Summary of Changes (9th Scope of Work)

Beneficiary Protection (C.6.1)

Outline of Major Questions (including indicated changes needed to Scope of Work):

Contract changes Warranted:

Question and Page Number	Task	Issue	Comment/Contract Change
HI6, p2	1	Add language for RACs	YES: CC
OR15, p6	1	Prospective review for cataract surgery as a type of review	YES: CC
MO5, p14	2	Eval: 1 QIA for every 50 confirmed quality of care concerns	YES: CC, also affects evaluation
FL101, p24-5 also PR10	8	RHQDAPU Contract Evaluation Criteria THESE ARE NEW TO THE CONTRACT	YES: CC
To further clarify the Theme, CMS has made the following change	2	Health Disparities—Analyze data from all QIAs to identify trends and develop and recommend changes having wide spread implications for quality improvement, **including but not limited to changes impacting health disparities.**	CC (page 33)
MO15	"Other"	Posting of QIO CR information. Conflict in language in scope.	YES: CC, clarified; Will post to individual website.
OGC Comment	8	Task 8.1.a. OGC recommended that the clinical measures listed be revised to be more general in case CMS adopts other measures in addition to those listed in the SOW.	CC.

Patient Safety (C.6.2.)

<u>Changes to the Patient Safety Theme SOW as a result of Q & As</u>.

1) Overview: Minor edits, without changing content or task intent.

2) Background: Minor edits, without changing content or task intent

3) Required Activities (# corresponds to Activity# in initial SOW): Generally clarification and expansion without changes to task intent. References to applicable components and deliverables added.

#1 – "Recruitment":
Extensive edits due to explanation required for "Table A" and Attachment J-17.

#2 – "Analyze…catalogue tools…":
Clarification provided to expand activity description. Language added to address expected standardization of quality improvement interventions. No significant changes to task intent. Incorporates intent of Activities # 9, 10.

#3 – "Administer….HLQAT and other Patient Safety Survey…"
Clarification provided to expand activity description. No significant changes to task intent.

#4 – "Conduct training sessions"
Extensive explanatory comments added to clarify activity. No significant changes to task intent.

#5 – "Persuade … providers and….executives…to participate"
Clarification provided to expand activity description. No significant changes to task intent.

#6 – "Review provider data"
Clarification provided to expand activity description. No significant changes to task intent. Incorporates intent of Activity #13.

#7 – "….convene meeting of key members…"
Clarification provided to expand activity description. No significant changes to task intent.

#8 – "Coordinate local QI community…"
Clarification provided to expand activity description. No significant changes to task intent.

#9 – "Customize tools….."
This Activity was combined with New Activity #2; no significant changes to task intent.

#10 – "Distribute…tools"
This Activity was combined with New Activity #2; no significant changes to task intent.

#11 – “Identify improvement…”
This Activity is now New Activity # 9. Explanatory comments added to further clarify activity; no significant changes to task intent.

#12 – “Instruct provider staff….measures and data collection”
This Activity is now New Activity # 10. Explanatory comments added to further clarify activity; no significant changes to task intent.

#13 – “Review improvement cycle data”
This Activity was combined with New Activity #6; no significant changes to task intent.

#14 – “Review individual provider processes of care”
This Activity was deleted. Uncertain as to intent of activity.

#15 – “Document TeamSTEPPS training… [MRSA]”
This Activity is now New Activity # 11. Explanatory comments added to clarify activity; no significant changes to task intent.

#16 – “Prescription Drug Therapy”
This Activity is now New Activity # 12. Explanatory comments added to clarify evaluation measures and expectations regarding deliverables. No significant changes to task intent.

#17 – “Nursing Homes In Need”
This Activity is now New Activity #13. Explanatory comments added to clarify activity; no significant changes to task intent. Language added to specify that some nursing homes may meet criteria as Special Focus Facilities but some nursing homes (NH) under this component may not. Schedule of the assignment of NH to QIOs needed clarification. Extensive explanation of related evaluation criteria was required including definition of measures. No significant changes to task intent.

