State of Colorado
Department of Health Care Policy and Financing

INTEGRATED CARE FOR DUAL ELIGIBLES
Program Options Report

Table of Content

Executive Summary

Following the completion of a research report based on a comprehensive literature review and peer state and federal officials' views of best practices on integrating care, PCG now submits the Integrated Care for Dual Eligibles: Program Options Report (Options Report) to the Department of Health Care Policy and Financing (the Department). This Options Report focuses on potential strategies for Colorado to explore in integrating individuals dually eligible for Medicaid and Medicare into its Accountable Care Collaborative (ACC) Program.

The Department has awarded contracts through a competitive procurement process to experienced and innovative entities with a strong community presence to partner with the Department in its ACC Program. Selected contractors, referred to as Regional Care Collaborative Organizations (RCCOs), will be accountable for controlling costs and improving the health of Medicaid clients in one (or more) of seven regions statewide. The Initial Phase of the ACC Program is currently limited to an estimated 60,000 Medicaid only clients (i.e. non-dual eligible clients) statewide, approximately 8,600 per region. The Department's initiation of dual eligible enrollment into the Expansion Phase of the ACC Program is scheduled to begin in July 2012.

In December 2010, the Innovation Center, in conjunction with the Office of Duals, issued a Request for Proposals for "State Demonstrations to Integrate Care for Dual Eligible Individuals." In April 2011, Colorado received a contract award in response to this solicitation to support the design of integrated service delivery and payment models for dual eligible individuals. Colorado's participation with Centers for Medicare and Medicaid Services (CMS) in the State Demonstrations to Integrate Care for Dual Eligible Individuals presents an unprecedented opportunity to significantly alter the financial relationship between the state and federal government for beneficiaries dually eligible for Medicaid and Medicare. Unlike previous efforts to integrate care for dual eligibles that have largely focused on constraining Medicaid long-term care costs, Colorado has the opportunity to generate and retain Medicare savings from improved care to dual eligibles, and disburse a portion of these savings to participating RCCOs and affiliated Primary Care Medical Providers (PCMPs) under the ACC Program as appropriate.

PCG examined various programmatic options for improving care delivery to dual eligibles and interventions that could be expected to achieve savings in Medicare acute care and Medicaid long-term care for the dual eligible population. In summary, PCG recommends that implementation planning for the State Demonstration to Integrate Care for Dual Eligibles project address the following options in conjunction with incorporating dual eligibles into the ACC Program.

Pursue the Medicaid Health Home Option

The Department should move forward with the request to CMS and study how best to identify those dual eligibles and Medicaid health home services eligible for the enhanced federal match, and incorporate the potential funding to support the ACC Program.

- The Department should develop a budget for planning resources outside the funding under the State Demonstrations to Integrate Care for Dual Eligible Individuals contract with CMS, and submit a Letter of Request to CMS to initiate detailed planning for implementing Medicaid health homes for dual eligibles to begin during the Expansion Phase.

- The Department should conduct an analysis of how care coordination interventions proposed – and implemented – by RCCOs align with the required activities of Medicaid health homes.

Leverage the Use of Physician Extenders

The Department should require RCCOs to incorporate Medicare Non-Physician Practitioners (NPP) into care coordination teams as a vehicle to access Medicare funding for applicable care management activities, like Care Plan Oversight (CPO), for dual eligibles.

- The Department should review RCCO staffing plans and care management structures to assess variation and the current use of NPPs to provide care coordination in the Initial Phase.

- The Department should review the potential for the required use of NPP in care coordination teams with RCCOs and PCMP representatives in an upcoming ACC Program advisory forum.

Prevent Avoidable Hospital Admissions and Readmissions

The Department should collaborate with RCCOs and other community-based entities to pursue Medicare Community-Based Care Transitions Program (CCTP) support where applicable.

- The Department should meet with the Department of Human Services to initiate a collaborative exploration of how enhanced coordination among Area Agencies on Aging (AAAs) and Colorado's Medicaid Single Entry Point (SEP) agencies could support RCCO care transition initiatives for dual eligibles.

- The Department should review the CCTP program and discuss opportunities for CCPT participation with RCCO representatives in an upcoming ACC Program advisory forum.

Formalize Emergency Department Redirection Management

The Department should formalize ED redirection management requirements for dual eligibles in anticipation of enrollment of these beneficiaries in the ACC Program, while maintaining appropriate flexibility for RCCOs to operate in alignment with the specific needs of their respective regions.

- The Department should convene RCCOs at an upcoming ACC Program advisory forum to share best practices, given the experience of existing RCCOs in this area, with attention to identifying infrastructure investments (e.g. information technologies) where a collaborative, statewide approach might be economical.

- The Department, given the RCCOs near universal recognition of the importance of data analytics to accomplish ED reductions, should begin work with the RCCOS and SDAC to develop parameters for identification and reporting of frequent ED users.

Promote Prevention Services and Assessment for Early Intervention

The Department should develop strategies to maximize Medicare preventive services for dual eligibles to achieve long-term savings from either avoiding or treating disease at an earlier stage. Additionally, mechanisms are needed to link assessment and screening to access HCBS for functionally impaired and at-risk beneficiaries.

- The Department should analyze the alignment of assessment protocols, specifically for how Medicare's initial preventive physical examination and annual wellness visits align with Medicaid's level of care requirements for covered long-term supports and services.
- The Department should meet with the Department of Human Services to initiate a collaborative exploration of how RCCOs can best access Older Americans Acts supports through AAAs and Medicaid HCBS through SEP agencies.

Fast Track Community Supports for Post-Acute Diversions

The Department should consider implementing "Fast Track" eligibility for Medicaid home and community-based services for dual eligibles. A statewide roll-out of the initiative could be developed and targeted to dual eligibles enrolled in the ACC Program during the Expansion Phase.

- The Department should review its previous Hospital Discharge Fast Track initiative with RCCO participants at an upcoming ACC Program advisory forum.
- The Department should develop a formal outreach strategy to county departments of Human/Social Services to gauge interest in their participation.

Expand Nursing Home Transition Activities

The Department should develop nursing home transition programs that leverage the Money Follows the Person (MFP) demonstration grant infrastructure. This will identify the dual eligible beneficiaries in a nursing facility under a Medicare covered rehabilitation stay not eligible for MFP due to the statutory restrictions.

- The Department should analyze MFP transition workflows to assess what changes would be needed to extend transition activities to dual eligibles covered under the Medicare Part A post-acute SNF benefit.

- The Department should link stakeholder engagement activities for the MFP grant with stakeholder engagements under the State Demonstrations to Integrate Care for Dual Eligible Individuals project to look for synergies between these two important initiatives.

Institute Selective Contracting for Select Services

The Department should consider complementary contracting with Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program to include Medicaid-covered equipment and supplies for which Medicaid is the primary payer.

- The Department should engage CMS to become an active participant in the Medicare DMEPOS Competitive Bidding Program as its rolls out in Colorado.

- The Department should identify and quantify the level of non-Medicare covered medical equipment and supplies that could be purchased through complementary selective contracting with Medicare's selected DMEPOS vendor.

Function as a State Medicare Prescription Drug Plan (PDP)

The Department should consider functioning as a Medicare PDP for dual eligibles enrolled in the ACC Program, or more broadly, for dual eligibles with behavioral health conditions.

- The Department should approach Medicaid Community Mental Health Services Program Behavioral Health Organizations (BHOs) and stakeholders to obtain qualitative and quantitative data on dual eligibles experience in accessing behavioral health medications under Medicare Part D.

- The Department should engage CMS to gauge initial receptivity to the state functioning as a Medicare PDP in order to begin to outline regulatory hurdles and operational issues that would need to be addressed in implementation planning.

Integrate Financing and Delivery through Behavioral Health Organizations

The Department should consider acting as the integrating entity to manage all behavioral health services for dual eligibles and work with CMS to develop a risk-based financing arrangement for

Medicare-covered behavioral health services and sub-capitate to contracted BHOs for the provision of these services to dual eligibles.

- The Department should focus on physical health and behavioral health system linkages under the Initial Phase of the ACC Program, with ongoing dialogue on this topic at upcoming ACC Program advisory forums.

- The Department should engage CMS to gauge initial receptivity to capitating and subcapitating Medicare behavioral health benefits in order to begin to outline regulatory hurdles and operational issues that would need to be addressed in implementation planning.

Expand the Use of Telemedicine

The Department should seek to expand the telemedicine best practices program for dual eligibles suffering from a chronic disease, including behavioral health disorders, to improve access and reduce the need for costly emergency room visits.

- The Department should convene RCCO, PCMP, and BHO representatives at an upcoming ACC Program advisory forum to share telehealth best practices, with attention to identifying policies that could promote greater system integrations.

- The Department should complete a comparative analysis of Medicare and Medicaid telehealth requirements to identify regulatory and policy variation that may need to be addressed in implementation planning.

The Department and the four advisory/coordinating committees of the ACC Program have multiple options for addressing issues and challenges that correspond to the financial, administrative, and legal aspects of the implementation process for incorporating dual eligibles into the ACC Program. The Department must vet various program options with stakeholders within the state, and its federal partners at CMS, to develop a concrete design for the implementation of a program resulting from planning under the State Demonstrations to Integrate Care for Dual Eligibles project.

A primary implementation challenge that will arise sometime in the Expansion Phase will be the question of how both Medicaid and Medicare expenditures for dual eligibles can be reduced – and measured – through the activities of the RCCOs and/or other innovations. The precise arrangements for any shared savings arrangements between the state and Federal government will emerge from ongoing collaboration with CMS under the State Demonstrations to Integrate Care for Dual Eligibles project. Greater innovation than previously imaginable is now possible through the State Demonstrations to Integrate Care for Dual Eligibles project. Further implementation planning and other Department-driven preparation measures are integral to Colorado aligning its ACC Program and State Demonstration to Integrate Care for Dual Eligibles project with the common goal of appropriately controlling utilization, reducing spending, and improving the quality of care received by dual eligibles.

Introduction

Following the completion of a research report based on a comprehensive literature review and peer state and federal officials' views of best practices on integrating care, PCG now submits the Integrated Care for Dual Eligibles: Options Report (Options Report) to the Department of Health Care Policy and Financing (the Department). This Options Report focuses on potential strategies for Colorado to explore in integrating individuals dually eligible for Medicaid and Medicare into its Accountable Care Collaborative (ACC) Program. The ACC Program provides "the framework within which other health care initiatives can thrive such as the Medical Home, health information technology, and payment reform. The ACC Program supports a shift by the Department from a volume-driven model to an accountable, outcome-based system of care[1]".

The Department has awarded contracts through a competitive procurement process to experienced and innovative entities with a strong community presence to partner with the Department in its ACC Program. Selected contractors, referred to as Regional Care Collaborative Organizations (RCCOs), will be accountable for controlling costs and improving the health of Medicaid clients in one (or more) of seven regions statewide. The Initial Phase of the ACC Program is currently limited to an estimated 60,000 Medicaid only clients (i.e. non-dual eligible clients) statewide, approximately 8,600 per region. The Department plans on initiating dual eligible enrollment in the Expansion Phase of the ACC Program, scheduled to begin in July 2012.

RCCOs will meet the definition of Primary Care Case Managers (PCCMs) as defined by the Centers for Medicare and Medicaid Services (CMS). Care coordination is the major theme presented throughout the various sections of this Options Report and PCCM is discussed in further detail in this report. Amidst the finalization of the implementation options for incorporating dual eligibles into the ACC Program, the efficiency and effectiveness of the initiative will be heavily dependent on coordination of Medicare and Medicaid benefits by RCCOs – and their affiliated Primary Care Medical Providers (PCMPs). More innovative options for changes in the financing and delivery of care to dual eligibles are also discussed in

[1] Taken from the Colorado Request for Proposals: Regional Care Collaborative Organizations for the Accountable Care Collaborative Program

this report. These innovations are more possible than ever in the current climate of health care reform. In late 2010, under the authority of section 2602 of the Affordable Care Act (ACA), CMS established the Federal Coordinated Health Care Office (CHCO), with the goal of improving the coordination between the federal government and states to develop innovative care coordination and integration models.

On November 16, 2010, CMS formally announced the establishment of the Center for Medicare and Medicaid Innovation (Innovation Center) created by section 3021 of the ACA. The Innovation Center is charged with exploring new health care delivery and payment models that will enhance the quality of care for Medicare and Medicaid beneficiaries, improve the health of the population, and lower costs through improvement. One of the Innovation Center's first initiatives to support the CHCO in implementing demonstrations will test different delivery systems and payment models that integrate care for dual eligibles. In December 2010, the Innovation Center, in conjunction with the Office of Duals, issued a Request for Proposals for "State Demonstrations to Integrate Care for Dual Eligible Individuals." In April 2011, CMS announced that Colorado and 14 other states received contracts of up to $1 million to support the design of integrated service delivery and payment models for dual eligible individuals.[2]

The ACC Program is a hybrid model, adding characteristics of a regional Accountable Care Organization (ACO) to the PCCM system. The Department's approach to the ACC Program and timing in respect to another significant health care reform are fortuitous indeed. On March 31, 2011, CMS issued a Notice of Proposed Rulemaking (NPRM) on requirements and payment incentives for ACOs, the centerpiece of the Medicare Shared Savings Program (MSSP) that will be implemented on January 1, 2012 under section 3022 of the ACA. ACOs participating in the MSSP may receive incentive payments from Medicare as a percentage of actual Medicare savings. This shared savings mechanism, also referred to as gain-sharing, is similar to the Department's approach to provide shared savings to RCCOs and PCMPs under the Expansion Phase of the ACC Program.

[2] Other states participating in the State Demonstrations are California, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.

Medicare is the primary payer of acute care services for dual eligibles. The conflicting coverage policies and incentives between Medicare and Medicaid are a major challenge, financially and administratively, to coordinating care for dual eligibles. At the State level, Medicaid has historically lacked financial incentives to reduce unnecessary acute care delivered to dual eligibles because Medicaid would assume virtually all costs and oversight to administer the interventions. Meanwhile, the financial benefits of reducing inappropriate use of Medicare services, like avoidable hospital stays, would solely belong to the federal government (or Medicare health plans).[3]

While efforts are underway to better coordinate Medicaid and Medicare programs from the federal level, integrated care models at the state or regional level also have an opportunity for leadership. Colorado's participation with CMS in the State Demonstrations to Integrate Care for Dual Eligible Individuals presents an unprecedented opportunity to significantly alter the financial relationship between the state and federal government for beneficiaries dually eligible for Medicaid and Medicare. Unlike previous efforts to integrate care for dual eligibles that have largely focused on constraining Medicaid long-term care costs, Colorado has the opportunity to generate and retain Medicare savings from improved care to dual eligibles, and disburse a portion of these savings to participating RCCOs and PCMPs under the ACC Program as appropriate.

This Options Report begins with detail on service description, cost-sharing, and payment methodologies for covered benefits for dual eligibles. These include Medicare acute and ancillary services for which Medicare is the primary payer, as well as Medicaid long-term care benefits. The report is not intended to be a comprehensive summary of all benefits, but rather to outline the interplay between Medicare and Medicaid with respect to covered services for dual eligibles. Special consideration is given to behavioral health care given the fragmentation of coverage in this important area. Next, various programmatic options are examined for improving care delivery to dual eligibles and interventions that could be expected to achieve savings in Medicare acute care and Medicaid long-term care for the dual eligible population. Lastly, issues and challenges that correspond to the financial, administrative, and legal aspects of the implementation process for incorporating dual eligibles into the ACC Program conclude the

[3] Center for Health Care Strategies, Inc. (2009, July) *Encouraging Integrated Care for Dual Eligibles.*

report. Further implementation planning and other Department-driven preparation measures are integral to Colorado aligning its ACC Program with its initially stated goal of appropriately controlling utilization, reducing spending, and improving quality of care received by dual eligibles.

Medicare Benefit Package and Payment Structures

This section addresses benefit offerings under Medicare, including cost sharing and reimbursement methodologies for Medicare acute care and ancillary medical services which is primary coverage for dual eligibles. Title XVIII of the Social Security Act (the Act) regulating Medicare does not explicitly define "acute care." Nonetheless, it implies a definition through its use of related terms and the benefits it offers. Medicare may cover acute inpatient care in hospitals, doctor services, outpatient care, as well as ancillary services provided in support of physician treatment or hospital care. Laboratory tests, durable medical equipment, and a host of other benefits are examples of ancillary services. Post-acute care – distinctly different from long-term care – provided in skilled nursing facilities or through home health services are discussed in conjunction with these Medicare benefits. Prescription drug coverage under Medicare is also discussed separately.

Medicare Consists of Multiple Parts	
Part	**Type of Benefit**
Part A	Hospital insurance, including skilled nursing, home health, and hospice services
Part B	Supplementary medical insurance, including physician and outpatient services, durable medical equipment, and other services
Part C	Alternative to receiving original Medicare. Beneficiaries enroll in a Medicare Advantage health plan
Part D	Prescription drug benefit
Note: Parts A and B are referred to as “Original Medicare.”	

Medicare Part A Benefits

Medicare Part A is hospital insurance that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Inpatient Hospitalization

Medicare Part A (Hospital Insurance) covers inpatient hospital care for up to 90 days of inpatient hospital services in each benefit period, and an additional 60 lifetime reserve days. A benefit period begins when a dually eligible beneficiary is admitted to the hospital and ends when the beneficiary has been out of the hospital for 60 days, or has not received Medicare-covered care in a skilled nursing facility (SNF) or hospital for 60 consecutive days from the day of discharge. Medicare provides 60 lifetime reserve days of inpatient hospital coverage following a 90-day stay in the hospital. These lifetime reserve days can only be used once but this is rare given very few people remain in a hospital for 150 consecutive days.

Section 1886(D) of the Act sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates. This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. Hospital benefits under Medicare also cover post-acute care in Long-Term Care Hospitals and Inpatient Rehabilitation Facilities. For more detail on variation in coverage and payment for these services see Appendix A.

There are services which, when provided in a hospital, are covered under Medicare Part B, even though the patient has Part A coverage for the hospital stay. The services are excluded from the statutory definition of inpatient hospital services[4]. Hospital services or partial hospitalization services incident to physician's or other practitioner's services rendered to outpatients (including drugs and biologicals which are not usually self-administered by the patient)may also be covered with payment for these services under Part B to a hospital.

[4]Part B covers the following services while a dual eligible beneficiary is in a hospital: Physicians' services ; physician assistant services; certified nurse-midwife services; qualified clinical psychologist services; screening mammography services; screening pap smears and pelvic exams; screening glaucoma services; colorectal screening; prostate screening; bone mass measurements; and diabetes self-management.

Payment may also be made under Part B for the medical and other health services, where no payment can be made for such services under Part A. For example, payment may be made under Part B for the services in question where the beneficiary is an inpatient of a hospital and has exhausted his or her allowed days of inpatient coverage under Part A (or has elected not to use his or her lifetime reserve days).

Post-Hospital Skilled Nursing Facility Care

Medicare Part A covers skilled care in a skilled nursing facility (SNF) under certain conditions for a limited time. Skilled care is health care given when you need skilled nursing or rehabilitation staffs to manage, observe, and evaluate your care. Medicare covers certain skilled care services needed daily on a short-term basis (up to 100 days of Medicare Part A SNF coverage in each benefit period).

Current eligibility for the SNF benefit is restricted to persons who have had a hospital stay of at least three days in the past 30-day period. Coverage is limited to a maximum of 100 days for each spell of illness. There is no deductible for SNF care. But after the first 20 days of a stay, a daily coinsurance payment is required of the beneficiary. In addition to these eligibility, coverage, and cost-sharing provisions, SNFs must have a transfer agreement with a hospital to accept patients recommended for SNF care; sufficient staff to provide 24-hour nursing services; a physician who supervises patient care and is available 24 hours a day on an emergency basis; and dietary, pharmaceutical, dental, and medical social services available.

Under the PPS system, a SNF receives a payment that is derived from a blend of (a) a case mix-adjusted Federal rate and (b) a facility-specific rate based on the facility's historical costs. The Federal rates are adjusted to account for a facility's case mix using a resident classification system, known as Resource Utilization Groups. Under PPS, SNFs with reasonable costs that exceed the routine cost limits can be granted exceptions from the limits for patients requiring more services than average. The exception payments are excluded from calculating the Federal rate. Facility-specific rates are based on fiscal year cost reports, trended forward. In contrast to the Federal rates, facility-specific rates include exceptions to the routine cost limits.

Home Health Services

Currently, Medicare provides home health benefits to beneficiaries who require intermittent or part-time skilled nursing care and therapy services, and who are homebound, defined flexibly to include individuals who "occasionally leave the home." Home health services may also include medical social services, part-time or intermittent home health aide services, medical supplies for use at home, durable medical equipment and an injectable osteoporosis drug. Although, these services must be prescribed and re-certified every 62 days by a physician, there is no prior hospitalization requirement or limit on the number of visits a person may receive.[5] Home health benefits under Medicare can be provided if a beneficiary meets all the following conditions:

- Is under the care of a doctor, and getting services under a plan of care established and reviewed regularly by a doctor.
- A doctor must certify that you need one or more of the following:
  - Intermittent skilled nursing care (other than just drawing blood),
  - Physical therapy,
  - Speech-language pathology services, or
  - Continued occupational therapy.
- The home health agency providing care is Medicare-certified.
- The beneficiary is homebound, and a doctor must certify homebound status. To be homebound means the following:
  - Leaving home isn't recommended because of the condition,
  - The condition keeps them from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person), and

[5]Prior to the Omnibus Budget Reconciliation Act of 1980, the home health benefit was split between Medicare's Part A and Part B, with each component subject to different coverage and payment requirements. Both Part A and B home health benefits were subject to 100-visit limits. The Part A benefit required a prior hospital stay (of at least three days). No cost sharing was required for post-hospital benefits under Part A, but coinsurance was required under Part B (until repealed in 1972). OBRA 1980 liberalized the home health benefit, while effectively consolidating it under Part A. For example, the three-day prior hospitalization requirement and 100-visit limit were removed.

– Leaving home takes a considerable and taxing effort.

A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. Medicare beneficiaries can also get home health care if they attend adult day care.

Hospice Care

For beneficiaries with a terminal illness, Medicare hospice coverage includes medical, nursing, and social services; certain durable medical equipment, drugs for pain relief and symptom management; and other covered services as well as services Medicare usually doesn't cover, such as spiritual and grief counseling. A physician must certify that the beneficiary is expected to live 6 months or less. Coverage for hospice care can continue as long as the hospice medical director or hospice doctor recertifies the terminal illness.

A Medicare-approved hospice usually gives hospice care in the home or other facility where the beneficiary lives like a nursing home. Hospice care doesn't pay for the stay in a facility (room and board) unless the hospice medical team determines that the need for short-term inpatient stays for pain and symptom management can't be addressed at home. These stays must be in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility that contracts with the hospice. Medicare also covers inpatient respite care - up to 5 days each time – which is care in a Medicare-approved facility.

Medicaid Part A Cost Sharing

While Medicare is the primary payer for the Part A benefits described above, Medicaid is responsible for copayments, coinsurance, and deductibles that may apply for each service covered under Part A. This includes a $1,132 deductible required before Medicare begins to pay. The coinsurance amounts for each Part A benefit that Medicaid is required pay as a share of the cost for services to dual eligibles is provided below.

Part A Benefit	Medicaid Cost Sharing Responsibility
Inpatient Hospitalization	
Days 1 – 60	$1,132 Deductable

Days 61 – 90	$238 a day
Days 91 – 150	$566 a day
Days 150+	All costs
Post-Hospital Skilled Nursing Facility Care	
Days 1 -20	No coinsurance
Days 20 – 100	$141.50 a day
Days 101+	All costs
Home Health Services	No coinsurance – as long as beneficiary meets Medicare requirement – except 20 percent of Medicare-approved amount for Durable Medical Equipment
Hospice Care	None – as long as physician certifies need – except 5 percent copayment for outpatient drugs and inpatient respite care

Medicare Part B Covered Benefits

Medicare Part B covers medically-necessary services like doctors' services and tests, outpatient care, therapy, durable medical equipment, and other medical services. Part B also covers some preventive services.

Physician Services

Physician services are the professional services performed by a physician or physicians for a patient including diagnosis, therapy, surgery, consultation, and care plan oversight. Physician services include surgery, consultation, office and institutional calls, and services and supplies furnished incident to a physician's professional service. Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Generally, a physician is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of "the Act"). In certain circumstances, services furnished by interns and residents within the scope of their training program are covered as physician services. Optometrists and chiropractors are considered a physician for Medicare coverage with some limitations. For addition detail on coverage requirements see Appendix B.

The professional component of provider-based physician services pertains to that part of the physician's activities that is directly related to the medical care of the individual patient. It

represents remuneration for the identifiable medical services by the physician that contribute to the diagnosis of the patient's condition or to his treatment. These services are covered under Part B. It is necessary to distinguish between the medical and surgical services rendered by a physician to an individual patient, which are paid under Part B, and provider services (including a physician's services for the provider) which are paid under Part A.

Medicare pays for physician services based on a list of services and their payment rates, called the Medicare Physician Fee Schedule (PFS). The PFS covers more than 10,000 physician services. The file contains the associated relative value units, a fee schedule status indicator, and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.). Under the fee schedule payment system, payment rates are based on relative weights, called relative value units (RVUs), which account for the relative costliness of the inputs used to provide physician services: physician work, practice expenses, and professional liability insurance (PLI) expenses. All services—surgical and non-surgical—are classified and reported to CMS according to the Healthcare Common Procedure Coding System (HCPCS).

PFS pricing amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice). The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component. The fee schedule's relative weights are updated at least every five years; HCPCS codes and the conversion factor are updated annually. The annual updates for the conversion factor are made according to the Sustainable Growth Rate (SGR) system. The SGR is a complex statutory formula created in 1997 as a target rate of growth in Medicare spending for physician and non-physician practitioners' (nurses, physical therapists, physician assistants, etc.) services consistent with a target based on growth in the national economy, Gross Domestic Product (GDP). The formula is flawed because the cost of operating a medical practice typically grows faster than the GDP.[6]

[6] Medicare Payment Advisory Commission (2007, March) *Report to the Congress: Assessing alternatives to the sustainable growth rate system*. Washington, DC: MedPAC.

