DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

MAR 2 3 2018

The Honorable Michael R. Pence
President of the Senate
Washington, DC 20510

Dear Mr. President:

Enclosed is a report entitled, "Report to Congress on the Administration, Cost and Impact of the Quality Improvement Organization (QIO) Program for Medicare Beneficiaries for Fiscal Year (FY) 2016."

As required by Section 1161 of the Social Security Act, this report details the administration, cost, and impact of the QIO Program during FY 2016, covering in part provider improvement in quality measures for hospitals, home health agencies, nursing homes, and physician practices.

I am also sending an identical copy of this report to the Speaker of the House of Representatives.

Sincerely,

Matthew D. Bassett
Assistant Secretary for Legislation

Enclosure

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Speaker of the House of Representatives
Washington, DC 20510

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Report to Congress

The Administration, Cost, and Impact of the Quality Improvement Organization (QIO) Program for Medicare Beneficiaries for Fiscal Year 2016

EXECUTIVE SUMMARY

Section 1161 of the Social Security Act (the Act) requires the submission of an annual report to Congress on the administration, cost, and impact of the Quality Improvement Organization (QIO) Program during the preceding fiscal year. This report fulfills this requirement for FY 2016. The statutory mission of the QIO Program is set forth in Title XVIII of the Act-Health Insurance for the Aged and Disabled. More specifically, section 1862(g) of the Act states that the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. The quality improvement strategies of the Medicare QIO Program are implemented by area and task specific QIO contractors, who work directly with health care providers and practitioners in their geographic service area (which likely encompasses multiple states, including the District of Columbia, or territories).

On August 1, 2014, the Centers for Medicare & Medicaid Services (CMS) launched the QIO Program's 11th SOW to enhance the quality of services provided to Medicare beneficiaries. These are 5-year contracts and will end in 2019. In FY 2016, QIO Program expenditures totaled approximately $776 million. FY 2016 covered the 16th -27th months of the 11th Scope of Work (SOW) contract. This report will summarize the main activities included in the 11th SOW, the suggested targets of the aims, include tables illustrating QIOs' performance during FY 2016 compared to the performance criteria, and describe how the 11th SOW was changed from the 10th SOW. The FY 2016 report will describe the targets and results from the 24th month evaluation of QIO performance.

The Trade Adjustment Assistance Extension Act of 2011 (Trade Bill) amended statutory provisions related to the service area of QIO contracts and the functions performed by QIOs; these changes also gave CMS discretion to separate the two key QIO functions under the 11th SOW into separate sets of QIO contractors: (1) Beneficiary and Family-Centered Care (BFCC) QIOs that serve the Medicare program's case review needs, and (2) Quality Improvement Network (QIN)-QIOs that support healthcare delivery professionals and systems as they perform quality improvement work.

The two BFCC-QIO contractors under the 11th SOW are Livanta LLC and KePRO. They are responsible for performing case reviews for various reasons, such as to review the quality of care provided to Medicare beneficiaries and review and respond to beneficiary complaints. They must ensure consistency in the review process with consideration of local factors important to beneficiaries. Table 1 below shows the BFCC-QIOs by Region and State.

Table 1: BFCC-QIOs by Region and State

Region	QIO	States
1	Livanta	ME, VT, NH, MA, RI, CT, NJ, PA, NY, PR
2	KePRO	DE, MD, WV, VA, NC, SC, GA, FL
3	KePRO	MT, WY, UT, CO, NM, TX, OK, ND, SD, AR, LA, TN, KY, MS, AL
4	KePRO	MN, WI, MI, IA, NE, KS, MO, IL, IN, OH

Region	QIO	States
5	Livanta	AK, WA, OR, ID, CA, NV, AZ, HI

The Quality Improvement Network (QIN) Quality Improvement Organization (QIO) Program is responsible for working with providers and communities on multiple, data-driven quality initiatives to improve patient safety, reduce harm, and improve clinical care at local and regional levels. The primary goals of the QIN-QIOs are to promote effective prevention and treatment of chronic disease, make care safer by reducing harm caused by the delivery of care, promote effective communication and coordination of care, and make care more affordable. The QIO Program includes 14 QINs covering a region that includes as many as six states, across the 53 US states and territories, as shown in Table 2.

