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

May 9, 2012

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

Dear Mr. President:

Enclosed is a report entitled, "Report to Congress on the Administration, Cost, and Impact of the Quality Improvement Organization (QIO) Program for Medicare Beneficiaries for Fiscal Year (FY) 2009."

As required by Section 1161 of the Social Security Act this report details the administration, cost, and impact of the Quality Improvement Organization Program during 2009, 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 Speaker of the House of Representatives.

Sincerely,

Kathleen Sebelius

Kathleen Sebelius

Enclosure

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WASHINGTON, D.C. 20201

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

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Report to Congress
The Administration, Cost, and Impact of the Quality Improvement Organization (QIO) Program for Medicare Beneficiaries for Fiscal Year 2009

Kathleen Sebelius
Secretary of Health and Human Services
2012

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. The statutory mission of the QIO Program is set forth in Title XVIII of the Act-Health Insurance for the Aged and Disabled. More specifically, section 1862(g) of the Act states that the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries and to ensure that those services are reasonable and necessary. The quality 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 contain an award fee plan based upon net performance expectations. The contractors get the fees for the expectations they meet and if the contractors do not meet expectations, they do not get the award fees. The QIOs' technical performance is evaluated at the 18th and 28th months of their 36-month contract for FY09. 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 Contracting Officer's Technical Representative (formerly Project Officer) 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[1] nationwide can work with QIOs. The providers and practitioners can request and receive QIO technical assistance. 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 the QIO.

In FY 2009, QIO Program expenditures totaled approximately $361 million.[2] QIO work has been carried out in 3-year contract cycles, known as Statements of Work (SOW). FY09 covered the 3rd through 14th months of the 9th SOW contract, which began for all QIOs simultaneously on August 1, 2008. 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

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[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 12/31/09; published 2009.
[2] The Department of Health and Human Services, Fiscal Year 2009, Centers for Medicare & Medicaid Services, Office of Financial Management. 2009.

measured during the entire length of the three-year contract. The discussion below includes details about the 9th SOW.

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 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. Part B of Title XI of the Act has been amended by Section 261 of the Trade Adjustment Assistance Extension Act of 2011, Improvements To Contracts With Medicare Quality Improvement Organizations (QIOS) In Order To Improve The Quality Of Care Furnished To Medicare Beneficiaries. Section 261 of the Trade Adjustment Assistance Extension Act of 2011 is effective January 1, 2012.

Based on the 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 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 1986 (§ 1867 of the Social Security Act, EMTALA), and other beneficiary concerns as required by the statute.

Under Title XI-General Provisions, Peer Review, and Administrative Simplification, section 1161 of the Act-The Secretary is required to submit an annual report to Congress on the QIO Program. According to statute, the Secretary is required to include in the report information on the administration, cost, and impact of the Program during the preceding fiscal year. Under Section 261 of the Trade Adjustment Assistance Extension Act of 2011, effective January 1, 2012 the Secretary has authority to contract with a broad range of entities.

I. PROGRAM ADMINISTRATION

Description of Quality Improvement Organization Contracts

In August 2008, CMS awarded contracts for the 9th Statement of Work (SOW) for the 53 Contractors participating in Medicare's QIO Program. The QIO contracts extended from August 1, 2008 through July 31, 2011. The 9th SOW focused on improving the quality and safety of health care services furnished to Medicare beneficiaries. The 9th SOW built 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 implemented 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 contracts provided additional tools for CMS and the QIOs themselves to track, monitor, and report on the impact that QIOs have on the care provided in their states/jurisdictions. The QIOs' technical performance during the 9th SOW has been evaluated at the 18th and 28th months of their 36-month contract and will be included in the 2010 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.

QIOs are monitored quarterly to determine if they are meeting certain benchmarks for specific activities under timeframes described in Section C.6. of the 9th SOW. 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 Contracting Officer's Technical Representative (formerly Project Officer) and Contract Specialist. QIOs are evaluated according to how well they reach CMS specified performance goals.

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

- Improving quality of care for beneficiaries;

- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Active Labor Act (EMTALA); and other related responsibilities as articulated in QIO law.

