NQF
National Quality Forum

Measure Applications Partnership Coordinating Committee

In-Person Meeting #2

MAP Workgroups Background Materials

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Clinician Workgroup

Tab 1

Overview of Clinician Quality Programs

Quality Initiative	Statute/Regulation	Description	Data Reporting/Data Submission	Incentive Structure/Payment Adjustment or Penalty	Public Reporting
Physician Quality Reporting System (PQRS)	• Tax Relief and Health Care Act of 2006 (TRHCA) — The initiative was first authorized by this act. The first measurement period went into effect in 2007. • Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) —- The continuation of the program was authorized for 2008 and 2009. • Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) —- The act made the program permanent; however, the incentive payments were authorized through —- 2010. • Affordable Care Act (ACA), 2010 —-The act expands the incentive payments through 2014 and adds a payment adjustment or penalty for eligible professionals who do not satisfactorily report the PQRS measures. [a]	The PQRS provides an incentive payment to eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries. [b]	For the 2007 measurement period, the reporting mechanism for the PQRS quality data was based on claims. MMSEA added alternative reporting mechanisms including medical registries and reporting measure groups. [c]	The incentive payment for 2007 consisted of 1.5 % (subjected to a cap) of total estimated allowed charges for covered professional services payable under the Medicare Part B Physician Fee Schedule (PFS). The incentive payment amount for 2008 and 2009 remained the same as the 2007 rate; however, the cap was removed. The incentive payment for 2010 measurement reporting period increased from 1.5 % to 2.0 %. According to the ACA, the incentive payment amount for the 2011 reporting period will be 1.0 % of the total estimated allowed charges. For the periods from 2012 through 2014, the incentive payment will be 0.5 %. Starting in 2015, eligible professionals who do not satisfactorily report for the reporting period will be subject to a payment adjustment or penalty, by which the PFS amount will decrease by 1.5 % for 2015 and 2.0 % for 2016 and every year thereafter. [d]	The Physician Compare Web site contains information about physicians and other professionals who satisfactorily participated in the PQRS; however, it does not yet include physician and eligible professional performance information. CMS is required to establish a plan for making information available on physician performance through the Physician Compare by January 1, 2013. The reporting period can begin on or after January 1. [e]

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E-Prescribing Incentive Program	Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) — The section authorizes a separate incentive program from and in addition to the PQRS for 2009 through 2013.[f]	The E-Prescribing Incentive Program provides incentive payments to eligible professionals who are successful electronic prescribers, and it is implemented through an annual rulemaking process published in the Federal Register. [g]	*2009 eRX Incentive Program* Eligible professionals must submit information via their Medicare Part B claims. *2010 eRX Incentive Program* Eligible professionals may submit information: 1. To CMS on their Medicare Part B claims 2. To a qualified registry 3. To CMS via a qualified electronic health record (EHR) product.[h]	*2009 eRX Incentive Program* Eligible professionals can earn a 2.0% incentive payment for the 2009 eRx Incentive Program if they report the eRx measure in at least 50% of the cases in which the measure is reportable by the provider during 2009. [i] *2010 eRX Incentive Program* Eligible professionals should report the eRX measure for at least 25 unique electronic prescribing events in which the measure is reportable during 2010, in order to be considered a successful electronic prescriber and qualify to receive a 2.0% incentive payment. The incentive payment also can be applied to a group practice and can amount to 2% of the group practice's total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during the 2010 reporting year. *2011 and 2012 eRX Incentive Program* The incentive will amount to 1.0% of the total estimated allowed charges submitted not later than 2 months after the end of the reporting period. *2013 eRX Incentive Program*	

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				The incentive amount will be reduced to 0.5%, and starting in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment or penalty. The PFS amount shall be reduced by 1.0% for 2012, 1.5% for 2013, and 2.0% for 2014.[j]	
Electronic Health Records (EHR)- Meaningful Use	• The American Recovery and Reinvestment Act of 2009 (ARRA) — The act supported the adoption of Electronic Health Records (EHRs) by investing as much as $27 billion over 10 years. • The Health Information Technology for Economic and Clinical Health Act (HITECH) 2009— According to the act, federal incentive payments will be available to eligible professionals upon adopting EHRs and demonstrating use in ways that can enhance quality, safety, and effectiveness of care. [k]	The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) for the "meaningful use" of certified EHR technology to enhance quality, safety, and effectiveness of care.[l]	Medicare eligible professionals, eligible hospitals and critical access hospitals will demonstrate meaningful use by inputting data into CMS' web-based Registration and Attestation System. Providers will complete numerators and denominators for the meaningful use objectives and clinical quality measures, and if applicable, exclusions to specific objectives, and legally attest to the successful demonstration of meaningful use. Additionally, providers can enter a completed report created by the	Medicare EHR Incentive Program: • Participation can start as early as 2011. Payments are also expected to begin in May 2011. • Eligible professionals can receive up to $44,000 over 5 years. Additional incentive will be paid to eligible professionals for providing services in a Health Professional Shortage Area (HSPA). • Eligible professionals must begin participation by 2012 in order to receive the maximum incentive payment. • Medicare eligible professionals, eligible hospitals, and CAHs that do not successfully demonstrate meaningful use will have a payment adjustment in their Medicare reimbursement, beginning 2015 and beyond. Incentive payments for the Medicare EHR Incentive Program will be made approximately four to six weeks after the eligible providers meet the program requirements and successfully attest they	

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			EHR system into the online Attestation System. The Attestation system for the Medicare EHR Incentive Program was slated for opening on April 18, 2011. For the Medicaid EHR Incentive Program, the dates for accepting registration are provided to CMS by States and are updated monthly. [m]	have demonstrated meaningful use of certified EHR technologies. Medicaid EHR Incentive Program: • States and territories will offer the incentive program on a voluntary basis, which may begin as early as 2011. Payments will be paid by the states and are expected to begin in 2011. • Eligible professionals can receive up to $63,750 over the 6 years. • There are no payment adjustments. Incentives for the Medicaid EHR Incentive Program will be issued within 45 days of providers successfully submitting their attestation. [n]	
Physician Feedback/Value Modifier — [Previously called The Physician Resource Use Measurement and Reporting (RUR) Program]	• Section 131 of the Medicare Improvements for patients and Providers Act of 2008 (MIPPA) — The section established the Physician Resource Use Measurement and Reporting (RUR) Program. • Section 3003 of the 2010 Patient Protection and Affordable Care Act— This section of the act expended and enhanced the PUR program and renamed it to the Physician Feedback Program. • Section 3007 of the Affordable	The program provides physicians and other medical professionals confidential information with respect to the resources used to treat the Medicare fee-for-service (FFS) patients and the quality of care provided to these patients, in comparison to the peer groups practicing in the same specialty.[p] The PUR/Physician Feedback Program consists of two phases. Phase I was completed in 2009 during which approximately 310 reports containing per capita and episode-based cost information[q]	Under the program, CMS uses claims data to create confidential reports gauging the resources and quality of care utilized in furnishing care to Medicare beneficiaries.[s]	According to the section 3007 of the ACA, CMS is required to include cost and quality data when calculating payments for physicians by applying a value-based payment modifier under the Medicare Physician Fee Schedule (MPFS), which will begin in 2015. By 2017, the value-based payment modifier will be applied to the majority of medical professionals, and ultimately it will be employed for the value-based payment modifier. [t]	

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	Care Act— The Section established the value-based payment modifier under the physician fee schedule. [o]	were sent to randomly selected physicians in 12 metropolitan areas throughout the U.S. Formative testing and retrospective analyses of the data from Phase I has assisted CMS in the formation of Phase II. CMS is developing Phase II reports that in addition to resource use measures include quality indices as well. The reports may contain measures used in the PQRS and claims-based measures such as the measures employed in the Generating Medicare Physician Quality Performance Measurement Results (GEM) Project. In Phase II, in addition to individual physicians, CMS may provide reports at the physician group level. [r]			
Physician Compare	Section 10331 of the Patient Protection and Affordable Care Act of 2010— The section sets requirements for the creation of the Physician Compare Web site. [u]	The Physician Compare web site was launched December 30, 2010, to serve as a healthcare professional directory on Medicare.gov. Individuals can search the site to locate a physician or other healthcare professional by specialty, type of professional, location, gender,	To collect the list of eligible professionals who satisfactorily reported PQRS measures, CMS mapped the National Provider identifiers (NPI's) of eligible professionals who		The Physician Compare Web site contains information about physicians and other professionals who satisfactorily participated in the PQRS; however, it does not yet include physician and eligible

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		and whether the healthcare professional accepts the Medicare-approved amount as payment in full on all claims. Additional information is also available such as languages spoken, group practice locations, education, and hospital affiliation. The website is updated on a monthly basis.[v]	satisfactorily reported PQRS measures for the 2009 program to Medicare Provider Enrollment, Chain and Ownership System (PECOS) to identify the name and state associated with each NPI. If the states or names could not be matched with NPI, then the National Plan and Provider Enumeration System (NPPES) was referenced for name and state identification.[w]		professional performance information. CMS is required to establish a plan for making information available on physician performance through the Physician Compare by January 1, 2013. The reporting period can begin on or after January 1. [x]
Medicare Advantage/5-star rating	The Affordable Care Act of 2010—The health reform law required the star ratings to be used to award quality-based payments to Medicare Advantage plans, beginning in 2012. [y]	Under this program, CMS rates Medicare Advantage plans on a scale of one to five stars, with five stars indicating the highest quality. MA Plan's quality is measured by computing a summary score which is a cumulative indicator of the following domains: staying healthy; screenings, tests, and vaccines; managing chronic (long-term) conditions; ratings of health plan responsiveness and care; health plan members' complaints and appeals; and health plan telephone customer	The five-star quality scores for MA plans for the 2011 reporting period included the following sources: CMS administrative data, including information about member satisfaction, plans' appeals processes, audit results, and customer service; the Consumer Assessment of Healthcare Providers and Systems (CAHPS); the Healthcare	Under the health reform law, MA plans will receive quality-based payments. Plans with higher quality ratings will receive higher rebates in the amounts of : • 70 % for plans receiving 4.5 or 5 stars; • 60 % for plan receiving 3.5 or 4 stars; • 50 % for plans receiving 3 stars or fewer. Plans with four or more stars will also receive bonus payments, and in certain counties, plans will receive double bonuses. Additionally, to achieve Medicare savings, lower county benchmarks will be phased-in over two, four, or six years, with longer phase-in period for counties with large	CMS posts quality ratings of Medicare Advantage plans on the Medicare.gov website to inform and educate Medicare beneficiaries with respect to their Medicare plan choices. [cc]

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		service. For the 2011 reporting period, CMS allocated stars for 36 performance measures and then the scores were averaged to calculate the summary score. The measures are adjusted for patient characteristics, where possible. The summary scores and quality ratings are assigned on the contract level versus plan level, since the data is mostly available to CMS at the contract level. The summary score also takes into account whether contracts have exhibited high and stable quality ratings across all measures, relative to other contracts. In conjunction with the health reform law which has required tying quality-based payments to the five-star rating, CMS has proposed a demonstration that would modify the rating system and provide additional quality-based payments to the MA plans, which would include all MA plans from 2012 through 2014. [z]	Effectiveness Data and Information Set (HEDIS); and the Health Outcome Survey (HOS).[aa]	changes in benchmarks. The bonus payment will be applied only to the new benchmarks, rather than the blended benchmarks which would result in the partial bonus payment to plans until the new benchmarks are fully phased-in. Under the CMS proposed demonstration, bonus payments would be provided to contracts that are rated as average performers (3 or 3.5 stars), in addition to those that receive 4 or more stars. Additionally, contracts that receive 4 or more stars would receive higher bonus payments than what has been authorized under the health reform law. Contracts that receive 5 stars would also receive higher bonus payments than the 4 and 4.5 star contracts with no bonus cap. However, the cap would apply to other contracts. Finally, bonuses for contracts with 5 stars would be applied to the blended benchmark versus the new benchmark, which will be applied for all other contracts. As a result of applying the blended benchmark, the 5 star plans would receive the full bonus amount before the changes are fully phased in. [bb]	

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CHIPRA Initial Core Set Measures	Section 401 of The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009— The section called for the Secretary of the U.S. Department of Health and Human Services (HHS) to identify and publish an initial core measure set of children's health care quality measures for voluntary use by state programs administered under titles XIX and XXI, health insurance issuers, managed care entities, and providers of items and services under Medicaid and CHIP. [dd]	The aim of the CHIPRA initial core set measures is to assist the Centers for Medicare and Medicaid Services (CMS) to better understand the quality of health care children receive through the Medicaid and CHIP programs. According to the CHIPRA legislation, the data collected from the core measures will inform part of the Secretary's Annual Report on the Quality of Care for Children in Medicaid and CHIP.[i] There are measures that overlap between the CHIPRA initial core measures and the EHR Incentive Program.[ii] For the first year of reporting, States collecting the overlapping measures may identify slight variations in measure specifications, which may be caused by using different versions for the same measure. The CHIPRA measures will use the most recent available version of measure specifications. Rarely, the methodology for calculating the measure may also vary between the two programs with no impact on the data result.	All states choosing to report the initial core measures should submit data to the CHIP Annual Template System (CARTS), a web-based data submission tool that is currently used by CHIP Programs. The data submitted to CARTS will include the numerators, denominators, and rates for each measure. Furthermore, states can list quality improvements activities related to the measure and any foreseeable quality improvement plans in CARTS. [ff] States may choose to report the core set measures data for their Medicaid program only, the CHIP program only, or both. The data reported should be representative of the entire population enrolled in Medicaid and	Implementation of the CHIPRA Initial Core Set Measures will assist CMS and states to build a national system for measuring healthcare quality across States, which may include benchmarking their performance against national averages to identify best practices and promote cross-state learning. [hh]	The Department of Health and Human Services (HHS) publishes the Annual Reports on the Quality of Care for Children in Medicaid and CHIP which will include state-specific and national measurement information on the quality of health care furnished to children enrolled in the Medicaid and CHIP programs. [ii]

[i] The first annual report is available at: http://www.cms.gov/MedicaidCHIPQualPrac/Downloads/secrep.pdf

[ii] The measures used in both CHIPRA and EHR include: Childhood immunization status; BMI assessment for children/adolescents; Chlamydia screening; and Appropriate testing for children with pharyngitis

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		Per CHIPRA requirements, the CHIPRA initial core set measures will be modified and expanded to better reflect children's health care quality across all settings including Medicaid and CHIP programs, providers, consumers, and health plans. AHRQ will assist CMS to launch a Pediatric Quality Measures Program (PQMP) consisting of seven Pediatric Centers of Excellence in Quality Measurement. The Centers will aim to enhance and simplify the data collection for the initial core set of measures and seek methods to strengthen States' ability to rely on non-Medicaid and CHIP data sources. [ee]	the CHIP program. [gg]		
Medicaid Core Measure Set	The Affordable Care Act of 2010— In accordance with the act, the HHS Secretary is required to identify and publish a core set of health quality measures for Medicaid-eligible adults. [jj]	Under this initiative led by the collaborative effort between CMS and AHRQ, the core measures will be reported to Congress every three years to assess improvements on the quality of care received by adults in Medicaid. To facilitate the assessment of the quality of care, HHS is required to develop a standardized reporting format for the core set of measures by			

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		establishing an adult quality measurement program, publishing an annual report by the Secretary on the reporting of adult Medicaid quality information, and producing updates to the initial core set of adult health quality measures that reflect new or enhanced quality measures. The Initial core set that is currently undergoing public comments consists of 51 measures. The measures are classified under the following domains: prevention and health promotion, management of acute conditions, management of chronic conditions, family experiences of care, and availability. Milestones and their corresponding deadlines to meet the ACA requirements regarding adult quality measurement in Medicaid are as follows: • Publish recommended initial core set in the Federal Register for public comments by January 1, 2011; • Publish final initial core set by January 1, 2012;			

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		• Develop a standardized reporting format on the core set and procedures to encourage voluntary reporting by the States by January 1, 2013; • Establish a Medicaid Quality Measurement Program to fund development, testing, and validation of emerging and innovative evidence-based measures by January 1, 2013; • Report to Congress by January 1, 2014; • Collect, analyze, and make publicly available the information reported by the States by September 30, 2014; and • Annually publish recommended changes to the initial core set, starting January 1, 2015. [kk]			
ACO Proposed Regulations	Section 3022 of the Affordable Care Act— This section requires CMS to establish the Medicare Shared Savings Program (Shared Savings Program), intended to increase accountability, promote care coordination, and encourage investment in infrastructure and redesigned care processes by supporting the development of Accountable Care Organizations (ACOs). [ll]	ACOs are projected to create incentives for health care providers such as doctors, hospitals, long-term facilities, and other health care providers to better coordinate care for and treatment of an individual patient across all settings. Participation in an ACO is voluntary for both patients and providers.[mm]	There are several mechanisms for data submission across domains which include: • Survey • Claims • Group Practice Reporting Option (GPRO) Data Collection Tool • EHR Incentive Program Reporting • eRX Incentive	The Medicare Shared Savings Program will incentivize ACOs that reduce health care costs while meeting performance standards on quality of care. The quality standards include patient/caregiver care experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly health. On the other hand, ACOs that do not meet quality standards cannot share in program savings and can be held accountable if they do not generate savings. [oo]	

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			Program Reporting • CDC National Healthcare Safety Network.[nn]		
IHA (Integrated Healthcare Association — California Pay-for-performance Program)		In 2002, The Integrated Healthcare Association (IHA) Launched the Pay-for-Performance (P4P) initiative to evaluate the performance of contracted physician organizations (POs) across California. The program aimed to develop a common set of measures with public reporting of the scores and to provide health plans[iii] with the information needed to reward POs financially based on their performance.[pp] Performance results released by IHA for measurement year 2008 contain a comparison of average composite scores in four performance measurement domains: clinical quality, patient experience, information technology-enabled systemness, and coordinated diabetes care.[qq] Effective 2011, the IT-Enabled	Participating health plans submit administrative results related to the clinical measures for their contracted POs to the data aggregator (NCQA/DDD). The data for clinical measures is collected from encounters, fee-for-service claims and in-network claims. A PO may collect and submit administrative results for clinical measures directly to the data aggregator. The data for the patient experience domain is captured through the Patient Assessment Survey (PAS). To collect and score	To calculate incentive payments, the measurement domains are weighted. Weighting for each domain differs among health plans. Payment methodology also varies across plans. Plans may choose to pay based on the following methodologies; • Use absolute threshold; • Use relative percentile ranking; • Pay for all or most IHA clinical measures; • Pay for IHA-recommended patient experience measures or use the health plan survey; • Pay for IHA IT measure or choose not to pay; • Pay using aggregated data set; and/or • Pay using IHA-recommended weightings.[tt] Additionally, POs need to meet the encounter rate threshold (number of encounters per member per year) in order for their data to be included in their aggregated scores. Health plans may not provide financial reward to a PO that does	The P4P annual physician group performance results are posted on a public website sponsored by the California Office of the Patients Advocate (OPA). www.opa.ca.gov Additionally, IHA provides financial transparency reports on its website which include the incentive payments made by each health plan participating in P4P, the payment methodology utilized by each health plan, adoption of uniform IHA measurement set, and use of aggregated data set. [vv]

[iii] The eight health included Aetna, Anthem Blue Cross, Blue Shield of California, CIGNA HealthCare of California, Health Net, Kaiser Permanente (public reporting only), UnitedHealthcare/Pacificare, and Western Health Advantage.

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		Systemness Domain has been renamed to Meaningful Use of Health IT in concert with the CMS effort to support the adoption and use of EHR and the implementation of "meaningful use" measures. [rr]	data on meaningful use of health IT, POs must declare their intentions for submitting the MU of Health IT survey in advance, attend a training session, submit PO level results using a scoring tool provided by NCQA, and submit an attestation of accuracy for each measure. Health plans and POs are not expected to report on the appropriate resource use measures—Thomson Reuters will run the resource use measures for MY 2011. [ss]	not meet the encounter rate threshold. [uu]	
Blue Cross Blue Shield of Massachusetts Alternative Quality Contract		Blue Cross Blue Shield of Massachusetts launched a new payment arrangement called the Alternative Quality Contract (AQC) in 2009. The AQC is a modified global payment model that links medical groups annual payments to a per member, per month budget and provides incentive payments to improve quality.	Blue Cross has in place a data-reporting system that supports medical group's implementation of timely medical management and includes a series of regular data and performance reports, consultative support, and organized sessions where the groups meet	The program provides quality incentive payments of up to 10 % of the total per member per month payments. Groups can earn bonuses of up to 5 %t based on their performance on 32 care measures for ambulatory or office-based services and up to 5 % for their performance on 32 measures of hospital care. The incentive payments are based on quality measures derived from nationally accepted sets of measures, and the quality	

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		The AQC lasts for five years to offer additional time and support to providers to develop the capacity to manage the new payment model. Blue Cross negotiates a base year's budget with each group based on its past year's medical spending on HMO and POS patients seen by their primary care physicians. Upon setting initial budgets, Blue Cross employs trend allowances to manage health care spending growth over the five-year contract period.[ww] Presently, the AQC applies only to HMO and POS plan enrollees.	jointly and share best practices. The reports assist groups in monitoring their performance on the quality bonus measures as well as current performance relative to their budgets. [xx]	bonus system is based on absolute performance. The bonus depends on an overall quality score that is developed by aggregating quality scores from each measure. [yy]	

[a] https://www.cms.gov/PQRS/.
[b] Ibid.
[c] Ibid.
[d] Ibid.
[e] Ibid.
[f] https://www.cms.gov/ERXIncentive/.
[g] Ibid.
[h] Ibid.
[i] Ibid.
[j] https://www.cms.gov/ERxIncentive/04_Statute_Regulations.asp#TopOfPage.
[k] Electronic Health Records at a Glance, July 13, 2010.

[l] https://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage.
[m] https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage.
[n] https://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage.
[o] CY 2011 Medicare Physician Fee Schedule Final Rule.
[p] https://questions.cms.hhs.gov.
[q] CY 2011 Medicare Physician Fee Schedule Final Rule.
[r] Ibid.
[s] https://www.cms.gov/physicianfeedbackprogram/.
[t] Ibid.
[u] http://www.cms.gov/Physician-Compare-Initiative/.
[v] Ibid.
[w] Ibid.
[x] Ibid.
[y] The Henry J. Kaiser Family Foundation. Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011. Feb 2011.
[z] Ibid.
[aa] Ibid.
[bb] Ibid.
[cc] Ibid.
[dd] CHIPRA Initial Core Set Technical Specifications Manual 2011.
[ee] Ibid.
[ff] Ibid.
[gg] Ibid.
[hh] Ibid.
[ii] Ibid.
[jj] http://www.ahrq.gov/about/nacqm/nacqmsum.htm.
[kk] http://www.ahrq.gov/about/nacqm/nacqm1.htm.
[ll] ACO proposed rule March 2011.
[mm] http://www.hhs.gov/news/press/2011pres/03/20110331a.html.
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[pp] http://www.iha.org/pdfs_documents/p4p_california/DraftMY2011P4PManual123010.pdf.
[qq] http://www.iha.org/program_results.html.
[rr] http://www.iha.org/pdfs_documents/p4p_california/DraftMY2011P4PManual123010.pdf.
[ss] Ibid.
[tt] Advancing Quality Through Collaboration: The California Pay for Performance Program, Feb 2006. Available at http://www.iha.org/pdfs_documents/p4p_california/P4PWhitePaper1_February2009.pdf
[uu] http://www.iha.org/pdfs_documents/p4p_california/DraftMY2011P4PManual123010.pdf.
[vv] http://www.iha.org/financial_transparency.html.

[ww] Chernew M, Mechanic R, Landon, B, Safran D. Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract', Health Affairs, 30, no.1 (2011): 51-61.
[xx] Ibid.
[yy] Ibid.

Ad Hoc Safety Workgroup

Tab 2

Fact Sheet: Partnership for Patients: Better Care, Lower Costs

Doctors, nurses and other health care providers in America work incredibly hard every day to deliver the best care possible to their patients. Unfortunately, an alarming number of patients are harmed by medical mistakes in the health care system and far too many die prematurely as a result.

The Obama Administration has launched the ***Partnership for Patients: Better Care, Lower Costs***, a new public-private partnership that will help improve the quality, safety and affordability of health care for all Americans. The Partnership for Patients brings together leaders of major hospitals, employers, health plans, physicians, nurses, and patient advocates along with State and Federal governments in a shared effort to make hospital care safer, more reliable, and less costly. The Partnership will help save 60,000 lives by stopping millions of preventable injuries and complications in patient care over the next three years and has the potential to save up to $35 billion, including up to $10 billion for Medicare. Over the next ten years, it could reduce costs to Medicare by about $50 billion and result in billions more in Medicaid savings. Already, more than 500 hospitals, as well as physicians and nurses groups, consumer groups, and employers have pledged their commitment to the new initiative.

The two goals of this new partnership are:

- *Keep patients from getting injured or sicker*. By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients, with more than **60,000 lives saved** over the next three years.

- *Help patients heal without complication*. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be **reduced by 20%** compared to 2010. Achieving this goal would mean more than **1.6 million patients** will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

Improving Patient Safety

In 1999, the landmark Institute of Medicine study, "To Err is Human," estimated that as many as 98,000 Americans die every year from preventable medical errors. Despite progress in some areas, meaningful improvement was not made in the decade that followed. Numerous patients continue to get injured or sicker from preventable, adverse events after being admitted to a hospital. Patients are also vulnerable once they leave the hospital to continue healing at home, in an assisted living facility, or in other care settings; many are readmitted due to preventable complications.

- A study published in April, 2011 in the journal *Health Affairs* found that on average, 1 in 3 patients admitted into a hospital suffer a medical error or adverse event – nearly 10 times greater than previously believed.
- On any given day, about 1 in every 20 patients is affected by an infection related to hospital care.
- On average, 1 in 7 Medicare beneficiaries is harmed in the course of care, costing the government an estimated $4.4 billion every year.

- Nearly 1 in 5 Medicare patients discharged from the hospital is readmitted within 30 days – that's approximately 2.6 million seniors at a cost of over $26 billion every year.

Successful efforts to improve patient safety have shown that collaboration and use of innovative practices to target specific types of medical errors and complications work. For example, a collaborative effort in Rhode Island between insurers and hospitals reported a 42 percent decrease in central line-associated bloodstream infections. In New Jersey, approximately 150 health care facilities reduced pressure ulcers by 70 percent. And more than 65 Institute for Healthcare Improvement Campaign hospitals reported going more than a year without a ventilator-associated pneumonia in at least one unit.

Partnership for Patients – A Common Commitment

Achieving the goals of the Partnership for Patients will take the combined effort of many key stakeholders across the health care system – physicians, nurses, hospitals, health plans, employers and unions, patients and their advocates, as well as the Federal and State governments. Many important stakeholders have already pledged to join this Partnership in a shared effort to save thousands of lives, stop millions of injuries and take important steps toward a more dependable and affordable health care system. They include:

- **Hospitals and national organizations representing physicians and nurses:** America has the best-trained and equipped health care system and workforce in the world, striving hard every day to care for patients. These providers are committed to improving their care processes and systems, and enhancing communication and coordination to reduce complication for patients.
- **Patient and consumer organizations:** Patients and their families are deeply affected by the harms from preventable health care complications. These organizations are committed to raising public awareness and developing information, tools and resources to help patients and families effectively engage with their providers to avoid preventable complications.
- **Employers, unions, health plans and States:** Employers, unions, health plans and States can provide the incentives and support that will enable clinicians and hospital to deliver high-quality health care to their patients, with minimal burdens.

