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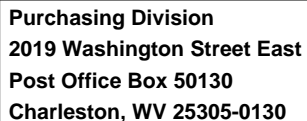
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State of West Virginia Solicitation Response

Solicitation Description : Cardiac Catherization Lab Audit

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WV MEDICAL INSTITUTE INC

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FEIN #

DATE _____

All offers subject to all terms and conditions contained in this solicitation

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
1	GRAND TOTAL FOR YEAR ONE				\$139,147.00

Comm Code	Manufacturer	Specification	Model #
94101610			

Extended Description :	Includes Contract Cost and ACC Data Costs - Year 1

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	GRAND TOTAL FOR YEAR TWO				\$142,071.00

Comm Code	Manufacturer	Specification	Model #
94101610			

Extended Description :	Includes Contract Cost and ACC Data Costs - Year 2 (1st Renewal)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	GRAND TOTAL FOR YEAR THREE				\$145,083.00

Comm Code	Manufacturer	Specification	Model #
94101610			

Extended Description :	Includes Contract Cost and ACC Data Costs - Year 3 (2nd Renewal)

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	GRAND TOTAL FOR YEAR FOUR				\$148,184.00

Comm Code	Manufacturer	Specification	Model #
94101610			

Extended Description :	Includes Contract Cost and ACC Data Costs - Year 4 (3rd Renewal)



CRFQ 0507 HCC1500000001: **Cardiac Catheterization Laboratory** **Auditing and Monitoring Services**

Proposal to West Virginia Health Care Authority

Submitted by:

West Virginia Medical Institute
3001 Chesterfield Ave.
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June 17, 2015



WVMI
West Virginia
Medical Institute

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1.0 Background and Introduction

According to its mission statement, “The Health Care Authority administers programs primarily to constrain the rising cost of health care and to assure reasonable access to necessary and quality health services.” In 2003, the West Virginia Health Care Authority (WVHCA) became concerned with the difficulty West Virginians might encounter getting invasive cardiology services. These are tests and procedures done in a cardiac catheterization laboratory, including coronary angiography and percutaneous cardiac intervention (PCI), which is mechanically opening blocked coronary arteries as well as placing stents to hold them open. At the time, the state had only six facilities doing PCI. They were concentrated in the more populated areas of the state. When three facilities that performed catheterization but not PCI approached the WVHCA seeking state authorization to provide PCI without onsite cardiac surgery (OCS), the agency foresaw an opportunity to improve access to PCI around the state -- if it was safe to do in those hospitals.

There is a growing body of literature supporting the safety and effectiveness of PCI in hospitals without OCS, but national medical groups, including the American College of Cardiology, once counseled against it. There were at least theoretical concerns that patients might have complications requiring immediate surgery to prevent death or serious injury that they could not receive in hospitals without OCS. Studies suggested that doing only non-emergency PCIs could minimize risk. At issue was whether West Virginia community facilities that already did coronary angiography could replicate experience elsewhere, offering PCI with a degree of safety comparable to facilities with OCS.

In September 2003, the WVHCA asked the West Virginia Medical Institute (WVMI) to evaluate the quality and safety of PCI performed in West Virginia facilities without OCS in the three hospitals that wanted to provide the service. WVMI was to devise a means of monitoring quality and safety of services, and to report its findings periodically to the WVHCA.

WVMI conducted a pilot project from 2004 to 2006 for the Health Care Authority, assessing quality and safety of invasive cardiac procedures performed in three pilot hospitals without OCS. Briefly, our charge was to examine data on PCI procedures performed in those facilities, and to compare outcomes with national benchmarks for such procedures in similar patients. To participate, the three hospitals agreed to report their cases individually to a national registry. Our initial findings suggested that there was no increased risk to West Virginia patients having non-emergency PCI in facilities without OCS compared with national outcomes.

Based on the positive results of this project, WVMI has continued to monitor performance of hospital cardiac cath labs by reviewing data submitted to the American College of Cardiology Foundation (ACCF) National Cardiovascular Data Registry (NCDR®) Cath-PCI Registry on each procedure from every participating hospital. This registry contains clinical and demographic data on the majority of patients undergoing coronary angiography or PCI in the United States. From time to time, the ACCF improves the registry, changing the structure and content of the data. Currently, the registry is in Version 4.

In 2006, the WVHCA expanded the project to cover most of the hospitals performing these procedures in the state, including those with OCS. This allowed for comparison among West Virginia facilities and to determine whether there were differences in PCI care between hospitals with and without OCS. In 2010 and 2011, additional facilities joined the project, resulting in a total of seventeen hospitals participating in the surveillance system. At present, nineteen hospitals participate, ten of which perform PCI without OCS, and four of which are currently doing coronary angiography only. The five remaining hospitals do all invasive procedures from elective catheterizations through coronary bypass surgery. The proposed project is a continuation and further expansion of this work.

The program has attracted attention from the American College of Cardiology and has been the subject of presentations at their national meeting (Brehm, JG. W.Virginia State QI Initiatives. NCDR Annual Meeting, March 28, 2008) where the program was described and reviewed for a very interested audience. The ACCF has used the WVHCA-sponsored project as a model for what it hopes will become organized, state-level quality monitoring and improvement activities everywhere there are invasive cardiologic facilities.

WVMI's reports and analyses are protected from legal discovery as peer review data. Facility staff can discuss quality issues with WVMI and other facilities in the context of this project without concern that their conversations can be taken out of context and used against them. Patient safety and quality are both enhanced when quality concerns can be openly discussed, adverse events fully investigated, and trends and patterns of occurrences analyzed. Peer review protection has helped assure that invasive cardiologic facilities in West Virginia can participate in frank discussions that lead to positive change.

WVMI has collected individual level data from facilities participating in the project since 2004. WVMI has used the data to create quality measures, compare West Virginia facility performance on these measures among each other and with relevant national comparison groups, and report de-identified aggregate data on findings to the WVHCA. Because the data to be used originated from the participating facilities, WVMI also has audited a sample of each facility's data for accuracy and reliability. We have provided feedback to the facilities involved, contributing to improved accuracy of reporting.

2.0 Technical Understanding

Under the new Request for Quotation (CRFQ 0507 HCC1500000001, Cardiac Catheterization Laboratory Auditing and Monitoring Services), the WVHCA indicates that it wants to continue and enhance the work begun in 2003. The Authority is seeking ongoing monitoring of PCI and angiography outcomes, auditing of the data underlying the monitoring program, and the provision of confidential feedback to participating hospitals with the intent of driving quality improvement and preventing excess utilization.

As the number of facilities that perform PCI across the state has increased, new concerns have arisen related more to utilization than to quality. Increased PCI access might increase inappropriate utilization, as has frequently occurred with other technologically-intense procedures. Additionally, there is evidence of underutilization of invasive cardiologic services

among women and disadvantaged groups in large, national studies. The situation in West Virginia is not clear. Finally, smaller facilities may lack the appropriate volumes needed to perform PCIs safely and effectively. To address these concerns, and consistent with its mission, the WVHCA is seeking analyses of utilization of invasive cardiology services across the state, as well as trends over time.

In the next section of the proposal, we show that WVMi's qualifications line up tightly against the requirements of the continuing and expanded work that the Authority requires, including increased attention to utilization in addition to monitoring and improving quality and safety. WVMi is a West Virginia company whose mission is improving the health of the people we serve. By assisting the WVHCA in this project, we can advance the mission of both organizations, protecting West Virginians, improving health care quality, improving access, and avoiding inappropriate health care utilization.

3.0 WVMi's Qualifications

WVMi meets all organizational requirements to provide auditing and monitoring services to the WVHCA. Specifically, we are a federally designated Quality Innovation Network-Quality Improvement Organization, and we currently provide services to the WVHCA and to the American College of Cardiology in the areas of monitoring and auditing data. We document and describe these services in Sections 3.1 and 3.2.

WVMi also meets or exceeds all personnel requirements, offering an experienced team of RN chart auditors, physician level experts, data analysts, and program managers ready to continue work on day one of contract award. We provide qualifications for our team in sections 3.3, 3.4 and 3.5.

3.1 QIN-QIO Designation and Quarterly Data Downloads

WVMi d/b/a Quality Insights Quality Innovation Network is one of only 14 Medicare Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) in the country and exclusively provides QIN-QIO services in West Virginia and four other states (PA, DE, NJ and LA). As a QIN-QIO, we collaborate with health care providers, community organizations and Medicare beneficiaries to achieve three high level aims: Healthy People, Healthy Communities; Better Healthcare for Communities; and Better Care at Lower Cost. To that end, we are recruiting providers from all health care settings, convening Learning and Action Networks (LANs) for sharing best practices and spreading innovation, and offering direct technical assistance to health care facilities.

This major project provides organizational experience and resources in data analysis, quality improvement, reporting and evaluation.

Evidence of our QIN-QIO designation is included in **Appendix A, Contract Documents**. **Appendix A** also includes **our agreement with the ACC to receive quarterly data downloads**. This agreement runs through June 30, 2015 and will be extended upon notification

of a new contract award from the WVHCA. We have already negotiated pricing for the extension period.

3.2 Experience Monitoring/Auditing the ACC/NCDR

WVMI offers direct and current experience with both WVHCA and ACC/NCDR data validation. Below, we briefly summarize our work. Documentation for each contract is included in **Appendix A, Contract Documents**.

- **WVHCA Cardiac Catheterization Lab Audit Services project.** Since conducting a pilot study from 2004 to 2006 (and in the most recent contract beginning in 2012), WVMI has served as a quality monitor for the WVHCA, validating cardiology data submitted by participating healthcare facilities across the state of West Virginia. WVMI has developed reports that trend outcomes, identify clusters of adverse events, and correlate audit findings with registry compilations. We have also assisted in providing feedback to participants, asking questions about their results, and helping them improve, when warranted.
- **ACCF National Cardiovascular Data Registry™ Data Validation.** WVMI has assisted the ACCF since 2006 in validating data submitted by hospitals to the National Cardiovascular Data Registry (NCDR) set of registries, by collecting, reporting, and aiding in the interpretation of data collected during such study validations. WVMI's extensive experience in quality improvement, quality indicator measure development, and clinical guideline development means that we understand the power of and need for high quality, systematically collected clinical data to drive improvements in care. This is only possible to the extent that the data in the registries reflect the actual care provided. In addition, WVMI has demonstrated its commitment to the key clinical goal of registries: using the information in them to improve patient care.

3.3 Registered Nurses that Conduct Chart Audits

WVMI offers a team of experienced, licensed RN Chart Auditors ready to begin abstraction and validation on day one. **Table 3.3.1** on the following page lists the team members, their credentials, and experience.

Table 3.3.1: WVMI offers an experienced team of licensed RN chart auditors

Name	Education/ Credentials	Active License (Number)	Experience				Hospital Conflict of Interest?
			Abstraction	WVHCA	ACC	QI	
Emma Dahmer	RN	16481	●	●	●	●	No
Cynthia Thumser	RN, CPHQ	72306-30	●	●	●	●	No
Cathy Browning	RN	24383	●	●	●	●	No
Sharon Miller	MSN, RN	22328	●	●	●	●	No
Kara Garten	RN	47845	●	●	●	●	No
Patti Connelly	RN	25433	●		●	●	No
Teddi Craddock	RN	44202	●		●	●	No

3.4 Physician Level Expertise

In addition to experienced abstractors, staff physicians and consultant physicians are experienced with both quality improvement and the ACC/NCDR cardiac registry data set analysis. We briefly summarize their credentials below and include a curriculum vitae for each in **Appendix B, Physician Curriculum Vitae**.

Sven Berg, MD, Chief Medical Officer. In his current position, Dr. Berg provides clinical oversight and guidance to all WVMI & Quality Insights projects. He is directly responsible for our End Stage Renal Disease (ESRD) Network quality improvement programs in nine states and U.S. territories and oversees our abstraction and validation services, including contracts with the Department of Veterans Affairs and the American College of Cardiology. Dr. Berg offers expertise in quality improvement methodology, implementation and evaluation.

Prior to joining WVMI, Dr. Berg spent his career in the U.S. Air Force, first in clinical practice and then in medical administration, with 14 years of increasingly responsible positions.

Dr. Berg served as Chief Medical Officer for the Air Force's largest and most complex hospital—Wilford Hall Medical Center at Lackland Air Force Base in Texas. In this position he oversaw delivery of over one million outpatient and 25 thousand inpatient encounters annually. His accomplishments included merging the professional and clinical services staff of two major medical centers, launching a physician engagement initiative that boosted productivity by 15% in its first year, and chartering 12 organization-wide lean events to improve efficiency and health care quality and patient safety.

Dr. Berg earned his M.D. from Cornell University Medical College, completed a residency program at Wilford Hall USAF Medical Center and held a fellowship in Pediatric Hematology/Oncology from St. Jude Children's Research Hospital in Memphis, Tennessee. Dr. Berg is a Diplomat of the American Board of Pediatrics, a Fellow of the American Academy of Pediatrics, and a Certified Physician Executive. He is licensed to practice in West Virginia, Texas and Ohio.

