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The Administration, Cost, and Impact of the Quality Improvement Organization Program for Medicare Beneficiaries

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Introduction

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 Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization (QIO) Program during the preceding fiscal year (FY). This report fulfills this requirement for FY 2024.

The statutory mission of the QIO Program is set forth in Title XVIII of the Act. Specifically, section 1862(g) of the Act provides that the purpose 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 that work directly with health care providers, health care practitioners, Medicare beneficiaries, and beneficiary representatives in the contractors' geographic service areas.

On November 7, 2019, CMS launched the QIO Program's 12th Statement of Work (SoW) contract period to enhance the quality of services provided to Medicare beneficiaries. Five-year contracts are currently divided between two sets of QIO contractors: Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) serving the Medicare program's complaint processing and case review needs; and Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) supporting health care delivery professionals and systems as they perform quality improvement work. FY 2024 was the fifth contract year for both BFCC-QIO and QIN-QIO contractors, closing out the 12th SoW. In FY 2024, QIO Program expenditures totaled $806,292,482. This amount includes funding for quality improvement activities (i.e., QIN-QIO program), for serving the Medicare program's complaint processing and case review needs (i.e., BFCC-QIO program), and other activities. This Report to Congress covers FY 2024 (October 1, 2023–September 30, 2024) and outlines the administration, cost, and impact of the QIN-QIO and BFCC-QIO Programs' 12th SoW QIO contract activities only. Please note that the scope of the report covers the final year of the previous Administration.

Background

The QIO program originated with the Peer Review Improvement Act of 1982 (P.L. 97-248, §§ 141-143, 96 Stat. 324), which established the Utilization and Quality Control Peer Review Organization program that has become the QIO program. The statutory provisions governing the QIO Program are found in Part B of Title XI of the Act. The Program's statutory mission is set forth in section 1862(g) of the Act, which provides that the purpose of the QIO Program is to promote the effectiveness, efficiency, economy, and quality of services furnished to Medicare beneficiaries and to make sure that those services are reasonable and necessary and not for custodial care. Part B of Title XI of the Act was amended by section 261 of the Trade Adjustment Assistance Extension Act of 2011 (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 separating the functions of the BFCC- QIOs and QIN-QIOs; modifying the eligibility requirements for QIOs, the terms of QIO contracts, and the geographic areas served by QIOs; and updates to the functions performed by the QIOs under their contracts.

Program Administration

Description of Quality Improvement Organization Contracts

CMS has identified the core functions of the QIO Program as:

- Improving quality of care for Medicare beneficiaries.
- Protecting the integrity of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds by working to ensure that Medicare pays only for services and goods that are reasonable and necessary and that services are provided in the most appropriate setting.
- Protecting beneficiaries by expeditiously addressing individual complaints; reviews or appeals of provider notices of discharge or termination of services; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities articulated in the Social Security Act and implementing regulations.

The QIOs are categorized and known as BFCC-QIOs and QIN-QIOs, depending on the QIO functions performed. QIOs are private, mostly not-for-profit, organizations staffed by doctors and other health care professionals. BFCC-QIOs are trained to conduct several types of contractually required reviews of beneficiaries' medical care and to respond to beneficiary quality of care complaints. QIN-QIOs work with health care providers, health care professionals, and community organizations to improve the quality of care in a variety of care settings. QIOs are reimbursed monthly, consistent with the Federal Acquisition Regulation. The 12th SoW also utilized a performance-based payment model in which a portion of the QIN-QIO reimbursement is tied directly to the achievement of quantitative outcomes. This model shifts from paying for services rendered, to paying QIN-QIOs for reaching meaningful and measurable targets as stipulated in their contracts.

QIOs Interacting with Health Care Providers, Practitioners, and Beneficiaries

BFCC-QIOs

The BFCC-QIO program represents CMS's commitment to ensuring that Medicare beneficiaries and their families are actively involved in quality improvement efforts while fostering a collaborative approach among healthcare partners to enhance the overall quality and cost-effectiveness of Medicare services. BFCC-QIOs interact with practitioners, providers, beneficiaries, beneficiary representatives, community organizations, and others to improve the quality of healthcare provided to Medicare beneficiaries. This is achieved by addressing beneficiary complaints regarding quality of care and conducting contractually required patient care reviews across various healthcare delivery systems.

Any provider or practitioner that treats Medicare beneficiaries and is paid under Title XVIII of the Social Security Act may be subject to review by a BFCC-QIO and may receive technical assistance associated with that review.

In addressing individual complaints, BFCC-QIOs analyze beneficiary records and other data to

identify needed improvements in care and ensure that beneficiaries' voices are heard, and their perspectives brought into the improvement process. For instance, Immediate Advocacy (IA), an informal alternative dispute resolution process, involves direct communication among BFCC-QIOs, providers/practitioners, and beneficiaries or beneficiary representatives to address complaints raised by the beneficiary. Through this process, BFCC-QIO staff work with providers/practitioners to resolve miscommunication or other concerns voiced by the beneficiary or beneficiary representative. IA is intended to resolve complaints as they are happening, for quick resolution and to avoid a formal complaint process.

