



THE SECRETARY OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20201

March 8, 2010

The Honorable Nancy Pelosi
Speaker of the House of Representatives
Washington, DC 20515

Dear Madam Speaker:

I am respectfully submitting the enclosed report entitled, "Report to Congress on the Evaluation of the Quality Improvement Organization (QIO) Program for Medicare Beneficiaries for Fiscal Year 2007." This report is being submitted to Congress to fulfill the requirements of section 1161 of the Social Security Act.

The report outlines the performance of the QIOs during the 8th QIO Statement of Work, a three year, performance-based contract for QIOs operating in all 50 states, the territories, and the District of Columbia. This report reviews Fiscal Year (FY) 2007 activities, detailing the administration, cost, and impact of the QIO program.

In FY 2007, through their work with participating providers, the QIOs helped contribute to a number of healthcare improvements for beneficiaries, including:

- a 17 percent relative reduction of pressure ulcers in nursing homes;
- a 40 percent relative reduction of physical restraints in nursing homes;
- a 10 percent relative reduction in acute care hospitalization through the home health campaign compared to a slight increase in the non participating groups in home health;
- a 17 percent relative improvement in a composite inpatient hospital measure for Acute Myocardial Infarction, heart failure, and pneumonia in hospitals and;
- implementation of a health information technology (HIT) project which helped more than 1,300 providers adopt electronic health records (EHR) in physician offices.

These improvements and the underlying efforts are significant. However, we are expecting even greater accountability and achievement reflected in future reports to Congress given the substantial changes made in the 9th Statement of Work, in response to recommendations from the Institute of Medicine, Congress, and other stakeholders.

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

Sincerely,

Kathleen Sebelius

Enclosure



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 8, 2010

The Honorable Joseph R. Biden, Jr.
President of the Senate
Washington, DC 20510

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Kathleen Sebelius

Enclosure

Report to Congress

**Evaluation of the Quality Improvement Organization (QIO) Program
for Medicare Beneficiaries for Fiscal Year 2007**

**Kathleen Sebelius
Secretary of Health and Human Services
2010**

BACKGROUND

Section 1161 of the Social Security Act (the Act) requires the submission of an annual report on the administration, cost, and impact of the Quality Improvement Organization (QIO) Program during the preceding fiscal year.

The statutory authority for the QIO Program is found in Part B of Title XI of the Act, which established the Utilization and Quality Control Peer Review Organization Program. The statutory mission of the QIO Program is set forth in Title XVIII of the Act. More specifically, section 1862(g) of the Act states that the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. Based on this statutory language, the Centers for Medicare & Medicaid Services (CMS) has identified the following goals for the QIO Program:

- Improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of health care;
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and items that are reasonable and medically necessary and that are provided in the most economical setting; and
- Protect beneficiaries by expeditiously addressing individual cases such as beneficiary quality of care complaints, contested Hospital Issued Notices of Noncoverage (HINNs), alleged violations of the Emergency Medical Treatment and Labor Act of (§ 1867 of the Social Security Act, EMTALA), and other beneficiary concerns as required by the statute.

The quality strategies of the Medicare QIO Program are carried out by state and territory specific QIO contractors working with health care providers and practitioners in their state, territory, and the District of Columbia. More specifically, the QIO Program is administered through 53 performance-based, cost-reimbursement contracts with 41 independent organizations. The 53 QIOs are staffed with physicians, nurses, technicians, and statisticians. Approximately 2,300 QIO employees nationwide conduct a wide variety of quality improvement activities to ensure the quality of care provided to Medicare beneficiaries. Approximately 54,000 providers and one million practitioners¹ nationwide can work with QIOs. The providers and practitioners can request technical assistance; additionally they are subject to QIO review for specific reasons including at the request of: beneficiaries, CMS, Fiscal Intermediaries, Medicare Administrative Contractors, and the OIG.

¹ These data and categories are from CMS Office of Research, Development, and Information. "CMS Program Data" Sources "ORDI/OACT/OFM/CMM" Providers Plans as of 12/31/06; published June 2007.

In FY 2007, QIO Program expenditures totaled approximately \$392.6 million.² QIO work has been carried out in 3-year contract cycles, known as Statements of Work (SOW). During FY 2007, the QIO Program was at the mid-stage of the 8th SOW contract, which was phased in with staggered starting dates several months apart beginning in August 2005.

I. PROGRAM ADMINISTRATION

Description of Quality Improvement Organization Contracts

In late summer of 2005, the QIO Program began its eighth 3-year contract cycle, the 8th Statement of Work (SOW); the contract was phased in with three staggered starting dates several months apart beginning in August 2005. This report reviews Fiscal Year (FY) 2007 activities, beginning October 2006 and ending in September 2007. In FY 2007 the QIO Program was in the middle of the 36-month contract.

The 8th SOW contract focused on quality improvement for nursing homes, home health agencies, hospitals, and physician practices through organizational “transformations” intended to produce more rapid, measurable improvements in care. The QIOs work intensively with subsets of individual providers to help them redesign care processes and make internal systemic changes, such as the adoption and implementation of health information and communication technologies. The 8th SOW contract also included case review and other beneficiary protection activities as well as the Hospital Payment Monitoring Program (HPMP).

The activities of the QIO Program are carried out by a network of organizations staffed with physicians, nurses, technicians and statisticians—experts in health care quality—responsible for all 50 states, the territories, and the District of Columbia. Approximately 2,300 QIO employees nationwide conduct a wide variety of quality improvement activities to improve the quality of care furnished to Medicare beneficiaries. The Program is administered through 53 performance-based, cost-reimbursement contracts with 41 independent organizations. A single organization can have more than one QIO contract.

These contracts contain a multi-tiered award fee plan based upon individual and group performance. The QIOs’ technical performance during the 8th SOW was evaluated at the 28th month of their 36-month contract. The QIOs submit vouchers on a monthly basis and are reimbursed for their costs. Their monthly invoices are thoroughly reviewed and certified by an assigned project officer and contract specialist. QIOs are evaluated according to how well they reach CMS specified performance goals. During the 8th SOW the goals pertained to performance in the following areas:

² The Department of Health and Human Services, Fiscal Year 2009, Centers for Medicare & Medicaid Services, Justification of Estimates for the Appropriations Committees; also known as the FY 2009 Congressional Justification (CJ).