Members of the Partnership will identify specific steps they will take to address reduce preventable injuries and complications in patient care. For example, the Association of American Medical Colleges also launched a complementary harm reduction effort – Best Practices for Better Care – a multi-year initiative to improve the quality and safety of health care. More than 200 teaching hospitals and health systems have joined the effort, and are pledging to take simple steps such as using surgical checklists for safer surgery and using proven practices to reduce central line infections. In addition, Partnership member California Public Employees' Retirement System (CalPERS), has already implemented an integrated care program that has reduced hospital readmissions by 22 percent, and has pledged to continue its efforts to improve patient safety.

To see which organizations have already joined the Partnership, visit partnershippledge.HealthCare.gov.

Investing in Better Care

Using up to $1 billion in new funding provided by the Affordable Care Act, the Department of Health and Human Services (HHS) will work with a wide variety of public and private partners to achieve the

two goals of this partnership – keeping patients from getting injured or sicker in the health care system and improving transitions between care settings.

- **Preventing Harm:** The new Innovation Center at the Centers for Medicare & Medicaid Services (CMS) will dedicate up to $500 million to test different models of improving patient care and patient engagement and collaboration in order to reduce hospital-acquired conditions and improve care transitions nationwide. The Partnership will target all forms of harm to patients but will start by asking hospitals to focus on nine types of medical errors and complications where the potential for dramatic reductions in harm rates has been demonstrated by pioneering hospitals and systems across the country, including preventing adverse drug reactions, pressure ulcers, childbirth complications and surgical site infections. The Innovation Center will help hospitals adapt effective, evidence-based care improvements to target preventable patient injuries on a local level, developing innovative approaches to spreading and sharing strategies among public and private partners in all States.

- **Improving Care Transitions:** The new Community-based Care Transition Program at the CMS Innovation Center will provide $500 million in funding to community-based organizations partnering with eligible hospitals for care transition services that include timely, culturally, and linguistically-competent post-discharge education, medication review and management, and patient-centered self-management support within 24 hours of discharge. Starting April 12, 2011, eligible community-based organizations and acute care hospitals that partner with community based organizations can begin submitting applications for that funding. Applications are being accepted on a rolling basis. Awards will be made on an ongoing basis as funding permits. Those interested in applying should visit: www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313

The programs announced today are just two of the many ways the Affordable Care Act is helping improve the health care system. Last month, HHS announced the first-ever National Quality Strategy, which will serve as a tool to help coordinate quality initiatives between public and private partners as well as to leverage and coordinate existing efforts by federal agencies and departments to improve patient care. HHS also announced new rules to help doctors, hospitals, and other providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). By 2015, a portion of Medicare payments to the majority of hospitals will be linked to whether hospitals are delivering safer care, using information technology effectively and meeting patient needs. Payment incentives and supports to improve quality and lower costs will also be available to State Medicaid programs.

For more information about the Partnership for Patients, visit www.HealthCare.gov/center/programs/partnership/index.html. For more information about the Community-based Care Transitions Program funding opportunity visit: www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313.

PARTNERSHIP FOR PATIENTS

AREAS OF FOCUS FOR MAKING CARE SAFER AND ASSOCIATED GOALS

Area of Focus	Goal
Preventable Hospital Readmissions	**By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010.** Achieving this goal would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.
Hospital-Acquired Conditions	**By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010.** Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years.
Adverse Drug Events	The Partnership for Patients estimates that 50% of the 1.9 million ADEs that occur in hospitals each year are preventable. **The goal set for hospitals is to reduce preventable ADEs by 50% by 2013**. Over three years, this would prevent 830,000 ADEs.
Catheter-Associated Urinary Tract Infections	The Partnership for Patients estimates that 40% of CAUTIs are preventable. **The goal set for hospitals is to cut the number of these preventable events in half by 2013.** Over three years, this would prevent a total of 185,500 cases of CAUTI.
Central-Line Associated Blood Stream Infections	The Partnership for Patients estimates that 50% of CLABSIs are preventable. **The goal set for hospitals is to reduce preventable CLABSIs by 50% by 2013.** Over three years, this would prevent 17,500 CLABSIs.
Injuries from Falls and Immobility	The Partnership for Patients estimates that 25% of fall injuries are preventable. **The goal set for hospitals is to cut the number of preventable fall injuries in half while maintaining or increasing patients' mobility by 2013.** Over three years, this would prevent a total of 43,750 fall injuries, while maintaining or increasing mobility.
Obstetrical Adverse Events	The Partnership for Patients estimates that 30% of obstetrical adverse events are preventable. **The goal set for hospitals is to cut the number of these preventable events in half by 2013.** Over three years this would prevent nearly 100,000 obstetrical adverse events.
Pressure Ulcers	The Partnership for Patients estimates that 50% of the most dangerous pressure ulcers that occur in acute-care settings are preventable. **The goal set for hospitals is to reduce these preventable hospital-acquired pressure ulcers by 50% by 2013.** Over three years this would prevent nearly 110,000 pressure ulcers.
Surgical Site Infections	The Partnership for Patients estimates that 35% of all SSIs are currently preventable. **The goal set for hospitals is to reduce preventable SSIs by 20% by 2013.** Over three years this would prevent over 13,000 SSIs.
Venous Thromboembolism	The Partnership for Patients estimates that 40% of VTEs are currently preventable. **The goal set for hospitals is to reduce 50% of preventable VTEs by 2013.** Over three years this would prevent 35,000 VTEs.
Ventilator-Associated Pneumonia	The Partnership for Patients estimates that 50% of VAP cases are preventable. **The goal set for hospitals is to reduce preventable cases of VAP by 50% by 2013.** Over three years, this would prevent 17,500 cases of VAP.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare	ACA Section 3025 establishes the **Hospital Readmissions Reduction Program.**[1]		To account for "excess readmissions," effective October 1, 2012, diagnosis related group (DRG) payment rates will be reduced based on a hospital's ratio of actual to expected readmissions. The reduction applies to the base DRG payment only. In fiscal year (FY) 2013, the maximum payment reduction is one percent, two percent in FY 2014, and capped at three percent for FY 2015 and beyond.	The measures included in the policy must represent high volume and high cost conditions and be endorsed by NQF. The measures must have appropriate exclusions for readmissions that are unrelated to the prior discharge (such as planned admissions or transfers to another hospital). For FY 2013 the readmissions policy will apply to: Heart Attack (AMI), Heart Failure and Pneumonia. In FY 2015, the policy expands to include COPD, CABG, PTCA and Other Vascular, as identified by MedPAC in its June 2007 report. In addition, hospitals will be required to submit the appropriate information for CMS to calculate hospital specific all-payer readmission rates, which would be publicly reported on Hospital Compare.

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: Quality Partners of Rhode Island	The Rhode Island Medicare Quality Improvement Organization (QIO) **Safe Transitions Project**[2]**:** • focuses on discharge care processes from the hospital to other care settings, • promotes cross-setting communication, • aims to improve patients' transition experiences, self-management skills, and outcomes.	Quality Partners' Safe Transitions Project team works with local providers across all care settings to implement patient and system-level interventions, track progress, measure and share results	Patient Level Care Transitions Interventions: Coaches include nurses, CNAs, and social workers. Coaches work with hospital staff to identify Medicare fee for service patients and follow up with patients after discharge through home visits and phone calls. Coaches focus on the use of a personal health record, assist with medication reconciliation and follow-up appointments, and teach the signs and symptoms of worsening conditions. Systems Level Cross-Setting Communication: An advisory board defined a vision for care transitions and collaborated on strategies to implement system change. The initiative developed two sets of best practices, one for hospitals and one for community physicians.	30 day readmission rate (CMS)
Medicare QIO Programs: Florida Medical Quality Assurance Inc. (FMQAI)	The **Care Transition Program** aims to address issues in medication management, post discharge follow-up and care plans for patients who move across health care settings. [3]	The program partners with consumers, physicians, hospitals, nursing homes, home health agencies and community organizations to implement system-wide quality improvement interventions in targeted areas of Miami-Dade County, Florida.	FMQAI based the collaborative intervention on the Institute for Healthcare Improvement (IHI) Collaborative Model for Achieving Breakthrough Improvement. The program addresses: • reasons for readmission with a focus on heart failure, myocardial infarction and pneumonia, • medication reconciliation, • communication and coordination of patient services between practitioners in multiple settings, and • patient empowerment to foster increased patient responsibility for the self-management of their disease conditions.	30 day readmission rate (CMS)

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: CIMRO of Nebraska	**CareTrek**, Nebraska's care transitions initiative focuses on improving care transitions across healthcare settings to reduce avoidable readmissions.[4]	The program engages the community of providers, beneficiaries and stakeholders in Douglas and Sarpy counties with a focus on transitions from the hospital to home, skilled nursing facility, home health care or any other care provider to prevent avoidable re-hospitalization.	The program used community mapping to identify gaps in known and standard processes. Community learning groups were formed to develop interventions that result in process improvements. These interventions address issues in medication management, post-discharge follow-up, communication and care coordination. CareTrek promotes increased self-management of chronic disease for patients and their caregivers through education, support and a patient healthcare record.	30 day readmission rate (CMS)

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: Colorado Foundation for Medical Care	**Connected for Health** aimed to make improvements by standardizing transfer processes, increasing patient engagement and caregiver support, promoting culture change around palliative care and end-of-life issues, creating community coalitions, and facilitating the creation of a regional health information exchange.[5]	The program brought together hospital leadership, physicians, employers, state policy leaders, and senior advocates.	The program developed a standardized personal health record (PHR) that is being used in two large hospitals, senior resource centers, physician offices, and nursing facilities; created a post-acute care decision support tool; and conducted training on palliative care; and implemented patient coaching programs.	**Hospital Measures** • % of patients +65 who rate hospital performance as meeting HCAHPS performance standard for medication management (HCAHPS questions 16 & 17). • % of patients +65 who rate hospital performance as meeting HCAHPS performance standard for discharge planning (HCAHPS questions 19 & 20) **Community Measures** • % of patients discharged and readmitted within 30 days who are seen by a physician between discharge and readmission. • % of patient care transitions (FFS Medicare), in the target community, for which implemented and measured interventions show improvement. • Reduction in the % of patients from the target community re-hospitalized within 30 days of discharge from an acute care hospital. • Reduction in the 30 day all-cause risk standardized readmission rates following HF, AMI and PNE hospitalizations.

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: eQHealth Solutions	**Louisiana Care Transitions Project** had a primary objective to reduce unnecessary all-cause readmissions. The program focused on intervention plans and patient coaching.[6]	The program engaged hospital leadership by emphasizing how reducing avoidable readmissions reduces cost, reduces the risk of HACs, and improves patient satisfaction. All five acute care hospitals in the Baton Rouge area participated as well as home health agencies, nursing homes, hospice agencies, and physician practices.	The program used coaches who made hospital visits followed by telephone sessions on day two, seven, 15, 21 and 30 post-charge. Coaches also assisted with medication reconciliation. The selection criteria for inclusion in the program were: • fee-for-service Medicare beneficiaries who lived in a designated ZIP code area, and were able to participate in self-care or had a caregiver, • discharged to home with no addition support services, • diagnosed with CHF, pneumonia, AMI or COPD, and • consented to participate in the program	30 day all-cause readmissions HCAHPS composite 5 score
Medicare QIO Programs: GMCF	The **Care Transitions Initiative** aims to improve post-acute care coordination and reduce readmission rate through community care transition interventions.[7]	The program focuses on improving provider communication at transfer and including community providers in planning.	The program focuses on: • enhanced assessment on admission of post-discharge needs (including caregivers and community providers in discharge planning, reconciling medications, initiating a standard care plan), • enhanced teaching and learning (improving patient understanding of self-care, assessing understanding of discharge instructions), • handoff communications (including reconciling medications and providing real-time information to the next care provider), • post-acute follow up (scheduling a visit within 48 hours for high-risk patients, and 5 days for moderate risk patients)	30 day readmission rate (CMS)

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: Healthcare Quality Strategies, Inc	The **New Jersey Care Transitions Project (NJCTP)** is a pilot project designed to improve care coordination and reduce unnecessary hospital admissions and readmissions.[8]	The program includes 10 hospitals, including the Virtua health system, 11 nursing and rehabilitation facilities, 6 home health agencies, 7 hospices, and 4 dialysis centers, as well as a number of physician practices, to implement strategies that will improve care transitions.	The program focuses on improving coordination as patients move between care settings, as well as educating and activating patients to facilitate self-management. The program emphasizes communication at the point of patient transfer, the transitional care model, and working with community agencies to raise awareness among Medicare beneficiaries.	30 day readmission rate (CMS)
Medicare QIO Programs: IPRO	IPRO included five New York counties (Rensselaer, Saratoga, Schenectady, Warren and Washington) in its **Care Transitions Initiative.** [9]	The provider community consists of 5 acute care hospitals, 6 home health agencies, 28 nursing homes, 5 dialysis centers, 5 hospice organizations, several physician health networks and primary care practices, 3 major payers and 2 Regional Health Information Organizations (RHIOs). A kick-off event was held with learning sessions featuring Eric Coleman and Mary Naylor.	The program: • trained participants in the Care Transitions Intervention Model, • focused on cross-setting medication reconciliation and medication discrepancy monitoring and communication, • created systems in the acute care setting to ensure a seven day post discharge physician visit in the discharge instructions, • ensured compliance with medications and discharge plan through follow-up calls, • educated patients and caregivers, • developed cross-setting partnerships, • encouraged self-management, • facilitated assessment for palliative care management, • utilized telehealth for high-risk patients, • developed standardized transfer of patient information .	Overall all-cause 30 day readmission rate; 30 day all-cause readmission rates for AMI, heart failure, and pneumonia; Patient satisfaction (HCAHPS)

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: MPRO	MPRO is conducting a **Care Transitions** project in the mid-Michigan area to measurably improve the quality of care for Medicare beneficiaries who transition between care settings. The project focuses on improving care coordination between providers and across settings by improving transitions from the hospital to home, skilled nursing care, home health care or other providers to prevent avoidable hospital readmission.[10]	MPRO is working with providers to implement interventions that result in process improvements and address issues in medication management, post-discharge follow-up, communication and coordination of care.	The Care Transitions project promotes increased self-management of chronic disease for patients and their caregivers through education, support and a patient health care record.	30 day readmission rate
Medicare QIO Programs: Qualis Health	The **Stepping Stones: Bridging Healthcare Gaps** is the care transitions project of Whatcom County aims to eliminate unnecessary readmissions to St. Joseph Hospital in Whatcom County, Washington. [11]	The project connects providers throughout the healthcare system to enable safe and effective transition of patients, eliminate unnecessary hospital readmissions, and enable patients and their families to participate fully in their health and healthcare, particularly when discharged from the hospital.	The program strategies are: • engaging providers to ensure coordination, communication and information exchange around the needs of each patient, particularly when patients are discharged. Activities include identifying patients at highest risk, using the CMS CARE tool, and implementing the teach-back technique. • implementing use of care transition coaches and coaching protocols to help patients self-manage their care. • expanding use of shared care plan personal health record • engaging key healthcare, business, nonprofit, and government entities	30 day readmission rate (CMS)

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: Quality Insights of Pennsylvania	Quality Insights is working on a community-based, cross-setting project called the **Care Transitions Cross-Setting Interventions** to help hospitals, skilled nursing facilities, home health agencies and physician offices improve coordination across the care continuum. The program aims to promote efficient transitions from hospital to home, skilled nursing care or home health care. Collaborators work to reduce unnecessary hospitalizations and readmissions. [12]	The program works with providers in Allegheny, Fayette, Washington and Westmoreland Counties. 5 hospitals, 2 in-patient rehabilitation facilities, 1 in-patient psychiatric unit, 6 home health agencies, 12 skilled nursing facilities participate in the project. The project also includes community resources, such as Area Agencies on Aging.	The project focuses on: • care transitions interventions, • care transitions coaching, • implementation of the continuity assessment record & evaluation tool, • the four pillars of care transitions: o medication self-management o red flags (knowledge of worsening condition and how to respond) o follow-up o personal health record • discharge process improvement • post-discharge follow-up • handover management communication • care plans for patients moving across health care settings	30 day readmission rate (CMS)
Medicare QIO Programs: TMF Health Quality Institute	TMF Health Quality Institute is conducting a **Care Transitions** project in the Lower Rio Grande Valley of Texas to improve the quality of care transitions between settings. [13]	The Care Transitions project aims to improve care coordination among providers and across settings by promoting transitions from the hospital to home, skilled nursing care, home health care or other providers to prevent avoidable readmission.	The program works with providers to implement interventions that result in process improvements and address issues in medication management, post-discharge follow-up, communication and care coordination. The project promotes increased self-management of chronic disease for patients and their caregivers through education, support and a patient health care record as patients transfer across care settings.	30 day readmission rate (CMS)

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: AQAF	The Alabama QIO project is **Post-Acute Transitions in Healthcare (PATH) Alabama**. The program is based in the Tuscaloosa Hospital Referral Region (HRR) that includes Tuscaloosa, Bibb, Greene, Hale, Fayette, Lamar and Pickens counties. PATH Alabama promotes improved transitions from the hospital to home, skilled nursing care, or home health care. [14]	Program partners are: AQAF, Tuscaloosa health care providers, Alabama Hospital Association, Alabama Nursing Home Association, Alabama Association of Home Health Agencies, Alabama Department of Public Health, American Heart Association- Birmingham chapter, and academic centers including University of Alabama Tuscaloosa - School of Medicine College of Community Health Services, University of Alabama Capstone Graduate Nursing Program, University of Alabama at Birmingham , Division of Geriatrics and Palliative Care, Auburn University Motivational Interviewing Training Institute, and Medicare beneficiary advocacy organizations such as Alabama Department of Senior Services, West Alabama Area Agency on Aging, and Tuscaloosa AARP.	The PATH Alabama project provides a framework for integrating and coordinating care with participating health care providers, and encourages Medicare patients to advocate for their care needs and self-manage their chronic conditions. The aims of PATH Alabama are: • Establishing a multidisciplinary, multi provider work group that will lead to effective partnerships between the community at large, providers, academic institutions, and patients; • Promoting capacity building in the targeted communities through increased knowledge and empowerment of community constituents; and • Engaging community providers in the development, application and dissemination of data driven strategies for reducing hospital readmissions	30 day readmission rate (CMS)

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Medicare QIO Programs: Health Care Excel	The **Care Transitions Program** focuses on improving care coordination, particularly promoting improved care transitions for Medicare beneficiaries from the hospital to home, skilled nursing facilities or home health care. This project is based in the Evansville Hospital Service Area, which includes Vincennes, Indiana. [15]	The program brings together healthcare providers, patients, caregivers, families, and the community to improve care coordination.	**The goals of the program are:** • eliminating unnecessary hospital readmissions, • improving communication and information exchange when a Medicare patient is discharged from the hospital, • forming partnerships in the community that include senior service organizations, community and business leaders and families to enable effective transitions for Medicare patients, and • engaging patients, caregivers and their families to actively participate in their healthcare **The strategies of the program are:** • coaching to help Medicare patients to self-manage their healthcare, • coaching and systems interventions for Medicare patients at the highest risk for hospital readmission, • individualized care plans for Medicare patients, • medication reconciliation, and • education about the importance of personal health records.	30 day readmission rate (CMS)

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Aetna	The **Transitional Care Model** program was created by a research team at the University of Pennsylvania to improve the health care and outcomes of Medicare beneficiaries with chronic illnesses who are making the transition from hospital to home. The 2006-2007 Aetna pilot program showed a drop in readmissions in the intervention group (N=45 compared to N=60 in the control group) and savings of $439 per member. Aetna is implementing the Transitional Care Model in Philadelphia, New York, Northern New Jersey, Florida, and Arizona. The program will expand to additional parts of the country where there are large populations of Medicare members. [16]	Aetna partnered with the University of Pennsylvania to implement the program.	The program arranges for a home visit by an advanced-practice nurse within seven days of hospital discharge. The nurse evaluates: patients' clinical and psychosocial needs; the safety of the home environment; and the ability of the patient and caregiver to follow the care plan recommended at hospital discharge. Following the initial home visit, the program provides for additional in-person visits and phone calls by the nurse to coordinate patient care, communicate with physicians as needed, and help patients access all of the resources necessary to follow the care plan successfully (e.g., physical therapy, social workers, financial assistance, and Meals on Wheels). The home visit nurses coordinate and communicate with the patient's physicians.	Avoidable admissions and readmissions are defined as those which most likely would not have occurred if care plans had been followed.

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Aetna	The **Aexcel Specialist Designation** is awarded in the areas of: • cardiology, • cardiothoracic surgery, • gastroenterology, • general surgery, • neurology, • neurosurgery, • obstetrics and gynecology, • orthopedics, • otolaryngology/ENT, • plastic surgery, • urology, and • vascular surgery.[17]	The program originated from discussions with large employer groups and patients who wanted to control rising costs and to have access to information about physicians. Aetna works with affected physicians before implementing the program.	Doctors who have met clinical performance criteria and, are efficient and statistically so, are Aexcel designated. Aetna is considering offering tiered insurance products of a sub-set of Aetna participating doctors, like Aexcel-designated specialists, who are identified based on a combination of clinical performance evaluation, efficiency measures and their utilization of a narrow network of hospitals.	**30-day hospital readmission rate:** Excludes expected readmissions.

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Anthem Blue Cross Blue Shield	The **Readmissions Prevention Program** attempts to engage members in the hospital via telephone prior to discharge to assist in identifying any care situations where assistance with discharge and follow-up care could prevent a gap in care, and a subsequent further unplanned readmission. [18]	WellPoint teams help identify high-risk patients while they are still in the hospital and meet regularly with patients and nursing staff.	The initial phone call assesses home support, offers case management services on discharge and verifies a contact number for post discharge follow-up calls. Case managers may be able to help with navigating the health system, identifying and engaging community resources, benefit maximization or transitions to other levels of care.	30 day readmission rate (CMS)
Blue Cross and Blue Shield of Illinois	**Preventing Readmissions through Effective Partnerships (PREP)** is collaboration between BCBS Illinois and the Illinois Hospital Association to reduce rates of readmissions by 2014. [19]	The program is collaboration between the Illinois Hospital Association (IHA) and BCBS of Illinois. BCBSIL provides financial support to IHA, which through its Quality Care Institute will provide hospitals with extensive technical assistance, strategic approaches, tools, and other resources. A standardized approach to discharge planning will be an integral part of the program.	The initiatives of the program are: • redesigning hospital discharge processes; • Improving transitions of care, • developing and improving palliative care programs, • reducing readmissions from infections, and • measuring reductions in readmissions using standardized metrics A focus of PREP will be educating the patient, assessing the patient's unique needs before discharge, and then making sure the patient has the information needed to ensure a smooth transition. This includes standardized discharge pathways that highlight medications, follow up, pending tests, self-management instructions, and goal setting.	3 day readmissions for heart failure, AMI, and pneumonia; 10 day readmissions heart failure, AMI, and pneumonia; 30 day readmissions heart failure, AMI, and pneumonia

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Blue Cross Blue Shield of MA	The **Blue Care Connection Aftercare Program** facilitates patients' transition from the hospital to home. Preliminary results show a 25 percent reduction in readmission rates at targeted hospitals, generating an initial cost savings of $4.4 million. Member satisfaction surveys also indicate that 95 percent of respondents were satisfied with the support that they received through the program.[20]		Case managers initiate calls to identified members within two days of hospital discharge and assess the patient's condition, reinforce discharge instructions and address self-management strategies.	Cost savings Member satisfaction
Blue Cross Blue Shield of Texas	Through the **Pre-Admission/Post Discharge Outreach Program** advisors reach out to members before and after surgery. [21]		Advisors review medications and if appropriate refer the member to BCBSTX case, condition, or lifestyle management programs.	
Blue Shield of California	The **CalPERs Accountable Care Organization (ACO)** pilot showed a 4% reduction in hospital admissions, a 9% decrease in average length of stay, and a 22% drop in readmissions, resulting in $15.5 million in annual savings. The pilot program involved approximately 40,000 CalPERs members.[22]	ACO with Catholic Healthcare West and Hill Physicians Medical Group.	The ACO was a joint effort between Blue Shield of California, Hill Physicians Medical Group, and Catholic Healthcare West, which operates local hospitals in a three-county area in the Sacramento, CA area. CalPERS members in the Sacramento area, for a reduced premium, could use the integrated network in which each of the three entities shared patient data and coordinated patient care. All three organizations agreed with CalPERS to maintain healthcare costs for the ACO at rates at or below 2009 levels in the Sacramento area. If they delivered care for rates less than those levels, they could keep the difference and share the savings. However, if costs went above the 2009 level, they would be responsible for paying the difference.	Average patient length of stay; Total patient length of stay; Number of patients with a 20-day or longer length of stay

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
BlueCross Blue Shield of Florida	The BCBS of Florida **Physician Home Visiting Program** uses predictive modeling software and claims analysis to determine which patients are most at risk of being readmitted to hospitals in the upcoming year and contacts these patients to conduct monthly home visits. [23]	Physicians and case managers can refer patients to the program.	Nurse case managers contact patients by phone to offer the program. The program's physicians (including family practitioners, internists, and geriatricians) conduct at least monthly home visits and evaluate patients' medications to identify duplicative or conflicting prescriptions; assess the safety of patients' homes; evaluate patients' diets; and examine the adequacy of patients' social support systems. Based on their assessments, physicians treat patients' medical needs and fill gaps in care. The visiting physicians coordinate care plans with patients' primary care physicians.	
CIGNA	The **Care Transitions Program** provides education and guidance from nurses who monitor and support the patient's hospital discharge, transition and recovery.[24]	Program nurses facilitate follow-up appointments and support the patient's hospital discharge.	The program provides support with identifying a caregiver, educates the patient and their caregivers about the hospital discharge plan, builds awareness of the patient's condition, signs and symptoms of the condition and what to do if the individual's condition worsens, helps patients manage prescriptions and other medications and facilitates follow-up medical appointments.	