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 would 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 FY 2009, QIO Program expenditures totaled $361 million. This spending represents approximately $9 annually for each of the over 45 million Medicare beneficiaries to improve quality of care, and less than one tenth of one percent (0.1%) of the $503.9 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 FY 2009 over 45 million persons 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.[3] These Medicare beneficiaries 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 FY 2009, 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 worked with providers and practitioners to use health information technology to improve care coordination and monitor Medicare expenditures to ensure program quality and efficiency.

This section provides information about QIO accomplishments and the impact on beneficiaries as a result of the 9th SOW. Impacts were made on beneficiaries by means of contractual mechanisms in the 9th SOW known as Themes. The 9th SOW was structured into 6 main Themes, each of which had specific "Tasks" under it. Each Theme also included components, which described the particular areas of concern or settings where QIOs were required to put their efforts when working on the Tasks. Under each Theme, QIOs provided technical assistance by means of quality improvement tools and techniques that improved beneficiary health care.

The 9th SOW was developed using the recommendations of the Government Accountability Office (GAO), the Department of Health and Human Services (HHS), Institute of Medicine (IOM), the 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 included:

- 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 Themes in the 9th SOW were based upon clinical need and/or contractor ability.

[3] CMS U.S. Department of Health and Human Services. CMS Office of Research, Development, and Information 2008 CMS Statistics. CMS Pub. No 03497. August2009.

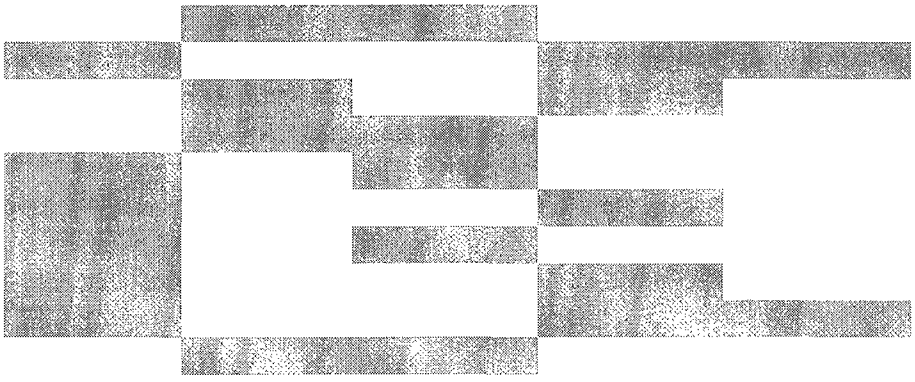
- Monitoring QIO performance closely, with an innovative continuous contract monitoring/accountability framework. QIOs were required to meet certain performance milestones or experience significant consequences; moreover, CMS was required to ensure that the contract was structured for success.
    - CMS had two contract evaluation periods at the 18th and 28th months with stringent requirements for each. Appropriate contract action was designed to take place against those QIOs that did not meet minimum performance criteria, as specified in sections C.6. and C.7 of the 9th SOW. Contract action included, but was 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 used performance-based contracting methods.
- Reporting progress throughout the contract to HHS and OMB regularly.
- Altering the procurement process to increase scrutiny during procurement, to increase contractor accountability, and to require contractor effort to improve efficiency, even before the contract began.
    - Procurement was 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**

New contractors were engaged in the jurisdictions of California and North Carolina. In California, the Health Services Advisory Group (HSAG) became the QIO and in North Carolina, the West Virginia Medical Institute (WVMI) (an affiliate of Quality Insights) was engaged. Both of these Contractors have served as QIOs in other jurisdictions under the 8th SOW—HSAG was the QIO for Arizona and is also affiliated with the Florida QIO, while WVMI was the West Virginia QIO and is also affiliated with the Pennsylvania and Delaware QIOs. However, Carolinas Center for Medical Excellence (formerly Medical Review of North Carolina), the NC QIO incumbent for the 8th SOW, protested and won back the NC QIO for the 9th SOW. Therefore WVMI did not remain the 9th SOW NC QIO.