Table 2: QIN-QIOs by Name and States

QIN Name	States
Great Plains Quality Innovation Network	KS, ND, NE, SD
TMF	AR, MO, OK, TX, PR
Lake Superior Quality Innovation Network/Stratis Health	MN, WI, MI
Telligen	CO, IA, IL
HealthInsight	NM, NV, OR, UT
Alliant-Georgia Medical Care Foundation	GA, NC
Atom Alliance	AL, KY, MS, TN, IN
Mountain Pacific Quality Health Foundation	AK, HI, MT, WY
Atlantic Quality Improvement Network	DC, NY, SC
Quality Insights Quality Innovation Network	DE, LA, NJ, PA, WV
VHQC	MD, VA
Qualis Health	ID, WA
Health Services Advisory Group	AZ, CA, FL, OH, VI
HealthCentric Advisors	CT, MA, ME, NH, RI, VT

BACKGROUND

The statutory provisions governing the QIO Program are in Part B of Title XI of the Act. Its statutory mission is set forth in Title XVIII of the Act-Health Insurance for the Aged and Disabled. Specifically, section 1862(g) of the Act states that the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to make sure that those services are reasonable and necessary. Part B of Title XI of the Act was amended by section 261 of the Trade Bill, which made several changes to the Secretary’s contracting authority for QIOs beginning with contracts entered into or renewed after January 1, 2012. These changes include eligibility requirements for QIOs, the term of QIO

contracts, the geographic area served by QIOs and updates to the functions performed by QIOs under their contracts. The contracts for the 11th SOW are subject to the changes made by the Trade Bill.

I. PROGRAM ADMINISTRATION

Description of Quality Improvement Organization Contracts

By law, the mission of the QIO Program is to improve the effectiveness, efficiency, and quality of services delivered to Medicare beneficiaries. Based on this statutory requirement, and CMS' program experience, CMS identified the core functions of the QIO Program as:

- Improving quality of care for Medicare beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing: individual complaints; reviews or appeals from provider notices of discharge or termination of services; violations of the EMTALA; and other related responsibilities.

The QIOs are now categorized and known as Beneficiary and Family-Centered Care (BFCC) QIOs and Quality Improvement Network (QIN)-QIOs, depending on the QIO functions that they perform. QIOs are private, mostly not-for-profit, organizations staffed by doctors and other health care professionals trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.

QIOs Interacting with Health Care Providers and Practitioners

QIOs work with and provide technical assistance to health care practitioners and providers such as physicians, hospitals [including Critical Access Hospitals (CAHs)], nursing homes, and home health agencies. QIOs also work with practitioners, providers, beneficiaries, partners, and other stakeholders to improve the quality of health care provided to beneficiaries through a variety of health care delivery systems and address beneficiary complaints regarding quality of care. For instance, a process called immediate advocacy involves direct communication between QIOs and beneficiaries in which the BFCC-QIOs try to address complaints raised by the beneficiary; through this process, QIO staff also work with providers to resolve miscommunication or other concerns voiced by the beneficiary or a family member. QIOs analyze data and beneficiary records to identify areas of improvements in care and ensure beneficiaries' voices are heard by addressing individual complaints and bringing their perspective into the quality improvement process.

Any provider or practitioner who treats Medicare beneficiaries and is paid under Title XVIII of the Social Security Act may have received technical assistance from a QIO and may be subject to review by the QIO in connection with Medicare participation. Interaction comes in a variety of

forms including direct intensive QIO assistance, occasional contact with the QIO at professional meetings, visits to the QIO website, and/or QIO record reviews.

II. PROGRAM COST

Under federal budget rules, the QIO Program is defined as mandatory spending rather than discretionary spending because QIO costs are financed directly from the Medicare Trust Fund and are not subject to the annual appropriations process. QIO costs are subject to the apportionment process administered through OMB. In FY 2016, QIO Program expenditures totaled $775,584,891.70.

III. PROGRAM IMPACT

The QIO Program impacts Medicare beneficiaries on an individual basis and the beneficiary population as a whole. In 2016, Medicare covered over 57 million beneficiaries: over 48 million people age 65 or older and 9 million people of all ages with certain disabilities and with end stage renal disease. As the QIO Program completed the 2nd year of the 11th SOW contracting period ending July 2016, some important results are as follows:

- 9,124 readmissions avoided in care coordination communities
- 467 Central Line-Associated Bloodstream infections avoided
- 432 *Clostridium difficile* infections avoided
- 1,884 participating practices have been recruited to work with Reducing Disparities in Diabetes Care: Everyone with Diabetes Care Counts

The sections below provide additional information about QIO accomplishments and the impact on beneficiaries during the 16th month – 27^{h} months of the period of performance of the 11th SOW. This period began on November 1, 2015 and ended October 31, 2016.

AIM REQUIREMENTS AND MEASURES

The QIO Program's 11th Statement of Work (SOW) activities and services are divided into three aims: better care, better health and lower costs. Each aim has an established set of quality measures that provides accountability to the QIOs for making changes at all levels of the health care system. Please note that task refers to the breakdown of the work in each Aim of the Task Order Contract for QIN QIOs and for the breakdown of work in the BFCC contract, for example, in Aim B, there are three tasks; there is no task A.