Charles Schade, MD, MPH. Dr. Schade has used his expertise in the ACC NCDR cardiac registry data set to guide WVMi's work with the WVHCA. Dating back to the pilot study initiated in 2004, he designed the methodology, the Internal Quality Control process, and oversaw creation of the reports. Overall, Dr. Schade offers more than 40 years of experience in epidemiology, quality improvement methodology, and evaluation. He is a physician epidemiologist and senior health services researcher with experience in public health administration, disease control, and applied epidemiology.

As WVMi's Director of Scientific Support, he designed and implemented large scale collection and analysis of outpatient and hospital quality performance data for the Veterans Health Administration. In addition, he conducted survey and secondary data research to evaluate communications activities, including diabetes, influenza and pneumonia vaccination, and mammography programs.

After earning a BA in mathematics and electrical engineering from Rice University, he obtained a medical degree from the Baylor College of Medicine and a master's degree in public health from the University of Texas. He completed a residency in public health and preventive medicine at Oregon Health Sciences University.

3.5 Project Oversight and Statistical Analysis

Complementing the team of nurse abstractors and physicians are an experienced project director, program manager and senior analyst. The project director, Cynthia Thumser, has overseen large scale abstraction and validation projects for WVMi since 2001. The program manager, Emma Dahmer, and analyst, David Lomely, have been instrumental in informing the approach to the work and assuring quality. We present brief bios for each.

Cynthia Thumser, RN, CPHQ, Project Director. Ms. Thumser offers a wealth of experience managing abstraction and validation projects at WVMi. She has overseen a number of studies for the Department of Defense (DoD), the Veterans Health Administration, and the University of Pennsylvania. For the DoD she led WVMi's efforts to abstract and analyze chart data in fifty-five (55) U.S. military medical treatment facilities (MTF) around the world. More than thirty-one (31) abstractors and other staff members were assigned to the project and its support. She currently provides oversight of registry validation for the American Joint Replacement Registry (AJRR) and the ACCF NCDR. She brings 32 years of management-level experience, of which 25 years have been spent in the area of quality improvement.

Emma Dahmer, RN, Program Manager. Since 2007 Ms. Dahmer has been responsible for managing abstraction and data validation for both the ACC and WVHCA projects. She offers 45 years of health care experience and particular expertise in abstraction, training, and inter-rater reliability. In her 35 year career with WVMI, she has been a nurse specialist, resource nurse, and regional review supervisor. She has abstracted data for WVMI's Veterans Administration External Peer Review Program, Medicare and Medicaid, and performed medical record abstraction and validation in support of WVMI's work with the American College of Cardiology.

David Lomely, Senior Analyst. Mr. Lomely has supported the WVHCA project since 2004 and the ACC NCDR project since 2007. He has been the lead analyst, instrumental in designing the collection process, inter-rater reliability and reports. In his senior analyst role for WVMI, he has helped design and evaluate population-based quality improvement projects as well as descriptive and observational studies about health care quality and effectiveness. In addition, he collaborates with other staff to analyze established programs and develop new ones. Mr. Lomely earned a BS in Physics with a minor in Mathematics from Marshall University.

4.0 Mandatory Requirements - Tasks/Deliverables:

The ultimate purpose of the cardiac catheterization laboratory auditing and monitoring services described in this proposal is to protect the health and safety of West Virginians. That means assuring that these procedures are safe and performed on people who need them.

To help the WVHCA meet these objectives, WVMI aggregates and examines data from each participating hospital. We compare each hospital's performance statistically with a national benchmark obtained from the ACCF, and we compare West Virginia hospitals with one another. The major safety concerns are avoidable complications and deaths. To help determine whether the right patients receive invasive cardiologic services, WVMI looks at their characteristics as determined from the information submitted to the NCDR. People who have cardiac angiography usually have specific symptoms or test results that document the need for the procedure. Those getting PCI may have had recent heart attacks and usually have one or more blocked coronary artery(ies) when they have catheterization.

WVMI expects hospitals' performance to improve, as demonstrated by reduced death rates and fewer complications from cardiac catheterization and PCI, with services targeted to patients who will benefit most from them. This provides the rationale for the work proposed below. In this project WVMI will:

- Receive and analyze PCI and catheterization data for West Virginia hospitals
- Compare hospitals' performance with national benchmarks
- Provide the WVHCA with periodic briefings summarizing hospital performance
- Aid hospital performance improvement by providing feedback and comparison with other hospitals in the state
- Be vigilant for patterns or trends in findings suggesting that patients are receiving inappropriate services or experiencing excessive complications, and report them to the WVHCA

- Intervene with individual hospitals, as directed by the Authority, if such patterns occur.

We describe each of these processes below.

WVMI recognizes that individual hospital performance information is sensitive and can be readily misinterpreted, especially if it involves small numbers of patients. This information, derived from patient medical records, is considered confidential peer review data under West Virginia and federal law. We hold the data securely and use them only for quality improvement and to support the WVHCA's regulatory oversight.

4.1 Quarterly Data Download, Deliverables #1 and #7

Report #1-Quarterly Download Report

Each quarter WVMI will download the data reported in the NCDR Cath Lab Version 4 data set from the ACCF, for each of the 19-22 facilities the Authority designates, provided that the facility reports to the NCDR and submits the required authorization to the ACCF. WVMI will notify the WVHCA of any designated facility that is not reporting to the CathPCI registry or that has not authorized the ACCF to transmit its data to WVMI. A current list of hospitals participating in the project is shown in **Table 4.1.1**.

Table 4.1.1: Nineteen hospitals currently report through the NCDR

Hospitals performing PCI without OCS
Bluefield Regional Medical Center
Cabell Huntington Hospital, Inc.
Camden-Clark Medical Center
Berkeley Medical Center
Raleigh General
Camden Clark Medical Center-St Joseph's Hospital
St. Francis Hospital
United Hospital Center, Inc.
Weirton Medical Center
Thomas Memorial Hospital
Hospitals performing coronary angiography only
Logan General Hospital, LLC
Ohio Valley Medical Center
Reynolds Memorial Hospital
Greenbrier Medical Center
Hospitals performing PCI with OCS backup
Charleston Area Medical Center
Monongalia General Hospital
St. Mary's Medical Center
West Virginia University Hospitals, Inc.
Wheeling Hospital
Additional hospitals
The Health Care Authority may expand this list by up to three (3) additional facilities.

WVMI maintains a database of submission data that spans multiple registry versions. We use the Statistical Analysis System (SAS version 9.3, SAS Institute, Cary, NC) for analyzing the data.

Customized SAS code gives WVMi the ability to analyze data across the different registry versions, creating extended time trends if needed. SAS allows WVMi to create custom reports to investigate issues discovered through standardized quarterly reports.

Facilities that are already collecting and submitting data to the ACCF will not have to undertake additional data collection efforts. New facilities that are not reporting to the NCDR will need to arrange to do so, and authorize release of the data to WVMi.

Each quarter, WVMi will report the identities of hospitals submitting data to the NCDR during the prior quarter. Unless the WVHCA directs otherwise, this will be the only report containing specific hospital identifiers. An example of a report is included in **Appendix C, Example Report**.

WVMi will work with the ACCF to assure timely availability of reports to the WVHCA. Data from the NCDR are generally available in the middle of the second month following the end of the quarter after the reporting period. **Table 4.1.2** presents the schedule for data availability and reporting for the first contract year. Option years are expected to follow a similar schedule.

Table 4.1.2: Working with the ACCF, WVMi reports promptly to the WVHCA

Data Period	Targeted Receipt Date from ACCF	Targeted Delivery Date to WVHCA
January 1 to March 31, 2015	Mid-August 2015	September 2015
April 1 to June 30, 2015	Mid-November 2015	December 2015
July 1 to September 30, 2015	Mid-February 2016	March 2016
October 1 to December 31, 2015	Mid-May 2016	June 2016

As described in Section 4.7, WVMi has already negotiated favorable pricing for quarterly data downloads. WVMi will notify the WVHCA within five (5) business days if it receives notice from the ACCF that a quarter's data will be delayed.

4.2 Data Monitoring and Notification, Deliverable #2

Report #2a-Notification of Significant Patterns or Trends

WVMi will monitor the data to identify potential excess complication rates or unexplained variation in patient characteristics. WVMi has created an approach to monitoring critical NCDR data elements, allowing for both comparison among West Virginia's facilities and comparison to a national database. We currently examine rates of complications and deaths in each facility, looking for trends and variation from national norms. Following are the data elements we will monitor for PCI and for catheterization, where applicable.

- Blood Transfusion
- Composite of Death, Emergency CABG, Stroke, Repeat PCI
- Significant Dissection
- Perforation of a Segment
- Any Serious Adverse Outcome, including
 - Myocardial Infarction
 - Cardiogenic Shock

- Heart Failure
- CVA/Hemorrhagic Stroke
- Tamponade
- New Requirement for Dialysis
- Any Vascular Complication, including
 - Vascular access site injury requiring treatment or major bleeding
 - Other vascular complication requiring diagnosis
 - Bleeding event within 72 hours (gastrointestinal bleeding, retroperitoneal bleeding, bleeding or hematoma at access site, other bleeding)

From the cumulative database, WVMI will calculate changes in occurrence of each of the complications from quarter to quarter. For complications, any significant increase in frequency may be a cause for concern, whether it is a sudden change from a previously acceptable level, or a significant longer term trend. We will assess the former using chi-square statistics, and the latter using linear regression or chi square for trend.

We will use the national benchmarks to test for significant differences between West Virginia facilities' complication rates, and those of comparable national facilities. Our benchmark will be the NCDR National Outcomes Report for the appropriate year. We will compare West Virginia facilities to benchmarks using exact binomial statistics and calculating confidence intervals. We will use a probability standard of 0.05 (corrected for multiple comparisons) to determine significance.

These techniques have proven to be particularly useful in the past. They enabled WVMI to bring an unusual referral pattern between two facilities to the attention of the WVHCA, which asked WVMI to contact the facilities to find out particulars. The answer proved to be a resource allocation decision among facilities in the same city that did not impact quality or appropriateness of care. Trends of death in ST-Elevation Myocardial Infarction (STEMI) cases identified potential concerns related to patient selection for PCI that have since been corrected without evidence of excessive risk to patients due to the procedures.

In addition to procedural complications and deaths, WVMI will monitor demographic and illness severity information and various indicators of utilization and quality. We describe these measures further in this section under Utilization Review and in section 4.4. WVMI will identify trends and patterns and provide a briefing to the WVHCA on a quarterly basis (**Report #4a**). Whenever we detect patterns or trends suggesting a significant quality or safety issue in a facility, we will notify the WVHCA by telephone within 5 days of its discovery (**Report #2a**).

Report #2b - Utilization Review

In prior years, WVMI has reported variation in indicators of utilization to the WVHCA. Some of these measures are intended to detect issues that could affect quality through volume of service, such as the annual number of PCI procedures at each hospital. Others may detect potentially inappropriate procedures, such as the proportion of catheterizations performed in patients with suspected coronary artery disease that have negative results. Measures we propose to use for ongoing surveillance of catheterization and PCI utilization are shown in **Table 4.2.1**.

The proposed measures can give indications of possible utilization issues, but they are generally relative measures that lack established norms. Most of the measures are percentages, representing rates of occurrence in each facility. WVMI will use them to detect unexplained variation among West Virginia facilities and include them in routine reports to the WVHCA. We will calculate statewide mean rates, and test for significant differences between each hospital's and the state average rate.

Two of them represent numbers and not percentages. We will interpret them differently. Fewer than 50 PCI procedures performed on Medicare patients in a year increases the risk of adverse patient outcomes due to low procedure volume.¹ Sudden, significant changes in the numbers of procedures in a facility need investigation. They may represent the impact of the opening or closing of other facilities in the same geographic area. But they may represent changes in the way a facility or its doctors select patients for procedures, including unnecessary repeat procedures or ones done for questionable reasons. We will track these numbers quarterly, and use statistical process control run charting to detect unexpected changes.

Table 4.2.1: Measures that can detect utilization issues

Measure	Utilization issue detected	
	Excess	Low
Percentage of catheterization patients suspected of having coronary artery disease without documented noninvasive testing	●	
Percentage of catheterization patients suspected of having coronary artery disease with negative stress tests	●	
Percentage of catheterization patients suspected of having coronary artery disease who did not have symptoms at the time of the procedure	●	
Percentage of catheterization patients suspected of having coronary artery disease whose angiogram showed no artery with significant disease	●	
Percentage of PCI patients undergoing elective procedures with stable angina or no symptoms	●	
Percentage of PCI undergoing elective procedures whose angiogram showed no artery with significant disease	●	
Total number of PCI procedures	●	●
Total number of catheterization procedures	●	●

We will include reports of utilization measures in quarterly and annual reports (**Reports #4a and 4b**). If WVMI discovers potential utilization issues affecting one or more facilities, we will report them as part of the quarterly briefing (**Report #4a**). The identification of a utilization anomaly does not necessarily mean improper utilization, but it does suggest the need for further inquiry. In the report we will recommend additional steps to investigate and resolve the anomaly. These may include:

- Ongoing surveillance to see if the issue was an isolated anomaly, or to confirm a trend.