1. Conducting statutorily mandated case review and reviewing of beneficiary complaints about the quality of health care services,
2. Measuring, monitoring, and reducing the incidence of improper fee-for-service inpatient payments,
3. Improving clinical performance,
4. Increasing clinical performance reporting,
5. Increasing adoption and use of health information technology systems,
6. Implementing key process changes, and
7. Improving organizational culture.

The last five goals listed above were specific to four settings: nursing homes, home health agencies, hospitals, and physicians' offices. For a complete explanation of QIO contract evaluation criteria, see the *Federal Register*, 72 *Fed. Reg.* 44,150 (August 7, 2007).

QIOs Interacting with Health Care Providers and Practitioners

QIOs work with and provide technical assistance to health care practitioners and providers such as physicians, hospitals, nursing homes, and home health agencies. In addition to working with practitioners and providers, QIOs work with beneficiaries, other partners, and stakeholders to improve care delivery systems, to safeguard the integrity of the Medicare Trust Fund, and to investigate beneficiary complaints about quality of care.

Any provider or practitioner who potentially treats Medicare patients and would be paid under Title XVIII of the Act may receive technical assistance from a QIO and may be subject to review by the QIO. CMS estimates that approximately 54,000 providers and one million practitioners nationwide may interact with QIOs each year. Interaction can come in a variety of forms including direct intensive QIO assistance to providers and practitioners, attending QIO meetings, visits to the QIO website, and/or QIO patient care and record review on behalf of beneficiaries.

II. PROGRAM COST

Under Federal budget rules, the QIO Program is defined as mandatory rather than discretionary because QIO costs are financed directly from the Medicare Trust Fund and are not subject to the annual appropriations process. In FY 2007, QIO Program expenditures totaled \$392.6 million. This spending represents approximately nine dollars annually for each of the over 44.1 million Medicare beneficiaries to improve quality of care, and less than one tenth of one percent (0.1 percent) of the \$429.7 billion Medicare expenditures during that year.

III. PROGRAM IMPACT

Overview

The QIO Program impacts Medicare beneficiaries on an individual basis and the beneficiary population as a whole. In 2007, 36.9 million aged were covered by Medicare. In other words, 97.4 percent of the aged population of the United States was covered by Medicare, which equates to virtually everyone 65 and older. Additionally 7.2 million disabled persons were covered.³ These 44.1 million Americans represent a significant portion of the nation's population (14.6 percent) that receives better health care as a result of QIO activity.

This section provides quantitative evidence of QIO accomplishments and the impact on beneficiaries as a result of the 8th SOW. Medicare beneficiary and beneficiary population impacts are made by means of contractual mechanisms in the 8th SOW known as *tasks*. In each of nine distinct tasks, QIOs provided technical assistance by means of quality improvement tools and techniques that improved beneficiary health care. The nine tasks include:

Five provider settings:

- Nursing homes (task 1a)
- Home health agencies (task 1b)
- Hospitals (task 1c1)
- Critical access hospitals (task 1c2)
- Physician offices (task 1d1);

And four tasks which address:

- Underserved outpatient population (task 1d2)
- Prescription drug program (task 1d3)
- Case review (task 3a)
- Hospital payment monitoring program (task 3b)

Tasks can include a number of quality measures or performance targets which address healthcare quality issues such as: error reduction, improved workflow, data reporting, and patient needs. QIOs are successful when they meet task specific performance targets. Examples of performance measures in the 8th SOW nursing home task are rates of pressure ulceration, use of physical restraints, and pain management.

The data tables below present accomplishments of the QIOs from the beginning of the 8th SOW to the end of FY 2007.⁴ Program impacts are reported in a variety of ways depending upon the contractually defined issues to be improved and the mechanisms and interventions used to make the impact. The data are collected by CMS for QIO Program and quality monitoring and are used by CMS and the QIOs.

³ CMS U.S. Department of Health and Human Services. CMS Office of Research, Development, and Information 2008 CMS Statistics. CMS Pub. No 03490. July 2008.

⁴ Data was collected throughout FY 2007. It takes several months for the data to be validated, aggregated, summarized, and formatted in a useful manner. The data were used for the 28th month QIO contract evaluation.

Most of the tables in this report consist of a baseline rate and a remeasurement rate. The baseline is the rate at the beginning of the 8th SOW and the remeasurement is the rate at the end of FY 2007. If the difference in the two rates is positive, performance on that measure improved. If the difference is negative, care has deteriorated. The difference in the two rates is called “absolute difference” or “absolute improvement” when the rate improves.

The tables may also show a relative improvement. Relative improvement is the difference in the baseline and remeasurement rate divided by the baseline rate. The amount of improvement in percent is “relative” to the baseline when the Program started. Large relative improvement numbers, for example double digit improvement numbers, mean the measure has improved substantially in relation to the baseline. Relative improvement is a way to compare the degree of improvement among different measures with the same starting date.

Table 1 shows the 8th SOW 28th month evaluation summary for the 53 QIOs. If every QIO was responsible for every task there would be 477 total tasks (53 X 9 =477); however, the table shows a total of 465 tasks because a few QIOs were exempt from one or more tasks. The most common reasons for exemption were low beneficiary “at risk” populations in a state and/or a low number of provider settings in a state. For example, QIOs in states such as Maryland and Rhode Island were excluded from the critical access hospital task because they had few or no critical access hospitals. The Virgin Islands was exempt from the Hospital Payment Monitoring Program due to its different, non-fee-for-service, payment system.

QIOs were judged as passing or failing the 28th month evaluation based upon goals for reaching health care measures that are discussed more specifically in each section below. QIOs reaching or surpassing the goal completed that contract task. Overall, QIOs successfully completed 453 of 465 tasks (97.4 percent). Thirty six (or 68 percent) of the QIOs completed their tasks with either a full or excellent pass; an excellent pass signifies the QIO went beyond the goal. Two QIOs, Idaho and Nebraska achieved an excellent pass on all tasks. At the 28th month evaluation of the 8th SOW, nine QIOs (17 percent) had performance deficiencies in the 8th SOW on at least one task. Of these nine, six failed one task and three QIOs failed two tasks. Six QIOs failed the physician office task and three QIOs failed the home health agency task. Most often multiple factors contributed to failure. For example, in New York, the State of NY offered grants to the City of NY and other entities with which the QIO partnered. However, these grants were promised but not delivered on time due to a change in State administration. The delays resulted in late EHR installation with a number of practices which impacted the QIO’s performance. In Alaska, because of the small numbers of physician practices, the QIO’s overall score was affected when one practice did poorly on the evaluation.