Beneficiary and Family Centered Care

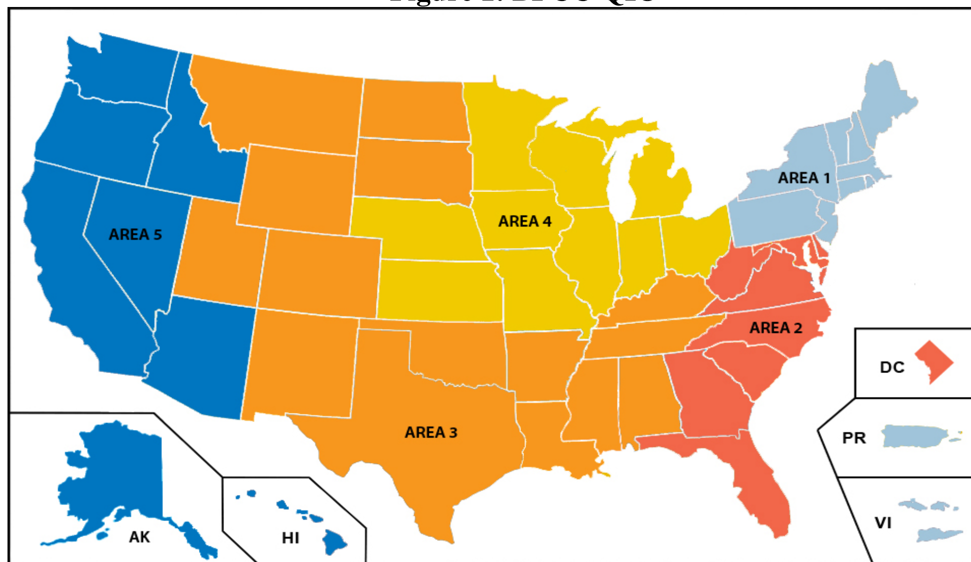
The BFCC program focuses on statutorily mandated QIO case review activities, as well as on interventions to promote responsiveness to beneficiary and family needs; providing opportunities for listening to and addressing beneficiary and family concerns; providing resources for beneficiaries and caregivers in decision making; and using information gathered from individual experiences to improve Medicare's entire system of health care. Beneficiary-generated concerns provide an excellent opportunity to explore root causes of adverse health care outcomes, develop

alternative approaches to improving care, and to improve beneficiary/family experiences within the health care system. Beneficiary and family engagement and activation efforts are needed to produce the best possible outcomes of care. These QIO beneficiary and family-centered efforts align with the National Quality Strategy, which encourages patient and family engagement.

Case review types include Quality of Care Reviews, Emergency Medical Treatment and Labor Act (EMTALA) Reviews, reviews of provider discharge/termination of service decisions and denials of hospital admissions, Higher-Weighted Diagnosis Related Group (HWDRG) Reviews and other review types. The QIO Manual includes discussion of the various case review types and provides additional detail and guidance on QIO responsibilities for the reviews.

The BFCC-QIO Program was restructured from 53 individual QIO contractors (one in each of the 50 states, the District of Columbia, and 2 U.S. territories) to two BFCC service contracts covering five geographic areas including U.S. territories. This reorganization was implemented in an effort to promote greater standardization, to facilitate the effective and efficient delivery of care, and to improve the quality of care for Medicare beneficiaries. CMS has contracted Livanta LLC and KePRO as the two BFCC-QIOs organized among 50 states, the District of Columbia, and 2 territories, as shown in Figure 1. The five BFCC-QIO areas are depicted below.

Figure 1: BFCC-QIO



The table below depicts the national summary of the BFCC-QIO Program performance on three timeliness measures for the 24th month reporting period of the contract. Performance for timeliness of reviews was consistent across both BFCC-QIOs for all their regions.

Table 3: BFCC–QIO Annual Performance Criteria Measures

Measure	Target	Result
Timeliness of Beneficiary Complaints and Other Quality of Care Reviews	95%	99.75%
Timeliness of Discharge/ Service Termination Reviews	98%	99.82%
Timeliness of EMTALA and HWDRG Reviews	95%	99.94%

The results of the timeliness analysis reveal that the BFCC-QIO performance exceeded Year 2 target requirements. As of July 2016, all three measures achieved results greater than 99 percent. The overall rate of timeliness is 99.84 percent.

QIN-QIO QUALITY IMPROVEMENT AIMS

Aim B: Healthy People, Health Communities: Improving the Health Status of Communities

Healthy People, Healthy Communities: Improving the Health Status of Communities includes tasks that promote effective prevention and treatment of chronic disease for Medicare beneficiaries. Health IT is also promoted in the task listed below. Three tasks included in the Aim are addressed separately below.

Task B.1: Improving Cardiac Health and Reducing Cardiac Healthcare Disparities

Task B.1 supports the Million Hearts initiative's goal to prevent one million heart attacks and strokes. The goal will be accomplished by working with clinical participants, Medicare beneficiaries, partners, and stakeholders to spread the implementation of evidence-based practices to promote: use of Aspirin therapy when appropriate; Blood pressure (BP) control; Cholesterol management; and Smoking/tobacco use assessment and cessation counseling. Physicians and other eligible professionals will be recruited to promote reporting through the Physician Quality Reporting System (PQRS) Program. Racial and ethnic minority beneficiaries and clinicians who serve them are included in the target populations for the task. Blood pressure control is the priority focus for the work and the QIN-QIOs are promoting the use of blood pressure protocols to achieve this goal. Below are results for Task B.1 through October 31, 2016, which is Quarter 6 of the contract.

