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

December 6, 2011

The Honorable John A. Boehner
Speaker of the House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

I respectfully submit the enclosed "Report to Congress on the Evaluation of the Quality Improvement Organization (QIO) Program for Medicare Beneficiaries for Fiscal Year 2008." This submission fulfills the Social Security Act requirement that the Secretary of Health and Human Services submit an annual Report to Congress on the QIO Program.

This report outlines the performance of QIOs during the 8th QIO Statement of Work (SOW), and describes the first two months of the 9th SOW. The SOW is a 3-year, performance-based contract for QIOs operating in all 50 states, the territories, and the District of Columbia. This report reviews Fiscal Year (FY) 2008 activities, from October 2007 (27th contract month of the 8th Statement of Work) to September 2008 (second month of the 9th Statement of Work).

In FY 2008, the QIO Program was at the end of the 36 month 8th SOW contract. The report details the administration, cost, and impact of the QIO program during FY 2008, covering provider improvement in quality measures for hospitals, home health agencies, nursing homes, and physician practices.

I am also sending an identical copy of this report to the President of the Senate.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

Enclosure

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WASHINGTON, D.C. 20201

December 6, 2011

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

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Enclosure

Report to Congress

The Administration,Cost,and Impact of the Quality Improvement Organization (QIO) Program for Medicare Beneficiaries for Fiscal Year 2008

Kathleen Sebelius
Secretary of Health and Human Services
2011

EXECUTIVE SUMMARY

Section 1161 of the Social Security Act (the Act) requires the submission of an annual Report to Congress on the administration, cost, and impact of the Quality Improvement Organization (QIO) Program during the preceding fiscal year. This report fulfills this mandate for FY 2008.

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.
In FY08, QIO Program expenditures totaled approximately $387.37 million.[1]
The 8th Statement of Work (SOW) focused on quality improvement for nursing homes, home health agencies, hospitals, and physician practices through organizational "transformation" intended to produce more rapid, measurable improvements in care.

The QIO Program impacts Medicare beneficiaries on an individual basis and the beneficiary population as a whole. In FY08, 37.5 million aged were covered by Medicare; that is 98.1 percent of the aged population of the United States; virtually everyone 65 and older. Medicare covered an additional 7.3 million disabled persons.[2] These 44.8 million Americans represent the significant portion of the nation's population (14.7 percent) that receives improved health care as a result of QIO activity.

The statutory mission of the QIO Program is set forth in Title XVIII of the Act--*Health Insurance for the Aged and Disabled.* More specifically, section 1862(g) of the Act states the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. The quality 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.

The QIO Program is administered through 53 performance-based, cost-reimbursement contracts with 41 independent organizations. These contracts last three years and are referred to as Statements of Work (SOWs). The majority of FY08, ten months, occurred during the 8th SOW and the remaining two months of FY08 occurred during the 9th SOW. These SOWs contain a multi-tiered award fee plan based upon individual and group

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[1] The Department of Health and Human Services, Fiscal Year 2009, Centers for Medicare & Medicaid Services, Office of Financial Management. February 19, 2009.

[2] 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.

performance. QIOs received an individual award fee based upon meeting performance criteria specified for each task in their SOW. For example, for individual Interim Awards in Task 1a (Nursing Homes), the QIOs identified participant group (IPG) were required to achieve a 60% threshold for the physical restraint measure by November 2007. In the Experience of Care measure for Task 1a, the QIOs were required to achieve a threshold of 100% for the baseline IPG survey. Whereas in Task 1b (Home Health), the QIOs were required to achieve 40% of the November 2007 threshold for acute care hospitalization and other clinical performance measures. Group awards were given to all QIOs for a task, if all QIOs met aggregate performance criteria as a group for that task. The QIOs' technical performance was evaluated at the 28th month of their 36-month 8th SOW contract during FY08 and will be evaluated at the 18th and 28th month of their 36-month contract for the 9th SOW during future FYs. 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 (PO) and Contract Specialist. 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 more than one million practitioners[3] nationwide can work with QIOs. The providers and practitioners can request and receive QIO technical assistance (TA). Additionally, providers and practitioners are subject to QIO review for specific reasons (e.g. record reviews for quality of care complaints) at the request of beneficiaries, CMS, Fiscal Intermediaries, Medicare Administrative Contractors, and when instigated by the QIO itself.

In FY08, QIO Program expenditures totaled approximately $387.37 million.[4] QIO work has been carried out in 3-year SOW contract cycles. For FY08, the QIO Program was still in a very early stage of the 9th SOW contract, which began August 1, 2008 for all QIOs simultaneously. The 9th SOW provides the Centers for Medicare and Medicaid Services (CMS) with additional tools to better manage the QIOs by linking the work completed by the organizations to measurable outcomes that are reviewed and measured during the entire length of the three-year contract. See below for further discussions of the 8th and 9th SOWs. A more detailed discussion of the 9th SOW and its impact will be included in the FY09 Report to Congress.

BACKGROUND

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, now known as the QIO Program. The statutory mission of the QIO Program is set forth in Title XVIII of the Act--*Health Insurance for the Aged and Disabled.* More

[3] 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 12/31/07; published June 2008.
[4] The Department of Health and Human Services, Fiscal Year 2009, Centers for Medicare & Medicaid Services, Office of Financial Management. February 19, 2009.

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, CMS identified the following goals for the QIO Program:

- Improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized health care standards

- 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

- Protect beneficiaries by expeditiously addressing individual cases such as beneficiary quality of care complaints

Under Title XI--*General Provisions, Peer Review, and Administrative Simplification*, section 1161 of the Social Security Act--CMS is required to submit an annual report to Congress on the QIO Program. CMS must include in the report information on the administration, cost, and impact of the Program during the preceding fiscal year.

I. PROGRAM ADMINISTRATION

Description of Quality Improvement Organization Contracts

In 2005, the QIO Program began its eighth 3-year contract cycle, the 8th SOW. This report reviews FY08 activities from October 2007 (the 27th contract month of the 8th SOW) to September 2008 (the second contract month of the 9th SOW, which began August 1, 2008 for all QIOs simultaneously). In FY08 the QIO Program was at the end of the 36 month 8th SOW, and the start of the 9th SOW contract.