Table 1. The 8th SOW 28th month evaluation summary for 53 QIOs based upon work accomplished in the first two fiscal years of the SOW; FY 2006 and FY 2007.

	Task									Total
	1a Nursing Home	1b Home Health	1c1 Hospital	1c2 Critical Access Hospital	1d1 Physician	1d2 Underserved	1d3 Part D	3a Beneficiary Protection	3b Hospital Payment Monitoring	
QIOs Passing task	53	50	52	43	47	51	53	53	52	453
QIOs Failing task	0	3	1	1	6	0	0	0	0	11
Total	53	53	53	44	53	51	53	53	52	465

Contract Tasks

In the first seven tasks, QIOs worked with two groups of providers/practitioners on quality improvement; first with an identified participant group (IPG) and second, in an informal manner, with all providers and practitioners in the state by providing materials to them at their request. Most task work involved an IPG and only some task measures included statewide work. The IPG consisted of providers who received individualized attention from QIOs on at least one quality measure within a task. QIOs selected task specific IPGs using contract and measure guidelines. For example for Task 1d1 Physician Offices, QIOs developed lists of physician practices and approached selected practices. Practices might also volunteer to participate as an IPG. Nursing Home, Hospital, and Home Health Agency IPGs were chosen by the QIO based upon certain criteria. Non-IPG providers did not receive individualized assistance and are included in the statewide measurement where applicable.

Contract Task 1a: Nursing Home

The nursing home task used two IPG groups, one (IPG1) composed of most IPG nursing homes, and another (IPG2) composed of nursing homes performing poorly on specific quality measures. For both IPG groups, the QIOs focused on decreasing the rate of pressure ulcers and the rate of physical restraint use; improvements in these measures are among the goals for nursing home care. With IPG1, QIOs also worked with nursing homes to improve the management of pain in long-stay residents.⁵ QIOs worked with all nursing homes in the state to set quality improvement targets for pressure ulcers and physical restraints. To promote individualized care for nursing home residents, the QIO worked with IPG homes to collect information on resident and staff experience/satisfaction with care and staff turnover. The QIO offered technical assistance to analyze this information and to use quality improvement science to suggest ways to improve both.

⁵ Long-stay residents are those in the nursing home 90 or more days. In addition to these measures of resident stays shown in the table, there are other measures of resident stay and resident pain used in nursing homes.

Table 2 shows that progress was found in all three of the principal nursing home measures at the 28th contract month. Notable was the physical restraints measure with a 2.9 percent improvement in the IPG1 group, a 5.0 percent improvement in the IPG2 homes, and 2.2 percent improvement statewide. Chronic care pain showed an improvement of 2.3 percent in the IPG1 group but was not a part of the IPG2 work.

Table 2. The 8th SOW 28th month 1a: Nursing Home Evaluation Summary: Baseline and Remeasurement Performance Rates for Statewide, IPG1, and IPG2 Nursing Homes.

Measures	Baseline Rate (%)	Remeasurement Rate (%)	Absolute (Relative) Improvement (%)
Statewide (N=16,047)			
Pressure Ulcers*	13.7	12.4	1.3 (9.5)
Physical Restraints**	7.5	5.3	2.2 (29.3)
Pain Management***	6.2	4.4	1.8 (29.0)
IPG1 (n=2350)			
	Rates	Rates	
Pressure Ulcers	13.7	11.3	2.4 (17.5)
Physical Restraints	6.7	3.8	2.9 (43.3)
Pain Management	6.3	4.0	2.3 (36.5)
IPG2 (n=145)			
	Rates	Rates	
Pressure Ulcers	15.6	12.8	2.8 (17.9)
Physical Restraints	10.1	5.1	5.0 (49.5)
Pain Management	N/A	N/A	N/A

* Long-stay high-risk patients with pressure ulcers

** Long-stay patients physically restrained

*** Long-stay residents with moderate to severe pain

Contract Task 1b: Home Health

For IPG home health agencies (HHAs), QIOs focused on reducing the rate of Acute Care Hospitalization (ACH) and improving one publicly reported Outcome and Assessment Information Set (OASIS) measure selected by the HHA.⁶ The most commonly selected OASIS measures were: improvement in pain interfering with activity, improvement in Dyspnea (difficulty breathing), or improvement in the management of oral medications. Identified participant home health agencies also worked to evaluate and improve organizational culture and implement telehealth (telemonitoring and phone monitoring). Statewide, the QIOs worked with HHAs to reduce the rate of ACH, to improve on one QIO-selected OASIS measure, and to promote Influenza and Pneumococcal vaccinations of home health patients.

⁶ Information on OASIS can be found at: <http://www.cms.hhs.gov/OASIS/>.

Table 3 shows, at the 28th contract month, progress in all four of the IPG HHA measures, with greater improvement in each of the four measures among IPG HHAs compared with statewide HHAs. For example the IPG HHAs showed an absolute improvement of 3.5 percent in ACH over 28 months, but the statewide HHAs' ACH measure actually deteriorated 0.7 percent. This across the board difference demonstrates the value of the individual attention each IPG HHA receives from its QIO; whereas statewide HHAs lack such individual assistance.

Table 3. The 8th SOW 28th month 1b: Home Health Evaluation Summary: Baseline and Remeasurement Performance Rates for Statewide and IPG Home Health Agencies.

Measures	Baseline Rate (%)	Remeasurement Rate (%)	Absolute (Relative) Improvement (%)
Statewide (N=6,770)			
	rates	rates	
Acute Care Hospitalizations*	30.9	31.6	-0.7 (-2.3)
Oral Medications**	35.8	39.6	3.8 (10.6)
Dyspnea***	52.8	57.1	4.3 (8.1)
Pain****	57.2	60.7	3.5 (6.1)
IPG (n=1,420)			
	rates	rates	
Acute Care Hospitalizations	32.5	29.0	3.5 (10.8)
Oral Medications	33.8	41.6	7.8 (23.1)
Dyspnea	49.4	60.3	10.9 (22.1)
Pain	54.0	63.7	9.7 (18.0)

* Patients admitted from home to hospital for acute care.

