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Report to Congress

Fiscal Year 2025

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. This report fulfills this requirement for Fiscal Year (FY) 2025.

The statutory mission of the QIO Program is set forth in Title XVIII (Health Insurance for the Aged and Disabled) of the Act. More 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 (QI) 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 May 1, 2024, CMS launched the QIO Program's 13th Statement of Work (SOW) contract period, which supports national health care QI efforts for Medicare beneficiaries. During FY 2025, the program continued to advance priorities aligned with the Administration's focus on Make America Healthy Again through continued efforts related to prevention, chronic disease management, patient safety, care coordination, and healthier communities. As one of the largest federally funded QI programs in the country, CMS directs QIOs to collaborate with health care providers nationwide to improve outcomes for Medicare beneficiaries.

Five-year contracts are currently divided between three sets of QIO contractors: Beneficiary and Family Centered Care-QIOs (BFCC-QIOs) serving the Medicare program's complaint processing and case review needs; Quality Innovation Network-QIOs (QIN-QIOs) supporting health care delivery professionals and systems as they perform QI work; and the American Indian Alaska Native-QIO (AIAN-QIO), which works with Indian Health Service (IHS), Urban Indian Organizations (UIOs), and tribally-managed facilities to improve the quality of health care for people with Medicare who are American Indian or Alaska Native.

This Report to Congress covers FY 2025 (October 1, 2024–September 30, 2025) and describes the main activities undertaken by the QIOs in the beginning of the 13th SOW which began before FY 2025 (on May 2024) for the BFCC-QIO Program. In FY 2025, QIO Program expenditures totaled approximately $789M. This report also describes key accomplishments achieved under the 12th SOW.

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.

Summary of 12th SOW

The 12th SOWs of two programs were completed at the end of 2024: the QIN-QIO Program and the Hospital Quality Improvement Contractor (HQIC) Program. Below are summaries of these two programs including strategies implemented, key achievements identified by the Independent Evaluation Contractor (IEC), and areas where the IEC did not find evidence of program impact.

Summary of the 12th SOW for the QIN-QIO Program

The 12th SOW for the CMS QIN-QIO Program was implemented from November 7, 2019, to November 6, 2024. CMS awarded contracts to 12 QIN-QIOs to provide data-driven and evidence-based QI interventions to improve the quality and safety of care for Original Medicare beneficiaries and reduce Medicare expenditures among beneficiaries receiving care in nursing homes and in the community.

The aims of the 12th SOW were to: 1) address the COVID-19 Public Health Emergency (PHE) through targeted infection control; 2) increase adult immunization; 3) improve patient safety; 4) reduce opioid utilization and misuse; 5) increase the care coordination between health care settings; and 6) improve chronic disease management. To achieve these aims, the QIN-QIO contractors provided technical assistance to nursing homes to improve quality of care for residents. Additionally, QIN-QIOs developed partnerships with health care providers, non-clinical organizations, and local community organizations to support improvements in health care outcomes for community-residing beneficiaries.

The IEC conducted a rigorous evaluation to assess QIN-QIO activities and their impact. QIN-QIOs leveraged data-driven customized approaches in their QI efforts. They used existing and newly collected data to tailor their services to each entity's unique needs. Their interventions were applicable to varied audiences, including facility administrators and leadership, clinicians and health care staff, and community partners. Whenever possible, QIN-QIO contractors aligned support efforts across nursing home and community settings to maximize efficiency and program impact. The contractors also utilized existing community infrastructure to prevent duplication of services and to help build foundations for work. Finally, QIN-QIOs established connections between health care facilities and helped facilities address non-clinical needs, such as transportation to appointments.

The IEC's evaluation determined the program improved health care outcomes for Medicare beneficiaries in some of the focus areas. Table 1 describes the key QIN-QIO Program achievements in the 12th SOW and the timeframes used in the evaluation for the different outcomes. The achievements included are those for which the evaluation found the program had an attributable impact. The evaluation timeframes vary by outcome based on program enrollment and intervention implementation timelines, and roll-out of vaccinations. These quality-of-care improvements resulted in estimated cost savings totaling $1.3B.

Table 1. Key Achievements of QIN-QIO Program in 12th SOW

Setting	Achievements	Evaluation Timeframe(s)
Nursing Homes	25.3% to 29.7% reduction in incidence of certain respiratory illnesses (among residents), resulting in an estimated 75K averted cases (all $p < 0.001$)	April 2020 to March 2021, June 2021 to December 2022
	11.9% to 19.1% reduction in incidence (among staff) of certain respiratory illnesses, resulting in an estimated over 48K averted cases ($p = 0.002 – 0.003$)	
	26.4% reduction in hospitalizations of certain respiratory illnesses, resulting in an estimated over 7K averted hospitalizations ($p = 0.001$)	April 2020 to March 2021
	24.3% reduction in mortality due to certain respiratory illnesses, resulting in an estimated over 6K, averted deaths ($p = 0.015$)	
	5.1% to 6.2% increase in nursing home residents' up-to-date vaccinations for certain respiratory illnesses, resulting in over 103K residents having up to date-vaccinations (all $p < 0.001$)	January 2022 to March 2024
	5.5% reduction in hospitalizations due to facility-acquired infections, resulting in an estimated over 32K averted hospitalizations ($p < 0.001$)	January 2019 to December 2024
	3.7% reduction in preventable emergency department (ED) visits, resulting in an estimated over 1K averted ED visits ($p = 0.033$)	
	1.9% reduction in 30-day hospital readmissions, resulting in an estimated over 13K averted hospital readmissions ($p = 0.003$)	
Partnerships for Community Health	0.2% to 0.6% increase in pneumococcal vaccination, resulting in an estimated over 54K more community-residing beneficiaries obtaining the pneumococcal vaccine (all $p < 0.001$)	November 2018 to December 2023
	2.5% reduction in 30-day hospital readmissions, resulting in an estimated over 75K averted hospital readmissions ($p = 0.028$)	January 2019 to December 2024

