# Report to Congress

# The Administration, Cost, and Impact of the Quality Improvement Organization Program for Medicare Beneficiaries for Fiscal Year 2018

## 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 2018. 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 July 2019. In FY 2018, QIO Program expenditures totaled approximately $934 million. FY 2018 covered the 40th through 51st 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 QIOs' performance compared to performance criteria. The FY 2018 report will describe the measures, targets and results for the 4th year evaluation.

Two key QIO functions under the 11th SOW are divided between two 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 |

Please note that on October 10, 2017 due to the impact of category 5 hurricanes: Irma and Maria, CMS issued technical direction letters (TDLs) to the QIOs pursuant to the terms of the QIO contracts. These TDLs waived the evaluation metrics for all tasks, (except for those related to Task E.1), pertaining to the territory of Puerto Rico (PR) and the U.S. Virgin Islands (VI), from November 1, 2017 to January 31, 2018, among other actions. Therefore, measures for PR and VI for that time period are not included in this report.

## 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 Adjustment Assistance Extension Act of 2011 (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 separating the functions of the BFCCs and QIN-QIOs, modifying the 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 11$^{th}$ 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 Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 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 are reimbursed on a monthly basis, consistent with the Federal Acquisition Regulation.

### 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-QIOs 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 case 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 Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds and are not subject to the annual

appropriations process. QIO costs are subject to the apportionment process administered through OMB. In FY 2018, QIO Program expenditures totaled $934,049,653.68.

## III. PROGRAM IMPACT

The QIO Program impacts Medicare beneficiaries on an individual basis and the beneficiary population as a whole. In 2018, Medicare covered over 60 million beneficiaries: over 51 million people age 65 or older and 9 million people of all ages with disabilities and with end-stage renal disease. As the QIO Program completed the 4th year of the 11th SOW contracting period ending July 2018, some important results are as follows:

- National case review volume (excluding 2-midnight reviews) 251,593
- 2-midnight review volume 16,327
- 58,764 Medicare beneficiaries completed diabetes self- management education (DSME) classes
- 63,679 readmissions avoided in care coordination communities cumulative through March 31, 2018

The sections below provide additional information about QIO accomplishments and the impact on beneficiaries during the 40th through 51st months of the period of performance of the 11th SOW. This period began August 1, 2017 and ended July 31, 2018.

