Report to Congress

The Administration, Cost, and Impact of the Quality Improvement Organization Program for Medicare Beneficiaries for Fiscal Year 2015

EXECUTIVE SUMMARY

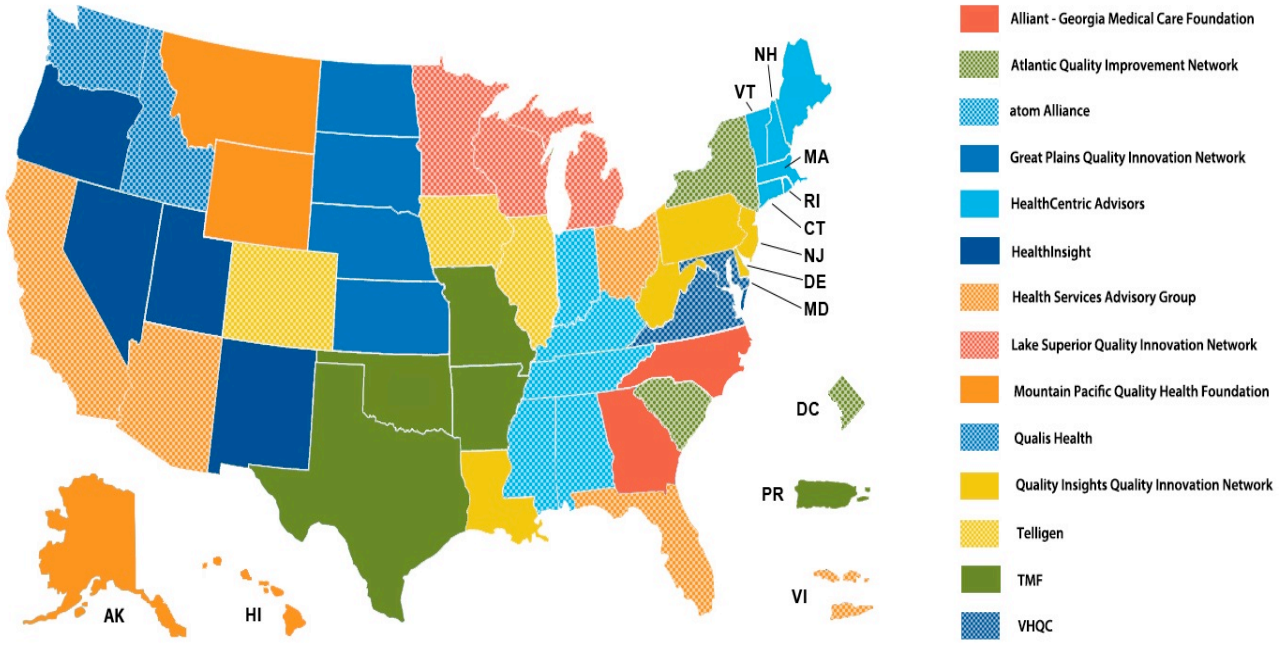
Section 1161 of the Social Security Act (the Act) requires the submission of an annual report to Congress on the administration, cost, and impact of the Quality Improvement Organization (QIO) Program during the preceding fiscal year. This report fulfills this mandate for FY 2015. The statutory mission 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 improvement strategies of the Medicare QIO Program are implemented by area specific QIO contractors, who work directly with health care providers and practitioners in their state, territory, and the District of Columbia.

On August 1, 2014, the Centers for Medicare and Medicaid Services (CMS) launched the QIO Program's 11th SOW to enhance the quality of services provided to Medicare beneficiaries. In FY 2015, QIO Program expenditures totaled approximately $668,216,451.81 million. FY 2015 covered the 4th through 15th months of the 11th Scope of Work (SOW) contract. This report will describe the main activities included in the 11th SOW, the suggested targets of the Aims, charts which indicate that performance was monitored during FY 2015 to assess if the QIOs were progressing to likely attain the performance criteria, and how the 11th SOW was changed from the 10th SOW. The FY 2016 report will describe the targets and results from the 18th month evaluation.