Notes: Achievements in nursing homes refer to outcome improvements among nursing home residents, except as noted. Achievements for Partnerships for Community Health refer to outcome improvements among QIN-QIO enrolled community-residing beneficiaries. Timeframes and achievements differ based on program enrollment, intervention implementation timelines, and roll-out of vaccinations (for incidence and vaccination outcomes of respiratory illnesses). Percentage reductions in vaccinations (other than pneumonia vaccination) refer to changes in percentage points, while reductions for other measures are relative to the baseline harm rate prior to QIN-QIO program support.

The evaluation did not find sufficient evidence to demonstrate that the QIN-QIO Program led to improvements in other outcomes. Within the nursing home setting, those QI categories included: influenza and pneumococcal vaccinations, adverse drug events, and hospitalizations due to *Clostridioides difficile.* Within partnerships for community health, this included influenza vaccination, opioid-related adverse drug events among high-risk patients, ED visits among super-utilizers, overall hospital utilization, management of chronic kidney disease, and cardiac rehabilitation participation.

The research literature and interviews with QIN-QIOs pointed to several potential reasons for the lack of program impact observed for these outcomes, including the emergence of the COVID-19 PHE, low provider prioritization of infrequent outcomes, and data limitations. Facilities and communities prioritized addressing COVID-19 outbreaks, which affected the QIN-QIOs' ability to consistently support other areas, such as chronic disease management and opioid-related adverse drug events. Another effect of the COVID-19 PHE was staffing shortages and increased staff turnover, which created, and in some instances, exacerbated, barriers to QIN-QIO support efforts. Additionally, the infrequent occurrence of some harm events, such as adverse drug events, decreased the prioritization by providers. Finally, QIN-QIOs commonly encountered barriers to collecting data from communities and nursing home facilities, which interfered with their ability to identify, provide support, and track improvements in outcomes with the most need for their assistance.

Summary of 12th SOW for the Hospital Quality Improvement Contractor (HQIC) Program

The 12th SOW for the CMS HQIC Program was implemented from September 18, 2020, to September 17, 2024. CMS awarded contracts to nine organizations (hereafter "HQICs") to improve health care quality and safety in hospitals.

The HQIC Program targeted hospitals that were in rural areas with limited access to high-quality care, served a high proportion of patients economically under-resourced, and/or had lower national quality ratings. The aims of the HQIC Program were to: 1) improve patient safety; 2) increase quality of care transitions with the goal of reducing hospital readmissions; and 3) decrease opioid misuse. HQICs also supported hospitals in responding to emerging public health crises.

HQICs worked with hospital stakeholders to achieve targets through QI activities using evidence-based practices. HQICs implemented a wide range of in-person, virtual, and hybrid intervention activities, including training hospital staff on evidence-based resources such as checklists and toolkits, providing technical assistance with implementation of those practices, holding office hours, and training staff on quality delivery of services. HQICs also provided data-related support, including helping hospitals understand QI data and developing data collection protocols to inform QI activities.

The evaluation from the IEC using data from Q1 2019 through Q1 2024 showed that the program was successful in improving the following health care outcomes for hospital patients who were Medicare beneficiaries:

- 1.4 percent reductions in 30-day hospital readmissions, resulting in an estimated 5K averted hospital readmissions ($p = 0.028$)
- 17.4 percent reductions in catheter-associated urinary tract infection (CAUTI) events, resulting in an estimated 524 averted CAUTI events ($p = 0.004$).

Improvements in quality of care resulted in an estimated cost savings totaling $55.4M for 30-day hospital readmissions and $8.3M for CAUTI events.

The evaluation did not find sufficient evidence to show that HQIC Program support resulted in attributable improvement in other outcomes: hospital-acquired infections (other than CAUTI), inpatient adverse drug events, pressure injuries, and high-dose opioid prescribing at hospital discharge.

Information derived from the research literature, government health agencies, and HQICs themselves suggested several potential reasons for the lack of impact in these outcomes, including rare or infrequent occurrences, and effects related to the COVID-19 PHE. To start, many of the targeted outcomes occurred infrequently. Notably, most enrolled hospitals were small, and therefore, the frequency of some events were especially rare in those settings.