The 8th SOW focused on quality improvement for nursing homes, home health agencies, hospitals, and physician practices through organizational "transformation" intended to produce more rapid, measurable improvements in care. The QIOs worked intensively with subsets of individual providers and practitioners 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).

In August 2008, CMS awarded contracts for the 9th SOW for the 53 Contractors participating in Medicare's QIO Program. The QIO contracts extend from August 1, 2008 through July 31, 2011. The 9th SOW focuses on improving the quality and safety of health care services to Medicare beneficiaries. The 9th SOW builds on the Administration's health care quality improvement initiatives and a growing evidence base about how to improve the quality and efficiency of health care delivery. It also

implements several recommendations from the Institute of Medicine, the Government Accountability Office, and members of Congress about how the Program can deliver maximum benefit to patients at the greatest value to the government. The new contracts provide additional tools for CMS and the QIOs to track, monitor, and report on the impact that QIOs have on the care provided in their states/jurisdiction. The QIOs' technical performance during the 9th SOW has been or will be evaluated at the 18th and 28th month of their 36-month contract. More detailed information regarding the 9th SOW will be provided in the FY09 report to Congress.

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. QIOs received an individual award fee based upon meeting performance criteria as specified for each task in their SOW. Group awards were given to all QIOs participating in a task if all QIOs met aggregate performance criteria as a group for that task. 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.

The goals in the 8th SOW pertain to performance in the following areas:

1. Conducting statutorily mandated case review, including reviewing beneficiary complaints about the quality of health care services,
2. Measuring, monitoring, and reducing rehospitalizations,
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 (including critical access hospitals), and physicians' offices.

QIOs Interacting with Health Care Providers and Practitioners

QIOs work with and provide technical assistance to health care practitioners and providers such as physicians, hospitals (including critical access hospitals), 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 treats Medicare patients and could be paid under Title XVIII of the Social Security 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 more than 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, occasional contact with the QIO at professional 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 spending rather than discretionary spending because QIO costs are financed directly from the Medicare Trust Fund and are not subject to the annual appropriations process. In FY08, QIO Program expenditures totaled $387.37 million. This spending represents approximately $8.65 annually for each of the over 44.8 million Medicare beneficiaries to improve quality of care, and less than one tenth of one percent (0.1%) of the $460.9 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 FY08, 37.5 million aged were covered by Medicare; that is 98.1 percent of the aged population of the United States; virtually everyone 65 and older. Additionally 7.3 million disabled persons were covered.[5] These 44.8 million Americans represent a significant portion of the nation's population (14.7 percent) that receives improved health care as a result of QIO activity.

Through the efforts of the QIOs in FY08, beneficiaries experienced less pain while coping with chronic conditions in home health care and in nursing homes. Beneficiaries in nursing homes also had fewer bed sores or pressure ulcers and were able to maintain their independence because restraints were used less frequently. After surgery, beneficiaries experienced improved recovery and had overall improvement in patient safety in critical access hospitals. The QIOs work with providers and practitioners to use health information technology to improve care coordination and monitor Medicare expenditures to ensure program integrity and efficiency.

[5] 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.

This section provides information on QIO accomplishments and the impact on beneficiaries as a result of the 8th SOW. CMS and the QIOs spent the two months of the 9th SOW that occurred during FY08 setting up the new contracts; there is no information on SOW impact that correlates with this early time period. We will discuss the impact of the 9th SOW in future FY reports. Impacts were made on beneficiaries by means of contractual mechanisms in the 8th SOW known as Tasks. In each of eight distinct Tasks, QIOs provided technical assistance by means of quality improvement tools and techniques that improved beneficiary health care.

Four tasks related to 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 addressed:

- 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: 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 1a are rates of pressure ulceration, use of physical restraints, and pain management. For their evaluation, the QIO focused on; a) improving clinical performance, b) setting improvement targets; and c) measuring the nursing home experience. In the area of clinical improvement, the QIO focused on decreasing the use of physical restraints, and improving the management of pain in chronic (long stay) residents. The QIOs worked with a selected group of identified participating nursing homes as well as with other nursing homes requesting assistance from the QIO.

Contract Tasks

In the first seven Tasks, QIOs sometimes worked with two groups of providers/practitioners on quality improvement: first with an identified participant group (IPG) and second with all providers and practitioners in the state (statewide) by providing materials to them at their request. 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 to serve as IPGs. Practices might also volunteer to participate as IPGs. IPGs for Nursing Homes, Hospitals, and Home Health Agencies were chosen by the QIO based upon certain criteria, e.g. percentage of Nursing Homes in the state/jurisdiction.

Non-IPG providers received no individualized or concentrated assistance, but they are included in the statewide measurement where applicable.

Contract Task 1a: Nursing Home

Under Task 1a, the QIOs focused on: improving clinical performance; setting improvement targets; and measuring the nursing home experience. CMS selected three chronic care quality measures (QM): high-risk pressure ulcers, physical restraints and chronic care pain. In the area of clinical improvement, the QIOs focused on decreasing the rate of pressure ulcers among high-risk individuals, decreasing the use of physical restraints, and improving the management of pain in chronic (long stay) residents among a select group of identified participating nursing homes (IPG1) as well as other non-IPG nursing homes requesting assistance from the QIO. The QIOs also worked with a second selected group of identified participants (IPG2) nursing homes that focused on decreasing the rate of pressure ulcers among high-risk individuals and also decreasing the use of physical restraints. However, IPG2 did not include as a focus pain management. In the area of organizational culture, the QIOs worked with both groups of identified participants (IPG1 and IPG2) to collect information on resident and staff experience/satisfaction with care and staff turnover by engaging in activity that is likely to improve organization culture.

Lower scores represent better performance for the QMs. The national mean scores, in order from lowest to highest, are chronic pain (4.36), physical restraints (5.09) and high-risk pressure ulcers (11.97). It is noteworthy that the national average on the physical restraints QM has demonstrated consistent improvement for all 17 reported quarters since the enhanced QMs were first reported in 2003 Quarter 3.

