/or materials in support of any Task or subtask in this SOW. If suitable production files or materials are available through a clearinghouse, the QIO shall use this content in original form or adapt it for local use.

e. Expand its resources by seeking and considering already developed, non-copyrighted materials (including Web-based materials) available from other experts or sources for use or modification. With documented permission from the owner when required, a QIO may modify such materials as needed for the QIO's communications strategy with local audiences and partners. The QIO shall utilize existing materials and resources to the extent possible when undertaking these activities.

f. Develop new materials and/or substantially modify existing materials, using the most efficient and effective methods possible, when materials that meet a QIO’s communication needs are not available. This may include exhibits and outreach materials when used as a supplement to a comprehensive local plan for communicating with a target audience about a CMS program or initiative.

    1) Exhibits (or public displays) may be used, if necessary, to attract the attention of a specific target audience that would benefit from a direct interaction with a QIO regarding a CMS quality improvement intervention or the quality care information provided by the exhibit or display.

2) Outreach materials may be provided by the QIO at no cost to the recipient and used for the purposes of extending the impact and reinforcing the awareness of a CMS message about its programs and the role of the QIO in supporting those programs or initiatives.

   Note: Because CMS recognizes the need for a QIO to establish and continually reinforce its role and identity within its community of partners, providers, and other health care organizations that it serves, a QIO organization's name (with or without logo) may be included on an item or exhibit as long as the name is not the only or primary message on the item or exhibit, and only if the name is immediately followed by the phrase "The Medicare Quality Improvement Organization for [state or other jurisdiction]." No QIO name or logo on an item or exhibit should compete in size or placement with the title of the primary CMS quality improvement intervention or quality care message. A QIO's Medicare helpline number may be included on an outreach item only if the item is used to support communication efforts related to Task 3a: Beneficiary Protection.

g. Make available to the general QIO community (1) any CMS-approved new materials developed by the QIO, and (2) any CMS-approved substantial adaptations by the QIO of CMS- and/or QIOSC-developed materials. The QIO shall provide a copy of such materials, in a file format specified by CMS, to the relevant QIOSC and (if directed) to the QIO's Project Officer.

h. Integrate its communications to ensure that there is consistent messaging across all Tasks and subtasks. Task and subtask leaders at the QIO should understand potential review requirements with regard to media activities and/or materials supporting high-profile events and national initiatives.

i. QIO Task and subtask leaders shall coordinate on which high-profile events and national initiatives require supporting materials and/or activities to be subject to review. In general, products and materials for Task 1: Assisting Providers in Developing the Capacity for and Achieving Excellence and Task 3: Protecting Beneficiaries and the Medicare Program are not subject to review. However, if materials from Tasks 1 and 3 are to be used in activities involving media on a national scale (see Section C.4.B.8.e), materials may require CMS review. The QIO shall ensure that Task and subtask leaders within its organization are aware of CMS-designated high-profile events and national initiatives. The QIO shall take the appropriate steps internally to ensure that key messages are integrated appropriately to foster a unified voice in support of each event or initiative. In addition, the QIO shall ensure that Task and subtask materials that are not subject to the review process are accurate and consistent with the message of the QIO Program, and that all

identified core messages are consistent with the messages in materials generated under other Tasks and subtasks.

Once a submitted document has been approved and any required changes made, the QIO shall provide a copy of the final version to the appropriate QIOSC in a format prescribed by CMS.

j. The QIO may conduct provider, practitioner, stakeholder, and beneficiary communication activities in support of Task 1 and/or 3 of this SOW. No additional communications activities beyond those that the QIO conducts to support Tasks 1 or 3 or as described in Section C.4.B.8 Communications are required of the QIO. The QIO's communications activities shall adhere to the following requirements:

1) Publications: Peer-Reviewed

A QIO that seeks to publish reports on results of specific activities in technical or professional journals or to present such results at technical or professional meetings shall follow the procedures included in Sections 12500–12530 of the *QIO Manual* and any other administrative directives.

2) Publications: Outreach Materials

All QIO-printed outreach material shall conform to the Department of Health and Human Services (DHHS)/CMS standards issued through CMS.

See Section C.4.B.8.d–i for additional requirements related to the development of outreach materials.

3) Use of Web Technology

In addition to the activities described in the preceding Sections, the QIO may consider engaging in other innovative and cost-effective ways of educating beneficiaries, providers, and practitioners. If a QIO creates or maintains any website(s) on which information regarding the QIO's Medicare contract activities appears, the QIO shall adhere to the following in presenting its Medicare contract-related information on that site(s):

a) Follow the CMS Contractor Website Guidelines at http://www.cms.hhs.gov/AboutWebsite/13_contractorwebguidlines.asp#TopOfPage. The QIO shall refer to this website on an ongoing basis for the most up-to-date standards and guidelines, as the standards and guidelines may be updated or revised periodically.

b) Follow the Accessibility and Section 508 Requirements located at http://qionet.sdps.org/training_resources/accessibility.shtml and http://www.section508.gov/ (providing equivalent alternatives to auditory and visual content meeting the Americans with Disabilities Act requirements). Follow the Department of Justice guidance for Executive Order 13166, "Improving Access to Services for People with Limited English Proficiency" (see the following website for additional information http://www.usdoj.gov/crt/cor/Pubs/lepqa.htm).

c) Refer to Federal Acquisition Regulation (FAR) 52.227-14 Rights in Data-General; SDPS Memo 03-476-QN; SDPS Memo 02-136-QN; PRO TOPS-01-05; PRO TOPS-00-23; PRO TOPS-99-30; and PRO TOPS-99-23; and any other administrative directives.

k. In the event of a pandemic flu outbreak, the QIO shall assist CMS's public health efforts by disseminating information and messages as directed by CMS. CMS will utilize the QIO relation with providers, including its partnerships and collaborations to serve as additional channels for communications. The QIO, in working with its state's/jurisdiction's Department of Health (DOH), shall ensure that the QIO has established point of contact(s) with the Immunization Bureau or others at the DOH to assure effective dissemination of HHS and CMS information. The QIO may need to work actively within its state/jurisdiction. For example, the QIO may be required to:
   - Assist the DOH in provider education/information;
   - Participate in the state's/jurisdiction's disaster planning process (The QIO is encouraged to establish contacts or make sure information on existing contacts are current to ensure coordination in advance of any disaster);
   - Participate in state/jurisdiction Pandemic Readiness Committee(s), as necessary, to help bridge communications and mobilize physician practices, hospitals, nursing homes, home health agencies, and ESRD Networks as necessary; and
   - Subscribe to established Pandemic listservs, as necessary, to ensure consistency with message and status for pandemic readiness.

9. Information Collection Activities

A QIO that seeks to conduct information collection activities, including surveys, as part of its work on the Tasks and subtasks included in Section C.6. shall do so in accordance with the Paperwork Reduction Act; Sections 12600–12670 of the *QIO Manual*; and other administrative directives. All information collection activity must be approved by the Project Officer prior to implementation.

The requirements in Task 1 of this SOW are designed to improve quality of care with respect to preventing clinical disorders and directing the treatment of clinical disorders. Any facts, opinions, or other types of information obtained initially or in follow-up requests from individuals or other entities within the care delivery system are in connection with these improvements in quality of care. In accordance with 5 CFR 1320.3(h)(5), these information collection activities are not subject to the Paperwork Reduction Act and, therefore, do not have to be submitted to the Office of Management and Budget (OMB) for clearance. Note that this does *not* exempt QIO information collection activities from the Quality Improvement Program's internal policies and procedures related to information collection, which are described in Sections 12600-12670 of the *QIO Manual*. This also means that, as described in the QIO Manual, a QIO's proposed information collection activities continue to require timely submission to the QIO's Project Officer/Division of Quality Improvement for review and approval.

10. Internal Quality Control

The objectives of the internal quality control (IQC) program are to support and foster continuous quality improvement within the QIO in support of each of the Tasks and subtasks in Section C.6.

The QIO shall implement an IQC program as described in Sections 13000–13030 of the *QIO Manual*. CMS encourages each QIO to collaborate with other QIOs in developing and implementing IQC programs. The QIO shall share lessons learned regarding these IQC activities with other QIOs using the available mechanisms, including QIO conferences, newsletters, and databases. The QIO shall submit its IQC plan in accordance with Section F – QIO Schedule of Deliverables.

11. Staffing

Within 30 calendar days of the contract effective date, the QIO shall employ a Chief Executive Officer/Executive Director (CEO) or equivalent. The CEO is responsible for leading the organization and obtaining the staff and resources necessary to effectively manage the contract. The CEO shall have experience in managing a QIO or QIO-like entity, or other related experience at an appropriate organizational level.

Replacement of the person identified in this position shall be conducted in accordance with the Key Personnel portion of Section G of this contract.

The QIO shall also have available the professional and technical expertise required to meet all performance expectations described in this SOW:

a. Expertise in medicine, nursing, and related medical/clinical disciplines– including expertise in nursing home, home health, hospital, and physician practice settings, and managed care, pharmacy, and prescription drug plans;

b. Expertise in health education, health promotion, social marketing and formative research, public relations, market research, media, Web design, and related communications disciplines;

c. Diagnostic coding expertise;

d. Expertise in quality and safety of care and performance improvement;

e. Expertise in epidemiology, statistics, survey research, data analysis, information systems, computer science, and related empirical and analytic disciplines;

f. Expertise in social and behavioral sciences including human factors disciplines;

g. Expertise in the administrative and clinical aspects of case review, including case management and the use of mediation to resolve complaints;

h. IT networking, file server, and workstation support expertise;

i. Database support and administration expertise; and

j. IT security and data management expertise.

12. Board of Directors

The QIO shall maintain consumer membership on its Board of Directors consistent with Sections 2200–2230 of the *QIO Manual*.

13. Independent Evaluation

Upon Project Officer approval, the QIO agrees to fully facilitate and provide requested data for any evaluation of QIO performance the Secretary chooses to conduct, either internally or using an external contractor, consistent with applicable statutes and regulations governing QIO information disclosure.

14. Provider Satisfaction and Knowledge Survey Subcontract

The QIO shall sign a subcontract with Westat as directed by CMS and in accordance with Attachment J-10 Provider Satisfaction and Knowledge Survey

Subcontract to accomplish the work required in Section C.6.B.1.5. The QIO shall work directly with Westat on survey contact information for the provider satisfaction and knowledge survey. The QIO shall (1) provide the IPG contact information electronically to Westat and (2) respond to Westat on any status inquiry related to the provider survey. Westat will work with the QIO to obtain the contact information and respond to the QIO on any status inquiry related to the contact information. The QIO shall submit deliverables in accordance with Section F – QIO Schedule of Deliverables.

C.5. OVERALL EVALUATION CRITERIA

Under this SOW, the QIO shall meet performance criteria on the Tasks and subtasks, as specified in what follows and in Section C.6., to be eligible to have its contract renewed non-competitively.

For all nine subtasks (1a, 1b, 1c1, 1c2, 1d1, 1d2, 1d3, 3a, and 3b), the QIO will be scored using the following four classifications:

- Excellent Pass
- Full Pass
- Conditional Pass
- Not Pass

For all nine subtasks, the QIO must achieve at least a Conditional Pass to be eligible to have its contract renewed non-competitively. A QIO that receives a Not Pass on any subtask will be invited to the CMS evaluation panel (subject to CMS approval).

In addition, the QIO must achieve at least a Full Pass or Excellent Pass on seven of the nine subtasks to be eligible to have its contract renewed non-competitively. That is, a QIO that receives a Conditional Pass on three or more subtasks will be invited to the CMS evaluation panel (subject to CMS approval). However, an Excellent Pass on one or more subtasks may negate a Conditional Pass on one subtask. That is, a QIO that receives an Excellent Pass on one or more subtasks and receives a Conditional Pass on no more than three subtasks and does not receive a Not Pass on any subtasks will be eligible to have its contract renewed non-competitively.

A QIO working only seven or eight subtasks due to valid exemptions as specified in the SOW will be treated as though it has received a Full Pass in the subtasks from which it is exempt. The QIO must still achieve at least a Full Pass or Excellent Pass on seven of the nine subtasks in order to have its contract non-competitively renewed.

CMS may revise its performance criteria for a QIO prior to signing a contract with that QIO. Thus, the target performance levels for individual Tasks and subtasks may vary

across QIOs. CMS will provide these specific performance criteria during or subsequent to the Request for Proposal (RFP) process.

The list of measures and performance criteria for each QIO will be recorded on the CMS Dashboard, which will be available on QIOnet (http://qionet.sdps.org), the standard information system that supports the QIO Program. CMS will also post these measures on the publicly accessible CMS website (http://www.cms.gov).

CMS will assess the QIO's Task- and subtask-specific performance in approximately November 2007. The specific evaluation criteria are described below for each Task and subtask.

Any Special Project that the QIO may carry out as part of Task 4: Special Projects will be evaluated separately and will not be subject to these evaluation criteria, except for Special Projects carried out under Task 3b: Hospital Payment Monitoring Program.

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

The CMS-wide panel will be made up of representatives from the Central Office and each of the four Division of Quality Improvement (DQI) Regional Offices. Additionally, the Task- or subtask-specific GTLs will be represented on the panel. The QIO's Project Officer will not be eligible to represent the Regional Office on the panel when it reviews the work of his or her QIO; however, the Project Officer will be available to answer the panel's questions. The QIO will be given an opportunity to provide additional information. The panels' procedures may vary, but a given panel's procedures will be consistent for all QIOs that it reviews.

The panel will use the criteria listed below and in any subsequent *Federal Register* notice to decide whether any unforeseen or uncontrollable events or forces have negatively impacted the QIO's work, or if there is any other reason to believe that it would be in the government's best interest to non-competitively renew the contract.

At a minimum, the panel will obtain information regarding the following:

- The degree of collaboration the QIO has exhibited with the QIOSCs and other QIOs, both by sharing the lessons it has learned and tools it has developed and by adopting practices and tools developed by other QIOs;

- The degree to which a sound strategic approach has been developed and implemented;

- The degree to which the QIO has conducted and used IQC monitoring and improvement techniques to enhance the effectiveness of its activities;

- Whether the QIO was a new contractor for this SOW;

- Whether specific identifiable circumstances have uniquely interfered with the QIO's efforts;

- The degree to which the QIO has been successful (either absolutely or relative to other QIOs) in improving providers' performance on any quality measures that were not explicitly included in the evaluation scheme;

- Evidence suggesting that the QIO has done exceptional work in one or more of the Task or subtask areas;

- Positive comments from CMS staff in regard to the QIO's collaboration with interim monitoring and support activities conducted by CMS during the contract period (The panel will avoid penalizing a QIO for participation in activities addressed at improving its poor performance); and

- Any other issues that the panel may deem relevant.

Upon completion of its review, the panel will make one of the following recommendations for a final disposition to the Director of the Office of Clinical Standards and Quality (OCSQ):

- The QIO's contract should be non-competitively renewed;

- The QIO's contract should be non-competitively renewed but with appropriate conditions and/or modified performance expectations. For example, a QIO may be required to close the gaps between its performance and that of an average QIO;

- While the QIO will not be considered to have had an adverse contract action because of performance deficiencies, the contract should be subjected to a competitive procurement process;

- The QIO contract should be subjected to a competitive procurement process and the QIO will be considered to have had an adverse contract action because of performance deficiencies.

CMS reserves the right at any point prior to the notification of CMS's intention not to renew the contract to adjust the expected minimum thresholds for satisfactory performance downward and/or remove criteria from a Task or subtask evaluation

protocol based on experience with the amount of improvement achieved during the contract cycle or in pilot projects currently in progress and/or any unforeseen circumstances.

C.6. TASKS

A. General Guidelines

Under this SOW, the QIO shall be responsible for completing the requirements of the following specific Tasks and subtasks:

1. Task 1: Assisting Providers in Developing the Capacity for and Achieving Excellence

    1a. Task 1a: Nursing Home
    1b. Task 1b: Home Health
    1c1. Task 1c1: Hospital
    1c2. Task 1c2: Critical Access Hospital/Rural PPS Hospital
    1d1. Task 1d1: Physician Practice
    1d2. Task 1d2: Physician Practice: Underserved Populations
    1d3. Task 1d3: Physician Practice/Pharmacy: Part D Benefit

2. Task 2: (Reserved)

3. Task 3: Protecting Beneficiaries and the Medicare Program

    3a. Task 3a: Beneficiary Protection
    3b. Task 3b: Hospital Payment Monitoring Program

4. Task 4: Special Projects

B. Specific Tasks

1. TASK 1: ASSISTING PROVIDERS IN DEVELOPING THE CAPACITY FOR AND ACHIEVING EXCELLENCE

1) Background

In this SOW, the QIO shall provide assistance to providers that enables them to develop the capacity for, and to achieve, the vision of the QIO Program, which is that every person receives the right care every time. The QIO shall accomplish this by working with providers, practitioners, Medicare Advantage organizations, health plans, beneficiaries, and other

stakeholders to implement quality improvement projects. Work on subtasks of this Task (Task 1a, 1b, etc.) will typically involve seeking to promote improvements in clinical performance measure results; improvements in clinical performance measurement and reporting; systems adoption and use; effective redesign of care processes; and/or changes in organizational culture. For each subtask of this Task, performance measures for promoting such improvements are specified.

2) Task Description

The requirements in Task 1 of this SOW are designed to improve quality of care with respect to preventing clinical disorders and directing the treatment of clinical disorders. Any facts, opinions, or other types of information obtained initially or in follow-up requests from individuals or other entities within the care delivery system are in connection with these improvements in quality of care. In accordance with 5 CFR 1320.3(h)(5), these information collection activities are not subject to the Paperwork Reduction Act and, therefore, do not have to be submitted to the Office of Management and Budget (OMB) for clearance. Note that this does *not* exempt QIO information collection activities from the Quality Improvement Program's internal policies and procedures related to information collection, which are described in Sections 12600-12670 of the *QIO Manual*. This also means that, as described in the QIO Manual, a QIO's proposed information collection activities continue to require timely submission to the QIO's Project Officer/Division of Quality Improvement for review and approval.

To do the work of this Task, the QIO shall:

a) Use data provided by CMS and information the QIO collects to identify opportunities to improve performance on the quality of care measures listed below for each subtask (Task 1a, Task 1b, etc.) of Task 1;

b) Develop and implement quality improvement projects (see Section 16025 of the *QIO Manual*, distributing contract resources across the subtasks of Task 1 to achieve the maximum improvement on the quality of care measures listed within each subtask. Thus, the QIO shall determine the type, level, duration, and intensity of support to offer in its state/jurisdiction within the budget constraints of each subtask of Task 1, except where otherwise noted below;

c) For quality improvement efforts in support of each subtask under Task 1, the QIO shall use the materials developed by the relevant QIOSC and available on MedQIC (http://www.medqic.org/). If appropriate

materials are not available from the relevant QIOSC, the QIO may develop its own material;

d) Build upon materials and information provided by CMS, other QIOs, and the QIOSC, and actively share with other QIOs (via the QIOSC when feasible) information on processes for implementing quality improvement activities; descriptions of interventions; materials; and any other information likely to help other QIOs to improve care for beneficiaries in their states/jurisdictions (see Chapter 16 of *QIO Manual*;

e) Respond to ad hoc information requests from CMS directly or from a QIOSC when authorized by CMS;

f) Invite all Medicare Advantage organizations in the state/jurisdiction to work with the QIO on Task 1;

g) Improve care for the greatest possible number of beneficiaries throughout the state/jurisdiction while utilizing contract resources efficiently and reducing the burden on providers, health plans, and practitioners that participate in quality improvement activities. Methods for accomplishing this include:

   i. Working with stakeholders (establishing new relationships or joining existing efforts) to improve care. Stakeholders are organizations that have common goals with those of the QIO and may include provider membership associations; health care alliances; professional associations; clinical specialty organizations; state licensing, certification, and survey agencies; state and local health departments; accreditation organizations; payers; beneficiary advocacy groups; Medicare suppliers; state Medicaid agencies; ESRD Networks;

   ii. Facilitating collaborative work with providers, Medicare Advantage organizations, health plans, practitioners, and other QIOs; and

   iii. Leveraging partnerships to reach stakeholders and to achieve goals and outcomes around clinical quality improvement that the QIO could not reach on its own. Partnerships may also be used to help expand a QIO's lines of communications to increase awareness of its message within the provider and beneficiary communities.

The QIO shall engage in partnership and communication activities related to specific content areas that shall include, but are not limited to:

- Public reporting of provider performance measure results;
- Pay-for-performance programs that reward improvements in quality;
- Increasing awareness of the services and value offered by the QIO Program; and
- ESRD Networks' initiatives, including the Fistula First Breakthrough Initiative.

A QIO shall make use of theories of social marketing, research and data, etc., to most effectively reach its intended audience. Materials supporting this Task must use messaging that is consistent with those of CMS and the national QIO Program.

The QIO shall conduct partnership and external communications activities based on the priorities described in this Task. Any such activity the QIO wishes to initiate outside of the scope of this Task shall be proposed as a Special Project, and shall be subject to the standard SP submission and review process. Any activity CMS may require will be issued as a Special Project. In either case, approved/awarded SPs shall be executed as described in Task 4: Special Projects, below.

h) For Task 1 the QIO shall direct senior leadership, as defined by CMS, of potential identified participants to sign a letter of commitment either hardcopy or electronic to request assistance from the QIO as directed by CMS. The QIO shall then form its IPG according to the requirements specified by CMS. To be included in an IPG for a Task 1 subtask, a potential identified participant must provide a signed letter of commitment to work with the QIO; and

i) CMS may establish minimum and/or maximum size levels for IPGs. A QIO must have IPGs that are of minimum size in order to pass a subtask, but cannot exceed the maximum size. When a QIO has requests for assistance that exceed the maximum size of an IPG for a subtask, the QIO will form the IPG at the maximum size according to CMS-specified requirements. Providers not selected for the IPG may then become part of a non-assistance group for program evaluation purposes.

3) Changes in Quality of Care Measures

CMS reserves the right to discontinue, change, and/or add measures. In the event that CMS alters the measures, CMS will, after discussions with the QIO and other interested parties, amend the contract and evaluation strategy as necessary to hold the QIO harmless from negative effects of such changes on performance results.

4) Support

To support this Task, CMS Central Office and Regional Office staff will guide and support QIO quality improvement work. CMS also will contract with QIOSCs (approximately one for each of the subtasks under Task 1) to assist CMS staff and the QIO in achieving quality improvement. The QIOSCs will facilitate QIO activities by:

a) Providing materials and information to the QIO for use in its activities to improve the quality of care;

b) Initiating communication, coordination, and collaboration within the QIO community;

c) Assisting with the development of national-level partnerships and providing information to assist the QIO with cooperation, coordination, and communication activities between the QIO and stakeholders within its state/jurisdiction;

d) Convening expert groups, working with national partners, providing individual and group consultation, and assisting with data analysis and interpretation;

e) Providing information on clinical topics and care processes, quality improvement methodologies and activities, and other areas relevant to QIO quality improvement projects–including care management systems, care processes, tools, and techniques; and

f) Assisting the QIO in meeting communications requirements in support of each subtask of Task 1.

5) Evaluation Overview

Subtasks of Task 1 will include statewide and identified participant components. (In this contract, the term “statewide” is used for activities

directed toward a QIO's entire state/jurisdiction—i.e., one of the 50 states, the District of Columbia, Puerto Rico, or the Virgin Islands.)

Subtask evaluation will be based on the following five (5) dimensions of performance:

- Performance measure results
- Clinical performance measurement and reporting
- Systems adoption and use
- Implementation of key process changes
- Changes in organizational culture

The specific measurement and scoring procedures for the subtasks of Task 1 are outlined in the appropriate sections below.

Each subtask of Task 1 will include a requirement to, at a minimum, meet Satisfaction and Knowledge/Perception performance criteria, based on provider (identified participants/non–identified participants) satisfaction and knowledge/perception surveys, and stakeholder knowledge/perception surveys. The QIO must achieve an overall score of ≥80% on the Satisfaction and Knowledge/Perception evaluation component. If the QIO meets this requirement, the QIO will receive the following toward its subtask evaluation score:

- Tasks 1a, 1b, 1c1, 1c2, 1d1, 1d2 = 0.10 of subtask score
- Task 1d3 = must achieve ≥80% on the Satisfaction and Knowledge/Perception evaluation component to receive a Full Pass or Excellent Pass (in addition to meeting other criteria)

a) Customer Satisfaction with QIO Services and Knowledge/Perception about CMS Quality Activities

   CMS will conduct surveys to (1) determine the quality of the QIO's services and their appropriateness for providers' needs and (2) measure the level of knowledge/perception about QIO services and CMS quality activities among providers and stakeholders.

   For Task 1d1 IPG only, the Satisfaction with QIO Services and Knowledge/Perception about CMS Quality Activities questions will be contained in the Office System Survey (OSS). Practices in the IPG will complete the OSS in August 2006 and October 2007. For QIO evaluation in Task 1d1, survey responses for all practices that complete an OSS at baseline (August 2006) or remeasurement (October 2007) will be used to evaluate the QIO's Satisfaction and

Knowledge/Perception score. The responses to the satisfaction element from August 2006 will be used for practices completing only the August 2006 OSS. For those practices responding in both August 2006 and October 2007, only the October 2007 satisfaction responses will be used.

The sample will include:

i. Identified participant providers (as reported by the QIO) for subtasks of Task 1 (excluding Task 1d1);

ii. Non–identified participant providers for subtasks of Task 1 that have a statewide focus;

iii. Medicare Advantage plans (not applicable for Task 1d1 for states/jurisdictions that had <20% Medicare Advantage enrollment among eligible Medicare beneficiaries during calendar year 2004);

iv. ESRD Networks;

v. Prescription Drug Plans (PDPs);

vi. Key stakeholders reported by the QIO in accordance with Section F – QIO Schedule of Deliverables; and

vii. Other key stakeholders with which CMS has required the QIOs to interact.

In accordance with Section F – QIO Schedule of Deliverables, the QIO shall submit one (1) stakeholder contact for participation in a pilot test of the Stakeholder and Knowledge/Perception survey. If applicable, CMS encourages the QIO to identify a stakeholder with which the QIO worked in the 7th SOW and will provide feedback on the survey.

Surveys will contain two types of questions – those to determine the level of satisfaction and those to measure the level of knowledge/perception about QIO services and CMS quality activities. The satisfaction score and the knowledge/perception score will be reported separately for each group.

The QIO will be kept informed regarding the content of the questionnaires, sample selection processes, the methodology for data collection, and procedures for calculating the final evaluation scores.

Individual questionnaire responses will be averaged (i.e., every respondent is weighted equally within each subtask). Surveys will be completed by approximately November 2007.

b) Calculation of Satisfaction and Knowledge/Perception score

Satisfaction and Knowledge/Perception Score						
						Contribution to Score
Provider Satisfaction	50%	Identified participants	70%			35%
		Non–identified participants	30%			15%
Provider and Stakeholder Knowledge/perception	50%	Provider knowledge of QIO Program and perception of QIO value	20%	Identified participants	50%	5%
				Non–identified participants	50%	5%
		Stakeholder knowledge of QIO Program and perception of QIO value	80%	QIO-submitted	50%	20%
				CMS-submitted	50%	20%
Total	100%					100%

SUBTASKS OF TASK 1

1a. TASK 1a: NURSING HOME

1) Background

Under Task 1a, the QIO will focus on:

a) Improving clinical performance;
b) Setting improvement targets; and
c) Measuring the nursing home experience.

In the area of clinical improvement, the QIO will focus on decreasing the rate of pressure ulcers among high risk individuals, decreasing the use of physical restraints, improving the management of depressive symptoms, and improving the management of pain in chronic (long stay) residents among a select group of identified participant nursing homes (IPG1) as well as other nursing homes requesting assistance from the QIO.

The QIO shall also work with a second select group of identified participants (IPG2) that focuses on decreasing the rate of pressure ulcers among high risk individuals and decreasing the use of physical restraints.

In the area of setting improvement targets, the QIO will set statewide targets for (at a minimum) pressure ulcers among high-risk residents and physical restraints. In addition, the QIO will work with all nursing homes throughout the state/jurisdiction to set quality improvement targets for (at a minimum) pressure ulcers and physical restraints on an annual basis.

In the area of organizational culture, the QIO shall work with both groups of identified participants (IPG1 and IPG2) to collect information on resident and staff experience/satisfaction with care and staff turnover by engaging in activity that is likely to improve organizational culture.

2) Task Description

The requirements in Task 1 of this SOW are designed to improve quality of care with respect to preventing clinical disorders and directing the treatment of clinical disorders. Any facts, opinions, or other types of information obtained initially or in follow-up requests from individuals or other entities within the care delivery system are in connection with these improvements in quality of care. In accordance with 5 CFR 1320.3(h)(5), these information collection activities are not subject to the Paperwork Reduction Act and, therefore, do not have to be submitted to the Office of Management and Budget (OMB) for clearance. Note that this does *not* exempt QIO information collection activities from the Quality Improvement Program's internal policies and procedures related to information collection, which are described in Sections 12600-12670 of the *QIO Manual*. This also means that, as described in the QIO Manual, a QIO's proposed information collection activities continue to require timely submission to the QIO's Project Officer/Division of Quality Improvement for review and approval.

The QIO shall update on a quarterly basis the documentation of PARTner activity codes as defined by CMS for its work in meeting the requirements of Task 1a in this SOW.

The clinical performance measures will be based on the publicly reported enhanced quality measures available on Nursing Home Compare (http://www.medicare.gov/nhcompare/home.asp). The baseline rate for high-risk pressure ulcers, physical restraints, and management of pain in chronic (long stay) residents will be based on data from the second quarter of calendar year 2004. For the management of depressive

symptoms measure, the baseline rate will be the highest rate achieved from the second quarter of calendar year 2004 through the second quarter of calendar year 2006. Remeasurement data for all clinical performance measures will be the most recently reported quarterly data available at approximately November 2007.

Detailed specifications for the calculation of the Publicly Reported Nursing Home Quality Measures are available at www.medicare.gov/nhcompare/home.asp.

In addition to the general requirements for Task 1, the QIO shall conduct the following activities consistent with Exhibit 1a: Nursing Home:

a) At the statewide level, the QIO shall:

i. Work with nursing homes and stakeholders to promote quality improvement on the clinical measures. The QIO shall, if requested, provide assistance to nursing homes on clinical measures as necessary and/or appropriate.

ii. Set statewide targets for (at a minimum) high-risk pressure ulcers and physical restraints. The QIO shall document the targets set by submitting them via the STAR interactive website, which will then transmit this information via the appropriate SDPS application according to Section F – QIO Schedule of Deliverables.

iii. Assist nursing homes throughout the state/jurisdiction to help them set targets at least annually for (at a minimum) pressure ulcers among high-risk residents and physical restraints. The QIO shall document the targets set by assisting the nursing homes in submitting this information via the STAR interactive website, which will then transmit this information via the appropriate SDPS application according to Section F – QIO Schedule of Deliverables. Nursing homes participating with the QIO as identified participants are expected to set targets at least annually for high risk pressure ulcers and physical restraints. The Nursing Home QIOSC will make available an interactive website that allows the QIO and nursing homes to set targets as well as providing resources for setting targets. Nursing homes may set any target (including below, above, or at the nursing home's current rate) for the publicly reported quality measures.

iv. (Optionally) Assist a subset of nursing homes in the state/jurisdiction (can overlap in whole or in part with the identified

participant group) to document their processes of care for 50% of new admissions (up to a maximum of 25 admissions per month) related to:

- skin inspection and pressure ulcer risk assessment;
- depression screening and treatment;
- evaluation of the necessity for and alternatives to the use of physical restraints; and
- pain assessment and treatment.

The minimum numbers of nursing homes that must transmit process improvement data in order for the QIO to receive credit for this optional activity are defined by the number of nursing homes in the state/jurisdiction:

Number of Nursing Homes in State/Jurisdiction	Minimum Number of Nursing Homes Transmitting Process of Care Data for QIO To Receive Credit
up to 30	5
31–150	8
151–300	15
301–500	25
more than 500	40

This information shall be transmitted monthly for at least 10 (not necessarily consecutive) months between January 2006 and September 2007 to the QIO Clinical Data Warehouse. The data transmitted to the QIO Clinical Data Warehouse will be available only to the QIO community. These data will be collected using the Nursing Home Improvement Feedback Tool (NHIFT) or a private tool that conforms to the same data specifications. NHIFT will be made available free of cost to all nursing homes beginning in October 2005. Training for the QIOs will begin in October 2005. Monthly reporting will begin in January 2006.

b) With the IPGs (IPG1 and IPG2), the QIO shall help its identified participants:

i. (IPG1 only) Significantly improve the clinical quality of the care provided to their nursing home residents in the areas of pressure ulcers among high-risk residents, physical restraints, management of depressive symptoms, and management of pain.

(IPG2 only) Significantly improve the clinical quality of the care provided to their nursing home residents in the areas of physical restraints and pressure ulcers among high risk residents.

ii. (IPG1 and IPG2) Collect and monitor resident and staff experience of care/satisfaction. Resident and staff experience of care/ satisfaction surveys must be conducted at least annually. Resident experience of care shall be collected only for persons capable of responding on their own behalf. The Nursing Home QIOSC will provide a list of acceptable resident and staff experience of care/satisfaction tools. For the QIO to successfully meet this requirement, at least 90% of all identified participants must complete three annual resident and staff surveys during the course of the SOW. The QIO shall submit each nursing home's baseline, interim, and final remeasurement rates as well as indicate which tool the nursing home has selected for use according to Section F – QIO Schedule of Deliverables; and

iii. (IPG1 and IPG2) Collect and monitor employee turnover. The turnover rate for a given facility will be based on Certified Nursing Assistants/Aides (CNAs) no longer employed by the facility over the course of a 12 month period. For the QIO to successfully meet this requirement, at least 90% of all identified participants must report the CNA turnover rate at baseline, interim, and remeasurement. For the baseline, this 12 month period will be from January 1, 2005 – December 31, 2005. For the interim (second reporting period), the 12 month period will be from December 1, 2005 – November 30, 2006. For the final (remeasurement) reporting period, this 12 month period will be from September 1, 2006 – August 31, 2007. The QIO shall submit the information needed to calculate CNA turnover rate according to Section F – QIO Schedule of Deliverables. The information needed to calculate CNA turnover rate will be calculated in accordance with CMS instructions.

c) In selecting IPG1, the QIO shall meet the following criteria:

i. The QIO shall select IPG1 identified participants based on the number of nursing homes in the state/jurisdiction, as indicated in the following chart.

Number of Nursing Homes in the State/Jurisdiction	Minimum Number of IPG1 Identified Participants	Maximum Number of IPG1 Identified Participants

≤30	All nursing homes in the state/jurisdiction (excluding homes in IPG2)	All nursing homes in the state/jurisdiction (excluding homes in IPG2)
31 to 300	30	45
>300	10% of nursing homes in the state/jurisdiction	15% of nursing homes in the state/jurisdiction

ii. CMS will utilize SAS mapping software to ensure that IPG1 identified participants are distributed across the state/jurisdiction, including any rural areas in which nursing homes are located. Feedback will be provided to the QIO prior to the date that the QIO must submit its list of IPG1 identified participants. The QIO's list of IPG1 identified participants must be approved by its Project Officer and the Task 1a GTL.

iii. The QIO shall work with its state/jurisdiction partners, specifically the State Survey Agency and local stakeholder organization(s), in its selection of IPG1 identified participants. However, the confidentiality of IPG1 identified participants will remain preserved unless the provider chooses to disclose its work with the QIO.

d) In selecting IPG2, the QIO shall meet the following criteria:

The QIO shall work with the State Survey Agency to identify persistently poor performing nursing homes in the state/jurisdiction. CMS encourages the QIO to work with as many of these poor performing nursing homes as possible. The QIO must select its IPG2 to meet the minimum number of IPG2 identified participants indicated in the following chart. IPG2 identified participants shall not overlap with IPG1 identified participants.

Number of Nursing Homes in the State/Jurisdiction	Minimum Number of IPG2 Identified Participants
≤30	1
31 to 300	2
>300	3

e) The QIO shall submit the following in accordance with Section F – QIO Schedule of Deliverables:

- a list of IPG1 and IPG2 identified participants;
- notification as to whether the QIO elects to have a subset of the nursing homes in the state/jurisdiction submit process of care data on a monthly basis and which nursing homes have committed to doing so.

Exhibit 1a: Nursing Home				
QIO Performance Expectations for Task 1a: Nursing Home				
Dimension	**Performance Measure**	**Statewide Performance Criteria**	**IPG1 Identified Participant Performance Criteria**	**IPG2 Identified Participant Performance Criteria**
Clinical Performance Measure Results (based on publicly reported nursing home quality measures)	Pressure Ulcers among High-Risk Residents	The Project Officer will evaluate performance based on the activity to promote statewide clinical quality.	If baseline is <10.5%: achieve a relative improvement rate ≥15% If baseline is 10.5% to 15%: achieve a relative improvement rate ≥25% If baseline is >15%: achieve a relative improvement rate ≥35%	10% relative improvement from baseline to remeasurement
	Physical Restraints		If baseline is <4%: achieve a relative improvement rate ≥15% If baseline is 4% to 10%: achieve a relative improvement rate ≥35% If baseline is >10%: achieve a relative improvement rate ≥60%	10% relative improvement from baseline to remeasurement
	Management of Depressive Symptoms		If baseline is <10%: achieve a relative improvement rate ≥30% If baseline is ≥10%: achieve a relative improvement rate ≥40%	
	Management of Pain In		If baseline is <5%: achieve a relative	

	Chronic (Long Stay) Residents		improvement rate ≥25% If baseline is 5% to 8%: achieve a relative improvement rate ≥35% If baseline is >8%: achieve a relative improvement rate ≥50%	
Process Improvement	**(Extra Credit)** Process Change Implementation	A subset of nursing homes in the state/jurisdiction submit monthly data to the QIO Data Warehouse on at least one of the following topics for 50% of new admissions (up to a maximum of 25 admissions per month) for 10 out of 21 months: (1) skin inspection and pressure ulcer risk assessment; (2) depression screening and treatment; (3) evaluation of the necessity for and alternatives to the use of physical restraints; and (4) pain assessment and treatment		
Organizational Culture Change	Target Setting	At least 25% of nursing homes in the state/jurisdiction must set targets for the clinical measures for (at a minimum) pressure ulcers among high-risk	All IPG1 identified participants must set targets for the clinical measures for (at a minimum) pressure ulcers among high-risk residents and physical restraints	All IPG2 identified participants must set targets for the clinical measures for (at a minimum) pressure ulcers among high-risk

		residents and physical restraints The QIO sets statewide targets for (at a minimum) pressure ulcers among high-risk residents and physical restraints		residents and physical restraints
	Data Collection on Experience of Care		≥90% of all identified participants collect data on and monitor resident satisfaction/experience of care annually for three years; and ≥90% of all identified participants collect data on and monitor staff satisfaction/experience of care annually for three years ≥90% of all identified participants collect and monitor total number of CNAs employed and total number of CNA terminations on an annual basis	≥90% of all identified participants collect data on and monitor resident satisfaction/experience of care annually for three years; and ≥90% of all identified participants collect data on and monitor staff satisfaction/experience of care annually for three years ≥90% of all identified participants collect and monitor total number of CNAs employed and total number of CNA terminations on an annual basis

3) Evaluation

The QIO will be held accountable for the following evaluation criteria for Task 1a.