Additionally, some outcomes had already been decreasing nationwide (e.g., pressure injuries, adverse drug events, some hospital acquired infections). These factors provided hospitals with fewer opportunities to make notable improvements, and dedicating limited resources to reduce rare events may not have been feasible or a priority for many hospitals. Furthermore, the contract began in September 2020, a time when treating patients with COVID-19 and reducing the risk of within-hospital infection transmission was a top priority; this often took precedence over other QI goals. Importantly, the pandemic led to staffing shortages, turnover, and burnout. Staffing shortages have been a concern for rural hospitals and critical access hospitals for some time, and the pandemic exacerbated these shortages, which further limited focus and resources directed at QI initiatives.

Program Administration

Description of Quality Improvement Organization Contracts in 13th SOW

CMS identified the core functions of the QIO Program in the 13th SOW as:

- Use data to track health care QI at the local level.
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting.
- Protect beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice beneficiary requested appeals; potential violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

The QIOs are categorized as BFCC-QIOs, QIN-QIOs, and AIAN-QIO depending on the functions performed. QIOs are private, mostly not-for-profit, organizations and include staffing from doctors and other health care professionals. BFCC-QIOs help beneficiaries exercise their rights to receive proper, quality care; conduct several types of contractually required reviews of

beneficiaries' medical care; and respond to, investigate, and resolve beneficiary quality of care complaints. QIN-QIOs and the AIAN-QIO work with health care providers, health care professionals, and community organizations to improve the quality of care in a variety of care settings, with the AIAN-QIO working closely with IHS and tribal organizations and leadership. QIOs are reimbursed monthly, consistent with the Federal Acquisition Regulation. The 13th SOW utilizes a deliverable-based payment model.

The 13th SOW aligns program focus and design with the Health & Human Services (HHS) Priorities[1] and CMS's National Quality Strategy, as well as CMS's Strategic Pillars, CMS's Behavioral Health Strategy, and CMS's Framework for Healthy Communities. This SOW uses the Community Health model to target QI needs for the health system in an integrated fashion, instead of discrete, fragmented models in isolation. The QIO Program's goals have shifted from providing QI education to leading the nation in effective QI implementation. The program's focus is to help facilities assess and build their internal capacity to drive culture change at all levels and to effectively implement a QI and management system.

The 13th SOW uses evidence-based strategies to drive QI and improve the health care provided to Medicare beneficiaries. CMS leads and directs QI – both the "what" and "how" it is done – with clearly defined interventions. State-of-the-art information technology systems and enhanced data analytics capabilities enable effective data collection and use that is foundational to QI. Strengthened links between the QIN-QIOs, the AIAN-QIO, and the BFCC-QIO enable quality-of-care issues to be identified and addressed across the QIO Program in real time.

For the 13th SOW, CMS optimizes all levers for outcomes, oversight and culture change, including program design, payment model, contract structure, selection of contractors, role of CMS staff, and use of technology. Hence, the QIO Program is positioned as the nation's resource for QI, providing integrated, systemic QI while also serving as CMS's rapid response arm to address quality and safety issues.

QIOs Interacting with Health Care Providers, Practitioners, and Beneficiaries

BFCC-QIOs

BFCC-QIOs interact with practitioners, providers, beneficiaries, beneficiary representatives, community organizations, and others to improve the quality of health care provided to Medicare beneficiaries. This is achieved by addressing beneficiary complaints regarding quality of care and conducting contractually required and mandated patient care reviews across various health care delivery systems.

Any provider or practitioner that treats Medicare beneficiaries and is paid under Title XVIII of the 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

[1] https://www.hhs.gov/about/priorities/index.html

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 intends to resolve complaints as they are happening, for quick resolution.

QIN-QIOs

QIN-QIOs work with health care 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 promote partnerships among health care practitioners and providers and local non-clinical community support, service organizations, and faith-based entities to work together on QI initiatives.

AIAN-QIO

The AIAN-QIO works with Medicare certified IHS, UIOs, and tribally managed hospitals, clinics, and nursing homes to improve quality of health care for targeted health conditions among Medicare beneficiaries who are American Indian or Alaska Native. The AIAN-QIO collaborates with IHS and other national and regional AIAN partners to create QI initiatives or support existing initiatives that work towards this Administration's goal of improving health outcomes for AIAN people.

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 Office of Management and Budget.

The statutory authority for the QIO Program is found in Part B of Title XI of the Act. The statutory provisions 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, now known as the QIO Program. These provisions were significantly amended by the Trade Adjustment Assistance Extension Act of 2011 (P.L. 112-40, § 261, 125 Stat. 401).

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 that are not for custodial care. In addition, the Secretary must enter these contracts to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. Toward those goals, section 1154(a) of the Act requires the QIO contractors to perform one or more functions listed in that section.

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 purposes of improving the quality of care furnished to Medicare beneficiaries.

In FY 2025, the total QIO Program expenditures totaled approximately $789M, not including funds expended under the American Rescue Plan Act of 2021. This amount includes funding for QI activities (i.e., the QIN-QIO Program, the AIAN-QIO Program), for serving the Medicare program's complaint processing and case review needs (i.e., the BFCC-QIO program), and other activities.

Program Scope

The QIO Program impacts Medicare beneficiaries on an individual basis and the beneficiary population. As of September 2025, Medicare covered more than 69M beneficiaries, including more than 62.4M people aged 65 years or older and 6.9M people of all ages with disabilities and/or with end stage renal disease or amyotrophic lateral sclerosis.[2]

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

During FY 2025, CMS's BFCC-QIO Program was implemented through two types of contracts: case review services and claims review services (see Table 2).