Table 4: Improving Cardiac Health and Reducing Disparities Monitoring Measures

Measure	Target	Results
Blood Pressure Control Rate	30%	61.3%
Tobacco Use Cessation Rate	45%	66.6%

- The purpose of this task is for the QIN-QIOs to work with home health agencies, physician's offices, clinics, and beneficiaries in collaboration with key partners and stakeholders to implement evidence-based practices to prevent heart attacks and strokes.
- Racial and ethnic minority beneficiaries and clinicians who serve them are included in the target populations for the task. 50+ resources are provided in multiple languages.
- Of the 10,059 total clinicians, 4,183 serve in rural areas.
- Total Patient Impact = 5,393,340.
- 2,071 Home Health Agencies engaged and impacting 1,629,409 patients in their homes and communities.

Task B.2: Reducing Disparities Care: Everyone with Diabetes Counts (EDC)

The goal of the EDC program is to improve health equity by improving health literacy and quality of care among Medicare and Dually Eligible beneficiaries with pre-diabetes and diabetes through knowledge empowerment, enabling them to become active participants in their care (which is also consistent with the goal of focusing on person centered care and person/patient engagement). The target populations are minority/medically underserved and rural beneficiaries. EDC will engage both beneficiaries and health care providers to decrease the disparity in diabetes care by improving testing for: HbA1c, Lipids; Eye Exams; Foot Exams; as well as improve Blood Pressure control and Weight control. Additionally, the focus is to facilitate the development of sustainable diabetes education resources in targeted communities by engaging public/private agency/organization partnerships at the community level, state level, and national level.

The table below identifies the national performance requirements for Year 2. As of July 2016, EDC exceeded the first two measures for Year 2 targets; however, the third measure was slightly less than the target.

Table 5: Evaluation Measures for Everyone with Diabetes Counts

Measure	Target	Result
Percentage of clinical outcome data collected for Medicare beneficiaries who complete diabetes self-management education (DSME) classes through EDC. Clinical outcomes are HbA1c, Lipids, Eye Exam, Blood Pressure, Weight and Foot Exam.	4%	6%
Percentage of physician practices recruited to participate in EDC	60%	96%
Percentage of new beneficiaries completing DSME	31%	29%

Task B.4: Improving Prevention Coordination through Meaningful Use of Health IT and Collaborating with Regional Extension Centers (RECs).

The purpose of this task is for the QIN-QIOs to leverage the capabilities of their recruited health care providers across the country as they work to collect, track, and report data through use of automated tools, such as certified electronic health records and registries, for data extraction, prevention and quality improvement as established by the Meaningful Use program.

Goals:

- Transform clinical practices, hospitals and critical access hospitals
- Promote interoperability & exchange of clinical information through health information exchanges
- Increase provider screenings and delivery of preventive services i.e. cardiac, diabetes, immunizations and cancer etc.
- Improve access to care and care coordination while identifying and reducing disparities

Below are the results for Task B.4 for the 24th month of performance requirements.

Table 6: Use of Health IT and Collaborating with Regional Extension Centers (RECs)

Measure	Target	Result
Percentage of recruited Eligible Professionals, Hospitals and Critical Access Hospitals with signed agreements	10% of agreed upon recruitment numbers	100% Met

Measure	Target	Result
Percentage of recruited Eligible Professionals, Hospitals and Critical Access Hospitals receiving Technical Assistance	10% of agreed upon recruitment numbers	100% Met
Percentage of recruited Eligible Professionals, Hospitals and Critical Access Hospitals attending Educational Sessions	25% of agreed upon recruitment numbers	100% Met

Aim C: Better Healthcare for Communities: Beneficiary-Centered, Reliable, Accessible and Safe Care

The Better Healthcare for Communities Aim includes initiatives to improve safety and care across the care continuum. Initiatives build upon the aims of the National Quality Strategy. Tasks included are summarized below.

Task C.1 Reducing Healthcare-Acquired Infections in Hospitals (HAIs)

Under the 11th SOW contract, QIN-QIOs are working to make health care safer and more affordable through the reduction and prevention of Healthcare-Associated Infections (HAIs) in the acute care setting. Reducing and preventing HAIs not only helps to improve quality of patient care and can make care more affordable, but it also helps save lives. QIN-QIOs are working towards HAI goals as outlined in the HHS HAI National Action Plan. During the FY 2016 period, the QIN-QIOs collaborated with other public and private organizations, (i.e., Agency for Healthcare Research and Quality's (AHRQ) Comprehensive Unit-based Safety Program (CUSP); the Centers for Disease Control and Prevention (CDC)) and CDC sponsored state based HAI initiatives; and the work of CMS' Partnership for Patients on programmatic initiatives. This work is intended to decrease HAI Standardized Infection Ratios (SIRs) nationally by demonstrating significant, quantitative and measurable reductions in hospital acute care settings for Medicare beneficiaries and prevent the occurrence of HAIs in hospitals using evidence-based HAI prevention strategies.

