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IPRO
Experts in Defining and Improving the Quality of Health Care

Health Care Quality Watch

MONTHLY NEWS BRIEFS FOR MANAGERS AND OPINION LEADERS

The most recent health care performance data posted to the WhyNotTheBest website demonstrate improvement in the number of acute care hospitals in the U.S. that get high marks from patients, according the New York City-based Commonwealth Fund. In March 2008, 2,500 hospitals reported high ratings in response to the question: "How do patients rate the hospitals overall?" More recent responses show that as many as 3,700 hospitals now receive highly favorable responses to the same question, which is drawn from the nationally recognized Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The website offers side-by-side comparisons on 4,500 hospitals across the U.S., shows how an individual hospital's performance trends against numerous benchmarks when measured over time and offers providers practical tools and resources they can use to improve performance on those same quality indicators. The Commonwealth Fund plans to add data on mortality, readmissions and cost to the website later this year. IPRO's e-Services Group developed and maintains the site: *www.whynotthebest.org*.

IPRO has been awarded a Medicaid Integrity Program (MIP) Task Order by the Centers for Medicare & Medicaid Services (CMS). Under this Task Order, IPRO will audit Medicaid claims to identify potential overpayments. The MIP is the first coordinated, federal program to help states reduce Medicaid provider fraud, waste, and abuse. The program was created in 2006 as part of the federal Deficit Reduction Act of 2005 and is overseen by the CMS. Cornerstones of the MIP are contracts awarded by the CMS to IPRO and other companies to conduct audits of Medicaid claims of providers across the country. With the award to IPRO, CMS has awarded four such contracts, covering 40 states, the District of Columbia, and five territories. IPRO will perform Medicaid provider audits in CMS' Region I, which includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont, as well as in Region II, which includes New York, New Jersey, Puerto Rico, and the Virgin Islands. The contract is valued at $5.5 million for the base year and may be renewed, on an annual basis, for up to four additional years, upon successful performance determinations by CMS. Key IPRO personnel, including the project director, Joseph L. Guy, Ph.D., formerly with the New York State Department of Health, Medicaid program, will be located in the company's Albany, New York office. Assisting with cost report audits will be Toski, Schaefer & Co, a CPA firm located in Williamsville, New York, as well as Digital Harbor, a software solutions company based in Reston, Virginia.

This fall the state of Illinois will begin online publication of hospital-acquired infection rates, nurse-to-patient staffing ratios and cost and volume information for selected procedures performed at hospitals and surgery centers. The state health department hasn't yet determined whether the initial data run will present aggregate or institution-specific data, according to a recent report in the *Chicago Tribune*. The ultimate goal, however, is to report data on an institution specific basis. Online performance reporting was mandated by a state law passed in 2004. IPRO's e-Services group was selected under a competitive procurement to analyze the data and create the Illinois website.

Despite a nearly 100 percent increase in average family premiums since 2,000, the overall quality of care in New York is just average, according to new state-by-state analysis released this summer by U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius. As many as 17 percent of children in New York are obese, while 18 percent of women over age 50 haven't received a mammogram in the past two years, according to 2007 data from the National Survey of Children's Health and the U.S. Centers for Disease Control and Prevention. The analysis finds that a third of New York men over age 50 have never had colorectal cancer screening. Twelve percent of New Yorkers says they haven't visited a doctor because of high costs. Family premiums in New York now average $13,971, which is roughly equivalent to the annual paycheck of a minimum wage worker. State-by-state cost and quality profiles are available at *www.HealthReform.gov*.

Providers will be able to request independent external appeals of managed care coverage denials in New York, under a new law just signed by Governor David A. Paterson. Prior to the new law's enactment, external appeals could only be filed by managed care enrollees and their representatives. By extending the right of a concurrent review to providers, the state is likely to experience a higher level of appeals than is currently the case. The new state law also establishes a new appeals standard for rare disease treatments and extends certain consumer protections to enrollees of plans that are similar to HMOs but not licensed as HMOs. Additionally, the new statute bars insurers from treating an in-network provider as an out-of-network provider in instances when the referring provider happens to be out-of-network. IPRO currently performs independent external appeals in the following states: Arkansas, Colorado, Connecticut, Maine, Maryland, Massachusetts, New

Hampshire, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, Vermont, Washington, Wisconsin, and the District of Columbia.