[2] CMS. Monthly Medicare Enrollment. *Centers for Medicare & Medicaid Services,* December 2025. https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment. Accessed on December 18, 2025.

Table 2. Overview of BFCC-QIO Contracts

BFCC-QIO Contract	Contract Activities
Case Review Services: Awarded to Kepro (now Acentra Health) and Livanta (now Commence Health) May 1, 2024 – April 30, 2029	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 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/practitioner, and only the provider/practitioner 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. BFCC-QIOs also refer QI initiatives to CMS, conduct sanction activities on violations of care and make recommendations to the Office of Inspector General, and conduct focused reviews.
Claims Review Services: Awarded to Commence Health on February 12, 2021 –August 11, 2025	The claims review BFCC-QIO contractor conducts Post Payment Hospital Part A Claims Review work. This includes Higher Weighted Diagnoses Related Groups (HWDRG) 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. This contract ended on August 11, 2025. The short stay reviews were transferred to the Medicare Administrative Contractors and CMS awarded the HWDRG claims review work to both BFCC-QIOs, for states in their awarded regions, on September 17, 2025.

BFCC-QIO Case Reviews

CMS contracts with Acentra Health and Commence Health 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 3).

Table 3. 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	Commence	NJ, NY, PR, VI
Region 3: Philadelphia	Commence	DE, DC, MD, PA, VA, WV
Region 4: Atlanta	Acentra	AL, FL, GA, KY, MS, NC, SC, TN
Region 5: Chicago	Commence	IL, IN, MI, MN, OH, WI
Region 6: Dallas	Acentra	AR, LA, NM, OK, TX
Region 7: Kansas City	Commence	IA, KS, MO, NE
Region 8: Denver	Acentra	CO, MT, ND, SD, UT, WY
Region 9: San Francisco	Commence	AS, AZ, CA, GU, HI, MP, NV
Region 10: Seattle	Acentra	AK, ID, OR, WA

The 10 BFCC-QIO regions align with the 10 CMS Regions, as shown in Table 3.

The two BFCC-QIO case review contractors, Acentra and Commence, 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 health care system. Beneficiary-generated concerns provide an excellent opportunity to explore the root causes of adverse health care outcomes, develop alternative approaches to improving care, and enhance beneficiary/family/caregiver experiences within the health care 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:

- General quality of care reviews;
- Beneficiary quality of care complaints;
- 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 post-acute skilled services);
- Beneficiary/caregiver-requested appeals of denials of hospital admissions;
- IA; and
- 5-Day and 60-Day EMTALA reviews.

CMS made several adjustments during the 13th SOW between May 1, 2024, and September 30, 2025, that affected how the BFCC-QIO case review contractors provided their services. At the start of the 13th SOW, BFCC-QIO case review contractors began implementing the IA process

with Original Medicare beneficiaries who filed appeals at hospital discharge. CMS mandated the BFCC-QIO case review contractors provide this service to help beneficiaries better understand the discharge process. Beginning in February 2025, in response to the ruling in the *Alexander v. Azar* nationwide class action case, CMS mandated the BFCC-QIO case review contractors begin processing expedited, standard, and retrospective appeals for Medicare beneficiaries with Part A coverage whose status changed from 'inpatient' to 'observation' during their hospital stay.

Additionally, CMS terminated two contracts due to HHS's contract efficiency initiative. In February 2025, CMS terminated the Audit and Interrater Reliability contract, which conducted interrater reliability validation checks on decisions in appeal cases completed by the BFCC-QIO case review contractors. Also in February 2025, CMS terminated the BFCC Survey Center contract, pausing the collection of beneficiary experience data related to the appeals, IA, and beneficiary quality of care complaints resolution services that the BFCC-QIO case review contractors provide to Medicare beneficiaries.

Since the beginning of the 13th SOW (May 1, 2024) through September 30, 2025, the BFCC-QIOs conducted 870K case reviews for beneficiary complaints, IA, discharge appeals, and other contract-specified review types. The volume of IA cases and discharge appeals continue to exceed CMS projections. From FY 2024 to FY 2025, the number of IA cases increased by 40 percent. Additionally, the number of hospital discharge appeals increased by 12.6 percent, post-acute Medicare Advantage appeals increased by 28.3 percent, and post-acute Original Medicare appeals increased by 8.6 percent.

Table 4 provides the national performance summary of the BFCC-QIO case review contractors on five timeliness measures from the beginning of the 13th SOW (May 1, 2024) through September 30, 2025. The overall percentage of cases meeting established criteria across the five timeliness measures in Table 4 was 99.1 percent. All targets were met as shown below.

Table 4. BFCC-QIO Case Review Performance (May 1, 2024, through September 30, 2025)

Measure	Target Percent of Cases Meeting Performance Standard	Percent of Cases Meeting Performance Standard
Timeliness of Beneficiary Complaint Reviews and Quality of Care Reviews	95%	99.6 %
Timeliness of Immediate Advocacy	95%	100%
Timeliness of Discharge/Service Termination Appeal Reviews	95%	96.1%
Timeliness of EMTALA Day 5 Reviews	95%	99.9%
Timeliness of EMTALA Day 60 Reviews	95%	100%

Beneficiary Complaint Reviews are initiated because a beneficiary or the beneficiary's representative has submitted a complaint 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 CMS, who then tasks the QIN-QIO to work with the provider in a QI initiative. For confirmed concerns that are not systemic or do not warrant technical assistance, the BFCC-QIO will recommend QI 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 5 for the BFCC-QIOs' review volume and number of cases with quality-of-care concerns where the BFCC-QIOs found that the provided care did not meet professionally recognized standards.