Medicare pays for services and supplies (including drug and biologicals which are not usually self-administered) that are furnished incident to a physician's or other practitioner's services; are commonly included in the physician's or practitioner's bills; and for which payment is not made under a separate benefit category listed in §1861(s) of the Act. Supplies usually furnished by the physician in the course of performing his/her services (e.g., gauze, ointments, bandages, and oxygen) are also covered.

Non-Physician Practitioner Services

Nurse practitioners, clinical nurse specialists, and physician assistants are health care providers who practice either in collaboration with or under the supervision of a physician. States are responsible for licensing and for setting the scopes of practice for all three specialties. Services provided by these non-physician practitioners can be reimbursed under Medicare Part B. The Balanced Budget Act of 1997 (BBA97) modified the way the Medicare program pays for their services. Prior to January 1, 1998, their services were reimbursed by Medicare only in rural areas and certain health care settings. Payments are now allowed in all geographic areas and health care settings permitted under State licensing laws. The services of a physician assistant, however, must continue to be billed using the physician's national provider identifier (NPI). Nurse practitioners and clinical nurse specialists are now allowed to bill Medicare directly. Specific NPP qualifications for Medicare billing can be found in Appendix B.

Medicare coverage for nurse practitioners, clinical nurse specialists, and physician assistants is limited to the services the practitioners who are legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law). The nurse practitioners, clinical nurse specialists, and physician assistant services may not be covered under Medicare if they are otherwise excluded from coverage even though the non-physician practitioner may be authorized by State law to perform them.

Outpatient Hospital Care

Medicare Part B covers medically-necessary services that dual eligibles receive as an outpatient from a Medicare-participating hospital for diagnosis or treatment of an illness or injury. Covered outpatient hospital services include:

- Emergency or observation services, services in an outpatient clinic, including same-day surgery;
- Laboratory tests billed by the hospital;
- Mental health care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it;
- X-rays and other radiology services billed by the hospital;
- Medical supplies such as splints and casts;
- Screenings and preventive services; and
- Certain drugs and biologicals.

Medicare Part B covers emergency department services. Emergency services may be covered in foreign countries only in rare circumstances. A medical emergency is when an injury or illness requires immediate medical attention to prevent a disability or death.

For hospital outpatient services, Section 4523 of the Balanced Budget Act of 1997 (BBA) provides authority for CMS to implement a prospective payment system (PPS) under Medicare, (as well as certain Part B services furnished to hospital inpatients who have no Part A coverage). All services paid under the new PPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter.

Ambulatory Surgical Services

Facility services furnished by ambulatory surgical centers (ASCs) in connection with certain surgical procedures are covered under Part B. To receive coverage of and payment for its

services under this provision, a facility must be certified as meeting the requirements for an ASC and enter into a written agreement with CMS. The law ties coverage of ASC services under Part B to specified surgical procedures, which are contained in a list revised and published periodically by CMS. Groupings and related prices are also published periodically in the Federal Register.

The ASC facility services are services furnished in an ASC in connection with a covered surgical procedure that are otherwise covered if furnished on an inpatient or outpatient basis. Not included in the definition of facility services are medical and other health services, even though furnished within the ASC, which are covered under other portions of the Medicare program, or not furnished in connection with covered surgical procedures. This distinction between covered ASC facility services and services which are not covered ASC facility services is important, since the facility payment rate includes only the covered ASC facility services.

An ASC for purposes of the Medicare benefit is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. It enters into an agreement with CMS to do so. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure, or control of a hospital). If a hospital based surgery center is not certified as an ASC it continues under the program as part of the hospital. In that case the applicable hospital outpatient payment rules apply. This is the outpatient prospective payment system (OPPS), for most hospitals, or may be provisions for hospitals excluded from OPPS.

Services which are not covered ASC facility services such as physicians' services and prosthetic devices (other than intraocular lenses) may be covered and billable under other Medicare benefits. Where such services are performed in an ASC, the physician and others who perform covered services may also be paid for his/her professional services. However, the "professional" rate is then adjusted since the ASC incurs the facility costs.

Laboratory and Diagnostic Services

Medicare Part B covers diagnostic tests, like CT scans, MRIs, EKGs, and X-rays. Section 410.32(b) of the Code of Federal Regulations (CFR) requires that diagnostic tests covered under §1861(s)(3) of the Act and payable under the physician fee schedule, with certain exceptions

listed in the regulation, have to be performed under the supervision of an individual meeting the definition of a physician to be considered reasonable and necessary and, therefore, covered under Medicare. Diagnostic x-ray services furnished by a portable x-ray supplier are covered under Part B when furnished in a place or residence used as the patient's home and in nonparticipating institutions.

Section 1833 and 1861 of the Act provides for payment of clinical laboratory services under Medicare Part B. Clinical laboratory services involve the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition. Laboratory services must meet all applicable requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), as set forth at 42 CFR part 493. Section 1862(a)(1)(A) of the Act provides that Medicare payment may not be made for services that are not reasonable and necessary. Clinical laboratory services must be ordered and used promptly by the physician who is treating the beneficiary as described in 42 CFR 410.32(a), or by a qualified non-physician practitioner, as described in 42 CFR 410.32(a)(3).

Speech, Physical and Occupational Therapy

Therapy services are a Medicare covered benefit in §§1861(g), 1861(p), and 1861(ll) of the Act. Covered therapy services are furnished by providers, by others under arrangements with and under the supervision of providers, or furnished by suppliers (e.g., physicians, non-physician practitioners, enrolled therapists), who meet the requirements in Medicare manuals for therapy services. Since the outpatient therapy benefit under Part B provides coverage only of therapy services, payment can be made only for those services that constitute therapy.

- **Physical therapy services** are those services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status.

- **Occupational therapy services** are those services provided within the scope of practice of occupational therapists and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status.

- **Speech-language pathology** services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability.

Providers of services are defined in §1861(u) of the Act, 42CFR400.202 and 42CFR485 Subpart H as participating hospitals, critical access hospitals (CAH), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), home health agencies (HHA), hospices, participating clinics, rehabilitation agencies or outpatient rehabilitation facilities (ORF). Providers are also defined as public health agencies with agreements only to furnish outpatient therapy services, or community mental health centers with agreements only to furnish partial hospitalization services.

Suppliers of therapy services include individual practitioners such as physicians, NPPs, physical therapists, and occupational therapists who have Medicare provider numbers. Regulatory references on physical therapists in private practice (PTPPs) and occupational therapists in private practice (OTPPs) are at 42CFR410.60 (C)(1), 485.701-729, and 486.150-163. Speech-language pathologists are not suppliers because the Act does not provide coverage of any speech-language pathology services furnished by a speech-language pathologist as an independent practitioner.

Outpatient therapy services furnished to a beneficiary by a provider or supplier are payable only when furnished in accordance with certain conditions such as an order (sometimes called a referral) for therapy service, if it is documented in the medical record, and provides evidence of both the need for care and that the patient is under the care of a physician. Therapy services are payable under the Physician Fee Schedule when furnished by 1) a provider to its outpatients in the patient's home; 2) a provider to patients who come to the facility's outpatient department; 3) a provider to inpatients of other institutions, or 4) a supplier to patients in the office or in the patient's home. (CORF rules differ on providing therapy at home.)

A hospital may bill Medicare for outpatient therapy (physical therapy, occupational therapy, or speech-language pathology) services that it furnishes to its outpatients either directly or under

arrangements in the hospital's outpatient department. Where a prospective payment system (PPS) applies, therapy services are paid when services conform to the requirements of that PPS. Reimbursement for therapy provided to Part A inpatients of hospitals or residents of SNFs in covered stays is included in the respective PPS rates. Payment for therapy provided by an HHA under a plan of treatment is included in the home health PPS rate.

Durable Medical Equipment

Medicare Part B covers Durable Medical Equipment (DME) only if prescribed by a physician for use in the beneficiaries home that is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his or her malformed body member. Medical equipment is equipment primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature, such as incontinent pads, lamb's wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, irrigating kits, sheets, and bags are not considered "durable" within the meaning of the definition. There are other items that, although durable in nature, may fall into other coverage categories such as supplies, braces, prosthetic devices, artificial arms, legs, and eyes.

In certain circumstances, the DME that Medicare covers includes, but isn't limited to the following:

- Air-fluidized beds,
- Blood sugar monitors,
- Canes (white canes for the blind aren't covered),
- Commode chairs,
- Crutches,
- Home oxygen equipment and supplies,
- Hospital beds,

- Infusion pumps (and some medicines used in infusion pumps if considered reasonable and necessary),
- Nebulizers (and some medicines used in nebulizers if considered reasonable and necessary),
- Patient lifts (to lift patient from bed or wheelchair by hydraulic operation),
- Suction pumps,
- Traction equipment,
- Walkers, and
- Wheelchairs.

Expenses incurred by a beneficiary for the rental or purchases of DME are reimbursable under Medicare. The decision whether to rent or purchase an item of equipment generally resides with the beneficiary, but the decision on how to pay rests with CMS. For some DME, program payment policy calls for lump sum payments and in others, for periodic payment. Where covered DME is furnished to a beneficiary by a supplier of services other than a provider of services, the Durable Medical Equipment Regional Coordinators (DMERC) makes the reimbursement. If a provider of services furnishes the equipment, the intermediary makes the reimbursement. The payment method is identified in the annual fee schedule update furnished by CMS.

Payment may also be made for repairs, maintenance, and delivery of equipment and for expendable and non-reusable items essential to the effective use of the equipment subject to certain conditions. DME suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If a supplier isn't enrolled, Medicare won't pay the claim submitted, even if the supplier is a large chain or department store that sells more than just DME.

Preventive and Screening Services

Preventative health services are an important component of good primary care. Medicare has strengthened coverage of prevention services over recent years. In addition to a one-time

"Welcome to Medicare" physical and a yearly "Wellness" Exam, Medicare Part B covers the following preventive and screening services:

- Abdominal aortic aneurysm screening;
- Bone mass measurement;
- Cardiovascular disease screenings;
- Colorectal cancer screening;
- Diabetes screenings;
- Diabetes self-management training;
- Glaucoma tests;
- HIV screening;
- Mammogram (screening);
- Medical nutrition therapy services exam;
- Pap test/pelvic exam (screening);
- Prostate cancer screening;
- Flu shots;
- Hepatitis B shots;
- Pneumococcal shots; and
- Smoking cessation counseling.

Pursuant to section 4103 of the ACA, CMS expanded coverage, as established by 42 CFR 410.15, effective for services furnished on or after January 1, 2011 and subject to certain eligibility and other limitations. Payments are allowed for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), when performed by qualified health

professionals, for a Medicare beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months.

Telehealth Services

Medicare Part B covers certain telehealth services, like office visits and consultations that are provided using an interactive two-way telecommunications system by an eligible provider who is at a location different than the patient. For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.[7]

Beneficiaries are eligible for telehealth services only if they are presented from an originating site located either in a rural health professional shortage area (HPSA) or counties not classified as a metropolitan statistical area (MSA).[8] As of January 2011, telehealth is available only if the patient is located at one of the following places, known as an "originating site": a doctor's office, hospital, critical access hospital, rural health clinic, federally-qualified health center, hospital-based or critical access hospital-based dialysis facility, skilled nursing facility, or community mental health center.

The use of a telecommunications system may substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. Section 223 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended §1834 of the Act to provide for an expansion of Medicare payment for telehealth services. Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services. Covered telehealth services now include:

[7] BIPA does allow the use of asynchronous "store and forward" technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii; BIPA does not require that a practitioner be present for the patient to receive interactive telehealth services.

[8] Additionally, Federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location.

- Consultations[9] (Effective October 1, 2001- December 31, 2009);
- Initial inpatient telehealth consultations (Effective January 1, 2010);
- Follow-up inpatient telehealth consultations (Effective January 1, 2009);
- Office or other outpatient visits;
- Subsequent hospital care services (with the limitation of one telehealth visit every 3 days) (Effective January 1, 2011);
- Subsequent nursing facility care services (with the limitation of one telehealth visit every 30 days) (Effective January 1, 2011);
- Individual psychotherapy;
- Pharmacologic management;
- Psychiatric diagnostic interview examination (Effective March 1, 2003);
- End stage renal disease related services (Effective January 1, 2005);
- Individual and group medical nutrition therapy (Individual effective January 1, 2006; group effective January 1, 2011);
- Neurobehavioral status exam (Effective January 1, 2008);
- Individual and group health and behavior assessment and intervention (Individual effective January 1, 2010; group effective January 1, 2011);
- Individual and group kidney disease education (KDE) services (Effective January 1, 2011); and

[9] Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits.

- Individual and group diabetes self-management training (DSMT) services (with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training) (Effective January 1, 2011).

With regard to payment amount, BIPA specified that payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telemedicine encounter) is equal to what would have been paid without the use of telemedicine. Distant site practitioners include the following Medicare providers:

- Physician;
- Nurse practitioner;
- Physician assistant;
- Nurse midwife;
- Clinical nurse specialist;
- Clinical psychologist;
- Clinical social worker; and
- Registered dietitian or nutrition professional.

Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended §1834(m) of the Act to add certain entities as originating sites for payment of telehealth services. Effective for services furnished on or after January 1, 2009, eligible originating sites include a hospital-based or critical access hospital-based renal dialysis center (including satellites); a skilled nursing facility (as defined in §1819(a) of the Act); and a community mental health center (as defined in §1861(ff)(3)(B) of the Act). MIPPA also amended§1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under §1834(m)(4)(C)(ii)(VII) from the consolidated billing provisions of the skilled nursing facility prospective payment system (SNF PPS). Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare.

BIPA also expanded payment under Medicare to include a $20 originating site facility fee (location of beneficiary). Previously, The BBA of 1997 required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

Medicaid Part B Cost Sharing

While Medicare is the primary payer for the Part B benefits described above, Medicaid is responsible for copayments, coinsurance, and deductibles that may apply for each service covered under Part B. This includes an annual deductible of $162 required before Medicare begins to pay. The coinsurance amounts – typically 20 percent of the Medicare-approved amount of the service – for each Part B benefit that Medicaid is required pay as a share of the cost for services to dual eligibles is provided below.

Part B Benefit	Medicaid Cost Sharing Responsibility
Annual Deductable	$162
Physicians and Non-Physician Practitioners	20 percent of Medicare-approved amount
Physicians and Non-Physician Practitioners	20 percent of Medicare-approved amount
Outpatient Hospital Care	20 percent of Medicare-approved amount
Ambulatory Surgical Services	20 percent of Medicare-approved amount
Laboratory and Diagnostic Services	
Clinical Lab Services	No coinsurance
Other Diagnostic	20 percent of Medicare-approved amount
Speech, Physical and Occupational Therapy	
Speech Therapy	20 percent of Medicare-approved amount, then all costs above the yearly benefit limit of $1840
Physical Therapy	20 percent of Medicare-approved amount, then all costs above the yearly benefit limit of $1840
Occupational Therapy	20 percent of Medicare-approved amount, then all costs above the yearly benefit limit of $1840
Durable Medical Equipment	20 percent of Medicare-approved

	amount
Preventive Services	20 percent of Medicare-approved amount
Telehealth	20 percent of Medicare-approved amount

Medicare Part D Prescription Drug Benefits

Dual eligibles have undergone major changes in their drug coverage policies as a result of the implementation of Medicare Part D prescription drug coverage. Under the provisions of the Medicare Modernization Act of 2003 (MAA), Medicare Part D replaced Medicaid as the primary payer for most drugs for dual eligible beneficiaries and as of January of 2006, 6.5 million dual eligibles moved from Medicaid to Medicare Prescription Drug Plans (PDPs).

A Medicare PDP is a stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare PDPs.

State Medicaid programs have continued to contribute to the cost of drugs for dual eligibles now covered under Medicare Part D. Medicare Part D uses three mechanisms to finance the cost of prescription drug benefits for dual eligibles: monthly premiums paid by Medicare Part D enrollees[10], the federal share of the savings from changing Medicaid drug coverage for dual-eligibles, and state "clawback" payments based on a formula specified in the MMA.[11] The formula required states to contribute an amount equal to 90 percent, declining to 75 percent, of the per capita cost of states' drug spending under Medicaid in 2003 multiplied by the number of dual eligibles enrolling in the new Medicare benefit.

[10] Generally, dual eligibles and others deemed eligible for low-income subsidy pay no Part D plan premiums or deductibles, but pay $1.10 or $2.40 for generic drugs and $3.20 or $6.00 for brand-name drugs, depending on their income.

[11] In addition to the phased-down contribution, Medicaid administrations are required to conduct eligibility determinations for individuals qualifying for assistance with co-pays under Part D.

The clawback essential requires each state participating in Medicaid to pay a monthly "premium" to the federal government to cover the costs of prescription drugs used by its dual eligible population. Instead of receiving federal Medicaid matching funds to cover the costs of outpatient prescription drugs for dual eligibles, the states are financially responsible for their share of these costs. In 2003, the Congressional Budget Office estimated that the clawback would potentially account for 25 percent of the offsets to the cost of Medicare Part D in the first five years of implementation of Medicare Part D.

Medicaid programs are specifically prohibited from continuing to cover drugs offered under the Medicare plans, but may, however, cover those drugs not included in Part D coverage. Medicaid will continue to pay for drugs in classes excluded from the Medicare prescription drug benefit. These drugs classes are benzodiazepines, barbiturates, select prescription vitamins, and certain non-prescription drugs. In addition, Medicaid will cover the following types of drugs through a limited wrap around benefit only when the enrollee's Part D plan will not pay for them:

- Atypical antipsychotics;
- Antidepressants;
- Antiretrovirals used in the treatment of HIV/AIDS; and
- Immunosuppressants used in the treatment of tissue and organ transplants.

Behavioral Health Benefits

The inextricably intertwined relationship between *mental health* and *physical health* and *well-being* is widely recognized. A significant finding of previous research is that the prevalence of many serious health conditions, such as cognitive or mental impairments, depression, and diabetes is also high for persons who are dually eligible.[12] Generally, the prevalence of chronic disease, as well as mental and cognitive conditions is significantly higher among dual eligibles compared to all other Medicare beneficiaries. Almost three in five dual eligibles have both a

[12] Mathematica Policy Research, (2010, June) Medicare and Medicaid Spending on Dual Eligibles, Presentation at the AcademyHealth Annual Research Meeting, Boston, MA.

physical disease and mental condition compared to only 17 percent of all other Medicare beneficiaries.[13]

Dual eligibles with multiple chronic conditions rely heavily on Medicare for benefits to address their physical health needs, such as hospital services. Nearly four in ten dual eligibles with more than one physical condition use inpatient hospital services in a given year. Use of inpatient hospital services is even greater for dual eligibles with multiple mental conditions; half of these duals access the service in a given year. Prescription drugs are an important aspect of treatment for behavioral health disorders. Reduction in the number of Medicare PDPs and an increase in utilization restrictions for some psychotropics since Medicare Part D began in 2006 have raised concerns about access to medications for dual eligibles with mental disorders.

Medicare covers a range of mental health services, including inpatient care under Medicare Part A and doctors', social workers', or therapists' services under Part B. Most State Medicaid programs cover more comprehensive treatments for mental illnesses than Medicare does not cover, including community-based services such as psychosocial rehabilitation and targeted case-management treatment. Dual eligibles with full Medicaid will receive coverage for these additional treatments as long as they see a provider who accepts Medicaid. Dual eligibles also access Medicaid for long-term services and supports. Nearly four in ten duals with more than one mental condition also use nursing facility services in a given year, while nearly three in ten with both a physical and mental condition access nursing facility care. Medicare and Medicaid per capita spending is substantially higher for dual eligibles with multiple chronic conditions, particularly when mental/cognitive conditions are present.[14]

Medicare Inpatient Psychiatric Care

Medicare Part A (Hospital Insurance) covers inpatient mental health care if dual eligibles are in a general hospital or a psychiatric hospital. If hospitalized for a mental condition like depression in a general hospital including specialized psychiatric units, Medicare will pay as it would for any other hospitalization. This includes room, meals, nursing, and other related services and supplies.

[13] Kasper, J., O'Malley Watts, M., Lyons, B., (2010, July), *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*, Kaiser Family Foundation, Washington, D.C.
[14] Ibid. Kasper, J., O'Malley Watts, M., Lyons, B., (2010, July)

Medicare Part B (Medical Insurance) covers physician services and the services of certain other practitioners during the hospital stay.

For mental health services covered under Medicare Part A, Medicaid's cost-sharing responsibility is the standard Medicare deductibles and coinsurance. For services in inpatient in a psychiatric hospital, Medicare Part A only pays for up to 190 days during the beneficiary's lifetime. The limitation applies only to services furnished in a psychiatric hospital. For dual eligibles, Medicaid as the secondary insurer must pay the costs if the beneficiary is hospitalized in a psychiatric facility for over 190 days.

Medicare Outpatient Mental Health Care Coverage and Payment

Medicare Part B covers mental health services on an outpatient basis when provided by a doctor, clinical psychologist, clinical social worker, nurse practitioner, clinical nurse specialist, or physician assistant. Mental health services generally covered outside of a hospital in an office setting, clinic, or hospital outpatient setting include visits with the following practitioners:

- General practitioners,
- Nurse practitioners,
- Physicians' assistants,
- Psychiatrists,
- Clinical psychologists,
- Clinical social workers, and
- Clinical nurse specialists.

Medicare will only pay for the services of psychologists and clinical social workers if the providers are Medicare-certified and take assignment, meaning that they accept Medicare's approved amount as payment in full. For more detail on coverage for services by clinical psychologists and clinical social workers, refer to Appendix C.

Other mental health services covered by Part B include psychiatric evaluations, individual and group psychotherapy, family psychotherapy (with beneficiary present) for treatment, and medication management. Medicare Part B also pays for partial hospitalization services. The service is a type of treatment provided by hospital outpatient departments or local community mental health centers that doesn't require an overnight stay.

Medicaid Cost Sharing

Like Medicare Part A and Part B benefits described previously, Medicaid is responsible for copayments, coinsurance, and deductibles that may apply for behavioral health services covered under Medicare for dual eligibles. After yearly Medicare Part A and Part B deductibles, how much cost sharing is required for mental health services depends on whether the purpose of the service to the beneficiary service is to diagnose the condition or treat it. The coinsurance amounts that Medicaid is required pay as a share of the cost for services to dual eligibles is provided below.

Benefit	Medicaid Cost Sharing Responsibility
Psychiatric Hospital	Same as hospital inpatient under Part A, with all costs after 190 day lifetime limit
Physicians and Other Practitioners for diagnosis	20 percent of Medicare-approved amount
Physicians and Other Practitioners for treatment	45 percent of Medicare-approved amount
Partial Hospitalization	
Days 1-60	No coinsurance after deductible of $1,132,
Days 60-90	$283 per day
Days 91-150	$566 per day

Medicaid Community Mental Health Services Program

Many state Medicaid programs cover treatments for mental illnesses that Medicare does not cover, including community-based services such as psychosocial rehabilitation and targeted case-management treatment. Dual eligibles with full Medicaid will receive coverage for these additional treatments as long as they see a provider who accepts Medicaid. Colorado's Medicaid program provides comprehensive mental health services through a statewide managed care

program, referred to as the Community Mental Health Services Program, to most Medicaid members dually eligible for Medicaid and Medicare.[15] C.R.S. 25.5-5-411 directed the Department to establish this statewide, prepaid, capitated system for providing mental health services under the state's medical assistance program. C.R.S. 25.5-5-202 establishes the statewide substance abuse treatment outpatient benefit. The Department operates the Community Mental Health Services Program under a waiver approved by CMS under Section 1915(b) of Title XIX of the Act.

Similar to RCCOs under the ACC Program, Medicaid members are assigned to a Behavioral Health Organization (BHO) based on where they live. A contracted BHO was chosen through a competitive procurement process for each of the defined geographic services areas covering the state. Each of the five geographic service areas in the Community Mental Health Services Program contains one or more whole counties and is served by one or more Community Mental Health Centers (CMHCs).

BHOs arrange or provide for medically necessary mental health services to members in their service areas. The Contractor shall provide or arrange for the provision of all medically necessary mental health services to enrolled members. Coverage under the Community Mental Health Services Program includes State Plan services authorized under Section 1902(a) of the Act. The Contractor's responsibility for inpatient Hospital Services is based on the primary diagnosis that is requiring inpatient level of care and is being actively managed within the treatment plan of the Member. The Contractor shall be financially responsible for the Hospital stay when the Member's primary diagnosis is a covered psychiatric diagnosis, even when the psychiatric diagnosis includes some physical health procedures, exclusive of substance abuse rehabilitation. These services are outlined below.

Inpatient Hospital is a program of psychiatric care in which the member remains twenty-four (24) hours a day in a facility licensed as a hospital by the State. For adults ages 21-64, this benefit excludes State Institutions for Mental Disease (IMDs). Individuals age 65 and over may be served in IMDs. Children under age 21 may also be served in psychiatric facilities classified

[15]In addition to clients enrolled in PACE, dual eligibles with the following partial Medicaid coverage are not eligible for enrollment in the Community Mental Health Services Program: QMB-only, QWDI, QI 1, and SLMB.

as IMDs. Services are limited to forty-five (45) days per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.280.