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
CIGNA	The **Chronic Health Improvement Program** is for patients who have congestive heart failure with diabetes and/ or chronic obstructive pulmonary disease (COPD). More than 80 percent of program participants are Medicare Advantage beneficiaries.[25]	Cigna staff contact primary care physicians whose patients have the targeted conditions, and discuss the impact the program can have on patients' health. The program receives referrals from physicians, nurse care coordinators, and other Cigna staff. The program works with patient's to help them follow their physician's recommendations.	The program's clinical team includes a hospitalist who also provides outpatient care, a board-certified cardiologist who practices internal medicine, nurses, a diabetes educator, and social workers. Patients receive detailed health risk assessments to identify medical and behavioral health care needs, psychosocial challenges (e.g., depression, inability to travel to medical appointments), lack of effective medications, and financial issues that may make it difficult to access care and follow physicians' recommendations. The care team develops comprehensive care plans and links patients with case management and community-based services. Nurses call patients regularly so that nurses can monitor the patients' health conditions and help them access needed care.	Preventable hospital and SNF admissions
CIGNA	The **Home-Based Care Program** aims to improve health-care for patients with complex medical needs and patients who have difficulty reaching doctors' offices.[26]	Primary care physicians are updated on the health status of their homebound patients and on the care they are receiving.	Clinicians and social workers visit patients' homes to develop care plans, monitor safety of home environments, check vital signs, help patients take medications correctly, and arrange to access community services such as transportation and Meals on Wheels.	Preventable hospital and SNF admissions

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
CIGNA	The **Transition of Care Nurse Program** helps patients after hospital discharge and aims to promote timely recovery and prevent worsening of health problems. The program initially was created for CIGNA HealthCare of Arizona's Medicare Advantage individual customers, and it has been expanded to include all Cigna Medical Group patients hospitalized in the facilities where the program exists.[27]	CIGNA nurses work with hospitalists to develop discharge plans and consult with hospitalists in the emergency room. The nurses also give all primary care physicians regular updates on their patients admitted to hospitals including information on who was admitted, why they were admitted, how their health status has changed in the hospital and immediately following discharge.	Transition of Care nurses: • Meet with patients in hospitals, answer their questions, review medications, and prepare for discharge • Relay critical clinical information from outpatient settings to emergency room physicians and hospitalists • Share up-to-date information about the health status of hospitalized patients with their primary care physicians • Coordinate with hospitalists to develop discharge plans • Contact patients by phone within 24 hours of discharge to check on their health status, review medications, and help with unmet needs • Consult with social workers to help patients access needed care and community services such as transportation and pharmacy assistance programs. Social workers coordinate with other behavioral health specialists to provide support to patients with depression, particularly those with multiple chronic medical conditions CIGNA is in the process of adding clinical pharmacists to the program. Clinical pharmacists will check new and previously prescribed medications for potential duplication, medication interactions, and gaps in medication that may have led to the hospitalization in the first place.	Patient satisfaction Preventable hospital readmissions

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Payer	Description	Payer Provider Collaboration	Program Features	Measure Characteristics
Humana	In the **Post-Hospital Transition Program,** Humana nurses contact patients within 72 hours of discharge from hospitals or skilled nursing facilities. Preliminary research suggests that 30 day readmission rates were lower among patients receiving post-discharge assessments than among those that did not.[28]		The program connects patients who have ongoing, complex needs with Humana's case management nurses, who help them access medical, social, and/or behavioral health services. The program nurses ask patients if they understand their health conditions and medications, have follow-up visits scheduled with their primary care physician, need durable medical equipment and/or home care, and know whom to call for help and when. The program arranges for patients to receive any of the items or services they need following hospital or SNF discharge. Nurses wok with patients to follow up with the primary care physician.	30 day readmission rates
Independence Blue Cross	Independence Blue Cross conducted the **Transitional Case Management Pilot Program** to help members dually eligible for Medicare and Medicaid transition safely from hospital to home.[29]		Based on the success of the pilot, Independence Blue Cross expanded and re-launched the program in 2009 and 2010 to include all members with Medicare Advantage and some with commercial coverage who had CHF, diabetes, pneumonia, COPD, atrial fibrillation; syncope and collapse, dehydration, cellulitis of extremities, or gastrointestinal bleeding. The pilot program was associated with a 10.7 percent effective reduction in readmissions.Nurses or social workers visit members in hospitals to: • describe the case management services, • ensure that they schedule follow-up visits with primary care physicians and take prescribed medications, • develop personal rapport with patients so that they feel comfortable with subsequent interactions. Following hospital discharge: • nurse case managers contact members to assess their functional capacity and needs, • provide case management services to arrange for medical care and help members access community resources (e.g., support groups, transportation), disease management programs, home health services, and durable medical equipment, and • nurses or social workers ensure patients schedule follow up visits with primary care physicians.	

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Purchaser	Program Description	Purchaser Provider Collaboration	Program Design	Measure Characteristics
Catalyst for Payment Reform (CPR)	The CPR health plan RFI coordinates purchaser signals and their "ask"—better organizing the private sector agenda for payment reform and providing a consistent set of expectations for the health plans that will be responsible for implementing such reforms. The RFI addresses many aspects of payment reform and contains a special module to assess health plan efforts that align with the Partnership for Patients. [30]	RFI includes value-based methods of payment (i.e., description of value-based component of payment reform program such as fee schedule adjustment, per diem/case rate/capitation increase or decrease, gain sharing, risk sharing, annual bonus, etc.)	Health plan RFI contract language that allows health care purchasers to query plans about their efforts to link payment to performance and quality improvement, using national standardized measures and goals such as the Partnership for Patients' areas of focus. CPR's RFI will be synched with NBCH's eValue8.	Readmissions for the following areas: • Acute Myocardial Infarction (AMI) • Pneumonia (PNE) • Heart Failure (HF) • Chronic obstructive pulmonary disease • Coronary artery bypass graft • Percutaneous transluminal coronary angioplasty • Other vascular
eValue8 (NBCH)	**eValue8™**, the nation's leading, evidence-based request for information (RFI) tool, is widely used by business health coalitions, their purchaser members, and national employers to assess and manage the quality of their health care vendors. In 2010, eValue8 was used by employers and coalitions to gather health care data from 64 health plans across the nation, representing more than 100 million Americans.[31]	One of the stated, public purposes of eValue8 is to collaborate with purchasers and health care providers to improve community health quality.	eValue8 prepares easy-to-compare performance reports that allow participants to assess health care vendors on a local, regional and national basis. With the resulting information, participating coalitions, purchasers, and plans will all be able to improve their management, administration, and/or delivery of health care services. Reports help: • Identify results-oriented health plans and networks • Designate "best in class" vendors • Determine health care consumer/employee education opportunities • Develop targeted strategies for improving results in future years • Inform rate negotiations and set performance guarantees	

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

Purchaser	Program Description	Purchaser Provider Collaboration	Program Design	Measure Characteristics
The Alliance	The Alliance, a not-for-profit cooperative of 160 ERISA employers and insurance trusts, holds managed care contracts with 47 hospitals and over 8.500 licensed practitioners in WI, IA, and IL. Collectively their members purchase $450 million worth of health care services annually.[32]	The Alliance has a gain sharing program with its contracted hospital that allows it to track readmissions and provide reward payments based on improved performance.	The Alliance contracts directly with hospitals in Wisconsin on behalf of their purchaser members. They pay out value-based methods of reward to hospitals for quality improvement and high achievement.	
The Alliance	The Alliance is a founding member and active participant of WHIO – the Wisconsin Health Information Organization. WHIO is a public-private, voluntary, nonprofit organization whose primary purpose is to aggregate, analyze, and disseminate health care data in a manner that supports the ongoing transition toward value-based health care purchase and delivery decisions. These data are used to inform patient and employer health care decision making, as well as assist in provider quality improvement efforts. Although The Alliance produces *QualityCounts*® reports on both in-patient and outpatient care, its members wanted information to compare the cost and quality of clinics and physicians. In order to measure care at this level, it needed a much larger pool of data to work with. That's why The Alliance, along with many other organizations, founded WHIO.[33]	The WHIO is a public-private collaboration between insurance companies, health care providers, major employers and public agencies. The data gathered through it is given back to the providers for quality improvement purposes.	With an unprecedented volume of data covering more than 233.5 million claims for care provided to 3.7 million Wisconsin residents, the WHIO Health Analytics Exchange is unique. It represents over 60% of the commercially insured Wisconsin market. The Exchange holds a rolling 27 months of claims data and a total of 21.5 million episodes of care are now found in the database. An episode of care is defined as the series of treatments and follow-up related to a single medical event such as a broken leg or heart surgery, or the year-long treatment of a diabetic patient. The Wisconsin Health Information Organization is composed of insurance companies, health care providers, major employers and public agencies.	Readmissions data is available through WHIO.

This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Readmissions Programs

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This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

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This table contains a convenience sample of public and private payer and purchaser initiatives to address readmissions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Medicare	**Section 5001(c) of Deficit Reduction Act of 2005** requires the Secretary to identify conditions that are: • high cost or high volume or both, • result in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis, and • could reasonably have been prevented through the application of evidence-based guidelines.[1]		The program involves a payment adjustment for healthcare-acquired conditions (HACs). On July 31, 2008, in the inpatient prospective payment system (IPPS) fiscal year (FY) 2009 final rule, CMS included 10 categories of conditions that were selected for the HAC payment provision.	The 10 categories of HACs include: • Foreign object retained after surgery, • Air embolism, • Blood incompatibility, • Stage III and IV pressure ulcers, • Falls and trauma, • Manifestations of poor glycemic control, • Catheter-associated urinary tract infection, • Vascular catheter-associated infection, • Surgical site infection following select procedures, • Deep vein thrombosis/pulmonary embolism following select procedures	• Pressure ulcers, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism
Medicare	**Affordable Care Act (ACA) Section 3008** states that beginning in FY 2015, hospitals scoring in the top quartile for the rate of HACs as compared to the national average will have their Medicare payments reduced by one percent for all DRGs. The applicable period for determination of the rates will be the fiscal year. In calculating the rates, the Secretary will establish and apply an appropriate risk-adjustment methodology. [2]		The program involves a payment adjustment for HACs.	The conditions included in this provision would be those already selected for the current HACs payment policy and any other conditions acquired during a hospital stay that the Secretary deems appropriate.	• Pressure ulcers, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, Venous thromboembolism

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Medicare	The **Medicare Modernization Act of 2003 (MMA)** under title 42 CFR Part 423, Subpart D, establishes the requirements that Part D sponsors must meet with regard to cost control and quality improvement including requirements for medication therapy management (MTM) programs. Amended by the Medication Therapy Management Empowerment Act of 2011. [3]	Requires a prescription drug plan (PDP) sponsor to offer any willing pharmacy in its network and any other qualified healthcare provider the opportunity to provide MTM services.	Requires the PDP sponsor to reimburse pharmacists and other qualified healthcare providers furnishing MTM services based on the resources used and the time required to provide such services.	Measures evaluate performance of pharmacies and other entities in furnishing MTM services; they do not directly measure impact on adverse drug events.	• Adverse drug events
Medicaid	ACA Section 2702 requires that Medicaid implement payment adjustments for HACs identified by Medicare.[4]		The program involves a payment adjustment for the 10 HACs in the Medicare payment policy.	The 10 categories of HACs include: • Foreign object retained after surgery, • Air embolism, • Blood incompatibility, • Stage III and IV pressure ulcers, • Falls and trauma, • Manifestations of poor glycemic control, • Catheter-associated urinary tract infection, • Vascular catheter-associated infection, • Surgical site infection following select procedures, Deep vein thrombosis/pulmonary embolism following select procedures	• Pressure ulcers, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Aetna	Aetna reviews inpatient claims to identify eight HACs and does not pay hospitals for additional inpatient days that directly result from the condition beyond the expected length of stay or that result in a preventable admission. Additionally, charges related to three never events and eight serious reportable events are not paid. [5]	Aetna's Quality Management Department reviews all identified never events and serious reportable events and follows up with individual facilities. If a never event or serious reportable event occurs, hospitals in the network must notify the plan and at least one designated patient safety organization. Facility representatives must identify root causes and identify changes to improve patient care systems and processes. Facility representatives must communicate with patients and their families when these events occur.	The program involves a payment adjustment for HACs. Aetna provides its members with information on its website on protecting themselves from medical error.	**HACs:** • Unintended retention of a foreign object in a patient after surgery or other procedure, • Hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products, • Failure to identify and treat hyperbilirubinemia in neonates, • A burn incurred from any source while being cared for in a healthcare facility, • Intravascular air embolism that occurs while being cared for in a healthcare facility, • Medication error, • A fall while being cared for in a healthcare facility, and • Deep vein thrombosis and/or pulmonary embolism following certain orthopedic procedures **Never Events:** • Surgery or invasive procedure performed on the wrong person, • Surgery or invasive procedure performed on the wrong side or body part, • Performance of the wrong surgical or invasive procedure **Serious Reportable Events:** • Unintended retention of a foreign object in a patient after surgery or another procedure, • Patient death or serious disability associated with a hemolytic	• Surgical site infections, • Adverse drug events, • Injuries from falls and immobility, • Venous thromboembolism

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
				reaction due to administration of incompatible blood or blood products, • Patient death or serious disability associated with an electric shock while being cared for in a health care facility, • Intraoperative or immediately post-operative death in an ASA Class I patient, • Patient death or serious disability associated with use of contaminated drugs, devices, or biologics provided by a health care facility, • Death or serious disability associated with failure to identify and treat hyperbilrubinemia in neonates, • Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances, • Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility	

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Aetna	The **Aexcel Specialist Designation** is awarded in the areas of: • cardiology, • cardiothoracic surgery, • gastroenterology, • general surgery, • neurology, • neurosurgery, • obstetrics and gynecology, • orthopedics, • otolaryngology/ENT, • plastic surgery, • urology, and • vascular surgery.[6]	The program originated from discussions with large employer groups and patients who wanted to control rising costs and to have access to information about physicians. Aetna works with affected physicians before implementing the program.	Doctors who have met clinical performance criteria and, are efficient and statistically so, are Aexcel designated. Aetna is considering offering tiered insurance products of a sub-set of Aetna participating doctors, like Aexcel-designated specialists, who are identified based on a combination of clinical performance evaluation, efficiency measures and their utilization of a narrow network of hospitals.	**Adverse event rate**: Only clinically appropriate events are used in Aexcel measures. Data is obtained from medical, pharmacy, and lab claims as well as member and provider data. **Annual monitoring for members on persistent diuretics** is endorsed by NQF **Annual monitoring for members on persistent anticonvulsants** is endorsed by NQF	• Surgical site infections, • Ventilator-associated pneumonia, • Venous thromboembolism, • Adverse drug events
Aetna	**Prospective Reviews and Retrospective Reviews** aim to promote drug safety.[7]	Aetna developed physician drug information programs to help promote appropriate, cost-effective prescribing	**Prospective Review:** Aetna requires precertification of certain drugs to help encourage appropriate prescribing in accordance with generally acceptable guidelines. Drugs requiring precertification have a narrowly defined use and present		• Adverse drug events

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
		and drug therapies. Aetna helps providers identify a systematic plan for members who are at risk for an acute asthma attack and provide the appropriate intervention. Aetna developed a vital plan-specific utilization and financial information for providers through quarterly pharmacy utilization reports.	a greater possibility for inappropriate use. Criteria are based on FDA, manufacturer labeling and peer-reviewed medical information. **Retrospective Review:** Retrospective review of pharmacy claims: • Measure the quality and appropriateness of primary care physician prescribing based on accepted guidelines through formulary compliance reports. • Provide physician drug information programs to help promote appropriate, cost-effective prescribing and drug therapies. • Help providers identify asthmatic plan members who are at risk for an acute asthma attack and provide the appropriate intervention. • Provide vital plan-specific utilization and financial information through quarterly pharmacy utilization reports.		

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Aetna	**Concurrent drug utilization** review helps promote appropriate dispensing and use of drugs that is consistent with established pharmaceutical guidelines. Prescriptions filled at participating pharmacies are automatically screened against the member's available drug history. [8]	Prescriptions filled at participating pharmacies are automatically screened against the member's available drug history. System automatically screens the patient's history for possible adverse reactions.	Concurrent drug utilization review helps promote appropriate dispensing and use of drugs that is consistent with established pharmaceutical guidelines. The review checks for: • Too-early refill, • Exact duplicate, • Step-therapy, • Drug gender • Geriatric and pediatric minimum/maximum dosing, • Minimum and maximum dosing, • Formulary drug, • Duplicate therapy, • Drug/drug interaction, • Side effects, • Drug-to-disease interaction, • Drug-to-disease by proxy, • Underutilization, • Drug-pregnancy/lactation, • Drug allergy		• Adverse drug events
Aetna	The **Rx Check** analyzes members' prescription drug claims to help prevent adverse drug events. [9]	Aetna reaches out to physicians to alert them to a possible drug-to-drug interaction, duplication in drug therapy or other serious issues.	The **Rx Check** program uses a computer system to analyze members' prescription drug claims.		• Adverse drug events

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Anthem Blue Cross and Blue Shield	Anthem Blue Cross and Blue Shield's New Hampshire launched an e-prescribing program.[10]	Anthem offers physicians free access to e-prescribing software, a free mobile pocket PC, and a discounted wireless telecommunication plan to access real-time patient eligibility, formulary and medication history information.	Anthem Blue Cross and Blue Shield's **New Hampshire e-prescribing program** gives access to e-prescribing tools, including resources to improve wellness and educate members on healthy living, from nearly any device with an Internet connection.		• Adverse drug events
Blue Cross and Blue Shield of Alabama	**Alabama Hospital Quality Initiative (AHQI)** is a Blue Cross and Blue Shield of Alabama partnership with CareFusion MedMined Services, the Alabama Hospital Association and Alabama hospitals. [11]	Hospitals are able to share best practices and evaluate interventions. AHQI promotes nursing unit-level goal setting, defines best practices, and encourages transparency and data sharing. Clinicians are provided with real-time, hospital-wide information to provide opportunities for interventions.	The program uses technology that enables hospital-wide use of real-time monitoring of patient conditions to minimize the incidence and effects of HACs, and has reduced HACs among participating hospitals by more than 20 percent.	Hospitals must use the MedMined technology and must have 18 months of data collected to be eligible the infection prevention performance measurement. Eligible hospitals receive a rating based on infection prevention performance. Performance is based on electronically identified signs that indicate potential healthcare associated infections and how well the hospital performed compared to what their predicted performance was for five quarters of data. Performance is based on the Nosocomial Infection Marker (NIM) developed by CareFusion MedMined. A NIM is a statistically proven indicator of a potential hospital infection. NIM rates are predicted and used to categorize hospitals by comparing their observed and predicted NIM rates	• Pressure ulcers, • Surgical site infections, • Catheter-associated urinary tract infections

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross and Blue Shield of Kanas City	Blue Cross and Blue Shield of Kansas City (BCBSKC) **BagIt! Program** encourages patients taking multiple medications, including prescription and over-the-counter drugs and vitamins, to bring them to their next doctor's appointment for a comprehensive medication review.[12]	BCBSKC sends a mailing to members over age 18 listed as taking more than five medications. The letter includes information on the risks of taking multiple prescriptions and a bag to bring their drugs to their next doctor's appointment. A follow up mailing provides safe medication use information and encouraged members to tell their physicians of changes in their drug regimen.	The program aims to improve patient safety by ensuring that members' physicians have a complete medication list, giving them the opportunity to prevent adverse drug events and limit unnecessary prescriptions.		• Adverse drug events

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross and Blue Shield of North Carolina	The Blue Cross and Blue Shield of North Carolina (BCBSNC) **ePrescribe program** provides resources to physicians to help prevent adverse drug events.[13]	BCBSN identified 1,000 network physicians with high prescribing volumes and gave them a handheld PDA, wireless network hardware and a software license free of charge. Since the launch of the ePrescribe program, more than 1,000 physicians have enrolled, and generic drugs have accounted for 59 percent of electronic prescriptions. In addition, 29 percent of orders have been flagged for potential ADEs, and 2 percent have been halted and changed based on patient allergy alerts.	Using claims data, BCBSNC uploaded members' medical information into each physician's e-prescribing system. The technology provides point-of-service access to formulary benefits and generic alternatives, as well as alerts regarding potential adverse drug events such as drug interactions and allergic reactions.		• Adverse drug events
Blue Cross and Blue Shield of Rhode Island	Blue Cross & Blue Shield of Rhode Island's (BCBSRI) **Polypharmacy Program** provided information to physicians to help prevent adverse drug events. [14]	The program targeted physicians of members taking prescription drugs in at least 10 medication classes and having three or more prescribers in a three-month period to reduce duplication and the risk of interactions.	Through the program, 1,419 providers received mailings identifying 3,267 eligible members, and 475 providers requested member profiles covering 2,230 individuals. The program does not apply to HIV, chemotherapy drugs and anti-neoplastics, antibiotics or immunosuppressants.		• Adverse drug events

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross Blue Shield Association	All 39 independent Blue Cross and Blue Shield companies established a payment policy that prohibits reimbursement to contracted acute care hospitals for HACs or "never events" – serious events or medical errors that are clearly identifiable and preventable. This is a Blue System-wide policy regarding never events for all commercial and Medicare Advantage business.[15]		Blue Cross and Blue Shield companies will not reimburse for surgery performed on the wrong patient, a wrong body part or for a wrong procedure. Blue companies also will assure that acute care hospitals in Blue networks must hold the member harmless for any charges associated with never events	The 10 categories of HACs include: • Foreign Object Retained After Surgery • Air Embolism • Blood Incompatibility • Stage III and IV Pressure Ulcers • Falls and Trauma • Manifestations of Poor Glycemic Control • Catheter-Associated Urinary Tract Infection • Vascular Catheter-Associated Infection • Surgical Site Infection Following Select Procedures • Deep Vein Thrombosis/Pulmonary Embolism following Select Procedures	• Pressure ulcers stages III & IV, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism
Blue Cross Blue Shield Association	The **Blue Patient Safety Toolkits** are online and printed resources for local network providers.[16]	BCBS developed toolkits for the 39 BCBS companies to share with local network providers.	Toolkit resources include the Blue Surgical Safety Checklist and the CLABSI checklist.		• Surgical site infections, • Central line associated blood stream infections
Blue Cross Blue Shield Association	**Blue Distinction** is a designation awarded to medical facilities. [17]	Measures are established with expert recommendations. For each specialty area, BCBS reviewed nationally established measures and gathered input from expert physicians and medical organizations.	The designation is awarded in the areas of bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery and transplants.		• Surgical site infections

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross Blue Shield Association	Several plans include a standard drug utilization review program that integrates prospective, concurrent and retrospective analysis to enhance the safety, appropriateness, and cost effective use of pharmaceuticals. Prospective review encourages selection of a cost-effective, therapeutically efficacious medication at the point of prescribing. Retrospective review uses drug utilization data gathered from databases to target patients, physicians, and pharmacists, who are non-compliant with formulary and other clinical programs. [18]	On-line systems provide pharmacists with concurrent review capabilities referencing member pharmacy claims history and indicating potential drug interaction information and formulary therapeutic recommendations.	Drug utilization review program		• Adverse drug events
Blue Cross Blue Shield of MA	The **Alternative Quality Contract (AQC**) is a global payment model that uses a budget-based methodology, which combines a fixed per-patient payment (adjusted annually for health status and inflation) with substantial performance incentive payments (tied to the latest nationally accepted measures of quality, effectiveness, and patient experience).[19]	BCBSMA worked closely with providers to restructure the traditional fee-for-service payment system. The AQC rewards high-performing providers.	The program involves a global payment, payment for coordination, and physician pay-for-performance.	Performance measures used for the performance incentives are drawn from nationally accepted measure sets, recognized as clinically important, and are shown to be stable and reliable.	• Adverse drug events, • Surgical site infections, • Ventilator associated pneumonia, • Venous thromboembolism, • Obstetrical adverse event

This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross Blue Shield of MA	BCBSMA is a member of the **eRx Collaborative.** [20]	The eRx Collaborative was formed in 2003 between Blue Cross Blue Shield of Massachusetts, Tufts Health Plan and Neighborhood Health Plan with a goal to promote electronic prescribing in Massachusetts as a way to increase safety, affordability and quality in the delivery of health care.	The eRx Collaborative promotes e-prescribing by subsidizing physicians' adoption costs. BCBSMA also has an incentive program to encourage providers to obtain and use the technology.		• Adverse drug events
Blue Cross Blue Shield of MA	Blue Cross and Blue Shield of Massachusetts's (BCBSMA) **Hospital Performance Incentive Program (HPIP**) is designed to link payment to performance on a set of nationally recognized quality indicators.[21]	BCBSMA worked closely with providers to restructure the traditional fee-for-service payment system. The HPIP rewards high-performing providers.	Hospitals receive payment for performance as well as for improvement. BCBSMA requires hospitals to implement and utilize computerized physician order entry as part of the criteria for participating in quality and incentive programs after 2012.	Quality indicators involve clinical outcomes, clinical processes, patient experience and hospital governance.	• Adverse drug events

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Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross Blue Shield of Michigan	Blue Cross Blue Shield of Michigan has provided two five year $6 million grants to the **Michigan Health and Hospital Association (MHA)** to support the MHA Keystone Center. From 2004-2009, the rate of CLASBIs in hospitals participating in the Keystone Center fell from 2.5 per 1,000 central line days to 0.86 per 1,000 days. From 2008 to 2010, the rate of VAP has been reduced by 70 percent, to less than 1.5 per 1,000 ventilator days. Among hospitals participating in the CAUTI initiative, the rate of catheter use fell from 19 percent to 14 percent from 2007-2010. [22]	MHA is a collaborative effort among Michigan hospitals, along with state and national patient safety experts, to improve patient safety and reduce healthcare-acquired infections. Approximately 140 Michigan hospitals participate in Keystone Center activities. To date, the MHA Keystone Center has used the following tools to improve patient safety and quality of care: • A standardized checklist and toolkit for installing central lines in intensive care unit (ICU) patients to avoid CLABSI, • An oral care toolkit to reduce VAP, • Daily patient rounds to promote better communication between doctors and nurses about patients' health	In addition to the funding it provides directly to the MHA Keystone Center, BCBSM provides funding to hospitals, in the form of incentive payments, to participate in selected Keystone initiatives and achieve specific performance targets related to the Keystone activities.	CLABSI rate, VAP rate, Catheter use rate	• Central line associated blood stream infections, • Ventilator associated pneumonia, • Catheter-associated urinary tract infections, • Surgical site infections

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Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
		status, • Pre- and post-surgical briefings to ensure that each surgical team member is aware of all surgical plans and outcomes, in order to avoid errors and surgical site infections; • Empowerment of all surgical team members to encourage individuals to speak out if they see an error about to happen; • Evidence-based procedures to promote timely removal of nonessential catheters and appropriate care of necessary catheters to reduce CAUTIs.			