The Trade Adjustment Assistance Extension Act of 2011 (Trade Bill) amended statutory provisions related to the service area of QIO contracts and the functions performed by QIOs; these changes also gave CMS discretion to separate the two key QIO functions under the 11th SOW into separate sets of QIO contractors: (1) Beneficiary and Family-Centered Care (BFCC) QIOs that serve the Medicare program's case review needs, and (2) Quality Innovation Network (QIN) QIOs that support healthcare delivery professionals and systems as they perform quality improvement work.

The two BFCC-QIO contractors under the 11th SOW are Livanta LLC and KePRO. They are responsible for performing case reviews for various reasons, such as to review the quality of care provided to Medicare beneficiaries and review and respond to beneficiary complaints. They must ensure consistency in the review process with consideration of local factors important to beneficiaries.

The QIN QIOs are working with providers and communities across the country on data-driven quality initiatives. The 14 QIN-QIO contractors are: Alliant-Georgia Medical Care Foundation, Atlantic Quality Improvement Network, atom Alliance, Great Plains Quality Innovation Network, HealthCentric Advisors, HealthInsight, Health Services Advisory Group, Lake Superior Quality Innovation Network, Mountain Pacific Quality Health Foundation, Qualis Health, Quality Insights Quality Innovation Network, Telligen, Texas Medical Foundation and Virginia Health Quality Care. The map provided below indicates which QIN-QIOs are working with each state in its region.



Specifically, each QIN-QIO works on strategic initiatives such as reducing healthcare associated infections, reducing readmissions and medication errors, working with nursing homes to improve care for residents, supporting clinical practices in using interoperable health information technology to enable the exchange of essential health information to improve the coordination of care, promoting prevention activities, reducing cardiac disease and diabetes, reducing health care disparities and improving patient and family engagement. QIN-QIOs also provide technical assistance for improvement in CMS value based purchasing programs, including the physician value based modifier program.

BACKGROUND

The statutory provisions governing the QIO Program are in Part B of Title XI of the Act. Its statutory mission is set forth in Title XVIII of the Act-Health Insurance for the Aged and Disabled. 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 make sure that those services are reasonable and necessary. Part B of Title XI of the Act was amended by section 261 of the Trade Bill, which made several changes to the Secretary's contracting authority for QIOs beginning with contracts entered into or renewed after January 1, 2012. These changes include eligibility requirements for QIOs, the term of QIO contracts, the geographic area served by QIOs and updates to the functions performed by QIOs under their contracts. The contracts for the 11th SOW are subject to the changes made by the Trade Bill.

I. PROGRAM ADMINISTRATION

Description of Quality Improvement Organization Contracts

By law, the mission of the QIO Program is to improve the effectiveness, efficiency, and quality of services delivered to Medicare beneficiaries. Based on this statutory requirement, and CMS' program experience, CMS identified 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 are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing: individual complaints; provider-based notice appeals; violations of the EMTALA; and other related responsibilities in QIO law.

The QIOs are now known as Quality Innovation Network (QIN)-QIOs and Beneficiary and Family-Centered Care (BFCC)-QIOs, depending on the QIO functions that they perform. QIOs are private, mostly not-for-profit organizations staffed by doctors and other health care professionals trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.

QIOs Interacting with Health Care Providers and Practitioners

QIOs worked with and provide technical assistance to health care practitioners and providers such as physicians, hospitals [including Critical Access Hospitals (CAHs)], nursing homes, and home health agencies. QIOs also work with practitioners, providers, beneficiaries, partners, and other stakeholders to improve the quality of health care provided to beneficiaries through a variety of health care delivery systems and address beneficiary complaints regarding quality of care. For instance, a process called immediate advocacy involves direct communication between QIOs and beneficiaries. Through this process, QIO staff work with providers to resolve miscommunication or other concerns voiced by the beneficiary or a family member. QIOs analyze data and beneficiary records to identify areas of improvements in care and ensure beneficiaries' voices are heard by addressing individual complaints and bringing their perspective into the improvement process.