¹ Wennberg DE, Lucas FL, Siewers AE, Kellett MA, Malenka DJ. Outcomes of percutaneous coronary interventions performed at centers without and with onsite coronary artery bypass graft surgery. JAMA 2004;292(16):1961-8)

- Sharing the finding with facility quality management staff to learn if the facility has noticed the issue, or if it has an explanation other than inappropriate utilization. WVMi may ask to review facility-collected data in such instances.
- Performing analyses to narrow the investigation. For example, we may suggest looking at measures by physician, or grouped by some other factor. We might ask the WVHCA to provide data from the all payor claims data it operates to compare with hospital registry submissions to confirm registry completeness or to calculate population-based rates of service use.
- Focused audits of data submitted from individual hospitals or physicians.
- Obtaining and reviewing individual cases. This is the most expensive and potentially contentious approach, but may be required if we can find no explanation for a persistent issue that is limited to a single physician or facility.

If the WVHCA notes unusual increases or decreases in PCI or catheterization rates among individual facilities or physicians from all payer claims data or other sources, the Authority may ask WVMi to provide confirmatory information through one or more of the above options. This could occur, for example, if a facility failed to report all cases to the Cath PCI registry, or inadvertently submitted duplicate cases not detected by submission software.

After the WVHCA and WVMi agree on necessary additional steps, WVMi will carry them out promptly. If we do additional analysis or inquiry of the facilities we will report our findings verbally to the WVHCA within 30 days of initiating the inquiry (**Report #2a**). The report will present the explanation of the anomaly or advise steps for further investigation.

In rare instances, audit or case review may be required to identify the causes. WVMi has the capacity to select cases for audit based on targeted criteria, and participating hospitals agree to audit as part of the monitoring program. Conditions suggesting the need to perform a focused audit include discrepancies between numbers of cases reported to the registry and case counts in claims or frequencies of data elements in the registry that are implausible based on known characteristics of the patient population. If a focused audit is necessary, WVMi will perform it as described in section 4.3 below. Unless there is an urgent concern, we will carry it out in conjunction with a routine audit.

Where concerns related to appropriateness of care are limited to a single physician and are not resolved through less intrusive investigations, WVMi will create a panel of physician experts to review cases. We will identify panelists from qualified cardiologists practicing in West Virginia. Using our customized software, we will first create detailed abstracts of the Cath-PCI registry illustrating the utilization issue, for example cases without symptoms or other indications for catheterization.

Report #2c - Review of Panel Findings (if needed)

The identification of a utilization anomaly does not necessarily mean improper utilization. Therefore, in the event a potential anomaly for either facility or physician is identified, WVMi proposes to convene a panel of technical experts, within available project resources. This panel will assist with determining whether the anomaly suggests that further analysis is needed or that

other steps for action are warranted. Panel findings and recommendations will be reported to the HCA for follow up action as necessary.

Routine quarterly and annual reports are described in section 4.4.

4.3 Audit, Deliverable #3

WVMI relies on data that participating hospitals enter into the national Cath-PCI registry to make judgments about the quality and necessity of invasive cardiology services. If those data are inaccurate, conclusions made from them may very likely be incorrect. To protect against this, it is important to audit the data, verifying correctness against the patients' medical records. Audits serve an additional purpose: by focusing providers' attention on consistency of data entry, they also focus attention on achieving consistently high quality care. For services as technically demanding as these, careful documentation is the essential condition for achieving and maintaining quality.

Audit sample

To assess and assure the reliability of the data that facilities submit to the ACCF NCDR, WVMI will audit 13 participating facilities per annum, including the ten facilities that are performing PCI without OCS, and an additional three facilities. The last three will be from those identified as having a potential utilization issue as described in section 4.2 above, or randomly selected from facilities with OCS, or specifically selected by the WVHCA. If new facilities that do PCI without OCS join the project, we will add them to the audit, reducing the number of additional facilities to maintain a total of 13.

WVMI has developed a sampling methodology that utilizes a logistic regression model to identify cases that are more likely to result in complications. This concentrated sample increases the precision of estimates of accuracy of facilities' report registry reporting of complications. We will nominally sample 30 records per facility using this method.

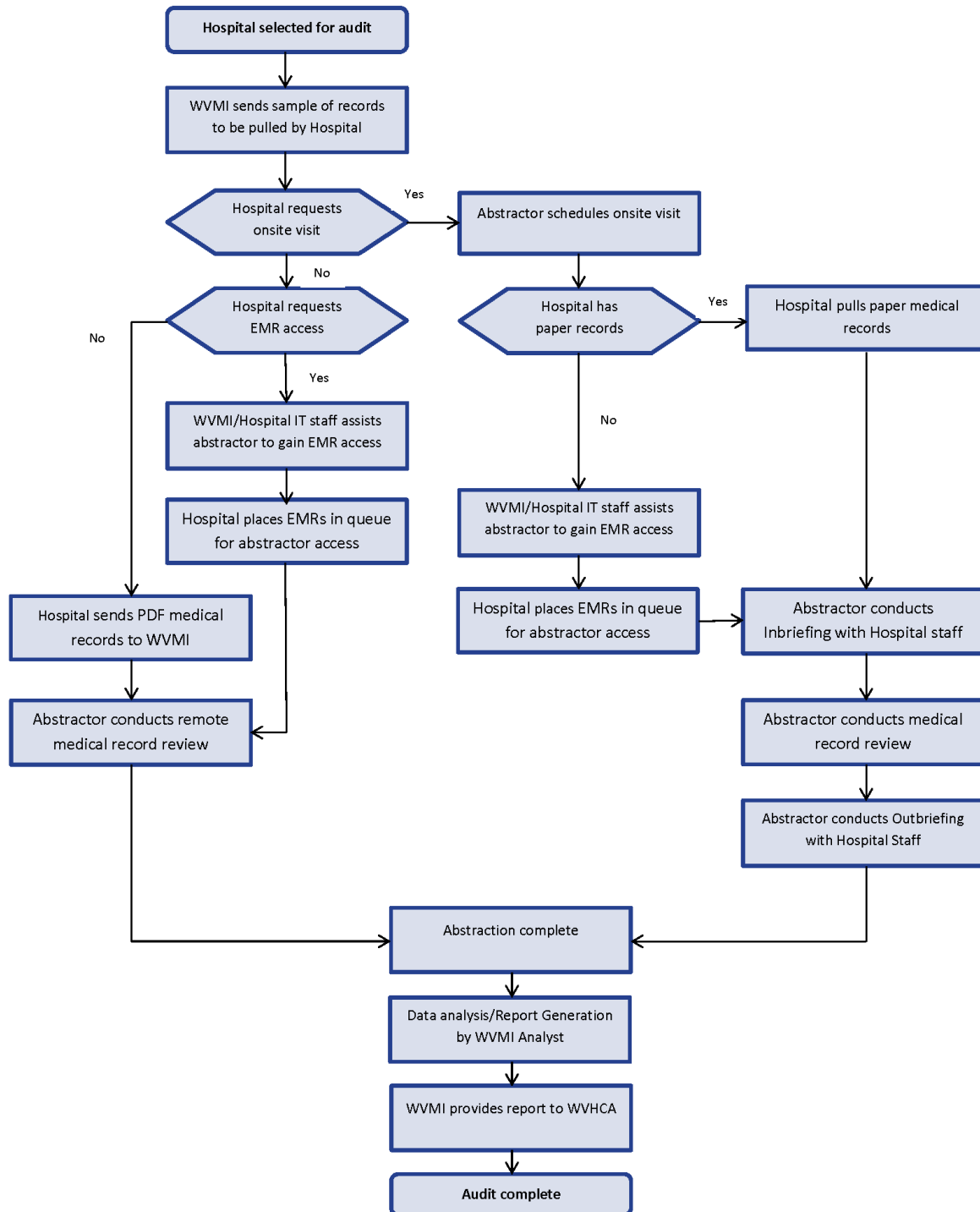
Audit tools

The data elements to be validated will mirror those included in the ACCF NCDR national audit during the applicable year. We will use custom abstraction software developed by WVMI programmers for the ACCF NCDR national audit, which means no startup software development costs or delays in beginning the work. This rigorously tested tool will be immediately available on day one of the contract. In addition, the software is easily customizable. If there are data elements of local concern that are not included in the national audit, the WVHCA may request WVMI to add them.

Audit procedure

Figure 4.3.1 shows the audit process schematically. After we identify hospitals in the audit, we will select a sample of records from the audit timeframe for each hospital. We will use this sample to create a "pull list" containing identifiers of the patients whose records we plan to review. WVMI's project manager will then contact the catheterization laboratory manager to

Figure 4.3.1: WVMI's Audit Process helps ensure timely, accurate data



inform him or her of the audit, its purpose, and the timeframe, and transmit the pull list securely to the facility.

The facility may then choose the least intrusive way to participate in the audit. Over the past several years, most facilities have found it easiest to provide copies of requested medical records in an electronic format or to authorize remote electronic medical record (EMR) access, as opposed to an onsite visit by our medical record reviewers. Nevertheless, as many as seven hospitals have required onsite medical record abstraction for the audit, which is more costly. We will work diligently with hospitals to identify those that have moved from paper medical records to EMR systems, and seek to gain remote access or to obtain electronic copies of medical records to control costs and reduce the burden on participants.

Remote or on site nurse abstractors will review each chosen medical record, entering items critical to the Cath PCI registry into the customized audit software. The abstractor will not be aware of the facility's entries into the registry. When the abstraction is completed, WVMI's audit analysis software will compare the abstractor's response to each data element with the facility's response. The software will produce item level agreement rates (or kappa scores if desired) and an analysis of cases where the abstractor and facility disagree. Finally, WVMI will produce a report of the audit, with recommendations for feedback to facilities and advice about reliability of reports that are based on Cath PCI registry data. This will also include our interpretation of findings of quality and utilization studies.

Audit Personnel

WVMI employs a well-tenured registered nurse abstraction team, led by an RN project manager with deep knowledge of the work and scheduling intricacies related to this project. As noted in section 3, these abstractors also perform the ACCF NCDR national audit. There are few issues related to auditing these records that our staff has not encountered. Nurses assigned to hospitals requiring onsite visits for medical record review are located in the Charleston, WV, area which helps to keep travel expenses at a minimum. And this staff is at the ready to begin the work on day one of the contract.

Report#3 – Audit Report

The audit report is a separate entity from other reports of this project, but it will be delivered with the annual report (See Section 4.4). It consists of quantitative reliability measures for each audited element in each facility, a summary of findings, and recommendations.

4.4 Reporting, Deliverable #4

Report #4a - Quarterly Briefing

Upon completion of the quarterly analysis of the registry data, WVMI will alert the WVHCA if we have discovered potential utilization issues, significant trends or anomalies that require intervention. We will provide details and recommendations for action to the WVHCA on a quarterly basis by telephone. If we have not observed anomalies in the data, we will inform the WVHCA, and be available to respond to questions about the current period's results.

Report #4b - Annual Report

We will make an annual, oral report of findings to the WVHCA in the form of an in person presentation at a time convenient to the WVHCA. The annual report will contain data from the most recently available full year in the NCDR as well as comparisons with prior years. We will add quarterly cumulative reports showing similar data for the individual quarters of a year in progress.

We will include the following elements in the annual report:

- Characteristics of patients receiving invasive cardiologic procedures
- Utilization of the procedures
- Complications and deaths, with comparison to national benchmarks
- Audit findings
- Other topics suggested by routine analysis or emerging from the conference with the hospitals
- Conclusions and recommendations.

Each annual report will include data by facility, with graphs and/or tables showing comparisons among facilities. To preserve the confidentiality of peer review data, WVMI will mask the identities of hospitals in the report. We will report on long term trends of selected measures, showing facilities with significant trends in complications or clusters of complications. We will separate catheterization and PCI cases for reporting complications and utilization. When appropriate, we will separate PCI reporting according to the presence or absence of OCS in the facility.

We will include special topics suggested by the WVHCA or the facilities as time and resources allow. For example, recently, we have analyzed the timing of invasive cardiac procedures, and found little difference in promptness of PCI between hospitals with and without OCS.

WVMI will review its data reporting capability annually, and update report content based on best science, requests from the WVHCA, and feedback from facilities. We will report these changes in conjunction with the annual presentation of summary data.

In making this proposal, WVMI assumes that the ACCF will continue using the NCDR CathLab data format for the duration of the contract. Modifications to the analytic and reporting programs to accept data from a new database version are not included in this proposal.

Report #4c Final Project Report

WVMI will provide a final project report at the end of the final option year. The final project report will contain a summary of WVMI findings over the course of the project including statewide trends and important changes in provision of these services. This report will be in a format mutually agreed upon by WVMI and the WVHCA. It will document the results of surveillance of quality and utilization of invasive cardiologic services in West Virginia over the contract period, and present recommendations resulting from the analyses we reported.