### 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.

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**

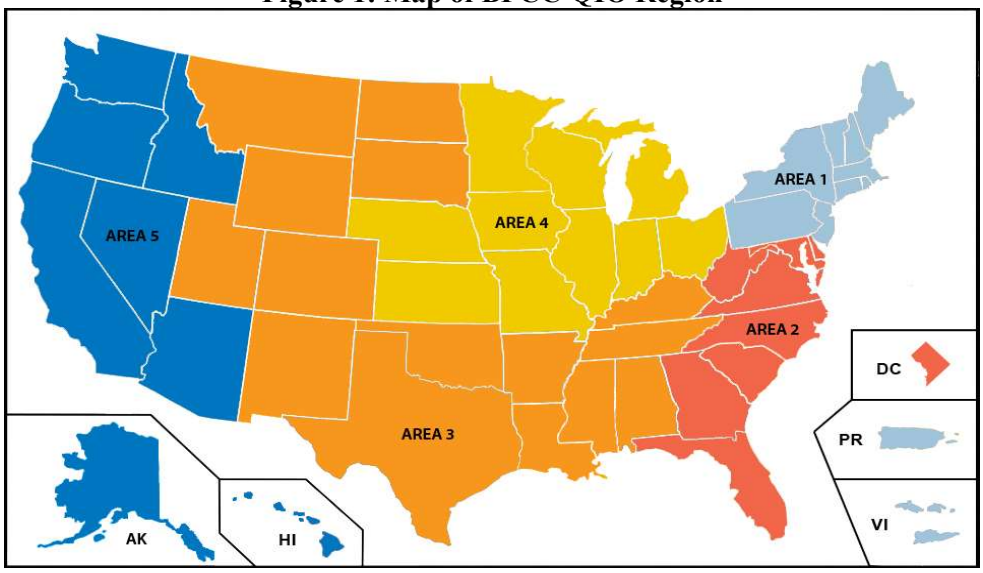


Table 3 provides national performance summary of the BFCC-QIO Program on three timeliness measures for the 48th month reporting period of the contract. As shown, the results of the timeliness analysis reveal that the BFCC-QIO performance exceeded Year 4 target requirements. As of July 2018, the BFCC-QIOs achieved national performance results greater than 98 percent on all three measures for the period from August 1, 2017 to July 31, 2018. The overall rate of timeliness is 99.5 percent.

**Table 3: BFCC –QIO Annual Performance Criteria Measures**

| Measure | Target | Result |
|---|---|---|
| Timeliness of Beneficiary Complaints and Other Quality of Care Reviews | 95% | 99.7% |
| Timeliness of Discharge/ Service Termination Reviews | 98% | 98.8% |
| Timeliness of EMTALA and HWDRG Reviews | 95% | 100% |

## QIN-QIO QUALITY IMPROVEMENT AIMS

### AIM REQUIREMENTS AND MEASURES

The Program's 11th SOW activities and services are divided into three aims intended to foster *better health, better care and better costs*. Each aim has an established set of quality measures to ensure that the QIOs are accountable for their performance. Please note that the work performed for each Aim is broken down into Tasks under the Task Order Contract for QIN-QIOs. There is no task A.

### 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 tobacco screening with cessation counseling.

Table 4 below identifies national performance targets and results for the latest available data (01/01/17-12/31/17) as reported to the Merit-based Incentive Payment System (MIPS) Program by eligible clinicians, many of who work with QIN-QIOs to improve these results. .

**Table 4: Blood Pressure Control and Tobacco Screening/Cessation Results**

| Measure | Target | Result* |
|---|---|---|
| Percentage of patients whose blood pressure was adequately controlled at < 140/90 (NQF 0018) | 65% | 65.6% |
| Percentage of patients identified as tobacco users who were provided with cessation counseling intervention (NQF 0028 or 0028b) | 65% | 86.4% |

* Results are based solely on the data reported for the patients the QIN QIO recruited clinicians were managing and reporting on.

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

The purpose of this Task is to improve the quality of the lives for persons with diabetes, and to prevent or lessen the severity of complications resulting from diabetes. The QIN-QIOs will promote diabetes self- management education (DSME) for empowering Medicare beneficiaries with diabetes to take an

active role in controlling their disease and improve clinical outcomes. The QIN-QIOs will work with healthcare providers, practitioners, certified diabetes educators, and community health workers to cultivate the knowledge and skills necessary to improve the quality of the lives for persons with diabetes. The QIN-QIOs will also work with stakeholders on preventing or lessening the severity of complications resulting from diabetes such as kidney failure, amputations, loss of vision, heart disease, and stroke. The QIN-QIOs will be working with communities most in need to establish sustainable diabetes education resources.

Table 5 below identifies national performance targets and results for the cumulative period: 8/1/2014 - 7/31/2018.

**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 classes through EDC. Clinical outcomes are HbA1c, Lipids, Eye Exam, Blood Pressure, Weight and Foot Exam[a] | 9% | 13.3%[b] |
| Percentage of physician practices recruited to participate in EDC | 100% | 149%[c] |
| Percentage of new beneficiaries completing DSME | 79% | 90.7%[d] |

[a] The goal is to obtain repeated measurements for the same beneficiaries longitudinally over time.
[b] This reflects the number and percentage of beneficiaries for whom the QIN QIOs have obtained clinical data results, both pre and post diabetes self-management education completion.
[c] This reflects physician practice sites and clinics, not the numbers of individual physicians. QINs are able to achieve a result over 100% if they recruit more than their target number of physician practices.
[d] This includes QIN QIO geographic areas affected by hurricanes. Pursuant to the terms of the QIO contracts, CMS issued TDLS to the QIOs for PR and VI to temporarily exempt them from teaching DSME classes; however, the QIOs generally still continued to teach classes and the results from PR and VI are included in this table.