Outpatient services involve a program of care in which the member receives services in a hospital or other health care facility, but does not remain in the facility twenty four (24) hours a day, including:

- Psychiatrists. Services provided within the scope of practice of medicine as defined by state law;
- Psychosocial Rehabilitation. Rehabilitative services include any remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under state law, for maximum reduction of mental disability and restoration of a recipient to his/her best possible functional level;
    - Group. Therapeutic contact with more than one member of up to and including two hours;
    - Individual. Therapeutic contact with one member of more than thirty (30) minutes, but no more than two (2) hours. This service, in conjunction with Individual Brief services, is limited to thirty-five (35) visits per state fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282;
    - Individual Brief. Therapeutic contact with one member of up to and including thirty (30) minutes. This service, in conjunction with Individual services, is limited to thirty-five (35) visits per state fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282;
    - School-Based Services. State Plan outpatient mental health services provided to pre-school and school-aged children and adolescents on site in their schools, with the cooperation of the schools;

- Clinic Services, Case Management. Medically necessary case management services provided in a licensed community mental health center or clinic by a licensed/qualified non-physician practitioner or physician; and
- Medication Management. Monitoring of medications prescribed and consultation provided to members by a physician or other medical practitioner authorized to prescribe medications as defined by State law, including associated laboratory services as indicated.

Emergency Services are those provided during a mental health emergency which involves unscheduled, immediate, or special interventions in response to a crisis situation with a member, including associated laboratory services as indicated.

The Section 1915(b)(3) Waiver authority allows the State to provide additional services (i.e. alternative services) to Medicaid beneficiaries via savings from the managed care product. BHOs provide or arrange for the following services mandatory 1915(b)(3) Waiver services in at least the scope, amount, and duration proposed by the BHO and specified in the BHO's contract with the Department.

Vocational Services are designed to assist adult and adolescent Members who are ineligible for state vocational rehabilitation services and require long-term services and supports in developing skills consistent with employment and/or in obtaining employment.

Home-based Services for Children and Adolescents are therapeutic services that address the mental health needs of youth Members with serious emotional disturbances, provided in their homes, and involving family members.

Intensive Case Management encompasses community-based services, average more than one (1) hour per week, and are provided to children with serious emotional disturbances and adults with serious mental illness who are at risk of a more intensive twenty-four (24) hour placement and who need extra support to live in the community.

Prevention/Early Intervention Activities include screening and outreach to identify at-risk populations as well as proactive efforts to educate and empower members to choose and maintain healthy behaviors and lifestyles that promote mental and behavioral health. Services

can be population-based, including proven media, written, peer, and group interventions, and are not restricted to face-to-face interventions.

Clubhouse and Drop-in Centers are settings in which members utilize their skills for clerical work, data input, meal preparation, and provide resource information or outreach to fellow Members. Staff and Members work side-by-side, in a unique partnership. In drop-in centers, Members with mental illnesses plan and conduct programs and activities in a club-like setting.

Residential Services are defined as twenty four (24) hour care, excluding room and board, provided in a non-hospital, non-nursing home setting, and are appropriate for children, youth, adults, and older adults whose mental health issues and symptoms are severe enough to require a 24-hour structured program but do not require hospitalization. Residential services are a variety of clinical interventions that, individually, may appear to be similar to traditional state plan services. By virtue of being provided in a setting where the client is living, in real-time (i.e. with immediate intervention possible), residential service become a unique and valuable service in its own right that cannot be duplicated in a non-structured community setting. These clinical interventions, coupled together, in real time, in the setting where a client is living, become a tool for treating individuals in the most cost-effective manner and in the least restrictive setting.

Assertive Community Treatment (ACT) is a service delivery model providing comprehensive, individualized, locally-based treatment to adult Members with serious mental illness. ACT services are provided by a multidisciplinary treatment team and are available twenty-four (24) hours a day, seven (7) days a week, 365 days a year.

Recovery-oriented services promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, social supports, and rights protection. Services may be provided at schools, churches, or other community locations. Services include, but are not limited to, peer counseling and support services, peer-run employment services, peer mentoring for children and adolescents, recovery groups, warm lines, and advocacy services. The Department expects Contractors to utilize the competency-based guidelines for training peer support specialists distributed to all Contractors in June 2007.

Respite care is temporary or short-term care of a child, adolescent, or adult provided by adults other than the birth parents, foster parents, adoptive parents, family members, or caregivers with

whom the Member normally resides. This care is designed to give the usual caregivers some time away from the Member to allow them to emotionally recharge and become better prepared to handle the normal day-to-day challenges.

Long Term Care Supports and Services

Long-term care is a variety of services that includes medical and non-medical care to people who have a chronic illness or disability. Long-term care helps meet health or personal needs. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living, or in nursing homes. It is important to remember that individuals can need long-term supports and services at any age.

Generally, Medicare doesn't pay for long-term care. Medicare pays only for medically necessary skilled nursing facility or home health care. Post-acute care includes the recuperation, rehabilitation, and nursing services following a hospitalization that are provided in skilled nursing facilities (SNFs), and by home health agencies (HHAs) under Medicare. Medicare payments have increased rapidly to these providers. Cost-related reimbursement survived in the Medicare program for post-acute care until passage of the BBA of 1997. That legislation mandated establishment of prospective payment systems, on a phased-in schedule, for all types of post-acute care providers.

Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Medicare doesn't pay for this type of care called "custodial care" that provides assistance with activities of daily living. Medicaid is the nation's major source of financing for long-term care services, paying for over 40 percent of total long-term care. While states have broad discretion over eligibility, coverage and payment for Medicaid long-term care services, most State Medicaid programs provide a wide range of long-term care services. These include comprehensive long-term care services provided in nursing homes, as well as a wide range of services and supports needed by people to live independently in the community. Long-term care represents 32.1 percent of total Medicaid spending.[16]

[16] Eiken, S. Sredl, K., Burwell, B. and Gold, L. (2010, August) *Medicaid Long-Term Care Expenditures in FY 2009*. Cambridge, MA: Thomson Reuters.

Both Medicare post-acute care and Medicaid long-term services and supports are important for dual eligibles in need of long-term care, but these benefits are poorly coordinated. Gaps often exist in some services while there is overlap in others. This can lead to inefficient delivery of services and confusion among program beneficiaries and providers alike. Spending on post-acute services in Medicare and long-term care services in Medicaid has grown more rapidly than enrollment in either program since 1999.[17]

Medicaid Nursing Facility Services

People entering nursing facilities typically fall into one of two groups: (1) those requiring short-term care following a hospital stay or other acute event; and (2) those requiring longer term nursing facility services. For most dual eligibles, Medicare finances most short stays in skilled nursing facilities, although Medicaid pays coinsurance and deductible amounts up to the Medicaid fee schedule for such stays.

Nursing home care is a mandatory Medicaid service that states must cover to receive federal matching funds. States, like Colorado, can expand eligibility for only long-term care services to people who meet the clinical criteria for institutionalization and have incomes up to 300 percent of the SSI limit. Many users of nursing home services would not qualify for Medicaid if they were not in a nursing home because their incomes exceed other Medicaid eligibility thresholds. As a result, Medicaid covers the largest share of nursing home costs and provides nursing home coverage to the largest number of people in the United States. Over 45 percent of total nursing home expenditures were covered by Medicaid in 2002. An even larger share of nursing home users were covered by Medicaid nationally.

States have the flexibility to set clinical criteria for nursing home admission. Prior to Medicaid approval for a nursing home admission in Colorado, a trained Single Entry Point (SEP) case manager will assess the individual's needs and level of care. A standardized assessment instrument is utilized to determine whether the individual meets the nursing home level of care and the options an individual has for where they are able to receive services (in a nursing home, in their own home or in an alternative care facility). If the individual chooses nursing home

[17] Terence Ng, T., Harrington, C., and Kitchener, M. (2010, January) *Medicare And Medicaid In Long-Term Care*, Health Affairs vol. 29 no. 1 22-28

placement, the case manager will determine the approved length of stay based on the needs of the person.

Upon admission to a nursing home, two screenings are used by trained case managers to assess the individual's needs and level of care. One screening is the Pre-admission Screening and Resident Review (PASRR). This federally-mandated screening tool is used to identify whether the individual has needs related to intellectual disability or severe and persistent mental illness (SPMI) in order to provide appropriate services or divert them into more appropriate settings as needed. A second tool, the Minimum Data Set (MDS) is a federally-mandated clinical assessment used to evaluate an individual's functional status and clinical needs in order to formulate the appropriate treatment plan upon admission to a SNF.

Medicaid Home and Community-Based Services

While provision of nursing home care is a mandatory service, provision of most community-based long-term care services--potentially used as an alternative to nursing home care--is optional. For example, expanded home health services and home and community-based service (HCBS) waivers are covered as a state option. Developing HCBS alternatives to institutional care has been a priority for many state Medicaid programs over the last three decades. While the majority of Medicaid long-term care dollars still go toward institutional care, the national percentage of Medicaid spending on HCBS has more than doubled from 19 percent in 1995 to 41 percent in 2007. Colorado uses two major vehicles provide Medicaid HCBSs: (1) an expanded home health benefit and (2) optional 1915(c) HCBS waivers.

Section 1905 of the Act authorizes State Medicaid agencies to provide home health to Medicaid recipients. Pursuant to 42 CFR § 440.70, these services include skilled nursing services, home health aide services, and medical supplies and equipment. In addition, the HHA services may also include physical therapy, occupational therapy, or speech pathology and audiology services.

According to 10 CCR 2505-10, section 8.528.11, reimbursement for the services of nursing, physical therapy, occupational therapy, and speech therapy is made on a per-visit basis. A visit is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours. Home health aide services are reimbursed through the use of two billing units: Basic Units (the first hour of the visit) and, for visits that last longer than one hour, Extended

Units (increments of fifteen minutes up to one-half hour). In addition, pursuant to 10 CCR 2505-10, section 8.523.11, HHA services are eligible for reimbursement under Medicaid only when the services are provided under a physician-signed plan of care and are medically necessary.

Home Health under Colorado's Medicaid Program includes Acute Home Health, Long Term Home Health (LTHH), or Long Term Home Health with an Acute Episode. Acute Home Health is provided for up to 60 consecutive calendar days after hospitalization, onset of exacerbations, or any of the conditions listed in 10 C.C.R 2505-10 8.520. Long Term Home Health is provided from the 61st day and ongoing for chronic long-term conditions. Long Term Home Health with an Acute Episode is provided to Long Term Home Health clients when any of the conditions listed in 10 C.C.R 2505-10 8.520 occur and lasts for up to 60 consecutive calendar days.

Colorado has implemented a series of home and community-based services waivers resulting in considerable cost-savings by virtue of fewer nursing facility admissions and covering some individuals that otherwise might not enroll in Medicaid. These waivers enable income-eligible individuals at risk of institutionalization to receive services in their home or community in addition to the standard Medicaid benefit package. HCBS services include personal care services for activities of daily living, homemaker services, adult day care, transportation, respite care, home modifications or electronics for independence, assisted living facilities, and community transition services. Colorado's waiver programs have enrollment ceilings and some have active waiting lists.

Medicaid Primary Care Case Management

Care coordination and care transition fall under the umbrella of care management in the ACC Program. Care coordination involves a team or an individual responsible for guiding a patient through various procedures, providers, and programs as they pertain to particular health needs. Care transition involves settling beneficiaries in a former care setting into another. Patient education, planned interventions, and strong provider-patient/care giver relationships are also a part of coordination. Ideally, a comprehensive care management model will meet the complete medical, behavioral, and social needs of the patient. The RCCOs and Primary Care Case Management (PCCM) providers working with PCMPs, will have primary responsibility for all

care management endeavors under the Integrated Care Program as dual eligibles are brought into the ACC Program during its expansion phase.

Options for Care Improvement and Cost Savings

This section of the Options Report discusses potential program initiatives that the Department can pursue to improve care and reduce cost for dual eligibles as these clients are brought into the ACC Program during the Expansion Phase. A number of these interventions tie directly to goals of the ACC Program and efforts RCCOs will establish for Medicaid-only clients during the Initial Phase. Some innovations that previously would have been difficult to accomplish are now feasible through Colorado's participation in the State Demonstrations to Integrate Care for Dual Eligible Individuals project. Interim steps in implementation planning, including engaging CMS where applicable, are recommended.

Pursue the Medicaid Health Home Option

There are two Federal initiatives related to PCCM and care coordination happening concurrently during the initial and expansion phases that should be leveraged to positively impact integration of dual eligibles into the ACC Program.

The first is the health home initiative authorized under Section 2703 of the ACA. Codified into the Act at Section 1945, Section 2703 of the ACA authorizes a State option under Medicaid to provide a health home for individuals with chronic conditions. This is of considerable interest because it carries an enhanced federal match of 90 percent for two years for any health home services provided. RCCOs and affiliated PCMPs fit the definition of health homes at Section 1945(h)(4). Health home services are to be provided to individuals with "chronic conditions" as defined at 1945(h) of the Act.

Section 1945(h)(4) defines health home services as:

> "(A) In general.—The term "health home services" means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

(B) Services described.—The services described in this subparagraph are—

(i) comprehensive care management;

(ii) care coordination and health promotion;

(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(iv) patient and family support (including authorized representatives);

(v) referral to community and social support services, if relevant; and

(vi) use of health information technology to link services, as feasible and appropriate."

These services are to be provided to individuals with "chronic conditions." Such conditions are defined at 1945(h) of the Act as

"1) Eligible individual with chronic conditions.—

(A) In general.—Subject to subparagraph (B), the term "eligible individual with chronic conditions" means an individual who—

(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

(ii) has at least—

(I) 2 chronic conditions;

(II) 1 chronic condition and is at risk of having a second chronic condition; or

(III) 1 serious and persistent mental health condition".

The Act adds, at 1945(h)(2) the following examples of chronic conditions:

- A mental health condition;

- Substance use disorder;
- Asthma;
- Diabetes;
- Heart disease; and
- Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

The November 16, 2010 guidance indicates that CMS is open to a substantive range of options. Allowable reimbursement methods include tiered capitation rates, case rates, and other types of bundled rates. Allowable provider entities that may serve as health homes include physician group practices, community health centers, and community mental health clinics. The guidance also encourages state Medicaid agencies to collaborate with state mental health agencies and with the Substance Abuse and Mental Health Services Administration (SAMHSA), which has awarded grants to 56 health home sites to improve integration of primary and behavioral health services as part of its Primary and Behavioral Health Care Integration (PBHCI) grant program.

To become eligible for the enhanced match, the State would have to submit a state plan amendment to CMS. Such amendments became possible on January 1, 2011. In November 2010, CMS issued a State Medicaid Director's letter that contained extensive implementation advice. The process begins by the state submitting a "Letter of Request" which opens the door to discussion with CMS. As of May 11, 2011, eight states had approved "Letters of Request": Arizona, Arkansas, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, and West Virginia. However, as of May 11, 2011 no states have yet submitted State Plan Amendments. [18]

Section 1945 also provides an opportunity to control utilization of not only Medicare hospital services but also Medicaid nursing home services through better primary care planning and use of personal care and home health services. The MSSP discussed above is primarily focused on reducing hospital utilization which lowers Medicare costs. However, the health home approach, when used with dual eligibles, potentially encompasses nursing home use and can result in cost savings for Medicaid programs in nursing home expenditures.

[18] Information obtained through personal communication by PCG staffs with CMS on May 10, 2011.

Section 1945 represents a significant opportunity to plan and implement coordinated care for persons with chronic conditions including dual eligibles. Section 1945 could be used to develop a funding mechanism to support the RCCOs and PCMPs during the next two years. As part of incorporating dual eligibles into the ACC Program, Colorado should move forward with the request to CMS and study how best to identify those dual eligibles and services for the enhanced match, and incorporate the potential funding to support the ACC Program in a way that does not add to the expenditure base.

PCG recommends:

- The Department should develop a budget for planning resources outside of the funding under the State Demonstrations to Integrate Care for Dual Eligible Individuals contract with CMS. By submitting a Letter of Request to CMS, the State would to initiate detailed planning for implementing Medicaid health homes for dual eligibles to begin during the Expansion Phase.

- Department should conduct an analysis of how care coordination interventions proposed – and implemented – by RCCOs align with the required activities of Medicaid health homes.

The second federal initiative from the ACA relates to a mandatory increase in payments to primary care physicians (PCPs) under Medicaid. Section 1202 of the ACA requires that Medicaid reimburse PCPs at parity with Medicare rates in 2013 and 2014. The Federal government will pay 100 percent of the additional costs to states that meet this requirement. This will mean substantial sums for Colorado doctors that take care of Medicaid patients, including PCMPs under the ACC Program. Colorado should address several issues related to the rate increases, including savings from working with RCCOs and the PCMPs so that some of these rates can be maintained after 2014. Colorado must also decide how to attract Medicare-participating PCPs not enrolled with Colorado Medicaid to serve as PCMPs as dual eligibles are enrolled in the ACC Program.

Leverage Use of Physician Extenders

In its sentinel 2002 work, *Crossing the Quality Chasm: A New Heath Care System for the 21st Century*, the Institute of Medicine recommended greater use of physician extenders. Today, the use of non-physician practitioners (NPPs) continues as an important topic in the discussion on how to reduce the cost of care while maintaining quality and access to care for as many people as possible. Under various arrangements for provision of care and payment, patients are able to receive quality care from licensed and certified providers. Either as direct providers or in the employ of physicians, NPPs may assist in the provision of care and expand the physicians' availability to patients for services that require a higher level of medical expertise.

The ACC Program builds upon the Patient-Centered Medical Home model and also incorporates additional elements to improve member care and outcomes while supporting providers and protecting the safety net. Critical to the success of the ACC Program will be the PCMP. In order to serve as a PCMP and establish an agreement with a RCCO, the PCMP must be a physician, advanced practice nurse or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.[19]

In theory, the use of services rendered by NPP presents a viable, less expensive addition and alternative to physician services, and in some cases, to hospital care. State law or regulation governing PA, NP, and CNS scope of practice in the state in which the services are performed applies under Medicare. The Department should fully understand those covered services that can be rendered by NPPs based on the State scope of practice, and leverage lower cost primary care fees, adjusted downward if furnished by certain under the Medicare PFS. For example, services billed separately and provided by nurse practitioners are paid at 85 percent of physicians' fees.

The use of non-physician practitioners is also important for care coordination. NPPs can clearly serve as a PCMP. This could have increased significance for dual eligibles Colorado's ACC Program depending on the success of recruiting Medicare participating physicians to enroll as PCMPs. Care coordination should serve as a viable vehicle to achieve the objectives of ACC Program applied to dual eligibles. It allows for investment in assessment and more aggressive

[19] Certified providers in the Medicaid and CHP+ Medical Homes for Children program may also serve as PCMP under the ACC Program.

primary care that should produce subsequent savings through reduced hospital utilization. It facilitates the use of different staffing mixes, including greater use of NPPs.

Numerous care coordination models make greater use of care teams involving mid-level practitioners for assessment, care planning, patient communication, and management. NPs, PAs, and CNSs practicing within the scope of state law may bill for care plan oversight (CPO) under Medicare Part B if these NPPs provide ongoing care for the beneficiary through evaluation and management services.[20] The Department should require RCCOs to incorporate NPPs into care coordination teams as a vehicle to access Medicare funding for applicable care management activities, like CPO, for dual eligibles.

PCG recommends:

- The Department review RCCO staffing plans and care management structures to assess variation and the current use of NPPs to provide care coordination in the Initial Phase.
- The Department should review the potential for the required use of NPPs in care coordination teams with RCCOs and PCMP representatives in an upcoming ACC Program advisory forum.

Prevent Avoidable Hospital Admissions

One significant area for care improvement and cost savings for dual eligibles under the ACC Program is reducing hospitalizations that could be prevented if individuals receive adequate ambulatory care. The concept of potentially avoidable hospitalization builds on the notion of ambulatory care sensitive conditions—conditions such as asthma and diabetes for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. Potentially preventable hospitalizations are a significant issue with regard to both quality and cost.

Hospital payments account for the largest share of Medicare spending, and Medicare is the largest single payer for hospital services. In 2009, more than 7 million Medicare beneficiaries

[20] NPPs **may not** bill for CPO if they have been involved only with the delivery of the Medicare-covered home health or hospice service.

experienced more than 12.4 million inpatient hospitalizations. One in seven Medicare patients will experience some "adverse" event such as a preventable illness or injury while in the hospital. One in three Medicare beneficiaries who leave the hospital today will be back in the hospital within ninety days.[21] Every year, as many as 98,000 Americans die from errors in hospital care.[22]

Recent data indicates that there are significant opportunities for cost savings from improved care for conditions that are commonly associated with potentially preventable hospitalizations. In 2008, dual-eligible hospital stays contributed to 14 to 37 percent of the total hospital costs for all Medicare stays for these selected chronic and acute conditions.[23] The proportion of total costs attributable to dual eligibles by each individual condition was similar to the proportion of stays. The data were drawn from 27 states that collected multiple payer variables to allow identification of duals covered by Medicare and Medicaid. Extrapolated to the national level, the total number of hospitalizations for all 9 conditions would be 727,906 for dual eligibles (9 hospital stays per 100 dual-eligible beneficiaries); the total hospital costs would be $6.37 billion.

Dual eligibles accounted for approximately one third of all Medicare stays with a principal diagnosis of pressure ulcers (36.0 percent), asthma (31.9 percent), and diabetes (31.6 percent). Dual eligibles also accounted for 25.9 percent of hospitalizations with a principal diagnosis of urinary tract infection (UTI), 24.2 percent of hospitalizations for chronic obstructive pulmonary disease (COPD), 24.0 percent for bacterial pneumonia, 20.1 percent for dehydration, 19.8 percent for congestive heart failure (CHF), and 13.3 percent for injurious falls.

The top three causes of potentially preventable hospitalizations for dual eligibles were bacterial pneumonia (2,041 stays per 100,000 enrollees), congestive heart failure (CHF; 1,829 stays per 100,000 enrollees), and COPD (1,179 stays per 100,000 enrollees). Compared with other Medicare beneficiaries, dual eligibles were more than twice as likely to be hospitalized for pressure ulcers, asthma, and diabetes, 52 percent more likely for urinary tract infection, and over 30 percent more likely for COPD and bacterial pneumonia.

---

[21] Jencks, S. et al. (2009), *Rehospitalizations among Patients in the Medicare Fee-for-Service Program*, New England Journal of Medicine, 360:1418-28.
[22] Institute of Medicine, (1999), *To Err is Human*, Washington, D.C.
[23] Jiang, J. et al. (2010, September) *Potentially Preventable Hospitalizations among Medicare-Medicaid Dual Eligibles, 2008.* Statistical Brief #96, AHRQ Healthcare Cost and Utilization Project, Washington, D.C.

More than one-third of dually eligible beneficiaries receiving Medicaid long-term care or skilled nursing facility care were hospitalized at least once, totaling almost 1 million hospitalizations. Of these hospitalizations, 382,846, or 39 percent, may have been avoidable, either because the condition might have been prevented, or because the condition might have been treated in a lower level of care setting than a hospital. Five conditions (pneumonia, congestive heart failure, urinary tract infections, dehydration, and chronic obstructive pulmonary disease/asthma) were responsible for 78 percent of the potentially avoidable hospitalizations across the settings.[24]

Section 3026 of the 2010 ACA created the Medicare Community-Based Care Transitions Program (CCTP). This is a five-year program that began on April 12, 2011. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measureable savings to the Medicare program.

Not all hospitals can participate in the CCTP program. As defined in section 3026(b)(1), to be eligible as an applicant, hospitals must have high readmission rates and partner with community-based organizations (CBOs) that provide care transition services. CMS has also provided data showing which hospitals have high readmission rates.[25] The data for Colorado show that five hospitals qualify for participation in the CCTP program.

- Longmont United Hospital in Longmont,
- Presbyterian/St Luke's Medical Center in Denver,
- Exempla Saint Joseph Hospital in Denver,
- Delta County Memorial Hospital in Delta, and
- Mt. San Rafael Hospital in Trinidad.

To the extent that any of these hospitals are involved with a RCCO, the Department has the option of raising participation in the CCTP program with the hospital. While the Federal

[24] Walsh, E.G. et al (2010, August) *Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community-Based Services Waiver Programs*, RTI International.
[25] See, retrieved on 5-10-2011, http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

Medicare program hopes this program will save money for Medicare, there is the possibility that a strengthening of discharge planning will strengthen the Department's objectives of reducing unnecessary emergency room visits by nursing facility residents, and of decreasing hospital readmissions within 30 days of discharge.

While hospitals that apply to be the primary applicant are limited to being hospitals with high readmission rates, there does not seem to be a similar limit on the applications of community-based organizations.[26] A community-based organization that is the primary applicant can work with any hospital and is not limited to working with the hospitals on the high readmission hospital file. Any community-based organizations that are part of the RCCO and currently perform care transition services could thus apply to Medicare for funds available under the program. This is an interesting funding opportunity that RCCOs might benefit from considering it would support activities that they would seek to strengthen anyway.

Section 3026(c)(3) gives preference to CBOs associated with the Administration on Agency such Area Agencies on Aging (AAAs), and Adult and Disability Resource Centers (ADRCs). When initially published, the Federal regulations were perceived to contain significant self-imposed limitations. The definition of "community-based organizations" could be interpreted to exclude all AAAs and ADRCs that are affiliated with counties or local governments. Moreover, community organizations may be unwilling or unable to adopt the governance structure specified in the CCTP regulations. On May 24, 2011 the Administration clarified in a FAQ that AAAs and ADRCs were considered community-based organizations.[27]

As of October 2010, Colorado, a 2010 AoA Care Transitions grantee, has one ADRC actively conducting care transition activities using the Care Transitions Intervention. One ADRC is assisting in the expansion of care transition using the Care Transitions Intervention model. The Department should collaborate with RCCOs and other community-based entities to pursue Medicare Community-Based Care Transitions Program (CCTP) support where applicable.

[26] A community-based organization is defined to be: "If the coalition is (1) a legal entity, such as a 501(c) (3) organization or other organization that has a taxpayer identification number and can accept payment, (2) has a governing body that includes broad community representation of multiple health care stakeholders, including consumers and (3) is physically located in the community it proposes to serve, then it could qualify as a CBO. In addition, there must be adequate consumer representation on the governing board with voting rights. The consumers may not be providers or immediate family members of providers to satisfy this requirement."