4.5 Peer Review, Deliverable #5

Studies have shown that one important way of improving quality of care in health systems is by providing feedback about performance to professionals involved in patient care. Throughout this project, WVMi has offered feedback to facilities, sometimes informally. Each year, facility representatives have convened to review performance and learn of issues related to invasive cardiology as reflected by statewide data.

WVMi will hold a yearly meeting of representatives from the various cath labs, as a peer-review event, to review global statistics developed under this program and compare individual facilities' findings. This event permits a unique opportunity for individual facilities to review their results compared to state-level peers. It also allows them to share successful strategies for improving quality and outcomes in their facilities. For example, in one recent meeting, a facility presented its novel approach to reducing the time between hospital arrival and PCI in patients having heart attacks. Finally, because we also discuss audit findings at the meeting, it allows facilities with issues related to specific data elements to investigate and report later whether they confirm the findings, and if so, the actions they plan for correction.

Appendix D, Peer Review Event Agendas, shows the agenda of a typical peer review event.

Participating facilities have responded positively to the annual peer review meeting.

Report #5 - Peer Review Report

WVMi will report on the peer review meeting verbally to the WVHCA within one week after its occurrence. In the report, we will describe facilities' responses to the information shared, commitments to further action, and concerns they may voice about the project.

4.6 Data Security, Deliverable #6

Security of the NCDR data and of WVMi data systems that house it is of paramount importance. WVMi will maintain the database downloaded from the ACCF and its analytic products on a secure server that follows Federal Information Security Management Act (FISMA)/ National Institute of Standards and Technology (NIST) security baseline configurations. WVMi has created a structure for individual facility reports, and for blinded results reporting to the WVHCA. As required under multiple governmental contracts and federal and state law, WVMi provides very stringent protection of these sensitive data.

WVMi handles large amounts of health care information. Because of this, we have implemented the privacy and security administrative, physical, and technical safeguards required to protect such information under state and federal law, specifically including the Health Insurance Portability and Accountability Act (HIPAA) as well as the Health Information Technology for Economic and Clinical Health (HITECH) Act. WVMi employs Certified HIPAA Professionals (CHP) and Certified Security Compliance Specialists (CSCS) to ensure industry best practices and regulatory requirements are in place and maintained. These security safeguards include Federal Information Processing Standards (FIPS) 140-2 compliant encryption for data in transit and in storage, need-to-know principle with access control management and monitoring, and the

implementation of NIST 800-53 Rev. 4 security controls. In addition, WVMI adheres to more stringent privacy and security requirements for personal health information promulgated by the Department of Veterans Affairs and Centers for Medicare & Medicaid Services.

WVMI employs a highly skilled software development and analytical team with nearly 20 years of corporate experience creating secure and reliable tools to collect and analyze sensitive health data. This team has extensive and proven industry experience allowing WVMI to apply cutting edge technology to develop technological solutions meeting the requirements and objectives of the contract. WVMI has built similar data collection tools previously for the American College of Cardiology, the University of Pennsylvania, the American Joint Replacement Registry, the Department of Defense, the Department of Veterans Affairs, and Centers for Medicare & Medicaid Services. We will collect, store, and use health data skillfully and securely.

4.7 Data Acquisition Costs

This project relies heavily on the data made available by the ACCF. As described in Section 2 and throughout this proposal, WVMI has a well-established relationship with the ACCF. In anticipation of this contract, WVMI has already negotiated favorable pricing for the quarterly data downloads.

Schedule of Deliverables

Notes:

1. Because some of the items to be reported may contain protected peer review data, WVMI will present the findings to the Health Care Authority orally on its premises at a time convenient to the Authority (items marked “slide presentation”) or verbally by telephone (“by telephone”). WVMI will deliver written reports electronically unless hard copy is requested.
2. The dates below have been approximated since exact dates of quarterly data downloads from ACCF may vary.
3. The dates reflect the contract year. Dates for the option years would be similar.

Table 4.7.1: Deliverable schedule summary

Deliverable Number	Description	How delivered	Due
1	Quarterly Download Report	Written; Telephone	March 15, June 15, September 15, December 15
2a	Notification of Significant Patterns/Trends	Telephone	Within 5 days of noticing
2b	Findings of Utilization Review Report	Telephone	Within 30 days of initiation of analysis
2c	Review Panel Findings Report	Telephone	Within 15 days of recommendation
3	Audit Report	Slide presentation	With Annual Report

Deliverable Number	Description	How delivered	Due
4a	Quarterly Briefing	Telephone	March 15, June 15, September 15, December 15 as needed
4b	Annual Report	Slide presentation	October
4c	Final Project Report	Written summary	July (in year contract expires)
5	Peer Review Report	Telephone	December
6	Data Security Compliance	N/A	Currently in place

RFQ Required Documents

In addition to the project information provided in this technical proposal response, WVMi has completed all required project forms and signatures required in the RFQ. These are included in **Appendix E: Required RFQ Documents**.



RFQ CRFQ 0507 HCC1500000001:

Appendix A: WVMI Contract Documents



WVMI
West Virginia
Medical Institute

ORDER FOR SUPPLIES OR SERVICES						PAGE OF PAGES		
						1	14	
IMPORTANT: Mark all packages and papers with contract and/or order numbers.								
1. DATE OF ORDER 07/18/2014		2. CONTRACT NO. (If any) HHSM-500-2014-QIN003I		6. SHIP TO:				
3. ORDER NO. HHSM-500-TWV01		4. REQUISITION/REFERENCE NO. OCSQ-393-2014-0295		a. NAME OF CONSIGNEE Not Applicable				
5. ISSUING OFFICE (Address correspondence to) [REDACTED]				b. STREET ADDRESS [REDACTED]				
7. TO: [REDACTED]				f. SHIP VIA				
a. NAME OF CONTRACTOR West Virginia Medical Institute, Inc.				8. TYPE OF ORDER				
b. COMPANY NAME				<input type="checkbox"/> a. PURCHASE		<input checked="" type="checkbox"/> b. DELIVERY		
c. STREET ADDRESS 3001 CHESTERFIELD PLACE				REFERENCE YOUR:		Except for billing instructions on the reverse, this delivery order is subject to instructions contained on this side only of this form and is issued subject to the terms and conditions of the above-numbered contract.		
d. CITY CHARLESTON				Please furnish the following on the terms and conditions specified on both sides of this order and on the attached sheet, if any, including delivery as indicated.				
e. STATE WV				f. ZIP CODE 253041126				
9. ACCOUNTING AND APPROPRIATION DATA P-209-14-005152-001				10. REQUISITIONING OFFICE Acquisition Support Group				
11. BUSINESS CLASSIFICATION (Check appropriate box(es))						12. F.O.B. POINT		
<input type="checkbox"/> a. SMALL <input checked="" type="checkbox"/> b. OTHER THAN SMALL <input type="checkbox"/> c. DISADVANTAGED <input type="checkbox"/> d. WOMEN-OWNED <input type="checkbox"/> e. HUBZone <input type="checkbox"/> f. SERVICE-DISABLED <input type="checkbox"/> g. WOMEN-OWNED SMALL BUSINESS (WOSB) ELIGIBLE UNDER THE WOSB PROGRAM <input type="checkbox"/> h. EDWOSB						Destination		
13. PLACE OF		14. GOVERNMENT B/L NO.		15. DELIVER TO F.O.B. POINT ON OR BEFORE (Date) 07/17/2019		16. DISCOUNT TERMS		
a. INSPECTION Destination		b. ACCEPTANCE Destination				Net 30		
17. SCHEDULE (See reverse for Rejections)								
ITEM NO. (a)	SUPPLIES OR SERVICES (b)	QUANTITY ORDERED (c)	UNIT (d)	UNIT PRICE (e)	AMOUNT (f)	QUANTITY ACCEPTED (g)		
	Tax ID Number: 55-0539692 DUNS Number: 084599174 "The purpose of this Task Order award under the QIN-QIO IDIQ Contract is to obtain services for the Tasks for Excellence in Operations in the state of West Virginia." Continued ...							
SEE BILLING INSTRUCTIONS ON REVERSE	18. SHIPPING POINT		19. GROSS SHIPPING WEIGHT		20. INVOICE NO.		17(h) TOTAL (Cont. pages)	
	21. MAIL INVOICE TO:							
	a. NAME DHHS, CMS, OFM, AMG						\$8,245,076.00	
	b. STREET ADDRESS (or P.O. Box) [REDACTED]							
c. CITY [REDACTED]						d. STATE [REDACTED]	e. ZIP CODE [REDACTED]	\$8,245,076.00
22. UNITED STATES OF AMERICA BY (Signature) [REDACTED]				23. NAME (Typed) [REDACTED] TITLE: CONTRACTING/ORDERING OFFICER				

ORDER FOR SUPPLIES OR SERVICES
SCHEDULE - CONTINUATION

PAGE NO

2

IMPORTANT: Mark all packages and papers with contract and/or order numbers.

DATE OF ORDER

CONTRACT NO.

07/18/2014

HHSM-500-2014-QIN003I

ORDER NO.

HHSM-500-TWV01

ITEM NO. (a)	SUPPLIES/SERVICES (b)	QUANTITY ORDERED (c)	UNIT (d)	UNIT PRICE (e)	AMOUNT (f)	QUANTITY ACCEPTED (g)
0001	Req Identifier: P CAN Number: 45990246 Appropriation: 75-4/0519 Object Class: 25235 Component ID: 209 Fiscal Year: 14 Project #: 005152 Sequence #: 001 Period of Performance: 07/18/2014 to 07/17/2019				8,245,076.00	

TOTAL CARRIED FORWARD TO 1ST PAGE (ITEM 17(H))

\$8,245,076.00

**FOURTH AMENDMENT OF AGREEMENT BETWEEN
WEST VIRGINIA MEDICAL INSTITUTE AND THE
AMERICAN COLLEGE OF CARDIOLOGY FOUNDATION**

THIS FOURTH AMENDMENT is made this 9 of January 2013
("Effective Date") between the [REDACTED] a
nonprofit, tax-exempt organization with offices located in Washington, DC and West Virginia
Medical Institute ("WVMI") (collectively "Parties").

RECITALS:

WHEREAS, ACCF and WVMI are parties to an agreement dated October 13, 2005
("Agreement") in connection with the services ACCF is providing to WVMI;

WHEREAS, Parties wish to amend Agreement to add a Statement of Work ("SOW") for
services to be provided by ACCF to WVMI;

NOW, THEREFORE, in consideration of the mutual promises and agreements
hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of
which are hereby acknowledged by the Parties,

IT IS AGREED:

1. The Parties agree that all of the Recitals are true and correct and are hereby incorporated
by reference into this Agreement.
2. Parties agree to add the additional Statement of Work hereto attached as Exhibit I.
WVMI agrees to compensate ACCF as described in Exhibit J.
3. Parties agree to extend the Term of the Agreement until June 30, 2013. WVMI may
exercise to accept the additional two (2) option years by providing ACCF written notice
of such decision by November 30, 2013.
4. All other terms of the Agreement shall remain in force and unchanged.

WITNESS WHEREOF, each of the parties hereto has caused this Fourth Amendment to be
executed by its duly authorized agent.

AMERICAN COLLEGE OF CARDIOLOGY FOUNDATION	WEST VIRGINIA MEDICAL INSTITUTE
By: [REDACTED]	By: <u>Kathleen A. Hensel</u>
Title: [REDACTED]	Title <u>Chief Financial Officer</u>
Date: <u>1/9/13</u>	Date: <u>12-19-12</u>

EXHIBIT I
STATEMENT OF WORK

TASK

Task 1: CathPCI Registry v4 Reporting

Description: [REDACTED] shall provide WVMI with one (1) custom report based on the approved technical requirements document and queries using the v4 data submissions. The custom report shall be for West Virginia. The custom report shall rely on the v4 dataset that shall be updated quarterly with successful and failing completeness status (i.e., green light and yellow light status) received according to the published call for data submission schedule in accord with the DQR process for any and all quarters necessary for the reporting period. The custom report shall include data for all hospitals which have submitted the necessary data release consent forms to [REDACTED] ten (10) business days prior to the report deliverable date and have maintained active participant status for the CathPCI Registry. [Note that additional data release consent forms may be received after this report upload and may be reflected in production deliverable but cannot be guaranteed without consent from WVMI to delay the deliverable.]

Task 2: Data Transfer License

Description: Data Transfer License fee includes data created and distributed to WVMI for NCDR participants on a quarterly, semiannual or annual basis for all or part of the contract year.

Task 3: CathPCI Registry v4 Institutional Outcomes Report All-Hospital Comparison Report

Description: Copy of the NCDR CathPCI Registry v4 Institutional Outcomes Report executive summary and details section with all-hospital comparison data will be provided for the published aggregation corresponding with the fourth quarter of patient discharges will be provided annually.