All measures showed improvement in all facility groups (IPG1, IPG2, non-IPG, and nationwide). The most notable improvement was in physical restraints: 2.41 percent absolute improvement, 32.1% relative improvement nationally; 3.25% absolute improvement, 46.5% relative improvement in the IPG1; and 5.15% absolute improvement, 48.5% relative improvement in the IPG2 facilities. Additionally, the chronic care pain measure showed remarkable improvement: 1.87 % absolute improvement, 30.0% relative improvement nationally; and 2.24% absolute improvement, 36.3% relative improvement in the IPG1 facilities; and 3.43% absolute improvement, 44.5% relative improvement for IPG2 facilities. There was continued improvements in high-risk pressure ulcers: 1.77 % absolute improvement, 12.9% relative improvement nationally; 2.63% absolute improvement, 19.5% relative improvement in the IPG1; and 3.27% absolute improvement, 20.1% relative improvement in the IPG2 facilities.

Nationally participating home rates of care measures were: Resident satisfaction for IPG1 (97.79%) and IPG2 (90.34%); Staff satisfaction -IPG1 (97.40%) and IPG2 (91.03%); and Certified Nursing Assistants/Aides (CNA) Turnover -IPG1 (96.93%) and IPG2 (96.55%).

Contract Task 1b: Home Health

With the 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 each of the participating HHAs.[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. QIOs also worked with identified participant home health agencies to evaluate and improve organizational culture and implement telehealth. Telehealth included the use of an electronic medical device that transmits the patient's health information to the HHA and/or telephone monitoring and follow-up directly with the patient.

Statewide, the QIOs worked with HHAs (non-IPGs) to reduce the rate of acute care hospitalization. The QIO selected one other publicly reported measure to work on with the non-IPGs. Also on the statewide level, the QIO worked to promote influenza and pneumococcal vaccinations of home health patients.

In all of the publicly reported measures, IPG HHAs improved more than statewide (non-IPG) HHAs. IPGs demonstrated an improvement of at least 6 percent over the non-IPG group for the oral medication and pain measures. The IPGs demonstrated at least a 4 percent improvement over non-IPGs for the dyspnea and ACH measures. 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.

Contract Task 1c1: Hospital

To improve the quality of care Medicare beneficiaries received during hospitalizations for four specific clinical conditions, QIOs worked with two IPG hospital groups. The first IPG targeted the care received by beneficiaries in three clinical areas: acute myocardial infarction (AMI), Heart failure (HF), and Pneumonia (PNE). QIOs were measured using a composite measure, called an Appropriate Care Measure (ACM). The ACM is a composite measure that captures whether or not a beneficiary received all the care he or she should have received (in a particular clinical area) as defined by scientific evidence of best practices.

The second IPG focused on the Surgical Care Improvement Project (SCIP). This IPG was 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 conducted at least 300 major surgical procedures per year. Process of care measures corresponding with SCIP infections and venous thromboembolism (VTE) are combined for a composite SCIP score (or a SCIP ACM). This SCIP ACM was calculated for only the IPG. While the QIO was only evaluated based on the two topics in the SCIP ACM (infection and VTE), the SCIP hospitals also worked on reducing cardiovascular complications and ventilator associated pneumonia.

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

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

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 Identified Participant Group of CAH and rural Prospective Payment System (PPS)[9] hospitals to improve their hospital's organizational safety culture.

As part of the IPG effort, QIOs provided technical assistance in administering, analyzing, and interpreting results of the Agency on Healthcare Research and Quality's (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.

The number of CAHs reporting to the CMS clinical warehouse more than doubled from 415 to 966 and the percent of CAH patients receiving appropriate care for selected HQA measures increased 26.2 percent. Nearly 60 percent of the 382 IPG CAH and PPS hospitals improved their Patient Safety Culture Survey scores at remeasurement.

Contract Task 1d1: Physician Practice

In task 1d1, QIO effort was directed toward improving quality of care with respect to preventing clinical disorders and directing the treatment of clinical disorders. To accomplish this, QIOs were required to increase the number of physician practices that installed and used Electronic Health Records (EHRs) technology. QIOs had a goal of recruiting at least five percent of the practice sites in their state/jurisdiction. At least 40 percent of the physicians in each practice site were required to have a primary specialty designation of general practice, family practice, or internal medicine. These five percent constituted the IPGs (identified participating practices). Five percent was the lower limit for the IPG size. QIOs were permitted to recruit up to ten percent of these practices in their state/jurisdiction.

The physician practice IPG focused on introducing basic changes in patient care through the use of EHR technology, care process redesign, and performance measurement. QIOs' 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, heart failure, coronary artery disease, hypertension, and

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[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.

preventive services, as well as teaching the practices how to utilize their EHRs to improve the quality of care for patients with these chronic diseases.

Four of five measures were above the 8th SOW goals. These five measures were: 1) recruitment, 2) use and produce electronic clinical information, 3) implement care management processes, 4) reporting, and 5) satisfaction. Eighty-eight percent (47 out of 53 QIO contracts) of the QIOs passed all contract Tasks. Forty-three QIOs (81 percent) 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. Of the practices recruited without a prior EHR vendor contract signed, 1,590 out of 3,076 practices installed EHRs. This exceeded the target by 200 percent (the target was 795 practices). Of the 3,471 practices recruited that did not have a prior EHR vendor contract signed, or a system installed, 1,428 practices installed an EHR. This exceeded the target by 128 percent (the target was 1,112 practices).

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 Medicare underserved racial/ethnic populations, i.e., the African American, Asian/Pacific Islander, American Indian/Alaskan Native, and/or Hispanic/Latino populations. Research demonstrates disparities in health care delivery and status based on race and ethnicity. For example, African Americans, Asian Americans, Hispanics, and Native Americans suffer disproportionately from chronic disease, cancer, and infectious disease.

Under this Task, QIOs were required to create 2 IPGs that were allowed to overlap. These IPGs were comprised of physician practice sites providing care to a proportionate number of Medicare beneficiaries (as specified by CMS) from Medicare-underserved racial/ethnic populations. One IPG consisted of practice sites to work on Task 1d1 activities under the Task 1d1 requirements. There was an overlap between Task 1d1 and Task 1d2 IPGs, requiring QIOs to promote EHR implementation in practice sites serving Medicare underserved populations. The QIOs worked with a second separate IPG on the CLAS/Cultural Competency 1d2-specific activities (Task 1d2 Specific IPG). Physician offices that worked with underserved populations were encouraged to adopt EHRs and to use them to improve the 1d2 measures, which were: HbA1c (hemoglobin A1c), Retinal Eye Exam, and Lipid Profile, some of which are taken from the Department's Office of Minority Health (OMH) Cultural Competency Program. EHR adoption and utilization by physician offices enabled the physicians to closely track the management of patients by disease condition. EHR systems can track how often lab tests are drawn, the results of those tests, and the patient's current clinical status.