PCG recommends:

- The Department should meet with Department of Human Services to initiate a collaborative exploration of how enhanced coordination among AAAs and Colorado's Medicaid Single Entry Point (SEP) agencies could support RCCO care transition initiatives for dual eligibles.

- The Department should review the CCTP program and discuss opportunities for CCPT participation with RCCOs representatives in an upcoming ACC Program advisory forum.

Formalize Emergency Department Redirection Management

Another area of potential care improvement and cost savings under Colorado's ACC Program is the reduction in Emergency Department (ED) usage among dual eligibles. High ED utilization is a considerable concern for the increasing cost of health care. Frequent and inappropriate use of hospital EDs is extremely costly and care could be provided in a less expensive setting. Patients, when possible, should be treated by their primary care provider for non-emergency conditions in order to promote consistent, quality care.

An estimated 50 million, or 42 percent, of the 120 million visits made in 2006 to U.S. hospital emergency departments were billed to the Medicaid and Medicare programs, according to an AHRQ report released in 2009. Of the 24.2 million ED visits billed to Medicare, 38.3 percent ended with the patients being admitted, compared with 9.5 percent of the 26 million visits billed to Medicaid. Beneficiaries living in long-term care facilities have particularly high rates of ED use, with 51 percent of beneficiaries with at least one Medicare-covered ED visit.[28]

Overcrowding in hospital emergency departments and inefficient flow are closely related to the presence of non-emergency patients. At least one-third of all ED visits are "avoidable" in that these were non-urgent or ambulatory care sensitive (ACS) and therefore treatable in primary care settings. Researchers found that among the patients admitted to inpatient care through the ED, 13.1 percent were non-emergency patients - admissions mostly preventable if care can be provided in an alternative setting. These non-emergency ED patients showed different health

[28] Walsh, E.G. et al (2010, August) *Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community-Based Services Waiver Programs*, RTI International.

care utilization characteristics in that 42.8 percent had 4 or more diagnoses.[29] Non-emergency patients admitted to hospitals through the ED department showed special needs for health care services: care continuity and improved access to treatment.

Several case studies highlighted that formal ED reduction programs between health centers and hospitals or structured health plan initiatives targeting ED use can make a broad impact on the health care system as a whole. Colorado's RCCOs have experience with interventions directed at reduced emergency department (ED) visits. Collectively, these programs include providing health education, teaching patients how to use the healthcare system, providing counseling on social/emotional issues, providing primary care alternatives during extended hours in evenings and on weekends, offering real time referrals to alternative non-emergency care through the use of Case Managers, and promoting the concept of a medical home for patients so that they will have a better understanding of their healthcare options and appropriately use health care services.

Rocky Mountain Health Plans (RMHP), the Region 1 RCCO, convened an ER Task Force to address increasing ED utilization rates in Mesa County. Representation on the Task Force included a wide array of members to achieve the "required joint action" seen as necessary by all participants. Collectively, representatives from RMHP, primary care and specialty physicians, Behavioral Health clinic leadership, leadership at the Department of Human Services, and Emergency Department physicians from each major hospital facility developed multiple initiatives to address the issue. These included two programs using RMHP Care Coordination staff to support this effort. In April 2008, CMS awarded twenty grants to twenty states for two year projects with the goal of reducing use of hospital emergency rooms by Medicaid beneficiaries for non-emergent reasons. One of these projects, the San Luis Valley Region Project, was housed in Valley-Wide which is a part of Integrated Community Partners, the Region 4 RCCO.

The RCCO in Regions 2, 3, and 5, Colorado Access, has notable experience through participation in the Colorado Regional Integrated Care Collaborative (CRICC) project. This pilot project, a collaborative effort involving Colorado Access, the Department, the Center for Health Care Strategies, and the Colorado Health Foundation, targets Medicaid clients with multiple,

[29] Hwang, J. and Chang, H. (2010, May) *Understanding Non-emergency Patients Admitted to Hospitals Through the Emergency Department for Efficient ED Functions*, Journal of Emergency Nursing, Volume 36, Issue 3 , 196-202.

complex healthcare issues. The project's focused care management activities aim to improve clients' ties with their PCP Medical Homes, increase coordination across systems of care (including specialty providers) and improve linkages with both appropriate healthcare providers and other community resources. Early results have shown, among other findings, decreased emergency department utilization.[30]

The Department should formalize ED redirection management requirements for dual eligibles in anticipation of enrollment of these beneficiaries in the ACC Program. While maintaining appropriate flexibility for RCCOs to operate in alignment with the specific needs of their respective regions, the Department could identify minimum standards (e.g. follow-up contact within 24 hours of ED encounter) for redirection management.

PCG recommends:

- The Department should convene RCCOs at an upcoming ACC Program advisory forum to share best practices, given the experience of existing RCCOs in this area, with attention to identifying infrastructure investments (e.g. information technologies) where a collaborative, statewide approach might be economical.

- The Department, given the RCCOs near universal recognition of the importance of data analytics to accomplish ED reductions, should begin work with the RCCOS and SDAC to develop parameters for identification and reporting of frequent ED users.

Promote Prevention Services and Assessment

There is broad debate over whether preventive health services save money or represent a good investment. Keeping dual eligibles healthier is one of most effective ways to reduce long-term health care costs. Some estimate that increasing the utilization rate of evidence-based preventive services recommended for the general population by the U.S. Preventive Services Task Force or the Advisory Committee on Immunization Practices to 90 percent would result in total savings of 0.2 percent of health care spending.

[30] Waxmonsky, J. et al (2011, April) *Colorado Access' Enhanced Care Management for High-Cost, High-Need Medicaid Members: Preliminary Outcomes and Lessons Learned*, Journal of Ambulatory Care Management, Volume 34, Issue 2, 183–191.

The Partnership for Prevention, a nonprofit membership-based organization dedicated to increasing the resources and knowledge about disease prevention and health promotion policy and practice, developed the following predictive estimates in its report entitled *Covering Preventive Services under Medicare: A Cost Analysis:*

- Cholesterol screening would generate a net savings by the seventh year as the prevention benefits from screening in earlier years are realized. Over a 10-year period, screening would prevent more than 62,000 heart attacks and almost 45,000 strokes.

- Tobacco cessation counseling would result in small net savings to Medicare in the ninth and tenth years as the savings from long-term quitters in prior years accumulate. The analysis projected that over a ten-year period, 95,000 years of life would be saved.

- Vision screening would save an average of $5 per enrollee per year in years six to 10. Over a 10-year period, 21,000 hip fractures and 4,400 forearm fractures would be prevented.

In addition to the long-term cost from reduced disease burden, preventative services may provide opportunities for identification of predictive factors relevant to the utilization of long-term care institution services. Specifically, Medicare's AWV includes a review of the individual's functional ability and level of safety, including assessment of the ability to successfully perform activities of daily living, fall risk, and home safety. More prompt identification of individuals at risk for functional disability would allow opportunities for referral of HCBS. Referrals serve as an intervention to avoid potential institutional placement.

The Department should develop strategies to maximize Medicare preventive services for dual eligibles to achieve long-term savings from avoiding disease or by treating at an earlier stage, as well as mechanisms to link assessment and screening to access HCBS for functionally impaired and at-risk beneficiaries.

PCG recommends:

- The Department should analyze the alignment of assessment protocols: Medicare's initial preventive physical examination and annual wellness with Medicaid level of care requirements for covered long-term supports and services.

- The Department should meet with the Department of Human Services to initiate a collaborative exploration of how RCCOs can best access Older Americans Acts supports through AAAs and Medicaid HCBS through SEP agencies.

Fast Track Community Supports for Post-Acute Care Transitions

People who need care following a hospital stay are routinely referred to nursing homes, instead of being offered community-based services. SNFs are the most numerous post-acute care providers, with 15,000 facilities in 2009. The majority of SNFs also are licensed as nursing homes to provide long-term support services, which are not covered by Medicare. SNFs have been providing a higher intensity of rehabilitation services to Medicare patients in recent years. Although this might reflect changes in patient need, many believe it is a consequence of Medicare payment policy changes that reward the provision of more therapy services to patients needing rehabilitation. Medicare admissions per 10,000 FFS beneficiaries were 740 in 2008, up from 670 per 10,000 in 2004.

The nursing home referrals occur because hospital discharge planners are often more familiar with Medicaid nursing home eligibility rules and because institutional services are readily in place. To ensure that people leaving hospitals are offered community care options, states are establishing "fast-track" eligibility for Home and Community-Based Services (HCBS). Key program elements include streamlining the HCBS application processes, establishing presumptive Medicaid eligibility for community care, increasing resource levels, providing around-the-clock assistance, and making services available within 24 to 48 hours.

Colorado has experience with a fast-track demonstration project. CMS, in association with Office of the Assistant Secretary for Planning and Evaluation (ASPE), sponsored the Nursing Home Transition Demonstration Program to assist states in providing transition options to nursing home residents who wish to move back to the community. CMS and ASPE awarded grants to 12 states, including Colorado, between 1998 and 2000.

Unlike other Nursing Home Transition Demonstration Grants, Colorado's grant focused on preventing nursing home admissions, rather than assisting people who want to move into the community. The Fast Track program was actually implemented in 1997, a year before Colorado

received its Nursing Home Transition Demonstration grant, to divert people from nursing homes to community living by:

- Providing hospital-based case management and Medicaid financial eligibility determination, called the Fast Track program;
- Piloting an assessment designed to identify people at risk of nursing home placement early in a hospital stay;
- Developing a brochure to inform people about community options; and
- Surveying people with disabilities to identify specific challenges to community living, for people at risk of nursing home placement and nursing home residents.

Between March 1999 and June 2001, the case manager assessed 234 Fast Track candidates. During that time, 149 consumers (64 percent) received successful Fast-Track placements, defined as a hospital discharge in which a person avoided nursing home admission as a result of expedited Medicaid eligibility and development of appropriate community supports and services.

The Department should consider implementing similar Fast Track diversion efforts in the ACC Program for dual eligibles. Using the existing model developed by the Department with Denver Department of Social Services and Denver Health Medical Center, a statewide roll-out of the initiative could be developed targeted to dual eligibles enrolled in the ACC Program during the Expansion Phase.

PCG recommends:

- The Department should review the Hospital Discharge Fast Track initiative with RCCO participants at an upcoming ACC Program advisory forum.
- The Department should develop a formal outreach strategy to County Department of Human/Social Services agencies to gauge interest in their participation.

Expand Nursing Home Transition Activities

Colorado has historically been a leader among states providing supportive services to people with all types of disabilities enabling them to live in the least restrictive settings possible.

Currently, Colorado has an extensive infrastructure of home and community based services designed specifically for the elderly and people with disabilities to live in the least restrictive settings possible. However, there are still barriers to transitioning for some individuals who wish to and are qualified for living in less restrictive settings, and who currently live in an institution or nursing facility.

In January 2011, the Department applied for the Money Follows the Person (MFP) Rebalancing Demonstration grant offered by CMS. A total of $2.25 billion over five years was made available through the ACA to support states' efforts to rebalance long-term care from institutionally-based care to community-based care. In February 2011, CMS announced that Colorado was one of 13 states that will be collectively receiving $45 million in grants for implementing the MFP demonstration program this year. Colorado was awarded $22.2 million through 2016. Colorado and other recent awardees will join the 29 original states given MFP grants in 2007.

The MFP grant will help Colorado improve the state's ability to provide home and community based care as an alternative to institutional placement and transition Medicaid clients out of expensive nursing homes into their own home. In 2009, the average annual cost per client on Medicaid for a full year who was living in an institutional setting was $60,180. For the same time period, the annual cost for an average client on Medicaid for a full year who was using HCBS waiver services was $30,343; nearly half the cost of care for an individual in an institutional setting. The costs represented include the institutional or waiver services plus the costs of other Medicaid covered services.[31]

Under the MFP demonstration, all HCBS services and HCBS demonstration-specific services for successfully transitioned clients would be covered at 75 percent of the federal match for one year. The grant will also support system re-design and infrastructure building, including a new information management system to better coordinate information and referral; intake and screening; assessment; eligibility determination; and case management.

Data that will be used to identify individuals to transition will include Minimum Data Set (MDS) data and the State's Preadmission Screening and Resident Review (PASRR) database. Under the

[31] Colorado Department of Health Care Policy & Financing (2010, July) *Olmstead: Recommendations and Policy Options for Colorado*.

code of federal regulations at 42 CFR 483.20, nursing facilities that participate in the Medicare or Medicaid programs must complete the MDS assessment for all residents admitted to the facility. CMS recently made changes to the MDS as of October 2010 and added a new requirement under MDS 3.0 Section Q. Nursing homes are now obligated, as a mandatory follow-up action, to make a "community referral" within ten days to the designated Local Contact Agency (LCA) for any resident who, in response to the MDS questions, indicates he/she wishes to talk to someone about returning to the community. The Department has had to identify agencies that will serve as these LCAs. Individuals who request transition information through the Section Q procedure will be included in MFP transition efforts. Referrals to the MFP demonstration will also be accepted from individuals, family members, advocates, and/or providers. Section 6071 of the ACA liberalized the minimum institutional residency period for MFP eligibility - to a minimum of 90 consecutive days in an institutional setting from the previous minimum of 120 days established in the DRA, but Medicare covered days are excluded from counting this required residency period.

Dual eligible beneficiaries who enter a skilled nursing facility under Medicare's post-acute benefits would not be eligible for transition services at enhanced federal matching rates due to the statutory restrictions. However, the Department and RCCOs should develop transition programs that leverage the MFP demonstration infrastructure to identify dual eligible beneficiaries in a nursing facility under a Medicare covered rehab stay.

PCG recommends:

- The Department should analyze MFP transition workflows to assess what changes would be needed to extend transition activities to dual eligibles covered under Medicare Part A post-acute SNF benefit.
- The Department should link stakeholder engagement activities for the MFP grant with stakeholder engagement under the State Demonstrations to Integrate Care for Dual Eligible Individuals project to look for synergies between these two important initiatives.

Institute Selective Contracting for Select Services

In recent years, several state Medicaid programs have used selective contracting for certain services. Selective contracting is an approach for purchasing health care services that relies on competition and market forces to set prices. Selective contracting requires service providers to bid for the state's business; generally, the lowest bid by a technically qualified provider determines the price the buyer will pay for the services. Vision laboratory services (the preparation of eyeglasses, frames, and lenses) are the most common Medicaid services provided in this way, used by Maine, Montana, Ohio, Vermont, and Washington. Vermont and Washington use selective contracting to obtain oxygen and related respiratory equipment.

Medicare spent about $8.6 billion on DME in fiscal year 2007. Oxygen and related supplies has been the largest category of DME, representing about a quarter of DME spending in recent years.[32] Medicare is now phasing in a new program called "competitive bidding" for equipment, supplies, and services mandated under the MMA to control cost and help limit fraud and abuse. In some areas of the country if Medicare beneficiaries need certain items, they must use specific suppliers, or Medicare won't cover the item. As a result of the first phase (i.e. Round 1) of bidding, the program is in effect in the following states: California, Florida, Indiana, Kansas, Kentucky, Missouri, North Carolina, Ohio, Pennsylvania, South Carolina, and Texas. The Medicare Improvements for Patients and Providers Act (MIPPA) provides that the delayed Round 2 competition will cover additional MSAs in 2011, including the Denver-Aurora area in Colorado.

Medicaid covers a broader range of medical supplies than coverage available under Medicare. For example, disposable supplies, including gloves, are a benefit of the Colorado Medicaid Program for use by the client in his/her home. A number of home and community-based waiver programs also cover specialized medical equipment and supplies. The use of selective contracting would provide a more systematic, efficient, and comprehensive approach for providing durable medical equipment, medical supplies, and related services.

To use selective contracting in Medicaid, generally the state must obtain a section 1915(b) or "Freedom of Choice" waiver from CMS to allow the state to restrict Medicaid clients' choice of

[32] MedPAC (2008, October) *Durable Medical Equipment Payment System.*

providers to those chosen by the state. A federal waiver would not be necessary to implement selective contracting for some services. Section 1915(a) of the Social Security Act, for instance, allows states to establish special procedures for purchasing medical devices and laboratory and X-ray tests through competitive bidding. Although "medical device" is not defined in Medicaid law, the federal government has interpreted it to include durable medical equipment and supplies.

Colorado should consider complementary contracting with Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program to include Medicaid-covered equipment and supplies for which Medicaid is the primary payer.

PCG recommends:

- The Department should engage CMS to become an active participant in the Medicare DMEPOS Competitive Bidding Program as its rolls out in Colorado.
- The Department should identify and quantify the level of non-Medicare covered medical equipment and supplies that could be covered through complementary selective contracting with Medicare's selected DMEPOS vendor.

Other selective contracting for Medicaid ancillary services may also be advantageous in producing savings for the dual eligible population under the ACC Program.

State as Medicare Prescription Drug Plan

The Medicare Part D Plan created by the MMA changed the financial relationship between the federal and state governments in regards to the coverage of prescription drugs. Individuals who were previously dependent upon on Medicaid for covering the costs of their drugs are now enrolled in a Medicare PDP that provides prescription drug coverage.

State Medicaid programs have significant experience managing drug costs, many through the use of pharmaceutical benefits managers (PBMs), including the provision of prescription drug benefits to dual eligibles prior to the implementation of Medicare Part D. In addition to use of PBMs, states use a variety of administrative services intended to improve quality and control costs, such as, mail order pharmacy operations, prescription checks for adverse drug interactions

through Drug Utilization Review (DUR) programs, restricted pharmacy and prescriber networks to curtail abuses through lock-in programs, and developing Preferred Drug Lists (PDL). States are able to obtain deeper discounts for pharmaceuticals that would not otherwise be available under federal law through supplemental rebate negotiations with manufacturers. Additionally, many states have achieved savings by participating in multi-payer bulk purchasing pools to negotiate on prices and rebates for drugs required by the multiple states Medicaid programs or intra-state pools with other in-state agencies such as state employees' plans and local governments.

The Medicaid Drug Rebate Program has been around for 20 years. It requires drug manufacturers to rebate to the states about 15 percent of the amount the state pays for brand name prescription drugs, or 11 percent for generics. Because of the rebates, states may get a lower effective price for each drug. The MMA specifically prohibited the federal government from directly negotiating drug prices, relying instead on the purchasing power of PDPs. While PDPs are not entitled to the best private price like Medicaid, they can negotiate prices below Medicaid's "best price" without those prices being counted as a best price (i.e., the manufacturer need not rebate the lower amount to Medicaid). However, researchers found that manufacturers of the four most widely-used atypical antipsychotics all noted favorable price changes that resulted from the shift of dual-eligibles to Part D in 2006, suggesting that Medicare is paying higher prices for these drugs than Medicaid did.[33]

The Part D market may be more prone to adverse selection. Plans with relatively generous coverage draw a disproportionate share of enrollees with high expected costs than other health insurance markets because of the persistence and predictability of drug expenditures[34]. The high expected drug spending of dual-eligibles with mental disorders creates incentives for PDPs to avoid enrolling them. Formulary coverage of psychotropic medications has been relatively generous overall since Part D's implementation due to the special protections for antidepressants, antipsychotics, and anticonvulsants. Utilization management requirements are common in these cases, and the number of plans using them has generally increased since 2006. These data tell us

[33] Frank RG, Newhouse JP. Should Drug Prices Be Negotiated Under Part D of Medicare? And if so, How? *Health Affairs.* 2008;27(no 1):33–34.

[34] Pauly MV, Zeng Y. Adverse Selection and the Challenges to Stand-alone Prescription Drug Insurance. *Frontiers in Health Policy Research.* 2004;7(no 1):55–74.

that a substantial number of dual-eligibles with mental disorders will face utilization restrictions that may lead to medication discontinuities.[35]

One of the new models emerging in the climate of reform and possibilities for innovation is the state acting as the integrated entity to blend Medicare and Medicaid funding. This new model would allow states to receive a predetermined amount of Medicare funding in exchange for assuming full responsibility for administering a Medicare benefit, or set of benefits. While states have previously sought authority to blend Medicare and Medicaid funding through managed care organizations (MCO), the new climate of innovation could make it permissible for CMS to provide authority for a state to function as a Medicare MCO. The State Demonstrations to Integrate Care for Dual Eligibles project creates the possibility for states to receive Medicare funding, to become integrated entities and administer both Medicare and Medicaid benefits themselves, and several states have proposed to do so. Colorado could consider functioning as a Medicare PDP for dual eligibles enrolled in the ACC Program, or more broadly to dual eligibles with behavioral health conditions.

PCG recommends:

- The Department should approach Medicaid Community Mental Health Services Program BHOs and stakeholders to obtain qualitative and quantitative data on dual eligibles' experience in accessing behavioral health medications under Medicare Part D.
- The Department should engage CMS to gauge initial receptivity to the state functioning as a Medicare PDP in order to begin to outline regulatory hurdles and operational issues that would need to be addressed in implementation planning.

Integration through Behavioral Health Organizations

Addressing outpatient behavioral health care under Colorado's Integrated Care Program presents opportunities for greater care coordination and cost savings, and also improves access. Under the ACC Program, the majority of behavioral health services will continue to be delivered through

[35] Julie M. Donohue, J., Huskamp, H., and Zuvekas, S. (2010, May) *Dual-eligibles with Mental Disorders and Medicare Part D: How are they faring?*, Health Aff (Millwood). 2009 May–Jun; 28(3): 746–759.

Community Mental Health Services Program BHOs. RCCOs are expected to work with these BHOs to integrate physical and behavioral health care needs. In this respect, care coordination efforts extend beyond physical health to include efforts to link to available behavioral health services.

BHOs are also responsible for providing care coordination to address the member's need for integration of mental health and other services. This includes identifying, providing, or arranging for services and/or coordinating with other agencies to ensure that the member receives the health care and supportive services that shall allow the member to remain in her/his community. BHOs must assign a Care Coordinator to each Member receiving mental health services. Recognizing its importance, BHOs must make reasonable efforts to assist individuals to obtain necessary medical treatment. If a member is unable to arrange for supportive services necessary to obtain medical care due to her/his mental illness, these supportive services are arranged for by the BHO whenever possible.

The potential for savings from integrating behavioral health and primary care can be achieved through cost offsets, improved cost-effectiveness, and leveraging. Cost offset savings are accrued by preventing additional health care costs, such as ER visits, hospitalizations, and high utilization. For example, cost-offset savings results with the reduction in the duplication of screenings and unnecessary services, such as an MRI for a headache. Savings related to cost-effectiveness derives from more effectively treating the physical problem because behavioral health is addressed or by treating behavioral health issues that otherwise might not be addressed. For example, cost-effectiveness is achieved when patients who receive counseling for substance use show marked improvement with their medical conditions. Leveraging occurs by freeing up physician time when behavioral health staff picks up some responsibilities for the patient. For example, a primary care physician's time can be freed up when patients with psychosocially complex needs can access behavioral health services. Close collaboration in a fully integrated system where behavioral health providers and primary care providers are part of the same team provide the greatest potential for substantial cost-offset savings, in addition to savings from cost-

effectiveness and leveraging. This type of integrated care is possible when per member per month (PMPM) or capitation financing systems are available.[36]

One of the benefits of capitation is the potential for substitution of services. Capitation in mental health may encourage the substitution of less expensive services for more expensive hospitalization. For example, Assertive Community Treatment (ACT) is provided as a structured alternative to hospitalization. Additionally, program evaluation results, from Colorado's Community Mental Health Services Program, indicated that reductions in the costs of providing mental health care to consumers, with little change in outcomes of care, could be attributed to capitation. Jointly capitating BHOs to provide all covered behavioral health care for dual eligibles, may present significant opportunity for savings in addition to inpatient care. For example, studies also indicate the decline in the use of partial hospital services over the past 25 years due to increases in various psychosocial rehabilitative services, including ACT.[37]

Medicaid is the secondary payer for dual eligibles with respect to Medicare covered behavioral health benefits provided under the Community Mental Health Services Program. Under the Community Mental Health Services Program, services are delivered through the BHOs own or contracted provider network. BHOs must make efforts to identify and include providers in their contracted networks that are capable of billing Medicare for dual eligible members and ensure that providers bill Medicare or assist the member in finding qualified Medicare providers who are willing to provide covered services. However, if qualified Medicare providers cannot be identified, BHOs are required to provide medically necessary mental health services. Roughly 40 percent of practicing psychologists do not accept Medicare, a fact that may make it difficult for many dual eligibles to receive mental health care.

Improved management to ensure appropriate delivery of Medicare covered mental health care for dual eligibles through managed care arrangements would indeed be warranted. In 2007, the Center for Medicare and Medicaid Services (CMS) released a report entitled *Medicare Payments*

[36] Collins, C. et al (2010) *Evolving Models of Behavioral Health Integration in Primary Care*, Milbank Memorial Fund, New York, New York.
[37] Maryland Health Care Commission (2008, May) *Best Practices: Crisis Response and Diversion Strategies*. Prepared for the Task Force on the Plan to Guide the Future Mental Health Service Continuum.

for 2003 Part B Mental Health Services: Medical Necessity Documentation and Coding.[38] Its most significant findings were that 47 percent of claims did not meet Medicare requirements, 26 percent of claims were miscoded and 19 percent were insufficiently documented. According to the Inspector General (IG), this resulted in $718 million in improper payments. A 2001 HHS Inspector General report found Medicare allowed $185 million in 1998 for inappropriate outpatient mental health services. While some beneficiaries received excessive therapy services, others did not receive needed medication management services.[39]

Given the current infrastructure in place, Colorado should consider acting as the integrating entity to manage all behavioral health services for dual eligibles. The Department could work with CMS to develop a risk-based financing arrangement for Medicare-covered behavioral health services and sub-capitate to contracted BHOs for the provision of these services to dual eligibles enrolled in the Integrated Care Program.

PCG recommends:

- The Department should focus on physical health and behavioral health system linkages under the Initial Phase of the ACC Program, with ongoing dialogue on this topic at upcoming ACC Program advisory forums.
- The Department should engage CMS' initial receptivity to capitating, and sub-capitating, Medicare behavioral health benefits in order to begin to outline regulatory hurdles and operational issues that would need to be addressed in implementation planning.