** Patients improving in taking their oral medications correctly.

*** Patients who are short of breath less often.

**** Patients who have less pain when moving around.

Contract Task 1c1: Hospital

To improve clinical performance, QIOs worked with IPG hospitals on an Appropriate Care Measure (ACM). The ACM is a single number that evaluates the care provided to beneficiaries in three clinical areas: acute myocardial infarction (AMI), Heart failure (HF), and Pneumonia (PNE). The ACM captures whether or not a beneficiary received all the care he or she should have received as defined by scientific evidence of best outcomes. Because the ACM is a composite measure of care at the patient level, Table 4 in a footnote, shows the numbers of beneficiaries used in the measure denominator at baseline (statewide 581,920 and IPG 150,544) and remeasurement (statewide 588,849 and IPG 152,487).

QIOs also worked with IPG hospitals on improvement of surgical care. The Participating Hospital Surgical Care Improvement Project (SCIP) performance rates are limited to Prospective Payment System (PPS) and Critical Access Hospital (CAH) providers (PPS and CAH are defined in the next section, Contract Task 1c2) that conduct at least 300

major surgical procedures per year. Care related to surgical site infections and venous thromboembolism are combined and used as the Appropriate Surgical Care measure. This measure is collected for only the IPG.

Table 4. The 8th SOW 28th Month 1c1 Hospital Evaluation Summary: Clinical Performance Rates of Statewide and IPG Hospitals. -

Measures	Baseline Rate (%)	Remeasurement Rate (%)	Absolute (Relative) Improvement (%)
<u>Statewide</u>			
Appropriate Care Measure (ACM)	73.4*	84.5**	11.1 (15.1)
Appropriate Surgical Care	N/A	---	---
<u>IPG</u>			
Appropriate Care Measure (ACM)	73.1 [#]	86.2 ^{##}	13.1 (17.9)
Appropriate Surgical Care	76.0	83.0	7.0 (9.2)

- * Statewide baseline rate based on N=581,838 opportunities for appropriate care
- ** Statewide remeasurement rate based on N=588,849 opportunities for appropriate care
- [#] Baseline rate based on n=150,986 opportunities for appropriate care in IPG
- ^{##} Remeasurement rate based on n=152,985 opportunities for appropriate care in IPG

Table 4 shows that at the 28th month there was improvement in the ACM both statewide and at IPG hospitals; with good absolute improvement in both statewide (11.1 percent) and IPG (13.1 percent) rates. The Appropriate Surgical Care measure also improved 7.0 percent. The IPG had better relative improvement in ACM rates (17.9 percent) than did the statewide (15.1 percent).

Contract Task 1c2: Critical Access Hospital/Rural PPS Hospital

QIOs assisted non-reporting Critical Access Hospitals (CAHs)⁷ to begin reporting Hospital Quality Alliance (HQA)⁸ measures to the CMS Data Warehouse and worked with CAHs that reported HQA measures to improve performance on at least one of their reported measures. QIOs also assisted an IPG of CAH and rural Prospective Payment System (PPS)⁹ hospitals to improve their hospital's organizational safety culture.

⁷ A Critical Access Hospital (CAH) is a hospital that is certified to receive cost-based reimbursement from Medicare. They are in general small, rural hospitals with no more than 25 inpatient beds.

⁸ The HQA Improving Care through Information is a public/private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care. Quality performance information collected from the more than 4,000 participating hospitals is reported on *Hospital Compare*, a website tool developed by CMS.

⁹ Prospective payment system provides a single payment to the hospital for the patient's stay based on the patient's diagnosis.

As part of the IPG effort, QIOs provided technical assistance in administering, analyzing, and interpreting results of AHRQ's Hospital Survey on Patient Safety Culture. The goal of the work was to make an improvement in hospital staffs' perception of hospital management's support for Patient Safety between baseline and remeasurement timeframes.

Table 5. The 8th SOW 28th month 1c2 Critical Access and Rural PPS Hospital Evaluation Summary: Performance Numbers and Rates for Statewide and IPG Hospitals

Measures	Baseline (%)	Remeasurement (%)	Absolute (Relative) Improvement (%)
Statewide			
Number of CAHs reporting HQA measures to the CMS Clinical Warehouse	415	966	551 (132.8)^
Percent CAH patients receiving appropriate care for selected HQA measure	47.9	74.1	26.2 (54.7)

^More than doubled.

At the 28th month, the number of CAHs reporting to the CMS Data Warehouse more than doubled from 415 to 966 and the percentage of CAH patients receiving appropriate care for selected HQA measures increased 26.2 percent. Finally, 58.6 percent of the 382 IPG facilities improved their Patient Safety Culture Survey scores when taking the survey a second time at remeasurement.

Contract Task 1d1: Physician Practice

In task 1d1, QIO efforts were targeted at increasing the number of physicians who installed and used Electronic Health Record (EHRs) technology. QIOs had a goal of working with at least five percent of internists, family, and general physician practices in each state as a lower limit. This five percent constituted the IPG practices.

The physician practice IPG focused on introducing basic changes in patient care through the use of EHR technology, care process redesign, and performance measurement. QIO interactions with physician practices helped guide the physician practices through the process of implementing an EHR. Subsequent to installation of an EHR system, QIOs assisted practices with patient care by providing tools for management of chronic diseases, e.g., diabetes and heart disease.

Table 6. The 8th SOW 28th month 1d1: Physician Offices Evaluation Summary: Goals and Final Numbers for Electronic Health Record (EHR) Implementation and Use

Measures	Goal Number	Final Number	Performance
Recruit Practices	3,695	3,710	15 over
Practices with EHR Contract	795	1,513	718 over
Practices that Installed EHR	1,112	1,358	246 over
Practices that Used and Produced*	1,112	1,002	110 under
Care Management**	1,105	1,216	111 over

* Use and Produce means specific EHR capabilities as defined by CMS. For example, identify criteria, generate problem and medication lists, enter and retrieve laboratory data, select and print safety checks for medications.

** Care Management is defined as using the EHR for disease management of targeted conditions as determined by CMS. Using the EHR the physician should be able to identify the patient, generate reminders and prompts; and provide patient specific care plans for more than two clinical topics.

Table 6 shows task 1d1 accomplishments in terms of the numbers of practices meeting process goals. Four of five measures were above the 8th SOW goals. At the 28th contract month, 88 percent of the QIOs passed all contract tasks. Thirty-three QIOs met or exceeded the goal to work with a minimum of five percent of the practices in their state and had recruited additional physician practice sites ranging from one to thirty-eight practices. To further this goal, CMS has implemented a Doctor's Office Quality Information Technology University Web site that offers assistance to practices nationally with the goal of improving patient care.

Contract Task 1d2: Underserved Populations

As part of the work in the physician practice setting, QIOs worked at the statewide level to improve clinical quality indicators for diabetes in underserved populations.