DELIVERABLES

Task 1 Deliverable: [REDACTED] shall deliver reports on April 23rd, May 28th, August 13th, and November 12th of each year the Agreement is in force. Transfer in the reports of any subsequent modifications to the requirements document is not included in this item.

Task 2 Deliverable: CathPCI Registry v4 Institutional Outcomes Report for the calendar year reporting period executive summary and details section in PDF and Excel format via NCDR file upload service by May 28th for each year the Agreement is in force.

EXHIBIT I
COMPENSATION

YEAR 1 (Base Year): July 1, 2012 – June 30, 2013

Task	Description	Est. Quantity	Price Per	Extended
1	Data Uploads	4	\$500	\$2,000
2	Per Facility Licensing Fee	19-22	\$1,600 per facility	\$30,400 – \$35,200
3	Annual IOR Fee	1	\$2,500	\$2,500
	Project Management	1	\$2,000	\$2,000
TOTAL YEAR 1				\$36,900 – \$41,700

YEAR 2 (Option Year): July 1, 2013 – June 30, 2014

Task	Description	Est. Quantity	Price Per	Extended
1	Data Uploads	4	\$500	\$2,000
2	Per Facility Licensing Fee	19-22	\$1,600 per facility	\$30,400 – \$35,200
3	Annual IOR Fee	1	\$2,500	\$2,500
	Project Management	1	\$2,000	\$2,000
TOTAL YEAR 2				\$36,900 – \$41,700

YEAR 3 (Option Year): July 1, 2014 – June 30, 2015

Task	Description	Est. Quantity	Price Per	Extended
1	Data Uploads	4	\$500	\$2,000
2	Per Facility Licensing Fee	19-22	\$1,600 per facility	\$30,400 – \$35,200
3	Annual IOR Fee	1	\$2,500	\$2,500
	Project Management	1	\$2,000	\$2,000
TOTAL YEAR 3				\$36,900 – \$41,700



Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia Contract

Order Date : 2014-07-17

CORRECT ORDER NUMBER
MUST APPEAR ON ALL PACKAGES,
INVOICES, AND SHIPPING PAPERS.
QUESTIONS CONCERNING THIS
ORDER SHOULD BE DIRECTED TO
THE BUYER.

Order Number : CCT 0507 2770 HCC1500000003	Procurement Folder : 15401
Document Name : WV Medical Institute Inc	Change Order Number:
Document Description: WV Medical Institute Inc	Reason for Modification:
Procurement Type : Central Contract - Fixed Amt	
Buyer Name : Paula Marshall	
Telephone : 3045587000	
Email: pmarshall@hcawv.org	
Shipping Method: Best Way	Effective Start Date : 2014-07-01
Free on Board : FOB Dest, Freight Prepaid	Effective End Date : 2015-06-30

VENDOR	DEPARTMENT CONTACT
WV MEDICAL INSTITUTE INC 3001 CHESTERFIELD PL CHARLESTON WV 25304 US Vendor Contact Phone : 999-999-9999 Extension : Discount Percentage : 0.0000 Discount Days : 30	Requestor Name : Paula Marshall Requestor Phone: 304-348-2236 Requestor Email : pmarshall@hcawv.org

INVOICE TO	SHIP TO
PROCUREMENT OFFICER HEALTH CARE AUTHORITY 100 DEE DR CHARLESTON WV 25311-1692 US	PROCUREMENT OFFICER HEALTH CARE AUTHORITY 100 DEE DR CHARLESTON WV 25311-1692 US

Extended Description :

This is the final renewal (change order #2) of HCC 13001. Effective date of renewal 7-1-14 - 6-30-15. 0 renewals remaining.

VENDOR COPY

PURCHASING DIVISION AUTHORIZATION SIGNED BY : <i>[Signature]</i> DATE : 7/29/14	ATTORNEY GENERAL APPROVAL AS TO FORM SIGNED BY : <i>[Signature]</i> DATE : 7/25/14	ENCUMBRANCE CERTIFICATION SIGNED BY : DATE :
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Line	Commodity Code	Manufacturer	Model No	Delivery Date	Qty	Unit	Unit Price	Total Price
1	94101610				0.00000		\$0.00	\$149,223.00

Description : Professional standards review boards

Extended Description : Cardiac Catherization Lab Audit Services

Total Order Amount :	\$149,223.00
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**MASTER AGREEMENT FOR SERVICES
BETWEEN THE AMERICAN COLLEGE OF CARDIOLOGY
AND WEST VIRGINIA MEDICAL INSTITUTE**

THIS AGREEMENT FOR SERVICES (the "Agreement") is made this 23 day of June, 2014 ("Effective Date") by and between the American College of Cardiology Foundation, a District of Columbia not-for-profit corporation located at 2400 N Street NW Washington, DC ("ACCF") and West Virginia Medical Institute ("Vendor").

WHEREAS, ACCF has developed the National Cardiovascular Data Registry program ("NCDR"), to collect and report on standardized national clinical cardiovascular data in connection with different cardiovascular procedures;

WHEREAS, the NCDR currently operates five hospital based registries: the CathPCI Registry[®], the ICD Registry[™], the IMPACT Registry[®], the CARE Registry[®], and the ACTION Registry[®]-GWTG[™] and also one office based registry: the PINNACLE Registry[®];

WHEREAS, ACCF desires to retain Vendor to provide the services described herein; and

WHEREAS, Vendor has assured ACCF that it is able and willing to provide such services to ACCF, pursuant to the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the foregoing premises and the representations, warranties, covenants and agreements contained in this Agreement, the parties agree as follows:

SECTION 1
SERVICES

1.1 **Description of Service.** Vendor shall supply all labor, services, resources and consultation necessary to perform, and shall perform, the services as described in Statements of Work attached hereto as Exhibit A and as provided to Vendor via amendments executed by both parties to this Agreement and shall develop, create and/or otherwise provide the deliverables described therein (respectively, the "Services" and the "Deliverables"). The Services shall be performed in a manner, sequence and timing so as to coordinate with the work of contractors, suppliers and other Vendors, if applicable, and Vendor agrees to cooperate in good faith with third parties working on ACCF's behalf with respect to the Services and/or Deliverables.

1.2 **Performance Schedule.** Vendor shall commence the Services on the Effective Date and Vendor shall continue to provide Services until December 31, 2016.

1.3 **Reports.** Vendor shall submit a report detailing the Services performed versus the objectives under this Agreement, and progress copies of drawings, reports, specifications and other necessary information, all as applicable, on a monthly basis, or more frequently, as reasonably requested by ACCF.

SECTION 2
CONSIDERATION, INVOICING AND PAYMENT

2.1 **Fees.** ACCF shall provide WVMI with the compensation outlined in Exhibit B for the Services and Deliverables outlined in the Statement of Work, attached as Exhibit A. For additional Statements of Work, each Statement of Work executed via an amendment to this Agreement shall include compensation for Vendor's performance of the Services outlined in such Statement of Work.

2.2 **Payment Terms.** All payments by ACCF to Vendor pursuant to this Agreement and any subsequent Statements of Work are due and payable within thirty (30) calendar days after the receipt by ACCF of an undisputed invoice. Invoices must be rendered in duplicate.

2.3 **Taxes.** ACCF will only pay sales, use or similar state or local taxes in connection with the Services and will not pay any employment taxes or taxes related to Vendor's income. Invoices shall not include any taxes for which ACCF has furnished a valid exemption certificate.

2.4 **Books and Records; Audit.** Vendor shall maintain complete and accurate records to support and document the charges for Services and/or the Deliverables under this Agreement, in accordance with the requirements of this Agreement and otherwise in accordance with generally accepted accounting principles consistently applied with respect to prior periods for the purposes of review and audit. Vendor shall also provide reasonable assistance to ACCF or its designated agent to conduct such review and audit. Any such audit will be conducted upon reasonable notice and during regular business hours, and shall be at ACCF's expense, unless such audit reveals a discrepancy resulting in the disallowance of more than five percent (5%) in the total amount

invoiced by Vendor, in which event Vendor shall pay for, or reimburse ACCF the cost of, the portion of the audit fees applicable to Vendor.

2.5 Disputed Invoice. In the event ACCF shall dispute an invoice submitted by Vendor, it shall notify Vendor in writing within ten (10) business days of receipt. Parties shall promptly discuss the reasons surrounding the dispute. Invoices under dispute shall remain unpaid until the dispute is resolved. Once the dispute is resolved, the invoices shall be payable within thirty (30) calendar days.

SECTION 3 INTELLECTUAL PROPERTY AND CONFIDENTIALITY

3.1 Intellectual Property. Unless otherwise agreed to in writing by the parties, all Deliverables and portions thereof, and all intermediate and partial versions thereof, as well as all artwork, negatives, plates, documentation, program, materials, flow charts, notes, outlines, and the like created in connection therewith, and all formulas, processes, algorithms, ideas, inventions, know how or techniques, and any other information generated by Vendor under this Agreement, and the copyright, patent, trademark, trade secret, and all other proprietary rights therein, and any derivative works created therefrom (collectively, the "Work Product"), shall be the sole and exclusive property of ACCF. Such ownership shall inure to the benefit of ACCF from the date of the conception, creation or fixation of the Work Product in a tangible medium of expression, as applicable. ACCF and Vendor agree that all copyright aspects of the Work Product shall be considered a "work-made-for-hire" within the meaning of the Copyright Act of 1976, as amended. If and to the extent the Work Product, or any part thereof, is found by a court of competent jurisdiction not to be a "work-made-for-hire" within the meaning of the Copyright Act of 1976, as amended, Vendor expressly assigns to ACCF all exclusive right, title and interest in and to the copyright, patent, trademark, trade secret and all other proprietary rights in and to the Work Product without further consideration, free from any claim, lien for balance due or rights or retention thereto on the part of Vendor. With respect to data collection tools, ACCF and Vendor agree that: (1) the data collection software developed by Vendor specifically to perform the Services required by this Agreement shall be treated as a Deliverable and shall become the property of ACCF pursuant to this Section 3.1; (2) Vendor shall provide to ACCF upon request the application specifications, functional requirements and pseudo code related to the data collection software; and (3) all server-based components of the data collection tools used by Vendor, which are on the Vendor's network, and which are used to program the data collection software or distribute pull lists to abstractors, are not Deliverables or Work Product and shall not become the property of ACCF pursuant to this Section 3.1 or any other provision of this Agreement. ACCF and Vendor agree that such sever-based components of the data collection tools used by Vendor were developed by Vendor prior to and independent of this Agreement, are proprietary to Vendor, and are and shall remain the sole and exclusive property of Vendor, together with all ownership rights and interests therein.

3.2 Confidentiality. For the purposes of this Agreement, "Confidential Information" means any software, material, data or business, financial, operational, customer, vendor and other information disclosed by one party to the other and not generally known by or disclosed to the public or known to the receiving party solely by reason of the negotiation or performance of this Agreement, and shall include, without limitation, the terms of this Agreement. Each party shall maintain all of the other party's Confidential Information in strict confidence and will protect such information with the same degree of care that such party exercises with its own Confidential Information, but in no event less than a reasonable degree of care. Except as provided in this Agreement, a party shall not use or disclose any Confidential Information of the other party in any manner without the express prior written consent of such party. Access to and use of any Confidential Information shall be restricted to those employees and persons within a party's organization with known discretion and with a need to use the information to perform such party's obligations under this Agreement. A party's consultants and subcontractors may be included within the meaning of "persons within a party's organization," provided that such consultants and subcontractors have executed a non-disclosure or confidentiality agreement with provisions no less stringent than those applicable to such party under this Agreement, and such party shall make such signed agreements available to the other party upon request. Notwithstanding anything herein to the contrary, Confidential Information shall not include information that is: (a) already known to or otherwise in the possession of a party at the time of receipt from the other party and that was not known or received as the result of violation of any obligation of confidentiality; (b) publicly available or otherwise in the public domain prior to disclosure by a party; (c) rightfully obtained by a party from any third party having a right to disclose such information without restriction and without breach of any confidentiality obligation by such third party; (d) developed by a party independent of any disclosure hereunder, as evidenced by written records; or (e) disclosed pursuant to the order of a court or administrative body of competent jurisdiction or a government agency, provided that the party receiving such order shall notify the other prior to such disclosure and shall cooperate with the other party in the event such party elects to legally contest, request confidential treatment, or otherwise avoid such disclosure.

3.3 Return of Confidential Information. All of a party's Confidential Information disclosed to the other party, and all copies thereof, shall be and remain the property of the disclosing party. All such Confidential Information and any and all copies and reproductions thereof shall, upon the expiration or termination of this Agreement for any reason, or within fifteen (15) days of written request by the disclosing party, be promptly returned to it, or destroyed, at the disclosing party's direction. In the event of such requested destruction, the party receiving such request shall provide to the other party written certification of compliance therewith within fifteen (15) days of such written request.