NOTE: For four states/jurisdictions (WY, AK, DC, and PR), the QIO shall work with its Project Officer to develop alternative Task 1a evaluation criteria for this SOW. The QIO shall submit its alternative Task 1a evaluation criteria in accordance with Section F – QIO Schedule of Deliverables. The QIO must receive approval from its Project Officer and the Task 1a GTL on its alternative Task 1a evaluation criteria. If the QIO fails to receive approval, the QIO will receive a Not Pass for its Task 1a evaluation.

a) Core Activities

i. Clinical Quality (0.40 point possible)

Each clinical measure contributes to the Clinical Quality score according to the following potential points. Relative improvement rates by state/jurisdiction and IPG subset are available quarterly through the Standard Analytical Report (SAR):

For a QIO with ≤800 nursing homes in the state/jurisdiction, the QIO score shall be based on the following potential points:

0.08 IPG1 improvement on high-risk pressure ulcers
0.08 IPG1 improvement on physical restraints
0.08 IPG1 improvement on management of depressive symptoms
0.08 IPG1 improvement on management of pain
0.04 IPG2 improvement on physical restraints
0.04 IPG2 improvement on high risk pressure ulcers

For a QIO with >800 nursing homes in the state/jurisdiction, the QIO score shall be based on the following potential points:

0.09 IPG1 improvement on high-risk pressure ulcers
0.09 IPG1 improvement on physical restraints
0.09 IPG1 improvement on management of depressive symptoms
0.09 IPG1 improvement on management of pain
0.02 IPG2 improvement on physical restraints
0.02 IPG2 improvement on high risk pressure ulcers

ii. Target Setting (0.10 point possible)

25% or more of the nursing homes in the state/jurisdiction report targets for at least pressure ulcers and physical restraints

iii. Experience of Care (0.30 point possible)

For a QIO with ≤800 nursing homes in the state/jurisdiction, the QIO score shall be based on the following potential points:

0.08 IPG1 staff satisfaction
0.08 IPG1 resident satisfaction
0.08 IPG1 CNA turnover
0.02 IPG2 staff satisfaction
0.02 IPG2 resident satisfaction
0.02 IPG2 CNA turnover

For a QIO with >800 nursing homes in the state/jurisdiction, the QIO score shall be based on the following potential points:

0.09 IPG1 staff satisfaction
0.09 IPG1 resident satisfaction
0.09 IPG1 CNA turnover
0.01 IPG2 staff satisfaction
0.01 IPG2 resident satisfaction
0.01 IPG2 CNA turnover

iv. Statewide Clinical Quality (0.10 point possible)

The Project Officer will evaluate performance based on the activity to promote statewide clinical quality.

v. Satisfaction and Knowledge/Perception (0.10 point possible)

0.10 80% or greater score on Satisfaction and Knowledge/Perception criteria (see Section C.6.B.1.5)

b) Non-Core Activities

I. Process Improvement (0.20 point possible)

Monthly submission of all required information contributes to the Process Improvement score according to the following weights:

0.05	Inspection and pressure ulcer risk assessment
0.05	Depression screening and treatment
0.05	Evaluation of necessity and alternatives for physical restraints
0.05	Assessment and management of pain

c) Calculation of Task 1a Evaluation Score

Total Score = Core Activities + Non-Core Activities

Where:
Core Activities = IPG Clinical Quality + Target Setting + Experience of Care + Statewide Clinical Quality + Satisfaction and Knowledge/Perception

Non-Core Activities = Process Improvement

The maximum score for Task 1a is 1.20

Excellent Pass =	≥0.95
Full Pass =	0.75 – 0.94
Conditional Pass =	0.65 – 0.74
Not Pass =	<0.65

The minimum requirement for Full Pass for Task 1a is a positive (non-zero) score for each of the core activities plus a total score of 0.75 or higher.

The minimum requirement for Conditional Pass for Task 1a is a positive (non-zero) score for each of the core activities plus a total score of 0.65 or higher.

A QIO with a zero score in any one of these core activities will be considered as Not Pass regardless of its final evaluation score.

CMS will use the achievement of excellent in one or more areas of the evaluation to determine a QIO's ability to apply for flexibility in future contracts with CMS.

4) Deliverables

See Section F – QIO Schedule of Deliverables

5) Changes in Quality of Care Measures

CMS reserves the right to discontinue, change, and/or add measures. In the event that CMS alters the measures, CMS will, after discussions with the QIO and other interested parties, amend the contract and evaluation strategy as necessary to hold the QIO harmless from negative effects of such changes on performance results.

6) Support

In order to support the task requirements described in Task 1a, CMS will provide software and free train-the-trainer educational session related to use of a process improvement database.

In support of the task requirements described in Task 1a, the Nursing Home QIOSC will:

- provide technical information and reports about CMS's publicly reported nursing home quality of care measures;
- provide train-the-trainer and other educational materials regarding the nursing home culture, regulatory/compliance environment, Minimum Data Set (MDS), and nursing home systems approaches;
- provide endorsed collaborative guidelines and frameworks related to each of the core clinical topics upon which evaluation for this Task is based;
- provide step-by-step project implementation and training materials as well as other template project materials for all publicly reported quality measures;
- Continue to establish and foster good working relations with national nursing home stakeholders;
- provide ongoing assistance and consultation to the QIO in the areas of (1) helping nursing homes improve their organizational quality systems and clinical systems related to the selected measures, and (2) queries about working in the nursing home setting;

- provide ongoing technical support to the QIO to assist it in helping nursing homes to understand the differences between the publicly reported data and other CMS nursing home quality reports (e.g., State Survey Agency results);

- provide guidance for the QIO to use in helping nursing homes establish targets;

- provide structured communication among QIOs working with nursing homes; and

- foster inter-QIO sharing and collaboration.

1b. TASK 1b: HOME HEALTH

1) Background

QIO work in the home health setting will focus at the statewide level on meeting or exceeding the statewide target reduction in failure rates (RFRs) on the Outcome and Assessment Information Set (OASIS) measure for acute care hospitalization and one additional QIO-selected publicly reported OASIS measure. In addition, the QIO shall work with home health agencies (HHAs) in setting targets for acute care hospitalization and other publicly reported OASIS measures to be determined by CMS. The QIO shall also work to increase the number of HHAs that incorporate an assessment of influenza and pneumococcal vaccination status into the patient comprehensive assessment, offer these vaccinations, and provide follow-up.

The QIO shall also work with two groups of identified participants: a Clinical Performance Identified Participant Group (IPG) and a Systems Improvement and Organizational Culture Change IPG.

The QIO will focus in the Clinical Performance IPG on meeting or exceeding the IPG target RFRs on the OASIS measure for acute care hospitalization and one additional HHA-selected publicly reported OASIS measure through the Outcome Based Quality Improvement (OBQI) process.

With the Systems Improvement and Organizational Culture Change IPG, the QIO will work to implement and/or utilize emerging telehealth technologies to help reduce acute care hospitalization and work to build

capacity within these HHAs to evaluate and improve organizational culture.

2) Task Description

The requirements in Task 1 of this SOW are designed to improve quality of care with respect to preventing clinical disorders and directing the treatment of clinical disorders. Any facts, opinions, or other types of information obtained initially or in follow-up requests from individuals or other entities within the care delivery system are in connection with these improvements in quality of care. In accordance with 5 CFR 1320.3(h)(5), these information collection activities are not subject to the Paperwork Reduction Act and, therefore, do not have to be submitted to the Office of Management and Budget (OMB) for clearance. Note that this does *not* exempt QIO information collection activities from the Quality Improvement Program's internal policies and procedures related to information collection, which are described in Sections 12600-12670 of the *QIO Manual*. This also means that, as described in the QIO Manual, a QIO's proposed information collection activities continue to require timely submission to the QIO's Project Officer/Division of Quality Improvement for review and approval.

The QIO shall update on a quarterly basis the documentation of PARTner activity codes as defined by CMS for its work in meeting the requirements of Task 1b in this SOW.

In addition to the general requirements for Task 1, the QIO shall conduct the following activities consistent with Exhibit 1b: Home Health:

a) Both at the statewide level and with a Clinical Performance IPG, the QIO shall improve clinical performance measure results based on the target RFRs in the chart below.

SOW Target Reduction in Failure Rates (RFRs)		
Publicly Reported OASIS Measures	**Target RFR**	
	Statewide	**Identified Participants**
Improvement in Bathing	14%	34%
Improvement in Transferring	8%	31%
Improvement in Ambulation/Locomotion	9%	20%
Improvement in Management of Oral	8%	18%

Medications		
Improvement in Pain Interfering with Activity	11%	41%
Improvement in Status of Surgical Wounds	6%	38%
Improvement in Dyspnea	17%	41%
Improvement in Urinary Incontinence	9%	34%
Any Emergent Care Provided	This measure will not be used for the 8th SOW	This measure will not be used for the 8th SOW
Acute Care Hospitalization	30%	50%
Discharge to Community	10%	35%

The evaluation of clinical performance improvement will be based on baseline risk-adjusted rates computed from data available in OBQI roll-up reports. The baseline periods are as follows:
-Round 1 QIOs – August 2003 – July 2004
-Round 2 QIOs – November 2003 – October 2004
-Round 3 QIOs – February 2004 – January 2005

Identified participants shall be selected based on the PRS database as of June 1, 2005. HHAs that first appear as open agencies in the PRS database after June 1, 2005, are not eligible to become identified participants.

After determining open, non-pediatric agencies in the PRS database, the QIO will use OBQI roll-up reports to determine agencies with 10 or more episodes of care on the acute care hospitalization measure in the 12-month baseline period. Identified participants must not be pediatric agencies, and must also have at least 10 episodes of care in the 12-month period from the OBQI roll-up reports covering the period March 1, 2004–February 28, 2005. From this list, the QIO shall select identified participants according to agency size, in order to fulfill CMS HHA size requirements regarding the IPG, as shown below. Also, an identified participant HHA shall not have an acute care hospitalization risk-adjusted rate of ≤23.9% for the baseline data period.

However, in the event that a QIO is required to recruit >65% of HHAs that are eligible for the IPG to fulfill all IPG requirements (Clinical Performance IPG, Systems Improvement IPG, and substitute/extra insurance HHAs), the QIO shall be allowed to include a portion of HHAs with baseline acute care hospitalization risk-adjusted rates below 23.9%. The maximum portion allowable shall be equal to the minimum number necessary to bring the ratio of IP HHAs needed out

of the number of HHAs eligible to ≤65%. If a QIO chooses to work with any of these HHAs, each HHA will be evaluated in a similar fashion as those HHAs considered high performers in the states required to submit a strategic plan for reducing acute care hospitalization.

The remeasurement period will be approximately November 2007 (based on September 2006 to August 2007 OBQI roll-up report data). The criteria for inclusion of HHAs in the statewide pool shall be equal to the criteria for IPG eligibility (open as of June 1, 2005, non-pediatric, 10 episodes or greater at baseline and February 2005). HHAs that do not meet these criteria will not be included in the statewide pool at evaluation. For evaluation purposes, the Clinical IPG outcome results will be included in the statewide evaluation.

If the performance through August 2005 for the QIO's state/jurisdiction for statewide work or each individual HHA for IPG work is ≥90% for any OASIS publicly reported measure (except for Improvement in Status of Surgical Wounds or Acute Care Hospitalization), the QIO shall select to work on a different measure. The statewide rates are the unweighted average of agency risk-adjusted rates.

If the statewide rate for the acute care hospitalization measure is ≤25.0% through August 2005 (based on data from May 2004–April 2005 OBQI roll-up report), the QIO shall submit a strategic plan for the acute care hospitalization measure that details the QIO's work statewide and with the Clinical Performance IPG. The QIO's strategic plan shall describe: (1) a strategy for decreasing both the statewide and IPG acute care hospitalization rates, and (2) the QIO's statewide and IPG target RFRs. The QIO, its Project Officer, and the Task 1b GTL shall agree on the plan's content and implementation by the deliverable due date. The QIO shall submit its CMS-approved strategic plan to its Project Officer and the Task 1b GTL in accordance with Section F – QIO Schedule of Deliverables. The QIO's strategic plan will replace the contract requirements and evaluation criteria for the acute care hospitalization components of Task 1b. All other contract requirements and evaluation criteria shall apply as written in this SOW.

For extra credit, the QIO may elect to work with HHAs in the state/jurisdiction to set quality improvement target rates for Acute Care Hospitalization and other OASIS publicly reported measures. If the QIO elects to pursue this extra credit, the QIO shall instruct HHAs on target setting to promote quality improvement. Although HHAs may set targets for any of the publicly reported measures, for purposes of

QIO evaluation, targets must be set annually by the home health agency on both the Acute Care Hospitalization measure and one additional measure. The additional measure is the statewide measure for all non-Clinical IPG agencies. The additional measure is the HHA-selected measure for all Clinical IPG HHAs. Extra Insurance Clinical IPGs must set targets on Acute Care Hospitalization and either their agency-selected measure or the statewide measure.

The QIO shall work to have the HHA document its targets by submitting them via the HH STAR interactive website, which will then transmit this information in accordance with Section F – QIO Schedule of Deliverables.

The QIO shall work with HHAs to set targets at least annually for the aforementioned OASIS measures. Targets are to be documented by HHAs via the HH STAR website twice during the SOW. The first annual target setting period ends October 31, 2006. The second annual target setting period begins November 1, 2006, and ends October 31, 2007. The Home Health QIOSC will make available the HH STAR interactive website that allows the QIO and HHAs to set targets as well as provide resources for setting targets. As the HH STAR website was not available at the beginning of the SOW contract, some HHAs have already set targets and submitted documented target information to the QIO. In these instances where HHAs have documented and submitted targets to the QIO before the HH STAR website was available, the QIO may enter HHA targets (those targets selected and documented by the HHA) into the HH STAR website for the first target setting period (ending October 31, 2006). For the second target setting period (November 1, 2006 – October 31, 2007) the QIO must work with the HHA to enter its own targets into the HH STAR website. The QIO may assist HHAs as needed to enter HH STAR targets.

HHAs may set any target rate (including below, above, or at the HHA's current rate) for the OASIS publicly reported measures. An HHA may choose to change their target rates. This will not affect the QIO evaluation as the QIO is evaluated on the act of setting by the HHA. Plans of Action are not required for target setting.

The QIO is not required to work with the HHAs to set quality improvement target rates in this SOW. This is an extra credit activity. For target setting extra credit, 50 percent of the QIO's total IPGs (Clinical Performance and Systems Improvement Organizational Culture Change) must set targets annually (twice during the SOW). It

is not specified which percentage of targets are required from each IPG. The 50 percent will be measured as 50 percent of the total IPG during the first target setting period (ending October 31, 2006) and 50 percent of the total IPG during the second target setting period (November 1, 2006 – October 31, 2007). Different HHAs may set targets in each annual target setting period to count toward the 50 percent. The evaluation will be based upon 50 percent target setting in each of the annual target setting periods. In addition to the requirement that 50 percent of the IPGs set targets, 25 percent of non-IPG HHAs must set targets in each annual target setting period for a QIO to receive extra credit points. Different HHAs may set targets in each annual target setting period to count toward the 25 percent.

For target setting, non-IPG HHAs are defined as HHAs in the statewide pool at baseline that are not chosen as identified participants. HHAs not included in the statewide pool at baseline are not eligible for extra credit target setting, although the QIO is encouraged to work with these HHAs as resources permit.

At the statewide level, the QIO shall work to incorporate influenza and pneumococcal immunization into the HHA comprehensive patient assessment. The QIO shall conduct baseline and remeasurement surveys, using the CMS survey tool, of all HHAs in its state/jurisdiction (excluding pediatric agencies and HHAs with fewer than 10 episodes of care) to determine their immunization practices. The QIO shall use the same CMS survey tool for baseline and remeasurement. HHAs that are non-pediatric agencies with 10 or more episodes of care based on data from March 2004–February 2005 OBQI roll-up report and that are open in PRS as of June 1, 2005, will be included in the baseline and remeasurement survey.

The QIO shall achieve a minimum 50% response rate (percent completing surveys) from the HHAs within its state/jurisdiction. The QIO shall submit the baseline and remeasurement survey results in accordance with Section F – QIO Schedule of Deliverables. The QIO shall achieve a 50% improvement (i.e., a 50% increase in the number of HHAs offering immunizations assessment) from baseline to remeasurement, or achieve 80% statewide performance. The remeasurement is based on all HHAs initially available to be surveyed, not just those completing the baseline survey. The surveys measure the percent of HHAs that have incorporated influenza and pneumococcal immunizations into their comprehensive patient assessment, including offering these vaccinations (or aligning themselves to a vaccination source such as a physician practice or

health department) as well as providing follow-up activities that include verifying patients have received vaccinations. HHAs that are not able to provide vaccinations shall demonstrate sufficient evidence of partnering.

With the Clinical Performance IPG, the QIO shall work to meet or exceed the targeted RFRs for Acute Care Hospitalization and one additional publicly reported measure selected by the HHA (excluding Emergent Care) by utilizing the OBQI process. The use of the OBQI process does require the creation of a Plan of Action (POA). The QIO may work with the HHA to document the POA on the POA Tool (on the www.medqic.org website) or as a hardcopy (paper) POA. The QIO may work with the HHA to submit the POA to the QIO in person, electronically, via fax, or via postal mail. The QIO shall have a copy (electronic or paper) of the POA for all Clinical Performance IPG HHAs. As the POA is an evolutionary document for an HHA, the POA does not need to be completed by the February 1, 2006, deliverable date for POA entry into PARTner. The QIO shall work to implement all POAs (Acute Care Hospitalization and the other publicly reported measure, excluding Emergent Care) with the HHA between May, 1, 2005, and February 1, 2006. The implementation date shall be documented in accordance with Section F – QIO Schedule of Deliverables.

With a Systems Improvement and Organizational Culture Change IPG, the QIO shall:

i. Implement and/or utilize telehealth as a tool to help reduce Acute Care Hospitalization. Telehealth as defined for this SOW in the home health setting will include both types: phone monitoring (planned telephone interactions with patients/caregivers) and telemonitoring (use of telemonitoring equipment and technology). It would be expected that QIOs would predominantly work with HHAs that have not previously implemented telehealth. However, some HHAs that have implemented telehealth may benefit from the assistance of the QIO to assure that telehealth is used as an effective tool to reduce avoidable hospitalizations. Therefore, a QIO may work with HHAs that have previously implemented telehealth.

   All Systems Improvement Organizational Culture Change IPG HHAs must follow the Home Telehealth Guidelines. The HH QIOSC has supplied the QIO and Home Health Community with the Telehealth Reference Manual 2005 (found at www.medqic.org). This manual is a tool to assist HHAs and the QIO in understanding,

implementing, and evaluating telehealth use at the individual HHA level. The QIO is encouraged to educate HHAs on Home Telehealth using the Home Telehealth Reference Manual 2005.

The QIO shall be evaluated on the implementation and/or utilization of telehealth to reduce avoidable hospitalizations per the Home Health Guidelines.

Home Telehealth Guidelines for this SOW are as follows: An HHA must select to use phone monitoring and/or telemonitoring as the type of telehealth. The focus of home telehealth for this SOW will be to use telehealth as a practice tool to reduce avoidable hospitalizations. The use of phone monitoring and/or telemonitoring will be documented on the individual patient care plan at the HHA level. Use of telehealth tools will also require that the HHA identify the patient population that will be targeted for home telehealth (e.g., a disease-specific group of patients, patients that are high-risk for re-hospitalization, patients that have a certain characteristic such as ≥9 medications, etc.). All HHAs currently conduct teletriage activities by triaging incoming patient calls. The QIO shall work with Systems Improvement and Organizational Culture Change IPG to refine their teletriage processes (with phone monitoring or telemonitoring). Refinement of teletriage may include specific agency processes for triaging calls, both during business hours and after hours, and implementation of a monitoring system to monitor teletriage processes.

An HHA may change the type of telehealth during this contract period. This would include changing from phone monitoring to telemonitoring, from telemonitoring to phone monitoring, or changing the patient population at risk. The QIO shall document the type of telehealth and patient population in accordance with Section F – Schedule of Deliverables, but will not be required to document any changes in the type of telehealth or patient population for changes made by the Systems Improvement and Organizational Culture Change IPG.

Telehealth implementation and/or utilization by the Systems Improvement and Organizational Culture Change IPG in this SOW are for the purpose of reducing avoidable hospitalizations. The Systems Improvement and Organizational Culture Change IPG will be included in the statewide evaluation for Acute Care Hospitalization. An OBQI Plan of Action (POA) is not required for telehealth. However, the QIO may work with the Systems

Improvement and Organizational Culture Change IPG to document their ACH telehealth activities on an OBQI POA.

CMS may contact Systems Improvement and Organizational Culture Change IPG to survey them on their telehealth and Acute Care Hospitalization activities.

ii. Using the CMS survey tool, conduct an organizational quality culture change survey of its Systems Improvement and Organizational Culture Change IPG. This survey will focus on organizational practices including, but not limited to, teamwork; communication; leadership; quality improvement; and patient-centeredness. The QIO shall submit these survey results and the results of a remeasurement survey in accordance with Section F – QIO Schedule of Deliverables. Two months after each survey, the QIO shall help each identified participant HHA create and implement a Plan of Action (POA) and the QIO shall submit the POA in accordance with Section F – QIO Schedule of Deliverables. A POA template will be provided by the Home Health QIOSC by August 2005.

b) For Task 1b, identified participants are HHAs designated by the QIO to work intensively on improvement activities.

The QIO shall select two groups of identified participants (the Clinical Performance IPG and the Systems Improvement and Organizational Culture IPG) based on the number of HHAs in the state/jurisdiction, as indicated in the following chart. The identified participants for these two groups may overlap.

Number of HHAs in the State	**Number of Clinical Performance Identified Participants**	**Number of Systems Improvement and Organizational Culture Change Identified Participants**
≤14	6	2
15 to 25	8	3
26 to 45	10	4
46 to 65	14	5
66 to 90	16	6
≥91	20% of all HHAs in the state/jurisdiction	8% of all HHAs in the state/jurisdiction
Note: Pediatric agencies, agencies not open in PRS as of June 1, 2005, and agencies with less than 10 episodes in the baseline period or as of June 1, 2005 (March 2004-February 2005 data)		

are excluded from the number of HHAs in the state/jurisdiction for the purpose of IPG selection.

In selecting the Clinical Performance IPG, the QIO shall meet the following criteria:

The QIO shall include a minimum percentage based on the chart below of each size HHA within its Clinical Performance IPG. HHA size will be determined by eligible cases for utilization outcomes from the OBQI roll-up report as of June 1, 2005 (data from May update, covering the period March 1, 2004 – February 28, 2005).

Small HHAs	≤90 episodes of care annually
Medium HHAs	91– 350 episodes of care annually
Large HHAs	≥351 episodes of care annually

If a QIO does not have an adequate percentage of HHAs of a specific size in its state/jurisdiction, the QIO shall demonstrate this to its Project Officer. Upon approval from its Project Officer, the QIO may work with a set of HHAs selected without restrictions on size.

HHA Size	Minimum Percent of HHAs in Clinical Performance IPG
Small	10%
Medium	10%
Large	15%

The QIO may select up to eight (8) additional, substitute/extra insurance, HHAs (or 8% additional for states/jurisdictions with more than 100 HHAs, to be based on PRS data as of June 1, 2005) to work on identified participant activities. For the purpose of the Task 1b evaluation, the QIO may utilize one or more of these HHAs toward its identified participant evaluation score only if an identified participant in its state/jurisdiction has either 1) gone out of business, or 2) changed ownership. The QIO may select which, if any, of these substitute/extra insurance HHAs that it wants to utilize as an identified participant prior to or at the time of evaluation. A substitute/extra insurance HHA utilized for evaluation purposes is not required to be working on the clinical measure the original identified participant selected. Also, a substitute/extra insurance HHA can be utilized for evaluation purposes for either the Clinical Performance IPG or the Systems Improvement and Organizational Culture Change IPG, or both. A substitute/extra insurance HHA that is utilized for QIO evaluation purposes is not required to be the same size category of the agency it replaced as an

IPG, as long as the QIO maintains the minimum requirements of each size category.

The QIO will receive up to a maximum extra credit of 0.05 point added to its overall Task 1b evaluation score for improvement on both the OASIS Acute Care Hospitalization measure and the selected publicly reported OASIS outcome measure. This extra credit excludes substitute/extra insurance HHAs that are not a part of the original IPG. Telehealth and culture change work will not be included in any potential extra credit.

The QIO shall submit the following deliverables in accordance with Section F – QIO Schedule of Deliverables:

i. a list of identified participants for the Clinical Performance IPG with their POAs, which are not subject to change and which will be used for the evaluation in approximately November 2007. The QIO may begin to collect POAs in May 2005;

ii. a list of identified participants for the Systems Improvement and Organizational Culture Change IPG;

iii. a list of up to 8 or 8% (depending on state/jurisdiction size) substitute/extra insurance HHAs with their POAs (if the QIO chooses to work with substitute/extra insurance HHAs);

iv. the additional statewide measure selected for improvement; and

v. targets for HHAs for the OASIS publicly reported measures.

Exhibit 1b: Home Health			
QIO Performance Criteria for Task 1b: Home Health			
Dimension	**Performance Measure**	**Statewide Performance Criteria**	**Identified Participant Performance Criteria**
Clinical Performance Measure Results	Publicly reported OASIS quality measure (excluding Acute Care Hospitalization and Emergent Care)	Meet or exceed the statewide target RFR for one QIO-selected publicly reported OASIS quality measure (excluding Acute Care Hospitalization and Emergent Care)	Meet or exceed the IPG target RFR for one HHA-selected publicly reported OASIS quality measure RFR for the QIO is calculated from the average indicator rate at baseline and remeasurement.

	Acute care hospitalization	Meet or exceed the statewide target RFR for the acute care hospitalization measure	Meet or exceed the IPG target RFR for the acute care hospitalization measure. RFR for the QIO is calculated from the average indicator rate at baseline and remeasurement.
Systems Improvement	Implementation and/or utilization of telehealth		Telehealth Implementation and/or utilization by Systems Improvement and Organizational Culture Change IPG of telehealth that meets CMS Telehealth Guidelines specified in this SOW
Process Improvement	Immunization assessment survey Percent of HHAs incorporating influenza and pneumococcal immunizations into comprehensive patient assessments, offering vaccinations (or alignment with a vaccination source), and providing follow-up	Achieve at a minimum 50% response rate on the immunization assessment survey Achieve a 50% improvement from baseline to remeasurement (or achieve 80% statewide at remeasurement) on the percent of HHAs that have incorporated influenza and/or pneumococcal immunizations into their comprehensive patient assessment. The remeasurement consists of all HHAs initially available to be surveyed, not just HHAs who completed surveys.	

Organizational Change	CMS-approved survey tool to measure organizational culture		All IPG HHAs implement a CMS-approved survey tool that measures organizational culture All IPG HHAs implement a quality improvement activity and submit a POA based on the results of the organization culture survey
	Target Setting	At a minimum, 25% of non-IPG HHAs set targets for acute care hospitalization and other OASIS publicly reported measures	At a minimum, 50% of IPG HHAs set targets for acute care hospitalization and other OASIS publicly reported measures

3) Evaluation

The QIO will be held accountable for the following statewide and identified participant evaluation criteria for Task 1b.

a) Core Activities (0.75 point possible)

Each core activity contributes to the overall score according to the following points.

The QIO must, at a minimum, achieve a non-zero score for each of six core activities.

i) Satisfaction and Knowledge/Perception criteria as outlined in Section C.6.B.1.5 (SKPS): 0.10 point for achieving a score ≥80%.

ii) Identified participant HHA-selected OASIS measure (IP OASIS): 0.09 point for achieving target RFR; 0.02 point extra credit available (0.11 point maximum); partial points as shown.

RFR	50% – 26% below target RFR	<25% below target RFR	At RFR	5% – 9.9% above target RFR (extra credit)	≥10% above target RFR (extra credit)
Points	0.07	0.08	0.09	0.01	0.02

iii) Identified participant Acute Care Hospitalization measure (IP ACH): 0.27 point for achieving the identified participant RFR; 0.05 point extra credit available (0.32 point maximum); partial points as shown.

If the QIO achieves an IPG indicator rate (average indicator rate for all HHAs in the IPG) on the ACH measure of ≤23%, the full point value plus extra credit will be awarded (0.32 point).

The average indicator rates at baseline/remeasurement will be calculated according to the following:

(Sum of indicator rates for HHAs in IPG) / (Number of HHAs in IPG)

The RFR for the IPG will then be calculated using the following formula:

(Average at remeasurement – Average at baseline) / (Average at baseline – 23)

RFR	50% – 26% below RFR	<25% below RFR	At RFR	5% – 9.9% above RFR (extra credit)	≥10% above RFR (extra credit)
Points	0.23	0.25	0.27	0.04	0.05

iv) Statewide Acute Care Hospitalization measure (ST ACH): 0.19 point for achieving the statewide RFR; 0.03 point extra credit available (0.22 point maximum); partial points as shown.

If the QIO achieves a statewide indicator rate (average indicator rate for all HHAs in the state/jurisdiction) on the ACH measure of ≤23%, the full point value plus extra credit will be awarded (0.22 point).

The average indicator rates at baseline/remeasurement will be calculated according to the following:

(Sum of indicator rates for HHAs in state/jurisdiction) / (Number of HHAs in state/jurisdiction)

The statewide RFR will then be calculated using the following formula:

(Average at remeasurement – Average at baseline) / (Average at baseline – 23)

RFR	50% – 26% below RFR	<25% below RFR	At RFR	5% – 9.9% above RFR (extra credit)	≥10% above RFR (extra credit)
Points	0.15	0.17	0.19	0.02	0.03

v) Implementation and/or utilization by identified participants of telehealth that meets CMS Telehealth Guidelines (TELEH IMPLEM) as specified in this SOW. Obtain HHA implementation form, signed by the HHA Administrator (or his/her executive-level designee) specifying that home telehealth implementation has occurred (including the date in which HHA telehealth implementation, staff education, policy updates, and procedure revisions were completed within the agency) (in accordance with Section F – QIO Schedule of Deliverables): 0.05 point; no partial credit given.

vi) Collection of immunization survey data by at a minimum 50% of the HHAs in the PRS database on June 1, 2005 (IMMUN DATA); 0.05 point; partial points as shown.

Percent of HHAs collecting surveys	<15.9%	16% – 39.9%	40% – 49.9%	≥50%
Points	0	0.01	0.02	0.05

vii) Acute Care Hospitalization strategic plan (only applicable for a QIO required to submit an acute care hospitalization strategic plan)

a) Identified Participants (0.32 point maximum, of which 0.05 are extra credit)

1. Work with one IPG according to the total number of HHAs required under this SOW. HHAs are not required to have baseline rates above 23.9%, but the baseline rates will be used to determine the applicable evaluation criteria, as described below.

The QIO shall work to maintain the baseline acute care hospitalization rate for all HHAs with risk-adjusted baseline rates ≤23.9%, according to the following table (percentages based on absolute change):

Remeasurement Rate	<1% Above Baseline Rate	Equal to Baseline Rate	0.1 - 1% Below Baseline Rate (Extra Credit)	1.1 - 2% Below Baseline Rate (Extra Credit)	>2.1% Below Baseline Rate (Extra Credit)
Points	0.16	0.17	0.18	0.20	0.22

The QIO shall also work to improve the baseline acute care hospitalization rate for all HHAs with risk-adjusted baseline rates above 23.9%, as per the 50% target RFR under this SOW, according to the following table:

Remeasurement Rate	50 - 26% Below RFR	<25% Below RFR	At RFR	5 - 9.9% Above RFR (Extra Credit)	≥10% Above RFR (Extra Credit)
Points	0.15	0.17	0.18	0.20	0.22

The average indicator rate for the IPG at remeasurement will be calculated according to the following (Sum of indicator rates for HHAs in IPG) / (Number of HHAs in IPG).

The number of HHAs in this IPG must adhere to the SOW. HHA size requirements (small/medium/large) do not apply to this IPG.

2. Other acute care hospitalization strategic plan requirements (0.10 point maximum)

    a. Three times during the SOW, when called upon by the GTL and the Home Health QIOSC, the QIO shall share its lessons learned, best practices, etc. on a national call (0.02 point per call).

b. The QIO shall submit a 10-15 page report detailing its best practices; the acute care hospitalization climate in its state/jurisdiction, including reasons the QIO feels the acute care hospitalization is low; how the QIO improved its acute care hospitalization; and how low the QIO feels the acute care hospitalization can get in the future (0.04 point).

b) Statewide (0.22 point maximum, of which 0.03 are extra credit)

1. At the statewide level, the QIO shall work to maintain the un-weighted risk-adjusted baseline rate, according to the table below (percentages based on absolute change).

Remeasurement Rate	<1% Above Baseline Rate	Equal to Baseline Rate	>1% Below Baseline Rate (Extra Credit)	1.1 - 2% Below Baseline Rate (Extra Credit)	≥2.1% Below Baseline Rate (Extra Credit)
Points	0.16	0.19	0.20	0.21	0.22

b) Non-Core Activities (0.25 point possible)

i) Statewide QIO-selected OASIS measure (ST OASIS): 0.10 point for achieving the statewide RFR; 0.03 point extra credit available (0.13 point maximum); partial credit as shown.

RFR	50% – 26% below RFR	25% – 0.1% below RFR	At RFR	5% – 9.9% above RFR (extra credit)	≥10% above RFR (extra credit)
Points	0.04	0.07	0.10	0.02	0.03

ii) Improving the statewide vaccination assessment rate by 50% at remeasurement relative to baseline or 80% statewide rate at remeasurement (ST VACC): 0.09 point; 0.02 point extra credit available (0.11 point maximum); partial credit as shown.

The QIO will be evaluated only on its ability to work with HHAs to incorporate influenza and pneumococcal immunizations into the comprehensive patient assessment. Individual HHA improvement for this measure will be calculated by the improvement in the HHA's ability to provide an assessment of patients' immunization history and the need for vaccination as part of the HHA's comprehensive patient assessment for:

- Pneumonia (0.5 point)
- Influenza (0.5 point)
- Both, pneumonia and Influenza (1.0 point)
- Neither pneumonia nor influenza (0 point)

The QIO will be evaluated by the improvement in remeasurement over baseline by 50% (i.e., 50% relative improvement over baseline) or an 80% statewide rate at remeasurement of HHAs incorporating both the pneumonia and influenza assessment as part of the HHA's comprehensive assessment.

Percent of HHAs implementing immunization assessments from baseline to remeasurement	10% – 29.9% relative improvement	30% – 49.9% relative improvement	50% – 59.9% relative improvement or 80% statewide rate	≥60% relative improvement (extra credit)
Points	0.02	0.04	0.09	0.02

iii) Organizational culture change (ORG CULT):

- Implementation of a CMS survey tool that measures specific dimensions of organizational culture change: 0.02 point for 100% of HHAs in IPG; no partial credit will be given.

- Submission by HHAs of POAs based on the results of the organizational culture change survey and implementation of a quality improvement activity: 0.04 point for 100% of HHAs in IPG; no partial credit will be given.

c) Extra Credit (0.27 point possible)

i) The QIO will receive up to a maximum extra credit of 0.05 point added to its total Task 1b evaluation score for improving results on

both the OASIS acute care hospitalization measure and the selected publicly reported OASIS outcome measure among identified participants not substituted into the IPG. (EXTRA CR); 0.05 point possible.

These extra credit points will be calculated as follows:

If x for a given identified participant = Actual RFR (ACH) / Expected RFR (ACH) + Actual RFR (IP OASIS) / Expected RFR (IP OASIS), then the number of extra credit points =

(# of HHAs for which x ≥2) / (# of HHAs in Extra Credit Pool) (0.05)

ii) The QIO may receive up to a maximum extra credit of 0.15 point added to its total 1b evaluation score for one or more of the following:

- improving results for the identified participant OASIS measure;
- improving results for the statewide and identified participant Acute Care Hospitalization measure;
- improving the statewide immunization assessment rate beyond the target rate

iii) The QIO may receive up to 0.07 point added to its total Task 1b evaluation score for working with HHAs to set targets. For any extra credit points to be awarded, the QIO must at a minimum achieve 50% IPG participation.

Percent of non-IPG HHAs Setting Targets	Extra Credit Points Awarded
<25%	0
26%–35%	0.03
36%–45%	0.04
46%–55%	0.05
>55% or 200 HHAs	0.07

d) Calculation of Task 1b Evaluation Score

An overall score for Task 1b will be calculated as follows:

i) Overall Score = Core Activities Score + Non-Core Activities Score

(SKPS) + (IP OASIS) + (ST ACH) + (IP ACH) + (TELEH IMPLEM) + (IMMUN DATA)

ii) Non-Core Activities Score =

ST OASIS + ST VACC + ORG CULT + EXTRA CR

Excellent Pass = ≥0.95
Full Pass = 0.75 – 0.94
Conditional Pass = 0.65 – 0.74
Not Pass = <0.65

The QIO must, at a minimum, achieve a non-zero score for each of six core activities.

CMS will use the achievement of excellence in one or more areas of the evaluation to determine a QIO's ability to apply for flexibility in future contracts with CMS.

4) Deliverables

See Section F – QIO Schedule of Deliverables.

5) Changes in Quality of Care Measures

CMS reserves the right to discontinue, change, and/or add measures. In the event that CMS alters the measures, CMS will, after discussions with the QIO and other interested parties, amend the contract and evaluation strategy as necessary to hold the QIO harmless from negative effects of such changes on performance results.