QIN-QIOs

QIN-QIOs work with healthcare practitioners and providers, such as nursing homes, hospitals, and outpatient clinics, providing technical assistance to improve the quality of care for targeted health conditions. QIN-QIOs also support partnerships among health care providers/practitioners from various clinical settings and local non-clinical community support, service organizations, and faith-based entities to work together on quality improvement initiatives. During FY 2024, QIN-QIOs worked in approximately 11,498 priority ZIP code communities with 500 clinical and community partners, potentially impacting more than 22.4 million Medicare beneficiaries.

Program Cost

The QIO program operates under an indefinite, mandatory appropriation authorized by section 1159 of the Act and discretionary funding and is financed by the Hospital Insurance and Supplementary Medical Insurance trust funds. The QIO program is not subject to the annual appropriations process. QIO costs are subject to the apportionment process administered through the federal Office of Management and Budget (OMB).

Section 1862(g) of the Act requires the Secretary to enter into contracts with QIOs for purposes of making determinations about whether items and services provided to Medicare beneficiaries are reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, and are not for custodial care. In addition, the Secretary must enter into these contracts to promote the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

Section 1154 of the Act requires QIOs to perform, subject to the terms of their contracts, activities that the Secretary determines may be necessary for the purpose of improving the quality of care provided to Medicare beneficiaries.

In FY 2024, expenditures for BFCC-QIOs and QIN-QIOs totaled $806,292,482 in the 12th SoW not including funds expended under the American Rescue Plan Act of 2021. This amount includes funding for quality improvement activities (i.e., the QIN-QIO Program), for serving the Medicare program's complaint processing and case review needs (i.e., the BFCC-QIO program), and other activities.

American Rescue Plan Act of 2021 (P.L. 117-2)

In addition to the funding provided through the QIO Program, approximately $200 million in funding was allocated to the QIN-QIO Program by the American Rescue Plan Act for infection prevention efforts in nursing homes. Section 9401 of the American Rescue Plan Act amended subsection 1862(g) of the Act and appropriated, out of funds not otherwise obligated, $199.7 million to remain available until expended through the 12th SoW. Since 2021, the focus of infection prevention technical assistance has remained on the reduction of respiratory infections in nursing homes. In FY 2024, technical assistance provided by QIN-QIOs to nursing homes through ARPA funding totaled approximately $54 million. At the end of the QIN-QIO contract, approximately $28 million of ARPA funding is expected to be returned to the Treasury.

Program Scope

The QIO Program impacts Medicare beneficiaries on an individual basis and the beneficiary population. As of September 2024, Medicare covered nearly 68 million beneficiaries, including more than 60.5 million people aged 65 years or older and 7.5 million people of all ages with disabilities and/or with End Stage Renal disease (ESRD) or amyotrophic lateral sclerosis (ALS).[1]

Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs)

In March 2019, CMS launched a new contract structure for four additional BFCC-QIO contractors using multiple award/indefinite delivery/indefinite quantity (IDIQ) five-year contracts. The case review contracts were extended on April 29, 2024, for a second five-year contract.

CMS's BFCC-QIO Program is implemented through several types of contracts (see Table 1): case review contracts, claims review contracts, a National Coordinating and Oversight Review contract (ended May 7, 2024), an Audit Inter-Rater Reliability (AIIR) Contract, and a BFCC Survey Center contract.

From October 1, 2023, through September 30, 2024, the BFCC-QIOs conducted 550,307 case reviews for beneficiary complaints, IA, discharge appeals, and other contract-specified review types. IA and discharge appeal volumes continue to exceed CMS projections. From FY 2023 to FY 2024, the number of IA cases decreased by 6.54%, and the number of discharge appeals increased by 10.65%.

Table 1. Overview of BFCC-QIO Contracts

BFCC-QIO Contract	Contract Activities
Case Review Services: Awarded to Acentra, formerly Kepro, and	The case review BFCC-QIOs help Medicare beneficiaries exercise their right to high-quality health care. They manage all reviews of beneficiary quality of care complaints, as well as general quality of

[1] Medicare Monthly Enrollment, *Centers for Medicare and Medicaid Services,* November 2024. https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment. Accessed on December 2, 2024

Livanta on May 1, 2019.	care reviews. Beneficiary quality of care complaint reviews are initiated by the beneficiary or their representative. In this process, the BFCC-QIO communicates with the provider/practitioner and the beneficiary or their authorized representative throughout the review process. When the provider/practitioner or beneficiary/representative is not satisfied with the review decision, they have the right to request another review, called a reconsideration review. In the general quality of care review process, the BFCC-QIO does not communicate with the beneficiary. In this process the BFCC-QIO communicates only with the provider/physician, and only the provider/physician has the right to request a reconsideration review in a general quality of care review. The BFCC-QIOs ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families. They also handle cases in which beneficiaries want to appeal a health care provider's decision to discharge them from a facility or discontinue other types of Part A–covered services (e.g., inpatient hospital admissions, skilled nursing facilities, hospice, home health, comprehensive outpatient rehabilitation facilities). BFCC-QIOs review referrals from the CMS Survey Operations Group for potential EMTALA violations.
Claims Review Services: Awarded to Livanta on February 12, 2021	The claims review BFCC-QIO contractor conducts Post Payment Hospital Part A Claims Review work. This includes Higher Weighted Diagnoses Related Groups (HWDRGs) reviews, hospital inpatient short-stay reviews (reviews conducted under the Two-Midnight Rule), and focused reviews. The goal is to ensure that claims are billed and paid appropriately as per CMS policies.
National Coordinating and Oversight Review Center (NCORC): Awarded to Avar Consulting, Inc. on May 8, 2019. This contract ended on May 7, 2024.	Provided support and assistance to CMS for all BFCC-QIO-related activities by facilitating collaboration meetings, maintaining BFCC-QIO Program dashboards, and conducting independent BFCC-QIO Program evaluation and monitoring. The NCORC also partners with the CMS Clinical Data Abstraction Center and the Agency for Healthcare Research and Quality (AHRQ) to conduct reviews of medical charts for preventable patient safety events.