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Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Blue Cross Blue Shield of Michigan	The **Southeastern Michigan e-Prescribing Initiative (SEMI)** aims to accelerate the adoption of e-prescribing standards and technology. SEMI hopes to reduce medication errors and improve care quality, as well as reduce prescription drug costs. [23] Results to date include: • 3,000+ physicians enrolled, • More than 350,000 prescriptions transmitted monthly, and • Approximately 25,000 prescription changes per month resulting from warnings of potential adverse drug events such as drug-to-drug interactions and patient allergies	SEMI is a partnership between BCBS of Michigan, several large automakers and healthcare providers with support from regional pharmacies and data connectivity from RxHub and SureScripts.	SEMI subsidizes physician groups' implementation costs for e-prescribing and provides incentives for using the system. BCBSM offers a free two-year web solution for e-prescribing through the WebDENIS provider portal.		• Adverse drug events
Blue Cross Blue Shield of Texas	The **Educate Before You Medicate** program focuses on improving patient education and communication.[24]	Blue Cross Blue Shield of Texas is collaborating with the Dallas–Ft. Worth Hospital Council, the Dallas and Tarrant County Medical Societies, physicians, pharmacies, other insurers and organizations.	The program promotes medication safety to patients. The program emphasizes the importance for health care consumers to: •Know what medications they take and why (educate), •Be prepared to accurately communicate medication information to health care providers (communicate), •Carry a list of the medicine they take (participate).		• Adverse drug events

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Overview of Healthcare-Acquired Conditions Programs

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Blue Cross of California	The **Members-at-Risk Program** identifies members whose prescription utilization patterns may put them at risk for adverse drug events. The program targets members who appear to have a high utilization of medications or a lack of coordinated care among providers. [25]	The program aims to help physicians to monitor total drug therapy for members who see multiple providers, utilize the services of multiple pharmacies, or use many medications.	Member information is reviewed to prevent drug-related problems such as drug interactions, duplicate therapies, or drug overutilization.		• Adverse drug events
Blue Cross of California	The **Seniors-at-Risk Program** promotes the continuity and coordination of care for Blue Cross senior members with chronic diseases. [26]	Feedback is provided to treating physicians for members who may be at risk for adverse drug interactions.	Program objectives include monitoring pharmacy claims for evidence of polypharmacy.		• Adverse drug events
Blue Cross of California	The **Primary Care Physician Notification Program** works with primary care physicians to prevent adverse drug events and promote patient safety.[27]	Primary care physicians receive a list of their Blue Cross members who have chronic diseases and who are taking psychotropic medications prescribed by a psychiatrist.	The program provides information to primary care physicians.		• Adverse drug events
Blue Shield of California	The **California Healthcare-Associated Infection Prevention Initiative** was funded by Blue Shield of CA with the aim to use technology to reduce HACs. [28]	CHAIPI provides hospitals with tools and data as well as the opportunity to collaborate with other organizations across the state to implement best practices	CHAIPI uses a comprehensive technology services model to identify and track infection outbreaks. CHAIPI also tracks antibiotic resistance at the local and state levels, mines data to identify opportunities for intervention, and holds quarterly meetings with to share best practices.		• Central line associated blood stream infections, • Catheter-related urinary tract infections, • Ventilator-associated pneumonia, • Surgical site infections

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Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
CIGNA	CIGNA has both pay-for-performance initiatives and HAC payment limitations to promote better care. [29]	As part of the health plan's pay-for-performance initiative, hospitals can earn percentage increases in reimbursement for following standardized protocols to improve patient safety and reduce surgical site infections. Specific incentive amounts and measures are negotiated on a hospital-by-hospital basis. CIGNA requires hospitals to perform root cause analyses of never events and take action to reduce them in the future.	CIGNA may reduce payments to hospitals for services required to treat HACs that were not present upon admission. CIGNA does not pay facilities or health care practitioners for never events and patients must not be held financially responsible for them. Furthermore, CIGNA does not provide reimbursement to any services related to the never event.	• Catheter-associated urinary tract infections, • Mediastinitis after coronary artery bypass surgery, • Surgical site infections following orthopedic procedures, • Surgical site infections following bariatric surgery	• Surgical site infections, • Pressure ulcers, • Injuries from falls and immobility, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Venous thromboembolism
CIGNA	The **Concurrent Drug Utilization Review (CDUR)** allows pharmacist to check the patient's history before dispensing medication.[30]	CDUR identifies potential drug utilization issues and sends messages to the dispensing pharmacist to reduce patient risk of adverse drug events.	CDUR a point-of-sale, system based review process that screens incoming prescriptions for safety considerations prior to dispensing by comparing it to the patient's drug history and medical profile (self-reported and medical claims).		• Adverse drug events

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Overview of Healthcare-Acquired Conditions Programs

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Excellus Blue Cross Blue Shield	Excellus BlueCross BlueShield has provided a total of $7 million to 18 hospitals for initiatives to reduce HACs. From 2008-2011, the number of HACs, including urinary tract infections, CLABSI, and respiratory infections, declined by 17 percent among hospitals receiving funds from Excellus. This reduction translates into $6.3 million in savings for the hospitals. [31]	In 2010, quality improvement incentive payments were provided to 52 upstate NY hospitals. Payments are used to support hospitals' use of data mining technology to track and reduce infections in hospitals and in surrounding communities. The program also provides staff of participating hospitals with monthly web-based educational sessions on how to use the technology, and enables ongoing measurement of outcomes.	The program provides resources to the hospitals and uses a pay-for-performance approach.	The pay-for-performance approach includes benchmarks in the areas of clinical quality, patient safety, patient satisfaction, and hospital efficiency.	• Catheter-associated urinary tract infections, • Central line associated bloodstream infections
Highmark	The **QualityBLUE** hospital pay-for-performance program is a partnership with hospitals to improve patient care and safety. In 2010, the rate of CLABSI in hospitals participating in Highmark QualityBLUE was 0.96, compared to the national rate of 1.96 as reported by the CDC. From 2008-2010, the rate of MRSA infections in Highmark Quality Blue hospitals declined from 0.33 to 0.17. [32]	Highmark's infection prevention and quality improvement professionals are available for consultation, guidance, and support with patient safety efforts. Additionally, Highmark hosts an annual Best Practices Forum to share best practices and lessons learned.	A portion of hospitals' reimbursement depends on their performance in providing evidence-based services and reducing healthcare-associated infections. At first, Highmark rewarded hospitals for implementing evidence-based guidelines. Now to receive QualityBLUE reimbursements, hospitals must demonstrate progress in improving health outcomes.	The program includes benchmarks to improve surgical safety and indicators to reduce: • Surgical site infections, • Methicillin resistant Staphylococcus aureus (MRSA) infections, • Central line associated bloodstream infections, • Catheter-associated urinary tract infections, • Clostridium difficile infections, • Gram negative rod infections	• Surgical site infections, • Venous thromboembolism, • Central line associated bloodstream infections, • Catheter-associated urinary tract Infections

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Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Horizon Blue Cross Blue Shield of New Jersey	Horizon Blue Cross Blue Shield aims to improve patient safety through electronic medication history technology. [33]	The program provides physicians access to the SureScripts-RxHub, a third party network that, with patient consent, offers providers secure access to medication histories from retail pharmacies and pharmacy benefits managers.	Horizon Blue Cross Blue Shield has invested in installing electronic medication history technology in select network hospitals with the goal of improving patient safety.		• Adverse drug events
Humana	Humana uses the Centers for Medicare & Medicaid Services (CMS) policy for preventable conditions and the National Quality Forum (NQF) and Leapfrog Group's recommendations of "never event" reporting for commercial and Medicare contracts. [34]		Payment adjustment for HACs	The 10 categories of CMS HACs include: • Foreign object retained after surgery, • Air embolism, • Blood incompatibility, • Stage III and IV pressure ulcers, • Falls and trauma, • Manifestations of poor glycemic control, • Catheter-associated urinary tract infection, • Vascular catheter-associated infection, • Surgical site infection following select procedures, • Deep vein thrombosis/pulmonary embolism following select procedures Program also includes NQF serious reportable events	• Surgical site infections, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Pressure ulcers, • Injuries from falls or immobility, • Venous thromboembolism

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Overview of Healthcare-Acquired Conditions Programs

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Humana	**Medication Therapy Management** programs give information to members. [35]	The MTM program provides guidance to members who need specific medication and health interventions.	All eligible members receive a summary of drug use. Members with a higher risk of drug reactions are offered a personal consultation at no extra cost.		• Adverse drug events
Humana	The **RxMentor program** provides resources to members with the aim of reducing adverse drug events.[36]	Eligible members are provided one-on-one telephone consultations with a pharmacist.	Pharmacist consultations advise members of on their medications and help optimize their medication regimen to improve their overall health. RxMentor initial consultations consist of: • comprehensive medication review – including non-prescribed medications, • adherence, • medication safety, • over-the-counter medications, • optimal use of medication, • cost-savings opportunities, and • physician follow up, if applicable To stay eligible, members must meet these requirements each new plan year: multiple chronic disease conditions, fill a certain number of different Part D medications in a 90-day period, medication costs over $3,000 in a calendar year.		• Adverse Drug Events

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Overview of Healthcare-Acquired Conditions Programs

Payer	Program Description	Payer Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Humana	Concurrent and retrospective drug utilization reviews. [37]	Allows the pharmacist filling the per to review medication history or prescriptions at the point of service to check for potential problems, including: • drug interactions, • compliance issues, • excessive drug use, • therapeutic duplications, and • overutilization and early refills	Humana conducts concurrent and retroactive reviews of drug utilization.		• Adverse drug events
Independence Blue Cross	Independence Blue Cross is a member of the **Partnership for Patient Care.** [38]	The partnership grew out of the success of a collaboration called the Regional Medication Safety Program. The program used expertise from the Institute for Safe Medication Practices and ECRI Institute. A set of action goals and best practices were defined and tools to benchmark area hospitals' standing against those goals were developed. Hospitals work to close gaps and improve practices before a reassessment of the institution's progress.	IBC has a pay-for-performance program where hospitals select projects they are working on and those that demonstrate quantitative improvement receive financial support.	Benchmarks were developed to measure performance against goals.	• Adverse drug events

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Overview of Healthcare-Acquired Conditions Programs

Purchaser	Program Description	Purchaser Provider Collaboration	Program Design	Measure Characteristics	Partnership for Patients Area of Focus
Catalyst for Payment Reform (CPR)	The CPR health plan RFI coordinates purchaser signals and their "ask"— better organizing the private sector agenda for payment reform and providing a consistent set of expectations for the health plans that will be responsible for implementing such reforms. The RFI addresses many aspects of payment reform and contains a special module to assess health plan efforts that align with the Partnership for Patients. [39]	RFI includes value-based methods of payment (i.e., description of value-based component of payment reform program such as fee schedule adjustment, per diem/case rate/capitation increase or decrease, gain sharing, risk sharing, annual bonus, etc.)	Health plan RFI contract language that allows health care purchasers to query plans about their efforts to link payment to performance and quality improvement, using national standardized measures and goals such as the Partnership for Patients' areas of focus. CPR's RFI will be synched with NBCH's eValue8.	• Heart Attack (Acute Myocardial Infarction) • Heart Failure (HF) • Pneumonia (PNE) • Surgical Care Improvement Project (SCIP) • Mortality Measures • AHRQ PSI and Nursing Sensitive Care Measures • Inpatient Quality Indicator Measures • Cardiac Surgery Measure • Patients' Experience of Care • Stroke Care Measure • Nursing Sensitive Care Measure • Meaningful Use • Hospital-Acquired Conditions (HACs)	• Pressure ulcers, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism

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eValue8 (NBCH)	**eValue8**™, the nation's leading, evidence-based request for information (RFI) tool, is widely used by business health coalitions, their purchaser members, and national employers to assess and manage the quality of their health care vendors. In 2010, eValue8 was used by employers and coalitions to gather health care data from 64 health plans across the nation, representing more than 100 million Americans. [40]	One of the stated, public purposes of eValue8 is to collaborate with purchasers and health care providers to improve community health quality.	eValue8 prepares easy-to-compare performance reports that allow participants to assess health care vendors on a local, regional and national basis. With the resulting information, participating coalitions, purchasers, and plans will all be able to improve their management, administration, and/or delivery of health care services. Reports help: • identify results-oriented health plans and networks • designate "best in class" vendors • determine health care consumer/employee education opportunities • develop targeted strategies for improving results in future years • inform rate negotiations and set performance guarantees	The 10 categories of HACs include: • Foreign object retained after surgery, • Air embolism, • Blood incompatibility, • Stage III and IV pressure ulcers, • Falls and trauma, • Manifestations of poor glycemic control, • Catheter-associated urinary tract infection, • Vascular catheter-associated infection, • Surgical site infection following select procedures, • Deep vein thrombosis/pulmonary embolism following select procedures	• Pressure ulcers, • Catheter-associated urinary tract infections, • Central line associated blood stream infections, • Surgical site infections, • Injuries from falls and immobility, • Venous thromboembolism

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The Alliance	The Alliance, a not-for-profit cooperative of 160 ERISA employers and insurance trusts, holds managed care contracts with 47 hospitals and over 8.500 licensed practitioners in Wisconsin, Iowa, and Illinois. Collectively their members purchase $450 million worth of health care services annually. The Alliance uses Medicare logic to assign MS-DRG values when purchasing inpatient hospital care, which precludes payment for all of the HACs (as defined by CMS). [41]	The Alliance pays out an incentive "cost of living adjustment" payment to hospitals that perform well on the AHRQ patient safety indicators.	The Alliance contracts directly with hospitals in Wisconsin on behalf of their purchaser members. They pay out value-based methods of reward to hospitals for quality improvement and high achievement.	The 10 categories of HACs include: • Foreign object retained after surgery, • Air embolism, • Blood incompatibility, • Stage III and IV pressure ulcers, • Falls and trauma, • Manifestations of poor glycemic control, • Catheter-associated urinary tract infection, • Vascular catheter-associated infection, • Surgical site infection following select procedures, • Deep vein thrombosis/pulmonary embolism following select procedures AHRQ patient safety indicators	• Surgical site infections, • Adverse drug events, • Injuries from falls and immobility, • Venous thromboembolism, • Pressure ulcers, • Catheter-associated urinary tract infections, • Obstetrical adverse events, • Central line associated blood stream infections, • Ventilator associated pneumonia

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This table contains a convenience sample of public and private payer and purchaser initiatives to address healthcare-acquired conditions.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0019	Documentation of medication list in the outpatient record	Percentage of patients having a medication list in the medical record.	NCQA	ADE				
0020	Documentation of allergies and adverse reactions in the outpatient record	Percentage of patients 18 years and older who received at least 180-day supply of medication therapy for the selected therapeutic agent and who received annual monitoring for the therapeutic agent. Percentage of patients on ACE inhibitors or ARBs with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Percentage of patients on digoxin with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Percentage of patients on a diuretic with at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Percentage of patients on any anticonvulsant for phenytoin, phenobarbital, valproic acid or carbAMA/zepine with at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year. The sum of the four numerators divided by the sum of the five denominators.	NCQA	ADE				
0021	Therapeutic monitoring: Annual monitoring for patients on persistent medications	Percentage of patients having documentation of allergies and adverse reactions in the medical record.	NCQA	ADE				
0022	Drugs to be avoided in the elderly: a. Patients who receive at least one drug to be avoided, b. Patients who receive at least two different drugs to be avoided.	Percentage of patients ages 65 years and older who received at least one drug to be avoided in the elderly in the measurement year. Percentage of patients 65 years of age and older who received at least two different drugs to be avoided in the elderly in the measurement year.	NCQA	ADE			X	

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0419	Universal documentation and verification of current medications in the medical record	Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verified with the patient or authorized representative documented by the provider.	CMS	ADE				
0553	Care for older adults – medication review (COA)	Percentage of adults 65 years and older who had a medication review	NCQA	ADE			X	X
0554	Medication reconciliation post-discharge (MRP)	Percentage of discharges from January 1 to December 1 of the measurement year for patients 65 years of age and older for whom medications were reconciled on or within 30 days of discharge.	NCQA	ADE				
0646	Reconciled Medication List Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	AMA-PCPI	ADE				
0138	Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients	Percentage of intensive care unit patients with urinary catheter-associated urinary tract infections	CDC	CAUTI				
0453	Urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero	Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero.	CMS	CAUTI			X	

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0684	Percent of Residents with a Urinary Tract Infection (Long-Stay)	This measure updates CMS' current QM on Urinary Tract Infections in the nursing facility populations. It is based on MDS 3.0 data and measures the percentage of long-stay residents who have a urinary tract infection on the target MDS assessment (which may be an annual, quarterly, or significant change or correction assessment). In order to address seasonal variation, the proposed measure uses a 6-month average for the facility. Long-stay nursing facility residents are those whose stay in the facility is over 100 days. The measure is limited to the long-stay population because short-stay residents (those who are discharged within 100 days of admission) may have developed their urinary tract infections in the hospital rather than the nursing facility.	CMS	CAUTI				
0686	Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long-Stay)	This measure updates CMS' current QM on catheter insertions. It is based on data from Minimum Data Set (MDS) 3.0 assessments of long-stay nursing home residents (those whose stay is longer than 100 days). This measure captures the percentage of long-stay residents who have had an indwelling catheter in the last 7 days noted on the most recent MDS 3.0 assessment, which may be annual, quarterly, significant change or significant correction during the selected quarter (3-month period). Long-stay residents are those residents who have been in nursing care at least 100 days. The measure is restricted to this population, which has long-term care needs, rather than the short stay population who are discharged within 100 days of admission.	CMS	CAUTI				
	Catheter-Associated Urinary Tract Infection			CAUTI				
0139	Central line catheter-associated blood stream infection rate for ICU and high-risk nursery (HRN) patients	Percentage of ICU and high-risk nursery patients, who over a certain amount of days acquired a central line catheter-associated blood stream infections over a specified amount of line-days	CDC	CLABSI				

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0298	Central Line Bundle Compliance	Percentage of intensive care patients with central lines for whom all elements of the central line bundle are documented and in place. The central line bundle elements include: •Hand hygiene , •Maximal barrier precautions upon insertion •Chlorhexidine skin antisepsis •Optimal catheter site selection, with subclavian vein as the preferred site for non-tunneled catheters in patients 18 years and older •Daily review of line necessity with prompt removal of unnecessary lines	Institute for Healthcare Improvement	CLABSI	X			
0464	Anesthesiology and Critical Care: Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter (CVC) Insertion Protocol	Percentage of patients who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique (cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis) followed.	AMA-PCPI	CLABSI				
	Central Line Associated Bloodstream Infection (CLABSI)			CLABSI				
	Vascular Catheter-Associated Infections			CLABSI	X			

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0035	Fall risk management in older adults: (a) Discussing fall risk; (b) Managing fall risk	Percentage of patients aged 75 and older who reported that their doctor or other health provider talked with them about falling or problems with balance or walking. Percentage of patients aged 75 and older who reported that their doctor or other health provider had done anything to help prevent falls or treat problems with balance or walking	NCQA	Injury from Falls and Immobility				
0101	Falls: screening for fall risk	Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months	NCQA	Injury from Falls and Immobility				
0141	Patient Fall Rate	All documented falls, with or without injury, experienced by patients on an eligible unit in a calendar quarter.	ANA	Injury from Falls and Immobility				
0202	Falls with injury	All documented patient falls with an injury level of minor (2) or greater.	ANA	Injury from Falls and Immobility				
0203	Restraint prevalence (vest and limb only)	Total number of patients that have vest and/or limb restraint (upper or lower body or both) on the day of the prevalence study.	The Joint Commission	Injury from Falls and Immobility	X			
0266	Patient fall	Percentage of ASC admissions experiencing a fall in the ASC.	Ambulatory Surgical Center Quality Collaboration	Injury from Falls and Immobility	X			
0537	Multifactor fall risk assessment conducted in patients 65 and older	Percent of home health episodes in which the patient was 65 or older and was assessed for risk of falls (using a standardized and validated multi-factor Fall Risk Assessment) at start or resumption of home health care	CMS	Injury from Falls and Immobility			X	

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	CMS	Injury from Falls and Immobility				
0687	Percent of Residents Who Were Physically Restrained (Long Stay)	The measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents who were physically restrained. The measure reports the percentage of all long-stay residents in nursing facilities with an annual, quarterly, significant change, or significant correction MDS 3.0 assessment during the selected quarter (3-month period) who were physically restrained daily during the 7 days prior to the MDS assessment (which may be annual, quarterly, significant change, or significant correction MDS 3.0 assessment).	CMS	Injury from Falls and Immobility			X	
0697	Risk Adjusted Case Mix Adjusted Elderly Surgery Outcomes Measure	This is a hospital based, risk adjusted, case mix adjusted elderly surgery aggregate clinical outcomes measure of adults 65 years of age and older.	American College of Surgeons	Multiple: CAUTI, SSI, VTE	X			
0303	Late sepsis or meningitis in neonates (risk-adjusted)	Percentage of infants born at the hospital, whose birth weight is between 401 and 1500 grams OR whose gestational age is between 22 weeks 0 days and 29 weeks 6 days with late sepsis or meningitis with one or more of the following criteria: Bacterial Pathogen, Coagulase Negative Staphylococcus, Fungal Infection	Vermont Oxford Network	Obstetrical Adverse Events				
0304	Late sepsis or meningitis in very low birth weight (VLBW) neonates (risk-adjusted)	Percentage of infants born at the hospital, whose birth weight is between 401 and 1500 grams OR whose gestational age is between 22 weeks 0 days and 29 weeks 6 days, who have late sepsis or meningitis, with one or more of the following criteria: Bacterial Pathogen, Coagulase Negative Staphylococcus, Fungal Infection	Vermont Oxford Network	Obstetrical Adverse Events				
0474	Birth Trauma Rate: Injury to Neonates (PSI #17)	Percentage of neonates with specific birth trauma per 1000 births. Exclude infants with injury to skeleton and osteogenesis imperfecta, subdural or cerebral hemorrhage in preterm infant.	AHRQ	Obstetrical Adverse Events				

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Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0477	Under 1500g infant Not Delivered at Appropriate Level of Care	The number per 1,000 livebirths of <1500g infants delivered at hospitals not appropriate for that size infant.	California Maternal Quality Care Collaborative	Obstetrical Adverse Events				
0716	Healthy Term Newborn	Percent of term singleton livebirths (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care.	California Maternal Quality Care Collaborative	Obstetrical Adverse Events				
0201	Pressure ulcer prevalence	The total number of patients that have hospital-acquired (nosocomial) stage II or greater pressure ulcers on the day of the prevalence study.	The Joint Commission	Pressure Ulcers				
0337	Decubitus ulcer (PDI 2)	Percent of surgical and medical discharges under 18 years with ICD-9-CM code for decubitus ulcer in secondary diagnosis field.	AHRQ	Pressure Ulcers				
0538	Pressure ulcer prevention included in plan of care	Percent of patients with assessed risk for Pressure Ulcers whose physician-ordered plan of care includes intervention(s) to prevent them	CMS	Pressure Ulcers				X
0539	Pressure ulcer prevention plans implemented	Percent of patients with assessed risk for Pressure Ulcers for whom interventions for pressure ulcer prevention were implemented during their episode of care	CMS	Pressure Ulcers				X
0540	Pressure Ulcer Risk Assessment Conducted	Percent of patients who were assessed for risk of Pressure Ulcers at start/resumption of home health care	CMS	Pressure Ulcers				

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0678	Percent of Residents with Pressure Ulcers That Are New or Worsened (Short-Stay)	This measure updates Centers for Medicare & Medicaid Services ' current QM pressure ulcer measure which currently includes Stage 1 ulcers. The measure is based on data from the MDS 3.0 assessment of short-stay nursing facility residents and reports the percentage of residents who have Stage 2-4 pressure ulcers that are new or have worsened. The measure is calculated by comparing the Stage 2-4 pressure ulcer items on the discharge assessment and the previous MDS assessment (which may be an OBRA admission or 5-day PPS assessment).The quality measure is restricted to the short-stay population defined as those who are discharged within 100 days of admission. The quality measure does not include the long-stay residents who have been in the nursing facility for longer than 100 days. A separate measure has been submitted for them.	CMS	Pressure Ulcers				
0679	Percent of High Risk Residents with Pressure Ulcers (Long Stay)	CMS currently has this measure in their QMs but it is based on data from MDS 2.0 assessments and it includes Stage 1 ulcers. This proposed measure will be based on data from MDS 3.0 assessments of long-stay nursing facility residents and will exclude Stage 1 ulcers from the definition. The measure reports the percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s). High risk populations are those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition. Long-stay residents are those who have been in nursing facility care for more than 100 days. This measure is restricted to the population that has long-term needs; a separate pressure ulcer measure is being submitted for short-stay populations. These are defined as having a stay that ends with a discharge within the first 100 days.	CMS	Pressure Ulcers				
	Pressure Ulcer Stages III and IV			Pressure Ulcers				
0171	Acute care hospitalization (risk-adjusted)	Percentage of patients who had to be admitted to the hospital.	CMS	Readmissions				

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Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0212	Proportion with more than one hospitalization in the last 30 days of life	Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life	NCI	Readmissions			X	
0329	All-Cause Readmission Index (risk adjusted)	Overall inpatient 30-day hospital readmission rate.	United Health Group	Readmissions				
0330	Hospital 30-day, all-cause, risk-standardized readmission rate following heart failure hospitalization	The measure estimates a hospital 30-day risk-standardized readmission rate (RSRR), defined as readmission for any cause within 30 days after the date of discharge of the index admission for patients discharged from the hospital with a principal diagnosis of heart failure (HF).	CMS	Readmissions				
0335	PICU unplanned readmission rate	The total number of patients requiring unscheduled readmission to the ICU within 24 hours of discharge or transfer.	National Association of Children's Hospitals and Related Institutions	Readmissions				
0336	Review of unplanned PICU readmissions	Periodic clinical review of unplanned readmissions to the PICU that occurred within 24 hours of discharge or transfer from the PICU.	National Association of Children's Hospitals and Related Institutions	Readmissions		X		
0505	Thirty-day all-cause risk standardized readmission rate following acute myocardial infarction (AMI) hospitalization.	Hospital-specific 30-day all-cause risk standardized readmission rate following hospitalization for AMI among Medicare beneficiaries aged 65 years or older at the time of index hospitalization.	CMS	Readmissions		X		

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
506	Thirty-day all-cause risk standardized readmission rate following pneumonia hospitalization.	Hospital-specific 30-day all-cause risk standardized readmission rate following hospitalization for pneumonia among Medicare beneficiaries aged 65 years or older at the time of index hospitalization	CMS	Readmissions		X		
0695	Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)	This measure estimates hospital risk-standardized 30-day readmission rates following PCI in patients at least 65 years of age. As PCI patients may be readmitted electively for staged revascularization procedures, we will exclude such elective readmissions from the measure. The measure uses clinical data available in the National Cardiovascular Disease Registry (NCDR) CathPCI Registry for risk adjustment that has been linked with the administrative claims data used to identify readmissions.	CMS	Readmissions		X		
0698	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase I project's call for measures (ED and E&M) or is already approved by NQF (readmissions). Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.	CMS	Readmissions		X		

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Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0699	30-Day Post-Hospital HF Discharge Care Transition Composite Measure	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase I project's call for measures (ED and E&M) or is already approved by NQF (readmissions). Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.	CMS	Readmissions	X			
0699	30-Day Post-Hospital HF Discharge Care Transition Composite Measure	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase I project's call for measures (ED and E&M) or is already approved by NQF (readmissions). Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.	CMS	Readmissions				
	Heart Failure 30 day readmission Rate			Readmissions				

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Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0125	Timing of antibiotic prophylaxis for cardiac surgery patients	Percent of patients aged 18 years and older undergoing cardiac surgery who received prophylactic antibiotics within one hour of surgical incision or start of procedure if no incision was required (two hours if receiving vancomycin or fluoroquinolone)	Society of Thoracic Surgeons	SSI				
0126	Selection of antibiotic prophylaxis for cardiac surgery patients	Percent of patients aged 18 years and older undergoing cardiac surgery who received preoperative prophylactic antibiotics recommended for the operation.	Society of Thoracic Surgeons	SSI				
0128	Duration of prophylaxis for cardiac surgery patients	Percent of patients aged 18 years and older undergoing cardiac surgery whose prophylactic antibiotics were discontinued within 48 hours after surgery end time	Society of Thoracic Surgeons	SSI				
0130	Deep sternal wound infection rate	Percent of patients aged 18 years and older undergoing isolated CABG who, within 30 days postoperatively, develop deep sternal wound infection involving muscle, bone, and/or mediastinum requiring operative intervention	Society of Thoracic Surgeons	SSI				
0178	Improvement in status of surgical wounds	Percentage of patients whose wounds improved or healed after an operation	CMS	SSI				
200	Death among surgical inpatients with treatable serious complications (failure to rescue)	Percentage of surgical inpatients with complications of care whose status is death	AHRQ	SSI				
0264	Prophylactic intravenous (IV) antibiotic timing	Rate of ASC patients who received IV antibiotics ordered for surgical site infection prophylaxis on time	Ambulatory Surgical Center Quality Collaboration	SSI				