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. Physician practices were recruited by the QIOs through office visits. Face-to-face visits have proven to be the most effective recruitment strategy with physician practices. Practices were chosen based on criteria defined in the 8th SOW contract. The QIOs also conducted office visits for physician training regarding the

cultural competency tools. The actual use and completion of the tools by the physicians took place online, at any time at the physicians' convenience. 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 different approaches are considered useful in addressing cultural competency in health care.

The Task saw improvement in each of the four measures among IPG Task 1d2 physician offices compared with non-IPG offices. Three of the measures, HbA1c (hemoglobin A1c), Retinal Eye Exam, and Lipid profile, are especially important in the control of diabetes. The Medicare and underserved populations have a high prevalence of diabetes. Uncontrolled diabetes leads to medical complications, increased hospitalizations and treatments, and increased health care expenditures.

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 quality improvement assistance pertaining to prescription drug therapy to Medicare providers and practitioners, Medicare Advantage organizations offering Medicare Advantage plans, and organizations offering Medicare prescription drug plans (PDPs).

QIOs implemented quality improvement projects focused on improved prescribing, using evidence-based guidelines. CMS worked with the QIO to develop and implement new methods to gather and disseminate better evidence for healthcare decision-making. This activity included collecting, linking, and de-identifying Part D and other public and private administrative data; assisting in the implementation of clinical registries; 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. CMS worked closely with dispensing pharmacists because they detect errors and problems with the medications they dispense quickly and they also interact with the beneficiary directly. Pharmacy policies, procedures, and quality checks need to be implemented to be consistent with quality, safety, and cost-effectiveness goals.

All 53 QIO Contractors developed an approved prescription-drug quality improvement project. These projects are shown in Table 1, listed by care settings. The table shows the adverse events QIO were working on controlling.

Table 1. Prescription drug quality improvement projects

Target Audience Description	Control of Potentially Inappropriate Medication	Control of Drug-Drug Interaction

Health Plans	3	3
LTC	1	1
MAO/PDP	6	6
Nursing Home	1	1
Physician Offices	9	10
Multiple	33	32
TOTALS	53	53

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 about termination of services, all hospital requested higher-weighted diagnosis related groups (DRGs) and fiscal intermediary referrals.

QIOs respond to beneficiary quality of care complaints. Any beneficiary who receives services from a Medicare provider 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, beneficiary 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.

In FY08, QIOs reviewed 57,514 medical records, and 96.5 percent of these reviews were completed within timeframes prescribed by CMS. Nationally, the QIOs completed 2,746 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 84.9 percent of these cases. Based on quality improvement activity by state, 2,040 records had at least one confirmed quality of care concern and a quality improvement activity was started for 1,466 of the records with a confirmed quality of care concern.

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 instances, 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 FY08, there were 6 referrals to the OIG for sanction activity, 2 cases in which pre-sanction activity occurred and 6 corrective action plans.

Six cases referred to the OIG for sanction activity

Referral Source

- 2 of 6 resulted from an undetermined cause not associated with case review
- 1 of 6 resulted from a quality of care CMS Referral
- 2 of 6 resulted from a Beneficiary Complaint
- 1 of 6 resulted from an Intensified Review of Physician

Preliminary Violation (Defined as the sanction violation identified by the QIO)
- 1 of 6 resulted from a substantial violation in a substantial number of cases
- 2 of 6 resulted from a gross and flagrant violation
- 3 of 6 resulted from a gross and flagrant and substantial violation in a substantial number of cases

Two cases in which Pre-Sanction activity occurred
- 2 of 2 resulted from quality of care reviews (1-Intensified Review, 1-Bene Complaint)
- 2 of 2 had a pre-sanction designation of gross and flagrant

Six Corrective Action Plans
- 6 of 6 resulted from a quality of care review (1-quality review in which HPMP concern identified and Intensified Review, 1-Intensified Review and Referral, 2-Intensified Reviews, 2-Beneficiary Complaints)
- 2 of 6 resulted in monitoring activities and educational activities
- 1 of 6 resulted in educational activities
- 1 of 6 resulted in monitoring activities
- 1 of 6 resulted in procedure/policy change
- 1 of 6 was unspecified

Contract Task 3b: Hospital Payment Monitoring Program

The QIO Hospital Payment Monitoring Program (HPMP) protected the integrity of the Medicare Trust Fund by ensuring that Medicare paid only for inpatient acute care services that are reasonable and medically necessary, were provided in the most appropriate setting, and were appropriately coded. The purpose of HPMP was 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 were reported annually in the "Improper Medicare Fee-for-Service Payments" report and contributed to the overall error estimate that is included in the Agency's financial statements. CMS reviewed 41,400 sampled acute care inpatient hospital discharges (the sampling timeframe for the FY08 estimate varied by the type of claim with most being sampled from November 1, 2007 to October 31, 2008 discharges) for the FY08 fee-for-service estimate. It cost $10 million to generate the error estimate; we found $14.2 million in overpayments and $1.8 million in underpayments for a net of $12.4 million recovered. A comparison of the estimates from FY07 to FY08 shows the improper payment error rate was reduced from 4.8 ± 0.10 percent to 4.6 ± 0.10 percent.

Following the procedures established by regulation, QIOs were to review all medical records 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, 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 is a CMS contractor. 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 (state-based and hospital-specific reports were supplied). The QIOs were required to conduct a quality improvement project to reduce improper payments in areas they identified for their jurisdiction. Part of the evaluation criteria included improvement in their payment error rates.

The gross payment error rate is calculated using the sum of underpayments plus overpayments divided by the total reimbursements; this is the metric utilized by CMS for the agency's payment error rate. There are two major categories of payment errors for acute care inpatient claims —those related to coding and those related to admission necessity. Coding errors accounted for 27 percent of the gross payment errors identified in the FY08 estimate. Most (67 percent) of the dollars paid in error identified by HPMP were related to admission of patients who do not meet medical necessity criteria. These errors arise from issues including improper billing for inpatient admission rather than observation status and unnecessary inpatient admissions for purposes of qualifying for the skilled nursing facility benefit. The additional 6 percent consist of payment errors due to: lack of documentation, billing errors, and Maryland length of stay errors. Maryland is not paid under the DRG system.

