CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-10 Medicare Quality Improvement Organization	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 27	**Date: July 8, 2016**

SUBJECT: QIO Manual Chapter 12 – "Communications, Outreach, and Program-related Information Activities"

I. SUMMARY OF CHANGES: This revision of the QIO Manual provides general updated language consistent with current program operations and removes outdated operational instructions that the program updates and maintains outside of the QIO Manual.

EFFECTIVE DATE: July 8, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 8, 2016

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Table of Content
D	BENEFICIARY INFORMATION ON MEDICARE RIGHTS
R	12/12100/Authorities
D	12/12110/Beneficiary Helpline
D	12/12115/Beneficiary Complaints
D	12/12120/Interaction with Beneficiary Groups
D	12/12130/Other Activities
D	12/12140/Evaluation
D	PHYSICIANS AND PROVIDERS MEETINGS
R	12/12200/Beneficiary Support and Outreach Activities
R	12/12210/Annual Medical Services Report
N	12/12220/Beneficiary Helpline
D	COORDINATION WITH PAYERS
R	12/12300/Outreach and Information Collection
D	12/12310/ Additional QIO/Carrier Coordination Activities
D	ANNUAL MEDICAL SERVICES REPORT

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
D	12/12400/Background
D	12/12410/Confidentiality Requirements
D	12/12420/Report Requirements
D	12/12430/Publication Requirements
D	12/12440/Distribution Requirements
D	PUBICATION POLICY
D	12/12500/Publications Policy
D	12/12510/Definition
D	12/12520/Requirements
D	12/12530/Disagreements
D	INFORMATION COLLECTION
D	12/12600/Information Collection Policy 212610 - CMS/Office of Clinical Standards and Quality Requirements
D	12/12620/ Statutory and Regulatory Requirements - Paperwork Reduction Act (PRA)
D	12/12630/ Statutory and Regulatory Requirements - Office of Management & Budget (OMB) Role
D	12/12640/ CMS Information Collection Approval Process
D	12/12650/CMS Approval Process - Approval of Proposed Activity -Information Collection Proposal Submission
D	12/12650.01/Regional Office (RO) Endorsement of Proposed Information Collection Intent and Concept
D	12/12650.02/RCO Approval of Request for Exception to OMB Clearance
D	12/12660/ CMS Approval Process - Approval of Actual Activity - Information Collection Justification, Methods, and Instrument Submission
D	12/12660.01/Regional Office (RO) Approval of Information Collection Documents - Justification, Methods, and Instrument
D	12/12670/Additional Considerations When Medicare Beneficiaries Are Respondents
D	EXHIBITS
D	12/ Exhibit 12-1/Information Collection (IC) - Proposal Approval
D	12/Exhibit 12-2/Information Collection (IC) - Activity Approval

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions

regarding continued performance requirements.

IV. ATTACHMENTS:

Manual Instruction

Quality Improvement Organization Manual
Chapter 12 - Communications, Outreach, and Program-related Information Activities

Table of Contents
(*Rev.*27, 07-16)

12100/*Authorities*
(Rev.27, Issued: 07-08-16, Effective: 07-08-16, Implementation: 07-08-16)

This chapter describes the minimum requirements and responsibilities of QIOs for communications and outreach. QIO Program communication, outreach, and information collection activities must comply with the following statutory and regulatory responsibilities as applicable based upon the QIO functions, care settings, types of reviews, and service areas defined by CMS in each QIO contract:

- *Maintain a beneficiary outreach program to apprise providers of healthcare services and individuals receiving care of their rights to QIO case reviews, and of a QIO's obligation for making review determinations as authorized by Section 1154(a)(1) and 1154(a)(4) of the Social Security Act (the Act)*
- *Provide a physician representing a QIO to meet several times a year with medical and administrative staff of hospitals whose services are reviewed by the QIO as required by Section 1154(a)(6)(B)(i) of the Act*
- *Publish and distribute not less often than annually a report that describes the QIO's review findings as required by Section 1154(a)(6)(B)(ii) of the Act*
- *Coordinate activities for economical and efficient operation of the program as required by Section 1154(a)(10) of the Act*
- *Conduct activities deemed necessary for improving the quality of care as required by Section 1154(a)(18) of the Act*
- *Perform communication and outreach activities in accordance with the confidentiality and nondisclosure requirements defined in 42 CFR 480 and sections of the Health Insurance Portability and Accountability Act (HIPAA)*