Table 5. BFCC-QIO Case Review Beneficiary Complaint and General Quality of Care Review Volume and Outcomes (May 1, 2024, through September 30, 2025)

Quality of Care Review Type	Review Volume	Number of Cases where Care Did Not Meet Professionally Recognized Standards
Beneficiary Complaint Reviews	3,407	1,167
General Quality of Care Review	2,750	536

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 appeals are conducted when an Original Medicare 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 an Original Medicare or MA beneficiary receives an Important Message from Medicare, and the beneficiary or representative contacts the BFCC-QIO to appeal the discharge decision in the hospital inpatient setting. An Original Medicare 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 Original Medicare appeals. Original Medicare beneficiaries with post-acute appeals may request reconsideration with the Qualified Independent Contractor. See Table 6 for the appeal review volume, initial review outcomes, and reconsideration review outcomes.

Table 6. Volume of BFCC-QIO Case Reviews and Case Decision Outcomes (May 2024 through September 2025)

Appeals Review Type	Review Volume	Initial Appeal Review Outcome: Agreement	Number of Cases with Reconsideration Requests	Appeal Reconsideration Review Outcome: Decision Upheld
Post-Acute MA Appeal	625,608	51%	96,897	58%
Post-Acute Original Medicare Appeal	71,453	59%	110	65%
Hospital Discharge Appeal	134,373	86%	15,894	90%

Notes: "Agreement" as the outcome of initial appeal reviews refers to the percentage of reviews in which the BFCC-QIO agreed with the payer or provider's decision to discharge or terminate coverage of services. "Decision upheld" as the outcome of appeal reconsideration reviews refers to the percentage of reconsideration appeals in which the BFCC-QIO upheld the initial decision to discharge or terminate coverage of services.

In FY 2025, one of the BFCC-QIOs conducted a focused review of Skilled Nursing Facility (SNF) care and MA coverage decisions from May 2024 through February 2025. The review found that 92 percent of MA beneficiaries still required skilled services when coverage was terminated, and 72 percent were at high risk for functional decline or readmission if discharged prematurely. SNFs often issued NOMNCs around day 15 of care coverage, suggesting administrative timelines were applied rather than individualized recovery in guiding these decisions. Repeated NOMNCs and gaps in care planning—nearly 40 percent lacked individualized goals—highlighted inconsistencies in Medicare coverage practices. The findings emphasize the need for standardized assessments, risk-based discharge planning, and stronger documentation to ensure clinically appropriate, person-centered care for MA beneficiaries.

BFCC-QIO Claims Reviews

Through August 11, 2025, CMS contracted with Commence Health for BFCC-QIO Claims Review. Commence performed three types of post-payment reviews on a nationwide basis for inpatient claims submitted by hospitals: 1) reviews of Higher-Weighted Diagnosis-Related Group (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. Starting August 12, 2025, CMS transferred the responsibility for conducting SSRs from the BFCC-QIO case review contractors to the Medicare Administrative Contractors. In addition, in September 2025, CMS processed contract modifications for both BFCC-QIO case review contractors to conduct HWDRG reviews for their respective regions and there was a temporary pause on HWDRG reviews from August 2025 to November 2025.

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 the Act § 1154(a)(1)(A), which links to § 1862(a)(1) and (9), and regulations promulgated at 42 C.F.R. § 476.71(a); and

2) Diagnoses Related Groups (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 the Act § 1866(a)(1)(F) and regulations promulgated at 42 C.F.R. §§ 412.60(d)(2) and 476.71(c)(2).

Table 7 provides the national performance summary of the BFCC-QIO claims review work on two timeliness measures. 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 7. BFCC-QIO Claims Review Performance, May 1, 2024, to July 31, 2025

Measure	Target Percent of Cases Meeting Performance Standard	Percent of Cases Meeting Performance Standard
Timeliness of HWDRG Reviews	95%	97.2%
Timeliness of SSRs	95%	99.96%

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

The 13th SOW QIN-QIO contract was awarded on May 28, 2025, to six QIN-QIO contractors across seven regions, with one contractor supporting two regions. Each QIN-QIO contractor covers a region that includes as many as 14 states across the United States, the District of Columbia, and five U.S. territories, as shown in Table 8.