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Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0268	Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis	AMA-PCPI	SSI				
0269	Timing of prophylactic antibiotics - administering physician	Percentage of surgical patients aged > 18 years with indications for prophylactic parenteral antibiotics for whom administration of the antibiotic has been initiated within one hour (if vancomycin, two hours) prior to the surgical incision or start of procedure when no incision is required.	AMA-PCPI	SSI				
0270	Timing of antibiotic prophylaxis: ordering physician	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required)	AMA-PCPI	SSI				
0271	Discontinuation of prophylactic antibiotics (non-cardiac procedures)	Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time	AMA-PCPI	SSI	X			
0299	Surgical Site Infection Rate	Percentage of surgical site infections occurring within thirty days after the operative procedure if no implant is left in place or with one year if an implant is in place in patients who had an NHSN operative procedure performed during a specified time period and the infection appears to be related to the operative procedure.	CDC	SSI	X			
0301	Surgery patients with appropriate hair removal	Percentage of surgery patients with surgical hair site removal with clippers or depilatory or no surgical site hair removal.	CMS	SSI	X			

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Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0452	Surgery Patients with Perioperative Temperature Management	Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom either active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 30 minutes immediately after anesthesia end time	CMS	SSI	X			
0515	Ambulatory surgery patients with appropriate method of hair removal	Percentage of ASC admissions with appropriate surgical site hair removal.	Ambulatory Surgical Centers Quality Collaborative	SSI	X			
0527	Prophylactic antibiotic received within 1 hour prior to surgical incision SCIP-Inf-2	Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.	CMS	SSI	X			
0528	Prophylactic antibiotic selection for surgical patients	Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).	CMS	SSI	X			
0529	Prophylactic antibiotics discontinued within 24 hours after surgery end time	Surgical patients whose prophylactic antibiotics were discontinued within 24 hours after Anesthesia End Time (48 hours for CABG or Other Cardiac Surgery). The Society of Thoracic Surgeons (STS) Practice Guideline for Antibiotic Prophylaxis in Cardiac Surgery (2006) indicates that there is no reason to extend antibiotics beyond 48 hours for cardiac surgery and very explicitly states that antibiotics should not be extended beyond 48 hours even with tubes and drains in place for cardiac surgery.	CMS	SSI	X			
0534	Hospital specific risk-adjusted measure of mortality or one or more major complications within 30 days of a lower extremity bypass.	Hospital specific risk-adjusted measure of mortality or one or more of the following major complications (cardiac arrest, myocardial infarction, CVA/stroke, on ventilator >48 hours, acute renal failure (requiring dialysis), bleeding/transfusions, graft/prosthesis/flap failure, septic shock, sepsis, and organ space surgical site infection), within 30 days of a lower extremity bypass (LEB) in patients age 16 and older.	CMS	SSI				

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Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0637	Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time.	AMA-PCPI	SSI			X	
0696	The STS CABG Composite Score	This multidimensional performance measure is comprised of four domains consisting of 11 individual NQF-endorsed cardiac surgery metrics: (1) Operative Care--use of the internal mammary artery; (2) Perioperative Medical Care (use of preoperative beta blockade; discharge beta blockade, antiplatelet agents, and lipid-lowering agents--an "all-or-none" measure); (3) Risk-adjusted Operative Mortality; and (4) Risk-Adjusted Postoperative Morbidity (occurrence of postoperative stroke, renal failure, prolonged ventilation, re-exploration, or deep sternal wound infection--an "any-or-none" measure). All measures are based on audited clinical data collected in a prospective registry and are risk-adjusted (with the exception of internal mammary artery use and the four perioperative medications). Based on their percentage scores, a 1 (below average), 2 (average), or 3 (above average) star rating is provided for each STS database participant for each performance domain and overall. Furthermore, the composite score is also deconstructed into its components to facilitate performance improvement activities by providers. This scoring methodology has now been implemented for over two years and has become for many stakeholders the preferred method of evaluating cardiac surgery performance. STS plans to make this report publicly available in the near future. (Additional materials are available upon request)		SSI			X	
	Foreign Object Retained After Surgery			SSI				X
0140	Ventilator-associated pneumonia for ICU and high-risk nursery (HRN) patients	Percentage of ICU and HRN patients who over a certain amount of days have ventilator-associated pneumonia.	CDC	VAP				

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Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0302	Ventilator Bundle	Percentage of intensive care unit patients on mechanical ventilation at time of survey for whom all four elements of the ventilator bundle are documented and in place. The ventilator bundle elements are: •Head of bed (HOB) elevation 30 degrees or greater (unless medically contraindicated); noted on 2 different shifts within a 24 hour period •Daily “”sedation interruption” and daily assessment of readiness to extubate; process includes interrupting sedation until patient follow commands and patient is assessed for discontinuation of mechanical ventilation; Parameters of discontinuation include: resolution of reason for intubation; inspired oxygen content roughly 40%; assessment of patients ability to defend airway after extubation due to heavy sedation; minute ventilation less than equal to 15 liters/minute; and respiratory rate/tidal volume less than or equal to 105/min/L(RR/TV< 105) •SUD (peptic ulcer disease) prophylaxis •DVT (deep venous thrombosis) prophylaxis	Institute for Healthcare Improvement	VAP	X			
0217	Surgery Patients with Recommended Venous Thromboembolism (VTE) Prophylaxis Ordered	Percentage of surgery patients with recommended Venous Thromboembolism (VTE) Prophylaxis ordered during admission	CMS	VTE				
0218	Surgery Patients Who Received Appropriate Venous Thromboembolism (VTE) Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery End Time	Percentage of surgery patients who received appropriate Venous Thromboembolism (VTE) Prophylaxis within 24 hours prior to surgery to 24 hours after surgery end time	CMS	VTE				

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0239	Venous Thromboembolism (VTE) Prophylaxis	Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	AMA-PCPI	VTE				
0371	Venous Thromboembolism (VTE) Prophylaxis	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.	The Joint Commission	VTE				X
0372	Intensive care unit (ICU) VTE prophylaxis	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).	The Joint Commission	VTE				
0373	VTE Patients with Overlap of Anticoagulation Therapy	This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [sub cu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) = 2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications.	The Joint Commission	VTE				

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0374	VTE Patients Unfractionated Heparin (UFH) Dosages/Platelet Count Monitoring by Protocol (or Nomogram) Receiving Unfraction-ated Heparin (UFH) with Dosages/ Platelet Count Monitored by Protocol (or Nomogram)	This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.	The Joint Commission	VTE				
0375	VTE discharge instructions	This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health or home hospice on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.	The Joint Commission	VTE				
0376	Incidence of potentially preventable VTE	This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	The Joint Commission	VTE	X			
0434	Deep vein thrombosis (DVT) prophylaxis	Patients with an ischemic stroke or a hemorrhagic stroke and who are non-ambulatory should start receiving DVT prophylaxis by end of hospital day two.	The Joint Commission	VTE	X			
0450	Postoperative DVT or PE (PSI 12)	Percent of adult surgical discharges with a secondary diagnosis code of deep vein thrombosis or pulmonary embolism	AHRQ	VTE				
0503	Anticoagulation for acute pulmonary embolus patients	Anticoagulation ordered for acute pulmonary embolus patients.	American College of Emergency Physicians	VTE				

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
	STK-2 Discharged on Antithromboembolism Therapy			VTE	X			
	STK-1 Venous Thromboembolism Prophylaxis			VTE	X			
0353	Failure to Rescue 30-Day Mortality (risk adjusted)	Percentage of patients who died with a complication within 30 days from admission.	The Children´s Hospital of Philadelphia	Multiple: Pressure Ulcers, SSI, VTE	X			
0531	Patient Safety for Selected Indicator	A composite measure of potentially preventable adverse events for selected indicators	AHRQ	Multiple: Pressure Ulcers, SSI, VTE	X			
0532	Pediatric Patient Safety for Selected Indicators	Number of potentially preventable adverse events	AHRQ	Multiple: Pressure Ulcers, SSI, VTE			X	
0706	Risk Adjusted Colorectal Surgery Outcome Measure	This is a hospital based, risk adjusted, case mix adjusted morbidity and mortality aggregate outcome measure of adults 18+ years undergoing colorectal surgery.	American College of Surgeon	Multiple: ADE, CAUTI, Injury from Falls and Immobility, Pressure Ulcers, Readmissions, VTE				
0704	Proportion of Patients Hospitalized with AMI that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Percent of adult population aged 18 – 65 years who were admitted to a hospital with acute myocardial infarction (AMI), were followed for one-month after discharge, and had one or more potentially avoidable complications (PACs). PACs may occur during the index stay or during the 30-day post discharge period.	Bridges to Excellence	Multiple: ADE, CAUTI, Injury from Falls and Immobility, Pressure Ulcers, Readmissions, VTE	X			

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0705	Proportion of Patients Hospitalized with Stroke that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period)	Percent of adult population aged 18 – 65 years who were admitted to a hospital with stroke, were followed for one-month after discharge, and had one or more potentially avoidable complications (PACs). PACs may occur during the index stay or during the 30-day post discharge period.	Bridges to Excellence	Multiple: ADE, CAUTI, Injury from Falls and Immobility, Pressure Ulcers, Readmissions, VTE	X			
0166	HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems Survey			Multiple: ADE, Readmissions	X			
0555	Monthly INR monitoring for beneficiaries on warfarin	Average percentage of monthly intervals in which Part D beneficiaries with claims for warfarin do not receive an INR test during the measurement period	CMS	Multiple: ADE, VTE			X	
0556	INR for beneficiaries taking warfarin and interacting anti-infective medications	Percentage of episodes with an INR test performed 3 to 7 days after a newly-started interacting anti-infective medication for Part D beneficiaries receiving warfarin	CMS	Multiple: ADE, VTE				
0581	Deep Vein Thrombosis Anticoagulation >= 3 Months	This measure identifies patients with deep vein thrombosis (DVT) on anticoagulation for at least 3 months after the diagnosis	Resolution Health, Inc.	Multiple: ADE, VTE				
0586	Warfarin - PT/ INR Test	This measure identifies the percentage of patients taking warfarin during the measurement year who had at least one PT/INR test within 30 days after the first warfarin prescription in the measurement year	Resolution Health, Inc.	Multiple: ADE, VTE				

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0593	Pulmonary Embolism Anticoagulation >= 3 Months	This measure identifies patients with pulmonary embolism (PE) on anticoagulation for at least 3 months after the diagnosis.	Resolution Health, Inc.	Multiple: ADE, VTE				
0612	Warfarin - INR Monitoring	Percentage of patients taking warfarin with PT/INR monitoring	ActiveHealth Management	Multiple: ADE, VTE				
0708	Proportion of Patients Hospitalized with Pneumonia that have a Potentially Avoidable Complication (during the Index Stay or in the 30-day Post-Discharge Period	Percent of adult population aged 18 – 65 years who were admitted to a hospital with Pneumonia, were followed for one-month after discharge, and had one or more potentially avoidable complications (PACs). PACs may occur during the index stay or during the 30-day post discharge period.	Bridges To Excellence	Multiple: CAUTI, CLABSI, Pressure Ulcer, SSI, VTE	X			
0709	Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year	Percent of adult population aged 18 – 65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs).	Bridges To Excellence	Multiple: CAUTI, CLABSI, Pressure Ulcer, SSI, VTE				
0472	Prophylactic antibiotic received within one hour prior to surgical incision or at the time of delivery – cesarean section	Percentage of patients undergoing cesarean section who receive prophylactic antibiotics within one hour prior to surgical incision or at the time of delivery.	MGH/Partners Health Care System	Multiple: Obstetrical Adverse Events, SSI	X			
0473	Appropriate DVT prophylaxis in women undergoing cesarean delivery	Measure adherence to current ACOG, ACCP recommendations for use of DVT prophylaxis in women undergoing cesarean delivery	Hospital Corporation of America	Multiple: Obstetrical Adverse Events, VTE	X			

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Healthcare-Acquired Condition (HAC) and Readmissions Measures Table

NQF #	Title	Description	Steward	Partnership for Patients Area of Focus	Hospital Compare	Nursing Home Compare	PQRS	ACO (Proposed)
0352	Failure to Rescue In-Hospital Mortality (risk adjusted)	Percentage of patients who died with a complication in the hospital.	The Children´s Hospital of Philadelphia	Multiple: Pressure Ulcers, SSI, VTE	X			
0351	Death among surgical inpatients with serious, treatable complications (PSI 4)	Percentage of cases having developed specified complications of care with an in-hospital death.	AHRQ	Multiple: VAP, VTE	X			X

Partnership for Patients Abbreviation Key
ADE: Adverse Drug Events
CAUTI: Catheter-Associated Urinary Tract Infections
CLABSI: Central Line Associated Blood Stream Infections
SSI: Surgical Site Infections
VTE: Venous Thromboembolism
VAP: Ventilator-Associated Pneumonia

This table contains NQF-Endorsed®, Hospital Compare, Nursing Home Compare, PQRS and ACO HACs and readmissions measures.

Dual Eligible Beneficiaries Workgroup

Tab 3

kaiser commission on MEDICAID FACTS

medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

December 2010

Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries

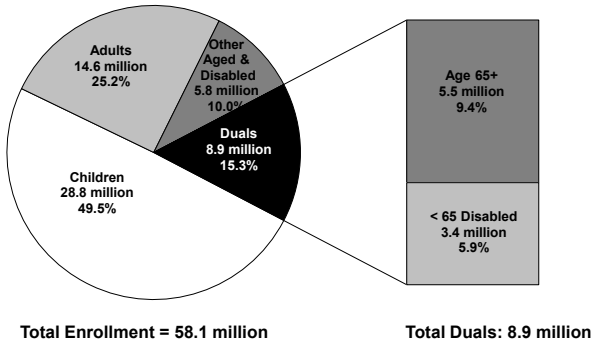
Nearly 9 million Medicaid beneficiaries are "dual eligibles" – low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs. Dual eligibles are among the sickest and poorest individuals covered by either the Medicaid or Medicare programs. They must navigate both Medicare and Medicaid to access services, and rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as long-term care. Because dual eligibles have significant medical needs and a much higher per capita cost than other beneficiaries, they are of great interest to both Medicare and Medicaid policymakers and to the state and federal governments that fund and manage the programs.

Who Are Dual Eligibles?

Dual eligibles account for 15% of Medicaid enrollees. About six in ten dual eligibles (5.5 million) were individuals age 65 and over, and more than a third (3.4 million) were younger persons with disabilities. (Figure 1) Most dual eligibles have very low-incomes: 55% have annual income below $10,000 compared to 6% of all other Medicare beneficiaries. Most dual eligibles have substantial health needs: half are in fair or poor health, more than twice the rate of others on Medicare. Dual eligibles are also more likely to have mental health needs and to live in nursing homes compared to other Medicare beneficiaries. (Figure 2)

Figure 1

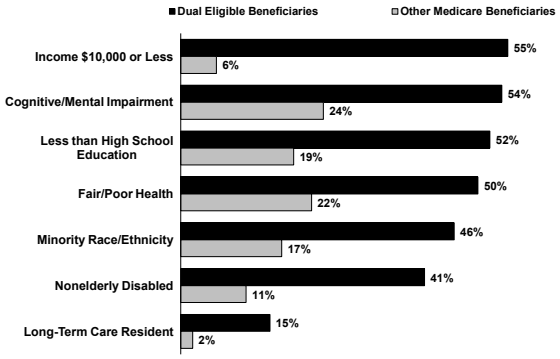
Medicaid Enrollment, FFY 2007



Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

Figure 2

Comparison of Dual Eligible and Other Medicare Beneficiaries, 2008



SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2008 Access to Care File.

How Do Dual Eligibles Qualify for Medicaid?

Medicare beneficiaries who have low incomes and limited assets can obtain Medicaid coverage through different eligibility "pathways," and the kind of assistance that Medicaid provides varies accordingly. Most dual eligibles qualify for Supplemental Security Income (SSI) cash assistance – generally 75% of the FPL for individuals – or have exhausted their resources paying for health and long-term care (sometimes known as "medically needy" or "spend-down"). These individuals receive assistance with Medicare premiums and cost sharing and coverage of Medicaid benefits. While some protections exist for spouses, those who spend down to receive assistance with nursing home care must apply all of their income, except for a small personal needs allowance, toward the costs of their care and assets must be below $2,000 for an individual and $3,000 for a couple in most states.

For Medicare beneficiaries with income or resources just above the federal poverty level, Medicaid's assistance is more limited, primarily covering Medicare premiums. This assistance is referred to as "Medicare Savings Programs." Qualified Medicare beneficiaries (QMBs) have incomes up to the poverty line (with assets up to $6,600 for an individual and $9,910 for a couple) and receive help with Medicare premium and cost sharing obligations. Specified Low-Income Beneficiaries (SLMBs) have slightly higher incomes (100-120% of FPL) and receive help with Medicare premiums only.

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What Services Does Medicaid Provide for Duals?

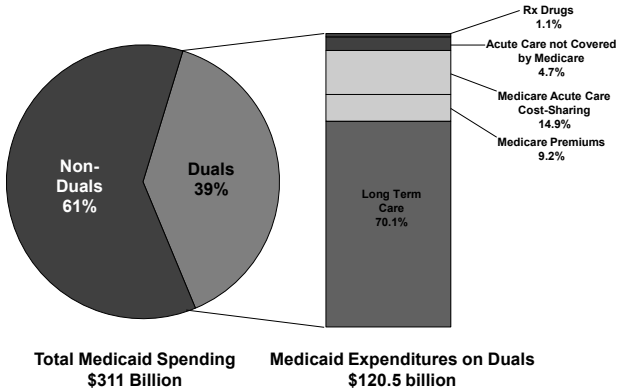
For 21% of Medicare beneficiaries, Medicaid fills in the gaps in Medicare coverage. For those who qualify, Medicaid pays the Medicare Part B premium (Medicare part B premiums are $96.40/month for most beneficiaries in 2010); pays the cost sharing charged for many Medicare services; and covers a range of benefits not covered by Medicare such as long-term care, dental care, and eyeglasses. The majority of dual eligibles (6.9 million) receive full Medicaid benefits and assistance with Medicare premiums and cost-sharing. The remaining dual eligibles (2.0 million) receive assistance only with their Medicare premiums and cost-sharing. Most dual eligibles, whether eligible for full or partial Medicaid benefits, have very low incomes and significant health care needs.

Medicaid Spending for Dual Eligibles

Dual eligibles account for a large share (39%) of total Medicaid spending, although they represent just 15 percent of Medicaid enrollment. In 2007, more than two-thirds (70%) of Medicaid expenditures for dual eligibles were for long-term care services; payments for cost sharing on Medicare-covered services accounted for about 15 percent; payment of Medicare premiums accounted for 9 percent of spending; and an additional 5 percent were for other acute services that Medicare does not cover. (Figure 3) Prescription drug spending accounted for just 1 percent of Medicaid spending on dual eligibles. In 2006 prescription drug spending for the duals was absorbed into Medicare Part D, but states are still required to make a contribution towards this benefit. States' spending on duals varies, and is largely determined by the mix of institutional versus home and community based long-term care, and the share of duals who are receiving full versus partial Medicaid benefits.

Figure 3

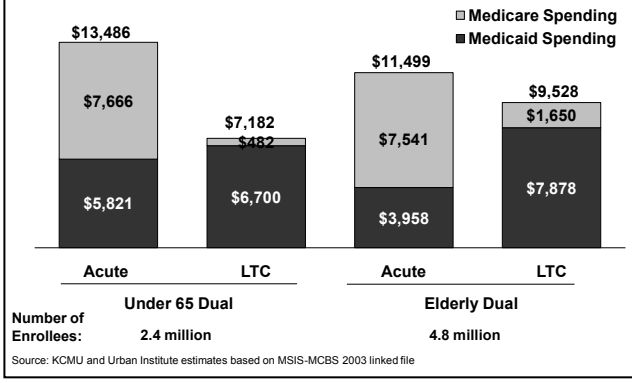
Medicaid Spending on Dual Eligibles, FFY 2007



Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

Figure 4

Medicaid and Medicare Spending Per Dual Enrollee, by Age and Setting



Source: KCMU and Urban Institute estimates based on MSIS-MCBS 2003 linked file

Dual eligibles are a high-cost population, with combined Medicaid and Medicare spending totaling nearly $200 billion in 2005. Medicare and Medicaid spending averaged over $20,000 per dual, about five times greater than spending on other Medicare beneficiaries. This higher level of spending reflects their greater health needs and utilization of services compared to other Medicare beneficiaries. Medicare predominantly pays for acute care spending for dual eligibles while Medicaid finances the majority of long term care, since Medicare's coverage is limited to short term post acute care. (Fig. 4) Dual eligibles often have multiple chronic conditions and are more likely to be hospitalized, use emergency rooms and require long-term care than other Medicare beneficiaries. Younger duals who are disabled and the oldest duals who rely on long-term care are the most expensive. Dual eligibles with certain conditions, including cerebral palsy, Alzheimer's, and multiple sclerosis have substantially higher per capita spending than other duals.

Looking Forward

Dual eligibles are among the sickest and poorest individuals covered by either the Medicaid or Medicare programs. Given their complex health needs, high level of spending, and use of long-term care, dual eligibles will continue to be a focus of state and federal policy. The Affordable Care Act establishes two new federal entities—the Federal Coordinated Health Care Office (FCHCO) and the Center for Medicare and Medicaid Innovation (Innovation Center)—that will be involved in efforts to study and improve care for dual eligible beneficiaries. Furthermore, health reform provides new opportunities to promote care in the community and reduce the reliance on institutional care. Looking forward, improving care coordination and payment structures for dual eligibles across the range of acute and long-term services while assuring beneficiary safeguards will be important elements in improving access and quality of care, and efforts to strengthen both the Medicare and Medicaid programs in the years ahead.

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CHAPTER 5

Coordinating the care of dual-eligible beneficiaries

CHAPTER 5

Coordinating the care of dual-eligible beneficiaries

Chapter summary

Dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid) have higher medical expenses than other beneficiaries. While they make up disproportionate shares of Medicare and Medicaid spending relative to their enrollment, neither program assumes full responsibility for coordinating all of their care. The Medicare and Medicaid programs often work at cross-purposes in ways that impede the coordination of care for dual-eligible beneficiaries. Conflicting program incentives encourage providers to avoid costs rather than coordinate care, and poor coordination can raise spending and lower quality.

Within the dual-eligible population, there are distinct groups of beneficiaries with widely different care needs. They vary considerably in the prevalence of chronic conditions, their physical and cognitive impairments, and whether they are institutionalized. Many have multiple chronic conditions that make care coordination especially important. Other duals have no or one physical impairment and no chronic conditions. Reflecting this wide range in care needs, spending varies by a factor of four according to physical and cognitive impairment. Likewise, spending on specific types of services differs by subgroup, with some having higher spending on nursing home or hospital services than others. Care coordination activities, and the need for them, should reflect these differences, tailoring specific activities to each beneficiary.

In this chapter

- Characteristics of dual-eligible beneficiaries
- Conflicting incentives of Medicare and Medicaid
- Approaches to integrate the care of dual-eligible beneficiaries
- Challenges to expanding enrollment in integrated care
- Concluding observations

Improving the care for dual-eligible beneficiaries requires two fundamental changes in financing and delivering care to them. First, the financing streams need to be more integrated so that the current conflicting incentives between Medicaid and Medicare no longer undermine care coordination. Second, an integrated approach to care delivery is needed to ensure quality care for this complex population. An integrated approach could involve a single entity at financial risk for the care furnished to beneficiaries with the responsibility for coordination of all care furnished to dual-eligible beneficiaries.

In integrated approaches, beneficiaries are regularly assessed for their risk for hospitalization or institutionalization and a multidisciplinary team manages a beneficiary's care according to an individualized care plan. Entities that furnish integrated care need to be evaluated by using outcome measures such as risk-adjusted per capita costs, potentially avoidable hospitalization rates, rates of institutionalization, and emergency room use. In addition, condition-specific quality measures and indicators that reflect the level and success of care integration need to be gathered so that the success of care integration for different subgroups of duals can be assessed.

Two approaches currently in use—managed care programs implemented through Medicare Advantage special needs plans that contract with states and the Program of All-Inclusive Care for the Elderly—offer more fully integrated care. These programs combine funding streams so that the conflicting financial incentives of Medicare and Medicaid are mitigated. Entities are also at full financial risk for all (or most) services, including long-term care, and provide care management services. Given the diversity of the care needs of the dual-eligible population, a common approach to full integration and care coordination may not be best suited for all beneficiaries.

While integrated approaches have the potential to be successful, they are few in number and enrollment in some programs is low. Numerous challenges inhibit expanding their numbers and enrollment. Challenges include a lack of experience managing long-term care, stakeholder resistance (from beneficiaries and their advocates, and from providers), the costly initial program investments and uncertain financial viability, and the separate Medicare and Medicaid administrative rules and procedures. Also, by statute Medicare beneficiaries must have the freedom to choose their providers and cannot be required to enroll in a health plan that could integrate care. However, several states have successfully implemented fully integrated care programs, illustrating that it is possible to overcome these obstacles. ■

Dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid) have, on average, higher medical expenses than other beneficiaries and the care they receive is likely to be uncoordinated. They make up 16 percent of Medicare's enrollment but one-quarter of its spending (Medicare Payment Advisory Commission 2009a). On the Medicaid side, they make up 18 percent of Medicaid enrollment but almost half (46 percent) of its spending (Lyons and O'Malley 2009). However, there are distinct groups of beneficiaries with widely different care needs. Given the multiple chronic conditions of many dual-eligible beneficiaries, care coordination is paramount but often lacking.

The Medicare and Medicaid programs often work at cross-purposes in ways that impede the coordination of care for dual-eligible beneficiaries. Conflicting program incentives in Medicare and Medicaid encourage providers to avoid costs rather than coordinate care, and poor coordination can raise total federal spending and lower quality. Neither program assumes full responsibility for coordinating the care furnished to dual-eligible beneficiaries.

This chapter describes the dual-eligible beneficiaries and spending on them. It then describes examples of fully integrated programs in which an entity receives revenue from Medicaid and Medicare, assumes full (or most of the) financial risk for the enrollees, and manages all the services furnished to them. It discusses performance measures that would be relevant to the dual-eligible population, which are particularly important if enrollment in integrated plans is to expand.

The chapter discusses approaches being used to coordinate the care for dual-eligible beneficiaries—Medicare Advantage (MA) special needs plans (SNPs) that contract with the state Medicaid agencies to provide integrated managed care programs, and the Program of All-Inclusive Care for the Elderly (PACE). These programs make two fundamental changes to the financing and delivery of care to dual-eligible beneficiaries. First, entities are at financial risk for all (or most) of the care furnished to duals, so that the current conflicting incentives no longer undermine care coordination. Second, a single entity takes responsibility for care coordination. Few beneficiaries are enrolled in these programs and the last section discusses the challenges to expanding their enrollment.

Background

Dual-eligible beneficiaries are people who receive health care coverage through both Medicare and Medicaid. In 2005, approximately 16 percent of Medicare beneficiaries were also enrolled in Medicaid. Of these dual-eligible beneficiaries, almost two-thirds were aged 65 or older and one-third were disabled and under age 65 (Medicare Payment Advisory Commission 2008). Many beneficiaries who would otherwise qualify for Medicaid do not enroll in the program.[1] Most dual-eligible beneficiaries remain eligible for state coverage over time because they typically do not experience large changes in assets or income. About 5 percent of dual-eligible beneficiaries lose their eligibility each year; about 40 percent of them reenroll within a year (Stuart and Singhal 2006).