Underserved populations are those populations that research demonstrates are subject to disparities in health care delivery and status, often based on race and ethnicity. For example, African Americans, Asian Americans, Hispanics, and Native Americans suffer disproportionately from chronic disease, cancer, and infectious disease. For this QIO task, underserved populations include:

- African Americans
- Hispanic/Latinos
- Asian/Pacific Islanders
- American Indian/Alaskan Natives

QIOs also worked to promote systems improvement through Doctor's Office Quality (DOQ) activities with an underserved population under task 1d1. Physician offices that worked with underserved populations were encouraged to adopt EHRs and to use them to improve the 1d2 measures shown below, some of which are taken from the Department's Office of Minority Health (OMH) Cultural Competency Program.

With a task 1d2 specific IPG, QIOs worked on practice and practitioner changes related to Culturally and Linguistically Appropriate Services (CLAS) standards and culturally competent care. The QIO used either the online Office of Minority Health cultural competency or the Manhattan Cross Cultural Group (MCCG) tool to conduct cultural competency improvement education. Two different tools were used because addressing cultural competency is a relatively new idea in healthcare and different approaches are considered useful.

The OMH tool consists of three themes.

- Theme 1 addresses culturally competent care (completion of Theme 1 was optional)
- Theme 2 addresses language access services
- Theme 3 allows the clinical administrator or a practitioner to complete the Office of Minority Health (OMH) “A Family Physician’s Practical Guide to Culturally Competent Care” tool. The MCCG tool consists of a non-clinical and a clinical component which addresses culturally competent care education. Practices/practitioners completing the cultural competency education programs should be able to communicate more effectively and efficiently with the underserved Medicare population, which in turn should improve the quality of healthcare received by the underserved population.

Table 7. The 8th SOW 28th month 1d2 Evaluation Summary: Clinical Care for Underserved Populations and Cultural Competency Training in Physician Offices

Measures	Baseline Rate (%)	Remeasurement Rate (%)	Absolute (Relative) Improvement (%)
Statewide			
Hemoglobin A1C*	76.9	80.8	3.9 (5.1)
Retinoptic Eye Exam*	50.4	51.4	1.0 (2.0)
Lipid Profile*	66.6	72.7	6.1 (9.2)
Mammography**	52.2	54.4	2.2 (4.2)

*Care provided for diabetic underserved patients: baseline (N =720,483) remeasurement (N=741,787)

**Eligible underserved women who received a mammogram in the past 2 years (N = 285,593).

Table 7 shows at the 28th contract month improvement in each of the four statewide measures. In addition, the number of underserved patients served increased by 21,304 and 285,593 eligible underserved women received a mammogram during the 8th SOW. Over 1,100 physician offices nationally, 63.2 percent of those eligible, included at least one administrator or physician who used Theme 3 to increase their awareness of underserved issues.

Contract Task 1d3: Physician Practice/Pharmacy: Part D Benefit

As part of QIO efforts in the physician practice setting, QIOs focused on improving safety in the delivery of prescription drugs using evidence-based guidelines. As

authorized by section 109(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), QIOs offered some quality improvement assistance pertaining to prescription drug therapy to Medicare providers and practitioners; however for the most part QIOs worked with organizations offering Medicare prescription drug plans (PDPs).

QIOs implemented quality improvement projects focused on improved prescribing, using evidence-based guidelines. CMS worked with the QIOs to develop and implement new methods to gather and disseminate better evidence for healthcare decision-making. This activity included collection, linkage, and de-identification of Part D and other public and private administrative data; assistance in implementation of clinical registries¹⁰ and other work necessary to support the development and use of better evidence for decisions.

A variety of methods were available to accomplish these activities. CMS supported engaging physicians because improved prescribing begins with modifying physicians' behavior. This is accomplished by providing data and information in ways that support behavior change. CMS supported working with dispensing pharmacists because they detect errors and problems with the medications they dispense, and they interact with beneficiaries. Pharmacy policies, procedures, and quality checks need to be implemented to be consistent with quality, safety, and cost-effectiveness goals.

At the 28th contract month, all 53 QIO contracts will have completed an approved prescription-drug quality improvement project; however, because the projects were new, there are no results to report at this time. Results will be forthcoming in the FY 2008 Report.

Table 8. The 8th SOW 28th month 1d3 Part D Evaluation Summary: Types and numbers of Patient Safety/Quality Improvement Project Assistance Provided by QIOs to Medicare Prescription Plans.

Projects	
-	
Topic	
Prescribing	16
Medication Therapy Management	48
Medicare Part A, B, D Data	7
Other*	6

*Other includes:

- Increasing the use of medical diagnosis or ICD-9 codes on prescription order to improve the quality and safety of the drug benefit.

¹⁰ A clinical registry is used by providers to track patients with specific needs and conditions.

- Building a stakeholder coalition to promote best practices, share data, choose interventions and establish medication treatment guidelines.
- Promoting e-prescribing
- Medication Reconciliation among a hospital, community pharmacy, Prescription Drug Plans (PDP) and with a QIO Partnership. Medication Reconciliation is a process of identifying the most accurate list of all medications a patient is taking — including name, dosage, frequency, and route — and using this list to provide correct medications for patients anywhere within the health care system.
(<http://www.ihl.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/Medication+Reconciliation+Review.htm> 05/05/08)
- Investigate and analyze the formulary impact on Medicaid/Medicare recipients participating in the Medicare Part D drug program as of 1/1/06.
- Using a Handheld Order Writer to Improve Quality and Cost of Prescribing for Medicare Patients
- Evaluation of Warfarin Management by Community Pharmacists

Contract Task 3a: Beneficiary Protection

This task involved all case review activities necessary to conduct statutorily mandated review of beneficiary complaints about the quality of health care services. It also involved all activities associated with other required case reviews, including Emergency Medical Treatment and Labor Act (EMTALA) reviews, beneficiary appeals of termination of services, all hospital requested higher-weighted diagnosis related groups (DRGs) reviews, and fiscal intermediary referrals.

QIOs respond to beneficiary quality of care complaints. Any beneficiary who receives services from a Medicare provider or his or her representative may request review of those services for quality of care concerns and the review must be responsive to beneficiaries. The QIO contract includes performance expectations related to timeliness, satisfaction with the complaint process, and the implementation of quality improvement plans by providers. When appropriate, QIOs offered alternative dispute resolution methods to resolve beneficiary complaints.