6) Support

In support of the task requirements described in Task 1b, the Home Health QIOSC will:

- provide detailed technical information and reports about OASIS outcome measures and the CMS publicly reported OASIS quality of care measures;

- post to the external MedQIC website (http://www.medqic.org/) or the QIOnet Intranet website (http://qionet.sdps.org/) resources for HHAs and QIOs. These resources will include: OBQI training materials; descriptions of clinical outcome enhancement techniques, effective

systems changes, change concepts, best practices, and interventions; POA templates; and guidelines;

- provide ongoing technical support to the QIO to assist it in helping HHAs to understand the differences between publicly reported data and other CMS HHA quality reports (e.g., State Survey results);

- provide guidelines and criteria for the QIO to use in determining which HHAs in its state/jurisdiction will be recruited as identified participants; and

- provide ongoing technical assistance and consultation to the QIO in the areas of (1) helping HHAs improve their organizational quality systems and clinical systems related to selected measures, and (2) providing assistance to HHAs regarding data collection in connection with immunization processes.

1c1. TASK 1c1: HOSPITAL

1) Background

For Task 1c1 in this SOW, the QIO shall work with hospitals to achieve system-level changes through the use of four strategies: improving clinical performance measure results; increasing clinical performance measurement and reporting; process improvement; and systems improvement and organizational culture change.

The QIO will work to improve quality of care in hospitals through several distinct efforts aligned with each strategy. For *clinical performance measure results*, the QIO will assist an Identified Participant Group (IPG), including both rural and urban Prospective Payment System (PPS) hospitals, in improving performance on an Appropriate Care Measure (ACM). (The ACM is defined as a composite measure of care at the patient level for three clinical topics – AMI, HF, and PNE). For *clinical performance measurement and reporting*, the QIO will work at the statewide level to encourage hospitals to submit data on the full Hospital Quality Alliance (HQA) measure set, and work to increase the validity of all data the hospitals submit to the QIO Clinical Data Warehouse. See Table 1 below for a list of measures.

With a major focus on *process improvement* in this SOW, the QIO will work through identified participant efforts to get hospitals to adopt standard processes of care in five different areas: prevention of surgical

site infections, cardiovascular complications, venous thromboembolism, ventilator-associated pneumonia, and promotion of the use of fistulas for hemodialysis.

To encourage *systems improvement* and *organizational culture change*, the QIO will work with identified participants (including both PPS and Critical Access Hospitals [CAHs]) to engage senior hospital leadership in the use of Computerized Physician Order Entry (CPOE), barcoding, and/or telehealth systems.

Table 1. Full Hospital Measure Set (N = 22)

Topic	Quality Measures
Acute myocardial infarction (AMI)	1. AMI-1: Aspirin at Arrival* 2. AMI-2: Aspirin Prescribed at Discharge* 3. AMI-3: ACEI or ARB for LVSD* 4. AMI-4: Adult Smoking Cessation Advice/Counseling 5. AMI-5: Beta Blocker Prescribed at Discharge* 6. AMI-6: Beta Blocker at Arrival* 7. AMI-7a: Thrombolytic Agent Received Within 30 Minutes of Hospital Arrival 8. AMI-8a: PCI Received Within 120 Minutes of Hospital Arrival
Heart failure (HF)	1. HF-1: Discharge Instructions 2. HF-2: LVF Assessment* 3. HF-3: ACEI or ARB for LVSD* 4. HF-4: Adult Smoking Cessation Advice/ Counseling
Pneumonia (PNE)	1. PN-1: Oxygenation Assessment w/in 24 Hours of Hospital Arrival* 2. PN-2: Pneumococcal Vaccination* 3. PN-3b: Blood Culture Before First Antibiotic 4. PN-4: Adult Smoking Cessation Advice/Counseling 5. PN-5b: Initial Antibiotic Received Within 4 Hours of Hospital Arrival* 6. PN-6: Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients 7. PN-7: Influenza Vaccination**
Surgical Care	1. SCIP-Inf 1: Prophylactic Antibiotic

Improvement Project (SCIP) measures	Received Within 1 Hour Prior to Surgical Incision 2. SCIP-Inf 2: Prophylactic Antibiotic Selection for Surgical Patient 3. SCIP-Inf 3: Prophylactic Antibiotic Discontinued Within 24 Hours After Surgery End Time
*Measure required under Section 501(b) of the MMA for full annual payment update. **Measure currently being suppressed from public reporting. NOTE: SCIP-Inf 2 is excluded from the evaluation for this contract.	

2) Task Description

The requirements in Task 1 of this SOW are designed to improve quality of care with respect to preventing clinical disorders and directing the treatment of clinical disorders. Any facts, opinions, or other types of information obtained initially or in follow-up requests from individuals or other entities within the care delivery system are in connection with these improvements in quality of care. In accordance with 5 CFR 1320.3(h)(5), these information collection activities are not subject to the Paperwork Reduction Act and, therefore, do not have to be submitted to the Office of Management and Budget (OMB) for clearance. Note that this does *not* exempt QIO information collection activities from the Quality Improvement Program's internal policies and procedures related to information collection, which are described in Sections 12600-12670 of the *QIO Manual*. This also means that, as described in the QIO Manual, a QIO's proposed information collection activities continue to require timely submission to the QIO's Project Officer/Division of Quality Improvement for review and approval.

The QIO shall update on a quarterly basis the documentation of PARTner activity codes as defined by CMS for its work in meeting the requirements of Task 1c1 in this SOW.

In addition to the general requirements for Task 1, the QIO shall conduct the following activities:

a) Statewide

i. Clinical Performance Measurement Reporting:

The QIO shall work with PPS hospitals statewide to achieve a 25% participation rate for hospitals reporting data on the

expanded set of measures shown in Table 1: Full Hospital Measure Set.

In addition, the QIO shall provide assistance to all PPS and CAH hospitals to improve the validity, timeliness, and completeness of data submitted to the QIO Clinical Data Warehouse. The QIO shall work to achieve a 95% passing rate for chart validation for the full hospital measure set shown in Table 1 (i.e., 95% of hospitals submitting data to the QIO Clinical Data Warehouse, must achieve ≥80% match of data elements on the re-abstracted charts, or minus 1 if fewer than 20 hospitals in the state) for the last two quarters prior to approximately November 2007. This validation criterion only applies to PPS hospitals. The confidence interval applied to validation for the purposes of the Annual Payment Update will not be used in the evaluation of performance of this contract.

The QIO shall:

- Facilitate hospitals' use of the CMS Abstraction and Reporting Tool (CART) by providing technical support and assistance;

- Encourage voluntary participation under the HQA in reporting on the additional measures;

- Manage the interface between the hospitals and QualityNet Exchange through the Provider Reporting System (PRS) by keeping the data on the status of hospitals current; and

- Under CMS direction, support hospitals in their efforts to comply with the Hospital Consumer Assessment of Health Plans Survey (HCAHPS) if it is incorporated into the HQA.

ii. Clinical Performance Results:

The QIO shall work with hospitals and stakeholders to promote quality improvement on the Appropriate Care Measure (ACM) and SCIP measure. If requested by a hospital in the state/jurisdiction, the QIO shall provide assistance on improving the Appropriate Care Measure (ACM) and SCIP measures.

b) Identified Participants

The QIO shall work with its Project Officer and the Task 1c GTLs to identify a list of identified participants for each of three IPGs in accordance with Section F – QIO Schedule of Deliverables. The three IPGs are: an Appropriate Care Measure (ACM) IPG, a Surgical Care Improvement Project (SCIP) IPG, and a Systems Improvement and Organizational Culture Change (SIOC) IPG. The QIO shall issue an invitation to the hospital Chief Executive Officer (CEO) requesting participation in the IPGs. To solicit hospital participation, the QIO may use the standard letter that CMS will supply to the QIO, alter this standard CMS letter, or use a letter developed by the QIO. The CEO of any hospital interested in participating in any of the IPGs will need to sign and submit the completed CMS form letter, an alternate form letter provided by the QIO, or submit a signed letter of interest in order for his/her facility to be considered for inclusion in one or more of the IPGs. If the CEO is unavailable to sign the letter, his or her designated representative may sign for the hospital.

The QIO shall select identified participants that reflect a broad distribution within the state/jurisdiction with regard to the following characteristics: size of provider, geographic distribution, performance at baseline, and need for QIO assistance. The Project Officer and Task 1c GTLs must review and approve the QIO's IPGs based on these criteria.

Data from all hospitals initially selected for inclusion in the IPGs will be used for evaluation purposes.

Each IPG for Task 1c1 must consist of 15% of the PPS hospitals in the state/jurisdiction, with no fewer than 6 and no more than 36 hospitals. Smaller states may request approval from the PO and GTLs to include less than 6 hospitals in the IPG. NOTE: the SCIP and SIOC IPGs may include CAHs as described below. For the SCIP IPG, the 15% pertains to the PPS hospitals meeting the 300 major surgical procedures criterion. For the SIOC IPGs, the 15% includes both PPS and reporting CAHs.

Public Health Service and tribally owned hospitals are eligible to become identified participants if they meet the criteria stated below.

All identified participant hospitals in Tasks 1c1 (excluding CAHs participating in the SCIP IPG) must submit performance data on the 10-measure set as required under Section 501(b) of MMA indicated in Table 1. The IPGs can overlap to any degree.

Extra credit is available for doing additional work in either the ACM or SCIP IPGs, but not both IPGs. QIOs may elect to participate in extra credit for both IPGs. The successful completion of the extra credit will only be counted one time for this task. In order to receive the extra credit a QIO must meet the requirements as specified below under each IPG description. Partial credit will not be given if a QIO falls short of the full requirement for extra credit.

The QIO shall document its intention to pursue extra credit in the ACM and/or SCIP IPGs, including designating the hospitals participating in the extra credit for the ACM IPG and intention to achieve extra credit for the SCIP IPG, in accordance with Section F – QIO Schedule of Deliverables.

The QIO has the option of withdrawing without penalty from its request to participate in the extra credit option up through October 31, 2007. This will not affect the QIOs' core work in the IPG.

i. Clinical Performance Measure Results: ACM IPG

The QIO's work with the ACM IPG shall focus on improving clinical performance measure results in PPS hospitals for AMI, HF and PNE. To be eligible for the ACM IPG, hospitals must submit data on these measures to the QIO Clinical Data Warehouse. A hospital that submits data in compliance with Section 501(b) of the MMA that has cases for only one or two of the three clinical topics is still eligible to be part of the ACM IPG.

The QIO's performance will be measured by their success in the use of the ACM. All patients eligible for at least one of the 10 measures are counted in the denominator. To be counted in the numerator, the patient must receive all of the care specified by the measures. A patient must receive all the care he or she is eligible to receive in order to be considered as having appropriate care. For example, an AMI patient who has a contraindication to aspirin would be eligible for only three AMI measures. If the patient received care that satisfied all three of these measures, the patient would be counted in the numerator. If the patient received care in only one or two of the three measures, the patient would not be counted in the numerator because the patient did not receive appropriate care. In either case, the patient would be counted in the denominator. There is no weighting in this calculation.

CMS will distribute a list to each QIO of ACM results for all PPS hospitals in the state/jurisdiction with a notation of their urban or rural status. CMS expects the QIO to select hospitals for this IPG that represent a diverse group based on ACM performance, urban/rural status, and size. The Project Officer and Task 1c GTLs can provide further guidance to the QIO if necessary. The QIO shall achieve a 50% RFR for 75% or more of the hospitals in the IPG.

NOTE: For purposes of Tasks 1c1 and 1c2, the U.S. Census Bureau definitions of urban and rural will be used. The census defines a set of urban areas, known as Metropolitan Statistical Areas (MSAs), as areas consisting of one or more counties that contain a city of 50,000 or more inhabitants, and have a total population of at least 100,000 (75,000 in New England). The counties that make up MSAs are defined as urban. Those counties not within a MSA are considered rural. Hospitals located within an MSA will be defined as urban facilities, and hospitals located outside will be defined as rural.

Extra credit for the ACM IPG:

- for states/jurisdictions with 33 or more PPS hospitals, the QIO must recruit a total of 20% of the PPS hospitals (rounded to the nearest whole number) ***and*** meet the IPG evaluation criteria as described above.

- for states/jurisdictions with fewer than 33 PPS hospitals, the QIO can obtain extra credit by achieving the stated goal of either (1) increasing the 50% RFR to a 60% RFR *or* (2) increasing the percentage of hospitals that achieve a 50% RFR from 75% to 85%, or by one additional hospital, whichever is greater in absolute numbers.

- The QIO may earn an extra 0.10 points for extra credit in the ACM IPG.

ii. Process Improvement: SCIP IPG

Hospitals must conduct at least 300 major surgical procedures per year to be eligible for the SCIP IPG. (See Attachment J-16 for a list of major surgical procedures.) The QIO shall select 15% of the eligible (conduct at least 300 major surgical procedures) PPS hospitals for participation in the IPG. Critical Access Hospitals (CAHs) meeting the minimum surgical

procedure requirement may also be included in the IPG, but they are not included in the 15% requirement for IPG participation. The CAHs participating in this IPG are not required to meet the definition of a reporting CAH.

The SCIP IPG is part of a larger national effort that utilizes both process and outcome measures (see Table 2 below). The QIO, however, will be evaluated based only on the process measures. The National SCIP initiative focuses on adopting standard processes of care in five areas: the prevention of surgical site infections, cardiovascular complications, venous thromboembolism, ventilator-associated pneumonia, and promotion of the use of fistulas for hemodialysis. However, hospitals in the SCIP IPG will focus on two areas: surgical site infections and venous thromboembolism. When the Cardiovascular, Respiratory, Vascular Access, and Global measures are available, hospitals can work on those as well, but the QIO will not be evaluated on them. The QIO shall assist hospitals in collecting data on as many of the SCIP process and outcome measures as possible since the national effort will use the entire measure set for CMS hospital evaluation purposes.

The QIO may, and is highly encouraged by CMS, work with the SCIP IPG hospitals to use a monitoring tool that will provide the hospital and the QIO with an idea of how the hospital's SCIP measures are performing on a quarterly basis. This will allow the hospitals and the QIO to adjust their intervention techniques and tailor their quality improvement. The QIO may share the aggregated quarterly data from its SCIP IPG with the Project Officers and Task 1c GTLs. The HI QIOSC has a collection of simple monitoring tools currently in use by QIOs. The HI QIOSC will distribute these tools and provide training to any QIO that is not currently using a monitoring tool with its SCIP IPG.

In addition, the QIO shall provide technical assistance to all SCIP IPG hospitals that want to use CART to submit their own SCIP data to the QIO Clinical Warehouse. If a hospital requests assistance that is JCAHO-accredited and uses an ORYX vendor, the QIO shall provide assistance commensurate with the assistance provided for all hospital public reporting and quality measures.

In addition, the QIO will be assessed on the Satisfaction and Knowledge/Perception Survey (see Section C.6.B.1.5.) in relation to the ESRD vascular access outcome measure. In the survey, each ESRD Network will have the opportunity to evaluate the QIO's involvement in the National Fistula First Project.

The QIO shall contact the state/jurisdiction chapter of the American College of Surgeons (if any) to discuss coordination of its SCIP activities. The QIO shall document this in accordance with Section F – QIO Schedule of Deliverables.

iii. Systems Improvement and Organizational Culture Change: SIOC IPG

The QIO shall work with senior leadership (i.e., the Chief Executive Officer [CEO], Chief Operating Officer [COO], Chief Information Officer [CIO], and/or Chief Financial Officer [CFO)]) and the Board of Directors to engage leadership in the PPS hospitals and/or reporting CAHs in using CPOE, barcoding, or telehealth systems. The QIO shall provide technical support to hospital leadership to help them develop the business case for the use of CPOE, barcoding, or telehealth systems and implement an interventions tool kit that will be provided by CMS. In addition, the QIO shall educate the IPG about all aspects of CPOE, barcoding, or telehealth systems (i.e., infrastructure requirements, funding opportunities, day-to-day staffing requirements and associated costs, available applications, network partnership and successful examples) as part of each hospital's implementation plan. The QIO shall then facilitate the implementation of the plan.

Measurement for this IPG will be based on the percent of hospitals in the IPG that complete the readiness/use tool at baseline and remeasurement and have a positive change as measured by this tool. The QIO shall submit results for the readiness/use tool and implementation plans to CMS in accordance with Section F – QIO Schedule of Deliverables. There is a template for the submission of this plan located on MedQIC. The QIO shall use either this template on MedQIC or its own format as long as all the components in the template on MedQIC are included.

3) Evaluation

a) Statewide

i. Clinical performance measurement and reporting

Statewide HQA expanded reporting (HQA) (0.10 point possible). Scoring is based on the percent of hospitals in the state/jurisdiction reporting on the full measure set. CMS will use the last quarter of complete data prior to approximately November 2007. If ≥25% of PPS hospitals submit data on the full set of measures, the QIO will receive the available points.

Data validity (VAL) (0.10 point possible). If ≥95% of PPS hospitals submitting data to the QIO Clinical Data Warehouse achieve a passing score on their two latest quarterly validations (i.e., ≥80% of the data elements match on the re-abstracted charts) prior to approximately November 2007, the QIO will receive the available points.

ii. Satisfaction and Knowledge/Perception (0.10 point possible)

In order to receive 0.10 point for the Satisfaction and Knowledge/Perception survey, the QIO must achieve an 80% or greater score according to the criteria outlined in Section C.6.B.1.5.

b) Identified Participants

i. Clinical Performance Measure Results: ACM IPG

IPG improvement on ACM (0.30 point possible). Baseline data will consist of quality measure performance data for the final quarter of available data prior to August 2005 (4th quarter 2004). The remeasurement period will be the latest quarter for which validated data are available prior to approximately November 2007.

The QIO will receive the available points if ≥75% of hospitals in this IPG achieve a 50% RFR and pass validation (i.e., ≥80% of the data elements match on the re-abstracted charts).

ii. Process Improvement: SCIP IPG

IPG improvement on SCIP (0.30 point possible). The CDAC will abstract the data for baseline and remeasurement. Baseline data will be abstracted from hospital charts for first quarter of 2005 discharges. Remeasurement data will be abstracted from hospital charts for first quarter of 2007 discharges.

CMS will calculate a combined topic average at baseline and remeasurement across the following two SCIP topics: surgical site infections (five measures), and venous thromboembolism (two measures). For each time period, the measure rates within each topic will be averaged, and then the two topic averages will again be averaged. Each topic and measure will be weighted equally. The baseline and remeasurement CTA will be determined and an overall RFR will be calculated for the SCIP IPG. For the QIO to receive the available points, the SCIP IPG must have an average (mean) RFR ≥25% across the two topics. Partial credit will be granted for SCIP IPG average RFR below 25% using a linear scale. For example, 0.24 points ((.2/.25)*0.30 points) will be granted for an average RFR of 20% across the two topics). No points will be granted for a negative SCIP IPG average RFR across the two topics.

Extra credit: A maximum of an extra 0.10 points is available to the QIO if the SCIP IPG achieves an average (mean) RFR ≥30%. The RFR for the extra credit will use the same CTA as described above.

CMS acknowledges that QIO IPG selection and technical assistance are currently designed to meet the previous median RFR performance evaluation criteria. Limited resources prevent CMS from estimating reliable RFR's for baseline and remeasurement data using the CDAC sample, and require CMS to modify the evaluation criteria.

The QIO is required to meet at least one of the following two RFRs:

- Unbiased mean–each sampled case is weighted according to its sample probability of selection; or
- Mean with each IPG hospital's summed weights are equivalent–this alternative estimate is not designed to produce hospital-level estimates, but instead estimates hospital-level performance by effectively weighting each IPG hospital equally.

For example, a state's/jurisdiction's IPG sample totals 330 cases, and the IPG is comprised of six hospitals. Assuming sample size counts of the following:

	Sample Size	Weight of Hospital Using Rate1	Weight of Hospital Using Rate 2
Hospital 1	240	(240/330)	(1/6)
Hospital 2	30	(30/330)	(1/6)
Hospital 3	20	(20/330)	(1/6)
Hospital 4	15	(15/330)	(1/6)
Hospital 5	15	(15/330)	(1/6)
Hospital 6	10	(10/330)	(1/6)

The evaluation score will use the best of the two rate RFRs. CMS will not combine the two rates (e.g., use baseline rate using rate 1 and remeasurement rate using rate 2 to compute RFR), but instead compute baseline to remeasurement RFR using Rate 1, and a second baseline to remeasurement RFR using Rate 2.

iii. Systems Improvement and Organizational Culture Change: SIOC IPG (0.20 point possible)

Completion of assessment tool (assess readiness/use at baseline and remeasurement)
Positive changes in terms of readiness/use continuum for CPOE, barcoding, or telehealth

The unweighted score for the SIOC IPG = (% hospitals completing assessment tool at baseline and remeasurement (0.04) AND achieving a higher score on the readiness tool at remeasurement relative to baseline) (0.16). If % >0, then the QIO will receive the available points.

c) Calculation of Task 1c1 Score

The score for Task 1c1 will be calculated as follows:

Statewide	Available Points
HQA	0.10
VAL	0.10
Satisfaction/Knowledge/Perception	0.10
	0.30

Identified Participants	Available Points

ACM	0.30
SCIP	0.30
Extra credit for ACM or SCIP IPG	0.10
SIOC	0.20
	0.90
Total Possible Points	1.20

Excellent Pass = ≥0.95
Full Pass = 0.75 – 0.94
Conditional Pass = 0.65 – 0.74
Not Pass = <0.65

4) Deliverables

See Section F – QIO Schedule of Deliverables.

5) Changes in Quality of Care Measures

CMS reserves the right to discontinue, change, and/or add measures. In the event that CMS alters the measures, CMS will, after discussions with the QIO and other interested parties, amend the contract and evaluation strategy as necessary to hold the QIO harmless from negative effects of such changes on performance results.

6) Support

In support of the task requirements described in Task 1c1, the Hospital Interventions QIOSC will provide at a minimum:

- Intervention tools related to each SCIP topic;
- Communication tools for SCIP;
- Regular updates on progress of national SCIP project;
- Toolkit for assessing readiness for CPOE, barcoding, or telehealth use;
- Characteristics of high performing hospitals;
- Technical information and reports about CMS's publicly reported hospital quality of care measures; and

- Guidelines and criteria for the QIO to use in determining which hospitals in its state/jurisdiction will be eligible for recruitment as identified participants.

Table 2. SCIP Measures	
Topic	Quality Measure(s)
Infection	SCIP-Inf 1: On-time prophylactic antibiotic administration* SCIP-Inf 2: Appropriate selection of prophylactic antibiotics SCIP-Inf 3: Prophylactic antibiotics discontinued within 24 hours after surgery* SCIP-Inf 4: Controlled perioperative serum glucose (≤200 mg/dL) among major cardiac surgery patients * SCIP-Inf 5: Post-operative wound infection diagnosed during index hospitalization SCIP-Inf 6: Appropriate hair removal* SCIP-Inf 7: Perioperative normothermia among colorectal surgical patients*
Cardiovascular	SCIP-Card 2: Major surgery patients received beta-blocker perioperatively if they were maintained on a beta-blocker prior to surgery SCIP-Card 3: Intra- or post-operative AMI diagnosed during index hospitalization and within 30 days of surgery
Thrombo-emoblic	SCIP-VTE 1: Thromboembolism prophylaxis* SCIP-VTE 2: Appropriate venous thromboembolism prophylaxis* SCIP-VTE 3: Intra- and post-operative pulmonary embolism SCIP-VTE 4: Intra- and post-operative deep venous thrombosis
Respiratory	SCIP-Resp 1: Post-operative orders and documentation of elevation of HOB SCIP-Resp 2: Post-operative ventilator associated pneumonia during index hospitalization SCIP-Resp 3: Peptic ulcer disease prophylaxis received SCIP-Resp 4: Ventilator-weaning protocol
Vascular Access	SCIP-ESRD 1: Permanent hospital ESRD vascular access procedures that are autogenous AV fistulas
Global	SCIP-Global 1: Mortality within 30 days of surgery SCIP-Global 2: Readmission within 30 days of surgery
* Process measure on which QIO will be evaluated.	

1c2. TASK 1c2: CRITICAL ACCESS HOSPITAL/RURAL PPS HOSPITAL

1) Background

NOTE: If CMS determines that the circumstances for a given state/jurisdiction do not warrant the performance of the work under this task, the Contracting Officer may exclude performance of the task from the QIO(s) contract. Notification of the removal of the requirement to perform the task work will be made through a formal written notice to the QIO issued by the Contracting Officer. A reduction in contract funding commensurate with the removal of the Task work will be executed through formal contract modification.

As a part of QIO efforts in the hospital setting in this SOW, the QIO shall promote transformational change in Critical Access Hospitals (CAHs) and rural PPS hospitals by working on clinical performance quality measures and organizational safety culture relevant to the care provided in these hospitals. For purposes of Task 1c2, a rural PPS hospital is defined as a PPS hospital located in a non-MSA county. (See Section J, Attachment J-1, Glossary, for a definition of “rural PPS hospital”).

NOTE: A QIO with less than two CAHs in its state/jurisdiction in August 2005 is excluded from all aspects of this Task for the duration of the contract period.

A minimum of six CAHs and/or rural PPS hospitals is required for the IPG work. A state/jurisdiction that does not have at least six CAHs and/or rural PPS hospitals must receive permission from its Project Officer and the Task 1c GTLs to work with fewer than six facilities.

At the statewide level, the QIO shall work to increase the number of non-reporting CAHs submitting data to the QIO Clinical Data Warehouse. The QIO will assist reporting CAHs with implementing quality improvement methods that encourage best practice use of resources through process redesign. The QIO shall additionally work on organizational safety culture change with an IPG of CAH and rural PPS hospitals.

In addition, the QIO can obtain extra credit for working with at least one non-reporting CAH (that does not participate in reporting data on the full measure set, and therefore is excluded from the IPG for Task 1c1 on CPOE, barcoding, or telehealth systems. If the hospital(s) achieves the evaluation criteria for Task 1c1, the QIO will receive extra credit for this work under Task 1c2.

Additional extra credit may be available for Task 1c2 if the transfer measures identified in Table 2 below are released prior to the end of this SOW.

2) Task Description

The requirements in Task 1 of this SOW are designed to improve quality of care with respect to preventing clinical disorders and directing the treatment of clinical disorders. Any facts, opinions, or other types of information obtained initially or in follow-up requests from individuals or other entities within the care delivery system are in connection with these improvements in quality of care. In accordance with 5 CFR 1320.3(h)(5), these information collection activities are not subject to the Paperwork Reduction Act and, therefore, do not have to be submitted to the Office of Management and Budget (OMB) for clearance. Note that this does *not* exempt QIO information collection activities from the Quality Improvement Program's internal policies and procedures related to information collection, which are described in Sections 12600-12670 of the *QIO Manual*. This also means that, as described in the QIO Manual, a QIO's proposed information collection activities continue to require timely submission to the QIO's Project Officer/Division of Quality Improvement for review and approval.

The QIO shall update on a quarterly basis the documentation of PARTner activity codes as defined by CMS for its work in meeting the requirements of Task 1c2 in this SOW.

In addition to the general requirements for Task 1, the QIO shall conduct the following activities consistent with Exhibit 1c2: Critical Access Hospital/Rural PPS Hospital:

a) At the statewide level, the QIO shall:

i. Work with all reporting CAHs to improve their performance, through process redesign approaches, on at least one (1) measure, from the list of 22 measures, selected by each CAH and the QIO. The hospital and QIO may also choose to work on all measures for 1 topic, or one or more measures under different topics. However, the QIO must select one measure to be reviewed for evaluation purposes. The QIO shall submit a report to the Project Officer and Task 1c GTLs listing the measure(s) or topic selected for improvement in accordance with Section F – QIO Schedule of Deliverables. All selected measures must have a non-zero baseline denominator. The

remeasurement data may include a zero denominator. The QIO shall achieve a 10% statewide RFR from baseline to remeasurement on the measure selected for evaluation. The QIO can receive extra credit for achieving up to a 20% statewide RFR on the measure selected for evaluation. Reporting CAHs that do not participate in quality improvement activities will be scored as a "0" RFR in the evaluation formula. The statewide RFR will be calculated by summing the numerators and the denominators across all participating CAHs for each selected measure. The QIO shall submit a final report describing the QIO's quality improvement activities with each hospital in accordance with Section F – QIO Schedule of Deliverables.

NOTE: CMS considers a CAH to be "reporting" if it successfully submitted data to the QIO Clinical Data Warehouse for at least one HQA measure for both the third and fourth quarters of 2004. It does not have to be the same measure for each quarter.

ii. Work with all non-reporting CAHs to promote reporting of data on at least one clinical measure (see Task 1c1 Table 1) topic (including all the measures for that topic) for two consecutive quarters. The goal is to achieve 50% increase in reporting by non-reporting CAHs. A QIO may receive extra credit for recruiting up to 100% of non-reporting CAHs to begin reporting.

iii. Potential extra credit may be earned by the QIO for working with CAHs to promote reporting of data on the new AMI transfer measures and/or ED transfer measures for at least one quarter prior to approximately November 2007 if these measures become available prior to approximately November 2007. In addition to promoting the reporting of data on the new measure(s), the QIO shall work with hospitals to identify a quality improvement project for one of the measures. The QIO must also submit a final quality improvement plan for each hospital that reports data on the new measure(s) in accordance with Section F – QIO Schedule of Deliverables.

Participating CAHs will collect, enter, and submit data to the QIO Clinical Data Warehouse via CART or an authorized vendor.

Quality Improvement Measures for Task 1c2: CAH quality indicators	Status
AMI-1: Aspirin at Arrival	Current measure

AMI-1A: Aspirin at Arrival (no transfer exclusion)	Will be incorporated into new CART module
AMI-2: Aspirin Prescribed at Discharge	Current measure
AMI-3: ACEI or ARB for LVSD	Current measure
AMI-6: Beta Blocker at Arrival	Current measure
AMI-6A: Beta Blocker at Arrival (no transfer exclusion)	Will be incorporated into new CART module
AMI-5: Beta Blocker at Discharge	Current measure
AMI-7: Time to thrombolytics (no transfer exclusion)	Will be incorporated into new CART module
HF-2: LVF Assessment	Current measure
HF-3: ACEI or ARB for LVSD	Current measure
PN-1: Oxygenation Assessment	Current measure
PN-2: Pneumococcal vaccination	Current measure
PN-5b: Initial antibiotic received within 4 hours of hospital arrival	Current measure
SCIP-Inf 1: Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision	Current measure
SCIP-Inf 2: Prophylactic Antibiotic Selection for Surgical Patient	Current measure
SCIP-Inf 3: Prophylactic Antibiotic-Discontinued Within 24 Hours After Surgery End Time	Current measure
Emergency Department Transfer	New measure expected by end of the 8th SOW

b) The QIO shall work on organizational safety culture change with an IPG consisting of at least six hospitals, unless approval is obtained from the Task 1c GTL and the Project Officer to work with fewer than six. Both CAHs and rural PPS hospitals are eligible for inclusion in the IPG. The QIO shall submit the list of identified participants for the IPG in accordance to Section F – QIO Schedule of Deliverables.

The QIO, using a Rural Organizational Safety Culture Change (ROSC) toolkit, shall work with hospital senior leadership (i.e., CEO, COO, CIO, CFO) to assess its organization's safety climate at baseline and remeasurement. The QIO shall use AHRQ's Hospital Survey on Patient Safety Culture to assess the safety climate in each of the IPG hospitals. The QIO shall assist its IPG hospitals in selecting and implementing change models that will require direct involvement from senior leaders (e.g., senior leadership walk-around, formal support in establishing safety briefings, establishment of a “just culture” hospital policy, etc). QIO evaluation will be based upon three questions related to hospital management, under Section F of the Safety Culture Survey (#1, #8 and #9). The QIO will be scored based on the percent of its

IPG hospitals achieving an RFR ≥1.0% between the baseline and remeasurement survey results of the three (3) selected questions. The RFR will be determined based on an aggregate composite score of the three questions across all hospitals.

Specifically, the QIO shall work with its ROSC IPG to ensure that each hospital will have: (1) its own database of baseline and remeasurement responses from the AHRQ Hospital Patient Safety Culture Survey; and (2) a working knowledge of how to resurvey, enter results, analyze the data, and report/interpret results. The QIO shall work with its IPG using guidance provided in the AHRQ Survey User's guide to assist these hospitals in determining: (1) data collection methods (e.g., Web-based or paper tool); and (2) who should complete the survey (i.e., all staff, a representative sample of staff, or a subset of staff, such as nurses) to obtain the most consistent responses and collect the most accurate baseline and remeasurement data.

In accordance to Section F – QIO Schedule of Deliverables, the QIO shall submit the safety culture baseline and remeasurement results (a composite score of the three CMS-selected survey items) and information on whether results are derived from a sample, a subset of providers, all hospital staff, or a combination of strategies (i.e., 100% of nurses and a sample of the non-nursing staff). If a sample is used, the QIO shall provide information on the size of the sampling frame, the number in the sample, and the number of responses. If the results are derived from a hospital-wide survey or a subset of staff, the QIO shall provide information on the total number of staff eligible to take the survey and the number of responses. If a combination of strategies is used, the QIO shall provide information for each component. The QIO shall also submit information on the senior leadership change models implemented in accordance with Section F – QIO Schedule of Deliverables.

Extra credit may be earned in Task 1c2 by recruiting at least one non-reporting CAH (from among those that are not eligible for the Task 1c1 IPG) to work on CPOE, barcoding, and/or telehealth activities, and achieving the evaluation criteria for the 1c1 SIOC IPG. The QIO will use the same toolkit and supporting materials that are provided for the 1c1 IPG.

3) Evaluation

The QIO will be evaluated on a point basis, with scores calculated to two decimal places. Total points available = 1.35 points.

a) Statewide (0.80 point possible)

Scoring on statewide activities is weighted to reflect each state/jurisdiction's proportion of reporting CAHs. For example, a QIO in a state/jurisdiction in which most CAHs already report data to the Warehouse will earn more points for quality improvement activities than for recruiting non-reporting CAHs to report. Any statewide RFR greater than 20% will be counted as 20% in the current calculation. Additional extra credit may not be earned for achieving a higher RFR.

Definitions:

QI Weight = number of reporting CAHs in state/jurisdiction / total number of CAHs in state/jurisdiction

HR Weight = number of non-reporting CAHs in state/jurisdiction / total number of CAHs in state/jurisdiction

QI Weight + HR Weight = 1.0

i. Selected quality improvement measure

If the QIO achieves an RFR ≤10%:

QI Score = QI Weight *0.5* (statewide RFR/ 10%)

If the QIO achieves a >10% statewide RFR:

QI Score = (QI Weight *0.5) +
(QI Weight *0.1* ((statewide RFR – 10%)/10%))

ii. Reporting of data on one HQA measure for at least two consecutive quarters

If ≤50% of non-reporting CAHs report for at least two consecutive quarters:

HR Score = HR Weight *0.5* (% of non-reporting CAHs reporting at remeasurement / 50%)

If >50% of non-reporting CAHs report for at least two consecutive quarters:

HR Score = (HR Weight *0.5) +
(HR Weight *0.1* ((% of newly reporting CAHs – 50%) / 10%

iii. Potential extra credit (if measures are available): Work with CAHs to promote reporting of data on the new AMI transfer measures and/or ED transfer measures for at least one quarter prior to approximately November 2007. Score: (Number of CAHs reporting data on AMI transfer and/or ED measures) / (Number of CAHs reporting data on at least one measure for at least two quarters) * 0.20

b) Identified Participants (0.45 point possible)

The QIO must identify its IPG in accordance with Section F – QIO Schedule of Deliverables.

i. Systems Improvement

Extra credit is available for recruiting at least one non-reporting CAH (from among those that are not eligible for the Task 1c1 IPG) to work on CPOE, barcoding, or telehealth activities, and achieving the evaluation criteria for the 1c1 SIOC IPG. The formula for this extra credit is ([% of hospitals completing assessment tool at baseline and remeasurement] * 0.2 + [% hospitals with positive change from baseline to remeasurement on tool] * 0.8). Score = 0.05 point.

ii. Organizational Culture Change

The QIO shall assist identified participant CAHs/rural PPS hospitals in assessing their organizational safety culture using a safety culture survey provided in the ROSC toolkit. The QIO shall also assist these hospitals in selecting, testing, and implementing changes that will demonstrate improvement in the organization's safety culture as measured via a re-survey of hospital staff. Baseline and remeasurement scores will be used to calculate an RFR for each identified participant. The percent of identified participants that achieve an RFR $\geq$1.0% will be used in evaluating the QIO performance of work in this subtask. Score = (% hospitals achieving RFR $\geq$1.0%) * 0.40.

Identified participants that reach the highest attainable score for both baseline and remeasurement surveys shall be considered as attaining at least 1% RFR for this contractual requirement.

c) Satisfaction and Knowledge/Perception (0.10 point)

To receive 0.10 point for the Satisfaction and Knowledge/Perception survey, the QIO must achieve an 80% or greater score according to the criteria outlined in Section C.6.B.1.5.

d) Calculation of Task 1c2 Score

The total score for Task 1c2 is computed as the sum of the points scored for the statewide efforts, IPG efforts, and the Satisfaction and Knowledge/Perception criteria.

Statewide	Available Points
Points Available (inc. extra credit)	0.80

Identified Participants	Available Points
Points Available (inc. extra credit)	0.45

Satisfaction/Knowledge Perception	0.10

Total Possible Points	1.35

Excellent Pass =	≥0.95
Full Pass =	0.75 – 0.94
Conditional Pass =	0.65 – 0.74
Not Pass =	<0.65

4) Deliverables

See Section F – QIO Schedule of Deliverables.

5) Changes in Quality of Care Measures

CMS reserves the right to discontinue, change, and/or add measures. In the event that CMS alters the measures, CMS will, after discussions with the QIO and other interested parties, amend the contract and evaluation strategy as necessary to hold the QIO harmless from negative effects of such changes on performance results.

6) Support

In support of the requirements for Task 1c2, the Hospital Interventions QIOSC will provide:

- Assistance regarding AMI transfer measures, ED transfer measures, the CART module, and other data reporting issues;
- Toolkit and training for measuring and improving organizational/ patient safety culture;
- Final report template for reporting data on the QIO's quality improvement selected measure;
- Technical information and reports about the potential of CMS publicly reporting rural hospital quality of care measures; and
- Guidelines and criteria for the QIO to use in determining which hospitals in its state/jurisdiction will be eligible for recruitment as identified participants.