Table 8. QIN-QIOs by States/Other Jurisdictions

CMS Region	QIN-QIO Contractor	States/Other Jurisdictions
Region 1: Northeast	Superior Health Quality Alliance, Inc.	CT, ME, MA, NH, RI, VT, NJ, NY, PR, VI
Region 2: Mid-Atlantic	Island Peer Review Organization, Inc.	DE, DC, MD, PA, VA, WV
Region 3: Southeast	Health Quality Innovators	AL, FL, GA, KY, MS, NC, SC, TN
Region 4: Great Lakes	Superior Health Quality Alliance, Inc.	IL, IN, MI, MN, OH, WI
Region 5: Southcentral	TMF Health Quality Institute	AR, LA, NM, OK, TX
Region 6: Midwest	Telligen, Inc.	IA, KS, MO, NE, CO, MT, ND, SD, UT, WY, AK, ID, OR, WA
Region 7: West	Health Services Advisory Group	AZ, CA, HI, NV, American Samoa, Northern Mariana Islands, and Guam

The purpose of the QIN-QIO Program is to improve health care quality and safety through the provision of technical assistance and education to those providing health care services. Providers targeted include those with performance challenges based on CMS's measurement and enforcement data, those serving high percentages of dual-eligible Medicare beneficiaries, and those serving Medicare beneficiaries residing in locations with low levels of economic resources. CMS procures expert health care QI services from the QIN-QIOs to improve care for Medicare beneficiaries in nursing homes, hospitals, and outpatient clinical practices in which beneficiaries seek care. Under CMS's direction and aligned with the Agency's priorities, QIN-QIOs work with providers and beneficiary-focused community partnerships (clinical and non-clinical) on data-driven quality initiatives to improve prevention and chronic disease management, patient safety, clinical care, and QI systems.

The five broad goals established by CMS for the 13th SOW QIN-QIO Program are:

- Improve quality management infrastructure (to ensure resilience in the health care system, including establishing quality management systems, emergency preparedness plans, workforce planning strategies, supply chain management, drug shortage prevention, and cybersecurity readiness);
- Increase prevention and chronic disease management (through preventive medicine and wellness, vaccinations, type 2 diabetes screening, hypertension management, chronic kidney disease evaluation, and obesity management);
- Increase patient safety (related to infection control and prevention, adverse drug events, and safety events);
- Improve behavioral health outcomes (focusing on decreased drug and alcohol misuse, chronic pain management, and depression and suicide prevention);
- Increase care coordination (by reducing hospital readmissions and emergency department utilization).

Each goal has an associated set of quality measures for the three care settings that hold the six QIN-QIOs accountable for measurable outcomes. QIN-QIOs harness the power of timely, high-quality data to both identify and remedy gaps to expand access to quality care for beneficiaries.

QIN-QIOs Activities in FY 2025 (May 28, 2025, to September 30, 2025)

Foundational activities in the first year of the contract focused on engaging nursing homes, hospitals, and outpatient clinical practices to participate in the QIN-QIO Program; conducting environmental scans of health needs and available QI resources in each state/territory; and assessing QI needs of participating providers. Below is a description of the major QIN-QIO activities implemented from the award of QIN-QIO contracts on May 28, 2025, through the end of FY 2025, September 30, 2025.

A key priority for QIN-QIOs during the initial contract period was to conduct outreach and engage eligible providers. For example, QIN-QIOs obtained written endorsements from state professional and health care associations and targeted corporate leadership of health systems and nursing homes to ensure leadership approval. QIN-QIOs also coordinated with local health departments and associations to conduct provider outreach and to promote awareness of the

QIN-QIO Program. QIN-QIOs used multiple communication modes, including mail, email, and fax, to share QIN-QIO website and webinar information or to set up virtual or in-person meetings with individual facilities. Some QIN-QIOs used commercial customer relations software to deploy automated, personalized emails based on a provider's responses to introductory emails. These marketing strategies conserved human resources while keeping providers engaged.

Table 9 summarizes provider enrollment in the QIN-QIO Program as of September 30, 2025. Note that enrollment will continue through the end of May 2026.

Table 9. Enrollment in QIN-QIO Program by Setting and Task Area as of September 30, 2025.

Provider Setting	**Task Area**	**Eligible Providers (Total: 24,683)**	**Enrolled Providers (Total: 1,220, 4.9%)**
Nursing Homes	Contract-specified provider-based QI services intended to better resident outcomes in nursing homes	8,483	1,023 (12.1%)
Acute Care Hospitals	Contract-specified provider-based QI services and technical assistance intended to promote health care quality and safety goals for patients in hospital settings	3,381	144 (4.3%)
Outpatient Clinical Practices	Contract-specified clinic-based QI services intended to better outcomes among Medicare beneficiaries residing in the community receiving outpatient clinical services	12,819	52 (0.4%)

In addition to provider outreach and enrollment, the QIN-QIOs conducted state and territory-level assessments to identify QI needs and existing initiatives. In the 13th SOW, CMS introduced the A3C Model (Assess, then Complement, Coordinate, or Create) to guide this process. The first step of the model is to conduct an environmental scan (Assess) to understand health issues impacting each state/territory and identify potential QI partners. QIN-QIOs compile and analyze data, such as demographics, state health rankings, and key drivers of health, to understand the current environment and emerging trends in health care needs. Based on this assessment, the QIN-QIOs determine whether to *complement* or *coordinate* existing initiatives tied to QI partners or *create* new QI initiatives, as needed. Understanding and identifying these needs and efforts is critical to tailoring interventions appropriately, avoiding duplication of services, and reducing provider burden. As of September 30, 2025, the QIN-QIOs completed two A3C assessments and identified 147 potential QI partners. The A3C assessments continued through the completion deadline of May 27, 2026.