SECTION 4 REPRESENTATIONS, WARRANTIES AND COVENANTS

4.1 Service and Performance Warranty. Vendor represents, warrants, and covenants that it shall perform all Services hereunder in a timely, competent and workmanlike manner and that all Deliverables will be performed in accordance with the applicable documentation, functional specifications, and/or requirements, as applicable. Vendor agrees and acknowledges that ACCF will be relying on the accuracy, competence and completeness of the Services in utilizing the Deliverables and the result of such Services.

4.2 Pass-Through Warranty. If applicable, Vendor shall "pass through" to ACCF any product and third party end-user warranties and indemnities. To the extent Vendor is not permitted to so pass-through, Vendor agrees to enforce such warranties and indemnities on behalf of ACCF.

4.3 Warranty of Title. Vendor represents, warrants, and covenants that it has and shall maintain full authority to license and/or sublicense the Deliverables and other items provided to ACCF hereunder.

4.4 Intellectual Property Warranty. Vendor represents, warrants and covenants that the Services and Deliverables do not and will not infringe upon and are free from any claim by any third party of infringement of any patent, trademark, copyright, trade secret or any other proprietary right of any third party.

4.5 Mutual Warranties. Each party represents and warrants to the other that: (a) it is organized and validly existing under the laws of the state of its incorporation and has full corporate power and authority to enter into this Agreement and to carry out the provisions hereof; (b) it is duly authorized to execute and deliver this Agreement and to perform its obligations hereunder; (c) this Agreement is a legal and valid obligation binding upon it and enforceable according to its terms; and (d) the execution, delivery and performance of this Agreement by such party does not conflict with any agreement, instrument or understanding, oral or written, to which it is a party or by which it may be bound.

4.6 Compliance with Laws. Vendor represents, warrants and covenants that the Services and Deliverables are and will be provided in compliance with the requirements of all applicable federal, state and local laws, ordinances, regulations and codes, including procurement of required permits (if any) in the performance of this Agreement. Vendor specifically recognizes that the data sets and the development of a Deliverable will be governed by the Subcontractor Business Associate Agreement attached hereto as Attachment A and the Data Use Agreement hereto attached as Attachment B.

SECTION 5 TERM, TERMINATION AND REMEDIES

5.1 Term. This Agreement shall commence as of the Effective Date and shall terminate December 31, 2016 or until terminated pursuant to the provisions of this Section 5, whichever is earlier.

5.2 Termination. Either party shall have the right to terminate this Agreement, without cause, at any time upon ninety (90) days advance written notice to the other party. Such termination will not affect ACCF's or Vendor's rights or obligations for any Services or Deliverables accepted by ACCF prior to the effective date of such notice.

5.3 Termination for Default. In the event either party breaches any material provision of this Agreement, the non-breaching party may terminate this Agreement without penalty upon thirty (30) days advance written notice to the other party, provided such breach is not cured within such thirty (30) day period. Notwithstanding anything herein to the contrary, Vendor agrees and acknowledges that a good faith dispute regarding payment of monies owed shall not be deemed to be a breach of this Agreement.

5.4 Equitable Relief. Notwithstanding anything in this Agreement to the contrary, where a breach of certain provisions of this Agreement may cause either party irreparable injury or may be inadequately compensable in monetary damages, either party will be entitled to seek and to obtain injunctive relief, specific performance and/or other equitable relief against the breach or threatened breach of those provisions of this Agreement which give rise to such irreparable injury and/or are non-compensable by monetary damages, in addition to any other remedies which may be available.

5.5 Remedies Not Exclusive. Notwithstanding any other provision to the contrary in this Agreement, all remedies available to either party under this Agreement are cumulative and may be exercised concurrently or separately; the exercise of any one remedy will not be deemed an election of such remedy to the exclusion of other remedies; and the rights and remedies of the parties as set forth in this Agreement are not exclusive and are in addition to any other rights and remedies available to it at law or in equity.

5.6 Limitation of Liability. IN NO EVENT SHALL ACCF'S OR VENDOR'S AGGREGATE LIABILITY HEREUNDER, BASED ON ANY THEORY OF LIABILITY OR CAUSE OF ACTION, EXCEED THE TOTAL AMOUNT OF FEES PAID BY ACCF TO VENDOR UNDER THIS AGREEMENT DURING THE TWELVE (12) MONTHS PRIOR TO THE EVENT GIVING RISE TO SUCH CAUSE OF ACTION. NOTWITHSTANDING ANYTHING IN THIS AGREEMENT TO THE CONTRARY, IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR ANY INDIRECT, SPECIAL OR CONSEQUENTIAL DAMAGES, INCLUDING BUT NOT LIMITED TO LOST PROFITS, SAVINGS OR REVENUE, EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

SECTION 6 INDEMNITY

6.1 Proprietary Rights and Use Indemnity. Vendor agrees to indemnify, defend and hold harmless ACCF, its officers, directors, employees, agents and representatives from and against all costs, damages, expenses, and liabilities, including reasonable attorneys' fees, arising out of all claims of any nature or kind brought against ACCF, or ACCF customers or members, based on any claim that the Deliverables or any portion thereof, or any use by ACCF or its customers or members of the Deliverables or portion thereof, infringes or misappropriates any patent, copyright, trademark or other proprietary right of any third party. ACCF agrees to notify Vendor promptly in writing and to cooperate with Vendor, at Vendor's expense, by providing such information and assistance as is reasonably necessary and appropriate for the handling of the defense of such claim. If the use of any Deliverables or portion thereof is enjoined by reason of such an infringement, Vendor shall procure at its own expense the right for ACCF to continue using such Deliverables or portion thereof, or Vendor agrees to modify or replace the enjoined items with equivalent or better items so they become non-infringing without adversely altering their functionality, or if neither of these options is reasonably available, Vendor shall refund the amount paid by ACCF for the infringing Deliverables or portion thereof, together with damages incurred by ACCF to cover. Vendor shall provide ACCF an opportunity to participate in the settlement of any such claim, and any such settlement shall require ACCF's approval to be entered into, such approval not to be unreasonably withheld.

6.2 General Indemnity. Each party ("Indemnitor") agrees to indemnify, hold harmless and defend the other party ("Indemnitee"), including its officers, directors, employees, agents and representatives, from and against any claim, demand, cause of action, loss, expense or liability, including reasonable attorney's fees, which may arise, in whole or in part, out of (i) the negligence or willful misconduct of the Indemnitor, its officers, directors, employees, agents or representatives, or (ii) a breach by the Indemnitor of its obligations under this Agreement. Nothing contained herein shall be construed as prohibiting either party and its officers, agents or employees from retaining their own legal counsel, at such party's own expense.

SECTION 7 INSURANCE

7.1 Insurance. Vendor agrees to procure and maintain during the term of this Agreement policies of insurance with insurance companies having a rating of at least A VII or better in the current Best's Insurance Reports published by A.M. Best Company and adequate to fully protect Vendor as well as ACCF from and against all expenses, claims, actions, liabilities and losses related to the subjects covered by the following policies of insurance:

(a) Worker's Compensation insurance covering all costs, benefits and liabilities under Workers Compensation and similar laws which may accrue in favor of any person employed by Vendor for all states in which Vendor operates, and Employer's Liability insurance with limits of liability of at least \$500,000.00 per accident or disease and \$500,000.00 aggregate. Such insurance shall contain a waiver of subrogation in favor of ACCF. Limits of liability requirements for Employer's Liability may be satisfied by a combination of Employer's Liability and Umbrella Excess Liability Policies.

(b) Commercial General Liability insurance, including but not limited to, premises/operations liability, contractual liability, personal and advertising injury liability, and products and completed operations liability, with limits of at least \$1,000,000.00 for bodily injury and property damage combined. Limits of liability requirements may be satisfied by a combination of Commercial General Liability and Umbrella Excess Liability policies.

7.2 Certificates of Insurance. ACCF shall be listed on all insurance policies required herein as an "additional insured." Vendor's policies of insurance shall expressly provide that they shall not be subject to material change or cancellation without at least thirty (30) days' prior written notice to ACCF. Vendor shall furnish ACCF with certificates of insurance or, at ACCF's request, copies of policies, prior to execution of this Agreement and upon each policy renewal during the term of this Agreement. If Vendor does not provide ACCF with such certificates of insurance or Vendor's policies of insurance expire or are cancelled during the term of this Agreement or are materially modified, ACCF will so advise Vendor, and if Vendor does not furnish evidence of acceptable coverage within fifteen (15) days, ACCF shall have the right, in its sole discretion, to (i) withhold payments from Vendor until evidence of such acceptable coverage is provided, or (ii) immediately terminate this Agreement upon written notice to Vendor.

7.3 No Limitation. Failure to obtain and maintain required insurance shall not relieve Vendor of any obligation contained in this Agreement. Additionally, any approval by ACCF of any of Vendor's insurance policies shall not relieve Vendor of any obligation contained in this Agreement, including liability for claims in excess of described limits. Nothing herein is intended to imply that Vendor's liability to ACCF is limited to the amount of insurance carried by Vendor.

SECTION 8 MISCELLANEOUS

8.1 Use of Name; Publicity. Vendor shall not use the word or symbol trade marks or service marks or, without prior written approval of ACCF, make any reference to ACCF or its member plans in its advertising, letterhead, symbol or logo, or in any other manner, including press.

8.2 Code of Business Conduct. ACCF prohibits its employees and contractors from engaging in conduct detrimental to ACCF. Such conduct includes conflict of interest, gifts or gratuities, kickbacks, entertainment, improper payments, and failure to keep information confidential. Vendor agrees that neither it nor any of its employees, representatives or agents will engage in any such prohibited conduct.

8.3 Notices. Any notice, request, or other communication to be given in writing under this Agreement will be deemed to have been given by either party to the other party upon the date of receipt, if hand delivered, or four (4) business days after deposit in the U.S. mail, if mailed to the other party by registered or certified mail, properly addressed, postage prepaid, return receipt requested, or one (1) business day after deposit with a national overnight courier for next business day delivery, or upon the date of electronic confirmation of receipt of a facsimile transmission, when followed by the original copy mailed to the applicable addresses listed in the Contact Information Sheet hereto attached as Exhibit C. Either party may change its address by a notice given to the other party in the manner set forth herein.

8.4 Assignment. This Agreement, including without limitation, any of the duties and obligations hereunder, may not be delegated or assigned, in whole or in part, by Vendor without the prior written consent of ACCF. The provisions of this Agreement are binding upon and inure to the benefit of the parties hereto and their respective permitted successors and assigns. ACCF may assign this Agreement to a parent or subsidiary organization upon written notice to Vendor.

8.5 Amendments and Modifications. No addition to or change in the terms of this Agreement, its Exhibits or Attachments will be effective or binding on either of the parties unless reduced to writing and executed by the respective duly authorized representative of each of the parties.

8.6 Independent Contractor. Vendor's status in all matters pursuant to this Agreement shall be that of an independent contractor. The parties agree that Vendor is an independent contractor and not an agent of ACCF. Personnel supplied by Vendor are not employees or agents of ACCF. Vendor will be solely responsible for the payment of compensation, workers compensation, unemployment insurance and for withholding or paying employment related taxes to its employees, agents, representatives and subcontractors assigned to render services under this Agreement. Vendor may not directly or indirectly represent or imply in any way that Vendor is an employee of ACCF. Vendor is not eligible for ACCF employee benefits or any other considerations of ACCF employment, nor is Vendor allowed to use ACCF's letterhead, business cards, trademarks, or other forms of ACCF identification. Vendor is not entitled to privileges, services, facilities, and benefits which are available to ACCF employees, such as the following:

(a) Benefits: because Vendor is engaged in Vendor's own business, Vendor is not eligible for, and shall not participate in any company-provided benefit of ACCF employees such as pension; health, disability or Workers' Compensation insurance; paid holiday; vacation; sick leave; ACCF-sponsored functions and activities; and the like.

(b) Facilities, Materials, and Support Services: Vendor shall supply, at Vendor's expense, all facilities and materials needed to accomplish the work to be performed, such as office space, furnishings and machines, support staff, stationery, telecommunications, mail, office supplies, credit cards, and support services.

(c) Insurance: Vendor is liable for providing all necessary and adequate insurance to protect against losses, claims, injury, damage, compensation, and/or other actions for which Vendor is responsible, pursuant to this Agreement. Each party agrees that it will not make any warranties or representations or assume or create any other obligations on the other party's behalf.

8.7 Force Majeure. Neither party shall be responsible for any delay or failure in performance caused by flood, riot, insurrection, fire, earthquake, strike, communication line failure, power line failure, explosion, act of God, or any other force or cause beyond the reasonable control of the party claiming the protection of this Section 8.7. If any of the above enumerated

circumstances prevent, hinder or delay performance of either party's obligations for more than thirty (30) calendar days, the party not prevented from performing may, at its option, terminate this Agreement without liability or penalty as of the date specified by such party in a written notice of termination to the other party. The parties acknowledge and agree that labor shortages, disputes and strikes shall not be considered a force majeure event hereunder.