1d1. TASK 1d1. PHYSICIAN PRACTICE

1) Background

For Task 1d1 in this SOW, the QIO will work with physician practice sites statewide and with an IPG.

At the statewide level, the QIO will promote quality initiatives including the Physician Voluntary Reporting Program (PVRP); support collaborative quality improvement activities involving Medicare Advantage organizations; (if requested) work with End-Stage Renal Disease (ESRD) Networks to improve rates of fistula use and influenza and pneumococcal vaccinations; and collaborate with the Medicare Care Management Performance Demonstration (Section 649 of MMA) contractors.

With an IPG, the QIO will focus on more reliable delivery of preventive services and effective management of patients with chronic conditions, in particular diabetes and heart disease. Working with their IPG, the QIO will seek to demonstrate improvement in clinical performance measures through the production and effective use of electronic clinical information in conjunction with redesign of patient care processes within the physician practice sites.

In addition to executing the work described for Task 1d1, the QIO will work collaboratively with other organizations and agencies that have similar goals. These other organizations and agencies include, but are not limited to, the Agency for Healthcare Research and Quality's (AHRQ's) National Health IT Resource Center (NHITRC), the Office of the National Coordinator of Information Technology (ONCHIT), and other federal agencies.

The QIO shall be actively involved with or promote the convening of local multi-stakeholder organizations that seek to promote the production and use of electronic clinical information and healthcare information exchange necessary for improving clinical performance.

The QIO may work with these organizations to:

- Provide information on products, functionality, value, and costs of electronic clinical information systems;
- Promote production and use of electronic clinical information;
- Promote electronic clinical information sharing in accordance with HIPAA standards (including the Privacy and Security Rules) and QIO confidentiality requirements, as applicable; and
- Promote improved healthcare through use of and reporting of performance on the clinical quality measures specified for this Task.

The QIO may be required to subcontract for the provision of assistance relating to this task that CMS determines to be outside of the expertise of the QIO.

2) Task Description

The requirements in Task 1 of this SOW are designed to improve quality of care with respect to preventing clinical disorders and directing the treatment of clinical disorders. Any facts, opinions, or other types of information obtained initially or in follow-up requests from individuals or other entities within the care delivery system are in connection with these improvements in quality of care. In accordance with 5 CFR 1320.3(h)(5), these information collection activities are not subject to the Paperwork Reduction Act and, therefore, do not have to be submitted to the Office of Management and Budget (OMB) for clearance. Note that this does *not* exempt QIO information collection activities from the Quality Improvement Program's internal policies and procedures related to information

collection, which are described in Sections 12600-12670 of the *QIO Manual*. This also means that, as described in the QIO Manual, a QIO's proposed information collection activities continue to require timely submission to the QIO's Project Officer/Division of Quality Improvement for review and approval.

The QIO shall update the documentation of PARTner activity codes as defined by CMS for its work in meeting the requirements of Task 1d1 in this SOW.

In addition to the general requirements for Task 1, the QIO shall meet the following requirements:

a) Statewide

i. Clinical Performance Measure

The QIO shall work with physician practice sites and others to improve care for Medicare beneficiaries on a statewide basis. The QIO shall support quality initiatives including Physician Voluntary Reporting Program (PVRP) by:

- Making information available to physicians and stakeholders. Include PVRP information (including participation requirements and PVRP implementation status) as part of ongoing Task 1d communication and partnership activities with physicians and physician stakeholder groups;
- Providing technical assistance regarding PVRP participation and submission of information. On request, assist physicians in registering for PVRP through registration in QNet Exchange, and validate registration information. On request, assist physicians in understanding clinical measure specifications and how to submit information using G-code/claims and EHRs; and
- Supporting physicians in EHR adoption and improvement on performance measures. Provide information on request regarding using QNet Exchange to obtain performance feedback reports, and provide assistance on request regarding interpretation of those reports. Consistent with Task 1d activities, provide information regarding systems adoption and process changes that enable physicians to improve performance.

The QIO shall promote statewide quality improvement (e.g., diabetes, mammography, and immunizations) by working with

public health, provider groups, and other broad-based agencies to support the use of appropriate preventive and disease-based care processes, including the “Welcome to Medicare Visit.”

The QIO shall report any activity to support PVRP and other statewide work in accordance with Section F – QIO Schedule of Deliverables.

ii. Work with Medicare Advantage Organizations

The QIO shall include Medicare Advantage organizations in its physician practice site efforts as well as support statewide/regional/local collaborative quality improvement activities by Medicare Advantage organizations by acting as a convener, facilitator, and/or collaborator for quality improvement projects in the topic areas listed above. The QIO shall assist Medicare Advantage organizations within the limits of Part C of Title XI of the Act.

The QIO shall work with Medicare Advantage organizations to encourage and support incentive programs that are coordinated with the QIO quality initiatives.

The QIO may provide data to and/or analyze data for Medicare Advantage organizations to support existing pay-for-performance programs or to help spread knowledge to and/or replicate a program with other Medicare Advantage organizations in the state/jurisdiction.

The QIO shall develop a plan for working with Medicare Advantage organizations in its state/jurisdiction (i.e., initial contact, follow-up regarding the QIO’s initiatives to include Medicare Advantage plans in its statewide and IPG efforts) and include how the QIO plans to support any pay-for-performance efforts and/or quality improvement work. The QIO shall perform the above work with the Medicare Advantage Organization(s) in the state/jurisdiction with Medicare Advantage plans, including a state/jurisdiction where the Medicare Advantage enrollment is below 20% during calendar year 2004. The QIO shall report quarterly any assistance given to Medicare Advantage organizations in accordance with Section F – QIO Schedule of Deliverables.

iii. End-Stage Renal Disease (ESRD) Networks

At the request of an ESRD Network, the QIO shall work collaboratively with the ESRD Network on mutually agreed upon activities to engage physician practice sites to improve rates of native fistula use and influenza and pneumococcal immunizations.

iv. Medicare Care Management Performance Demonstration

The QIO shall collaborate with the Medicare Care Management Performance Demonstration (Section 649 of MMA) contractors to provide physician practice information as requested and agreed to by the individual practices. This includes collection of a readiness assessment and signed consent form that meet the requirements outlined by CMS.

b) Identified Participants

The QIO shall undertake activities necessary to develop the capability to provide assistance to physician practice sites seeking to achieve transformational change in quality through the production and use of electronic clinical information, care process redesign, and performance measurement. The QIO shall stimulate physician practice sites to undertake quality improvement through its recruitment activities and through partnerships with stakeholders.

The QIO must work with a minimum of 5% of the practice sites in the state/jurisdiction. As applicable, this shall include practice sites serving Medicare-underserved populations as described under Task 1d2.

The QIO shall calculate the minimum number of practice sites that constitutes 5% of practice sites in the state/jurisdiction using information derived from the state licensure board, state medical associations, CMS Physician Registry, or other relevant sources of information. The use of a data source other than the CMS physician registry is subject to CMS approval based on the documentation provided to CMS by the QIO about the data source and the methodology used to arrive at the 5% count. For a QIO that uses the CMS registry data, acceptable criteria for elimination or addition of entries to the CMS registry are:

- Eliminate duplicate entries in the solo and group practice registry list (e.g., misspellings of practice names);
- Eliminate entries in the solo and group practice registry list that no longer provide care in the state/jurisdiction (e.g., for solo—died,

moved out of state/jurisdiction; for group—no longer in practice in the state/jurisdiction);

- Eliminate entries for solo and group practices that do not provide primary care services. (CMS will accept elimination of listings for practices with names that indicate dedicated specialty services (e.g., Sleep Center, Hospitalist);
- Eliminate entries for sites where a physician or group does not primarily provide care in accordance with the definition below of "a practice" when physicians care for patients in multiple sites or satellites;
- A QIO may not extrapolate validation results based on a sample to estimate their state/jurisdiction count of physician practices;
- Eliminate entries for multi-specialty physician practices where there are not at least 40% of the physicians designated as general practice, family practice, or internal medicine; and
- Addition of solo and group practices that were identified by the QIO, but are not included in the CMS registry.

Definition of a physician practice for the IPG:
For Tasks 1d1, 1d2, and 1d3, a physician practice is defined as a single physician or a group of physicians/clinicians working together, whose practice includes primary care at a specific practice site (office or clinic site). The definition of "a practice" where physicians care for patients in multiple sites or satellites will be limited to the site where those specific physicians' primarily (at least 50%) provide their care. Urgent care centers are not included in the IPG. Federally qualified heath centers (FQHCs) and rural health clinics (RHC) may be included if the FQHC or RHC submits a bill for laboratory services to the carrier.

Group Practice:
To be included in the 1d1 IPG, at least **40%** of the physicians in the practice must be primary care physicians (i.e., physicians who have a primary specialty designation of General Practice, Family Practice or Internal Medicine). (A Certificate of Additional Qualification in Geriatric Medicine would not change the status of a physician whose primary specialty designation is Family Practice or Internal Medicine.)

Solo Practice:
To be included in the 1d1 IPG, a solo practice must have a physician with a primary specialty designation of General Practice, Family Practice, or Internal Medicine. (A Certificate of Additional Qualification in Geriatric Medicine would not change the status of a physician whose primary specialty designation is Family Practice or Internal Medicine.)

Primary specialty designations are self-attested by the physician(s).

An identified participant will submit to the QIO a practice site readiness assessment form and a signed consent form that meet CMS requirements for these forms.

Identified participants may include physician practice sites at any stage of production/use of electronic clinical information.

Practices with ECI:
No more than 25% of the identified participant physician practice sites shall have pre-existing ECI defined as a practice that has begun installation of an electronic health record (EHR) system, unless extenuating circumstances are evaluated by CMS (see below). That is, at a minimum, 75% of the CMS-approved 5% count must be practices without ECI.

Practices without ECI:
Includes those practices that have not begun installation of an EHR system or practices that decide to completely remove an existing EHR system and are starting over in the selection and implementation of an EHR system, a practice that does not implement a new system and decides to stay with its original system would not be included in the practices without ECI.

The practices without ECI will be further divided into two groups;
- Those that have a contract for installation of an EHR or e-prescription and registry as of April 1, 2006; and
- Those that are pre-contract as of April 1, 2006.

Determination of whether a practice has pre-existing ECI or no ECI occurs at the time the QIO recruits the practice or August 1, 2005, whichever is later.

The QIO shall provide assistance in:
- Production and effective use of electronic clinical information necessary for improving clinical performance;
- Process redesign that incorporates care management and self-management by patients with chronic conditions and preventive services needs; and
- Quality measurement reporting to the QIO Data Warehouse on specified clinical quality measures.

The QIO shall provide this assistance using a methodology that includes:

- Assessment of practice site readiness/needs and consultation to promote electronic clinical information production and use;
- Practice site workflow redesign, project and system selection planning, and coordination of assistance to produce and use electronic clinical information;
- Care process redesign that promotes assessment, planning, coordination, patient self-management, and monitoring of services to meet an individual's health needs; and
- Quality measurement: reporting on the DOQ measures to the QIO Data Warehouse.

The QIO shall select identified participants to achieve a distribution of physician practice sites, as applicable based on the characteristics of the state/jurisdiction, to meet the following guidelines:

Physician Practice Site Size	Percentage of Identified Participants
Small (1–3 physicians)	at least 40%
Medium (4–8 physicians)	no more than 60%
Large (≥9 physicians)	no more than 20%

Physician assistants and nurse practitioners do not count in determining the practice site size. For multi-specialty clinic sites where greater than 40% of the physicians are primary care providers as specified above, all practitioners whether primary care or specialist are included for the purposes of practice size determination.

The QIO may allow for continuous recruitment of identified participants throughout the SOW; however, only practice sites that submit a baseline office systems survey (see below) and complete a re-measurement office systems survey in accordance with Section F – QIO Schedule of Deliverables will be counted in the evaluation denominator.

The QIO shall submit the following deliverables in accordance with Section F – QIO Schedule of Deliverables:

- A detailed recruitment plan that uses the information gained from the QIO's environmental scan regarding identified support of other stakeholders to successfully maximize the number of participating physician practice sites. This recruitment plan shall include the total number of physician practice sites that the QIO intends to work with (including those providing care to patients from Medicare-underserved populations);

- A detailed work plan that indicates how assistance will be offered to: (1) physician practice sites that do not produce and use electronic clinical information for improving clinical performance; (2) physician practice sites that already have EHR systems installed but lack care management capabilities; and (3) the nature of the projected improvements in electronic clinical information production and use and care management that are anticipated over the contract period;
- A list of identified participant physician practice sites that have been recruited to date to receive QIO assistance. QIO recruitment of physician practices is a continuous process;
- Only physician practices that submit both baseline and remeasurement Office Systems Surveys in accordance with Section F – QIO Schedule of Deliverables, will be included in the evaluation;
- A description of the QIO's strategy to assist physician practice sites that have already adopted and are using an EHR to submit data on the DOQ measures to the QIO Data Warehouse;
- If applicable, a justification as to why more than 25% of identified participants had preexisting electronic clinical information systems;
- An environmental scan; and
- Information showing QIO efficiencies in working with IPGs.

Incremental Funding:
Incremental Funding is available as specified in Section B.6. Special Funding Requirements. The practices that are approved for incremental funding must be separate and distinct from the Task 1d1 IPG. Practices eligible for this group must meet all of the inclusion criteria stated above (exceptions specified below), complete a readiness assessment and consent form, be primary care physicians (i.e., family practice, general practice, or internal medicine), and complete a baseline and remeasurement OSS. The baseline period for the OSS in the incremental funding group may differ from the baseline period for the IPG and may or may not be used for evaluation of the incremental funding group as specified in the evaluation plan for the incremental funding group as proposed by the QIO and approved by CMS. Exceptions to the inclusion criteria specified above are:

- The QIO is not required to include underserved practices in the Incremental Funding group;
- The QIO shall work only with practices that want to implement an EHR. Practices that wish to implement a registry and e-prescription are not eligible for the incremental funding group; and

- The QIO shall work only with practices that have no ECI unless a justification is submitted and approved for working with practices that have pre-existing ECI.

Exhibit 1d1: Physician Practice			
QIO Performance Criteria for Task 1d1: Physician Practice			
Dimension	**Performance Measure**	**Statewide Performance Criteria**	**Identified Participant Performance Criteria**
Clinical Performance Measure Results	Work with physician practice sites and others to improve care for Medicare beneficiaries on a statewide basis. Support quality initiatives including PVRP by making information available to physicians and stakeholders, providing technical assistance regarding PVRP participation and submission of information, supporting physicians in ECI adoption and improvement on performance measures. Promote statewide quality improvement by working with public health, provider groups, and other broad-based agencies to support the use of appropriate preventive and disease-based care processes, including the "Welcome to Medicare Visit"	Improvement as evaluated by Project Officer using guidelines to be developed	
	Assistance to Medicare Advantage Organizations	Assistance provided to Medicare Advantage plans, as evaluated by Project Officer as specified in SDPS memo 06-056-PO.	
	Assistance to ESRD Network(s), if requested	Assistance provided to ESRD Network(s) if requested, as evaluated by Project Officer	
	Medicare Care Management	Collaboration with the	

	Performance Demonstration	Medicare Care Management Performance Demonstration (Section 649 of MMA) contractors to provide physician practice information as requested and agreed to by the individual practices	
Clinical Performance Measurement and Reporting	Ability to export data to the QIO Data Warehouse on at least one of the DOQ clinical measures; coronary artery disease, hypertension, heart failure, diabetes care, and preventive care. For no ECI pre-contract IPGs implementation of a CCHIT certified system may provide partial credit in lieu of reporting. (See conditions/weighting below)		**No ECI Pre-contract group** 4% achieve requirement for reporting or implementation of a CCHIT certified system as specified below. **No ECI contract group** 12% of sites submit data using their EHR to the QIO Data Warehouse on at least one of the specified DOQ clinical measures for at least one patient **Practices with existing ECI:** 20% of sites submit data using their EHR to the QIO Data Warehouse on at least one of the specified DOQ clinical measures for at least one patient.
Care Management	Adoption of a care management process that assesses, plans, implements, coordinates, monitors, and evaluates treatment options and services to meet an individual's health needs, as assessed by office systems survey		**No ECI pre-contract group** 12% of sites. **No ECI contract group** 37% of sites and **ECI Group** 75% of sites adopt care management processes as assessed in OSS.
Systems Improvement (Use and	Implementation and Utilization of: e-prescribing and registry; or fully integrated EHR, as		**No ECI pre-contract group** 25% of sites and **No ECI contract group**

Produce ECI)	assessed by office systems survey		75% of sites meet the criteria for produce and use ECI, as assessed by the Office System Survey.

3) Evaluation

To pass Task 1d1, the QIO must achieve a total score of at least 0.65 after summing the scores earned for the three 1d1 components: Satisfaction and Knowledge/Perception (SS), Statewide (SW), and the Identified Participant Group (IPG).

1d1 score = SS + SW + IPG

Each component is assigned a weight for the purposes of score summation: SS = 0.1, SW = 0.1, and IPG = 0.8

For a QIO requesting and receiving incremental funding (IF), evaluation of those practices will be given a weight of 0.1 with a reduction in the IPG weight to 0.70 and the components will be summed as follows:

1d1 score = SS + SW + IPG + IF

a) Satisfaction and Knowledge/Perception

Satisfaction and Knowledge/Perception criteria as determined by the OSS outlined in Section C.6.B.1:

SS = score achieved on satisfaction and knowledge/perception survey * wt of 0.1
threshold of 0.8

b) Statewide

To receive the available points, the QIO must perform successfully as follows, as evaluated by its Project Officer using guidelines that CMS will develop:

SW = [Clin perf measure + MA + ESRD + MCMP (when applicable)] * wt of 0.1

i. Clinical Performance Measure

The Project Officer will evaluate performance based on the activity to support PVRP and other statewide initiatives that is

reported in accordance with Section F – QIO Schedule of Deliverables.

The QIO shall work with physician practice sites and others to improve care for Medicare beneficiaries on a statewide basis. The QIO shall support quality initiatives including PVRP by activities that include providing information to physicians on participation in the initiative and on physician performance and improvement for those that report.

The QIO shall promote statewide quality improvement by working with public health, provider groups, and other broad-based agencies to support the use of appropriate preventive and disease-based care processes, including the "Welcome to Medicare Visit."

ii. Medicare Advantage

The Project Officer will evaluate performance based on the assistance provided to Medicare Advantage organizations that is reported in accordance with Section F – QIO Schedule of Deliverables.

The Medicare Advantage part of Task 1d1 will be waived for states/jurisdictions that had <20% Medicare Advantage enrollment among the eligible Medicare beneficiaries during calendar year 2004.

For states/jurisdictions with Medicare Advantage enrollment of at least 20% during calendar year 2004, the following components will be included in the evaluation:

- Any assistance offered to Medicare Advantage organizations for any quality improvement projects related to the physician practice site clinical topics; and
- Support for pay-for-performance initiatives: Any work with Medicare Advantage organizations to encourage/support pay-for-performance programs that incorporate the QIO quality initiatives.

iii. End-Stage Renal Disease (ESRD) Networks

At the request of an ESRD Network, the QIO shall work collaboratively with the ESRD Network on mutually agreed upon activities to engage physician practice sites to improve rates of

native fistula use and influenza and pneumococcal immunizations.

iv. Medicare Care Management Performance Demonstration

The QIO shall collaborate with the Medicare Care Management Performance Demonstration (Section 649 of MMA) contractors to provide physician practice information as requested and agreed to by the individual practices.

c) Incrementally-funded Group of Practices (if applicable)

If CMS awards incremental funding to work with an additional group of practices, the QIO shall work with these practices to implement ECI (or care management if the practice has ECI and an appropriate justification has been approved by CMS) as outlined in its technical proposal and will be evaluated using the criteria deemed acceptable by CMS as outlined in the QIO's proposal.

IF = evaluation score for incrementally-funded group of practices * wt of 0.1

d) Identified Participants

The IPG may be constructed to include up to 25% of practice sites that have pre-existing EHR systems defined as a practice that has begun installation of an EHR or a combination of e-prescription and registry software (Practices with ECI group).

The remaining practice sites fall into a "No ECI" group. The no ECI group is further partitioned into a pre-contract group and contract group as of the practice site status on April 1, 2006, and assessed by the Office Systems Survey.

The following table contains the evaluation thresholds for each of the three groups in the IPG: ECI, No ECI pre-contract, and no ECI contract.

Identified Participant Group		Ability to Produce and Use Electronic Clinical Information (% of identified participants in group)	Implementation of Care Management Processes (% of identified participants in group)	Clinical Performance Measurement and Reporting (% of identified participants in group)*

No ECI pre-contract		25%	12%	4%
No ECI contract		75%	37%	12%
ECI		NA	75%	20%

* For practices in the No ECI pre-contract group, the QIO may also receive partial credit for implementation of a CCHIT certified EHR.

The QIO will be evaluated on the performance of all practices in its no ECI and ECI groups. The QIO may elect to work with more practice sites than the approved 5% number, but for the purposes of evaluation, no more than 10% of practice sites in the state/jurisdiction will be included in the IPG for the Office Systems Survey.

Descriptions of the three elements in the tables above for QIO work with identified participants follow.

Ability to Produce and Use Electronic Clinical Information:
In order to be counted in the numerator for "Use and Produce Electronic Clinical Information", a practice (whether implementing an EHR or e-prescribing and a registry) must meet all of the following capabilities as assessed by the office systems survey:

- generate a medication list;
- generate a problem list;
- enter laboratory tests and retrieve results (it is not required that the e-lab interfaces with a laboratory); and
- select medications, print prescriptions or transmit them (if allowed under state law), and conduct safety checks.

Implementation of Care Management Processes:
The office systems survey will be used to assess IPG physician practice sites to determine if they have implemented processes for disease management for targeted chronic conditions that incorporate:

- the ability to identify specific patients by disease;
- reminders and prompts; and
- patient-specific care plans.

To be included in the numerator for care management, a practice site must meet each of the three criteria above in at least 2 of the 5 following clinical topics:

- Hypertension;
- Diabetes;
- Preventive Services;
- Heart Failure; and

- Coronary Artery Disease.

An office systems survey approved by CMS will be completed by each identified participant physician practice site at baseline and remeasurement. This survey will serve as the data source for the assessment of Ability to Produce and Use ECI and Implementation of Care Management Processes.

Clinical Performance Measurement and Reporting:
The object of work on this element is to encourage physician practice sites to submit data on the DOQ clinical measures to the QIO Data Warehouse for all Medicare patients. To be counted in the numerator for evaluation purposes, practice sites must demonstrate some ability to submit data using their EHR to the QIO Data Warehouse on at least one of the DOQ measures for at least one patient in any of the following categories:

- coronary artery disease;
- hypertension;
- heart failure;
- diabetes care; and
- preventive care.

For no-ECI pre-contract practices, partial credit may be received if the practice does not submit to the warehouse but does implement a CCHIT certified EHR. Practices that submit to the warehouse on at least one patient in one of the specified measures provide a count of 1 to the numerator. Practices that do not submit to the warehouse, but implement a CCHIT certified EHR provide a count of 0.5 to the numerator. Practices that implement a CCHIT certified system and submit to the warehouse provide a count of 1 to the numerator (no additional credit is received for both).

To count as installing a CCHIT certified EHR, the contract for the system must have been signed *after* public notification on the CCHIT website (CCHIT.org) that the EHR was CCHIT certified.

Removal of IPG practice sites:
CMS will provide direction to QIOs for submission of a list of IPG practice sites that do not meet eligibility criteria for the purposes of removal from the denominator and numerator.

Calculation of Identified Participant Evaluation:
A score for the evaluation of identified participants (IPG) consists of the sum of scores for the following components:

- Percentage of CMS targeted number of identified participants with baseline and remeasurement that completed the Office System Survey (Recruitment)
- Ability to Produce and Use Electronic Clinical Information (Use ECI)
- Implementation of care management (Care Management)
- Clinical Performance Measurement Reporting (Reporting) or CCHIT certification

Definition of evaluation terms:

ECI	the count of practices in the IPG that complete the OSS and had electronic clinical information at baseline
NECI	the count of practices in the IPG that complete the OSS and had no electronic clinical information at baseline
NECIpc	the count of practices in the NECI group that were pre-contract at baseline
NECIc	the count of practices in the NECI group that had a contract at baseline
5PC	the 5% count of practices in the state approved by CMS
IPG_{OSS}	the number of practices in the IPG that complete the OSS at baseline and remeasurement
UPE_{pc}	the number of practices in the pre-contract subset of the no ECI group that meet criteria for “use and produce ECI”
UPE_{c}	the number of practices in the contract subset of the no ECI group that meet criteria for “use and produce ECI”
CM_{NECIpc}	the number of practices in the pre-contract subset of the no ECI group that meet the criteria for “care management”
CM_{NECIc}	the number of practices in the contract subset of the no ECI group that meet the criteria for “care management”
CM_{ECI}	the number of practices in the ECI group that meet the criteria for “care management”
RC_{NECIpc}	the number of practices in the pre-contract subset of the no ECI group that meet the criteria for “clinical performance measure reporting” or certified system
R_{NECIc}	the number of practices in the contract subset of the no ECI group that meet the criteria for “clinical performance measure reporting”
R_{ECI}	the number of practices in the ECI group that meet the criteria for “clinical performance measure reporting”
T_{NECIpc}	the threshold for use and produce ECI in the pre-contract subset of the no ECI group
T_{NECIc}	the threshold for use and produce ECI in the contract subset of the no ECI group
T_{NCMpc}	the threshold for care management in the pre-contract subset of the no ECI group
T_{NCMc}	the threshold for care management in the contract subset of the no ECI group
T_{CM}	the threshold for care management in the ECI group
T_{NRCpc}	the threshold for reporting/certification in the pre-contract subset of the no ECI group
T_{NRc}	the threshold for reporting in the contract subset of the no ECI group

T_R	the threshold for reporting in the ECI group

Recruitment:
Recruitment = (Number of IPG practice sites completing OSS at baseline and remeasurement / 5% count of practice sites) x weight (0.05)

Note: For purpose of this calculation, the IPG size is restricted to 10% of practice sites in the state/jurisdiction.

Use and Produce ECI:
Practices that have no ECI at baseline (whether pre-contract or contract) and meet the criteria outlined above are included in the numerator with the appropriate thresholds for pre-contract and contract multiplied by their respective proportions in the denominator.

$$\text{Use \& produce ECI} = \frac{UPEpc + UPEc}{(T_{NECIpc}*NECI_{pc}) + (T_{NECIc}*NECI_{c})} * \text{wt (0.4)}$$

Care Management:
For Care Management and Reporting, CMS will calculate a weighted target proportionate to the ratio of No-ECI and ECI practice sites to the total number of practice sites in the IPG.

$$\text{Care management} = \frac{CM_{NECIpc} + CM_{NECIc} + CM_{ECI}}{(T_{NCMpc}*NECI_{pc}) + (T_{NCMc}*NECI_{c}) + (T_{CM}*ECI)} * \text{wt (0.25)}$$

Reporting

$$\text{Report or certified system} = \frac{RC_{NECIpc} + R_{NECIc} + R_{ECI}}{(T_{NRCpc}*NECI_{pc}) + (T_{NRC}*NECI_{c}) + (T_R*ECI)} * \text{wt (0.1)}$$

RC_{NECIpc} = Number of NECIpc practices reporting + (0.5 * Number of NECIpc practices not reporting that implement CCHIT certified system)

IPG = Recruit + Use ECI + Care Management + Report

Completion of OSS less than 5% count of practices:

If the count of practices that complete the OSS at baseline and remeasurement is less than 5PC (the 5% count of practices), the following terms will be substituted for ECI, NECIpc, and NECIc in the equations above: CNECIpc for NECIpc, CNECIc for NECIc, and CECI for ECI. Calculations for these terms are:

$CNECIpc = (NECIpc/NECI) * 5PC_{NECI}$
$CNECIc = (NECIc/NECI) * 5PC_{NECI}$
$CECI = 5PC_{ECI}$

Where:

$$5PC_{NECI} = \frac{NECI}{(NECI + ECI)} * 5PC$$

and

$$5PC_{ECI} = \frac{ECI}{(NECI + ECI)} * 5PC$$

For those QIOs that are provided incremental funding to work with an additional group of practices, the IPG total weight is reduced to 0.70 with a distribution as follows:

Recruitment	wt = 0.05
Use and Produce ECI	wt = 0.35
Care management	wt = 0.20
Report or certified system	wt = 0.1

e) Calculation of Task 1d1 Score

Task 1d1 Score = SS + SW + IPG

For those QIOs that are provided incremental funding to work with an additional group of practices, CMS calculates the task 1d1 score as follows:

Task 1d1 Score = SS + SW + IPG + IF

The overall score is then evaluated as follows (1.0 points possible):

Excellent Pass	= $\geq$ 0.95
Full Pass	= 0.75 – 0.94 points
Conditional Pass	= 0.65 – 0.74 points
Not Pass	= $\leq$ 0.65 points

f) Secondary Evaluation–For a QIO with a score of <0.65 points (not pass) or a conditional pass (0.65–0.74 points) in Task 1d1 that contributes to the QIO being invited to the CMS evaluation panel using the above evaluation methodology, a second performance assessment will be conducted using the following evaluation methodology.

To pass Task 1d1, the QIO must:

1. Recruit 5% of practices in the state/jurisdiction (using the count approved by CMS);
2. Achieve at least an 80% score on the Satisfaction and Knowledge/Perception survey criteria as outlined in Section C.6.B.1.5.,
3. Pass the statewide requirements described below,
4. Achieve the conditional pass threshold (65%) for "Use and Produce ECI", and
5. Achieve the conditional pass threshold for "Clinical Performance Measurement and Reporting" in at least one of the two IPG groups—either the no ECI group (5% threshold) or the ECI group (10% threshold)

For a QIO that is provided incremental funding to work with an additional group of practices, the QIO must pass the evaluation for the incrementally funded group as proposed by the QIO and approved by CMS.

Identified Participants

The IPG may be constructed to include up to 25% of practice sites that have pre-existing EHR systems or a combination of e-prescription and registry software (Pre-Existing Electronic Clinical Information [ECI] group). The remaining practice sites fall into a "No ECI" group.

Ability to Produce and Use Electronic Clinical Information:

In order to be counted in the numerator for "Use and Produce Electronic Clinical Information", a practice (whether implementing an EHR or e-prescribing and a registry) must meet all of the following capabilities as assessed by the office systems survey:

- generate a medication list;
- generate a problem list;
- enter laboratory tests and retrieve results (it is not required that the e-lab interfaces with a laboratory); and
- select medications, print prescriptions or transmit them (if allowed under state law), and conduct safety checks.

Implementation of Care Management Processes:
The office systems survey will be used to assess IPG physician practice sites to determine if they have implemented processes for disease management for targeted chronic conditions that incorporate:

- the ability to identify specific patients by disease;
- reminders and prompts; and
- patient-specific care plans.

To be included in the numerator for care management, a practice site must meet each of the three criteria above in at least 2 of the 5 following clinical topics:

- Hypertension;
- Diabetes;
- Preventive Services;
- Heart Failure; and
- Coronary Artery Disease.

An office systems survey approved by CMS will be completed by each identified participant physician practice site at baseline and remeasurement. This survey will serve as the data source for the assessment of Ability to Produce and Use ECI and Implementation of Care Management Processes. A QIO in a state/jurisdiction where fewer than 5% of the practices in the state/jurisdiction (using the 5% counts approved fore each state/jurisdiction) complete both a baseline and remeasurement OSS will automatically fail the Task.

Clinical Performance Measurement and Reporting:
The object of work on this element is to encourage physician practice sites to submit data on the DOQ clinical measures to the QIO Data Warehouse for all Medicare patients. To be counted in the numerator for evaluation purposes, practice sites must demonstrate some ability to submit data using their EHR to the QIO Data Warehouse on at least one of the DOQ measures for at least one patient in any of the following categories:

- coronary artery disease;
- hypertension;
- heart failure;
- diabetes care; and
- preventive care.

The tables below describe the evaluation thresholds and points system used for the no-ECI and ECI groups. Elements marked with an asterisk (*) are core elements and must be passed (i.e., if the conditional pass

threshold is not achieved, the QIO will fail the subtask). Additionally, only one of the two reporting to QIO Clinical Data Warehouse elements may *not* be passed.

Determination of whether a practice falls into the no-ECI or ECI group is based on the practice's status as of August 1, 2005, or when the QIO began working with the practice, whichever is later.

In situations where the QIO has elected to work with up to 10% of practices in the state/jurisdiction, CMS will assess achievement of the thresholds below based on the entire number of practices that complete the OSS at baseline and remeasurement. A bonus of 0.025 points will be awarded for each percentage point above 6% with which the QIO works to a maximum of 10% or 0.1 points (i.e., for 6% to <7% 0.025 points, for 7% to <8% 0.05 points, etc.).

No ECI Identified Participants	Ability to Produce and Use Electronic Clinical Information* (% of no ECI identified participants)		Implementation of Care Management Processes (% of no ECI identified participants)		Clinical Performance Measurement and Reporting (% of no ECI identified participants)	
	Threshold	Points	Threshold	Points	Threshold	Points
Full Pass	≥75%	0.20	≥30%	0.20	≥10%	0.20
Conditional Pass	65% ≤ x <75%	0.10	20% ≤ x <30%	0.10	5% ≤ x <10%	0.10
Not Pass	<65%	0	<20%	0	<5%	0

Pre-Existing ECI Identified Participants	Implementation of Care Management Processes (% of pre-existing ECI identified participants)		Clinical Performance Measurement and Reporting (% of pre-existing ECI identified participants)	
	Threshold	Points	Threshold	Points
Full Pass	≥75%	0.20	≥20%	0.20
Conditional Pass	65% ≤ x <75%	0.10	10% ≤ x <20%	0.10
Not Pass	<65%	0	<10%	0

Calculation of Task 1d1 Score:

If the QIO meets the must pass requirements designated above, an overall score will be calculated as follows:
Task 1d1 Score = SS + SW + IPG
If the ECI group includes one or more practices

Excellent Pass	> 1.2
Full Pass	> 0.9 - 1.2 points
Conditional Pass	≥ 0.7 - 0.9 points
Not Pass	< 0.7 points

A maximum of 1.2 points is possible without extra credit, 1.3 points with extra credit)

If the ECI group is zero

Excellent Pass	> 1.0 points
Full Pass	> 0.7-1.0 points
Conditional Pass	≥ 0.5-0.7 points
Not Pass	< 0.5 points

A maximum of 1 point is possible without extra credit, 1.1 points with extra credit).

4) Changes in Quality of Care Measures

CMS reserves the right to discontinue, change, and/or add measures. In the event that CMS alters the measures, CMS will, after discussions with the QIO and other interested parties, amend the contract and evaluation strategy as necessary to hold the QIO harmless from negative effects of such indicator changes on performance results.

5) Support

A QIOSC will provide support to the QIO in performing the activities of this Task.

1d2. TASK 1d2. PHYSICIAN PRACTICE: UNDERSERVED POPULATIONS

1) Background

NOTE: If CMS determines that the circumstances for a given state/jurisdiction do not warrant the performance of the work under this task, the Contracting Officer may exclude performance of the task from the QIO(s) contract. Notification of the removal of the requirement to perform the task work will be made through a formal written notice to the

QIO issued by the Contracting Officer. A reduction in contract funding commensurate with the removal of the Task work will be executed through formal contract modification.

As part of QIO efforts in the physician practice setting, the QIO shall, at the statewide level, work to improve clinical performance measure results for the four clinical quality indicators in the areas of diabetes and mammography for underserved racial/ethnic populations.

With one Identified Participant Group (IPG), the QIO will work to promote systems improvement through DOQ activities with a representative underserved population under Task 1d1. With a Task 1d2–specific IPG, the QIO will work on practice site and practitioner system changes related to Culturally and Linguistically Appropriate Services (CLAS) standards and culturally competent care.

2) Task Description

The requirements in Task 1 of this SOW are designed to improve quality of care with respect to preventing clinical disorders and directing the treatment of clinical disorders. Any facts, opinions, or other types of information obtained initially or in follow-up requests from individuals or other entities within the care delivery system are in connection with these improvements in quality of care. In accordance with 5 CFR 1320.3(h)(5), these information collection activities are not subject to the Paperwork Reduction Act and, therefore, do not have to be submitted to the Office of Management and Budget (OMB) for clearance. Note that this does *not* exempt QIO information collection activities from the Quality Improvement Program's internal policies and procedures related to information collection, which are described in Sections 12600-12670 of the *QIO Manual*. This also means that, as described in the QIO Manual, a QIO's proposed information collection activities continue to require timely submission to the QIO's Project Officer/Division of Quality Improvement for review and approval.

CMS may direct the QIO to update its documentation of PARTner activity codes for its work in meeting the requirements of Task 1d2 in this SOW.

In addition to the general requirements for Task 1, the QIO shall conduct the following activities consistent with Exhibit 1d2: Physician Practice: Underserved Populations:

Statewide

a) At the statewide level, the QIO shall work to improve clinical performance measure results (as shown in the table below) for Medicare-underserved racial/ethnic populations–i.e., the African American, Asian/Pacific Islander, American Indian/Alaskan Native, and/or Hispanic/Latino populations. The QIO will demonstrate an absolute improvement of at least 4% for the summary underserved clinical performance measure results. The "Unknown" and "Other" populations, as identified in the Enrollment Database (EDB), are excluded from this assessment. All measurement for the statewide level will consist of Medicare fee-for-service (FFS) claims data for the four clinical topic quality indicators, with each indicator weighted equally. Results presented quarterly on the CMS QIOnet Dashboard will be considered as the official evaluation metric. Absolute improvement will be measured using the official baseline and latest remeasurement data available prior to approximately November 2007, as determined by CMS.

Task 1d2: Underserved Clinical Measures	
Topic	**Quality of Care Measure(s)**
Care for chronic disease: diabetes	Biennial retinal exam by an eye professional Annual HbA1c testing Biennial testing of lipid profile
Preventive services:	
Cancer screening	Biennial screening mammography

QIOs in states/jurisdictions in which more than 3% of Medicare beneficiaries fall into one or more of these racial/ethnic groups shall complete this requirement. CMS will provide the QIO with data prior to August 2005 to determine eligibility for this requirement. The Virgin Islands and Puerto Rico are excluded from this requirement.