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

Background of 9th SOW

The 9th SOW was built 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 had 6 main sections or Themes; three of them were required of all 53 QIO contractors, while 3 were 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: To Reduce Hospital Readmissions
6. Prevention: Efforts to Reduce Health Disparities among Diabetes Patients

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

In addition, QIOs focused their intervention projects across the spectrum of care, rather than in "silos" based on settings of care, as has been the case with previous scopes of

work. This allowed the QIOs to have a sector-wide impact on the provision of care to Medicare beneficiaries. Furthermore, QIOs focused their interventions on those providers and practitioners who were most in need of quality assistance. QIOs focused on providing intensive, one-on-one support to low-performing providers and practitioners.

This strategy is consistent with recommendations from both the IOM and GAO in the reports cited above. Both of these reviews stated that the Program should direct its resources to those facilities in which the greatest impact to patient care will be made.

It is important to note that CMS did not prescribe every facility with which the QIOs had to 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 assisted were determined by CMS using CMS data. The QIOs chose the remaining 15 percent.

CMS chose providers based on the greatest need for assistance. The "facilities targeted for improvement" related to projects under the Patient Safety Theme, which was one of three national core program areas under the 9th SOW. Facilities were 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).

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 were 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 allocated resources where they were needed most, rather than providing a steady, uniform funding stream across all 53 QIO jurisdictions.

CMS used 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 were 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 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 as a component of their SOW 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 Care Transitions, QIOs submitted a separate proposal for each project. A total of 19 QIOs shown below were awarded at least one sub-national project under the 9th SOW. Two of them—Georgia and New York— performed all three, while Florida, Louisiana, Rhode Island, and Texas performed 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 (10/11): Florida, Georgia, Missouri, Montana, Nevada, New York, Rhode Island, Tennessee, Texas, Utah. An eleventh QIO, the Virgin Islands (VI) is also working on the Chronic Kidney Disease Sub-national Theme, but it is part of their core 9th SOW contract.

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) also worked on the Health Disparities Sub-national Theme, but this was 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

Each of the Themes in the 9th SOW had an established set of quality measures that provided accountability to the QIOs for making changes at all levels of the health care system.

Theme C.6.1. Beneficiary Protection

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

This Theme focused 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 were 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 were required to meet timeliness of review standards; furthermore beneficiary satisfaction scores with the Beneficiary Protection process had to improve each quarter. In addition, QIOs' implementation of quality improvement activities (QIAs) with Medicare providers were required to increase in number and provide continually improving results each quarter. Along with implementing quality improvement activities based on individual beneficiary complaints, QIOs were required to complete a system-wide change QIA. A system-wide change QIA is designed to have an impact beyond an individual beneficiary or provider, result in a tangible improvement to a system or process, and improve the quality of health care for all Medicare beneficiaries.

Theme C.6.2. Patient Safety

Patient Safety as defined in the 9th SOW was freeing patients from the risk of harm or injury resulting from their interaction with the health care delivery system. To that end, CMS focused QIO activities on six components (or focus areas) which can adversely affect patients in both the hospital and long term care settings. These six components were: (1) improving inpatient surgical safety and heart failure (SCIP/HF); (2) reducing the rates of pressure ulcers in nursing homes and hospitals (PrU-NH and PrU-H);(3) reducing the rates of physical restraints (PR) in nursing homes; (4) reducing the rates of healthcare associated Methicillin-resistant Staphylococcus aureus (MRSA) infections in the acute care setting; (5) improving drug safety; (6) and improving the clinical outcomes of nursing homes that have been deemed by CMS as Special Focus or candidates for the Special Focus Facility List (Nursing Homes in Need – NHIN).

