DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

The Honorable Paul D. Ryan
Speaker of the House of Representatives
Washington, DC 20510

AUG 0 3 2018

Dear Mr. Speaker:

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) 2017."

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 FY 2017, covering in part 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. Should you have any questions, please do not hesitate to contact me or my staff at (202) 690-7627.

Sincerely,

Matthew D. Bassett
Assistant Secretary for Legislation

Enclosure

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The Honorable Michael R. Pence
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Report to Congress

The Administration, Cost, and Impact of the Quality Improvement Organization Program for Medicare Beneficiaries for Fiscal Year 2017

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 requirement for FY 2017. 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 and task specific QIO contractors, who work directly with health care providers and practitioners in their geographic service areas (which generally encompass multiple states, including the District of Columbia, or territories).

On August 1, 2014, the Centers for Medicare & Medicaid Services (CMS) launched the QIO Program's 11th Statement of Work (SOW) to enhance the quality of services provided to Medicare beneficiaries. These five-year contracts will end in 2019. In FY 2017, QIO Program expenditures totaled approximately $883 million. FY 2017 covered the 28th through 39th months of the 11th SOW contract. This report will describe the main activities included in the 11th SOW and the suggested targets of the aims; and include tables that illustrate QIO performance compared to performance criteria. The FY 2017 report will describe the measures, targets and results from the 36th 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. Table 1 below shows the BFCC-QIOs by Region and State.

Table 1: BFCC-QIOs by Region and State

Region	QIO	States
1	Livanta	ME, VT, NH, MA, RI, CT, NJ, PA, NY, PR
2	KePRO	DE, MD, WV, VA, NC, SC, GA, FL
3	KePRO	MT, WY, UT, CO, NM, TX, OK, ND, SD, AR, LA, TN, KY, MS, AL
4	KePRO	MN, WI, MI, IA, NE, KS, MO, IL, IN, OH
5	Livanta	AK, WA, OR, ID, CA, NV, AZ, HI

The QIN-QIO Program is responsible for working with providers and communities on multiple, data-driven quality initiatives to improve patient safety, reduce harm, and improve clinical care at local and

regional levels. The primary goals of the QIN-QIOs are to promote effective prevention and treatment of chronic disease, make care safer by reducing harm caused by the delivery of care, promote effective communication and coordination of care, and make care more affordable. The QIO Program includes 14 QINs covering a region that include as many as six states, across the United States, District of Columbia, and U.S. territories, as shown in Table 2.

Table 2: QIN-QIO by Name and States

QIN Name	States
Great Plains Quality Innovation Network	KS, ND, NE, SD
TMF	AR, MO, OK, TX, PR
Lake Superior Quality Innovation Network/Stratis Health	MN, WI, MI
Telligen	CO, IA, IL
HealthInsight	NM, NV, OR, UT
Alliant-Georgia Medical Care Foundation	GA, NC
atom Alliance	AL, KY, MS, TN, IN
Mountain Pacific Quality Health Foundation	AK, HI, MT, WY
Atlantic Quality Improvement Network	DC, NY, SC
Quality Insights Quality Innovation Network	DE, LA, NJ, PA, WV
VHQC	MD, VA
Qualis Health	ID, WA
Health Services Advisory Group	AZ, CA, FL, OH, VI
HealthCentric Advisors	CT, MA, ME, NH, RI, VT

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 Medicare 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; reviews or appeals from provider notices of discharge or termination of services; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities articulated in the Act and implementing regulations.

The QIOs are now categorized and known as BFCC-QIOs and QIN-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 work 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 in which the BFCC-QIO try to address complaints raised by the beneficiary; through this process, QIO staff also 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 in connection with Medicare participation. 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 2017, QIO Program expenditures totaled $882,551,783.49.