Identified Participant Groups

b) For Task 1d2, the QIO shall create two IPGs that may overlap. These IPGs shall be composed of practice sites providing care to a proportionate number of beneficiaries (as specified by CMS) from Medicare-underserved racial/ethnic populations. One IPG shall consist of practice sites to work on Task 1d1 activities under the 1d1 Task requirements. The QIO shall work with the second separate group of identified participants, the CLAS/Cultural Competency IPG, on Task 1d2-specific activities. With this IPG, the QIO shall promote adoption

of CLAS standards at the practice level and completion of cultural competency requirements by individual practitioners.

At baseline, CMS will provide to the QIO a process that will assist the QIO to target primary care practice sites within its state/jurisdiction for each of these two IPGs. In selecting the identified participants, the QIO shall select practice sites and their practitioners that serve Medicare-underserved racial/ethnic populations represented within the state/jurisdiction. All selected primary care practice sites must provide care to FFS Medicare beneficiaries such that FFS line item Part A & B Medicare claims representing diabetes quality improvement measures (i.e., HbA1C, Eye Exams and Lipid Testing), care may be linked to the providers selected.

The QIO shall identify and register the members of the two IPGs in accordance with Section F – QIO Schedule of Deliverables. Identified participants from the Task 1d1 Underserved IPG must be registered according to the Task 1d1 timeframe for IPGs. Identified participants for the CLAS/Cultural Competency IPG must be registered no later than January 31, 2007. The QIO shall submit an interim list of practice site identified participants in accordance with Section F – QIO Schedule of Deliverables. CMS will monitor the QIO's recruitment progress and provide comparison reports to the QIO and its Project Officer. During interim time periods, the QIO may also choose to substitute any practice site that has not completed the Task 1d2 requirements, for which the QIO has reason to perform the substitution (e.g., change in type of practice, indications that the participant will not be able to complete the Task, etc.). Any substitutions are applicable only to Task 1d2 requirements and may not be accepted by CMS if they impact other Tasks that do not allow substitution (e.g., Task 1d1). All identified participants must meet all Task 1d2 requirements pertinent to this IPG.

Task 1d1 Underserved IPG

Practices are considered "underserved practices" and thus count towards the proportion of "underserved practices" in the Task 1d1 IPG (which must equal the proportion of Medicare beneficiaries in the state/jurisdiction) if they meet one of the following criteria:

- The proportion of underserved Medicare beneficiaries in the practice is ≥25%; or
- The proportion of underserved Medicare beneficiaries in the practice is greater than or equal to the proportion of underserved Medicare beneficiaries in the state/jurisdiction (for example, if the state/jurisdiction proportion of underserved Medicare beneficiaries

is 12%, a practice would be considered underserved if the proportion of underserved Medicare beneficiaries in the practice is ≥12%).

In those instances where the QIO's Task 1d1 IPG, calculated using the above definitions for "underserved practices," is not greater than or equal to the proportion of underserved Medicare beneficiaries in the state/jurisdiction, the QIO shall provide to its Project Officer and the Task 1d1 and 1d2 Government Task Leaders a justification that provides the following:

- the proportion of practices in the IPG that do not meet the above criteria;
- the proportion of underserved Medicare beneficiaries in the state/jurisdiction;
- the proportion of underserved Medicare beneficiaries in the IPG; and
- a description of the method (including any other data sources) used by the QIO to assure that the IPG maximizes the proportion of the underserved patient population in the state/jurisdiction.

For the Task 1d1 Underserved IPG (the 1d2 portion of the 1d1 IPG), the QIO shall select an IPG of practice sites equivalent in proportion to the overall 1d1 IPG as the representation of the underserved population in the state/jurisdiction (e.g., if the QIO works with 50 practice sites for its Task 1d1 IPG, and the state/jurisdiction has a 10% underserved population, at least 5 practice sites in the 1d1 IPG must provide patient care to the underserved population). The practices must include an underserved patient population that maximizes the proportion of the underserved patient population in the state/jurisdiction. The QIO's work with the IPG will be evaluated as part of the Task 1d1 evaluation.

CLAS/Cultural Competency IPG

The CLAS/Cultural Competency IPG shall be composed of 5% of the total primary care practice sites within the state/jurisdiction, with a minimum of 20 practice sites and a maximum of 50 practice sites that are required to complete the Task requirements. The QIO is encouraged to over-select practice sites, if feasible, sufficiently to account for lost-to-follow-up and those who will not likely fulfill the Task requirements in order to allow the QIO to successfully complete the Task. The QIO may have additional practice sites and/or practitioners complete the OMH modules, as resources will allow. No additional credit will be provided beyond the maximums provided for in the evaluation criteria outlined below.

The QIO shall use the online OMH cultural competency tool to conduct cultural competency improvement for the CLAS IPG at the practice site and practitioner level. Additional cultural competency materials may be provided by the QIO, so long as they do not conflict with the content of the OMH tool.

At the practice level with this IPG, the QIO shall promote the adoption of CLAS standards. The QIO shall accomplish this through having at least one practitioner or clinic administrator at the practice site complete Theme 3 (Modules 7–9) of the Office of Minority Health (OMH) "A Family Physician's Practical Guide to Culturally Competent Care." At least 80% of practice sites must achieve this requirement to receive full credit as weighted in the evaluation formula. The QIO may receive up to 0.10 points extra credit at a proportional rate for each practice site that has at least one practitioner who also completes Theme 1 (Culturally Competent Care).

At the practitioner level, the QIO shall select at least 10% of the practitioners from the CLAS IPG practice sites, with a minimum of 20 practitioners and a maximum of 100 practitioners, who will be required to complete Theme 2 (Language Access Services) of the OMH tool. At least 80% of the selected practitioners must complete Theme 2 to receive full credit as weighted in the evaluation formula. For the purposes of advancing cultural competency at practice sites, CMS encourages the QIO to promote completion of Theme 2 by at least one practitioner in each IPG practice site.

Theme completion for each theme is defined as receiving a score of at least 70% on the post-test for each module within the Theme.

In addition, the QIO shall work with the IPG practice sites to assess adoption of the CLAS standards through a practice-site self assessment. The QIO shall utilize a CMS-provided tool for practice pre-/post- CLAS assessment. The tool will be provided by the Underserved QIOSC prior to the start of the 8th SOW. Results of the pre-/post- CLAS assessment will not be utilized for QIO evaluation purposes, other than the requirement for results to be provided to CMS in accordance with Section F – QIO Schedule of Deliverables. Pre-CLAS assessments should be conducted prior to completion of any of the OMH modules. Post- CLAS assessments should not be conducted sooner than three months following the completion of at least Themes 2 and 3 of the OMH tool.

The QIO shall provide assistance to the practice sites in meeting or exceeding at least one of CLAS Standards 4-7 prior to completion of the Post- CLAS assessment. The QIO shall use tools provided by DHHS agencies, the Underserved QIOSC, MedQIC, or other appropriate materials to meet this requirement. QIO assistance to meet additional CLAS Standards is strongly encouraged.

c) The QIO shall make all reasonable efforts to include all Medicare-underserved populations represented within the state/jurisdiction in its project activities. The QIO shall provide a report, using a CMS-provided template, in accordance with Section F – QIO Schedule of Deliverables, that describes the activities involving underserved populations in the state/jurisdiction.

Exhibit 1d2: Physician Practice: Underserved Populations			
QIO Performance Criteria for Task 1d2: Physician Practice: Underserved Populations			
Dimension	**Performance Measure**	**Statewide Performance Criteria**	**Identified Participant Performance Criteria**
Clinical Performance Measure Results	Improvement on claims-based clinical measures: 1) Biennial retinal exam by an eye professional 2) Annual HbA1c testing 3) Biennial testing of lipid profile 4) Biennial screening mammography	≥4% absolute improvement in claims-based rates from baseline to remeasurement, based on summary measure for all applicable underserved populations for the four quality indicators for diabetes and mammography	
Clinical Performance Measurement and Reporting	Task 1d1 activities		Selection of an underserved practice IPG that is at least equal to the underserved population represented in the state/jurisdiction; IPG activities evaluated under Task 1d1
Systems Improvement	Promotion of CLAS standards		CLAS/Cultural Competency IPG: achieve 80% of practice sites in the IPG with at least one practitioner/clinic administrator completing the Theme 3 modules of the

			OMH tool
Process Improvement	Cultural competency education and measure improvement		CLAS/Cultural Competency IPG: achieve at least 80% of primary care practitioners in the 10% subset of primary care practitioners complete Theme 2 of the OMH tool
*The Underserved QIOSC will provide a CMS-approved educational program prior to August 2005 that will train the QIO on cultural competency interventions and assessment.			

3) Evaluation

The QIO will be held accountable for the following statewide, IPG, and Satisfaction and Knowledge/Perception evaluation criteria for Task 1d2.

a. Statewide (weight = 0.25 of total Task 1d2 score)

For statewide clinical topic improvement measures, each clinical topic will be weighted equally across all four clinical measures and proportional to the Medicare-underserved populations identified in the state/jurisdiction. All measurement will be Medicare FFS claims-based, with quarterly updates provided to the QIO.

The QIO will be evaluated on achieving an absolute improvement of 4% on the statewide summary clinical topic quality measure. The "Unknown" and "Other" identified populations in the EDB will be excluded. Proportional scoring will be used for the actual statewide absolute improvement achieved, up to 8% absolute improvement, which will receive a maximum of twice the weight for this component of the Task. Statewide absolute improvement beyond 8% will receive only the maximum weighting of 0.50 for this Task.

b. Identified Participant (weight = 0.65 of total Task 1d2 score)

i. Implementation of CLAS Standards (weight = 0.25 of total Task 1d2 score, with proportional scoring for those achieving above or below the expected threshold)

The QIO shall promote adoption of CLAS standards to the CLAS IPG practice sites by having at least one practitioner or site administrator complete Theme 3 of the OMH Tool. The QIO shall achieve at least 80% of practice sites in this IPG

completing this requirement, with proportional scoring, (up to 100%), of actual completed results.

The QIO may receive up to 0.10 of extra credit points based on the proportion of practice sites which have at least one practitioner complete Theme 1.

ii. Promotion of Provider Cultural Competency (weight = 0.40 of total Task 1d2 score, with proportional scoring for those achieving above or below the expected threshold)

The QIO shall select a subset of the primary care practitioners from the CLAS IPG practice sites to be educated on cultural competency using the OMH tool. Practitioners must complete Theme 2 of the OMH tool. The QIO shall achieve at least 80% of primary care practitioners in this IPG completing this requirement (i.e. 80% of the practitioners from the 10% pool completing Theme 2), with proportional scoring, (up to 100%), of actual completed results.

c. Satisfaction and Knowledge/Perception (weight = 0.10 of total Task 1d2 score)

The QIO shall achieve an 80% or greater score on the Satisfaction and Knowledge/Perception criteria outlined in Section C.6.B.1.5.

d. Calculation of Task 1d2 Score

An overall score for Task 1d2: Physician Practice: Underserved Populations will be calculated as follows:

Task 1d2 Score = (S * 0.25 + (IPG_{CLAS} * 0.25) + (IPG_{PCC} * 0.40) + (Satisfaction * 0.10) + Extra Credit

Where:

S = Task 1d2 statewide score = 0.25* % absolute improvement, with expected 4% improvement and maximum of 8% given credit.

IPG_{CLAS} = Task 1d2 identified participant completion of OMH Tool Theme 3 modules = 0.25% * % completion with expected 80% completion threshold. (maximum allowable=100%)

IPG_{PCC}= Task 1d2 identified participant score for Provider Cultural Competency = 0.40 * % completing Cultural Competency, with expected 80% completion threshold. (maximum allowable=100%)

Satisfaction = Satisfaction and Knowledge/Perception, with score based on achievement of at least 80% score for relevant respondents.

Extra credit = 0.1 * (# of practices with at least one practitioner that completes Theme 1/ # of practices in CLAS IPG)

Task 1d2 is composed of core and non-core tasks. The core tasks include satisfactory completion of the CLAS/Cultural Competency IPG at the practice site and practitioner level and the Satisfaction and Knowledge/Perception survey for the relevant respondents. The non-core task is statewide measure improvement. Satisfactory completion of the core tasks will achieve a Full Pass for Task 1d2.

Scoring:

Excellent Pass =	≥0.95
Full Pass =	0.75 – 0.94
Conditional Pass =	0.65 – 0.74
Not Pass =	<0.65

4) Deliverables

See Section F – QIO Schedule of Deliverables.

5) Changes in Quality of Care Measures

CMS reserves the right to discontinue, change, and/or add measures. In the event that CMS alters the measures, CMS will, after discussions with the QIO and other interested parties, amend the contract and evaluation strategy as necessary to hold the QIO harmless from negative effects of such indicator changes on performance results.

6) Support

The Underserved QIOSC will provide all support activities for this Task, including training for the Task (including indoctrination on the cultural competency tools), and serving as liaison for all issues related to the underserved populations covered under Task 1d1.

1d3. TASK 1d3. PHYSICIAN PRACTICE/PHARMACY: PART D BENEFIT

1) Background

As part of QIO efforts in the physician practice setting in this SOW, the QIO shall focus on improving safety in the delivery of prescription drugs. Widespread use of e-prescribing with comprehensive decision support tools is expected to improve the quality of prescription drug delivery. Until this broader use is in place, the QIO shall implement quality improvement projects focusing on improved prescribing, using evidence-based guidelines.

Over the course of this SOW, CMS will work with the QIO to develop and implement new methods to gather and disseminate better evidence for healthcare decision-making. This activity will include collection, linkage, and de-identification of Part D and other public and private administrative data; assisting in implementation of clinical registries and practical clinical trials; and other work necessary to support the development and use of better evidence for decisions.

A variety of methods are available to accomplish these activities. CMS supports engaging physicians because improving prescribing begins with modifying physicians' behavior. This can be accomplished by providing data and information in ways that support behavior change. CMS supports working with dispensing pharmacists because they detect errors and problems with the medications they dispense, and they interact with beneficiaries. Pharmacy policies, procedures, and quality checks need to be implemented to be consistent with quality, safety, and cost-effectiveness goals.

By partnering with prescription drug plans (PDPs) and using the drug data available, the QIO can affect prescribing by physicians and improve delivery of services at the pharmacy level. Medicare Advantage PDPs will have similar goals as fee-for-service (FFS) Medicare and will have both more information and more direct control than FFS Medicare over the care that Medicare beneficiaries receive.

With the enactment of MMA, CMS is committed to providing a robust drug benefit to seniors, implementing responsible cost management provisions, as well as monitoring and improving drug therapies using current evidence-based guidelines. As authorized by Section 109(b) of MMA, the

QIO shall offer quality improvement assistance pertaining to prescription drug therapy to the following:

- All Medicare providers and practitioners;
- Medicare Advantage organizations offering Medicare Advantage plans PDPs under Part C; and
- Organizations offering PDPs under Part D.

The Part D benefit will be implemented January 1, 2006. The QIO shall begin to implement quality improvement projects starting August 2006. Prior to August 2006, CMS will identify the set of quality measures for Task 1d3 derived from evidence-based guidelines and developed in collaboration with participating PDPs, physician societies, and other national leaders.

The QIO, prior to August 2006, shall determine, as appropriate, the baseline levels for its project quality measures, conduct information acquisition and outreach as described in the Task requirements, and respond to any requests for assistance. Also, the QIO shall plan for its interventions that will start in August 2006.

2) Task Description

The requirements in Task 1 of this SOW are designed to improve quality of care with respect to preventing clinical disorders and directing the treatment of clinical disorders. Any facts, opinions, or other types of information obtained initially or in follow-up requests from individuals or other entities within the care delivery system are in connection with these improvements in quality of care. In accordance with 5 CFR 1320.3(h)(5), these information collection activities are not subject to the Paperwork Reduction Act and, therefore, do not have to be submitted to the Office of Management and Budget (OMB) for clearance. Note that this does *not* exempt QIO information collection activities from the Quality Improvement Program's internal policies and procedures related to information collection, which are described in Sections 12600-12670 of the *QIO Manual*. This also means that, as described in the QIO Manual, a QIO's proposed information collection activities continue to require timely submission to the QIO's Project Officer/Division of Quality Improvement for review and approval.

CMS may direct the QIO to update its documentation of PARTner activity codes for its work in meeting the requirements of Task 1d3 in this SOW.

In addition to the general requirements for Task 1, the QIO shall meet the following requirements consistent with Exhibit 1d3: Physician Practice/Pharmacy: Part D Benefit:

a) General Requirements for Task 1d3

When a PDP or Medicare Advantage PDP and the QIO agree that a proposed quality improvement activity is supportive of the QIO's contractual goal of quality improvement and the PDP's goal of risk for prescription cost, the QIO shall provide resources of staff and data, including Part D data integrated with Part A and B data, when that enhances the PDP's activities.

For Task 1d3, identified participants are physician practice sites, PDPs, MA-PD plans, and/or pharmacies designated by the QIO to engage in quality improvement activities. The QIO shall work with identified participants on clinical performance measure improvement.

The QIO shall conduct the following activities:

- Report the required information on PDPs and physician practice sites/pharmacies with which it has worked and quality improvement projects that it has deployed;
- Develop and deploy an intervention strategy;
- Contribute to the QIO Program knowledge base through inter-QIO (including the QIOSC for this Task) sharing of information and conducting projects that contribute to Program learning; and
- Other appropriate activity to include PDPs and providers in quality improvement activities as determined by the Project Officer and Task 1d3 GTL.

If one or more PDPs, pharmacies, or physician practice sites in a QIO's state/jurisdiction serve Medicare beneficiaries in other states/jurisdictions, the QIO shall coordinate outreach and improvement work with the QIO(s) in the other state(s)/jurisdiction(s) in which such multi-state/jurisdiction entities operate.

b) Information Acquisition and Outreach

The QIO shall identify all PDPs that serve beneficiaries within its state/jurisdiction and offer to help them implement quality improvement programs under Part D of MMA.

The QIO shall meet with representatives of the PDPs and provide them with information about the role of the QIO in quality improvement in general, as well as the QIO's potential role in the areas of review and interventions for improvement in Part D. The QIO shall obtain information about the operation of the PDP, its collection and utilization of data, and its project plan for quality improvement. In addition, the QIO shall prepare a directory of contact persons for all PDPs operating within the state/jurisdiction. The QIO shall cooperate with other QIOs in dealing with PDPs that serve beneficiaries in more than one state/jurisdiction. This cooperation may include one QIO taking the lead for multiple QIOs in interactions with a multi-state plan.

The QIO shall also distribute appropriate materials to the media and target audiences in coordination with CMS and respond to beneficiary inquires.

The QIO shall submit the following deliverables in accordance with Section F – QIO Schedule of Deliverables:

i. Assessment of physician practice site/pharmacy environment in relation to e-prescribing and continuous quality improvement (CQI); and
ii. QIO staffing/training plan, including a timeline for physician practice site/pharmacy project readiness.

c) Quality Improvement Projects

- The QIO shall offer help to physician practices/PDPs in designing and implementing quality improvement projects.

The QIO shall submit a concept paper to perform a project in either Option 1 or 2 and either Option 3 or 4. CMS will review the two (2) concept papers, assess the degree to which the submitted concept papers from all QIOs constitute an appropriately diverse portfolio of projects, and direct the QIO to submit a project proposal for the approved project. The QIO shall then submit a project proposal according to specifications that CMS will supply.

These requirements depend upon measures that are still under development and will be further specified prior to August 1, 2006.

Before being finalized, the measures will be presented to external stakeholders for comment and refinement. The QIO, in collaboration with the physician practices and/or PDP(s), shall use the finalized measures in each quality project to determine the baseline level of performance of practitioners, providers, and PDPs working with the QIO to develop and implement interventions; to assess the interventions' effect on the measures; and to report on the PDPs and practitioners improvement results. Project development should occur as these measures are being developed, with guidance on the measures development process from CMS and a Part D QIOSC. In the absence of CMS-provided measures, the QIO shall obtain Project Officer approval to use data provided by plans and providers or other suitable measurements that reasonably approximate the CMS measure specifications. QIO interventions, to be implemented starting in August 2006, will be supported by a Part D QIOSC.

The QIO partner in all of these projects is a PDP or Medicare Advantage PDP. The target for the activities will be either those prescribing or pharmacies or both. Because PDPs and Medicare Advantage PDPs will bear risk for drug costs, these activities are voluntary and need to be constructed and presented in ways that bring added value and resources to support the PDP's cost management goals and CMS's quality protection goals. Partnerships with PDPs may involve sharing of data only for the purposes of appropriate targeting of QIO quality improvement activities.

CMS recognizes that PDPs in a QIO's area may conduct projects without the assistance of the QIO, and that these PDPs may be submitting progress reports on their work plans to other offices within CMS. In these situations, the QIO shall work more closely with physician practice sites on QIO-directed projects unique to physician practice sites and use of QIO data, as well as work more closely with physicians engaged in e-prescribing.

i. Option 1: Improve prescribing using Part D data

In this option, the QIO shall work with physician practice sites and PDPs to improve prescribing with a particular emphasis on assisting physician practice sites that use or are adopting e-prescribing. CMS may specify that a percentage of the participating physicians must be e-prescribing.

Quality of care measures for this option are currently under development. CMS anticipates that these measures will address the following domains:

- Use of avoidable drugs in the elderly

  National guidelines have been published (including the Beers criteria and others) that deal with avoidance of use of specific medications in the elderly. For beneficiaries 65 years of age and older, the following classes of medications or specific medications have been defined as drugs that should be avoided:

Barbiturates	Flurazepam	Propantheline
Belladonna alkaloids	Meperidine	Trimethobenzamide
Chlorpropamide	Meprobamate	
Dicyclomine	Pentazocine	

  Sample activity:

  - Using the Beers list, develop or collect educational materials for physicians;

  - Using the Beers' list and data from the PDP(s) or Medicare Advantage PDP(s), develop reports describing physician prescribing habits, identify outliers, and define interventions;

  - Remeasure performance after the intervention; and

  - Implement an intervention directly involving beneficiaries.

- Frequency of selected, clinically important drug interactions

  Some of the drug interactions flagged by current drug interaction systems may not be clinically relevant. The U.S. Pharmacopoeia Convention, Inc., is developing a stratification of drug interactions, expected to be available by August 2005, that will identify clinically important interactions. CMS will, through a contractor, use this and other information to develop a short list of clinically important drug interactions for which measures will be developed.

  Sample activity:

- Working with Part D data and the U.S. Pharmacopoeia Convention, Inc., list, identify physicians who prescribe the second drug in clinically important interactions;

- Develop and implement physician interventions; and

- Measure impact as reduction in prescribing interacting drugs.

- Generic prescribing ratios within certain therapeutic categories

  For some conditions, a variety of generic drugs are available. A generic drug product is one that is comparable to a brand name drug in dosage form, strength, route of administration, quality, performance characteristics, and intended use. One measure that some prescription plans use to determine the frequency of generic medication is use within a specific therapeutic class (e.g., anti-hypertension drugs, NSAIDS, antibiotics, antilipemics), calculated as the number of generic drugs dispensed to the patient within a given time period divided by the total number of drugs dispensed to the patient in that time period. CMS will make these measures available when they are developed and agreed to by national consensus.

  Sample activity:

  - Using data from the PDP(s) and/or Medicare Advantage PDP(s), develop reports on total costs of prescriptions per patient per physician;

  - Identify outliers;

  - Educate physicians regarding preferred drug lists, formularies, and the availability of generics;

  - Measure impact as the decrease in total prescription cost per patient; and

  - Implement an intervention directly involving beneficiaries.

- Use of selected medications within certain therapeutic categories

Within certain classes of medications (e.g., ACE-inhibitors), although multiple medications are available, one or two medications are preferred because they have undergone more intensive evidence-based study and publication or they are as effective as other products that are more costly. CMS, or the PDP with which the QIO is working, will prepare a list of the medications in each of the selected drug categories, specifying the "preferred" medications. The QIO shall measure the frequency with which "preferred" medications are prescribed relative to the number of new prescriptions for medications in a given drug category. Physicians who have prescribed a low percentage of these "preferred" medications within the category shall be targeted for an intervention in concert with any PDP efforts.

Sample activity:

- Using data from the PDP(s) and/or the Medicare Advantage PDP(s), develop reports by physician on use of preferred medications;

- Identify outliers;

- Educate physicians regarding preferred drug lists, formularies, and the availability of generics;

- Measure impact as increased use of preferred medications per physician; and

- Implement an intervention directly involving beneficiaries.

- Duplication of drugs in a therapeutic class

The frequency of use of multiple medications within therapeutic categories will be used to measure polypharmacy. A medication record for selected patients can be created from prescription data, which will include prescriber information. Patient profiles will be updated with information on new and discontinued prescriptions on a regular basis. Each new prescription will be checked against the patient's medication record to determine whether it is in the same therapeutic category as another medication the patient is currently taking, either regularly or on an "as needed" basis. Although there may be circumstances when

redundancy is appropriate (e.g., when the clinician is switching the patient from one medication to another), use of similar medications is more likely to be problematic when medications in the same class are prescribed by different clinicians.

ii. Option 2: Improving patient self-management through medication therapy management services (MTMS)

In this option, the QIO, partnering with the PDP(s), shall offer assistance on quality of care measures (currently under development) to all pharmacies or the delivery locus of the MTMS that serve beneficiaries in the state/jurisdiction, as well as multi-state PDPs, to improve MTMS. If QIO assistance is accepted, the QIO shall select and assist an IPG of pharmacies that is no smaller in number than 5% of the total pharmacies participating in the PDP(s).

Quality of care measures for this option are under development. CMS anticipates that these measures will address the following domains:

- Medication management services: process measures

  - Identification of appropriate patients;

  - Percent of appropriate patients utilizing MTMS;

  - Percent of appropriate patients for whom: (1) systematic reviews of medications are conducted, or (2) drug profiles held by patients are created;

  - Provider of the MTMS; and

  - Improvement in patients' understanding of medication therapy and its potential side effects.

- Medication management services: outcome measures

  - Patient experience—including patient satisfaction, knowledge acquisition, and self-management capability—as assessed by means of a Consumer Assessment of Health Plans Survey (CAHPS) that is anticipated to be available in 2006; and

- Comparisons between those who have and have not used MTMS on rates of utilization of emergency room visits or re-hospitalizations for the same condition for selected conditions (e.g., acute myocardial infarction, diabetes mellitus).

iii. Option 3: Improving disease-specific therapy using integrated Part A, B, and D data

In this option, the QIO, partnering with the PDP(s), shall work with physician practice sites to improve management of patients who have specific conditions or who are receiving specific medications, focusing on physician practice sites that are using EHRs or e-prescribing. The QIO shall select and provide assistance to IPG physician practice sites from Task 1d1 that are using EHRs and e-prescribing in addition to working with those that already use these technologies outside of the scope of Task 1d1.

Quality of care measures for this option are under development. CMS anticipates that these measures will address the following domains:

- Avoidance of specific drugs in beneficiaries with certain conditions (drug-disease interaction)

  Selected diseases/conditions and classes of medications identified for cautious use are:

Disease/Condition	**Medication Class(es)**
Benign prostatic hypertrophy	Tricyclic antidepressants
Chronic renal failure	Non-aspirin NSAIDs
Peptic ulcer disease	NSAIDs
Congestive heart failure	First-generation calcium channel blockers
Dementia	Anticholinergic agents
Heart block	Digoxin or tricyclic antidepressants

- Therapeutic monitoring for patients receiving specific drugs

  Patients who receive certain medications will be identified and data retrospectively reviewed to determine whether patients received the appropriate therapeutic monitoring.

Therapeutic monitoring can be identified from Part B claims for specific tests (identified by use of CPT codes). The following groups of beneficiaries for whom no Part B claims data would be available will be excluded: fee-for-service beneficiaries who are hospitalized during the observation period, residents in a Part A-covered Skilled Nursing Facilities, and beneficiaries not enrolled in Part B fee-for-service Medicare.

The selected medications and appropriate tests are:

Medication	**Monitoring**
ACE inhibitors	Serum potassium, serum creatinine, or blood urea nitrogen testing
Digoxin	Serum potassium, serum creatinine, or blood urea nitrogen testing
Diuretics	Serum potassium, serum creatinine, or blood urea nitrogen testing
Tricyclic antidepressants	Electrocardiogram
Warfarin	INR performed in timely fashion
Anticonvulsant therapy	Blood level of drug performed

iv. Option 4: QIO-directed project

The QIO may develop a proposal to address identified and potentially significant issues in drug therapy and submit them to its Project Officer and the Task 1d3 GTL for approval. The development and implementation of any project must be well documented. Additionally, CMS may direct the QIO to conduct specific drug therapy quality improvement projects.

CMS will provide a table that will describe the QIO's accountability to its various constituents (i.e., physicians, pharmacies, Medicare Advantage plans, and PDPs) for all projects.

Exhibit 1d3: Physician Practice/Pharmacy: Part D Benefit
QIO Performance Criteria for Task 1d3: Physician Practice/Pharmacy: Part D Benefit

Dimension	Performance Measure	Statewide Performance Criteria	Identified Participant Performance Criteria
Clinical Performance Measure Results	Implementation and improvement on approved projects		Implementation of one, approved quality improvement project from Options 1–4 Report via templates to the Part D QIOSC (or CMS if no Part D QIOSC exists) in accordance with Section F – QIO Schedule of Deliverables Improvement in outcomes on the set of quality measures from baseline to remeasurement

3) Evaluation

The QIO will be held accountable for work with identified participants on clinical performance measure results.

The Project Officer, in conjunction with the Task 1d3 GTL, will perform the evaluation based on the following criteria:

A QIO will merit an excellent pass if its quality improvement project achieves measurable improvement (improvement criteria to be defined in project plan) and more than 80% of respondents to the Part D component of the customer satisfaction survey report being at least satisfied (See Section C.6.B.1.5.).

A QIO will merit a full pass if it designs a project that is approved by CMS and is performed (per the project plan) to CMS's satisfaction

and more than 80% of respondents to the Part D component of the customer satisfaction survey report being at least satisfied (See Section C.6.B.1.5.).

A QIO will receive a conditional pass if a project has been approved and performed (per the project plan) to CMS's satisfaction.

A QIO will not pass if it achieves less than required to receive a conditional pass.

4) Deliverables

See Section F – QIO Schedule of Deliverables.

5) Changes in Quality of Care Measures

CMS reserves the right to discontinue, change, and/or add measures. In the event that CMS alters the measures, CMS will, after discussions with the QIO and other interested parties, amend the contract and evaluation strategy as necessary to hold the QIO harmless from negative effects of such indicator changes on performance results.

6) Support
CMS intends to create a Part D QIOSC to assist the QIO in performing the Task 1d3 requirements in this SOW.

TASK 2: (RESERVED)

TASK 3: PROTECTING BENEFICIARIES AND THE MEDICARE PROGRAM

Under Task 3: Protecting Beneficiaries and the Medicare Program, the QIO shall adhere to all the requirements described herein for Task 3a: Beneficiary Protection and Task 3b: Hospital Payment Monitoring Program.

3a. TASK 3a: BENEFICIARY PROTECTION

1) Background

This Task involves all case review activities, including mediation, that are necessary to conduct statutorily mandated review of beneficiary complaints about the quality of health care services. It also involves all

activities associated with other required case reviews, including EMTALA reviews, beneficiary appeals of discharge, and fiscal intermediary referrals. All case review activities shall be conducted in accordance with CMS instructions in Section J, Attachment J-4 Specific Manual Sections and any other administrative directives.

Additional required activities under this Task are physician acknowledgment monitoring; inter-rater reliability (IRR) assessment; beneficiary satisfaction assessment; procedures based on the result of a review or analysis of review data; development of an Annual Report; and maintenance of a Medicare Helpline.

2) Task Description

CMS may direct the QIO to update its documentation of PARTner activity codes for its work in meeting the requirements of Task 3a in this SOW.

The QIO shall meet the following specific requirements under Task 3a:

a) Beneficiary Complaints

The QIO shall conduct beneficiary complaint reviews in accordance with CMS instructions, including offering and conducting mediation for appropriate cases determined to have no significant quality of care concerns and/or other alternative dispute resolution options such as early intervention facilitated resolution as instructed by CMS. Beneficiary complaint review includes an assessment of beneficiary or beneficiary representative satisfaction with the complaint process and outcome. The QIO shall fully participate in the exchange of information with the CMS-designated entity to include timely and complete data entry, as necessary for the conduct of this assessment.

b) Beneficiary Appeals

The QIO shall:

i. conduct HINN and NODMAR reviews in accordance with CMS instructions;

ii. conduct fast-track appeals of Medicare Advantage notices of non-coverage in accordance with CMS instructions;

iii. conduct expedited appeals of fee-for-service notices of non-coverage in accordance with CMS instructions; and

iv. ensure the availability of appropriate personnel to conduct appeal reviews on non-business days to the extent such review is required by CMS. Appropriate personnel include those personnel necessary to ensure receipt and acceptance of appeals and conduct of required reviews as necessary to meet established timeframes.

c) Other Case Review Activity

The QIO shall:

i. conduct quality of care reviews in accordance with CMS instructions;

ii. conduct EMTALA (anti-dumping) 5- and 60-day reviews in accordance with CMS instructions;

iii. as appropriate, conduct reviews of cases referred from the CMS Central Office or Regional Offices as well as properly referred cases from Medicare Administrative Contractors [MACs (i.e., carriers and fiscal intermediaries)], Program Safeguard Contractors (PSCs), and other referral entities or sources, in accordance with CMS instructions;

iv. conduct higher-weighted Diagnosis-Related Group (DRG) reviews in accordance with CMS instructions;

v. conduct reviews for assistants at cataracts in accordance with CMS instructions;

vi. conduct outlier review in accordance with CMS instructions. Although there is currently no routine selection of cases for outlier review, such cases may be identified and selected by CMS as a matter of special interest;

vii. conduct re-reviews or reconsiderations of cases in which the QIO has rendered an initial decision or determination and for which the QIO has a responsibility, in accordance with CMS instructions, to conduct such re-review or reconsideration;

viii. institute quality improvement plans and other appropriate follow-up and remedial activities as a result of review in accordance with CMS instructions, including pre-sanction and sanction activities;

ix. analyze review findings for trends and patterns, as appropriate, and utilize the findings to generate or enhance quality improvement activities, with emphasis on current areas of CMS interest. The QIO shall clearly document its efforts;

x. make appropriate referrals of cases and issues not within the scope of QIO case review or as otherwise required, including the preparation case files for Administrative Law Judge (ALJ) or Qualified Independent Contractor (QIC) review, in accordance with CMS instructions;

xi. issue technical denials for non-receipt of medical records in accordance with CMS instructions;

xii. coordinate with fiscal intermediaries as necessary and as instructed by CMS;

xiii. conduct physician acknowledgement monitoring in accordance with CMS instructions;

xiv. establish or maintain Memoranda of Agreement (MOAs) or Joint Operating Agreement (JOAs) with MACs, providers, and other appropriate entities in accordance with CMS instructions;

xv. record information collected or generated in the conduct of case review activities in the Case Review Information System (CRIS) in accordance with CMS instructions;

xvi. conduct internal (within a QIO) IRR on a sample of cases in accordance with CMS instructions. IRR will apply to a sample of cases drawn from those types of cases specified by CMS and may include any or all types of Task 3a or 3b reviews. The sample is expected to include, at a minimum, those reviews conducted as a result of beneficiary complaints, hospital-requested higher-weighted DRGs, and the Hospital Payment Monitoring Program (HPMP);

xvii. participate, upon request, in a pilot project of external (between QIOs) IRR to be funded under Task 4: Special Projects; and

xviii. undertake quality improvement activities as a result of:

- Internal IRR results;

- External IRR results; and
- Other analyses of case review results identifying opportunities for improved performance, including analysis of Task 3b case reviews.

d) Annual Report

The QIO shall publish an Annual Report following the publication deadlines, content, and format requirements outlined in Sections 12400–12440 of the *QIO Manual* as well as any other administrative directives. All Annual Reports posted to a QIO website must follow the requirements in Section C.4.B.8.j.3: Use of Web Technology.

e) Medicare Helpline

The QIO shall maintain and staff a Medicare helpline to facilitate communications pursuant to all Tasks within this SOW. The QIO shall provide timely and appropriate response to all calls to this helpline. Staffers shall refer all requests for assistance not covered in this SOW to other appropriate entities (such as 1-800-MEDICARE, Social Security District Offices, state agencies, etc.). The QIO shall enter and track information regarding its performance using an instrument as directed by CMS.

Exhibit 3a: Beneficiary Protection	
QIO Performance Criteria for Task 3a: Beneficiary Protection	
Performance Measure (Points)	**Statewide Performance Criteria**
Timeliness for all Task 3a reviews (24 possible points)	Conditional Pass: Meet 80% timeliness requirement based on reports generated by the SDPS system. This is a cumulative measure based on those cases completed during the contract cycle prior to the point at which the evaluation is conducted. (18 points) Full Pass: Meet 90% timeliness requirement based on reports generated by the SDPS system. This is a cumulative measure based on those cases completed during the contract cycle prior to the point at which the evaluation is conducted. (18 points + 3 additional points = 21 points) Excellent Pass: Meet ≥ 95% timeliness requirement based on reports generated by the SDPS system. This is a cumulative measure based on those cases completed during the contract cycle prior to the point at which the evaluation is conducted.