Any provider or practitioner who treats Medicare beneficiaries and is paid under Title XVIII of the Social Security Act may have received technical assistance from a QIO and may be subject to review by the QIO. Interaction comes in a variety of forms including direct intensive QIO assistance, occasional contact with the QIO at professional meetings, visits to the QIO website, and/or QIO record reviews.

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. QIO costs are subject to the apportionment process administered through OMB. In FY 2015, QIO Program expenditures totaled $668,216,451.81.

III. PROGRAM IMPACT

The QIO Program impacts Medicare beneficiaries at the individual level and the beneficiary population as a whole. In FY 2015, over 55.8 million persons were covered by Medicare. Virtually all citizens 65 and older - 98.1 percent of the older adult population of the U.S., Puerto Rico, Washington D. C. and U. S. Territories are Medicare beneficiaries. There are 9.1 million people with disabilities enrolled as part of the 55.8 million persons currently on Medicare.[1] A significant portion of the

[1]CMS, U.S. Department of Health and Human Services. CMS Office of Information Products and Data Analytics CMS Pub. No 03540. August 2015.

nation's population (14.7 percent of the nation's population are Medicare beneficiaries) receive important health care improvements as a result of QIO activity.

The sections below provide information about QIO accomplishments and the impact on beneficiaries during the 4th through 15th months of the period of performance of the 11th SOW. This period began in November of 2014 and ends with October of 2015. Some tasks have reported 12th month monitoring results in this report, others were not monitored at the 12th month.

Aim Requirements and Measures

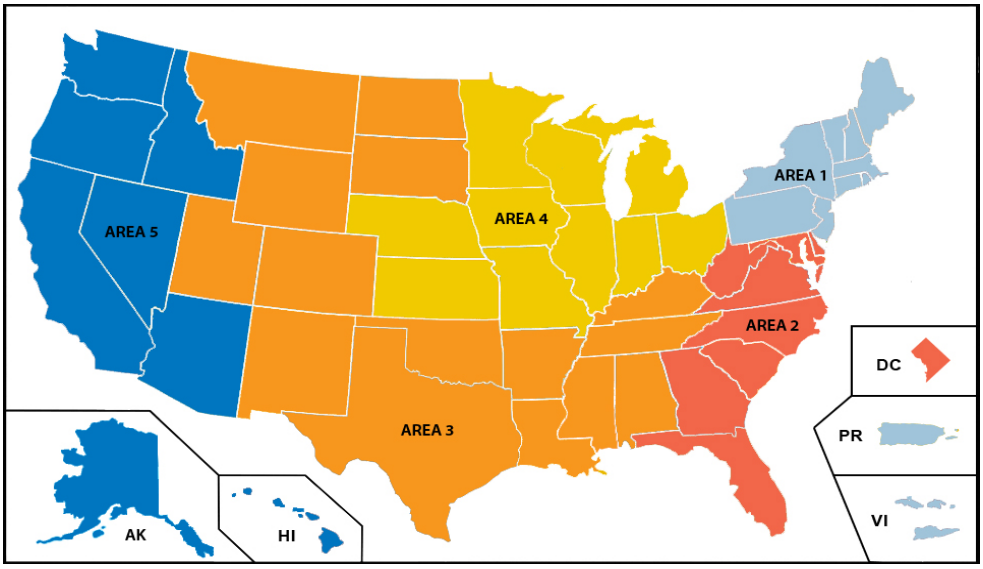
The 11th SOW is based upon two core functions: quality improvement and case review. Each of the functions target quality measures that provide accountability to QIOs that support CMS in its effort to seek to improve beneficiary and family experiences within the health care system. The separate QIOs (i.e., QIN-QIOs and BFCC-QIOs) have separate contracts based on their respective functions.

Beneficiary and Family Centered Care

The BFCC-QIO program focused on QIO statutorily mandated case review activities, as well as on interventions to promote responsiveness to beneficiary and family needs; providing opportunities for listening to and addressing beneficiary and family concerns; providing resources for beneficiaries and caregivers in decision making; and using information gathered from individual experiences to improve Medicare's entire system of health care. Beneficiary-generated concerns provide an excellent opportunity to explore root causes of adverse health care outcomes, develop alternative approaches to improving care, and to improve beneficiary/family experiences within the health care system. Beneficiary and family engagement and activation efforts are needed to produce the best possible outcomes of care. These QIO beneficiary and family-centered efforts align with the National Quality Strategy, which encourages patient and family engagement.