8.8 Approval of Subcontractors. Vendor shall obtain ACCF's written consent, which ACCF may withhold in its sole discretion, before entering into agreements with any subcontractors who may supply any Services related to this Agreement. Unless otherwise agreed hereunder, ACCF shall not be bound by the terms of such agreements entered into by Vendor and such agreements shall not contain any obligation with respect to ACCF including, without limitation, a guarantee of payments to such subcontractor. Any approval of Vendor's right to use a subcontractor shall be conditioned upon, among other things, ACCF's ability to obtain a full assignment of such agreement upon written notice by ACCF to the subcontractor following any default by Vendor under this Agreement; including, without limitation, any warranties contained herein. Vendor agrees that assignment of any subcontractor agreement to ACCF shall in no way diminish, reduce, modify or affect Vendor's duties or warranties to ACCF hereunder.

8.9 Time is of the Essence. The parties agree and acknowledge that time is of the essence in this Agreement.

8.10 Interpretation; Captions. In the event of any conflict or inconsistency between any provision of this Agreement and any Exhibit or document referred to or incorporated by reference, this Agreement will prevail. Section headings are used for convenience only and shall in no way affect the construction or interpretation of this Agreement.

8.11 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute but one and the same instrument.

8.12 Third Party Beneficiary. The parties agree to look solely to each other with respect to this Agreement and the Services provided hereunder. This Agreement and each and every provision thereof is for the exclusive benefit of ACCF and Vendor and not for the benefit of any third party. No third party shall be entitled to rely upon or enforce this Agreement or any portion thereof or to be a third party beneficiary thereof.

8.13 Survival. The following sections shall survive the expiration or termination of this Agreement for any reason: Section 2.4, Section 3.1-3.3, Section 5.6, Section 6.1, Section 6.2, Section 8.1-8.16.

8.14 Waiver and Severability. A waiver of a breach of any provision to this Agreement will not constitute a waiver of any other breach. Whenever possible, each provision of this Agreement, as well as any Exhibit, will be interpreted in such manner as to be effective and valid under applicable law, order, code, rule or regulation, but if any provision, or Exhibit is held to be invalid, illegal or unenforceable, such invalidity, illegality or unenforceability will not affect any other provision or Exhibit, but this Agreement will be reformed, construed and enforced in such jurisdiction as if such invalid, illegal or unenforceable provision or Exhibit had never been contained herein or attached hereto.

8.15 Governing Law. This Agreement will be governed by and construed in accordance with the laws of the District of Columbia, without regard to any conflicts of law principles applied therein. The parties agree that United Nations Convention on Contracts for the International Sale of Goods does not apply to this Agreement. Any suit or proceeding relating to this Agreement shall be brought only in the District of Columbia. Process in any action or proceeding regarding this Agreement may be served on Vendor by any method referenced in Section 8.3. EACH PARTY CONSENTS TO THE EXCLUSIVE PERSONAL JURISDICTION AND VENUE OF THE COURTS LOCATED IN THE DISTRICT OF COLUMBIA.

8.16 Entire Agreement. This Agreement, together with all Exhibits and Attachments, constitutes the entire agreement of the parties and supersedes all prior negotiations, discussions or representations, whether written or oral.

8.17 Representation and Warranty. Vendor represents and warrants that its principals are not presently debarred, suspended, proposed for debarment, ineligible or voluntarily excluded from covered transactions by any federal department or agency and have not within a three (3) year period been convicted of or had a civil judgment against them for committing fraud or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violating a Federal or State antitrust statute; embezzlement, theft, bribery, falsification, or destruction of records, or making false statement or receiving stolen property; are not presently indicated or otherwise criminally or civilly charged by a government entity (Federal, State, or local) with commission of any of the offences enumerated above; and have not within a three (3) year period proceeding this Agreement had any public transaction (Federal, State, or local) terminated for cause of default.

IN WITNESS WHEREOF, each of the parties has caused this Agreement to be executed by its duly authorized representative as of the date first written above.

AMERICAN COLLEGE OF CARDIOLOGY FOUNDATION	VENDOR
Signature: <u>[Signature]</u>	Signature: <u>[Signature]</u>
Name: Thomas E. Arend, Jr.	Name: <u>Kathleen D. Merrill</u>
Title: General Counsel & COO	Title: <u>Chief Financial Officer</u>
Date: <u>6/23/14</u>	Date: <u>6/20/14</u>

EXHIBIT A **STATEMENT OF WORK**

The Parties acknowledge that in order for WVMI to perform the services outlined in this Statement of Work ("SOW"), WVMI shall have access to protected health information ("PHI") as this term is defined by the Health Insurance Portability and Accountability Act of 1996 as amended. Without limitation WVMI agrees that all services performed under this Statement of Work must comply with the Subcontractor Business Associate Agreement and Data Use Agreement attached to the Agreement and as amended from time to time.

Description of Relationship and Background

Under the direction of ACCF, WVMI shall deploy an audit for the CathPCI Registry[®], ICD Registry[™], IMPACT Registry[™] and ACTION Registry[®]-GWTG[™] (each "Registry" and collectively the "Registries"). Such audit shall include, but shall not be limited to collecting data from source documents to determine the quality of a subset of predetermined elements, analyzing audit findings and reporting the data quality for the year being audited. ACCF shall determine the elements to be audited. WVMI understands that the purpose of the audit is to provide a quantitative measure of the reliability of data collected in the version 4.4 data collection form for CathPCI Registry[®], version 2.1 data collection form for ICD Registry[™], version 1.0 data collection form for IMPACT Registry[™], and version 2.3 data collection form for ACTION Registry[®]-GWTG[®].

Objectives

WVMI shall conduct an audit on facilities who are current participants of one or more Registries ("Participant"). In an effort to assess data accuracy and compliance for submitting records, this audit shall review the data submitted in the Registry during the calendar years 2013 and 2014.

Period of Performance

This SOW shall be implemented for two years unless indicated otherwise over the duration of this Agreement.

For year 1, this SOW shall encompass calendar year of 2014 for three (3) hybrid (i.e. onsite and remote review) audits (Site/Records selection, data abstraction and preliminary Site-Specific Reports for all registries), and the first (1st) quarter of 2015 for the final audit reports of the last audit conducted.

For year 2, the same approach would apply for year 2015 for four (4) hybrid (i.e., onsite and remote review) audits according to the schedule as outlined in Appendix I.

Statement of Work

Roles of the Parties

1. WVMI shall provide necessary qualified abstractors to conduct three (3) hybrid (i.e. onsite and remote) audits on data collected between 1/1/2013 to 12/31/2013 ("Audit Period") for the Registries : CathPCI Registry[®], ICD Registry[™], and ACTION Registry[®]-GWTG[®] for year 1 and CathPCI Registry[®], ICD Registry[™], IMPACT Registry[™], and ACTION Registry[®]-GWTG[®] for year 2. WVMI shall also update and maintain the necessary statistical programs for analysis, data collection tools, and reports for ACCF.
2. ACCF shall review and approve WVMI's reports to ensure compliance with the requirements outlined in this SOW.



RFQ CRFQ 0507 HCC1500000001:

Appendix B: Physician Curriculum Vitae



WVMI
West Virginia
Medical Institute

SVEN BERG, MD, MPH, CPE, FAAP
Chief Medical Officer

EDUCATIONAL BACKGROUND AND/OR TECHNICAL TRAINING

Institution	Degree or Certification	Year
Uniformed Services University of the Health Sciences	MD, MPH, in International Health and Health Services Administration	2003
St. Jude Children's Research Hospital	Fellowship in Pediatric Hematology/Oncology	1990-1993
Wilford Hall USAF Medical Center, Lackland Air Force Base	Residency Program in Pediatrics	1987-1990
Cornell University Medical College	MD	1987
Utah State University	BS, Chemistry	1983

APPLICABLE EMPLOYMENT EXPERIENCE

West Virginia Medical Institute, Charleston, WV

Chief Medical Officer, 2011 – present

Provides clinical oversight and guidance to all WVMi & Quality Insights projects. Directly responsible for WVMi's End Stage Renal Disease (ESRD) Network quality improvement programs in nine states and U.S. territories and oversees abstraction and validation services, including contracts with the Department of Veterans Affairs and the American College of Cardiology. Orchestrates and directs quality improvement, leadership and medical education activities.

Wilford Hall Medical Center, Lackland Air Force Base, TX

Chief of the Medical Staff, 2007 – 2011

Orchestrated delivery of over one million outpatient and 25,000 inpatient encounters annually at the Air Force's largest and most complex medical center with about 6,000 employees and 600 students and a \$330 million annual operating budget. Oversaw clinical quality services and health care improvement at major academic medical center affiliated with the Uniformed Services University of the Health Sciences and the University of Texas Health Science Center. Forged integration of professional staffs and clinical services during merger of two major medical centers. Redesigned committees to increase physician engagement in clinical and business improvement. Increased outpatient productivity by 15% the first year.

Organized and directed steering committee that unified the medical staff during the merger, established new bylaws, redesigned and safely phased the redistribution of clinical services for 228,000 beneficiaries. Chartered 12 organization-wide lean events to streamline patient throughput; optimize business practices; and improve health care quality, patient safety and experience. Dismantled information system roadblocks, doubling utilization of the electronic outpatient medical record and deploying an inpatient medical record across the institution. Achieved near-universal utilization of both systems.

Chief of Clinical Services, 59th Medical Operations Group, 2006 – 2007

Responsible for medical and quality of care issues, setting and enforcing standards of professional practice for over 400 group physicians. Oversaw process improvement and patient safety activities. Maintained an active clinical practice. Coauthored five-year strategic plan for \$65 million congressionally funded diabetes prevention and treatment project. Established diabetes center of excellence, serving over 1,000 local patients and providing consultation and decision support tools to ensure clinical practice excellence across the Air Force. Oversaw medical evacuation of over 3,000 wounded and ill combatants from Balad Joint Base in Iraq to definitive care. Directed outpatient, occupational and preventive health services for 8,500 deployed airmen.

United States Southern Command, Miami, FL
Deputy Combatant Command Surgeon, 2003-2006

Planned and facilitated medical support for humanitarian operations and for all Department of Defense military personnel assigned and deployed within the 32 nations and 12 dependencies comprising the Caribbean, Central and South America. Orchestrated medical evacuation of patients to definitive care. Served as Department of Defense lead in the Caribbean and Latin America for the President's Emergency Program for AIDS Relief. Envisioned medical security cooperation strategy that established regional and country plans. Aligned priorities to ensure the success of 270 humanitarian missions and formulation of ten pandemic influenza plans. Built comprehensive medical support for coalition forces in Haiti during a political and humanitarian crisis and established the region's first-ever patient movement operations center. Guided deployment of over \$6.7 million of medical equipment to Colombian military fighting narcoterrorists, established training and drove a medical culture change that reduced combat mortality by 70 percent. Managed \$1.8 million HIV/AIDS prevention and treatment program for ten foreign militaries. Coauthored interagency plans in support of host nation goals. Established two regional centers of excellence.

30th Medical Group, Vandenberg Air Force Base, CA
Commander, 30th Aerospace Medicine Squadron, 2000-2002

Served as Chief of Aerospace Medicine for a comprehensive community health care system that provides medical support for all Department of Defense space and missile launch activities on the West Coast. Managed 82 employees, a \$300,000 operational budget and contracts worth \$160,000 to administer medical services for operational personnel and their dependents. Oversaw occupational health program for over 2,000 workers in 79 industrial workplaces. Maintained an active clinical practice as a flight surgeon. Directed medical response to 10,000-acre wildfire, orchestrating 'round-the-clock support for 1,000 firefighters.

65th Medical Group, Lajes Field, Azores, Portugal
Deputy Commander and Chief of Clinical Service, 1998-2000

Led organization to first-ever accreditation by the Joint Commission on Accreditation of Healthcare Organizations. Implemented extended hours evening and weekend clinics and opened women's health clinic. Negotiated agreements with Portuguese health officials to obtain

local access to 22 specialties and inpatient care to improve clinic that provided medical and dental care for 2,900 assigned and 60,000 U.S. and allied personnel transiting the Atlantic area.

Wright-Patterson USAF Medical Center, Wright-Patterson AFB, OH

Chief of Pediatric Specialty Clinic, 1996-1998

Directed sub-specialty care for 14,000 children and adolescents and trained 92 resident physicians in pediatrics and hematology/oncology. Chaired the medical center's Clinical Pathways Steering Group, implementing seven facility-wide critical pathways. Coauthored proposal garnering \$250,000 grant to implement telemedicine at 301-bed academic medical center with 2,000 employees and an annual operating budget of \$160 million.

Wilford Hall USAF Medical Center, Lackland Air Force Base, TX

Chief of Pediatric Hematology-Oncology, 1993-1996

Directed merger with Pediatric Hematology-Oncology service at Brooke Army Medical Center, establishing the San Antonio Military Pediatric Cancer and Blood Disorders Center. Successfully led the new organization to accreditation by the Pediatric Oncology Group.