III. PROGRAM IMPACT

The QIO Program impacts Medicare beneficiaries on an individual basis and the beneficiary population as a whole. In 2017, Medicare covered over 58 million beneficiaries: over 49 million people age 65 or older and over 9 million people of all ages with disabilities and with end-stage renal

disease. As the QIO Program completed the 3rd year of the 11th SOW contracting period ending July 2017, some important results are as follows:

- National case review volume (excluding 2-midnight reviews) 219,082
- 2-midnight review volume 30,696
- 38,388 Medicare beneficiaries completed diabetes self-management education (DSME) classes
- DSME classes are being taught in 14 additional languages: Spanish, Mandarin, Cantonese, Vietnamese, Korean, Hmong, Samoan, Tagalog, Russian, French, Portuguese, Somali, Swahili, and Indian dialects from South Asia
- 30,347 readmissions avoided in care coordination communities cumulative through March 31, 2017
- 87.76 % of the 1,078 Ambulatory Surgical Centers, Inpatient Psychiatric Facilities, and CAHs receiving technical assistance were able to demonstrate improvement on quality reporting measures

The sections below provide additional information about QIO accomplishments and the impact on beneficiaries during the 28th through 39th months of the period of performance of the 11th SOW. This period began November 1, 2016 and ended October 31, 2017.

AIM REQUIREMENTS AND MEASURES

The Program's 11th SOW activities and services are divided into three aims: better care, better health and lower costs. Each aim has an established set of quality measures that provides accountability to the QIOs for making changes at all levels of the health care system. Please note that task refers to the breakdown of the work in each Aim of the Task Order Contract for QIN-QIOs and for the breakdown of work in the BFCC contract, for example, in Aim B, there are three tasks; there is no task A.

Beneficiary and Family Centered Care

The BFCC program focuses on statutorily mandated QIO 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 (NQS), which encourages patient and family engagement.

Case review types include Quality of Care Reviews, EMTALA Reviews, reviews of provider discharge/termination of service decisions and denials of hospital admissions, Higher-Weighted Diagnosis Related Group (HWDRG) 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 53 individual QIO contractors (one in each of the states, the District of Columbia, and two U.S. territories) to two BFCC service contracts covering five geographic areas including U.S. territories. 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. CMS has contracted Livanta LLC and KePRO as the two BFCC-QIOs organized among 50 states, the District of Columbia, and two territories, as shown in Figure 1. The five BFCC-QIO areas are depicted below.

Figure 1: Map of BFCC-QIO Region

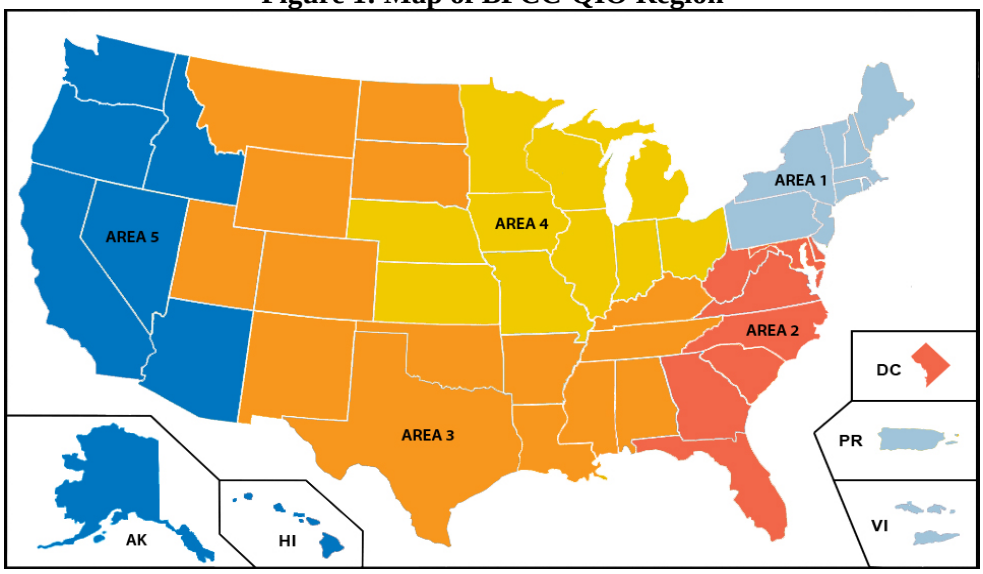

Table 3 provides national performance summary of the BFCC-QIO Program on three timeliness measures for the 36th month reporting period of the contract. As shown, the results of the timeliness analysis reveal that the BFCC-QIO performance exceeded Year 3 target requirements. As of July 2017, the BFCC-QIOs achieved national performance results greater than 98 percent on all three measures for the period from August 1, 2016 to July 31, 2017. The overall rate of timeliness is 99.2 percent.