## 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:

- The National Nursing Home Quality Care Collaborative (the Collaborative) 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. 12,217 nursing homes were recruited into Collaborative I and II, which represent approximately 78% of the nation's nursing homes.

- Continuation of the use of the Collaborative Quality Measure Composite Score composed of 13 National Quality Forum-endorsed quality of care measures to measure success 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.

- Through the *Clostridium Difficile* Infection (CDI) Reporting and Reduction Project, the QIN-QIOs enrolled 2,341 nursing homes in CDC's National Healthcare Safety Network (NHSN). Of the 2,341 nursing homes enrolled in NHSN, 2,292 nursing homes submitted CDI data to NHSN every month during the baseline period March 1, 2017 – December 31, 2017, exceeding the 5% goal recommended by the HHS HAI Action Plan in 2013. Nursing homes will continue to report CDI data through December 31, 2018.

Table 6 identifies the evaluation measures and targets for the 48th month of performance requirements.

**Table 6: Reduce HACs in Nursing Homes**

| Measure | Target | Result |
|---|---|---|
| Reduction in percentage of long-stay residents who received antipsychotic medications | 15% Relative Improvement Rate | 28.2% |
| 50% of recruitment target number will achieve the quality measure composite score of 6.0 or less by 1/2019 | ≥ 45% | 59.7% |
| Number of NH-NHSN cohort submitting data for 10 consecutive months to create cohort derived *C. difficile* national baseline | 80% of NH-NHSN cohort target number | 98.4% |
| Percentage of Nursing Homes reporting CDI by NH-NHSN cohort | 80% NH-NHSN cohort target number | 86.1% |

## Task C.3: Coordination of Care and Medication Safety

The purpose of this task is to improve hospital admission and readmission rates, and reduce 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 48th 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)<br><br>Period: 8/1/2017-7/31/2018 | 60% | 96.6 % |
| Percentage of 30-day readmissions per 1,000 Fee-for-Service (FFS) beneficiaries in cohorts A[a] B[b]& C[c]<br><br>Period: 4/1/2017-3/31/2018 | 10 % relative improvement rate (RIR) cohort A<br>6% RIR cohort B<br>2% RIR cohort C | 2.8% RIR<br>5.1% RIR<br>1.5% RIR |
| Percentage of admissions per 1,000 FFS beneficiaries in cohorts A, B & C<br><br>Period: 4/1/2017-3/31/2018 | 7% RIR cohort A<br>4.2% RIR cohort B<br>1.4% RIR cohort C | 3.7% RIR<br>4.2% RIR<br>2.1% RIR |
| Percentage of state/territory-wide 30-day readmissions per 1,000 FFS beneficiaries<br><br>Period: 4/1/2017-3/31/2018 | 2% RIR | 3.6% RIR |
| Percentage of state/territory-wide admissions per 1,000 FFS beneficiaries<br><br>Period: 4/1/2017-3/31/2018 | 2% RIR | 3.8% RIR |
| Increased community tenure[d] in state/territory-wide coalition.<br><br>Period: 4/1/2017-3/31/2018 | 2 % RIR cohort A<br>1.2% RIR cohort B<br>0.4% RIR cohort C | 0.3% RIR<br>0.19% RIR<br>0.19% RIR |

[a] Cohort A recruitment timeframe is 7/1/2013-6/30/2014.
[b] Cohort B recruitment timeframe is 1/1/2014-12/31/2014 (some overlap with cohort A).
[c] Cohort C recruitment timeframe is 1/1/2015-12/31/2015.
[d] 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 as 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 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 at the 48th month.