Case review types include Quality of Care Reviews, Emergency Medical Treatment and Labor Act (EMTALA) Reviews, reviews of provider discharge/termination of service decisions and denials of hospital admissions, Higher-Weighted Diagnosis Related Group (DRG) Reviews and other review types. The QIO Manual includes discussion of the various case review types and provides additional detail and guidance on QIO responsibilities for the reviews.

The BFCC-QIO Program was restructured from individual QIO contractors in each of the 53 states and U.S. territories, to five BFCC regional contracts covering the geographic areas. This reorganization was implemented in an effort to promote greater standardization, to facilitate the effective and efficient delivery of care, and to improve the quality of care for Medicare beneficiaries. Two QIOs were awarded these five BFCC regional contracts.



The chart below depicts the summary of BFCC-QIO Program performance on three timeliness measures for the 12th month reporting period of the contract.

Measures	Targets	Results
Timeliness of Beneficiary Complaints and Other Quality of Care Reviews	90%	95.8%
Timeliness of Discharge/ Service Termination Reviews	95%	96.8%
Timeliness of EMTALA and HWDRG Reviews	90%	98.2%

The results of the timeliness analysis reveal that the trend of BFCC performance on each timeliness measure exceeded Year 1 target requirements. All three measures achieved results greater than 95 percent. The overall rate for timeliness is 97.1 percent.

QIO-QIN Quality Improvement Aims

Aim B – Healthy People, Health Communities: Improving the Health Status of Communities

Healthy People, Healthy Communities: Improving the Health Status of Communities, includes tasks that promote effective prevention and treatment of chronic disease for Medicare beneficiaries. Health IT is also promoted. Three tasks included in the Aim are:

Task B.1: Improving Cardiac Health and Reducing Cardiac Healthcare Disparities

Task B.1 supports the Million Hearts initiative's goal to prevent one million heart attacks and strokes. The goal will be accomplished by working with clinical participants, Medicare beneficiaries, partners, and stakeholders to spread the implementation of evidence-based practices to promote: use of Aspirin therapy when appropriate; Blood pressure (BP) control; Cholesterol management; and Smoking/tobacco use assessment and cessation counseling. Physicians and other eligible professionals will be recruited to promote reporting through the Physician Quality Reporting System (PQRS) Program. Racial and ethnic minority beneficiaries and clinicians who serve them are included in the target populations for the task. Blood pressure control is the priority focus for the work and the QIN QIOs are promoting the use of blood pressure protocols to achieve this goal.

Below are results for Task B.1 through October 31, 2015, which is Quarter 5 (Q5) of the Contract:

Recruitment and Participation in the QIN QIO Task B.1 Efforts	Target	Q5 Results
Total Clinical Participants	4,651	7,880
PQRS Reporting	1,327	3,006
Home Health Agencies (HHA) Participating	1,740	2,027
Other Clinical Participants	1,584	2,825
Partners/Stakeholders Participating	646	913
Blood Pressure (BP) Protocol Use by all Clinical Participants	766	2,389
Total #Patients Impacted	1,568,679	2,029,371
Total # Patients Impacted by BP Protocol-driven care*	495,703	641,281

*Based on the latest (2013-2014) prevalence of hypertension (HTN) at 31.6%, the estimated patient impact number related to BP protocol-driven care = 641,281 for Q5

Task B.2: Reducing Disparities in Diabetes Care: Everyone with Diabetes Counts (EDC)

The goal of EDC is to improve health equity by improving health literacy and quality of care among Medicare and Dually Eligible beneficiaries with pre-diabetes and diabetes through knowledge empowerment, enabling them to become active participants in their care (person centered care/ person/patient engagement). The target populations are minority/medically underserved and rural beneficiaries. EDC will engage both beneficiaries and health care providers to: decrease the disparity in diabetes care by improving testing for: HbA1c, Lipids; Eye Exams; Foot Exams; as well as improve Blood Pressure control and Weight control. Additionally, the focus is to facilitate the development of sustainable diabetes education resources in targeted communities by engaging public/private agency/organization partnerships at the community level, state level, and national level.