Table 3: BFCC –QIO Annual Performance Criteria Measures

Measure	Target	Result
Timeliness of Beneficiary Complaints and Other Quality of Care Reviews	95%	98.2%
Timeliness of Discharge/ Service Termination Reviews	98%	99.6%
Timeliness of EMTALA and HWDRG Reviews	95%	99.9%

QIN-QIO QUALITY IMPROVEMENT AIMS

Aim: 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 described below.

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

The purpose of this task is for the QIN-QIOs to work with home health agencies, physician's offices, clinics, and beneficiaries in collaboration with key partners and stakeholders to implement evidence-based practices to prevent heart attacks and strokes. It aligns with and supports the Department of Health and Human Services' Million Hearts® initiative's goal to prevent one million heart attacks and strokes by 2022. The Million Hearts® website is found at www.millionhearts.hhs.gov. While the QIN-QIO's work targets Medicare beneficiaries of all races and ethnicities, the QIN-QIOs intentionally target populations disproportionately affected by heart attacks and strokes (including African American, Hispanic, Asian, and Pacific Island populations). While the QIN-QIOs are charged with working to facilitate appropriate aspirin use and cholesterol management, success is measured by data results for blood pressure (BP) control and smoking screening with cessation counseling.

Table 4 below shows the national results for blood pressure control and tobacco cessation counseling (relative to the target) for patients seen in physicians' offices.

Table 4: Blood Pressure Control and Tobacco Cessation Results, 01/01/16-12/31/16

Measure	Target*	Result
Percentage of patients whose blood pressure was adequately controlled	30%	64.2%
Percentage of patients identified as tobacco users who were provided with cessation counseling intervention	45%	75.7%

**The target represents the interim, 2017 target soley for the QIN QIO's work in Task B.1. The Million Hearts initiative's national targt is 70%. Million Hearts partners internal and external to HHS are also contributing to achievement of this national 70% goal.*

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

The goal of the EDC program 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 (which is also consistent with the goal of focusing on person centered care and person/patient engagement). The target populations are minority/medically underserved and rural beneficiaries. EDC engages 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, state, and national level.

Table 5 below identifies national performance targets and results for the cumulative period: 8/1/2014 - 7/31/2017.

Table 5: Reduce Disparities in Diabetes Care

Measure	Target	Result
Percentage of clinical outcome data obtained/collected for Medicare beneficiaries who completed diabetes self-management education (DSME) classes through EDC. Clinical outcomes are HbA1c, Lipids, Eye Exam, Blood Pressure, Weight and Foot Exam[1].	7%	10.1%
Percentage of physician practices recruited to participate in EDC	100%	147.3%
Percentage of new beneficiaries completing DSME	55%	59.4%

[1] The goal is to obtain repeated measurements on the same beneficiaries longitudinally over time.

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

Initiatives associated with this Aim are designed to assist in achieving the goals of improving individual care throughout the course of the contract. Two of the six priorities that build on the broad aims of the NQS for quality improvement in health care include making care safer and making care more affordable for patients and governments by reducing the costs of care through continual improvement. Below are four specific initiatives associated with this Aim under the 11th SOW.

Task C.2: Reduce Healthcare Acquired Conditions (HACs) 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 for beneficiaries residing in nursing homes. The activities associated with this task include:

- Recruiting no less than 75% of nursing homes within each state and two territories with a CMS Certification Number (CCN) and star-status into the 11th SOW National Nursing Home Quality Care Collaborative (NNHQCC) Collaborative I and/or II. 12,217 nursing homes were recruited into Collaborative I and II which represent approximately 78% of the nation's nursing homes.