The table below addresses the measures for the reporting period June 1, 2015 through May 31, 2016

Table 7: Reducing Healthcare –Acquired Infections in Hospitals

Measure	Target	Result
The number of CLABSI cases in a facility over the predicted number of CLABSI cases for that facility over a specified amount of time	0.6435(Target reflects ≤ to 130% of the national	60% of states met the CLABSI 24th month

Measure	Target	Result
	CLABSI SIR at the time of the evaluation.)	evaluation criterion of 0.6435
The number of CAUTI cases in a facility over the predicted number of CAUTI cases for that facility over a specified amount of time.	1.30 (Target reflects ≤ to 130% of the national CAUTI SIR at the time of the evaluation)	100% of states met CAUTI 24th month evaluation criterion of 1.3
Number of urinary catheter days per number of patient days per each individual patient care location/unit that is chosen for monitoring.	60% (Target reflects the percentage of patient care units that achieve a device utilization ratio (DUR) < national ratio for each patient care location type	29% of states met the Cath DUR 24th evaluation criterion of 60%
The reduction in the SIR of CDI for a targeted facility compared to the baseline CDI SIR in that same facility.	1.2012 (Target reflects ≤ to 130% of the national CDI SIR at the time of evaluation)	94% of states met the CDI SIR 24th month evaluation criterion of 1.2012.

It should be noted that this task was removed from the SOW effective September 30, 2016, so no further data past the 24th month is available. CMS' Hospital Improvement Innovation Networks (HIINs) are continuing the work on HAI reduction in the hospital setting.

Task C.2: Reduce Healthcare Acquired Conditions in Nursing Homes

The 11th SOW C.2 Reducing Healthcare-Acquired Conditions in Nursing Homes Task Order aims to improve the quality of care and quality of life received by beneficiaries residing in nursing homes. The activities associated with this task include:

- Recruiting no less than 75% of the nursing homes within each state and two territories with a CMS Certification Number (CCN) and star-status into the 11th SOW National Nursing Home Quality Care Collaborative (NNHQCC) Collaborative I and/or II. By April 1, 2017, this will represent approximately 11,000 of the 15,600 nursing homes with a CCN.
- Increasing the participation of low-performing nursing homes to 75% of nursing homes within each state and two territories with a CMS Certification Number (CCN), identified by a One-Star status, to participate in the NNHQCC, Collaborative I and/or II. By April 1, 2017, this will represent approximately 1,449 of the approximately 1,900 1-star homes before the re-basing of the Medicare.gov 5-Star system in February 2015.

- Continuation of the use of the Quality Measure Composite Score as a means to measure the success of both collaborative efforts I and II, and expanding the use of the Composite Score to identify progress in individual nursing homes and individual QIN-QIOs.
- Continuing the alignment of the QIN-QIO with the National Partnership to Improve Dementia Care in Nursing Homes* in an effort to drive-down the inappropriate use of antipsychotic medications in Medicare beneficiaries in long-stay facilities.
- Increasing mobility among long-stay residents. This performance evaluation measure is under development. QIN-QIOs are focusing work on increasing mobility among long-stay nursing home residents. The current performance evaluation measure is listed as developmental to indicate the importance of mobility as an area of improvement and to add in a measure once a quality measure for mobility is finalized. The QIN-QIOs are not currently being evaluated on the increasing mobility among long-stay residents.

The table below identifies the evaluation measures and targets for 11th SOW C2 Nursing Home Task Order at the start of the 11th SOW.

Table 8: Evaluation Measure for Reduce Healthcare Acquired Conditions in Nursing Homes

Measure	Target	Result
Reduction in percentage of long-stay residents who received antipsychotic medications	Three percent reduction in percentage of long-stay residents who received antipsychotic medications by 07/2016	51 of 52 states = 98% (AK not met)
50% of Recruitment Target Number (RTN) will achieve the Quality Measure Composite Score of 6.00 or less by January 2019	Greater than or equal to 15% of RTN achieve score of 6.00 by 07/2016	42 of 52 states = 81% (KS, ND, IL, NC, KY, PA, WV, VA, WA, VT not met)
Sum of percentages of Recruitment Target Number recruited for Collaboratives I and II	100% of RTN by 3/31/2017	N/A
Sum of Percentages of One-Star Category Target Number recruited for Collaboratives I and II	100% of One-Star Nursing Homes by 3/31/2017	N/A
Percentage of long-stay residents with improved mobility	Under development	Under development

* CMS partners with federal and state agencies, nursing homes, other providers, advocacy groups, and caregivers to improve comprehensive dementia care. The Partnership promotes a multidimensional approach that includes public reporting, state-based coalitions, research training, and revised surveyor guidance. The initial focus was on reducing the use of antipsychotic medications and the larger mission is to enhance the use of non-pharmacologic approaches and person-centered dementia care practices.