BFCC-QIO Case Reviews

CMS contracts with Livanta LLC and Acentra, formerly Kepro as the two BFCC-QIOs conducting case reviews. The two case review contractors cover the 50 states, the District of Columbia, and five U.S. territories (Table 2).

Table 2. BFCC-QIO Case Review Contractors by CMS Region and States/Other Jurisdictions

CMS Region	BFCC-QIO Case Review Contractor	States/Other Jurisdictions
Region 1: Boston	Acentra	CT, ME, MA, NH, RI, VT
Region 2: New York	Livanta	NJ, NY, PR, VI
Region 3: Philadelphia	Livanta	DE, DC, MD, PA, VA, WV
Region 4: Atlanta	Acentra	AL, FL, GA, KY, MS, NC, SC, TN
Region 5: Chicago	Livanta	IL, IN, MI, MN, OH, WI
Region 6: Dallas	Acentra	AR, LA, NM, OK, TX
Region 7: Kansas City	Livanta	IA, KS, MO, NE
Region 8: Denver	Acentra	CO, MT, ND, SD, UT, WY
Region 9: San Francisco	Livanta	AS, AZ, CA, GU, HI, MP, NV
Region 10: Seattle	Acentra	AK, ID, OR, WA

Ten BFCC-QIO regions align with the 10 CMS Regions, as shown in Table 2.

The two BFCC-QIO case review contractors, Acentra (formerly Kepro) and Livanta, focus on statutorily mandated case review activities, as well as interventions to promote responsiveness to beneficiary and family needs. These interventions include providing opportunities for listening to and addressing beneficiary and family/caregiver concerns, offering resources to help beneficiaries and caregivers in decision-making, and using information gathered from individual experiences to improve Medicare's healthcare system. Beneficiary-generated concerns provide an excellent opportunity to explore the root causes of adverse healthcare outcomes, develop alternative approaches to improving care, and enhance beneficiary/family/caregiver experiences within the healthcare system.

Beneficiary and family engagement and activation efforts are necessary to produce the best possible outcomes of care. These BFCC-QIO beneficiary and family-centered efforts align with the CMS National Quality Strategy, which encourages patient and family engagement.

Case review types include:

- Quality-of-care review;
- Beneficiary/caregiver-requested appeals of provider discharge decisions (e.g., discharge from an inpatient hospitalization);
- Beneficiary/caregiver-requested appeals of provider termination of service decisions (e.g., termination of home health services);
- Beneficiary/caregiver-requested appeals of denials of hospital admissions; and
- EMTALA reviews.

In FY 2024, there were limited changes to the BFCC contracts. The Case Review contracts were modified and extended to a second 5-year contract period. One modification included communication and outreach plans with partners, such as CMS Regional Offices and State Health Insurance Programs, to educate beneficiaries on their Medicare rights and the services

available from the BFCC-QIOs. This is a multi-year plan, and the BFCC-QIOs report to CMS on plans to work with partners. /;;Table 3 provides the national performance summary of the BFCC-QIO case review contractors on four timeliness measures and one beneficiary experience measure in Contract Year 5 (May 1, 2023, through April 30, 2024). The BFCC-QIOs met national performance standards in more than 99.7% of cases on four timeliness measures during this period. The overall percentage of cases meeting established criteria across the four timelines and one beneficiary experience measure in Table 3 was 97.3%. All targets were met in Contract Year 5, as described below (see Table 3).

Table 3. BFCC-QIO Case Review Performance, Contract Year 5 (May 2023 through April 2024)

Measure	Target % of Cases Meeting Performance Standard	% of Cases Meeting Performance Standard
Timeliness of Beneficiary Complaint Reviews and Quality of Care Reviews	95%	99.5%
Timeliness of Immediate Advocacy	90%	100%
Timeliness of Discharge Appeal/Service Termination Reviews	95%	99.7%
Timeliness of EMTALA Reviews	95%	99.7%
Positive Beneficiary Experience with BFCC- QIO*	85%	87.7%

* *A positive beneficiary experience with the BFCC-QIO is one by which a BFCC-QIO representative provides excellent customer service to Medicare beneficiary callers and staff are effective in the customer service domains of: communication, courtesy and respect, accessibility, and responsiveness in the provision of case review services*.

Beneficiary Complaint Reviews are initiated because a beneficiary or the beneficiary's representative has complained to the BFCC-QIO about the quality of care rendered to a Medicare beneficiary. In these reviews, the beneficiary or their representative is actively involved and is notified of the outcome. General Quality of Care Reviews are conducted because the BFCC-QIO has independently identified a potential quality issue or quality issue has been referred from another entity or a care complaint by a beneficiary who wants to remain anonymous. In General Quality of Care Reviews, the beneficiary is not involved nor notified of the process. When the BFCC-QIO confirms quality of care concerns, there are follow-up actions required depending on the nature or severity of the concern(s). For confirmed concerns that warrant technical assistance and interventions, the BFCC-QIO refers the concern to the QIN-QIO to work with the provider in a quality improvement initiative. For confirmed concerns that are not systemic or do not warrant technical assistance, the BFCC-QIO will recommend quality improvement activities such as offering advice or a continuing education course and/or conducting an informal teleconference. For gross and flagrant concerns and/or concerns in a substantial number of cases (more than three), the BFCC-QIO conducts sanction activities that include; coordinating with the Office of Inspector General regarding potential sanctionable conduct of the provider and/or practitioner; creating opportunities for discussions with the provider and/or practitioner; and

developing and imposing corrective action plans on the provider and/or practitioner.