Table 9. The 8th SOW 28th month 3a Evaluation Summary: Progress on Beneficiary Protection Measures

Measures	Performance in percent
Timeliness of Review *(N =73,344)	97.5
Beneficiary Satisfaction with the complaint Process **(N =1,973)	86.6
Quality improvement activities resulting from case review activities ***(N =2,149)	73.0

* QIOs are required to complete various beneficiary protection reviews within CMS' proscribed time limits.

** QIOs are measured on the complainants or their representatives' satisfaction level regarding the management and resolution of their complaint concerning the quality of

their healthcare. Complainants are surveyed on the effectiveness, responsiveness and sensitivity of the QIOs during the complaint process.

*** QIOs are required to conduct quality improvement activities on those cases that have a confirmed quality of care concern. This is defined as those cases in which the care rendered, failed to meet professionally recognized standards of care.

In FY 2007, QIOs reviewed 95,538 medical records, and 97.5 percent of these reviews were completed within timeframes prescribed by CMS. Nationally, the QIOs completed 3,533 reviews in which a beneficiary or the beneficiary representative complained about the quality of services. The beneficiary or beneficiary representative was satisfied with the process in 85.6 percent of these cases. At the 28th contract month, data indicated that all 53 QIOs met the evaluation requirements related to the Beneficiary Protection task.

Sanction and Pre-sanction Activities

QIOs are charged with referring practitioners and providers to the Office of the Inspector General (OIG) when they identify a case or cases meeting criteria for either grossly and flagrantly violating any obligation in section 1156(a) of the Act in one or more circumstances, or failing in a substantial number of cases to substantially comply with any obligation imposed in section 1156(a) of the Act. Section 1156(b) (1) of the Act requires that the QIO provide the practitioner or other person with an opportunity to enter into and complete a corrective action plan (CAP), if appropriate. In FY 2007, there were no referrals to the OIG for sanction activity, 14 cases in which pre-sanction activity occurred, 10 corrective action plans and 2 cases from prior fiscal years that were resolved as providers or practitioners successfully completed a CAP. These are summarized below.

Fourteen cases in which pre-Sanction activity occurred.

10 of 14 resulted from a quality of care review (2- Higher Weighted Diagnosis Related Group (HWDRG), 2-Referrals, 3-Intensified Reviews¹¹, 3-Bene Complaints);

- 1 of 14 resulted from an undetermined cause;
- 11 of 14 had a pre-sanction designation of gross and flagrant;
- 3 of 14 had a pre-sanction designation of gross and flagrant and substantial violation in a substantial number of cases;
- 10 of 14 had CAPs associated with them; the QIO completed other quality improvement activity for the remaining 4

Ten corrective action plans (CAP) were developed.

10 of 10 resulted from a quality of care review (2- Higher Weighted Diagnosis Related Group (HWDRG), 2-Referrals, 3-Focused Reviews¹¹, 3-Beneficiary Complaints).

- Some CAPs had multiple CAP activities associated with them as follows:
 - 8 of 10 resulted in monitoring activities;
 - 5 of 10 resulted in educational activities;
 - 1 of 10 resulted in procedure/policy change;

¹¹A QIO focusing on a particular provider or physician based on data evidencing a trend or pattern of health care needing improvement.

Two cases from prior fiscal years were resolved as a CAP was successfully completed. 2 of 2 resulted from a quality of care review (2-Beneficiary/Anonymous Complaint);

- The CAPs were 6 months and 21 months in duration.

Contract Task 3b: Hospital Payment Monitoring Program

The QIO Hospital Payment Monitoring Program (HPMP) protects the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for inpatient acute care services that are reasonable and medically necessary, are provided in the most appropriate setting, and are appropriately coded. The purpose of HPMP is to measure, monitor, and reduce the incidence of improper payments for short-term and long-term acute hospital care. Payment error estimates resulting from measuring and monitoring such payments are reported annually in the “Improper Medicare Fee-for-Service Payments” report and contribute to the overall error estimate that is included in the Agency’s financial statements.

We reviewed 41,399 sampled inpatient hospital discharges (the sampling timeframe for the FY2007 estimate was calendar year 2006 discharges) for the FY 2007 fee-for-service estimate. It cost \$10 million to generate the error estimate. We found \$15.1 million in overpayments and \$2.2 million in underpayments for a net of \$12.9 million recovered. A comparison of FY 2007 with FY 2006 shows the gross error rate improved from 4.90 ± 0.10 percent to 4.42 ± 0.10 percent from FY 2006 to FY 2007 and the net error rate was steady from 3.59 ± 0.10 percent to 3.55 ± 0.10 percent from FY 2006 to FY 2007.

Following the procedures established by regulation, QIOs were tasked with reviewing all medical records that had been referred to ascertain whether the services provided were reasonable and medically necessary, efficiently provided in the most appropriate setting, consistent with the provider-supplied medical information and coded appropriately, correctly billed, and if denied, appropriately denied. QIOs were required to review cases selected by CMS and referred by the Clinical Data Abstraction Center (CDAC), which are CMS contractors. In addition, QIOs were required to monitor patterns of hospital billing, admission, and coding practices and to act upon both their monitoring data as well as reports supplied by CMS. The QIOs were required to conduct a quality improvement project associated with errors that they identify in their analyses. Further, this task was evaluated by improvement in the gross and net payment error rate.

Gross payment errors include underpayment plus overpayment. CMS distinguishes between two major categories of gross payment errors—those related to coding and those related to admission necessity. Coding errors accounted for 31.3 percent of the gross payment errors identified in the FY 2007 estimate. The frequency of overpayments based on coding error was 57 percent and exceeded the frequency of underpayments due to coding error which was 43 percent.

Most (61.5 percent) of the gross payment errors identified by HPMP were related to admission of patients who did not meet medical necessity criteria. These errors arose from issues including improper billing for inpatient admission rather than observation status; improper acute care admissions billing for beneficiaries under the hospice benefit;

and unnecessary inpatient admissions for purposes of qualifying for the skilled nursing facility benefit. The additional 7.2 percent consisted of payment errors due to: lack of documentation, billing errors, and Maryland length of stay errors. Maryland is not paid under the hospital inpatient prospective payment system (IPPS).¹²

Table 10. The 8th SOW 3b Evaluation Summary: Performance on Hospital Payment Monitoring Program Measures

Measures	Performance in percent
On-time Case Review (N =56,241)	98.6
Percent of Successful Error Reduction Projects (N =52)	86.5
Percent of Error Reduction Projects Published in a healthcare journal by QIO (N =52)	25.0

At the 28th month contract evaluation, 52 of 53 QIOs had conducted a Quality Improvement Project which was intended to improve the payment error addressed and 86.5 percent were successful in doing so.