Expand the Use of Telemedicine

Colorado Medicaid covers telemedicine services for already covered services when an in-person encounter between a provider and a client is not available within a reasonable distance, the client lives in a county of 150,000 or fewer residents, and the service is medically necessary for treatment. Telemedicine allows Colorado Medicaid clients, particularly those in medically

[38] www.oig.hhs.gov/oei/reports/oei-09-04-00220.pdf
[39] Department of Health and Human Services, (2001, May) *Medicare Part B Payments for Mental Health Service*, Office of the Inspector General, Washington, D. C. report #OEI-03-99-00130. Retrieved on 6-3-2011from http://oig.hhs.gov/oei/reports/oei-03-99-00130.pdf

underserved and rural areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

Telemedicine involves two providers in separate locations, an "originating provider" and a "distant provider." The originating provider is located at the site where the client is located at the time the telemedicine service occurs. The distant provider is located at the site where the client is not located at the time the telemedicine service occurs. In most cases the distant provider is a clinician who acts as a consultant to the originating provider. However, in some cases such as – mental health services and speech pathology, for example – the distant provider may be the only provider involved in the service. Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.

With telemedicine, health care providers can merge technology with medicine to provide remote diagnostic services to patients in need of immediate or constant medical evaluation. Telemedicine services include distance examination and diagnosis, and require that the necessary equipment be installed at the remote location. Some of the available devices for remote monitoring include blood pressure monitors, digital stethoscopes, video cameras, and even digital cameras. In 2011, authorized by HB 10-1005, the Department is expected to begin delivery of telemedicine and telehealth services in the home setting for Colorado Medicaid clients. Participating home care agencies will use telehealth devices to monitor Medicaid patients' health status and collect vital signs such as weight, temperature, blood glucose, blood pressure, pulse, and breath sounds in near or actual real time. Telehealth devices may also be used to educate patients as well as to remind patients to take medications.

The Department should seek to expand the telemedicine best practices program for dual eligible patients suffering from a chronic disease, such as congestive heart failure, diabetes, or pulmonary disease. As part of its ACC Program, Colorado should provide remote monitoring tools for some dual eligibles needed to improve access and reduce the need for costly emergency room visits. The Department should also seek to use telehealth to improve linkages between RCCOs, PCMPs, and BHO providers.

PCG recommends:

- The Department should convene RCCO, PCMP, and BHO representatives at an upcoming ACC Program advisory forum to share telehealth best practices, with attention to identifying policies that could promote greater system integrations.

- The Department should complete a comparative analysis of Medicare and Medicaid telehealth requirements to identify regulatory and policy variation that may need to be addressed in implementation planning.

Implementation Challenges

This section of the Options Report addresses implementation challenges and issues related to enrolling dual eligible individuals in the ACC Program. Implementation challenges should be put in perspective before discussing them. Colorado's accountable care and medical home efforts are built upon a strong foundation. Legislative approval has been obtained, funding is in place, a model has been developed after a multi-year planning effort, RFPs have been issued and awarded, and a multi-year implementation has begun. The Initial Phase enrollment is approximately 60,000 members. The health provider networks that the Department has chosen to work with are large coalitions that have decades of experience in managed care and Medicaid programs. These networks have sufficient PCMPs to provide services in the first year to the 8,600 members they are each expected to have.

The health provider networks forming the RCCOs also have considerable sophistication in operating and growing provider networks, using quality-of-care metrics, providing case management and care coordination functions, and operating complex data processing systems with electronic health record transmissions and claims analysis. On the one hand, these are complex areas to acquire expertise in and implementation problems frequently arise when attempting them. On the other hand, the track records of the Colorado regional care collaboratives are impressive and show their considerable success at mastering these difficult tasks.

Relatively speaking, because of the provider capacity and sophistication in accomplishing key tasks, PCG would expect that there will be broad areas absent of significant implementation challenges related to integrating dual eligibles during the expansion phase of the ACC Program. Moreover, the implementation experience built in a year-long start-up during the Initial Phase of

the ACC Program has an opportunity to develop relationships and work out procedures addressing implementation challenges associated with enrolling dual eligibles during the Expansion Phase. However, the following issues deserve due consideration as the Department moves forward with the design of its Integrated Care Program under the State Demonstrations for Integrating Care for Dual Eligibles project.

Potential Cost Savings and Shared Savings Methodologies

As highlighted in PCG's research report, persons who are dually eligible for both Medicaid and Medicare incur a disproportionate share of total costs. In 2005, dual eligibles were 18 percent of Medicaid enrollment and 46 percent of Medicaid spending.[40] Dual eligibles will be added to the RCCO membership in the expansion phase of the ACC Program. Below, PCG lays out high-level estimates of overall cost savings that might be available from the various innovations previously described as implementation options. Greater innovation than previously imaginable is now possible through the State Demonstrations to Integrate Care for Dual Eligibles project.

However, that is not to say that reforms to financing and delivering care to dual eligibles is not without constraints. The Department must vet various program options with stakeholders within the state, and its federal partners at CMS, to develop a concrete design for the implementation of a program resulting from planning under the State Demonstrations to Integrate Care for Dual Eligibles project. PCG has approached this as a very high-level estimate in the absence of real integrated data for dual eligibles that would allow for detailed cost modeling if program design assumptions were known. A discussion of issues related to shared savings methodologies, focused on the applicability of CMS' approach to the MMSP follows.

Total expenditures for Colorado Medicaid's dual eligible population are estimated at roughly $1.1 billion in 2010 for approximately 60,000 eligible beneficiaries. PCG applied a distribution of state Medicaid spending for services used by dual eligibles. The distribution factors for service use were derived from Urban Institute estimates based on 2005 data from the Medicaid

[40] Medicaid and CHIP Payment and Access Commission, (2010, October 28-29), *Overview on Dual Eligibles, Session Brief*, Washington, D.C. Retrieved on 5-24-2011 http://www.macpac.gov/home/meetings/2010_10

Statistical Information System (MSIS) and Medicaid Financial Management Reports (CMS Form 64) prepared for the Kaiser Commission on Medicaid and the Uninsured.[41]

Medicaid Benefits	Description	Estimated Expenditures
Medicare premiums	Medicare premiums paid by Medicaid	**$77,000,000**
Medicare-covered services	Part A and Part B deductibles and co-insurance paid by Medicaid	**$154,000,000**
Acute Not Covered by Medicaid	Acute care services, including ancillary services, (e.g. transportation, dental, and vision services) not currently covered by Medicare that Medicaid covers	**$33,000,000**
Prescribed Drugs	Medicaid coverage for Part D excluded drugs and state clawback payments	**$11,000,000**
Long-Term Care	Medicaid long-term care services, including institutional and community-based care	**$836,000,000**

Colorado's participation in the CMS State Demonstrations to Integrate Care for Dual Eligibles project provides the Department with an opportunity to shared savings arrangements for Medicare covered benefits – similar in concept to the ACO shared savings model in Section 3022 of the ACA – and incorporate such gain-sharing payments into the ACC Program as appropriate. Therefore, PCG examined current national Medicare costs available from MedPAC as a basis for estimated levels of Medicare expenditures that could be impacted. The source of this data was a MedPAC analysis of the revised Current Beneficiary Survey Cost and Use file, from 2006, which was converted from average payment per beneficiary costs to estimated aggregate expenditures for Colorado's approximately 60,000 dual eligibles. This data only reflects estimates for FFS Medicare beneficiaries.[42]

[41] Distribution of Medicaid Spending for Dual Eligibles by Service accessed through Kaiser Commission on Medicaid and the Uninsured at http://www.statehealthfacts.org/profileind.jsp?ind=661&cat=6&rgn=7.
[42] MedPAC (2010, June) *A Databook: Healthcare Spending and the Medicare Program.*

Medicare Benefits	Cost Per Beneficiary	Estimated Expenditures
Inpatient Hospital	$5,269	**$332,763,695**
Outpatient Hospital	$1,729	**$109,194,995**
Physician Services/Other	$3,075	**$194,201,625**
Prescribed Medicine	$3,184	**$201,085,520**
Skilled Nursing Facility	$1,068	**$67,449,540**
Home Health	$709	**$44,776,540**
Hospice	$331	**$20,904,305**

PCG made certain adjustments to allocate estimated expenditures in the grouping addressed in the Benefits section of this report that could potentially be impacted by Colorado's Integrated Care Program. Acute physical care, which includes ancillary services, addresses those covered by both Medicare and Medicaid. Medicaid payment for Medicare cost sharing for deductibles and coinsurance is included in this group. Medicaid payment for Medicare premiums were excluded, as it is assumed that these expenditures would not be impacted. Segregating expenditures for behavioral health into a separate grouping was created based on data that indicates mental health services represent three percent of Medicare spending. Medicaid behavioral health expenditures were estimated using weighted averages for FY 2007 rates for the Colorado Community Mental Health Services Program. Long-Term Care includes both Medicare Skilled Nursing Facility and Home Health services (considered post-acute care) and all Medicaid spending for long-term services and supports.

Because the design of the integrated care program for dual eligibles under the Expansion Phase of the ACC Program has yet to be developed in any detail, PCG estimated the range of the potential savings based on two established target thresholds. First, RCCOs and PCMPs will have the potential to share in any savings generated through the ACC Program beyond cost neutrality defined as an aggregate reduction in costs of 7 percent. PCG considered this 7 percent reduction as a high-end target threshold for savings for dual eligibles.

Recognizing the complexity of care coordination for dual eligibles, and potential limitations to innovation that may be placed on the state by CMS, PCG included a more conservative, low-end savings threshold. To establish this threshold, PCG elected to use the 2 percent floor for the

Minimum Savings Rate (MSR) for ACOs under the Medicare Shared Savings Program (MSSP) as outlined in a proposed rule published in the Federal Register on March 31, 2011. A goal of the MSSP is to use a portion of the savings (the difference between the ACO's actual expenditures and an established benchmark) to encourage and reward participating ACOs for coordinating the care for an assigned beneficiary population in a way that controls the growth in Medicare expenditures for that patient population. The proposed MSR is higher for ACOs with less than 60,000 covered lives to account for greater uncertainty regarding normal variation in expenditures for smaller populations. For example, the proposed MSR is 3.9 percent for ACOs of 5,000 beneficiaries, 2.5 percent for 20,000 beneficiaries, and 2.2 percent for 50,000 beneficiaries.

This 2 percent savings threshold is consistent with CMS' experience in shared savings arrangements under the Medicare Physician Group Practice (PGP) Demonstration implemented in 2005. CMS's PGP Demonstration tested a hybrid payment methodology that combines Medicare FFS payments with a bonus payment that participating physician groups can earn by demonstrating savings through better management of patient care and services. Under the PGP demonstration, the MSR was initially set at a flat 2 percent of the benchmark, regardless of the number of assigned beneficiaries. It should be noted that the feasibility of achieving the 2 percent savings is not without controversy. In July 2007, CMS reported that for the first program year (PY1) of the PGP Demonstration, only two (2) of the ten (10) participating physician groups participating earned a shared savings bonus payment. By CMS' report to Congress in 2009, there were only four sites earning performance payments in program year two (PY2).

To achieve cost savings in the PGP demonstration, all 10 participating physician groups implemented or expanded care coordination programs. Despite early positive indicators of cost savings for some sites, the full impact of programs implemented for the PGP Demonstration, particularly in care coordination, is largely unknown. Many programs were not in place for all 12 months of the first performance year. Only 1 of the 10 participants had all of its programs in place for all 12 months of PY1. By the beginning of PY2, only 6 of the 10 participants had all of their care coordination programs operational. The four PGPs that earned shared savings bonus payments in PY2 had lower inpatient and outpatient expenditures, consistent with the expectations about improved care coordination, than the six PGPs not earning bonus payments.

However, insufficient data was available for CMS to test this correlation using a rigorous analysis.

Combined Benefits	Estimated Expenditures	Potential Savings (2 percent Threshold)	Potential Savings (7 percent Threshold)
Acute Physical Care	**$804,075,506**	$16,081,510	$52,285,285
Prescription Drugs	**$212,085,520**	$4,241,710	$14,845,986
Behavioral Health	**$44,564,063**	$891,281	$3,119,484
Long-Term Care	**$948,226,435**	$18964,529	$66,375,850

The precise arrangements for shared savings between the state and Federal government will emerge from ongoing collaboration with CMS under the State Demonstrations to Integrate Care for Dual Eligibles project. Final arrangements are likely to depend on the level of risk assumed by the state, with higher returns available for greater risk bearing at the state level. For example, the potential savings retained would likely be higher – up to 100 percent of the savings - if Colorado were to accept full-risk capitation to function a Medicare PDP for prescription drugs for enrolled dual eligibles. The ability to retain a more significant portion of savings is likely lower if the state were to, for example, implement only medication reconciliation programs through RCCOs that assist with tracking patient medications to avoid adverse events related to prescription medications – where the state had no financial risk in the cost of drugs to Medicare under Part D or hospitalizations under Part A resulting from the adverse events.

An equal split (50 percent/50 percent) between the state and Federal government for Medicare covered services is assumed for this analysis. PCG assumes no shared savings split on the reduction of Federal Financial Participation (FFP) for Medicaid covered services to dual eligibles. The state would retain all of the savings from reduction in the state share of Medicaid covered services. These assumptions would result in Colorado retaining roughly 63 percent of the total potential savings estimated at both low-end and high-end thresholds. The proposed MSSP regulations allow for ACOs not at financial risk to share up to 50 percent of the total savings generated and 60 percent for ACO under the risk model, required by the third year of

operation. Practices participating in the PGP Demonstration received back 80 percent of the savings achieved in excess of the MSR.

Combined Benefits	Estimated Expenditures	Potential Savings (2 percent Threshold)	Potential Savings (7 percent Threshold)
Acute Physical Care Medicare Shared Savings	$617,075,506	$12,341510	$43,195,285
Acute Physical Care Medicaid State Share Savings	$93,500,000	$1,870,000	$6,545,000
Prescription Drugs Medicare Shared Savings	$201,085,520	$4,021,710	$14,075,986
Prescription Drugs Medicaid State Share Savings	$5,500,000	$110,000	$385,000
Behavioral Health Medicare Shared Savings	$19,084,809	$381,696	$1,335,937
Behavioral Health Medicaid State Share Savings	$12,739,627	$254,793	$891,774
Long-Term Care Medicare Shared Savings	$112,226,435	$2,244,529	$7,855,850
Long-Term Care Medicaid State Share Savings	$418,000,000	$8,360,000	$29,260,000
Total Estimated State Savings Potential		**$25,386,911**	**$88,854,190**

A probable implementation challenge that will arise sometime during the Expansion Phase will be the question of how both Medicaid and Medicare expenditures for dual eligibles can be reduced – and measured – through the activities of the RCCOs and/or other innovations. RCCO management techniques used to moderate hospitals usage produce Medicaid savings for non-dual eligibles, but do not produce Medicaid savings on dual eligible hospital utilization. Thus efforts to reduce preventable admissions and readmissions will be operationally different for

Medicare members compared to Medicaid members. PCG expects that the measurement of savings from these efforts will also have some differences.

It is important that the Department be mindful of shared savings methodologies that might be possible for retaining Medicare savings realized through enrolling dual eligibles in RCCOs and/or other innovations. This must be done concurrently with the development of a gain-sharing methodology in the ACC Program for Medicaid-only members enrolled in RCCOs during the Initial Phase. PCG believes it is helpful for the Department to understand the savings methodology for the MSSP proposed by CMS. In summary, shared savings limits proposed for MSSP include:

- Savings payments to the ACOs are limited to either 50 percent or 60 percent of total savings depending on the amount of risk incurred by the ACO. The structure assumes savings and risk for all years of the program, similar to the "Track Two" in the shared savings NPRM.

- Savings are further limited by a minimum savings rate (MSR) as per section II.F. 10. of the NPRM.

- Savings are also further limited by a 2.0 threshold amount. "We further propose that, unless exempted, ACOs that exceed the MSR would be eligible to share in net savings above a 2 percent threshold, calculated as 2 percent of its benchmark (updated according to statute)" as per section II.F. 11. of the NPRM.

- Savings are again limited by how well the ACO does on some 65 quality measures. A percentage of measuring accomplishment on these measures will be constructed and this percentage will be used to further discount possible savings as per section II. E.5

- Twenty-five percent of savings are withheld until the full three years have been complied with as per section II. F.

Given these limitations on savings, PCG does not feel this methodology would be the ideal or most advantageous arrangement for the state. For example, functioning as a Medicare MCO at full risk might allow a state to get 100 percent of the savings in its Medicare Advantage programs. Additionally, national reaction to the shared savings regulations is still evolving

although less than enthusiastic comments have been publically made about the proposed rules.[43] A significant comment on the cost of the new regulations has been made by the American Hospital Association (AHA). In its report, the AHA itemized the expenses a new ACO could incur in four areas: 1) network development and management; 2) care coordination, quality improvement and utilization management; 3) clinical information systems; and 4) data analytics. The AHA found that the costs associated with developing these capabilities range from $5.3 to $12.0 million depending on the type of ACO.[44] The decision to participate in the MSSP must be made carefully with an understanding of risk and weighing of the costs of participation versus potential savings.

CMS is proactively responding to the kinds of concerns expressed by the AHA. On May 17, 2011, CMS announced it would consider making advance payments to:

> "..ACOs entering the Medicare Shared Savings Program to test whether and how pre-paying a portion of future shared saving could increase participation in the Medicare Shared Savings Program. Some providers have expressed a concern about their lack of ready access to the capital needed to invest in infrastructure and staff for care coordination. Under the proposed initiative, eligible organizations could receive an advance on the shared savings they are expected to earn as a monthly payment for each aligned Medicare beneficiary. ACOs would need to provide a plan for using these funds to build care coordination capabilities, and meet other organizational criteria. Advance payments would be recouped through the ACOs' earned shared savings."[45]

After the publication of the ACO and shared savings NPRM discussed above, in May 2011, CMS issued a Request for Applications for Pioneer ACOs.[46] This Pioneer ACO application states that CMS intends to enter into agreements with a limit of 30 organizations. Except for

[43] See for example, retrieved on 5-25-2011 http://e-caremanagement.com/trend-spotting-1-medicare-aco-dead-in-the-water-2-payers-awaken-to-aco-opportunities/ Comments received by CMS on the shared savings NPRM can be read at http://www.regulations.gov using the keyword "CMS–1345–P" and document type "Public Submission."

[44] American Hospital Association, (2011, April) THE WORK AHEAD: *Activities and Costs to Develop an Accountable Care Organization*, Washington, D.C. See, retrieved on 5-21-2011, from http://www.aha.org/aha/content/2011/pdf/aco-white-paper-cost-dev-aco.pdf

[45] See, retrieved on 5-21-2011, http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/advance-payment/

[46] See the announcement, retrieved on 5-21-2011, from http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/

rural organizations, CMS requires Pioneer ACOs to have a minimum of 15,000 aligned Medicare beneficiaries, up from the 5,000 requirement in the shared savings NPRM. The application appears to be geared towards larger, more experienced organizations that might have participated in the shared savings program anyway.

The Pioneer ACO application contains a detailed appendix describing the differences between the original ACO NPRM and the subsequent ACO program. Significant similarities include the use of quality measures and governance requirements. Significant differences include:

- The calculation of beneficiary benchmark costs. The Pioneer ACO Model may include either prospective or retrospective assignment of beneficiaries to an ACO whereas the Shared Savings ACO approach in the NPRM assumes a retrospective assignment based on the actual beneficiaries served during the year for which the savings are being calculated. The description of programmatic procedures in the Pioneer ACO application are consistent with prospective assignment wherein beneficiaries are assigned to an ACO based on the utilization in previous years.

- Savings and risk percentages. Savings percentages can go up to 70 percent in the Pioneer ACO options versus 60 percent in the shared savings ACO approach and risk percentages can go up to 15 percent versus 10 percent.

- Payments. The Pioneer ACOs will receive fee-for-service payments at 50 percent of fee-for-service payment rates on submitted claims for services delivered to beneficiaries. CMS will then provide a monthly population-based payment as a per-beneficiary-per-month payment (PBPM) that will equal the remainder of the ACO's projected FFS revenue. CMS says the advantage of this is to allow Pioneer ACOs the revenue flexibility to provide services not currently paid for under FFS, and to invest in infrastructure to support care coordination.

As with the MSSP, shared savings approach the Department should closely examine the opportunities and consequences of payment mechanisms for the Pioneer ACO program.

Program Evaluation Metrics and Application

This section of the report outlines the types of evaluation metrics needed to assess coordination of services dual eligibles receive under the integrated care model the State will authorize. Colorado has several options when selecting how care will be evaluated and which care entity or provider will need to meet the determined evaluations.

Care coordination is a principle theme in evaluating care for dually eligible persons. RCCOs, working with PCMPs, will have primary responsibility for all care management endeavors and must leverage standards for coordinated care with the necessary tailoring to meet the needs of different subgroups of duals. Research findings show that dual eligibles are a unique group of Medicare and Medicaid beneficiaries with varying levels of medical conditions, disabilities, and institutional status.

The care coordination protocol for duals with multiple chronic illnesses will take on a different approach from that of duals with mental illnesses. While both populations should receive appropriate medication and necessary monitoring, and be properly transitioned between different care settings, it is particularly important that mentally disabled duals receive their care in a timely manner and be assessed for changes in cognitive status. . Coordination for duals with multiple chronic conditions will most likely bring together several specialists and strong medication monitoring. Some providers may face patients with two chronic conditions while other providers have clients with five or more chronic conditions making coordination of services all the more pertinent. Adopting the same approach for duals with mentally disabilities and duals with multiple chronic conditions will not warrant positive health outcomes for the two groups.

Similarly, care coordination will also vary between those living in nursing homes and those living in community based facilities. The reduction of error and hospitalization rates is important. Nursing home patients are the mo costly and it is necessary to ensure that they do not needlessly visit the hospital to contribute to their high per capita spending. It is also important to conduct frequent evaluations in order to determine if institutionalization is the best care setting for them. Care transition protocols therefore should be up to date and periodically reviewed. Community based management should have a different approach from a nursing home model

because care will most likely not be centralized. The main goal for community based residents is how to align their need for services in accordance to their specific needs in the community. Personal preferences and community support systems are more significant for this population. Care coordinators and the measures to evaluate their performance must be cognizant of this fact. Outreach and patient education will be particularly important for duals living in the community.

Poor care management for any subpopulation of dual eligibles is directly linked to preventable hospitalizations. Medicare covers inpatient hospital charges and therefore reduction in unnecessary hospitalizations will be an effective cost saving measure. Furthermore, once in a hospital, patients are at a greater risk of contracting a nosocomial (hospital) associated infection. Numerous reports have been both issued and spurred by states that are mandated to report these statistics. Dual eligibles, a sicker and more disabled population, are likely to have poor health status and require hospitalization. Effective hospital care and proper transition of duals from inpatient hospitals into other care facilities can help to reduce admission days and the likelihood of acquiring a hospital associated infection.

Standard measures should also be in place for the treatment of a specific clinical condition to ensure that all resources were utilized during the course of treatment. Preventative health measures such as screenings and counseling are just as important as diagnostic evaluations, treatment of physical ailments, and medication management. Moreover, clinical conditions common for duals should also have a set of measures to improve outcomes, manage the condition, and reduce hospitalization rates. Common dual conditions include: Alzheimer's and related conditions, Depression, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Heart Failure.

A detailed inventory of applicable measures is provided in Appendix D. The word "domain" simply refers to an area of evaluation in this paper. Each domain represents a major goal or theme upon which entities, such as hospitals, primary care providers, care coordination teams, and RCCOs, will be evaluated. Under each domain there will be a set of metrics to evaluate how the entities are performing. These metrics are taken from long-standing performance measurement systems which include:

- The Physician Quality Reporting Initiative (PQRI);

- The CMS Quality Matrix and Framework for Home and Community Base Services;
- The HHS Hospital Acquired Conditions (HAC);
- Medicare Shared Savings Program (MSSP) Performance Measures;
- Special Needs Plans (SNP) Structure and Process Measures;
- HEDIS 2011 measures;
- The National Quality Forum Measures;
- Healthy People 2020 and;
- External Quality Review Technical Report for Colorado Medicaid[47]

Evaluation of the ACC Program, particularly as it relates to potential gain-sharing with RCCOs and participating providers, can be organized in several ways:

- Option 1-Evaluation Uniformity: All entities are evaluated based on the same measures across all domains,
- Option 2- Evaluation Assignments: Certain measures/domains are assigned to specified entities, or
- Option 3- Hybrid Evaluation: Certain measures/domains are assigned to all entities for evaluation while others will only be assigned to particular entities.

In the paragraphs that follow, each option will be described in further detail.

[47] Health Services Advisory Group (2010, September) *2009-2010 External Quality Review Technical Report for Colorado Medicaid.* In accordance with the Code of Federal Regulations (CFR) and the BBA physical and behavioral state health plans must conduct an external quality review and develop a technical report. The Department has contracted with the Health Services Advisory Group Inc. (HSAG). The company evaluates 3 physical health plans (MCOs, PIHP, and PCCM) and 5 BHOs in the following areas: Performance measures, compliance monitoring standards and validation of performance improvement projects. Each contract with a Medicaid managed care organization evaluates these areas over three domains outlined in the BBA: access, timeliness and quality.

Evaluation Uniformity

In this option, the State uses the same measures to evaluate each entity in the entire system of care, with shared savings tied to the collective performance of all participants involved in care delivery for dual eligibles. The approach in evaluation uniformity is to create overarching measures for the ACC Program to collect data on rather than using separate measures for the RCCO, providers, and the care management team.

Care management goes beyond the efforts of the RCCO and PCMP and can speak to entity-wide efforts such as management of hospitalization trends and transitions from one care setting to another. RCCOs should be evaluated for their care coordination capacities. Care coordination, however, is often wrapped up into large evaluation systems for physicians, hospitals, and long term care providers. Examples of this include the Physician Quality Reporting Initiative (PQRI) and the Quality Matrix and Framework for Home and Community Base Services. The care management/coordination domains within these evaluation systems can be used to evaluate the RCCO as a whole rather than solely used for the evaluation of physicians.