At the 28th month contract evaluation, 52 of the 52 QIOs that had HPMP as part of their base contract (the Virgin Islands are excluded) had conducted a Quality Improvement Project which was intended to improve the payment error addressed and 86.5 percent were successful in doing so. In addition, 11 QIOs published the results of their projects in 10 peer reviewed journal articles.

The responsibilities toward improper payments under HPMP ended with the 8th SOW; the work was transitioned to the Office of Financial Management and the Comprehensive Error Rate Testing Program.

Summary of QIO Activities during FY08

This report shows QIO Program impact from 10/01/07 of the 8th SOW through the end of the 8th SOW (towards the end of FY08), on a variety of healthcare quality measures across the four major settings of nursing homes, home health agencies, hospitals, and physician offices. Table 2 is a Summary of Selected QIO Activities and Examples of Results for FY08. The dollar amounts noted in this table refer to the 8th SOW tasks in FY08. Their total ($171 million rounded) does not include support contracts, special projects, SDPS costs, 9th SOW related activities, or other prior year adjustments resulting from contract close-out activities.

Table 2. Summary of Selected QIO Activities and Examples of Results for FY08.

QIO Task –	Dollar	Activity and goals	Example of results where

8th SOW	Amount Spent on Task in millions 10/01/07 to 09/30/08		data is available for the time period of the Report
1a.Nursing Home	$23.8M	The QIOs worked with nursing home facility groups (IPG1, IPG2, non-IPG) to improve clinical performance, setting improvement targets; and measuring the nursing home experience.	All measures showed improvement in all facility groups (IPG1, IPG2, non-IPG). The most notable improvement was in physical restraints: 2.41% absolute improvement, 32.1% relative improvement nationally; 3.25% absolute

			improvement, 46.5% relative improvement in the IPG1; and 5.15% absolute improvement, 48.5% relative improvement in the IPG2 facilities. Additionally, the chronic care pain measure showed remarkable improvement: 1.87 % absolute improvement, 30.0% relative improvement nationally; and 2.24% absolute improvement, 36.3% relative improvement in the IPG1 facilities; and 3.43% absolute improvement, 44.5% relative improvement for IPG2 facilities. There was continued improvements in high-risk pressure ulcers: 1.77 % absolute improvement, 12.9% relative improvement nationally; 2.63% absolute improvement, 19.5% relative improvement in the IPG1; and 3.27% absolute improvement, 20.1% relative improvement in the IPG2 facilities.
1b. Home Health	$17.5M	QIOs worked intensely with 1,420 IPG home health agencies to decrease the acute care hospitalization (ACH) rate and the rate for one other agency selected publicly reported measure. Worked less intensely with other agencies	In each of four critical measures IPG HHAs improved more than statewide HHAs. The largest differences were in Oral Medications and Pain with IPGs at least 6 % greater; and in Dyspnea and ACH measures, the IPGs were 4 % or greater than statewide HHAs. This across the board difference

		within a statewide group (non-IPGs) to improve the ACH rate and the rate for one other QIO selected publicly reported measure.	demonstrates the value of the individual attention each IPG HHA receives from its QIO, whereas statewide HHAs lack such individual assistance.
1c1. Hospital	$24.7M	QIOs continued to work with statewide and IPG hospitals on an Appropriate Care Measure (ACM) to improve clinical performance. The ACM is a composite measure that evaluates the care provided to beneficiaries in three clinical areas: acute myocardial infarction (AMI), Heart failure (HF), and Pneumonia (PNE	Data outcomes from FY07 were used to rank and prioritize hospitals that need the most assistance based on the composite ACM. These hospitals were selected for intensified efforts (identified participant groups) for FY08.
1c2. Critical Access Hospital/Rural PPS Hospital	$6.8M	QIOs assisted non-reporting Critical Access Hospitals (CAHs)[10] to begin reporting Hospital Quality Alliance (HQA)[11] measures to the CMS Data Warehouse and worked with CAHs that reported HQA measures to improve performance	The number of CAH reporting to the CMS clinical warehouse more than doubled from 415 to 966 and the percent of CAH patients receiving appropriate care for selected HQA measures increased 26.2 %. Nearly 60 percent of the 382 IPG CAH and IPG hospitals improved their Patient Safety

[10] 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.

[11] 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.

		on at least one of their reported measures. QIOs also assisted an Identified Participant Group of CAH and Rural Prospective Payment System (PPS)[12] hospitals to improve their hospital's organizational safety culture.	Culture Survey scores at remeasurement.
1d1. Physician Practice	$23.9M	QIOs worked with 3,710 IPG practices for increased use of health information technology to improve patient care.	Four of five measures were above the 8th SOW goals; 88 percent of the QIOs passed all contract tasks. 43 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 38 practices. Of the practices recruited without a prior EHR vendor contract signed, 1,590 out of 3,076 practices installed EHRs. This exceeded the target by 200 % (the target was 795 practices). Of the 3,471 practices recruited that did not have a prior EHR vendor contract signed, or a system installed, 1,428 practices installed an EHR. This exceeded the target by 128 % (the target was 1,112 practices).

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

1d2. Underserved Populations	$8.3M	QIOs worked at the statewide level to improve clinical quality indicators for diabetes in Medicare underserved racial/ethnic populations. Under this Task, QIOs were required to create 2 IPGs that were allowed to overlap. These IPGs were comprised of physician practice sites providing care to a proportionate number of Medicare beneficiaries (as specified by CMS) from Medicare-underserved racial/ethnic populations. With one of the IPGs, the 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 task saw improvement in each of the four measures among IPG Task 1d2 physician offices compared to non-IPG offices.
1d3. Part D Benefit	$4.3M	QIOs each worked with one project designed to increase safety in the delivery of prescription drugs.	All 53 QIOs successfully completed the development and deployment of a prescription drug quality improvement project.
3a. Beneficiary Protection	$59.8M	QIOs conducted statutorily mandated review of beneficiary complaints about the	QIOs conducted 96.5% of reviews within timeframes prescribed by CMS, 84.9% of
		quality of health care services and all activities associated with other required case reviews.	beneficiaries were satisfied with the complaint process.
3b. Hospital	$9.4M	QIOs measured,	The Program reviewed 41,400

Payment Monitoring Program		monitored, and reduced the incidence of improper fee-for-service inpatient payments.	acute care inpatient hospital discharges for the FY08 payment error estimate; recovering a net of $12.4 million. The payment error rate was reduced from 4.8 ± 0.10 percent to 4.6 ± 0.10 percent from FY07 to FY08. All 52 QIOs with HPMP as part of their base contract conducted a project intended to reduce improper payments and 86.5% were successful in doing so. Eleven QIOs published the results of their projects in 10 peer reviewed journal articles.