- Increasing the participation of low-performing nursing homes to 75% of nursing homes within each state and two territories with a CMS Certification Number (CCN), identified by a One-Star status, to participate in the NNHQCC, Collaborative I and/or II. 2,630 nursing homes with a One-star status were recruited into Collaborative I and II.

- A NNHQCC is comprised of local communities of nursing homes, residents and families, and community stakeholders, dedicated to improving nursing home care in a QIN-QIO region. The Collaborative identifies and implements solutions to decrease healthcare-acquired conditions and healthcare-associated infections, increase resident satisfaction, improve quality of life and lower health care costs in the Medicare program

- Continuation of the use of the Quality Measure Composite Score as a means to measure the success of both collaborative efforts 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.

Table 6 identifies the evaluation measures and targets for the 36th month of performance requirements.

Table 6: Evaluation Measure for Reduce HAC in Nursing Homes

Measure	Target	Result
Reduction in percentage of long-stay residents who received antipsychotic medications[1]	9% Relative Improvement Rate	23.9%
Sum of percentages of one-star category target number recruited for Collaboratives I and II	100%	134.0%
Sum of percentages of recruitment target number (RTN) recruited for Collaboratives I and II	100%	105.2%
50% of RTN will achieve the quality measure composite score of 6.0 or less by 1/2019[2]	≥ 25%[2]	47 of 53 states = 88% met
Percentage of NH-National Healthcare Safety Network (NHSN) cohort homes completing enrollment in CDC NHSN long term care database	100%	34 of 52 states = 65% met

[1] The Puerto Rico QIN-QIO uses short-stay antipsychotic medication measure instead of the long-stay measure. Criteria: Interim Rate <= 3% instead of Reduction.
[2] The Puerto Rico QIN-QIO uses short-stay moderate to severe pain measure instead of composite score. Criteria: Relative Improvement >= 20%.

Task C.3: Coordination of Care and Medication Safety

The purpose of this task is to improve hospital admission and readmission rates, and adverse drug event rates by improving effective communication and the continuity and coordination of patient care using methods such as interoperable health IT. The QIN-QIO work is designed to improve the quality of care for Medicare beneficiaries who transition among care settings including home through a comprehensive community effort. These efforts aim to reduce readmissions following hospitalization and to yield sustainable and replicable strategies to achieve high-value health care, particularly for chronically ill and disabled Medicare beneficiaries. The QIN-QIOs continue to support the development of community coalitions for improving communication and the coordination of clinical decisions. A summary of the national performance targets and results for the 36th month of data collection during each specific period are presented in Table 7.

Table 7: Coordination of Care

Measure	Target	Result
Percentage of interventions implemented (for a minimum of 6 months) that show improvement (for a minimum of 5 interventions across the state/territory annually) Period: 8/1/2016-7/31/2017	60%	92.6%
Percentage of 30-day readmissions per 1,000 Fee-for-Service (FFS) beneficiaries in cohorts A[1] & B[2] Period: 4/1/2016-3/31/2017	6 % relative improvement rate (RIR) cohort A 2% RIR cohort B	1.8% RIR 3.7% RIR
Percentage of admissions per 1,000 FFS beneficiaries in Cohort A & B Period: 4/1/2016-3/31/2017	4.2% RIR cohort A 1.4% RIR cohort B	2.5% RIR 2.9% RIR
Percentage of state/territory-wide readmissions per 1,000 FFS beneficiaries Period: 4/1/2016-3/31/2017	1.2% RIR	2.8% RIR
Percentage of state/territory-wide admissions per 1,000 FFS beneficiaries Period: 4/1/2016-3/31/2017	1.2% RIR	2.7% RIR
Increased community tenure[3] in state/territory-wide coalition. Period: 4/1/2016-3/31/2017	1.2 % RIR cohort A 0.4% RIR cohort B	-0.21% RIR -0.12% RIR

[1]Cohort A recruitment timeframe is 7/1/2013-6/30/2014
[2]Cohort B recruitment timeframe is 1/1/2014-12/31/2014 (some overlap with cohort A)
[3]The number of days beneficiaries spends in their home setting.