Task C.3: Coordination of Care

The focus of the C.3 task is to promote effective communication and coordination of care through a quality improvement framework that focuses on community organizing and a population based strategy.

Under the 11th SOW, QIN-QIOs are working with existing community-based efforts and recruiting and engaging community coalitions that focus on improving care coordination for Medicare fee-for service (FFS) beneficiaries. This includes recruiting and engaging providers across all care settings (such as acute and post-acute settings), and other community stakeholders to identify and target interventions at the causes of poor care coordination. Recruitment for this task occurs in three Cohorts: Cohort A (August 1, 2014- December 31, 2014), Cohort B (January 1, 2015 through December 31, 2015) and Cohort C (January 1, 2016 through December 31, 2016). Recruitment numbers for the cohorts include: Cohort A: 131 communities serving 6,816,932 beneficiaries. Cohort B: additional 120 communities serving an additional 8,317,033 beneficiaries. Cohort C: additional 129 communities serving an additional 7,910,870. This brings the total number of recruited communities to 380 communities serving 23,044,835.

In addition, QIN-QIOs are specifically targeting interventions related to coordination of care for vulnerable populations such as individuals with multiple chronic conditions who take multiple medications, behavioral health issues, socioeconomic issues, individuals dually enrolled in Medicare and Medicaid, and individuals with Alzheimer's and other dementia disorders.

The table below identifies Task C-3 results for the 24th month of performance. Through much of the care transitions work, we have found that socioeconomic issues contribute to readmissions. These readmissions may stem from any number of complications such as: inability to purchase new prescriptions, having to make decisions to purchase food or medications, or a lack of healthy food options. Through our care transitions efforts, we continue to work to mobilize community resources to address these needs.

Table 9: Coordination of Care

Measure	Target	Result
Percentage of interventions implemented (for a minimum of 6 months) that show improvement (for a minimum of 5 interventions across the state/territory annually) Time period: 8/1/2015 – 7/31/2016	40%	• 48 states/territories met the 40% target of 5 or more eligible interventions for evaluation by July , 2016 • 9% (5/53) of states/territories had less than five QIN-QIO identified intervention
Rate of 30-day readmissions per 1,000 Fee-for-Service (FFS) beneficiaries in Cohort A Time period: 4/1/2015 – 3/31/2016	2% Relative Improvement Rate (RIR)	55 percent (29/53) of states/territories in Cohort A met the 24th month RIR criterion
Rate of admissions per 1,000 FFS beneficiaries in Cohort A	1.4% RIR	62 percent (33/53) of states/territories in Cohort A met the 24th Month Evaluation RIR Criterion

Measure	Target	Result
Time period: 4/1/2015 – 3/31/2016		
Rate of state/territory-wide readmissions per 1,000 FFS beneficiaries Time period: 4/1/2015 – 3/31/2016	0.4% RIR	59 percent (31/53) of states/territories met the 24th Month Evaluation RIR Criterion
Rate of state/territory-wide admissions per 1,000 Time period: 4/1/2015 – 3/31/2016	0.4% RIR	75 percent (40/53) of states/territories in Cohort A met the 24th Month Evaluation RIR Criterion
Community tenure in state/territory-wide coalition. "Community tenure" is defined as the number of days beneficiaries spend in their home setting Time period: 4/1/2015 – 3/31/2016	0.4% RIR target	Only six (11%) of the 53 states/territories (NE, NH, SC, UT, VA, and WI) in Cohort A met the 24th Month Evaluation RIR Criterion for community tenure

Task C.3.6: Medication Safety and Adverse Drug Event Prevention

In the 11th SOW QIN-QIOs were tasked with improving medication safety and reducing adverse drug events (Task C.3.6). QIN-QIOs are required to recruit providers, practitioners and pharmacies that provide care for Medicare beneficiaries that are at high risk for an adverse drug event. QIN-QIOs are working to implement or identify tools to track and increase surveillance of adverse drug events to help prevent them, improve medication safety by providing evidence-based clinical information and best practices, and increase medication safety across the community as an integrated part of care transitions efforts. The QIN-QIO program developed a claims based method of identifying high-risk beneficiaries, adverse drug events, and hospitalizations for the high-risk population using Medicare claims data, including Medicare Part D data.

Specific goals under Task C.3.6 are to improve care coordination and reduce adverse drug events for beneficiaries that are at high risk for an adverse drug event.

Please note that there is no 24th month evaluation for this task, as QIN-QIOs continue to recruit and collect data for this task. The first evaluation for this task is in July 2017.