Within the dual-eligible population, there are different levels of assistance through what are called Medicare Savings Programs. Most "duals" (almost 80 percent) qualify for full Medicaid benefits, including long-term care (often referred to as "full benefit duals"). Medicaid also pays their Medicare premiums and cost-sharing expenses. Medicare beneficiaries with higher incomes (often referred to as "partial duals") do not receive Medicaid benefits other than assistance with Medicare premiums and cost sharing.[2]

Medicare is considered the primary payer for dual-eligible beneficiaries and pays for all Medicare-covered services (such as hospital and physician services; see Table 5-1, p. 132). For Medicaid, all states are required to cover certain services, including nursing home care, Medicare cost sharing (the Part A and Part B deductibles, the Part B premiums, and the Part B coinsurance), coverage for inpatient hospital and skilled nursing facility services when Part A coverage is exhausted, and home health care for those dual-eligible beneficiaries who would otherwise qualify for nursing home services. States have the option to cover other services—such as dental, vision, and hearing; home- and community-based services; personal care services; and home health care (for those duals who do not qualify as needing nursing home services). Not surprisingly, there is considerable variation across states in the services covered and in eligibility rules, resulting in different benefits for duals, depending on where they live. States can cap their payments for Part B cost sharing to what they would pay for the service if the beneficiary had only Medicaid coverage.[3] As a result, most states do

TABLE 5–1 **Services paid for by Medicare and Medicaid for dual-eligible beneficiaries**

Medicare	Medicaid
• Acute care (hospital) services • Outpatient, physician, and other supplier services • Skilled nursing facility services • Home health care • Dialysis • Prescription drugs • Durable medical equipment • Hospice	• Medicare cost sharing (Part A and Part B deductibles, Part B premiums and coinsurance) • Coverage for hospital and skilled nursing facility services if Part A benefits are exhausted • A portion of the cost of prescription drugs • Nursing home care • Home health care not covered by Medicare when the beneficiary qualifies as needing nursing home care • Transportation to medical appointments • Optional services: dental, vision, hearing, home- and community-based services, personal care, and home health care (when the beneficiary does not qualify for Medicare and does not need nursing home care) • Durable medical equipment not covered by Medicare

not, in effect, pay for cost-sharing expenses (Mitchell and Haber 2004).

Over the last three decades, programs delivering home- and community-based services (HCBS) such as home health care and personal care have become an attractive alternative to institutional care for persons who require long-term care. Between 1995 and 2007, Medicaid spending on HCBS as a percentage of its total long-term care obligations has more than doubled from 19 percent to 41 percent (Kaiser Family Foundation 2009b). Demand is high because many beneficiaries prefer to remain at home and receive support services that allow them to avoid being institutionalized. States fund such programs because they believe the services will reduce facility-based expenditures on long-term care, which is the single largest spending item for Medicaid, constituting a third of its total spending (Kaiser Family Foundation 2009a). Differences in state policies to fund these services contribute to the considerable variation in average per capita HCBS spending. In 2006, per capita spending on HCBS ranged from $5,407 in Texas to $33,862 in Rhode Island (Kaiser Family Foundation 2009b).

Although Medicaid is a state-run program, there is considerable federal support. The federal government contributes to each state's Medicaid program based on a formula that yields higher matching funds for poorer states. The average "match rate" is 57 percent, but it ranges from 50 to 76 percent. To provide short-term fiscal relief to states, the Congress included a provision in the American Recovery and Reinvestment Act of 2009 that temporarily (through 2010) raised the minimum match rate to 65 percent and the maximum to 83 percent (Department of Health and Human Services 2009).

Characteristics of dual-eligible beneficiaries

On average, dual-eligible beneficiaries differ from other beneficiaries. They are more likely to be young and disabled and to have multiple chronic conditions. But the dual-eligible population is not homogeneous. Duals differ considerably in their physical and cognitive impairments, their abilities to perform activities of daily living, and whether they are institutionalized. Some duals have multiple chronic conditions that will raise their spending year after year. Others—the essentially well duals—have minimal care needs. These factors will shape the amount and type of services that need to be coordinated and the opportunities and benefits of integration.

Dual-eligible beneficiaries differ from other beneficiaries

To qualify for Medicaid, dual-eligible beneficiaries must have low incomes. More than half of duals have incomes below the poverty line (in 2006, poverty was defined as $10,294 for an individual and $13,167 for married couples) compared with 8 percent of non-dual-eligible beneficiaries. Their poverty shapes their basic living needs. If they have inadequate housing or cannot afford heat and food, they cannot focus on and manage their health care

TABLE 5–2

Demographic differences between dual-eligible beneficiaries and non-dual-eligible beneficiaries

	Percent of beneficiaries	
Characteristic	**Dual eligible**	**Non-dual eligible**
Disabled	41%	11%
Report poor health status	20	7
Race		
White, non-Hispanic	58	82
African American	18	7
Hispanic	15	6
Other	9	4
Limitations in ADLs		
No ADLs	49	71
1–2 ADLs	23	19
3–6 ADLs	29	10
Living arrangement		
In an institution	19	3
With a spouse	17	55
Education		
No high school diploma	54	22
High school diploma only	24	31
Some college or more	18	45

Note: ADLs (activities of daily living). Totals may not sum to 100 percent due to rounding and the exclusion of an "other"category.

Source MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2006.

needs. For example, the lack of adequate heating can delay recovery from illness.

Compared with other Medicare beneficiaries, dual-eligible beneficiaries are, on average, more likely to be young and disabled, report poor health status, and be a member of a racial or ethnic minority group (Table 5-2). Dual-eligible beneficiaries are almost three times more likely than other beneficiaries to have three or more limitations in their activities of daily living (such as dressing, bathing, and eating), with 29 percent reporting this level of physical impairment. Dual-eligible beneficiaries are more than six times more likely to be living in an institution, with 19 percent living in one compared with 3 percent of other beneficiaries. Compared with other beneficiaries, duals are much less likely to live with a spouse. More than half of dual-eligible beneficiaries did not complete high school, compared with fewer than one-quarter of other beneficiaries.

The disabled group make up about one-third of dual-eligible beneficiaries. Among them, 44 percent are mentally ill, one-third have one or no physical impairment, and 18 percent are developmentally disabled (Table 5-3). A small share have dementia, reflecting their younger age.

The group of beneficiaries entitled based on their age make up about two-thirds of dual-eligible beneficiaries. Among them, more than half have one or no physical impairment, 26 percent are mentally ill, and 16 percent have dementia. A small fraction of the aged dual-eligible beneficiaries have two or more physical impairments.

Beneficiaries in these impairment groups vary considerably in what share are institutionalized, which will have a large impact on per capita spending. High proportions of aged duals with dementia or with at least two physical impairments are institutionalized (Figure 5-1, p. 134).[4] But only a small fraction (2 percent) of those with no or one physical impairment are institutionalized. The rates of institutionalization among the other groups—the mentally ill, the developmentally disabled, and the disabled with

TABLE 5–3

Physical and cognitive impairments vary considerably among dual-eligible beneficiaries

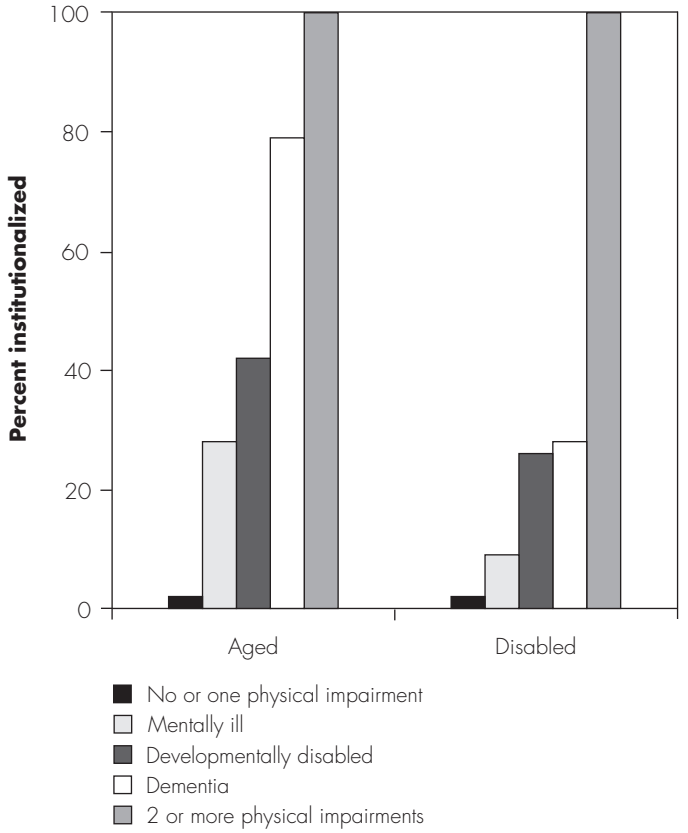
Dual-eligible group	Aged	Disabled
Mentally ill	26%	44%
Dementia	16	3
Developmentally disabled	2	18
One or no physical impairments	54	33
Two or more physical impairments	3	3

Note: Beneficiaries were grouped into the "aged" and "disabled" groups based on how they qualified for Medicare coverage. The grouping uses a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Beneficiaries are then assigned to a cognitive impairment group and, if none, are assigned to a physical impairment group (a beneficiary with both would be assigned to a cognitive impairment group). Physical impairment refers to a limitation to perform activities of daily living such as bathing, dressing, or eating. Beneficiaries with end-stage renal disease were excluded.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2004–2006.

FIGURE 5–1

Rate of institutionalization varies by group of dual-eligible beneficiaries



Note: Beneficiaries were grouped into the "aged" and "disabled" groups based on how they qualified for Medicare coverage. The grouping uses a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Beneficiaries are then assigned to a cognitive impairment group and, if none, are assigned to a physical impairment group (a beneficiary with both would be assigned to a cognitive impairment group). Physical impairment refers to a limitation to perform activities of daily living such as bathing, dressing, or eating. Beneficiaries with end-stage renal disease were excluded.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2004–2006.

dementia—are more variable, ranging from 9 percent to 42 percent. In general, aged duals are more likely to be institutionalized than disabled duals.

Using CMS's chronic conditions warehouse data, we found that many dual-eligible beneficiaries have three or more chronic conditions—41 percent of duals who do not have end-stage renal disease (ESRD) and 74 percent of those who do. The most common chronic conditions include cardiovascular, diabetes, Alzheimer's and related disorders, rheumatoid arthritis or osteoarthritis, and depression (Mathematica Policy Research 2010).

The frequency of chronic conditions varied considerably among the disabled and the aged groups (Table 5-4). More than one-quarter of the aged dual-eligible beneficiaries had the five most frequent chronic conditions—ischemic heart disease, heart failure, Alzheimer's and related conditions, diabetes, and rheumatoid arthritis or osteoarthritis. Except for diabetes, many fewer of the under 65 and disabled dual-eligible population had these conditions. For example, only 17 percent had ischemic heart disease, compared with 43 percent of the aged dual-eligible beneficiaries. Among those under 65 and disabled, only two conditions—depression and diabetes—were as prevalent (at least 20 percent of duals had the condition). It is likely that the under 65 and disabled population has other conditions not included in the Chronic Conditions Warehouse (CCW), such as schizophrenia, other psychosis, serious neurosis, and substance abuse, which are not captured in the data. The vast majority of dual-eligible beneficiaries admitted to inpatient psychiatric hospitals had a diagnosis of psychosis (see Chapter 6). The unreported conditions will understate the prevalence of mental illness among duals.

TABLE 5–4

Five most frequent chronic conditions vary among the aged and the under 65 and disabled dual-eligible beneficiaries

	Percent of group with the condition	
Chronic condition	**Aged**	**Under 65 and disabled**
Alzheimer's and related conditions	30%	5%
Chronic obstructive pulmonary disease	18	10
Depression	18	28
Diabetes	36	23
Heart failure	33	11
Ischemic heart disease	43	17
Rheumatoid arthritis/osteoarthritis	31	13

Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

Duals also vary in the number of chronic conditions they have (Figure 5-2). While 19 percent had five or more chronic conditions, a large share (38 percent) had none or one. Half of the 22 percent with dementia also had four other chronic conditions.

Dual-eligible beneficiaries' health status characteristics—whether they are aged or disabled, their physical and cognitive impairments, and their chronic conditions—shape the amount of care coordination they require, the mix of providers serving them, and their inclination and ability to seek timely care. Those with minimal physical impairments are likely to require much less support than dual-eligible beneficiaries with serious impairments. Care needs will also vary according to the chronic condition. Beneficiaries with conditions particularly at risk for hospitalization, such as heart failure and chronic obstructive pulmonary disease, should be closely monitored to avert unnecessary hospitalization. Beneficiaries who live alone are at risk for institutionalization, which HCBS may be able to delay or avoid.

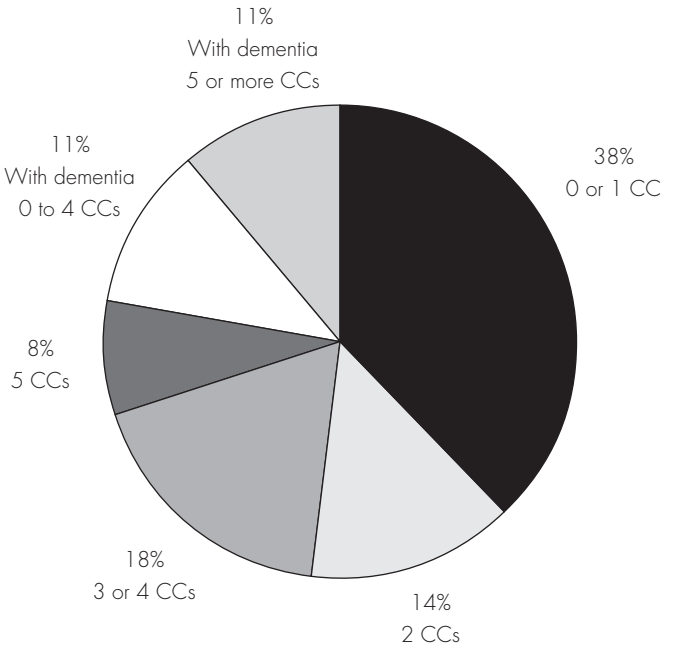
Mentally ill and cognitively impaired dual-eligible beneficiaries are typically limited in their abilities to understand instructions and adhere to them. In addition, although mental health care providers often serve as the central health care resource for mentally ill beneficiaries, they may not routinely screen their patients for general health problems or adequately monitor health effects of medications that are frequently prescribed. Furthermore, the network of mental health care providers treating a dual-eligible beneficiary is often separate from that furnishing general health care, requiring mentally ill duals to navigate yet another system of care. This landscape should shape care coordination activities for this group of dual-eligible beneficiaries.

Per capita spending on dual-eligible beneficiaries varies by subgroup

The variation in health status, cognitive and physical impairments, and living arrangements across dual-eligible beneficiaries is reflected in the large differences in per capita spending across these beneficiaries' subgroups. A large factor is whether the beneficiary is institutionalized, which affects Medicaid spending and combined program spending. Chronic conditions also contribute to higher spending levels, particularly for patients with dementia, as do cognitive and physical impairments.[5]

FIGURE 5–2

Number of chronic conditions and presence of dementia vary considerably among dual-eligible beneficiaries



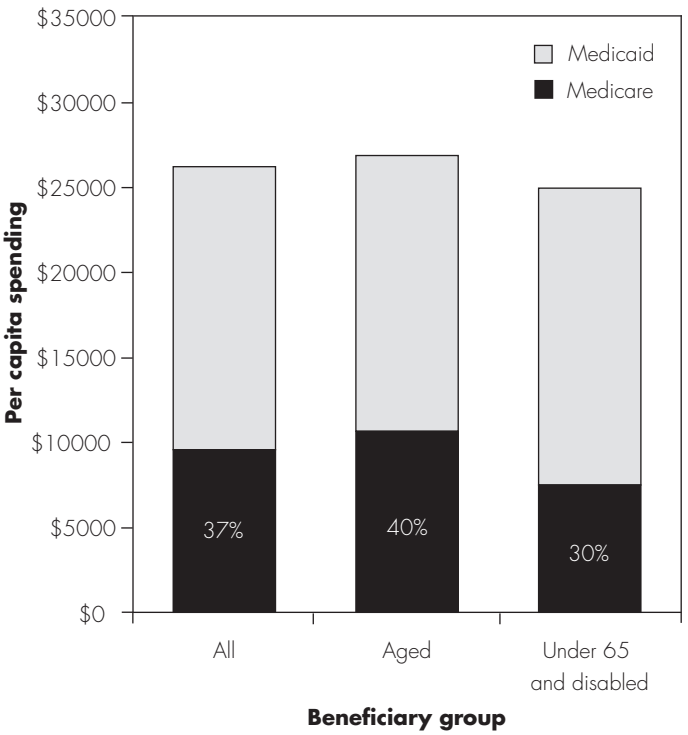
Note: CC (chronic condition). The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

Medicaid and Medicare per capita spending on dual-eligible beneficiaries totaled $26,185 in 2005, with Medicare spending accounting for 37 percent of the total (Figure 5-3, p. 136). Combined per capita spending was slightly higher (3 percent) than average for the aged dual-eligible beneficiaries, while per capita spending for the under 65 and disabled was 5 percent less than the average. Medicare's share of the combined varied from 30 percent (under 65 and disabled) to 40 percent (aged), largely reflecting the share of beneficiaries receiving Medicaid-financed long-term care and prescription drugs. These data predate the implementation of Medicare's drug benefit, so prescription drug spending is included in Medicaid's spending.

FIGURE 5–3

Medicare and Medicaid per capita spending on dual-eligible beneficiaries in 2005



Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans. Spending on prescription drugs is included in Medicaid spending (the data predate Part D). Percents are Medicare share of combined spending.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

Per capita spending varies by nursing home use

The differences in per capita spending for the aged and the under 65 and disabled groups of dual-eligible beneficiaries were more pronounced once we controlled for nursing home use (Table 5-5). For duals with no nursing home spending (i.e., living in the community), combined Medicare and Medicaid per capita spending for the under 65 and disabled was one-third higher ($22,530) than that for the aged ($16,916). For duals with the highest nursing home spending (those in the 20th percentile of nursing home spending), the difference between the groups was smaller. Combined per capita spending was 13 percent higher for the under 65 and disabled group ($84,339) than the spending for the aged group ($74,439).

Nursing home use has a large impact on total combined spending. Combined per capita spending for dual-eligible beneficiaries with the highest per capita nursing home spending was about four times that of duals with no nursing home spending.

Impact of chronic conditions on per capita spending

Considerable differences in combined per capita spending also exist by category of chronic condition (Table 5-6 and online Appendix 5-A, available at http://www.medpac.gov). Among the most frequent conditions, combined per capita spending ranged from 20 percent higher than average for dual-eligible beneficiaries with diabetes or with rheumatoid arthritis or osteoarthritis to 80 percent higher than average for duals with Alzheimer's disease and related conditions. Per capita spending for duals with five or more chronic conditions was almost double the per capita spending for all duals. Because beneficiaries can have more than one chronic condition, the differences reported here are not the additional spending associated with the condition alone. For example, many beneficiaries in the diabetes group have other chronic conditions that raise program spending. Twenty percent of duals had none of the chronic conditions recorded in the CCW.

Dementia plays a key role in per capita spending differences. Across the most prevalent chronic conditions, combined per capita spending for dual-eligible beneficiaries with dementia was 30 percent to 60 percent higher than for duals without it.

Spending also varied considerably by the number of chronic conditions the beneficiary had (Figure 5-4, p. 138). Combined per capita spending for duals with one chronic condition was just over $16,000 but with dementia it increased to more than $31,000. Spending for duals with five or more chronic conditions was $43,000; combined spending on those with dementia was more than $55,000.

Physical and mental impairments influence per capita spending

To examine spending differences by physical and mental impairments, we examined Medicare Current Beneficiary Survey data and used a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Then, it assigned beneficiaries first into cognitive impairment groups and then, if not already

TABLE 5–5

Controlling for nursing home use, per capita spending for under 65 and disabled duals is higher than for aged duals, 2005

	Total	No nursing home spending	Top nursing home spending
All dual eligibles	$26,185	$19,171	$75,469
Aged	26,841	16,916	74,439
Under 65 and disabled	24,924	22,530	84,339

Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans. Top nursing home spending includes the top 20th percentile of spending for beneficiaries who used nursing home services.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

assigned, into physical impairment groups. A beneficiary with both types of impairments is assigned to a mental impairment group.[6]

Within the aged and disabled groups, Medicare and Medicaid per capita spending ranged by a factor of four (Figure 5-5). In both the disabled and aged groups, spending on duals with no or one impairment was about half of the average; in contrast, the highest spending groups (those with two or more physical impairments and those with dementia) were about double the average. Other differences were difficult to discern. Groups with high rates of institutionalization tended to have high spending, but not always. For example, while spending was about twice the average for duals with two or more physical impairments (groups with high institutionalization rates, see Figure 5-1), spending was about 20 percent above average for the developmentally disabled aged group (a group in which fewer than half were institutionalized). For any given impairment group, spending for the aged groups

TABLE 5–6

Total Medicare and Medicaid per capita spending for dual-eligible beneficiaries varied for most frequent chronic conditions

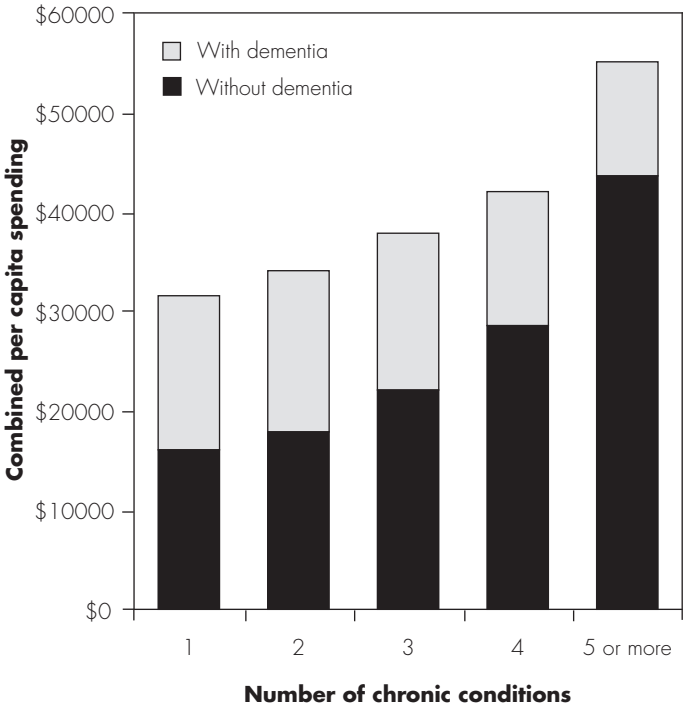
Select chronic condition	Share of all duals with condition	Medicare and Medicaid spending	Spending relative to average
All dual-eligible beneficiaries	100%	$26,185	1.0
Alzheimer's and related conditions	22	46,578	1.8
COPD	15	40,645	1.6
Depression	21	38,829	1.5
Diabetes	32	32,188	1.2
Heart failure	26	40,632	1.6
Ischemic heart disease	34	34,568	1.3
Rheumatoid arthritis & osteoarthritis	25	31,864	1.2
4 or more chronic conditions	30	43,986	1.7
5 or more chronic conditions	19	50,278	1.9

Note: COPD (chronic obstructive pulmonary disease). The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

FIGURE 5–4

Combined per capita spending increases with dementia and number of chronic conditions



Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

tended to be higher than for the disabled groups, but not always. Spending was higher for the aged groups with cognitive impairments, but the disabled group with two or more physical impairments had higher spending than its aged counterpart.

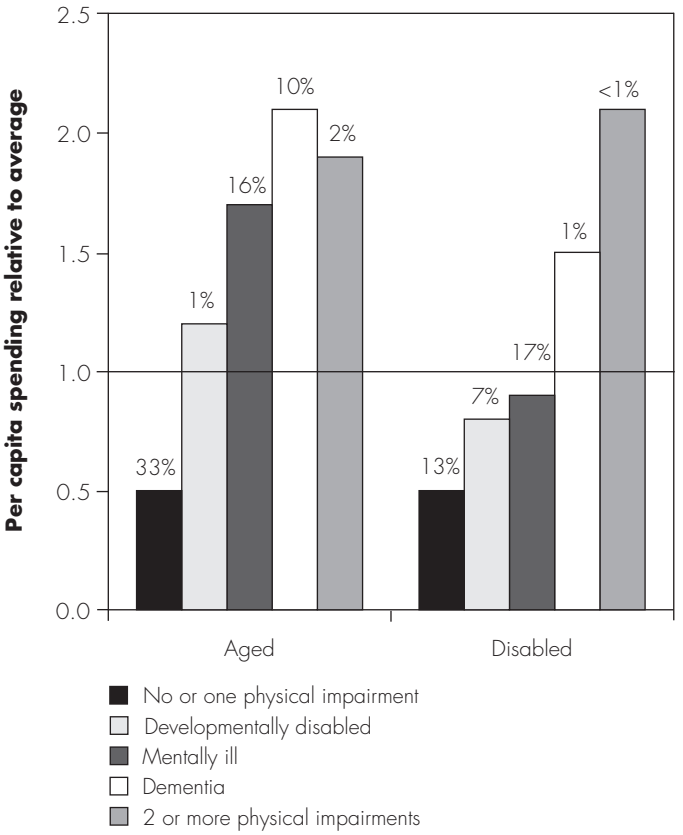
Mix of service spending varies by clinical condition

The impairments and chronic conditions shape the mix of services beneficiaries use. Dual-eligible beneficiaries who are institutionalized have a high proportion of combined per capita spending on nursing home services. Those with minimal impairments, living at home, and without a hospitalization are likely to have a greater share of combined program spending on physician and other community-based services. Those with conditions that are susceptible to frequent hospitalizations, such as chronic obstructive pulmonary disease (COPD) and heart failure, have a high share of combined spending on hospital services.