The QIN-QIOs conducted other foundational activities in FY 2025, including hiring and training staff, developing comprehensive work plans, and completing other SOW requirements. The QIN-QIOs also addressed Focused QIO Service referrals, as described in greater detail below.

Focused QIO Service (FQS): Meeting Urgent and Emerging Needs for the QIN-QIO Program

In the 13th SOW, CMS introduced the FQS to position the QIO Program as the Agency's "Quality Improvement Ready Resource" for emerging and unanticipated quality and safety concerns. FQS ensures QIO support and resources are available for immediate deployment, complementing the QIOs' long-term, planned systemic QI work. FQS is a just-in-time, time-limited, technical, "boots on the ground" service to meet an urgent, emerging need that is not already covered within the scope of the 13th SOW clinical aims and other CMS priorities. This service is also available to facilities not enrolled in the QIN-QIO Program.

CMS may deploy a QIN-QIO to provide FQS support in several scenarios. For example, specific events, such as complementing public health department during regional infectious disease outbreaks to provide surge support to facilities with targeted needs, drug shortages due to supply chain disruptions, or high priority BFCC referrals may trigger an FQS response. Additionally, providers, provider associations, partners, and interested parties may directly request assistance from CMS or QIN-QIOs to resolve specific quality or safety issues.

Upon deployment, the QIN-QIO FQS team engages the provider(s) and formulates a short-term FQS action plan. Subsequently, the QIN-QIO executes these actions in 15- or 30-day sprints to meet the urgent need and ensure FQS will not be needed for the same issue in the future.

CMS deployed 91 FQS referrals through September 30, 2025. Table 10 provides a summary of completed and in-progress FQS referrals by domain, region, and provider type.

Table 10. FQS Referrals Received through September 30, 2025

Referral Characteristics	Number Completed	Number In-Progress (as of September 30, 2025)
Domain		
Safety	27	55
Quality	0	9
Coordination	0	0
Region		
Northeast	N/A	N/A
Mid-Atlantic	1	9
Southeast	N/A	N/A
Great Lakes	7	14
Southcentral	9	11
Midwest	2	10
West	8	20
Provider Type		
Nursing Home	5	20
Hospital	7	28
Outpatient Clinical Practice	9	4

Referral Characteristics	Number Completed	Number In-Progress (as of September 30, 2025)
Other	6	12

Note: There is no available FQS data for the Northeast and Southeast Regions through September 30, 2025, due to award protests that delayed their engagement.

Completed FQS sprints highlight the impact of this service. For example, a nursing home faced the possibility of decertification and closure due to deficiencies that posed harm to residents and non-compliance with regulations. The facility required urgent QIN-QIO assistance to improve the standard of care. The QIN-QIO addressed each area of concern. Some of the interventions included guidance to establish policies and procedures for medication checks and documentation and staff training on resident de-escalation. The QIN-QIO also created a sustainability plan for the facility to ensure the facility would not face potential termination again. As a result of the FQS sprint, the facility maintained their certification.

Another successful sprint involved a SNF that struggled with influenza infection control. CMS required the facility to engage with the QIN-QIO to address its compliance challenges within 10 days. The QIN-QIO implemented a comprehensive plan of correction that included: 1) updating infection-related policies based on gaps and deficient practices; 2) establishing protocols for increased inventory management of influenza test kits; and 3) conducting staff education and training on standardized communication practices, proper transmission precautions, and updated facility policies. Due to the QIN-QIO's focused efforts, the facility achieved compliance by achieving a 100 percent passing-rate on trainings and meeting inventory supply levels. The QIN-QIO continues to monitor compliance through weekly reviews which will transition to monthly once sustained performance is demonstrated.

American Indian Alaska Native-Quality Improvement Organization (AIAN-QIO)

The 13th SOW contract was awarded to Comagine on January 6, 2025. The contractor serves facilities across 11 AIAN Program Regions, as shown Table 11 below.

Table 11. AIAN-QIO Program Regions

AIAN Tribal Region	States
Rocky Mountain Region	MT, WY
Great Lakes Region	MN, MI, WI, IL, IN
Southwest Region	NV, UT*, AZ*
New Mexico Region	CO, NM*
Northwest Region	WA, OR, ID
Great Plains Region	ND, SD, NE, IA
California Region	CA
Navajo Region	UT*, AZ*, NM*
Oklahoma Region	KS, OK,
Alaska Region	AK

AIAN Tribal Region	States
Eastern Region	AL, AR, CT, DE, DC, FL, GA, KY, LA, ME, MD, MA, MS, MO, NH, NY, NJ, NC, OH, PA, RI, SC, TN, TX, VT, VA, WV

Note: States marked with an asterisk (*) cross more than one AIAN-QIO Program Region.

The purpose of the AIAN-QIO Program is to improve quality of care and health care outcomes for AIAN Medicare beneficiaries. To achieve this, the AIAN-QIO works with IHS, UIOs, and tribally managed health care facilities. The AIAN-QIO works with providers and other key partners (e.g., tribal health boards, state and local health departments, tribal leadership, patients and families, among others) on data-driven quality initiatives at the local, regional, and national levels.