There were specific Tasks associated with the Patient Safety Theme:

- Recruiting CMS-specified providers;
- Assessing quality improvement tools and interventions by component;
- Assessing provider culture as it relates to Patient Safety;
- Training providers by component;
- Analyzing and sharing with each participating provider data received from that provider;
- Creating action oriented meetings of key members of provider staff, including community champions of the Patient Safety work;
- Identifying successful improvement methods with details on implementing successful strategies; sharing best practices with CMS and QIO community; and

- Documenting and sharing quality improvement activities

Patient Safety is everyone's responsibility. For practices to be successful and for safety to become ingrained in the fabric of any organization, it requires the commitment of the upper ranks of the provider organization, an understanding by the provider of where the organization stands with regards to patient safety and data transparency and the will to execute proven effective practices that come from every layer of the organization. The tasks above allowed the QIOs to work within their own community framework to improve clinical outcomes. The QIOs could then seek to replicate successful practices across their service area, resulting in positive movement in each of the patient safety metrics. Within one year of the contract, QIOs had made considerable progress in laying a firm foundation that will ultimately result in better clinical outcome measures for beneficiaries. Below is a summary of the 12-month results by Patient Safety Theme Components.

SCIP/HF: The Surgical Care Improvement Project is a national quality partnership of organizations focused on improving surgical care by significantly reducing surgical complications. The Heart Failure Measure was added due to the large numbers of patients who suffer from heart failure post surgery and because there was considerable improvement to be made in the measure. QIOs working in the SCIP/HF component at the 12th month were expected to have at least 15% of their hospitals with a pre or post operative venuos thrombolytic embolism (VTE) standing order or protocol in place and 30% of their hospitals with an established prophylactic antibiotic standing order or protocol. At the 12th month, 100% of QIOs had met or exceeded the 15% and 30% goals respectively.

Pressure Ulcers: Pressure Ulcers are a painful, costly and largely preventable condition that when not appropriately treated can cause serious illness and even death. In the 9th SOW, QIOs were tasked with reducing pressure ulcer rates in both the long term care and hospital settings. Because pressure ulcers can generally be attributed to system failures, the QIOs were tasked with ensuring that the foundations for improvement were in place with the issuance of two process measures by the 12th month in the long term care setting. Specifically, preventative measures of identified pressure ulcers are in place at least 25% of the time and that appropriate wound treatment occurs at least 30% of the time. In both instances 100% of QIOs met or exceeded their targets.

There was not a 12 month target associated with hospital pressure ulcers. However, QIOs were on track to meet the 18 month goal of having 31% of participating facilities follow established protocols for the treatment of identified pressure ulcers. We will discuss the results of the QIOs' efforts in the FY 2010 Report to Congress.

Physical Restraints: The use of physical restraints when used improperly can greatly diminish the quality of life for our long term care beneficiaries. Therefore, the QIO

program was dedicated to dramatically reducing the rate of physical restraints in the 9th SOW. QIOs were given the goal of having at least a 5% relative improvement rate by the 12th month. Ninety-six percent of participating QIOs met or exceeded the 5% goal.

MRSA: Methicillian Resistant Staphyloccus Aureus is a rising threat to patients in all settings. For the purposes of the 9th SOW, CMS in conjunction with the Centers for Disease Control (CDC), and the Agency for Healthcare Research and Quality (AHRQ) focused efforts on hospitals. The CDC developed a new data collection mechanism, the National Healthcare Safety Network Multi-Drug Resistant Organism (NHSN-MDRO) and the AHRQ has developed a team work methodology, TeamSTEPPS, which has proven to be effective in maximizing communication in clinical settings. Communication is a key component in reducing the transmission of MRSA. Considerable time and energy was spent by the QIO community in assisting providers with the proper reporting processes on the NHSN-MDRO. At the 12 month period an assessment of those units reporting on the NHSN-MDRO was conducted by the QIOs with a goal of 10% reporting of both MRSA metrics. Fully 76% of QIOs in conjunction with their hospital partners had achieved the 12th month goal.

Drug Safety: Under this component, QIOs in accordance with Section 1154(a)(17), as added by Section 109(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, were required to offer quality improvement assistance pertaining to prescription Drug Therapy to:

- All Medicare providers and practitioners;
- Medicare Advantage organizations offering Medicare Advantage plans under Part C; and
- Prescription drug sponsors offering prescription drug plans (PDPs) under Part D.

Under the 9th SOW, QIOs worked with the above entities to decrease the rates of drug interaction and potentially inappropriate medication prescribed. QIOs were given latitude to decide on the type of projects they would embark upon under this component. The first deliverable for this task was due at the 18th month. We will discuss these projects in the FY 2010 Report.