**Table 8: Medication Safety and Adverse Drug Event Prevention**

| Measure | Target | Result |
|---|---|---|
| Rate of adverse drug events per 1,000 screened beneficiaries (Self- Reported)<br><br>Pperiod: 8/1/2017 -7/31/2018 | Cohort A & B: 35% RIR<br>Cohort C: 10% RIR | Cohort A & B: 30% RIR<br>Cohort C: 20% RIR |
| Rate of adverse drug events per 1,000 high-risk medication (HRM) Medicare Beneficiaries in state/territory (Alternate-Claims Based)<br><br>Period: 10/1/2016 - 9/30/2017 | 2% RIR | 5.1% RIR |
| Rate of state/territory-wide 30-day readmissions per 1,000 HRM opioid Fee-for-Service (FFS) beneficiaries<br><br>Period: 10/1/2016 - 9/30/2017 | 0.75% RIR | -3.1% RIR* |
| Rate of state/territory-wide 30-day readmissions per 1,000 HRM anticoagulant FFS beneficiaries<br><br>Period: 10/1/2016 - 9/30/2017 | 0.75% RIR | 3.7% RIR |
| Rate of state/territory-wide 30-day readmissions per 1,000 HRM diabetic FFS beneficiaries<br><br>Period: 10/1/2016 - 9/30/2017 | 0.75% RIR | 4.6% RIR |
| Rate of state/territory-wide admissions per 1,000 HRM opioid FFS beneficiaries<br><br>Period: 10/1/2016 - 9/30/2017 | 0.75% RIR | -1.4%RIR* |
| Rate of state/territory-wide admissions per 1,000 HRM anticoagulant FFS beneficiaries<br><br>Period: 10/1/2016 - 9/30/2017 | 0.75% RIR | -1.1%RIR* |
| Rate of state/territory-wide admissions per 1,000 HRM diabetic FFS beneficiaries<br><br>Period: 10/1/2016 - 9/30/2017 | 0.75% RIR | 0.5% RIR |

* A negative RIR indicates an increase in the rate of adverse drug events, readmission, or admission reported in cohorts in the state or territory, relative to the respective baseline for each cohort.

## 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.

Table 9 below addresses the measure for the national performance target and result for the cumulative period: 10/1/2016-7/31/2018.

**Table 9: Antibiotic Stewardship**

| Measure | Target | Result |
|---|---|---|
| Percentage of recruited outpatient settings which have implemented an Antibiotic Stewardship program that meet and maintain minimum requirements* | 60% | 101.3 %** |

* Minimum requirements are defined as meeting the core elements of antibiotic stewardship for outpatient settings as defined by the Centers for Disease Control and Prevention[1]

** The result is calculated using the target outpatient setting number (5,117; It was originally 5186, but we did not include the targets for PR and VI). QINs are able to achieve a result over 100% if they recruited and implemented all four core elements with more settings than their target number.

## 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 eligible clinicians that are not being supported by the Small, Underserved, and Rural Support contracts or the Transforming Clinical Practice Initiative. 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

[1] See https://www.cdc.gov/antibiotic-use/community/pdfs/16_268900-A_CoreElementsOutpatient_508.pdf

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

**Table 10: 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<br><br>Period: numerator: 1/1/2017-12/31/2017<br>denominator: 8/1/2014-6/30/2017 | 15% | 89.7% |
| Percentage of eligible hospitals meeting measure thresholds for the Hospital Outpatient Quality Reporting Program<br><br>Period: numerator: 7/1/2016-6/30/2017<br>denominator: 8/1/2014-6/30/2017 | 85% | 100% |
| Percentage of eligible hospitals performing at or better than the median (50th percentile for Hospital Value-based Purchasing Program)<br><br>Period: numerator: 1/1/2017-12/31/2017<br>denominator: 8/1/2014-6/30/2017 | 55% | 95.4% |
| 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<br><br>Period: 8/1/2017-7//31/2018 | 95% | 99.7% |

## 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; task E.1 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 one or more 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. 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 by using proven methodologies to achieve the best overall outcomes for beneficiaries.
Table 11 summarizes the pace of technical assistance initiation to providers and practitioners and the rate of success for QIIs for the performance results.

**Table 11: 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 | 90% | 99.5% |
| Percentage of QIIs successfully resolved | 80% | 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

Immunization rates among adults have historically been low. Immunization rates vary in the Medicare population. While 66 percent of the Medicare population has been immunized for influenza only 8 percent has been immunized 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 B.1 (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 12) for the 36$^{th}$ month reporting period.