Aim D: Better Care at Lower Cost

Task D.1: Quality Improvement through Value-Based Payment, Quality Reporting, and the Physician Feedback Reporting Program

CMS is seeking to promote higher quality of care and more efficient health care for all Medicare beneficiaries. Under this task, QIOs are called upon to assist hospitals, PPS-exempt Cancer Hospitals (PCHs), Inpatient Psychiatric Facilities (IPFs), Ambulatory Surgical Centers (ASCs), Critical Access Hospitals (CAHs) and eligible professionals. Activities of the QIN-QIOs involve education and outreach, learning forums (Learning and Action Networks (LANs)), webinars, teleconferences.) and direct technical assistance support to hospitals, facilities, and

physician/professionals in identifying and capitalizing on opportunities for improvement in the quality, efficiency, and coordination of care. General desired outcomes for this task include:

- To increase the number of eligible physicians and eligible professionals in group practices that submits data through the Physician Quality Reporting System (PQRS)
- To increase the number of eligible physicians and eligible professionals in group practices that demonstrates improvement in quality of care delivered (as determined by reported quality measures)
- To increase the national performance levels on Hospital VBP measures
- To increase the percentage of ASCs and IPFs that successfully improve performance on a quality measure where there had been poor performance previously
- To increase the percentage of hospital outpatient departments that demonstrate improvement in quality of care delivered (as determined by reported quality measures); and
- To increase PCH performance on American College of Surgeons and CDC National Healthcare Safety Network measures included in the PCH quality reporting program.

Table 10 presents the national key performance metrics for data collection during each specific period. The learning forum attendance measure has proven challenging in light of the large population size, and the need to document attendance consistently across numerous learning forum providers. This measure has been modified to allow for enhanced flexibility in the scope of forums that would constitute a learning forum. As a result of the 2015 MACRA legislation, this measure was further modified to align with the Quality Payment Program in 2017. CMS worked with the those QIN-QIOs who were unable to meet the measure in order to identify the cause for failing to meet the measures, and most were due to those challenges listed above.

Table 10: Quality Improvement through Value-Based Payment, Quality Reporting and the Physician Feedback Reporting Program

Measure	Target	Result
Learning Forum Percentage of eligible physicians/ professional groups attending QIO-convened forums related to Task D.1 topics.	8/1/14 through 7/31/16 Target: 55% (323,125 eligible group practices)	43 percent of states met the criterion
Quality Improvement/PQRS Percentage of eligible physician/ professional groups that demonstrate improvement in quality-of-care measures (per PQRS) after receiving TA related to PQRS measures.	N:1/1/15 through 12/31/15 D:8/1/14-6/30/15 Target: Document Actions	All states (100%) met the 24th month contract evaluation criterion
Percentage of eligible ASCs that demonstrate improvement in quality-of-care measures (per Ambulatory Surgical Center Quality Reporting) after receiving TA from QIOs.	N:1/1/15 through 12/31/15 D:8/1/14-6/30/15 Target: Document Actions via Deliverable	All states (100%) met the 24th month contract evaluation criterion

Measure	Target	Result
Percentage of eligible IPFs that demonstrate improvement in quality-of-care measures (per Inpatient Psychiatric Facility Quality Reporting) after receiving TA from QIOs. Percentage of eligible CAHs that demonstrate improvement in quality-of-care measures (per Inpatient Quality Reporting or Outpatient Quality Reporting (OQR)) after receiving TA from QIOs.		
Percentage of eligible PCHs that demonstrate improvement in quality-of-care measures (per PPS-Exempt Cancer Hospital Quality Reporting) after receiving TA from QIOs.	N:1/1/15 through 12/31/15 D:8/1/14-6/30/15 Target: Document Actions via Deliverable	All states (100%) met the 24th month contract evaluation criterion
Percentage of eligible Hospitals meeting measure thresholds for Hospital OQR program measures.	N:7/1/14 through 6/30/15 discharges D:8/1/14-6/30/15 Target: 65%	All states (100%) met the 24th month contract evaluation criterion
Percentage of eligible Hospitals meeting measure thresholds for Hospital IQR program measures used in value-based purchasing (HVBP).	N:1/1/14 through 12/31/14 D:8/1/14-6/30/15 Target: Document Actions via Deliverable	All states (100%) met the 24th month contract evaluation criterion
Percentage of eligible physician/professional groups participating in VM.	N:8/1/15 through 7/31/16 D:CY 2014 VM Eligible Population Target: Document Actions via Deliverable	All states (100%) met the 24th month contract evaluation criterion

Task E.1: Quality Improvement Initiatives (QIIs) Technical Assistance

The purpose of this Task is to improve the quality of health care for Medicare beneficiaries by providing technical assistance to providers and practitioners; it serves all the Aims of the 11th SOW. The QIN-QIO improves healthcare quality by assisting providers and/or practitioners in identifying the root cause of a concern, developing a framework in which to address the concern, and improving a process or system based on their analyses. A Quality Improvement Initiative (QII) is any formal activity designed to serve as a catalyst and/or support for quality improvement that uses proven methodologies to achieve these improvements. The improvements may relate to safety, healthcare, health and value and involve providers, practitioners, beneficiaries, and/or communities.