Nursing Homes in Need: QIOs were expected to provide assistance to a small number of nursing homes, up to three per contract year, who had been identified by CMS as requiring quality improvement assistance. QIOs were evaluated on their ability to improve both physical restraints and pressure ulcers as well as the homes' overall satisfaction with the assistance received. While the QIOs were being evaluated on clinical outcome measures, the assistance they provided was varied, based upon the improvements each nursing home needed in order to graduate from the Special Focus Facilities list. There was not a 12 month goal for NHIN.

Theme C.6.3. Prevention

CMS recognizes the crucial role that health care professionals play in promoting potentially lifesaving preventive services and screenings to Medicare patients, educating beneficiaries, and providing the care. Medicare now pays for more preventive benefits than ever before; however, many Medicare beneficiaries are not yet taking full advantage of them, leaving significant gaps in their preventive health program. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease or even that they may already have a condition that preventive services are intended to detect. QIOs can assist physician practices and beneficiaries in understanding the importance of disease prevention, early detection and lifestyle modifications that support a healthier life. The QIOs can also assist physicians in using EHR, which can improve communications between patients and providers, giving patients better access to timely information. EHR can also improve physician office efficiency.

The Prevention Theme contained 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 Theme, the QIO was required to improve rates for mammography and colorectal cancer screening, and influenza and pneumonia vaccinations among Medicare beneficiaries. To achieve these goals, the QIO recruited Participating Practices (PPs) from its state/jurisdiction. To be enrolled as a PP, the practice site must have implemented and be presently using a Certification Commission for Health Information Technology (CCHIT) certified electronic health record (EHR). The QIO assisted 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 educated each PP on using its EHR capabilities and QIO interventions to improve rates of breast cancer and CRC screening and immunizations.

There were 8 Tasks associated with the Prevention core theme:

- Recruitment of participating practices (PPs);
- Identification/recruitment of non-participating practices (NPs);
- Promotion of care management processes for preventive services using EHR (post-recruitment educational sessions);
- Completion of an assessment of care processes;
- Submission of PP and NP data to CMS (EHR-derived rates);
- QIO monitoring of statewide rates (mammograms, CRC screens, influenza immunizations, pneumococcal pneumonia immunizations) and disparities
- Production of an annual report; and

- Optimization of performance.

Both recruitment of participating practices and promotion of care management processes for preventive services (post recruitment training sessions) using EHRs were to be completed by QIOs by February 1, 2009.

The QIOs were very successful in meeting their monitoring targets for recruitment and training: 99% of the QIOs met the recruitment and post recruitment education requirement by February 1, 2009.

By July 31, 2009, QIOs had to submit baseline rates for breast and colorectal cancer screenings and influenza and pneumococcal vaccinations.

By July 31, 2009, 99% of the QIOs had reported data using the aggregate file structure worksheet.

By October 31, 2009, QIOs were expected to report rates (using the aggregate file structure worksheet) which reflected at least a 2% average relative improvement in breast cancer screening and pneumococcal immunizations, as well as a 3% improvement in the colorectal cancer screening.

98% of QIOs (52 of 53) submitted EHR rates for Quarter 5. 82% of the QIOs reported rates for all 3 of the clinical measures mentioned above.

Although quarterly monitoring targets were expected to be met, the next milestone was the 18th month evaluation. At the 18th month evaluation, QIOs were expected to have: 1) recruited and maintained at least 80% of the PP target number through 12/31/09; 2) provided 90% of PPs with the initial post-recruitment educational session on the task; and 3) have at least 70% of recruited PPs electronically reporting quality data (rates) at least once for each of the 4 measures to the QIO, CMS or support contractor on or before 10/31/09. The 18th month evaluation will be discussed in the 2010 Report.

The Virginia QIO was the Prevention QIO Support Center (QIOSC). The Prevention QIOSC was instrumental in assisting QIOs in meeting their goals and monitoring targets for the 9th SOW. They developed tools for the QIOs to use in producing monthly, quarterly and yearly deliverables. They conducted essential community of practice calls which allowed the QIOs to interact and engage experts in the fields of cancer screening, immunization and EHRs, to ensure improvement in the clinical measures listed above. The QIOSC analyzed and assisted the QIOs with reporting rates from their PPs' EHRs. They provided critical data processing and statistical support to CMS for QIO monitoring and evaluation.