Other Aspects of the QIO Program

9th SOW Contracts

Much of FY08 was devoted to developing, finalizing, and executing the contract agreements for the 9th SOW. On August 8, 2008, CMS publicly announced the award of 53 contracts for the QIO Program 9th SOW with an effective date of August 1, 2008.

In February 2008, CMS anticipated conducting as many as 13 competitions under the 9th SOW. CMS identified 8 QIOs (California, Minnesota, Mississippi, New York, Nevada, North Carolina, Oklahoma, and South Carolina) from the 8th SOW that did not meet our performance criteria for automatic renewal shown as "Failed" in the table below. In addition, CMS identified five QIOs whose organizations were located outside of the state they service; therefore, in accordance with the "out-of-state" rule in section in 1153(i) of the Social Security Act (42 U.S.C. 1320c-2(i)), CMS is required to conduct competitions for these states, should any in-state offerors bid for them. These states were Alaska, Idaho, Maine, Vermont, and Wyoming.

The 9th SOW was developed using the recommendations of the Government Accountability Office (GAO), Institute of Medicine (IOM), the Assistant Secretary for Planning and Evaluation (ASPE), Congress, and other internal and external experts. In May 2007, the GAO, at the request of the Senate Finance Committee, reviewed the QIO Program, and recommended ways to re-allocate QIO resources to make greater Program impacts. This, along with the IOM report, resulted in a number of reforms which were included in the 9th SOW QIO contract. The 9th SOW represents a significant shift in the Quality Improvement Organization Program.

Specific reforms in the 9th SOW contract include:

- Expanding the entities eligible for QIO contracts.
    - CMS competitively awarded 13 contracts.
- Awarding contracts based on a demonstrated need for QIO intervention in a geographic area for a particular clinical improvement and demonstrated ability on the part of the contractor.
    - Three of the six major components in the 9th SOW were based upon the clinical need and/or contractor ability.
- Monitoring QIO performance closely, with an innovative continuous contract monitoring/accountability framework. QIOs must meet certain performance milestones or experience significant consequences; moreover, CMS must ensure that the contract is structured for success.
    - CMS has two contract evaluation periods at the 18th and 28th months with stringent requirements for each. Appropriate contract action will be taken against those QIOs that do not meet minimum performance criteria as specified in sections C.6. and C.7 of the 9th SOW. Contract action includes, but may not be limited to, initiation of performance improvement plans, termination of certain activities within the contract, and early termination of the contract.

- Training CMS staff to provide more thorough, effective oversight of contract costs and contractor performance.
    - CMS is using performance-based contracting methods.
- Reporting progress throughout the contract to HHS and OMB regularly.
- Altering our procurement process to increase scrutiny during procurement, to increase contractor accountability, and to require contractor effort to improve efficiency, even before the contract begins.
    - Procurement has been tightened and staff trained.
- Basing every performance element on evidence that interventions can improve quality and can be done by QIOs.

For the awards, CMS conducted a full-and-open competition for the 13 jurisdictions, the eight that failed and the five required by the out-of-state rule. Competitive Bids were received for seven of the thirteen. All thirteen contracts were awarded: Eleven to the original QIO and two, California and North Carolina, to a new QIO.

Table 3. QIO Competitive Process for 9th SOW QIOs

	Contracts to be competed		Results of competition		Award Status
States	Failed	Out-of-state rule	No Bid Received	Bid Received	New Contractor
Alaska					
California					
Idaho					
Maine					
Minnesota					
Mississippi					
New York					
Nevada					
N Carolina					
Vermont					
Wyoming					
Oklahoma					
S Carolina					
Total	**8**	**5**	**6**	**7**	**2**

A new contractor is engaged in the jurisdiction of California. In California, the Health Services Advisory Group (HSAG) is the QIO. This contractor has served as a QIO in other jurisdictions under the 8th SOW. HSAG was the QIO for Arizona and is also affiliated with the Florida QIO.

The Carolinas Center for Medical Excellence (CCME), the North Carolina QIO contract was competed under the 9th SOW. The initial contract was awarded to the West Virginia

Medical Institute (WVMI). However, CCME protested the contract award and was successful in being reinstated as the QIO for North Carolina.

This increased competition was designed to provide incentives to QIO contractors to achieve better productivity, less cost to the government, and greater efficiency.

Background of 9th SOW

The 9th SOW builds on the Department's health care initiatives and a growing evidence base about how to improve the quality and efficiency of the health care sector. The 9th SOW has 6 six main sections. Three of them are required of all 53 QIO contractors, while 3 have been competed among the QIOs to be conducted sub-nationally.

For All QIOs:
1. Beneficiary Protection
2. Patient Safety
3. Core Prevention

For Certain QIOs, Determined Competitively:
4. Chronic Kidney Disease (CKD) Project
5. Care Transitions Project
6. Prevention: Efforts to Reduce Health Disparities among Diabetes Patients

In response to the recommendations described above, CMS has used the 9th SOW as a way to develop a robust framework of quality measures that hold QIOs accountable for changes at many levels of the health care system; and to implement a management information system that helps CMS monitor the Program through system and program metrics.

In addition, QIOs focus their intervention projects across the spectrum of care, rather than in "silos" based on settings of care, as we have with previous scopes of work. This allows the QIOs to have a sector-wide impact on the provision of care to Medicare beneficiaries. Furthermore, QIOs focus their interventions on those providers and practitioners who are most in need of quality assistance. QIOs provide intensive, one-on-one support with low-performing providers rather than casting their net of limited resources in less strategic ways, as may have been done in the past.