Evaluation: This section required extensive edits to clarify definition on activities, measures and outcome expectations.

4) <u>“First Contract Evaluation Criteria”</u> – Deleted this line; “Contract Evaluation” added to include language which provides overall evaluation expectations.

5) <u>“Months 1-6 – Activity Detail Guide”</u> – clarification added that states this is a guide for some measures with reference made to Secn F – Deliverables – for complete schedule, language added to indicate which components are included in that activity, “obtain individual provider data” was deleted as it is an ongoing activity. No significant changes to task intent.

6) "Months 7-12" – Language added to clarify that goals delineated prior tomonth 18 are "guidelines" only. Language added to clarify what the "%" in each cell represented for each measure. No significant changes to task intent.

Measure designations clarified based on input from CDC, information about data source for NH 18 month measures: (minor changes to task intent).

- "MRSA surveillance" measure changed to "reporting" and related interim goals changed.
- "Wound treatment within 24 hours [Pressure Ulcers – NH]" measure changed to "Wound treatment of Identified Pressure Ulcers".
- "Preventative Measures within 24 hours of High Risk Identification [Pressure Ulcers – NH] measure changed to "Preventative Measures for Identified Pressure Ulcers".

7) "Months 13-18" – Language added to include reference to validation and lag time. (minor changes to task intent)

Measure designations clarified as indicated in prior section for Months 7-12.

8) "Second Phase Evaluation" – Deleted this line (inconsistent use of "phase", confusing terminology); "Second Evaluation Period" (Months 19-36)" added to address complete description for all Patient Safety measures included in 28-month evaluation hurdle. Deleted reference to "Activity Detail" at Month 35; this is a deliverable.

- "The grade for each provider will be based on percentage of the re-measurement score relative to the baseline Achievable Benchmarks of Care (ABC) for each measure with 70% as the minimum average passing score for each topic." – This sentence was deleted. Each component will be evaluated based on criteria reflecting goals that are attainable for that measure. (major changes but consistent with task intent)

For SCIP: "70% ABC" is retained. SCIP Inf-7 measure is removed; Heart Failure-3 measure is added.–SCIP/HF now indicates this component.

For the remaining components (Pressure Ulcers, Restraints, MRSA, Drug Safety), reference to evaluation criteria based on ABC is deleted.

For Nursing Homes: Pressure Ulcers, Restraints:

- Pressure Ulcers: goal: 8% relative improvement (based on work done in the 8th SOW)
-
- Physical Restraints: goal: 20% relative improvement (based on work done in the 8th SOW)

For Hospitals: Pressure Ulcers: goal: 8% relative improvement

For MRSA: goal: 40% reduction from baseline for MRSA metrics (at least one infection rate and at least one transmission rate)

9) "Attachment B" is now "Table A"

- "Maximum" numbers updated to reflect new data
- Explanatory language expanded to include:
  - Additional clause that allows for "up to 15%" of the total at QIO discretion
  - Reference to Attachment J-17
  - Direction regarding "substitute" facilities
  - Direction regarding submission of separate list of "closed facilities" or facilities otherwise erroneously listed on Attachment J-17.
  - Additional instruction for states with "0" maximums listed
  - Additional instruction related to MRSA component
  - Criteria used to determine pools for Table A and J-17

Summary of "Activity" Edits to 9th SOW: Patient Safety (02/11/08)

"Old" Activity		"New" Activity – Revised SOW	
#1 – "Recruitment"		No change	
#2 – "Analyze…catalogues tools"		#2 – expanded "tools" to include Old Activities #9, 10 (customize and distribute tools)	
#3 - "HLQAT, Patient Safety Surveys"		No change	
#4 – "Conduct Training Sessions"		No change	
#5 – "Persuade provider, executives"		No change ("Contact providers, executives)	
#6 – "Review Provider Data"		#6 – expanded "data" to include Old Activity #13 (review improvement cycle data)	
#7 – "Meeting of Key members"		No change	
#8 – "Coordinate Local Quality Improvement Community"		No change	
#9 – "Customize tools"		Combined with New Activity #2	
#10 – "Distribute tools"		Combined with New Activity #2	
#11 – "Identify		No change – New Activity #9	