The Medicare Shared Savings Program (MSSP) regulations have taken largely – but not exclusively – from the PQRI to focus on five (5) domains, with corresponding evaluation metrics. The 2010 PQRI Measures List contains 179 measures that the MSSP reviewed and restructured to create 65 measures. The MSSP guidelines evaluate ACOs based on: patient/caregiver experience, care coordination, patient safety, preventative health, and at-risk population/frail elderly health (diabetes, COPD, hypertension, coronary artery disease).

Similarly, the CMS HCBS Quality Framework outlines seven domains with over 30 measures. The measures focus on disabled adults, who mainly live in the community.[48] The framework, created by the National Quality Inventory project, focuses on provider capacity, system performance, service planning and delivery, and participant safety, access, rights, health outcomes, and satisfaction. Colorado can use similar approaches to develop its own set of domains and the specific measures for evaluation drawing on a variety of different performance measurement systems.

[48] Center for Medicaid and State Operations Disabled and Elderly Health Programs Group (2002, August) *Quality in Home and Community Based Services: The Quality Matrix and Framework.*

Although poor coordination is strongly correlated to unnecessary hospitalization rates, the rates should still be measured separately for the potential cost savings associated with fewer hospital visits. The Department of Health and Human Services developed risk adjusted hospital readmission measures to monitor and identify ten hospital acquired conditions (HAC).[49] These conditions are all outlined in the Inpatient Prospective Payment System (IPPS) FY2009 Final Rule. Although HHS announced its initiative to reduce and eliminate HAC by an average of 40 percent by FY 2013, managed care should make appropriate preparations to avoid preventable hospitalizations all together.

System delivery is also an important component of the ACC Program. Particular domains within the Healthcare Effectiveness Data and Information Set or HEDIS measures do evaluate the effectiveness of care plans. Over ninety percent of the nation's health plans use HEDIS measures. Applicable to both Medicaid and Medicare along with commercial plans, HEDIS examines health plans for effectiveness of care, access/availability of care, satisfaction with the experience of care, use of services, cost of care, health plan descriptive information, health plan stability, and informed health care choices. HEDIS measures are used to compare plans within the same plan type. The Department can utilize these measures to create a baseline standard of measurements for comparison and improvement purposes.

In addition to HEDIS, Medicare Special Needs Plans (SNPs) specifically use Structure and Process Measures in their evaluation of health plans. These measures focus on: complex case management, improving member satisfaction, clinical quality improvements, care transitions, institutional SNP relationship with care facilities, and coordination of Medicare and Medicaid coverage.

Evaluation Assignments

In this option, the State uses the specific measures that correspond to a particular entity within the entire system of care with shared savings tied to the individual efforts of various participants involved in the care delivery for dual eligibles. RCCOs are only one component of care that can be evaluated. As seen above, primary care providers, hospitals, and long-term care systems –

[49]CDC's National Healthcare Safety Network (NHSN) (2009, June) *First State Specific Healthcare-Associated Infections Data Summary Report.*

although related to the care coordination efforts of the RCCOs – have the possibility of also being separately evaluated.

Under this option, Colorado can customize its own measurement system comprised of domains taken from HEDIS, PQRI, and other systems to apply them to the specific entities participating in the ACC Program. By assigning domains to specific entities, each entity is accountable to a set of measures but not to other domains. Incentivizing will hold each entity accountable to the measures they are assigned. For physicians, payments can be incentivized to encourage quality care. The Health Information Technology for Economic and Clinical Health (HITECH) Incentive Program can be used to incentivize care coordination. HITECH incorporates both electronic prescribing incentives (eRx) and Patient Centered Medical Homes (PCMH) which are meant to improve care coordination, patient registries, electronic health records, and health insurance exchanges. Also, mandatory HAI reporting makes incentivizing hospitals and healthcare facilities more efficient.

Hybrid of Evaluation

The final option Colorado can consider is a mixture of evaluation procedures. It is clear that same domains or goals apply to several entities and can be considered a joint measure. Such an example is care management, which may occur both at the provider level and the administrative level of the RCCOs.

However, at the same time there are some measures that apply to a specific entity. Such an example is quality measures that evaluate one or a series of patient appointments and can be directed to the corresponding primary care provider. Another example is the evaluations of HAI rates. The RCCO entity itself can be assessed for care coordination and hospital admission recidivism.

Ultimately, Colorado must decide on the most effective way to annually evaluate the performance of its ACC Program, RCCOs, and related entities. The feasibility of achieving measurement compliance is equally as important as the administrative capacity to perform and monitor the evaluation process. For example, in the evaluation uniformity option, Colorado would have to develop multiple sets of evaluation measures to correspond to all entities involved in the functioning of a RCCO. This will involve heavy planning to appropriately determine

which measures are most applicable to a particular entity. In general, a detailed review of the supplied appendix, key evaluation material, and the determination of specific metrics is necessary. The Managed Care Measures and Standards Advisory Workgroup (MCMSA) can anticipate much of this decision making responsibility. An important preliminary step for this workgroup and other key stakeholders is to establish domains, or simply what aspects of care and service delivery are to be included in the evaluation protocol. Once the domains are created, they can then be paired with any particular entity, the ACC program as a whole, or a combination of both.

Integration and Analysis of Medicare Data with the SDAC

The SDAC has multiple responsibilities. These include suggesting which PCMPs members might be assigned to, building a data warehouse containing claims data from the state's Medicaid Management Information System (MMIS) and other data sources, providing sophisticated analytics including predictive modeling to create member risk scores, monitoring performance on key measures, evaluating utilization data of members, and providing provider-level data on provider performance. Additionally, the SDAC will create a web portal to be used by the RCCOs to obtain claims and other data on their members. Finally, the responsibilities of the SDAC include bringing a national perspective on the best ideas and data to help the RCCOs as well as analyzing savings that result from program operation. The RCCO will not have direct access to the state's data. Rather, the SDAC will take data from MMIS and other sources and make it available to the RCCOs.

A review of the proposals submitted by the organizations that were awarded RCCO status and the vendor that was awarded SDAC contractor shows the experience of these organizations. These are organizations that are used to sophisticated analyses of clinical utilization and outcome data. The ACC Program has the potential to accumulate significant amounts of data. Data sources for the SDAC to integrate include Colorado hospital data, Medicaid MMIS data, and electronic health record data from the Colorado Regional Health Information Organization (CORHIO). The data can range across multiple types: inpatient, outpatient, other acute care medical services, therapy service, ancillary services, clinical histories, case management records, health risk assessments, demographics, and pharmacy claims.

In order to successfully integrate dual eligibles into the ACC Program, the state must be able to obtain Medicare data and integrate the Medicare data with Medicaid data. The state envisions obtaining some Medicare data through a Coordination of Benefits Agreement (COBA) with CMS and obtaining other Medicare data from regularly released Medicare data bases. The integration of Medicare and Medicaid data, including Medicare Part D pharmaceutical claims history, is a significant task since it decisively impacts the management of dual eligibles care by the accountable care collaboratives. Such integration also has coordination and planning challenges since the Medicare integration vendor will need to coordinate with the SDAC contractor and the collaboratives.

This volume and breadth of data has multiple potential uses:

- Basic claim and utilization trends can be reported for segments of the RCCO membership;
- Members in general, and members associated with particular PCMPs, can be analyzed into clinical risk groups (CRG);
- Potentially preventable events (PPE) can be analyzed including preventable complications; admissions, readmissions, ancillary service use, and emergency room use; PPE analyses can be done using 3M PPE methodology or similar methodologies;
- Ambulatory Case Sensitive Conditions (ACSCs) can be analyzed;
- Performance metrics can be developed and tracked, and
- Costs and savings can be analyzed taking into account potential differences in savings between the initial and expansion phases because of the non-random selection of focus communities.

A major challenge will be the integration of acquisition and integration of Medicare data. An option the Department has is to encourage the development of a multi-year information management plan that outlines:

- Which and when specific data will be added to the SDAC Data Warehouse;

- Which and when specific data analytical capabilities will be available to the RCCOs;
- Specifications for integrating the data repositories of the RCCOs with the SDAC Data Warehouse;
- The kind and amount of training that will be offered to RCCO staffs;
- How anticipated future "nuts and bolts" technical events will be dealt with such as the HIPAA ANSI format change from X12 4010 to X12 5010 in 2011 and the October 2013 implementation of ICD-10; and,
- Potential changes from the Initial Phase, to the Expansion Phase, to a fully-operational Integrated Care Program.

The development of such an information plan could be one of the tasks of the SDAC Operations Advisory Committee. The potential good that can come from appropriate analysis of Medicare data is considerable and managing the data to extract maximum value, including enabling the Department to operate in a gain-sharing environment, over a multi-year period is a significant implementation issue.

Recruitment of Medicare Providers as PCMPs

Under the ACC Program, RCCOs are large, community-based organizations with considerable experience working with Medicaid and physician practices. These RCCOs should have no difficulty absorbing an additional 8,600 members during the Initial Phase. Where implementation challenges are likely to arise is in the Expansion Phase where enrollment will quickly increase. The four proposals reviewed do not present detailed plans or capacity analyses supporting the proposed expansions. One of the proposals, the Region 6 proposal, did sketch out a capacity analysis and said that approximately 100 more PCMPs would be needed in their network.

The quantitative dynamics underlying this projection are that the expansion will require going beyond traditional safety net providers and recruiting private physicians, and in the case of dual eligibles, this may include providers that might not be currently participating in Colorado's Medicaid program. Private physicians will place a limit on the number of Medicaid recipients

they are willing to see. As the number of members increases, a greater number of physicians have to be recruited. There might even be a "diminishing return" marginal effect if the remaining physicians needed prefer lower percentages of Medicaid in their practices.

The four proposals do contain numerous reasonable ideas about understanding why some providers are reluctant to see Medicaid members, ideas about what can be done to mitigate this reluctance, the efforts the RCCOs will make to talk to physicians, the benefits that affiliating with a RCCO can bring to a physician practice, and the building capacity support of the larger parties to the RCCO, e.g., the capability of Centura in Region 6 to increase capacity if needed.

In the context of dual eligible enrollment, a key provider recruitment strategy should be the identification of physician practices that take Medicare clients. This identification will be aided by efficiently obtaining and integrating Medicare claims data with Medicaid eligibility data. This integration needs to be done during the initial year to aid the enrollment of dual eligibles in subsequent years. When the vendor is hired to obtain Medicare data, the vendor should be explicitly tasked with the identification of Medicare providers and the linkage of Medicare provider history to dual eligibles.

An option the Department could consider is how to leverage enhanced funding from the Medicaid Health Home State Plan Option under Section of the Act created under section 2703 of the ACA, as well as increased primary care provider (PCP) rates required by section 1202 of the ACA, to attract Medicare-participating PCPs to affiliate with RCCOs as PCMPs.

Enrollment Coordination and Sustainable Participation Levels

When optimizing the true benefits of integrated care, enrollment cannot be overlooked. Enrolling a critical mass of individuals also ensures the financial viability needed to cover investments in infrastructure for care coordination programs, delivery system enhancements, and payment reforms. The three options below represent enrollment strategies PCG recommends the Department consider as feasible solutions to historically low dual eligible enrollment rates in Integrated Care Programs. These options take into account federal regulations on Freedom of Choice, opportunities for mandated enrollment, and approaches Medicare is proposing for ACOs as outlined in the MSSP NPRM. Without innovation, low enrollment of dual eligibles in the ACC Program will likely remain a barrier to effective Medicare-Medicaid integration.

Passive Enrollment

Passive enrollment is a form of voluntary enrollment that is more conducive to achieving viable enrollment than a voluntary, proactive selection by a beneficiary before enrollment is initiated. During the Initial Phase of the ACC Program, all members are enrolled utilizing a passive enrollment process. This process of voluntarily enrolling clients into a specific program includes the selection of clients appropriate for enrollment, notification of clients selected for enrollment, and Choice Counseling through an Enrollment Broker to assist clients in making a decision regarding enrollment.

Advance notice and the opportunity for clients to make an informed choice are critical components in the passive enrollment process employed for the ACC Program in its Initial Phase. The Enrollment Broker is responsible for sending notices to all clients identified for enrollment by the Department through a Statewide Date and Analytics Contractor (SDAC). The notice informs clients of the Department's intent to enroll them in the ACC Program, provides them with information about their Colorado Medicaid enrollment choices, provides contact information for the Enrollment Broker's Choice Counseling services, and allows 30 days for the client to make an active choice to be enrolled in the ACC Program. A client that chooses not to participate in the ACC Program must contact the Enrollment Broker. The client may choose to enroll in another Colorado Medicaid managed care organization, if available, or to remain in the Medicaid Fee-For-Service (FFS) program. Clients that do not "opt out" of participation in the ACC Program will then be enrolled with the RCCO responsible for the region in which they live.

Traditionally, there have been challenges in Colorado and across the nation in enrolling dual eligibles into managed care arrangements. Moreover, managed care has a history of serving relatively healthy populations, particularly in Medicaid managed care. Sicker individuals usually remain in a FFS setting which is less restrictive. Dual eligibles, which have poorer health status, also tend to remain with long-standing Medicare providers who may not belong to a managed care network.[50] Passive enrollment is still voluntary and state experience indicates that voluntary enrollment into managed care programs result in lower overall enrollment rates for dual

[50] Miller A Edward, and William Weissert (2004, December) *Managed Care for Medicare-Medicaid Dual Eligibles: Appropriateness, Availability, Payment, and Policy* Journal of Applied Gerontology 23:4 333-348.

eligibles.[51,52] While beneficiaries receive unrestricted care in FFS, the lack of coordination eliminates opportunity for increased preventive medicine, disease management, quality measures, and accountability.

One option the Department could utilize for enrolling dual eligibles in the ACC Program during the expansion phase is to modify its passive enrollment process to eliminate the advanced notice provision. Under this option dual eligibles identified for enrollment would be automatically enrolled with a RCCO *prior to* the provision of appropriate notice. Informed choice would remain an essential component of this more aggressive voluntary arrangement. Similar to the current ACC Program passive enrollment process, dual eligibles would be instructed to request opt-out within a specified time period, but could always disenroll at any time after that. North Carolina utilizes this opt-out approach in its Medicaid primary case care management program, and credits this method for a dramatic increase in dual eligible enrollment.[53] Under this method, all Medicare participants are automatically enrolled into a RCCO and will only be removed upon request. Active choice is still maintained in that clients can opt-out at any time, eliminating push back from advocacy groups in favor of choice.

Creating a time period before individuals can begin to opt-out also gives the RCCOs time to win over its clients. Additionally, clients may be less likely to return to FFS if they have acclimated to a more coordinated care environment and the benefits of accountable care. RCCOs have not been allowed to perform marketing activities to increase their enrollments during the Start-Up Initial Phases. However, under any passive enrollment approach the RCCOs should be permitted to invest in outreach campaigns to ensure that the dual eligible enrollees stay enrolled in the ACC Program. Dual eligible members should understand the programmatic differences and advantages of accountable care not only to reach and maintain sufficient enrollment levels but also to guarantee consumer understanding.[54]

[51] Bella, M. & Palmer, L., (2009, July), *Encouraging Integrated Care for Dual Eligibles*, Center for Health Care Strategies, Inc. Hamilton, NJ.
[52] Milligan, C. & Woodcock, C., (2008, February), *Coordinating Care for Dual Eligibles: Options for Linking State Medicaid Programs with Medicare Advantage Special Needs Plans*, The Commonwealth Fund, New York, NY
[53] Key Informant Interview with North Carolina Department of Health and Human Services staff conducted by PCG on March,, 2011.
[54]http://www.chcs.org/usr_doc/Enrollment_Options_for_Medicaid_Managed_Care_for_People_with_Disabilities.pdf

Mandatory Medicaid Enrollment

A more direct way of ensuring sufficient enrollment of dual eligibles in the ACC Program is through mandatory enrollment. State plan amendments and waivers, specifically Sections 1115 and 1915b, give state Medicaid programs authority to mandate enrollment in Medicaid managed care. The Department, subject to approval from CMS, could amend its existing PCCM authority to require dual eligibles to participate in the ACC Program with respect to Medicaid covered benefits. Under this option, all dual eligibles would be mandatorily enrolled in ACC Program for Medicaid coverage, and would have the option to voluntarily enroll in the Integrated Care Program with respect to Medicare benefits. Since there is no existing authority to compel Medicare beneficiaries to enter managed care arrangements for Medicare-covered benefits (outside Part D drug benefits), innovation that promotes sufficient enrollment of the dual eligible population is important.

Colorado would likely have to initiate robust outreach campaigns promoting the benefits of enrolling with a RCCO in order to persuade clients, and their Medicare-participating providers who could serve as PCMPs, to move from the current Medicaid FFS system into a more coordinated care environment under the ACC Program.

Dual eligible beneficiaries may need to be incentivized, whether this includes providing additional benefits, promoting disease management campaigns, or ensuring that services are accessible to all clients in all parts of the region the RCCO services. Outreach measures and incentives alike should be unique to the dual eligible population. The needs of this population are distinct and more likely, more severe than the general Medicare population. For example, advertising exercise promotions do not necessarily align with the priorities of a chronically ill or disabled dual eligible beneficiary. Passive enrollment could be used in conjunction with mandatory Medicaid enrollment with a RCCO. Similar to the modified passive enrollment approach described above, some level of outreach campaigns to ensure that the dual eligible enrollees stay enrolled in the Integrated Care Program would be needed.

The relationship between the beneficiary and the RCCO forged by the mandatory Medicaid enrollment would most likely result in increased participation of dual eligibles in the coordination of Medicare benefits under the ACC Program.

Medicare Attribution

Another option that could be employed for the enrollment of dual eligibles in Colorado's Integrated Care Program is the attribution method. The term "attribution" in this context refers only to an operational process by which the Department would determine whether a client has chosen to receive a sufficient level of the requisite primary care services from a PCMP associated with a specific RCCO. Therefore, the PCMP and RCCO may be appropriately designated as exercising basic responsibility for that beneficiary's care under Medicare.

The ACC Program currently employs an attribution approach to identify existing Medicaid clients appropriate for enrollment that have an established relationship with a PCMP participating in the RCCO's network. The SDAC is given a list of participating PCMPs, and uses an attribution method to determine whether a Member-PCMP relationship already exists. To accomplish this assignment, the SDAC mines historical MMIS claims data to identify the primary care provider the client has seen most often during the past twelve (12) months. Careful data analysis links a client to a PCMP according to the types of services accessed and the types of providers chosen. For beneficiaries with insufficient claims data to mark a trend, the Enrollment Broker facilitates a Member-PCMP match.

CMS is familiar with such processes through Medicaid demonstrations. An attribution algorithm was used to assign Medicare beneficiary to a Physician Group Practice (PGP) Demonstration. "Assigned Beneficiaries" or ABs were those identified with a plurality of office or other outpatient Evaluation and Management (E&M) visits that are furnished by that PGP. A similar attribution approach will be employed with respect to the MSSP. Section 1899(c) of the Social Security Act (the Act) provides the Secretary with discretion to determine an appropriate method to assign Medicare FFS beneficiaries to an ACO participating in the MSSP. This discretion is limited, however, by the fact that under the Act, assignment must be based on beneficiaries' utilization of primary care services provided under Medicare by an ACO professional who is a physician as defined in section 1861(r)(1) of the Act.

The proposed methodology for assignment of beneficiaries under the MSSP is to attribute Medicare beneficiaries to an ACO based receipt of a plurality of their primary care services as described in section II. D. of the NPRM from a physician affiliated with the ACO. Only

physicians with a specialty designation of general practice, family practice, internal medicine, and geriatric medicine are considered. As required by the statute, the assignment methodology requires data that identify the precise services rendered (i.e., primary care HCPCS codes), type of practitioner providing the service (i.e., a MD/DO as opposed to PA, NP, or CNS), and the physician specialty in order to be able to assign beneficiaries to ACOs.

CMS has proposed to assign beneficiaries to an ACO retrospectively under MSSP. The NPRM states that CMS believes that ACOs should be evaluated on the quality and cost of care furnished to those beneficiaries who actually chose to receive care from ACO participants during the course of each performance year. Another reason for retrospective assignment cited in the NPRM is to encourage the ACO to redesign its care processes for all Medicare FFS beneficiaries, not just for the subset of beneficiaries upon whom the ACO is being evaluated.

CMS intends to provide Medicare claims data to ACOs but ACOs must first notify beneficiaries that their providers are participating in the ACO. The ACO must also notify each beneficiary of the ACOs ability to request claims data about them from CMS. The beneficiary could opt-out of having his or her information shared with the ACO. The decision to opt-out in no way effects use of the beneficiaries' data or assignment to the ACO for purposes of determining such calculations as ACO benchmarks, per capita costs, quality performance, or performance year per capita expenditures for share savings.

CMS has recognized that providing a list of historically assigned beneficiaries may provide an opportunity for inappropriate avoidance by an ACO because the ACO may believe that it will be more likely to realize shared savings against its benchmark costs if it can avoid having higher-cost patients assigned to it during a performance year. CMS is addressing this concern through the proposal described in section II.H. of the NPRM by outlining steps to identify trends and patterns suggestive of avoidance of at-risk beneficiaries and impose sanctions -including termination of the ACOs MSSP agreement – to ensure ACOs do not avoid at-risk beneficiaries.

Transparency is the key to Medicare attribution, in order to maintain the rights of the population. Although Medicare beneficiaries can possibility be assigned to a RCCO, this decision must still be voluntary. Similar to MSSP, dual eligible beneficiaries first should be aware of their RCCO

assignments and second, should have the opportunity to make informed decision about participation.

Increased Complexity in Coordination Among Various Entities

The state design of the ACC Program is complex because there are various entities besides the Department that the RCCOs must have close coordination with to achieve the desired results of improved care and reduced costs. From an administrative perspective, these entities include the SDAC, Enrollment Broker, and Medicaid's Utilization Management Entity. This complexity, applied to enrolling dual eligibles in the ACC Program, creates additional implementation challenges.

One possible challenge is around the management of services that are not paid for by Medicare. A review of the proposals submitted by the organizations that were awarded RCCO status shows requests for utilization management data, specifically, lists of outstanding requests, denied, and approved prior authorizations. The Utilization Management Entity is responsible for receiving and approving referrals to specialists made by the PCMPs. The RCCO does not have approval authority over access to the specialists that RCCO members are referred to by the PCMPs. The proposals indicate that this is normal information that the RCCOs use to manage their business operations and the RCCOs are concerned that they may lack such information in their ACC Program management.

While Medicare fee-for-service access to professional specialists is not prior authorized, Medicaid pays for long-term care, home and community-based services, dental services, dentures, hearing aids, and transportation that Medicare does not cover. To the extent that these services are prior authorized there may be coordination issues with the utilization management entity.

One option the Department has is reviewing methods for linking the Medicaid utilization management information and Medicare data to be made available to the RCCOs. The Department's information management plan should address what sort of information on Medicare-covered services would be necessary, and optimal, to provide RCCOs and what frequency of reporting is needed. Denied claims data is also an issue in the management of specialists. The number and kind of denied claims impacts the RCCO members' use of specialty

services and are important for RCCO operations. If certain PCMPs are not properly coordinating with the Medicare-participating specialists providing Medicare-covered specialty services, the absence of routine information reports will likely result in inefficient attempts by RCCO staffs to obtain such information. The likely result is thousands of avoidable phone calls as RCCO staff contact the practices to find out the status of referrals so that care coordination can be maintained and performance metrics monitored. Not only does this have impacts on the RCCOs operations and capability to provide care coordination, but has potential consequences related to the willingness of specialty providers to see RCCO members.

Secondly, the accountable care model requires the RCCOs to establish significant relationships with hospitals. Relations with hospitals are especially important for the RCCOs as emergency room usage, admission notification, and discharge planning are coordination points needed by the RCCOs to manage care effectively. For example, the Emergency Department Diversion outreach specialists used by the Community Health Partnership require close and continuing cooperation with hospital staff. Establishing close working relations with hospitals to ensure emergency department coordination, admission notifications, and joint discharge planning is a task that each RCCO has to do with each hospital in its region.

One option the Department has is to review how it may help expedite the necessity of establishing these hospital relations. It is possible that central planning and leadership by the Department may facilitate or make it easier for the RCCOs to establish and maintain relationships with hospitals. For example, the Department could explore a uniform information reporting system that could be developed to inform RCCOs when a member has been admitted to or discharged from a hospital.

RCCOs also need to connect with other local community agencies. Creating effective patient centered care coordination systems requires a grounded understanding of and cooperation with other local organizations that affect how and when persons obtain health care. These organizations include: early childhood programs, public housing authorities, transportation providers, community mental and substance abuse providers, public health departments, independent living centers, and single entry points (SEPs) for access to institutional and home and community-based long-term care services.

Creating relationships with this multiplicity of organizations which differ across communities is an implementation challenge. Maintaining relationships is an ongoing challenge. The proposals submitted by the RCCOs identify these challenges and discuss ways they can be met such as establishing community advisory committees consisting of representatives from community organizations.

Linkages with providers of community-based long-term services and supports are critically important to drive potential savings by reducing Medicaid nursing facility care for dual eligibles. An option the Department might wish to consider is working with the RCCOs to develop diversion and transition plans. Roughly defined, "diversion" efforts are procedures that prevent persons from using higher cost services and "transition" efforts are procedures that shift persons from higher to lower costs programs. The Department is already involved in transition planning around nursing homes.

For example, diversion and transition efforts might entail:

- The RCCOs organizing an advisory committee of home and community-based (HCBS) long-term care providers to provide advice on how RCCO members can most efficiently access HCBS services;
- Having the RCCO staffs that ordinarily work with hospital discharge planners be aware that a home and community-based placement may be appropriate;
- RCCO staff working with the LCA and local MFP effort to aid persons transitioning;
- RCCO staff reviewing the transition care planning to ensure that the member's needs will be met at the least costly level of HCBS services since HCBS services are not prior authorized; and
- RCCO staff monitoring the member utilization patterns to prevent unnecessary readmissions to institutional care.