CMS provides QIO contractors with program guides and handbooks that it routinely updates and revises as the program environment and operations change. The QIO Program Communications Handbook and the QIO Program Brand Guidelines Manual provide QIO Program contractors information regarding communications, outreach, information collection, and development of publications. QIO Program guides also direct QIO contractors to agency and departmental resources such as the CMS Contractor Website Guidelines and federal accessibility standards to comply with Section 504 and Section 508 of the Rehabilitation Act of 1973. CMS expects QIOs to use these guidance documents as a reference for operational questions not addressed in the QIO Manual. The QIO Program Communications Handbook and the QIO Program Brand Guidelines Manual are available to QIO contractors through the CMS-furnished secure Intranet site (secure log in is required).

12200/*Beneficiary Support and Outreach Activities*
(Rev.27, Issued: 07-08-16, Effective: 07-08-16, Implementation: 07-08-16)

QIOs conduct a variety of communications and outreach activities that may include positioning the organization as a resource to the public in support of case review functions and quality of care improvement initiatives, in addition to outreach efforts that support specific contract requirements. CMS contracts require QIOs to maintain a communication plan outlining the specific beneficiary communication and outreach activities it will conduct to educate beneficiaries, providers, and other non-QIO organizations working in the same service area(s) about the QIO Program, the exercise of beneficiary rights, and coordination of quality program activities.

For QIOs that perform case review, the communication plan shall also address planned outreach activities to comply with the statutory responsibility for physician/provider meetings required by Section 1154(a)(6)(B)(i) of the Act and Annual Reports required by Section 1154(a)(6)(B)(ii) of the Act.

12210/*Annual Medical Services Report*
(Rev.27, Issued: 07-08-16, Effective: 07-08-16, Implementation: 07-08-16)

For QIOs that perform case review, the communication plan should provide the means to transparently disseminate the QIO's review findings and comply with the statutory responsibility to publish and distribute not less often than annually, a report that describes a QIO's medical services review findings as required by Section 1154(a)(6)(B)(ii) of the Act.

The QIO Annual Report, subject to prior-approval of the CMS Contracting Officer's Representative, disseminates findings where the QIO has determined that:

- *inappropriate or unnecessary care was provided*
- *services were furnished in inappropriate settings; or*
- *services did not meet professionally recognized standards of care in its service area(s).*

The Annual Report must include statistical data that does not implicitly or explicitly identify any individual patients, practitioners, or reviewers, and must not contain confidential information as defined in 42 CFR 480.101. *The Annual Report must not* report any case-specific or summary statistical information on cases that a QIO referred to the Office of the Inspector General (OIG) or to any other *federal or state* agency responsible for identifying and investigating fraud and abuse.

12220/Beneficiary Helpline
(Rev.27, Issued: 07-08-16, Effective: 07-08-16, Implementation: 07-08-16)

QIOs that perform case review are required to maintain a toll-free helpline, operated according to QIO contract requirements, to handle beneficiary complaints, provide beneficiary support, and coordinate with providers and practitioners. QIOs must publish and promote both their own helpline as well as the national 1-800-MEDICARE helpline for all information related to beneficiary rights and responsibilities, protections, and various programs and activities.

QIOs should provide information regarding Medicare beneficiary rights and responsibilities, beneficiary protections (including Hospital-Issued Notices of Noncoverage [HINNs], *Medicare discharge notices*, discharge planning, and beneficiary complaints), and appropriate health education issues related to active projects. *QIOs should make appropriate referrals when information or assistance inquiries are outside of the assigned scope of QIO activities or responsibilities.*

12300/Outreach and Information Collection

(Rev.27, Issued: 07-08-16, Effective: 07-08-16, Implementation: 07-08-16)

QIOs promote practices that meet professionally recognized standards and *promote improvements in* the quality of health care provided to Medicare beneficiaries. One tactic that QIOs use to accomplish this goal is the implementation of cooperative *quality improvement* projects. As part of such projects, CMS encourages QIOs to develop innovative approaches that include collaborative efforts with the medical community, use of evidence-based interventions to change behavior and improve care, communication with beneficiaries and providers, and monitoring of the health care services furnished to beneficiaries.

The QIO Program Communications Handbook is a resource for guidelines and procedures on outreach and information collection requirements, including compliance with statutory and regulatory responsibilities, to support QIOs in developing and evaluating quality of care and quality improvement interventions. The QIO Program Communications Handbook is available to QIO contractors through the CMS-furnished secure Intranet site (secure log in is required).