A QII may consist of system-wide and/or non-system-wide changes and may be based on a single, confirmed concern or multiple confirmed concerns. QIIs may also be based upon referrals made

by other contractors in the QIO Program. Additionally, the QIN-QIO will collaborate with the Beneficiary and Family Centered Care-QIO to improve Beneficiary ("Patient") and Family Engagement in healthcare quality improvement efforts and actively support projects aimed at shared decision-making with beneficiaries, families, and caregivers and families.

The general desired outcomes for this task are to support providers and practitioners to develop and implement quality improvement initiatives that achieve the desired established metric outcome, provide technical assistance and educational interventions. It is expected that any request or referral that is submitted be addressed timely and improved by using proven methodologies to achieve the best overall outcomes for beneficiaries. The table below summarizes the timeliness and success rate of technical assistance to providers and practitioners, aggregated for all QIN-QIOs for the performance period of August 1, 2015-Jully 31, 2016.

Table 11: QII Technical Assistance Evaluation Measure

Measure	Target	Result
Percentage of QIIs initiated within 30 days of the receipt of a referral or a request for QII technical assistance	80%	96%
Rate of Successful QIIs	70%	100%

Task F.1: Improving Medicare Beneficiary Immunization Rates through Improved Tracking, Documentation, and Reporting with a Special Focus on Reducing Immunization Health Care Disparities

This task supports the aim: Better Health: Healthy People, Healthy Communities.

Immunization rates among adults have historically been low. Immunization rates vary in the Medicare population from the high of about 66 percent for influenza to a low of 8 percent for tetanus and diphtheria boosters. There is an even greater variation between racial and ethnic groups. For example according to the National Health Interview Survey (2015), white adults aged 65 years and older had a pneumococcal immunization rate of 68.1 percent, whereas Asian adults aged 65 years and older had a rate of 49 percent; similarly, white, non-Hispanic adults aged 65 years and older had an influenza immunization rate of 41.7 percent while black, non-Hispanic adults had a rate of 50.2 percent.

The focus of this Task is on improving the assessment and documentation of Medicare beneficiary immunization status, increasing overall immunization rates, and reducing the immunization disparities. This work also supports the National Vaccine Advisory Committee Standards for Adult Immunization Practice and the adult immunization recommendations of the Advisory Committee on Immunization Practices. Additionally, there is evidence annual influenza immunization decreases morbidity and mortality in persons with cardiovascular disease.

Task G.1: Improving Identification of Depression and Alcohol Use Disorder in Primary Care and Care Transitions for Behavior Health Conditions

This task supports the aim of Better Healthcare for Communities: Beneficiary-Centered, Reliable, Accessible, and Safe Care.

Depression and alcohol use disorder are common behavioral health conditions in the Medicare population and are frequently under-identified in primary health care settings. Major depression is a leading cause of disability in the United States, complicates the treatment of other serious diseases and is associated with an increased risk of suicide. Alcohol use disorder is the most prevalent type of addictive disorder in those 65 and older and is often associated with depression. Additionally, challenges in effective care transitions for these and other behavioral health conditions contribute to high readmission rates and problems in treatment adherence.

Under this task, six regional QIN-QIOs provide technical assistance and educational interventions to help primary care providers screen for and increase the identification of people with depression or alcohol use disorder. In addition, QIN-QIOs work with inpatient psychiatric facilities to improve transitions of care and reduce readmissions for these and other patients after discharge. Assistance includes developing processes for successful transmission of discharge information to the follow-up practitioner, helping Medicare beneficiaries and their family/caregivers understand medications and treatment instructions, and coordinating communication between the inpatient facility, outpatient providers and Medicare beneficiaries.

Implementation for task G.1 was offset from the other tasks in the 11th SOW; it was implemented on June 12, 2015. Recruitment for the task was not completed until December 31, 2015; therefore, 24-month results were not available until July 2017, and to date the evaluation for this task has not been completed.

IV. CONCLUSION

Medicare beneficiaries, like all Americans, deserve to have confidence in their health care system. A system that delivers the right care to every person, every time, is the way to achieve that goal. The QIO Program, with a national network of knowledgeable and skilled independent organizations under contract with Medicare, is charged with identifying and spreading evidence based health care practices as well as conducting case reviews to make sure that the quality and standard of care provided to Medicare beneficiaries is satisfactory. The work of the QIO Program has been and continues to be a major contributing factor for improvements in American health care.

Many changes were made in the 11th SOW, and CMS believes the changes will impact critically important aspects of patient care provided to Medicare beneficiaries and their families.