Among the most prevalent chronic conditions, the share of total per capita spending devoted to nursing home services ranged from 20 percent for dual beneficiaries with heart failure or COPD to 45 percent for duals with Alzheimer's disease and related conditions (Figure 5-6 and online Appendix 5-A, available at http://www.medpac.gov). Per

FIGURE 5–5

Per capita spending by cognitive and physical impairment group

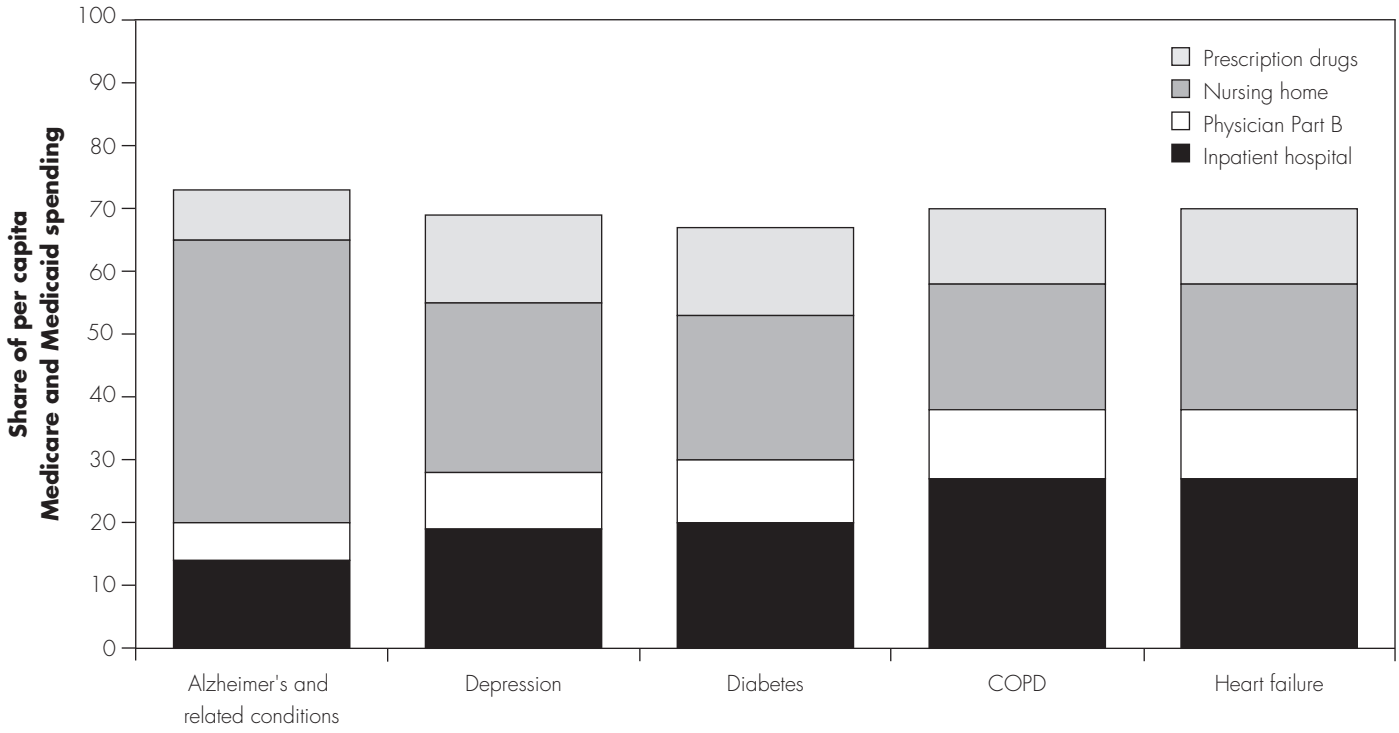


Note: Beneficiaries were grouped into the "aged" and "disabled" groups based on how they qualified for Medicare coverage. The grouping uses a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Beneficiaries are then assigned to a mental impairment group and, if none, are assigned to a physical impairment group (a beneficiary with both would be assigned to a mental impairment group). Physical impairment refers to a limitation to perform activities of daily living such as bathing, dressing, or eating. The percentages represent the share of all duals included in the group. Beneficiaries with end-stage renal disease were excluded.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2004–2006.

FIGURE 5–6

Differences in per capita spending by select chronic condition



Note: COPD (chronic obstructive pulmonary disease). The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

capita spending for inpatient services was more concentrated (27 percent of per capita spending) for duals with heart failure or COPD compared with duals with any chronic condition (17 percent of per capita spending). Across the most common chronic conditions, per capita spending on prescription drugs ranged from 8 percent (Alzheimer's disease and related conditions) to 14 percent (depression and diabetes). Per capita spending on physician and other Part B services ranged from 6 percent (Alzheimer's disease and related conditions) to 11 percent (COPD, heart failure, ischemic heart disease, and rheumatoid arthritis and osteoarthritis).

Implications for coordinating care

The design and targeting of care coordination approaches could be tailored to match the care needs of different groups of dual-eligible beneficiaries. Given the variation in the level and mix of spending, a uniform way to coordinate care for all dual-eligible beneficiaries is unlikely to be as effective as more targeted approaches for individual subgroups. For example, coordinating the care for dual-eligible beneficiaries living in the community will require managing services across a wide array of providers, especially for beneficiaries with multiple chronic conditions. In contrast, for beneficiaries residing in nursing homes, care coordination might be best based at the facility. It might be possible to avoid premature institutionalization of some dual-eligible beneficiaries with minimal care needs if they are managed appropriately.

Beneficiaries with certain clinical conditions are at greater risk of hospitalization than others. Care management approaches that emphasize preventing unnecessary hospitalizations would avoid the unnecessary spending and care transitions that undermine good quality of care. Such techniques would differ for community-dwelling and institutionalized beneficiaries. In addition, specific medication management approaches

could be used for beneficiaries with high spending on prescription drugs or with certain diagnoses, similar to the medication therapy management programs that prescription drug plans and Medicare Advantage–Prescription Drug plans are required to implement for high-risk beneficiaries. There has been considerable variation in how these programs were implemented and CMS strengthened plan requirements for 2010 (Medicare Payment Advisory Commission 2009b, Medicare Payment Advisory Commission 2010).

Conflicting incentives of Medicare and Medicaid

Care coordination is hampered by the conflicting incentives of Medicare and Medicaid. The two programs can work at cross-purposes that undermine cost control and good patient care. At the payer level, Medicaid and Medicare have incentives to minimize their financial liability by avoiding costs through coverage rules. Medicare covers services that are restorative or improve a beneficiary's functional status, denying payment for services that are considered "maintenance." In contrast, Medicaid may pay for services that prevent further deterioration. At times there is ambiguity about whether a service helps maintain the status quo or is restorative.

Examples of these conflicting incentives include the financial incentive to hospitalize nursing home residents, shift costs to the next provider ("downstream") in an episode of care, and shift coverage for home health care from one program to another (see text box on conflicting incentives). States' longstanding use of "Medicare maximization" strategies—raising a state's federal match dollars through illusory financial arrangements—underlines the importance of designing financially integrated approaches that successfully balance state flexibility with adequate fiscal controls and the need for carefully specified policies.

Fee-for-service payment methods discourage care coordination

Medicare and Medicaid pay for post-acute care (PAC) by using fee-for-service (FFS) payment methods that typically limit spending per visit, day, or episode. These payment methods create incentives to hospitalize patients with above-average costs rather than invest in the resources (such as skilled nursing staff) to manage patients in-house. Estimates of the rates of potentially avoidable rehospitalizations vary from 18 percent to 40 percent, depending on the PAC setting, the risk adjustment method, and the clinical conditions considered (Grabowski et al. 2007, Medicare Payment Advisory Commission 2010, Saliba et al. 2000).

Hospitalization rates appear to be sensitive to the level of payments. One study of nursing homes found that for every additional $10 in Medicaid daily payment above the mean, the likelihood of hospitalization declined 5 percent (Intrator et al. 2007). Another nursing home study found that Medicaid residents were more likely than other higher payment patients to be rehospitalized, with risk-adjusted hospitalization rates that were 15 percent lower for Medicare and private pay patients (Konetzka et al. 2004).

As a result of the FFS payment methods, providers typically have no incentive to take into account the impacts of their own practices on total spending over time. What may be in a provider's own financial interest in the short term may result in higher federal spending over the longer term. Medicare's PAC transfer policy under the hospital inpatient prospective payment system counters the financial incentive to prematurely discharge inpatients to PAC settings. However, PAC settings do not have transfer penalties. PAC providers can lower their own costs by shifting patients to other PAC settings or to the community. Although bundling Medicare payments for hospital and PAC services could encourage more efficient use of Medicare resources, it would not address the incentive to shift costs to another program.

Further discouraging care coordination is the lack of a care coordination benefit in Medicare. Although care coordination per se is not covered, certain providers are required to conduct some of these activities, such as discharge planning by hospitals. Because MA plans are required to provide only those services covered in FFS, they are not required to furnish care coordination. However, these activities may improve a plan's quality indicators and its financial performance, particularly plans that enroll high-cost beneficiaries. Plans enrolling an essentially well mix of beneficiaries may have little financial incentive to offer care coordination activities.

Conflicting incentives may lower quality of care

Because Medicaid and Medicare have no incentive to improve overall efficiency and care coordination for duals, each program focuses on minimizing its own payments instead of investing in initiatives that would lower overall

Examples of conflicting incentives

Three examples illustrate how providers and states can shift the responsibility for beneficiaries from one program to another and, at the same time, raise total federal spending (Grabowski 2007).

- *Nursing home transfer to hospitals*—Transferring dual-eligible beneficiaries receiving long-term care in nursing homes to hospitals is financially advantageous to facilities and states but raises Medicare spending. A nursing home benefits first by avoiding the high costs associated with care the hospital had to provide. State bed-hold policies that pay nursing homes a daily amount while a resident is in the hospital can also affect hospitalization rates. States with bed-hold policies had hospitalization rates that were 36 percent higher than states without them (Intrator et al. 2007). Second, the facility may qualify for a higher payment under Medicare when the beneficiary is readmitted and requires skilled nursing facility (SNF) services.[7] The state also benefits when beneficiaries qualify for Medicare-covered SNF stays because its financial liability is to pay only for the copayments and deductibles for Medicare-covered services.
- *Hospital transfer to nursing home*—Hospitals do not have a financial incentive to consider the "downstream" costs of long-term care. Rather, their financial incentive is to lower their own costs by transferring patients to nursing facilities, which increases state and federal spending.
- *Home health care*—As a result of a 1988 U.S. Supreme Court decision, Medicare broadened the coverage guidelines for home health care.[8] Medicare's home health benefit expanded from covering mostly short-term, post-acute care to one that can cover patients over longer periods of time (Government Accountability Office 2000). Because Medicare and Medicaid home health care coverage can be ambiguous (does the patient qualify for skilled care, is the patient homebound), Medicare and Medicaid can jockey to avoid paying for care by asserting the beneficiary does or does not meet Medicare's criteria for coverage (being homebound, requiring skilled care, or receiving part-time or intermittent services).[9] ■

spending and improve quality. States are more inclined to invest in programs to lower their long-term care spending than in programs that avoid unnecessary hospitalizations because these benefits accrue to Medicare. Reflecting the ambivalence to lower rehospitalization rates, none of the four state nursing home pay-for-performance programs (Iowa, Kansas, Minnesota, and Ohio) uses hospital readmissions as a performance measure (Grabowski 2007).

The patterns of care that result from shifting patients for financial, rather than clinical, reasons can lead to suboptimal care for beneficiaries. Nursing homes have little incentive to provide preventive care and avoid acute flare-ups of chronic conditions if their efforts raise their costs. Moreover, to the patient's detriment, unnecessary hospitalizations expose beneficiaries to hospital-acquired disease that can delay patients' recovery or erode their health status. We found that dual-eligible beneficiaries make up the majority of beneficiaries with repeat hospitalizations (four or more within two years). Multiple transitions between settings increase the likelihood that a patient will experience fragmented care, medical errors, medication mismanagement, and poor follow-up care. The Health and Human Services Office of Inspector General found that more than one-third of episodes of patients with multiple hospital skilled nursing facility stays were associated with quality-of-care problems (Office of Inspector General 2007).

Care can also be fragmented when dual-eligible beneficiaries are enrolled in multiple plans for their health care coverage. Some dual-eligible beneficiaries are enrolled in different Medicaid and Medicare managed care plans or in a managed care plan under one program and FFS in the other, in addition to a separate plan for prescription drug coverage. Duals in these circumstances do not have a single person or entity taking responsibility

for their care. Such fragmentation can lead to medication mismanagement, poor coordination of treatment plans, and low patient adherence to medical instructions.

For cognitively impaired dual-eligible beneficiaries, efforts to effectively coordinate care are further complicated. Focus groups have revealed that dual eligibles often do not understand their benefits and coverage (Ryan and Super 2003). This complexity of coverage can result in discontinuities in care, involuntary disenrollment, and inappropriate charges for cost sharing. These experiences were echoed in focus groups on prescription drug coverage conducted by the Commission in 2009. We found that some low-income beneficiaries were confused about coverage of the various programs they were enrolled in.

Fragmentation can occur even when beneficiaries are enrolled in SNPs, the MA plans that focus on special needs populations, including dual-eligible beneficiaries. Until 2010, SNPs were not required to contract with states to provide Medicaid benefits and most did not. In 2008, the Commission recommended that the Secretary require SNPs to contract with the states of their service areas (Medicare Payment Advisory Commission 2008). The Medicare Improvements for Patients and Providers Act of 2008 required SNPs to contract with states to provide Medicaid benefits (for a summary of the legislative changes to SNP provisions, see online Appendix 5-B, available at http://www.medpac.gov).

Approaches to integrate the care of dual-eligible beneficiaries

There are approaches to coordinate the care for dual-eligible beneficiaries that combine the financing of Medicare and Medicaid and make a single entity (such as a provider or managed care plan) responsible for coordinating all services. Two approaches are being used to integrate the care for dual-eligible beneficiaries: Medicare Advantage special needs plans (SNPs) that contract with the state Medicaid agencies to provide all services and PACE. These approaches shift the current silos of financing and care delivery to one entity that is responsible for all services and at full financial risk. While the models integrate the financing and care coordination, they differ in whether the entity is acting essentially as an insurer (managed care plans) or primarily as a set of providers assuming risk (PACE). They also vary considerably in their target populations and enrollment, the services they manage, and how they organize and integrate services.

Some policy analysts have proposed approaches that integrate the financing of the two programs (but do not coordinate the care) as a way to help overcome the programs' conflicting incentives. Financial integration approaches include giving block grants to the states or shifting the responsibility of dual-eligible beneficiaries to the Medicare program. In block grants, a state would be given a funding allotment each year (a block grant) to pay for all services covered by Medicaid and Medicare.[10] If a state's spending is less than the block grant, the state would keep the difference; if spending exceeds the grant amount, the state would be financially liable. Block grants would require enforcement to ensure that state programs maintained beneficiary access to services and that states funded the intended services.[11] Financial integration could also be achieved if Medicare assumed primary administrative responsibility for the services furnished to the dual-eligible population (Bruen and Holahan 2003, Government Accountability Office 1995, Holahan et al. 2009, Moon 2003). Although approaches to financially integrate Medicaid and Medicare would mitigate the conflicting incentives of the programs, they would not, by themselves, result in coordinated care.

Features of a fully integrated model of care

Fully integrated models of care manage both Medicare and Medicaid services and benefits. Many other efforts manage either Medicaid or Medicare services (but not both), and those that manage only Medicaid services typically exclude long-term care. However, given the incentives to shift costs between the programs, fully integrated models of care should consider including both programs and extend to all services.

Integrated care has the potential to offer enrollees enhanced, patient-centered, and coordinated services that target the unique needs of the dual-eligible enrollees (Table 5-7). Case management, individualized care plans, assistance with accessing community services, and care transition services are intended to lower total program costs by averting hospitalizations, institutional care, medication mismanagement, and duplicative care.

Care coordination begins by assessing patients to identify their level of risk and matching coordination efforts to the person's needs. Then, a multidisciplinary team develops a patient-specific plan of care that is regularly updated

TABLE 5–7 **Sample activities of an integrated model of care**

Feature	Coordinated care activity
Assess patient and assign to a risk group	• Use protocols, service use (e.g., hospital and SNF admissions, ER and specific prescription drugs), referrals from community service and medical care providers, and predictive models to identify high-risk beneficiaries • Care coordination plan reflects the patient's level of risk
Devise and update individualized care plan	• Design a plan of care for each beneficiary; share plan with patient and all providers; update plan periodically to reflect changes in health status or service provision • Educate patients about their prescription drugs and how to manage their disease • Visit at home those patients who are at risk for falls; identify and coordinate installation of safety measures • Socially isolated beneficiaries may be enrolled in adult day care • Adapt patient education and counseling activities for cognitively impaired beneficiaries so that patient/family member recognizes warning signs of the need for prompt medical attention
Assist beneficiary in negotiating health care and community services systems	• Schedule appointments • Arrange for prescriptions, DME, and transportation • Link beneficiary to community services (such as heating assistance programs) that could undermine medical regimen if left unattended
Manage nursing home use	• Visit patients in nursing homes to monitor and treat conditions that if left untreated could result in hospitalization
Coordinate behavioral and primary health care	• Clinical social workers may screen patient population for mental health care needs • Behavioral health providers update primary care physicians on a quarterly basis
Multidisciplinary teams manage care	• Teams may consist of primary care physician, clinical social worker, pharmacist, behavioral health provider, and medical assistant

Note: SNF (skilled nursing facility), ER (emergency room), DME (durable medical equipment).

Source: Lukens et al. 2007.

so that it remains a current map of the care each patient should receive. A comprehensive provider network ensures that patients have access to the full spectrum of services that address the special care needs of dual-eligible patients. Ideally, a beneficiary would have one plan card with one set of rules for Part A, Part B, and Part D coverage. Data are shared across providers so that all participants know the care plan, the services furnished to beneficiaries, and the outcomes and results so that care can be optimally managed.

Performance measures for fully integrated care

Performance measures for fully integrated plans should include outcome-based measures of quality that span all providers over an episode of care as well as metrics specific to the clinical conditions prevalent among the dual-eligible population. In addition, measures should gauge the level and success of care coordination and case management. Tying providers' performance on these types of measures to payments can give them an incentive to collaborate.

One set of outcome measures could be used to gauge the overall performance of all types of fully integrated programs, which would allow for comparison of plans along comparable dimensions of care. Quality measures for managed care plans (such as MA plans) currently assess the extent to which patients receive appropriate preventive care, medication, and acute care and also assess patient satisfaction. In addition, outcome measures could include hospital readmission rates, rates of hospital

admissions for ambulatory-care-sensitive conditions, potentially preventable emergency department visits, and mortality rates for specific conditions. Changes over time in functional and cognitive status may also be appropriate measures for the dual-eligible population. For all outcome measures, it is important to use risk adjustment as much as technically feasible to control for patient characteristics that can affect outcomes but are beyond the providers' influence.

Furthermore, some metrics should be tailored to the care needs of the relevant population, defined by specific factors such as diagnoses, cognitive state, disability status, and institutional status. For example:

- *Nursing home residents:* Although publicly reported Nursing Home Compare measures report on many aspects of institutional long-term care, they do not assess the appropriateness of the admission, medication errors, or rates of potentially avoidable hospitalizations. Ideally, quality measures would detect, for example, if patients were prematurely institutionalized or if their medical condition or functioning deteriorated more quickly than expected once they were institutionalized. In addition to measures for the elderly, measures should include those specifically designed to gauge the quality of care furnished to beneficiaries with physical or cognitive disabilities.
- *Beneficiaries living in the community:* Measures could gauge whether beneficiaries who need supportive care and other social services receive them and the degree of care coordination (e.g., does the patient have a primary care physician who is regularly seen and are medications being managed). CMS established a quality framework for HCBS that included the following categories of measures: beneficiary access, patient-centered service planning and delivery, provider capacity and capabilities, beneficiary safeguards, patient rights and responsibilities, outcomes and patient satisfaction, and system performance.[12] Because a large fraction of the disabled live in the community, measures specifically designed for adults with disabilities would need to be able to gauge the quality of care furnished to this population.
- *Duals with significant mental health care needs:* Given the chronic nature of some severe mental illness, outcome measures for many duals will be hard to develop (see Chapter 6). In the interim, process measures could gauge whether the care coordination identifies persons needing mental health services, ensures beneficiaries receive care in a timely manner, checks that patients' medications are reconciled periodically and every time they transition from one care setting to another and that the medications are being taken, and facilitates communication between a beneficiary's mental health professional and his or her primary care physician. Hospitalization rates for selected psychiatric conditions would provide feedback on the success of managing beneficiaries on an outpatient basis.

Fully integrated care programs should also assess the degree of care coordination and care management provided. As of 2009, SNPs are required to report on structure and process measures of case management, care transitions, and dual-eligible integration. For example, one measure looks at how frequently an organization identifies members who need case management services, while another measure counts how many processes focused on reducing unplanned transitions. Regarding Medicare–Medicaid coordination, SNPs must report whether they have, or are working toward, an agreement with the relevant state Medicaid agency. An inherent shortcoming of these structure and process measures is that they do not assess the effectiveness of these care coordination efforts. Patient and physician surveys on care transitions and case management efforts may be helpful in assessing how much managed care programs facilitate patient understanding of postdischarge plans and improve provider collaboration.

Examples of fully integrated care programs

There are two main types of fully integrated care programs: state–SNP integrated managed care programs and PACE. These programs receive capitated Medicare and Medicaid payments to cover all Medicare and Medicaid services including all or some long-term care services. The programs are at full financial risk for all (or most) of the services they cover. This risk structure gives the programs the incentive to coordinate the Medicare and Medicaid services they offer to reduce unnecessary utilization or high-cost services that programs would otherwise have to pay for.

The type of entity that receives the capitated payments and manages the benefits differs in the two approaches. In the state–SNP programs, the integration is through a managed care plan; under PACE, these functions are carried out by a PACE provider. All the state–SNP programs and PACE target dual-eligible beneficiaries, although the specific subgroups of dual-eligible beneficiaries that

are targeted for enrollment differ across programs. In addition, while the intensity of care coordination varies across programs, this variation may reflect the level of needs of the programs' target population. For example, the PACE program offers an intense care management structure with frequent monitoring and management of participants; however, PACE serves the frail elderly living in the community who require this level of care. A program serving a healthier dual-eligible population may require a less intense form of care management than PACE provides.

A number of states are considering other models to improve care coordination for the dual-eligible population. These alternative models include state-administered managed care plans and medical homes. Each has the potential to improve the care coordination for the dual-eligible population but, for different reasons, may have limited success and one model could raise significant concerns about adequate fiscal controls and accountability (see text box, p. 147).

State–SNP integrated managed care programs

To date, at least eight states—Arizona, Massachusetts, Minnesota, New Mexico, New York, Texas, Wisconsin, and Washington—have fully integrated Medicare and Medicaid programs for dual-eligible beneficiaries through SNPs (all of which are MA plans) or through MA plans that are not SNPs (see text box on SNPs, p. 148). Under these programs, a managed care organization, often operating in MA as a SNP, receives capitated payments from both Medicare and Medicaid. The plans are then responsible for establishing provider networks and implementing the model of care, including care coordination or case management services. An estimated 120,000 dual-eligible beneficiaries nationwide are enrolled in fully integrated managed care programs (Center for Health Care Strategies 2009). These individuals represent less than 1.5 percent of the dual-eligible population and about 8 percent of the dual-eligible beneficiaries enrolled in MA plans (SNP and non-SNP MA plans) (Center for Health Care Strategies 2010).[13]

Integrated managed care programs through SNPs could be an option for all subgroups of the dual-eligible beneficiaries—the nonfrail aged, the nursing-home certifiable, the institutionalized, the physically disabled, and the mentally retarded and developmentally disabled. Currently, programs exist to serve these individual subgroups, but few programs serve all subgroups in the same program.

The state programs vary in their eligibility requirements (their target populations), their enrollment, covered services, risk structures, and models of care. There is also variability in results, if any, to date. The key characteristics and differences across state–SNP integrated managed care programs are discussed below (Table 5-8). A brief description of each state–SNP integrated managed care program is provided in a text box (see text box on state–SNP integrated managed care program descriptions, pp. 150-151).

Eligibility While the programs vary in the subgroups of dual-eligible beneficiaries they serve, the two broadest groups of dual-eligible beneficiaries—the aged and disabled—are eligible to enroll in almost all of the programs. Six of the programs (Arizona, New Mexico, New York, Texas, Wisconsin, and Washington) enroll the aged and disabled in the same program. Minnesota has separate programs for the aged and disabled. Some programs exclude large subgroups of duals, such as the non–nursing home certifiable (beneficiaries who are healthy or not frail enough to require a nursing home level of care), institutionalized duals, or the mentally retarded and developmentally disabled. The programs that do not restrict eligibility to the nursing home certifiable can enroll both beneficiaries who are healthy or not frail enough to require nursing home services and frail dual-eligible beneficiaries who require a nursing home level of care.

Fully integrated state–SNP programs appear to more selectively target subgroups of the disabled duals compared with the aged duals. Regarding the disabled populations, some programs exclude the non–nursing home certifiable and institutionalized disabled, while others restrict eligibility to the physically disabled, thus excluding the mentally retarded and developmentally disabled population. Regarding the aged, the non-nursing home certifiable is the most common subgroup of the aged duals that is excluded from these programs, and one program also excludes the institutionalized aged. These restrictions may be indicative of the challenges in designing and implementing multiple models of care in a single program to serve the distinct subgroups of dual-eligible beneficiaries.

Enrollment Most states with strong enrollment in their integrated care programs had statewide Medicaid managed care programs in place before adding the integrated programs. Other states' programs, such as the one in New York, struggled with enrolling large numbers of eligible duals. In New York, voluntary program enrollment and

TABLE 5–8 **Characteristics of fully integrated care programs**

State	Program name	Eligible population: Aged	Eligible population: Disabled	Mandatory or voluntary enrollment
Arizona	Arizona Long-Term Care System (ALTCS)	Nursing home certifiable only	Nursing home certifiable only	Mandatory enrollment in ALTCS for Medicaid long-term care services, but voluntary enrollment in a Medicare managed care plan
Massachusetts	Massachusetts Senior Care Options	Yes	No	Voluntary
Minnesota	Minnesota Senior Health Options (MSHO)	Yes	No	Voluntary for MSHO, but mandatory for aged Medicaid beneficiaries to enroll in a managed care plan. MSHO is one of the managed care options.
	Special Needs Basic Care	No	Yes	Voluntary; disabled are not required to enroll in a managed care plan
New Mexico	Coordination of Long-Term Services	Yes	Yes, but excludes beneficiaries with developmental disabilities who are enrolled in a 1915(c) waiver	Mandatory
New York	Medicaid Advantage Plus	Nursing home certifiable only	Nursing home certifiable only	Voluntary
Texas	Texas Star+Plus	Yes, except for beneficiaries residing in nursing facilities	Yes, except for beneficiaries residing in intermediate care facilities for the mentally retarded	Mandatory
Washington	Washington Medicaid Integration Partnership	Yes	Yes	Voluntary
Wisconsin	Wisconsin Partnership Program	Nursing home certifiable only	Physically disabled only	Voluntary

Source: Center for Health Care Strategies 2010, Centers for Medicare & Medicaid Services 2007, Edwards et al. 2009, Frye 2007, Korb and McCall 2008, and Osberg 2009.

competition from nonintegrated SNPs contributed to the program's low enrollment (Korb and McCall 2008). In addition, most programs operate in select regions within each state rather than across the entire state, which can also limit enrollment.

Covered services and risk structure The nine state–SNP fully integrated programs cover Medicare acute care benefits, Medicaid acute care wraparound benefits, and Medicaid long-term care services. Most also cover behavioral health services. A few of these programs, however, place limits on the amount or type of long-term care services that are covered. For example, Minnesota's programs, Minnesota Senior Health Options (MSHO) and Special Needs Basic Care, cover nursing home utilization up through 180 days and 100 days, respectively. Any nursing home utilization incurred after these limits is paid through Medicaid FFS although enrollees remain in the program. New York's Medicaid Advantage Plus program also caps

Alternative models may be limited in their ability to effectively control spending and coordinate care

Some states are considering other ways to improve the care coordination for dual-eligible beneficiaries, including state-administered managed care plans and medical homes. In state-administered managed care plans, a state entity would receive special needs plan–like payments from Medicare and Medicaid and would be responsible for all health care benefits for dual-eligible beneficiaries. One model considers state-administered Medicaid Advantage plans in which participating states contract with competing health plans to manage the care for dual-eligible beneficiaries (Turner and Helms 2009). The state would have the option of managing the care itself, if its state capacities were sufficiently developed, or contracting with private health plans. Each state could tailor benefit packages to target specific groups of dual-eligible beneficiaries, use performance-based payments, and encourage plans to engage in active care management.

This model may have potential in some states but may not result in adequate beneficiary access to care and proper use of federal spending in every state. Policymakers should note a long history of state financial strategies to maximize federal support while minimizing the state's own contributions. Such strategies generated considerable controversy because the higher federal spending did not always expand coverage or get used to furnish or improve health care (Coughlin and Zuckerman 2002). The strategies underline the importance of adequate fiscal controls and accountability to ensure that spending remains focused on target populations and services.