See Table 4 for the BFCC-QIOs' review volume and number of cases with confirmed quality of care concerns.

Table 4: BFCC-QIO Case Review Beneficiary Complaint and General Quality of Care Review Volume and Outcomes, Contract Year 5 (May 2023 through April 2024)

Quality of Care Review Type	Review Volume	Number of Cases with Confirmed Concerns
Beneficiary Complaint Review	2,388	664
General Quality of Care Review	1,325	311

BFCC-QIOs conduct beneficiary requested appeals of discharge and service termination reviews. Post-Acute Care Medicare Advantage (MA) Appeals are conducted when a MA beneficiary receives a Notice of Medicare Non-Coverage (NOMNC) from their provider or MA plan, and the beneficiary or representative contacts the BFCC-QIO to appeal the decision to end post-acute services. Post-Acute Care Fee For Service (FFS) Appeals are conducted when a FFS beneficiary receives a NOMNC from their provider, and the beneficiary or representative contacts the BFCC-QIO to request an appeal of the decision to end post-acute services. Hospital Discharge Appeals are conducted when a Medicare FFS or MA beneficiary receives an Important Message from Medicare (IM), and the beneficiary or representative contacts the BFCC-QIO to appeal the discharge decision in the hospital inpatient setting. An FFS or MA beneficiary who is dissatisfied with a BFCC-QIO's decision may request a reconsideration for all appeal review types except for post-acute FFS appeals. FFS beneficiaries with post-acute appeals may request reconsideration with the Qualified Independent Contractor (QIC). See Table 5 for the appeal review volume, initial review outcomes, and reconsideration review outcomes.

Table 5: BFCC-QIO Case Review Beneficiary Requested Appeals of Discharge/Termination of Services Review Volume and Outcomes Contract Year 5 (May 2023, through April 2024)

Appeal Review Type	Review Volume	Initial Review Outcome (Percentage of Disagreement with the Discharge or Service Termination Decision)	Number of Cases with Reconsideration Requests (Beneficiary only)	Reconsideration Review Outcome (reversed initial decision)
Post-Acute MA Appeal	354,217	39%	65,363	20,728
Post-Acute FFS Appeal	49,744	32%	73	23
Hospital Discharge Appeal	88,057	11%	11,084	839

BFCC-QIO Claims Reviews

CMS contracts with Livanta, LLC, for BFCC-QIO Claims Review. Livanta performs three types

of post-payment reviews on a nationwide basis for inpatient claims submitted by hospitals: 1) reviews of HWDRG payments; 2) Short Stay Reviews (SSRs) for Two Midnight Rule compliance; and 3) Focused Reviews on topics specified by CMS as needed. The goal is to advance oversight and protection through the promotion of efficient and effective care and decreasing the overall Part A payment error rate.

HWDRG Review is composed of two separate (and statutory) reviews:

1) Utilization Review is the medical necessity/admission review. The BFCC-QIO determines whether the hospital admission itself was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient. When a BFCC-QIO finds that the beneficiary should never have been admitted, the BFCC-QIO denies the claim and retracts Medicare payment for the care. *See Social Security Act §1154(a)(1)(A), which links to §1862(a)(1) and (9), and regulations promulgated at §476.71(a)*; and

2) DRG Validation Review. The BFCC-QIO evaluates the medical record to verify the accuracy of the hospital's coding of all diagnoses and procedures that affect the DRG. When a BFCC-QIO finds inaccuracies in the DRG coding, the BFCC-QIO makes the appropriate changes to the procedural and diagnostic information, resulting in a change of DRG assignment decision. *See §1866(a)(1)(F) and regulations promulgated at 42 CFR §§412.60(d)(2) and 476.71(c)(2).*

Table 6 provides the national performance summary of the BFCC-QIO claims review work on two timeliness measures.

- Final review results are counted for timeliness. The measurement of this metric was modified in January 2023. All previous months were adjusted to accommodate this change.
- To meet timeliness for short stay reviews, the QIO must complete the review within 6 months of the claim through date. This is important to allow the hospital sufficient time to bill Medicare Part B when the Part A claim is denied.

Table 6. BFCC-QIO Claims Review Performance, FY 2024

Measure	Target % of Cases Meeting Performance Standard	% of Cases Meeting Performance Standard
Timeliness of HWDRG Reviews	95%	97.4%
Timeliness of SSRs	95%	99.5%

See Table 7 for review volume, volume claims denied, and estimated dollar amount denied.

Table 7: BFCC-QIO Claims Review Outcomes, FY 2024

Review Type	Review Volume	Volume Claims Denied	Estimated Dollar Amount Denied
HWDRG Reviews	56,231	6,145	$32,742,484

Short Stay Reviews	20,009	2,819	$24,270,431

Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs)

The 12th SoW contract was awarded to 12 QIN-QIO contractors on November 7, 2019. Each QIN-QIO contractor covers a region that includes as many as 12 states, across the United States, the District of Columbia, and five U.S. territories, as shown in Table 8 and Figure 2.