The chart below identifies the 12th month preliminary results of the task for all applicable QIN QIOs of Task B.2.

Measures: 11th SOW Task B.2/Everyone with Diabetes Counts (EDC)	National Targets through Q5, Oct. 31, 2015	Results through Q5, Oct. 31, 2015
Percentage of Physician Practices Recruited to Participate in EDC	30%	53.7%
Percentage of New Medicare Beneficiaries Completing Diabetes Self Management Education (DSME)	13%	9.0%
Percentage of Clinical Outcome Data Obtained by QINs for Medicare Beneficiaries Completing DSME	2%	15.1%

Task B.4: Improving Prevention Coordination through Meaningful Use of Health IT and Collaborating with Regional Extension Centers (RECs).

The purpose of this task is for the QIN/QIOs to leverage the capabilities of their recruited health care providers across the country as they work to collect, track and report data, through use of automated tools, such as certified electronic health records and registries, for data extraction, prevention and

quality improvement as established by the Meaningful Use program.

Key Goals

- Transform clinical practices, hospitals and critical access hospitals
- Promote interoperability & exchange of clinical information through health information exchanges.
- Increase provider screenings and delivery of preventive services i.e. cardiac, diabetes, immunizations and cancer etc.
- Improve access to care and care coordination while identifying and reducing disparities

Below are the 12th month measures for Task B.4.

B.4.Task Order	Measure	Criteria for 12th Month Evaluation Period Aug. 2014–July 2015	Results
Recruitment	% of recruited Eligible Providers, Hospitals and Critical Access Hospitals with signed agreements	10% of agreed upon recruitment numbers	100% Met
Provider Technical Assistance	% of recruited Eligible Providers, Hospitals and Critical Access Hospitals receiving TA	10% of agreed upon recruitment numbers	100% Met
Educational Sessions (attending Learning and Action Network trainings and meetings)	% of recruited Eligible Providers, Hospitals and Critical Access Hospitals attending Educational Sessions	25% of agreed upon recruitment numbers	100% Met

Aim C – Better Healthcare for Communities: Beneficiary-Centered, Reliable, Accessible and Safe Care

Better Healthcare for Communities includes initiatives to improve safety and care across the care continuum. Initiatives build upon the aims of the national quality strategy. Tasks included are:

Task C.1 - Reducing Healthcare-Associated Infections in Hospitals (HAIs)

CMS is working with QIN-QIOs in efforts to make health care safer and more affordable through the reduction and prevention of Healthcare-Associated Infections (HAIs) in the acute care setting. Reducing and preventing HAIs not only helps to improve quality of patient care and can make care more affordable, but it also helps save lives. QIN-QIOs are working towards HAI goals as outlined in the HHS HAI National Action Plan. During the FY 2015 period, the QIN-QIOs collaborated with other public and private organizations, (i.e., Agency for Healthcare Research and Quality's (AHRQ) Comprehensive Unit-based Safety Program (CUSP); the Centers for Disease Control and Prevention (CDC)) sponsored state based HAI initiatives; and the work of CMS' Partnership for Patients on programmatic initiatives. This work is intended to decrease HAI Standardized Infection Ratios (SIRs) nationally by demonstrating significant, quantitative and measurable reductions in hospital acute care settings for Medicare beneficiaries and prevent the occurrence of HAIs in hospitals using evidence-based HAI prevention strategies.

The chart below addresses the 12th month measures for Task C.1.

** Note: There is no 12th month evaluation for this task, as QIN-QIOs continue to recruit and collect data for this task. The first evaluation for this task is in July 2016.