	(21 points + 3 additional points = 24 points)
Beneficiary satisfaction with the complaint process (21 possible points)	Conditional Pass: Conduct surveys of beneficiaries or their representatives who have utilized the beneficiary complaint review process to measure beneficiary satisfaction with the complaint process. Among beneficiaries completing the satisfaction survey, the proportion of complainants with a specified level of satisfaction with the beneficiary complaint process must be ≥80%, based on reports generated by the SDPS system. (14 points) Full Pass: Conduct surveys of beneficiaries or their representatives who have utilized the beneficiary complaint review process to measure beneficiary satisfaction with the complaint process. Among beneficiaries completing the satisfaction survey, the proportion of complainants with a specified level of satisfaction with the beneficiary complaint process must be ≥90%, based on reports generated by the SDPS system. (14 points + 3 additional points = 17 points) Excellent Pass: Among beneficiaries completing the satisfaction survey, the proportion of complainants with a specified level of satisfaction with the beneficiary complaint process must be ≥95%, based on reports generated by the SDPS system. (17 points + 4 additional points = 21 points)
Beneficiary satisfaction with the complaint outcome (13 possible points)	Conditional Pass: Conduct surveys of beneficiaries or their representatives who have utilized the beneficiary complaint review process to measure beneficiary satisfaction with the complaint outcome. Among beneficiaries completing the satisfaction survey, the proportion of complainants with a specified level of satisfaction with the beneficiary complaint outcome must be ≥40% as measured through beneficiary surveys. (5 points) Full Pass: Conduct surveys of beneficiaries or their representatives who have utilized the beneficiary complaint review process to measure beneficiary satisfaction with the complaint outcome. Among beneficiaries completing the satisfaction survey, the proportion of complainants with a specified level of satisfaction with the beneficiary complaint outcome must be ≥50% as measured through beneficiary surveys. (5 points + 4 additional points = 9 points) Excellent Pass: Among beneficiaries completing the satisfaction survey, the proportion of complainants with a specified level of satisfaction with the beneficiary complaint outcome must be ≥70% as measured through beneficiary surveys. (9 points + 4 additional points = 13 points)

Quality improvement activities resulting from case review activities (21 possible points)	Conduct a quality improvement activity for a specified percentage of cases reviewed under Task 3. CMS will provide guidelines for cases appropriate for this quality improvement activity. CMS will set the required percentage of cases that result in a quality improvement activity by November 2006. The QIO will be evaluated on a measurement from approximately November 2006 to November 2007, based on SDPS reporting. Conditional Pass: 14 points. Full Pass: 14 points + 3 additional points = 17 points. Excellent Pass: 17 points + 4 additional points = 21 points.
Internal IRR assessment (21 possible points)	Conditional Pass: Achieve ≥70% agreement among physician reviewers and achieve ≥70% agreement among non-physician reviewers, as measured under the internal IRR assessment program with final evaluation to be based on a measurement period to be specified by CMS beginning no less than one year after the contract start date. (14 points) Full Pass: Achieve ≥80% agreement among physician reviewers and achieve ≥ 80% agreement among non-physician reviewers, as measured under the internal IRR assessment program with final evaluation to be based on a measurement period to be specified by CMS beginning no less than one year after the contract start date. (14 points + 3 additional points = 17 points) Excellent Pass: Achieve ≥90% agreement among both physician and non-physician reviews as measured under the internal IRR assessment program. (17 points + 4 additional points = 21 points)

3) Evaluation

For Task 3a, the QIO will be evaluated on a point basis, with a total of 100 points possible, as shown in Exhibit 3a. The QIO will receive a Conditional Pass in this Task if it attains 65 out of 100 points. The QIO will receive a Full Pass in this Task if it attains 75 out of 100 points. The QIO will receive an Excellent Pass if it attains 90 points or greater.

4) Deliverables

See Section F – QIO Schedule of Deliverables.

5) Support

A Medicare Beneficiary Protection QIOSC will be established to provide technical expertise and analytic support to CMS and the QIOs in the conduct of case review as well as to support training activities for QIOs.

3b. TASK 3b: HOSPITAL PAYMENT MONITORING PROGRAM

1) Background

In this SOW, CMS is directing the QIOs to continue the Hospital Payment Monitoring Program (HPMP). The purpose of HPMP is to measure, monitor, and reduce the incidence of improper fee-for-service inpatient payments, including errors in: DRG coding; provision of medically necessary services; and appropriateness of setting, billing, and prepayment denial.

The basis for HPMP is statutory and regulatory. Section 1154 of the Act statutorily mandates utilization review of professional activities subject to the requirements of Subsection (d) (i.e., those of short-term acute care fee-for-service hospitals, for which payment is made). In accordance with 42 CFR §412.508(a), QIO review shall include long-term acute care services. For fee-for-service inpatient hospital claims (paid and denied), HPMP fulfills the CMS requirement to comply with the Improper Payment Information Act of 2002 (Public Law No. 107-300).

2) Task Description

CMS may direct the QIO to update its documentation of PARTner activity codes for its work in meeting the requirements of Task 3b in this SOW.

The QIO shall meet the following specific requirements under Task 3b:

a) Follow the procedures specified in Chapters 4 and 7 of the *QIO Manual* to review, for all records referred, the services provided to Medicare beneficiaries under the Medicare program to determine whether such services:

i. are reasonable and medically necessary;

ii. are provided efficiently and in the most appropriate setting;

iii. are consistent with medical information supplied by the provider and demonstrate the coding validity of that information;

iv. are correctly billed; and

v. are properly denied.

Subsequently, the QIO shall make an initial determination that may result in approval or denial of payment and/or DRG changes.

The QIO shall review all cases:

- referred by the CDAC as part of a random sample to estimate national and state/jurisdiction payment error rates for short-term acute care inpatient fee-for-service reimbursements. The short-term inpatient acute care payment error rate shall be monitored and reported nationally and for each state/jurisdiction;

- referred by CMS as part of a random sample to estimate a national payment error rate for long-term acute care inpatient fee-for-service payments; and

- referred as part of a random sample to estimate national and fiscal intermediary–specific payment error rates for denied claims.

b) The QIO shall monitor hospital admission, coding, and billing patterns in its state/jurisdiction by conducting hospital profiling and trend monitoring for short-term acute care inpatient services. To supplement information that the QIO has available to it, CMS will supply the QIO with periodic hospital-specific monitoring reports for hospitals in the QIO's state/jurisdiction. The QIO shall analyze these reports and, coupled with information the QIO has developed through analysis of case review data and other appropriate sources, determine potential target areas of inappropriate utilization, coding errors, and billing errors.

c) The QIO shall submit a proposal for a project to work on one of the following:

- Address identified and potentially significant inappropriate utilization, aberrant coding patterns, and/or billing errors that affect payment for short-term acute care inpatient fee-for-service reimbursements; and/or

- Address identified and potentially significant inappropriate utilization, aberrant coding patterns, and/or billing errors that affect

payment for long-term acute care inpatient fee-for-service reimbursements.

If the QIO determines that a project to reduce such payment errors (inappropriate utilization, aberrant coding, and/or billing errors) is unnecessary for its state/jurisdiction, the QIO may submit a written justification to CMS for exclusion from submitting a project proposal.

All project proposals or justifications for exclusion must be approved by the Task 3b GTL and the QIO's Project Officer.

All project proposals or justifications for exclusion shall be submitted in accordance with Section F – QIO Schedule of Deliverables.

A project proposal, or justification for exclusion, shall be well documented and supported by data from the QIO's monitoring of hospital admission, coding, and billing patterns. A project proposal must also be substantiated by estimates of potential cost savings.

The QIO may submit more than one project proposal and, with CMS approval, may work on more than one project. If a QIO works on multiple projects, the first approved project proposal shall be the basis of the QIO's evaluation. Additionally, CMS may direct the QIO to conduct specific error prevention projects aimed at reducing payment errors for short-term or long-term acute care inpatient services.

All projects approved or directed by CMS shall be funded as Special Projects under Task 4: Special Projects.

All approved project proposals, approved justifications for not doing a project, quarterly progress reports, and final project reports shall be submitted by the QIO to its Project Officer electronically in a designated database as directed by CMS.

Exhibit 3b. Hospital Payment Monitoring Program		
QIO Performance Criteria for Task 3b: Hospital Payment Monitoring Program		
Performance Measure	**Statewide Performance Criteria**	**Project-Specific Performance Criteria**
Payment error rates	Absolute and net payment error rates no greater than 1.5 standard errors greater than baseline absolute and net payment error rates	Approval of a project proposal or justification for exclusion from conducting a project. CMS-approved project: 1) completion of the project within

		specified timeframes; 2) actual or estimated reduction in payment errors; 3) payment error reduction knowledge; and 4) publication of results.
Timeliness of reviews	≥90% of reviews completed within prescribed timelines	
Implementation of and reporting on monitoring activities	Submission of monitoring activities report	

3) Evaluation

For Task 3b, the QIO will be evaluated on a point basis. A total of 8 "regular" points will be possible. There will be 1 possible "extra credit" point and 3 possible "minus" points. With the extra credit point, a total score of 9 is possible. The QIO's evaluation score will be based on the net total of points, including regular, minus, or extra credit points, earned according to the following scale:

Excellent Pass = ≥ 7 points
Full Pass = 6 points
Conditional Pass = 5 points
Not Pass = ≤ 4 points

Note: Inter-rater reliability (IRR) for those reviews conducted as a result of HPMP cases will be evaluated within Task 3a: Beneficiary Protection.

a) Absolute and net payment error rates [2 points: Absolute (1) + Net (1)]

The QIO will be judged successful if, at remeasurement, the absolute (gross total of under- and overpayments) and net (difference between over- and underpayments) payment error rates are no greater than 1.5 standard errors above the respective absolute and net baseline payment error rate. The baseline payment error rates shall be the respective rates from approximately November 2004. A re-measurement net payment error rate that is no more than 1.5 standard errors greater than the baseline net payment error rate will be worth 1 point. A remeasurement absolute payment error rate that is no more than 1.5 standard errors greater than the baseline absolute payment error rate will be worth 1 point.

b) Timeliness of review (2 points)

To be successful with respect to timeliness of review, the QIO shall complete ≥90% of reviews for all referred cases as part of HPMP (both paid and denied claims) within the prescribed timeframes based on reports generated by the SDPS system. Meeting timeliness of review for referred HPMP cases will be worth 2 points.

c) Monitoring activities (1 point)

Monitoring activities shall be summarized for payment error rates and hospital admission, coding, and billing patterns for short-term acute care inpatient fee-for-service reimbursements in the QIO's state/jurisdiction including hospital profiling and trend monitoring. The QIO shall submit its summary electronically to the Project Officer via a designated database as directed by CMS (1 point).

d) Project proposal and implementation (3 points + 1 extra credit point possible)

To be eligible to receive "regular" and "extra credit" points, the QIO must:

- Obtain CMS approval for a project or for justification to not conduct a project in a timely manner as defined by CMS. Failure to obtain CMS approval in a timely manner as defined by CMS will result in a reduction of 2 points (-2). Anything short of full CMS approval, including but not limited to a project that is not approved, a project that is approved pending further information that is not submitted, and/or a proposal that is returned unapproved for further information that is not submitted, does not fulfill the requirement to obtain CMS approval.

If the QIO receives CMS approval for a project, the QIO must:

- Complete the project within the timeframes specified in the QIO's CMS-approved project proposal.
- Publish a description of the project, including background, methods, results, and discussion of the results. Publication in the QIO's newsletter or another professional newsletter will meet this requirement. Acceptance for publication or publication in a peer-reviewed journal will be worth 1 "extra credit" point (+1). Failure to publish in any forum will result in a reduction of 1 point (-1).

If a QIO works on multiple projects, the first approved project proposal shall be the basis of the QIO's evaluation.

Scoring for Project Proposal and Implementation:

Submission and approval of a written justification for exclusion from submitting a project proposal OR Completion of a CMS-approved project	1 point
Completion of a CMS-approved project demonstrating increased substantive knowledge related to reducing the dollars or percent of dollars paid in error (but not demonstrating estimated or actual reductions in dollars or percent dollars paid in error for the area targeted by that project)	1 point
Completion of a CMS-approved project demonstrating estimated or actual reductions in dollars or percent dollars paid in error for the area targeted by that project (whether or not demonstrating increased substantive knowledge related to reducing the dollars or percent of dollars paid in error)	2 points
For Example: 1 + 0 = 1 1 + 1 = 2 1 + 2 = 3	3 points possible

Whether demonstrations of reductions in dollars or percent dollars paid in error and whether substantive knowledge are gained in the project will be determined by the Task 3b GTL and the QIO's Project Officer.

4) Deliverables

See Section F – QIO Schedule of Deliverables.

5) Support

In support of the task requirements described in Task 3b, the Hospital Payment Monitoring Program (HPMP) QIOSC will:

- maintain the payment error surveillance and tracking system;
- provide analysis of QIO project data;
- develop and maintain the system for processing the CMS Medicare Part A inpatient administrative records;

- develop and maintain the payment error surveillance and tracking system for denied inpatient claims;
- provide ad hoc data analysis as requested by CMS;
- develop a compendium of payment error reduction tools produced and provided by QIOs;
- provide periodic updates to QIOs via an electronic newsletter;
- continue to assist the SDPS contractor in maintaining an HPMP area of the QIOnet website, including but not limited to providing surveillance data and tools;
- provide content training on the data collection tool for HPMP projects, as requested; and
- attend and provide administrative support for regularly scheduled weekly HPMP issues teleconferences.

4. TASK 4: SPECIAL PROJECTS

1) Background

CMS reserves the right to direct the QIO to initiate a Special Project (SP) not currently defined under this SOW or to approve an application from the QIO to conduct a Special Project.

2) Task Description

A Special Project is defined as work that CMS directs a QIO to perform or work that a QIO elects to perform with CMS approval that is not defined under Tasks 1–3 of this SOW. The Special Project work shall fall within the scope of the contract and of Section 1154 of the Act. The Special Project shall be conducted in accordance with B.4. Task 4 Special Projects, G.18. Procedures for Special Projects; and H.12. CMS-Directed Subcontracts/Special Project Lead QIOs. The term “Special Project” is a more accurate term for the type of activities and requirements characteristically implemented under Task 4. Other terms, previously commonly used, for activities under this Task include “special study”, “special study project”, and “special work.” Any request to perform a

Special Project shall be submitted using the template in Section J, Attachment J-15 Special Project.

3) Evaluation

All Special Projects awarded/approved under Task 4 will be evaluated individually. The QIO's success or failure on a Special Project will not be factored into the evaluation of the QIO's work under Tasks 1–3 in this SOW, except for projects funded to meet the requirements of Task 3b: Hospital Payment Monitoring Program. With the exception of projects funded to meet the requirements of Task 3b, the assessment of performance on special projects under Task 4 will be used as past performance information for future special project award considerations. The assessment of performance on special projects under Task 4 will not affect the renewal/non-renewal of the QIO contract. Although individual projects may include additional project-specific assessment criteria and performance measures, every project awarded/approved under Task 4 is subject to evaluation on at least the following dimensions of performance, which apply to any and all projects awarded/approved under Task 4:

- Completion of specific tasks (deliverables) required in the special project
- Financials
- Appropriateness of QIO staffing for this special project including number of staff as well as skill sets of staff
- Performance in meeting the needs of QIOs, other QIOSCs, GTLs, etc., and the quality of activities to improve performance
- Participation in other improvement activities
- Efforts to address issues/barriers identified

Performance assessment for each project will be conducted jointly by the QIO's regularly assigned CMS Project Officer and the specific Special Project GTL (SPGTL).

4) Special Project Progress and Performance Monitoring

The QIO's Project Officer and each project's SPGTL will conduct periodic monitoring of the contractor's progress towards completion of the special project. The frequency and nature of this monitoring is to be determined by the Project Officer and SPGTL, but is anticipated to occur on a quarterly basis by teleconference or videoconference. The contractor will participate in these monitoring activities, including the provision of a brief summary of activities, internal quality improvement efforts, barriers and

efforts to address those barriers, and other pertinent information as directed by the Project Officer or SPGTL if so delegated.

C.7. TRANSITION FROM INCUMBENT QIO TO SUCCESSOR QIO

A. General Guidelines

During performance of this contract should termination or non-renewal of an existing QIO's contract occur, CMS may require the successor QIO to provide transition services beginning at the earliest mutually agreeable date. During this period, the incumbent QIO shall work with the new QIO, CMS staff, as well as other identified CMS contractors to ensure continued operation of the QIO Program.

Prior to commencement of transition, CMS will request a transition plan from the incumbent QIO. The Transition Plan shall provide adequate coverage to ensure uninterrupted service to the QIO Program, be effectively and efficiently administered, and be completed within a reasonable timeframe.

The successor QIO shall cooperate fully with the incumbent QIO, as directed by the Project Officer, to ensure that all services continue without interruption.

B. Contract Phase-Out Services

At the end of this contract, if a determination is made to terminate or not renew the incumbent QIO's contract, the QIO shall provide similar transition/phase-in/ phase-out support to the successor QIO selected by CMS (refer to Federal Acquisition Regulation 52.237-3 Continuity of Services).

C. Transition Plan

At a minimum, the Transition Plan shall provide detailed methods that will be used to ensure a smooth transition from the incumbent QIO's operation to sole operation by the successor QIO. At a minimum, the Transition Plan shall provide for the following:

- A plan to complete or transition to the new contractor all case reviews within 30 calendar days;
- A plan to transition (without any lag time), receipt and processing of all expedited and fast-track appeals;
- A milestone chart detailing the timelines and stages of transition from the effective date of contract performance until the QIO assumes sole responsibility for the QIO Program work;
- An organizational chart that displays internal and external organizational relationships. The organizational chart shall identify the individuals (at all levels) who will be responsible for the transition and their respective roles; detail the lines of

communication and how the QIO will interface with CMS during this phase of contract performance; and
- Plans to communicate and cooperate with the current incumbent QIO.

Transition services will include transfer of Government-Furnished Property (GFP) (e.g., hardware, software, records/data) from the incumbent QIO to the successor QIO, or to CMS or another CMS contractor. CMS may elect to require the transition of GFP as follows:
- Prior to procurement of an asset, the QIO shall propose a transition charge to be evaluated and negotiated by CMS;
- A successor QIO to this contract, or CMS, will be afforded the opportunity to acquire QIO assets at a reasonable transition charge;
- All existing assets shall remain installed and usable by CMS through the transition of assets for their replacement by the successor QIO;
- In the event a decision is made not to procure the assets, the QIO has the responsibility to dispose of the assets as instructed by CMS.

D. Transition of Quality Improvement Activity Materials

At a minimum, the incumbent QIO shall include all materials necessary for the successful transition of the quality improvement activities to the successor QIO. These materials shall include the following items so that the successor QIO can build upon the work of the incumbent QIO with regard to its SOW quality improvement activities:
- Materials associated with SOW communications activities and information collection activities;
- Materials and relevant information regarding coordination with stakeholders and other activities focused on provider satisfaction and provider/stakeholder knowledge/perception of the QIO Program;
- Materials and relevant information regarding identified participant and statewide efforts, including recruitment, measures, and background information and materials for the Task 1 subtasks; and
- Other materials and information that the incumbent QIO determines necessary for the successful transition of its quality improvement activities to the successor QIO.

E. Transition of Information Systems Activities

The incumbent QIO shall:
- Contact SDPS Help Desk and provide locations;
- Point of Contact's (POC's) of QIO to initiate process;
- Coordinate actions with CMS Management Team (QIG, RO, ISG, etc.);
- Coordinate actions with QIO Primary POC;
- Coordinate with the SDPS contractor to determine what application access rights need to be changed for any systems access and perform a master backup of the QIO applications data;

- Coordinate and work with CMS Network GTL in ISG to shutdown the T1/Network lines;
- Coordinate with CMS, SDPS contractor, and BCSSI to ensure that all the workstations/file servers are functioning properly and have been properly repaired in accordance with the warranty/service agreement per the terms of the lease;
- Coordinate Secondary Domain shut down procedures with QIO/SDPS contractor/BCSSI/CMS prior to performing any “Wipe Clean” applications on the Dell File Servers and Dell System Administration desktop work stations;
- Coordinate “Wipe Clean” shut down procedures with CMS on the Dell desktop work stations prior to site visit to perform the shutdown;
- Coordinate w/ SDPS contractor to obtain all necessary packing materials from Austin Foam to ship to QIO to be utilized by contractor staff to box up the systems for shipment (transfer to successor QIO or return to Dell);
- Coordinate File Server backup procedures with CMS on the Dell File Servers prior to site visit to perform the shutdown and move;
- Coordinate any Data Server backup procedures with SDPS contractor on the RS-6000 Database Servers prior to site visit to perform the shutdown and move;
- Coordinate with SDPS contractor to determine if transfer or return of the systems is being executed prior to site visit to perform the shutdown and move;
- Coordinate with SDPS contractor /QIO/CMS Property Disposal Office to obtain up to date inventory prior to site visit;
- Coordinate with SDPS contractor to obtain moving contractors/supplies prior to site visit to perform the packing & shipment of IT assets. Paid for by incumbent QIO;
- Coordinate Site Visit with Project Officer: perform inventory and reconcile any discrepancies;
- Coordinate Secondary Domain shut down to close out Novell GroupWise email accounts on the Dell File Servers with BCSSI/CMS;
- Coordinate with SDPS contractor /CMS all backups and prepare for delivery to successor QIO;
- Perform “Wipe Clean” on Dell File Server and System Administrator desktop work station;
- Coordinate with shipping contractor to prepare, box, and ship all inventory to new location; and
- Complete the DHHS Property Action Forms and return to CMS Property Disposal Office.

SECTION D - PACKAGING AND MARKING

All deliverables shall be marked clearly using the contract number and shall follow any directions provided in Section F.2, Deliverable Schedule.

SECTION E - INSPECTION AND ACCEPTANCE

E.1. FAR 52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this address:

www.arnet.gov/far/fac.html

52.246-5 Inspection of Services - Cost Reimbursement (APR 1984)

E.2. PERFORMANCE IMPROVEMENT PLAN (PIP)

In the event a QIO fails to meet its contract requirements for acceptability, a PIP may be required in accordance with QIO Manual Section 15400-15420.

SECTION F - SCHEDULE OF DELIVERABLES

F.1. PERIOD OF PERFORMANCE

The period of performance for the Quality Improvement Organization (QIO) contracts for Group 1 is August 1, 2005 – July 31, 2008.

All work and deliverables required under this contract shall be completed by the ending date of the period of performance.

For Section F – QIO Schedule of Deliverables, unless otherwise specified all deliverable due dates required monthly, quarterly, or annually are defined as due 10 days after the given time period based on the start date of the period of performance.

For example: If the contract period of performance begins on August 1, then a deliverable due date of "quarterly" would be due on the 10th day following the end of each quarter (i.e., November 10 for the period of August 1 – October 31; February 10 for the period of November 1 – January 31; etc.).

F.2. ITEMS TO BE FURNISHED AND DELIVERY SCHEDULE

The QIO shall furnish the reports and deliverables required under this contract in accordance with the Delivery Schedule and Reporting Instructions as set forth below:

Deliveries or Performance Reports/Items to be Furnished and Delivery Schedule

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
C.4. REQUIREMENTS					
C.4.B.1. Infrastructure Operations Support and Data Management					
1.	Provide list of assigned disaster recover individuals with specified responsibilities and actions [Point of Contact (POC) list] (C.4.B.1.)	QIO Project Officer (PO) Standard Data Processing System (SDPS) Government Task Leader (GTL)	November 30, 2005, or 10 days after PARTner release whichever is later Update when staff changes	PARTner	
2.	Provide a written	QIO PO	November 30,	PARTner	Template

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	Contingency Plan that details the roles, responsibilities, and process for recovering data and that documents procedures for making and safeguarding backup copies of software, operating data, and user data (C.4.B.1.)	SDPS GTL	2005 11:59 PM Eastern Annually thereafter on November 30		will be provided by CMS
3.	Record daily iterative and weekly full tape backup (Tape Backup Rotation Schedule and Logs) (C.4.B.1.)	QIO PO SDPS GTL	Monthly, upon PARTner release	PARTner	
4.	Record offsite storage of backups and rotation (Offsite Storage Logs) (C.4.B.1.)	QIO PO SDPS GTL	Monthly, upon PARTner release	PARTner	
5.	Provide list of assigned QIO Information Technology (IT) Representatives with contact information (i.e., name; position; phone numbers; email addresses) (C.4.B.1.)	QIO PO SDPS GTL	November 30, 2005, or 10 days after PARTner release whichever is later Annually thereafter on November 30 Update when staff changes	PARTner	
6.	Complete Remedy ticket assignments within the designated	QIO PO SDPS GTL	As assigned to QIO IT Representative through Remedy	Remedy AR System	Perform task and close ticket in Remedy

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	timeframe (C.4.B.1.)		Action Request (AR) System		AR System If required, include any documentation with ticket to validate completion
7.	Maintain systems and software to be in compliance with current standard configuration (C.4.B.1.)	QIO PO SDPS GTL	As Released	Memorandums or Remedy AR System	Perform task as assigned through Memorandums or Remedy AR System and maintain as required
8.	QNet System Security Policies Handbook (SSPH) Training (C.4.B.1.)	QIO Security POC	Before QIO employee receives a User Account to access a QNet system/application Annually thereafter	Maintain a log locally onsite	Train QIO employees on QNet Security Policies and maintain a log locally onsite with Security POC of QIO employee signatures confirming receipt of the QNet SSPH Training
9.	QNet Security POC Site Compliance Letter	CMS QualityNet Information	November 30, 2005 11:59 PM	Mail hard copy of Signed	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	(C.4.B.1.)	System Security Officer	Eastern Annually thereafter on November 30	Compliance Form Letter to CMS QualityNet Information System Security Officer	
10.	Sign in log for visitors (C.4.B.1.)	QIO Security POC	As required when visited by external personnel	Maintain Visitors Log (current and historical) locally onsite	
11.	List of current Active users accounts with access roles and privileges identified and a log of deactivated users (C.4.B.1.)	QIO Security POC	As required when establishing or changing user access and when user leaves the organization	User account and permission logs maintained locally onsite	
12.	Records of incident response (C.4.B.1.)	CMS QualityNet Information System Security Officer	As required when a security incident occurs	Incident report maintained locally onsite and a hard copy (and/or electronic copy depending on the sensitivity of the incident) of incident reports sent to CMS QualityNet Information System Security	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
				Officer via the Remedy Tracking System as outlined in QualityNet Incident Response Policy Version 1.1 (http://qionet.sdps.org/training_resources/IncidentResponse.pdf)	
13.	Update Remedy inventory for all procured and received IT equipment (hardware and software) (C.4.B.1.)	QIO PO SDPS GTL	As required when hardware or software equipment received	Update record in Remedy Inventory Module	
14.	List of all purchased and leased IT equipment (hardware and software) in HHS-565 submission (C.4.B.1.)	CMS Property Officer	Annually on November 30 11:59 PM Eastern	Mail hard copy printout of HHS-565 to CMS Property and Contract Officer	
15.	HHS-22 submission (C.4.B.1.)	CMS Property Officer	When hardware or software equipment is transferred and/or retired or disposed	Submit HHS-22 for approval via fax or email to CMS Property Officer Update	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
				record in Remedy Inventory Module	
C.4.B.8. Communications					
16.	Partnership and Communications Plan (C.6.B.8.)	PO Communications GTL Region Office Communications Specialist Communications QIOSC (working through Communications GTL)	August 31, 2005 11:59 PM Eastern Every 6 months thereafter Available upon request	PARTner and electronically by request (includes Communications QIOSC) as directed by the Communications GTL	Template provided by the Communications QIOSC working through the Communications GTL
C.4.B.10. Internal Quality Control					
17.	Internal Quality Control (IQC) Plan which includes each subtask and major activity (C.4.B.10.)	PO	September 30, 2005 11:59 PM Eastern Update Project Officer during regular subtask discussions or as otherwise requested by the Project Officer	PARTner and as directed by the Project Officer	
C.6. TASKS					
Task 1. Assisting Providers in Developing the Capacity for and Achieving Excellence					
18.	List of key stakeholders (C.6.B.1.5.a.)	PO Communications GTL Regional Office	Upon request from CMS Ongoing	PARTner	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
		Communications Specialist	thereafter		
18A.	Identify one key stakeholder (C.6.B.1.5.a.)	PO Communications GTL Regional Office Communications Specialist	Available upon request	Electronically as directed by CMS	
19.	Notification of signed subcontract with Westat (C.4.B.14.)	PO	Within two weeks after the date of contract modification	Email notification to PO	
19A.	Notification of survey contact data submission to Westat (C.4.B.14.)	PO	April 13, 2007 11:59 PM Eastern	Email notification to PO	
Task 1.a. Nursing Home					
20.	RESERVED				
20A.	Alternative Task 1a evaluation criteria (only applicable for WY, AK, DC, and PR) (C.6.B.1a.3.)	PO	September 1, 2005 11:59 PM Eastern	Electronically	
21.	List of identified participants for IPG1 and IPG2 (C.6.B.1a.2.e.)	PO	February 1, 2006 11:59 PM Eastern 30 days after PARTner release	Electronically as directed by CMS PARTner, upon release	
22.	RESERVED				
22A.	Indicate whether QIO elects to have nursing homes submit process improvement information and which nursing	PO	February 1, 2006 11:59 PM Eastern 30 days after PARTner release	Electronically as directed by CMS PARTner, upon release	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	homes will be submitting this information (C.6.B.1a.2.a.iv. and C.6.B.1a.2.c.iii)				
23.	Identify the quality measure targets set for each nursing home on: high risk pressure ulcers; physical restraints; management of depressive symptoms (optional); and management of pain in chronic (long stay) residents (optional) (C.6.B.1a.2.a.)	PO	February 1, 2006 11:59 PM Eastern December 31, 2006 11:59 PM Eastern November 1, 2007 11:59 PM Eastern	Electronically as directed by CMS	
24.	Identify the QIO's statewide target for high risk pressure ulcers, physical restraints, management of depressive symptoms (optional), and management of pain in chronic (long stay) residents (optional) (C.6.B.1a.2.a.)	PO	February 1, 2006 11:59 PM Eastern December 31, 2006 11:59 PM Eastern November 1, 2007 11:59 PM Eastern	Electronically as directed by CMS	
25.	RESERVED				
26.	Documentation of PARTner activity codes (C.6.B.1a.2.)	PO	Quarterly	PARTner	
27.	Documentation of baseline and annual	PO	March 31, 2006 11: 59 PM Eastern	Electronically as directed by CMS	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	remeasurement rates for resident satisfaction (C.6.B.1a.2.b.)		Feb 1, 2007 11:59 PM Eastern November 1, 2007 11:59 PM Eastern		
28.	Documentation of baseline and annual remeasurement rates for staff satisfaction (C.6.B.1a.2.b.)	PO	March 31, 2006 11: 59 PM Eastern Feb 1, 2007 11:59 PM Eastern November 1, 2007 11:59 PM Eastern	Electronicall y as directed by CMS	
29.	Documentation of annual Certified Nursing Assistants/ Aides (CNA) information to calculate turnover rate (C.6.B.1a.2.b.iii)	PO	March 31, 2006 11: 59 PM Eastern Feb 1, 2007 11:59 PM Eastern November 1, 2007 11:59 PM Eastern	Electronicall y as directed by CMS	
30.	(Optionally) Monthly submission by a subset of nursing homes of mandatory process of care data (C.6.B.1a.2.a.)	QIO Data Warehouse	Ongoing beginning January 2006	Nursing Home Improvemen t Feedback Tool (NHIFT)	
Task 1.b. Home Health					

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
31.	List of identified participants for the Clinical Performance IPG with their Plans of Action (POA) – including up to 8 or 8% additional HHAs and their POAs (C.6.B.1b.2.b.i. and C.6.B.1b.2.b.iii.)	QIO data warehouse	February 1, 2006 11:59 PM Eastern	Electronically as directed by CMS	
32.	List of identified participants for the Systems Improvement and Organizational Culture Change IPG (C.6.B.1b.2.b.ii.)	PO Home Health GTL Home Health QIOSC	February 1, 2006 11:59 PM Eastern	Electronically as directed by CMS	Include type of telehealth and purpose of utilization
33.	OASIS measure selected as the statewide measure (C.6.B.1b.2.b.iv.)	PO Home Health GTL Home Health QIOSC	February 1, 2006 11:59 PM Eastern	Electronically as directed by CMS	
34.	Acute care hospitalization strategic plan (C.6.B.1b.2.a.)	PO Home Health GTL Home Health QIOSC	February 1, 2006 11:59 PM Eastern	PARTner	Only applicable to those states with an acute care hospitalization rate of 25% or lower
34A.	Acute care hospitalization strategic plan final report (C.6.B.1b.3.a.vii.a.2.b.)	PO Home Health GTL	September 28, 2007 11:59 PM Eastern	Electronically as directed by CMS	Only applicable to those states with an acute care hospitalization rate of

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
					25% or lower
35.	Systems Improvement and Organizational Culture Change IPG organizational culture change survey results (C.6.B.1b.2.a.)	PO Home Health GTL Home Health QIOSC	30 days after PARTner release March 1, 2007 11:59 PM Eastern	PARTner, upon release	Include list of HHAs and aggregate survey results
36.	Systems Improvement and Organizational Culture Change IPG organizational culture Plans of Action (POAs) (C.6.B.1b.2.a.)	PO Home Health GTL Home Health QIOSC	July 3, 2006 11:59 PM Eastern May 1, 2007 11:59 PM Eastern	PARTner	Include date of POA and type of organizational culture change initiative
37.	Baseline and remeasurement results of statewide immunization practice survey of home health agencies (C.6.B.1b.2.a.)	PO Home Health GTL Home Health QIOSC	September 1, 2006 11:59 PM Eastern November 1, 2007 11:59 PM Eastern	PARTner	Include total number of HHAs surveyed, number of HHAs that completed survey, and number of HHAs with immunizations processes
38.	Documentation of PARTner activity codes (C.6.B.1b.2.)	PO	Quarterly	PARTner	
38A.	Telehealth Implementation Forms, signed by SIOCC HHA Administrators (or executive-level	PO Home Health QIOSC	August 1, 2007 11:59 PM Eastern	Electronically as directed by CMS	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	designee) (C.6.B.1b.3.a.v.)				
38B.	Target Setting – Year 1 Entry Completion (C.6.B.1b.2.a.)	PO Home Health QIOSC	October 31, 2006 11:59 PM Eastern	HH-STAR website	
38C.	Target Setting – Year 2 Entry Completion (C.6.B.1b.2.a.)	PO Home Health QIOSC	October 31, 2007 11:59 PM Eastern	HH-STAR website	
Task 1.c.1. Hospital					
39.	Update data on hospital status on Provider Reporting System (PRS) (C.6.B.1c1.2.a.i.)	PO	Monthly	PRS	
40.	Submit list of identified participants for Acute Care Measure (ACM) IPG, Surgical Care Improvement Project (SCIP) IPG, and Systems Improvement and Organizational Culture Change (SIOC) IPG (C.6.B.1c1.2.b.)	PO Task 1c GTLs	February 1, 2006 11:59 PM Eastern May 1, 2006 11:59 PM Eastern (updated list following PARTner release)	Electronically as directed by CMS PARTner, upon release	
40A.	Document intent to pursue extra credit in ACM and/or SCIP IPGs (C.6.B.1c1.2.b.)	PO Task 1c GTLs	September 1, 2006 11:59 PM Eastern	PARTner	
41.	Document date and time of contact with local chapter president of the American College	PO Task 1c GTLs	December 16, 2005	Electronically on December 16, 2005	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	of Surgeons to discuss coordination of SCIP activities (C.6.B.1c1.2.b.ii.)		10 days after PARTner release	PARTner, upon release	
42.	Submit results of readiness/adoption tool for Computerized Physician Order Entry (CPOE), barcoding, or telehealth (baseline) (C.6.B.1c1.2.b.iii.)	PO Task 1c GTLs	April 3, 2006 11:59 PM Eastern August 1, 2006 11:59 PM Eastern	Electronically as directed by CMS PARTner	
43.	Submit results of readiness/adoption tool for CPOE, barcoding, or telehealth (remeasurement) (C.6.B.1c1.2.b.iii.)	PO Task 1c GTLs	November 30, 2007 11:59 PM Eastern	PARTner	
44.	Submit each of the SIOC hospitals' plans for implementation of CPOE, barcoding, or telehealth (C.6.B.1c1.2.b.iii.)	PO Task 1c GTLs	September 30, 2006 11:59 PM Eastern	PARTner, using template on MedQIC or equivalent template addressing similar content	
44A.	Documentation of PARTner activity codes (C.6.B.1c1.2.)	PO	Quarterly	PARTner	
Task 1.c.2. Critical Access Hospital/Rural PPS Hospital					
45.	Critical Access Hospital (CAH) measure set submitted to clinical	QIO Clinical Warehouse	Ongoing	CMS Abstraction and Reporting	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	warehouse (C.6.B.1c2.2.a.)			Tool (CART)	
46.	Submit list of measure(s) or topic quality improvement initiative in CAH (C.6.B.1c2.2.a.)	PO Task 1c GTLs	September 1, 2006 11:59 PM Eastern	Electronicall y as directed by CMS	
46A.	Final report describing the QIO's quality improvement activities with each reporting CAH (C.6.B.1c2.2.a.)	PO Task 1c GTLs	November 30, 2007 11:59 PM Eastern	Electronicall y via CMS provided template	
47.	Submit list of ROSC IPG hospitals (C.6.B.1c2.2.b.)	PO Task 1c GTLs	February 1, 2006 11:59 PM Eastern May 1, 2006 11:59 PM Eastern (following PARTner release)	Electronicall y as directed by CMS PARTner, upon release	
48.	Submit baseline results and sampling methods for safety culture survey (C.6.B.1c2.2.b.)	PO Task 1c GTLs	July 31, 2006 11:59 PM Eastern	Electronicall y as directed by CMS	
48A.	Submit report of ROSC interventions/ change models implemented (C.6.B.1c2.2.b)	PO Task 1c GTLs	November 1, 2007 11:59 PM Eastern	PARTner	
48B.	Submit baseline results for safety culture survey (C.6.B.1c2.2.b.)	PO Task 1c GTLs	August 31, 2006 11:59 PM Eastern	PARTner	
49.	Submit	PO	November 1,	PARTner	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	remeasurement results for safety culture survey (C.6.B.1c2.2.b.)	Task 1c GTLs	2007 11:59 PM Eastern		
49A.	Documentation of PARTner activity codes (C.6.B.1c2.2.)	PO	Quarterly	PARTner	
49B.	Final report describing the quality improvement plan for hospitals reporting data on new measures (C.6.B.1c2.2.a.)	PO Task 1c GTLs	November 1, 2007 11:59 PM Eastern	Electronicall y as directed CMS	
Task 1.d.1. Physician Practice					
50.	Report any assistance given to Medicare Advantage plans (C.6.B.1d1.2.a.ii.)	PO Task 1d1 GTL	Quarterly	PARTner	
50A.	Report activity to support PVRP and other statewide work (C.6.B.1d1.2.a.i.)	PO Task 1d1 GTL	Quarterly	Electronicall y as directed CMS	
51.	Detailed recruitment plan (C.6.B.1d1.2.b.)	PO Task 1d1 GTL	September 1, 2005 11:59 PM Eastern	PARTner	
52.	Detailed work plan that indicates how technical assistance will be offered to IPG physician practice sites including those practice sites in 1d2	PO Task 1d1 GTL	September 1, 2005 11:59 PM Eastern	PARTner	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	(C.6.B.1d1.2.b.)				
53.	List of identified participant physician practice sites and the progress made on the EHR roadmap (C.6.B.1d1.2.b.)	PO Task 1d1 GTL Physician Practice QIOSC	December 16, 2005 11:59 PM Eastern Monthly thereafter	Electronically as directed by CMS PARTner, upon release	
54.	Strategy and assistance for physician practice sites with an electronic health record (EHR) to submit data on the Doctor's Office Quality (DOQ) measures to the QIO Data Warehouse (C.6.B.1d1.2.b.)	PO Task 1d1 GTL	September 1, 2005 11:59 PM Eastern	PARTner	
55.	Office System Survey to assess status of IPG electronic clinical information production and use (C.6.B.1d1.2.b.)	PO Task 1d1 GTL Outpatient Data QIOSC	August 1, 2006	PARTner/Q Net Exchange	Final IPG submission due for Baseline OSS measurement
55A.	(If applicable) List of incrementally-funded practices (C.6.B.1d1.3.c.)	PO Task 1d1 GTL Physician Practice QIOSC	Upon CMS request	Electronically as directed by CMS	
56.	Updated environmental scan (C.6.B.1d1.2.b.)	PO Task 1d1 GTL	Available upon request after December 1, 2005	PARTner	
57.	List of the physician practice sites that expressed an	PO Task 1d1 GTL	December 16, 2005 11:59 PM	Electronically as directed by CMS	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	interest to receive QIO assistance (C.6.B.1d1.2.b.)		Eastern Monthly thereafter	 PARTner, upon release	
58.	Updated list of physician practice sites that are using EHR to date (including vendors) (C.6.B.1d1.2.b.)	PO Task 1d1 GTL	December 16, 2005 11:59 PM Eastern Monthly thereafter	Electronicall y as directed by CMS	
59.	Information showing QIO efficiencies, i.e., the cost of working with the IPGs. (C.6.B.1d1.2.b.)	PO Task 1d1 GTL	March 1, 2006 11:59 PM Eastern	PARTner	
60.	Office System Survey of IPGs (C.6.B.1d1.2.b.)	PO Task 1d1 GTL Outpatient Data QIOSC	October 15, 2007 11:59 PM Eastern	As directed by CMS	Completion of OSS for remeasure ment
60A.	Documentation of PARTner activity codes (C.6.B.1d1.2.)	PO	Quarterly	PARTner	
Task 1.d.2. Physician Practice: Underserved Populations					
61.	Identify Task 1d1 underserved IPG identified participants (C.6.B.1d2.2.b.)	PO Task 1d2 GTL	February 1, 2006 11:59 PM Eastern Monthly thereafter	Electronicall y as directed by CMS PARTner, upon release	
62.	Identify CLAS IPG identified participants, including practices and practitioners (C.6.B.1d2.2.b.)	PO Task 1d2 GTL	February 1, 2006 11:59 PM Eastern July 31, 2006 11:59 PM	Electronicall y as directed by CMS PARTner, upon	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
			Eastern January 31, 2007 11:59 PM Eastern	release	
63.	Report of efforts to reach underserved populations in Task 1d2 activities in the state/jurisdiction (C.6.B.1d2.2.c.)	PO Task 1d2 GTL	February 1, 2006 11:59 PM Eastern Every 6 months thereafter	PARTner	
64.	Report of results of CLAS standard assessments (C.6.B.1d2.2.b.)	PO Task 1d2 GTL	February 1, 2006 11:59 PM Eastern July 31, 2006 11:59 PM Eastern January 31, 2007 11:59 PM Eastern November 1, 2007 11:59 PM Eastern	PARTner	By July 31, 2006, and January 31, 2007, the QIO shall add assessments for any new identified participants
65.	RESERVED				
65A.	RESERVED				
Task 1.d.3. Physician Practice/Pharmacy: Part D Benefit					
66.	Assessment of physician practice site/pharmacy environment in relation to e-prescribing and CQI (C.6.B.1d3.2.b.i.)	PO Task 1d3 GTL	December 30, 2005 11:59 PM Eastern	PARTner	
67.	QIO staffing/training plan, including a	PO Task 1d3 GTL	November 1, 2005	PARTner	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	timeline for physician practice site/pharmacy project readiness (C.6.B.1d3.2.b.ii.)		11:59 PM Eastern		
68.	Measurement report for Task 1d3 project indicators (C.6.B.1d3.2.c.)	PO Task 1d3 GTL 1d3 QIOSC	Baseline (as available) September 29, 2006 11:59 PM Eastern Quarterly thereafter	PARTner	Limited to indicators being used in approved project. Format (spreadsheet) to be supplied by CMS
69.	Submit two concept papers for quality projects to be developed in collaboration with PDPs and Medicare Advantage PDPs (C.6.B.1d3.2.c.)	PO Task 1d3 GTL	March 1, 2006 11:59 PM Eastern	PARTner	
69A.	Submit one project proposal, as directed by CMS, for one quality project developed in collaboration with PDPs and Medicare Advantage PDPs (C.6.B.1d3.2.c.)	PO Task 1d3 GTL	August 31, 2006 11:59 PM Eastern	PARTner	
70.	RESERVED				
71.	RESERVED				
72.	Report the required information on PDPs and physician practice sites/pharmacies with which it has worked and quality	PO Task 1d3 GTL	August 31, 2006 11:59 PM Eastern Every 6 months thereafter	PARTner	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	improvement projects that it has deployed (C.6.B.1d3.2.a.)				
73.	Directory of the contacts persons within each PDP (C.6.B.1d3.2.b.)	PO Task 1d3 GTL	August 31, 2006 11:59 PM Eastern	Electronicall y	
74.	RESERVED				
Task 3.a. Beneficiary Protection					
75.	Data entry of all required case review information, including Medicare Helpline information (C.6.B.3a)	PO Task 3a GTL	Ongoing as case review is conducted	Case Review Information System (CRIS)	Reports based on case review information , including timeliness & Inter-Rater Reliability (IRR) will be generated from CRIS
76.	Documentation of performance improvement activities conducted as a result of analysis of case review information (C.6.B.3a.2.c.ix.)	PO Task 3a GTL	Ongoing documentation to be available upon request	Electronic availability	
77.	Annual Report in accordance with CMS instructions (C.6.B.3a.2.d.)	PO Public availability	Annually	PARTner Publication	PO approval required
78.	Documentation of case reviews conducted under Task 3 that resulted	PO Task 3a GTL	Ongoing	SDPS	SDPS report will be developed