Summary of QIO Activities during FY 2007

This report shows QIO Program impact from the beginning of the 8th SOW through FY 2007, on a variety of healthcare quality measures across the four major settings: nursing homes, home health agencies, hospitals, and physician offices.

Table 11 illustrates that providers in the IPGs (providers receiving intensive QIO technical assistance) in three settings outperformed their non-IPG counterparts given the same opportunity for patient care. The magnitude of the improvements between IPG and non-IPG providers range from 0.5 percentage point for nursing home pain management to 6.6 percentage points for home health's Dyspnea measure. The random chances of IPG provider groups outperforming non-IPG providers 100 percent of the time is close to zero. In other words, this consistent trend is solid evidence of the positive impact of the QIO Program. The large relative differences are an indication of the strength of the QIO efforts on these tasks and measures.

¹² When the DRG system was originally legislated, States were given an "opt-out" option allowing a hospital to request exemption from the prospective payment system based on an approved state based hospital reimbursement control plan. Although the initial statutory language is discretionary, it is followed by many requirements that appear to require approval of such a plan if it meets all of the IPPS statutory requirements. At the outset of prospective payment systems, Maryland implemented such a cost containment and control plan and therefore has never fallen under the IPPS rules.

Table 11. Comparison of the absolute change (improvement) at the 28th month between baseline and remeasurement for Statewide and IPG providers in nursing homes, home health agencies and hospitals. The absolute difference is IPG minus non-IPG. The relative difference is the result of the subtraction divided by the statewide rate multiplied by 100.

Measures	Statewide Improvement (%)	IPG Improvement (%)	Absolute (Relative) Difference (%)*
Nursing Homes (Task 1a)			
Pressure Ulcers	1.3	2.4	1.1 (84.6)
Physical Restraints	2.2	2.9	0.7 (31.8)
Pain Management	1.8	2.3	0.5 (27.8)
Home Health (Task 1b)			
Acute Care Hospitalizations	-0.7	3.5	4.2 (600.0)
Oral Medications	3.8	7.8	4.0 (105.3)
Dyspnea	4.3	10.9	6.6 (153.5)
Pain	3.5	9.7	6.2 (177.1)
Hospitals (Task 1c)			
Appropriate Care Measure (ACM)	11.1	13.1	2.0 (18.0)

Table 12. Summary of major Program activities and examples of results during FY 2007. The dollar amounts noted in this table refer to the 8th SOW tasks in FY 2007. Their total (\$229 million rounded) does not include support contracts, special projects, SDPS costs, or other prior year adjustments resulting from contract close-out activities.

QIO/Task	Dollar Amount Spent on Task in thousands 10/01/06 to 09/30/07	Activity and goals	An example of results from this Report where data is available for the time period of the Report	Percent of QIOs meeting or exceeding expectations and other benchmarks FY 2007
1a. Nursing Home	\$32,334	Worked with 2,487 IPG nursing homes for decreased use of physical restraints; improvement in management of chronic pain, improvement in high risk pressure ulcer; and worked in advancing excellence in care.	Physical restraints showed a 2.9% improvement in the IPG1 group, a 5.0% improvement in the IPG2 homes, and 2.2% improvement statewide.	100%
1b. Home Health	\$26,527	Worked with 1,420 IPG agencies for decreased avoidable hospitalizations (ACH); improvement in management of pain; improvement in Dyspnea; and improvement in oral medications.	IPG HHAs showed an absolute improvement of 3.5% in ACH, 7.8% in Oral Medications, 10.9% in Dyspnea, and 9.7% in Pain management.	94.3%
1c1. Hospital	\$32,096	Worked with 1,658 IPG facilities for decreased surgical site infections, cardiovascular complications, venous thromboembolism, ventilator-associated pneumonia; and promote the use of fistulas for hemodialysis. Statewide hospitals report on Hospital Compare.	IPG hospitals showed 13.1% improvement in appropriate care measures and 7.0% improvement in appropriate surgical care.	98.1%
1c2. Critical Access Hospital/Rural PPS Hospital	\$9,827	Worked with 415 IPG facilities to increase CAH and PPS hospital safety culture.	IPG hospitals showed 58.6% improvement on the Patient Safety Survey.	97.7%
1d1. Physician Practice	\$34,102	Worked with 3,710 IPG practices for increased use of health information technology to improve patient care.	QIOs went over goals in recruiting, establishing EHR contracts, installing EHRs, and care management using EHRs.	88.7%

QIO/Task	Dollar Amount Spent on Task in thousands 10/01/06 to 09/30/07	Activity and goals	An example of results from this Report where data is available for the time period of the Report	Percent of QIOs meeting or exceeding expectations and other benchmarks FY 2007
1d2. Underserved Populations	\$11,347	Worked with 1,100 physician offices nationally who used Office of Minority Health tools to increase awareness of underserved issues.	Among underserved population increased the rates of testing for diabetes (HA1C 3.9%, Lipid Profile 6.1%) and the rates of mammography 2.2%.	100%
1d3. Part D Benefit	\$8,387	Worked with CMS to begin one project to increase safety in the delivery of prescription drugs.	All 53 QIOS successfully completed a prescription drug quality improvement project.	100%
3a. Beneficiary Protection	\$61,368	Conducted statutorily mandated review of beneficiary complaints about the quality of health care services and all activities associated with other required case reviews.	Conducted statutorily mandated review of beneficiary complaints about the quality of health care services; 97.5% of reviews done in appropriate time, 86.6% of beneficiaries satisfied with the complaint process, and 73.0% of the reviews resulted in quality improvement activities.	100%
3b. Hospital Payment Monitoring Program	\$12,970	Measure, monitor, and reduce the incidence of improper fee-for-service inpatient payments.	The purpose of HPMP is to measure, monitor, and reduce the incidence of improper fee-for-service inpatient payments, including those resulting from errors in: DRG coding; provision of medically necessary services; and appropriateness of setting, billing, and prepayment denial.	41,399 sampled medical records found \$15.1 million in overpayments and \$2.2 million in underpayments

Other Aspects of the QIO Program

The Program sponsors other activities and resources that support and add value to the QIO Program. This includes QIO Support Contractors (QIOSCs) and QIO Special Projects.