Table 8. QIN-QIOs by States/Other Jurisdictions

QIN-QIO	States/Other Jurisdictions
Alliant Health Solutions	AL, FL, GA, KY, LA, NC, TN
Comagine Health	ID, NV, NM, OR, UT, WA
Great Plains	ND, SD
Health Quality Innovators (HQI)	KS, MO, SD, VA
Health Services Advisory Group (HSAG)	AZ, CA
Island Peer Review Organization (IPRO)	CT, DE, D.C., ME, MD, MA, NH, NJ, NY, OH, RI, VT
Mountain-Pacific Quality Health	AK, AS, GU, HI, MP, MT, WY
Qsource	IN
Quality Insights	PA, WV
Superior Health Quality Alliance	MI, MN, WI
Telligen	CO, IL, IA, OK
TMF Health Quality Institute	AR, MS, NE, PR, TX, VI*

**The Virgin Islands (VI) have no nursing homes that accept Medicare*.

Figure 2. QIN-QIO Coverage by States/Other Jurisdictions

The purpose of the QIN-QIO Program is to promote health care quality and safety through the provision of technical assistance and education to those providing health care services. CMS procures expert health care quality improvement services from the QIN-QIOs to improve care for Medicare beneficiaries in nursing homes and the communities in which beneficiaries reside. Under CMS's direction and aligned with the Agency's priorities, QIN-QIOs work with providers and beneficiary-focused community partnerships on data-driven quality initiatives to improve patient safety, reduce harm, and improve clinical care at the local and regional levels.

The five broad goals established by CMS for the 12th SoW QIN-QIO Program are:

- Improve Behavioral Health Outcomes, Focusing on Decreased Opioid Misuse;
- Increase Patient Safety;
- Increase Chronic Disease Self-Management (Cardiac and Vascular Health; Diabetes; Slowing Chronic Kidney Disease and Preventing ESRD);
- Increase Care Coordination; and
- Improve Nursing Home Quality

Each goal has an associated set of quality measures for nursing homes, beneficiary-focused community partnerships, or both that hold the 12 QIN-QIOs accountable for measurable outcomes.

Table 9 delineates how QIN-QIOs address these goals across care settings.

Table 9. QIN-QIO Activities by Setting and Task Area

Setting	Task Area	Examples of Types of Activities
Nursing Homes	Contract-specified provider-based quality improvement services intended to better resident outcomes in nursing homes	• In-person, large group events focusing on infection control, vaccination, emergency preparedness, and support for reporting infection data to the Centers for Disease Control and Prevention (CDC) and National Healthcare Safety Network (NHSN). • Activities focused on smaller groups, including organizing vaccination clinics, providing staff training, connecting health care practitioners and residents/families with tools to facilitate resident health decisions, and training in Quality Assurance and Process Improvement (QAPI) approaches to quality improvement. This work was initiated under the first Trump administration and carried forward into the prior administration. • Providing reports to nursing homes to help them track their progress on targeted health outcomes
Partnerships for Community Health	Contract-specified community-based quality improvement services intended to better outcomes among Medicare beneficiaries residing in the community	• Building and sustaining community partnerships through community coalitions comprised of health care practitioners, providers, and/or other representatives from various clinical settings, health care groups, non-clinical organizations, and local community support/service organizations, as indicated by CMS • Supporting implementation of opioid use best practices within participating communities: naloxone distribution and education/outreach, prescription monitoring, medication-assisted treatment, and local solutions developed in communities • Supporting local health systems in organizing health fairs
Targeted Response Quality Improvement	Ad-hoc quality improvement projects to address immediate identified needs,	• Cultivation of messengers (QI Champion) within nursing homes • Coaching nursing home staff on motivational interviewing techniques

Initiatives (TR QIIs) in nursing homes	emerging trends, etc.	• Development of public displays of quality improvement targets and results. Support for nursing homes that struggled to report infection rates to the NHSN to help these facilities report accurately

QIN-QIO quality improvement work was addressed by expanding access to quality health care through partner engagement and innovation.

Older adults continue to be disproportionately affected by respiratory-related illnesses and other infections, as they are at higher risk for severe illness, hospitalization, and death from infections compared to younger people. The continued vulnerability of the older population, with nursing home residents being at particular risk, has made infection prevention a continuous priority of CMS and the QIN-QIO Program.

Table 10 provides a high-level overview of the QIN-QIO Program's activities with respect to infection prevention among nursing home residents during FY 2024.

Table 10. Infection Prevention Activities During Fiscal Year 2024

Infection Prevention Activities
Infection Control TR-QIIs: CMS referred 6,978 nursing homes for assistance with infection control in FY 2024. The 12 QIN-QIOs engaged in targeted response with 5,267 of these referred nursing homes. The QIN- QIOs continued to engage in infection control targeted response with 3,942 previously referred facilities.
Respiratory Infection TR-QIIs: CMS referred 11,694 unique nursing homes for QI support related to respiratory illness prevention. More than 8,600 (74%) of these facilities received at least one targeted assistance encounter. In total, QIN-QIOs had more than 27,900 one-on-one encounters with referred nursing homes (working with a nursing home multiple times, if needed) as part of their TR-QIIs in FY 2024.
Community Health Partners Enrollment: Enrollment for community health partners concluded in January 2023. The QIN-QIOs had enrolled a total of 11,498 unique nursing homes as part of community partnerships and continued to work with these partners in FY 2024. Nearly 500 Partnerships for Community Health were created that covered more than 26 million fee-for-service Medicare beneficiaries and more than 56 million total Medicare beneficiaries. As part of their community health work, the QIN-QIOs partnered with state and local health departments and other agencies to provide information about prevention of respiratory-related illnesses.