A number of states are considering the use of medical homes to manage care for dual-eligible beneficiaries. In this model, primary care practitioners are paid (typically on a per member per month basis) to coordinate care for patients between visits and across providers. In 2008, the Commission recommended that Medicare establish a pilot program for medical homes that pays qualified medical practices to coordinate the care of beneficiaries with multiple chronic conditions.

In January 2010, the North Carolina Community Care Networks, an existing medical home and shared savings program serving the Medicaid population, began providing dual-eligible beneficiaries with care management in return for a portion of the savings that may eventually accrue. Any Medicare savings beyond a certain threshold will be reinvested in other services, including home-based services, health information technology, and coverage expansions (Community Care of North Carolina 2009). According to CMS, at least half of the shared savings payments will be contingent on those providers meeting certain quality goals.

Under current payment policies, because medical homes do not assume full risk for their patients' care, their effectiveness at controlling spending will be limited. Medical homes operate within the context of fee-for-service (FFS) medicine and their ability to control total spending will be limited by the portion of payments attached to performance measures. That said, medical homes represent a potentially effective way to bridge the unmanaged world of FFS and more fully integrated care. ■

covered nursing home utilization at 100 days. Texas's program covers community-based long-term care services but not institutional nursing home care (Center for Health Care Strategies 2010, Edwards et al. 2009, Osberg 2009, Texas Health and Human Services Commission 2010b).

Model of care for state–SNP programs The state–SNP programs manage the Medicare medical services and Medicaid medical and support services for the dual-eligible beneficiaries. For example, in addition to managing the Medicare and Medicaid medical services, care coordinators typically consider the need for nonmedical services and supports that facilitate beneficiaries living in the community. These services include HCBS, transportation, heating, food, and housing-related supports; they can help beneficiaries function at home so they can more effectively seek medical attention and adhere to treatment regimens, resulting in appropriate service use.

Special needs plans

Special needs plans (SNPs) are Medicare Advantage (MA) plans that target enrollment to certain groups of Medicare beneficiaries. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized SNPs to target enrollment to the following types of beneficiaries with special needs: those dually eligible for Medicare and Medicaid services, the institutionalized, and beneficiaries with severe or disabling chronic conditions. SNPs were originally authorized through December 2008; first extended through 2009 by the Medicare, Medicaid, and SCHIP Extension Act of 2007; extended again through 2010 by the Medicare Improvements for Patients and Providers Act of 2008; and again through 2013 by the Patient Protection and Affordable Care Act (H.R. 3590).

SNPs receive capitated payments from Medicare to offer Part A and Part B services as well as prescription drug coverage under Part D. Medicare pays SNPs through the same payment method as other MA plans. Payments are risk adjusted for factors that include dual-eligibility status, health condition, disability status, and residence in an institution. SNP per capita payments tend to be higher than payments to other MA plans in the same geographic area because of the risk-adjustment factors and the populations SNPs enroll.

SNPs can also contract with states to receive Medicaid payments to offer Medicaid benefits for dual-eligible beneficiaries. Beginning in 2010, new and expanding dual-eligible SNPs are required to have contracts with states; however, existing dual-eligible SNPs that are not expanding have until January 1, 2013, to establish state contracts (see summary of main legislative changes in online Appendix 5-B, available at http://www.medpac.gov). SNPs can offer a range of Medicaid services for the dual-eligible beneficiaries including coverage of Medicare cost sharing, supplemental acute care services that are not offered by Medicare (such as vision, dental, and transportation), and institutional and community-based long-term care services and supports. SNPs that offer all Medicare and Medicaid acute and long-term care services are considered fully integrated programs. More information on SNPs is available in online Appendix 5-B, available at http://www.medpac.gov. ■

Source: Saucier et al. 2009, Verdier 2006

Each program has a single care coordinator or a care management team to oversee the enrollee's care. For example, in Minnesota's MSHO program for the aged, enrollees are assigned a care coordinator who works with the enrollee's primary care physician and coordinates the enrollee's health care and social services. In the Massachusetts Senior Care Options program for the aged, care management teams coordinate the care for enrollees and authorize the services that enrollees can receive. Similarly, in the Wisconsin Partnership Program, which enrolls both the nursing home certifiable aged and physically disabled adults, the managed care plans employ staff who work together as care coordination teams and nurse practitioners who are responsible for overseeing enrollees' care (Centers for Medicare & Medicaid Services 2007).

Programs also include other coordination activities in their models of care. Arizona's program, for example, focuses on rebalancing nursing home– and community-based long-term care. Institutionalized enrollees are reassessed every six months to see if they can be placed in the community (Centers for Medicare & Medicaid Services 2007). Some integrated care programs have adopted elements of the Evercare Nursing Home Program, a model of managing Medicare benefits for long-stay nursing home patients. The goal of the program is to provide better Medicare primary care services in order to lower Medicare spending by reducing hospitalizations and emergency services. The health plans employ nurse practitioners who work with nursing home residents' primary care physicians to provide enhanced primary care, care coordination, and customized care planning.

Results Outcomes research on the integrated programs is limited; however, analyses of some of the programs demonstrate their ability to reduce institutional and inpatient utilization. The Massachusetts Senior Care Options and Minnesota Senior Health Options program reduced nursing home utilization. Specifically, the

Massachusetts program reduced the number of nursing home admissions and nursing home lengths of stay. Under the Minnesota program, nursing facility utilization declined over a recent five-year period by 22 percent and the number of seniors receiving HCBS increased by 48 percent (JEN Associates 2009, Osberg 2009). An analysis of Evercare demonstration sites found that patients had a lower incidence of hospitalizations, fewer preventable hospitalizations, and less emergency room utilization compared with two control groups (Kane et al. 2002).

Program of All-Inclusive Care for the Elderly

PACE is a Medicare benefit and an optional Medicaid benefit that fully integrates care for the frail elderly, most of whom are dual eligible. To qualify for coverage, beneficiaries must be at least 55 years of age, nursing-home certified, and live in a PACE service area. Enrollees attend an adult health day care center where they receive medical attention from an interdisciplinary team of health care and other professionals. States vary in their licensing requirements for PACE entities—as day care centers, home care providers, outpatient clinics, or some combination of them.

Under capitation with both Medicare and Medicaid, the PACE organization is responsible, and at full risk, for providing all medically necessary care and services, including primary care, occupational and recreation therapy, home health care, and hospital and nursing home care. The interdisciplinary team consists of a physician, registered nurse, social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietician, PACE center manager, home care coordinator, personal care attendants, and drivers. PACE sites directly employ the majority of PACE providers and establish contracts with providers such as hospitals and nursing facilities. If an enrollee needs nursing home care, the PACE program pays for it and continues to coordinate his or her care, even though the beneficiary resides in the facility. Beneficiaries are provided transportation to attend the day care center during the week.

Evaluations of this program have been positive. In its demonstration phase, the program demonstrated higher rates of ambulatory service utilization and significantly lower rates of nursing home utilization and hospitalization relative to those of a comparison group (Chatterji et al. 1998). Concurrently, quality measures were good—enrollees reported better health status and quality of life, and mortality rates were lower. The Balanced Budget Act of 1997 authorized the coverage of PACE benefits in the Medicare program, and PACE programs began expanding across the country.

Overall enrollment in PACE programs is low, although the number of PACE organizations has more than doubled since 1999. The number of PACE programs grew from 30 in 1999 to 72 in 2009, and as of February 2010, 18,000 beneficiaries in 30 states were enrolled in PACE (National PACE Association 2010).[14] In a survey of PACE program officers and researchers, one study identified a number of barriers to expansion (Lynch et al. 2008). First, many beneficiaries did not find the program appealing, given that they would have to frequently attend the adult day care center and change their existing provider relationships. Second, the program had significant upfront costs that nonprofit entities often could not afford. Third, it is more difficult to make PACE programs financially viable in rural areas. The distances raise transportation costs and place a greater premium on information technology to integrate the care coordination and centralize medical records. Despite these challenges, officials from the National PACE Association mentioned that 14 programs are operating in rural areas. Some of these programs use teleconferencing for team meetings and information technology to facilitate the sharing of medical charts from multiple locations.

The PACE model is not a match for some beneficiaries. The program targets the frail elderly who live in the community and are eligible for nursing home care. Patients who have modest care needs are not appropriate for this level of care.

Challenges to expanding enrollment in integrated care

States and managed care entities have faced a number of challenges when implementing integrated care programs. While some states and entities have overcome these factors, they still remain as challenges to more wide-scale implementation of these programs.

Lack of experience with long-term care

Most states, Medicare managed care plans, and medical homes do not have experience with managed care for long-term care services. Only 10 states had some form of Medicaid managed long-term care by January 2009 (Edwards et al. 2009). The remaining states either do not have Medicaid managed care programs for the aged

State–special needs plan integrated managed care program descriptions

Arizona Long-Term Care System

The Arizona Long-Term Care System (ALTCS) program is an example of a mandatory Medicaid managed care program in which the state contracts with managed care plans to also offer enrollees Medicare benefits. It is one of the programs within the Arizona Health Care Cost Containment System—a statewide mandatory 1115 waiver demonstration program for Medicaid beneficiaries. ALTCS provides long-term care services. Participation in ALTCS is mandatory for the elderly and disabled who are nursing home certifiable; however, enrollees can choose to enroll in one of the Medicare managed care plans or special needs plans (SNPs) for their Medicare benefits or they can receive their Medicare benefits through fee-for-service (FFS). Most ALTCS members reside in the community and receive home- and community-based services (HCBS) such as home health, attendant care, personal care, transportation, adult day care, and homemaker services. Institutionalized enrollees are reassessed every six months to see if they can be placed in the community (Centers for Medicare & Medicaid Services 2007).

Massachusetts Senior Care Options

The Massachusetts Senior Care Options (SCO) program began in 2004 as a demonstration program and converted to SNP authority. All aged Medicaid beneficiaries, both nursing home certifiable and non–nursing home certifiable, are eligible to enroll in the program on a voluntary basis. The program covers all Medicare and Medicaid benefits, including institutional and community-based long-term care services. Care management teams coordinate the care for enrollees and the teams authorize the services that enrollees can receive. An evaluation of SCO published in 2009 found that the program reduced both the number of nursing home admissions and nursing home length of stay (Centers for Medicare & Medicaid Services 2007, JEN Associates 2009).

Minnesota Senior Health Options

Minnesota's program, Minnesota Senior Health Options (MSHO), originally began in 1997 under Medicare demonstration authority. The managed care plans participating in MSHO are now required to be SNPs. MSHO is a voluntary program for dual-eligible seniors who are nursing home certifiable and non-nursing home certifiable. Although the program is voluntary, it has been mandatory since 1983 for Minnesota's elderly Medicaid population to enroll in a managed care plan for primary and acute Medicaid services, and the elderly Medicaid beneficiaries must choose from MSHO and another plan that offers only Medicaid services. All Medicare and Medicaid acute care services are integrated in MSHO as well as behavioral health and community-based long-term care services and up to 180 days of nursing home care. Nursing home utilization after 180 days is paid for through FFS. Each enrollee has a care coordinator who works closely with the enrollee's primary care physician and coordinates the enrollee's health care and social services. MSHO data show that nursing facility utilization for MSHO members declined by 22 percent from 2004 to 2009 and the number of seniors receiving HCBS increased by 48 percent (Centers for Medicare & Medicaid Services 2007, Edwards et al. 2009, Osberg 2009).

Minnesota Special Needs Basic Care

The Minnesota Special Needs Basic Care program (SNBC), is a voluntary program for all dual-eligible beneficiaries with disabilities. SNBC coordinates all Medicare and Medicaid acute services and Medicaid behavior health services. The program covers the first 100 days of nursing home care, but all other HCBS and long-term care services are FFS (Center for Health Care Strategies 2010, Osberg 2009).

New Mexico Coordination of Long-Term Services

New Mexico's Coordination of Long-Term Services (CoLTS) program began in 2008. CoLTS is a mandatory program for dual-eligible beneficiaries, Medicaid beneficiaries living in nursing facilities, and Medicaid beneficiaries enrolled in New Mexico's disabled and elderly waiver program. The program excludes Medicaid beneficiaries with developmental disabilities who are enrolled in New Mexico's 1915(c) waivers. CoLTS offers all Medicare acute care benefits and

(continued next page)

State–special needs plan integrated managed care program descriptions

Medicaid acute and long-term care services through SNPs (Edwards et al. 2009, Korb and McCall 2008).

New York Medicaid Advantage Plus

The Medicaid Advantage Plus program (MAP) is a Medicare and Medicaid managed care program for dual-eligible beneficiaries who are nursing home certifiable. MAP offers Medicare acute and Medicaid long-term care services, including up to 100 days of care in a nursing home and HCBS such as personal care, case management, adult day care, and social support services. New York contracts with a SNP to offer the program. MAP is voluntary; however, beneficiaries must enroll in the SNP to receive their Medicare benefits before they are permitted to enroll in the SNP for their Medicaid benefits (Edwards et al. 2009).

Texas Star+Plus

Texas Star+Plus is a mandatory program for elderly Medicaid recipients and nonelderly Medicaid beneficiaries with a physical or mental disability who reside in the community. Current nursing home residents, beneficiaries in intermediate care facilities for the mentally retarded, and Star+Plus enrollees who spend more than 120 days in a nursing facility are not allowed to participate in the program. The state contracts with some SNPs to offer both Medicare and Medicaid benefits for the dual-eligible enrollees, and by 2010 contractors will be required to be SNPs. The program covers community-based long-term care but does not cover nursing facility care. Star+Plus health plans are still responsible for members who enter a nursing facility and must work with service coordinators to assess the member at 30 days and 90 days after admission to determine whether the individual can return to the community. However, nursing facility services are paid by the state directly to the nursing facility and after four months of nursing facility utilization, Star+Plus members are disenrolled from the program and return to Medicaid fee-for-service (Center for Health Care Strategies 2010, Texas Health and Human Services Commission 2010a, Texas Health and Human Services Commission 2010b).

Washington Medicaid Integration Partnership

The Washington Medicaid Integration Partnership (WMIP) is a voluntary pilot project for elderly and nonelderly disabled dual-eligible beneficiaries. The program began in 2005 and operates in one county through a SNP. WMIP offers both Medicare acute and Medicaid acute and long-term care services (Korb and McCall 2008).

Wisconsin Partnership Program

The Wisconsin Partnership Program (WPP) began in 1999 under Medicare demonstration authority and now operates through SNPs. The program is voluntary and targeted to adults with physical disabilities and the nursing home certifiable elderly. WPP covers all Medicare services and all Medicaid acute services, community-based long-term care services, and nursing home services. The managed care plans employ staff to function as care coordination teams for enrollees, and a nurse practitioner is responsible for overseeing each enrollee's care. WPP also integrates the services of independent physicians who participate in the program's network (Centers for Medicare & Medicaid Services 2007, Frye 2007). ■

and disabled or carve long-term care services out of their managed care programs. Although institutional SNPs have relationships with long-term care providers, they offer Medicare benefits to the institutional population and are not required to contract with states for Medicaid long-term care services. All dual-eligible SNPs are required by 2013 to have contracts with states. These contracts are likely to initially cover Medicaid cost-sharing, wraparound, or supplemental services but not long-term care services. Managed care entities also may not be willing to cover institutional or community-based long-term care services if they lack experience establishing a provider network for those services. Some states are considering various risk-sharing agreements to give plans incentives to include long-term care services in their benefits packages.

Stakeholder resistance

Many states faced resistance from stakeholders during the development of integrated care programs for dual-eligible beneficiaries. In some states, stakeholder opposition has derailed implementation of integrated managed care programs or expansion of these programs to additional dual-eligible populations. Resistance has come from provider groups concerned about payment rates, the loss of clients and autonomy, and dealing with managed care organizations.

Beneficiaries and their advocates are concerned with the impact of the programs on enrollee benefits, freedom of choice, and quality of care (Korb and McCall 2008). In addition, beneficiaries often are not interested in selecting managed care options for their care. They prefer seeing their current set of providers and do not want to switch physicians. Furthermore, because Medicaid currently covers the cost-sharing requirements of Medicare, dual-eligible beneficiaries are not likely to benefit financially (i.e., reduced cost-sharing obligations) by joining a managed care option.

Such resistance could be overcome with program designs that accommodate stakeholder concerns and better understanding of the benefits of the program. For example, in Minnesota and New Mexico, support for these programs grew as the states addressed some of the advocates' concerns through the program design and as advocates understood the benefits of the programs, especially the increased access to community-based long-term care. New Mexico asked for input on program design elements such as enrollment and quality from stakeholder groups including advocates, providers, and Native Americans (Edwards et al. 2009).

Initial program investments and program financial viability

Integrated care programs require initial program investments. Managed care plans, for example, have to dedicate resources to managing the care of enrollees and may hire health care professionals to coordinate care. Plans would also have to invest in technology, such as electronic medical record systems. New PACE program sites incur the initial capital costs of establishing a day care and outpatient clinic and of hiring professional staff. Surveys of PACE sites show that lack of start-up capital limited the expansion of existing nonprofit organizations (Lynch et al. 2008).

In addition, there is concern among states about Medicaid program investments generating Medicare program savings. States must secure a waiver from the federal government to implement mandatory Medicaid managed care programs, offer beneficiaries additional services under voluntary or mandatory Medicaid managed care, expand Medicaid eligibility, or test a new payment system. As part of the waiver application, states must demonstrate to the Office of Management and Budget (OMB) that federal Medicaid expenditures under the waiver will be budget neutral. Yet states may incur costs as they invest in care management services designed to lower rehospitalizations, emergency room and skilled nursing facility use, and nursing home placements. Thus, although state Medicaid programs fund care management services (many are not Medicare-covered services), the savings accrue to Medicare. States cannot use expected savings in Medicare to offset any increases in Medicaid spending when demonstrating budget neutrality. These budget-neutrality rules are longstanding OMB policy, not statutory or regulatory requirements (Rosenbaum et al. 2009).

Waiver rules also require that budget neutrality be achieved within two to five years, depending on the waiver. Savings are likely to accrue more quickly from lower hospital, emergency room, and skilled nursing facility use than from averted nursing home admissions. However, under current policies as noted, savings from one program cannot be used to underwrite costs from the other in an integrated managed care program.

Separate Medicare and Medicaid administrative rules and procedures

Medicare and Medicaid have separate and often different procedures for administrative tasks, such as enrollment, disenrollment, eligibility, marketing, appeals, and performance reporting. Navigating and trying to align the two programs' administrative rules and processes is challenging for states, managed care entities, and dual-eligible individuals with limited resources. In addition, states can take many years to obtain federal approval for a Medicare and Medicaid managed care program. Further, each program cannot access health care claims from the other, and lack of data sharing in real time can inhibit care management and coordination between SNPs and states on covered services. SNPs and states can address some of the administrative barriers through close collaboration. For example, all but one of the SNPs participating in Minnesota's integrated care program contract with the state to be responsible for the plans' Medicare enrollment (Edwards et al. 2009).

The Patient Protection and Affordable Care Act established the Federal Coordinated Health Care Office within CMS. The Federal Coordinated Health Care Office goals include simplifying processes for dual-eligible beneficiaries and eliminating regulatory conflicts between Medicare and Medicaid and may help alleviate the administrative burdens of integrated care programs.

Low program enrollment

States can obtain waivers from CMS to mandate enrollment into Medicaid managed care; however, in contrast to states' authority over Medicaid benefits, states cannot require dual-eligible beneficiaries to enroll in a SNP to receive Medicare benefits. Under Medicare, beneficiaries have freedom of choice to select providers. Dual-eligible beneficiaries are permitted to receive their Medicare benefits through any MA plan (and can change plans monthly) or through any FFS provider. Duals may not recognize the advantages of an integrated care program (such as enhanced care coordination) and therefore may not choose to enroll in integrated care programs for their Medicare benefits.

Concluding observations

Approaches to better care coordination for dual-eligible beneficiaries need to combine financing streams and actively manage the care that beneficiaries receive. Without combined finances, an approach will not fully align provider and program incentives. A strategy to coordinate care is also needed. Likewise, care coordination alone would not align financial interests across providers and programs. Conflicting financial incentives could continue to result in unnecessary and fragmented care. Excluding long-term care from any approach will make it difficult to control federal spending for these services and result in less optimal coordinated care.

This review has not concluded whether one or more approaches to care integration are more or less likely to be successful. We have not assessed whether provider-based models (such as PACE) or health plan-based models (such as a state–SNP approach) will have better results. State–SNP arrangements appear to be successful at coordinating care for dual-eligible beneficiaries, but such arrangements were often initiated by states with a history of Medicaid managed care. States vary in their experience with and aversion to managed care and this model will not be equally replicable in all states. Future work will consider the characteristics of successful fully integrated programs and how enrollment might be expanded.

Care coordination activities should be tailored to patients' characteristics and their relative risk for costly undermanagement—potentially avoidable hospitalizations, medication mismanagement, and premature institutionalization. Beneficiaries at risk for institutionalization will need to be more closely monitored than the essentially well dual-eligible beneficiaries. Approaches for dual-eligible beneficiaries with several chronic conditions will need to emphasize communication and data sharing across the multiple providers and appropriate primary care to avert unnecessary facility-based care. Care management activities for cognitively impaired beneficiaries (a high-spending group) will need to be tailored to their ability to understand and adhere to care plans.

Integrated models of care should, like all beneficiary care, be evaluated with measures that gauge their relative efficiency—such as risk-adjusted hospitalization rates, nursing home use, emergency use, and per capita costs. Other measures should capture the extent to which and how well programs integrate the care dual-eligible beneficiaries receive using measures of care coordination and care transitions. Tying provider payment to these measures will put them at risk for achieving good patient outcomes.

Even if best models are identified, implementing full care integration for all dual-eligible beneficiaries will require a transition from the essentially uncoordinated world to one with active care management. There are multiple ways it could be accomplished. Integration could begin with certain services, such as cost sharing and optional Medicaid services. After successfully integrating these services, the models could be expanded to take on the more difficult (but more important, given the dollars at stake) set of long-term care services. Integration could also start with certain subgroups—either the high cost, those most at risk for costly undermanagement, or those with the most beneficiaries. Partial integration efforts need to be designed with enough flexibility so that other services and groups of beneficiaries can be folded in over time. ■

Endnotes

1 One study found that fewer than half of all Medicare beneficiaries with incomes at or below 100 percent of the federal poverty level were enrolled in Medicaid (Pezzin and Kasper 2002). Reasons for low participation rates include welfare stigma, a lack of information about program and eligibility criteria, and cumbersome enrollment processes.

2 There are four ways to be eligible for the Medicare Savings Program (MSP). Beneficiaries whose income is less than 100 percent of the federal poverty level (FPL) qualify for the qualified Medicare beneficiaries (QMBs) benefit, and Medicaid pays for their Medicare premiums and cost sharing. Some QMBs do not qualify for full Medicaid benefits (and are referred to as "QMB only"). In some states, higher income beneficiaries do not qualify for cost-sharing benefits but they do qualify for other Medicaid benefits. If their income is between 100 and 120 percent of FPL, then they qualify for the specified low-income Medicare beneficiaries benefit, and Medicaid pays for their Medicare Part B premiums. If their income is between 120 and 135 percent of FPL, then they qualify for the qualifying individuals benefit, and Medicaid pays for their Medicare Part B premium. If beneficiaries are working, disabled individuals with an income up to 200 percent of FPL, then they qualify for the qualified working disabled individuals benefit, and Medicaid pays their Medicare Part A premium. Under the provisions of the Medicare Improvements for Patients and Providers Act of 2008, for all these programs, beneficiary assets cannot exceed twice the Supplemental Security Income limit—$6,600 for individuals and $9,910 for couples (Centers for Medicare & Medicaid Services 2009). In 2008, the Commission recommended that the Congress raise the MSP income and asset criteria to those of the low-income drug subsidy criteria, which the Congress adopted beginning in 2010. This alignment updated the criteria (they were last revised in 1989) and will simplify the application process for beneficiaries and lower administrative costs of the programs.

3 The Balanced Budget Act of 1997 permitted states to not pay Medicare cost sharing if the Medicare rate minus the cost sharing is higher than the Medicaid rate for those services.

4 It is possible that there are community-dwelling duals with two or more physical impairments who, given our hierarchical categories, have been assigned to a cognitive impairment group.

5 Dual-eligible beneficiaries with end-stage renal disease (ESRD) were excluded from the analysis. They make up a small share of all dual-eligible beneficiaries (2 percent) and the very high spending on them would distort the underlying picture for the majority of dual-eligible beneficiaries. The average spending for ESRD dual-eligible beneficiaries is about three times that for other duals. In addition, physicians caring for beneficiaries with ESRD receive a monthly fee to manage their patients' dialysis. Therefore, ESRD patients have, to varying degrees, at least one of their underlying conditions managed by a physician.

6 The subgroups draw directly on the approach of Foote and Hogan in their analysis of the Medicare disabled population (Foote and Hogan 2001).

7 Most facilities are dually certified for both Medicaid and Medicare. To be covered under Medicare, a skilled nursing facility stay must be preceded by a three-day hospitalization and the patient must require skilled care (such as therapy or skilled nursing services). Medicare Advantage plans may waive the three-day hospital stay requirement and cover skilled care in a nursing facility as a Medicare-covered benefit.

8 In Duggan v. Bowen, beneficiaries and providers charged that Medicare's interpretation that services be "part-time or intermittent" was too narrow and denied care to eligible beneficiaries.

9 Many states have pursued Medicare maximization strategies to increase federal payments. When coverage for services is ambiguous for some beneficiaries—such as nursing home and home health services—states may require providers to first bill Medicare for services (or to pay the providers directly and then pursue Medicare reimbursement) as a way to have Medicare be the primary payer. States and providers prefer to have Medicare pay the claim: Providers prefer the higher payments generally paid by Medicare, while states can avoid paying for the service. Claims that are rejected by Medicare are then submitted to Medicaid for payments. This back-and-forth between payers can leave beneficiaries with unpaid bills until the coverage is sorted out. Some states have used contingency fee consultants to implement strategies—such as new methods to maximize federal reimbursements, state staff training in the claims submission process, and preparation of claims for federal reimbursement—designed to maximize federal reimbursements to state Medicaid programs (Government Accountability Office 2005).

10 Block grants to cover Medicaid services are not a new idea. A proposal to move Medicaid to block grants was made in 1981; they were again proposed in 1995 and 2003. These proposals outlined options for coverage and populations who had to be covered and included federal spending limits and annual increases. Although the limits on federal spending and the expanded state autonomy were attractive, a strong commitment to cover a vulnerable population and concerns about the fiscal impact on states have kept Medicaid as an entitlement program (Lambrew 2005).

11 For example, in 2003 the Bush Administration's block grant proposal included a provision that states show "maintenance of efforts" to receive federal funds—a kind of reverse matching funds (Mann 2004).

12 Application to §1915(c) HCBS Waiver Version 3.4. Appendix H. Available from http://www.hcbs.org/browse.php/sby/Date/type_tool/146/Waiver%20templates.

13 Commission calculations: estimated number of dual-eligible beneficiaries in integrated care programs and estimated number of dual-eligible beneficiaries in MA plans, including SNPs (Center for Health Care Strategies, Inc. 2009).

14 The 30 states with PACE programs are Arizona, California, Colorado, Florida, Hawaii, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, and Wisconsin. Source for states with PACE programs: MedPAC analysis of CMS, MA enrollment by state/county/contract, March 2010; source for PACE enrollment estimate: MedPAC calculation of CMS MA and Part D contract and enrollment data, February 2010.

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