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
	in a quality improvement activity (C.6.B.3a.2.c.viii.)				to provide percentage of case reviews that result in quality improvement activities
79.	Documentation of how the organization determines the need for a quality improvement activity (C.6.B.3a.Exhibit 3a.)	PO Task 3a GTL	Within 30 days of SDPS availability and ongoing	SDPS	Text entry subject to PO review
80.	RESERVED				
Task 3.b. Hospital Payment Monitoring Program					
81.	Project Proposal or Justification (C.6.B.3b.2.c.)	PO Task 3b GTL CS	March 1, 2006 11:59 PM Eastern	Electronically or Hardcopy	
82.	Monitoring reports (C.6.B.3b.2.b.)	PO	April 28, 2006 11:59 PM Eastern January 31, 2007 11:59 PM Eastern	PARTner	
G. Contract Administration					
83.	Electronic submission of voucher in FIVS (G.2.A.2.)	PO	Monthly	Electronic	
84.	Notice of request for provisional rates from DCAA (G.3.D.)	CO	Ongoing	Hardcopy	

Schedule F: Item #	Task Description	Recipient	Due Date(s)	Reporting Mechanism	Notes
85.	Annual Indirect Cost Rate Proposal (G.3.E.)	CO	Annually	Hardcopy	
85A.	Form 565 Report of Accountable Personal Property (G.11.)	CMS Property Administrator	Annually	Hardcopy	
85B.	Standard Form (SF) 294, Subcontracting Report of Individual Contracts (G.13.)	CO CMS Small Business Specialist	Semi-annually	Hardcopy	
85C.	SF 295, Summary of Subcontract Report (G.13.)	CO	Annually	Hardcopy	
H. Special Contract Requirements					
86.	Organizational Conflict of Interest (H.11.E.)	CO PO	Within 30 days the date of agreement	Hardcopy	
87.	Organizational Conflict of Interest (H.11.F.)	CO	Annually February 28th	Hardcopy	
88.	Organizational Conflict of Interest (H.11.G.)	CO	At time of proposal submission and annually February 28th	Hardcopy	
89.	Severance Plan (H.13.)	CO	Within 60 days of contract award	Hardcopy	

* Any changes to the Deliverable due dates for Tasks 1–3 of this contract not exceeding 60 days and do not have a cost impact on the contract may be authorized in writing by the Project Officer. However, due dates must not exceed the period of performance of this contract.

A. Project Officer (PO):
As assigned

B. Contracting Officer (CO):
Centers for Medicare & Medicaid Services
OAGM/MCG/DQC
Attn: Naomi Haney-Ceresa
7500 Security Boulevard, MS C2-21-15
Baltimore, MD 21244-1850

C. Contract Specialist (CS):
As assigned

D. SDPS Government Task Leader (GTL):
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Tina Donahue
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

E. CMS Property Officer:
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Michael Reinhold
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

F. SDPS Contractor:
Iowa Foundation for Medical Care (IFMC)
Attn: Ronna Pochter
6000 Westown Parkway, Suite 350E
West Des Moines, IA 50266

G. Communications GTL:
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Richard McNaney
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

H. Regional Office Communications Specialists:

Centers for Medicare & Medicaid Services
Boston Regional Office
Attn: Judy Kaplan
JFK Federal Building
Room 2350

Boston, MA 02203-0003

Centers for Medicare & Medicaid Services
Dallas Regional Office
Attn: Eddie Newman
1301 Young Street, Suite 766
Dallas, TX 75202-4348

Centers for Medicare & Medicaid Services
Kansas City Regional Office
Attn: Maribeth Fonner
601 E. 12th Street
Kansas City, MO 64106-2808

Centers for Medicare & Medicaid Services
Seattle Regional Office
Attn: Louise Roumagoux
2201 Sixth Avenue, MS RX 42
Seattle, WA 98121-2500

I. Communications QIOSC:
Qualis Health
Attn: Evan Stults
P.O. Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133
commqiosc@waqio.sdps.org

J. Task 1a: Nursing Home GTL:
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Yael Harris
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

K. Nursing Home QIOSC:
Quality Partners of Rhode Island
Attn: Gail Patry, RN
235 Promenade Street, Suite 500
Providence, RI 02908

L. Task 1b: Home Health GTL
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality

Attn: David Dietz
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

M. Home Heath QIOSC:
Quality Insights of Pennsylvania
Attn: Marian Essey
Penn Center West, Building II, Suite 220
Pittsburgh, PA 15276

N. Task 1c1: Hospital GTL:
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Rebecca Hudson and Maria Hammel
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

O. Task 1c2: Critical Access Hospital/Rural PPS Hospital GTL:
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Maria Hammel and Rebecca Hudson
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

P. Task 1d1: Physician Practice GTL:
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Kathleen Winchester
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

Q. Outpatient Data QIOSC:
Iowa Foundation for Medical Care (IFMC)
Attn: Mike Sacca
6000 Westown Parkway, Suite 350E
West Des Moines, IA 50266

R. Task 1d2: Physician Practice: Underserved Populations GTL:
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Jacqueline Harley and Steven Preston
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

S. Task 1d3: Physician Practice: Part D Benefit GTL:
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Eugene Freund
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

T. Task 3a: Beneficiary Protection GTL:
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Yvette Williams and Donna Williamson
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

U. Task 3b: Hospital Payment Monitoring Program GTL:
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Anita Bhatia
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

V. CMS Small Business Specialist
Centers for Medicare & Medicaid Services
Office of Operations Management
Attn: Alice Roache
7500 Security Boulevard, MS C2-21-15
Baltimore, MD 21244-1850

W. CMS Property Administrator
Centers for Medicare & Medicaid Services
OICS, Administrative Services Group
Division of Property and Space Management
7500 Security Boulevard, MS SLL-14-06
Baltimore, Maryland 21244-1850

X. CMS QualityNet Information System Security Officer
Centers for Medicare & Medicaid Services
Office of Clinical Standards and Quality
Attn: Michael Blake
7500 Security Boulevard, MS S3-02-01
Baltimore, MD 21244-1850

Y. Contract Specialist
As assigned

F.3. 52.252-2 CLAUSES INCORPORATED BY REFERENCE. (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this address:

www.arnet.gov/far/fac.html

52.242-15 Stop Work Order, Alt 1 (April 1984)

SECTION G - CONTRACT ADMINISTRATION

G.1. ACCOUNTING AND APPROPRIATION DATA

CAN	PR #	OFFICE CODE	AMOUNT

G.2. INVOICING AND PAYMENT INFORMATION

A. Submission of Invoices/Vouchers:

1. A complete invoice/voucher shall consist of the following forms and shall clearly identify the following information:

- Standard Form (SF) 1034, Public Voucher for Purchases and Services Other than Personal;
- The cover sheet to the SF 1034 shall clearly document costs invoiced under any Special Project (Task 4) with a CAN number different than the base contract award. Note: The fist digit of the CAN number can be different without reporting it separately as the first digit represents the fiscal year.
- CMS Revised Form 719, Quality Improvement Organization Contract Activity and Voucher;
- CMS Form 618, Quality Improvement Organization Voucher Certification;
- Any additional supporting documentation
- Monthly fixed fee clearly and separately identified on the voucher;
- At a minimum, the following additional supporting documentation must be supplied with the monthly invoice:

a. A listing of the total direct employee costs charged to the invoice per employee including the hours charged, the average rate per employee and the total cost per employee.

b. A detailed listing of the individual accounting line item direct costs charged for reproduction and printing, telephones, meetings and conferences, dues and subscriptions, travel, other-attached schedule

exceeding $1,000 per invoice and consultant and subcontracts. The detailed list shall include the following information:

Subject Area (i.e. meetings and conferences)

Title of the Cost	Purpose of the Cost	Total Cost

c. Additional information may be requested by the Contracting Officer, the contract specialist or the project officer for each monthly invoice.

2. One (1) original and 3 copies of the above forms shall be submitted in hard copy to CMS to the following address:

For overnight Mail:

DHHS, CMS
OFM, Division of Accounting
7500 Security Boulevard/C3-11-03
Baltimore, MD 21244-1850

For regular Mail

DHHS, CMS
OFM, Division of Accounting
P.O. Box 7520
Baltimore, MD 21207-0520

Simultaneously, upon submission of the hardcopy voucher to the Division of Accounting, the QIO shall also submit a hardcopy of the voucher to the Project Officer. **Advance/duplicate copies should not be submitted to the Contract Specialist or Contracting Officer. Facsimile versions of a voucher will not be accepted for payment.**

The QIO shall also submit an electronic version of the above-referenced forms and the 719A Backup Forms via the CMS FIVS Telecommunications Network.

NOTE: Invoice/Voucher payment is based upon the **original hard copy** submission and not on the electronic CMS FIVS submission.

B. Payment of Invoices/Vouchers

1. Payment Schedule

Payment will be made within 15 days of the close of the previous month. In accordance with the Omnibus Reconciliation Act (OBRA) of 1985 (P.L.99-272), the assumption is made that acceptable vouchers will be submitted by a QIO within 15 days of the close of the previous month. For payment date calculation purposes, the 15 days will commence upon receipt of the hardcopy voucher by CMS' Division of Accounting.

Discrepancies found as a result of Project Officer/Contracting Officer review of an invoice/voucher may result in the issuance of a suspension notice.

QIOs may log into the following website maintained by the Department of Treasury in order to check on voucher payment status:

hhtp://fms.treas.gov/paid

2. Electronic Payment

Payments will only be made by electronic funds transfer using the Central Contractor Registration (CCR) database.

In the event that during the performance of this contract, the QIO elects to designate a different financial institution for receipt of payment using the electronic funds transfer procedures, the QIO shall provide written notification of the change (including all required information) to the Contracting Officer thirty (30) days in advance of the effective date of the change.

The documents furnishing the information relating to the above change must be dated and must include the signature, title and telephone number of the QIOs official representative authorized to provide the information, as well as the QIOs name and contract number.

The QIO shall notify CMS's Division of Accounting (per the address information provided in Section G.2) of any change in the QIOs address information in the CCR database via the following e-mail address: CCRChanges@CMS.HHS.GOV.

G.3. INDIRECT COSTS

A. All non-profit QIOs shall adhere to the cost principles as set forth under OMB Circular A-122. All non-profit QIOs are required to use one (1) of the three (3) current allocation methodologies described in the Circular.

B. All for-profit QIOs shall adhere to the cost principles as set forth under the Federal Acquisition Regulation (FAR).

All QIOs, both non-profit and for-profit, shall establish indirect cost rates.

C. Indirect Cost Rates

For the purposes of this contract, the following indirect cost rates are established and the pools defined:

TYPE	COST CENTER	PERIOD	RATE	BASE
TBD*	TBD	TBD	TBD	TBD

D. Provisional Rates

QIO(s) that did not hold a 7th round QIO contract, must submit an indirect cost rate proposal (both electronic and hardcopy) to the Defense Contract Audit Agency (DCAA) no later than ninety (90) days from the effective date of the award of this contract at the address provided below:

Defense Contract Audit Agency
Chesapeake Bay Branch Office
One Mall North, Suite 200
10025 Governor Warfield Parkway
Columbia, MD 21044
Attn: Jane Galloway, Focal Point for CMS Audits
JGalloway@DCAA.MIL

Upon submission of the QIO(s) indirect cost rate proposal to DCAA, the QIO(s) shall inform (by letter) the Contracting Officer of the date of submission to DCAA.

Pending establishment of an indirect cost rate(s), the QIO will be reimbursed on the basis of indirect costs paid (actual expenditures). Reimbursement of indirect costs will be subject to monthly analysis, and may require submission of additional documentation in order to support the costs.

If the QIO fails to submit an acceptable indirect cost rate proposal within the 90 days from the effective date of this award, the Contracting Officer reserves the right to suspend payment until such time as an acceptable proposal is received by the DCAA.

Once established, provisional indirect rates should be utilized by the QIO for submission of interim vouchers. Established provisional indirect rates may be prospectively or retroactively revised by mutual agreement between the Contracting Officer and the QIO to prevent substantial overpayment or underpayment. It is the responsibility of the QIO to notify the Contracting Officer, in writing, of any significant variances in the actual rates in comparison to the established provisional indirect rates.

E. Final Rate

On an annual basis, each QIO shall submit an indirect cost rate proposal to the DCAA no later than six (6) months after the close of the QIOs fiscal year. In the event that the QIO does not submit an acceptable indirect cost rate proposal within six (6) months after the close of the QIOs fiscal year, the Contracting Officer reserves the right to suspend payments until such time as an acceptable proposal is received by DCAA. Upon submission to DCAA, the QIOs shall also provide one (1) copy of the annual indirect cost rate proposal to the Contracting Officer.

For each final rate established through an annual indirect rate audit, the Contracting Officer reserves the right to grant an increase of no more than five (5) percentage points above the first year provisional rate(s) as established in Section G.3. The five (5) percentage point fluctuation is at the discretion of the Contracting Officer for the purpose of reflecting possible changes in the QIO's business during the three (3) years of the contract. The indirect rate ceiling(s) provided in Section B.5 is/are inclusive of the five (5) percentage point fluctuation factor.

G.4. A-133 INTERIM AUDITS (for non-profit QIOs only)

For each non-profit QIO, there shall be an A-133 audit in accordance with OMB Circular entitled, "Audits of States, Local Governments, and Non-Profit Organizations." The QIO will contract independently with a CPA firm to perform these audits. The Office of Inspector General (OIG) for the Department of Health and Human Services (DHHS) shall serve as the cognizant oversight agency as defined by OMB Circular A-133. The QIO shall share all A-133 findings with any audit entity authorized by CMS.

G.5. CLOSEOUT AUDITS FOR PROFIT AND NON--PROFIT ORGANIZATIONS

The contract closeout audit will be performed in accordance with the terms and conditions of the contract, FAR, OMB Circular A-122 (as applicable) and other appropriate guidelines such as generally accepted accounting principles.

G.6. KEY PERSONNEL

A. HHSAR 352.270-5 Key Personnel (APR 1984)

The personnel specified in this contract are considered to be essential to the work being performed hereunder. Prior to diverting any of the specified individuals to other programs, the Contractor shall notify the Contracting Officer

reasonably in advance and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the program. No diversions shall be made by the Contractor without the written consent of the Contracting Officer, provided that the Contracting Officer may ratify in writing such diversion and such ratification shall constitute consent of the Contracting Officer required by the clause. The contract may be amended from time to time during the course of the contract to either add or delete personnel, as appropriate.

Note: Contractor shall be interpreted as QIO.

B. Chief Executive Officer (CEO)/Executive Director/Equivalent Position

1. _____ is the _____ for this contract. This position is defined as Key Personnel in accordance with HHSAR 352.270-5, as provided in paragraph A, above. It is his/her responsibility to lead the organization and obtain the staff and resources necessary to conduct the contract.

   As a key person, this position may not be vacant and may not be filled in a temporary capacity for more than 180 consecutive days of the contract. In the event that the QIO cannot meet this timeframe for a permanent CEO/Executive Director, CMS will institute a performance improvement plan and will consider the necessity of termination for default in accordance with the Termination Clause as provided in Section I of the contract.

2. The CEO shall be responsible for all staff employed by the QIO organization, including consultants paid for work under this QIO contract.

3. The CEO/Executive Director shall be responsible for all work performed under this contract and shall be held accountable for the outcomes of the QIO and the resolution of obstacles to achieving the outcomes necessary for success under this contract.

4. The CEO/Executive Director shall be required to provide the QIO Board of Directors with information necessary for the Board to make informed decisions regarding this contract, including all evaluations and reviews.

5. The CEO/Executive Director shall be required to have a Standard Data Processing System (SDPS) address for critical communications between the Contracting Officer and the QIO.

G.7. PROJECT OFFICER

A. Designation

_____is hereby designated as the Government Project Officer.

B. Responsibilities

1. Authority for directing and managing implementation of the program/technical aspects of the Act, as amended, has been redelegated from the Administrator through the Director of the Office of Clinical Standards and Quality.

2. Performance of the work under this contract shall be subject to the technical direction of the Project Officer. The Project Officer shall be the authorized representative of the Contracting Officer and the person representing CMS for the purpose of providing technical direction and monitoring of contract performance. It is within the purview of the Project Officer to conduct on-site visits as deemed necessary. Such visits are to be used as a tool to gather or verify information regarding such things as SDPS property, performance issues and/or financial issues.

3. It is the responsibility of the Project Officer to conduct necessary evaluations throughout the term of the contract. The Project Officer may include any CMS personnel considered necessary in order to conduct these reviews.

4. It is the responsibility of the Project Officer to monitor the contractor's progress against the QIO's contract management plan. The Project Officer may use the contract management plan as a tool in providing appropriate technical direction to the QIO.

5. The term "technical direction" is defined as government guidance of a Contractor's effort toward areas of effort that fall within the statement of work. For the purposes of this contract, this definition shall include the following:

    - recommendations from the Project Officer that must be implemented by the Contractor to bring their performance into compliance with the minimum requirements of the contract,
    - review, and, where required by the contract, approval of reports and other technical information to be delivered by the Contractor under the contract.

6. The Project Officer may also provide advice and consultation on the Statement of Work and deliverables and services to be furnished under the provisions of the

contract. Unlike technical direction, however, the Contractor is not required to implement these suggestions.

7. The Project Officer may work with the Government Task Leader to provide information to the Contractor which assists in the interpretation of the work and services to be furnished within a given task area.

8. Any and all technical direction and advice and consultation must be within the general scope of the contract. The Project Officer does not have the authority to and shall not issue any technical direction or advice which:

- constitutes an assignment of additional work outside the scope of the contract;
- constitutes a change as defined in the contract clause at FAR 52.243-2, Alt I;
- in any manner, causes an increase or decrease in the total estimated contract cost; and,
- changes any of the expressed terms, conditions, or specifications of the contract.

9. Technical direction which is within the scope of the contract, as written, shall, whenever possible, be in writing and a copy submitted to the Contracting Officer.

10. The Contractor shall proceed promptly with the performance of technical direction duly issued by the Project Officer in the manner prescribed by his/her authority under the provisions of this article.

11. If the Contractor believes that instruction issued by the Project Officer does not follow the definition of technical direction, and results in a contractual change or cost impact, the Contractor shall not proceed but shall notify the Contracting Officer immediately.

If the Contractor believes that information provided as a result of interaction with other technical personnel as defined in G.8.0 below is inconsistent with the statement of work, the Contractor shall contact the Project Officer for resolution.

G.8. GOVERNMENT TASK LEADER (GTL)

A. Designation

The following are hereby designated as the Government Task Leader(s):

Task 1 (Communications Activities): Richard McNaney
Task 1a: Yael Harris
Task 1b: David Dietz
Task 1c1: Rebecca Hudson and Maria Hammel
Task 1c2: Maria Hammel and Rebecca Hudson
Task 1d1: Kathleen Winchester
Task 1d2: Jacqueline Harley and Steven Preston
Task 1d3: Eugene Freund
Task 3a: Yvette Williams and Donna Williamson
Task 3b: Anita Bhatia
SDPS: Tina Donahue

B. Responsibilities

1. Authority for directing and managing implementation of the program/technical aspects of the Act, as amended, has been redelegated from the Administrator through the Director of the Office of Clinical Standards and Quality.

2. The Government Task Leader (GTL) will be the authorized representative of the Contracting Officer and the person representing CMS for the purpose of providing program content and clarification.

3. It is the responsibility of the GTL to participate with the Project Officer in monitoring the contractor's progress against the QIO's contract management plan.

4. It is the responsibility of the GTL to provide information to the Contractor which assists in the interpretation of the work and services to be furnished within their task area.

5. The GTL may provide advice and consultation on a Contractor's implementation of the Statement of Work and deliverables and services to be furnished under the provisions of the contract. The GTL, however, may not provide technical direction to the Contractor as distinguished from advice and consultation in section G. 7.

6. Any and all advice and consultation must be within the general scope of the contract. The GTL does not have the authority to and shall not issue any advice which:

    - constitutes an assignment of additional work outside the scope of the contract;

- constitutes a change as defined in the contract clause at FAR 52.243-2, Alt I;

- in any manner, causes an increase or decrease in the total estimated contract cost; and,

- changes any of the expressed terms, conditions, or specifications of the contract.

G.9. OTHER TECHNICAL PERSONNEL

Through performance of this statement of work, each QIO has the potential to interact with some or all of the following workgroups/personnel (this list is not all-inclusive):

QIOSC
DPAT
Special Project Lead QIOs

As a result of this contract, the QIO shall recognize that only the Project Officer identified, above, has the legal authority to issue technical direction. In the event that the QIO believes that technical direction has been issued by any other person/group such as those noted above, the QIO shall follow the procedures established in G.7. for resolution.

G.10. CONTRACTING OFFICER (CO)

A. The Contracting Officer is the only person under this contract with the ability to bind the government legally by signing the contract and any/all subsequent modifications.

B. The Contracting Officer is responsible for ensuring performance of all necessary actions for effective contracting, for ensuring compliance with all terms and conditions of the contract, and for safeguarding the interest of the government in its contractual relationships.

C. The Contracting Officer is the only individual authorized to:

- accept nonconforming work or waive any requirement of this contract;

- authorize reimbursement to the Contractor for any costs incurred during the performance of the contract; and

- modify any term or condition of this contract, extend the period of performance, change the delivery schedule…etc.

D. The Contracting Officer may conduct status conferences with members of the QIO Board of Directors, the QIO CEO/Executive Director, or QIO staff at any time during the period of performance.

G.11. PROPERTY ADMINISTRATION

A. The QIO is responsible for an annual physical inventory accounting for all government property under this contract. The inventory must be conducted by September 30th and the Form 565 Report of Accountable Personal Property (provided in Section J, Attachment J-11) submitted by October 31st of each year.

B. The inventory report shall include all items acquired, furnished, rented or leased under the contract. Employees who conduct the inventories should not be the same individuals who maintain the property records. Following the physical inventory, the QIO shall prepare an inventory report and submit the report to the CMS Property Administrator at the address on the following page:

Centers for Medicare & Medicaid Services
OICS, Administrative Services Group
Division of Property and Space Management
7500 Security Boulevard, MS SLL-14-06
Baltimore, Maryland 21244-1850

C. Commercially leased software is subject to these reporting requirements.

D. The QIO shall submit a consolidated report of all accountable government property under this contract, including subcontractor inventory information.

E. The final inventory report shall indicate that all items required for continued contract performance are acceptable and free from contamination. Property that is no longer usable or required shall be reported and disposition requested.

G.12. REPRESENTATIONS AND CERTIFICATIONS

The QIOs Representations and Certifications provided in response to Section K of the Request for Proposal are incorporated by reference as Section G.12

G.13. SUBCONTRACTING PROGRAM FOR SMALL, SMALL DISADVANTAGED AND WOMEN-OWNED AND HUBZONES

A. A non-profit QIO is considered a large business and shall submit a subcontracting plan and reports. A for-profit QIO shall follow the size standards provided at www.SBA.gov in order to determine the applicability of the subcontracting plan and subsequent reports. For the purposes of this contract, the NAICS is 923120.

B. The Subcontracting Plan submitted by the QIO and approved by the Contracting Officer for this contract is incorporated into the contract. The required documents are provided at www.hhs.gov/osdbu and www.gsa.gov/forms

C. The required subcontracting reports shall be submitted to both the Contracting Officer and to the CMS Small Business Specialist:

1. Standard form (SF) 294, Subcontracting Report of Individual Contracts submitted semi-annually during the life of the contract for the six (6) month period ending March 31 and September 30. A final report is required upon contract completion.

2. A standard form SF 295, Summary of Subcontract Report submitted annually for the twelve (12)-month period ending September 30.

   The SF 294 and SF 295 may be found at http://sbo.od.nih.gov.

G.14. CONSENT TO SUBCONTRACT

A. The QIO shall be in compliance with FAR 44.202-2 and FAR 52.244-2 when entering into a subcontract arrangement for the purpose of performing this contract.

B. Each QIO shall complete and submit the Subcontract Checklist (provided in Section J, Attachment J-9) in order to obtain subcontract consent after award of the contract.

C. Based upon this cost-type contract, prior consent is required for all cost reimbursement, time and materials, labor hour, and fixed price subcontracts over $100,000 or 5% of the total estimated cost of the contract. Consent is not required for Physician Reviewers.

D. Consent is granted to the following subcontracts:

CDAC
IFMC for SDPS
Physician Reviewers

E. Consent is required for consultants. There is no distinction in the FAR between subcontracts and consultants.

G.15. PAST PERFORMANCE DATABASE AND CENTRAL CONTRACTOR REGISTRATION

In accordance with the past performance requirements of the FAR, CMS requires each QIO to register with the National Institutes of Health (NIH) Contractor Performance System. This database allows for electronic collection, maintenance and dissemination of Contractor performance information. Registration instructions are provided at https://cpscontractor.nih.gov/

In addition, per FAR 52.204-7, each QIO shall register in the Central Contractor Registration (CCR) database. Failure of a QIO to register may prohibit CMS from making a contract award, contract renewal or issuance of future contract modification(s).

G.16. DATA DE-IDENTIFICATION PROCESS

A. The Standard Data Processing System (SDPS) Contractor shall be responsible for de-identifying, duplicating and maintaining duplicate data requests received from QIOs on behalf of entities engaging in Data Use Agreements with the QIOs are provided at Section J, Attachment J-13.

B. For all data requests under this contract, the QIO shall follow the procedures identified below:

1. The QIO shall submit a written request for de-identified data to the SDPS Help Desk.

2. Within seven (7) working days, the SDPS Contractor shall provide to the QIO a budget for the de-identification of the data. The budget shall include only the costs associated with the effort and shall not provide for any associated fee.

3. The QIO shall submit payment to the SDPS Contractor based upon the budget.

4. Within ten (10) working days of receipt of payment by the SDPS Contractor, the data de-identification request shall be completed and returned to the QIO for distribution to the requesting entity.

5. In the event that the size of the data request is too large to be completed within the above timeframe, the SDPS Contractor will notify the QIO when the SDPS Contractor provides the QIO with the budget. The SDPS Contractor and the QIO shall reach agreement on a reasonable timeframe for processing the data request.

G.17. ENGINEERING REVIEW BOARD (ERB) PROCESS FOR OBTAINING ADDITIONAL HARDWARE/SOFTWARE

NOTE: The procedures provided below apply to requests for "ADDITIONAL HARDWARE/SOFTWARE." CMS will determine each QIO's initial Hardware/Software configuration. CMS will initiate an order for such hardware/software with the CMS Contractor. CMS will inform the QIO of the CMS determined configuration.

A. Requests for additional SDPS equipment (including software) shall be submitted through the QualityNet (QNet) SDPS Engineering Review Board (ERB) process using the Purchase Request form (see Section J, Attachment J-6) in the Remedy AR system.

B. The QNet SDPS ERB Team shall review a QIO request and provide a written recommendation and cost estimate to CMS for approval/disapproval with ten (10) working days of receipt of a completed ERB Purchase Request form (provided in Section J, Attachment J-6).

C. CMS will review the QNet SDPS ERB Team's recommendation and provide a signed and dated approval/disapproval of the Purchase Request (within seven (7) working days) in the Remedy AR system. In cases where there is not enough information on the Purchase Request or there is a request for Non-Standard equipment, the Purchase Request may be held for an undetermined period in a Pending status before it is approved/disapproved.

D. Within three (3) working days of the CMS decision (approved/disapproved), the status of the ERB Purchase Request will be updated in the Remedy AR system.

E. If the Purchase Request is approved, the QNet Support Contractor will use the Remedy AR system to request a Purchase Order (PO) from the QIO. Upon receipt of a QIO PO number in Remedy, the QNet Support Contractor will order the requested item and have it shipped to the QIO.

F. Within ten (10) working days of receipt of the CMS approval from the ERB, the QNet Support Contractor shall submit a Purchase Order (PO) to the vendor of the required equipment.

G. The QIO shall pay the QNet Support Contractor directly for all materials within thirty (30) days of receipt of the required materials. The QIO will be reimbursed for the equipment by CMS in accordance with the monthly vouchering procedures as identified in this contract.

H. The QIO shall notify the QNet Support Contractor within five (5) working days of receipt of equipment will fax a copy of the packing slip to the QNet Support Contractor and provide all hardware item serial numbers and/or software license keys in the Remedy AR system's Inventory module for tracking and government auditing purposes.

NOTE: The QIO shall be responsible through its QIO contract for installation services and associated costs. The QNet Support Contractor is not responsible for payment issues between the selected vendor, CMS, and the QIO.

G.18. PROCEDURES FOR TASK 4 SPECIAL PROJECTS (SP)

In addition to the work performed under Tasks 1 through 3 of the contract, CMS reserves the right to incorporate Special Projects (SP). All SP incorporated into this contract shall be authorized through the formal contract modification process. See Section J, Attachment J-15 for details.

A. Competition

To the extent practicable, CMS-initiated SP will be competed among the QIO community. In determining the extent of competition, CMS reserves the right to consider factors such as time, QIO expertise, and specific scientific requirements which may impact location for performance of the SP.

For each SP awarded, whether based on a CMS-initiated concept paper or a QIO-initiated concept paper, the QIO shall submit a technical and business proposal to the Contracting Officer. Each SP technical proposal shall include a proposed project management/work plan in sufficient detail for CMS to determine the timing of project activities in relation to one another and the work performed under the QIO's base contract.

B. CMS-initiated:

SP initiated by CMS, whether competed among several or all QIOs or directed to specifically identified QIOs, may or may not (at CMS's discretion) require that QIO proposals include a proposed work statement and schedule of deliverables for meeting CMS's stated objectives for the project. Specifications for the technical and business proposal will be identified individually for each CMS-initiated SP. The SP (Statement of Work and Schedule of Deliverables) will be

funded and incorporated into the contract through execution of a bilateral modification. SP will be incorporated as a Section J attachment. The QIO is required to perform the SP according to the work statement and schedule of deliverables. **Performance of the SP shall not commence until a fully executed modification incorporating the SP into the contract has been completed.**

C. QIO-Initiated SP:

QIO initiated SP shall include a technical and business proposal. The technical proposal shall include, but not necessarily be limited to, a detailed draft work statement and schedule of deliverables. If accepted by CMS, the work statement and schedule of deliverables will be incorporated into the contract and funded through execution of a bilateral modification. **Performance of the SP shall not commence until a fully executed modification incorporating the SP into the contract has been completed.**

D. Revised Budget

Upon execution of the modification incorporating the SP, the QIO shall submit a revised three (3) year budget via the Financial Information and Vouchering System (FIVS).

E. Order of Precedence for Contract Terms and Conditions

All SP shall comply with the terms and conditions of the contract. In the event of a conflict between the terms and conditions of the SP and the base contract, the terms and conditions of the base contract shall supersede the terms and conditions of the SP.

G.19. ON-SITE VISITS

At any time during the period of performance, the Contracting Officer, and delegated/authorized CMS personnel may conduct an on-site visit to the QIO. These visits may be announced or unannounced. The visits will be conducted during normal working hours of the QIO and will not disrupt the on-going work of the QIO.

G.20. BIENNIAL WAGE DETERMINATIONS

Every two (2) years, calculated from the anniversary date of the contract, the Contracting Officer will obtain revised wage determination rate table from the U.S. Department of Labor. The revised wage determination will be incorporated into the contract as Section J, Attachment 14. The revised wage determination shall be implemented within 45 days of issuance of the modification by CMS.

G.21. FOOD

The purchase of food, including meals and refreshments on this contract is prohibited and is considered an unallowable cost.

SECTION H - SPECIAL CONTRACT REQUIREMENTS

H.1. CONDITIONS FOR PERFORMANCE

In addition to the performance requirements as set forth under Section C, DESCRIPTION/SPECIFICATIONS/WORK STATEMENT, the QIO is required to comply with the requirements of any revisions in legislation or regulations which may be enacted or implemented during the contract term as they are directly applicable to the performance requirements. Such requirements shall become a part of this contract effort only through the Contracting Officer's execution of a modification to the contract. The Contracting Officer shall afford the QIO an opportunity to consult and participate in negotiations which may be necessary to effect the contract modification.

H.2. RESERVED

H.3. PERFORMANCE EVALUATION /MONITORING

During the term of the contract, the Project Officer, in concert with the necessary GTLs and other CMS personnel, will monitor and conduct reviews of the QIO's performance.