"Old" Activity		"New" Activity – Revised SOW	
improvements"			
#12 – "Instruct provider staff"		No change – New Activity #10	
#13 – "Review improvement cycle data"		Combined with New Activity #6	
#14 – "Review Individual provider processes of care"		Deleted	
#15 – "Document TeamSTEPPS training [MRSA]"		Expanded to clarify MRSA component; New Activity #11	
#16 – "Drug Safety"		No change – New Activity #12	
#17 – "Nursing Homes In Need"		No change – New Activity #13	
		Added New Activity #14 (report on disparities in nursing home population)	

Prevention Core Theme (C.6.3)

Summary of Questions and Changes

1) Overview: Clarification of content and requirements.

2) Background: Many questions pertained to the practice recruitment and eligibility criteria for both Tasks 1 & 2 and role of the QIO for nonparticipating practices.

3) Required Activities:

a) Non-participating Practices (NPs) & Participating Practices (PPs). Questions addressed the alignment of eligibility criteria for NPs and PPs. Additionally, the QIO role in recruitment, monitoring, and assessment of the NPs and PPs was a common concern. Eligibility requirements under new heading "EHR & Other Requirements of Participating Practices"

- Eligibility criteria is the same for NPs & PPs, [primary care practice + using CCHIT-certified EHR + implementing care management for 1 topic + agree to reporting/care management + provide identification info + signed consent form]
- QIOs provide support to nonparticipating practices for patient and summary-level reporting & data feedback. QIOs will not provide NPs with specific education regarding care management for the prevention measures. QIOs shall identify potential NPs, then assist the NPs with reporting, monitoring, and advising CMS on progress with reporting and

care management functionality and providing the NPs with data feedback reports.

b) Data Sources. Clarification of data sources for Tasks 1, 2 & 6.

- Added measures for electronic health records.
- Tasks 1, 2 & 5 PPs & NPs. QIOs will use new CMS Management Information System and CMS templates to report data derived from the practices EHR. By the 18th month, QIOs are required to attain at least 70% of their PPs to report EHR data for the prevention measures.
- Added 28th month criteria based on work with PPs, not statewide.

c) Surveys/information collection. The current OSS in the 8th SOW is not applicable to the 9th SOW. CMS and the QIOs will develop a template to collect eligibility requirements for NPs and PPs and use of care management processes. Task 4 describes the Assessment of Care Process. The QIO is expected to report information on practices to one other CMS contractor that will administer a satisfaction survey to practices.

Appendix (Issues listed in order encountered in revised RFP.

Question	Task	Issue	Proposed Change
IA41, KY10, NJ27 etc	Introduction	References & attachments not included in RFP	Delete references to references
AR6 & 24 other	1	What EHR standards as of when are required for NP/PP eligibility?	EHR must be certified as of October 31, 2008
54 Qs	1&2	What are the eligibility criteria for recruitment of PP & NPs	Listed under Task 1
IA47 & others	1 & 2	Eligibility for RHC & FQHC?	Included in Practice Site description under Task 1
AZ89, CT95, FL79 +	3	QIOs' responsibility for developing EHR vendor-specific & training materials	QIOs will use existing resources. A support contractor will assist in development of any new or revised tools.
CT85, AZ90, 39 Qs	4	Need to consolidate multiple assessments.	One QIO assessment of are practices and one survey conducted by another CMS contractor to measure satisfaction.
DE298 & others	2, 5	Define QIO role with NPs	Expectations defined for QIOs support of NPs under Task 5
AR103	5	Are PPs & NPs required to	Task 5: Expected to