The three broad goals established by CMS for the 13th SOW AIAN-QIO Program are:

- Improve quality of care through focused QI interventions, development of a provider engagement strategy, and quality action plan to guide provider involvement.
- Build QI foundations through the utilization of health information technology such as telehealth and building community resilience and engagement to support infrastructure improvements.
- Improve clinical quality outcomes for preventive health and wellness, patient safety, and behavioral health, in addition to improvements in facility capacity to support the clinical outcomes.

Each goal has an associated set of activities the AIAN-QIO can use to engage and continue working with providers to improve quality of care. The AIAN-QIO must seek to understand the needs of tribal communities and help them achieve optimal outcomes in a way that combines traditional medicine with evidence-based practices to ensure sustainability and effectiveness.

AIAN-QIO Activities Completed in FY 2025 (January 6, 2025, to September 30, 2025)

Similar to the QIN-QIOs, CMS designed the AIAN-QIO's initial contract activities to establish a strong foundation for the program. In FY 2025, the AIAN-QIO focused on establishing relationships with tribal and community partners and eligible providers, building trust with AIAN communities and eligible providers, and increasing program awareness. To ensure outreach fostered trust and meaningful partnerships with providers serving AIAN beneficiaries, all AIAN-QIO staff received cultural attunement training. The training addressed the provision of culturally and linguistically appropriate services, tribal sovereignty and government-to-government relationships, tribal health care systems and needs, and best practices when working with tribes.

The AIAN-QIO employed multiple approaches to outreach and provider engagement. The AIAN-QIO drew on experience, established relationships, and AIAN subject matter experts to engage organizations and agencies working on tribal matters. For example, the AIAN-QIO collaborated with IHS leadership to understand IHS priority areas. The AIAN-QIO also established new partnerships with national and local organizations, health boards, and advisory

boards focused on tribal health to connect with AIAN communities and providers. Direct outreach to providers and community members to increase program awareness included emails, phone calls, attendance at AIAN health conferences, and webinars. Once engaged with the program, the AIAN-QIO collaborated with providers to establish Provider Service Agreements and outline QI goals based on their QI needs while meeting providers where they are at.

Provider enrollment began in April 2025 and will continue through March 2026. Table 12 shows provider enrollment in the AIAN Program by provider setting and task area after the first six months of recruitment. In total, 69 eligible providers (27 percent) enrolled in the program as of September 30, 2025. Fifty-six percent of eligible hospitals and 23 percent of eligible outpatient clinical practices had been enrolled, while none of the eligible nursing homes had been enrolled as of September 30, 2025. Notably, the AIAN-QIO enrolled all eligible IHS-managed providers, attributable to the AIAN-QIO's engagement efforts and close collaboration with IHS.

Table 12. Enrollment in AIAN Program by Provider Setting, Task Area, and Facility Type as of September 30, 2025.

Provider Setting	Task Area	Eligible Providers	Enrolled Providers
Overall	---	254	69 (27%)
Nursing Homes	Contract-specified provider-based QI services intended to better resident outcomes in nursing homes	19 (All Tribal)	0 (0%)
Acute Care Hospitals	Contract-specified provider-based QI services and technical assistance intended to promote health care quality and safety goals for patients in hospital settings	Total: 43 IHS: 24 Tribal: 19	Total: 56% (24) IHS: 100% (24) Tribal: 0% (0)
Outpatient Clinical Practices	Contract-specified community-based QI services intended to better outcomes among Medicare beneficiaries residing in the community receiving outpatient clinical services	Total: 192 IHS: 32 Tribal: 119 UIO: 41	Total: 45 (23%) IHS: 32 (100%) Tribal: 7 (6%) UIO: 7 (17%)

In addition to provider outreach and enrollment, the AIAN-QIO conducted regional- and community-level assessments to identify health issues, QI needs, and existing initiatives using CMS's A3C model described earlier. Each AIAN-QIO region is distinctly unique due to the variety of tribal entities and independent sovereign nations bringing their own languages, customs, and medical traditions. In addition to these cultural nuances, each region covers diverse geographic landscapes with varying health care infrastructure, impacting access to high quality and culturally relevant health care and food sources. Therefore, understanding and identifying QI needs and existing efforts at the regional and community level is critical to tailoring interventions appropriately, avoiding duplication of services, and reducing provider burden. The AIAN-QIO identified 86 communities, or geographic subregions, across the 11 program regions to conduct community assessments. As of September 30, 2025, the AIAN-QIO completed assessments for 11 communities (13 percent) and identified 231 potential QI partners. The AIAN-QIO's community assessments will continue through early January 2026 and will be

updated annually to ensure the program continues to meet providers and communities where they are.

During FY 2025, the AIAN-QIO also hired and trained staff, began conducting assessments of provider QI capabilities and needs, and implemented other requirements from the SOW.

Conclusion

Medicare beneficiaries, like all Americans, deserve to have confidence in a health care system that delivers access to high-quality, affordable health care. Under CMS's direction, the BFCC-QIO, QIN-QIO, and AIAN-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, QIN-QIO, and AIAN-QIO Programs has been and continues to contribute to improvements in health care for Medicare beneficiaries.

Preview of Next Report

FY 2025 marked the initial stages of the QIO Program's 13th SOW contract period. Our next report will include a summary of activities completed and key accomplishments achieved during FY 2026.