H.4. RENEWAL OF A QIO CONTRACT

A. In-State QIO

The contract of a successful QIO that is an In-State organization, as defined in Section 1153(i)(3)of the Social Security Act (the Act), may be renewed for an additional three (3) year term at CMS's discretion.

B. Not In-State

For all QIOs that are not In-State organizations, CMS is required to publish a notice in the Federal Register announcing when the current contract will expire. This notice will be published no later than six (6) months before the expiration date of the contract and will specify the period of time during which any In-State organization may submit a statement of interest to compete for the QIO contract for this state. CMS reserves the right to issue more than one notice provided the notice(s) is not issued after the six (6) month timeframe previously stated.

CMS will determine In-State organization statement of interest submissions and make a determination that the In-State organization is qualified and responsible. In the event that CMS receives one (1) or more statement of interest submissions from organizations that are determined to be In-State, qualified and responsible,

within the published time for response, CMS is prohibited from noncompetitively renewing the contract. CMS will utilize full and open competition procedures to award a new contract.

In the event that CMS does not receive a statement of interest from an In-State organization or if CMS receives a statement of interest from an In-State organization that is determined to be unqualified and not responsible, CMS may noncompetitively renew the contract.

H.5. NON-RENEWAL OF A QIO CONTRACT

In accordance with Section 1153(c)(4) of the Act, if CMS does not intend to renew the contract, the QIO shall be notified in writing at least ninety (90) days prior to the contract expiration date. The QIO shall be given an opportunity to present data, interpretations of data, and other information pertinent to its performance under the contract, which will be reviewed in a timely manner. The QIO will be notified of the final decision by the Contracting Officer. Any determinations of non-renewal of a QIO contract made by the Contracting Officer in accordance with Section 1153(f) shall not be subject to judicial review.

H.6. PERFORMANCE EVALUATION CRITERIA

The evaluation criteria are provided in Section C – Statement of Work. The evaluation criteria will also be published in the *Federal Register*. In accordance with 1153(e)(1) of the Act, neither the evaluation criteria nor the application of the evaluation criteria is subject to the Disputes Clause contained in this contract (FAR 52.233-1, Alt I).

H.7. TERMINATION

A. Contractor Initiated Termination

Pursuant to Section 1153(c)(5) of the Social Security Act, the QIO may terminate this contract upon 90 days written notice to the Contracting Officer.

Within five (5) working days of issuing the notice of termination, the QIO shall contact the Administrative Services Group, Division of Property and Space Management, in order to arrange for the disposal of government acquired property under the terms of the contract.

In accordance with the requirements of this contract, all financial records and supporting documents shall be retained three (3) years by a designated responsible individual of the outgoing contract. The three (3)-year period begins on the date CMS makes final payment to the outgoing QIO. If at the end of the

three (3)-year period, there are any outstanding litigation claims, unsatisfied judgments or unresolved audit issues, all records shall be retained until the completion of the action.

B. Government-Initiated Termination

Notice of Intent to Terminate: Prior to making any termination under Section 1153(c)(6) of the Act, the Contracting Officer will issue a notice of intent to terminate the contract.[1] The Act defines two distinct authorities for termination: 1153(c)(6)(A) and 1153(c)(6)(B). CMS will follow the processes as stipulated in 1153(c)(6) of the Act depending upon which authority is cited as the basis for the termination.

Final Notice of Termination: CMS will issue a final written notice of termination ninety (90) days prior to the effective date of termination unless a shorter period of time is agreed to by the QIO.

H.8. APPROPRIATE USE AND DISCLOSURE OF DATA

For the purposes of this contract, the different types of data and parties are defined as follows:

Data:

CMS Data: the data and/or information that CMS provides to the QIO to enable it to carry out its functions under this contract. CMS data also includes data housed by CMS that has not been released to the QIO.

QIO Data: any data or information collected, acquired or generated by a QIO in the exercise of its duties and functions under Title XI Part B or Title XVIII of the Act. All information maintained by the QIO must me stored in a facility in the United States.

Parties:

Requestor: person or entity that makes a request to the QIO for de-identified data.

QIO: Quality Improvement Organization

[1] During the period after CMS has given notice of intent to terminate a contract, and prior to the time that CMS enters into a contract with another Contractor, CMS may transfer review responsibilities of the organization under the contract being terminated to another QIO, or to an FI or carrier having an agreement under Section 1816 or a contract under Section 1842 of the Act.

SDPS Contractor: Iowa Foundation for Medical Care (IFMC)

A. The QIO shall collect information relevant to its functions, keep and maintain records, and permit access to and use of (including delivery of) any such information and records as the Contracting Officer may require.

B. Data and information that CMS provides to the QIO, or to any subcontractor under this contract, shall be used, duplicated or disclosed only for the purposes of the contract unless the Contracting Officer specifically permits another use in writing.

C. The QIO shall not disclose confidential information to any person, except as allowed in Section 1160 of the Act, 42 CFR 480, and Section H.8.A and H.8.D of this contract. For purposes of this contract, confidential information is defined at 42 CFR 480.101. The QIO shall refer any questions regarding the appropriate release of confidential information to the Contracting Officer.

D. The QIO shall disclose non-confidential information as required in 42 CFR 480.120 and in accordance with the procedures in 42CFR 480.

E. The QIO may have confidential quality review study information de-identified by the SDPS Contractor and release it as non-confidential if the QIO conforms to the following conditions:

1. The QIO must obtain prior written consent from its Project Officer.

2. Upon request by the QIO, the SDPS Contractor shall prepare the de-identified data set. The QIO shall not perform the de-identification. The SDPS Contractor shall provide the de-identified data set to the QIO for release to the requestor. The QIO shall execute the Agreement for Use of Health Care Data.

3. In accordance with 42 CFR 480.104(c), the QIO may charge a fee for this service which shall not exceed the amount necessary to recover the cost to the QIO and the SDPS Contractor for providing the information.

4. The SDPS Contractor may, at the request of the QIO and with the approval of the QIO's Project Officer, link the data with either CMS data or other data provided by the requestor as long as all explicit and implicit identifiers are removed from the data set.

5. The QIO shall maintain a log of all data requests under this Section of the contract. The SDPS Contractor shall maintain a copy of each data set requested.

6. The QIO shall conclude a new Data Use Agreement, prior to data release, if the same researcher requests to use the data set. The QIO shall provide its Project Officer with a copy of the signed agreement no later than ten (10) working days after signature.

7. The QIO shall ensure that the terms and conditions of the Data Use Agreement are met (e.g., data is returned or destroyed in accordance with the terms of the agreement).

F. The QIO may release to a third party, confidential quality review study information that identifies a practitioner or provider with the consent of the practitioner or provider, or at the request of the practitioner or provider.

The QIO may disclose non-confidential information in a publication, subject to the requirements of this Section. "Publication" is defined as any peer-reviewed, referenced, and/or referenced document which a QIO submits on its own behalf to a professional or trade journal and which results from a CMS funded quality improvement activity. The definition also includes abstracts submitted for publication or for presentation at professional meetings (excluding CMS, QIO and/or American Health Quality Association sponsored meetings). "Publication" does not refer to press releases, newsletters, brochures, pamphlets or letters to the editor (with the exception of a letter to the editor that includes CMS data that has not been previously published elsewhere). If the QIO is unsure whether a document falls within the definition of "publication," the Project Officer shall make a determination.

Any manuscript that the QIO submits for publication shall meet all requirements specified in Section 1160 of the Act, 42 CFR 480, and Section 16300 of the QIO Manual. It shall also contain the required disclaimer language as set forth in the QIO Manual at Section 16320B.

The QIO shall submit all manuscripts to the Project Officer for approval prior to publication. The QIO shall follow the approval process contained in Section 16300 of the QIO Manual. Within thirty (30) days after publication, the QIO shall provide a copy of all manuscripts or abstracts, as published to its Project Officer.

The QIO shall continue to comply with the requirements of Section 1160 of the Act, regarding the prohibition against disclosure of information, and other applicable laws, and regulations after termination or non-renewal.

Upon the request of the Contracting Officer or the expiration date of this contract, whichever shall come first, the QIO shall, upon instructions from the Contracting Officer, return, destroy or retain all data given to the contractor by the

Government. If the Contracting Officer directs that the data be retained by the QIO, the time period for retention will be subject to agreement by the QIO. The Contracting Officer has sole discretion to determine whether the data are to be returned, retained, or destroyed. The QIO shall retain no data, copies of data, or part thereof, in any form, when the Contracting Officer directs that the data be returned or destroyed.

H.9. RESERVED

H.10. DIVERSITY FOR QIOs

In promoting the current federal diversity requirements of Title VI of the Civil Rights Act of 1964, QIOs are encouraged to accept and implement the following guidelines:

Recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Define diversity to include demographic variables, including, but not limited to, race, religion, color, gender, national origin, disability, age, education, geographic origin, and professional skills.

Define diversity in staff as being representative of the diverse demographic population of the service area; this includes the leadership of the organization as well as its governing boards, clinicians, and administrative personnel. Staff refers not only to personnel employed by the organization but also its subcontracted and affiliated personnel.

While CMS acknowledges the practical difficulties in achieving full diversity, this standard emphasizes commitment and a good-faith effort rather than specific outcomes. The focus is not on numerical goals or quotas, but rather on the continuing efforts of an organization to design, implement and evaluate strategies for recruiting and retaining a diverse staff as well as continual quality evaluation of improvements in this area.

H.11. ORGANIZATIONAL CONFLICT OF INTEREST

A. Organizational conflict of interest rules that govern QIOs are established in the Social Security Act (SSA); 42 U.S.C. 1320c et seq.; Title 42 of the Code of Federal Regulations Subchapter D; Title 42 of the Code of Federal Regulations Part 421 to the extent made applicable by this contract; and Title 48 of the Code of Federal Regulations Chapter 1, Part 9.

B. It is a prohibited organizational conflict of interest for a QIO to be owned by or affiliated with a Medicare health care facility, or association of facilities, payor organization or health plan, in the QIO area, through management, common control or ownership.

For the purposes of this contract, a Medicare health care facility is defined as an institution that directly provides or supplies health care services for which payment may be made in whole or in part under Title XVIII of the Act. A health care facility may be a hospital, skilled nursing facility, a health care agency, free standing ambulatory surgery center or outpatient facility or any other entity which provides or supplies direct care to Medicare beneficiaries.

For the purposes of this contract, a payor organization means any organization, other than a self-insured employer which makes payments directly or indirectly to health care practitioners or providers whose health care services are reviewed by the organization or would be reviewed by the organization if it entered into a QIO contract. Payor organization also means any organization which is affiliated with an entity which makes payments as described above, by virtue of the organization having more than 20 percent of the members of the governing body who are also governing body members, officers, partners, five percent (5%) or more owners or managing employees in a health maintenance organization or competitive medical plan.

For the purposes of this contract, a health plan means an entity that furnishes or arranges under agreement with contract health care providers for the furnishing of items or services to enrollees, or furnishes insurance coverage for the provision of such items and services, in exchange for a premium or a fee.

For the purposes of this contract, a QIO is considered to be affiliated with a health care facility or association of facilities if more than 20 percent of the members of the governing body of the QIO are also a governing body member, officer, partner, five percent (5%) or more owners or managing employees in a health care facility or association of health care facilities in the QIO area.

C. CMS encourages QIOs to work with health care facilities, payor organizations and health plans cooperatively. This cooperation, even if beyond the scope of the QIO contract, can benefit the general community beyond the Medicare population. QIOs may enter into a contract, agreement or arrangement with health care facilities, payor organizations, health plans or other private or public entities for work relating to individuals who are not Medicare beneficiaries in the QIO's area, even if such work is similar or identical to the work which the QIO performs under its contract with CMS for the Medicare population. In entering any such agreements, however, the QIO should exercise due diligence in order to avoid entering into any contract, agreement, or arrangement that represents

an actual or apparent conflict of interest per QIO program policy and the detailed requirements and specifications of the QIO contract.

D. If a QIO enters into a contract or agreement with a health care facility, payor organization, health plan, or other public or private entity, the QIO shall ensure that CMS does not reimburse it for work that is properly compensable under such other contract or agreement.

E. Thirty (30) days prior to entering into a contract, agreement or arrangement with

1. a health care facility, payor organization and health plan;

2. an organization that manufactures or markets pharmaceuticals or any entity that owns or is owned by such an organization; or,

3. a health information technology (HIT) or electronic clinical information (ECI) systems, software, or support services vendor organization or entity that owns or is owned by such an organization;

4. an organization other than an organization described in E.2. above, a health care facility, payor organizations or health plans where the contract or agreement exceeds the lesser of $100,000 or two percent (2%) of the total CMS contract (excluding fee), the QIO shall disclose to the CMS Contracting Officer and Project Officer:

(a) Dollar value of contract/agreement/arrangement

(b) Parties to the contract/agreement/arrangement

(c) Period of Performance of the contract/agreement/arrangement

(d) Type of work to be performed under the contract/agreement/arrangement

F. Each year within the contract period of performance, the QIO shall provide to the Contracting Officer, or the assigned Contract Specialist, and to the Project Officer, on a quarterly basis, a list of all organizations with which the QIO has a contract, agreement or arrangement outside of the CMS QIO contract. The information identified in E.4(a)-(d) above, shall be provided in this report in a consistent summary format.

None of this information is subject to disclosure under the Freedom of Information Act under any exemption identified at 5 U.S.C. 552.

G. A QIO shall submit the following information with its proposal and shall update the information by February 28th of each contract year.

1. The name of any organization listed below in which the QIO has an ownership interest

   (a) A health care facility or association of facilities;

   (b) A payor organization;

   (c) A health plan or association of health plans;

   (d) A university, college or other educational institution that owns or is associated with a medical school and/or health care facility;

   (e) A pharmaceutical company or manufacturer;

   (f) A laboratory;

   (g) A DME supplier;

   (h) A provider of ambulance or medical transport services;

   (i) A health information technology vendor (including vendors of hardware and/or software and/or support services);

   (j) A corporation, partnership, joint venture or other entity comprised of, affiliated with, reimbursed by or funded by any of the above organizations; or

   (k) Any other entity CMS identifies for disclosure;

2. The type of organization named, i.e., which of the above categories applies to the organization;

3. All sources of income that are not disclosed pursuant to H.11.F. dollar amounts received by the QIO need not be disclosed unless requested by the Contracting Officer; and

4. For each member of the governing body of a QIO

(i) The name of any organization listed in H.11.G.1(a)-(j) above in which the governing body member has an ownership interest, except ownership interests excluded by 42 CFR 411.356(a) and (b), and

(ii) The type of organization named, i.e., which of the above categories applies to the organization.

None of this information is subject to disclosure under the Freedom of Information Act under any exemption identified at 5 U.S.C. 552.

H. The following language shall be included in any and all contracts/agreements or arrangements between the QIO and any health care facility, payor organization or health plan:

□It is acknowledged that this contract/agreement or arrangement between (Name of QIO) and (Name of Entity) is developed outside of the QIO contract with the Centers for Medicare & Medicaid Services. In entering into this contract/agreement or arrangement, the QIO did not abuse its authority as a QIO over the health care facility, payor organization or health plan in an attempt to gain a competitive advantage. If the health care facility, payor organization or health plan believes that such an abuse occurred, it has the right to contact the CMS Contracting Officer directly at (410) 786-1607.

In the event that a determination of abuse is made by CMS, CMS may exercise its contract enforcement provisions, including termination.

I. CMS maintains the right to seek a modification to the requirements contained in H.11 in the event abuses or appearances of conflicts are identified.

J. If CMS determines that a conflict of interest or an appearance of a conflict of interest exists or arises during the term of the contract, it may take any action it deems appropriate, including

1. requiring the QIO to mitigate the conflict or the appearance of a conflict;

2. requiring the QIO to terminate the relationship that creates the conflict or the appearance of a conflict; or

3. terminating the contractual relationship with the QIO.

H.12. CMS-DIRECTED SUBCONTRACTS/SPECIAL PROJECT LEAD QIOS

A. Each QIO is directed to enter into a subcontract or coordinate with QIOSCs and Special Project Lead QIOs for performance of the work under this contract:

CLINICAL DATA ABSTRACTION CENTER (CDAC)
STANDARD DATA PROCESSING SYSTEM (SDPS)
TELECOMMUNICATIONS (PIC-TEL) CONTRACTOR
SPECIAL PROJECT LEAD QIOS/SUPPORT QIOs (TO BE NAMED)
WESTAT

B. QIO Liability

CMS will not hold the QIO responsible for any performance problems/delays attributable to any of the above named subcontractors/Lead QIOs.

If the QIO becomes involved in a suit, action or proceeding pursuant to Section 1157(d) of the Act as a result of a subcontractor action, the QIO may seek relief from the related legal expenses it incurs as a result of the suit, action, or proceeding. To the extent that the QIO's costs are not reimbursed under Section 1157(d), the QIO may seek relief through the Disputes clause contained in this contract.

C. QIO/Subcontractor/Lead QIO Performance Disagreements

1. The QIO shall notify its Project Officer and the Contracting Officer of any performance disagreements between the QIO and the above directed subcontractors/Lead QIOs which cannot be resolved by the parties. Regardless of any performance disagreements, both parties are still contractually bound to continue performance of their contract/subcontract.

2. If a performance disagreement results in the QIO incurring a financial liability, the QIO may request financial relief from the Contracting Officer to the extent allowable under the prime contract with CMS.

H.13. SEVERANCE PAY/TERMINATION COSTS

Within sixty (60) days of the effective date of this contract, each QIO shall submit a copy of its severance plan to the Contracting Officer. The plan must be approved, in writing, by the Contracting Officer prior to reimbursement of severance costs.

CMS will recognize normal severance costs in accordance with OMB Circular A-122 effective June 1, 1998. In the event that the QIO contract is terminated or

not renewed for any reason, the QIO shall not be reimbursed for severance costs paid by the QIO to its employees. Requests for reimbursement of severance (other than normal severance) will be reviewed on a case-by-case basis by the Contracting Officer.

H.14. CHANGES IN CLINICAL SCIENCE

CMS acknowledges that clinical science may change during the course of this contract; and, as such, CMS reserves the right to drop, alter or add indicators. In this event, the contract will be modified accordingly. Any modifications to the contract will be handled in such a way as to hold the QIO harmless to any negative effects of a change in indicator.

H.15. QIO MANUAL CHANGES AND SDPS USER'S GUIDE

CMS maintains a unilateral right to make changes to the QIO Manual and the SDPS User's Guide. Changes to the QIO Manual and SDPS Users' Guide are not subject to contract modification unless such changes affect the SOW or result in a cost impact. If the QIO believes that changes to the Manual or the SDPS Users' Guide have resulted in a change to the SOW and/or a cost impact, the QIO shall immediately provide written notification to the Contracting Officer.

Ongoing changes to these documents will be provided to the QIO through Project Officer and SDPS User's Guide. It is the responsibility of the QIO to perform in accordance with all the incorporated Sections of the QIO Manual. All other portions of the QIO Manual, as updated, are reference material only.

H.16. GENERAL MAILING REQUIREMENTS

The QIO shall submit all contract deliverables, reports, general correspondence...etc, through the process identified in Section F.2.0. Hard copy (non-electronic mail) contract products shall be submitted utilizing the most cost efficient method (e.g., regular mail, 1st class mail, etc.). The QIO shall not submit items such as ongoing monthly reports, annual subcontracting reports, etc., items such as these shall be submitted utilizing the most cost efficient means. QIOs will be required to demonstrate the cost reasonableness of utilizing overnight mail for contract products other than those authorized under Section B.5.C. of the contract.

H.17. DEFINITION OF A QIO AS A LARGE BUSINESS

The Department of Health and Human Services has determined that all non-profit organizations are defined as large businesses for reporting purposes. A sample Subcontracting Plan may be found at www.hhs.gov/osdbu

H.18. HIPAA BUSINESS ASSOCIATE PROVISION

Definitions:

All terms used herein and not otherwise defined shall have the same meaning as in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA,” 42 U.S.C. sec. 1320d) and the corresponding implementing regulations. Provisions governing the Contractor’s duties and obligations under the Privacy Act (including data use agreements) are covered elsewhere in the contract.

"Business Associate" shall mean the Contractor.
"Covered Entity" shall mean CMS’s Medicare fee-for-service program and/or Medicare’s Prescription Drug Discount Care and Transitional Assistance Programs.
"Secretary" shall mean the Secretary of the Department of Health and Human Services or the Secretary’s designee.

Obligations and Activities of Business Associate

(a) Business Associate agrees to not use or disclose Protected Health Information (“PHI”), as defined in 45 C.F.R. § 160.103, created or received by Business Associate from or on behalf of Covered Entity other than as permitted or required by this Contract or as required by law.

(b) Business Associate agrees to use safeguards to prevent use or disclosure of PHI created or received by Business Associate from or on behalf of Covered Entity other than as provided for by this Contract. Furthermore, Business Associate agrees to use appropriate administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information (“EPHI”), as defined in 45 C.F.R. 160.103, it creates, receives, maintains or transmits on behalf of the Covered Entity to prevent use or disclosure of such EPHI.

(c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Contract.

(d) Business Associate agrees to report to Covered Entity any use or disclosure involving PHI it receives/maintains from/on behalf of the Covered Entity that is not provided for by this Contract of which it becomes aware. Furthermore, Business Associate agrees to report to Covered Entity any security incident involving EPHI of which it becomes aware.

(e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, agrees to the

same restrictions and conditions that apply through this Contract to Business Associate with respect to such information. Furthermore, Business Associate agrees to ensure that its agents and subcontractors implement reasonable and appropriate safeguards for the PHI received from or on behalf of the Business Associate.

(f) Business Associate agrees to provide access, at the request of Covered Entity, to PHI received by Business Associate in the course of contract performance, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.

(g) Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 upon request of Covered Entity.

(h) Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity, available to Covered Entity, or to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the various rules implementing the HIPAA.

(i) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

(j) Business Associate agrees to provide to Covered Entity, or an individual identified by the Covered Entity, information collected under this Contract, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Contract, Business Associate may use or disclose PHI on behalf of, or to provide services to, Covered Entity for purposes of the performance of this Contract, if such use or disclosure of PHI would not violate the HIPAA Privacy or Security Rules if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity.

Obligations of Covered Entity

(a) Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

(b) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

(c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Privacy or Security Rules.

Term of Provision

(a) The term of this Provision shall be effective as of the effective date of the contract, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

(b) Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

(1) Provide an opportunity for Business Associate to cure the breach or end the violation consistent with the termination terms of this Contract. Covered Entity may terminate this Contract for default if the Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or

(2) Consistent with the terms of this Contract, terminate this Contract for default if Business Associate has breached a material term of this Contract and cure is not possible; or

(3) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) Effect of Termination.

(1) Except as provided in paragraph (2) of this Section, upon termination of this Contract, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on

behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

(2) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon such notice that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Contract to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

Miscellaneous

(a) A reference in this Contract to a Section in the Rules issued under HIPAA means the section as in effect or as amended.

(b) The Parties agree to take such action as is necessary to amend this Contract from time to time as is necessary for Covered Entity to comply with the requirements of the Rules issued under HIPAA.

(c) The respective rights and obligations of Business Associate under paragraph (c) of the Section entitled “term of Provision” shall survive the termination of this Contract.

(d) Any ambiguity in this Contract shall be resolved to permit Covered Entity to comply with the Rules implemented under HIPAA.

H.19. CAPABILITY ENHANCEMENT PLAN

Based on the performance planning requirements in Section L.8 of this contract, a QIO may be required to submit and conduct a Capability Enhancement Plan (CEP) for one or more Tasks in this contract.

If a CEP is required, the QIO must address how it will improve its performance results in the areas where it failed to meet performance planning requirements and must meet the requirements in Sections 15400-15420 of the QIO Manual, including approval by the Project Officer.

H.20. POST AWARD CONFERENCE

Upon award of contract, CMS may require that the QIO attend a Post Award Conference. Should CMS determine that a Post Award Conference is necessary, the Post Award Conference will be conducted as follows:

Within ten (10) business days after the award of the contract, the QIO shall meet with the Contracting Officer, the Project Officer(s) and other government technical personnel to thoroughly review the requirements of the contract document, contract administration procedures and invoicing requirements. QIO representatives attending the Conference shall consist of a company representative authorized to bind the company, the Program Director responsible for overall contract administration and all Key Personnel. The Conference may be held by telephone or at: DHHS/CMS/OAGM, Division of Quality Contracts, 7500 Security Blvd., 2C-21-15, Baltimore, MD 21244

H.21. TRANSITION FROM INCUMBENT QIO TO SUCCESSOR QIO

A. General

During performance of this contract should termination or non-renewal of an existing QIO's contract occur, CMS may require the successor QIO to provide transition services beginning at the earliest mutually agreeable date. During this period, the incumbent QIO shall work with the new QIO, CMS staff, as well as other identified CMS Contractors to ensure continued operation of the QIO Program.

Prior to commencement of transition, CMS will request a transition plan from the incumbent QIO. The Transition Plan shall provide adequate coverage to ensure uninterrupted service to the QIO Program, be effectively and efficiently administered, and be completed within a reasonable timeframe.

The successor QIO shall cooperate fully with the incumbent QIO, as directed by the Project Officer, to ensure that all services continue without interruption.

B. Contract Phase-Out Services

At the end of this contract, if a determination is made to terminate or not renew the incumbent QIO's contract, the QIO shall provide similar transition/phase-in/ phase-out support to the successor QIO selected by CMS (refer to Federal Acquisition Regulation 52.237-3 Continuity of Services).

C. Transition Plan

At a minimum, the Transition Plan shall provide detailed methods that will be used to ensure a smooth transition from the incumbent QIO's operation to sole operation by the successor QIO. At a minimum, the Transition Plan shall provide for the following:

A milestone chart detailing the time lines and stages of transition from the effective date of contract performance until the QIO assumes sole responsibility for the QIO Program work;

An organizational chart that displays internal and external organizational relationships. The organizational chart shall identify the individuals (at all levels) who will be responsible for the transition and their respective roles; detail the lines of communication and how the QIO will interface with CMS during this phase of contract performance;

Plans to communicate and cooperate with the current incumbent QIO; Transition services will include transfer of Government-Furnished Property (GFP) (e.g., hardware, software, records/data) from the incumbent QIO to the successor QIO, or to CMS or another CMS Contractor. CMS may elect to require the transition of GFP as follows:

a. Prior to procurement of an asset, the QIO shall propose a transition charge to be evaluated and negotiated by the CMS.
b. A successor QIO to this contract, or CMS, will be afforded the opportunity to acquire QIO assets at a reasonable transition charge.
c. All existing assets shall remain installed and usable by CMS through the transition of assets for their replacement by the successor QIO.
d. In the event a decision is made not to procure the assets, the QIO has the responsibility to dispose of the assets as instructed by CMS.

SECTION I - CONTRACT CLAUSES

I.1. FAR 52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this address:

www.arnet.gov/far/fac.html

Clause No.	Title
52.202-1	Definitions (JUL 2004) (See HHSAR352.202-1 Authorized FAR Deviation
52.203-3	Gratuities (APR 1984)
52.203-5	Covenant Against Contingent Fees (APR 1984)
52.203-6	Restrictions on Subcontractor Sales to the Government (JUL 1995)
52.203-7	Anti-Kickback Procedures (JUL 1995)
52.203-8	Cancellation, Rescission, and Recovery of Funds for Illegal or Improper Activity (JAN 1997)
52.203-10	Price or Fee Adjustment for Illegal or improper Activity (JAN 1997)
52.203-12	Limitation on Payments to Influence Certain Federal Transactions (JUN 2003)
52.204-4	Printed or Copied Double-Sided on Recycled Paper (AUG 2000)
52.209-6	Protecting the Governments Interest When Subcontracting with Contractors Debarred, Suspended, or Proposed for Debarment (JANL 2005)
52.215-2	Audit and Records--Negotiation (JUN 1999) -- Alternate II (APR 1998)
52.215-8	Order of Precedence—Uniform Contract Format (OCT 1997)
52.215-10	Price Reduction for Defective Cost or Pricing Data (OCT 1997)
52.215-11	Price Reduction for Defective Cost or Pricing Data--Modifications (OCT 1997)
52.215-12	Subcontractor Cost or Pricing Data (OCT 1997)
52.215-13	Subcontractor Cost or Pricing Data—Modifications (OCT 1997)
52.215-15	Pension Adjustments and Asset Reversions (OCT 2004)
52.215-17	Waiver of Facilities Capital Cost of Money (OCT 1997)
52.215-18	Reversion or Adjustment of Plans for Post Retirement Benefits (PRB) Other than Pensions (OCT 1997)

52.215-21	Requirements for Cost or Pricing Data or Information Other than Cost or Pricing Data--Modifications (OCT 1997) -- Alternate III (OCT 1997)
52.216-7	Allowable Cost and Payment (DEC 2002)
52.216-8	Fixed Fee (MAR 1997)
52.219-8	Utilization of Small Business Concerns (MAY 2004)
52.219-9	Small Business Subcontracting Plan (OCT 2001)— Alternate II (OCT 2001)
52.219-16	Liquidated Damages—Subcontracting Plan (JAN 1999)
52.222-1	Notice to the Government of Labor Disputes (FEB 1997)
52.222-2	Payment for Overtime Premiums - (JUL 1990)
52.222-3	Convict Labor (JUN 2003)
52.222-26	Equal Opportunity (APR 2002)
52.222-35	Equal Opportunity for Special Disabled Veterans, Veterans of the Vietnam Era and Other Eligible Veterans (DEC 2001)
52.222-36	Affirmative Action for Workers with Disabilities (JUN 1998)
52.222-37	Employment Reports on Special Disabled Veterans, Veterans of the Vietnam Era and Other Eligible Veterans (DEC 2001)
52.222-41	Service Contract Act of 1965, As Amended (MAY 1989)
52.223-6	Drug-Free Workplace (MAY 2001)
52.223-14	Toxic Chemical Release Reporting (AUG 2003)
52.224-1	Privacy Act Notification (APR 1984)
52.224-2	Privacy Act (APR 1984)
52.225-13	Restrictions on Certain Foreign Purchases (JAN 2004)
52.226-1	Utilization of Indian Organizations and Indian-Owned Economic Enterprises (JUN 2000)
52.227-3	Patent Indemnity (APR 1984)
52.227-17	Rights in Data – Special Works (JUN 1987)
52.229-10	State of New Mexico Gross Receipts and Compensating Tax (APR 2003)
52.230-2	Cost Accounting Standards (APR 1998)
52.230-3	Disclosure and Consistency of Cost Accounting Practices (APR 1998)
52.230-4	Consistency in Cost Accounting Practices (AUG 1992)
52.230-5	Cost Accounting Standards – Educational Institution (APR 1998)
52.230-6	Administration of Cost Accounting Standards (NOV 1999)
52.232-17	Interest (JUN 1996)
52.232-18	Availability of Funds (APR 1984)
52.232-19	Availability of Funds for the Next Fiscal Year (APR 1984)
52.232-20	Limitation of Cost (APR 1984)
52.232-22	Limitation of Funds (APR 1984)
52.232-23	Assignment of Claims (JAN 1986)
52.232-25	Prompt Payment (OCT 2003)

52.232-33	Payment by Electronic Funds Transfer Central Contractor Registration (OCT 2003)
52.233-1	Disputes (JUL 2002) -- Alternate I (DEC 1991)
52.233-3	Protest After Award (AUG 1996) Alternate I (JUN 1985)
52.237-3	Continuity of Services (JAN 1991)
52.239-1	Privacy or Security Safeguards (AUG 1996)
52.242-1	Notice of Intent to Disallow Costs (APR 1984)
52.242-3	Penalties for Unallowable Costs (MAY 2001)
52.242-4	Certification of Final Indirect Costs (JAN 1997)
52.242-13	Bankruptcy (JUL 1995)
52.243-2	Changes – Cost-Reimbursement (AUG 1987)—Alternate I (APR 1984)
52.244-2	Subcontracts (AUG 1998)
52.244-5	Competition in Subcontracting (DEC 1996)
52.245-1	Property Records (APR 1984)
52.245-5	Government Property (Cost-Reimbursement, Time-and-Material or Labor-Hour Contracts) (MAY 2004)
52.246-25	Limitation of Liability - Services (FEB 1997)
52.248-1	Value Engineering (FEB 2000)
52.249-6	Termination (Cost-Reimbursement) (MAY 2004)
52.249-14	Excusable Delays (APR 1984)
52.251-1	Government Supply Sources (APR 1984)
52.253-1	Computer Generated Forms (JAN 1991)

I.2. HHSAR 352-252-20 DEPARTMENT OF HEALTH AND HUMAN SERVICES ACQUISITION REGULATIONS (HHSAR)

352.202-1 Definitions (JAN 1997)—Authorized FAR Deviation

As prescribed in HHSAR 302.201, FAR 52.202-1 is modified as follows:

Substitute the following as paragraph (a):

"(a) The term "Secretary" or "Head of the Agency" (also called "Agency Head") means the Secretary, Under Secretary, or any Assistant Secretary, Administrator or Commissioner of the Department of Health and Human Services; and the term "his/her duly authorized representative" means any person, persons, or board authorized to act for the Secretary."

Add the following paragraph (h):

"(h) The term "Project Officer" means the person representing the government for the purpose of technical

monitoring of contract performance. The Project Officer is not authorized to issue any instructions or directions which affect any increase or decreases in the scope of work or which would result in the increase or decrease of the cost of this contract or a change in performance period of this contract. In addition, the Project Officer is not authorized to receive or act upon the Contractor's notification of a revised cost estimate pursuant to the Limitation of Cost or Limitation of Funds clause of this contract."

352.228-7	Insurance – Liability to Third Persons (DEC 1991)
352.232-9	Withholding of Contract Payments (APR 1984).
352.233-70	Litigation and Claims (APR 1984)
352.242-71	Final Decisions on Audit Findings (APR 1984)
352.270-4	Pricing of Adjustments (JAN 2001)
352.270-6	Publications and Publicity (JUL 1991)

I.3. FAR 52.215-19 NOTIFICATION OF OWNERSHIP CHANGES (OCT 1997)

(a) The Contractor shall make the following notifications in writing:

(1) When the Contractor becomes aware that a change in its ownership has occurred, or is certain to occur, that could result in changes in the valuation of its capitalized assets in the accounting records, the Contractor shall notify the Administrative Contracting Officer (ACO) within 30 days.

(2) The Contractor shall also notify the ACO within 30 days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership.

(b) The Contractor shall--

(1) Maintain current, accurate, and complete inventory records of assets and their costs;

(2) Provide the ACO or designated representative ready access to the records upon request;

(3) Ensure that all individual and grouped assets, their capitalized values, accumulated depreciation or amortization, and remaining useful lives are identified accurately before and after each of the Contractors ownership changes; and

(4) Retain and continue to maintain depreciation and amortization schedules based on the asset records maintained before each Contractor ownership change.

(c) The Contractor shall include the substance of this clause in all subcontracts under this contract that meet the applicability requirement of FAR 15.408(k).

I.4. FAR 52.222-42 STATEMENT OF EQUIVALENT RATES FOR FEDERAL HIRES. (MAY 1989)

In compliance with the Service Contract Act of 1965, as amended, and the regulations of the Secretary of Labor (29 CFR Part 4), this clause identifies the classes of service employees expected to be employed under the contract and states the wages and fringe benefits payable to each if they were employed by the contracting agency subject to the provisions of 5 U.S.C. 5341 or 5332.

This Statement is for information Only and is not a Wage Determination

Employee Class Monetary Wage-Fringe Benefit (See Attachment J-14)

I.5. SERVICE CONTRACT ACT WAGE DETERMINATIONS

A. Renewal QIO Contracts

This contract is subject to the Service Contract Act. Renewal QIOs are advised that the Contracting Officer will obtain revised wage determination rate tables from the U.S. Department of Labor for incorporation into the 8th Statement of Work contract prior to the date of award. For information and proposal preparation purposes, wage determination rate tables may be viewed on the following website: http://www.wdol.gov

B. Competitive Proposals

The exact place of contract performance for the States of Colorado, Nevada, and Oregon is unknown at the time of issuance of this solicitation. Prior to contract award, the Contracting Officer will obtain the most current wage determination rate tables from the U.S. Department of Labor based upon the place of performance identified by the successful Contractor(s). The wage determination rate tables will be incorporated into the contract as Section J, Attachment J-14. For information and proposal preparation purposes, Offerors submitting competitive proposals may view the wage determination rate tables on the web site provided in item A, above, for proposal preparation purposes.

I.6. FAR 52.244-6 SUBCONTRACTS FOR COMMERCIAL ITEMS (DEC 2004)

(a) *Definitions.* As used in this clause -

Commercial item has the meaning contained in the clause at 52.202-1, Definitions.

Subcontract includes a transfer of commercial items between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial items or non-developmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial items:

(i) 52.219-8, Utilization of Small Business Concerns (OCT 2000) (15 U.S.C. 637(d)(2) and (3)), in all subcontracts that offer further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds $500,000 ($1,000,000 for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(ii) 52.222-26, Equal Opportunity (FEB 1999) (E.O. 11246);

(iii) 52.222-35, Equal Opportunity for Disabled Veterans, Veterans of the Vietnam Era, and Other Eligible Veterans (DEC 2001) (38 U.S.C. 4212(a));

(iv) 52.222-36, Affirmative Action for Workers with Disabilities (JUN 1998) (29 U.S.C. 793); and

(v) 52.247-64, Preference for Privately Owned U.S.-Flagged Commercial Vessels (JUN 2000) (46 U.S.C. Apx.1241) (flow down not required for subcontracts awarded beginning May 1, 1996).

(2) While not required, the Contractor may flow down to subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.

(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

SECTION J- LIST OF ATTACHMENTS

Attachment No.	Description
J-1	Glossary
J-2	Award Fee Plan
J-3	QIO Communication Handbook – External
J-4	Specific QIO Manual Sections
J-5	Data Supplied by CMS
J-6	ERB User's Guide
J-7	RESERVED
J-8	Business Proposal Format
J-8a	Business Proposal Spreadsheet
J-9	Consent to Subcontract
J-10	Provider Satisfaction and Knowledge Survey Subcontract
J-11	HHS Form 565 Report of Accountable Property
J-12	SDPS Site Plan and Inventory
J-13	Data Use Agreement (see *QIO Manual*, Chapter 10 Confidentiality and Disclosure, Exhibit 10-1 Model Data Use Agreement)
J-14	Wage Determination (To be incorporated at the time of award)
J-15	Special Project Concept Process
J-16	List of Major Surgical Procedures for SCIP, IPG Selection