Question	Task	Issue	Proposed Change
		submit EHR data?	report either patient or summary-level
AZ84, DE91, IA38, OH50 +	5	Concerns with support and specifications for EHR data submission (reporting)	Task 5 clarified
AZ91	6	Data support. Clarify data sources	Support contractor or CMS will provide designated data. Support contractor and QIO will provide EHR baseline data.
AR104	7	Need for OSS	OSS is eliminated. QIO and support contractor will develop template or database to collect.
	Evaluation		
IA27, NH26, NJ45 +		Define baseline periods	Baseline periods defined
AZ94 +		Correct formula for RIR	Correction made
		Table 1 not aligned with 28mo evaluation criteria	Table 1 corrected
		28th month criteria missing	Evaluation criteria
IA 42, NH28, OH56, TX91 +		Measure specifications incomplete	Refined measurement specifications. Additional refinements may be forth coming.

Prevention: Disparities (C.7.1.)

Disparities Subtask			
Question	Task	Issue	Proposed Change
		Unnecessary description/explanation of claims data lags/issues, and of DQIP (diabetes quality improvement project)	Changes made to eliminate these references in RFP SOW, pages 64 and 67. They are not relevant to the contract.
AR 122 and others	Task 1	To optimally assess the effectiveness of the DSME programs, actual lab results and clinical data measures results would yield the highest evidence of efficacy.	Language was added to page 65 of RFP SOW: To optimally assess the effectiveness of the DSME programs, actual lab results and clinical data measures results would yield the highest evidence of efficacy. These measures are HbA1c, Lipids, Weight, and BP. It is the intention of CMS to create one additional reporting mechanism to include these measures. CMS will operationalize this through a separate data contractor. Data will flow from the PPs to this contractor. CMS expects that technical support to the practices will be provided by this data contractor, with minimal technical support to the practices from QIOs. Each QIO working in this subtask is required to cooperate with this contractor. CMS will be providing further guidance.
GA 63 and others	Table 2	Is this clinical measures data, or claims data?	Table 2, page 68 and 69 in the RFP SOW was clarified to state recruitment and utilization data, which is claims data, and BP column was clarified to state it is PQRI data.
NM 76		PQRI data versus Medicare FFS Claims data	Page 69 of RFP SOW was clarified to distinguish between PQRI and FFS Claims

Care Transitions (C.7.2.)

Changes to the Patient Pathways/Care Transitions Theme Core SOW as a result of Q's & A's:

Task 1: Community/Provider Recruitment/Selection:

1) Minor edits, without changing content or task intent.

Task 2: Interventions:

1) Minor edits to more clearly state the areas of activity.
2) Clarified the meaning of the three intervention topic areas within the Intervention Plan.
3) Clarified data expectations and provisions.

Task 3: Monitoring and Reports

1) Minor edits and fixed references to Appendices and Deliverables

Task 4: Evaluation of Task Performance

1) Corrected the performance threshold for I-5 to reflect the number of implemented interventions vs. the transitions.
2) Minor edits and clarification to data sources for measures.

<u>Changes Based on OGC Review:</u>

Task 1: Community/Provider Recruitment/Selection:

1) Minor edits, without changing content or task intent, yet adding clarification to terms and intent.

Task 2: Interventions:

1) Minor edits to more clearly state the areas of activity.

Task 3: Monitoring and Reports

1) Minor edits, without changing content or task intent.

Task 4: Evaluation of Task Performance

1) Minor edits, without changing content or task intent.

Table 1: Fixed problem with printed version not revealing the Title of the Table.

Chronic Kidney Disease (C.7.3)

Changes Executed to the Scope of Work

Edits were made in response to RFP questions to increase clarity of language used, with the exception of the changes to page 117. The page 117 changes were made so that a third independent party will administer the provider and partner experience with QIO services survey, not the QIO as originally stated in the RFP.

Page 106 Overview

First Sentence: The goal of the Task is to detect the incidence, decrease the progression of chronic kidney disease (CKD), **and improve care** among Medicare beneficiaries through provider adoption of timely and effective quality of care interventions; participation in quality incentive initiatives; beneficiary education; and key linkages and collaborations for system change at the state and local level.