Task C.3.6: Adverse Drug Events Data Collection and Support

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 including 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. The QIN-QIO program developed a claims based method of identifying high-risk beneficiaries, adverse drug events, and hospitalizations for the high-risk population using Medicare claims data, including Medicare Part D data.

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. Table 8 identifies performance summary on the two measures.

Table 8: Medication Safety and Adverse Drug Event Prevention, 8/1/2016-7/31/2017

Measure	Target	Result
Percentage of adverse drug events per 1,000 screened beneficiaries (self-reported)	10% RIR (cohorts A & cohort B)	17.9% RIR
Percentage of adverse drug events per 1,000 HRM Medicare Beneficiaries in State/Territory (alternate measure)	1% RIR	1.8% RIR

Task C.3.10: Antibiotic Stewardship (AS)

The scope of work relating to antibiotic stewardship was added to the section C.3 of the current QIN-QIO 11th SOW: "Promote Effective Communication and Coordination of Care", as Task C.3.10 Combatting Antibiotic Resistant Bacteria through Antibiotic Stewardship in Communities.

Antibiotic stewardship is a program by which facilities are able to monitor, reduce and prevent misuse and/or overuse of antibiotics within a healthcare system using a multidisciplinary team and strategic approach. Often seen in hospitals in different forms, antibiotic stewardship principles need to be expanded beyond the inpatient setting as part of a comprehensive patient care model. Part of the task of CMS' quality improvement program in this arena is to spread the principles of antibiotic stewardship among recruited outpatient settings at the point of care, where antibiotics are being prescribed. Therefore, QIN-QIOs are required under the 11th SOW to provide outreach, education and technical assistance to encourage the spread of antibiotic stewardship, directed to practitioners, pharmacists, healthcare system leadership as well as to recipients of care, the beneficiaries.

Please note that there is no 36th month evaluation for this task, as QIN-QIOs continue to collect data for this task. The first evaluation for this task is in July 2018.

Aim: Better Care at Lower Cost

Task D.1: Quality Improvement through Quality Reporting Programs and Supporting Clinicians in the Quality Payment Program

The purpose of this task is to assist inpatient and outpatient hospitals, PPS-exempt Cancer Hospitals (PCHs), Inpatient Psychiatric Facilities (IPFs), Ambulatory Surgical Centers (ASCs), and eligible clinicians (as defined in Social Security Act Section 1861(r)) in improving their quality of care and efficiency of care through direct technical assistance, Learning and Action Networks (LANs), and outreach and education about CMS value based payment and quality reporting programs. QIN-QIOs are working to reach all of those Merit-based Incentive Payment System (MIPS) eligible clinicians that are not being supported by the Small, Underserved, and Rural Support contracts or the Transforming Clinical Practice Initiative. As a result of a contract modification, QIN-QIOs ensure that MIPS eligible clinicians receive support to help them successfully participate in the Quality payment Program. QIN-QIOs assist eligible clinicians with their transition from the existing quality programs into the MIPS Program by incorporating a service-oriented approach when providing technical assistance, education and outreach, distribution and dissemination of learning modules, and LAN activities. QIN-QIOs ensure eligible clinicians have opportunities to engage in broad-reaching technical assistance that maximizes benefit to the customer and requires minimal effort. The QIN-QIOs continue to work to

improve healthcare by identifying gaps and opportunities for improvement in quality, efficiency, and care coordination.

Table 9 presents the national key performance metrics for data collection during each specific period.

Table 9: Quality Improvement through Quality Reporting Programs and Supporting Clinicians in the Quality Payment Program

Measure	Target	Result
Percentage of ASC, IPF and CAH facilities receiving technical assistance that demonstrate improvement in quality-of-care measures Period: numerator: 1/1/2016-12/31/2016 denominator: 8/1/2014-6/30/2016	15%	87.8%
Percentage of eligible hospitals meeting measure thresholds for the Hospital Outpatient Quality Reporting Program Period: numerator: 7/1/2015-6/30/2016 denominator: 8/1/2014-6/30/2016	75%	100%
Percentage of eligible hospitals performing at or better than the median (50th percentile for Hospital Value-based Purchasing Program) Period: numerator: 1/1/2016-12/31/2016 denominator: 8/1/2014-6/30/2016	50%	94.6%
Percentage of customers referred to QIN-QIOs by Quality Payment Program services center line that are contacted by the QIN-QIO within one business day of receiving the referral Period: 9/20/2016-7//31/2017	95%	99.8%