Theme C.7.1. Prevention Disparities

This Task was 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 identified both the practice sites and the ancillary organizations (e.g., community health centers, senior centers, faith-based organizations, etc.) that they would work with as part of the CMS-approved Diabetes Self-Management Education (DSME) process. The QIO facilitated 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 (PPs). The QIO was required to establish a partnership with the primary care physician (PCP), CDE, and CHW to facilitate the accessibility of DSME services to patients. The QIO was required to work with the PPs to improve/increase their adherence to clinical guidelines for appropriate use of utilization measures for HbA1c, Lipids, and Eye Exams, as evidenced by Medicare fee-for-service claims billed by physicians for beneficiaries in priority populations with diabetes.

A Special Project was conducted to assist this Theme. The QIOs abstracted clinical data results from medical records in physician offices for a sample of Medicare beneficiaries who complete the DSME training classes. The clinical results abstracted were for HbA1c, Lipids, Eye Exam, Weight, and BP (blood pressure). These results were reported to, and analyzed by Masspro, the QIO that was awarded the Disparities Data Center (DDC) Special Project. This project was ongoing throughout the 9th SOW.

Theme C.7.2. Care Transitions

The QIO work under the Care Transitions Theme aimed to measurably improve the quality of care for Medicare beneficiaries who transition among care settings through a comprehensive community effort. These efforts aimed to reduce readmissions following hospitalization[4] and to yield sustainable and replicable strategies to achieve high-value health care for sick and disabled Medicare beneficiaries. QIOs having contracts served the following States: AL, CO, FL, GA, IN, LA, MI, NE, NJ, NY, PA, RI, TX, and WA.

[4] 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.

In the first year of the 9th SOW, the 14 QIOs had defined their communities with precision, conducted root cause analyses in their communities and had begun to implement evidence based interventions based on the Table of Evidence Based Interventions listed in the SOW. The 18th month interim evaluation measures were reported in February 2010.

Task C.7.3. Prevention: Chronic Kidney Disease

The goal of this Theme was 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; provider 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 considered providing technical assistance to providers and practitioners in Medicare quality measure reporting programs that were directly aligned, and supported 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.

The QIOs charged with improving care for people with CKD partnered with participating providers to identify and implement needed health systems changes. This process is referred to as "academic detailing" and is also called "practice coaching". Local coalitions made up of a variety of provider, state, and patient organizations worked to promote the common goals of preventing the progression of kidney disease and improving kidney care. QIOs used materials identified from their partners (and in some cases supplemented those evidence-based materials with materials developed in-house) to help healthcare providers analyze their workflow. This process is in keeping with utilizing the Chronic Care Model to improve care. The model emphasizes Delivery System Design, Decision Support and Clinical Information systems.

The Chronic Care Model is comprised of several thematic elements that when combined improves care in health systems at the community, organization, practice and patient levels. QIOs adopted several thematic processes included in the Chronic Care Model. For example, QIO interventions incorporated elements titled Delivery System Design, Decision Support and Clinical Information Systems that are some of the formalized concepts constituting the Chronic Care Model. QIOs having CKD Task contracts served the following States: FL, GA, MO, MT, NV, NY, RI, TN, TX, and UT. In addition, VI worked on CKD as part of their core contract.

The focus areas for quality improvement in CKD included:

- 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 angiotensin converting enzyme (ACE) inhibitor and/or an angiotensin receptor blocking (ARB) agent; and
- Arteriovenous fistula (AV fistula) placement and maturation (as a first choice for arteriovenous access where medically appropriate) for individuals who elect, as a part 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 existed in its state, the strategy for reducing the disparity, and the target to be achieved. The QIO included, 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 Eighth and Ninth 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 addressed not only Program impact but also the mechanisms whereby this occurs. Note that the Program evaluation undertaken by the Mathematica Contractor was 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 focused 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.

The table below lists examples of the QIO results for FY 09.