Infection Control TR-QIIs

CMS continued to direct the QIN-QIOs to provide intensive one-on-one support on CDC guidelines and infection control practices to nursing homes.

CMS deploys the QIN-QIOs to provide targeted assistance to nursing homes serving rural residents, and populations requiring greater care, to improve nursing home quality. CMS's Provider Enrollment List was comprised of nursing homes most in need of quality improvement, specifically facilities with a Star rating of 4 stars or less based on the latest available Nursing

Home Compare data, small & rural providers including those serving vulnerable populations, and providers who lacked the resources to otherwise access quality improvement assistance. Each QIN-QIO was required to enroll a specified number of nursing homes from this list to collectively achieve CMS's national recruitment goal.

With the expiration of the Public Health Emergency (PHE) in 2023, the focus of infection control TR-QIIs shifted. In FY 2024, TR-QIIs were more generalized, than previous years and addressed other communicable disease like influenza. Specific TR-QIIs were developed to support the nursing homes. CMS used data from infection control practice deficiencies documented during inspection, county respiratory infection rates, and nursing home infection case counts to identify and refer those in greatest need of direct assistance to QIN-QIOs for TR-QIIs each week. In each referred facility, QIN-QIOs provided onsite or virtual intensive support within 5 days of referral and provided continuing support until the QIN-QIO documented clear evidence that the problem had been addressed, a process that usually took between 6 and 9 months. The QIN-QIO assisted providers and/or practitioners in identifying the root cause(s) of concern, developing a customized plan to address concerns, coaching the facility's administration or staff in implementing at least one process or system-based improvement consistent with the plan, and providing support to monitor changes in processes and outcomes.

Advancing Health in the Community

QIN-QIOs supported Partnerships for Community Health and collectively collaborated with various healthcare providers and community organizations, to improve healthcare outcomes for the beneficiaries that they served. QIN-QIOs engaged communities to coordinate care for cost effectiveness, efficiency, and to reduce barriers of access to care. Enrollment for Community Partnerships was completed in November 2023. Over 61 million Medicare beneficiaries were included in these partnerships.

The Partnerships for Community Health also worked to improve the health of beneficiaries in the community. The work ensured that beneficiaries with the greatest need had access to services that aligned with CMS, HHS, and White House priorities. Under CMS's direction, QIN-QIOs worked with providers and communities on data-driven quality initiatives to advance beneficiary health outcomes. Community work included 61 million Medicare beneficiaries in 35,249 ZIP codes, and focused on a subset of these ZIP codes, identified as priority ZIP codes, based on the Area Deprivation Index, United States Department of Agriculture's Food Access Research Atlas, and CDC's Social Vulnerability Index. There were 22 million beneficiaries in 11,498 priority ZIP codes. QIN-QIOs also coordinated existing community-based efforts and utilized the Local Interactive Network of Knowledge Sharers (LINKS). LINKS was the non-clinical local community organization/entity subgroup within the Partnership for Community Health that was convened by the QIOs to support improvement of the measures and healthcare outcomes of the SoW and to discuss, make recommendations, and support other healthcare related and community issues. Working with LINKS, QIN-QIOs identified innovative and interactive activities with community partners that promoted public health awareness, disseminated information, and sought community level feedback on various healthcare topics relevant to the community and/or specific measures in the statement of work.

Engaging Partners and Driving Innovation

QIN-QIOs harness the power of timely, high-quality data to both identify and remedy gaps to expand access to quality care for beneficiaries. In QIN-QIO work, technical assistance is most successful when one-on-one connections are made. Building trust with communities is a necessary precursor for QIN-QIOs to share their expertise and resources to expand access to quality care. QIN-QIOs may initiate community partnerships, but ultimately the community's ownership of coalitions and interventions is key to their sustainability. Often QIN-QIOs help build, maintain, and strengthen relationships with state partners, such as state surveys, epidemiology, immunization agencies, and local CMS officials to partner with Patient and Family Advisory Coalitions associated with facilities.

Collaborating with the Community to Increase Cardiopulmonary Rehabilitation Rates

A QIN-QIO created a coalition to increase cardiac rehabilitation in Iowa. They collaborated with the Iowa Association of Cardiopulmonary Rehabilitation, the Iowa Heart Foundation, and Iowa Health and Human services to design a framework for continued improvement in cardiac rehabilitation enrollment. Interventions included sharing rehabilitation networks, creating a patient ambassador for program education, and addressing costs to the patient through a patient assistance program. While not achieving their target of 15% relative improvement rate, they did improve over baseline by 8%.

Use of Artificial Intelligence (AI) to predict outcomes

A QIN-QIO partnered with Dell to use AI in a review of NHSN data to determine if an AI model tool could be used to predict infection control outcomes within nursing homes. Preliminary results show that AI can be successfully used to predict outcomes. The findings include enforcing appropriate use of Personal Protective Equipment (PPE) and restricting symptomatic staff from working. Future work should expand the model to include broader population demographics and Long-Term Care Facility settings.

