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Healthcare Quality Watch

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NEWS BRIEFS FOR MANAGERS AND OPINION LEADERS

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IPRO Supports Chronic Care Quality Evaluation

New York is ahead of other states in developing quality measures for poor and elderly residents with multiple chronic conditions, by virtue of early work done by the New York State Department of Health and IPRO. That's a finding included in a new report from the United Hospital Fund that examines the need for measures addressing the quality of services provided to "dual eligibles" who qualify for Medicare and Medicaid, as well as individuals with multiple physical and mental health deficits and long term care needs. The report author notes that beginning in April 2012, adult dual eligibles in need of more than 120 days of community-based long term care will be required to be enrolled in managed long term care plans or long-term care coordination programs. In relation to other states, New York is viewed as in "an enviable place" in developing quality measures for individuals with multiple chronic conditions. The author singles out the New York State Department of Health's (NYSDOH's) Quality Assurance Reporting Requirements; the managed long term care plan member satisfaction survey created by IPRO; and the managed care Supplemental Security Income (SSI) survey developed by IPRO and NYSDOH to assess services provided to blind and disabled seniors. "Quality measures for high-risk populations should be closely aligned with requirements for care management organizations," according to study author Alice Lind, RN, MPH, of the New Jersey-based Center for Health Care Strategies, Inc. For a copy of "Measuring Quality for Complex Medicaid Beneficiaries in New York," visit UHF's website at www.uhf.org.

CMS Names 73 "Innovation Advisors"

Seven New Yorkers are among the first group of "Innovation Advisors" selected by the U.S. Centers for Medicare & Medicaid Services (CMS) to test new models of healthcare delivery. CMS announced the first 73 individuals chosen to participate in the program in December 2011; the agency plans to select as many as 200 Advisors during the first full-year of the national program. In order to participate, advisors must be experts in healthcare economics and finance; population health; systems analysis and/or operations research. Eligibility is limited to individuals employed by public health or healthcare facilities, institutions or departments. Advisors are required to spend at least 10 hours per week on a specific project during an initial six month period. The Program is administered by the CMS Innovation Center. New Yorkers included in the initial announcement hail from Mount Sinai and Montefiore Medical Centers in New York City; the University of Rochester Medical Center; Catholic Health Services of Long Island; the Westchester County Health Care Corporation and Empire State Medical Associates of Roosevelt Island. For more information about the program, visit the CMS website at www.cms.gov.

Feds Publish Medicaid Quality Measures

The U.S. Department of Health & Human Services has published an initial core set of 26 quality measures for states to use in evaluating the performance of Medicaid programs, applicable to both managed care and fee-for-service providers. As mandated by the Affordable Care Act, HHS was charged with developing a uniform set of performance measures in advance of implementing a national, voluntary Medicaid public reporting program to begin in the fall of 2014. Of the 26 measures included in the final notice published in the January 4, 2012 *Federal Register,* twelve address prevention/health promotion; three address acute conditions, seven address chronic care, and two address family experiences, with a single care coordination measure and another addressing availability of care. The vast majority of measures are derived from the National Committee for Quality Assurance (NCQA) and the U.S. Agency for Healthcare Research and Quality. According to HHS: "States

that choose to collect the initial core set will be better positioned to measure their performance and develop action plans to achieve the three part aims of better care, healthier people, and affordable care as identified in HHS' National Strategy for Quality Improvement in Health Care." For more on the National Quality Strategy, visit www.ahrq.gov/workingforquality/nqs/.

NY Workgroup Offers Medicaid Reform Package

The Payment Reform and Quality Measurement Work Group of New York's Medicaid Redesign Team released its final recommendations in December. Chaired by Dan Sisto, President of the Healthcare Association of New York State, and William Streck, MD, Chair of the New York State Public Health and Health Planning Council, the 21-member Work Group agreed on four goals: (1) seek a waiver from the Centers for Medicare & Medicaid Services to integrate Medicaid and Medicare service delivery for 700,000 "dual eligible" individuals with chronic conditions; (2) adopt incentive-based performance reporting across all sectors of the health care system; (3) reform the state's Indigent Care Program using a simple and fair approach that targets uncompensated care and Medicaid service delivery but does not include bad debt; and, (4) establish an Essential Community Provider Network and a Vital Access Providers Program offering temporary funding to facilitate closures and mergers, as well as long-term enhanced reimbursement to financially-stressed providers treating vulnerable populations. The Payment Reform and Quality Measurement Work Group is one of ten panels supporting the State's Medicaid Redesign Team. Phase 1 of the Team's work centered on developing proposals to meet the Governor's first-year budget target. Phase 2 is intended to address multi-year program enhancements. The Redesign Team Chairs are Michael Dowling, President and CEO of North Shore LIJ Health System, and Dennis Rivera, Senior Advisor to the International President of SEIU.

Government Revamps Quality Rules

While adding requirements for hospitals, the new "Conditions of Participation" issued by the Centers for Medicare & Medicaid Services (CMS) will actually save more than $900 million annually in administrative efficiencies, according to senior managers at the agency. "Conditions of Participation" are the quality and safety standards that government survey teams and private accreditation agencies use to evaluate hospitals and other providers during onsite visits. Failure to comply with the conditions can result in penalties, including removal from the Medicare and Medicaid programs. The new conditions for hospitals issued in a proposed federal rule last fall would be the first update of the standards since 1986. Officials at CMS indicate that the agency considered stakeholder input gathered for a year prior to publication. Among the changes are revisions meant to strengthen care coordination between settings and to encourage patient-centered care. Efficiencies include permitting a single governing body for multiple institutions in a hospital system; eliminating a requirement for nursing care plans separate from other care plans; and permitting pharmacies to approve electronic standing orders. To read the proposed rule: "Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation," issued October 24, visit www.federalregister.gov.

Feds Greenlight More Physician Performance Reporting

Qualified non-governmental organizations will be able to publish physician-specific Medicare performance information beginning in 2012, so long as they combine that data with other claims information, according to a final rule issued December 5 by the Centers for Medicare & Medicaid Services (CMS). Under the terms of the final rule, qualified entities can publish Medicare Parts A, B and D claims data that identify physicians while safeguarding the identities of Medicare beneficiaries. The ban on performance data publications consisting solely of Medicare data was included in the authorizing language in the Affordable Care Act; Congress wanted to assure that reports are broadly representative of physicians' entire performance activity, rather than just a portion of it. Publishers will have to demonstrate skill and experience in such areas as risk-adjustment. They will also have to provide 60 day notice to providers and suppliers prior to public reporting of their findings. Consumers groups such as Consumers' Checkbook are generally supportive of the final rule, as are groups like the Business Roundtable. For a copy of Medicare Program; Availability of Medicare Data for Performance Measurement, Final Rule, published December 7, 2011, visit www.Federalregister.gov.

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

IPRO, 1979 Marcus Avenue, Lake Success, NY 11042

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