Task E.1: Quality Improvement Initiatives (QIIs) Technical Assistance

The purpose of this task is to improve the quality of health care for Medicare beneficiaries by providing technical assistance to providers and practitioners; it serves all the Aims of the 11th SOW. The QIN-QIO improves healthcare quality by assisting providers and/or practitioners in identifying the root cause of a concern, developing a framework in which to address the concern, and improving a process or system based on their analyses. A Quality Improvement Initiative (QII) is any formal activity designed to serve as a catalyst and/or support for quality improvement that uses proven methodologies to achieve these improvements. The improvements may relate to safety, healthcare, health and value and involve providers, practitioners, beneficiaries, and/or communities.

A QII may consist of system-wide and/or non-system-wide changes and may be based on a single, confirmed concern or multiple confirmed concerns. Additionally, the QIN-QIO collaborates with the BFCC-QIO to improve Beneficiary ("Patient") and Family Engagement in healthcare quality improvement efforts and actively supporting projects aimed at shared decision-making with beneficiaries, families, and caregivers and families. QIIs may also be based upon or responsive to referrals made by other contractors in the QIO Program.

The general desired outcomes for this task are to support providers and practitioners to develop and implement quality improvement initiatives that achieve the desired established metric outcome, provide technical assistance and educational interventions. It is expected that any request or referral that is submitted be addressed timely and improved by using proven methodologies to achieve the best overall outcomes for beneficiaries.

Table 10 summarizes the pace of technical assistance initiation to providers and practitioners and the rate of success for QIIs. The national results reveal that QIN-QIO performance exceeded Year 3 target requirements by 14.3 to 25 percent.

Table 10: QII Technical Assistance Evaluation Measure

Measure	Target	Result
Percentage of QIIs initiated within 30 days of the receipt of a referral or a request for QII technical assistance	85%	99.3%
Percentage of QIIs successfully resolved	75%	100%

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

This task supports the aim of Better Health: Healthy People, Healthy Communities.

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 according to the National Health Interview Survey (2015), white adults aged 65 years and older had a pneumococcal immunization rate of 68.1 percent, whereas Asian adults aged 65 years and older had a rate of 49 percent; similarly, white, non-Hispanic adults aged 65 years and older had an influenza immunization rate of 41.7 percent while black, non-Hispanic adults had a rate of 50.2 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 annual influenza immunization decreases morbidity and mortality in persons with cardiovascular disease. As such, QIOs working on this task are expected to work closely with the providers and practitioners recruited in Task 001 (Improving Cardiac Health and Reducing Cardiac Healthcare Disparities) to address immunization disparities.

Below are results for task F.1 showing performance summary data of the improved Medicare Beneficiary Immunization Rates (table 11) for the 36th month reporting period.

Table 11: Improved Immunization Rates

Measure	Target	Result
Task F.1-2 Provider and Practitioner Recruitment Percentage of providers and practitioners recruited	100%	100 percent (37/37) of states met the July 2017 evaluation criterion (100%)
Task F.1-3 Medicare Beneficiary Recruitment Percentage of Medicare beneficiaries recruited	100%	100 percent (37/37) of states met the July 2017 evaluation criterion
Task F.1-4 Medicare Beneficiary Recruitment for PPV Percentage of Medicare beneficiaries recruited receiving pneumonia vaccination	50%	100 percent (37/37) of states met the July 2017 evaluation criterion
Task F.1-5 Preventive Care and Screening Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization or who reported previous receipt of an influenza immunization (NQF #0041)	50%	62 percent (21/34) of states met the July 2017 evaluation criterion.
Task F.1-6 Influenza Immunization for Current Flu Season Percentage of home health episodes of care during which patients received influenza immunization for the current flu season (NQF #0522)	50%	100 percent (37/37) of states met the July 2017 evaluation criterion.
Task F.1-7 Pneumonia Vaccination Status for Older Adults The percentage of Patients aged 65 years and older who have ever received a pneumococcal vaccination (NQF #0043)	50%	94 percent (32/34) of states met the July 2017 evaluation criterion
Task F.1-8 PPV Vaccine Ever Received Percentage of home health episodes of care during which patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV) (NQF #0525)	50%	97 percent (36/37) of states met the July 2017 evaluation criterion
Task F.1-10 HHA Recruitment Percentage of Home Health Agencies recruited	100%	100 percent (37/37) of states met the July 2017 evaluation criterion