This strategy is consistent with recommendations from both the IOM and GAO made in the reports cited above. Both of these reviews stated that if the QIO Program's resources are limited, the Program should direct its resources to those facilities in which the greatest impact to patient care will be made. The "facilities targeted for improvement" relate to projects under the Patient Safety Theme, which is one of three national core program areas under the 9th SOW. Facilities are identified based on factors such as their performance related to antibiotic administration to surgical patients (for hospitals), their rates of high-risk pressure ulcers, or use of physical restraints (for nursing homes).

It is important to note that CMS is not prescribing every facility with which the QIOs must work under the 9th SOW. In previous SOWs, QIOs had complete latitude to select the providers to assist. However, under the 9th SOW roughly 85 percent of the provider facilities that QIOs will assist will be determined by CMS using CMS data. The QIOs choose the remaining 15 percent.

Disparities and sub-national projects

CMS made efforts to develop interventions and contract awards based on demonstrated need for a particular clinical improvement and the ability of a contractor to meet that need within the area. This resulted in three of the main projects under the QIO Program to be developed on a "sub-national" level based on full-and-open competition. These projects are the Chronic Kidney Disease (CKD) project, the Care Transitions project, and the Prevention project on Efforts to Reduce Health Disparities among Diabetes Patients. This approach allocates resources where they are needed most, rather than providing a steady, uniform funding stream across all 53 QIO jurisdictions.

CMS uses the 9th SOW as a platform for addressing health disparities among the nation's underserved populations. For the purpose of the 9th SOW, "underserved" populations are defined as those persons who are of African American, Hispanic/Latino, Asian/Pacific Islander, or American Indian/Alaska Native as defined by the data source utilized for evaluation measurement. In addition, under the Patient Safety Theme, we have identified a number of rural facilities in our lists of hospitals and nursing homes to target for improvement.

CMS determined that 33 of the 53 QIO states/jurisdictions were eligible for competition to receive the Health Disparities Sub-national Theme contract. The 33 QIO states/jurisdictions were selected based on the numbers of Medicare diabetic "underserved" within the state/jurisdiction (having at least 5,000). All 53 QIOs were eligible to compete for the CKD and Care Transitions projects. To be considered for a sub-national project in prevention, CKD, or Transition, QIOs submitted a separate proposal for each task. A total of 19 QIOs shown below have been awarded at least one sub-national project under the 9th SOW. Two of them—Georgia and New York—will perform all three, while Florida, Louisiana, Rhode Island, and Texas will perform two.

Care Transitions States (14): Alabama, Colorado, Florida, Georgia, Indiana, Louisiana, Michigan, Nebraska, New Jersey, New York, Pennsylvania, Rhode Island, Texas, Washington

Chronic Kidney Disease States (10): Florida, Georgia, Missouri, Montana, Nevada, New York, Rhode Island, Tennessee, Texas, Utah

Prevention Disparities: Efforts to Reduce Health Disparities among Medicare Beneficiaries with Diabetes States/Jurisdictions (5/6):

District of Columbia, Georgia, Louisiana, Maryland, New York. A sixth QIO, the Virgin Islands (VI) is also working on the Health Disparities Sub-national Theme, but it is part of their core 9th SOW contract. Given the composition of the population of the VI, they did not compete for this as sub-national theme work; it was awarded as part of their core 9th SOW QIO contract.

Theme Requirements and Measures

The 9th SOW six main sections are referred to as Themes. Each Theme has an established set of quality measures that provides accountability to the QIOs for making changes at all levels of the health care system.

Theme C.6.1. Beneficiary Protection

Beneficiary Protection activities emphasize statutory and regulatory mandated review activity and quality improvement. Primary case review categories include utilization review, quality of care review, review of beneficiary appeals of certain provider notices and reviews of potential anti-dumping cases. Quality of care review includes the review of beneficiary complaints.

This Theme will focus on conducting activities to meet in an efficient and effective manner, regulatory and statutory requirements, to enhance QIO collaboration with the Beneficiary Complaint Survey Contractor, Fiscal Intermediaries (FIs), Carriers, Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), State Survey Agencies (SSAs), and the Office of Inspector General (OIG), and to clearly establish the link between case review and quality improvement through data analysis and improvement assistance.

Beneficiary Protection Tasks are measured in terms of cases reviewed and the satisfaction of the beneficiary with the case review process. As noted, 90 percent of all cases reviewed by the QIO must meet timeliness of review standards; furthermore beneficiary satisfaction scores with the Beneficiary Protection process must improve each quarter.

Theme C.6.2. Patient Safety

QIO activities under the Patient Safety Theme focus on six components: improving inpatient surgical safety and heart failure (SCIP/HF), reducing rates of pressure ulcers (PrU) in Nursing Homes and Hospitals), reducing rates of and use of physical restraints (PR) in nursing homes, improving drug safety, reducing rates of healthcare associated Methicillin-resistant Staphylococcus Aureus (MRSA) infections in the acute care setting and activities aimed at nursing homes in need (NHIN).

In order to accomplish these tasks, the QIO must recruit up to a specified maximum number of Medicare providers from a state pool defined by CMS for SCIP/HF, PrU, and PR. Furthermore the QIO must collect tools, review use, and assess their effectiveness for specific interventions related to each component of Patient Safety. The QIO is also expected to administer and collect results of several surveys related to the components.

The surveys to be administered during the 9th SOW are: Agency for Healthcare Research and Quality's (AHRQ) Hospital Survey on Patient Safety Culture, and AHRQ's Nursing Home Resident Safety Culture Survey, and the Hospital Leadership and Quality Assessment Tool (HLQAT) as directed by CMS.

Theme C.6.3. Prevention

The Prevention Theme contains two cancer screening Tasks (breast cancer and colorectal cancer (CRC)), two immunization Tasks (Influenza and Pneumonia), and Tasks on disparities related to diabetes self-management and chronic kidney disease (CKD) prevention.

For the Prevention and Immunization Tasks, the QIO must implement effective interventions to improve rates for mammography and colorectal cancer screening, and influenza and pneumonia vaccinations among Medicare beneficiaries. To achieve their goals the QIO recruits Participating Practices (PPs) from its state/jurisdiction. To be enrolled as a PP, the practice site must have implemented and be presently using an electronic health record (EHR). The QIO assists each PP in the use of their EHR to redesign and/or implement care management and patient self-management interventions for preventive service needs. The QIO educates each PP on using its EHR capabilities and QIO interventions to improve rates of breast cancer and CRC screening and immunizations.