Hospital-specific 30-day readmission rates are included among the performance measures now reported on the federal Medicare Compare website (*www.MedicareCompare.gov*). The measure focuses on fee-for-service Medicare patients who are at least 65-years old and were first hospitalized with a principal diagnosis of acute myocardial infarction, health failure or community-acquired pneumonia. The data are risk-adjusted and show whether a hospital's rate is lower than the national rate, no different from the national rate or higher than the national rate. The findings include readmissions to the same or different hospital, for the same or different reason. A recent study in *The New England Journal of Medicine* found that almost one-fifth of Medicare patients are rehospitalized within 30 days and more than a third of patients are rehospitalized within 90 days. Overall, the authors estimated that unplanned rehospitalizations cost Medicare $17.4 billion in 2004. IPRO is one of 14 Quality Improvement Organizations nationwide with special federal funding to address care transitions and to work with providers to reduce avoidable readmissions. IPRO's three-year project is underway in the Upper Capital Region of New York and takes an innovative approach emphasizing collaboration across care settings and among distinct provider groups to better coordinate care delivery. For more information on the project, visit *www.ipro.org*.

The State of New York's second public report on hospital-acquired infections, and the first to identify individual hospitals by name, finds a statistically higher rate of infections from hip replacement surgery at institutions performing fewer than 50 procedures a year. The report issued this summer shows no statistically significant difference between the state's 1.3 percent rate of surgical site infections (SSIs) for 2008 and the national rate of 1.5 percent for 2006-2007. The state found no significant regional differences in SSI rates and found that a majority of New York hospitals had either one or no hip SSIs in 2008. The other SSIs selected for reporting include colon infections, coronary artery bypass graft (CABG) surgical site infections, central line-associated bloodstream infections in intensive care units (ICUs) and umbilical catheter-associated infections in neonates. The report finds colon and CABG SSIs to be lower than national rates but central line-associated bloodstream infection rates in ICUs to be the same or higher than national rates for 2006-2007. New York is one of 25 states with laws requiring public reporting of surgical site infection rates, according to a survey conducted at the end of last year by the Committee to Reduce Infection Deaths. To view the state report, go to *www.nyhealth.gov/statistics/facilities/hospital/hospital_acquired_infections/*.

While a majority of New York Medicaid recipients are enrolled in managed care plans, the majority of costs are still incurred in the fee-for-service sector, according to a recent report from the Medicaid Institute at the United Hospital Fund (UHF). The authors note that the sickest and most disabled seniors are exempted from joining Medicaid managed care plans, as are the most vulnerable non-elderly recipients. For this reason, they argue, it is essential to use predictive modeling to identify patients at highest risk of hospitalization and to improve service delivery to reduce reliance on costly inpatient services. Using fee-for-service Medicaid claims information, the authors present five different case studies that illustrate important cost and quality issues. In one case, a 57-year old man with numerous health issues was hospitalized 10 times at four different hospitals in 2005 at a cost of $182,000 but with no evidence of having filled any prescriptions. In another case study, a 62-year old male diabetic with hypertension, congestive heart failure and other illnesses averaged 99 inpatient days of treatment and $158,000 in costs over a three-year period, but had only four primary care visits and one filled prescription during the same timeframe. *Rethinking Service Delivery for High-Cost Medicaid Patients* is available at *www.medicaidinstitute.org*.

The U.S. Agency for Healthcare Research and Quality (AHRQ) has outlined its plans to spend $300 million in federal stimulus funding to support Comparative Effectiveness Research (CER). Total two-year American Recovery and Reinvestment Act funding for CER is $1.1 billion, with $400 million slated for the National Institutes of Health and $400 million to be spent at the discretion of the Secretary of Health & Human Services. AHRQ intends to devote its funding to discrete activities including "horizon scanning," evidence synthesis, identification of evidence needs and gaps, evidence generation and dissemination and translation of findings. The initial 14 areas of inquiry include arthritis and nontraumatic joint disorders, cancer, cardiovascular disease, dementia, depression, developmental delays, diabetes, functional limitations and disability, infectious diseases including HIV/AIDS, obesity, peptic ulcer disease, pregnancy, pulmonary disease and susbstance abuse. AHRQ also plans to fund clinical scientist development programs, institutional research training and a "Citizen Forum" to engage stakeholders in CER goals and findings. For additional information on AHRQ's CER Operating Plan, visit *www.ahrq.gov.*

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We welcome your comments and suggestions. Please forward them to the Editor, Spencer Vibbert, at **svibbert@ipro.org**.

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