**Table 12: Improved Immunization Rates**

| Measure | Target | Result |
|---|---|---|
| Percentage of providers and practitioners recruited | 100% | 100% (36/36) of states met the July 2018 evaluation criterion |
| Percentage of Medicare beneficiaries recruited | 100% | 100% (36/36) of states met the July 2018 evaluation criterion |
| Percentage of Medicare beneficiaries recruited receiving pneumonia vaccination | 75% | 100% (36/36) of states met the July 2018 evaluation criterion |
| 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) | 70% OR Achievement of at least a "Satisfactory" rating on the COR Qualitative Assessment | 100% (36/36) of states met the July 2018 evaluation criterion and received a Satisfactory rating on the Qualitative Assessment |
| Percentage of home health episodes of care during which patients received influenza immunization for the current flu season (NQF #0522) | 70% | 97% (35/36) of states met the July 2018 evaluation criterion. |
| The percentage of Patients aged 65 years and older who have ever received a pneumococcal vaccination (NQF #0043) | 75% OR Achievement of at least a "Satisfactory" rating on the COR Qualitative Assessment | 100% (36/36) of states met the July 2018 evaluation criterion and received a Satisfactory rating on the Qualitative Assessment |
| Percentage of home health episodes of care during which patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV) (NQF #0525) | 75% | 94% (34/36) of states met the July 2018 evaluation criterion |
| Percentage of Home Health Agencies recruited | 100% | 100% (36/36) of states met the July 2018 evaluation criterion |

## Task G.1: Improving Identification of Depression and Alcohol Use Disorder in Primary Care and Care Transitions for Behavioral 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 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 13 shows the currently available national performance results covering 1/1/2017 – 12/31/2017.

**Table 13: Transitions Behavioral Health Conditions**

| Measure | Target | Result |
|---|---|---|
| Percentage of the annual Medicare case load* receiving screening for alcohol use | 50% | 23.1% |
| Percentage of the annual Medicare case load receiving screening for depression | 50% | 42.9% |
| 30-day all-cause psychiatric readmission rate** | ≤ 22.3% | 24.4% |

* Case load is the total number of beneficiaries seen by clinicians
** 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 Cost: Lower Healthcare Costs for Communities. 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 results covering 8/1/2017 – 7/31/2018 for this task. The measure evaluates "the percentage of submitted assessments completed", which corresponds to the QINs having to ensure that 95% 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 14: Transforming Clinical Practice**

| Measure | Target | Result |
|---|---|---|
| Percentage of submitted assessments completed * | 95% | 100% |

* **T**he measure looks at how much of the assessment tool a practice completes. The goal is that the QIN ensures that each practice completes at least 95% of the assessment tool.

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

The American 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 capacity building for Indian Health Service (IHS) facilities that participate in the Medicare program. To date, the QIN-QIO has engaged with all 24 Medicare certified IHS service units.[2] HealthInsight has developed and deployed quality improvement technical assistance in key areas of importance to each facility in the areas of patient safety, accreditation readiness, strengthening organizational capacity, patient, family and community engagement, improvement of the patient's experience and access and workflow in the emergency department. Building upon the facilities interests, the QIN-QIO has provided educational opportunities for all staff by facilitating access to educational resources, including webinars, the Institute for Healthcare Improvement Open School, coaching calls and on-site technical assistance. Additionally, the QIN-QIO operates a well-received Leadership Learning and Action Network to further develop the skills of facility leadership. For the final year of contract support, the focus will be on three aims: increasing patient safety and harm reduction; instituting a robust Quality Assurance Performance Improvement Plan (QAPI) to assist with identifying and implementing systems to remain in compliance with federal regulations and maintain accreditation; and identifying and implementing systems to ensure smooth care transitions across the care continuum beginning in the emergency department.

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.

[2] The statutory definition for a service unit is an administrative entity of the Service or a tribal health program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area, 25 U.S.C. § 1603(20).

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.