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

This task supports the aim of Better Healthcare for Communities: Beneficiary-Centered, Reliable, Accessible, and Safe Care.

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 and increase the identification of people with depression or alcohol use disorder. In addition, QIN-QIOs work with inpatient psychiatric facilities to improve transitions of care and reduce readmissions for these and other patients after discharge. 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.

Please note that a few of the targets were not met, in part because data were pulled from claims and not all claims had been submitted at the time data collection took place. CMS is currently working to address this issue. Table 12 shows the currently available national performance data covering 1/1/2016 – 12/31/2016.

Table 12: Transitions Behavioral Health Conditions

Measure	Target	Result
Percentage of the annual Medicare case load receiving screening for alcohol use	25%	6.2%
Percentage of the annual Medicare case load receiving screening for depression	25%	19.6%
30-day all-cause psychiatric Readmissions readmission rate[1]	≤ 22.3%	23.5%

[1] A positive rate difference reflects a decreased readmission rate from baseline (22.3%)

Task H.1: Transforming Clinical Practice Initiative (TCPI)

This task supports Better Care at Lower Cost. Transforming Clinical Practice is designed to support more than 140,000 clinician practices in achieving practice transformation and performance improvement through extensive collaboration, key change package concepts, technical assistance, and peer-based learning networks.

The table below represents national performance data for this task. Both measures relate to the practice assessment tool, which is used to evaluate where a practice falls within the TCPI 5 phases of practice transformation. For the first measure "percentage of assessments completed", each QIN was awarded a certain number of assessments to perform, and QINs were to perform 33% of their total number of assessments during the period of 12/23/2015 to 7/31/2017. This measure ensures that the expected numbers of assessments are being performed in order to evaluate a practice's progression through the phases of transformation. For the second measure, "the percentage of submitted assessments completed", this corresponds to the QINs having to ensure that 97% of all fields of the assessment tool are addressed (answered) in order to appropriately evaluate where a practice falls within the phases of transformation.

Table 13: Transforming Clinical Practice

Measure	Target	Result
Percentage of assessments (baseline and follow-up) completed[1]	33%	20.6%
Percentage of submitted assessments completed	95%	100%

[1] Please note that the time periods covered are cumulative (12/23/2015 -7/31/2017)

Task I: American Indian Alaskan Native Healthcare Quality Initiative (AIANHQI)

The Amercian Indian Alaskan Native Healthcare Quality Initiative was launched in the fall of 2016. CMS awarded a contract to HealthInsight, a QIN-QIO, to help support best practices in health care and other operational improvements for Indian Health Service (IHS) facilities that participate in the Medicare program. The overarching goals for the QIN-QIO are to support and build IHS hospital operating infrastructure in order to provide high-quality health care services to Medicare beneficiaries. Through a collaborative strategy, IHS and CMS are working together to achieve and sustain improvements in quality of care. To date, the QIN-QIO has worked with 24 Medicare certified facilities to develop technical assistance plans in key areas of importance to each facility. Building upon those plans, the QIN-QIO has provided educational opportunities for all staff by facilitating access to educational resources, including webinars, coaching calls and on-site technical assistance. Additionally, the QIN-QIO operates a Leadership Learning and Action Network to further develop the skills of facility leadership.

CMS is committed to assisting the IHS in their work to ensure that its facilities provide high quality care to 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.