Table 2. Summary of Selected QIO Activities and Examples of Results for FY 2009. The dollar amounts noted in this table refer to the 9th SOW tasks in FY09. Their total ($175 million rounded) does not include support contracts, Special Projects, SDPS costs, or other prior year adjustments resulting from contract close-out activities.

QIO Task – 9th SOW	**Dollar Amount Spent on Task in millions 10/01/08 to 09/30/09**	**Activity and goals**	**Example of results where data is available for the time period of the Report**
C.6.1 Beneficiary Protection	$62.4M	QIOs conducted statutorily mandated review of beneficiary complaints about the quality of health care services and all activities associated with other required case reviews.	QIOs conducted 98.05 % of reviews within the timeframes prescribed by CMS, 83.71 % of beneficiaries were satisfied with the complaint process, and QIOs conducted quality improvement activities in 95.20% of cases that had confirmed quality of care concerns.
C.2 Patient Safety	$61.3M	QIOs were tasked to improve inpatient surgical safety and heart failure (SCIP/HF), reduce the rates of pressure ulcers in nursing homes and hospitals (PrU-NH and PrU-H), reduce the rates of physical restraints (PR) in nursing homes, reduce the rates of	Measures were reported at the 18th month and will be included in the 2010 Report to Congress.

		healthcare associated Methicillin-resistant Staphylococcus aureus (MRSA) infections in the acute care setting, improve drug safety and improve the clinical outcomes of nursing homes that have been deemed by CMS as Special Focus or candidates for the Special Focus Facility List (Nursing Homes in Need – NHIN).	
C.6.3 Core Prevention	$24.4M	The QIO was required to improve rates for mammography and colorectal cancer screening, and influenza and pneumonia vaccinations among Medicare beneficiaries.	The QIOs were very successful in meeting their monitoring targets for recruitment and training: 99% of the QIOs met the recruitment and post recruitment education requirement by February 1, 2009. By July 31, 2009, QIOs had to submit baseline rates for breast and colorectal cancer screenings and influenza and pneumococcal vaccinations. By July 31, 2009, 99% of the QIOs had reported data using the aggregate file structure worksheet. By October 31, 2009, QIOs were expected to report rates (using the aggregate file structure worksheet) which reflected at least a 2% average relative improvement in breast cancer screening and

			pneumococcal immunizations, as well as a 3% improvement in the colorectal cancer screening. 98% of QIOs (52 of 53) submitted EHR rates for Quarter 5. 82% of the QIOs reported rates for all 3 of the clinical measures mentioned above. Although quarterly monitoring targets are expected to be met, the next milestone will be the 18th month evaluation.
C.7.1 Prevention: Disparities	$5.8M	The QIO was tasked with working with the PPs to improve/increase their adherence to clinical guidelines for appropriate use of utilization measures for HbA1c, Lipids, and Eye Exams, as evidenced by Medicare fee-for-service claims billed by physicians for beneficiaries in priority populations with diabetes.	Measures were reported at the 18th month and will be included in the 2010 Report to Congress.
C.7.2 Care Transitions	$12.5M	The 14 QIOs were required to define their communities with precision, conduct root cause analyses in their communities and implement evidence based interventions accordingly.	The 18th month interim measures were reported in February 2010 and will be included in the 2010 Report to Congress.
C.7.3 Prevention: Chronic	$8.2M	The QIOs charged with improving care for people with CKD were	Measures were reported at the 18th month and will be included in the 2010 Report to Congress.

Kidney Disease		tasked with partnering with participating providers to identify and implement needed health systems changes. This process is referred to as "academic detailing" and is also called "practice coaching". Local coalitions made up of a variety of provider, state, and patient organizations worked to promote the common goals of preventing the progression of kidney disease and improving kidney care.	

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 healthcare practices. The work of the QIO Program has been, and will continue to be, a major contributing factor for improvements in American healthcare. Based on legislative language of Title XI of the statute, 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, Notice of Discharge and Medicare Appeal Rights, and Medicare Advantage appeal); Emergency Medical Treatment and Labor Act violations; and other related statutory QIO responsibilities.

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