Measures	Targets	Results
C.1-1 CLABSI Standardized Infection Ratio	Not Applicable	Not Applicable
C.1-2 CAUTI Standardized Infection Ratio (SIR)	Not Applicable	Not Applicable
C.1-3 Urinary Catheter Utilization Rate	Not Applicable	Not Applicable
C.1-4 CDI Standardized Infection Ratio (SIR)	Not Applicable	Not Applicable
C.1-5 Recruitment	Not Applicable	Not Applicable

By July 31, 2015, 96% of QIN-QIO targeted hospitals (848 hospitals out of 882 hospitals) had been recruited for HAI work.

Aim C.2 - Reduce Healthcare Acquired Conditions in Nursing Homes

The 11th SOW C.2 Reducing Healthcare-Acquired Conditions in Nursing Homes Task Order aims to improve the quality of care and quality of life received by beneficiaries residing in nursing homes. The activities associated with this task include:

- Recruiting at least 75% of nursing homes within each state and in two territories with a CMS Certification Number (CCN) and star-status into the 11th SOW National Nursing Home Quality Care Collaboratives (NNHQCC) I and/or II. By April 1, 2017, this will represent approximately 11,000 of the 15,600 nursing homes with a CCN.
- Increasing the participation of low-performing nursing homes to 75% of low-performing (identified by a One-Star status) nursing homes within each state and two territories with a CMS Certification Number (CCN) to participate in the NNHQCC, Collaborative I and/or II. By April 1, 2017, this will represent approximately 1,449 of the approximately 1,900 1-star homes before the re-basing of the Medicare.gov 5-Star system in February 2015.
- Continuing of the use of the Quality Measure Composite Score as a means to measure the success of both Collaboratives I and II, and expanding the use of the Composite Score to identify progress in individual nursing homes and individual QIN-QIOs.
- Continuing the alignment of the QIN-QIO with the Partnership to Improve Dementia Care effort to drive-down the inappropriate use of antipsychotic medications in Medicare beneficiaries in long-stay facilities.
- Increasing mobility among long-stay residents; a measure is under development.

The table below identifies the evaluation measures and targets for 11th SOW C2 Nursing Home (NH) Task Order at the start of the 11th SOW and those results that were available during FY2015.

Measures	Targets	Target Dates	Results
Antipsychotic medication Use	3% reduction in percentage of long-stay residents who received antipsychotic medications	7/2016	Not Available for 12-month Time-Period: 7/2015-7/2016.

Recruitment of One-Star Nursing Homes (NHs) for Collaborative I	≥ 35% of One-Star NHs	3/31/2015	72.1%.
Achieve Recruitment Target Number (RTN) for Collaborative I	≥ 35% of RTN	3/31/2015	56.2%
Quality Measure Composite Score	≥ 15% of RTN achieve score of 6.00	7/2016	Not Available for 12-month evaluation Time Period: 7/2015
Recruitment Target Number for Collaborative I and II	100% of RTN	3/31/2017	Not Available for 12-month Time Period
Recruitment of One-Star Nursing Homes (NHs) for Collaboratives I and II	100% of One-Star NHs	3/31/2017	Not Available for 12-month Time Period
Increase Mobility among long-stay residents	Percent of long-stay residents with improved mobility	**To Be Developed**	**To Be Developed**

Task C.3 – Coordination of Care

The focus of the C.3 task is to promote effective communication and coordination of care through a quality improvement framework that focuses on community organizing and a population based strategy.

QIN-QIOs are working with existing community-based efforts and recruiting and engaging community coalitions that focus on improving care coordination for Medicare Fee-For-Service (FFS) beneficiaries. This includes recruiting and engaging providers across all care settings (such as acute and post-acute settings), and other community stakeholders to identify and target interventions at the causes of poor care coordination. Recruitment for this task occurred in 3 Cohorts: Cohort A (August 1, 2014 through December 31, 2014), Cohort B (January 1, 2015 through December 31, 2015) and Cohort C (January 1, 2016 through December 31, 2016).

In addition, QIN-QIOs are specifically targeting interventions related to vulnerable populations such as individuals with multiple chronic conditions who take multiple medications, behavioral health issues, socioeconomic issues, individuals dually enrolled in Medicare and Medicaid, and individuals with Alzheimer's and other dementia disorders.

The chart below lists the evaluation measures for Task C.3. Please note that there is no 12th month evaluation for Task C.3 because QIN-QIOs continue to recruit and define their communities.