QIO Support Contractors

The Outpatient Physician Office QIOSC

The Outpatient Physician Office QIOSC (Virginia QIO) reviewed and provided best practices and lessons learned to the MedQIC website. In the last three months of the fiscal year, they averaged 41 new postings to the site per month. Additionally, they managed task-related national phone calls, consulted on various data problems, reviewed literature, made presentations, and other work to support task 1.d.

The Home Health QIOSC

CMS and the Home Health QIOSC (Pennsylvania QIO) launched the 12-month home health quality campaign on January 11, 2007, focusing on the reduction of avoidable hospitalizations. The campaign kick-off began with a summit that included CMS staff, QIOs, State Associations, home care chain leaders and home care agencies from across the country. More than 85 percent of the 8,100 Medicare-certified home health agencies in the nation participated in the campaign.

The Home Health QIOSC's national campaign was a "virtual" campaign, centering on www.homehealthquality.org, which was a clearinghouse for tools to assist with staff education. These tools included monthly best practice intervention packages, educational videos, podcasts, and other associated resources. The continued dedication of these participating agencies contributed to the number of monthly Web site visits, which averaged around 11,000 each month.

Each home health agency enrolled in the national campaign was provided with monthly performance reports, containing actual and risk-adjusted monthly acute care hospitalization (ACH) rates, along with some characteristics of hospitalized patients. National and statewide ACH benchmarking based on CMS data was also provided monthly. The QIOSC's success included:

- Developing and implementing best practice intervention packages to improve the rates for the home health publicly reported measures.
- Developing and implementing the Telehealth Guidelines for the QIOs. This guide assisted the QIOs in working with the home health agencies to reduce unnecessary hospitalizations and improve the rates of other publicly reported measures.
- Developing and implementing practices to improve the pneumonia and influenza vaccination rates of home health patients.
- Working with the QIOs to develop their ability to assess and improve organizational culture within individual home health agencies.

QIO Special Projects

QIO Special Projects are used to provide emphasis and energy to important aspects of the QIO Program. Two examples of Special Projects are outlined below.

The Better Quality Information to Improve Care for Medicare Beneficiaries (BQI) Project

This project is an 8th SOW special study project that was launched in the summer of 2006 and was carried on through October 2006 and 2007. The project provided support to the Secretary of Health and Human Services' Value-driven Health Care Initiative. We awarded an \$11.4 million contract to the Delmarva Foundation for Medical Care (the QIO for the state of Maryland) to subcontract with and oversee 6 regional, multi-stakeholder health care collaboratives. The primary goal of the BQI Project was to test methods to aggregate Medicare claims data with the six pilot sites' local data sources, which included data from other payers and, in some cases, data obtained directly from providers, in order to calculate and report quality measures for physician groups and, in some cases, individual physicians. The BQI Project aimed to:

1. Provide beneficiaries in these six communities with health care performance information on the physicians who treat them, in order to help them select physicians and make treatment choices, and
2. To provide performance information to the physician groups and/or physicians who treat these beneficiaries, which were used by the physician groups and/or physicians to improve the quality of care they provide.

We believe that the results from this project will be useful in guiding future efforts for aggregating Medicare claims data with data from other payers to produce quality measure results that provide a more comprehensive picture of the quality of services being provided by physicians to Medicare beneficiaries.

Much of FY 2007 was devoted to finalizing and executing the subcontract agreements with the six pilot sites and/or their external data aggregators, if applicable. The last of the necessary contractual agreements (including those between the pilot sites and any external data aggregators) were not executed until April 30, 2007. By the end of FY 2007, all but two of the six pilot sites completed the first cycle of data aggregation and calculated multi-payer physician group or individual physician level results on five quality of care measures based on the Medicare administrative data and the pilot sites' local data sources. By the end of the BQI Project in October 2008, the pilot sites were expected to complete at least three more cycles of data aggregation to calculate multi-payer physician group or individual physician level results on 12 quality of care measures.

Advancing Excellence in America's Nursing Homes Campaign

As a Special Project under the QIO 8th SOW, CMS launched the Advancing Excellence in America's Nursing Homes Campaign. The purpose of the two-year campaign was to leverage stakeholders' and consumers' involvement in quality and in supporting the 8th QIO SOW clinical measures. It included nursing home providers, health care practitioners and professionals, unions, advocates and consumer groups, nursing home

residents, researchers, caregivers, medical and quality improvement experts, government agencies, and foundations. More than one-third of the nation's 16,000 nursing homes participated. QIOs served as Local Area Networks of Excellence to provide evidenced-based care practices and systematic approaches to care. The campaign focused on four clinical goals to improve quality at the national level and over three years succeeded in reducing high risk pressure ulcers, the use of daily physical restraints, improving pain management for longer term nursing home residents, and improving pain management for short stay, post-acute nursing home residents.

Data Infrastructure Improvements and Oversight for the QIO Program

The QIO Program depends upon valid and reliable data to monitor and evaluate the Program. All of the tables in this Report are the result of the QIO Standard Data Processing System (SDPS) data collection and analysis system. During FY 2007, the SDPS strategy planning sessions resulted in identifying: (1) the need to consolidate the SDPS infrastructure from three different complexes into one in order to reduce costs, increase efficiency, provide higher availability, and establish better monitoring; and (2) the need to stabilize applications by restructuring them into more discrete modules where changes to one would have less impact on others. Implementation plans were established that will result in completion of these items in the following fiscal years.

IV. CONCLUSION

In summary, the QIO Program—with a national network of knowledgeable and skilled independent organizations under contract with Medicare, is charged with identifying, disseminating, and encouraging evidence-based healthcare practices. The contract states: “Based on legislative language and the experience of the Centers for Medicare & Medicaid Services (CMS) in administering the Program, CMS has identified the following requirements for the QIO Program:

- Improve quality of care for beneficiaries;
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and medically necessary and that are provided in the most appropriate setting; and
- Protect beneficiaries by expeditiously addressing individual complaints, notices, and appeals, such as beneficiary complaints; provider-issued notices of noncoverage (Hospital-Issued Notice of Non-Coverage [HINN], Notice of Discharge and Medicare Appeal Rights [NODMAR], and Medicare Advantage appeal); Emergency Medical Treatment and Labor Act (EMTALA) violations; and other related statutory QIO responsibilities.”

This report demonstrates the success of the QIOs in carrying out the contract mandates.