Page 106 Cost Impact of CKD to Medicare

Line 8 of section: According to the United States Renal Data System (USRDS), the savings to Medicare for each patient who does not progress to dialysis is estimated to be $250,000 per patient ($65,000 annual cost of Medicare **ESRD** services times' four-year life expectancy).

Page 107

Line 2: Patients with any of these conditions, alone or in combination with one another, account for 61.2% of the Medicare population, but they **consume** 80.8% of total expenditures[1].

Line 4: For example, in **hypertensive** persons with diabetes, when all patients were treated with angiotensin converting enzyme (ACE) inhibitors which have been shown to slow the progression of disease by 50%, the cost effectiveness ratio is $7,500 per QALY (Quality-adjusted Life Years) gained.

Second Paragraph:

Quality Intervention Focus for CKD

The focus areas for quality improvement in CKD include:

1. **Annual** testing to detect the rate of kidney failure due to diabetes;
2. Slowing the progression of disease in **hypertensive** individuals with diabetes through the use of ACE inhibitor and/or an angiotensin receptor blocking (ARB) agent; and

Page 108

Task 1.b. Slowing the progression of *kidney* disease in *hypertensive* individuals with diabetes through the use of ACE inhibitor and/or an ARB agent

Page 109

First paragraph of text under Task 1.c., line two.
The overall goal of this clinical focus area is to ensure that Medicare patients receive comprehensive renal replacement therapy (RRT) **counseling** (including discussion of all available treatment options) timely enough to allow sufficient time for AV fistula evaluation, placement where appropriate, and maturation to occur if hemodialysis is the treatment choice for kidney failure.

Page 114

Last sentence under NST note. Deletion: "Trace" urine macroalbumin test results are not considered numerator compliant.

Last line of page 114: Second Evaluation Performance Target: 10% **relative** improvement at the end of the evaluation period (statewide rate).

Page 115
Eleventh line from bottom of page under Task 1.b: Second Evaluation Performance Target: 10% **relative** improvement over baseline (statewide-rate).

Page 117

Provider Experience with Service

As a component of the QIO plan, the QIO shall plan for a survey administered **by an independent entity that** targets providers and partners to determine the effect the QIO interactions had on driving change. The survey will be developed by an independent source. The survey is not an evaluation of satisfaction with the services provided by the QIO; rather, the survey will be aimed at gathering information to determine the impact the QIO activities had on driving quality improvement. An independent third party will be responsible for administering the survey to a random selection of providers and partners, at initiation of the contract, at mid-course review, and near the end of the contract for use in the final evaluation. All participating providers/partners will be included in the survey.

The QIO is responsible for working with the independent entity in the manner specified by CMS. The results of the survey shall be used for IQI by the QIO and for verification by CMS of system change reported by the QIO. Additionally, results will be used in an aggregate manner in the QIO Program level evaluation. Therefore, the QIO is responsible for monthly documentation of system level changes in programs, policies, procedures, and the action(s) that caused system change so that they can be analyzed with intermediate clinical outcomes and longer-term outcomes to strengthen correlation of change with activities.

Section F - CKD Deliverables

Page 122: CKD Deliverable number 63; four weeks was changed to one month for clarification.

Page 124: CKD Deliverable number 72, 73, and 74 is edited to reflect that the survey would be administered by a CMS contractor and the QIO must use the survey for CQI purposes.

Section L.12

Page 248, Theme 7.3: Delete CKD proposal page number information and replace with the following language: A QIO is limited to 15 pages in response to Theme C.7.3 required tasks. In addition, a QIO may submit up to 15 pages of supplemental information (charts, graphs, etc) that provides support for their plan and proposed activities. Please identify the supplemental pages using an index tab. A QIO may submit up to 10 additional pages for each optional task they elect to include in their QIO plan (i.e. up to 30 additional pages if a QIO elects to include all three optional tasks in their Theme C.7.3. CKD proposal).