Measures	
C.3-1:Interventions Implemented	Percentage of interventions implemented (for a minimum of 6 months) that show improvement (for a minimum of 5 interventions across the state/territory annually).
C.3-2: 30-day Readmissions	Rate of 30-day readmissions per 1,000 FFS beneficiaries in cohort(s).

C.3-3: Admissions	Rate of admissions per 1,000 FFS beneficiaries in cohort(s).
C.3-4: State/territory-wide Readmissions	Rate of state/territory-wide readmissions per 1,000 FFS beneficiaries.
C.3-5:State/territory-wide Admissions	Rate of state/territory-wide admissions per 1,000 FFS beneficiaries.
C.3-7:Community Tenure	Community tenure in state/territory-wide coalition. "Community tenure" is defined as the number of days beneficiaries spend in their home setting.

Aim C.3.6 - Medication Safety and Adverse Drug Event Prevention

In the 11th SOW QIN-QIOs were tasked with improving medication safety and reducing adverse drug events (Task C.3.6). QIN-QIOs are required to recruit providers and practitioners and pharmacies that provide care for Medicare beneficiaries that are at high risk for an adverse drug event. Medicare beneficiaries that were identified to be at high risk are beneficiaries taking three or more medications and a high risk medication, referenced in the HHS National Action Plan for adverse drug event prevention as opioids, diabetic agents, and anticoagulants. QIN-QIOs are working to implement or identify tools to track and increase surveillance of adverse drug events to help prevent them, improve medication safety by providing evidence-based clinical information and best practices, and increase medication safety across the community as an integrated part of care transitions efforts.

Specific goals under Task C.3.6 are to improve care coordination and reduce adverse drug events for beneficiaries that are at high risk for an adverse drug event.

There is no 12th month evaluation for this Task C.3.6, because QIN-QIOs continue to recruit and collect data for this task. The first evaluation for this task is in July 2017.

Task D.1 - Quality Improvement through Value-Based Payment, Quality Reporting, and the Physician Feedback Reporting Program

CMS is seeking to promote higher quality of care and more efficient health care for all Medicare beneficiaries. Under this Task, QIOs are called upon to assist hospitals, PPS-Exempt Cancer Hospitals (PCHs), Inpatient Psychiatric Facilities (IPFs), Ambulatory Surgical Centers (ASCs), Critical Access Hospitals (CAHs), and eligible professionals. Activities involving education and outreach, learning forums (Learning and Action Networks (LANs)), webinars, teleconferences, etc.), and direct technical assistance support to hospitals, facilities, and physicians/professionals in identifying and capitalizing on opportunities for improvement in the quality, efficiency, and coordination of care.

General desired outcomes for this task include:

- To increase the number of eligible physicians and eligible professionals in group practices that submit data through the Physician Quality Reporting System (PQRS);
- To increase the number of eligible physicians and eligible professionals in group practices that demonstrate improvement in quality of care delivered (as determined by reported quality measures);
- To increase the national performance levels on Hospital VBP measures;
- To increase the percentage of ASCs and IPFs that successfully improve performance on quality measure where there had been poor performance previously;

- To increase the percentage of hospital outpatient departments that demonstrate improvement in quality of care delivered (as determined by reported quality measures); and
- To increase PCH performance on American College of Surgeons and CDC National Healthcare Safety Network measures included in the PCH quality reporting program.

First year evaluations for Task D.1 were deferred and considered "N/A" as a result of modifications to the task during the first year.