Infection Preventionist Training

A QIN-QIO held an "Infection Preventionist Leadership Bootcamp" for infection preventionists in underserved areas in West Virginia. Response to this educational offering was excellent, with an 82% attendance rate, representing 58 unique facilities, 47% of all West Virginia nursing homes. There was a strong connection within the Nursing Home community by collaborating with the West Virginia Healthcare Association, and the West Virginia Department of Health and Human Resources, and Project Firstline.

The conference marked the commencement of an extensive six-month educational initiative, characterized by a baseline program evaluation. This evaluation revealed insights into the experience levels of the attendees, with 20% being new to the role (less than 1 year), and 28% having 1-2 years of experience. Furthermore, only 30% of the participants felt fully supported in their roles, underscoring the need for continued professional development and support. Participants reported a percentage increase in knowledge to as high as 78%, depending on the

topic (Emergency preparedness and how it relates to infection control).

CMS-CDC-Sepsis Alliance Collaboration

The CMS QIN-QIO clinical and data staff analyzed hospital readmission rates from nursing homes for FY2023. Sepsis was found to be the highest driver behind readmissions (12,356 resident readmissions during FY2023). As is the general practice in the QIO Program, CMS uses data to identify areas for improvement, thus sepsis reduction was chosen as a primary quality improvement project for FY 2024.

The analysis of sepsis events showed that 211 nursing homes had more than 11 sepsis cases each. CMS determined that these nursing homes would benefit greatly from 1:1 technical assistance by the QIN-QIOs. CMS developed a two-phased approach, which involved targeted QIO assistance to those nursing homes in need and a Nationwide Sepsis Reduction Program. CMS partnered with the CDC and Sepsis Alliance to determine best practices for sharing with the nursing homes and to guide quality improvement plans. Both entities were generous in sharing their resources.

Phase 1: Targeted QIO assistance to nursing homes

- CMS directed technical assistance referrals for 211 NHs to the QIN-QIOs in May 2024.
- The QIN-QIOs initiated intensive sepsis reduction projects in these 211 NHs.

Phase 2: Nationwide Sepsis Reduction Program

- CMS planned a shared learning series held in partnership with the CDC and Sepsis Alliance. Each QIN-QIO was asked to enroll several of their staff who would serve as consistent Sepsis Reduction Champions for their region throughout the learning series.
- A total of four Shared Learning Events were held between May and August 2024, with interactive breakout sessions for attendees. The four events received satisfaction scores between 4.66 and 4.91 on a scale of 1-5 from the attendees, regarding the quality and usefulness of the information shared during the events.

The focus in both phases is on prevention and early detection of sepsis. A key component of the initiatives is to educate the family and residents on signs and symptoms of sepsis, as they may be the first to identify changes in the resident. Special resources such as badge cards and decision trees were provided to nurses and nursing assistants. Resources from CMS, CDC, and Sepsis Alliance were distributed and posted to the QIO Program website[2].

The QIN-QIO 12th SoW ended on November 7, 2024, however, CMS's collaboration with the CDC and Sepsis Alliance will continue into the 13th SoW to ensure nursing homes residents are closely monitored to improve health outcomes, and quality improvement assistance is provided where needed and based on the data.

[2] www.qioprogram.org

Quality Improvement and Innovation Projects

The Quality Improvement and Innovation Projects test innovative, creative approaches, and new ideas on a small scale to inform large scale financial investments in the area of quality improvement. The program strategically uses funding to further the goals of the program to:

- Test quality improvement models that have had promising results in the private sector and may potentially be implemented at large scale using government funding.
- Test solutions to questions, problems, and/or barriers faced in current work to inform program design in future work.
- Incorporate modern, emerging health care technologies and practices into current quality improvement programs, after testing and refinement in a low-risk experimentation context.
- Explore areas of quality improvement assistance that are new, emerging, and untested in the program's history.
- Explore further implementation of the Administration's priorities beyond the 12th SoW.

Organ Procurement Organization (OPO) Quality Improvement Project

The OPO Quality Improvement Project ran from March 2023 to March 2025, and was developed in response to Congressional concerns about the need for more immediate action and technical assistance to improve OPO performance on organ donation and transplant rates. OPOs are surveyed by CMS for Medicare recertification purposes on-site every 4 years. An OPO must pass the survey and meet the OPO Conditions-for-Coverage requirements in order to continue to be a Medicare-certified OPO. CMS then ranks OPOs into three Tiers based on their performance (Tier 1 are the highest performing). The purpose of this project was to provide technical assistance to OPOs in Tiers 2 and 3, between quadrennial surveys, for improvement on the OPO performance outcomes of organ donation rate and transplant rate.

The improvement project contractor used the most current OPO Annual Public Performance Report, and subsequent reports released each spring, for outreach to the OPOs. The contractor offered quality improvement support for the development of root cause analyses (RCAs) to assist the OPO with performance improvement. As part of the TA, the contractor assisted the OPOs to identify which barriers (when resolved) had the greatest ability to impact outcomes. CMS continues to work with OPOs to implement standardized processes and structure (e.g., QAPI) to reduce variation, achieve expected results, and improve outcomes.