Systematic linkages between RCCOs and diversion and transition efforts will increase the savings on dual eligible utilization of Medicaid-covered long-term care services. Some RCCOs already have built linkages. For example, Colorado Access reports that it and its partner PCMPs

have already made linkages to the single entry point in Region 2, the Weld County Area Agency on Aging through its Colorado Regional Integrated Care Collaborative (CRICC) program and Medicare Advantage programs.[55]

Given the considerable savings potential related to Medicaid savings in the long-term care arena, the Department has the option of introducing a shared savings program around institutional use which would encourage the RCCOs to emphasize and systematize their use of diversion and transition. A consideration of this implementation challenge would imply that sometime during the Expansion Phase, both institutional and home and community based care would need to be added to the savings calculation.

Applicability of Federal and State Legislation

Colorado's ACC Program is consonant with the current national emphasis on ACOs. Colorado and its RCCOs are subject to Federal Medicare and Medicaid statues and regulations as well as state statute and regulations.[56] The following discussion considers these various regulatory structures and their applicability to the Integrated Care Program operations.

Code of Federal Regulations

Some constituent parts of the RCCOs are already health maintenance organizations and as such are regulated at 42 CFR § 438 and operate as a managed care organization (MCO) or prepaid inpatient health plan (PIHP). PCCM programs are also regulated at 42 CFR 438. For example, the definition of a Primary Care Case Manager (PCCM), set forth in 42 CFR § 438.2, is "an entity that employs or arranges with physicians to furnish primary care case management services."

The definition of primary care case management services at 1905(t) in the Act contains broad language and authorizes state Medicaid agencies to pay a "primary care case manager" for providing "primary care case management services" and these services are defined below in the Act at 1905(t)(1) and (2).

[55] See Colorado Access, Region Two Submission to the Accountable Care Collaborative Program, p. 109.
[56] Title XVIII of the Social Security Act contains the congressional language regulating Medicare and title XIX of the Act contains the comparable Medicaid congressional language.

"(t)(1)The term "primary care case management services" means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

(2) The term "primary care case manager" means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option—

(i) a nurse practitioner (as described in section 1905(a)(21));

(ii) a certified nurse-midwife (as defined in section 1861(gg)); or

(iii) a physician assistant (as defined in section 1861(aa)(5))."

These provisions are directly applicable to the physicians and physician practices that work with the RCCOs. The Code of Federal regulations further authorizes that such services can be provided as a voluntary option under the State plan; or on a mandatory basis under section 1932 (a)(1) of the Act, or under section1915(b) or section 1115 waiver authorities.[57]

When PCCM services are provided in the context of a managed care organization, CMS provisions regarding beneficiary enrollment, disenrollment, and other provisions applicable to managed care would also apply to the PCCM service.

Colorado Revised Statues (CRS)

Provider qualifications have traditionally been left to the states and it is state laws that license health care practitioners, not Federal laws. For example, Colorado hospitals are licensed under the authority of state statue at Title 25 Article 3. Colorado statutes at Section 12-36-107 set forth

[57] See, retrieved on 5-10-2011, http://edocket.access.gpo.gov/cfr_2010/octqtr/pdf/42cfr440.168.pdf

minimum qualifications for physician licensure. The Colorado Medical Board, which is part of the Department of Regulatory Agencies (DORA), establishes additional requirements and confirms that applicants meet these requirements.

Another significant regulatory framework for the work of the RCCOs is the state statues structuring managed care. The RFP for the RCCOs cited the authority of C.R.S. 25.5-5-402 Statewide Managed Care System, and thus the RFP text presumes that the RCCOs are managed care entities. Both managed care entities and primary care case managers are included in the definitions of managed care at CRS 25-5-4-402. These definitions imply that organizations of hospitals and physician practices are thus already properly included in existing state law. It does not appear to be necessary to broadly amend state statue although the state has the option of reviewing the existing managed care language and making some possible changes such as defining accountable care organizations.

More specifically,

- Section 25.5-5-405 on quality measurements authorizes the Medical Services Board (Board) to promulgate rules to clarify and administer quality measurements. This general authorization would permit the establishment of new quality measure used in conjunction with RCCOs.

- Section 25.5-5-407.5. on prepaid inpatient health plan agreements permits the state to enter into agreements for inpatient health services including the making of quality incentive payments and payment of rates that are not included in the State Medicaid Plan. Such authority could extend to a state pay-for-performance or shared savings program.

- Section 25.5-5-411 addresses mental health and substance abuse and establishes the need to have well organized and coordinated programs that address behavioral health needs. The operations of the RCCOs will take this need into account either through placing responsibility to separate behavioral health organizations or behavioral health components of their own organization, and providing transitional care planning and follow up. The CMS concept of health homes certainly emphasizes the need to include behavioral health management as part of the health home.

- Section 25.5-5-413 permits direct contracting between the Department and health care providers. This is an important provision because the RCCOs are health care providers and not insurance companies. This provision ensures the managed care statutes are not construed to permit only contracting with insurance companies that do not provide direct care.

The scope of practice of nurse practitioners is specified in CRS at CRS 12-38-111.5, 12-38-111.6 and 12-38-111.8. As specified at 12-38-111.5 (7)(a), nurse practitioners may sign a document that:

- Documents a patient's current health status;
- Authorizes continuing treatment, tests, services, or equipment; or
- Gives advance directives for end-of-life care.

Other language in CRS also permits a nurse practitioner to make diagnoses and referrals and prescribe medications. The ability to prescribe medications has extensive training and supervision requirements.[58]

Colorado legislative authority is broad and allows nurse practitioners to open up their own primary care office. While insurance issues are still a problem for nurse practitioners it is possible for a group of nurse practitioners to open up a primary care clinic and apply to become a Federally Qualified Health Care (FQHC) center.[59]

Code of Colorado Regulations (CCR)

Hospitals are regulated by the Colorado Department of Public Health and Environment (CDPHE) under regulations at 6 CCR 1011: Standards for Hospitals and Health Facilities.[60] Medicaid regulations regarding hospitals are at 10 CCR 2505-10 8.300 and are administered by the Department. Medical and nursing activities conducted as part of the RCCOs would be

[58] See retrieved on 6-21-2011 from http://www.dora.state.co.us/nursing/statutes/NursePracticeAct.pdf
[59] See the example in Sheridan, retrieved on 6-22-11 from http://www.pbs.org/newshour/rundown/2011/05/in-colorado-health-care-law-opens-nurse-run-clinic.html
[60] http://www.cdphe.state.co.us/regulations/healthfacilities/index.html

regulated as they were before the operation of the RCCOs and no additional licensing or other regulations would appear necessary.

For example, in 2010, Colorado had approximately 3,100 nurse practitioners and these medical professionals would be expected to participate in the collaborative care organizations.[61] Nurse Practitioner activities are regulated by the Board of Nursing at 3 CCR 716-1 Chapters XIV and XV. CCR regulations in Chapter XIV at 4.3 state that the scope of Advanced Practice Nursing (APN) "…may include, but is not limited to: performing acts of advanced assessment, diagnosing, treating, prescribing, ordering, selecting, administering, and dispensing diagnostic and therapeutic measures." Chapter XIV at 4.4 also states that "Prescribing medication is not within the scope of practice of an APN unless the APN has applied for and been granted Prescriptive Authority by the Board."

The Code of Colorado Regulations at 10 CCR 2505-10 8.205 contains the regulatory language for managed care. Language at 8.205 is primarily focused on client responsibilities, rights and protections, and enrollment and disenrollment. A review of the sections of 10 CCR 2505-10 8 does not appear to contain a discussion of the RCCOs and medical homes. One implementation option the state has is to update the CCR language in Section 8 to incorporate these newer developments.

Another implementation option is review the question of whether the operations of the RCCOs need additional oversight in 3 CCR 702 regulations. On the one hand, it is not clear that Insurance Division language at 3 CCR 702-4 is germane since the RCCOs are not creating rates or selling an insurance product. Moreover, constituent parts of the RCCOs are organizations such as health maintenance organizations and are already regulated, at for example, 3 CCR 702-4-7-1. On the other hand, the language in part of 3 CCR 702-4, for example at 3 CCR 702 4-3-1 Section 19 Standards for Marketing and 3 CCR 702-4-7-1 Section 6 Application for Licensure, contain code provisions relevant to operational standards. The state has the option of deciding what regulation, if any, should be enacted to govern the operations of RCCOs given that the

[61] Retrieved on 6-22-1011 from http://www.statehealthfacts.org/profileind.jsp?cat=8&sub=103&rgn=7

contractual obligations entered into by the RCCOs provide a detailed explication of the Department's expectations.[62]

Constituent parts of RCCOs are already well regulated in both statue and administrative code, both at the Federal and state level. Since RCCOs are not referenced in state law or regulations, there may be some merit to acknowledging their organizational presence in state administrative code.

Forums to Address Implementation Challenges

The Department, the RCCOs, and the four advisory/coordinating committees of ACC Program have multiple options. For example, these options range from studying the expansion done during the Initial Phase for lessons learned and how they may apply to the expansion phase to reviewing the planning for the expansion phase that the RCCOs are doing. An example of a concrete activity that could be done, for example, is to quantify how new Medicare-participating PCMPs will have to be added in each region and how this addition will be done.

The design of the ACC Program envisions four advisory and coordination committees.[63] These forums should be utilized to address implementation challenges and issues as dual eligibles are brought into the ACC Program during the Expansion Phase. These advisory and coordination committees are:

- RCCO Performance Improvement Advisory Committee,
- ACC Program Improvement Advisory Committee,
- Medical Management Oversight Advisory Committee, and
- SDAC Operations Advisory Committee.

[62] Note also, Appendix H of the RFP soliciting bids from potential ACCO's contains a two-page description of the Department's expectations of primary medical care providers. Such a description is neither a regulation nor a contractual obligation; however, it is a clear statement of Departmental expectations.

[63] The composition and duties of these committees are discussed at length in the RFP soliciting RCCO bids at pp. 51 and 52. Retrieved on 5-25-2011, http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251590284796

For example, the ACC Program will have a Program Improvement Advisory Committee. This committee will be directed and chaired by the Department and include representation from each RCCO, the SDAC, the utilization management contractor, and the provider and member communities. This Committee could provide a potential venue where these coordination implementation issues can be discussed. For example, there does appear to be a need to coordinate agreements across RCCOs. Are standard procedures needed for dealing with a situation where a PCMP wishes to be enrolled in two RCCOs? What should be done when a member moves and now lives in another region? All of the implementation challenges identified above can be potentially addressed by one or more of the four committees listed above.

APPENDIX A

Medicare Long-Term Care Hospital and Inpatient Rehabilitation Facilities

Long-term care hospitals (LTCHs) are certified as acute care hospitals, but LTCHs focus on patients who, on average, stay more than 25 days. Many of the patients in LTCHs are transferred there from an intensive or critical care unit. LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home. Services provided in LTCHs typically include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. Inpatient rehabilitation facilities (IRFs) must meet all acute care hospital conditions of participation plus additional criteria related to the ability to provide intensive rehabilitation. Eligibility for both rehabilitation and long-term care hospital benefits from Medicare is physician-determined. Rehabilitation hospitals must demonstrate that 75 percent of their patients have at least one of thirteen specific conditions defined by Medicare. Patients must require frequent physician involvement, 24-hour rehabilitation nursing, generally at least three hours of therapy a day, and a coordinated group of skilled professionals. In order for Medicare to cover rehabilitation hospital services, patients are expected to improve as a result of therapy. For long-term care hospital admission, Medicare coverage for inpatient services is included under the basic Part A hospital benefit.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) provide for payment for both the operating and capital-related costs of hospital inpatient stays in LTCHs under Medicare Part A based on prospectively set rates. Section 123 of the BBRA requires the PPS for LTCHs to be a per discharge system with a diagnosis-related group (DRG) based patient classification system. Beginning in FY 2008, the Centers for Medicare & Medicaid Services (CMS) adopted a Medicare Severity Diagnosis Related Group (MS-DRG) classification system for the LTCH PPS, referred to as MS-LTC-DRG. Section 4421 of the Balanced Budget Act of 1997, as amended by section 125 of the BRRA, and by section 305 of BIPA, authorizes the implementation of a per discharge prospective payment system (PPS), through section 1886(j) of the Act, for IRFs.

Both types of hospitals also have a deductible of $764 for each spell of illness (the same as for the Medicare benefit for an acute care hospital) and a daily coinsurance rate of $191 after the first 60 days. Both types of hospitals also have the same maximum length of stay--90 days per spell of illness.

The number of LTCHs rose from 278 in 2001 to 432 in 2009, although they are still not available in most areas of the country. In areas with no LTCH, acute care hospitals and SNFs substitute. The number of Medicare fee-for-service (FFS) beneficiaries treated in LTCHs continues to increase, as have average per-case payments, reaching over $35,000 per stay. Of all post-acute care providers, LTCHs treat the fewest number of Medicare beneficiaries (37.7 per 10,000 FFS beneficiaries in 2008); however, their rapid growth and high cost have raised concerns about their impact on Medicare spending. The number of patients treated in IRFs grew rapidly between 2002 and 2004 to reach 124.9 FFS beneficiaries per 10,000 after implementation of a prospective, per-case payment method. Medicare patients then fell steadily to 95.6 per 10,000 by 2008, which was expected as a result of enforcement of the 60 percent rule.

APPENDIX B

Medicare Physicians Other than MDs/DOs

Part B covers services that attending physicians (other than interns and residents) render in the teaching setting to individual patients. Medical and surgical services furnished by interns and residents within the scope of their training program are covered as provider services. For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools. Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed outside the facility where they have their training program, are covered as physician services when certain the requirements are met. Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed in an outpatient department or emergency room of the hospital where they have their training program, are covered as physicians' services only under limited circumstances.

The term "physician" under Part B includes a chiropractor who meets the specified qualifying requirements but only for treatment by means of manual manipulation of the spine to correct a subluxation. A chiropractor must be licensed or legally authorized to furnish chiropractic services by the State or jurisdiction in which the Medicare services are furnished. In addition, a licensed chiropractor must meet specific uniform minimum standards to be considered a physician for Medicare coverage. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation provided such treatment is legal in the State where performed. All other services furnished or ordered by chiropractors are not covered.

Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of the hands. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

A doctor of optometry is considered a physician with respect to Medicare services the optometrist is authorized to perform under State law or regulation.

APPENDIX C

Medicare Coverage for Clinical Psychologist and Clinical Social Worker Services

Clinical Psychologist (CP) services are Diagnostic and therapeutic services that the CP is legally authorized to perform in accordance with State law and/or regulation. These diagnostic and therapeutic services of CPs and services and supplies furnished incident to such services are covered as the services furnished by a physician or as incident to physician's services are covered. However, the CP must be legally authorized to perform the services under applicable licensure laws of the State in which they are furnished. Medicare pays all qualified CPs based on the physician fee schedule for the diagnostic and therapeutic services.

To qualify as a CP, a practitioner must meet the following requirements:

- Hold a doctoral degree in psychology;
- Be licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

Clinical Social Worker (CSW) services are defined under Section 1861(hh)(2) of the Act as those services that the CSW is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed for the diagnosis and treatment of mental illnesses. The services of a CSW may be covered under Part B if they are the type of services that are otherwise covered if furnished by a physician, or as incident to a physician's service.

Covered CSW services must be rendered by a person who meets the definition of a CSW. Section 1861(hh) of the Act defines a CSW as an individual who:

- Possesses a master's or doctor's degree in social work;
- Has performed at least two years of supervised clinical social work; and
- Is licensed or certified as a clinical social worker by the State in which the services are performed; or

- In the case of an individual in a State that does not provide for licensure or certification, has completed at least 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, SNF, or clinic.

APPENDIX D

Inventory of Potential Care Measures

DOMAIN NAME	TYPE OF MEASURE	MEASURE TITLE	SOURCE
Domain 1: Care Management	*Complex Case Management*	Complex Case Management: Identifying Members for Case Management	SNP 1: Complex Case Management
		Complex Case Management: Access to Case Management	SNP 1: Complex Case Management
		Complex Case Management: Case Management Systems	SNP 1: Complex Case Management
		Complex Case Management: Frequency of Member Identification	SNP 1: Complex Case Management
		Complex Case Management: Providing Members with Information	SNP 1: Complex Case Management
		Complex Case Management: Case Management Process	SNP 1: Complex Case Management
		Complex Case Management: Informing Educating Practitioners	SNP 1: Complex Case Management
	Care Transition	Care Transitions: Managing Transitions	SNP 4: Care Transitions
		Care Transitions: Supporting Members through Transitions	SNP 4: Care Transitions
		Care Transition Measure: Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one's self-care role in the post-hospital setting 2. Medication management 3. Having one's preferences incorporated into the care plan	MSSP: GPRO

		30 day post discharge physician visit	MSSP: GPRO
		Medication Reconciliation: Percentage of patients aged 65 years and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing ongoing care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	MSSP: GPRO National Quality Forum: AQA EHR measure
		Advance Care Plan Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	PQRI
		Care Transitions: Analyzing Performance	SNP 4: Care Transitions
		Care Transitions: Identifying Unplanned Transitions	SNP 4: Care Transitions
		Care Transitions: Analyzing Transitions	SNP 4: Care Transitions
		Care Transitions: Reducing Transitions	SNP 4: Care Transitions
	Institutional Relationships	Institutional SNP Relationship with (Nursing/Long-Term Care) Facility: Monitoring Members' Health Status	SNP 5: Institutional SNP Relationship with (Nursing/Long-Term Care) Facility
		Institutional SNP Relationship with (Nursing/Long-Term Care) Facility: Monitoring Changes in Members' Health Status	SNP 5: Institutional SNP Relationship with (Nursing/Long-Term Care) Facility
		Institutional SNP Relationship with (Nursing/Long-	SNP 5:

		Term Care) Facility: Maintaining Members' Health Status	Institutional SNP Relationship with (Nursing/Long-Term Care) Facility
	Coordination of Medicare and Medicaid Coverage	Coordination of Medicare and Medicaid Coverage: Coordination of Benefits for Dual Eligible Members	SNP 6: Coordination of Medicare and Medicaid Coverage
		Coordination of Medicare and Medicaid Coverage: Administrative Coordination of Dual-Eligible Benefit Packages	SNP 6: Coordination of Medicare and Medicaid Coverage
		Coordination of Medicare and Medicaid Coverage: Relationship with State Medicaid Agency for Dual Eligible Benefit Packages	SNP 6: Coordination of Medicare and Medicaid Coverage
		Coordination of Medicare and Medicaid Coverage: Administrative Coordination for Chronic Condition and Institutional Benefit Packages	SNP 6: Coordination of Medicare and Medicaid Coverage
		Coordination of Medicare and Medicaid Coverage: Service Coordination	SNP 6: Coordination of Medicare and Medicaid Coverage
		Coordination of Medicare and Medicaid Coverage: Network Adequacy Assessment	SNP 6: Coordination of Medicare and Medicaid Coverage
	ASC Admissions	Ambulatory Sensitive Conditions Admissions: Diabetes, short term complications	MSSP: Claims
		Ambulatory Sensitive Conditions Admissions: Uncontrolled diabetes	MSSP: Claims

		Ambulatory Sensitive Conditions Admissions: Chronic obstructive pulmonary disease	MSSP: Claims
		Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure	MSSP: Claims
		Ambulatory Sensitive Conditions Admissions: Dehydration	MSSP: Claims
		Ambulatory Sensitive Conditions Admissions: Bacterial pneumonia	MSSP: Claims
		Ambulatory Sensitive Conditions Admissions: Urinary infection	MSSP: Claims
	HITECH/EHR	Percentage of all physicians meeting stage 1 HITECH Meaningful Use Requirements	MSSP Program: (GPRO)/ EHR Incentive Program Reporting
		Percentage of PCPs Meeting Stage 1 HITECH Meaningful Use Requirements	MSSP Program: (GPRO)/ EHR Incentive Program Reporting
		Percentage of PCPs using Clinical Decision Support	MSSP Program: (GPRO)/ EHR Incentive Program Reporting
		Percentage of PCPs who are successful electronic prescribers under the eRx Incentive Program	MSSP Program: (GPRO)/ EHR Incentive Program Reporting
		Patient Registry Use	MSSP Program: (GPRO)/ EHR Incentive Program Reporting

		Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	PQRI: GPRO
	Quality measurements for HCBS providers and programs	Documentation of Current Medications in the Medical Record	PQRI: GPRO
		Post-Fracture – Communication with Physician Managing Ongoing Care	National Quality Forum: AQA EHR measure
		Emergency Medicine – Care Coordination for PCI for AMI: ED Communication with Cardiology Intervention Service Within 10 Minutes	National Quality Forum: AQA EHR measure
		Participant Access Desired Outcome: Individuals have ready access to home and community based services and supports in their communities	HCBS Quality Framework: Focus 1 (National Quality Inventory Project)
		Participant-Centered Service Planning and Delivery Desired Outcome: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community	Focus II
		Provider Capacity and Capabilities Desired Outcome: There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants	Focus III
		Participant Safeguards Desired Outcomes: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices	Focus IV
		Participant Rights and Responsibilities Desired Outcome: Participants receive support to exercise their rights and in accepting personal responsibilities.	Focus V
	Medication Management	Empiric Antibiotic for CAP	National Quality Forum: AQA EHR Measures
		Pneumonia - Initial Antibiotic Received within 6 Hours of Hospital Arrival	National Quality Forum: HQA EHR

			Measures
		Pneumonia - Appropriate Initial Antibiotic Selection	National Quality Forum: HQA EHR Measures
		Surgical Care - Timing of Prophylactic Antibiotics – Ordering Physician	National Quality Forum: AQA EHR Measures
		Surgical Care - Timing of Prophylactic Antibiotics – Administering Physician	National Quality Forum: AQA EHR Measures
		Surgical Care - Selection of Prophylactic Antibiotics – 1st or 2nd Generation Cephalosporin	National Quality Forum: AQA EHR Measures
		Surgical Care - Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	National Quality Forum: AQA EHR Measures
		Surgical Care - Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	National Quality Forum: AQA EHR Measures
		Preoperative Beta-Blockade for Cardiac Surgery Pts	National Quality Forum: AQA EHR Measures
		Duration of Antibiotic Prophylaxis for Cardiac Surgery Pts	National Quality Forum: AQA EHR Measures
		Timing of Antibiotic Administration for Cardiac Surgery Pts	National Quality Forum: AQA EHR Measures
		Selection of Antibiotic Administration for Cardiac Surgery Pts	National Quality Forum: AQA EHR

			Measures
		Surgical Care - Prophylactic Antibiotic Selection	National Quality Forum: HQA EHR Measures
		Surgical Care - Prophylactic Antibiotic Received within 1 Hour Prior to Incision	National Quality Forum: HQA EHR Measures
		Surgical Care - Prophylactic Antibiotics Discontinued within 24 Hours after Surgery End Time	National Quality Forum: HQA EHR Measures

Domain 2: Patient Safety		HAC Composite**:
		• Foreign Object Retained After Surgery
		• Air Embolism
		• Blood Incompatibility
		• Pressure Ulcer, Stages III and IV
		• Falls and Trauma
		  ○ Fractures
		  ○ Dislocations
		  ○ Intracranial injuries
		  ○ Crushing Injuries
		  ○ Burns
		  ○ Electric Shock
		• Catheter-Associated UTI
		• Manifestations of Poor Glycemic Control
		  ○ Diabetes Ketoacidosis
		  ○ Non-ketotic Hyperosmolar Coma
		  ○ Hypoglycemic Coma
		  ○ Secondary Diabetes with Ketoacidosis
		  ○ Secondary Diabetes with Hyperosmolarity
			CMS Hospital Acquired Conditions (Hospital Consumer Assessment of Healthcare Providers and Systems survey)
			
			Medicare Shared Savings Program: Claims or CDC National Healthcare Safety Network
			
			** MSSP will evaluate these 8 measures. Unclear how CMS will evaluate hospitals beginning July 1, 2011-

			may evaluate each condition separately

		HAC Composite Continued :
		• Central Line Associated Blood Stream Infection (CLABSI)
		• Surgical Site Infection
		  ○ Coronary Artery Bypass Graft (CABG)-Mediastinitis
		  ○ Bariatric Surgery
		  ▪ Laparoscopic Gastric Bypass
		  ▪ Gastroenterostomy
		  ▪ Laparoscopic gastric restrictive surgery
		  ○ Orthopedic Procedures
		  ▪ Spine
		  ▪ Neck
		  ▪ Shoulder
		  ▪ Elbow
		• AHRQ Patient Safety Indicator (PSI) 90 Complication/Patient Safety for Selected Indicators (composite)
		  ○ Accidental puncture or laceration
		  ○ Iatrogenic pneumothorax
		  ○ Postoperative DVT or PE
		  ○ Postoperative wound dehiscence
		  ○ Decubitus ulcer
		  ○ Selected infections due to medical care (PSI 07: Central Venus Catheter-related Bloodstream Infection)
		  ○ Postoperative hip fracture
		  ○ Postoperative sepsis
			MSSP: Claims or CDC National Healthcare Safety Network

		Health Care Acquired Conditions: (CLABSI) Bundle	MSSP: Claims or CDC National Healthcare Safety Network
		Hospital Acquired Conditions • Vascular catheter-associated infection	CMS (Hospital Consumer Assessment of Healthcare Providers and Systems survey)