Measures	Measure Description
D.1-1 Learning Forum	Percentage of eligible physicians/ physician groups attending QIO-convened forums related to Task D.1 topics
D.1-2 Quality Improvement/PQRS	Percentage of eligible physician/professional groups that demonstrate improvement in quality-of-care measures (per PQRS) after receiving TA from QIOs.
D.1-3 Quality Improvement after receiving Technical Assistance (ASCs, IPFs, & CAHs)	Percentage of eligible facilities that demonstrate improvement in quality-of-care measures after receiving technical assistance from QIOs
D.1-4 Quality Improvement PPS-Exempt Cancer Hospital (PCH)	Percentage of PCHs that demonstrate improvement in quality-of-care measures (per PCHQR) after receiving TA from QIOs.
D.1-5 Quality Improvement Hospital Outpatient Department	Percentage of eligible Hospitals meeting measure thresholds for Hospital OQR program measures
D.1-6 Quality Improvement Hospital VBP Inpatient Department	Percentage of eligible Hospitals meeting measure thresholds for Hospital IQR program measures used in value-based purchasing
D.1-7 Physician/Professional Group Participation	Percentage of eligible physician/professional groups participating in VM

Task D.1 was modified from the original version to have a broader reach. The modification focused efforts on quality improvement, provided direction for recruitment and outreach, defined eligibility and recruitment, as well as continued work on promoting engagement and successful participation of eligible physicians and professionals in group practices in the Physician Quality Reporting System (PQRS) and Value-based Modifier (VM) Programs. The modification encouraged synergy with other tasks and initiatives and broadened the definition of recruitment to allow for large numbers to be engaged while emphasizing electronic outreach and education as opposed to direct technical assistance. In terms of evaluation measures, the modification provided flexibility in evaluation measures to account for the first year evaluation being deferred.

Task F.1 – Improving Medicare Beneficiary Immunization Rates Through Improved Tracking, Documentation, and Reporting with a Special Focus on Reducing Immunization Health Care Disparities

Immunization rates among adults have historically been low. Immunization rates vary in the Medicare population from the high of about 66 percent for influenza to a low of 8 percent for tetanus and diphtheria boosters. There is an even greater variation between racial and ethnic groups. For example, in 2012, white adults aged 65 years and older had a pneumococcal immunization rate of 64 percent, whereas Asian adults aged 65 years and older had a rate of 41.3 percent; similarly, white, non-Hispanic adults aged 65 years and older had an influenza immunization rate of 67.9 percent while black, non-Hispanic adults had a rate of 54.5 percent.

The focus of this Task is on improving the assessment and documentation of Medicare beneficiary immunization status, increasing overall immunization rates, and reducing the immunization disparities. This work also supports the National Vaccine Advisory Committee Standards for Adult Immunization Practice and the adult immunization recommendations of the Advisory Committee on Immunization Practices. Additionally, there is evidence that annual influenza immunization decreases morbidity and mortality in persons with cardiovascular disease. As such, QIOs working on this Task should work closely with the providers and practitioners recruited in Task 001 (Improving Cardiac Health and Reducing Cardiac Healthcare Disparities) to address immunization disparities.

Task G.1 – Improving Identification of Depression and Alcohol Use Disorder in Primary Care and Care Transitions for Behavior Health Conditions

Depression and alcohol use disorder are common behavioral health conditions in the Medicare population and are frequently under-identified in primary health care settings. Major depression is a leading cause of disability in the United States, complicates the treatment of other serious diseases, and is associated with an increased risk of suicide. Alcohol use disorder is the most prevalent type of addictive disorder in those 65 and older and is often associated with depression. Additionally, challenges in effective care transitions for these and other behavioral health conditions contribute to high readmission rates and problems in treatment adherence.

Under this task, six regional QIN-QIOs provide technical assistance and educational interventions to help primary care providers screen for depression and alcohol use disorder. In addition, QIN-QIOs work with inpatient psychiatric facilities to improve transitions of care and reduce readmissions for patients with these conditions. Assistance includes developing processes for successful transmission of discharge information to the follow-up practitioner, helping Medicare beneficiaries and their family/caregivers understand medications and treatment instructions, and coordinating communication between the inpatient facility, outpatient providers and Medicare beneficiaries.

IV. CONCLUSION

Medicare beneficiaries, like all Americans, 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 health care practices as well as conducting case reviews to make sure that the quality and standard of care provided to Medicare beneficiaries is satisfactory. The work of the QIO Program has been and continues to be a factor for improvements in American health care.

Many changes were made in the 11th SOW, and CMS believes the changes will impact critically important aspects of patient care provided to Medicare beneficiaries and their families.