Theme C.7.1. Prevention Disparities

This Task is limited to a sub-set of states with sufficient underserved Medicare diabetes populations, as determined by CMS. QIOs which were eligible to compete for a contract served one of the following 33 states, territories, and District of Columbia: AL, AR, AZ, CA ,CT, DC, DE, FL, GA, HI, IL, IN, KY, LA, MA, MD, MI, MO, MS, NC, NJ, NM, NY, OH, OK, PA, PR, SC, TN, TX, VA, WA, WI. Underserved Populations are those persons who are African American, Hispanic/Latino, Asian/Pacific Islander, or American Indian/Alaska Native. Contracts were awarded to: DC, GA, LA, MD, and NY.

The QIO identifies both the practice sites and the ancillary organizations (e.g., health centers, senior centers, churches, etc.) that they will work with as part of the CMS approved Diabetes Self-Management Education (DSME) process. The QIO will facilitate training of appropriate personnel (e.g., nurses, Certified Diabetes Educators (CDEs) , Community Health Workers (CHWs), etc. at the identified organizational sites using evidence-based DSME programs within the underserved population of the Participating Practices (PP). The QIO will establish a partnership with the primary care physician, CDE, and CHW to facilitate the accessibility of DSME services to patients.

Theme C.7.2. Care Transitions

The QIO work under the Care Transitions Theme aims to measurably improve the quality of care for Medicare beneficiaries who transition among care settings through a comprehensive community effort. These efforts aim to reduce readmissions following

hospitalization[13] and to yield sustainable and replicable strategies to achieve high-value health care for sick and disabled Medicare beneficiaries. QIOs having contracts serve the following States: AL, CO, FL, GA, IN, LA, MI, NE, NJ, NY, PA, RI, TX, and WA. The QIOs provided a written, site-selection report for CMS approval within one month of contract award. The report characterized the proposed geographic area and its health care delivery system and described the potential origins and drivers (root causes) of observed patterns and the opportunities that current leadership and recent history provide for collaboration and vigorous improvement activities. This report presented the initial intervention plan.

Theme C.7.3. Prevention: Chronic Kidney Disease

The goal of the Theme is to detect the incidence and decrease the progression of chronic kidney disease (CKD), and improve care among Medicare beneficiaries through provider adoption of timely and effective quality of care interventions; participation in quality incentive initiatives; beneficiary education; and key linkages and collaborations for system change at the state and local level.

In developing its plan, the QIO was encouraged to consider providing technical assistance to providers and practitioners in Medicare quality measure reporting programs that are directly aligned, and support the CKD clinical focus areas defined in this SOW. Such quality measure reporting programs could include Physician Quality Reporting Initiative (PQRI), which accepts measures that are similar to the QIO clinical focus areas for CKD, and other targeted CMS-sponsored quality initiatives that support the achievement of the CKD clinical focus areas and are consistent with QIO statutory authority for quality improvement.

There is an opportunity to increase participation in PQRI through Medicare practitioners' participation and performance in this clinical quality improvement area as there are companion measures in the PQRI measurement set covering the same clinical area (e.g., testing for CKD).

QIOs having contracts serve the following States: FL, GA, MO, MT, NV, NY, RI, TN, TX, and UT. In addition, VI is working on CKD as part of their core contract.

The focus areas for quality improvement in CKD include:

- Annual testing to detect the rate of kidney failure due to diabetes
- Slowing the progression of disease in hypertensive individuals with diabetes through the use of ACE inhibitor and/or an angiotensin receptor blocking (ARB) agent
- Arteriovenous fistula (AV fistula) placement and maturation (as a first choice for arteriovenous access where medically appropriate) for individuals who elect, as a part

[13] In this contract, "hospitalization" refers to "acute care" hospitals reimbursed by Medicare under PPS. This does not include critical access hospitalization that is not followed by hospitalization at a PPS hospital, nor does it include psychiatric hospitals, inpatient rehabilitation facilities, long-term acute care hospitals, or other special-purpose hospitals.

of timely renal replacement counseling, hemodialysis as their treatment option for kidney failure

In addition to the above, the QIO identified in its proposal disparities that exist in its state, the strategy for reducing the disparity, and the target to be achieved. The QIO includes, as a component of its plan, activities aimed at the reduction of any disparities in care, such as ethnic, racial, socio-economic, geographic, and other forms of inequity that may exist within its state.

Program Evaluation

CMS has awarded a competitive contract to Mathematica Policy Research of Washington DC to design and conduct an analysis to evaluate the impact of both the 8th and 9th SOWs of the QIO Program on regional and national health outcomes and processes. In keeping with the prior evaluations and consistent with recommendations of the IOM and other reports, the evaluation will address not only Program impact but also the mechanisms whereby this occurs. Note that the Program evaluation undertaken by the Mathematica contractor is quite different from the contract evaluation conducted by CMS and discussed above. Contract evaluation looks at the performance of individual QIOs in relationship to their contractual obligations. Program evaluation provides scientific estimates of the effects of the QIO Program on Medicare Beneficiaries' health and welfare as a whole.

The Program evaluation shall focus on these major areas:

- The relative impact of the QIO on the quality of care for Medicare beneficiaries in the geographic area served by the QIO
- The QIO Program's impact on the quality of care for Medicare beneficiaries nationwide
- Determining if the QIO Program improved healthcare for the underserved and adequately addressed the healthcare disparities issue
- Cost and benefits of the QIO Program
- Overall cost-benefit ratio of the QIO Program
- Factors that mediate the cost-benefit ratio across states, across regions, and nationally. Utility (Quality Adjusted Life Years - QALYs) of the various improvements

IV. CONCLUSION

In summary, American seniors, the disabled, and all those covered by our Medicare program deserve to have confidence in their health care system. A system that delivers the right care to every person every time is the way to achieve that goal. The QIO Program—with a national network of knowledgeable and skilled independent organizations under contract with Medicare, is charged with identifying and spreading evidence based best health care practices. The work of the QIO Program has been, and will continue to be, a major contributing factor for improvements in American health care. 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
- 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 appeals; 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.