Domain 3: Patient Caregiver Experience			
	Health Plan Information	Health Plan Stability: Total Membership	HEDIS 2011
		Health Plan Descriptive Information: Board Certification	HEDIS 2011
		Health Plan Descriptive Information: Enrollment by Product Line	HEDIS 2011
		Health Plan Descriptive Information: Enrollment by State	HEDIS 2011
		Health Plan Descriptive Information: Language Diversity of Membership	HEDIS 2011
		Health Plan Descriptive Information: Race/Ethnicity Diversity of Membership	HEDIS 2011
	Access to Care	Access to Preventative/Ambulatory Health Services: • 20-44 years • 45-64 years • 65+ years	HSAG: HEDIS
		Access to Services (Physical Health) • Coordination and Continuity of Care • Member Information • Member Rights and Protections • Grievance System	HSAG: Compliance Review Standards
		Access to Services (Behavioral Health) • Emergency and Post-stabilization Services • Member Rights and Protections • Provider participation and Program Integrity • Subcontracts and Delegation • Quality Assessment and Performance Improvement	HSAG: Compliance Review Standards
	Quality of Care	Timeliness of Care: (Physical Health) • Coordination and Continuity of Care • The Grievance System	HSAG: Compliance Review Standards
		Timeliness of Care (Behavioral Health) • Emergency and Post-stabilization Services • The Grievance System • Provider Participation and Program Integrity • Subcontracts and Delegation • Quality Assessment and Performance	HSAG: Compliance Review Standards

		Improvement	
		Quality of Care (Physical Health) • Coordination and Continuity of Care • Member Rights and Protections • Member Information • The Grievance System • Quality Assessment and Performance Improvement	HSAG: Compliance Review Standards
		Quality of Care (Behavioral Health) • Emergency and Post-stabilization Services • Member Rights and Protections • The Grievance System • Credentialing and Re-credentialing • Quality Assessment and Performance Improvement	HSAG: Compliance Review Standards
		Validation of Performance Improvement Projects: (Physical and Behavioral Health programs)	HSAG: CMS Quality Assessment and Performance Improvement standards
	Utilization Measurements	Use of Services: Guidelines for Use of Services Measures	HEDIS 2011
		Use of Services: Frequency of Ongoing Prenatal Care	HEDIS 2011
		Use of Services: Frequency of Selected Procedures	HEDIS 2011
		Use of Services: Frequency of Selected Procedures • Dilation & Curettage o 15-44 Female o 45-64 Female • Hysterectomy, Abdominal o 15-44 Female o 45-65 Female • Hysterectomy, Vaginal o 15-44 Female o 45-65 Female • Cholecystectomy, Open o 30-64 Male o 15-44 Female o 45-64 Female • Cholecystectomy, Closed (laparoscopic) o 30-64 Male o 15-44 Female	HSAG: HEDIS

		○ 45-64 Female • Back Surgery ○ 20-44 Male or Female ○ 45-64 Male or Female • Mastectomy ○ 15-44 Female ○ 45-64 Female • Lumpectomy ○ 15-44 Female ○ 45-64 Female	
		Use of Services: Ambulatory Care	HEDIS 2011
		Use of Services: Ambulatory Care • Outpatient Visits • ED Visits • Ambulatory Surgery/Procedures • Observation Room Stays Resulting in Discharge	HSAG: HEDIS
		Use of Services: Inpatient Utilization-General Hospital/Acute Care	HEDIS 2011
		Use of Services: Inpatient Utilization-General Hospital/Acute Care (Total Inpatient) • Discharges (Per 1000 member months) • Average Length of Stay	HSAG: HEDIS
		Use of Services: Inpatient Utilization-General Hospital/Acute Care (Medicine) • Discharges (Per 1000 member months) • Average Length of Stay	HSAG: HEDIS
		Use of Services: Inpatient Utilization-General Hospital/Acute Care (Maternity) • Discharges (Per 1000 member months) • Average Length of Stay	HSAG: HEDIS
		Use of Services: Identification of Alcohol and Other Drug Services	HEDIS 2011
		Use of Services: Mental Health Utilization	HEDIS 2011
		Use of Services: Antibiotic Utilization	HEDIS 2011
		Use of Services: Antibiotic Utilization • Average Scrips PMPY for All Antibiotics • Average Scrips PMPY for Antibiotics of Concern • Percentage of Antibiotics of Concerns of all Antibiotics Scrips	HSAG: HEDIS
		Use of Services: Plan All-Cause Readmissions	HEDIS 2011

	Physician Quality Evaluations	Satisfaction with the Experience of Care: CAHPS Health Plan Survey 4.0H, Adult Version	HEDIS 2011
		Clinician/Group CAHPs: Getting Timely Care, Appointments, and Information	MSSP: CAHPS Survey HSAG: CAHPS Survey-Quality, Timeliness and Access Measures
		Clinician/Group CAHPs: How well do your doctors communicate	MSSP: CAHPS Survey
		Clinician/Group CAHPs: Helpful, courteous, respectful office	MSSP: CAHPS Survey
		Clinician/Group CAHPs: Patients' Rating of Doctor	MSSP: CAHPS Survey
		Clinician/Group CAHPs: Health Promotion and Education	MSSP: CAHPS Survey
		Clinician/Group CAHPs: Shared Decision Making Improving Member Satisfaction: Assessment of Member Satisfaction	MSSP: CAHPS Survey HSAG: CAHPS Survey-Quality Measures
		Quality CAHPS topic: Customer Service	HSAG: CAHPS Survey
		Quality CAHPS topic: Rating of Specialist Seen Most Often	HSAG: CAHPS Survey
		Quality CAHPS topic: Rating of All Health Care	HSAG: CAHPS Survey
		Quality CAHPS topic: Rating of Health Plan	HSAG: CAHPS Survey
		Clinical Quality Improvements: Relevance to Members	SNP 3: Clinical Quality Improvements

	Behavioral Health Performance Measures	Access Performance Measures: Inpatient Utilization (Rate/1000 Members, All Ages) Non-State Hospitals All Hospitals	HSAG: BH Compliance Review Standards and the Mental health statistics improvement program (MHSIP) Consumer Surveys
		Access Performance Measures: Hospital Average Length of Stay Non State Hospitals All Hospitals Emergency Room Utilization (Rate/1000 Members All Ages)	HSAG: BH Compliance Review Standards and the (MHSIP) Consumer Surveys
		Timeliness Performance Measures: Follow-up After Hospitalization for Mental Illness (7 and 40 day follow-up) • Non-State Hospitals-7 days • 30 days • All Hospitals-7 days • 30 days	HSAG: BH Compliance Review Standards and the (MHSIP) Consumer Surveys
		Access Performance Measure: Emergency Department Utilization	HSAG: BH Compliance Review Standards and the (MHSIP) Consumer Surveys
		Quality Performance Measures: Hospital Recidivism • Non-State Hospitals-7 days • 30 days • 90 days • All Hospitals-7 days • 30 days • 90 days	HSAG: BH Compliance Review Standards and the (MHSIP) Consumer Surveys
		Access Performance Measure: Overall Penetration Rates	HSAG: BH Compliance Review Standards and the (MHSIP)

			Consumer Surveys
		Access Performance Measures: Penetration Rates by Service Category • Inpatient Care • Intensive Outpatient/Partial Hospitalization • Ambulatory Care • Overall Penetration Rates	HSAG: BH Compliance Review and the (MHSIP) Consumer Surveys Standards
		Access Performance Measures: Penetration Rates by Age Category • Adults 18-64 • Adults 65+	HSAG: BH Compliance Review Standards and the (MHSIP) Consumer Surveys
	Member Satisfaction	Improving Member Satisfaction: Opportunities for Improvement	SNP 2: Improving Member Satisfaction
		Access/Availability of Care: Call Abandonment	HEDIS 2011
		Access/Availability of Care: Call Answer Timeliness	HEDIS 2011
	Costs of Care	Cost of Care: Guidelines for Cost of Care Measures	HEDIS 2011
		Cost of Care: Relative Resource Use for People with Diabetes	HEDIS 2011
		Cost of Care: Relative Resource Use for People with Low-Back Pain	HEDIS 2011
		Cost of Care: Relative Resource Use for People with Cardiovascular Conditions	HEDIS 2011
		Cost of Care: Relative Resource Use for People with Uncomplicated Hypertension	HEDIS 2011
		Cost of Care: Relative Resource Use for People with COPD	HEDIS 2011
	Patient Satisfaction	Participant Outcomes and Satisfaction Desired Outcome: Participants are satisfied with their services and achieve desired outcomes	HCBS Quality Framework: Focus VII
		System Performance Desired Outcome: The system supports participants efficiently and effectively and constantly strives to improve quality	HCBS Quality Framework: Focus VI

	Depression Management	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD	PQRI: GPRO
		Major Depressive Disorder (MDD): Diagnostic Evaluation	PQRI: GPRO
		Follow-Up After Hospitalization for Mental Illness	HEDIS 2011
		Antidepressant Medication Management	HEDIS 2011
		Antidepressant Medication Management: Effective Acute Phase Treatment	HSAG (HEDIS) National Quality Forum: AQA EHR measure
		Antidepressant Medication Management: Effective Continuation Phase Treatment	HSAG (HEDIS) National Quality Forum: AQA EHR measure
	IVD Management	Ischemic Vascular Disease (IVD): Blood Pressure Management Control	PQRI: GPRO
		Ischemic Vascular Disease (IVD): Complete Lipid Profile	PQRI: GPRO
		Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control	PQRI: GPRO
		Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	PQRI: GPRO
	CKD Evaluations	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile	PQRI: GPRO II
		Chronic Kidney Disease (CKD): Blood Pressure Management	PQRI: GPRO II
		Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)	PQRI: GPRO II
		Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	PQRI: GPRO II
	Hepatitis C	Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia	PQRI: GPRO
		Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	PQRI: GPRO
		Hepatitis C: HCV Genotype Testing Prior to Treatment	PQRI: GPRO

		Hepatitis C: Antiviral Treatment Prescribed	PQRI: GPRO
		Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment	PQRI: GPRO
		Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	PQRI: GPRO
		Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	PQRI: GPRO
		Hepatitis C: Hepatitis A Vaccination in Patients with HCV	PQRI: GPRO
		Hepatitis C: Hepatitis B Vaccination in Patients with HCV	PQRI: GPRO
	Otitis-Related Conditions	Acute Otitis Externa (AOE): Topical Therapy	PQRI: GPRO
		Acute Otitis Externa (AOE): Pain Assessment	PQRI: GPRO
		Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	PQRI: GPRO
		Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	PQRI: GPRO
	COPD related therapies	Pharmacotherapy Management of COPD Exacerbation	HEDIS 2011
		Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	HSAG: HEDIS
		Pharmacotherapy Management of COPD Exacerbation: Bronchodilator	HSAG: HEDIS
		Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	PQRI: GPRO
	Perioperative Care	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	PQRI: GPRO
		Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	PQRI: GPRO
		Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	PQRI: GPRO
		Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients	PQRI: GPRO
		Perioperative Care: Discontinuation of Prophylactic	PQRI: GPRO

		Antibiotics (Cardiac Procedures)	
		Perioperative Temperature Management	PQRI: GPRO
	End Stage Renal Disease	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD	PQRI: GPRO
		End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients	PQRI: GPRO
		End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis	PQRI: GPRO
	HIV/AIDS	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage	PQRI: GPRO
		HIV/AIDs: Anti-D Immune Globulin for Pregnant Women	National Quality Forum: AQA EHR measure
		HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	PQRI: GPRO
		HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	PQRI: GPRO
		HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	PQRI: GPRO
		HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea	PQRI: GPRO, HEDIS 2011
		HIV/AIDS: Screening for High Risk Sexual Behaviors	PQRI: GPRO
		HIV/AIDS: Screening for Injection Drug Use	PQRI: GPRO
		HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	PQRI: GPRO
		HIV/AIDS: Screening for HIV for Pregnant Women	National Quality Forum: AQA EHR measure
	ECG	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	PQRI: GPRO
		12-Lead Electrocardiogram (ECG) Performed for Syncope	PQRI: GPRO
	Pneumonia	Community-Acquired Pneumonia (CAP): Vital Signs	PQRI: GPRO

		Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	PQRI: GPRO
		Community-Acquired Pneumonia (CAP): Assessment of Mental Status	PQRI: GPRO
		Community-Acquired Pneumonia (CAP): Empiric Antibiotic	PQRI: GPRO
	Wound Care	Wound Care: Use of Compression System in Patients with Venous Ulcers	PQRI: GPRO
	Otologic Evaluation	Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear	PQRI: GPRO
		Referral for Otologic Evaluation for Patients with History of Active Drainage From the Ear Within the Previous 90 Days	PQRI: GPRO
		Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss	PQRI: GPRO
	Glaucoma	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15 percent OR Documentation of a Plan of Care	PQRI: GPRO
	Chiropractics	Functional Outcome Assessment in Chiropractic Care	PQRI: GPRO
	Thoracic Surgery	Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection	PQRI: GPRO
		Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)	PQRI: GPRO
		Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection	PQRI: GPRO
	Myeloma Complications	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	PQRI: GPRO
		Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	PQRI: GPRO
		Multiple Myeloma: Treatment with Bisphosphonates	PQRI: GPRO
	Breast Cancer	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	PQRI: GPRO
		Breast Cancer Resection Pathology Reporting: pT	PQRI: GPRO

		Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	
	Prostate Cancer	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	PQRI: GPRO
		Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients	PQRI: GPRO
		Prostate Cancer: Three-Dimensional (3D) Radiotherapy	PQRI: GPRO
	Colorectal Cancer	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	PQRI: GPRO
	Oncology	Oncology: Medical and Radiation – Pain Intensity Quantified	PQRI: GPRO
		Oncology: Medical and Radiation – Plan of Care for Pain	PQRI: GPRO
		Oncology: Cancer Stage Documented	PQRI: GPRO
	Radiology	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	PQRI: GPRO
		Oncology: Radiation Dose Limits to Normal Tissues	PQRI: GPRO
		Radiology: Stenosis Measurement in Carotid Imaging Studies	PQRI: GPRO
	Nuclear Medicine	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	PQRI: GPRO
	Melanoma	Melanoma: Continuity of Care – Recall System	PQRI: GPRO
		Melanoma: Coordination of Care	PQRI: GPRO
		Melanoma: Overutilization of Imaging Studies in Stage 0-IA Melanoma	PQRI: GPRO
Domain 4: At-Risk Population/ Frail Elderly Health			
	Diabetes	Diabetes Mellitus: Hemoglobin A1c Control (<8 percent)	MSSP: GPRO National

			Quality Forum AQA: EHR Measure PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Diabetes: LDL Cholesterol < 130	National Quality Forum AQA: EHR Measure
		Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	MSSP: GPRO PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Diabetes Mellitus: Tobacco Non Use	MSSP: GPRO
		Diabetes Mellitus: Aspirin use	MSSP: GPRO
		Diabetes Mellitus: Foot Exam	MSSP: GPRO PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	MSSP: GPRO

			National Quality Forum AQA: EHR Measure PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient	MSSP: GPRO National Quality Forum AQA: EHR Measure PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	PQRI: GPRO I & II, Claims, DM Measures Group, DHR National Quality Forum AQA: EHR Measure
		Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	PQRI: GPRO I & II, Claims, DM Measures Group, DHR National Quality Forum: AQA EHR measure
		Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	MSSP: GPRO PQRI: GPRO I & II, Claims, DM

			Measures Group, DHR
		Diabetes Mellitus: Hemoglobin A1c Testing	MSSP: GPRO National Quality Forum AQA: EHR Measure PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Diabetes Mellitus: Lipid Profile, Measurement	PQRI: GPRO I & II, Claims, DM Measures Group, DHR National Quality Forum AQA: EHR Measure
	Heart Failure	Heart Failure (HF): Left Ventricular Function (LVF) Testing	MSSP: GPRO PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Heart Failure: Left Ventricular Function (LVF) Assessment	MSSP: GPRO National Quality Forum AQA: EHR Measure PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Heart Failure: Patient Education , Discharge Instructions	MSSP: GPRO National Quality

			Forum AQA: EHR Measure PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Heart Failure: Weight Measurement	MSSP: GPRO PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Heart Failure: 30-Day Mortality	National Quality Forum HQA: EHR Measure
		Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation	MSSP: GPRO National Quality Forum AQA: EHR Measure PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	MSSP: GPRO National Quality Forum AQA: EHR Measure PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	MSSP: GPRO National Quality Forum AQA:

			EHR Measure PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Heart Failure - ACE-I/ARB for LVSD	National Quality Forum HQA: EHR Measure
	Acute Myocardial Infarction	Emergency Medicine - Aspirin at Arrival for AMI	National Quality Forum AQA: EHR Measure
		Emergency Medicine - EKG Performed for Non-Traumatic Chest Pain	National Quality Forum AQA: EHR Measure
		Emergency Medicine – Fibrinolytic Therapy Ordered Within 20 Minutes of ECG for AMI	National Quality Forum AQA: EHR Measure
		Beta-Blocker Treatment after Heart Attack	National Quality Forum AQA: EHR Measure
		Beta-Blocker Therapy – Post MI	National Quality Forum AQA: EHR Measure
		Beta-Blocker Therapy – Prior MI	National Quality Forum AQA: EHR Measure
		AMI – ACE-I/ARB for LVSD	National

			Quality Forum HQA: EHR Measure
		AMI - Aspirin at Arrival	National Quality Forum HQA: EHR Measure
		AMI - Aspirin Prescribed at Discharge	National Quality Forum HQA: EHR Measure
		AMI - Beta-Blocker at Arrival	National Quality Forum HQA: EHR Measure
		AMI - Beta-Blocker Prescribed at Discharge	National Quality Forum HQA: EHR Measure HEDIS 2011
		Aspirin Use and Discussion	HEDIS 2011
		Aspirin at Arrival for Acute Myocardial Infarction (AMI)	PQRI: GPRO National Quality Forum HQA: EHR Measure
		AMI - Primary PCI Received within 120 Minutes of Hospital Arrival	National Quality Forum HQA: EHR Measure
		AMI - Thrombolytic Agent Received within 30 Minutes of Hospital Arrival	National Quality Forum HQA: EHR Measure
		AMI - 30-Day Mortality	National Quality

			Forum HQA: EHR Measure
	Coronary Evaluation	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	MSSP: GPRO PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	MSSP: GPRO PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	MSSP: GPRO PQRI: GPRO I & II, Claims, DM Measures Group, DHR National Quality Forum AQA: EHR Measure
		Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	MSSP: GPRO PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Disease (CAD): Symptom and Activity Assessment	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Disease (CAD): LDL level < 100 mg/dl	MSSP: GPRO
		CAD Pts with Diabetes and/or LVSD Prescribed ACE-	National

		I/ARB Therapy (AQA)	Quality Forum AQA: EHR Measure
		Antiplatelet Therapy (AQA)	National Quality Forum AQA: EHR Measure
		Lipid Profile (AQA)	National Quality Forum AQA: EHR Measure
		Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	PQRI: GPRO I & II, Claims, DM Measures Group, DHR

		Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
		Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling	PQRI: GPRO I & II, Claims, DM Measures Group, DHR
	Stroke and Rehabilitation Evaluation	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	PQRI: GPRO
		Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	PQRI: GPRO
		Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	PQRI: GPRO
		Ischemic Stroke or TIA: Discharged on Antiplatelet Therapy	National Quality Forum: AQA EHR measure
		Ischemic Stroke or TIA: Anticoagulant Therapy Prescribed for Atrial Fibrillation	National Quality Forum: AQA EHR measure
		Ischemic Stroke: tPA Considered	National Quality Forum: AQA EHR measure
		Ischemic Stroke or Intracranial Hemorrhage: Screening for Dysphagia	National Quality Forum: AQA EHR measure
		Ischemic Stroke or Intracranial Hemorrhage: Consideration of Rehabilitation Services	National Quality Forum: AQA EHR measure
		Ischemic Stroke or Intracranial Hemorrhage: DVT Prophylaxis	National Quality Forum: AQA EHR measure

		Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	PQRI: GPRO
		Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	PQRI: GPRO
		Stroke and Stroke Rehabilitation: Screening for Dysphagia	PQRI: GPRO
		Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	PQRI: GPRO
		Stroke and Stroke Rehabilitation: Thrombolytic Therapy	PQRI: GPRO
		Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy (Stroke prevention)	PQRI: GPRO
	Functional Communication and Deficit Evaluations	Functional Communication Measure - Spoken Language Comprehension	PQRI: GPRO
		Functional Communication Measure - Attention	PQRI: GPRO
		Functional Communication Measure - Memory	PQRI: GPRO
		Functional Communication Measure - Motor Speech	PQRI: GPRO
		Functional Communication Measure - Reading	PQRI: GPRO
		Functional Communication Measure - Spoken Language Expression	PQRI: GPRO
		Functional Communication Measure - Writing	PQRI: GPRO
		Functional Communication Measure - Swallowing	PQRI: GPRO
		Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments	PQRI: GPRO
		Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments	PQRI: GPRO
		Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments	PQRI: GPRO
		Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments	PQRI: GPRO
		Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder	PQRI: GPRO

		Impairments	
		Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments	PQRI: GPRO
		Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments	PQRI: GPRO
	Cataracts	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery	PQRI: GPRO
		Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	PQRI: GPRO
	Elderly Health	Physical Activity in Older Adults	HEDIS 2011
		Falls: Screening for Risk	National Quality Forum: AQA EHR measure
		Management of Urinary Incontinence in Older Adults	PQRI, HEDIS 2011
	End of Life Care	Advance End-of-Life Care Plan	National Quality Forum: AQA EHR measure
Domain 5: Preventative Health			
		Adult Weight Screening	PQRI: GPRO, HEDIS 2011, HSAG: HEDIS and MSSP: GPRO
	Medication Monitoring	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	PQRI: GPRO, and HEDIS 2011
		Annual Monitoring for Patients on Persistent Medications	HEDIS 2011 HSAG: HEDIS
		Drugs to be Avoided in the Elderly (Use of High Risk Medications and Potentially harmful drug-disease interactions)	PQRI: GPRO, HEDIS 2011, and MSSP: GPRO

	Arthritis	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	PQRI: GPRO and MSSP: GPRO
		Rheumatoid Arthritis (RA): Tuberculosis Screening	PQRI: GPRO
		Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	PQRI: GPRO
		Rheumatoid Arthritis (RA): Functional Status Assessment	PQRI: GPRO
		Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	PQRI: GPRO
		Rheumatoid Arthritis (RA): Glucocorticoid Management	PQRI: GPRO
		Osteoarthritis (OA): Function and Pain Assessment	PQRI: GPRO
		Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications	PQRI: GPRO
	Pain Assessment	Use of Imagining Studies for low back pain	HEDIS 2011 HSAG: HEDIS
		Back Pain: Initial Visit	PQRI: GPRO
		Back Pain: Physical Exam	PQRI: GPRO
		Back Pain: Advice for Normal Activities	PQRI: GPRO
		Back Pain: Advice Against Bed Rest	PQRI: GPRO
		Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	PQRI: GPRO
	Asthma	Use of Appropriate Medication for People with Asthma	HEDIS 2011 National Quality Forum: AQA EHR measure
		Asthma: Asthma Assessment	PQRI: GPRO National Quality Forum: AQA EHR measure
		Asthma: Pharmacologic Therapy	PQRI: GPRO National Quality Forum: AQA

			EHR measure
		Asthma: Tobacco Use: Screening - Ambulatory Care Setting	PQRI: GPRO
		Asthma: Tobacco Use: Intervention - Ambulatory Care Setting	PQRI: GPRO
	Influenza	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	PQRI and MSSP: GPRO
		Flu Shots for Adults Ages 50-64	HEDIS 2011 National Quality Forum: AQA EHR Measure
		Flu Shots for Older Adults	HEDIS 2011
		Pneumonia Vaccination	National Quality Forum: AQA EHR Measure
		Pneumonia - Pneumococcal Vaccination Status Assessed	National Quality Forum: HQA EHR Measure
		Pneumonia - Influenza Vaccination Status Assessed	National Quality Forum: AQA EHR Measure
	Breast Cancer Screening	Mammography Screening	HEDIS 2011, PQRI, MSSP National Quality Forum: AQA EHR Measure
		Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	PQRI: GPRO
		Radiology: Reminder System for Mammograms	PQRI: GPRO
	Colon Screening	Colorectal Cancer Screening	HEDIS 2011, PQRI, MSSP National Quality Forum: AQA EHR

			Measure
		Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	PQRI: GPRO
	Cervical Screening	Cervical Cancer Screening	HEDIS 2011 National Quality Forum: AQA EHR Measure
	Screening for Chronic Conditions	Blood Pressure Measurement	HEDIS 2011, PQRI, MSSP HSAG: HEDIS
		Comprehensive Diabetes Care	HEDIS 2011, PQRI, MSSP
		Cholesterol Management for Patients with Cardiovascular Conditions	HEDIS 2011, MSSP, PQRI
	Mental Health	Screening for Clinical Depression and Follow-Up Plan	MSSP: GPRO, PQRI
		Major Depressive Disorder (MDD): Suicide Risk Assessment	PQRI
	Tobacco and Alcohol Use	Tobacco Use: Screening and Cessation Intervention	HEDIS 2011, MSSP, PQRI
		Tobacco Use Query	National Quality Forum: AQA EHR measure
		Advising Smokers to Quit	National Quality Forum: AQA EHR measure
		AMI - Adult Smoking Cessation/Counseling	National Quality Forum: HQA EHR measure
		Heart failure - Adult Smoking Cessation Advice/Counseling	National Quality Forum: HQA EHR measure
		Pneumonia - Adult Smoking Cessation Advice/Counseling	National Quality Forum: HQA EHR measure
		Preventive Care and Screening: Unhealthy Alcohol Use – Screening	PQRI: GPRO
	Chest	Preventive Care and Screening: Pneumonia	HEDIS 2011,

	Evaluation	Vaccination for Patients 65 Years and Older	MSSP, PQRI
		Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	HEDIS 2011, PQRI HSAG: HEDIS
		Use of Spinometry Testing in the Assessment and Diagnosis of COPD	PQRI: GPRO, HEDIS 2011
	Eye Evaluation	Glaucoma Screening in Older Adults	HEDIS 2011
		Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	PQRI: GPRO
		Chlamydia Screening • 16-20 • 21-24 • Total	HSAG: HEDIS