OTHER EXPERIENCE AND PROFESSIONAL ACCOMPLISHMENTS

- Diplomat, American Board of Pediatrics, 1991 (recertified in 1999 and 2006)
- Certified Physician Executive, 2008
- Fellow, American Academy of Pediatrics, 2011
- Licensure: Texas, Ohio and West Virginia
- American College of Physician Executives
- American Academy of Pediatrics
- National Quality Forum
- Healthcare Information and Management Systems Society
- West Virginia State Medical Association
- Kanawha County Medical Society
- Pediatric Oncology Group, Principal Investigator, 1993 – 1996
- Children's Cancer Study Group, Principal Investigator, 1996 – 1998
- Santa Barbara County Bioterrorism Working Group, Member, 2000 – 2002
- Physician Executive Forum for Quality and Patient Safety, Greater San Antonio Hospital Council, Member, 2007 – 2009
- Bexar County Medical Society, Member of Public Health and Patient Advocacy Committee and Legislative and Socioeconomics Committee, 2008 – 2011
- Houston Physician Executive Network, Member, 2008 – 2011

CHARLES P. SCHADE, MD, MPH

Medical Epidemiologist

EDUCATIONAL BACKGROUND AND/OR TECHNICAL TRAINING

Institution	Degree or Certification	Year
Oregon Health Sciences University	Residency Public Health/Preventive Medicine	1977
University of Texas	MPH	1974
Baylor College of Medicine	MD	1972
Rice University	BA Math/Electrical Engineering	1968

APPLICABLE EMPLOYMENT EXPERIENCE

West Virginia Medical Institute, Charleston, WV

Medical Epidemiologist-1995-Present

Provides medical and epidemiologic support of design, analysis, and dissemination of results of WVMI's care quality improvement projects. Work includes research, data analysis and interpretation, consulting with internal and external customers, teaching, and developing collaborative relationships with institutions that have goals compatible with those of the WVMI.

District Health Department No. 2, West Branch, MI

Health Officer, Medical Director-1993-1995

American Public Health Association, Washington, D.C.

Associate Executive Director, Professional Affairs-1989-1993

National Institute on Drug Abuse, Rockville, MD

Medical Epidemiologist-1987-1989

Multnomah County Health Department, Portland, OR

Health Officer-1980-1987

Assistant Health Officer-1979-1980

Staff Physician-1977-1979

Centers for Disease Control, Atlanta, GA

Epidemic Intelligence Service Field Officer-1974-1976

OTHER EXPERIENCE AND PROFESSIONAL ACCOMPLISHMENTS

- Brehm, J., Hannah, K., Ruddick, P., & Schade, C. (2004). Physician supply in key medical specialties in West Virginia hospitals, 2001-2004. W V Med J, 100(4), 132-135.
- Hannah, K. L., Schade, C. P., Cochran, R., & Brehm, J. G. (2005). Promoting influenza and pneumococcal immunization in older adults. Jt Comm J Qual Patient Saf, 31(5), 286-293.

- Schade, C. P. (1995). A preliminary comparison between local public health units in the Canadian Province of Ontario and in the United States. *Public Health Rep*, 110(1), 35-41.
- Schade, C. P. (2002). WVMI provides follow-up on beta blocker use. *W V Med J*, 98(5), 183.
- Schade, C. P., Brehm, J. G., Stephens, M. K., & Rezek, G. (2002). Beta blocker use in acute myocardial infarction in West Virginia. *W V Med J*, 98(2), 56-60.
- Schade, C. P., Cochran, B. F., & Stephens, M. K. (2004). Using statewide audit and feedback to improve hospital care in West Virginia. *Jt Comm J Qual Saf*, 30(3), 143-151.
- Schade, C. P., Hannah, K., Ruddick, P., Starling, C., & Brehm, J. (2006). Improving self-reporting of adverse drug events in a West Virginia hospital. *Am J Med Qual*, 21(5), 335-341.
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- Schade, C. P., & Hannah, K. L. (2007). Quality of ambulatory care for diabetes and lower-extremity amputation. *Am J Med Qual*, 22(6), 410-417.
- Schade, C. P., Hannah, K. L., Rezek, G., & Brehm, J. G. (2006). ACE inhibitor use and mortality reduction: do controlled trial results equal clinical practice? *W V Med J*, 102(1), 304-306.
- Schade, C. P., Jones, E. R., Jr., & Wittlin, B. J. (1998). A ten-year review of the validity and clinical utility of depression screening. *Psychiatr Serv*, 49(1), 55-61.
- Schade, C. P., & Komorwska, D. (1988). Continuing outbreak of hepatitis A linked with intravenous drug abuse in Multnomah County. *Public Health Rep*, 103(5), 452-459.
- Schade, C. P., & Lambert, E. Y. (1989). Factors in hepatitis A transmission. *Am J Public Health*, 79(11), 1571.
- Schade, C. P., & McCombs, M. (2005). Do mass media affect Medicare beneficiaries' use of diabetes services? *Am J Prev Med*, 29(1), 51-53.
- Schade, C. P., & McCombs, M. A. (2000). Influenza immunization and mortality among diabetic Medicare beneficiaries in West Virginia. *W V Med J*, 96(3), 444-448.
- Schade, C. P., Stephens, M. K., & Cochran, R. F. (2001). Improvements achieved in medical care to Medicare beneficiaries. *W V Med J*, 97(5), 235.
- Schade, C. P., Sullivan, F. M., de Lusignan, S., & Madeley, J. (2006). e-Prescribing, efficiency, quality: lessons from the computerization of UK family practice. *J Am Med Inform Assoc*, 13(5), 470-475.
- Stephens, M. K., Cochran, R. F., & Schade, C. P. (2001). Improving medical care for West Virginia seniors. *W V Med J*, 97(4), 188-193.



RFQ CRFQ 0507 HCC1500000001:

Appendix C: Example Report



WVMI
West Virginia
Medical Institute

**West Virginia Medical Institute Cardiac Catheterization Laboratory Monitoring
Facility Reporting Status – Quarter 4, 2010**

Listed below are the facilities submitting data to the National Cardiovascular Data Registry (NCDR) whose data were present in the download to WVMI for 2010 Quarter 4, which WVMI received on 7/6/2011.

Facility	Quarter
Cabell Huntington Hospital Inc.	2010Q4
Camden-Clark Memorial Hospital	2010Q4
Charleston Area Medical Center	2010Q4
Monongalia General Hospital	2010Q4
Reynolds Memorial Hospital	2010Q4
Saint Josephs Hospital	2010Q4
Saint Marys Medical Center	2010Q4
St. Francis Hospital	2010Q4
Thomas Memorial Hospital	2010Q4
United Hospital Center, Inc.	2010Q4
Weirton Medical Center	2010Q4
West Virginia University Hospitals Inc	2010Q4
Wheeling Hospital	2010Q4
Williamson Memorial Hospital	2010Q4

The following three facilities, which are on the current list of hospitals that should be reporting, had no data in the download.

BLUEFIELD REGIONAL MEDICAL CENTER
CITY HOSPITAL
RALEIGH GENERAL HOSPITAL

If there are no data for a facility, it is possible that the facility (1) is not reporting to the NCDR at all; (2) was late reporting in a particular quarter; or (3) reports to the registry but has not agreed to release its data to WVMI.



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Appendix D: Peer Review Event Agendas



WVMI
West Virginia
Medical Institute

**West Virginia Medical Institute
Annual Meeting of Invasive Cardiology Facilities
December 7, 2011**

AGENDA

- | | |
|---|--|
| 1. Welcome | Sven Berg, MD, MPH |
| 2. Introductions | Facility staff
WVMI staff |
| 3. Purpose of meeting and peer review status | Charles P. Schade, MD, MPH |
| 4. Analysis of registry data | Dr. Schade
David Lomely |
| 5. Facility presentations
Wheeling Hospital
City Hospital | Tish Holden, R.N., B.S.N
Lynette Dalton |
| 6. Audit results | David Lomely
Emma Dahmer, RN, CPHM |
| 7. Discussion | All |
| Lunch (provided) | |
| 8. Patterns and trends | Dr. Schade |
| 9. Wrap-up and follow-up plans | Dr. Berg |

**West Virginia Medical Institute
Annual Meeting of Invasive Cardiology Facilities
January 12, 2012**

AGENDA

- | | |
|--|---------------------------------------|
| 1. Welcome | Sven Berg, MD, MPH |
| 2. Introductions | Facility staff
WVMI staff |
| 3. Purpose of meeting and peer review status | Charles P. Schade, MD, MPH |
| 4. Analysis of registry data | Dr. Schade
David Lomely |
| 5. Audit results | David Lomely
Emma Dahmer, RN, CPHM |
| 6. Patterns and trends | Dr. Schade |
| 7. Wrap-up and follow-up plans | Dr. Berg |



RFQ CRFQ 0507 HCC1500000001:

Appendix E: Required RFQ Documents



WVMI
West Virginia
Medical Institute

State of West Virginia

VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with **West Virginia Code**, §5A-3-37. (Does not apply to construction contracts). **West Virginia Code**, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the **West Virginia Code**. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Vendor Preference, if applicable.

1. Application is made for 2.5% vendor preference for the reason checked:

- ____ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or**,
 ____ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or**,
 ____ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or**,

2. Application is made for 2.5% vendor preference for the reason checked:

- ____ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or**,

3. Application is made for 2.5% vendor preference for the reason checked:

- ____ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or**,

4. Application is made for 5% vendor preference for the reason checked:

- X Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or**,

5. Application is made for 3.5% vendor preference who is a veteran for the reason checked:

- ____ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or**,

6. Application is made for 3.5% vendor preference who is a veteran for the reason checked:

- ____ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

7. Application is made for preference as a non-resident small, women- and minority-owned business, in accordance with West Virginia Code §5A-3-59 and West Virginia Code of State Rules.

- ____ Bidder has been or expects to be approved prior to contract award by the Purchasing Division as a certified small, women- and minority-owned business.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: West Virginia Medical Institute, Inc.

Signed: 

Date: June 16, 2015

Title: Chief Financial Officer

STATE OF WEST VIRGINIA
Purchasing Division**PURCHASING AFFIDAVIT**

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

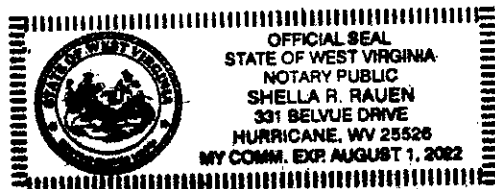
"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceeds five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code §61-5-3*) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:Vendor's Name: West Virginia Medical Institute, Inc.Authorized Signature: *Katherine D. McNeill* Date: June 16, 2015State of West VirginiaCounty of Kanawha, to-wit:Taken, subscribed, and sworn to before me this 16 day of June, 2015.My Commission expires August 1, 2022.

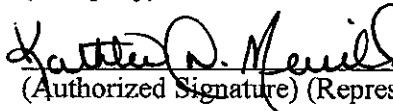
AFFIX SEAL HERE

NOTARY PUBLIC *Shella R. Rauwen*

CERTIFICATION AND SIGNATURE PAGE

By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

West Virginia Medical Institute, Inc.
(Company)

 (Kathleen D. Merrill, Chief Financial Officer)
(Authorized Signature) (Representative Name, Title)

(304) 346-9864 ext. 2228 (304) 346-9863 June 16, 2015
(Phone Number) (Fax Number) (Date)

CENTRALIZED REQUEST FOR QUOTATION
CRFQ 0507 HCC1500000001
Cardiac catheterization laboratory auditing and monitoring services

11. MISCELLANEOUS:

11.1. Contract Manager: During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract. Vendor should list its Contract manager and his or her contact information below.

Contract Manager: Emma Dahmer
Telephone Number: 304-346-9864 x 3237
Fax Number: 304-292-1912
Email Address: edahmer@wvmi.org

**West Virginia Medical Institute, Inc.
Pricing Proposal**

**CRFQ 0507 HCC1500000001
EXHIBIT A: PRICING PAGE**

CONTRACT COST	YEAR 1	YEAR 2 (Optional First Renewal)	YEAR 3 (Optional Second Renewal)	YEAR 4 (Optional Third Renewal)
Quarter 1	\$ 24,362	\$ 25,093	\$ 25,846	\$ 26,621
Quarter 2	\$ 24,362	\$ 25,093	\$ 25,846	\$ 26,621
Quarter 3	\$ 24,362	\$ 25,093	\$ 25,846	\$ 26,621
Quarter 4	\$ 24,361	\$ 25,092	\$ 25,845	\$ 26,621
CONTRACT COST SUB-TOTAL (Quarters 1 - 4) =	\$ 97,447	\$ 100,371	\$ 103,383	\$ 106,484
ACC DATA COST (NTE)=	\$ 41,700	\$ 41,700	\$ 41,700	\$ 41,700
GRAND TOTAL FOR EACH YEAR (CONTRACT COST SUB-TOTAL + ACC DATA COST For Year)=	\$ 139,147	\$ 142,071	\$ 145,083	\$ 148,184
OVERALL CONTRACT GRAND TOTAL (TOTAL OF ALL FOUR GRAND TOTALS FOR EACH YEAR)=				\$ 574,485