As of September 2024, 95.2% of OPOs (40/42) in Tiers 2 and 3 were participating. The other 2 OPOs declined due to recent leadership changes and existing contracts in place to support quality improvement.

Community Providers and Local Students (PALS) Innovation Project

The PALS Innovation Project was a 1-year Innovation Project that began in March 2023, ended March 2024, and was developed to test an improvement model of utilizing a CMS student engagement program to improve the quality of care and services for Medicare beneficiaries

residing in nursing homes located within priority ZIP Codes provided by CMS. Most students receive their education on aging in the hospital, where they may only see hospitalized older adults who are often debilitated and physically deteriorating. There is a need to continue the work of the student engagement projects implemented at the university level to help students gain a better understanding of an aging population and avoid ageist stereotypes to improve the quality of care the older adults receive.

The contractor recruited nursing homes in priority ZIP Codes and students who were based in schools of medicine, pharmacy, and nursing, including one school that was part of a Historically Black College or University (HBCU).

The PALS pilot was implemented in three nursing homes in Houston, TX, using two cohorts of students paired with older adults, each lasting four months (May–August 2023; September–December 2023). Cohort 1 saw an improvement in the University of California, Los Angeles (UCLA) Geriatric Attitudes Scale (GAS) scores, used to assess the students' attitudes toward older adults and caring for older patients. The Medicare beneficiaries in Cohort 1 showed an improvement in their Lubben Social Network Scale (LSNS), which measures the frequency of interactions with family and friends.

Students received focused learning on Aging Topics, Social Isolation and Loneliness, and Empathetic Communication. During the nursing home sessions, intergenerational social connections were forged using strategies such as storytelling and conversation practices and prompts to help facilitate deeper and more meaningful connections.

Rapid Competency Quality Improvement (RCQI) Innovation Project

The RCQI was a 1-year Innovation Project that began September 15, 2023, and ended on September 14, 2024. The project was developed as a result of CMS listening sessions with 7 national hospital and health system stakeholders. Stakeholders shared their need for rapid competency and skill development for their newly hired staff including nurses, technicians, and allied health professionals. Persistent staff shortages forced health care facilities to increase their use of contract workers to fill nursing, technician, and other frontline positions. These temporary health care workers require rapid onboarding and training that can help them quickly become proficient in quality improvement and patient safety to help provide patient care in a safe, competent manner.

The RCQI Innovation Project contractor utilized the latest standards of practice, participant and stakeholder expertise, and environmental scans to identify and/or develop content for rapid competency, skills-based training modules and related quality improvement resources on a self-service, online web-based platform for healthcare staff. The audience intended for this platform and training are staff such as nurses and allied health professionals in a variety of settings.

For rapid competency and skill development for staff, the contractor was also required to work with federal partners to identify/improve training modules for the following:

- Infection Control: Hand Hygiene (e.g., CDC, AHRQ, and the Indian Health Service

(IHS).
- Patient Safety: Sepsis–Recognition, Treatment, and Technology (e.g., CDC, AHRQ, HHS, IHS),
- Culturally and Linguistically Appropriate Services (CLAS): Engagement, Community Leadership, and Accountability (e.g., HHS, Health Resources and Services Administration (HRSA), IHS).
- Behavioral Health: Depression Screening, Awareness (e.g., Substance Abuse and Mental Health Services Administration (SAMHSA), Food and Drug Administration (FDA), IHS).
- QAPI in Nursing Homes.
- Overview of Basic Quality Management Tools in Healthcare.
- Other topics as identified from assessment (as agreed upon by CMS).

The intended outcome of this project was to improve the time to reach proficiency for new and existing staff, accessibility of a variety of resources, increased training module utilization, and enhanced expertise and skill in patient care because of the accessible, on-demand resources.

The pilot experience was successful in demonstrating that shorter and more engaging training modules are a welcome change for busy front line/direct care health care workers, especially nurses and aides caring for heavy patient loads under persistent workforce shortages. The RCQI pilot experience also demonstrated that workforce training methods to update direct care workers on the latest developments or proficient in QI standards and best practices needs micro-learnings that incorporate bite-sized information and real-world scenarios in gamified content, that pertains to their care settings and the types of patients they serve.

The RCQI project piloted new types of modules that were developed using human-centered design among a diverse mix of frontline health care workers that represented multiple care settings. Recommendations for future efforts based on the results of the pilot include ensuring modules are short (10-20 minutes on average), trainings must be applicable to the clinical context of the learner, pretests should include a "test out" option if participants receive a high score on the proficiency test, interactive and video-based scenarios are preferable, and trainings should be structured with bite-sized content.

Conclusion

Medicare beneficiaries, like all Americans, deserve to have confidence in a health care system that delivers access to high-quality, affordable healthcare. Under CMS's direction, the BFCC-QIO and QIN-QIO Programs, with national networks of knowledgeable and skilled independent organizations under contract with Medicare, are charged with identifying and spreading evidence-based health care practices to help ensure that the quality and standard of care provided to Medicare beneficiaries is satisfactory. The work of the BFCC-QIO and QIN-QIO Programs has been and continues to contribute to improvements in health care for all Medicare beneficiaries.

Preview of Next Report

FY 2024 marked the final stages of the QIO Program's 12th SoW contract period. Our next report will include both notable accomplishments achieved under the 12th SoW contract overall and a summary of the launch of the 13th SoW contract period and activities completed during FY 2025.